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Life style of aged people in selected areas of Dhaka city

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Abstract
This study was to assess the life style of aged people in Dhaka city. A cross sectional study was done in Jatrabari, Sonir Akhra and Matuail. A total number of respondents was 333, the range of age were from 60 to 89 years. Majority 28.8% of them were higher secondary school certificate holders, 98.2% were married, 87.4% were Muslim, 89.2% male, The mean income was 28081.40±15386.178 tk. 32.43% business man, 54.05% respondent's family depended on their income, 50.91% relations with their family was very good, 67.57% relations with their relatives were good 50.45% relations with their friends were good, 93.7% took food as per self-minded, 45.9% took their meal after every three hours, 63.06% took food regularly, 52.3% of them didn't get more time for taking food regularly, 70.27% rolled on in social ceremony,61.3% exercised regularly, 95.1% of them walked regularly, 63.2% of them exercised about one hour, 39.1% didn't exercise regularly for Pressure of work from working place,79.6% were suffered from tension, 26.4% of them suffered from tension for house rent, 66.67% had diseases, 51.9% of them had diabetes, 98.2% of them took treatment for their diseases,61.26% took treatment from non-government hospitals, 53.2% of the respondents were looked after by their husband/wife, 24.32% liked to take news and watch it in their relax time. Further research is recommended to develop standard life style for quality assurance of aged people.

Keywords: life style, aged people, Dhaka city

Introduction
Aging is a natural, multidimensional process of human life. Old age is the closing period of the life of an individual. The aim of the present study was to evaluate the life style of aged people in Dhaka city. A person's activities, attitudes towards life, relationships to the family and work, biological capacities and physical fitness are all confined by the position in the age structure of the particular society in which she/he lives. Aging is generally defined as a process of deterioration in the functional capacity of an individual that results from structural changes with the advancement of age [1].

Successful aging is largely determined by individual lifestyle choices and not by genetic inheritance. Few factors contribute as much too successful aging as having a physically active lifestyle. Regular physical activity is important for the primary and secondary prevention of many chronic diseases (e.g. coronary heart disease, non-insulin dependent diabetes mellitus, and obesity) disabling condition (e.g. osteoporosis, arthritis), and chronic disease risk factors (e.g. high blood pressure, high cholesterol) [2].

In any case, life at old age becomes typically more fragmented, disorderly, and unpredictable. Major events of life are no longer parts of a predictable or natural pattern. Although the rigidity of the linear life plan has failed to keep up with new demographic realities, it offered a degree of security. In the new post-industrial life, people are increasingly isolated. Familiar social institutions like marriage and employment can no longer be counted on for security throughout adulthood, and therefore the last stage of life also becomes less predictable. Society has not yet come to terms with the meaning of aging in such unpredictable times [3].

The lifestyle matters project was inspired by the United States (US) well elderly study, which involved the delivery of a health-promoting intervention called lifestyle redesign. Based on an occupational approach to healthy ageing, lifestyle redesign helps older people to improve their quality of life and to avoid the negative spiral of decline. In Bangladesh, age is expected to accelerate and by 2050 the number of persons aged 60+ are projected to be approximately 40.5 million [4]. Supporting person of the aged people will be reduced. It is the time for thinking about aged person and develops their life style. In Bangladesh government published an act "National Policy on Older Persons, 2013" but there is only one geriatric hospital in Argagoan [3]. With a view to this background, my aims to gather information from the aging people and identify best practices in the field of health promotion for older people. There is a focus on those models that have a sustainable approach and which regard socio-economic, environmental and life-style related determinants. To develop a common vocabulary and a glossary was in order to create a terminology and understanding for health promotion of aging people. To develop a set of criteria for the selection of models of good practices in the health promotion of older people as well as models of best practice. To inform and raise the awareness were amongst experts and authorities throughout dissertation about the issue of ageing and the impact of the demographic change on our society.

Materials & Methods
A descriptive cross sectional study was done to assess the life style of aged people in selected areas of Dhaka city. Study place were Jatrabari, Sonir Akhra & Matuail was chosen for the study from January 2016 and end August 2016 (Eight months). Study populations were all the aged people who were interested to give interview. Inclusion criteria were who were available to answer the question and who gave consent and

participate to fill the questionnaire. Exclusion criteria those who refused to provide inform consent & interview. For the study a total number of samples were 333. Purposive sampling technique was applied for data collection. A pre tested structure questionnaire was used for data collection tool. Data collection was done by face to face interview. One male interviewers, one female interviewer and researcher himself were involved in data collection. The interviewers were trained up before the beginning of data collection. Data was analyzed by using the software SPSS 16.0 version. And data are presented in tables, graphs, charts and bars. University ethical clearance committee was approved this protocol.

Results

A total number of 333 respondents were interviewed. Mean age of the respondents were (68.82±10.384) years.

Regarding educational status, majority 28.8% of them were higher secondary school certificate holders in contest 1.8% respondents were master's degree holders. 23.4% of the respondents were graduate while 9.9% were illiterate. 20.7% of them completed primary school certificate course while 15.3% of them completed secondary school course.

Among the respondents, majority 98.2% were married while .9% was unmarried in the contest only .9% were found widowed.

87.4% of respondents were found Muslim in the contest only.9% were Buddhist. 11.7% respondents were found Hindu. The majority respondents (89.2%) were male while 10.8% were female. Mean income of the respondents were 28081.40±15386.178 tk. (table-1).

Table 1: Distribution of the respondents according to socio-demographic characteristics Number (n=333)

Age (In years)	Number	Percentage (%)
60-69	219	65.7
70-79	63	18.9
80-89	51	15.4
Mean ± SD (68.82 ±10.348)		
Education		
Illiterate	33	9.9
Primary	69	20.7
Secondary	51	15.3
Higher secondary	96	28.8
Graduate	78	23.4
Masters	6	1.8
Marital status		
Unmarried	3	.9
Married	329	98.2
Widowed	3	.9
Religion		
Muslim	291	87.4
Hindu	39	11.7
Buddhist	3	.9
Sex		
Male	297	89.2
Female	36	10.8
Income (Tk.)		
6000-20000	105	40.7
21000-35000	78	30.2
36000-50000	51	19.8
51000-65000	21	8.1
66000-80000	-	-
81000-95000	3	1.2
Mean ± SD (28081.40±15386.178 Tk.)		

Among the respondents most of them (32.43%) were business man in the contest 1.8% were unemployed. 31.53% of them were retired persons while 2.7% of them were day labor. 13.51% of them were service holders in contest of that 2.7% were teachers. 9.91% of them were housewife and 5.41% of them were shopkeepers (figure 1).

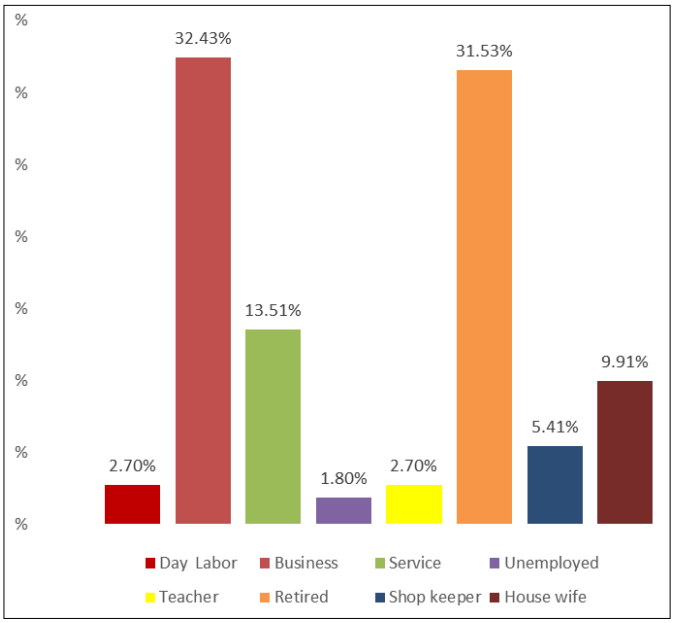

Fig 1: Distribution of the respondents according to occupation

Most of the respondent's (54.05%) family depended on their income while 45.95% of them were not depending on their income (figure 2).

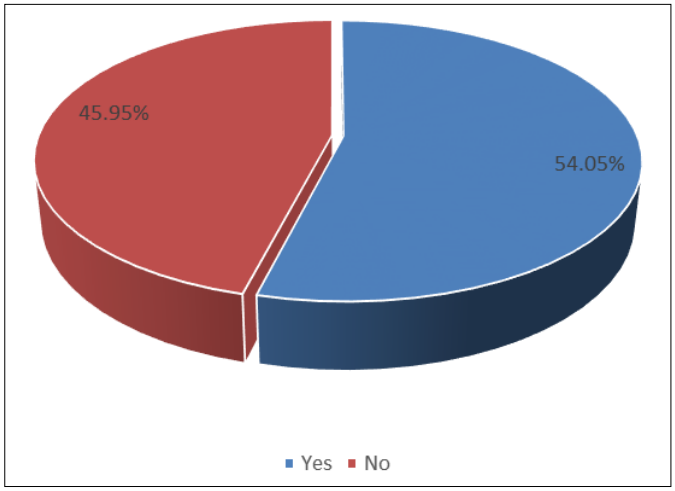

Fig 2: Distribution of the respondents according to family dependent on income

Regarding the study, most of the respondent's (50.91%) relations with their family was very good in the contest of that 3.64% relations with their family were little good. 45.45% of the respondent's relations with their family were good.

More than two third of the respondent's (67.57%) relations with their relatives were good in the contest of that 4.5% relations with their relatives were little good. 27.93% of the respondent's relations with their relatives were very good.

More than fifty respondent's (50.45%) relations with their friends were good in the contest of that 5.3% relations with their friends were very good. 44.14% of the respondent's relations with their friends were little good.

About three fourth of the respondent's (74.77%) relations with their neighbors were little good in the contest of that .9% relations with their neighbors were bad. 20.72% of the respondent's relations with their neighbors were good while 3.6% of the respondent's relations with their neighbors were very good (figure 3).

Most of the respondents (93.7%) took food as per self-mind in the contest 2.7% of them maintain food chart. 3.6% of the respondents took food as per their need.

Most of the respondents (45.9%) took their meal after every three hours in the contest 1.8% of them took food every one hour's after. 44.1% of the respondents took their meal after every four hours while 2.7% of them took their meal after every five hours. 5.4% of them took their meal after every two hours.

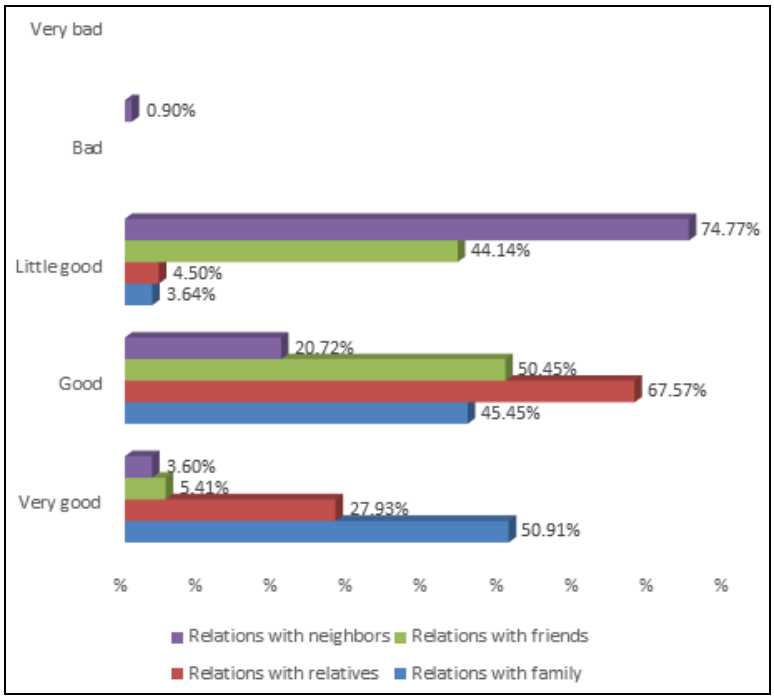

Fig 3: Distribution of the respondents according to relations with people

Responses presented in percentages in 5-point Likert scale

About two third of the respondents (63.06%) took food regularly in contest 5.41% of them didn't comments about it. 31.53% if the respondents answer were negative about taking food regularly (figure 4).

More than fifty percentage 52.3% of them didn't get more time for taking food regularly in the contest 22.7% of them didn't take food for their mind loss. 25% of the respondents didn't take food timely for not feeling better.

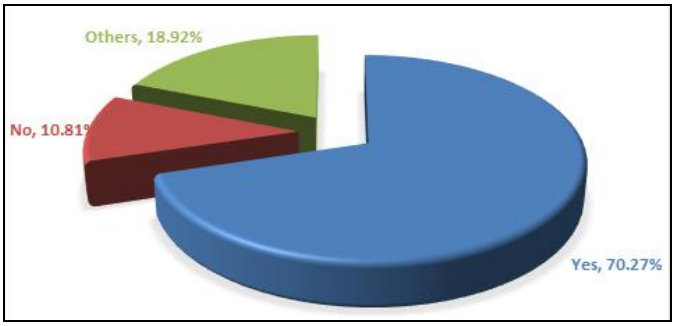

Fig 4: Distribution of the respondents according to taking food regularly

Most of the respondents (70.27%) rolled on in social ceremony in the contest 10.81% of them didn't roll on in social ceremony. 18.92% of them didn't like to comments about maintaining social ceremony (figure 5).

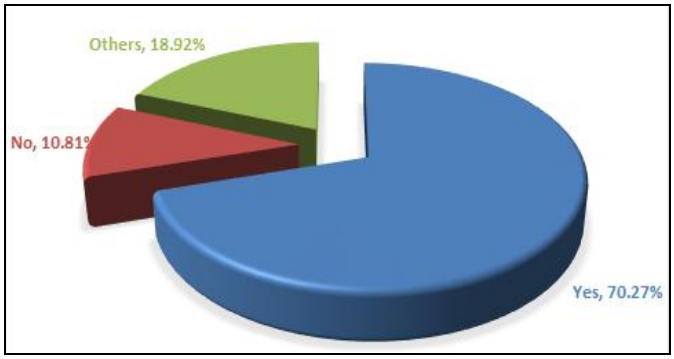

Fig 5: Distribution of the respondents according to roll on in social ceremony

Most of the respondents (42.9%) rolled on in social ceremony two times in a month in the contest 19.4% of them rolled on in social ceremony 3/4 times in a month. 37.4% of them rolled on in social ceremony one times in a month.

More than fifty percentages of the respondents (61.3%) exercised regularly while 7.2% of them didn't like to comments about exercise. 32.5% of them didn't exercise regularly.

95.1% of them walked regularly while 4.9% of them exercised yoga. 63.2% of them exercised about one hour while 10.5% of them had no exercised seclude.26.3% of them exercised about 30 minutes.

Most of the respondents (39.1%) didn't exercise regularly for Pressure of work from working place while 7.2% of them didn't exercise regularly for not feeling better. 29% of the respondents didn't exercise regularly for sickness in contest 7.2% of them didn't exercise regularly for any better place. 17.4% of them didn't exercise regularly for their habit (Table-2).

Table 2: Distribution of the respondents according to excuses of habit of exercise regularly Number (n=333)

Status of no exercise	Number	Percentage (%)
Pressure of work from working place	81	39.1
For sickness	60	29
For no habit	36	17.4
For not feeling better	15	7.2
No better place	15	7.2

Most of the respondents (79.6%) were suffered from tension in the contest 2.8% of them didn't like to comments about this. 17.6% of them were not suffer from tension. 26.4% of them suffered from tension for house rent while 2.2% of them suffered from tension about death. 24.2% of them suffered from tension about high rate of products while 8.8% of them suffered from tension for the pressure from working place. 19.8% of them suffered from tension of their loan and 18.7% of them suffered from tension for their child.

About two third of the respondents (66.67%) had diseases while 5.41% of them didn't like to comments about their diseases in the contest 27.93% of them had no diseases. More than fifty percentage (51.9%) of them had diabetes in the contest 1.2% had kidney diseases. 18.5% of them had body pain while 3.7% of them had general weakness. 16% of the respondents had heart diseases and 8.6% of them had asthma. 98.2% of them took treatment for their diseases while 1.8% of them didn't take treatment (Table 3).

Table 3: Distribution of the respondents according to present diseases, Number (n=333)

Pattern of diseases	Number	Percentage (%)
Diabetes	126	51.9
Heart diseases	39	16
Asthma	21	8.6
Kidney diseases	3	1.2
Body pain	45	18.5
General weakness	9	3.7

Most of the respondents (61.26%) took treatment from non-government hospitals in the contest 4.50% of them took treatment from pharmacy. 23.42% of them took treatment from private chamber while 10.81% of them took treatment from government hospitals. About two third of the respondents (62.2%) liked Allopathic medicine in the contest 2.7% of them liked Unani medicine. 18.9% of them liked Homeopathic medicine while 3.6% of them liked all medicine. 6.3% of them liked Ayurvedic medicine and 6.3% of them 6.3% liked as per doctors give (figure 6).

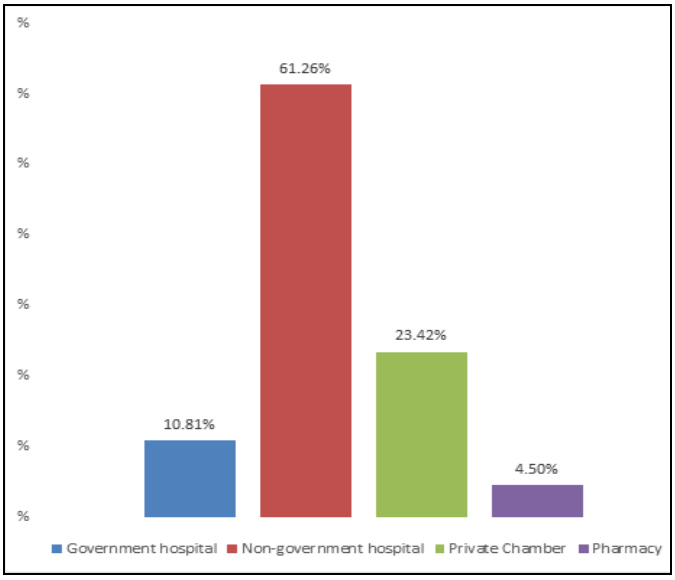

Fig 6: Distribution of the respondents according to treatment place

About fifty percentages of the respondents (43.1%) liked capsule as medicine in the contest 3.7% of them liked all types of medicine as doctors give. One fourth 25.7% of them liked tablet as medicine while 11% of them liked all types of medicine. 16.5% of them liked syrup as medicine.

More than fifty percentages (53.2%) of the respondents were looked after by their husband/wife in the contest .9% of them were looked after by their relatives. 30.6% of them were looked after by their husband/wife and son/daughter while 15.3% of them were looked after by their son/daughter.

Most of the respondents (24.32%) liked to take news and watch it in their relax time in the contest 2.7% of them liked playing games in their relax time. About 21.62% of them liked to watch Television in their relax time while 3.6% of them liked to listen song in their relax time. 18.02% of them liked to gossip in their relax time in the contest 6.31% of them liked to read Quran in their relax time. 13.51% of them liked to sleep in their relax time while 9.91% of them liked to read books in their relax time (figure 7).

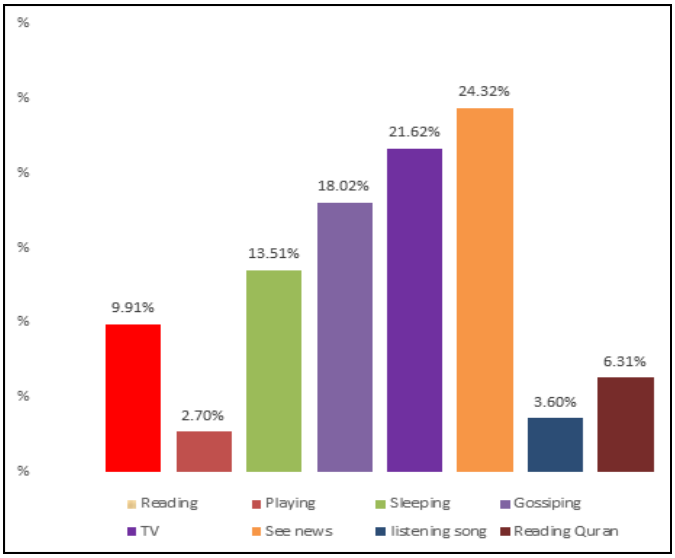

Fig 7: Distribution of the respondents according to favorite work in relax time

Discussion

The interplay of health with other factors, such as bereavement and other losses, living arrangements, personal resilience and available networks of support in determining coping abilities, was confirmed [5].

In common with the results obtained from many previous studies, the findings obtained from the qualitative interviews echoed the significance of health and related issues in determining independence and continued participation [6].

The aim of this feasibility study was to see if an occupation-based health-promoting intervention for community-living older people could be delivered successfully. The participants' ages ranged from 60 to 89 years.

A total number of 333 respondents were interviewed. Majority 28.8% of them were higher secondary school certificate holders, 1.8% was master's degree holders, and 23.4% were graduate, 9.9% were illiterate. 20.7% primary school certificate, 15.3% completed secondary school course.

Majority 98.2% were married, .9% was unmarried and .9% was found widowed. 87.4% were found Muslim, only 9% were Buddhist and 11.7% were found Hindu. 89.2% were male, 10.8% were female. Mean income of the respondents were 28081.40±15386.178 tk. 32.43% were business man, 1.8% were unemployed, 31.53% were retired persons, 2.7% of them were day labor, 13.51% of them were service holders, 2.7% were teachers, 9.91% were housewife and 5.41% were shopkeepers. 54.05% respondent's family depended on their income and 45.95% respondent's family was not depending on their income. 50.91% relations with their family were very good and 45.45% of the respondent's relations with their family were good.67.57% relations with their relatives were good and 27.93% of the respondent's relations with their relatives were very good. 50.45% relations with their friends were good, 5.3% relations with their friends were very good and 44.14% of the respondent's relations with their friends were little good. 74.77% relations with their neighbors were little, .9% relations with their neighbors were bad, 20.72% of the respondent's relations with their neighbors were good and 3.6% of the respondent's relations with their neighbors were very good.93.7% took food as per self-mind in, 45.9% took their meal after every three hours, 1.8% of them took food every one hour's after and 44.1% of the respondents took their meal after every four hours 63.06% took food regularly, 31.53% if the respondents answer were negative about taking food regularly. 52.3% of them didn't get more time for taking food regularly, 22.7% of them didn't take food for their mind loss and 25% of the respondents didn't take food timely for not feeling better. 70.27% rolled on in social ceremony, 10.81% of them didn't roll on in social ceremony and 18.92% of them didn't like to comments about maintaining social ceremony. 42.9% rolled on in social ceremony two times in a month, 19.4% rolled on in social ceremony 3/4 times in a month and 37.4% of them rolled on in social ceremony one times in a month.61.3% exercised regularly and 32.5% of them didn't exercise regularly. 95.1% of them walked regularly, 63.2% of them exercised about one hour, 26.3% of them exercised about 30 minutes. 39.1% didn't exercise regularly for Pressure of work from working place.29% of the respondents didn't exercise regularly for sickness and 17.4% of them didn't exercise regularly for their habit. 79.6% were suffered from tension and 17.6% were not suffer from tension. 26.4% of them suffered from tension for house rent, 24.2% of them suffered from tension about high rate of products, 19.8% of them suffered from tension of their loan and 18.7% of them suffered from tension for their child. 66.67% had diseases, 27.93% of them had no diseases. 51.9% of them had diabetes, 18.5% of them had body pain, and 16% of the respondents had heart diseases. 98.2% of them took treatment for their diseases while 1.8% of them didn't take treatment. 61.26% took treatment from non-government hospitals, 23.42% of them took treatment from private chamber while 10.81% of them took treatment from government hospitals. 62.2% liked Allopathic medicine, 18.9% of them liked Homeopathic medicine 6.3% liked Ayurvedic medicine.43.1% liked capsule as medicine, 25.7% liked tablet as medicine and 16.5% of them liked syrup as medicine.

53.2% of the respondents were looked after by their husband/wife, 30.6% of them were looked after by their husband/wife and son/daughter and 15.3% of them were looked after by their son/daughter. 24.32% liked to take news and watch it in their relax time, 21.62% of them liked to watch Television in their relax time, 18.02% of them liked to gossip in their relax time, 13.51% of them liked to sleep in their relax time.

Meeting with community activists and giving taster workshops and talks to small groups was the key to successful recruitment, but in engaging older people who were already linked to groups of various kinds it did not necessarily reach isolated older people. Further work is indicated to explore how older people disconnected from community life can be successfully reached and involved. However, it should also be noted that the analysis of pre-programme interview data suggests that those in transition have a wide range of coping abilities, extending from those with early signs of diminishing confidence and capacities to those who are dependent upon others for certain activities of daily living. That the intervention was able to meet the needs of older people aged from 47 to 99 years was also unexpected. It appeared to have relevance and be beneficial for that in early retirement as well as for individuals who were very old, which was also evidenced by the continuance and growth of both groups. This example of the development of community capital [7-8] is striking. Nevertheless, the population of older people who volunteered for Lifestyle Matters was homogeneous in that only one person of mixed race participated; the rest were white British. Further work is required to explore the adaptability of the Lifestyle Matters programme to different populations of older people. The qualitative findings revealed that the qualified staff and those without an occupational therapy qualification were equally competent as facilitators. However, qualified staff involvement resulted in timely responses to problems resulting from ill health and disability; for example, arranging for assistive technologies to be made fit for purpose and suggesting ways of adapting activities. All facilitators took time to adjust to working in the absence of a service infrastructure, where case records can be accessed to obtain information. Another challenging aspect for all facilitators was allowing individual older people to take personal decisions about their level of risk taking. The older people particularly valued the opportunity to learn from each other, the time to engage in thoughtful discussion and the opportunities to put ideas into practice. This meant that the facilitators had to step back and relinquish the role of expert to the older people themselves. Thus the established professional

role was challenged. At the end of the project, all facilitators reported obtaining personal benefit from their involvement. The obtained results suggest that staff other than occupational therapists were able to deliver the programme, provided that they are adequately supported by occupational therapists. The intervention may therefore be appropriate for use by other community staff, such as health trainers and community matrons, but this assumption warrants further testing [7-8]. The findings also raised questions about the sensitivity and relevance of some current services for older people, and the need to recognize the potentially limiting as well as the helpful and supportive nature of some family relationships. The post-programme interviews revealed the much individualized benefits received by the participants. The greater self-efficacy that they experienced was a significant theme. It has been previously observed that self-confidence, which arises from the interaction of personal, behavioral and environmental factors, can result in positive health outcomes.

Therefore, self-efficacy could be an outcome measure in a future trial. The improvements to wellbeing that all participants reported were in the main related to improved engagement and mental wellbeing, and not directly to physical health. In order to engage in a more fulfilling lifestyle, many participants did, by default, become more physically active, a fact that was not acknowledged during the interviews. The range of activities pursued by the participants and the varied benefits that they described illustrate the flexibility of the programmed and its appropriateness for active older people, as well as for those who are more frail and dependent. The extent to which the older people took forward the activities pursued during Lifestyle Matters into their lives is a further positive outcome. The prime reason for this study was to explore the feasibility of implementing a programmed inspired by Lifestyle Redesign in a UK setting. The extent of uncertainty regarding the success of this intention (for example, the extent of anticipated attrition from the programmed) did not lend itself to a research design where numbers of participants are identified to power a future study of clinical and cost effectiveness. Furthermore, the extent of project funding limited the remit of the project to two groups. So even though the phase 1 (modelling) of the Medical Research Council (2000) complex interventions framework was adhered to, phase 2 requirements could not be fulfilled through this small study. Therefore, the results obtained from analysis of the pre-intervention and post-intervention measurement have to be viewed with caution, and the numbers required to power a future trial will be identified through the results obtained by Clark *et al*. [9] from application of the SF36. However, in common with the findings of previous studies [10-11] the problems of applying existing quality of life scales to an older population were apparent, emphasising the urgent need to develop more appropriate measures.

Conclusions

As a result of its findings, this inquiry recommends the introduction of healthy ageing programmers by local authorities in partnership with other agencies. The results of the feasibility study of Lifestyle matters confirm the tangible benefits that older people can obtain from a health-promoting, occupation-based intervention delivered over time. It also illustrates the complexity that underpins successful provision. Health-promoting services, where older people can choose to be involved, need to be embedded into communities and even then questions remain regarding how to reach the most isolated. To date, there are few tools available to assist service providers to develop health-promoting services for older people and little available research to underpin service innovation. Life style matters were demonstrably able to fulfill the service gap, but there is a need for further research to test the programme rigorously and to explore applicability in a range of settings. This includes how to measure accurately the range of outcomes that the older people described. Finally, it is becoming apparent that this programme may well have significant implications for the UK occupational therapy profession, particularly when guidelines on health promotion for older people are published by the National Institute of Health and Clinical Excellence in October 2008. This study was recommended to older people wanted the health and aged care system to treat them with respect and dignity and better understand their various needs as individuals.

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