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Psychosocial Determinants Of Morbidity In The Aged In A Rural Area Of Punjab, India

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Abstract:

Background: In most countries, proportion of people more than 60 years of age is growing much faster than that in any other age group. It is an established fact now that the world over, there will be a significant increase in the proportion of people with conditions like dementias and Alzheimer's disease.

Methods: A cross-sectional descriptive study to determine the morbidity pattern of geriatric population residing in a rural area of the state of Punjab in India. All individuals ≥ 60 years of age, who were permanent residents of this village were included in the study.

Results: Out of the total 265 study subjects who participated in the study, 53.72% were males and 46.28% were females. The most common morbidities found in the study subjects were those pertaining to the musculoskeletal system. Amongst these, the most common was chronic low back ache. An equal percentage of male and female study subjects had ophthalmic morbidities, with the most common findings being refractive errors and cataract followed by glaucoma. Cardiovascular cases had a majority of hypertension cases. There was a significant percentage of psychiatric cases. Amongst them, the common ones were those having depression and dementia.

Conclusion: More number of women neglected their health compared to the males. The health seeking behavior of the menfolk was better than the women. Preventive, curative and rehabilitative programmes for the elderly need to be improved and health education as well as awareness drives need to be undertaken for better dissemination of the facilities provided by the government.

Key words: Psychosocial, aged, health, morbidity, rural

1.Introduction

In most countries of the world, the proportion of people who are 60 years of age and above is growing much faster than that in any other age group. This is due to both longer life expectancy and the decline in fertility rates¹. Ageing is a universal process. This ageing population can be viewed as a success story for the public health policies and also for socioeconomic development. But at the same time, it challenges the society to adapt, so as to maximize the health as well as functional capacity of older people. This also influences social participation and security¹. Old age is not a disease in itself, but the elderly are vulnerable to long term diseases of insidious onset. The importance of this stage of a human life cycle can be gauged from the fact that the WHO declared the world health day for the year 2012 focusing on ageing. The theme for that was, "Good health adds life to years".

The population of the world is ageing rapidly. By 2050, the proportion of the world's population > 60 years is estimated to double from approximately 11% to 22%. The absolute number of all people aged ≥ 60 years is expected to increase to 2 billion by that time. As per the WHO, most low- and middle-income countries will be experiencing the most rapid demographic change. It took over a 100 years for the population of France ≥ 65 years of age double from 7% to 14%. In contrast, for countries like Brazil and China it has taken less than 25 years for the same growth². India is following on the same lines as the latter. It is now an established fact that there will be an exponential increase in the number of people living with dementias such as Alzheimer's disease, the world over. Risk of dementia increases dramatically with age. There is an estimated 25% to 30% people aged ≥ 85 who are having a certain degree of cognitive decline. Most of the old people suffering from dementia in low- and middle-income countries, invariably have no access to long-term care that their condition may warrant. More often, their families too do not have publicly funded support for their care at home².

Both in the developing and the developed countries, ageing of the population indicates improvement in global health. The population of people ≥ 60 years of age has doubled in the world since 1980. This is forecast to increase to 2 billion by 2050. On one hand, older people make some important contributions to the society with their experience, which makes them an important social resource³. On the other hand, however, they pose certain special challenges of the society, where their own health and security is concerned. It is important, therefore, for health providers and societies to prepare to meet these needs of older people. This includes training in old-age care; prevention and management of chronic diseases associated with age and designing of sustainable policies focusing on long-term care and palliative care. Developing age-friendly services are also imperative³.

Active ageing is a process recognized for optimizing the opportunities for health and participation, as well as security, so as to enhance the quality of life of people, as they age⁴. This allows the people to realize their own potential for physical, mental and social well-being throughout their life. The word "active" refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force⁴. Active ageing aims to extend healthy life expectancy and quality of life for all people as they age⁴. Maintenance of autonomy and independence of older people is one of the key goals in the policy framework made for active ageing⁴. The Global brief for World Health Day 2012 takes a fresh look at health data on ageing to help us better understand the needs of older people⁵.

In view of the increasing number of aged people, the present study was undertaken in a rural area of the state of Punjab, India, to study the psychosocial determinants of morbidity in people at this stage of the life cycle.

2. Material And Methods

A cross-sectional descriptive study was undertaken to determine the morbidity pattern of the geriatric population in this rural area of Punjab, India. All individuals, ≥ 60 years of age, who were permanent residents of this village were included in the study. Those who did not fulfil this criteria, were excluded. Age was ascertained from the office of the village Panchayat, as well as valid documents like birth certificate/ ration card/ passport/ aadhar card (wherever available). Total number of persons who were 60 years old and above was 271 out of which 265 (147 males and 118 females) participated in the study. Out of the remainder six, three were away visiting relatives during the period of study while the other three were admitted in the hospital (one with a fracture of the left femur, second with acute myocardial infarction and third due to viral pneumonia).

Prior to data collection, sensitization of the villagers was done. Each individual aged 60 years and above, as well as their family members, was informed at his/ her place of residence about the survey and its objectives. The purpose of the study was explained and confidentiality of the information was assured. Information about conduct of the survey was also passed through the office of the village panchayat. Subsequently, door to door survey was carried out for data collection. Each individual included in the study was subjected to a personal interview and thorough clinical examination. The information was collected on an investigator administered pre-tested and validated questionnaire. A detailed history was also taken regarding housing and sanitary condition along with the history of present and past illness. Wherever feasible, they were examined at the primary health centre. Laboratory tests were carried out by employing field methods, so that the individuals part of the study feel comfortable in the environment of their respective homes. The laboratory tests done on each individual included estimation of haemoglobin, random blood sugar by electronic glucometer, urine for albumin and sugar by Uristix and Diastix. Besides, a twelve lead ECG was taken for each one of them by a trained technician operating the ECG machine. All these investigations were conducted at the same time or an appointment was given for the following day as per the convenience of the study subjects.

3. Results And Statistical Analysis

Out of the total 265 study subjects who participated in the study, 53.72% were males and 46.28% were females. The lower limit of age was 60 years while the oldest subject was 93 years old. For ease of analysis, the age groups were divided as shown in table – 1. Maximum number of study subjects were from the age group of 60-64 years. As shown in table – 1, in all age groups, there were more number of males than females.

Note: Values given in parenthesis refer to respective percentages.

Age groups (Years)	Male	Female	Total
60-64	65 (53.72)	56 (46.28)	121 (100.00)
65-69	48 (54.55)	40 (45.45)	88 (100.00)
70-74	26 (61.90)	16 (38.10)	42 (100.00)
≥ 75	08 (57.14)	06 (42.86)	14 (100.00)
TOTAL	147 (55.47)	118 (44.53)	265 (100.00)

Table 1: Distribution Of The Respondents By Their Age And Gender

Morbidities	Male	Female	Total
Ophthalmic	21 (50.00)	21 (50.00)	42 (100.00)
Auditory	07 (63.64)	04 (36.36)	11 (100.00)
Gastro-intestinal	0	02 (100.00)	02 (100.00)
Cardiovascular	28 (70.00)	12 (30.00)	40 (100.00)
Musculoskeletal	39 (48.83)	48 (55.17)	87 (100.00)
Respiratory	24 (75.00)	08 (25.00)	32 (100.00)
Dermatological	09 (81.82)	02 (18.18)	11 (100.00)
Psychiatric	19 (47.50)	21 (52.50)	40 (100.00)
TOTAL	147 (55.47)	118 (44.53)	265 (100.00)

Table 2: Distribution Of The Respondents By Their Gender And Morbidity Status

Note: Many Of The Subjects Reported With Multiple Symptoms

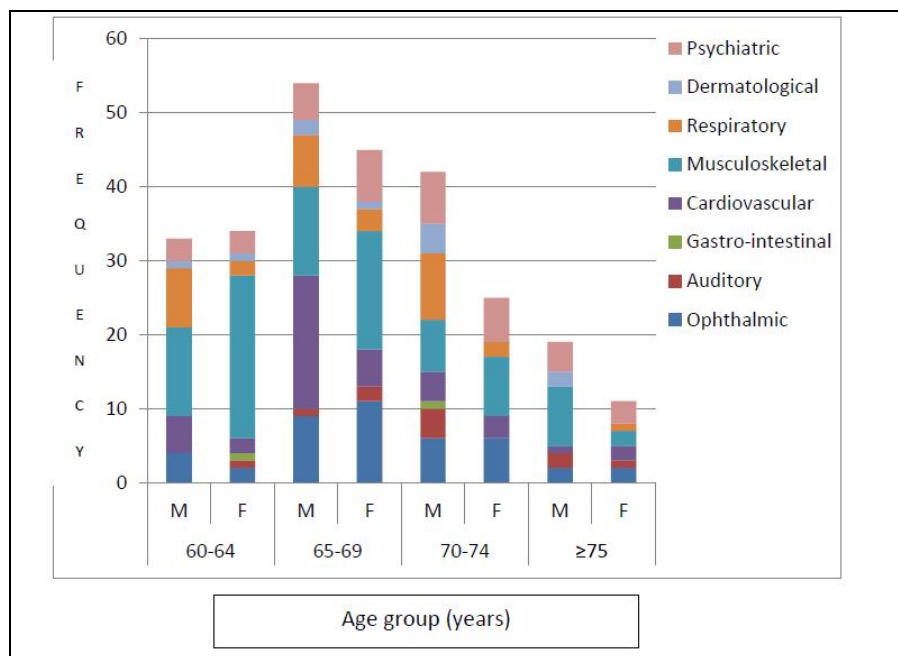


Figure 1: Distribution Of The Respondents By Their Age And Morbidity Status

Note: Many Of The Subjects Reported With Multiple Symptoms

On studying the distribution of the respondents by their gender and morbidity status (table – 2, fig - 1), it was found that the most common morbidities found in the study subjects were those pertaining to the musculoskeletal system. Amongst these, the most common was chronic low back ache. An equal percentage of male and female study subjects had ophthalmic morbidities, with the most common findings being refractive errors and cataract followed by glaucoma. Cardiovascular cases had a majority of hypertension cases. There was a significant percentage of psychiatric cases. Amongst them, the common ones were those having depression and dementia. It was noticeable that both musculoskeletal and psychiatric ailments were relatively more in the females compared to the males.

4. Discussion

From the present study we observed that the most common morbidities were those pertaining to the musculoskeletal system, followed by ophthalmological morbidities. There were a significant percentage of psychiatric cases found in this study. Amongst them, the common ones were those having depression and dementia. It was noticeable that both musculoskeletal and psychiatric ailments were relatively more in the females compared to the males. The findings of this study are comparable to a cross-sectional study conducted by Kishore S et al⁶ in which they found that the commonest morbidity was hypertension (41.4%), which was followed by musculoskeletal problems (36.8%) and respiratory problems (36.1%). The prevalence of psychosocial problems among patients was found to be 28.8 % (males-16.9%, females-48.1%). Cardiovascular morbidities were present in 70% males and 30%, females, which is comparable with the findings of Kishore S et al⁶ and also Prakash et al⁷ in which 48% of the elderly persons were hypertensive. Similarly, Chadha et al⁸ reported a prevalence rate of 52.2% and 58.4% among males and females respectively. In contrast, Garg et al⁹ found prevalence of hypertension as 16.5% in people > 55 years in an urban area of U. P.

In the present study, 44.9% of the subjects were having psychiatric morbidities. This was greater than the proportion found in another study, in which the prevalence of psychosocial problems among patients attending RHTC was found to be 28.8% (males-16.9%, females-48.1%)². However, like the present study, the proportion of females suffering from psychiatric ailments was more than that of the males. Patients were suffering from depression, loneliness or dementia. The prevalence of psychosocial problems among females is comparable in both the studies.

From the history of the subjects, when inference was derived about probable aetiology of the morbidity pattern, it was observed that more number of women neglected their health compared to the males. The health seeking behavior of the menfolk was better than the women. Moreover, men had better access to outdoor health facilities since they ventured out much more often compared to the women. The most likely reasons for psychiatric ailments seemed to be neglect by the children due to the migration of the younger generations to foreign countries or due to the exigencies of their respective services even while working in the same country/ state; besides being familial in certain other cases.

5. Conclusion

The present study conducted among the elderly in a rural area of Punjab, India has highlighted a high prevalence of morbidity and identified common existing medical problems such as like anaemia, arthritis, cataract, depression, hypertension, and diabetes mellitus. With changing patterns of family, migration of family members and other socio-demographic factors, there occur some very important and dramatic changes in the psychosocial determinants of morbidity in the elderly in developing countries. Consequently, it makes a bigger demand on the health services of the community⁶. Both perceived health and chronic illness are major elements of health status in the elderly, because perceived health declines with age and chronic health problems increase with age¹⁰. In view of the growing incidence of non-communicable diseases, the WHO has updated the general principles for screening for common non-communicable diseases as well as psychiatric ailments in health systems. Most countries, including India have since developed and implemented programmes for screening of the population¹¹. However, strengthening of geriatric health care services is required, especially for mental health. Preventive, curative and rehabilitative programmes for the elderly need to be improved and health education as well as awareness drives need to be undertaken for better dissemination of the facilities provided by the government.

6. Conflicts Of Interest

None identified.

7. References

1. <http://www.who.int/topics/ageing/en/>. Accessed on 06 November 2013.
2. WHO. Ageing and Life Course. Interesting facts about ageing. 28 March 2012. Available at: <http://www.who.int/ageing/about/facts/en/index.html>. Accessed on 06 November 2013.
3. WHO. 10 facts on ageing and the life course. April 2012. Available at: <http://www.who.int/ageing/about/facts/en/index.html>. Accessed on 06 November 2013.
4. WHO. Ageing and Life Course. What is "active ageing"? Available at:
5. http://www.who.int/ageing/active_ageing/en/index.html. Accessed on 06 November 2013.
6. WHO. World Health Day - Global brief. 03 April 2012. Available at:
7. <http://www.who.int/world-health-day/2012/en/index.html>. Accessed on 06 November 2013.
8. Kishore S, Juyal R, Semwal J, Chandra R. Morbidity profile of elderly persons. JK Science 2007; 9 (2): 87-89.
9. Prakash R, Choudhary SK, Singh US. A Study of Morbidity Pattern among Geriatric Population in an Urban Area of Udaipur, Rajasthan. IJCM 2004; 29(1): 35-40.
10. Chadha SL, Radhakrishna S. Epidemiological Study of Coronary Heart Disease in Urban Population of Delhi. Ind J Med. Research 1990; 92:424-30.
11. Garg BS, Gupta SC, Mishra VN, Singh RB. A Medico Social Study of Aged in Urban Area. Indian Medical Gazette 1982; 14(3):95-99.
12. Eun-kyung W, Han C, Ahn Jo S et al. Morbidity and related factors among elderly people in South Korea: results from the Ansan Geriatric (AGE) cohort study. BMC Public Health 2007; 7:10.
13. WHO. Meeting of interested parties: Non-communicable diseases and mental health – Progress report of 2000. Geneva 2001.