SciMedCentral

Medical Journal of Obstetrics and Gynecology

Research Article

Community Based Study of Magnitude of Health Problems Of Rural, Tribal, Elderly Women

Chhabra S*

Department of Obstetrics and Gynaecology, Mahatma Gandhi Institute of Medical Sciences, India

***Corresponding author**

Chhabra S, Department of Obstetrics and Gynaecology, Mahatma Gandhi Institute of Medical Sciences, Sevagram, Maharashtra, India, Email: chhabra_s@rediffmail.com ; schhabra@mgims.ac.in

Submitted: 26 October 2020

Accepted: 18 November 2020

Published: 20 November 2020

ISSN: 2333-6439

Keywords

- Elderly
- Rural tribal women
- Health disorders
- Services

Abstract

Background: Elderly women live with many disorders. They suffer more in developing countries because of poverty, access problems, inequalities and dependence. Community based studies about rural tribal women are scarce.

Objectives: To know about burden of disorders in elderly, rural, tribal women, action taken in low resource settings.

Methodology: Community based study was conducted in 100 villages after institute's ethics committee's approval. In these villages community based mother and child services were initiated after having created a health facility in one village. Women, five years beyond menopause were included as they did not know birth years and menopause was most recent event, minimum fifteen in each village by random house to house visits making1982 study subjects. Information of health problems of elderly women was collected with predesigned, pretested tool. Some work up was done by research assistant. If blood pressure, blood sugar were elevated, were repeated and accordingly action was taken for final diagnosis, therapy.

Results: Most women were illiterate, belonged to low economic class. Over all 1277 (64.42%), of 1982 women had disorders with or without complaints or treatment, 109(5.5%), women had vision problems, 149 (7.5%), gynaecological diffuculty, 140 (7.1%), hearing problem, 35 (6.9%), dental, 601 (30.32%), hypertension and 142 (7.2%), diabetes. Many were apathetic about complaints which affected their everyday life. Total 1400 (70.63%), women said they did not want to be examined by male doctor during any sickness. Overall 1550 (78.20%), of 1982 women were satisfied with rural life, though 1599 (80.68%), women did say that same action was needed for improving their living conditions.

Conclusion: Many elderly women had disorders, some had sought care but without action. Care providers included quacks,. They expected special system for care in villages.

BACKGROUND

Elderly, women live with many disorders and suffer a lot specially in developing countries because they lack resources, health services, social support and have dependence in the male dominated society. They live with many disorders, including non-communicable diseases (NCDs), known to be big threats to women's health worldwide though not difficult to diagnose but continue to affect their everyday life. In a cross-sectional study by World Health Organization, it was revealed that diabetes, hypertension, dyslipidaemia, and overweight were higher in the urban population compared to rural [1]. However rural women suffer more because they lack resources, services and infrastructure. They also have access problems. There is inequality and dependence. In developing countries poverty adds to their problems. Socio cultural milieu also affects their every day life. Rural community based studies are scarce. In Melghat region of Amravati District of Maharashtra, India, rural, hilly and forestry region with high maternal, neonatal, infant and child mortality, attempts have been made to help the needy mothers but hardly anything is known about elderly women, the magnitude of their health problems and quality of their lives. Maharashtra is one of the few provinces of India with better health indicators. But communities of Melghat suffer a lot, due to its location, access problems, lack of awareness, health services and low resources with extreme poverty. Probably their beliefs are also major issues which may be responsible for many health problems of elderly women. How much was the burden of rural tribal elderly women's health sufferings in the remote rural

region was not well known. So it was decided to find out about health problems of elderly women.

OBJECTIVES

Objectives were to know about the burden of obvious disorders like visual, joint-muscle related, dental and gynaecological complaints and hypertension, diabetes in elderly, rural, tribal women of low resource communities.

MATERIAL AND METHODS

After institute's ethics committee's approval, community based study was conducted in 100 villages of Melghat region of Amravati, Maharashtra, India. These villages were around the village where health facility was created for 24 hrs 7 days services for various disorders, specially for women with thrust on mother and child care. In these 100 villages community based mother and child services were initiated. During the village visits by nurse midwives for mother and child care elderly women came out and asked for help for them also. So the initiative of finding about their problems was taken. Since it was decided to find out about problems of elderly women, it was essential to decide which women to include. As far back as 1875, in Britain, the Friendly Societies Act, enacted the definition of old age as, "any age after 50". Yet pension schemes mostly used 60 or 65 years for eligibility of being called elderly [2]. Most developed countries in the world have accepted the chronological age of 65 years as a definition of 'elderly' age. Though this definition was felt some what arbitrary, the UN also did not adopt a standard criterion, but generally used 60+ years to refer to the older population. The women of the study region did not know their birth year and there were no records. Menopause was the most recent event in their lives. So it was decided to include women five years beyond menopause as the study subjects. It was decided to randomly have minimum 15 women per village by getting women as her criteria by house to house visits. Some villages were small and others little bigger. In 100 villages with population of 68376, a total of 1982 women, 2.89% of population became study subjects. Most women belonged to low economic class and were illiterate. Consent was taken before collecting the information, through predeveloped and pretested tool in the language desired information was collected by direct interviews and direct observations during house to house visits for getting information in the villages. Women were asked to tell about their own health problems, visual, difficulty in walking, dental, gynaecological or any other. Blood pressure was measured and blood sugar was estimated by the research assistant. If blood pressure was higher in the first reading, it was repeated after 4 hours. Similarly if blood sugar was elevated, it was reestimated before further investigations at the base hospital for final inclusion as case of hypertension or diabetes and also therapy. However therapy was not part of the study. Information was recorded on the tool by research assistant. No one was given the questionnaire to fill. Information was entered on weekly basis after visits to villages 5 days a week with one day for all entries.

RESULTS

It was revealed that of 1982 women, 35.57% (705), had no idea of disorders which elderly women could have. Overall 1277, (64.42%), did know something about problems in elderly women and most of them were of 56-60 years. Among 1982 women, 601 (30.32%) themselves were having Hypertension, 149 (7.5%), gynaecological complaints, 142 (7.2%), had Diabetes, 140 (7.1%), Hearing problems, 109 (5.5%), had Vision problems and 35 (6.9%), had Dental problems. Out of 1982 study subjects 1936 were illiterate, of which 699 (36.1%), had no knowledge of health problems which elderly women could have, and 1237 (63.9%), women did know something about likely health problems of elderly women. Out of 1936 illiterate women, 594 (48%), themselves had hypertension, 137 (11.1%), had hearing problems, 128 (10.3%), dental problem, and 131 (10.6%), had diabetes. Out of total 1982, women 1659 (83.70%), were from lower economic class, 647 (39%), of them had no knowledge of likely health problems of elderly women and 528 (31.8%) had hypertension, 126 (7.6%), had gynaecological complaints, 114 (6.9%), had diabetes, 99 (6%), had hearing problems, and 87 (5.2%), had dental problems. Overall 1398 (65%), women were labourer, of them 909 (65%), 256 (66.8%), of 383 of those who used to work in their own farms and 112 (55.7%), of 201 who were farm owners had some knowledge about health problems elderly women could have. Overall 427 (30.5%), labourers and 140 (36.6%), own farm labourers had hypertension.

Total 1400 (70.63%), of 1982 women did not want to be examined by male doctor during their own illnesses. Most of them were of 50-60 years. However 544 women did say that male doctor was not a problem. Over all 911 women wanted that only female doctor could examine them during their own illnesses, 422 said nurse and 105 said others which included quacks and witch crafts too. Of 1936 illiterate women 1370 (70.76%), had problems if examined by male doctor. Overall 895 (42.22%), women had sought help from female doctors for their own complaints, 531 (27.42%), were examined by male doctor and 99 (11%), had sought help from others for sickness. Out of 1982 study subjects, 1659 (83.7%), who belonged to lower economic class, 778 (46.89%), wanted female doctor and 369 (22.24%), said nurse was the best. Of 1398 labourers 977 (69.8%), women did not like the idea of getting examined by male doctor. However 354 (25.32%), women did seek care from male doctors, 315 (22.53%), wanted only female doctors and 47 (3.36%), others.

Out of 1982 elderly women, 1550 (78.20%), were satisfied with their lives in villages in spite of extreme visible poverty in these communities and 432 (21.79%), were not satisfied, 1599 (80.68%), of 1982 did say some action was needed for improving living condition of communities. Of but 1514 (78.2%), of 1936 were illiterate and satisfied with their lives, 1564 (80.79%), of 1936 said some action was needed 1356 (86.97%), of 1659 belonging to lower economic class were satisfied but 1398 (84.27%), of 1659 said action was needed, 1115 (79.75%), of 1398 were labourer who were satisfied with their rural lives, but 1148 (82.12%), of 1398 said some action was needed (Table 1-3).

DISCUSSION

Basu et al. [3], reported that studies revealed that health of elderly, specially tribes, still remained unsatisfactory. They were most neglected and highly vulnerable to diseases with high degree of morbidity and mortality. Overweight, obesity, hypertension and anaemia were in nearly half cases they

Table 1: Knowledge of Disorders and Health Problems amongst Elderly Women.

Variable Age	Total	Knowledge of Problems				Own Symptoms and Disorders											
		No	%	Yes	%	Visual	%	Hearing	%	GYE	%	DENTAL	%	Diabe-tes	%	Hyperten-sion	%
40-44	36	10	27.8	26	72.2	2	5.6	3	8.3	7	19.4	4	11	6	17	4	11.1
45-50	194	76	39.2	118	60.8	17	8.8	19	9.8	24	12.4	15	7.7	12	6.2	31	16
51-55	270	92	34.1	178	65.9	12	4.4	9	3.3	24	8.9	28	10	32	12	73	27
56-60	482	166	34.4	316	65.6	28	5.8	32	6.6	27	5.6	29	6	32	6.6	168	34.9
61-65	463	158	34.1	305	65.9	23	5	42	9.1	29	6.3	27	5.8	22	4.8	162	35
66-70	383	129	33.7	254	66.3	15	3.9	27	7	28	7.3	26	6.8	26	6.8	132	34.5
71-75	129	59	45.7	70	54.3	9	7	8	6.2	3	2.3	7	5.4	12	9.3	31	24
76-80	25	15	60	10	40	3	12	0	0	7	28	0	0	0	0	0	0
Total	**1982**	**705**	**36**	**1277**	**64**	**109**	**5.5**	**140**	**7.1**	**149**	**7.5**	**136**	**6.9**	**142**	**7.2**	**601**	**30.3**
Education																	
Illiterate	1936	699	36.1	1237	63.9	103	8.3	137	11.1	144	11.6	128	10.3	131	10.6	594	48.0
Primary	32	4	12.5	28	87.5	4	14.3	3	10.7	5	17.9	4	14.3	6	21.4	6	21.4
Secondary	8	1	12.5	7	87.5	2	28.6	0	0.0	0	0.0	2	28.6	2	28.6	1	14.3
Higher Sec-ondary	6	1	16.7	5	83.3	0	0.0	0	0.0	0	0.0	2	40.0	3	60.0	0	0.0
Graduate	0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	**1982**	**705**	35.6	**1277**	64.4	**109**	5.5	**140**	7.1	**149**	7.5	**136**	6.9	**142**	7.2	**601**	30.3
Economics																	
Upper	15	2	13.3	13	86.7	0	0.0	5	33.3	2	13.3	4	26.7	2	13.3	0	0.0
Upper Middle	65	26	40	39	60	14	22	7	11	2	3.1	3	4.6	4	6.2	9	13.8
Middle	52	14	26.9	38	73.1	8	15	9	17	4	7.7	3	5.8	7	14	7	13.5
Upper Lower	191	16	8.4	175	91.6	29	15	20	11	15	7.9	39	20	15	7.9	57	29.8
Lower	1659	647	39	1012	61	58	3.5	99	6	126	7.6	87	5.2	114	6.9	528	31.8
Total	**1982**	**705**	**36**	**1277**	**64**	**109**	**5.5**	**140**	**7.1**	**149**	**7.5**	**136**	**6.9**	**142**	**7.2**	**601**	**30.3**
Profession																	
Labourer	1398	489	35	909	65	70	5	113	8.1	116	8.3	89	6.4	94	6.7	427	30.5
Own Farm Labourer	383	127	33.2	256	66.8	24	6.3	19	5	24	6.3	28	7.3	21	5.5	140	36.6
Farm Owner	201	89	44.3	112	55.7	15	7.5	8	4	9	4.5	19	9.5	27	13	34	16.9
Other Work	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1982**	**705**	**36**	**1277**	**64**	**109**	**5.5**	**140**	**7.1**	**149**	**7.5**	**136**	**6.9**	**142**	**7.2**	**601**	**30.3**
Parity																	
P1	251	105	41.8	146	58.2	19	7.6	24	9.6	28	11.2	20	8	34	14	21	8.4
P2	352	56	15.9	296	84.1	14	4	41	12	19	5.4	28	8	38	11	156	44.3
P3	439	184	41.9	255	58.1	28	6.4	27	6.2	39	8.9	22	5	17	3.9	122	27.8
P4	486	181	37.2	305	62.8	12	2.5	25	5.1	29	6	22	4.5	25	5.1	192	39.5
P5 Above	454	179	39.4	275	60.6	36	7.9	23	5.1	34	7.5	44	9.7	28	6.2	110	24.2
Total	**1982**	**705**	**36**	**1277**	**64**	**109**	**5.5**	**140**	**7.1**	**149**	**7.5**	**136**	**6.9**	**142**	**7.2**	**601**	**30.3**

GYN – Gynaecological

studied. Sonwane [4], also reported that elderly tribal women experienced a high burden of chronic illnesses, disabilities and comorbidities and the burden was highest among economically disadvantaged women. Studies have revealed that NCDs were also common among post-menopausal women which needed timely detection and treatment [5,6] . In the rural tribal communities many elderly women had complaints and some had sought care too but no action was taken by many of them after visits for their health care. Many women had sought health care but services were sought from quacks and witch craft too. In elderly age many cancers specially ovarian, cervical are common and coronary artery disease is also common but elderly women of these communities had apathy about their own complaints. Women desired that special system for helping elderly women was needed so that they could have quality life. Previous studies have examined how individual and community characteristics, including use of services, were associated with elderly women's health and functional status. Over all in the present study of 1982 study subjects, 1277 (64.42%), had complaints. On work up 601 (30.32%), had hypertension and 142 (7.2%), seemed to have

Table 2: Desired Health Providers and Health Providers Sough for Care.

Variable Age	Total	Male Doctor A Problem				Health Providers Sought			
		No	%	Yes	%	Male doctor	Female doctor	Nurse	Other
40-44	36	14	38.88	25	69.44	10	13	7	6
45-50	194	61	31.44	133	68.55	36	96	53	9
51-55	270	83	30.74	187	69.25	76	109	63	22
56-60	482	142	29.46	340	16.38	137	227	98	20
61-65	463	132	28.50	331	71.49	118	226	95	24
66-70	383	104	27.15	279	72.84	119	175	71	18
71-75	129	40	31.00	89	68.99	44	52	27	6
76-80	25	9	36.00	16	64.00	4	13	8	0
T0tal	**1982**	**582**	**29.36**	**1400**	**70.63**	**544**	**911**	**422**	**105**
Education									
Illiterate	1936	566	29.24	1370	70.76	531	895	411	99
Primary	32	12	37.50	20	62.50	7	12	10	3
Secondary	8	3	37.50	5	62.50	2	3	0	3
Higher Secondary	6	1	16.67	5	83.33	4	1	1	0
Graduate	0	0	0.00	0	0.00	0	0	0	0
Total	**1982**	**582**	**29.36**	**1400**	**70.64**	**544**	**911**	**422**	**105**
Economics Class									
Upper	15	8	53.33	7	46.67	5	6	3	1
Upper Middle	65	11	16.92	15	23.08	20	29	16	0
Middle	52	36	69.23	16	30.77	25	21	6	0
Upper Lower	191	33	17.28	158	82.72	50	77	28	36
Lower	1659	494	29.78	1165	70.22	44	778	369	68
Total	**1982**	**582**	**29.36**	**1400**	**70.64**	**544**	**911**	**422**	**105**
Profession									
Laborer	1398	421	30.11	977	69.89	354	682	315	47
Own Farm Laborer	383	94	24.54	289	75.46	150	148	58	27
Farm Owner	201	67	33.33	134	66.67	40	81	49	31
Other Work	0	0	0.00	0	0.00	0	0	0	0
Total	**1982**	**582**	**29.36**	**1400**	**70.64**	**544**	**911**	**422**	**105**
Parity									
P1	251	53	21.12	198	78.88	36	98	98	19
P2	352	118	33.52	234	66.48	124	127	95	6
P3	439	141	32.12	298	67.88	154	198	68	19
P4	486	188	38.68	298	61.32	98	289	65	34
P5Above	454	82	18.06	372	81.94	132	199	96	27
Total	**1982**	**582**	**29.36**	**1400**	**70.64**	**544**	**911**	**422**	**105**

diabetes. Overall 149 (7.5%), had gynaecological complaints, 140 (7.1%), hearing problems, 35 (6.9%), dental complaints, and 109 (5.5%), had vision problem. Most subjects were illiterate of low economic class.

Overall 1400 (70.63%), women had problem if examined by male doctor, 911 (65.07%), wanted only lady doctor, 422 (30.14%), nurses and 105 (75%), others which included quacks. Overall 1161 (58.57%), desired that special system was needed for care of elderly women. Howe [6], also suggested that health systems needed to incentivise for care of elderly. This may mean additional resource allocation, training and financial drivers such as no cost for medication, annual care plans, vaccines and needed care. Public service system needs to have service design which helped elderly. It needs to be integrated around the persons not their diseases with planned services depending on what is needed, what they wished and could be done for their quality life.

Table 3: Satisfaction with Rural Life and Need of Action.

Variable Age	Total	Satisfaction with Rural Life				Action needed			
		No	%	Yes	%	No	%	Yes	%
40-44	36	6	60.21	30	83.33	10	27.78	26	72.22
45-50	194	36	18.55	158	81.44	37	19.07	157	80.93
51-55	270	73	27.03	197	72.96	60	22.22	120	44.44
56-60	482	123	25.51	359	74.48	100	20.75	382	79.25
61-65	463	102	20.03	361	36.26	92	19.87	371	80.13
66-70	383	76	19.84	307	80.15	92	24.02	315	82.25
71-75	129	14	10.85	115	89.14	12	9.30	117	90.70
76-80	25	25	48	23	92	4	16.00	21	84.00
T0tal	**1982**	**432**	**21.79**	**1550**	**78.2**	**383**	**19.32**	**1599**	**80.68**
Education									
Illiterate	1936	422	21.79	1514	78.2	372	19.21	1564	80.79
Primary	32	6	18.75	26	81.25	6	18.75	26	81.25
Secondary	8	1	12.5	7	87.5	2	25.00	6	75.00
Higher Secondary	6	3	50	3	50	3	50.00	3	50.00
Total	**1982**	**432**	**21.79**	**1550**	**78.2**	**383**	**19.32**	**1599**	**80.68**
Economic Class									
Upper	15	4	26.66	11	73.33	3	20.00	12	80.00
Upper Middle	65	5	7.69	60	92.3	13	20.00	52	80.00
Middle	52	3	30.15	49	94.23	2	3.85	50	96.15
Upper Lower	191	117	61.25	74	38.74	104	54.45	87	45.55
Lower	1659	303	19.43	1356	86.97	261	15.73	1398	84.27
Total	**1982**	**432**	**21.79**	**1550**	**78.2**	**383**	**19.32**	**1599**	**80.68**
Profession									
Laborer	1398	282	20.17	1115	79.75	250	17.88	1148	82.12
Own Farm Laborer	383	128	33.42	255	66.57	111	28.98	272	71.02
Farm Owner	201	128	63.68	180	89.55	22	10.95	179	89.05
Other Work	0	0	0	0	0	0	0.00	0	0.00
Total	**1982**	**432**	**21.79**	**1550**	**78.2**	**383**	**19.32**	**1599**	**80.68**
Parity									
P1	251	121	48.21	130	51.79	52	20.72	199	79.28
P2	352	74	21.02	278	78.98	39	11.08	313	88.92
P3	439	98	22.32	341	77.68	42	9.57	397	90.43
P4	486	67	13.79	419	86.21	165	33.95	321	66.05
P5Above	454	72	15.86	382	84.14	85	18.72	369	81.28
Total	**1982**	**432**	**21.8**	**1550**	**78.2**	**383**	**19.32**	**1599**	**80.68**

For helping elderly women attempts should be made through existing system as well as going beyond. Civil societies can also help in addition to public health system. Basu et al. [7], reported that low back pain (73.3%), alcohol addiction (63.3%), smoking (56.0%), vision (50.0%), problems were common in elderly problem. One in every four studied felt unhappy or depressed. Severe distress was found among one in every five respondents. Distress was more in those beyond 70 years of age, illiterate and in lower social class. Vishnoi et al. [8], also reported that high prevalence of morbidity and social problems were observed in the elderly subjects. The geriatric health care services need to be strengthened along with provision of social support to the elderly for enabling them lead quality life. Subudhi [9], reported that an effective health care policy regarding the health care management for the elderly tribal women was required. Surveillance of risk factors is important for right policies and programs for NCDs and care of elderly. Point of care technologies, local community support, home based care, with accessibility can change the life of elderly. Access, availability, affordability, and acceptability all matter, as do the skill mix needed to meet the health and social needs of elderly people who need to be helped for lives with wellness. There are roles for family doctors, nurses,

and health care assistants for care of elderly specially women who lack services. Also in this age there is significant need for social and community support, home assessment, and nursing care, as well as interface with other services and specialities. The consequences of a mismatch between the organization, delivery and financing of health care for elderly women and their actual needs fall disproportionately on low-income women. Korean National Health and Nutrition Examination Survey of 2012 [10], revealed that both the amount and pattern of chronic diseases have been associated with QOL in elderly populations. Elderly women have low levels of QOL due to multimorbidity and a higher prevalence of chronic diseases, which is related to impaired QOL. Sarwari et al. [11], did a study to evaluate whether elderly women living alone were less likely to experience functional decline when compared with women who lived with others unless severely physically impaired, women living independently have less deterioration in functional health when compared with peers in alternate living arrangements. Ramanathan et al. [12], reported that yoga should be a part of health-care facilities for elderly as it can enhance the QOL improving their overall mental health status. It could provide a healthy and positive alternative from depressing negative thoughts, and give them a sense of purpose and hope. Adjaye-Gbewonyo et al. [13], reported that NCDs are viewed as lifestyle conditions, attention is paid to individual behaviours rather than to wider social and commercial determinants of health. Assembly [14], reported that the current 5 × 5 approach to NCDs, favoured by WHO, focuses on five diseases (cardiovascular disease, cancer, diabetes, chronic respiratory diseases, and mental ill-health), and five risk factors (tobacco use, unhealthy diets, physical inactivity, harmful use of alcohol, and air pollution). But, as the NCD Countdown 2030 showed, "Although premature mortality from NCDs is declining in most countries, for most the pace of change is too slow to achieve SDG target 3.4". Countdown [15], reported that the global NCD community needs to consider a different approach to the framing of chronic diseases. Zuccala et al. [16], reported that despite the importance of NCDIs to the health and wellbeing of the world's poorest billion, the Commission's economic analysis reveal that funding to address this burden is grossly inadequate and that the share of development assistance for NCDIs directed at countries where most of the world's poorest reside is declining. The case for investment is nonetheless strong. The commission shows that addressing NCDIS is key to achieving progress towards universal health coverage (UHC), with NCDIS accounting for 60–70% of the UHC financing needs in the low-income and lower-middle-income countries where the poorest billion live.

CONCLUSION

Many elderly women had disorders and some had sought health care but with inaction. They were apathetic about their own problems. System needs to exist for helping them so that they can have quality life.

REFERENCES

1. Oommen AM, Abraham VJ, George K, Jose VJ. Prevalence of risk factors for non-communicable diseases in rural & urban Tamil Nadu. The Indian Journal of Medical Research. 2016; 144: 460.
2. Roebuck J. When does" old age begin?: The evolution of the English definition. J Social History. 1979; 12: 416-428.
3. Basu G, Mondal P, Roy SK. Health of elderly tribes: a community based clinico-epidemiological study in West Bengal, India. Int J Community Medicine and Public Health. 2018; 5: 970.
4. Sonwane PV. TRIBAL ELDERLY WOMEN AND THEIR HEALTH. SAMAJSHASTRA Sanshodhan Patrika, Marathi Samajshashtra Parishad (J). 2015: 36-40.
5. Kwak H, Lee C, Park H, Moon S. What is Twitter, a social network or a news media?. InProceedings of the 19th international conference on World wide web. 2010; 26: 591-600.
6. Lee TM, Markowitz EM, Howe PD, Ko CY, Leiserowitz AA. Predictors of public climate change awareness and risk perception around the world. Nature climate change. 2015; 5: 1014-1020.
7. Basu G, Mondal P, Roy SK. Health of elderly tribes: a community based clinico-epidemiological study in West Bengal, India. Int J Community Med and Public Health. 2018; 5: 970.
8. Vishnoi BR, Solanki SL, Singhal G, Meharda B, Mishra N. Morbidity profile of elderly in urban slum of Udaipur, Rajasthan. Int J Oral Health Med Res. 2015; 2: 9-12.
9. Subudhi C, Padmanaban S, George A. Health Care Support Among Elderly Triabl Women Of Paniya Tribe in Wayanad District Of Kerala, India.
10. Kim KI, Lee JH, Kim CH. Impaired health-related quality of life in elderly women is associated with multimorbidity: results from the Korean National Health and Nutrition Examination Survey. Gender Medicine. 2012; 9: 309-318.
11. Sarwari AR, Fredman L, Langenberg P, Magaziner J. Prospective study on the relation between living arrangement and change in functional health status of elderly women. Am J Epidemiol. 1998; 147: 370-378.
12. Ramanathan M, Bhavanani AB, Trakroo M. Effect of a 12-week yoga therapy program on mental health status in elderly women inmates of a hospice. International journal of yoga. 2017; 10: 24.
13. Adjaye-Gbewonyo K, Vaughan M. Reframing NCDs? An analysis of current debates. Global Health Action. 2019; 12: 1641043.
14. Assembly UG. Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases. New York: United Nations. 2018.
15. Countdown NC. NCD Countdown 2030: pathways to achieving Sustainable Development Goal target 3.4. The Lancet. 2020.
16. Zuccala E, Horton R. Reframing the NCD agenda: a matter of justice and equity. The Lancet. 2020; 396: 939-940.

Cite this article

Chhabra S (2020) Community Based Study of Magnitude of Health Problems Of Rural, Tribal, Elderly Women. Med J Obstet Gynecol 8(3): 1139.