

IDENTIFYING THE RISK FACTORS BEHIND NUTRITIONAL AND HEALTH ISSUES OF OLD PEOPLE IN RURAL BLOCKS OF DISTRICT SAHARANPUR(UP)

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Abstract

Background-In India the population of older people of low income group takes inappropriate dietary intake and unhealthy life style.

Objective-The purpose of the study was to determine the risk factors that influence nutritional and health issues among low income old age people in rural areas of district Saharanpur. Specifically the study sought to identify factors determining nutrition among low income rural old people with regard to socioeconomic, demographic and personal characteristics.

Materials and methods-This cross sectional study was done from February 2019 to December 2019 in the 24 villages of Saharanpur (12 villages of Nanauta block and 12 villages of Gangoh block), Uttar Pradesh India. The old people those over 60 years and above age in male and 58 years and above age in female who meet the inclusion criteria participated in this study. A total no of 240 old people were selected for this study, in this structured questionnaire has been used. This is filled by personal interview.24 hour food recall method and diet history was used for dietary assessment; Analysis of data was performed using Microsoft Office Excel 2007. Analysis for qualitative variables was done using Chi-Square test.

Result- Among the study majority of participants old people 54.5% were malnourished,83.3% respondents consumes deficient intake (P value <0.05),this shows need of nutritional improvement in elderly,70.4% respondents were illiterate(P value =0.000001(<0.05)), 57.5% were dependent financial status ($\chi^2=268.8$, P value <0.05) and 32% respondents were adopt unhealthy life style ($\chi^2= 42.9$, P value 0.0001(<0.05)).42.5% respondents had poor hygiene knowledge($\chi^2=5.8$, P value 0.05).The main predictors that positively influenced nutritional and health issues among low income rural elderly respondents was age, gender, education, food intake, economic condition, life style. These coefficients were significant at p-value=<0.05 percent significance level.

Keywords: Nutritional status, socioeconomic, demographic, personal characteristics.

Introduction-As the number and percentage of older people in India continue to increase little is As per 2011 census, 69.23 % population of Saharanpur districts lives in rural areas of villages. The total Saharanpur district population living in rural areas was 2,399,856 of which males and females were 1,269,803 and 1,130,053 respectively. According to the report, India, where 116.6 million people over 60 are living, ranked a low 71 on the list of 96 countries when it comes to social and economic wellbeing of older people. In 2030, those over 60 will make up 12.5 per cent of the country's population while the number is expected to rise to 19.4 per cent by 2050. The report also found that a combination of a lifetime of gender discrimination, combined with inequality in old age, can have a devastating effect on older women. Globally 46.8 per cent of women aged 55 to 64 were economically active, compared with 73.5 per cent of men. In addition, women usually earn less than men, so opportunities to save for

later life was limited and this increasing their risk of poverty in old age(1). 71% of elderly population resides in rural areas in this 66% of elderly men and 28% of elderly women were working (2). Nutrition is one of the major determinants of successful ageing; food was not only critical to physiological well being but also contributes to social, cultural and psychological quality of life. Understanding the range of factors that contribute to nutrition risk in older people can identify ways to prevent nutritional problems before it occur. A decline in food intake may compromise dietary variety which is positively associated with nutritional quality and positive health outcomes (3). Nutrition risk screening was a process to identify factors related to nutritional status that could lead to malnutrition. Its purpose was to identify individuals who were malnourished or at nutrition risk so the questions of Nutrition risk screening were added in the questionnaire which was used in this study.

S.Saha et.al(2014) explain in his study that there were different causes of nutritional risks like physiological causes including diseases, intake of excess medicines, disabilities like walking, hearing. optical, economical causes like reduction of income, higher expenses for medicine, low purchasing capacity, social causes like isolation, getting less importance and attention from family members, religious causes including avoidance of foods at particular days and objection to some foods, psychological causes including depression, loneliness and insecurity(4).

C. Pemberton (2009) study concludes that age, sex, and level of aspiration were the only useful predictors that determined nutritional status among low-income rural elderly in Trinidad(5). Vitolins et.al.(2007), reported that a vast majority of low socio-economic status, older, southern rural adults were not meeting recommended nutrition guidelines; they had low Healthy Eating Index scores and 98.4% of the participants consumed diets that were poor or needed improvement(6). H.Eino (2003) reported that the old age has identified non-modifiable risk factors such as age, gender and genetics, and modifiable risk factors such as age-related diseases, impairments, functional limitations, poor coping strategies, sedentary lifestyles and other unhealthy behaviours, as well as social and environmental obstacles. Many of these stem from earlier phases of life and the prevalent socioeconomic conditions (7).M.J.Prince et.al.(1997) concludes in his research that Problems of collinearity, and the cross-sectional design of the study limited interpretation of the exact nature of the relationship between social support, loneliness, handicap and depression. However, the clustering of these four factors can be used to define a large part of the elderly population with a poor quality of life. An important avenue for future research will be the development and implementation of population intervention strategies designed to address some or all of these problems among older people in general (8). Ryan et al. (1992) nationwide household survey to determine nutrient intakes of free living elderly people (65 and older) reported that a substantial percentage of persons surveyed had inadequate intakes of energy and nutrients (9).Therefore, the problem of this study was to identify the risk factors that influence the nutritional and health status in old age population of Nanauta and Gangoh block of district Saharanpur. The purpose of this article is to determine if personal, demographic and socioeconomic factors affect nutritional and health issues among low income old age population in various blocks of district Saharanpur.

Materials and methods-This cross sectional study was under taken in 24 villages of Nanauta and Gangoh block, Saharanpur district, Uttar Pradesh, India .This study was conducted from February 2019 to December 2019.

Study population-A total of 240 older people above 60 years age of male and above 58 years age of female living in the villages under the block were included in this study. Those who were seriously ill, feed by tube and living alone and in nuclear family excluded from the study. The population examined in this study consists of low income old people both educated, illiterate.

Tools for data collection –the survey tool was developed questionnaire named “A NUTRITION RELATED HEALTH ASSESSMENT PERFORMA”, which were filled by face to face interview. The questionnaire was designed to obtain information on the key components related to the study, and the themes were therefore organized into three steps as follows: The personnel, socioeconomic and demographic characteristics of the respondents; 24 hour recall method and dietary history for assessing calorie intake, anthropometric measurements for BMI calculation.

Dietary History and Anthropometric Measurements-Dietary intake was assessed by a one-day 24-Hour Food Recall and a dietary history. These methods were used to assess the calorie intake of the older people. The calorie requirement was calculated by using recommended dietary allowances (RDA) 2010, guidelines as per the weight of the elderly. The interviewer asked each participant to give a detailed description of all food and beverages consumed including a description of cooking methods, brand names of products used, the amount/quantity and the time the meals were consumed. The respondents were asked to list all the food items consumed over a twenty-four hour period or about foods

and beverages usually consumed at each meal. The amount/quantity of different foods and drinks were expressed in terms of either cups, glasses, tins/cans, empty bottles, bundles, pot spoon, heaps or numbers based on the local measuring utensils identified. Weights and volumes were determined with use of a variety of foods and beverages. Information on the respondents’ dietary habits and eating patterns was collected. The Healthy Eating Index was used to assess overall diet quality of the low income elderly.

The physical measurement of the respondents’ included the weight, standing height were measured and their body mass index calculated. The body mass index (BMI) was calculated by the ratio: weight(kg), height (m²).

The Body Mass Index is a simple index of weight-for-height that is commonly used to classify underweight, overweight and obesity in adults. It is calculated as the weight in kilograms divided by the square of the height in meters (kg/ m²). The BMI is a measure of an individual body weight or fat in relation to their height, and an indicator of an individual risk for undernutrition and over nutrition.

$$\text{BMI} = \frac{\text{body weight in kilograms}}{(\text{Height in meters})^2}$$

Information of low income of participants was taken from every panchayat secretary of villages of block Nanauta and Gangoh.

Statistical analysis: Analysis of data was performed using Microsoft Office Excel 2007. Analysis for qualitative variables was done using Chi-Square test.

Results-[Table-2] Summarize the Sociodemographic characteristics of the older people as determined by the questionnaire tool. The study sample included 120 male and 120 female .Mean age was 66(ranging from 58 to 90).More male and female respondents were found in the age group 58-68.the majority of the respondents 65.4% were married ,15% were widower and 20% widow,0.8% only unmarried male and 0.4% female were found,(Table-1)The majority of respondents(70.4%)were found illiterate.(Table-2)The association between old age nutritional and health risk factors and age, marital status, education and family support was found to be significant. Household net income was found between 1 Lakh to 3 Lakh.

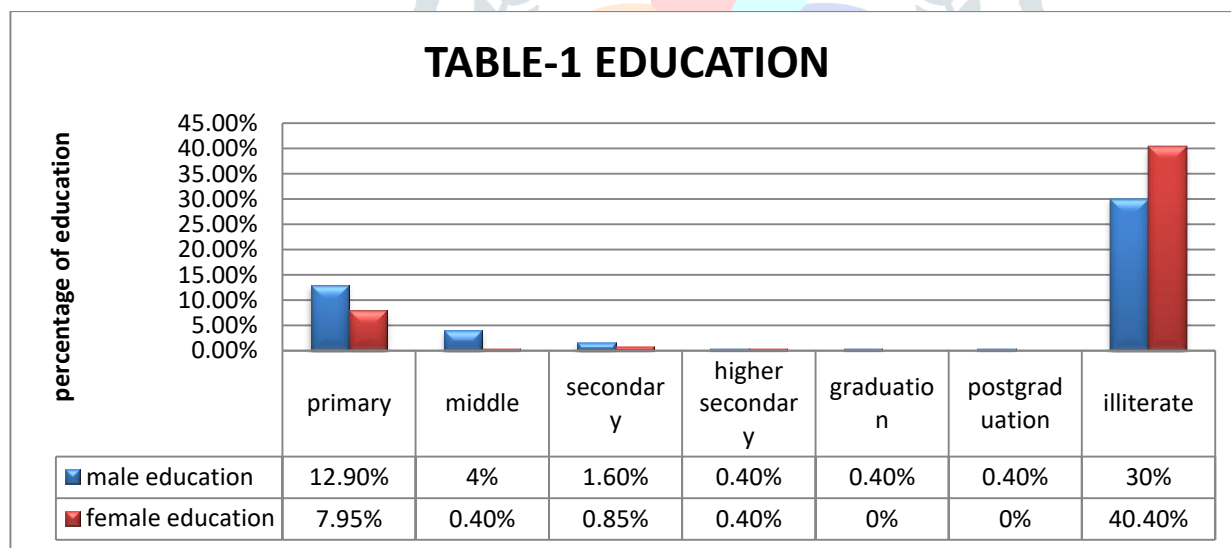


Table -2 Sociodemographic characteristics by nutritional and health risk factors

	male	female	total	X ²	P value
Age(years) N=240					
58-68	69(44.2%)	87(55.7%)	156(100%)	X ² =28.	<0.05
69-79	40(57%)	30(42.8%)	70(100%)	39	P=0.000001
80<	11(78.5%)	03(21.4%)	14(100%)		
Marital status					
Currently Married	82(50.6%)	71(46.4%)	153(100%)	X ² =5.7	P=<0.05
Unmarried	02(66%)	01(33%)	03(100%)		
Widow/widower	36(48%)	48(57%)	84(100%)		
Divorced	0	0			

Separated/deserted	0	0			
Education					
Illiterate	72(42.6%)	97(57.3%)	169(100%)	X ² =101	<0.05
Primary	31(62%)	19(38%)	50(100%)		P=0.000001
Middle	10(90%)	01(9%)	11(100%)		
Secondary	04(66%)	02(33%)	06(100%)		
Higher secondary	01(50%)	01(50%)	02(100%)		
Graduate	01(100%)	0	01(100%)		
Postgraduate/professional	01(100%)	0	01(100%)		
Household net income	1 Lakh to 3 Lakh	1 Lakh to 3 Lakh			
Family support					
• Household related activities	40(33%)	80(66%)	120(100%)	X ² =273	<0.05
• Occupational related activities	60(85%)	10(14%)	70(100%)	.3	P=0.000001
• Leisure activities	20(40%)	30(60%)	50(100%)		

Table-1 Shows that age, marital status, education, family support was found statistically significant at <0.05

Table 3 Summarizes that 0.8% male were found currently in paid employment and no female were found in this category, 49.5% male and 50% females were found not in paid employment. The association between old age nutritional and health risk factors and employment, financial status, smoking, alcohol was found to be significant. The malnutrition universal screening tool (MUST) questions were included in the questionnaire to find out risk of malnutrition in old age. Most respondents 54.5% was found malnourished in this 26% male and 28% female had low BMI range (<18), 30.8% was found at risk in this 17.5% male and 13.3% female had average range of BMI (18-20), 12.9% was found healthy (BMI 21-24.5) and 1.6% was found obese (BMI 25 above). There no significant association was found between nutritional and health risk factors in old age and type of house, last main occupation and current economic activity. The association was found to be significant between nutritional and health risk factors in old age and Eating habits, Health status, Hygiene, Psychological distress, Perceptions about life style, Use of health services, calories intake. In calories intake score indicates a need of diet improvement. (Table-4) Total no study population (N=240) only 9% old age people consume adequate diet intake in this 0.8% male and 0.8% female was found and in total of 83.3% respondents consumes deficient intake in this 36% male and 47% female was found who was mostly at risk and malnourished, this indicates old age population needs intervention in their diet for their health improvement. Researcher found reduced appetite due to illness, psychosocial stress, tooth loss, gum disease and difficulties in chewing and swallowing had serious nutritional consequences as less, or more limited selections of food was taken. This may lead to an inadequate energy and micronutrient intake at a time when the body needs it most.

Table -3 Socioeconomic characteristics by nutritional and health risk factors

	Male	Female	Total	X ²	P value
Employment					
Currently in paid employment	02(100%)	00	02(100%)		
Not in paid employment	118(49.5%)	120(50.4%)	238(100%)	116.0	<0.05
Financial status					
Independent	100(79%)	26(20%)	126(100%)	268.8	<0.05
Dependent	20(17.5%)	94(82%)	114(100%)		
Smoking					
Current	40(58.8%)	28(41%)	68(100%)	17.9	<0.05
Former	16(66.6%)	08(33%)	24(100%)		P=0.0001
never	64(43%)	84(56.7%)	148(100%)		2
Alcohol					
Occasionally	33(89%)	04(10%)	37(100%)	217	<0.05
never	87(42%)	116(57%)	203(100%)		P=0.0000 1
BMI					
Malnourished	63(48%)	68(51%)	131(100%)		<0.05

At Risk	42(56.7%)	32(43%)	74(100%)	X ² =4.7 P=0.03
Healthy	13(41.9%)	18(58%)	31(100%)	
Obesity	02(50%)	02(50%)	04(100%)	
Type of house				1.27 P=0.52
Kaccha	05(38%)	08(61%)	13(100%)	
Semi pucca pucca	30(51.7%) 85(50.2%)	28(48%) 84(49.7%)	58(100%) 169(100%)	
Last main occupation				7.8 P=0.33
Unskilled worker (Agricultural laborer, Farming, homemaker, barber, temple worker)	112(63%)	65(36.7%)	177(100%)	
Skilled worker	02(100%)	00	02(100%)	
Shopkeeper	04(100%)	00	04(100%)	
Petty trader	00	00	00(100%)	
Home maker	02(3.5%)	55(96%)	57(100%)	
other				
Current Economic activity				P=0.89
Unskilled worker (Agricultural laborer, Farming, homemaker, barber, temple worker)	110(75%)	36(24%)	146(100%)	
Skilled worker	02(100%)	00	02(100%)	
Shopkeeper	04(100%)	00	04(100%)	
Petty trader	00	00	00(100%)	
Home maker other	04(4.5%)	84(95%)	88(100%)	
Eating habits				5.9 P=0.05
Healthy eating habits	20(60%)	13(39%)	33(100%)	
Unhealthy eating habits Bad eating habits	60(45.8%) 40(52.6%)	71(54%) 36(47%)	131(100%) 76(100%)	
Health status				6.3 P=0.04
Good health status	14(43.7%)	18(56%)	32(100%)	
Fair health status Poor health status	44(57.8%) 62(46.9%)	32(42%) 70(53%)	76(100%) 132(100%)	
Hygiene				5.8 P=0.05
Proper hygiene	23(56%)	18(43.9%)	41(100%)	
Fair hygiene Poor knowledge	42(43%) 55(53.9%)	55(56.7%) 47(46%)	97(100%) 102(100%)	
Psychological distress				7.0 P=0.03
No psychological distress	12(57%)	10(47.6%)	21(100%)	
Have psychological distress Severe psychological distress	78(46.7%) 30(57.6%)	90(53.8%) 20(38.4%)	167(100%) 52(100%)	
Perceptions about life style				42.9 P=0.0001
Good life style	10(55.5%)	08(44.4%)	18(100%)	
Fair life style Unhealthy life style	78(53.7%) 32(41.5%)	45(31.03%) 67(87%)	145(100%) 77(100%)	
Use of health services				4.17 P=0.04
Proper use	43(55%)	33(42%)	78(100%)	
No use	77(47.5%)	87(53.7%)	162(100%)	

Table-3 shows that employment, financial status, smoking, alcohol BMI, habits, Health status, Hygiene, Psychological distress, Perceptions about life style, Use of health services, calories intake was found statistically significant at <0.05

	Adequate intake no (%)		P-Value	Deficient intake no (%)		Total	P-Value
	male	Female		Male	Female		
Normal	12(38.7%)	14(45%)	P=0.03 <0.05	02(6%)	03(9.6%)	31	P=0.05 <0.05
At risk	08(10.8%)	06(8%)		28(37.8%)	32(43%)	74	
Malnourished	-	-		56(42.7%)	75(57.2%)	131	
Over weight	02(50%)	02(50%)		-	-	04	
Total	22(9%)	22(9%)		87(36%)	113(46%)	240	

Table 5 summarizes that 1.6% male and 0.8% female had less mobility they was bound with bed or chair and dependent on others for their daily activities, 0.4% male and 3.3% female was able get out of bed and chair but they can't go out because of less mobility, 47.9% male and 45.8% female goes out and they have better mobility for their living. The association was found to be significant between nutritional and health risk factors in old age and mobility, drugs consumption, mode of feeding, activities of daily living, sensory loss, oral health, physical exercise. Personally various diseases affects old age people and in this mostly found with abnormal blood pressure, the association was found to be significant at <0.05 between nutritional and health risk factors in old age and blood pressure, blood cholesterol and heart disease, arthritis, respiratory disease, diabetes, influenza and pneumonia.

Table 5 -Personal risk factors affects nutritional and health status

Mobility	Male	Female	Total	X ²	P value
<ul style="list-style-type: none"> • Bed or chair bound • Able to get out of bed/chair but not go out • Goes out 	04(66%)	02(33%)	06(100%)	8.3	P=0.01 <0.05
	01(11%)	08(88%)	09(100%)		
	115(51%)	110(48.8%)	225(100%)		
Drugs per day(takes more than 3 prescription drugs)					
Yes	90(45%)	108(54.5%)	198(100%)	30.0	P=0.0001 <0.05
no	30(71%)	12(28.5%)	42(100%)		
Mode of feeding					
Unable to eat without assistance	04(66%)	02(33%)	06(100%)	16.5	P=0.0002 <0.05
Self feed with some difficulty	51(60.7%)	33(39.2%)	84(100%)		
Self feed without any problem	65(43.3%)	85(56.6%)	150(100%)		
Activities of daily living					
Independent in daily living	38(56.7%)	29(43%)	67(100%)	6.15	P=0.04 <0.05
Partially Independent in daily living	78(46.7%)	89(53%)	167(100%)		
Completely dependent in daily living	04(66%)	02(33%)	06(100%)		
Sensory loss					
No Sensory loss	23(34.3%)	44(65.6%)	67(100%)	16.15	P=0.0003 <0.05
Sensory loss Problem	88(55.6%)	70(44%)	158(100%)		
Severe Sensory loss problem	09(60%)	06(40%)	15(100%)		
Oral health					
No Oral health Problem	05(62.5%)	03(37.5%)	08(100%)	6.87	P=0.03 <0.05
Oral health Problem	93(90%)	103(52.5%)	196(100%)		
Severe Oral health Problem	22(61%)	14(39%)	36(100%)		
Physical exercise					

Good Physical exercise	105(64%)	59(35.9%)	164(100%)	76.9	P=0.00001
Less Physical exercise	11(15.7%)	59(84.2%)	70(100%)		<0.05
No Physical exercise	04(66%)	02(33%)	06(100%)		
Blood pressure					
Normal BP	27(69.2%)	12(30.7%)	39(100%)	20.8	P=0.000005
Abnormal BP	93(46.2%)	108(53.7%)	201(100%)		<0.05
Blood cholesterol					
Normal Blood cholesterol and heart disease	117(51.3%)	111(48.6%)	228(100%)	4.32	P=0.03
Abnormal Blood cholesterol and heart disease	03(25%)	09(75%)	12(100%)		<0.05
Arthritis					
Not affected	10(71.4%)	04(28.5%)	14(100%)	9.31	P=0.002
Effected	110(48.6%)	116(51.3%)	226(100%)		<0.05
Respiratory disease					
Effected	39(60.9%)	25(39%)	64(100%)	3.60	P=0.05
Not effected	81(46%)	95(53.9%)	176(100%)		<0.05
Diabetes					
Effected	16(37.2%)	27(62.7%)	43(100%)	5.78	P=0.01
Not effected	104(52.7%)	93(47%)	197(100%)		<0.05
Influenza and pneumonia					
Effected	03(20%)	12(80%)	15(100%)		P=0.006
Not effected	117(52%)	108(48%)	225(100%)	7.5	<0.05

Table-3 Shows that mobility, drugs consumption, mode of feeding, activities of daily living, sensory loss, oral health, physical exercise, blood pressure, blood cholesterol and heart disease, arthritis, respiratory disease, diabetes, influenza and pneumonia was found to be statistically significant at <0.05

DISCUSSION-The elderly population will grow dramatically during the 21st century. Although overall economic and educational and functional, physical activities with multiple risks for poorer nutritional and health status. This study reveals that there was many risk factors associated with poorer nutritional and health status among older people. In this study a total of 240 old people of age 58 and above females and 60 and above males were studied. Age group 58-68 years constituted the majority of study subjects (65%), followed by 69-79 years (29.1%) and 80 years and above (5.8%). Similar findings was confirmed by other observers in their studies (10). In the present study gender distribution was equal 50% male and 50% female in this marital status of old people shows that 65.4% were married and 35% were widowed, 1.25% were unmarried. This finding was comparable to that of a report published by United Nation Population Fund (UNFPA), where about 60% of the elderly were currently married and 38% widowed. Mohapatra SC et al, Mishra CP et al confirmed the same (11,12).

It was found that education level was very low in low income old age people of rural areas of Saharanpur. In this study 70.4% participants was found illiterate in this 42.8% male and 57% female, 20.8% primary level educated, 6.65 secondary level educated, 1.6% higher secondary level educated near similar findings was found in the study by Sowmiya et al (13). The family support in old age was found in various activities like Household related activities 50% old people need support in this 33% male 66% female was found, in occupational related activities 29.1% old people need support in this 85% male and 14% female was found, in leisure activities 20.8% old people need support in this 40% male 60% female was found, Soldo and Agree, 1988 reported that the family provides the individual the emotional, social, and economic support in old age (14). In this study 0.8% male out of 240 elderly was found currently in paid employment but no female was found in this category. 49.5% male and 50% females were found not in paid employment. As per the 2001 census, labour force participation of older persons is 40.3 per cent: 60.2 per cent for men and 20.9 per cent for women in rural areas of India (15). In this study mostly participants 54.5% was found malnourished, 30.8% found at risk and 12.9% was found healthy, 1.6% was found obese. The magnitude of malnutrition among the elderly in India is under-reported. The few studies that have been done showed that more than 50% of the older population is under weight (16). In this study participated elderly population 5.4% lives in Kutcha house in this 38% male and 61% female was found, 24% lives in semi pucca house in this 51.7% male and 48% female was found and majority 70.4% lives in pucca house in this 50.2% male and 49.8% female was found. Nimmathota Arlappa et al. (2016) reported that the Most of the elderly were living in semi-pucca houses (65%) followed by Kutcha houses (mud walls with thatched roof) (19%) (17). In this study

participated elderly population last main occupation and in current economic activity Major occupation of the household was labourer. Elderly last main occupation 73.7% was unskilled worker, 0.8% was skilled worker, 1.6% was shopkeeper and 23.75% was home maker. Current economic activity of elderly population 60.81% was unskilled worker, 0.83% skilled worker, 1.61% shopkeeper, 36.6% was home maker, Harasankar Adhikari (2016) reported in his study that occupationally, they were mainly agriculture labour, daily wages labour and rural artisans. The result showed that they had no any relaxation in their rest life and they had to manage their own needs. (18). In this study 54.5% unhealthy eating habits, 31.6% bad eating habits, 31.6% fair health status, 55% poor health status, S. Jung et al. reported the same in his study (19). In this study elderly 40.4% fair hygiene, 42.5% poor knowledge of hygiene 69.5% was found and similar findings was found in the study by Abdul Bashet (2019). In this study on the physiological problems of elderly found that 52.5% have psychological distress 21.6% severe psychological distress similar findings was found in the study by Verna M. Keith (1993). In this study 60.4% Fair life style, 32% Unhealthy life styles similar findings was found in the study by Yan-Ru Cheng (2015)

In this study calories intake from total no study population (N=240) only 9% old age people consume adequate diet intake and 83.3% respondents consumes deficient intake was found who was mostly at risk and malnourished but Teresa A. et al. (26 May 2001) finding was Less than 20% of subjects (n 5 41) consumed adequate levels 34% of subjects (n 5 76) still had inadequate intakes in this researcher was found inadequate intakes more than Teresa A. research paper. Researcher found reduced appetite due to illness, psychosocial stress, tooth loss, gum disease and difficulties chewing and swallowing had serious nutritional consequences as less, or more limited selections of food was taken. This may lead to an inadequate energy and micronutrient intake at a time when the body needs it most. In this study 1.6% male and 0.8% female had less mobility they was bound with bed or chair and dependent on others for their daily activities, 0.4% male and 3.3% female was able get out of bed and chair but they can't go out because of less mobility, 47.9% male and 45.8% female goes out and they have better mobility for their living and similar findings was found in the study by John Pucher, in his study Mobility levels in rural areas are generally higher than in urban areas (24). In this study 198 (82.5%) elderly consumes drugs 2 or 3 times per day in this 90 (45%) male and 108 (34.5%) female was found, 42 (17.5%) elderly have less consumption of drugs in this 30 (71%) male and 12 (28.5%) female was found, this shows that in elderly drugs consumption was very high, in the study of Birpal Kaur Regarding consumption of prescribed drugs 188 (47.2%) was consuming more than three prescribed drugs per day. (25). In this study 27% elderly was found Independent in daily living, 69% Partially Independent in daily living, 2.5% was Completely dependent in daily living, Le V Hoi (2011) also found in his study that The majority of older people do not need of support for each specific ADL item (26). In this study majority have sensory loss problem and oral health problem Corrado Carabellese MD (1996) also reported the same in his study, in this study high physical exercise was found in elderly of low income group rural areas and PA. A Swiss (2013) study showed that elderly were more likely to be physically active (27). Personally various diseases affects old age people and in this mostly found with abnormal blood pressure 83.7% in this 93 (46.2%) male and 108 (53.7%) female was affected, there only 16.25% old people found with normal blood pressure. Arthritis which decrease the freedom of old people with severe pain 94.16% people 110 (48.6%) male and 116 (51.3%) female was found affected with this disease and only 5.8% people was not affected with arthritis. Only 5% old people 3 (25%) male and 9 (75%) female was found Abnormal Blood cholesterol and heart disease. 64 (26.8%) old people 39 (60.9%) male and 25 (39%) female was found affected with respiratory diseases like asthma, tuberculosis, infection in lungs and respiratory tract shortness of breath and 176 (73%) old people was not affected with this disease. 43 (17.9%) old people 16 (37.2%) male 27 (62.7%) was affected with diabetes and 82% was found not affected, 15 (6.25%) old people 3 (20%) male and 12 (80%) female was found affected with Influenza and pneumonia and 93.7% people was found unaffected from this disease. In the study of Anil Jacob (2005) found near about 27 (9%) heart illnesses and in respiratory 22 (7.3%) was very less found diabetes in 26 (8.3%). Hypertension was found in 83 (25.9%) (30).

CONCLUSION- Result shows that older people face many problems related to the food requirements, poor life style, psychological distress, employment wise financially dependent, affected with various disease like arthritis, sensory and oral health problems, low and high blood pressure and Considering the high prevalence of poor nutritional and health status, deficient food intake and unhealthy eating habits. So more focus shown on diet and possible nutritional interventions are required for reducing the severe malnutrition rate among elderly. Lower income group should receive particular attention to meet their special needs. So it can be concluded that age, gender, education, food intake, economic condition, life style was the main risk factors affect the nutritional and health status among old people.

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