**Original Research Article** 

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# MORBIDITY PATTERN AND HEALTH SEEKING BEHAVIOUR OF GERIATRIC PATIENTS IN BAPUBHETI GAON OF SONITPUR DISTRICT OF ASSAM, INDIA

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#### ABSTRACT

**Background:** This study aims to study the morbidity patterns and sociodemographic determinants of health care among rural elderly. **Materials and Methods:** A cross-sectional study was carried out among elderly population above 60 years of age in Bapubheti Gaon Sonitpur District of Assam, India for a period of 3 months from July to September 2024. **Result:** Out of 300 subjects, 56% were females and 63% were in age group of 60-69 years. Overall 93.3% subjects had one or more morbidities with musculoskeletal disorders being most common (57.3%) followed by visual impairment and cataract (54.0%) and hypertension (49.0%). 77.7% elderly preferred allopathic system of medicine with private facilities preferred by 40%. **Conclusion:** Morbidity load among elderly was very high and health seeking behaviour was poor.

# **INTRODUCTION**

The global population is aging at an unprecedented rate, and by 2050, the number of people aged 60 years and above is projected to reach 2.1 billion.<sup>[1]</sup> In India, the proportion of elderly citizens has been steadily increasing, and it is estimated that by 2050, the country will have 340 million people aged 60 years and above.<sup>[2]</sup> This demographic shift has significant implications for healthcare systems, as elderly individuals are more prone to chronic diseases and require specialized care.<sup>[3]</sup> In this context, understanding the morbidity pattern and health-seeking behavior of geriatric patients is essential for improving their health outcomes.

Several studies have investigated the health status and healthcare utilization patterns of geriatric patients in India. A study conducted by Chakraborty et al,<sup>[4]</sup> in Kolkata found that hypertension, diabetes, and osteoarthritis were the most prevalent health conditions among the elderly population. Another study conducted in rural Maharashtra by Madhu et al,<sup>[5]</sup> reported a high prevalence of visual impairment and hearing loss among geriatric patients. These studies highlight the need for further research on the morbidity pattern and healthcare needs of elderly individuals in different regions of India. The geriatric population defined as individuals aged 60 years and above, is growing rapidly worldwide. With this growth comes a rise in age-related illnesses and the need for specialized healthcare services for the elderly. Bapubheti Gaon, located in the Sonitpur district of India, is home to a significant number of geriatric patients. According to Census 2011 information the location code or village code of Bapu Bheti Gaon village is 286227. Bapu Bheti Gaon village is located in Tezpur subdivision of Sonitpur district in Assam, India. It is situated 25km away from Tezpur, which is both district & sub-district headquarter of Bapu Bheti Gaon village.<sup>[6]</sup>

The total geographical area of village is 171 hectares. Bapu Bheti Gaon has a total population of 1,279 peoples, out of which male population is 634 while female population is 645. Literacy rate of bapu bheti gaon village is 70.91% out of which 73.82% males and 68.06% females are literate. There are about 291 houses in bapu bheti gaon village. Pincode of bapu bheti gaon village locality is 784153.<sup>[6]</sup> Tezpur is nearest town to bapu bheti gaon village for all major economic activities.

This study aims to investigate the morbidity pattern and health-seeking behavior of these elderly patients in Bapubheti Gaon. Understanding the healthcare needs and utilization patterns of this vulnerable population is crucial for improving their health outcomes and ensuring appropriate allocation of healthcare resources. Through this study, we hope to identify gaps in the existing healthcare system and provide insights that can form some policies aimed at improving the health and well-being of geriatric patients in Bapubheti Gaon and beyond. Hence our objectives of study were to determine the prevalence of chronic diseases among elderly population and identify the types of healthcare services utilized by these individuals in this region.

# **MATERIALS AND METHODS**

**Study Design:** A cross-sectional study was carried out among elderly population above 60 years of age (both males and females) in Bapubheti Gaon Sonitpur District of Assam, India for a period of 3 months from July to September 2024.

**Sample Size:** Sample size was calculated considering prevalence of morbidity among geriatric as 9% at 3.5% absolute error and 95% confidence interval which came out to be 257.<sup>[8]</sup> After accounting for non-response and rounding off, the final sample size came out to be 300. Elderly with severe disabilities and those who did not give consent to participate in the study were excluded from the study.

Sampling Strategy and Data Collection: The sampling frame for the study was the rural field practice area of the Department of Community Medicine, and the list of elderly individuals was obtained from the records of health workers. Simple random sampling was used to select study participants. Data collection was carried out by undergraduate medical students who were trained on the study protocol. A pre-designed and pre-tested structured questionnaire was used to collect data on socio-demographic factors, morbidity status, and health-seeking behavior of the subjects. The study subjects were interviewed at their homes, and the data was collected through self-reported data on the history of illness followed by scrutiny of health records, if available. The inclusion criteria of study were age 60 years or older, permanent resident of the village and voluntary willingness to participate in the study whereas the exclusion criteria was severe disabilities that prevent participation in the study.

**Data Analysis:** The data collected from the study was analyzed using the SPSS-21 software. Descriptive statistics were used to summarize the socio-demographic variables and morbidity pattern of the study participants. Mean and standard deviation were used to describe continuous variables, and frequency and percentage were used to describe categorical variables.

Chi-square test and Student t-test were used for comparing proportions and means, respectively, between different groups. The level of significance was set at p < 0.05.

**Ethical Considerations:** The study was conducted following approval from the Institutional human Ethical Committee, Tezpur medical college and Hospital (IEC approval no.- 2024/061/TMC&H dated 22/06/2024) and informed consent was taken from study participants after explaining the objectives of the study.

# **RESULTS**

A total of 300 elderly individuals were included in the study, with 60% falling in the age group of 61-69 years, followed by 30% in the age group of 70-79 years and 11% in the age group of 80 and above. The majority of the participants were females (56%) and Hindu (96%). Regarding education, 68% of the participants were either illiterate or just literate, and only 7% had completed high school or above.

In terms of marital status, 63% of the participants were married, while 35% were widowed or widower. The majority of the participants (80%) were not working, and out of those who were employed, only 20% were currently working. About 58% of the participants were staying with their spouse and children, while 34% were staying with their children only. The rest were staying alone or with others.

More than half of the participants (56%) were not registered under any government scheme for the elderly. About 46% of the participants were partially dependent on others for their economic needs, while 36% were fully dependent.

Socio-demographic factors		n (number of study subjects)	% (Percent)
Age	60-69	180	60%
-	70-79	89	30%
	80 and above	31	10%
Sex	Male	132	44%
	Female	168	56%
Education	Illiterate/just literate	204	68%
	Primary	45	15%
	Middle school	30	10%
	High school and above	21	7%
Religion	Hindu	289	96%
-	Muslim	11	4%
Marital status	Married	189	63%
	Widow/widower	104	35%
	Divorced/living away from spouse	7	2%
Employment	Currently working	60	20%

 Table 1: Socio-demographic profile of study subjects (n=300)

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	Not working	240	80%
	Spouse only	14	5%
	Spouse and children 174	173	58%
Currently staying with	Spouse and Children	174	58%
	Children only	102	34%
	Alone	16	5%
	Others	8	3%
Registered under a government	Yes	133	44%
scheme for elderly	No	167	56%
Economic dependence	Independent	55	18%
	Partially dependent	137	46%
	Fully dependent	108	36%

Table 2: Morbidity pattern among study subjects (n=300).						
Total N (%)	Male N (%)	Female N (%)	Chi- square (P value)			
147 (49.0)	59 (19.7)	88 (29.3)	0.186			
36 (12.0)	18 (6)	18 (6)	0.439			
172 (57.3)	58 (19.3)	114 (38)	0.001**			
162 (54.0)	61 (20.3)	101 (33.7)	0.016**			
50 (16.6)	22 (7.3)	28 (9.3)	1			
39 (13)	16 (5.3)	23 (7.7)	0.688			
85 (28.3)	28 (9.3)	57 (19)	0.015**			
53(17.7)	32 (10.7)	21 (7.3)	0.008**			
20 (6.7)	8 (2.7)	12 (4)	0.709			
37 (12.4)	11 (3.7)	26 (8.7)	0.062			
	ng study subjects (n=30( Total N (%) 147 (49.0) 36 (12.0) 172 (57.3) 162 (54.0) 50 (16.6) 39 (13) 85 (28.3) 53(17.7) 20 (6.7) 37 (12.4)	ng study subjects (n=300).Total N (%)Male N (%)147 (49.0) $59 (19.7)$ 36 (12.0)18 (6)172 (57.3) $58 (19.3)$ 162 (54.0)61 (20.3)50 (16.6)22 (7.3)39 (13)16 (5.3)85 (28.3)28 (9.3)53(17.7)32 (10.7)20 (6.7)8 (2.7)37 (12.4)11 (3.7)	Image study subjects (n=300).           Total N (%)         Male N (%)         Female N (%)           147 (49.0)         59 (19.7)         88 (29.3)           36 (12.0)         18 (6)         18 (6)           172 (57.3)         58 (19.3)         114 (38)           162 (54.0)         61 (20.3)         101 (33.7)           50 (16.6)         22 (7.3)         28 (9.3)           39 (13)         16 (5.3)         23 (7.7)           85 (28.3)         28 (9.3)         57 (19)           53(17.7)         32 (10.7)         21 (7.3)           20 (6.7)         8 (2.7)         12 (4)           37 (12.4)         11 (3.7)         26 (8.7)			

P value <0.05 significant, P value <0.001 highly significant

The most prevalent morbidity was musculoskeletal problems, with 57.3% of participants reporting it, followed by eye problems at 54%. Chronic lung diseases and acid peptic disorder were also relatively common, with 17.7% and 28.3% of participants reporting them, respectively.

When looking at the distribution by sex, more females reported hypertension, musculoskeletal

problems, eye problems, and acid peptic disorder than males, although the differences were not statistically significant except for musculoskeletal problems and eye problems (p values of 0.001 and 0.016, respectively). On the other hand, more males reported senile deafness and chronic lung diseases than females, and the difference in chronic lung diseases was statistically significant (p=0.008).

Table 3: Association between morbidity pattern and age of study subjects.						
Morbidities	Total	Age groups				P value*
		61-64 (130)	65-69 (59)	70-74 (62)	75 and above (49)	
Hypertension	147	66	23	33	25	0.383
Diabetes	36	16	6	10	4	0.587
Musculoskeletal	172	81	32	34	25	0.404
problems						
Eye problems	162	59	34	39	30	0.066
Senile deafness	50	8	12	13	17	0.001**

P value <0.05 significant, P value <0.001 highly significant

For hypertension, there was no statistically significant difference in the distribution of participants across different age groups (P = 0.383). Similarly, for diabetes and musculoskeletal problems, there was no significant difference in the distribution of participants across age groups (P = 0.587 and P = 0.404, respectively).

For eye problems, there was a borderline significant difference in the distribution of participants across

age groups (P = 0.066). The highest number of participants with eye problems were in the 70-74 age group.

For senile deafness, there was a statistically significant difference in the distribution of participants across age groups ( $P = 0.001^{**}$ ). The highest number of participants with senile deafness were in the 75 and above age group.

Table 4: Association between morbidity pattern and socio-demographic variables.						
Socio-demographic variables		Ν	Mean number of morbidities±S.D.	P value		
	<70	233	2.61±1.615	0.127		
Age (years)	71-80	56	3.02±1.883			
	>80	11	3.36±2.618			
	Male	132	2.41±1.667	0.006		
Sex	Female	168	2.96±1.721			
Marital status	Married	189	2.53±1.629	0.014		
	Divorced/Widow	111	3.04±1.822			
	Illiterate	204	2.90±1.738	0.026		
Education	Primary and middle	75	2.37±1.707			

	High school and above	21	2.19±1.250	
	Independent	55	2.24±1.33	0.064
Financial Dependence	Partial dependence	137	2.78±1.67	
	Complete dependence	108	2.88±1.91	
Registered under government	Yes	133	2.89±1.68	0.109
scheme	No	167	2.57±1.74	
Insurance	Yes	22	2.55±1.37	0.628
	No	278	2.73±1.74	
Substance use	Yes	136	3.12±1.72	0.036
	No	164	2.71±1.64	

P value <0.05 significant, P value <0.001 highly significant

In this study, socio-demographic factors such as age, sex, education, marital status, financial dependence, registration under a government scheme for the elderly, insurance status, and substance use were analyzed to determine their association with the mean number of morbidities in the sample population.

The mean number of morbidities was  $2.61\pm1.615$  for those below the age of 70,  $3.02\pm1.883$  for those aged 71-80, and  $3.36\pm2.618$  for those above 80 years of age. The difference in mean number of morbidities between these age groups was not statistically significant (p=0.127).

Males had a lower mean number of morbidities  $(2.41\pm1.667)$  compared to females  $(2.96\pm1.721)$ , and this difference was statistically significant (p=0.006).

Married individuals had a lower mean number of morbidities  $(2.53\pm1.629)$  compared to those who were divorced or widowed  $(3.04\pm1.822)$ , and this difference was statistically significant (p=0.014).

Education level showed a significant association with the mean number of morbidities (p=0.026), with illiterate individuals having a higher mean number of morbidities ( $2.90\pm1.738$ ) compared to those with primary and middle school education ( $2.37\pm1.707$ ) and high school and above education ( $2.19\pm1.250$ ).

Financial dependence did not show a statistically significant association with the mean number of morbidities (p=0.064), with those who were partially dependent having a mean number of  $2.78\pm1.67$  morbidities and those who were fully dependent having a mean number of  $2.88\pm1.91$  morbidities.

Registration under a government scheme for the elderly did not show a statistically significant association with the mean number of morbidities (p=0.109), with those who were registered having a mean number of  $2.89\pm1.68$  morbidities and those who were not registered having a mean number of  $2.57\pm1.74$  morbidities.

Insurance status also did not show a statistically significant association with the mean number of morbidities (p=0.628), with those who had insurance having a mean number of  $2.55\pm1.37$  morbidities and those who did not have insurance having a mean number of  $2.73\pm1.74$  morbidities.

Substance use showed a statistically significant association with the mean number of morbidities (p=0.036), with those who reported using substances having a higher mean number of morbidities  $(3.12\pm1.72)$  compared to those who did not use substances (2.71±1.64).

Table 5: Source of treatment during minor and major illness (n = 300).						
Healthcare facility	Males (Total Females (Total number		Total (Total	%		
	number-132)(%)	168) (%)	number-300)			
Government	49 (37.12 %)	64(38.09 %)	113	37		
Private	49(37.12 %)	71(42.26 %)	120	40		
Ayush	12(9.09 %)	19(11.30 %)	31	10.3		
Home remedies and traditional healers	22(16.66 %)	14(8.33 %)	36	12		

Based on the data presented, the healthcare facility utilization among the study population was analyzed. Out of the total sample size, 37% of participants utilized government healthcare facilities, 40% utilized private healthcare facilities, 10.3% utilized Ayush healthcare facilities, and 12% utilized home remedies and traditional healers. When comparing healthcare facility utilization by gender, males and females showed similar patterns of utilization across all types of healthcare facilities.

# **DISCUSSION**

Aging is a universal phenomenon that brings with it both obstacles and opportunity for the family and society.<sup>[8]</sup> The extent of chances for the elderly and their participation in numerous activities are strongly dependent on one element, namely their health. While health is normally inversely related to age, disease prevalence and severity are directly connected to age.<sup>[9]</sup> This was demonstrated in our study, where 93.3 percent of the elderly had one or more morbidities. Our findings are comparable to those of a research conducted in rural Karnataka, where 96.3 percent of the elderly had one or more morbidities.<sup>[10]</sup> Another study conducted in Bangladesh found that 98.8 percent of the elderly were unwell. 11 Several studies conducted in various parts of India have revealed a significant frequency of morbidities in India (84 percent in Shimla, 88.9 percent in northern India, 88 percent in Varanasi).<sup>[12-14]</sup>

In our study, the mean number of morbidities was  $2.72\pm1.72$ , which is comparable to the findings of Jospeh et al, who reported a mean of  $2.4\pm1.2$  in southern India.<sup>[15]</sup> Musculoskeletal problems were the most common morbidity among the elderly, accounting for 57.3 percent of the total. Sharma et al. reported a similar conclusion in Shimla hills, that musculoskeletal issues were the most prevalent morbidity (56.5 percent).<sup>[12]</sup> Verma et al. found 59.7 percent prevalence of musculoskeletal illnesses in Allahabad district, which is similar to our findings.<sup>[16]</sup> Our findings are congruent with those of other studies conducted throughout India.<sup>[17-19]</sup>

In our study, the prevalence of hypertension was 49 percent, which is comparable to the findings of Hameed et al in Karnataka and Joseph et al in South India.<sup>[10,15]</sup> The prevalence of cataract in our study was 30%, which is similar to the findings of Sharma et al.<sup>[12]</sup> Few studies, however, have found a lower prevalence of morbidities than ours. Sudarshan et al. conducted a study in the southern rural area of Pondicherry and discovered that hypertension was widespread in 14.2 percent of individuals, arthritis in 12.3 percent of subjects, and the magnitude of other morbidities was similarly modest. 9. Air pollution has a well-known effect on a variety of acute and chronic ailments such as hypertension, chronic lung disease, vision impairment, and so on. 20 Substance abuse is also more prevalent in this area, leading to increased morbidity.

We investigated numerous factors that influence the prevalence of morbidities in the elderly. Females had a higher mean number of morbidities than males, which is consistent with prior study findings.<sup>[12,15,21]</sup> In our study, female participants had significantly more musculoskeletal issues, ocular problems, and acid peptic disorders, whereas male subjects had significantly more chronic lung diseases. Sharma et al found that females had a larger prevalence of musculoskeletal disease and males had a higher prevalence of chronic lung disease, whereas other morbidities were almost the same in both sexes.<sup>[12]</sup> Prakash et al. supported the same in their study conducted in an urban environment.<sup>[19]</sup> The elderly who were divorced or widowed, illiterate, or substance users had a greater mean number of morbidities. This finding is consistent with the findings of Sharma et al in Shimla and Shankar et al in Varanasi, which found that morbidity was higher among widowed elderly.[12,14]

In terms of health-seeking behaviour, our study found that 77.7 percent of the elderly favoured allopathic medicine (including public and private), which was similar to the findings of Sharma et al, who found an 81.2 percent prevalence.<sup>[12]</sup> The majority of the elderly favoured private healthcare facilities for their ailments, which was consistent with the findings of Narapureddy et al.<sup>[22]</sup> However, in our study, the proportion of seniors who favoured government facilities was higher, which may be related to a higher proportion of females in our study population who may utilise government services during set morning hours.

### CONCLUSION

The provided data includes information about the socio-demographic and health status of a group of elderly people. It was found that the majority of the participants were females, illiterate or just literate, and married. Most of them were not currently employed and were either partially or fully dependent on their family members. The most common morbidities observed were musculoskeletal problems, eye problems, hypertension, and acid peptic disorder.

It was also found that there was a significant difference in the mean number of morbidities among males and females, with females having a higher mean number of morbidities. Similarly, the mean number of morbidities was found to be higher among those who were divorced or widowed, illiterate, and financially dependent.

In terms of healthcare facilities, it was found that the majority of the participants visited either government or private healthcare facilities, while a small percentage relied on Ayush or home remedies and traditional healers.

Overall, the findings suggest that there is a need to focus on the healthcare needs of elderly individuals, especially females, those who are illiterate or financially dependent, and those who are divorced or widowed. Efforts should be made to provide better access to healthcare facilities, including government-sponsored schemes and private healthcare facilities. Additionally, more research is needed to understand the factors contributing to the higher prevalence of morbidities in females and how to address them effectively.

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