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Sociodemographic Profile and Health Status Perception of Elderly People in Hajin Block of Kashmir Valley: A Cross-Sectional Study

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Abstract
Ageing is a universal process affecting every individual, family, community and society. It is a normal, progressive and irreversible process which can be broadly characterized by time-altered changes in an individual's biological, psychological and health related capabilities and its implications for the consequent changes in the individual's role in the economy and the society. All these features of aging imply that the problems of the elderly need a special focus and approach. The aim of this study was to assess the distribution of various sociodemographic variables & perception of health status of this vulnerable age group of elderly people. A cross sectional study design was adopted and the study was conducted in the rural field practice area of the Deptt. of Community Medicine, SKIMS for a period of 1 year. The study was carried out in a total of 1020 individuals aged 60 years & above. Data was collected using a pre tested and pre structured proforma which included assessment of sociodemographic profile including SES and health status perception of the study population. In the present study, out of total 1020 study subjects, majority i.e 55.3% were Young aged (60-69 y);46.4% were males;85.5% were illiterate;81.4% of elderly were living in joint family;74% of study population were married; 83% were not working at all;65.9% belonged to SES class IV;89.8% of study subjects perceived that they were currently ill and among those 53.2% were hypertensives. Majority of elderly in present study were young aged (60-69y) , females, illiterate, married, living in joint family, not engaged in any work, belonging to SES class IV, perceiving themselves to be currently ill (hypertensives).

Key words: *Elderly, Sociodemographic profile, socioeconomic status (SES), Health status, Geriatrics.*

Introduction

Geriatrics is a newly emerging speciality concerned with clinical, public health and psychological aspect of health and disease in the elderly. The United Nations uses the benchmark of 60 years of age or above to refer to older people (UNFPA, 2012). However, in many high-income countries, the age of 65 is used as a reference point for older persons as this is often the age at which persons become eligible for old-age social security benefits. This higher age category is less appropriate to the situation in developing countries including Africa where life expectancy is often lower than that in high-income countries[1]. The elderly are a precious asset for any country. With rich experience and wisdom, they contribute their might for sustenance and progress of the nation. Their special health and economic issues differ from those of the general population. The United Nations addresses the independence, participation, care, self-fulfillment and dignity of older persons to ensure their due care[2].Aging is not merely a matter of accumulating years but also a process of "adding life to years, not years to life." The world health day theme in 2012 was *Ageing and health* with the theme "Good health adds life to years". The focus is how good health throughout life can help older men and women lead full and productive lives and be a resource for their families and communities. Ageing concerns each and every one of us – whether young or old, male or female, rich or poor – no matter where we live[3]. The world is in the midst of a unique and irreversible process of demographic transition that will result in older populations everywhere. In 2000, there were 600 million people aged 60 years and above; there will be 1.2 billion by 2025 and 2 billion by 2050. Today, about two thirds of all older people are living in the developing world; by 2025, it will be 75%. In the developed world, the very old i.e above 80 years is the fastest growing population group. Women outlive men in virtually all societies; consequently in very old age, the ratio of women to men is 2:1[4].According to projections by the UN Population Division, there will be two elderly persons for every child in the world by 2050.This implies that the aged 60 and above population will account for 32 % of the population by 2050. By 2050 about 80% of the elderly will be living in developing countries. Population ageing is occurring in parallel with rapid urbanization: in 2007 more than half of the world's population lived in cities. By 2030 that figure is expected to rise to more than 60%.[5]

As per the Census of India (2011) the aged population 60 years and above constitutes 8.6 percent to the total population of country. In Jammu and Kashmir, the elderly population has risen from 432 thousand in 1991 to 675 thousand in 2001.The proportion of the elderly has risen from 5.78 percent in 1991 to 6.71 percent in 2001 and 7.4 percent in 2011(Census 2011 J&K)[6].

WHO categorizes old age into three age brackets as “Young aged” (60 to 69 years), “Middle aged” (70 to 79 years) & “Old aged” (80 years and above)[7].

India has the second largest aged population in the world; 45% of them have chronic diseases and disabilities. In India the elderly people suffer from both communicable as well as non communicable diseases. This is further aggravated by impairment of sensory functions like vision and hearing. Age related physiological changes and immunoco-mpromised condition in the elderly make them more vulnerable to chronic, disabling and multiple health problems. Moreover there is economic inadequacy and degradation in family values. A large proportion of geriatric people are living below the poverty line and from the unorganized sector with no social security. Therefore they require a different approach and management. The common diseases among the ambulatory elderly are Hypertension, Cataract, Osteoarthritis, Chronic obstructive pulmonary diseases, Diabetes mellitus, benign prostatic hypertrophy, Dyspepsia, Irritable bowel syndrome and Depression which account for 85% of the burden of ill health. Therefore the quality of life is deteriorating among geriatric age group[8].

With this background the present study was done to assess the distribution of various sociodemogr-aphic variables & perception of health status of

this vulnerable age group of elderly people as very less data is available on it at national level & in particular our state of J&K.

Material and Methods

The study was conducted in Hajin Block of district Bandipora of Kashmir Valley that is the rural field practice area of Department of Community medicine of SKIMS situated about 30 kms from Srinagar city. The study population comprised of geriatric population (i.e. aged 60 years and above) which accounts 7.4 percent of total population. The study was conducted for a period of one year (10 Jan 2015 to 9 Jan 2016). It was a community based cross sectional multistage study.

Inclusion Criteria: Elderly people aged 60 years and above and who consent to be the part of study were included in the study.

Exclusion Criteria: All those elderly people not willing to participate or those who were not in a condition to give information due to any reason were excluded from the study.

The sample size was calculated using the equation $\{n = Z^2P (1- P)/e^2 \}$.Taking confidence limit (e) as 3 % &Z = 1.96 at 95 % CI, the sample size came out to be 928, assuming non- response rate to be 10%, a total of 1020 individuals were taken up for the study.

This multistage sampling study was conducted in Hajin Block which is divided into three health zones namely Hajin, Sumbal and Ajas. Study Sample was drawn from these three health zones by applying Probability Proportionate to Size (PPS) technique which has been estimated to be Hajin- (413), Sumbal–(390) and Ajas–(217) to a total of 1020.All the villages in each zone were enlisted (list of villages obtained from office of Block Medical Officer Hajin) and subsequently desired sample was drawn from each village again using PPS technique. Household was the final sampling unit. In each village one house (first house) in the centre of village (nearer to a landmark) was selected. Subsequent houses were selected by moving in one direction only. If the desired sample of elderly was not achieved in this direction then the house opposite to the first selected house was taken and further houses lying in that direction were selected till the desired sample required by PPS technique for that village was got. The geriatric population in the selected houses who consent to be the part of study were taken as the study population. If more than one elderly was found in the same household, each one of them was taken as study subject. Same technique was applied to each and every village. Informed and written consent was taken from participants before starting the interview. The purpose of the study was explained to the subjects and their confidentiality ensured. The eligible subjects who agreed to participate were interviewed at their respective homes. After building a friendly rapport with the subject, their socio-demographic data and their response to health perception was recorded on a standard pretested questionnaire containing socio-demogr-aphic characteristics (name, age, sex, residence, marital status) including socio-economic status using Udai Pareek scale (updated).[9]

Ethical permission for this study was obtained from Ethical Clearance Committee of S.K.I.M.S.

Data collected from the study was analyzed using SPSS version 20, Chicago, USA for Windows.

Results

The descriptive analysis of the study population revealed that out of total 1020 elderly, 55.3% were Young aged (60-69 y), 34.7% were Middle aged (70-79 y) & 10 % were Old aged (≥ 80 y); 38.2% belonged to zone Sumbal, 40.5% to zone Hajin & 21.3% were from zone Ajas; 46.4% were males & 53.6% were females; 85.5% were Illiterate & 14.5% were literate; 81.4% of elderly were living in joint family & 18.6% in nuclear family; 74% were married, 24.8% widowed & only 1.2% combined were Single/Separated/ Divorced; 83% were not working at all,11.7% were farmers,3.9% were engaged in independent business & 1.4% were labourers; 7.9% belonged to SES class V, 65.9% to SES class IV, 19.8% to SES class III, 6.3% to SES class II & 0.1% to SES class I. The present study also revealed that 89.8%

of study subjects perceived that they were currently ill and among them 53.2% were hypertensives,7% were diabetics and 34.8% were having other problems i.e, hypothyroidism, osteoarthritis, cataract, dyspepsia, COPD, joint pains, anemia or anxiety.

Table 1: Sociodemographic profile of study population

SD Variables		Frequency	Percent
Age Group (Years)	60 to 69 Y	564	55.3
	70 to 79 Y	354	34.7
	80 & above	102	10.0
	Total	1020	100.0
Zone	Sumbal	390	38.2
	Hajin	413	40.5
	Ajas	217	21.3
	Total	1020	100.0
Sex	Male	473	46.4
	Female	547	53.6
	Total	1020	100.0
Educational Status	Illiterate	872	85.5
	Literate	148	14.5
	Total	1020	100.0
Family Type	Nuclear	190	18.6
	Joint	830	81.4
	Total	1020	100.0
Marital Status	Married	755	74.0
	Widowed (Widow/Widower)	253 (185 / 68)	24.8 (18.1 / 6.7)
	Others(Single/Separated/ Divorced)	12 (8 / 2 / 2)	1.2 (0.8/ 0.2 / 0.2)
	Total	1020	100.0
Occupation Type	None	847	83.0
	Labourer/ Farmer	133(14 / 119)	13.0(1.4 / 11.7)
	Business	40	3.9
	Total	1020	100.0

Table 1.displays the frequency distribution of socio demographic variables along with the corresponding percentages for each of the sub classes of socio demographic variables for study population consisting of 1020 respondents. Most of the socio demographic variables like age group, family type, occupation type and marital status shows heavy skewed nature and a few like gender, zone are close to symmetry.

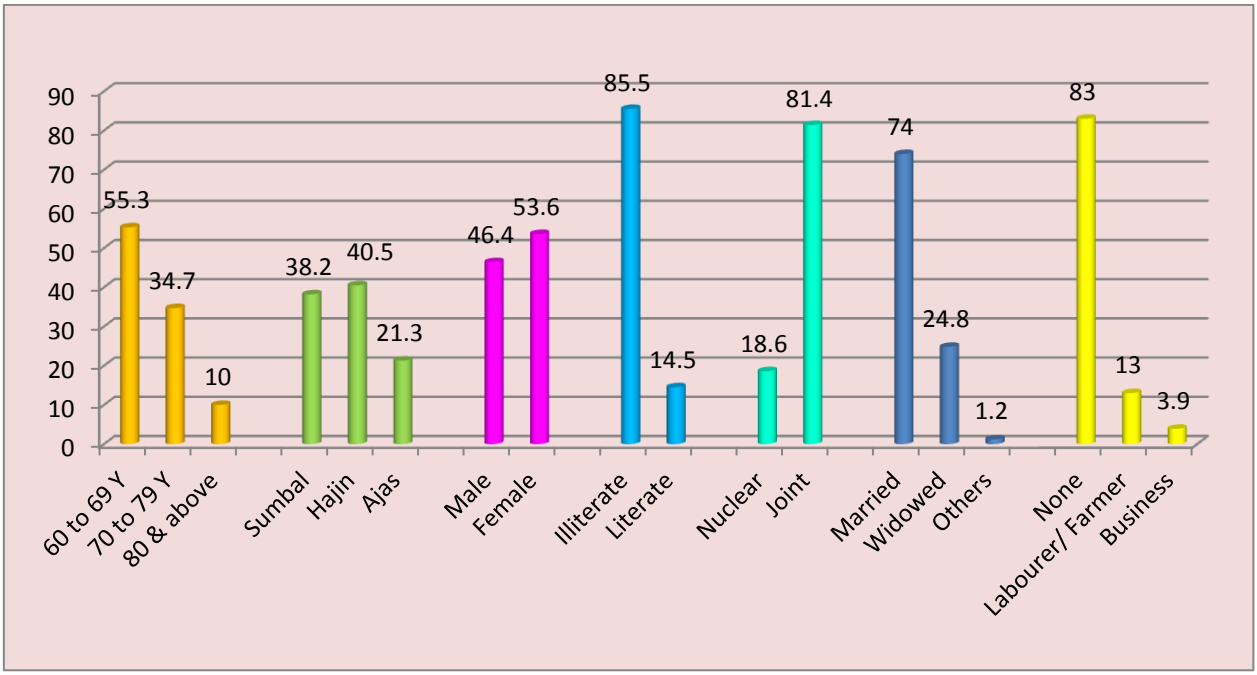

Fig. 1 Sociodemographic profile of study population

Table 2: Socioeconomic status of study population (Updated UdaiPareek Scale, 2013)

Socioeconomic status				
Socioeconomic Class	n	%	N	%
I	1	0.1	Upper class 65	6.4
II	64	6.3		
III	202	19.8	Middle class 202	19.8
IV	672	65.9	Lower class 753	73.8
V	81	7.9		
Total	1020	100	1020	100

Table 2.displays a frequency distribution of socioeconomic class along with the percentages of each class. In the first phase, socioeconomic class was consisting of five classes but due to low frequencies in the end classes, the I& II i.e Upper& Upper middle classes were pooled into Upper class and IV & V i.e Lower middle & Lower classes were pooled into Lower class to balance the weight age of each class to some extent and it was observed that majority (753) of study population belonged to Lower class (73.8%).

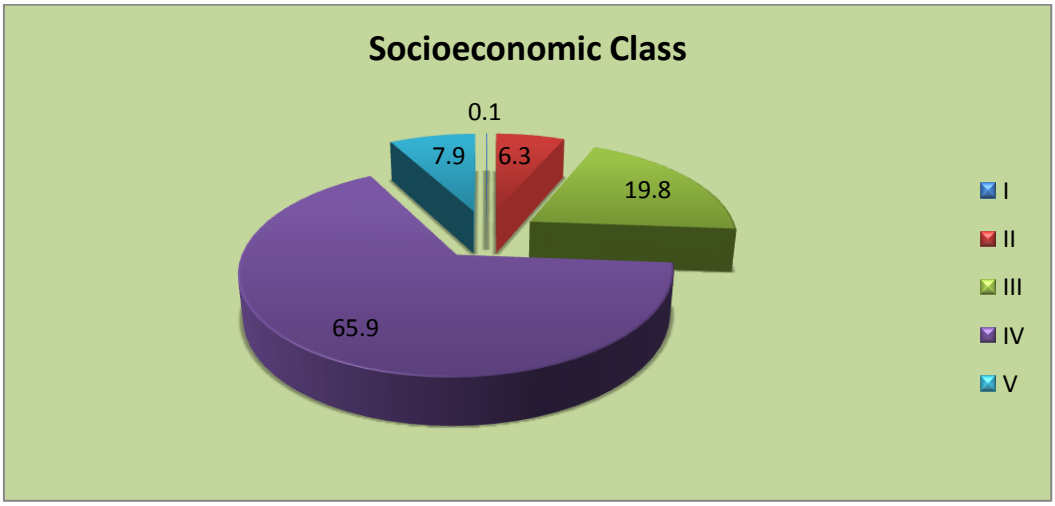

Fig. 2 Socioeconomic status of study population (Updated Udai Pareek Scale, 2013)

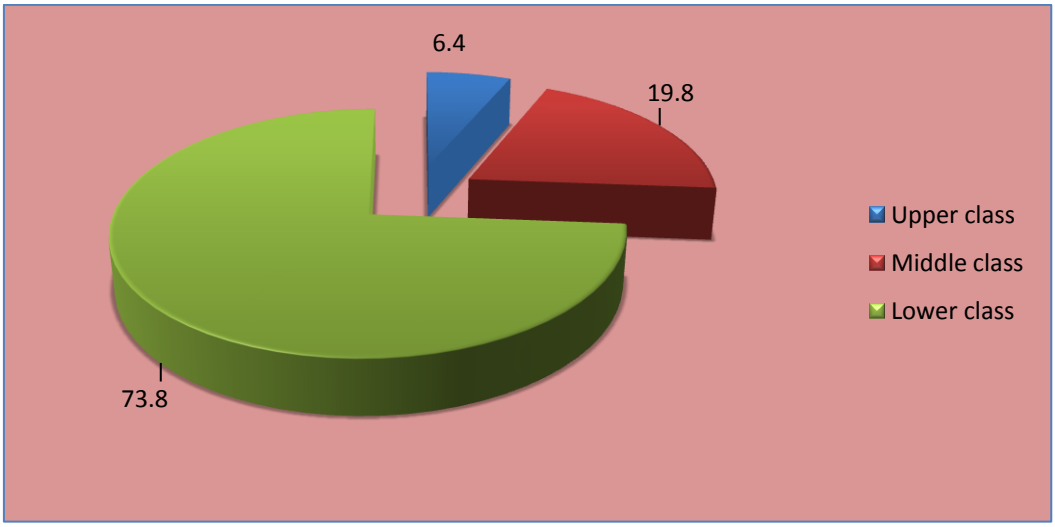

Figure 3 Socioeconomic status of study population

Table 3: Distribution of health status of study population

Health Status		Frequency	Percent
Are you currently ill	Yes	916	89.8
	No	104	10.2
	Total	1020	100.0
Type of health problem	None	104	10.2
	Hypertension	491	48.1
	Diabetes	18	1.8
	Both hypertension and diabetes	52	5.1
	Others	355	34.8
	Total	1020	100.0

Table 3. provides the overview of the frequency distribution of health status of study population and it can be seen that majority (916) fall into the illness domain (89.8%) and among these Hypertension alone was found in about 53.2 % (48.1 + 5.1) while as 34.8 % were having Other problems (i.e Hypothyroidism, Osteoarthritis, Cataract, Dyspepsia, joint pains, anxiety, etc.)

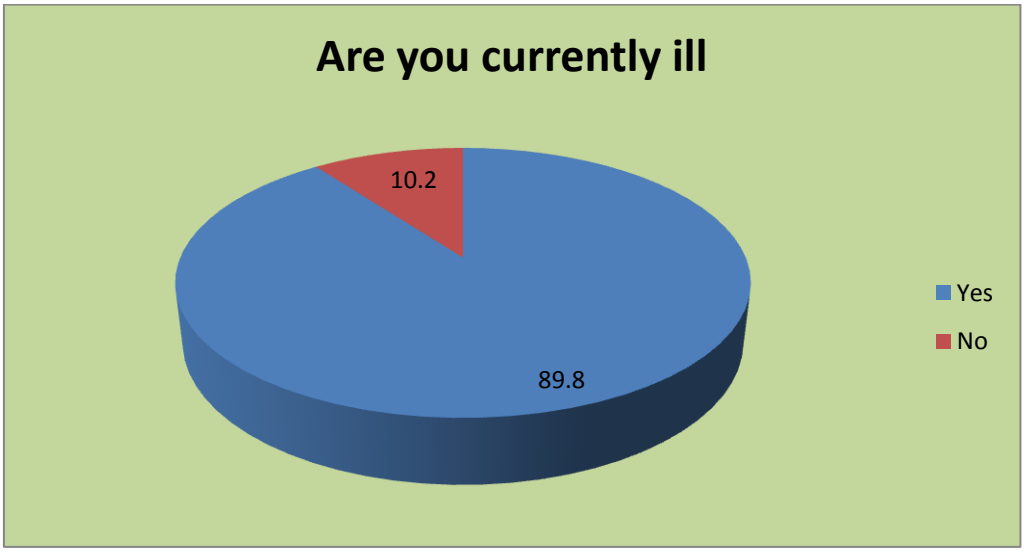

Fig. 4 Distribution of health status of study population

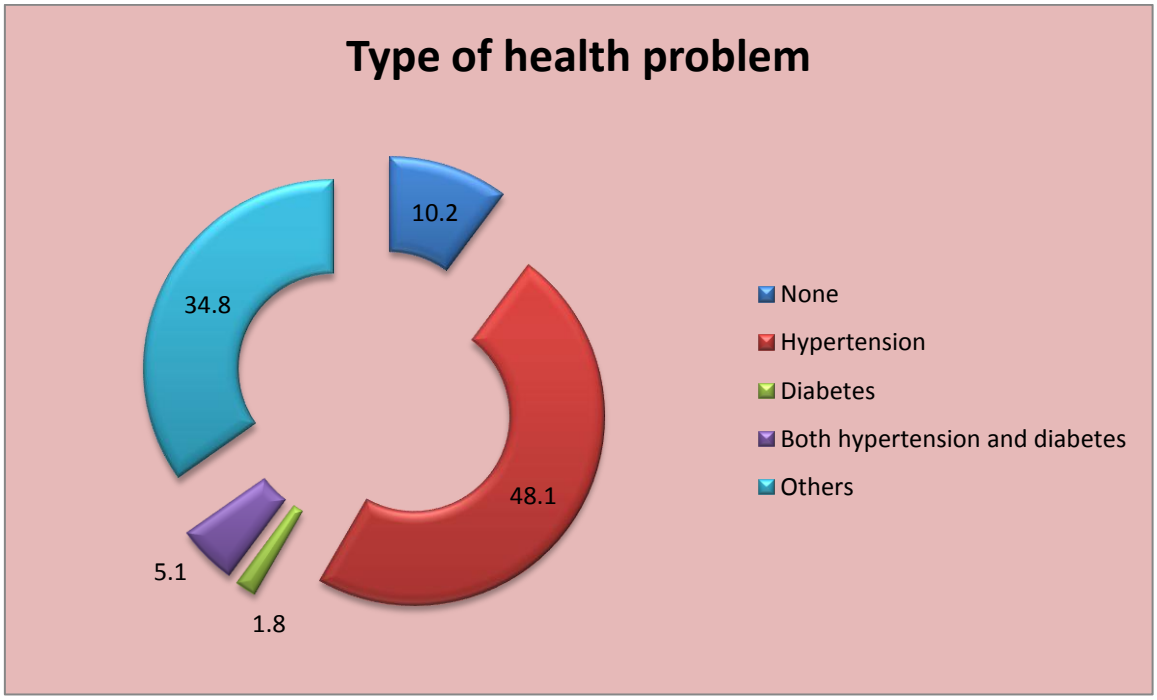

Fig. 5 Distribution of health status of study population

Discussion

The present study was carried out in a total of 1020 individuals aged 60 years & above in Hajin Block of district Bandipora of Kashmir Valley that is the rural field practice area of Department of Community medicine of SKIMS. In the present study, out of total 1020 study subjects, majority i.e 55.3% were Young aged (60-69 y). 34.7% belonged to Middle aged group (70-79 y) and 10 % were Old aged (≥ 80 y). Similar results were found in a study in Brazil by Figueira A. Helena et al in which percentages of older population were 54.8% (60-69 y), 29% (70-79 y) & 16.4% (80 y & above)[7].Another study by Sowmiya KR, Nagara-niin Mettupalayama rural area of Tamilnadu found that the proportion of young old (60-69yrs) were more (57.8%) than the old –old (70-79yrs) and the oldest –old (80 & above) being 33.4% and 8.8% respectively[10]. In the present study, 46.4% were males & 53.6% were females, with similar results found in a study in a Brazilian Sample of Older Adults by C.M. Trentini et al in which males were 44% & Females were 56% (40). In another study on Quality of Life among Rural and Urban Elderly Population of Wardha District, Maharashtra by Mudey et al, among 400 rural participants, 44% were males & 56% were females.[11]

In present study, 85.5% were illiterate & 14.5% were literate with similar results in a study on the evaluation of Quality of Life of the Elderly Population covered by health care centers of Marivanin 2010by Farzianpour F et al in Iran in which 87.2% were illiterate &12.8% were literate[12]

In present study, 81.4% of elderly were living in joint family & 18.6% in nuclear family setup. Similar findings were observed by Gaur DR et al in their in urban areas of North lndia where they found that 83.9% of elderly subjects were staying in joint family and 16.1% were staying in nuclear families.[13]

In present study, 74% of study population were married, 24.8% widowed & only 1.2% were Single/Separated/Divorced. Almost similar results were found in a study by Farzianpour F et al in Iran in 2010 in which 74.8% of study population were married.[12]

In present study, 83% of study population were not working at all,11.7% were farmers,3.9% were doing some independent business & 1.4% were labourers. A study in Brazil by C.M. Trentini et al

found that out of total sample,72% were retired i.e not working[14]

In present study, out of total sample, 7.9% belonged to SES class V,65.9% to SES class IV, 19.8% to SES class III, 6.3% to SES class II & 0.1% to SES class I, using Udai Pareek scale. A study in Visakhapatnam City by Chandrika.S et al found 10%,54%,34%,2% & 0% of elderly residing in community belonging to SES classes V,IV,III,II & I respectively.[15] Somewhat comparable results were also found in a study in rural area, Karad of Maharashtra by Durgawale P et al wherein percentage of elderly belonging to SES classes V,IV ,III,II & I was 31%,41%, 21%,3% & 4% respectively.[16] This variation in results is attributed to use of different SES scales in these studies, however, it can be seen that in all these studies similarity is that majority of elderly belong to SES class IV.

In present study, 89.8% of study subjects perceived that they were currently ill & rest 10.2% perceived to be healthy and among those elderly who were ill,53.2% were hypertensives,7% were diabetics and 34.8% were having other problems i.e, hypothyroidism, osteoarthritis, cataract, dyspepsia, COPD, joint pains, anemia, anxiety. In a study in South India by Joseph et al, most of the participants, 194 (94.2%) had some morbidity, the most common being hypertension (46.6%), diabetes mellitus (39.3%) and joint problems (30.6%). Other morbidities reported were cardiac diseases (18.9%), hearing disorders (17.9%), respiratory diseases (13.1%), visual defects (19.9%), digestive disorders (11.7%), skin diseases (6.3%), cancers (4.4%), stress (8.7%), anxiety (5.8%) and depression (3.8%).[17]

Conclusion and Recommendations

Majority of elderly in present study were young aged (60-69y) , females, illiterate, married, living in joint family, not engaged in any work, belonging to SES class IV , perceiving themselves to be currently ill and hypertensives.

Based on the results of our study the following recommendations are put forth:

1) The government agencies should carry out special surveys to identify the vulnerable aged and the deprivations suffered by them.
2) The community should be encouraged to form local support group for those older people living in nuclear families or alone.
3) The Life insurance Corporation should introduce "old age health insurance scheme" on very low premium.
4) Better income & occupation are strong predictors of QOL so the government should create job opportunities for the elderly also.
5) As most of the elderly are either not working or working in low paid informal sector with no pension or retirement benefits, the access to and the amount of social pension must increase and be indexed to inflation. The social pension benefits have to be extended for BPL families.
6) The National Programme for the Health Care for the Elderly (NPHCE) launched by the Ministry of Health and Family Welfare during the 11th Five Year Plan has to be effectively implemented by prioritising states having a higher proportion of elderly population. Further, the recently introduced RSBY guidelines will need to be expanded to ensure coverage of all BPL elderly households and the cash limit for these households need to be enhanced.

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