QUALITY OF LIFE OF THE ELDERLY IN MIZORAM

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QUALITY OF LIFE OF THE ELDERLY IN MIZORAM

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Submitted in partial fulfillment of the requirement of the Degree of Doctor of Philosophy in Social Work of Mizoram University, Aizawl.

Dedicated to my parents, for your unconditional love and support. My only sister Lalnunmawii (Late) affectionately called Mamawii, I love you, my life is incomplete without you.

D E C L A R A T I O N

Mizoram University

December, 2010.

I, Lalmuanpuii, hereby declare that the subject matter of this thesis is a record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to do the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/ Institute.

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C E R T I F I C A T E

This is to certify that the thesis entitled "**Quality of Life of The Elderly In Mizoram"** submitted by Lalmuanpuii has been written under my supervision.

She has fulfilled all required norms laid down within the Ph.D regulations of Mizoram University. The thesis is the result of her own investigation. Neither the thesis as a whole or part of it was ever submitted to any other University for any research degree.

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APL	:	Above Poverty Line
BPL	:	Below Poverty Line
CBO	:	Community Based Organization
NGO	:	Non-Governmental Organization
NPOP	:	National Policy on Older Persons
OAH	:	Old Age Home
MHIP	:	Mizo Hmeichhe Insuihkhawm Pawl
MUP	:	Mizoram Upa Pawl
PHC	:	Primary Health Centre
SPSS	:	Statistical Packages for Social Sciences
WHO	:	World Health Organization
VC	:	Village Council
YMA	:	Young Mizo Association

Contents

CHAPTER 1

INTRODUCTION

1. Introduction

The present study is an attempt to understand the 'Quality of Life of the Elderly in Mizoram'. This chapter introduces concepts related to aging and outlines the characteristics of the elderly in the world, India and in the state of Mizoram.

Further, this chapter describes Mizoram the setting in which the study is based. The chapter ends with a statement of the problem, the objectives of the study and the chapter scheme that is followed.

Overview of Concepts Related to Ageing

The Field of adult development and aging is a relatively young topic in the social sciences. Despite the growing concern in this area, a lot of research is required to be done. Old age is usually regarded as synonymous with pensionable age or age at retirement. Ageing as a process has been recognized from time immemorial. Folklore, tradition and wisdom in all cultures have been known to have reposited with people who lived unto a 'ripe old age'. Old age is mostly fixated at any age over 60 years or so in most nations around the world. Increasing life spans and longevity of populations would however mean that there is a substantial population of persons living in a category that is often referred to as the 'aged'. However to place the entire population of persons of 60 years – 100 years (or more) in a one compartment of 'the Elderly' would be erroneous if we intend to plan interventions or programmes for them since 30-40 life span is a huge range in years.

Most developed countries have accepted the chronological age of 65 years as a definition of 'elderly' or older persons, but like many westernized concepts, this does not apply well to other countries especially the developing countries. Although there are commonly used definitions of old age, there is no general agreement on the age at

which a person becomes old. The common use of calendar age mark the threshold of old age assumes equivalence with biological age, yet at the same time, it is generally accepted that these two are not necessarily synonymous.

Schaie K.W. and Sherry L.Willis (2002) states that placing the entire population in one category and viewing them as undergoing a single stage of life is erroneous. In any life stage people differ radically and so it is with this stage of life. Suzman & Riley (In Schaie K.W. and Sherry L.Willis) categorize the person over 65 years into three stages; *the young old (65 to 75 years); the old old (75 to 85 years); the very old or the oldest old (85 years & above).* It is evident that in the older population, both capacities as well as a decline in abilities would be different for persons in the extremes of the age range. Hence, there is need for researcher, scholars, and practitioners to view this stage in a non-totalitarian manner and recognize the range in abilities of the elderly.

The problems that can arise due to aging – (a) economic (b) familial (c) health and medical care (d) housing. Psychological and emotional problems and social problems are the derivatives of familial problems.

The age at which a person may be considered as old has been changing over the years and quality of life dimensions have been an outcome of how to view ageing as both a psychological and physical process. Other authors (Hurlock.E.B., 1998) have categorized the elderly from 60 years and above into the same categories of *young old (60-70 years old), old old (71-80 years old) and the very old (81 and above years old)*

The increased concern for old age is a recent development and is a result of rapid increase in the population of elderly persons above sixty years of age. According to the UNESCO estimate*, the number of the aged above sixty is likely to go up from 350million in 1975 to 590million in 2005. About half of them live in*

developing countries. Elderly population in India comprises of the largest and more rapidly expanding minorities in India. In 1950, it was classified that 5.6 percent of India's population as the elderly. By 1991, it rose to 6.75 percent (male) and 6.78percent (female). And the elderly population is higher in rural than urban. The life expectancy of life at birth has been increasing on an average by 0.05 per year.

Quetelet in 1835 was among the first to bring attention to research on ageing. Later Francis Galton and others too focused on understanding dimensions related to ageing but it was in 1922 that the Seminal Work by G. Stanley Hall *"Senescence"* in 1922 that placed major international attention by researchers on ageing.

Biological age refers to the present position of an individual relative to his potential life span. **Psychological age** refers to the position of individuals relative to some population with regard to adaptive capacities as observed or inferred from measurements of behavior. Psychological age may also include subjective reactions to development. **Social age** refers to the social habits and roles of the individual relative to his group or society.

There is a tremendous change seen in the lifestyle and ***quality of life*** of the elderly. The changes are at the *Physical, Psychological and Social levels*. For many who were earlier used to drawing a fixed income from work, old age is a stage when they are compelled to adjust to changes that cessation of income brings with it. Additionally, the changes are seen in relationships, work and activity levels. This may also be a stage when there are many physical health problem that range from minor weakness and loss of function to major disabilities and health problems. On account of lack of exercise a few of them develop orthopedic, cardiac ailments, diabetes and respiratory ailments. All of them become more vulnerable to common diseases. Many elderly also suffer from mental symptoms and diseases. Anxiety states, depression

and melancholia are ailments common among the aged. In few cases restoration in the brain tissue gives rise to organic psychosis including dementia. One of the problems unique to old age is making new friends to replace those who have died, moved away, or are invalid. Homes for the elderly offer excellent opportunities to solve these problems for some elderly. Feeling useless and unwanted, many elderly people develop feelings of inferiority and resentment feelings that are not conducive to good personal and social adjustment (Lalmuanpuii, 2004).

There is increasing attention in research with reference to health and social issues that include elderly abuse in families, maintenance of elderly homes, Need for home based care, nursing homes and day care facilities. Recognition of the seriousness and extent of elderly abuse has been slow. Abuse can be verbal (verbal assaults, threats, use of abusive and obscene languages), physical (battering, shaking, tying to bed, withholding physical care), medical (sedating) or failing to procure needed appliances such as walking stick, glasses, hearing aids or financial (misuse of assets and exploitation).

1.2 World Scenario

The Worlds Population is ageing rapidly. The ageing of population refers to the proportion of old people in the total population of the nation. The global ageing process that first took place in the developed countries has now become a worldwide phenomenon. Today, out of every ten persons is 60 years ot above; by 2050, one out of five will be 60 years or older; and by 2150, one out of three persons will be 60 years or older. One significant aspect of the global ageing process is that the 80 years or over age group is the fastest growing segment of the population. In terms of total population, 80 or above people today constitute a little more than 1 per cent, the proportion is expected to increase to 4.1 percent in 2050. Globally, the average annual

growth rate of persons aged 80 years or over (3.8%) is currently twice as high as the growth rate of population over 60 years of age (1.9%). In 2000 there were estimated 180,000 centenarians throughout the world. By 2050, their number will increase to be 3.2 millions. (Vanlalchawna , 2007).

1.2.2 India Scenario

The ageing population in India has started since 1961 which marked the process of the beginning of sharp decline in the overall death rate and also in mortality levels in the older age groups (age 60 and above years). The elderly population increased from 12.06 million in 1901 to 19.61 million in 1951, an increase about 63 per cent. Between 1951 and 1971, the number of elderly persons increased by about 67 per cent, reaching 32.70 million by 197, during 1971-81, the increase in the aged population was about 32 per cent as against the increase of 24.7 per cent recorded for the total population during this period. The Technical Group on population Projections estimated that the likely number of the elderly by year 2016 will be around 113 millions. About 78.1 per cent of the elderly in India live in rural areas against 74.3 per cent of the total population living in urban areas. The mortality rate for the elderly, as obtained from the scheme of the Sample Registration System (SRS) indicated that mortality rate in the 60+ in 1996 was 50 per 1000 elderly population. This was 55 for males as compared with 46 females. (Vanlalchawna, 2007).

1.2.3 Mizoram Scenario

Mizoram covering 21,081 square kilometers, has approximately ten lakh persons and it occupies 30th position in terms of population size among the 35 states

and union territories. The state consists of 8 districts with 22 Rural Development (RD) Blocks and 817 villages, out of which 707 are inhabited and 110 are uninhabited. The state is young and attained statehood only in `1987 . The urban area of the state in the 2001 Census comprised of 22 statutory towns. The state is unique on many counts . The rural population consists of 50.4 per cent of the total population while 49.6 per cent live in urban areas, making it a near equal Rural-urban distribution. Mizoram is one of the highest urbanized states in the country, next to Delhi. The state has registered 28.8 per cent growth rate of population during 1991-2001 compared to 39.7 per cent during the 1981-1991. the growth rate of the population in 1991-2001 is higher than the national growth of 21.5 per cent. The overall literacy rate is 88.8 per cent in 2001 Census. People aged 60 years and over have increasingly a larger share in the total population. From 4.42 per cent in 1981, the share of the old age population has increased to 5.52 per cent in 2001. Between 1981 to 2001 the population grew by 80 per cent while the elderly population grew by 124 per cent. According to Census of India, 2001 the total number of elderly persons (60 years and over) in Mizoram is 49023 (Vanlalchawna, 2007).

According to the Census of India, 2001, the elderly population is growing at a fast rate and age 80 years and above is the fastest growing population in the world. It is documented that today out of every ten person one elderly is present, it is estimated that in the year 2050, out of every five persons one elderly (60+years) will be present, further in the year 2150, it is projected that out of every three persons one elderly (60+) will be present. In India, in 1901, the elderly comprised of 5.1 per cent of the entire population, in 1951 the figure rose to 5.4 per cent. According to the 2001, Census of India, in 2001 7.7 per cent constituted of the elderly population where more than half (78.1%) of them reside in the rural areas. It is projected that by the year

2016, the elderly population in India will rise to 113 million. In Mizoram, in the year 1981, the elderly population was 4.42 per cent, in 1991, the figure rose to 4.81 per cent. According to the Census of India, 2001, 5.52 per cent of the population in Mizoram constituted the elderly. According to the same source, majority of the male elderly in Mizoram (77%) are literate against less than half (43%) of female elderly (Census of India, 2001). This study attempts to document the quality of life as perceived by the elderly. It explores perceptions related to Personal Hygiene, Physical Health, Diet, Mental health, habits , recreation and leisure time pursuits , services and Social Support and Perceived Life satisfaction. The need to document the quality of Life has been necessitated by the fact that the elderly are among the fastest growing population in the world, with increasing longevity and life span. If this crucial area is neglected, it would have severe implications on health, within family and within the community and global contexts.

According to the annual report of the Health Directorate, Government of Mizoram, 2010, the death rate of the state stands at 5.10 against India which is 9. The birth rate for Mizoram is 21.90 while India is 25. The decade growth rate is 28.82 while in India the figure is 21.54. The per capita income is 19,696 whereas in India it is 17,978. The mortality rate is with specific reference to the elderly indicated in the table below:

Age group	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
65 to 69	363	282	245	272	277	254
70 and above	758	961	973	998	1135	1173

Source: Annual Report, Directorate of Health Services, Government of Mizoram

The Table indicates a steady rise in mortality of people over the age of 70 years while there is a fall in mortality of people between 65-75 years. The quality of life of the young old may be fairly adequate.

Mizoram is a unique state with several associations and organizations . All Mizos by virtue of being Mizo are members of the Young Mizo Association (YMA) and it is the YMA that organizes all community activities and events and offers maximum support during the times of crisis and death. YMA organizes the funeral services of all its members . The MHIP (Mizo Women's Federation) is an association of women and all Mizo women are part of it . The *Mizoram Upa Pawl* (Mizoram Senior Citizen's Organization) was founded in 1957 to work on the issues, needs and challenges of the elderly in Mizoram. The motto of the organization is "to be a blessing to others". The age at which a person may be a part of the Mizoram Upa Pawl (MUP) is over fifty years. A majority, however are persons over the age of sixty (Lalmuanpuii, 2004). The Census figures of Age wise data in Mizoram indicates that there are approximately over a lakh in population of persons over the age of 50 years (Census of India 2001). This means that approximately over ten percent of the total population in Mizoram would require care and protection as older persons. Headquarters of the MUP is located in Aizawl, the capital of Mizoram. The MUP today has more than 500 units and 4 Sub-Headquarters all over the state. All urban localities and rural villages have a branch of the MUP. The executive committee assembly has recently resolved to constitute Charity Fund amounting to 50 lakhs to assist the needy members of the organization. The MUP has also instituted 'Mizo Medal' award to those persons who exhibit extra-ordinary bravery, scholarship, high quality of social contribution. Besides these activities, the MUP also give consensus

to the families (those belonging to below poverty line) of the member who has passed away.

In Mizoram, the elderly are respected within the family, neighbourhood and in the society as a whole. This may be due to religious beliefs, traditional values, cultural heritage, social norms and education. Better living conditions and health care, diet and nutrition owing to modernization, are possible reasons why people do not show the physical signs of ageing today as they did until the mid sixties or even the early seventies. However, the living standards of rural and urban, educated and uneducated elderly does differ. (Thanseia, 2007)

In August 1998, the Government of India announced the **National Policy on older persons (See Appendix 3)**. The policy looks at ways to empower the aged. It provides for setting up of a pension fund for ensuring the security and empowerment of those in the unorganized sector. The policy also aims at subsidizing the health care network with private sector involvement. The policy assures that the education and training of older persons will be met.

The National seminar on Globalization and Ageing organized by TISS recommended few guiding principles for the well being of older persons. It concluded that positive perception on older persons need for out- reach to vulnerable older persons, rights of older persons, family and community as natural support systems, sensitivity to the background of older persons, barrier free environment and participatory approach were required in the context of the elderly

The National Policy on Older persons seeks to assure that the state will help older persons to live with purpose, dignity and place; it also assures support for financial security, health care, shelter, provide protection against abuse and exploitation and provide services so that they can improve quality of their lives. The

policy views the life cycle as a continuum and consider 60+ as a phase when t he individual should have the opportunities to lead an active, creative, productive and satisfying life, thrusting on productive involvement of older persons and not just their care. The policy recognizes the older persons as a resource and believes in the empowerment of elderly. Further, the policy emphasized that the families, individuals, communities and institutions of civil society have to join hands as partners.

Regarding the Government measures for the care of the elderly in India, there is no comprehensive social security system, which ensures financial support for the elderly persons, especially the Rural Aged in unorganized sector, thus the working of pension schemes for the unorganized sector are not satisfactory. These pension schemes should reach most of the Rural Elderly – needy persons. (In Lalmuanpuii, 2004)

Old age pension to the poor aged 65 years and above @ Rs 75-p.m. is one of the components of the National Social Assistance Programme (1995). It is quite inadequate. The rate of monthly pension needs to be revised and the quick selection and disbursement would be of great help particularly to the Rural Elderly. Social workers working in this area should advocate for the rights and opportunities of the Rural Elderly. This can be done at all the levels of social work intervention. Day Care centers should also be advocated so as to provide mid day meals for the Rural Elderly and a recreational center for the Rural Elderly. For this purpose a well planned and furnished building is the requirement for the proper functioning of the Day Care center however, building construction is a costly affair Global Funding agencies working for the elderly may come forward to meet their requirement. Besides these, social workers may act as a coordinator of services, a counselor, a guide, a moderator, and a research investigator. Social workers working in this area of work with

individuals, families, communities, welfare agencies and other professionals like doctors, psychiatrist, psychologist, and lawyers for more productive welfare services.

The well being of older persons has been mandated in the constitution of India. It recognizes the duty of the state towards all citizens including the aged, to make effective provision to secure the right to work, the right to education, and the right to public assistance in the cases of unemployment, old age, sickness and disability. These social policies find expression in social security and socio-economic programmes.

The present study is an attempt to understand the problems of the elderly as well as their perceived life satisfaction so as to develop strategies for the well being of older persons. The study wishes to explore the extent to which the changes in economic, social and health aspects of elderly are causing the need for strategies for the well being and to promote care of the elderly.

The ***quality of life of an elderly*** is defined first and foremost, by the respect they have for themselves and secondly by the respect the outside world shows them. Seniors who have a healthy quality of life, continue to be active and are well groomed. This can be seen easily in the Mizo society as it is a close knit one when compared to other societies in the country. Active elderly in Mizo society may be studied based on level of (local) church participation. Mizoram is a hilly area and the location of local church is not always easily accessible especially for the elderly, however, in spite of this, elderly who are active are usually found to attend church services regularly. Besides, many of the elderly are found to be very active in the elderly organization (MUP), also some elderly especially 'church elders' are deeply valued in the society for their varied contributions. Church elderls are appointed based

on their significant contributions to the society and by virtue of being 'morally' of high standard.

The Greying of India or 'Population Ageing' as it has been referred to has been largely a result of both the decline in mortality as in the decline in the overall death rate. Morbidity figures to indicate that there is better control of disease that has impacted on the quality of life. Further decline in fertility has a role to play in the overall ageing of populations.

Improvements in quality of life and development in general have resulted in dramatic increase in ageing populations across the world. In the 1950's there were around 200 million older persons (over age 60 years) in the world and this number tripled in a fifty year span. Even more dramatic is the rise in people over 80 years of age. Demographers are agreed that the ageing trends are sharpest in developing countries.

In India, the average years people were expected to live following 60+ years in 1951 was just 10.9 years for men and 11.4 years for women. Today it has doubled and women can hope to live for another 20 years at least following 60 years while men may live another 17.3 years (Desai M & Siva Raju, 2000). The percentage of persons living beyond 60 years of age to total population has also steadily been rising and today approximately 7.5% of the population in India is older persons.

The John Hartford Foundation (SWLI) suggests that these rapid demographic changes globally are forcing our planners to reshape their policies and improve the health Care delivery needs of the older persons. It compels also the expansion of ageing competent professionals to deal with the range of issues thrown up in the wake of 'a next Generation'.

Social work profession is a profession that addresses a range of challenges faced by a range of persons. It attempts to help persons overcome these challenges in their life through systematic interventions that are planned to bring about change. The profession of social work is based on the scientific study of human beings and uses a knowledge base that recognizes diversity in populations. The value base of social work is empowering and protecting of the dignity of the individuals it wishes to serve. Professional social work is differentiated from voluntary social service in that the former uses a scientific knowledge of human behavior, delineates specific skills and techniques in dealing with people and rets on value base that places emphasis on non-judgmental attitudes, recognition of the inherent worth and dignity of persons, acceptance, acceptance and recognition of the right to self determination by all persons.

It further stipulates a controlled emotional involvement with client populations and assures confidentiality to them in information made available to Social Workers. Traditionally social work began to address specific needs of populations in certain areas and specializations within the subject were built around these areas. Family and Child Welfare, Medical & Psychiatric Social Work, community Development etc were the specializations of the academic discipline of social work. Today, there is an attempt to follow integrated methods in Social Work and there is a concerted effort to practice a generalized method. However, social workers who work exclusively with older persons are referred to as Gerontological Social Workers or Geo-Psychiatric Social Workers (if they work in clinical settings).

Desai K.N. and Lalmuanpuii stated that Gerontological social work is concerned with maintaining and enhancing the quality of life of older adults and their families. It is particularly concerned with ameliorating those physical, psychological,

familial, cultural, ethnic, and racial, organizational, and societal factors which serve as barriers to physical and emotional well-being in later life. Gerontological social work interventions are directed at enhancing dignity, self determination, personal fulfillment, quality of life, optimal functioning, and ensuring the least restrictive living environment possible. Interventions that enhance older adults coping and problem solving capabilities are perhaps the most basic and crucial aspect of gerontological social work. Because services are sought at times of crisis, gerontological social workers give special attention to the cognitive and social factors experienced by the older adults and family (Desai K.N. and Lalmuanpuii, 2007)

1.2 Scope of the Study

The notions with reference to this stage of life are changing rapidly and it is no longer considered to be an unproductive stage of life. The contributions and role of the elderly in several aspects of family and Community life is increasingly being valued and regarded as crucial for development. In this regard, presence of elderly persons in the household and their influence on the health, growth and development of youth has been discussed in several contexts.

The population of the elderly is growing at a fast rate all over the world. Even in Mizoram, due to the development in education, improvement in health, hygiene, sanitation and nutrition, the population of the elderly is growing at a fast rate. However, due to factors like availability of resources both human and material, impact of education, level of awareness, living standards, and improvement in health, impact of media, the living conditions of the elderly differ across urban and rural settings. The elderly unfortunately are also subjected to many complications with the advanced age that may result in both physical and psychological decline.

Comparatively, ageing brings more miseries for women than for men. It is mainly due to the patriarchal character of the society and culturally prescribed norms of seclusion between women and their husband that this problem is further compounded.

This study documents and highlights the Quality of Life aspects among the elderly. It to explores the dynamics related to income, status of elderly within and outside the family, participation in decision making, Support systems as well as their self perceived Life satisfaction so as to develop strategies for the well being of the elderly in Mizoram. This study is restricted to the district of Aizawl but it includes two urban and two rural areas to understand and document the problems and quality of life of this important category of persons.

1.3 Statement of the Problem

Growing older is neither a social problem nor a disease but is a process of biological change which begins at birth and continues through life. People are never static, instead, they constantly change. These changes are the natural accompaniment of what is commonly known as 'aging'. According to Erikson, the socialization process consists of eight phases. The last of these stages is referred to as *Integrity versus Despair (wisdom)* and this is what is generally considered as old age. Age affects the quality of life since physical abilities decline and further since there is diminishing social support, as one grows older. The most common problems that arise due to aging include problems in the family, economic, health and medical care areas as well as in relation to housing. Psychological, emotional problems and social problems are the derivatives of familial problems.

The elderly have a set of problems which are somewhat unique to them. With the advanced age they experience psychomotor difficulties and disabilities in hearing, vision and memory. A few of them developed orthopedic and cardiac ailments,

diabetes and respiratory ailment. All of them become more vulnerable to common diseases due to decline in metabolism. Many elderly also suffer from mental health problems such as anxiety, depression and melancholia. In a few cases restoration in the brain tissue gives rise to organic psychosis including dementia. Feelings of uselessness and unwanted, many elderly people developed feelings of inferiority and resentment that are conducive to good persons and social adjustments.

There are some changes in appearance that occur in old age, which includes head region, trunk region limps. A common change in sensory functioning in old age includes vision, hearing, taste, smell, touch and sensitivity to pain. Common changes in motor abilities in old age are strength, speed, learning new skill. A mental change in old age includes learning, reasoning, creativity, memory, recall, reminiscing, and sense of humor, vocabulary and mental rigidity.

1.4 Objectives of the study

The following are objectives of the present study

1. To prepare a profile of the elderly population in Mizoram.
2. To focus on the Quality of Life of the elderly in Mizoram.
3. To study the social support systems in Mizoram.

1.5 Chapter Scheme

The report of the study is divided into five chapters. The first chapter deals with introduction where basic concepts related to aging and demographic particulars are presented along with the statement of the problem, objectives and scope of the study. This is followed by review of literature in the second chapter. The third chapter deals with methodology. The fourth chapter consists of results and discussion and it

presents the main findings in relation to the objectives of the study. The fifth chapter deals with summary and conclusions.

CHAPTER 2

REVIEW OF LITERATURE

2. Overview of Relevant Studies

Growing older is neither a social problem nor a disease but a process of biological change which begins at birth and continues through life. As stressed repeatedly, people are never static. Instead, they constantly change. These changes are the natural accompaniment of what is commonly known as 'aging'. However, senior citizens are sometimes viewed as problems in the world due to many circumstances like health related care, dependency factors, prone to terminal illness etc.

Gerontology is the study of the phenomena of the aging process from maturity into old age, as well as the study of the elderly as a special population.

Saxena, D.P states that in there are 70 million elderly in India today, 90 per cent of them are from the unorganized sector who after the age of 60 years do not get any pension or gratuity fund etc. and are, therefore, not linked with any medical scheme. This means that they have to continue working even after attaining the age of 60. The educated can still find an alternative job or some means of substance. Besides, about 40 per cent of these 70 million elderly live below the poverty line. They are mainly laborers, etc. When they become old their bodies cannot do the same activity, job as before. But as they have no other option since they have to survive, they keep on working. About 80 per cent of these elderly are illiterate. Out of these 70 million, half of them are women. Nearly 55 per cent of the women over the age of 60 years are widows which in the Indian society mean that they are receivers rather than givers (Saxena, D.P 2006).

Previous studies are a great source in guiding present studies. In fact literature review helps the researcher to map out what aspects of social reality or natural phenomena should be undertaken for research. The population of the elderly is the fastest growing in the world. Among the elderly, the age group of the oldest old (80+)

comprises the fastest growing group in the world, jumping from 13 million in 1950 to over 50 million today and a projected 137 million by 2025 (WHO 2004)

2.1. Ageing-Nature

Old Age is a natural phenomenon. The number of old people is increasing all over the world, in absolute terms and in proportion to the population. Very few people reach old age completely free of disease. Of the global population of over 6 billion almost 10 percent are elderly. Further it is projected that the older population in developing countries will rise much faster than the developed countries. In India, the proportion of older persons has risen from 4.9% in 1901 to 5.5% in 1951, 6.5% in 1991, 7.7% in 2001 and will be 12% in 2025. Increased longevity (currently 64 years in the country) has given rise to greater expectations of health and services necessitating various research in aspects of health and disease in old age and innovations in providing social and economic services. The term “ageing” has three different but inter-related connotations namely, biological and physiological ageing, social ageing, and psychological ageing (United Nations, 1983). The major turning point in the recognition of the potentials of the problem of aging in India was the “Vienna International Plan of Action on Aging” adopted by the World Assembly on Ageing. (Morgan, Weisz and Schopler, 1986)

The long term memory of older adults differs little from those of young adults. From the middle age on, the content of long-term memory may become selective, with focus more on reminiscences from their youth and early adulthood than more recent times (Goleman, 1987, Rubin 1986).

There is some evidence that aged people are less pious, less conformist, and less concerned about matters of principle. However, Bhatia 1983, stated that there is considerable evidence that aging identifies with the central values of their society and do not differ much from other age groups as far as their conceptions of the good life are concerned. Recent research also indicates that in spite of the considerable intergenerational discontinuity brought about by the process of accelerated change, the parent-child relationship bond is of crucial importance during the process of aging. The development of the child begins from conception, therefore it is very clear that familial relationships are important in the all round development of human beings, which again is an important factor in old age. This is so because the self perceived life satisfaction of an individual can be greatly determined by familial relationship (Cumming & Henry in Birren J.E. 1972).

In a study done by Achenbaum, (1978) it was found that the population of the elderly is marked by a series of special challenges and insecurities, and as pointed out by the researcher himself, senior citizens are recognized as a "national problem". However, this view is very subjective. This is so because of the value system held by the researcher and also the research area. In some societies the elderly populations is greatly respected and are considered as treasures. While in some they maybe neglected due to poverty, ignorance and other factors. The value system of any individual is greatly determined by the way he/she was raised, the environment in which an individual was brought up upon.

Joshi A. K is of the view that ageing has become a social problem because socio-economic shifts are affecting the ability of the family to continue with traditional care giving role towards elders. The value system may alter due to all the changes that occur in and around an individual (Joshi A. K 2006), it is to be noted that

although an elderly in the family needs attention, if the family is financially short and unable, care of the elderly may not be possible to a large extent which will ultimately affect the quality of the elderly life. Therefore, in order to consider good standard quality of life of the elderly, the system of social, familial, financial, psychological assistance has to be intact.

Leonard is of the opinion that for successful ageing different factors like marital status, occupational prestige, years of formal education, race, annual income and specific life satisfaction measures have significance to a very large extent (In Joshi U. & Shah A. 2006).

A theory of disengagement, developed recently by Cumming and Henry discards the view of old age as an extension of middle age. Aging leads to a triple withdrawal from society: a loss of roles, a contraction of relationships, and a decline in commitment to norms and values. Thus the aging person becomes increasingly egotistical- relaxation, comfort and self-gratification are his main preoccupations (In Yonina T, 1972).

As discussed earlier, according to these studies, successful aging can be attained by fulfilling the mentioned factors. Therefore, it may be taken into account that the past life of any individual will always determine the future. If investments (financial, family, friends etc) are made carefully and consciously, successful aging is possible. Hence, according to this study qualitative aging is only possible by investing in the past life.

2.2. Social Aspects of Ageing

The concept is viewed in the context of roles and how society perceives persons and their contributions. Thus, social ageing occurs in the life span individual when others perceive his/her role as being that of an old person. These are herald by

social developments such as becoming grandparents, taking retirement, assignment of social responsibilities etc (Bhatia H.S. 1983).

Mishra S. fears that the changing social structure, preponderance of individualistic and materialistic values, negative values of the younger generation towards the elderly from economic activities will contribute a great deal in the emergence of old age as a social problem. This study highlighted a very important and relevant point. With series of development in technology in the world, there is a wide range of competition going on amongst the youth of every nation. Owing to these, parents have also diverted their attention, financial investments on their children rather than for the care of the elderly in their family. The youth have spent so much time in the competitive world that familial life and values have a very little affect on them. Spontaneous and fast showing results have more meaning in their lives, hence values change. This will ultimately affect the love they have for their family especially the elderly due to the fact that the elderly populations are more prone to physical problems, in short, the youths will have no time to attend to them (In Desai M & Raju S, 2000).

Punias further reported that majority of the urban aged (86%) were literate where as majority of the rural aged (67%) were illiterate. They also found that age at marriage was lower among the rural aged than the urban aged. From this study it can be understand that the urban area have better opportunities than in the rural areas. It is also clear that the value system of families differ largely between the two areas. This is so because; in the urban area education was considered important as found in the study mentioned above (In Desai M & Raju S, 2000).

Pushpa Kumari (2001) in her Study: Problems of the Rural Aged and the need for Social Work Intervention 2001 has referred to Crowley who reported that many

older rural and urban black and Hispanic persons live in unsafe, dilapidated housing because they are poor. Asian and Pacific Islanders elderly, in general, do not experience such dire poverty, but many must live unsuitable housing. Studies done in India as well would certainly highlight this aspect.

In a study of 25 persons drawn from Sihphir Vengthar, a sub-urban area of Aizawl City in Mizoram in the age group of 60 to 70 years Lalmuanpuii (2004), it was found that more number of male widowed persons were there as compared to female widowed, contrary to most studies elsewhere. Maximum number of the respondents (40 per cent) in this study belonged to the age group of 70 to 80 years with an educational status of 28 per cent illiteracy among them with more number of females being illiterate.

According to Gee (1999) one of the most striking changes in the living arrangements of elders, especially over the last thirty years, is the increased propensity for widows to live alone – a trend observed in Canada. In his study of the distinctiveness of Chinese Canadian elders' living arrangements, he found that just over one-third lives with their spouse only. In contrast, among Canadians as a whole, nearly 90 per cent live with their spouse only. Among widows, 41 per cent of Chinese lives alone, compared with 90 per cent within the wider population. Thus, there is considerably more variation in living arrangements within a marital status grouping among Chinese elders than there is in the whole elderly population. Also, not insignificant percentages of Chinese elders are living in "western" living arrangements. The data of their study clearly highlight the importance of race/ethnicity in determining the patterning of living arrangements among the elderly. According to A. Lowenstein (1999) Living arrangement patterns of the elderly are changing. There is a decline of older people who live in extended or shared family

households and an increase in the number of elderly living alone (by themselves or with a spouse only) – "elderly households". This is especially so in Western Europe. In the UK, for example, the proportion of the aged living alone almost doubled from 1962 to 1992. In 1992, in Unified Germany, 41% were living alone: similarly, in the Nordic countries 53% of those 70+ live alone. In most Western countries, approximately 15–20% of elderly people are childless. This proportion is even higher in Eastern Europe and in the UK, where up to 30% of the 65+ age group are childless. The situation is somewhat different in Austria, Italy, and Hungary, as well as in the Mediterranean countries where married children are more likely to live with their parents – 10–12 per cent as compared to 3–6 per cent in Scandinavia o the UK. In Israel, the percentage is higher – close to 23 per cent and in Spain, this percentage is especially high – 37.8 per cent of the elderly (either a couple or a single person) live with their offspring.

Binstock, is of the opinion that the elderly population is gaining sympathy in their needs and aspirations. He further states that the public has embraced a "compassionate stereotype", under which seniors are perceived as a group in deserving need- not withstanding that the stereotype in various a distortion of reality in a manner potentially harmful to the specialized needs of various subjects of the elderly (In Henry J. Pratt, 1995).

Sodei. T, (1995) states that the status of the elderly in Japan is not high in the society because they are "seniors" although seniority is practiced in the work place, it is maintained only during service, therefore common men after retirement lost influence, however the case of older politicians and business men may differ.

Mishra. S. says that the technological breakthrough due to industrialization, westernization, and urbanization contribute to the neglected ascribed statuses by the

weakening of unity and integrity of the Indian family system and caste group that lead to the negligence of the role and status of the elderly. Ambedkar in Raju S.S, 2002, is of the opinion that the issues relating to the elderly is the result of conflict between traditionalism of the elderly individuals and the uncritical eagerness of the youths towards the western values (In Raju S.S., 2002).

Prior to industrialization, the cultural heritage of Indian society was given the leadership roles and powerful positions of decision-makers and advisors in the Indian joint family and community to the elderly persons; as their knowledge and experience were considered to be great value in the proper functioning of society (De Souza, Bhatia; and Mishra, In Mishra, S. 1987).

Henslin M.J. (1990) concluded that old persons are seen as weak, indolent, calm etc in the society compared to the youths who are considered to be smart, courageous and sportive.

Mishra A.K. & Mishra B. K. (2006) are of the view that in accordance with the sociological perspective, ageing, a social process is not an offshoot of the more biological aspect rather a by-product of larger socio-cultural milieu. Hence, the liberation of ageism does not simply imply a collaborative effort, public, private institution or agency, NGO's and community and the 'self', which will retrieve cognitive tradition of Indian civilization.

Partha N. Mukherji shares his view by distinguishes between biological and sociological or psychological age by saying biologically a person may be 'old', but if he/she possesses a youthful mentality, sociologically and psychologically speaking, hence, therefore he/she should be included in the younger generation (In Mishra A. K. & Mishra B. K. 2006).

2.1.1 Elderly as Grandparents

Elderly are generally considered as pride of the community for their wisdom. The 1st of October every year is observed as the world elderly day all over the world. Every family is unique, however, elderly are considered valuable in families. In Mizoram, the elderly are respected in a variety of ways, in the family, neighborhood, in the society as a whole. This may be due to religious beliefs, traditional values, mores, cultural heritage, social norm and education. Owing to numerous developments in the area of health care system, education, better living conditions today physical sign of aging do not show until the mid sixties, however, rural and urban area may differ numerously.

Elderly are valuable asset especially to their immediate family. They serve as loving and understanding grandparents to their grand children. Inter-generational gap between the elderly and their grand children can somehow create a favorable relationship between them. It is often understood that some elderly grandparents maintain better relationship with their grandchildren than their own children. Hence, are valuable to their grandchildren.

Troll, in Judith Stevens- Long, 1984 suggested that to generalize about the meaning and role of grand-parenting is difficult as he stated that it differs from one family to another. He also found that the age of grandparents as an important factor since he indicates that grandparents tend to be closer to young children.

In a study by Robertson, he suggested that grand parenting underlines the potential importance of grandmothers, in particular, for family functioning. He suggested that grandmothers provide baby-sitting and may even serve as a surrogate parent for the children of widowed or divorced parents, and also as the lineage family as interveners in crisis situations, and as the bearers of tradition. He also found that

socioeconomic level was a good predictor of the type of grandmother a woman would become, and that life satisfaction and marital status also seemed important. Yet despite their differences he explains that a majority of grandmothers agree that a good grandmother is a person who loves and enjoys her role, sets a good example, provides help, and is a good listener, but does not interfere (In Judith Stevens- Long, 1984).

Neugarten and Weinstein, in their study found that the theme of emotional self- fulfillment was most silent among paternal grandfathers who in their middle had the leisure time to relate to their grandchildren in ways they had found impossible with their own children (In Judith Stevens- Long, 1984).

Thanseia states that older citizens all over the world including Mizoram are getting more and more attention as their number increases. He further states that there is ample evidence that older people- those over the age of 60 years though their number increased, have become more fit, and have more to offer than any other time in the past. Today even in Mizoram many well known politicians, businessmen and professionals continue to work and contribute to the society well beyond the usual age of retirement. As such, old age should be thought of as bonus and as an opportunity for individual renaissance (In Lianzela and Vanlalchhawna, 2007).

Taking all the above studies into consideration, it is to be noted that the social aspects in the aging process are an important aspect. One of the determinants of aging gracefully is that the social ageing process of a person must be healthy, satisfying and comfortable. Hence, the roles of the elderly in the society, how the society perceives the elderly are important factor in determining the quality of life of the elderly in the society.

2.3. Quality of Life and the Elderly

Quality of Life (QOL): Meaning & Definition

Quality of life maybe understood as the standard of living lived by an individual or family. It does not necessarily imply wealth and property assets. It is explained in terms of social and psychological well being. QOL is measured in terms of living standard, eating habits or diet, clothing, level of satisfaction in life, self esteem, values and health. However, a person need not be wealthy in order to have most desirable Quality of Life, it is the living standard, sense of belongingness, happiness etc., that is essential.

The World Health Organization (2004) defines quality of life as "(an) individual's perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards and concerns. It is a broad-ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships and their relationship to silent features of their environment".

Conceptually, it continues to remain a rather vague term, which means different things to different people. Quality of Life has been variously defined as, "the subjective satisfaction expressed or experienced by an individual in his physical, mental and social situation" (Jonsen, 1982), "the capacity of an individual to realize his life plans" (Cohen, 1982).

In the view of Janssen QOL may be defined as subjective well-being**.** Recognizing the subjectivity of QOL is a key to understanding the construct. QOL reflects the difference, the gap, between the hopes and expectations of a person and their present experience. Human adaptation is such that life expectations are usually adjusted so as to lie within the realm of what the individual perceives to be possible.

This enables people who have difficult life circumstances to maintain a reasonable QOL (Janssen 2001).

According to McCall QOL may be understood as measurement to measure the extents to which people's 'happiness requirements' are met – i.e., those requirements which are necessary (although not sufficient) condition of anyone's happiness – those 'without which no member of the human race can be happy' (McCall, S.: 1975).

Frankl V.E, discusses Quality of Life as tied to the perception of 'meaning'. "The quest for meaning is central to the human condition and we are brought in touch with a sense of meaning when we reflect on that which we have created, loved, believed in or left as a legacy" (Frankl V.E. 1963).

Quality of Research Unit, University of Toronto, is of the opinion that Quality of Life is "the degree to which a person enjoys the important possibilities of his/her life". Possibilities result from the opportunities and limitations each person has in his/her life and reflect the interaction of personal and environmental factors. Enjoyment has two components: the experience of satisfaction and the possession or achievement of some characteristic, as illustrated by the expression: "She enjoys good health." Three major life domains are identified: Being, Belonging and Becoming.

Quality of Research Center, Denmark, 1991 distinguishes between the subjective and objective quality of life. Subjective quality of life is about feeling good and being satisfied with things in general. Objective quality of life is about fulfilling the societal and cultural demands for material wealth, social status and physical well-being.

Renwick and Brown 1996 defined Quality of Life as the condition of satisfaction and well-being achieved as a result of their experiences with the

consideration of life conditions of elderly individuals. Unruh (1983) stated that the quality of life of the elderly is affected by declining economic resources and residential relocation.

Mor et al. suggested quality of life to refer to those aspects of life and human function considered essential for living fully (In Joseph I. Inodey, 2005).

Cella and Cherin are of the opinion that quality of life is a person's appraisal of and satisfaction with their current levels of functioning compared to what they perceive to be possible or ideal (In Joseph I. Inodey, 2005)

Health related quality of life is however more limited in substance and in boundaries. It can be defined as "the value assigned to the duration of life as modified by the social opportunities, perceptions, functional states and impairments that era influenced by disease, injuries, treatment or policy' (Patrick & Erickson, 1998).

Studies related to Quality of Life in the Elderly population

It is important to understand the studies done on the Quality of Life of the elderly population have been highlighted on the following. This is with the intention of understanding previous studies in order to gain relevant knowledge in the field of quality of life.

In a study by Lalmuanpuii (2004) in Aizawl, most of the elderly complained of feelings of loneliness and used coping mechanisms such as praying, reading, singing, talking with friends, visiting friends and watching television or listening to the radio. Almost a quarter of the respondents believed that God predetermines their present condition and an almost number believed that social problems were on the rise in Mizoram. Their problems were found to be financial in more than a third of the respondents, personal (32 %) and familial in more than a quarter.

It was further observed that with reference to the quality of life of the elderly in a suburban sample on the outskirts of Aizawl, all respondents stated that they include *rice* and *vegetable* daily in their diet while a fifth consume *milk* daily and over third consumed *dal* daily. *Fruit* as consumed by only 4 per cent Better life and health was wished for by 40 per cent

The increasing aged population has recently become a focus of interest in developing countries. The aim of their study was to evaluate chronic diseases and measure the quality of life of elderly people in Samsun. There were 8350 elderly people in the study area. The study group consisted of 835 elderly people. Except for a tenth individual, others participated in this study. In the first step of the study, the data of 737 elderly people were used, and then in the second step the data of 150 elderly people with a chronic disease were compared with the data of 150 elderly people, matched according to age, without any chronic disease. All data was analyzed by using analysis of covariance (ANCOVA) for continuous and post-hoc Bonferroni test. More than quarter of males and sixth of females stated they did not have a chronic disease. In the study group, the scores of the SF-36 life quality scale subgroup decreased with age in most of the categories except "pain and general*"(P < 0.05).* Participants with a chronic disease possessed significantly lower scores in all subgroups of the scale than the participants without a chronic disease *(P < 0.001).* While aging is an unpreventable physiological state, determining and solving the problems of elderly people might improve their quality of life (Murlow C.D, Aguilar C, Edicott J.E, Velez R, et al,1990).

In a study done by Joshi A. K. (2006) in the five villages of Varanasi (India) it was found that less than a third of the respondents were not happy because their son(s) are living separately. It was found that a significant majority of them were not

satisfied with their present quality of life and an overwhelming majority of them have no hope for better quality of life.

Somayaji G states that in accordance with his study the elderly couples who stay together are far better placed than those who stay single are, hence, enjoying a far better quality of life (In Joshi A. K. 2006).

Liebug S. P, Rajan I. S, (2005) found the Indian society is blessed with old age traditional virtues- "good family virtues, vegetarianism, non-sedentarism, spirituality, practice of cost effective medical approaches, indulging Yoga" which promotes healthy aging among the elderly. They also found that the Indian elders have great capacity and potentiality remarkable for adaptation to the changing world in so many fields without envy which creates satisfaction in their quality of living.

Unruh (1983) stated that the quality of life of the elderly is affected by the declining economic resources and residential relocation.

Mor et al. in Joseph I. Inody (2005), suggested quality of life to refer to those aspects of life and human function considered essential for living fully.

Cella and Cherin, in Joseph I. Inody (2005), are of the opinion that quality of life is a person's appraisal of and satisfaction with their current levels of functioning compared to what they perceive to be possible or ideal.

In a study done by Omer Oguzturk et al (2005) it was found that the psychological status and quality of life of 70 stable patients with asthma age 60 years and 40 age-matched comparison subjects were examined. The patients with long-standing asthma (duration < 8 years). In multivariate linear regression analysis with adjustment for age, gender, duration of disease and level of bronchial hyper reactivity, worse quality of life was predicted by anxiety, depression and asthma severity scores. In the elderly patients with long-standing asthma, disease severity significantly

impairs quality of life. Impaired quality of life in these patients may be partly related to psychological status indicators.

It is important to note that according to the National Sample Survey Organization (NSSO) (1998) in India; about 80% of the Indian elders still reside in the rural areas where 40% live below the poverty line with nearly 33% just above it.

It was found that more than a sixth of the rural elders get pension or retirement benefits while less than half of the urban elderly get these benefits (Liebug S.O.P., Rajan I.S., 2005).

Lalmuanpuii (2004) observed in her study of the rural aged in a north Eastern state of India that nobody belongs to the upper socio-economic status and with most of the aged categorized themselvesas middle income status. In this study, roughly a third of the aged each belonged to the category of having land holdings below 3 acres, between 3 to 5 acres and over 5 acres.

In a study by Miyoko Matsuo, Junko Nagasawa, Akiko Yoshino, Kimiko Hiramatsu and Keiko Kurashiki, 2003 *(Department of Adult and Elderly Nursing, School of Health Sciences, Tottori University Faculty of Medicine, Yonago 683-8503 Japan)* Quality of Life (QOL) and personality were examined in 2 groups of elderly subjects with and without activity participation (AP). A survey was conducted with 321 elderly subjects over 65 years of age using a 24-item questionnaire regarding personality and depressive inclination and the visual analogue scale-happiness to measure QOL. The AP group was involved in 5 types of activity: community center activity course, learning and lecture participation, club activity, elderly manpower service activity and other activities. The QOL of the AP group was significantly higher than the non-AP group as expected. The perceptual difference between the 2 groups obtained by the correspondence and cluster analyses was that although the

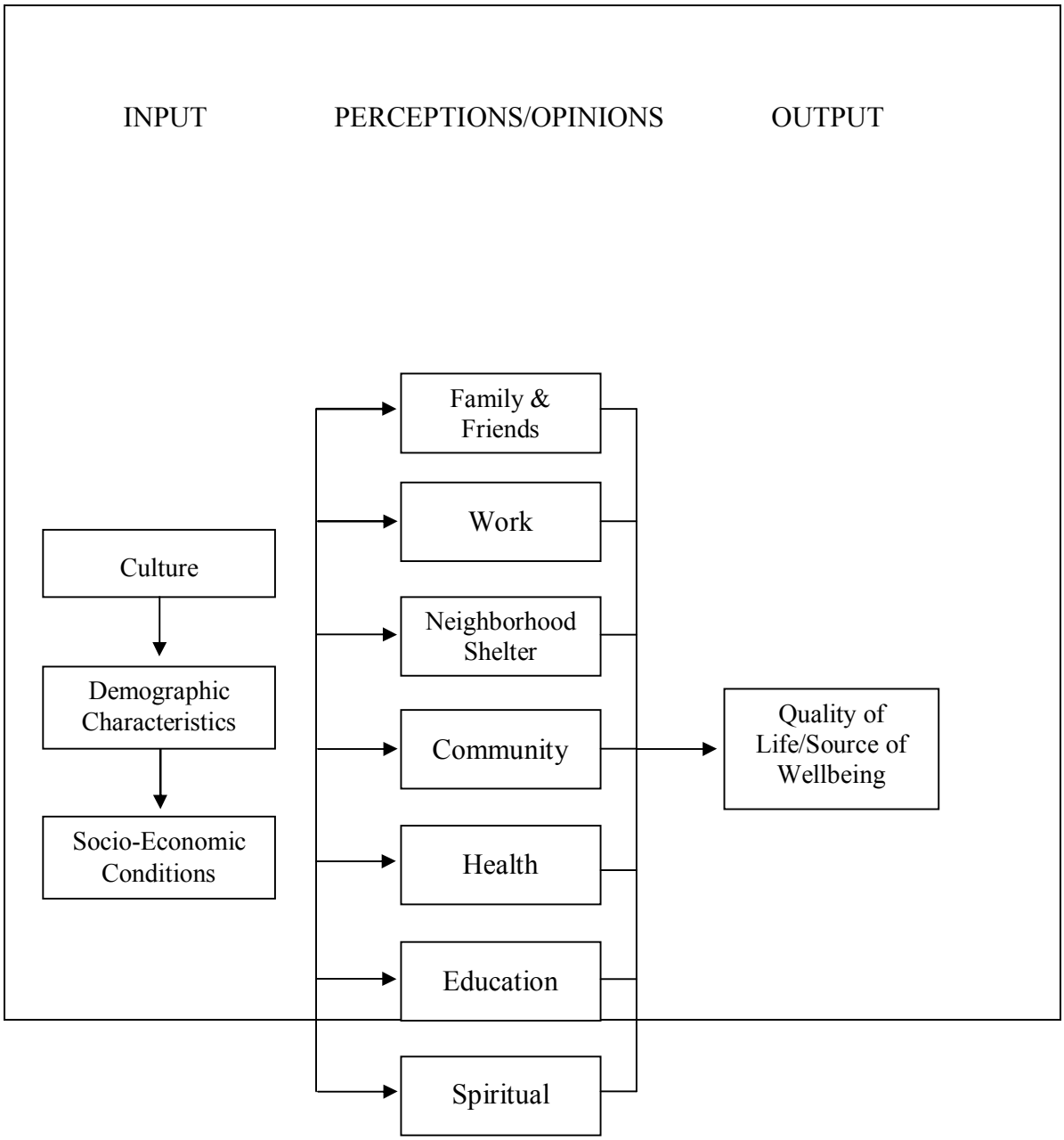
elderly of the AP group were satisfied and not bored with their current life, this trend was not clear for the non-AP group. Among the 5 activity types, other activities, characterized as activities adhered to by participants over a long period, showed the highest QOL compared with the other 4 types. In conclusion, the AP of the elderly should be encouraged and continuing AP might be an important factor in improving QOL of the elderly.

In a study done by Hasnain, N. & Dilip Kapoor, (1997) on Self Perception of the Elders on a sample of 195 elderly persons with an age range from 60 to 75 years of age from Rampur City, India, it was found that majority of the elders were heads of household enjoying a good quality of life. However, a large majority (80%) of the respondents was found to be having physical problems but all the respondents were found not having any problems with unfulfilled aspirations and none of them were feeling of worthy or useless, this confirms that they are satisfied. However, a tenth of the respondents felt that their adjustment in the society is appreciated in the society and stated that they felt more appreciated at home than in the society. This also implies that these elderly are well taken care of at home, hence affecting their quality of living. Half of the respondents were found to have achieved more than half of their aspirations, where as an insignificant minority have achieved nothing of their aspirations. Among the respondents, a fifth were found to have aspirations for better education. Perhaps because of this another fifth of them aspired for better living condition however stating that their present condition is not something they would complain about. This indicates that, although most of the elderly are content with their aspiration fulfillment and status in the family, they also long for better quality of living if at all possible for them. (Hasnain, N. & Dilip Kapoor, 1997)

Measurement of QOL

The approach to the measurement of the quality of life derives from the position that there are a number of domains of living. Each domain contributes to one's overall assessment of the quality of life. The domains include family and friends, work, neighborhood (shelter), community, health, education and spiritual. Robertson, (1985) emphasises that there is no value free quality of life indicators. The value judgment rests with the individual who can form an evaluation of the quality of his own life and in that sense quality of life is rather idiosyncratic. According to the author it could also reside with the observer who selecst particular criteria by which to evaluate the lives of others; or it resides with the political or service delivery system which selects quality of life indexes and a means of policy and as a way of evaluating the impact of intervention. A reliance on a totally subjective report of quality of living possesses certain potential problems he warns The necessity for measuring Quality of Life was realized when it was found that Quality of Life could serve as an indicator of effectiveness of medical and health care interventions.

QUALITY OF LIFE: SYSTEMS MODEL



(The University of Oklahoma School of Social Work, 1991).

The City of Vancouver QOL is measured using the following indicators: Community Affordability Measure, Quality of Employment, Quality of Housing Measure, Health Community Measure, Community Social Infrastructure, Human Capital Measure, Community Stress Measure, Community Safety Measure and Community Participation Measure. *(Website of the City of Vancouver) UNDP* has

been publishing the annual *Human development Index (HDI)* for countries around the world. It examines the health, education and wealth of each nation's citizens by measuring:

- Life expectancy
- Educational achievement – adult literacy plus combined primary, secondary and tertiary enrolment; and
- Standard of living – real GDP per capita based on PPP exchange rates. (Human development report, UNDP, 1997).

Ramkrishna Mukherjee, (1989) is of the view that there are essentially two perspectives taken in quality of life research: *social indicators* research which considers the elites' valuation of what the people need, and *conventional quality of life* research which studies what people want, in order to improve their quality of life.

Quality of Life is seen as the product of the interplay among social, health, economic and environmental conditions which affect human and social development (Ontario Social Development Council, 1997)

In accordance with various sources QOL compare with 'Standards of Living': *Standards of Living* is a measure of the quantity and quality of goods and services available to people. It measures such aspects ,as GDP Per Capita, life expectancy, Births/1000, Infant Mortality/1000, Doctors/1000, Cars/1000, TV/1000, Telephones/1000, Literacy levels, %GDP spent on Education, %GDP spent on Health, Cinema attendance, Newspaper circulation, Fertility Rate, Density, Population per dwelling, etc. *Quality of Life* is the product of the interplay among social, health, economic and environmental conditions which affect human and social development.

Quality of Life Scales

The following Quality of Life Scales were reviewed with a view to gain more information. Seven QOL Scales are reviewed with one Self Esteem Scale.

a) Vale Com QOL: Caveats to using the comprehensive Quality of Life Scale

The Fifth Edition of the Com QOL scale, which is available through the Australian Centre on Quality of Life (http://acqol.deakin.edu.au), was created in 1997 by ' Robert A. Cummins following some five years of development. It has subsequently received modest attention, receiving 32 citations up to the end of 2000. To a reasonable extent, the scale is valid, reliable, and sensitive to change. The published manuals present these data. It has proven utility as a quality of life measure and the data that have been obtained through its use are informative of the quality of life construct. However, Com QOL has always been a 'work in progress' and much new information and understanding has been produced since the 1997 edition was created. During this intervening period, considerable thought has gone into the options of either creating a Sixth Edition of the scale or using the new information and understanding to create a derivative scale. The latter course has been chosen. However, it is now clear that the scale can be improved in a number of different ways. This makes it simpler to create a new derivative scale, rather than persist with the constraints of the old scale structure.

b) Perceived Quality of Life (PQOL): The PQOL was originally developed at the University of North Carolina, Chapel Hill by a team of researchers. Later it was expanded and further developed by a team of researchers from the University of Washington, Seattle under the direction of Dr. Donald Patrick. Extensive testing of the PQOL has been conducted in cooperation with Group Health Cooperative of Puget Sound. The Perceived Quality of Life Scale (PQOL) is a measure based on a

model defining quality of life as evaluation of major categories of fundamental life needs. Scale items were developed using human needs theory and interviews with different populations of older adults, well persons, and persons with disabilities to establish the content of the instrument. The measure is consistent with the needs based theory of quality of life and the World Health Organization Definition of quality of life as people's *"perceptions of their position* in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns". Originally The PQOL was originally brief and a 12-item version for assessing the quality of life of persons following intensive care and was later expanded to 19 items to include evaluation of satisfaction with areas of functional status considered important to persons with varying levels of wellness and disability. This measure also incorporates the areas of dysfunction included in the Sickness Impact Profile (SIP) developed in the United States and the Functional Limitations Profile (FLP), a culturally-adapted and UK weighted version of the SIP developed in the United Kingdom. The PQOL can be correlated with SIP or FLP Category Scores to investigate the relationship between functional status and satisfaction with functioning. The PQOL is also part of a generic health and quality of life outcomes package being developed at the University of Washington that includes the assessment of functional status using the Short Profile of Illness Impact developed from the SIP, the PQOL. and a current health state desirability or preference measure.

c) Internet Mental Health Quality of Life Scale (IMHQOL): The Internet Mental Health Quality of Life Scale is a measure of an individual's quality of life. It was constructed by Dr. Long in 1995 and is available on the Internet Mental Health website. It measures social and occupational functioning, mental health, physical

health, and progress. This is not a diagnostic program yielding a psychiatric diagnosis; rather, this scale is a global measure of an individual's overall functioning. A 25% decrease in the Quality of Life Scale total score represents a significant improvement. A 25% increase in the Quality of Life Scale total score represents a significant worsening. The Internet Mental Health Quality of Life Scale has only been used by Dr. Long on his psychiatric outpatients.

d) Quality of Life Questionnaire - Respondent Self Reported Version was created by Douglas A. Bigelow PhD, Madeline M, Olson, Susan Smoyer, and Linda Steward in 1991, The Quality of life Questionnaire is available in two versions - the Respondent Self-Report version and the Interviewer Rating version. The Respondent Self-Report version is a fixed-response questionnaire which is designed to be administered in a structured interview following the Respondent Self-Report Guidelines. The Interviewer

Rating version is a semi-structured interview which allows for a great deal of interviewer discretion. The user is advised to examine both versions of the Quality of Life Questionnaire and to review the pertinent journal articles before selecting the version of the instrument to be used in a specific project.

e) EORTC QLQ-C15: The EORTC QLQ-C-15-PAL is an abbreviated 15- item version of the EORTC QLQ-C30 (version 3.0) developed for palliative care by the EORTC Quality of Life Unit, Avenue E Mounier 83/11 1200, Brussels, Belgium. This scale is recommended for use in patients with advanced, incurable, and symptomatic cancer with a median life expectancy of few months.

f) EORTC QLQ-C30**:** The EORTC quality of life questionnaire (QLQ) is an integrated system for assessing the health related quality of life (QOL) of cancer patients participating in international clinical trials. It is the product of more than a decade of collaborative research released in 1993 by the EORTC Quality of Life Unit, Avenue E Mourner 83/11 1200, Brussels, Belgium. It is composed of both multi item scales and single item measures. These include five functional scales, three symptom scales, a global health status/ QOL scale, and six single items. Each of the multi item scales includes a different set of items-no item occurs in more than one scale. All the scales and single item measures a range in score from 0 to 100. A high scale score represents a higher response level. Thus, a high score for a functional scale represents a high/ healthy level of functioning, a high score for the global health status/ QOL represents a high QOL, but **a** high score for a symptom scale/ item represents a high level of symptomalogy/problems.

g) EORTCOLQ-C32:

EORTC Satisfaction with Care Module , Scoring Procedure for the EORTC IN-PATSAT32 [Ref, Brédart et al, EJC, 41 (200S) 2120-2131]

The international field-testing study of the EORTC cancer in-patient satisfaction with care measure (EORTCIN-PATSAT32) was developed by the EORTC Quality of Life, Brussels, Belgium. The first part consist of questions with regard to doctors and their level of satisfactions towards their trust, knowledge, and the treatment received, second the nurses service, third of the care organization and lastly general questions like their opinions.

h) Rosenberg Self Esteem. Scale (In Rosenberg, 1965):The scale is a ten item Likert scale with items answered on a four point scale - from strongly agrees to strongly disagree. The original sample for which the scale was developed consisted of 5,024 High School Juniors and Seniors from 10 randomly selected schools in New York State. Instructions: The list of statements deals with general feelings about oneself. If strongly agree, circle SA. If agree with **the** statement, circle A. If disagree, circle D. This scale was considered as it measures the self esteem of a person which in turn can be a factor to analyze the Quality of Life of a person.

Dimension of QOL considered for present study

In order to assess the Quality of Life of the elderly population different dimensions have to be considered. As stressed repeatedly wealth only cannot be the determinant of a desired QOL of the elderly. From the review of the different studies cited, it is possible to understand that different dimensions play a very important part in distinguishing QOL. Gerontologists are considering the concept of quality of life in terms of dimensions such as physical, psychological functions, life satisfaction and psychological wellbeing. For the present study, these dimensions were taken into account for collecting and highlighting QOL in the elderly population. The different dimensions are the following:-

1) Social*:* Different factors like family, friends, and social participation, level of recreational activities, sense of belongingness can be taken into account. Being close with family members, having a spouse or a special person, being a member of an organization can determine a person's Quality of Life.
2) Education: Educational background of a person can-play a significant role in the Quality of Life of a person as it can be a determining factor for occupation,

achieved

and ascribed status, psychological peace, of mind, level of satisfaction and fulfillment.

3) Physical (Health, Living arrangements, diet): Growing older is almost synonymous with acquiring physical health decline due to many diverse reasons. Failure to enjoy good health can play a vital role of discomfort in a person's life especially with the absence of a care taker or in poverty whereas enjoying good health can provide desirable consequences hence, determining his/her Quality of Life. Another significant factor for examining Quality of Life is to understand the living arrangements like who they live with as well as the problems faced in terms of space, facilities available. Also diet can determine the Quality of Life of a person with respect to availability of sufficient food and nutrition, drinking water and sanitation.

4) Psychological*:* This includes the psychological being: being free of worries, depression, moods, and level of satisfaction (with oneself and with situations), adjustments, desires, dreams and aspirations, achievements, disappointments, happiness, sadness.

5) Economic Status*:* Another important dimension in Quality of Life is the economic condition of the person. However, economic power can never be the only factor essential for happiness or the desired Quality of Life. Despite this, poverty can play a significant role in depressing the Quality of Life of a person not only the elderly. In the case of the elderly population, due to factors like change of roles, retirement, pension, decline in physical or mental health can lead to undesirable economic condition which can ultimately affect the QOL many

studies also reveal that due to lower educational status especially in female widow elderly QOL can be rather undesirable. This present study shall attempt at discovering the significance between the two.

2.4 Ageing and Gender issues

Gender issues are prevailing all over the world in terms of better opportunities and empowerment. At every stage of life especially in a society like the Indian society, gender issue is a significant area of study. This may be traced back to the olden days when the practice of female infanticide, sati, widow-remarriage and dowry burdened the Indian society to a great extent. Till today due to these factors the status of women in India is still very undesirable.

Keith found that women age with less difficulty than men do. On the one hand, women are forced with less discontinuity in duties and expected behaviors as they get older, as compared to men. On the other hand, when there is normative age-related change in role behaviors, it tends to favour women, who also may be more experienced at adjusting to change expectations. For example, in many cultures, men lose their status built up earlier in life, whereas women as they age shift from timid bride to a powerful household head. (In Husain M.G. 1997)

Lowenthal et al. stated that many women in their old age may face an almost complete loss of role, as children attain adulthood and leave home to establish independent lives. Role discontinuity can be severe for women whose prime focus has been on nurturance and provision of child for 20 years. But more women react positively to the empty nest. Women whose children have left are more satisfied, less self-pitying, and less easily hurt than women whose children are still at home. (In Lawrence S. & Wrightsman, 1994)They generally show fewer depressive symptoms when their children are on their own (Radloff, 1975).

The Mizo society being a patriarchical society as well, women face similar problems in terms of inheritance, preferences, education, employment issues, opportunities etc. In a study in 2004 the sample consisted of a larger percentage of the illiterate ie; 20 percent constituted women elderly against only 8 percent of male elderly (Lalmuanpuii, 2004).

Venkoba Rao in a study in the late eighties on 1910 subjects identified in his Kallandri study that a majority of women (70.9%) were widowed as compared to men who were widowed (28.2%).This is due to the fact that men tend to remarry more than women do. Many studies have highlighted that widowed women tend to remain widowed and are likely to found similar elderly widowed women and stay friends with them. It is also important to take into account that elderly women who are widowed tend to remain in the household and take important part in housekeeping whereas elderly men socialize more (In Bose and Gangrade, 1988).

Neutragen and Gutmann stated that women as they aged seem to become more tolerant of their aggressive, egocentric impulses; while men as they aged seem to become more tolerant of their own nurturant and affiliate impulses. This may be because women have the tendency to socialize more than man normally does. Also women when they socialize can talk and express emotions and tend to somehow ventilate themselves, whereas, men usually keep to themselves and also some men find it hard to share their problems to others (In Warner and Willis, 2002).

Bengtson et al have reported that women generally live longer than men and are more likely to be widowed. Also when a woman is widowed late in life, she is likely to find a group of similar widowed women who can provide support and a network of friendship. Women generally have great tendency to share emotions to friends which is a healthy way of living. This is so because when any individual

suppress so many problems they tend to have so many complications, when the mind is happy and interacting it affects the body in a positive way. Also women are understood to make friends faster and easier than men (In Warner and Willis, 2002).

Sodei. T (1995) states that Japanese men, especially those employed work very hard and often spend holidays at the company and are therefore isolated in the community they live in where women are the main host of the activities. From this study, it is clear that individual value system varies across communities. This is because of the fact that socialization process differs across community to community, hence affecting our value system in different ways. In some societies, men are in-charge of activities while women's roles are solely in the housekeeping area. This is the reason why studies that address self Perceived Life Satisfaction gain importance.

In another study done by Srivastava A. R. N. (2006) in western Uttar Pradesh in India, less than 3 per cent of both the males and females in the 60+ age group were found to have been never married. It was also found that the widows among 60+ females was almost three time the proportion of widowers in 60+ male populations. The reason is possibly because the male elderly who have lost their wives remarry to a much greater extent than the women, who experience loss of their husband (who never remarry). The difference in this aspect is also found relevant in the urban areas.

Joshi U. & Shah A. (2006) from their study concluded that the elderly women's position in India is low and 'pathetic' as non-acceptance of widow remarriage, illiteracy and low economic is found in abundance. From this study it may be noted that poverty, ignorance, religious beliefs etc plays an important role in the life of women elderly in India. Although some studies have begun to address elderly women in India, the problems of the rural elderly still remains the same. This is because of different important factors like lack of education, socialization, tradition,

beliefs, religious beliefs, poverty, ignorance, corruption etc. It is high time to take necessary steps to improve the quality of life of women elderly in India.

In a study done by Devi K. R. (2006) in the Kannan Kurichi Village, Salem District (India) it was found that elderly men show better educational achievement than the females, hence, contribute better to the family, thus, enjoying a better quality of life. This is because of the better opportunities given to the male gender from the family in the initial socialization. Boys are preferred to girl child due to traditional religious beliefs. According to this finding it is clear that elderly men will enjoy better quality of life as more opportunities were given to males from birth. As discussed earlier, past investments determine future life to a large extent.

In a study done by Kohli , in the area of physical disability, it was found that in the rural areas, 5.4 per cent of all the elderly (6.7% females and 4.7% males) are physically disabled and in the urban areas, more females than males were physically disabled. The official statistics revealed that large segment of the elderly were illiterate, out of work force where women constitutes larger number than men elderly (Kholi, 1996).

The prevalence of gender issues is found around the globe. India being a patriarchal society, men are more favored than females in terms of education, opportunities etc. Even in the case of the elderly, from the study highlighted women elderly especially from the rural areas are currently facing a number of problems. On the other hand, the study highlighted male elderly as facing a number of problems as well. Research gaps addressing such issues and dimensions in order to aim for better Quality of Life.

2.5 Physical Health and Ageing

The aged have a set of problems which are somewhat unique to them. With advanced age, they experience psychomotor difficulties and problems of hearing and vision. A few of them are unable to adapt to their food habit which affect their low quality of living. In developing countries infectious diseases and tropical conditions like pneumonias, septicemia and protozoal diseases that tend to get complicated, coexist simultaneously with diseases such as hypertension, diabetes, milletus, coronary artery disease, cerebrovascular stroke and neoplasm, situations that were hitherto predominantly associated with developed countries. It is true that both the challenges and opportunities for geriatric medicine are enormous. The growth of geriatric medicine as a formal academic discipline is rather slow and needs concerted efforts at the university/Council for the process to be hastened. As stressed repeatedly, old age tend to be characterized and associated with multiple diseases. Advanced age is in fact a risk factor by itself in the causation of several undesirable diseases, particularly vascular, hence affecting the quality of living of the elderly persons especially those living in the developing countries tremendously.

Pathak stated that an estimated quarter of the aged from middle and upper classes of the society suffer from multiple disorders. Sen Gupta & Chakroborty in their study also found that an overwhelming majority of the elderly covered in their study were chronically ill, Ahmed also found that the problem of vision is foremost which constitutes to more than eighty per cent in his study followed by psychomotor (78.8%), bone joint (78%), memory (58.8%) and sleep problem (58%) (In Husain M.G. 1997).

Hearing impairment is one of the most common chronic health problems of elderly Americans. Although adverse effects on quality of life are thought to be

considerable, they have not been rigorously evaluated. This study was designed to identify the types and extent of dysfunction experienced by elderly individuals with hearing loss, and to define the most appropriate measures for assessing this dysfunction. Elderly male veterans attending a primary care clinic were screened for hearing loss and had their quality of life assessed with a comprehensive battery of disease-specific and generic measures. Of 472 people who had their hearing tested, 106 had hearing loss. Hearing loss was associated with significant emotional (P = .0001), social (P = .0001), and communication (P = .02) dysfunction. More than two thirds perceived these dysfunctions as severe handicaps even though audio logic loss revealed only mild to moderate impairment (pure tone average loss, 27-55 dB). Adverse effects were best detected with disease-specific rather than generic functional status measures. They concluded that hearing impairment is associated with important adverse effects on the quality of life of elderly individuals, and that these effects are perceived as severe handicaps even by individuals with only mild to moderate degrees of hearing loss. (Murlow C.D, Aguilar C, Edicott J.E, Velez R, Tuley M.R , et al,1990)

Gopalan et al, exhorts that the Indian elderly, especially the aged women, are at high risk of chronic under nutrition. (In Nag NG, 1987)

Dutt (1986) says that the term ageing signifies the progression of changes in bio-chemical process. Hence it implies that the factors causing the ageing process as mainly the environmental, genetic mutation and free radical theory. He further states that the chronological age is a poor predictor of fundamental ageing.

As the degree of activeness or infirmity is an important consideration for examining the problems of the old, they can also be categorized on the basis of their

mobility status: (1) bed-ridden; (2) house-bound; (3) ambulatory; (4) capable of going out with difficulty; and (5) capable of going out without difficulty.

A study conducted in Delhi by the Delhi School of Social Work, indicated that more than half of the aged had impaired vision, besides the following other main problems such as poor dental health; insomnia; impaired hearing/deafness; giddiness/hypertension; forgetfulness/nervous disorders; lack of free moving limbs (In Nag NG, 1987).

Health statistics define important aspects of the psychological context of older persons. The number of older persons (over 65 years) classified as deaf or blind is 10 to 50 times greater than in the young adult age group. The number of days of restricted activity because of medical problems rises markedly after age 65 years. One survey by the U.S. Public Health Service (1959) reported that about 13 per cent of those in the 45 to 54 age range have some limitations of activities compared to more than half of the sample over the age of 65 years actually have two or more sources of limitations (Birren J.E, 1972).

Even in the study done in Aizawl by Lalmuanpuii (2004), on 25 elderly respondents, more than half had hearing impairment and aches and pains in bone joints. Almost two third reported problems with memory, while a quarter reported disturbances in sleep.

Assessment of nutritional requirements of the elderly is an important pre-requisite for designing meaningful interventions for the elderly. Quoting a study done in the late ninetines by Natrajan, it was observed that Anaemia among the rural aged was found to be a common complaint in over 80% of the population as compared to the urban aged (62.7%) (Ramamurti S in Ramamurti P V & Jamuna D 2004).

Agate, (1970); Rockstein, suggested that muscles that lift the ribs weaken, and changes in the structure of the ribs interfere with the expansion of lungs hence reduction in the number of alveoli and bronchioles become less elastic creating shortness of breath in among older persons and emphysema to some extend is present in the elderly. Emphysema is a much more severe and occurs earlier in smokers. They also implicate that the mucosa that protect the gastrointestinal lining atrophy and the volume of gastric juices secreted is reduced resulting in occurrence of general intestinal distress as well as to poor nutrition and are responsible for one of the most frequent complaints of the elderly, constipation (In Judith Stevens- Long, 1984).

Kalache in Liebug S. P, Rajan I. S, 2005, is of the opinion that the promotion of health and cost-effective interventions base on primary health-care approach over a lifelong course will help to achieve the goal of healthy aging.

According to the Government of India statistics the leading causes of elderly deaths in India are respiratory diseases followed by cardiovascular disorders, stroke, and neoplasms (In Liebug S. P, Rajan I. S, 2005).

In a study done by Anklesaria et al., smoking was found to be frequent among the elderly and according to another study by Kumar & Nagarkar, 1996, smoking was one of the factors contributing to the mortality of the elderly population (In Liebug S. P, Rajan I. S, 2005).

In a study done by Joshi A. K. (2006) in the five villages of Varanasi (India) it was found that 87 per cent were smokers or tobacco chewers, which is believed to cause many tobacco induced health complications.

In a study done by S. F. Ho et al (2001) titled 'Dysponea and quality of life in older people at home" done in South Wales in a sample of 1404 elderly persons above the age of 70 years elderly living at home. The study found that the overall

population of prevalence of dysponea (MRC grades 3-5) was estimated as 32.3% (95% confidence intervals: 30.3, 34.3,); 27.6% in men and 35.4% in women. The prevalence of dysponea increased with age in both men (p=0.006) and women (p=0.023). The population prevalence of self reported arthristis was 34.2% (29.6, 42.9), self reported stroke 7.7% (5.02, 10.37) and diabetes mellitus 8.25% (5.7, 11.35). The population prevalence of obesity was 26.7% 922.4, 31.0).

The physical health of any person is an important indicator for his/her quality of living especially for the elderly due to diverse reasons who are subjected to a number of physical illnesses. Therefore, for an elderly person to attain a healthy quality of life, it is important to understand of the physical illness aspect. Besides, the illness conditions warrant.

2.6 Mental Health, Mental Illness and Ageing

Mental changes in old age include learning, reasoning, creativity, memory, recall, reminiscing, and sense of humor, vocabulary and mental rigidity.

The term 'Senility' is used to refer to the period during old age when a more or less complete physical breakdown and when there is mental disorganization. The individual who became eccentric, careless, absent minded, socially withdrawn and poorly adjusted is usually described as 'Senile'. Senility may come as early as the fifties, or may never occur because the individual dies before deterioration sets in (Elizabeth B. Hurlock, 1998).

Desai K.N. & Lalmuanpuii (In Lianzela & Vanlachawna, 2007) stated that psychological ageing refers to the process of mental decline normally accompanying old age and this stage may not be synchronous with physical change and/or deterioration. Further the authors quote Schaie, K. W. and Sherry L. Lewis, 2002, to suggest that psychological changes are often heralded by tragic events in ones life,

loss of spouse or intimate other and /or due to leading a highly stress life. People who have aged psychologically may exhibit greater despair, less interest in surroundings and greater feeling of having grown 'old'.

Erik Erikson, 1985, described this stage of life as one in which individuals seeks balance between 'search for Ego Integrity and Sense of Despair'.

The community –based mental health studies have revealed that the point prevalence of depressive disorders among the geriatric population in India varies between 13 and 25 per cent. The Indian Population is currently the second largest in the world (WHO, 2001) Therefore in accordance with this study there is a large number of depressive elderly population which is second largest in the entire world.

There is high prevalence of mental disorders in the old age. Predominant among these are mood disorders. In a study conducted by Lar et al, it was concluded that mood disorders especially depressions were found to be very common among the elderly population. Different studies have also indicated the high prevalence of suicide in old age. It may be noted that there is a clear relationship between these depressions in the elderly and suicide in the elderly. Depressions especially in the elderly population can be easily over cited. Patients of depression coming for treatment of depression are smaller in number than those suffering in the community, unreported or untreated. Depression is more common in the elderly especially those afflicted by bereavement and physical disease. It adversely affects the outcome of the treatment for the ailments. Numerous reasons like lack of training and knowledge, lack of elderly care services etc and also it may be due to lack of population based and easy-to-administer screening measure. Hence, mental health is an important indicator of the quality of life of an elderly, Measures to improve, moderate, and treatment of

the mental problems of the elderly should be taken into account at a numerous level (In Joshi A. K. 2006).

In a study done by Soneja S., Khetarpal and Kumar V, of the Incidence of depression in the Elderly from the Geriatric Clinic of the All India Institute of Medical Sciences, New Delhi, India, total of 177 elderly males and 83 elderly females were included. Out of these, it was found that 66 (25.4%) of the respondents complained of depression, 65.5 per cent were males and 34.8 per cent were females respectively. Out of the three cases of Parkinsonism reported by the study, two males were depressed while the third (female) was not. Incidence of diabetes and locomotors ailments was the same in the depressed and the other group and so was the living status with families, spouse only or alone. All these cases diagnosed have been referred to the psychiatrist. This study also discovered that depression is more common in the lower socio-economic groups. In conclusion, it is obvious that a positive attitude towards life inculcated in childhood and prime of life, goes a long way in preventing depression in old age. However, all the elderly seen to be suffering from depression needs to be helped or treated by psychotherapy and pharmacology wherever indicated to improve and neutralize their quality of living (Soneja S., Khetarpal and Kumar V, 1997).

Insomnia is a frequent complaint in older persons which often relates to depressive syndromes. It is also found that the frequency of depression increases with age and also that older people do have more problems than the young, the relationship between physical and mental health is of special interest in dealing with the elderly (Judith Stevens- Long, 1984).

Dementia is also considered as one of the commonest and most disabling late-life mental disorders. Some may say that dementia is more closely related to old age rather than the younger chronological age. This may be due to a number of factors such as decline in physical and mental health due to advanced age. The prevalence of dementia in the elderly may vary from one country to another and also from one individual to another. Its prevalence in developed countries, in adults older than 65 years is 3-11% (Evans et al., 1989) and tend to increase as the population ages further raising up to 20% in the over 80s.

In a study by Lalmuanpuii (2004) on 'Self Perceived Life Satisfaction & Problems of the Rural Aged' on a sample of 25 respondents from Sihphir Vengthar in Mizoram, it was found that only one out of 25 respondents was observed to be suffering from dementia.

Ms. K.C. Lalparmawii, 2005, in her study conducted in partial fulfillment of her MSW degree drew a sample between 35-38 years of 60 women from a suburban in Mizoram using convenience sampling to include all women who have attained menopause. Although this may not include many older persons as menopause may occur in younger years too. The study is significant as it addresses mental health issues faced by women who have lost their reproductive capacity through menopause. Over two thirds (68.3%) stated that there is no primary social support to help them deal with menopause. It is therefore evident that social support is high in the case of loss of spouse but low in the case of loss of function particulary reproductive function. Menopause in women is known to lead various psychological changes and therefore these are newer challenges to be studied in respect of aging.

In India due to a number of factors like poverty, illiteracy etc the exact prevalence of dementia may not be easy to establish. But according to studies the

prevalence of dementia in India varies from 0-84% to 3.5% (Shaji et al., 2005; Vas et al., 1998; Rajkumar et al., 1997; Shaji et al., 1996). A higher proportion of older people live in developing countries and little research has been carried out in these settings. However, there are evidences that age- specific prevalence rates for dementia is often not recognized as an illness but is constructed as part of normal aging (Patel and Prince, 2001). This may attributed both to ignorance of the subject of mental health as also due to neglect to the problems of the elderly as a whole.

On Weeks and Cuellar who have stated that older persons do not want to live with their children and fear being a burden to them. (In Pushpa Kumari V., 2001)

Some studies have highlighted the prevalence of mental morbidity among the elderly. Venkoba Rao and Madhavan in Ramamurti & Jamuna, 2004, in their study of the Aged (60+) in a semi urban area near Madurai , Tamil Nadu, in India yielded the prevalence rate of mental morbidity of *89/1000* of the aged population which when projected works out to 3.65 million for the country. (In Gangrade, 1988) The number of mentally ill persons (60 years and above) is said to be around 36 million (Ramamurti & Jamuna, 2004).

The study on aged persons in Madras revealed that only 2 per cent suffered from bouts of loneliness. These were mostly widows/widowers living either alone or with a son or a daughter (Nag NG 1987). Although this study revealed a low percentage of loneliness amongst the elderly, it is important to keep in mind that besides loneliness, different factors like quality of life in different areas like diet, clothing, medical needs, recreation time, socializing etc have a role to play in the measuring the quality of life of the elderly.

The U.S. Public Health Service reported that the rate of suicide for those over sixty-five years is about three times that of the general population, especially among

males aged seventy-five to eighty-five. Depression in old age is known to be very common. There are different factors contributing to development of depression such as poverty, fear of being a burden, loss of loved ones, terminal illness, debt worry etc. It is found that most of the elderly who commit suicide are found to have these kinds of the mentioned problems. It is also important to note that complications in mental heath area can result to depression. Therefore, to avoid suicide in the elderly, maintaining a better quality of life of the elderly is essential (In Judith Stevens- Long, 1984).

According to a study done in the eighties it was found that although depression is more common among the elderly than among other age groups, there is little evidence that psychiatric disorders in general increase with age. They also suggested that hypochondriasis, paranoid reactions, and chronic anxiety are also more common in elderly population than in any other age groups which implicates that the elderly population are likely to suffer from mental disorder than the rest of the population. If they develop any mental ailments they are more likely to be diagnosed as depression (In Judith Stevens- Long, 1984).

In a study done by Nick Stinnett and his colleagues they found that among the elderly married couples, more than 90 percent had a “Very Happy” or “Happy” and well over half stated that it improved with time while the majority felt that the later years were the happiest years of marriage still some experienced some problems due to differences in values and life philosophies as well as lack of mutual interest (In Judith Stevens- Long, 1984).

In a study by Conwell et al., it was concluded that the elderly have higher suicide rates than any other age group. It was found that the young today [commit] suicide more frequently than did our elders in their youth. Dueing to this factor, it is

expected that both the rate and the absolute number of late life suicide will increase through the early part of the century as the population of the elderly is in fact the fastest growing segment of the population (In Tout, K.1995).

In a study done by Devi K. R. (2006) in the Kannan Kurichi Village, Salem District (India) the main abuser of the elderly in a family was discovered as females (70 %). Among the abusers the daughter-in-law is the main perpetrator causing depression and stress among elderly. According to several studies suicide is common among the elderly population and one of the main reasons is depression in elderly. In his study the main reason cited by the elderly to commit suicide is because they were abused by females in the family especially by their daughter-in-law.

In a study conducted by Joshi A. K. (2006) in Kerala in India it is shown that the social work intervention in the socio-psychological, economic, cultural and information development of the elderly can greatly affect positive change in the personality of the elderly which are conducive to sustainable social development and improvement of their living and working conditions.

In a study done by Khan M.Z., Agarwal B.B. and Mishra S. K, 1997 on Anxiety and Pessimism-Optimism among the Elderly in Delhi, India, on a sample of 933 elderly persons (60 years or more in age), it was found that majority of the respondents (97.6%) live with their family members. However, an insignificant minority (3.07%) live alone. About a quarter (25%) were widowed. In this study 60 per cent of them were advanced in chronological years, over the age of 70 years. Among these, the proportion of widows is predominantly higher (74%) than widowers. Only a little over a third were found to be literate and 40.3 percent were in salaried jobs, 42.3 per cent were in business and professionals and the rest were daily wage earners. It was found that many of the respondents were often full of

apprehensions and feelings of hopelessness. Many tended to become frustrated and aggressive and was dealt with by withdrawal from society and friends or compromised reactions. In high anxiety states there is generally a lack of sleep or state of insomnia. Majority of the respondents (75%) reported that they sleep for an average 7 to 8 hours a day and about one fourth did not have adequate sleep. It was found that elderly living with a spouse have better quality of sleep. It was also found that 86.5 per cent of the respondents with healthy habits sleep comfortably as against 27 percent of the respondents with poor habits sleep with some difficulty. A small percentage of the respondents state that they are scared or upset due to one reason or the other, sometimes on account of darkness, loneness, water, height, crowd etc. More than two thirds of the respondents were suffering from fear or phobia of living in a slum area.

In a study done by Sidney Chocron et al (1995) at the Nottingham Health Profile, a questionnaire to assess the quality of life of elderly survivors of open-heart surgery was attempted. From January 1984 to October 1993, 146 patients over 75 years of age underwent open-heart surgery in the Department of Cardiovascular Surgery at Besancon (France). In the social isolation section, less than a fifth of patients felt they were a burden to people and a fifth felt lonely. In the emotional reaction section, more than a tenth of patients felt that life was not worth living and an almost equal number had forgotten what it was like to enjoy themselve. In reference to sleep one patient out of two took sleeping pills and over a third took a long time to get to sleep. In reference to energy, more than half of the patients reported running out of energy and 27 per cent were tired all the time.

2.7. Economic Aspects of Ageing

The social problems of older persons include income maintenance and employment, housing, medical services, social mobility and opportunities for compatible interpersonal relations. Aged persons tend to have low incomes and little accumulated wealth and are therefore in low position to maintain their standards of food, clothing housing and social amenities. In addition, poor health and sensory defects frequently limit social mobility, resulting in a still further lowering of the standard of living. (Birren, 1972) Being unwell physically tends to be very expensive to manage. When the elderly can no longer work to keep themselves well off, it is difficult to makes ends meet. The lives of the elderly population can be very hard and depressing. Therefore, families have important roles to play in the care of the elderly. Care mentioned here need not only be assistance to physical health problems but also attending to other care areas like diet, clothing, mental health, recreational time etc. The quality of life of the elderly is numerously affected by attending and moderating to the mental health area (In Desai M & Raju S, 2000).

It is important to note that according to the National Sample Survey Organization, (NSSO) (1998) in India; about 80 % of the Indian elders still reside in the rural areas where 40 % live below the poverty line with nearly 33 % just above it. As found in some studies the rural elderly have lower educational status than the urban elderly, this study revealed that more number of elderly reside in the rural area hence indicating undesirable quality of life of the elderly in India as a whole.

Simsons has stated that in the pre-industrial society, the old people use to get enough opportunities to satisfy their various needs. In the society dominated by

agricultural and handicraft economy they participated in productive activities as specialists (In Husian M.G. 1997).

Barron , Streib, and Suchman stated that aging becomes more disturbing in a society whose culture provokes irreverence towards the aged and where the economic competition works for the disadvantages (In Husian M.G. 1997).

Burns, Orback and Hauser are of the opinion that owing to the rapid industrial technology for the expansion of productivity through high energy system, the 20th century society restricted the participation of older employees in the labour market (In Husian M.G. 1997).

A study by Punias reported that more than half (55%) of the rural aged and less than one-third (29%) of the urban aged are from families with annual income of less than Rs10, 000 that can be estimated below poverty line. Almost half the number of urban families and a fifth of the rural families had annual incomes more than Rs20, 000 (In Desai M & Raju S, 2000).

Krause have found that chronic financial strain is related to depressive symptoms in older persons. It was also found that social support counterbalance or buffers the deleterious effects of financial stain. Hence, in elderly persons financial situation is one of the problems affecting their quality of living. This indicates that the financial condition of a person is a huge factor that determines the living conditions. However, it maybe argued that a person having money and material possessions can have a low quality of living if the person has mental deficiencies, no companions with feeling of loneliness and uselessness etc. Therefore, in order to measure the quality of life of any person only one factor cannot explain the dimension of measurement (In Husian M.G. 1997).

Studies on elderly abuse such as the one by Madhurima (1989) on the inmates of the state managed Old Age Home at Chandigarh reveals that *economic dependency of the kinsmen on the elderly led to their harassment.* The aged who owned property transferred it to their own children or kinsmen in order to win over the affection of their kinsmen so that they can be properly looked after.(Bhatia, 1983) Studies such as this reveal the lack of choices by the elderly in keeping their own property and the compulsions they face in order to secure the care and attention by relatives. Often however, willing away the property to a relative fails to guarantee their continued care and protection.

In a poor country like India the major problem of the aged is economic. A survey conducted in Madras city by the Madras School of Social Work (1972) showed that 68 per cent reported poverty as their main problem as they found it difficult to make both ends meet. About a quarter reported that they were financially well-to-do, while the remaining just managed to eke out their livelihood (In Nag NG, 1987).

Lalmuanpuii (2004) in a study on a sample of 25 persons from suburb in Aizawl found that none of the respondents belongs to the upper socio economic status and most of the aged were categorized as belonging to middle income status. Roughly a third of the aged each belonged to the category of having land holdings below 3 acres, between 3 to 5 acres and over 5 acres.

In a study done by Singh, Dak, Sharma,; Singh, Singh, & Sharma, it was found that among the Indians, nearly 90 per cent of the workers are found in the agricultural sector with no retirement age. They stressed that the rural elderly continue to work but reduce the number of working hours due to different health related complications, but still they have to work (In Liebug S. P, Rajan I. S, 2005).

> Irudaya Rajan, Mishra, & Sharma, found that an approximate of 40 per cent of older men were cultivators, while over two third of them were found to be agricultural laborers with widows predominating. It was found that a little over a sixth of the rural elders get pension or retirement benefits while less than half of the urban elderly get these benefits (In Liebug S. P, Rajan I. S, 2005).

Rajan et al., 1999, are of the view that the financial situation of the elderly is determined closely with the socio-economic environment in which they reside. The economic status of a person is therefore dependent on his/ her past work status, level of education and present activity status. Therefore, in order to have better quality of life it is crucial to have financial stability, better diet facility, clothing, good access to health care facilities, healthy leisure time etc. To make these possible, investments have to be made by an elderly in the past life, that is, to get a good education for employment and savings etc. In India more number of the elderly still reside in the rural area where there are less opportunities with less facilities hence affecting in the decline of the care of the elderly.

With regard to employment of the elderly, when we see the data pertaining to the employment of rural and urban elderly during the period from 1961 to 1981, there seems to be a marked downward trend. Kohli, (1996) suggests that this decline may be due to adoption of new technology or method of production difficult for the elderly to work or work conditions have become harder and unsuitable for them. The very fact that more elderly persons are out of work force shows that there is increasing risk for them to become totally or more economically dependent. It is also important to note that as vast majority of the elderly persons in the rural areas are working in informal and unorganized sectors of the economy and hence, not being covered by any social security program.

In a study done by Arora P.N. and Saxena S, (1997) on pattern of adjustment of retired working and non-working women in a sample of 50 elderly women each from each sectors respectively, it was found that there is no significance difference in the pattern of adjustment of both the groups in nuclear family. However, the study revealed that retired working women have scored higher marks in vocational aspects and interest in old age than the non-working women.

Economic factor is a very important dimension that can denote the quality of life of a person. Realizing the needs and problems cannot solve the problem alone, financial assistance and security is important and necessary to attain goods. In other words, financial insecurities can lead to mental headache especially for the elderly person which has indirect and indirect affect.

2.8 Services Utilization by the Elderly

Old people should not be considered as mere service beneficiaries. They are also good resource providers with their experiences and wisdom. Therefore, in their spare time when utilized, they are capable of putting these qualities for use in the community work such as adult literacy; welfare work among women groups, children and the challenged, relief work, medical care, legal aid, taxation and advice providers etc. Voluntary organizations and agencies should take active part in mobilizing the services of retired people and, wherever necessary, provide them with means, so that they can contribute to the well-being of the community and society. This will in turn facilitate the process of their integration and make them feel capable as a valued member of the society. Among other aspects are that the need consideration and the ways of accessibility and availability of experiences and learned elders to educate other elderly persons for the services available to the elderly population, this includes

the benefits and facilities in public travel, old age pensions, hearing aid, wheel chair, health check ups, transport and about other different organizations and the centers rendering social services etc.

Pushpa Kumari (2001) in her study on problems of the Rural Aged reported that the respondents had expressed greater satisfaction rendered by the day care centers. An overwhelming majority reported that the day care centers met the physical needs like food, clothing, day accommodation health needs such as regular health check up, supply of medicines, cataract operations (95.45%), physical needs like companionship, emotional support (79.55%), social and recreational needs (72.73%) indicating the inevitable support to the rural aged by an external agency.

In developed countries, voluntary home visiting services have been organized which help in solving the problems of loneliness and reducing the strains and tensions of the aged and infirm persons. (In Nag NG, 1987) If such services are available in India it greatly help the elderly especially those living in the rural areas, slum areas in short those who live in poverty. This will better their living conditions, which will also reduce tragedies like suicide of elderly in the society. Also if this type of service which really reaches the target group is available, the immediate families of the elderly will come to understand that the care of the elderly is an important assignment which is assigned to families.

Economic plight and inflation have enhanced the difficulties of old persons as a large number of families do not have the means to meet the physical needs of their members and, understandably, the old and the infirm in particular are adversely affected. Some of them even leave their families to fend for themselves in the community owing to frustration due to neglect and hardships faced by them. Rao, reported in his study from a rural center in south India that of 603 elderly, only one

third utilized services the services of the primary health centers and sub-centers. Of the remaining persons, more than half utilized services of the hospitals and private practitioners, and over a tenth preferred indigenous methods of treatment, the rest claim that they did not need services. Can the limitation of the health sector be the low utilization of its services by the target, or due to the complication of receiving the services provided (non-target friendly) is an important issue for intervention that needs to be addressed (In Liebug S. P, Rajan I. S, 2005).

The study by Yong, 1996, He found that low utilization of the available services limit health care delivery among the elderly population in the South East Asia Regions (SEAR) compared to the developed countries like Australia where services are availed by the elderly population at a much higher level. In India some services which were meant for the elderly never reach the target groups. This is so due to corruption and also due to ignorance to the subject. If immediate families take these important issues into account, it will be more effective and meaningful.

Tout. K, (1993) is of the view that the elderly population is to a large extent responsible for their welfare, he states that until and unless they themselves are fully involved in their own density, they maybe "one of the potential crisis subjects in the future".

There are 1018 Old Age Homes (OAH) in India today; 118 homes exclusively for women. Kerala has a total number of 186 homes for the elderly (Joshi. A.K, 2006).

Sandel & Johnson, (In Cathy Jay Mc Dermott, 1989) Weisberg, 1983 have suggested that the demand for the care of the elderly is increasing and states that for social workers to creatively intervene is important.

Zarit, Reever and Back Peterson, in Audrey Sistler, 1989 noted in their study that care givers who received support from family and friends perceived less burden than care givers who did not receive the support.

Barnes et al. in Audrey Sistler, 1989 also indicates that the usefulness of support groups for providing the well being of care givers themselves.

Folkmaen et al., found that coping related to psychological symptoms, with some strategies being more effective in receiving symptoms. They further implicated that planned problem solving was negatively correlated with psychological symptoms but confirmative coping was positively correlated with symptoms (In Audrey Sistler, 1989).

Holahan and Moos, in their study found that persons who used family support and used fewer avoidance strategies, suffered less distress and were protected from negative consequences namely psychological symptoms and depressions (In Audrey Sistler, 1989).

2.9 Leisure and the Elderly

It is apparent that the elderly persons have a lot of leisure time with hardly any recreational activity: Their main leisure activities are going for morning and evening stroll, listening to religious disclosures, visiting places of worship and playing cards (Nag NG, 1987).

The majority of the elderly people spend at least part of their day doing nothing whatsoever and the amount of time spent in semi somnolent idleness increases with age according to Beyer & Woods. The problem is not so much the increase of the quantity of un obligated time as the shift in its function and significance. During adulthood, leisure is delimited and patterned to a large extent by

work; once the rhythm of work and leisure is upset, free time is often experienced as unstructured. After retirement, activities that were fully absorbing and gratifying throughout adulthood often lose their meaning due to alterations in interest and capabilities. Similarly, leisure time activities that are part of family life may also lose it attraction (In Talman Y, 1972).

In a study done by Joshi A. K. (2006) in the five villages of Varanasi (India) it was revealed that a majority of the respondents spends most of their time with spouse or grandchildren. Rural elderly were found not having any special leisure activities. Only a quarter of the respondents read newspapers regularly, while the rest were found to receive information from socializing with others. Also, due to absence of electrification, television was not commonly used by the rural elderly.

In a study done by Saxena, D.P. 2006, in Gorakhpur city, India with an elderly urban sample of 240 it was found that less than half of the elderly listen to the radio and watch television in their leisure time. The distribution among the superannuated civil servants (80 respondents) as per their preference is Listening to the radio and cassettes and seeing the television (100 %), Recitation of holy books (88%). Morning and Evening walks (88%), reading novels and magazines/Newspapers/New Publications/Current Professionals journals (50%), Indoor games (25%0, Writing letters, Articles, Reports, preparing notes and writing poems etc (12%), Gardening (25%), Gossip with friends and neighbors (25%). Similarly among the elderly lawyers (80 respondents) we find distribution on priority basis as: listening to Radio and cassettes (96%), , Reciting of holy books (83%), writing letters, Articles, reports, preparing notes and writing poems (58%) and reading novels/magazines/newspapers/new publications/current professionals Journals (50%), Gossip with friends and neighbors (16%), doing social service (16%), Indoor games

(12%), Gardening (8%) and Attending Club (8%). Among the elderly doctors (80 respondents) leisure time activities are on priority basis: Reading novels/ Magazines/ Newspapers/ New Publications/ Current Professional journals (92%), Attending Club (79%), Listening to the radio/cassettes and seeing television (66%), Morning and Evening walk (66%), Gardening (66%), Doing Social service (26%), Reciting of holy books (26%), Writing letters/ Articles/ Preparing Notes and Writing Poems (13%) and Gossip with friends/ neighbors (13%).

In a study done by Matsuo M. et al (2003) among 321 elderly persons above 65 years of age in Yonago, Japan, to study the activity participation of the elderly on quality of life. Quality of life (QOL) and personality were examined in two groups of elderly subjects with and without activity participation (AP). The AP group was involved in five types of activities namely community center activity course, learning and lecture participation, club activity, elderly manpower service activity and other activities. The perceptual difference between the two groups obtained by the correspondence and cluster analysis was that although the elderly with AP group were satisfied and not bored with their current life, this trend was not clear for the non-AP group. Among the five activities, other activities characterized as activities adhered to by participants over a long period showed highest QOL compared to with the other four types. The data also revealed that there was no significant difference between the AP and non-AP groups for living with family or alone and in gender. Though it is believed that being healthy is one of the conditions for participating in an activity, participation in the activity itself was found to help elderly in this study to feel better and healthier. In conclusion, the AP of the elderly should be encouraged and continuing AP might be an important factor in improving QOL of the elderly.

In a study done by Joshi A.K. (2006) it was identified that 70 percent of the respondents spend most of their time with spouse or grandchildren. Rural elderly were found not having any special leisure activities. Only a small portion of 25 percent of the respondents read newspapers regularly, while the rest were found to receive information from socialising with others. Also, due to absence of electrification, television was not a common scenario for the rural elderly, implicating a lower quality of living than the elderly in the urban areas due to availability of resources.

2.10 Group work with the elderly

The elderly population is the fastest growing population in the world. However, this age group is where some lose their loved ones, having to adjust to numerous physical and mental changes. Due to these factors, working with the elderly is a very important sector. To improve their quality of living steps like group work, day care centre, leisure centre etc is essential for the elderly.

Mary Pane observes that elderly population differs from the other population. She takes a point to explicates differences in issues and the efficacy of group work for the various cohorts of the elderly population – the young old(50-70 yrs), the old old (75yrs or older), and the mentally or the physically impaired (In Audrey Sistler, 1989).

The age group 60 years and over is also a time for despair and adjustment for most elderly. Some loss their spouses, friends etc and have to find another friend to replace the ones who are gone, some developed illnesses etc. It is healthier to be in a group than be isolated for any individual. Hence, for more productive living conditions, group work among the elderly can serve as an important means for them in attaining mental ease which in turn can affect their quality of living in a positive way.

2.11 Institutionalized Elderly

Gifford & Golde, studied on the issues of institutionalized elderly. They came to the conclusion that the potential for improving the quality of life in the nursing home residents is enormous, they concluded that social acceptance, promoting self esteem, creating a sense of purpose and providing security is essential in serving the elderly (In Cathy Jay Mc Dermott, 1989).

In a study done by Nagpal & Chadha, the elderly who are institutionalized are found to have lower life satisfaction, they stressed to conclude that such finding is in consistent with research result of other cultural settings (In Chadha, N. K, Willigen V. J, 2003).

2.12 Living Wills

It is important to note that an elderly living alone does not necessarily mean that the elderly experience loneliness. Similarly, elderly living with a spouse or children does not necessarily mean that the elderly do not experience loneliness.

Margai, in Colleen Galambas, 1989, pointed out importance of the 'Living Wills' of the elderly in his study. He implies that this is important for the elderly as it is the use of appropriate measure to maintain the life of an individual during a critical illness. Collen Galambas, (1989) suggested that the 'Living Will' legislation has created a dilemna within the medical profession as in some cases the doctors may hesitate to terminate treatment because of the fear of being charged with negligence. She further observes that a living will for the elderly population is to regain a sense of control as it gives them the power to choose.

In a study done by Joshi A. K. (2006) it was found that almost all preferred to live on their own/ ancestral homes and also with their sons. In this study all of the

elderly were found residing in their own home with their families with low quality of living.

2. 13 Minorities among the Elderly

2.13.1 Black elderly

R.J. Taylor & Chatters, (1988); R.J. Taylor &W.H Taylor, 1982 in their research suggested that large segments of the older black population face obvious disadvantages in socioeconomic status. R.J Taylor, 1982 found that among black adults religion and religious behavior of many forms is permanent feature of their lives, Prayer as a very important coping mechanism among the black elderly as quoted in the above study.

R.J. Taylor & W.H Taylor, (1982) in their study found that health and finance were most significant problems of the black elderly indicating the low income and poor health conditions.

2.13.2 Chinese Elderly in the United States

Marlides Smindel, suggested that the older Chinese elderly were traditionally inclined although the traditional structure has never been reproduced in the United States. In studies done by Chen, Cheung, Cho, Lum, Tang& Yau, Ikels, Lum Cheung, Cho, Tang & yau , Nagasawa, 1980 (In Monit Cheung, 1989) they found that the elderly Chinese parents were living and supported by their children. Filial piety, respect, care and support of older persons is considered as a moral duty and a person's way of gaining status in the Chinese community. Cheng, 1978 also further implicates that Chinese elderly persons possess strong ethnic identity and a drive to maintain their dignity and a strong will to preserve their culture.

2.14 Elderly in the North East India (Nagaland & Arunachal Pradesh)

India is a country with diverse cultures and ethnicity. People from the different regions differ from one another. Hence, the people from the north, south, east west of India speaks different dialect, belonged to diverse religions etc. Similarly, the people from the north east differ from the people from the plains. North east is a hilly region, where the tribal are found.

In a study done by Ketshukietuo Dzuvichu on a sample of 380 elderly from the Angami tribe of Nagaland, it was found that a significant majority of the respondents (75.78%) lived with their children and only a few elderly (8.64%) lived alone. In the same study it was found that less than half (48.94%) of the female respondents were educated with formal education against male respondents who were lesser in number (46.83%). There is predominance of married men (35.26%) and widows (26.31%) over married women (22.89%) and widowers (13.94%) in all age groups. In an Angami society, according to the author marriage is considered to be a compulsory assignment for everyone, however, in this study it was found that an insignificant minority (0.52%) of the female respondents never got married and remained single (In A. Lanununsang Ao, 2007).

In a study done by Visielie 2007 in Nagaland, north east India among a sample of 100 elderly, it was found that there were more female elderly (21) illiterate against the male illiterate (15) elderly. The study also found that one female elderly was literate with no formal education. Educated till primary school among the male elderly was ten persons and female elderly was nine. The data also revealed that twelve male elderly received formal education till secondary standard against eleven female elderly. Male elderly who received education till pre-university was seven whereas female elderly was only five. Graduate male elderly were four against three

female elderly. With regard to technical education, there was one male elderly for civil engineering and MBBS respectively. In the same study, it was found that there were more number of chief bread earners among the male elderly (34) against the female elderly (19). However, prime time bread earners were more in number among the female elderly respondents (26) than the male elderly respondents (14). Non-earners were five among the female respondents against two male respondents (In A. Lanununsang Ao, 2007).

In a study done by Nayak B. D and Sarkar. S, 2008 on a ample of 124 elderly from Arunachal Pradesh, north east India, among four tribes (Adi, Apatani, Galo and Nishi). The female elderly constituted more than half (52%) of the sample where male respondents were almost an equal number (48%). Majority of the respondents (86%) were illiterate and less than one-sixth (14%) were educated till primary school level. Less than two-thirds of the respondents (62%) were found to be married. An overwhelming majority of the respondents (95%) were living with children and only an insignificant number (2%) were found living alone. In the same study, it was found that majority of the respondents were earners (83%) against more than one-sixth (17%) respondents who were dependent. Among the respondents, pensioners formed a minority (4%) and those engaged in agricultural work were less than half (48%). Majority of the respondents (79%) were found be earn livelihood by collection of minor forest product produce, and an over whelming majority (98%) were engaged in preparation of crafts and other products for domestic use. More than half of the respondents (59%) were found to be engaged in selling of items in the market. Majority of the respondents (76%) perceived that their children do listen to them. However, only less than half of the respondents (43%) felt that their grandchildren listen to them. An overwhelming majority of the respondents (98%) have quality time

in taking meals together with their family. Majority of the respondents (85%) felt that they play an important role in the family especially on important family occasions. More than one-third of the respondents felt that their community cares for them. More than two-thirds of the respondents (69%) felt that their family cares for them. Majority of the respondents (85%) felt that their family and society take good care of them in sickness. All the respondents (100%) felt that there is a change in their family due to modernization of the society. An insignificant minority of the respondents (4%) expressed that they would like to live in an old age home, however, an overwhelming majority (98%) felt that living in an old age home will spoil the value system in the family and society.

In a study done by Neethirajan S. J. and Latha S. D. S 2008, on a sample of 60 elderly age group from 50 and above among six different tribes (Emchi, Mani, Hari, Hirja, Rani, Sille) from Arunachal Pradesh, north east India it was found that less than a tenth of the elderly (5%) of the respondents reported negligence from their family and more than one-sixth (16%) of the respondents are facing financial and material exploitation. More than a tenth (11%) of the respondents were found to be lonely, and one-third (15%) of the respondents are facing problems of depression. It was also found that less than a tenth (6.6%) of the respondent's loss their confidence and will power and felt mentally weak. Less than half of the respondents (43.5%) complained problems of ill health and almost the same number (40%) are suffering from poor sanitation and complained inadequate preventive and curative practices. More than a fifth (23.5%) of the respondents have financial problems and less than half (40%) complained of unsatisfactory diet pattern. The same study found that less than half (41%) of the respondents were unable to adapt to changes due to modernization, and more than half (53%) complained of neglect of use of mother-

tongue by the younger generation. More than half of the respondents (56%) are found to be concerned about the declining importance for religious activities and less than half (40.5%) feared of loss of identity and recognition.

2.2 Magnitude and Growth of the Elderly population

2.2.1 World Scenario

The Worlds Population is ageing rapidly. The ageing of population refers to the proportion of old people in the total population of the nation. The global ageing process that first took place in the developed countries has now become a worldwide phenomenon. Today, out of every ten persons is 60 years ot above; by 2050, one out of five will be 60 years or older; and by 2150, one out of three persons will be 60 years or older. One significant aspect of the global ageing process is that the 80 years or over age group is the fastest growing segment of the population. In terms of total population, 80 or above people today constitute a little more than 1 per cent, the proportion is expected to increase to 4.1 percent in 2050. Globally, the average annual growth rate of persons aged 80 years or over (3.8%) is currently twice as high as the growth rate of population over 60 years of age (1.9%). In 2000 there were estimated 180,000 centenarians throughout the world. By 2050, their number will increase to be 3.2 millions. (Vanlalchawna, 2007)

2.2.2 India Scenario

The ageing population in India has started since 1961 which marked the process of the beginning of sharp decline in the overall death rate and also in mortality levels in the older age groups 9age 60 and above years). The elderly population increased from 12.06 million in 1901 to 19.61 million in 1951, an increase about 63 per cent. Between 1951 and 1971, the number of elderly persons increased by about 67 per cent, reaching 32.70 million by 1971. during 1971-81, the increase in

the aged population was about 32 per cent as against the increase of 24.7 per cent recorded for the total population during this period. The Technical Group on population Projections estimated that the likely number of the elderly by year 2016 will be around 113 millions. About 78.1 per cent of the elderly in India live in rural areas against 74.3 per cent of the total population living in urban areas. The mortality rate for the elderly, as obtained from the scheme of the Sample Registration System (SRS) indicated that mortality rate in the 60+ in 1996 was 50 per 1000 elderly population. This was 55 for males as compared with 46 females. (Vanlalchawna, 2007)

There is increasing attention in research with reference to health and social issues that include elderly abuse in families, maintenance of elderly homes, Need for home based care, nursing homes and day care facilities. Recognition of the seriousness and extent of elderly abuse has been slow. Abuse can be verbal (verbal assaults, threats, use of abusive and obscene languages), physical (battering, shaking, tying to bed, withholding physical care), medical (cover sedating) or failing to procure needed appliances such as walking stick, glasses, hearing aids or financial (misuse of assets and exploitation.

2.2.3 Mizoram Scenario

Mizoram covering 21081 square kilometers, has 888,573 people (2001 Census) and it occupies 30th position in terms of population size among the 35 states and union territories. The state consists of 8 districts with 22 Rural Development (RD) Blocks and 817 villages, out of which 707 are inhabited and 110 are uninhabited. The urban area of the state according to the 2001 Census comprise of 22 statutory towns. The rural population consists of 50.4 per cent of the total population while 49.6 per cent live in urban areas. Mizoram is one of the highest urbanized states in the country,

next to Delhi. The state has registered 28.8 per cent growth rate of population during 1991-2001 compared to 39.7 per cent during the 1981-1991. the growth rate of the population in 1991-2001 is higher than the national growth of 21.5 per cent. The overall literacy rate is 88.8 per cent in 2001 Census. People aged 60 years and over have increasingly a larger share in the total population. From 4.42 per cent in 1981, the share of the old age population has increased to 5.52 per cent in 2001. Between 1981 to 2001 the population grew by 80 per cent while the elderly population grew by 124 per cent. According to Census of India, 2001 the total number of elderly persons (60 years and over) in Mizoram is 49023 (Vanlalchawna, 2007).

CHAPTER 3

METHODOLOGY

3. Methodology

The study is descriptive and cross- sectional in nature. The objectives stated in the first chapter were pursued through investigation using standard procedure. This chapter on methodology deals with the description of sample selection and procedures adopted for collection of data for the study and also treatment of the data.

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population increased from 12.06 million in 1901 to 19.61 million in 1951, an increase about 63 per cent. Between 1951 and 1971, the number of elderly persons increased by about 67 per cent, reaching 32.70 million by 1971. during 1971-81, the increase in the aged population was about 32 per cent as against the increase of 24.7 per cent recorded for the total population during this period. The Technical Group on population Projections estimated that the likely number of the elderly by year 2016 will be around 113 millions. About 78.1 per cent of the elderly in India live in rural areas against 74.3 per cent of the total population living in urban areas. The mortality rate for the elderly, as obtained from the scheme of the Sample Registration System (SRS) indicated that mortality rate in the 60+ in 1996 was 50 per 1000 elderly population. This was 55 for males as compared with 46 females. (Vanlalchawna, 2007)

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urban area of the state according to the 2001 Census comprise of 22 statutory towns. The rural population consists of 50.4 per cent of the total population while 49.6 per cent live in urban areas. Mizoram is one of the highest urbanized states in the country, next to Delhi. The state has registered 28.8 per cent growth rate of population during 1991-2001 compared to 39.7 per cent during the 1981-1991. the growth rate of the population in 1991-2001 is higher than the national growth of 21.5 per cent. The overall literacy rate is 88.8 per cent in 2001 Census. People aged 60 years and over have increasingly a larger share in the total population. From 4.42 per cent in 1981, the share of the old age population has increased to 5.52 per cent in 2001. Between 1981 to 2001 the population grew by 80 per cent while the elderly population grew by 124 per cent. According to Census of India, 2001 the total number of elderly persons (60 years and over) in Mizoram is 49023 (Vanlalchawna, 2007).

The need for elderly care and protection was realized and given importance among the Mizos during the 1950's among the Mizos elderly. The Mizoram Upa Pawl (Mizoram Senior Citizen's Organization) was founded in 1957 to work on the issues, needs and challenges of the elderly in Mizoram. The motto of the organization is "to be a blessing to others". The age range for a person to be a part of the Mizoram Upa Pawl (MUP) is fifty years or more and the criteria is the Indian citizenship. A majority, however are pensioners and retired persons over the age of sixty (Lalmuanpuii, 2004). The Census figures of Age wise data in Mizoram indicates that there are approximately over a lakh in population of persons over the age of 50 years (Census of India 2001). This means that approximately over ten percent of the total population in Mizoram would require acre and protection as older persons. Headquarter of the MUP is located in Aizawl, the capital of Mizoram. The MUP today has more than 500 units and 4 Sub-Headquarters all over the state. The execute

committee assembly has recently resolved to constitute Charity Fund amounting to 50 lakhs to assist the needy members of the organization. The MUP has also instituted 'Mizo Medal' award to those persons who exhibit extra-ordinary bravery, scholarship, high quality of social contribution. Besides these activities, the MUP also give consensus to the families (those belonging to below poverty line) of the member who has passed away.

In Mizoram, the elderly are respected in a variety of ways, in the family, neighbourhood, in the society as a whole. This maybe due to religious beliefs, traditional values, cultural heritage, social norms and education. Because of better living conditions and health care, diet and nutrition owing to modernization, most men and women today do not show the physical signs of ageing until the mid sixties or even the early seventies. However, rural and urban, educated and uneducated elderly living standard may differ.

3.2 Selection of the Respondents and Sample Size

Aizawl District, which consists of one third of the population of Mizoram, is selected as the area of study. Two urban and two rural blocks *within* the district based on the highest concentration of population was selected namely Tlangnuam (Urban) Block and Phullen and Thingsulthliah (Rural) Blocks. All the elderly who reside within the selected blocks formed the sample frame.

These particular blocks were selected due to the following reasons:

1. These blocks are categorized as Urban and Rural Blocks under the Aizawl District Tlangnuam Block.
2. The elderly population in these areas especially Tlangnuam Blocks are found to be very active in their elderly organization (MUP).

3. These blocks were chosen based on the number of household, population (male, female), number of electrified houses, LPG connection, telephone connection, water connection, etc
4. Under **Tlangnuam Block (urban)** Aizawl city area has a total of 93 localities where the number of household ranges from 70 to 3000 numbers. Majority of the households have telephone & LPG connection. Sub-centres are available and functional in all the localities. There are 6 government hospitals and several private hospitals. There are a number of government run primary to higher secondary schools and numerous private educational institutions with a central university called Mizoram University. There are a few professional educational institutions namely RIPANS, Women Polytechnic, etc and a number of beauty culture, handloom, tailoring etc training centres.
5. Under the **Phullen (Tlangnuam Rural) Block** there are twelve villages. The number of households rages from 70 to 350 households. Majority of the village's population is males. However, with regard to the elderly population it was found that in some villages there were more females when compared to male elderly. In these villages it was found that there is a sub-centre and governments run primary, middle and high schools. There is a very less telephone connection and LPG connection. Most of these villages are not so far from the capital, however due to the fact that Mizoram is a hilly area travelling is not as easy as it is in the plains.

6. Under the **Thingsulthliah (Tlangnuam Rural) Block** there are 24 villages. The number of household in these villages ranges from 40 to a 1000 numbers. Majority of the population is males to females, however elderly population varies. There are some villages with numerous telephone and LPG connection where in some villages it is close to Nil. Sub- centres and government primary to high schools are available.

The respondents of the study were chosen using systematic sampling method. The size of the sample is 300 respondents in total, where the rural elderly constituted 150 respondents and urban area elderly constituted 150 respondents respectively.

3.4 Tools of Data Collection:

The data was collected through interview method giving the scholar quality time with the respondents. The data was collected with the help of four schedules as follows:

1. Semi-Structured Interview schedule for respondents' socio-demographic particulars.
2. Semi-Structured Interview schedule to study the Family particulars and major challenges faced by the elderly.
3. Semi-Structured Interview schedule to study the quality of life of the elderly covering personal hygiene, physical health, diet, and satisfaction level, mental health, habit, recreation & leisure time pursuits, services and social support, and perceived life satisfaction.
4. Semi-Structured Interview schedule to study the social support systems-primary, secondary and tertiary social support respectively.

5. Secondary data was collected from MUP office records, government offices including directorate of health services and directorate of Economic & Statistics, hospitals etc.

Numerous schedules and scales were reviewed for use in this study, however, due to unsuitability and uniqueness of the Mizo society an appropriate schedule was developed in order to collect more meaningful data. These schedules include information on

1. Socio demographic particulars: The Socio demographic particulars comprised of sixteen items, namely, ethnicity, religion, place of residence (urban –rural) marital status, education, occupation, income status, land ownership, housing, type of house, facilities at home, economic status.
2. Family particulars: This schedule consists of type of family details such as joint, nuclear and extended families. Members in the family relationship, age, education, occupation, health status (of the family members). The size of the family small (1-3), medium (4-6) and large (7 and above).
3. Quality of Life: This schedule consists of nine items Personal hygiene was assessed on a five point scale, physical health on a four point scale, diet on a four point scale, Mental health on a four point scale, habit (cigarette, zozial, alcohol usage, frequency, quantity and amount spent), recreation &Leisure time pursuits, Services and social support in a four point scale, Perceived life satisfaction on a four point scale respectively.
4. Social support: A tool was developed to measure type of support (instrumental and emotional). There are three dimensions of social support which were assessed

(a) **Primary** Social Support comprising of husband, daughter, son, grand children, son-in-law, daughter –in-law, brothers, sisters, (b) **Secondary** social support comprising of cousins, cousins- \in-law, nephews, nieces, friends, neighbors. (c) **Tertiary** social support comprising of MUP (Mizoram Elderly Organization), YMA (Young Mizo Association), Village Council, Church, Hospital/dispensaries, Primary/sub-health centers, MHIP (Mizo Women's federation) and the Social Welfare Department. *Instrumental support* was used in this study refers to all support that is of a practical nature involving accompanying the elderly to hospitals for health care, to visit relatives, buying or purchasing things for them and attending to such needs. *Emotional support* on the other hand refers to all psychological support and care offered to the elderly to meet their challenges. All such support was rated in terms of 'availability' and 'adequacy'. Respondents were asked to rate if support was available or nor, adequate or not.

3.5 Data Analysis

Data was processed with the help of SPSS package. Data is presented in percentages and averages. Appropriate statistical measures were employed to present data.

3.6 Chapterisation

The report of the study consists of five chapters. The first chapter dealt with introduction, followed by review of literature in the second chapter. The third chapter dealt with methodology. The fourth chapter presented results and discussion and in the fifth chapter summary and conclusions was presented.

CHAPTER 4

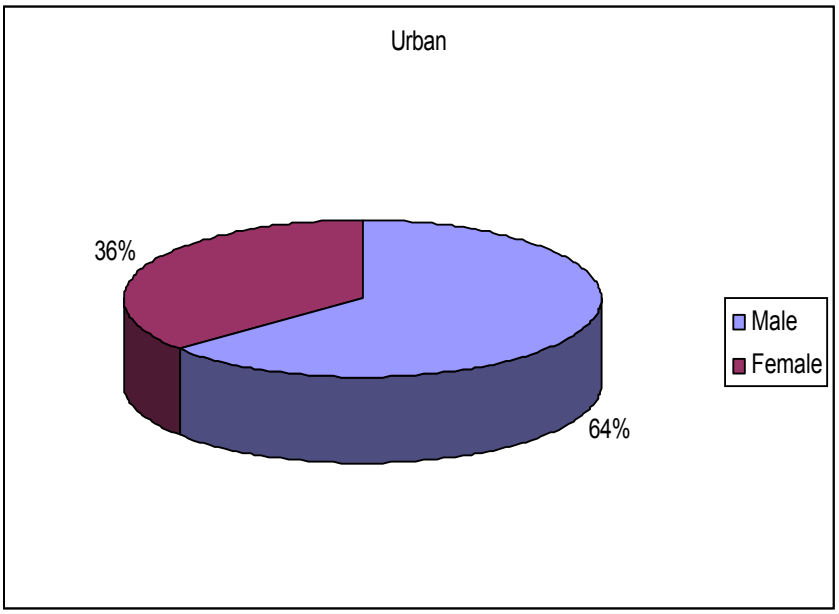
RESULTS & DISCUSSIONS

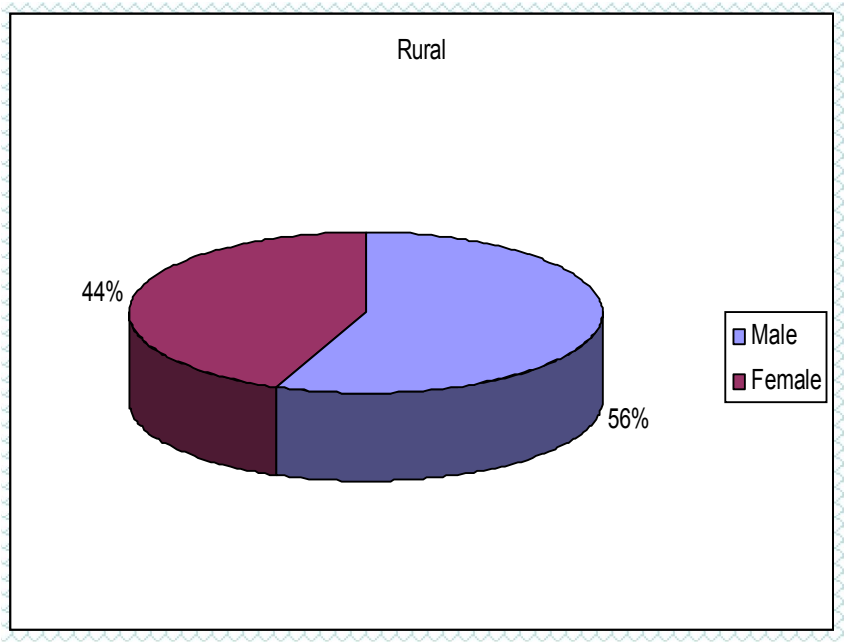
4. Results & Discussions

In the second chapter on 'Methodology', it has already been mentioned that the number of the respondents both from rural and urban area is 150 each respectively. A tool were prepared in the form of semi-structured schedules which sought information from the respondents. Quality time was spent with each respondent problem were used to gather information. From these responses results and discussions are presented which is based on the findings of the study. These results are presented under heads as follows:-

Social Composition: In order to study the quality of life of the elderly, socio-demographic factors are an important determinant. Similarly, in this study, an attempt has been made to understand the socio-demographic particulars of the respondents. Two Hundred and Ninety Nine (299) of the respondents were Mizos belonging to diverse clans. One (1) respondent was a non-Mizo (Nepali), and however, he has been staying in Mizoram for more than thirty years and is Christian and married to a Mizo.

Figure 1. Gender Distribution of Respondents





Gender: The dynamics of gender is also covered in this study. With regard to education, marital status, occupation etc there are gender differences which can be studied extensively in order to understand the quality of life of the elderly. Females constituted more than half (55.63%) of the rural respondents whereas the corresponding male respondents was less (43.7%). However, with to regard the urban sample male elderly was found to be almost two thirds of the respondents (63.76%) whereas the urban female respondents were more than a third (36.24%) of the sample (Figure 1). With reference to gender it is possible that the rural elderly women have longer life span as compared to their urban counterparts. In general, it is not uncommon to see that women have greater longevity as compared to men. This is corroborated by Husain M.G. 1997, who states that women age with less difficulty than men do.

Figure 2: Age Distribution of Respondents

Figure 2.1 Urban Respondents

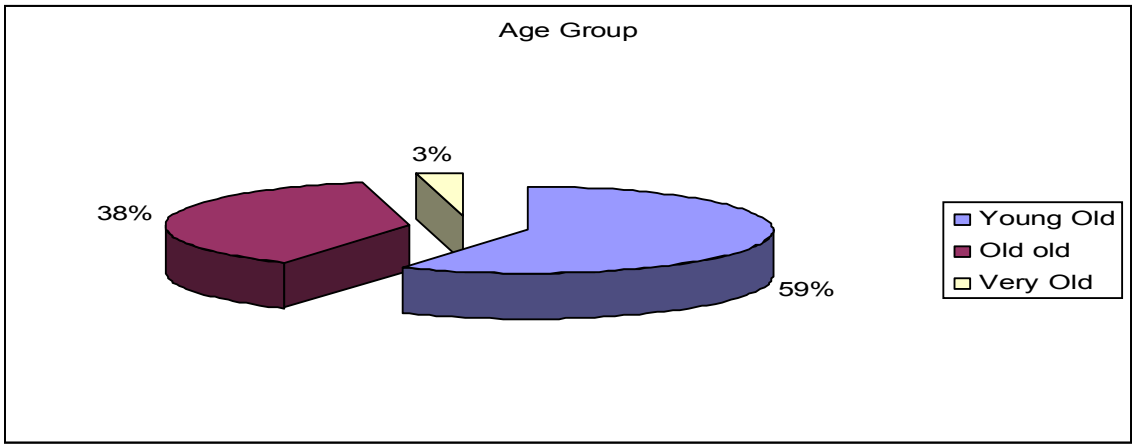
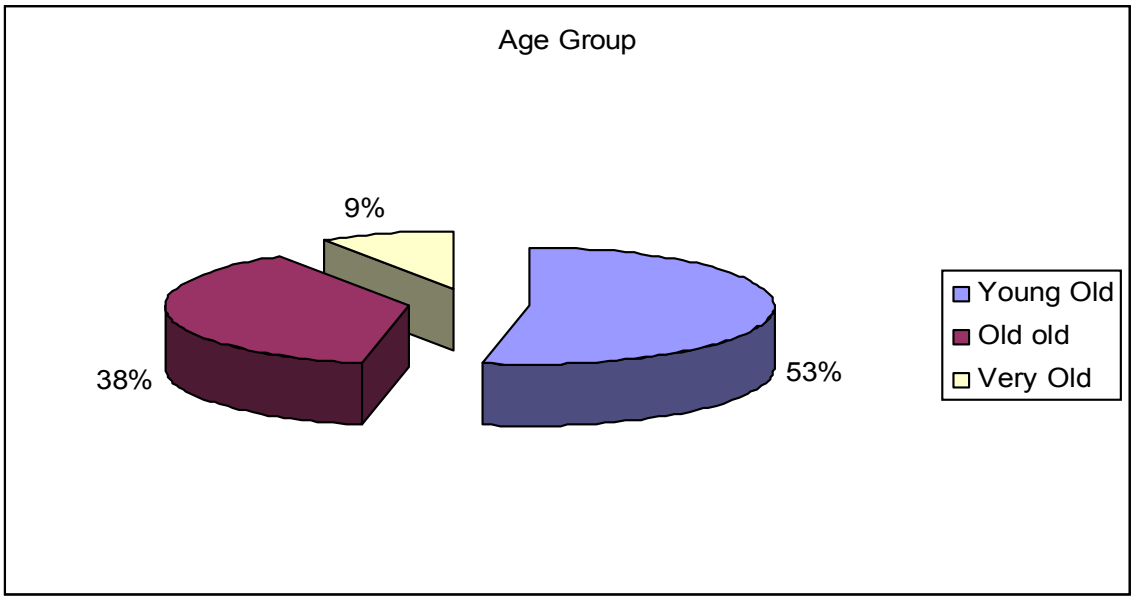


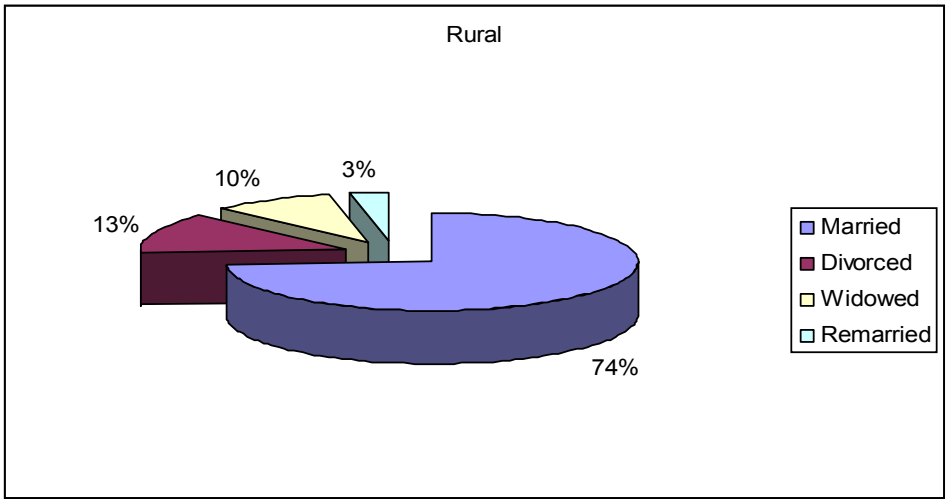
Figure 2.2 Rural Respondents

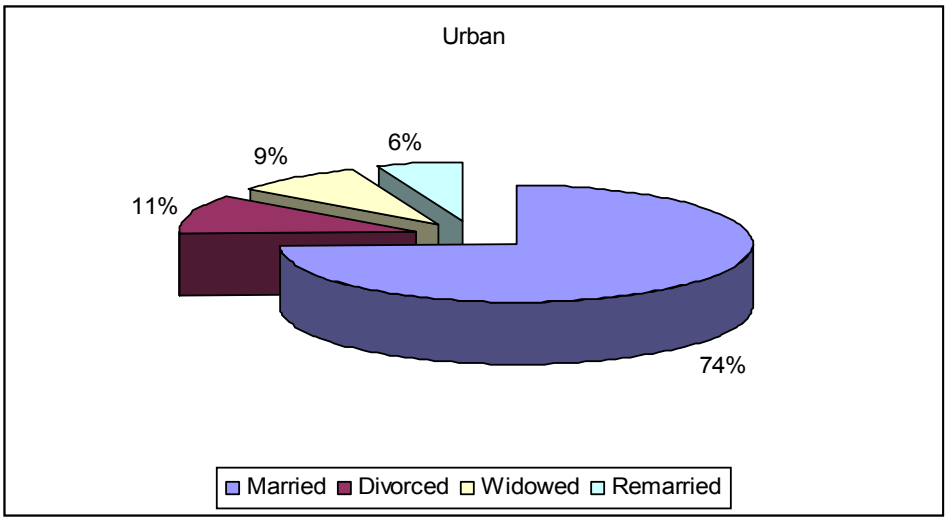


Age: The elderly is a category that includes a vast range in years. Age has a definite bearing on abilities, life satisfaction and general quality of life. In this study more than half of the respondents (55.67%) belonged to the age group of the *young old* ie 60 to 70 year's age group. The Urban elderly constituted more than half of the respondents belonging to this age group (53.39%) where the rural elderly also constituted more than half (52.98%) but less than the urban elderly in this age group. In the *old old* (71 to 80 years) category more than a third of the elderly (38.26%) were from the urban area and an almost equal number (37.75%) were from the rural area. *The very old* (81 and above years) were found to be in a much smaller number forming barely six per cent of the sample. However, of the rural elderly respondents the *very old* constituted a higher number (9.27%) as compared to the urban area where there was an insignificant minority (3.36%).

This finding maybe understood in the context of greater rural life span as compared to urban life span. The average life expectancy of a person in India is 60 years for male and 61 years for female. In a study by Bengston et al (In Warner and Warner, 2002), it was found that women generally live longer than males and are more likely to be widowed. He also states that women who are widowed are likely to find similar widowed women who can provide support and a network of friendship. Also women are understood to make friends faster and easier than men which in turn promote their mental health to a great extent.

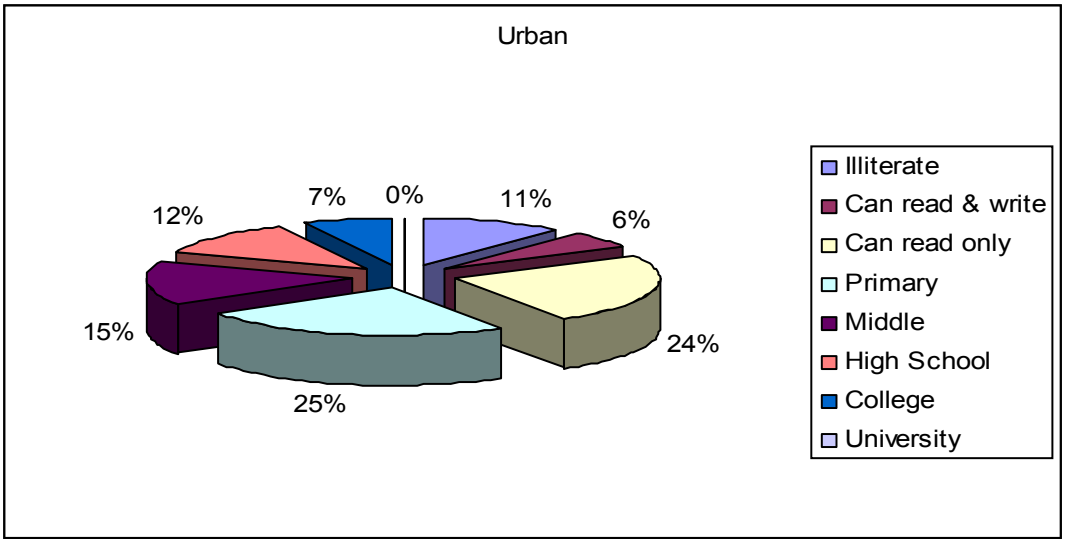
Figure 3. Marital Status of the Respondents

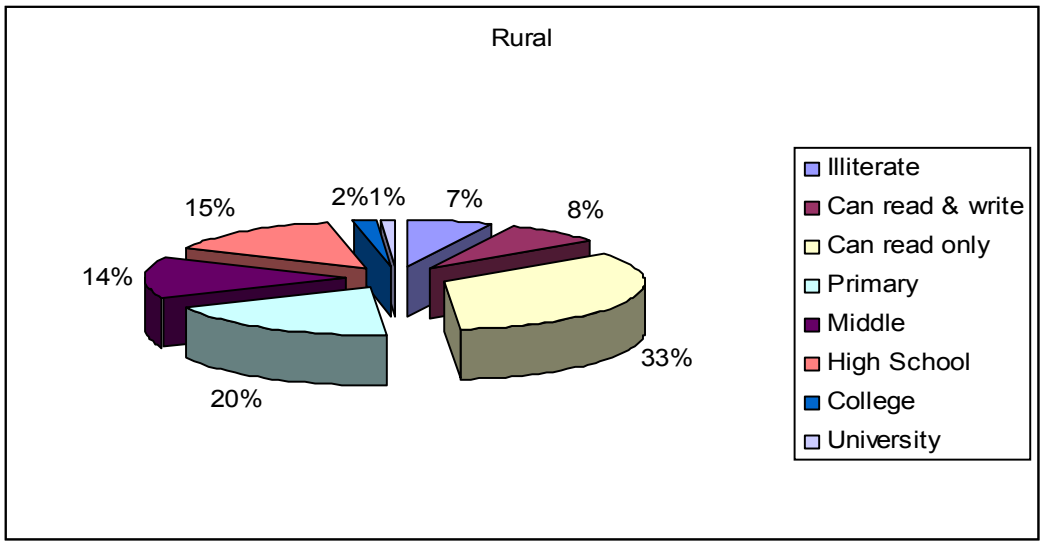




Marital Status: Marital status of a person is also a factor that can determine the quality of life of a person. Elderly whole live with a spouse and without desirable living conditions affects the mental stability and life satisfaction of the elderly. In this study, majority of the respondents both from the rural (73.51 %) and urban (74.50 %) area were found to be *married*. In the urban area it was found that more than a tenth of the elderly were *divorced* (10.74%) whereas in the rural area the figure of *divorced* persons is a little higher (13.25%). More number of *widows and widowers* were found in the rural area (9.93%) than in the urban area (8.72%). Some of the respondents were found to have *remarried* in both the urban and rural areas; urban *remarried* elderly formed a higher percentage (6.04%) than the rural *remarried* elderly (3.31%) In a study done by Ketshukietuo Dzuvichu on a sample of 380 elderly from the Angami tribe of Nagaland, which is a north-eastern state and hence comparable to Mizoram, it was found that married men constituted more than a third of the respondents (35.26%) while widows constituted more than a quarter of the respondents (26.31%) and married women were more than a fifth (22.89%) with widowers forming more than a tenth (13.94%) in all age groups. A tenth (10%) of males from the urban area and less than a tenth (8%) of male respondents from the rural areas were widowers. Less than a tenth (7%) of the urban female respondents and more than a tenth (12%) of the female respondents from the rural area were widowers. In an Angami society, marriage according to the author is considered to be a compulsory assignment for everyone, however, in the study quoted above, it was found that an insignificant minority (0.52%) of the female respondents never got married and remained single.

Figure 4. Educational Status of the Respondents

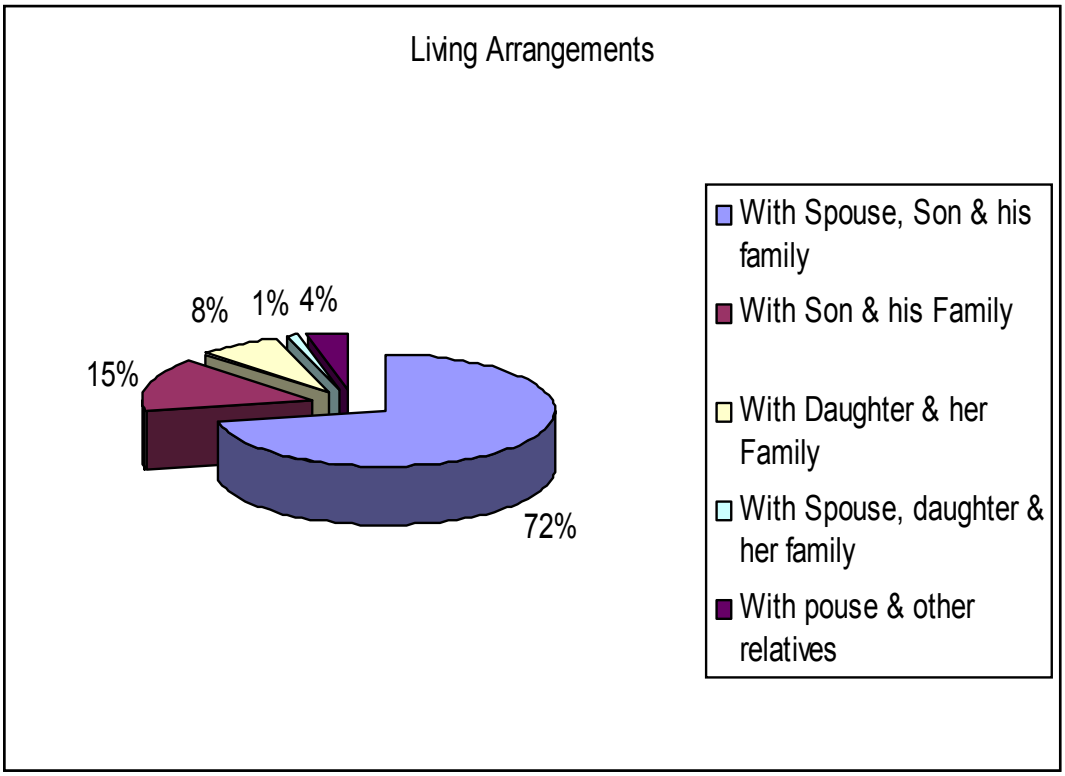




Educational Status: Level of education achievement is expected to have a bearing on both life satisfaction as well as quality of life. This study documented more than just the formal educational achievement and sought information on abilities with reference to reading and writing. Such abilities are of great importance in a tribal society that is in transition. The data revealed that *illiteracy* was more in the urban (10.74%) area compared to the rural area (6.62%). However, it is important to note that urban elderly have moved from the rural area to the urban area due to greater need of social support. In a tribal society like Mizoram, movement from the rural to the urban or vice versa is not uncommon since there is a rural -urban continuum. Further, mobility within the state is frequent. The study also discovered that elderly who *can read only* were more in the rural area (7.95%) whereas in the urban area the figure was less (6.04 %). One-third of the rural elderly were able to *read and write* (33.77%), whereas among the urban elderly, those able to *read and write* were less than a quarter (24.16%). From the urban area, the elderly who had been educated till *primary level* of education was almost a quarter (24.83%), but the elderly in the rural area who were educated till *primary level* was less than a fifth (19.87%). Respondents from the urban area who had been educated till *middle school* level were found to be less than one-sixth (14.77%), *high school* also constituted over a tenth (12.08%), *college level* was much less (7.38%). None of the respondents from the urban area had a *post graduation* although there was one respondent in the rural sample with a *post graduation*. As for the respondents from the rural area, those educated till *middle school* level was about one-sixth (15.23%), high school was an insignificant minority (1.99%), and *graduates* were even less (0.66%). In Mizoram formal education was introduced only in 1894, however, in just over a hundred years of education, Mizoram has the attained the enviable position of being the second most literate state. The discrepancy between

urban and rural elderly in this study is not very stark however, in a study done by Punias on urban and rural elderly in India, it was found that 14 per cent of the urban aged and 67 per cent of the rural aged were illiterate. In a study done by Ketshukietuo Dzuvichu on a sample of 380 elderly from the Angami tribe of Nagaland, it was found that less than half (48.94%) of the female respondents were educated with formal education against male respondents who were lesser in number (46.83%). In a study done by Lalmuanpuii, 2004 on a sample of 25 rural elderly it was found that more number of female elderly were illiterate when compared to the male elderly. In this reference study however, the findings have to be seen in the context of the fact that there is a near Urban-Rural continuum and therefore mobility across areas do not exist across rural and urban areas and most higher educational opportunities exist only in the state capital.

Figure 5. Living Arrangements of Respondents



Living Arrangements: The living arrangements comprise of the space, facilities and persons with whom the elderly live. Such living arrangements are likely to have a definite bearing on perceived life satisfaction. In this study the elderly were observed to be living with *spouse, son and his family*, with *spouse, daughter and her family*, with *spouse and other relatives*, with *son and his family*, with *daughter and her family*. In Mizoram it is customary for the youngest son to look after elderly and aging parents for which purpose property is also handed over to the youngest son. The data revealed that a high percentage (72 %) of the elderly from both the areas were living with their *spouse, son and his family*. In the urban area it was found that a majority of the elderly (73.15%) as compared to the rural area(70.9%) living with *spouse, son and his family*. More than a tenth (10.74%) of the urban elderly were observed to be living with their *daughter and her family* in the urban area and the figure was much

less in the rural area (4.64%). This is not surprising since younger populations in rural areas show a high degree of mobility and migration into urban areas. Even in Mizoram, it is the same.

Less than a quarter (21.19%) of the elderly from the rural area were found to be living with *son and his family*, indicating that they had either lost their spouse or had a single status (divorced or separated) but in the urban area, less than a tenth (8.72%) were in this category, as discussed earlier.

An insignificant minority (2.68%) of the elderly in the urban area were found to be living with *spouse, daughter and her family* whereas in the rural area there was no such respondent. Elderly living with *spouse and other relatives* was found to be more common among elderly who remarry. In the urban area it was a small number (4.70%) as compared to the rural area (3.31%). According to Gee (1999) one of the most striking changes in the living arrangements of elders, especially over the last thirty years, is the increased propensity for widows to live alone – a trend observed in Canada. In his study of the distinctiveness of Chinese Canadian elders' living arrangements, he found that just over one-third lives with their spouse only. In contrast, among Canadians as a whole, nearly 90 per cent live with their spouse only. Among widows, 41 per cent of Chinese lives alone, compared with 90 per cent within the wider population. Thus, there is considerably more variation in living arrangements within a marital status grouping among Chinese elders than there is in the whole elderly population. Also, not an insignificant percentage of Chinese elders are living in "western" living arrangements. The data of their study clearly highlight the importance of race/ethnicity in determining the patterning of living arrangements among the elderly. According to A. Lowenstein (1999) Living arrangement patterns of the elderly are changing. There is a decline of older people who live in extended or

shared family households and an increase in the number of elderly living alone (by themselves or with a spouse only) – "elderly households". This is especially so in Western Europe. In a study done by Ketshukietuo Dzuvichu on a sample of 380 elderly from the Angami tribe of Nagaland, it was found that a significant majority of the respondents (75.78%) lived with their children and only a few elderly (8.64%) lived alone. In a study done by Nayak B.D. and Sarkar. S, 2008 on a sample of 124 elderly from Arunachal Pradesh, north east India, among four tribes (Adi, Apatani, Galo and Nishi) it was found that an overwhelming majority of the respondents (95%) were living with children and only an insignificant number (2%) were found living alone. An insignificant minority of the respondents (4%) expressed that they would like to live in an old age home, however, an overwhelming majority (98%) felt that living in an old age home will spoil the value system in the family and society. *In the current study in Mizoram, none of the respondents were found to be living alone*. Even in comparison to two other North Eastern States of India which have tribal communities, Mizoram seems to be in an enviable position since none of the respondents from a sample size of 300 are living alone. Mizoram is esconed in a remote corner of the North-East and bounders international territories. The community has adopted Christianity only less than over a hundred years. It is possible that change in religion as well as Education seem to have had an encouraging role in maintaining community traditional practices.

Table 1: Earner / Dependent Details of Respondents

		Locality		
Sl.No.	**Characteristic**	**Urban**	**Rural**	**Total**
		n = 150	**n =150**	**N = 300**
VI	**Earner or Dependent**			
	Earner	65	56	121
		(43.62)	(37.09)	(40.33)
	Dependent	84	95	179
		(56.38)	(62.91)	(59.67)

Source: Computed (Figures in parenthesis indicate percentages)

Earner or Dependent: Quality of life is inextricably linked to perceived and actual economic dependence on others to meet daily needs. In this study an attempt was made to understand the status of the elderly with reference to earning and dependency. More than half of the urban elderly (56.38%) and less than two-thirds (62.91%) of the rural elderly were found to be *dependant* on the family with regard to income. With regard to the elderly *earner* status, it was found that less than half (43.62%) of the urban elderly were *earners* as compared to more than a third (37.09%) among the rural elderly. In a study done by Visielie,2007, in Nagaland, north east India among a sample of 100 elderly it was found that there were more number of chief bread earners among the male elderly against the female elderly. However, prime time bread earners were more in number among the female elderly respondents (26) than the male elderly respondents (14). Non-earners were five among the female respondents against two male respondents (In A. Lanununsang Ao, 2007).

Figure 6. Occupation of Respondents

Figure 6.1 Rural Respondents

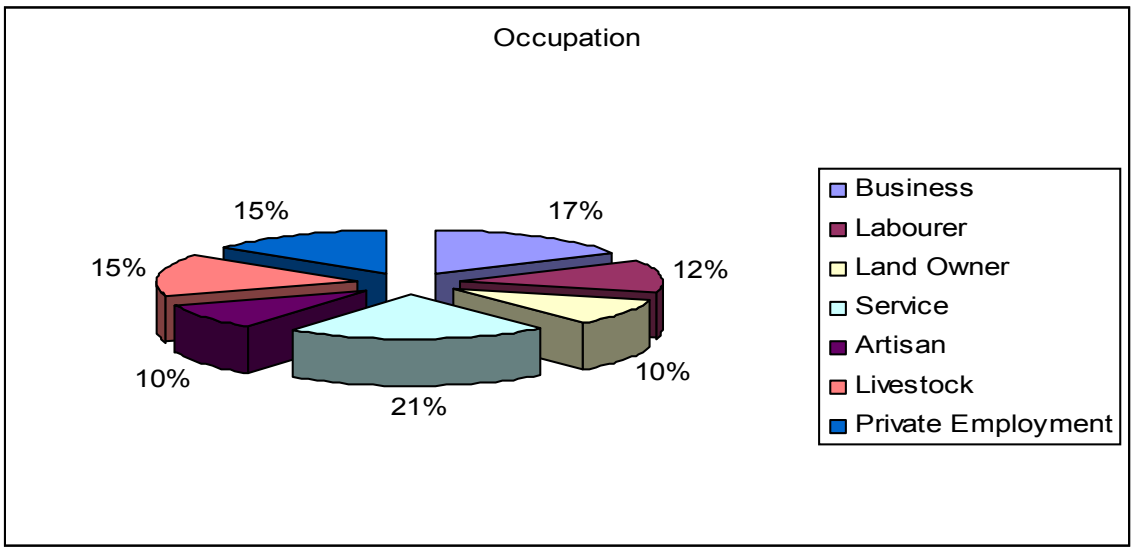
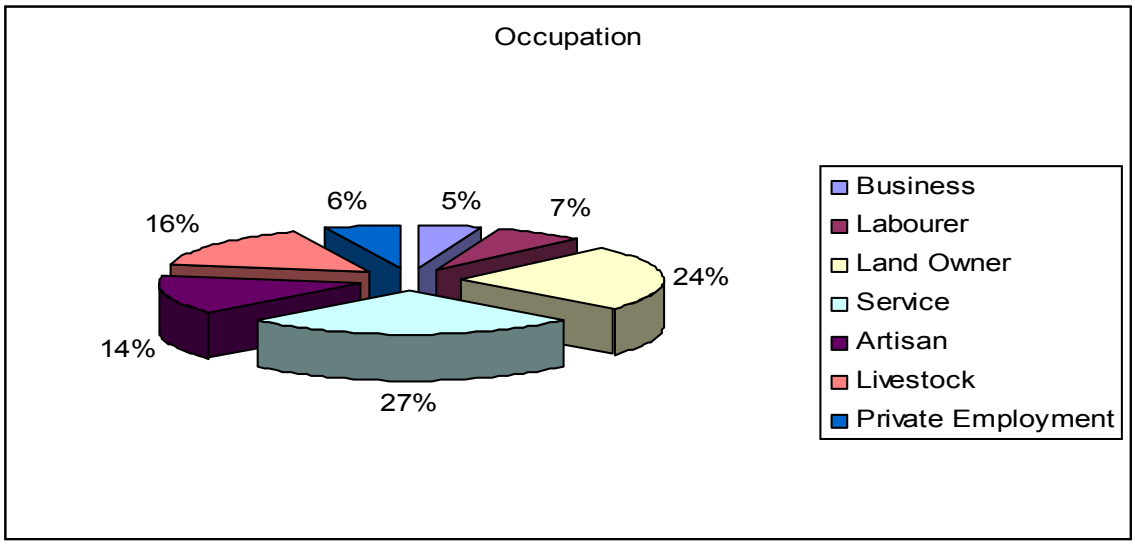


Figure 6.2 Urban Respondents



Occupation: Occupation of a person has a definite bearing on the quality of living of a person. In this study, it was found that over-all more of the rural elderly were found to be in occupations that served as means of livelihood as compared to their urban counterparts. This was particularly true with reference to running of petty businesses such as shops, sale of produce from agricultural holdings and with reference to labour on farm holdings as well as private employment. More than a quarter (26.85%) of those with occupations in the urban area were employed in *service* occupations while the corresponding figure among the rural elderly was a little over a fifth (21.19%). Not too surprisingly *land ownership* was higher among the urban elderly (24.83%) as compared to the rural elderly (9.93%) which was less than a tenth. *Private employment* was more than double among the rural elderly as compared to the urban elderly and it includes occupations such as driver, teacher, watch-man etc. (Figure 6)

In a study done by Singh, & Sharma In Liebug S. P, Rajan I. S, 2005, it was found that among the Indians, nearly 90 per cent of the workers are found in the agricultural sector with no retirement age. They stressed that the rural elderly continue to work but reduce the number of working hours due to different health related complications, but still they often are compelled to continue working.

Irudaya Rajan, Mishra, & Sharma, found that an approximate 40 per cent of older men were cultivators, while over two third of them were found to be agricultural labourers with widows predominating. It was found that a little over a sixth of the rural elders get pension or retirement benefits while less than half of the urban elderly get these benefits (In Liebug S. P, Rajan I. S, 2005). There are several ways of interpreting the working pattern and Earning ability of the elderly, consequent ability of life, the elderly would be living longer. Decline in abilities and productivity would be signification and in developing country like India, the unemployment status is likely to

further increase the problems of the elderly. Loss of functions, loss of earnings and increase in dependency will further aggravates problems and create mental health challenges for the elderly.

Table II Ownership of Land of Respondents

Sl. No.		Locality		
II	No. of Plots Owned	Urban n = 150	Rural n =150	Total N = 300
	1 Plot	66 (44.30)	78 (51.66)	144 (48.00)
	2 Plots	83 (55.70)	50 (33.11)	133 (44.33)
	3 or More Plots	0 (0.00)	23 (15.23)	23 (7.67)

Source: Computed (Figures in parenthesis indicate percentages)

Ownership of Land: In order to study the quality of life of the elderly from both the areas, information on ownership of land status was sought from them as it is understood to have a direct impact on the quality of life of the elderly. This variable covered income on rent as well and not only agricultural land holdings. A 100 percent of the elderly who constituted respondents of this study were found to have at least *one plot of la*nd with a tenth owning more than *three plots of land*. The findings showed that more than three *plots of land* were owned by the elderly from the rural areas which constituted to one third (15.23%) where in the urban area none of the respondents were found to own more than *three plots of land*. However, more than half the elderly from the urban area were found to own *two plots of land* (55.70%) while the rural elderly who own two plots of land only constituted a third of the sample (33.11%). Elderly having *one plot of land* in the urban area was less than half (44.30%), whereas elderly from the rural area was more than half (51.66%). Of the total number of rural elderly respondents

Table III Socio Economic Category of Respondents

Sl. No.		Locality		
III	Socio Economic category	Urban n = 150	Rural n =150	Total N = 300
	BPL	0 (0.00)	47 (31.13)	47 (15.67)
	APL	149 (100.00)	104 (68.87)	253 (84.33)

Source: Computed (Figures in parenthesis indicate percentages)

Socio Economic Category: The socio-economic status of the elderly is an important determinant which affects the quality of life of a person. In this study, it was found that less than a third (31.13%) of the elderly from the rural areas belonged to *below poverty line* (BPL) where as none of the elderly from the urban areas were found to belong to this category. All the respondents (100%) among the urban elderly belonged to *above poverty line* category (APL) whereas more than two-third (68.87%) of the elderly from the rural area were found to be *above poverty line*. According to the National Sample Survey Organization, (NSSO) (1998) in India; about 80 per cent of the Indian elders still reside in the rural areas where 40 per cent live below the poverty line with nearly 33 per cent just above it. As found in some studies the rural elderly have lower educational status than the urban elderly, this study revealed that more number of elderly reside in the rural area.

Table IV Access to Main Road by Respondents

Sl.No.		Locality		
IV	Access to Main Road	Urban n = 150	Rural n =150	Total N = 300
	Very Easy	44 (29.53)	24 (15.89)	68 (22.67)
	Easy	73 (48.99)	83 (54.97)	156 (52.00)
	Difficult	30 (20.13)	38 (25.17)	68 (22.67)
	Very Difficult	2 (1.34)	6 (3.97)	8 (2.67)

Source: Computed (Figures in parenthesis indicate percentages)

Access to Main Road: Mizoram comprises of a hilly terrain. The very steep hills pose tremendous challenges to the elderly, particularly if there are physical challenges and disability to contend with. Accessibility of the main road was studied which is an important determinant factor of facilities available to the elderly. The data revealed that less than half of the elderly from the areas urban area (48.99%) and more than half of the elderly from the rural area (54.97%) found it *easy* to access the main road. Elderly from the rural area comprising a quarter (25.17%) found it to be *difficult*, and a smaller percentage (3.97%) of the rural elderly found it *very difficult* only a sixth (15.89%) of the elderly found it to be *very easy* to access the main road. In the urban area more than a quarter of the elderly (29.53%) found it *very easy*, and a fifth (20.13%) found it *difficult* and only a few (1.34%) of the elderly found it *very difficult* to access the main road. The quality of life determined by this indicator would suggest that the urban elderly enjoy better Quality of Life. Access to main road would mean access to health care and facilities as also access to better social opportunities. Thrice times the number of rural elderly found it *very difficult* to access the road.

Table V Ownership of House

		Locality		
Sl.No. **V**	**Ownership of House**	**Urban n =150**	**Rural n =150**	**Total N = 300**
	Owned	101 (67.79)	126 (83.44)	227 (75.67)
	Rented	48 (32.21)	25 (16.56)	73 (24.33)
	Type of House			
	kuchha	32 (21.48)	8 (5.30)	40 (13.33)
	semi pucca	59 (39.60)	79 (52.32)	138 (46.00)
	pucca	58 (38.93)	64 (42.38)	122 (40.67)

Source: Computed (Figures in parenthesis indicate percentages)

Ownership of House and Type of House: Ownership of house is an important variable for measuring the quality of life of a person. The data revealed that in both the study areas majority of the respondents were living in a home *owned* by them. In the urban area two-thirds (67.79%) of the respondents *owned* their present accommodation and nearly one-third (32.21%) of the elderly were living in a house *rented* by them. In the rural area, a significant majority (83.44%) of the respondents were found to *own* the house they were living in and only more than one-sixth (16.56%) of the respondents were living in a *rented* home. With regard to the type of house they lived in, more than a third of the respondents from urban (39.60%) and more than half of the respondents from the rural (52.32%) area were found to be living in a *semi-pucca* type of house. Elderly from the rural area living in a *pucca type* of house was more (42.38%) than in the urban area (38.93%). More than a fifth (21.48%) urban elderly were found to live in a *kuchha type* of house whereas a much

less percentage (5.30%) of the rural elderly were living in a *kuchha type* of house. The data also revealed that the house of the elderly had more than one rooms.

Table VI Facilities and Amenities

		Locality		
Sl. No.	**Characteristic**	**Urban n = 150**	**Rural n =150**	**Total N = 300**
VI	**Facilities and Amenities**			
	Separate Bathroom	147 (98.66)	148 (98.01)	295 (98.33)
	Separate Toilet	149 (100)	150 (99.34)	299 (99.67)
	water connection	137 (91.95)	124 (82.12)	261 (87.00)
	Telephone	123 (82.55)	118 (78.15)	241 (80.33)
	Television	133 (89.26)	128 (84.77)	261 (87.00)
	LPG	142 (95.30)	143 (94.70)	285 (95.00)
	Electricity	149 (100)	146 (96.69)	295 (98.33)

Source: Computed (Figures in parenthesis indicate percentages)

Facilities and Amenities: For the purpose of assessing the quality of life of the elderly, the availability, access and the availing of certain basic facilities were examined. Respondents were asked if they had access to *separate bathroom, separate toilet, water connection, telephone connection, television, LPG connection, Electricity connection.* The data revealed that in the urban area, bathrooms were available in the house for an overwhelming majority (98.66%), toilet for all the respondents (100%), water connection (91.95%), telephone (82.55%), television (89.26%), LPG (95.30%) and electricity (100%). In the rural area the findings differ. Separate bathroom (98.01), separate toilet (99.67%), water connection (82.12%), telephone (78.15%),

television (84.77%), LGG (94.70%) and electricity (98.33%). The findings reveal that there is only a marginal difference between the urban and rural elderly with regard to access and availability of facilities and amenities. Overall, the elderly in Mizoram enjoy more of the basic facilities as compared to elderly in rest of the country.

Table VII Personal Hygiene

Personal Hygiene

		Locality					
Sl.No	**Habit**	**Urban**		**Rural**		**Total**	
		Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**
1	Cleaning hair	3.83	1.18	4.29	1.09	4.06	1.15
2	Taking Bath	3.19	1.24	3.83	0.44	3.51	0.98
3	washing clothes	3.01	1.01	3.38	0.81	3.20	0.93
4	Changing clothes	2.66	1.39	3.62	0.77	3.14	1.22
5	hair cutting	2.91	1.49	3.28	1.35	3.10	1.43
6	Combing hair	2.70	1.51	2.08	1.54	2.39	1.55
7	Shaving	2.34	1.65	1.38	1.07	1.86	1.46

Source: Computed

Personal Hygiene: Personal hygiene of a person is an important aspect to be considered in understanding the quality of life of a person in terms of facilities for maintenance of hygiene routinely available as well as practiced by him/ her respectively.

The mean score for the urban elderly was 3.83 which means that most of the urban elderly clean hair more than *once a week* and not *daily* whereas the rural elderly were found to clean hair almost daily (4.29). During probes used in the interview , it was revealed that this may be attributed to the rural elderly being more engaged in their work and going out of the house more often than the urban elderly. They therefore find it more necessary to clean up more often than the elderly in the urban

areas. Also during the course of interview, it was observed that the rural areas were more unsanitary than the urban area. With regard to taking a bath the urban elderly (mean score of 3.19) was lower than the rural elderly (mean score 3.83), the explanation being the same as that of cleaning hair. The rural elderly were found to be clean in reference to their clothing more often (3.38) than the urban elderly mean score (3.01). This was also due to the fact that the working area of the rural elderly was found to be dirtier than in the urban areas. The rural elderly change their clothing more often (mean score 3.62) than the urban elderly (mean score 2.66). The elderly in the urban area were found to cut hair at less frequency (mean score 2.91) than the rural (mean score 3.28) but the urban elderly were found to comb hair more frequently at a higher mean score (2.70) and shave (2.34) than the rural elderly who comb hair was just more than a quarter (1.54) and shaving routine frequency among the rural elderly (1.38) respectively.

TableVIII Physical Health

Physical Health

Sl.No		Locality				Total	
		Urban		Rural			
		Mean	SD	Mean	SD	Mean	SD
1	Difficulty in seeing	3.0	0.8	3.1	0.8	3.1	0.8
2	Difficulty in hearing	2.8	0.7	3.2	0.7	3.0	0.7
3	My memory is failing me	2.8	0.6	3.2	0.7	3.0	0.7
4	Difficulty in falling asleep at night and waking up in the morning	2.9	0.6	3.0	0.8	2.9	0.7
5	Aches and pain in joints	2.9	0.7	3.0	0.8	3.0	0.7
6	Difficulty in moving around	3.0	0.6	3.3	0.7	3.2	0.7
7	Regular Bowel functions	3.1	0.7	3.1	0.8	3.1	0.7
8	Blood Pressure Tends to remain normal	3.0	0.5	3.1	0.7	3.0	0.6
9	Difficulty in Breathing	3.1	0.6	3.3	0.8	3.2	0.7
10	Sugar Level is Under Control	2.7	0.8	3.3	0.8	3.0	0.8
11	No Problem in Liver	2.9	0.9	3.3	0.8	3.1	0.9
12	Bladder Control Regular	2.8	1.0	2.9	1.0	2.9	1.0
13	Regular Monthly Medical Check Up	2.7	1.1	3.2	1.0	3.0	1.1
14	Satisfied the treatment Received	2.1	1.1	1.9	1.1	2.0	1.1

Source: Computed

Physical Health: Physical health has a direct affect on the well-being of a person especially on the elderly, which in-turn affects and moderate the quality of life they enjoy. The physical health aspect was also studied where different variables were rated on a four point scale .Mean and Standard Deviation was calculated for these variables. It was found that the rural elderly (mean 3.1) of the urban elderly had more difficulty in seeing than the rural elderly (Mean 3.0).The findings also revealed that

the rural elderly (mean 3.2) had more problems in hearing than the urban elderly (mean 2.8) Even memory failure was more common among the rural elderly (mean 3.2) than the urban elderly (mean2.8). The elderly in this study had a problem or difficulty in falling asleep at night and waking up in the morning and also had pain in joints; it was found to be more common in the rural elderly (3.0) than among the urban elderly (2.9). Most of the respondents were found to have difficulty in moving around, rural elderly (3.3) and urban elderly (3.0). In spite of having other physical complaints most of the respondents from both the areas were found to have regular bowel functions, rural and urban elderly mean score was equal (3.1). Most of the respondents were also found to have normal blood pressure, urban elderly (3.0) and rural elderly (3.1) . However, difficulty in breathing prevailed among the elderly more among the urban elderly (3.1) than among the rural elderly (3.3). In the case of sugar level, the urban elderly (2.7) were found to have a poorer sugar level than the rural elderly (3.3). Also liver was not found to be as problematic for both respondents - rural elderly (3.3) and urban elderly (2.9). Most of the respondents were also found to have a controlled bladder, where among the urban elderly the mean score was lower (2.8) and among the rural elderly (2.9). The respondents were also found to have a monthly regular check up where this was more common among the rural elderly (2.9) than the urban elderly (2.8) due to frequent medical camps by the health directorate of Mizoram. However, in spite of these frequent check ups the respondents were found to be *not very satisfied* with the treatment they received. Dissatisfaction was more among the rural elderly with a mean score (1.9) higher than the urban elderly mean score (2.1). In a study done by Birren and Schale (1997) it was found that the main physical problems of the elderly were poor vision, diabetes mellitus, arthritis, hypertension, rheumatism. In a study done by Sitara Balan V and Girija Devi V

(2010) among 800 elderly respondents above 60 years of age in Kerala, India, it was found that a third (33.37%) of the elderly suffer from hypertension, which is high among women (39.75%) when compared to male elderly (27%). It was followed by Diabetes (33.25%) Poor vision (23%), asthma (11.12%), Arthritis (8.62%), Rheumatism (8.25%), cardiac Problems (8.12%). It was found that women elderly were having more chronic morbidities than male elderly. In a study done by Omer Oguzturk et al (2005) in a sample of 70 non-smoking elderly asthma patients from the Respiratory Diseases Clinic of Kirikkale University Hospital, Turkey, it was found that disease severity in elderly patients with long standing asthma significantly impairs quality of life and that the impairment in quality of life may be rated to psychological status indicators.

Table IX Diet and Intake

	Diet	**Locality**					
Sl.No		**Urban**		**Rural**		**Total**	
		Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**
1	Leafy Vegetables	4.0	0.0	4.0	0.3	4.0	0.2
2	Vegetables	4.0	0.3	4.0	0.3	4.0	0.3
3	Dal	2.3	1.3	1.9	1.3	2.1	1.3
4	Egg	2.0	1.2	1.3	0.8	1.7	1.1
5	Meat	2.0	1.1	1.9	1.3	2.0	1.2
6	Milk	2.2	1.2	1.8	1.3	2.0	1.3
7	Fruits	1.4	0.8	1.0	0.3	1.2	0.6
8	Food satisfaction	1.0	0.2	0.7	0.5	0.9	0.4

Source: Computed

Diet: Diet pattern has definite bearing on level of satisfaction and affects the quality of life of a person. The diet pattern and consumption was also covered in this study. In order to understand the quality of the life of the elderly an attempt was made with

regard to understanding their dietary habit which includes leafy vegetables, Vegetables, Dal, Egg, Meat, Milk, Fruits . Respondents were asked to rate consumption on a four point scale namely daily(4), twice a week (3), thrice a week (2) and occasionally(1). Satisfaction with food was also sought in the form of *yes* and *no* responses. The results reveal that the respondents from both the areas were found to include green leafy vegetables and other type of vegetable daily (urban 4.0, rural 4.0). Dal was more frequently consumed in the urban area (2.3) than in the rural area (1.9). Egg was also more frequently consumed among the urban elderly (2.0) than the rural elderly (1.3). It may be said that meat is considered an essential item in the meal for the Mizos who are essentially a tribal population .However, in this study it was found that meat was not consumed frequently by all respondents. The frequency was less among the rural elderly (1.8) than the urban elderly (2.2). Finally, fruit consumption among the respondents. The rural elderly (1.0) were found to consume less fruits than the urban elderly (1.4) which is also quite a low rate. Using probes, it was discovered that the elderly stated that they did not like fruits much. An attempt was made to discover the level of satisfaction of the dietary habit of both the rural and urban elderly. During the course of interview it was expressed by most of the respondents that they were unable to consume large quantities of food as compared to the time of their younger days hence, satisfaction of consumption of food is quite low for both the areas- urban (1.0) and rural area (0.7). It was also understood that the respondents from rural area explained that types or varieties of food was absent in the rural areas even if they have the financial opportunities to purchase these foods. This was particularly so in the case of milk , meat and variety of seasonal vegetables . A variety of dals was absent in most places and therefore satisfaction was based on these restricted choices. In a study done by Sitara Balan V and Girijia Devi V (2010) among

800 elderly respondents above 60 years of age in Kerala, India, it was found that majority (87.3%) of the respondents followed of meal routine three meals per day. A small percentage of the respondents (7.8%) consumed two meals a day due to poor appetite, four meals/snacks in a day pattern was followed by a very small percentage (3.5%) and a few elderly (0.3%) admit to having meals spread over five or more times in a day. It was also found that a vast majority of the respondents (85%) were satisfied with the food they consumed. A few respondents (1.4%) were found to be dissatisfied with the quality of food they consumed. In the urban area all the respondents were found to be satisfied with the food they consume. However, in the rural area, more than two-thirds (67%) of the female respondents were satisfied and majority of the male respondents (70%) were also found to be satisfied with the food they consume. In a study done by Neethirajan S. J. and Latha S. D. S 2008, on a sample of 60 elderly age group from 50 years and above among six different tribes (Emchi, Mani, Hari, Hirja, Rani, Sille) from Arunachal Pradesh, north east India it was found that less than half (40%) complained of unsatisfactory diet pattern.

TableX Mental Health Particulars

	Mental Health	Locality					
Sl.No		Urban		Rural		Total	
		Mean	SD	Mean	SD	Mean	SD
1	I feel anxious all the time	1.9	1.0	2.5	0.8	2.2	1.0
2	I have few friends with who I can spend time	1.9	0.9	2.7	0.7	2.3	0.9
3	People avoid me because of my age-	2.1	0.9	2.6	0.8	2.3	0.9
4	I get angry easily	2.0	0.9	2.5	0.8	2.2	0.9
5	I dislike being on my own in the house	2.0	0.9	2.6	0.8	2.3	0.9
6	Sometimes I tend to get upset over little things but cannot help it-	1.9	0.9	2.2	0.8	2.1	0.9
7	I have no one to talk to when I am upset or happy-	1.9	1.0	2.8	0.8	2.3	1.0
8	I have dropped many of my interests due to my age	2.2	1.1	2.6	0.7	2.4	0.9
9	I feel my life is empty, and get bored easily	2.0	1.0	2.3	0.8	2.1	0.9
10	I often fear that something bad is going to happen to me	2.1	1.1	2.6	0.9	2.4	1.0
11	I feel that my memory is failing me	2.0	0.9	2.2	0.8	2.1	0.9
12	I think that most people are better off than I am	1.8	0.9	2.3	0.9	2.0	0.9
13	I feel that life is wonderful and I am very happy and content all the time	2.1	1.0	2.5	0.8	2.3	0.9
14	I feel on top of the world when I am complimented	2.2	0.9	2.2	0.8	2.2	0.9
15	I am afraid of the future	1.7	1.0	1.0	0.2	1.4	0.8

Source: Computed

Mental Health: An important factor in understanding the quality of life of a person is numerously determined by his/her mental health. An attempt has been made to understand the mental health of the elderly from both the rural and urban area on a four point scale namely Strongly Agree(4), Neither Agree or Disagree(3), Disagree(2) and Strongly Disagree(1). Mean and Standard Deviation was calculated as the score for these variables. With regard to anxiety, the urban respondents (1.9) were moderately anxious as compared to the rural elderly 2.5). The rural elderly (2.7) were found to have more friends than the urban elderly (1.9). The rural elderly (2.6) were found to have an attitude that people avoid them because of their age, but the urban elderly (2.1) were found to have a moderate feeling towards their age and people's attitude than the rural elderly. The rural elderly (2.6) were found to be more irritable than the urban elderly (2.1). The rural elderly (2.6) were also found to dislike being in the house alone whereas the urban elderly (2.0) found it more manageable to be alone in the house. The elderly from the rural area (2.8) were found to be more irritable and tend to get upset over little things than the urban elderly (1.9). The rural elderly (2.6) have dropped many interests due to their age more than the urban elderly (2.2). The rural elderly (2.3) were found to have a feeling of emptiness and boredom more than the urban elderly (2.0). It was also found that a feeling of fear that something bad is going to happen prevailed more among the rural elderly (2.6) than the urban elderly (2.1). Worry of memory failure was found to be more among the rural elderly (2.2) than the urban elderly (2.0). With regard to self esteem that people are better, the rural elderly (2.3) were found to have more anxiety than the urban elderly (1.8). The rural elderly (2.5) were found to be more content than the urban elderly (2.1). This was so the rural elderly have contributed more to their respective families financially than the urban elderly. It was found that compliments made the

elderly from both the areas happy (men score is 2.2 respectively). With regard to fear of the future, both the elderly from urban (1.7) and rural (1.0) areas were found to be very calm. They are predominantly Christians and cited that the future is not something that they are worried about, however, the fear of economic security of their children and grandchildren earn their often made them pray to God numerously. In a study done by Bhandary P.V. and Latha K.S (2010) on a sample of 112 elderly patients with mean age 72.6 (S.D.9.8) from Department of Psychiatry, Kasturba Hospital, Manipal, Karnataka, India, it was found that over 90 per cent of the respondents reported of having depression. It was found that respondents above 72 years of age (especially male) had dementia as compared to respondents below this age. However, most of the evidence showed that there were no gender differences in the overall prevalence of dementia. In the study, it was discovered that Alzheimer's was the most common sub-type of dementia. Depression and dementia are common in older persons and their association is very complex. Major and minor depression occurs often in patients with dementia and can associate with deterioration in cognitive functioning. Although in this study, the majority of patients complain of having dementia it was however found that dementia did not develop major depression in them but more than half suffer from depressive symptoms such as anxiousness, sadness, irritability, agitation or psychomotor retardation, sleep problems, diminished social activity, or loss of interest. In the same study, delusions and hallucinations, both visual and auditory were found up to 25 per cent.

In a study done by Neethirajan S. J. and Latha S. D. S 2008, on a sample of 60 elderly age group from 50 and above among six different tribes (Emchi, Mani, Hari, Hirja, Rani, Sille) from Arunachal Pradesh, north east India it was found that less than a tenth of the elderly (5%) of the respondents reported negligence from their family

and more than one-sixth (16%) of the respondents are facing financial and material exploitation. More than a tenth (11%) of the respondents were found to be lonely, and one-third (15%) of the respondents are facing problems of depression. It was also found that less than a tenth (6.6%) of the respondents complained of loss of their confidence and will power and felt mentally weak

Table XI Habits

	Habit	**Locality**					
		Urban		**Rural**		**Total**	
Sl.No		**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
I	**Frequency**						
	Cigarette	1.2	1.3	0.6	1.1	0.9	1.3
	Zozial	1.3	1.6	0.3	0.8	0.8	1.3
	Chewing tobacco	0.9	1.6	0.1	0.4	0.5	1.2
	Alcohol	0.0	0.0	0.0	0.0	0.0	0.0
	Drugs	0.0	0.0	0.0	0.0	0.0	0.0
II	**Quantity**						
	Cigarette	1.1	1.4	0.7	1.2	0.9	1.4
	Zozial	1.1	1.3	0.3	0.8	0.7	1.1
	Chewing tobacco	0.7	1.2	0.0	0.3	0.4	1.0
	Alcohol	0.0	0.0	0.0	0.0	0.0	0.0
	Drugs	0.0	0.0	0.0	0.0	0.0	0.0

Source: Computed

Habit: Habit has a direct and indirect implication on a person. A habitual practice of a person can widely determine the quality of life and is one of the indicators of the person's value systems and life satisfaction in general. In order to understand the quality of life of the elderly, habit formation in the area of tobacco, alcohol and drug usage was covered in this study and respondents answered about frequency in a four point scale namely daily (4), weekly (3), fortnightly (2), and monthly (1) However, none of the respondents were found to be engaged in using alcohol and drugs.

Among the elderly consuming cigarette, it was found that the frequency of consumption was more among the urban elderly (1.2) than the rural elderly (0.6). However, it is also evident that consumption was less among the elderly from both the areas. With regard to '*Zozial*' which is a local made cigarette and smoked form of tobacco, the frequencies of consumption mean score was about a quarter (1.3)for urban elderly and much less (0.6) for rural elderly. The frequency of using chewing tobacco was more among the urban elderly (0.9) than the rural elderly (0.1).

The quantity of consumption of cigarette and Zozial among the urban elderly mean score was fourth (1.1) each whereas the rural elderly score was lesser (0.7, 0.3) respectively. The quantity of using chewing tobacco was very less (0.7) among the urban elderly whereas among the rural elderly the mean score was 'nil' (0.0). During the course of interview it was learnt that most of the elderly quit of abstain the habit of using tobacco due to developing diverse health problems. In a study done by Sithara Balan.V. and Girjia Devi .V in Kerala , among a sample of elderly persons above 60 years of age in a 800 sample, it was found that only a minority (18.5%) used tobacco and other intoxicants such as drugs (0.4%). Smoking was practised by only a few percentage (8%) of the elderly, chewing tobacco was practised by another few (7.4%) of the elderly, and chewing of heal leaves by another few (5.0%). The reasons cited for starting the habit vary among the elderly, majority of the users (46.7%) were specifically not known. While few of then (4.72%) stated that it helped reduce tension and kept their body warm.

Table XII Recreation and Leisure

Sl.No.	Locality	Urban n=150	Rural n=150	Total N=300
1	I watch Television frequently	105 (70.47)	142 (94.04)	247 (82.33)
2	I listen to the Radio frequently	100 (67.11)	143 (94.70)	243 (81.00)
3	I read newspapers regularly	73 (48.99)	99 (65.56)	172 (57.33)
4	I visit my friends/relatives often	68 (45.64)	106 (70.20)	174 58.00)
5	Church	74 (49.66)	123 (81.46)	197 (65.67)
6	My friends/ relatives visit me often	67 (44.97)	98 (64.90)	165 (55.00)
7	I am involved in church activities	55 (36.91)	91 (60.26)	146 (48.67)
8	I am involved in a number of social activities through CBOs	55 (36.91)	105 (69.54)	160 (53.33)
9	We have frequent family get-togethers	53 (35.57)	107 (70.86)	160 53.33)
10	I go to the bazaar regularly	98 (65.77)	129 (85.43)	227 (75.67)
11	I spend a lot of time with my children/ grand children	131 (87.92)	151 (100.00)	282 (94.00)

Source: Computed (Figures in parenthesis indicate percentages)

Recreation & Leisure Time Pursuits: The recreational activity of a person has a direct affect on the quality of life, facilities available to them and level of satisfaction of a person. The detail of recreation and leisure time pursuits was also studied study. A higher percentage of the elderly from the rural (94.04%) area were found to view Television more frequently than the urban elderly (70.47%). The elderly from the rural area constituting a higher percentage (94.70%) were found to be more fond to tuning to the radio than the urban elderly (67.11%) of the urban respondents. With regard to newspaper, the rural elderly less than two-thirds (65.56%) were also found

to have read them regularly as compared to the urban elderly who read the newspaper were found to be less than half (48.99%). As all the respondents were Christians, church was found as one of the most important activity centres of the elderly. The rural elderly who attended the church constituted a large percentage (81.46%) whereas the urban elderly were less amounting to less than half (49.65%) of the total urban respondents. In this regard, it was expressed by the urban elders that the location of the church is far and up hill which created a problem for them to attend the church on a regular basis. More than half of the rural elderly (64.90%) were found to have frequent visitors whereas the urban elderly who had frequent visitors only constituted to less than half of the total urban sample (44.97%). A high percentage of the rural elderly (69.54 %) were found to be involved in the church activities whereas the urban elderly only constituted just above a third (36.91%). Social activities through CBOs was high among the rural elderly (70.86%) whereas the urban elderly it was just above a quarter (36.91%). It was also found that frequent family get togethers was practiced more among the rural elderly with a higher percentage (70.86%) than among the urban elderly (35.57%). Most of the urban elderly have explained that these get togethesr was difficult since other family members settled in different part of the city and are very busy with their work while some were out of the state due to studies and work etc. Most of the rural elderly (85.43%) went to the bazaar often whereas the urban elderly (65.77%) were not as active as the rural elderly. All the rural elderly (100%) were found to spend lots of time with their children and grandchildren whereas not all but a high percentage (87.92%) of the urban elderly had the opportunity to have the similar activity. In a study done by Saxena, D.P. 2006, in Gorakhpur city, India with an elderly urban sample of 240 it was found that less than half of the elderly listen to the radio and watch television in their leisure time. The

distribution among the superannuated civil servants (80 respondents) as per their preference is Listening to the radio and cassettes and seeing the television (100 %), Recitation of holy books (88%). Morning and Evening walks (88%), reading novels and magazines/Newspapers/New Publications/Current Professionals journals (50%), Indoor games (25%0, Writing letters, Articles, Reports, preparing notes and writing poems etc (12%), Gardening (25%), Gossip with friends and neighbors (25%). Similarly among the elderly lawyers (80 respondents) we find distribution on priority basis as: listening to Radio and cassettes (96%), , Reciting of holy books (83%), writing letters, Articles, reports, preparing notes and writing poems (58%) and reading novels/magazines/newspapers/new publications/current professionals Journals (50%), Gossip with friends and neighbours (16%), doing social service (16%), Indoor games (12%), Gardening (8%) and Attending Club (8%). Among the elderly doctors (80 respondents) leisure time activities are on priority basis: Reading novels/ Magazines/ Newspapers/ New Publications/ Current Professional journals (92%), Attending Club (79%), Listening to the radio/cassettes and seeing television (66%), Morning and Evening walk (66%), Gardening (66%), Doing Social service (26%), Reciting of holy books (26%), Writing letters/ Articles/ Preparing Notes and Writing Poems (13%) and Gossip with friends/ neighbours (13%).

Table XIII Perceived Life Satisfaction

	Life Satisfaction	Locality							
Sl.No		Urban		Rural		Total		t	Sig.
		Mean	SD	Mean	SD	Mean	SD		(2-tailed)
1	Food	2.99	0.53	3.21	0.47	3.10	0.51	3.78**	0.00
2	Clothing	3.07	0.49	3.18	0.53	3.13	0.51	1.77	0.08
3	Accommodation	2.90	0.60	2.87	0.63	2.89	0.61	0.35	0.72
4	Quality of drinking water	2.70	0.65	2.90	0.57	2.80	0.62	2.85**	0.00
5	Adequate Time for Rest	2.58	0.68	3.05	0.44	2.82	0.62	7.09**	0.00
6	Family life	2.72	0.69	3.04	0.46	2.88	0.60	4.67**	0.00
7	Health Status	2.77	0.61	2.83	0.62	2.80	0.61	0.79	0.43
8	Financial Condition	2.87	0.57	3.12	0.54	2.99	0.57	3.97**	0.00
9	Assets Possessed	3.17	0.54	3.14	0.59	3.16	0.57	0.54	0.59
10	Accomplishment of Childhood Expectations	3.09	0.65	3.07	0.44	3.08	0.55	0.33	0.74
11	The way Children Raised	2.86	0.60	3.09	0.47	2.98	0.55	3.75**	0.00
12	The Way the Parents Raised	2.83	0.77	2.97	0.61	2.90	0.70	1.85	0.07
13	The quality Time Spend with Grandchildren	2.79	0.73	3.03	0.46	2.91	0.62	3.42**	0.00
14	The Family Eats Together Everyday	3.04	0.69	3.07	0.38	3.05	0.55	0.41	0.68
15	Family' s Respect for the Elderly	3.25	0.62	3.09	0.41	3.17	0.53	2.56**	0.01
16	Children sharing of their problems	3.19	0.64	3.03	0.51	3.11	0.58	2.31**	0.02
17	Treatment Received from in-laws	3.25	0.59	3.10	0.43	3.17	0.52	2.5**	0.01
18	Family Takes Good Care	3.11	0.59	3.03	0.50	3.07	0.55	1.18	0.24
19	Family assists for regular medical Check up	3.19	0.92	3.50	0.76	3.35	0.86	3.09**	0.00
20	Life Satisfaction	56.36	4.1	58.32	6.4	57.35	5.5	3.15	0.00

Source: Computed

Life Satisfaction: Life satisfaction of a person has a definite bearing on mental health and quality of life. Component matrix was applied for measuring the life satisfaction of the respondents. Different variables were included the respondents were asked to answerin a four point scale namely Very Satisfied (4), Satisfied (3), Dissatisfied (2)

and Very Dissatisfied (1). It was found that satisfaction for clothing, present accommodation, drinking water, family life, health status, assets possessed, childhood expectations, raising children, time with grandchildren, family eating pattern, respect for elderly were the most satisfying area of the elderly in this study. Next to these, respect for the elderly, problem shared by the children, care in sickness was the next area for satisfaction. It was found that financial condition of the elderly was not found to be satisfactory for the most of the elderly which in turn affects the quality of food, adequate time for rest they had and the frequency for thorough medical check up was obstructed.In a study done by Nayak B.D. and Sarkar. S, 2008 on a ample of 124 elderly from Arunachal Pradesh, north east India, among four tribes (Adi, Apatani, Galo and Nishi) it was found that majority of the respondents (76%) felt that their children listen to them. However, only less than half of the respondents (43%) felt that their grandchildren listen to them. An overwhelming majority of the respondents (98%) have quality time in taking meals together with their family. Majority of the respondents (85%) felt that they play an important role in the family especially on important family occasions. More than one-third of the respondents felt that their community cares for them. More than two-thirds of the respondents (69%) felt that their family cares for them. Majority of the respondents (85%) felt that their family and society take good care of them in sickness. All the respondents (100%) felt that there is a change in their family due to modernization of the society. Minority of the respondents (4%) expressed that they would like to live in an old age home, however, an overwhelming majority (98%) felt that living in an old age home will spoil the value system in the family and society.

Table XIV Primary Social Support

		Urban		Rural		Total	
Sl.No	**Primary Support**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
I	**Instrumental Support**						
1	**Availability**						
	Daughter(s)	3.19	0.92	2.93	0.91	3.06	0.92
	Husband/ Partner	3.03	1.16	2.54	1.06	2.78	1.13
	Sisters	2.36	1.05	2.73	1.05	2.54	1.06
	Son(s)	2.63	1.08	2.38	0.98	2.50	1.04
	Grandchildren	2.01	1.05	2.31	1.06	2.16	1.06
	Son-in-law	1.64	0.89	2.07	0.88	1.85	0.91
	Brothers	1.58	0.83	1.98	0.92	1.78	0.90
	Daughter in - law	1.50	0.82	1.89	0.91	1.69	0.89
	Availability of Primary Instrumental Support	2.24	0.47	2.35	0.55	2.30	0.52
2	**Adequacy**						
	Daughter(s)	2.48	1.07	2.86	0.95	2.67	1.03
	Sisters	2.29	1.16	2.74	1.14	2.51	1.17
	Husband/ Partner	2.31	1.06	2.60	1.06	2.45	1.07
	Son(s)	2.25	1.03	2.43	0.96	2.34	1.00
	Grandchildren	1.95	1.03	2.38	1.08	2.17	1.07
	Son-in-law	1.72	0.95	2.18	0.93	1.95	0.97
	Brothers	1.60	0.89	2.08	1.01	1.84	0.98
	Daughter in - law	1.50	0.83	1.99	0.98	1.75	0.94
	Adequacy of Primary Instrumental Support	2.012	0.542	2.407	0.608	2.211	0.609
II	**Emotional Support**						
3	**Availability**						
	Daughter(s)	2.58	1.18	2.78	0.97	2.68	1.08
	Sisters	2.42	1.20	2.84	1.13	2.63	1.18
	Husband/ Partner	2.38	1.12	2.48	1.04	2.43	1.08
	Son(s)	2.36	1.10	2.34	0.96	2.35	1.03
	Grandchildren	2.09	1.12	2.34	1.07	2.22	1.10
	Brothers	1.86	1.02	2.25	1.16	2.06	1.11
	Son-in-law	1.53	0.91	2.17	0.95	1.85	0.98
	Daughter in - law	1.52	0.87	1.93	0.92	1.73	0.92
	Availability of Primary Emotional Support	2.09	0.62	2.39	0.63	2.24	0.64

4	**Adequacy**						
	Daughter(s)	2.42	1.23	2.98	1.02	2.70	1.16
	Husband/ Partner	2.37	1.18	2.68	1.19	2.53	1.19
	Grandchildren	2.28	1.18	2.61	1.21	2.44	1.20
	Son(s)	2.15	1.21	2.70	1.07	2.43	1.17
	Daughter in - law	2.05	1.20	2.26	1.15	2.16	1.18
	Son-in-law	1.73	1.16	2.45	1.14	2.09	1.20
	Brothers	1.87	1.17	2.23	1.17	2.05	1.19
	Sisters	1.51	1.04	1.90	1.08	1.71	1.08
	Adequacy of Primary Emotional Support	2.05	0.89	2.48	0.84	2.26	0.89

Source: Computed

Primary Social Support: One of the objectives of this study is to understand the social support systems of the elderly. The quality of life of the elderly is greatly determined by the care and support received from his/ her primary group. The primary group of a person is the most important group that can determine the level of satisfaction, aspirations, mental health, and quality of life of the person. Information was sought on two categories- instrumental support(availability and adequacy) and emotional support (availability and adequacy) on a four point scale. In both the areas it was found that *daughters* were most available as social supports. The primary social support group included *husband/partner, daughter (s), son (s), grandchildren, daughter-in-law, son-in-law, brothers, and sisters.* and adequate. In the urban area *daughters* were found to be most available to the elderly in regard to instrumental support with a higher mean score (3.19) and their support was rated as adequate (mean score 2.48) as compared to the rural area**.** After *daughters*, *husband/ partner* were found to be second in offering of primary social support among the urban elderly with instrumental support rated as high on availability (3.03) and were also found to be offering adequate support. In contrast in the rural area, *sisters* were found to be in second place as providers of social support scoring high on availability and adequacy.

Sisters were found to be rated as the third highest in the urban area, (2.36) in availability and (2.73) in adequacy. Sons were found to be higher on availability than on adequacy. Next to these were *grandchildren, son-in-law and brothers and daughter-in –law* in the urban areas. In the rural area the third primary social support providers were found to be *husband/partner, sons, grandchildren, son-in-law, brothers* and the least available or adequate primary instrumental support givers were *daughters-in-law* in both the rural and urban areas.

In emotional primary social support, for both the areas *daughters* were found to be the best support. In the urban area the mean score was higher (2.58) in availability but lower than the rural areas in the adequacy (2.78) of the emotional support given or received. Next to daughters in the urban area sisters were found to be the second emotional primary support providers in the urban area but in the rural area *husband/partner* scored higher than *sisters* in this category. Third service providers were found to be *husband/partne*r in the urban area but in the rural area grandchildren scored to be third. The fourth service providers were son(s) in both the urban and rural areas. The fifth service providers were found to be *grandchildren* in the urban area whereas in the rural areas *daughter-in-law* filled this spot. The sixth service providers were *brothers* in the urban area but it was found to be *son-in-law* in the rural areas. *Brothers Son-in-law* came to be the seventh service providers in the urban areas but brothers were found to be the seventh in the rural areas. The least emotional support providers among the primary group were found to be *daughter-in-law* in the urban area and sisters in the rural area. In a study done by Devi K. R. (2006) in the Kannan Kurichi Village, Salem District (India) the main abuser of the elderly in a family was discovered as females (70 %). Among the abusers the daughter-in-law is the main perpetrator causing depression and stress among elderly. According to several studies

suicide is common among the elderly population and one of the main reasons is depression in elderly. In his study the main reason cited by the elderly to commit suicide is because they were abused by females in the family especially by their daughter-in-law.

Table No. XV Secondary Social Support

	Type of Support	Urban		Rural		Total	
Sl.No		**Mean**	**S.D**	**Mean**	**S.D**	**Mean**	**S.D**
I	**Secondary Instrumental Support**						
1	**Availability**						
	Cousins	1.48	0.85	1.43	0.80	1.45	0.83
	Cousins-in-law	1.64	0.94	1.71	1.00	1.68	0.97
	Nephews	1.41	0.79	1.61	0.99	1.51	0.90
	Nieces	1.66	0.93	2.30	0.95	1.98	0.99
	Friends	1.89	0.98	2.25	0.96	2.07	0.99
	Neighbours	1.56	0.87	1.36	0.79	1.46	0.84
	Availability of Secondary Instrumental Support	1.61	0.24	1.78	0.44	1.69	0.36
2	***Adequacy***						
	Cousins	1.79	0.96	1.61	0.92	1.70	0.95
	Cousins-law	1.24	0.71	1.76	1.05	1.50	0.93
	Nephews	1.61	0.93	1.95	1.04	1.78	1.00
	Nieces	1.32	0.70	2.11	1.00	1.72	0.95
	Friends	1.58	0.90	1.83	1.02	1.70	0.97
	Neighbours	1.46	0.83	1.18	0.57	1.32	0.72
	Adequacy of Secondary Instrumental Support	1.50	0.38	1.74	0.41	1.62	0.41
II	**Secondary Emotional Support**						
3	**Availability**						
	Cousins	1.12	0.48	1.42	0.84	1.27	0.70
	Cousins-in-law	1.26	0.67	1.63	0.91	1.44	0.82
	Nephews	1.26	0.66	1.52	0.92	1.39	0.81
	Nieces	1.46	0.83	1.64	0.91	1.55	0.88
	Friends	1.38	0.77	1.86	0.95	1.62	0.90
	Neighbours	1.56	0.83	1.97	0.97	1.77	0.93
	Availability of Secondary Emotional Support	1.34	0.32	1.67	0.44	1.51	0.42
4	**Adequacy**						
	Cousins	1.42	0.79	1.50	0.87	1.46	0.83
	Cousins-in-law	1.10	0.43	1.47	0.87	1.29	0.71
	Nephews	1.15	0.50	1.54	0.94	1.35	0.78
	Nieces	1.16	0.52	1.70	0.97	1.43	0.82
	Friends	1.59	0.85	1.96	0.96	1.78	0.93
	Neighbours	1.54	0.88	1.91	0.99	1.72	0.95
	Adequacy of Secondary Emotional Support	1.33	0.30	1.68	0.46	1.50	0.43

Source: Computed

Secondary Social Support: Secondary social support of a person has a direct implicit on the life satisfaction and quality of life of the elderly. The secondary social support providers were *set to be cousins, cousins-in-law, nephew(s), niece(s), friends, neighbours* who were to be measured based on instrumental availability and adequacy and emotional availability and adequacy on a four point scale respectively. In the urban area, *friends* were the first support providers with a nearly half the mean score (1.79) in availability and adequacy (1.58) in the rural area *friends* were most instrumentally available with a more than half mean score (2.25) but *nieces* support was found the most adequate with a high mean score (2.11). Nieces were found to be second instrumental available support givers in the urban area with nearly half a mean score (1.66) in availability and a lesser mean (1.32) in adequacy. In the rural area as well *nieces* were found to be the second support givers with more than half mean score (2.30) in availability and (2.11) adequacy. The third instrumentally available person was *cousin-in-law* in the urban area with a mean (1.64) more than in adequacy (1.24) in the rural area, as well *cousin-in-law* were found to be in the third available person category with close to half mean score (1.71) in availability and adequacy (1.76). The fourth was *neighbours* in the urban area whereas in the rural area cousins were in this category, the least available person was nephew in the urban area and *neighbour* in the rural area.

Secondary Emotional support providers from both the areas were also studied. The data showed that for the urban and rural areas, *neighbours* were most available emotionally where the rural mean score was higher (1.97) than in the urban area (1.56). However, the support of *friends* was found most adequate in the urban area with near half a mean score (1.59) in the rural area friend's support was found to be most adequate as well with a higher mean score (1.96). . *Nieces* support was found to

be second in the urban area with a not so high mean score (1.46) whereas in the urban area *friends* were found to be second support providers with a high mean score of nearly half (1.86). But *neighbours* support was found to be second adequate in the urban area (1.54) but in the rural area *neighbours* support was found to be second adequate (1.91). The third available support system in the urban area was *friends* (1.38) whereas in the rural area cousins-in-law (1.63) occupied to this category. The third emotional adequate support group in the urban area was *cousins* (1.42) but in the rural area it was the *nieces* (1.70). The fourth available group for the urban elderly was the *cousins-in-law* and nephews with the same mean score (1.26) but in the rural area it was the *cousins-in-law* (1.63). The fourth emotionally adequate service provider in the urban area was *nieces* (1.16) but in the rural area it was *cousins* (1.50). The fifth and least emotionally available support group for the urban elderly was the *cousins* (1.26) but in the rural area *nephew*s (1.52). The emotionally adequate support group for the urban elderly was the *nephews* (1.15) in rural area as well *nephews* (1.54) also constituted to this category. The least emotionally available person for the rural elderly was found to be *cousins* (1.42). The least emotionally adequate support group for the urban elderly was *cousins-in-law* (1.10) which was also for the case of the rural elderly (1.47). The data revealed that for the secondary social support, the urban elderly enjoyed less support both in availability and adequacy than the rural elderly whose mean score was higher at all respect.

Table XVI Tertiary Social Support

	Type of Support	Urban		Rural		Total	
Sl.No		**Mean**	**S.D**	**Mean**	**S.D**	**Mean**	**S.D**
I	**Tertiary Instrumental Support**						
1	**Availability**						
	YMA	1.26	0.67	1.15	0.51	1.20	0.60
	Village Council	1.14	0.51	1.42	0.82	1.28	0.70
	Church	1.19	0.59	1.13	0.49	1.16	0.54
	Hospital/Dispensaries	1.01	0.16	1.13	0.47	1.07	0.35
	Primary health centre	1.04	0.28	1.28	0.68	1.16	0.54
	MHIP	1.19	0.57	1.11	0.46	1.15	0.52
	Social Welfare Department	1.01	0.08	1.05	0.25	1.03	0.19
	Availability of Tertiary Instrumental Support	1.12	0.25	1.18	0.39	1.15	0.33
2	**Adequacy**						
	YMA	1.20	0.60	1.22	0.62	1.21	0.61
	Village Council	1.19	0.59	1.08	0.41	1.13	0.51
	Church	1.00	0.00	1.03	0.26	1.01	0.18
	Hospital/Dispensaries	1.00	0.00	1.01	0.11	1.01	0.08
	Primary health centre	1.00	0.00	1.02	0.18	1.01	0.13
	MHIP	1.01	0.08	1.01	0.08	1.01	0.08
	Social Welfare Department	1.00	0.00	1.01	0.08	1.00	0.06
	Adequacy of Tertiary Instrumental Support	1.06	0.17	1.05	0.17	1.05	0.17
II	**Tertiary Emotional Support**						
1	**Availability**						
	YMA	1.00	0.00	1.02	0.18	1.01	0.13
	Village Council	1.01	0.16	1.06	0.37	1.04	0.29
	Church	1.00	0.00	1.02	0.18	1.01	0.13
	Hospital/Dispensaries	1.00	0.00	1.03	0.26	1.01	0.18
	Primary health centre	1.00	0.00	1.02	0.14	1.01	0.10
	MHIP	1.01	0.08	1.03	0.20	1.02	0.15
	Social Welfare Department	1.00	0.00	1.00	0.00	1.00	0.00
	Availability of Tertiary Emotional Support	1.00	0.04	1.02	0.17	1.01	0.12
2	**Adequacy**						
	YMA	1.00	0.00	1.01	0.08	1.00	0.06
	Village Council	1.00	0.00	1.04	0.34	1.02	0.24
	Church	1.00	0.00	1.02	0.14	1.01	0.10
	Hospital/Dispensaries	1.00	0.00	1.03	0.20	1.01	0.14
	Primary health centre	1.00	0.00	1.01	0.08	1.00	0.06
	MHIP	1.01	0.08	1.00	0.00	1.00	0.06
	Social Welfare Department	1.00	0.00	1.00	0.00	1.00	0.00
	Adequacy of Tertiary Emotional Support	1.00	0.01	1.01	0.11	1.01	0.08

Source: Computed

Tertiary Social Support: Tertiary social support available to the elderly have a direct and indirect affect on the quality of life of the elderly in terms of services available, means of acquiring the services and the consequences of the services it has on the elderly. The tertiary social support system was studied in a four point scale which was measured in terms of instrumental availability and adequacy, and emotional availability and adequacy. The tertiary support was grouped in seven categories namely the *Young Mizo Association (YMA), the Village Council (VC), the Church, Hospital/Dispensaries, Primary Health Centres, The Mizo Women's federation (MHIP) and the Social Welfare Department*.

The data revealed that the elderly felt very low support from all these groups. In the urban area, the *YMA* was found to be most instrumentally available with a low mean score (1.26) whereas in the rural area the *Village Council* scored the highest mean (1.82). Instrumentally adequate for the urban area was also the *YMA* (1.20) for the rural elderly it was also the *YMA* (1.22). Next to *YMA* instrumentally available tertiary support providers was the *Church* and *MHIP* with the same mean score (1.19) whereas in the rural area it was the *Primary Health Centre* (1.42). However, the second instrumentally adequate tertiary support group was the *Village Council* (1.19) for the urban elderly for the rural elderly as well *Village Council* (1.08) constituted to this category. The third instrumentally available tertiary support group was the *Village Council* (1.14) for the urban elderly but for the rural elderly it was the *YMA* (1.15). Instrumentally adequate third groups for the urban elderly were the *MHIP* (1.01) but it was the *Church* (1.03) for the rural elderly. Instrumentally available fourth and least support provider was the *Primary Health Centres* and the *Social Welfare Department* with the same mean score (1.01) but for the rural elderly it was the *Church* and *Hospital Dispensaries* with the same mean (1.13). The fourth and least instrumentally adequate tertiary support group was the

Church, hospital/Dispensaries, Primary Health Centres and the Social Welfare Department with all same mean score (1.00) for the urban elderly. The fourth and least instrumentally adequate support group was the *Hospital/Dispensaries, Primary Health Centres and the Social Welfare Department* with the same mean score (1.01) for the rural elderly. The least instrumentally available tertiary support group was the *Social Welfare Department* for the rural elderly (1.05). From the findings it maybe noted that the elderly from both the urban and rural areas had experienced a weak tertiary social support system hence affecting their quality of living numerously.

Secondary tertiary emotional support (availability and adequacy) was also explored in this study. The data revealed that none of the elderly from both the areas experienced a healthy emotional support from the tertiary group; the mean score was generally very low. During the course of interview, it was discovered tertiary support was lacking for the elderly. The respondents expressed that many programms and benefits were available for children, women and youth but the government is not taking effort to enhance the quality of living of senior citizens. It was also expressed that from this study, it was hoped that elderly needs, problems and issues be heard by the authority to take immediate measures to improve the quality of living of the elderly.

CHAPTER 5

SUMMARY & CONCLUSIONS

5. Summary and Conclusion

This study aims to understand the Quality of Life of the rural and urban elderly in Mizoram. The study had 300 respondents drawn through systematic Random Sampling using a multi-stage sampling procedure. Aizawl district was chosen purposively since it has the highest concentration of population in the state. In the next stage, the tlangnuam rural development block was chosen based on select development indicators. In the next stage, two blocks (Phullen and Thingsulthliah) were identified. These blocks were chosen based on the number of household, population (male, female), number of electrified houses, LPG connection, telephone connection, water connection, etc Under **Tlangnuam Block (urban)** Aizawl city area have a total of 93 localities where the number of household ranges from 70 to 3000 numbers. Under the **Phullen (Tlangnuam Rural) Block** there are twelve villages. The number of households **ranges from 70 to 350 households**. Under the **Thingsulthliah (Tlangnuam Rural) Block** there are 24 villages. The number of household in these villages **ranges from 40 to a 1000 numbers**. All the elderly who resided within the identified areas comprised the universe. Using systematic random sampling, the final sample consisting of 150 urban and 150 rural elderly was arrived at. The study had as its objectives the following:

4. To prepare a profile of the elderly population in Mizoram.
5. To focus on the Quality of Life of the elderly in Mizoram.
6. To study the social support systems in Mizoram.

5.1 Profile of the Elderly in Mizoram

In keeping with the objectives of the study, a profile of the elderly in Mizoram was prepared. An attempt to understand the elderly in terms of distribution of elderly into age group categories, gender distribution, marital status of elderly, educational status, details

on earner / dependency, occupation, ownership of land, access to main road, ownership of house, facilities and amenities, living conditions and perceived life satisfaction was made.

5.1.1 Two Hundred and Ninety Nine (299) of the respondents in this study were Mizos belonging to different clans with only one non-Mizo (Nepali) respondent.

Majority of the respondents from this study belongs to the *Young Old (60 to 70 years)* age group. The urban elderly were found in a larger number than the rural elderly in this category. More than a quarter of the respondents belonged to the *Old Old (71 to 80 Years)* and an insignificant minority of the respondents belonged to the *Very Old (81 years and above)* age group.

The maximum number of the respondents from the rural area were female while the male respondents was less. However, the urban male respondents were more than the urban female respondents. Majority of the respondents in this study from both the areas were found to be married. The respondents in this study also comprised of divorcees, widows and widowers, and an insignificant minority of remarried elderly also constituted the sample.

The data revealed that illiterate elderly was more among the urban elderly than among the rural elderly. Less than a tenth elderly from the rural and urban area were found to be able to read and write. It was found that many of the elderly from both the areas received formal education (Primary, Middle, High Schools and College level). However, only one respondent from the rural area have a post graduation.

In this study, it was found that maximum of the respondents were dependent on their family with regard to income where the rural elderly constituted a larger number than the urban elderly. With regard to elderly earner status, there were more earner elderly among the respondents from urban area.

Majority of the respondents from both the areas were found to be engaged in the service profession. Other professions of the elderly includes land owner, Artisan, livestock, labourer, business, private employment etc. it was also found that the rural elderly had longer hours of work than the urban elderly.

The data revealed that the elderly from both the areas owned land. The urban elderly were found to own land to one to two plots whereas the rural elderly had land more than three plots as well.

In this study, it was discovered that none of the respondents from the rural area belonged to Below Poverty Line category, whereas, above a quarter of the elderly from the rural area belonged to this category.

To understand the elderly mobility system in their community, society the level of difficulty to access the main road was enquired. This is also because of the fact that Mizoram being a hilly place which may have an implicit on the quality of life of the elderly. The data revealed that difficulty to access the main road was more among the urban elderly respondents, whereas, more than a fifth of the respondents from the rural elderly found it to be very easy.

Maximum of the respondents from both the areas was found to be living in a house owned by them. In the rural area more than one-sixth were found to live in a house rented by them and in the urban area just above a quarter of the respondents were living in a rented home.

The data revealed that less than a half of the rural elderly were living in a *pucca* type of house, more than half in a *Semi-Pucca* and an insignificant minority in a *Kuchha* type of house. More than one-third of the urban elderly were found to live in a *Pucca* and *Semi-Pucca* type of house. More than a fifth live in a *Kuchha* type of house.

Majority of the respondents from both the urban and rural area were found to be living with spouse, son and his family. One-sixth of the respondents were living with son and his family. This is common among the widow/ widower elderly. Less than a tenth of the respondents were found to live with spouse, daughter and her family and an insignificant minority of the respondents live with spouse and other relatives. This was found among elderly who remarry.

This study covered the facilities and amenities available to the elderly. It was found that overwhelming majority of the respondents from urban and rural area has a separate bathroom and separate toilet. Majority of the respondents have water connection, telephone connection, television and LGP connection.

5.2 Quality of Life of the Elderly

In this study, the quality of life of the elderly was measured in terms of personal hygiene, physical health, diet, mental health, habit, recreation and leisure time pursuits, life satisfaction. All of these variables have direct and indirect implications on the quality of life status of the elderly.

The data revealed that cleaning of hair, taking bath, washing clothes, hair cutting, was undertaken at a more frequent interval among the elderly in the rural areas. However, the urban elderly were found more active in combing hair and shaving than the rural elderly.

With regard to physical health, the rural elderly were found to complain of their vision, hearing, falling asleep at night and waking up in the morning, aches and pain in joints than the respondents from the urban area. The data also revealed that the elderly in this study have no major problem with their liver and bowel habits. However, the respondents from the urban area were found to have more problems with their sugar level than the urban elderly. It was also found that frequency for medical check up was more among the rural elderly than the elderly in the urban areas. The satisfaction level for both the elderly

from urban and rural areas was very low with regard to the treatment received from medical care.

The diet pattern of the elderly was covered in this study. It was found that vegetables (leafy etc) were consumed at a frequent rate by both the elderly from the urban and rural areas. Dal, Eggs, Meat, Milk, Fruits was consumed more by the urban elderly than the elderly from the rural areas. This may also be due to the unavailability of the food products in their villages. The urban elderly were found to be more satisfied with the food they consumed.

This study attempts to find out the mental health status of the elderly. It was found that with regard with anxiety the urban elderly were found to be more relaxed than the rural elderly. However, the rural elderly were found to have more friends than the urban elderly. The rural elderly were found to be more irritable than the urban elderly. The rural elderly were found to have more difficulty in staying alone in the house whereas the urban elderly found it to be manageable. Most of the respondents have dropped many of their earlier activities due to their age. Feelings of emptiness and boredom were more common among the urban elderly respondents than the rural elderly respondents. Problems during interviews revealed that the rural elderly have more of financial problems. It was also found due to the financial faced by the elderly problems in terms of availing medical assistance and adequate time for lack was lacking.

The data revealed that only a few of the elderly use tobacco (smoke and smokeless). The frequency of use and quantity was also not much. The respondents have dropped the habit due to the development of physical health complaints.

The recreation and leisure time pursuits of the respondents included watching television, tuning to the radio, reading the newspaper, visiting friends/relatives or vice versa, church activities, involvement in CBO's, family get together, going to the bazaar, spending time

with grandchildren. The data revealed that the rural elderly watched television more frequently than the urban elderly. It was also found that tuning to the radio, reading newspaper, visiting friends/relatives, church activities, CBO's activities, and family get together, spending time with grandchildren was more among the rural elderly than the respondents from the urban areas.

The data revealed that the elderly from this study were mostly satisfied with their food habits, clothing, accommodation, quality of drinking water, health status, family life, the way they raised their children etc. However, it was found that financial problem was present among the elderly which in turn affects the quality of time for rest and medical assistance.

5.3 Social Support

The third objective of this study is to understand the social support of the elderly. Social support was studied in relation to primary (instrumental and emotional), secondary (instrumental and emotional), and tertiary (instrumental and emotional), social support respectively. Primary social support includes immediate family members while secondary social support includes friends, relatives, neighbours and peers. Tertiary social support includes governmental and non-governmental institutional support. Instrumental support was used in this study to refer to all support that is of a practical nature involving accompanying the elderly to health care, to visit relatives, buying or purchasing things for them and attending to such needs. Emotional support on the other hand refers to all psychological support and care offered to the elderly to meet their challenges. All such support was rated in terms of 'availability' and 'adequacy'.

The data revealed that with reference to primary social support, daughters were most likely to be available as instrumental support while daughters-in-law were considered least available for all such practical support in the urban area. However, in the rural areas

while daughters were considered most available for all practical help, the elderly rated their own bothers as least available. Sisters however were considered to offer adequate support for all challenges that required instrumental support. Adequacy of support was found to be highest in favour of daughters as compared to daughters-in-law who ranked least even in the rural areas.

Since this study also sought information on psychological challenges faced by the elderly, it was considered important to explore availability and adequacy of emotional support. The data revealed that the most emotionally available primary social support system was found to be 'daughters' and least emotionally available in the primary social support system was found to be 'daughters-in-law' in the urban elderly. In the rural area the most emotionally available primary social support system was found to be sisters and the least was daughter-in-law. The most adequate emotional primary social support system was offered by daughters in the urban area, while sisters provided the least. The same was found in the rural areas as well. This is so because of the fact that sisters get married and leave their homes. Although they are much preferred as explained by the elderly as social support, this study reveals that they are not able to offer the support expected of them.

As far as secondary social support is concerned, friends and peers were considered to be most helpful for all instrumental issues while nephews were considered to be the least in the urban area. On the other hand, in the rural areas since most people earn their through agriculture based occupations, neighbours were considered as being least available while friends and peers were rated high. On adequacy of social support however, cousins were ranked high as were neighbours in the rural areas. Cousins-in-law were considered as not offering adequate social support in the urban areas.

The most available tertiary social support system was found to be the Young Mizo Association in the urban area whereas in the rural area it was the Village Council. The least available was Social Welfare Department for the elderly from both rural and urban areas. The most adequate was found to be the YMA in both the areas particularly in reference to arrangement of burial and in times of need. The least was the Social Welfare Department in both the areas. The data revealed that all of these tertiary social support systems of the elderly is far from adequate.

The data revealed that all of the tertiary social support of the elderly namely, the YMA, Village Council, Church, Hospital/Dispensaries, Primary Health Centres, MHIP, Social Welfare Department are all not available to the elderly emotionally.

5.4 Social Work Implications

The study is an attempt to document the profile, quality of life, and social support dynamics of the elderly. In accordance with the findings of this study, social work implications are suggested as follows:

1. Research on Gender dimensions of the elderly, the very old and on the network and support system are inadequate and require further exploration.
2. Advocacy on issues of "elder abuse" and on "inclusiveness in political and social spheres"
3. Geriatric Clinics- Since physical health and medical problems constitute an important aspects of the quality of life of the elderly and further since there are no geriatric clinics in the entire state, suggestions from this study indicate the need for both the government and the NGO Sector to host geriatric clinics.
4. Strengthening of social support networks for the elderly particularly in the tertiary sector is a direct implication derived from this study
5. Opportunities for employment and livelihood of older persons
6. Development of Recreational Centres- Most of the respondents spoke about the lack of access to recreational opportunities despite having a lot of time on their hands. This suggestion has implications for the government, NGO and

communities to be involved in the creation and development of opportunities for learning.

7. Opportunities for life long Learning- The study reveals that most of the elderly are not educated beyond minimum and may just have the ability to read and write. Today, the opportunities for life long learning would capitalize on developing new abilities in older populations as well as maintaining abilities and talents already possessed by them.
8. Policy Implications- The elderly is a fast growing population with higher quality of life and therefore decision making processes at the society level needs to be more inclusive.

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APPENDIX I

Quality Of Life of the Elderly in Mizoram

This schedule prepared is in partial fulfillment of doctorial thesis of Miss Lalmuanpuii, Research Scholar of Department of Social Work, Mizoram University. It is a tool to examine the Quality of Life of the Elderly (Mizoram context). I humbly request your kind and sincere participation in answering these questions so that accurate data can be collected with your answers. Thank you for taking time, your contribution is deeply valued; this study is not valid without you.

1. Socio Demographic Particulars

i) Name of the Respondent:
ii) Gender: Male / Female
iii) Age:
iv) Religion:
v) Clan:
vi) Locality : Urban / Rural
vii) Block : Aizawl / Phullen / Thingsulthliah

v) Marital Status: Unmarried/ Married/ Divorced/Widowed/ Remarried/Separated

vi) Education: Illiterate/Can read only/Can read and write/Primary/Middle/High school/College/ University

vii) Occupation: Professional/Business/Laborer/ Land owner/Service/Artisans/Live Stock Rearing/Private Employment/Others

viii) Income Status: Earner /Dependant/Pensioner

ix) Average Family Monthly Income:

x) Which of the following do you own?Land/Plot/Farm/others (specify)

xi) Ownership of House: Owned/Rented

xii) Type of House: Kutcha/ Semi-Pucca/ Pucca
xiii) Number of Rooms: 0-1, 2-3, 3-4, 4& above

xiv) Facilities: Separate Bathroom/ Separate Toilet/ Water Connection/ Electricity Connection, Telephone connection/ Televison/ LPG

xv) Ease of access of house from main road: very easily/easy/difficult/very difficult
xvi) Economic Status: BPL/APL

2. Family Particulars
i) Type of Family: Joint/Nuclear/Extended
ii) Living with spouse, Son & his family/ spouse, daughter & her family/ son & his family/ daughter & her family/ spouse & other relatives
iii) Size of family you stay with: Small (1-3)/ Medium (4-6)/ Large (7&above)

3. Major challenges

i) My most severe personal problems are_____

ii) With reference to family, my problems are_____

iii) In relation to my social function my problems are _____

iv) As far as finance is concerned I face problems like_____

v) My most major problems related to health are _____

4. Quality of Life

I .Personal Hygiene

i)What is the general habit in regard to the following?

Habits	**Daily**	**More than once**	**Weekly**	**Fortnightly**	**monthly**
Taking bath					
Cleaning hair					
Combing hair					
Shaving					
Hair cutting					
Changing clothes					
Washing clothes					

II. Physical Health Aspects:

Sl. No.	**Health Aspect**	**Strongly Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
1	I have difficulty in seeing				
2	I have difficulty in hearing				
3	My memory is failing me				
4	I have difficulty in falling asleep at night and waking up in the morning				
5	I have aches and pain in my joints				
6	I have difficulty in moving around				
7	My Bowel functions are regular				

8	My Blood Pressure tends to remain normal				
9	I have difficulty in breathing				
10	My Sugar level is under control				
11	I do not have any problem with my liver				
12	My Bladder control is regular				
13	I go for regular monthly medical check up				
14	I am satisfied with the treatment I received				

i) Number of major hospitalization in the last two (2) years-

ii) Major illnesses in the last two (2) years-

III. Diet:

i) How frequently do the following constitute your diet?

Name of the Item	**Daily**	**Twice a week**	**Thrice a Week**	**Occasionally**
Vegetables				
Dal (specify)s				
Egg				
Milk				
Meat(Specify)				
Fruits				
Any other (specify)				

ii)

I am satisfied with the food I consume	Yes / No	Specify reasons

IV. Mental Health:

Sl. No.	**Condition**	**Strongly agree**	**Agree**	**Neither agree nor**	**Strongly disagree**

				disagree	
1	I feel anxious all the time				
2	I have few friends with who I can spend time				
3	People avoid me because of my age				
4	I get angry easily				
5	I dislike being on my own in the house				
6	Sometimes I tend to get upset over little things but cannot help it				
7	I have no one to talk to when I am upset or happy				
8	I have dropped many of my interests due to my age				
9	I feel my life is empty, and get bored easily				
10	I often fear that something bad is going to happen to me				
11	I feel that my memory is failing me				
12	I think that most people are better off than I am				
13	I feel that life is wonderful and I am very happy and content all the time				
14	I feel on top of the world when I am complimented				
15	I am afraid of the future				

V. Habit

i) Which of the following items do you use?

Sl. No	**Substance**	**Usage**	**Frequency**				**Qty per week**	**Amt spent per week**
		Yes/No	***Daily***	***weekly***	***Fortnightly***	***monthly***		
1	Cigarette							
2	Zozial (localmade)							
3	Chewing tobacco							
4	Alcohol/IMFL/ Local							
5	Drugs/Ganja/ Heroin/SP							

VI. Recreation & Leisure time pursuits.

i)

Sl.NO	Recreation	Yes/No	Remarks
1	I watch Television frequently		
2	I listen to the Radio frequently		
3	I read newspapers regularly		
4	I visit my friends/relatives often		
5	My friends/ relatives visit me often		
6	I am involved in church activities		
7.	I am involved in a number of social activities through CBOs		
8	We have frequent family get-togethers		
9	I go to the bazaar regularly		
10	I spend a lot of time with my children/ grand children		

ii) During your leisure time what gives you maximum satisfaction and why?

VII. Services and Social Support.

i) Are you a member of the MUP? Yes / No
ii) Do you know the members of MUP in your area? Yes / No

iii) How satisfied are you with the functioning of the following?

Sl. No	Organization	Very Satisfied	Satisfied	Dissatisfied	Very dissatisfied
1	MUP				
2	MHIP				
3	YMA				
4	NGO				
5	Church				
6	Social Welfare Department				
7	Hospital services				
8	Transportation				
9	NGO				

VIII. Perceived Life Satisfaction:

Sl.no	Item	Very Satisfied	Satisfied	Dissatisfied	Very dissatisfied
1	I am satisfied with the food my family gives me.				
2	I am satisfied with the				

	clothing I have.				
3	I am satisfied with my present accommodation				
4	I am satisfied with the quality of drinking water.				
5	I have adequate time for rest.				
6	I am satisfied with my family life.				
7	I am satisfied with my health status				
8	I am satisfied with my financial condition .				
9	I am satisfied with the assets I possess.				
10	I am satisfied in accomplishing my childhood expectations.				
11	I am satisfied with the way I raised my children.				
12	I am satisfied with the way my parents raised me.				
13	The quality time my grandchildren spend with me is satisfactory.				
14	Our family eats together everyday				
15	Our family shows a lot of respect for the elderly				
16	I feel satisfied that my children share their problems with me.				
17	I am happy with the treatment I received from my in-laws.				
18	My family takes good care of me when I am sick.				
19	My family assists me for regular medical check up.				

5. Social Support

I. Needs

i) Social support is most required for assistance in
a) day to day needs b) medical needs c) shopping
d) visiting relatives e) any others (specify)

II. Primary Social Support

Please rate the availability and adequacy of care and support from your primary Kin when you are in need.

Sl.No	Source	Type of Support															
		Instrumental								Emotional							
		Availability				Adequacy				Availability				Adequacy			
a.	Husband/Partner	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
b.	Daughter(s)	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
c.	Son(s)	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
d.	Grandchildren	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
e.	Daughter-in-law	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
f.	Son-in-law	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
g.	Brothers	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
h.	Sisters	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1

Availability: (4) Always, (3) Mostly, (2) Sometimes, (1) Never
Adequacy: (4) Fully; (3) Highly; (2) Somewhat; (1) Inadequate

III. Secondary Social Support

Please rate the availability and adequacy of care and support from your secondary Sources when you are in need.

Sl.No	Source	Type of Support															
		Instrumental								Emotional							
		Availability				Adequacy				Availability				Adequacy			
a.	Cousins	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
b.	Cousins-in-law	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
c.	Nephew(s)	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
d.	Niece(s)	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
e.	Friends	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
f.	Neighbors	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
g.	Others *(Specify)	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1

IV. Tertiary Social Support

Kindly rate the organizations in terms of their availability and adequacy of support

Sl.No	Source	Type of Support															
		Instrumental								Emotional							
		Availability				Adequacy				Availability				Adequacy			
a.	MUP	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
b.	YMA	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
c.	Village Council	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
d.	Church	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
e.	Hospital/dispensaries	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
f.	Primary/Sub Health Centre	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
g.	MHIP	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
h.	Social Welfare Dept.	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
i.	Others(Specify)	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
j.	Others(Specify)	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1

APPENDIX II

Quality Of Life of the Elderly in Mizoram

Heng Zawhna (Schedule) te hi Nl.Lalmuanpuii, Research Scholar, Department of Social Work, Mizoram University in doctorate degree a hmuh theih nan a buatsaih a ni. Upa te nun leh an dinhmun zir chian nan a buatsaih a ni. Heng zawhna te hi khawngaih a min lo chhan sak turin ka ngen ngawih ngawih che a ni. He zirna hi I channa pawimawh tak tel lo chuan a hlawh tling thei lo a ni. I hun hlu tak I seng avangin ka lawm tak zet a ni.

1. Socio Demographic Particulars

i) **Chhangtu Hming**:

ii) **Kum**:

iii) **Sakhua**:

iv) **Hnam:**

v) **Din hmun**: nupui, pasal la nei lo/ nupui pasal nei/ inthen/Midang neih san/ nupui, pasal nei leh /awn hrang

vi) **Zirna lam**: Ziak leh chhiar thiam lo/chhiar thei/ Ziak leh chhiar thiam/ Primary/Middle/High school/College/ University

vii) **Eizawnna**: Professional/Business/Laborer/ /Service/Ram man la/Mahni thil siam a eizawng/Ran vulh/mahni eizawnna nei/a dangte (sawifiah la)

viii) **Eizawn dan**: eizawngtu ber/engmah thawk lo/Pension la

ix) **Thla khat chhung a hhungkhua sum hai luh zat:** Rs._____

x) **Heng ah te hian engnge I neih?** Ram Lian//Ram lian vak lo/ Huan? (sawifiah la)

xi) **Chenna In leh lo chhungchang**: Mahni ta/ Mi in luah hawh

xii) **Chenna in**: Kutcha/ Semi-Pucca/ Pucca

xiii) **Room awm zat**: 0-1/ 2-3/ 3-4/ 4 leh aia tam

xiv) **In leh lo awm dan**: Inbualna awm hrang/ Inthiarna hrang/ Tui Connection/ Electric Connection, Telephone connection/ Televison/ LPG

xv) **Kawngpui atanga in awmna**: kal awlsam lutuk/ kal vel awlsam/ buaithlak/ buaithlak lutuk

xvi) **Chhungkua Dinhmun**: BPL/APL

2. Chhungkua Chhungchang

i) Chhungkua Dinhmun: Nupui fanau ten en chheng ho/ Kawpui leh fa hrin ten en/ Heng bakah chhung khat te nen

ii) : Chhungkua Kawsak Dan Dinhmun:

Sl. No	In chhung khat dan	Kum	Zirna lam	Eizawnna	Hriselna dinhmun	Sawi tur dangte

iii) In Chhungkua khawsa awm zat: thahnem vak lo (1-3)/ pangai (4-6)/ thahnem (7&above)

3. Mimal Harsatna lam

i) Keima nuna ka harsatna ber chu_____

ii) Khhungte nen kan kawsak ho a ka ka harsatna ber chu _____

iii) Khawtlang a ka harsatna tawn ber chu _____

iv) Sum leh pai dinhmun a ka harstana chu _____

v) Ka taksa hrisel na lam ka ka harsatna ber chu _____

4. Quality of Life

I .Mi mal in Vawn kawngah

i) A hnuai a tarlan ah te hian I nun dan ene?

Habits	**Daily**	**More than once**	**Weekly**	**Fortnightly**	**monthly**
Inbual fai					
Lu suk					
Sam khuih					
In meh fai					
Sam tan					

Silhfen in thlak					
Silhfen insuk					

II. Taksa Hriselna Lam:

Sl. No.	**Hriselna Lam**	**Dik lutuk**	**Hre chuang lo**	**Dik lo**	**Dik lo lutuk**
1	Ka khaw hmuh a fiah meuh tawh lo				
2	Ka beng hriatna a chak tawh lo				
3	Ka hriat rengna tun hma aiin tha tawh lo hle				
4	Muthilh mai ka harsat, zing thawh nen				
5	Ka taksa a na them thum thin				
6	Han vei vah mai mai pawh ka thei ta meuh lo				
7	Ka zun leh ek hun ka la vang tha lutuk				
8	Ka BP a la tha hle				
9	Thawk lamah harsatna ka nei				
10	Thisen/ zun thlum ka la nei lo				
11	Ka thin ka sawisel lo				
12	Ka zun kawng a tha				
13	Thla tin ka in check up thin				
14	Min enkawl tu te lakah ka lawm				

i) Kum 2 chhung a Hopsital in admit zat: _____
ii) Kum 2 chhung a in sawiselna lian deuh te:_____

III. Ei leh In Lam

i) A hnuai mi te hi engtia zing in nge I ei in?

Hming	**Nitin**	**Kar khat ah vawi 2**	**Kar khat ah vawi 3**	**A chang changin**
Thlai hring				
Dal (eng ang chi)				
Artui				
Bawnghnute				
Sa (eng sa nge sawifiah la)				
Thei				
A dangte (saifiah la)				

ii)

Ka ei leh in ah ka lungawi tawk khop mai	dik / diklo	A chhan (sawifiah la)

IV. Rilru Lam:

Sl. No.	**Rilru ngaihtuahna**	**Dik lutuk**	**Dik**	**Hre chuang lo**	**Dik lo lutuk**
1	Engtik lai pawh hian ka rilru hah deuh reng				
2	Hun awl hmanpui tur thian te ka nei thanhnem lo hle				
3	Kum upat tak ah hian mi ten min kawm chak lo				
4	Ka thinrim hma				
5	Mahni in a awm nuam lo ka ti				
6	Ka lungawi lo hma hle mahse insum har ka ti				
7	Ka hlim emaw lungawih in emaw sawipui tur ka nei lo				
8	Kum upat tak ah chuan duh zawng tih harsa ta hle mai				
9	Ka nun hi ruak riau in ka hria a ka ning zung zung				
10	Thil engamaw tha lo ka chung ah thlen dawn tlat in ka hre thin				
11	Ka hriat rengna tha lo tawlh tawlh in ka hria				
12	Mi dang hi kei aiin an hlawhtlin in ka hria				
13	Ka hlim thei reng a ka lawm em em a ni				
14	Mi ten min han fak der hian ka lawm tak zet a ni				
15	Hun lo thleng tur ka ngaihtuah hian hlauhna ka nei thin				

V. Habit

i) A hnaui a mi te I hman dan?

Sl. No	**Substance**	**Hman**	**Hman Dan**				**Kar khat hman tam zawng**	**Kar tin som sen zat**
		Dik/ Diklo	***Nitin***	***Kartin***	***Kar khat ah vawi 4***	***Thlatin***		
1	Cigarette							
2	Zozial (localmade)							
3	Sahdah/khaini/ etc							
4	Zu/Sap Zu/ Local							
5	Drugs/Ganja/ Heroin/SP							

VI. Hun awl hman dan leh intihhlim da lam.

i)

Sl.NO	**Intihhlimna**	**Dik/Diklo**	**Chhan/ saibelh duh**
1	T.V. ka en zing		
2	Radio ka ngaithla nasa		
3	Newspapers ka chhiar nasa		
4	Thiante leh chhungte ka tlawh zing		
5	Thiante leh chhungten min lo tlawh zing		
6	Kan Kohhran ah ka in hmang		
7.	Kan khawtlang ah ka in hmang		
8	Chhungkhat in hmuhkhawn kan nei zing		
9	Bazar ah te ka leng thin		
10	Ka tu leh fate nen hun hlimawm kan hmang zing		

iii) Hun awl I hman dan ah eng in nge ti hlim ber che? Engnge a chhan?

VII. Khawtlanng Nun Lam

i) MUP Menber I ni em? Ni / Nilo

ii) In veng MUP member te I hmelhriat em? Hria/Hrelo

iii) A hnuai a mi hnathawhna hi enge I ngaihdan?

Sl. No	**Organization**	**Lungawi lutuk**	**Lungawi**	**Lungawi lo**	**Lungawi lo lutuk**
1	MUP				
2	MHIP				
3	YMA				
4	NGO				
5	Church				
6	Social Welfare Department				
7	Hospital				
8	Transport				
9	NGO				

VIII. Mimal nun a lungawina Lam:

Sl.no	**Item**	**Lungawi lutuk**	**Lungawi**	**Lungawi Lo**	**Lungawi lo lutuk**
1	Ei leh in ka chhungte lakah ka lungawi tawk.				
2	Ka silh leh fen neih ah ka llungawi.				
3	Kan in chhungkhur hi lungawi thlah ka ti.				
4	Tui in tur kan neih hi tha ka ti tawk.				
5	Hahchawlna hun ka nei tha hi ka lungawi.				
6	Ka chhungte nen kan chen ho dan ah ka lungawi.				
7	Ka hriselna hi lungawi thlak ka ti.				
8	Ka sum leh pai dinhmun hi ka lungawi				
9	Ka ro neih ah ka lungawi				
10	Ka naupang lai atanga ka beisei ang ka tih hlawhtlin				

	dan ah ka lungawi				
11	Ka fate ka enkawl dan lungawi thlak ka ti.				
12	Ka nu leh pa ten min enkawl dank ha ka lungawi				
13	Ka tu ten an hun min hmanpui dan a ah ka lungawi.				
14	Chhungkua in nitin chawhlui kan kil ho				
15	Kan chhungkhua in aia up ate an zah thiam				
16	Ka faten an harsatna min sawipui dan ah ka lungawi				
17	Ka fate nupui pasal in min enkawl dan ka lungawi				
18	Ka damloh a min enkawl dan ah ka lungawi				
19	Ka chhungten in entirna ah min hruai thin				

5. Social Support
I. Mamawh Lam

i) **Tanpui ka ngaihna ber chu**: a) nitin mamawh ah b) damloh na ah c) bazaar na ah d) Chhungte tlawh na ah e) a dangte (sawifiahna)

II. Chhungte a Puitu in a puih dan

I mamawh lai taka tanpui tu che a zirin a hnuai a mi te hi khawngaih in chhanng rawh.
Chhungte mamawh lai a tanpuitu.

Sl.No	Puitu	Puih Dan Zawng															
		Hmuh Theih								Rilru Lam							
		Remchhan dan				That Tawkna				Remchhan Dan				That Tawkna			
i.	Nupui/pasal	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**
j.	Fanu (te)	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**
k.	Fapa (te)	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**
l.	Tute	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**
m.	Fapa nupui (te)	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**
n.	Fanu pasal (te)	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**
o.	Unaupa	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**
p.	Unaunu	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**	**4**	**3**	**2**	**1**

Remchhan Dan tlangpui:(4) engtiklai pawhin (3)a tlangpuiin,(2) a changin, (1) awmlo
That tawkna: (4) tha; (3)tha ve tho; (2) tha vak lo; (1)tawk lo hle

III. Chhungkhat laina Puitu
I mamawh lai taka tanpui tu che a zirin a hnuai a mi te hi khawngaih in chhanng rawh.
Chhungte mamawh lai a tanpuitu.

Sl.No	Puitu	Puih Dan Zawng															
		Hmuh Theih								Rilru Lam							
		Remchhan dan				That Tawkna				Remchhan Dan				That Tawkna			
h.	Cousins	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
i.	Cousins te nupui pasal	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
j.	Unau te fapa	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
k.	Unau te fanu	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
l.	Thainte	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
m.	Thenawm te	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
n.	Dangte *(Sawifiah)	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1

IV. Tertiary Social Support

I mamawh lai taka tanpui tu che a zirin a hnuai a mi te hi khawngaih in chhanng rawh.

Chhungte mamawh lai a tanpuitu

Sl.No	Puitu	Puih Dan Zawng															
		Hmuh Theih								Rilru Lam							
		Remchhan dan				That Tawkna				Remchhan Dan				That Tawkna			
k.	MUP	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
l.	YMA	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
m.	Village Council	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
n.	Kohhran	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
o.	Hospital/dispensaries	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
p.	Primary/Sub Health Centre	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
q.	MHIP	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
r.	Social Welfare Dept.	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
s.	A dangte (sawifiah la)	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
t.	A dangte (sawifiah la)	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1

APPENDIX III

NATIONAL POLICY ON OLDER PERSONS

(Formulated by the Govt. Of India, Social Justice and Empowerment Ministry and adopted by the Union Cabinet on 13th February 1999)

I THE BACKGROUND

DEMOGRAPHIC TRENDS

1. **Demographic Ageing** : A global phenomenon has hit Indian shores as well. People are living longer. Expectation of life at birth for males has shown a steady rise from 42 years in 1951 – 60 to 58 years in 1986-90, it is projected to be 67 years in 2011-16, an increase of about 9 years in a twenty five year period (1986-90) to 2011-16), in the case of females, the increase in expectation of life has been higher, about 11 years, during the same period, from 58 years in 1986-90 to 69 years in 2011-16, At age 60 too, the expectation of life shows a steady rise and is a little higher for women. In 1989-93 it was 15 years for males 16 years for females.
2. Increased life expectancy has contributed to an increase in the number of persons 60+. From only 12 million persons 60+ in India in 1901, the number crossed 24 million in 1951 and 57 million in 1991. Population projections for 1996-2016 made by the Technical group on population projections (1996) indicate that the 100 million mark is expected to be reached in 2013. Projections beyond 2016 made by the United Nations (1996) Revision), has indicated that India will have 198 million persons 60+ in 2020 and 326 million in 2050. The percentage of persons 60+ in the total population has seen a steady rise from 5.1 percent in 1901 to 6.8 percent in 1991. It is expected to reach 8.9 percent in 2016. Projections beyond 2016 made by United Nations (1996 Revision) has indicated that 2.1 percent of the India Population will be 60+ by 2050.
3. Growth rate on a larger demographic base implies a much larger increase in numbers. The will be the case in the coming years. The decade 2001-11 is expected to witness an increase of 25 million persons 60+, which is equivalent to the total population of persons 60+ in 1961. The twenty five year period from 1991 to 2016 will witness an increase of 55.4 million persons 60+, which is nearly the same as the population of persons 60+ in 1991. In other words, in the twenty five year period starting from 1991, the population 60+ will nearly double itself.
4. Sixty three percent of the old population in 1991 (36 million) is in the age group 60-69years. Often referred to as young old or not so old, while 11 percent (6 million) is in the age group 80 years and over i.e in the older old or very old category. In 2016, the percentage in those age groups will be almost the same, but the numbers are expected to be 69 million and 11 million respectively. In other words, close to six-tenths of the population 60-69 years can be expected to be in reasonably good physical and mental health, free of serious disability and capable of leading an active life. About one-third of the population 70-79 can also be expected to be fit for a reasonably active life. This is indicative of the huge reserve of human resource.
5. Men outnumber women in India even after age 60 (29 million males and 27 million females 60+ in 1991). This will continue to be the situation in 2016, when there will be an estimated 57 million males and 56 million females 60+.
6. Incidence of widowhood is much higher among females 60+ than among males of the same age group, because it is customary to get married to men older than them ny several years, also they do not remarry and live longer. There were in 1991, 14.8

million widowed females 60+ compared to 4.5 million widowed males. In other words, there were four times as many widow females as widowed males.

2. IMPLICATIONS

7. The demographic ageing of population has implications at the macro and also at household level. The sheer magnitude of numbers is indicative, both of the huge human reserve and also of the scale of endeavours necessary to provide social services and other benefits.
8. Demographic transition has been accompanied by changes in society and economy. These are of a positive nature in some areas and a cause of concern on others.
9. A growing number of persons 60+ in the coming decades will belong to the middle and upper income groups, be economically better of with some degree of financial security, have higher professional and educational qualifications, lead an active life in their 60s and even first half of 70s and have a positive frame of mind, looking for opportunities for a more active, creative and studying life.
10. Some areas of concern in the situation of older persons will also emerge, signs of which are already evident, resulting in pressures and fissures in living arrangements of older persons. It is true that family ties in India are very strong and an over whelming majority live with their sons or are suopported by them. Also, working examples find the presence of old persons, emotionally bonding and of great help in managing the household and caring for children. However, due to the operation of several factors, the position of a large number of older persons has become vulnerable due to which they cannot be taken for granted that their children will be able to look after them when they need care in old age, specially in view of the longer life span implying an extended period of dependency and higher costs to meet health and other needs.
11. Industrialization, urbanization, education and exposure to life style in developed countries bring in changes in values and life styles. Much higher costs of bringing up and educating children and pressures for gratification of their desires affects transfer of shares of income for the care of parents. Due to shortage of space in dwellings in urban areas and high rents, migrants prefer to leave their parents in their native place. Changing roles and expectations of women, their concepts of privacy and space, desire not to be encumbered by caring responsibilities of old people for long periods, career ambitions, and employment outside the home implies considerably reduced time for care-giving. Also, adoption of small family norms by a growing number of families, daughters, too are fully occupied. Pursuing their educational career. The position of single persons, particularly females, is more vulnerable in old age as few persons are willing to take care for non-lineal relatives. So also is the situation of widows have no independent source or income, do not own assets and are totally dependent.

3. THE MANDATE

12. Well-being of older persons has been mandated in the Constitution of India. Article 41, Directive Principle of State Policy, has directed that the State shall, within the limits of its economic capacity and development, make effective provision for securities, the right to public assistance in case of old age. There are other provisions too, which direct the state to improve the quality of life of its citizens. Right to equality has been guaranteed by the Constitution as a Fundamental right. There provisions apply equally to older persons. Social security has been made the concurrent responsibility of the central and state Governments.

13. The last two decades have witnessed considerable discussions and debate on the impact of demographic transition and of changes in society and economy on the situation of older persons. The United Nations principle for Older persons adopted by the United Nations General Assembly in 1991, the Proclamations on Ageing and the Global targets as Ageing for the year 2001 adopted by the General Assembly in 1992, and various other Resolutions adopted from time to time, are intended to encourage governments to design their policies and program in this regard.
14. There has for several years been a demand for a policy statement by the state towards its senior citizens so that they do not face an identity crisis and know where they stand in the overall national perspective. The need has been expressed at different forums where ageing issues has been deliberated. The statement, by indicating the principles underlying the policy, the directions, the needs that will be addressed and the relative roles of the government and non-government institutions, is expected to facilitate carving out of respective areas of operations, and action in the direction of a humane, age-integrated society.

II NATIONAL POLICY STATEMENT

15. The National policy, seeks to assure older persons that their concerns are national concerns and hey will not live unprotected, ignored or marginalized. The goal of the National Policy is the well - being of older persons. It aims to strengthen their legitimate place in society and help older persons to live their last phase of their life with purpose, dignity and peace.
16. The Policy visualizes that the state will extend support for financial security, healthcare, shelter, welfare and other needs of older persons, provide protection against abuse and exploitation, make available opportunities for the development of the potential and provide services so that they can improve the quality of their lives. The policy is based on some broad principles.
17. The Policy recognizes the need for affirmative action in favour of the elders. It has to be ensured that the rights of older persons are not violated and they get opportunities and equitable share in development program and administrative actions will reflect sensitivity towards older persons living in rural areas. Special attention will be necessary to older females so that they do not become victims of triple neglect and discrimination on account of gender, widowhood and age.
18. The Policy views the life cycle as a continuous one of which past-60 phase of life is an integral part. It does not view age 60 as the cut off point for beginning a life of dependency. It considers 60+ as a phase when the individual should have the chances and opportunities to lead an active, creative, productive and satisfying life. An important thrust is, therefore, an active and productive involvement of older persons and not just their care.
19. The Policy values of an age-integrated society. It will endeavour to strengthen integration between generations, facilities two-way flows and interactions and strengthen the bonds between the young and the old. It believes in the development of social support system, informal as well as formal, so that the capacity of families to take care of older persons is strengthened and they can continue to live in their family.
20. The Policy recognizes that older persons too are a resource. They render useful service in the family and outside. They are not just consumers of goods and services, but also their producers. Opportunities and facilities need to be provided so that they can continue to contribute more effectively to the family, community and the society.

21. The policy firmly believes in the empowerment of older persons so that they can acquire better control over their lives and participate in decision-making on matters which affect them as well as the other issues as equal partners in the development process. The decision-making process will seek to involve them to a much larger extent, specially since they constitute 12 percent of the electorate, a proportion which will rise in the coming years.
22. The Policy recognizes that larger budgetary allocations from the state will be needed and the rural and urban poor will be given special attention. However, it is neither feasible nor desirable for the state alone to attain the objectives of the National Policy. Individuals, families, communities and institutions of civil society have to join hands as partners.
23. The Policy emphasizes the need for expansion of social and community services for older persons, particularly women, and enhance their accessibility and use by removing sociocultural, economic and physical barriers and making the services client-oriented and user-friendly. Special efforts will be made to ensure that the rural areas, where more than three-fourths of the older population lives, are adequately covered.

III PRINCIPAL AREAS OF INTERVENTION AND ACTION STRATEGIES

4. FINANCIAL SECURITY

24. A great anxiety in old age relates to financial insecurity. When the issue seen in the context of the fact that one-third of the population (1993-94) is below the poverty line and about one-third above it but belong to the lower income group, the financial situation of two-thirds of the population 60+ can be said to be fragile. Some level of income security in old age is goal which will be given very high priority. Policy instruments to cover different income segments will be developed.
25. For elderly persons below the poverty line, old age pensions provide some succor. Coverage under the old age pensions scheme for poor persons will be significantly expanded from the January, 1997 level of 2.76 million with the ultimate objective of covering all older persons below the poverty line. Simultaneously it will be necessary to prevent delays and check abuses in the matter of seletion and disbursement. Rate of monthly pension will need to be revised at intervals so that inflation does not deflate its real purchasing power. Simultaneously, the public distribution system will reach out to cover all persons 60+living below the poverty line.
26. Employees of government and quasi-government bodies and industrial workers desire better returns from accumulations in provident funds, through prudent and safe investment of funds. Issues involved will be given consideration. It will be ensured that settlement of pensions, provident fund, gratuity and other retirement benefits is made promptly and superannuated persons are not put to hardship due to administrative lapses. Accountability for delays will be fixed. Redressal mechanisms for superannuated persons will be ensure prompt fair and humane treatment. Widows will be given special consideration in the matter of settlement of benefits accruing to them on demise of husband.
27. Pension is a much sought after income security. The base of pension coverage needs to be considerably expanded, it would be necessary to facilitate the establishment of pension scheme both in the private and in the public sector for self-employed and salaried persons in non-government employment with provision for employees also to contribute
28. Taxation polices will reflect sensitivity to financial problems of older persons, which accelerate due to very high costs of medical and nursing care, transportation and

support services needed at home. Organization of Senior Citizens have been demanding a much higher standard deduction for then and standard deduction for them and a standard annual rebate for medical expenses treatment, whether domiciliary or hospital-based in cases where superannuated persons do not get medical coverage from their erstwhile employers. There are also demands, that some tax relief must be given to son of daughter when old parents co-reside and also allow some tax rebate of medical expenses. These and other proposal of tax relief will be considered.

29. Long term savings instruments will be promoted to reach both rural and urban areas. It will be necessary for the contributors to feel assured that the payments at the end of the stipulated period are attractive enough to take care of the likely erosion in purchasing power due to erosion. Earners will be motivated to save in their active working years for financial in old age.
30. Pre-retirement counseling programs will be promoted and assisted.
31. Employment in income-generating activities after superannuation should be the choice of the individual organizations which provide career guidance training and orientation and support services will be assisted. Programs of non-governmental organizations for generating income of old persons will be encouraged. Age-related discrimination in the matter of entitlement to credit marketing and other facilities will be removed. Structural adjustment policies may affect the older workers in some sectors more adversely. Specially those on household or small scale industry. Measures will be taken to protect their interests.
32. The right of parent without any means to be supported by their children having sufficient means has been recognized in Section 125 of the Criminal Procedure Code. The Hindu Adoption and Maintenance Act, 1956 too secures this right to parents. To simplify the procedure provide speedy relief, lay down the machinery for processing cases and define the rights and circumstances in a comprehensive manner, the Himachal Pradesh Maintenaces of Parents and Dependent bill, 1996. The Government of Maharashtra has prepared a Bill on similar lines. Other States will be encouraged to pass similar legislation so that old parents unable to maintain themselves do not face abandonment and acute neglect.

5. HEALTHCARE AND NUTRITION

33. With advancing age, old persons have to cope with health and associated problems some of which may be chronic, of a multiple nature, requires constant attention and carry the risk of disability and consequent loss of autonomy. Some health problems, specially when accompanied by impaired functional capacity require long term management of illness at home and of nursing care.
34. Health care needs of older persons will be given high priority. The goal should be affordable health services, very heavily subsidized for the poor and graded system of user charges for others. It will be necessary to have a judicious mix of public health services, health insurance, health services provided by not-for profit organizations, including trusts and charities and private medical care. While the first of these will require greater State participation, the second category will need to be promoted by the state, the third category given some assistance, concessions and relief and the fourth encouraged, preferably by an association of providers of private care.
35. Primary health care system will be the basic structure of public healthcare. It will be basic structure of public healthcare. It will be strengthened and oriented to be able to meet the health care needs of older persons as well public health services, preventive,

curative, restorative and rehabilitative, will be considerably expanded and strengthened and geriatric care facilities provided at secondary and tertiary levels. This will imply much larger public outlays, proper distribution of services in rural and urban areas and much better health administration and delivery systems.

36. The development of health insurance will be given high priority to cater to the needs of different income segments of the population and have provided for varying contributions and benefits. Package catering for the lower-income groups will be entitled to state subsidy. Various reliefs and concessions will be given to health insurance to enlarge the base of coverage and make them affordable.
37. Trusts, charitable societies and voluntary agencies will be promoted, encouraged and assisted by way of grants, tax relief and land at subsidized rates to provide free beds, medicine and treatment to the very poor elder citizens and reasonable user charges for the rest of the population.
38. Private medical care has expanded in recent years, offering the latest medical treatment facilities to those who can afford it. Where land and other facilities are provided at less than market rates, bodies representing private hospitals and nursing homes will be requested to direct their members to offer a discount to older persons. Private general practitioners will be extended opportunities for orientation in geriatric care.
39. Public hospitals will be directed to ensure that elderly patients are not subjected to long waits and visits to different counters for medical tests and treatment. They will endeavour to provide separate counters and convenient timings on specified days. Geriatric wards will be set up.
40. Medical and paramedical personnel in primary secondary and tertiary health care facilities will be given training and orientation in health care of the elderly. Facilities for specialization in geriatrics medicine will be provided in the medical colleges. Training in nursing care will include geriatric care. Problems of accessibility and sue of health services by the elderly arise due to distance and absence of escort and transportation. Difficulties in reaching a public health mobile health services, special cases and ambulance services by charitable institutions and not for profit health care organizations. Hospitals will be encouraged to have a separate Welfare Fund, which will receive donations and grants for providing free treatment and medicines to poor elderly patients.
41. For the old who are chronically ill and are deprived of family support, hospitals supported or assisted by the state public charity and voluntary organizations will be necessary. These are also needed to cater to cases of abandonment to public hospitals.
42. Assistance will be given to geriatric care societies for the production and distribution of instruction material on self care by older persons. Preparation and distribution of easy-to-follow guidance material on health and nursing care of older persons for the use of the family care givers will also be supported.
43. Older persons and their families will be given access to educational material on nutritional needs in old age. Information will be available on the foods to avoid and the right foods to eat. Diet receips suiting tastes of different regions and which are nutritious tasty, fit into the dietary pattern of the family and the community, are affordable and can be prepared from locally available vegetables, cereals and fruits will be disseminated.
44. The concept of healthy ageing will be promoted. It is necessary to educate older persons and their families that diseases are not a corollary of advancing age, nor is a particular chronological age the starting point for decline in health status. On the

contrary, preventive health care and early diagnosis can keep a person in reasonable good health and prevent disability.

45. Health education programmes will be strengthened by making use of mass media and other communication channels, which reach out to different segments of the population. The capacity to cope with illness and manage lomiciliary care will be strengthened. Programs will also be developed targeting the younger and middle age groups to inform them how life styles during early years affect health status in late years. Messages on how to stay healthy for the entire life span will be given. The importance of balanced food diets, physical exercise, regular habits, reduction of stress, regular medical check up, allocation of time for leisure and recreation and pursuit of hobbies will be conveyed. Programs on Yoga, Meditation and methods of relaxation will be developed and transmitted through different channels of communication to reach diverse audiences.
46. Mental health services will be expanded and strengthened. Families will be provided counselling facilities and information on the care of treatment of older persons having mental health problems.
47. Non-governmental organizations will be encouraged and assisted through grants, training and orientation of their personnel and various concessions and relief to provide ambulatory services, day-care and health care to complement the efforts of the state.
48. Shelter is a basic human need. The stock of housing for different income segments will be increased. Housing schemes for urban and rural lower income segments will earmark 10 percent of the houses, house-sites for allotment to older persons. This will include Indira Awas Yojana and other schemes of the Government. Earning persons will be motivated to invest in their housing in their earning days so that they have no problems of shelter when they grow old. This will require speedy urban land development for housing, time-bound provision of civic services and communication links, availability of loans at reasonable rates, easy repayment installments, time bound construction schedule and tax reliefs. Development of housing has to be a joint endeavour of public and private sectors and require participation of housing development boards, civic authorities, housing finance institutions and private developers and builders. Older persons will be given easy access to loans for purchase of housing and for major repairs, with easy repayment schedules.
49. Layouts of housing colonies will have to respond to the life styles of the elderly. It will have to be ensured that there are no physical barriers to mobility and accessibility to shopping complexes, community centres, parks and other service is safe and easy. A multipurpose centre for older persons is a necessity for special interaction and to meet other needs. It will therefore be necessary to earmark sites for such centres in all housing colonies. Segregation of older persons in housing colonies has to be avoided, as it prevents interaction with the rest of the community. Three or four storeyed houses without lifts are unfriendly to older persons, tend to isolate them, restrain their movement outside the home, and are a serious barrier to access to services. Preferences will be given to older persons in the allotment of flats on the ground floor.
50. Group housing of older persons, comprising of flatlets with common service facilities for meals, laundry, common room and rest room will be encouraged. Those would have easy access to community services, media care parks, recreation and cultural centres.

51. Education, training and orientation of town planners, architects, and housing administrators will include modules on needs of older persons for safe and comfortable living.
52. Older Persons and their families will be provided of accidents and on measures which enhance safety, taking cognisance of reduced physical capacity and infirmities.
53. Noise and other forms of pollution affect children, the sick and older persons more adversely. Norms will be laid down and strictly enforced.
54. Civic authorities and bodies providing public utilities will be required to give top priority to attending to complaints of older persons. Payment of civic dues will be facilitated. Older persons will be given special consideration in promptly dealing with maters relating to transfer of property, mutation, property tax and other matters, harassment and abuses in such cases will be checked.

6. EDUCATION

55. Education, training and information needs of older persons will be met. These have received virtually no attention in the past. Information and educational material specially relevant to the lives of older people will be developed and widely disseminated using mass media and non-formal communication channels.
56. Discrimination, if any against older persons for availing opportunities for education, training and orientation will be removed. Continuing education programs will be encouraged and supported. These would cover a wide spectrum ranging from career development to recreation use of leisure and imparting skills in community work and welfare activities. Assistance of open universities will be sought to develop packages using distance education learning techniques. Access of older persons to libraries of universities, research institutions and cultural centres will be facilitated.
57. Educational curriculum at all stages of formal education as also non-formal education will incorporate material to strengthen inter- generational bonds and mutually supporting relationships. Interactions with educational institutions will be facilitated, whereby older persons with professional, qualifications and knowledge in science, arts, environment, socio - cultural heritage, sports and other areas could interact with children and young persons. Schools will encouraged and assisted to develop out-reach programs for interacting with older persons on a regular basis, participate in the running of senior citizens centres and develop activities in them.
58. Individuals of all ages, families and communities will be provided with information about the ageing process and the changing roles, responsibilities and relationships at different stages of the life cycle. The contributions of older persons inside the household and outside will be highlighted through the media and other forum and negative images, myths and stereotypes dispelled.

7. WELFARE

59. The main thrust of welfare will be to identify the more vulnerable among older persons such as the poor, the disabled, the infirm, the chronically sick and those without family support and provide welfare services to them on a priority basis. The policy will be to consider institutional care as the last resort when personal circumstances are such that their stay in old age homes becomes absolutely necessary.
60. Non-institutional services by voluntary organisations will be promoted and assisted to strengthen the coping capacity of the older persons and their families. This has become necessary, since families become smaller and women work outside the home,

have to cope with scarcity of full-time care givers. Support services will provide some relief through sharing of the family's caring responsibilities.

61. Assistance will be provided to voluntary organisations by way of grants-in-aid for homes. Those for the poor will be heavily subsided. It is important that such institutions become lively places of stay and provide opportunities to residents to interact with the outside world. Non-governmental organisations will be encouraged to seek professional expertise in the designing of old age homes, keeping in view needs of group living at this stage of the life cycle and the class of clients they serve. Minimum standards of services in such homes will be developed and facilities provided for training and orientation of persons employed in those homes.
62. Voluntary organisations will be encouraged and assisted to organise services such as daycare, multi-service citizen's centres, reach-out services, supply of disability related aids and appliances, assistance to old persons to learn to use them, short term stay services and friendly home visits by social workers. For old couples or persons living in their own, helpline, telephone assurance services, help in maintaining contacts with friends, relatives and neighbours and escorting older persons to hospitals, shopping complexes and other places will be promoted for which assistance will be given to voluntary organisations. Older persons will be encouraged to form informal groups of their own in the neighbourhood which satisfy the needs for social interaction, recreation and other activities. For a group of neighbourhood villages, the formation of senior citizen's forum will be encouraged.
63. A welfare fund for older persons will be set up. It will obtain funding support from government, corporate sector, trusts, charities, individual donors and others contributions to the fund will be given tax relief. States will be expected to establish similar funds.
64. The need for popularity of arrangements for welfare services in recognised government, voluntary organisations and private sector agencies, all have a place, the latter catering to those who have the means and desire better standards of care.

8. PROTECTION OF LIFE AND PROPERTY

65. Old persons become soft targets for criminal elements. They also become victims of fraudulent dealings and of physical and emotional abuse within the household by family members to force them to part with their ownership rights. Widow's right of inheritance, occupancy and disposal at times, violated by their own children and relatives. It is important that protection is available to older persons. The introduction of special provisions in IPC to protect older persons from domestic violence will be considered and machinery provided to attend all such cases promptly. Tenancy legalisation will be reviewed so that the rights of occupancy of older persons are restored steadily.
66. Voluntary organisations and associations of older persons will be assisted to provide protective services and help to senior citizens through helping services, legal and other measures.
67. Police will be directed to keep a friendly vigil on older couples or old single persons living alone and promote mechanisms of interaction with neighbourhood associations. Information and advice will be made available to older persons on the importance of keeping contacts on phone with relatives, friends and neighbours and on precaution to be taken on matters such as prevention of un-authorised entry, hiring of domestic help, visits of repair and maintenance persons, vendors and others and the handling of cash and valuables.

9. OTHER AREAS OF ACTION

68. There are various other areas which would need affirmative action of the state to ensure that cards by the administration, fare concessions in all modes travel, preference in reservation of seats in local public transport, modification in the design of public transport vehicles for entry and exit, strict enforcement of traffic discipline at zebra crossings to facilitate older persons to cross streets, priority in gas and telephone connections and in fault repairs, removal of physical barriers to facilitate easy movement, concessions in entrance fee in leisure and entertainment facilities, art and cultural centres and places of tourist interest.
69. Speedy disposal of complaints of older persons relating to fraudulent dealings, cheating and other matters will go a long way in providing relief to them. Machinery for achieving this objective will be put in place.
70. Issues pertaining to older persons will be highlighted every year on the National Older Persons Day. The year 2000 will be declared as the National Year of Older Persons. Activities during the year will be planned and executed with the participation for different organisations.
71. Facilities, concessions and reliefs given to older persons by the central and state governments and other agencies will be compiled, updated at regular intervals and made available to associations of older persons for wide dissemination.

10. NON-GOVERNMENTAL ORGANISATIONS

72. The state alone cannot provide all the services needed by the older persons. Private sector agencies cater to a rather small segment of the population. The National Policy recognised the NGO sector as a very important institutional mechanism to provide user-friendly affordable services to complement the endeavours of the state in this direction.
73. Voluntary effort will be promoted and supported in a big way and efforts made to remedy the current uneven spread, both within a state and between states. There will be continuous dialogue and communication with NGO's on ageing issues and on services to be provided. Networking exchange of information and interaction among the NGOs will be facilitated. Opportunities will be provided for orientation and training of manpower. Transparency, accountability, simplification of procedures and timely release of grants to voluntary organisations will ensure better services. The grant-in-aid policy will provide incentives to encourage organisations to raise their own resources and not become dependent only on government funding and providing services on a sustainable basis.
74. Trusts, charities, religious and other endowments will be encouraged to extend their areas of concern to provide services to the elderly by involving them on ageing issues.
75. Older persons will be encouraged to recognise themselves to provide services to fellow senior citizens thereby making us of their professional knowledge, expertise and contacts. Initiative taken by them in advocacy, mobilisation of public opinion, raising of resources and community work will be supported.
76. Support will be provided for setting up volunteer programmes which will mobilise the participation of older persons and other in community affairs to interact with elders and help them with their problems. Volunteers will be provided opportunities for training and orientation on handling problems of the elderly and kept abreast of development in the field to promote active ageing. Volunteers will be encouraged to assist the home bound elderly, particularly frail and elderly women and help them to overcome loneliness.

77. Trade unions, employers' organisations and professional bodies will be approached to organise sensitivity programmes for their members on ageing issues and promote and organise services for superannuated workers.

11. REALISING THE POTENTIAL

78. The national policy recognises that 60+ phase of life is a huge untapped resource. Facilities will be made available so that the potential is realised and individuals are enabled to make the appropriate choices.
79. Older Persons, particularly women, perform useful but unsung roles in the household. Efforts will be made to make family members appreciate and respect the contribution of older persons in the running of the household specially when women too are working outside the home. Special programmes will be designed and disseminated through the media targeted at older persons so that they can enrich and update their knowledge, integrate tradition with contemporary needs and trasmit more effectively socio cultural heritage to the grand children.

12. FAMILY

80. Family is the most-cherished institution in india and the most vital non-formal social security for the old. Most older persons stay with one or more of their children, particularly when independent living is no longer feasible. It is for them the most-preferred living arrangement and also the most emotionally satisfying. It is important that the family support system continues to be functional and the ability of the family to discharge its caring responsibilities is strengthened through support services.
81. Programmes will be developed to promote family-values, sensitise the young on the necessity and desirability of intergenerational bonding and continuity and the desirability of meeting filial obligations.Values of sharing and caring need to be reinforced. Society will need to be sensitised to accept the role of married daughters in sharing in the light of the changing context where parents have only one or two children in some situations only daughter. This would require some adjustment and changes in perception of in-laws in regard to sharing of caring responsibilities by some and daughters as a rollary to equal rights to inheritance and the greater emotional attachment the daughters have with their parents.
82. State policies will encourage children to co-reside with their parents by providing tax relief, allowing rebates for medical expenses and giving preferences in the allotment of houses. Parents will be encouraged to go in for long-term savings instrument and health insurance during their earning days so that financial load on families can be eased. NGOs will be encouraged and assisted to provide services which reach out to older persons in the home or in the community short term stay in facilities for older people will be supported so that families can get some relief when they go out. Counselling services will be strengthened to relieve intra-familial stresses.

13. SEARCH

83. The importance of a good data base on ageing will require to be strengthened. Univedrsities, Medical colleges and research institutions will be assisted to set up centres of gerontology studies and geriatrics. Corporate bodies, Banks, Trusts and endowments will be requested to institute chairs in universities and medical colleges in gerontological and geriatrics. Funding support will be provided to academic bodies for research projects on ageing. Superannuated scientists will be assisted so that their professional knowledge can be utilised.

84. An interdisciplinary co - ordinating body on research will be set up. Data collecting agencies will be requested to have a separate age category 60+ years and above. Professional association of gerontologists will be assisted to strengthen research activity, disseminate research findings and provide a platform for dialogue debate and exchange of information.
85. The necessity of a national institute of research, training and documentation is recognised. Assistance will be given for setting up research centres in different parts of the country.

14. TRAINING OF MANPOWER

86. The policy recognises the importance if trained manpower. Medical colleges will be assisted to offer specialities in geriatrics training institute for nurses and for the paramedical personnel need to introduce specific courses of geriatrics in their educational and training curriculum. In-service training centres will be strengthened to take up orientation courses on geriatric care. Assistance will be provided for development of curriculum and course material. Schools of social work and university departments need to give more attention to their curriculum to issues relating to older persons intervention strategies and organisations of services for them. Facilities will be provided and assistance given for training and orientation of personal non-governmental organisations providing service to older persons. Exchange of training personnel will be facilitated.
87. Assistance will be given for development and organisation of sensitation programmes on ageing for legislative, judicial and executive wings at different levels.

15. MEDIA

88. The National Policy recognises that media have a very important role to play in highlighting the changing situations of older persons and in identifying emerging issues and areas of action. Creative use of media can promote the concept of active ageing and help dispel stereo types and negative images about this stage of the life cycle. Media can also help to strengthen inter-generation bonds and provide individuals, families and groups with information and educational material which will give better understanding of the ageing process and of ways to handle problems as they arise.
89. The policy aims to involve media as well as informal and traditional communication channels on ageing issues. It will be necessary to provide opportunities to media personnel to have access to information apart from their aim independent sources of information and reporting of field situations. Their participation in orientation programmes on ageing will be facilitated. Opportunities will be extended for greater interaction between media personnel and persons active in the field of ageing.

IV IMPLEMENTATION

90. The National policy on older persons will be very widely disseminated for which an action plan will be prepared so that its features remain inconstant public focus.
91. The policy will make a change in the lives of the senior citizens only if it is implemented. While the government and the principal organs have some basic responsibilities in the matter, other institutions as well as individuals will need to consider how they can play their respective roles for the well-being of older persons. Collaborative action will go a long way in achieving a more human society, which gives older persons their legitimate place. Apex level organisations of older persons

have special responsibilities in this regard so that they can function as a watchdog, energise continuing action, mobilise public opinion and generate pressure for implementaiton of the policy.

92. The ministry of social justice and empowerment will be the nodal ministry to coordinate all matters relating to the implementation of the policy. As separate bureau of older persons will be set up. An Inter-ministerial committee will coordinate matters relating to implementation of the national policy and monitor its progress. States will be encouraged to set up separate directorate of older persons and set up machinery for coordination and monitoring.
93. Five year and annual action plans will be prepared by each ministry top implement aspects which concern them. These will indicate steps to be taken to ensure flow of benefits to older persons from general programmes and from schemes specifically formulated for their wellbeing. Targets will be set within the framework of a time schedule. Responsibility for implementation of action points will be specified. The planning commission and the finance ministry will facilitate budgetary provisions required for implementation. The Annual report of each ministry will indicate progress achieved during the year.
94. Every three years the nodal ministry and orientation of personal non will prepare a detailed review - governmental organisations providing service to older persons. Exchange of training personnel will be facilitated.
95. Assistance will be given for development and organisation of sensitation programmes on ageing for legislative, judicial and executive wings at different levels.

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102. Every three years a detailed review will be prepared by the nodal ministry on the implementation of the National policy. There will be non-official participation in the preparation of the document. The review will be a public document. It will be discussed in a National convention state government and union territories will be urged to take similar action.

103. An autonomous national council for older persons, headed by the minister for social justice and empowerment will be set up to persons. The council will include representatives of relevant central ministries and the planning commission. Five states will be represented on the council by rotation. Adequate representation will be given to non-official members representing non-government organizations, academic bodies, Media and experts on ageing issues from different fields.

104. An autonomous registered national association of older persons (NAOPs) will be established to mobilize senior citizens, particulate their interests, promote and undertake programs and activities for their wellbeing and to advise the government on all matters relation to older persons. The association will have national, state and district level officers and will choose its own office-bearers. The government will provide financial support to establish the national and state level offices while the district level offices will be established by the association from its own resources, which may be raised through membership subscriptions, donations and other admissible means. The government will be able to provide financial assistance to the national and state level offices to cover both recurring as well as non-recurring administrative costs for a period of 15 years and thereafter the association is to be expected to be financially self-sufficient.

105. Panchayat Raj institutions will be encouraged to participate in the implementation of the national policy, address local levels issues and needs of the ageing and implement programs for them. They will provide forums for discussing concerns of older persons and activities that need to be taken. Such forums will be encouraged at Panchayat, block and district level. They will have adequate representation of older women. Panchayat will mobilize the talents and skills of older persons and draw up plans for utilizing these at the local level. Amongst others, the help of the social justice committees of the village panchayats will be taken to advocate different measures for giving effect to the policy.

106. In order to ensure effective implementation of the policy t different levels, from time to time the help of experts of public administration shall be taken to prepare the

details of the organizational setup for the implementation, coordination and monitoring of the policy.

APPENDIX IV

Bio-data of Candidate

Name : **Lalmuanpuii**

Father's Name : **Dr. Lalvawna**

Address : **T-9/B. Tuikhuahtlang, Aizawl, Mizoram**

Phone No. : **(0389) 2326031**

Email Id. : **maanisown@gmail.com**

Educational Qualification:

Sl. No.	Year	Name of Examination	Board/University	Percentage of marks
1	1997	HSLC	Mizoram	49.3%
2	1999	HSSLC	Meghalaya	57.8%
3	2002	BA	Punjab	51.75%
4	2004	MSW	Mizoram	70.50%
5	2004 (Dec)	NET	UGC	-

Field Work Experience:

Sl.No	Name of Agency/Organization	Name of Post	Duration
1	Remand Home, Social Welfare Department, Aizawl, Mizoram	Trainee	6 Months
2	Psychiatric Ward, Civil Hospital, Aizawl, Mizoram	Trainee	6 Months
3	Sihphir Vengthar, Aizawl, Mizoram	Trainee	12 Months
4	St. Paul's Cathedral, Kolkata, India	Trainee	6 Weeks
Work Experience:			
1	WHO, Tobacco Cessation Clinic, Civil Hospital, Aizawl, Mizoram	Medical Social Worker	5 years
2	Bloomberg Initiative to Reduce Tobacco Use	Project Coordinator	15 Months

	(Bloomberg Foundation) Project, Aizawl, Mizoram		

Publication:

1.Social Work Intervention with the Elderly co-written with Dr. Kalpana N. Desai, In Lianzela and Vallalchhawna (EDS), Aging in North East India - Magnitude of The Problem of Elderly Persons In Mizoram, Volume 1, PP 84 – 101, ICSSR-NERC, Akansha Publishing House, New Delhi-110 002.

Un-published Dissertation:

1. Dissertation on 'Self Perceived Life Satisfaction and Problems of the Rural Aged' submitted to the Department of Social Work, Mizoram University in partial fulfilment of the requirement for the Degree of Masters of Social Work.

(KALAPNA SARATHY)

Head
Department of Social Work
School of Social Sciences
Mizoram University

APPENDIX V

PARTICULARS OF THE CANDIDATE

NAME OF CANDIDATE		:	**Lalmuanpuii**
DEGREE		:	**Doctor of Philosophy**
DEPARTMENT		:	Social Work
TITLE OF DISSERTATION		:	"Quality of Life of The Elderly In Mizoram"
DATE OF PAYMENT OF ADMISSION		:	25th October 2005
APPROVAL OF RESEARCH PROPOSAL			
1.	BPGS	:	17th May 2006
2.	SCHOOL BOARD	:	23rd May 2006
	REGISTRATION NO. & DATE	:	MZU/Phd/115/ 23.5. 2006
	EXTENSION (if any)	:	Nil

(KALAPNA SARATHY)

Head
Department of Social Work
School of Social Sciences
Mizoram University

APPENDIX VI


DELHI
INDIA
Mizoram
To Silchar
MIZORAM
TOURIST MAP
Assam
Manipur
Tripura
Union
Of
Myanmar
Bangladesh
Chhimtuang
Sakawrdai
Bilkhawthlir
Darlawn
Kolasib
Zawlnuam
NH 54
Thingdawl
Rengdil
Bualpui
Phaileng
Saitlaw
Kawnpui
Chiahpui
Kawrthah
Phullen
Mamit
Lungdai
Ngopa
Lengpui
Serhmun
Aizawl
Seling
Kawlkulh
Dampa
Thingsulthliah
Saitual
Hnahlan
W.Phaileng
Paikhai
Reiek
Tuisen
Champhai
Aibawk
Sabual
Dilkawn
Pukzing
Thenzawl
Khawhai
Hruaikawn
Buar
Serchhip
Buangpui
Keitum
Bungzung
Laisawr
Chekkawn
Khawbung
Bunghmun
E.Lungdar
Pangzawl
Farkawn
Sirte
Hnahthial
N.Vaolaiphai
Thingsai
Tlabung
Saza
Leite
Lungsen
Lunglei
Zobawk
Hrangchalkawn
Sangau
Tawipui
Mt.Phawngpui
Thingfal
Saiha
Chawngte
Lawngtlai
Lungbun
Hmunnuam
Ainak
Serhmun
Bungtlang
Mualpui
Tuipang
Zawngling
Kaisih
Tuidangtlang
Sabualtlang
Vahai
Chhippui
Tawngkawlawng
Parva
Aizawl
Phullen
Thingsulthliah