SOCIAL CAPITAL, COMMUNITY PARTICIPATION AND QUALITY OF LIFE: A CASE OF OLDER WOMEN FROM AN URBAN CONTEXT IN INDIA

Nidhi Gupta,
Assistant Professor,
Tata Institute of Social Sciences, Mumbai.

Abstract

Social capital plays a key role in determining the quality of life of people, and more so for older persons. Social networks and participation in them are elements of social capital that act as catalysts of coordination/cooperation, and essential to achieve better (social and/or economic and/or health) outcomes or quality of life (QoL). Social participation and social networks have a bidirectional relationship that strengthens the social capital which determines the QoL of an individual. A cross-sectional study was undertaken to understand the QoL and its determinants among older women living in an urban context. It was observed that social capital and its elements (social networks operationalised as social contacts and social relations; being able to trust someone and the participation of older women in political processes) were important determinants of their QoL. Older women are more prone to social isolation, and age and economic class are important determinants of social capital as well as the QoL. Social work interventions to improve the social capital of older women by adopting a multi-pronged approach - of strengthening family and social ties at one end, and improving infrastructure in the form of designing age-friendly environments, alongside improving access to transportation at the other end - facilitate social networking and promote positive ageing.

Key words: Social capital, community participation, quality of life of older women

Introduction

Social capital plays a major role in determining the quality of life of people, more so for the elderly. Several definitions of social capital

have been proposed in the sociological literature since the 19th century. Bourdieu (1986) define*s* it as the capital of social connections, mutual acquaintances and social recognition. Coleman (1988) refers to social capital as all those features of the social structure that might facilitate the actions of individuals within the social structure itself and social relationships per se are a form of social capital as they establish obligations, expectations and trustworthiness. Putnam et al. (1993:167) define*s* social capital as those "features of social organization, such as trust, norms, and networks that can improve the efficiency of society by facilitating coordinated actions". Although all definitions refer directly or indirectly to *social connections or social networks as elements of social capital*, the Putnam definition points to the role of social capital as a catalyst of coordination/cooperation, an essential device to achieve better (social and/or economic and/or health) outcomes or quality of life. Putnam defines social capital as 'features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit' (Putnam, 1995, p. 67). This perspective of Putnam and colleagues' has been adopted in this paper to operationalise the concept of social capital, as they focus on the individual origin and source of social capital.

A growing body of research has found that the presence of social capital through social networks and communities has a protective quality on health (Zunzunegui, *et. al* 2003). Social capital affects health risk behavior in the sense that individuals who are embedded in a network or community rich in support, social trust, information, and norms, have resources that help achieve health goals. Inversely, a lack of social capital can impair health. There is a wide consensus that participation in social networks is highly beneficial and connected with ageing that is comfortable, secure, and productive. There is growing evidence from developed countries about the individual and collective benefits of participation in the local community, and society in general, and in the areas of the health and well-being of the elderly in particular (Berkman et al, 2000; Rocco L. & Suhrcke M., 2012). The WHO (2002) also acknowledges the role of community participation by advocating it as one of three pillars (health, security and community

participation) that promote active ageing amongst older people. Community participation lies on the foundation of social networks that are developed through shared activities and culture, history or circumstances. As ageing is often associated with reduced social participation resulting in social isolation and exclusion, it has serious consequences on the physical and psychological well-being and overall QOL of older persons in general, and older women in particular.

Against this backdrop, the main objective of this study was to explore the relationship between social capital and the quality of life of older women in an urban context in India. In order to understand social capital, various indicators were studied, such as social networks, someone to trust, community participation (both social and political), and social relations. The quality of life was assessed at two levels: a subjective (self-rating of QOL) and an objective assessment through the QOL index using the WHO framework (1996).

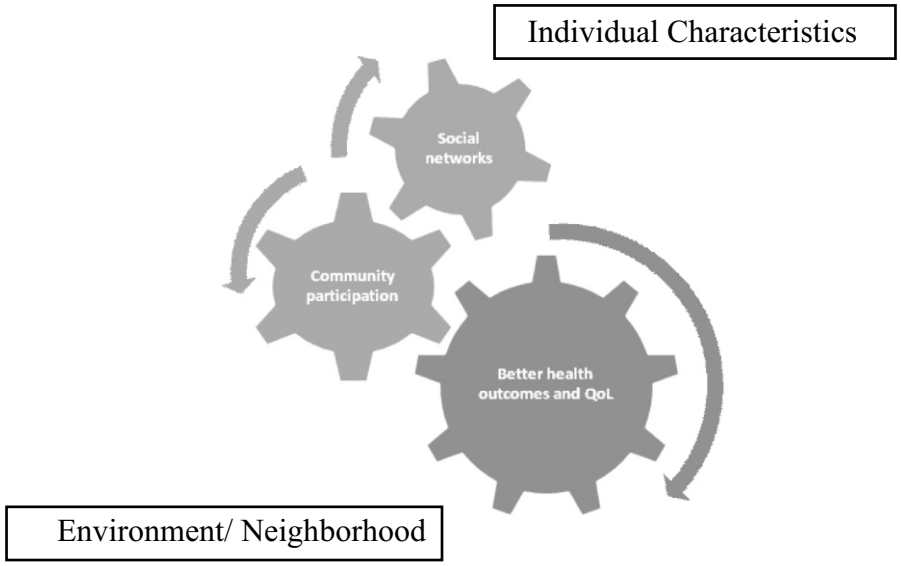

Figure 1. Illustrating the Relationship between Social Networks, Community Participation and QOL

Methods and data

A cross-sectional sample survey study was conducted in Navi Mumbai (a suburb of Mumbai), Maharashtra, to understand the quality of life of

older women across three class groups: Poor, Middle Income Group (MIG), and Well-to-do (WTD). A total of 450 respondents (150 from each income group) was selected using disproportionate stratified sampling. The multistage sampling technique was used to draw the sample. Navi Mumbai has 13 planned nodes and a few slum pockets, of which one node was purposively selected for this study as more than a quarter of the elderly in the study area live there, and one slum pocket adjoining this node was selected. Each node in Navi Mumbai is divided into various sectors, each with different localities. HIG and MIG respondents were selected from the planned node, and the LIG from the slum pocket. The sectors in the selected node were listed and eight selected, based on the presence of the City and Industrial Development Corporation (CIDCO) of Maharashtra Limited, a Government of Maharashtra Undertaking-constructed housing societies (CIDCO housing is based on the criterion of income). The localities were listed under each sector and localities from the selected sectors, based on housing type, were listed under each strata (i.e. MIG and WTD). Similarly, localities were listed in slums and a few randomly selected till the sample of 150 was achieved. Face-to-face interviews with the elderly were conducted using a structured schedule to obtain information relating to their socio-demographic, economic, health and healthcare utilisation and quality of life details. A tool was specifically designed for this study and the WHOQOL-BREF used to assess social relations and the environment, in addition to physical health, psychological well-being and older women's perception of their quality of life and satisfaction with general health. Bi-variate analysis and multivariate analysis were used to meet the objectives of the study and social capital measured by exploring *social networks*, trust, and the community participation of older women.

Social Networks

Older people's participation in social networks is a significant component of well-being. Social networks are being increasingly regarded as an important element of social capital for the elderly, allowing them access to social support. Very often, social capital and networks are frequently seen as synonymous. However, social

networks may be conceptualised as an element of social capital. Many older people are socially active and participate in cultural, recreational and other activities. Social contact with friends and relatives outside the home declines significantly with age, with serious consequences on older women's participation in community activities and events. Most community-dwelling older women participate in informal social activities, such as visiting friends or socialising with them. Social networks can be defined by their structure (the number of ties and the proximity of the relationship), function (the frequency of contact, reciprocity, and duration), and according to the nature of the relationship (friends, relatives, children, and spouses). All of these characteristics may have significant and distinct effects on the experiences and circumstances of ageing (Zunzunegui et al., 2005). In addition to the individual characteristics that influence the scope and nature of social networks among older people in cities, the neighborhoods in which older people live influence their social networks and the quality of their lives. These networks help maintain morale even in the face of serious illness and disability, and contribute to motivating physical activity and making it enjoyable. Engagement in social activities is associated with optimal cognitive and physical functioning and a rewarding emotional life.

Findings

Socio-demographic characteristics

The average age of the older women studied was 67 years and there was no significant difference in the age of the respondents by class. Over half of the total older women (50.9%) were widows. Older women from the poor strata (61.3%) were more likely to be widowed. Almost half of the total older women (46.4%) had no formal education. Almost all (94%) from the poor group had no formal education. A little over a quarter (28.7%) from the MIG, and about a fifth (16.7%) from the well-to-do class, had no formal education. Although almost half (50.9%) of the respondents had migrated from Mumbai, it was observed that a majority (54.0%) from the poor strata had migrated from Maharashtra's rural areas owing to the drought in their respective villages during the 1970s, while respondents from the upper strata migrated from Mumbai as this place offered them better living conditions.

On exploring the living space of older women, it was observed that a majority (78.0%) from the poor strata had no separate living space for themselves, while in the upper strata a majority (88% in the WTD and 61% in the MIG) of the respondents did. About half of the respondents had participated in the work force. However, on disaggregating the data by class, it was observed that a majority from the poor class (80.7%), a little over one-third (38.0%) from the MIG, and over a quarter (28.7%) from the WTD had never worked. About half of the respondents (49.6%) had no income and were dependent on their family for their needs. The mean income of the respondents (and spouses) with some source of income, from the poor, MIG, and well-to-do class, was about Rs 4302, Rs 8568 and Rs 15287 respectively.

Morbidity and healthcare utilisation

In order to better understand the health of older women, which is a significant determinant of the quality of life, information about acute morbidity (i.e., any episode of illness reported during the last two weeks of the survey), chronic morbidity (i.e., any diagnosed illness or hospitalization in the previous year), the effect of illness on daily life, perceptions about levels of stress, and satisfaction with general health was collected. Nearly half of the total respondents (45.1%) reported acute morbidity in the last 2 weeks prior to the survey. Although the proportion of respondents from the poor class reporting acute illnesses like fever, cough, and diarrhea was the highest, followed by the well-to-do class and MIG (49.3%, 44.0% and 42.0% respectively), it is not statistically significant (Gupta, 2015).

About two-fifths of the total respondents (40.2%) reported chronic morbidities in the previous year. Most respondents reporting chronic morbidities were from the well-to-do class, followed by those from the poor and MIG (48.0%, 41.3% and 31.3% respectively) classes, and the differentials were observed to be statistically significant. Most respondents from the well-to-do class reported lifestyle-related morbidities those while those from the poor class reported chronic ailments like pain in the joints, and asthma, which are directly related to their occupations in construction, industry and manual labour. Illness,

especially of a chronic nature, has a negative effect on ADLs in older people. Over two-fifths of the total respondents (45.6%) reported that their illness affected their ADLs. On a class-wise disaggregation, it was observed that one in two respondents from the well-to-do class (56.7%) reported that their ADLs had been affected by their illness (Gupta, 2015). As most of the older women from the well-to-do class reported suffering from a diagnosed chronic illness, it has a direct bearing on their reports of a higher restriction in their ADLs. Over two-fifths of the respondents (46.0%) from the poor strata also reported that their ADLs has been affected by chronic illness. There is a significant difference in reporting the effects of illness on ADLs.

Social capital and community participation of older women

In this study, social capital was measured by exploring social networks like the frequency of visits to family and friends, trust, and community participation of older women. The participation of the respondents in community activities was explored by seeking information on their contribution in fixing neighbourhood issues or improving things for the benefit of the community, and their involvement in religious programmes organised at the community level in the last year. The nature of social relationships and their functions were explored to better comprehend older women's social networks.

Frequency of visits to friends/relatives

Frequent visits to friends and relatives helps older women step out of home keeps them mobile and emotionally connected. In this study, about one in ten respondents (12.4%) had no contact with relatives and friends outside their homes, while another half (45.3%) visited friends or relatives only once or twice a year (Table 1). This is suggestive of the inadequate social contacts and weak social networks of older women in India's urban settings. Very few respondents (7.6%) met their friends and relatives once or twice a week. A majority from the poor (56.0%) and MIG (46.0%) classes visited family and friends only once or twice a year, while a majority from the well-to-do class (42.7%) visited their relatives and friends once or twice a month.

Table 1: Percent distribution of respondents according to class and the frequency of their visits to relatives or friends in the last one year

Frequency of visit to friends/ relatives in the last one year	Poor (150)	MIG (150)	Well-to-do (150)	Total (450)
Never	15.3	15.3	6.7	12.4
	(23)	(23)	(10)	(56)
Once or twice a year	56.0	46.0	34.0	45.3
	(84)	(69)	(51)	(204)
Once or twice a month	25.3	32.0	42.7	33.3
	(38)	(48)	(64)	(150)
Once or twice a week	3.3	5.3	14.0	7.6
	(5)	(8)	(21)	(34)
Daily	0.0	1.3	2.7	1.3
	(0)	(2)	(4)	(6)
$\chi^2(8, 450) = 37.7,\ p < 0.001$				

There is a significant class differential in the frequency of social contacts, suggesting that respondents from the well-to-do class have better social contacts as compared to those from the MIG and poor classes. It was further expected that with an increase in the age of the respondents, the frequency of their social contacts would decrease. One in five respondents aged 70 years and above, as compared to about one-tenth of the total respondents (8.4 percent) who were less than 70 years of age, never left home to visit friends or relatives (Table 1a).

Table 1a: Percent distribution of respondents according to age and frequency of visits to relatives or friends in the last one year

Frequency of visits to friends/ relatives in the last one year	Young-old (60-69) (299)	Old (70 & above) (151)	Total (450)
Never	8.4	20.5	12.4
	(25)	(31)	(56)
Once or twice a year	46.5	43.0	45.3
	(139)	(65)	(204)
Once or twice a month	35.8	28.5	33.3
	(107)	(43)	(150)
Once or twice a week	8.0	6.6	7.6
	(24)	(10)	(34)
Daily	1.3	1.3	1.3
	(4)	(2)	(6)
$\chi^2(4, 450) = 14.07,\ p < 0.01$			

More than one-third of the young-old respondents left home to visit friends and relatives once or twice a month, compared to only a little over a quarter (28.5%) of older-old women. This difference was statistically significant in the frequency of visits to relatives and friends in terms of the age of the respondents ($p < 0.01$). Hence, this study observed the phenomenon of reduced social contacts as older women age. The data clearly indicates that older women from the poor strata and those aged 70 years and above visited relatives and friends less frequently and were, consequently more vulnerable to increased social isolation

.

COMMUNITY PARTICIPATION

Participation

Participation is the result of interaction between the individual's health and contextual factors that include both personal and environmental factors. The WHO clearly differentiates between activity and participation by defining activity as an individual's ability to perform a

task or action, and participation as involvement in a life situation including the accomplishment of daily activities and social roles (WHO, 2001). The definition of "participation" brings in the *concept of involvement* i.e., incorporating, taking part in, being included in or engaged in an area of life, being accepted, or having access to the resources needed. In the present study, the contribution of the respondents in community activities was explored by seeking information on their participation in fixing neighbourhood issues or improving things for the benefit of the community, as well as their involvement in religious programmes organised at the community level in the last one year.

Frequency of attending social group meetings

Frequency in attending group, club, society, or organisational meetings ensures the active participation of older women in social matters and helps them feel independent and capable of taking decisions. This positively influences their psychological and physical well-being, in addition to their contribution as a resource to the community. In this study, a majority of the respondents (85.3%) said they never attended social meetings (Table 2). Less than one-tenth of the total respondents attended once or twice a year.

Table 2: Percent distribution of respondents according to class and frequency of attending group or organisational meetings in the last one year

Participation in social group meetings (in the last 1 year)	**Poor (150)**	**MIG (150)**	**Well-to-do (150)**	**Total (450)**
Never	81.3	88.0	86.7	85.3
	(122)	(132)	(130)	(384)
Once or twice a year	14.0	6.7	4.7	8.4
	(21)	(10)	(7)	(38)
Once or twice a month	4.7	5.3	7.3	5.8
	(7)	(8)	(11)	(26)
Once or twice a week	0.0	0.0	1.3	0.4
	(0)	(0)	(2)	(2)
χ^2 (6, 450) =14.0, p = 0.029				

One-tenth of the respondents from the poor class reported attending social meetings once or twice annually while over three-fourths did not. Similarly, a majority of the respondents from the MIG (88.0%) and well-to-do (86.5%) classes reported that they had abstained from attending social meetings in the last one year. Apparently, there is a significant class differential in respondents attending social meetings, with a slightly higher frequency of the well-to-do class in attending them.

Frequency of attending public meetings

All the respondents were asked about the frequency of attending public meetings held in their communities. A majority of the respondents (88.4%) hadn't attended a public meeting in the last one year (Table 3). An almost negligible proportion (6.0% percent) admitted that they had rarely attended any in the last one year. Less than one-tenth (8.7 percent) from the poor class occasionally attended, while an overwhelming proportion of respondents from the well-to-do class (90.7%) never attended public meetings.

Table 3: Percent distribution of respondents according to class and frequency of participation in public meetings in the last one year

Participation in public meetings (in the last 1 year)	**Poor (150)**	**MIG (150)**	**Well-to-do (150)**	**Total (450)**
Never	87.3	87.3	90.7	88.4
	(131)	(131)	(136)	(398)
Rarely	4.0	6.7	7.3	6.0
	(6)	(10)	(11)	(27)
Occasionally	8.7	4.7	2.0	5.1
	(13)	(7)	(3)	(23)
Frequently	0.0	1.3	0.0	0.4
	(0)	(2)	(0)	(2)
χ^2 (6, 450) =12.3, p = 0.056				

Resolving neighbourhood issues

It was observed that a majority of the respondents (86.7%) participated

in no community activity for the benefit of the neighbourhood (Table 4). Community participation was worse amongst respondents from the well-to-do class, as compared to those from the poor class. Almost all the respondents from the well-to-do class (94.7%) participated in no community activity for neighbourhood improvement while about three-fourths from the poor class did not.

Table 4: Percent distribution of respondents according to class and frequency of participation in working with people in the neighbourhood to fix or improve something in the last one year

Participation in working with people in the neighbourhood	Poor (150)	MIG (150)	Well-to-do (150)	Total (450)
Never	76.0	88.7	94.7	86.4
	(114)	(133)	(142)	(389)
Once or twice a year	10.0	2.7	4.0	5.6
	(15)	(4)	(6)	(25)
Once or twice a month	7.3	8.7	1.3	5.8
	(11)	(13)	(2)	(26)
Once or twice a week	5.3	0.0	0.0	1.8
	(8)	(0)	(0)	(8)
Daily	1.3	0.0	0.0	0.4
	(2)	(0)	(0)	(2)
$\chi^2(8, 450) = 39.3,\ p < 0.001$				

The data reveals that the community participation of the older women in the study to help resolve neighbourhood issues is negligible in urban settings, especially among the well-to-do class.

Participation in religious programmes

The participation of older women in religious events in India is generally better than their participation in a range of community activities, reflected in the findings of this study as well. Less than a quarter of the total respondents (22.4%) did not participate in a religious programme organised at the community level while the rest participated at different frequencies (Table 5). About two-fifths of the total respondents participated in religious programmes at the

community level only once or twice in the last one year, while nearly one-fifth (21.6%) participated once or twice a month.

A class-wise disaggregation of the data revealed that about half of the total respondents from the poor class (54.7%) participated once or twice a year in religious programmes like Ganpati Chathurthi or Navratri festivals. The respondents' participation in religious events at the community level increased significantly in frequency with surges in economic prosperity, as reflected from the findings of this study.

Table 5: Percent distribution of respondents according to class and frequency of participation in religious activities in the last one year

Participation in religious programmes (in the last 1 year)	Poor (150)	MIG (150)	Well-to-do (150)	Total (450)
Never	23.3	28.7	15.3	22.4
	(35)	(43)	(23)	(101)
Once or twice a year	54.7	33.3	32.7	40.2
	(82)	(50)	(49)	(181)
Once or twice a month	12.7	21.3	30.7	21.6
	(19)	(32)	(46)	(97)
Once or twice a week	8.7	12.7	16.7	12.7
	(13)	(19)	(25)	(57)
Daily	0.7	4.0	4.7	3.1
	(1)	(6)	(7)	(14)
$\chi^2(8, 450) = 37.2,\ p < 0.001$				

About one-third of the respondents from the well-to-do class (30.7%), nearly one-fifth from the MIG (21.3%) and only a little over one-tenth from the poorer classes participated in community religious festivals once or twice a month.

Older women from the poor class participate in community-level religious activities more frequently than those from the MIG and well-to-do classes. This clearly reveals a pattern of increasing individualism with improved financial standing. On disaggregating the data by the age of the respondents and the frequency of their participation in

religious events, it was seen that the frequency of older respondents (i.e., 70 years and above) was significantly lesser than those aged below 70. More than one-third of the respondents (33.1%) who were 70 years and above never participated in religious events, as compared to less than one-fifth (17.1%) who were less than 70.

Table 5a: Percent distribution of respondents according to age and frequency of attending or participating in religious activities in the last one year

Participation in religious programmes (in the last one year)	**young old (60-69) (299)**	**old (70 and above) (151)**	**Total (450)**
Never	17.1	33.1	22.4
	(51)	(50)	(101)
Once or twice a year	42.1	36.4	40.2
	(126)	(55)	(181)
Once or twice a month	23.1	18.5	21.6
	(69)	(28)	(97)
Once or twice a week	14.0	9.9	12.7
	(42)	(15)	(57)
Daily	3.7	2.0	3.1
	(11)	(3)	(14)
$\chi^2(4, 450) = 15.56,\ p < 0.01$			

This clearly reflects that the participation of older women in community events gradually declines with increased age.

Satisfaction with the frequency of outings

To ascertain if older women were satisfied with the frequency of their outings to meet relatives or friends or participate in community activities, details on the degree of satisfaction were sought. Where the respondents were dissatisfied with the frequency of their outings and wanted to go out more often, the reasons for not doing so were ascertained to understand the barriers restricting their movements. Most respondents (71.1%) reported that they were satisfied with the

frequency of their outings, and another one-tenth (13.0%) reported no desire to go out more often (Table 6).

Nearly one-fifth (15.6%) of the total respondents reported that they would like to go out more often than they presently do. Most respondents who wanted to increase the frequency of their visits outside were from the poorer and MIG (18.1% and 18.8% respectively) classes. In addition, the most who expressed satisfaction with the frequency of their outings were from the well-to-do and MIG (81.1% and 72.5% respectively) classes, compared to about half from the poorer strata (59.6%). It is worth mentioning that about a quarter of the respondents from the poorer strata (22.1%) said they would not like to go out more often though they were dissatisfied with the frequency of their outings.

Table 6: Percent distribution of respondents according to class and satisfaction with the frequency of outings

Satisfaction with the frequency of outings	**Poor (149)**	**MIG (149)**	**Well-to-do (148)**	**Total (446)**
Would like to go out more often	18.1	18.8	10.8	15.9
	(27)	(28)	(16)	(71)
Satisfied with the frequency of outings	59.7	72.5	81.1	71.1
	(89)	(108)	(120)	(317)
Would NOT like to go out often	22.1	8.7	8.1	13.0
	(33)	(13)	(12)	(58)
χ^2 (4, 446) =22.9, p <0.001				

Note: No response (4 respondents)

On disaggregating the data on the respondents' satisfaction with the frequency of their outings with their age (Young-old and Old), it was observed that about a quarter (24.5%) of the older respondents

(70 years and above) reported dissatisfaction (Table 6a). Most from the young-old category (76.9%) reported satisfaction with the frequency of their visits outside, as compared to a little less than two-thirds from the category, Old (59.6%).

Table 6a: Percent distribution of respondents according to age and satisfaction with the frequency of outings

Satisfied with the frequency of outings	Young old (60-69) (295)	old (70 and above) (151)	Total (446)
Would like to go out more often	11.5	24.5	15.9
	(34)	(37)	(71)
Satisfied with the frequency of outings	76.9	59.6	71.1
	(227)	(90)	(317)
Would not like to go out often	11.5	15.9	13.0
	(34)	(24)	(58)
$\chi^2(2, 446) = 16.26,\ p < 0.001$			

Note: No response (4)

The data clearly reflects that as the respondents' age increases, the frequency of their visits outside their homes decreases, though they would like to go out more often.

Reasons for not going out more often

Respondents who reported that they would like to go out more often but could not do so was because a majority of them (91.5%) had problems with health, the prime reason restricting their movements (Table 7). A little over one-tenth of the respondents (11.1%) from the poor strata reported that their movements were restricted by financial constraints.

Table 7: Percent distribution of respondents who would like to go out more often according to class and reasons for notdoing so

Main reason for not getting out more often	Poor (27)	MIG (28)	Well-to-do (16)	Total (71)
Health issues	85.2	96.4	93.8	91.5
	(23)	(27)	(15)	(65)
Safety or security concerns	3.7	0.0	0.0	1.4
	(1)	(0)	(0)	(1)
Financial problems	11.1	3.6	0.0	5.6

	(3)	(1)	(0)	(4)
Nobody to accompany them	0.0	0.0	6.3	1.4
	(0)	(0)	(1)	(1)

Hence, health issues are barriers affecting the movement of older women, culminating in their social isolation and exclusion as a result of reduced social contacts.

Awareness about community resources

The current study observed that there is scarce awareness amongst older women about senior citizens' clubs as well as day care centres in the community. In the study area, the municipal corporation has established senior citizen day care centres called '*virangula kendras'* with a good geographical spread in Navi Mumbai's planned nodes, though awareness about these centres was limited among all the classes studied. A majority of the respondents (91.8%) were unaware of the presence of such centres (Table 8). Nearly one-fifth from the well-to-do class were aware of the existence of senior citizens' clubs or day care centres in the vicinity.

Table 8: Percent distribution of respondents, classwise, according to their awareness about senior citizens' clubs and day care centres for older persons and class

Awareness about senior citizens' clubs/ day care centres	**Poor (150)**	**MIG (150)**	**Well-to-do (150)**	**Total (450)**
Yes	4.0	4.0	16.7	8.2
	(6)	(6)	(25)	(37)
No	96.0	96.0	83.3	91.8
	(144)	(144)	(125)	(413)

The proportion of respondents with membership of senior citizens' clubs or day care centres is so low that only 4.7 percent of the total (Table 9) had any, most of which was reported by those from the MIG and well-to-do classes (5.3 percent and 6.7 percent respectively).

Table 9: Percent distribution of respondents according to their membership in a community organization and class

Membership in a community organization	Poor (150)	MIG (150)	Well-to-do (150)	Total (450)
Yes	2.0	5.3	6.7	4.7
	(3)	(8)	(10)	(21)
No	98.0	94.7	93.3	95.3
	(147)	(142)	(140)	(429)

The data reflects a need to improve awareness among older women on the community resources available, such as senior citizens' organisations and day care centres for senior citizens, besides enhancing their utilisation, increasing capacity and popularizing access to community resources for older women.

Political participation - Casting votes

To ascertain the participation of older women in political matters, information was sought on their involvement in terms of casting votes in the previous elections. In this study, an overwhelming proportion of the respondents (94.9%) had cast their votes in the previous elections (Table 10).

Table 10: Percent distribution of respondents, classwise, according to their participation in voting in previous elections

Voted in the previous election	Poor (150)	MIG (150)	Well-to-do (150)	Total (450)
Yes	95.3	92.7	96.7	94.9
	(143)	(139)	(145)	(427)
No	4.7	7.3	3.3	5.1
	(7)	(11)	(5)	(23)

These findings are clearly suggestive of older women's active participation in political matters.

Trust in someone

It has been demonstrated that having friends and confidantes positively affects the well-being and QOL of older people. Trust in someone you

can share your feelings with is a social capital that positively impacts the QOL of older women and keeps them from psychological illnesses and social isolation. In the current study, a majority of the total respondents (83.3%) reported that they have someone to trust and confide in (Table 11). Nearly one-fifth of the respondents from the poorer strata reported that they have no one to trust or confide in; reflective of the level of isolation and distress faced by them. There is no significant difference, classwise, between the proportion of older women who trust someone.

Table 11: Percent distribution of respondents according to class and whether they have a trusted confidante

Someone you can trust/ confide in	Poor (150)	MIG (150)	Well-to-do (150)	Total (450)
Yes	80.7	84.0	85.3	83.3
	(121)	(126)	(128)	(375)
No	19.3	16.0	14.7	16.7
	(29)	(24)	(22)	(75)

The data clearly reflects that a majority of the older women in each class have someone to trust or confide in, however, about one in five have none to confide in, reflective of a lack of companionship impacting their emotional well-being and, consequently, the overall quality of life.

The findings suggest that socio-economic and demographic factors are related to social resources, such as social networks, participation, social support and trusting someone, all indicative of a social gradient in the social capital of older women. The frequency of social contacts and networks was observed to be the least among older women from the poorer strata, increasing with improvements in the class of the respondents. Age was inversely related to social capital. Similarly, participation at the community level in miscellaneous events and activities also reflected their social gradient.

Social Relations

Social relations are an important factor affecting the quality of life of

older people. Social relations have been measured here by detailing information on the satisfaction experienced by respondents in facets like personal relationships, sex life and support from friends, as operationalised by the WHOQOL Framework, 1996. In this study, most respondents provided information on two of the three facets. Less than one-fourth (21.3%) responded to the question on satisfaction with sex life, given that discussing sex with older people is taboo in Indian culture for two reasons (Table 12). Firstly, because the respondents were older women who have crossed the age of reproduction (as, in India, sexual activity is closely linked to reproductive life for women) and, secondly, a majority of the older women were widows (seeking information about sexual activity from women who have no partners was a sensitive issue). Hence, only married women were questioned about their satisfaction with sexual activity (based on experiences from a pilot test).

In this study, nearly half of the total respondents (49.1%) reported satisfaction with their *personal relationships* (relationships with children, family and friends), while less than one-tenth (7.1 percent) reported dissatisfaction. Nearly two-fifths of the total respondents took a neutral position of being neither satisfied nor dissatisfied with their personal relationships. It was also observed that a majority from the well-to-do and MIG (56.7% and 52.7% respectively) classes were satisfied with their personal relationships, compared to only a little over one-third of the respondents from the poor strata (38.0%). a statistically significant difference.

A majority of those who responded to questions on their *sex life* reported satisfaction. However, as only about a quarter of the total respondents responded to this question, this facet was deleted from the domain with less than 80% responses. Only about one-third of the total respondents (33.8%) reported *satisfaction with support from friends*. A majority (53.3%) expressed neither satisfaction nor dissatisfaction as they reported having no friends, hence the question of support from them was irrelevant in the context. A class -wise disaggregation showed that over two-fifths of the respondents from the well-to-do class reported satisfaction with support from friends, compared to only about

a quarter of those (26.0%) from the poor strata and about one-third (33.3% per cent) from the MIG.

Table 12: Percent distribution of respondents according to the Social Relations domain of the QOL (item wise) and class

Satisfaction with personal relationships	**Poor (N=150)**	**MIG (N=150)**	**Well-to-do (N=150)**	**Total (N=450)**
Dissatisfied	12.7	3.3	5.3	7.1
	(19)	(5)	(8)	(32)
Neither satisfied nor dissatisfied	49.3	44.0	38.0	43.8
	(74)	(66)	(57)	(197)
Satisfied	38.0	52.7	56.7	49.1
	(57)	(79)	(85)	(221)
$\chi^2(4,450)=18.29, p<0.001$				
Sex life	**Poor (N=19)**	**MIG (N=37)**	**Well-to-do (N=40)**	**Total (N=96)**
Dissatisfied	0.0	5.4	7.5	5.2
	(0)	(2)	(3)	(5)
Neither satisfied nor dissatisfied	21.1	24.3	12.5	18.8
	(4)	(9)	(5)	(18)
Satisfied	78.9	70.3	80.0	76.0
	(15)	(26)	(32)	(73)
$\chi^2(4,96)=3.16, p=0.531$				
Satisfaction with support from friends	**Poor (N=150)**	**MIG (N=150)**	**Well-to-do (N=150)**	**Total (N=450)**
Dissatisfied	16.0	11.3	11.3	12.9
	(24)	(17)	(17)	(58)
Neither satisfied nor dissatisfied	58.0	55.3	46.7	53.3
	(87)	(83)	(70)	(240)
Satisfied	26.0	33.3	42.0	33.8
	(39)	(50)	(63)	(152)
$\chi^2(4,450)=9.36, p=0.053$				

Social relations and QOL

The mean scores for social relations for the total respondents were higher than those for the physical and psychological domains at 13.30 (Table 13). The mean scores gradually increase with the improved economic status of the older women (poor: 12.69; MIG: 13.45; WTD: 13.74). These class differences were statistically significant. The overall quality of life also improved as the economic standing of the respondents escalated; however, there was more variation in the mean scores of the overall QoL among respondents from the HIG, as compared to those from the MIG and LIG.

Table 13: Distribution of the means of the domains of QOL and QOL index by the economic class of the respondents (ANOVA)

Domain	Poor (N=150)			MIG (N=150)			Well-to-do (N=150)			Total (N=450)			F-value
	Mean	SD	CV	Mean	SD	CV	Mean	SD	CV	Mean	SD	CV	
Physical health	12.67	1.88	0.15	13.06	2.13	0.16	13.23	2.45	0.18	12.99	2.17	0.17	2.62
Psychological state	11.79	1.79	0.15	12.88	1.94	0.15	13.59	2.07	0.15	12.75	2.07	0.16	33.11*
Social relations	12.69	2.12	0.17	13.45	2.04	0.15	13.74	2.28	0.17	13.30	2.19	0.16	9.53*
Environmental	13.12	1.55	0.12	14.11	1.55	0.11	14.97	1.81	0.12	14.06	1.80	0.13	46.68*
Specific facets of old age	13.78	1.37	0.10	14.43	1.10	0.08	14.97	1.48	0.10	14.39	1.41	0.10	29.99*
Overall QOL Index	12.81	1.21	0.09	13.59	1.28	0.09	14.10	1.66	0.12	13.50	1.49	0.11	32.37*

Note: *(Note: * indicates sig level, i.e. p<0.001); ANOVA was calculated across 3 class groups (Poor, MIG and Well-to-do);* CV is the coefficient of variation; SD the standard deviation.

The data thus clearly revealed that the economic class of older women is a crucial background characteristic in explaining their quality of life , as reflected in different domains. The QOL of respondents from each class differed from one another, as seen in paired comparisons of the means across economic class groups. The overall QOL index across economic class groups reflected a significant difference in mean scores across the economic class of older women. It clearly suggests that the overall QOL index of older women improves with enhanced economic

status. Older women from the poor strata reported the lowest mean scores for all domains of the QOL. However, the mean of the psychological state was the lowest (M=11.79) of all domains, reflective of the pressing need for intervention to address the psychological health of the older women in the poor class.

Conclusion

The findings suggest that socio-economic and demographic factors are related to social resources such as social networks, participation, social support and trust. They indicate a social gradient in the social capital of older women. The frequency of social contacts and networks was observed to be the least among older women from the poor strata, increasing with improvements in the class of the respondents. Age was also inversely related to social capital. Similarly, participation at the community level in assorted events and activities also reflected their social gradient. Very clearly, the role of social networks, social relations, having a confidant, and being able to trust someone are among the various elements of social capital impacting the quality of life of older women, as illustrated from this empirical study conducted in India's urban settings. There is a need to ameliorate the social contacts of older women by strengthening family and social ties at one end and upgrading infrastructure like designing age-friendly environments and improving access to transportation at the other end. The community and social participation in it of older women living in urban areas is fundamental, as they tend to be more socially isolated than most. Social work interventions - such as initiating community-level activities like the mahila mandals for women from the LIG, located in close proximity, and designed in line with the interests of women of all age groups, strengthening intergenerational bonds by engaging elderly women in aanganwadis and primary school education as storytellers and moral value educationalists - can be experimented with. There is a need to adopt a life-course approach, for instance, through promoting volunteerism among young people so that they connect with the community of the elderly, help enhance their social network, and promote positive ageing on their part.

REFERENCES

Alesina, A. and La Ferrara, E. (2002). Who trusts others? *Journal of Public Economics*, 85(2):207234.

Berkman, Lisa F., Thomas Glass, Ian Brissette, and Teresa E. Seeman (2000). From social integration to health: Durkheim in the new millennium. *Social Science & Medicine,* 51 (2000) 843-857.

Bourdieu, P. (1986). The forms of capital. In: Richardson J G, ed. *Handbook of theory and research in the sociology of education.* New York: Greenwald Press, 241258.

Coleman, J (1988). Social capital in the creation of human capital. *American Journal of Sociology,* 94 (Suppl): S95S120.

Gupta, Nidhi (2015). Physical and Psychological Health of Older Women in Urban India. *Indian Journal of Gerontology,* Vol. 29 No. 1, 2015 pp 23-45.

Putnam R. D., Leonardi, R. and Nanenetti, R. (1993). *Making democracy work: Civic traditions in modern Italy.* New Jersey: Princeton University Press.

Putnam, R. D. (1995). Bowling alone: America's declining social capital. *Journal of Democracy, 6*, 65-78.

Rocco, L. and Suhrcke, M. (2012). Is social capital good for health? A European perspective. Copenhagen, WHO, Regional Office for Europe.

WHO (1996). WHOQOL-BREF Introduction, administration, scoring and generic version of the assessment, Field trial version, December 1996, WHO Geneva. accessed online at http://www. who.int/ mental _health/media/en/76.pdf?ua=1

WHO (2002). Active ageing: A policy framework accessed online on 1 Jan 2017 at http://www.who.int/ageing/publications/ active_ageing / en/ Zunzunegui, M. V., Rodriguez-Laso, A., Otero, A. and Pluijm, S. M. F.(2005). Disability and social ties: Comparative findings of the CLESA study. *European Journal of Ageing 2*(1):40-47.

Zunzunegui, Mar´ıa-Victoria, Beatriz E. Alvarado, Teodoro Del Ser and Angel Otero (2003). Social Networks, Social Integration, and Social Engagement Determine Cognitive Decline in Community-Dwelling Spanish Older Adults. *Journal of Gerontology: SOCIAL SCIENCES.* Vol. 58B, No. 2, S93S100.