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HEALTH STATUS OF THE OLDEST OLD WOMEN
A GERONTOLOGICAL STUDY IN MEDINIPUR TOWN, WEST BENGAL

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ABSTRACT ■ The term 'oldest old', generally used to refer to the population aged 85 and older, was coined in 1984 in the annual meeting of the American Association for the Advancement of Science (AAAS). During 2011 elderly people of India of 80 years and above age has been categorized as 'Super Senior Citizen' by the Department of Finance, Government of India for the purpose of income tax assessment. However, while conducting the gerontological studies most of the scholars of India presented their data for the entire age 60 and older population in a single open-ended age category termed as 'elderly'. This categorization effectively ignored the great heterogeneity within the older population in terms of mobility and health status.

Since this oldest old sub population is growing faster and because they are the most likely group to need medical and social services than any other age group, it is necessary to investigate the demographic, socio-economic and health status of the oldest-old. Therefore, the present paper aims to highlight the health condition of the oldest old female populations residing in Medinipur Municipal Town of West Bengal so that the same may be useful for micro-level planning for the welfare of the marginalized section of the society.

For the purpose of the present study 5 oldest-old female were sampled using S+ random sampling table from each of the 24ward of Medinipur municipal town Religion and mother tongue were never a bar for selecting the participants, but care was taken about the physical and mental alertness of the participants. The nature of research was communicated to the participants and consent was taken from them. Data on the health profiles of the respondents were collected on the basis of the Measurement of Activities of Daily Living (ADL), Self reported ailment and Self reported ailment symptom.

Key words: Oldest old, Super Senior Citizen, Health condition, ADL, Self reported ailment and ailment symptom.

INTRODUCTION

Neugarten (1974) separated the older population into the 'Young Old' (age 65 to 74) and the 'Old Old' (age 75 and over). Prior to that, gerontological studies used to consider all the elderly irrespective of their age, obscuring important differences and offering little insight into the social realities of the oldest old (Hillier and Barrow, 2007). The term 'oldest old', generally used to refer

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to the population aged 85 years and older, was coined for a 1984 session on this population in the annual meeting of the American Association for the Advancement of Science (AAAS). However, even in US, limitations of survey data, resulting from small sample sizes at the oldest ages, forced several studies of the oldest old to define them as those ages 80 years and older (Suzman and Riley, 1985).

Since last decade, the Election Commission of India has started to publish separate voter list for the Indian citizens who are 80 years and above age. In the year 2011, these elderly people have been categorized as 'Super Senior Citizen' by the Department of Finance, Government of India for the purpose of income tax assessment (ENS Economic Bureau, The India Express, New Delhi, March 01, 2011). However, one may be tempted to assume that the identification of the population of 80 years and above age as separate category in India may have its genesis in the categorization of 'Oldest Old' in 1984 during the annual meeting of the American Association for the Advancement of Science (AAAS).

However, while conducting the gerontological studies most of the Indian scholars presented their data for the entire age 60 years and above in a single open-ended age category termed as 'elderly'. This categorization effectively ignored the great heterogeneity within the older population in terms of mobility and health status. Moreover, these studies primarily centered around the economic crises, family environments and care, extra familial rehabilitation, living conditions in Old Age Homes, abuse, leisure and recreation, socio-psychological adjustment, health status, etc. of the elderly living in different parts of the country (Chakrabarty, 2003).

It is evident that the proportion of individuals leading active daily lives declines and the disability rate increases dramatically with age among the oldest old (Yi et al., 2002). The oldest old subpopulation is numerically increasing faster than any other age groups and they are the most likely group that need medical and social services. Therefore it becomes necessary to investigate the demographic, socio-economic and health status of the oldest-old group (Yi et al., 2002). In some of the developed countries, efforts have been made to draw the attention of academics and policy makers to the circumstances of the oldest-old (Suzman et al,, 1992; Baltes and Mayer, 1999; Veupal and Lundstrom, 1994, Vaupal et al., 1998). On the contrary, elsewhere little attention has been paid to ensure statistically sufficient representation of the oldest-old in national surveys, and most of the studies on the elderly include few or no subjects aged 80 and older (Grundy et.al,1996).

In the above background the present study aims to investigate the health aspects of the oldest old female population residing within the Medinipur municipal town at a micro level.

MATERIALS AND METHODS

The present study was conducted among the oldest old (80 years and above) female populations distributed over 24 wards of Medinipur Municipal Town in Paschim Medinipur District of West Bengal.

For the purpose of the study the oldest-old female population of Medinipur Municipal town was recruited from the separate voter list prepared by the Election Commission of India for the entire 24 Wards of Medinipur Municipal town. A total number of 1545 oldest old people represented in the list, of which 742 were male and 803 were female. Thereafter, 5 oldest-old female were sampled using S+ random sampling table from each

of ward. Finally, a total number of 120 respondents were considered for the study. In case of sampling of respondents provisions were made for one substitutes from each ward so as to replace the same in case of the originally sampled respondent were not available during the field survey. Religion and mother tongue was never a bar for selecting the participants, but care was taken about the physical and mental alertness of the participants. The nature of research was communicated to the participants and consent was taken from them.

Data on the health profiles of the respondents were collected on the basis of the followings:

(i) Measurement of Activities of Daily Living (ADL). For this purpose ADL functional status with respect to eating, dressing, getting in and out of bed or chair, using the toilet, bathing and continence are used to measure the degree of independence of the respondents in daily living. In this study, if none of the six ADL activities is impaired, the individual is classified as "active", if one or two activities are impaired, she is classified as "mildly disabled", and "severely disabled" refers to the elderly who have three or more activities impaired.

(ii) Self reported ailment.

(iii) Self reported ailment symptom

All the schedules/questionnaire was pretested prior to the application in the field situation.

RESULTS AND DISCUSSION

It is revealed from the table-1 that the maximum number of the respondents is fairly mobile, which represent 35.83% of the total respondents whereas, 31.67% are slightly mobile, 14.17% have the mobility with a stick, 3.33% have the mobility with a wheel chair and 15% are the totally bed ridden.

It appears from table -2 that out of the total respondents 10.83% did not made any complain about their health condition. But remaining respondents have reported single or multiple health complaints which include diabetes, asthma, arthritis, leprosy, cardio-vascular disease (CVD), anemia, thyroid problem, high or low blood pressure, vision problem, hearing problem, disabilities in arms and legs, etc. It is evident from the table that 94.17 % of the respondents are suffering from vision problem whereas 44.17% are suffering from arthritis. The table shows that out of the total respondents self-reportedly 19.17% have diabetes, 11.67% have heart disease and 0.83% in each case is respectively suffering from kidney trouble, cataract, goiter, pyorrhea and leprosy. Similarly, 10% of the total respondents are suffering from fever, 20.83% suffering from cough and asthmatic trouble. The table also reflects that 7.50% are paralyzed, 6.67% have speech defects, 3.33% are deaf, and 5% suffering from anemia, 2.50% suffering from giddiness and 11.67% are suffering from

Table- 1: Mobility wise distribution of the respondents

Mobility of the Respondents	No. of respondents	Percentage (%)
Bed Ridden	18	15.00
Slightly mobile	38	31.67
Fairly mobile	43	35.83
Mobility with wheel chair	4	03.33
Mobility with a stick	17	14.17
Total	**120**	**100.00**

Table- 2: Distribution of self reported ailment among the respondents

Self reported ailment types	No. of respondents	Percentage (%)
No complaint	13	10.83
Diabetes	23	19.17
High BP	56	46.67
Low BP	12	10.00
Paralysis	9	07.50
Asthma	25	20.83
Cough	25	20.83
TB	0	00.00
CVD	14	11.67
Forgetfulness	14	11.67
Kidney trouble	1	00.83
Arthritis	53	44.17
Cataract	1	00.83
Vision problem	113	94.17
Deafness	4	03.33
Anemia	6	05.00
Giddiness	3	02.50
Blindness	2	01.67
Disabilities of arms &legs	37	30.83
Leprosy	1	00.83
Speech defects	8	06.67
Fever	12	10.00
Skin disease	14	11.67
Stomach complaints	19	15.83
Gynecological problem	1	00.83
Filaria	4	03.33
Goiter	1	00.83
Spondylitis	3	02.50
Thyroid problem	5	04.17
Pyorrhea	1	00.83
Others	8	06.67

forgetfulness. Among the total respondents 2.50% are suffering from spondylitis, 4.17% have thyroid problem and 3.33% have filaria. Among the total respondents 11.67% have skin disease, 30.83% have the disabilities in arms and legs, 15.83% have the stomach complaints.

Table -3 exhibits that 33.33% of the total respondents have no ailment symptom. However, the remaining of them reported about various types of ailment symptoms. The most frequently reported symptoms were headache (57.5%), repeated pain in the chest (36.67%) and backache (34.17%). The less frequently reported symptoms include sore throat (8.33%), running nose with fever (25.0%), cough more than a week, fever with more than 3 days (10.0%).

Table – 4 shows that in terms ADL status 50% of the total respondents were active, and rest of them were either mildly or severely disabled in equal frequency.

It appears from table -5 that out of total respondents 94.17% were suffering from vision problem, 53.33% from the problem with hearing and 59.17% from the problem with walking. It is to be mentioned that most of the respondents are suffering simultaneously from multiple health problems.

Table-6 shows that most of the respondents use foot wears (88.33%) and spectacles (80.83%). Similarly, 26.67% of the total respondents use walking stick. It is evident that 17.5% use dentures. Although it is evident that a large percentage of respondents have hearing problem (53.33%) only 9.37% of them use hearing aid. More than half of the respondents use walking stick as a support.

Table-3: Distribution of Ailment Symptoms among the respondents

Ailment symptom types	No. of respondents	Percentage (%)
No Symptom	40	33.33
Sore throat or running nose with fever	10	08.33
Coughed more than a week	30	25.00
Repeated indigestion and stomach upset	2	01.67
Vomited several times for more than a day	11	09.17
Abdominal pain lasting more than a day	9	07.50
Blood mixed in stool frequently	1	00.83
Fresh blood dripping with stool	2	01.67
Repeated pain in the chest	44	36.67
Shortness of breath after light work	13	10.83
Sudden attack of weakness and fainting	6	05.00
Feeling tired frequently	10	08.33
Frequent backache	41	34.17
Frequent headache	69	57.50
Fever with shiver more than 3 days	12	10.00
Pain in the ear more than one week	5	04.17
Discharge in the ear for more than one week	4	03.33
Night blindness	1	00.83
Blindness	6	05.00
Skin disease	7	05.83

Table-4 : ADL status wise distribution of the respondents

ADL Status	No. of respondents	Percentage (%)
Active	60	50.00
Mildly Disabled	30	25.00
Severely Disabled	30	25.00
Total	**120**	**100.00**

Table-5: Frequency distribution of the problems related to vision, hearing and walking

Problem types	No. of respondents	Percentage (%)
Vision	113	94.17
Hearing	64	53.33
Walking	71	59.17

Table- 6: Frequency distribution of different types of aid used by the respondents

Types of aid	No. of respondents	Percentage (%)
Spectacles	97	80.83
Hearing Aid	6	05.00
Wheel Chair	4	03.33
Walking Stick	32	26.67
Denture	21	17.50
Footwear	106	88.33

Table - 7: Personal help needed for everyday living

Types of the Personal help	No. of respondents	Percentage (%)
Eating	4	3.33
Dressing	9	7.50
Getting in & out of bed or chair	18	15.00
Using the toilet	17	14.17
Bathing	4	3.33
Continence	3	2.50
Walk for some distance	2	1.67
No help needed	61	50.83
All help needed	26	21.67

Table-8: Dependency on the type of medical treatment

Dependency on the type of Medical treatment	No. of respondents	Percentage (%)
Allopathy	75	62.50
Homeopathy	43	35.83
Both Allopathy and Homeopathy	2	1.67
Total	**120**	**100.00**

Table -7 exhibits that 50.83% of the total respondents need no help for their everyday living Compared to 21.67%, who need all types of help for their everyday living, the remaining 14.17% of the total respondents need help while using the toilet, 3.33% need help for eating, 7.50% need help for dressing, 15% need help for getting in and out of bed or chair, 3.33% need help for bathing and 2.50% need help for continence.

Table -8 exhibits the distribution of the respondents as per their dependency on the type of medicine/ medical treatment, either Allopathy or Homeopathy or both of the medicine/ medical treatment. The table represent that 62.50% of the total respondents depend on the Allopathic medicinal treatment whereas, 35.83% of the total respondents depend on the homeopathic medicinal treatment and remaining 1.67% depend on both the said types of treatment.

It is revealed from table-9 that 65.83% of the total respondents have children as the main sources of health care support whereas, 35% receive health care support from other family members, and remaining 4.17% depend on hired caregivers.

Table -10 shows that among the total respondents 67.50% has the perception that they feel fairly good in terms of their health condition whereas, 26.67% perceive that they are unhealthy and only 5.83% feel that they are very healthy.

CONCLUSION

The study reveals that although the respondents were ranging from octogenarian to nonagenarian, yet aging does not constrain their normal life activities. With regard to the health condition of the respondents the present researchers relied on self reported ailments and in spite of the fact that the respondents have some health problems, but none of them reported to have been suffering from disease like cancer, Cardio-vascular disease (CVD), Alzheimer and Dementia.

In terms of availability of health care, the oldest old women of Medinipur town are in better position since majority receives health care support from their immediate or distant kin. Like other parts of the world, India is also experiencing an increase in elderly population. Improvement in medical science, coupled with change in socioeconomic con-

Table -9: Distribution of the respondents in terms of main source of care during illness

Source of care	No. of respondents	Percentage (%)
Spouse	10	08.33
Children	79	65.83
Other family members	42	35.00
Live-in-caregiver	5	04.17
No one	7	05.83

Table-10: Self Perception about the own health condition

Self- perception about own health	No. of respondents	Percentage (%)
Very Healthy	7	05.83
Fairly all right	81	67.50
Unhealthy	32	26.67
Total	**120**	**100.00**

dition of the people has made this possible. Thus, care for the elderly is emerging as an urgent issue. But, the policy makers and health planners could only succeed if they receive the data base about the types of health problem of elderly population. Such assessment may be build up out of the micro level study. Only then it is possible to put the problems in their proper perspective and to find effective ways to tackle them even at macro level.

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