



**T.C.
ÇANKIRI KARATEKİN UNIVERSITY
HEALTH SCIENCES INSTITUTE
DEPARTMENT OF NURSING
PUBLIC HEALTH NURSING MASTER PROGRAM**

**DETERMINING THE QUALITY OF LIFE OF THE ELDERLY
LIVING IN TURKEY AND IRAQ, AND THE ASSOCIATED
INTERCULTURAL DIFFERENCES**

Master Thesis

Hatem Wahhab Ali AL- YASARI

Çankırı 2021

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THESIS SUPERVISOR

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Çankırı 2021

KABUL VE ONAY

We testify that the Master student (Hatem Wahhab Ali ALYASARI - Student ID : 198205306) at Çankırı University - Institute of Health Sciences - Department of Public Health Nursing has been examined and defended his thesis entitled (Determining the quality of life of the elderly living in Turkey and Iraq, and the associated intercultural differences) and after fulfilling all the necessary conditions determined by the relevant regulations, we saw, as jury members whose signatures are below, that the thesis is sufficient to obtain a master's degree in public health nursing.

Date : 10.03.2021

Members of discussion committee

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ETHICAL DECLARATION

I present to you my Master's thesis entitled 'Determining the quality of life of the elderly living in Turkey and Iraq, and the associated intercultural differences' under the supervision and guidance of my research supervisors including idea and hypothesis, and certify that I have written this thesis according to ethics and scientific values, upon which scientific research is based.

Signature

Date : 10 March 2021

Student

**Hatem Wahhab Ali AL
YASARI**

ACKNOWLEDGEMENT

I dedicate this thesis....

To God Almighty, “Teach human what he did not know“ (علم الانسان ما لم يعلم) he is our creator and our focus on success.

To my parents, mom and dad, who have been my pillars and lifelong support.

To my beautiful family, my wife and daughter, who have been the bright spot in my life.

To my supervisor, Dr. Öğr. Üyesi T. Barış DEĞER, who was the source of my confidence in the success of our work.

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ABBREVIATIONS AND SYMBOLS

QOL	: Quality of Life
WHOQOL	: World Health Organization Quality of Life
WHOQOL-OLD	: Scale for World Health Organization Quality of Life-Older
HRQOL	: Health-related quality of life
AMCI	: Amnesic mild cognitive impairment
CFS	: Chronic fatigue syndrome
IADL	: Instrumental activities of daily life
ADLs	: Activities of daily living
RAC	: Residential age care
SEIQOL-DW	: Schedule for Evaluation of Individual QoL - Direct Weighting
SES	: Socioeconomic status
ADRD	: Alzheimer's disease and underlying dementia
SWB	: Subjective well-being
OQOL	: Overall Quality of Life
OHS	: Overall Health Status

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ÖZET

AL- YASARI, Hatem. Türkiye ve Irak'ta yaşayan yaşlıların yaşam kalitelerinin ve buna bağlı kültürler arası farklılıkların belirlenmesi, (Yüksek Lisans Tezi), Çankırı, 2021

Arka plan: Bireylerin genel yaşam beklentisi dünya çapında artmıştır. Yaşam kalitesi, ekonomik durum ve sağlık durumu, yaşam tarzı ve dengeli beslenme gibi birçok faktörden etkilenebilir. **Amaç:** Çalışma, Türkiye ve Irak'ta yaşayan yaşlıların yaşam kalitesini ölçmeyi, yaşam kalitesine etki eden faktörleri belirlemeyi ve iki ülke arasında karşılaştırmalar yapmayı amaçlamaktadır. **Yöntemler:** Karşılaştırmalı çalışma tasarımı, Irak ve Türkiye'deki yaşlıların yaşam kalitesini karşılaştırmak için Ocak 2020 – Ocak 2021 döneminde gerçekleştirildi. Çalışma, Irak ve Türkiye olmak üzere iki ülkede gerçekleştirildi. Irak'ta araştırmacı, toplumda yaşayan 100 yaşlıyla anket uyguladı. Yaşlılar, Irak'ın Babil şehrinde ikamet edenlerden oluşuyordu. Araştırmacı, danışmanı ile birlikte Türkiye'nin Çankırı ili, ilçe ve merkezinde ikamet eden ulaşılabilen 100 yaşlıyı araştırdı. Görüşmeler yüz yüze yapıldı. Araştırmacılar tarafından tasarlanan Yaşlı Tanıtım Formu ve WHOQOL-OLD ölçeği iki ülkenin yaşlılarından oluşan katılımcılara uygulandı. **Sonuçlar:** Yaşam kalitesini etkileyen faktörler ve iki ülke arasındaki farklılıklar tespit edildi. Iraklı yaşlıların yaşam kalitesi ile yaş, cinsiyet, medeni durum, eğitim, ekonomik durum, kronik hastalıklar, engellilik, ilaç tedavisi, sağlıklı beslenme, egzersiz ve manevi durum arasında önemli bir ilişki vardı. Türkiye'de yaşlıların yaşam kalitesi ile ekonomik durum, kronik hastalıklar, sağlıklı beslenme, egzersiz ve manevi durum arasında anlamlı bir ilişki vardı. **Sonuç:** Türkiye'de yaşlıların yaşam kalitesi Irak'tan yüksekti. **Anahtar Kelimeler:** Ülke, Kültürlerarası fark, Yaşam kalitesi, Yaşlı.

SUMMARY

AL- YASARI, Hatem. Determining the quality of life of the elderly living in Turkey and Iraq, and the associated intercultural differences, (Master Thesis), Çankırı, 2021.

Background: The overall life expectancy of individuals has risen worldwide. Quality of life can be influenced by many factors, including economic and health status, way of life, and balanced diet. **Aim:** The study aims to measure the quality of life of the elderly living in Turkey and Iraq, to determine the factors that affect the quality of life and to make comparisons between the two countries. **Methods:** The comparative study was carried out in the period January 2020 to January 2021 to compare the quality of life of the elderly in Iraq and Turkey. The study was carried out in two countries, Iraq and Turkey. In Iraq, the researcher completed questionnaires with 100 community-dwelling elderly. The elderly people consisted of those who resided in the city of Babylon, Iraq. The researcher, together with his advisor, surveyed 100 elderly people accessible residing in the district and center of Çankırı province in Turkey. Interviews were held face-to-face. The Elderly Information Form designed by the researchers and the WHOQOL-OLD scale was applied to participants consisting of elderly people in both countries. **Results:** Factors affecting quality of life and differences between the two countries were identified. There were significant relationships between the quality of life of elderly Iraqis with age, gender, marital status, education, economic status, chronic diseases, disability, medication, eating healthily, exercise and spiritual status. There were significant relationships between the quality of life of elderly in Turkey with economic status, chronic diseases, eating healthily, exercise and spiritual status. **Conclusion:** Quality of life of the elderly in Turkey was higher than in Iraq.

Key Words: Country, Intercultural differences, Elderly, Quality of life.

1. INTRODUCTION

Aging in normal life is due to the natural alterations in the metabolic activity of organs. The overall life expectancy of individuals has risen worldwide. The longevity of life is influenced by many factors, including heredity, way of life, and balanced diet (Datta et al., 2013).

Aging is a major mechanism common to all living species, involving gene sequencing, cumulating and permanent errors, which means that over time the organism's ability to deal with environmental stress will be reduced and thus its chance of death enhanced. Every person whose life ends with the objective of biological death has a unique and individual life experience, governed by cultural and social patterns (Ferreira et al., 2015).

Aging is a global phenomenon due in large part to reductions in death rates and birth rates. According to demographic projections in the world, the number of elderly people over the age of 60 will be more than the number of children for the first time in the world in 2047. The number of elderly is expected to increase from 841 million in 2013 to more than 2 billion people in 2050 (Miranda et al., 2016).

Everyone has an idea about QOL, but no one really knows what it signifies. John Stewart Mill pointed out that human perceptions of well-being are "the greatest form of information that beats those which anybody else can hold." Therefore, QOL is strongly personal and may also be an 'idiosyncratic puzzle' owing to the great degree of disparity between people (Netuveli and Blane, 2008).

The World Health Organization defines quality of life as an individual understanding their place in life in the context of the structures of societies, beliefs, desires, standards, and interests. Furthermore, the physical, functional, emotional and social factors of well-being are known to be the quality of life (Khaje Bishak et al., 2014).

QOL is usually a subjective and nuanced concept; QOL is a health-related feature. How the person feels about themselves and the degree to which they may carry out their work and efforts are examples of quality of life that is associated with

well-being. Moreover QOL linked to health will experience and convey feelings such as frustration, disappointment, anxiety and satisfaction in the psychological sense. On the other hand, the definition of QOL is also used to test the influence of the disease on QOL (Bilgili and Arpacı, 2014).

QOL is one of the most relevant indicators for geriatrics, gerontology, and gerontology nursing. Maximum quality of life is one of the most significant targets for elderly care and to a degree is a measure of nursing quality (Soósová, 2016).

Elderly people are more likely to have numerous medical problems as their physical and psychological roles are diminished. Factors related to mental disorders may be isolation, impairment of sexual activity and chronic metabolic disorders. This can reduce the senior individual's quality of life (Farzianpour et al., 2012).

Generally, elderly people are exposed to various biopsychosocial changes, such as dysfunction, obliviousness, slow thought, physical fatigue, lower physical stamina, illness, dementia, frailty, immobility, image decline, occurrence of wrinkles, intolerance, flippancy, asexuality, reliance, helplessness, family refusal, neglect, togetherness, melancholy, and gloom (Ferreira et al, 2015).

People's QOL, the belief structure they work in, their targets, aspirations, standards and objectives are linked to community. The perceived QOL is influenced by physical and mental fitness, independence, social ties, personal values or the environment. QOL is one of the theoretical frameworks to test the living standards of human populations (Chruściel et al., 2018).

Quality of life and enjoyment of life are various definitions which are compatible at the same time. The satisfaction with life is a measurement of QOL, as it focuses on spiritual, cognitive, and affective dimensions, on tasks performed separately and on satisfaction with earned social assistance, and is, in general, connected to life expectancy. Instead, quality of life is more closely linked to health factors. In reality, many older people connect quality of life to the capacity to be autonomous in their daily activities, more specifically and pragmatically. This is why it is so important to take into account improvements in self-esteem, fulfillment of working duties, the freedom of the workforce, and a sense of engagement which are essential elements of a whole system compatible with quality-of-life standards for elderly people (García and Navarro, 2018).

Earlier research associated social support with QOL. Social reinforcement involves actual services or supposed resources to make people feel appreciated. For seniors who are dependent on organizations or friends to conduct regular tasks and to promote their well-being, it may be significant. Analysis has shown a strong social link (with family, friends, and neighbors) promotes quality of life. In comparison, diminished social interactions, which may be caused by the lack of members of a social network, were related substantially to low living conditions. Higher social support levels were associated with a lower risk of mental illness, infection, death, and greater quality of life (Onunkwor et al., 2016).

Emotional, social and economic care is offered by the family. The willingness of elderly people to deal with changes in their health, income, social events, etc. depends heavily on the help they obtain from their family members. Most elderly people in India live with their family members and the family is also the biggest supplier of elderly treatment. Eldercare meets the basic interests and needs of elderly people. Traditionally, eldercare is a family member's responsibility and is given within the extended home of the family. Elder care is now given by government or care institutions in western communities. In a social sense, while the role of the family as a key source of support for the elderly seems to be diminishing in the recent past, family networks remain the predominant source of psychosocial care and deep-rooted societal values for the family. Effective family care thus is a core aspect of elderly people's general well-being (Kaur et al., 2015).

Elderly are exposed to more diseases compared to younger adults. Per year, nearly 100,000 deaths are caused by diseases in the elderly worldwide. According to the UN, when the percentage of the elderly in a country is 7%, the country has an elderly population (Doosti-Irani et al., 2018).

A loss in sensory-motor power, decreased strength, flexibility and speed hindering everyday tasks and difficulty sustaining a balanced lifestyle mark the physiological progression of aging. The physiological ability to perform a wide range of tasks can impact, likely influence, the quality of life. Previous studies clearly found diminished breathing capacity with age and the effect of everyday physical activity on this decline (Pernambuco et al., 2012).

Changes that a person undergoes in aging include lower physical skills, a change in the response of the body to medications, essential lives like pension, the

elderly living in nursing homes, lower income and lack of social interaction occasions which contribute to isolation of seniors. This will influence the QOL of elderly people. The key cause of mental health problems is loss of jobs, loss of social status, retirement recession, loss of children and husband, multiple diseases and disability leading to sadness, loss of independence, loss of fixity and economic performance, loss of senses and changes in self-image. These changes in the elderly are dangerous to the mental health of senior citizens (Sherizadeh et al., 2016).

Demographic growth in the group over sixty years of age is a characteristic of the 21st century globally. The World Health Organization refers to a demographic revolution and expects the world's population of 60 years and older to reach 1.2 billion by 2025, while this population will reach 2 billion by 2050. To make aging a positive experience, aging needs to be enabled through ongoing choices for health, participation and protection (Soósová, 2016).

Population aging is one of the major demographic trends in developing countries. In Europe, the percentage of the population aged over 60 years was 25% and in Russia it was 21% in 2017. In 2050, this percentage will be increase to 34% for Europe and 28% for Russia. A growing group of the elderly population deserve to live with respect in the later years of their lives. Better knowledge of old-age happiness and its causes is a critical social concern, apart from a research topic (Kutubaeva, 2019).

Older adult individuals face major changes, including changes in their functions, pension, and the death of their relatives (close friends and family members). These interactions can boost their level of stress and reduce the resources people believe they have in their everyday life (Sachs-Ericsson et al., 2014).

Old age is perceived to be a stereotypical time of progressive decline, thereby increasing the pressure on healthcare in society, while experts reject this predisposition in social narratives on aging. For these reasons and from a holistic viewpoint, empirical studies that allow psychological and overall health to be assessed in the third age are increasingly important (Gerino et al., 2017).

The World Health Organization identified the most important risk factors that appear with advancing age and consider them to be dangerous and affect the activity of the elderly. Among the most important of these factors are: depression, loss of

self-esteem, lack of initiative in daily activities, isolation, and withdrawal from social relationships that lead to feeling lonely all the time (Evaa et al., 2015).

In Iraq, the prevalence of mental disorders among the elderly was one of the most important statistical results, and the percentage was 38.7% according to statistical analysis. The rate of mental disorders was high (55.8%) among the elderly who live in nursing homes compared with the elderly who live with their families (21.5%). When comparing the percentage of mental disorders between the two groups (who live in nursing homes and those who live with their families), it was found that: anxiety (32.6% vs 9.9%), dementia (19.3% vs 5%), depression (35.4% vs 16.6%), and suicide thoughts (25.4% vs 4.4%). The direct and most important factors associated with mental disorders in the analysis include low income, inability to meet the requirements of the person, reliance on others and neglect by parents or care providers. Most of the elderly living in nursing homes in Iraq complained of poor vision and hearing, and the deteriorating economic situation (Ibrahim et al., 2019).

Quality of life in the elderly is affected by many factors. The most important factor is economic situation. It is reported that the quality of life of poor elderly people is lower than those with high income (Jian et al., 2020).

Another factor that has an impact on the quality of life of the elderly is the social security system. Aging is one of the main social threats within the social welfare system. The social security service is one of the programs provided to the elderly in Turkey. A large part of the programs for elderly persons comprise social security for individuals that were employed and are entitled to pensions for a defined period of time. In addition to the social risk reduction duty (old age, loss of ability, workplace disorders, illnesses, motherhood, family income, and unemployment), it also plays a preventive function through social insurance. The social security program ensures that elderly people who are part of the system are shielded from financial distress by changing social factors and provides monthly income and health care support for aged people and their dependents (Top and Dikmetaş, 2012).

Higher freedom, higher marriage, higher income, less illness, and fewer years of tobacco use were reported to increase quality of life scores in Brazil (Gambin et al., 2015).

Access to health care is frequently restricted in low-income nations or in poor capital conditions about the world. Health professionals have no experience in

coping with popular concerns of the aged and options for early diagnosis and conditions treatment may be limited. Increasing access to health services and the quality of geriatric health services will increase the quality of life for the elderly (Tariq and Lafta, 2018).

1.1 Hypothesis of the study

H₀: There is not difference between the quality of life of Iraqis and Turkish old age people.

H₁: There is a difference between the quality of life of Iraqis and Turkish people in old age.

1.2 Aim of the study

The study aims to examine the quality of life of older people in two countries (Iraq and Turkey) and compare the findings about quality of life between Iraqi elderly people and Turkish elderly people.

1.3 Limitations

There was the COVID-19 pandemic in the world during the study. So we could collect the data in the limited time that in August and September. Because there was a restriction on the elderly in the other months.

The study was conducted on the elderly in two-country, but the results of the study don't generalizable to whole the society.

2. GENERAL INFORMATION

Literature review

2.1 Quality of life

Quality of life (QoL) is a general term that involves many definitions and meanings depending on the context under consideration. It is described as a perception that the person has of their place in life in a cultural, social, and environmental context. The quality of service is spacious and includes many domains, including the fields of physics, psychology, society, families, and the environment. Evaluating these domains will illustrate the extended-term effect of disease on the life of a patient. It was found that QoL contributes more to a person's perception of well-being, fitness, and happiness than objective life condition indicators (Barakovic et al., 2020).

The Schedule for Evaluation of Individual QoL - Direct Weighting (SEIQoL-DW) was developed during the last decade and is based on the original SEIQoL. The SEIQoL-DW assesses the perception of individuals about their present QoL and lets them select the domains to be assessed followed by a weighting process that generates qualitative and quantifiable results (Hamidou et al., 2017).

Assessing the advantages of health insurance will help balance limited financial resources in health care by optimizing health benefits. The effectiveness of interventions in health systems is currently best calculated by quality-of-life adjusted years. Quality-adjusted life-years incorporate quality and volume of life in a single dimension. Generic utility measures are commonly used for the measurement of health QoL (Pietersma et al., 2014).

It is important to realize the influence of different socio-demographic factors and how particular symptoms impact the different quality of life domains to improve health and well-being for people living with common health problems. For example, it is very useful to know if these clinical symptoms are special in their contribution over and above the impact of socio-demographic variables on a particular quality of

life domains. These details could have long-ranging clinical implications concerning evaluation and treatment of common health problems in primary care (González-Blanch et al., 2018).

2.2 Domains of quality of life

2.2.1 Physical Health

Around 50 percent of people 65 years and older are at greater risk of having chronic illnesses, often one or more chronic diseases. Heart disease, stroke, cancer, and diabetes are among the most prevalent and expensive chronic illnesses causing 2 - 3 deaths annually. Moreover, people with co-morbidity or multimorbidity (coexistence of two and more chronic diseases) have more complex health requirements than people with single chronic illnesses. They are more likely to have a lower standard of living, greater incapacity, and higher death rates than those with one single chronic disorder (Parker et al., 2014).

Older people have clear links to the degree of disability that is dictated by their age, their illnesses, and their lack of exercise. Aging also entails a greater burden of co-morbidity and greater severity of disease. Aging-related illnesses like cardiac disease, stroke, degenerative arthritis, and falls also reduce the ability of older adults to be active. Disability can be described in various ways, including troubles with activities of daily life (ADL), troubles with instrumental activities of daily life (IADL), and restriction of mobility, disability, and participation restrictions (Chen and Chen, 2017).

The physical impairment burden in the population due to various combinations of chronic conditions must be calculated. Interventions in public health targeting the conditions that increase the risk of incapacity modestly but which are highly prevalent in the population (e.g., heart disease) may impact the incidence of population functional decline more significantly than disability-related conditions that are less prevalent in the population (e.g., stroke, Parkinson's disease, hip fractures) (Raina et al., 2020).

❖ Energy and fatigue

Physical activity is particularly important to the elderly who are active members of society so that disabilities, illnesses, and negative effects of old age can

be reduced to allow older people to continue their lives independently. Fatigue is a significant geriatric condition recently described in the older population and can adversely affect work performance, family life, and social relationships. Although the fatigue rate is 10-25% in the general population, it is as high as 50% in the elderly population. Elderly people with restricted activities are more likely to be exhausted and impairment in elderly women is reported to result in fatigue (Soyuer and Şenol, 2011).

Tiredness is one of the most common reasons for limiting behavior in the elderly population and is also identified as a cause of disability. Fatigue can be overwhelming and distressing, restricting the ability to work and engage in the community, and worsening results for morbidity and death. Promotional studies show that the self-reported fatigue rate among the elderly is high (25% in primary care to 98% in long-term care), although it is unknown if the propagation rates for older adults are higher in comparison with the older ones (Egerton, 2013).

Fatigue is strongly linked to low physical activity and is a good indicator of numerous adverse effects for elderly people (including hospitalization, increased healthcare usage, disability of accidents, life spending). It is normal in many conditions (e.g., cancer, neurodegenerative disorders, rheumatological diseases, cardiac failure) and can, directly and indirectly, affect the health and life quality of the person. In reality, tiredness is a prolonged symptom in many neurological as well as musculoskeletal disorders such as multiple sclerosis, myasthenia gravis, and physical fibromyalgia. On the other hand, the so-called chronic fatigue syndrome (CFS) may be an isolated and chronic symptom with unexplained etiology (Azzolino et al., 2020).

❖ Pain and discomfort

In the United States, persistent pain is projected to be reported by at least 60 – 75% of the population aged 65 years and older and the figure for people in supported accommodation or nursing homes is significantly higher. The most common pain complaint among elderly adults is osteoarthritis, particularly in the low back low or lower neck (around 65 percent), consistent with a greater propagation of chronic medical comorbidity later in puberty, muscle-skeletal pain (around 40%), peripheral neuropathic pain (diabetes or postherpetic neuralgia usually 35%), and chronic joint pain (15%–25%). Epidemiological findings show that age increases the

incidence of pain and women typically experience chronic pain more than men. Surveys in other large studies found that, while the incidence of pain rises with age, the severity of pain during the middle of life (for example 45-65 years) could be greater when extreme pain peaks occur. In older adults experiencing pain, most (60%) claim it is "moderate" and about 25% say it is "severe" (Molton and Terrill, 2014).

Painful neuropathies from diabetes, herpes zoster, chemotherapy, and surgery are particularly frequent in later life. Other pain types, including cancer and cancer pain, are also common in older adults. Advanced phases in several chronic diseases like congestive heart failure, renal disease in the final stages, and chronic obstructive pulmonary disease often include pain. Moreover, millions of joint repair and replacement operations take place each year, and a large number of these patients experience chronic pain despite the intervention. Finally, vertebral compressions are particularly common in older women, which causes severe pain and discomfort (Reid et al., 2015).

The prevalence of chronic pain increases in elderly patients. In elderly patients, the most common reasons for the increase in pain are asthma, cancer, diabetes mellitus, cardiovascular and neurological disorders. Pain will affect the ability of patients to focus, sleep, and cope with stressors of daily life. This means that undertreated pain not only affects patients' QOL but also greatly increases their health care expenses (Robeck, 2020).

❖ Sleep and rest

Aging affects health care systems, largely due to the depletion of physiological and functionally-developed reserves over life. This is a clinical disorder. Similarly, sleep chemistry deteriorates. Sleep complaints increase with age and rhythm changes perturb elderly people. Frequent and long nightly waking, increased nap numbers, and poor sleep quality can lead to degenerative conditions affecting circadian rhythm regulation regions such as the suprachiasmatic nucleus. Visual degradation, depression, dementia, chronic pain, and night life, as well as social and environmental factors, encourage low quality sleep and sleepiness during the day in the elderly. In older populations, sleep disturbances are common. About 50% of elderly people have some difficulty sleeping. Conversely, co-morbidity also leads to issues with sleep. The linkage between chronic diseases and sleep problems

progresses in the form of a vicious cycle either directly or indirectly (Piovezan et al., 2013). Around 40% to 70% of older adults suffer from sleep disorders that can lead to social isolation, decreased physical activity, greater risk of falling, reduced cognitive function, and increased morbidity and death (Sheth and Thomas, 2019).

Elderly individuals with Alzheimer's disease and underlying dementia (ADRD) report extreme dysfunction in sleep and rest vigor, clinically present as prolonged sleepiness, night walking, restlessness, irritability, reverse day-to-day activity, and reduced cognitive functioning (Figueiro et al., 2019).

Sleep disorders, which are normal symptoms in adults, involve caffeine, smoking, and alcohol, sleep patterns, and co-morbid diseases. The following are often diagnosed in subjects who suffer from sleep disturbances: apnea syndrome (SAS), restless leg syndrome (RLS), rapid eye motion (REM), sleep behavior disorder (SBD), and psychological disorders like depression and anxiety. Modern life is marked by shortened periods of sleep and bad sleep due to lifestyle changes (watching television late at night) (Suzuki et al., 2017).

2.2.2 Psychological

Emotional issues in the elderly have become one of the main health problems. Depression is the most common psychiatric condition in elderly adults for mental health and chronic medical treatment. Common signs include constant depression, slowed emotions, unnecessary financial concerns, and medical conditions, tearfulness sometimes, feeling useless and powerless, weight changes, pace or fidgeting, attention difficulties, sleep problems and somatic complaints like unforeseen physical discomfort, gastrointestinal problems, and withdrawal from social interactions. Depression in elderly people is frequently related to medical emergencies irrespective of their severity and decreases the capacity of recovery in the long term (Jha et al., 2019).

Depression is treatable but impairing and is one of the main health challenges for elderly people. Moreover, the risk of depression is also raised in residential age care (RAC). Depression occurrence is estimated to range from approximately 9 to 50% based on the stated (major or minor) severity of depression, the form of residential age care (level of care is low or high), and resident cognitive state. However, there is some controversy about the propagation of depression among RAC residents, partially because of the use and awareness of various depression

interventions, but there is unanimity that depression is a major impediment to the health of the population. Depression is strongly associated with quality of life and with self-concept bi-directionally. Analysis shows that this cohort has substantially greater pessimistic conceptions of themselves than elderly people living alone, in addition to the high incidence of depression and suicide ideation among RAC residents (Gracea and Toukhsati, 2014).

❖ **Bodily image and appearance**

Bodily image is a systemic, emotional, affective, aware, and unconscious representation where people reflect on their bodies as they grow and socially (Farias et al., 2018).

Eventually, younger people will become adults, but people who are in late middle age are mindful of the stigma inherent in growing old and may be at risk of reduced psycho-psychological well-being as they transition to a lower status community. In other words, women are regularly judged by their bodies and conventional beauty ideals allow for young appearance. Women may be especially vulnerable to discrimination on the grounds of age. Since noticeable aging signs such as wrinkles and gray hair also offer social importance to people, ageism is focused on the ideals of beauty that are based on a youthful body (Sabik, 2015).

❖ **Feelings**

Good adaptation in older age is related to the equilibrium of positive and negative influences, the identification of positive targets for psychological and emotional exploitation, the reduction in severity and inconsistency of positive and negative expertise, and the capacity to experience more nuanced emotional expertise, to consider one's thoughts and emotions, and to appreciate them (rather than information and status, which are typical themes of youth and adult life) (Cachioni et al., 2017).

The psycho-effects that can contribute to depression in the brain, effects of chronic pain, biological influences of certain conditions and drugs, and social constraints that certain disorders impose on the way older people live lead to loneliness and solitude. Loneliness is a subjective, negative feeling related to insufficient social relationships of the individual. The effects of isolation may be

severe in terms of health. It is a significant cause of suicide and suicide attempts. It contributes to depression (Singh and Misra, 2009).

❖ **Thinking, learning, memory, and concentration**

Dementia is a more prevalent condition in the elderly. The most prevalent type of dementia is the Alzheimer's disease which affects over five million people in the U.S. Alzheimer's disease begins with loss of memory, language, and critical reasoning difficulties (Sabayan and Sorond, 2017).

Memory deficiencies in the older adult community are a common subject in mainstream culture, such as the notorious "senior moment." Young and older adults agree that memory reduces with age and decreases may be highly important for concerns about the possible development of dementia in older people. Age improvements in metamemory and reduced memory complaints are well-known in older people (Ossher et al., 2013).

Memory changes are an ordinary aspect of the mechanism of aging. Older people have more memory loss than normal for their age, which may reflect an amnesic mild cognitive impairment (AMCI). AMCI involves subjective and quantitative memory alterations and is associated with the absence of pervasive cognitive decreases or functioning in everyday life and is considered a risk factor for Alzheimer's disease. AMCI memory impairments are more substantial than those found with natural age, but less severe than Alzheimer's disease memory impairments. Similarly, people with moderate cognitive disabilities experience changes in social and family roles, humiliation and guilt, emotionality, burden, anger, lack of self-confidence, and distress with recognized memory issues (Parikh et al., 2016).

2.2.3 Level of Independence

The purpose of modern society is to enhance the quality of life. Quality of life research measures health because poor health will restrict everyday mobility and the ability to travel and function. The physical losses which occur with increasing age and result in decreased muscle strength or muscle power may be the leading cause of limitations in daily mobility. These losses decrease the functional potential for activities such as level walking or stepping, including ability and strength (Grimmer et al., 2019).

Age-related physiological changes contribute to a decline in functional capacities in the course of population aging. Decreasing functional skills contribute to difficulties with self-care, everyday tasks, and psychosocial issues. Advancing age increases disability in basic physical, intellectual, and moral functions due to chronic disease and limitations. These disabilities obstruct routine tasks and instrumental daily life activities (IADLs) with age. Age, chronic disease, exercise, walking problems and fear of falling all pose risks for functional independence (Bozkurt and Yılmaz, 2016).

❖ **Mobility**

Mobility is important for active aging and is closely related to health and living standards. Decline predictors can be used to avoid issues, focus on health and social care and offer greater awareness of the disability process. The three primary causes of mobility deficiency are pain, obesity, and fracturing. Musculoskeletal pain mostly increases the risk of movement disability for seniors even after tolerance to other causes like depression, multiple chronic illnesses, and muscle strength (Khan, 2017).

In a more mature generation, urban facilities such as food markets, doctor offices, banks, and other vital facilities are also more difficult to reach and it is harder to engage in socio-cultural events. Decreased mobility is an indicator of institutionalization, failing, dependency and mortality and inversely related to health and quality of life (Giannouli et al., 2016).

Growing questions about aging processes such as physical and morphological changes and particularly their effect on mobility also increase among this segment of the population. Mobility applies to all types of motion, moving from a bed to a chair, to recreation and daily tasks, such as climbing a flight of stairs and moving on the pavement among others. Mobility also involves physical and work-related tasks; for example, driving a vehicle and various modes of public transport (dos Santos et al., 2017).

❖ **Activities of daily living**

The basic tasks of everyday life, such as feeding, washing, dressing, toileting, and transferring (e.g., getting into and out of a bed or chair) are included in "activities of daily living" or ADLs. When people cannot do these things, they need

support from other people or automated equipment, or both to deal with them. Problems in the everyday life of individuals with arthritis, osteoporosis, and stroke are diagnosed and highly prevalent. General health assessments such as diagnosis or medical conditions are minimal indicators of an individual's independence and functionality (Hoyt, 2018).

ADL is used as a functional status indicator for an individual. The failure to carry out ADLs results in becoming dependent on other persons or mechanical devices. The inability to carry out essential daily living activities can lead to unsafe and poor living conditions (Guidet et al., 2020).

Decline or impairment in physical function arises from many conditions. Aging is an environmentally friendly process that may lead to a decrease in the functionality of patients and is a common cause of ADL loss. Conditions of the musculoskeletal, neurological, circulatory, or sensory systems may lead to a decline in ADL functions. A decline in cognition or intelligence may also contribute to deficiency in activities of daily living. Extreme cognition fluctuations in patients with dementia lead to reduced physical function that has a detrimental effect on QOL. Social isolation can deteriorate the experiential activities of daily life. Other factors like adverse drug reactions, social isolation, or the home environment of the patient can influence ADLs (Geriatric Medicine Research Collaborative, 2019; Edemekong et al., 2020).

❖ **Dependence on medications and medical aids**

Longer lifetime involves a common worry that higher illness levels will lead to decreased capacity and mobility as health and welfare demands increase. Increased longevity in very old age does not always lead to further population impairment and reliance on selective mortality of the most dependent; however, it is unclear if this observation will proceed with advances in medical technology. Moreover, the expected reduction in conventional formal and unpaid family support at home and by long-term residential care staff, and social spending cuts affecting discharge from hospitals, will be key problems for aging communities worldwide (Kingston et al., 2017).

Functional dependency is the failure to conduct everyday life tasks. In the elderly, this can lead to health issues, depression, loneliness, and dependence; thus, rehabilitation and family support are necessary to promote the return to everyday life,

and the recovery of autonomy, which is central to quality of life. However, there are obstacles to this autonomy, including the absence of physical facilities inside and outside the house, overprotective relatives that frequently handle them incompetently leaving the elderly in complicated and difficult circumstances and discouraging them from carrying out activities which they can still perform (de Oliveira and Pedreira, 2012).

Older adults constitute a very important group of healthcare users and the effect of their treatment on healthcare expenditures is huge. As a frequent user of medical care, many older adults across the globe still have vital participation in their everyday lives. With the 'third generation' prolonged over longer average lives, even older people with both chronic and acute health conditions and health care systems can sustain their lives over longer periods (Wyman et al., 2018).

2.2.4 Social Relations

Many respondents claim that they have a deep desire and a better QOL if they are surrounded by those they know well. If you have someone you can rely on or call for help nearby, you will be more comfortable. Often community or social resources were found to be valuable. Many people indicated that a good neighbor relationships enhances their QOL. In the last 100 years, the living standards of older people have improved. While the majority of the elderly lived with their children in the early 1900s (if they had them), the majority live with their wives alone today or exclusively (Cantarero and Potter, 2014).

It is understood that social contact with elderly people are inspired by activities that offer positive support and successful social connections. Social contacts that are consistently established are those that have more value as social assistance brokers. From this perspective, there is the promotion of educational programs for this age group. These programs, which can include physical and therapeutic experiences, meaning and happiness with life, play an important role in the establishment of subjective well-being (SWB) for the elderly through engagement and social responsibility suggested by them and by the chance to learn, develop and sustain social awareness and life (Mackowicz and Wnek-Gozdek, 2016).

In the elderly, people experience shifts in their social networks which can conflict with their access to social care. Renaissance and wellbeing conditions continue to minimize social contact, people begin to rely more and more on their

intimate partners (Waite and Das, 2010). As a result, elderly adults become dependent on social support from friends and family members (Williams, 2015).

Social partnerships can be seen as a form of social capital for the elderly, an essential resource for life that helps in times of difficulty, supports in times of pain as well as providing knowledge in times of need. Social interactions can also include detrimental human relationship factors that may serve as a cause of tension and terror. The range of social relations in which elders may participate include formal (ties to the government, healthcare providers, and/or other organizations) and informal (family, friends, neighbors) support (Ajrouch et al., 2017).

2.2.5 Financial resources

When elderly adults retire, they face expanded financial and healthcare management obligations, undertake actions previously handled by employers for medical, medicine, and life insurance policies based on employers' wishes and perhaps even more significantly, their supportive services. Meanwhile, healthcare and the arrangements of healthcare plans are becoming more complicated in a fast-moving healthcare environment, costs are changed more regularly, and coverage of pharmaceutical drugs by prescription programs is constrained. Furthermore, many older adults have inadequate financial and health education to resolve these many issues (MacLeod et al., 2017).

The literature extensively recorded the favorable correlation of the elderly with socioeconomic status (SES) which can be summarized into two perspectives: social cause and health selection. Social causes indicates that the person's health level is related to the role of the social system. People with higher socioeconomic status have greater health benefits than people with lower socioeconomic status. Higher working and living environments can also reduce the risk of harm to health. High incomes enable individuals to build a reasonably healthy lifestyle and enhance access to medicine and service (Wang et al., 2018).

While the numbers of the elderly affect potential social care expenses, the key drivers of funding are problems in performing simple self-care tasks. Discrepancies in health and disability among older people in the sense of different social class indicators were well reported. In comparison, older adults typically have access to financial support for life, and they have more significant associations with physical

disabilities than their role in earlier adulthood (education, occupation, or social class) (Morciano et al., 2015).

Older frail men and women are more likely to die than those who are not frail, institutionalized, or have reductions in work. Frailty is a lack of potential for reserves in one or more usable areas that makes people vulnerable to all forms of internal and external stressors. Strong socio-economic status (SES) prevents fragility. However, the longitudinal link between these variables over the long term remains unclear. In lower socioeconomic classes, the growth of fragility will be faster in the future than in higher socioeconomic groups (Hoogendijk et al., 2018).

2.2.6 Spirituality/Religion/Personal beliefs

As Imam Ali said 14 centuries ago (May God's blessing be upon him), "be mindful that poverty is more dangerous than suffering and that physical ill-health is much worse than a heart's disease, and note that the greatest blessing is heart-piety, accompanied by, in important respects, body-health and financial protection." Imam Ali also recommended that the influence of priests and worship of God on physical and psychological well-being be avoided with meditation on suffering, and difficulties (Tabei et al., 2016).

Spirituality can be conceptualized (i.e. neuroticism) as the results suggest that spirituality is strongly associated with negative personality attributes (e.g., extraversion) and negatively associated with negative personality qualities. In every single person and community, there is spirituality, regardless of individual membership of any particular religious group. The supposition is that spirituality is a positive feature of a healthy aging process and one of the predictors of the longevity of a person over the years (Hajinejad et al., 2019).

Patient aging internationally focuses on modifiable factors that may improve health in the future. Religiousness and spirituality were demonstrated to be among these causes. The elderly population tends to have a high degree of religious and/or spiritual activity and the rising prevalence of religious and spiritual activity worldwide can be related to an aging population (Zimmer et al., 2016).

Old age and spirituality are themes that have long been distant from the focus of the interest in scientific discussions. Old age was considered only because of the end of life and spirituality – the search for the meaning of life was always seen as

something within contrary orientation to the rationality of science (Chaves and Gil, 2015).

The structure, importance, and interpretation of daily lives and support when faced with life challenges remain central for many people. Faith, spirituality, and/or belief remain. The literature recognizes the potential health, well-being, and quality of life (QOL) advantages, especially for elderly people, of faith, spirituality, and/or belief. However, many in the UK today have ambiguous, customized spiritual values unconnected to religion and this is a relatively bad and untested resource to cope with aging (Malone and Dadswell, 2018).



3. MATERIAL AND METHOD

3.1 Study design

The study was descriptive and cross-sectional. The comparative study design was carried out in the period from January 2020 to January 2021 to compare the quality of life of the elderly in Iraq and Turkey. The process started with the submission of the thesis proposal to the Institute of Health Sciences in February. After the thesis topic was accepted by the institute, an application was made to the Ethics Committee in May. Data began to be collected in July after the approval of the ethics committee in June. The study, whose statistics were finished in November, began to be written in December and was presented on March 10, 2021.

3.2 Sampling and data collection

The study was carried out in two countries, Iraq and Turkey. Convenience sampling methods were used. Elderly people who were available and who volunteered to participate in the study were included. Data collected from 100 elderly people in Iraq in July. The elderly people consisted of those who resided in the city of Babylon, Iraq. Questionnaires were conducted face-to-face with the elderly and informed consent was obtained. The researcher together with his advisor surveyed 100 elderly people residing in the district and center of Çankırı province in Turkey. The Turkish Government has imposed a ban on the elderly due to the COVID-19 pandemic that has occurred in Turkey. Data were collected after the ban on the elderly was lifted in August and September. Older adults who could be reached and accepted for voluntary study were included. Interviews were held face-to-face and informed consent was obtained from all participants.

3.3 Research instrument

The tool of the research was a questionnaire. The instrument comprised two parts.

Part 1:

The 1st part is related to the sociodemographic characteristics of the sample. It includes questions about sociodemographic features (age, gender, marital status, educational status, no. of children, social security, those lived with, history of chronic diseases, economic status, presence of caregiver, presence of any disabilities, use of medicines, dietary habits, nutritional status, religious status, employment and physical activity). The questionnaire was developed by the researchers and was called the 'elderly introduction form'.

Part 2:

The 2nd part is related to the World Health Organization quality of life module for the elderly. It is a scale called WHOQOL-OLD developed by the World Health Organization specifically for the elderly (WHO, 2006). It is composed of 6 domains. The 1st domain is related to sensory abilities and includes 4 items. The 2nd domain is related to autonomy and includes 4 items. The 3rd domain is related to past, present, and future activities and includes 4 items. The 4th domain is related to social participation and includes 4 items. The 5th domain is related to death and dying and includes 4 items. The 6th domain related to intimacy and includes 4 items.

❖ Rating and scoring of the WHOQOL-OLD

The instrument rating and scoring uses a 5-point Likert scale with 1 point for none, 2 points for sometimes, 3 points for moderate, 4 points for very, and 5 points for completely.

❖ Instrument validity and reliability

The Turkish validity and reliability study for the WHOQOL-OLD was conducted (Eser et al, 2010). This study shows it is a general-purpose improved quality of life scale for the elderly not only in Turkey, for the first time in a geographical area covering the Eastern Mediterranean and the Middle East (Eser et al, 2010, p:39).

Power analysis was done before starting study, and it was arranged with 100 subjects in each group, determined with 76.324% power. Reliability was made for the WHOQOL-OLD scale in the study. Cronbach alpha (α) coefficient was used for reliability analysis.

In the questionnaire, there is no item with a total correlation value of less than 0.20. For this reason, no item was removed due to the high reliability value of all 24 items. As a result of the application as a result of the item analysis, the result of 24 items was found in our favor. Then, the reliability coefficient of the questionnaire was examined. The ways to calculate the reliability coefficient differ according to the type of variables, source, number of applications. The difference in the way of calculation also changes the interpretive meaning of the reliability coefficient. The reliability coefficient is the degree of purity from random errors and gives information about the amount of error involved in the measurement results. Reliability is required to take values ranging from 0 to +1, but values must be close to +1. It is a desired result that the reliability coefficient is more than 0.70. Since each item of the measurement tool is scaled between 1 and 5 Likert-type, there is a reliability meaning in terms of cronbach's alpha (α) reliability and internal consistency.

The cronbach alpha (α) coefficient of the questionnaire used in the study; sensory ability 0.865, autonomy 0.67, past, present and future activities 0.766, social participation 0.821, death and dying 0.629 and intimacy 0.757 were found in Iraq. Sensory ability 0.644, autonomy 0.65, past, present and future activities 0.784, social participation 0.803, death and dying 0.89 and intimacy 0.787 were found in Turkey. Cronbach alpha was calculated for the 24 items used in the application. Reliability coefficient of 0.72 in Iraq, 0.776 in Turkey, and was found 0.748 for the full scale. Since this coefficient was above 0.70, the scale was accepted appropriate.

3.4 The ethical dimension

The present study was submitted to and approved by the Ethics Committee of the Çankırı Karatekin University (Decision Number: 15 , Date: June 8, 2020), by the Training and Human Development Center Research Unit, Babel health Directorate, Governorate of babel, Republic of Iraq NO: 174 Date: February 10, 2020 (Appendix 3).

3.5 Statistical data analysis

The data obtained in this study were analyzed using the SPSS 21 package program. Normality tests of the data were completed with the Kolmogorov-Smirnov test. Since the data do not show a normal distribution, the Mann-Whitney U test was used for comparisons between two groups and the Kruskal-Wallis H test for comparisons of three or more groups. The level of significance was taken as 0.05 and it was stated that there was a significant difference when $p < 0.05$.



4. RESULTS

4.1 Descriptive statistics

Table 4.1: Sociodemographic data

		Group					
		IRAQ		TURKEY		Total	
		N	%	n	%	N	%
Age	65-84 years	77	77.0	80	80.0	157	78.5
	≥85 years	23	23.0	20	20.0	43	21.5
	Total	100	100.0	100	100.0	200	100.0
Gender	Female	40	40.0	58	58.0	98	49.0
	Male	60	60.0	42	42.0	102	51.0
	Total	100	100.0	100	100.0	200	100.0
Marital status	Married	55	55.0	68	68.0	123	61.5
	Widow	40	40.0	30	30.0	70	35.0
	Divorced	3	3.0	1	1.0	4	2.0
	Not married before	2	2.0	1	1.0	3	1.5
	Total	100	100.0	100	100.0	200	100.0
Education	Non literate	25	25.0	32	32.0	57	28.5
	Quit primary school	20	20.0	8	8.0	28	14.0
	Primary school	15	15.0	39	39.0	54	27.0
	Secondary school	5	5.0	8	8.0	13	6.5
	High school	24	24.0	9	9.0	33	16.5
	University	11	11.0	4	4.0	15	7.5
	Total	100	100.0	100	100.0	200	100.0
Number of child	0-3 >Child	20	20.0	37	37.0	57	28.5
	4-6 Child	45	45.0	40	40.0	85	42.5
	≥7 Child	35	35.0	23	23.0	58	29.0
	Total	100	100.0	100	100.0	200	100.0

The study included 100 elderly individuals living in Iraq and 100 elderly individuals living in Turkey. 77% of elderly people from Iraq were aged 65-84 and 23% were aged 85 and over. 80% of elderly people from Turkey were between the ages of 65 and 84 and 20% were 85 years of age or older. 40% of the elderly from Iraq were women, 60% were men, and those from Turkey were 58% female and 42%, male. 55% of elderly people in Iraq were married, 40% were widows, 3% were divorced and 2% not married before. 68% of elderly people in Turkey were married, 30% were widows, 1% were divorced and 1% not married before. 25% of elderly people in Iraq were not literate, 20% quit primary school, 15% primary school, 5% secondary school, 24% high school, and 11% university. 32% of elderly people in Turkey were not literate, 8% quit primary school, 39% primary school, 8% secondary school, 9% high school, and 4% university. 20% of elderly people in Iraq had 0-3 children, 45% 4-6 child, 35% more than 7 children. 37% of elderly people in Turkey had 0-3 children, 40% 4-6 child, 23% more than 7 children.

Table 4. 2: Data for health, economic, social, and religious status in participants

		IRAQ		TURKEY		Total	
		N	%	N	%	N	%
Chronic disease	Yes	92	92.0	76	76.0	168	84.0
	No	8	8.0	24	24.0	32	16.0
Disability	No	45	45.0	76	76.0	121	60.5
	Blind	21	21.0	7	7.0	28	14.0
	Hearing impairment	12	12.0	9	9.0	21	10.5
	Walking impairment	20	20.0	8	8.0	28	14.0
Number of medication	No	7	7.0	15	15.0	22	11.0
	1-3 medication	77	77.0	53	53.0	130	65.0
	≥4 medication	16	16.0	32	32.0	48	24.0
Do you eat healthy?	Yes	12	12.0	66	66.0	78	39.0
	Middle	72	72.0	26	26.0	98	49.0
	No	16	16.0	8	8.0	24	12.0
Economic status (income)	No	2	2.0	9	9.0	11	5.5
	Older salary	13	13.0	14	14.0	27	13.5
	Disability salary	0	0.0	1	1.0	1	0.5
	From spouse	2	2.0	18	18.0	20	10.0
	Retired salary	46	46.0	54	54.0	100	50.0
	Other	37	37.0	4	4.0	41	20.5
Is there other income?	No	28	28.0	55	55.0	83	41.5
	Rent	48	48.0	22	22.0	70	35.0
	Garden/field	12	12.0	16	16.0	28	14.0
	Bank	9	9.0	5	5.0	14	7.0
	Support	3	3.0	2	2.0	5	2.5
Is your income enough?	Yes	74	74.0	67	67.0	141	70.5
	Sometimes	19	19.0	24	24.0	43	21.5
	No	7	7.0	9	9.0	16	8.0
Do you exercise or walk regularly?	No	37	37.0	19	19.0	56	28.0
	Walking	58	58.0	48	48.0	106	53.0
	Regular exercise	5	5.0	33	33.0	38	19.0
Do you pray every day?	Yes	95	95.0	77	77.0	172	86.0

	No	5	5.0	23	23.0	28	14.0
How often do you wish or thank to God?	Sometimes	13	13.0	4	4.0	17	8.5
	Usually	15	15.0	22	22.0	37	18.5
	Every/all time	72	72.0	74	74.0	146	73.0
Do you read the Quran?	Yes	38	38.0	41	41.0	79	39.5
	No	62	62.0	59	59.0	121	60.5

The finding in this table indicate that 92% of elderly people in Iraq had a chronic disease, 8% had not. 76% of elderly people in Turkey had a chronic disease, 24% had not. 45% of elderly people in Iraq had not a disability, 21% had blind, 12% had hearing impairment, 20% had a walking impairment. 76% of elderly people in Turkey had not a disability, 7% had blind, 9% had hearing impairment, 8% had a walking impairment. 7% of elderly People in Iraq no-take medication, 77% take 1-3 medication, 16% take more than 4 medications. 15% of elderly People in Turkey no-take medication, 53% take 1-3 medication, 32% take more than 4 medications. 12% of elderly People in Iraq eat healthily, 72% middle, 16% does not eat healthily. 66% of elderly People in Turkey eat healthily, 26% middle, 8% not eat healthily. 2% of elderly people in Iraq had not income, 13% older salary, 0% disability salary, 25% from a spouse, 46% retired salary, 37% other. 9% of elderly people in Turkey had not income, 14% older salary, 1% disability salary, 18% from a spouse, 45% retired salary, 4% other. 28% of elderly people in Iraq have not had another income, 48% rent, 12% garden field, 9% bank, 3% support. 55% of elderly people in Turkey have not had another income, 22% rent, 16% garden field, 5% bank, 2% support. 74% of elderly people in Iraq had enough income, 19% sometimes 7% not enough. 67% of elderly people in Turkey had enough income, 24% sometimes 9% not enough. 37% of elderly people in Iraq do not do exercise, 58% walking, 5% regular exercise. 19% of elderly people in Turkey do not do exercise, 48% walking, 33% regular exercise. 95% of elderly people in Iraq pray and 5% not pray. 77% of elderly people in Turkey pray and 23% not pray. 13% of elderly people in Iraq sometimes wish and thank to god, 15% usually, 72% all the time. 4% of elderly people in Turkey sometimes wish and thank god, 22% usually, 74% all the time. 38% of elderly people in Iraq read Quran, 62% not read. 41% of elderly people in Turkey read Quran, 59% not read.

4.2 Scores of quality of life

Table 4.3: Examination of the quality of life in the elderly with six sub-facets and differences between the two countries

								Mann-Whitney U test		
		N	Mean	Median	Minimum	Maximum	Sd	Mr	U	P
Sensory abilite	Iraq	100	7.88	8.00	4.00	18.00	2.93	73.4	2293	0.0001*
	Turkey	100	10.97	10.00	5.00	18.00	3.12	127.6		
	Total	200	9.43	9.00	4.00	18.00	3.39			
Autonomy	Iraq	100	13.06	14.00	6.00	20.00	2.90	86.0	3546	0.0001*
	Turkey	100	14.54	15.00	4.00	20.00	3.25	115.0		
	Total	200	13.80	14.00	4.00	20.00	3.16			
Past, present and future activities	Iraq	100	11.45	11.00	6.00	17.00	2.35	80.7	3021	0.0001*
	Turkey	100	13.74	14.00	6.00	20.00	3.69	120.3		
	Total	200	12.60	12.00	6.00	20.00	3.30			
Social participati on	Iraq	100	9.08	9.00	4.00	15.00	2.67	76.5	2596.5	0.0001*
	Turkey	100	12.08	12.00	4.00	20.00	3.58	124.5		
	Total	200	10.58	10.00	4.00	20.00	3.49			
Death and dying	Iraq	100	12.12	12.00	4.00	17.00	1.87	102.3	4819	0.656
	Turkey	100	11.60	12.00	4.00	20.00	5.23	98.7		
	Total	200	11.86	12.00	4.00	20.00	3.93			
Intimacy	Iraq	100	11.88	11.00	6.00	18.00	2.30	74.5	2395.5	0.0001*
	Turkey	100	14.77	15.00	7.00	20.00	3.30	126.5		
	Total	200	13.33	13.00	6.00	20.00	3.18			
Quality of Life	Iraq	100	65.47	66.00	49.00	83.00	7.20	69.3	1879.5	0.0001*
	Turkey	100	77.70	78.50	54.00	98.00	11.40	131.7		
	Total	200	71.59	70.00	49.00	98.00	11.31			

Sd: Standart deviation, Mr: Mean rank, **Statistically significant $p < 0.05$

The WHOQOL-OLD scale was applied to the participants, consisting of the elders of two countries. Quality of life scores and quality of life sub-dimensions scores were determined. Accordingly, the difference in scores between the participants of the two countries was compared. It is observed that Sensory Functioning scores are significantly higher in Turkish elderly ($p < 0.05$). It is observed that autonomy scores are significantly higher in Turkish elderly ($p < 0.05$). It is seen

that past, present and future activities scores are significantly higher in Turkish elderly ($p < 0.05$). It is observed that Social Participation scores are significantly higher in Turkish elderly ($p < 0.05$). It is observed that the proximity scores are significantly higher in Turkish elderly ($p < 0.05$). Elderly It is seen that the total scores of quality of life are significantly higher in Turkish elderly ($p < 0.05$). There is no significant difference between the groups in terms of Death and Dying scores ($p > 0.05$).



4.3 Factors affecting quality of life

Table 4. 4: The effect of sociodemographic data on quality of life in Iraq

	N	Mean	Median	Minimum	Maximum	Sd	Mr	U/K WH	P	Dc
Age							Mann-Whitney U test			
65-84	77	66.48	67	49	83	6.82	54.48	579	0.012*	
85+	23	62.09	60	50	79	7.53	37.17			
Total	100	65.47	66	49	83	7.2				
Gender							Mann-Whitney U test			
Female	40	60.03	60.50	49.00	72.00	5.86	28.36	314.5	0.0001 *	
Male	60	69.10	69.00	57.00	83.00	5.54	65.26			
Total	100	65.47	66.00	49.00	83.00	7.20				
Marital status							Mann-Whitney U test			
Married	55	68.64	69.00	57.00	83.00	5.92	63.13	543	0.0001 *	
Single	45	61.60	62.00	49.00	76.00	6.75	35.07			
Total	100	65.47	66.00	49.00	83.00	7.20				
Education							Mann-Whitney U test			
≤Primary	60	62.42	62.50	49.00	79.00	6.71	37.85	441	0.0001 *	
≥Secondary	40	70.05	69.50	58.00	83.00	5.25	69.48			
Total	100	65.47	66.00	49.00	83.00	7.20				
Number of child							Kruskall-Wallis H test			
0-3 Child	20	64.50	65.50	50.00	74.00	6.89	47.35	2.3	0.322	-
4-6 Child	45	66.93	67.00	52.00	83.00	7.53	55.30			
7+ Child	35	64.14	65.00	49.00	75.00	6.76	46.13			
Total	100	65.47	66.00	49.00	83.00	7.20				

Dc: Dual comparison, Sd: Standart deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

U/KWH: Test statistic of U test or Kruskal-Wallis H test

The quality of life of the elderly living in Iraq between the ages of 65-84 was found to be higher than those aged 85 and over. This result was statistically significant ($p < 0.05$).

In terms of gender, the quality of life scores of men were significantly higher than that of women ($p < 0.05$).

In terms of marital status, quality of life scores were significantly higher in those who were married than those who were not married (spouse died, never married, divorced) ($p < 0.05$).

In terms of educational status, the quality of life scores were significantly higher in the reasonably school and upper (Reasonably school, high school and university graduate) groups compared to the group (who are illiterate, literate but not graduated from primary school) ($p < 0.05$).

In terms of the number of children, it was observed that having up to 3 children, 4-6 children and having 7 children or more did not have any effect on the quality of life in the elderly. It did not make sense statistically ($p < 0.05$).

Table 4.5: The effect of sociodemographic data on quality of life in Turkey

	N	Mean	Medi an	Minim um	Maximum	Sd	Mr	U/K WH	P	Dc
Age							Mann-Whitney U test			
65-84	80	77.48	78.00	54.00	98.00	11.43	49.81	388	0.476	
85+	20	79.70	82.50	61.00	96.00	11.51	56.70			
Total	100	77.70	78.50	54.00	98.00	11.40				
Gender							Mann-Whitney U test			
Female	58	77.69	78.00	56.00	98.00	11.67	49.87	1181.5	0.799	
Male	42	77.71	79.00	54.00	98.00	11.14	51.37			
Total	100	77.70	78.50	54.00	98.00	11.40				
Marital status							Mann-Whitney U test			
Married	68	77.47	78.00	54.00	98.00	11.55	49.74	1036	0.701	
Single	32	78.19	79.00	59.00	96.00	11.23	52.13			
Total	100	77.70	78.50	54.00	98.00	11.40				
Education							Mann-Whitney U test			
≤Primar y	79	77.89	78.00	54.00	98.00	11.66	50.66	816.5	0.912	
≥Second ary	21	77.00	79.00	56.00	96.00	10.60	49.88			
Total	100	77.70	78.50	54.00	98.00	11.40				
Number of child							Kruskall-Wallis H test			
0-3 Child	37	75.35	76.00	59.00	97.00	9.43	43.92	4.13	0.127	-
4-6 Child	40	79.93	80.50	55.00	98.00	11.95	57.28			
7+ Child	23	77.61	78.00	54.00	96.00	12.94	49.30			
Total	100	77.70	78.50	54.00	98.00	11.40				

Dc: Dual comparison, Sd: Standart deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

U/KWH: Test statistic of U test or Kruskal-Wallis H test

When we analyzed according to sociodemographic data of the elderly living in Turkey; No statistically significant difference was found in any of the age, gender, marital status, education, and number of child groups ($p < 0.05$).

Table 4.6: Effect of economic status on quality of life in Iraq

	N	Mean	Median	Min	Max	Sd	Mr	U/K WH	P	Dc
Income							Kruskall-Wallis H test			
No/Older salary	15	57.20	56.00	49.00	67.00	6.38	20.07	30.8	0.0001*	1-2 1-3
Retired salary	46	69.28	69.00	58.00	83.00	5.64	65.63			
Other/Spouse	39	64.15	64.00	52.00	77.00	5.99	44.36			
Total	100	65.47	66.00	49.00	83.00	7.20				
Is your income enough?							Kruskall-Wallis H test			
Yes	74	66.70	67.00	49.00	83.00	6.74	54.89	9.4	0.009*	3-1 3-2
Sometimes	19	63.47	64.00	50.00	74.00	7.37	43.95			
No	7	57.86	56.00	52.00	69.00	6.31	21.93			
Is there other income?							Mann-Whitney U test			
No	31	63.26	64.00	50.00	74.00	6.73	42.18	811.5	0.054	
Yes	69	66.46	67.00	49.00	83.00	7.22	54.24			

Dc: Dual comparison, Sd: Standart deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

U/KWH: Test statistic of U test or Kruskal-Wallis H test

When the distribution of the participants in the study belonging to Iraq according to their economic status is examined, it is seen that the quality of life scores of those with income-disabled-elderly pensions are significantly lower than those of the group receiving pensions and compared to the other group ($p < 0.05$). The result was statistically significant ($p < 0.05$). Is your income sufficient to meet your needs? It is observed that the quality of life of those who say "no" to their question is significantly lower than other groups ($p < 0.05$). Do you have any other income? It is observed that there was no significant difference between the two groups that who answered the question as "yes" and "no", and the scores those who said yes were higher, although it was not statistically significant ($p < 0.05$).

Table 4.7: Effect of economic status on quality of life in Turkey

	N	Mean	Median	Min	Max	Sd	Mr	U/K WH	P	Dc
Income							Kruskall-Wallis H test			
No/Older salary	24	79.50	80.00	56.00	96.00	10.90	55.44	1.09	0.581	
Retired salary	54	77.22	79.00	54.00	98.00	11.55	49.82			
Other/Spouse	22	76.91	76.50	60.00	96.00	11.86	46.77			
Total	100	77.70	78.50	54.00	98.00	11.40				
Is your income enough?							Kruskall-Wallis H test			
Yes	67	80.22	79.00	59.00	98.00	10.35	56.25	8.4	0.015*	1-2 1-3
Sometimes	24	73.25	72.00	54.00	98.00	12.74	40.81			
No	9	70.78	72.00	55.00	84.00	9.55	33.50			
Is there other income?							Mann-Whitney U test			
No	57	75.09	76.00	54.00	98.00	11.90	44.34	874.5	0.014*	
Yes	43	81.16	80.00	61.00	98.00	9.79	58.66			

Dc: Dual comparison, Sd: Standart deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

U/KWH: Test statistic of U test or Kruskal-Wallis H test

When examining the distribution of the participants in the study belonging to Turkey according to their economic status, there is no significant difference in terms quality of life between the groups who have no income-disabled-elderly pension, pension, and other-spous salary ($p > 0.05$). It is observed that those who say “yes” to the question of whether your income is sufficient to meet your needs, have significantly higher quality of life scores compared to the other groups ($p < 0.05$). It is seen that those who say “yes” to the question “Do you have another income?” have significantly higher quality of life scores ($p < 0.05$).

Table 4.8: Effect of health status on quality of life in Iraq

	N	Mean	Medi an	Mini mum	Max	Sd	Mr	U/K WH	P	Dc
Chronic disease							Mann-Whitney U test			
Yes	92	64.85	65.00	49.00	79.00	6.93	48.27	163	0.009*	
No	8	72.63	72.00	66.00	83.00	6.61	76.13			
Disability							Kruskall-Wallis H test			
No	45	67.24	68.00	52.00	82.00	5.57	56.10	8.6	0.034*	4-1
Blind	21	65.95	67.00	54.00	79.00	6.01	50.50			4-2
Hearing impairment	12	65.50	66.00	54.00	79.00	8.46	49.42			4-3
Walking impairment	20	61.50	61.00	49.00	83.00	9.08	33.65			
Medication							Kruskall-Wallis H test			
No	7	71.14	72.00	66.00	82.00	5.52	72.71	7.1	0.029*	1-2
1-3 medication	77	65.57	67.00	49.00	83.00	6.99	51.06			1-3
≥4 medication	16	62.50	62.00	51.00	79.00	7.57	38.06			
Total	100	65.47	66.00	49.00	83.00	7.20				

Dc: Dual comparison, Sd: Standard deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

U/KWH: Test statistic of U test or Kruskal-Wallis H test

Elderly people living in Iraq, Those who say "no" to the question of whether you have chronic disease for which you receive continuous treatment, have a significantly higher quality of life ($p < 0.05$). It is observed that the QOL-S (Quality of Life Score) is significantly lower in those with walking impairment than other groups ($p < 0.05$). It is observed that the Quality of life is significantly higher in those who do not use medication ($p < 0.05$)

Table 4.9: Effect of health status on quality of life in Turkey

	N	Mean	Median	Minimum	Maximum	Sd	Mr	U/K WH	P	Dc
Chronic disease							Mann-Whitney U test			
Yes	76	75.20	76.00	54.00	98.00	11.57	47.32	670	0.041*	
No	24	82.13	81.50	64.00	98.00	9.79	60.58			
Disability							Kruskall-Wallis H test			
No	76	77.96	79.00	54.00	98.00	11.04	51.54	2.1	0.539	-
Blind	7	79.14	80.00	66.00	96.00	11.23	54.14			
Hearing impairment	9	73.44	71.00	64.00	92.00	8.78	37.11			
Walking impairment	8	78.75	81.00	56.00	96.00	17.51	52.50			
Medication							Kruskall-Wallis H test			
No	15	83.40	84.00	56.00	98.00	13.14	64.57	4.3	0.111	-
1-3 medication	53	77.09	78.00	54.00	98.00	10.56	49.20			
≥4 medication	32	76.03	77.00	55.00	97.00	11.43	46.06			
	100	77.70	78.50	54.00	98.00	11.40				

Dc: Dual comparison, Sd: Standard deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

U/KWH: Test statistic of U test or Kruskal-Wallis H test

Quality of life scores are high in those who do not have chronic diseases, it is statistically significant ($p > 0.05$). There is no significant difference in the Quality of life score between the groups with disability ($p > 0.05$). There is no significant difference in the Quality of life score between groups of drug use ($p > 0.05$), but higher quality of life scores are observed in patients who do not use drugs compared to the elderly who use drugs.

Table 4.10: Effect of Life style on quality of life in Iraq

	N	Mean	Median	Min	Max	Sd	Mr	U/K WH	P	Dc
Do you think you are eating healthy?							Kruskall-Wallis H test			
Yes	12	72.42	72.50	62.00	83.00	5.99	77.75	23	0.0001*	1-2 1-3
Middle	72	65.69	67.00	49.00	79.00	6.51	51.60			
No	16	59.25	60.50	50.00	72.00	5.90	25.09			
Total	100	65.47	66.00	49.00	83.00	7.20				
Do you exercise or walk regularly?							Kruskall-Wallis H test			
No	37	60.89	61.00	49.00	83.00	7.17	31.68	25.4	0.0001*	1-2 1-3
Walking	58	67.88	68.50	54.00	79.00	5.59	60.68			
Exercise regularly	5	71.40	71.00	64.00	82.00	7.13	71.70			

Dc: Dual comparison, Sd: Standart deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

KWH: Test statistic of Kruskal-Wallis H test

Elderly in Iraq; It is seen that the quality of life is significantly higher in the elderly who say they eat healthy (those who say “yes”) ($p < 0.05$). Quality of life score is observed to be as significantly lower in the elderly who do not walk at all ($p < 0.05$).

Table 4.11: Effect of Life style on quality of life in Turkey

	N	Mean	Median	Min	Max	Sd	Mr	U/K WH	P	Dc
Do you think you are eating healthy?							Kruskall-Wallis H test			
Yes	66	79.94	80.00	56.00	98.00	11.36	56.06	10	0.007*	1-2 1-3
Middle	26	75.04	74.50	54.00	95.00	10.44	44.40			
No	8	67.88	64.50	59.00	78.00	8.06	24.44			
Total	100	77.70	78.50	54.00	98.00	11.40				
Do you exercise or walk regularly?							Kruskall-Wallis H test			
No	19	70.00	69.00	54.00	96.00	11.79	31.82	15.6	0.0001*	1-2 1-3
Walking	48	77.10	77.50	55.00	98.00	11.18	48.40			
Exercise regularly	33	83.00	81.00	64.00	98.00	8.67	64.32			

Dc: Dual comparison, Sd: Standart deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

KWH: Test statistic of Kruskal-Wallis H test

Elderly in the Turkey; The elderly who eat healthy are observed to have significantly higher quality of life scores in the “yes” group ($p < 0.05$). Exercise status; Quality of life score is seen to be significantly lower in those who say "no" ($p < 0.05$).

Table 4.12: Effect of religious factors on quality of life in Iraq

	N	Mean	Median	Mini mum	Maxi mum	Sd	Mr	U/K WH	P	Dc
Do you pray five times a day?							Mann-Whitney U test			
Yes	95	65.99	67.00	49.00	83.00	6.89	52.37	60	0.005*	
No	5	55.60	53.00	51.00	66.00	6.11	15.00			
Total	100	65.47	66.00	49.00	83.00	7.20				
How often do you wish or thank to God?							Kruskall-Wallis H test			
Sometimes	13	62.31	64.00	51.00	75.00	8.23	40.08	2.84	0.241	-
Usually	15	67.40	69.00	53.00	83.00	7.30	58.57			
Every time	72	65.64	66.00	49.00	82.00	6.90	50.70			
Total	100	65.47	66.00	49.00	83.00	7.20				
Do you read the Quran?							Mann-Whitney U test			
Yes	38	69.63	69.50	58.00	83.00	5.25	67.82	520	0.0001*	
No	62	62.92	63.00	49.00	79.00	7.06	39.89			
Total	100	65.47	66.00	49.00	83.00	7.20				

Dc: Dual comparison, Sd: Standart deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

U/KWH: Test statistic of U test or Kruskal-Wallis H test

In Iraq; It is observed that the quality of life scores of the elderly who pray 5 times a day are significantly higher ($p < 0.05$). How often do you wish or thank to God? The answer to the question was not significant in the quality of life score. It is observed that the quality of life scores are significantly higher in elderly who read the Quran ($p < 0.05$).

Table 4.13: Effect of religious factors on quality of life in Turkey

	N	Mean	Median	Mini mum	Maxi mum	Sd	Mr	U/K WH	P	Dc
Do you pray five times a day?							Mann-Whitney U test			
Yes	77	78.17	79.00	54.00	98.00	10.66	51.75	789	0.429	
No	23	76.13	73.00	56.00	96.00	13.73	46.30			
Total	100	77.70	78.50	54.00	98.00	11.40				
How often do you wish or thank to God?							Kruskall-Wallis H test			
Sometimes	4	67.25	67.50	61.00	73.00	6.13	22.00	6.7	0.035*	1-2 1-3
Usually	22	81.55	80.50	56.00	97.00	11.08	60.57			
Every time	74	77.12	78.00	54.00	98.00	11.33	49.05			
Total	100	77.70	78.50	54.00	98.00	11.40				
Do you read the Quran?							Mann-Whitney U test			
Yes	41	78.32	78.00	57.00	98.00	11.42	50.91	1192.5	0.905	
No	59	77.27	79.00	54.00	98.00	11.45	50.21			
Total	100	77.70	78.50	54.00	98.00	11.40				

Dc: Dual comparison, Sd: Standart deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

U/KWH: Test statistic of U test or Kruskal-Wallis H test

How often do you wish or thank to God? The Quality of life scores of those who answered as 'every time' and 'usually' were found to be significantly higher than those who said 'sometimes' ($p < 0.05$).

4.4 Comparison of data between two countries

Table 4.14:Table of differences between the two countries (economic)

		Group						Mann-Whitney U test		
		N	Mean	Median	Minimum	Maximum	Sd	Mr	U	P
Income	Iraq	46	69.28	69.00	58.00	83.00	5.64	37.76	656	0.0001*
	Turkey	54	77.22	79.00	54.00	98.00	11.55	61.35		
	Total	100	73.57	72.00	54.00	98.00	10.08			
Another income (Yes)	Iraq	69	66.46	67.00	49.00	83.00	7.22	39.66	321.5	0.0001*
	Turkey	43	81.16	80.00	61.00	98.00	9.79	83.52		
	Total	112	72.11	71.50	49.00	98.00	10.94			
Another income (No)	Iraq	31	63.26	64.00	50.00	74.00	6.73	27.89	368.5	0.0001*
	Turkey	57	75.09	76.00	54.00	98.00	11.90	53.54		
	Total	88	70.92	69.00	50.00	98.00	11.79			
Income enough (Yes)	Iraq	74	66.70	67.00	49.00	83.00	6.74	46.74	684	0.0001*
	Turkey	67	80.22	79.00	59.00	98.00	10.35	97.79		
	Total	141	73.13	72.00	49.00	98.00	10.96			
Income enough (No)	Iraq	7	57.86	56.00	52.00	69.00	6.31	5.21	8.5	0.015*
	Turkey	9	70.78	72.00	55.00	84.00	9.55	11.06		
	Total	16	65.13	64.00	52.00	84.00	10.41			

Dc: Dual comparison, Sd: Standart deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

U: Test statistic of U test

Pensioners in their quality of life scores were significantly different between the two countries and Turkey appear to in significantly higher scores ($p < 0.05$).

For those who say “yes” to another income; The quality of life in elderly living in Turkey appears to be significantly higher ($p < 0.05$).

For those who say "no" to another income; The quality of life in elderly living in Turkey appears to be significantly higher ($p < 0.05$).

Quality of life scores of elderly people who have enough income living in Turkey were significantly higher ($p < 0.05$).

Income enough to the needs of those (those who say "no") quality of life in elderly living in Turkey appears to be significantly higher ($p < 0.05$).

Table 4.15: Table of differences between the two countries (life style)

		Group						Mann-Whitney U test		
		N	Mean	Median	Minimum	Maximum	Sd	Mr	U	P
Exercise/walk (No)	Iraq	37	60.89	61.00	49.00	83.00	7.17	24.07	187.5	0.004*
	Turkey	19	70.00	69.00	54.00	96.00	11.79	37.13		
	Total	56	63.98	62.00	49.00	96.00	9.90			
Exercise/walk (Walking)	Iraq	58	67.88	68.50	54.00	79.00	5.59	40.84	657.5	0.0001*
	Turkey	48	77.10	77.50	55.00	98.00	11.18	68.80		
	Total	106	72.06	71.00	54.00	98.00	9.71			
Exercise/walk (Exercise regularly)	Iraq	5	71.40	71.00	64.00	82.00	7.13	7.80	24	0.011*
	Turkey	33	83.00	81.00	64.00	98.00	8.67	21.27		
	Total	38	81.47	80.50	64.00	98.00	9.29			
eating healthy (Yes)	Iraq	12	72.42	72.50	62.00	83.00	5.99	25.46	227.5	0.019*
	Turkey	66	79.94	80.00	56.00	98.00	11.36	42.05		
eating healthy (Middle)	Iraq	72	65.69	67.00	49.00	79.00	6.51	41.69	373.5	0.0001*
	Turkey	26	75.04	74.50	54.00	95.00	10.44	71.13		
eating healthy (No)	Iraq	16	59.25	60.50	50.00	72.00	5.90	10.16	26.5	0.021*
	Turkey	8	67.88	64.50	59.00	78.00	8.06	17.19		

Quality of life score of Turkey elderly who answer "no" on the question (Do you exercise or walk regularly? It seen as significantly higher ($p < 0,05$) compared with the elderly in Iraq, who also answered "no".

Quality of life score of Turkey elderly who exercise walking, it seen as significantly higher ($p < 0,05$) compared with the elderly in Iraq, who also exercise walking.

Quality of life score of Turkey elderly who exercise or walking regularly, it seen as significantly higher ($p < 0,05$) compared with the elderly in Iraq, who also exercise or walking regularly.

Do you think you are eating healthy? Those who say "yes" to the question in quality of life scores in elderly persons living in Turkey were found significantly higher ($p < 0,05$).

Do you think you are eating healthy? Those who say "reasonably" to the question in quality of life scores in elderly persons living in Turkey were found significantly higher ($p < 0,05$).

Do you think you are eating healthy? Those who say "no" to the question in quality of life scores in elderly persons living in Turkey were found significantly higher ($p < 0,05$).

Table 4.16: Table of differences between the two countries (religion factors)

		Group						Mann-Whitney U test		
		N	Mean	Median	Minimum	Maximum	Sd	Mr	U	P
Pray 5 times (Yes)	Iraq	95	65.99	67.00	49.00	83.00	6.89	60.92	122.5	0.0001*
	Turkey	77	78.17	79.00	54.00	98.00	10.66	118.06		
Pray 5 times (No)	Iraq	5	55.60	53.00	51.00	66.00	6.11	4.50	7.5	0.003*
	Turkey	23	76.13	73.00	56.00	96.00	13.73	16.67		
Wish from God (Sometimes)	Iraq	13	62.31	64.00	51.00	75.00	8.23	8.35	17.5	0.335
	Turkey	4	67.25	67.50	61.00	73.00	6.13	11.13		
Wish from God (Usually)	Iraq	15	67.40	69.00	53.00	83.00	7.30	10.67	40	0.0001*
	Turkey	22	81.55	80.50	56.00	97.00	11.08	24.68		
Wish from God (Every time)	Iraq	72	65.64	66.00	49.00	82.00	6.90	51.39	1072	0.0001*
	Turkey	74	77.12	78.00	54.00	98.00	11.33	95.01		
Read the Quran (Yes)	Iraq	38	69.63	69.50	58.00	83.00	5.25	29.54	381.5	0.0001*
	Turkey	41	78.32	78.00	57.00	98.00	11.42	49.70		
Read the Quran (No)	Iraq	62	62.92	63.00	49.00	79.00	7.06	40.52	559	0.0001*
	Turkey	59	77.27	79.00	54.00	98.00	11.45	82.53		

Dc: Dual comparison, Sd: Standart deviation, Mr: Mean rank, *Statistically significant $p < 0.05$

U: Test statistic of U test

Quality of Life Score of Turkey elderly is seen as significantly higher in those who prayer 5 time than the Iraqis elderly ($p < 0.05$). Quality of Life Score of Turkey elderly is seen as significantly higher in those who not prayer 5 time than the Iraqis elderly ($p < 0.05$). Quality of Life Score of Turkey elderly is seen as significantly higher in those who wish from god usually than the Iraqis elderly ($p < 0.05$). Quality of Life Score of Turkey elderly is seen as significantly higher in those who wish from god every time than the Iraqis elderly ($p < 0.05$). Quality of Life Score of Turkey elderly is seen as significantly higher in those who read the Quran than the Iraqis elderly ($p < 0.05$). Quality of Life Score of Turkey elderly is seen as significantly higher in those who not read the Quran than the Iraqis elderly ($p < 0.05$).

5. DISCUSSION

Part 1: Discussion of the demographic characteristics of the sample

In a cross-sectional study carried out with 184 elderly people in Iran, the mean age in the elderly was 69.4 ± 7.9 years and about 52% were males (Khaje-Bishak, et al., 2014). In another descriptive study, the findings indicated that the average age of seniors was 71.0 ± 7.2 years and 22 (84.6%) of them were women who did not live alone (Ferreira et al., 2015). This finding is consistent with findings in Iraq.

In a descriptive study of 500 people in Spain, findings indicated that 43% of the elderly were aged between 60 and 70 years, compared to 57% between 70 and 87 years old (Garcia and Navarro, 2018).

In a cross-sectional study in Kuala Lumpur, 64.5% were males and 35.5% were females, 46.3% were aged 60 to 69 years, and 53.7% were aged 70 years or more. Most of the respondents were married (61.6%) and 38.4% were single, while 57.6% of the respondents had 1 child and 42.4% had 2 children or more. The majority of the respondents had secondary education (46.8%), while 39.9% had primary or no education (Onunkwor et al., 2016). This finding supports the present study finding.

Part 2: Discussion about the health, economic, and social status of participants

When the examination the other study, most of the respondents previously worked in the private sector (61.1%), while 29.5% were self-employed, and 3% were unemployed. Most of the respondents were not receiving a pension (90.6%). Only 6.4% perceived their economic status as good, 8.4% reported intermediate status, and 85.2% reported poor economic status. Most of the respondents engaged in outdoor leisure activities (78.3%), and 31.5% were physically active. The majority (82.8%) had at least one chronic co-morbidity. Only 5.4% reported a high level of social support, while low and medium levels of social support were reported by 47.8% and 46.8%. respectively (Onunkwor et al., 2016).

Part 3: Examination of the quality of life in the elderly and differences between the two countries

In a study conducted with 400 elderly individuals over the age of 60 in Iran, the validity and reliability of the WHOQOL-OLD scale in Persian-speaking Iranian and elderly people with different cultures was investigated and accepted. Sensory abilities subscore was 13.98 ± 3.16 , autonomy subscore was 12.67 ± 2.63 , past present and future activities subscore was 13.52 ± 2.38 , social participation subscore was 13.45 ± 2.54 , death and dying subscore was 10.89 ± 4.10 , intimacy subscore was 13.20 ± 2.93 and total overall score was 77.72 ± 10.41 for the elderly participants in Iran (Rezaeipandari et al., 2020). The results of this study are consistent with the results of our work in Turkey.

Sensory ability scores were seen to be significantly higher in Turkish seniors ($p < 0.05$). Autonomy scores were significantly higher in Turkish seniors ($p < 0.05$). Past, present and future activities scores were significantly higher in Turkish seniors ($p < 0.05$). Social participation scores were significantly higher in Turkish seniors ($p < 0.05$). Intimacy scores were significantly higher in Turkish seniors ($p < 0.05$). There was no significant difference between groups in terms of death and dying scores ($p > 0.05$). Total scores for quality of life in the elderly were seen to be significantly higher in Turkish seniors than in Iraq seniors ($p < 0.05$). As a reason for this, the number of participants without chronic disease and disabilities were slightly more in Turkey. It also the number of participants that considered they had eating healthy and exercised regularly was more in Turkey than in Iraq. We think that these are the reasons for the high quality of life scores of participants in Turkey compared to scores for participants in Iraq.

The quality of life of dozens of elderly people in Turkey was higher than the rates in Iraq, From the researcher's point of view, life in Iraq is difficult because it lacks the necessities of life that every person needs. The level of the large financial deficit experienced by the state, which leads to a decrease in the monthly income of a large number of citizens, the weakness of the elderly care program in the Iraqi Ministry of Health, and the lack of recreational places, which negatively affects the psyche of the elderly and thus increases the complications of their chronic diseases and the absence of social care And healthy that the elderly need. Therefore, the quality of life in Iraq is very low compared to other countries.

In a study comparing the quality of life of elderly living in a geriatric institution with that of elderly living in the community in Brazil, total median scores for the WHOQOL-OLD were 71 and 67, respectively (Ferraz Teston and Silva Marcon, 2015). The results of this study are consistent with our study.

In another study, regarding the score for Overall Quality of Life (OQOL) and Overall Health Status (OHS), results showed that overall quality of life and overall health status in participants were about at moderate level (Khaje-Bishak et al., 2014).

Part 4: Effect of sociodemographic data on quality of life in Iraq and Turkey

According to Nguyen's (2017) findings in Vietnam, the percentage of older men with somatic and psychosomatic health and the milieu with higher levels of QoL was higher than that of female counterparts. Inversely, females represented a higher proportion than males with medium and lower QoL. In all four QoL domains, the average QoL score was higher in the elderly (75.32) than in women (72.32).

There were no significant differences between gender and age variables with the total score of quality of life (Khaje-Bishak et al., 2014). This finding is consistent with the present study for Turkey.

In the findings of another study, most seniors evaluated their QoL as good or very good (20; 76.9%), but almost all of them were dissatisfied with their health (24; 92.4%) (Ferreira et al., 2015).

In the findings of another study, the socio-demographic variables and gender were significantly associated with all domains of QOL. Age was significantly associated with the physical domain. The level of education was significantly associated with the physical domain, psychological domain, and social domain (Onunkwor et al., 2016). This finding is consistent with the present study findings for Iraq.

Part 5: Effect of economic status on quality of life in Iraq and Turkey

Economic status was significantly associated with the physical domain, psychological domain, and social domain (Onunkwor et al., 2016).

In a descriptive study in China, economic exporter and migratory workers among poor, rustic, and low-income older age groups were significantly different. The QoL-old of the low income rustic elderly was considerably higher in all 5

dimensions than the low income elderly. The EuroQol Visual Analogue Scale (EQVAS) was 65,689 on average, lower for poor elderly people than for not poor elderly people (71.039). There is a substantial statistical disparity among the disadvantaged and the non-low income elderly in the overall utility score of EQ-5D after controlling the uncertainty variables. Quality of life in the elderly is affected by many factors (Jian et al., 2020). The most important factor is the economic situation. It is reported that the quality of life of poor elderly people is lower than those with high income.

In a descriptive study, the findings indicated that the socioeconomic level of the participants is medium-low, with an average income ranging from 500 to 600 € per month and the income did not significantly affect the quality of life (Garcia and Navarro, 2018).

Part 6: Effect of health status on quality of life in Iraq and Turkey

In our study of Iraq and Turkey, scores of quality of life for older people with chronic diseases were lower than for those without chronic diseases. Chronic illness reduced the quality of life in the elderly.

In a study conducted with 5166 elderly people over 60 years old in China, it was reported that chronic disease negatively affected the quality of life in the elderly. It was reported that WHOQOL-OLD scores decreased as the number of chronic diseases increased (Liu et al., 2020). The findings of this study are consistent with our study.

Quality of life was significantly higher in those who said "no" to the question of whether they had chronic disease which required constant treatment. QOL-S (Quality of Life Score) is significantly lower in people with walking disabilities than in other groups. Quality of life was significantly higher in those who did not take medications. Quality of life scores were high for those with non-chronic diseases and this was statistically significant. There was no significant difference in the quality of life score between block status groups. There was no significant difference in the quality of life score between groups with drug use, but those who did not take medications had higher quality of life scores than older people who used drugs.

In another study, the health status had a significant effect on the quality of life (Garcia and Navarro, 2018).

In a descriptive study, factors affecting QOL among participants with low economic status were the presence of arthritis, alcohol consumption, subjective health, and depressive symptoms, and the explanatory power of these factors was 54.3% (Kwon, et al, 2020). This reflects that poor economic status affects quality of life in old age.

Part 7: Effect of Lifestyle on quality of life in Iraq and Turkey

Of factors related to individual health and quality of life, 60% are correlated to lifestyle. Millions of people follow an unhealthy lifestyle. Hence, they encounter illness, disability, and even death. Problems like metabolic diseases, joint and skeletal problems, cardiovascular diseases, hypertension, being overweight, violence, and so on, can be caused by an unhealthy lifestyle. The relationship between lifestyle and health should be highly considered (Farhud, 2015).

In an experimental study, the results revealed that the regression model is statistically significant in predicting changes in the health-related quality of life (HRQOL) according to lifestyle-based intervention, stress, and social support. Educational levels, race, and stress at baseline are significant predictors for the change in stress, while social support at baseline is a significant predictor for change in social support (Chen et al., 2018).

In another study, lifestyle and quality of life were poorly related in elderly people (Li et al., 2018).

Part 8: Effect of religious factors on quality of life in Iraq and Turkey

The relationship between spirituality and old age emerges through the capacity to bear the limitations, difficulties, and losses inherent in the process; thus, the nature of living a spiritual life was observed to be heterogeneous. However, all had in common the recognition of its importance and its significance for living an old age with quality of life (Chaves and Gil, 2015). The study results consist with present study.

In another study, there was a positive correlation between the quality of life and spirituality (Seraji et al., 2016). Another study found this reflects that the spirit had a significant effect on quality of life (Garcia and Navarro, 2018). It was also important in our work in Iraq and in Turkey.

6. CONCLUSION AND RECOMMENDATION

❖ Conclusion

The Turkish elderly had better scores for sensory ability, autonomy, past, present, and future activities, social participation, intimacy, and overall quality of life than the Iraqi elderly. While the Iraqi elderly had better scores for death and dying than the Turkish elderly. This indicates that the quality of life of Turkish elderly people is better than Iraqis elderly people.

There were significant relationships between the quality of life of Iraqi elderly people with age, gender, marital status, education, economic status, chronic diseases, disability, medication, eating healthy, exercise, and spiritual status.

There were significant relationships between the quality of life of the Turkish elderly with economic status, chronic diseases, eating healthy, exercise, and thanking god.

The economic status, lifestyle, and spiritual status in Turkey was better than in Iraq. The physical activity of the Turkish elderly was better than Iraqi. The elderly prayed and thanked god in both countries. The elderly in Turkey had better nutrition than the elderly in Iraq. According to results of the present study H_1 hipotesis was accepted.

❖ Recommendation

1. Implementing health care programs and instructing to provide all medical supplies and complete services for the elderly, as they are at risk of exposure to several of chronic diseases.
2. Implementing social welfare programs that ensure the improvement of their lives, both socially and financially.
3. The state provides a monthly income that covers the needs of the elderly Providing good nutrition for the elderly to reduce the risk of chronic diseases and vitamin deficiency.
4. Paying attention to the elderly from the physical side of examinations and providing sports programs commensurate with their abilities.
5. Providing social and cultural seminars for the elderly to get out of the situation of social isolation and integrate into social life more.

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APPENDICES

Appendix 1: QUESTIONNAIRE

YAŞLI KATILIM FORMU	
1. Age?	1. 65-74 age 2. 75-84 age 3. 85 and over
2. Gender	1. Female 2. Male
3. Marital Status?	1. Married 2. Widow 3. Divorced 4. Never Married
4. Educational Status?	1. Illiterate 2. Literate 3. Primary School 4. Secondary School 5. Highschool 6. University
5. How many children do you have?	
6. Social Security	1. Yes 2. No
7. Who do you live with?	1. Alone 2. Spouse 3. Spouse and Children 4. Children 5. Other (.....)
8. Do you have a chronic illness that you are constantly treated with?	1. Yes (.....) 2. No
9. Economic Situation	1. No income 2. Aged salary 3. Disabled salary 4. Gets a salary from spouse 5. Retirement salary 6. Other
10. Do you have any other income?	1. No 2. Rental income 3. Plantation 4. Bank 5. Aid income
11. Is your income enough to meet one's own needs?	1. Yes 2. Sometimes 3. Not enough
12. Is there any caregiver?	1. Yes 2. No
13. Do you have any disabilities?	1. No 2. Partially-sighted 3. Hearing-impaired 4. Walking disabled 5. Other (.....)
14. The number of medicines you use regularly?	
15. Has there been an important life event in your life in the last 15 days?(death, birth)	1. Yes (.....) 2. No
16. Have you had an acute illness in the past week?	1. Yes (.....) 2. No
17. Do you experience pain in the past 1 week?	1. Yes (.....) 2. No
18. Do you have a complaint with chronic pain?	1. Yes (.....) 2. No
19. What do you like to do in your spare time?	1. TV 2. Social media 3. Newspaper/book/koran 4. Sports event 5. Art activity 6. Field-Garden 7. Cognitive 8. Cafe games 9. Association 10. Tour 11. Visiting friends and relatives 12. Meeting with friends
20. How many hours do you sleep per day?	1. Under 4 2. 4-6 3. 6-8 4. Above 8
21. How satisfied are you with your sleep quality?	1. None 2. Sometimes 3. Medium 4. Much 5. Quite a number
22. Is your appetite right?	1. Yes 2. Medium 3. No
23. Do you think you are eating healthy?	1. Yes 2. Sometimes 3. No
24. Which oil do you prefer in your nutrition?	1. Olive oil 2. Sunflower seed 3. Corn oil 4. Butter 5. Margarin
25. Which of the food types do you consume	1. Vegetable 2. Pulse 3. Pastry

the most?	4. Fish 7. Fruit	5. Red meat 8. All of them	6. Chicken meat
26. How often do you pray?	1. None 3. Occasionally	2. Rarely 4. Usually	5. Always
27. To what extent does prayer / worship relieve you?	1. None 4. Too much	2. Too little 5. Extremely	3. Medium
28. What worship do you do regularly?	1. Prayer (5 times) 3. Prayer(Friday) 6. Haj	2. Prayer(Sometimes) 4. Fasting 7. Umrah	5. Koran
29. Do you exercise or walk regularly?	1. None 4. Exercise	2. Walk 3. Walking regularly	
WORLD HEALTH ORGANIZATION LIFE QUALITY MODULE FOR THE ELDERLY (WHOQOL-OLD)			
Sensory Functions			
30. To what extent does the deterioration in your senses (such as hearing, sight, taste, smell, touch) affect your life?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
31. How do you think your functions related to your senses are?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
32. To what extent do the loss of hearing, sight, taste, smell and touch senses affect your participation in daily activities?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
Autonomy			
33. How much do the problems in your senses affect you to relate to others?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
34. How free are you to make your own decisions?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
35. To what extent do you believe that you control your future?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
36. To what extent do you believe that you can do what you want to do?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
37. Do you think that people around you respect your freedom?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
Past, present, future activities			
38. How satisfied are you with being able to wait for something in your life, to hope for something?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
39. How satisfied are you with your opportunities to lead a successful life?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
40. How much do you think you have achieved the dignity you deserve in life?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
41. How satisfied are you with what you have achieved in your life?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
Social participation			
42. How satisfied are you with the way you use your time?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
43. How satisfied are you with the amount of activities you do?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
44. To what extent do you think you have enough work to do every day?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
45. How satisfied are you with your opportunities to participate in social activities?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
Death and die			
46. How concerned are you about how to die?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
47. How scared do you have the chance to	1. None	2. Sometimes	3. Medium

control your death?	4. Much	5. Quite a number	
48. How scared are you to die?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
49. How afraid are you suffering before you die?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
Proximity			
50. How long do you experience the feeling of friendship and friendship in your life?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
51. To what extent do you experience and feel love in your life?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
52. How much do you have the opportunity to love people?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium
53. How much are you able to be loved by people?	1. None 4. Much	2. Sometimes 5. Quite a number	3. Medium

