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Physical Activities of Daily Living of Elderly of Lalitpur (Nepal)

Archana Bista and Sarala Joshi
TU IOM Nursing Campus, Maharajgunj, Kathmandu, Nepal

ABSTRACT

In the present cross sectional survey 1178 elderly residing in their home were purposively selected. In the phase I of this study, physical activities of elderly of the sample were assessed and the factors associated with physical activities were measured. In phase II, experiences of elderly regarding physical functional activities were explored. To triangulate the findings of both phases, A convergent design (QUAN + QUAL) was adopted. The elderly were interviewed individually using a structured interview schedule (Nepali version). In phase II, hermeneutical phenomenological approach was adopted. Findings from both phases were triangulated and compared. Findings from phase I revealed that in performing basic activities 28.9 per cent elderly were fully dependent where as in performing intermediate activities 53.0 per cent elderly were fully dependent. Triangulated findings confirmed that functional limitations were mostly identified on taking bath, getting dressed, moving inside the house, using telephone, doing simple household activities, going outside the home and going for health check up were higher among increased aged, female and illiterate elderly.

Key Words: Elderly, Physical activities, Mixed Method

Recently population ageing is an emerging social issue for Nepal. Demographic trend during the year 2001 to 2010 shows that there is a

rapid growth rate of aged people (CBS Nepal, 2012). This ageing population can be viewed as a success story for the public health policies and also for socioeconomic development. But at the same time, it challenges the society to adapt and maximize the health care cost and functional capacities of older Nepalese people. Further, effect of urbanization, migration of youth to other countries and changing role of women towards activities outside the house further challenges the health care situation of elderly in our country (CBS, Nepal, 2014)

Independence of elderly can be achieved through their abilities to perform Activities of Daily Livings (ADLs). ADLs is the term used to refer to the basic daily activities of self-care of an individual such as taking bath, ability to self dress, eating, control over urination and defecation, going to toilet and moving inside house and intermediate activities which includes ability to use phone, to take self medication and to do simple house hold activities and going outside house or abilities to perform basic and intermediate activities both (Shelley, 2012). Inability to perform basic and instrumental activities of daily living is known as functional impairment which affects the wellbeing in elderly (Mohanty, *et al.,* 2012).

It is a fact that threat to functional independence in elderly arises as a result of physiological changes from the ageing process and effect of chronic diseases, psychological problems as depression and cognitive impairment which demand for long term health care cost and support from society (Hudakova, & Hornakova, 2011; Tripathi & Tripathi, 2012). Research studies have revealed that functional limitations are associated with different socio-demographic factors like increased age, female sex, illiteracy, non communicable illnesses (Duca, *et al.*, 2009; White, *et al.*, 2009; Badiger, *et al.*, 2010).

Some of the qualitative studies reflected that impairment in activities of daily living is a stressful life situation experienced by older adults which in turn affects the elderly individual's experiences of well being (Biker land & Native, 2009; Soderhamm and Soderhamm, 2009; Jancey, *et al.,* 2011;). With the help of research findings Government of Nepal can prepare for a better ageing society through enhancing functional independence among elderly. Thus, this study aimed to

assess the functional activities of daily living among elderly and to determine the factors associated with functional activities of daily living among urban elderly of Lalitpur, Nepal through mixed method.

Methodolgy

Phase 1

Sample

1178 elderly of both sexes, residing in Lalitpur sub-metropolitan city, who were getting old age allowance from related metropolitan office, were selected by purposive sampling technique for this study. Verbal consent from the participants was the criterion of selection.

Tools used

Data was collected by using pretested structured interview guideline modified in two item wise questions of Katz index of dependence in ADL in Nepali version. The basic activities were measured using a 6 item scale and intermediate activities were measured by 4 item scale. Responses were dichotomized as "unable to do performance at all as score"0, able to do with help coded as score of '1 'and able to perform independently as score of "2". A cut off score of 10 was considered as point to level dependency. The more the score obtained higher the level of independency.

Statistical Analysis

Collected date were edited and analyzed by using Statistical Package for Social Science Version (SPSS–20). Descriptive statistics were used to describe percentage, mean and standard deviation of demographical variables. For measuring association between selected demographical variables with functional abilities Pearson-chi-square test was used (Kothari, 2014).

The study was initiated from obtaining ethical approval from IRB of Institute of Medicine. This study adopted a onvergent mixed method with equal priority (QUAN + QUAL) in order to obtain breadth and depth of phenomena which was conducted in two phases

(Creswell, *et al.*, 2011). The study was conducted during the period of six months from March to July 2014.

For phase II

In phase II, hermeneutic approach was adopted (Johnson & Onwuegbuzie, 2004). From the respondents of quantitative survey, 12 elderly who gave verbal permission for further interview were included in the study on the basis of nested sampling technique.

Qualitative data was collected by researcher herself through in-depth interview method with use of an unstructured interview guideline having grand tour and probed questions (Joshi, 2008). In-depth Interview was scheduled in the mutually convenient time of the participants and researcher. Researcher conducted interviews that were audio taped. On average three to four interviews conducted with each participant lasted for 40 to 60 minutes. Privacy was maintained by interviewing in a separate room. Each interview was started with grand tour questions such as: How do you describe your functional health? What types of self care activities are you able to do at present days? Do you face any difficulties to perform your activities? Do you take any support from family members to accomplish your activities? Do you have any health issue related to functional physical activities of daily living?

Participants were encouraged to provide detailed descriptions of their experiences through active listening and sometimes repeating their last word. Before subsequent interviews, memory call was given to the participants. Interview was stopped when data saturation was achieved by the interviewer. The recorded information was downloaded to a password protected personnel computer of the researcher. Field notes were reported by the facilitator. Data were thematically analyzed by using Gibson's qualitative data analysis method in five stages and four themes were generated (Gibson, 2011). Finally, qualitative data were quantified and transformed into quantitative data in percentage and were triangulated.

Results

Table 1
Physical Functional Activities of Daily Living among Elderly

n = 1178

Level of Functional Dependency#	*Number*	*Per cent*
Dependent	699	59.4
Independent	479	40.6
Among dependent (699)		
Partially dependent	632	90.4
Fully dependent	67	9.6
Basic Activities*	Number	Per cent
Dependent	340	28.9
Independent	838	71.1
Among Dependent (340)		
Partially dependent	298	87.6
Fully dependent	42	12.4
Intermediate Activities**		
Dependent	625	53.0
Independent	553	47.0
Among Dependent (625)		
Partially dependent	526	84.1
Fully dependent	99	15.9

#Assessed by using modified Katz activities of daily living 6 basic* and 4 intermediate activities**

Table 1 shows that 59.4 per cent of the elderly were dependent in performing activities of daily living. Further, regarding performing six different basic activities 28.9 per cent of respondents were dependent Regarding performing instrumental activities 53.0 per cent were dependent among them 84.1 per cent were partially dependent who need some assistance in performing such activities and remaining 15.9 per cent were fully dependent who needed full assistance to perform these activities.

Table 2
Physical Functional Dependency in Different Activities among Elderly

Types of Activities#	*Dependent*		*Independent*	
Basic Activities	*Number*	*Per cent*	*Number*	*Per cent*
Taking bath	197	16.7	981	83.3
Mobility inside house	150	12.7	1,028	87.3
Control of urination and defecation	147	12.4	1,031	87.5
Getting Self Dress	143	12.1	1,035	87.9
Going to the toilet	123	10.4	1,055	89.6
Eating	96	8.1	1,082	91.9
Intermediate activities				
Using the phone	567	48.1	611	51.9
Doing Simple house hold Job	219	18.5	959	81.5
Going for Shopping	204	17.3	974	82.7
Taking self medication	166	14.0	1,012	85.9

Table 2 reveals that in performing six different basic activities of daily living taking bath and doing household mobility were the difficult activities. Concerning intermediate activities using phone, doing simple household activities and going outside the house were the activities in which elderly were more dependent.

Table 3
Association of Selected Demographical Variables with Functional Abilities

Variables	*Dependent (699)*	*Independent (479)*	*Total (1178)*	*P value (x2)*	*OR (95%CI)*
Age					
< 80	479	378	857	0.000*	0.582 (0.443-.763)
= 81	220	101	321		
Sex					
Female	425	250	675	0.004*	0.704 (0 .556-.890)
Male	274	229	503		
Educational Status					
Illiterate	517	266	783	0.000**	2.275 (1.777–2.912)
Literate	182	213	395		

** P value significant at < 0.01 * p value significant at # 0.05

Table 3 signifies that there is a strong statistical association between age and functional dependency with (p value 0.000, OR, 0.582 (CI 0.443-.763)). Likewise, there is a strong statistical association between educational status and functional dependency (p 0.000, OR, 2.275 (CI 1.777–2.912). Similarly, female sex had statistical association with having functional dependency with (p value 0.004, OR 0.704 (CI 0 .556-.890).

Qualitative Results (Findings of in-depth interviews)

Decreased Self Care Activities and Need for Assistance

Most of the participants (8/14) experienced partial dependency on their family members in performing some of their self care activities. Oldest old age elderly need more assistance from their family members. As they narrated: Italicized words in brackets are in local Nepali version.

> "I can dress myself slowly, my granddaughters-in-law who are living with me help me to take bath (Buharii harulee maddat garchha nuhaunna). Also they help me for walking and for getting up right position as I cannot not walk independently". Since the age of 92 my strength of doing simple household activities and doing self care activities has reduced. Two years before, I was able to make food by myself but nowadays my daughters-in-law and a female helper help me in doing these activities of daily living such as doing morning care, changing clothes and getting food cooked '(94yrs female)
>
> I am living with my daughter. My daughter is helping me to do difficult activities of daily living like washing clothes, making food, taking bath (92 yrs, female*)*
>
> "Earlier, I used to do by activities of self care but now I need help from my daughter in laws while bathing. Regarding doing all the household jobs my daughters in law are taking responsibilities for all household activities and doing accordingly " (92 yrs female).

Decreased intermediate activities

Unable to carry out some previous household activities

Participants of all age groups were unable to carry out some of their previous household activities and their hobbies which causes them distress they narrated as:

"In my previous days, I used to do to gardening a lot as it is my hobby but nowadays I get tired easily even when I do a little work of gardening which causes distress feeling (Kaam garna naseekara nyasroo lagchha) (74 yrs, female).

"Since this year, I have been feeling decreased stamina to do household activities such as cooking, washing clothes, but I have to do all as I am keeping my old mother of 92 years with me" (74 yrs female)

"I had good stamina up to 85 years. I used to carry all my goods during travel up to 84 years. Nowadays also I can go to buy goods for myself but have to leave all things in one place and need to get help of person to carry things to bring home" (86yrs female). "My working efficiency has been decreased for some years. I used to take care of my grandchildren in past days but now I cannot take care of my grand children which gives me feeling of emptiness (Natee Nateeneee harulai hyerrnaa nasakdaa naramroo llagchha) "(87 yrs female*)".*

"I cannot walk as before. When I saw you people walking, I wished if I could walk like you people. Today, I am able hardly to go for shopping in nearby places. I can walk inside the house but can not go outside the house as before" (76 yrs, female*).*

Functional Limitation to go Outside the House

I feel sad for my inability to walk around the house. Remaining in the same place every day in one flat is very much distressing. I wish I could walk around the house upstairs and downstairs so that my days would pass easily. I wish if I could walk ... (Kaam garnna napaayee panee yesoo hidna payee hunthyoo jastoo lagcchha)" (87 yrs female)

Same Participant Narrated

I feel very sad for my inability to visit my maternal house for taking part in religious activities (Yessoo daan dharma garnaa jaana koo laagi maitwee jaana man lagchha, jaana napsakdda peerlagchha. Yesoo maitee samma jaana panee sakdina)" She cried in low voice ... for short time while expressing it.

In past days, I used to walk for 1 to 2 hours but now a days I cannot walk at that level which makes me sad. "In past, I used to walk fast sometimes I attended big political rallies too. Now a days I get tired easily and feel decrease in stamina while waking vigorously (76yrs, female).

Another 87 yrs, male expressed that "Sitting idly, by not doing anything is difficult for me. Mostly I spend my time by sitting in balcony and watching television.

In some cases elderly people lost their walking capacity because of not getting safe environment to walk:"I go to the school garden nearby daily so that I can walk safely. In crowded places I am scared of getting injury from vehicles and from other people (94 yrs, female).

Using Supportive of Devices to Walk (oldest-told)

Besides this some participants of oldest-old group need to take support of assistive devices (sticks)

"I walk by using a stick. I can only walk in on flat space inside the house. It is difficult for me to walk up and down. Now a days, I take support of right hand in walking. Strength of hand has also decreased so I feel scared of going up and down as there is risk of fall injury (Haat maa pahilee jastoo bhar chhinaa tyesailee ladchhhha kee baneeraa daar lagchhaa" (87 yrs, female).

"My walking level has decreased for last 5–6 years. I can go up and down in nearby places with the help of stick but not far away places" (86 yrs male)

From the age of 85 years I have been using stick to walk around. With the help of stick, I also carry light stuffs for daily necessities" (86 yrs, female).

"I cannot walk without support. Daughters-in-law help me for walking up in right position (91 yrs, female)

"I feel scared of walking up and down as my right hand has become weaker now a days (Daayaa haath lee rammarii samunna sakdainaa). I need to take support of stick while walking up and down. I get problem of dizziness sometimes (Daar lagcchaa ladchhaki bhaneeraa) ". As I mostly get pain in extremities it is difficult for me to go up and down in house (Tala Maathii garnaa sakdainaa ekkai talla ma bashnu parchha, khutta dhukchha. Ringatta lagchhe yestaichha budeskaal...) 87 yrs female.

Par IV: Triangulation of both quantitative and qualitative data findings in Table 4.

Table 4

Triangulation of Findings: Functional Dependency

Dependency in Different Activities	*Quantitative Findings (n = 1178)*		*Qualitative Findings (n = 12)*	
	Dependent		*Dependent*	
Basic Activities	*Number*	*Per cent*	*Number*	*Per cent*
Bathing	197	16.7	4	33
Mobility inside house	150	12.7	2	16
Control over urination and defecation	147	12.4	–	–
Self Dressing	143	12.1	3	33
Going to toilet	123	10.4	1	8
Eating	96	8.1	–	–
Intermediate activities				
Using the phone	567	48.1	4	33
Doing Simple household Job	219	18.5	6	50
Going for Shopping/Moving outside house	204	17.3	7	58
Taking self medication	166	14.0	4	33
Need	–	–	6	50
Need supportive devices to walk	–	–	3	25

Table 4 from quantitative findings shows that on performing basic activities such as taking bath, going fom one place to other inside

house and changing the dress were the difficult activities. Likewise, in performing intermediate activities elderly were more dependent in using telephone and doing simple household activities and going outside the house. Beside these qualitative findings explored that going for medical checkup was the difficult task for which participants 50 per cent need assistance from family members. Some of the participants 25 per cent were using supportive devices to maintain their functional abilities. Participants need assistance in performing their activities of daily living such as going outside the house.

Discussion

Physical Functional Disabilities

Physical functional activities of daily livings (ADLs) represent the individual's functioning abilities to perform basic daily activities such as bathing, dressing, eating, toileting and moving from one place to another and individual's abilities to perform intermediate activities such as using telephone, going outside house, doing simple household jobs. Both the basic and intermediate activities are considered as determinants for enhancing quality of life of older adults (Hudakova & Hornakava, 2011; Tripathi & Tripati, 2012). Impairment in performing such activities is considered as functional disabilities.

In this study, concerning the prevalence of dependency in overall activities we investigated a quiet high prevalence of functional dependency which was 59. 4 per cent in overall activities of which dependency on intermediate activities (IADLs) was 53.0 per cent and 28.9 per cent dependency on performing basic activities of daily living.

International and National Comparison

Consistent to this study Duca, *et al.,* (2009) identified that 26.8 per cent elderly were dependent in performing their basic activities and 28.8 per cent were dependent in performing IADL. Jose *et al*., (2010) revealed that 34.6 per cent elderly were dependent for doing at least one ADL and 53.5 per cent were dependent in carrying out IADL. Barua, *et al*., (2012) revealed that 36.2 per cent had at least one or more functional impairment. The common problems were difficulties in moving one or both limbs among 42.5 per cent and difficulties in adjusting with physical environment was among 32.9 per cent elderly.

In Nepal, Chalise (2012) found that among less age group elderly functional difficulties in performing one basic activity of daily living was 8.1 per cent and intermediate activities of daily living was 32.8 per cent while it was identified more (12. 8%) in basic activities dependency and 38.2 per cent in intermediate activities among elderly with age 65 years and above. Regarding item wise dependency taking bath, eating, control over urination and regarding intermediate activities transportation, meal preparation were identified difficult activities on which elderly were more dependent.

Different from these findings study by Dolai and Chakrabati (2013) observed that elderly dependent in doing IADL were 83.9 per cent and dependent in doing basic activities were 32.9 per cent. These differences might be due to difference in scale of measurement. Previous researchers used Lawton IADL assessing sale for measuring functional disability. Hairi, *et al.,* (2010) among Malasyian elderly found that functional limitation in performing ten different activities was only 26 per cent among elderly of 75 years and above. This varied results might be due to use of different tool. The earlier researcher had used Barthel Index of 10-item questions for measuring activities.

Also Kumar, *et al.*, (2015) found that among elderly living in a slum of Delhi, elderly of age 60 years and above were able to walk around independently. These differences in result might be due to differences in age group of the elderly included in different studies.

This study found that concerning the dependency in performing basic item wise activities as taking bath and self grooming were the most difficult activities. Regarding the dependency in performing basic item wise activities using the telephone and doing simple household activities were the most difficult activities. Consistent to this, study by Rajapakse *et al*., (2012) among Srilankan elderly identified that bathing and going outside for shopping were the most difficult activities for elderly. Study by Chalise (2012) among 509 Nepalese elderly revealed that elderly with advanced age needed more assistance in performing instrumental activities than basic activities. Item wise activities score showed that on basic activities bathing was the most common difficult activity in which old age people needed assistance while for intermediate activities going to shop and doing simple household activities were most difficult activities in which

elderly were mostly dependent. Similarly, Sekhon and Minhas (2015) showed that both basic and intermediate activities dependency level increased with higher age.

Association of Socio-demographic Variables with Functional Disabilities

In the present study functional disabilities was significantly associated with increased age (p = 0.000), educational status (p= 0.000, OR 95% CI, 2.275 (1.777–2.912), female sex (p = 0.000).

Consistent with this findings, Jose *et al*., (2009) among 598 elderly revealed that 53.5 per cent were dependent for performing at leastsone activity of daily living and dependency was higher among increased age (p= 0.000, OR 3.458), female (p= 0.001, OR 2.458). Similarly, Barua *et al*., (2011) revealed that prevalence of functional impairment was found to be significantly higher with increased (p = 0.009). Mohanty *et al*., (2012) observed that there was a significant decline in the capacity to perform instrumental activities among older adults with age of 80 years and above (p = 0.001). Barua, *et al.*, (2011) found that Intermediate activities significantly predicted wellbeing in increase older age group (p < 0.001). Logistic regression analysis revealed that age of 74 years onwards, presence of two to three chronic illnesses and having accidents were independently associated with functional impairment.

Another study by Badiger, *et al.,* (2010) determined that age had reverse effect in functional abilities ($ = –2.316, p value = 0.000 and income level with ($ = 8.997, p= 0.002) and significant relationship with functional abilities. Hudakova and Hornakava (2011) identified positive relationship between activity of daily living mobility and WHO QOL-BREf with (r=–0.785). Hiriel *et al*., (2010) found the variables independently associated with 10 different item ADL were advance age (above 75 years prevalence ratio (PR) 3.0; 95% CI 1.7–5.2), female sex (PR 2.7; 95% CI 1.2–6.1), presence of arthritis (PR 1.6; 95% CI 1.2–2.1) and depressive symptoms (PR 2.0; 95% CI 1.5–2.7). Jose (2010) found significant association between increased age (OR=1.10) with functional dependency and female gender with functional dependency (OR=1.10). Feng *et al*., (2011) identified that number of

chronic disease, self related health status, cognitive function and environment independently contributed to functional disability.

In addition, Mohanty, *et al.,* (2012) revealed that intermediate activities level was poor among higher age group above 80 years with (p value= .001) and the intermediate activities of daily living significantly predicted well being among older age group (above 80 years) with the adjusted R^2 of .540, $p < .001$ and the adjusted R^2 in less age group of 65 years to 80 years was only .022. Barua, *et al.*, (2012) found that increased age above 75 years and above (x^2 for linear trend = 10.9, p= 0.002) were independently associated with functional impairment. Wanderer, *et al.,* (2014) found increased age had association with functional disability.

Qualitative Reflections

We explored that unable to carry out some household activities as earlier, functional limitation to go outside the house, uses of supportive devices to walk, getting help from their family members for increasing motilities and in performing basic activities related to self care were emerged theme which was common among higher age elderly.

Similar to this result the findings by Birkeland and Natvig (2009) showed that sitting inside home is the main activity for most of the elderly as they were not able to walk more than a few minutes. Some elderly were using wheel chairs. The activity they can perform are mainly indoor activities like reading, solving crossword, puzzles, listening to music, knitting, and watching television. Likewise, a study by Grundberg, *et al.,* (2011) found decreased mobility led to strong dependence on others and inability to maintain the home environment. Impairment in activities of daily living is an experience of stressful life situation common among elderly which adversely affects the well being of elderly. Further, desire to walk as before was identified as a perceived factor to prevent loneliness.

In contrast Soderhamm, *et al.,* (2010) identified that most of elderly of 65 above age were maintaining their self-care such as maintenance of balance between activity and rest, social interaction and managing their other basic activities. These discrepancies might be due to variation in age group in different studies.

We found that some elderly people lose their walking capacity because of not getting safe environment to walk. Similar findings by Elo, *et al.*, (2010) which depicted that an environment that enables safe activity comprises both safety at home and immediate surroundings that enables safe mobility. Pleasant environment consists of tidiness at home and natural environment like parks and gardens in nearby places for social interaction. Likewise, qualitative study by Sundsli, *et al.*, (2013) found that elderly participants who experienced limitation in hearing and impaired balance chose an easier walking route, more gentle exercise or adjustment of their speed according to their physical capacity.

In our study pain in calf region, pain in extremities and joints, fear of falling while climbing were the factors that hinder functional abilities. Similarly, a study by Jancey *et al.,* (2009) emerged that role of pai management as crucial perceived enablers for promoting physical activities among elderly and they desire to engage in less age appropriate physical activities. In addition, Mathews *et al*., (2013) depicted the need of social support as enabling factor for promoting physical activity and fear of falling and incontinence were barriers which decrease functional abilities.

Conclusion

Physical-functional disability was higher among Nepalese elderly than those of other developed countries. Elderly with increased age, female and illiterate were more functionally dependent. Elderly with less age need assistance to perform intermediate activities while elderly with advanced age need assistance even to perform some self-care activities such as getting dressed and taking bath. Elderly are maintaining their functional status by getting assistance from family members and by using supportive devices like support of sticks. Also the need of safe and pleasant environment was highlighted as enabling factors to promote functional abilities. Thus, based on these findings of mixed method there should be provision of enhancing mobility level of elderly in their home environment through provision of assistive devices and safe environment. And family members need to be encouraged in care of elderly through national policies.

Implications of Study

The findings of this study might be informative to health policy makers to develop new policy to increase functional activity for elderly in home settings in local context. Also the future researcher can get insight for conducting Mixed Method research in health field concerning geriatric people.

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State Boredom and Emotion Regulation among the Institutionalised Elderly

Deepa M Rasquinha, and Priyanka Bantwal
Department of Psychology,
St. Agnes Centre for Postgraduate Studies and Research, Mangalore–575002

ABSTRACT

The present study was planned to assess the relationship between State Boredom and Emotion Regulation among the 50 institutionalised, literate elderly persons of 60 years and above, from Mangalore city. Multidimensional State Boredom Scale (MSBS) and Cognitive Emotion Regulation Questionnaire (CERQ) were administered individually. The data was statistically analysed using Pearson's Correlation. The study revealed as disengagement increases, the institutionalised elderly increasingly attribute the cause of their disengagement on others. Elders experience inattention, which comes in way of using adaptive strategies like Refocus on Planning, Positive Reappraisal and Putting into Perspective dimensions. As the elders perceive the time to pass slow, their natural ability to think positive or attribute time in positive ways is reduced.

Key words: State Boredom, Cognitive Emotion Regulation and Institutionalised Elderly

Boredom can be viewed as a lived experience, an aversive state that is characterised by feelings of dissatisfaction, weariness and restlessness. It can also be viewed as the unfulfilled desire for satisfying activity; it can occur in anyone who has too much time and too little meaning or purpose in their life. Chronic boredom can lead to restlessness, feelings of worthlessness, and even a belief that life is no longer worth living, and emerging evidence suggests that it puts people

at greater risk for depression. It is seen to be something that is both negative and unpleasant in nature. When an individual is bored, they may experience a host of emotional states like being angry, anxious, irritable, and frustrated. Not all experience all of it, but it definitely to some degree adds up to the emotional experience of boredom.

Elderly are prone to experience boredom because of various kinds of physical, psychological, emotional, social and financial problems they face when they hit their later years of life, which can come in way of them attaining optimal or successful ageing.

Emotion regulation skills develop over the course of an individual's life. Poor emotion regulation skill (called emotional dysregulation) is viewed as a core feature of emotional problems and maladjustment. Emotion Regulation has an adaptive functioning that is crucial for a healthy physical and mental well being. The elderly in institutions have concerns like being deserted by their primary social supports, territorial concerns, narrating old miseries over and over again, feelings over insecurity coupled with the already age-related problems.

One of the first theorists to feature Emotion Regulation was Carstensen (1993), whose Socio emotional Selectivity Theory (SST) postulates that shrinking time horizons in older age prompt a greater emphasis on Emotion Regulation. It has always had an adaptive functioning that can be seen to be crucial for a healthy physical and mental well being.

Review of Literature

Smith *et al*., (1990) conducted a prospective study of 81 independently living elderly. Canonical Correlation analysis was used to examine the relationship between coping factors and health status measures. Correlation of 0.53 (28% of variance) indicated that those who responded to stressful life events with self-blame, wishful thinking, and avoidance tended to be more symptomatic four months later. In a regressiNn analysis, avoidant coping significantly contributed to the prediction of psychological disturbance at the time of the second interview. These results were consistent with the notion that coping strategies modulate the influence of life events on health and well-being.

Slama and Bergman (2000) concluded in their study that lack of companionship, no opportunity to care for others, and little variety result in the problems of loneliness, helplessness, and boredom for many nursing home residents.

Gross and Urry (2010) in their research paper highlighted that one possible reason for some elderly to experience much more enhanced sense of well being despite these losses than do younger adult is Emotion Regulation. Enhanced emotion regulation would be consistent with the increased positive and decreased negative emotion reported by older adults.

Sharma *et al.,* (2014) conducted a study to assess the geriatric problems among the inmates of old age home. The data were generated by using structured interview schedule; random sampling technique was adopted to select 50 subjects. He found that almost 22 per cent have mild psychological problems, 54 per cent have moderate psychological problems and 24 per cent have severe psychological problems indicating overall presence of geriatric problems.

Objectives

1. To assess state boredom among the institutionalised elderly
2. To assess the relationship between State Boredom and Emotion Regulation among the institutionalised elderly
3. To assess the relationship between dimensions of State Boredom and dimensions of Emotion Regulation among institutionalised elderly

Hypotheses

1. There is a significant relationship between State Boredom and Emotion Regulation among the Institutionalised Elderly
2. There is a significant relationship between the dimensions of State Boredom and dimensions of Emotion Regulation among the Institutionalised Elderly

Method

Sample

The sample consisted of 50 literate institutionalized elderly, who were above the age of 60 years living in old age homes, free from any form of psychological disturbances but have lost their partners were taken for the study.

Tools used

Multidimensional State Boredom Scale (Fahlman, et al., 2008)

It is the only and first full scale measurement measure of state boredom, designed to measure the experience of boredom itself and be

unrestricted by particular context of the participants. It is a 29 item scale with 5 sub dimensions: Disengagement, Agitated Affect, Dysphoric Affect, Inattention and Time Perception. It is a 7 point Likert scale. All items are positively scored. Both dimension based as well as total scores are attained. Test has good internal consistency reliability for all the five sub scales (0.80 to 0.88) and 0.94 for the full scale. Convergent and criterion validity is well established.

Cognitive Emotion Regulation Questionaire (Garnefski, Nadia Kraaij, Vivan and Spinhoven P., 2002)

Nine strategies were developed and distinguished within the CERQ on theoretical and empirical bases; each referring to what someone thinks after the experience of threatening or stressful events. These are Self-blame, Other-blame, Rumination or focus on thought, Catastrophizing, Putting into perspective, Positive refocusing, Positive reappraisal, Acceptance and Refocus on planning. It is 5 point Likert scale. The higher scores on a dimension indicate greater likelihood for the individual to use the style of cognitive emotion regulation. Test has an internal consistencies ranging from 0.68 to 0.83 and Cronbach's alpha exceeding 0.80. Test-retest correlations ranged between 0.40 and 0.60 reflecting moderately stable styles.

Procedure

The participants were selected only after getting their consent to participate in the study and they were provided with information about the nature and purpose of the study. The scales were administered to the elderly as per the instructions in the manual individually. The administration of the scales took an average of 25 minutes for each individual.

Results and Discussion

Table 1

Pearson's Correlation Coefficient between State Boredom and Emotion Regulation among the Institutionalised Elderly

Variable	Emotion Regulation
State Boredom	0.085 NS

NS: Not Significant

Table 1 represents the correlation coefficient between the two independent variables of the study: State Boredom and Emotion Regulation. The obtained correlation is 0.085 which is not significant. Hence the hypothesis stating that State Boredom and Emotion Regulation are related is rejected. Since, the scale used for assessing Emotion Regulation has both adaptive and non adaptive styles; the results could imply that the Institutionalised Elderly could be employing more non adaptive coping styles than adaptive ones to cope with State Boredom. Also, this could be because of the multidimensionality of the concept i.e. State Boredom not only being an emotion, but also having a perceptions, affect, cognitions, and attribution components to it.

Table 2

Pearson's Correlation Coefficient of the 5 sub scales of State Boredom wit 9 Dimensions of Emotion Regulation among Institutionalised Elderly

Dimensions of Emotion Regulation	*Dimensions of State Boredom*				
	Diseng-agement	*Agitated Affect*	*Inattention*	*Dysphoric Affect*	*Time perception*
Self Blame	0.22 NS	0.07 NS	–0.02 NS	–0.04 NS	–0.12 NS
Acceptance	0.14 NS	0.008 NS	–0.22 NS	0.09 NS	–0.26 NS
Rumination	0.23 NS	–0.06 NS	0.08 NS	0.16 NS	0.13 NS
Positive Refocusing	0.26 NS	0.04 NS	–0.01 NS	–0.02 NS	–0.13 NS
Refocus on Planning	0.18 NS	–0.03 NS	–0.301*	0.07 NS	–0.26 NS
Positive Reappraisal	0.03 NS	–0.11 NS	–0340*	0.03 NS	–0.37**
Putting into Perspective	0.20 NS	0.12 NS	–0.314*	0.04 NS	–0.13 NS
Catastrophizing	0.19 NS	–0.02 NS	–0.04 NS	–0.009 NS	0.01 NS
Other Blame	0.43**	0.22 NS	0.01 NS	0.19 NS	0.18 NS

NS: Not significant; *p < .05; **p < .01

From the table it can be seen that the Disengagement dimension was having positive correlation with the Other Blame dimension indicating that maybe when the institutionalised elderly experiences disengagement, they tend to engage in using other blame, a form of maladaptive strategy i.e. they tend to put up the cause of their disengagement on other people.

Inattention dimension displayed negative correlation with Refocus on planning, Positive Reappraisal and Putting into Perspective, indicating that when the elderly experiences in attention, they do not engage in any of the three strategies. In boredom,

inattention goes beyond the normal concept of difficulty in concentrating on the current activity. Leary *et al.,* (1986) stated inattention in boredom occurs when an individual must exert concerted efforts to maintain their attention on a particular stimulus. Rather than switching one's attention when a stimulus is not 'intrinsically captivating', the individual continues to attend it and thus becomes bored. The results of the current study imply that when experiencing inattention, the institutionalized elderly are not in the state to attribute a positive meaning to the event/situation at hand or look at its positive sides. Their routine, monotonous schedule and lack of adequate stimulation in the institutions could be a reason that stops them from playing down the seriousness of the event or even take steps to deal with the event or change the situation

Time perception had negative correlation with Positive reappraisal i.e. when time is perceived to move more slowly institutionalised elderly find it difficult to find any positive meaning in the event that can foster personal growth. As the elders perceive the time to pass slow, their natural ability to think positive or attribute time in positive ways are affected.

Findings

1. As disengagement increases, the institutionalised elderly increasingly attribute the cause of their disengagement on others.
2. As the elders perceive the time to pass slow, their natural ability to think positive or attribute time in positive ways is reduced.
3. As inattention increases, institutionalized elderly's ability to look at the situation positively, tone down the seriousness when compared to others or take steps to deal with the event diminishes.

Implications

The current research adds to the existing wealth of research on this aspect. The findings of the study highlight the fact that elderly in the institutions are not employing adaptive strategies to regulate the effects of boredom that in turn is leading to a negative impact on the Mental Health of the elderly. Individual and Group Counselling targeted at it, along with framing policies and devising of programs in the old age homes for tackling the issues of disengagement, agitated affect and time perception among the Institutionalised Elderly would be useful.

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Gender, Quality of Life and Perceived Social Support among Rural Elderly Population: A Study from Sonitpur District, Assam

Arif Ali and Pallavi Kwan Hazarika

Department of Psychiatric Social Work,
LGB Regional Institute of Mental Health, Tezpur (Assam)

ABSTRACT

The present cross-sectional study, aimed to examine the gender differences in quality of life and perceived social support among 104 elderly people (male =48, female=56) in age group of 60 years and above, selected from two villages in Tezpur, Sonitpur district of Assam. Socio-demographic data sheet, Multidimensional scale of perceived social support and World Health Organization Quality of Life Scale (WHOQOL-BREF) were administered to the respondent's. The findings of study revealed that significant gender difference was not found in the domain of physical health, psychological, social relationships and environment in quality of life of elderly population. An independent samples t test indicated that the scores on family social support were significantly higher for the female elderly (M=20.64, SD=4.07) than the male elderly respondents (M=17.04, SD= 5.97), t=3.454, p=.001. Female elderly scored higher in friends social support (M=21.45, SD= 4.30) than the male elderly respondents (M=17.07, SD= 5.31), t=2.670, p=.001. In the domain of significant other female scored higher (M=21.14, SD= 4.37) than the male elderly (M=17.68, SD= 5.706), t=3.33, p=.000. The findings of the study shows that significant gender difference was not found in domain of physical health, psychological, social relationships and environment domain of

quality of life (WHOQOL scale) among male and female elderly population. On the basis of the results obtained it can be said that the female elderly respondents were having better perceived social support than the male elderly population and significant gender differences were found in all the domain of multidimensional scale of perceived social support scale.

Keys words: Elderly, Quality of Life, Perceived Social Support

The World Health Organization (WHO) defines Quality of life (QOL) as, "An individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives. It is a broad ranging concept, incorporating in a complex way the person's physical health, psychological state, and level of independence, social relationships, and their relationship to salient features of their environment". Quality of life and social support is widely accepted as an indicator of successful ageing, and it is monitored as a means of measuring the effectiveness of social policies, welfare programmes, and health care programme. Disparity in Quality of life (QOL) among elderly male and female has been revealed by various researchers (Barua *et al*., 2005; Campos, *et al.*, 2014; Hsu, 2005; Mrus *et al.,* 2005; Murtagh and Hubert, 2004; Widar, *et al.,* 2004). It is important to differentiate between the elderly males and females in the rural population as gender is powerful factor which affects QOL at all stages of life.

Social support has been shown to have health benefits for elderly population. Reduced social support, can affect the physical and mental health of the elderly people (Iliffe *et al.,* 2007; White, *et al.*, 2009; Bisconti & Bergeman, 1999; Holt, 2010; Costa, *et al.,* 2011). Gender differences have been found in social support across the elderly population (Simon, *et al.*, 2014; Shye *et al*., 1995; Paskulin, & Vianna, 2007; Vaux, 1985; Antonucci & Akiyama, 1987). It is generally viewed that during old age there is gradual shrinking of the social network and decreasing social support. Because social support is associated with a subsequent, physical and psychological change in the elderly, it is important to assess the gender difference for understanding and strengthening the social network and enhancing support.

Understanding of gender differences is especially important to know in the rural areas because of the various health issues linked with elderly population. In India not many health facilities are available in rural areas for elderly population, social care and welfare provision are lacking. The available literature indicates that hardly any effort is made to understand the gender difference in quality of life and perceived social support among elderly people, especially in north eastern part of India.

Aim and Objective of the Study

The purpose of the present study was to examine the gender differences in quality of life and perceived social support among elderly population.

Method

Research Design

For the present cross-sectional community based study 104 elderly persons (male = 48 and female = 56) in age group of 60 years and above, who are permanent members of their respective household of Ranga Pukri Para and Dekargoan village of Tezpur, Sonitpur district of Assam were selected for the present study. There was 1,490 adult population in the electorate list in both the villages. Out of these 1,490 persons there were only 104 people of age 60 and above in the electorate list.

Tools for Data Collection

Socio-demographic data sheet: Relevant socio-demographic details were collected using this pro forma. It consists of age, gender, education, marital status, religion, community, occupation, family type, socioeconomic status.

Mini-Mental State Examination (MMSE): The Mini-Mental State Examination (MMSE) is a rating of cognitive function and takes 10 minutes to administer by a trained interviewer (Folstein *et al.*, 1975). The MMSE test includes simple questions and problems in a number of areas: the time and place of the test, repeating lists of words, arithmetic such as the serial sevens, language use and comprehension, and basic motor skills.

Multidimensional Scale of Perceived Social Support (Ziimet, *et al.*, 1988): It is a 12 item scale, divides perceived social support from family members, friends, and from Significant Others. Norms for the general population have been published with higher scores indicating more social support. Its internal consistency reliability is .88.

World Health Organization Quality of Life Scale (WHOQOL-BREF) (The WHOQOL Group, 1998): WHOQOL-BREF is a short version of WHOQOL – 100. It has been developed and field – tested in 15 centers all over the world including New Delhi and Chennai. WHOQOL – BREF is available in 19 different languages. The WHOQOL – BREF looks at 4 domain level profiles, using data from the pilot WHOQOL assessment. The WHOQOL – BREF contains a total of 26 questions. There are 4 domains in WHOQOL – BREF. Domain 1 is regarding "Physical health", domain 2 is concerned with the "Psychological aspect", domain 3 is about "Social relationship" and domain 4 is concerned with questions regarding "the environment ".

Process of Data Collection

Informed consent was taken from the respondents before eliciting relevant information. The nature and purpose of the study was explained. Firstly respondents were interviewed and assessed with the help of socio-demographic data sheet. Thereafter, Mini-Mental State Examination (MMSE) was administered to rule out severe behavioral or cognitive impairment. Those subjects who score positive in MMSE were excluded from the study. Those respondents who score negative in MMSE were administered, perceived social support scale and WHO QOL scale.

Statistical Analysis

Data was coded and entered into a master chart. With the help of SPSS 16 data was analyzed. Frequencies and percentages, Mean, standard deviation, chi square and independent sample "t" test (two tailed) were carried out.

Table 1
Gender Distribution

Variables		*N=104*	*Percentage*
Gender	Male	48	46.2
	Female	56	53.8

The table (1) shows the gender distribution of the respondents. In the total population of 104, 46 per cent were male and 56 per cent were female.

Table 2
Gender Difference in Age

Variables	*Male*		*Female*		*df*	*t*	*P*
Age	*Mean*	*SD*	*Mean*	*SD*			
	66.60	2.76	65.19	3.01	94	2.39	.714

M=mean, SD = standard deviation, df = degree freedom

The table (2) shows the gender comparisons in the age. An independent samples t test indicated there was no significant difference in the age in male (M=66.60, SD=2.76) and female (M=65.19, SD=3.01), t=2.39, P= .714, elderly respondents.

Table 3
Socio Demographic Profiles

Variables		*Male N=48*	*Female N=56*	*df*	*x2*	*P (significance level)*
Education	Illiterate	16(33.3%)	27(48.2%)			
	Primary	12(25%)	18(32.1%)			
	Secondary	9(18.8%)	8(14.3%)	4	9.156	.057
	Graduate	8(16.7%)	2(3.6%)			
	Post graduates	3(6.2%)	1(1.8%)			
Marital status	Married	48(100 %)	41(73.2%)	1	15.02	.000
	Widow	0	15(26.8%)			
Community	Assamese	46(95.8 %)	55(98.2 %)			
	Bengali	1(2.1%)	1(1.8 %)	2	1.194	.551
	Nepali	1(2.1 %)	0			

Contd...

Contd...

Occupation	House wife	0	44(78.6 %)			
	Agriculture worker unskilled or semi skilled	24(50 %)	0	3	77.03	.000
	Retired person	18(37.5 %)	4(7.1 %)			
	Others	6(12.5 %)	8(14.3 %)			
Family type	Nuclear	44(91.6 %)	39(69.6 %)	1	77.7	.005
	Joint	4(8.3 %)	17(30.4 %)			
Socio economic status	Low middle	11(22.9 %)	34(60.7 %)			
	Upper middle	37(77%)	21(37.5 %)	2	16.65	.001
	Upper	0	1(1.8 %)			

df= degree of freedom, x^2= chi square

The table (3) shows gender comparisons in the socio demographic characteristics of the respondents. In education 33.3 per cent of male respondents were illiterate, 25 per cent were educated up to primary level, 18.8 per cent were educated up to secondary level, 16.7 per cent were educated up to graduation level and 6.2 per cent were educated up to post graduation level, while in female 48.2 per cent were illiterate, 32 per cent were educated up to primary level, 14.3 per cent were educated up to secondary level, 3.6 per cent were graduate and 1.8 per cent were educated up to post graduates level. In the study it was found that all the male respondents were married, while among female respondents 73.2 per cent were married and 26.8 per cent were widows. In occupation 50 per cent of male respondents were engaged as agriculture worker unskilled or semi skilled and 37.5 per cent of them were retired persons and 12.5 per cent were engaged in some other occupation (owning their own shops, teas stall, involved in social work activity). In the study 78.6 per cent of female respondents were house wives. In both the groups majority of the respondents belonged to Assamese community. When chi square was computed, significant difference was found between male & female elderly population in terms of marital status (x^2=15.02, p=.000), Occupation (x^2 = 77.03, p = .000), Family type (x^2 = 77.7, p = .005) and Socio economic status (x^2 = 16.65, p = .001).

Table 4
Gender Difference in Domain of Quality of Life (WHOQOL-BREF)

Variables Domain of quality of life	*Male*		*Female*		*df*	*t*	*P (significance level)*
	Mean	*SD*	*Mean*	*SD*			
Physical health	21.77	3.6	23.41	3.9	94	2.12	.656
Psychological	19.08	3.4	19.58	3.2	94	.724	.564
Social relationships	10.25	2.7	11.29	2.5	94	1.95	.596
Environment	24.72	4.7	25.6	5.3	94	.881	.259

M = mean, SD = standard deviation, df = degree freedom

Table (4) shows the gender difference between the domains of Quality of life (WHOQOL-BREF), independent t-test was applied to find out the significant difference between two groups. Significant gender difference was not found in domain of physical health, psychological, social relationships and environment in quality of life. However the mean score suggested that females were having a better quality of life in the domain of physical, social relationship and in environment.

Table 5
Gender Difference in Domain of Multidimensional Scale of Perceived Social Support Scale

Variables Domain of perceived social support	*Male*		*Female*		*df*	*t*	*P (significance level)*
	Mean	*SD*	*Mean*	*SD*			
Family social support	17.04	5.97	20.64	4.07	94	3.454	.001
Friends social support	17.07	5.31	21.45	4.30	94	2.670	.001
Significant others	17.68	5.706	21.14	4.37	94	3.333	.000

M = mean, SD = standard deviation, df = degree freedom

The table (5) shows the gender comparisons in the domain of perceived social support. An independent samples t test indicated that the scores on family social support domain were significantly higher for the female elderly (M = 20.64, SD = 4.07) than the male elderly respondents (M = 17.04, SD = 5.97), t = 3.454, p = .001. Female elderly scored higher in the domain of friends social support (M = 21.45, SD =

4.30) than the male elderly respondents (M=17.07, SD= 5.31), t=2.670, p=.001. In the domain of significant others female scored higher (M=21.14, SD= 4.37) than the male elderly (M=17.68, SD= 5.706), t=3.33, p=.000). On the basis of the results obtained it can be said that the female elderly respondents were having better perceived social support than that of the male elderly population.

Discussion

Quality of life in elderly population can be affected by many environmental and social factors (poor economic condition/poverty, cultural, educational and health care conditions, inadequate social interactions, breakdown in family values and the family support system, economic insecurity and social isolation). In the present study significant gender difference was not found in domain of physical health, psychological, social relationships and environment domain of quality of life (WHOQOL scale). Similar finding was reported by Barua *et al*., (2005) in a study on assessment of the domains of quality of life in the geriatric population. The results of their study shows that the total means score as well as the mean scores in each of the four domains for both men and women were found to be similar. The difference between the two groups was not found to be statistically significant for any of the four domains. Khaje-Bishak, *et al.,* (2014) also reported that there was no significant difference between gender and age variables with total score in the quality of life.

In the present study it was found that the scores on family social support, friend's social support and in significant other domain of perceived social support were higher in female as compared to males and significant gender difference was found in all the domain of perceived social support. Research in social support in elderly population has reported that gender differences have been found in social support. Research studies have reported that Social connectedness varies across the gender and other demographic variables (Simon, *et al.*, 2014; Shye *et al.*, 1995; Paskulin, & Vianna, 2007; Vaux, 1985, Antonucci & Akiyama,. 1987). Shye *et al*., (1995) in a 15 year follow-up study of elderly reported that network size affected men's mortality risk indirectly, through their health status, while no such indirect effect was found for women. Women have

larger and more varied social networks with more friends and mor social support than men. They stated the need for a gender-specific approach to measure variables that capture the different meaning and value of social network participation for men and women. Antonucci & Akiyama (1987) in their study on an examination of sex differences in social support among older men and women reported that men tend to maintain intimate relationships with only a few people, while women identify more people as being important to them or as people they care about.

There were certain limitation in the present study. The findings of the present study cannot be generalized to the entire population; as the sample size was small and was restricted to only two villages, Secondly the use of only rural population included in the present study was another limitation and thirdly only quality of life and social support was assessed, variables like family functioning and home environment should have been added for better generalization of results.

Conclusion

The present study shows that significant difference was not found in domain of physical health, psychological, social relationships and environment domain of quality of life (WHOQOL scale) among male and female elderly population. The scores on family social support, friends' social support and significant other social support were higher in female as compare to males and significant difference was found in all the domain of perceived social support. There is need to develop strategies for the implementation of various psycho social care programmes for the elderly population for enhancing well being and support system in the rural areas.

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Understanding the Life Course through Newspaper Obituaries

Ajani Oludele Albert, Adegoke Anthony and Adisa Ademola Lateef*
Department of Sociology and Anthropology,
Obafemi Awolowo University, Ile Ife, Nigeria,
*Department of Psychology, Obafemi Awolowo University, Ile Ife, Nigeria

ABSTRACT

Obituaries are known to be one of the most frequently read sections of daily newspapers. They announce the passage of persons of diverse backgrounds to the generality of the public. As they announce deaths, obituaries also give an insight into the shape and cultural interpretation of life and death. In this paper, the authors have examined a sample of obituaries drawn from three Nigerian newspapers (The Punch, Guardian and Nigerian Tribune) from 2002 to 2008. This study opines that the data provided by these publications was beyond the ordinary communication that a death has occurred for the living; they reaffirm what is important to a society in terms of life accomplishments and why certain cultural practices are normatively legitimate for a particular period in history. In addition, it analyzes obituaries as an expression of a cultural blueprint of attitudes, values and ideals of a society.

Key words: Obituaries, Newspapers, Death, Media representation, Cultural analysis, Life accomplishments.

Obituaries in print media are yet to become a universal ritual; they remain a practice mostly among the educated and other elites who can afford the charges on this service by media owners, especially

in developing countries. However, obituaries in a way immortalize the dead when they are documented and published by the print media. Most cultures in Africa have had their indigenous ways of announcing the passage of their loved ones. Most times these might be dictated by a number of factors, namely: religion, ethnicity, occupation, and social status. For instance, among the Yoruba people of southwestern Nigeria, the way the death of a king is announced is different from that of a hunter/warrior. Sometimes it may involve only the initiated and not the general public in the first instance. This is to enable the observance of certain rituals before the announcement is made a public knowledge. In the recent times, there was an outright condemnation of the instant announcement by a London hospital of the passage of a prominent traditional ruler from the southwestern region of Nigeria. By implication, the aura of respect for occupants of some key traditional positions does not depart even in death.

By almost universal common consent, death has a bad reputation and words like awful and catastrophic are practically synonymous with it (Dunn, 2000; Shneidman, 2007). With the negative identity of death and inability of humanity to mitigate its ultimate occurrence, this phenomenon has remained an essential condition of life. Mcllwain (nd) stated that death is a counter-pole of life and a fundamental aspect of culture and communication; and, life is meaningful only in the face of death. He opined that the transcultural nature of death makes it the most significant life experience that which happens to everyone regardless of race, class, culture, nationality or any other means by which we distinguish ourselves one from the other. However, obituaries while conveying some images of the life course, may contain soothing words that give encouragement, hope of reunion in world yonder, and so on (Dunn, 2000; Bytheway, *et al.,* 1996).

This study is motivated by three factors. First is the import of funerary rituals such as obituaries in the understanding of society. Obituaries as a form of biography provide both objective factual information and subjective view of the writer. In spite of the universal nature of death, the behaviours associated with expressing grief and funerary rites are culture bound. All cultures, whether western, Asian or African, have developed practices to cope with death in a respectful manner. Funerary rituals include the announcement of death, treatment of the corpse for immediate or later burial and specific

observances following the deposition. While some of these practices present some similarities, there are variations across cultures. Funerary rites or burial traditions are often guided by religious beliefs, norms and values of societies, which are not stagnant but subject to change over time. However, knowledge of burial traditions is capable of providing an alternative source of useful information about life or living. Cohen (nd) opined that the analysis of mortuary practices provides rich data on the behavior of kin and community as it leads to people's notion of gods, souls, witches, spirits and after worlds; promises access to their belief and value systems; the conceptions of the social and moral worlds; and informs that ritual has consequences for both the individuals and society".

The second motivation for this study was the fact that media representations and interpretations of dying, death and bereavement draw upon and shape societal understandings of these related phenomena (David and Tony, 2003). As obituaries report deaths, they provide a valuable opportunity to reflect upon popular perceptions of the association between age, health and death in later life (Bytheway and Johnson, 1996). David and Tony (2003), contradicted the commonly held belief that death is hidden from public view, relegated to the side-wards and the widow's private emotions. They stated that although death may be hidden in some arenas, it is dominant in the mass media. The two most dominant channels through which death is presented in the public space through the mass media are obituaries and remembrance of deaths, and they structure how we think about the life course.

Obituary and remembrance of deaths are two popular sections in many local and national dailies. While announcing the passage of an individual, they are repertoires on views on death and dying within a given culture. Obituaries constitute a hybrid genre in which both information and publicity coexist, type of discourse halfway between truth and an exaggerated display of the virtues of the deceased or the grief of surviving members (Fernandez, 2007). In line with this definition, Hernando (2001) distinguished between two types of obituaries: informative, that is, those obituaries whose aim is the transmission of relevant details about the death, the deceased or the place and time of the funeral; and opinative, that is, personal and intimate notices devoted to produce a particular effect on the readers

by stressing the social status, virtues or religious fervour of the deceased.

Fernandez (2007) suggested that informative obituaries tend to be objective, impersonal and highly standardized. The editorial staff member in charge of writing it does not resort to hyperbolic or figurative language to portray emotions, provide any relief or praised the deceased whatsoever. By contrast opinative obituary usually written by relatives, friends or the funeral home staff offer a more emotive and intimate account of the deceased by means of consolatory and laudatory tactics used to compliment the departed and, in so doing satisfy the surviving family members. From the second type of obituaries it can be affirmed that obituaries are a common and popular way of honouring and remembering those who have died (Bytheway, *et al.*, 1996). The content of an obituary serves a function for the dead and the living. It reports the outcome of the negotiation of identity between the individual and society by reporting what is considered to be important about the life of the decedent. In the opinion of Moses and Marelli (2004), obituary reflects the belief system of those who compose them and influence the thinking of those who read them.

The social experience of death, and in turn the construction and presentation of obituaries do change overtime. These issues and many others have featured prominently in several works on obituaries such as those of Phillips, 2007; Moses and Morelli, 2004; and Fernandez, 2007. These authors presented obituaries as an expression of cultural blueprint, of attitudes, values and ideals which an individual learns as a member of society. Hence, if the attitudes and practices that surround death change, the presentation of death will also change in these rituals.

Though the history of obituary and remembrance dates back to the colonial era and the introduction of print and media technology in Nigeria, the practice has become an integral part of death ritual. Whether printed and pasted on walls in public places or published in newspapers, aired on radio or television, they announce the passage of an individual to the masses and transmit useful information about a people. This study opines that the data provided by these publications are beyond the ordinary communication that a death has occurred for the living, they reaffirm what is important to a society and why certain cultural practices are normatively legitimate for a particular

period in history. It analyzes obituaries as an expression of a cultural blueprint of attitudes, values and ideals of a society.

Theories on the Media's Impact

The role and influence of the media has featured prominently over time in sociological theory. Sociological thinking about the relationship between media contents and the audience has developed from simple models of cause and effect to the general consensus that the media reflect, draw upon the society, and shape societal understandings of social phenomena.

Method

The present study was based on a sample of fifty obituaries selected from three Nigerian national newspapers: The Punch, The Nigerian Tribune and The Guardian, for a period of seven years (2002 to 2008). A thematic content analysis was done with a view to relating meanings to the content of obituaries as a reflection of their social context and the various images of the life course that are conveyed in published obituaries.

Results

The qualitative data from the study were analyzed under ten interrelated themes, namely: captions, life accomplishments, causes of death, funeral programme, religion, survivors, announcers, emotional expressions, age and gender differentials in obituaries. These themes were captured with a view to understanding obituaries as an expression of cultural blueprint of attitudes, values and ideals of a society.

Captions

One common feature of obituaries in the selected newspapers were captions in the announcement of death. Majority of the obituaries came under various captions such as 'call to glory', 'adieu', 'we mourn your loss', 'transition to glory', 'celebration of life', 'a glorious exit', 'final demise of a great gem', 'gone too soon', and 'a fulfilment of life'. These captions also varied by the ages of the deceased; where the deceased were aged 65 and above, the captions included: 'call to glory', 'celebration of life', and 'a glorious exit'. These obituaries present a society that mourns and celebrates older persons in death. Conversely,

those who died 'prematurely' (below 30 years) the captions such as 'gone too soon, 'adieu' and 'we mourn your loss' indicate an expression of sorrow and disappointment. For the older decedent, the captions presented an expression of joy, and appreciation of joyful and meaningful life lived by the dead. Age at death is important in the way the dead is mourned in the Nigerian society. In addition, many of the captions are indicative of a strong belief in life after death. They expressed a form of continuity beyond this life.

Christianity and Islam are the major religions practiced by most Nigerians. Though there exist pockets of traditional religion worshippers. Christianity was the religion of the majority (over 90%) of the dead in the data while less than 10 per cent were Muslims. The burial practice of the moslems does not allow for elaborate preparations and delay like the Christians. According to the Prophet Mohammed (SAW), Muslim Ummah should not waste time on three things which are *salat*, marriage and burying of the dead. Hence, the dead is buried immediately death is confirmed. This partly explains the paucity of obituaries of dead moslems in the sampled newspapers.

Causes of Death

In most of the obituaries, the cause of death is not usually stated. All that was reported in most of the obituaries was death 'after a brief illness'. Only a case of death resulting from cardiac arrest was reported in the sample. In many African societies, the cause of death is usually omitted in death announcement. This may not be unconnected with the popular belief that the surviving family members may have to contend with social stigma if the cause of death is reported, especially if the cause of death is an illness believed to be hereditary in nature. In addition, certain types of deaths are seen as 'bad'. These include deaths as a result of suicide or chronic diseases like cancer, diabetics, and mental illness. Hence, writers of obituaries in the study location omit this aspect in order to prevent possible psychological humiliation that may accrue to family members of the dead if the cause of death is stated. Also, citing negative information about the dead is often frowned at in many cultures. There is often the tendency to omit any negative information for the dignity of the dead, and his or her survivors. The dead is assumed to have been well behaved; no complain; no fuss.

Life Accomplishments

Based on people's cultural and religious background, there are certain accomplishments that are expected for a life to be seen as a success. Obituaries in the data record life accomplishments. Secular and religious accomplishments constitute most reported in obituaries. Majority of the dead were reported to have been religious leader, headmaster, judge, custom officer, professor, chief, politician, trader, farmer, legal practitioner, traditional ruler, and mother. In many instances, the picture of the deceased in the regalia office constitute the only picture in many obituaries. It can be inferred that in contemporary Nigeria these life accomplishments are highly valued; they are parts of the story and source of pride for the living. Obituaries as a component of funerary rites provide a channel for family members to demonstrate the social, religious, political and economic accomplishments of the deceased; and by extension, a sense of pride and joy for the survivors. These information could be a source of personal, social and religious aspirations for the living.

Interment Place and Time

Place of interment refers to where the dead are buried. From the analysis it is observed that there is high preference for the dead to be buried in their homes while a few people were buried in public and private cemeteries owned by churches and private organizations. This affirms the persistence of an age old African practice of burying the dead in private residences despite the existence of a law against the practice in Nigeria. In many Nigerian cities, provision of public cemetery is still a rare social infrastructure. The time of interment for the Muslim, is usually short and immediate irrespective of the age of the deceased. But for the Christian, especially when the dead is above 70 years, the remains may be kept in the mortuary until funeral arrangements are completed by the family members.

Funeral Programmes

The data also indicate the number of days for funeral rites. It is observed that apart from the variation by religion, the number of days used in celebrating the dead vary by the age and the socio-economic status of the dead and/or the family. For most of the obituaries, the funeral program indicate a minimum of one day and maximum of 8 days depending on the position of the deceased in the society. One key

observation is the mixture of both religious and secular activities in the funeral programs. While many of the programs might commence with religious activities, they often conclude with a reception and entertainment of guests.

Announcers

From the data, the announcements of death of persons who were 65 years and above were usually done by their family while 30 years and below were done by their friends or employers. In other instances, obituaries of holders of public offices were placed by political party, social clubs or town unions. The death of a former deputy governor of cross river state was announced by the governor, a farmer by his son, legal practitioner by family. There is only a record which indicated the wife as the announcer of the sudden death of her husband. Sudden deaths were announced by committee of friends, institution, or organization they worked for.

Emotional Expression

Majority of the obituaries are filled with words of emotion. Though the death of an aged person is presented with mild emotional outbursts by the writers of the obituaries, the death of a young person is reported with strong words of sorrow, regrets and pain. What can be inferred from this is that death at old age is more tolerated and celebrated by the living than death in younger years. This indicates that despite the inevitability of death, its social acceptability is dependent on the age at death.

Conclusion

The inevitability and the universality of death make its study or things relating to it a veritable source of information on culture and communication. Contrary to the commonly held belief that death is hidden from public view, obituary announcements remain the most dominant channels of presentation in the mass media. Obituaries as part of the mourning process truly present life in death. They go beyond a simple announcement of death to include information about the socio-economic status of the deceased and/or his survivors. Obituary announcements represent an alternative data source on a people's perceptions of life, death and dying, and derive their meanings from the socio-cultural codes of traditions, beliefs, religions

and such other practices. Their presentations cover achievements from birth till death, the inevitability of death and the beliefs about the continuity of life after death. However, the practice of not to speak ill of the dead (which is prevalent in many cultures) presents a major limitation to the effective utilization of the data source in cultural analysis. This is evident in our study as no single obituary announcement detailed any wrong doing of the deceased. Nevertheless our findings have helped to understand that obituaries can be a useful tool for tracking societal norms and values in the face of rapid societal transformation.

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Physical and Mental Activity, Self Acceptance of Ageing as Correlates to Social Supports among Older Men and Women

Lalitha, K. and Bharath Arun
Department of Psychology, Yogi Vemana University, Kadapa–516003

ABSTRACT

Social supports play an important role in our day-to-day life. They are considered to be one of the markers of successful ageing. The present study was aimed to study the social supports in 120 older men and women and to see its association with other psychological aspects like physical and mental activity, self acceptance of ageing and other sub-variables. Results indicate that there are sub-group differences with regard to social supports and physical and mental activity and self acceptance of ageing. The results are discussed in the light of elder-care policy issues.

Key word: Social support, Physical and Mental activity, Gender differences

Ageing is an inevitable stage that all roles go through just like any other stage; this is also one that has several social aspects. Ageing takes place within a social context. At each phase of human cycle, the individual belongs to a variety of kinship and social groups. The social role played by older people reveals their self-worth and assurance in life. The extent to which an older person is enmeshed within a social network of kin, friends and neighbours greatly affect their experience of aging. This is critical issue in gerontology that needs to be studied at

personal levels. Optimization of the role of informal social supports from family, friends and detours emerged as an important social public priority.

The social support and physical health are two very important factors that help the overall well-being of the individual. The benefit of social support for individuals confronted with life crises has been the subject of research for more than two decades. A general theory that has been drawn from many researchers' postulations is that social support essentially predicts the outcome of physical and mental health for everyone. It was found that having contacts with children was important for well-being and understanding qualities of social ties helped clarify social involvements (Ward, 1984). Hawley and Klaukave (1988) study showed that subjects satisfied with interpersonal relationships were more satisfied and engaged in more healthful practices than subjects who were not satisfied. Social participation is shown to have a strong effect on mortality and loneliness affects chronic disease, functional status and self-rated health (Sugisawa *et al.,* 1994). Bowling (1994) contends that there is a fairly strong empirical evidence of relationship between social support network structure and health status, mobility and risk of entry into institutional care. Barrett (1999) examined the role of social support measured as presence of a confident, perceived social support and frequency of formal interaction in determining life satisfaction among the never married and results indicate that age moderates the effects of marital status on social support.

The review reveals that there are many studies carried out on social supports related to variables like family supports (Dak, 1991; Desai & Naik, 1971; Bali, 1996); well being and depression in institutionalized elderly (Chadha, 1989); Social support network (Chadha *et al*., 1990); health status (Sharma, 1971; Sharma, 2000); quality of life (Chadha *et al*., 1991; Easwaramoorthy & Chadha, 1997, 1999; Jamuna *et al*., 1999); memory (Pershad, 1979; Lalitha, 2000); loneliness (Patel, 1998; Prakash, 2003); spirituality (Rastogi, 1996); life satisfaction (Chadha & Aggarwal, 1990; Vijayasree, 1998), etc., there is a paucity of studies on social supports and its relationship with self-acceptance of ageing and physical and mental activity.

The present study was planned with the following objectives:

1. To examine the social supports among older men and women.
2. To assess physical and mental activity among older men and women.
3. To assess the self-acceptance of ageing among older men and women.
4. To find out the association between social supports and other sub-group variables

Sample of the Study

Table 1
Socio-Demographic Details of the Sample

S. No.	*Variable*	*Subgroups*	*N*	*%*
1.	Gender	Female	60	50
		male	60	50
2.	Age	60–70	96	80
		70+	24	20
3.	Work	Organized	60	50
		unorganized	60	50
4.	Economical Status	Low middle	108	90
		middle	12	10
5.	Number of Children	2	20	16.6
		3	24	20
		4	28	23.3
		5	18	15
		6	18	15
		7	10	8.3
		No children	2	1.66

Table.1 shows the socio-demographic details of the sample. From the table, it is clear that gender was equally distributed in the sample. 80 per cent of the sample belongs to 60–70 years of age group. And 50 per cent of them from organized and remaining from the unorganized sector. The no. of children to the subjects shows that 60 per cent of them are having 2 to 4 children and remaining subjects are having more than four children.

Tools

The Social Supports Inventory (Jamuna & Ramamurti, 1991) which consists of 36 statements with three response categories was used to examine the social supports among aged. The Physical and

Mental activity scale (Jamuna *et al*., 1999) which consists of 5 statements with five categories of responses was used to assess the physical and mental activity levels of the sample. Self-acceptance of ageing scale (Jamuna *et al*., 1999) which consists of 10 items with three categories of responses was used to examine the perceptions related to ageing of the subject. A personal data sheet also used to get information on socio-demographic details of the subject.

Procedure

The subjects are those who crossed 60 years of life living in the community along with their kith and kin. All the subjects were individually contacted by taking prior permission and the selected tools were distributed and explained the significance of the study. Generally they took 45 minutes to 1 hr. to complete the inventories. After collecting the inventories the responses are scored accordingly.

Results and Discussion

Firstly, results related to social supports were analyzed. From the data it is clear that social supports are better in those who are 65+, the male, those who are in the organized and those who belonged to low middle income group than others. The age–wise differences were significant and no significant differences were found based on gender, job and economic status wise.

Table 2

Shows Social Supports among Different Subgroups

S. No	*Sub-groups*	*N*	*Means*	*S.D*	*'T' value*
1.	**Age groups**				
	60–70	96	68.17	10.8	3.082**
	70+	24	64.69	9.17	
2.	**Gender**				
	Male	60	61.63	8.60	1.07
	Female	60	60.33	10.10	
3.	Job				
	Organized	60	65.43	12.76	0.298
	Un organized	60	64.52	8.89	
4.	Economic status	108	65.70	10.23	0.724
	Low middle Middle	12	63.00	9.12	

** Significant @0.01 level

Table 3
Per cent of Major Supports as Reported by Men and Women

S. No.	*Type of supports*	*Men (%)*	*Women (%)*
1.	Family supports	21	41
2.	Economic supports	44	18
3.	Traditional supports	17	20
4.	Custom supports	8	12
5.	Health & Disability supports	10	9

When the analysis was made with regard to the per cent of supports reported by men and women, it shows that men are having good economic supports (44%) and family supports (21%) compared to other supports where as women are having good family supports (41%) and traditional supports (20%) compared to other supports.

Table 4
Shows Self-acceptance of Ageing (SAA) in Different Sub-Groups

S. No.	*Sub-groups*	*N*	*Mean*	*S.D*	*"t"*
1.	**Gender**				
	Male	96	18.20	3.02	3.08**
	Female	24	20.73	3.89	
2.	**Age**				
	60–70	60	19.25	3.47	1.07
	70+	60	20.33	4.47	
3.	**Work**				
	Organized	60	19.14	2.71	0.29
	Unorganized	60	18.75	3.51	
4.	**Economic Status**				
	Low middle	108	19.30	3.6	0.66
	Middle	12	20.71	4.1	

** Significant @0.01 level

The results related to self acceptance of ageing were analyzed. From the data it is clear that the female, the subjects who crossed 65+, those who worked in organized sector and those who belonged to middle income group are having better self-acceptance of ageing and the gender wise differences were statistically significant. In other sub-groups no significant differences were found.

Further analysis related to physical and mental activity shows that there are significant gender-wise differences with regard to physical and mental activity (t=2.07*). Other sub-groups did not differ significantly with regard to physical and mental activity (age (t=1.07); work (t=0.33); economic status (t=0.06)). But it is good in the female subjects (M=14.53), those who are 65+ yrs., (t=14.58) are having better physical and mental activity compared to others.

Table 5

Shows Physical and Mental Activity (PMA) in different sub-Groups

S. No.	*Sub Groups*	*N*	*Mean*	*SD*	*'t' Values*
1.	**Gender**				
	Male	96	13.07	2.083	
	Female	24	14.53	3.267	2.07**
2.	**Age**				
	60–70	60	13.60	2.456	1.07
	70+	60	14.58	3.988	
3.	**Work**				
	Organized	60	13.48	1.778	0.33
	Unorganized	60	13.72	3.011	
4.	**Economic status**				
	Middle	108	13.43	1.51	0.06
	Low middle	12	13.85	2.951	

** Significant @ 0.01 level

Table 6

Shows Correlation Matrix of Social Supports with other Variables

S. No.	*Socio-demographic Variable*	*Social Support*
1.	Age	.139
2.	Gender	.375**
3.	Job	.056
4.	Economical status	–087
5.	No. of children	.036
	Psychological Variables	
6.	Physical and Mental activity	.352**
7.	Self Acceptance of Ageing	.196

Further analysis was carried out to see the association between social supports and sub group variables (see table–6). From the table it

is clear that among the socio-demographic variables gender is significantly correlated with social supports (r=0.375) whereas no significant association was found between social supports and age (r=.139), job (r=056), economic status (r=.087) and no of children (r=.036) among the psychological variables physical and mental activity was significantly correlated (r=.352*) and no significant association between social supports and self-acceptance of ageing (r=0.196) was found. From the above data, it is clear that the subjects who are having good physical and mental activities in their day to day life are maintain good social supports.

Important findings and Implications

Results of the present study shows that there are significant gender differences with regard to social supports. The social supports are better in the age group of 60–70, males, organized sector and in the subjects of low middle than others. Data clearly shows that older men are having good economic supports and family supports compared to other supports where as older women are having good family supports and traditional supports compared to other supports. There are significant gender differences in the self-acceptance of ageing, i.e., the male and female accept the aging in different ways. The subjects in the age–group of 60 to 70 yrs., female subjects reported good physical and mental activity than other sub groups. The data related to correlation shows that variables like gender and physical and mental activity is significantly associated with social supports. The study implies that self-acceptance of ageing is an important factor for successful ageing but it is not correlated significantly with social supports whereas physical and mental activity is significantly correlated to social supports indicates the importance of social supports in maintaining well-being in the later years of life.

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Functional Competence among the Chakhesang Elders

Sezolu Khamu and B.T. Langstieh,
Department of Anthropology, North-Eastern Hill University, Shillong, Meghalaya–793022

ABSTRACT

This paper presents a study on the functional competence among the free-dwelling elderly Chakhesang population living in the rural areas of Phek district, Nagaland, India. The total sample size was 912 (425 men and 487 women), with ages between 60–101 years. Primary data was collected by using a interview schedule containing questions related to functional health which included Activities of Daily Living, (ADL), information on dental health and sensory tests. The Katz Index of Independence in Activities of Daily Living (ADL) describes the common activities of dressing, bathing, eating, toileting, transferring from bed to chair, and walking across a small room. The findings revealed that the Chakhesang elders were highly functional in their autonomy. It was also found that there was no significant difference in the functional ability between the men and the women ($\chi^2 = 4.403$, p. 0.05). Among the reported incompetence in Activities of Daily Living, the most common problem was that of urinary incontinence. With regard to sensory impairments, it was revealed that elders complained more of visual impairment (57%) as compared to hearing impairment (37.4%). With regard to vision impairment, more women (61.4%) complained of impaired vision as compared to men (52.0%). Hearing impairment was recorded at 35.5 per cent among men and 39.0 per cent among the women.

Regarding the dental health, majority of the elders had partial dentition (44.5%) while a lesser percentage (33.2%) reported as having complete dentition. Women respondents reported more dental problems than the men.

Keywords: Chakhesang, Elderly, Functional competence

Functional autonomy is a core condition of successful ageing. Functional competence is usually conceptualised as the ability to have self-care, self-management and to carry out physical activities of daily living without support (Chilima, 2000; Subramanyam, 2011). It can be described as a combination of the overall impact of medical conditions, lifestyle and age-related physiological changes in the context of the environment and social support system (Suthers & Seeman, 2004). Functional incompetence includes visual impairment, hearing impairment, poor mobility, speech and difficulty in chewing. It should be distinguished from disability, such that older adults may have difficulty performing specific physical tasks, yet experience no interference in their daily life (Ibid.). The functional health status of the elderly is intricately dependent on many factors including mental health status, physical health status, ability to perform basic daily activities, locomotor status, cognitive status, social support status, ability to cope with the life situation and proper use of leisure time. Functional ability declines with advancing age (Chilima, 2000).

However, the degree of functionality is wide and ill-defined ranging from 'maintenance of life' to 'socio-economic productivity', thus there is always an ambiguity about the definition of the term 'functionality' between its medical and social usage (Dey, 2009). Preserving functional ability is of particular importance as continued participation of elderly people in the daily life of the household will depend on their level of functional ability. It may also affect the way they are treated and respected (Manandhar, 1995). Thus, understanding the mechanisms behind the maintenance of functional ability, and devising strategies to preserve it for as long as possible, will have a beneficial impact on millions of elderly people and their families in a number of physical, economic, social and emotional ways (Ibid).

One of the best ways to evaluate the health status of older adults is through functional assessment which provides objective data that may indicate future decline or improvement in health status (Wallace & Shelkey, 2007). Compared to the other functionalities, prevalence of visual impairment is found to be the most common (Miller *et al*., 2000; Goswami *et al*., 2005; Sengupta *et al*., 2007; Dey, 2009). Changes in vision can cause a significant number of problems for elderly patients, including an increased risk of falls which is a common chance event/accident among the aged. Hearing loss is another common problem of the elderly which results in the inability to interpret speech, which can lead to a decreased ability to communicate and a subsequent increased risk of social isolation and depression (Miller *et al*., 2000). Hearing loss in the elderly can also adversely affect physical, emotional and cognitive well-being. Male elderly surpasses female elderly even in visual and hearing levels (Swain, 2007) as well as the mobility levels (Sithara & Devi, 2010). In his study among the older citizens of Delhi, Dey (2009) found out that the determinants of functionality included age, gender, marital status, chronic illnesses, SES, nutritional status, depression, lifestyle and access to health care. Sensory deprivation is a serious impediment to the older person's ability to respond and navigate the environment and in an emergency situation; a safe and secure environment can potentially become confusing and threatening (Fee *et al*., 2004). Overall functional impairments contribute to falls in elderly.

There are also associations between oral health, general health and well being of older people (Tirth *et al*., 2012). Teeth are essential for the proper mastication of food, and much flatulence and dyspepsia in the older person can be corrected by obtaining properly fitted dentures (Becker, 1959). Moreover, oral health problems can hinder a person's ability to be free of pain and discomfort to maintain a satisfying and nutritious diet, and to enjoy interpersonal relationships and a positive self-image (Tirth *et al*., 2012). A possible cause of indigestion among the aged, apart from faulty food and insufficient intake of fluid, would be their incapacity to chew food properly (Dzüvichü, 2005). As such, oral health problems, whether from missing teeth, generalised attrition, ill-fitting dentures, cavities, gum disease, or any infection,

can cause difficulty in eating and can force people to adjust the quality, consistency, and balance of their diet (Tirth *et al*., 2012).

Materials and Methods

Sample

912 (425 men and 487 women) rural Chakhesang elders who were 60 years and over were selected using purposive sampling for this study. The Fieldwork was undertaken in 20 Chakhesang villages under Phek district, Nagaland, viz., Enhulumi, Chizami, Kami, Khezhakeno, K. Basa, K. Bawe, Lekromi, Lasumi, Leshemi, Losami, Mesulumi, Pfutseromi, Phusachodu, Phuyoba, Rihuba, Sakraba, Thenyizu, Thetsumi, Thipuzu, and Zapami. The respondents were mentally receptive and willing to participate in the study. Almost all the aged individuals had no official record of their birth date; hence the age was estimated by matching recall of particular historical events. The arrival of the Japanese army to the area during World War-II (April, 1944) was most often used as the point of reference.

Tools used in data Collection

1. Data on Functional Health (Katz Index of Independence in Activities of Daily Living, ADL): One of the first self-report measures of functional competence/ability was developed by Katz and colleagues (1970), to reflect difficulties in performing what were referred to as 'Activities of Daily Living'. The Katz Index primarily contains six questions (dressing, bathing, eating, toileting, transferring from bed to chair, walking across a small room) and the participants were asked to report on their basic functional abilities. The information was collected in terms of dichotomous as yes/no responses. The scorings are classified as-

   2 points = Severe Functional Impairment

   4 points = Moderate Impairment

   6 points = Full Function

2. Sensory Tests-Vision and Hearing: Vision was tested by a finger counting method that has a cut-off point at finger counting less than one metre while hearing was evaluated by whispering test (Clausen *et al*., 2000).

3. Dental Health: Dental health of the elders was also collected based on the number of teeth still intact. Those who still had a complete set of teeth were categorised as possessing a 'Complete dentition'; set of teeth which are below half of the total dentition (i.e., ?16), were categorised as 'Partial dentition'; 'Worn out' where the root is intact and the crown is worn out and 'Dentures' for those who were using dentures.

Results and Discussion

Functional Health or Competence as discussed here under the following categories of Activities of Daily Living, Hearing and Vision or Sightedness and Dental Health.

Table 1

Activities of Daily Living (ADL) in the Present Study

Activities of Daily Living	*Chakhesang (n=912)*					
	Men (n=425)	*%*	*Women (n=487)*	*%*	*Total*	*%*
Severe Functional Impairment (=2)	1	0.2	1	0.2	2	0.2
Moderate Impairment (=4)	1	0.2	6	1.2	7	0.8
Full Function (=6)	423	99.5	480	98.6	903	99.0

With regard to Katz Index of Independence in Activities of Daily Living (ADL) which describes the common activities of dressing, bathing, eating, toileting, transferring from bed to chair, walking across a small room, etc., it was found that the Chakhesang elders were highly functional in their autonomy. It was found that there was no significant difference in the functional ability between the men and the women ($\chi^2 = 4.403$, p. 0.05). It was found that only a negligible percentage of the elders belonged to either category of severe and moderate functional impairment which were 0.2 per cent and 0.8 per cent respectively. With regard to age and functional impairment, a negative correlation was observed between age and functional competence, that with the increase in age, a decrease in ADL score was recorded ($r = -0.097$, p. 0.01). On the whole, the sample representation from the Chakhesang elders seems to indicate that it is a healthy elderly population with 99.0 per cent elders reporting to be fully functional and independent in their daily activities.

Table 2
Details of the Activities of Daily Living (ADL) among the Chakhesang elders

Activities of Daily Living	*Bathing*	*Dressing*	*Toileting*	*Transferring*	*Continence*	*Feeding*
Men (n=34)	4	1	4	1	23	1
%	11.8	2.9	11.8	2.9	67.6	2.9
Women (n=36)	5	1	7	3	20	0
%	13.9	2.8	19.4	8.3	55.6	0

Among the reported incompetence in Activities of Daily Living, the most common problem was that of urinary incontinence, with men reporting at 67.6 per cent and women at 55.6 per cent, followed by problem with toileting and bathing. Issues with dressing and transferring were less reported while, problem with feeding was least reported.

Table 3
Sensory Test Response on Vision and Hearing Impairment in the Present Study

Sensory Tests	*Chakhesang (n=912)*		
	Men (n=425)	*Women (n=487)*	*Total*
Vision Impairment	221	299	520
%	52.0	61.4	57.0
Hearing Impairment	151	190	341
%	35.5	39.0	37.4

Among the sensory impairments, it was revealed that elders complained more of visual impairment (57%) as compared to hearing impairment (37.4%). With regard to vision impairment, more women (61.4%) complained of impaired vision as compared to men (52.0%), the difference in the level of association being significant ($\chi^2 = 8.176$, p. 0.01). Hearing impairment was recorded at 35.5 per cent among men and 39.0 per cent among the women and the difference between gender was not significant ($\chi^2 = 1.177$, p. 0.05).

Table 4
Dental health among the Chakhesang Elders in the Present Study

Dental Health	*Chakhesang (n=912)*		
	Men (n=425)	*Women (n=487)*	*Total*
Complete dentition	173	130	303
%	40.7	26.7	33.2
Partial dentition	168	238	406
%	39.5	48.9	44.5
Worn out	55	92	147
%	12.9	18.9	16.1
Dentures	29	27	56
%	6.8	5.5	6.1

Table 4 shows the report on the dental health of the Chakhesang elders. The reports revealed that majority of the elders have partial dentition (44.5%) while a lesser percentage (33.2%) reported as having complete dentition, with women reporting more of dental problems. Also, 16.1 per cent of the elders were seen to have worn out dentition with only remnants of teeth left. A slightly lesser percentage of the elders reported using dentures. The difference in the level of association between the men and the women was significant ($\chi^2=23.449$, p. 0.001), with women complaining of more dental problems.

Comparing the present study with available data on other reported studies, ADL score of men and women shows that distinctly more number of women showed reduced ADL score. ADL score is related to age, in both men and women.

In the present study, more women than men complained of vision impairment among the Chakhesang elders as well as hearing impairment. Similar findings were reported by earlier studies carried out by Gupta *et al.*, 2009; Sithara & Devi, 2010; Balamurugan & Ramathirtham, 2012; Ghosh & Singh, 2014, etc., where more women reported to have difficulty in vision as well as in hearing. Choudhary *et al.,* (2013) found that the major geriatric problem reported was that of visual problem which was reported at 65 per cent.

Table 5
Comparison of the Present Study with Data on other Studies with Respect to Vision and Hearing Impairment among the Aged

Area of Study	*Vision Impairment (%)*	*Hearing Impairment (%)*	*Reference*
Rural	57	37.4	Chakhesang
	29.05	19.63	Gupta et al., 2009
	34.1	23.5	Balamurugan & Ramathirtham, 2012
	30.0	40.52	Dzüvichü, 2005
Urban	11	11	Moharana et al., 2008
	42.7	...	Bhatt et al., 2011
	65	22	Choudhary et al., 2013
Multi-centric	54.01	...	Padda et al., 1998
	23	2.25	Sithara & Devi, 2010
	73.33	63.33	Ghosh & Singh, 2014

Among the sensory impairments, it was revealed that elders complained more of visual impairment (57%) as compared to hearing impairment (37.4%) in the present study. Similar results were also reported by Dey (2009) where it was found that visual disability was the most frequently perceived disability, followed by difficulty in chewing, walking and hearing in that order. Padda *et al.*, (1998) found visual impairment among 54.01 per cent of the elders in a study in Amritsar. In another study by Ghosh & Singh (2014) among the rural community, visual impairment was found among 73.33 per cent and hearing declination among 63.33 per cent of the elders, the results of which are diametrical to those carried out by Dzüvichü (2005) among the Angami Nagas, which revealed that the major complaint was that of 'hard of hearing' (40.52%) followed by impaired eyesight (30.0%). In a study by Moharana *et al.,* (2008), equal percentages of elders (11%) complained of visual problems and impaired hearing. However, in the present study, it was observed that most of the elders did not bother to use spectacles, hearing aids or dentures. They considered these incompetences as natural processes of growing old. Likewise, in 2005, Dzüvichü reported that impaired vision and hearing were common complaints among the Angami elderly but it didn't seem to bother them much since they could continue with their daily chores without using hearing aids or spectacles.

In a study by Gupta *et al.,* (2009), dental problem was found to be the commonest reported problem among 40.83 per cent rural elders in Rajasthan. Krall *et al.,* (1998) studied the effects of the number of teeth, denture type and masticatory function on nutrient intake in elderly men. They found that nutrient intake progressively decreased with impaired dentition independent of age, smoking status and alcohol intake. In addition, the dietary deficiencies were inversely related with masticatory function.

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Gender Disparity of Ageing Process in Bangladesh: An Assessment through Decomposing Life Expectancy

M. Taj Uddin, M. Nazrul Islam, A. Kabir and M. Kamal Hossain[1]

Department of Statistics, Shahjalal University of Science and Technology, Bangladesh
[1]Department of Statistics, Bangabandhu Shekh Mujibur Rahman Science and Technology University, Bangladesh

ABSTRACT

The average life expectancy in developed and developing countries has been increasing dramatically. This gain can be attributed to the significant decrease in childhood mortality. The aim of this study was to investigate the sex differences in aeging process by Arriga's method of decomposing life expectancy at birth in Bangladesh during 1986 and 2010. For this, the life table data of Bangladesh population was considered. The result shows that the life expectancy at birth has increased remarkably between these two periods. The infant group contributes the highest to increase life expectancy at birth where the elderly population contributes the least. This contribution is not gender neutral as the female contribution is higher than male especially at the old age group.

Keywords: Life expectancy, Decomposing method, Peak ageing, Gender disparity

One of the most notable achievements of modern societies is a large rise in human longevity. The causes of this massive increment of

life expectancy include the declining pattern of mortality, improvements in standards of living, nutrition and education, implementation of wide-ranging public health measures and more effective and accessible medical care (Riley, 2001). Life expectancy has increased steadily all over the world during the last century. However, this considerable improvement has been unequal between men and women. Women live longer than men with functional limitations (Belon *et al.,* 2014). Nevertheless, the female advantage in life expectancy does not necessarily mean that women are healthier than men. Studies using self-reported health status measures indicate higher prevalence of functional limitations and poor health among women, suggesting that the additional years may not necessarily be lived in healthy conditions (Zunzunegui *et al.,* 2009).

The Life expectancy at birth is frequently used as a measure of mortality of a population. It is also used for assessing trends in mortality and trends in mortality differentials. The relationship between mortality and expectation of life is essentially reciprocal (Pollard, 1982). Life expectancy at birth has varied strikingly over the last 50 years for few countries of the world. It is 75 years in developed countries and 51 years in sub-Saharan Africa (PRB, 2001). A study conducted by Trovato and Odynak (2011) to investigate the sex difference in life expectancy in Canada found that females enjoy the higher life expectancy than male. They also observed that Immigrants in Canada have a higher life expectancy than their Canadian-born counterparts. Immigrants in Canada have a smaller sex differential in life expectancy than the Canadian born.

Decomposition methods are about breaking down the value of the difference between two indicators into specific underlying elements. These techniques have been used in demography since the 1980s (Vaupel *et al.,* 2003). There are mainly two approaches to decompose the difference in life expectancies: a continuous approach developed by Pollard (1982) and a discrete approach developed by Arriaga (1984). These two approaches are formally similar but Arriaga's formula is easier to apply to a life table where the majority of data is given by a discrete time. Many researchers (Arriaga, 1984; Velkovo *et al.,* 1997; Preston *et al.,* 2001; Zhao and Kinfu, 2005; Gu *et al.,* 2007) have applied Arriaga's method for decomposition. This

method is based on calculating the contribution of individual age groups to the overall difference between two life expectancies at birth.

Life expectancy at birth in China has doubled in the twentieth century from below 35 years to over 70 years (Gu *et al.,* 2007). The Swedish life expectancy was increased substantially during the 20th century. Similarly Japanese life expectancy rose from 75.91 to 78.80 years, with an estimated annual increase of 0.288 from the decade 1980 to 1990. Three fifths of this increase in life expectancy can be attributed to a reduction in mortality due to Cerebrovascular disease and heart disease (Vaupel and Romo, 2002).

India's life expectancy has increased from 58.5 years in 1990 to 66.4 years in 2013. While this is a significant increase, both Pakistan and Bangladesh have slightly better life expectancy. Among the developing countries, only South Africa has a lower life expectancy at 56.9 years, primarily due to the HIV/AIDS epidemic. China's life expectancy is 75.3 years. The average for the whole world is 70.8 years, while among the developed countries with very high human development levels, it is 80.2 years (HDR, 2014).

Life expectancy at birth varies all over the world. It may also vary within the countries over time. For example, the life expectancy at birth in Bangladesh was 50.59 in 1974 and 67.22 in 2009 (CPD, 2000; BBS, 2011).

Although, a good number of research works have been done in the area of sex differences in mortality (Madigan, 1957; El-Badry, 1969; Verbrugge, 1976; Nathanson, 1984; Luy, 2003) but systematic analysis of sex differences in ageing process is virtually absent. The target of this study is to address this void in research literature. Decomposing life expectancies might provide a clear picture of the age patterns of mortality. Therefore, the objective of the present study is to assess the sex difference in ageing process through decomposing life expectancies between two periods.

Methods and Materials

This study uses life table data of Bangladesh population for the period 1986 and 2010 constructed from the Sample Vital Registration System (SVRS). Arriaga's (1984) method for decomposing the

differences of life expectancy has been applied to the data during the period 1986 and 2010.

Arriaga's Method of Decomposition

When analyzing changes in life expectancy at birth between two periods, it is sometimes useful to estimate what mortality differences in a specific age group contribute to the total difference in life expectancy. The common reason is that different people are exposed differently to the risk of death. Thus, a change in the mortality rate between age x and $x + n$ has an effect on the life expectancy at birth (Preston *et al*., 2001). Arriaga's (1984) method is as follows:

$$n\ x\frac{l_x^l}{l_0^1}\cdot\ \frac{{}_nl_x^2}{l_x^2}\quad\frac{{}_nL_x^1}{l_x^1}\qquad\frac{T_{x\ n}^2}{l_0^1}\cdot\ \frac{l_x^1}{l_x^2}\quad\frac{l_{x\ n}^1}{l_{x\ n}^2} \tag{1}$$

where, ${}_n\Delta_x$ refers to the change of mortality on life expectancy, the superscripts 1 and 2 refer to time period 1 and 2.

For the open-ended age interval, the following equation is applied:

$$x\frac{l_x^l}{l_0^1}\cdot\ \frac{T_x^2}{l_x^2}\quad\frac{T_x^1}{l_x^1} \tag{2}$$

It is further estimated that the difference of life expectancy at birth is equal to the sum of change of mortality on life expectancy i.e.

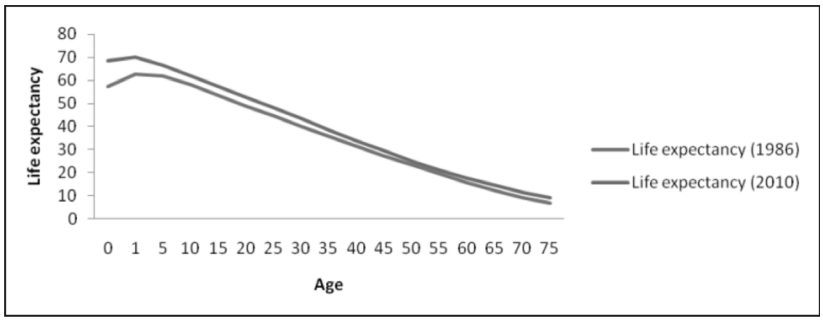
$$e_0^0(2)\quad e_0^0(1)\qquad_{x\ 0}{}^{n}\quad x \tag{3}$$

Where, e_0^0 (1) and e_0^0 (2) are life expectancy at birth at time 1 and time 2 respectively.

Discussion

It is found that the life expectancy at each age is higher in 2010 than the life expectancy in 1986 in Bangladesh. The difference in life expectancies at birth is higher than the other age groups (Figure 1).

Figure 1
Pattern of life expectancy of Bangladesh population, 1986–2010



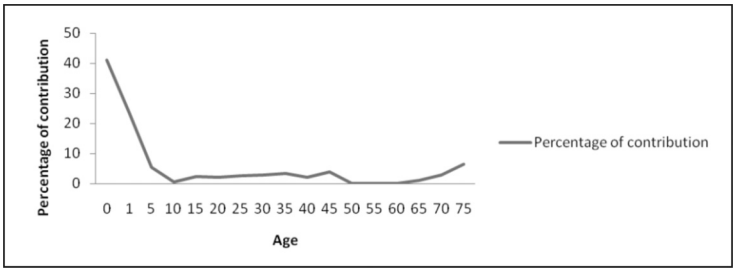
The life expectancy at birth in 1986 and 2010 is 57.17 and 68.47 respectively. Thus, the difference of life expectancy at birth between these periods is 11.30 years (Table 1).

Table 1
Life Expectancy at birth of Bangladesh Population for the period 1986 to 2010

Year	*Life Expectancy at birth*			*Difference between male and female*
	Person	*Male*	*Female*	
1986	57.17	57.74	56.63	1.11
2010	68.47	67.62	69.45	1.83
Difference	11.30	9.88	12.82	

All the age groups have a positive mortality contribution to the changes in life expectancy during the period 1986 to 2010. The mortality contribution on life expectancy for Bangladesh population shows variation for each age. The highest contribution is in the infant age group and the lowest contribution in the old age group (55–59 and 60–64 age group). The mortality contribution to the infant age group is much higher than the other age groups (1–4 age group, 5–9 age group and 10–14 age group). The adult age group (15–59) shows almost equal contribution of mortality on the life expectancy (Figure 2).

Figure 2
Contribution of mortality differentials in life expectancy at birth in Bangladesh, 1986–2010



The infant age group shows the highest contribution of 41 per cent to increase the life expectancy, followed by 24 per cent in the 1–4 age group and 6 per cent is in the 75+ age group. The total contribution for young age group (0–14), adult age group (15–59) and old age group (60+) are 70 per cent, 20 per cent and 10 per cent respectively. Note that the difference of life expectancy during the study period is 11.30 years. This massive change of life expectancy is due to significant change in infant age group (Table 2). It is clear that the average life expectancy of Bangladesh population has increased mainly due to significant reduction in child mortality.

Table 2
Age Decomposition of Differences in Life Expectancies at Birth in Bangladesh Population, 1986–2010

Year	*1986*			*2010*			${}_n\Delta_x$	*Percentage of contribution*
Age	l_x	${}_nLx$	T_x	l_x	${}_nL_x$	T_x		
0	1,00,000	90,307.23	57,17,469	1,00,000	96,503	68,47,296	4.63	41.00
1	89,797.09	3,49,772.5	56,27,162	96,318	3,83,517	67,50,794	2.67	23.65
5	85,089.15	4,22,027.3	52,77,389	95,440	4,76,058	63,67,277	0.62	5.48
10	83,721.78	4,17,252.8	48,55,362	94,983	4,73,602	58,91,218	0.05	0.42
15	83,179.35	4,13,683.6	44,38,109	94,457	4,71,074	54,17,617	0.25	2.23
20	82,294.07	4,08,985.8	40,24,426	93,972	4,68,398	49,46,543	0.24	2.15
25	81,300.24	4,03,395	36,15,440	93,387	4,65,155	44,78,145	0.29	2.52
30	80,057.78	3,97,013.5	32,12,045	92,675	4,61,828	40,12,990	0.32	2.82
35	78,747.63	3,89,357.9	28,15,031	92,056	4,58,174	35,51,162	0.38	3.32
40	76,995.52	3,80,440.9	24,25,673	91,213	4,52,839	30,92,989	0.23	2.04
45	75,180.82	3,67,632.4	20,45,233	89,923	4,44,413	26,40,149	0.43	3.82

Cont'd...

Cont'd...

50	71,872.13	3,50,296.7	16,77,600	87,843	4,28,240	21,95,736	0.01	0.07
55	68,246.56	3,30,212	13,27,304	83,453	4,03,770	17,67,496	0.00	0.00
60	63,838.23	3,02,888.2	9,97,092	78,055	3,69,141	13,63,726	0.00	0.00
65	57,317.05	2,60,502.4	6,94,203	69,602	3,20,479	9,94,585	0.12	1.11
70	46,883.92	2,01,703.3	4,33,701	58,590	2,61,055	6,74,106	0.33	2.93
75	33,797.41	2,31,997.6	2,31,998	45,832	4,13,051	4,13,051	0.73	6.42
Sum		11.3	100					

Gender Disparity

Gender disparity of life expectancy of Bangladesh population is not ignorable. The life expectancy of male at each age is slightly higher than their female counterpart in 1986 (Figure 3) but the reverse scenario is observed in 2010 (Figure 4).

Figure 3
Pattern of Age Specific Life Expectancy in Bangladesh with Respect to Sex, 1986

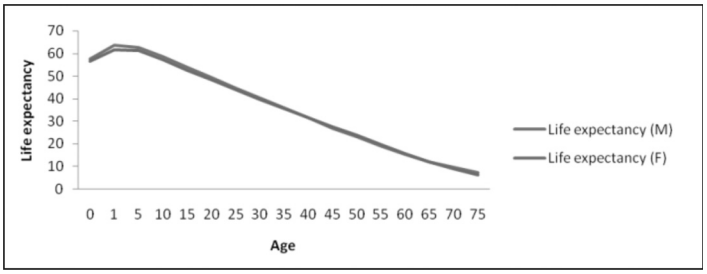
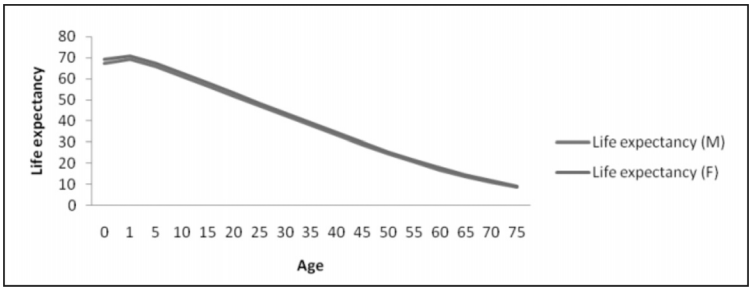


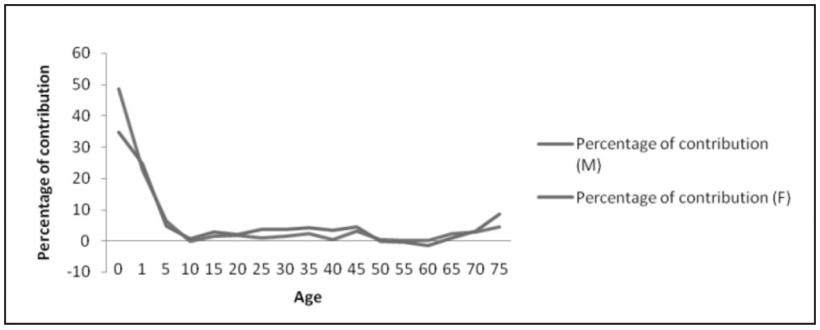
Figure 4
Pattern of age Specific Life Expectancy in Bangladesh with Respect to Sex, 2010



The life expectancy at birth in 1986 is 57.74 for male and 56.63 for female while in 2010, these values are 67.62 and 69.45 respectively. Thus, the difference of life expectancies at birth between these two periods is 9.88 for male and 12.82 for female. It is clear that the female life expectancy has increased more than male (Table 1).

For male, all the age groups during the period 1986–2010 have a positive mortality contribution to the changes in life expectancy except for 10–14 age groups. The highest contribution is observed in the youngest age group. The mortality contribution for adult age group is fairly smooth and almost equal in each group. The older age group contributes very poor to increase life expectancy. This implies that the young age group contributed more to the change in life expectancy than adult age groups and older age group (Figure 5).

Figure 5
Contribution of Mortality Differential at Each Age Group in Bangladesh, 1986–2010



The mortality contribution of female on life expectancy is same as that of male with few exceptions. The contribution of male is higher than female in the young age group. On the other hand, the female contribution is little bit higher than male in the old age group. More specifically, the contribution of the oldest old group is higher for female than male. The contribution of mortality for female is slightly higher than male in the adult age group (Figure 5). It is evident that there exists a variation of contribution on life expectancy with respect to sex.

Conclusion

The overall life expectancy of Bangladesh population has increased markedly from 1986 to 2010. The highest contribution to increase this life expectancy is due to improved child mortality. The infant group's contribution is the highest to increase life expectancy of Bangladesh population. The findings also indicate that the life expectancy at old age (60+) was not increased significantly. There exists a gender variation of contribution on life expectancy where the female contribution is higher than male at the old age.

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Life behind the Bars: Plight of the Aged Prisoners in Central Correctional Homes of Kolkata – An Unexplored Reality

Kaushik Mukherjee
Rashtriya Madhyamik Siksha Abhiyan
(Paschim Banga Sarva Siksha Mission), North 24 Parganas, (West Bengal)

ABSTRACT

The present study was planned to understand the consequence of ageing among the prisoners in Central Correctional Homes of Kolkata.36 elderly prisoners age varying from 60 years and above, of both the sexes (Male=30 and female=6) were selected purposely from three correctional homes of Kolkata. These subjects were interviewed personally to find out how they reached in these homes. Their views about policing or adjudication and their experiences with the criminal justice system were also found out. The study also aimed to find out their health problems and the issues related to their rehabilitation. The elderly prisoners' perception about mainstreaming with the society was also explored. The findings of this study revealed that the so called 'images of old age' in Indian tradition (which include old age as dignified, graceful, rewarding experience, a prosperous and a successful age) was totally distorted in case of these convicted elderly inmates of correctional homes.

Key words: Ageing, Crime, Prisoners, Images of ageing, Old age.

Sri Das, aged 87, was released from incarceration last month from the central jail of Kolkata after spending more than half a century behind bars awaiting trial. Das babu had been arrested at his home

village of Habra in 1965 under section 326 of the Indian Penal Code for "causing grievous harm." According to civil rights groups who have investigated Mr Das's case, there was no substantive evidence to support the charge against him. In any event, those found guilty of this offence typically receive sentences of no more than ten years imprisonment. Less than a year after he had been taken into custody he was transferred to a psychiatric hospital. Sixteen years later, in 1967, doctors confirmed that he was "fully fit" to be released, but instead he was transferred to one of the central jails in Kolkata, where he was imprisoned until this summer. "It seems the police just forgot about him thereafter". After so many tussles, Sri Das's case was finally heard and he was released after paying a token bond of one Indian rupee. He is a simple villager and his life had been destroyed by a cruel system. He should sue the authorities for millions of rupees, but he mutely tolerates all the odds. At this twilight years, he thinks that all the odds which had happened in his life were nothing but the ultimate fate of his life.

The above is the case of an aged prisoner. The very same situation may be found in the correctional homes of the states of India. This is because in general the socio-economic and cultural basis is the same everywhere. Society renders an antagonistic mentality towards those individuals who have made mistakes in their youth and undergone adequate punishment legally. Mournfully those individuals hardly have any scope to get back to the mainstream of life.

In Sociological or social gerontological perspective concepts of 'age' and 'ageing' have different connotations, namely biological and physiological, psychological, spatio-temporal and social. Traditionally all over the world old age can be a rewarding experience, a prosperous and a successful second age, full of meaning and purposes. Historical evidences also reveal that old age itself was considered to be a matter of prestige and such people were accorded a place of honour in society. But with the advancement of industrial capitalism it becomes critical to understand how a society uses this term according to its own social construct. But the concept and application of the term 'old age' becomes complex and can create complications while conducting research on the phenomena of crime and ageing. These ageist ideologies around old age and the meaning of old age both affect and are

reflected within criminology particularly in relation to the construct of victimhood and old age. However, criminal behaviour and criminological studies have focussed predominantly on young people's activities. Until recently criminological imagination regarded 'age' as less important than gender. Age was discussed and focussed on the question of youth. This perspective instils the author to think over this issue and the present research paper has been visualized in this perspective.

Both men and women commit crimes and as with younger people some are arrested, some are convicted, some are sent to prison and grow old in prison. Despite the various conceptual and methodological issues, a number of criminologists have attempted to research on the extent, nature and impact of criminal victimisation of the elderly. Studies have utilised both quantitative and qualitative techniques, and despite questions concerning the reliability of some of the findings, a number of points can be drawn out as to the nature and extent of the criminal victimisation of the elderly people Since 1960s, fear of crime has been one of the major growth areas for both academic research and policy development (Fattah, 1995). Researches on crime and old age in the western context have identified four groups who particularly fall into this vulnerability category – women (Gerdon, 1980; Warr, 1985), the poor, ethnic minorities (Tayler, and Hale 1986, Box and Andrews, 1988) and the old (Autunes, 1977; Baldassare, 1986; Braungart, 1980; Clarke, 1982; (Giles-sims, 1984; (Yin, 1985). Some of the important studies on different issues of old and crime are – crime, abuse and the elderly (Cohen Fred, 1985), crime and the elderly (Aday, 1984), crime, age and social explanation (Greenberg, 1985), fear of elder sexual abuse (Berrington, and Jones 2002), victimization of elderly people (Pantazis, 2000), old age and corporate crime (Powell and Wahidin, 2007), domestic violence and crime against older women (Jones, 1987), etc. While in the Indian context studies on crime and old age are very much inadequate. However some sporadic writings were found which discussed about life and activities of criminals. These are women prisoners of India (Shankardass, 2012), life and experience of a prisoner (Bandopadhyay, 1933), description of jails and its administration (Chakraborty, 1384 in Bengali), mental condition and jail atmosphere before hanging (Bhaduri, 1973), description of a jail

(Mukhopadhyay, 2009), psychosocial consequences of crime (Ghosal, 1365 in bengali), etc. Many studies mentioned above in no way make an exhaustive list of publications on crime and old age both in India and the west. Therefore omission is unintentional.

The present research aims at understanding the consequence of ageing among the prisoners in central correctional homes of Kolkata. Thus the objectives are – how they get there, to understand the nature of policing or adjudication in relation to the aged, elderly offenders and their experiences with the criminal justice system, to understand the nature of heath and health care system available for the aged prisoners, to understand the nature of rehabilitation and finally their perception about mainstreaming with the society. It is expected that this micro study will be able to throw light for a clear understanding about the aged prisoners and their twilight years under the precinct of central correctional homes of Kolkata.

Dum Dum Central Correctional Home

Dum Dum central correctional home was established in the year 1937 near Dum Dum cantonment. Basically it was the administrative office of the British soldiers. In course of time it was transformed into the Dum Dum central correctional home. Women correctional unit started on 24th July 2009. There are several

Method of Study

In the present study conducted on 36 elderly inmates in the three central correctional homes (Presidency Correctional Home,–5 Hindu and 5 Muslims, Alipore Central Correctional Home,–5 Hindu and 5 Muslims and Dum Dum Central Correctional Home–5 Hindu and 5 Muslims and 6 Hindu females) of Kolkata. For this reason, instead of any sampling, total numeration was used for proper presentation. Representations of the respondents from three central correctional homes are as follows:

Both qualitative and quantitative techniques were used for data collection. Qualitative methods such as – case studies, participant observation, in–depth and face-to-face interview, focus group discussion were used for collection of data. Quantitative data were

collected mainly through interviews with the help of a semi structured questionnaire.

Findings

Socio-demographic Characteristics of the Elderly Inmates

Table 1
Age group, Community and Gender of the Elderly Convicted Inmates of the Three Central Correctional Homes in Kolkata

Age Group	*Community and Gender*				
	Hindu Male	*Hindu Female*	*Muslim Male*	*Muslim Female*	*Total*
60–69	5 (33.33%)	3 (50.00%)	6 (40.00%)	–	14 (38.89%)
70–79	6 (40.00%)	1 (16.67%)	7 (46.67%)	–	14 (38.89%)
80+	4 (26.67%)	2 (33.33%)	2 (13.33%)	–	8 (22.22%)
Total	15	6	15	–	36

Table 1. depicts the age group, community and gender distribution of the elderly convicted inmates of the three central correctional homes in Kolkata. The respondents have been divided into three age groups namely 60–69 years, 70–79 years and 80 years and above. Total number of the male respondents (30 out of 36) is higher than their female (6 out of 36) counterpart. This trend is seen in all age groups irrespective of community and gender. Majority of the convicted elderly respondents belong to the lower age groups (60–79). The most interesting feature is the absence of Muslim female respondents. The table reveals that irrespective of community most of the convicted offenders are male.

Table 2
Marital Status of the Elderly Convicted Inmates of the Three Central Correctional Homes in Kolkata: Hindu and Muslim Combined

Marital Status	*Male*	*Female*	*Total*
Unmarried	4 (13.33%)	–	4 (11.11%)
Married	15 (50.00%)	2 (33.33%)	17 (47.22%)
Widowed	6 (20.00%)	4 (66.67%)	10 (27.78%)
Divorce/Separated	5 (16.67%)	–	5 (13.89%)
Total	30	6	36

Marriage is an essential factor for emotional and social health both for men and women (Khan, 1997). This is all the more important in a tradition based society like India where marital status of an individual particularly the aged, conveys many things like – socio-economic status, health care, role performance and even the nature of dependence on the family. Also to be noted is the fact, that the married persons fare much better than single ones on a number of parameter, such as, economic, social, emotional and care giving with the progression of age (Myers, 1986).

Table 2 brings out marital status of the elderly convicted inmates in three central correctional homes in Kolkata. It is interesting to note that even in a small universe the trend of marital status reflects our national trend. Irrespective of community, majority of the male respondents are married (50%) whereas female respondents are widow (66.7%). Either unmarried or separated female respondents are not found. Only five male respondents are found who are separated. Interestingly, all these five males are Muslim. During interview it was reported that they were separated from their wives (*through Talak*).

Table 3

Level of Education of the Elderly Convicted Inmates of the Three Central Correctional Homes in Kolkata: Hindu and Muslim Combined

Level of Education	*Male*	*Female*	*Total*
Illiterate	8 (26.67%)	1 (16.67%)	9 (25.00%)
Primary	10 (33.33%)	3 (50.00%)	13 (36.11%)
Upper Primary	4 (13.33%)	1 (16.67%)	5 (13.89%)
Madhyamik	3 (10.00%)	1 (16.67%)	4 (11.11%)
Higher Secondary & above	5 (16.67%)	–	5 (13.89%)
Total	30	6	36

Education is a hallmark of social development. People who are deprived of education are generally also deprived of economic uplift. It is generally assumed that education directly contributes to personality development. Furthermore, a common observation reveals that the educated elderly have a larger adjustive efficiency than those who are not literate or less educated (Khan, 1997).

Table 3. highlights the level of educational attainment of the elderly convicted inmates residing in three central correctional homes in Kolkata. It is seen that majority of the elderly convicted males (33.3%) and females (50.0%) attained primary level of education. Except one female no females were able to continue their education up to madhyamik level. Only five males were able to continue their education even after higher secondary level. However, except one female and eight males, no respondents are found illiterate. Therefore it cannot be an overstatement that the educational attainments of the convicted elderly inmates are not very much disappointing.

Table 4

Family Type and Gender of the Elderly Convicted Inmates of the Three Central Correctional Homes in Kolkata: Hindu and Muslim Combined

	Gender		
Family Type	*Male*	*Female*	*Total*
Nuclear	12 (40.00%)	2 (33.33%)	14 (38.89%)
Joint/Extended	18 (60.00%)	4 (66.67%)	22 (61.11%)
Total	30	6	36

Family is the smallest and most universal of all forms of institutions. In India, as in other oriental and developing countries, the family has been a well-knit social institution, which met the social, economic and emotional needs of its members (Karve, 1965). This is also true even in case of our convicted respondents. Before their punishment all of them were living either in nuclear or in extended type of families.

Table 4. reflects that irrespective of community and gender more than sixty per cent of the respondents (m–60.0%, f–66.6%) were the member of extended families. Only fourteen respondents (m–12, f–2) were living in nuclear families. Here we also find the reflection of our Indian tradition. It is surprising to note that even the convicted elderly inmates before coming to the central correctional homes preferred to live within the precinct of an extended family.

Table 5

Nature of Livelihood of the Elderly Convicted Inmates of the Three Central Correctional Homes in Kolkata: Hindu and Muslim Combined

Nature of Livelihood	*Male*	*Female*	*Total*
Farmer	11 (36.67%)	–	11 (30.55%)
Agricultural Labour	3 (10.00%)	–	3 (8.33%)
Labour	8 (26.67%)	–	8 (22.22%)
Business	1 (3.33%)	–	1 (2.78%)
Service	2 (6.67%)	–	2 (5.55%)
Private Employee	3 (10.00%)	–	3 (8.33%)
House wife	–	6 (100.00%)	6 (16.67%)
Total	30	6	36

Table 5. presents the nature of livelihood of the convicted elderly inmates before coming in the correctional homes. It is seen that irrespective of community male respondents earned their livelihood from different sources namely – agriculture, agriculture labour, industrial labour job, business, service (both government and private). A sizeable section of the elderly male respondents earned their livelihood from agriculture (36.6%) and agricultural labour (10%). Next to agriculture, the male respondents earn their livelihood from industrial labour job (26.6%), business (3.3%), service (6.6%) and private employment (10.0%) respectively. However, it is interesting to note that all the elderly female inmates prefer to engage themselves in housekeeping activities. Here we also find the reflection of our Indian family tradition where males are involved in earning and females are maintaining household activities.

Table 6

Nature of Offense Committed by the Elderly Convicted Inmates of the Three Central Correctional Homes in Kolkata: Hindu and Muslim Combined

Nature of Offense	*Male*	*Female*	*Total*
Torture – Cruelty by Husband and Relation and Death	–	6 (100.00%)	6 (16.67%)
Kidnapping	1 (3.33%)	–	1 (2.78%)
Murder	7 (23.33%)	–	7 (19.44%)
Kidnapping and Murder	6 (20.00%)	–	6 (16.67%)
Kidnapping, Rape and Murder	4 (13.33%)	–	4 (11.11%)
Robbery and Dacoity	5 (16.67%)	–	5 (13.89%)
Bank Dacoity	2 (6.67%)	–	2 (5.55%)
Cheating	2 (6.67%)	–	2 (5.55%)
Narcotic	3 (10.00%)	–3 (8.33%)	
Total	30	6	36

Table 6. brings into account the nature of crime committed by the convicted elderly inmates in three central correctional homes in Kolkata. During field work and through face-to-face elderly convicted inmates reported their nature of offence. It is seen that irrespective of community, elderly male convicted committed mainly four types of crime. These are murder (23.3%), kidnapping and murder (20.0%), kidnapping, rape and murder (13.3%), robbery and dacoity (16.6%) respectively. Whereas female convicted offenders mainly committed torture-cruelty and death. Besides, male offenders committed some other types of offenses such as bank dacoity, cheating and selling of narcotics. During interview it was also reported that all kinds of offences committed by the elderly convicted inmates mostly in the threshold of their old age. As a result all of them spent their bitter ashes of prison life behind the bars.

Present Health Condition

However, health is an important aspect in every stage of human life. For several reasons, health needs of older adults are different from others. The physical and mental conditions of the aged do not remain what these used to be in their earlier life. As a result they are more susceptible to ailments and diseases. During field work an intensive discussion was conducted with the respondents and also with the medical officers of the respective correctional homes to understand the occurrence of diseases among the aged respondents during last one year prior to the field work.

The discussion reveals that irrespective of community and gender elderly convicted inmates are suffering from different kinds of ailments such as head related problems, problems related to ENT, limbs related problems, muculo skletal problems, respiratory tract infection, cardiovascular problems, gastrointestinal problems, genito urinary problems, other nerve and skin related problems. During focus group discussion it was reported that irrespective of age male respondents are suffering from respiratory tract infection, cardiovascular problems and gastrointestinal problems. Whereas, female respondents are mainly suffering from musculo skeletal and genito urinary problems. Thus it may not be an overstatement that except

some gender differences, occurrence of disease among the elderly convicted inmates shows a normal physiological trend with ageing.

Table 7

Coping Strategies used by the Elderly Convicted Inmates of the Three Central Correctional Homes in Kolkata: Hindu and Muslim Combined

Nature of Coping Strategies	*Male*	*Female*
Discuss individual problems with other inmates (m=30, f=6)	80.0	85.0
Engage self with physical exercise and meditation (m=30, f=6)	60.0	30.0
Blame own luck and repentance for bad work (m=30, f–6)	45.0	55.0
Avoid gathering and seek for complete isolation (m=30, f=6)	60.0	90.0
Self devotion in religious performances (m=30, f=6)	90.0	95.0
Mental preparation for the last resort (m=30, f=6)	55.0	60.0
Multiple responses occurred		

During fieldwork and close interaction with the convicted elderly inmates certain unexpressed realities came into surface. It was asked to every elderly inmates, 'how do you cope yourself with this prison environment at your twilight years?' As a consequence of this question, I got several answers. From the very beginning of my fieldwork the issue which touched my heart has been how these elderly persons cope themselves with this prison environment. During focus group discussion everyone expressed their views about their individual coping mechanism with this prison environment. I got several answers. Irrespective of community and gender, the most prominent answer was devotion towards religious performances (m–90.0, f–95.0). Both male and female respondents feel that only submission towards Almighty can save them. There is no other alternative in this mundane world. Though some other views like sharing individual problems with other inmates, physical exercise and meditation, complete isolation, and mental preparation for the last destiny were expressed. From this discussion it cannot be an overstatement that in old age only religious feelings and submission towards Almighty can improve the mental strength which indirectly enhances the quality of life even in old age.

Case studies

Society Refuses, Correction Home Refuges

At the age of 69 Mr. Burman came to Presidency Central Correction Home. He somehow got involved in a local settlement affair leading to burning a woman to death, suspecting her a witch. Gradually he grew older biologically and suffered from various ailments and became well after treatment. But his own family has avoided him and has cut off all contact with him. So his hope for going back home has gradually faded out. In the main time sixty nine years have passed and now Mr. Burman is 75. After the completion of his tenure of punishment when the authority tried to send him back home, it did not work. Finding no hope for him there the prison authority had to bring him back to prison. Now Mr. Burman's true home is Presidency Central Correction Home.

Such scenario can be seen after correction homes of this state. This is because the usual socio economic and cultural backdrop is present everywhere and is more or less the same. If a person, out of his or her wrong doing, in middle phase of life, gets convicted, after the tenure of punishment the person finds himself almost unacceptable to main current of social life. Even after being corrected in correctional home the person could hardly change the social hostility towards himself.

Solo Effort to Healthy Life

Mr. Ghosh, a lifer in Presidency Central Correction Home is quite senior in age yet he has been providing medical facilities to the male prisoners with solitary effort. With the rapid increase in the number of the male prisoners here it has become rather difficult to provide medical facility to all of them But Mr. Ghosh has been able to create awareness about the infectious diseases and how to protect the prisoners from such diseases.

Mr. Ghosh has been a permanent resident of the Presidency Central Correction Home haveing been charged of kidnapping, rape and then murder. He was a dealer in medicines. He has been behind the bars here for ten long years. On coming here he felt that every prisoner has the right to receive medical treatment. To establish the

availability of this human right he got himself appointed in the prison hospital on the basis of his previous experience in the field of drugs and pharmaceutical products.

Here, Mr. Ghosh first noticed the lack of suitable man power to provide medical facility to all the prisoners present. Initially he made a list of those diseases which are generally found among prisoners. Then he started discussing about those with the prisoners so that they became aware of such ailments. He used to visit various wards and interacted with the ailing prisoners. Mr. Ghosh, in spite of not receiving positive response initially, did not lose hope and continued with his effort. After a period of time his perseverance got rewarded and he could at present bring almost all the prisoners within the net work of clinical facilities. Regular health examinations of a long list of patiesuts chronically ill for long are reality now. The authority, because of his pursuation, has arranged for proper diet for such patients. Now Mr. Ghosh has become apprehensive of his old age. He is 75 now and is anxious about how he will continue such a huge task in future.

Human Rights Movement Even From Prison

Mr. Rahaman, 70 years old was the resident of Basanti, Kultali P.S. of South 24 Parganas. He was a political activist who got victimized in political conspiracy and framed in a murder case prior to the election in 2000. The verdict for him was life time imprisonment. Under this circumstance Mr. Rahaman decides to start his movement about human rights from within the correction home. This resident of Alipure Central Correction Home, started his movement related to human rights within the premises of this Central Correction Home, primarily for the under trial residents. At present his objective is to see to the fact that not a single innocent person undergoes punishment. He also arranges for the proper Legal Aid of the prisoners and find for them contacts of N.G.O. and other voluntary sources so that funds can be arranged to meet Legal Aid and other expenses. Mr. Rahaman puts his sincere effort to inspire prisoners to adjust with others in a friendly manner behind the bars. He teaches them to adjust with others in Central Correction Home. He also sincerely puts effort to draw the attention of the authority towards the issue where human

rights of the prisoners are violated. Through initially Mr. Rahaman displeased the authority but with the cooperation from the prisoners ultimately he could effectively pace up his movement rather successfully.

Literacry Drive within Prison

84 years old Mrs. Das is the permanent prisoner of the Dum Dum Central Correction Home. She was convicted for torturing and murdering daughter-in-law. She is here for thirty years.

Losing her own parents at a very early childhood Mrs. Das had to stay in her maternal uncle's house and eventually she grew up in neglect and even beating. Naturally she could not have the scope for formal education in school. After the early marriage the rearing up of her son in her family was her primary occupation. In the mean time her husband died. But she fought to make her son established and got him married. But Mrs. Das failed to adjust with the modern wife of her son. Eventually the coercion within the family grew extreme and the daughter-in-law committed suicide. Mrs. Das and her son were convicted for life time imprisonment.

From there only she started suffering from melancholy, acute depression and anxiety. Then with the help of prison authority she became literate. But Mrs. Das did not stop there. Later on she passed out Madyamik (10th standard) examination from the Rabindra Muktoo Bidyalay with first division. On receiving education her perspective of life has changed and she is teaching other female prisoners to live like that. For this she reads them stories, novels, plays, epics, etc. In this very way even from within the Central Correction Home she has truly become educated and has made the Right to Education Act 2009 successful.

Disha: The New Ray of Hope

One canteen, within the Dum Dum Central Correction Home, is run by 'Disha', a Self-Sufficient Organization. All the five members of this Self-Help Group are life time prisoners. This canteen, on one side, caters various good quality tasty foods to the resident prisoners. On another side, following the regulations of the prison authority this canteen provides other necessary things to the prisoners. The residents

of this Central Correction Home could buy their necessary things through coupons against the money deposited by their family members.

The chief person of this Self-Help Group is a 70 years old lifer named Mr. Sarkar. He is here for long 15 years. 'Disha' is actually meant for the rehabilitation of the resident prisoners. The profit of the canteen is spent on benevolent work for the resident prisoners within the very premises of the Dum Dum Central Correction Home. The authority also agrees with the claim that 'Disha' is meant for the benevolence of the prisoners and purchase things from 'Disha' through coupons. The price of such goods is rather less than the market price outside.

Drama plays role to Light

She tried to bring back her misdirected daughter who eventually died and the 63 years old Mrs. Nath was convicted for homicide and life time imprisonment. She is now the permanent resident of the Dum Dum Central Correction Home. For six long years she has been here. While staying here she was gradually losing interest in life due to acute depression. Then a step was taken by the Dum Dum Central Correction Home authority to spread awareness regarding the rehabilitation programmes for the prisoners. This programme impressed the prisoners deeply.

The Dum Dum Central Correction Home authority took the initiative and Tagore's drama 'Raktoo Korobi' (Red Oleander) was staged. Various people convicted for heinous crimes took part in this play. Under the direction of well known Swatilekha Sengupta this play was staged at different places for considerable number of times by courtesy of the prison authority. The play became very popular among the prisoners.

The role of Nandini in 'Raktoo Korobi' (Red Oleander) was acted by Mrs. Nath, which in a sense, reflected her life and it provided her with a new perspective. She learnt to live again shedding all the prejudices. In future too after completing her tenure, going back home she wants to act against superstitions and prejudices. Mrs. Nath wants to work among the backward people to decrease the tendency towards crime and enhance the quality of life. This has become the motto of

her life now. She is optimistic about getting help from government and non government sources in her mission.

From the above mentioned case studies, it is evident that every case is an example of mental refinement. In each case, crime, conviction and long prison life made their social ageing disgraceful and as a result of which their last resort become the boundaries of central correctional homes of Kolkata. But it cannot be an overstatement that in spite of being a convicted prisoner, their solo effort is really a good reflection of refined personhood.

(Note: All names and addresses have been changed to maintain field ethics of Empirical Social Science Research.)

Discussion and conclusion

In India, the beginning of researches on ageing or old age dates back to early 60s. But researches on crime and old age are rather scant. This situational study was mooted with specific aims to understand the consequence of ageing among the convicted elderly in the three central correctional homes of Kolkata. In the present research total numbers of respondents are thirty six. The numbers of female convicted elderly are only six. The numbers of convicted elderly is rather small among all the central correctional homes of Kolkata. For this reason, instead of any proper sampling method, total enumeration was conducted for proper representation of the respondents. Among the male respondents, representation of both Hindu and Muslim community are equal in number. It is to be mentioned here that all the female respondents are Hindu.

Age group wise distribution of the respondents highlights that irrespective of gender majority of the respondents belong to lower age bracket (60–70 yrs.) though there are some respondents who belong to the 80 years and above age group. Majority of the male respondents are married but a sizeable section of the female respondents are widow. One interesting feature comes out from the analysis that no divorced/separated Muslim respondents are found. It may be due to their religious norms. Regarding level of education, it is worth mentioning that except some few, majority of the elderly respondents are literate. However, very few of the male respondents were able to continue their education after higher secondary. Data also reveal that

most of the respondents were the members of extended family before coming to the correctional home. Therefore it may not be an overstatement that in spite of so many social changes living in an extended family is still preferred by our parental generation. Moreover before coming to the correctional home, all the male respondents earned their livelihood from different sources – namely, from agriculture and related works, labour job, business and service. But all the women respondents were very much engaged in their domestic chores. Besides, the most important issue related to this kind of study is the context of health. For in-depth understanding, both the respondents and the respective health officials of the correctional home were interviewed. It is evident from the analysis of the data that except some gender differences, all the elderly respondents are suffering from different kinds of diseases. But male respondents are the major victims of respiratory tract infection due to their smoking habits; whereas female respondents are the victims of musculo skeletal problems. However from Sociological point of view, the most important concern was the coping mechanism of those convicted elderly inmates within the precinct of correctional home. During interview each of them was asked as to how they adjusted themselves with this environment. Different kinds of answers were reported. In spite of difference in their opinion, the most common thing was complete devotion in religious activities and total submission towards Almighty. Majority of them think that only this submission can give them peace even after death.

Finally it can be said that in our Indian tradition the 'images of old age' is very graceful. In our cultural tradition, old age is a rewarding experience, a prosperous and a successful second age, full of meaning and purposes. But this dignity and graceful image has been totally distorted in case of these convicted elderly inmates of correctional homes. In spite of their long punishment in correctional home, everyone is in distress whether they will be rehabilitated in their family life or not at their twilight years. Being a student of human rights, the issue which haunted the author very much was who is responsible to return their fundamental human rights – family – society or the state? Lastly it can be said that the present study is a micro level study, but it has all the invariants of empiricity and there are innumerable ways by means of which it can be augmented at the macro level.

Implications for Future Research

This study fills gaps in the literature about aged prisoners. This study tries to give a new perspective to the literature on prisoners by addressing the needs and rehabilitation of the elderly prisoners. The findings of this study can serve as a guide, a tool for advocacy, and as a needs assessment for organizations to develop programmes for elderly prisoners and their rehabilitation. The study can be a guide for practitioners to understand the needs and challenges of this age specific group. This study has the potential to help, build and create policies and programs for organizations. With the knowledge gained from this study, practitioners can work more efficiently with this age specific group. This study will advocate for new policy framing that look at these elderly prisoners as victims and calls for their rehabilitation. Only with policy changes such socially excluded group can find a suitable place for themselves in mainstream society.

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Vedic Ashrams of Life: a Step Towards Successful Ageing and Accepting Death Gracefully

Priyanka Suryavanshi
Department of Home Science, KMCUAF University, Lucknow (UP)

ABSTRACT

The present paper reviews various factors or reasons for fear of death and the role that religion can play in facing these fears. Vanaprastha and sanyasa ashramas, a way of living elerdy phase of life in vedic literature, is discussed and how it helps in answering fears of death in elderly. The paper helps in relating scope of religion in helping elderly to face the last phase of human life successfully.

Key Words: Ageing, Death Fear, Religion, *Vanaprastha Ashram.*

Ageing is the collection of changes occurring in the organism or object over time (Brown and Atwood 2004). The elderly may find abundant evidence of death due to physical changes, poor health, disability and loss of relatives. Therefore, the elderly think of death and talk about it. Death is part and parcel of human life (Powell, K., 2010). It is not an accident but a reality associated with life so that the history of human thought cites the eternal fusion of life and death. Death anxiety is a unique characteristic of human beings because they are the only creatures considering the inevitability of death (Cicirelli, VG, 1997 & 1998). Religiosity brings about peace and comfort, guarantees individuals' safety, fills ethical, emotional and spiritual gaps

in the individual and society, and provides us with a barrier against problems and deprivations.

Religion acts as a mediator to affect thought processes and evaluations of daily events in the individual. Thus, even negative incidents may be interpreted as positive so that the individual might attribute them a positive function. Religious teachings and services may effect satisfaction with life that is considered as an indicator of good life AL Berg, 2008 and usually reflects individuals' attitudes towards past, present and future in terms of their psychological well-being (Chadha, N.K. and J Van Willigen, 1995). Life satisfaction in the elderly is an important concept as it gives us a general view of the adjustment and also individual adaptability (Varshney, 2007).

Various Fears in Facing Death Faced by Elderly

Even though all humans may experience death, conceptions about death and how we respond to issues of death and dying vary widely across cultures. As the world is increasingly shrinking due to the extensive interaction of people from cultures across the world, it is important to understand the complexities that surround the issues of death, just as we do the issues of life. This will better prepare us to respect and understand people from other cultures, and respond to them in ways that are meaningful to them and ourselves so that their lives and ours may be enriched in the process.

Most humans do not willingly welcome the idea of their own or their loved ones' death. In fact, the most common reaction to the thought of dying is fear. Becker (1973) is among the many theorists who believe that the fear of death is a major motivator of all behavior. When the fear of death is channeled properly, it can be a motivating force to propel individuals into phenomenal achievements with the goal that those achievements would transcend their physical mortality.

Given and Range (1990) investigated the relationship between satisfaction with life and death anxiety in two groups of elderly: those who lived in the nursing home and those who lived at their own home. The results revealed that the elderly with higher life satisfaction had lower levels of death anxiety and held a more positive attitude towards ageing. However, their living location seemed to play no role in life

satisfaction and death anxiety. Considering the discussed issues and the increasing population of elderly as well as the fact that they are more concerned with thinking of death, it seems necessary to heed the factors that may reduce death anxiety in the elderly.

The fear of death has been thought to play an important role in depression, psychosomatic disorders and psychopathology in general (Feifel, 1977). Death is thus separation from everything that gives our life form; it is the loss of everything that we hold dear (Hinton, 1967). The loss of a loved one to death is often one of the most emotionally painful experiences that a human can have (Rosemary, 2000). Even when the death is not that of a loved one, simply being a witness to death can evoke a natural horror and revulsion (Malinowski, 1948).

Hoelter and Hoelter (1978) distinguish eight dimensions of the death fear: fear of the dying process, fear of premature death, fear for significant others, phobic fear of death, fear of being destroyed, fear of the body after death, fear of the unknown, and fear of the dead.

The concept of death is intricately tied to the human body. It is the body that dies. The body is corruptible; the body is the recipient of disease and subject to decay. It is the physical corpse that rots away, whereas the soul, according to many belief systems, is set free and lives forever. The body feels pain, and bodily misery is the source of most human misery. Passion is of the body; contemplation is of the soul. Man's body can thus make him a slave to passion while the contemplative power of his spirit sets him free. This basic fact is behind many religious practices, philosophical systems, and science (Heinz, 1999).

Bodily desires are also depicted as problematic and linked to death in Eastern religions. "Desire is suffering," says Buddha, anticipating both the apostle Paul and Freud. The fear in Buddhism is not of an unpleasant afterlife. Rather, the fear is that unless freed from bodily desires, the individual will remain trapped in the birth-death cycle that prevents the self from being united with the oneness of the universe (Prabhu, 1989). Oneness is the state of nirvana that Buddhists seek. Rather than fearing the annihilation of the self, practitioners of Buddhism seek such annihilation. The body and bodily desires act as hindrances to the attainment of nirvana. The body and its desires maintain the separateness of the self from the universal one as long as the individual remains enslaved to bodily passions (Carse, 1980). The

self is an equal restraint in Hinduism, in which the individual also seeks self-annihilation and union with oneness (Glucklich, 1989). Whereas the Greeks emphasized thought as the path to freedom, Buddhism and Hinduism emphasize meditation (Carse, 1980). "Meditation is in truth higher than thought," states a master in the Upanishads, the great Hindu philosophical/religious work. Meditation with the mind is the path to freedom and nirvana in Hinduism and Buddhism, but both Eastern and Western systems of thought reverberate the overall human theme of restraining the body's passions through self-discipline and self-denial.

Hoelter and Epley (1979), for example, found that religiosity serves to reduce certain fears about death, such as fear of the unknown, while heightening others, such as fear of being destroyed, fear for significant others, fear of the dead, and fear for the body after death. Cicirelli (2002) suggests that the fear of death among the aged is variable and may be related to weak religiosity, lack of social support, and low self-esteem. People who have lost a spouse or child can have severe fears of death, as their universe is also destroyed and life no longer has meaning. Of course it can lead to depression and even suicide, but in those persons who are not prone to depression, it can lead to anxiety and fear about death.

Worden (1991) identified four main categories under which a broad range of grief reactions can be classified – feelings, physical sensations, cognitions and behaviors. Feelings include reactions of shock and numbness, sadness, anger and anxiety. Physical sensations can include shortness of breath, tightness in the chest, and, in some cases, even feelings of depersonalization. Common cognitions are disbelief, preoccupation with thoughts of the deceased and hallucinations (these last two are usually transient). Behaviors include sleep disturbance, eating difficulties and absentmindedness.

Religion & Its Impact on Fear of Death

There are several ways to help people deal with their fear of death. One way, suggested by Kalish (1984, 1987) is to live life to its fullest. The rationale here is that even if the person were to die, he or she would not have a sense of having been cheated out of life, and therefore have few regrets. Another way of reducing death anxiety is

through death education. There are several of these programmes and they differ in the nature of topics covered, but tend to focus around such topics as religion, philosophy, ethics, psychology, and medicine. They also discuss issues involving the death process, grief and bereavement. Death education helps mainly by increasing people's awareness of the range of emotions experienced by the people dying and their families. Research evaluating the experiences of those who have undergone training in these experiential workshops suggests that they are effective in lowering death anxiety (Abengozar, *et al.*, 1999).

Neimeyer, *et al.,* (2006) suggest that the greatest difficulties in grieving arise when the individual has an inability to make sense of the loss of their loved one. The ability to make sense of the loss may be greatly influenced by an individual's beliefs and fears about death, and so perhaps further knowledge about the fears associated with death, in particular the leaving, or loss, of loved ones as indicated by the present study, may assist future developments in therapeutic interventions.

Vedic Ashrams of Life: A Step Towards Successful Ageing and Accepting Death Gracefully.

According to the Hindu view of life, the entire life span can be divided into four *ashramas: Brahmacharya, grihasthya, vanaprastha* and *sanyasa.* During each stage, one is enjoined upon to achieve a goal specific to that stage and at the same time one has to prepare for the next stage and the goal related to it. *Vanaprastha* and *sanyasa* are both renunciation-oriented *ashramas.* Both are helpful in making ageing smooth and well directed towards facing the death of physical body gracefully. Vana prasth ashrama prepares individual for giving up family attachments in all respect and become active outside the pale of family. Above given review of literature shows that the major fears of elderly stage are losing life property and family members. And some are worried about what will happen after them to the close family members and relatives. Thus a person who really tries to follow the vedic path of *vanaprastha* and *sanyasa* ashramas would really be relieved from these fears. The main goal of these ashramas is to address and finish the attachment a person has from his body and relationships. The stage says that one should leave his family and move to forest. In present world it represents leaving the family in the form of stop thinking about materialistic worries of family and amassing more

and more for coming generations. The elderly has to accept that now the children are grown up and are fully capable of facing the world with their own reasoning. It is a tough task as moving to forest or a place where no relations would be visible to you is easy because physically they are not visible but in present world one has to get detached to members in their physical presence. There may be another argument that detaching elderly from family and friends would leave them lonelier rather than helping successful ageing. The vedic way of leading life in vanaprastha asharam shows different aspects of aging theories in modern context. It represents the disengagement theory in the way that one should disengage oneself from family, friends and materialistic pleasures on the other hand it expects the person to engage himself in self-awareness self-actualization and helping the society with different unbiased activities that help the needy. The stage expects oneself to engage in good deeds or punya by helping the society in different ways. To engage in meditation and spiritual upliftment by studying religious literature and doing religious acts. Thus it says about disengaging from one aspect and engaging in the other aspect.

This way of life can be helpful in successful ageing because it can be analyzed that the major issues that really disturbe elderly are addressed in the Vedic stages of life. The various fears that disturb elderly are linked to their body, relations and materialistic wealth. *vanaprastha* and *sanyasa* ashramas talk about disengagement or detachment from these. It stresses on detachment from physical appearance and attachment towards the internal psych and its growth. If well followed the result would be that though the physical body has to decline but with self-actualization and self reliance one would be in a stronger condition to accept ageing and death. Thus meditation and religious acts help in this process.

The other major concern is family and relations. The word used in Hinduism is moh which is a major hindrance in the process of self actualization. Thus the stage expects to leave the place so that slowly that physical cut off converts to psychological disconnection from relation and their memories. In present world one has to understand that practically we can't move to forest but what can be done is that elderly have to free their mind from the thoughts of taking decision

for children or helping them in this with the idea that children cannot take decisions by themselves. They have to accept that a time will come when they will have to do themselves so let them begin that much before. Thus once they disengage from interference in their children's lives slowly would be able to engage themselves in other bigger causes.

The last but not the least is wealth and property. A human being spends his whole life collecting wealth and property thus at the end stage one major concern is about this. They are worried about it and who is going to possess it, how he will get and weather after getting it they will take care of it or not. Thus this stage addresses other major disengagement from attachment to wealth. The religion through various sources says that one has to go all alone and everything will be left behind. Thus living with basic amenities and donating to the needy is expected at this stage. Thus it can be said that if religion is rightly understood it really helps in aging successfully and accepting death gracefully.

Conclusion

Hinduism, more than a religion, is a way of living life to ultimately reach the highest level which is nothing but self-actualization. Thus if religion is understood with right interpretation spirituality certainly will help in successful ageing. Thus the Vedic Asharams specifically *vanaprastha* and *sanyasa* ashramas give a simple and straight path to live this phase of life which, if followed, would answer the major fears of death that disturb the elderly. Thus when the fear of death gets removed and self realization and awareness happen the path to face death becomes smooth and graceful.

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Gender Differentials in Chronic Morbidities and Related Issues among Urban Elderly

P. Phamila Jesintha Rajee and Dr N. Audinarayana
Depatment of Sociology & Population Studies, Director, School of Social Sciences
Bharathiar University, COIMBATORE – 641 046

ABSTRACT

An attempt was made in this paper to examine the prevalence of elderly suffering from selected morbidities, duration of years they suffered and treatment taken or not for one or the other morbidity under consideration from any health facility across their gender background. For this purpose, data from 778 elderly persons (364 men and 414 women) who are residing in Coimbatore city, Tamil Nadu, was collected and analysed with the help of cross-tabulations/means and Chi-square/ANOVA tests. The findings revealed that the percentages of elderly suffering from Arthritis and Cataract and related closely followed by Blood Pressure, Diabetes, Back pain and Asthma are higher among women than among men. On the other hand, while the duration of years suffering from Cataract and related, Arthritis, Blood Pressure Asthma and Ulcer problem is significantly higher among men than their women counterparts, the reverse pattern is noticed in the case of Diabetes. By and large, men tend to avail medical treatment for majority of the chronic morbidities under consideration to a large extent than their women counterparts. Based on the findings suitable policy implications have been proposed and discussed.

Key words: Gender differentials, Elderly, Chronic Morbidity

With an increase in aged population (60+ years) in most of the less developed countries in the World, women are going to live longer than their men counterparts and thereby, they have longer period of exposure to one or the other diseases. Due to this, women are more likely to suffer with chronic morbidities for a longer period of time, besides negligence in getting treatment for the diseases. Several studies around the world give the picture of near-constant female excess in morbidity persistence, in part because few studies examine gender differences across health measures by age (Gorman and Read, 2006). Likewise, it has been observed that in most societies across the globe women tend to report higher levels of depression, distress, and chronic illness (McDonough and Walters, 2001). Some argued that women report higher levels of health problems because of their reduced access to material and social conditions that foster health and from the greater stress associated with their gender and marital roles (Singh *et al.,* 2013). Furthermore, when it comes to duration of years suffered with various morbidities, one can observe that men tend to suffer for a longer period since they are more exposed to hazardous environment outside home, work and public places as compared to women. Of course, one need not deny the fact that women living in urban areas nearby factories emitting polluted gases are also more likely to suffer even if they restrict themselves to homes. With regard to taking treatment one can postulate women generally tend to go for health facility for medical and health services to a lesser extent than their men counterparts, as men are the breadwinners/major decision makers at the family level. Besides this socio-cultural taboos and negligence on the part of women to avail such services as soon as possible is another factor. With this background, in this paper an attempt was made to understand the gender differentials in morbidity and related issues among urban elderly based on the data collected from Coimbatore city, Tamil Nadu.

Review of Literature

In Indian context, a few studies have been carried out in urban areas/settings which have highlighted the prevalence/magnitude of chronic morbidities among eldlery persons and medical/health facilities availed or utilsed by them. Joshi *et al.,* (2003) among 200 elderly in Chandigarh city and a rural area of Haryana state found that a greater

percentage (89%) of them reported one or the other illness (91% women and 84% men). The majority of them (43%) were diagnosed as having 4–6 morbidities, 23 per cent had 7–9, 1.5 per cent had a maximum of 13 and only 0.5 per cent had no morbidity. The mean number of morbidities among male elderly was 5.9 compared with 6.4 among females ($p < 0.05$). Among those who perceived themselves as ill (177), 44 per cent sought treatment/taken medicines at the time of survey; females marginally higher than males (48% vs. 42%). The most prevalent morbidities among elderly persons were anaemia, dental problems, hypertension, chronic obstructive airway desease (COAD), cataract and osteoarthritis (in the range 67%–33%). Most of the morbidities were common in rural areas except for hypertension (56%) and osteoarthritis (34%). Based on a cross-sectional study among 300 elderly persons residing in an urban area of Udaipur, Rajasthan, Prakash *et al.*, (2004) stated that cataract (70%) was the most common morbidity from which the elderly suffered followed by hypertension (48%), respiratory diseases (36%) and musculo-skeletal diseases (15%). It was also conspicuous to note that except the respiratory diseases (41% in men and 27% in women), other three morbidity conditions were higher among women than men (75% & 67%, 55% & 44% and 20 & 12%, respectively).

In a cross-sectional community-based study among elderly – 293 from Dibrugarh city and 230 from tea garden community, Assam – Medhi *et al.,* (2006) observed that among both tea garden and urban elderly, hypertension (81% and 69%, respectively) closely followed by musculoskeletal (68% and 63%), respiratory problems (32% and 30%) and cataract (33% and 40%) were major health problems. Gender differentials in this regard were neither consistent nor significant. About two-fifths (39%) of urban as against 8 per cent of tea garden elderly used health services only during the preceding one year of the survey. Bhatia *et al.,* (2007) in their study among 362 aged persons (65+ years) from Chandigarh Union Territory observed that a greater percentage of the elderly (86%) reported to be suffering from one or more health-related problems, with an average of two illnesses. Illness was higher among females (60%) as compared to males (41%). The main health-related problems among the aged were those of circulatory system (hypertension and heart attack – 50%) closely followed

by musculo-skeletal system (48%), connective tissues disorder (46%), cataract (19%) and diabetes mellitus (12%). Hypertension as well as diabetes mellitus were significantly ($p < 0.05$ in both the cases) more in females (46% and 18%, respectively) than males (35% and 6%, respectively). With a few exceptions, such gender differentials were more prominently noted among those who belong to 65–74 years, but negligible in 75+ years age group. While analyzing the NSSO's 60th round data for Kerala state, Mini (2009) noted that about 16 per cent of elderly persons were suffering from at least one acute disease (15.9% in males and 17.2% in females) and little over 47 per cent were suffering from at least one chronic disease (47.6% in males and 47% in females) at the time of survey. Hypertension was reported to be the most prevalent disease among both males and females (12.4% and 18.6%) followed by disorders of joints and bones (6.9% and 14.9%), diabetes mellitus (20% and 14.3%) and asthma (3.8% and 3.7%).

A study among 360 community dwelling urban elderly (65+ years) from middle socio-economic strata in Bangaluru (Srinivasan *et al.,* 2010) revealed that a greater majority (85%) reported to be suffering from medical problems. Hypertension was reported by majority of the elderly (49%) followed by diabetes (32%) and arthritis, coronary heart disease & genitourinary diseases (28% in each case). While diabetes and hypertension were equally prevalent in both genders, arthritis was significantly more common among women. About fifty per cent of them made 3 or less physician visits and 13 per cent were hospitalized for health related problems during 1 year preceding the survey. In another study carried out among 100 elderly residing in an urban slum of Pune city, Pandve and Deshmukh (2010) observed that cataract was the most common morbid condition (68%) among the elderly followed by musculoskeletal disorders (53%) and hypertension (27%). A large majority of the sample elderly utilized the medical and health services from urban health training center attached to a Medical College in Pune, whereas about three-tenths of them (29%) availed such services from private practitioners and just about 3 per cent from municipal hospital. All these reviews highlight the fact that the prevalence of majority of morbidities is higher among elderly women than their men counterparts.

Objectives

The following were the major objectives of the present study:

1. To study the magnitude of chronic morbidities from which the elderly persons are suffering across their gender background in Coimbatore city, Tamil Nadu.
2. To understand the duration of years suffering from chronic diseases by the elderly persons across their gender background in Coimbatore city, Tamil Nadu.
3. To know whether those elderly persons who were suffering from chronic morbidities had taken treatment were not across their gender background in Coimbatore city, Tamil Nadu.

Data and Methods

Data for the present paper was drawn from an ICSSR sponsored research project entitled *'Care Giving to the Urban Elderly across their Living Arrangements: A Study in Coimbatore City, Tamil Nadu'*. The sample frame for this survey was 4 wards (out of 72 wards) in Coimbatore Municipal Corporation (CMC), which was selected based on their literacy rates (one of the best indicators of social development) – 2 wards from those which had comparatively higher literacy rates; 96.4 and 94.0, and 2 wards from those which had lower literacy rates; 80.3 and 80.0 – according to 2001 census on simple random basis. Out of these four wards, 8 clusters (streets or parts of streets), comprising about 1000 population each, were selected on simple random basis. The sample size intended to collect was fixed about 800 elderly persons (60+ years in age), which was thought to distribute equally among the 8 clusters out of four wards. Finally, the data was collected, through interview schedule, from 778 elderly persons of which 364 were males and 414 were females (Audinarayana, 2012).

In the present paper, an attempt was made to analyse the elderly persons' chronic morbidity status, which has been measured by asking the respondents for about 13 morbidities; of which 9 morbidities (from whom at least 5 per cent of them were suffering at the time of survey) only were analysed. Next to this, the duration of years from which the elderly persons were suffering from these 9 morbidities were computed based on mean number. of years (duration). Likewise,

whether the elderly took treatment or not was analysed among those who were suffering from the said chronic morbidities. Further, since the major intension of the paper was to understand gender differentials, if any, in the selected phenomenon, all these analyses were carried out across their gender background. Simple percentage and cross-tabular analyses with Chi-square test as well as mean and one-way ANOVA were the statistical tools used here. All these analyses were done making use of SPSS software (Version 22.0).

Results and Discussion

Magnitude of Elderly Suffering from Different Chronic Morbidities by their Gender

Information about the prevalence of different chronic morbidities among the urban elderly persons across their gender background is provided in Table 1. On the whole, it is observed that majority of the elderly are suffering from poor vision/cataract related problems and rheumatism/arthritis followed by blood pressure. Some are suffering from the chronic morbidities like diabetes, back pain/slipped disc and asthma/lung problems. A few of them suffer from heart problem, ulcer/gas problem and dental problems. It is conspicuous to note that the elderly women are invariably suffering from almost all the said chronic morbidities to higher extent than their men counterparts, except in the case of ulcer/gas problems. However, it is interesting to note that such gender differentials in chronic morbidities are strikingly large and the chi-square test results also turned out as highly significant ($p < 0.001$) in the case of poor vision/cataract, rheumatism/arthritis and back pain/slipped disc, whereas somewhat large (and significant) in the case of blood pressure ($p < 0.05$), dental problems ($p < 0.01$) and lung problems/asthma ($p < 0.10$). As noted earlier, percentage of elderly persons suffering from ulcer/gas problems is higher among men as compared to their women counterparts, which also turned out as moderately significant ($p < 0.05$). On the whole, 75 per cent of the elderly are suffering from one or the other chronic morbidities under consideration. As expected, such percentage is higher among women (81%) as compared to their men counterparts (69%) and the chi-square test results also turned out as highly significant ($p < 0.001$).

Table 1
Percentage Distribution of the Elderly Suffering from Chronic Morbidities by their Gender Background

Chronic Morbidities	*Gender*				*Total*	
	Male		*Female*			
	%	*No.*	*%*	*No.*	*%*	*No.*
Poor Vision/Cataract***	36	131	49.3	204	43.1	335
Rheumatism/Arthritis***	31	113	50.5	209	41.4	322
Blood Pressure*	25.3	92	31.6	131	28.7	223
Diabetes	15.9	58	17.4	72	16.7	130
Back Pain/Slipped Disc***	9.1	33	19.8	82	14.8	115
Lung Problem/Asthma+	9.9	36	15.5	64	12.9	100
Heart Problem	8	29	9.2	38	8.6	67
Ulcer/Gas Problem*	11.3	41	7.5	31	9.3	72
Dental Problem**	3	11	7	29	5.1	40
Suffering from One or more Chronic Morbidities***	68.7	250	80.9	335	75.2	585

Note: +, *, ** and *** = The Chi-square test results for each of the morbidity across their gender background are significant at 0.10, 0.05, 0.01 and 0.001 levels, respectively

Duration of Years Suffering from Different Chronic Morbidities by Gender

Data related to the duration of years suffering from different chronic morbidities among the urban elderly persons across their gender background is given in Table 2. By and large, one can notice that the duration of years (mean no. of years) elderly suffering from different chronic morbidities is higher for diabetes (8.2 years) closely followed by lungs problem/asthma (7.1), blood pressure (6.2), which are noted as chronic among general population too in the recent past. Next in that order are: heart problem, ulcer/gas problem, poor vision/cataract. Such duration of suffering is comparatively less in the case of chronic diseases like dental problems, back pain/slip disc and rheumatism/arthritis. Gender differentials in the mean number of years of suffering from the chronic diseases under consideration are noteworthy. Out of the 9 chronic morbidities, the mean number of years of suffering from 6 morbidities is higher among elderly men as against women and in the case of remaining 3 morbidities the reverse pattern is noticed. However, the one-way ANOVA results highlighted

that such gender differences (higher for men compared to women) in the mean duration of years of suffering from chronic morbidities is much higher and turned out as highly significant ($p < 0.001$ or $p < 0.01$) for ulcer/gas problem, rheumatism/arthritis and lung problem/asthma, whereas such differences are moderately significant for poor vision/cataract and blood pressure and also for diabetes mean years is higher for women as against men – $p < 0.05$).

Table 2
Distribution of Elderly by Mean Duration of Years Suffering from Chronic Morbidities across their Gender Background

Chronic Morbidities	*Gender*				*Total*	
	Male		*Female*			
	Mean	*N*	*Mean*	*N*	*Mean*	*N*
Poor Vision/Cataract*	5.97	131	4.79	204	5.25	335
Rheumatism/Arthritis**	4.57	113	3.63	209	3.96	322
Blood Pressure*	6.95	92	5.66	131	6.19	223
Diabetes*	7.04	57	9.08	73	8.18	130
Back Pain/Slipped Disc	4.21	33	4.3	82	4.28	115
Lung Problem/Asthma**	8.56	36	6.2	64	7.05	100
Heart Problem	5.41	29	6	38	5.75	67
Ulcer/Gas Problem***	6.73	41	4.35	31	5.71	72
Dental Problem	4.45	11	4.28	29	4.33	40

Note: *, ** and *** = The one-way ANOVA test results for each of the morbidity across their gender background are significant at 0.05, 0.01 and 0.001 levels, respectively

Extent of Elderly Taking Treatment or Not for Different Chronic Morbidities by their Gender

Table 3 highlights the information about the extent of elderly persons taken/taking treatment for various chronic morbidities under consideration across their gender background. Among the total sample elderly, one can see that almost all of those who suffered/suffering from heart problem (96%) have taken treatment from one or the other health facility closely followed by a greater extent in the case of ulcer/gas problem (86%) and diabetes (77%). Elderly persons have taken treatment for diseases like dental problem (53%) closely followed by poor vision/cataract (58%) comparatively to an average extent. The percentages of elderly who have taken

treatment for the other morbidities under consideration fall in between these two extremes.

Table 3
Percentage Distribution of the Elderly by Whether Treatment for Chronic Illness is taken or Not across their Gender Background

Chronic Morbidities/ Treatment Taken or Not	*Gender*				*Total*	
	Male		*Female*			
	%	*N*	*%*	*N*	*%*	*N*
Poor Vision/Cataract*	100	131	100	204	100	335
Treatment Taken	64.9	85	35.1	46	57.9	194
Not Taken	35.1	46	46.6	95	42.1	141
Rheumatism/Arthritis**	100	113	100	209	100	322
Treatment Taken	77	87	59.3	124	65.5	211
Not Taken	23	26	40.7	85	34.5	111
Blood Pressure+	100	92	100	131	100	223
Treatment Taken	76.1	70	60.3	79	66.8	149
Not Taken	23.9	22	39.7	52	33.2	74
Diabetes*	100	57	100	73	100	130
Treatment Taken	86	49	69.9	51	76.9	100
Not Taken	14	8	30.1	22	23.1	30
Back Pain/Slipped Disc*	100	33	100	82	100	115
Treatment Taken	54.5	18	72	59	67	77
Not Taken	45.5	15	28	23	33	38
Lung Problem/Asthma*	100	36	100	64	100	100
Treatment Taken	77.8	28	56.3	36	64	64
Not Taken	22.2	8	43.8	28	36	36
Heart Problem	100	29	100	38	100	67
Treatment Taken	93.1	27	97.4	37	95.5	64
Not Taken	6.9	2	2.6	1	4.5	3
Ulcer/Gas Problem+	100	41	100	31	100	72
Treatment Taken	92.7	38	77.4	24	86.1	62
Not Taken	7.3	3	22.6	7	13.9	10
Dental Problems	100	11	100	29	100	40
Treatment Taken	54.5	6	51.7	15	52.5	21
Not Taken	45.5	5	48.3	14	47.5	19

Note: +, *, ** and *** = The Chi-square test results for each of the morbidity across their gender background are significant at 0.10, 0.05, 0.01 and 0.001 levels, respectively

Notable gender differentials in the percentage of treatment taken for different morbidities are also seen. By and large, out of the 9 morbidities, for 7 morbidities men elderly have taken treatment to a higher extent than their women counterparts. Moreover, such percentage differentials have turned out to be significant in the case of rheumatism/arthritis ($p < 0.01$), poor vision/cataract, diabetes, lung problem/asthma ($p < 0.05$ in each of these cases) and blood pressure ($p < 0.10$). It is conspicuous to note that the percentage of elderly who have taken treatment for chronic morbidities like back pain/slipped disc and heart problem is higher among women than among men, but the chi-square test results emerged significant ($p < 0.05$) only in the case of back pain/slipped disc.

Conclusions and Implications

From the foregoing analysis and discussion, the following major conclusions have been drawn. Among the Coimbatore urban elderly, poor vision/cataract, rheumatism/arthritis and blood pressure are the most prevalent chronic morbidities. Women appear to be suffering from most of the chronic morbidities longer than their counterparts, except in the case of ulcer/gas problems. Such patterns are noticed in the other studies mentioned earlier. On the other hand, while the duration of years suffering from poor vision/cataract, rheumatism/arthritis, blood pressure, asthma and ulcer/gas problem is significantly higher among men than their women counterparts, the reverse pattern is noticed in the case of diabetes. These figures clearly establish that men are suffering from different chronic morbidities for longer periods than their women counterparts. Life style habits followed by men like tobacco use, drinking alcohol, eating unhygienic foods, etc. could be the major reasons for such finding, in addition to their exposure to polluted environment outside home. It is also visible that in the case of majority of the chronic morbidities elderly men tend to seek treatment more frequently from any health facility (mainly allopathic system) than women. Of course, to some extent it depends upon the intensity of chronic disease. For example, while women got treatment to a higher extent than men in the case of heart problems, the reverse pattern is noticed in the case of ulcer/gas problems and diabetes.

Based on the conclusions a few policy implications are suggested. Firstly, Government should evolve strategies to provide geriatric services through special camps at district level hospitals, or mobile vans may be organized at their door steps offering both preventive and curative services to the elderly persons. Non-communicable diseases emerged as the major ones among elderly, which deserves special attention of policy makers and programme managers. Early identification of chronic morbidities like diabetes, blood pressure, heart problems, asthma, etc. should be ensured through periodic screening and regular health checkups. Efforts should also be made to provide training to health care providers to manage the commonly existing health problems among the elderly. Strategies may also be evolved to create awareness among the younger/other family members to understand the intensity of the morbidity status of the elderly persons and encourage them to help the elderly in availing proper medical/health care as and when there is need without any delay.

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