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DISCRIMINATION AND HEALTH STATUS OF ELDERLY PEOPLE IN CHAKWAL: PAKISTAN

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ABSTRACT

The main objective of the present study was to find out the association between the level of discrimination and health status of elderly people. A survey method was used as a technique of data collection, semi-structured interview schedule was developed to collect data and it was pre-tested form eight respondents. Convenience sampling technique was used to draw 120 respondents form three villages consisted in union council number 33 in district Chakwal. A great significance was seen after the data analysis and interpretation between the level of discrimination and health status of elderly people. They were discriminated in different ways like as communication, decision making and house hold activities due to old age.

Keywords: Discrimination, Health Statu, Elderly, Chakwal, Pakistan

INTRODUCTION

The elderly population affects all aspects of society, which includes health, social, environment related issues, education, business, socio-cultural activities and family life. Ageing is an issue that needs to be view with much significance as like in developed countries. Discrimination in older age plays a vital role in lower health status among elderly people. They are victims of the poor treatment in long-term or elderly assisted living facilities due to the discrimination felt against older people. People in older ages facing medical problems due to discrimination they face in many ways such as discrimination in communication, decision making, recreation activities, access to household activities or goods. This position is even worst in developing countries such as Pakistan where elderly people are not only discriminated on many forums but they are treated as second citizens.

There are three interrelated processes of aging: physical, psychological and social. It is a series of transition from one set of social roles to another, which is structured by the social system rather than mere biological one (Mishra, 2004). The changing demographic scenario at regional and global levels, the population aged 60 years or older comprises 10 percent of the world's 6 billion inhabitants in the year 2000. This proportion is projected to increase to about 22 percent of the world population by 2050, and a large part of this increase would be due to the rapid increment of the elderly population in developing countries (U.N.2002).

In Pakistan, the demographic transition has begun since the 1990s. The evidence shows a consistent decline in mortality with a resultant rise in life expectancy and a reduction in total fertility rate in recent years [Sathar and Casterline 1998; Mubashir and Hussain (2001); Hakim, et al. (1998)]. As a result, the proportion of elderly population is expected to increase in the years to come. Based on U.N. (2002) projection estimates, the proportion of population 60 years and above in Pakistan will increase from 5.8 percent in the year 2000 to 7.3 percent in 2025 and 12.4 percent in 2050.

The government of Pakistan has designed a National Policy for the health of the Elderly in 1999. This comprehensive policy included training of primary care doctors in geriatrics, provision of domiciliary care, dental care and a multi-tiered system of health care providers for elderly including social workers, physical therapists. Unfortunately implementation of this policy is still being awaited (Azhar et. al 2010).

The unique medical and psychosocial needs of our elderly are thus often unmet. The disease burden in our elderly is high and some data is available regarding common diseases in the elderly but by and large most numbers are observational. The Population census of Pakistan of 1998 cites a 28% disability rate of people aged 60 and older. Disability was defined as crippled status, deafness, blindness and mental retardation. One study identified that hypertension, diabetes and arthritis as the most common illnesses in elderly population of Pakistan (Zafar et al. 2006).

David et al. (2008) reviewed the available empirical evidence from population-based studies of the association between perceptions of racial/ethnic discrimination and health. This research was limited to population-based empirical studies that examined the association between perceptions of racial/ethnic discrimination and a particular indicator of health.

OBJECTIVES OF THE STUDY

1. To explore socio-economic characteristics
2. To find out the level of discrimination of elderly
3. To analyze the health status of elderly
4. To find out the association (if any) between the level of discrimination and health status

MATERIAL AND METHODS

For the present study 120 respondents were selected through convenience sampling. Because sampling frame of the older people was not available. Sample was selected from three villages of Union Council number 33, District Chakwal on the basis of the characteristics like a) demographic profile of the respondents b) level of discrimination and c) health status of elderly people. Semi-structured interview schedule was developed to collect information from the respondents. Further the data was analyzed by using SPSS version 16.0. Percentage and statistical test was used to test the hypothesis and to draw conclusions.

RESULTS AND DISCUSSIONS

Table No.1.1 shows the age structure of the respondents. According to this table, 67(55.83%) respondents belonged to age group 60-75, 44(36.66%) respondents had age group of 76-90 and 9(7.51%) respondents belonged to age group 90 & above. More than half of the respondents belong to age group of 60-75. Education is very important aspect to discuss here because it is a social institution through which society provides its members with important knowledge, including basic facts, job skills, and cultural norms and values (Macionis, 2006). Table No.1.2 depicts educational attainment of the respondents. According to this data, 33(27.5%) respondents were illiterate, 23(19.16%) respondents got primary education and 19(15.85%) respondents had education up to middle.

Table No.1.3 describes the current marital status of the respondents. According to this table, 77(64.2%) respondents were married and 38(31.7%) respondents were widow. More than half of the respondents were married. Table No.1.4 explains the current living status of the respondents. According to this data, 98(81.7%) respondents were living with their children, while only 9(7.5%) respondents were living with spouse. Majority of the respondents were living with children.

Table 1. Demographic Characteristics of the Respondents

1.1 Age of the Respondents			1.3 Marital Status of the Respondents		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
60-75	67	55.83	Married	80	66.7
76-90	44	36.66	Divorced	2	1.7
90 & above	9	7.51	Widow	38	31.7
Total	120	100.0	Total	120	100.0
1.2 Education of the Respondents			**1.4 Currently Living Status of the Respondents**		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
Illiterate	33	27.5	Alone	8	6.7
Primary	23	19.16	With Spouse	9	7.5
Middle	19	15.85	With Children	98	81.7
Metric	19	15.85	Relatives	5	4.2
Intermediate	18	15	Total	120	100.0
B.A. & above	8	6.2			
Total	120	100.0			

Discrimination is the prejudicial treatment of an individual based on their membership in a certain group or category. It is the actual behavior towards members of another group. It involves excluding or restricting members of one group from opportunities that are available to other groups. Table No.2.1 shows respondent's satisfaction about living arrangements. According to this table, 73(60.8%) respondents were to some extent, 35(29.2%) respondents were to great extent and only 12(10%) respondents were not satisfied with their living arrangements. More than half of the respondents are to some extent satisfied with living arrangements.

Table No.2.2 describes respondent's participation in solving family issues. According to this data, 44(36.7%) respondents to some extent, 42(35%) to great extent and only 34(28.3%) respondents participated to solve their children's problems. Table No.2.3 shows the respondent's participation in household activities. According to this data, 45(37.5%) respondents did not participate in household activities, 38(31.7%) respondents to some extent and only 37(30.8%) respondents to great extent participated in household activities.

Table No.2.4 explains respondent's satisfaction about family behavior. According to this data, 49(40.8%) respondents to some extent, 41(34.2%) respondents to great extent and 30(25%) respondents were not satisfied with their family behavior. Majority of the respondents were satisfied with the family behavior.

Table 2. Discrimination Level of the Respondents

2.1 Satisfaction about Living Arrangements			2.6 Involvement in Family Discussions		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
To Great Extent	35	29.2	To Great Extent	33	27.5
To Some extent	73	60.8	To Some extent	48	40.0
Not At All	12	10.0	Not At All	39	32.5
Total	120	100.0	Total	120	100.0
2.2 Participation to Solve family Issues			**2.7 Importance of Decision in Family**		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
To Great Extent	34	28.3	To Great Extent	31	25.8
To Some extent	44	36.7	To Some extent	39	32.5
Not At All	42	35.0	Not At All	50	41.7
Total	120	100.0	Total	120	100.0

2.3 Participation in Household Activities			2.8 Access to Households Goods		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
To Great Extent	37	30.8	To Great Extent	33	27.5
To Some extent	38	31.7	To Some extent	60	50.0
Not At All	45	37.5	Not At All	27	22.5
Total	120	100.0	Total	120	100.0
2.4 Satisfaction about Family Behavior			**2.9 Attending Social Gatherings**		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
To Great Extent	41	34.2	To Great Extent	42	35.0
To Some extent	49	40.8	To Some extent	25	20.8
Not At All	30	25.0	Not At All	53	44.2
Total	120	100.0	Total	120	100.0
2.5 Respondent's Leisure Time Management			**2.10 Social Support by Family**		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
With Media	11	9.2	To Great Extent	41	34.2
With Spouse	6	5.0	To Some extent	66	55.0
With Children	31	25.8	Not At All	13	10.8
With Friends	34	28.3	Total	120	100.0
Alone	38	31.7			
Total	120	100.0			

Table No.2.5 depicts respondent's Leisure time management. According to this data, 38(31.7%) respondents spent their leisure time alone, 34(28.3%) respondents with friends, 31(25.8%) respondents with their children while only 11(9.2%) respondents with media. Majority of the respondents spent their leisure time alone. Time for leisure varies from one society to the next, although anthropologists have found that hunter-gatherers tend to have significantly more leisure time than people in more complex societies. As a result, band societies such as the Shoshone of the Great Basin came across as extraordinarily lazy to European colonialists. (Farb, 1968)

Table No.2.6 describes respondent's involvement in family matter discussions. According to this data, 48(40%) respondents to some extent, 33(27.5%) respondents to great extent and 39(32.5%) respondents were not involved in family matter discussions. Majority of the respondents were involved in family matters discussions. Table No.2.7 depicts about importance of the respondent's decisions in the family. According to this data, 50(41.7%) respondents decisions had no importance in the family, 39(32.5%) respondents decisions to some extent and only 31(25.8%) respondents decisions in family matters had to great extent importance.

Table No.2.8 explains that respondent's access to household goods. According to this data, 60(50%) respondents to some extent, 33(27.5%) respondents to great extent and 27(22.5%) respondents had no access to household goods. Half of the respondents had to some extent access to household goods. Table No.2.9 shows about respondent's social gathering. According to this data, 42(35%) respondents to great extent, 25 (20.8%) respondents to some extent and 53(44.2%) respondents did not attend social gatherings or social events. Table No.2.10 describes about socially support of the respondents by family. According to this table, 66(55%) respondents to some extent, 41(34.2%) respondents to great extent and 13(10.8%) respondents were not supported socially.

Table No.3.1 shows about disease of the respondents. According to this data, 82(68.3%) respondents were facing and 38(31.7%) respondents were not facing any type of disease. Majority of the respondents were facing diseases. Table No.3.2 describes the respondent's source of treatment. According to this data, 40(33.3%) respondents used allopathic treatment, 38(31.7%) respondents did

not use any source of treatment, 20(16.7%) respondents used homeopathic and only 19(15.8%) used Hakeem methods for treatment. It shows respondents were using different source of treatment. Table No.3.3 shows about the illness of the respondents. According o this data, 69(57.7%) respondents to some extent, 40(33.3%) respondents to great extent face and only 11(9.2%) respondents did not face illness.

Table 3. Health Status of the Respondents

3.1 Respondents Facing Disease			**3.6 Physical Disability of the Respondents**		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
Yes	82	68.3	Yes	32	26.7
No	38	31.7	No	88	73.3
Total	120	100.0	Total	120	100.0
3.2 Source of Disease Treatment			**3.7 Assisted by at the Time of Disease**		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
Allopathic	40	33.3	Wife / Husband	10	8.3
Homeopathic	20	16.7	Son	85	70.8
Hakeem / Quaker	19	15.8	Daughter	20	16.7
Spiritual Healings	3	2.5	Any Other	5	4.2
No Treatment	38	31.7	Total	120	100.0
Total	120	100.0			
3.3 Respondents Facing Illness			**3.8 Respondents Facing Sickness**		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
To Great Extent	40	33.3	To Great Extent	27	22.5
To Some extent	69	57.5	To Some extent	87	72.5
Not At All	11	9.2	Not At All	6	5.0
Total	120	100.0	Total	120	100.0
3.4 Respondents Facing Tension			**3.9 Frustration Faced by the Respondents**		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
To Great Extent	49	40.8	To Great Extent	14	11.7
To Some extent	51	42.5	To Some extent	34	28.3
Not At All	20	16.7	Not At All	72	60.0
Total	120	100.0	Total	120	100.0
3.5 Respondents Facing Body Pain			**3.10 Respondents Facing Problem of Sleepless**		
Categories	**Frequency**	**Percentage**	**Categories**	**Frequency**	**Percentage**
To Great Extent	43	35.8	To Great Extent	67	55.8
To Some extent	36	30.0	To Some extent	25	20.8
Not At All	41	34.2	Not At All	28	23.4
Total	120	100.0	Total	120	100.0

Table No.3.3 shows about the illness of the respondents. According o this data, 69(57.7%) respondents to some extent, 40(33.3%) respondents to great extent face and only 11(9.2%) respondents did not face illness. Table No.3.4 depicts about tension of the respondents. According o this data, 51(42.5%) respondents to some extent, 49(40.8%) respondents to great extent face and 20(16.7%) respondents were not facing tension. Table No.3.5 describes about body pain of the respondents. According o this data, 43(35.8%) respondents to great extent, 36(30%) respondents to some extent face body pain and 41(60%) respondents did not face body pain. Majority of the respondents had faced body pain.

Table No.3.6 shows about physical disability of the respondents. According to this table, 88(73.3%) respondents had physical disability and 32(26.7%) respondents had no physical disability. Therefore

majority of the respondents were facing physical disability. Table No.3.7 explains about assisted by respondents at the time of disease. According to this data, 85(70.8%) assistants of the respondents were their sons and only 20(16.7%) were assisted by their daughters. Majority of the respondents were assisted by their sons.

Table No.3.8 describes about sickness of the respondents. According o this data, 87(72.5%) respondents to some extent, 27(22.5%) respondents to great extent face and 6(5%) respondents did not face sickness. Table No.3.9 shows frustration of the respondents. According o this data, 72(60%) respondents did not face frustration, 34(28.3%) respondents to some extent, and only 14 (11.7%) respondents faced frustration to great extent.

Table No.3.10 depicts respondent's problems of sleepless. According o this data, 67(55.8%) respondents to great extent, 25(20.8%) respondents to some extent had the problems of sleepless and 28(23.4%) respondents did not face the problems of sleepless. Generally, the context in which an individual lives is of great importance on health status and quality of life. It is increasingly recognized that health is maintained and improved not only through the advancement and application of health science, but also through the efforts and intelligent lifestyle choices of the individual and society. According to the world Health Organization, the main determinants of health include the social and economic environment, the physical environment, and the person's individual characteristics and behaviors. (WHO, 2011)

Table 4: Level of Discrimination and Health Status of Elderly

Health Status	Level of Discrimination			Total
	Low	Medium	High	
Low	29(24.16%)	15(12.5%)	3(2.5%)	47(39.16%)
Medium	13(10.83%)	27(22.5%)	15(12.5%)	55(45.83%)
High	0	2(1.67%)	16(13.33%)	18(15%)
Total	42(35%)	44(36.67%)	34(28.34%)	120

Table No.4 presents the level of discrimination and health status of elderly. According to data, 42(35%) respondents faced low level of discrimination, 44(36.67%) respondents faced medium and only 34(28.34%) respondents had faced high level of discrimination. The above cited table also shows that the health status of the respondents. According to this table, 47(39.16%) of the respondents had low level of health status, 55(45.83%) of the respondents had medium while only 18(15%) of the respondents had high level of health status. The level of discrimination and health status had positive relationship.

Table 5: Statistical Test Kendall's tau-b, and c

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.	Exact Sig.
Ordinal by Ordinal	Kendall's tau-b	.549	.061	8.353	.000	.000
	Kendall's tau-c	.525	.063	8.353	.000	.000
N of Valid Cases		120				

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Table No.5 describes the statistical results. The p value is used to determine the significance of a hypothetical test here it is found to b 0.000 which shows that it is less than the level of significance value therefore the H_o is rejected and H_1 is accepted and it is concluded that the level of discrimination and health status are statistically associated.

CONSLUSION

The situation of the elderly people in rural areas of Chakwal has not yet changed. They are still discriminated. There is an association between the level of discrimination and health status of the elderly. The findings indicated that discrimination against elderly people has greater impact on elderly health status. Majority of the respondents belonged to age group of 60-75 and have low health status. They have less access to household goods, not proper medical treatment and treated as second citizen. They are discriminated in different ways like as communication, decision making and household activities due to old age. These findings also drawn attention to need for satisfactory living conditions, respect, care and access to house hold goods, access to health care and increase recreational activities for elderly people. The need of the day is therefore to devise medical and social programs for our elderly that help them to meet their needs in the comfort of their homes. Such programs should also provide caregiver education, training and facilities to family members caring for their older relatives (Baig et al. 2000).

REFERENCES

Azhar, G. & Sabzwari, S. R. 2010. *Aging in Pakistan*, Department of Family Medicine, The Aga Khan University Hospital, Karachi, Pakistan.

Baig, L., Hasan, Z., & Iliyas, M. 2000. *Are the elderly in Pakistan getting their due share in health services?* Results from a survey done in the peri-urban communities of Karachi. Journal of Pakistan Medical Association, 50(6), 192–196.

David, R ., Harold, W. And Jackson, J. 2000. *Racial/Ethnic Discrimination and Health, Institute for Social Research*, University of Michigan, Ann Arbor.

Farb, Peter. (1968). Man's Rise to Civilization As Shown by the Indians of North America from Primeval Times to the Coming of the Industrial State. New York City: E.P. Dutton. pp. 28.

Hakim, A. , Cleland, J. and Bhatti, M. (1998). *Pakistan Fertility and Family Planning Survey 1996-97 (PFFPS)*. Main Report. National Institute of Population Studies, Islamabad.

Macionis, J. John. (2006). Sociology. Pearson Education, Inc. India: Dorling Kindersley Publishing Inc.

Mishra, A. K. 2004. *The Process of Aging in India*, India.

Mubashir, A. and Hussain, J. 2001. *Fertility Transition in Pakistan: Evidence from Census*. The Pakistan Development Review 40:4. *Pakistan Demographic Survey (2001)*. Federal Bureau of Statistics. Retrieved from http://www.statpak.gov.pk/depts/fbs/statistics/pds2001/pds2001.html

Sathar, Zeba A. and Casterline, J. B. 1998. *The Onset of Fertility Transition in Pakistan*. Population and Development Review 24:4.

United Nations (2002). *World Population Ageing 1950–2050*. New York: Economic and Social Affairs, Population Division.

World Health Organization. (2011). The Determinants of Health. Geneva.

Zafar, S. N., Ganatra, H. A., Tehseen, S., & Qidwai, W. 2006. *Health and needs assessment of geriatricpatients*: results of a survey at a teaching Hospital in Karachi. Journal of Pakistan Medical Association, 56(10), 470–473.