"A DESCRIPTIVE STUDY TO ASSESS THE POST COVID QUALITY OF LIFE AMONG ADULT IN SELECTED RURAL AND URBAN AREA JUNWANI BHILAI DURG (C.G)"

[1]Ms Shilpa, [2]Prof. Mr. Krodhi Dilliwar, [3]Asso.Prof. Jaya Saurabh Sonekar

[1]Final Year M.Sc Nursing Student, [2]Professor, [3]Associate Professor

[1]Community Health Nursing,

[1]Shankaracharya Swami Swaroopanand College Of Nursing, Junwani, Bhilai, Chhattisgarh

[1]sippukuldeep76321@gmail.com, [2]krodhi.dilliwar@gmail.com,[3]jayasaurabhsonekar@gmail.com

ASBTRACT - The COVID-19 pandemic has affected not only physical health but also the psychological, social, and economic well-being of individuals. This descriptive study aimed to assess the post-COVID quality of life among adults in selected rural (Village Nikum) and urban (Supela, Bhilai) areas of Durg (C.G.), and to determine its association with socio-demographic variables.

A quantitative approach was used with a sample of 60 post-COVID adults (30 rural and 30 urban). The findings showed that in rural areas, 10% had poor, 43.33% moderate, and 46.66% good quality of life, whereas in urban areas, 16.66% had poor, 46.66% moderate, and 36.66% good quality of life. Rural adults had a higher mean score (89.6 ± 2.91) compared to urban adults (80.33 ± 4). A strong positive correlation ($r = 0.71$, $p < 0.05$) was found between rural and urban quality of life.

Significant associations were observed between quality of life and variables such as age, education, marital status, occupation, severity of COVID-19, and hospitalization status. The study concludes that quality of life differs between rural and urban populations and is influenced by socio-demographic factors.

Keywords: Post-COVID-19, Quality of Life, Rural Population, Urban Population, Adults, Socio-Demographic Variables, COVID-19 Impact, Descriptive Study.

INTRODUCTION

Health is a dynamic state of complete physical, mental, and social well-being and not merely the absence of disease. Over the past decades, the understanding of health has evolved from a purely biomedical concept to a multidimensional model that includes psychological resilience, social integration, economic stability, and environmental safety. The concept of **quality of life (QOL)** has become central in evaluating health outcomes, especially after major global health crises.

In late 2019, a novel coronavirus emerged in Wuhan, China, which rapidly spread across continents and transformed into a global pandemic. The disease caused by this virus, known as COVID-19, disrupted every aspect of human life. The outbreak was officially declared a pandemic by the World Health Organization in March 2020. Since then, millions of individuals worldwide have been infected, and many have experienced not only acute illness but also long-term health consequences.

India reported its first case of COVID-19 in early 2020, and the infection rapidly spread across states, including Chhattisgarh. The districts of Durg and Bhilai witnessed significant case numbers during different waves of the pandemic. Strict lockdowns, quarantine measures, and social distancing protocols were implemented to control transmission. While these measures were necessary, they also led to economic instability, social isolation, and psychological distress among the population.

Although much attention was initially focused on survival and reducing mortality, it has now become clear that recovery from COVID-19 does not necessarily indicate complete restoration of health. Many individuals continue to experience persistent symptoms such as fatigue, breathlessness, joint pain, cognitive difficulties, sleep disturbances, anxiety, and depression. This condition, often referred to as "post-COVID syndrome" or "long COVID," affects individuals physically, emotionally, and socially.

Quality of life refers to an individual's perception of their position in life within the context of culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns. It encompasses several domains including physical health, psychological health, social relationships, and environmental conditions. After a pandemic of such magnitude, assessing the quality of life among adults becomes essential to understand the broader impact beyond clinical recovery.

The pandemic affected individuals differently depending on their socio-economic background, occupation, access to healthcare, and place of residence. Rural and urban populations faced unique challenges. Urban residents often encountered higher infection rates due to population density, whereas rural populations struggled with limited healthcare facilities and delayed access to medical care. Therefore, comparing post-COVID quality of life in rural and urban settings can provide meaningful insights into disparities and unmet needs.

Junwani, located in Bhilai of Durg district in Chhattisgarh, presents a mixed demographic pattern consisting of both rural and urban communities. The socio-economic structure, healthcare accessibility, and living conditions vary significantly between these areas. Understanding how adults in these communities are coping after COVID-19 infection is essential for planning targeted health interventions.

RESEARCH PROBLEM

"A Descriptive study to Assess the post covid quality of life among adult in selected rural and urban area Junwani Bhilai Durg (C.G)"

OBJECTIVES:

1. To assess the post Covid quality of life among adult in selected rural and urban area Junwani Bhilai Durg (C.G)
2. To correlate the post Covid quality of life urban and rural area, Junwani Bhilai Durg (C.G)
3. To find out association between quality of life of post Covid-19 rural and urban adults with their selected Socio Demographic Variables.

MATERIAL AND METHODS

This study employed a **quantitative approach** with an exploratory descriptive design to assess the quality of life among post COVID-19 adults in rural and urban areas of Bhilai, Durg, Chhattisgarh. The study was conducted in Village Nikum (rural) and Supela (urban). A total of 60 participants (30 rural and 30 urban)

were selected using a non-probability convenient sampling technique.

Participants included adults aged 18 years and above who had recovered from COVID-19 and were willing to participate, while those below 18 years, above 60 years, or without a history of COVID-19 were excluded. Coping strategy was considered the independent variable and quality of life the dependent variable, along with selected socio-demographic variables.

Data were collected using a structured questionnaire consisting of socio-demographic details and a modified WHOQOL-BREF scale with 50 items. Scores ranged from 0 to 150 and were categorized as poor, moderate, and good quality of life. The tool demonstrated good reliability (r = 0.84) and content validity confirmed by experts.

Data collection was conducted after obtaining necessary permissions and informed consent from participants, ensuring confidentiality. Data were analyzed using descriptive statistics (frequency, percentage, mean, standard deviation) and inferential statistics (chi-square test and correlation).

RESULTS

Table-I Depicts that majority of adult in rural 17(56.66%) were 31-35 years, 8(26.66%) were 25-30 years and remaining 5(16.66%) were 20-24 years of age. In urban area 20(66.66%) were 31-35 years, 7(23.33%) were 25030 years of age and remaining 3(10%) were 20-24 years of age. Majority adults in rural area 18(60%) were male and remaining 12(40%) were female. In urban majority of subject 16(53.33%) were female and remaining 14(46.66%) were male. Majority of subject in rural 12(40%) were graduate, 9(30%) were middle school education, 6(20%) were higher secondary education and remaining 3(10%) were primary education. In urban majority of subjects 13(43.33%) were middle education, 8(26.66%) were primary education, 5(16.66%) were higher education and remaining 4(13.33%) were graduate. Majority of subjects in rural 27(90%) were married and remaining 3(10%) were unmarried. In urban 25(83.33%) were married and remaining 5(16.66%) were unmarried. Majority of subject 30(100%) were residing in rural area and 30(100%) were residing in urban area. Majority of subjects 11(33.33%) were private employee, 10(33.33%) were government employee and remaining 9(30%) were business. In urban majority of subjects 12(40%) were government employee, 9(30%) were business man and remaining 9(30%) were private employee. Majority of subject in rural 13(43.33%) were moderate, 9(30%) were acute and remaining 8(26.66%) were severe. In urban 15(50%) were acute, 11(36.66%) were moderate and remaining 4(13.33%) were severe. Majority of subject in rural 28(93.33%) were vaccinated and remaining 2(6.66%) were not vaccinated. in urban 27(90%) were vaccinated and remaining 3(10%) were not vaccinated. Majority of subject in rural 18(60%) were hospitalized and remaining 12(40%) were not hospitalized. In urban 17(56.66%) were hospitalized and remaining 13(43.33%) were not hospitalized.

Table no. -I Distribution of subjects according to socio demographic variables in frequency and percentage.

(N_1-30+ N_2-30=60)

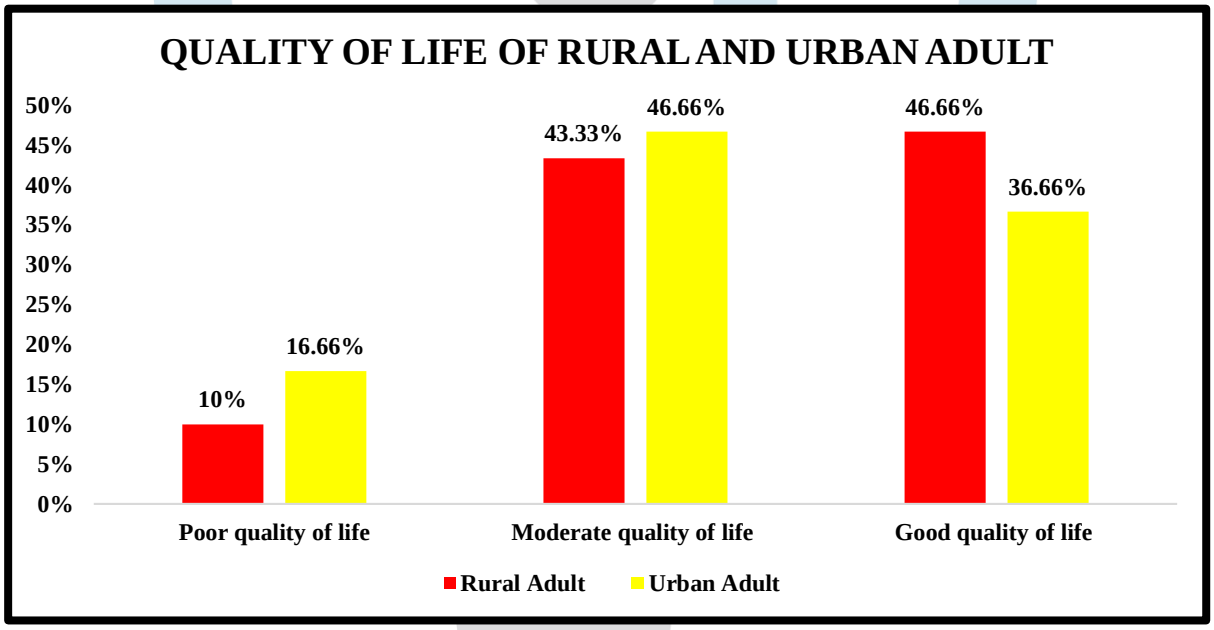
	DEMOGRAPHICAL DATA	Rural Adult		Urbana Adult	
		F	%	F	%
1.	**Age (in years)**				
a.	18-22	0	0%	0	0%
b.	20-24	5	16.66%	3	10%
c.	25-30	8	26.66%	7	23.33%
d.	31-35	17	56.66%	20	66.66%
2.	**Gender**				
a.	Male	18	60%	14	46.66%
b.	Female	12	40%	16	53.33%
3.	**Education-**				
a.	Primary education	3	10%	8	26.66%
b.	Middle school education	9	30%	13	43.33%
c.	Higher secondary education	6	20%	5	16.66%
d.	Graduate	12	40%	4	13.33%
4.	**Marital status**				
a.	Unmarried	3	10%	5	16.66%
b.	Married	27	90%	25	83.33%
5.	**Residential status**				
a.	Rural	30	100%	0	0%
b.	Urban	0	0%	30	100%
6.	**Occupation**				
a.	Private	11	36.66%	9	30%
b.	Government	10	33.33%	12	40%
c.	Business	9	30%	9	30%
7.	**Severity of covid-19**				
a.	Acute	9	30%	15	50%
b.	Moderate	13	43.33%	11	36.66%
c.	Sever	8	26.66%	4	13.33%
8.	**Covid -19 vaccination status**				
a.	Vaccinated	28	93.33%	27	90%
b.	Unvaccinated	2	6.66%	3	10%
9.	**Hospitalization status in covid-19**				

a.	Yes	18	60%	17	56.66%
b.	No	12	40%	13	43.33%

Table no. II Shows analysis related to assess the post covid quality of life among adult in urban and rural area.

(N_1-30+ N_2-30=60)

Quality of life	Rural Adult		Urban Adult	
	F	%	F	%
Poor quality of life	3	10%	5	16.66%
Moderate quality of life	13	43.33%	14	46.66%
Good quality of life	14	46.66%	11	36.66%
Total	**30**	**100%**	**30**	**100%**



It shows in rural adults 3(10%) were poor quality of life, 13(43.33%) were moderate quality of life and remaining 14(46.66%) were good quality of life. In urban 5(16.66%) were poor quality of life, 14(46.66%) were moderate quality of life and remaining 11(36.66%) were good quality of life.

Table. No. III shows comparison of quality-of-life score of rural and urban post covid-19 adults by using Mean, Mean % and SD.

(N_1-30+ N_2-30=60)

	Total Score	Total Obtained	Total Mean score	Total Mean %	SD
Rural Adults	4500	2688	89.6	59.73	2.91
Urban Adults	4500	24.25	80.33	53.55	4

Predicts that overall mean of subject in rural mean was 89.6, mean % was 59.73 and SD was 2.91. In urban adults mean was 80.33, mean% 53.55% and SD was 4 which is different with rural adult.

Table no. IV- shows that correlation between quality of life of rural and urban adults by Carl Pearson correlation of coefficient.

N=60

STUDY VARIABLE	MEAN	SD	Pearson Correlation coefficient ®	INFERENCE
Rural	89.6	2.91	0.71	STRONG POSITIVE CORRELATION
Urban	80.33	4		

There is strong positive correlation between rural and urban quality of life after post covid-19 r =0.71, P<0.05.

Table no. V- Chi square analysis to association of the quality of life of post covid-19 in rural adults with their selected socio demographic variables.

N-30

Demographic Variable	Df	P Value 0.05	Chi Square	Inference
1. Age in Year	04	9.48	12.49	**Significant**
2. Gender	02	5.99	3.2	Not Significant
3. Education Status	6	12.59	14.56	**Significant**
4. Marital Status	2	5.99	10.25	**Significant**
5. Occupation	4	9.48	2.29	Not Significant
6. Severity of Covid-19	4	9.48	3.21	Not Significant
7. Vaccination Status of covid-19	2	5.99	3.42	Not Significant
8. Hospitalization Status of covid-19	2	5.99	6.52	**Significant**

TABLE NO. V- Shows that There is significance association between age in year as the calculated chi square value 12.49 (df 4) is greater than table value 9.48 at 0.5 level of significance. There is significance association between education status as the calculated chi square value 14.56 (df 6) is greater than table value 12.59 at 0.5 level of significance. There is significance association between marital status as the calculated chi square value 10.25 (df 2) is greater than table value 5.99 at 0.5 level of significance. There is significance

association between hospitalization status of covid-19 as the calculated chi square value 6.52 (df2) is greater than table value 5.99 at 0.5 level of significance. There is not significance association between gender as the calculated chi square value 3.2 (df 2) less than table value 5.99 at 0.5 level of significance. There is not significance association between occupation as the calculated chi square value 2.29 (df 4) less than table value 9.48 at 0.5 level of significance. There is not significance association between severity of covid-19 as the calculated chi square value 3.21 (df 4) less than table value 9.48 at 0.5 level of significance. There is not significance association between vaccination status of covid-19 as the calculated chi square value 3.42 (df 2) less than table value 5.99 at 0.5 level of significance.

Table. No. VI - Chi square analysis to association of the quality of life of post covid-19 in urban adults with their selected socio demographic variables.

N-30

Demographic Variable	Df	P Value 0.05	Chi Square	Inference
1. Age in Year	04	9.48	3.4	Not Significant
2. Gender	02	5.99	1.82	Not Significant
3. Education Status	6	12.59	2.23	Not Significant
4. Marital Status	2	5.99	3.21	Not Significant
5. Occupation	4	9.48	10.3	**Significant**
6. Severity of Covid-19	4	9.48	12.14	**Significant**
7. Vaccination Status of covid-19	2	5.99	0.91	Not Significant
8. Hospitalization Status of covid-19	2	5.99	6.42	**Significant**

TABLE NO. VI Shows that There is significance association between occupation as the calculated chi square value 10.3 (df 4) is greater than table value 9.48 at 0.5 level of significance. There is significance association between severity of covid-19 as the calculated chi square value 12.14 (df 4) is greater than table value 9.48 at 0.5 level of significance. There is significance association between hospitalization status of covid-19 as the calculated chi square value 6.42 (df 2) is greater than table value 5.99 at 0.5 level of significance. There is not significance association between age as the calculated chi square value 3.4 (df 6) is lower than table value 9.48 at 0.5 level of significance. There is not significance association between gender as the calculated chi square value 1.82 (df 2) less than table value 5.99 at 0.5 level of significance. There is not significance association between educational status as the calculated chi square value 2.23 (df 6) less than table value 12.59 at 0.5 level of significance. There is not significance association between marital

status as the calculated chi square value 3.21 (df 2) less than table value 5.99 at 0.5 level of significance. There is not significance association between vaccination status of covid-19 as the calculated chi square value o.91 (df 2) less than table value 5.99 at 0.5 level of significance.

DISCUSSION:

This chapter presents the discussion of data collected to analyse to "A Descriptive study to Assess the post covid quality of life among adult in selected rural and urban area Junwani Bhilai Durg (C.G)". The data was obtained from 30 urban and 30 rural final result of the study in in rural adults 3(10%) were poor quality of life, 13(43.33%) were moderate quality of life and remaining 14(46.66%) were good quality of life. In urban 5(16.66%) were poor quality of life, 14(46.66%) were moderate quality of life and remaining 11(36.66%) were good quality of life.

CONCLUSION:

The study found that most adults in both rural and urban areas had a moderate to good quality of life after COVID-19. Rural adults showed slightly better outcomes, with higher mean scores compared to urban adults. A strong positive correlation (r = 0.71) was observed between both groups. Significant associations were found with socio-demographic and clinical factors—age, education, marital status, and hospitalization in rural areas, and occupation, severity, and hospitalization in urban areas. Overall, these factors influence post-COVID quality of life and should be considered in care planning.

REFERENCES:

1. Polit, D. F., & Beck, C. T. (2017). Nursing Research: Generating and Assessing Evidence for Nursing Practice. Wolters Kluwer.
2. World Health Organization (2021). Post COVID-19 Condition. https://www.who.int
3. Ministry of Health & Family Welfare, Govt. of India. COVID-19 Dashboard. https://www.mohfw.gov.in
4. CDC (2022). Long COVID or Post-COVID Conditions. https://www.cdc.gov
5. WHOQOL-BREF Manual (1998). https://www.who.int/tools/whoqol