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Research Article

Health status of the rural elderly in the East Godavari District of Andhra Pradesh.

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Abstract

Background: The World population is ageing rapidly , although old age is not a disease itself, the elderly are vulnerable to chronic diseases. These chronic illnesses lead to impairments and disabilities. **Objectives:** To study the health status of the elderly people in the rural area. **Material and Methods:** Study design: Cross sectional study. Setting: Rural field practice area of Konaseema Institute of Medical Sciences(KIMS), Andhra Pradesh, India. Subjects: 100 subjects (50 male and 50 female) of age ≥ 60 years. Study variables: Age, educational status, marital status, economic dependence, self rating of health status, common disabilities. Statistical analysis: It was done using Epi-info version 7.0. **Results:** Majority (68%) were in the age group of 60 – 69 years, 58% were illiterate, 27% were widowed, 62% were economically fully dependent on their children, majority (42%) of the participants self rated their health status as poor. **Conclusion:** Educating people regarding time management and safety precautions is necessary for reducing domestic accidents.

Keywords: Health status, Rural area, Elderly people.

Introduction

The World population is ageing rapidly because of advancement medicare, improvement in living conditions and the general quality of life and effective measures for birth control could be attributed to this emerging global phenomenon[1]. According to 2011 census in India 76,622,321 are 60 years and above constituting 7.5% of the total population. Although old age is not a disease itself, the elderly are vulnerable to chronic diseases. These chronic illnesses lead to impairments and disabilities[2].

The physiological decline in ageing refers to the physical changes an individual experiences because of the decline in the normal functioning of the body resulting in poor mobility, vision, hearing, inability to eat and digest food properly, a decline in memory, the inability to control certain physiological functions and various chronic conditions. Change in socio-economic status adversely affects the individual's way of life after retirement. The economic loss is due to a change from salary to pension or unemployment leading to economic dependency on children or relatives.

A feeling of low self worth may be felt due to the loss of earning power and social recognition[3]. Majority of the elderly in rural India live with no social security[4]. Problem of aging is more in rural areas due to rural urban migration of youth in search of education employment leaving behind the elders in villages. In a study of Health status of rural aged in A.P. found that the health problems tend to

increase with advancing age and often due to neglect, poor economic status social deprivation and inappropriate dietary intake lack of medical facilities in villages and poor economic conditions might be responsible for low health status of the elderly in villages.[5] Therefore keeping this in mind the present study was done in order to know the health status of elderly in our catchment area.

Materials and Methods

The present study is a community based cross sectional study carried at two randomly selected revenue villages in the rural field practice area of Konaseema Institute of Medical Sciences(KIMS), Andhra Pradesh, India. By using convenient sampling method 100 subjects (50 male and 50 female) ≥ 60 years who are residing in the selected villages, who were available at the time of visit, who were willing to participate were included in the study. Approval from the Institutional Ethics Committee was taken prior to the study initiation and written consent was taken from the participants after explaining the objectives and procedure of the study. Pretested semi structured questionnaire was used to collect the data regarding demographic profile, self rating of health status and common disabilities. The data was processed and statistical analysis was done using Epi-info version

Results and Discussion

The study participants were 50 male and 50 female of age equal to are more than 60 years. Majority (68%) were in the age group of 60 – 69 years. Marital status determines ones position with in the family a well as the status in the society. In our study 72% of the participants were married and 27% were widowed, in contrast to this a study by Lena et.al., reported 79.8% were widow / widower.[3]

In our study 58% were illiterate and there is a lot of difference between male and female educational status. Among the males 38% were illiterate where as among females 78% were illiterate and it is found statistically significant. In contrast to this Padda et.al., reported 38.6% illiteracy at Amritsar.[6] The difference between male and female educational status was mainly because of the rural area in those days they used to give least importance to the education of the females in the rural areas. In our study 62% were economically fully dependent on their children, among the males 24% were economically independent where as among females only 4% were economically independent and it is found statistically significant (Table – 1). In another study by M. Bhaskaraiah et.al., stated that 54% were fully dependent on their children followed by 27.67% were independent.[7]

Table – 1: Socio demographic profile of the participants

Variables		Male (%) N = 50	Female (%) N = 50	
Age	60-69	35 (70)	33 (66)	χ^2 = 0.2134 P = 0.8988
	70-79	11 (22)	12 (24)	
	≥80	4 (8)	5 (10)	
Marital Status	Married	39 (78)	33 (66)	χ^2 = 3.3148 P = 0.1906
	Widowed	10 (20)	17 (34)	
	Unmarried	1 (2)	0 (0)	
Educational Status	Illiterate	19 (38)	39 (78)	χ^2 = 21.468 P = 0.0003
	Primary	12 (24)	9 (18)	
	Secondary	12 (24)	2 (4)	
	Intermediate	4 (8)	0 (0)	
	Degree and above	3 (6)	0 (0)	
Economic Dependence	Fully Dependant	25 (50)	37 (74)	χ^2 = 29.2713 P = 0.0000
	Independent	24 (48)	2 (4)	
	Partially Dependent	1 (2)	11 (22)	

The perception of health is the feeling of people about their own health. Perceived health was the best single indicator of life satisfaction for elderly. Self rating of health was important psycho-social parameters in the evaluation of health status in determining the quality of life of elderly. In our study majority (42%) of the participants self rated their health status as poor among them female are more (57.14%) followed by 26% reported as fair, 24% as good and 8% as excellent (Table – 2). In contrast to that Nilesh Agarwal et.al., in their study observed that 68.3% of the participants reported their own health as fair, poor by 14.9%, good by 13.5%, very poor by 1.8% and excellent by 1.5% of the participants.[8]

Table – 2: Self rating of health status of the participants

Health status	Male Number (%)	Female Number (%)	
Excellent	5 (10.00%)	3 (6.00%)	$\chi^2 = 3.011$ P = 0.3899
Good	15 (30.00%)	9 (18.00%)	
Fair	12 (24.00%)	14 (28.00%)	
Poor	18 (36.00%)	24 (48.00%)	

Disability was a major health concern among the older people. Certain disabilities like impairment in vision, hearing and decreased mobility were common consequences of deterioration of muscles and senses in old age.

Elderly with mobility disorders have difficulty in walking, climbing steps, carrying things, but also in managing their personal day to day activities like bathing, grooming, dressing, washing cloths by themselves. In our study majority (64%) were freely mobile, 34% had difficulty in the mobility and 2% were bed ridden (Table 3). These findings were almost similar to another study by M. Bhaskaraiah et.al., where 58.67% of the participants were freely mobile followed by 38.33% were walking with difficulty and 3% were bed ridden.[7] It is because majority of the participants were still in the early phase of old age.

54% had good vision ability, 46% had vision with difficulty there is not much change among the male and female. These findings were almost similar to another study by M. Bhaskaraiah et.al., where they have observed 51.33% are having good vision.[7] and incontrast to that in another study by Deepthi et.al., reported 12.6% as blind.[9] 78% had good hearing ability, 22% had difficulty in hearing among the females 84% and among the males 72% had good hearing ability. These findings were almost similar to another study by M. Bhaskaraiah et.al., where they have observed only 12.67% have poor hearing ability.[7] Various studies have shown an increase in hearing impairment as age advances.[10]

74% had good chewing ability, 22% had difficulty in chewing among the females 6% and among the males 2% had poor chewing ability. In contrast to this M. Bhaskaraiah et.al., stated that only 30.67% have good chewing ability.[7] Studies have reported reduced chewing ability with increasing age.[11]

52% had normal sleep followed by 42% had disturbed sleep and 6% had sleeplessness. M. Bhaskaraiah et.al., found that 41.33% have normal sleep, 34% of disturbed sleep.[7] With age several changes occurred that can place one at risk for sleep disturbance including increased prevalence of medical conditions, increased medication use, age related changes in circadian rhythm and environmental and lifestyle changes.[12]

Table – 3: Common disabilities among the elderly

Variables		Male (%) N = 50	Female (%) N = 50	
Physical mobility	Freely mobile	34 (68)	30 (60)	χ^2 = 0.7206 P = 0.6975
	With difficulty	15 (30)	19 (38)	
	Bed ridden	1 (2)	1 (2)	
Vision ability	Good	28 (56)	26 (52)	χ^2 = 0.1594 P = 0.4205
	With difficulty	22 (44)	24 (48)	
	Poor	0 (0)	0 (0)	
Hearing ability	Good	36 (72)	42 (84)	χ^2 = 2.0769 P = 0.1135
	With difficulty	14 (28)	8 (16)	
	Poor	0 (0)	0 (0)	
Chewing ability	Good	41 (82)	33 (66)	χ^2 = 3.5012 P = 0.1737
	With difficulty	8 (16)	14 28)	
	Poor	1 (2)	3 (6)	
Sleeping ability	Normal sleep	29 (58)	23 (46)	χ^2 = 1.7399 P = 0.419
	Disturbed sleep	19 (38)	23 (46)	
	Sleeplessness	2 (4)	4 (8)	

Conclusion

Special focus is needed regarding the literacy of the rural people and aged population should be brought under an economic security plan. Domiciliary services to be improved through ANM / ASHA workers for the common health problems of the rural elderly. Geriatric departments should be initiated at all levels of health care and adhoc programmes for rural elderly to be initiated along with public private partnership.

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