Original Article

Anthropological Study of Ageing

Health, Marital Status and Mode of Living: An Anthropological Study of Ageing Community in Rawalpindi City

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ABSTRACT

Background: Culture is a learned behavior. It is a community's knowledge and set of practices that evolves out of continuous interactions with the outer environment feedback either positive or negative. In a strict sense culture is a man-made nature opposite to physical nature to survive.

Objective: The objective of the study was to investigate the interrelationship of older persons' (OPs) marital status and mode of living with their medical history.

Study Design: Cross Sectional Study

Place and Duration of the Study: The study was conducted on behalf of Help Age Pakistan. The data collection was done in various union councils of Rawalpindi city. The study duration was three months and lasted from Sep-2013 to Dec-2013.

Materials and Methods: Structured questionnaire was developed to collect information on Older Persons' health, economic and psychological status. In this regard, an extensive questionnaire was designed and pre-tested vigorously. Questionnaires were filled by the graduates of PMAS-Arid Agriculture University.

Results: The respondents who were single were mostly heart patients (n=14, 21.4%). The married respondents reported other diseases that included mental health, skin problems, paralysis, eye and hearing impairments and TB etc (n=704, 20.7%). Widows and widowers were in the third category with the same problems reported in second category (n=274, 20.1%). Results in the category of hypertension explain that elder peoples living in their own houses reported 9.1% hypertension, OPs living in rented houses suffering from hypertension were 10.3%, in case of hired residence percentage recorded was 0.0% and in the other category of living like living with relatives, friends or any other, 14.3% OPs were fighting with hypertension in their lives.

Conclusion: The data reveal that OPs living single are likely to catch heart problems, the married OPs were suffering from mental illnesses, dermatological problems, paralysis as well as hearing and visual impairments. The results show that OPs living in their own houses were better off than the ones living in other mode of living. Rented houses reported high percentiles of hypertensions, heart problems, and diabetes.

Key Words: Older Persons, Mode of Living, Marital Status, Diabetes, Heart Problems, Hypertension, Skin Problems

INTRODUCTION

It is widely accepted that some of the new attitudes and ways of life that are spreading rapidly around the world as a result of faster communication and transportation have the possibility of endangering healthy local practices. New technology, leisure, and wealth also carry an element of danger. Anthropology offers a powerful, systematic way of understanding what factors are affecting people's health, and how to evaluate public health plans that affect people's behavior.[1]

Medical anthropology is the primary discipline addressing the interfaces of medicine, culture, and health behavior and incorporating cultural perspectives into clinical settings and public health programs. Health professionals need knowledge of culture and cross-cultural relationship skills because health services are more effective when responsive to cultural needs. Cross-cultural skills also are important in relationships among providers of different cultures when, for example, African American and Filipino nurses interact with each other or with Anglo, Hispanic, or Hindu physicians. Knowledge of culture is also necessary for work in community settings, such as collaborating with diverse groups and organizations to develop culturally relevant public health programs. Health care providers and patients are more effective in managing their health and care with cultural awareness and the ability to manage the numerous factors that affect well-being.[2].

Ethnomedical studies (see Bannerman, Burton, and Wen-Chieh, 1983) reveal that health problems and treatments are conceptualized within cultural frameworks. Culture directly affects the manifestations of conditions, their assessment and social implications,

and processes of treatment. Ethnomedical analyses show the importance of understanding healing from the cultural perspective of the group, their social dynamics, the social roles of healers, and the conceptual and cosmological systems[3,4]

Gerontology is the study of old age and ageing. Although everyone has an intuitive sense of what 'old age' and 'ageing' are, providing a watertight objective definition is surprisingly difficult. *Ageing* could be said simply to be the process of growing older[5].

Falling on custom and practice, we can state that *old age* is defined as the final segment of the lifespan, and for those who must have a number to attach to this, it is further defined as beginning at around 60 years of age. Different gerontologists have different threshold ages for the onset, but 60 is a reasonable compromise figure. In fact, it has been accepted by the mainstream literature for nearly 200 years[6].

Inadequate social support is associated not only with lower overall general health and wellbeing, but also with higher levels of emotional distress, more illness and higher mortality rates[7].

There is a wide consensus that participation in social networks is highly beneficial and connected with ageing that is comfortable, secure and productive. Such participation, to the extent that it means feeling valued and appreciated, is regarded as a significant component of wellbeing[8].

Ageing is a sociologically interesting phenomenon because although it is a virtually universal experience – almost all of us will get old before we die – it occurs within very diverse and complex social and power dynamic contexts, including socio-economic grouping, health status, and access to financial resources, gender, ethnicity and geographical location. It is paradoxical that, on the one hand, we congratulate ourselves that in our society more people live longer than at any other time in history, but on the other hand, old people are demonized for the caring and/or financial burden they impose on their family, the community and the state[9].

Most research on older people has been grounded in problem assessing and addressing, and as such has pathologized the experience of ageing. It is only comparatively recently that gerontology has attempted to develop theoretical frameworks that seek to make sense of the social experience of ageing[10].

Reflection on ageing is as old as intellectual thought itself – from ancient times, philosophers, scientists, theologians, economists, artists and writers have pondered the meanings and experiences of growing and being old. What is definitely not a phenomenon of the twentieth and twenty-first centuries is the heartfelt cry of older people that they are not treated with the respect they consider their due from younger generations– certainly not the way they respected their elders in their youth. Note the following quotation from a thirteenth-century sermon (popularly ascribed to St Peter Celestine; this sermon is sometimes ascribed to the eleventh century Peter the Hermit). The young people of today think of nothing but themselves. They have no reverence for parents or old age. They are impatient of all restraint. As for girls; they are forward, immodest and unwomanly in speech, behavior and dress[11].

Older men are married, have children and grandchildren, and enjoy better health and greater wealth than previous cohorts or never married peers[12].

The many different areas of medical anthropology reflect a growing trend of applying cultural knowledge to resolve health problems; a variety of aspects are listed below in "Applications: Areas of Medical Anthropology." Cultural knowledge and intercultural perspectives help facilitate relations among provider cultures, patient cultures, and institutional cultures. Cultural perspectives inform providers regarding how patients, families, and significant others conceptualize health problems and will respond to proposed care. Cultural perspectives enhance effectiveness in clinical practice and community health by enabling changes in professional style, institutional practices, and community behaviors where appropriate. Understanding a patient's personal and social life in relationship to the treatment plan helps ensure effective communication, appropriate resource utilization, and the success of treatments. Culturally sensitive approaches also help patients by helping providers accommodate to patients' concerns with alienation, powerlessness, distress, and despair[13].

The World Health Organization (WHO) characterized health as complete physical, mental, and social well-being and the capability to function in the face of changing circumstances. The WHO also emphasized the "highest possible level of health" that allows people to participate in social life and work productively[14]. Health involves social and personal resources in addition to physical conditions; a sense of overall well-being derived from work, family, and community; and other relations, including psychosocial and spiritual[15].

Cultural effects on health are part of a system linking the physical environment, social institutions, and biology. Although they also include the physical environment, I refer to these systems as cultural systems models out of recognition that culture shapes our understandings of and interactions with the physical environment, including having effects on the physical environment. Similar cultural systems models have been proposed by physicians, nurses, and public and community health practitioners (Brody, 1973; Engel, 1977, 1980; Blum, 1983; Leininger, 1991, 1995; Baer, Singer, and Johnsen, 1986; Sallis and Owen, 1998), who use cultural systems approaches as conceptual frameworks for addressing health, disease, and care in relationship to the ecology, the total physical and social environment. These models also incorporate demographic, technological, economic, political, and

other social conditions that affect the physical environment[16-21].

MATERIALS AND METHODS

For data gathering a structured tool was developed on Older Persons' health, economic and psychological status. An extensive questionnaire was designed and pre-tested vigorously. Questionnaire contained bio-informatics including demographic information of clients and the second part covered base-line information, Third part contained information on economic status, fourth part was about the medical histories of the older persons, fifth section comprised information on Social and Psychological profile of OPs, and the last and sixth part consisted information about legal and social protection issues of OPs. Questionnaires were administered with the help of a research team that comprised the graduates of department of Anthropology of PMAS-Arid Agriculture University along with professionals of Regional Development Network (RDN) as well as field staff of Pakistan National Center on Ageing (PNCA).

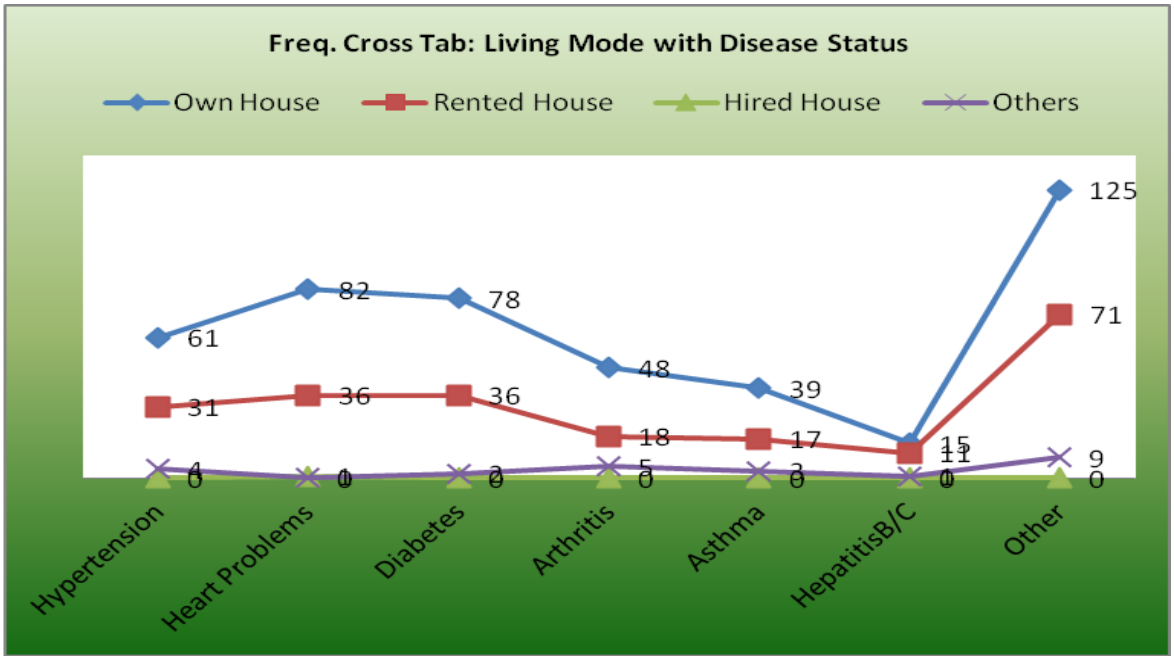
RESULTS

Marital Status with Disease Status: The table educates that correlation of diseases with the marital status of the respondents. The respondents who were single were mostly heart patients (n=14, 21.4%). The married respondents reported other diseases that included mental health, skin problems, paralysis, eye and hearing impairments and TB etc (n=704, 20.7%). Widows and widowers were in the third category with the same problems reported in second category (n=274, 20.1%). The divorced OPs revealed a different trend in which an equal percentile of 33.3% was recorded in Hypertension, Heart problems and other diseases. The respondents living separately from the spouses scored equally in three categories those were heart problems, arthritis and other diseases.

Living Mode with Disease Status: Mode of Living is very imperative especially for elders it is always an important factor when discussed in terms of health status and other problems. Results in the category of hypertension explain that elder peoples living in their own houses reported 9.1% hypertension, OPs living in rented houses suffering from hypertension were 10.3%, in case of hired residence percentage recorded was 0% and in the other category of living like living with relatives, friends or any other, 14.3% OPs were fighting with hypertension in their lives. Highest rate of Heart ailments recorded in the category of hired houses. Diabetes was more prominent among the elders living in rented houses, the category of 'others' depicted the highest percentage of arthritis and asthma among respondents. The table also contends that living mode is directly related with the health status. As stated earlier in the study that living conditions of the families on a general level was not satisfactory at all. This situation goes more severe in terms of studying the livings of OPs. Mostly the families were found to living in accommodations ranging from one to two room dark and damp apartments with serious compromises on privacy issues.

Table No.1: Comparison of Marital Status with Diseases

Marital Status	Do you have any of the following								Total
	Hypertension	Heart Problems	Diabetes	Arthritis	Asthma	Hepatitis B/C	Other	NA/ No disease	
Single	0	3	0	2	1	0	2	6	**14**
	.0%	21.4%	.0%	14.3%	7.1%	.0%	14.3%	42.9%	**100.0%**
Married	60	83	81	38	39	18	146	239	**704**
	8.5%	11.8%	11.5%	5.4%	5.5%	2.6%	20.7%	33.9%	**100.0%**
Widow/ widower	35	31	35	30	19	9	55	60	**274**
	12.8%	11.3%	12.8%	10.9%	6.9%	3.3%	20.1%	21.9%	**100.0%**
Divorced	1	1	0	0	0	0	1	0	**3**
	33.3%	33.3%	.0%	.0%	.0%	.0%	33.3%	.0%	**100.0%**
Separated	0	1	0	1	0	0	1	2	**5**
	.0%	20.0%	.0%	20.0%	.0%	.0%	20.0%	40.0%	**100.0%**
Total	**96**	**119**	**116**	**71**	**59**	**27**	**205**	**307**	**1000**
	9.6%	**11.9%**	**11.6%**	**7.1%**	**5.9%**	**2.7%**	**20.5%**	**30.7%**	**100.0%**



Graph: Living Mode & Diseases

DISCUSSION

The data reveals that marital status is strongly related to the OPs' medical history. Pakistan being a third world country always finds its cultural roots in the ancient Indus river civilization. The social institution of family has always been very influential and only recognized social support network existing for the last many centuries. Family is the socio-cultural bond that lays out the foundations of identity as well as the social reference. Family is not only a natal bond rather it also acts as building social support networks that are operational to provide social and psychological support to its members in the larger context of society. Marriage institution is the cultural arrangement of extending social ties and enhancing the alliances to other non-familial layers of society to in order to bring them in familial brethren and thus ensuring survival against hard outer-external hostile environment. The individuals not practicing marital options are more prone to contract ailments which put them at the mercy of their peer groups or extended family ties for look after and medical attentions. Marital partners and off-springs are the only support group that play important role in caring for OPs. The data reveal that heart problems being the most important are higher among the OPs who remained single throughout their lives. It is not to say that the married OPs did not face any medical issues rather it is to say that the severity of medical issues goes higher among unmarried OPs as compared to the married OPs who usually suffer less intensity medical ailments including neurosis, dermatological problems and hearing and visual impairments.

The mode of living also affects the disease status of OPs. The data show that the socio-economic status of OPs is strongly correlated with the medical history of the respondents. Mode of living can not only be taken as a mere living pattern rather it is directly associated with the economic stability of the respondents. Generally, it was observed that the respondents' economic stability liberates them from fear of getting displaced. The genuine human wish of owning a shelter frees the respondents from many mental stresses and thus positively saves them from many psychological and pathological issues. The OPs living in their own homes are less likely to be affected from hypertensions, heart problems, diabetes and arthritis. The vital statistical details also bring forth the fact that the quality of living also affects the health status of OPs. For example, health status among OPs goes better if there is a separate room for them that ensures their privacy. Residential apartments ranging from one to two rooms usually scored poor in case of OPs where they are not enjoying their privacy as well as those rooms were found to be darker and damper.

CONCLUSION

The aim of paper was study two important variables regarding the general welfare of older persons in Rawalpindi city. The first variable that was studied was to see the marital status of OPs with their medical history. The second variable highlighted the relationship of more of living with the medical problems. On the basis of the information collected it can be safely concluded that marital status positively affects the health of older persons which means that in case of being married the health status of older persons is generally found to be more satisfactory. The underlying fact is that the older persons are being taken

care of by their marital partners as well as their off-springs. The marital status also provides an opportunity for psychological care by the rest of the family members. On the other hand, the mode of living is directly related to the economic stability of older persons which directly affects the health status of them. The respondents living in their homes owned by them bring a mental satisfaction from the fear of being at the mercy of others. The further details reveal that houses ranging from two to three rooms also positively affect the medical status of OPs as they enjoy their privacy. Houses from one to two rooms report that OPs usually are given place in darker and damper rooms which negatively affects their health.

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