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Research Article

Effectiveness of Video-Assisted Teaching on Knowledge Regarding Prevention of Alzheimer's Disease Among Senior Citizens in Selected Old Age Homes, Bengaluru

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Abstract

Alzheimer's disease is a progressive neurodegenerative disorder and the leading cause of dementia among older adults, for which no cure currently exists, making early awareness and prevention essential. This study aimed to evaluate the effectiveness of video-assisted teaching on knowledge regarding prevention of Alzheimer's disease among senior citizens in selected old age homes in Bengaluru. An evaluative approach with a one-group pre-test post-test design was adopted. Sixty senior citizens were selected through non-probability purposive sampling, and their knowledge was assessed using a structured questionnaire before and after (on the 8th day) video-assisted teaching. The pre-test showed that 76.6% of participants had inadequate knowledge, whereas the post-test showed that 90% had adequate knowledge. The mean knowledge score increased from 12.58 to 25.13, with a calculated 't' value of 53.15 ($p < 0.05$), indicating a statistically significant improvement. A significant association was also found between pre-test knowledge and source of information. The study concludes that video-assisted teaching was effective in improving knowledge regarding prevention of Alzheimer's disease among senior citizens.

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KEYWORDS: Alzheimer's disease; Video-assisted teaching; Knowledge; Prevention; Senior citizens; Old age homes.

1. INTRODUCTION

“Though those with Alzheimer’s might forget us, we as a society must remember them”.

-Scott Kirschenbaum

Alzheimer’s (AHLZ-high-merz) is a disease of the brain that causes problems with memory, thinking and behavior. It is not a normal part of aging. Alzheimer’s gets worse over time. Although symptoms can vary widely, the first problem many people notice is forgetfulness severe enough to affect their ability to function at home or at work, or to enjoy hobbies. The disease may cause a person to become confused, get lost in familiar places, misplace things or have trouble with language. Currently, there is no cure for Alzheimer’s and no way to stop the underlying death of brain cells. But drugs and non-drug treatments may help with both cognitive and behavioral symptoms.¹

Alzheimer’s disease is a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks. In most people with the disease those with the late-onset type symptoms first appear in their mid-60s. Early-onset Alzheimer’s occurs between a person’s 30s and mid-60s and is very rare. Alzheimer’s disease is the most common cause of dementia among older adults.²

Individuals with mild symptoms often may continue to work, drive and participate in their favorite activities, with occasional help from family members and friends. However, Alzheimer’s disease is a progressive disease, meaning it gets worse with time. How quickly it progresses and what abilities are affected vary from person to person. As time passes, more neurons are damaged and more areas of the brain are affected. Increased help from family members, friends and professional caregivers is needed to carry out activities of daily living, such as dressing and bathing, and to keep the individual safe. Individuals with Alzheimer’s may develop changes in mood, personality or behavior. One behavior that is of special concern is wandering, which refers to individuals walking away from a particular location and not being able to retrace their steps. Individuals who wander may become lost, putting them at risk of significant injury and death.³

Alzheimer disease (AD) is a neurodegenerative disorder featuring gradually progressive cognitive and functional deficits as well as behavioral changes and is associated with accumulation of amyloid and tau depositions in the brain. Cognitive symptoms of AD most commonly include deficits in short-term memory, executive and visuospatial dysfunction, and praxis. Several rarer variants of AD with relative preservation of memory have been recognized. Clinical assessment, including cognitive testing, remains critical for the diagnosis and staging of AD, although recent advances in amyloid imaging and genetics show great promise for facilitating early and pre symptomatic diagnosis of AD and its discrimination from other neurodegenerative disorders.⁴

Alzheimer’s illness, as indicated by researchers, is brought about by a blend of genetic, conduct and ecological elements that harm the cerebrum after some time. Alzheimer’s infection is brought about by specific hereditary anomalies that almost ensure an individual will gain the condition under 1% of the time. This disintegration in protein freedom limit is age-related, constrained

by cerebrum cholesterol, and connected other neurodegenerative diseases. Unsettling influences in memory and language, visuospatial direction, and higher chief capacity are clinical signs of Alzheimer’s infection.⁵

Globally, the population is aging rapidly. Between 2015 and 2050, the proportion of the world’s population over 60 years will nearly double, from 12% to 22%. Mainly reasons are that the people become older, the human body structure further aging, each organ function gradually appear obstacles, body resistance gradually weak, activity is reduced, and function is lost. There are five kinds of disease are the most common. Hypertension chronic bronchitis, diabetes heart disease and mental disease.⁶

The focus on dementia and Alzheimer’s disease has continued to increase in recent years. In September 2020, the National Health Commission announced the management of screening for Alzheimer’s disease within basic national public healthcare services (National Health Office Disease Control Letter, 2020, No. 726) and instituted the requirement that public awareness rates regarding the prevention and treatment of AD in pilot areas be increased to 80% by 2022. All relevant medical staff in grassroots healthcare services should thus have knowledge about the prevention and treatment of dementia.⁷

Alzheimer’s worsens over time. Alzheimer’s is a progressive disease, where dementia symptoms gradually worsen over a number of years. In its early stages, memory loss is mild, but with late-stage Alzheimer’s, individuals lose the ability to carry on a conversation and respond to their environment. On average, a person with Alzheimer’s lives 4 to 8 years after diagnosis but can live as long as 20 years, depending on other factors.⁸

Alzheimer’s disease (AD) is an age-related neurodegenerative disease that is the most prevalent source of dementia in the elderly. Though primarily afflicting those aged 65 and over, AD also is increasingly being observed in younger people starting from around age 40 (Zhu et al., 2015; NHS 2021). It has been estimated that AD currently strikes one in 20 people over the age of 65 (up to 35 million in 2015) and that the rate doubles about every 5 years beyond age 65 to where about one third of all people aged 85 or older may have AD (NIH 2019; NHS, 2021). The average duration of AD after diagnosis is 10 years, but as many as 20 years may elapse from initiation of mild cognitive impairment, wherein one does not suffer any significant barriers, to impacted functioning in daily activities or work, to where participating in life’s activities becomes problematical (Sutherland et al., 2013). AD is not curable or reversible at this time.⁹

2. OBJECTIVES OF THE STUDY

- To assess the pre-test knowledge regarding prevention of Alzheimer’s disease among senior citizens in selected old age Homes, Bengaluru.
- To implement video assisted teaching on knowledge regarding prevention of Alzheimer’s disease among senior citizens in selected old age Home, Bengaluru.
- To evaluate the effectiveness of video assisted teaching on knowledge regarding prevention of Alzheimer’s disease among senior citizens in selected old age Home, Bengaluru.

- To determine the association between pre-test scores on knowledge regarding prevention of Alzheimer's disease with selected socio demographic variables among senior citizens in selected old age Homes, Bengaluru.

3. METHODOLOGY

Research methodology is the systematic way of doing research to solve the problem. It comprises of the variables under the study; the methods used for data collection and the statistical methods used for analyzing the data and the logic behind it.

This chapter deals with the methodology of the present study which includes research approach, research design, variables under the study, study setting, population and sample, sampling technique, criteria for sample selection, description of the tool, pilot study, data collection process and plan for data analysis. The present study aims to "Effectiveness of video assisted teaching on knowledge regarding prevention of Alzheimer's disease among senior citizens in selected old age Homes, Bengaluru".

Research approach

The selection of research approach is the basic procedure for conducting research enquiry. The research approach helps the investigator to determine how to collect the data and analyze the data. In view to the nature of the problem selected for the study and the objectives to be accomplished, Experimental research approach was considered appropriate to assess the knowledge regarding prevention of Alzheimer's disease among senior citizens.

Research design

Research design is a structural framework for implementation, including selection of design, data collection methods, sampling framework and data analysis plan. A pre-experimental one-group, pre-test and post-test design was adopted for the study. The pre-test was carried out for assessing through structured questionnaire the knowledge regarding prevention of Alzheimer's disease among senior citizens and the video assisted teaching was imparted. Post-test was conducted on the eighth day following the pre-test and video assisted teaching.

Figure 2: Pre-experimental one-group pre-test post-test design was adopted in the study

Subjects	Pre-test	Intervention	Post-test
Senior Citizens who are staying at Sri Mahalakshmi Old Age Home and Basaveshwaranagar, Mahalakshimpura, Bengaluru	Day 1 Assessment of knowledge using a structured questionnaire regarding prevention of Alzheimers Disease.	Day 1 Video-assisted teaching on knowledge regarding prevention of Alzheimers disease.	After 7 days, Video Assisted teaching program on knowledge of regarding prevention of Alzheimers disease using same structured knowledge questionnaire.

O1: Administration of structured questionnaire for assessing the knowledge regarding prevention of Alzheimer's disease among senior citizens.

X: Administration of video assisted teaching in small groups for assessing the knowledge regarding prevention of Alzheimer's disease among senior citizens.

O2: Administration of structured questionnaire for assessing the gain in knowledge regarding prevention of Alzheimer's disease among senior citizens on the eighth day.

The study design comprises of three phases as shows in the figure 2, phase1 deals with preparation, validation of tool and video assisted teaching. Phase 2 consists of the assessment of knowledge regarding prevention of Alzheimer's disease among senior citizens by structured questionnaire (o1) and administration of video assisted teaching on the same day (X), phase 3 comprises of post-test on the eighth day using the same structured questionnaire (O2) by using same video assisted teaching, and finally evaluation of effectiveness of video assisted teaching by descriptive and inferential statistics.

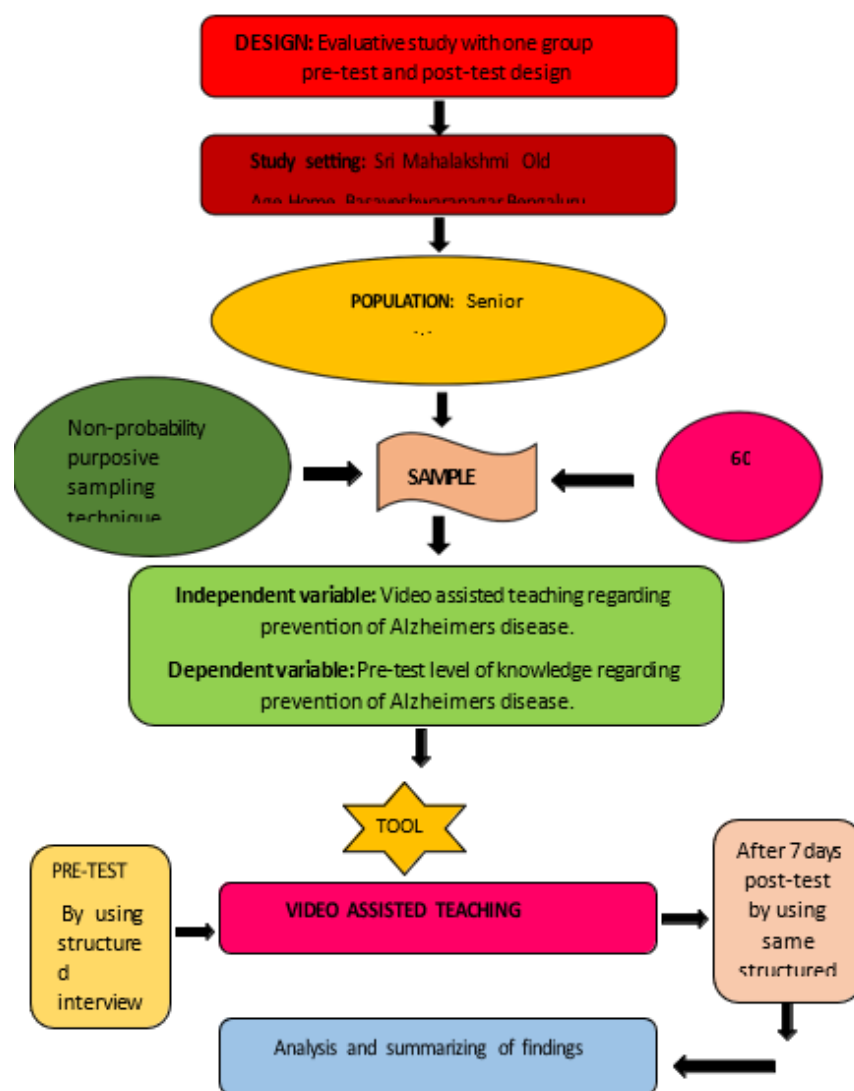


Fig 2: Schematic Representation of the Study

Variables under the study:

Independent variable: In this study independent variable was video assisted teaching regarding prevention of Alzheimer's disease among senior citizens.

Dependent variable: In this study dependent variable was post-test Knowledge scores regarding prevention of Alzheimer's disease among senior citizens.

Demographic variables: It includes the age, religion, religion, type of family, gender, marital status, education, income, previous knowledge, sources of information, habits, practice, treatment.

Setting

The study was conducted at Sri Mahalakshmi Old Age Home Basaveshwaranagar and Mahalakshmpura, Bengaluru. This setting was selected for the study on the basis of its

geographical proximity, feasibility of conducting the study and availability of samples.

Population

In the present study target population were senior citizens staying at Sri Mahalakshmi old Age Home Basaveshwaranagar and Mahalakshmpura, Bengaluru.

Sampling technique

Sampling is a process in which we select a part of the population which meets the pre-test criteria of the researcher. In this study, non-probability purposive sampling technique was used to draw the subjects.

Sample

Sample consists of the 60 senior citizens who met the inclusion criteria and who are Staying in Sri Mahalakshmi Old Age Home Basaveshwaranagar and Mahalakshmpura, Bengaluru.

Criteria for sample selection

The sampling frame structured by the researcher consists of the following criteria. **Inclusion criteria:** Senior citizens who are willing to participate in the study, who are able to read and write Kannada and who are available at the time of data collection.

Exclusion criteria: Senior citizens, who are sick during the data collection and who are having visual and hearing impairment.

4. RESULTS

Section –1: Description of Demographic Characteristics of Respondents.

Table No. 1: Frequency and Percentage distribution of respondents according to their age N=60.

Sl. NO	Age(years)	Number	Percentage
1	60-65	35	58.3
2	65-70	14	23.3
3	70-75	07	11.7
4	>75	04	6.7
Total		60	100.0

The above table depicts that majority 35 (58.3%) of the respondents belongs to 60- 65 years of age, 14 (23.3%) were aged between 66-70 years, 07 (11.6%) were aged between 71-75 years and followed by 04 (6.6%) were 76 and above of aged.

Fig 3: Percentage distribution of respondents according to their Age

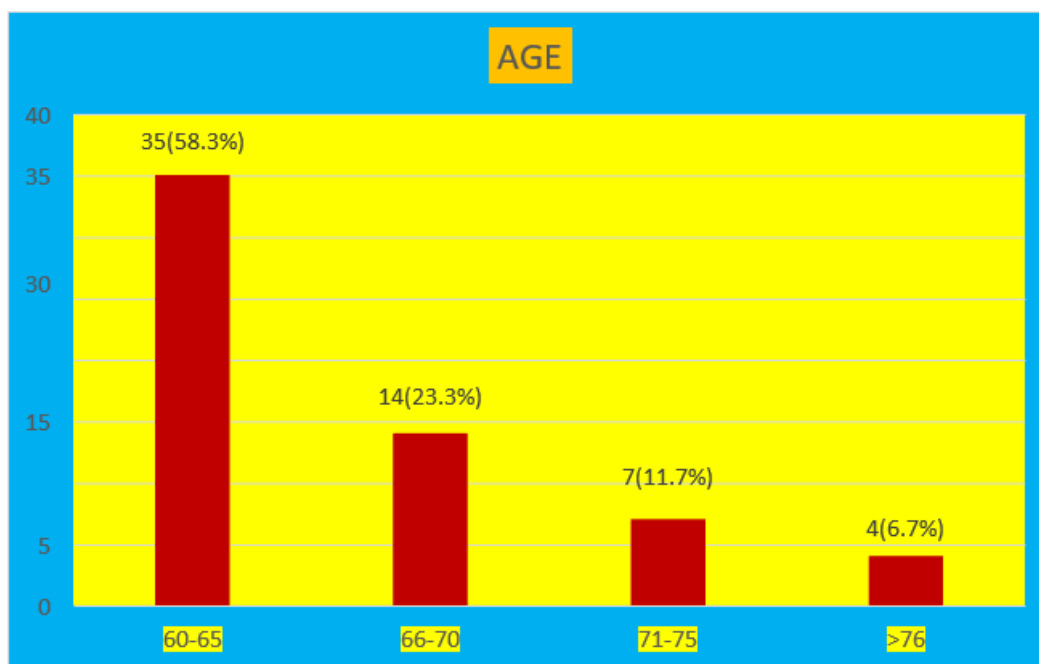


Table 2: Frequency and Percentage distribution of respondents according to their Religion N=60

Sl. NO	Religion	Number	Percentage
1	Hindu	52	86.7
2	Muslim	06	10.0
3	Christian	02	3.3
4	Others	00	0.0
Total		60	100.0

The above table revealed that 52 (86.7%) of respondents were Hindus followed by 06(10.0%) were Muslims and 02(3.3%) were Christians.

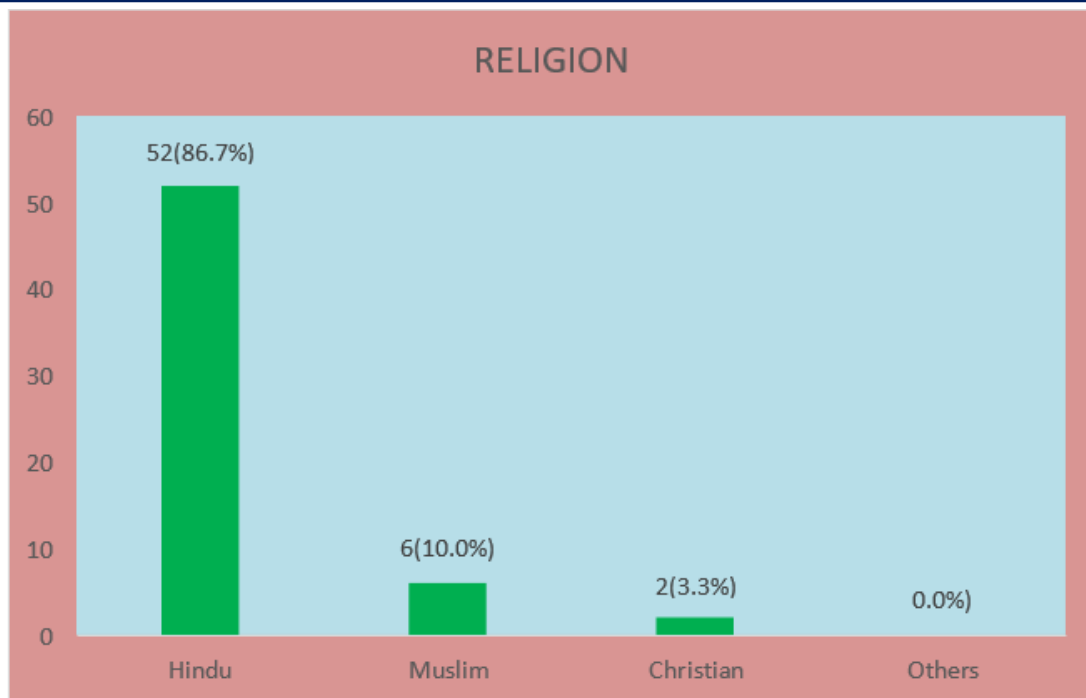


Figure 4: Frequency and Percentage distribution according to their Religion.

Table No. 3: Frequency and Percentage distribution of respondents according to their Type of Family. N=60

Sl.NO	Type of Family	Number	Percentage
1	Nuclear Family	46	76.7
2	Joint Family	14	23.3
3	Extended Family	00	0.0
Total		60	100.0

the above table revealed that majority 46 (76.7%) of the respondents came from a nuclear family and remaining 14 (23.3%) of the respondents came from a joint family.

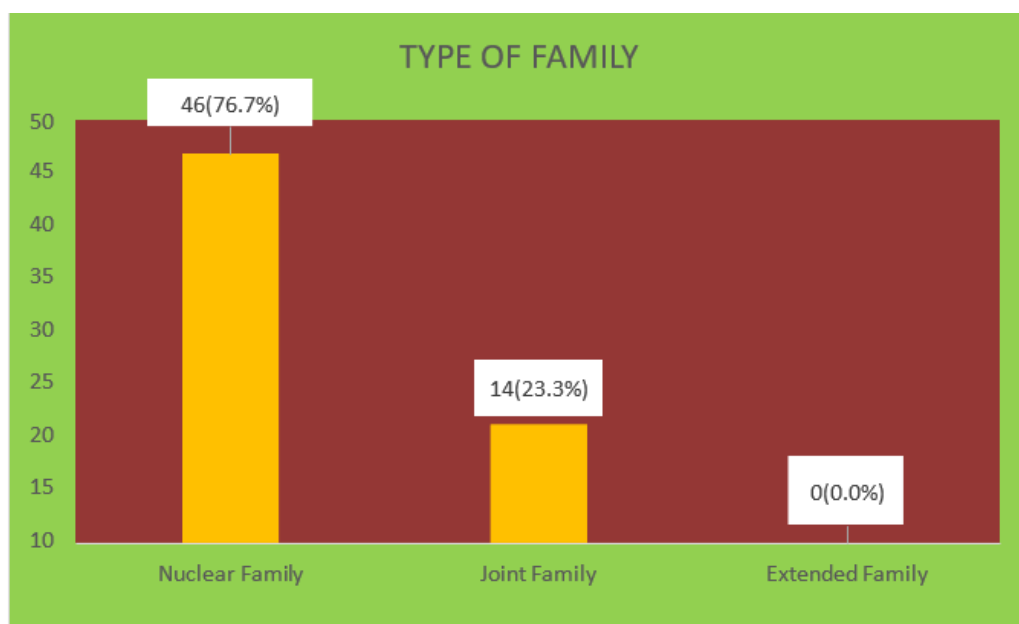
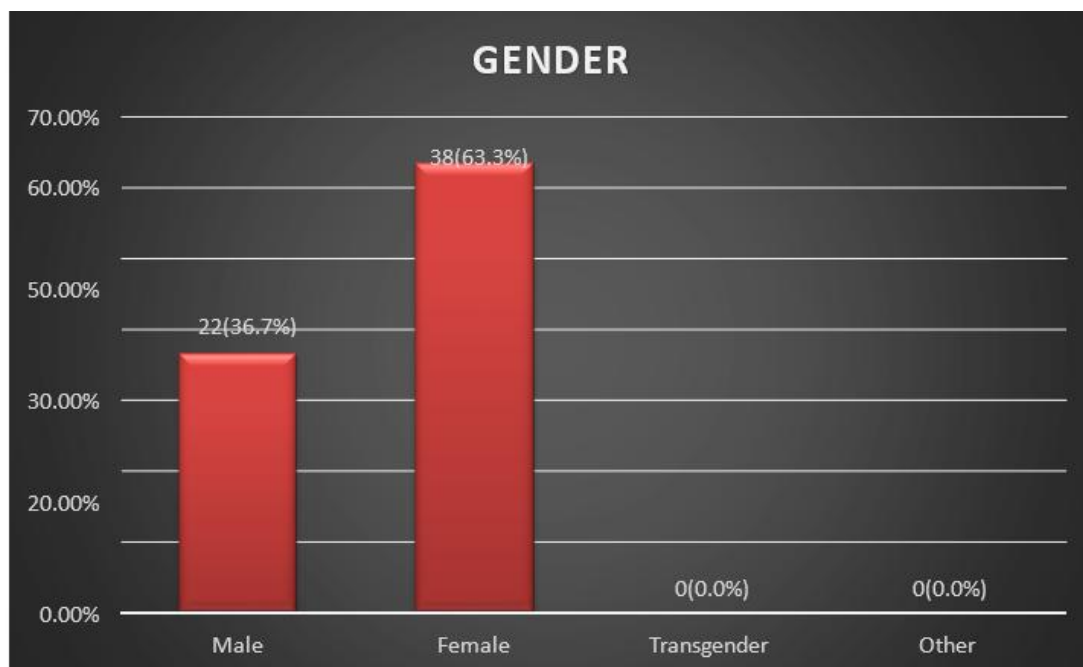


Figure 5: Frequency and Percentage distribution of according to their Type of family.

Table 4: Frequency and Percentage distribution according to their Gender N=60

SL.NO	Gender	Number	Percentage
1	Male	22	36.7
2	Female	38	63.3
3	Transgender	0	0.0
4	Other	0	0.0
Total		60	100.0

The above table shows that majority 22 (36.7%) of respondents were Males and remaining respondents 38 (63.3%) who were Females.

**Figure 6:** Frequency and Percentage distribution according to their Gender**Table 5:** Distribution of respondents according to their Marital Status N=60

SL.NO	Marital Status	Number	Percentage
1	Married	44	73.3
2	Unmarried	00	0.0
3	Widow	16	26.7
4	Separated	00	0.0
Total		60	100.0

The above table shows that majority 44 (73.3%) of the respondents were married and 16 (26.7%) of the respondents were widows.

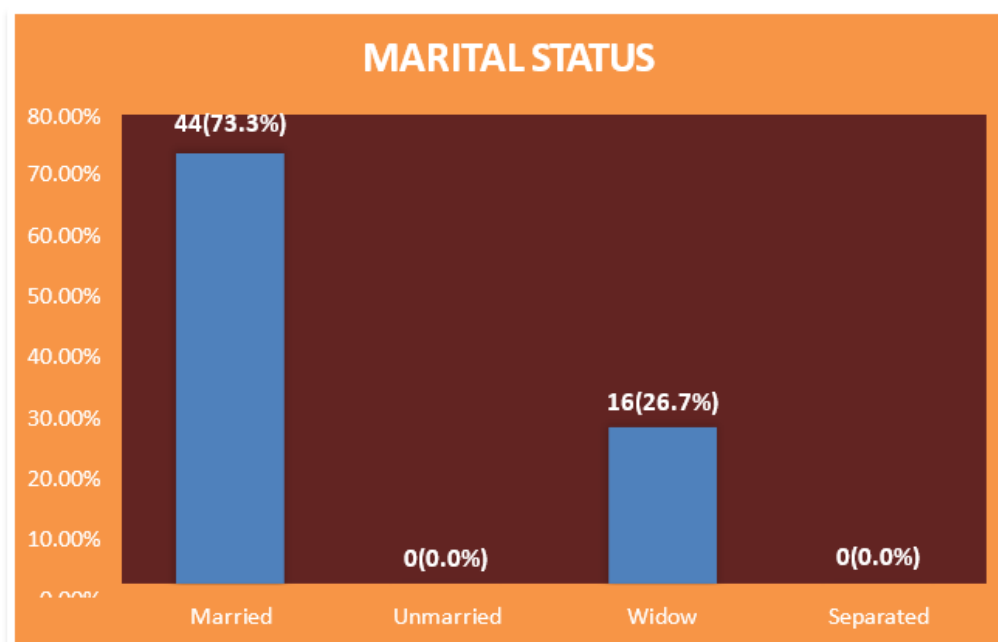


Figure 7: Percentage distribution of respondents according to their Marital status

Table 6: Distribution of respondents according to their Education N=60

Sl.NO	Education	Number	Percentage
1	No formal education	00	0.0
2	Basic education	27	45.0
3	Higher Education	25	41.7
4	Graduation & above	08	13.3
Total		60	100.0

The above table shows that majority 27 (45.0%) of the respondents had basic education followed by 25 (41.7%) of the

respondents who had higher education and remaining 8 (13.3%) of the respondents were graduates and above.

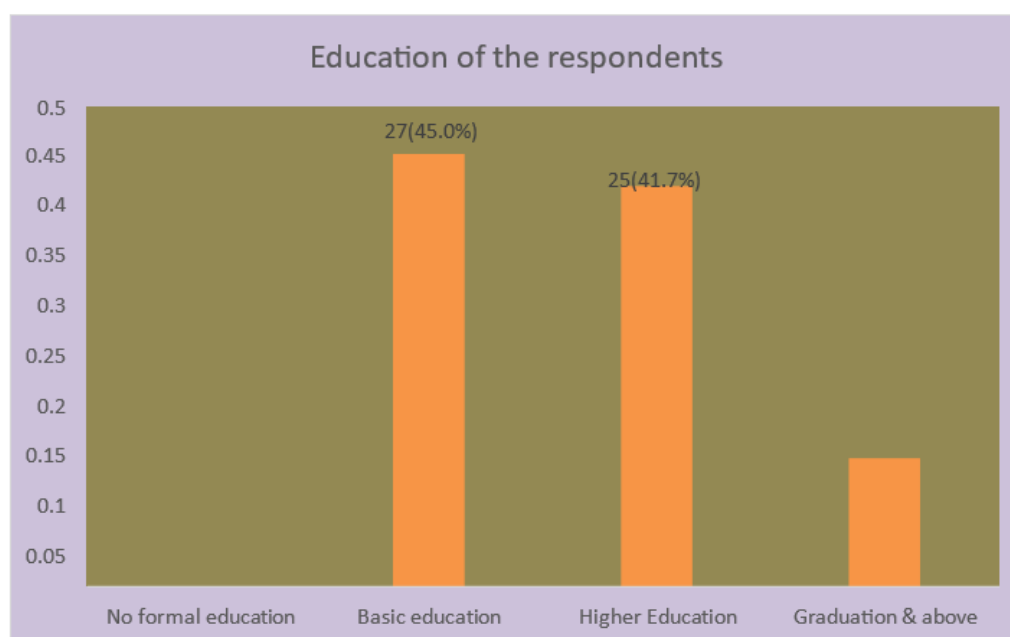


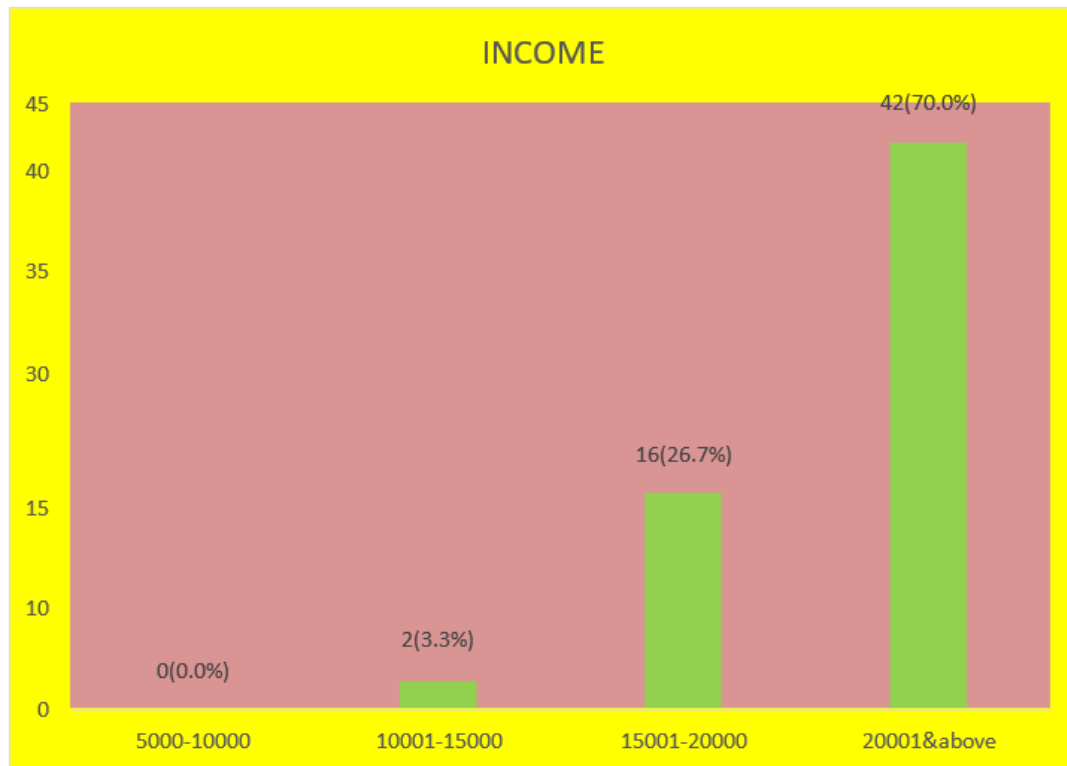
Figure 8: Percentage distribution of respondents according to their Education

Table 7: Distribution of respondents according to their Income N=60

Sl.NO	Income	Number	Percentage
1	5000-10000	00	0.0
2	10001-15000	20	3.3
3	15001-20000	16	26.7
4	20001& Above	42	70.0
Total		60	100

The above table reveals that 42 (70.0%) of the respondents having 20001& above income per month followed by 16 (26.7%) of the respondents were having 15001-20000 income

per month and 2 (3.3%) of the respondents were having 10001-15000 income per month.

**Figure 9:** Percentage distribution of respondents according to their Income per month.**Table 8:** Distribution of respondents according to their Previous Knowledge regarding Alzheimers disease N=60

Sl.NO	Previous knowledge	Number	Percentage
1	Yes	07	11.7
2	No	53	88.3
Total		60	100

The above table shows that majority 53 (88.3%) of the respondents had no previous knowledge regarding Alzheimers

disease and remaining 7(11.7%) of the respondents had previous knowledge regarding Alzheimers disease.

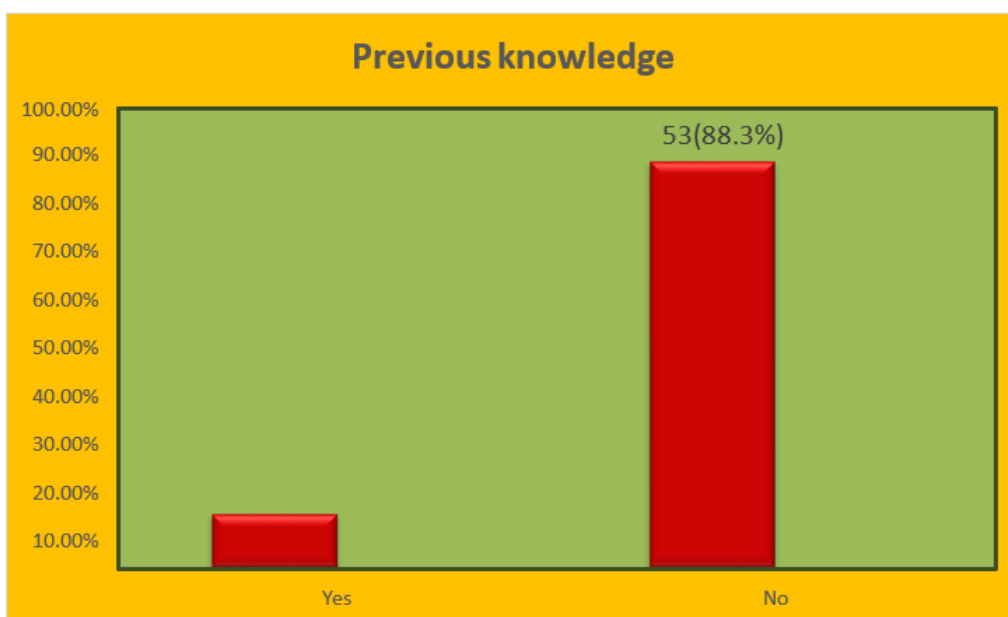


Figure 10: Percentage distribution of respondents according to their previous knowledge regarding Alzheimer's disease.

Table 9: Distribution of respondents according to their Sources of information, N=60

Sl.NO	Sources of Information	Number	Percentage
1	Television	23	38.3
2	Newspaper/Books	10	16.7
3	Social media	15	25.0
4	Health Personnel	12	20.0
Total		60	100.0

The above table reveals that 23 (38.3%) of the respondents heard about Alzheimer's disease through Television followed by 15 (25.0%) who heard about it through social media, 12

(20.0%) heard it through health personnel and 10 (16.7%) of respondents heard about it through Newspaper/ Books.

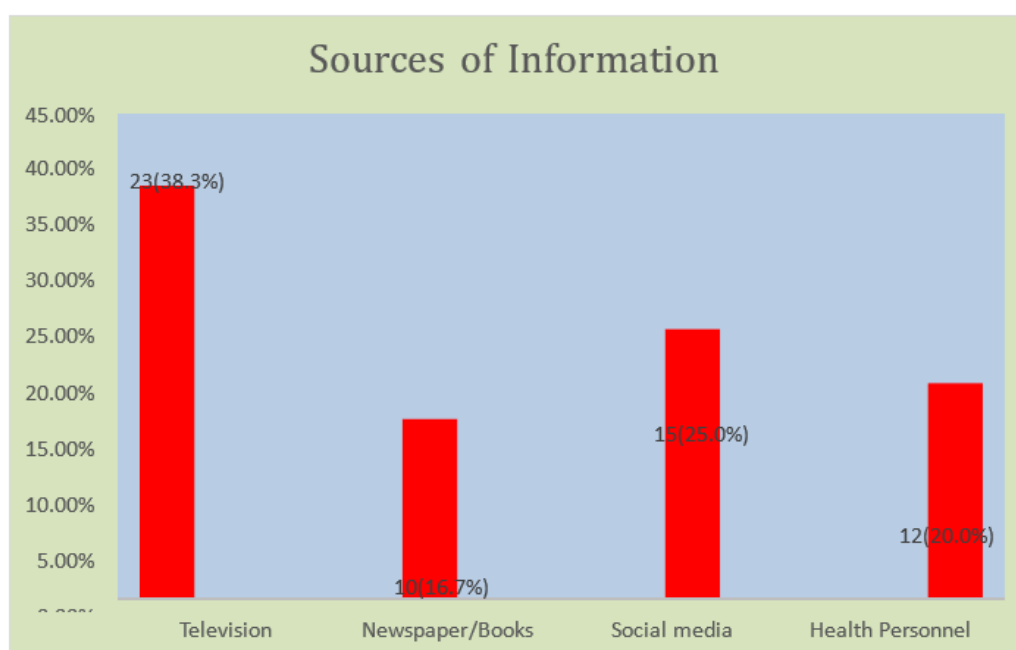


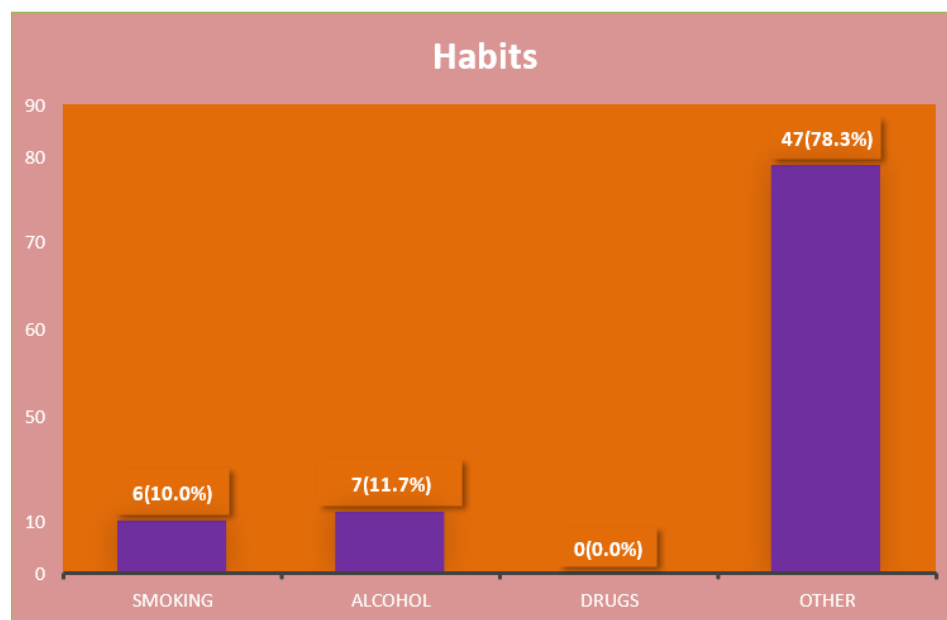
Figure 11: Percentage distribution of respondents according to their Sources of Information

Table 10: Distribution of respondents according to their Habits N=60

SI.NO	Habits	Number	Percentage
1	Smoking	06	10.0
2	Alcohol	07	11.7
3	Drugs	00	0.0
4	No Habits	47	78.3
Total		60	100.0

The above table reveals that 47 (78.3%) of the respondents has no habit followed by 07 (11.7%) of the respondents were

having a habit of alcohol and remaining 06 (10.0%) of the respondents were having a habit of smoking.

**Figure 12:** Percentage distribution of respondents according to their Habits.**Table 11:** Distribution of respondents according to their Practice N=60

SI.NO	Practice	Number	Percentage
1	Yoga	06	10.0
2	Exercise	26	43.4
3	Meditation	11	18.3
4	Walking	17	28.3
Total		60	100.0

The above table reveals that 26 (43.4%) of the respondents were practicing exercise followed by 17 (28.3%) of the respondents were practicing walking, 11 (18.3%) of the respondents were

practicing meditation and 06 (10.0%) of respondents were practicing yoga.

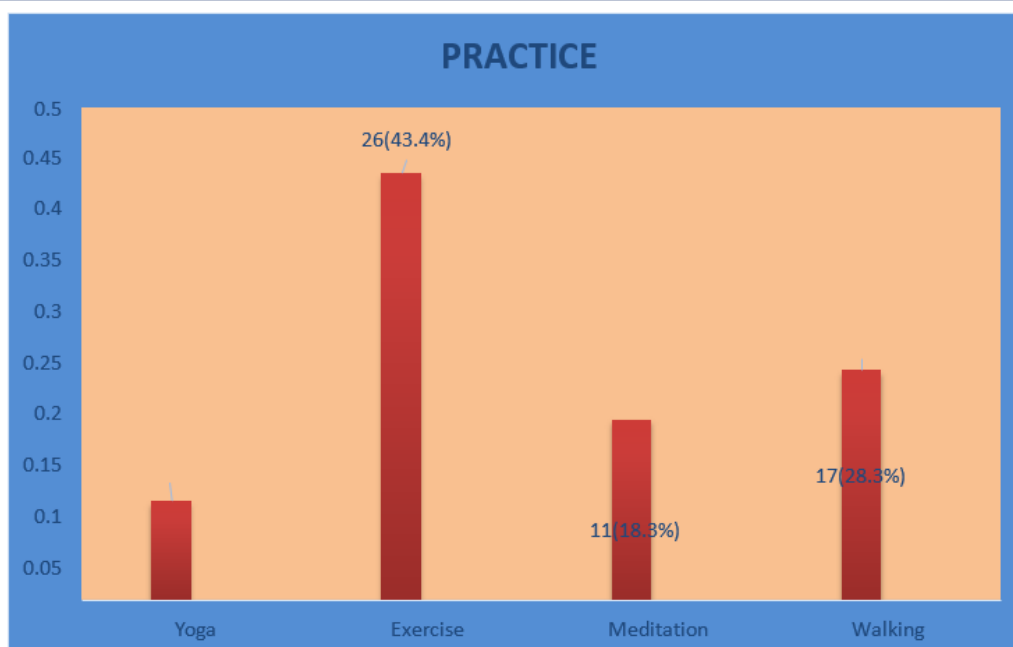


Figure 13: Percentage distribution of respondents according to their practice.

Table 12: Distribution of respondents according to their Treatment for any other Illness N=60

Sl.NO	Treatment	Number	Percentage
1	Hypertension	26	43.3
2	Diabetic Mellitus	22	36.7
3	Psychiatric illness	12	20.0
4	Other	00	0.0
Total		60	100.0

The above table reveals that 26 (43.3%) of the respondents were under treatment for hypertension and remaining 22 (36.7%) of the respondents were under treatment for Diabetic mellitus.

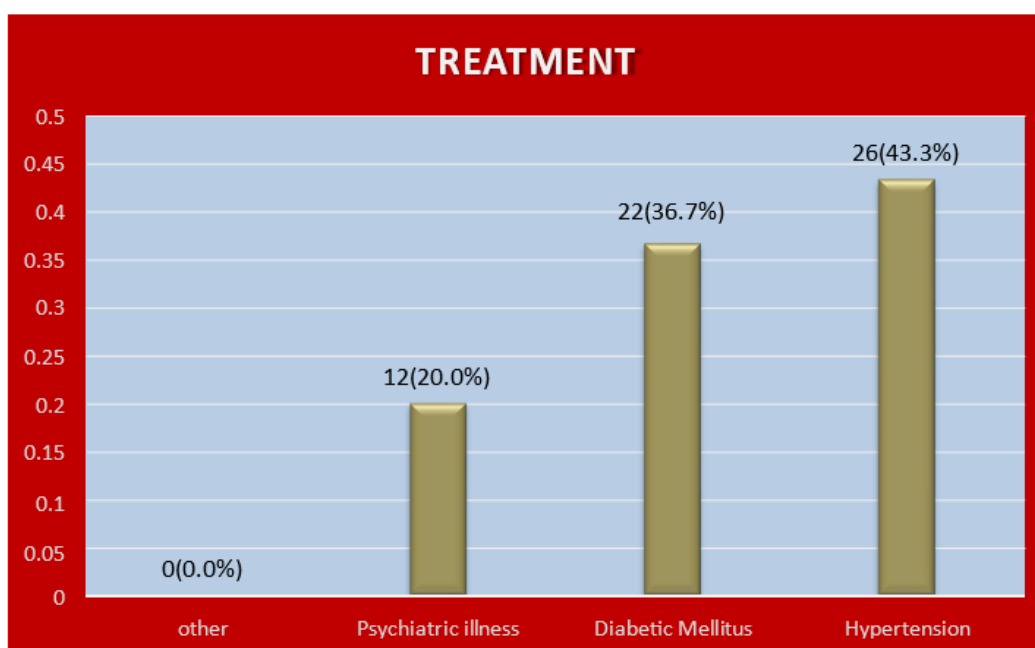


Figure 14: Percentage distribution of respondents according to them Treatment for any other illness

SECTION II: Description of Aspect-Wise Pre-Test and Post-Test Knowledge of Respondents Regarding Prevention of Alzheimer's Disease.

Table 13: Distribution of aspect-wise pre-test knowledge scores of respondents regarding prevention of Alzheimers disease. N=60

Knowledge aspects	No. of items	Max. scores	Mean	Mean %	SD
Basic concepts regarding prevention of AD	03	03	1.20	40.0	0.73
Causes, risk factors, signs & Symptoms, diagnosis of AD	10	10	4.20	42.0	0.88
Stages and complications of AD	06	06	2.58	43.05	0.75
Preventive measures of AD	11	11	4.60	41.81	0.88
Overall knowledge	30	30	12.5	41.9	1.57

The above table shows that the maximum mean percentage obtained by the sample found in the aspect of Stages and complications of AD 43.05% followed by Causes, risk factors, signs & Symptoms, diagnosis of AD 42% followed by

Preventive measures of AD 41.81% and least mean percentage obtained Basic concepts regarding prevention of AD 40%. overall mean percentage of pre-test knowledge score was 41.9% with the standard deviation of 1.57.

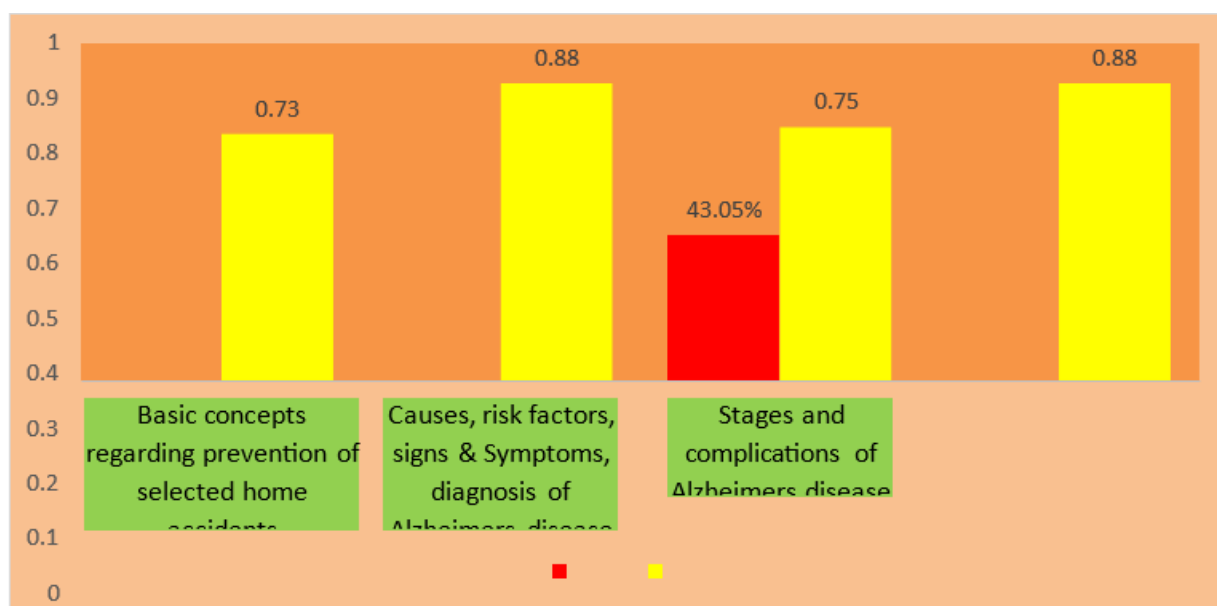


Figure 15: Distribution of aspect-wise pre-test knowledge scores of respondents regarding prevention of Alzheimers disease.

Table 14: Distribution of aspect-wise post-test knowledge scores of respondents regarding prevention of Alzheimers disease N=60

Knowledge aspects	No. of items	Max. scores	Mean	Mean %	SD
Basic concepts regarding prevention of AD	03	03	2.8	90.50	0.45
Causes, risk factors, signs & Symptoms, diagnosis of AD	10	10	8.1	81.70	0.85
Stages and complications of AD	06	06	05.0	83.33	0.75
Preventive measures of AD	11	11	9.2	84.09	0.79
Overall knowledge	30	30	25.13	83.6	1.7

The above table reveals that the maximum mean percentage obtained by the sample was found in the aspect of Basic concepts regarding prevention of AD 90.50% followed by Preventive measures of AD 84.09% followed by Stages and complications

of AD 83.33% and causes, risk factors, signs & Symptoms, diagnosis of AD 81.70%. The overall mean percentage of post-test knowledge score was 83.6% with the standard deviation of 1.7.

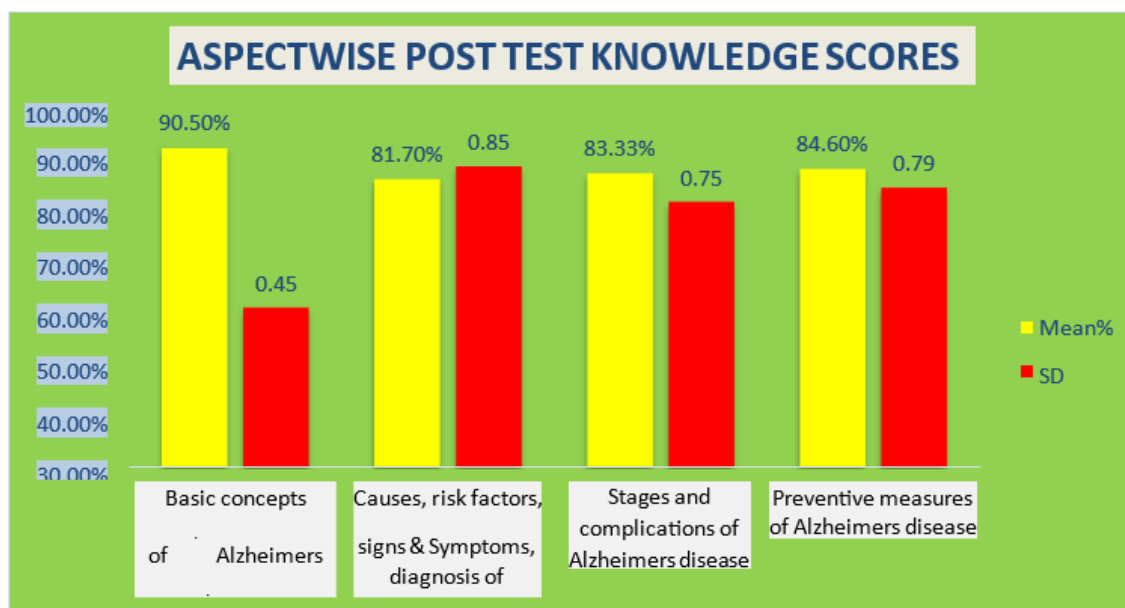


Figure- 16: Distribution of aspect-wise post-test knowledge scores of respondents regarding prevention of Alzheimers disease.

TABLE- 15: Classification of pre-test and post-test knowledge scores according to knowledge level of Senior citizens. N=60

Sl no.	Knowledge level	Pre-test		Post-test	
		Frequency	%	Frequency	%
1	Inadequate	46	76.6	00	0.0
2	Moderate knowledge	14	23.3	06	10.0
3	Adequate	00	0.0	54	90.0
Total		60	100	60	100

The above table shows that majority 46 (76.6%) of the respondents had Inadequate knowledge, 14 (23.3%) of the respondents had moderate knowledge and no respondents had adequate knowledge in pre-test and 54 (90.0%) of the

respondents had adequate knowledge, 06 (10.0%) of the respondents had moderate knowledge in post- test regarding prevention of Alzheimers disease.

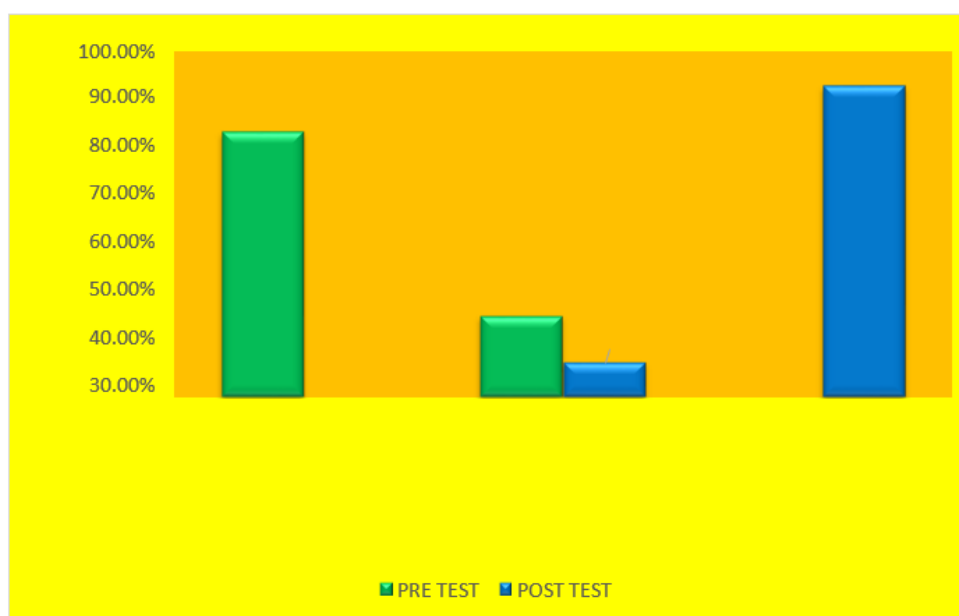


Figure-17: Distribution of pre-test and post-test knowledge scores according to knowledge level of the respondents.

SECTION III: Description of Overall Pre-Test and Post-Test Knowledge Scores of Respondents Regarding Prevention of Alzheimer's Disease.

Table 16: Overall Pre-test and Post-test knowledge scores of respondents regarding prevention of Alzheimers disease, N=60

Overall scores	Pre-test		Post-test		't' value	Df	Inference
	Mean	SD	Mean	SD			
	12.58	1.57	25.13	1.7			

From the table 16, it is evident that the obtained 't' value 53.15 was greater than the 2.00 table value at 0.05 level of significance. It means there is gain in knowledge level of senior citizens regarding prevention of Alzheimers disease. This supports that video assisted

teaching on prevention of Alzheimers disease was effective in increasing the knowledge level of senior citizens.

SECTION IV: Association of Pre-Test Knowledge Scores of Senior Citizens with Their Selected Demographic Variables

Table 17: Association between pre-test knowledge scores of senior citizens with their selected demographic variables regarding prevention of Alzheimer's disease.

Sl. NO	Pre-test knowledge		Chi-sq	Df	p-value	Result
	≤ M	>M				
Age						
60-65	23	12				
66-70	06	06				
71-75	03	04				
>76	01	03	4.31	3	0.2299	NS
Religion						
Hindu	28	24				
Muslim	04	02				
Christian	01	01				
Others	00	00	0.35	3	0.9504	NS
Type of Family						
Nuclear	28	18				
Joint	05	09				
extended	00	00	2.60	1	0.1069	NS

Gender						
Male	13	09				
Female	20	18			0.21	1
Marital Status						
Married	24	20				
Unmarried	00	00			0.01	1
Widow	09	07				
Education						
No Formal Education	00	00				
Basic Education	14	13				
Higher Education	15	10				
Graduation & above	04	04			0.29	2
Income						
5000-10000	00	00				
10001-15000	02	00				
15001-20000	08	8				
>20001	23	19			1.21	2
Previous Knowledge						
Yes	3	4				
No	30	23			0.46	1
Sources of Information						
Television	10	13				
Newspaper/books	03	07				
Social Media	10	05			8.06	3

Health Personnel	10	02				
Habits						
Smoking	03	03				
Alcohol	06	01				

Drugs	00	00	3.03	2	0.2198	NS
Nothing Practice	24	47				
Yoga	06	00	5.58	3	0.1339	NS
Exercise	13	13				
Meditation	06	05				
Walking	08	09				
Treatment			0.18	2	0.9139	NS
Hypertension	15	11				
Diabetic Mellitus	12	10				
Psychiatric Illness	06	06				
Others	00	00				

The above table shows that knowledge score of senior citizens regarding prevention of Alzheimers disease was not associated with their selected variables such as age, occupation, religion, type of family, gender, marital status, education, income, previous knowledge, habits, practice, treatment. But it was highly associated with sources of information with chi-square p-value less than 0.05.

5. DISCUSSION AND CONCLUSION

The findings of the study revealed that there is significant difference in the mean pre-test and post-test knowledge scores of senior citizens. The mean post-test knowledge scores were higher than mean pre- test scores. There was significant improvement in the knowledge after the intervention among the senior citizens. It can be concluded the video assisted teaching was effective in improving the knowledge of senior citizens, H1 is accepted. There is significant association between the pre- test knowledge scores and selected demographic variable such as source of information. Therefore, H2 is accepted.

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