Available online at http://www.journalijdr.com

IJDR

International Journal of
DEVELOPMENT RESEARCH

ISSN: 2230-9926

International Journal of Development Research
Vol. 4, Issue, 10, pp. 2136-2139, October, 2014

Full Length Research Article

CO-VARIANTS INFLUENCING MORBIDITY PATTERN AMONG AGING WOMEN

***Dr. Shubha Dube and Ms Kirti Sharma**

Department of Home Science, (Human Development) University of Rajasthan, Jaipur

ARTICLE INFO

Article History:

Received 30th July, 2014
Received in revised form
31st August, 2014
Accepted 22nd September, 2014
Published online 25th October, 2014

Key words:

Ageing Women,
Morbidity Pattern,
Age,
SES.

ABSTRACT

Health and Human rights has explicit intrinsic connections and has emerged as powerful concepts. Health is a major instrument of social and economic development and it can play a very important role in the creation of a new world. The Extension of human life in the 21st century has been achieved due to a combination of improved medical, social and evolutionary factors, resulting in a growing number of ageing population in most countries of the world, including India. The graying world is also witnessing several other phenomena, one of which is that of 'graying feminization of aging'. The level of development achieved by a society is often determined on the basis of the level of health and the system of health care services prevalent in the society. The right to health is a fundamental right of every human being leading to enjoyment of the highest attainable standard of health. Aging brings in its fold innumerable problems to the aged, especially women. Older women are more likely to be widowed, poor and suffer vulnerability. The women suffering from chronic ill health and disability are a reflection of the low status of women in society. Psychologists strive to evaluate and appreciate the diversity in the aging process, particularly the influence of socio-cultural factors on the experience and expression of health and psychological problems in later life. The present study is an attempt to review and report some of the risk factors that affect the morbidity pattern among aging women in India.

INTRODUCTION

Aging is a sequential series of processes that begin with life and continue throughout the life cycle. The extension of human life years, in the 21st century has been achieved due to a combination of improved medical, social and evolutionary factors, resulting in a growing number of ageing population in most countries of the world, including India (Gupta *et al*., 2009). The graying world is also witnessing several phenomena, one of which is that of '*graying feminization of aging*'. There has been a steady rise in the share of elderly population (age 60 years or above) in the total population over the decades. As against 5.6% in 1961, the proportion goes up to 7.4% in 2001. For males, the rise was more modest from 5.5% to 7.1%, while for females there had been a steep rise from 5.8 to7.8% during the five decadal Censuses from 1991 to 2001. It can also be observed that the percentage (of elderly) had all along been higher in rural areas than that in urban with a female preponderance (Census, 2011).

****Corresponding author: Dr. Shubha Dube***
Department of Home Science, (Human Development) University of Rajasthan, Jaipur

Men and women think about aging differently, because of biological, social, and psychological differences between the sexes. Strengthening health equity globally and within countries means, going beyond contemporary concentration on the immediate causes of disease, the fundamental structures of social hierarchy and the socially determined conditions in which people grow, live and work. (Steinbrook, 2008) Health and Human rights has explicit intrinsic connections and has emerged as powerful concepts. The right to health is a fundamental right of every human being and it implies the enjoyment of the highest attainable standard of health (Rajan, 2006). Healthy living conditions and access to good quality health care for all citizens are not only basic human rights, but it is also essential prerequisites for social and economic development and can play a very important role in the creation of a new world (Shiva, 2002). Any inequality in social, economical or political context between various population groups in a given society will affect the health indicators of that particular society (Narayan, 2000). The level of development achieved by a society is often determined on the basis of the quality of its population's health, how fairly health is distributed across the social spectrum, the degree of

protection provided from ill-health, the system of health care and services prevalent in the society. If women suffer from chronic ill health and disability, it is a reflection of their lower status in society (Shanta, 2011). Women issues frequently arise as concerns to be dealt with sensitively. (Banks, Ackerman, & Clark, 1986; Trotman & Brody, 2002). Morbidity (from Latin *morbidus*, meaning "sick, unhealthy") has been defined as any departure subjective or objective from a state of physiological well being, and is equivalent to terms, such as sickness, illness and disability. It is important to delay the onset of disability or morbidity to ensure optimal quality of life for older people. Morbidity pattern among the elderly varies from country to country. (Davida, 2007) From the morbidity point of view, almost 50% of the Indian elderly have chronic diseases and 5% suffer from immobility. Chronic conditions which produce infirmity and disability become more common in old age. (Census, 2011).

Many older women live with multiple chronic /compromised health conditions that can limit mobility and thus further restrict their capacity to socialize. (Stevens & Olsen 2000) Women, have higher rates of disabling non-fatal chronic conditions, like arthritis and osteoporosis. One of the most devastating complications of osteoporosis is a fracture, especially of the hip region, which causes the greatest morbidity and mortality. Therefore, women remain in a disabled state for a longer period of time (Leveille *et al*., 2000). Women are also more likely to be institutionalized. There are various reasons for these gender differences (Sternfeld, 2002) Socio-cultural factors , demographic profile, life-style patterns, support system, behavioral, psychological, and biological characteristics of an individual are some of the antecedents that affect, the severity of impairment, functional limitation and disability. (Jejeebhoy, 2001) Social and cultural differences also affect how we deal with aging (Rajshree Bhatt *et al*., 2011).

Specialists in Human Development and Gerontologists strive to understand diversity in the aging process, particularly how socio-cultural factors may influence the experience and expression of health and psychological problems in later life particularly among women (Singh, 2009). To summarize it can be said that aging and health problems in women are interrelated. They are facing numerous physical, psychological and social role changes that challenge their sense of self and capacity to live happily. Various socio-cultural factors influence overall well-being of aging women. (Evenhuis, 2001). Though, there are many factors that affect the morbidity pattern, but in our literature review we are looking on the influence of age, socio-economic status, education, marital position and family system of aging female on their morbidity pattern.

Age

Age has special implications for women as far as health problems are concerned. The existing hypothesis holds that aging brings decline in physical and mental health of people. The problem becomes more acute in the case of women. As women age, they are subjected to social, economic and medical negligence and abuse (Asokan, 2001). Oldest old are greatly influenced from the aging process and as a consequence they appear to have more disabilities and physical limitations than older and lack of autonomy depriving them from participating in social activities or meeting their friends. Some physical changes and cognitive decline are most marked amongst people who do not use their abilities. Short-term memory is likely to be most affected by age-related changes. (McCarthy, 2002) Other issues, however, may be more specific to late life, such as grand parenting problems, adapting to typical age-related physical changes, including health problems, lifetime aspirations, achievements and failures (Evenhuis, 2001)

Older people may unwittingly assume the stereotypes of old age. Expectations regarding health diminish with age, sometimes realistically, but often not. Ageing adults with treatable symptoms tend to dismiss their problems as an inevitable part of aging. As a result they may not seek medical care and may suffer needless discomfort and disability. They may not even seek treatment for serious conditions including visual and hearing impairment. (Tasman, 2005) Women are more vulnerable to higher levels of loneliness, because of their greater longevity compared to men. As women age, they often outlive spouses, friends and family members who previously provided the social and emotional support that are important for their health and well-being (Prasher, 2003). The feeling of loneliness along with decline in physical and physiological functioning makes them prone to psychological disturbance (Ghosh, 2006).

Socio-Economic Status

Social and economic inequality is detrimental to the health of any society. Especially when the society is diverse, multicultural, overpopulated and undergoing rapid but unequal economic growth like in India. Among the several problems of the elderly in our society, economic problems occupy an important position. Poverty, which is a result of social and economic inequality in a society, is detrimental to the health of population. The outcome indicators of health (mortality, morbidity and life expectancy) are all directly influenced by the standards of living of a given population. (Deogaonkar, 2004). Old age is a real challenge in India because of an absence of adequate economic and social security programmes for the aged by the government and the problem has been aggravated because of lack of personal saving (Bhattacharya, 2002). The problems faced by the females are more critical compared to that of men due to low literacy rate, higher incidence of widowhood, customary ownership of property by men and majority of women being not involved in economic and financial tasks during their prime age with only very few in the organized sector. As female live longer, they need more intensive and long term care, which in turn may increase financial stress in the family (Siva, 2002). About 65% of the aged have to depend on others for their day-to-day maintenance. The situation is worse for elderly females with about only 14% to 17% being economically independent in rural and urban areas respectively, while the remaining are dependent on others - either partially or fully (Census, 2011).

Education

Education is an objective variable that is easily measured and generally fixed early in life. Unlike occupation or income, education can be determined for all individuals. (Hoffmann

2008), education is chronologically and causally prior to occupation and income. Therefore, the attained educational level anticipates future occupational chances and income. Moreover, education affects potential earnings, and thus access to material sources. The level of education also influences health behavior, providing better knowledge and access to information about health risks and healthy behaviors, as well as the cognitive ability to deal with such information. Lower levels of education tend to have a higher probability of becoming functionally disabled, and face a higher mortality risk, than people with higher educational levels (Elo and Preston 1996, Freedman and Martin 1999, Minicuci and Noale 2005). People with a low level of education have shorter lives and fewer years in good health than people with a higher level of education. (Manor, 2004) Worldwide, ageing women have extraordinarily high levels of illiteracy, and there is a predictable gender gap regarding education. (World Population Ageing, 2005) Older women have the highest rates of illiteracy, even in countries with high literacy levels. This limits their ability to be active citizens, workers and members of their society, and infringes on their access to fundamental human rights. (Reyes Gomez, 2002) Eliminating gender disparity in primary and secondary education would help improve literacy levels in generations to come. It is essential to address the literacy needs of ageing cohorts. Governments, civil society, and employers need to make efforts to support the participation of ageing women in literacy, skills and jobs training, and life-long learning activities. (World Health Organization, 2003)

Marital Position

Marriage is said to have a protection effect due to greater financial and material resources, greater social support, and better health-related behavior. The absence of partner creates insecurity and isolation to the other spouse. (Hyer & Sohnle, 2001). Elderly women have lower quality of life and more loneliness than elderly men because of their health problems, physical limitations, social inactivity and marital status. (Kumar, 2003). It is believed that married women have better quality of life and lower loneliness than divorced and widows. Older women are more likely to be widowed, live alone, poor, suffer vulnerability and to experience an increased number of years with declining health (Shanta, 2011). Although marriage has a beneficial effect for both sexes, it seems that the advantages of marriage are greater for men than for women. This can be explained through the different traditional role models men and women adopt in marriage. While wives often serve as caretakers, providers of information, and inhibitors of unhealthy behaviors, they are also more likely to suffer from stress because of their restricted gender role. On the other hand, husbands often provide greater financial support to their wives, which might reduce stress concerning material well-being. (Radhey, 2002) Becoming a widow or getting divorced is often associated with worse health outcomes. This is due to the fact that becoming widowed is a stress-provoking crisis that may lead to worse health and higher mortality rates (Sujithkumar 2008).

Family System

In traditional Indian culture aged people are well respected, but the situation is changing in present setup because of conspicuous reasons, like the disintegration of joint family system, migration, rapid industrialization, urbanization and deteriorating social values. (P.S. 2008) The joint family system is being replaced by a smaller nuclear family. With the traditional system of the lady of the house looking after the older family members at home is slowly getting changed as the women are also participating in activities outside home and have their own career ambitions. All these changes are causing adverse effects on well-being of the aged people (Subrahmanya, 2000). In Indian culture family is a sort of insurance that one will be looked after in one's old age. As a consequence of urbanization and industrialization, the integrity of the family and the existence of the aged as an integral part of the family are being uprooted. The young generation should understand that the aged need physical attention and emotional caring. The old love to spend their days in surroundings very familiar to them, filled with the sounds and touch of those most dear to them. (Raakhee, 2003)

Concluding Remarks

Population aging can be seen as a success story for public health policies and socioeconomic development in the 21st century. However, it also challenges society to adapt, in order to maximize the health and functional capacity, social participation and security of ageing adults (WHO, 2002). Many aging female of our society are unable to live meaningful and independent life. As a result they develop dementia, progressive or irreversible decline in cognitive abilities, neurological deficits, behavioral and psychological problems. (Sommer, 2003). Vast resources will be required towards support, health care, quality of life and treatment of older women (Goyal, 2008). A rehabilitation program may help them to overcome this disability and to live life meaningfully and as independently as possible. Though, literally speaking 'rehabilitation' means 'to restore to a former position or status', but in case of aging adults it means to make efforts towards improving their quality of life. (Dantas, 2008) Thus, quality of life, not just quantity, must be a priority. This literature review is an attempt to summarize the variety and the large volume of research findings on selective Socio-cultural factors influencing morbidity among aging women. It allows us to identify areas where more research is needed.

REFERENCES

Raakhee. A.S. & H. Sam Sananda Raj 2003. Alienation among the Institutionalized and Non-Institutionalized aged Psychological Studies National Academy of Psychology, India, and Vol.48.No. (2) 65-68

Asokan, NN 2001. Demography and social impact. Geriatrics updates Proceedings of Indo-US Conference of geriatrics Feb 2001, OP Sharma (Ed) Geriatric Society of India, New Delhi. 5-12,

Bhattacharya, Prakash 2002. Old Age Income Security: Indian Perspective, Insurance Chronicle.

Census, 2011. Situation Analysis of the Elderly India, Central Statistic office Ministry of Statistics & Programme Implementation Government of India.

Dantas, Estelio H.M. & Vale, R.G. 2008. Physical Activity and Healthy Aging. Shape. Riodke Janeiro.

Davida Kindig 2007. Understanding Population Health Terminology, The Milbank Quarterly, Vol. 85, No. 1, (pp. 139–161)

Deogaonkar, Milind. 2004: Socio-economic inequality and its effect on healthcare delivery in India: Inequality and healthcare, Electronic Journal of Sociology, ISSN: 1198 3655s

Elo, I.T. & Preston, S.H. 1996. Educational differentials in mortality - United States, 1979-85. *Social Science and Medicine.* 42(1): 47-57.

Evenhuis, H., Henderson, C., Beange, H., Lennox, N. and Chicoine, B. 2001 'Healthy ageing- adults with intellectual disability: Physical health issues.' Journal of Applied Research in Intellectual Disabilities 14, 3, 175-194.

Freedman, VA. & Martin, L. G. 1999. The role of education in explaining and forecasting trends in functional limitations among older Americans. *Demography.* 36(4): 461-473.

Ghosh 2006. Psychiatry in India: Need to focus on geriatric psychiatry. Indian Journal of Psychiatry. 48: 4-9.

Goyal V.C & Dixit Usha 2008. Technology Intervention for Elderly people, Help Age India.R & D Jl.Vol.14, No.2

Gupta Sitaram, Rathore M.S. & Shekhawat SS 2009. A Cross Sectional Study of Health Profile among Rural Elderly of North-West Rajasthan. Indian Journal of Gerontology, Vol.23, No.1. PP 26-31

Hyer, L. A., & Sohnle, S. J. 2001. Trauma among older people: Issues and treatment. Philadelphia: Bruner-Routledge.

Jejeebhoy SJ, Sathar ZA 2001. Women's autonomy in India and Pakistan: the influence of region and religion. Popul Dev Rev; 27,687-712

Leveille, S.G., Resnick, H.E., and Balfour, J. 2000. Gender differences in disability: Evidence and underlying reasons. *Aging Clinical and Experimental Research.*12 (2): 106-112.

Manor, O 2004. Educational differentials in mortality from cardiovascular disease among men and women: The Israel Longitudinal Mortality Study. Annals of Epidemiology, 14(7):453–460.

McCarthy, M. & Millard, L. 2002. Supporting Women with Learning Disabilities through the Menopause. Brighton: Pavilion.www.pavpub.com

Minicuci, N. and Noale, M. 2005. Influence of level of education on disability free life expectancy by sex: The ILSA Study. Experimental Gerontology. 40: 997- 1003. doi:10.1016/j.exger.2005.08.011.

Narayan D, Patel R, Schafft K, Rademacher A, Koch-Schulte S. 2000: Changing gender relations in the household. In: Voices of the poor: can anyone hear us? New York, NY: Oxford University Press.

Sujithkumar, P.S. 2008: Work Participation and Household Activity Participation by ELDERLY Population: some Observations, Man In India, 88 (4): 665-670

Prasher, V. & Janicki, M. 2003. Physical Health of Adults with Intellectual Disabilities. Oxford: Blackwell.

Kumar, S, Vijay. 2003: "Economic Security for the Elderly in India: An Overview", An Aging India: Perspectives, Prospects and Policies, The Haworth Press p.45-65, New York.

Radhey Shyam & Yadav Sudesh 2002. A Study of Depression, Self-esteem and Social Support Amongst Institutionalized and Non-Instituttionalized Aged, Journal of Personallity and Clinical Studies, 79-86.

Rajshree Bhatt, Minal S Gadhvi1, K N Sonaliya, Anand Solanki, Himanshu Nayak 2011: An Epidemiological Study Of The Morbidity Pattern Among The Elderly Population In Ahmedabad, Gujarat National Journal of Community Medicine Vol 2 Issue 2 July-Sept 2011 Page 233

Reyes Gomez L. 2002. Vejez y pobreza: el caso de los zoques de Chiapas.VI Meeting of the Mexican Society of Demography, Mexico City. In: HelpAge International, London.

Singh, Archna & Misra Nishi 2009. Loneliness, depression and sociability in old age. Industrial Psychiatry Journal, Vol 18, Issue 1

Siva Raju, S. 2002: "Meeting the Needs of the Poor and Excluded in India", Situation and Voices, The Older Poor and Excluded in South Africa and India, UNFPA, Population and Development Strategies, No. 2, 93-110.

Sommer-Pere & M. Le. 2003. Old Age: ethical problems in old aged in Moral philosophy and Ethics Dictionary.Org. Monique Canto- Sperber Unisions, V.2, PP. 745-748, Rio Grande do sol.

Steinbrook R. 2008. HIV in India: a downsized epidemic. New England journal of medicine, 358:107-109.

Sternfeld, B., Ngo, L., Satariano, W.A., & Tager, I.B. 2002. Associations of body composition with physical performance and self-reported functional limitation in elderly men and women. *American Journal of Epidemiology.* 156(2): 110-121.

Tasman, W. & B. Rovner. 2005. Age-related Macular Degeneration: Treating the whole Patient. Canadian Journal of Opthalmology 40.3: 389-91.

Trotman, F. K., & Brody, C. M. 2002. Psychotherapy and counseling with older women: Cross-cultural, family, and end-of-life issues. New York: Springer.

World population ageing, 2005. New York United Nations Department of Economic and Social Affairs, Population Division.

WHO 2002. Active Aging: A Policy Framework, World Health Organization.

****