

HEALTH CONDITION OF THE ELDERLY WOMEN: A NEED TO ENHANCE THEIR WELL BEING

J Sheela & M Jayamala

Abstract

Ageing is a multidimensional process; old age is the closing period of the life of an individual. A person's activities, attitude towards life, a relationship to the family and the work, biological capacities and physical fitness are all conditioned by the position in the age structure of the particular society in which he lives. Today in India elderly women face the miserable conditions in their life, as they are family bonded and not ready to live in old age homes. In order to study the condition of elderly women the present study was conducted in Coimbatore district with the focus on socio-economic and health status of elderly women. Totally 333 samples were selected by using the simple random sampling method. It was inferred that the elderly women have psychological problems like depression, isolation, loneliness and irritation. Health problem is the most serious thing that has to be concerned by the society on the whole.

Ageing is a biological process and experienced by the mankind in all times. It refers to a sequence of changes across a life span of an individual. Though ageing is a multidimensional process, old age is the closing period of the life of an individual. It is a period when people move away from their more desirable period or times of 'usefulness'. Kumar (1992)¹ have stated that ageing is a toil some treadmill grinding to a tragic halt as the years pile up. It is a life spanning process of growth and development running from birth to death. It is generally associated with decline in the functional capacity of the organs of the body due to physiological transformation.

Though old age is the universal phenomenon with varying degrees of probability, it is overlooked as fundamental aspects of social structure and social dynamics. A person's activities, attitude towards life, a relationship to the family and the work, biological capacities and physical fitness are all conditioned by the position in the age structure of the particular society in which he lives. The term 'old age' conjures up images of frustration and pity, sickness and poverty, despair and senility, warmth and responsibility. The relationship between ageing and the society's response are complex in the industrial society. Aging is more difficult in the rapidly changing materialistic society. The modernization plays a vital role in the aging process of an individual. The aged feel a sense of social isolation because of

DrJ Sheela & Dr M Jayamala are Lecturers, Centre for Women's Studies, PSGR, Krishnammal College for Women, Peelamedu, Coimbatore – 641 004, sheelawilson_11@yahoo.co.in, drjmala@yahoo.co.in

the disjunction from various bonds viz., work relationships, and diminish of relatives and friends, mobility of children to far off places for jobs. The situation of the elderly still worsens when there is physical incapacity and financial stringency.

The general characteristics of old age are physical and psychological changes. It is common to associate old age with disability. Older people are heterogeneous i.e., extreme losses of physical, mental and social functions are often seen in old people. Yet many people continue to maintain high level of function. However, as “young-old” move in to the “old-old” category, they tend to have more health complaints and diagnosed illness. The presence and duration of the chronic diseases account for a portion of variation in the functional disability of the aged (Camacho et al., 1993)². The elderly people face number of problems and adjust to them in varying degrees in their old age. These problems range from absence of ensured and their dependents, to ill-health, absence of social security, loss of social role and recognition, and the non-availability of opportunities for creative use of free time.

Today aging is a concern world over. Inadequate support from the care givers leads to lack of moral, emotional and physical support for elderly. The living condition of elderly differs in both developed and developing countries. When comparing the world scenario of elderly population, China is not alone with respect to extremely rapid populating aging among developing countries. The proportion of elderly in Korea will climb to a higher level with a large annual increase rate than in China. Mexico and India, two developing countries with large population sizes also will undergo very rapid population aging at annual increase rates of 2.6 and 2.1 per cent, although the proportion of elderly in 2050 will be substantially lower than in China. The annual increases in the proportion of the elderly between 1990 and 2050 in China, India, Korea and Mexico are all much higher than in European and north American countries. This fact deserves serous attention not only in those developing countries, but also from international organizations and developed countries (Kevin et al., (1992)³, Linda et al., (1994)⁴).

International Comparison of Indicators of Population Aging

Countries	Percent of elderly aged 65+		
	1990	2030	2050
China	5.6	15.7	22.6
India	4.3	9.7	15.1
Korea	5.0	18.1	24.7
Mexico	4.0	19.9	18.6
Canada	11.2	22.6	23.8
France	14.0	23.2	25.5
Germany	15.0	26.1	28.4
Italy	15.3	29.1	34.9
Japan	12.0	27.3	31.8
UK	15.7	23.1	24.9
USA	12.4	20.6	21.4

Source: UN Population Division (1999)⁵

In India according to the 2001 census estimates the elderly constitute about 7.45 per cent of the total population. India is one of the few countries where the elderly sex ratio favours males. Dependency ratio for the old has been rising from 10.5 in 1961 to 11.8 in 1991 and is projected to be 16.1 by 2021 (Rajan et al., 1999)⁶.

For a developing country like India, rapid growth in the number of older population creates issues that hardly perceived yet, this must be addressed for social and economic development. Gore (1993)⁷ opined that in developed countries, population ageing has resulted in a substantial shift in emphasis a significant change in the share of social programmes going to older age groups. But in developing society these transfers will take place informally and will be accompanied by high social and psychological costs by way of intra-familial misunderstanding and strife. In the Indian scenario, as such found in many developing countries health problems and medical care are the major concern among a large majority of the elderly. The health problem in West Bengal was studied by Chakraborty (2005)⁸ in which he found that among the elderly (> 60 years) residing in a rural area neighbouring to a cosmopolitan city showed that 72.6% of the elderly were suffering from chronic illnesses. The step-wise multiple logistic regression model showed that income,

socio-economic status, absence of any affect on daily physical activity and accompanying persons were found to be inversely related to irregular treatment. Significant gap was seen between need and treatment provision particularly for visual and hearing problems. Rural government facilities and unqualified practitioners were the two most frequent providers as first contact. Qualified private practitioners were seen to play a major role in peri-urban rural areas. Homeopaths and medicine shops were not first choice of rural elderly but their substantial presence as current provider (30%) indicates inadequacy of rural government facility as regards health needs of aged.

Elders suffer from desires, psychological problems of usefulness and abundant. Women react in different ways in this diminishing role. Those who have not occupied positions previously with little authority or influence perhaps feel it the least those who have occupied positions of authority have considerable difficulty in coping. It should be noted that problems of the old age are highly individualistic in nature. In order to provide better living condition of the elderly women the government of India decided in the year 1983-84 for the first time to give grants to voluntary organization for services to the aged, for health care, income generation subsistence, training and old age homes.

Thus the growing concern with the problem of ageing and constant development of services have brought about demands for professionalisation of care of older people through man power development and training. Yet old women face the miserable conditions in their life, as they are family bonded and not ready to live in old age homes; they suffer aloof until their life ends. This is the condition that prevails in the present scenario in most of the rural as well as in urban areas in our country. In order to study the condition of elderly women the present research study was carried out with the focus on socio-economic and health status of elderly women in city areas of Coimbatore District. The main objectives of the study are: to know the socio-economic condition of the elderly women in urban areas, to understand the psychological and health problems faced by the elderly women and to bring out the physical and moral support rendered by the family members to the elderly women.

Materials and Methods

Coimbatore the selected study area is the 2nd largest growing city in Tamil Nadu. As it is exposed to the Palghat gap of Western Ghats it enjoys a salubrious climate. There are more than 25,000 small, medium, large and tiny industries and textile mills in Coimbatore. No wonder it is rightly called the Manchester of South India. The present population of the

city is approximately 13 lakhs including a floating population of around 1.5 lakhs. Coimbatore is a place where age old customs survive, where family bonds are strong and where fusion of tradition and modernity remains.

Coimbatore was selected mainly due to the increase in the number of old age homes. The research was carried out in the entire four zone of Coimbatore city. In the study area totally 333 samples were selected by using the simple random sampling method. The tool used for the study was a detailed interview schedule. The schedule consists of questions about the elderly women's economic condition, family background, health problems, societal responsibilities, their hobbies, daily activities, and caregivers of elderly. All the information was collected from the elderly women in the age group of 60 years and above. Data collection was carried out for a period of three months i.e. from the month of February to April 2006. Frequency distribution and cross tabulations are the statistical tools used for the analysis of the data.

Results and Discussion

Age is an important criterion, which shows the physical and mental ability of a person. The sample includes 333 women, who are in the age group of 60 to 85 years old. Panel 1 of Table 1 highlights that among the elderly women, 52 per cent of them are in the age group of below 65 years, followed by 22.8 and 14.4 per cent of them are in the age group of 66-70 and 71-75 years. The remaining 10.8 per cent of the elderly women fall in the age category of 76 years and above. The mean age of the elderly women is 67 years. India, the land of spirituality and philosophy considers religion as an integral part of its entire tradition. Worship of various religions and its ritual plays a significant role in every aspect of human life it also has a great impact on the personal lives for every individual. The population in Indian society is diversified in religious practices it is obvious from the study too (panel 2 of Table 1) that as high as 95.5 per cent of the elderly women belong to Hindu religion whereas meager percentage of 2.4 and 2.1 of them belong to Christian and Muslim religion respectively.

Caste is the most distinguishing cultural stratification in Indian society. It influences the socio-cultural relationships of each and every individual. In the study caste classification is of three types namely backward caste, most backward caste and scheduled castes/tribes. The analysis on percentage distribution of the elderly women by caste indicates that (panel 3 of Table 1) more than half of them (58.6 %) belong to backward community and nearly one-

fourth (24.9%) of them belong to SC/ST and only 16.5 per cent of the elderly women belong to most backward caste.

Among the cultural variables, type of family and marital status are the two important factors that plays the pivotal role in identifying the living arrangement/condition of the elderly persons. The results based on the type of family (panel 4 of Table 1) shows that 52.9 per cent of them live in nuclear family and the remaining 47.1 per cent of them live in joint family. The analysis on the marital status of the elderly women (panel 5 of Table 1) indicate that three-fourths of the respondents (76.0%) are married, while 21.3 per cent of the respondents are widowed and only very few i.e., 2.7 per cent of them are separated from their husband. Education is a crucial ingredient for a person's professional development. Data related to educational status of the elderly women given in panel 6 of Table 1 highlighted that as high as 83.8 per cent of the elderly women are illiterates and the remaining percentages of them are literates.

Financial problems add to the misery of the aged. Having spent all their hard earned money on children's education and marriage, they are generally demoralized when their off spring refuse to give them shelter. No doubt, economic security is vital for the elderly. However very often this gets undue attention at the expense of psychological, social, occupational and cultural needs. Income is generated to fulfill the economic needs of the family. Occupation occupies or engages the time and attention of the elderly person and it also act as a bridge for the family and elders. The occupation of the elderly women (panel 7 of Table 1) infers that majority of women (83.8%) are homemakers and 16.2 per cent of them are working as coolie, servant maids, clerks and those involved in petty business. Based on the occupation 9.6 per cent of the elderly women received Rs. 1000 and below as their monthly income, whereas 5.4 percent and 1.2 per cent of them each receive Rs. 1001-2000 and Rs. 2001 and above as their monthly income.

Illness of the Elderly Women

For an individual, measures of disability and independence are directly influenced by the number and severity of chronic diseases present and are central components of quality of life. At the population level, disability measures are key indicators of overall health status and whether women can generally expect to spend more years of their lives with some functional limitations. Healthy life expectancy as normally used refers to life expectancy without limitation of functions that may be the consequences of one or more chronic conditions.

There are powerful economic, social, political and cultural determinants which influence how women age with far reaching consequences for health and quality of life, as well as costs to the health care systems. Poor economic status earlier in life and is a determinant of health at all stages of life. The older women often reflect the cumulative impact of poor diets. Another determinant of health is education. Increased literacy for older women will bring health benefits for them and their families. Lack of good food and safe drinking water, a gender based division of domestic chores; environment hazards etc also have a cumulative negative impact on the health of women as they age. Table 2 explains the illness of elderly women suffering for the past six months due to various chronic diseases like cough, diabetics, joint pain, ulcer, heart problem, blood pressure, paralysis, viral fever asthma etc. It is inferred that nearly half (46.8%) of the women are suffering from joint pain for the past six months, 33.0 per cent of them are suffering from blood pressure, and 17.1 per cent of them have diabetics. Remaining 6.6 per cent, 4.8 per cent, 4.5 per cent, 2.7 per cent, 2.4 per cent, 1.2 per cent and 0.6 per cent of them suffer from diseases like heart problem, back pain, cough, nerve disorder, skin problem, ulcer, brain tumour, kidney trouble respectively.

Care of the Elderly Women

Physical incapacity is common for the elderly people. Medical treatment is vital for their effective function. Results from panel 1 and 2 of Table 3 infer that 200 elderly women visit government hospital for their treatment, another 126 elderly women visit private hospitals and the remaining 7 elderly women visit naturopathy and homeopathy hospitals. Different types of treatment taken by the elderly women are allopathic (97.9%), homeopathic (0.9%) and ayurvedic (1.2%).

Indian social system exhorts the individual to look after the old, the infirm and the elderly. The aged parents live in their own roof with their grown up children who take care of their well being especially during illness. Panel 3 of Table 3 explains the care giver to the elderly women. It is obvious that nearly half of the respondents i.e., 42.3 per cent of them are taken care by their sons during their ill health. Another 27.6 per cent of the elderly women are taken care by their daughters. For 10.5 per cent of the elderly women both sons and daughters are the care givers during the illness of their mother, whereas 11.4 per cent of the elderly women happened to be alone with out the care of anybody even during their ill health. The lack of physical or emotional support even during the ill health of the elderly women by their offspring is due to the migration of them to various places with regard to their education, occupation, marriage etc. Only 8.5 per cent of the elderly women are taken care by

their close relatives. Thus the elderly women seek the support of their son, daughter and relatives during their ill health and some remains alone due to radical changes, not only in occupational pattern, but also in population dynamics. Migration breaks the bond of traditional family structures and functions.

Women are economically, physically weaker as they age. They are support seekers for their living in most of the condition especially when they are ill. Though some women may have savings as their economic security, their son, husband, daughters and relatives who are bonded with them meet their medical expenses. The panel 4 of Table 3 gives the clear picture about the person who meet medical expenses for the elderly women. It is inferred that 42.6 per cent of the women's medical expenses are met by their son, another 27.9 per cent of the aged women's medical expenses are met by their daughter and for 7.8 per cent of the elderly women, their husbands met the medical expenses, but 19.8 per cent of the elderly women met their medical expenses through their savings and there is no one to share the medical expenses for 1.8 per cent of the aged women.

In addition to physical changes, elderly individuals also experience psychological and social changes. Some individual cope with these changes effectively but others experience extreme frustration and mental distress. It is important for the family members to be aware of the psychosocial changes and stresses experienced by the elderly.

Physical disability in the aged often gives rise to profound anxiety and a sense of apathy and helplessness. This situation is indeed very difficult, since the aged in such conditions invariably tend to be withdrawn, negative and inflexible. In such cases, the role of the family is crucial and calls for greater sensitivity and tolerance. It is also observed that women resist more than the men, in receiving and accepting any kind of correctional help or support. This tends to alienate and push the elderly, especially women into a cycle of depression and social isolation. Panel 5 of Table 3 explains the problems like depression, loneliness, irritation and isolation faced by the elderly women due to their inability and lack of proper support. It is observed that 42.9 per cent of the women have no problem whereas another 23.7 per cent of the women suffer from both depression and isolation; another 20.4 per cent of the women have depression alone and the remaining 10.8 and 2.1 per cent each of the women have loneliness and irritation due to their physical and psychological inability.

Nature of Treatment by Background Characteristics

Use of non-allopathic treatment practices has been a long tradition in India. Even after the emergence of the fast growing allopathic treatment in recent years, many people resort to alternative treatment such as ayurvedic, homeopathic, naturopathy, indigenous herbs etc. Particularly the elderly people adopt the non-allopathic therapy because this may represent a trend towards mysticism in the modern world. These so called alternative therapies act as placebo or the ingredients may specially treat the diseases. An attempt is made here to examine the type of treatment undergone by the women by their age. The results showed that (panel 1 of Table 4.) 98.3 per cent of the elderly women who are in the age group of below 65 years take allopathic treatment. Similarly the other age group women too take allopathic treatment in large number. In all age group only few of them take homeopathic (5.5%) and ayurvedic (4.6%) treatment. Conspicuously the difference in the age and the nature of treatment taken by the elderly women turned out to be statistically insignificant ($\chi^2 = 3.822$; $p < .701$). Type of hospitals adopted for the treatments by the elderly women are shown in panel 2 of Table 4. It is exhibited that the elderly women who take allopathic treatment visit both government and private hospitals. In case of homeopathic and ayurvedic treatment elderly women visit private hospitals and other type of informal places. The Chi square result do support the fact at highest level ($\chi^2 = 193.47$; $p < .000$).

Type of Hospitals by Background Characteristics

The hospitals are committed to ensure that, it provides quality health care and social welfare services to all leading to a healthy production and prosperous nation. It is important that elderly persons get medical checkups regularly to prevent the onset of any of the health conditions. The aging population will likely have a major impact on hospital utilization. This research allowed comparisons on usage of type of hospitals among different age groups and educational categories of elderly women. Details about the age group of the elderly women (panel 1 of Table 5) by the type of hospitals visited when they are sick exhibited that out of 333 elderly women 173 of them in the age group of below 65 years visit government hospitals (65.9%), private hospitals (32.4%) and other (1.7%). In the age group 66-70 years there are totally 76 elderly women. Among them 60 per cent of them visit government hospital and 36.8 per cent visit private hospitals. Similar pattern is observed in the age group of 71-75 years. Contradictory to this elderly women who are in the age group of 76 years and above visit private hospitals (58.3%). This is mainly because the old-old category elderly women have the high risk of survival. The family members have a notion that private hospitals are well equipped than the government hospitals. So the preference of private

hospitals during the sickness of old-old women shows at large number. The differences in age vs type of hospital they visit is statistically significant at lower level ($\chi^2 = 11.290$; $p < .080$). Difference in visiting the type of hospital based on their educational category is described in panel 2 of Table 5. It is obvious that 279 elderly women are illiterates and majority of them (62.0%) visit government hospitals. In case of elderly women who attained primary school of education, half of them visit private hospitals, 13 elderly women have completed middle school education and among them the primary preference is government hospital when they are sick. The similar pattern is observed for those elderly women who have completed high school and above too. As a result the differences in educational category and the hospitals they visit is insignificant.

Health Problem by Age

It is evident that (Table 6) in the age group of below 65 years, out of 173 elderly women 42.2 per cent of them have no health problem. Depression and the combination of depression and isolation are the health problems faced by 21.4 per cent and 20.8 per cent of the elderly women. Similar results were observed in the other age groups of the elderly women too, though all the age groups have one or the other health problems due to various circumstances and physical conditions, this becomes more severe and vulnerable for the age groups of 55 and above. It is widespread that elderly women suffer from depression due to their physical and mental inability. Such suffering causes helpless condition for them to survive. Moreover they suffer from isolation as their younger ones leave them alone for their work without giving proper care to their elderly parents.

Conclusion

Elderly women are the growing population in our country. It is estimated that by the year 2050 elderly population will out reach the youth population and India will be in the first position all over the world. Due to the change in the social outlook the elderly population are unconsidered in most of the circumstances both in rural and urban areas. Thus they have become the most vulnerable sufferers in the society especially the older women. The living conditions of the elderly women are dynamic. They change over the life course, adopting changing life circumstances. Their conditions are mainly influenced by variety of factors like marital status, financial well being, health status and family size and structure as well as cultural traditions. Moreover as age grows they suffer from lack of physical and mental well being mainly due to the improper support received from their family members.

Health problem is the most serious thing that has to be concerned by the society on the whole. It was observed that almost all the women suffer from one or the other disabilities like visual (58.0 %), hearing (11.1%), speech (1.6%) and physical (0.9%). The other physical problems they suffer from are chronic diseases like cough, diabetics, joint pain, ulcer, heart problem, blood pressure, paralysis, viral fever etc. In order to receive the medical treatment most of them prefer allopathic treatment and they visit government hospitals followed by private hospitals. Very few respondents also took the treatments like naturopathy and homeopathy. Care giving is essential for the elderly women during their illness. Nearly half of them receive care from their sons next from their daughters. Half of the elderly women have psychological problems like depression, isolation, loneliness and irritation.

The result on allopathic treatment by age does not show any significant result. The 'young old' group visits government hospitals whereas the 'old old' groups prefer to go to private hospitals due to the natural tendency that private hospitals are well equipped than the government hospitals. The educational status and the preference to go to the hospital shows no significant difference. During their ill health they prefer to be cared by their sons and daughters. Thus elderly women suffer from ill health without the proper attention and care.

Recommendations

- Rural government facilities lacked essential geriatric care facilities. As a result, the elderly had to be satisfied with the mobile care units. Therefore, geriatric care at the rural areas should be strengthened.
- Health care delivery staff must be equipped to give proper health care counseling to the elderly.
- Volunteers must be encouraged to accompany the elderly in seeking health care.

References

- Camacho, T C, Strawbridge, W J, Cohen, R D and Kaplan, G. A. (1993): "Functional Ability in the Oldest Old", *Journal of Aging and Health*, vol. 5, No. 4, pp.439-454.
- Chakraborty, S. (2005): *Health Seeking Behaviour of Aged Population of a Rural Block of West Bengal*, Working Paper No. 8. Achutha Menon Centre for Health Science Studies, Sri Chitra Tirunal Institute for Medical Science and Technology, Thiruvananthapuram, Kerala.
- Gore M.S. (1993): "The Elderly in an Ageing Society", Contributed to Volume IV of Encyclopedia on Ageing Japan. p 25.

Kinsella, Kevin and Suzman, Richard, (1992): “Demographic Dimensions of Population Aging in Developing Countries”, *American Journal of Human Biology*, Vol. 4. pp. 3-8.

Kumar, G. S. J. (1992): “Health of the Elderly”, *Journal of Social Welfare*, pp. 3-5.

Martin, Linda, G and Kinsella, Kevin (1994): “Research on the Demography of Aging in Developing Countries”, pp. 356-403, in: Linda, G. Martin and Samuel, H. Preston (eds.), *Demography of Aging*. Washington, D.C: National Academic Press.

Population Division, United Nations (1999): *World Population Prospects. The 1998 Revision Volume I: Comprehensive Tables*. New York: United Nations.

Rajan, S.Irudaya, U.S. Mishra and P.Sankara Sharma (1999): *India's Elderly: Burden or Challenge?* NewDelhi: Sage Publication.

Table 1: Percentage Distribution of Elderly Women by their Socio-economic Characteristics

Characteristics	No. of Respondents	Percent
1. Age		
≤ 65	173	52.0
66 – 70	76	22.8
71 – 75	48	14.4
76 – 80	24	7.2
81 +	12	3.6
2. Religion		
Hindu	318	95.5
Christian	8	2.4
Muslim	7	2.1
3. Caste		
SC/ST	83	24.9
MBC	55	16.5
BC	195	58.6
4. Type of Family		
Nuclear	176	52.9
Joint	157	47.1
5. Marital Status		
Married	253	76.0
Widowed	71	21.3
Separated	9	2.7
6. Educational Status		
Illiterate	279	83.8
Primary	34	10.2
Middle School	13	3.9
High School & above	7	2.1
7. Occupational Status (Current)		
Not Working	279	83.8
Coolie	11	3.3
Petty Business	16	4.8
Clerical Work	10	3.0
Servant Maid	17	5.1
8. Income		
No Income	279	83.8
≥ 1000 Rupees	32	9.6
1001 – 2000 “	18	5.4
2001+	4	1.2
Total	333	100.0

Table 2: Percentage Distribution of Elderly Women by their Illness

Diseases	Yes		No	
	No.	%	No.	%
Cough	15	4.5	318	95.5
Diabetics	57	17.1	276	82.9
Joint Pain	156	46.8	177	53.2
Ulcer	4	1.2	329	98.8
Heart Disease	22	6.6	311	93.4
Blood Pressure	110	33.0	223	67.0
Paralysis	6	1.8	327	98.2
Fever	2	0.6	331	99.4
Asthma	15	4.5	318	95.5
Nervous Disorder	9	2.7	324	97.3
Skin Problem	8	2.4	325	97.6
Brain Tumour	2	0.6	331	99.4
Kidney Problem	2	0.6	331	99.4
Back Pain	16	4.8	317	95.2

Table 3: Percentage Distribution of Elderly Women by their Health Related Characteristics

Characteristics	No. of Respondents	Percent
1.Type of Hospital		
Government	200	60.1
Private	126	37.8
Others	7	2.1
2.Nature of Treatment		
Allopathic	326	97.9
Homeopathy	3	0.9
Ayurvedic	4	1.2
3.Care Giver		
No one	38	11.4
Son	141	42.3
Daughter	92	27.6
Son and Daughter	35	10.5
Other Relatives	27	8.5
4.Persons Meet Medical Expenses		
No Expenses	6	1.8
Husband	26	7.8
Son	142	42.6
Daughter	93	27.9
Savings	66	19.8
5.Psychological Problems		
No Problem	143	42.9
Depression	68	20.4
Loneliness	36	10.8
Irritation	7	2.1
Depression & Isolation	79	23.7
Total	333	100.0

Table 4: Elderly Women’s Nature of Treatment Undergone by Selected Characteristics

Characteristics	Nature of Treatment							
	Allopathic		Homeopathy		Ayurvedic		Total	
	No	%	No	%	No	%	No	%
1.Age								
≥ 65	170	98.3	1	0.6	2	1.2	173	100.0
66 - 70	75	98.7	-	-	1	1.3	76	100.0
71 - 75	46	95.8	1	2.1	1	2.1	48	100.0
76 +	35	97.2	1	2.8	-	-	36	100.0
	χ^2 Value & Sig. Level: 3.822 ; 0.701							
2.Type of Hospital								
Government	200	100.0	-	-	-	-	200	100.0
Private	123	97.6	3	2.4	-	-	126	100.0
Others	3	42.9	-	-	4	57.1	7	100.0
	χ^2 Value & Sig. Level: 193.472 ; 0.000							
Total	326	97.9	3	0.9	4	1.2	333	100.0

Table 5: Type of Hospital by background Characteristics of the Elderly Women

Characteristics	Type of Hospital When Sick							
	Government		Private		Others		Total	
	No.	%	No.	%	No.	%	No.	%
1.Age								
≥ 65	114	65.9	56	32.4	3	1.7	173	100.0
66 - 70	46	60.5	28	36.8	2	2.6	76	100.0
71 - 75	25	52.1	21	43.8	2	4.2	48	100.0
76 +	15	41.7	21	58.3	-	-	36	100.0
	χ^2 Value & Sig. Level: 11.290 ; 0.080							
2.Educational Status								
Illiterate	173	62.0	102	36.6	4	1.4	279	100.0
Primary School	15	44.1	17	50.0	2	5.9	34	100.0
Middle	8	61.5	4	30.8	1	7.7	13	100.0
High School & above	4	57.1	3	42.9	-	-	7	100.0
	χ^2 Value & Sig. Level: 8.282 ; 0.218							
Total	200	60.1	126	37.8	7	2.1	333	100.0

Table 6: Elderly Women's Health Problem by their Age

Age	No Problem		Depression		Isolation		Irritation		Depression & Isolation		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
≥ 65	73	42.2	37	21.4	23	13.3	4	2.3	36	20.8	173	100.0
66 – 70	32	42.1	18	23.7	7	9.2	1	1.3	18	23.7	76	100.0
71 – 75	20	41.7	7	14.6	3	6.3	2	4.2	16	33.3	48	100.0
76+	18	50.0	6	16.7	3	8.3	-	-	9	25.0	36	100.0
	χ^2 Value & Sig. Level: 8.793 ; 0.720											
Total	143	42.9	68	20.4	36	10.8	7	2.1	79	23.7	333	100.0