CHAPTER-I

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Ageing is universal and a natural process of gradual and spontaneous change. Human ageing is a progressive decline in the homeostatic reserve of every organ system. The decline of each organ system is influenced by disease, hormonal disorder, diet, environment, personal habits, and genetic factors. Degenerative diseases and chronic disorders also affect the ageing. The most common diseases and disorders in this category are visual problems, hearing impairment, heart diseases, respiratory diseases, arthritis, hypertension, diabetes, cancer, etc. Older persons suffer more from chronic illness compared with younger persons.

The elderly are vulnerable group of chronic diseases and functional disability. Knowledge of health related problems of elderly are essential to the provision of cost-effective service and the planning of strategies for intervention and care. Symptoms in the elderly are often not as clear as those in younger people, and many old people including their family and health workers regard these symptoms as inevitable accompaniments of age therefore, they may not seek medical care.

The elderly who are incapable of doing any work need to be specially understood because of their dependence upon others for physical, emotional care. Moreover, the elderly population is the unique and diversified group in today's society, because they have lived the longest life and participated in and adapted to the complex societal changes.Old age should be regarded as a normal, inevitable biological phenomenon, but it can be make enjoyable by our intervention to protect and promote it.

According to the World Health Organization (WHO), aged group 65 years and more are designated as elderly.In Nepal, retiring age for a person is 58 years in government civil service, 60 years in government health service, and 63 years in government university service.

Health is multidimensional phenomenon; therefore, various socio-economic factors are highly associated with health problems. **World Health Organization defines health as a state of complete physical, mental and social as well as spiritual well being not merely the absence of disease and infirmity.** Health seeking behavior is a usual habit of a individual, people or a community that is resulted by the interaction and balance of health needs, health resources, and socio-economic, cultural as well as political and national/international contextual factors. The elderly are subject to multiple chronic conditions and multidimensional assessment of health status and its sociological factors is necessary to improve physical, mental and social wellbeing of this group.

1.2 STATEMENT OF THE PROBLEM

Elderly is an inevitable fact. In every society there are more or less elderly people. Degenerative diseases and chronic disorders are a natural phenomenon of old age. Six out of every ten elderly people reported serious health problems and almost all reported one or more minor health problems

During past few decades, there has been an increase in both the number and proportion of elderly in Nepal. According to the population census, 2001, 6.5 percent of total population was 60 years and above. In Nepal, more than 85 percent of the elderly populations live in rural areas

In global context, the population of age group 65 years and more was 7 % in 2002. It is continuously increasing in last 3-4 decades. According to the UN population estimation, the number of people with age 60 years and over was 600 million in 2002 and will be 1200 million in 2025. Thus, the twenty-first century will be characterized by the ageing of the global population. Most of the elderly are in the developing countries. In, Asia there was 53 % elderly in 2002 and it will increase to 59 % in 2025.Therefore, we can say Asiawill be the centre of population ageing.

In Nepal, an elderly male is socially active as a leader of village affairs. The care and honor given to the elderly in traditional Nepal is structured through socialization. Children are brought up to treat the grandparents as if they are deities.

The family in Nepalese society is the fundamental multipurpose organization for many of the principal life function of the individual and life society. The joint family system was the familiar system from ancient times.

However, this system has by now shown the sign of breaking because of modernization and developed activities, still in many part of rural and urban Nepal joint family system is still alive. Though the joint family system was, an ideal form of family structure in Nepalese society it has began to be disrupted because of job and other income-generated activities and shifting of living place to different parts of the country. This has resulted in the breaking up of joint family, which has tremendous impact on the security and care of aged person in the family. Likewise, Tharu communities are also facing these impacts. In this community elderly people are having many health problems, among them six common physical health problems and there health seeking behaviors are studied in this dissertation.

1.3. OBJECTIVES OF THE STUDY

The general objective of the study was to identify the common physical health problems and factors affecting to health seeking practice among elderly people.Specific objectives of the study were as follows:

1. To find out common physical health problems of elderly people of Tharu community.
2. To find out health seeking practices of elderly people of Tharu community.
3. To explore factors affecting to the health seeking practices of elderly people of Tharu community.

1.4 SIGNIFICANCE OF THE STUDY

Like in the other developing countries, Nepalese elderly population is gradually increasing and facing many health problems. Therefore, they need attention, and understanding from the younger generation preferably of their own family. The increasing growth and demand of elderly people in Nepal urges the active involvement of health personnel from different disciplines in developing health services for them.

The constitute of the kingdom of Nepal, 1991: Article 26 states that for the welfare and betterment of orphan, children, helpless people, women, elderly, handicapped and incapacitated people. The Nation shall adopt policies for education, health, and social security.

Likewise, the geriatric problem has been viewed as emerging health issue in second long term health plan (1997-2017).In Nepal, very few studies are reported on elderly health. However, all are focused on elderly of urban area and geriatric home only. Nepal Health Research Council (NHRC) has enlisted areas of elderly health issue in its short-term research priority area.Studies on health problems and its determinants of elderly are necessary to aid sociologist to address the sociological factors which are related to the health problems and seeking practices among elderly population. Therefore, it is justifiable to study on the common physical health problem and health seeking practice among elderly population in the sociological eye by sociologist, which may be helpful for policy makers as well as social workers.

1.5 DILIMITATION OF THE STUDY

The study covers pre-defined aspects of elderlysix common physical health problems of Tharu community. The six common physical health problems are hearing, visual, coughing, dysponea,,joint pain and backache. Study does not cover all health and socio-economic problems of study population. This study does not represent attitude and practice of elder people of the whole country. Five hundred and seventy household in the VDC is covered by Tharu community. Hundred samples equally male and female from Tharu community of age 60 years and above reside in the study area are the targeted people for the study.Simple random sampling method is used to collect required data.

1.6 OPERATIONAL DEFINATION OF THE KEY TERMS

Tharu:

Tharu, the forth major population, is a kind of ethnic group in Nepal mainly inhabitant of Terai region,also called “DhartiPutra”of Terai.

Awareness: Knowing something, knowing that something that exists and is important, being interested in something: an awareness of the importance of family planning and its consequences.

Health :

"Health is a state of complete physical, mental and social as well as spiritual well being not merely the absence of disease and infirmities"

Physical Health :

The conditions of body. There are many more meaning of physical health but this report include mainly vision, hearing, breathing, coughing, backache and joint pain.

Health Seeking Behavior:

Health seeking behavior is a usual habit of a individual, people or a community that is resulted by the interaction and balance of health needs, health resources, and socio-economic, cultural as well as political and national/internationalcontextual factors.

Ageing:

Ageing is the process of being physically, mentally and socially weak.

Population :

The total number of people living in certain area within specific period of time.

Elderly People:

Male and female population age 60 years and above residing in the study area.

Visit to Health Facilities:

Visit to government, non-government, community or private hospital, primary health care centre, health post, sub health post and doctor’s private clinic.

Visit to Traditional Healers:

Visit to local traditional healer such as dhami, jhankri, herbs users, etc.

Self-Medication:

Use of allopathic or ayurvedic medicine without the prescription of registered doctors or health workers or use of any kind of medicine, herbs and other things with own perception and empirical knowledge.

Common Physical Health Problems:

Common physical health problem means the perceived and experienced, that follows six common health issues and the functional disabilities expressed by the respondents.

I. Hearing problem

II. Visual problem

III. Coughing problem

IV. Dyspnoea (difficulty breathing)

V. Joint pain

VI. Backache

Hearing Problem:

Sensory problems relating to determining spoken language and distinguishing it from other sound during conversation reported.

Visual Problem:

Blindness or any other difficulties seeing with one or both eye for both distant and near vision perceived and reported.

Coughing Problem:

Illnesses or infection that causes person to cough frequently.

Dyspnoea (Difficulty Breathing):

Difficulty in breathing during rest or by exertion.

Joint Pain:

Pain in one or more joints of limbs with or without swelling that creates difficulty in performing daily endorsement.

Backache:

Pain or stiffness of backbone which produces difficulty in performing daily activities.

Occupation:

The prime source of earning of respondent in present time.

Economic Status:

Lower class: Family income which is insufficient to fulfill minimum basic requirement (lodging and fooding) for less than six months.

Medium class: Family who's earning is near about meeting the basic requirement for at least six month time period.

Higher class: Family income which is sufficient to fulfill minimum basic requirement for whole year, including savings.

Economically Active:

Those who are working in gainful activities which make them to earn goods or money.

Non-Economically Active:

Activities such as cooking, cleaning, rearing and caring children etc. which do not posses economic value.

Accessibility of Health Services:

The health services which are available within 30 minutes and more walking distance form respondent's residence.

Educational Status:

Illiterate: The respondent who can neither read nor write.

Literate: The respondent who can at least read and write with understanding and perform simple arithmetic calculation.

Knowledge of Available Health Facilities:

Knowledge of available health facilities provided by private or public sectors such as, hospital, primary health care centre, health post, sub health post and private clinic and nursing home available nearby their community.

CHAPTER-II

REVIEW OF RELATED LITERATURE

2.1 Review of Theoretical Literature

As the study area of this study is typical indigenous group of Nepal, the elder population belongs to the some of the sociological model of the society. With the reference of different models of society, this study is carried out with perspective of two leading sociological Models.

Ethno methodological model is one of the popular new micro level study models, which study the natural behaviors of the community people. This model was developed young American sociologist "Harold Garfinkel" in 1967 by published ' Studies in Ethnomethnodolgy ' book. After that, John Heritong (1984) published book "Garfinkel and Ethnomethodology" and written on his books “Ethno Methodology is the study of the body of commonsense knowledge and the range of procedures and consideration (the method) by means of which the ordinary members of society make sense of find their way about in and act on the circumstance in which they find themselves". So the Ethno Methodological Model refers to the study of methods used by people or members of society gives meaning to their social world. Understanding a community, making decisions, being rational accounting, for action, the subject matter of ethno methodology is how members of the society understand seeing, describing and explaining the daily life in the social world. Ethno methodology is concerned with everyday life. The literal meaning of ethno methodology is "the method that people use on a daily basis to accomplish their everyday life". To put at slightly differently, the world is seen as an ongoing practical accomplishment.

The Health Seeking Behaviors of elder people was also looked like main theme of ethno Methods of the sociological model. Their social practice to confidence to cure disease by traditional healers is the ethno methodological social system in their health seeking practice. Their Knowledge is a product of one's social position within a society. One develops it by interaction withothers. Everyday reality is a socially constructed system in which each member of elder people gives reality in practice.

As the ethno methodological model deals, elder people do have shared understanding depends on the everyday activities of society's members that is concerned to the analysis of cognitive process of human being and these seem people's method rather than scientific producers

Structure functional model is one of the important models to study the social system. This theory was developed by the well-known sociologists ie Emile Durkhim, Malinowski, Radicliffe brown, RK Morton and others. According to the Collins Dictionary of sociology – "Structure functionalism is a theoretical approach in which society are conceptualized as social system, and particular feature of social structure are explained interim of their contribution of the maintenance of these systems ie religious, ritual explained in term of the contribution on it make to social integration". Normally this Structure-Functionalism theory is applied to understand and analyze the social structure of particular arrangement of the interrelated social institutions, agencies and social pattern, as well as the status and the roles, which each institution assumes in the groups. This is the model which views the society as an integrated whole of the different elements functioning together. All the elements have their own functions and contributions. All of these are united together. This unity is due to their interrelation and interdependency. If a small change appear in it, it effects and defects whole system. Functionalism states a society as the integrated whole of the different parts with its elements i.e. individuals, institutions, norms, values, ceremonies, marriage, groups etc.

The theory of Structure-Functional Model of society, though principally a macro social theory, serves the theoretical linkage with the social composition of Health seeking behavior of elder people. The study has showed the elder people also does have complete pattern of norms, values, laws, costumes, religion, morals and practice. These all parts are working together for to continue the daily life of elder people. In Health Seeking Behaviors same kind of elements are affecting the community. Education, economic status, decision making practice, traditional health cure system and modern medicine systems, occupations, Traditional Healers, Health workers are the parts and the Health Seeking Behavioral system is the complete whole for this community.

2.2Review of Emperical Literature /Previous Study

Ageing is a natural process. Discoveries in medical science and improved social conditions during the past few decades have increased the life span of people. Many people in the developed countries are living up to the age of 70 years and over.

Disabilities incident to ageing process is not known much. However, the disabilities such as, senile cataract, glaucoma, nerve deafness, bony changes affecting mobility, emphysema, failure of special senses, and change in mental outlook are considered as incident to it. This list is not exhaustive; we need to know a lot more about the disabilities incident to the ageing process. There is ample scope for research into the degenerative geriatrics and the epidemiology of conditions affecting the aged.

According to textbook of Preventive and Social Practice (Park and Park 2002: 266), a hospital-based study have been made in India on the health status of the aged persons, but such studies provide only a partial view of the spectrum of illness of the aged population. The overall data on aged are scarce. The main cause of illness is Arthritis, Cataract, Bronchitis, Avitaminosis, Ear diseases, Hypertension and Diabetes.

The Indian Council of Medical Research (ICMR) survey of elderly persons over 60 years of age attending geriatrics clinic in rural India showed visual impairment/compliant 88 percent, locomotive disorders, joint, muscles 40 percent, cardiovascular diseases 17.4 percent, respiratory disorder 16.1 percent and hearing loss 8.2 percent. The spectrum of diseases in the elderly is varied.

Ghai OP 1999, India, explained that there are most common age related problems are hearing impairment, blindness, respiratory disorders, nutritional deficiencies, cardiovascular disorder diseases, cancer, diabetes and dementia.

Thapa B 2004, described in the rural community survey made by the Indian council of medical research, health problems of elderly were as follows: visual 65 percent, locomotion 36 percent respiratory 10 percent, skin 8 percent, central nervous system 7.4 percent, cardiovascular system 6.3 percent and hearing 5.8 percent of the sample.

A community based survey on the health status of elderly carried out in the western province of Sri Lanka in 1992 produced health problems as follows- eyesight 59 percent, hearing 22 percent, mastication 30 percent and mobility 7 percent.

Natrajan V S 1999, study conducted in Chennai, Lucknow and New Delhi, nearly one third of elderly population are not living with their families, mainly because of better job opportunities of younger generation. The reasons for breakdown of joint families systems are lack of adjustment among family members, poverty and accommodation problem, and elderly are forced to live terrible life.

Compared with younger persons, older persons suffer more from chronic and less from acute illness. Of especial importance to the elderly are disorders that affect hearing and vision. Between one third and one-half of the people interviewed in WHO eleven countries study, reported difficulty in hearing. About 20 percent had difficulty in seeing to read and write.

Not enough has yet to know of the health, social and environmental factors that promote autonomy and prevent dependence among the elderly in different cultures. The elderly have their own demographic structure, their own mortality indices and their own especial problems of disease, disability and need for support found in report of WHO in 1984. The WHO Brasilia declaration in healthy ageing, 1996 declared – ageing is a development issue- healthy older people are a resource for their families, their community and the economy.

A retrospective study in Bir Hospital by Doctor MP Pandey, 1980 compiled the figure of 6 years from 1969-1975, the major chronic corpulmonale in old age 60 and over constitute 46 percent of all heart disease.

Domestic smoke pollution is very common in our country where majority used firewood without chimney in poorly ventilated house for cooking and heating purposed and it is suspected to have been causing chronic obstructive pulmonary disease (COPD).

Based on study carried out by Chaudhary R H, 2004, the disability status is determined in terms of blindness, deafness, physical, mental, and multiple disabilities. The data on disability for the older were found that the percent of older population (60 years and more) who are disabled was male 0.63 percent, female 1.3 percent and total 0.97 percent. This data reveal an overall low disability rate (less than 1%) for the entire population. This may be attributed, among other factors, to an under

numeration of disabled persons. Disability in the socio cultural background of Nepal is considered as a “curse” from God and a taboo subject. Given the circumstances, respondents are likely not to faithfully report on the questions of disability, leading to an under numeration of disabled persons in the census.

According to Upadhya N P, 2004 old age is a true and universal fact that those process who are retired from their assigned duties or post, they need to be properly looked after from the family as well as government side. Basically, the old age people have had lot of experiences and the government must share their ideas and thought in project planning and other policy formulation. Furthermore, proper medical facilities and effective family environments must be given to them for maintaining the health of old age people.

Acharya BK, 1991 study said that the health ethics and choice of healing indicates that we should not misunderstand what the patients use to do before deciding to consult any health professional. They generally do not take precautions during initial stage of illness. They either tolerate or ignore the case and do not tell others about the suffering and if the condition becomes worsening, they employ self-known measures. They call upon health professional or visit health institution only after realizing that some remedies prescribed by health professional might relieve the pain or disease. Choice and preference depends also on relative performance or efficacy of health care providers. Thus, many literature and studies indicate the importance of the explorations on health seeking behavior and consumer's satisfaction from service providers. They are searching options which is less expensive, adjustable, faith and affordable. This study assesses types of medication that the consumers are using further the study explains the satisfactions of consumers.

Gaurtoulla RP, 1998 study conducted in modern medication practice (Allopathic) is scientific because of enormous research accomplished. It has predominant role in the health system of country. Contrary to this, self-medication is an often chosen practice in Nepal. Gartoulla states that self-medication consists of drug shops and various types of practitioners of traditional medicine (Ayurvedic, Chinese, Homeopathic, etc.). Spiritual practitioner such as shamanism, priests, dhami/jhakri, and astrologers are also included in this category. People have the option of using herbal medicine

(roots, grasses, plants etc.) which they can either collect themselves in the forests or purchase from practitioners or shops.

Dixit H, 1999, study also explained that the people those in the rural areas is that they first seek treatment from the system / form near at hand e.g. traditional healers (dhami, jhankri, gubaju, jharphuk and sudeni), herbalist with their traditional remedies, and laterally follows ayurvedic and other medication. The expansion of the health has not occurred neither in the government nor the private sector to the extent that is even required for the increase of the population.

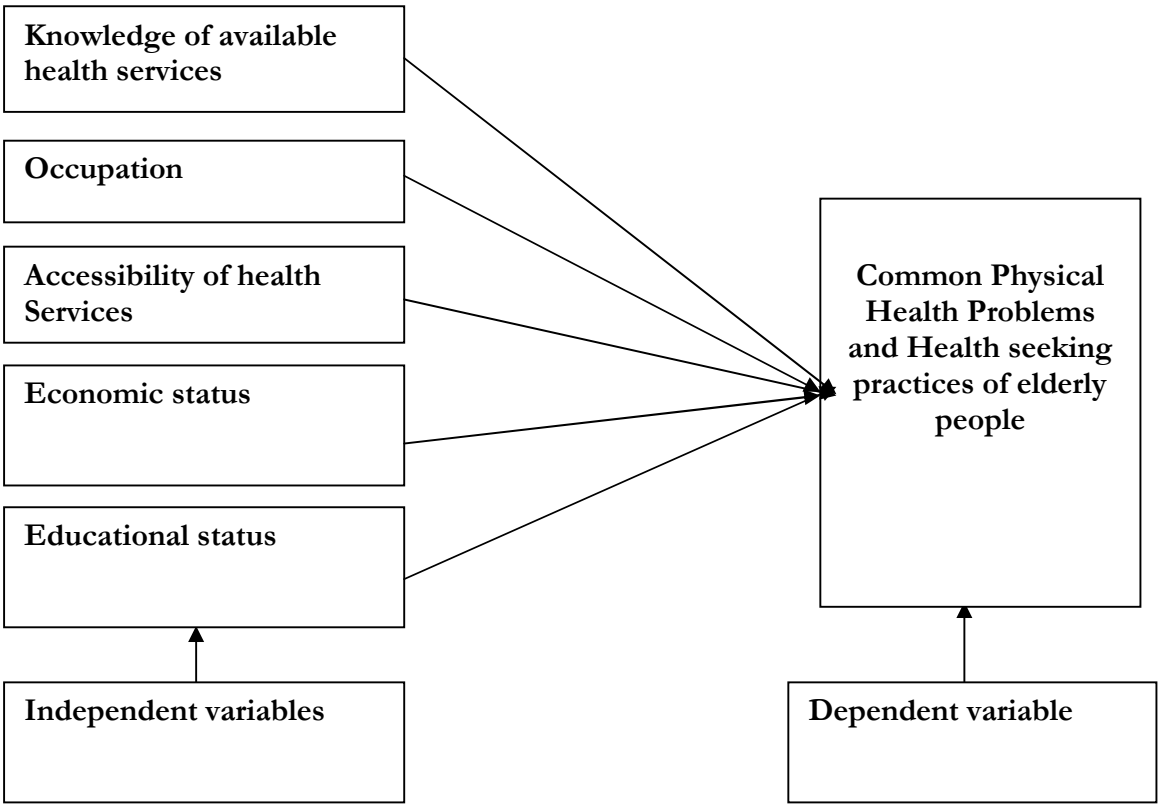
2.3 Implications of the Review for the Study

This study report can be implimented in different areas of elderly people to manage and to make policies related to physical health problem and health seeking behaviors.

1. This report can help the Lakhantari VDC as well as other VDCs elderly people to forecast their common physical health problems.
2. This report can help the government to make policies and strategies related to elderly people health problem and their health seeking behavior.
3. This report can be helpful to provide essential medicines and man power for elderly people in local health intuitions.
4. Ageing is a natural process thus the ageing people of Nepal is growing so this study will help to open Elderly Care institution in different areas.

2.4 Theoretical/ Conceptual framework

Health problem of elderly people and health seeking practices of elderly people is dependent variable, which directly and indirectly affected with the independent variables mentioned above ie (knowledge of available health service, occupation, accessibility of health services, economy status and education status etc).



In above-mentioned conceptual framework, common physical health problems of elderly people were defined ie [hearing problem, visual problem, coughing problem, dyspnea (difficulty to breathing), joint pain and backache] and health-seeking practices of elderly people defined ie (self-medication practices, modern medical services utilization and traditional medicine practices).

Health Seeking Behavior or practices is closely related with traditional medicine, Shamanism, religious act, self -medication etc. These are also influenced by tradition family pattern, cultural appropriateness, faith, low cost, internal personal relationship, crudeness or kindness of the service providers, advice from neighbors/ relatives and siblings, availability of service providers, personal chosen, occupation, education etc. Availability and accessibility of modern medication facilities such as Hospital, Primary Health Center (PHC), Health Post (HP), Sub-Health Post (SHP) and private clinics & Nursing homes also major determinants factor of the health seeking behavior or practices of the community. Therefore, those aspects also incorporated in this study.

Studies have shown that the poor and illiterate people are more disliked to provide the information. Validity of the health seeking behavior as a means of assessing the demographic situation, economic aspects, educational status, decision–making and distance of modern health facility etc have found consistent and valid to the result of standardized study.

CHAPTER-III

METHODS AND PROCUDERS OF THE STUDY

3.1. Design and Method of the Study

A research design deals with problems related to develop the research questions recognizing and relevant data and interpreting the results. It includes a logical sequence from study of data to its conclusion. Research designs have been divided into three main types namely exploratory, analytical and descriptive. This research was based on the descriptive method.

3.2 Population Smple and Sampling Strategy

Among five hundred seventy households of tharu's community, hundred respondents of both sexes sixty years and above were equally selected respectively on the basis of random sampling techniques.

3.3study area/field.

Total population size of Lakhantri VDC, Morang is 4007. Among them 570 household in the VDC wassheltered by Tharu community. The socio-economic condition of this VDC was found poor. Literacy rate was low and most of the inhabitants were landless. Health indicator of this community was found good but health status of elderly people of this community were found poor.

3.4 Data collection Tools and technique

The study was based mainly on primary source of data. The information was collected from field survey at Lakhantari VDC in Morang district. Tharu community people aged 60 years and above were the source of information. Secondary data were drawn from literatures such as from relevant books, journals and annual report of DHO/HP and VDC profile etc

The questionnaire is the main tool for collecting necessary information. The tool was developed on the basis of related references. The main purpose of the

questionnaire is to collect information from the respondent to identify their common physical health problems and their treatment seeking behavior.

3.5 Data Collection Procedure

At first, the researcher visited the VDC office with an authorized request letter and explains the reasons of the study. After this, the researcher prepared the list of elderly people residing from Tharu community. For assistance and support friendswho can understand local language were also selected. Then the researcher visited home to collect the necessary information along with assistant. Before asking formal questions, the researcher and his assistant tried to motivate them to answer the questions without any hesitation. After performing informal exchange and explaining about the study, the information was collected on the basis of interview schedule.

3.6 Data Analysis and Interpretation Procedure

After collecting needed data, it was analyzed and interpreted quantitatively & qualitatively. For this, the raw data were tabulatedon a master chart according to the objectives of the study and variables. Gathered data was analyzed and interpreted descriptively with the help of the computer using software (SPSS 14).

CHAPTER-IV

ANALYSIS AND INTERPRETATION OF RESULTS

4.1. Demographic Situation of Respondents

The entire respondents were 60 years of age and above from Tharu community of Lakhantari VDC. Respondent's age, sex, marital status, ethnic group, religion, language, education, economic status, involvement in economical activity and their occupation were asked at the time of data collection.

4.1.1 Elderly People by Age and Sex

Ageing is a universal and natural process of gradual and spontaneous change. Elderly is an inevitable fact. In every society there are more or less elderly people. Table 4.1 describes the elderly people by age and sex.

Table 4.1Percent distribution of elderly people by age and sex

Age Groups	Male (n=50)		Female (n=50)		Total (%)	N
	n	%	n	%		
60-69 yrs	27	54.00	29	58.00	56.00	56
70-74 yrs	16	32.00	15	30.00	31.00	31
75 yrs +	7	14.00	6	12.00	13.00	13
Total	**50**	**50.00**	**50**	**50.00**	**100.00**	**100**

The table4.1 shows that the number of male (50) and female (50) respondents in the study area were taken uniformly. Among them, 56 percent of them were of age 60-69 years followed by 31 percent of age 70-74 years and 13 percent of age 75 years and above respectively. Compared to age group, percent contribution of male (54%) and female (58%) were noticed higher in the age group 60-69 years.

4.1.2 Caste and Ethnic Groups

The entire respondents were taken from Tharu caste which belongs to the ethnic group "Janjati" and there religion was Hindu.

4.1.3 Marital Status

Marriage is the socio-economic and cultural interrelationship between couples within the family. This section examines the marital status of elderly people of Tharu community in term of married, widow/widower and separated. Table 4.2 and 4.3 present the percent distribution of male and female by marital status according to their age groups.

Table 4. 2Percent distribution of male respondents by marital status according to age groups

Age groups	Married	Widower	Separated/Divorced	N
60-69yrs	62.16	30.76	-	27
70-74 yrs	32.43	30.76	-	16
75 yrs +	5.40	38.46	-	7
Total	**74.00**	**26.00**	**-**	**50**

Table 4.3Percent distribution of female respondents by marital status according to age groups

Age groups	Married	Widow	Separated/Divorced	N
60-69yrs	67.85	42.85	100.00	29
70-74 yrs	**28.57**	**33.33**	**-**	**15**
75 yrs +	3.57	23.80	-	6
Total	**56.00**	**42.00**	**2.00**	**50**

The table 4.2 and 4.3 show that all the respondents were found ever married. In comparison, the percent of currently married elderly is noticed higher in male (74%) than female (56%) but the magnitude of widow was higher (42%) than widower (26%). The percent of divorced and separated was found trivial. This signifies that there is a nominal case of divorced/separated in this ethnic group. The above data also indicates that the percent of widower was increasing with the increase in age. But the percent of widow was noticed higher in the age group 60-69 years. This proves female were biologically more survival than male.

4.1.4 Literacy Status

The definition of literacy has changed over the years. The definition which was used in the 2001 census, same definition has been used in this study. Table 4.4 shows the literacy status of the respondents.

Table 4.4Percent distribution of respondents by sex and literacy status

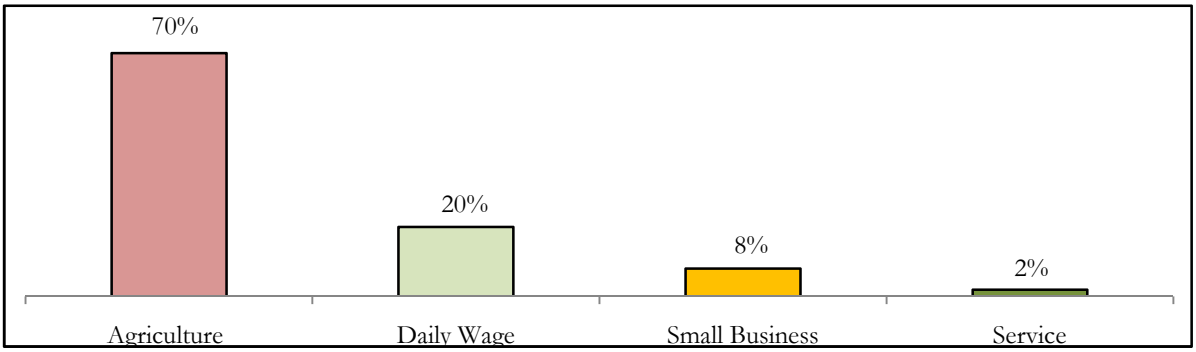
Sex	Illiterate	Literate	N
Male	42.00	58.00	50
Female	86.00	14.00	50
Total	**64.00**	**36.00**	**100**

The table 4.4 shows that it was observed that overall illiteracy rate of the elderly people was 64 percent. The gender gap in literacy was noticed higher in this community. Emphasis must be given in increasing female literacy rate. Old age education (PraudSiksha) should be lunched in this VDC to raise the literacy rate of this community.

4.1.5 Main Source of Household Income

The main source of household income of elderly people is presented in Figure 4.1.

Figure 4. 1Percent distribution of respondents by main source of household income

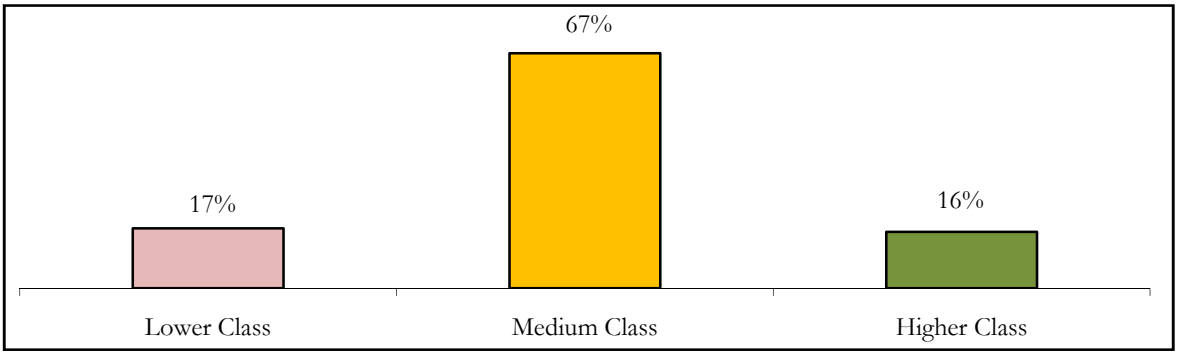


The study found that agriculture was the main source of household income (70%) followed by daily wage (20%) and small business (8%). Governmental or non-governmental services were seen nominal (2%). Agriculture was therefore the dominant household income source in the rural area also in this community too.

4.1.6 Socio-economic Status

Socio-economic status of the family plays the supportive role to enhance the betterment of health status of the family members. Figure 4.2 provides the percent distribution of respondents by household's socio-economic status.

Figure 4. 2 Percent distribution of respondents by household's socio-economic status



Overall, one in every six (17%) respondent's household belongs to the lower class family i.e. family income which was insufficient to fulfill their basic requirement (lodging and fooding) for less than six month. 16 percent belongs to higher class family i.e. family income which was sufficient to fulfill minimum basic requirement for whole year and have saving also. An overwhelming majority of elderly people (67%) were from the medium class family i.e. family income which is insufficient to fulfill their basic needs (lodging and fooding) for six month.

4.1.7 Involvement in Income–generating Activities

Those who were working in gainful activities which make them to earn goods or money is considered as economically active, whereas involving in household activities such as cooking, cleaning, rearing and caring children etc. that does not convert directly in economic value is considered as inactive in economic activities. Table 4.5 shows percent distribution of elderly people involvement in income generating activities.

Table 4.5 Percent distribution of respondents by involvement in economic activities

Sex	Economically Active	Non-economically Active	Dependent	N
Male	52.00	30.00	18	50
Female	48.00	30.00	22	50
Total	**50.00**	**30.00**	**20.00**	**100**

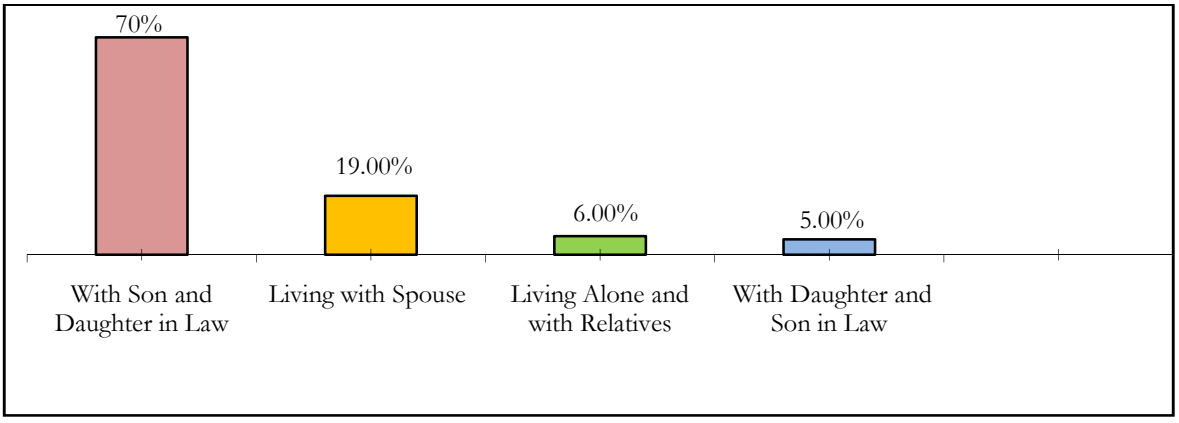
The table 4.5, among the total respondent most of them (50%) were engaged in economically active activities whereas 30 percent of both sexes were involved in non-economic active activities. One out of five elderly people were dependent.

Men were mostly involved in economical activities so their percent was high (52%) compared to female (48%). But the data shows that the percent of female elderly people (22%) were more likely dependent compared to male (18%).

4.1.8 Living Arrangement

Ageing people need rearing and caring support as well as security in old age. Figure 4.4 reflects the patent depiction of elderly population living arrangement according to selected characteristics.

Figure 4. 3 Percent distribution of respondents by living arrangements



Most of the respondents (70%) were living with their son and daughter in law followed by living with spouse 19 percent, living alone and with relatives 6 percent, living with daughter and son in law 5 percent respectively. Though the joint family system was an ideal form of family structure in Nepalese society it has began to be

disrupted because of modernization resulting tremendous impact on the security and care of aged person in the family.

4.2 Common Physical Health Problems and Seeking Behaviors Related Issues

This chapter deals about the respondent's perceived common physical health problems and its treatment seeking practice in their daily life. Basically in this section we described major six health problems i.e. hearing problem, visual problem, coughing problems, dyspnoea (difficulty in breathing), joint pain and backache of the respondents.

4.2.1 Hearing Problem

Hearing problem is one of the common problems of the elderly people. It is a sensory problem relating to determine spoken language and distinguishing it from other sound during conversation period.

At the time of field visit, hearing problems related data were collected from the respondent. Table 4.6 describes detail about the respondent age and sex wise hearing problem.

Table 4.6:Percent distribution of hearing problem by age and sex

Sex	Age Groups	Yes	No	N
Male	60-69 yrs	7.40	92.60	27
	70-74 yrs	18.75	81.25	16
	75 yrs +	57.14	42.86	7
	Total	18.00	82.00	50
Female	60-69 yrs	10.34	89.66	29
	70-74 yrs	13.33	86.67	15
	75 yrs +	33.33	66.67	6
	Total	14.00	86.00	50
Total		**16.00**	**84.00**	**100**

The table 4.6, among the total respondents the reported cases of perceived hearing problem was found one-sixth (16%). The rural community survey made by ICMR 2004, stated that the elderly people were suffering from hearing impairment by 5.8 percent.

Compared to female (14%), prevalence of hearing problem was identified higher in male (18%). Percent of hearing problem was found higher in the age group 75 years and above in both the sexes. The data prevails that the number of hearing problem was increasing simultaneously as increasing in age in both sexes.

4.2.1.1 Treatment Seeking Behavior for Hearing Problem

Among the respondents who were facing hearing problem, all of them (100%) seek help to any place or person for treatment.

4.2.1.2 Place of First Visit for the Treatment of Hearing Problem

Treatment procedure and the place of treatment preferred for hearing problem among elderly population are important factors for its prevention and cure. Table 4.7 illustrates about the place of first visit for the treatment of hearing problem.

Table 4.7Percent distribution of place of first visit during hearing problem by age groups and sex

Sex	Age Groups	Health Facility	Traditional Healer	Self -Medication	n
Male	60-69 yrs	50.00	-	50.00	2
	70-74 yrs	66.66	33.33	-	3
	75 yrs +	25.00	50.00	25.00	4
	Total	44.44	33.33	22.22	9
Female	60-69 yrs	66.66	-	33.33	3
	70-74 yrs	100.00	-	-	2
	75 yrs +	50.00	-	50.00	2
	Total	71.42	-	28.57	7
Total		**56.25**	**18.75**	**25.00**	**16**

The table 4.7 shows that among the total respondent who seek treatment for hearing problem, only 56 percent visited to health facility. One fourth elderly people take self medication . Percent of health facility visit was noticed higher among all other visit which was a positive sign of being aware about the health problem.

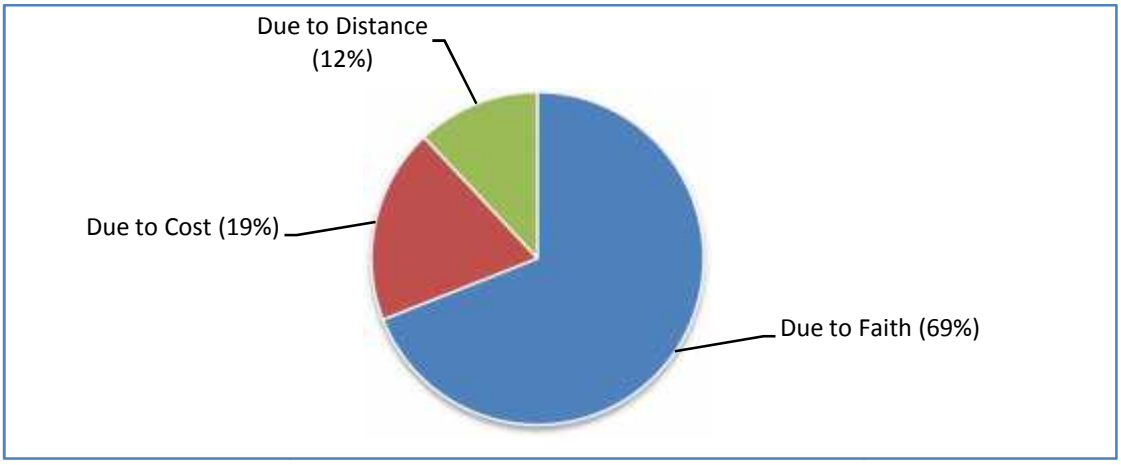
Compared to male (44%), a higher proportion of female (71%) tend to seek treatment from health facility signifying that female were more conscious. Male were more

inclined towards traditional healers and self-medication compared to female. With regard to age groups, percent visit to health facility was recognized higher in male (60%) in the age group 70-74 years and in female (100%) in the age group 70-74 years.

4.2.1.3 Reason for Place of First Visit in Hearing Problem

Figure 4.4 shows that most common reason for the place of first visit of the respondent for the treatment of hearing problem was due to their faith. Among the total respondent who have hearing problem and visited for treatment, 69 percent desired the particular place for treatment due to faith. Likewise, 19 percent due to cost and 12 percent due to distance.

Figure 4. 4Percent distribution of respondent by reason for the place of first visit in hearing problem



4.2.2 Visual Problem

A visual problem was one of the major health problems among elderly people. This problem was mostly seen from the age forty plus so in Nepali it is called 'ChalisayRog'. At the time of field visit visual problems related data were collected. Table 4.9 shows the percent distribution of visual problem by age and sex.

Table 4.8Percent distribution of visual problem by age and sex

Sex	Age group	Yes	No	N
Male	60-69 yrs	37.00	63.00	27
	70-74 yrs	37.50	62.50	16
	75 yrs +	42.85	57.154	7
	Total	38.00	62.00	50
Female	60-69 yrs	41.37	58.63	29
	70-74 yrs	46.66	53.33	15
	75 yrs +	66.66	33.33	6
	Total	46.00	54.00	50
Total		**42.00**	**58.00**	**100**

The table 4.8, among the total respondent the reported cases of perceived visual problem i.e. blindness or any other difficulties seeing with one or both eye for both distant and near vision was noticed 42 percent. Four out of ten elderly people were suffering from clear visibility. A community based survey on health status of elderly carried out in the western province of Sri Lanka in 1992 stated visual problem 59 percent.

Compared to males (38%), the percent of visual problem is recognized higher in females (46%). The prevalence of visual problem was seen greater in the age group 75 years and above in both the sexes.

4.2.2.1 Treatment Seeking Behavior for Visual Problem

Table 4.9 describes the detail about the treatment seeking behavior for visual problem faced by elderly people in the study area.

Table 4.9 Percent distribution of treatment seeking behavior for visual problem by age groups and sex

Sex	Age group	Yes	No	n
Male	60-69 yrs	100.00	-	10
	70-74 yrs	100.00	-	6
	75 yrs +	100.00	-	3
	Total	100.00	-	19
Female	60-69 yrs	83.33	16.67	12
	70-74 yrs	100.00	-	7
	75 yrs +	100.00	-	4
	Total	91.30	8.70	23
Total		**95.23**	**4.77**	**42**

The table 4.9 shows that among the total respondent having visual problems, 95 percent of them moved for medical aid in health facilities or anywhere else. Treatment seeking behaviors were found higher in male (100%) than in female (91%).In accordance to the age groups, the treatment seeking behavior was relatively low in the age group 60-69 years in female (83%) compared to other age groups of both sexes.

4.2.2.2 Place of First Visit for the Treatment of Visual Problem

Health seeking practices of the community people depend upon three categories; either they visit health facilities, traditional healers or take self-medication. The table 4.10 below presents the place of first visit for the treatment of visual problem.

Table 4.10Percent distribution of place of first visit during visual problem by age groups and sex

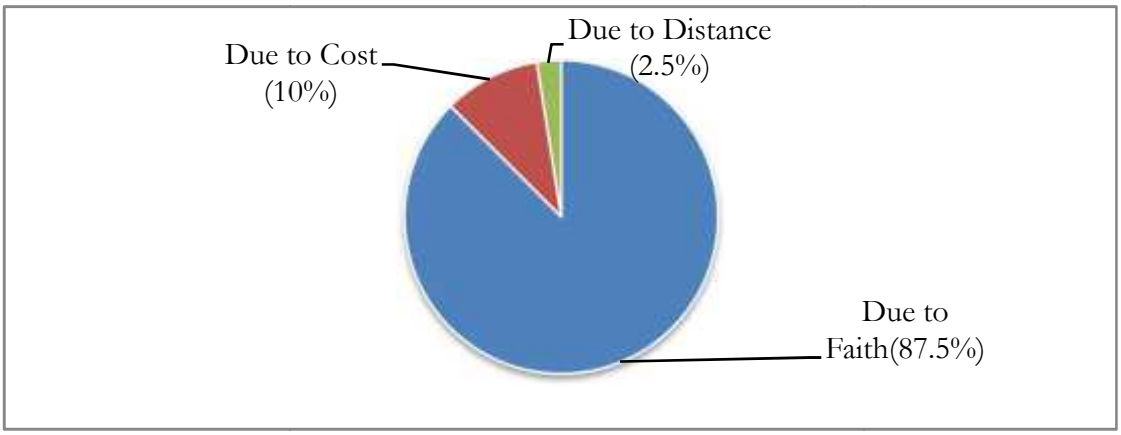
Sex	Age Group	Health Facility	Traditional Healer	Self Medication	n
Male	60-69 yrs	70.00	-	30.00	10
	70-74 yrs	100.00	-	-	6
	75 yrs +	66.66	33.33	-	3
	Total	78.94	5.27	15.79	19
Female	60-69 yrs	100.00	-	-	10
	70-74 yrs	85.71	14.29	-	7
	75 yrs +	100.00	-	-	4
	Total	95.23	4.77	-	21
Total		**87.50**	**5.00**	**7.50**	**40**

The table 4.10, nine out of ten elderly people (87.5%) visited health facility for the treatment of visual problem and the reason to visit health facility was identified, two episode eye camp, which was conducted nearby their community during last one year and most of the elderly people got treatment. Percent visit to traditional healer (5%) and taking self-medication (7.5%) was found marginal. Although percent visit to health facility was higher but compared to female (95%), male percent was found 16 percent lower. In both the sexes with regard to age groups, percent of health facilities visit was observed comparatively low in male (67%) in the age group 75 years and above and in female (86%) in the age group 70-74 years.

4.2.2.3 Reason for Place of First Visit in Visual Problem

Figure 4.5 shows that among the total respondents who had visual problem and visited for treatment, about nine out of ten (87.5%) has chosen the particular place for treatment due to faith. Likewise, 10 percent and 2.5 percent has choosen the place due to cost and distance respectively.

Figure 4. 5 Percent distribution of respondent by reason for the place of first visit in visual problem.



4.2.3 Coughing Problem

Coughing problems was one of the major health problems of the elderly people. People in rural areas due to illiteracy and ignorance were directly contacted with the smoke in their daily life. They use 'Guitha' and fire woods in their kitchen which produces more and more smoke. The poor housing conditions and habit of smoking also lead in causing different respiratory diseases. Table 4.11 presents the information on percent distribution of coughing problem by age and sex.

Table 4. 11Percent distribution of coughing problem by age and sex

Sex	Age group	Yes	No	N
Male	60-69 yrs	14.81	85.19	27
	70-74 yrs	31.25	68.75	16
	75 yrs +	28.57	71.43	7
	Total	22.00	78.00	50
Female	60-69 yrs	10.34	89.66	29
	70-74 yrs	13.33	86.67	15
	75 yrs +	33.33	66.67	6
	Total	14.00	86.00	50
Total		**18.00**	**82.00**	**100**

The table 4.11 show that among the total respondent about one-fifth (18%) perceived coughing problem. The rural community survey made by ICMR 2004, prevailed that the elderly people were suffering from respiratory problem by 10 percent.

Compared to female (14%), male occurrence of coughing problem (22%) was identified higher. According to age group, prevalence of coughing problem was seen higher in the age group 70-74 years in male (31%). Likewise, 33 percent female in the age group 75 years and above.

4.2.3.1 Treatment Seeking Behavior for Coughing Problem

Among the respondents who were facing coughing problem, all of them (100%) seek help to any place or person for treatment.

4.2.3.2 Place of First Visit for the Treatment of Coughing Problem

Table 4.12 shows the detail about the place of first visit for the treatment after feeling coughing problem. Four out of ten (44 %) visited equally health facility and took self medication for the treatment of coughing problem. With regard to sex, percent of male (54%) visiting health facility was found higher than female (28%). Compared to male, 28 percent female were found more inclined to visit traditional healer whereas the male percent to take self-medication was 45 percent.

Table 4.12Percent distribution of place of first visit during coughing problem by age groups and sex

Sex	Age Group	Health Facility	Traditional Healer	Self-Medication	n
Male	60-69 yrs	75.00	-	25.00	4
	70-74 yrs	60.00	-	40.00	5
	75 yrs +	-	-	100.00	2
	Total	54.54	-	45.46	11
Female	60-69 yrs	33.33	33.33	33.33	3
	70-74 yrs	50.00	50.00	-	2
	75 yrs +	-	-	100.00	2
	Total	28.57	28.57	42.86	7
Total		**44.44**	**11.11**	**44.44**	**18**

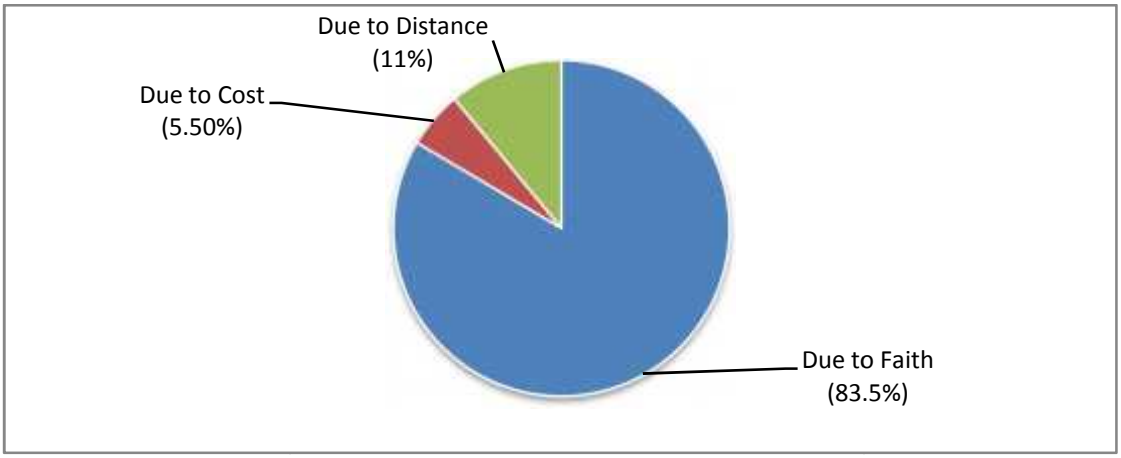
The table 4.12, cent percent male and female in the age group 75 years and above were tending towards taking self medication. None of the male were visiting traditional healer but female in the age group 70-74 years were more inclined towards

traditional healer (50%) whereas male were more likely to visit health facility (75%) in the age group 60-69 years.

4.2.3.3 Reason for Place of First Visit in Coughing Problem

Figure 4.6 provides the information about reason for place of first visit in coughing problem.

Figure 4. 6 Percent distribution of respondent by reason for the place of first visit in coughing problem



Among the total respondent having coughing problem and visit place for treatment, most of them (83.5%) has chosen the particular place for treatment due to faith. Likewise, 11 percent due to distance and 5.5 percent due to distance respectively.

4.2.4 Dyspnoea (Difficult Breathing)

Dyspnoeais a part of respiratory disease and one of the major health problems of elderly people which occur due to narrowing of bronchi and great increase in mucus.

Table 4.13Percent Distribution of Dyspnoea by Age and Sex

Sex	Age group	Yes	No	N
Male	60-69 yrs	11.11	88.89	27
	70-74 yrs	12.50	87.50	16
	75 yrs +	14.28	85.72	7
	Total	12.00	88.00	50
Female	60-69 yrs	6.89	93.11	29
	70-74 yrs	13.33	86.67	15
	75 yrs +	33.33	66.67	6
	Total	12.00	88.00	50
Total		**12.00**	**88.00**	**100**

Table 4.13 shows that among total respondent one out of ten (12%) were suffering from dyspnoea. The prevalence of dyspnoeawas noticed equally in both sexes. Compared to male, higher percent of female (11% and 33%) in the age group 60-69 years and 75 years and above respectively were suffering from dyspnoea. Percent victim of dysponeawas increasing with the increase in age in both sexes.

4.2.4.1 Treatment Seeking Behavior for Dyspnoea (Difficult Breathing)

Among the total respondents who perceive dyspnoea, all of them seeked treatment either visiting health facility or anywhere. Both male and female were aware about the pretext of dyspnoea.

4.2.4.2 Place of First Visit for the Treatment of Dyspnoea Problem

Table 4.14 illustrates the place of first visit by respondent who seek help for the treatment of dyspnoea.

Table 4.14Percent distribution of place of first visit of dyspnoea by age groups and sex

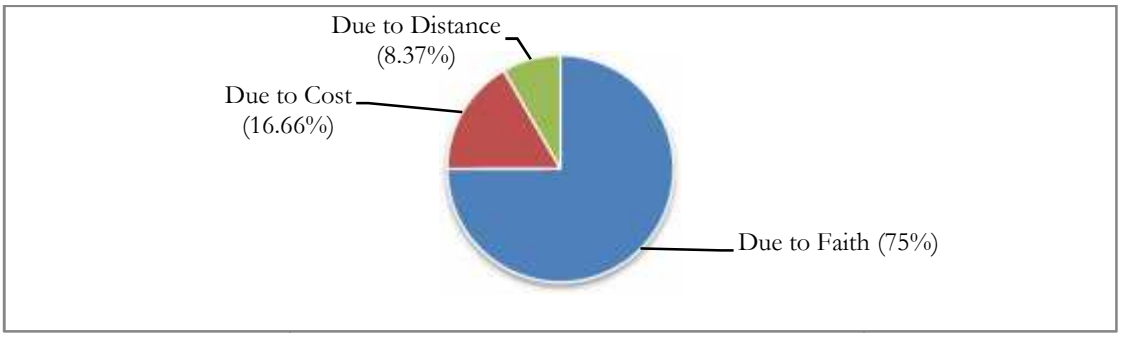
Sex	Age Group	Health Facility	Traditional Healer	Self Medication	n
Male	60-69 yrs	100.00	-	-	3
	70-74 yrs	50.00	-	50.00	2
	75 yrs +	-	-	50.00	1
	Total	66.66	-	33.34	6
Female	60-69 yrs	100.00	-	-	2
	70-74 yrs	50.00	50.00	-	2
	75 yrs +	50.00	-	50.00	2
	Total	66.66	16.67	16.67	6
Total		**66.66**	**8.33**	**25.00**	**12**

Table 4.14, seven out of ten (67%) visit health facility after facing dyspnoea. Likewise, 25 percent took self medication and 8 percent visited traditional healers for the treatment. Female were found more inclined towards traditional healer (17%) compared to male. Percent visit to health facility in the age group 60-69 years in both sexes 100 percent. Percent visit to health facility for treatment was declining with the increase in age.

4.2.4.3 Reason for Place of First Visit in Dyspnoea

Figure 4.7 shows the percent distribution of respondent by reason for the place of first visit in dyspnoea

Figure 4. 7 Percent distribution of respondent by reason for the place of first visit in dyspnoea



Most common reason for the choice of place for treatment in dyspnoeawas noticed due to faith (75%). Likewise, 17 percent and 8 percent choose the particular place due to cost and distance respectively.

4.2.5 Joint Pain

Most of the elderly people complain pain in one or more joints of limb with or without swelling which creates difficulty in performing their daily works. Table 4.15 provides the information about the prevalence of joint pain among elderly people.

Table 4.15 Percent distribution of joint pain by age and sex

Sex	Age group	Yes	No	N
Male	60-69 yrs	51.85	48.16	27
	70-74 yrs	50.00	50.00	16
	75 yrs +	28.57	71.43	7
	Total	48.00	52.00	50
Female	60-69 yrs	48.27	51.73	29
	70-74 yrs	46.66	53.36	15
	75 yrs +	33.33	66.67	6
	Total	46.00	54.00	50
Total		**47.00**	**53.00**	**100**

The table 4.15, about half of the elderly people (47%) reported that they were suffering from joint pain. The rural community survey made by ICMR 2004, overcome that the elderly people were suffering from locomotion problem by 36 percent.

The prevalence of joint pain was found relatively higher in male (48%) compared to female (46%). In the age group 60-69 years, male (52%) and female (48%) both perceive higher frequency of joint pain. The data prevails the incidence of joint pain was found low as increase in age. Also it reflects that joint pain was found to be very general in the study area of Tharu community.

4.2.5.1 Treatment Seeking Behavior for Joint Pain

Table 4.16 describes the detail about the help seeking practices for joint problem faced by elderly people in the study area.

Table 4.16Percent distribution of treatment seeking behavior for joint pain by age groups and sex

Sex	Age group	Yes	No	n
Male	60-69 yrs	100.00	-	14
	70-74 yrs	100.00	-	8
	75 yrs +	50.00	50.00	2
	Total	95.83	4.17	24
Female	60-69 yrs	92.85	7.15	14
	70-74 yrs	100.00	-	7
	75 yrs +	100.00	-	2
	Total	95.65	4.35	23
Total		**95.74**	**4.26**	**47**

Specifies that among the respondents having joint pain, majority of them (96%) seek treatment either in health facility or anywhere. The percent seeking help for treatment in male and female was identified equal (96%). In the age group 75 years and above, compared to male (50%) a higher proportion of female (100%) tend to seek treatment.

4.2.5.2 Place of first visit for the treatment of joint pain problem

Table 4.17 shows the place of first visit by respondents when they felt joint pain.

Table 4.17Percent distribution of place of first visit of joint pain by age groups and sex

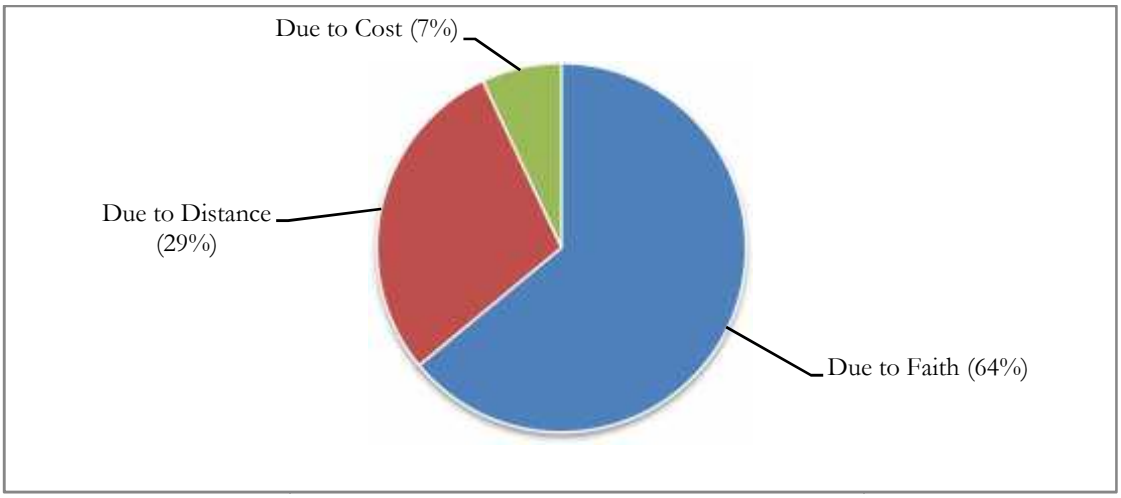
Sex	Age Group	Health Facility	Traditional Healer	Self Medication	n
Male	60-69 yrs	64.28	7.14	28.58	14
	70-74 yrs	62.50	-	37.50	8
	75 yrs +	-	-	100.00	1
	Total	60.86	4.34	34.80	23
Female	60-69 yrs	38.46	-	61.54	13
	70-74 yrs	85.71	-	14.29	7
	75 yrs +	-	-	100.00	2
	Total	50.00	-	50.00	22
Total		**55.56**	**2.22**	**42.22**	**45**

The table 4.17 show that most of the respondent, 55 percent made their visit to health facility for the treatment of joint pain. Similarly 42 percent took self-medication and nominal percent visited traditional healers. Compared to female (50%), male (61%) visit to health facility was noticed relatively high. Likewise, 64 percent male in the age group 60-69 years and 86 percent female in the age group 70-74 years visited health facility for treatment. As the age increase the percentage of taking self medication was found cent percent in both sexes in the age group 75 years and above because they were unable to walk for a distance.

4.2.5.3 Reason for Place of First Visit in Joint Pain Problem

Figure 4.8 shows that most common reason for the choice of particular place for treatment in joint pain was due to faith (64%), 29 percent due to distance and 7 percent due to cost respectively.

Figure 4. 8Percent distribution of respondent by reason for the place of first visit in joint pain



4.2.6 Back-ache

Pain or stiffness of backbone which produces difficulty to perform daily activities was considered as back-ache. It was the common reported problem by elderly people. Table 4.18 describes on this regard.

Table 4.18: Percent distribution of back-ache by age and sex

Sex	Age group	Yes	No	N
Male	60-69 yrs	29.62	70.38	27
	70-74 yrs	25.00	75.00	16
	75 yrs +	42.85	57.15	7
	Total	30.00	70.00	50
Female	60-69 yrs	31.03	68.97	29
	70-74 yrs	20.00	80.00	15
	75 yrs +	16.66	83.34	6
	Total	26.00	74.00	50
Total		**28.00**	**72.00**	**100**

The above data prevails that among the total respondents one-third (28%) were suffering from back-ache.

The prevalence of backache problem was identified to some extent higher in male (30%) than in female (26%). Compared to age groups, the frequency of backache was observed higher in male (43%) in the age group 75 years and above and in female (31%) in the age group 60-69 years. In male the problem of backache was found increasing simultaneously with the increment in age but it was just reverse in case of female.

4.2.6.1 Treatment Seeking Behavior for Backache Problem

Among the total respondents who perceive back-ache, all of them seek for treatment either in health facility or anywhere.

4.2.6.2 Place of First Visit for the Treatment of Backache Problem

Table 4.19 provides the information about the place of first visit for the treatment of back-ache. About six out of ten (57%) respondent visited health facility for treatment, followed by 11 percent visited towards traditional healers and 32 percent took self medication. Compared to male (47%), a higher proportion of female (69%) tend to seek treatment in health facility. Percent visiting health facility was identified 75 percent in male and 78 percent in female in the age group 70-74 years and 60-69 years respectively. Male (20%) were more likely to visit traditional healer than female.

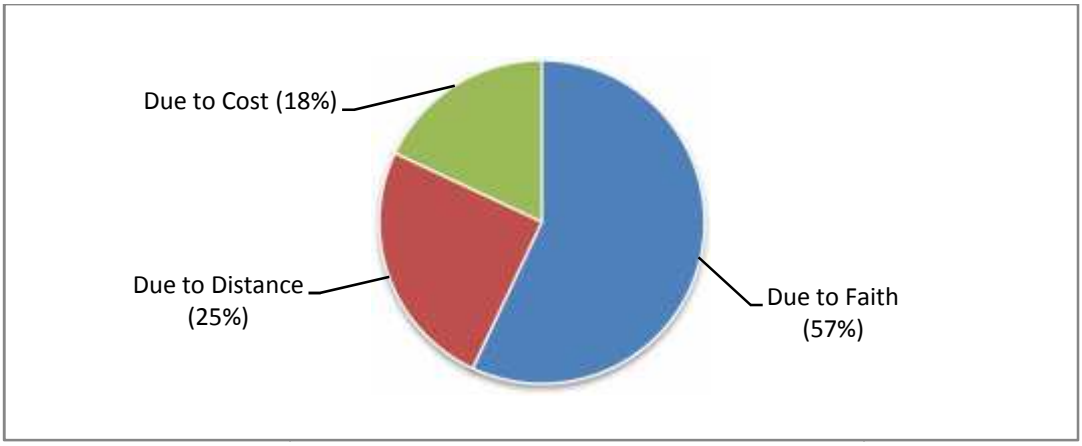
Table 4.19Percent distribution of place of first visit of back-ache by age groups and sex

Sex	Age Group	Health Facility	Traditional Healer	Self Medication	n
Male	60-69 yrs	37.50	25.00	37.5	8
	70-74 yrs	75.00	-	25.00	4
	75 yrs +	33.33	33.33	33.33	3
	Total	46.66	20.00	33.37	15
Female	60-69 yrs	77.77	-	22.23	9
	70-74 yrs	66.66	-	33.33	3
	75 yrs +	-	-	100.00	1
	Total	69.23	-	30.77	13
Total		**57.14**	**10.72**	**32.14**	**28**

4.2.6.3 Reason for Place of First Visit in Backache Problem

Figure4.9 shows the percent distribution of respondent by reason for the place of first visit in back-ache.

Figure 4.9: Percent distribution of respondent by reason for the place of first visit in back-ache



Among the total respondents who had backache problem and visited for treatment, majority of them (57%) has chosen the particular place for treatment due to faith. Likewise, 25 percent of respondent made their visit considering the distance and 18 percent taking into consideration of cost.

4.3 Awareness, Utilization and Perception about Available Health Facilities

This section describes the detail about respondent's knowledge of utilization of health services, preferred places for treatment, availability of health service facilities, perception, walking distance of health facilities, frequency of visit and feeling about the received treatment at the health facilities. In this table qualitative information regarding the factor affecting health seeking practices among elderly people of Tharu community were also described.

4.3.1 Place of First Preference for Treatment in General

Among all the respondent, a question was asked that where would they prefer to go when they get ill for the first time. Table 4.20 describes about it.

Table 4.20Percent distribution of respondent by place of first preference for treatment

Description	Male(n=50)	Female(n=50)	Total(N=100)
Local Health facility	62.00	70.00	66.00
Other than health facility	38.00	30.00	34.00

The table 4.19 shows that majority of respondent, about seven out of ten (66%) sought to visit health facilities. Remaining 34 percent respondent were likely to visit other than health facilities like traditional healer i.e. dhami, jhankri or spiritual practitioner such as shamanism, priests and astrologers palmist and consult discuss with neighbour/relative. Compared to male (62%), a higher proportion of female (70%) prefer to visit health facility when they become ill.

4.3.2 Knowledge about Available Local Health Facility

Table 4.21 shows that 86 percent were aware about health facility locally available nearby their community but 14 percent were not aware about it. 86 percent male and female were equally alert about this knowledge.

Table 4.21Percent distribution of respondent by knowledge about available local health facility (HP)

Description	Male (n=50)	Female (n=50)	Total(N=100)
Yes	86.00	86.00	86.00
No	14.00	14.00	14.00

4.3.3 Walking Distance to Health Facility

Table 4.22 describes the walking distance to local health facility.

Table 4.22Percent distribution of respondent by walking distance to local health facility (HP)

Description	Male (n=50)	Female (n=50)	Total (N=100)
Within half an hour	76.00	72.00	74.00
More than half hours	24.00	28.00	26.00

Seven out of ten (74%), elderly people residence was within half an hour distance from the local health facility (HP). It shows that the access to health facility in the study area was significantly good.

4.3.4 Visit to Local Health Facility (HP) during Last One Year

Table 4.23 provides the information about visit to local health facility during last one year.

Table 4.23Percent distribution of respondent by visit to local health facility (HP) during last one year and frequency of visit

Visit to Local Health Facility	**Male (n=50)**	**Female (n=50)**	**Total (N=100)**
Yes	50.00	64.00	57.00
No	50.00	36.00	43.00
Frequency of Visit	**Male (n=25)**	**Female (n=32)**	**Total (N=57)**
Two or less than two	60.00	50.00	54.38
3-5 visit	24.00	31.25	28.07
More than five visit	16.00	18.75	17.55

Six out of ten (57%) visited local health facility during last one year for check up and treatment of any kind of health problems. Compared to male (50%), a higher proportion of female (64%) were visiting health facility.

Among respondent who visited local health facility, 54 percent visited health facility two or less than two times followed by 28 percent visit 3-5 times and 17 percent visit more than five times in the health facility for health check up and treatment during last year time period.

4.3.5 Perception about Received Treatment at Local Health Facility (HP)

Table 4.24 shows that among the total respondents who visited health facilities were asked how they feel about the treatment of health facility when they go for the treatment.

Table 4.24Percent distribution of respondent by perception about received treatment at local health facility

Description	Male(n=25)	Female(n=32)	Total(N=57)
Good/ satisfactory	96.00	96.87	96.49
Not satisfactory/ bad	4.00	3.13	3.51

Nine out of ten (96%) have positive feeling about treatment (i.e. they felt good or satisfactory) whereas 4 percent have negative feelings (i.e. not satisfactory or bad) about the treatment they receive from the local health facility.

4.3.6 Reasons of Positive or Negative Feelings about Received Treatment during Last One Year

Table 4.25 describes reasons of positive or negative feeling of the respondents after receiving treatment from the local health facility. Among total respondents who perceive positive feeling about the treatment in the local health facility, 45 percent were found satisfied due to availability of free medicines. Likewise, 28 percent and 26 percent respondents were satisfied due to good behavior of health worker and availability of regular medicine at the local health facility respectively.

Table 4. 25Percent distribution of respondent by reason (negative and positive feeling) about received treatment of health facility

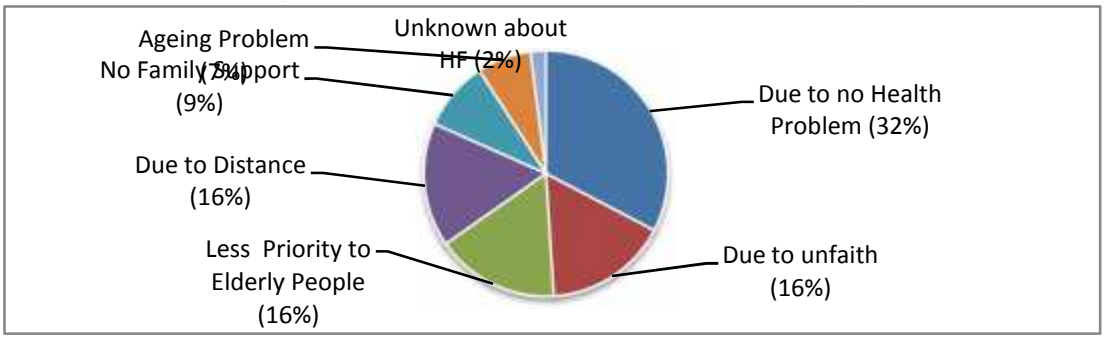
Reasons of Positive Feeling	Percent	Frequency(n=55)
Available free medicine	45.26	26
Good behavior of health worker	28.42	20
Available regular medicine	26.32	9
Total	**100.00**	**55**
Reasons of Negative Feeling	**Percent**	**Frequency (n=2)**
Not available of Medicine	50.00	1
Not convenient time	50.00	1
Total	**100.00**	**2**

Among total respondents who perceive negative feeling about the treatment in the local health facility, 50 percent were not satisfied due to unavailability of medicine as they desire. Likewise, 50 percent of them have negative felling towards health facility due to inconvenient time for them.

4. 3.7 Reason for Not Visiting Health Facility during Last One Year

Figure 4.10 below describes the reasons for not visiting health facility during last one year.

Figure 4.10 Percent distribution of respondent by reason for not visiting local health facility during last one year



About three out of ten (32%) were not visiting health facility because they do not have any health problem. 16 percent do not visit due to unfaith on getting treatment from health facility. Similarly 16 percent of them were not visiting because of ageing and they do not give importance to their health problem and also due to distance too.

Likewise, 9 percent not visiting health facility because they were lacking from family support. Family support is a crucial factor making elderly people to seek help for treatment. It mentally motivates and creates psychological will power. 7 percent not visiting because of ageing and they do not give importance to their health problems. Nominal percent (2%) of elderly people were not visiting health facility due to unknown about health facility locally available nearby their community.

4.3.8 Place of first visit of elderly people suffering from physical health problem by lower economic status

The health status of lower economic class people is very weak in developing countries like Nepal. To enhance their health conditions, Nepal Government had built-in many health policies. In all VDCs of Nepal there is at least one PHC/HP/SHP to provide preventive, curative and promotive service.

Table 4.26Percent distribution by lower economic status and place of first visit of elderly people suffering from common physical health problem

Common Physical Health Problems	Lower Economic Status			
	Place of First Visit			
	Health Facility	Traditional Healer	Self-Medication	Total (n)
Hearing Problem	100.00	-	-	2
Visual Problem	100.00	-	-	4
Coughing Problem	100.00	-	-	3
Dyspnoea	100.00	-	-	2
Joint Pain	57.00	-	43.00	7
Back-Ache	100.00	-	-	4

The table 4.26 reveals that most of the elderly people who belongs from lower economic status are inclined to visit health facility which is situated nearby there community when they feel problem. This is likely to happen due to free health services provided by the government and they have faith on taking medication from HF too.The study also shows that high and medium class family people are tending to visit traditional healer and taking self medication rather than visiting health facility.

4.4 SUMMARY /DISCUSSION OF FINDINGS

4.4.1 Summary

With the increase in the elderly population, the problem of elderly people is also certain to increase. Nepal's population is ageing as fertility and mortality level decline. During the last three decades, the total fertility rate has declined by one third from, around 6 children per woman in the 1970s to around 4 at the turn of the century. The older population grew faster (2.73%) than the national population growth rate (2.24%). In Nepal, information on population ageing is inadequate to provide a basis for the formulation of a sound policy to meet the needs of the emerging older population. The present study is a partial attempt to fill this gap by providing knowledge about elderly health and social problems.

The general objective of this study was to identify the prevalence of six common perceived physical health problems like hearing problem, visual problem, coughing problem, dyspnoea, joint pain and backache problem and factors affecting health-seeking practice among elderly people. The cross-sectional, descriptive study was done in Lakhantari VDC of Morang district. Out of 570 households of Tharu community, 100 elderly people of both sexes of age 60 years and above were equally selected from different clusters using random sampling techniques. Data were collected by pre-tested semi-structured interview questionnaire. Fieldwork was carried out during 2015.

Out of the 100 respondents 50 percent were male and 50 percent were female. Entire respondents belonged to Janjati. In the study currently married participants constituted 74 percent male and 56 percent female. The main source of household income was agriculture (70%). 67percent of the elderly people belongs from medium class family and remaining of them equally belongs from higher and lower class family. 64percent of the elderly people were illiterate.

The gender gap in literacy was noticed higher (86%). 50 percent elderly people were engaged in income generating activities whereas 30 percent were engaged in non-economic activity. Twenty percent elderly people were totally dependent. 70 percent elderly people were living with son and daughter in law.

The prevalence of most common physical health problems among elderly people of Tharu community were found as following: Hearing problem 16 percent, visual problem 42 percent, cough problem 18 percent, dyspnoea 12 percent, joint pain 47 percent and back- ache 28 percent. Among which maximum cases were related with joint pain and visual problem. Compared to female, prevalence of health problem was noticed comparatively high in male as well as in the age group 75 and above in both the sexes. In average more than 98 percent of the elderly people who had health problems seek any help for treatment either in health facility, person or anywhere else.

Health care seeking practices for explored common physical health problems were different. Six out of ten seek treatment within the health facilities but in the case of visual problem 87 percent seek treatment from health facility. Compared to male (59%) in average treatment seeking practices in health facility is identified higher in female (63%).Compared to other health problems self- medication practice was identified relatively higher in coughing (44%), in joint pain (42%) and in back-ache (32%). Similarly health seeking practices with traditional healer were found less for explored common physical health. Male percent was noticed relatively higher than female to take treatment from traditional healers. Similarly elderly people aged 70-74 years were more inclined towards traditional healers.

66 percent elderly people preferred to visit local health facility at first when they become ill, but in practice 57 percent visited health facilities for treatment or health check up during last one year. Sex wise preference or willingness to visit health facilities were found higher in female (70%) than in male (62%). Eighty-six percent respondents, who were made aware of available health facilities nearby their community among them 74 percent residence were within the half an hour distance from the local health facility.

Knowledge about available health facility near by their community was found equal in both the sex (86%). Ninety-six percent elderly people perceived positive feeling (good and satisfactory) about the treatment they received from the local health facility.

Preference to visit health facilities for treatment was found associated with educational status, ethnicity and economic status of the respondents. Health facility visit during last one year (practice) was found associated with sex, ownership of fix assets and knowledge about available health service.

On the basis of above mentioned facts, we can conclude that there exist high prevalence of common health problems perceived by respondents, high health seeking practice but utilization of available health services by elderly people was relatively low. Further in-depth study is needed to solve these all problems of the elderly people. The family, community and state should pay special attention to promote health and wellbeing and improve the social status of elderly people of Tharu community of Lakhantari VDC.

4.4.2 Discussion of Findings

The study on elderly people carried out in Lakhantari VDC, Morang of Tharu community emerged the following findings.

1. All the elderly people were ever married.
2. The magnitude of widow was higher (42%).
3. Illiteracy rate of elderly people was 64 percent whereas national literacy rate (2058 BS) was 54 percent.
4. Gender gap in literacy was identified higher.
5. Majority of the household main source of income was agriculture (70%). Likewise, 67 percent belonged to medium class family.
6. Twenty percent of the elderly people were totally dependent.
7. Joint family structure had been destructed due to modernization.
8. Sixteen percent elderly people were suffering from hearing problem and the frequency of hearing problem is increasing simultaneously as increasing in age in both sexes.

9. Forty two percent perceived visual problem and the prevalence of visual problem was identified higher in female.

10. Eighteen percent were tormented from coughing problem but the incidence was seen higher in male.

11. Occurrence of dyspnoea was 12 percent and the percent victim of difficulty breathing was increasing with the increase in age.

12. The dilemma of joint pain was found extremely common in the study area (47%).

13. Twenty eight percent elderly were suffering from back-ache and percent of back-ache was noticed higher in male.

14. In general the incidences of common six physical health problems were noticed higher as increment in age.

15. Treatment seeking behavior of elderly people was perceived more than 95 percent to any place or person for treatment.

16. Most of the elderly people were inclined to go health facilities when they cause problems.

17. Sixty-six percent of elderly people soughed to visit health facilities when they feel ill and 86 percent were aware about health facility locally available nearby their community.

18. Seventy four percent elderly people residence was within half an hour distance from the local health facility.

19. Ninety six percent elderly people had good/satisfactory perception about received treatment provided by local health facility.

20. Most of the elderly people from lower economic class are inclined to take treatment from health facility which is located nearby their community.

CHAPTER-V

CONCLUSION AND RECOMMENDATION

5.1 Conclusion

Some important findings emerge from the analysis of data obtained from study. The following conclusions were drowning on the basis of those findings. The elderly people were most disadvantaged than the general population in terms of educational attainment, economic, social activities and disabilities due to health problems. Among the elderly people, the quality of life of women compares unfavorably than men on various dimensions. They were likely less educated, economically dependent and physically demerit as compared with men. They were also more likely widowed and the loss of their husband is likely to cause them great emotional stress. Female were more vulnerable for health problem thus the special attention should be given for female elders.

Most of the respondents preferred to visit health facilities at first when they became ill but in practice; six out of ten only visited health facilities for treatment during last one year. Still there were small gap between willingness and practice. The common causes between these gaps were faith, previous experienced about treatment of health facilities and knowledge about available health care facility etc.

Finally there was high prevalence of common physical health problems and low utilization of available health services as whole. The elderly as well as their family members regarded the problem posed by elderly as inevitable accompaniment of age and need health care and support. This study only explored and sensitized the situation, there are ample of scope for research into degenerative and other health problems of old ages.

5.2 Recommendations

Findings of this research raise a number of important issues for family members, researchers, health and social development workers, policy planners in recognizing

and addressing the problems of elders. Based on findings discussed above, the following recommendations were suggested.

5.2.1 Policy level

- Senior citizen care center unit should be established in every VDC as policy level.
- Elderly are suffering from one or more health problems. So screening service should be initiated by the Government to enhance their health.
- Health workers should be trained on elderly health problems and essential medicine for the treatment of common health problems should be provided to all level of health institutions with free of cost.
- Senior citizens Policies and programmes should be designed for improving the social and economic wellbeing of elderly people especially focusing on health and socialization aspects.
- Depending on nature of problem, appropriate treatment or remedy service should be established separately for elder people.
- Senior citizen incentive should be increased.

5.2.2 Community level/Practice Related

- Elderly and their family should be sensitized about major health problems of elder people and utilization of available health care services should be raised through appropriate awareness programme.
- Gender discrimination in utilization of health service should be minimize or eliminate by intervene of awareness programme to the family and community level.
- Avoid Self-medication practices by promoting appropriate intervention and prescribed drugs should be practiced.

- Mobilization of NGOs/CBOs for awareness rising on the issues of elder people.
- Senior citizen prestige program should be organized to recognize elderly people.

5.2.3 Further Research Related

1. This survey helps to support for find out more details about elderly people and their physical health problems and behaviors.
2. It helps to support for the new comers about the problem related to elderly people.
3. It helps to study more details to researchers.

BIBLIOGRAPHY

Achrya, B. (2000). *Health Ethics and Choice of Healing, A Sociological and Anthropologica society of Nepal,* Bidhyarthi Prakashan, Nepala

CBS (2003). *Population Monograph Nepal Vol II,* National Planning Commission Secretarait, Kathmandu, Nepal.

CBS (2002). *Population Census 2001, Eastern Development Region,* National Planning Commission Secretarait, Kathmandu, Nepal.

Chaudhary, R.H. (2004). *Ageing in Nepal, Asia-Pacific Population Journal,* UNFPA

Dixit, H. (1999). *The Quest for Health, Educational Enterprise,* Kathmandu, Nepal.

Ghai, O.P. and Gupta, P. (1999). *Essential Preventive Medicine,* Vikash Publishing Hose Pvt. Ltd, India

Giri, K. (2004). *Ageing Process and Health needs of ageing Nepali women SraddhaSuman, Vol 4,*

HMG, Ministry of Women, Children and Social Welfare, Kathmandu, Nepal.

Gartoula, R.P. (1998). *An Introduction to Medical Sociology and Medical Anthropology,* RECID, Kathmandu, Nepal,

Government of Nepal (2002). *Senior Citizen Policy and working Policy-2058,* HMG, Ministry of Women, Children and Social Welfare, Kathmandu, Nepal

Kabir, M.D. (1998). *Demographic and socio economic aspect of Ageing,* Dhaka University, Bangladesh.

Ministry of Health Nepal (2007). *Nepal Population Report,* Ministry Of Health, Kathmandu, Nepal

Natrajan, V.S. (1999). *Social Problems among the elderly Health education in south East Asia, Volume, XIV, No-2,* Quarterly Official Publication of IOHPE-SEARB, India

Park, K and Park (2002).*Text Book of preventive and social medicine, 17th edition,* India M /S Banarasindas Banot.

Pandey, M.R. (1990).*Corpulmonale in Nepal, Journal of Nepal Medical Association, of Nepal* Medical Association, Kathmandu, Nepal

Thapa,B.(2004). *Perceptions and Feelings of health problems by elderly people among Tharu community, A case from Chitwan District,* MPH Thesis, IOM Kathmandu, Nepal.

United Nation (2002). *Population Ageing 2002,* Population Division, Department of Economic and Social affairs UN, 2002.

Upadhyaya N.P. (2004). *How Society perceives the old people SraddhaSuman, Vol 4,* HMG, Ministry of Women, Children and Social Welfare, Katmandu, Nepal.

APPENDIX I:

QUESTIONNAIRE

Common Physical Health Problems and Health Seeking Practices of Elderly People of Tharu Community of Lakhantari VDC of Morang District, Nepal

Households Number: Date of data collection:

Respondent I.D. No.: Ward No…

Q.N.	Question	Coding
	1. General Information	
1.1	Age of the respondent (in year):	
1.2	Sex: 1. Male 2. Female	
1.3	Family name/ Ethnicity:	
1.4	Marital status: 1. Married 2. Unmarried 3. Widow 4. Divorced/ Separated	
1.5	Living arrangement: 1. Living with spouse 2. Living with own son and daughter in low 3. Living with own daughter and son in low 4. Living with other relatives 5. Living alone	
1.6	Occupation of respondent: 1. Agriculture 2. Service 3. Business 4. Others (specify) ……	
1.7	Occupation of care taker: 1. Agriculture 2. Service 3. Business 4. Others (specify) ….	
1.8	Economic status: 1. Lower 2. Medium 3. Higher	
1.9	Education status: 1. Illiterate 2. Literate If literate passed class…….	
1.10	Are you doing any work now? ……	

1.11	Who is the decision maker of your family? ……..	
	2. Health problems and health seeking practice	
2.1	a) Do you have problem to hear speech during conversation? 1. Yes 2. No (If no go to the Q. No. 2.2) b) If yes for how long have you had this problem? 1. Less than one month 2. More than one month c) What did you do when you feel the problem? …… d) Did you visit somewhere or someone for your hearing problem? 1. Yes 2. No (if no go to the Q. No. 2.2) e) If yes where did you visit first? …….. f) Why did you go there? ……	
2.2	a) Do you have problem to see near or distance? 1. Yes 2. No (If no go to the Q. No. 2.3) b) If yes for how long have you had this problem? 1. Less than one month 2. More than one month c) What did you do when you feel the problem? …… d) Did you visit somewhere or someone for your eye problem? 1. Yes 2. N (If no go to the Q. No. 2.3) e) If yes where did you visit first? …….. f) Why did you go there? ……	
2.3	a) Do you have coughing problems? 1. Yes 2. No (If no go to the Q. No. 2.4) b) If yes for how long have you had this problem? 1. Less than one month 2. More than one month c) What did you do when you feel the problem? …… d) Did you visit somewhere or someone for your coughing problem? 1. Yes 2. No (If no go to the Q. No. 2.4)	

	e) If yes where did you visit first? …….. f) Why did you go there?……	
2.4	a) Do you have difficulty in breathing? 1. Yes 2. No (If no go to the Q. No. 2.5) b) If yes for how long have you had this problem? 1. Less than one month 2. More than one month c) What did you do when you feel the problem? …… d) Did you visit somewhere or someone for your breathing problem? 1. Yes 2. No (If no go to the Q. No. 2.5) e) If yes where did you visit first? …….. f) Why did you go there? ……	
2.5	a) Do you have joint pain? 1. Yes 2. No (If no go to the Q. No. 2.6) b) If yes for how long have you had this problem? 1. Less than one month 2. More than one month c) What did you do when you feel the problem? ……d) Did you visit somewhere or someone for your joint pain problem? 1. Yes 2. No (If no go to the Q. No. 2.6) e) If yes where did you visit first…… f) Why did you go there? ……..	
2.6	a) Do you have backache problems? 1. Yes 2. No (If no go to the Q. No. 3) b) If yes for how long have you had this problem? 1. Less than one month 2. More than one month c) What did you do when you feel the problem? …… d) Did you visit somewhere or someone for your backache problem? 1. Yes 2. No (If no go to the Q. No.3) e) If yes where did you visit first?	

	…….. f) Why did you go there? ……	
3. Knowledge, utilization and feeling about available health service		
3.1	a) At first where do you prefer to go treatment or for suggestion when you feel that you are ill? ……. Why do you prefer to go there? ……	
3.2	Do you know local health facility available in your locality? 1. Yes (specify) 2. No (if no go to the Q.No.3.4)	
3.3	How far is local health facility nearby your residence? 1. Within half an hour walk 2. More than half an hour walk	
3.4	a) During last one year, did you visit to local heath facility to seek health check-up for treatment? 1. Yes 2. No (If no go to the Q.No.3.4) b) If yes, how often have you visited? ……	
3.5	How did you feel the treatment you received in local health facility? 1. Excellent 2. Satisfactory 3. Not satisfactory 4. Bad Why? ……	
3.6	If did not visit local health facility during last one year for check-up, why? ……	