



A SURVEY TO ASSESS THE KNOWLEDGE REGARDING CARDIAC REHABILITATION AMONG PEOPLE IN SELECTED VILLAGES OF VISNAGAR.

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Abstract:

Introduction:

Cardiovascular diseases (CVDs) cause 31% of all deaths worldwide[1]. This indicator reaches 39%-47% (for females and males, respectively) in Europe[2] and most deaths in the United States are due a CVD[3]. The annual global number of CVD deaths is 17.9 million; these mainly (85%) due to coronary artery disease (CAD) and stroke.

Objective:

The aim of the research was to assess the Knowledge Regarding Cardiac Rehabilitation Among People in Selected Villages Of Visnagar.”

Methodology:

The research design selected for the study was (Non-experimental survey Design). Sampling Techniques (non-probability convenient sampling) was used to obtain sample of 100 who satisfied the inclusion criteria.

Conclusion:

The following conclusion are drawn from the study the knowledge of cardiac rehabilitation could be useful for people to improve their health. The expected survey result supported the knowledge of cardiac rehabilitation one of the best method to promote the overall health of people.

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Introduction:

CVDs constitute a common reason for hospitalization[6] and cause an inability to work[7]. Stroke and CAD are the most frequent causes of disability and are responsible for approximately 20% of age-standardized disability-adjusted life years[8,9]. According to the American Heart Association (AHA), a sum of USD 351 billion (*i.e.*, 14% of total funds spent on health care) was spent on the treatment of CVDs during 2014-2015. This amount is expected to approach USD 1100 billion in 2035[3]. This is a serious issue affecting both the social sphere and the national economy.

There are predispositions and risk factors of CVDs on a behavioral, biological, and social level. The etiology and pathogenesis of these diseases depend appreciably on the style of living. Major risk factors include smoking, lack of physical activity, and unhealthy diets (including excessive alcohol consumption)[1]. Behavioral risk factors can result in hypertension, increased blood sugar/lipid levels, and overweight or

obesity[2,3]. Such intermediary factors can be controlled within primary prevention. Determinants also exist at the social, economic, and cultural levels—globalization, urbanization, and population aging[1]. Additional risk factors include male gender, poverty, stress, and genetic pre disposition [1].

The occurrence and development of CVDs are also related to psychological disorders such as anxiety, depression, and sleep disorders[10]. A comprehensive approach to cardiac rehabilitation (CR) can contribute favorably to the diagnosis of such conditions and the initiation of treatment[10]. According to the World Health Organization [1,11], up to 80% of premature heart disease, stroke, and diabetes and 75% of recurrent cardiovascular events could be prevented, reinforcing the need for optimized and holistic prevention strategies.

The following text presents a review on CR basics, including its components, prescription, safety, effectiveness, and conventional and alternative training modalities. The next section

contains information about CR delivery around the world, its uptake, and potential barriers. Finally, the last part offers strategies to improve CR participation, focusing on T). This work aims to provide a comprehensive overview of contemporary CR and to outline its future perspectives.

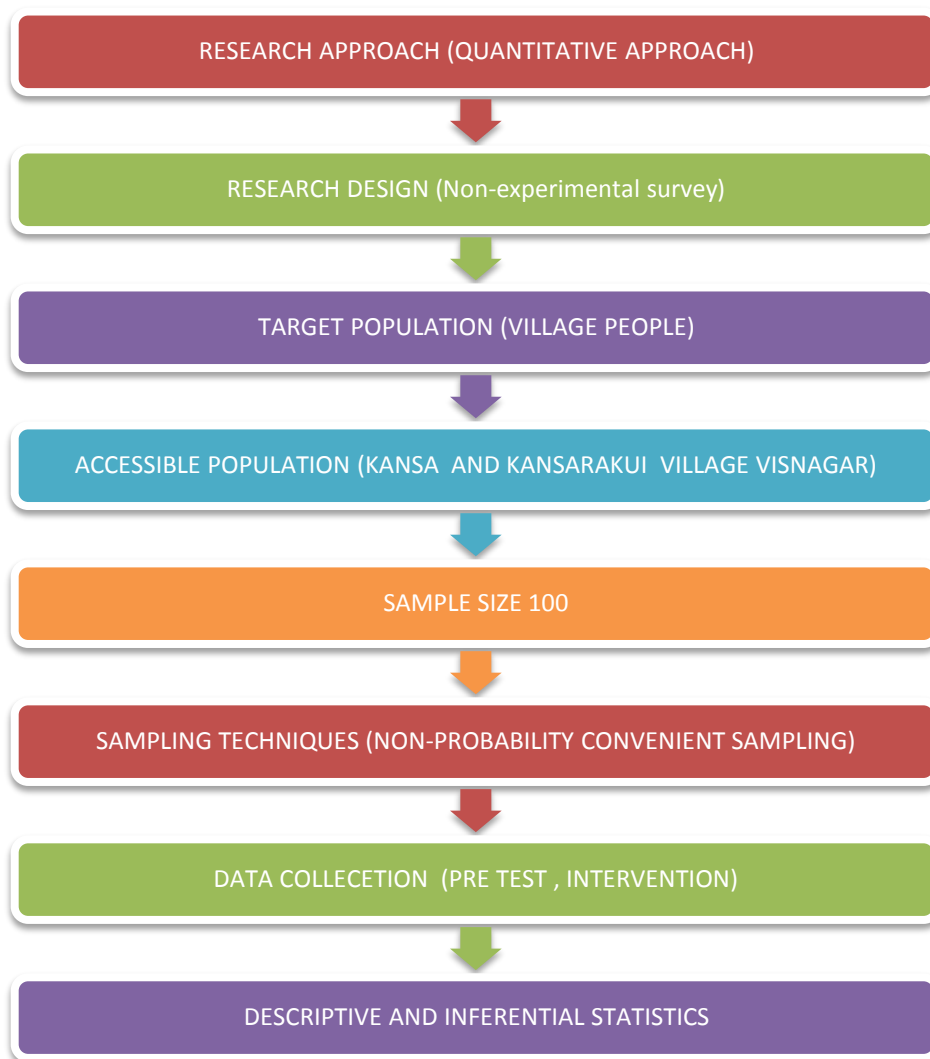
Cardiac rehabilitation is a complex intervention that includes exercise training, physical activity promotion, health education, cardiovascular risk management and psychological support, personalized to the individual needs of patients with diagnosed heart disease (12). In addition to secondary prevention and improvement in cardiovascular prognosis, a focus of modern cardiac rehabilitation has been the drive to improve patient well being and health-related quality of life.

Cardiac rehabilitation programs aim to limit the psychological and physiological stresses of CVD, reduce the risk of mortality secondary to CVD,

and improve cardiovascular function to help patients achieve their highest quality of life possible. Accomplishing these goals is the result of improving overall cardiac function and capacity, halting or reversing the progression of atherosclerotic disease, and increasing the patient's self-confidence through gradual conditioning.

METHODOLOGY

The primary phase of research is methodology, during which the researcher decides on a variety of materials to be used to explore the research problem, primarily through the gathering of data. The methodology describes the research approach, research design, location and environment, sampling strategy, department of the instrument, validation of the instrument and its reliability, data collection techniques, pilot study, and plan for statistical analysis.



RESULT

Table 1: Frequency And Percentage Distribution Of Rhe Sample According To The Demographic Variable In Group:-

SR. NO	DEMOGRAPHIC VARIABLE	FREQUENCY	PERCENTAGE
1	Age		
	31-40 year	12	12%
	41-50 year	25	25%
	51-60 year	28	28%
	61-70 year	35	35%
2	Area of residency		
	Rural	97	97%
	Urban	3	3%
3	language		
	Gujarati	94	94%
	Hindi	3	3%
	English	3	3%
4	Educational status		
	Illiterate	2	2%
	10 th and below	48	48%
	12 th pass	22	22%
	Graduation	28	28%
5	Marital status		
	Married	75	75%

	Unmarried	20	20%
	Health care provider	5	5%
6	Source of Information		
	Mass media	10	10%
	Family member	24	24%
	Health care provider	56	56%
	All of above	10	10%

The data presented in the table-1 indicate result as follow:

1. AGE IN YEARS: -

Regarding age category of the respondents has been divided into four different categories among people in that highest score of people were 35%

which indicate 61-70 years old and the lowest score were 12% which 31-40 years old and 25% people were 41-50 years old and other 28% people were 51-60 years old.

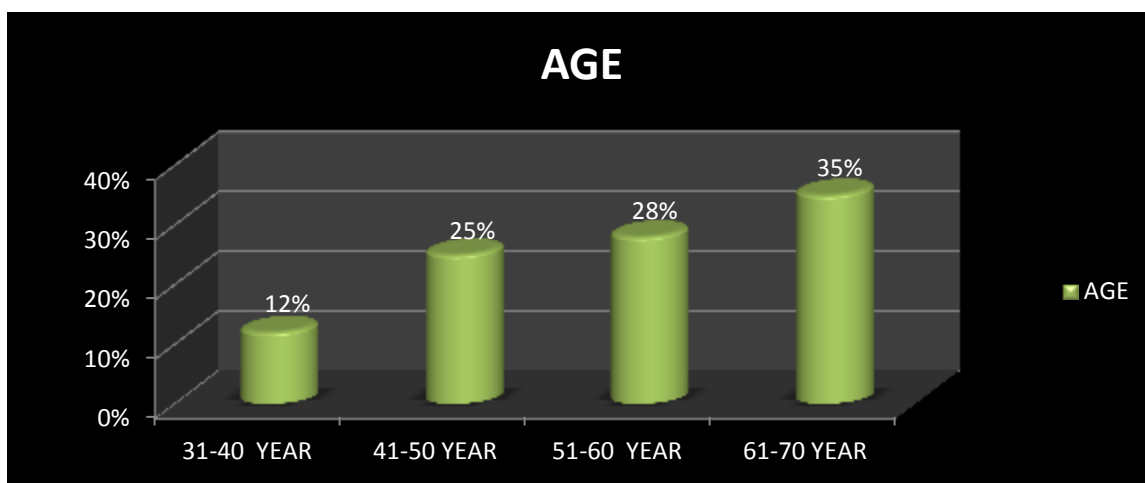


Figure:1 Column diagram showing percentage wise distribution according to their age.

2. AREA OF RESIDENCE:-

Regarding area of residence the highest percentage is 97% people were lives in rural area

and the lowest percentage is 3% people were lives in urban area.

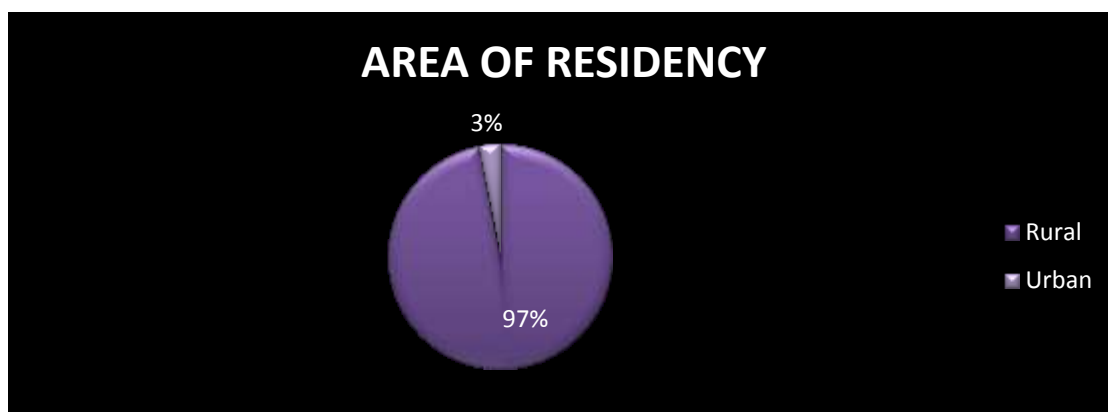


Figure: 2 Pie diagram showing percentage wise distribution according to their area of residence.

3. LANGUAGE:-

Regarding language in sample highest percentage is 94% people were having Gujarati as native language and the lowest percentage are 3% people

having Hindi as native language also other 3% people having English as native language.

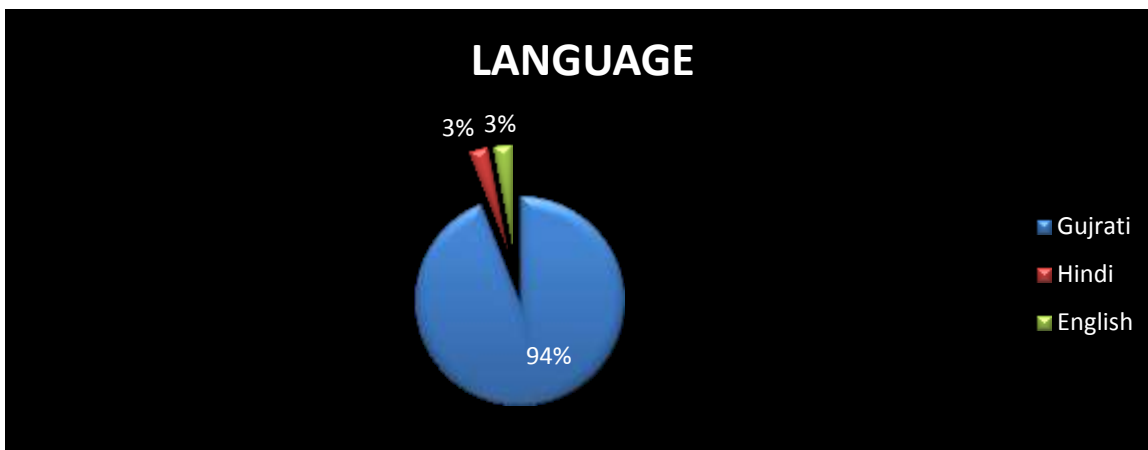


Figure:3 Pie diagram showing percentage wise distribution according to their language.

4. EDUCATIONAL STATUS:-

Regarding educational status highest percentage is 48% people were 10th and below, lowest

percentage is 3% people were illiterate, 28% people were graduate and 22% people were 12th pass.

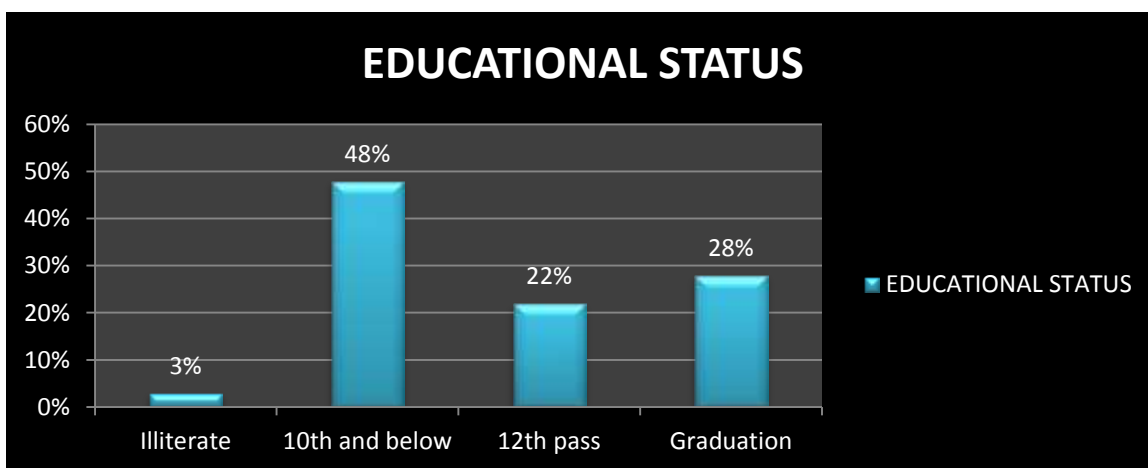


Figure :4 Column diagram showing percentage wise distribution of mothers according to their education status

5.MARITAL STATUS :-

Regarding marital status highest percentage is 75% people were married, lowest percentage is

5% people were widow and 20 % people were unmarried.

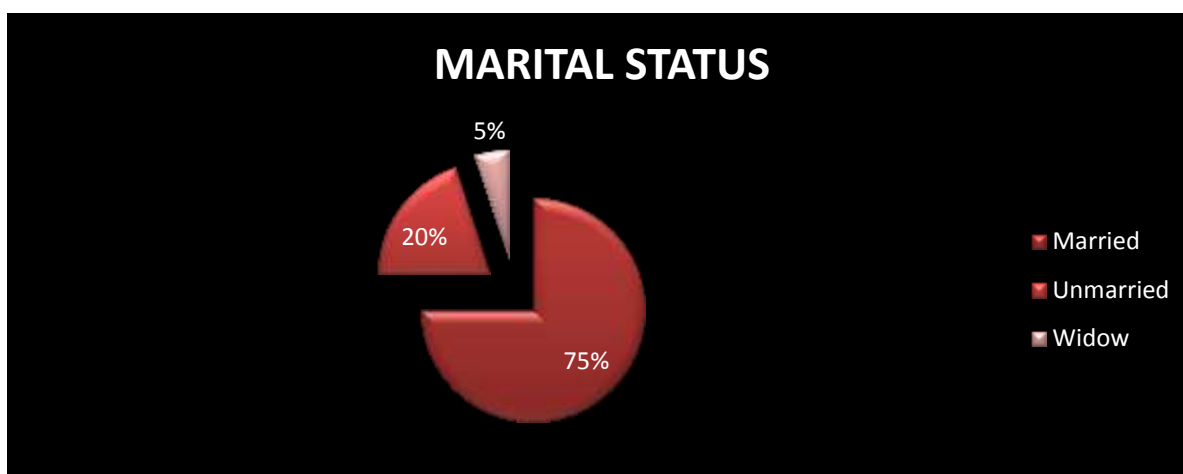


Figure:5 Pie diagram showing percentage wise distribution according to their marital status.

6. SOURCE OF KNOWLEDGE:-

Regarding sources of knowledge the highest percentage is 56% people were gain knowledge from health care provider and lowest percentage is 10% in which people gain knowledge from mass

media and another 10% in which people were gain knowledge from all mass media, family member and health care provider and 24% people were gain knowledge from family members.

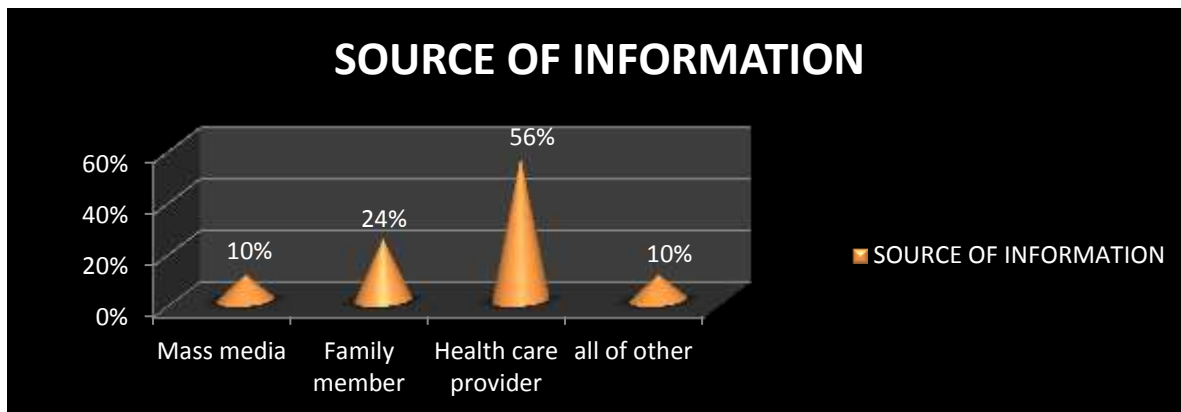


Figure:6 Doughnut diagram showing percentage wise distribution of people according to their sources of knowledge.

Data show the highest value in MEAN (9.78) and the lowest value in STANDARD DEVIATION (3.82)

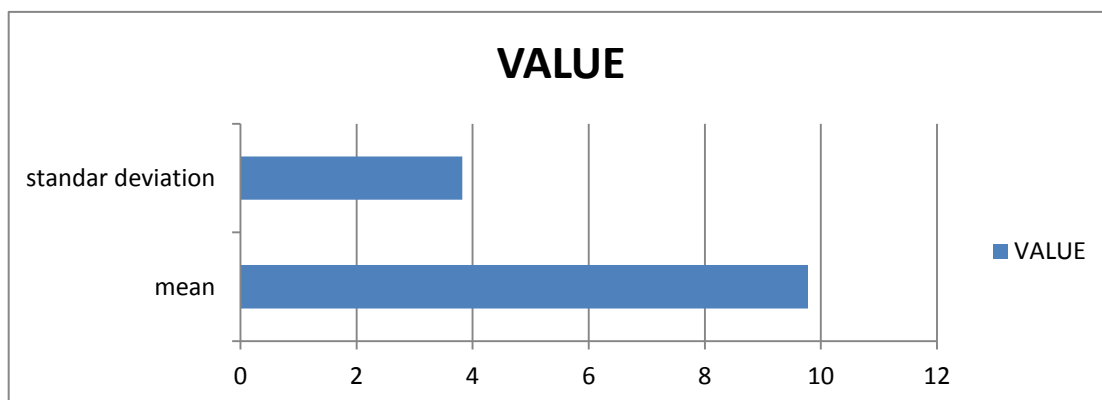


Figure:7 Bar diagram showing value of mean and standard deviation.

Table No:- 2 Frequency And Percentage Regarding Level Of Knowledge.

SR NO.	LEVEL OF KNOWLEDGE	FREQUENCY	PERCENTAGE
1	Poor	56	56%
2	Average	41	41%
3	good	3	3%

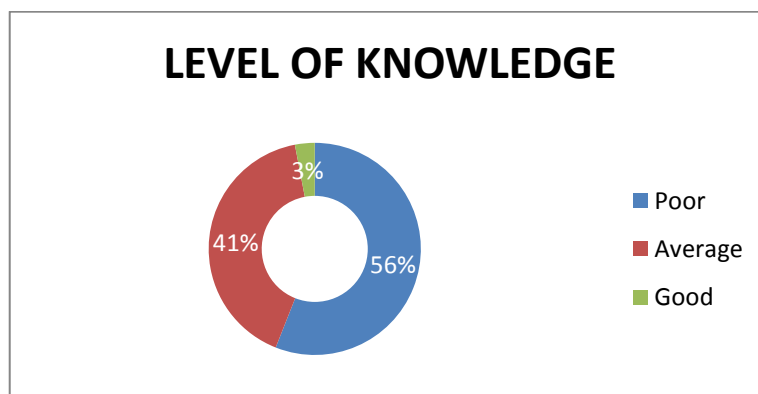


Figure :7 Doughnut diagram showing percentage of level of knowledge.

Table No 3: Association Between The Knowledge Scores On Knowledge Regarding Cardiac Rehabilitation And Demographic Variables:-

SR NO.	DEMOGRAPHIC VARIABLE	FREQUENCY	LEVEL OF KNOWLEDGE			Chi-square X ²
			POOR	AVERAGE	GOOD	
1.	Age:-					
	31-40 year	12	4	6	2	0.459 NS
	41-50 year	25	8	12	5	
	51-60 year	28	10	14	4	
	61-70 year	35	12	18	5	
2.	Area of residence:-					
	Rural	97	65	30	2	9.99 S
	Urban	3	1	1	1	
3.	Language:-					
	Gujarati	94	70	22	2	15.29 S
	Hindi	3	1	1	1	
	English	3	1	1	1	
4.	Educational status:-					
	Illiterate	3	1	1	1	2.591 NS
	10 th and below	48	18	20	10	
	12 th pass	22	8	12	2	
	Graduation	28	10	14	4	
5.	Marital status :-					
	Married	75	30	39	6	1.929 NS
	Unmarried	20	7	10	3	
	Widow	5	1	13	1	
6.	Source of Information :-					
	Mass media	10	3	5	2	2.208 NS
	Family member	24	8	13	3	
	Health care provider	56	16	36	4	
	All of above	10	3	6	1	

S = Significant at 0.05 level

NS = Non significant at 0.05 level

To identify the association between knowledge scores on cardiac rehabilitation of people and the selected demographic variables.

The table show above chi square is carried to find out the association between the knowledge on cardiac rehabilitation of the people and demographic variables.

The result show there is a significant association between area of residence and language but there was no association between age, educational status, marital status and source of information.

Discussion:

The whole research work depends on finding of study was to assess the knowledge of cardiac rehabilitation among people in selected villages of visnagar.

Conclusion:

The following conclusion are drawn from the study the knowledge of cardiac rehabilitation could be useful for people to improve their health. The expected survey result supported the knowledge of cardiac rehabilitation one of the best method to promote the overall health of people

Author's contribution statement:

Dr. B Mahalakshmi & Dr. N. Siva Subramanian, Mr. Kuldeep jain conceptualized, designed, gathers, analyzed these data and inputs were given by' **Miss Barot Sapana S, Miss Bumbadiya Meena B, Miss Bumbadiya Komal N, Miss Chaudhari Dhruval P, Mr Chenva Tarun R., Mr Vaghela Yuvraj G.** discussed the methodology, results and contributed to the final manuscript.

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Conflict of interest:

Conflict of interest declared none.

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