

Research Article

Holistic Health Assessment among the Adult Population of an Urbanized Village of South Delhi, India

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A B S T R A C T

Introduction: Holistic health is an integrated model for providing not only physical, mental, and social dimensions of health but also spiritual, ethical, environmental, economic, religious, cultural, and international relations.

Objectives: To assess holistic health concepts and practices among the adult population of South Delhi. To identify the role of body, mind, and spirit in health and wellness. To study the association of holistic health with socio-demographic variables.

Material and Methods: It was a community-based, cross-sectional, descriptive study of one year duration. People residing in an urbanized village of South Delhi for more than 6 months and who were more than 18 years old, were study participants. Nonprobability Convenient sampling was used for data collection. A pre-tested, semi-structured, interviewer-based holistic health assessment Questionnaire was used. The data was entered in MS Excel and then analyzed in SPSS Version 23. Descriptive analysis was done by calculating proportions, mean, and standard deviation. Ethical approval was obtained from the Institutional Ethics Committee (IEC). Informed consent was taken from each participant before data collection.

Results: A total of 384 study participants were included in the present study. Less than half (48.7%) of the study population had fair health, followed by below-average health in nearly 29.7% of study subjects. More males (34.3%) had below satisfactory health than females (21.3%), and this difference was statistically significant. More than half (55.6%) of the younger population had below satisfactory health. More than one-fourth (33%) Hindu population had below satisfactory health, while it was somewhat better in other religions. Nearly half of the working population (45.4%) had below satisfactory health.

Conclusion: One-third of the study population has below-average holistic health, which varies with gender, age, and religion. Further in-depth studies are required to understand the lower level of health and its variation.

Keywords: Holistic Health Assessment, Integrated Health, AYUSH

Introduction

WHO defines health as “a state of complete physical, mental, and social well-being and not merely absence of disease or infirmity”. This definition is always criticized for its incompleteness; therefore, many more concepts and ideas are introduced to make it complete. The whole purpose of such modifications is to bring wholesome development of the individual and the world. The health status of the individual and nation is a critical factor that determines happiness, well-being, and consequently quality of life.¹ Dharmshuktu (2018) has emphasized that the absence of environmental determinants is important for health.² Kishore J (2013) said, “Health is more personal, and the rest are environmental and social concepts in which the mind is the center surrounded by body, environment, family, society, institution, national, and international forces with the aim to live in peace and happiness. In brief, health is a dynamic process of living with peace and happiness in all dimensions of life”.³

It also exerts an immense effect on the economy. Good health status reduces poverty and increases productivity, ultimately stimulating economic growth.⁴ With the changing era, health is limited to only physical health. However, it also encompasses social and mental well-being. Holistic health is an integrated model that covers all these health dimensions, including spiritual, ethical, environmental, economic, religious, cultural, international relations, and many others. It visualizes body and mind as a single internal unit and works for achieving harmony among all these components. The philosophy behind holistic care is based on the idea of holism, which emphasizes that for human beings, the whole is greater than the sum of its parts and that mind and spirituality affect the body.⁵ This concept has been central to many of the systems of care in India and worldwide. Holistic care includes a wide range of approaches, including medication, education, communication, self-help, meditation, and complementary treatment.⁶

But, as time progresses, people have forgotten the focus given in traditional systems of medicine, which valued holistic health. As a result, people are suffering from many communicable, non-communicable diseases and mental health disorders. India's burden of non-communicable diseases (NCDs) is escalating. NCDs typically present in individuals aged 55 years or older in many developed countries, but their onset starts in India a decade earlier (≥ 45 years of age).

Many studies have shown that good health status can be achieved through the practice of healthy behaviors.⁷⁻¹⁰ From ancient times, India has been practicing AYUSH (Ayurveda, Yoga, Unani, Siddha, Homeopathy). AYUSH is supposed to complement the modern system by integrating best

practices. The Ayushman Bharat Yojana of the Ministry of Health & Family Welfare has long worked for integrating the different systems of AYUSH with modern medicine for service delivery.¹¹⁻¹³

There are fewer Indian studies about the awareness of holistic health care among the general population. Therefore, it was crucial to carry out such a study so that the general perception about holistic health care could be understood better.

Material & methods

Study design and duration: It was a community-based, cross-sectional descriptive study. The study duration was one year.

Study Area

The Present study was carried out in South Delhi. Many people settled down here from not only Delhi but also from adjoining states such as Uttar Pradesh, Haryana, Punjab, Bihar, Jharkhand, etc., in search of occupation, education, and future prospects.

Study Population

People above 18 years of age, residing in the area for the last 6 months or more, were included in the study. Sampling Technique: Nonprobability Convenience sampling method was used to select the participants for the study.

Sample size estimation

The sample size was calculated using Epi-info software version 7.2.2.2 (Developed by CDC), taking the population of South Delhi as approximately 2.73 million¹¹ and prevalence of awareness about holistic healthcare as 50%, with a 5% acceptable margin of error and 95% confidence interval, it was 384. It was taken 50% prevalence because no previous study was found on a similar topic.

Study tool

Pre-tested, semi-structured, interviewer-based Questionnaire taken as per standard questionnaire (Holistic Health Assessment) from the American Board of Holistic Medicine.¹² A Hindi translated version of the questionnaire was used for better understanding with the local people. The questionnaire consists of three domains: Body/Physical health, Mind/emotional health, and Spiritual health.

Each of the three domains has 25 questions, making a total of 75 questions, each worth 5 marks. Thus, a composite maximum score of 375 was achieved. Based on scoring, the status of health was given, which could range from optimal health to extremely poor health.

For determining the association between health status and socio-demographic factors, a concise table has been formulated for our study purpose, which is as given below:

The questionnaire was translated into Hindi and back translated into English, and a draft final version of Hindi was pilot tested on 10% of the sample size. After minor modifications based on the observations in the pilot final version was applied to study participants.

| | |
|--------------------------------|---------------------------|
| Optimal Health (325-375) | Above satisfactory Health |
| Excellent Health (275-324) | |
| Good Health (225-274) | |
| Fair Health (175-224) | Satisfactory Health |
| Below Average Health (125-174) | Below satisfactory Health |
| Poor Health (75-124) | |
| Extremely Poor Health (0-74) | |

Data Analysis

The data was entered in MS Excel and then analyzed in SPSS Version 23. Descriptive analysis was done by calculating proportions, mean, and standard deviation. Data was presented as tables and appropriate diagrams, and the association between proportions was assessed using the chi-square test. P value <0.05 was considered significant.

Ethical consideration

Ethical approval was obtained from the Institute Ethics Committee (IEC). Informed consent was taken from each participant before data collection.

Results

A total of 384 study participants were included in the present study. Sociodemographic characteristics of the study participants are given in Table 1.

Table 1. Socio-demographic profile of study population
N=384

| Age (in completed years) | Number (%) |
|--------------------------|------------|
| 18-30 | 72(18.7) |
| 31-45 | 263(68.7) |
| 46-60 | 46(12) |
| >60 | 3(0.6) |
| Gender | |
| Male | 248(65) |
| Female | 136(35) |

Table 2. Distribution of study population based on composite scoring

N=384

| Scores on the Health scale | Health status | Number (%) | Operational definition | No (%) |
|----------------------------|------------------|------------|---------------------------|-----------|
| 325-375 | Optimal health | 0 | Above satisfactory health | 83 (21.6) |
| 275-324 | Excellent health | 9(2.3) | | |

| Education | |
|------------------------------|-----------|
| Illiterate | 11(3) |
| Upto Primary school | 42(11) |
| Upto Senior Secondary school | 224(58) |
| Graduate | 90(24) |
| Above graduate | 17(4) |
| Religion | |
| Hindu | 320(83.3) |
| Muslim | 40(10.4) |
| Others | 24(6.3) |
| Caste | |
| General | 265(61.5) |
| OBC | 100(26) |
| SC/ST | 46(12) |
| Occupation | |
| Working | 262(68.2) |
| Non-working/homemakers | 122(31.8) |

Most (69%) of the study participants were in the age group 31-45 years, followed by 18-30 years (19%). More than half (58%) of the study participants were educated up to senior secondary school, and nearly one-fifth (24%) of them were graduates. About 68% of study participants were working, and nearly 32% of participants were non-working/homemakers. A majority (83%) stated their religion as Hindu and caste as general (61.5%), followed by OBC caste (26%).

The above table reflects that less than half (48.7%) of the study population had fair health, followed by below-average health in nearly 29.7% of study subjects. It is to be noted that only about 21.6% of participants had above satisfactory health.

The above table reveals that more males (34.3%) had below satisfactory health than females (21.3%), and it was statistically significant. More than half (55.6%) of the younger population had below satisfactory health, and this was also statistically significant. More than one-fourth (33%) of the Hindu population had below satisfactory health, while satisfactory health was significantly higher in Muslim and other religions. Nearly half of the working population (45.4%) had below satisfactory health, while fewer (39%) of the non-working population had below satisfactory health.

| | | | | |
|---------|-----------------------|-----------|--------------------|------------|
| 225-274 | Good health | 74(19.3) | | |
| 175-224 | Fair health | 187(48.7) | Satisfactory | 187 (48.7) |
| 125-174 | Below Average health | 102(26.6) | Below satisfactory | 114 (29.7) |
| 75-124 | Poor health | 12(3.1) | | |
| 0-74 | Extremely Poor health | 0 | | |

Table 3. Association of health status with sociodemographic variables

N=384

| Variables | Above Satisfactory health n=83 (%) | Satisfactory health n=187 (%) | Below Satisfactory health n=114 (%) | P value |
|------------------------|------------------------------------|-------------------------------|-------------------------------------|---------|
| Male | 57(22.9) | 106(42.7) | 85(34.3) | 0.005* |
| Female | 26(19.1) | 81(59.6) | 29(21.3) | |
| Age group | | | | |
| 18-30 | 11(15.3) | 21(29.2) | 40(55.6) | 0.001* |
| 31-45 | 66(25.1) | 135(51.3) | 62(23.6) | |
| >45 | 6(12.2) | 31(63.3) | 12(24.5) | |
| Educational status | | | | |
| Illiterate | 1(9.1) | 8(72.7) | 2(18.2) | 0.003* |
| Upto Secondary school | 61(22.9) | 113(42.5) | 92(34.6) | |
| Above Secondary school | 21(19.6) | 66(61.7) | 20(18.7) | |
| Religion | | | | |
| Hindu | 69(21.6) | 145(45.3) | 106(33.1) | 0.004* |
| Muslim | 10(25) | 24(60) | 6(15) | |
| Others | 4(16.7) | 18(75) | 2(8.3) | |
| Occupation | | | | |
| Working | 57(21.8) | 86(32.8) | 119(45.4) | 0.08 |
| Non-working | 20(16.4) | 54(44.3) | 48(39.3) | |

Discussion

In today's world, the realization of the original health concept is a prime necessity for a healthy life. Body, mind and social aspect should be working jointly to lead a productive and meaningful healthy life. This concept is revised through the model of holistic care, which recognizes four systems centered on the person – organs, the whole person, behaviour, and social role function – and four contextual factors that influence these systems – personal factors, physical environment, social environment, and time.¹³ A holistic approach also looks at choice and quality of life. In India, people used to pay more attention to physical health and related factors. Other aspects of health i.e., mental, social, and spiritual health, are often missing from their perception. The concept of holistic health care is often described with respect to health care providers and nursing personnel. Previous studies have addressed the importance of various components of health; for instance, the definition of health by the World Health Organization as “a state of complete physical, mental, and social well-

being” is a prevailing idea.¹⁴ However, there is now a growing argument that emphasizes the interconnectedness of all dimensions of health.^{15,16} Here, health is defined as a holistic health dynamic that requires balance among physical, social, environmental, mental including spiritual elements. It is suggested that one dimension affects the state of another.^{17,18}

Despite these definitions, the holistic health care concept is not known to the general population. It is also reflected in the present study. Less than half (49%) of the study subjects had satisfactory health. While nearly 30% of them had below satisfactory health. Similar findings were observed in one of the studies done among the Korean population.¹⁹

Regarding holistic health care assessment, it was found that more males (34.3%) were below satisfactory health than females (21.3%), and this was statistically significant. It could be due to the fact that males work outside and are preoccupied with their jobs, so they couldn't focus on their health. There is a higher prevalence of risk factors such as tobacco and alcohol use in males as compared to females,

which could be due to seeking enjoyment or relief from stressful conditions.

More than half (55.6%) of the younger population were below satisfactory health. Nowadays, the younger population is in the habit of eating junk food, engaged in digital media like mobile, tablet, computer, etc. This leads to a sedentary lifestyle and unhealthy habits. Readily available, readymade foods and highly sweetened beverages are more convenient and highly desirable, especially to young people. These food items are high in calories and fat content, making young people susceptible to an obesogenic environment.²⁰⁻²² and inclined towards unhealthy habits.²³

Nearly half of the working population (45.4%) had below satisfactory health. The result is consistent with previous studies reporting that job strain may promote adverse health behaviors and may impede the practice of planned health behavior.^{24,25}

The level of health was very poor among the general population, which could be due to a lack of awareness. In Iran, a qualitative study was carried out among nurses regarding effective barriers in providing holistic care. They found that there was a high need for closer attention to the compatibility of the educational system with the idea of holistic care, revision of the contents and methods of education, and modification of the conditions at work to encourage holistic care.²⁶

One of the limitations of this study was taking a convenient sample of a particular area of South Delhi, which restricts the generalizability of the findings. Data was collected by the undergraduate medical students, which could be the cause of inter-observer variations, although they were trained in the questionnaire and supervised by the senior residents. Findings of the study have implications for the National Health Policy implementation because various indicators are used to project people's health status without emphasizing satisfaction level in terms of physical, social, and mental well-being.

Conclusion

It is high time that the concept of holistic health should be incorporated in determining satisfaction level in health status in the National Health Policy and further disseminated to the general population so that people can understand physical, mental, and social health as a single entity. More comprehensive health promotion programs should be planned at the community level to reach out general population to achieve quality health.

Conflict of Interest: None

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