International Journal of Science and Research (IJSR)
ISSN: 2319-7064
ResearchGate Impact Factor (2018): 0.28 | SJIF (2019): 7.583

A Comparative Study to Assess the Knowledge and Practices of Healthy Living among the Elderly in the Selected Urban and Rural Areas of Kamrup Metro, Assam

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1. Introduction

"There is no shame in growing old,
We're all doing it.
Age is, after all, the one thing we are all share"
-Maggie Kuhn

Background of the Study

The growing ageing population is a source of both joys and worries. Joy because people are living longer and healthier lives. Worries are about how to respond to a future with a larger older population with their rightful demands and needs. Healthy aging is the development and maintenance of optimal mental, social and physical well-being and function in older adults. This is most likely to be achieved when communities are safe, promote health and well-being, and use health services and community programs to prevent or minimize disease [1]

At the global level, the number of those over age 60 is projected by the UN Population Division to increase from just under 800 million today (representing 11% of world population) to just over 2 billion in 2050 (representing 22% of world population). World population is projected to increase 3.7 times from 1950 to 2050, but the number of those aged 60 and over will increase by a factor of nearly 10. Among the elderly, the "oldest old" – i.e., those aged 80 and over – is projected increase by a factor of 26 [2].

The growth in ageing population in India has been faster than in other developing countries. In 1947, when India became independent from British rule, life expectancy was around 32 years and the life expectancy has more than doubled to 67 years in 2007 with projected increase to 74 years by 2045-2050 [3].

Currently, the 60+ population accounts for 8% of India's national population,. By 2050, its 60+ population share is projected to climb to 19%, or approximately 323 million people [4]. The number of elderly persons above 70 years of age (old-old) is likely to increase more sharply than those 60 years and above. The oldest old (80+) among the elderly in India is expected to grow faster than any other age group in the population.(census-2011) [5].

Healthy and active aging means retention of physical, physiological and social fitness, spiritual activities of daily life, being productive and contributory to family and community [6]. Healthy behaviors include regular exercise, hobbies, relaxing, sufficient nutrition, stress relieving activities, avoiding health risk behaviors such as tobacco exposure and alcohol consumption, and preventing disease and injury. All are associated with better health, functioning, and longevity across the lifespan [7].

Promoting healthy living the elderly people have specific health needs these are:

Diet and nutrition: A good diet reduces the chances of developing the diseases of old age. Elderly people need to maintain their optimal weight by maintaining balance with less saturated fats and oil, moderate carbohydrate and high protein, high fibers and should contain lots of fruits and vegetables [8, 9].

Physical activity: Physical activity improves health and well-being. It reduces stress, strengthens the heart and lungs, increases energy levels, helps maintain activities like house cleaning, gardening, shopping, lifting grandchildren, carrying groceries, household chores, tying shoes and regular exercises can help keep the brain active which can prevent memory loss, cognitive decline and dementia, brain disorder such as Alzheimer's disease. Regular physical activity and exercise can help to maintain and enhance functioning, health, and well-being among elderly people [10].

Social activity: Social activities give elderly people the opportunity to interact with other people in the society. As a result they feel that they are a part of the society. People, who become socially isolated, rarely go out, do not join in the community activities, have few friends or do not see much of their family-are less healthy. Getting out and keeping involved with others creates a sense of belonging. Social activities effective in preventive depression among older people [11].

Spiritual activity: Spirituality is an important factor that helps individuals achieve the balance needed to maintain health and well-being and to cope enhances health, quality of life, health promotion behaviors, and disease prevention activities Those who are spiritually healthy experiences joy, are able to forgive themselves and others, accept hardship and morality, report enhance quality of life, and have a positive sense of physical and emotional well-being.[11].

2. Need of the Study

Some geriatric studies revealed that the elderly healthy living was strongly associated with nutrition, physical wellness and social wellness and their psychological wellness etc. Elderly population has not given serious consideration and only a few studied have been attempted in our country as well as in Assam. The above facts made the investigator realized the importance of research study on particular problem because they are revered member of our family, wise sages & keeper of traditions. But unfortunately old age becomes burden of most of the individuals and society. By keeping that mind, Investigator tried to bring awareness among the elderly about healthy living and circulate the massage to general community on importance of healthy living practices among the elderly people in Kamrup metro, Assam.

Statement of the Problem

A Comparative study to assess the knowledge and practice among the elderly on healthy living in selected urban and rural areas of Kamrup Metro, Assam.

Objectives

1) To find out the knowledge on healthy living among the elderly in selected urban and rural areas.
2) To identify the practices of healthy living among the elderly in selected urban and rural areas.
3) To compare the knowledge and practice on healthy living among the elderly in selected urban and rural areas.
4) To associate the knowledge and practice on healthy living among the elderly in selected urban and rural areas, with their selected demographic variables

Operational Definitions

To assess: According to Oxford English Dictionary it mean to evaluate the value or quality.

In this study to 'assess' means to find out the knowledge and practices of elderly elicited by using structured questionnaire.

Knowledge: According to American Heritage Dictionary it means familiarity, awareness, or understanding gained through experiences or study. In this study 'knowledge' is the information what elderly possesses elicited by using structured questionnaire that included diet, exercise, physical activities, social activities, spiritual activities etc.

Practices: According to Oxford Reference Dictionary it means doing of something repeatedly to improve one's skill. In this study, 'practices' mean activity and habits of the elderly elicited by using inventory checklist in relation to – Diet, Physical activity & Exercises including yoga ,Social activity Spiritual activities like Prayer.

Elderly: according to oxford dictionary it means particular stage in human life. In this studies 'elderly' means people who are in age of 60 and above

Healthy living: According to oxford English dictionary it means that healthy living is the steps ,action and strategies that one puts in place to achieve optimum health. In this study, healthy living means eating healthy food, getting physically fit, emotional wellness, spiritual wellness and maintaining all necessities that maintain healthy lifestyle.

Urban and rural elderly: according to British medical dictionary senior citizens or elderly who lives in cities or town is known as urban elderly and elderly who lives in villages is known as rural elderly.

In this study urban elderly means elderly lives nearby the capital state dispensary Dispur and rural elderly means elderly lives in villages nearby Sonapur primary health centre.

Assumptions

1) Elderly may have some knowledge regarding healthy living among elderly
2) Elderly may have proper practices regarding healthy living among elderly.
3) There may be difference between knowledge and practice on healthy living with respect to urban and rural areas.

Hypothesis

HO1: There is no significant difference between knowledge and practices on healthy living among the elderly in selected urban areas.

HO2: There is no significant difference between knowledge and practices on healthy living among the elderly in selected rural areas.

Delimitation of the Study

The study only explores the Knowledge and Practices on healthy living among elderly.

Research Design

The non-experimental descriptive design was adopted for the study.

Setting of the Study

The study was conducted in some selected urban and rural areas of Kamrup metro, Assam. The researcher was given permission to conduct study for urban elderly nearby the Dispur area and for rural elderly the area was nearby villages under disposal of Sonapur primary health centre.

Variables of the Study

1) **Study variables:** The study variables were knowledge and practices on healthy living among elderly.
2) **Demographic variables:** The demographic variables of this study were age, sex, education, occupation, income, marital status, family size, family type and diet up,

Population

Study the population consists of elderly people from the age group of 60 and above, who were residing in Kamrup metro. In Kamrup metro the total urban population was 10, 44,832, and the total rural population was 2, 15, 587. Total population of the selected urban area was 74,794. The total population of the selected rural area was 1, 88,221 the total

population of the selected rural area was 1, 88,221 which were under the disposal of Sonapur primary health centre that comprised 228 numbers of revenue village and 44 numbers of non revenue village.

Target Population

The target population consists of elderly people from the age group of 60 and above and who were residing in selected urban area of Dispur and in selected villages nearby the Sonapur Primary Health Centre respectively

Sample Size and Sample Technique

Total numbers of sample was 100 which consist of 50 numbers from urban area and 50 numbers from rural area. They were selected by purposive sampling technique.

Inclusion criteria (1) Person who were the age of 60 years and above. (2) Who were willing to participate in the study.

Exclusion criteria: Who are suffering from chronic illness.

Ethical Consideration

Ethical clearance has been obtained from institutional ethic committee. All the ethical principles such as obtaining consent, ensuring confidentiality has been adhering to throughout the study.

Method of Data Collection

Formal written permission obtained from joint director of health service, kamrup metro. Then permission letter was submitted to medical superintendent of Capital State Dispensary Dispur and Sonapur primary Health Center for conducting the study in urban and rural area respectively. Selection of subject were done by checking Voter list from Gram Panchyat office and then investigator went door to door for collecting data. Structure questionnaire was prepared for the knowledge and inventory checklist was prepared for the practices on healthy living among elderly. Before giving the questionnaire the consent was taken and purpose of the study was explained to participants.

3. Data Analysis

Table 1: Socio Demographic Characteristics

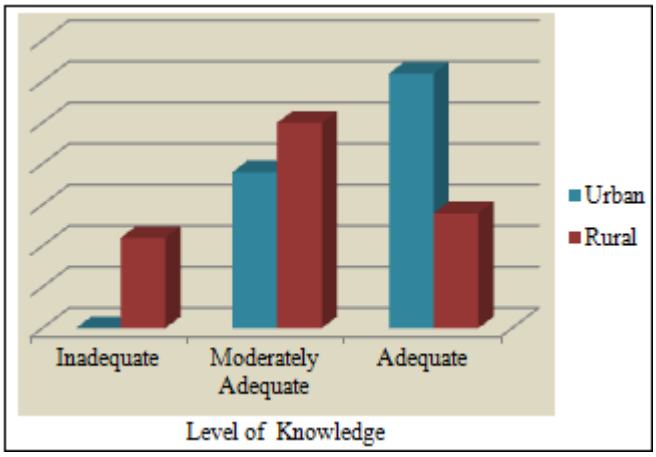
Socio Demographic Characteristics	Urban Elderly		Rural Elderly		Total
	Frequency	Percentage	Frequency	Percentage	n=100
1. Age in Years					
60-70	29	58%	28	56%	57
70-80	15	30%	18	36%	33
80-90	4	8%	3	6%	7
Above 90	2	4%	1	2%	3
2. Level of education					
Illiterate	3	6%	8	16%	11
primary school	2	4%	8	16%	10
Middle school	6	12%	12	24%	18
High school	10	20%	8	16%	18
Higher secondary	14	28%	10	20%	24
Graduate, others	15	30%	4	8%	19
3. Level Occupation					
Farmer	0	0%	13	26%	13
Retired person	23	46%	17	34%	40
Businessman	6	12%	4	8%	10
Labours	0	0%	2	4%	2
Housewife	16	32%	12	24%	28
Others	5	10%	2	4%	7
4. Level of Income					
Up to Rupees 2000	0	0%	3	6%	3
2000-3000	0	0%	5	10%	5
3000-4000	9	18%	6	12%	15
Above 4000	41	82%	36	72%	77
5.Marital Status					
Married	37	74%	35	70%	72
Unmarried	2	4%	2	4%	4
Other	11	22%	13	26%	24
6.Family size					
Nuclear	37	74%	30	60%	67
Joint	13	26%	18	36%	31
Extended	0	0%	2	4%	2
7. Dietary Habit					
Vegetarian	10	20%	8	16%	18
Non-vegetarian	40	80%	42	84%	82

Majority of the elderly male were fall in between the age group of 70-80 and majority of the female elderly were in between age group of 60-70 who lived in urban area and rural areas respectively. Among them 27% were female and 23% were male from urban area and 28% were male and 22% were female from rural areas. Majority of elderly, both

urban and rural area had studied up to the high school level .16% from rural and 6% of urban elderly were found illiterate.46% of urban elderly were retired person and 34% of rural elderly were retired person .82% urban and74% rural of elderly earned more than Rs 4000 per month 74%of urban elderly and70% of rural elderly were lived with their spouse.74% of urban elderly and 60% of rural elderly lived in nuclear families. 20% of urban elderly and 16% of elderly were consumed vegetarian diet and 80% urban and 84% of rural elderly were consumed non vegetarians in their meals.

Table 2: Level of knowledge of Elderly in urban & rural area, N=100

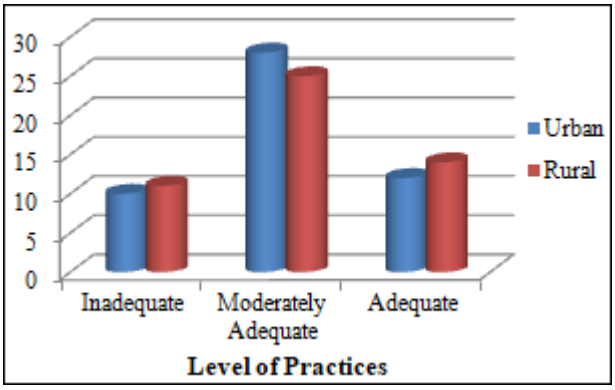
S. No	Level of Knowledge	Frequency	Percentage	Cumulative Frequency	Mean	Median	SD
Urban Elderly	Inadequate (0-50)	0	0	0	78	79.8	12.13
	Moderately adequate (50-75)	19	38%	19			
	Adequate (75-100)	31	62%	50			
Rural Elderly	Inadequate (0-50)	11	22%	11	61.25	78	21.97
	Moderately adequate (50-75)	25	50%	36			
	Adequate (75-100)	14	28%	50			



(Table 2 and Fig-1) shows frequency and Percentage Distribution of elderly according to their level of knowledge in urban area, majority 62% 0f elderly had adequate (75-100) knowledge. 38%of elderly showed moderately adequate (50-75) knowledge on healthy living. And in case of Rural elderly, it showed that majority 50% of elderly had moderately adequate knowledge. 28% of elderly showed adequate knowledge, 22% showed inadequate knowledge on healthy living.

Table 3: Level of Practices on Healthy living among the Urban & Rural Elderly people

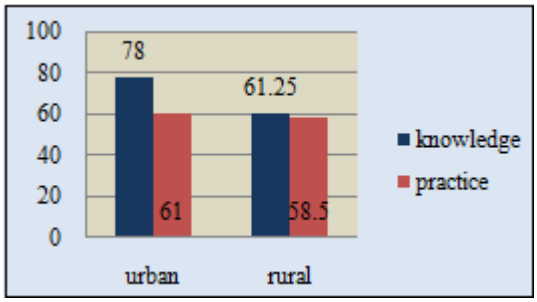
Sl. No	Level of Practice	Frequency	Percentage	Cumulative Frequency	Mean	Median	SD
Urban Elderly	Inadequate (0-50)	10	20%	10	61	76.78	20.71
	Moderately adequate (50-75)	28	56%	38			
	Adequate (75-100)	12	24%	50			
Rural Elderly	Inadequate (0-50)	11	22%	11	61.25	78	21.97
	Moderately adequate (50-75)	25	50%	36			
	Adequate (75-100)	14	28%	50			



(Table 3and figure-2) shows that, in Urban Elderly Majority 56% were had moderately adequate practice; 58% of elderly were adequate practice, 20% were had inadequate practices on healthy living. And majority 56% 0f elderly had moderately adequate practices. 24% of elderly showed inadequate practices, only 20% were showed adequate practices on healthy living in Rural Elderly.

Table 4: Correlation co-efficient of knowledge and practice score of Elderly on Healthy Living Urban area &Rural Area, n=100

Variable	Urban Elderly			Rural Elderly		
	Mean	Standard deviation	'r ' value	Mean	Standard deviation	'r ' value
Knowledge	78	12.13	r = -0.25	61.25	21.97	r = -0.34
Practice	61	20.71		58.5	21.13	



(**Table 4 &Figure 3)** shows in urban area, the mean performance for knowledge 78 and practice score was 61. ['r' value was -0.25]. Again in case of rural elderly mean

performance of knowledge was 61.25 and practice was 58.5 ['r' value was -0.34,] so in both urban and rural elderly people have more knowledge on healthy living but the effort on practice among the elderly were significantly less

Table 5: Significant of correlation and the difference between mean performance level of Knowledge and Practice of elderly in urban and rural areas

S No	Test(Mean)	Calculated Value of	Tabulated value of Z		Remark
			0.05	0.01	
1	K & P in Urban area	5.01	1.96	2.58	Highly Significant
2	K & P in Rural area	0.64	1.96	2.58	Not Significant
3	Knowledge Urban Vs Rural	4.73	1.96	2.58	Highly Significant
4	Practice Urban Vs Rural	0.59	1.96	2.58	Not Significant

(Table 5) shows the mean performance in knowledge and practice level of elderly in urban area and it shows highly significance (5.01) and in rural (0.64), not significant. Again the difference between mean performance of knowledge level of elderly in urban and rural area was 4.73 that was highly significant, and again in rural area 0.59 not significant.

Table 5: The association of knowledge and practice with selection demographic variables in urban and rural areas

S. No	Variables	Urban Elderly		Rural Elderly	
		Calculated χ^2 value	Remarks	Calculated χ^2 value	Remarks
1	Age	1.51	Not significant	1.77	Not significant
2	Sex	1.70	Not significant	0.55	Not significant
3	Education	9.18	Highly significant	4.16	Significant
4	Occupation	0.065	Not significant	12.146	Highly significant
5	Income	0.275	Not significant	3.05	Less significant
6	Diet	0.51	Not significant	0.052	Not significant

4. Discussion

The difference between mean performance of knowledge in urban and rural area was 4.73 and the difference between mean performance of practice in urban and rural area was 0.59.It reflected that the urban elderly people had knowledge and practices scores were highly significant but in case of rural elderly people the knowledge and practices were not significant this study supported by the finding of Tzu-yo Lin et.al.(2012) conducted the comparative study on successful aging and leisure activities among the urban and rural elderly reported that urban elderly were more knowledgeable than rural elderly. Debora Rizzuto et.al. (2012) Study stated that life style behaviour such as not smoking, physical activity. Eating right was associated with longer survival.

The analysis revealed that there was highly significant association of knowledge and practice on healthy living among elderly in urban and rural areas .In urban areas Education was highly significant ($\chi^{2=}$9.18 and p=0.002) in knowledge level but in practice level age ($\chi^{2=}$5.09and p=0.023) and education ($\chi^{2=}$8.20and p=0.042) was highly significant. Again in rural elderly the knowledge level was associated with occupation i.e. highly significant ($\chi^{2=}$12.146 and p=0.001); but in practice level education ($\chi^{2=}$14.266 and p=0.001); occupation ($\chi^{2=}$7.28 and p=0.0038); income ($\chi^{2=}$8.002and p=0.004) and diet ($\chi^{2=}$7.35 and p=0.0038) was also highly significant. It was implied that there was strong association of knowledge and practices between education, income, occupation and dietary habit with healthy living practices. This study supported the study by Rizzuto D.et.al the positive effects of healthy living in the elderly by Karolinska Institute in Sweden found individuals over the age of 75 years who maintained physical activity and social interactions lived 5.4 years longer than persons did with less positive interactions and less activity [12]

5. Recommendation & Conclusion

The study revealed that elderly people had adequate knowledge on healthy living but they put less effort in healthy living practice may be due to some physiological changes in ageing process. And there was a strong association between knowledge and practice with education, occupation, income and dietary habit**.** Study concluded that the elderly healthy living knowledge and practices associated with education, occupation, income and their dietary habits. Community health nurse can play a very important role to change their behavior for healthy living practices and transmitting the vital message of healthy living among elderly in urban and rural areas. Organized and need based elderly patient education has to be developed as an interesting innovation function of health care delivery system.

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