ELDERLY WOMEN'S QUALITY OF LIFE IN A CONFLICT BORDER AREA OF INDIA

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Abstract: *Elderly persons have been considered very important member of joint families in India and their number is increasing due to declining fertility and increasing life expectancy. Despite poor health and decreasing functional capacity, elderly persons can lead good quality of life depending upon their physical, psychological and social well beings and condition of environment around them. The Quality of Life (QoL) of elderly women, particularly in border areas, has been inferior to men because of gender based discrimination stemming up from deep cultural and social bias and access to property right. Randomly selected 157 women above 60 year age were surveyed in three blocks of Punjab near India- Pakistan border line for understanding and improving their quality of life. The mean age of respondents was 68 year with mean household size 8.6 belonging to mostly farming (46%) and laborers (45%) families. The QoL scores decreased with increasing age group. The majority of elderly women were dependent on inter-generational understanding and support and this is reflective of the current Ageing Policy of India which prioritizes family as the basic institution of care and support for the elderly people. This study indicated a high degree of correlation between household socio-economic status and quality of life, but not between wealth and quality of life.. A very high proportion of these women suffered from weak eyesight, joint pain, blood pressure and headache. Quality of Life scores do not differ much for family occupations (agriculture and labour) as agricultural holdings are very small.*

Key Words: *Elderly women, Quality of life, Border area, socio-economic status, Aging Policy.*

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INTRODUCTION

Poor health and decreasing functional capacity normally affect the sense of well being of elderly people. Their goal of health in the society may not be that of freedom from diseases but the possibility of having a good life despite poor health and decreasing functional capacities (Sarvimaki and Stenback,2000). Studies on elderly persons have shown that quality of life and subjective evaluation of life satisfaction are determined by several factors (Jakobsson et al, 2007 & Patel et al, 2007). Elderly persons have been important member of joint families in India but their qualities of life have been changing due to cultural, social and environmental changes with the passage of time. With declining fertility along with the increase in life expectancy, the number of older persons is expected to increase by more than double, from 71 million in 2001 to 173 million in 2026, indicating an increase in their share to the total population from 6.9 to 12.4 per cent (Registrar General, 2006). The demographic profile depicts that during the first half of this century, between 2000-2050, the overall population in India will grow by 55 per cent whereas population of people over 60 year and above age will grow by 326 per cent and those in the age group of 80 years and above by 700 per cent (United Nations, 2002). The quality of life of elderly persons is affected by several factors such as those related to their health, psychological well being, local environment, social network and support. The challenge for India is not only to add further years to life but more importance to add life to years and to ensure high quality of life for the elderly persons.

Women and men have their own concerns and their aging process vary differently. A life time gender based discrimination worsens the quality of life of the elderly women. The discrimination is often stemming from deep rooted cultural and social bias coupled with patriarchal hierarchy and access to property rights.

This paper is based on the results of a survey conducted among elderly women residing in Punjab near India-Pakistan border line, experiencing frequent conflicts. This study was designed to fulfill the following objectives:

i) To provide a deep insight into the quality of life and health condition of elderly women living in an area located close to hostile neighbouring country.

ii) To bring out the self perception of the elderly women about their own health status and quality of life.

Iii) To analyse the quality of life of the elderly women in terms of their socio-economic characteristics.

iv) To highlight the problems faced by the elderly women living in the rural areas of the border belt.

Materials and Methods

This study was conducted in the rural areas of three blocks (namely Valtoha, Bhikhiwind and Gandiwind) of Tarn Taran district of Punjab, located within a radius of sixteen kilometers from zero line (International Border with Pakistan). It is bounded by Amritsar district in the north, Ferozepur district in the south, Kapurthala district in the east and Pakistan in the west. The Tarn Taran district covers an area of 2914 Square kilometers and accounts for 4 per cent of Punjab population. According to 2011 census, the rural population of the district was 976,611. It is an alluvial plain (fertile agricultural region) drained by Patti rivulet of Sutlej river.After partition of the country, strained relations between the two countries have created wars and war like situations in the border region, adversely affecting the population. A quality of life questionnaire was designed based on World Health Organization's measure having 26 items (The WHOQOL Group, 1996,1998 and WHO,1998) and 157 women in the age group of 60+ years living in the villages of the border areas were randomly selected and interviewed. The questions were formed in such a way as to assess the physical, social and psychological well being of the elderly women and also the conditions of their environment. Accordingly, the questions were grouped into four models as given in table : 1

Table 1 : Division of questions among different models:

Model	Factors	Question No.
Model- A	Physical well-being	-3, -4, 9,16,17
Model-B	Psychological well-being	5,6,10,18,-24
Model-C	Social well-being	13,-14,15,19,20
Model -D	Environment	7,8,11,12,21,22,23

Note: Negative signs in front of some questions denote that their responses are reversed.

The physical well being was analysed on the basis of the responses in 5 questions that covered health related aspects such as ability to do work, frequency of medical aid and pattern of sleep. Similarly, the psychological well being was analysed on the basis of responses in 5 questions related to happiness, meaningfulness of life, bodily appearance,

etc. The social well being was analysed on the basis of the responses in five questions that covered social aspects such as contact with family members, participation in social activities, etc. Likewise, the status of environment was assessed on the basis of the responses in seven questions related to perception of their immediate environment.

Median values for all the above said 4 models were computed and used to define cutoff points for assessing good or poor status. The overall quality of life scores were formed by adding the responses of the respective questions under the four models separately and then adding responses together for the four models. For every particular response, an average was calculated and out of these averages every central value median was calculated. In order to find out the association of age ,caste, education, marital status, and household occupation with quality of life, the data were classified on the basis of these characteristics and quality of life scores were calculated, according to above mentioned method. Besides this, simple statistical tools, such as averages (mean, median) and percentage were used to interpret the results.

RESULTS & DISCUSSIONS

Out of the 157 elderly women in the age group of 60 plus interviewed, the mean age of respondents was 68 years with a standard deviation of 9.58 and co-efficient of variation 14.08 per cent. Majority of these women (63.7%) were within the age group of 60-70 years, and 40.1 per cent of the respondents were widowed, while 74.5 per cent had no formal education. Distribution of respondents among age groups, marital status and education levels are depicted in the following bar diagram (Fig. 1):

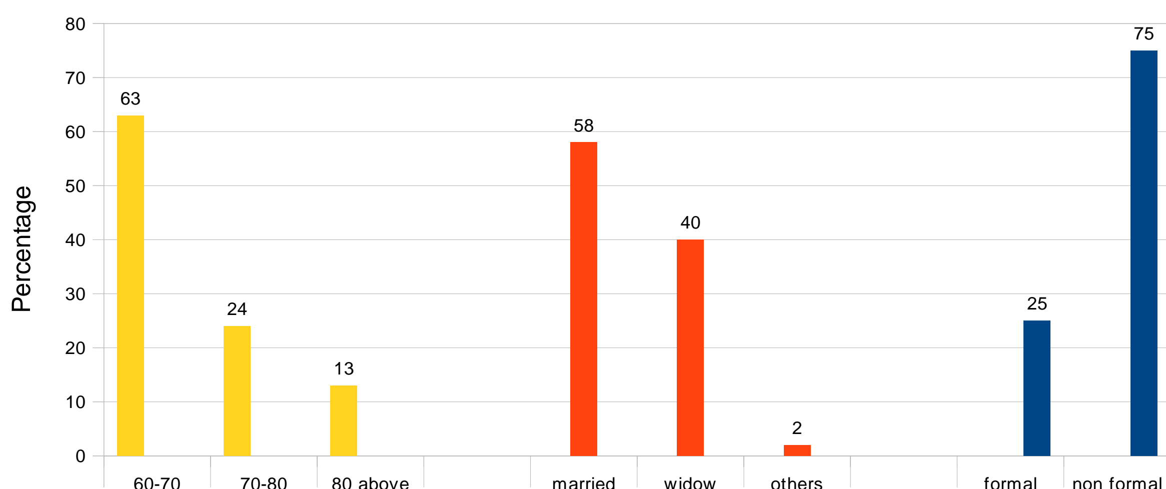


Figure: 1: Age group, marital status and education level of the elderly women.

The mean household size of the elderly women was 8.6 and more than half (51.9%) of the elderly women belonged to the Jat Sikh caste. About 50% of these women lived in Katcha-Pucca house. Occupation wise, about 46% elderly women belonged to farmers' family and about 45% belonged to labourers households.

The economic status of household was estimated by taking an inventory of household and personal item such as television, fridge, cycle, motor cycle, fan, tractor, four wheeler, L.P.G. telephone/mobile, water purifier etc. 'This is a standard and validated method of estimating economic wealth of elderly persons in low income settings'.(Ferguson et al; 2003). Economic status of respondents is assessed by dividing each households possession of these items by the median of items for the entire group. Thus economic status is rated low if its ratio to the median is 0.5 or less, low average if the ratio is 0.5-1.0, average if it is between1.0-1.5, high average if it is 1.5-2.0 and high if it is over 2.0.(Gureje et al 2008). It was found that 33 percent respondents falls in the category of low economic status, 11 percent in low average category, 32 percent in the range of average and only 24 percent in the upper two categories.

The individual respondents quality of life scores were calculated using their scores in the four different domains and correlation coefficients were worked out with that of economic status scores. The correlation coefficient came out to be positive .82 indicating that households having better asses to necessities of life enjoy a better quality of life than the vice versa. Mathew et al. (2010) also reported an association between household socio-economic status and quality of life but not between wealth and self reported health description which may be due to the reason that who owns the wealth and who is the head of the family.

It is customary for women to get married to men older by several years (4 to 8 years) in this area and they do not re-marry after death of their husband. That is why incidence of widowhood is high (Fig. 1) among the elderly women of the study area. Moreover, being a border area it remained a battlefield during wars with Pakistan. A large proportion (40%) of the elderly women is widowed and this situation brings these women in vulnerable position. This border area has been under frequent conflicts as these two neighbouring countries do

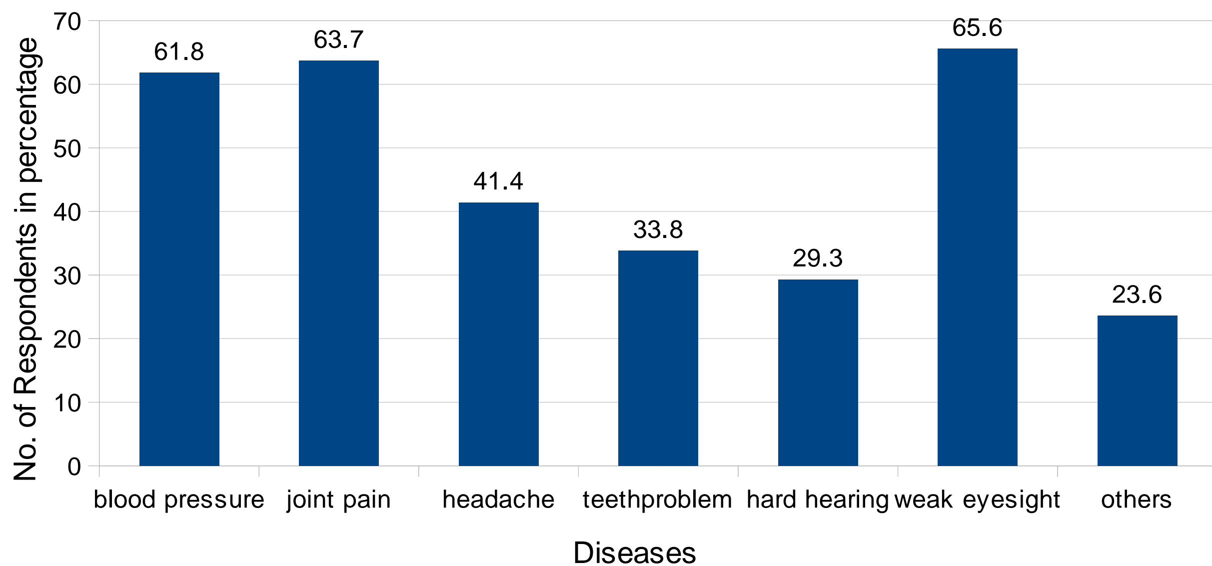
not share cordial relation with each other. It also lacks basic health care infrastructure and adequate housing. Under the above social situations, the quality of life of elderly women suffers a lot.

Economic condition of the peoples in this border area is not so good and many households are too poor to save for their old age and have hand to mouth existence. The National Old Age Pension Scheme is a mockery of the situation with only 52.2 per cents of the respondents getting just a nominal amount of Rs.250/- per month. Even this meager amount of pension is not paid regularly, every month. It is normally paid once in 5-6 months. More than 90 percent of the respondents are spending this amount on buying the medicines only. Major interventions are, thus, required in old age, related to financial insecurity. More than 70 per cent of the respondents complained of sleeplessness owing to financial stress.

The study area portrayed a dismal picture in terms of the access of the elderly women to preventive and curative health care facilities. The mean and median Quality of life scores of the surveyed population were 172.9 and 160.3 respectively. Poor Quality of life was associated with increasing age, (QoL scores: 94.8, 32.5, 21.75 for age groups 60-70, 70-80 and above 80, respectively), being a widow (QoL score: 70) and a schedule caste (Qol: 54.80).

The mean household size of 8.6, observed for households of the elderly women, is broadly reflective of socio-cultural practices in rural areas of most developing countries, where older people tend to live in extended family households rather than independently. It further highlights that the majority of the elderly women were dependent on inter-generational understanding and support. This is reflective of the current Ageing Policy of India which prioritizes family as the basic institution of care and support for the older people. The current study also detected an association between household socio-economic status and quality of life, but not between wealth and quality of life. When asked if they posses sufficient wealth for their sustenance, 59.2 per cent replied in negative (response ' very less' and ' less). This may be due to the fact that household asset-based wealth indices can be unrelated to individual wealth status, depending on which member of the household is head and who owns assets. About 40 per cent of the elderly women, covered in the study area, were dissatisfied with their quality and with the emotional and financial support from the family members.

Half of the elderly women were dissatisfied with their health status and more than half described access to health care as dismal (responses ' extremely bad' and 'bad'). Access to



healthcare was further worsened by poor transportation with nearly 62.5 per cent of the respondents being extremely dissatisfied with the modes of transportation. A very high proportion of the elderly women suffered from weak eye sight, joint pains, blood pressure and headache (Fig. 2).

Figure 2: Major diseases among elderly women in the study area (in percentage).

Quality of life scores do not differ much for family occupations (Agriculture & Labour) which may be accounted to the factor that agricultural land holdings are very small which do not ensure a better quality of life. The survey results indicate that the problems faced by elderly women in the study area are: i) social and financial insecurity, ii) meager pension amount coupled with its untimely delivery, iii) poor access to health care facilities, iv) inadequate mode of transportation, v) drug menace and fear of own children failing prey to it, and vi) dismal future of the children owing to lack of creation of jobs, poverty, backwardness of the area and lack of quality education.

SUGGESTIONS

The quality of life of the elderly women is related to the general well being of their household and a holistic approach for overall development of the border area which would surely go a long way in enhancing their quality of life. There is a need to promote value education, not only at primary level of education, but also at higher level, so as to instill

caring for the elderly. Recognition of elderly women as a valuable resource would help in enhancing their quality of life. Timely and more frequent transport services in the border area should be introduced. There should be adequate provision of social security and the universal pension of at least Rs. 2000/- per elderly women per month. Health care in the border area, through mobile clinics, should be strengthened and medical and eye-camps and distribution of free generic medicines should be implemented.

Rampant drug addiction and trafficking has instilled insecurity in the minds of elderly women and has worsening impact on their quality of life. This evil has to be curved in this region.

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