HEALTH AND SOCIAL STATUS OF SENIOR CITIZENS IN RURAL AREAS

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ABSTRACT:

Research Problem: What is the quality of life of the elderly people, as also the available support system, in rural areas?

Objectives:

i) To determine the demographic profile of elderly

ii) To assess the socio-economic, nutritional, health, morbidity and dependency status, and health care utilization.

Study Design: Population based cross sectional study.

Setting: Community Development Block - Lakhanmajra

Participants: Persons above the age of 65 years.

Sample Size: 809 elderly above the age of 65 years.

Study Variables: Demographic profile, Literacy, Occupation, Health, Nutrition, Mobility, Dependency, Substance abuse, Support system.

Statistical Analysis: By simple proportions.

Result: In this study, majority of the elderly were self reliant and mobile, being an asset to the family and led socially useful and productive lives. Their predominant problems were visual impairment, joint pains, respiratory diseases and hearing impairment. Joint family and government pension was the major support system to the elderly. However, there is an imperative need to organize education, training and special service programmes for the elderly at the village level.

Key words: Demographic profile, Socio-economic status, Nutrition, Health, Dependency, Joint family, Visual impairment, Joint problems, Respiratory diseases.

INTRODUCTION:

Due to progressive health and developmental measures, life expectancy has risen to 62 years in India, and is likely to rise further in the coming years. This has contributed to a sharp rise in over-all population in general and of aged in particular. This demographic shift has several implications in managing the problems of elderly. The joint family system, a sheet anchor for the care of elderly people, is on the decline and is a matter of special concern. Magnitude of the problems, the spectrum of chronic diseases, and disabilities amongst aged in future put additional demand on resources which are so scarce. The available information on the subject of aged, for comprehensive planning of programme, is too scanty and patchy. Similarly, the status of new information through operational and applied research on the subject of ageing is limited. In the past, I.C.M.R. and Helpage India has strived to collect some information, but it is too patchy and inadquate[1]. Similarly, National Organization Sample Survey Organization, Census Data of India and National Family Health Survey Data provided some information of interest on elderly people [2,3]. There are no well defined indicators or measurements of health, nutrition and psychological status of the elderly population. In view of this grim background, this small effort was made to undertake rapid assessment of the situation of aged in rural areas with the following aims and objectives:

i) To know the demographic profile of aged.

ii) To determine health, disability , dependency and disease status of the elderly.

iii) To ascertain the health care requiremens.

The community based study was carried out in a rural area of Haryana, in Community Development Block, Lakhanmajra, covering a population of one primary health centre area (PHC Chiri), distributed in six villages. The Integrated Child Development Services are operating in this area since 1976. Anganwadi workers are in position in all these villages. The household registers of anganwadi workers were used to identify the target population of aged, 65 years above.

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12 medical interns and one postgraduate were used as field investigators. Two days orientation training was organized at PHC Chiri and village Chiri. The thrust areas of training were: to ascertain correct age by use of local events calender, method of interview, sequencing of questions and observation of elderly for obvious deviations. Each investigator practised interview on two elderly cases in the presence of preceptor, apart from interviewing some elderly in outpatient department of PHC Chiri.

The instrument developed by NIPHC, Delhi was used to collect the information by interview technique, observation of elderly and study of limited home based records. The quality of data collection was ensured through spot supervision on sample basis as also by sample checks of filled - in forms and in discussion session every evening.

OBSERVATIONS:

Demographic Profile:- The proportion of elderly (i.e. persons of 65 years or more) in this geographical area was around 3.57% on the basis of household enumeration done by the anganwadi workers and verified by the investigators. Of 928 enumerated elderly persons 809 could be contacted for interview, giving a response rate of 87.18% which can be considered as good coverage.

The surviving men beyond 65 outnumbered women by an impressive margin of 109 (Table - I) . Over 59% of surviving "young old" were in age brackets 65 - 70 years, 27% of "old" between 71-75 years, 9.6% "very old" between 76-80 and the remaining 3.4% were above octogenarians.

Socio - economic status:- The economic status was judged by simple criteria like land holdings and assets. According to rapid subjective judgement, 21.5% of elderly categorized in "low socio-economic groups", belonged to economically weaker sections and were landless. This is a rough approximation of elderly living below poverty line. Majority of the aged (62.8%) were placed in "middle socio - economic group", who had land holdings and other means of income; and the remaining 15.7% were placed in the "high socio - economic group". (Table - II)

Overwhelming proportion of 84.4% of the elderly were illiterate, who missed the opportunity of schooling, while 15.6% were lucky to graduate in schools and colleges. More women were illiterate than men (Table III).

In rural areas, over 94.34% of men pursued unskilled and other jobs in the agricultural sector, mostly in the farms and fields or household chores. Only 5.66% of men were in skilled jobs, like carpenters, weavers and blacksmiths etc. Most of the elderly females (78.85%) were engaged in household works and only 1.43% were engaged as skilled workers. It can be, thus, concluded that most of the elderly above 65 years were engaged in economically useful activities either at household level or in the field, thus providing useful support to the family.

In terms of marital status, 1.2% of elderly were currently unmarried, while 66.5% were living with their spouses. 30.9% had lost their life partners and were probably leading a lonely life without partner and 1.3% had separated from their spouses. This could be an indicator for identifying at risk elderly, needing more attention / care.

Health Status: On rapid subjective assessment through observation, interview, examination, 12.36% of elderly above the age of 65 were classified in "Good health status." These elderly were free from apparent disease/disability. A large proportion of 76.27% of the aged were in the category of "Fair health status" without any severe impediment, able to perform their routine functions and works and were self reliant physically. 11.37% of the elderly were placed in "Poor health status" on account of advanced chronic ailments or some disabilities necessitating some interventions. (Table VI).

Mobility: Over two thirds (66.7%) of them were actively mobile and the remaining one thirds (33.3%) were having limited mobility allowing them to perform the daily routines. Fortunately, none was totally incapacitated in our study sample.

Disability: No disability on account of physical, mental and social factors was discernible amongst 85.6% of elderly. Rest 14.4% of elderly had some physical or mental disability, restricting their performance of activities / functions in terms of mobility, vision or hearing. They suffered from impairments of various grades, but not severe enough to incapacitate their lives, or rendering them to hopeless situations or total dependence. Mental disabilities were

prevalent to the extent of 0.6% (Table VII).

Morbidity: 100 (12.36%) of 809 elderly enjoyed good health status and 84 (10.38%) had no manifesting morbidity. Multiple morbidities were common in 89.62% of aged. Amongst men, the leading symptoms or group of symptoms pertained to visual impairment / diminished vision (65.0%), chronic cough with or without expectoration and difficulty in breathing (58.06%), joint pains (51.86%), hearing problems (18.36%), gastrointestinal problems (9.18%), heart and urinary problems (1.98% each) and 4.2% experienced problems of isolation, loneliness and felt depressed. The above disease pattern is associated with life style, as most men in our situation were smokers(71%). Impaired vision was predominantly due to senile cataract.

Amongst females, the predominant prevalent morbidities comprised of visual impairment (56.2%), joint pains (55.2%), cough and breathing problems (27.95%), hearing problem (22.05%), gastrointestinal problems (7.14%), followed by loneliness and depression (5.8%). (Table -VIII). Most of these morbidities are long term diseases, not easily amenable to cure with medicines, thereby neccessitating measures like exercises and change in habits. Intervention like cataract surgery is certainly rewarding. For most other morbidities, the dictum of "What can't be cured must be endured" holds true for elderly people and their families.

Average sickness load was 1.77 per person. Men had more sickness load as compared to women because of their life styles and habits. (Table - IX)

In view of the prevalent morbidities / disabilities observed, only 1.98% of elderly needed institutional care, where the morbidity or disease condition was incapacitating , needing advanced intervention. (Table - X) Rest of the conditions were amenable to home treatment or consultation from workers at the level of subcentre or nearby primary health centre. There is, thus, an imperative need to impart short term training to health workers in the area of "Geriatric Care."

Dependency: Excellent family support was available to more than two thirds (67.12%) of elderly and they felt happy and contented in the environment of family. Nearly half of the elderly depended financially on their families. In addition, 86.16% were being supported by the government through pension scheme of Rs. 100/-per month (Table- XI). This measure has, in fact, raised their self esteem and self reliance to some extent.

Over 71% of men were smokers against 34% of women. Overall 55% enjoyed smoking on the pretext of relieving abdominal problems and for good digestion. Over one fifth of these elderly used tobacco snuffs and 3.58% were addicted to other drugs (Table - XII).

Nearly half of the elderly were actively working with all vigour on the farm, and in fields and domestic chores. Thus, they were economically active and productive and leading socially useful lives. Over 51% had retired from active work and pursued works within the home and limited works on the farm and fields or animal care within their capacity. (Table - XIII)

In rural setting, family provides eternal support structure to elderly and for that reason, nearly 85% of elderly were staying with the family, in joint family or with other members of family and were playing the effective role of "Home Makers" within the family. In return, the family provided them security and catered to their emotional needs. The fabric of joint family system still plays a pivotal role in the meeting the needs of elderly. (Table - XIV)

Nutrition: In the absence of well defined parameters, nutritional status was not easy to measure. On observation and limited examination, 23% of the elderly were classified as of poor nutritional status, 62.6% had fair and 14.2% enjoyed good nutritional status. Dietary allowances and needs of elderly leaves much to be desired. (Table - XV)

In rural setting, over 86% of the elderly spent their leisure time with their peer group, in their neighborhood, taking care of young children, in group smoking, gossiping, playing cards, sharing news in village chaupals or any easily accessible place. Reading, writing, gardening, exercise and yoga were not much practised because of several inherent constraints like illiteracy, cultural practices and non-availability of material. Over 10% of elderly indulged in spiritual pursuits. (Table-XVI)

An overwhelming 95.9% did not merit any

special attention and the rest 4% needed some special attention for restoration of various health, social and economic conditions. (Table - XVII).

Over 71% of the elderly commanded full respect in the family and had their say and authority in all matters. Nearly 29% of the elderly felt that they had no say and these individuals had to adopt themselves by changing their attitudes. Nearly 15% felt loneliness, as they stayed out side family environments, were either alone or the only spouse and with no siblings. 14.5% expressed their desire to pursue some vocation. (Table - XVIII)

Nearly 17% of elderly were edentulous (no teeth), 78.37% had some teeth missing and only 1.48% were using artificial denture. Around 3.2% had intact teeth. (Table - XIX)

DISCUSSION:

All the 809 elderly contacted in villages were living with their families.

The present community based study identified 3.57% of elderly people above the age of 65. The corresponding figure of 4% was reported by the Registrar General and Census Commissioner of India (1992). National Family Health Survey data reported 5% of elderly above the age of 65 in rural India and a higher percentage of 6% in the State of Haryana. This could be due to difficulties in assessment of age of elderly people in rural areas[2-3], overwhelming (84.42%) being illiterate, there being no record of age in any register and their memory failing to recall the long past.

In rural setting, around one fifths of the elderly lived below poverty line. During 42nd round, the National Sample Survey Organization in 1986-87 determined the socio - economic status of the elderly.

The ICMR study of the rural aged at Madurai (Tamilnadu) during 1981-84 reported 65% of the elderly having visual handicap, which is almost similar to our observation of 61.1%. Another ICMR study on cataract estimated the prevalence of cataract in the range of 31 to 70% in rural population above the age of 40 years[2].

Visual impairments topped the list in a study of rural elderly conducted by S. Vijay Kumar, wherein 98% of elderly reported visual impairments[4].

The other morbidities like respiratory problems and joint problems were much higher in our study in comparison to ICMR Madurai study. These differences could be due to habits and ways of life in different regions.

Apparent cardiovascular problems in our study were prevalent to the extent of 2% against the higher rate of 7.9% reported by ICMR study[5].

Madurai Rural Study reported 40% of subjects having depressive disorders as against 5.8% in our study, which is not easily explainable.

Most elderly (89%) enjoyed good and fair status of health and only 11% of the aged had poor status of health, and only 1.5% needed institutional services. Sweden Study quotes figure of 3% elderly needing institutional care[6]. In terms of mobility, it can be stated that more than two thirds were actively mobile and restriction of mobility was experienced by only 33% of aged. Physical disabilities were experienced by 13.8%, and 97.2% needed care at home or of nearby subcentre workers to ameliorate their sickness.

CONCLUSION:

All the aged, (809) without any exception, lived with their families or near their family in the same village. Family undertook the responsibility to maintain and look after the elderly. Over 67% of the elderly had no problem or grievances against the family, one thirds had some grievances in terms of neglect and not being listened to . Half of them were dependent on the family for financial support and over 86% of the elderly derived the benefit of Government Pension Scheme. Thus, family needed elderly people and elderly people needed family support. Thus, institution of family is a harbinger of harmony and support for the elderly[6-8].

- Over two thirds of the elderly were active and indulge in socially acceptable and economically useful activities in their village environment.
- Only 10% had poor health status needing some support of referral services.
- The present study identified 2% of aged needing care at the institutional level and the remaining could be managed with ambulatory care

through health workers or outdoor of subcentre or primary health centre.

- Only 14.4% has some disability, mostly physical (13.8%) and only 0.6% had mental disabilities.
- Over 89% of elderly were having one, or more than one morbidity, predominantly of eyes, lungs and joints.
- Substance abuse was prevalent widely, predominant being smoking and snuffing tobacco.

Recommendations:

- Education and awareness of responsibilities of young people and family towards elderly needs to be stepped up.
- Paramedical personnel needs to be oriented towards the problems of elderly.
- There is an imperative need to organize the elderly in the community for subtainability. The Govt. and NGO can spearhead this movement or elderly can themselves take up such initiatives with the support of local self government.
- The capacities and skills of the elderly should be used for village development activities like informants, health education, voluntary work in various sectors.
- Village chaupal should have some inputs for elderly in the form of newspapers and recreational material.
- Eye camps and camps for other mass diseases on periodical basis to impart information of self care and 'how to live a healthy life' should be organized periodically at the block level or for two or three blocks at one place. Pension forum can be used to generate awareness and disseminate messages.

TABLE - I

POPULATION AND COVERAGE OF ELDERLY (65+) IN THE SURVEY

	Popu-lation	House-holds	No. of elderly enumerated			Covered		
			Total	M	F	Total	M	F
Total:	25982	3721	928	504	424	809	459	350
%			3.57	1.94	1.63	87.18	91.07	82.54

(M = male, F= female)

TABLE - II

NO. OF ELDERLY SURVEYED BY AGE, SEX & SOCIO - ECONOMIC GROUP

Age group	Socio-economic group			
	Low	Middle	High	Total
65-70 M	47	164	46	257
F	35	163	25	223 480(59.33)
71-75 M	36	80	19	135
F	20	50	14	84 219(27.07)
76-80 M	11	31	5	47
F	13	6	12	31 78(9.64)
> 80 M	7	9	4	20
F	5	5	2	12 32(3.95)
Total M	101	284	74	459
F	73	224	53	350 809(100)
	174 (21.5)	508 (62.8)	127 15.7)	

(Figures in parenthesis are percentages).

TABLE - III

EDUCATIONAL STATUS

Level of education	Men		Women		Total	
	No.	%	No.	%	No.	%
Illiterate	372	81.01	311	88.9	683	84.42
school	80	17.46	38	10.8	118	14.58
Middle/ High School	0	0	0	0	0	0
College	7	1.53	1	0.3	8	1
TOTAL	459	100	350	100	809	100

TABLE - IV

OCCUPATIONAL STATUS

Occupation	Men		Women		Total	
	No.	%	No.	%	No.	%
Skilled worker	26	5.66	5	1.43	31	3.83
Unskilled worker	74	16.12	7	2	81	10.01
Housewife	--	--	269	76.85	269	33.25
Others	359	78.22	69	19.71	428	52.9

TABLE - V

MARITAL STATUS

Marital status	Male		Female		Total	
	No.	%	No.	%	No.	%
Unmarried	7	1.52	3	0.86	10	1.2
Married	318	69.28	220	62.86	538	66.5
Widow/ Widower	124	27.01	126	36.00	250	30.9
Separated	10	2.18	1	0.29	11	1.35
TOTAL	459		350		809	

TABLE - VI

HEALTH AND MOBILITY STATUS

Health status	Men		Women		Total	
	No.	%	No.	%	No.	%
Good	59	12.86	41	11.71	100	12.36
Fair	348	75.81	269	76.86	617	76.27
Poor	52	11.33	40	11.43	92	11.37
TOTAL	459	100	350	100	809	100
Mobility status						
Mobile (Active)	303	66.01	237	67.71	540	66.7
Limited	156	33.99	113	32.29	269	33.3
TOTAL	459	100	350	100	809	100

TABLE - VII

DISABILITY ASSESSMENT

Disability	Men		Women		Total	
	No.	%	No.	%	No.	%
Nil	389	84.75	303	86.57	692	85.5
Physical	66	14.38	46	13.14	112	13.8
Mental	4	0.87	1	0.29	5	0.6
Both	0		0		0	
TOTAL	455	100	350	100	809	100

TABLE - VIII

ANALYSIS OF MORBIDITY PATTERN

Morbidity pattern	Men		Women		Total	
	Diseased=403 Normal = 56		Diseased=322 Normal = 28		Diseased=725 Normal = 84	
	No.	%	No.	%	No.	%
Heart	8	1.98	4	1.24	12	1.65
Lung	234	58.06	90	27.95	324	44.69
Joints	209	51.86	178	55.28	387	53.38
Eye	262	65.01	181	56.21	443	61.10
Ear	74	18.36	71	22.05	145	20
G.I. Tract	37	9.18	23	7.14	60	8.28
Urinary	8	1.98	3	0.93	11	1.52
Nervous	3	0.74	3	0.93	6	0.83
Diabetes	1	0.25	1	0.31	2	0.28
Mental	20	4.96	22	6.83	42	5.8
Others	0	0	1	0.31	1	0.14
Total sickness	856		577		1433	

TABLE - IX

AVERAGE SICKNESS LOAD

Sex	Average sickness load
Men	1.86
Women	1.65
Both sexes	1.77

TABLE - X

HEALTH / SOCIAL CARE SERVICES REQUIRED

Health/Social care services	Men		Women		Total	
	No.	%	No.	%	No.	%
OPD/Home care (Ambulatory care)	452	98.45	334	95.14	796	97.26
Psychological	3	0.65	4	1.14	7	0.86
Institutional	4	0.09	12	3.43	16	1.98
TOTAL	459		350		809	

TABLE-XI

DEPENDENCY & SUPPORT SYSTEM FOR AGED

Dependency	Men n= 459		Women n = 350		Total n = 809	
	No.	%	No.	%	No.	%
Financial	247	53.81	187	53.43	404	49.94
Family	279	60.78	264	75.43	543	67.12
Social	246	53.59	179	51.14	425	52.53
Govt. pension benefit	368	80.17	329	94	697	86.16

TABLE-XII

SUBSTANCE ABUSE

Addiction	Men		Women		Total	
	No.	%	No.	%	No.	%
A. Smoking						
Smokers	326	71.02	119	34	445	55
Non-smokers	133	29.0	231	66.0	364	45.0
Total	459	100.00	350	100.00	809	100.00
B. Addiction						
Naswar	90	19.6	82	23.43	172	21.26
Drug & others	13	2.83	16	4.57	29	3.58
TOTAL	103	22.44	98	28	201	24.84

TABLE-XIII

WORKING STATUS

Working status	Male		Female		Total	
	No.	%	No.	%	No.	%
Actively working	220	43.93	170	48.57	390	48.2
Not actively working	239	52.06	180	51.43	419	51.8
TOTAL	459	100.0	350	100.0	809	100.0

TABLE-XIV

STAYING WITH

Staying with	Male		Female		Total	
	No.	%	No.	%	No.	%
Alone	26	5.66	23	6.57	49	6
With spouse	42	9.15	32	9.14	74	9.15
With other family members	71	15.47	47	13.43	118	14.6
Joint family	320	69.71	248	70.86	568	70.2
TOTAL	459	100	350	100	809	100

TABLE-XV

NUTRITIONAL STATUS

Nutritional status	Male		Female		Total	
	No.	%	No.	%	No.	
Good	87	18.95	28	8.00	115	
Fair	311	67.76	196	56.0	507	
Poor	61	13.29	126	36.0	187	
TOTAL	459	100	350	100	809	(100)

TABLE-XVI

LEISURE TIME

Leisure time activity	Male	Female	Total	
	No.	No.	No.	%
Reading	3	1	4	0.49
Writing	1	0	1	0.12
Spiritual pursuits	28	56	84	10.38
Gardening	1	0	1	0.12
Exercise	0	0	0	0
Walking	16	6	22	2.72
Yoga	1	0	1	0.12
Others - village chaupal, group sitting	409	287	696	86.03
TOTAL	459	350	809	100

TABLE-XVII

SPECIAL ATTENTION NEEDED

Special attention needed	Male		Female		Total	
	No.	%	No.	%	No.	%
Not needed	448	97.6	328	93.71	776	95.9
Needed:						
Domiciliary care	5	1.08	13	3.71	18	2.22
Institutional care	5	1.08	7	2.0	12	1.48
Terminal care	0	0	1	0.28	1	0.12
Social care	0	0	1	0.28	1	0.12
Other care	1	0.22	0	0	1	0.12
TOTAL	459	100	350	100	809	100

TABLE-XVIII

SPECIAL FEATURES

Special Features	Male n=459		Female n= 350		Total n= 809	
	No.	%	No.	%	No.	%
Desirous of recreational facility	72	15.69	43	12.28	115	14.21
Has got say in the family	362	78.87	213	60.86	575	71.07
Effects of loneliness seen	81	17.65	39	11.14	120	14.8
Wishes to do some vocation	72	15.69	47	13:43	119	14.7

TABLE-XIX

TEETH

Status	Male		Female		Total	
	No.	%	No.	%	No.	%
Absent	60	13.07	77	22.0	137	16.93
Partial	378	82.39	256	73.14	634	78.37
Intact	16	3.5	10	2.86	26	3.21
Dentures	5	1.1	7	2.0	12	1.48
TOTAL	459	100	350	100	809	100

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