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Review Article

A review of the physical and psychosocial support systems for the aged in rural Punjab

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ABSTRACT

Background: The world over, in most countries, proportion of people who are 60 years of age or more, is growing much faster than that in any other age group. Old age is not a disease in itself, but the elderly are vulnerable to long term diseases of insidious onset. Therefore, the support system available to them at this juncture in life is very essential. This analytical study evaluated the quality of psychosocial support systems available for the aged in rural Punjab, India. *Materials and methods:* This study was conducted in a rural area of district Moga in the state of Punjab, India. The demographic data and profile of the village population was studied and out of the total population of 9,456, individuals who were 60 years or older of age who met the inclusion criteria were included in the study. *Results:* Out of the total of 1870 elderly population who met the inclusion criteria, 980 were females while the remainder 890 were men. 93% of the study population stated that the primary health care services provided in the village were not adapted to the needs of people of their age. 86% agreed that the infrastructure was not comfortable for them.*Conclusion:* There is a need to review the quality as well as the distribution of services offered to the elderly in rural Punjab, India, including the content of the services, especially where their mental health is concerned.

Key words: Aged, elderly, Punjab, rural, support

1. INTRODUCTION

In most countries of the world, proportion of people who are 60 years of age or more, is growing much faster than that in any other age group[1]. This is due to both longer life expectancy and the decline in fertility

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rates[1]. 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.[1, 2] This also influences social participation and security[1]. 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 World Health Organisation (WHO) declared the world health day for the year 2012 focusing on ageing [1, 3, 4] 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% [4, 5] The absolute number of all people aged ≥60 years is expected to increase to 2 billion by that time. [6] As per the WHO, most low- and middle-income countries will be experiencing the most rapid demographic change.[7] In a study conducted in Punjab, India, most of the study subjects from the elderly age group were found to be depressed and also diagnosed to be having other psychiatric morbidities.[8] The world will probably have more number of people who will live to be in their 80s or 90s compared to ever before.[9] For example, the number of people of 80 years or more of age, will be almost four times of the present, between 2000 and 2050. The world over, many of the older people are at a risk of maltreatment. There is a rising need for long-term care.[9] There will be a large number of older people by 2050, who are no longer capable of looking after themselves in developing countries. Most of the elderly lose their ability to live independently since they have limited mobility, frailty or certain other physical or mental health problems. Many of these require some or the other form of long-term care. Globally, there is bound to be a dramatic increase in the number of people diagnosed with dementias like Alzheimer's disease, as the people live longer. Further, in emergency situations, the elderly can be especially very vulnerable.[9, 10]

The WHO has coined a term "active ageing" [4, 5, 6]to describe the process of optimizing the opportunities for good health, better participation and improved security so as to enhance the quality of the life as people age. It applies both to individuals as well as population groups. Active ageing allows the people to realize their own potential for physical, social, as well as mental well-being. It influences this throughout the life course of the individuals and also their participation in society, at the same time, providing them an adequate protection, good security as well as care whenever they need. The word "active", in fact, refers to the continuing participation of the people in social, economic, spiritual, cultural and civic affairs. It is not just the mere ability to be active physically. Elderly people who retire from their work, are in ill or live with some disabilities, can possibly remain quite active contributors to their own families, their peers, communities and the nations. Active ageing, thus, aims to extend a healthy life expectancy as well as quality of life for all the people as they are ageing. "Health" refers to physical, mental and social well being as expressed in the WHO definition. Maintenance of autonomy and independence of the elderly is an important goal in the policy framework made for active ageing. Ageing, in itself, takes place amongst other things, within the context of friends, the work associates, neighbours and the family members. Due to this interdependence and intergenerational solidarity are the important tenets of active ageing.[6, 11]

2. MATERIALS AND METHODS

This was an analytical study conducted in a rural area of district Moga in the state of Punjab, India. The

demographic data and profile of the village population was studied and obtained from the office of the Panchayat, after taking due permission from the authorities. The total population was 9,456, out of which, individuals who were 60 years or older of age were 1873. The inclusion criteria were all the individuals who were 60 years of age or older, were permanent residents of this village, were physically residing there during the period of the study and consented to participate in the study. Ten of the 1873 were not in the village during the period of the study, while three were admitted in different hospitals for treatment of ailments and therefore excluded from the study. The remainder 1870 people were included in the study. After taking informed consent from all participants, data was collected as per a pre-tested and validated questionnaire administered by the investigators. The questionnaire was validated after translating it into Punjabi language, followed by back translation. Data thus collected, was analysed with appropriate statistical software.

3. RESULTS AND DISCUSSION

Out of the total of 1870 elderly population who met the inclusion criteria, 980 were females while the remainder 890 were men. Further distribution as per the age groups is as given in table-1. The figures in parenthesis correspond to the respective percentages.

The results were recorded for the specified age groups since it was observed in the pilot study that there were no significant differences in the responses of the male and female study subjects.

The morbidity profile of the study population showed a wide variety of ailments, most of which were chronic in nature, except for certain cases of fractures. Most of the individuals had more than one complaint or ailment, the common ones being hypertension, diabetes mellitus, arthritis, cardiovascular diseases, besides few cases of carcinomas. The history of falls and fractures was taken for the events that had occurred over the last one year from the duration of commencement of the study.

Table 1: Distribution of the study population as per their age

Age group	Male (%)	Female (%)	Total (%)
≥60 to <70	553 (52.72)	496 (47.28)	**1049 (100)**
≥70 to <80	386 (50.46)	379 (49.54)	**765 (100)**
≥80 to <90	17 (36.17)	30 (63.83)	**47 (100)**
≥90 to <100	03 (37.50)	05 (62.50)	**08 (100)**
≥100	0	01 (100)	**01 (100)**
Total	**890** (47.59)	**980** (52.41)	**1870 (100)**

The distribution of the study population as per their age and type of fractures is shown in figure-1. It was observed that the commonest fractures were those of the limbs in the individuals belonging to the minimum age group while fracture of the hip bone was commoner in the most aged ones. The former were more of traumatic in origin while the latter had a pathological aetiology, as is seen commonly.

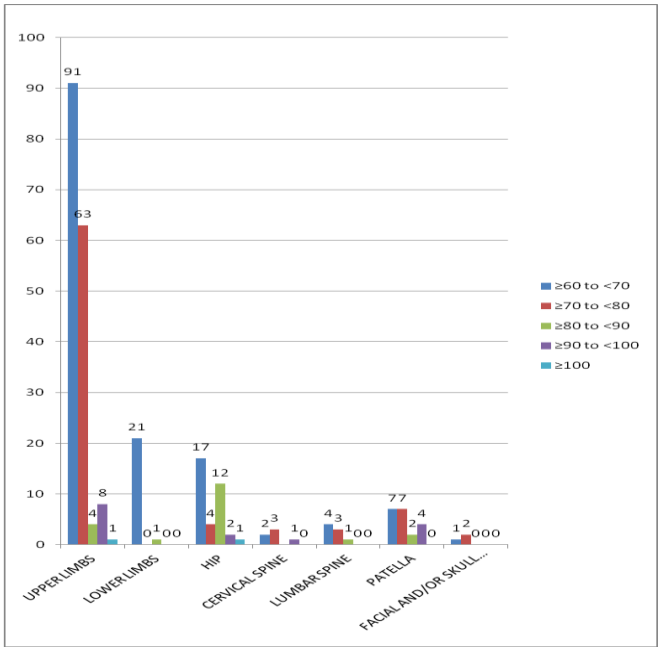

Fig 1: Distribution of the study population as per their age and type of fractures

The distribution of the study population as per their age and morbidity profile for the (so-called) four giants of geriatrics, as stated by the WHO[11], is shown in figure-2. The X-axis shows the distribution of memory loss, incontinence of urine, depression and falls or

immobility against the Y-axis that depicts the age groups.

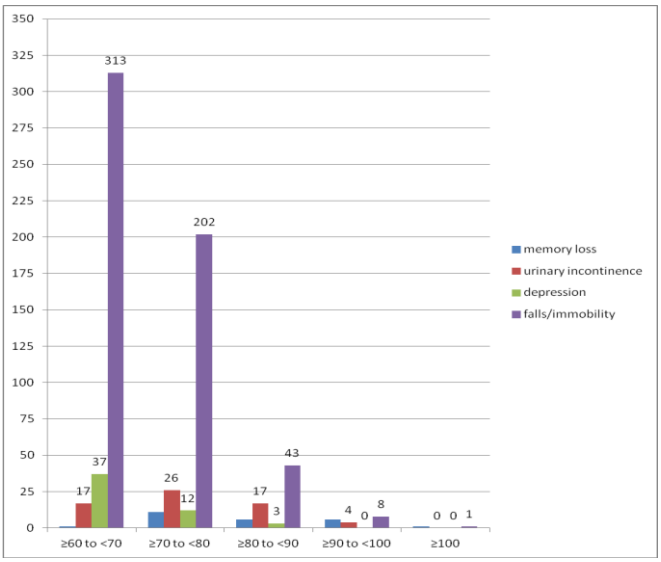

Fig 2: Morbidity profile for the (so-called) four giants of geriatrics in the study population as per their age

Besides this morbidity profile, it was observed that 98% of the study population said that they were generally satisfied with their lives. The remainder 2% had more of a resigned attitude towards the realities of life. 93% of the study population stated that the primary health care services provided in the village were not adapted to the needs of people of their age. 86% agreed that the infrastructure was not comfortable for them. Especially, there were two high steps right at the entrance of the PHC which were difficult for most of the individuals above 80 years of age to climb up to enter the building. The ramp that was constructed adjacent to the steps was broken and so rarely used for moving an elderly individual on a wheelchair. Surprisingly, therefore, they had to be literally lifted physically for gaining entry into the Primary Health Centre (PHC) building. This entailed that the patient had to have at least two able bodied individuals in the form of relatives or attendants, to help them for this purpose. 100% of the study subjects agreed that the equipment required for their examination and physiotherapy was satisfactory. Some of this was part of the PHC authorization for the government supplies while the remainder comprised of the items donated by people who were earning their livelihood in the cities within the country and abroad. This was indeed a big help for them since 43% of them gave a history of arthritis or poly arthralgia or having sustained falls of varying severity in the last one year, and having availed the services of the physiotherapy wing made in the PHC. 27% of the study population were known to be suffering from psychiatric ailments, the most prevalent being depression. It was noted that there were no primary health services for mental health. The nearest psychiatrist was located at 32 kilometres distance in the government hospital. This, of course, was as per the authorization. But, a glaring fact was that there was practically no system in place for a structured conduct of preventive practices for good health. Mental health was never talked about, be it within the families or in the PHC set up, with the health care workers (HCW). Interestingly, this was not due to any stigma, but due to lack of knowledge and awareness amongst all. 23% of the study population admitted that they felt there was some problem with their memory, as if it had decreased with age. However, there was no significant difference in the loss of memory as the age advanced, since most of the individuals over 80 years of age had a good memory.

When inquired about the general feeling of hopelessness or worthlessness, none of the study participants gave any affirmation, i.e., none of them had these feelings. 2%, however, admitted that there had been some stressful situations in the family in the past, once or twice, when they did harbor these feelings for few days to few months. After the respective precipitating factors were taken care of, their feelings too reverted to normal. None of those affected, however, had sought any counseling or psychiatric consultation during those times. In fact, they were not even aware that these facilities exist at specialized

centres. No stigma was found related to availing the services of a counselor in these matters.

64% of the study subjects stated that their family members offered a good support to them mentally and emotionally at all times or most of the times. 30% were not very sure of their response while the remainder were almost unhappy with their respective families, where the support system was concerned.

100% of the study population owned a television set at home along with a cable connection or private dish. 87% of these watched television programmes regularly. Further, only 3% of these individuals claimed to have seen any program related to mental health, even once. 31% of the study population had read articles on or related to mental health and illnesses in the newspapers. All of the latter study subjects were men. The aptitude for reading was found to be decreasing as the age progressed from 60 years up to 100 years. The main reason for the decrease in this aptitude was diminishing vision.

The WHO states that falls are the second important leading cause of accidental and/or unintentional injuries and deaths worldwide. Every year, approximately 424 000 individuals die as a result of falls globally. Out of these over 80% are residents of low- and middle-income countries. Adults older than 65 years of age have been found to suffer the largest number of fatal falls. Prevention strategies should, therefore, emphasize on education, good training, creation of safer environments, prioritization of fall-related research as well as establishment of effective policy making in order to reduce risk. . Across the world, in all regions, death rates are the highest among adults who are over 60 years of age. Though not fatal, every year, an estimated number of 37.3 million of the falls are severe enough so as to require medical attention. The largest proportion of morbidity occurs in the people who are aged 65 years or older. While nearly 40% of total DALYs that are lost due to different falls worldwide, occur amongst children, this measurement might not accurately reflect the actual impact of the fall-related disabilities for the elderly who have comparatively fewer years of life to lose. In addition, the individuals who fall and as a result suffer a disability, particularly the older people, are at an increased risk for subsequent long-term care and/or institutionalization.

4. CONCLUSION

There is a need to review the quality as well as the distribution of services offered to the elderly in rural Punjab, India, including the content of the services, especially where their mental health is concerned. A structured Behaviour Change Communication program is recommended for developing improved services for the elderly so that both the family members and the health care providers align with the needs and requirements of the elderly.

Besides, the strategies for fall prevention should be as comprehensive and multifaceted as possible. They should prioritize research as well as public health initiatives in order to further define the burden and explore the variable risk factors. They should also support policies that aim to create safer environments for the people and reduce risk factors. Besides, they should promote engineering methods to remove the potential for falls, training of health care providers with respect to evidence-based prevention strategies; and also the education of as many individuals and communities, as possible, to build risk awareness.

The concept of Age-friendly Primary Health Care (PHC) Centres recommended by the WHO, needs to be brought closer home and implemented for the benefit of this vulnerable population[11].

There is a toolkit developed that assists the health care workers in making themselves well versed in the

diagnosis as well as management of chronic diseases and the so-called four giants of geriatrics (memory loss, urinary incontinence, depression and falls/immobility) that often impact people as they age. It is, therefore, imperative to communicate with the elderly for an effective age-friendly health promotion.

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Conflicts of interest: none