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Research Article

Impact of social factors on health practices of the elderly: an analytical study in rural Surendranagar

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ABSTRACT

Introduction: Increased attention to health promotion and disease prevention are important for the appropriate care of the elderly. With the increasing life expectancy, a focus on preventive measures to decrease morbidity and improve quality of life in old age has also developed. To that end, health behavior and lifestyle have become important areas of concern over the last 20 years. Social factors lay a significant impact on the health practices. This study was therefore taken up to study the above factor and draw conclusions.
Aims and objectives: 1. To study the various health practices of the elderly. 2. To find out association between the socio demographic features and the prevailing health practices.
Methods: A Cross sectional analytical study was carried out. All the subjects were interviewed personally to know the details and were treated with due respect after a consent. Out of all the talukas in rural Surendranagar, Sayla was selected randomly after which Sayla village was selected in a similar manner from all the villages in the talukas.
Results: The mean age of the subjects was 68±7.5. Majority of the subjects were unemployed and illiterate (58%). Social factors like Social class, staying with children and staying in joint family were significantly associated with good health practices.
Conclusions: The Health practices of the elderly can be improved upon by large scale health education programmes which can be targeted on the age group. Patient compliance improvement can be achieved by explaining them about the disease and treatment protocol in detail at the time of their health visit.

Keywords: Health practices, Social factors, Geriatric, Cross sectional, Association, Health education

INTRODUCTION

There has been an increased attention paid to health promotion & disease prevention activities in the elderly because of economic, medical & social concerns.[1-3] Increased attention to health promotion and disease prevention are important for the appropriate care of the elderly. With the increasing life expectancy, a focus on preventive measures to decrease morbidity and improve quality of life in old age has also developed. To that end, health behavior and lifestyle have become important areas of concern over the last 20 years.[4,5] In early 1970s, Belloc and Breslow identified a list of seven health practices which were associated with health status: having never smoked, drinking less than 5 drinks at one sitting, exercising, sleeping 7-8 hours a night, maintaining desirable weight for height, avoiding snacks & eating breakfast regularly.[6] Additional investigations

has supported the importance of smoking, drinking, exercise & weight control.[7-9] More recently, other general health practices have also been suggested as important: maintaining a balanced diet (fruits, vegetables & whole grains but limits on caffeine and salt intake) has been suggested as important health practices and maintaining social networks.[10-19]

Social factors lay a significant impact on the health practices. This study was therefore taken up to study the above factor and draw conclusions

Aims and objectives

1. To study the various health practices of the elderly
2. To find out association between the socio demographic features and the prevailing health practices

METHODS

A Cross sectional analytical study was carried out. All the subjects were interviewed personally to know the details and were treated with due respect after a consent. Out of all the talukas in rural Surendranagar, Sayla was selected randomly after which Sayla village was selected in a similar manner from all the villages in the taluka. Out of the total estimated geriatric population of the village (which was 7%), 3 % was selected as the sample which came to 306.

RESULTS

Table 1: Distribution of the subjects according to their age & sex (N=306).

Age group	Sex					
	Male		Female		Total	
	No.	↓%	No.	↓%	No.	↓%
<65	33	22.91	51	31.48	84	27.45
65-75	60	41.66	60	37.03	120	39.21
75-100	51	35.43	51	31.49	102	33.34
Total	144	100	162	100	306	100

The mean age of the subjects was 68 ± 7.5 with the median age of 65.

In the rural area as shown in the table, there were 47.1% males and 52.9% females. Majority (39.21%) of them were in the age group of 65-75 yrs followed by those in the age group 75-100 (33.34%). In the age group of 70-75years however, the males were more as compared to females.

Only about 54% of the subjects in the rural areas were from Open Category, followed by ST (17%) and SC (16%). Almost 13% of the subjects in rural areas were from OBC caste.

In the rural areas, about 9% of the males were from professional class of occupation. About 24.3 % were unskilled workers and nearly 33% of them unemployed. Majority of females (81.48%) were unemployed presently. About 87.5 of the males and 14% of the females who were unemployed presently were employed somewhere in the past.

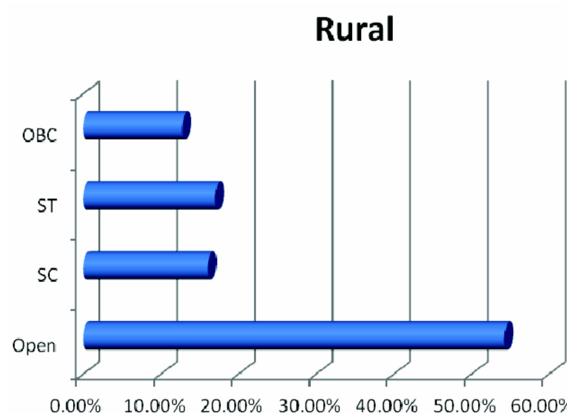

Figure 1: Distribution of the subjects as per their caste (N=306).

Table 2: Present occupational status of the subjects (N=306).

Occupation	Sex					
	Males		Females		Total	
	No.	↓%	No.	↓%	No.	↓%
Professional	13	9.02	0	0	13	4.24
Semi Professional	3	2.08	0	0	3	0.98
Clerical/Shop/Farm	22	15.27	06	3.7	28	9.15
Skilled Worker	14	9.72	09	5.5	23	7.51
Semi-skilled worker	09	6.25	06	3.7	15	4.9
Unskilled worker	35	24.30	09	5.5	44	14.37
Unemployed	48	33.33	132	81.48	180	58.82
Total	144	100	162	100	306	100

Table 3: Distribution of the rural subjects according to their education (N=306).

Education	Sex					
	Males		Females		Total	
	No.	↓%	No.	↓%	No.	↓%
Graduate	13	9.02	0	0	13	4.24
Intermediate diploma	3	2.08	0	0	3	0.98
High school	18	12.5	0	0	18	5.88
Middle school	22	15.27	9	5.55	31	10.13
Primary school	44	30.55	21	12.96	65	21.24
Illiterate	44	30.55	132	81.48	176	57.51
Total	144	100	162	100	306	100

Nearly 81% of the females were illiterate and among the illiterates, 75% were females. Only 31% of males and 13% females had attended primary school while 15% male and only 6% females had education upto middle school. No female in rural areas had education above middle school while amongst males, 12.5% had high school education, 2.08% had intermediate diploma and 9% were graduates.

In the rural, there were 67.32 % subjects who were married whereas 29% were widow/widower. Out of these 80% were females.

Table 4: Distribution of the subjects according to their marital status Rural (N=306).

Marital Status	Sex					
	Males		Females		Total	
	No.	↓%	No.	↓%	No.	↓%
Married	120	83.3	86	53.8	206	67.32
Single	2	1.38	0	0	2	0.65
Divorcee	1	0.69	2	1.23	3	0.98
Widow/Widower	18	12.5	72	44.44	90	29.47
Separated	3	2.88	2	1.23	5	1.63
Total	144	100	162	100	306	100

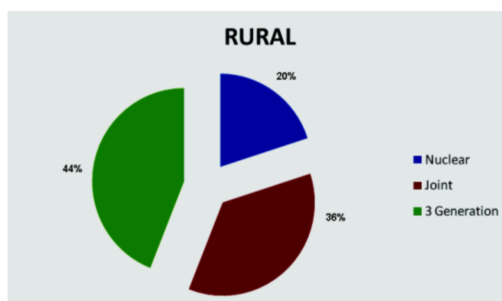

Figure 2: Distribution of the families as per their type (N=190).

Majority of the families were 3 generation (44%) followed by joint families which accounted to nearly 36% of the total families.

Table 5: Distribution of the families according to their social class (Modified Prasad Classification 2009).

Social Class	Rural (N=190)	
	Number	Percentage
Class 1	10	5
Class 2	8	4
Class 3	34	18
Class 4	49	26
Class 5	89	47
Total	190	100

Table 6: Financial position of the subjects (Rural, N=306).

Financial position	Sex					
	Males		Females		Total	
Independent	74	51.38	6	3.70	80	26.14
Partly dependent	31	21.52	18	11.11	49	16.01
Totally dependent	39	27.08	138	85.18	177	57.84
Total	144	100	162	100	306	100

Majority of the families were from social class 5 (47%) followed by those from social class 4 (26%) as per the modified Prasad's classification of 2009 with AICPI of Rs. 741.

About 51.38% of the males and only 3.7 % of females were financially independent. Nearly 16% of subjects were partly and 58% were totally dependent on someone.

When asked about the details, the subjects were predominantly dependant on their children (mainly sons).

It was interesting to know that nearly 81% of the subjects were staying with children, which shows the still persisting Joint family system in rural India.

Table 7: Table showing the scoring system of the various health practices.

Health practice	Quality of health practice	Score
EXERCISE		
Exercising regularly (>5 days a week)	Good	3
Exercising Irregularly (<4-5 days a week)	Average	2
Not exercising at all	Poor	1
TOBACCO (any form)		
Not consuming at all	Good	3
Occasionally	Average	2
Everyday	Poor	1
SLEEP PATTERN		

Health practice	Quality of health practice	Score
7-8 hours a day	Good	3
<7 or >8 hours a day	Average	2
Irregular sleep pattern	Poor	1
CAFFEINE CONSUMPTION (TEA/COFFEE)		
<5 cups/day	Good	3
5-8 cups/day	Average	2
>8 cups/day	Poor	1
SALT INTAKE		
Never adding extra salt to diet on table	Good	3
Occasionally adding extra salt to diet	Average	2
Regularly adding extra salt to diet	Poor	1
SOCIAL LIFE		
Regularly in contact with friends, relatives & attending social gatherings	Good	3
Not regular in contact & not regularly attending social gatherings	Average	2
Not in touch and not attending social gatherings at all	Poor	1
WEIGHT CONTROL		
BMI normal	Good	3
BMI overweight	Average	2
BMI obesity	Poor	1
BREAKFAST		
Regular	Good	3
Occasionally	Average	2
Never	Poor	1
EATING FRESH FRUITS/ VEGETABLES/ WHOLE GRAINS		
Regularly	Good	3
Occasionally	Average	2
Rarely	Poor	1
SCORING SYSTEM		
Good Health practice		18-27
Average health practice		9-18
Poor health practice		<9

To assess the health practices, several variables were taken into consideration. In each of the variable, score was assigned to the good, average and poor health practice.

After this a total to the score of each subjects assessing all variables was computed and then the subjects were generalized as having good, average or poor health practice.

Table 8: Table showing the health practices of the subjects (N=306).

Health practice	Number	Percentage
Good health practice	43	14
Average health practice	86	28
Poor health practice	177	58

It can be seen from the above table that as the sample was from rural area, the quality of the self care and health practices among them was predominantly poor with a majority of them showing poor health practices (58%). Nearly 28% showed average and a meager 14% showed good health practices.

To assess the impact of social factors on health practices, all of the above factors were analyzed & association was sought using chi squared test at 5% level of significance.

It was seen that the higher social class (Class 1 & 2) had better health practices than the lower class. Those employed as professionals (Professional & business class) also had much better health practices as compared to labor class & the unemployed.

Table 9: Table showing the association of health practice with Several Social Variables.

Social factors	Health practices					
	Good	Average	Poor	Total	Chi square	P value
SOCIAL CLASS*						
Class 1	10	3	3	16	141.65	<0.0001
Class 2	8	3	2	13		
Class 3	11	33	10	54		
Class 4	7	32	41	80		
Class 5	7	15	121	143		
OCCUPATION						
Professional/ Semi Prof. **	23	16	5	44	83.345	<0.0001
Workers ***	12	13	57	82		
Unemployed	8	57	115	180		
EDUCATION						
Higher secondary or more	18	10	6	34	144.075	<0.0001
Primary to Secondary	22	51	23	96		
Illiterate	3	25	148	176		
MARITAL STATUS						
Married	32	59	115	206	1.493	0.4740
Divorcee/ Single	11	27	62	100		
TYPE OF FAMILY						
Joint/ 3 generation	12	67	166	245	94.419	<0.0001
Nuclear	31	19	11	61		
FINANCIAL STATUS						
Independent	35	21	24	80	82.633	<0.001
Partially/ fully dependent	8	65	153	226		
STAYING WITH CHILDREN						
Yes	26	77	145	248	15.979	0.0003
No	17	9	32	58		

* *Social class as per Modified Prasad`s Classification of 2009 (AICPI= Rs. 741/-)*

*** Professional/ Semi including Professional class, Semi-professional class and business class*

**** Workers including skilled, semi skilled & unskilled workers*

Those educated upto higher secondary or more had better health practices as compared to those educated upto primary or illiterate. Nearly 80% of the subjects were from Joint or 3 generation families and they showed better health practices than those living in nuclear families.

The financial status of the elderly also had a significant impact showing that those who were independent showed better health practices.

Marital status had no impact on health practices and showed not significant association.

Those staying with children had better health practices than those not staying with them.

Nearly 55% of the subjects were suffering from a disease and majority of them were either not taking treatment regularly or visiting health centers for obtaining regular follow-up and medical attention. This reflected poor health practice and compliance among the elderly in the area.

DISCUSSION

In the present study, nearly 27% of the respondents were aged below 65, which is lower than similar study conducted by Mahjabeen Sultana Begum where 53% of the respondents were from that age group.[20] In the same study nearly 67% of the subjects were married and out of them 14% were living with spouse. This is similar to the present study. In the present study, nearly 80% of the subjects were staying with children which is similar to above study where 86% were staying with children. This explains the still persistent Joint family system found in two countries.

In the same study, 67% of the subjects were health conscious and had good health practices which is very

low than the present study. This difference could be because the formal is a hospital based study as compared to present which is a community based study. Another hospital based study carried out by Jabeen et al showed similar findings to the mahjabeen study.[21]

In a study conducted by Lubben et al, it was found that Smoking, lack of exercise and weight problems were significantly high, this was similar to the present study.

The study has highlighted the importance of social factors which can influence the health practices of the elderly. The financial and educational status had a significant impact over the latter, which shows the pressing need of education right in the formative years of the upcoming generation. The study reiterates one of the major advantages of the Joint family system i.e. family members caring for the elders which are shown by their better health practices than the nuclear family counterparts.

CONCLUSIONS

The Health practices of the elderly can be improved upon by large scale health education programmes which can be targeted on the age group. Patient compliance improvement can be achieved by explaining them about the disease and treatment protocol in detail at the time of their health visit.

Establishment of geriatric clinics in rural areas is the need of the hour and must be pushed up in the priority list of the government interventions. Training of health staff including medical officer and health workers regarding various health problems of the elderly is reiterated as they can play a pivotal role in improving their health practices and educating them.

REFERENCES

1. Lubben JE, Weiler PG, Chi I. Health practices of the elderly Poor, Am J Public Health 1989;79:731-4.
2. Stults BM. Preventive health care and the elderly. West J Am Med 1984;41:832-45.
3. Dychtwlad K (ed). Wellness and health promotion for the elderly. Rockville, MD: Aspen Systems, 1986.
4. Fries JF, Carpo L. Vitality and aging: Implications of the rectangular curve. New York: W.H. Freeman, 1981.
5. Rowe JW, Kahn RL. Human aging: Usual and successful. Science 1987;237:143-9.
6. Belloc NB, Breslow L. Relationship of physical health status and health practices. Prev Med 1972;1:409-21.
7. Wiley JA, Camacho TC. Lifestyle and future health: evidence from the Alameda County study. Prev Med 1980;9:1-21.
8. Wingard DL, Berkman LF, Brand RJ. A multivariate analysis of health related practices: A nine year mortality follow up of the Alameda county study. Am J Epidemiol 1982;116:765-75.
9. Kaplan GA, Seeman TE, Cohen RD, Knudsen LP, Guralnik J. Mortality among the elderly in Alkameda county study: behavioral and demographic risk factors. Am J Public Health 1987;77:307-12.
10. Dawber TR. The Framingham study: The epidemiology of atherosclerotic disease. Cambridge: Harvard University Press, 1980.
11. Kane RL, Kane RA, Arnold SB. Prevention and the elderly: risk factors. Health Serv Res 1985;19:945-1006.
12. Pritikin N, Cisney N. Dietary recommendations for older Americans, In: Dychtwald K (ed): Wellness and health promotion for the elderly. Rockville, MD: Aspen Systems, 1986.
13. Berkman LF, Syme SL. Social networks, host resistance and mortality: A nine year follow-up study of Alameda County residents. Am J Epidemiol 1979;109:186-204.
14. Kasl SV, Berkman LF. Some psychosocial influences on the health status of the elderly: the perspective of social epidemiology. In: Mc Gaugh JL, Kiesler KB (eds): Aging: Biology and Behavior. New York: Academic Press, 1981.
15. Greenbaltt M, Becerra RM, Serafetinedes EA. Social networks and mental health: an overview. Am J psychiatry 1982;139:977-84.
16. Ell K. Social networks, social supports, and health status: A review. Soc Serv Rev 1984;58:133-49.
17. Zuckerman DM, Kasl SV, Ostfeld AM. Psychosocial predictors mortality among elderly poor: The role of religion, Well-being, and social contacts. Am J Epidemiol 1984;119:410-23.
18. Berkman LF. The relationship of social networks and social supports to morbidity and mortality. In: Cohen S and Syme LS (eds): Social Support and Health. Orlando, FL: Academic Press, 1985.
19. Minkler M. Social Support and health care of the elderly. In: Cohen S, Syme LS (eds): Social Support and Health. Orlando, FL: Academic Press, 1985.
20. Mahajabeen Sultana Begum. Geriatric health problems and health care seeking practice among elderly people attending one selected geriatric hospital. Bangladesh J Physiol Pharmacol 2007;23(1&2):20-4.
21. Jabeen S. Self health care among the senior citizen attending BAAIGM, Dhaka, Bangladesh, 1998.

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