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A Study to Assess the Awareness on Healthy Lifestyle among Geriatric Population in a selected village of Trichy District, Tamilnadu

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ABSTRACT

Awareness on healthy lifestyle among geriatric population was assessed in a selected village of Trichy District, Tamilnadu. The study was conducted by adopting descriptive survey design. The sample size was102 and they were selected by convenience sampling technique. Structured Questionnaire was used to collect the data related to Knowledge, Attitude and Practice of elderly people regarding healthy life style. The findings revealed that the majority of the elderly people reported moderately adequate knowledge, healthy life style practices and desirable attitude towards healthy lifestyle.

KEYWORDS : Awareness, healthy lifestyle, geriatric population

Introduction

Ageing is an important marker of the accumulation of modifiable risks for chronic disease: the impact of risk factors increases over the life course. In India, the elderly constitute about 7 percent of the total population (Census, 2001) and by 2016 AD; this is likely to increase to 10 percent.

Between 2008 and 2030, the global population is projected to grow by 20% from 6.7 billion to 8.1 billion people. A major shift is currently underway in the overall disease burden in the world. In 2008, five out of the top ten causes for mortality worldwide, other than injuries, were non-communicable diseases; this will go up to seven out of ten by the year 2030. By then, about 76% of the deaths in the world will be due to non-communicable diseases (WHO, 2005).

The transition from independent living to a residential home or to sheltered housing challenges the resilience of all elderly people. Lifestyle risk factors, including dietary habits, physical inactivity, and smoking, strongly influence the established cardiovascular risk factors and also affect novel pathways of risk such as inflammation/oxidative stress, endothelial function, thrombosis/ coagulation and arrhythmia (Mozaffarian D, 2008).

Background of the Study

Lifestyle is the way a person lives. This includes patterns of social relations, consumption, entertainment and dress. The term lifestyle also reflects an individual's attitudes, beliefs and, essentially, the way the person is perceived by himself/herself and, at times, also how he/she is perceived by others.

Lifestyles of populations across the world have changed dramatically in the 20th century. These changes (collectively termed as epidemiological transition) have been brought about by a number of developments in science and technology that now affect every facet of human existence. Most human societies have moved from agrarian diets and active lives to fast foods and sedentary habits. Combined with increasing tobacco use, these changes have fuelled the epidemic of obesity, diabetes, hypertension, dyslipidaemia and cardiovascular diseases (Prabhakaran D, 2010).

The disease profile is changing rapidly. The World Health Organization (WHO) has identified India as one of the nations that is going to have most of the lifestyle disorders in the near future.

In most of these lifestyle diseases, the onset is insidious and is usually after the age of 30 years. In general, majority of health problems among the elderly are nutrition related. Consumption of nutritious foods rich in micronutrients including antioxidant vitamins and minerals and fiber, comfortable level of physical activity will enable the elderly to live active and meaningful healthy lives.

Promoting healthy lifestyles including physical activity, healthy eating and social activity have a range of health benefits for older people and impact on quality of life. A better understanding of the determinants of healthy lifestyle behaviours amongst older adults is needed to tailor and target health promotion strategies and programs to maximise health outcomes for older people. This research study explores older people's knowledge, attitude and practice of healthy life style.

Objectives of the study

1. To assess the level of knowledge, attitude and practice of elderly people towards healthy life style.
2. To compare the findings with selected demographic variables of geriatric people in a selected village of Trichy District, Tamilnadu.

Research Approach

Non-Experimental Quantitative Descriptive Survey approach was used.

Research Design

The research design for this study is descriptive survey design.

Setting of the Study

The study was conducted among the geriatric people of Inamkulathur village. The village is located in Srirangam Taluk, Trichy District, Tamilnadu. It has a total of 4000 population.

Population

The geriatric people aged 60 years and above residing in Inamkulathur village, Srirangam Taluk, Trichy District.

Sample and Sample Size

The geriatric people who fulfilled the inclusion criteria were selected for the study. The sample size was 102.

Sampling Technique

Non probability convenience sampling technique was used.

Sampling Criteria

The samples were selected based on the following criteria:

Inclusion Criteria

1. Subjects who were in the age group of 60 years and above in the selected village of Trichy District.
2. Both male and female elderly people.
3. Subjects who were willing to participate in the study.
4. Subjects who were present at the time of data collection

Exclusion Criteria

1. Elderly people who were unconscious or semiconscious.

2. Elderly people who were unable to respond the questionnaire due to various morbidity conditions.

Tools and Technique
The tool consisted of the following sections:

Section A: Demographic data of the elderly people. It included 9 items such as age, gender, religion, marital status, educational qualification, cost of living, habits/risk factors, health care resource and the system of medicine.

Section B: Structured Questionnaire was used to collect the data related to Knowledge, Attitude and Practice of elderly people regarding healthy life style. It included three parts. The Part-I consisted of Knowledge Questionnaire which has a total of 18 items in a true or false pattern. Among them 8 questions were framed as negative statements and the remaining were framed as positive statements. The correct answer was scored as one and the wrong answer was scored as 0. The Part-II consisted of Attitude Questionnaire which has a total of 7 items in a rating scale format and the total score value ranges between 0-7. The Part-III consisted of Practice Questionnaire in a rating scale pattern. The score value ranges from 0-3 for each question. It has a total of 10 questions.

Data collection Procedure
After getting formal permission from concerned authorities the data was collected from the elderly people who fulfilled the inclusion criteria. The data was collected by house to house visit. The purpose of the study was explained to the sample and the data was collected individually by using interview technique. Each subject had taken approximately 20 -30 minutes to complete the assessment.

Data Analysis
The collected data were coded under three facets (i.e) Knowledge, Attitude and Practice. In the knowledge facet, the positively worded items were coded as per their scores (i.e) the higher value represents the higher knowledge level. Then the negatively worded items were recoded. That is, the numeric value assigned was reversed: 1=0 and 0=1. By recoding, the high scores reflect higher knowledge level. Each facet was analyzed using descriptive statistics such as frequency, percentage, mean and standard deviation. Inferential statistics such as Chi-square test was used to analyze the association with the knowledge level of elderly people towards healthy life style and their selected demographic variables.

Results of the Study
Table-1.
Demographic Profile of the Respondents

Age	**f**	**%**
≤ 65 years	65	63.72
>65 years	37	36.28
Gender		
Male	34	33.33
Female	68	66.67
Religion		
Hindu	22	21.56
Muslim	79	77.46
Christian	01	0.98
Marital Status		
Single	05	04.90
Living with spouse	52	50.98
Death of Spouse	45	44.12
Educational Status		
Illiterate	59	57.85
Primary	36	35.29
Secondary	07	06.86
Cost of Living		
with job/salary	06	05.89
Retired/salary	03	02.94
Children	81	79.41
Relatives	12	11.76
Habits/Risk Factors		
a. Alcohol		
Yes	0	0
No	102	100
b.Smoking		
Yes	09	08.82
No	92	90.18
c.Tobacco chewing		
Yes	21	20.59
No	81	79.41
Health care Resource		
Government Hospital	46	45.09
Primary Health Centre	39	38.23
Private Hospital	17	16.67
System of Medicine		
Allopathy	46	45.09
Homeopathy	39	38.23
Siddha	17	16.67

The above table shows the characteristics of the participants which are as follows:

Majority of the study subjects (63.72%) were belonged to the age group of < 65 years and with regard to gender 66.67% were females. A great majority of the elderly 77.46% (79) belonged to Muslim religion and only one (0.98%) respondent was from Christian religion.

Among the respondents, nearly half of them (50.98%) were living with spouse and only 4.9% were remained single. With regard to the educational status, 57.85% were illiterate and only 6.86% have completed their secondary level of school education. Most of the elderly (79.41%) were financially depend on their children.

With regard to the habits / Risk factors, all of them (100%) were self-reportedly non-alcoholics. Nine of them (8.82%) were smokers and 21 of them (20.59%) had Tobacco chewing habit. The data about utilization of health care resource shows that majority of the respondents (83.32%) had used the Government Health Care sectors and only 16.67% of them had utilized private sector. Allopathy was the preferred System of Medicine for about 45.09% of elderly people.

Table-2.
Distribution of subjects based on their knowledge regarding healthy life style. (N=102).

Level of Knowledge	f	%
Inadequate knowledge (<50%)	3	2.94
Moderately adequate knowledge (50-75%)	81	79.41
Adequate knowledge (>75%)	18	17.65

The data presented in table 2 displays that 79.41% of elderly people had moderately adequate knowledge and 17.65% of them had adequate knowledge about healthy lifestyle while only 2.94% of elderly people had inadequate knowledge.

Table-3.
Distribution of subjects based on their practice of healthy lifestyle (N=102).

Type of Practice	f	%
Unhealthy practice (0 - 50%)	27	26.48
Healthy Practice (51-100%)	75	73.52

Table- 3 reveals that 73.52% of elderly people had healthy lifestyle practice whereas, 26.48% had unhealthy life style practice.

Table-4.
Distribution of subjects based on their attitude towards healthy lifestyle (N=102).

Type of Attitude	f	%
Undesirable attitude (0 - 50%)	13	12.75
Desirable attitude	30	29.41
Most desirable attitude	59	57.84

The above table depicts that 12.75% of elderly people had undesirable attitude regarding healthy lifestyle. Whereas, majority of the geriatric people had desirable attitude regarding healthy lifestyle (i.e.) 29.41% had desirable attitude and 57.84% had most desirable attitude.

There was no significant association between the knowledge regarding healthy life style and selected demographic variables like age, sex and religion. But there was an association between the knowledge regarding healthy lifestyle and variables like marital status, educational status and cost of living ($p < 0.05$).

Discussion

The knowledge base with regard to the elderly in terms of their demographic, social and economic conditions, health needs and their living arrangements are fairly extensive in developed countries, it is woefully inadequate in India.

The present study revealed that 79.41% of elderly people had moderately adequate knowledge and 17.64% of them had adequate knowledge about healthy lifestyle. Majority of elderly people (73.52%) had healthy lifestyle practices whereas, 26.48% had unhealthy life style practices. With regard to the attitude towards healthy lifestyle, only 12.75% of elderly people had undesirable attitude while majority of the geriatric people (87.25%) had desirable attitude. The study further stated that there was an association between the knowledge regarding healthy life style and variables like marital status, educational status and cost of living.

Conclusion

Since the population of the present study was elderly people, the researcher encountered to some problems. The questions of study were long and so some of the participants felt fatigue during interview. The researcher enforced to remove some participants due to sever diseases and other age related problems. So the representativeness of sample confounds. However, the practice can be improved by increasing the knowledge. Hence, Awareness should be created among the elderly people and their family members regarding healthy lifestyle to reduce morbidity and mortality among geriatric population.

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