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Poverty-Related Quality of Life among Community Dwellers in Barangay Poro, City of San Fernando La Union, Philippines: A Self- Reported Study

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ABSTRACT

Poverty and inequality remains a significant problem in spite of the economy's swift stride of growth over the past two years in Philippines. This study aimed to assess the poverty-related quality of life among community dwellers in Barangay Poro, City of San Fernando La Union, Philippines. A cross-sectional study using the poverty-related quality of life questionnaire was administered to 99 respondents. Overall, the global index score for the poverty-related quality of life among the respondents was 57.09±9.71. Aged 41-50 years had a significantly poorer relationship with family compared with those who were 31- 40 years old ($p<0.05$). In terms of income, participants with more than P3000 monthly income reported better future perception. The respondents with primary school certificate reported significantly better relationship with friends ($t=2.14$, $p<0.05$) and higher global index ($t=1.99$, $p<0.05$). Those without health insurance reported better relationship with family ($t=-2.69$, $p<0.01$), better autonomy was ($t=-2.52$, $p<0.05$) and higher global index was ($t=-2.26$, $p<0.05$). In conclusion, respondents' demographic profiles are strongly related to some dimensions of poverty-related quality of life, which strengthens the existing knowledge that socioeconomic status has a key role to play in the quality of life among poor people.

Keywords: Poverty, Quality of life, Social determinants of health

INTRODUCTION

The issue of poverty and inequality remains a significant problem in spite of the economy's swift stride of growth over the past two years in Philippines as presented by[(1)]**.** Many studies by[(2),(3),(4)] are of the opinion that poverty yield to increased morbidity and mortality affecting the current economic situation. The Philippine Statistics Authority (PSA) reported by[(5)] stated that the poverty incidence was accounted to 25.8% in the first half of the year 2014, giving rise from 24.6% in 2013 which may indicate that the combat to poverty reduction has been slower than expected. Whereas, significant problems on poverty are anticipated to grow even further, negatively affecting the health of the people[(6)] leading to low quality of life.

Background

A plethora of literature according to[(7)] revealed that people below the economic ladder are those living in rural areas, working in the agricultural sector (farming, fishing), having large family size (six or more members) while the head of the family has elementary education or below. In addition to this, are those who have no or few assets and minimal access to credit? As a result, population belonging to this group continuous to have

limited access to care as they cannot afford to pay for their medical consultation including treatment as stated by[8]. Conversely,[7] believed that these people described their ill-health in multidimensional way, affecting not only the presence of physical disease, but also include hunger, pain, exhaustion, isolation, poor family relationship, insecurity, and powerlessness. Likely, Wardle, & Steptoe, (2003) narrated that sedentary lifestyle and cigarette smoking is a socially patterned among the population of this group further resulting to health damages. Also[9] reported that poverty experience may even lead physiological activation to increase the risk for cardiovascular disease. Thus, assessing and intervening to people seeking care in lower income group plays a vital role for health care professionals including nurses to address the issue of health inequalities[10]. This is because having a good health among low income population is claimed to be major component of their good quality of life.

Previous research by [11], and [12] have reported the social determinants of health related quality of life but none of this had mainly focused on the poverty which is one major determinant of health, instead many had utilize the generic World Health Organization Quality of Life (WHOQOL) where it measures general health such as physical, emotional, spiritual and psychological wellbeing, including social and interpersonal relationship, support and environmental resources. Importantly according to the authors, one study found an existence of social determinants of health related quality of life (HRQoL), respectively. These four social indicators as presented by the authors are determinants of HRQoL such as living among the couple, level of education, occupational status and net income per household documented in their study indicates that poverty and residency, individually and/or in combination, are significant predictors of an environment, physical health and social relationships HRQOL.

Similar studies have been conducted to assess the quality of life among Filipinos but none of these specifically focusing the poverty-related quality of life Filipino people. On one hand a study conducted by[13] showed that nearly five in ten Filipinos do not see any improvement in their quality of life. Of the 1,200 respondents, 45 percent said their personal circumstances will be the same in 2014 while 37 percent expressed optimism and 19 percent thought it will be worse than the previous year [14]. Conversely, there are two common instruments being used in the Philippines to study poverty and quality of life, respectively these are the Human Development Index, (HDI), and the Quality of Life Index. [15],[14],[16] posit that the two common instruments that was used in the Philippines to study poverty and quality of life, were based on conventional and economic indicators of poverty such as occupation, socioeconomic income, and level of educational attainment. These instruments as stated by[17], lack the capacity of assessing or detecting multidimensional aspects of poverty in quality of life. Also, in these instruments according to[15], existing income and poverty measurements may not be applicable or difficult to replicate at the local level. Nevertheless, there is scarcity of Filipino studies in relation to poverty-related quality of life.

In a null-shell, most of the studies have failed to assess or address the ability of an individual to engage with the social aspect of their health conditions, and less attention to poverty-related quality of life. The researchers aim to assess the poverty-related quality of life among community dwellers in Barangay Poro, San Fernando City using a validated tool specifically designed for this study in order to effectively evaluate community dwellers' quality of life while appropriate interventions measures are proffer.

Objectives of the Study

Specifically, this study seeks to:

1. Determined respondents' demographic characteristics and their poverty-related quality of life.
2. Identify the association of respondents' demographic characteristics and their poverty-related quality of life.

Conceptual Framework

The conceptual framework created by the Commission for Social Determinants of Health guided this study. The framework exhibit how social, economic and political system play a role in those demographic profile particularly the socioeconomic position, wherein the population are grouped or stratified based on their income, education, occupation, sex, race or ethnicity, including several factor. All of the socioeconomic profile therefore forms as specific determinants of health status which may indicate of individuals' place within the social ladder. This may be due to their current position, where they experience differences in exposure together to health-compromising situation.[18] stated that the social reasons behind these factors determines the distribution of those causes between the rich and the poor, which eventually affect the quality of life among each group.

METHODS

Design

Descriptive, cross-sectional research was utilized for the study.

Participants and Setting

The study population was the community dwellers of Barangay Poro, "Banks area" San Fernando City, La Union. A purposive sampling was employed in this study. The inclusion criteria were: (a) residents of Barangay Poro "Banks area" of not less than 6 months (b) male and female (c) are 18 years old and above (d) willing to participate.

Data Collection

Data were collected from July 16 to 28, 2018. The researcher conducted a house to house visit among the residents of Barangay Poro. Verbal information was given to the respondents about the significant information such as the purpose and importance of the study, the expected participation of the respondents, and their right to refuse to participate. Respondents who verbally signify their intentions to participate were given the self-administered Filipino version questionnaire, and while those who cannot read nor write were assisted by the researcher.

Measure

Two-part questionnaires were used to gather data. Part 1 contained questions that gather the demographic variables of the respondents (age, gender, civil status, income, etc). Part 2 will utilize the 17-items Poverty-related Quality of Life (PQoL) questionnaire. Respectively, the tool consists of seven dimensions (self/esteem/vitality [4 items], psychological well-being [3 items], relationship with family [2 items], relationship with friends [2 items], autonomy [2 items], physical well-being/access to care [2 items], and future perception [2 items]).

All items were answered using a five-point Likert scale: never, rarely, sometimes, often, and always. For each individual, scores of the dimensions were computed if at least half of contributive items were answered. The score of each dimension were obtained by computing the mean of the item scores of the dimension. A global index score as narrated by[17] can be used for computation hence it used to compute the mean of the dimension scores. All dimension scores and the index were linearly transformed and standardized on a 0-100 scale (0 indicates lowest QoL, and 100 indicates the highest QoL). Each item achieved the 0.40 standard for item internal consistency, and Cronbach a coefficient were > 0.70.

The PQoL questionnaire was originally created in the English language and for the purpose of gathering reliable data; it was translated to a Filipino version. Forward-backward translation was used as a guideline to translate the original English version of the tool into the Filipino edition. For the translation procedure, two bilingual translators who were fluent in both English and Filipino and knowledgeable about the content of the survey questionnaire were invited to translate the instrument. Subsequently, the Filipino version was back-translated into English by two other translators who were fluent in both languages; they were blinded to the original versions. The blinding assured that the meaning of the English version was properly translated into the Filipino version. Finally, the researcher compared the original and back-translated versions for simplicity and accuracy. For item number 15 which ask respondents “waited to be sick to go in to emergency?” were change to “waited to be sick to go to hospital?” to fit to the current study. The translated PQoL was subjected to reliability test and demonstrated an acceptable Cronbach a coefficients 0.73.

Ethical Consideration

The study protocol was reviewed and permission to conduct the study was obtained from the authorities of Barangay Poro. Verbal informed consent was obtained from each participant before receiving the questionnaire. No incentives were given to the respondents or to the authorities of the Barangay. Once

completed, the questionnaire were placed in a sealed envelope and no data were obtained to identify this participants in order to maintain anonymity and confidentiality.

Data Analysis

Completed questionnaires were entered, cleaned and analyzed using Statistical Package for Social Sciences (SPSS) version 21. To determine the reliability of the PQoL questionnaire in the current study, Cronbach's alpha was obtained. Descriptive statistics was used to describe the respondents' characteristics and responses to each item of the scale. Univariate analysis, such as independent *t*-test and One-way ANOVA were utilized to determine significant differences in the mean scores between demographic characteristics. If the ANOVA revealed statistical results, a Tukey HSD test was performed. All statistical analysis was set at 0.05 levels.

RESULTS

Respondents Characteristics

From the 120 questionnaires distributed, 99 were completed and returned to the researchers giving a response rate of 82.5%. More than one-third of the respondents belong to 41 to 50 years old at 34.3%. The majority of the respondents were female (58.6%), with a partner (76.8%), had less than five family members (61.6%), and Roman Catholic (94.9). Almost half of the respondents were own account workers (46.5%), having an income less than 3000 pesos per month and with PhilHealth insurance (51.5%). Nearly three-fourth of them had some and finished secondary education (68.7%). The summary of demographic characteristics is displayed in table 1.

Table 1. Demographic characteristics of the respondents (n = 99)

Characteristics		n	%
Age	18 to 30	25	25.3
	31 to 40	18	18.2
	41 to 50	34	34.3
	51 and above	22	22.2
Gender	Male	41	41.4
	Female	58	58.6
Marital Status	Without partner	23	23.2
	With partner	76	76.8
Family Member	< 5 members	61	61.6
	> 5 members	38	38.8
Income	< 3000/ month	56	56.6
	>3000/ month	43	43.4
Employment	Wage and salary worker	14	14.1
	Own account worker	46	46.5
	No work	39	39.4
Education	Elementary	31	31.3
	High school	68	68.7
Insurance	With PhilHealth	51	51.5
	Without PhilHealth	48	48.5
Religion	Roman Catholic	94	94.9
	Inglesia ni Kristo	3	3.0
	Baptist	2	2.0

Source: Researchers 2016

Comparison of poverty-related quality of life among respondents

The poverty-related quality of life is reflected in table 2. The overall global index score was 57.09±9.71. The physical well-being/ access to care received the highest mean score among the seven factors of the scale (Mean±SD=71.97±19.81), followed by self-esteem/ vitality (Mean±SD=59.09±21.15). On the other hand, autonomy received the lowest mean score of 52.96±22.29, followed by psychological well-being (48.93±19.37).

Table 2. Respondents characteristics' on the dimensions of poverty-related quality of life (n =99)

The variables	Minimum	Maximum	Mean	SD
Self-esteem/vitality	0.00	100.00	59.09	21.15
Psychological well-being	0.00	100.00	48.93	19.37
Relationship with family	0.00	100.00	58.44	23.81
Relationship with friend	0.00	100.00	54.69	21.11
Autonomy	0.00	100.00	52.96	22.29
Physical well-being/access to care	0.00	100.00	71.97	19.81
Future perception	0.00	100.00	53.54	25.37
Global Index	14.29	80.70	57.09	9.71

Source: researchers 2016

The association of the poverty-related quality of life of the respondents in terms of their demographic characteristics is reflected in Table 3.

1. The ANOVA revealed a statistically significant difference in the relationship with family dimension ($F=3.15$, $p<0.05$) and future perception dimension ($F=4.99$, $p<0.01$) when the respondents are grouped according to their age.
2. The Tukey HSD test revealed that respondents aged 41 – 50 years had significantly poorer relationship with family compared with those who were 31 – 40 years old ($p<0.05$), but had significantly better future perception than those who were 18 – 30 years old ($p<0.01$).
3. In terms of income, the respondents with more than P3000 monthly income reported better future perception than those receiving less than P3000 ($t=-3.53$, $p<0.01$).
4. Also, those who had finished primary schooling only reported significantly better relationship with friends ($t=2.14$, $p<0.05$) and higher global index ($t=1.99$, $p<0.05$) than those who finished secondary schooling.
5. In terms of health insurance, those who did not have health insurance reported better relationship with family ($t=-2.69$, $p<0.01$), better autonomy ($t=-2.52$, $p<0.05$) and higher global index ($t=-2.26$, $p<0.05$) compared with those who had health insurance.

Table 3. Comparison of PQoL scores according to the demographic data

Demographic	**SE/VI**[a] Mean±SD	PsWB[b] Mean±SD	RFa[c] Mean±SD	RFr[d] Mean±SD	AUT[e] Mean±SD	PhWB/ACf Mean±SD	FUT[g] Mean±SD	Index Mean±SD
Age 18- 30	64.00±19.79	48.89±16.67	54.86±25.31	63.43±17.54	56.57±22.77	74.50±21.49	40.80±22.72	57.57±9.17
31- 40	53.33±22.49	54.94±19.61	73.02±18.91	56.35±17.99	54.76±22.59	72.22±16.36	46.67±24.73	58.76±10.11
41- 50	58.82±21.71	47.06±17.53	53.36±22.05	50.00±22.59	51.26±23.09	74.26±17.39	62.94±23.68	56.82±8.14
> 51	58.63±20.77	46.97±24.47	58.44±24.90	50.65±22.79	50.00±21.03	65.34±23.44	59.09±25.05	55.59±12.31
P-value	0.446	0.524	**0.029***	0.074	0.721	0.347	**0.003****	0.771
Gender Male	53.90±23.97	50.14±19.90	57.84±24.94	55.05±21.80	57.15±24.54	73.78±20.50	60.49±25.09	58.33±11.09
Female	62.76±18.24	48.08±19.19	58.87±23.19	54.43±20.81	54.43±20.81	70.69±19.39	48.62±24.60	56.21±8.59
P-value	0.050	0.606	0.834	0.887	0.117	0.447	0.021	0.285
Civil status w/ partner	64.78±18.80	43.96±20.78	50.93±25.42	52.80±23.76	51.55±23.09	66.85±26.55	51.30±23.99	54.60±12.84
w/o partner	57.37±21.63	50.44±18.81	60.71±22.99	55.26±20.38	53.38±22.18	73.52±17.20	54.21±25.89	57.84±8.50
P-value	0.141	0.161	0.084	0.626	0.732	0.266	0.632	0.161
Family Member <5	58.52±20.72	50.09±20.04	55.50±24.89	55.03±21.16	53.40±22.87	72.34±21.05	55.74±25.85	57.23±10.18
>5	60.00±22.06	47.08±18.35	63.16±21.43	54.14±21.31	52.26±21.60	71.38±17.89	50.00±24.49	56.86±9.02
P-value	0.738	0.454	0.120	0.838	0.806	0.817	0.276	0.853
Income <3000	62.14±20.42	49.01±19.39	60.46±24.21	55.87±22.01	53.32±21.53	71.88±21.75	46.07±24.69	56.96±10.39
>3000	55.12±21.64	48.84±19.57	55.81±23.29	53.16±20.04	52.49±23.48	72.09±17.22	63.26±23.07	57.25±8.85
P-value	0.102	0.966	0.338	0.529	0.856	0.957	**0.001****	0.884
EW& SW	15.28±4.08	15.28±4.08	15.28±4.08	15.28±4.08	15.28±4.08	15.28±4.08	15.28±4.08	15.28±4.08
OAW	22.23±3.28	17.95±2.65	24.74±3.64	22.59±3.33	25.84±3.81	21.12±3.11	23.87±3.52	10.99±1.62
No work	21.88±3.50	19.30±3.09	23.83±3.81	19.44±3.11	20.51±3.28	20.18±3.23	27.10±4.34	9.31±1.49
P-value	0.683	0.806	0.823	0.944	0.734	0.830	0.185	0.900
Education Primary	64.52±19.81	54.12±19.19	58.06±25.54	61.29±22.19	55.76±22.54	72.18±20.08	53.54±26.02	59.93±7.09
Secondary	56.62±21.41	46.57±19.13	58.61±23.17	51.68±20.06	51.68±22.22	71.88±19.84	53.53±25.26	55.80±10.48
P-value	0.084	0.072	0.916	**0.035***	0.401	0.944	0.997	**0.049***
HIWPhiHealth	60.19±20.35	60.19±20.35	60.19±20.35	60.19±20.35	60.19±20.35	60.19±20.35	60.19±20.35	60.19±20.35
WOPhiHealth	57.92±22.12	57.92±22.12	57.92±22.12	57.92±22.12	57.92±22.12	57.92±22.12	57.92±22.12	57.92±22.12
P-value	0.594	0.323	**0.008****	0.210	**0.013***	0.647	0.696	**0.026***

Source: researchers 2016

Note: [a]Self-esteem/vitality; [b]Psychological well-being; [c]Relationship with family; [d] Relationship with friend; [e]Autonomy; [f]Physical well-being/access to care; [g] Future perception

*p<0.05; **p<0.01

Note: * When the ANOVA test revealed significant difference, Tukey's honest significant difference (HSD) test was performed.

DISCUSSION

This study was conducted to assess the poverty-related quality of among community dwellers of Barangay Poro. It also seek to compare respondents' characteristics in relation to their PQoL. In this study PQoL focuses on human ends (''Seen/talked with your spouse/partner or your family?''; ''Felt supported by your friends''; ''Seen/talked with your friends?''; ''Felt supported by your friends''. Yet, exploring ends which is being measured by the tool may prevent bias by encompassing individuals' characteristics and capabilities. Nevertheless, interpretation of result may be limited due to the fact that the tool has only been use for this population and setting. Here the researchers discuss two key findings. First, the results showed that the respondents over all PQoL are low as evident in the global index result of the questionnaire. In addition, among the seven dimensions, autonomy followed by psychological well-being obtained the lowest score a finding which is similar to earlier study by[19]. Conversely[9] (2003) documented that low level of psychological well-being are known to be involved in the occurrence of cardiovascular diseases.

Although there is a significant need to manage and pay more attention to psychological outcomes and traumatic stress as presented by[(20),] effective treatments such as coping skill training and stress management are rarely proposed**.** Moreover, according to[(19),] low autonomy among respondents may be associated with lower level of empowerment or to opportunity of freedom, giving the respondents no choice but to live what they have and keep relying on the government. In general, the results draw attention to the lack of control dealt by the poor over their lives, together with incapacity to experience any sense of co-authorship of their lives. At the standard of everyday activity stated by[(21),] they feel their choices or even decisions are limited to trivial elements, similar to choosing between going to a movie theater or getting food for the following day.

Second, comparison between PQoL scores and respondents' socio-demographic characteristics of poverty data are different from other results. One for instance is the age, older individuals reported significantly better in future dimension than their younger counter part, this is in contrast to the study of[(17)] where they found that older adults have lower perception to future dimension, One possible reason maybe owning to the fact that older adults' accumulated income where it had implications for their future planning as stated by[(22),] which is also supported by study of[(15)] that was conducted in the Philippine where having income plays a major factor on influencing future perception. Another study by[(22),(23)] are also in contrast with the result finding in this study where it was found that older adult social network is more important. Nonetheless, this part of the result of this study needs further research. Respondents with higher income in the study, perceived better future dimension which is congruent to previous study as narrated by[(15),] which places a major factor influencing quality of life**.** This may also be due to the case among older adult who perceive better in future dimension due to accumulated income for future planning as narrated by[(22)]**.** In contrast, [(24),(25)] believed that poverty must be viewed from a human development perspective, stressing that poverty is not simply the lack of income but that it is also the denial of choices and opportunities for a tolerable life.

The authors further stated that these opportunities for a tolerable life will lead to healthy and long life, creative life as well as to enjoy a decent standard of living, freedom, dignity, self-esteem, and respect to others**".** With regards to education and health insurance, the respondents with elementary level of education and not having health insurance such the PhilHealth had better quality of life as indicated with higher global index and in particular had better relationship to friends than those with secondary or who have completed secondary education. The association between PQoL and health coverage according to[(17),] was not expected, given that for people with no or only partial health insurance, medical costs can have serious financial impacts on daily life and can also lead to a patient choosing to forego treatment which may lead to low quality of life.

This result of this study needs further follow up since studies by[(26)] suggested that education and health insurance are both basic determinant of the quality of life of individuals**.** Furthermore, people with limited skills and competencies are excluded from good jobs and have fewer prospects for economic prosperity. According to research by[(27)], early school leavers face a higher risk of social exclusion and poverty and are also less likely to participate in the civic life and political affairs of their society**.** Yet, the result of this study shows that the respondents without health insurance have better autonomy which is in contrast with the above premise. Nevertheless, respondents' demographics were conceptualized as a social standing, as it correlates to lower quality of life among poor people, while further examination indicates inequities in access to and distribution of resources.

Limitations of the Study

The study sample size is limited and this warrants a larger sample size for future research studies. The study also used purposive sampling technique, which limits the generalizability of the result. However, the response rate of the study is high, which serves as a strength of the study. Although the questionnaire was a self-administered, respondents may have been helped, that assistance may have influenced the respondents' answer. Another limitation of the study is the tool, where it did not undergo further psychometric analysis, this should be further explored. Nevertheless, this study contributed to the existing body of knowledge about poverty issue which is a major gradient of social determinants of health. More importantly, the findings contributed to the limited literature about quality of life among Filipino people and within Asian region.

CONCLUSION

Some dimensions of poverty-related quality of life are strongly related to demographic profile, which strengthens the existing knowledge that socioeconomic status has a key role in the quality of life among poor people. Given the low quality of life among the respondents, the local government and concerning agencies need to provide services such as education for all, and enhancement of health coverage which are essential in tailoring the need of this population group.

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