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Disease Contour and Household Decision Making: A Gender Comparative Study of Older Persons

Abstract: *Aging is a global demographic phenomenon. This study dedicated to discovering the association between disease profile and participation of older persons (OPs) in domestic decision making. A sample of 384 OPs was selected from Rawalpindi for data collection. Data were entered and analyzed in SPSS. Male participation was 70% and 30% of females. The findings of the research indicate 8.1% of cases of hypertension among older persons, heart problems were reported in 12.8% cases and 15.1% of the sample suffering from Diabetes. Cross-tabulation of data shows that the Pearson value is 32.552 and the calculated p-value is .000 [p<05], this shows that a significant association prevails among household decision making of older persons and their disease profile with special reference to gender group. This also helps to conclude that active yet age bound involvement in household matters in old age is healthy for older persons.*

Introduction

Aging is a bio-physiological miracle that is commonly observed around the globe. Furthermore, females now have a reduced number of children than 3 decades back as the trend of high population growth is made slow. The fertility rate in the early 1970s was 4.7 children and that trend was reduced to 2.7 by the millennia (UN, 2000).

Aging is a biological and physiological miracle commonly observed among all the countries everywhere on the globe. Furthermore, it is witnessed that women have become lesser kids than in 3 decades back after the fashion of high population growth becomes slow. In the early 1970s, the fertility rate of women was 4.7 kids which were concentrated to 2.7 by the times (UN, 2000). Consideration was given to health, nutrition, lifestyle, and medication in the modern time that has headed to the endurance of human life. Life expectancy all over the world has been improved enormously between 45 to 69 years from 1945 to 2000. Further rise is projected up to 78 years in 2050. Data shows that the rapidly increasing populace group is the elderly. Elder population i.e., 606 million today will be increased around 300 times by 2050 with age 60 years and above (UNPD, 2007). Data also confirm that above 60% of the older persons live in developing countries which will rise to 70% as predicted by 2020 (WHO, 1999).

Gerontology is a subject deal with the information of older age or aging (Chaudhry et al., 2014; Kirkwood, 1999). The majority of the gerontologists-built agreement that aging is a process or a combination of numerous developments, of consistent transformation, and then decay that defines the life span of an organism (UN, 2009). As the definition is concerned, an elder person defined as an individual or individuals overpasses the yardstick of 60 years of age. Various scholars mark aging in diverse scopes while enlightening it, similarly aging is different in different disciplines (Ahmed and Chaudhry, 2015). As pointed out by Cohen that aging is an unclear inherent state: "a time of both, highest experience and highest weakness, concurrently praised and avoided" (Chen and Dreze, 1992). The study of aging or old age is also termed as 'gerontology' (Chaudhry et al., 2014; Ahmed and Chaudhry, 2015). Besides, aging also defined as a person's growth on the day-to-day bases (Ahmed, Chaudhy and Khan, 2015).

The world population of 60 years or above totaled 962 million in 2017, two times more than in 1980 when 382 million older persons lived globally. These numbers expected to be double in 2050, and estimated to touch nearly 2.1 billion. Pieces of evidence show that two-thirds of total elders live in developing countries, where numbers graph is growing faster as compared to developed regions. In 2050, projection reveals that nearly 8 in 10 of the total older persons will be living in developing countries (UN, 2017).

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The fact observed among many of the states is that women lived longer as compared to males (UN, 2000). The proportion of aging men to women is, therefore, swelling with age, 55% of the elder's population of the globe constitute of females. This proportion is expected to stay stagnant in the next half-century (UN, 2001).

In addition to this, elder women contribute a significant portion to the world's population that is growing steadily. A rapid increase in the numbers of women age 60 and above was observed from 2000 to 2050 and that is 336 million in 2000 leads to 1 billion in 2050 (WHO, 2006)

UN report advocates that 6% of the total elder population is living in Asia (UN, 1998; Ahmed, Chaudhry, and Farooq, 2014). Pakistan is at number 6 among the most populated country in the world, where its population is projected around 166 million in the year 2006. It is probable that due to growing geriatric populace offers new challenges to the health care system in the future (PDP, 2018).

The older persons in a culture signify the heart of its presence; representing history. Older persons are the transporter of socio-cultural norms and values, traditions, knowledge, and life experiences, the guiding soul for the young generation. Development that society achieved, morally and culturally, is revealed in the fashion it treats its elders (Schoeni, 1992). Before industrialization, the conservative civilization grants older persons with responsible governance duties and commanding decision-making authority due to their enormous experience and knowledge (Phua, 2000). The technological progress because of industrialization and rapid urban growth under the umbrella of a distorted form of modernism have ignored the status of older persons by fading the integrity and unity of the joint family. Furthermore, the beginning of attained belongings like wealth, education, etc. has occupied the mindset of the young generations by accepting the individualistic beliefs of the West (United Nations, 1994).

Literature depicts that man and woman age differently so their understandings also differ. It is also witnessed that aging females have maintained a strong social net as compared to males. Along with, woman as a mother is more close association with her adult children and therefore more valued (EC, 2001; UNFPA and HelpAge International, 2012).

In the case of Pakistan, the older population is unnoticed, therefore very nominal or limited availability of literature regarding their social and health issues. A contemporary survey, hospital-based held in Karachi highlights the health status, requirements, and problems confronted by this very vulnerable part of the population. According to the data, almost half of the older persons were taking three or more drugs daily that underlined the requisite to forestall unpleasant drug experiences. The most commonly reported diseases among older persons are dyspnea, visual impairment, immobility, and urinary issues that seriously affected their lives. Besides, the prevalence of chronic ailment among elder are Arthritis, Hypertension, and Diabetes mellitus which highlights the mobilization of resources (Zafar et al., 2006).

The objective of the current research was to find out the relationship between older participation in domestic decision making and their present health profile with special reference to gender groups.

Methodology

The Locale of Study

Primarily, the Rawalpindi District was designated as the research locale in the 1ˢᵗ phase of this study. Tehsil Municipal Administration [TMA] Potohar Town and Tehsil Municipal Administration [TMA] Rawal Town were selected in the second phase of sampling. UC # 46 was selected from TMA Rawal Town, and from TMA Potohar Town UC # 36 was selected. The calculated sample was equally distributed at both research locations.

Sampling

The projected population of Rawalpindi city was around 21.96 million with a growth rate of 1.86%. At the level of significance 95%, response distribution 50%, error margin 5% the calculated sample was 384 older persons of Rawalpindi city.

Tool

to collect data for the present research, a mixed tool was developed which includes both close-ended questions and open questions to keep a margin of descriptive opinions of respondents for qualitative data. The

tool was developed, pre-tested, and modified in the light of previous studies before final implementation to collect data for the present research.

Data Collection

Data collection was done from 384 older persons from the target research area. To address an ethical concern, verbal consent was taken after briefing them about the purpose of the study, and then the tool was filled from them. For data collection, local influential, political leaders and religious representatives were also taken on board to avoid any unforeseen circumstances.

Data Coding, Entry, and Analysis

after data collection exercise, data was carefully edited. Before data entry, data coding exercise was done to convert all responses into numeric coding. A code file in SPSS was developed by using that coding file. After coding, the data was entered and analyzed accordingly.

Inclusion Criteria

every person [men and women] having age 60 years and above is our target sample. After age criteria, their will is the main component before collecting data.

Results and Discussion

Table 1. Gender Participation

Responses	n	%
Male	269	70.05
Female	115	29.95

Table 1 shows the participation of older persons concerning their gender. Percentiles show that around 70% of the interviewed sample was male and 30% of respondents were females.

Table 2. Age Distribution

Age	n	%
60-65	207	53.9
66-70	80	20.8
71-75	51	13.3
76-80	31	8.1
80+	15	3.9

The above table depicts the participation of older persons according to their age distribution. Age categories are stated from 60 years of age to 80 years and above age. Older persons from the age group 60-65 years show the maximum participation in present study with the percentage 53.9%. The table reveals that as age increased the participation is getting decreased and in the age category of above 80 years only 3.9% data was recorded.
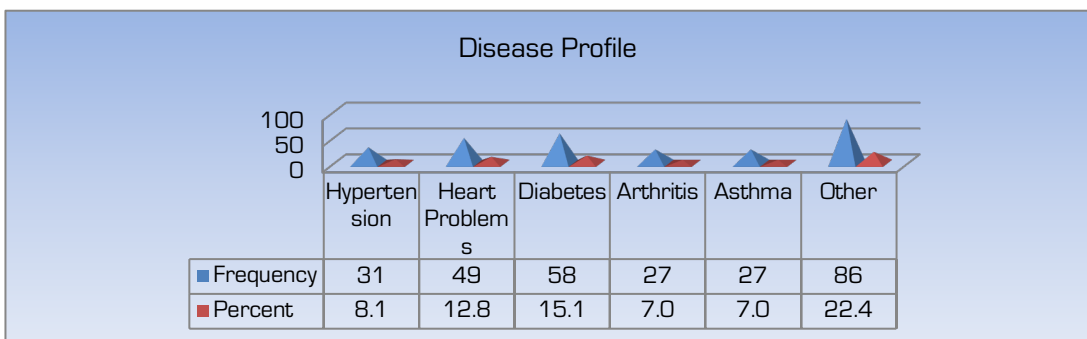

Disease Profile						
	Hypertension	Heart Problems	Diabetes	Arthritis	Asthma	Other
Frequency	31	49	58	27	27	86
Percent	8.1	12.8	15.1	7.0	7.0	22.4

Figure 1: Disease Profile of older persons

Figure 1 reveals the distribution of respondents according to the reported disease status. Percentages show that 8.1% of the respondents currently facing hypertension, 12.8% older persons reported heart problems, in 15.1% cases Diabetes was recorded and Arthritis was observed in 7% cases.

Table 3. Participation in Household Decision Making

Responses	n	%
Yes	302	78.6
No	82	21.4
N	384	100.0

Table 3 represents the participation of older persons in routine daily household decision making. It also shows the elder's level of involvement in their family concerns. Data shows that more than 78percent of older persons are involved in household decision making which represents the larger portion of our sample. In 21.4percent cases, our community elders were not involved in household decision making, it is either volunteer disengagement or family never consider their opinion.

Table 4. Gender, Disease and Household Decision Making

Gender Distribution of the Respondents			Involve in HHds Decision making		Total
			Yes	No	
Male	Disease Profile	Hypertension	64.7%	35.3%	100.0%
		Heart Problems	80.0%	20.0%	100.0%
		Diabetes	89.5%	10.5%	100.0%
		Arthritis	53.3%	46.7%	100.0%
		Asthma	94.4%	5.6%	100.0%
		Other	74.6%	25.4%	100.0%
		NA/ No disease	95.2%	4.8%	100.0%
	Total		83.3%	16.7%	100.0%
Female	Disease Profile	Hypertension	42.9%	57.1%	100.0%
		Heart Problems	85.7%	14.3%	100.0%
		Diabetes	65.0%	35.0%	100.0%
		Arthritis	58.3%	41.7%	100.0%
		Asthma	55.6%	44.4%	100.0%
		Other	65.2%	34.8%	100.0%
		NA/ No disease	87.0%	13.0%	100.0%
	Total		67.8%	32.2%	100.0%
Total	Disease Profile	Hypertension	54.8%	45.2%	100.0%
		Heart Problems	81.6%	18.4%	100.0%
		Diabetes	81.0%	19.0%	100.0%
		Arthritis	55.6%	44.4%	100.0%
		Asthma	81.5%	18.5%	100.0%
		Other	72.1%	27.9%	100.0%
		NA/ No disease	93.4%	6.6%	100.0%
	Total		78.6%	21.4%	100.0%

Pearson value: 32.552, p = .000, D.F (r) = 382 and N = 384

Table 4 shows the cross-tabulation results of three variables, i)- contribution in familial decision making, ii)- gender distribution and iii)-disease status. Percentile of the table represents the outcomes of input in household decision making and the prevalence of different diseases among older persons. Those respondents either male and females involved in family-related decision making reported a high rate of disease as compared to those who are not actively participating. And if we look at the Chi-square value [32.552], that depicts the positive relationship between decision making and disease occurrence. If participation in household decision making increased, this leads to an increase in disease incidence. Calculated value of $p=.000$ [$p < .05$] shows that significant association prevails between these variables.

As elder person numbers all around the world are growing, consideration of their married status, social concerns, and wellbeing concerns are elevated in the older population (Gulati and Rajan, 1999; UN, 2007;

Gubhaju, 2008; Agrawal and Keshri, 2014). Concerning health issues, previous research shows that the occurrence of optical impairment, dyspnoea, immovability, and urinary matters had seriously affected the elder's lives. Frequently stated chronic diseases among elder persons are; hypertension, arthritis, and diabetes mellitus which highlights mobilization of resources (Zafar et al., 2006). Heart disease and strokes are remarkable causes for frailty and death between women alike in industrialized and developing nations, and absolutely between those women who are poor (Leeder et al., 2004).
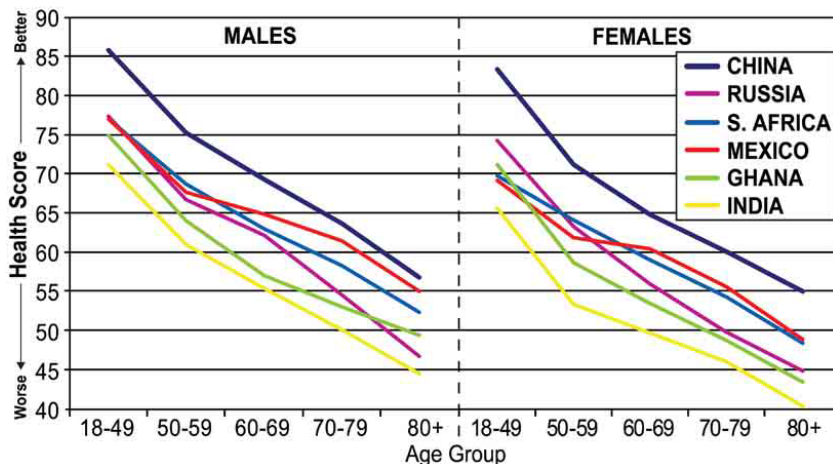

Figure: Declining Health Status with Age

Source: data given by the WHO Multi-Country Studies Unit, Geneva, grounded on statistics from the Study on global AGEing and adult health (SAGE).

Previous studies disclose that gender assisted as a leading source of mental health that cooperates with many other aspects including social support, age, culture, violence, and biology (WHO, 2007). Some of the researches exposed that there is a developed susceptibility of depression between women which is least partially responsible for damaging attitudes towards them, deficiency of acknowledgment for their work, minor chances in training and occupation, and a bigger risk of home violence (WHO, 2000). Matthews et al., (1990) stated that depression in the later time of life might be correlated to psychosocial factors.

In-addition, preceding studies pointed out similar findings, social participation is not always advantageous, but it also has a negative side (Steptoe et al., 2015; Lee, 2016; Sugihara et al., 2012). As Mitchell e& LaGory (2002) has stated that social participation is positively linked with mental issues, and recommended that further leads to add extra obligations in existing traumatic daily life, causing for a negative relationship between social participation and mental health.

Not simply the biotic and health care factors influence health, the socio-cultural, political, and physical settings equally reasoned for the way people live and grow older (Wilkinson & Marmot, 2005). Along with these socio-cultural dimensions, previous studies also unveil the gender differences dimension. As gender variation is concerned with the health outcomes of social participation; it may damage the mental health of the female side more than the male side. The reason is, females tend to more value passionate affiliations than males and more readily bear psychological suffering by involving themselves with concerns resultant from those people external to their family with whom they have fabricated emotional relations (Lee, 2016). However, some studies have described that social participation harvests larger benefits on physical function (Ministry of Health, 2019) and mental health (Cohrdes & Bretschneider, 2018) in females compared to males. Furthermore, previous research has stated that men are greatly influenced by the care from their spouse, on the other hand, females are meaningfully influenced by support from relatives and friends (Wakai et al., 2011).

The dilemma in Pakistan is that the geriatric population is ignored and there is little or limited availability of data on their social and health issues. A fresh hospital-based review held in Karachi sheds light on health standings, requirements, and concerns faced by this highly susceptible part of the population. According to the observations, half of the elderly were taking three or more medicines per day that highlighted the need to anticipate unpleasant drug experiences (Zafar et al., 2006).

The issue is rising, but the state response is not satisfactory even the state has not yet developed any strategy for the well-being of OPs. Some periodic effort is seen in the form of welfare homes for Ops in the Punjab and Sind, but the intake of OPs in old homes displays a diverse attitude of the community and the utilization of the services was below mark because of traditional and sacred reasons. The key issues that OPs face in our culture are their poverty, the elder abuse within families, lack of state-sponsored social security, and health issues (Ashiq and Asad, 2017).

Although many studies have pointed out that social participation has encouraging effects on elders' health, but there have been few other pieces of research on its negative health consequences (Tomioka et al., 2017). The present study reveals 70% of males and 30% female participation of older persons. Data were collected from 384 older people of Rawalpindi City. Around 79percent of the study respondents were actively involved in household decision making. On the one hand, this is a good sign that elders of the community have some sort of social participation but on the other hand, this leads to poor health profiles of them. The study also reveals the prevalence of hypertension, heart problems, Diabetes and Arthritis, etc. The results of correlation explain the positive significant relationship between study variables. So, we conclude the active and high rate of participation of family-related decision making by older persons leads to the high prevalence rate of disease. Consequently, this situation leads to poor and disadvantageous living in old age.

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