Turkish Journal of Geriatrics
2005; 8 (4): 169-183

Erhan ESER[1]
Sultan ESER[2]
Beyhan Cengiz ÖZYURT[1]
Caner FİDANER[3]

RESEARCH

PERCEPTION OF QUALITY OF LIFE BY A SAMPLE OF TURKISH OLDER ADULTS: WHOQOL-OLD PROJECT TURKISH FOCUS GROUP RESULTS

ABSTRACT

Purpose: The purpose of this study was to demonstrate the decisions and attitudes of the Turkish older adults on the pre-defined dimensions related with health and being and old person, during the development process of WHOQOL-OLD (World Health Organization Quality of Life Instrument , older Adults Module).

Methods: This study is qualitative study based on the results of Izmir, one of 23 centers of WHOQOL-OLD Project supported by European Union Framework 5 program. Each center carried our six focus groups. Four of these six focus groups composed of older persons. Each of the focus group sessions were performed in an independent room, under the management of one focus group moderator, one inspector and 4 to 6 older persons between the age range 62-85. The focus group discussions were carried out in Izmir, Ankara and Manisa city centers between the time period 25th December 2001 and 4th Februray 2002.

Findings: The mostly agreed quality of life concepts were: being healthy, independence (the ability of organising everyday activities without any support from others), being physically active, peace of mind and happiness, having economic independence, and right of resting.

When all 24 fields of WHOQOL-100 were probed one by one, 14 facets were regarded as "very important", six facets "somewhat important" and four facets "not important at all". "Work Capacity", "Dependence on Medical Substances and Medical Aids" (except for insulin) were regarded as "not important" or "almost not important" for both male and female participants and sexual activities for women and bodily image for men only.

All of the additional items extracted by the co-ordinating center (Edinburg) (e.g. Sensory functions, Cognitive capacity, Social support/relations, Living situation, Social isolation/ lonliness, The financial and economic issues, Coping with loss and Significant life events) were considered as "very important" by all of the Turkish focus group participants. Among the items stated as "somewhat important" during the other centers' focus groups, Feelings about hospitalisation/institutionalisation, Grief over lost abilities, Relevance of family communications , Freedom of decision-making and choice and Importance of role as grandparent and Eating well/appetite were the items that most of the Turkish focus groups found important or very important. On the other hand Importance of perceived achievement/recognition for contribution to community/society, Concern about ageing/ perceived impact of negative discrimination and Importance of voluntary occupations were the items found not important by the majority of the Turkish groups.

Conclusion: The WHOQOL-100 was regarded as a very long quality of life instrument.

Turkish older adults' sociological norms reflects the properties of Eastern cultur mostly with a difference between rural and urban originated ones. These aspects should be taken into account during the preventive, curative and rehabilitative services given to the elderly in Turkey and in case of subjective evaluations such as quality of life assessments, short, clear forms should be applied by using interviewer administration (face to face administration).

Key words: elderly, Quality of life, Qualitative research, WHOQOL.

İletişim *(Correspondance)*

Erhan ESER
Celal Bayar Üniversitesi Halk Sağlığı Anabilim Dalı MANİSA
Tlf: 0236 239 1319
e-mail: eseres@ttnet.net.tr

Geliş Tarihi: 14/03/2005
(Received)

Kabul Tarihi: 02/05/2005
(Accepted)

1 Celal Bayar Üniversitesi Tıp Fakültesi Halk Sağlığı Anabilim Dalı MANİSA
2 İzmir İl Sağlık Müdürlüğü Kanser Kayıt Merkezi Tıp Fakültesi Halk Sağlığı Anabilim Dalı İZMİR
3 İzmir İl Sağlık Müdürlüğü Meme Kanseri Erken Tanı Merkezi İZMİR

ARAŞTIRMA

TÜRK YAŞLILARI ÖRNEĞİNDE YAŞAM KALİTESİ ALGISI: WHOQOL-OLD PROJESİ TÜRKİYE ODAK GRUP SONUÇLARI

Öz

Amaç: Bu çalışmanın amacı bir sağlıkla ilgili genel yaşam kalitesi ölçeği olan Dünya Sağlık Örgütü Yaşam Kalitesi Ölçeği Yaşlı Modülünün (WHOQOL-OLD) oluşturma sürecinde yaşlıların algılanan sağlık ve yaşlılıkla ilgili olarak önceden belirlenmiş alanlara ilişkin tutum ve düşüncelerini ortaya koymak, eksik kalan boyutlar ile ilgili önerileri almaktır.

Gereç ve Yöntem: Bu çalışma, Avrupa Birliği 5 inci Çerçeve Programı tarafından desteklenen WHOQOL-OLD projesine katılan 23 merkezden biri olan Izmir merkezinin verileri üzerinde yürütülmüş niteliksel bir çalışmadır. Her bir merkez 6 odak grup gerçekleştirmiştir. Bunlardan dördü yaşlı bireylerden oluşmuştur. Her bir odak grup bir moderatör ve bir gözlemci eşliğinde, bağımsız bir odada bir masa etrafında bir ses kayıt cihazı yardımıyla 4-6 yaşlı katılımcı (62-85 yaş), ile gerçekleştirilmiştir. Görüşmeler 25 Aralık 2001 ve 4 şubat 2002 tarihleri arasında İzmir, Manisa ve Ankara'da yürütülmüştür.

Bulgular: Üzerinde en çok ortaklaşılan yaşam kalitesi kavramları, sağlıklı olmak, bağımsız olmak (günlük faaliyetleri, herhangi birinden destek almadan yürütebilmek), bedensel olarak aktif olmak, huzur ve mutluluk içinde olmak, ekonomik açıdan bağımsız olmak ve özgürce dinlenebilme hakkıdır.

WHOQOL-100 ölçeğinin 24 bölümü değerlendirildiğinde, 14 bölüm çok önemli, 6 bölüm kısman önemli, 4 bölüm de önemsiz bulunmuştur. Bunlardan "İş kapasitesi", "İlaçlara (insulin hariç) tıbbi tedaviye bağımlı olmak" her iki cinsiyet için de önemsiz veya hemen hemen önemsiz olarak değerlendirilmiş; cinsel faliyetler yalnız kadınlar için, beden imgesi de yalnız erkekler için önemsiz bulunmuştur.

Araştırmanın koordinatör merkezi (Edinburg) tarafından uzmanlar ve literature bilgileri ışığında hazırlanmış olan ek soru veya alanların tümü araştırmaya katılan yaşlılarınca da önemli kabul edilmişlerdir. Bunlar, Duyu işlevleri, Bilişsel kapasite, Sosyal destek veya ilişkiler, Sosyal izolasyon veya yalnızlık, Yaşam koşulları, Ekonomik durum, Kayıplarla başa çıkma ve Önemli yaşam olaylarıdır. Diğer merkezlerin odak gruplarında kısmen önemli Kabul edilen bazı maddeler Türk odak gruplarında "çok önemli" olarak ifade edilmişlerdir. Bunlar, Hastaneye yatma, yeti kaybı, aile ilişkileri, karar verme özgürlüğü, büyük anne büyük baba rolü, iştahın yerinde olmasıdır. Diğer taraftan, topluma katılım , yaşlılıkla ilgili negatif ayrımcılık, gönüllü faaliyetlere katılım ise diğerlerinin aksine araştırmamıza katılan yaşlılar için önemsiz bulunmuştur.

Sonuç: WHOQOL-100 uzun bulunmuştur. Türk yaşlılarının toplumsal normları, kent kır ayrımı olmakla birlikte, çoğunlukla Doğu kültürlerinin özelliklerini yansıtmaktadır. Bu durum, Türkiye'de yaşlılara verilen koruyucu, sağaltıcı ve esenlendirici sağlık hizmetlerinde dikkate alınmalı, yaşam kalitesi gibi öznel değerlendirmeler, kısa, kolay anlaşılır ve yüz yüze sesli okunarak uygulanan ölçeklerle yapılmalıdır.

Anahtar sözcükler: Yaşlılık, Yaşam kalitesi, Niteliksel araştırma, WHOQOL.

INTRODUCTION

Quality of life can be defined as an individual's perception of his/her position in life in the context of culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns. This definition highlights the views that quality of life refers to a subjective evaluation, which induces both positive and negative dimensions, and which is embaded an a cultural, social and environmental context (1). The scope of quality of life, therefore, extends beyond traditional symptoms and includes patients' subjective feelings of well-being, satisfaction, functioning and impairment (2).

In recent decades the world's population has getting increased parallel to the increase in the longevity. Of 7.3% of the world's population is expected to be older than 65 years of age in the year 2010. During the following 25 years, a 88% increase is expected in the population over 65 years of age.(3). The growing percentage of the elderly, caused and increased chronic disease burden on the health services and, chronic conditions have a very deteriorating effect on the health related quality of life of the older adults.. Beyond the biochemical and clinical disease outcomes, quality of life emerged an important outcome measure in the evaluating of the success of the health interventions and has been used as a proxy health measure in the community level. The emerging quality of life concept is also an offspring of the movement of patients' rights. The intention to use quality of life approach in the elderly is parallel to these developments (4). When developing a quality of life measure, its crucial to take into account the target population's opinions in which the scale will be used on. This is because the quality of life is a multidimensional concept which is related to the interactions of the person with other people and the physical and social environment and, the expectations and the daily living experiences of the individual. The developing of generic HRQOL (Health Related Quality of Life) measures for elderly is a very new agenda and there is a growing need of such measures, since no acceptable or satisfactory measure will have been developed. The main question that arise here, is "whether or not questionnaires that have been developed in younger adult populations can be used equally validly for older populations?". It was found in the literature that, two commonly used generic measures, namely, the EuroQol and the SF-36 could be fairly satisfactorily used on older adults (5, 6), but there are still some problems exist about the way of administration, consistency of responses, and some floor effects were seen on particular sub-scales of these HRQOL instruments.

The WHOQOL (World Health Organisation Quality of Life Instrument) (7,8) project which was carried by a number of participating and contributing centers in the world, began in 1992 and the instrument was translated to more than 40 languages including Turkish (9-11) in the world. WHOQOL as a generic measure of quality of life was developed for younger adults (the WHOQOL-100 and the WHOQOL-BREF). The WHOQOL Project team decided to study on developing a quality of life instrument to be used on older adults. The production of the WHOQOL makes it ideal for adaptation to the assessment of quality of life in older adults..

WHOQOL Older Adults Module (WHOQOL-OLD) development project was conducted between the period 2001 and 2004 and supported by European Union 5th Framework Program. WHOQOL-OLD project, which was carried on by 23 international field centers was based on the simultaneous development of the modules among participating centers (cultures) as it was in the core project. The overall aim of the project was to adapt the younger adults version of the WHOQOL for use with older adults. This adaptation may consist of the development of a supplementary module that can be added to the existing WHOQOL, though this possibility will need to be tested with focus group work and with data analysis. Thus, the guidelines of the WHOQOL-OLD project involve focus groups (to elicit the universe of interest), development and piloting of an international item bank, participating in instrument construction procedures and conducting a validation study. This study is about the first stage – the conduct of focus groups – results of Izmir center of WHOQOL-OLD project.

The purpose of this study is to present the attitudes and decisions of the Turkish older adults on the pre-defined dimensions about health and aging, and to obtain their recommendations on the lacking dimensions during the process of WHOQOL-OLD project.

MATERIALS AND METHODS

Izmir/Turkey center is one of the contributing centers of the core WHOQOL project. WHOQOL instruments (WHOQOL-100 and WHOQOL-Bref) are generic HRQOL questionnaires which were developed simultaneously by more than 40 cultures in the world and have been used to assess the perceived quality of life of younger adults around the world. The WHOQOL instruments have been validated into Turkish (9,10) and have been using on clinical settings and public health for a couple of years in Turkey. In addition to the previous modules like Spirituality, Izmir center is also one of 23 WHOQOL-OLD project centers.

Table 1— The consecutive steps of the focus group methodology

1. Making contacts with the older persons for inviting them to the focus group discussion
2. The application of the inclusion and exclusion criteria
3. Determining the study participants
4. Invitation subjects to the focus group discussions
5. The organising of the technological background and personnel of focus group sessions
6. Looking over to the focus group guide (hand book)
7. Conducting focus group sessions
8. Collecting focus group documents
9. Analysis of the focus group documents
10. Obtaining preliminary results
11. Preparing focus group report

This study presents the Izmir center's focus group discussions which was the 1st step of the WHOQOL-OLD methodology which followed the establishment of question pool by expert committee and WHOQOL core project centers. The aim of this study was to assess the Turkish older adults' thoughts and decisions on the perception and the determinants of health and quality of life. The findings are expected to help the development of the Older Adults' module of the WHOQOL instrument (WHQOL-OLD).

The following steps of WHOQOL-OLD project was to develop the draft pilot questionnaire, pilot analysis, filed trial, filed trail analysis and development of final module structure (12). The results of these following steps of Turkish center will be published elsewhere.

The general methodological structure of this study was determined by the scientific adviser sub-committee of this multi-center study consortium According to this structure, the consecutive steps of the study was as follows (Table 1).

Each project center carried on this procedure independently from the consortium.

Focus Group Sessions

The focus group sessions were conducted between dates 25th December 2001 and 4th February 2002 in Izmir. The standard proposed focus group procedure for this multi-centre project is as follows: Each centre conducted 6 focus groups, four of them for older adults, one for non-professional care givers and one for professionals who give health service to the older persons. Each of focus group session was carried out on a round table with a moderator and an inspector in an independent silent room. A tape recorder were used during the discussions. Turkish older adults' focus groups were composed of 3 to 6 persons with an age range between 62 and 85. Some demographic characteristics of the focus group participants are presented on the table 2 below. Detailed information about the groups was given on the tables i,ii,iii, and table iv appendix section of this paper. The care givers' and professionals' focus groups results are the scope of this paper and will be presented elsewhere.

Procedure of the sessions included the stages below:

1. At the beginning, the group members were asked to complete demographic questionnaire and signed the written informed consent.
2. After then the focus group objectives, aims, the approximate duration and outline of the session were explained to the participants in detail. And the participants were encouraged to give their opinions and suggestions as freely and openly as possible. It was explained that discussions were anonymous and confidential, and it was again stressed that the tapes will only be listened to by the staff and will be deleted after the end of the work.

Table 2— Some characteristics of the Focus Groups*

Some characteristics of the focus group sessions	Focus Group 1 (n=5)	Focus Group 2 (n=6)	Focus Group 3 (n=6)	Focus Group 4 (n=3)
Province	Ankara	Manisa	Manisa	İzmir
Type of the Venue	A private house	Residential Care Unit	University	
	Nursing home			
Residential backround	Urban	Urban – rural mixed	Urban – rural mixed	Urban – rural mixed
Age (range)	62-74	71-85	65-78	74-81
Gender (F/M)	5 / 0	4 /1	3/3	3/0
Years of formal education (range)	5-17 years	5-15 Years	5-17 years	8 years

*Please refer to tables i, ii, iii and iv for further details on the focus group participants in the Appendix section of this paper.

3. Warm-up and free-form discussion of Quality of life and *description of quality of life*
4. *Discussion of WHOQOL-100* – review of facets. Brief outline of every facet (Following the application of WHOQOL-100 to the participants, the 24 facets of WHOQOL, were each evaluated by the focus group participants)
5. *List of additional items/areas* for consideration (These items were suggested by the other contributing centers - by the other older adults living in different cultures- of this project)
6. Probe of suggestions for new items
7. Closing with summary of the suggestions, evaluations.

The focus group kit was composed of the socio-demographic questionnaire, WHOQOL-100, and a list of additional items suggested. WHOQOL-100 instrument is a100 item questionnaire with 5 point Likert type response scales. WHOQOL-100 has 24 facets (each having 4 questions) and 6 domain structure as shown on the table 3 below.

A number of additional facets that were suggested by the other contributing centers of this multi-center study were discussed in the focus group sessions of the Turkish center as well. Some of the proposed facets were regarded as very important and some were somewhat important by the other cultures of the global WHOQOL-OLD study.

List of Additional facets that were regarded as very important by the other centers were as follows: Sensory functions (vision, hearing) Cognitive capacity (the capacity of cognition or perception. e.g. memory, decision making, thinking, the ability to concentrate on a topic), Social support/relations (both formal or informal relations, family relations) Living situation (recent conditions), Social isolation/lonliness (the effect of experiencing this on the quality of life of the older adults), The financial and economic issues (sources of income, impacts), Coping with loss (of friends, family members) Significant life events (retirement; grandparenthood etc.).

On the other hand the additional facets that were regarded as somewhat important by the other centers can be listed as:

Table 3— The WHOQOL-100 facet/domain structure

Domains	Facets
1. Physical well-being	• Overall Quality of Life and General Health • Pain and discomfort • Energy and fatigue • Sleep and rest
2. Psychological well-being	• Bodily image and appearance • Negative feelings • Positive feelings • Self esteem • Think, memory, learning and concentration
3. Level of Independence	• Mobility • Activities of daily living • Dependence on medical substances and medical aids • Work capacity
4. Social Relationships	• Personal relationships • Social support • Sexual activity
5. Environmental well-being	• Financial resources • Freedom, physical safety and security • Health and social care: accessibility and quality • Home environment • Opportunities for acquiring new information and skills • Participation in and opportunities for recreation / leisure • Physical environment (population/noise/traffic/climate) • Transport
6. Religion / Spirituality/Personal beliefs	• Religion / Spirituality/Personal beliefs

Feelings about hospitalisation/institutionalisation, Grief over lost abilities, Relevance of family communications, Freedom of decision-making and choice and Importance of role as grandparent and Eating well/appetite, Importance of perceived achievement/recognition for contribution to community/society, Concern about ageing/perceived impact of negative discrimination and Importance of voluntary occupations, opportunities for leisure/recreational activities, Perceptions of death/existential issues.

RESULTS

The subjects in this qualitative research asked the focus group moderators to read the given written material aloud. The WHOQOL-100 was regarded as a very long quality of life instrument difficult to concentrate by the Turkish older adults. On the other hand the brief version of the WHOQOL (WHOQOL-BRE.) was evaluated as an instrument lacking family support which is a very crucial component of life for the Turkish elderly.

APPENDİX Tables i-iv show the distribution of the focus groups participants in terms of age, gender, education, marital status, number of grand children, living condition, health status and medications.

The number of participants in all of the four older adults focus groups was 21, with only 4 male and 17 female. The mean age of the participants was 73.90 ± 6.03. Two of the focus groups were conducted in Manisa, one in Ankara and one in Izmir. As for the origin of the participants, one group consisted of urban and the other focus groups participants were mixed (urban-rural) origin.

The results of this study can be presented under three main headings:

1. The perception of quality of life in general,
2. The findings related with WHOQOL-100.
3. The findings related with additional items proposed.

1. The perception of quality of life in general:

The quality of life concept were discussed during the initial part of the free discussions.

Group 1: The group members described the key factors impacting upon quality of life. According to their opinion, "quality of life" was:

- To become physically active,
- To be independent,
- To feel healthy,
- To perform the daily routines without help of any caregiver,
- Right of "resting",
- To be able to cope with separations from loved ones,
- To live in a safe and clean physical environment.

They have determined level of their quality of life as "well" compared with that of other adults of the same/similar age. General health level was the most important factor in determining level of their quality of life.

Group 2: According to their opinion Quality of life is:

a situation of "being healthy". In other words, being healthy is the most important factor determining quality of life. "Being healthy concept" includes mainly

- To be physically active and independent and
- To be firm about sensory functions like hearing and vision.

They all mentioned that economic independence is a crucial aspect of life quality.

When they were asked to define Quality of life briefly, they mostly agreed on "peace of mind" and "happiness".

Group 3: Quality of life was,

- Being Healthy,
- Hopeful of the future,
- Peace of happiness in mind and
- Economic independence.

According to the group members.

Group 4: quality of life can be described as follows:

- To have positive feelings, and to feel love and affection to people living around.
- To feel him/herself in security, to live in a safe place
- To be respected for their privacy and secrecy
- The right of resting
- To be independent in all aspects of life
- To be able to cope with separations from loved ones
- To be able to do what they want (such as going to a trip, left from residentially house when they need)
- To create a balance between inner and outer world

They have found "well" the level of their quality of life compared with that of other adults of the same/similar age. Stigmatisation as "a member of resting house" was one of the important factor in determining the level of their quality of life, both positive and negative directions.

The conceptual definitions of the quality of life are summarised in the table 4. The mostly agreed quality of life concepts were: being healthy, independence (the ability of organising everyday activities without any support from others), being physically active, peace of mind and happiness, having economic independence, to be able to cope with separations from loved ones and right of resting.

On the other hand, the factors that might affect quality of life in a negative or positive way were expressed as:

Table 4— The Quality of Life Concept stated in the Focus Groups

	FG* 1	FG 2	FG 3	FG 4
Being healthy	✓	✓	✓	
Physically active	✓	✓		
İndependence	✓	✓		✓
Can perform daily duties without help	✓			
Right of resting	✓			✓
To be able to cope with separations from loved ones	✓			✓
Safe and clean physical environment	✓			
To be firm about sensory functions		✓		
Economic independence		✓	✓	
Peace of mind and happiness		✓	✓	
Without any doubt of future life			✓	
Positive feelings and feel love				✓
Safety and security				✓
To be respected for their privacy and secrecy				✓
To create a balance between inner and outer world				✓

*Focus Group

- love and respect,
- at peace with herself-himself.
- the happiness of the children, the – economical and psychological- goodness and happiness of their children,
- devotion (to the family, children) and, be appreciated with their children and, harmony/disharmony within family members and friends
- pride of children,
- the others (children, friends, relatives) to show interest with her-him, the others (children, friends, relatives) to show interest with her-him. They expressed their feelings by a Turkish proverb as "loniless is only belongs to god"
- acquire new information and skills,
- friendship and sharing of feelings,
- perform the daily routines without any support (independence)
- to continue her-his habituals but to be oriented with some new things and life-styles.
- to be met with new persons,
- see new places, environments,
- not to loose to the bindings (contacts) with the ongoing life and world,
- independence

Table 5— The WHOQOL-100 based evaluations of the participants

The facets regarded as "Very important"	The facets regarded as "Somewhat important"	The facets regarded as "Not important at all"
Pain and discomfort	Think, memory, learning and concentration	Work Capacity
Sleep and rest	Physical environment (population/noise/ traffic/climate)	Dependence on Medical Substances and Medical Aids (except for insulin)
Negative feelings	Transport (except in certain events)	Sexual activities
Positive feelings	Energy and fatigue	(only female participants)
Mobility	Self confidence (not self esteem) and	Bodily image and appearance (only male participants)
Activities of daily living	Participation in and opportunities for recreation / leisure	
Personal relationships		
Social support		
Financial resources		
Freedom, physical safety and security		
Health and social care: accessibility and quality		
Home environment		
Opportunities for acquiring new information and skills		
Religion/Spirituality/Personal beliefs		

2. Findings based on WHOQOL –100

When all 24 fields (facets) of WHOQOL-100 were probed one by one during the focus group sessions, 14 facets were regarded as "very important", six facets "somewhat important" and four facets "not important at all"(table 5).

When all 24 fields (facets) of WHOQOL-100 were probed one by one during the focus group sessions, "Work Capacity", "Dependence on Medical Substances and Medical Aids" (except for insulin) were regarded as "not important" or "almost not important" for both male and female participants. On the other hand, sexual activities and bodily image and appearance-which were reported as "not important" facets as well-, were the fields that showed gender differences: "Sexual Activity" was not important at all for female participants, whereas "Bodily Image and Appearance " for male participants.

The fields that were stated as "somewhat important" can be listed as: Think, memory, Learning and concentration; Physical environment (population/noise/traffic/climate); Transport (except in certain events); Energy and fatigue; Self confidence (not self esteem) and; Participation in and opportunities for recreation/leisure.

As we look at the "non-important " facets, we see that there is a gender difference and the two of the facets were belong to the "Level of Independence" domain of the WHOQOL-100. On the other hand those which were categorized as "Somewhat Important" are mostly belong to the "Environment" domain of the WHOQOL-100.

3. Additional Suggested Items

Additional items extracted by the co-ordinating center (Edinburg) which suggested in consensus with the experts of all of the project centers based on recent literature and clinical experience. These additional facets which are listed in the Materials and Methods section above were considered as "very important" by all of the Turkish focus group participants, but there are some different interpretations of Turkish older adults on the items that were suggested additionally and mentioned as important or somewhat important by the other WHOQOL-OLD Project centers. These are presented in the table 6. Among the items stated as "somewhat important" during the other centers' focus groups, Feelings about hospitalisation/institutionalisation, Grief over lost abilities, Relevance of family communications, Freedom of decision-making and choice and Importance of role as grandparent and Eating well/appetite were the items that most of the Turkish focus groups found important or very important. On the other hand Importance of perceived achievement/recognition for contribution to community/society, Concern about ageing/perceived impact of negative discrimination and Importance of voluntary occupations were the items found not important by the majority of the Turkish groups. The item Opportunities for leisure/recreational activities was mentioned as important by two groups and not important by the others.

The groups were not sure if "Perceptions of death/existential issues" is important or not? But they mostly tended to ignore death issues.

Table 6- The evaluation of the Turkish older adults on the issues considered

"somewhat important" by majority of the project centres.

About the new additional items for inclusion were listed as:

- To have a separate bedroom for his/her own. Described above;
- To meet their root, e.g. to visit motherland or the city of born (at least once a year), to see childhood friends, etc.

Table 6— The evaluation of the Turkish older adults on the issues considered "somewhat important" by majority of the project centres

Evaluated as Important by Turkish participants (ID number of Focus Group)	Evaluated as Not-Important by Turkish participants (ID number of Focus Group)
• Eating well / appetite (1, 2,3)	• Eating well / appetite (4)
• Importance of voluntary occupations (4)	• Importance of voluntary occupations (1,2,3)
• Opportunities for leisure / recreational activities (1,4)	• Opportunities for leisure/recreational activities, (2,3)
• Feelings about hospitalisation / institutionalisation (1,2,4)	• Feelings about hospitalisation / institutionalisation (3)
• Grief over lost abilities (1,2,3,4)	• Importance of perceived achievement / recognition for contribution to community/society (1,2,3,4)
• Relevance of family communications (1,2 ,3,4)	• Concern about ageing/perceived impact of negative discrimination (1,2,4)
• Freedom of decision-making and choice (1,2,3,4)	
• Importance of role as grandparent (1,2,3,4)	

- To get continue habituation (reading newspaper, watching TV, sewing, etc). In another words, to have the right of continuing doing the things they used to do every time. They described that their habits are vital for them. This item was expressed mainly to be in contact with past. So this includes special attention with the places where they lived; with the things they use; with the language (old words) they speak and finally with the social norms and rules they are belong to.
- To continue and not to loose contacts with the past" were stated as a national/cultural item. But although they try to be in contact with past (the place where they spent their young age, and the persons they were familiar before) they also try to integrate with the current life.
- The happiness of children" is a crucial factor in their life. This could be thought as a kind of traditional decision seen mostly "Mediterranean cultures".

DISCUSSION

Healthy older persons remain a resource to their families, communities and economies, as stated in the WHO Brasilia Decleration of Ageing and Health in 1996. It was also stated in the WHO Active Aging report that, "….chronological age is not a precise marker for the changes that accompany ageing. There are dramatic variations in health status, participation and levels of independence among older people of the same age" (13) On the other hand, cultural background may have a very great impact on the perception of health, quality of life and the determinants of them. This paper presents the perceptions of the Turkish older adults on various aspects of quality of life as a part of a multi-national study to develop a valid quality of life measurement tool for the elderly, which is expected to allow comparisons among older people from different cultures.

In regard to the perception of quality of life concept, the results of this study appeared to support the assumptions about the multi-dimensionality of the QOL concept. The most agreed concepts for Qol can be listed as being healthy, physically active, being independent from others, economic independence, to be able to cope with separations from loved ones, right of resting, and peace of mind and happiness. A number of study conducted on Turkish elderly gave consistent results with these obtained from our focus groups (28,30,32). The first three (healthy, active, independent) were stated in three of four focus groups and the remaining in two of four. Similar results were found in a number of western and eastern cultures (14-17), with an exception that, "right of resting" was not listed in any of the cultures as a QOL concept. This may strongly be attributed to the sociological norms of Turkey, since the older persons especially older women are in continuing duty of in-family responsibilities. As a matter of fact, the two focus groups' members who stated "right of resting" were all women. One other evidence that supports this assertion comes from the previous work during the development of the core questionnaire of WHOQOL, which extracted "social pressure" as a national domain (9). Although slight differences in the perception of the QOL concept were detected in the Turkish older adults, the most agreed abstracts are same as other cultures.

Considering all of the 24 facets of the WHOQOL-100, 14 facets were regarded as "very important", six were "somewhat important" and four "not important". Especially being physically and economically firm and independent are those core dimensions regarded as very important in some other national Turkish elderly studies (28,30) The 14 facets which were stated as important are those mainly regarded as important in other study centers and a number of literature as well. Negative and positive feelings, activities of daily living, financial resources, social support and home environment are some of the domains in which Turkish elderly share with almost all of the different cultures. The dimensions that partially separate Turkish sample from some of the other cultures are those regarded as "not important" by Turkish older adults which can be listed as work capacity, dependence on medications, sexual activities and bodily image. These facets were regarded the facets to be modified in Brazil center as well. In addition of this four facets, Brazilian elderly added "negative feelings" facet which need modification during focus group discussions (18). On the other hand in the Turksih focus groups, the last two showed gender differences: sexual activity was not important for women while bodily image was not for men. The previous national studies conducted on Turkish elderly also indicated the gender differences on the perceived quality of life (9,10,11). These gender differences could be attributed to real perceptions or population norms and roles in the country. For instance women (especially the old generation women) are generally unwilling to express their real thoughts on sexuality and it is not very usual for older men to pay a great attention of body appearance in Turkey.

The global WHOQOL-OLD project focus group stage extracted some potential additional facets to be included in the WHOQOL-OLD module. The additional facets that were considered as important by the other centers were all regarded as important by Turkish participants as well. Some recent Turkish studies conducted on Turkish older adults have

shown consistent findings on these dimensions: Cognitive ability (31), Sensory Functions (32) and Social Support and Isolation (27) were reported as very important aspects of quality of life by Turkish elderly.

Among the additional proposed facets that were considered as "somewhat important" in majority of the international centers, those which are stated as "not-important" by the Turkish participants were: Importance of voluntary occupations, Importance of perceived achievement for contribution to community, and Concern about ageing/perceive impact of negative discrimination. In a recent study conducted in Manisa province on 65 and over aged persons showed that "community participation" was regarded as "not important" by the majority of the study population (9). On the other hand, eating well/appetite, Feelings about hospitalisation/institutionalisation, Grief over lost abilities, Relevance of family communications, Freedom of decision-making and Importance of role as grandparent were regarded as "important" for the sample of this study. These findings reflects an Eastern pattern for the elderly which were reported in the literature (21-23) and very consistent with the traditional rules and experiences of everyday life in Turkey. In Turkey, the older persons always want to feel the leader of his/her family and the inter-family solidarity always more important that community relations (9,10,11,29). They used to be respected by family members and until modern times, there is no need of concern about negative discrimination about ageing which different from the Western cultures. The negative impact of living in a nursing house compared to living in a family on the quality of life of the elderly was well demonstrated in the study conducted by Özer (29). The results of a Chinese study showed the same tendency for the elderly to be very strictly bounded to the traditional rules and family (21). On the other hand the effect of religion on the quality of life was evaluated as positive in the participants of this study which was very consistent with the results of Fleck conducted on Brazilian older adults (25).

Eating well/appetite and Opportunities for leisure activities should be separately interpreted. An old Anatolian belief says that "soul comes from eating" which could probably generated from the old times of wars and civil struggles. The old people always say "Eat when you find, otherwise you could catch disease" to their grandchildren. One other possible explanation to the importance of eating might be attributed to the fact that eating whatever a person wants is a proxy determinant of being rich. The studies conducted on western cultures presented the importance of "Opportunities for leisure activities" for the elderly (26). When we look for the evaluation of the focus groups on the importance of "Opportunities for leisure activities", we saw that in the focus groups that consisted of urban originated participants (FG 1 and 4) regarded this facet important whereas in those rural originated groups (FG 2 and 3) evaluated this facet as "not important". This a very clear evidence that Turkish older adults should be differentiated by urban and rural during health promotion interventions.

CONCLUSION

The WHOQOL-100 was regarded as a very long quality of life instrument difficult to concentrate by the Turkish older adults sample of this study. On the other hand the brief version of the WHOQOL (WHOQOL-BREF) was evaluated as an instrument lacking family support which is avery crucial component of life for the Turkish elderly in general.

The sociological norms of the sample of this study reflects the properties of Eastern cultur mostly with a difference between rural and urban originated ones. The mostly agreed quality of life concepts for the

Turkish participants were: being healthy, independence (the ability of organising everyday activities without any support from others),and being physically active.

The facets of the WHOQOL: "Work Capacity", "Dependence on Medical Substances and Medical Aids" (except for insulin) were regarded as "not important" for the participants. Among the items stated as "somewhat important" during the other centers' (mostly Western) focus groups, Feelings about hospitalisation/institutionalisation, Grief over lost abilities, Relevance of family communications, Freedom of decision-making and choice and Importance of role as grandparent and Eating well/appetite were the items that most of the Turkish focus groups found important or very important.

These aspects should be taken into account during the preventive, curative and rehabilitative services given to the elderly in Turkey and in case of subjective evaluations such as quality of life assessments, short, clear forms should be applied by using interviewer administration (face to face administration).

IN COMMEMORATION OF Prof. Dr. HURAY FIDANER WITH RESPECTS

We want to express our grief and respects in commemoration of Prof. Dr. Huray Fidaner who spent a very great effort to every stage of this study, we lost on 3rd August 2002.

Prof. Dr. Hüray Fidaner'i SAYGIYLA ANIYORUZ

Bu çalışmanın tüm aşamalarına yoğun emek veren, 3 Ağustos 2002 tarihinde aramızdan ayrılan Dokuz Eylül Üniversitesi Tıp Fakültesi Psikiyatri Anabilim Dalı başkanı merhum Prof. Dr. Hüray Fidaner'i saygıyla anıyoruz.

APPENDIX

Table I— FOCUS GROUP 1: The description of the older adults focus group sessions and participants according to some sociodemographic and life conditions variables

Province: Ankara Type of the Venue: A private house Duration: 120 min. Origin of the Participants: Urban								
Gender M/F	Age	Education	Marital status	No. of grand children M/F	Health status	Subjective Health status	Use of medication/non-medicinal substances	Current living circumstances
F	69	8 years (Retired)	Married	1/2	Operated hyperthyroidism (two months ago)	Well	None	Currently living at home with her husband without external support.
F	74	17 years (retired medical doctor)	Married	1/1	Mastectomy (15 years ago)	Well	Vitamins	Currently living at home with her husband without external support.
F	69	5 years (Housewife)	Widow	3/0	Dysthymic disorder, Hypertension	Well	Antidepressants Antihypertensives	Currently living at home with her married son (with financial support)
F	62	5 years (Housewife)	Married	5/1	Osteoporosis, Hypertension	Well	Calcium Analgesics	Currently living at home with her husband and two adult children without external support.
F	74	8 years (Housewife)	Married	3/2	Hypertension, Osteoarthritis	Well	Antihypertensives Anti-inflammatory drugs	Currently living at home with her husband without external support.

Table II— FOCUS GROUP 2: The description of the older adults focus group sessions and participants according to some sociodemographic and life conditions variables

Province: Manisa
Type of the Venue: Residential Care Unit
Duration: 105 min.
Origin of the Participants: Urban – rural mixed

Gender M/F	Age	Education	Marital status	No. of grand children	Health status	Subjective Health status	Use of medication/non-medicinal substances	Current living circumstances
74	F	High school	Married	3 / 5	Hypertensive	well	Antihypertensive agent	Residential Care House
81	F	University	Divorced	-	-	well	-	Residential Care House
85	F	Primary school	Widow	2 / 3	-	well	-	Residential Care House
75	F	High school	Single	-	Hypertensive and diabetic	well	Antihypertensive agent and oral antidiabetics	Residential Care House
82	F	Primary school	Widow	3 / 5	Hypertensive, asthmatic and diabetic	ill	Antihypertensive and antiasthmatic agents and oral antidiabetics	Residential Care House
71	M	Primary school	Widow	2 / 5	KOAH	well	KOAH medicines and Smoking	Residential Care House

Table iii— FOCUS GROUP 3: The description of the older adults focus group sessions and participants according to some sociodemographic and life conditions variables

Province: Manisa Type of the Venue: University Duration: 90 min. Origin of the Participants: Urban – rural mixed								
Gender M/F	Age	Education	arital status	No. of grand children	Health status	Subjective Health status	Use of medication/non-medicinal substances	Current living circumstances
68	Male	Primary school (retired)	Widow	4 / 8	Chronic peptic ulcus	well	H2 receptor blocker medicine / Ex smorer. He smoked for 40 years.	Living at home (supported by family,/carers or partner)
78	Male	University (medial doctor, still working in his private clinic)	Married	2 / 2	Gloaucoma Prostate hyperplasy Mild hypertension	well	An antiglaucome eye medication An antihypertensive / He is a mild alcahol drinker	Living at home (unsupported)
67	Female	Primary school (house wife)	Married	3 / 6	Hyperthyroidism, hypertension, gastrointestinal complains, Mild vision disability	ill	Anti-throid mediacation, antihypertensives	Living at home
65	Female	Primary school (house wife)	Widow	1 / 2	Diabetes mellitus, Coronary disease, Diffuse Guatr and Osteoporosis.	ill	Oral antidiabetics + insulin , coronary diatator, thyroid hormones, antiosteoporosis medication.	Living at home (unsupported)
75	Female	Primary school (house wife)	Married	5 / 7	Rheumatic arhritis	ill	Anti-rheumatic medication	Living at home (with her husband and her 53 years old mental disabled daughter)
76	Male	High school (retired teacher)	Widow	3 / 10	KOAH	ill	KOAH medicines / Current heavy smoker	Living at home (supported by family,/carers or partner)

Table iv— FOCUS GROUP 4: The description of the older adults focus group sessions and participants according to some sociodemographic and life conditions variables

Province: İzmir
Type of the Venue: Nursing home
Duration: 90 min.
Origin of the Participants: Urban – rural mixed

Gender M/F	Age	Education	Marital status	No. of grand children	Health status	Subjective Health status	Use of medication/non-medicinal substances	Current living circumstances
F	81	8 years	Widowed (Husband died seven years before, by MI)	2/3	Peripheric Vasculer Complaints	Well	Salicilate Vasculer diladators Anti-hyper-tensives	Retired house without support (in summer she leaves for holiday)
F	74	8 years	Widowed (since 1972)	1/1	Hypertension	Well	Anti-hyper-tensives	in retired house without support
F	78	8 years	Widowed	1/1	Hypertension	Well	Anti-hyper-tensives	in retired house without support

REFERENCES

1. Orley j, Kuyken W. Quality of Life Assessment:International Perspectives. Berlin Heidelberg, Springer Verlag, 1994.
2. World health Organization. Wolrd Health Report 1998. Cenеve,1998:117-119.
3. Arslan Ş, Gökçe Kutsal Y. Geriatride Yaşam Kalitesinin Değerlendirimi Geriatri (Turkish Journal of Geriatrics) 1999; 2 (4):173-178
4. Eser E., Fidaner H., Fidaner C., Yalçın Eser S., Elbi H., Göker E. "WHOQOL -100 ve WHOQOL-Bref 'in Psikometrik Özellikleri" 3 P (Psikiyatri Psikoloji Psikofarmakoloji) Dergisi, 1999, 7(ek2): 23-40.
5. Yalçın Eser S., Fidaner H., Fidaner C., Elbi H., Eser E., Göker E "Yaşam Kalitesinin Ölçülmesi, WHOQOL-100 ve WHOQOL-Bref", 3 P (Psikiyatri Psikoloji Psikofarmakoloji) Dergisi, 1999, 7 (ek2): 5-13.
6. Fidaner H., Elbi H., Fidaner C., Yalçın Eser S., Eser E., "WHOQOL Türkçe Versiyonu Çalışması Odak Grup Görüşmeleri ve Ulusal Soruların Değerlendirilmesi" 3 P (Psikiyatri Psikoloji Psikofarmakoloji) Dergisi, 1999, 7(ek2): 48-54.
7. WHOQOL Group: Development of the World Health Organization WHOQOL-BREF quality of life assessment. Psychological Medicine, 1998. 28: 551-558.
8. WHOQOL Group: The World Health Organization quality of life assessment (WHOQOL). Development and general psychometric properties. Social Science and Medicine, 1998; 46 (12): 1569 – 1585.
9. Saatli G., Yaşlılarda Yaşam Kalitesi Bileşenleri ve Bu Bileşenleri Etkileyen Değişkenler Yayımlanmamış Yüksek Lisans Tezi 2004 – Manisa.
10. Azak A., Karamanoğlu A., Sert H., Çetinkaya B., Çınar İ., Kartal A. Huzurevinde Yaşayan Yaşlılarda Yaşam Kalitesinin Değerlendirilmesi 1. Sağlıkta Yaşam Kalitesi Sempozyumu İzmir 2004; p:25
11. Turgul Ö., Mandıracıoğlu A., Özuğurlu B., Özgener N., Deveci H. Narlıdere İlçesinde 65 Yaş Üstü Nüfusun Yaşam Kalitesinin Değerlendirilmesi 1. Sağlıkta Yaşam Kalitesi Sempozyumu İzmir 2004:p:26
12. De Vries J., Seebregts A., Drent M., assesing health status and quality of life in idiopathic pulmanary fibrosis which measure should be used?; Resp. Med. 2000; 94(3):273-8
13. Fleck MP, Bonges ZN, Bolgnesi G, da Rocha NS Development of WHOQOL spirituality, religiousness and personal beliefs module. Rev. Saude publica, 2003; 37(4):446-55.
14. Leung KK, Wu EC, Lue BH, Tang LY The use of focus groups in evaluating quality of life components among elderly Chinese people. Qual. Life Res. 2004;13(1):179-190
15. Brazier J, Roberts J, Tsuchiya A, Busschbach. J.A comparison of the EQ-5D and SF-6D across seven patient groups. Health Econ. 2004;13(9):873-84.
16. Walters SJ, Munro JF, Brazier JE.Using the SF-36 with older adults: a cross-sectional community-based survey. Age Ageing. 2001;30(4):337-43.
17. Quilty LC, von Amerigen M, Mancini C, Oakman J, Farvolden P. Quality of life and anxiety disorders. Anxiety Dis 2002; 430: 1-22.
18. WHOQOL Group. The World Health Organization Quality of Life assessment (WHOQOL): Development and general psychometric properties. Soc. Sci Med. 1998; 46: 1569 – 1585.
19. World Health Organization. 2002. Active Ageing: A policy framework. WHO/NMH/02.8.
20. Lau A, Mckenna K. Perception of Quality of Life by Chinese elderly persons with stroke. Disabil Rehabil. 2002 10;24(4):203-18.
21. Lau AL, McKenna K, Chan CC, Cummins RA. Defining quality of life for Chinese elderly stroke survivors. Disabil Rehabil. 2003 8;25(13):699-711.
22. Nilsson J, Parker MG, Kabir ZN. Assessing health-related quality of life among older people in rural Bangladesh. J Transcult Nurs. 2004;15(4):298-307.
23. Fleck MP, Chachamovich E, Trentini CM. WHOQOL-OLD Project: method and focus group results in Brazil] Rev Saude Publica. 2003;37(6):793-9.
24. Zunker C, Rutt C, Meza G. Perceived health needs of elderly mexicans living on the u.s.-Mexico border. J Transcult Nurs. 2005;16(1):50-6.
25. Leung KK, Wu EC, Lue BH, Tang LY. The use of focus groups in evaluating quality of life components among elderly Chinese people. Qual Life Res. 2004;13(1):179-90.
26. Tseng SZ, Wang RH.Quality of life and related factors among elderly nursing home residents in Southern Taiwan. Public Health Nurs. 2001;18(5):304-1
27. Sütoluk Z.,Demirhindi H.,Savaş N.,Akbaba M., Adana Huzurevlerinde Kalan Yaşlilarda Depresyon Sıklığı ve Nedenleri. Turkish Journal Of Geriatrics 2004;7(3),148-151
28. Kuzeyli Yıldırım Y.,Karadakovan A., Yaşlı Bireylerde Düşme Korkusu ile Günlük Yaşam Aktiviteleri ve Yaşam Kalitesi Arasındaki Ilişki Turkish Journal Of Geriatrics 2004;7(2):78-83
29. Özer M.,huzurevinde ve aile ortamında yaşayan yaşlıların yaşam doyumunun incelenmesi. Turkish Journal Of Geriatrics 2004;7(1),33-36
30. Gülseren Ş., Koçyiğit H, Erol A, Bay A, Kültür S, Memiş, Vural N, Huzurevinde Yaşamakta Olan Bir Grup Yaşlıda Bilişsel Işlevler, Ruhsal Bozukluklar, Depresif Belirti Düzeyi ve Yaşam Kalitesi. Turkish Journal Of Geriatrics 2000;3(4):133-140
31. Birtane M, Tuna H, Ekuklu G, Uzunca K,Akçi C,Kokino S, Edirne Huzurevi Sakinlerinde Yaşam Kalitesine Etki Eden Etmenlerin İrdelenmesi. Turkish Journal Of Geriatrics 2000;3(4):141-145
32. Inal S, Subaşı F, Mungan Ay S, Uzun S,Alpkaya V,Hayran O, Akarcay V. Yaşlıların fiziksel kapasitelerinin ve yaşam kalitelerinin değerlendirilmesi. Turkish Journal Of Geriatrics 2003;6(3):95-99