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# Gender, Marital Status and Disease Profile: A Case Study of Older's Wellbeing

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**Abstract** *Pakistan's aging population is increasing daily. This paper uncovered the comparative relationship between marital status and disease manifestation among older persons. Maximum participation of older persons was in category 66-70 years. Data reveals; widowed women were suffering more as compared to older men of same age. The percentile reflects that 68.8 percent of women were hypertensive, 57.1 percent had heart problems, 70.6 percent suffered diabetes, 66.7 percent were affected by arthritis, 62.5 percent faced asthma issues and 40.9 percent were caught by other diseases. The study concludes that women in older age need more attention and care for their wellbeing.*

**Key Words:** Gerontology, Aging, Gender and Marital Status, Disease and Aging, Aging and Women, Gender and Aging

## Introduction

Aging and death are like an intrinsic biological clock that has its own pace and keeps its time track, initiates as a process of aging the conditions are satisfied and all this is 'pre-programmed' as Hayflick (1996) states [1]. It is not merely a matter of today; rather it is the most vital social issue of tomorrow which needs to be tackled cautiously, else it will not be manageable in the future. The developed nations are dealing with this issue for about ten decades, which has generated more knowledge to devise policies and rules to face the challenges.

On the contrary, the developing nations need to focus on this issue which is highly neglected. An aged person can be defined as an individual or individuals crossing the benchmark of 60 years. Different scholars target aging in different dimensions while explaining it similarly aging is for different subjects [2]. As indicated by Cohen, aging is a vague inherent state: "a time both of maximal experience and maximal debility, simultaneously vaunted and evaded" [3]. Studies on aging or old age are also called as 'gerontology' [2, 4]. In other words, aging can be defined as a person's growth on the day-to-day bases [5].

Aging is a physiological and biological phenomenon that is common amongst all the populations around the globe. It is further observed that females now have lesser children than 30 years back as the trend of high population growth is made slow. In the early 1970s, the fertility rate was 4.7 children per female which were reduced to 2.7 by the millennia [6]. Attention paid to health and nutrition, lifestyle and medicine in the modern world has led to the longevity of life. Life expectancy throughout the globe has increased tremendously from 45 years to 69 years from 1945 to 2000 respectively, which is projected to rise till 78 years by 2050. According to this ratio, the fastest growing population group is now of the elderly, which suggests that population i.e. 606 Million today for above 60 years will be around three times more than today by 2050 [7]. This affirms that more than 60% of the aged individuals reside in the developing nations which will rise to 70% as predicted by 2020 [8].

UN report suggests that 6% of the world's population age 65 years and above reside in Asia [9]. Pakistan is the 6th most populated country of the world and is ranked amongst the developing nations, where its populations are estimated in the year 2006 to be around 166 million. Life expectancy in Pakistan

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is 62 years whereas above 65 years constitutes 4.48% of the total populace. It is likely that due to increasing geriatric population gives new challenges to health care providers in the future [10].

The dilemma in Pakistan is that the geriatric population is ignored and there is little or limited availability of data on their exclusion

and health issues [29]. A recent hospital-based survey held in Karachi sheds light on health status, needs and issues faced by this highly susceptible part of the population. According to the observations, half of the elderly were taking three or more medicines per day that highlighted the need to anticipate unpleasant drug experiences [11]. As reported by the aged persons, visual impairment, dyspnea, immobility, and urinary issues had badly affected their lives. Commonly reported chronic illness in older persons are; arthritis, hypertension and diabetes mellitus which highlights mobilization of resources [11].

Male and female age differently so their experiences also differ. It is observed that elderly females have a strong social network as contrasted by their male counterparts. Also, females in the role of mother are more close to her adult children and hence more cherished unlike their father in receiving support both in terms of material (financial support) and non-material (emotional support) [12, 13].

The fact observed across most of the countries is that females have a longer life span as compared to males. This gap is noticed as low as 3 years among South-Central Asian countries and as large as 10.5 years in Eastern Europe. It is highlighted that in developed nations of the world, females live more than 7.5 years more than males. One such example is Latin America where this gap advances to 6.5 years [6]. The ratio of elderly males to females is hence increasing with age, 55% of the older population of the world today constitute of females. Also, around 65% of women can be categorized in the oldest of the old population presently. This proportion is expected to stay stagnant in the next half-century [14].

Chaudhry et al., (2014) cited Christina while describing ageism and argued that old age experience varies both for males and females but the later (female) also experiences sexism in addition to ageism. They are not only discriminated against being old but also viewed negatively for being female [15, 16]. This research study was conducted keeping in view the objective of exploring the relationship between marital status and disease profile with special reference to gender among older persons of Rawalpindi City.

## Materials and Methods

### The Locale of Study

Initially, Rawalpindi city was selected as the study locale in the 1st phase. TMA Potohar Town and TMA Rawal Town were selected in the second phase. From TMA Rawal Town, UC # 46 and UC # 36 from TMA Potohar Town were selected. A sample of 384 respondents was drawn statistically that was further subdivided proportionately among the two UCs.

### Sampling

According to Rawalpindi Development Authority [RDA], the reported projected population of Rawalpindi was around 2 million in total and according to the 1998 census the figure is 1142430 persons [the data was collected in Oct-2014 to Marc-2015 and hence the population estimates of 1998 census survey were referred]. While drawing the sample, the level of significance was estimated at 95%, error margin 5% and response distribution was 50% from the calculated sample of 384.

### Tool

To collect data, the Interview schedule was designed that was comprised of a set of close-ended questions followed by their responses to guide the interviewer. The tool also included some open-ended questions to keep a margin of descriptive opinions of respondents for qualitative data. An interview schedule was modified after initial pre-testing activities conducted under a similar environment. 384 interview schedules

were completed with the respondents to meet the study requirements whereas the incomplete responses were filtered out alongside.

### Data Management

Collected data was initially coded to complete the data entry process successfully. Once all data collected was entered by designing a coded file into SPSS, data were analyzed for further explanations.

## Results and Discussion

Table 1. illustrates the distribution of respondents in accordance to gender and age group, this reveals that 32 percent females were interviewed in age category 60-65 years, 31 percent were in the age group 66-70 years, 23 percent belong to age group 71-75 years, 36 percent female responses recorded from 76-80 years of age group and 41 percent were more than 80 years of age.

**Table 1.** Gender and Age

| | Gender | |
|---|---|---|
| Age Category | Male | Female |
| 60-65 | 68% | 32% |
| 66-70 | 69% | 31% |
| 71-75 | 77% | 23% |
| 76-80 | 64% | 36% |
| 80+ | 59% | 41% |
| Total | 69% | 31% |

**Table 2.** Gender, Marital Status, and Disease Profile

| Disease | Gender | Marital Status | |
|---|---|---|---|
| | | Currently Married | Widow/Widower |
| Hypertension | Male | 70.6% | 31.2% |
| | Female | 29.4% | 68.8% |
| Heart Problems | Male | 78.8% | 42.9% |
| | Female | 21.2% | 57.1% |
| Diabetes | Male | 75.6% | 29.4% |
| | Female | 24.4% | 70.6% |
| Arthritis | Male | 81.8% | 33.3% |
| | Female | 18.2% | 66.7% |
| Asthma | Male | 85.0% | 37.5% |
| | Female | 15.0% | 62.5% |
| Other | Male | 80.6% | 59.1% |
| | Female | 19.4% | 40.9% |

Pearson value is 33.313 with $p$ value is .015, which means strong association prevails among these 3 indicators.

As the aging population all around the globe is increasing, the concerns to their marital status, social issues, and health concerns are raised in the older population. The ratio of older female widows has increased more in years than males that lead to vast gender differentiation in the elderly population [17-19-27].

Gender structures the entire life of an individual from birth until old age, making an influence on the resource distribution and opportunities in taking its role and making life choices. The gendered base structures are playing their significant roles in shaping the lives of both males and females in older age which results in diverse challenges, prospects, and limitations faced by them throughout their lives [21-28]. As the literature above sheds light on the issues faced by aging, females are different from the men; Table II shows the relationship between three major variables including gender, disease profile, and marital status of older persons in Rawalpindi city. The findings of the research suggest that the gender relations of the elderly are of prime significance. In the category of disease, data reveals that married women reported only 29.4 percent prevalence of hypertension while in the widowed category, hypertension was recorded at 68.8 percent. That is around 40 percent higher from the currently married status category.

The impact of inequality and gender-based discrimination, in education and employment, has increased in every phase of individual, hitting most in older age. So the probability for an older female to be poor is more than the older male. Males and females suffer differently with different health-related issues as they grow, but lack in access to adequate health facilities has made these issues more complicated for the older females accompanied by a higher rate of poverty [21]. The data further suggests that, in the category of the cardiac issue, responses were recorded 21.2 percent among married and 57.1 percent currently among widowed aged women. On the contrary, if we look at the males with cardiac issues, 78.8 percent of respondents are suffering in currently married status and 42.9 percent in widower in the widower category.

Data shows that 24.4 percent of married females reported diabetes whereas 70.6 percent of widowed women had it. In the category of arthritis, male respondents who are currently married dominated the result figures by 80% whereas females dominated with a figure of 66.7% in the widowed category. 85.0 percent of sampled males reported asthma and were married whereas 62.5 percent of widow females had asthma. The data shows that most of the widowed females were diseased. Security in health, shelter, and financial soundness are the basic needs of the aging population to live with pride and dignity. Apart from the individual choices and decision making play a partial role in its provision [20].

The topic in association to older person health, their marital status along with the utilization of health care is heavily documented internationally in recent studies. Widowhood is known to have an impact on the physical and mental wellbeing of the elderly. It is noticeable that health care in the married elderly female is higher than the widowed individual of the same age group [3, 22-26].

The supporting argument about the quantitative analysis conducted in the study, are highlighted to elaborate on the background of the increase rate of diseases in female older person that is widowed as compared to the married population. First and foremost is the matter of financial support. The female elderly respondents highlighted that they are fewer dependents on their children when their husbands are alive and with them as their needs are fulfilled by their spouse who takes more care of them. But as one gets widowed, or gets single otherwise, they feel hesitant to ask for money or any other utilities and healthcare from their children. Second, the widowed women try to take more responsibility in family matters to stay involved as compared to the older couple. Respondents added that as their spouse passed, they noticed that their children got more involved with their family matters surrounding their wives and kids rather than giving importance to them (older women). Third, it is observed that due to lesser attention paid by their children and reduced social mobility their health is adversely affected which makes them more vulnerable and deprived of attaining any health care facility to maintain their health. Fourth, the responsibility of a mother with multiples sons gets diffused as she widows and results in more negligence. As in this case, two situations are observed mostly; she either settles with the eldest or the youngest of her sons or she keeps on visiting them all turn by term on a weekly or monthly basis. If she settles with one of her sons, she is bothered by the tension of her other offsprings and remains upset. The situation worsens further where the widowed woman has no permanent settlement and she keeps on visiting to

live with all of them since no one takes her complete responsibility especially in terms of her health and wellbeing. So, it was concluded by the elderly widowed women that life without their spouse is very difficult irrespective of how many wells off or how many children they have.

## Conclusion

This study focuses on the health disorders prevalent in the elderly community of an urban setting that includes hypertension, asthma, cardiac issues, and diabetes (commonly known as sugar). The most affected and the most vulnerable is the cohort of elderly widowed females of the city. The elderly women after losing their husbands often complained of ignorance from their children in terms of attention, care, and health. This brings into account a serious concern by this neglected segment of the society firstly by their immediate family, society and then by the stakeholders i.e. government-based welfare organizations, human rights organizations, and the NGO to maintain the good health of widowed elderly female persons. The need of the time is to spread awareness in terms of the socio-cultural and religious responsibility of the family and the society to serve by incorporating the elderly in the household matters with dignity and honor that will lessen their health issues and improve their psychological and social well being which turn will reduce their health issues. Since most of the health issues are related to their physiological health that resultantly affects their physical wellbeing. Also, loneliness aggravates the deterioration of the well-being of the women who do not have their male counterparts anymore.

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