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Research Article

QUALITY OF LIFE OF THE SENIOR CITIZENS: A STUDY OF FEMALE SENIOR CITIZENS IN MUMBAI

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A R T I C L E I N F O

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A B S T R A C T

The life expectancy has increased worldwide, which has resulted in a sharp increase in the number of senior citizens. There is a growing concern about how the elderly people will be supported and cared for in the 21st century. The present challenge is how to ensure that people will be enabled to age with security and dignity. The lack of understanding and insight into the factors influencing Quality of Life (QOL) of the senior citizens is largely responsible for the elderly being denied a dignified existence. The present research study is undertaken for understanding the status and quality of life of female senior citizens in Mumbai. Many of the females if not working earlier depend completely on their spouse and children for their respectful living after the age of 60 years. The present study focus on analysis of quality of life of female senior citizen in Mumbai on the basis of three parameters: Financial support, Family and Social Support and Health Conditions. Total 400 women respondents above 60 years of age from suburban and urban districts of Mumbai participated in the survey. The data regarding quality of life has been collected through a structured questionnaire method. The findings of the present study aimed to benefit and empower women senior citizens by focusing on specific parameters to improve their quality of Life.

INTRODUCTION

The life expectancy has increased worldwide, which has resulted in a sharp increase in the number of senior citizens. The population of elderly people in India has also grown, both in absolute terms (104 million) and in percentage (8.6% of the total population). There is a growing concern about how the elderly people will be supported and cared for in the 21st century. The present challenge is how to ensure that people will be enabled to age with security and dignity.

The lack of understanding and insight into the factors influencing Quality of Life (QOL) of the senior citizens is largely responsible for the elderly being denied a dignified existence. The diversity among the elderly and varied environmental factors calls for serious consideration of the researchers and policy makers. The present research study is undertaken for understanding the status and quality of life of female senior citizens in Mumbai. Many of the females if not working earlier depend completely on their spouse and children for their respectful living after the age of 60 years. The present study focus on analysis of quality of life of female senior citizen in Mumbai on the basis of three parameters: Financial support, Family and Social Support and Health Conditions.

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There are not many studies conducted on the Quality of life of senior citizens. The present study attempted to look into the quality of life of female senior citizens.

Quality of Life

The literature revealed no single agreed upon definition of Quality of Life (QOL).QOL appears to be a complex, multidimensional concept with psychological, social, emotional, spiritual, physical, functional and environmental domain. QOL depends on the external conditions of people's lives; but the value that individuals attach to those conditions and how they interpret them has a greater impact on QOL (Felce& Perry 1995; Low 2005,Prutkin and Feinstein 2002). Moreover, QOL does not remain static: as the life situations, aspirations and objectives of the individuals changes, so does the life quality (Carr & Higginson 2001; Felce& Perry 1995; Hepner 2003) The Quality of Life group at the World Health Organization defines QOL as "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." (WHO 1998). This definition stressed on how people perceive and internally evaluate their lives.

Scope and Objectives of the Research Study

The research paper aims to provide insight into the quality of life of the female senior citizen in Mumbai. The Quality of life

depends on three key aspects financial support, family and social support and their health conditions. The present research paper is undertaken with the following objectives:

1. To assess the sociodemographic profile and the quality of life of the senior citizens.
2. To analyse the quality of life of the senior citizens on three parameters: financial support, family and social support and health conditions.
3. To recommend region specific inputs for enhancement of Quality of Life of senior citizens.

RESEARCH METHODOLOGY

The present research study is based on the data collected through a field survey undertaken by the DLLE students. Total 400 women respondents above 60 years of age from suburban and urban districts of Mumbai participated in the survey. The data regarding quality of life has been collected through a structured questionnaire method related to three parameters: financial support, family and social support and health conditions. The judgement sampling technique was applied to represent the different geographical areas, age group and education level. The data collected is analysed by calculating percentages.

REVIEW OF LITERATURE

Gibson, Maggie C and others in their paper 'Principles of good care for long term care facilities', identified broad principles that may underpin the drive towards meeting the mental health needs of residents of long-term care facilities and their families, as well as to enhance the overall delivery of residential care services. Methods: Principles of good care are extrapolated from an analysis of international consensus documents and existing guidelines and discussed in relation to the research and practice literature. Results: Although the attention to principles is limited, this review reveals an emerging consensus that: (1) residential care should be situated within a continuum of services which are accessible on the basis of need; (2) there should be an explicit focus on quality of care in long-term care facilities; and (3) quality of life for the residents of these facilities should be a primary objective. We take a broad perspective on the challenges associated with actualizing each of these principles, taking into consideration key issues for families, facilities, systems and societies. They recommended for practice, policy and advocacy to establish an internationally endorsed principles-based framework for the evolution and development of good mental health care.

Dhali, S. C in his study on 'Older people: A New Power for Development' mentioned that with the improvement in health services, life-expectancy for both males and females has shown a steady rise and it has contributed to an increase in the number of persons in the 60-plus category. As the world develops socioeconomically, the number of old persons increases and their contribution through government service, honorary jobs, volunteer work, sharing of experience and knowledge, helping their families in caring responsibilities and participation in gainful employment will also grow. The Government of India is implementing various schemes with the objective of improving the quality of life of senior citizens by providing basic amenities like shelter, food, medical care and entertainment opportunities, by encouraging productive and active ageing through providing support for capacity-building of government/ Non-governmental organization /panchayati raj institutions/local bodies and the community at large.

Misra (2001) expressed in his study of traditional cultures that, "the situation is complex and there are no programs available to train people taking care of the aged in India". The entire responsibility of taking care of the old continues to be with the traditional institution of the family. But in urban areas, the problem is getting further accentuated. Community support is weak and the kin network is diffused over a large area and relatively ineffective.

Saini, Sarita in her study, 'A Multidimensional Assessment of Quality of Life of Elderly across varying Support System', performed a multidimensional assessment of Quality of Life of elderly (65 years & above) living in various types of support systems. The study comprised a sample of 400 subjects from Ludhiana city, equally drawn from four support systems viz. elderly living with sons, living with daughters, living alone, and living in institutions. A Quality of Life Profile, senior's version prepared and published by Quality of Life Research Unit, University of Toronto, Canada (2000) was administered to measure the Quality of Life (QOL) of the subjects across various dimensions of QOL and different support systems. This Quality of Life approach recognizes that there are three different 'Components' of living that contribute to Quality of Life (QOL) of an individual. These are Being, Belonging and Becoming Components. The spectrum of strong and weak dimensions of the Quality of Life across four support systems was developed which clearly pointed towards Leisure Becoming, Growth Becoming and Community Belonging as the most vulnerable dimensions of Quality of Life of elderly living across four support systems.

Analysis of the Data

Demographic profile of the respondents

The survey was conducted from women respondents above 60 years of age. 48.25% of the women respondents were in the age group of 60 to 69 years, 37.25% were in the age group of 70 to 79 years and 14.5% were in the age group of 80 years and above 80 years of age. Table 1 and 2 in the Appendix shows the information related to age group, education level, marital status, ownership status and other relevant general information collected from the respondents.

Appendix

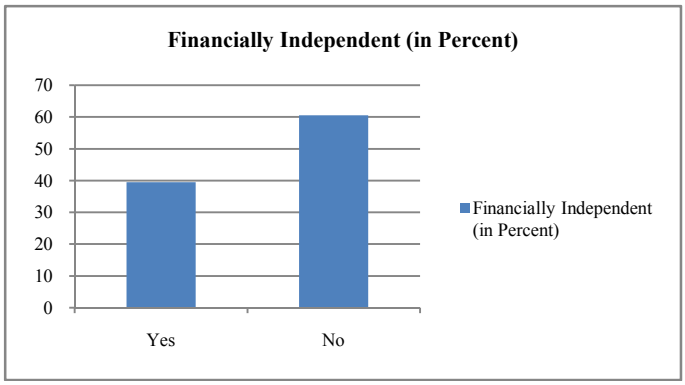
Table No 1 Demographic Profile of the Respondents

Particulars	Sub-groups	Number	Percentage
1. Age Group (in Years)	60-69	193	58.25
	70-79	149	37.25
	80 +	58	14.50
2. Education	No Education	52	13.03
	Less than SSC	103	25.81
	SSC	84	21.05
	HSC	55	13.81
	Graduate	83	20.80
	Post Graduate	22	5.50
3. Marital Status	Married	228	57.15
	Single	10	2.5
	Divorced	14	3.5
	Widow	145	36.35
	other	2	0.5

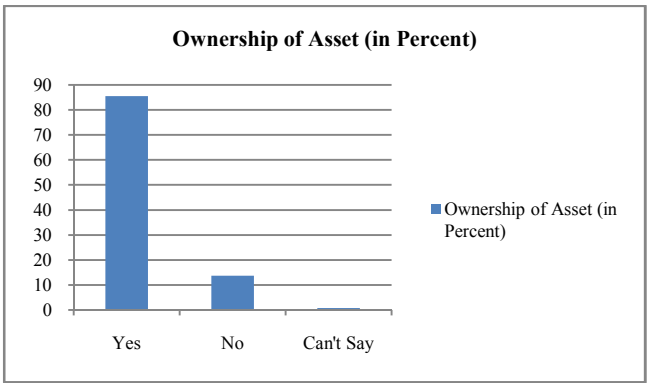
Table No 2 General Information about the Respondents

Particulars	Sub-groups	Number	Percentage
1. Ownership Status	Owner	163	40.85
	Co-Owner	132	33.09
	Rented	52	13.03
	Any Other	52	13.03
2.Living Arrangements	Alone	42	10.55
	Sibling	8	2.1
	With Spouse	178	44.72
	Son	133	33.42
	Daughter	18	4.53
	Grand Children	7	1.76
	Other	12	3.01
3.Reason For Living Alone	No Support	5	11.90
	Children Stay Away	27	64.29
	No children	10	23.81
Are You the Head of the Household?	Yes	204	51.76
	No	190	48.24
If No, then who is the Head of the Household	Son	70	36.84
	Daughter In Law	6	3.16
	Spouse	93	48.95
	Daughter	9	4.74
	Grand Children	1	0.53
	Other	11	5.78

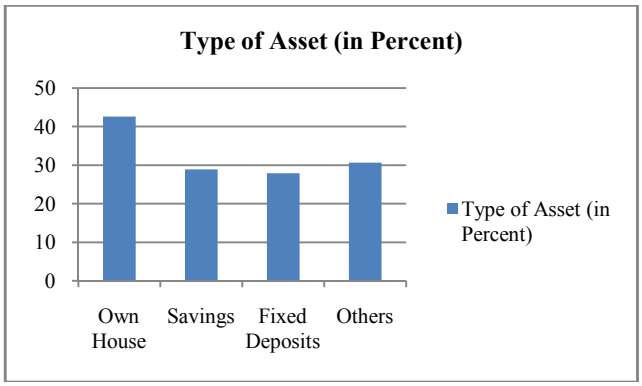
Financial Support



1. With regards to the financial independence 39.5% of the respondents mentioned that they are financially independent, whereas 60.5% of the total respondents were not financially independent.
2. Asked to give the ranking to the sources of their income among salary, pension, transfer from children, house rent, business, interest from savings, spouse support and no source.79 respondents gave rank I to income transferred from children and 60 of the total respondents stated that spouse support is the main source of income. Rank II was given to the interest from savings by 108 respondents, followed by support from children and support from spouse respectively. Rank III was given by 47 of the respondents to interest from saving and rank IV was given by 26 respondents to having no source of income.
3. When asked about ranking of the major expenditure among food, utilities, transport and health care. Rank I was assigned to the expenditure on food, rank II to health care expenditure, rank III to utilities expenditure. Whereas 337 of the total respondents gave rank IV to the transportation expenditure.
4. With regard to the question regarding whether they are still working or not, only 18.30% of the respondents told that they were working whereas 81.70% were not working. Among the working women 58.90% did part time job, 28.77% were employed full time on permanent basis and 12.33% in shift work. When inquired about reason for working 43.84% stated that due to financial necessity, 30.14% work to lead an active life and 26.02% work to keep them busy. When asked about monthly salary, 41.09% earned more than Rs. 10000, 23.29% earned between Rs.6000- Rs. 10000 and 20.55% earned less than Rs. 5000. 15.07% of the respondents did not disclose about the salary they get.
5. When asked about getting pension, 75.72% of the respondents were not getting any pension and only 24.28% were getting pension. 42.22% were getting pension more than Rs. 5000. 27.78% were getting between Rs. 2500- Rs. 5000 and 5.56% were getting less than Rs. 2500. Whereas 24.44% did not disclose the amount of their monthly pension.



1. With regard to the ownership of any asset, 85.49% told that they own asset and 13.72% did not own any asset and 0.79% did not mention regarding their ownership status. About the category of assets: 42.62% own house, 28.89% had savings, 27.87% in fixed deposits whereas only 0.62% invest in other assets. Owning a house provides them security and investment in the savings and fixed deposits ensure liquidity and is low risky.

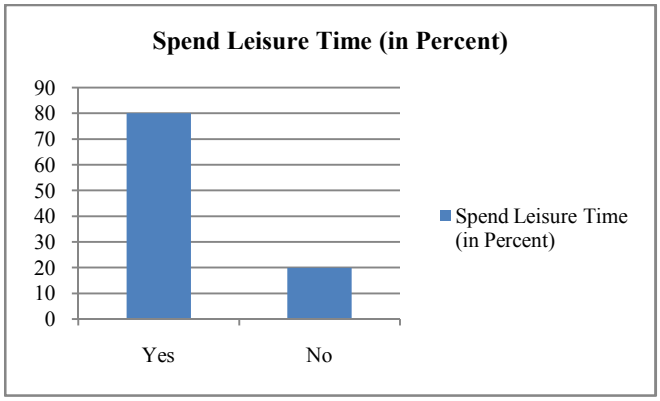


2. When asked whether they are financially adequate? 74.60% of the respondents felt that they were financially adequate, 25.40% did not feel financial adequacy. In case of financial inadequacy 36.17% expected more financial support from family, 35.12% felt need for higher savings, 8.5% wished for more community support and 7.45% expected higher rental income.

Family and Social Support

1. The quality of Life depends on the family and social support which includes their family members and friends. When asked about that were they in contact

with their children? 88.80% stated that they were in contact with their children and 11.2% mentioned that they were not in contact with their children. Regarding frequency of contact 68.48% got in touch on daily basis, 17.9% once in a week, 9.17% 2to 3 times in six months and 2.01% got in touch with their children 2-3 times in a year.



2. When asked about spending leisure time with their children, 88.10% stated that they spend quality time with their children and 19.9% did not spend leisure time with their children. Regarding the frequency of spending leisure time with their children 64.82% mentioned daily, 16.27% once in a week, 12.05% 2-3 times in a month, 4.89% 2-3 times in 6 months and only 1.97% stated 2-3 times in a year.
3. Regarding having active social life, 66.58% stated that they have an active social life, whereas 34.42% did not have an active social life. With regard to ranking of closeness to relatives and friends: rank I was given to spouse, rank II to son, rank III to daughter, rank IV to grandchildren, rank V to daughter in law and rank VI to friends respectively. The dependency on relatives is ranked I when they fell ill, rank II assigned to financial assistance, rank III for dependency for daily chores and rank IV was to dependency for going out.
4. When asked about experience of any abuse from family: 80.8% have not experienced any abuse from their family whereas 19.20 replied affirmative. Those who went through agony of abuse stated that 30.88% went through verbal abuse, 20.59% mentioned neglect, 17.65% mentioned emotional abuse, 14.70% stated physical abuse, 13.24% mentioned disrespect and 2.94% stated they went through economic abuse. Regarding question about by whom had they experience abuse? 44.45% from relatives, 36% from children, 11.11% from daughter in law, 5.56% from grandchildren and 2.88% from their maid.

Health Conditions

1. With regard to describing their health conditions 36% reported to be very good with no health problems, 50.5% told health to be good with seasonal health problems, 32.5% rated fair with one chronic disease and 7.75% rated poor due to more than one chronic disease.
2. Regarding their physical independence, 88.75% were physically independent and 16.25% were not physically independent. 58.75% reported to use physical aid and 16.25% did not use any physical aid. Regarding the ranking of health problems rank I was given to high blood pressure problem, rank II to diabetes, rank III to knee problem, rank IV to eyesight problem, rank VI to hearing problem, rank VII to depression, rank VIII to other types of health related problems and rank IX to cancer.
3. When asked about whether they had been hospitalized in last one year, 28.79% reported yes they had been and 71.21% replied in negative. 84.5% reported that they have been treated for their medical conditions and 14.25% reported that they have not been treated for their medical conditions. Whereas to 1.25% the question was not applicable. 43.37% took the medical treatment in private hospitals, 36.25% took the medical treatment from general private practitioners, 15.86% in government hospitals and 4.52% took self-medication. Those who have not taken any medical treatment 56.60% reported that it was mild illness, 37.74% stated they took self-medication and 5.66% did not take medical treatment due to financial constraints.
4. With regard to having life/medical/accident insurance 67.01% had insurance whereas 32.99% did not have any insurance policy. 65.75% did regular health checkup, 33.25% did not go for regular health checkup. The payment for their health checkup in case of 36.67% respondents was made between, by spouse (28.36%), self (16.20%), insurance company (10.87%), daughter (3.20%), daughter in law (0.85%), grand children (0.43) and others (3.42%).
5. When asked about what do they need the most? 23.08% of the respondents need emotional support, 16.25% expect better medical services, 13.90% expect security, 11.75% need free health insurance, 8.97% expect free treatment, 7.05% require financial aid, 6.62% expect physical support and 5.55% expect no discrimination.

RECOMMENDATIONS AND CONCLUSION

1. 65.5% of the respondents were financially dependent. This financial dependence is mainly on transfer from children and support from their spouse apart from income from savings. As 81.70% of the respondents were not working so financial security is the prime concern for improving the quality of life.
2. 80.80% of the women were in contact with their children and 68.48% mentioned that they got in touch with their children on daily basis. Regarding active social life, 66.58% of the respondents mentioned that they have an active social life. Regarding closeness to relatives and friends Rank I was assigned to the closeness to the spouse.
3. Regarding their health conditions, 83% of the respondents rated health to be good and fair. 88.75% of the respondents were physically independent. 23.08% of the senior citizens need emotional support, 16.25% expects better medical services and 13.90% expect security.

The senior citizens are required to cope up with new challenges and high level of stress as they grow old. To extend the life span and to improve the quality of Life, old age should be evaluated from the view point of the continuity of roles and functions rather than the perception of withdrawal. The concept of productive ageing needs to be promoted as it can increase the contribution of the elderly people in the family and community at large.

Enlarging social networking through participation in the various group activities through senior citizens clubs, associations and formal and informal organizations for social interactions needs to be promoted. Building a social network may provide senior citizens opportunity to share their life's experiences and provide an emotional outlet to their existing problems. It might also be rewarding to actively engage themselves in social roles and various types of occupational activities rather than to remain socially isolated and withdrawn. However the level of activity and the nature of engagement have to be determined by the health and family support of the senior citizen. It is desirable to spend time for social and hobby related activities. It would transform feeling of inadequacy into feeling of being productive.

Bibliography

Carr, A. J., & Higginson, I. J. D2001]. Are quality of life measures patient centered? British Medical Journal, 322D7298], 1357-1360 Document ID: 74107945].

Dhali, S.C.Alive; New Delhi, Iss.373 (Nov 2013): 56-59, 'Older People: A New Power for Development'.

Felce, D., & Perry, J. (1995). Quality of life: its definition and measurement. Research in Developmental Disabilities, 16(1), 51-74. doi:10.1016/0891-4222(94) 00028-8.

Gibson, Maggie C; Carter, Mary W, Helmes, Edward, Edberg, Anna Karin, 'Principles of good care for long term care facilities', International Psychogeriatric Suppl., Focus on mental health issue in long-term care-homes; Cambridge Vol. 22, Iss. 7, (Nov 2010): 1072-83.

Mista, P. K. (2001).Integration of endogenous cultural dimension into development: Development problems and traditional cultures. Reflections on the Management of the Aged in India, http://ww.ignca. nic.in/cd-05020.html.

Saini, Sarita, 'A Multidimentional assessment of Quality Of Life of elderly across varying support system', *Indian Journal of Health & Wellbeing*, Hisar Vol.4, Issue1, March 2013: pp 136-140.

Smith, A. E., Sim, J., Scharf, T., & Phillipson, C. (2004). Determinants of quality of life amongst older people in deprived neighborhoods. Ageing & Society, 24, 793-814. doi:10.1017/S0144686X04002569.

World Health Organization. (1996). WHOQOL-BREF: Introduction, administration, scoring and generic version of the assessment: Field trial version. Retrieved from: http://www.who.int/mental_ health/media/en/76.pdf

World Health Organization, Division of Mental Health and Prevention of Substance Abuse. (1998). WHOQOL User manual. Retrieved from: http://www.who.int/ mental_health/evidence/who_qol_user_manual_98.pdf

Hepner, K. A. (2003). The role of experience-expectation discrepancy and depressive symptomatology in quality of life. Retrieved from Dissertations & Theses: Full Text database. (AAT 3106999)

Mukherjee Anita J, Diwan, Sadhna, 'Late life immigration and Quality of Life among Asian Older Adults', *Journal of Cross-Cultural Gerontology*; Dordrecht, Vol. 31, Iss 3 (Sep 2016): 237-253.

Prutkin, J., & Feinstein, A. (2002). Quality-of-life measurements: Origin and pathogenesis. The Yale *Journal of Biology and Medicine*, 75(2), 79-93. Retrieved from MEDLINE database.

Usha V K, Lalitha K. Quality of Life of Senior Citizens: A Rural-Urban Comparison, '*Indian Journal of Social Psychiatry*', Mumbai, Vol.32, Iss 2, (April-June, 2016)

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