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The Frailty Syndrome and Lifestyle Practices among Elderly Muslims

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Original Article

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Keywords

Frailty Syndrome, Lifestyle Practices, Old Age, Muslim

Abstract

This cross-sectional study examines lifestyle factors and a positive attitude towards aging as predictors of general wellness and life satisfaction in older adults. The sample comprised 203 randomly selected elderly Muslims, aged 60 to 85 years, from six urban and rural areas of Khyber Pakhtunkhwa. Data was collected using self-constructed questionnaires designed to assess the prevalence of frailty and other health-related conditions. The Subjective Psychological Wellbeing Scale (Diener & Biswas-Diener, 2008) was supplemented with additional scales to evaluate satisfaction with current life circumstances. The findings revealed that the mean age of the respondents was 68.28 years (SD = 5.48). Chronic frailty was prevalent among the elderly population, with cognitive decline being more pronounced than physical decline. Women were more affected by this condition than men. Chronic frailty and poor nutritional status emerged as significant concerns. Nutritional status in older adults was found to be compromised due to several factors, including reduced appetite, dysphagia, limited access to healthy foods, and chronic health conditions. A sharp decline in physiological functions, such as blood pressure and renal issues, was reported by the majority of respondents, along with complaints of general exhaustion and weakness. The results also revealed that participation in religious activities increases with age. Most respondents cited religion as a source of strength, helping them cope with life's challenges and the unpleasant experiences associated with aging. The study concludes that religious life style and a positive attitude towards aging can decrease frailty and improve general wellbeing and life satisfaction among older adults. It is recommended that Comprehensive care plans should integrate religious resources to address psychological well-being. Community-based frailty prevention programs must be introduced to address the unique needs of elderly women, focusing on nutritional support, mental health, and social inclusion.

Introduction

Frailty is highly prevalent condition worldwide among elderly people (Smith et al., 2019). The study aims to understand the process of frailty for health promotion practices among elderly population and identify factors associated with adopting healthy lifestyle practices, as the elderly population is predicted to grow exponentially, reducing disabilities and healthcare costs. Research on elderly population with reference to frailty syndrome and lifestyle practices in Pakistan is limited (Ahmad & Khan, 2020). It is a significant public health concern, affecting 6% of the population who are above 60 years of age (World Health Organization, 2021). Unfortunately, the state policies primarily target young population, leaving elder uninvolved. According to a survey conducted in 2010, 74% of elderly lack financial means to afford healthcare, shelter, food and clean water (National Statistics Bureau, 2010). Frailly along with poor quality of life is making the process of aging more difficult (Johnson & Lee, 2018). Further, the evolving family dynamics and lack of social support further exacerbate this issue (Rahman et al., 2021). Community, state and researchers need to prioritize the needed of this neglected population so that to ensure their healthy aging and overall wellbeing.

The term “frail older adult” was first introduced by Lewis in 1978 for those elderly people who had chronic health problems and had difficulty maintaining independence (Lewis, 1978). Pawlson (1982) and Macdam (1985) considered frail older adults to be the population with chronic diseases, but there is no distinction between the concept of frailty and those of disease or disability. In the mid-1990s, a mechanism was devised by Smith et al., (1995) to measure frailty. This breakthrough in frailty measurement led to a broader, biopsychosocial vision, recognizing frailty as multidimensional and age-related. Fried (2001) defined frailty as a multidimensional geriatric syndrome characterized by decreased energy reserves, physical abilities, cognition, and adaptive abilities, leading to vulnerability.

Factors leading to frailty include socio-demographic factors, physical factors, psychological factors, acute events, or chronic diseases (Jones et al., 2010). The typical frailty symptoms include: unintentional weight loss, self-reported exhaustion, weakness, slow walking speed, and low physical activity (Fried et al., 1999). Physical factors such as lower hemoglobin (Leng et al., 2002, 2004) increased monocytes and microphages (Leng et al., 2011; Ramanathan et al., 2013) inflammation, hormonal imbalance (Puts et al., 2005; Shardell et al., 2009; Maggio et al., 2012, 2014) are core determinants and components of frailty. Among the common physical condition elderly develop is the Sarcopenia-a skeletal muscle disorder characterized by low muscle mass and quality (Cruz-Jentoft et al., 2019). Genetic endowment and lifestyle typically contribute this disorder (Smith et al., 2018). The most important causes are inactivity, eating habits, diseases, and medications (Brown et al., 2020). Muscle aging is another related condition caused by excessive adipose tissue in the body (Johnson et al., 2016).

Cognitive frailty is another emerging concept and condition of reduced neuropsychological reserve coexists with physical frailty (Yaffe et al., 2013). Cognitive impairment is more frequently detected in physically frail patients, with adverse clinical outcomes linked to physical (functional independence, hospitalization, and risk of death) and cognitive components of frailty, particularly Alzheimer’s disease (Livingston et al., 2020). Stress, depression, low activity levels, lower dietary protein, and micronutrient intake can accelerate the process of frailty (Fried et al., 1999). Other contributing causes of frailty include social isolation, alcohol abuse, smoking, chronic diseases, and polypharmacy (Strawbridge et al., 1998). A special contribution to physical frailty comes from sarcopenia and the decay of muscle quantity and quality, which can be considered its biological substrate (Rosenberg, 1997).

Studies affirm that frailty predisposes elderly people to number of adverse medical and psychological conditions (Clegg et al., 2013; Fried et al., 2001). Many theorists believe that health and disease are

mutually exclusive, with some defining health as a state of complete physical, mental, and social well-being, while others allow for an organism to be healthy and have a disease at the same time (World Health Organization, 1948). Boorse (1977) argues that an organism is healthy if it does not have any disease. The World Health Organization urges that health must emphasize the importance of encompassing healthy activities more than just the absence of disease (WHO, 1948). Nordenfelt (2018) also supports the similar view, added that "health" and "disease" can co-exist and still a person can live a healthy life at the same time.

Zhang et al (2020) has identified four frailty subtypes, namely multi-frail, cognitive and functionally frail, psychologically frail and physiologically frail. While some studies (Chen et al., 2014) highlight interconnectedness of these subtypes. Despite of this, the physical and cognitive frailties are separately approached in clinical settings (Chen et al., 2014). Different disciples such as social sciences and medical sciences focus on specific subtypes, but these studies often treat physical functioning and cognitive state as independent components, neglecting other disciplines. Integrating these disciplines could better explain human functioning.

The progression of physical and cognitive frailty leads to physical disability, cognitive deficits and dementia (Rockwood & Mitniski, 2007). The compromised physical functions often results in multiple organ failure (Fried et al.m 2004). Gobben et al. (2010) proposed a bio-psycho-social model of frailty. According to them frailty is multifactorial condition characterized by changes in one or more than psychological, social, and physical domains, and determining an increased risk of unfavorable outcomes. Ottenbacher et al., (2009) and Carneiro et al., (2017) reported that the progressive nature of frailty can increase the risk of adverse outcomes, such as from decline in functional and physical ability to death and disability.

Recent studies (Clegg et al., 2013; Fried et al., 2001) have shown that frailty syndrome if accompanied by other comorbid conditions may seed up deterioration process. However, it is important to differentiate between age-related frailty and frailty related to comorbidity. Age-related frailty is a common biological vulnerability that does not always lead to disease (Vellas et al., 2013; Rockwood & Mitnitski, 2007). It manifests with the progression of age, resulting depletion of physiological reserves and problems related to maintaining homeostasis (Gale et al., 2015; Morley, 2013). The main question remains whether it is possible to isolate age alone from other possible causes of frailty and propose a model of age-related frailty (Fried et al., 2001; Hubbard et al., 2010). Frailty related to comorbidity refers to comorbid conditions refer to the presence of two or more chronic diseases leading to frailty (Chou et al., 2013; Collard et al., 2012). From this perspective, a single or multiple chronic diseases may trigger the onset of frailty such as chronic psychiatric conditions, heart diseases, diabetes, and hypertension have been seen to increase the risk for frailty (Kojima et al., 2019; Morley et al., 2013). However, further studies are needed to clarify the relationship between frailty and comorbidity (Zhao et al., 2020; Fried et al., 2004).

Studies reveal that frailty is a dynamic process that can be treated and reversed (Fried et al., 2001; Walston et al., 2002). The aim is to maintain and prolong the optimal human functioning for active and successful aging (Cesari et al., 2016; Puts et al., 2005). Treatments aim purposes of facilitate independent living, improve the quality of life, mitigate age related morbidity, and reduce healthcare costs (Cesari et al., 2016; Puts et al., 2005). Timely detection of frailty and healthy life style can effectively prevent frailty to progress among elderly individuals (Yu & Wang, 2015; Rejeski et al., 2009). This requires multimodal treatment to prevent the progression of prefrailty into functional decline (Farid et al., 2001).

Research has shown that Pakistan has higher prevalence of certain diseases, including coronary heart diseases (Khan et al., 2017; Khan et al., 2014), anemia (Jamal et al., 2010), diabetes (Hussain

et al., 2013; Jafar et al., 2005), stroke (Mahmood et al., 2017), cataracts (Aziz et al., 2012), hypertension (Rehman et al., 2013) and cancer (Bokhari et al., 2016). Nisar et al. (2008) and Aslam et al (2019) have also found unhealthy life style among Pakistani population in general and elderly in particular. Research shows dietary habits have an impact on health and wellbeing. Pakistani population typically consumes 2 to 3 meals per day (Siddiqui et al., 2013). They prefer consumption of high-fats, sweets, spices, salts and vegetarian diet (Saleem et al., 2016; Ahmed et al., 2012). The use of Dairy products, meat and fruit is limited in their diet (Rashid et al., 2017). A sedentary life style along with high fat diets, poor sleep hygiene, smoking and stress fuel serious health conditions (Zaidi et al., 2016; Mirza et al., 2013). Further, many face barrier when accessing health services. Most of the elderly population is on very little income and struggle meeting their health related needs (Din, 2014). The commission on Health for Development (1990) stressed the importance of national health research in developing countries (Hyder et al., 2003). It is suggested that at least 2% of the national budget be made available for health research which remains near impossible for developing countries such as Pakistan (Rao, 2015).

Pakistan is a Muslim country where people incorporate the teachings of Islam in their daily lives. The impact of religious activities on the health of elderly Muslims in Pakistan is mainly positive (Pasha, 2012; Aslam et al., 2019), with those highly engaged in religious practices showing better quality of life and health outcomes (Khan et al., 2018; Jamil et al., 2017)). However, other factors like socioeconomic status, physical activity, and educational level also play a role in their health (Hussain et al., 2014; Mubeen et al., 2015). Further studies are needed to explore the impact of different religious activities on the elderly's health. Cultural concordance and generational differences also influence health behaviors within the Pakistani community, highlighting the need for more research in this area (Ali & Hunjra, 2015; Shah & Jahan, 2018).

A changing family dynamics and social roles is another great source of distress for this population as many elders experience loneliness, lack of social support (Siddiqui & Haider, 2016; Ali & Raza, 2014). A facility of old-age homes is not very popular in Pakistan (Zaheer & Rehman, 2017). However, few private old-age homes do exist but is beyond the financial reach of elderly people and their families (Khan et al., 2015). Beside all this, there is a limited body of research available on lifestyle practices and associated outcomes for elderly Muslims. This study is an attempt to ensure that this oversight does not exist. It endorses healthy practices among elderly population and. The findings will guide policymakers in overcoming these challenges.

Research Objectives

1. To identify the most prevalent form of disorder among elderly.
2. To explore area of frailty in relation to Gender.
3. To gauge degree of frailty

Hypotheses

1. Poor health status tends to decrease the quality of life among elderly subjects.
2. Depression tends to increase with the increase in age.
3. Elderly men and Elderly women tend to get equally affected by age related health conditions.

Methodology

This cross-sectional study involved N=203 elderly individuals elderly with n= 70 men and n=133 women aged 60-85, with a mean age of 68.275±5.480 years. Using a Stratified sampling technique, data was drawn from six localities of Khyber Pakhtunkhwa. Localities included were Peshawar, Nowshehra, Mardan, Charsada, Sawabi, and Chitral. Later, thirty-three elderly from main residential areas within each stratum were selected, contacted and requested their time to participate in the study. The investigators of this study obtained informed written consent from participants, who were

briefed about the study's objectives and methods, and oriented to the data collection procedure. Confidentiality and privacy were also maintained throughout the study. After obtaining permission from elderly residents, the required information was obtained through an interview technique. The sample only represented Muslim population from both urban and rural areas of Khyber Pakhtunkhwa. A questionnaire on frailty and other health related conditions was designed for those with gradually accumulating health deficits with focus on four features: movement, function, thought, and feeling about their health over the last two weeks. Information was based on subjective experience of the elderly and researchers' observation. The health of individuals with chronic conditions was assessed based on the person's level of physical activity, symptoms, and overall health status. Frailty was graded on 9 levels such as, Very Fit, Well, Managing Well, Vulnerable, Mildly Frail (impaired mobility, changes in function), Moderately Frail (instrumental dependence), Severely Frail (progressive dependence) and Terminally Ill. *Subjective Psychological Wellbeing Scale (Diener& Biswas Diener, 2008)* Subjective Psychological Wellbeing Scale was supplemented with other scales. It yields three sub-scores on Satisfaction with Life, Emotional Wellness and Flourishing.

Results

Table 1

Demographic and Socioeconomic Characteristics of the Elderly Respondents

Demographic Variables		N	%
Gender	Elderly Men	70	34.5
	Elderly Women	133	65.5
Marital Status	Married	188	92.6
	Unmarried	15	7.4
Family System	Nuclear	60	29.6
	Joint	143	70.4
Financial Dependence	Independent	65	32
	Dependent	138	68
Frailty	Mild frailty	70	34.4
	Chronic frailty	113	55.6

The sample consists of 203 individuals, with a higher proportion of elderly women (65.5%) compared to elderly men (34.5%). Majority of the respondents (92.6%) are married, while 7.4% are unmarried. In terms of family system, the data shows that 70.4% of respondents live in a joint family system, while 29.6% live in nuclear families. The results also indicate that 68% of elderly individuals are financially dependent, while 32% are independent. Lastly, frailty levels show that the majority of respondents (55.6%) experience chronic frailty, while 34.4% experience mild frailty. Overall, these findings reflect key trends in the elderly population of Pakistan, with significant implications for healthcare, social support, and elderly care policies.

Table 2

Descriptive Statistics of Respondent Demographics: Age and Family Size

	N	Min	Max	Mean	SD
Age	203	60	85	68.276	5.480
Family Size	203	3	40	14.96	8.70

Table 1 provides information about the age and family size of the respondents. The study sample consisted of 203 individuals with ages ranging from 60-85 years. The mean age of the respondents is 68.28 years with standard deviation of 5.48. The maximum age limit is found to be 85 years, reflecting improved longitivity in elderly people. Family size varied significantly with in the sample.

The size of the family ranges from 3-40 members. The average family size is 14.96 members in a family.

Table 3

Gender Differences in Decline of Functional Areas among the Elderly Population

Area of Functioning	Present	Absent	X^2	Sig
Declined Physical Functions				
Elderly Men	35	35		
Elderly Women	50	83	2.900	.060
Total	85(42%)	118(58%)		
Declined Cognitive Functions				
Elderly Men	30	40		
Elderly Women	85	48	8.277	.003
Total	115(57%)	88(43%)		
Declined Sensory Functions				
Elderly Men	50	20		
Elderly Women	78	55	3.216	.092
Total	128(63%)	75(37%)		
Declined Physiological Functions				
Elderly Men	70	0		
Elderly Women	128	5	2.698	1.67
Total	198(98%)	5(2.5%)		
General Fatigue and weakness				
Elderly Men	45	20		
Elderly Women	93	40	9.75	.008
Total	138(68%)	60(29.5%)		
Declined Social Functions				
Elderly Men	15	55		
Elderly Women	25	108	.201	.392
Total	40(19.7%)	163(80.3%)		

Overall, both men women have not shown a significant decline in the ability to perform daily activities that are essential for independent living, such as walking, climbing stairs, and managing personal care tasks. Similarly, no gender wise variation exists between the genders on the level of physical mobility, x^2 (1,203) 2.900, $p > .05$. Cognitive decline is more pronounced in the elderly population

than physical decline. Cognitive functioning, function is found more obvious in women than men, x^2 (1,203) 8.277, $p < .05$. Majority of the respondents irrespective of gender reported about sensory decline with more women than men found affected with this condition, x^2 (1,203) 3.216, $p > .05$. A sharp decline in physiological function such blood pressure and renal problems is reported by majority of the respondents. However, the gender wise difference is not statistically significant, x^2 (1,203) 2.698, $p > .05$, suggesting that physiological decline is equally prevalent in both genders. Irrespective of gender, majority of the respondents complained about general weakness and fatigue. However, more women than men suffered this condition, x^2 (1,203) 9.75, $p < .05$. The results indicate that both men and women are socially active. No gender wise variation is observed pertaining sociability, x^2 (1,203).201, $p > .05$.

Table 4

Gender Differences in Health Issues among the Elderly

	Present	Absent	X^2	Sig
Poor Nutritional Status				
Elderly Men	50	20		
Elderly Women	98	35	.118	.427
Total	148(72%)	55(27%)		
Blood Pressure				
Elderly Men	45	25		
Elderly Women	103	30	11.387	.001
Total	148(72%)	50(27%)		
Urine Control Problems				
Elderly Men	45	25		
Elderly Women	88	45	.072	.453
Total	133(66%)	70(34%)		
Constipation				
Elderly Men	10	60		
Elderly Women	35	98	3.847	.035
Total	45(22%)	158(78%)		

The result in Table 4 highlights the high prevalence of poor nutritional status, high blood pressure, and urine control problems. For poor nutritional status, 50 elderly men and 98 elderly women have been affected. No statistically significant difference between genders are observed, x^2 (1,203) .118, p. >.05. In contrast, more women than men have reported the presence of high blood pressure and this difference is found, x^2 (1,203) 11.387, $p < .05$. Regarding urine control problems, more women than have reported issues, but the difference is not statistically significant, x^2 (1,203) .072, p. >.05). Lastly, constipation is not commonly found in old age. However, the condition is more prevalent among women than men, x^2 (1,203) 3.847, p. <.05. Overall, the results indicate significant gender differences in blood pressure and constipation, while poor nutritional status and urine control problems appear to affect both genders similarly.

Table 5

Gender Differences in Leisure Time Activities among the Elderly

Leisure Time Activities	Yes	No	X^2	Sig
Religious Activities	150	53		
Elderly men	(73.9%)	(26.1%)	1.23	.176
Elderly Women	55	15		
	95	38		
Pet Keeping	60 (30%)	143		
Elderly men	25	(70%)	.196	.109
	35	45		
Elderly Women		98		
Listening to Music	20 (9.9%)	183		
Elderly men	10	(90.1%)	2.36	.100
	10	60		
Elderly Women		123		
Watching Television	110	93 (56%)		
Elderly men	(54%)	25	4.389	.025
	45	68		
Elderly Women	65			
Gardening	73 (36%)	130		
Elderly men	30	(64%)	2.20	.092
	43	40		
Elderly Women		90		

Table 5 examines the leisure time activities of elderly men and women, highlighting their engagement in various activities. Results reveal that participation in religious activities and Television viewing is more common among elderly. However, the statistical significance suggests no significant gender differences in the overall participation in religious activities, (x^2 (1,203) 1.23, p >.05. While the television viewing is found to be more common among women than men, x^2 (1,203) 4.389, p<.0. However, the preference for pet keeping, music and gardening is generally low.

Table 6

The Frequency Table Showing Religious Coping for N=203 Elderly

Religious Coping	High	Low
Engagement in Religious activities	148 (73%)	55 (27%)
Participation in religious rituals	148 (73%)	55 (27%)
Enhanced emotionally security	153 (75.4%)	50 (24.6%)
Acceptance of Aging	123 (60.6%)	80 (39.4%)
Perceived Health benefits from Prayers and Recitation	128 (63.1%)	75 (36.9%)

The table explores presence of religious coping and associated emotional outcomes, and perceptions among elderly respondents. Majority of elderly (73%) are actively engaged in religious activities and rituals, compared to 27% with low participation. Similarly, 75.4% of respondents participate in religious activities to derive a sense of emotional security as coping mechanism to deal with the challenges the life throw at them. Approximately, 60.6% of respondents have reported that religion has helped them accept their aging. Additionally, 63.1% has a belief that participation in religious activities can promote health and wellbeing.

Table 7

Difference between the means on scale measuring religious coping

		Religious Coping Scale (RCS)											
		Total Score on RCS				Religion as a source emotional Security				Perceived Health benefits of religion			
1.life Satisfaction	N	M	SD	t	sig	M	SD	t	sig	M	SD	t	sig
Satisfied	155	15.63	3.03	-2.4	.02	2.74	.567	-4.28	.000	2.61	.607	-3.16	.002
Dissatisfied	48	14.35	3.88			2.27	.916			2.27	.791		
2.Major Regrets													
With regrets	135	15.00	3.47	-2.1	.040	2.55	.739	-2.19	.030	2.51	.689	-.40	.69
Without regrets	68	16.00	2.80			2.77	.568			2.55	.632		
3.Attitude towards aging													
Optimistic	123	14.6	3.41	2.74	.007	2.56	.71	1.13	.261	2.38	.70	2.74	.007
Pessimistic	80	15.84	3.11			2.67	.68			2.63	.63		

The results from Table 7 reveal differences in religious coping among the elderly population. Religious coping is found to be high among those who are satisfied with life (N = 155) as compared to the dissatisfied group (N = 48). The difference is found significant at the alpha 0.05 level. The satisfied elderly individuals derive emotional security (M = 2.74) and health benefits from participating in religious activities as compared to the dissatisfied group, who reported lower scores on both measures (M = 2.27 for both).

Elderly people with no regrets in life (N = 68) scored significantly higher on the RCS (t (1, 203) -2.1, $p < .05$) and reported a high sense of security. These differences are found significant at the alpha .05 level. Similarly, optimistic elderly individuals (N = 123) showed a significantly higher RCS total score ($p = .007$). Significant differences are noticed in the perceived health benefits between the two groups ($p = .007$).

Discussion

This study explores the association of life style factors with general wellbeing of older adults residing in Khyber Pukhtunkhwa, Pakistan. The mean age of the respondents is found to be 68.28 years, reflecting improved longitivity in older population. One plausible reason can be the advancements in healthcare. However, average age of women is found to be higher than men. The potential contributing factors can be the presence of estrogen, a hormone that is associated with cariovescular and immunity benefits. Similarly the genetic endowment of women makes them more resilient because they possess two X chromosomes; it gives them genetic edge to have greater resilience against diseases. A hormonal influence, such as estrogen, lowers the risk of cardiovascular diseases. Similarly, women are more proactive about their health and less prone to engage in risky activities than men.

Advanced health care facilities have decreased the chances of premature death. Preventative care, such as vaccination programs, routine screenings, and public health initiatives, has also played a vital role in reducing mortality rates. Better treatment options, advanced diagnostic instruments have been instrumental in extending life expectancy. Further, life expectancy has increased by improved living conditions. Access to quality food, improvements in sanitation and housing conditions have drastically reduced the prevalence of infectious diseases. Online healthcare facility is associated with longer lifespans. It provides instant medical advice and is cost effective for patients now.

Findings reveal that majority of respondents live in a joint family system. This reflects the traditional preference for joint family structures in Peshawar. The average family size consists of 14.96 members. This large family size is indicative of the cultural context in which many elderly individuals live. In Peshawar elderly individuals live in joint family systems where multiple generations live together. Strong family bond among the members of the family is the reason why this traditional social structure is still deep-rooted in Pashtun culture. This cultural framework encourages larger family sizes as individuals find value in collective living arrangements, promoting a sense of belonging and shared responsibility.

Family size depends on how members in a family are closely bonded with one another. In Pashtun culture religious values, cultural norms, family values and group ideologies are valued over individualism. The culture and religion are important predictors of family-size norm, family dynamics and fertility behavior of men and women in this culture. Data collected from 15 countries show that the rate of polygamy is high. Muslim also prefers to have more children.

Families prefer to have multiple children as a sign of prosperity and success, reinforce the desire for larger family sizes. Economic factors do also influence the living arrangement of family members. Large families are perceived as a form of old-age security. Parents often rely on their children to support them in their later years; making larger family sizes a practical choice.

The results also indicate that financial dependency among elderly individuals is a pressing concern. To overcome older people's financial health needs, Pakistan has to introduce programs for elderly population. Unfortunately, most of the social protections programs such as Benazir Income Support Program, Sehat Sahulat Card, Zakat Funds, Pakistan Baitulmal, Individual Financial Assistance, Pak Great Homes, and Employee Old Age Benefits Institution have been launched by the state but a small portion of older people are getting benefits from these programs. Most national policies focus young population. Limited coverage, insufficient benefits, and lack of awareness contribute to this vulnerability, leaving a significant portion of the elderly financially vulnerable.

Significant portion of elderly experience frailty, indicated by symptoms of weight loss, exhaustion, general weakness, and slow reaction time. The consequences of frailty are profound, leading to

increased mortality and disability among the elderly. Research indicates that frail individuals have a two to five times higher risk of mortality compared to their non-frail counterparts due to increased vulnerability to acute illnesses and complications from chronic diseases (BMC Geriatrics, 2020; Academic Gerontology, 2020; Public Health Reviews, 2020). Frailty often leads to functional decline, affecting the ability to perform daily living activities. The present health care systems, on the hand, work in way that it cannot handle the complex medical conditions of elderly. The reason is that the system is built address organ-specific and disease specific medical conditions one at a time (De Lepelerie et al., 2009). As a consequence, fragmented approach of treatment approach results in older individuals receiving poor care (Clarfield, Bergman, & Kane, 2001).

Aging is a natural process that brings forth physical, cognitive, and social changes. While physical decline is common among both genders, cognitive decline is more prominent in elderly women. Cognitive decline in elderly women encompasses various issues, including memory impairment, decreased processing speed, and difficulties in attention and executive functioning. This decline can lead to significant challenges in daily life, affecting independence and the quality of life. Among the biological factors contributing to this increased vulnerability include hormonal changes, genetic predispositions, chronic health conditions, and cognitive reserve.

General fatigue is a common complaint among elderly women, which can stem from various interconnected factors. Physical health, such as muscle mass loss and sleep disturbances, can lead to decreased strength and increased fatigue. Psychological factors, such as depression and anxiety can also contribute to feelings of fatigue and cognitive decline.

Both men and women, are found with physical and physiological problems such as high blood pressure, diabetes, decreased muscle strength, reduced bone density, and impaired mobility. Decline in sensory functions are observed equally among both genders, with changes in vision, hearing, and sensory perception. General fatigue and weakness are more likely to be reported by elderly women compared to their male counterparts. Factors contributing to this phenomenon include chronic conditions, traditional social roles, and increased stress and exhaustion from traditional caregiving burdens.

Utility of leisure time is important for all ages, particularly for the elderly. Health free time activities improve the quality of life in old age and slow down the aging process. Results regarding the leisure time activities of elderly men and women show greater preference for religious activities and television watching. Pet keeping and listening are not very more common among elderly people. Television watching is more common in elderly men than in elderly women. Gardening is another least popular activity among elderly men and women.

Leisure activities are crucial for maintaining a healthy lifestyle, especially for the elderly. They contribute to increased satisfaction, happiness, and emotional health, as well as helping with retirement adjustment and fostering new social networks. Additionally, leisure activities can slow the aging process by promoting physical health and mental agility. However, there is an alarming trend of decreasing leisure opportunities for the elderly, which could be due to factors such as social isolation, limited accessibility, and changing values and attitudes. Research on leisure preferences among elderly men and women reveals distinct trends. Religious engagement is a common preference, with many elderly individuals reporting high levels of engagement in spiritual activities. Television watching is a popular leisure activity, particularly among elderly men, suggesting a preference for passive engagement over more interactive forms of leisure. Pet keeping and listening are less popular among the elderly, possibly due to the responsibilities associated with pet

ownership and the need for active participation in listening activities. Gardening ranks as one of the least popular activities among both elderly men and women, possibly due to physical limitations, lack of interest, or the need for mobility and stamina.

Conclusion

This study examined the impact of life style factors and attitude towards aging in relation to health outcomes in older adults. Chronic frailty, particularly cognitive decline, is prevalent among the elderly population, with women being more affected than men. Poor nutritional status, driven by factors such as reduced appetite, dysphagia, and chronic health conditions, also poses a major concern. Additionally, the study indicates a notable decline in physiological functions like blood pressure and renal issues among the elderly. Despite these challenges, the study reveals that participation in religious activities increases with age, with many respondents viewing religion as a vital source of support in coping with the difficulties of aging. It is recommended that Comprehensive care plans should integrate religious resources to address psychological well-being. Community-based frailty prevention and intervention programs must be introduced to address the unique needs of elderly women, focusing on nutritional support, mental health, and social inclusion

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