



ISSN 2278 – 0211 (Online)

Health and Associated Factors among the Chakhesang Elders

Sezolu Khamu

Research Scholar, Department of Anthropology, NEHU, Shillong, Meghalaya, India

B. T. Langstieh

Associate Professor, Department of Anthropology, NEHU, Shillong, Meghalaya, India

Abstract:

This paper attempts to look at the health of the Chakhesang elders by taking into account the self-perceived health, self-reported morbidity, physical impairments, nature of treatment and healthcare seeking behaviour. The study was conducted among the rural elderly Chakhesang population, a tribal community of Nagaland, India. A total sample of 912 individuals participated in the study with age ranging from 60-101 years. From the study, it was revealed that the elders suffer from multiple health problems. Musculoskeletal problems such as backache (18.6%), joint pain (12.1%) and body pain (12.0%) were most frequently complained by both men and women. Impaired vision was reported by the elders at 57%. Majority of them (61%) turned to allopathic drugs in times of sickness while 31.25% of the elders never sought any kind of treatment. With regard to the health seeking behaviour, majority of the elders (men=40.9% & women=46.6%) visit government health centres in times of sickness. It is felt that health awareness drives and mobile healthcare services would be of immense relief to the elders, especially in these rural areas.

Keywords: Health, chakhesang, elders

1. Introduction

Ageing is a normal part of the life span. The ageing process is a biological reality which has its own dynamism, largely beyond human control. It results from the complex interplay of physiological, psychological and social elements. Apart from the visible changes of greying hair and wrinkling skin, there are other changes that occur within the body at the tissue and cellular level. There is an overall physiological deterioration in all vital functions like respiration, cardiac function, kidney function, muscular function, etc. That is when the aged become thoroughly sopped in diverse ailments and health problems. Prevalence of health problems increase with advancement in years (Batra, 2004; Basu & Das, 2008; Bhosale & Devi, 2008; Sithara & Devi, 2010) and most of the time, the health problems of the elderly are multiple involving more than one health disorder (Batra, 2004; Goswami *et al.*, 2005; Joshi *et al.*, 2006; Bhatia *et al.*, 2007; Heath & Wason, 2008). With the increasing pace of population ageing, the health of elderly persons has become the focus of recent attention.

Health includes normal functioning of all parts of the human organism, resulting in physical strength and vigour, mental equilibrium and satisfaction with life. It also connotes a complex interaction between human and their environment, more particularly between social and economic factors, physical environment and biological environment. The constitution of the World Health Organisation sees health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' Health status is thus, an important factor that decides the quality of life of an individual and more so consociated with the elderly. Older adults have more complex health problems and use health care services at a greater rate than any other subgroup of the population (Bales & Ritchie, 2004). Graying of the world's population marks the culmination of successful human development during the last century and presents major challenges for this century. Living longer is the fruit of critical gains in public health and in standards of living. But the essence of longevity is to add life to the extended years and not merely addition of years to life. While older adults may be an important resource, they do not always live in settings in which they are able to flourish and those in rural communities may be doubly disadvantaged (Keating, 2008). Like others, they require supportive and enabling living environments to compensate for physical and social changes associated with ageing. While some may live in idyllic settings, buffered from the social problems of urban areas, many face challenges of poor service infrastructure, isolation, poverty and harsh climate.

2. Study Area

The State of Nagaland was formally inaugurated on December 1st, 1963, as the 16th State of the Indian Union. It is bounded by Assam in the West, Myanmar (Burma) on the east, Arunachal Pradesh and part of Assam on the North and Manipur in the South. The State consists of eleven Administrative Districts, inhabited by 16 major tribes along with other sub-tribes. Each tribe is distinct in character from the other in terms of customs, costumes and languages. Phek district is home to the Chakhesang and Pochury tribes. The district has a geographical area

of 2,026 sq km., sharing boundaries with Zunheboto and Tuensang Districts in the North, Kohima District in the West, Myanmar in the East and Manipur in the South. According to the 2011 census, the population of the district is 163,418 and the literacy rate is 78.05%.

The Chakhesang Nagas constitute one of the major tribes of Nagaland. They were long considered to be a part of the Angami Naga tribe and were known as the Eastern Angamis. In course of time, they came to be regarded as a distinct entity in 1948 when Chokri, Khezha and Sangtam joined to create an amalgam and the brand-new designation 'Chakhesang' was coined. At present, there are three sub-tribes i.e., Chokri, Khezha and Poumai within the Chakhesang tribe. Agriculture is the mainstay of the people. Rice is the staple food. They also cultivate maize, job's tear, millet, sesame, variety of vegetables, etc. Smoked meat, fermented bamboo shoot, fermented soya bean and the likes constitute most culinary. The Chakhesangs are patriarchal, patrilocal, and patrilineal and follow Christianity.

3. Methodology

The present study was conducted among 912 (425 men and 487 women) rural Chakhesang elders who were 60 years and over. The oldest individual in the sample was a 101 years old man. The data collection was done in 20 Chakhesang villages viz., Enhulumi, Chizami, Kami, Khezhakeno, K. Basa, K. Bawe, Lekromi, Lasumi, Leshemi, Losami, Mesulumi, Pfutseromi, Phusachodu, Phuyoba, Rihuba, Sakraba, Thenyizu, Thetsumi, Thipuzu, and Zapami. The sample included those aged individuals who were willing to participate in the study and who mentally receptive. Hence, random sampling was used for the purpose of this study. Most aged individuals did not have an official record of their birth date; as such, the age was estimated by matching recall of particular historical events. Socio-demographic details and Self-Reported Morbidity were recorded by preparing a structured schedule.

4. Results

4.1. Socio-demographic Characteristics

Characteristics	Men		Women		Total	
	N	%	N	%	N	%
Sample Size (N)	425	46.6	487	53.4	912	100
Age (Mean±SD)	73.6±9		71.8±8.6		72.6±8.8	
Living Arrangements						
Nuclear	164	38.6	166	34.1	330	36.2
Joint	124	29.2	134	27.5	258	28.3
Living with spouse	89	20.9	69	14.2	158	17.3
Living alone	48	11.3	118	24.2	166	18.2
Marital Status						
Married	333	78.4	252	51.7	585	64.1
Widowed	70	16.5	212	43.5	282	30.9
Unmarried	21	4.9	18	3.7	39	4.3
Divorced	1	0.2	5	1.0	6	0.7
Educational Levels						
Illiterate	259	60.9	453	93.0	712	78.1
Primary	75	17.6	18	3.7	93	10.2
Middle	50	11.8	11	2.3	61	6.7
High School	33	7.8	5	1.0	38	4.2
Higher Secondary	5	1.2	-	-	5	0.5
Graduate	3	0.7	-	-	3	0.3
Occupational Levels						
Farmers	336	79.1	477	97.9	813	89.1
In Govt. Service	14	3.3	3	0.6	17	1.9
Retired Govt. Servants	61	14.4	6	1.2	67	7.3
Religious	4	0.9	1	0.2	5	0.5
Village Officials	10	2.4	-	-	10	1.1
Levels of Activity						
Primary	252	59.3	342	70.2	594	65.1
Secondary	153	36.0	122	25.1	275	30.2
Sedentary	20	4.7	23	4.7	43	4.7
Types of Income						
Salaried	69	16.2	14	2.9	83	9.1
Old Age Pension	116	27.3	182	37.4	298	32.7

Table 1: Socio-demographic Characteristics of the Chakhesang Elders

Source: Fieldwork 2012-2013

The mean age of men in the sample was 73.6 years while that of women was 71.8 years and the overall mean was 72.6 years. The nuclear family type (36.2%) was the most common type of living arrangement while living alone was more prevalent among the women (24.2%)

than it was among men (11.3%). Similar trend was also observed with regard to the marital status where married men (78.4%) were more than married women (51.7%) and percentage of widowed women (43.5%) surpassed those of widowed men (16.5%). This can be explained by the fact that men tend to have lower longevity, as is proven by numerous researches and also society is more lenient towards remarriage for men. Majority of the samples are illiterate (78.1%) and cultivators (89.1%) while there is a gender disparity in all the levels of education and various occupations as is evident from Table 1. The most common level of activity is the primary level (65.1%) which includes everyday agricultural chores. Both men and women are equally involved in agricultural activities as there is no concept of “conventional housewife” in this society. More men (36%) are involved in secondary level of activity such as axing, lifting heavy loads, clearing forests, etc as compared to women (25.1%). A comparatively low percentage (4.7%) of the elders is sedentary, mainly due to infirmities or sicknesses. As with monetary income from Government sources, a mere 9.1% are salaried while 32.7% are recipients of the National Old Age Pension Scheme. The rest are dependent on farming, husbandry, basketry, weaving, etc. for generating income.

4.2. Self-Perceived Health

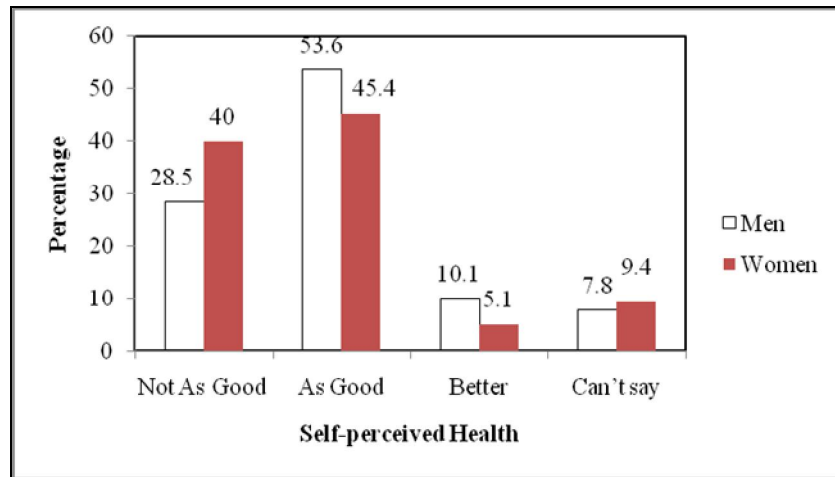


Figure 1: Self-perceived health of the Elderly
Source: Fieldwork 2012-2013

Self-perception of health is very essential for establishing the psycho-social parameters in the evaluation of health status and in determining the quality of life among the elderly. The respondents were asked to consider their health status in comparison to their contemporaries. Among the Chakhesang elders, 49.2% consider themselves to be in a similar footing with their peers (Table 2). Of these, more men (53.6%) than women (45.4%) are satisfied with their health status. A similar assessment is observed among the elderly men and women (10.1% and 5.1% respectively) who feel that they are in a better health status. A larger percentage of women (40.0%) feel that their health is not as good as their peers in comparison to 28.5% of men, while, 8.7% of the respondents were not sure of their health status. Self-perceived health can be a good indicator of the health status but it is equally likely that the perception can be over/underrated at times. Different individuals perceive health differently. What constitutes ‘good’ health for some individuals in one period of life may constitute ‘poor’ health for others (D’Souza, 2011) and vice versa. Nonetheless, it is undeniable that self-perceived health is an indispensable component in the assessment of health status.

4.3. Self-reported Morbidity

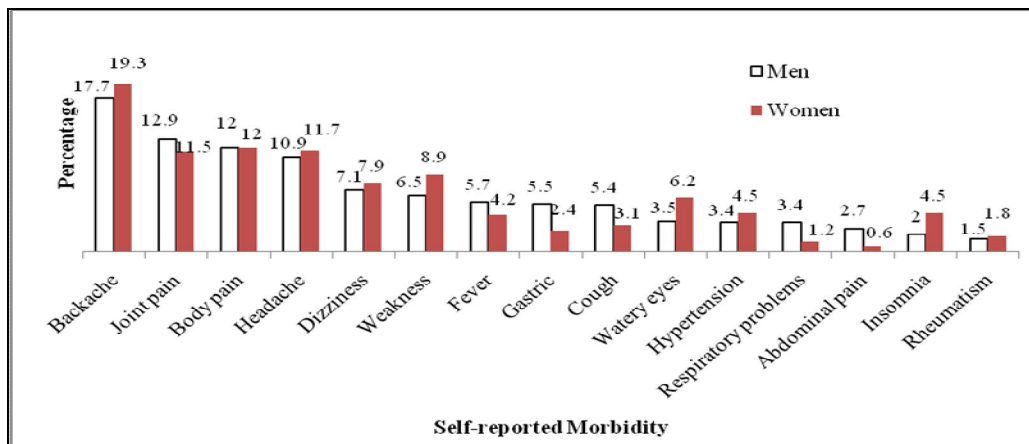


Figure 2: Self-reported Morbidity
Source: Fieldwork 2012-2013

Figure 2 presents the Self-reported morbidity among the elders. The respondents were asked about the various ailments that might have bothered them during the past 3 months prior to the day of investigation. Most of the elders reported multiple health problems. Musculoskeletal problems such as backache (18.6%), joint pain (12.1%) and body pain (12.0%) were the most prevalent complaints, both among the men and women. These afflictions, they explained, were due to arduous physical activities and some of them even encountered fortuitous which have left them with physical deformities like broken backs and deformed limbs. Headache (11.3%), dizziness (7.6%) and weakness (7.9%) were also more frequently reported by women than men. Many studies have shown that women tend to experience more of hypertension than men. A similar record was also reported among the respondents where women (4.5%) complained more problems of hypertension than men (3.4%). Cough and respiratory problems were more frequently reported by men (5.4% and 3.4% respectively) than the women folk (3.1% and 1.2%). There are numerous factors which causes cough and respiratory problems but one factor can be related to men and their lifestyle habit like smoking.

4.4. Physical Impairments among the Elderly

Physical Impairments	Men		Women		Total	
	N	%	N	%	N	%
Impaired Vision	221	52.0	299	61.4	520	57.0
Impaired Hearing	151	35.5	190	39.0	341	37.4
Functional Impairment (ADL)	2	.5	7	1.4	9	1

Table 2: Physical Impairments among the elderly
Source: Fieldwork 2012-2013

Vision was tested by finger counting method which has a cut-off point at finger counting less than one metre while hearing was evaluated by whispering test (Clausen *et al.*, 2000). Impaired vision was highly reported by the Chakhesang elders at 57% where 52% of men and 61.4% of women complained about blurry vision. In a study about the health problems of the aged Angami Nagas, Dzüvichü (2005) explained the various degrees of blindness, such as, some of them cannot put the thread across the eye of the needle, whereas others cannot recognize a person approaching until the same arrives very near. There are still others who need to adjust the distance of the book or newspaper in order to be able to read the same. Similar reasons were also described by the respondents in the present study. People in this society are avid craftsmen. Men are involved in basketry and allied activities which involve working with thin strips of split bamboo. Similarly, the womenfolk are skilful weavers and thus weave with thin strings of yarns, creating intricate designs and embroideries. The mentioned activities involve long hours of strenuous engrossments, thereby causing additional diminution in their visual acuities. There were also reported instances of blindness among such craftsmen. Only a handful of the respondents were using spectacles. The rest of the affected individuals either feel that impaired vision is a part of ageing; that the use of spectacles are not necessary nor are they very convenient, while others feel embarrassed conceiving that spectacles are for the educated.

Hearing impairment was also reported at 37.4% (35.5% among men & 39% among women) and it was considered as part of old age. Hearing aids were not popular. Functional impairment was assessed by asking the respondents whether they were able to perform everyday activities independently such as bathing, dressing, toileting, transferring, continence and feeding according to Katz Index of Independence in Activities of Daily Living (Katz *et al.*, 1970). From the answers, it was revealed that 99% of the respondents belonged to the 'full function' category while 1% reported to have been experiencing 'severe functional impairment', due to old age, ailments and past accidents. The record shows a very high independence index. However, it can be a little of an overestimation too. People in this community are hard-working and they continue work way into old age. As long as they are not weighed down by chronic ailments or are bed-ridden, they continue with the daily agricultural chores even with afflictions.

4.5. Nature of Treatment

There was either a dispensary, Primary Health Centre or Community Health Centre within each of the village. The respondents were enquired about their nature of treatment. Majority of them (61%) turned to allopathic drugs in times of sickness. It was also revealed that many of them practice self-medication, often taking hints from their counterparts. When enquired further, these drugs were mostly analgesics used in times of fever, cold, headache, body ache, etc. A handful was reported to receive homeopathic (1.64%) and ayurvedic (0.55%) treatments. Also, 1.10% was reported to have practiced traditional means of disease healing, mostly herbal therapy and zoo therapy.

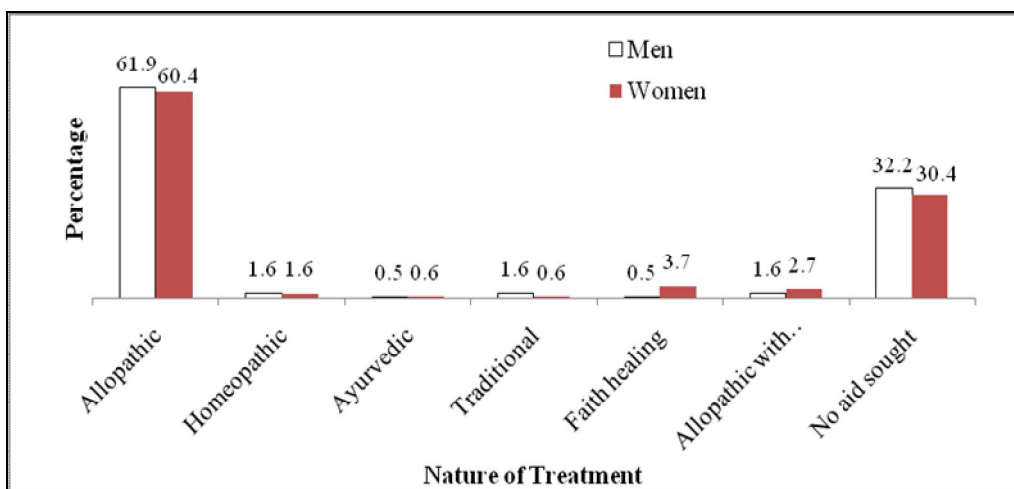


Figure 3: Nature of Treatment
Source: Fieldwork 2012-2013

The elders have a vast knowledge about the various ethno medicines. It was also revealed that the elders seek the help of self-made osteopaths in times of fractures and accidents. These local osteopaths use natural remedies and have proven to be unmistakable healers. Also, 2.19% of elders prefer faith healing i.e., healing through prayer. Another 2.19% reported to have multiple modes of treatment. People in rural areas are less concerned and conscious about their health and so it is not surprising that 31.25% of the elders never sought any kind of treatment. Most of them disregard ailments and try to endure until they develop immunity. It was also interesting to learn that some of them had never taken ill during their lifetime.

4.6. Healthcare Seeking Behaviour

Healthcare Seeking Behaviour	Men		Women		Total	
	N	%	N	%	N	%
No aid sought	141	33.2	178	36.6	319	35.0
Government Health Centres	174	40.9	227	46.6	401	44.0
Private Clinics	55	12.9	48	9.9	103	11.3
Both	19	4.5	18	3.7	37	4.1
Self treatment	36	8.5	16	3.3	52	5.7

Table 3: Healthcare seeking behaviour
(Source: Fieldwork 2012-2013)

As with the healthcare seeking behaviour, majority (men=40.9% & women=46.6%) of the elders visit government health centres, 11.3% (men=12.9% & women=9.9%) prefer to go to private clinics while 4.1% reported to visit both. Further, it was revealed that 5.7% (men=8.5% & women=3.3%) of the elders were on self-medication in consultation with their peers or family members. A large percentage of the elders (35.0%) reported to not have sought medical help at all.

5. Discussion

From the present study, it was found that the Chakhesang elders reported of multiple ailments with an average of 1.9 problems per individual among the men and 2.4 problems among the women. Multiplicity of diseases among the elders have also been reported by several studies such as those carried out by Batra, 2004; Goswami *et al.*, 2005; Joshi *et al.*, 2006; Bhatia *et al.*, 2007; Heath & Wason, 2008; Rahman, 2009, etc. Several studies have also revealed that women are more morbid than their men counterparts (Popli, 2005; Bhatia *et al.*, 2007; Bhosale & Devi, 2008; Rahman, 2009; Sithara & Devi, 2010). The Self-reported Morbidity showed elders to have more reports of musculoskeletal problems which is similar to studies carried out by Clausen *et al.*, 2000; Balamurugan & Ramathirham, 2012, etc. In the present study, the elders reported more of impaired vision (57.0%) as compared to impaired hearing (37.4%), similar to those studies carried out by Gupta *et al.*, 2009; Sithara & Devi, 2010; Ghosh & Singh, 2014. While, the results of which are diametrical to those carried out by Dzüvichü (2005) among the Angami Nagas, which revealed that the major complaint was that of 'hard of hearing' (40.52%) followed by impaired eyesight (30.0%). Also, a larger percentage of women (40.0%) perceived that their health is not as good as their peers in comparison to male counterparts (28.5%). Similar results were also revealed by Rahman, 2009 and Sithara & Devi, 2010.

As with regard to the health care seeking behaviour, 11.3% reportedly visited private clinics for treatment while 44.0% visited Government-run health centres. In a study by Narapureddy *et al.*, 2012 among rural geriatric population of Allahabad, only 18.9% sought treatment from Government hospital while 32.3% sought help from private hospital. As such, the present studied population seem to be using more of Government facilities which also differs from the study by Dominic *et al.*, 2013, which revealed that majority of the samples were utilising the private health care facilities during their period of health problems.

6. Conclusion

From the study, it was observed that most of the elders suffer from multiple ailments, which they attribute to old age and arduous physical activities. The elders were not really concerned and conscious about their health. They often disregard ailments and try to endure until they develop immunity or else, succumb to their illnesses. Majority of them do not seek medical help due to lack of awareness, sheer negligence and also due to financial constraints. As such, it is felt that the elders should be encouraged to undergo timely medical check-ups. It is also imperative to sensitize them on the hazards of self-medication. Geriatric care units are crucial in all the health centres to cater to the needs of the elders in particular and these units should be highly accessible and affordable. Mobile healthcare services for the aged will be of immense help to those elders from rural areas because most of the elders do not seek medical help due to poverty and difficulties in travelling long distances. As such, conducting mobile medical camps by trained medical personals for consultations and treatments will be a huge relief to the aged. These kinds of special packages for the elderly will ensure that the elders experience a happy, active and successful ageing. With the increasing pace of population ageing, the health of elderly persons has become the focus of recent attention. Hence, it is the need of the hour to design special packages for the elders in congruence to population ageing, which is fast gaining momentum.

7. References

- i. Balamurugan, J. & Ramathiratham, G. (2012). Health problems of Aged People. *International Journal of Research in Social Sciences*, 2(3), 139-150.
- ii. Bales, C.W. & Ritchie, C.S. (2004). *Handbook of Clinical Nutrition and Ageing*. Totowa: Humana Press.
- iii. Basu, S. & Das, P.K. (2008). Socio-economic and Health Implications of Population Ageing in India. *Indian Journal of Gerontology*, 22(1), 85-106.
- iv. Batra, S. (2004). Health Problems of Elderly-An Intervention Strategy. *Indian Journal of Gerontology*, 18(2), 201-218.
- v. Bhatia, S.P.S., Swami, H.M., Thakur, J.S. & Bhatia, V. (2007). A Study of Health Problems and Loneliness among the Elderly in Chandigarh. *Indian Journal of Community Medicine*, 32(4), 239-307.
- vi. Bhosale, B. & Devi, R. (2008). Health Status of Institutionalized Elderly. *Indian Journal of Gerontology*, 22(2), 227-232.
- vii. Clausen, F., Sandberg, E., Ingstad, B. & Hjortdahl, P. (2000). Morbidity and Health Care Utilisation among Elderly People in Mmankgodi Village, Botswana. *Journal of Epidemiological Community Health*, 54, 58-63.
- viii. D'Souza, A.J. (2011). Health of the Elderly in Rural Dakshina Kannada. *Indian Journal of Gerontology*, 25(3), 329-344.
- ix. Dominic, R.A., Shashidhara, Y.N. & Nayak, M.G. (2013). Health Seeking Behavior of Rural Adults. *Nitte University Journal of Health Science*, 3(3), 77-82.
- x. Dzüvichü, K. (2005). Health Problems of the Aged among the Angami Nagas. *Journal of Human Ecology*, 17(2), 101-107.
- xi. Ghosh, A. & Singh, A. (2014). Health Status of Elderly in a Rural Area of North East Region of India. *National Journal of Community Medicine*, 5(2), 236-239.
- xii. Goswami, A., Reddaiah, V.P., Kapoor, S.K., Singh, B., Dey, A.B., Dwivedi, S.N. & Kumar, G. (2005). Health Problems and Health Seeking Behaviour of the Rural Aged. *Indian Journal of Gerontology*, 19(2), 163-180.
- xiii. Gupta, S., Rathore, M.S. & Shekhawat, S.S. (2009). A Cross Sectional Study of Health Profile among Rural Elderly of North-West Rajasthan. *Indian Journal of Gerontology*, 23(1), 26-31.
- xiv. Heath, I. & Wasson, J. (2008). Making a Difference. *British Medical Journal*, 336, 950-951.
- xv. Joshi, S.V., Menson, K.S., Sawant, S.M., Laxmi, V.A. & Dhar, H.L. (2006). Demographic Health Profile in Urban and Rural Elderly population. *Indian Journal of Gerontology*, 20(4), 337-346.
- xvi. Katz, S., Down, T.D., Cash, H.R., et al. (1970). *Gerontologist*, 10, 20-30.
- xvii. Keating, N. (2008). *Rural Ageing: A Good Place to Grow Old?*, Bristol: Policy Press.
- xviii. Narapureddy, B., Naveen, K.H., Madithati, P., Singh, R.K. & Pirabu, R.A. (2012). Socio-demographic Profile and Health care Seeking Behaviour of Rural Geriatric Population of Allahabad District of UP: A Cross Sectional Study. *International Journal of Medical Science and Public Health*, 1(2), 87-92.
- xix. Popli, U.K. (2005). Status of Health of Women after retirement. *Indian Journal of Gerontology*, 19(2), 193-206.
- xx. Rahman, M.M. (2009). Health Status and Health Needs among the Aged Population in Chapai Nawabganj District of Bangladesh. *Indian Journal of Gerontology*, 23(1), 32-41.
- xxi. Sithara, B.V. & Devi, V.G. (2010). Health Status of the Elderly. *Indian Journal of Gerontology*, 24(2), 194-209.