TJFM&PC Turkish Journal of Family Medicine and Primary Care

Original Research / Özgün Araştırma

Examining the Relationship between Self Efficacy Perception and Healthy Lifestyle Behavior of Elderly Individuals Taking Care at Home

Evde Bakım Hizmeti Alan Yaşlı Bireylerin Öz Etkililik Algıları ve Sağlıklı Yaşam Biçimi Davranışları Arasındaki İlişkinin İncelenmesi

Nuray Besleyici[1], Fatma Ersin [2]*

ABSTRACT

Some physical, mental, and social changes that occur with increasing age in elderly people reduce their functional capacities, increase their need for assistance, lengthen hospital stays, and impose a material and moral burden. The purpose of this study was to look into the relationship between self-efficacy perception and healthy lifestyle behavior in elderly people who are cared for at home. It is a descriptive investigation. The study's participants comprised of 258 elderly people. The information was gathered using the Patient Diagnosis Form, the Healthy Lifestyle Behavior Scale II, and the Self Efficacy-Sufficiency Scale.While the total point average obtained from the Healthy Lifestyle Behavior Scale-II was 123.08±22.86, the total point average of Self Efficacy-Sufficiency Scale was 72.37±15.16. The total point average of the healthy lifestyle behavior scale-II and the self-efficacy sufficiency scale were both positive, and a significant relationship at the middle level (r=.623 p=.000) was discovered. Given that self-efficacy sufficiency perception is a critical determinant of healthy lifestyle behavior, trainings that increase self-efficacy sufficiency perception while also providing sustainability may be suggested.
Key words: Home care, Self-efficacy perception, Healthy lifestyle behaviors, Elderly individuals

ÖZET

Yaşlı bireylerde artan yaşla birlikte ortaya çıkan fiziksel, zihinsel ve sosyal alanlardaki bazı değişiklikler fonksiyonel kapasitelerini azaltmakta, hastanede kalış sürelerini uzatmakta ve yardım ihtiyaçlarını artırmakta, maddi ve manevi yük getirmektedir. Bu çalışmanın amacı evde bakım alan yaşlı bireylerin öz-etkililik algıları ile sağlıklı yaşam biçimi davranışları arasındaki ilişkiyi incelemektedir. Tanımlayıcı bir çalışmadır. Araştırmanın örneklemini 258 yaşlı birey oluşturmuştur. Veriler Hasta Tanı Formu, Sağlıklı Yaşam Biçimi Davranış Ölçeği II ve Öz Yeterlik-Yeterlilik Ölçeği ile toplanmıştır. Sağlıklı Yaşam Biçimi Davranış Ölçeği-II toplam puan ortalaması 123.08±22.86, Öz Yeterlik-Yeterlilik Ölçeği toplam puan ortalaması 72.37±15.16'dır. Sağlıklı yaşam biçimi davranış ölçeği-II ile öz-etkililik ölçeği toplam puan ortalaması arasında pozitif yönde, orta düzeyde, anlamlı bir ilişki saptanmıştır (r=.623 p=.000). Sağlıklı yaşam biçimi davranışlarının öz-etkililik algısının yaşamsal bir belirleyicisi olduğu düşünüldüğünde öz-etkililik algısını artıran ve sürdürülebilirliği sağlayan hemşirelik eğitimleri önerilebilir.
Anahtar Kelimeler: Evde bakım, Öz etkililik algısı, Sağlıklı yaşam biçimi davranışları, Yaşlı bireyler

Received / Geliş tarihi: 08.09.2021, **Accepted / Kabul tarihi:** 07.01.2022

[1] Sağlık Bakanlığı, Şanlıurfa Ertuğrulgazi Aile Sağlığı Merkezi
[2] Harran Üniversitesi, Sağlık Bilimleri Fakültesi, Halk Sağlığı Hemşireliği Anabilim Dalı
***Address for Correspondence / Yazışma Adresi:** Fatma Ersin, Harran Üniversitesi Sağlık Bilimleri Fakültesi, Halk Sağlığı Hemşireliği Anabilim Dalı, Şanlıurfu-TÜRKİYE, E-mail: fatmaersin1@gmail.com

Besleyici N., Ersin F. Examining the Relationship between Self Efficacy Perception and Healthy Lifestyle Behavior of Elderly Individuals Taking Care at Home. TJFMPC, 2022;16 (1): 104-110.

DOI: 10.21763/tjfmpc.992785

INTRODUCTION

The concept of aging, which is more prevalent in developed countries, is becoming more important in developing countries, including our own..[1] According to the data of Turkey Statistical Institute, The elderly population is 9.1% in 2019. In 2019, 44.2% of the elderly population was male and 55.8% was female. According to population projections, it was predicted that the proportion of the elderly population would be 10.2% in 2023, 12.9% in 2030, 16.3% in 2040, 22.6% in 2060 and 25.6% in 2080.[2]

Many factors, including health perception, self-efficacy perception, people lived with, social environment, diseases, and healthy lifestyle behaviors, play a role in improving the health of the elderly. Increasing self-efficacy perceptions and adopting healthy lifestyle behaviors are regarded as the two most important factors. As a result, it is critical for individuals to accept responsibility for their own health, to pay attention to their health, to be informed about health, and to require the support of a health professional or institution when necessary..[3] At this stage, nurses, who will help elderly people avoid negative behaviors that are destructive and provide them with healthy lifestyle behaviors that are beneficial to their health should understand self-efficacy, which is effective in this process, by evaluating the individual's behavioral process..[4]

In the literature, it has been stated that there is a relationship between a healthy lifestyle and the perception of self-efficacy. In addition, individuals with high self-efficacy were found to perform very healthy behaviors in the field.[5-7] However, no studies demonstrating a link between this issue and elderly people receiving home care could be found. As a result, the purpose of this study was to investigate the relationship between self-efficacy and healthy lifestyle behaviors among elderly people receiving home care services..

METHODS

This descriptive study was carried out in the regions where the home care units of two hospital are in service. The study covered the period of October 2016-May 2017.

The population of the study comprised of 790 elderly people over the age of 65 who were receiving home care in Anlurfa, and 258 of them were included in the sample using the sample size calculation method. Using the stratified random sampling method, it was calculated how many elderly people would be included in the sample from the regions where the two home care units mentioned above provided services.The elderly individuals, with speech and comprehension problems in Turkish, severe hearing and vision loss, Dementia or Alzheimer's disease, and a Standardized Mini Mental Test score of less than 24 were excluded from the study. Substitutes were used in the study to replace those who died during the study (10 elderly people) or refused to participate in the study (5 elderly people).

In the collection of the data, 16-item questionnaire form[8,9] which was formed by the researchers through the literature review, Standardized Mini Mental State Examination,[10,11] Standardized Mini Mental State Examination for Illiterate Individuals[12] Healthy Lifestyle Behavior Scale II (HLBS II) [3,13,14] and Self-Efficacy Scale[4,15] were used.

HLBS II is a scale developed by Walker et al.[13] in 1987, revised in 1996.[14] and whose reliability and validity in the Turkish language were performed by Bahar et al.[3] in 2008. It is a 4-point Likert scale. The lowest score of the scale is 52 and the highest score is 208. Cronbach's alpha value is 0.94.[3] Cronbach's Alpha value in this study was determined as 0.94.

It was developed and revised by Sherer et al.[15] in 1982. Its Turkish validity and reliability were done by Gözüm and Aksayan in 1999.[6] The minimum and maximum scores that can be obtained from the scale are 23 and 115, respectively. Obtaining a high score from the scale indicates that the self-efficacy perception is also high. It is a 5-point Likert-type scale. The scale Cronbach's Alpha value is 0.81.[6] Cronbach's Alpha value of this study was determined as 0.90.

The data was evaluated using the SPSS 16.00 packaged program. The data was analyzed using descriptive statistics (number, percentage, mean), t-tests in independent groups, Mann-Whitney U tests, Kruskal-Wallis analysis, and pearson correlation analysis.

Written permission was obtained from the Ethics Committee of A University (Decision no. 16/07/13, dated 01.09.2016), institutions and individuals who would participate in the research.

RESULTS

The average age of individuals is 71.45 ± 4.24 (Min-Max:65-90). 77.9% of the elderly individuals were in the 65-74 age range, 52.7% were females, 59.3% were married and 40.7% were illiterate. It was detected that 93.0% of the elderly individuals were

unemployed, 79.8% had social security and 96.5% had children. 82.9% of the individuals stated that they were living with their families. In addition, it was determined that 77.5% of the participants had a chronic disease, 61.5% of those with chronic disease had at least one chronic disease, 39.9% had been receiving home care service for 2 years and 83.7% received support from their family members regarding their care. It was determined that 44.2% of the elderly individuals perceived their health as moderate, 89.9% of them were satisfied with home care service and 5.4% of those who were not satisfied with home care service were not satisfied because they found the duration of care insufficient.

A significant difference is observed between health assurance and HLBS II total score and mean score of self-efficacy scale ($p<0.05$) (Tablo 1).

It was seen that there was a positively and moderately significant relationship between the HLBS II sub-dimensions and scale total score and Self-Efficacy Scale total mean score (r=.623 p=.000) (Table 2)

Table 2. The correlation between healthy life style behaviors scale II sub-dimensions and total mean score and self-efficacy scale total mean score

	Healthy Life Style Behaviors Scale II Sub-dimensions Mean Scores						
Self-Efficacy Scale Mean Scores	**Health Responsibility**	**Physical Activity**	**Nutrition**	**Spiritual Development**	**Interpersonal Relations**	**Stress Management**	**Total**
	r=.490* p=.000	r=.369* p=.000	r=415* p=.000	r=.614* p=.000	r=.557* p=.000	r=.512* p=.000	r=.623* p=.000

*Pearson Correlation Analysis

DISCUSSION

In the study, as the ages of the elderly individuals increase, HLBS II mean scores decrease. A significant difference is observed between the mean scores of HLBS II physical activity sub-dimension by age. In the studies conducted, it is stated that the age of individuals does not affect HLBS II total and sub-dimension mean scores,[11] scale mean scores increase with age[16] and physical activity level decreases with age.[17,18] This study's results indicate that the loss of strength that occurs with age reduces physical activity. Furthermore, the decrease in the mean score of the self-efficacy scale with increasing age can be explained by the fact that as people age, they become unable to perform their own care and daily life activities, and they become more reliant on others for their needs. In the study, a statistically significant difference was determined between the physical activity sub-dimension mean score of the married individuals. Similar to this study, a significant difference was detected between HLBS II physical activity sub-dimension by marital status in the study conducted by Çelik et al.[9] In other study, no difference was found between marital status and HLBS II.[19] The fact that married people's HLBS II mean scores are high is an expected result due to their responsibilities. In the study, it was seen that HLBS II mean scores of the individuals at high school and above educational level were high and there was a significant difference between educational status and HLBS II nutrition sub-dimension mean score. Kaçan Softa et al.[19] found that there was a significant difference between educational status and HLBS II, as the educational status increased, the mean scores that the elderly individuals obtained from HLBS II also increased. Differently from this study, it was observed that there was a significant relationship between HLBS II interpersonal relations sub-dimension and total mean scores of the illiterate individuals.[10] In the study conducted by Polat et al.,[16] it was determined that health responsibility, self-actualization, nutrition and interpersonal support sub-dimension mean scores were significantly high in the individuals who were primary school graduates. The fact that the mean scores of individuals who were high school graduates or above are high in the study is an expected result. However, the fact that the study included a large number of illiterate people and a small number of people with high school and higher education levels may have influenced the outcome. It was seen that the HLBS II mean scores were higher in the individuals living with their families. The literature also supports this result.[20] In addition,

it is seen that the self-efficacy scale mean scores of the individuals living with their families are higher. The fact that the elderly individuals living with someone have high HLBS II and self-efficacy scale mean scores is an expected result, because it is thought that they are highly likely to contact and receive support from the people with whom they live. In the study, it is seen that the HLBS II sub-dimensions and total mean scores of the individuals who have health insurance are higher compared to those who do not have health insurance. Furthermore, it was detected that health assurance affected HLBS II health responsibility, physical activity, nutrition and stress management sub-dimensions. In the study conducted by Dalak,[20] a significant difference was found between social security and HLBS II. In the study of Yuvaklıgil,[21] no significant relationship was found between the health assurance status of elderly individuals and their HLBS II mean scores. The result obtained from the study suggests that individuals with health assurance access to health services more easily and this affects their lifestyle behaviors positively. Likewise, individuals with health insurance had a higher mean self-efficacy scale score when compared to others. The study's findings show that elderly people who have health insurance are more likely to engage in healthy behaviors.

In the study, as the durations of home care increase, the mean scores of elderly individuals decrease. In a study conducted, the health responsibility and stress management sub-dimension mean scores of the elderly individuals who lived in nursing homes for less than a year were found to be higher.[10] Furthermore, it was noticed that as elderly people's home care durations increased, their self-efficacy scale scores decreased. According to the findings of this study, as the duration of care increases, elderly people's beliefs about realizing behaviors and their chances of exhibiting healthy lifestyle behaviors decrease. The reason for this is that elderly people require more assistance as the duration of their care increases, and they are unable to meet their needs at the desired level due to strength losses.As the health perception of elderly individuals progresses from very good to very bad, the HLBS II mean score and self-efficacy scale mean score decrease. In a study conducted, it was determined that individuals who perceive their health positively and have high level of self-efficacy perception exhibit more healthy lifestyles behaviors.[22] In the study conducted by Yuvaklıgil[21] the HLBS II total mean score of the elderly individuals, who evaluated their health as "good", was found to be higher compared to others. In addition, in other studies conducted, it was concluded that elderly individuals who evaluated their health as “good" had higher level of healthy lifestyle behaviors.[23] In the study, the fact that scale mean scores decrease as the health perception decreases is an expected result.

In this study, it was observed that there was a positive, moderate and significant relationship between HLBS II and self-efficacy scale mean scores. Similarly, in the study conducted by Owens,[24] it was determined that there was a significant relationship between elderly individuals' self-efficacy perceptions and HLBS II total scores. Self-efficacy perception was the only determinant on healthy lifestyle behaviors.[24] In their study, Conn,6 Kwong and Kwan[25] reported that there was a positive relationship between self-efficacy perceptions and healthy lifestyle behaviors of elderly individuals and self-efficacy perception was the most powerful determinant of health behaviors. The result obtained from this study suggests that self-efficacy perception is an important determinant in terms of the realization of healthy lifestyle behaviors.

CONCLUSION AND SUGGESTIONS

As a result, it was revealed that there was a relation between HLBS II and mean self-efficacy scores. When it is considered that self-efficacy perception is an important determinant of healthy lifestyle behaviors in elderly people, it is suggested that efforts to increase self-efficacy perception be planned, implemented, and sustained.. '

Conflict of Interest: No conflicts of interest.

Funding: No financial support was received

The study was presented as an oral presentation at the 2nd International 3rd National Public Health Nursing Congress.

Table 1. Comparison of the healthy lifes style behaviors scale ıı mean scores and self- efficacy scale total meanscores of the elderly ındividuals receiving home care service by demographic characteristics

Scales									
Healthy Life Style Behaviors Scale II Sub-dimensions Mean Scores									**Self- Efficacy Scale**
		Health Responsibility	Physical Activity	Nutrition	Spiritual Development	Interpersonal Relations	Stress Management	Total	Total
Characteristics	**n**	**X̄±SD**	**X̄±SD**	**X̄±SD**	**X̄±SD**	**X̄±SD**	**X̄±SD**	**X̄±SD**	**X̄±SD**
Age									
65-74	201	21.95 ± 5.57	13.47 ± 5.14	21.18 ± 4.00	23.89 ± 5.14	24.32 ± 5.39	19.15 ± 4.10	123.99±23.58	72.58 ±15.86
75-80	57	21.24 ± 4.92	11.08 ± 3.35	21.08 ± 3.29	23.26 ± 4.93	24.26 ± 5.23	18.91 ± 3.81	119.85±19.99	71.63 ± 12.51
Statistical Value		t=.863 p=.389	**t=4.169 p=.000**	t=.175 p=.861	t=.826 p=.410	t=.075 p=.940	t=.407 p=.685	t=1.206 p=.229	t=.096 p=.675
Gender									
Female	136	22.13 ± 5.52	12.70 ± 4.74	21.46 ± 3.67	23.62 ± 5.02	24.54 ± 5.57	19.20 ± 3.98	123.67± 22.49	71.75 ±15.65
Male	122	21.41 ± 5.33	13.22 ± 5.07	20.83 ± 4.03	23.90 ± 5.19	24.04 ± 5.09	18.99 ± 4.10	122.41± 23.35	73.06 ± 14.63
Statistical Value		t=1.054 p=.293	t= -.843 p=.400	t=1.307 p=.192	t= -.434 p=.664	t=.741 p=.459	t=.424 p=.672	t=.441 p=.660	t= -.691 p=.490
MaritalStatus									
Married	153	21.96 ± 4.98	13.47 ± 4.89	21.39 ± 3.78	24.22 ± 4.85	24.59 ± 5.29	19.32 ± 4.06	124.95 ±27.85	72.58 ± 15.38
Single	105	21.55 ± 6.04	12.18 ± 4.82	20.83 ± 3.94	23.07 ± 5.38	23.89 ± 5.43	18.78 ± 4.00	120.32 ±23.60	72.07 ± 14.90
Statistical Value		t=592 p=.554	**t=2.101 p=.037**	t=.585 p=.257	t=.132 p=.076	t=.754 p=.303	t=.907 p=.287	t=1.609 p=.109	t=.263 p=.793
Education Status									
Literate	95	21.27 ± 5.03	12.43 ± 4.66	20.47 ± 3.63	23.38 ± 5.01	24.00 ± 5.31	18.62 ± 3.87	120.00 ±21.90	71.38 ± 14.20
Primary-Secondary School	44	21.54 ± 4.75	12.93 ± 5.07	21.27 ± 3.36	23.97 ± 4.99	24.25 ± 5.16	19.61 ± 3.50	123.59± 20.77	71.90 ± 24.52
High School and Higher	14	26.00 ± 6.91	13.92 ± 5.58	22.35 ± 5.56	26.35 ± 5.45	24.92 ± 6.33	19.64 ± 4.95	134.21± 30.17	75.14 ± 14.68
Statistical Value		KW=.345 p=.557	KW=1.971 p=.160	**KW=4.904 p=.027**	KW=.183 p=.669	KW=.417 p=.518	KW=.982 p=.322	KW=3.831 p=.280	KW=2.607 p=.456

Individuals living with									
Alone	16	20.81 ± 6.53	12.43 ± 4.08	21.12 ± 4.48	21.25± 5.47	20.82 ± 5.39	18.81 ±4.29	115.25± 23.26	68.12 ±16.07
Family	214	21.89 ± 5.19	13.14 ± 5.05	21.25 ± 3.67	24.07 ± 4.88	24.70 ± 5.21	19.17 ±3.94	124.24±21.92	72.43 ± 14.79
Relatives	28	21.57 ± 6.64	11.71 ± 4.01	20.53 ± 4.81	22.78± 6.09	23.32 ± 5.72	18.75 ±4.71	118.67±27.49	74.32 ± 17.46
Statistical Value		KW=1.026 p=.599	KW=2.474 p=.290	KW=.286 p=.867	KW=4.603 p=.100	**KW=9.643 p=.008**	KW=.395 p=.821	KW=3.274 p=.195	KW=2.636 p=.268
Working State									
Not Working	240	21.66 ± 5.41	12.85 ± 4.90	21.18 ± 3.84	23.62 ± 5.14	24.16 ± 5.35	19.01 ±3.95	122.50 ± 22.82	72.17 ±15.14
Working	18	23.55 ± 5.58	14.27 ± 4.72	20.94 ± 4.02	25.55 ± 4.13	26.22 ± 5.07	20.27 ±4.98	130.83 ±22.65	75.00 ± 15.62
Statistical Value		U=-1.409 p=.159	U=-1.662 p=.097	U=-.095 p=.924	U=-1.458 p=.145	U=-1.573 p=.116	U=-.187 p=.235	U=-1.649 p=.099	U= -.616 p=.538
Health Insurance									
Available	206	22.22 ± 5.28	13.46 ± 5.14	21.47 ± 3.87	23.92 ± 4.96	24.57 ± 5.23	19.39 ±3.91	125.04±22.62	72.43 ± 14.49
Unavailable	52	20.09 ± 5.75	10.90 ± 3.07	19.96 ± 3.54	23.09 ± 5.59	23.26 ± 5.73	17.96 ±4.34	115.28±22.38	68.19 ± 17.11
Statistical Value		**t=2.548 p=.011**	**t=3.438 p=.001**	**t=2.552 p=.011**	t=1.044 p=.297	t=1.574 p=.117	**t=2.303 p=.022**	**t=2.786 p=.006**	**t=2.243 p=.026**

REFERENCES

1. Ministry of Health Turkey, Turkey Healthy Aging Action Plan and Implementation Program (2015-2020) 2015, https://sbu.saglik.gov.tr/Ekutuphane/Yayin/508, accessed:14.09.2021.

2. Turkish Statistical Institute. Seniors with Statistics, 2019. https://data.tuik.gov.tr/Bulten/Index?p=Istatistiklerle-Yaslilar-2019-33712

3. Bahar Z, Beşer A, Gördes N, Ersin F, Kıssal A. Healthy Life Style Behavior Scale II: A Reliability And Validity Study. Journal Of Cumhurıyet University School of Nursing 2008;12(1):1-13.

4. Gözüm S. Construct validation of Turkish form of the self·efficacy scale; the relationship between self·efficacy perception of cope with stress. Atatürk Üniviversitesi Hemşirelik Yüksekouku Dergisi 1999; 2(1):35-43.

5. Berg GV, Hedelin B, Sarvimaki AA. A holistic approach to the promotion of older hospital patients' health. Int Nur Rev 2005 Mar;52(1):73-80.

6. Conn VS. Older women: social cognitive theory correlates of health behavior. Women & Health 1997; 26(3):71-85.

7. Chang SH, Wung SF, Crogan NL. Improving activities of daily living for nursing home elder persons in Taiwan. Nurs Res 2008;57(3):191-198.

8. Yaşar EŞ. Research The degree of family caregivers burden and related factors affect caregiver burden. Master's Thesis, Ege University, İzmir,2009;51-68.

9. Çelik A, Kardaş KÖ, Karadakovan A. Loneliness status and healthy life style behaviors of nursing home residents. İzmir Kâtip Çelebi Üniversitesi Sağlık Bilimleri Fakültesi Dergisi 2017;2(3):17-23.

10. Folstein MF, Folstein S, Mc Hugh PR. "Mini mental state" a practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res 1975;12(3):189-198.

11. Güngen C, Ertan T, Eker E, Yaşar R, Engin F. Reliability and validity of the standardized mini mental state examination in the diagnosis of mild dementia in Turkish population. Turkish Journal of Psychiatry 2002;13(4):273-281 79.

12. Ganguli M, Ratcliff G, Chandra V. A hindi version of the mmse: the development of a cognitive screening instrument for a largely illiterate rural elderly population in India. Int J GeriatrPsychiatry 1995; 10:367-377.

13. Walker SN, Sechrist KR, Pender NJ. The health promoting lifestyle profile development and psychometric characteristics. Nurs Res 1987;36(2):76-80.

14. Walker SN, Hill-Polerecky DM. Psychometric evaluation of the Health Promoting Lifestyle Profile II. Unpublished manuscript, University of Nebraska Medical Center.1996. https://deepblue.lib.umich.edu/bitstream/handle/2027.42/85349/HPLP_II-Dimensions.pdf?sequen-ce=2, accessed:14.09.2021.

15. Sherer M, Maddux JE. The self-efficacy scale construction and validatian. Psychological Reports 1982; 51:663-71.

16. Polat Ü, Kahraman BB, The relationship between the healthy lifestyle behaviors of elderly ındividuals and the perceived social support. Fırat Medical Journal 2013; 18(4):213-218.

17. Lima MG, Barros MBA, Cesar CLG, Goldbaum M, Carandina L, Alves MCGP. Health-related behavior and quality of life among the elderly: a population based study. Rev Saúde Pública 2011; 45(3),485-493.

18. Dinç Horasan G. Ünal B, Ergör G (Ed). Physical activity, Turkey chronic diseases and frequency of risk factors study, Ministry of Health. Ankara, 2013;167-188.

19. Kaçan SH, Bayraktar T, Uğuz C. Elders' perceived social support systems and factors effecting their healthy life-style behaviour. EIRJ 2016; 9: 1-12.

20. Dalak H. The relationship between healthy lifestyle behaviours and social support with essential hypertension persons. Master's Thesis, Mersin Üniversitesi Sağlık Bilimleri Enstitüsü, Mersin. 2010;70.

21. Yuvaklıgil Z. Determine The Relationship Between Perceived Socıal Support Levels, The Size of Social Networks with Healthy Lifestyle Behavior and Affecting Factors in Elderly People, Adnan MenderesUniversityInstitute of Health Sciences, Master's Thesis, Aydın. 2017;35.

22. Mi-Lim Y, Joo KY. Factors affecting health-promoting behaviors of community-dwelling korean older women. J Gerontol Nurs 2010;36(10):42-50.

23. Yılmaz F, Çağlayan Ç. The effects of healthy lifestyle on the quality of life among elderly. Turkish Journal of Family Practice 2016; 20(4):129-140.

24. Owens L. The relationship of healthlocus of control, self-efficacy, health literacy, and health promoting behaviors in older adults. The Degree of Doctor of Philosophy, University of Memphis, United States.2006;43

25. Kwong EWY, Kwan AYH. Participation in health-promotingbehaviour: ınfluences on community-dwelling older Chinese people. J Adv Nurs 2007;57(5):522-5.