ELDERLY MUSLIM OF RURAL WEST BENGAL: A SOCIAL GERONTOLOGICAL STUDY

Thesis Submitted for the Degree of

DOCTOR OF PHILOSOPHY (SCIENCE)
UNDER VIDYASAGAR UNIVERSITY

Submitted by

SK. SIRAJ ALI

DEPARTMENT OF ANTHROPOLOGY
VIDYASAGAR UNIVERSITY
WEST BENGAL, INDIA
2016

Falguni Chakrabarty
Professor of Anthropology
M. Sc., Ph. D. in anthropology

Department of Anthropology
Vidyasagar University
Midnapore - 721 102
West Bengal, India
E-mail: falguni.mita@yahoo.co.in
Cell Phone: 9433185391

Date: 24-11-2016

TO WHOM IT MAY CONCERN

This is to certify that Mr. Sk. Siraj Ali, a registered Ph. D. research scholar (bearing Registration No. 0233/Ph.D. (Sc) dated: 01.12.2011), did his research for Ph.D. degree under my guidance and supervision in the Department of Anthropology, Vidyasagar University, West Bengal. The title of his Ph. D. dissertation is "Elderly Muslim of Rural West Bengal: A Social Gerontological Study".

Mr. Sk. Siraj Ali personally carried out fieldwork in connection with his Ph. D. work and his Ph. D. thesis is based on original data-set collected by him and the contents of his thesis has not been submitted to any other University/institution for the procurement of Ph.D. Degree/any Degree/Diploma/other academic award.

This is to further certify that Mr. Sk. Siraj Ali has incorporated all the recommendations/ suggestions/ modifications forwarded by the Ph. D. committee in Anthropology of Vidyasagar University for improvement of his thesis. His performance related to the Ph. D. work is satisfactory.

Finally, it is recommended that Mr. Sk. Siraj Ali may be allowed to submit his thesis entitled above for the procurement of Ph. D. degree in Anthropology under the Faculty of Science at Vidyasagar University and I hope he will be awarded a Ph. D. Degree after completion of necessary formalities.

Falguni Chakrabarty.
(FALGUNI CHAKRABARTY)

Prof. Falguni Chakrabarty
Dept. of Anthropology
Vidyasagar University
Midnapore-721102

DECLARATION

I do hereby declare that the present thesis entitled "Elderly Muslim of Rural West Bengal: A Social Gerontological Study" is based on my original work except for Quotations and Citations, which have been duly acknowledged. I also declare that the present thesis has not been previously or concurrently submitted for procurement of Ph. D. degree/ any other degree/diploma/other academic award at any other University or institution. The supplementary / other aspect of the present data-set has been partially / fully utilized productively for research papers. All the recommendations/ suggestions/ modifications forwarded by the Ph. D. committee in Anthropology of Vidyasagar University have been incorporated for improvement of thesis.

Date: 24-11-2016

Sk. Siraj Ali

(SK. SIRAJ ALI)

CONTENTS

ACKNOWLEDGEMENTS

I express my deep sense of gratitude to those Muslim elderly people of Nandigram-I CD Block who smilingly allowed me to interview them for the present research. To all I iterate my apology for perturbing their tranquil life.

I take this opportunity to express my deepest gratitude to Professor Falguni Chakrabarty, Department of Anthropology, Vidyasagar University, who is my teacher and supervisor of the present Ph.D. work. He not only inspired me to undertake this research but also provided various thought provoking ideas about this work.

I am grateful to all my teachers who have strengthened my foundation in Anthropology during my under-graduate and post-graduate study namely Prof. Krishnendu Bhattacharya, Dr. Dipankar Chowdhury, Prof. Rajat Kanti Das, Prof. Abhijit Guha, Prof. Kaushik Sankar Bose, Dr. Sudip Dutta Banik, Dr. Dipak Kumar Middya, and Dr. Amit Kumar Kisku.

I am grateful to my parents and family members for their love and support without which I could not achieve the status of a Ph.D. scholar.

I am thankful to Dr. Mohan Chandra Dolai for his valuable suggestion and active co-operation with regard to my Ph.D. thesis. I am thankful to Dr. Bigitendriya Debsharma for his co-operation during the drafting of my thesis.

I thankfully acknowledge the active co-operation of Miss. Indraja Bankura, Sri Rajkumar Karan and Sri Parikhshit Chakraborty, the Research Scholars of the Department of Anthropology, Vidyasagar University.

I thankfully acknowledge the University Grant Commission (UGC), New Delhi for awarding me 'Moulana Azad National Fellowship' to carry out the present research.

I am grateful to Dr. Sovanjan Sarkar, Assistant Professor and Teacher-in-Charge of the Department of Anthropology whose initiative made it possible to present this pre-submission seminar and finally submit the present thesis.

Finally, I remain thankful to the officers and administrative staffs of the Vidyasagar University in general and Department of Anthropology in particular for providing me different infrastructural facilities.

Date: 24-11-2016

Sk. Siraj Ali
(SK. SIRAJ ALI)

LIST OF USED ABBREVIATAIONS

Abbreviation	Full Form
AAAS	American Association for the Advancement of Science
AD	Anno Domini
ADL	Activities of Daily Living
CDB	Community Development Block
COPD	Chronic Obstructive Pulmonary Disease
DDAS	Death and Dying Anxiety Scale
EPIC	Elector's Photo Identity Card
F	Female
HRQOL	Health-Related Quality Of Life
HTN	Hypertension
IADL	Instrumental Activities of Daily Living
ILO	International Labour Organization
M	Male
MANF	Moulana Azad National Fellowship
MI	Monthly Income
N	Number
NCOP	National Council for Older Persons
NPOP	National Policy for Older Persons
NREGA	National Rural Employment Guarantee Act
NSSO	National Sample Survey Organization
PWD	Persons with Disabilities
SES	Socio Economic Status

Abbreviation	Full Form
SES	Self Esteem Scale
SSA	Social Security Act
SSS	Social Support Scale
TISS	Tata Institute of Social Sciences
UGC	University Grant Commission
UK	United Kingdom
UN	United Nations
UNO	United Nations Organization
US	United States
UT	Union Territories
WHO	World Health Organization

LIST OF TABLES

LIST OF FIGURES

CHAPTER-1

INTRODUCTION

Section-I

1.1. Definition, Scope and Sub fields of Gerontology:

1.1.1. Definition and Scope:

The study (logy) of ageing has taken its name from *geront*, the Greek word for old man. The term 'Gerontology' was first coined in 1906 by Russian biologist Ilya Ilyich Metchnikoff. By definition, gerontology is the scientific study of the biological, psychological, historical, sociological, economic aspects of human ageing (Birx, 2005). Gerontology, as defined in the Merriam-Webster Dictionary is "the comprehensive study of ageing and the problems of the aged." Contemporary gerontology includes all of the followings: (1) scientific studies of processes associated with ageing; (2) scientific studies of mature and aged adults; (3) studies from the perspective of the humanities (e.g. history, philosophy, literature); and (4) applications of knowledge for the benefit of mature and aged adults (Kastenbaum, 1992).

The above mentioned multidisciplinary focus of gerontology suggests that there are a number of sub-fields, as well as associated fields such as biology, psychology and sociology that also cross over into gerontology (Hooyman and Kiyak, 2011). However, such overlap does not imply that they are the same. For example, a psychologist may specialize in early adults (and not be a gerontologist) or specialize in older adults (and be a gerontologist).

Many people confuse Gerontology with Geriatrics. Whereas, geriatrics focuses strictly on the medical conditions and disease of the ageing, gerontology is a multidisciplinary study that incorporates biology, psychology and sociology. Because, gerontology deals with multi-faceted aspects of aging, on gerontology professionals can

be found in a variety of sectors including, government, voluntary association and the business house.

A brief discussion on major sub-fields of Gerontology has been discussed in the following paragraphs:

1.1.2. Sub-fields:

There are two broad sub-fields of gerontology and they are namely Biogerontology and Social gerontology.

1. ***Biogerontology:***

Biogerontology is the study of the biological processes of aging. It is composed of the interdisciplinary research on causes, effects and mechanisms of biological aging in order to get better understanding of human senescence. Biogerontologists usually work at research universities or laboratories. Some within biogerontology have worked to show that aging is a biological process that we are far from being able to control. The multidisciplinary focus of gerontology and biogerontology means that there are a number of subfields. As with biogerontology, geriatrics studies the biological causes and effects of aging. Both fields are considered by many scientists to be the most important frontiers in aging research. There is a sub discipline of biogerontology that is biomedical gerontology.

Biomedical gerontology, also known as experimental gerontology and life extension, is a sub-discipline of biogerontology that endeavors to slow, prevents, and even reverses aging in humans. Curing age-related diseases is one approach, and slowing down the underlying processes of aging is another. Most "life extensionists" believe the human life span can be altered within the next century, if not sooner. Some biogerontologists take an intermediate position, emphasizing the study of the aging

process as a means of mitigating aging-associated diseases, while either claiming that maximum life span cannot be altered or that it is undesirable to try.

2. ***Social Gerontology:***

Tibbitt states that social gerontology is concerned with changes in the social characteristics, circumstances, status, and roles of individuals over the second half of the life span; with the nature and processes of adjustment, personality development, and mental health in the ageing individual; and with the biological and psychobiological processes of ageing in so far as they influence social capacity and performance in later life. Secondly, social gerontology seeks to discover the role of the environment, culture, and social change as determinants of ageing and of the behavior and position of older people in society; the behavior of older people as groups and in the aggregate; and their impact on social values and institutions and on economic, political, and social organization, structure, and function (Tibbitt, 1963).

1.1.3. Concepts of Old Age and Elderly:

Definition of an older person has not been universally agreed upon. It varies from society to society and in different periods of development in a given society. "Old age" is assigned on the basis of chronology (age 60, for example), biology (how well one function physically), and social standards (the point at which, for example, a woman is considered "too old" to wear a dresses of too bright colors). In Western culture, ageing is most often seen as a biological process of decline of bodily functions (Gullette, 2003). Biological signs like graying hair, changing skin texture, failing eyesight, waning muscular strength, or reduced vitality etc. are commonly thought of as the defining features of old age.

Many researchers consider that Old age is natural, normal, universal and inevitable biological phenomenon. It is a development phase in the life process which

begins at conception and continues until death. Old age is the last stage in the life journey and closing period in the life span of a man with decreased capacity for adaptation (Neeraja, 2006).

Old age is also defined as a time when one seeks balance between the search for ego integrity and feelings of despair (Erikson, 1979, 1982). On the individual level, in old age one might achieve a sense of integrity, a sense of completeness, of personal wholeness strong enough to offset the downward psychological pull of inevitable physical disintegration (Fleeson & Heckhausen, 1997).

In the United States of America, and the United Kingdom, the age of 65 was traditionally considered the beginning of the senior years because, until recently, United States and British people became eligible to retire at this age with full social security benefits.

Most developed countries of the world have accepted the chronological age of 65 years as a definition of 'elderly' or older person, but like many westernized concepts, this does not adapt well to the situation in Africa. While this definition is somewhat arbitrary, it is many times associated with the age at which one can begin to receive pension benefits.

The more traditional African definitions of an elder or "elderly" person correlate with the chronological ages of 50 to 65 years, depending on the setting, the region and the country (www.who.int/healthinfo/survey/ageingdefnolder/en/). Adding to the difficulty of establishing a definition, actual date of birth is quite often unknown because many individuals in Africa do not have an official record of their dates of birth (Gorman, 2006).

The Older Persons Act No.13 of 2006 of South Africa states that a male is an aged person at 65 years of age and a female at 60 years. The *Encarta Dictionary* (2009) explains an elderly person as someone past middle age and approaching the later stages of life.

In 1935, the United States (US) passed the Social Security Act (SSA) under President Franklin D. Roosevelt. In that act, 65 was named as the onset of old age, in accordance with a tradition by then established in Europe. As far back as 1875, in Britain, the Friendly Societies Act, enacted the definition of old age as, "any age after 50", yet pension schemes mostly used age 60 or 65 years for eligibility (Roebuck, 1979). In line with Social Security standards, most companies as well as state/provinces and local governments of western countries developed pension programs beginning at age 65 for retiring workers. This legal definition has become a social definition since on retirement, a person's lifestyle generally changes dramatically, creating a point of entry from one phase of life to another that has become a social event.

The chronological definition of old age is linked with life expectancy. In India, when the average life expectancy was 27 years, the age of retirement under the government was 55 years, which meant that a person of more than 55 years of age was considered as aged or elderly. With the rise of life expectancy, the age of retirement was raised to 58 years. At present it is 60 years in non-governmental organizations such as public undertakings and autonomous institutions (Chowdhray and Paul, 1992). Presently age of retirement is 65 in case of the universities and research institute financed entirely by Government of India.

In view of the increasing need for intervention in area of old age welfare, Ministry of Social Justice and Empowerment, Government of India adopted 'National Policy on Older Persons' in January, 1999. The policy defines 'senior citizen' as a person who is 60 years old or above. This policy may have been adopted in tune with the recommendation of UNO made in 1980 to consider population aged 60 years and above as the older population.

We find that as early as 1974, Bernice L. Neugarten separated the older population into the 'Young Old' (age 65 to 74) and the 'Old Old' (age 75 and over). Before that, gerontological studies used to consider all the elderly together, obscuring

important differences and offering little insight into the social realities of the oldest old (Hillier and Barrow, 2007). The term 'oldest old', generally used to refer to the population aged 85 and older, was coined for a 1984 session on this population in the annual meeting of the American Association for the Advancement of Science (AAAS). However, even in US, limitations of survey data, resulting from small sample sizes at the oldest ages, forced several studies of the oldest old to define them as those ages 80 and older (Suzman & Riley, 1985).

Since last decade the Election Commission of India has started to publish separate voter list for the Indian citizens belonging to 80 years and above age. In the year 2011 these elderly people have been categorized as 'Super Senior Citizen' by the Department of Finance, Government of India for the purpose of income tax assessment (ENS Economic Bureau, The India Express, New Delhi, March 01, 2011). However, one may be tempted to assume that the identification of the population of 80 years and above age as separate category in India may have its genesis in the categorization of 'Oldest Old' in 1984 during the annual meeting of the American Association for the Advancement of Science (AAAS).

SECTION-II

1.2.1. Aspects of Ageing:

The term aging is synonymous with decline, often encompassing a range of situation including deterioration, chronic illness and a failure to thrive whereas, the word 'old' derives from the Latin root *alere,* which means to grow or nourish; however, the connotations are usually negative, equated with words such as antiquated, archaic, frail and behind the times (Phillips et al. 2010).

Different aspects of aging which are commonly identified by the gerontologists are namely: *chronological, biological, psychological, social or situational and socio-psychological or behavioral.*

1.2.1.1. Chronological Aspects of Aging:

Chronological ageing refers to the number of years since someone was born, but is generally not recognized as an adequate measure of the extent of ageing because, as a process, it is thought to vary between individuals. Chronological age also provides individuals with a means of distinguishing roles and relationships in terms of the behavior and expectations that are linked to different chronological groupings (ibid, 2010).

1.2.1.2. Biological Aspects of Ageing:

Biological ageing, often known as senescence (declines of a cell or organism due to ageing) and sometimes functional ageing, refers to biological events occurring across time which progressively impair the physiological system so that the organism becomes less able to withstand disease, ultimately increasing its susceptibility to death. From this perspective, aging process stems from several physiological factors, and is modified throughout the life course by environmental factors (such as nutrition), experience of disease, genetic factors and life stage (Phillips et al. 2010). Biologists

regard the normal ageing process as a complex of progressive changes in cellular composition and capacity for growth; in tissue structure and function; in the speed, strength, and endurance of the neuromuscular system; and in the reduction in the capacity to integrate organ systems (Shock, 1951). Parallel to these changes and no doubt related to them is an increasing prevalence of long-term, chronic disease arising from cumulated insults to the organism (Carlson and Stieglitz, 1952).

1.2.1.3. Psychological Aspects of Ageing:

Psychological ageing focuses upon changes that occur during adulthood to an individual's personality, mental functioning and sensory and perceptual processes (Phillips et al. 2010). Psychological ageing is being studied in terms of changes in the central nervous system, in sensory and perceptual capacities, and in ability to organize and utilize information (Anderson, 1956).

Studies on psychological ageing encompasses intellective and motor performance, including changes in learning, memory, creativity, speed of input and output, skills, and performance of work. Attention is paid to external influences, such as cultural expectations and environmental factors. Most of the changes in these areas are currently thought to be normal ageing process or functions of such processes. There is evidence, however, that maturation of some capacities may extend into middle adulthood and that declines are highly differential and usually very gradual. Psychologists are concerned also with changes in personality and with the external behavior of the ageing individual (Tibbit, 1960).

1.2.1.4. Social or Situational Aspects of Aging:

Social ageing refers to the changing experiences that individuals will encounter in their roles and relationships with other people and as members of broader social structures (such as religious group) as they pass through different phases of their life

course. Social ageing can also be shaped or 'constructed' by social and cultural contexts which dictate the normative expectations about the roles, positions and behavior of older people in society (Phillips et al. 2010).

This aspect of aging is also called the "sociological", "socioeconomic", or "situational" changes. They include completion of parental role; social attitudes and behavior toward the ageing or ageing individual; retirement from work and reduced income; restricted mobility induced by disease, disability, or loss of energy; need for special living arrangements; and loss of spouse (Tibbit, 1960).

1.2.1.5. Behavioral Aspects of Ageing:

A fifth aspect of ageing is concerned with the meaning to the individual of the changes with the internal and external adjustments he makes to them. Interest lies, on the one hand, in his inner reactions with regard to such matters as changing self-image, feelings, efforts to maintain ego balance, maintenance or loss of mental well-being, and tolerance of stress. On the other side, social psychologists and social gerontologists are studying changing status and roles through successive phases of the life-cycle; relationship to family, work, and others; and organization of behavior in terms of content and expansion or constriction of life space (ibid).

1.2.2. Concept of Population Ageing:

Population ageing, sometimes referred to as societal ageing, is a process where by a group (such as a country or an ethnic group) experiences the progressive increase in the actual numbers and proportion of older people within its total population. This change brought about largely by socio-economic improvements in health and living standards, progressively reduces mortality and fertility, resulting in increased life expectancy and fewer births, and ultimately, an increase in the older population in relation to younger age groups. Population ageing has long-term implications for

governments in terms, for example, of the cost of health and social care for an increasingly important number of older people (Phillips et al. 2010).

According to World Health Organization (WHO), population ageing is one of humanity's great triumphs. Throughout the twentieth century and twenty first century, it has become a worldwide phenomena reflected on changing demographic scenario of aged population. Ageing is basically the result of two dimensional demographic transformations which is explained by overall declines in mortality and fertility. So, population ageing is a process whereby a group (a country or an ethnic group) experiences the progressive increase in the absolute numbers and proportion of older people within its population. This change brought about largely by industrialization, modernization and progressively reduces mortality and fertility, resulting in increased life expectancy and fewer births, and ultimately, an increase in the older population in relation to younger age groups. Population ageing occurs as the result of a complex interaction between health, mortality and fertility transition, which together change the number of people at each age in a given population (Kinsella and Velkoff, 2001). The impact of these demographic processes occurs over time so that a population will experience different phases to its age transition. For example, when fertility and mortality are high a population will be quite 'youthful' in its age structure, but by the time mortality and then fertility have declined significantly (so that the population will not 'rejuvenate' quickly by the addition of babies and that more people will be living longer), and the earlier large birth cohorts are reaching old age, the age transition will have led to an 'ageing' population. Declines in mortality and improvements to health care therefore eventually lead to increasing numbers of older people; declines in fertility eventually lead to a higher proportion of older people in a population over time. Demographer Notestein (1945) elaborated his Demographic Transition Theory through three patterns of population growth: Stages one represents the potential for high growth because of high birth and death rates. While women may bear many children, those children are also more likely to die due to infectious diseases. As a result, few

members are surviving into middle adulthood, and even less into old age. With the advent of antibiotics, improved sanitation and medical technologies, the first transition occurs as mortality rate decrease. Stage two of the demographic transition is associated with rapid population growth as death rates drop before fertility begins to decline. In the third stage, death rates reach their lowest levels and fertility may continue to decline, with the effect that populations might eventually be unable to replace themselves.

The focus in the field of gerontology has been mainly directed to the conditions in the developed countries of the world, those that have already experienced considerable population ageing. The World Assembly on Aging, convened in 1982, drew attention to the worldwide importance of the phenomena, even in developing countries. Demographers have been in the forefront in noting that a majority of the world's older persons are located in such countries. In coming decades these numbers will continue to increase rapidly, as will the proportions they represent in the total populations of many developing countries (Kinsella & Taeuber, 1993). The significance of the spread of the demographic revolution from developed to developing nations was recognized by the United Nations in its declaration of year 1999 as the International Year of older Persons. Thus, while 1999 saw the addition of its six billion citizens, this year also marked the recognition that the world as a whole is entering a phase in which populations are maturing.

Global population ageing reflects the unprecedented gains in life expectancy due to a combination of factors such as declining infectious diseases, better standards of living, progress in education, improved nutrition and health care, as well as improvement of biomedical technology and the benefits that come from overall socio-economic development (Bagga and Sakurakar, 2000).

1.2.2.1. World Context of Population Ageing:

Ageing of population is a by-product of demographic revolution which is the consequence of industrial revolution as well as change in public health and education. The world is graying and this process is accelerated and intensified by the decreasing birth rate and mortality rate and increasing longevity. The world demographic situation shows that the percentage of age 65+ is increasing from 5.5 percent in 1970 to 5.77 percent in 1985 and 6.39 percent in AD 2000. The rate of incidence of ageing has been higher in developed regions and lesser in developing countries. As against 38 percent increase in the total world Population for the period 1981 to 2000, the increase of population of 60+ age is 5.71 percent.

The ageing of populations is now a global phenomenon. In 1950 there were 200 million persons aged 60 and above in the world constituting 8 percent of the total global population. By 2025, there will be six fold increases in this number; the world elderly population is projected to be 1.2 million people about 14 per cent of the total figure. The median age of the world population will jump from 23.4 years in 1950 to 31.1 years in 2025 (world population prospects). By 2025, seventy two percent of the elderly, i.e. about 858 million people will be living in developing region. By 2025 the very old will number about 137 million, 11 per cent of the total elderly. Between 1985 and 2025, projected increases for persons aged 70 and above are 32 million for males and 317 million for females in the developing regions. Sex differences in absolute increments are more apparent at older ages. Thus, over the same period, projected increase in the number of persons aged 80 and above is 8 million males and 14 million for females in the developed regions and 24 million for males and 35 million for females in the developing countries.

1.2.2.2. Indian Context of Population Ageing:

Increased life expectancy has contributed to an increase in the number of persons aged 60 years and above. From only 12 million persons 60+ in India in 1901, the number

crossed 24 million in 1961 and 55.30 million in 1991 and in 2001 it had gone to 76 million and again in 2011 it reached at 104 million.

In the beginning of 20th century, the life expectancy for India was just 23 years for both the sexes (Davis, 1951). In the year 1947, when India became independent from the British rule, life expectancy was around 32 years and again added another 9 years during the first half of the twentieth century. Improvements in public health sectors and better medical services have led to substantial control of specific infectious diseases and eradicated few more diseases, which translated into significant decreases in mortality rates among all ages. Government sponsored sanitation and maternal and child immunization programs which have improved maternal health and reduced infant mortality rate. The infant mortality in 2002 for India is 62-63 for males and 65 for females (Registrar General of India, 2003). The average life expectancy in India at birth was 32 years in 1951 and it became around 65 years in 2001 (International Federation of Ageing, 1992).

The India's aged population is currently the second largest in the world after China. Indian population has approximately tripled during the last 50 years, but the number of elderly Indians has increased more than fourfold. The absolute number of 60 and over in India will likely to increase from 77 million in 2001 to 137 million by 2021 (United Nations, 2003). While the elderly constituted only 24 million in 1961, it increased to 43 million in 1981 and to 57 million in 1991. The proportion of elderly persons in the population of India rose from 5.63 per cent in 1961 to 6.58 per cent in 1991 (Irudaya Rajan, Mishra and Sarma, 1999) and respectively 7.5 and 8.6 per cent in 2001 and 2011. The Decadal growth rate among elderly population during 2001 to 2011 is about 36 per cent- double than the general population growth of 16 per cent. The percentage of elderly in India has increased from 5.5 per cent in 1951 to 6.4 per cent in 1981 and further to 8.6 in 2011. If the percentage of elderly population is above seven per cent in any country, as per the UN criterion that country is ageing. In other words, India has emerged as "ageing India" in the beginning of 21st century. Thus twenty first

century is the century of old (Leibig and Rajan, 2003). However, from 1951 onwards the elderly population started growing steadily. The growth of elderly population in India is reflected by the following tables.

Table – 1.1.

Per cent Distribution of Population by Broad Age Groups in India since 1951

Year	Age Groups		
	0-14	15-59	60+
1951	38.4	56.1	5.5
1961	41.1	53.3	5.6
1971	42.0	52.0	6.0
1981	39.7	53.9	6.4
1991	37.6	55.7	6.7
2001	35.3	56.9	7.4
2011	29.0	62.7	8.6

Source: Population Census of India

It is anticipated that the elders in India would increase both in absolute numbers and relative strength, indicating a gradual swing to a senior population. As per Census of India projections, the percentage of elders as a percentage of total population in the country would jump from 7.4% in 2001 to 12.4% in 2026 and touch 19.7% in 2050. In 2011, India had about 104 million seniors above the age 60 years and it is expected that this figure will grow to 173 million by 2025, future increasing to about 240 million by 2050.

Table – 1.2.

Decadal increase of General Population and 60+ Populations, India

Decade	Increase in General population (%)	Increase in 60 + population (%)
1951-61	21.51	22.40
1961-71	24.80	32.32
1971-81	24.75	31.60
1981-91	23.87	38.02
1991-01	20.43	37.43
2001-11	16.19	36.64

In India, since 1961 sharp decline in the overall death rate and also in mortality levels in the older age groups initiated a process of ageing. This has accelerated after

1971 when the fertility level also started declining. The elderly population in India was 12.06 million in 1901 and it became 19.61 million in 1951 thus the increase is about 63 per cent. Between 1951 and 1971 there was 67 per cent increase of elderly persons in India. 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. During the decade 1981-91 the old age population increased by 13.5 million with a decadal growth rate of 31 per cent. According to estimates made by the Technical Group on Population Projections, the likely number of the elderly by the year 2016 will be around 113 millions (Census of India, 1999). The data clearly reveal that the absolute number of elderly population (60 years and above) is increasing rapidly, and the population is beginning to age (Table 1.2).

Life expectancy in India has almost doubled from 33 years at the time of independence to the present 62 years and India is one of the few countries where the sex ratio is biased favoring males at all ages. But the change now is visible in older age groups where women are out numbering men (Bagga, 1999).

Table – 1.3.

Growth of Elderly Population (60+) by gender, India (millions)

Year	Total population (in millions)	Male (in millions)	Female (in millions)
1901	12.06	5.5	6.56
1911	13.17	6.18	6.99
1921	13.48	6.48	7.00
1931	14.21	6.94	7.27
1941	18.04	8.89	9.15
1951	19.61	9.67	9.94
1961	24.71	12.36	12.35
1971	32.7	16.87	15.83
1981	43.98	22.49	21.49
1991	55.3	28.23	27.07
2001	75.93	38.22	37.71
2011	103.85	51.07	52.78

Source: Ageing in India: occasional paper No.2 of 1991, office of the Registrar General & Census Commissioner, India.

1.2.3. State wise distribution of the Indian Elderly:

Table – 1.4.

States & Union Territories wise Distribution of Elderly Population of India

India and States/ UT	Total Population (N)	N	%
India	1210854977	103849040	8.58
Jammu & Kashmir	12541302	922656	7.36
Himachal Pradesh	6864602	703009	10.24
Punjab	27743338	2865817	10.33
Chandigarh	1055450	67078	6.36
Uttarakhand	10086292	900809	8.93
Haryana	25351462	2193755	8.65
NCT of Delhi	16787941	1147445	6.83
Rajasthan	68548437	5112138	7.46
Uttar Pradesh	199812341	15439904	7.73
Bihar	104099452	7707145	7.40
Sikkim	610577	40752	6.67
Arunachal Pradesh	1383727	63639	4.60
Nagaland	1978502	102726	5.19
Manipur	2855794	200020	7.00
Mizoram	1097206	68628	6.25
Tripura	3673917	289544	7.88
Meghalaya	2966889	138902	4.68
Assam	31205576	2078544	6.66
West Bengal	91276115	7742382	8.48
Jharkhand	32988134	2356678	7.14
Orissa	41974218	3984448	9.49
Chhattisgarh	25545198	2003909	7.84
Madhya Pradesh	72626809	5713316	7.87
Gujarat	60439692	4786559	7.92
Daman & Diu	243247	11361	4.67
Dadra & Nagar Haveli	343709	13892	4.04
Maharashtra	112374333	11106935	9.88
Andhra Pradesh	84580777	8278241	9.79
Karnataka	61095297	5791032	9.48
Goa	1458545	163495	11.21
Lakshadweep	64473	5270	8.17
Kerala	33406061	4193393	12.55
Tamil Nadu	72147030	7509758	10.41
Puducherry	1247953	120436	9.65
Andaman & Nicobar Islands	380581	25424	6.68

Source: Census of India, 2011

Table – 1.5.

Religion wise Distribution of the Indian Elderly

Different Religious Group	Total		Male		Female	
	N	%	N	%	N	%
India	103849040	---	51071872	49.18	52777168	50.82
Hindu	85551029	82.38	42034546	49.13	43516483	50.87
Muslim	11054723	10.64	5542401	50.14	5512322	49.86
Christian	2736402	2.63	1293585	47.27	1442817	52.73
Sikh	2400953	2.31	1221728	50.89	1179225	49.11
Buddhist	795405	0.77	369821	46.49	425584	53.51
Jain	553762	0.53	270300	48.81	283462	51.19
Other including Persuasion	756766	0.73	339491	44.86	417275	55.14

Source: Census of India, 2011

1.2.4. Situation of Aged in India:

1.2.4.1. Social Situation:

Industrialization, urbanization, westernization in countries like India brings change in values and life styles. 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, adoptions of small family norms by a growing number of families, daughters, too are fully occupied. 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 (National Policy for Older Persons, 1999).

It is true that family ties in India are very strong and an over whelming majority live with their sons or are supported 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 people 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, especially in view of the longer life span implying an extended period of dependency and higher costs to meet health and other needs. (Dam et al, 2010).

1.2.4.2. Poverty among the Elderly in India:

India is a poor country, with per capita income being one of the lowest in the world. This poverty is greater in our rural areas. The cities also have their poor living in hutments or pavements. Though the joint family still survives in the rural areas, the chances are that the well being of aged in the indigent families would be sacrificed first. The social planners have to take special note of this possibility. It is also evident from Indian data that 40 per cent of the elderly live below the poverty line and 90 per cent are neither covered by any state pension nor have any family to take care of them (http://medicine.creighton.edu/Projectcure/Poverty%20in%20India.htm). However, still little is known about poverty among the elderly (Deaton and Paxson, 1995; Dreze and Srinivasan, 1997; Pal and Palacious, 2008).

Government of India has some anti-poverty programs particularly for disabled people. Persons with Disabilities Act, 1995 (PWD hereafter) is one of the most important step forward in policy towards disabled people in India. However, World Bank (2007) finds some weaknesses in its design and coverage. Two important limitations are important in our context. One, the act covers only designated types of disability, which are not inclusive of several significant categories of disability (e.g. autism). Second, safety nets for PWD offer low coverage and limited financial protection, for example, the PWD act commits to reservations for PWD of not less than 3 per cent in all poverty alleviation schemes, but it appears that PWD are well below 3 per cent of beneficiaries in all schemes. Also, the new National Rural Employment Guarantee Act (NREGA) has dropped the provision for reservations for disabled people. However, social assistance

cash payments for destitute elderly, widows and PWD is provided by the government through social pension and is one of the most helpful anti-poverty programs operating in recent times. One problem with such programs is the identification of functionally disabled people.

Gore (1992) estimated that about 6 per cent of the poor persons i.e. about 16.3 million persons were above the age of 60 years and pensions. Although current official estimates of poverty among the older people are not available, we can be sure that there are millions of older people below the official poverty line. But, it is important for us to bear in mind, the many limitations of official poverty estimates. Despite the fact that official poverty estimation relies almost completely on monetary sources of income, Census data cover the other aspects such as illiteracy, employment, dependency, living arrangements, and health problems among the elderly.

In general, poverty incidence is lower among households with elderly members than those without. The same trend holds for households with female elderly heads. Interestingly, there is not much difference between the total elderly population and elderly females. Meanwhile, individual poverty incidence is generally higher among the non-elderly than elderly. This implies that older persons contribute to their households in terms of paid and unpaid work (Pal and Palacios, 2008).

1.2.4.3. Illiteracy:

In India, literacy levels have increased between 1961 and 1981 in the general population and in the population aged 60 years and above. In 1981, among the elderly males, only 34.79 per cent were literate as against 46.89 per cent in the overall male population. Among the female elderly, only 7.89 per cent were literate as against 24.82 per cent in the overall female population. Although there seems to be an increasing trend, it is disturbing to note the fact that, in 1981, majority of male and female elderly were remaining illiterate. Moreover, the situation seems to be worse in the case of the

elderly females. During the last decade, the government implemented many literacy programs throughout the country very vigorously. In many parts of the country, many districts have been declared as 100 per cent literate. But, there are no official data regarding the improvement in the literacy level among the older people.

1.2.4.4. Employment:

When we see the data pertaining to the employment of rural and urban older people during the period from 1961 to 1981, there seems to be a marked downward trend. This decline may be due to adoption of new technology or methods of production difficult for the elderly or work conditions have become harder and unsuitable for them. Whatever be the reason, the very fact that more older people are out of the work force shows that there is increasing risk for them to become totally or more economically dependent. It is also important to note that a 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 programme.

1.2.4.5. Dependency:

To obtaining accurate data from older population on their income is difficult. Even if respondents were willing to report incomes, several factors complicate data gathering such as seasonal variations in income, self-employment in agriculture and the extent of informal or non-monetized economy in the country and also the frequent pooling of household resources. The human life cycle begins and ends with stages of dependency, this applies on average to age groups, but not necessarily to individuals so far as old age is concerned. The average shape appears to be universal, although ages and extent of dependency may vary widely from population to population (Martin and Preston, 1994). Majority of the women elderly in both rural (77.51 per cent) and urban (86.04 per cent) areas are totally dependent on others for economic support. Similarly,

16.20 per cent male of the older people in rural areas and 16.90 per cent of the older people in urban areas are partially dependent on others. Elderly people (51.06%) who were nondependent in rural areas and 45.71% in urban areas. The lower rate of total dependency among the older people in the rural areas appears that the rural families are more supportive to the older people. There are many reasons for this phenomenon. In rural areas, there is a greater continuity in the occupational and familial roles of the elderly, particularly among the males. They continue to be active until physical incapacity prevents them from working. Whether a man is self-employed as a cultivator, or an artisan, or is working as a farm laborer, the chances are that he will continue to remain 'employed' longer in the rural areas than in urban areas (Gore, 1992).

Based on indicators on economic dependency and ownership of property and assets as indicators, Rajan (2005) assesses the level of poverty among the elderly from the data set of 60th NSS round (January-June 2004). A question to the elderly under this survey included their economic independence, categorised as (1) "not dependent"; (2) "partially dependent"; and (3) "fully dependent" on others for food, clothing and health care. The data are disaggregated by gender, place of residence and marital status. From these data, it is presumed that the fully dependent elderly live below the poverty line and therefore need economic support. In rural areas, 58.2 per cent of women and 45.0 per cent of men were totally dependent, whereas in urban areas, the corresponding figures were 64.2 per cent and 45.4 per cent. There was thus a marked gender difference, with the most vulnerable being elderly women in urban areas.

1.2.4.6. Health Condition:

In our country rural older people suffer with various health problems such as high blood pressure, heart disease and urinary problems are more common among the elderly in the urban areas. As far as physical disabilities are concerned, in the rural

areas, 5.4 per cent of all the elderly (6.8 per cent females and 4.4 per cent males) are physically disabled while in the urban areas, 5.5 per cent of all the elderly (6.7 per cent females and 4.7 per cent males) are physically disabled. In both rural and urban areas, more females than males are physically disabled (Kohli, 1996). In India, the majority of the population is barely able to live above the poverty line, the most important function that the state performs is to be able to provide to its citizens a good health - it ensures a medical system, which aids people in living a normal life. The problem arises when a large percentage of the older people become handicapped because of health problems. These problems become obstacles in their everyday lives because most problems of the elderly begin with their biological decline; it became essential to lay emphasis on the quality of life of the elderly.

The problems faced by this segment of the population are numerous owing to the social and cultural changes that are taking place within the Indian society. The major area of concern is the health of the elderly with multiple medical and psychological problems. Falls are one of the major problems in older people and are considered one of the "Geriatric Giants". Recurrent falls are an important cause of morbidity and mortality among the older people and are a marker of poor physical and cognitive status (Cummings, 1998).

As India is taking big strides towards industrialization with the consequent urbanization, and revolutionary changes in the socio-economic structure, it would be wise to assess the condition of the aged and the ageing to gauge the nature and proportion of the problems that attend the transformation. Only then we would be able to put the problems in their proper perspective and to find effective means to tackle them. Full and clear grasp of the whole problem is basic to the successful planning in this regard. The growing momentum of the accelerating progress of development is shaking simultaneously from the traditional mooring, all the section of the vast and diverse population of vast land in diverse ways, and leaves a trail of problem in the wake. These problems are big, deep and many and each section insists on the highest

priority and quickest action for the problems that affect it in particular. The tackling of so many big problems means heavy expenditure and the country is too poor to afford it. So the limited resources are by itself a difficult problem.

1.2.5. Provisions for the Welfare of Indian Aged Population:

In the Constitution of India, entry 24 in list III of schedule VII deals with the "Welfare of Labour, including conditions of work, provident funds, liability for workmen's compensation, invalidity and old age pension and maternity benefits. Further, Article 41 of Directive Principles of State Policy has particular relevance to Old Age Social Security. Item No. 9 of the State List and item 20, 23 and 24 of Concurrent List relates to old age pension, social security and social insurance, and economic and social planning. Article 41 of Indian Constitution deals with the State's role in providing social security to the aged persons. According to this article, "the State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in case of unemployment, old age, sickness and disablement and in other cases of undeserved want".

1.2.6. Welfare Approach for the Elderly in Five Year Plans:

The foundation of the welfare was laid down during the Third Five Year Plans. While the First and Second Five Year Plans had provision of social security measures for industrial workers, Third Five Year Plan recognized the needs of the older people, who had no one to support them. But the onus to carry out welfare activities was left to local bodies and voluntary organizations, without any plan allocation. In 1963 the Ministry of Labour made an outlay of Rs.20 million for social assistance programmes aimed at covering the older people and other categories such as the disabled but this was not utilized. Though the draft Fourth Five-Year Plan (1966-70) made a provision for an outlay of Rs.40 million for the benefit of old persons and disable, it remained

unutilized. Consequently, it was dropped from the Fourth Plan. The Fifth Plan recognized the need of having a social security system for the disadvantaged aged and the handicapped but again this was left to the discretion of the state governments. The Fifth Five- Year Plan, was a landmark in the progress towards the formation of a welfare programmes in India due to its special thrust, to make the maximum possible dent reducing poverty and ensuring that the country progresses towards economic independence. The Fifth Plan also recognized the need for having a social security system for the disadvantaged aged and the handicapped. However, this was again left to the discretion of state governments. There was no attempt to consider the problem as such and the concept of Old Age Homes was taken from the developed countries of the West and some grants were given for institutional care of the older people. However, the Sixth Five-Year Plan omitted the issue of caring for the older people altogether.

Ageing and growing awareness on the part of voluntary agencies, Government of India started giving grants to voluntary organizations for carrying out welfare programmes aimed at helping older people. As a consequence, Sixth Five Year Plan first time recognized the aged as a vulnerable group for whom welfare programmes were required. But no central Plan outlay was given and the matter was left to the discretion of the state governments. Again, the Seventh Five Year Plan did not recognize the older people as a separate group, in need of welfare support, but the pattern of grant started in the Sixth Five Year Plan was continued, albeit with no appreciable increase in outlay. From this time onwards, the state governments increased the grants and outlays for the pension given to the older people. Gradually, there was a growing realization that the older people need a care and support system. The notion of social security was sought to be put in place and a host of legislation in various states in subsequent years and few initiatives of the Central government prove this point. The Seventh Finance Commission took an important decision, to make a financial provision in each state to enable the payment of a monthly pension, by way of social security. The Eighth Finance Commission also allowed devolution of resources to the states for old age pensions. In

1983 – 84, Ministry of Welfare started a general grant scheme for the construction of homes for the older people and a plan and outlay was made. By the end of the Seventh Five Year Plan all the states and Union Territories had an old age pension scheme.

1.2.6.1. Strategy adopted by the Ministry of Social Justice & Empowerment:

Developing awareness and providing support to build the capacity of government, NGOs and the community at large to make productive use of older persons and to provide care to older persons in need; Sensitizing children and youth towards older persons; reinforcing the Indian family tradition of providing special care and attention to older persons and organizing older persons themselves into coherent self help groups capable of articulating their rights and interests. Under this scheme financial assistance up to 90 per cent of the project cost is provided to NGOs for establishing and maintaining old age homes, day care centres, and mobile medicare units and for providing non institutional services to older persons.

1.2.6.2. New Act on National Policy for Older Persons:

The Government of India announced a National Policy on Older Persons (NPOP) in January, 1999 under Article 51. This policy provides a broad framework for inter-sectoral collaboration and cooperation both within the government as well as between government and non-governmental agencies. In particular, the policy has identified a number of areas of intervention – financial security, healthcare and nutrition, shelter, education, welfare, protection of life and property etc. for the well being of older persons in the country. Amongst others the policy also recognizes the role of the NGO sector in providing user friendly affordable services to complement the endeavors of the State in this direction. While recognizing the need for promoting productive ageing, the policy also emphasizes the importance of family in providing vital non formal social

security for older persons. To facilitate implementation of the policy, the participation of Panchayati Raj Institutions, State Governments and different Departments of the Government of India is envisaged with coordinating responsibility resting with the Ministry of Social Justice & Empowerment. A National Council for Older Persons (NCOP) has been constituted by the Ministry of Social Justice and Empowerment to functionalize the National Policy on Older Persons.

The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 stipulates construction of at least one Old Age Home in each district of the country to accommodate deserving and destitute senior citizens. In addition to NPOP & Senior Citizen Act various concession, benefits are extended to the older people and incentives include income tax rebate, higher rates of interest in saving schemes, 30% concessions in all railway travel and 50% discount on basic fare for all domestic flights in the economy class in Indian Airlines, Jet Airways and others. A pension of Rs. 200 per month provided and States have been requested to add another Rs. 200/- to this scheme. The Eleventh Plan proposes to further the right-based approach and also focus on bridging the gap between rural and urban areas. A National Association for older persons, as per NPOP, has been set up to protect the life and property by utilizing the services of Panchayats/ Senior Citizens Association and other community – based groups and sensitizing and reorienting the law enforcement machinery to the vulnerability and special protection needs of older persons during Eleventh Plan. The National Old Age Pension schemes have been extended to all BPL persons above the age of 60 years. However, the issue of older persons learning has not been given any importance in the government policies and programs.

SECTION-III

1.3.1. Situation of Muslim Elderly in India:

Islam is the second largest religion in India, with 14.23% of the country's population or roughly 172 million people (2011 census) and falls under Minority group in respect of Religion. However, in India altogether six religious communities (like Muslims, Christians, Sikhs, Buddhists, Jains and Other groups or Sects including Persuasion) are considered as 'Minority Religious Groups', as their number when compared to that of Hindus in India as a whole, is observed to be less than 20 percent. Hence, the Section 2(c) of the National Commission for Minorities Act, 1992 of India recognizes the above mentioned religious groups as 'Minority communities'. Among the minority communities Muslims are the largest group (60.41%) than others. They are not only the largest minority community, but their presence is visible in all the states and union territories.

India's Muslim population is amongst the largest in the world, exceeded only by Indonesia's and close to the Muslim populations of Pakistan and Bangladesh (Prime Minister's High Level Committee, 2006). Though Muslim population has increased in India from 47 million in 1961 to 172 million in 2011, it has risen by less than one percent point a decade during the above four decades. As a result, Muslims are also well into the demographic transition. The role of migration in the overall growth of the Muslim population in India is observed to be very small. In respect of India’s total aged population Muslim elderly share 10.64 per cent. On the other hand, this minority section of aged population of India holds only 6.42 per cent out of the total Muslim elderly. Whereas, in case of West Bengal, among the total state aged population Muslims are share 19.38% and out of the total state Muslim population they also share 6.09% respectively.

Table – 1.6.

State and UT wise Distribution of Elderly Muslim Population

India and States/UT	Population		Muslim Population		Percentage of Muslim Elderly	
	Total	Elderly	Total	Elderly	Against Total Elderly	Against Total Muslim
India	1210854977	103849040	172245158	11054723	10.64	6.42
Jammu & Kashmir	12541302	922656	8567485	593139	64.29	6.92
Himachal Pradesh	6864602	703009	149881	9537	1.36	6.36
Punjab	27743338	2865817	535489	37213	1.30	6.95
Chandigarh	1055450	67078	51447	1690	2.52	3.28
Uttarakhand	10086292	900809	1406825	75806	8.42	5.39
Haryana	25351462	2193755	1781342	98752	4.50	5.54
NCT of Delhi	16787941	1147445	2158684	92034	8.02	4.26
Rajasthan	68548437	5112138	6215377	361074	7.06	5.81
Uttar Pradesh	199812341	15439904	38483967	2351901	15.23	6.11
Bihar	104099452	7707145	17557809	1087539	14.11	6.19
Sikkim	610577	40752	9867	228	0.56	2.31
Arunachal Pradesh	1383727	63639	27045	588	0.92	2.17
Nagaland	1978502	102726	48963	1208	1.18	2.47
Manipur	2855794	200020	239836	10829	5.41	4.52
Mizoram	1097206	68628	14832	426	0.62	2.87
Tripura	3673917	289544	316042	18177	6.28	5.75
Meghalaya	2966889	138902	130399	5315	3.83	4.08
Assam	31205576	2078544	10679305	576357	27.73	5.40
West Bengal	91276115	7742382	24654825	1500694	19.38	6.09
Jharkhand	32988134	2356678	4793994	288342	12.24	6.01
Orissa	41974218	3984448	911670	62071	1.56	6.81
Chhattisgarh	25545198	2003909	514998	34989	1.75	6.79
Madhya Pradesh	72626809	5713316	4774695	327672	5.74	6.86
Gujarat	60439692	4786559	5846761	39909	0.83	0.68
Daman & Diu	243247	11361	19277	1076	9.47	5.58
Dadra & Nagar Haveli	343709	13892	12922	441	3.17	3.41
Maharashtra	112374333	11106935	12971152	928633	8.36	7.16
Andhra Pradesh	84580777	8278241	8082412	564122	6.81	6.98
Karnataka	61095297	5791032	7893065	541174	9.35	6.86
Goa	1458545	163495	121564	6978	4.27	5.74
Lakshadweep	64473	5270	62268	5240	99.43	8.42
Kerala	33406061	4193393	8873472	725059	17.29	8.17
Tamil Nadu	72147030	7509758	42294779	337657	4.50	0.80
Puducherry	1247953	120436	75556	6776	5.63	8.97
Andaman & Nicobar Islands	380581	25424	32413	1977	7.78	6.10

Source: Census of India, 2011

Table – 1.7.

Districts wise distribution of Elderly Population of West Bengal

West Bengal and Districts	Total Population (N)	Elderly Population	
		N	%
West Bengal	91276115	7742382	8.48
Darjiling	1846823	141340	7.65
Jalpaiguri	3872846	266742	6.89
Koch Bihar	2819086	216262	7.67
Uttar Dinajpur	3007134	188891	6.28
Dakshin Dinajpur	1676276	133981	7.99
Maldah	3988845	254614	6.38
Murshidabad	7103807	499966	7.04
Birbhum	3502404	256874	7.33
Bardhaman	7717563	625691	8.11
Nadia	5167600	485962	9.40
North 24 Parganas	10009781	993575	9.93
Hugli	5519145	542164	9.82
Bankura	3596674	333826	9.28
Puruliya	2930115	254942	8.70
Haora	4850029	427135	8.81
Kolkata	4496694	529154	11.77
South 24 Parganas	8161961	641923	7.86
Paschim Medinipur	5913457	507320	8.58
Purba Medinipur	5095875	442020	8.67

Source: Census of India, 2011

Table – 1.8.

District wise Distribution of Elderly Muslim Population of West Bengal

West Bengal and Districts	Total Population (N)		Muslim Population (N)		Percentage (%) of Muslim Elderly	
	Total	Elderly	Total	Elderly	Against Total Elderly Population	Against Total Muslim Population
West Bengal	91276115	7742382	24654825	1500694	19.38	6.09
Darjiling	1846823	141340	105086	4758	3.37	4.53
Jalpaiguri	3872846	266742	445817	23556	8.83	5.28
Koch Bihar	2819086	216262	720033	45571	21.07	6.33
Uttar Dinajpur	3007134	188891	1501170	81030	42.90	5.40
Dakshin Dinajpur	1676276	133981	412788	25831	19.28	6.26
Maldah	3988845	254614	2045151	115430	45.34	5.64
Murshidabad	7103807	499966	4707573	295051	59.01	6.27
Birbhum	3502404	256874	1298054	78619	30.61	6.06
Bardhaman	7717563	625691	1599764	103259	16.50	6.45
Nadia	5167600	485962	1382682	99294	20.43	7.18
North 24 Parganas	10009781	993575	2584684	166844	16.79	6.46
Hugli	5519145	542164	870204	61454	11.33	7.06
Bankura	3596674	333826	290450	18000	5.39	6.20
Puruliya	2930115	254942	227249	13481	5.29	5.93
Haora	4850029	427135	1270641	70336	16.47	5.54
Kolkata	4496694	529154	926414	56816	10.74	6.13
South 24 Parganas	8161961	641923	2903075	159735	24.88	5.50
Paschim Medinipur	5913457	507320	620554	36506	7.20	5.88
Purba Medinipur	5095875	442020	743436	45123	10.21	6.07

Source: Census of India, 2011

This largest religious minority community is seriously lagging behind in terms of most of the human development indicators. While the perception of deprivation is widespread among Muslims, there has been no systematic effort since independence to analyse the condition of religious minorities in the country (Sachar Committee Report, 2006). Among all the religious communities, Muslims are the most socio-economically underdeveloped and politically under-representative community in Indian society, as the paper shall attempt to show. It has been noted that the underprivileged sections of this numerically significant minority group has not received social and political support from the state, if their position is compared with their counter part in the Hindu

community (Dasgupta, 2009). The poor situation of Muslims is similar in various Indian states except southern region comparatively.

Nonetheless, discrimination, social stagnation and educational marginalization have cumulatively resulted in growing economic backwardness of the Muslims in large parts of the country (Sikand, 2006). For the first time, the data on Muslims socio-economic indicators have been released by National Sample Survey Organisation (NSSO) through its 43 round survey conducting during 1987-1988. The analyzed state wise data reveals us that the presentation of Muslims are poor in most of the socio-economic indicators like literacy, work participation rate, land ownership, government jobs and school continuation rate (Shariff,1995, Kuran and Singh, 2010). In case of West Bengal, Muslims are at disadvantage position in terms of physical and infrastructure facilities even where they constitute the majority population of a district (Alam, 2009).

The Muslims living in West Bengal are poor and deprived instead of their rich history in pre-partition period. Muslims ruled Bengal for 500 years and more in pre-partition period but today they are under-privileged community in the state. They are educationally most backward, economically poor and politically a powerless community of the country in general and of West Bengal in particular (Mainuddin, 2008 and Hussain, 2009). Although they constitute 25 per cent of the total population of the state, yet no political party and religious leaders are known to have taken active interest in the social, economic and educational progress of the community and ensuring them safety and security (Dasgupta, 2009). However, of late, some exclusionary state policies are drawing lines between the majority and the minority communities. This is one of the factors that led to the marginalization of Muslims in West Bengal (Dasgupta, 2009). There is persistent under-representation of Muslims in central and state legislature (Hasan, 2009). The state government did not pay adequate attention to economic problems Muslims that became a cause for their alienation. There is a marked scarcity of sociological inquiry on the Muslim community in the state of West Bengal (Moinuddin,

2000). Moreover, no sociological inquiry has been made on Muslims to analyze the socio-economic and their political representation as a whole.

1.3.2. Social Status of Elderly in Muslim Society:

From the preceding paragraphs broadly two sets of information are being found. First one is that the rapid growth of Muslim population and the next is that among the religious minority communities of India are suffering from multiple problems. Overall, not only the Muslim population is increasing but longevity also growing rapidly likes other communities. Due to the increase of life span, simultaneously the absolute numbers of elderly are escalating fast. So, a large number of Muslim elderly are greatly affected by multiple disorders for long times, economic dependency etc. Impact of modern trend of family orientation i.e. nuclearization of family, loss of social value from family members or society, high household expenditure etc. are aggravate the situation of elderly. But responsibilities or duties of the children towards their parents are also prescribed in the holy sacred texts (Quran, Hadith) of Muslim.

In Islam, it is not enough that the children only pray for their parents, but they should act with limitless compassion for their great effort to nurture them, especially mothers are particularly honored. When Muslim parents reach old age, they are treated mercifully, with kindness and selflessness. In Islam (The Qura'nic provisions), serving one's parents is a necessary duty and it is the right of the parents to expect it because of their life experiences, wisdom and hierarchical position within the family unit. Children are valued because they provide parents with a higher social status, a purpose in life, and connectedness within the family system. Children are socialized to obey their parents, respect their elders, be loyal to their family, and demonstrate devotion to their parents (Ahmed, 2009). Conventionally, the Muslim family organization is comprehensive rather than nuclear as extended family members may or may not occupy and reside in a common residential unit

(Mahmood, 1989). Within the intergenerational roles prescribed by Islamic theory, older people have a place of honour in which the 'security, protection, and comfort' of the elderly are 'guaranteed by the behavioural norms and obligations' placed on younger members of the family. However, Muslim elderly in many cases are not beneficiary of such norms.

In the Islamic world the strain of caring for one's parents during their most difficult time of their lives in the old age is considered as an honor and a blessing as well as an opportunity for great spiritual growth. Similarly, in the Hadith, the Prophet (peace and blessings be upon him) considered respecting the elderly a way to show reverence for the almighty. He (peace and blessings be upon him) linked reverence for the Creator and his creatures with veneration of the all-powerful and the weak elderly. The Hadith implies all kinds of respect and care for the elderly: Health care, psychological care, social care, economic care, ending illiteracy, providing education and other forms of care that the international community calls for today. As a result, in Indian scenario it is found that the family members especially children of senior citizens do not protect them from all sort of necessities when required though the religious texts prescribed such duties of children.

SECTION-IV

1.4.1. Context of the Present Study:

First gerontological researches in India were started by Prof. P.V. Ramamurti in the early 1960s. The major aim of his research was to find out the specific psychological problems faced by the elderly people after their retirement.

In the late 1960s Prof. H.D. Marulassidiah started his research work among the old peoples of Makunti village (district Dharwar, Karnataka). The major emphasis of his research was to understand the influence of urbanization on older person.

In the early 1970s a group of social scientist from Tata Institute of Social Sciences (TISS) conducted research on the pensioner of Bombay. Their major aim was to understand the problems of pensioner of greater Bombay.

Since the 1970s, Gerontological writing in India has been dominated by a powerful and seldom challenged narrative of the decline of the Indian joint family and the consequent emergence of old age as a time of difficulty (Biswas, 1987; Bose and Gangrade, 1988; Desai, 1982; Mishra, 1989; Pati and Jena, 1989; Sharma and Dak, 1987; Sinha, 1989; Soodan, 1975). The annotated bibliography published in two volumes by the Tata Institute of Social Sciences, Mumbai (Elderly in India, compelled by Malini Karkal, 2000) containing abstracts of more than 2000 references of books, research article, M.A. /M.Sc., M.Phil. and Ph.D. dissertation also reveals the middle class bias of the researchers on aged population of India.

There are very few studies in India exclusively or partially among the Muslim elderly (Joshi et al, 2003; Deka et al, 2011; Mainuddin, 2011; Balamurugan et al, 2012; Kamble et al, 2012; Dolai et al, 2013; Thakur et al, 2013; Agarwal et al, 2015; Dutta et al, 2015; Rana et al, 2016) on various aspects like socio-economic conditions, living status, health etc.

From the above discussion it is revealed that most of the gerontological studies in India were limited to a particular aspect of non-Muslim elderly and mainly focused on urban aged. In fact, the present researcher is tempted to state that gerontological studies

in West Bengal are scanty (Mainuddin, 2011; Dolai et al, 2013). It is also revealed from the literature mentioned above that while dealing with a single or even multiple aspects of the non-Muslim elderly and they have very little or no attention towards the various aspects of such non-Muslim elderly residing in rural setting. However, the present researcher reiterates that due to time bound Ph.D. programme he could not extensively traverse the available literature on social gerontological research.

1.4.2. Background of the Present Study:

From the discussions in the preceding paragraphs it is revealed that most of the researcher in India, while dealing with the problems of the elderly, were respectively limited to a particular aspect like socio-economic state of affairs, physical health, psychological milieu, Governmental welfare measures etc. of the elderly. However, most of these gerontological studies were limited to the urban areas and a very few of them dealt with the situation of the Muslim elderly persons.

The present researcher is tempted to state that compared to other state of India the gerontological researches in West Bengal are very scanty and in most cases the studies were carried out among the non-Muslim elderly living in urban areas. In fact it may not be an exaggeration to state that while dealing with the aspects of the old age, the scholars of gerontology in West Bengal paid little attention on the Muslim elderly residing in rural areas of West Bengal.

Therefore, the present study is aimed to focus on the multiple aspects viz. socio-economic status, living conditions, social adjustment, social security measures, health status etc. of the Muslim elderly people residing in the rural areas of West Bengal.

In this context it may be mentioned that the endeavor of the present researcher was financially supported by the University Grants Commission (UGC) by way of awarding him UGC Moulana Azad National Fellowship (MANF) after considering the research proposal submitted by the present scholar during the year 2010-11.

1.4.3. Objectives of the Study:

In view of the above situation the present researcher, who himself is a Muslim by faith and permanent resident of a remote village, carried out his social gerontological studies among the Muslims elderly living in the rural areas under a particular Community Development (CD) Block of West Bengal with the objectives to:

1. Study on different aspects related to the family structure, education, occupation, economic pursuits, financial resources etc. of the population under the present study.

2. Study on different aspects related to the housing, food habit, health, medical care etc. of the elderly people under study.

3. Study on different aspects related to the leisure and recreation, pilgrimage etc. of the elderly people under study.

4. Study on different aspects related to the socio-cultural problems faced by the studied population owing to the urbanization, industrialization, modernization etc.

1.4.4. Significance of the present Study:

The present study have assessed the state of affairs of the family structure, education, occupation, economic pursuits, financial resources, housing, food habit, health, medical care, leisure and recreation etc. of the Muslim rural elderly of West Bengal. Therefore, findings of the present study have obvious significance since there are minimum empirical research and data on the Muslim elderly residing in rural areas of West Bengal, India. Furthermore, the research study will help the policy makers working in Government and Non-Government organizations to build up new policies for the welfare of all the elderly across the religion residing in the rural areas of the country.

CHAPTER-2

REVIEW OF LITERATURE

It has been observed that outpouring of literature on gerontology is related with the world wide increase of percentage of elderly population. Today it is found that there are innumerable publications on various aspects of aging. However, it is not possible to traverse all those literatures since the range and volume of such researches either in India or abroad are wide in terms of the topics as well as locality of study and enormous in terms of the volumes of study. Therefore, it is not possible at this juncture to present an extensive review of literature on different aspects of gerontology. However, in the following paragraphs the present researcher will consider those literatures for review which, as per his perception, are relevant to his present thesis.

2.1. A Brief Note on Global Scenario:

In the Western countries systematic approaches to the study of ageing began with research on biological and psychological aspects, followed by studies of behavioral and social phenomena. The advancement of the study on ageing has been most rapid since the late 1930s, when those biological scientist interested in time related changes in living cells, tissues, and physiological mechanisms gave impetus to the development of a gerontological science through the formation of mutual interest groups (Tibbitts, 1960).

A good number of studies of social and economic aspect of aging were made during the 1920s, 1930s, and early 1940s, but these were almost entirely in the nature of inventories, surveys and observational researches designed to aid in the immediate solution of practical problems (Ibid 1960).

Systematic approaches to the study of aging began with research on biological and psychological aspects, followed by studies of behavioral and social phenomena. The advancement of the study on aging has been most rapid since the late 1930s, when those biological scientist interested in time related changes in living cells, tissues, and physiological mechanisms gave impetus to the developmental of a gerontological science through the formation of mutual interest groups (ibid).

During the 1930's Leo W. Simmons did his doctoral dissertation on the aged in primitive societies. His monumental book entitled "The *Role of the Aged in Primitive Society*" appeared in 1945 and set the stage for evaluating the effects on the aged of the transition from agrarian to industrial cultures. In 1940 Landis completed his pioneering study, "Attitudes and Adjustments of Aged Rural People in Iowa," and others began to report studies of personal adjustment of older persons, primarily in institutions (ibid).

Linda G. Martin (1989) published a study on living arrangements of the elderly in Fiji, Korea, Malaysia, and the Philippines. Using logi techniques and data from surveys of the elderly conducted in 1984 under the auspices of the World Health Organization, the article reflects the investigations on socioeconomic, cultural, and demographic determinants of living arrangements of the elderly. The study shows that having a spouse or children to live with has important effects on living arrangements. The results provide only weak support, however, for hypotheses based on modernization theory and point to the need for detailed data on transitions in living arrangements and for information about the younger generation as well as the older generation, both of which are involved in deciding who lives with whom.

Mutchler et al. (1992) published their study on the living arrangements of unmarried elderly Hispanic females in US. The authors tried to examine the influence of cultural preferences on living arrangements for a sample of older unmarried Hispanic and non-Hispanic white females. The authors developed a conceptual framework composed of three sets of factors: availability of kin, economic and health

feasibility, and cultural desirability. Their analysis show that household living arrangements among Hispanic and non-Hispanic females were more similar when the authors control for these three sets of factors, and that cultural desirability factors were particularly important. The likelihood that elderly Hispanic females will reside in an institution is actually decreased, however, when the authors made control for these factors; the finding suggests a strong reluctance among Hispanics to use formal long-term care facilities.

Goldman et al. (1995) published a paper on the basis of a study they carried out in US on marital status and health among the elderly. Their study employed data from the Longitudinal Study of Aging (1984–1990) to explore whether marital status continues to exert any influence on health and mortality at the older ages. In the presence of an extensive set of controls for health status at the baseline survey, a series of logistic models were used to determine the (i) magnitude of effects of marital status on disability and on mortality among older males and older females; and the (ii) extent to which the social environment and economic status of the elderly can account for the existing disability and mortality differences by marital status.

John W. Lynch et al. (1997) published their study on the cumulative impact of sustained economic hardship on physical, cognitive, psychological and social functioning. Their analyses were based on 1081 and 1124 participants (median age, 65 years in 1994). It was revealed from their study that sustained economic hardship leads to poorer physical, psychological and cognitive functioning.

Nina Rautio et al. (2001) published their research carried out on the association of socio-economic factors with physical and mental capacity among the elderly men and women. This study explored the associations of socio-economic factors with physical and mental capacity as measured in laboratory tests and on the basis of self-report. The data were drawn from the Evergreen project, comprising all persons aged 75 (N=388) and 80 (N=291) in Jyvaskyla, central Finland. Women with a higher level of education

showed better functional capacity on all indicators, among men higher education was only associated with better vital capacity and cognitive capacity. Better perceived financial situation was associated with better functional capacity in both men and women. The association between socio-economic factors and functional capacity exists even when the numbers of chronic diseases are controlled. The results lend support to the assumption that socio-economic factors are associated with physical and mental capacity among the elderly people.

Grundy and Sloggett (2003) published a paper about the role of personal capital, social resources and socio-economic circumstances on the health inequalities among the older population. In their paper, they used data from three rounds of the Health Survey in England. A large nationally representative sample were used to analyze variations in the health of adults aged 65–84 by indicators of attributes acquired in childhood and young adulthood, termed as personal capital. Current social resources and current socio-economic circumstances were also considered while controlling for smoking behavior and age. The authors used six indicators of health status in the analysis, four based on self-reports and two based on nurse collected data, which they hypothesized would identify different dimensions of health. Results showed that socio-economic indicators, particularly receipt of income support (a marker of poverty) were most consistently associated with raised odds of poor health outcomes. Associations between marital status and health were in some cases not in the expected direction. Analysis of deviance showed that social resources (marital status and social support) had the greatest effect on the indicator of psychological health (GHQ) and also contributed significantly to variation in self-rated health. Their results are consistent with the view that self-rated health may provide a holistic indicator of health in the sense of well-being whereas; measures such as taking prescribed medications may be more indicative of specific morbidities. The results emphasized again the need to consider both socio-economic and socio-psychological influences on later life health.

Beydoun and Popkin (2005) published a study carried out by them on the impact of socio-economic factors on decline of functional status among community-dwelling older adults in China. The purpose of the study was to examine the impact of baseline socio-economic factors on decline of functional status over a period of 3 years among a sample of Chinese older men and women, using the China Health and Nutrition Surveys of 1997 and 2000. The study also tried to determine whether risk differentials by these socio-economic factors can be explained by other demographic, health-related and nutritional risk factors. The eligible study population was defined as women and men aged 55 years and over who at baseline were free from any form of disablement in Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADL) tasks. Among subjects with complete data at followed-up (*N*=976), the overall incidence proportions of any functional status decline, IADL only and ADL declines were 25.8%, 18.9% and 6.9%, respectively. The study found that education is strongly and inversely associated with incidence of combined functional status decline and IADL only but not with the onset of ADL disability. Similarly, household income per capita was inversely associated with declined functional status and IADL disability incidence, with a clear dose–response relationship, even after adjustment for age and gender. However, multivariate analysis demonstrated that the latter association was highly confounded by other demographic factors, especially urban–rural area of residence. Using a combined measure of socio-economic status that includes years of education and household income per capita, the age and gender-adjusted odds ratio for functional status decline and belonging to lower socio economic status (SES) class as compared to middle, upper middle and upper classes was 3.82 (95% CI: 2.15, 6.77) and 2.77 (95% CI: 1.52, 5.03) after further adjustment for urban–rural area of residence and living arrangements. Hence, there are wide socio-economic disparities in the functional health of older adults in China, although such disparities are seen more in case of IADL decline and are almost exclusively attributed to differentials in educational attainment.

Strine et al. (2008) made a publication based on their research on the associations between life satisfaction and health-related quality of life, chronic illness, and health behaviors among U.S. community-dwelling adults. The primary purpose of their study was to examine the associations between life satisfaction level and Health-Related Quality Of Life (HRQOL), chronic illness, and adverse health behaviors among adults in the U.S. and its territories. Data were obtained from the 2005 Behavioral Risk Factor Surveillance System, an ongoing, state-based, random-digit telephone survey of the no institutionalized U.S. population aged ≥18 years. An estimated 5.6% of U.S. adults (about 12 million) reported that they were dissatisfied or very dissatisfied with their lives. As the level of life satisfaction decreased, the prevalence of fair or poor general health, disability, and infrequent social support increased as did the mean number of days in the past 30 days of physical distress, mental distress, activity limitation, depressive symptoms, anxiety symptoms, sleep insufficiency, and pain. The prevalence of smoking, obesity, physical inactivity, and heavy drinking also increased with decreasing level of life satisfaction. Moreover, adults with chronic illnesses were significantly more likely than those without the report of life dissatisfaction. Notably, all of these associations remained significant after adjusting for socio-demographic characteristics. The findings of the authors showed that HRQOL and health risk behaviors varied with level of life satisfaction.

Lee and Marie (2010) published a paper on the rural-urban differences among the elderly taking in to consideration of economic, social, and subjective factors. Their study was primarily the review of previous research on differences between elderly persons respectively residing in urban and rural locations in USA. While the urban elderly have demonstrable advantages in terms of many "objective" indicators of quality of life, they appear to have no corresponding advantage in terms of subjective or emotional well-being, and perhaps even show a small disadvantage on such dimensions.

Bassuk et al. (2010) published their study on socioeconomic status and mortality among the elderly of four US communities. Data were obtained from four population-

based studies that enrolled elderly residents of four US communities (East Boston, Massachusetts; New Haven, Connecticut; East-central Iowa; and the Piedmont region of North Carolina) and followed them for 9 years starting from 1986. Higher socio economic status (SES), whether measured by education, by household income, or by occupational prestige, was generally associated with lower mortality. However, the pattern of findings varied by gender and by community. For men, all three SES indicators were associated with mortality in the majority of cohorts. For women, this was true only for income. SES-mortality associations were attenuated but not eliminated after adjustment for behavior and health status. SES-mortality associations were stronger in New Haven and North Carolina than in East Boston and Iowa. The latter communities are more homogeneous with respect to ethnicity, urbanization, and occupational history than the former. The findings of the study also suggest that it is important to consider not only individual characteristics but also community attributes that mediate or modify the pathways through which socioeconomic conditions may influence health.

A study conducted by Azaiza et al. (2010) among the elderly Arab Muslims of Israel on death and dying anxiety. The study includes total 145 aged Muslim people among whom 80 were residing in their communities and remaining 65 were living in nursing homes. The information was collected based on Self Esteem Scale (SES), Social Support Scale (SSS) and Death and Dying Anxiety Scale (DDAS). From the study it is revealed that nursing home residents reported higher death anxiety than other group; women and illiterate aged participants reported greater level of fear of death and dying than others. The study also shows that additionally, social supports and self-esteem were correlates with death anxiety for those living in nursing homes.

Strauss et al. (2010) made publication on the basis of research work on health outcomes and socio-economic status among the elderly in China. The authors were concerned with measuring health outcomes among the elderly in Zhejiang and Gansu provinces, China, and examining the relationships between different dimensions of

health status and measures of socio-economic status (SES). The authors also examined correlations between these health outcomes and two important indicators of SES: *education* and *per capita expenditure*. In general, education tends to be positively correlated with better health outcomes, as it is in other countries. However, unmeasured community influences turn out to be highly important, much more so than one usually finds in other countries. The authors also found a large degree of under-diagnosis of hypertension, a major health problems that afflicts the aged. This implies that the current health system is not well prepared to address the rapid aging of the Chinese population, at least not in Gansu and Zhejiang.

Alam et al. (2011) published their research work on household food security and nutritional status of the rural elderly in Bangladesh. The study reveals that, majority of the respondents was illiterate (68.6%), and 92% were Muslims. Mean family size and monthly family income was estimated at 5.5 and Taka 6106 respectively and 70% of the elderly were found to be dependent on their family members. Among the respondents 56% were underweight, 5.9% were overweight. Smoking, lower family income, poor housing, single family, irregularity in treatment were significant factors responsible with underweight.

Sultana (2011) conducted a study among elderly Muslim women of Bangladesh to find out their level of poverty, social vulnerability, expectations, health related and psychological problems, lifestyle and their role as well as acceptance in family. It is revealed that among the study population majority are illiterate, widow and not receiving health care facilities from governmental institution. They are suffering from various chronic diseases and mental disorders. Whereas, poverty takes a vital role in the life of the elderly, they expected to lead a happy old age with kins and neighbors.

Sooki et al. (2011) published their study on role of Quran recitation in mental health of the elderly and in this study had tried to identify the prognostic factors of mental health in elderly resided in geriatric centers. The present study was conducted

on 56 elderly residing in the Golabchi nursing home of Kashan in Iran. The present study reached the conclusion that providing the necessary facilities for religious activities in the nursing home helps the promotion of mental health of the elderly during their stay in the nursing home.

Baraz et al. (2012) published their study on the effect of self-care educational program on the quality of life of elderly people in Ahvaz, Iran. The aim of this study was to determine the effect of self-care educational program on quality of life of the elderly of Ahvaz in Iran during 2010. The authors believe that the most important and necessary requirements for the quality of life of the Iranian elderly relate to family and social issues. Therefore, programs targeting requirements such as rehabilitation centers, financial support systems, social security, treatment insurance, etc. should be implemented accordingly by governmental organizations. Also, family environment problems for those who live with their families should be solved through appropriate educational programmes for family members. Periodic programs should be carried out for nursing home workers to reinforce the need for an increase in the level of providing care and quality of life for the elderly.

Islam & Nath (2012) published their study on a future journey to the elderly support in Bangladesh and the study tries to show the future path of demographic support capacity for the elderly based on secondary (1981-2001) and projected (2011-2071) data. In concluding part, the authors stated that this study considers the future journey of the elderly support capacity with economic and carrying aspect. From the demographic point of view, elderly persons will face the problem of financial and nursing support. This familial support for the elderly may not be available due to lack of economic solvency of the society. The women empowerment of the country is increasing, and their participation in the working sector is rising day by day. The ongoing process of forming nuclear family will add more pressure on the elderly support system. These types of social changing along with the economic hardship will be serious threat to the elderly support system of Bangladesh. It is the high time to think

about it and to take long-term sustainable ageing policies to face the future problem. This policy may be taken phase by phase with the inclusion of this issue in the countries five year planning.

Minhat et al. (2014) published their study on the Malay ethnic elderly in Malaysia and this study aimed to explore the determinants of leisure participation among the Malay ethnic elderly in Malaysia. The study was conducted among 192 Malay ethnic elderly who were purposively selected from four different districts in the state of Selangor. The findings of the study suggest that the Malay ethnic elderly were more involved in social and cognitive activities during their leisure time. At the same time they were also found to have participating sedentary life style instead of participating in physical type of recreational activities. The study also revealed that although majority of the elderly involved in this study perceived that they received higher social support from family members, the social support received from friends was found to be the main and strongest predicting factor for leisure participation among them. Thus, the study indicates the needs to emphasize and focus on social interactions between the elderly in any health intervention programmes and activities in order to develop a more active and healthier senior citizen. This element should be integrated specially to the involvement of elderly in recreational physical activity.

Minhat (2014) also published his study on the reasons behind the frequent engagement of the Malay elderly female in religious activities during leisure. This study explored factors that could passively contribute to the higher involvement in religious activity among the Malay ethnic elderly in Malaysia. To a certain extent the findings from this study provide a local view on the factors that contribute to the high level of involvement in religious activities among the female elderly in Malaysia. Knowing the spiritual and social benefits that can be gained from participating in such activities, elderly should not be constrained from actively involved in religious activities, but to encourage them to specially involve in the sociable religious activities. At the same time, they should also be encouraged to diversify their leisure participation.

In a study comparing the effectiveness of four sources of social support; friends, children, family, and spouses, it was found that friends and spouses rank highest in value as a perceived source of social support (Dean, Kolody, and Wood, 1990). Children were viewed as being less significant sources of support and other relatives had very little effect on the depressive symptoms of the elderly (Dean et al, 1990). The researchers do address that if the survey were conducted using only elderly individuals with some illness or serious physical impairment, the results could turn out quite differently. Often in cases of sickness, it is the family and children that will step in to care for older adults before other elderly friends (Dean et al, 1990).

The relationship between living arrangement and social adjustment among a sample of 258 elderly Indo-Chinese refugees aged 55 years and above in the United States was examined by Tran (1991). The findings revealed that the elderly who lived within the nuclear or joint family had a better sense of social adjustment than those living outside family context.

In a study made in 1994 by Henry found that social disengagement occurs during old age. The marital dissolution of the senior citizens also has a strong bearing on their socio-economic well-being. It is frequently reported that married persons tend to enjoy higher social participation compared with unmarried ones and widows/ widowers.

2.2. A Brief Note on Indian Scenario:

Gerontological research in India was first initiated by Prof. P.V. Ramamurti in the early 1960s. The major aim of his research was to find out the specific psychological problems faced by the elderly people after their retirement.

In the late 1960s Prof. H.D. Marulassidiah started his research work among the old peoples of Makunti village (district Dharwar, Karnataka). The major emphasis of his

research was to understand the influence of urbanization on older person. This research work was published in the form of a book.

Bose et al. (1964) published their study on the aged population in rural society. In this study the age and sex composition, marital status, household characteristics and economic status of the aged population have been analyzed.

Since the 1970s, gerontological writing in India has been dominated by a powerful and seldom challenged narrative of the decline of the Indian joint family and the consequent emergence of old age as a time of difficulty (Cohen 2003). According to Cohen, the scholars whose name deserve special mention in this regard are namely Soodan (1975), Desai (1982), Biswas (1987), Sharma and Dak (1987), Bose and Gangrade (1988), Mishra (1989), Pati and Jena (1989), Sinha (1989).

Purohit and Sharma (1972) in their study showed that in terms of average number of diseases, aged females were a better off than the aged males. Pathak (1975) estimated that elderly, even from middle and upper strata of society, suffered from multiple disorders.

Anantharaman (1979) published a paper on his study among old men of Bangalore city to find out the relationship between activity and adjustment in old age. The author made an attempt to see whether old persons are better adjusted if they are actively engaged in some activities.

Anantharaman (1981) made a publication on the study carried out on physical health and adjustment in old age in Bangalore city. In his study an attempt was made to find out the self-rating of one's physical health, number of physical problems and their adjustment. A sample of 172 older men was interviewed in Bangalore City and their age ranged from 55 to 89 years.

Sengupta and Chakraborty (1982) reported in a research article that in Calcutta more than three fourth of the old people suffered from more than one ailment.

Biswas (1985) made a publication of the study he conducted on dependency and family care of the aged in a village of eastern India to understand in time perspective the specific nature of dependency and family care to the aged.

Punia et al. (1987) published on the problems of the aged from the perspective of rural-urban differentials. The study was conducted in Hissar district of Haryana where 130 aged persons from Hissar city and 230 persons from 23 villages were selected for interview. The study found that the aged in rural and urban areas differed in education, occupation and family income. It was also found that headship of the family was no more with the aged.

Dak et al. (1987) published an article on changing status of the aged in north Indian villages. The study compared the findings of two studies conducted in two villages in Punjab in 1962-63 with another two studies in two villages in Hariyana conducted in 1981 and 1984. The authors conclude that there is a close parallel between the conditions of the aged in the two studies and there was an erosion of the status of the aged in both. The villages were agriculturalists and not much affected by urbanization and yet the position of the aged was "precarious" and this was in spite of improvement of the economic condition.

Anantharaman (1990) published a research paper based on the study carried out among the elderly of the then Madras city in order to explore the factors associated with optimism in one's physical health. It is found that the senior citizens who evaluated their health to be good were found to be active, had professional and post-graduate education, and belonged to professional occupations. They also belonged to upper social class than the other who consider their health to be poor.

Bambawale (1993) made a publication on the basis of a study carried out on ageing and the economic factor in later life among the elderly women of Pune City in Maharashtra. For the purpose of the study ten percent of the total women in an area in a municipal ward in Pune were interviewed to find about their lifestyle and socio-economic position after 60 years and above age. Income distribution process in the household, ways of coping with life situation, work participation and dependence on children were taken in to consideration for study.

Chaudhuri (1993) made a publication on the basis of the study on some gerontological problems in North-East India with special reference to Arunachal Pradesh. In this study importance was given to find out the status of the old person in the tribal societies of Arunachal Pradesh. The study discusses the health hazards and the use of medical plants by the aged persons of Arunachal Pradesh. The data relating to this aspect were collected from the Idu Mishmi of Dibang Valley, Wancho of Triap district and Miji of West Kameng district of Arunachal Pradesh. The study also revealed that the aged people under study hardly faced any psychological depression.

Bagga (1994) published about her study on health status of women in old age homes in Maharashtra. The study revealed that the elderly woman inmates of the studied old age homes have the most common complain of blood pressure variation (52.23%) followed by digestive disorders (44.2%) and arthritis (43.3%).

Muthayya (1995) published an article on the basis of his study carried out on the existing conditions and problems of the rural elderly. The study was conducted among 450 elderly persons (270 men and 180 women) aged 60+ of two villages each of Mehboob Nagar district in Telengana, Krishna District in Coastal Andhra Pradesh and Chittoor district in Rayalseema. The objectives of the study were to assess the economic, social health and psychological needs/conditions affecting livelihood of the aged as well as to analyze the attitude of the aged towards family and society and vice versa.

Asharaf (1995) made a publication on the basis of a study he conducted among the old persons residing in the Western suburb of Bombay. There are 273 elderly in the 1027 households surveyed. The study revealed that there are more elderly among the female population. The elderly enjoy a poor social, economic and health status. The study also revealed that the chronic diseases are the major causes of death among the elderly.

Swarup (1995) wrote a research article on the basis of his survey conducted among outdoor patient Department of the Geriatric ward, Government General Hospital in the then Madras. The survey revealed that 28 percent of the aged were still found to be working. Of the 72 percent retired, 22 percent had the benefit of pension and 50 percent had no source of their own income including old age pension. The general complaints of elderly includes mainly fatigue (51.4 percent), alteration in appetite (10 percent), alteration in weight (20 percent) shortness of breath (24 percent), giddiness (24 percent) joint pains and stiffness (26 percent).

Srivastav (1996) published about his study carried out in Uttar Pradesh with the aim to present the economic condition and family responsibilities of 400 pensioners. The findings of the study throw light on the issue of how the occupational career of the respondent have enabled them to fulfill their family obligations such as children's marriage, education, housing problem etc.

Yadava et al. (1996) published their study on ageing and health hazards in rural northern India. The study aimed to explore the prevalence of diseases during ageing in different socio-economic and demographic groups of society. The study revealed that the socio-behavioral problems have been found to play a significant role in determining the health conditions of the aged people. Literacy and poverty have been found to have their own impact on health during ageing. It is also noted that due to an adverse familial relationship with aged people, many stress-related disorder occur which may result in the bad health of elderly.

Devi and Bagga (1997) published their study on health status of elderly women of Manipur. The study shows that though disease and disability go hand in hand with old age, there is a lot of individual and regional variation in epidemiological pattern.

Arora and Saxena (1997) published their study on pattern of adjustment of 50 retired working and 50 non-working women from Jaipur and Moradabad cities. It was found that retired working women showed higher scores in vocational and interest aspects than non-working women. Scores on certain other aspects such as physical status reflected that retired working women scored more on these aspects than non-working women but differences were negligible.

Khan (1997) published his study among the elderly in New Delhi metropolis. The study revealed that life in urban areas is characterized by both spatial and social mobility. They are also better off in terms of steady resources and in terms of civic amenities, including road and transport, medicare, public parks, etc. whereas; city life often breeds and sustains anonymity and alienation. This affects the situation of the elderly in ways more than one: family groups are small; dwelling units have limited space, and both husband and wife go to work which often makes looking after the elderly problematic.

Nayar (1999) conducted a study among the oldest old men and women of Kerala to understand their problems and published the same. For the purpose of the study a survey was conducted among 160 men and 160 women. The findings of the study show that 93% women and 42% men were widowed. Among the respondents 80% were totally dependent on their families (67% men and 86% women). Among the families keeping the old 62%were themselves poor. Adequate living space was not available to 37% men and 52% women. In the matter of food, clothing and health care, 225 men and 385 women were found marginalized. Among the respondents across both the sexes 39% had difficulty in ADL and many had restricted mobility. It was found that 22% men and 29% women reported neglect or abuse from family members. This increased

with age. Among the total respondents covered under study, 72% respondents are suffering from multiple morbidities. Common diseases reported were arthritis and rheumatism (71%), asthma and bronchial problems (37%), intestinal disorders (22%). Hypertension, heart diseases, diabetes and cancer were each around 10% and were found to increase with age. Depression claimed 85% (more men than women) and acute dementia accounted for 22%.

Sarasa Kumari (2001) published an article based on the study carried out on socio-economic conditions, morbidity pattern and social support among the elderly women in a rural area under Sreekaryam Panchayat in Kerala. It was revealed from the study that 20% of the respondents were partially or fully dependent physically. Urinary incontinence was a major psychosomatic problem of about 50% of the subjects. Loneliness seemed to be a common psychological problem. Among the respondents 20% rated their own health as poor, 74% as satisfactory and 6% as good. Majority of the subjects enjoyed non-formal support from family members. About 60% of the elderly women headed their families and had domestic responsibilities.

Chakrabarty (2003) published a research article based on the study on the contribution of the elderly in an agrarian setting in rural West Bengal. The study aimed to explore the different roles, engagement as well as contributions made by the elderly population living in a rural area and leading an agrarian way of life.

A study was conducted by Deka et al. (2011) on socio-demographic determinants of longevity among the Assamese and Bengali Hindu aged population and Assamese Muslim Population. Information was collected from 1005 elderly persons. The study shows that age and sex are the most important factors that affect mortality and health. Average length of life for women is greater compared to males due to lesser exposure to addiction, lower exposure to hazardous life styles, lower exposure to pollution, lesser tension etc. The study also shows that elderly spending their time by way of caring the

grand children, providing free service in social work, engagement in religious activities or spending leisure time by reading books etc. have a higher prospect of survivability.

Hariharan (2012) published about a study on economic satisfaction of the elderly in rural area of Madurai district in Tamil Nadu. The author made an attempt to explore the gender differences of the rural elderly population in their socio-demographic, economic and health characteristics. It was revealed from the study that most of the rural elderly males were married i.e. having spouse alive, while most elderly females were widowed. Elderly males mostly lived with their spouses and elderly females with their children. Marital status was found to be the most positive significant variable to an increase in economic wellbeing of the rural elderly, and living arrangements were found to be a significant negative one. The elderly suffer either from non-receipt of sufficient economic support, physical support, or the both due to a rising cost of living, less or no reliable employment opportunities in the village, and increasing nuclear families.

Kamble et al. (2012) published their work on mental health status of elderly persons in rural India. Among the total number of study population (2581), 82% were Hindu by religion followed by Muslims (12.8%), Buddhist (2.2%) and Jain (1%). The authors indicate that 41.3% elderly persons under study were having poor mental health status. Female sex, illiteracy, low socio-economic status, widowhood, lack of hobby, physical dependence and lack of family care as well as affection are the factors associated with poor mental health status of the elderly persons. They concluded that there was no significant association between religion and mental status of the respondents.

Dolai and Chakrabarty (2013) published their study on the functional status of the elderly Santal tribe living in a particular village in Jharkhand. The study also aimed to highlight the factors associated with functional status of the elderly people under study. The functional status has been assessed by adopting two scales namely:

Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). It is revealed from the study that most common ADL dependency among the studied population is bladder continence and in case of IADL it is handling finance. The study further revealed that the functional decline is common among the elderly population under study. The risk factors for functional decline are age as well as presence of ailments rather than socio-economic status. Compared to their male counterpart, declined functional level, development of the disability and dependence found more among the female elderly owing to their greater longevity and widowhood.

Dolai et al. (2013) published their study on determinants of the living arrangements among the rural Muslim elderly of West Bengal. The study aimed to explore the present nature of living arrangement and its determinants of the 133 elderly Muslim people from both sexes living in the villages. The study includes the analysis of socio-economic, demographic, household characteristics to determine the living arrangement of the respondent. It is revealed from the study that majority of the population under study were living with their spouse and surviving sons whereas, a very few were living alone.

Rana et al. (2016) published their study on abuse and, violence against the elderly residing in Haryana. The study was conducted to find out whether or not the elderly of a developed district of a developed state in India being abused and neglected, if abused, what are the reasons for so and what the feelings of the elderly against such abuse. The study was conducted in Rohtak district located in the south eastern part of Haryana. The study finds that elderly abuse, neglect and violence, have penetrated in Indian families. The study also reveals that although the policy makers and the governments think that strengthening the economic condition can bring the lost glory of elderly, but the respondents selected for the study feel other way. They feel that the young generation needs to understand the position of elderly which the governments cannot do. So, they believe that they have to pass their remaining life without any major change in the attitude. In this study the authors reached in conclusion that the society

needs to be constantly reminded and prepared to accept the responsibility of growing old, and to care for the elderly. The need of the hour is that the young generation should realize and recognize the role of their parents. It requires a change in attitudes not legislation.

In view of the above review of literature on social gerontological research in India and abroad it may be stated that most of the publications cited above include and not limited to the socioeconomic aspects of the elderly across the space. However, the present researcher reiterates that due to time bound Ph.D. programme he could not extensively traverse the available literature on social gerontological research.

CHAPTER- 3

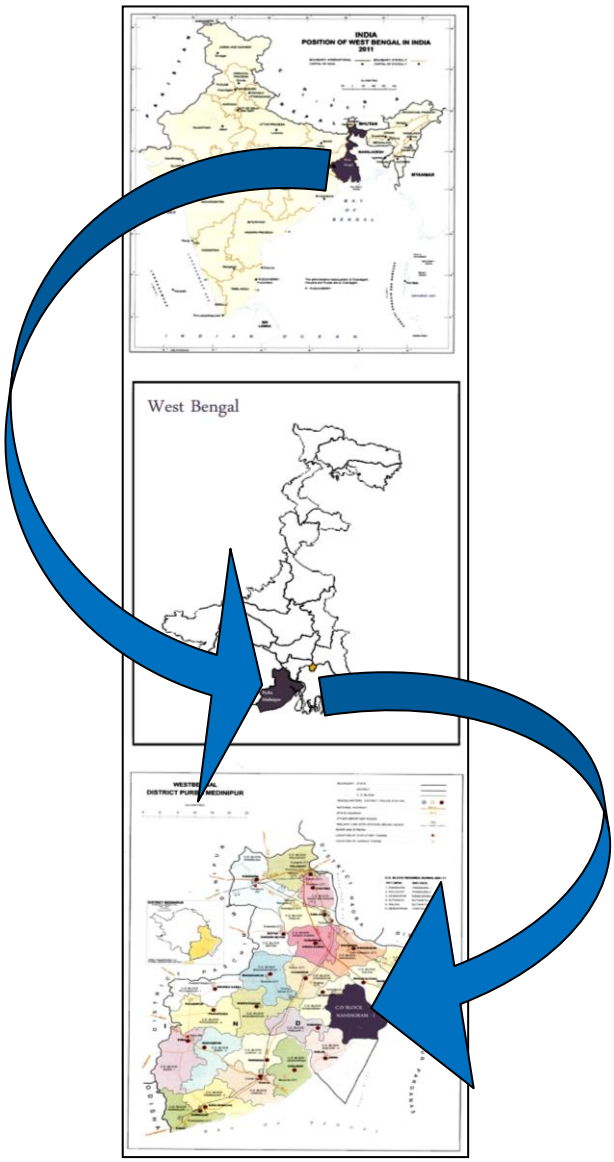
MATERIALS AND METHODS

3.1. A Brief Note on the Study Area:

For the present study ten villages under Nandigram-I CD Block in Purba Medinipur district of West Bengal have been selected. The location of the study area has been shown with the help of the following maps:

Figure - 3.1.

Location of the Study Area



Nandigram-I CD Block is within Haldia Sub-division of Purba Medinipur district, West Bengal. The district is situated between 22°057'10"N and 21°36'35" latitude and 88°12'40"E and 86 ° 33'50" E longitudes.

3.1.1. Profile of the West Bengal:

West Bengal is located in the Northeastern part of India. It is bounded on its north by Bhutan and the state of Sikkim, on its east by Bangladesh, on its northeast by the state of Assam, on its south by the Bay of Bengal, on its southwest by the state of Odisha, on its northwest by Nepal, and on its west by the state of Bihar. Some important Facts of West Bengal has been shown in the following table:

Table – 3.1.

Some Important facts of West Bengal

Area	88,752 sq km
Density	1,029/Km2
Population (2011)	91,276,115
Males Population (2011)	46,809,027
Females Population (2011)	44,467,088
No. of District	19
Capital	Kolkata
Rivers	Hooghly, Teesta, Jaldhaka, Rupnarayan
Languages	Bengali, Hindi, English, Nepali
Neighboring State	Assam, Sikkim, Bihar, Jharkhand, Odisha
Literacy Rate (2011)	86.43%
Females per 1000 males	947

Source: (www.westbengal.gov.in)

3.1.2. A Brief Note about Purba Medinipur District:

Purba Medinipur district is bounded by Paschim Medinipur district in the West and North, Howrah district in the East and South 24-Parganas district in the South-East. The following table shows some of the important statistics of Purba Medinipur district.

Table – 3.2.
Some Important Statistics of Purba Medinipur District

Area (in sq Km.)			4713.00
Population	Total	Persons	50,95,875
		Males	26,29,834
		Females	24,66,041
Density of Population (Persons per sq Km.)			1081
Distribution of Population	Rural	Persons	45,03,161
		Males	23,22,562
		Females	21,80,599
	Urban	Persons	5,92,714
		Males	3,07,272
		Females	2,85,442
Sex Ratio (Number of females per 1000 males)		Total	938
		Rural	939
		Urban	929
Number of Villages		Total	2,994
		Inhabited	2,928
		Uninhabited	66
Number of Towns		Statutory	5
		Census	20
		Total	25
Number of Households		Normal	11,12,041
		Institutional	1,743
		Houseless	386

****Source: District Census Hand Book 2011 of Purba Medinipur district.**

3.1.3. A Brief Note about Nandigram-I CD Block:

Nandigram-I CD Block is predominantly a rural area under Nandigram Police Station in the Haldia Sub-division of Purba Medinipur district, West Bengal. The head quarter of the Nandigram-I CD Block is Nandigram which is situated between 22°00′29″ N 87°59′01″ E.

The block head quarter is a semi-urban settlement and located on the bank of the Haldi River, opposite to the Haldia Industrial Township. The distance between the Nandigram-I Block head quarter and the head quarter of Purba Medinipur district located at Tamluk is about 46 km. The following table shows some of the important statistics** of Nandigram-I CD Block.

Table – 3.3.

Distribution of Household and Population in Nandigram- I CD Block

CD Block		Area in Square Kilometers	Number of Household	Total population (including institutional and houseless population)		
				Persons	Males	Females
Nandigram - I	Total	181.84	42,289	2,07,835	1,06,827	1,01,008
	Rural	179.28	41,064	2,02,032	1,03,880	98,152
	Urban	2.56	1,225	5,803	2,947	2,856

****Source: District Census Hand Book 2011 of Purba Medinipur district.**

As per 2011 census, Nandigram-I CD Block is consisted of ten Gram Panchayats namely Bhekutia, Daudpur, Gokulnagar, Haripur, Kalicharanpur, Kendemari-Jalpai, Mahammadpur, Nandigram, Samsabad and Sonachura which are distributed over ninety-nine Mouzas. There are altogether 98 inhabited villages under this CD Block (Census, 2011).

3.2. Note on Study Population:

The present study was conducted among 200 elderly (age 60 and above) Muslim populations among whom 100 were male and 100 were female. Both the male and the female were respectively selected from ten villages located within the jurisdiction of Nandigram-I CD Block under police administration of Nandigram in Purba Medinipur district. The selected elderly persons belong to the ages ranging from 60 years to 80 years and above.

3.3. Selection of the Population:

For the purpose of the present study 10 villages under Nandigram Police Station have been selected randomly by simple random sampling method. The villages are namely: Nilpur, Mahammadpur, Hazra Kata, Baicha Bari and Purushottampur under 2 No. Mahammadpur Gram Panchyaet and Hosenpur, Gopimohanpur, Raja Ram Chak, Gar Chakra Berya and Samsabad Barsar Beria under 3 No. Kendemari-Jalpai Gram Panchayet.

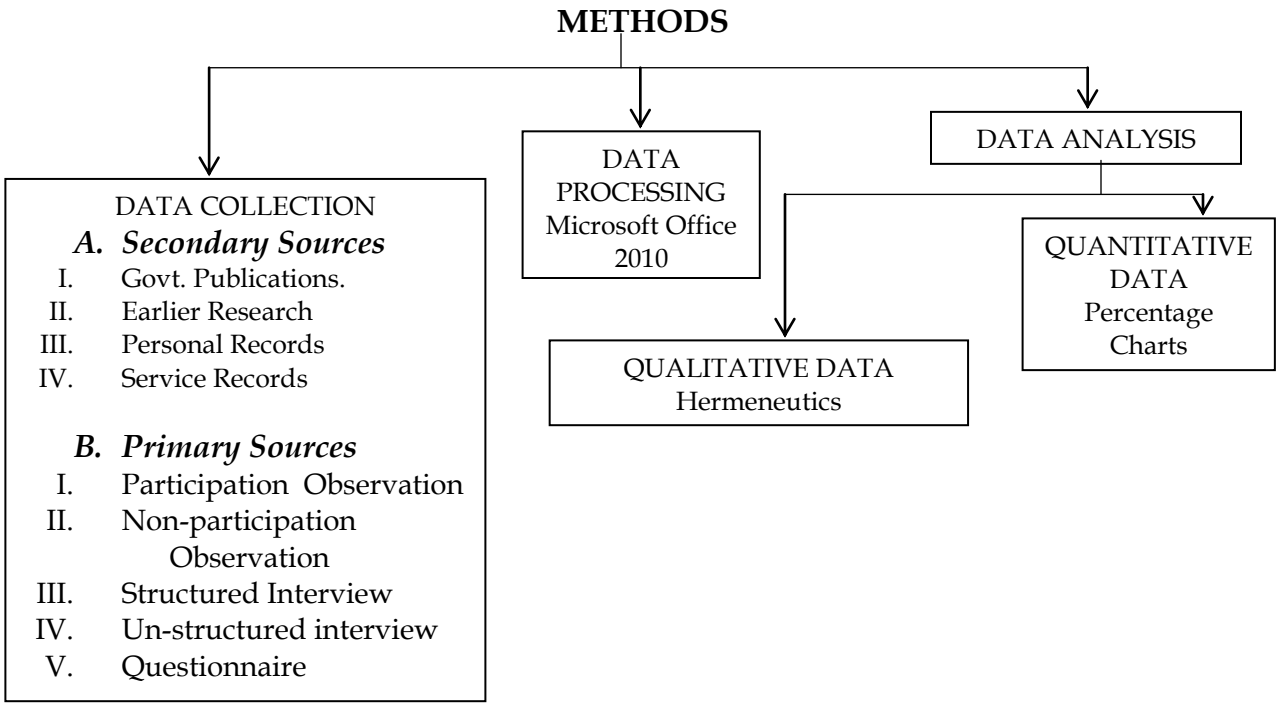
After selection of the villages, ten elderly male and ten elderly female were selected from each village. For the purpose of sampling the elderly persons across both the sexes, the present researcher collected voter list of above mentioned ten villages published by the Election Commission of India in the year 2011. From the collected voter lists the persons aged 60 and above across both the sexes were identified. Thereafter, 10 male and 10 female elderly persons were sampled from each of the village using random sampling table. Thus, altogether 200 elderly respondents were randomly selected for the present research among whom 100 were male and 100 were female. The age of all the sampled elderly persons were ranging from 60 years to 80 years and above. The age of the sampled elderly were further documented from their Electors Photo Identity Card (EPIC) or Ration card or Birth certificate or Admit Card or

School Leaving examination record etc. The data were collected from those selected elderly persons who have provided information voluntarily. The present researcher made the provision for substitution for few of the respondents in case of the non-availability of any sampled person. However, the provision did not exceed more than ten in number.

3.4. Methods for Collection and Analysis of Data:

The present researcher has resorted to different methods for collection and analysis of data required for the present thesis. Those methods have been presented with the help of following diagrams.

Figure – 3.2.
Diagram of Study Design



3.4.1. Types of Data:

There are two major approaches to gathering information about a situation, person, problem or phenomenon. Sometimes, information required is already available and need only be extracted. However, there are times when the information must be collected. Based upon these broad approaches to information gathering, data are categorized respectively as: Secondary data and Primary data.

3.4.1.1. Secondary Data:

Secondary data were collected from different books on ageing and gerontology, journals, reports, articles, encyclopedias, dictionaries, census records and many other resources those were relevant to this thesis.

3.4.1.2. Primary Data:

For the present research primary data were collected by the researcher personally from the elderly Muslim respondent of different villages of Nandigram-I CD Block of West Bengal.

3.5. Tools used for Collection of Primary Data:

Data on socio-economic background of the individual respondent, their living condition and day-to-day activities have been collected by adopting various techniques some of which are described in the following paragraphs.

3.5.1. Observation:

Observation is one way to collect primary data. Observation is a purposeful, systematic and selective way of watching and listening to an interaction or phenomenon as it takes place. There are many situations in which observation is the most appropriate method of data collection; for example, when you want to learn about the interaction in a group, study the dietary patterns of a population, ascertain the

functions performed by a worker, or study the behaviour or personality traits of an individual. It is also appropriate in situations where full and/or accurate information cannot be elicited by questioning, because respondents either are not co-operative or are unaware of the answers because it is difficult for them to detach themselves from the interaction.

Types of observation:

There are two types of observation:

- Participant observation;
- Non-participant observation.

Participant observation is when a researcher, participate in the activities of the group being observed in the same manner as its members, with or without their knowing that they are being observed. For example, one might want to examine the reactions of the general population towards people in wheelchairs. In that case one can study their reactions by sitting in a wheelchair. When using participant-observation as an ethnographic research method, the researcher enters the world of the people he or she wishes to study (Taylor & Bogdan, 1998; Wolcott, 2008).

Non-participant observation, on the other hand, is when a researcher does not get involved in the activities of the group but remains a passive observe, watching and listening to its activities and drawing conclusions from this. For example, a researcher might want to study the functions carried out by nurses in a hospital. As an observer, researcher could watch, follow, and record the activities as they are performed. After making a number of observations, conclusions could be drawn about the functions nurses carry out in the hospital. Any occupational group in any setting can be observed in the same manner.

3.5.1.1. Problems with using observation as a method of data collection

When individuals or groups become aware that they are being observed, they may change their behavior. Depending upon the situation, this change could be positive or negative – it may increase or decrease, for example, their productivity – and may occur for a number of reasons. When a change in the behaviour of persons or groups is attributed to their being observed it is known as the ***Hawthorne Effect***. The use of observation in such a situation may introduce distortion: what is observed may not represent their normal behavior.

- There is always the possibility of observer bias.
- The interpretations drawn from observations may vary from observer to observer.
- There is the possibility of incomplete observation and/or recording, which varies with the method of recording. An observer may watch keenly but at the expense of detailed recording. The opposite problem may occur when the observer takes detailed notes but in doing so misses some of the interaction.

Observations can be made under two conditions:

- Natural;
- Controlled.

Observing a group in its natural operation rather than intervening in its activities is classified as observation under natural conditions. Introducing a stimulus to the group for it to react to and observing the reaction is called controlled observation.

3.5.1.2. The recording of observation

There are many ways of recording observation. The selection of a method of recording depends upon the purpose of the observation. The following are the major ways of recording:

- **Narrative –** in this form of recording the researcher records a description of the interaction in his/her own words. Usually, a researcher makes brief notes while observing the interaction and soon after the observation makes detailed notes in narrative form. In addition, some researchers may interpret the interaction and draw conclusions from it. The biggest advantage of narrative recording is that it provides a deeper insight into the interaction. However, a disadvantage is that observers may be biased in their observation and, therefore, the interpretations and conclusions drawn from the observation may also be biased. Also, if the researcher's attention is on observing they might forget to record an important piece of interaction and, obviously, in the process of recording, part of the interaction may be missed. Hence, there is always the possibility of incomplete recording and/or observation. In addition, with different observers the comparability of narrative recording can be a problem.
- **Recording on mechanical devices** – observation can also be recorded on videotape and then analyzed. The advantage of taping the interaction is that the observer can see it a number of times before drawing any conclusions, and can invite other professionals to view the tape in order to arrive at more objective conclusions. However, one of the disadvantages is that some people may feel uncomfortable or may behave differently before a camera. Therefore the interaction may not be a true reflection of the situation.

The choice of a particular method for recording observation is dependent upon the purpose of the observation, the complexity of the interaction and the type of population being observed. It is important to consider these factors before deciding upon the method for recording the observation.

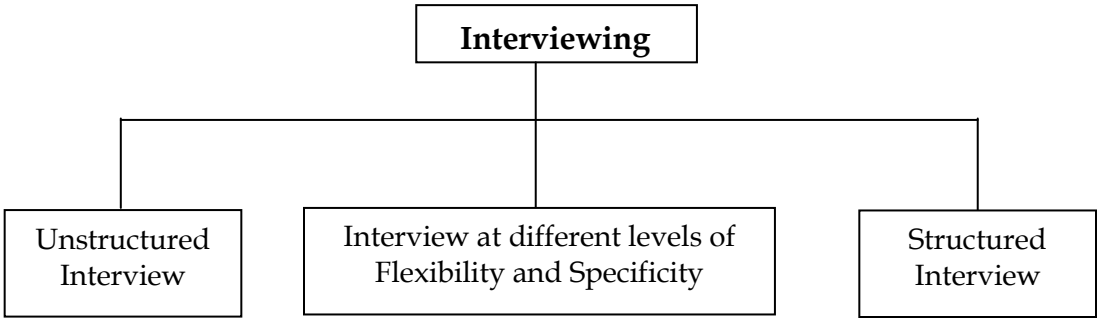
3.5.2. Interview:

Interviewing is a commonly used method of collecting information from people. In many walks of life we collect information through different forms of interaction with others. Any person-to-person interaction between two or more individuals with a

specific purpose in mind is called an interview. On the one hand, interviewing can be very flexible, when the interviewer has the freedom to formulate questions as they come to mind around the issue being investigated; and on the other hand, it can be inflexible, when the investigator has to keep strictly to the questions decided beforehand. Interviews are classified according to the degree of flexibility.

Figure – 3.3.

Diagram showing Different types of Interview technique



3.5.2.1. Structured interview

In a *structured interview* the researcher asks a predetermined set of questions, using the same wording and order of questions as specified in the interview schedule. An *interview schedule* is a written list of questions, open-ended or closed-ended, prepared for use by an interviewer in a person-to-person interaction (this may be face-to-face, by telephone or by other electronic media). Note that an interview schedule is a research tool/instrument for collecting data, whereas interviewing is a method of data collection.

One of the main advantages of the structured interview is that it provides uniform information, which assures the comparability of data. Structured interviewing requires fewer interviewing skills than does unstructured interviewing.

3.5.2.2. Unstructured Interview

The strength of *unstructured interviews* is the almost complete freedom they provide in terms of content and structure. A researcher is free to order these in any

sequence. A researcher also has complete freedom in terms of the use of wording and the way to explain questions to the respondents. A researcher may formulate questions and raise issue on the spur of the moment, depending upon what occurs to the researcher in the context of the discussion.

There are several types of unstructured interviewing like in-depth interview, focus group discussions, case study etc.

3.5.2.2.1. In-depth Interview:

In-depth interview helps to understand the social phenomena that individual have experienced in their everyday life (Cohen et al., 2000; Drew, Hardman & Hosp, 2008; Fontana & Frey, 2005).

3.5.2.2.2. Focused Group Discussion (FGD):

FGD is research technique that collects data through group interaction on a topic determined by the researcher. It is important method because - a) it locates the interaction in a group discussion as the source of data and b) it acknowledges the researcher's active role in creating the group discussion for data collection purpose. Others have argued that the value of FGD goes well beyond listening to others, since they can serve as either a basis for empowering "clients" (Magill 1993; Race et al 1994). It is more effective technique for idea generation (Fern 1982).

3.5.3. Case Study:

Case study is "an empirical inquiry about a contemporary phenomenon (e.g., a 'case'), set within its real-world context—especially when the boundaries between phenomenon and context are not clearly evident" (Yin, 2009a, p. 18). Case study research opens the door for researchers to examine small events in detail and then document complex characteristics that make a phenomenon unique (Yin, 2003). Researcher has used the case study as a strategy rather than method to better understand the particular situation which gives detailed description of a situation in

order to facilitate new meaning, and additional understanding on the part of readers (Merriam, 1998).

3.6. Analysis of Qualitative and Quantitative Data:

Bogdan and Biklen (2007) told that the data analysis to be the most difficult and most crucial aspect of qualitative research. It is difficult because it is not fundamentally a mechanical or technical exercise. It is a dynamic, intuitive and creative process of inductive reasoning, reflection, and theorizing (Merriam, 2009). Through analysis, the researcher attempts to gain a deeper understanding of what he or she has studied and to refine interpretations continually (Basit, 2003). The researcher draws on firsthand experience with the setting, informants, and documents to interpret the data (Bogdan & Bilkin, 2007; Merriam, 2009; Taylor & Bogdan, 1998).

Creswell (2007) divides data analysis into five parts: 1) data managing, 2) coding and developing themes, 3) describing, 4) interpreting, and 5) representing. The researcher enters with data as text and exits with an account or narrative (Creswell, 2007). So, the qualitative data analysis has several stages and every stage requires reflexivity and carefully checking. The data analysis is carried out through following interpretative technique:

i) Data preparation is the first stage of qualitative analysis.
ii) Next, researcher splits the data according to theme.
iii) After that, themes were categories into coding because it is essential to organize the data into categories.
iv) At last, the meaning of the data is interpreted.

Research findings are finally presented to a wider audience, typically in written format. Specific to theoretical approach, results could take the following form: chronological narrative of an individual's life (narrative research), a detailed description of an experience (phenomenology), a theory generated from the data (grounded

theory), a detailed portrait of a culture-sharing group (ethnography), or an in-depth analysis of one or more cases (Creswell 2009, 193).

In case quantitative data, researcher applies descriptive statistics (frequency) to get the socio demographic profile of the elderly.

3.7. Ethical Concern:

Ethic has become a cornerstone for conducting effective and meaningful research. As such, the ethical behaviour of individual researchers is under unprecedented scrutiny (Best & Kahn, 2006; Field & Behrman, 2004; Trimble & Fisher, 2006). Ethically sound research should guarantee the protection of human rights. These include disclosure concerning the study, privacy, anonymity, confidentiality, fair treatment, protection from discomfort and harm, and self-determination (Kylma et al, 1999).

Researchers should consider several issues before, during, and after the research has been conducted. Some of the issues involve the following:

i) Informed consent shall be taken from the respondents and it shall be considered whether the respondents have full knowledge of what is involved in the process of participation;
ii) *Risk of harm*: Researcher shall give attention on the issue that researcher not put participants in a situation where they might be at risk of harm as a result of their participation.
iii) Honesty and trust (is the researcher being truthful in presenting data);
iv) Privacy, confidentiality, and anonymity (will the study intrude too much into group behaviours). It is necessary to hide names, personal details and records of the participants/respondents.
v) Intervention and advocacy i.e. what should researchers do if participants display harmful or illegal behaviour (Holloway and Wheeler, 2002; Constable et al, 2005).

Elderly people as participants of a qualitative study may need extra protection owing to their vulnerability. The researcher has to respect the participants' humanity and ensure their autonomy, and be sensitive to their expressions and gestures in a reciprocal interaction throughout the research process (Jokinen et al, 2002).

During the interviews no offending behaviour should be occurred under any circumstances and participants should at all not be forced to give statements about issues they like to avoid or provide by vague answers (Teeri et al, 2006). Concerning the questionnaire data, all the participants shall be informed about the nature of the study and what participation would entail for them (Puotiniemi and Kyngas, 2004).

As per ethical issues presented in the preceding paragraphs of this section the present researcher firstly obtained consent from each respondent respectively. In all the cases prospective respondents were informed about the nature and purpose of the study. The respondents were informed that participation in this study by them was totally voluntary. Prior consent was also obtained for photography in connection with day-to-day activities and living conditions of the respondents. Anonymity has been protected not only during the work but also during the presentation of the data. The confidentiality of the data was taken into consideration at all phases of the research.

3.8. Limitation of the Study:

Every study has a set of limitations (Leedy & Ormrod, 2005), or "potential weaknesses or problems with the study identified by the researcher" (Creswell, 2005, p. 198). A limitation is an uncontrollable threat to the internal validity of a study. The internal validity refers to the likelihood that the results of the study actually mean what the researcher indicates they mean. Explicitly stating the research limitations is vital in order to allow other researchers to replicate the study or expand on a study (Creswell, 2005). Additionally, by explicitly stating the limitations of the research, a researcher can

help other researchers "judge to what extent the findings can or cannot be generalized to other people and situations" (Creswell, 2005, p. 198).

The researcher was cognizant of the limitation of this study. This research has covered only two hundred elderly residing in the villages under a single Community Development Block of a single district of West Bengal. The study could have been further enriched with inclusion of other rural areas of other districts of West Bengal from more other perspectives with new theoretical paradigm. This study did not focus on many aspects of life of the elderly which include but not limited to the role of local political parties and youth clubs and other Non-Government Organizations (NGOs), religious organization for the care and welfare of the elderly etc. However, the trend that emerged from this exploration served as a starting point to conduct intensive research on the socio economic and health condition of the rural elderly Muslims male and female.

3.9. Operational Definition/ Conceptual Framework:

3.9.1. Rural Area:

The National Sample Survey Organization (NSSO) defines 'rural' as follows:

- An area with a population density of up to 400 per square kilometer,
- Villages with clear surveyed boundaries but no municipal board,
- A minimum of 75% of male working population involved in agriculture and allied activities.

But, in this study the researcher considered rural area as those areas which are within the jurisdiction of three tiers Statutory Gram Panchayat System.

3.9.2. Selected Baseline Variables:

In this study selected baseline variables refers to age, sex, educational status, age at marriage, source of family income, occupational status before and after age 60 and above, living arrangements, present means of subsistence, number of children, family

types, health profiles, leisure activities, satisfaction and many others were taken under consideration.

3.9.3. Leisure Activities or Recreation:

Leisure is the time free from obligations, work and tasks. Leisure time is residual time. Some people argue it is the constructive use of free time. While many may view free time as all non-working hours, but only a small amount of time spent away from work is actually free from other obligations that are necessary for existence, such as sleeping and eating. Recreation is an activity that people engage in during their free time, that people enjoy, and that people recognize as having socially redeeming values.

Recreation is an activity of leisure. The "need to do something for recreation" is an essential element of human biology and psychology. Recreational activities are often done for enjoyment, amusement, or pleasure and are considered to be "fun". Recreational activities can be communal or solitary, active or passive, outdoors or indoors, healthy or harmful, and useful for society or detrimental. A list of typical activities could be almost endless including most human activities, a few examples being reading, playing or listening to music, watching movies or TV, gardening, hunting, hobbies, sports, studies, and travel.

3.9.4. Activities of Daily Living (ADL):

The term "activities of daily living" refers to a set of common, everyday tasks, performance of which is required for personal self-care and independent living.

3.9.5. Disability:

A disability is an umbrella term, covering impairments, activity limitations, and participation restrictions. Impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in

involvement in life situations. Disability is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives. Overcoming the difficulties faced by people with disabilities requires interventions to remove environmental and social barriers.

People with disabilities have the same health needs as non-disabled people – for immunization, cancer screening etc. They also may experience a narrower margin of health, both because of poverty and social exclusion, and also because they may be vulnerable to secondary conditions, such as pressure sores or urinary tract infections. Evidence suggests that people with disabilities face barriers in accessing the health and rehabilitation services they need in many settings.

3.9.6. Health:

According to Medilexicon's Medical Dictionary there are three definitions for health, the first being "*The state of the organism when it functions optimally without evidence of disease or abnormality*" According to World Health Organization (WHO) Health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'

3.9.7. Living Arrangements:

According to The Free Dictionary 'living arrangement' is "an arrangement to allow people (an idea) to co-exist". The term "living arrangements", when used in connection with the older population, encompasses aspects of type of residence-mainly, the distinction between institutional and private dwelling and of household composition that is, the presence or absence in the dwelling of others and the types of kin relationships among co-resident individuals (The Encyclopedia of Aging, 1995).

3.9.8. **Social Security:**

Social security, in its broadest sense, implies an overall security for a person within the family, work place, and society. It may be understood as measures designed to ensure that citizens meet their basic needs (such as adequate nutrition, shelter, education, health care, clean water and food supplies), as well as be protected from contingencies (such as illness, disability, accidents, death, unemployment, medical care, child birth, child care, widowhood, and old age) to enable them to maintain an adequate standard of living consistent with social norms. It must also by implication include protection of livelihoods and a guarantee of work and adequate and fair wages, because without this, other contingency benefits have no meaning. Social security deals with both absolute deprivation and risk and vulnerabilities.

Social security is a concept enshrined in Article 22 of the Universal Declaration of Human Rights, which states: "*Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality*".

In 1952, during Social Security Convention (nr. 102), the International Labour Organization (ILO) defined the traditional contingencies covered by social security as including:

Survival beyond a prescribed age, to be covered by old age pensions; the loss of support suffered by a widow or child as the result of the death of the breadwinner (survivor's benefit);

- Responsibility for the maintenance of children (family benefit);
- The treatment of any morbid condition (including pregnancy), whatever its cause (medical care);

- A suspension of earnings due to pregnancy and confinement and their consequences (maternity benefit);
- A suspension of earnings due to an inability to obtain suitable employment for protected persons who are capable of, and available for, work (unemployment benefits);
- A suspension of earnings due to an incapacity for work resulting from a morbid condition (sickness leave benefit);
- A permanent or persistent inability to engage in any gainful activity (disability benefits);
- The costs and losses involved in medical care, sickness leave, invalidity and death of the breadwinner due to an occupational accident or disease (employment injuries).

3.9.9. **Muslim:**

A Muslim, sometimes spelled Moslem, relates to a person who follows or practices the religion of Islam, a monotheistic and Abrahamic religion based on the Quran. Muslims consider the Quran to be the verbatim word of God as revealed to the Islamic prophet and messenger Muhammad. They also follow the Sunnah teachings and practices of Muhammad as recorded in traditional accounts called Hadith. "Muslim" is an Arabic word meaning "one who submits (to God)".

3.10. Coding of Socio-Economic Variables:

3.10.1. Age Groups:

Recorded ages of the elderly respondents were 60 to 80 and above years. The age groups were classified with four years intervals for those respondents whose ages are within the range from 60 to 79 years. The respondents whose ages are beyond 79 years

have been considered as a single age group of '80 years and above' for the convenience of statistical analysis.

Age Groups (Years)	Code
60-64	1
65-69	2
70-74	3
75-79	4
80 and above	5

3.10.2. Sex:

Sex was coded as: Male = 1 and Female = 2

3.10.3. Education:

The educational statuses were coded with the following categories:
Non-literate = (1); Ability to sign = (2); I-IV Class = (3); V-X Class = (4); Higher Secondary and above = (5).

3.10.4. Age at Marriage:

Age at Marriage was coded as: Age 10-14=1, 15-19=2, 20-24=3, 25-30=4, above 30=5.

3.10.5. Family type:

Family type was coded as: Nuclear Family=1, Joint/Extended Family=2, Broken Family=3.

3.10.6. Household Composition:

Household Composition was coded as: 1-3=1, 4-6=2, 7-9=3, 10 and above=4.

3.10.7. Ownership of House:

Ownership of the houses was coded as: 1 = Own single room constructed with Wattle and Daub; 2 = Free shelter in relatives' or neighbors' house; 3 = Own Mud walled house; 4 = Own Brick built house.

3.10.8. Income:

Monthly income was coded as: MI ≤2000 = 1; 2001-3000 = 2; 3001-4000 = 3 and ≥5000 = 4

Per capita income was coded as <500 = 1, 500-1000 = 2 and >1000 = 3.

3.10.9. Occupation:

Occupations of the respondent were coded as: Worker= 1; Marginal Worker = 2; Non-Worker = 3.

3.10.10. Community:

In the present study all the respondents are Muslim.

3.10.11. Marital Status:

Marital status was coded as: Married having spouse = 1; unmarried = 2; widow = 3 and widower = 4.

3.11. Data on Health Aspects:

Data on the health profiles of the respondents have been assessed on the basis of the (i) Activities of Daily Living (ADL) status. (ii) Self-reported ailments.

3.11.1. Activities of Daily Living Status:

Considering the social or cultural context of the studied population six questions about ADL functional statuses were considered. The questions were respectively on 'Eating', 'Dressing', 'Transferring', 'Using the Toilet', 'Bathing', and 'Continence'.

'Eating' refers to feeding oneself; *'Dressing'* refers to getting clothes and getting dressed, including tying shoes; '*Transferring*' refers to getting in and out of bed and in and out of a chair; '*Using the Toilet*' refers to going to the toilet and cleaning oneself afterward; '*Bathing*' refers to a sponge bath, shower, tub bath, or washing the body with a wet towel; '*Continence*' refers to control of urination and bowel movement.

In all the above cases questions were scheduled under three categories and they are namely: '*can do it*', or '*can do it but needs assistance*', or '*cannot do it*'. The questions were addressed to the elderly or a close family member if the respective elderly individual was not able to answer the questions.

In this study, if none of the six ADL activities is impaired, the individual is classified as *'active'* if one or two activities are impaired, he or she is classified as *'mildly disabled*'; '*severely disabled'* refers to elderly who have three or more activities impaired.

3.11.2. Self-reported Ailments:

In this study, self reported ailments were recorded from the respondents in terms of experiencing episodes of any kind of illness during the last one year excluding the last month. The recorded diseases were Parkinson's disease, Dementia, Cough, Fever, Skin diseases, Asthma, Tuberculosis, Low Blood Pressure and High Blood Pressure etc. Brief descriptions of the diseases that have been recorded are presented below:

3.11.2.1. Cough:

A cough is a sudden and often repetitively occurring reflex which helps to clear the large breathing passages from secretions, irritants, foreign particles and microbes. It is a nonspecific reaction to irritation anywhere from the pharynx to the lungs. Cough can be divided into acute self-limiting cough, lasting less than 3 weeks, or chronic persistent cough, that usually lasts for more than 8 weeks. Cough lasting for an intermediate period of 3-8 weeks is called sub acute cough. Frequent coughing usually indicates the presence of a disease. Many viruses and bacteria benefit evolutionarily by causing the host to cough, which helps to spread the disease to new hosts. Most of the time, irregular coughing is caused by a respiratory tract infection but can also be triggered by choking, smoking, air pollution, asthma, gastro esophageal reflux disease, post-nasal drip, chronic bronchitis, lung tumors and heart failure etc.

3.11.2.2. Fever:

Fever is one of the most common medical signs and is characterized by an elevation of body temperature above the normal range of 36.5–37.5 °C (97.7– 99.5 °F) due to an increase in the temperature regulatory set-point. As a person's temperature increases, there is, in general, a feeling of cold despite an increase in body temperature. Once the new temperature is reached, there is a feeling of warmth.

A fever can be caused by many different viral or bacterial conditions ranging from benign to potentially serious. Some studies suggest that fever is useful as a defense mechanism as the body's immune response can be strengthened at higher temperatures; however there are arguments for and against the usefulness of fever, and the issue is controversial. With the exception of very high temperatures, treatment to reduce fever is often not necessary. However, antipyretic medications can be effective at lowering the temperature, which may improve the affected person's comfort.

3.11.2.3. Skin disease:

Symptoms and signs of dry skin include itching and red, cracked, or flaky skin. As skin ages, it becomes thinner and more easily damaged. Intensifying this effect is the decreasing ability of skin to heal itself as a person ages. Among other things, skin aging is noted by a decrease in volume and elasticity. There are many internal and external causes to skin aging. For example, aging skin receives less blood flow and lower glandular activity.

3.11.2.4. Asthma:

Asthma is common in adults over age 65. Symptoms often begin slowly as a persistent cough and intermittent shortness of breath and often worsen over time. Some experts distinguish two categories of asthma in older adults. The first category comprises older patients whose typical symptoms of asthma developed in childhood or early adulthood and persisted through later life. Normal lung function is usually interspersed with intermittent periods of airflow obstruction, although chronic airway remodeling may lead to airflow limitation that does not fully reverse. The second category, which is less common, comprises patients who first develop new symptoms of asthma as older adults. The diagnosis in the first category is usually reasonably clear. The diagnosis in the second category may be challenging due to the higher incidence of Chronic Obstructive Pulmonary Disease (COPD) and the longer list of differential diagnoses.

3.11.2.5. Low Blood Pressure or Hypotension:

Low blood pressure that causes an inadequate flow of blood to the body's organs can cause strokes, heart attacks, and kidney failure. It's most severe form is shock. Common causes of low blood pressure include a reduced volume of blood, heart disease, and medications. Low blood pressure, also called hypotension, is blood pressure that is low enough that the flow of blood to the organs of the body is

inadequate and symptoms and/or signs of low blood flow develop. The symptoms of low blood pressure include lightheadedness, dizziness, and fainting. These symptoms are most prominent when individuals go from the lying or sitting position to the standing position (orthostatic hypotension). The cause of low blood pressure can be determined with blood tests, radiologic studies, and cardiac testing to look for arrhythmias.

3.11.2.6. High Blood Pressure or Hypertension:

High blood pressure is a serious condition that can lead to coronary heart disease, heart failure, stroke, kidney failure, and other health problems. "Blood pressure" is the force of blood pushing against the walls of the arteries as the heart pumps blood. If this pressure rises and stays high over time, it can damage the body in many ways. Hypertension (HTN) or high blood pressure, sometimes called arterial hypertension, is a chronic medical condition in which the blood pressure in the arteries is elevated. Hypertension is classified as either primary (essential) hypertension or secondary hypertension; about 90–95% of cases are categorized as "primary hypertension" which means high blood pressure with no obvious underlying medical cause. The remaining 5–10% of cases (secondary hypertension) is caused by other conditions that affect the kidneys, arteries, heart or endocrine system.

CHAPTER-4

RESULTS

The result of the present study may be revealed from the analysis of the demographical, socio-economic and activities of daily living status of the respondents who have been randomly selected for the present study by using S+ random sampling table. In this chapter presentation and analysis of various tables has been made which are relevant to the overall objectives of the present study. However, the chapter has been divided in to a number of sections under different headings aimed to highlight different aspects covered under the present study.

Section-I

Demographic Aspects of the Muslim Elderly

Table-4.1 exhibits the *age-sex composition of the respondents* under study. From the table it is revealed that out of the total number of respondents 100 are male and 100 are female. It is evident that out of the total number of respondents across both the sexes 28% belong in the age-group 60-64 years; 34% in the age-group 65-69 years; 23.5% in the age-group 70-74 years; 10.5% belong to the age-group 75-79 years and only 4% belongs in the age group of 80 years and above.

The table under discussion further reflects that in the age-group 60-64 years there are respectively 23% male and 33% female out of the total number of respondents under study. Similarly, in the age-group 65-69 years there are respectively 39% male and 29% are female; in the age-group 70-74 years there are respectively 24% male and 23% female; in the age-group 75-79 years there are respectively 10% male and 11% female and in the age-group 80 years and above male and female respondents constitute only 4% in both the cases respectively.

Table-4.2 shows the *marital status wise distribution of the respondents* under study. It is evident from the table that among the total numbers of respondents across both the sexes 71% married have their living spouse. Similarly, among the total number of respondents 13.5% are widow and 15.5% are widower respectively.

It is also revealed from the table that among the male respondents 69% have their living spouse and 31% are widower. Similarly, in case of female respondents 73% have their living spouseand 27% are widow. The table also reflects that there is not a single unmarried respondent of across both the sexes.

Table-4.3 shows the *marital status of the respondents in different age-group*. From the table it is revealed that among the total number of respondents in the age-group 60-64 years 24.16% are spouse alive; 38.34% are widow and only 20% are widower. Similarly, in the age-group 65-69 years there are 37.5%are spouse alive;16.66%are widow and 65% are widower; in the age-group 70-74 years 25.84% are spouse alive;23.34% widow and only 10% are widower; in the age-group 75-79 years 9.16% are spouse alive, 15% widow and only 5% are widower; in the age-group 80 years and above 3.34%are spouse alive and another 6.66% are widow.

Table-4.4 demonstrates the *incidence of marriage in the life of respective respondent* under study. From the table it is revealed that among the total number respondents, 89.5% have married respectively only one time in their life; whereas 9% have respectively married twice in their life time and remaining 1.5% have respectively married thrice in their life time.

The table also reflects that the number of marriage more than one time in the life occurred more prevalent among the male 11% compared to their female counterpart 7%. Among the male respondents 86% have married once in life time and in case of female the figure is 93%.

Table-4.5 exhibits *age at marriage of the respondents* under study. It is revealed from the table that age at marriage were between 10-14 years in case of 7.5% of the total respondents across both the sexes. Similarly, out of total number of respondents

age at marriage was between 15-19 years among 42%; between 20-24 years among 37.5%; between 25-30 years among 11%; and in case of only 2% of the total respondent age at marriage was above 30 years.

Table-4.6 exhibits *distribution of the literate and non-literate respondents* under study. It is revealed that out of the total number of respondents across both the sexes 23% are *non-literate* and 77% are *literate.* It is evident from the table that among the total number of *literate* respondents 82% are male and 72% are female. The table further exhibits among the total number of *non-literate* respondents 18%are male and 28% are female.

Table-4.7 exhibits the *educational standard wise distribution of the literate respondents.* The present scholar has divided all the *literate* respondents under different categories which are namely: *ability to sign, I-IV standard, V-X standard, Higher Secondary Pass and above.* It is evident from the table that out of the total number of respondents under ability *to sign* category 36.59% are male and 44.44% are female; under the category of *I-IV class* standard of literacy 26.83% are male and 54.17% are female; under the category of *V-X class* standard of literacy 24.39% are male and only 1.39% are female. From the table under discussion it is also revealed that out of the total number of respondents under the category of *Higher Secondary Pass and above* standard 12.19% are male and there is not a single female respondent.

Table-4.8 exhibits *family type wise distribution of the respondents* under study. From the table it is revealed that out of the total number of respondents across both the sexes considered under the present study 13.5% respondents live in *nuclear family*; 78.5% live in *joint family* and remaining 8% live in of *broken family*.

From the table it is also revealed that among the total number of male respondents 16% live in nuclear family; 76% live in joint family and 8% live in broken family. Similarly, among the total number of female respondents 11% live in nuclear family; 81% in joint family and only 8% in broken family.

Table-4.9 shows the *household size wise distribution of the respondents* under study. It is revealed from the table that among the total number of respondents across both the sexes 29% live in such households which are comprised of 1-3 members respectively; 35% live in the households comprised of 4-6 members respectively; 19% live in the households comprised of 7-9 members respectively and 12% live in such household which comprised of10 and above number of members respectively.

From the table it is also revealed that among the total number of male respondents 30% live in such household which are comprised of 1-3 members respectively; in case of 28% the household size is comprised of 4-6 members respectively; 21% respondents live respectively in the households composed of 7-9 members and 11% of them live respectively in such households whose size are composed of 10 or more than 10 members. Similarly, among the total number of female respondents 28% live respectively in such household whose size is composed of 1-3 members; 42% live respectively in the household composed of 4-6 members; 17% respondents live respectively in the household composed of 7-9 members and 13% of them live respectively in such household whose size is composed of 10 and above number of members.

Section-II

Socio-Economic Background of the Muslim Elderly

Table-4.10 shows the *types of house and Nature of ownership wise distribution of the respondents* under study. It is evident that out of the total number of respondents across both the sexes 35.5% live in own single room constructed with Wattle and Daub; 6% are respectively sheltered free of cost by the relatives or neighbors; 48% live in own mud walled house; and 11.5% live in own brick built house.

It is found that among the total number of respondents living in own single room constructed with Wattle and Daub 34% are male and 37% are female; among

the respondents sheltered free of cost by the relatives or neighbors 4% are male and 8% are female. On the other hand, among the total number of respondents living in own mud walled house 49% are male and 47% are female and among the total number of respondents living in own brick built house 13% are male and 8% are female.

Table-4.11 exhibits the *living arrangements wise distribution of the respondents* under study. It is revealed from the table that among the total number of respondents across both the sexes 7.5% are living alone; 42.5% are living with sons; 2.5%are living with married daughters; 6.5%are living with un-married daughters;31%are living with spouse; 3.5%are living with their relatives other than spouse and children whereas; 6.5% of the total number of respondents across both the sexes are living with non-kin neighbors.

From the table it appears that out of the total male respondents respectively 5% are living alone; 42% are living respectively with their sons; 2% are living are living respectively with their married daughters; 6% are living are living respectively with their un-married daughters; 41% are living are living respectively with their spouse; 4% are living respectively with their relatives other than spouse and children. Similarly, among the total number of female respondent 10% are respectively living alone; 43% are living are living respectively with their sons; 3% are living are living respectively with their married daughters; 7% are living are living respectively with their un-married daughters; 21% are living are living respectively with their spouse; 3% are living respectively with their relatives other than spouse and children; and 13% respondents are living respectively with their non-kin neighbors.

Table-4.12 exhibits the *parent-child proximity wise distribution of the respondents* under study. From the table it is revealed that among the total number of respondents across both the sexes 56.5% have proximity to their respective married sons; 8% to their respective un-married daughters; 4% to their respective spouse only

but married son live nearby; 24% to their respective spouse only and no children live nearby; 7.5% are respectively living alone.

Among the total number of male respondents 56% have proximity with their respective married sons; 16% with their respective un-married daughters; 8% with their respective spouse along only but married son live nearby; 15% with their respective spouse only and no children live nearby 5% are living alone. Similarly, among the total number of female respondents 57% have proximity with their respective married sons; 33% with their respective spouse only and no children live nearby; 10% are respectively living alone.

Table-4.13 exhibits the *working status wise distribution of the respondents*. It is evident that out of the total number of respondents across both the sexes respectively 19% are *workers*; 50.5%are *marginal workers* and 30.5% are *non-workers*.

From the table it also revealed that among the total number of male respondents 23% are workers; 54% are marginal workers and 23% are non-workers respectively. On the other hand, among the total number of female respondents15% are workers; 47% are marginal workers and 38% are non-workers. So, the table shows that there is more number of female as non-workers than their male counterpart.

Table-4.14 shows the *prevailing subsistence pattern wise distribution of the respondents* under study. The study reveals that among the total number of respondents under study 25.10%depend on the relatives other than spouse and children for their respective subsistence; 4.94% subsists by providing household chores to their respective neighboring families in lieu of daily wage; 14.81% subsists respectively by farming in own land; 11.93% subsists on earning as agricultural laborer or day laborer; 33.33% subsists on their respective Old Age Pension or Widow Pension; 4.12% subsists on the earning of their respective spouse; 4.12% subsists on their respective post-service pension and only 1.65%subsists respectively on begging.

It is found that out of the total number of male respondents 15.75% depend on their respective relatives other than spouse and children for their subsistence; 5.48% subsists by providing household chores to their respective neighboring families in lieu of daily wage; 24.66% subsists respectively by farming in own land; 19.86% subsists on earning as agricultural laborer or day laborer; 24.66% subsists on their respective Old Age Pension or Widow Pension; 2.74% subsists on the earning of their respective spouse; 6.85% subsists on their respective post-service pension.

Similarly, among the total number female 39.18% depend on their respective relatives other than spouse and children for their subsistence; 4.12% subsists by providing household chores to their respective neighboring families in lieu of daily wage; 46.39% subsists on their respective Old Age Pension or Widow Pension; 6.19% subsists on the earning of their respective spouse and only 4.12% subsists respectively on begging.

Table-4.15 shows the *monthly income wise distribution of the respondents*. It is revealed from this table that out of the total respondents across both the sexes 20% have the monthly income that ranges between Rs. 2000/- or below; monthly income of 14.5% respondents ranges between Rs. 2001/- to Rs. 3000/-; monthly income of 29.5%respondents ranges between Rs. 3001/- to Rs. 4000/-; monthly income of 14% ranges between Rs. 4001 to Rs. 5000/- and 22% respondents have the monthly income that go beyond Rs. 5000/-.

The table further exhibits that 19% of the total number of male respondents have the monthly income that ranges between Rs. 2000/- or below; 11% have the monthly income that ranges between Rs. 2001/- to Rs. 3000/-; 32% have the monthly income that ranges between Rs. 3001/- to Rs. 4000/- whereas; 15% have the monthly income that ranges between Rs. 4001 to Rs. 5000/- and 23% have the monthly income that go beyond Rs. 5000/-.

Similarly, it is evident from the table that out of the total number of female respondents 21% have the monthly income that ranges between Rs.2001/-or below; 18% respondents have the monthly income that ranges between Rs. 2001/- to Rs. 3000/-; monthly income of 27% respondents ranges between Rs. 3001/- to Rs. 4000/-

;13% have the monthly income that ranges between Rs. 4001 to Rs. 5000/- and it is revealed that 21% have the monthly income that go beyond Rs. 5000/-.

Table-4.16 shows the *distribution of the respondents as per their nature of employer before they attained 60 years age*. It is evident that out of the total number of respondents across both the sexes only 6.90% were employed respectively by the State or the Central Government; 18.62% were employed by shops and establishments under private ownerships; 43.45% were employed by Neighboring families; 31.03% were self-employed as farmer in own land.

It is revealed that among the total number of male respondents 10% were employed by either State or Central Government establishments; 27% were employed by the private owners of shops and establishments; 34% were employed by neighboring families; 29% were self-employed as farmer in own land. Among the total number of female respondents 64.44% were employed by neighboring families and 35.56% were self-employed as farmer in own land.

Table-4.17 shows the *recipients of pension wise distribution of the respondents*. It is revealed that out of the total number of respondents across both the sexes 45.5% are *recipients of pension* and 54.5% are *non- recipients of pension*. It is evident from the table that among the total number of *recipients of pension* 46% are male and 45% are female. The table further exhibits that among the total number of *non-recipients of pension* 54% are male and 55% are female.

Table-4.18 shows the *receipt of the type of pension wise distribution of the respondents*. It is revealed from this table that out of the total number of respondents across both the sexes 73.63% receive monthly Old-Age Pension; 10.99% receive monthly service pension and 15.38% receive widow pension.

It is also found that among the total number of male recipients of pension 78.26% receive Old-Age Pension; 21.74% receive Service Pension. Whereas, among the total number of female recipients of pension 68.89% receive Old-Age Pension and 31.11% receive widow pension.

Table-4.19 exhibits the *amount of pension received per month wise distribution of the respondents.* It is revealed from this table that among the total number of *pensioners* across both the sexes39.56% receive less than Rs. 500/- per month; 20.88% receive the amount of pension ranging from Rs. 501-1000/- per month; 10.99% receive the amount of monthly pension ranging from Rs. 1001-1500/- per month; 17.58% receive the amount of monthly pension ranging from Rs. 1501-2000/- per month; 10.99% of the total number of pensioners receive monthly pension that ranges from Rs. 2000/- and above.

From the table under discussion it also appears that among the total number of male pensioners39.13% receive less than Rs. 500/-per month; 15.22% receive pension the amount of which ranges from Rs. 501-1000/- per month; 13.4% receive amount of pension ranging from Rs. 1001-1500/- per month; 10.87% receive amount of pension ranging from Rs. 1501-2000/-per month; 21.74% receive amount of pension ranging from Rs. 2,000/- and above per month.

The table under discussion also suggests that among the total number of female pensioners 40% receive less than Rs. 500/- per month; 26.67% receive pension the amount of which ranges from Rs. 501-1000/- per month; 8.89% receive amount of pension ranging from Rs. 1001-1500/- per month; 24.44% receive amount of pension ranging from Rs. 1501-2000/-per month. There is not a single female pension receiver whose pension amount reaches Rs. 2,000/- per month.

Table-4.20 exhibits *Organization Selected for Deposit of Savings wise distribution of the respondents*. From the table under discussion it is revealed that among the total number of respondents 23.5% have selected Post Office to deposit their savings; whereas 43.5% have selected different Nationalized Bank to deposit their savings. The table also shows that 33% of the total number of respondents has not opened any savings account before any organization.

The table exhibits that among the total number of male respondents, 29% have selected Post Office to deposit their savings and 56% have selected different Nationalized Bank to deposit their savings. Similarly, among the total number of female respondents, 18% have selected different Post Office to deposit their savings

and 31% have selected different Nationalized Bank to deposit their savings. It is evident that 15% among the total number of male respondents and 51% among the total number of female respondents have not opened any savings account.

Table-4.21 exhibits the *ownership of arable land wise distribution of the respondents* under study. The table shows that among the total number of respondents 45.5% have the ownership of arable land. Among the owners of arable land 71% are male and 20% are female.

Table-4.22 exhibits *performance of house-hold chores wise distribution of the respondents*. It is evident that out of the total number of respondents across both the sexes 30% take the responsibility of their own house-hold *cooking*; 15% participate in their own house-hold *gardening and farming*; 7.5% perform the duty of *sweeping* their own house; 22.5% take the responsibility of *marketing their own house-hold necessities*; 5% assist their family members during different house-hold chores; 10% perform any chores of their house-hold assigned to them. However, there are 10% respondents who do not participate in any of their household chores.

It is revealed that among the total number of male respondents 30% their own house-hold *cooking*; 5% perform the duty of *sweeping* their own house. Similarly, among the total number of female respondents 10% assists their family members during different house-hold chores.

Table-4.23 exhibits the *recreational activity wise distribution of the respondents*. From the table it is found that among the total number of respondents across both the sexes 18.5% enjoy recreation by way of gossiping; 1.5% by reading fictions and religious texts books; 8% by listening to the radio programme; 13% by watching television programme; 36.5% by engaging themselves in religious activities; 10.5% walking in the morning and 12% enjoy recreation merely by sleeping.

The table also suggests that among the total number of male respondents 12% enjoy recreation by way of gossiping; 3% by reading fictions and religious texts books; 11% by listening radio; 15% by watching television; 31% by engaging

themselves in religious activities; 13% by walking in the morning and 15% merely by sleeping.

Similarly, among the total number of female respondents, 25% enjoy recreation by way of gossiping; 5% by listening radio; 11% by watching television; 42% by engaging themselves in religious activities; 8% by walking in the morning and 9% merely by sleeping.

Table-4.24 exhibits the *participation in pilgrimage wise distribution of the respondents* under study. From the table it is revealed that among the total number of respondents across both the sexes 53.5% go on pilgrimage. The table also suggests that among the total number of pilgrims 72% are male and 28% are female.

Table-4.25 demonstrates the *frequency of pilgrimage wise distribution of the respondents*. From the table it is revealed that among the total number of pilgrims across both the sexes 28.97% go on pilgrimage once in a month; 23.36% in every quarter of a year; 28.03% go on half-yearly and 19.63% go on pilgrimage once in a year.

The table also shows that among the total number of male pilgrims 36.11% go on pilgrimage once in a month; 27.77% in every quarter of a year; 13.89% go half-yearly and 22.22% go on pilgrimage once in a year.

Similarly, among the total number of female pilgrims 14.28% go on pilgrimage once in a month; 14.28% go in every quarter of a year; 57.14% go on pilgrimage half-yearly and 14.28% go once in a year.

Table-4.26 shows the *frequency of visit to relative's house wise distribution of the respondents* under study. From the table it is revealed that among the total number of respondents across both the sexes 10% visit their respective relatives' house once in a week; 22.5% visit once in a month; 29% visit quarterly; 16% visit half-yearly and 19% visit annually their respective relatives' house. However, 3.5% of the total respondents visit very rarely their respective relative's house.

The table further suggests that among the total number of male respondent 11% visit their respective relatives' house once in a week; 27% visit once in a month;21% visit quarterly; 23% visit half-yearly and 18% visit annually their respective relatives' house.

Similarly, among the total number of female respondent 9% visit their respective relatives' house once in a week; 18% visit once in a month; 37% visit quarterly; 9% visit half-yearly and 20% visit annually their respective relatives' house. However, 7% of the total respondents visit very rarely their respective relative's house.

Section-III

Health Status of the Muslim Elderly

Table-4.27 shows the *self-report on health problem wise distribution of the respondents.* The table reveals that out of the sum total of the respondents across both the sexes 9.5% have not reported any problem about their health; on the contrary, 90.5% have reported that they are suffering from different types of health problems.

The table further reveals that out of the total number of respondents devoid of any health problems 10% are male and 9% are female. Similarly, out of the total number of respondents facing different types of health problems 90% are male and 91% are female.

Table-4.28 shows the *self-reported types of health problem wise distribution of the respondents* under study. From the table it appears that in case of health problems self-reported by the respondents across both the sex the distribution of different types of disorders found among them are follows:Type-2 Diabetes mellitus28.99%; Hypertension 53.03%;Hypo-tension11.04%;Paralysis5.52%;Asthma18.23%;Bronchial disease23.75%; Cardio-vascular disorder 13.26%; Forgetfulness 14.36%; Renal disorder 1.1%; Arthritis 43.9%; Defective Vision 85.8%; Deafness 4.97%; Anemia 4.41%; Blindness 1.1%; Differently abled limbs 32.59%; Leprosy 1.1%; Vocal disorder

7.82%; Fever at regular interval 11.4%; Dermal infection 13.25%; Indigestion 12.15%; Filariasis3.31% and Goiter 1.1%.

From the table under discussion it also appears that in case of health problems self-reported by the male respondents, the distribution of different types of disorders found among them are follows: Type-2 Diabetes mellitus 20%; Hypertension 53.33%; Hypo-tension 11.11%; Paralysis 5.55%; Asthma 23.33%; Bronchial disease 25.55%; Cardio-vascular disorder 15.55 %; Forgetfulness 16.66%; Renal disorder 2.22%; Arthritis 45.55%; Defective Vision 83.33%; Deafness 6.66%; Anemia 7.77%; Blindness 2.22%; Differently abled limbs 26.66%; Leprosy 2.22%; Vocal disorder 10%; Fever at regular interval 8.89%; Dermal infection 16.66%; Indigestion 14.44%; andFilariasis5.55%. Case of Goiter was not found among the male under consideration.

From the table it further appears that in case of health problems self-reported by the female respondents, the distribution of different types of disorders found among them are follows: Type-2 Diabetes mellitus 21.98%; Hypertension 52.75%; Hypo-tension 10.99%; Paralysis 5.49%; Asthma 13.11%; Bronchial disease 21.99%; Cardio-vascular disorder 10.99 %; Forgetfulness 12.8%; Arthritis 40.66%; Defective Vision 86.81%; Deafness 3.29%; Anemia 1.9%; Differently abled limbs 38.46%; Vocal disorder 4.39%; Fever at regular interval 13.18%; Dermal infection 9.89%; Indigestion 9.89%; Filariasis1.9% and Goiter 2.1%. Case of Renal disorder, Blindness and Leprosy was not found among the female under consideration.

Finally, it is necessary to mention in the context of the present table under description that in many cases same respondent, either male or female, is simultaneously facing more than one types of health problem.

Table–4.29 exhibits the *presence of sources of care during their illness wise distribution of the respondents.* From the table it is revealed that among the total number of respondents across both the sexes 95.5% have sources of care during their illness. The table also suggests that among the total number of respondents having sources of care during their illness 94% are male and 97% are female.

Table–4.30 exhibits the *types of source of care during their illness wise distribution of the respondents* under study. It is evident that out of the total number of respondents across both the sexes 58.11% are cared by their respective *spouse*; 20.94% are cared by their respective *children;* 12.04% are by their respective *friends* and 8.9% are cared by their respective *neighbors.*

It also appears from the table that among the total number of respondents having respective *spouse to care* during their illness 65.96% are male and 50.51% are female. Similarly, among the total number of respondents having respective *children to care* during their illness 13.83% are male and 27.83% are female. Among the total number of respondents having respective *friends to care* during their illness 10.64% are male and 13.40% are female and among the respondents having respective *neighbor to care* during their illness 9.57% are male and 8.9% are female.

Table-4.31 exhibits the *nature of mobility wise distribution of the respondents* under study. Among the total number of respondents across both the sexes 7% are bed ridden; 20.5% are slightly mobile; 42% are fairly mobile; 27% are able to move with the help of walking stick and 3.5% are able to move with the help of wheel chair.

It is further revealed that among the total number of bed ridden respondents 6% are male and 8% are female whereas; among the total number of slightly mobile respondents 13% are male and 28% are female. Similarly, among the total number of fairly mobile respondents 52% are male and 32% are female. It is also revealed that among the total number of respondents able to move with the help of walking stick 25% are male and 29% are female whereas; among the total number of respondents able to move with the help of wheel chair 4% are male and 3% are female respectively.

Table-4.32 exhibits the *nature of mobility of the respondents in different age-group* under study. From the table it appears that among the resspondents of age-group 60-64 years there are 9.75% slightly mobile and 30.95% fairly mobile.

Similarly, among the respondent of the age-group 65-69 years there are 19.51% slightly mobile, 20.23% fairly mobile and 9.26% able to move with the help of walking stick.

It is also found that among the respondents of the age-group 70-74 years there are 28.57% bed ridden, 17.07% slightly mobile, 27.39% fairly mobile. In this age group 14.81% can move with the help of walking stick.

It is also found that among the respondents of the age group 75-79 years there are 21.43% bed ridden, 17.07% slightly mobile, 14.29% fairly mobile. In this age-group 37.04% move with the help of walking stick while 28.57% move with the help of wheel chair.

Among the respondents of the age group 80 years and above there are 50% bed ridden, 36.58% slightly mobile, 7.14% fairly mobile. In this age-group 38.89% move with the help of walking stick while 71.43% move with the help of wheel chair.

Table-4.33 shows the *ADL status wise distribution of the respondents*. From the table it is revealed that among the total number of respondents across both the sexes there are 59.5% *active,* 25.5% *mildly disabled* and remaining 15% *severely disabled* in respect of Activities of Daily Living (ADL).

It is also revealed from this table that among the total number of *active* respondents 58% are male and 61% are female. Similarly, among the total number of *mildly disabled* respondents 25% are male and 26% are female. It also appears from the table under discussion that among the total number of *severely disabled* respondents 17% are male and 13% are female.

Table-4.34 exhibits the *ADL status of the respondents in different age group*. From the table under discussion it is revealed that among the total number of respondents of the age-group 60-64 years there are 34.45% active, 35.29% mildly disabled and 20% severely disabled.

Similarly, among the respondents of the age-group 65-69 years there are 27.74% active, 23.54% mildly disabled and 13.33% severely disabled.

The table also reveals that among the respondents of the age-group 70-74 years there are 20.17% active, 25.49% mildly disabled and 16.66% severely disabled.

It also appears from the table under discussion that among the respondents of the age -group 75-79 years there are 13.44% active, 11.76% are mildly disabled and 13.33% severely disabled.

It is further revealed from this table that among the respondents of the age-group 80 years and above there are 4.20% active, 3.92% mildly disabled and 36.68% severely disabled.

Table-4.35 exhibits the *different ability wise distribution of the respondents* under study. The table shows that among the total number of respondents across both the sexes 43.83% are suffering from vision problem; 32.14% are suffering from hearing problem and 24.02% from locomotion problem.

From the table it is also revealed that among the total number of male respondents 46.89% suffering from vision problem; 23.17% suffering from hearing problem and 29.94% suffering from locomotion problem. Similarly, among the total number of female respondents 39.69% are suffering from vision problem; 44.28% are from hearing problem and 16.03% arer suffering from locomotion problem.

Table-4.36 shows the *use of supporting aid wise distribution of the respondents* under study. The table shows that among the total number of respondents across both the sexes 33.43% use spectacles; 12.16% use hearing aid; 2.13% use wheel chair; 34.35% use walking stick and 17.93% use denture.

The table also depicts that among the total number of male respondents 38.7% use spectacles; 15.6% use hearing aid; 2.15% use wheel chair; 29.03% use walking stick and 14.52% use denture respectively.

Similarly, among the total number of female respondents 38.95% used spectacles; 6.39% use hearing aid; 1.74% use wheel chair; 34.4% use walking stick and 18.7% use denture respectively.

Table-4.37 exhibits the *financial sources for purchasing supporting-aid wise distribution of the respondents*. From the table it is revealed that among the total number spectacles users 53.63% have purchased their respective spectacles from own fund; 41.82% from the fund provided by their respective children and remaining 4.54% from the fund provided by different sources other than their respective children.

Similarly, among the total number of hearing-aid users 65% have purchased their respective hearin-aid from own fund; 27.5% from the fund provided by their respective children and remaining 7.5% from the fund provided by different sources other than their respective children.

Among the total number wheel-chair users 57.14% have purchased their respective wheel-chair from own fund; 28.57% from the fund provided by their respective children and remaining 14.28% from the fund provided by different sources other than their respective children.

Among the total number of walking-stick users 46.1% have purchased their respective walking-stick from own fund; 49.56% from the fund provided by their respective children and remaining 4.42% from the fund provided by different sources other than their respective children.

Among the denture users 42.37% have purchased their respective denture from own fund; 55.93% from the fund provided by their respective children and remaining 1.69% from the fund provided by different sources other than their respective children.

Table-4.38 shows the *frequency of requirements for medical help wise distribution of the respondents* under study. From the table it is revealed that among the total number of respondents across both the sexes 55% need medical help rarely; 20% need medical help once in a week; 5% need medical help at the interval of 2-3 months and remaining 20% need regular medical assistance.

The table under discussion also shows that among the total number of male respondents 62% need medical help rarely;17% need once in a week;10% need such help at the interval of 2-3 months and remaining 11% regularly require medical help.

Similarly, among the total number of female respondents 48% need medical help rarely; 23% need once in a week and remaining 29% need medical help regularly .

Table-4.39 demonstrates the *frequency of eating per day wise distribution of the respondents* under study. From the table it is revealed that among the total number of respondents across both the sexes; 35% take food twice daily; 55% take 3-4 times daily and 10% take 5-6 times in a day. The table also suggests that among the total number of male 40% take food twice a day and 60% take 3-4 times within a day. It is also revealed that among the total number of female 30% take food twicw a day ; 50% take food 3-4 every day remaining 20% take 5-6 times in a day.

Table-4.40 exhibits the *vegetable and non-vegetable food habit wise distribution of the respondents* under study. From the table it is revealed that among the total number of respondents only 19.5% are vegetarian and remaining 80.5% are non-vegetarian respectively.

It is found from the table under discussioin that among the total number of vegetarian respondents 12% are male and 27% are female. Similarly, among the total number of non-vegetarian respondents 88% are male and 73% are female.

Table-4.41 shows the *frequency of milk consumption wise distribution of the respondents* under study. From the table it is revealed that among the total number of respondents 29% do not cosume milk; 51.5% consume milk occasionally and 19.5% consume milk regularly. From the table it is also revealed that among the non-consumers of milk 27% are male and 31% are female. Similarly, among the occassional consumers of milk 49% are male and 54% are female whereas; among the regular consumers of milk 24% are male and 15% are female.

Table-4.42 exhibits the *tobacco consumption wise distribution of the respondents*.It is revealed that out of the total number of respondents across both the sexes 46% do not consume *tobacco and* 54% consume *tobacco.* It is evident from the table that among the total number of tobacco consumer 72% are male and 36% are female. The table

further exhibits that among the total number of non-consumer of *tobacco* there are 28% male and 64% female.

Table-4.43 exhibits the *mode of consumption of tobacco wise distribution of the respondents*. It is revealed from this table that out of the total number of respondents across both the sexes 37.96% chew tobacco leaf and 62.3% are smokers of tobacco.

Similarly, among the total number of male respondents 15.28% chew tobacco leaf and 84.72% are smokers of tobacco. Among the total number of female respondents 83.33% chew tobacco leaf and 16.67% are smokers of tobacco leaf.

Table-4.44 shows the *sleeping hour per day wise distribution of the respondents*. The table under discussion shows that among the total number of respondents 35% sleep 6-7 hours for per day; 48.5% sleep 8-9 hours per day and 16.5% sleep more than 9 hours per day.

From the table it is also revealed that among the total number of respondents who sleep 6-7 hours per day 37% are male and 33% are female. Similarly, among the total number of respondents who sleep 8-9 hours per day 39% are male and 58% are female. It is further revealed that among the respondents who sleep more than 9 hours per day 24% are male and 9% are female respectively.

Table-4.45 exhibits the *self perception about present health condition wise distribution of the respondents* under study. From the table it is revealed that among the total number of respondents across both the sexes 29% respondents perceive on their own that they are very healthy; whereas, 49% respondents perceive on their own that their health condition is fairly well and remaining 22% perceive on their own that their health condition is not good.

The table under discussion also shows that among the respondents who perceive on their own that they are very healthy, there are 31% male and 27% female. Similarly, among the respondents who perceive on their own that their health condition is fairly well, there are 55% male and 43% female. It is also revealed that among the respondents who perceive on their own that their health condition is not good, there are 14% male and 30% female.

Section- IV

Psychological Aspects of the Muslim Elderly

Table-4.46 shows the *self comparison about life before and after 60 years of age wise disribution of the respondents*. From the table it is revealed that among the total number of respondents across both the sexes 20% have respectively expressed that no change has taken place in their life after 60 years of age; 7% have respectively expressed that life was or is not good either before or after 60 years of age respectively; 24% have respectively expressed that their present life is better compared to their life before 60 years of age; 19% have respectively expressed that their life before 60 years of age was much better and busier compared to their present life; 6% have respectively expressed that their life before 60 years of age was better compared to present life due to good health; 12.5% have respectively expressed that their life before 60 years of age was best compared to present life and 11.5% have respectively refused to make any comparison between their present life and the life before 60 years of age respectively.

From the table under discussion it appears that among the total number of male respondents 29% have respectively expressed that no change has taken place in their life after 60 years of age; 35% have respectively expressed that their present life is better compared to their life before 60 years of age; 22% have respectively expressed that their life before 60 years of age was much better and busier compared to their present life; 9% have respectively expressed that their life before 60 years of age was best compared to present life and 5% have respectively refused to make any comparison between their present life and the life before 60 years of age respectively.

Similarly, among the total number of female respondents 11% no change has taken place in their life after 60 years of age; 14% have respectively expressed that life was or is not good either before or after 60 years of age respectively; 13% have respectively expressed that their present life is better compared to their life before 60 years of age; 16% have respectively expressed that their life before 60 years of age was much better and busier compared to their present life; 12% have respectively

expressed that their life before 60 years of age was better compared to present life due to good health; 16% have respectively expressed that their life before 60 years of age was best compared to present life and 18% have respectively refused to make any comparison between their present life and the life before 60 years of age respectively.

Table-4.47 exhibits the *Self-perception about unpleasant aspects of old age wise distribution of the respondents* under study. However, among the total number of respondents across both the sexes under the present study altogether 17 persons did not express their perception about the 'Unpleasant Aspects of Old Age' and this constitutes 8.5% of the total number of respondents. Among these persons, the total number of male is 04 and female is 13 which are respectively 23.52% and 76.48% of the total number of persons who did not express their perception about the 'Unpleasant Aspects of Old Age'.

In view of the above facts the table under discussion has included only those respondents who have respectively expressed their perception about the 'Unpleasant Aspects of Old Age'. Thus, from the table it is revealed that among the total number of such respondents across both the sexes 22.4% perceive on their own that the 'fear of death' is the unpleasnt aspect of their respective old age; 19.67% perceive that the 'absence of care taking person' is the unpleasnt aspect of their respective old age; 25.68% perceive that 'irrepressible ageing process' is the unpleasnt aspect of their respective old age; 20.76% perceive on their own that the 'frequent ailment' is the unpleasnt aspect of their respective old age; 11.47% perceive on their own that the 'availibility of less attention from family members' is the unpleasnt aspect of their respective old age.

The table further shows that among the total number of male respondents who have respectively expressed their perception about the 'Unpleasant Aspects of Old Age 29.16% perceive on their own that the 'fear of death' is the unpleasnt aspect of their respective old age; 22.91% perceive that 'absence of care taking person' is the unpleasnt aspect of their respective old age; 25% perceive that 'irrepressible ageing process' is the unpleasnt aspect of their respective old age; 16.66% perceive that

'frequent ailment'is the unpleasnt aspect of their respective old age; 6.25% perceive that 'availibility of less attention from family members' is the unpleasnt aspect of their respective old age.

The table also shows that among the total number of female respondents who have expressed their perception about the 'Unpleasant Aspects of Old Age, 14.94% perceive on their own that the 'fear of death' is the unpleasnt aspect of their respective old age; 16.9% perceive that 'absence of any care taking person' is the unpleasnt aspect of their respective old age; 26.43% perceive that 'irrepressible ageing process' is the unpleasnt aspect of their respective old age; 25.29% perceive that 'frequent ailment'is the unpleasnt aspect of their respective old age; 17.24% perceive that 'availibility of less attention from family members' is the unpleasnt aspect of their respective old age.

Table-4.48 shows the *Self-perception about pleasant aspects of old age wise distribution of the respondents* under study. However, among the total number of respondents across both the sexes under the present study altogether 12 persons did not express their respective perception about the 'Pleasant Aspects of Old Age' and this constitutes 6% of the total number of respondents. Among these persons, the total number of male is 06 and female is also 06 which are respectively 50% in both the cases among the total number of persons who did not express their perception about the 'Pleasant Aspects of Old Age.

In view of the above facts the table under discussion has included only those respondents who have respectively expressed their perception about the 'Pleasant Aspects of Old Age'. Thus, from the table it is revealed that among the total number of such respondents across both the sexes 43.8% perceive on their own that the 'No task to fulfill' is the pleasnt aspect of their respective old age; 27.65% perceive that the 'Enhanced Proximity with the family members' is the pleasnt aspect of their respective old age; 29.25% perceive that 'Obligation free life in and outside the family' is the pleasnt aspect of their respective old age.

The table further shows that among the total number of male respondents who have respectively expressed their perception about the Pleasant Aspects of Old

Age 41.48% perceive on their own that the 'No task to fulfill' is the pleasnt aspect of their respective old age; 22.34% perceive that 'Enhanced Proximity with the family members' is the pleasnt aspect of their respective old age; 36.17% perceive that 'Obligation free life in and outside the family' is the pleasnt aspect of their respective old age.

The table also shows that among the total number of female respondents who have respectively expressed their perception about the Pleasant Aspects of Old Age 44.68% perceive on their own that the 'No task to fulfill' is the pleasnt aspect of their respective old age; 32.97% perceive that 'Enhanced Proximity with the family members' is the pleasnt aspect of their respective old age; 22.34% perceive that 'Obligation free life in and outside the family' is the pleasnt aspect of their respective old age.

Table-4.49 exhibits the *suggestions for improvement of elderly life as expressed by the different respondents* under study. From the table it appears that among the total number of respondents across both the sexes who extended their suggestions for improvement of their respective elderly life 37% were in favour of the 'good quality and quantity of food' 8% were in favour of the 'proper medical care'; 5.5% were in favour of the 'availability of assistance for everyday care'; 13.5% were in favour of the 'provisions for suitable recreational facilities' and 36% were in favour of the 'opportunity for religious activities'.

It is also found that among the total number of male 47% were in favour of the 'good quality and quantity of food' 9% were in favour of the 'proper medical care'; 11% were in favour of the 'availability of assistance for everyday care'; 13% were in favour of the 'provisions for suitable recreational facilities' and 20% were in favour of the 'opportunity for religious activities'.

It is also found from the table that among the total number of female 27% were in favour of the 'good quality and quantity of food' 7% were in favour of the 'proper medical care'; 14% were in favour of the 'provisions for suitable recreational facilities' and 52% were in favour of the 'opportunity for religious activities'. It may

be mentioned in this context that not a single female respondent extended any opinion in favour of the 'availability of assistance for everyday care'.

The table also shows that among the total number of respondents who suggest that the 'good quality and quantity of food' may improve their respective elderly life there are 63.51% male and 36.48% female. It is also found that among the total number of respondents who suggest that the 'proper medical care' may improve their respective elderly life there are 56.25% male and 43.75% female. Similarly, among the total number of respondents who suggest that the 'availability of assistance for everyday care' may improve their respective elderly life there is not a single female. It is further revealed that among the total number of respondents who suggest that the 'provisions for suitable recreational facilities' may improve their respective elderly life there are 48.15% male and 51.85% female. It is also found that among the total number of respondents who suggest that the 'opportunity for religious activities' may improve their respective elderly life there are 27.78% male and 72.22% female.

Table-4.50 shows the *opinion about the satisfaction in their respective life as expressed by the respondents* under study. However, among the total number of respondents across both the sexes under the present study altogether 59 persons did not express their respective opinion about the satisfaction in their respective life and this constitutes 29.5% of the total number of respondents. Among these persons, the total number of male is 30 and female is 29 which are respectively 49.64% and 50.35% of the total number of persons who did not express their opinion about the satisfaction in their respective life.

In view of the above facts the table under discussion has included only those respondents who have expressed their opinion about the satisfaction in their respective life. Thus, from the table it is revealed that among the total number of respondents across both the sexes 57.44% opined that they are 'fully satisfied' in their respective life; 21.98% opined that they are 'not at all satisfied' in their respective life; 20.57% opined that they are 'partially satisfied' in their respective life.

It is revealed from the table that among the total number of male respondents who have expressed their opinion about the satisfaction in their respective life 58.57% opined that they are 'fully satisfied'; 30% opined that they are 'not at all satisfied' 11.43% opined that they are 'partially satisfied' in their respective life.

The table also revealed that among the total number of female respondents who have expressed their opinion about the satisfaction in their respective life 56.34% opined that they are 'fully satisfied'; 14.8% opined that they are 'not at all satisfied' 29.58% opined that they are 'partially satisfied' in their respective life.

From the table under discussion it is further revealed that among the total number of 'fully satisfied' respondents there are 50.61% male 49.38 % female; among the total number of 'not at all satisfied' respondents there are 67.75% male 32.26 % female; among the total number of 'partially satisfied' respondents there are 27.58% male 72.41 % female.

Section-1

Demographic Aspects of the Muslim Elderly

Table - 4.1

Age-sex Composition of the Respondents

Age Group	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total number of Respondents
60-64	23	23	33	33	56	28
65-69	39	39	29	29	68	34
70-74	24	24	23	23	47	23.5
75-79	10	10	11	11	21	10.5
80 and Above	04	04	04	04	08	04
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.1

Bar Graph showing Age-sex Composition of the Respondents

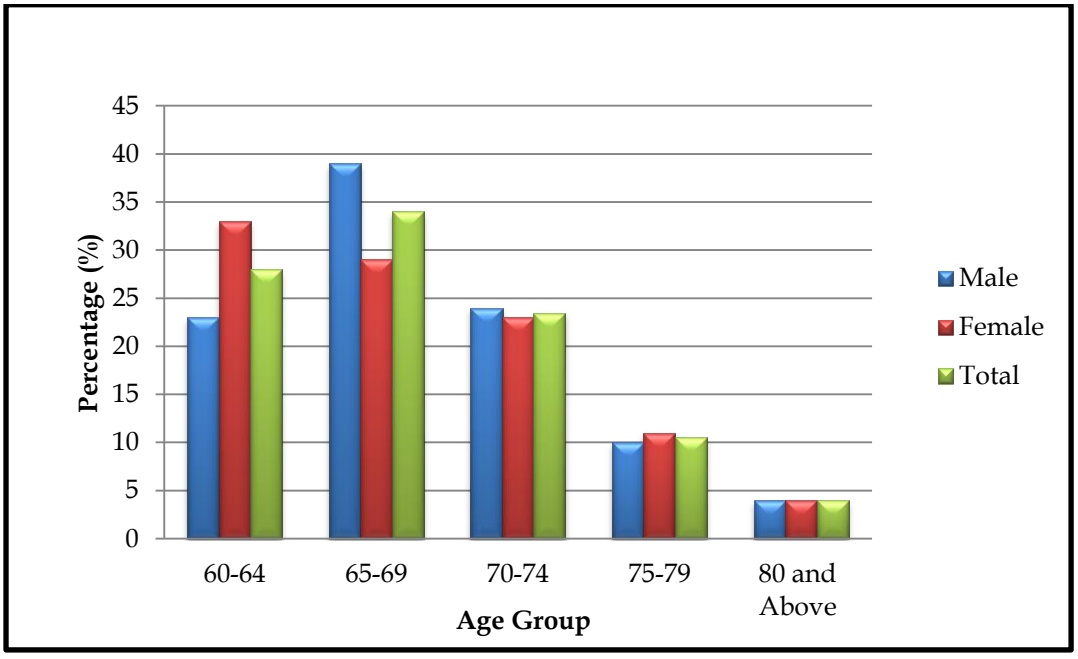


Table – 4.2

Marital Status wise Distribution of the Respondents

Marital Status	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total number of Respondents
Married Having Spouse	69	69	73	73	142	71
Unmarried	0	0	0	0	--	--
Widow	--	--	27	27	27	13.5
Widower	31	31	--	--	31	15.5
Total	**100**	**100**	**100**	**100**	**200**	100

Figure – 4.2

Bar Graph showing Marital Status Wise Distribution of the Respondents

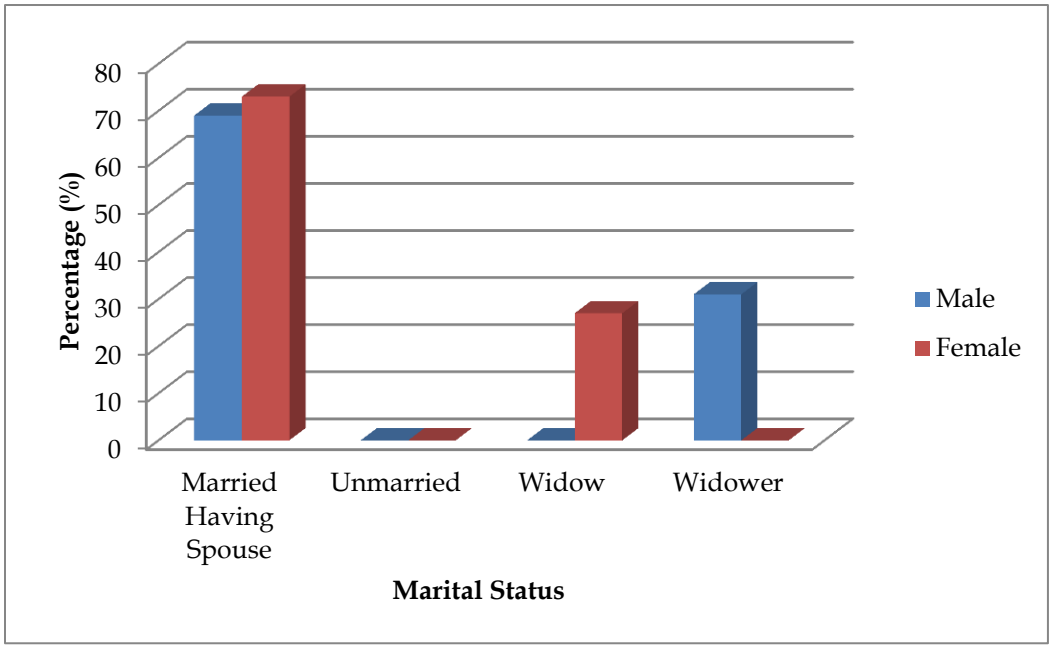


Table – 4.3

Marital Status of the Respondents in Different Age Group

Age Group	Distribution of the Respondents							
	Spouse Alive		Widow		Widower		Total	
	N	% against total number of Respondents	N	% against total number of Female	N	% against total number of Male	N	% against total number of Respondents
60-64	29	24.16	23	38.34	04	20	56	28
65-69	45	37.05	10	16.66	13	65	68	34
70-74	31	25.84	14	23.34	02	10	47	23.5
75-79	11	9.16	09	15	01	05	21	10.5
80 and Above	04	3.34	04	6.66	0	00	08	04
Total	**120**	**100**	**60**	**100**	**20**	**100**	**200**	**100**

Figure – 4.3

Bar Graph showing Marital Status of the Respondents in Different Age Group

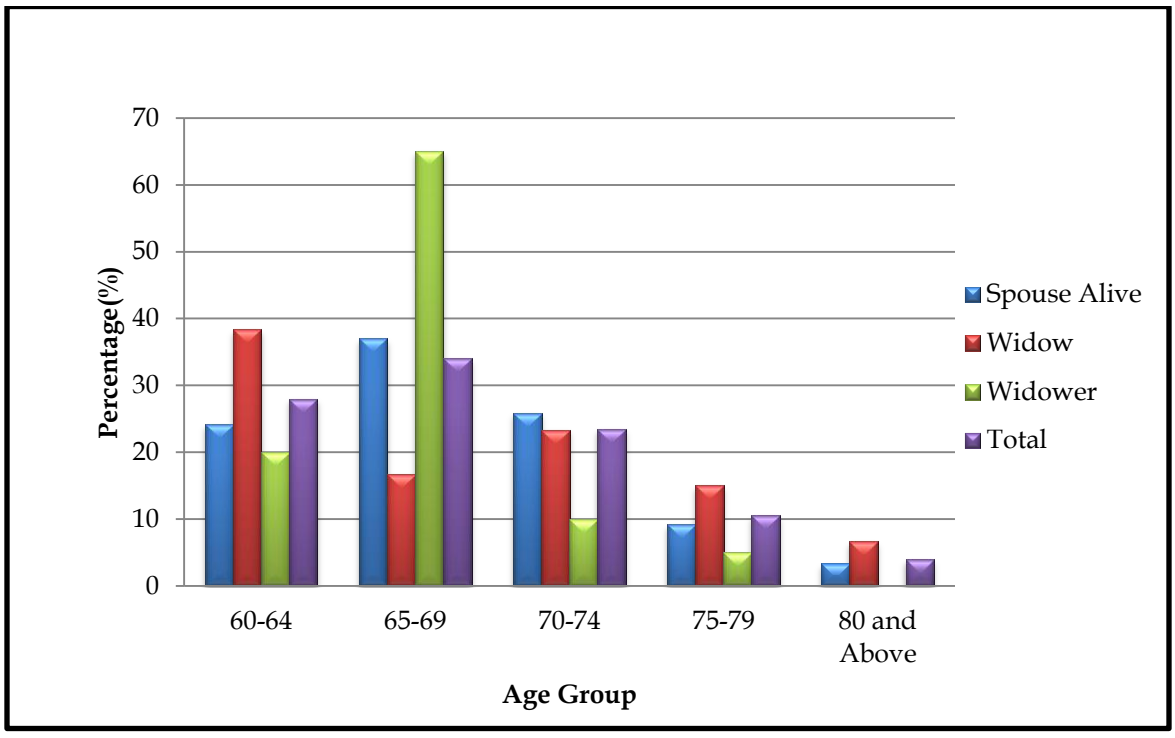


Table – 4.4

Incidence of Marriage in Life of Respective Respondent

Incidence of Marriage	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total number of Respondents
Once in life time	86	86	93	93	179	89.5
Twice in life time	11	11	07	07	18	09
Thrice in life time	03	03	0	0	03	1.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.4

Bar Graph showing Incidence of Marriage in Life of Respective Respondent

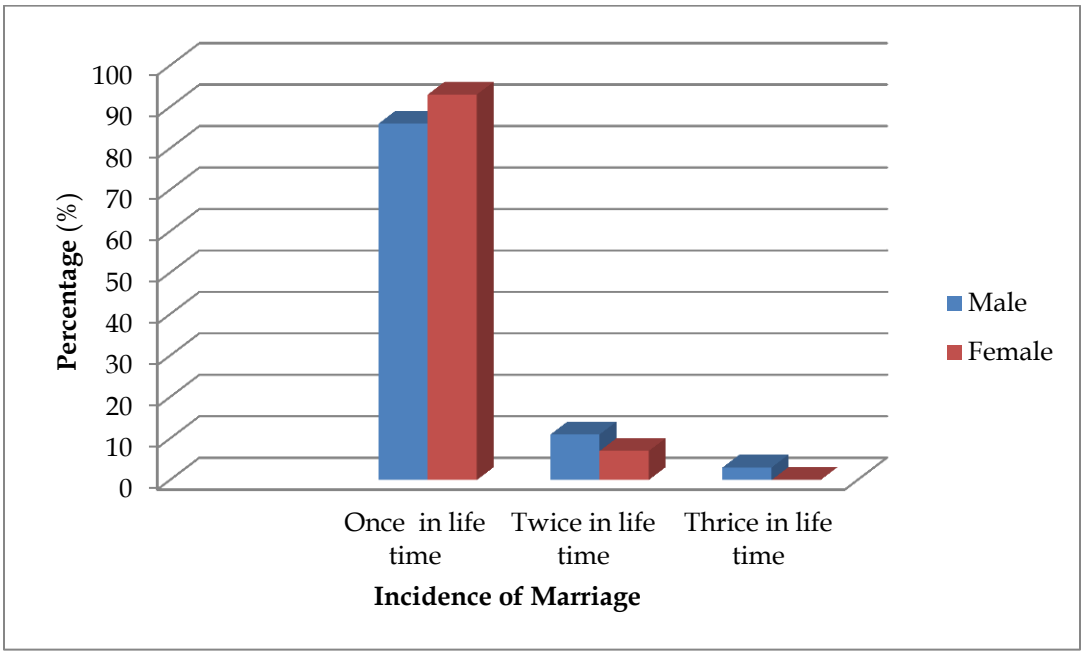


Table – 4.5

Age at Marriage wise Distribution of the Respondents

Age at Marriage	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total number of Respondents
10-14	0	0	15	15	15	7.5
15-19	13	13	71	71	84	42
20-24	65	65	10	10	75	37.5
25-30	18	18	04	04	22	11
Above 30	04	04	0	0	04	02
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.5

Bar Graph showing Age at Marriage wise Distribution of the Respondents

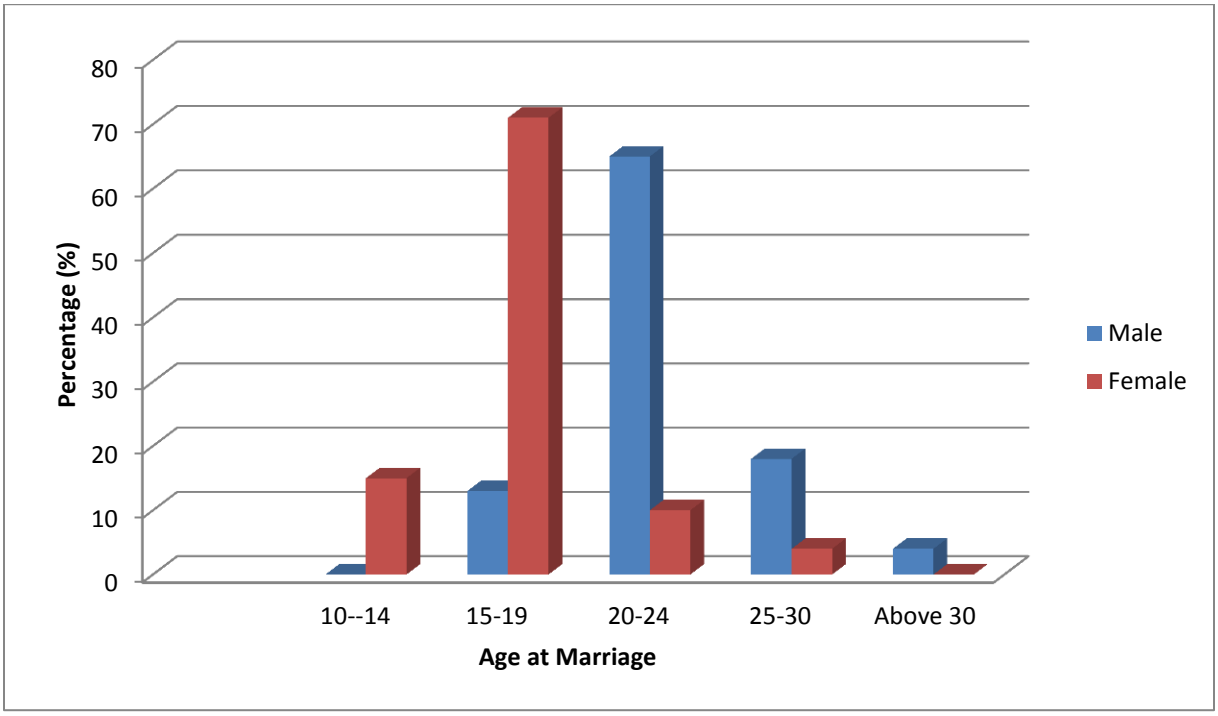


Table – 4.6

Distribution of the Literate and Non-literate Respondents

Literate and Non- literate	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total no. of Male Respondents	N	% against total no. of Female Respondents	N	% against total no. of Respondents
Literate	82	82	72	72	154	77
Non-literate	18	18	28	28	46	23
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.6

Distribution of the Literate and Non-literate Respondents Shown in the Pie Chart

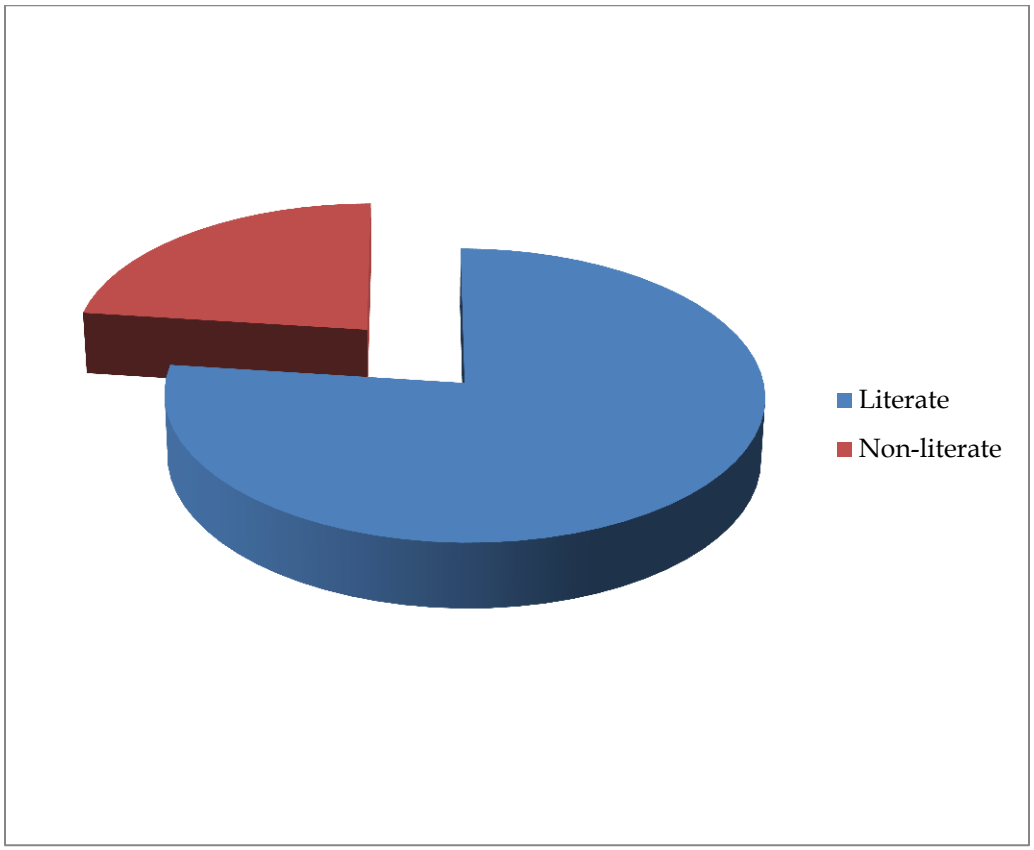


Table – 4.7

Educational Standard wise Distribution of the Literate Respondents

Educational Standard	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total no. of Male Literate	N	% against total no. of Female Literate	N	% against total no. of Literate
Ability to Sing	30	36.59	32	44.44	62	40.25
Class I – IV standard	22	26.83	39	54.17	61	39.61
Class V – X standard	20	24.39	01	1.39	21	13.64
Higher Secondary Pass and above	10	12.19	0	00	10	6.50
Total	**82**	**100**	**72**	**100**	**154**	**100**

Figure – 4.7

Pie Chart showing Educational Standard wise Distribution of the Literate Respondents

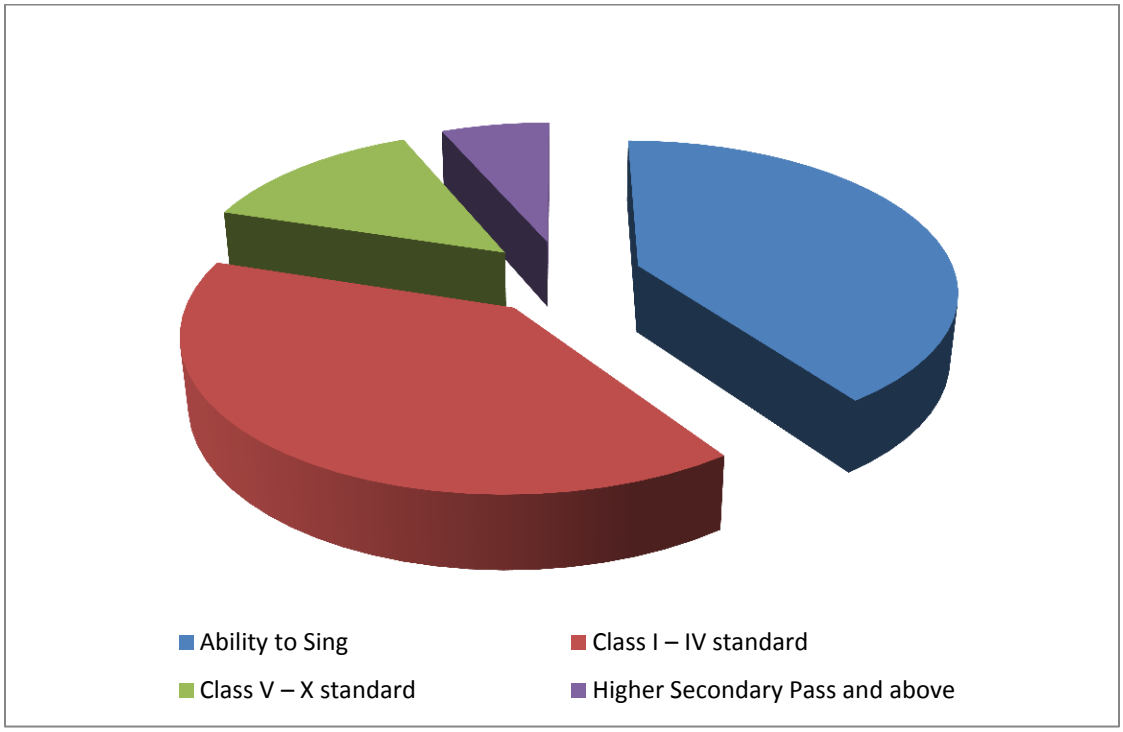


Table – 4.8

Family Type wise Distribution of the Respondents

Family type	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Nuclear Family	16	16	11	11	27	13.5
Joint /Extended Family	76	76	81	81	157	78.5
Broken Family	08	08	08	08	16	08
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.8

Pie Chart showing Family Type Wise Distribution of the Respondents

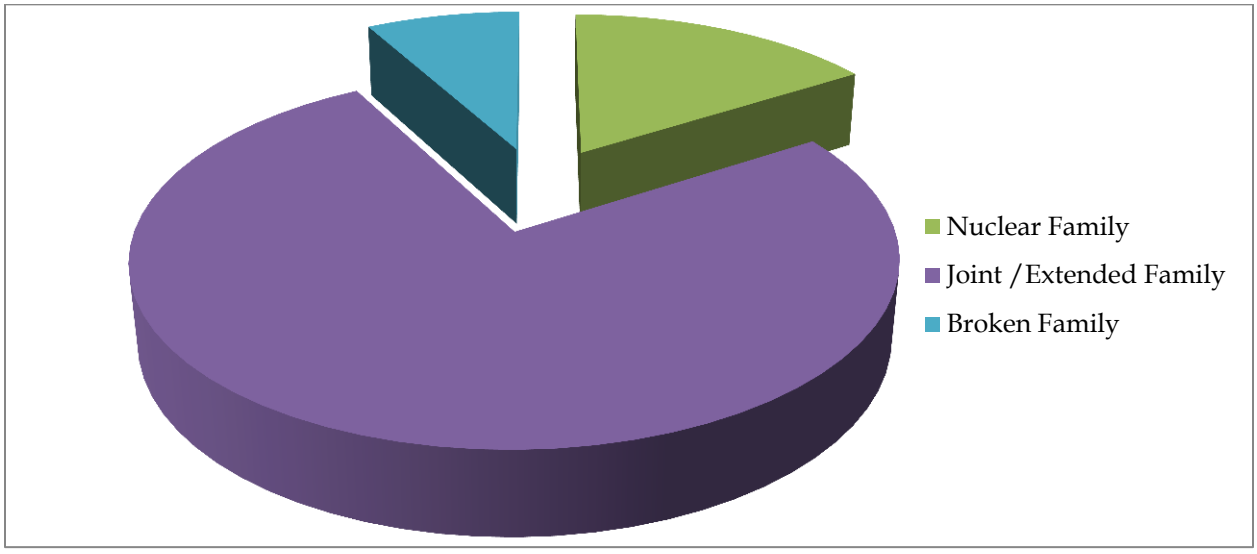


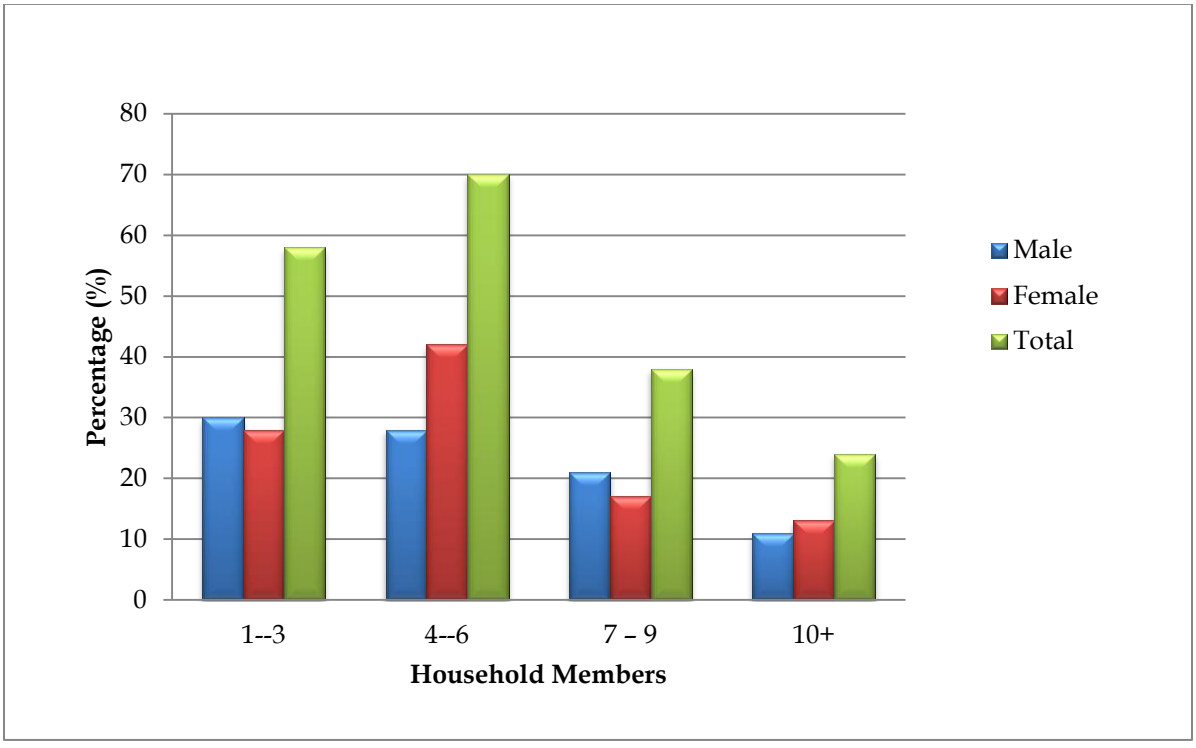
Table – 4.9

Household Size wise Distribution of the Respondents

Household Members	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
1 - 3	30	30	28	28	58	29
4 - 6	28	28	42	42	70	35
7 – 9	21	21	17	17	38	19
10+	11	11	13	13	24	12
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.9

Bar Graph showing the Household Size wise Distribution of the Respondents



Section- II

Socio-Economic Milieu of the Muslim Elderly

Table – 4.10

Types of House and Nature of Ownership wise Distribution of the Respondents

Ownership of House	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Own single room constructed with Wattle and Daub	34	34	37	37	71	35.5
Free Shelter in Relatives' or Neighbors' House	04	04	08	08	12	06
Own Mud walled House	49	49	47	47	96	48
Own Brick built House	13	13	08	08	21	11.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure -4.10

Bar Graph showing Types of House and Nature of Ownership Wise Distribution of the Respondents

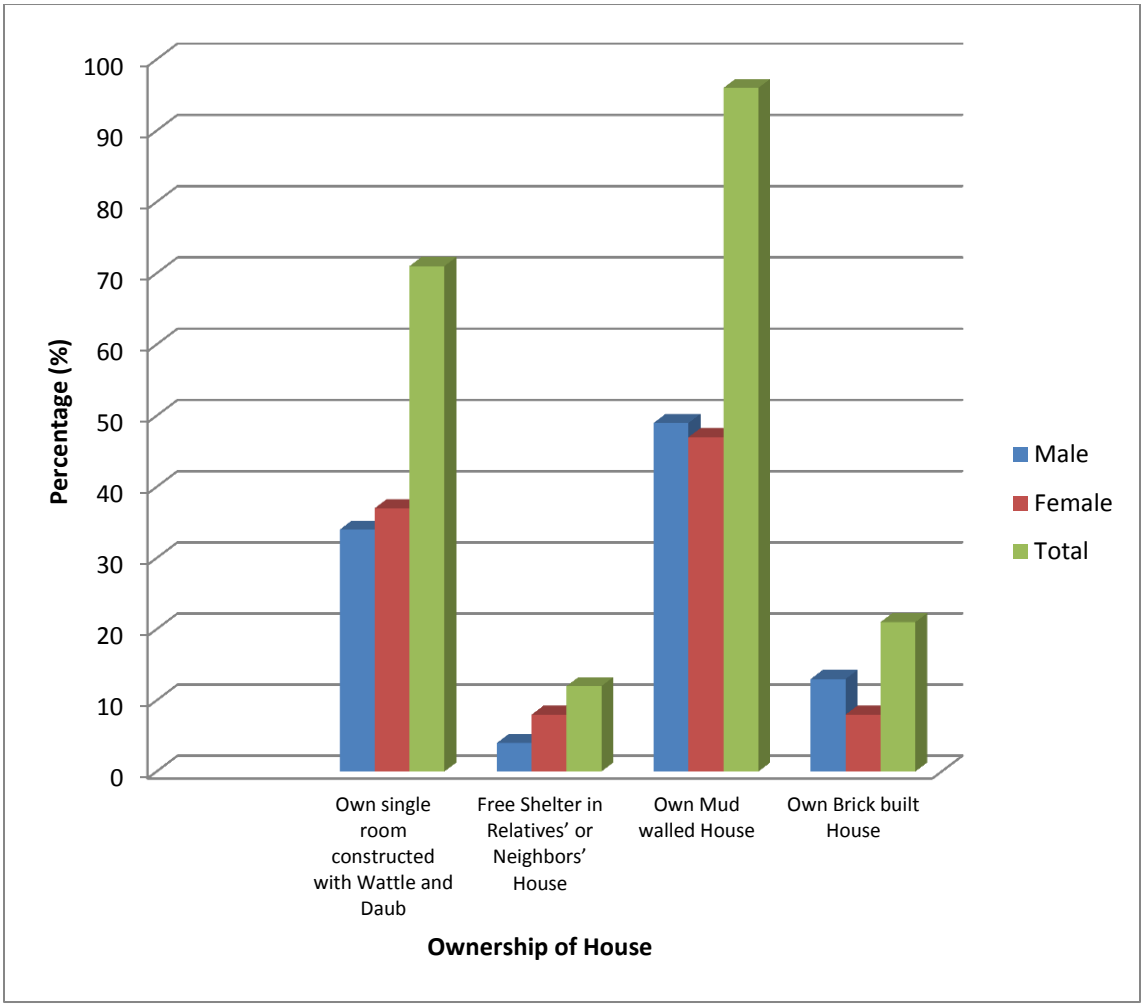


Table – 4.11

Living Arrangements wise Distribution of the Respondents

Living Arrangements	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Living alone	05	05	10	10	15	7.5
Living with Sons	42	42	43	43	85	42.5
Living with Married Daughters	02	02	03	03	05	2.5
Living with Un-married Daughters	06	06	07	07	13	6.5
Living with Spouse	41	41	21	21	62	31
Living with Relatives Other than Spouse & Children	04	04	03	03	07	3.5
Living with Non-kin Neighbors	0	0	13	13	13	6.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.11

Bar Graph showing Living Arrangements wise Distribution of the Respondents

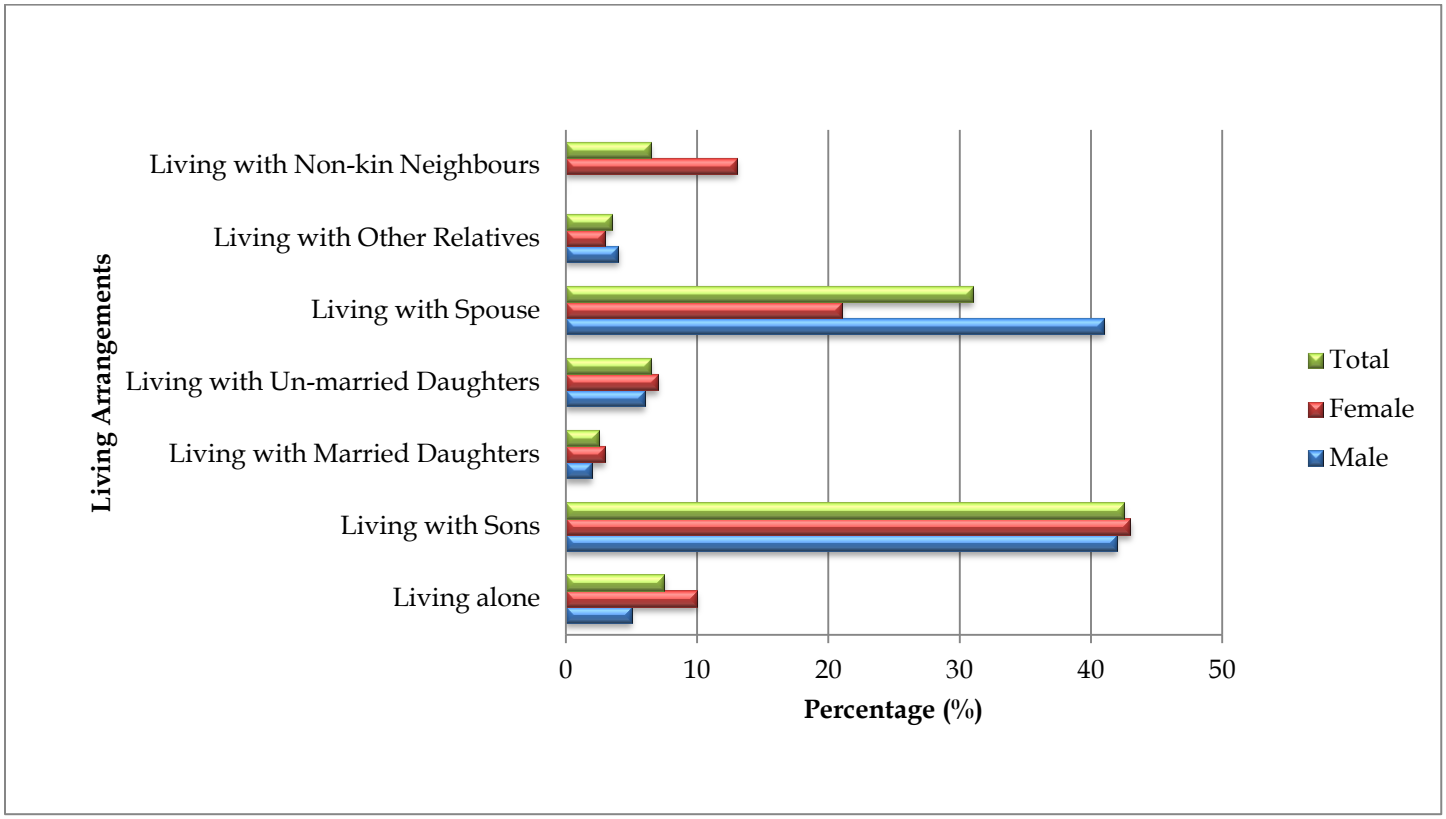


Table – 4.12

Parent-Child Proximity wise Distribution of the Respondents

Parent-Child Proximity	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Proximity to Married Sons	56	56	57	57	113	56.5
Proximity to Un-Married daughters	16	16	0	0	16	08
Proximity to Spouse only but married son live nearby	08	08	0	0	08	04
Proximity to Spouse only and no children live nearby	15	15	33	33	48	24
Living Alone	05	05	10	10	15	7.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.12

Bar Graph showing Parent-child Proximity wise Distribution of the Respondents

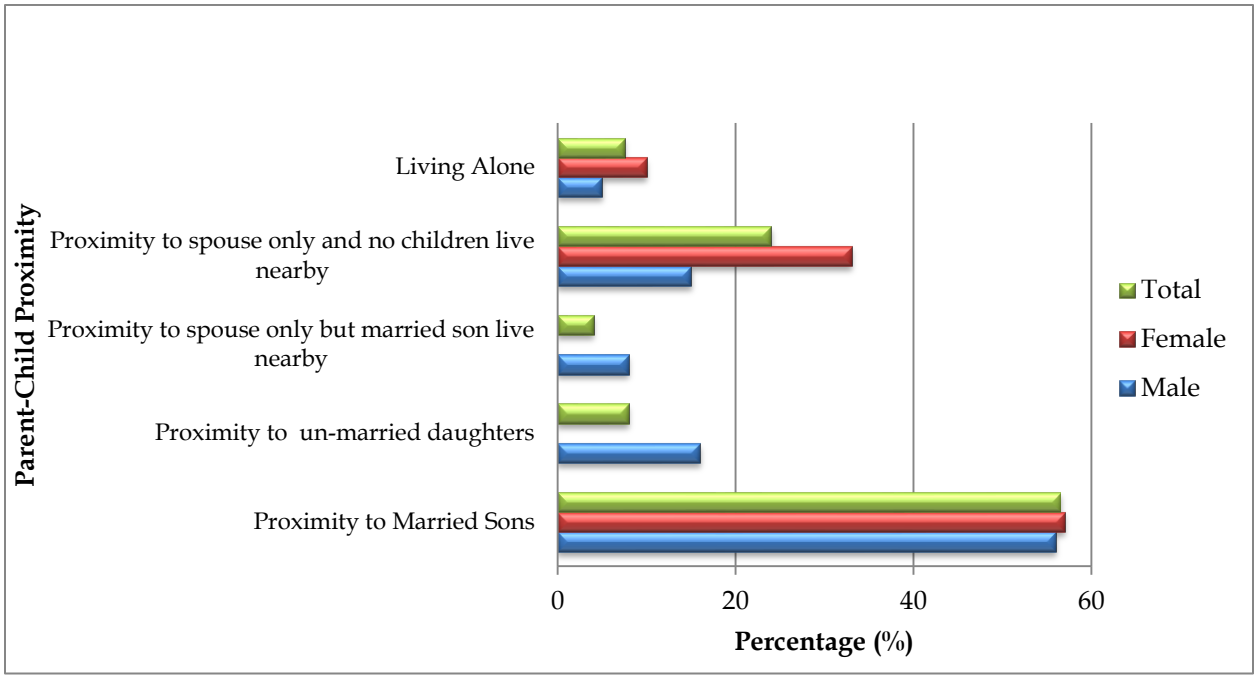


Table – 4.13

Working Status wise Distribution of the Respondents

Working Status	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Worker	23	23	15	15	38	19
Marginal Worker	54	54	47	47	101	50.5
Non-Worker	23	23	38	38	61	30.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.13

Bar Graph showing Working Status Wise Distribution of the Respondents

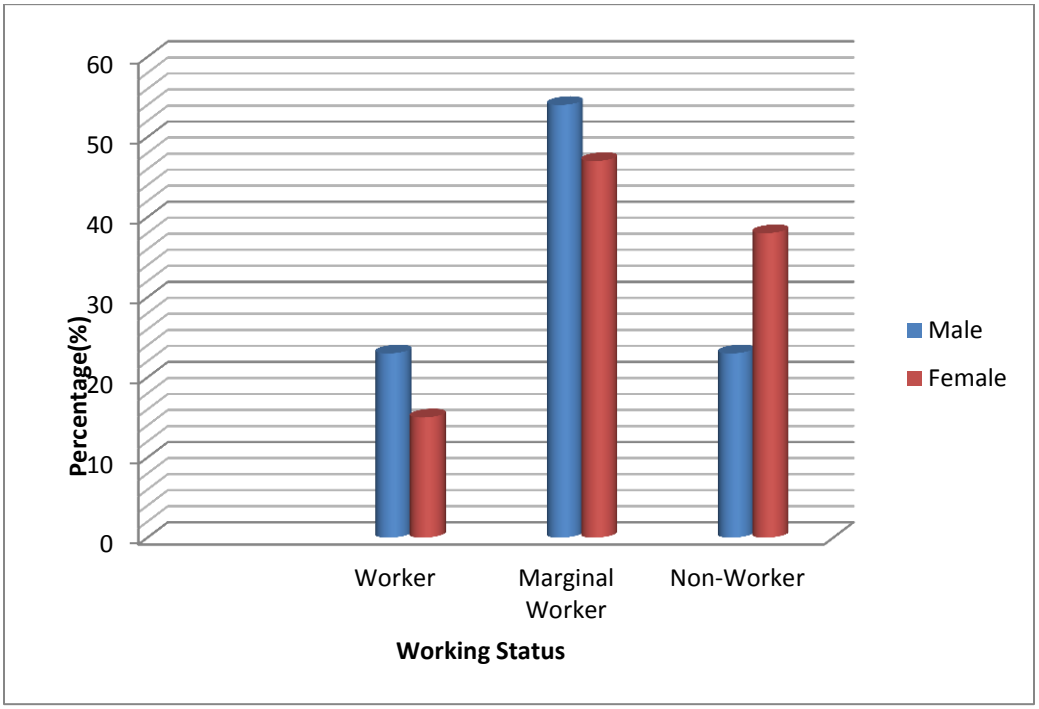


Table -4.14

Prevailing Subsistence Pattern Wise Distribution of the Respondents

Prevailing Subsistence Pattern	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male found under different types of subsistence	N	% against total number of Female found under different types of subsistence	N	% against total number of respondents found under different types of subsistence
Dependent on relatives other than spouse and children	23	15.75	38	39.18	61	25.10
Household Chores in neighboring family in lieu of Daily Wage	08	5.48	04	4.12	12	4.94
Own Farming	36	24.66	0	0	36	14.81
Agricultural Labour/Day Labour	29	19.86	0	0	29	11.93
Old Age or Widow Pension	36	24.66	45	46.39	81	33.33
Dependent on the earning of spouse	04	2.74	06	6.19	10	4.12
Post-Service Pension	10	6.85	0	0	10	4.12
Live by begging	0	00	04	4.12	04	1.65
Total	**146**	**100**	**97**	**100**	**243***	**100**

***Total no. of male and female shown in the table exceeds the actual no. of selected respondents since in many cases same person has been included simultaneously under different types of subsistence.**

Figure – 4.14

Pie Chart showing Prevailing Subsistence Pattern Wise Distribution of the Respondents

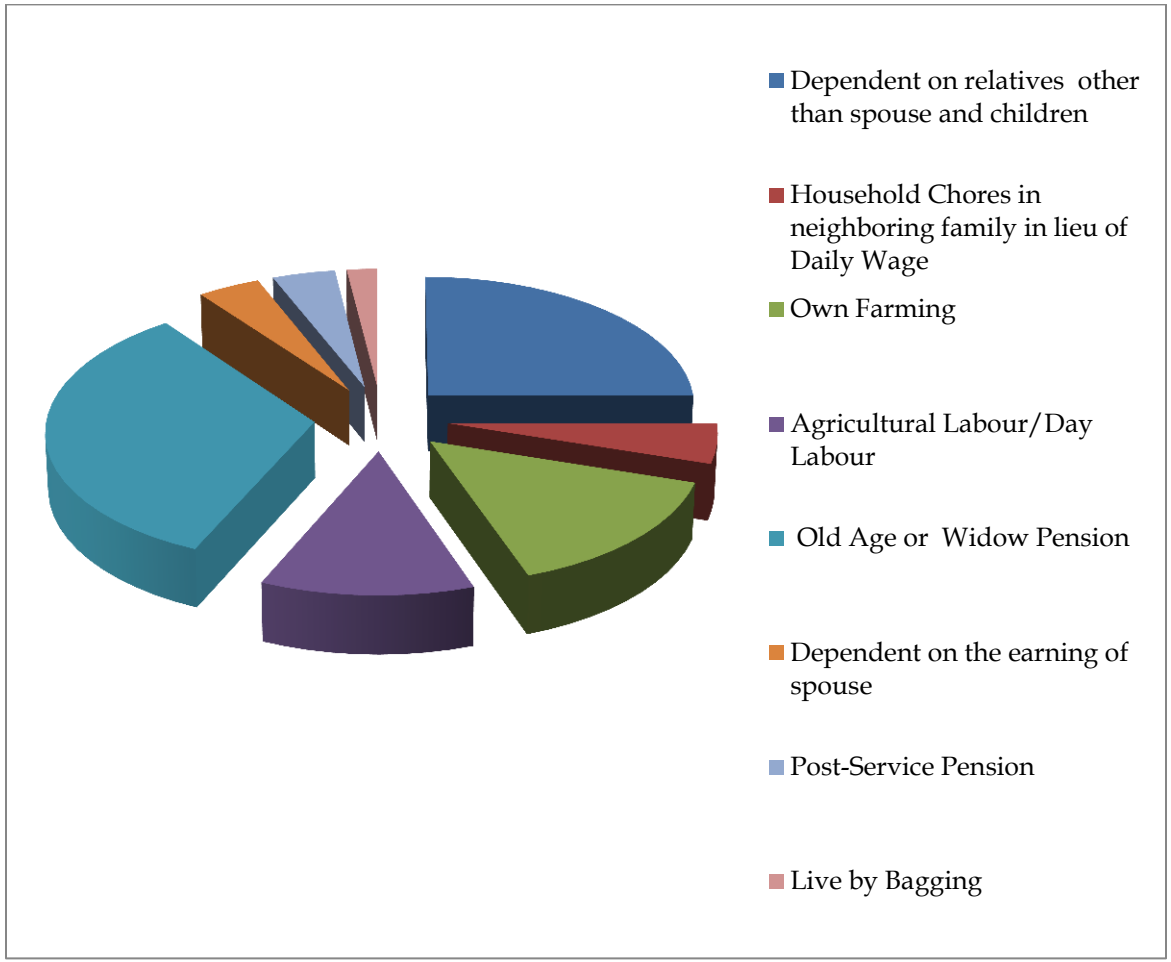


Table – 4.15

Monthly Income wise Distribution of the Respondents

Income Per Month	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Rs. <2000	19	19	21	21	40	20
Rs. 2001 - 3000	11	11	18	18	29	14.5
Rs. 3001 - 4000	32	32	27	27	59	29.5
Rs. 4001 - 5000	15	15	13	13	28	14
Rs. >5000	23	23	21	21	44	22
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.15

Bar Graph showing Monthly Income wise Distribution of the Respondents

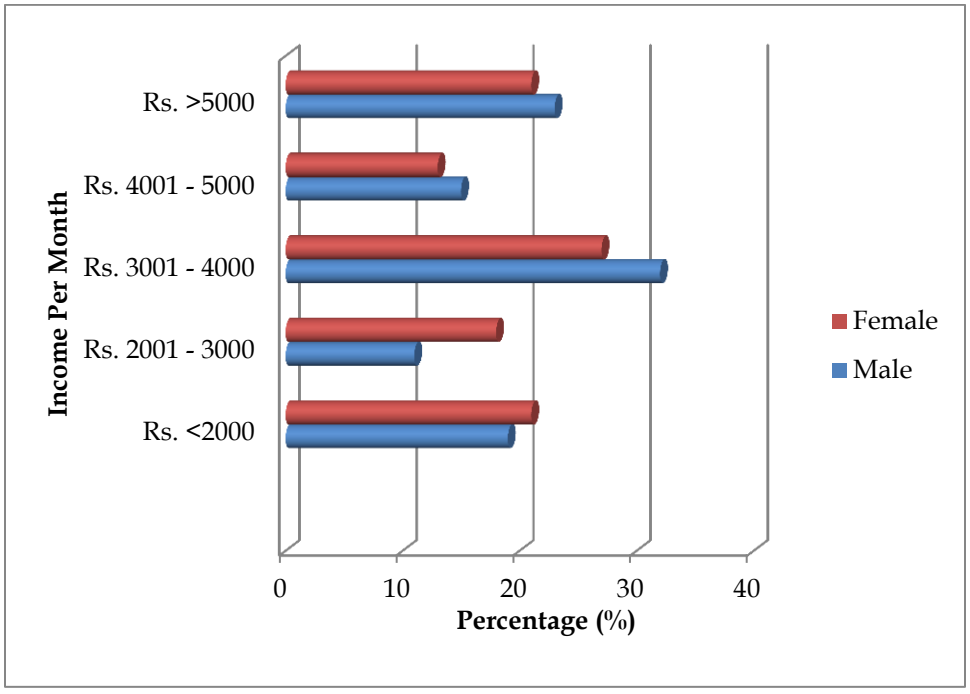


Table – 4.16

Distribution of the Respondents as per their Nature of Employer Before they Attained 60 Years of Age

Nature of Employer	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male found under different nature of Employer	N	% against total number of Female found under different nature of Employer	N	% against total number of respondents found under different nature of Employer
State or Central Government	10	10	0	0	10	6.90
Shops and Establishments Under Private Ownerships	27	27	0	0	27	18.62
Neighbouring Families	34	34	29	64.44	63	43.45
Self-employed as Farmer in Own Land	29	29	16	35.56	45	31.03
Total	**100**	**100**	**45***	**100**	**145**	**100**

***Sum total of the female presented in the table is less than the actual number of female selected for the present study since it was found that a large section of female respondents were house wife.**

Figure – 4.16

Bar Graph showing
Distribution of the Respondents as per their Nature of Employer
Before they Attained 60 Years of Age

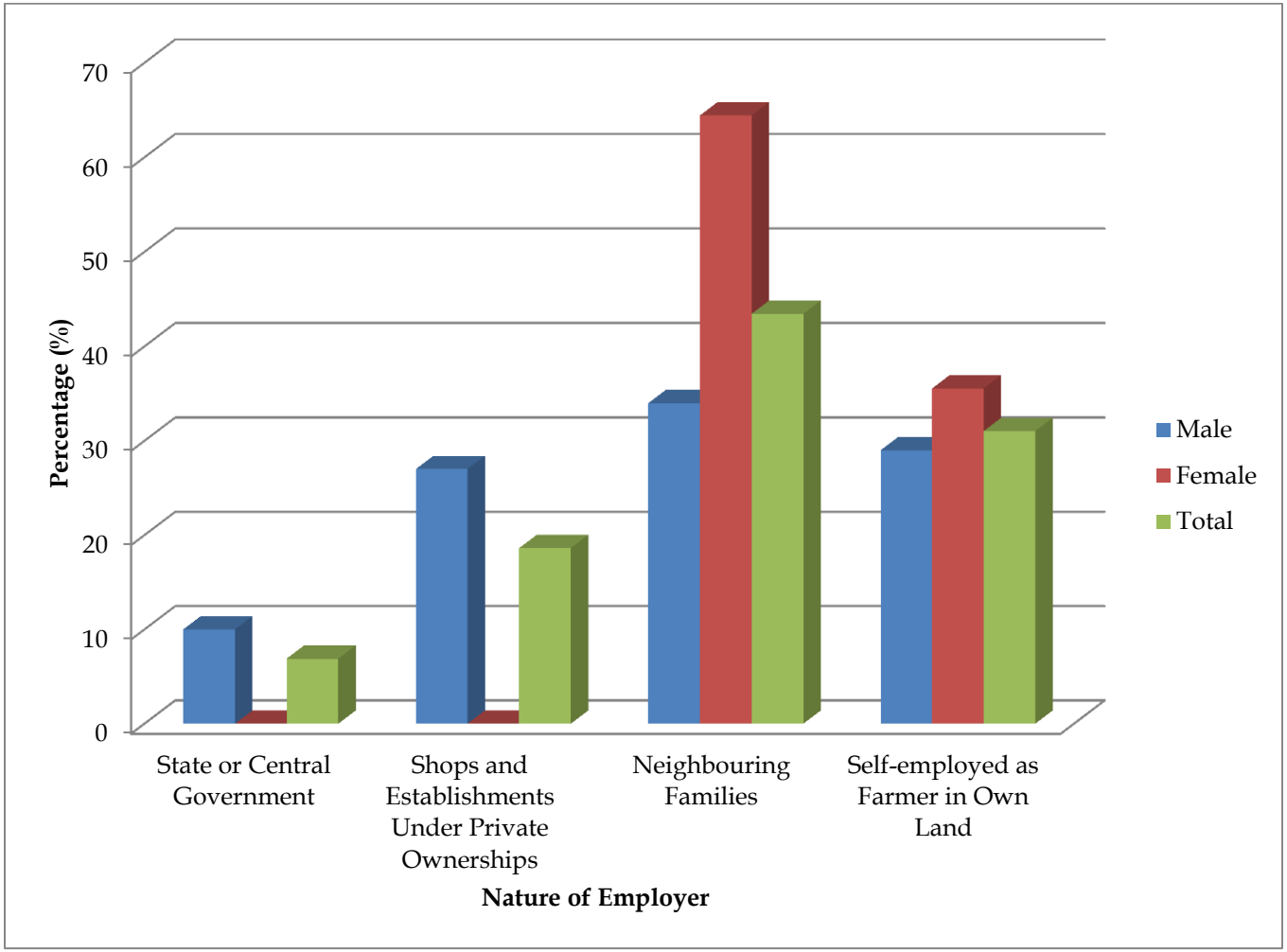


Table – 4.17

Receipt of Pension wise Distribution of the Respondents

Receipt of Pension	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total no. of Male Respondents	N	% against total no. of Female Respondents	N	% against total no. of Respondents
Receiver of Pension	46	46	45	45	91	45.5
Non-receiver of Pension	54	54	55	55	109	54.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.17

Pie Chart showing Receipt of Pension wise Distribution of the Respondents

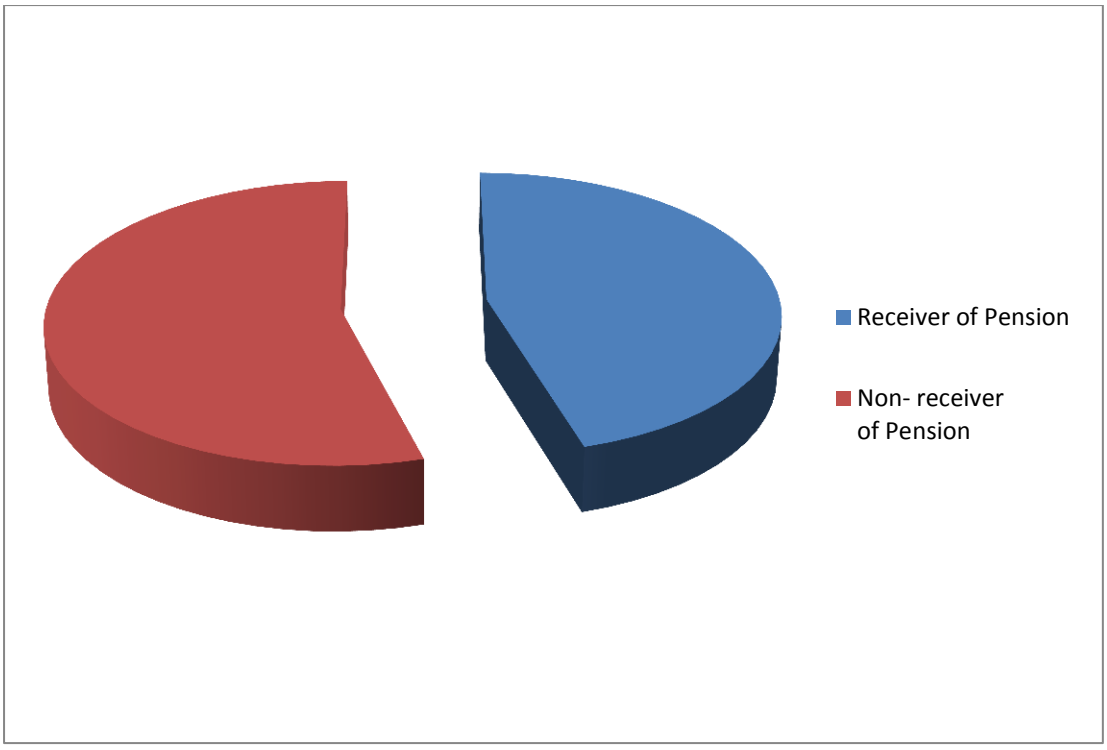


Table – 4.18

Receipt of the Type of Pension wise Distribution of the Respondents

Type of Pension Received per Month	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male Pensioners found under different types of Pension	N	% against total number of Female Pensioners found under different types of Pension	N	% against total number of Pensioners found under different types of Pension
Old Age Pension	36	78.26	31	68.89	67	73.63
Service Pension	10	21.74	0	0	10	10.99
Widow Pension	Nil	Nil	14	31.11	14	15.38
Total	**46**	**100**	**45**	**100**	**91**	**100**

Figure – 4.18

Pie Chart showing Recipient of the Type of Pension wise Distribution of the Respondents

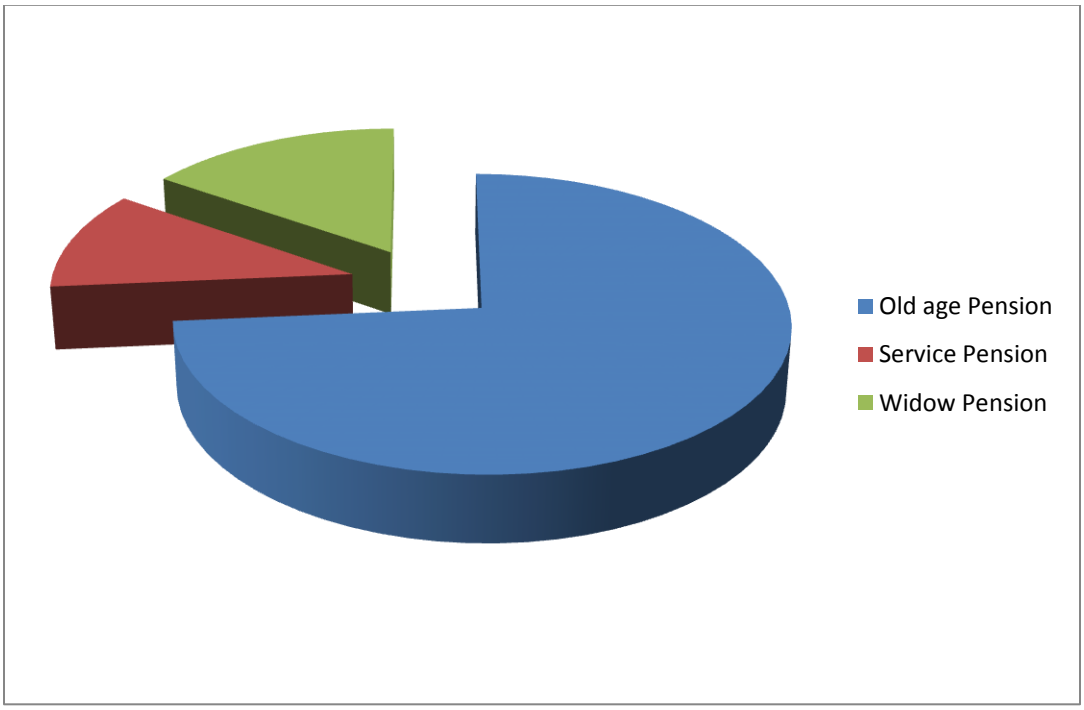


Table – 4.19

Amount of Pension Received Wise Distribution of the Respondents

Amount of Pension Received per Month	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male Pensioners	N	% against total number of Female Pensioners	N	% against total no. of Pensioners
Below Rs. 500	18	39.13	18	40	36	39.56
Rs. 501 - 1000	07	15.22	12	26.67	19	20.88
Rs. 1001 - 1500	06	13.04	04	8.89	10	10.99
Rs. 1501 - 2000	05	10.87	11	24.44	16	17.58
Above Rs. 2000	10	21.74	0	0	10	10.99
Total	**46**	**100**	**45**	**100**	**91**	**100**

Figure – 4.19

Bar Graph showing Amount of Pension Received Wise Distribution of the Respondents

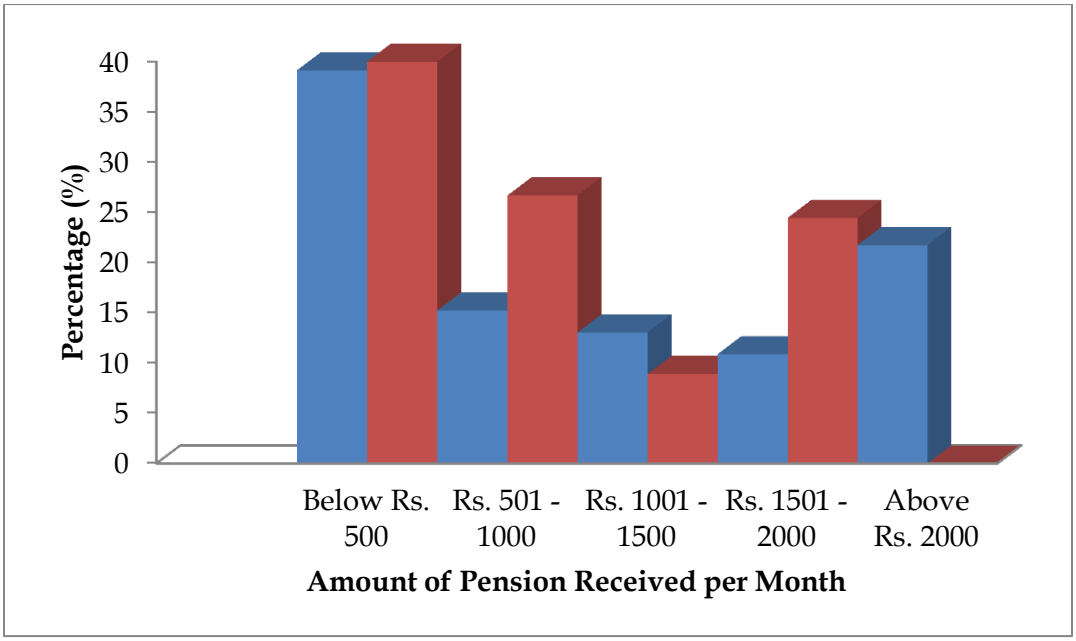


Table – 4.20

Organization Selected for Deposit of Savings Wise distribution of the Respondents

Organizations Selected for Savings	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
None	15	15	51	51	66	33
Post Office	29	29	18	18	47	23.5
Nationalized Bank	56	56	31	31	87	43.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.20

Bar Graph showing Organization Selected for Deposit of Savings wise distribution of the Respondents

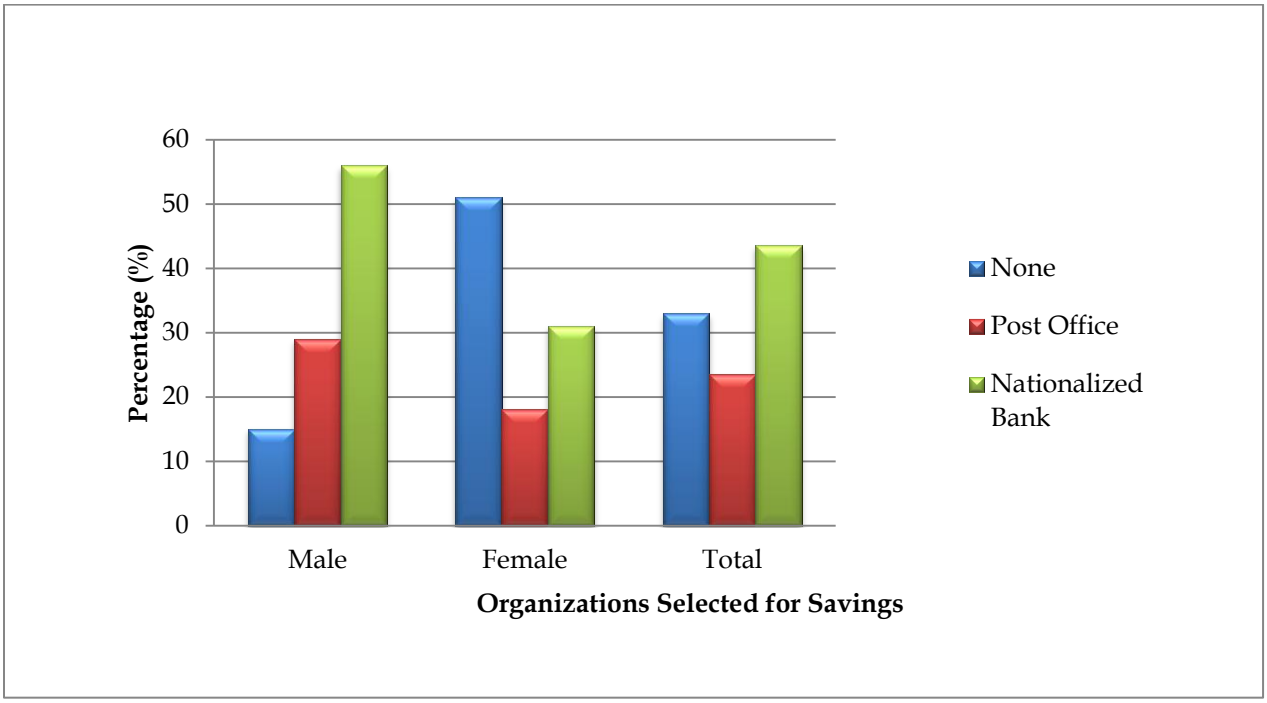


Table – 4.21

Ownership of Arable Land wise Distribution of the Respondents

Ownership of Arable Land	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Yes	71	71	20	20	91	45.5
No	29	29	80	80	109	54.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.21

Bar Graph showing Ownership of Arable Land wise Distribution of the Respondents

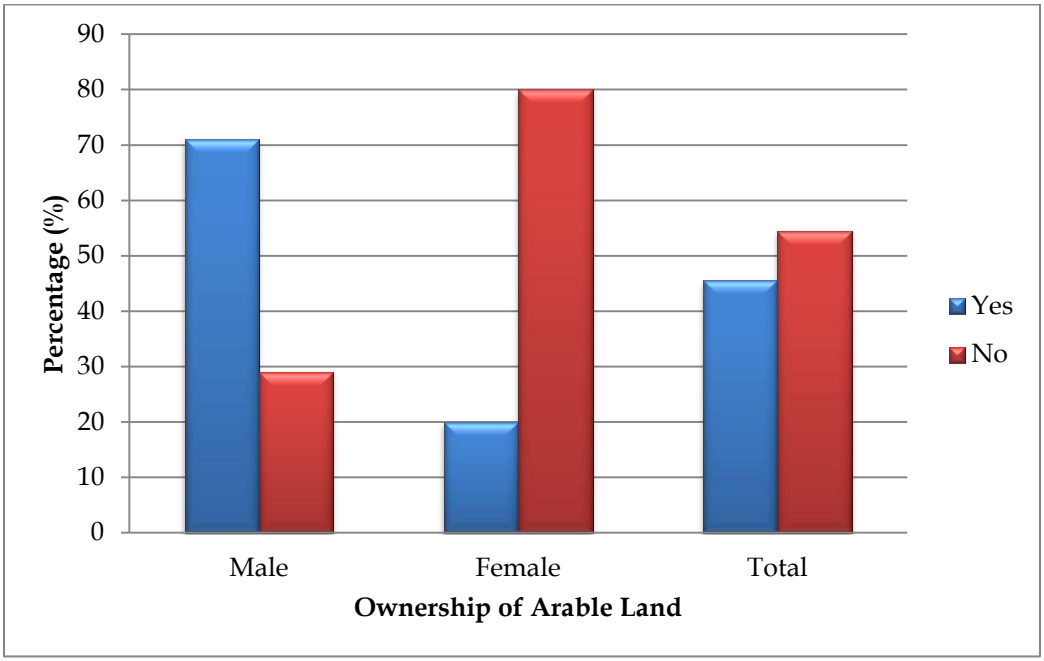


Table -4.22

Performance of House-hold Chores wise Distribution of the Respondents

Nature of the Chores	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Nothing	0	0	20	20	20	10
Cooking in Own House-hold	0	0	60	60	60	30
Gardening & Farming in Own House-hold	30	30	0	0	30	15
Sweeping of Own House	05	05	10	10	15	7.5
Marketing of own House-hold Necessities	45	45	0	0	45	22.5
Assists Family members During Different House-hold Chores.	0	0	10	10	10	05
Any Assigned House-hold Chores	20	20	0	0	20	10
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure -4.22

Bar Graph showing Performance of House-hold Chores Wise Distribution of the Respondents

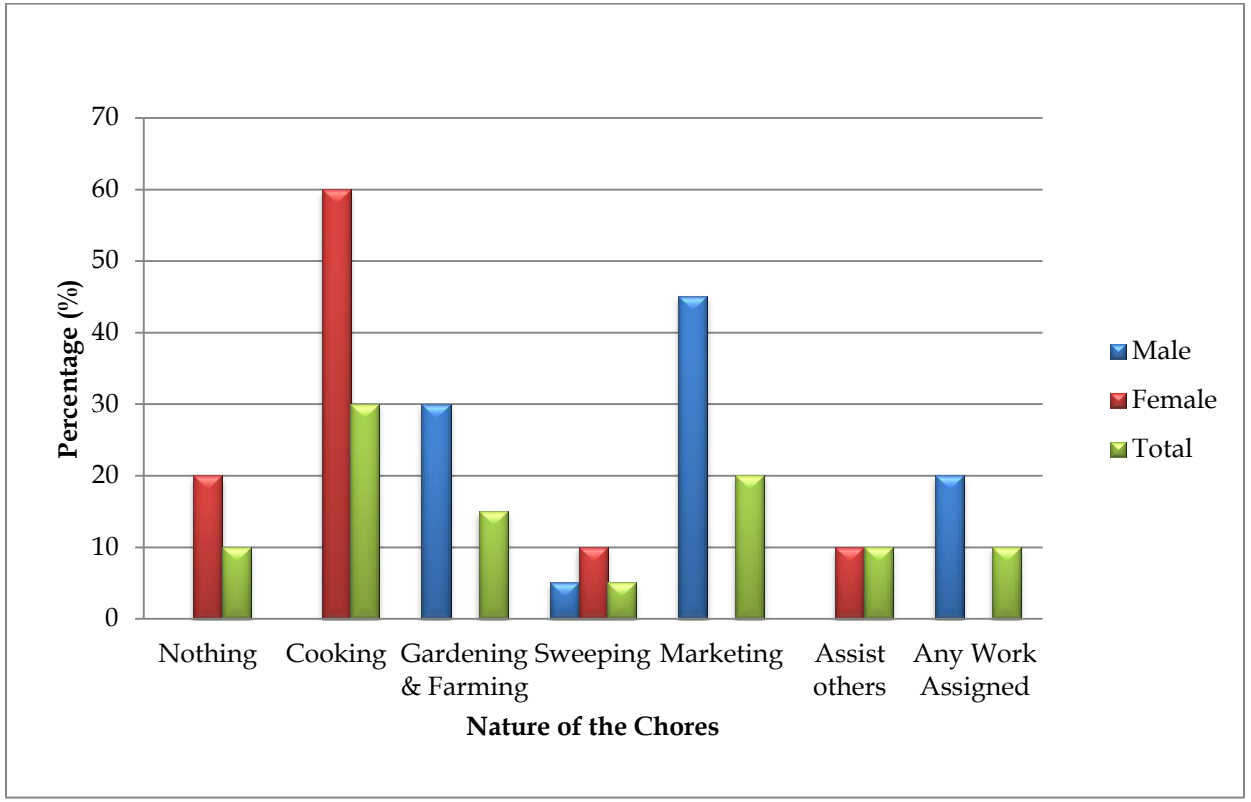


Table – 4.23

Recreational Activity wise Distribution of the Respondents

Types of Recreation	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Gossiping	12	12	25	25	37	18.5
Reading Fictions and Religious Texts	03	03	0	0	03	1.5
Listening to the Radio	11	11	05	05	16	08
Watching Television	15	15	11	11	26	13
Religious activities	31	31	42	42	73	36.5
Walking	13	13	08	08	21	10.5
Sleeping	15	15	09	09	24	12
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.23

Bar Graph showing Recreational Activity wise Distribution of the Respondents

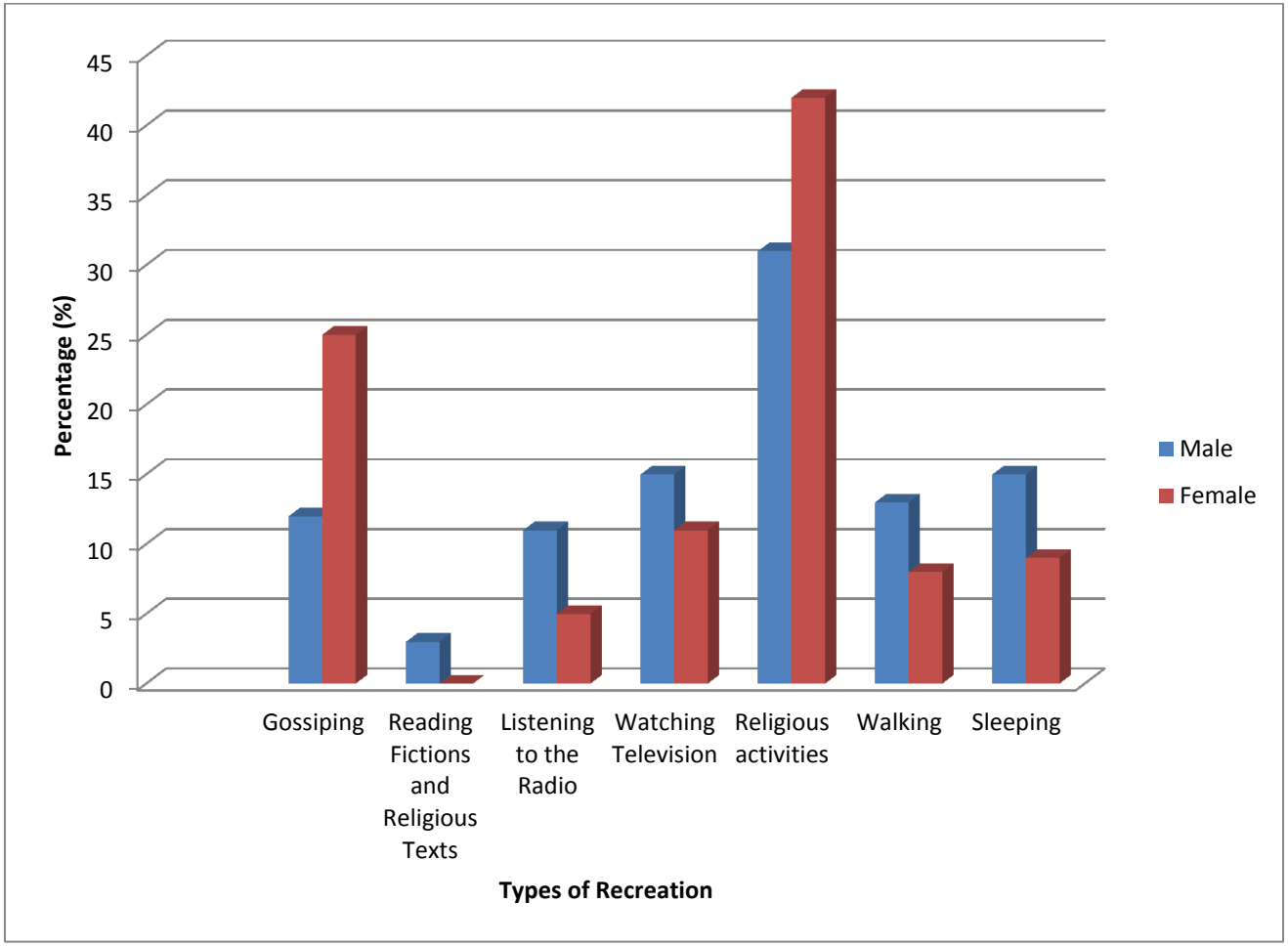


Table – 4.24

Participation in Pilgrimage wise Distribution of the Respondents

Participation in Pilgrimage	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Yes	72	72	35	35	107	53.5
No	28	28	65	65	93	46.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.24

Bar Graph showing Participation in Pilgrimage wise Distribution of the Respondents

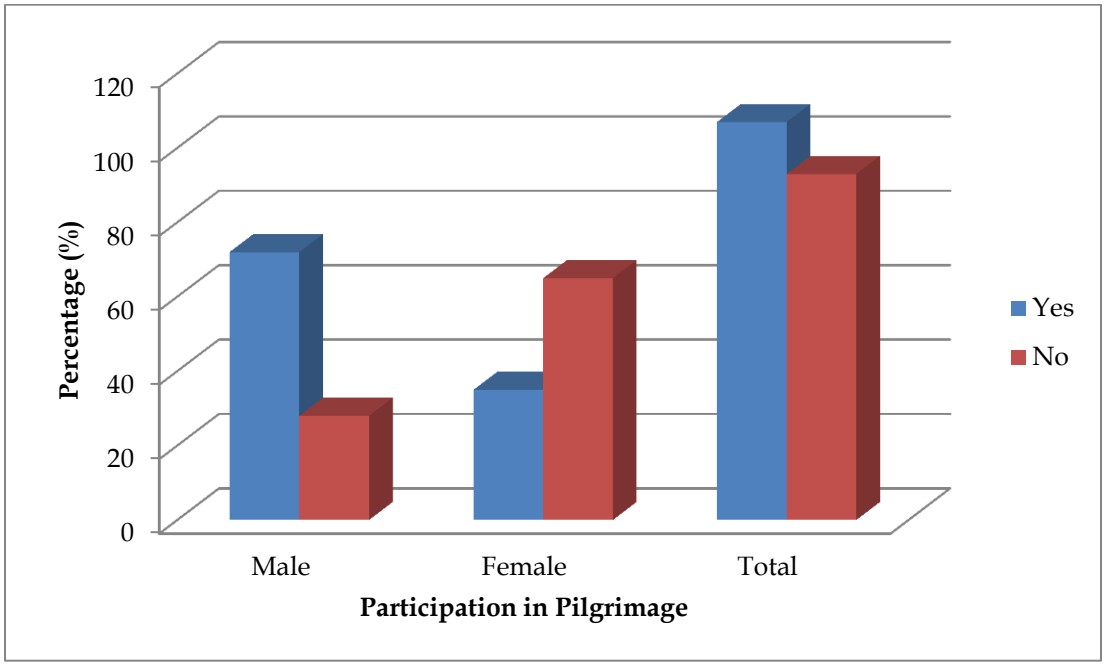


Table -4.25

Frequency of Pilgrimage wise Distribution of the Respondents

Frequency of Pilgrimage	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Monthly	26	36.11	05	14.28	31	28.97
Quarterly	20	27.77	05	14.28	25	23.36
Half-yearly	10	13.89	20	57.14	30	28.03
Annually	16	22.22	05	14.28	21	19.63
Total	**72**	**99.99**	**35**	**99.98**	**107**	**99.99**

Figure – 4.25

Bar Graph Showing Frequency of Pilgrimage wise Distribution of the Respondents

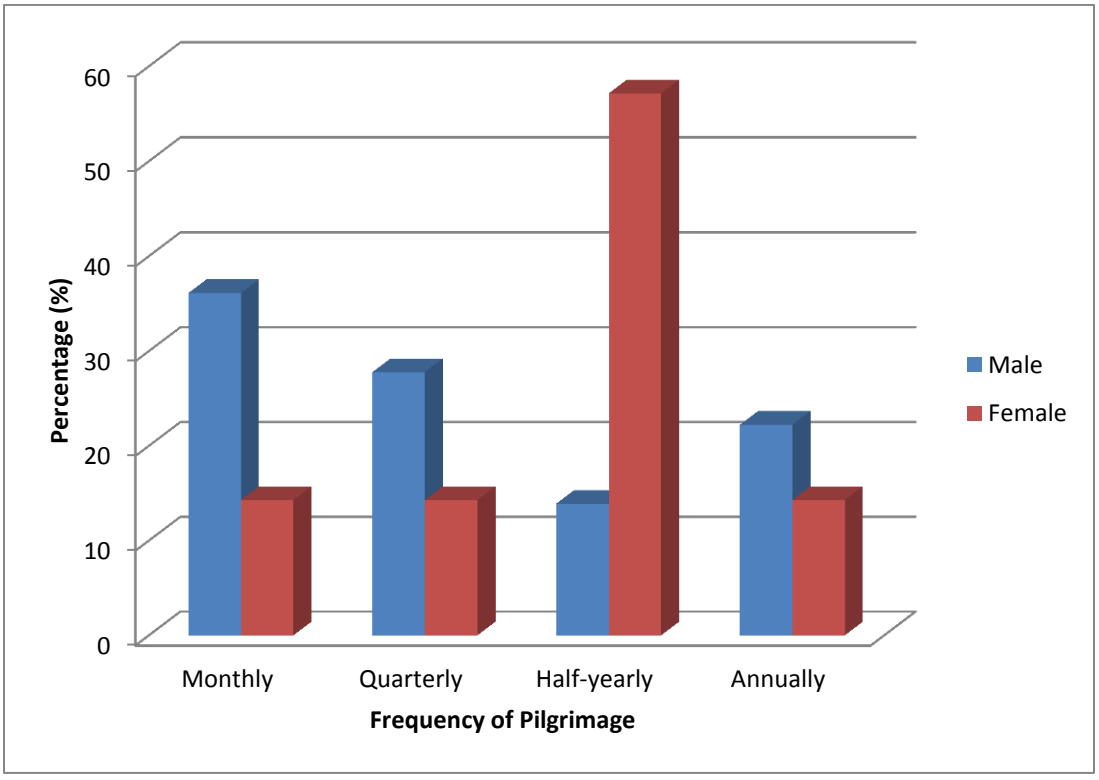


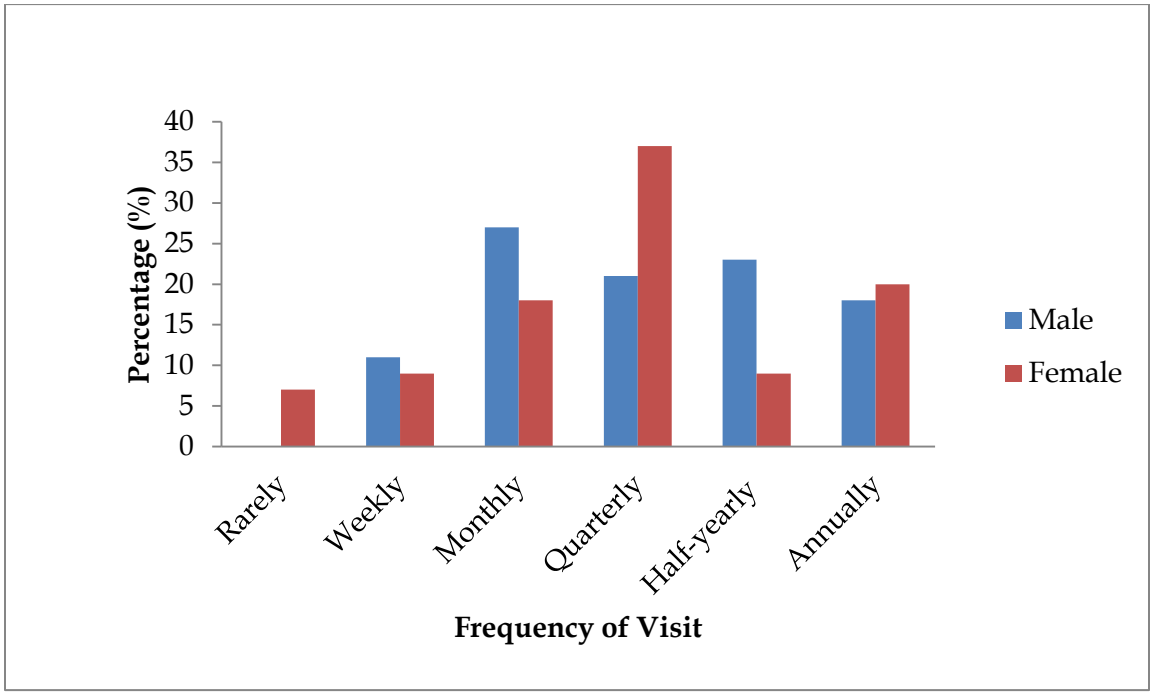
Table – 4.26

Frequency of Visit to Relative's House Wise Distribution of the Respondents

Frequency of Visit	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Rarely	0	0	07	07	07	3.5
Weekly	11	11	09	09	20	10
Monthly	27	27	18	18	45	22.5
Quarterly	21	21	37	37	58	29
Half-yearly	23	23	09	09	32	16
Annually	18	18	20	20	38	19
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.26

Bar Graph showing Frequency of Visit to Relative's House Wise Distribution of the Respondents



Section- III

Health Status of the Muslim Elderly

Table – 4.27

Self-report on Health Problem wise Distribution of the Respondents

Self Report on Health	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Devoid of any Problem	10	10	09	09	19	9.5
Facing Different Types of Health Problems	90	90	91	91	181	90.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.27

Pie Chart showing Self-report on Health Problem wise Distribution of the Respondents

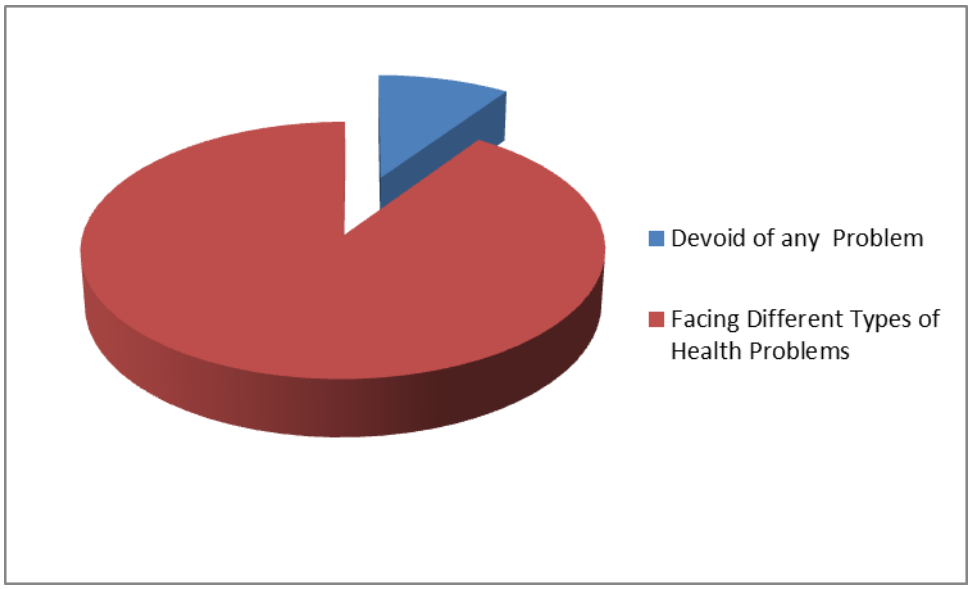


Table – 4.28

Self-reported Types of Health Problem Wise Distribution of the Respondents

Types of Health Problem	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total no. of health problems facing Male	N	% against total no. of health problems facing Female	N	% against total no. of health problems facing Respondents
Type-2 Diabetes Mellitus	18	20	20	21.98	38	28.99
Hypertension	48	53.33	48	52.75	96	53.03
Hypotension	10	11.11	10	10.99	20	11.04
Paralysis	05	5.55	05	5.49	10	5.52
Asthma	21	23.33	12	13.18	33	18.23
Bronchial Disease	23	25.55	20	21.99	43	23.75
Cardio-vascular disorder	14	15.55	10	10.99	24	13.26
Forgetfulness	15	16.66	11	12.08	26	14.36
Renal Disorder	02	2.22	0	0	02	1.10
Arthritis	41	45.55	37	40.66	78	43.09
Defective Vision	75	83.33	79	86.81	154	85.08
Deafness	06	6.66	03	3.29	09	4.97
Anemia	07	7.77	01	1.09	08	4.41
Blindness	02	2.22	0	0	02	1.10
Differently abled Limbs	24	26.66	35	38.46	59	32.59
Leprosy	02	2.22	0	0	02	1.10
Vocal Disorder	09	10	04	4.39	13	7.82
Fever at regular interval	08	8.89	12	13.18	20	11.04
Dermal Infection	15	16.66	09	9.89	24	13.25
Indigestion	13	14.44	09	9.89	22	12.15
Filariasis	05	5.55	01	1.09	06	3.31
Goiter	0	0	02	2.10	02	1.10

***It is to be noted that in many cases same respondent, either male or female, is simultaneously facing more than one types of health problem.**

Figure – 4.28

Bar Graph showing Self-reported Types of Health Problem Wise Distribution of the Respondents

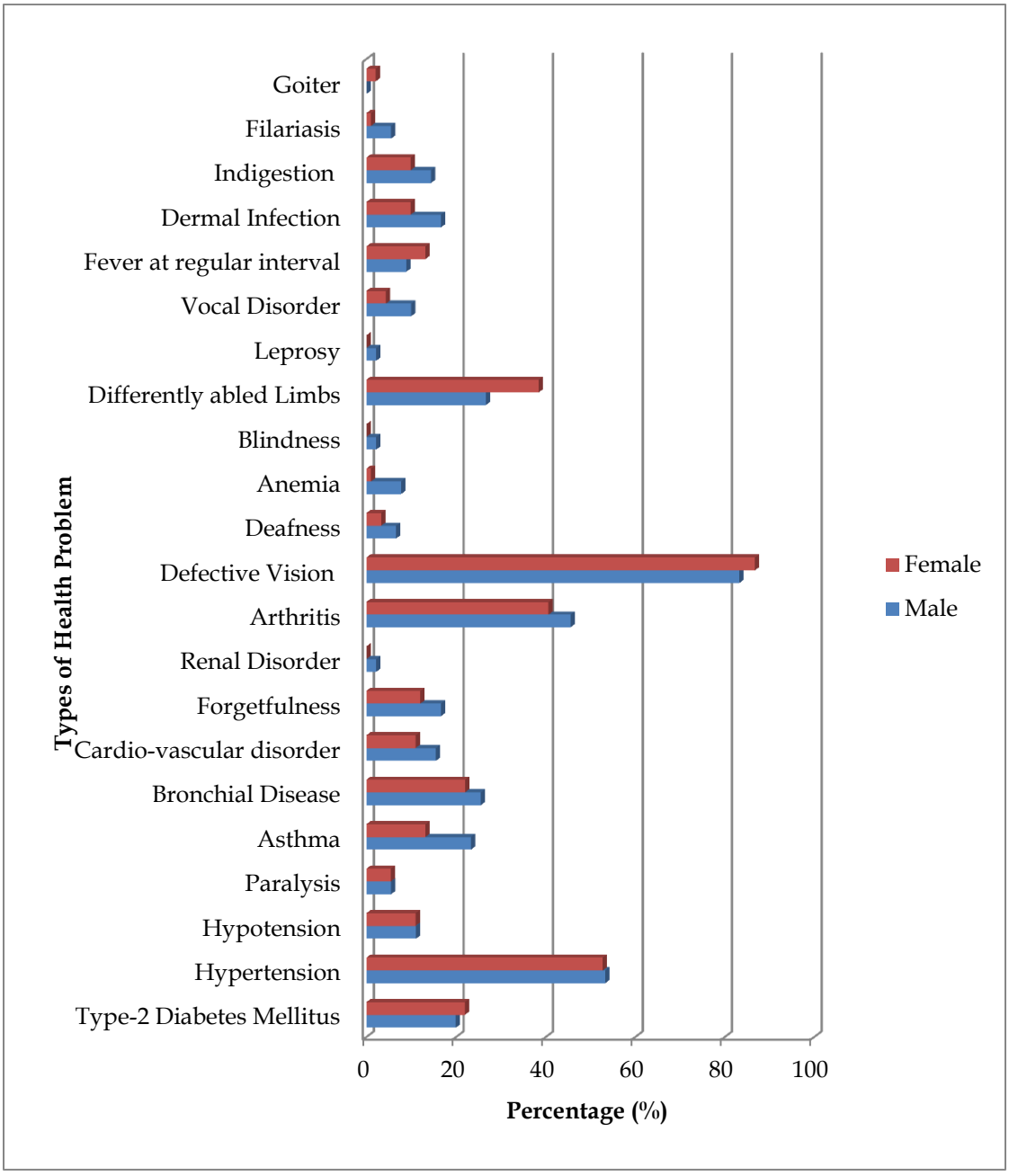


Table – 4.29

Presence of Sources of Care during their Illness Wise Distribution of the Respondents

Presence of Sources of Care	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Present	94	94	97	97	191	95.5
Absent	06	06	03	03	09	4.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.29

Pie Chart showing the Presence of Sources of Care during their Illness Wise Distribution of the Respondents

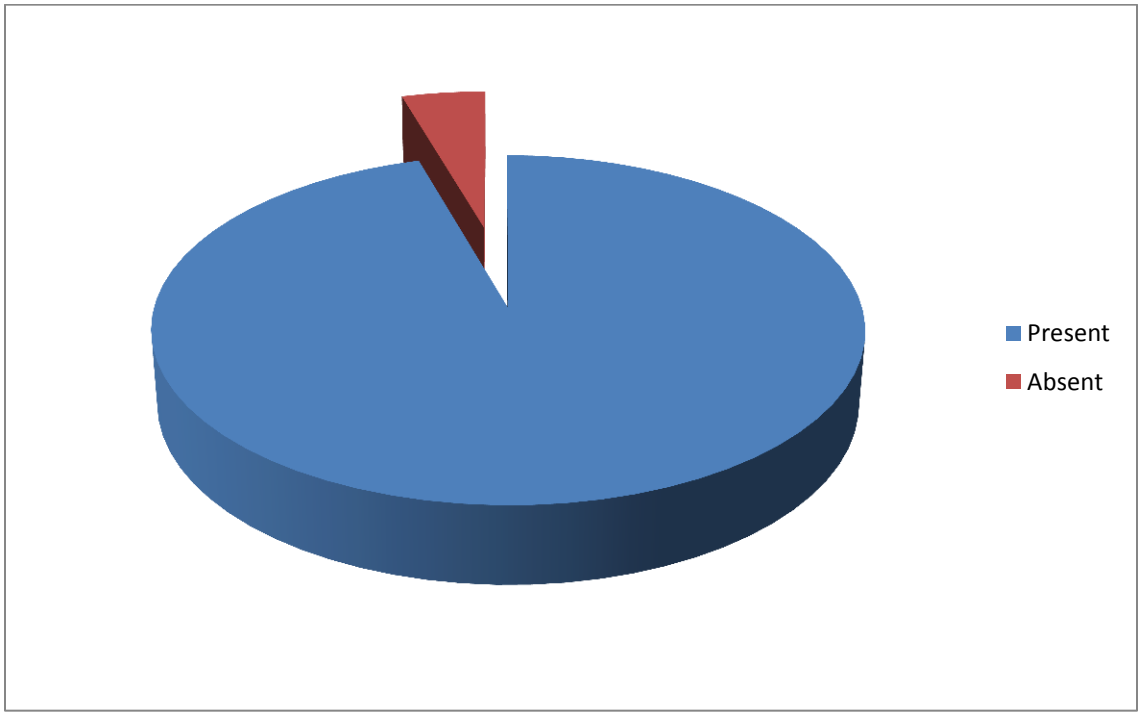


Table – 4.30

Types of Source of Care during their Illness Wise Distribution of the Respondents

Types of Source of Care	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Spouse	62	65.96	49	50.51	111	58.11
Children	13	13.83	27	27.83	40	20.94
Friends	10	10.64	13	13.40	23	12.04
Neighbours	09	9.57	08	8.25	17	8.9
Total	**94**	**100**	**97**	**99.99**	**191**	**99.99**

Figure – 4.30

Bar Graph showing the Types of Source of Care during their Illness Wise Distribution of the Respondents

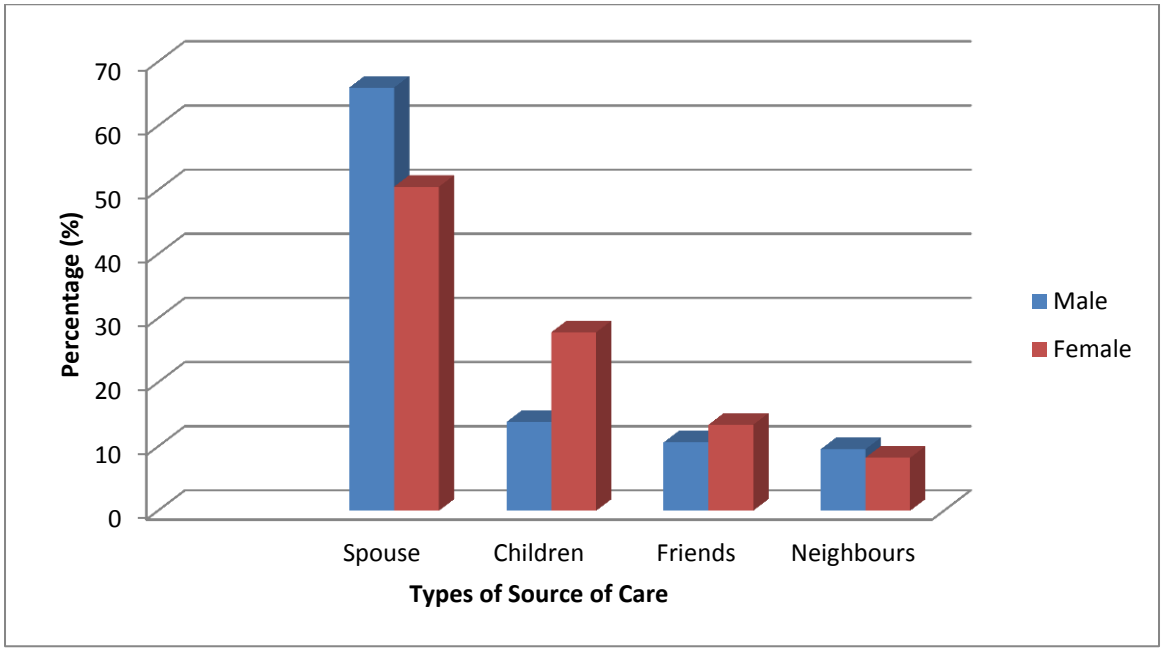


Table – 4.31

Nature of Mobility wise Distribution of the Respondents

Nature of Mobility	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Bed Ridden	06	06	08	08	14	07
Slightly Mobile	13	13	28	28	41	20.5
Fairly Mobile	52	52	32	32	84	42
Mobility with a Stick	25	25	29	29	54	27
Wheel Chair	04	04	03	03	07	3.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.31

Bar Graph showing the Nature of Mobility wise Distribution of the Respondents

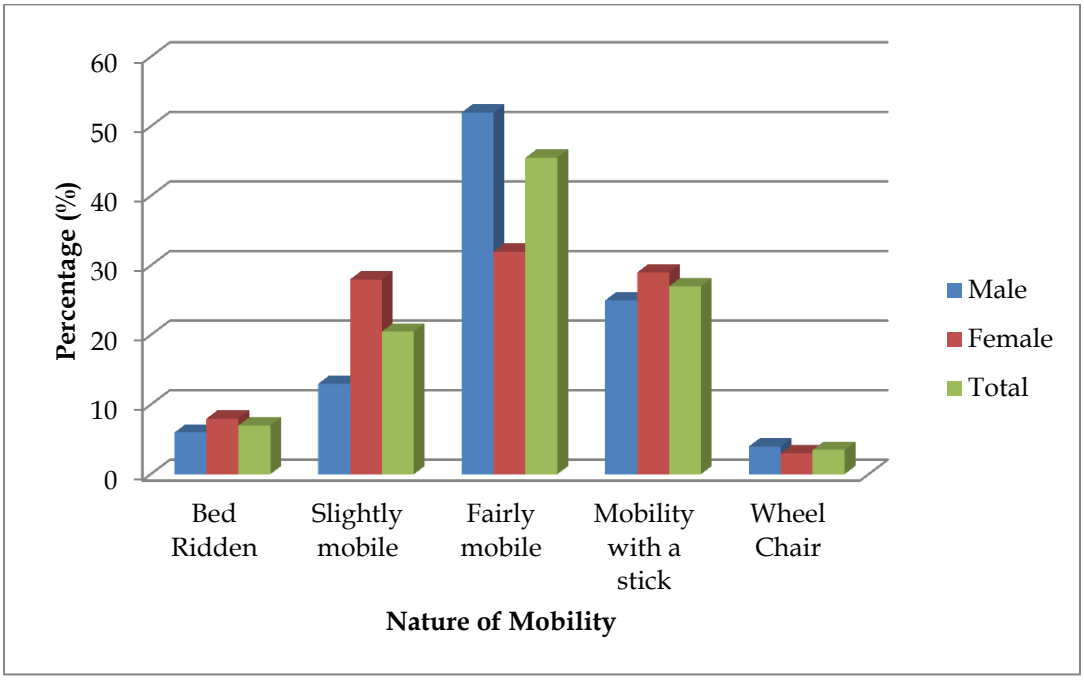


Table – 4.32

Nature of Mobility of the Respondents in Different Age Group

Age Group	Nature of Mobility wise Distribution of the Respondents											
	Bed ridden		Slightly Mobile		Fairly Mobile		Mobility with a Stick		Wheel Chair		Total	
	N	% against total no. of Bed ridden Respondents	N	% against total no. of Slightly Mobile Respondents	N	% against total no. of Fairly Mobile Respondents	N	% against total no. of Mobility with a Stick Respondents	N	% against total no. of Wheel Chair Respondents	N	% against total no. of Respondents
60-64	0	0	04	9.75	26	30.95	0	0	0	0	31	15.5
65-69	0	0	08	19.51	17	20.23	05	9.26	0	0	30	15
70-74	04	28.57	07	17.07	23	27.39	08	14.81	0	0	43	21.5
75-79	03	21.43	07	17.07	12	14.29	20	37.04	02	28.57	45	22.5
80 and above	07	50	15	36.58	06	7.14	21	38.89	05	71.43	51	25.5
Total	**14**	**100**	**41**	**100**	**84**	**100**	**54**	**100**	**07**	**100**	**200**	**100**

Figure – 4.32

Bar Graph showing Mobility of the Respondents in Different Age Group

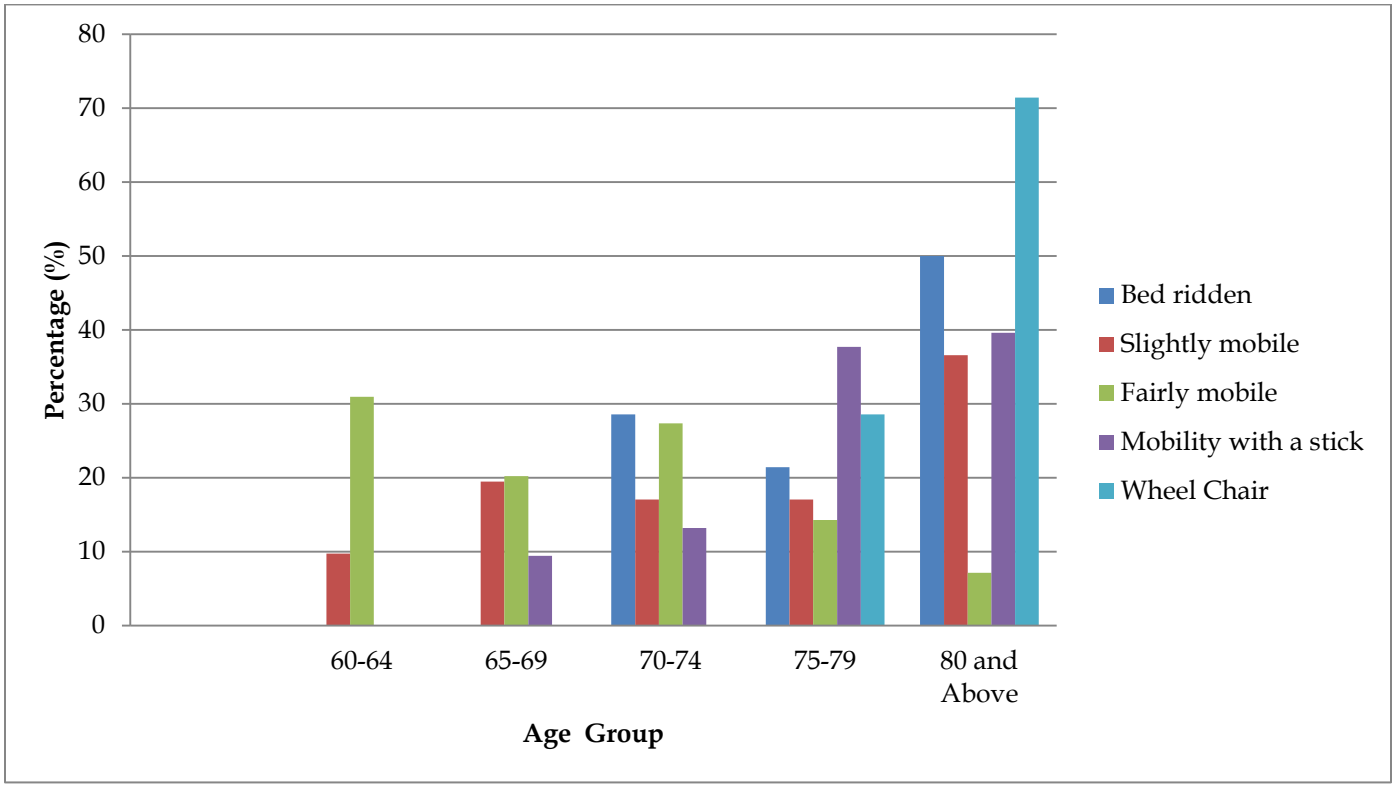


Table -4.33

ADL Status wise Distribution of the Respondents

ADL Status	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Active	58	58	61	61	119	59.5
Mildly Disabled	25	25	26	26	51	25.5
Severely Disabled	17	17	13	13	30	15
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure -4.33

Bar Graph showing ADL Status wise distribution of the Respondents

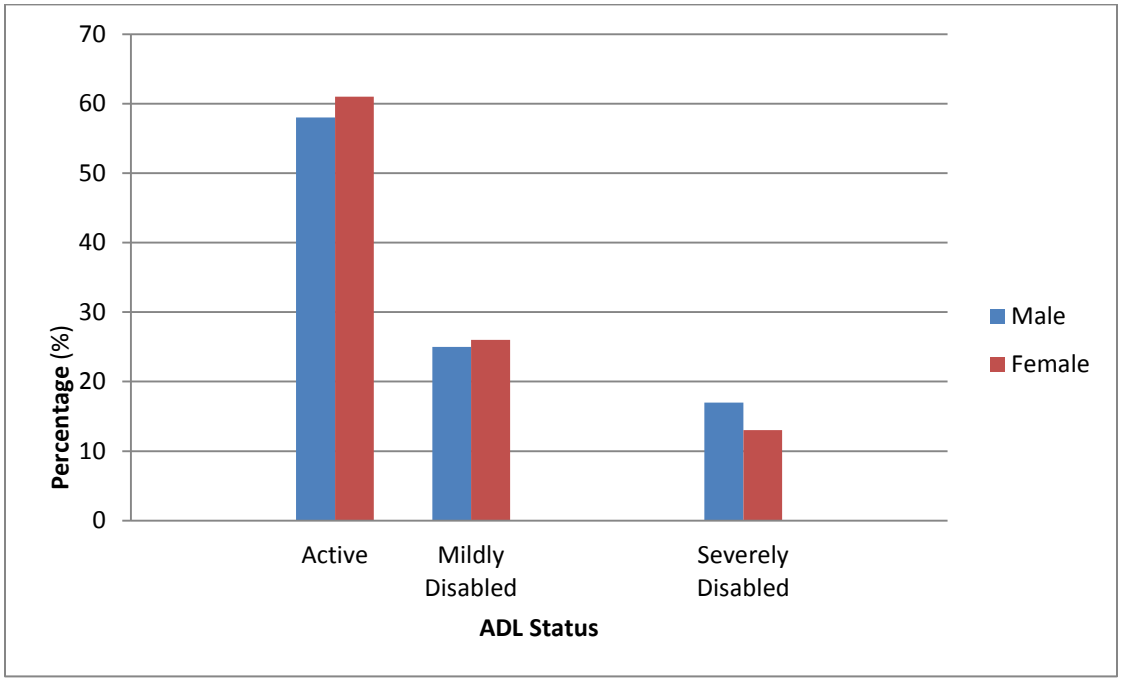


Table -4.34

ADL Status of the Respondents in Different Age Group

Age Group	ADL Status wise Distribution of the Respondents							
	Active		Mildly Disabled		Severely Disabled		Total	
	N	% against total no. of Active Respondents	N	% against total no. of Mildly Disabled Respondents	N	% against total no. of Severely Disabled Respondents	N	% against total no. of Respondents
60-64	41	34.45	18	35.29	06	20	65	32.5
65-69	33	27.74	12	23.54	04	13.33	49	24.5
70-74	24	20.17	13	25.49	05	16.66	42	21
75-79	16	13.44	06	11.76	04	13.33	26	13
80 & Above	05	4.20	02	3.92	11	36.68	18	09
Total	**119**	**100**	**51**	**100**	**30**	**100**	**200**	**100**

Figure – 4.34

Bar Graph Showing ADL Status of the Respondents In Different Age Group

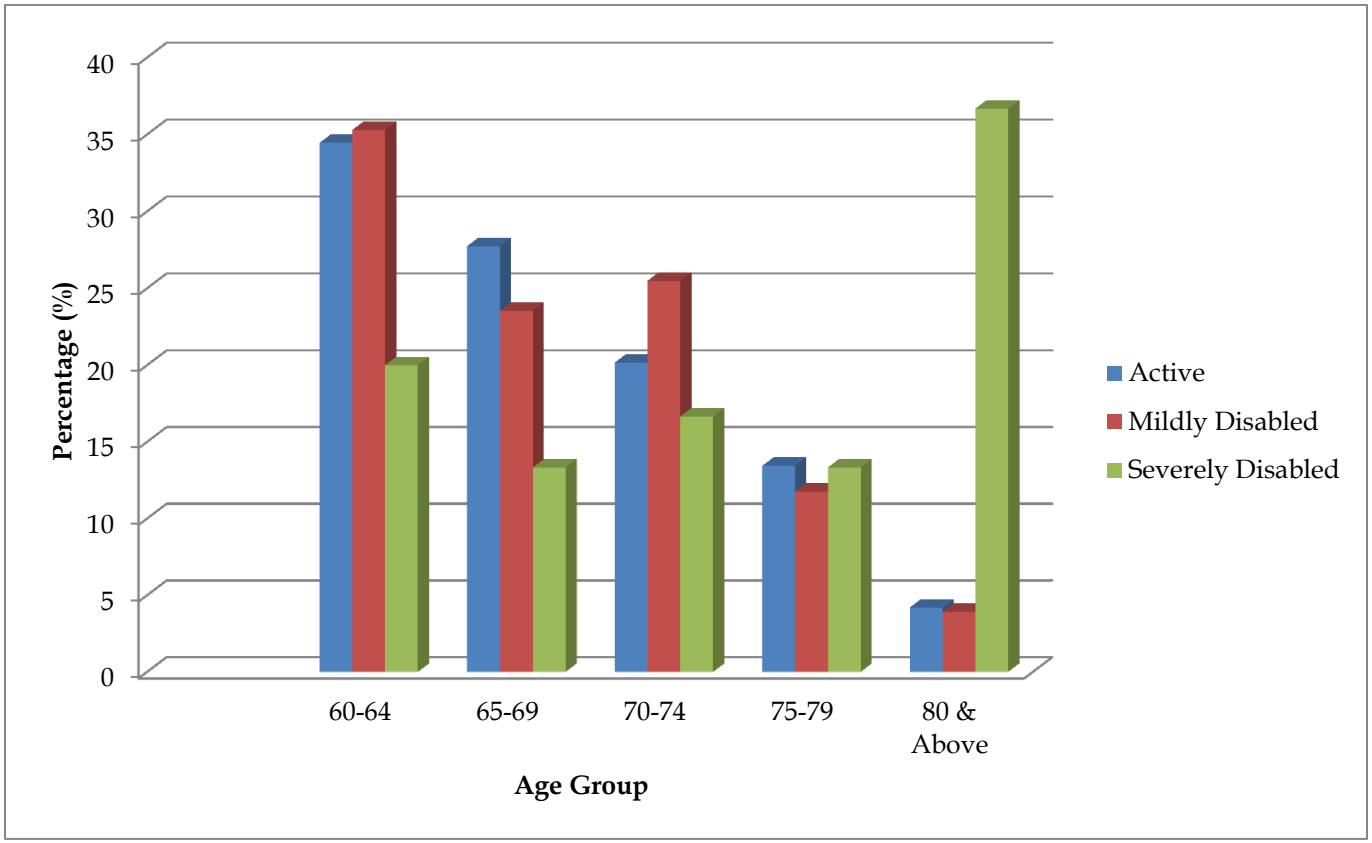


Table -4.35

Different Ability wise Distribution of the Respondents

Nature of Different Ability	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Differently Able Male	N	% against total number of Differently Able Female	N	% against total number of Differently Able Respondents
Vision	83	46.89	52	39.69	135	43.83
Hearing	41	23.17	58	44.28	99	32.14
Walking	53	29.94	21	16.03	74	24.02
Total	**177**	**100**	**131**	**100**	**308***	**100**

***Total no. of male and total no. of female shown in the table exceeds the actual no. of selected male and female respondents respectively since in many cases same person has been included simultaneously under more than one type of Different Ability.**

Figure – 4.35

Pie Chart showing the nature of Different Ability Wise Distribution of the Respondents

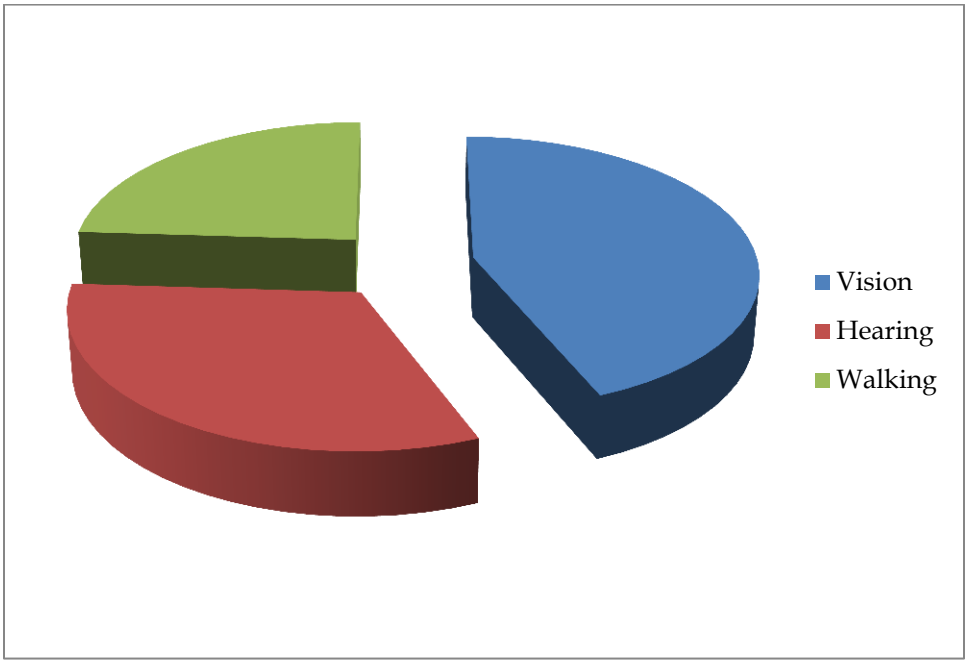


Table – 4.36

Use of Supporting Aid wise Distribution of the Respondents

Supporting Aids	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of male using Supporting Aids	N	% against total number of Female using Supporting Aids	N	% against total number of Respondents using Supporting Aids
Spectacles	72	38.7	67	38.95	110	33.43
Hearing Aid	29	15.6	11	6.39	40	12.16
Wheel Chair	04	2.15	03	1.74	07	2.13
Walking Stick	54	29.03	59	34.4	113	34.35
Denture	27	14.52	32	18.7	59	17.93
Total	**186**	**100**	**172**	**100**	**329***	**100**

***Total no. of male and total no. of female shown in the table exceeds the actual no. of selected male and female respondents respectively since in many cases same person has been included simultaneously under more than one type of Supporting Aid use.**

Figure – 4.36

Bar Graph showing Use of Supporting Aid Wise Distribution of the Respondents

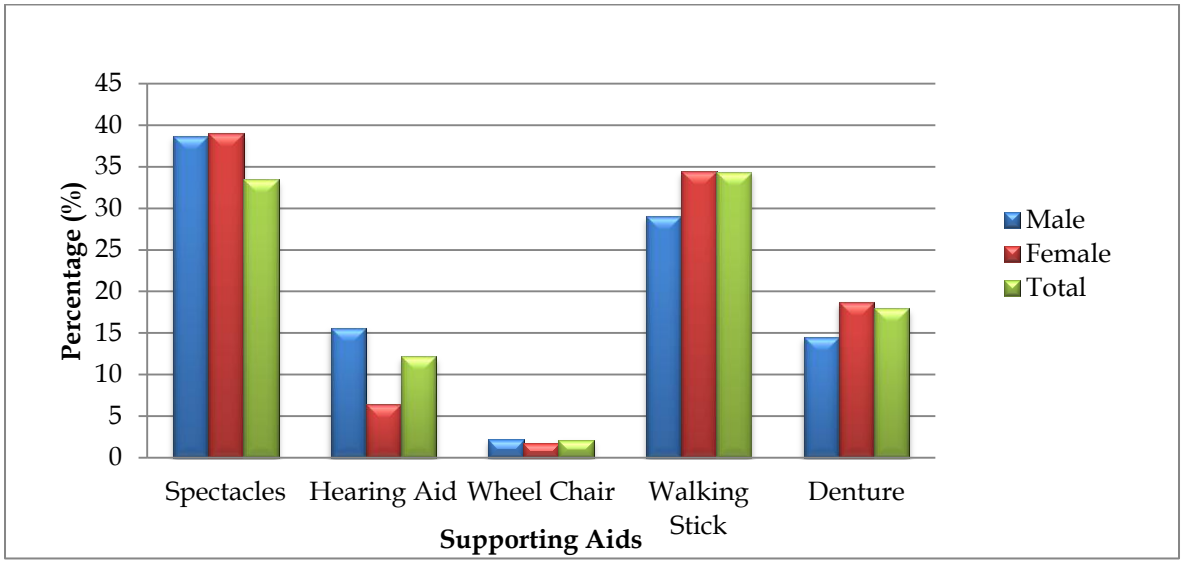


Table – 4.37

Financial Sources for Purchasing Supporting-Aids Wise Distribution of the Respondents

Types of Supporting Aids	Financial Sources of the Respondents						Total No. of Users of Different Types of Supporting-Aid	
	Own		Children		Others			
	N	% against total No. of Supporting-Aid Users	N	% against total No. of Supporting-Aid Users	N	% against total No. of Supporting-Aid Users	N	% against total No. of Respondents
Spectacles	59	53.63	46	41.82	05	4.54	110	55
Hearing Aid	26	65	11	27.5	03	7.5	40	20
Wheel Chair	04	57.14	02	28.57	01	14.28	07	3.5
Walking Stick	52	46.1	56	49.56	05	4.42	113	56.5
Denture	25	42.37	33	55.93	01	1.69	59	29.5

Total no. of users of Supporting-Aids appears in the table exceeds the sum total of selected respondents across both the sexes since in many cases same person use more than one supporting-aid simultaneously.

Figure – 4.37

Bar Graph showing Financial Sources for Purchasing Supporting-Aids Wise Distribution of the Respondents

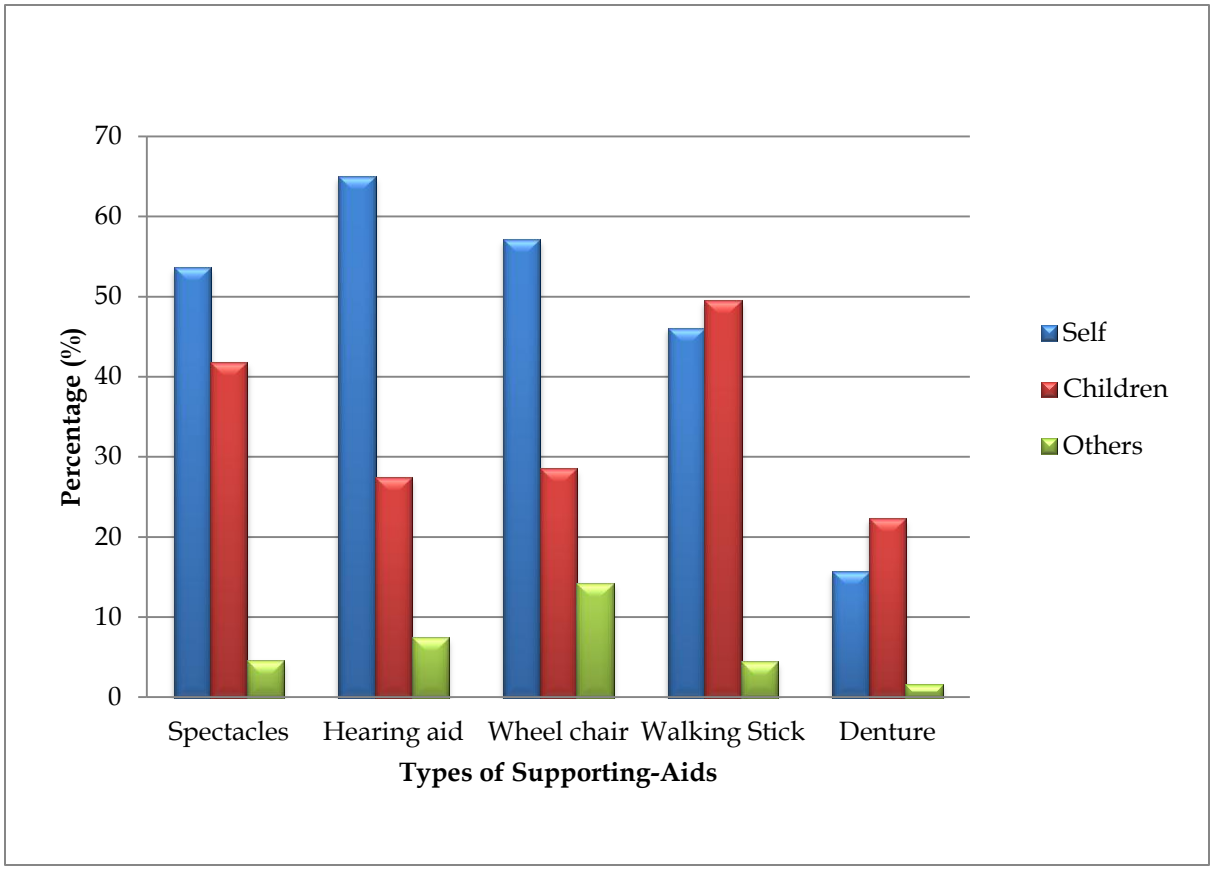


Table – 4.38

Frequency of Requirements for Medical Help Wise Distribution of the Respondents

Frequency of Requirements	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Regularly Required	11	11	29	29	40	20
Once in a Week	17	17	23	23	40	20
At the interval of 2-3 Months	10	10	0	0	10	05
Rarely Required	62	62	48	48	110	55
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.38

Bar Graph Showing Frequency of Requirements for Medical Help Wise Distribution of the Respondents

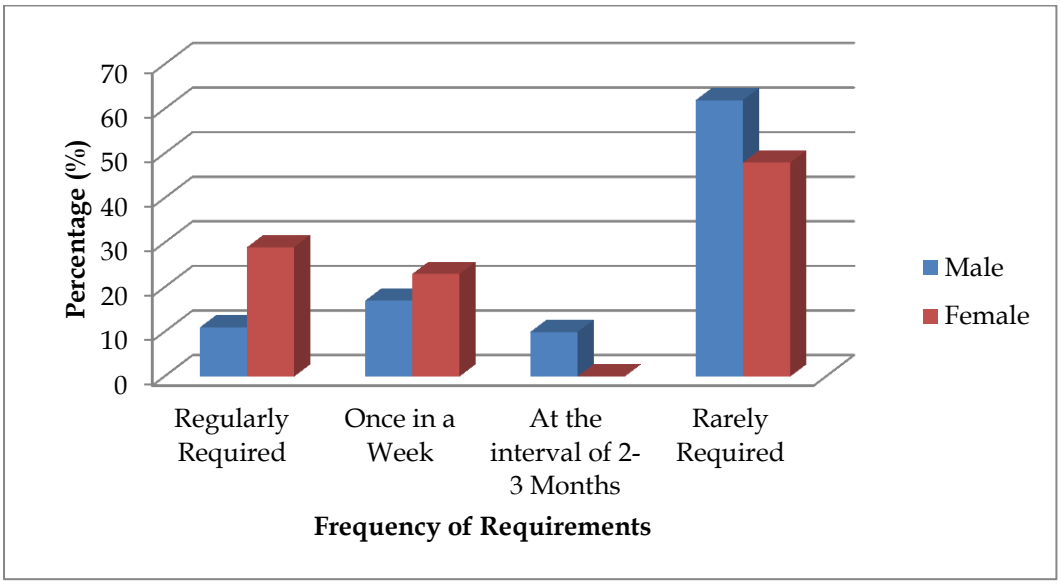


Table -4.39

Frequency of Eating per Day Wise Distribution of the Respondents

Frequency of Eating Per Day	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
1 -2 times	40	40	30	30	70	35
3 - 4 times	60	60	50	50	110	55
5 - 6 times	0	0	20	20	20	10
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.39

Bar Graph showing Frequency of Eating per Day Wise Distribution of the Respondents

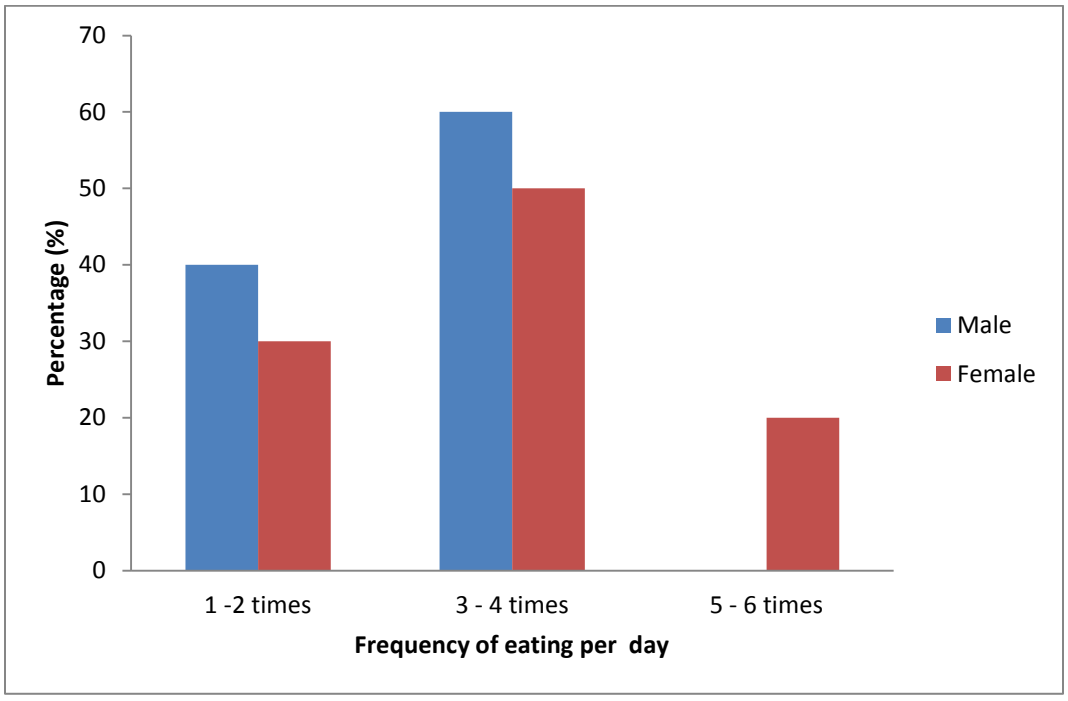


Table – 4.40

Vegetable and Non-Vegetable Food Habit Wise Distribution of the Respondents

Food Habit	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Vegetable Items	12	12	27	27	39	19.5
Non-vegetable Items	88	88	73	73	161	80.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.40

Bar Graph showing Vegetable and Non-Vegetable Food Habit Wise Distribution of the Respondents

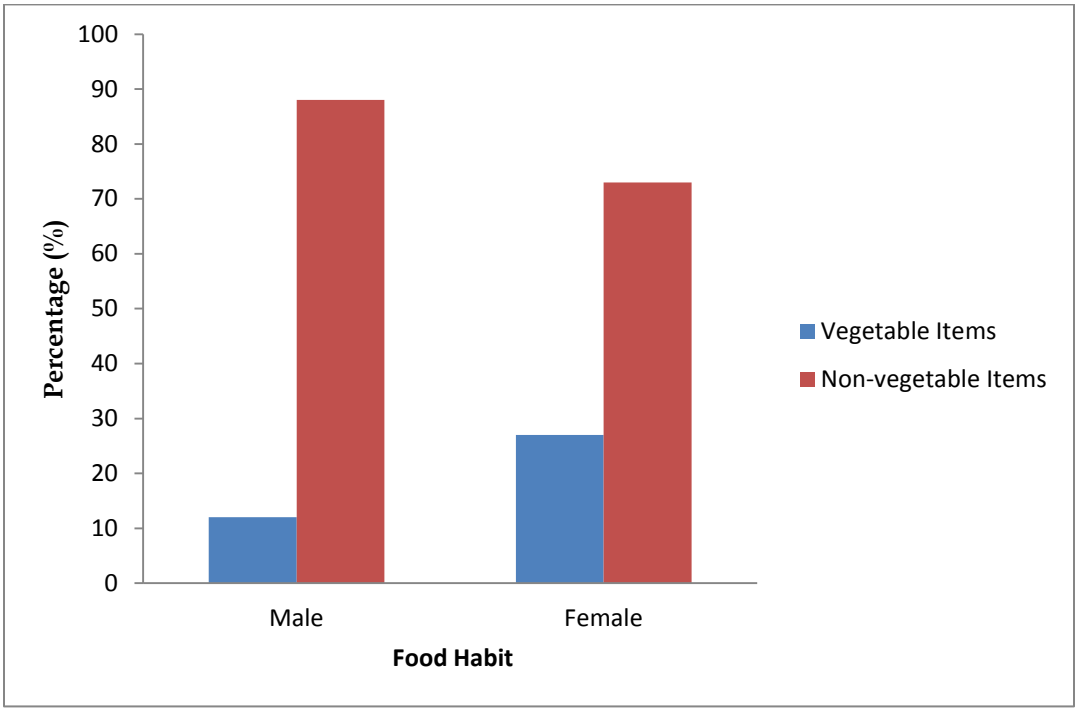


Table – 4.41

Frequency of Milk Consumption Wise Distribution of the Respondents

Frequency of Milk Consumption	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Regularly	24	24	15	15	39	19.5
Occasionally	49	49	54	54	103	51.5
Never	27	27	31	31	58	29
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.41

Bar Graph showing Frequency of Milk Consumption Wise Distribution of the Respondents

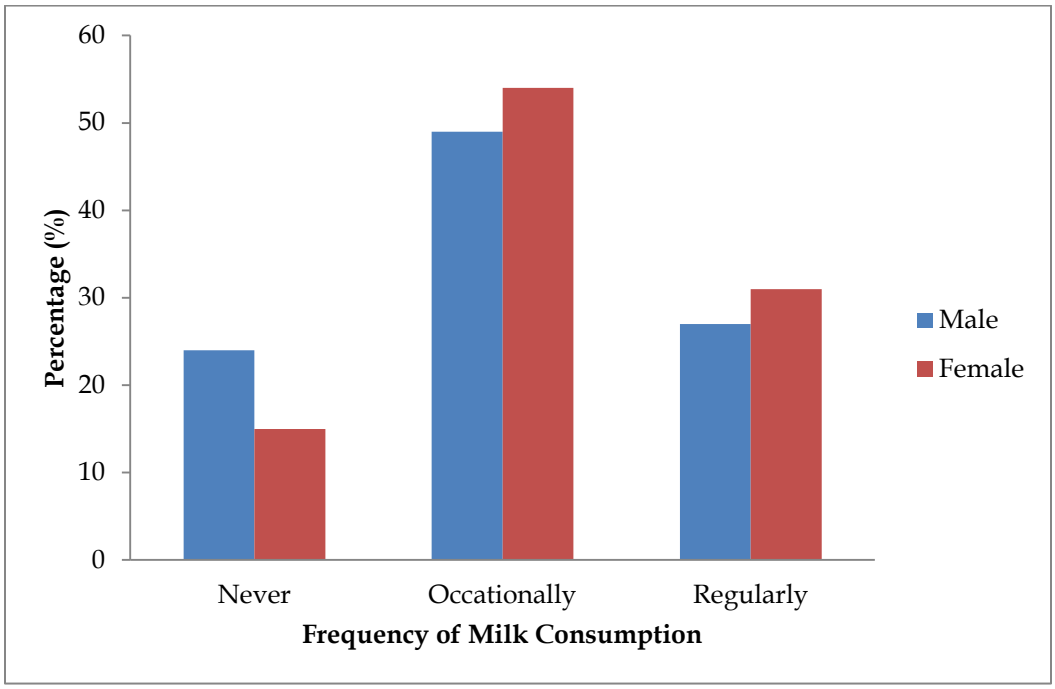


Table – 4.42

Tobacco Consumption wise Distribution of the Respondents

Consumption of Tobacco	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total no. of Male Respondents	N	% against total no. of Female Respondents	N	% against total no. of Respondents
Consumer	72	72	36	36	108	54
Non-Consumer	28	28	64	64	92	46
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.42

Pie Chart showing Tobacco Consumption Wise Distribution of the Respondents

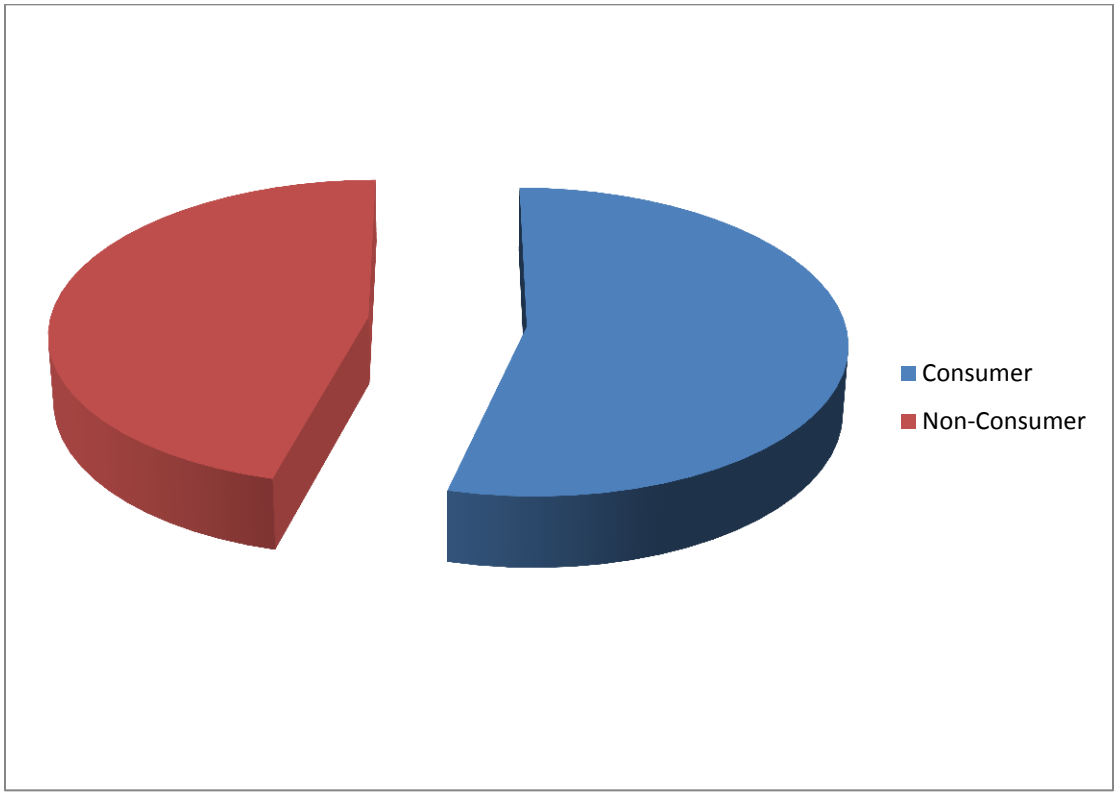


Table – 4.43

Mode of Consumption of Tobacco Wise Distribution of the Respondents

Mode of Consumption	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total no. of tobacco consumers	N	% against total no. of tobacco consumers	N	% against total no. of tobacco consumers
Chewing	11	15.28	30	83.33	41	37.96
Smoking	61	84.72	06	16.67	67	62.04
Total	**72**	**100**	**36**	**100**	**108**	**100**

Figure – 4.43

Pie Chart showing Mode of Consumption of Tobacco Wise Distribution of the Respondents

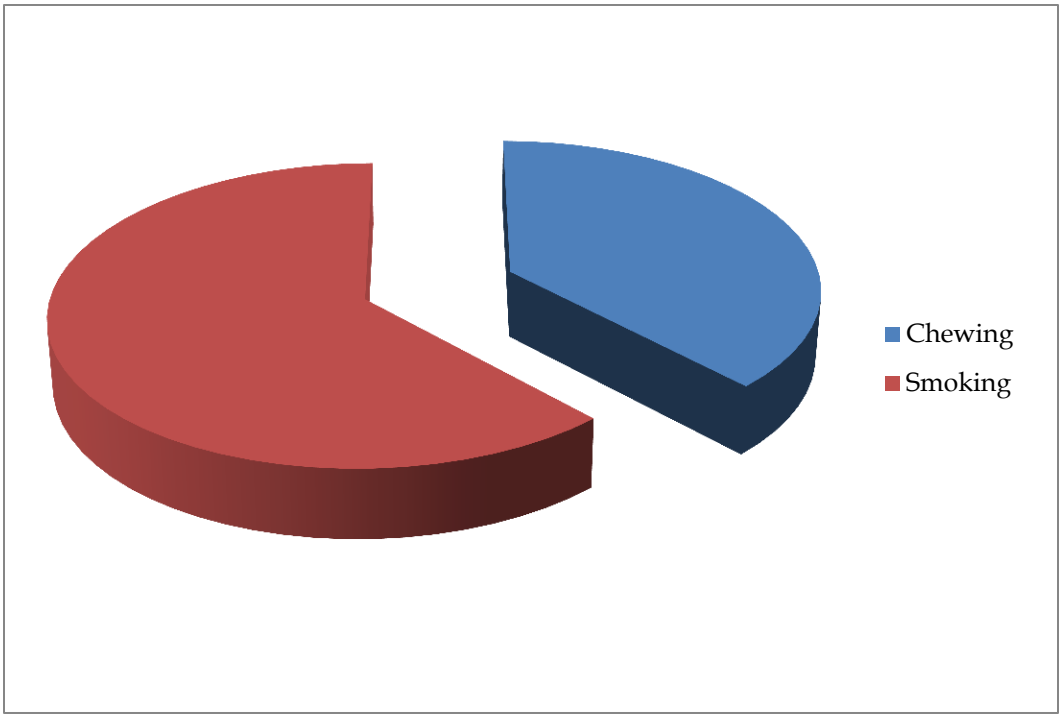


Table -4.44

Sleeping Hour per Day wise Distribution of the Respondents

Hour of Sleeping	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
6 - 7 Hours	37	37	33	33	70	35
8 - 9 Hours	39	39	58	58	97	48.5
More than 9 Hours	24	24	09	09	33	16.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.44

Bar Graph showing Sleeping Hour per Day Wise Distribution of the Respondents

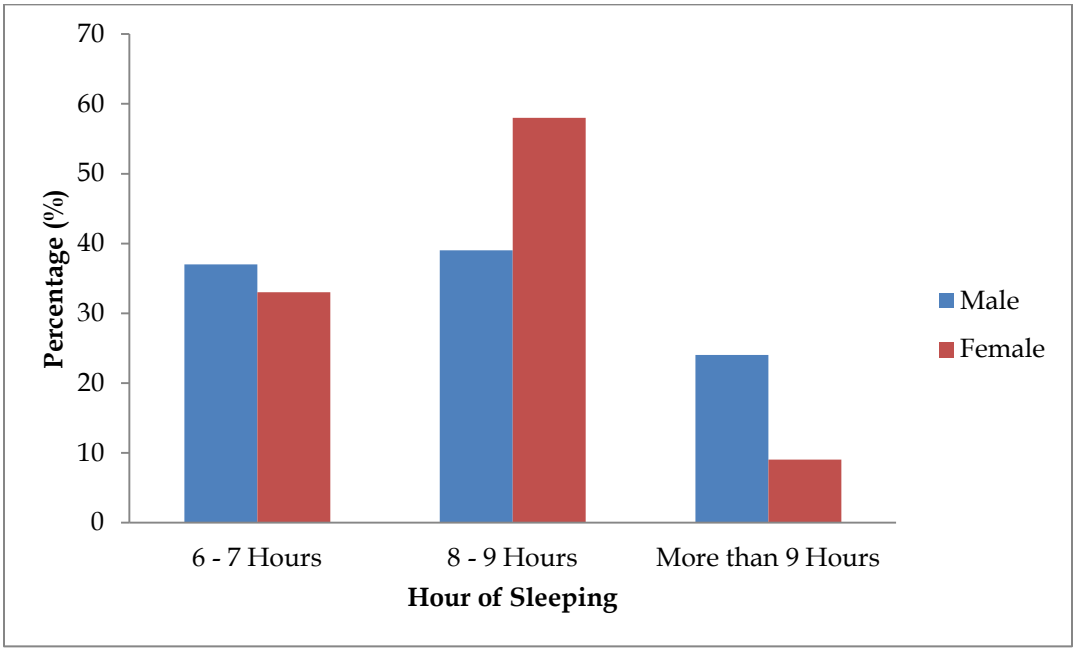


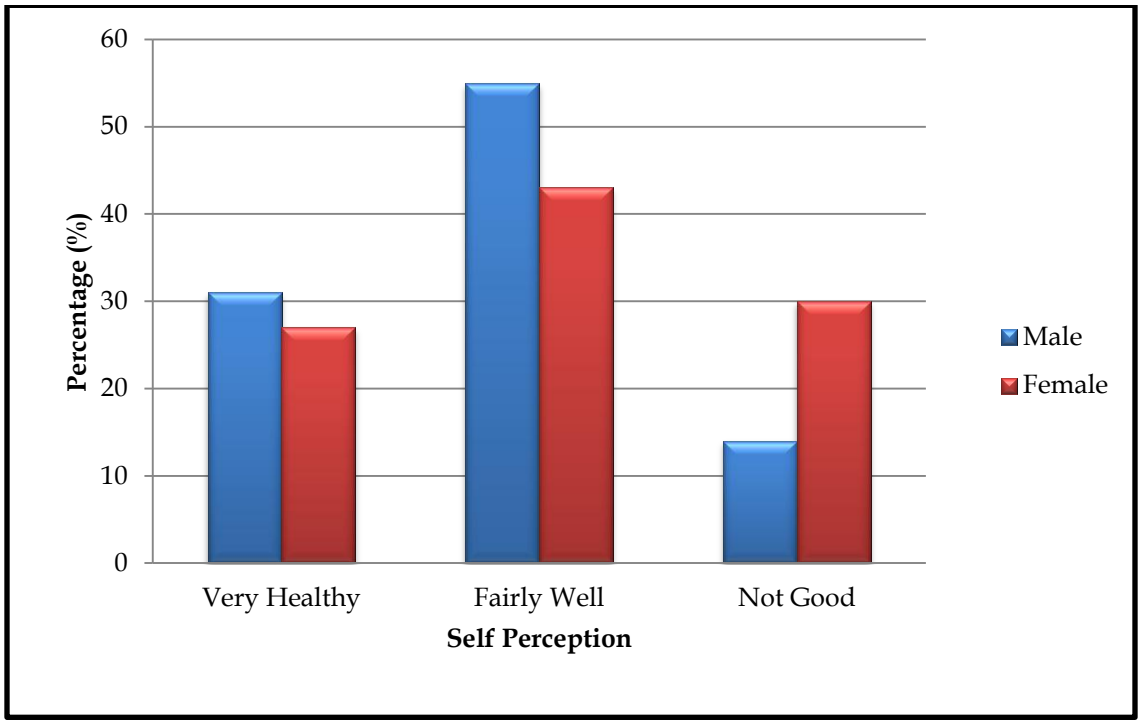
Table -4.45

Self Perception about Present Health Condition Wise Distribution of the Respondents

Self Perception	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
Very Healthy	31	31	27	27	58	29
Fairly Well	55	55	43	43	98	49
Not Good	14	14	30	30	44	22
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.45

Bar Graph showing Self Perception about Present Health Condition Wise Distribution of the Respondents



Section- IV

Psychological Aspects of the Muslim Elderly

Table – 4.46

Self-Comparison about Life before and After 60 Years of Age Wise Distribution of the Respondents

Self Comparison	Distribution of the Respondents					
	Male		Female		Total	
	N	% against total number of Male	N	% against total number of Female	N	% against total no. of Respondents
No Change	29	29	11	11	40	20
Both are not Good	0	0	14	14	14	07
Present life is Better	35	35	13	13	48	24
Earlier was much Better And Busier	22	22	16	16	38	19
Earlier life was Better due to Good Health	0	0	12	12	12	06
Earlier was Best	09	09	16	16	25	12.5
Nothing to Say	05	05	18	18	23	11.5
Total	**100**	**100**	**100**	**100**	**200**	**100**

Figure – 4.46

Bar Graph showing Self-Comparison about Life before and After 60 Years of Age Wise Distribution of the Respondents

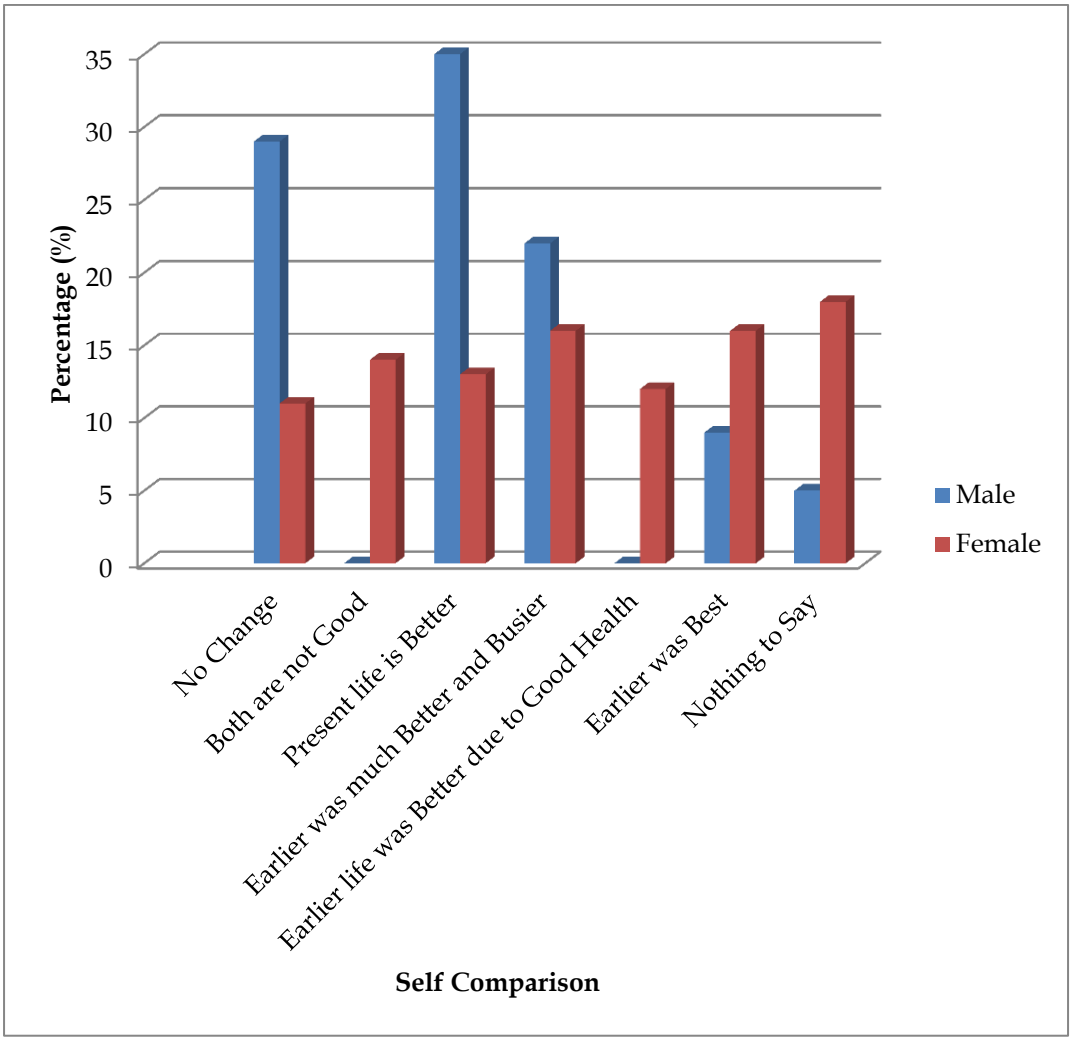


Table – 4.47

Self-Perception about the Unpleasant Aspects of Old Age Wise Distribution of the Respondents

Unpleasant Aspects	Distribution of the Respondents					
	Male		Female		Total	
	N	% against the total no. of Male who expressed their perception	N	% against the total no. of Female who expressed their perception	N	% against the total no. of respondents who expressed their perception
Fear of Death	28	29.16	13	14.94	41	22.40
Absence of Care Taking Person	22	22.91	14	16.9	36	19.67
Irrepressible Ageing Process	24	25	23	26.43	47	25.68
Frequent Ailment	16	16.66	22	25.29	38	20.76
Availibility of Less Attention from Family Members	06	6.25	15	17.24	21	11.47
Total	**96**	**99.98**	**87**	**99.99**	**183**	**99.98**

Note: Among the 100 male and 100 female respondents selected for the present study 04 male and 13 female respectively did not express their perception about the Unpleasant Aspects of Old Age.

Figure – 4.47

Bar Graph showing Self-Perception about Unpleasant Aspects of Old Age Wise Distribution of the Respondents

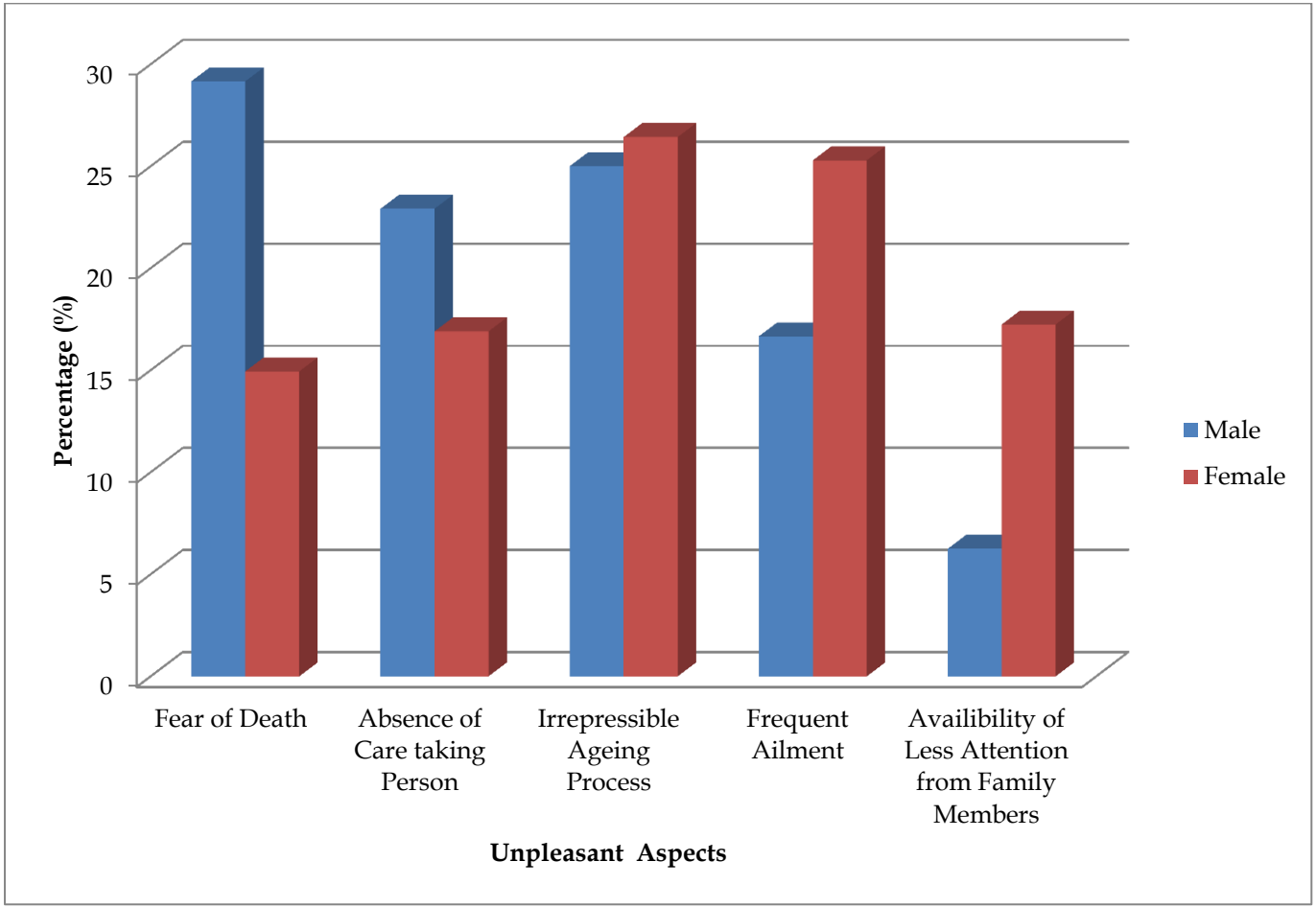


Table – 4.48

Self-Perception about Pleasant Aspects of Old Age Wise Distribution of the Respondents

Pleasant Aspects	Distribution of the Respondents					
	Male		Female		Total	
	N	% against the total no. of Male who expressed their perception	N	% against the total no. of Female who expressed their perception	N	% against the total no. of respondents who expressed their perception
No Task to Fulfill	39	41.48	42	44.68	81	43.08
Enhanced Proximity with Family Members	21	22.34	31	32.97	52	27.65
Obligation free Life in and Outside the Family	34	36.17	21	22.34	55	29.25
Total	**94**	**99.99**	**94**	**99.99**	**188**	**99.98**

Note: Among the 100 male and 100 female respondents selected for the present study 06 male and 06 female respectively did not express their perception on the Pleasant Aspects of Old Age.

Figure – 4.48

Bar Graph showing Self-Perception about Pleasant Aspects of Old Age Wise Distribution of the Respondents

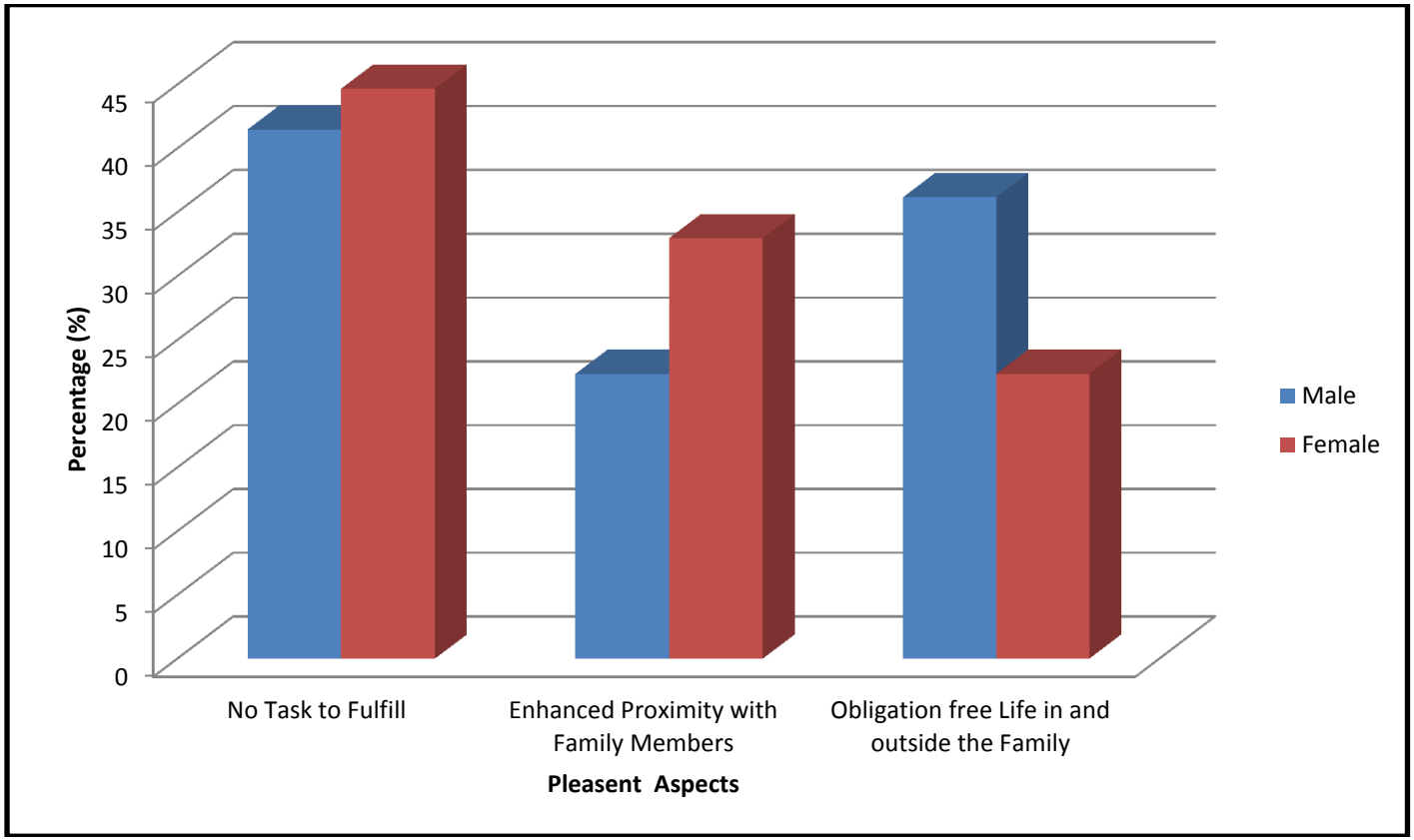


Table – 4.49

Suggestions for Improvement of Elderly Life As Expressed by the Different Respondents

Suggestions for Improvement	Distribution of the Respondents							
	Male			Female			Total	
	N	% against total number of Male	% against total No. of persons in favor of a particular suggestion	N	% against total number of Female	% against total No. of persons in favor of a particular suggestion	N	% against total no. of Respondents
Good Quality and Quantity of food	47	47	63.51	27	27	36.48	74	37
Proper Medical Care	09	09	56.25	07	07	43.75	16	08
Availability of Assistance for Everyday Care	11	11	100	0	0	0	11	5.5
Provisions for Suitable Recreational Facilities	13	13	48.15	14	14	51.85	27	13.5
Opportunity for Religious Activities	20	20	27.78	52	52	72.22	72	36

Figure – 4.49

Bar Graph showing Suggestions for Improvement of Elderly Life As Expressed by the Different Respondents

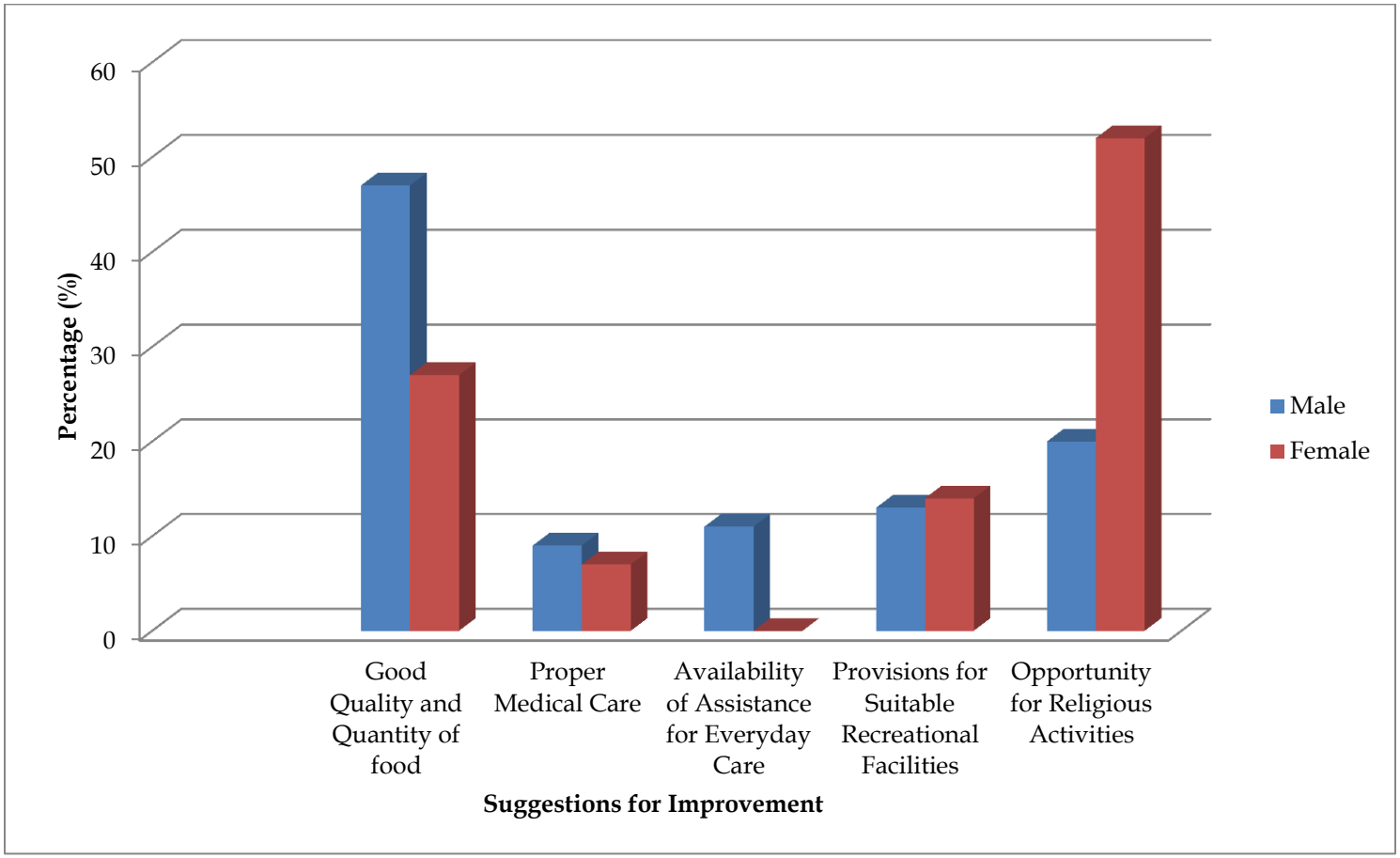


Table – 4.50

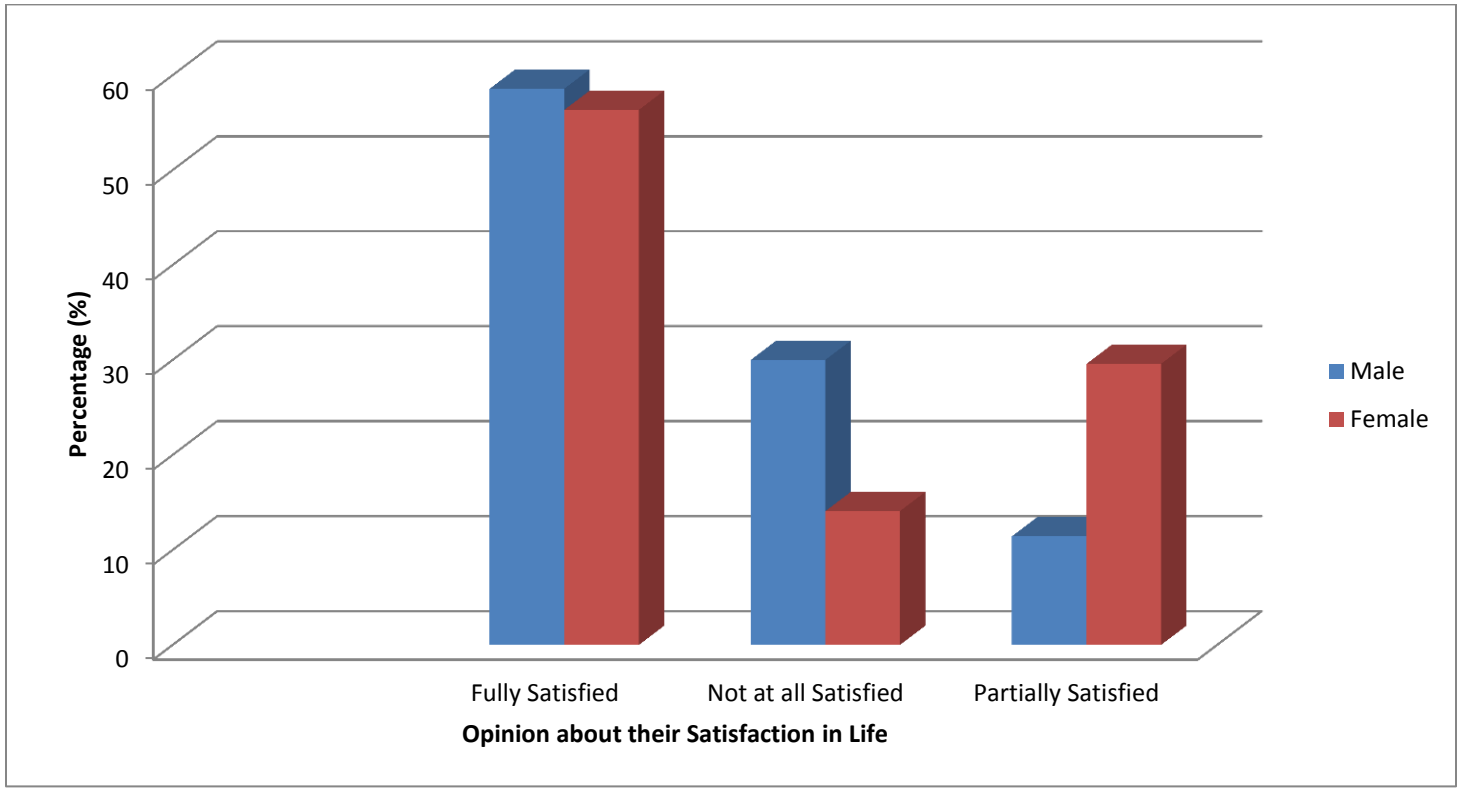
Opinion about the Satisfaction in their Respective Life As Expressed by the Respondents

Opinion about their Satisfaction in Life	Distribution of the Respondents							
	Male			Female			Total	
	N	% against total number of Male	% against the total no. of Respondents who expressed their opinion	N	% against total number of Female	% against the total no. of Respondents who expressed their opinion	N	% against the total no. of respondents who expressed their opinion
Fully Satisfied	41	58.57	50.61	40	56.34	49.38	81	57.44
Not at all Satisfied	21	30	67.75	10	14.8	32.26	31	21.98
Partially Satisfied	08	11.43	27.58	21	29.58	72.41	29	20.57

Note: Among the 100 male and 100 female respondents selected for the present study 30 male and 29 female respectively did not express their opinion about the Satisfaction in their respective life.

Figure – 4.50

Bar Graph showing Opinion about the Satisfaction in their Respective Life As Expressed by the Respondents



CAPTER-5
CONCLUSION

The present study has focussed on the demographic, socio-economic aspects as well as reported ailments and Activities of Daily Living (ADL) of the Muslim elderly people living in rural areas of West Bengal in some particular localities. These aspects have been considered simultaneously owing to the fact they are closely related with each other. Therefore, to gain an understanding on these issues the present research was carried out so that policies may be formulated in micro level for the improvement of the quality of life of the elderly who are minority in terms of religion.

The present social gerontological research among the Muslim elderly male and female population revealed that the upper age limit of the Muslim elderly under study rarely touches ninety years of age. However, the elderly population selected by random sampling method using S+ random sampling table for the present study suggests that there are more number of "young old" (60 years to 70 years) compared to the "old old" (70 years to 80 years) population. Presence of greater number of female elderly compared to their male counterpart in the category of 'young old' suggests that longevity among the female elderly is higher than the male elderly. However, there are insignificant number of 'oldest old' (80 years and above) elderly found among the population under study. Presence of lesser number of octogenarian and nonagenarian persons in the area under study tempted the present scholar to conclude that minimum access to the modern and improved medical facility may be responsible for this demographic feature.

Presence of more number of widowed male compared to the widowed female within the sampled population may lead us to conclude that higher mortality rate among the female compared to their male counterpart may be responsible for such demographic scenario. Such difference of mortality rate may also be caused by some socio-economic factors since it is revealed from the study that the woman elderly are

more marginalized compared to their male counterpart in terms of working status, ownership of landed property, monthly income, ownership and quality of house building, receipt of Government pension, etc.

It is found that literacy status of the male elderly under the present study is more compared to their female counterpart. It may be concluded that in the sphere of the education women are the victims of sexual discrimination within the household in particular and the community in general. However, it is interesting to note that literacy rate among the male and female in lower classes are almost equal but the difference in this regard is prominently increasing as far as the higher education is concerned. The fact that male elderly are much ahead than female elderly in terms of V to X and Higher Secondary standard may lead us to conclude that the gender difference at higher level of education may be due to the fact that there are more preference to promote the male members of the family for higher level of study compared to female members – a feature of male supremacy which is yet very common among the rural Muslims.

The fact that about seventy eight percent of the total elderly respondents across both the sexes under study live in joint/extended family contradict the notion that due to influence of urbanization and industrialization even in the rural areas joint family is a rare phenomenon. The result of the present study contradicts the prevailing notion that elderly living in the rural agrarian settings are deprived of care by their family members due to break down of the joint family caused by urbanization and industrialization. However, the result of the present study is also contrary to this impression.

From the living arrangements wise distribution of the elderly respondents it is found that the number of male elderly living with spouse is higher compared to the female elderly. Number of female elderly living with their married daughter is higher compared to the male elderly.

The fact that among the total elderly population under study there is more number of male working force compared to their female counterpart may tempt us

to conclude that male elderly have lesser scope of rest, leisure and recreation compared to the female elderly. This may be due to the fact that particularly in rural areas the activities of the women outside their respective family are not appreciated by the members of the Muslim society.

Prevailing subsistence pattern of the elderly rural Muslims under study suggests that more number of female elderly is dependent economically on the persons other than spouse and children. Since male elderly are more regularly engaged in heavy duty activities such as farming in own land or agricultural laborers in other's land therefore, they are financially independent compared to their female counterpart who are not engage either of the said two activities due to social taboo. Thus, female elderly are financially more dependent either on their sons, daughters or other close relatives. The majority of the elderly males reported that their source of income was their own occupation, as opposed to the elderly females whose financial sources are primarily their spouse and the children. This reveals the close association of elderly females with daughter-in-laws, grandchildren, and household activities, in contrast to the elderly men.

The fact that prior to their attainment of 60 years of age only male elderly were in service both in Government may be for the reason that male elderly were enabled to achieve higher standard of education compared to their female counterpart due to reported intra-house hold discrimination against the female in terms of promotion of education.

In case of earning as day laborer before the attainment of 60 years of age we find that not a single elderly woman belongs to this category. However, female elderly have outnumbered their male counterpart in terms of earning by way of serving neighboring families in the matter of house-hold chores All these facts suggest that in terms of outdoor activities male were more ahead than their female counter part before their attainment of sixty years of age. And such factors would not only enable the elderly male to interact in wider sphere but also used to provided them opportunity for establishing wider social network.

Although it is found that the phenomenon of male supremacy is reflected in various socioeconomic aspects of the elderly under study but ironically we find that in terms of the recipient of Government pension there is very little difference among the male and the female elderly. This scenario may be explained in terms of introduction of widow as well as old age pension scheme introduced by the Government. Thus, it is interesting to notice that in the present study we find that in terms of financial independence the female elderly are on equal standing with their male counterpart.

In terms of mobility, activities of daily living as well as the reported ailments there are thin difference between the male and the female elderly. This may direct us to conclude that despite the reportedly prevailing male dominancy within family the female elderly have been able to maintain their good health. Such maintenance may be possible due to their indirect exercise by way of active engagement in household chores within family.

The elderly male and female respondents selected for the present study live either within own family or within the family of their close relatives and the economic condition in general are not very satisfactory. Therefore, policies for creating economic support to enhance the quality of life of the rural elderly Muslims require more importance compared to formulating the scheme for extra familial rehabilitation of the rural aged. The economic support to the elderly may be extended by way of arranging part-time employment to supplement their income.

The study reveals that pensions were not yet available generally to every elderly suffering from the need of money or employment as a result they are eking out a miserable life. Therefore, introduction of well planned and duly executed pension schemes with wider coverage is necessary both for the male and female elderly who are leading a poverty stricken life.

It is revealed during the field work related to present study that generally male elderly have higher life satisfaction compared to their female counterpart.

Therefore, special programme is necessary for the wellbeing of the Muslim female elderly living in the rural areas under various types of social oppression.

Education standard of the elderly under study in general is not very satisfactory. The implementation of non-formal adult education programme may be used to for educating the elderly. This type of life-long education scheme may be instrumental for the elderly to gain knowledge on current scientific and technological innovations which in turn may be effective for lengthening of the life course, improved health and economic status among the aged adults. Furthermore, education and participation in the sphere of arts may actually help to delay the onset of dementia, counteract depression and social isolation and promote the new brain cells and connectivity.

The study further revealed that the female elderly are in better situation compared to their male counterpart in terms of overall ADL status, source of health care, scope of rest, leisure and recreation.

However, the elderly respondents under study across both the sexes in most cases are suffering from chronic diseases like blood pressures, diabetes, arthritis etc. To cater the affected elderly effectively the current health system is required to be reformulated.

Finally, the present gerontological study conducted among the Muslims living in rural areas may be helpful to the grassroots level planners to formulate some policy on the issues like economic support, pension scheme, welfare of the widowed, implementation of non-formal adult education, health care system as well as social justice and empowerment of elderly female.

REFERENCES

Ahmed. 2009. Rights of Parents. Haq Islam; http://www.haqislam.org/rights-of-parents.

Alam, M.A. et al. 2011. Household Food Security and Nutritional Status of Rural Elderly. *Bangladesh Medical Journal* 40(3): 8-11.

Anantharaman, R. N. 1990. Certain Associates of Physical Health in Old Age. *Journal of Psychological Researches* 34: 88-92.

Anantharaman, R. N. 1979. Activity Vs Disengagement for Successful Ageing in Old Age. *Journal of Psychological Researches* 23: 110-112.

Anantharaman, R. N. 1981. Physical Health and Adjustment in Old age. *Journal of Psychological Researches* 25: 46-50.

Anderson, J. E., eds.1956. *Psychological aspects of aging*. Washington, D. C.: American Psychological Association.

Arking, R. 1998. *Biology of Aging: Observations and Principles*. Sunderland: Sinauer Associates.

Arora, P. N., and S. Saxena. 1997. A Study of Pattern of Adjustment of Retired Working and Non-Working Women. In Changing Indian Society & Status of Aged. M G Husain, eds. Pp. 171-177. New Delhi; Manak Publication Pvt Ltd.

Asharaf, A. 1995. Profile of Elderly: A Study on Western Suburb of Bombay. *Ageing & Society: The Indian Journal of Gerontology* 5: 33-38.

Azaiza, F. et al. 2010. Death and Dying anxiety among Elderly Arab Muslims in Israel. *Death Studies* 34(4): 351-364.

Bagga, A. 1994. Health Status of Women in Old Age Homes. *Ageing & Society: The Indian Journal of Gerontology* 4: 11-21.

Bagga, A. 1999. Women and health in old age: The Indian scenario in aging and health: A global challenge for the twenty-first century. In *Proceedings of WHO Symposium,* Pp. 318-327. Koe.

Bagga, A., and A. Sakurakar. 2000. Twilight years and Health of Older Women. *Indian Journal of Gerontology* 14: 114-124.

Bambawale, U. 1993. Ageing and the Economic Factor in Later Life. *Ageing & Society: The Indian Journal of Gerontology* 3: 1-9.

Barz, S. et al. 2012. The effect of self-care educational program on quality of life of elderly people in Ahvaz, Iran. *Indian Journal of Science and Technology* 5(10): 3453-3460.

Basit, T. N. 2003. Manual or electronic? The role of coding in qualitative data analysis. *Edllcatill/lal Research* 45(2):143-54.

Bassuk, S. S., F. L. Berkman and A. C. Benjamin. 2010. Socioeconomic Status and Mortality among the Elderly: Findings from Four US Communities. *American Journal of Epidemiology 155*: 520-533.

Best J. W., and Kahn J. V. 2006. *Research in education*. Boston: Pearson Education, Inc.

Beydoun, A. and M. Barry Popkin. 2005. The impact of socio-economic factors on functional status decline among community-dwelling older adults in China. *Social Science & Medicine* 60: 2045–2057.

Birren, J. E. eds. 1959. *Handbook of aging and the individual: Psychological and Biological Aspect.* Chicago: University of Chicago Press.

Biswas, S. K. 1985. Dependency and Family Care of the Aged in Village India: A Case Study. *Journal of the Indian Anthropological Society* 20: 238-257.

Biswas, S. K. eds. 1987. *Aging in Contemporary India.* Calcutta: Indian Anthropological Society.

Bogdan, R. C., and Biklen, S. K. 2007. *Qllalitatifle reserlrcllfilf edllcatioll: A illtrodllctio/l to theories rlHd met/rods*. Boston: Pearson Education.

Bose, A. B. and K. D. Gangrade. eds. 1988. *The aging in India: Problems and Potentialities*. New Delhi: Abhinav Publications.

Bose, A. B. and P. C. Saxena. 1964. Some Characteristics of the Aged Population in Rural Society. *The Journal of Family Welfare* 10: 33-39.

Carlson, A.J., and Stieglitz. E.J. 1952. Physiological Changes in Aging. *The Annals of the American Academy of Political and Social Science,* 279: 18-31.

Chakrabarty, F. 2003. Contributions of the Elderly in an Agrarian Setting in Rural West Bengal: Perspective on Policy. *Journal of Indian Anthropological Society* 38: 349-354.

Chaudhuri, S. S. 1993. Struggle and Survival: Some Gerontological problems in North-East India with Special reference to Andhra Pradesh. *Ageing & Society: The Indian Journal of Gerontology* 3: 39-48.

Chowdhary, D. Paul. 1992. *Aging and the Aged*. New Delhi: Inter-India Publications.

Cohen, L. 2003. Old Age and the Global Economy of Knowledge. In *Oxford India Companion to Sociology and Social Anthropology*, Veena Das, eds. Pp. 956-973. New York: Oxford University Press.

Cohen, L., Manion, L., and Morrison K. 2000. *Research Methods in Education*. London: Routledge Falmer.

Constable, P.D., Ahmed, A.F. and Misk, N. A. 2005. Effect of suckling cow's milk or milk replacer on abomasal luminal pH in dairy calves. *J Vet Intern Med*,19:97-102.

Cowdry, E. V. eds. 1939. *Problems of ageing*. Baltimore: Williams & Wilkins Co.

Cresswell, J. W. 2005. *Educational research: Planning, conducting and evaluating quantitative and qualitative research*. Upper Saddle River, N.J.: Pearson Merrill Prentice Hall.

Cresswell, J. W. 2008. *Educational Research: Planning, Conducting and Evaluating Quantitative and Qualitative Research.* Upper Saddle River, NJ: Pearson Prentice Hall.

Cresswell, J. W. 2009. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Los Angeles: Sage Publications.

Cummings RG.1998. Epidemiology of medication related falls and fractures in the elderly. *Drugs* 12(1): 43-53.

Dak, T. M. and M. L. Sharma. 1987. Changing Status of the Aged in North Indian Villages. In *Ageing in India Challenge for the Society.* T M Dak, eds. Pp. 43-55. New Delhi; Ajanta Publications.

Dak, T. M. and R. K. Punia. 1987. Problems of the Aged: A study of Rural-Urban Differentials. In *Ageing in India Challenge for the Society.* T M Dak, eds. Pp. 55-66. New Delhi; Ajanta Publications.

Dam, T.T., Harrison. S., Fink, H.A., Ramsdell, J. and Barrett-Connor, E. 2010. Bone mineral density and fractures in older men with chronic obstructive pulmonary disease or asthma. *Osteoporosis International,* 21, 1341-1349.

Dasgupta, A. 2009. On the Margins: Muslims in West Bengal, *Economic and Political Weekly* 46(16): 91-96.

Dasgupta, A. 2009. On the Margins: Muslims in West Bengal. *Economic and Political Weekly*, 44(16):91-96.

Davis, K. 1951. *The Population of Indian and Pakistan*. Princeton: Princeton University Press.

Dean, Alfred, Bohdan Kolody and Patricia Wood. 1990. Effects of Social Support from Various Sources on Depression in Elderly Persons. *Journal of Health and Social Behavior*, 31: 148-161.

Deaton, Angus S., and Christina H. Paxson. 1995. Forthcoming. Economies of scale, household Size and the demand for food. *Journal of Political Economy* 106(5):897-930.

Deka, A.K. et al. 2011. Socio-Demographic Correlates Explaining the Longevity of Graying Population in a Traditional Society. *International Journal of Pure and Applied Sciences and Technology* 6(1): 21-34.

Desai, K. G., and R. D. Naik. 1971. *Problems of retired people in greater Bombay*. Bombay: The Tata Institute of Social Sciences.

Desai, K.G. and Naik, R.D. 1972. *Problems of Retired People in Greater Bombay*. Bombay: The Tata Institute of Social Sciences.

Desai, K.G. eds. 1982. *Ageing in India.* Bombay: Tata Institute of Social Sciences.

Devi Dayabati and Amrita Bagga. 1997. Health Status of Older Women of Manipur. *Ageing & Society: The Indian Journal of Gerontology*. 7: 27-42.

Dolai, M. C. and F. Chakrabarty. 2013. Functional Status of the Elderly Santal People. *International Journal of Humanities and Social Science Invention* 2(1): 01-06.

Dolai, M. C., F. Chakrabarty and N. Khatun. 2013. Determinants of the Living Arrangements among the Rural Muslim Elderly. *The Asian Man* 7: 52-60.

Drew, C. J., Hardman, M. L., and Hosp, J. L. 2008. *Designing and Conducting Research in Education*. LA: Sage Publications.

Dreze, J. and Srinivasan, P.V. 1997. Widowhood and poverty in rural India: Some inferences from household survey data. *Journal of Development Economics,* 54(2), 217-234.

Dutta, R.K. 2015. Health seeking behavior of elderly for common Morbidities in a Block of Dibrugarh District of Assam. *Journal of International Academic Research for Multidisciplinary.* 3(9): 149-157.

Edward F. Fern. Eds. 1982. Why Do Focus Groups Work: A Review and Integration of Small Group Process Theories. In *Advances in Consumer Research,* vol. 9. Pp. 444-451. Association for Consumer Research.

Encarta Dictionary, Dolon, D., & Holt, L. 2000. Accident and emergency theory in to practice. http://wwwgoogle.com,nal#htl=en&source=hp&stoyle+1 (accessed September 08, 2009).

Erikson, E. 1982. *The life cycle completed*. New York: W.W. Norton.

Field, M. J. and Behrman, R. E. eds. 2004. *Ethical conduct of clinical research involving children*. Washington, D. C.: National Academy of Sciences.

Fleeson, W., and J. Heckhausen. 1997. More or less "me" in past, present, and future: perceived lifetime personality during adulthood. *Psychology and Ageing* 12: 125-136.

Fontana, A., and Frey, J. H. 2005. The interview: From neutral stance to political involvement. In *The Sage Handbook of Qualitative Research.* N. K. Denzin and Y. S. Lincoln eds. Pp. 695-725. London: Sage Publications.

Goldman, N., K. Sanders and W. Rachel. 1995. Marital status and health among the elderly. *New England Journal of Medicine* 40: 1717–1730.

Gore, M.S. 1992. Aging of the Human Being. *The Indian Journal of Social Work* L(2): 212-219.

Gorman, M. 1999. Development and the rights of older people. In *The ageing and development report: poverty, independence and the world's older people*. Randel J, et al. eds. Pp. 3-21. London, Earth Scan Publications Ltd.

Gorman, M. 2006. Development and the rights of older people. In *The ageing and development report: poverty, independence and the world's older people*. Randel J, et al. eds. London, Earth Scan Publications Ltd.

Government of India. 1999. Ageing Population of India- An Analysis of the 1991 Census of Data. New Delhi: Office of the Registrar General, India.

Government of India. 1999. *National Policy for Older Persons.* New Delhi: Ministry of Welfare.

Government of India. 2006. Social Economic and Educational Status of Muslim Community in India. Sachar Committee Report. New Delhi: Cabinet Secretariat.

Government of India. 2006. Social, Economic and Educational Status of the Muslim Community of India. A Report of Prime Minister's High Level Committee, Cabinet Secretariat.

Government of India. 2011. District Census Hand Book, Purba Medinipur district, Series-20, Part XII-B. West Bengal; Directorate of Census Operations.

Government of India. Ministry of Home Affairs. 2016. http://www.censusindia.gov.in/2011-common/census_2011.html (accessed on 07.10.2016)

Government of West Bengal. Census data. 2011. www.westbengal.gov.in (accessed on 17.02.2016).

Grundy, E. and S. Andy. 2003. Health inequalities in the older population: the role of personal capital, social resources and socio-economic circumstances. *Social Science & Medicine* 56: 935–947.

Gullette, M. M. 2003. *Aged by Culture*. Chicago: University of Chicago Press.

Gullette, M. M. 2003. From life story telling to age autobiography. *Journal of Ageing Studies* 17: 101-111.

H. J. Birx. eds. 2005. *Encyclopedia of Anthropology*. Geneseo: Canisius College and State University of New York.

Hariharan., R. 2012. Economic Satisfaction of the Elderly in Rural Tamil Nadu: A Study with Special Reference to the Madurai District, *Disability Studies Quarterly 32:2.*

Hasan, Zoya. 2009. Poilitics of Inclusion: Caste, Minorities, and Affirmative Action, New Delhi: Oxford University Press.

Hillier, S. M., and Barrow, G. M. 2007. *Aging, the individual, and society*. Belmont, CA: Thomson Wadsworth.

Holloway, I., Wheeler, S. 2002. *Qualitative Research in Nursing*. Oxford: Blackwell.

Hooyman, N., and H. Kiyak. 2011. *Social gerontology a multidisciplinary perspective.* Boston, MA: Pearson.

How Do Muslims Treat the Elderly? 2016. *https://www.islam-guide.com/frm-ch3-15.htm (accessed on 07.10.2016)*

Hussain, N., and Siddiqui F.A. 2009. Literacy and Socio economic Marginalization of Muslim Population of Malda District, West Bengal (India). *Arab World Geographer* 12(1&2): 62-75.

International Federation of Ageing. 1992. The Report of the first Global Conference on Ageing. Bombay.

Irudaya Rajan, S., U. S. Mishra, and P. S. Sarma. 1999. *India's Elderly: Burden or Challenge?* New Delhi: Sage Publications and London: Thousand Oaks.

Irudaya Rajan, S. 2005. Emerging Demographic Scenario: Base for Concern. Paper presented at Consultative Meeting cum Workshop on Empowerment of Elderly, NIHFW, New Delhi, March 28-30.

Islam, M.N., and Nath, D.C. 2012. A Future Journey to the Elderly Support in Bangladesh. *Journal of Anthropology* 1-6.

John, W., A. G. Lynch, A. Kaplan and S. Sarahj. 1997. Cumulative Impact of Sustained Economic Hardship on Physical, Cognitive, Psychological, and Social Functioning *New England Journal of Medicine* 337:1889-1895.

Jokinen, J., McDonald, J. W. and Smith, P. W. F. 2006. Meaningful regression and association models for clustered ordinal data. *Sociological Methodology*. 36(1): 173-199.

Joshi, A. P., M. D. Srinivas and J. K. Bajaj. 2003. *Religious Demography of India*. Chennai: Centre for Policy Studies.

Kamble, V.S. et al. 2012. Mental Health status of elderly persons in rural area of India. *Indian Journal of Basic & Applied Medical Research* 1: 309-312.

Kaplan, O. J. 1946. The psychology of maturity. In *The encyclopedia of psychology.* P. L. Harriman, eds. Pp. 370-378. New York: Philosophical Library.

Kastenbaum, R. 1992. The creative process: A lifespan approach. *Generations* 22 (1): 285-306.

Kavitha, A. K. 2007. A comparative study on quality of life among senior citizens living in Home for the aged and family set up in Erode District. *Nightingale Nursing Times* 3(4): 47.

Khan, M.Z. 1997. *Elderly in Metropolis*. New Delhi: Inter India publications.

Kinsella, K. and C. M. Taeuber. 1993. *An aging world*. International population reports. Washington, DC: U.S. Department of Commerce.

Kinsella, K., and V. A. Velkoff. 2001. An Ageing World Population. An anthropological outlook. *Research & Development Journal, Help Age India* 57(6): 928-929.

Kohli, A.S. (1996). *Social Situation of the Aged in India*. New Delhi: Anmol Publications Pvt. Ltd.

Kuran, T. and A. Singh. 2010. *Economic Modernization in late British India: Hindu Muslim Differences.* ERID Working paper 53, Durham NC: Duke University Department of Economics.

Kylma, J., Vehvilainend-Julkunen, K. and Lahdevirta, J. 1999. Ethical considerations in a grounded theory study on the dynamics of hope in HIV-positive adults and their significant others, *Nursing Ethics* 6(3): 224-238.

Lee, G. R. and L. L. Marie. 2010. Rural-Urban Differences among the Elderly: Economic, Social, and Subjective Factors. *The Journal of Social Issue* 36: 2-14.

Leedy, P.D., and Ormrod, J.E. 2005. *Practical research: Planning and design*. Upper Saddle River, NJ, US.: Pearson Merrill Prentice Hall.

Liebig, P., and S. I. Rajan. 2003. *An Aging India: Perspectives, Prospects and Policies*. New York: Haworth Press.

Linda, G. M. 1989. Living Arrangements of the Elderly in Fiji, Korea, Malaysia, and the Philippines. *Demography* 26: 627-643.

Mainuddin, Md. 2008: Socio-Economic Conditions of Muslims in West Bengal. M.Phil Dissertation, Aligarh Muslim University, Aligarh, Department of Sociology and Social work.

Mainuddin, Md. 2011. Socio-Economic conditions and political representation of Indian Muslims: A study of West Bengal. *Journal of Arts, Science & Commerce*. 2(4): 123-134.

Martin, L. G., and K. Kinsella. 1994. Research on the demography of aging in developing countries. In *Demography of aging*. L. G. Martin and S. H. Preston, eds. Pp. 356-397. Washington, DC: National Academy Press.

Marulasiddaiah, H.M. 1960. *Old People of Makunti*. Dharwar: Karnataka University.

Merriam, S. B. 1998. *Qualitative research and case study applications in education*. San Francisco: Jossey-Bass.

Merriam, S. B. 2009. *Qualitative Research: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.

Miles, W. R. 1939. Psychological aspects of aging. In *Problems of ageing*. E. V. Cowdry eds. Pp. 535-571. Baltimore: William & Wilkins Co.

Minhat, H.S. 2014. Why Malay Elderly Female Frequently Engaged in Religious Activities during Leisure? A Quality Approach in Selangor. *Malaysian Journal of Public Health Medicine* 14(1): 39-46.

Minhat, H.S. et al. 2014. Determinants of Leisure Participation among the Malay Ethnic Elderly in Malaysia. *Middle-East Journal of Scientific Research* 21(9): 1442-1447.

Mishra, S. 1989. *Problems and Social Adjustment in Old Age: A Sociological Analysis.* New Delhi: Gian.

Moinuddin, S.A.H. 2000. *Divorce and Muslim Women*, New Delhi: Rawat Publications.

Moody, H. R. 2002. *Aging, concepts and controversies*, USA: Sage Publications.

Muhammad Mus`ad Yaqut. 2013. The Prophet's (Pbuh) Mercy Towards the Elderly.http://islam.ru/en/content/story/prophet-s-pbuh-mercy-towards-elderly (accessed on 07.10.2016)

Mutchler, E. and J. Jain. 1992. The living arrangements of unmarried elderly Hispanic females. *Demography* 29: 93-112.

Muthayya, B. C. 1995. The Rural elderly: A Study of their Existing Conditions and Problems. In *Challenges Before the Elderly: An Indian Scenario.* S Vijay Kumar eds. Pp. 3-14. New Delhi: M D publications.

Nayar, P. K. B. 1999. Society and the Oldest-Old. Paper presented at the Forth Global Conference of the International Federation of Ageing, Montreal, Canada, September 5-9.

Neeraja, K. P. 2006. *Textbook of Growth and Development for Nursing Students*. New Delhi: Jaypee Brothers Medical Publishers.

Nina, R., H. Eino, and H. Riitta-liisa. 2001. The association of socio-economic factors with physical and mental capacity in elderly men and women. *Archives of Gerontology and Geriatrics* 33:163–178.

Notestein, F. 1945. Population: The long view. In *Food for the World*. T. Schultz, eds. Pp. 36-57. Chicago, Illinois: University of Chicago Press.

Pal, S. and Palacios**,** R**.** 2008. Understanding Poverty among the Elderly in India: Implications for Social Pension Policy. *Scussion paper series*, 3431: 1-33.

Pathak, J.D. 1975. *Disorders of the Old*. Bombay: Medical Research Centre, Bombay Hospital Trust.

Pati, N. R. and B. Jena. 1989. *Aged in India: Social-Demographic Dimensions.* New Delhi: Ashish Publishing.

Phillips, D. R., Kevin H. C., Yeh, G.O., and Siu, O. L. 2010. Person–Environment (P–E) Fit Models and Psychological Well-Being Among Older Persons in Hong Kong. *Environment and Behavior*, 42: 221-242.

Punia, R. K., R. S. Mallik and D. Punia. 1987. Problems of the Aged: A study of Rural-Urban Differentials. In *Ageing in India Challenge for the Society*. M L Sharma, T M Dak eds. Pp. 56-66. Delhi: Ajanta publication.

Puotiniemi, T.A. and Kyngäs, H. 2004. The coping of an adolescent who has been in psychiatric inpatient care and her mother in every day life. *Journal of Psychiatry and Mental Health Nursing*, 11(6): 675-682.

Purba Medinipur (East Midnapore) District: Census 2011 data. 2016. http: //www.census 2011.co.in/census/district/19.purba-medinipur.htm. (accessed on 07.10.2016).

Purohit, C.K. and P. Sharma. 1972. A study of the aged 60 years above in social profile. *Indian Journal of Gerontology* 4: 71-83.

Ramamurthy, P.V. 1960. The specific psychological problems faced by the elderly people after their retirement. Jaipur: Indian Gerontological Association.

Ramamurthy, P.V. 1979. Psychological Research of the Aged in India: problems and perspectives. In *Developmental psychology*. E.G. Parmeswarn and S. Bhogle eds. New Delhi: Light and Life.

Rana, S. et al. 2016. Elderly Abuse, Violence and Neglect in Haryana-A Case Study. *The Asian Man* 10: 26-31.

Registrar General of India. 2003. SRS Reports.

Resources/295583 1171456325808/DISABILITYREPORTFINALNOV2007.pdf

Roebuck, J. 1979. When does old age begin? the evolution of the English definition. *Journal of Social History* 12: 416-628.

Sarasa Kumari, R.S. 2001. Socio-economic conditions, morbidity pattern and social support among the elderly women in a rural area.

Sengupta, D. K. and A. K. Chakraborty. 1982. Health status of aged 55 years and above in a slum area of Calcutta. *Indian Journal of Public Health* 27:112-117.

Sheriff, A. 1995. *Health Transition in India*. A working paper on No. 57 NCAER, New Delhi.

Shock, N.W. 1951. Biology of aging. In *Problems of America's aging population*. T.L. Smith eds. Pp. 37-46. Gainesville: University of Florida Press.

Sikand, Y. 2006. *Muslims in India: Contemporary Social and Political Discourses.* Gurgaon: Hope India.

Sinha, J.N.P. 1989. *Problems of Ageing*. New Delhi: Classical Publishing Company.

Soodan, K. S. 1975. *Ageing in India*. Calcutta: Minerva.

Sooki, Z. et al. 2011. Role of Quran recitation in mental health of the elderly. *Quarterly of Quran & medicine* 1(1): 17-23.

Srivastav, A. L. 1996. Economic Condition of the Old Aged Persons and their Pension Holding Status. *Indian Journal of Gerontology* 10: 51-60.

Strauss, J. et al. 2010. Health Outcomes and Socio-economic Status among the Elderly in China: Evidence from the CHARLS Pilot. *Journal of Population Ageing* 3: 111-142.

Strine, T. W. et al. 2008. The Associations between Life Satisfaction and Health-related Quality of Life, Chronic Illness, and Health Behaviours among U.S. Community-dwelling Adults. *Journal of Community Health* 33: 40-50.

Sultana, T. 2011. Expectations, Realities and Coping Strategies of Elderly Women in a Village of Bangladesh. *Bangladesh Development Research Center* 1-18.

Suzman, R. M. 1995. *The Encyclopedia of Aging*. George L. Maddox eds. Pp. 712-714. New York: Springer Publishing.

Suzman, R., and M. W. Riley. 1985. Introducing the 'oldest old'. *Milbank Memorial Fund Quarterly: Health and Society* 63: 177-185.

Swarup, V. 1995. Status of the Elderly in Madras: A case study. *Research & Development Journal* 2: 24-29.

Tahir Mahmood. 1989. Law and the Elderly in the Islamic Tradition- Classical Precepts and Modern Legislation, IX Islamic & Comp. L. Q; 33(33).

Taylor, S. J., and Bogdan, R. 1998. *Introduction to qualitative research methods: A guidebook and resources*. New York: John Wiley & Sons.

Thakur, R.P. 2003. Health problems among the elderly: A cross-sectional study. *Annals of Medical and Health Sciences Research*. 3(1): 19-25.

The World Bank. 2007. People with Disabilities in India: From Commitment to Outcomes. May 2007. http://siteresources.worldbank.org/INDIAEXTN/

Tibbitts, C. 1960. Origin Scope and Field of Social Gerontology. In *Handbook of Social Gerontology*. C. Tibbitts, eds. Chicago: The University of Chicago Press.

Tibbitts, C. 1963. Introduction of Social gerontology: Origin, scope and trends. *International Social Science Journal* 3: 339-354.

Tran, T.V. 1991. Family living arrangement and social adjustment among three ethnic groups of elderly Indo Chinese refugees. *The International Journal of Aging and Human Development* 32; 91-102.

United Nations. 1991. Health Survey Report.

Wolcott, H. F. 2008. *Ethnography as a way of seeing.* New York, NY: Alta Mira Press.

Yadava, K. N. S., S. S. Yadava and R. Roberts. 1996. Ageing and Health Hazards in Rural Northern India. *Health and Population: Perspectives and Issues* 19: 1-18.

Yin, R. K. 2009. *Case study research: Design and methods*. Thousand Oaks, CA: Sage Publications.

Yin, R. K. 2012. *Applications of case study research*. Thousand Oaks, CA: Sage Publications.

Yin, Robert K., 2003a. *Applications of Case Study Research.* Thousand Oaks, CA: Sage Publications.

Yin, Robert K., 2003b. *Case Study Research: Design and Methods.* Thousand Oaks, CA: Sage Publications.

Appendix

Structured Questionnaire Schedule used for the Survey on the Rural Elderly Muslims of Purba Medinipur District

1. Name of the Elderly:

2. Age:

3. Source of Age:

4. Sex:

5. Present Address:

6. Village Name:

7. J.L. No:

8. Police Station:

9. District:

10. Duration of stay (in years);

11. Marital Status:

12. Age at Marriage:

13. Family type:

14. Educational standard:

Non-literate	Ability to sign	I - IV	V- X	S.F.	H.S.	Graduate	Post Graduate	Others (Specify)

15. If you have any professional degree, then what is its nature?

16. What was your occupation before did you attain 60 years of age?

17. What was your economic pursuit before did you attain 60 years of age?

18. Present Working Status of the Respondent:

Working Status	Nature of Work Performed	Present place of work
Worker		
Marginal Worker		
Non worker		

19. Household Composition of the Respondent:

Sl. No.	Name	Age	Sex	Relation with elderly respondent	Marital Status	Educational Standard	Occupation	Yearly Income (In Rs.)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

Sl. No.	Questionnaire	Answers Options/Answer
20.	**What type of identity card do you hold?**	Not any identity card, Voter ID Card, Senior citizen card, Not aware about any type of identity card; Aware but does not know how to get it.
21.	**What is the Type and Nature of ownership of your house?**	Own single room constructed with Wattle and Daub; Own Mud walled House with thatched roof; Own Brick built House. Own house with brick wall and tile roof; Own house with brick wall and asbestos/ tin roof; Rented house; Free Shelter in Relatives'/ Neighbors' House;
22.	**What is the where about of your spouse?**	Dead; Alive and living together; Alive but live separately, Divorced.
23.	**If your spouse is dead, then what was the age at death of your spouse and how many years you have been widowed?**	
24.	**What was your age when your spouse expired?**	
25.	**If your spouse is alive then what is the age of your spouse?**	
26.	**If you are separated then, how long you are in separation?**	
27.	**What are the reasons for which your spouse is living separately?**	
28.	**With whom your spouse is living at present?**	
29.	**If you are divorced then what were the reasons for the divorce?**	
30.	**How many years you have been divorced?**	

Sl. No.	Questionnaire	Answers Options/Answer
31.	How many times marriage occurred in your life?	
32.	When your last marriage did take place?	
33.	How many children (male and female) were born out of your each marriage?	
34.	How many children (male and female) you have altogether out of your total number of marriage?	
35.	How many children are sharing the same house with you?	
36.	What are the Age, Sex and marital status wise distribution of your children who are sharing common house with you but not common kitchen?	
37.	How many children are at present sharing common house and hearth/kitchen with you?	
38.	In case, you are sharing common hearth/kitchen with your married children then, what are the terms and conditions of sharing?	
39.	What are the Age, Sex and marital status wise distribution of your the children who are sharing common house but not common kitchen with you?	

Sl. No.	Questionnaire	Answers Options/Answer
40.	**How many of your children are living in separate house and maintaining own kitchen?**	
41.	**With whom you are living at present? (Living arrangement)**	Living alone; joint family; with spouse only; with married son and his family; with un-married son; with married and un-married daughter; other relatives; family not related to respondents.
42.	**If you are living alone then how many years you are doing so?**	
43.	**With whom did you use to live earlier before you started to live alone?**	Unmarried son; Married son; Step sons; Married or Un-married daughter; Spouse; Unmarried brother; Married brother; Other relative (specify); Family not related to respondents.
44.	**What is about your Parent-child Proximity?**	Childless; Living with spouse and un-married children; Spouseless but living with un-married children; Living with spouse and married son; Spouseless but living with married son; Living with spouse and un-married daughter; Spouseless but living with un-married daughter; Living with spouse and married daughter; Spouseless but living with married daughter; Living with spouse only but married sons live in close proximity/ nearby place; Living with spouse only but married sons live in distant places; Living with spouse only but married daughter live in close proximity/ nearby place; Living with spouse only but married daughters live in distance places; Living with spouse only and both married sons and daughters live in distant places;
45.	**What types of Chores do you perform in your house?**	Escorting grand children to schools; Keeping watch on the grand children in absence of their parents; Kitchen chores other than cooking; Cooking; supervision of farming; Gardening and

Sl. No.	Questionnaire	Answers Options/Answer
		farming; Sweeping; Marketing; Helping others; Any other (specify).
46.	**What are your Present economic pursuits?**	None; Own business; Private tuition; Newspaper selling; Security service, Service in NGO; Clerical jobs in private farm; Non-registered medical practitioner; Midwifery; Non-registered nurse; Paper packet manufacturing, Chores in neighbor's house; Money lending; Chores in religious establishment; Animal husbandry; Fish farming; Poultry farming; Selling of own farm products; Supervisor of neighbor's agricultural farm; Any other (specify).
47.	**How much do you earn per month from your present economic pursuit?**	
48.	**What are your present financial sources other than your present economic pursuits?**	Service Pension; Family pension; Widow Pension; Old age Pension; Interest from Savings, Spouse; Sons and daughters; Son-in-law, Daughter-in-law; House rent; Leased out agricultural land; Leased out Orchard; Leased out water body; Others **(**specify).
49.	**What is the present economic pursuit of your spouse and how much he/she earns from such pursuit per month?**	
50.	**What are your present financial sources of your spouse other than her/his present economic pursuits?**	Service Pension; Family pension; Widow Pension; Old age Pension; Interest from Savings, Spouse; Sons and daughters; Son-in-law, Daughter-in-law; House rent; Leased out agricultural land; Leased out Orchard; Leased out water body; Others **(**specify).
51.	**What was the occupation of your spouse before he/she attained 60 years of age?**	

Sl. No.	Questionnaire	Answers Options/Answer
52.	**Do you save any money per month? If yes, how much do you save per month?**	
53.	**Where do you deposit your savings?**	Fixed deposit in Post-office/ Bank or both; Recurring deposit in Post-office; Recurring deposit in Bank; Government sponsored small scale scheme; Share Certificates; Monthly investment scheme; Others (specify)
54.	**Do you have any Medical insurance? If yes, how old is your policy, how much amount covered under the policy and what is the amount of policy?**	
55.	**Are you a beneficiary of government welfare schemes for the elderly? If yes, what are those schemes?**	
56.	**Are you a vegetarian or non-vegetarian? If you are a vegetarian then, how long you are vegetarian and what are the reasons for becoming so?**	
57.	**Do you have addiction to any of the following?**	Tea; Smoking; Tobacco the form of leaf (Khoini), paste (Gudaku), powder (Zarda or Dokta, Gutka); Betel leaf (Paan), Betel nut (Supuri); Alcohol; Any other (specify).
58.	**Do you visit your relative's house? If yes, what is the frequency of such visits?**	
59.	**In which manner do you enjoy your leisure time, outside of your house or locality?**	Visiting museums; Visiting trade fairs; Visiting art exhibitions, Watching Cinema in Hall; Watching Theatre in hall; Visiting pilgrim center within or outside the state or both; Tour in forest

Sl. No.	Questionnaire	Answers Options/Answer
		areas/ high altitude/ coastal areas within and/or outside the state.
60.	**How do you enjoy your leisure time within/ in the vicinity of your home?**	Gossiping; Gardening; Reading religious text; Reading fiction/Novel; Reading News Paper, Reading Magazines/ English daily/ both; Listening to the Radio; Watching Television; Passing time with grandchildren; SMS; Listening radio; Writing letters to friend / relatives / Editors of News Paper**;** Playing musical instruments; Singing vocal songs with/without accompaniment; Caring pets; Playing cards, Ludo, carom etc. Knitting**;** Morning Walk; Evening Walk, Meditation**;** Participation in religious activities; Attending religious gathering; Spending time in mosque.
61.	**Do you go for pleasure trip outside your locality? If yes, what is the frequency?**	
62.	**Do you go for pilgrimage? If yes, what is the frequency?**	
63.	**Are you engaged in any voluntary social services? If yes, what type of services do you offer?**	
64.	**Do you render any voluntary social service under any forum? If yes, what is the type of service do you provide and what is the nature of forum?**	

Sl. No.	Questionnaire	Answers Options/Answer
65.	**Are you member of any social / religious group which meets regularly? If yes, would you please name such social/religious body and their areas of activities?**	
66.	**Do your family members consult you in the family matters? If yes, then what are the major issues of consultation?**	
67.	**What do you feel about your health?**	Very healthy; Fairly all right; Unhealthy; Feels week, Become tired frequently every day.
68.	**How many hours do you sleep during day and night respectively in each day?**	
69.	**What are the common ailments from which do you suffer?**	Sore throat or running nose with fever; Headache, Cough and cold, Fever Backache, Muscle pain, Muscle cramp, Abdominal pain, Hyper acidity, Acute indigestion , Diarrhea, Discharge in the ear; Joint pain; Any other (specify) etc.
70.	**Do you suffer from common ailments very frequently? If yes, what are those ailments from which did you suffer very frequently for last three months?**	
71.	**Who meet the expenditure for the diagnosis and treatment of your common ailments?**	Self; Spouse, Children; Neighboring kin, Non-kin neighbor, Voluntary Agencies; others (specify).
72.	**Do you suffer from any chronic physical health problem/ diseases? If yes, what are those problems/diseases?**	Diabetes; High/ Low Blood Pressure; Heart Disease or Cardio Vascular Disease (CVD); Cardiac arrhythmia, Varicose veins, Paralysis, Tremor, Parkinsonism, Arthritis, Rheumatism;

Sl. No.	Questionnaire	Answers Options/Answer
		Chronic Obstructive Pulmonary Disease (COPD); Cancer, Asthma, Renal or Kidney function Problem, Hyperthyroidism or Overactive thyroid, Hypothyroidism or Underactive thyroid, Tuberculosis, Lever function problem, Gastritis, Indigestion, Irritable Bowel Syndrome (IBS), Constipation, Piles (Hemorrhoids), Fistula, Filaria, Goiter; Epilepsy, Insomnia, Anemia; Giddiness; Blindness; Schizophrenia; Leprosy; Convulsion; Periodontitis or Pyorrhea, Vision Impairment, Hearing impairment, Locomotion impairment, Gynecological Problem; Leucorrhoea; Any other problems(specify).
73.	**How much you are mobile?** *(Mobility of the respondent)*	Bed ridden; Slightly mobile; Fairly mobile; Mobility with wheel chair; Mobility with a stick; Limited mobility due to blindness.
74.	**What are the main sources of your care during your illness?**	Spouse, Children; Neighboring kin, Non-kin neighbor, Voluntary Agencies; others (specify).
75.	**Do you suffer from any chronic mental health problem/ diseases? If yes, what are those problems?**	Dementia, Alzheimer, Forgetfulness/ Amnesia, Depression, Claustrophobia, Alto-phobia/ Acrophobia, Thanatophobia, Autophobia/ Monophobia, Basophobia, Bovinophobia, katsaridaphobia, Any other problems (specify).
76.	**In case you have vision problem then how long you are suffering from such problems and what is your present magnitude of error of refraction (Power)?**	
77.	**Do you have spectacles or Contact lenses or both?**	
78.	**Who met the expenditure for the purchase of your spectacles/ contact lenses?**	Self; Spouse, Children; Neighboring kin, Non-kin neighbor, Voluntary Agencies; others (specify).

Sl. No.	Questionnaire	Answers Options/Answer
79.	**Do you have any problem with the hearing? If yes, how long you are suffering from such problem?**	
80.	**Do you use any hearing aid? If yes, how long you are using such aid?**	
81.	**Who spent the money to purchase the hearing aid?**	Self; Spouse, Children; Neighboring kin, Non-kin neighbor, Voluntary Agencies; others (specify).
82.	**Do you use any walking aid? If yes, then what type/types of walking aid do you use?**	Chair with two wheels/chair with three wheels/chair with four wheels/wooden stick/metal stick/ carbon fibre stick/ folding stick/ telocopic stick/ crutches/ open cuff crutch/ closed cuff crutch/ axilla crutch/ forearm crutch/ underarm crutch/ crook handle stick/ derby handle stick/ crutch handle stick/ cap stick/ thumbs stick/ knob handle stick.
83.	**Who met the expenditure to purchase your walking aid?**	Self; Spouse, Children; Neighboring kin, Non-kin neighbor, Voluntary Agencies; others (specify).
84.	**Who met the expenditure for your dentures?**	Self; Spouse, Children; Neighboring kin, Non-kin neighbor, Voluntary Agencies; others (specify).
85.	**Can you eat/ feed yourself?**	Can do it; Can do it but needs assistance; Cannot do it.
86.	**Can you dress yourself?** *("Dressing" refers to getting clothes and getting dressed, including tying shoes)*	Can do it; Can do it but needs assistance; Cannot do it.
87.	**Can you transfer yourself?** *("Transferring" refers to getting in and out of bed and in and out of a chair)*	Can do it; Can do it but needs assistance; Cannot do it.
88.	**Can you use toilet yourself?** *("Using the Toilet" refers to going to the toilet and cleaning oneself afterward)*	Can do it; Can do it but needs assistance; Cannot do it.

Sl. No.	Questionnaire	Answers Options/Answer
89.	**Can you bath yourself?** *("Bathing" refers to a sponge bath, shower, tub bath, or washing the body with a wet towel)*	Can do it; Can do it but needs assistance; Cannot do it.
90.	**Are you capable of continence?** *("Continence" refers to control of urination and bowel movement)*	Can do it; Cannot do it.
91.	**How often do you eat per day?**	Mention in digit
92.	**How is your appetite?**	Very good; Good; Fair; Bad.
93.	**Do you prepare your own food or does someone else help you in preparing your food?**	Prepare myself; Husband; Children; Relatives; Daughter-in-law; Wife; Others.
94.	**Do you get milk regularly?**	Never; Occasionally; Regularly. Frequency during last one week
95.	**Do you have the habit of Chewing?**	Never; Occasionally; Regularly.
96.	**Do you have the habit of smoking?**	Never; Occasionally; Regularly.
97.	**What type of smoking is practiced by you?**	Cigarette; Bidi; Hucca.
98.	**Did you have the habit of smoking?**	Never; Occasionally; Regularly.
99.	**How do you compare your present life with your past life?**	No change; Both are not good; Present life is better; Earlier was much Better and Busier; Earlier life was Better due to Good Health; Earlier was best; Nothing to Say.
100.	**What do you consider pleasant aspects during your Old Age**	No Task to Fulfill; Enhanced Proximity with Family Members; Obligation free Life in and Outside the Family.
101.	**What are the aspects of old age that you consider as unpleasant?**	Fear of death; Absence of Care Taking Person; Irrepressible Ageing Process; Frequent Ailment; Availibility of Less Attention from Family Members.

Sl. No.	Questionnaire	Answers Options/Answer
102.	**What kind of suggestions do you like to offer for improving your present living?**	No suggestions**;** Good Quality and Quantity of food**;** Proper Medical Care**;** Availability of Assistance for Everyday Care; Provisions for Suitable Recreational Facilities; Opportunity for Religious Activities
103.	**Are you satisfied with your present life?**	Fully satisfied**;** Not at all Satisfied**;** Partially satisfied.

Name of the Recorder:

Date: