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CLINICO-SOCIAL PROBLEMS OF GERIATRIC POPULATION IN RURAL AREA OF SOUTHERN MAHARASHTRA: A CROSS SECTIONAL STUDY

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Abstract

Background: - Old age is a normal, inevitable, biological phenomenon. Discoveries in medical science and improved social condition during past few decades have increased the life span of man, from 46.5 yrs in 1950-55 to 69 by 2008. The elderly population account for 7.2% 0f total population in 2003.both the share and size of elderly population is increasing over time from 5.6% in 1961 and is projected to rise to 12.4% of population by year 2026.
Aim: The present study was conducted to study the socio-demographic profile and to highlight the health and social problems of the elders. **Methodology:** Cross-sectional, observational study was conducted on elders a resident of that rural area for > 6 months. All the elders (304) of Raleras- subcentre of Vairag, PHC, Solapur were included in study.
Results: Female preponderance was seen with 54.93%. male:female ratio was 1:1.8. Only 21.7% elder persons were educated. Majority of elder persons (69.07%) were living in below poverty line. Prevalence of morbidity calculated was 87.04%. Different social problems faced by elderly were maladjustment (66.8 %), loneliness and family neglect [50%], alcohol and tobacco intake (22.30%) abusive language (17.3%), deprived social gatherings (13.80%), no peer group (7.30%) and beggary(1%).
Conclusion: The present study shows that condition of elderly persons is not so good as the perspective of healthy life and social security so there is need of more focused and intense health services and social securities services.

Keywords: Social problems, Geriatric population, Health problems.

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INTRODUCTION

Old age is a normal, inevitable, biological phenomenon (Park, 2013). Older patients in medical or geriatric care represent a population with a particularly high prevalence of comorbidities and functional disabilities. A high prevalence of multiple disorders ultimately leading to more complications (Zekry *et al.,* 2012). Discoveries in medical science and improved social condition during past few decades have increased the life span of man, from 46.5 yrs in 1950-55 to 69 by 2008. The elderly population account for 7.2% of total population in 2003 [1].Both the share and size of elderly population is increasing over time from 5.6% in 1961and is projected to rise to 12.4% of population by year 2026. The old age dependency ratio climbed from 10.9% in 1961 to 13.1 in 2001 for India as a whole. Out of these approximately 2/3rd live in rural area. The World Health Organization, United Nations as well as India have accepted the age of 60 years as a cut-off point for defining elderly.

Government of India adopted 'National Policy on Older Persons' in January, 1999 and the policy define 'senior citizen' or 'elderly' as a person who is of age 60 years or above (Situation Analysis of the Elderly in India, 2011). Urbanization, nuclearisation of family, migration are making it difficult to care for the elderly and increasing social problems like loneliness, negligence etc. Compared to urban areas there are more social problems like poverty, illiteracy and limited resources in rural area. In view of this the government of India has formulated various policies for welfare of elderly like support for financial security, healthcare etc (Park, 2013).The present study was conducted to study the socio-demographic profile and to highlight the health problems of the elders.

MATERIALS AND METHODS

The present Cross-sectional observational study was conducted on the elders (having age 60 years and above). Study was conducted for six month from January 2014 to June 2014, at

sub-centre situated at village Raleras which is attached to Primary Health Care Centre Vairag, Solapur. Vairag and its sub centres are attached to Dr. V M Government Medical College, Solapur for the Rural training of interns and residents doctors. All the elders of village and residing in rural area since 6 months were included in study. Socio-demographic data was collected with the help of ASHA and Anganwadi worker. For clinical data help of interns, residents doctors and Medical officer was taken in Raleras village of P.H.C. Vairag. Informed consent was taken and purpose of study was explained to all study subjects. No invasive procedure was performed during study.

RESULTS

The table 1 shows that out of 304 elderly, 45.06 % (137) were males and 54.93% (167) were females; male to female ratio was 1:1.8. Most common age group observed was 60-70 (55.6%) followed by 70-80 (33.2). The present study shows that 78.28 % (236) elderly were illiterate and only 21.7 % (66) were literate.

Table 1. Socio-demographic data of study subjects

Age group (in years)	Male (%) n=137	Female (%) n=167	Total (%) n=304
60-70	067 (22.1)	102 (33.5)	169 (55.6)
70-80	052 (17.1)	049 (16.1)	101 (33.2)
>80	018 (05.9)	016 (05.3)	034 (11.2)
Education Status			
Literate	038 (27.74)	030 (17.96)	068 (21.7)
Illiterate	099 (72.26)	137 (82.04)	236 (78.28)
Marital Status			
Married	117 (85.40)	131 (78.44)	248 (81.58)
Widow/widower	020 (14.60)	036 (21.56)	056 (18.42)

Above table shows that more males 117 (85.40 %) were married (living spouse) as compared to females 131 (78.44 %). More females 36 (21.56 %) were widowed compared to males 20 (14.60 %).

Table 2. Distribution of study subjects according to age and employment status

Age group	Male		Female	
	Employed (%)	Unemployed (%)	Employed (%)	Unemployed (%)
60-70	52 (37.9)	15 (10.9)	56 (33.5)	46 (27.5)
70-79	12 (08.7)	40 (29.1)	05 (02.9)	44 (26.3)
>80	00 (00)	18 (13)	02 (01.2)	14 (08.3)
Total	64 (46.6)	73 (53.1)	63 (37.6)	104 (62.8)

Above table shows that out of the total 137 males 53.1 % (73) were unemployed and 46.6 % were working. While out of the 167 females, 62.8% (104) were unemployed and 37.6% were working.

Table 3. Number of elderly living below poverty line

Socio economic class	No. of elderly persons	Percentage
BPL	209	68.75
APL	095	31.25
Distribution of Elderly according to type of family		
Alone	015	04.94
Nuclear	122	40.13
Joint	167	54.93

The above table shows that 68.75 % were below poverty line and 31.25 % were above poverty line. Most of the elderly (55%) were belonged to Joint family. The higher prevalence of joint families could be because of the rural study area. 40.13% were belonged to nuclear family while 5 % were living alone.

Table 4. Various morbidities observed in study subjects

Ailment	Male (n=137)	Female (n=167)	Total (n=304)
Difficulty in Vision	113 (82.48)	141 (84.43)	254 (83.55)
Musculo-skeletal problems	106 (77.37)	123 (73.46)	229 (75.32)
Headache & body ache	111 (81.02)	083 (49.70)	194 (63.81)
Dental Problem	086 (62.77)	056 (33.53)	142 (46.71)
Difficulties in hearing	069 (50.36)	062 (20.39)	131 (43.09)
Gastro-intestinal Complaints	058 (42.33)	047 (28.14)	105 (34.53)
Hypertension	021 (15.32)	029 (17.36)	050 (16.44)
Diabetes Mellitus	020 (14.59)	012 (07.10)	032 (10.52)
Asthama & COPD	020 (14.59)	006 (01.97)	026 (8.55)
Genitourinary Complaints	009 (06.56)	008 (02.63)	017 (5.59)
Others	006 (04.38)	001 (00.60)	007 (2.30)

*Others included heart related (4), cancer (1), Hemiplegia Paraplegia (1), Hypothyroidism in female (1)

In the present study, most common morbidity observed was Difficulty in Vision amongst male (82.48%) and female (84.43%). The difficulties of hearing, gastro-intestinal problems and diabetes mellitus were more common in males with percentages 50.36%, 42.33%, 14.59% respectively as compared to females with percentages 20.39%, 28.14% and 7.1% respectively. Musculo-skeletal problems were observed in 75.32% of total. 62.77% males, 33.53% females and total 46.71% were suffering from dental problems. While 8.55% were suffering from respiratory system complaints.

Table 5. Social problems faced by elders

Social problems	No. of patients
Maladjustment	203 (66.80)
Loneliness ,Neglect	151 (49.67)
Alcohol , tobacco intake	068 (22.37)
Abusive language	053 (17.43)
Deprived Social Gatherings	042 (13.81)
No peer group	022 (07.23)
Beggary	003 (00.98)

From the above table 66.80% were having maladjustment, 49.67% were suffering from loneliness and family neglect, 22.37% from alcohol and tobacco addiction, 17.43% facing abusive language, 13.81% were deprived from social gatherings, 7.23% were not having any peer group and 1% were doing beggary.

DISCUSSION

The present community based cross sectional study was carried out at Raleras village of PHC Vairag in Barshi Taluka of Solapur district in Maharashtra, India. Total 304 subjects were taken in study. Out of total 2534, There were 304 (12%) elderly in the rural area of Raleras which is far more than the national average of 7.2 %. Out of 304 respondents, 45.06 % were males and 54.93% were females, showing male to female ratio were 1:1.8. A study conducted by Narapureddy *et al.* (2012), they observed Out of the 411 elderly persons 214 (52.1%) were males and 197 (47.9%) were females. S=another study conducted by Piramanayagam *et al.* (2013) of the 594 elderly persons and observed that 309 (52.1%) were males and 285 (47.9%) were females. Study findings similar to present study. In our study, most of the males 22.03 %, females 33.52 % and total 55.55% were in age group 60-70.

Beyond age group 60-70, the age wise percentages of elderly population gradually declined, that might be due to as average life expectancy for Indians is 64.4 years.[1] In a study by Narapureddy *et al.* (2012) majority of the elders 59.6% were found in the age group 60-69 years. In the present study 78.28 % study subjects were illiterate and 21.7 % literate. According to the NSS 52nd round, 63% of the elderly were illiterate in India (Singh *et al.,* 1994). In study by Giri *et al.* (2010) there were 65% illiterate. In the present study out of the total males, 53.08% were unemployed and 46.6 % were in unskilled work. While out of the total females 62.81 % were unemployed and 37.6 % were in unskilled work. Higher work participation among the elderly might be due to the lack of proper social security safety nets and high levels of poverty. In a study carried out by Madhu *et al.* (2013) Majority of rural study subjects (40.41%) were not engaged in any occupation, 36.14% males, 24.60% females and total 30.20% were in unskilled work. Study findings parallel to present study.

In the present study most of the elderly (54.93%) were belonged to Joint family. In a study by Balamurugan *et al*. (2012) a joint family system was seen to be the most common (56.8%) among the population interviewed followed by the nuclear family. In the present study more males (85.4 %) were married (living spouse) as compared to females (78.4%). More females (21.5 %) were widowed compared to males (14.6 %). Two reasons might be there for the marked gender disparity in widowhood (i) longer life span of women compared to men (ii) the general tendency for women to marry men older than themselves (Gulati and Irudaya Rajan, 1999). In a study conducted by Aras *et al*. (2012) at the time of study, 73.3 % were married (with their spouse alive), 26.7% were widows/widowers.

In the present study, most common morbidity observed was Difficulty in Vision amongst male (82.48%) and female (84.43%). The musculo-skeletal problems were observed in 75.32% of study subjects. While 8.55% were suffering from respiratory system complains. 16.44% were suffering from hypertension and 1.31% patients were having cardiovascular complaints. In a study by Bankar *et al.* (2011) more than half (61.3%) of subjects were suffering from morbidity of musculoskeletal system. More than half 300 (56.6%) of inmates had one or the other diseases of cardiovascular system. Hypertension was found in maximum 287 (54.2%) inmates. Hypertension was more common among females (59.6%) as compared to males (47.7%). 9.4% of inmates had diseases of respiratory system. In this study findings parallel to present study except hypertension which was less prevalent in present study. In another study Piramanayagam *et al.* (2013) they found that most prevalent diseases were related to ocular system 71% followed by cardiovascular system 49%. Women 149 (52.3%) and men 84 (27.2%) were suffering from musculoskeletal problems. Respiratory system disorders were present in 77 (12.9%) elderly. Of the 594 elderly, 97 (23.6%) were affected by gastrointestinal diseases; men and women 52 (24.3%) and 45 (22.8%) respectively. 27 (4.5%) were suffering from genitourinary problems. Study findings were parallel to present study except hypertension which was less prevalent in present study. This might be due to only known hypertensives were taken into consideration.

Social problems observed in present study were-maladjustment (66.8%), loneliness and family neglect (50%), alcohol and tobacco intake (22.30%) abusive language **(**17.3%), deprived social gatherings (13.80%), no peer group (7.30%) and beggary (1%). Lena *et al.* (2009) found that approximately 40% of the respondents had feelings of insecurity while around 56.3% were deprived of financial security, half of the study subjects felt neglected by their family members. The study conducted by Singh *et al*. (1994) which reported that 26.1% felt neglected by family members, while Prakash, *et al.* (2004) reported 17.3% having feelings of neglect. In study by Lena *et al.* (2009) 47.9% of the respondents said that they were not happy in life as compared with 53.2% reported by Singh *et al.* (1994) Around 48% of the respondents mentioned that they felt sad mainly because of poverty followed by illness (41.3%).

Conclusions

The present study shows that condition of elderly persons is not so good as the perspective of healthy life and social security so there is need of more focused and intense health services and social securities services for elder population in rural area. Although governments run various health program, social societies schemes, pension schemes and rehabilitation schemes with special reference to geriatric population. But still old age persons are mostly dependent on their offspring for their survival. It means government efforts are not sufficient or implementation of these services is poor or needy persons are not getting sufficient or appropriate help. Rehabilitation for socially destitute aged in the form of homes for aged with treatment and referral facilities should be established.

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