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Older Adults' Social Support and its Effect on Their Everyday Self-maintenance Activities: Findings from the Household Survey of Urban Lahore-Pakistan

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ABSTRACT

Given the increasing frailty and disability with age, social networks and social support play cardinal role in the quality of life of older people in societies where formal support and social protection programs are not available. The present paper examines the social networks and the support available for the older people who suffered from various chronic conditions across different socio-economic neighborhoods of urban Lahore, Pakistan. The data were gathered in survey of households from six urban localities in September 2006 to accomplish PhD research, "Management of Chronic Conditions as Predictor of Healthy Ageing: An Analysis of Urban Population, Lahore, Pakistan". Affliction with chronic conditions and widowhood statuses were important determinants of support patterns in the sample population. Results of Univariate analysis indicated that older adults' social support had significant effect on their level of disability (everyday self-maintenance activities). Although older people were embedded in close networks, a considerable proportion of them received occasional instrumental and emotional support from their close ones, particularly family members. Increase in nucleated families and small sizes of families may mar availability of social support for the older people in the years to come. It underscores the need to devise future strategies to develop social protection programs for older people in Pakistan.

KEY WORD: Social Networks**,** Social Support, Impairment, Disability, Everyday Self-maintenance Activities.

Introduction

An individual's social support system comprises multiple networks. These networks comprise various relationships (such as family, relatives, friends and neighbors). The ageing experience of older people is largely influenced by the degree they are embedded in social support networks (Victor, 1994: 169). Social support becomes significant source of help for older people, particularly those living with chronic illnesses (Shippy et al., 2005) and acts as a buffer and alters

recovery patterns (Zink, 1994). Given the increasing prevalence of frailty and disability with age (Albert, 2004), social support, particularly instrumental and emotional support, offsets disability. Disability may be identified and assessed at various levels including (i) body level (impairment), (ii) individual level (activity) and (iii) societal level (participation) [WHO, 2002]. In other words, disability covers impairment in physical strengths and everyday self-maintenance activities (classified as activities of daily living – ADL; and instrumental activities of daily living-IADL).

Everyday self-maintenance activities (ADL and IADL) are considered central indicators of disability (Albert, 2004). Impairment in everyday activities indicates cognitive and motor deficits to carry out work-a-day routine tasks. Loss of these competencies affects disability at individual (activity) and societal (social participation) levels (Albert, 2004: 101).

Population ageing is becoming major issue of developing countries like that of Pakistan where its current nine million population aged 60 years and above is projected to increase to 42 million by the year 2050 (UN, 2002). Pakistan is experiencing an increase in the proportions of the disabled, particularly after the age of 50 years (Rukanuddin, 2003). Table 1 shows disability rates per 1000 population by disability type and age in urban Lahore. Disability rate per 1000 population for each type of disability has been calculated from Table 34 of 1998 District Census Report of Lahore. The data show that disability rate increased with age, particularly from the age of 50 years. The disability rate for the people aged 50-54 years is almost double to that of the total population below 50 years of age. Disability rate is almost 90.0 per 1000 people for people aged 75+ years. Disability rate for each type of disability is greater in the people aged 50+ years than their younger counterparts. Overall, the disability rate for people aged 50+ years was 36.1 per 1000 population compared to 11.9 per 1000 people aged below 50 years.

The data show disability rates regarding blind, deaf/mute, crippled, insane, mentally retarded and also those who reported multiple disabilities. The data did not yield information about disability in terms of functional limitation (ADL and IADL). The disability from this angle has received very little attention by researchers in Pakistan. However, age-related increase in disability implies that older people may not be receiving adequate social support due to the changing family structure.

Family structures and living arrangements of elderly people have changed considerably in the past few decades in developing countries (Zeng, 2006). The issue of changing family household structures in Pakistan has been documented by various studies. Many of the elderly people are not supported by their respective families to meet their basic needs and facing hardships in terms of no respect, no care, isolation, poor health, physical abuse (Afzal, 1999; clark et al., 2002). Even elderly individuals do not get proper attention in joint family set up due to large family size (Ali and Kiani, 2003). It implies that despite the availability of social

networks, particularly family members, many elderly people do not receive support from their families and close ones. This situation indicates that the quality of life of older people in Pakistan is likely to deteriorate and raise the demand for social protection nets for the older people in the coming years. For example, Afzal (1999) found that although many elderly people lived with their children, but many of them were dependent on themselves to meet their basic needs. The rising trends of poverty in Pakistan (Ali and Kiani, 2003) and declining share of economically active population (Nasir, 2003) will not only affect the quality of life of older people but also underscore the need for adequate provision of safety nets for the older people.

Table 1:
Disability rates per 1000 Population by disability type and age in Urban Lahore

Disability in Urban Population of Lahore										
Urban Population	**Blind**	**Deaf & Mute**	**Crippled**	**Insane**	**Mentally retarded**	**1 or more disabilities**	**Others**	**Total disabled**	**Total population**	**Disability rate per 1, 000 pop***
Total	**7,593**	**7,524**	**18,618**	**7,807**	**7,143**	**5,574**	**23,274**	**75,533**	**5,209,088**	**14.5**
<50	**5,627**	**6,269**	**12,037**	**6,560**	**5,876**	**4,337**	**16,431**	**55,137**	**4,644,819**	**11.9**
50-54	419	351	1,236	340	459	274	1,256	4,335	180,476	**24.0**
55-59	292	228	760	183	323	150	997	2,933	116,490	**25.2**
60-64	351	193	1,097	150	196	201	1,277	3,465	101,994	**34.0**
65-69	147	150	945	194	130	181	694	2,441	62,044	**39.3**
70-74	295	155	888	161	54	77	890	2,520	50,881	**49.5**
75+	462	178	1,655	219	105	354	1,729	4,702	52,384	**89.8**
Total 50+ Population	**1,966**	**1,255**	**6,581**	**1,247**	**1,267**	**1,237**	**6,843**	**20,396**	**564,269**	**36.1**
Disability rate per 1,000 for Population aged <50 and 50+ years**										
Total population	**1.5**	**1.1**	**3.6**	**1.5**	**1.4**	**1.1**	**4.5**	**14.5**	**5,209,088**	**N.A**
<50	1.2	0.9	2.6	1.4	1.3	0.9	3.5	11.9	4,644,819	
50+	3.5	2.2	11.7	2.2	2.2	2.2	12.1	36.1	564,269	

Source: Table 34 of 1998 District Census Report of Lahore, Population Census Organization *& **
Source: MCCPHA2010. NA= Not Applicable

Methods

The present study is based on the household survey conducted in September 2006 to accomplish author's PhD research, "Management of Chronic Conditions as Predictor of Healthy Ageing: An Analysis of Urban Population, Lahore, Pakistan". The data were gathered by interviewing 921 respondents (483 males and 438 females) aged 50 years and above from the households of six survey sites of City District Lahore. The major objective of the study was to ascertain self-reported

prevalence of chronic conditions and their management in the study population. Data were also gathered about older adults' support and everyday self-maintenance activities i.e., ADL and IADL capabilities. Social support systems are never one-sided, rather reciprocal in nature. But social support, in the present study, refers to the support older adults received from their close ones in sickness, financial matters, visiting friends/relatives and sharing their problems during last one year. The questions were also asked about the degree of their satisfaction with the support they received from their close ones. A score index was constructed to measure social support received by the respondents during the last one year. The range of score was determined by dividing the sample into third with lowest score, middle third with medium scores, and top third with highest scores. Categories were collapsed into low, average and high social support by using percentile ranks. Collapsing categories in this way has the advantage of letting the data define what is low, medium or high rather than imposing some external, unrealistic definition (deVaus, 1995).

Information was also attained about everyday self-maintenance activities i.e., activities of daily living (ADL) and instrumental activities of daily living (IADL). Self-reported difficulty with following ADL due to health problem included following capabilities:

a) Eating
b) Bathing and showering
c) Dressing
d) Using toilet.

Self-reported difficulty with IADL due to health problem included the following capabilities:

a) Doing light housework, such as washing dishes, light cleaning
b) Doing heavy housework, such as washing clothes, or cleaning floor
c) Using telephone
d) Preparing own meal
e) Going out for shopping.

Although ADL and IADL are important measures of disability (Albert, 2004), it is difficult to sum up the scores of respondents in ADL and IADL domains because people might be similar in overall score but markedly differ on particular items covered in the two domains. Therefore, sum of scores of self-reported difficulties of respondents in each of ADL and IADL domain were calculated to see the effect of social support on the mean impairment score of ADL and IADL capabilities by using univariate analysis of variance.

Major Findings and Results

1) Social Networks and Older Adults' Social Support

a) Support in Sickness

Table 2 presents information about percent distribution of respondents by support received in sickness over the last one year by gender and age. The data show that a substantial percentage (39.1 percent) of the respondents (40.2 percent women and 38.1 percent men) received occasional support in sickness by their close ones over the last one year. About 36.3 percent women and 31.3 percent men received frequent support in sickness. It is important to note that relatively greater fraction of respondents aged up to 60 years compared to those aged 61+ years received more support from their close ones during the last one year. It is understandable as significant proportion of respondents aged up to 60 years were afflicted with multiple chronic conditions. It is also argued that females tend to report more illness and receive more support than those of males in sickness.

However, a significant proportion of respondents received support in sickness over the last one year. It indicates that a substantial number of respondents experienced sickness over the last one year. The data implies that older adults were respected by their close relatives who looked after them well.

Table 2:
Percent distribution of respondents by support received in sickness during last one year by gender and age

Gender	Age (years)	Frequency of support received in sickness during last one year				
		Never	**Rarely**	**Occasionally**	**Frequently**	**Total**
Male	≤ 60	0.8	14.3	19.9	17.6	**52.6**
	61-69	00.0	7.0	7.7	5.4	**20.1**
	≥ 70	0.4	8.1	10.6	8.3	**27.3**
	Total	**1.2**	**29.4**	**38.1**	**31.3**	**100.0**
	N	**6**	**142**	**184**	**151**	**483**
Female	≤ 60	0.5	14.4	24.2	20.3	**59.4**
	61-69	0.9	3.4	5.5	5.3	**15.1**
	≥ 70	00.0	4.3	10.5	10.7	**25.6**
	Total	**1.4**	**22.1**	**40.2**	**36.3**	**100.0**
	N	**6**	**97**	**176**	**159**	**438**

Source: MCCPHA 2010

b) **Support for Financial Resources**

Financial support, a type of instrumental support, is associated with the well-being of older people. Financial support helps people, particularly those having low income, to cope with the setbacks and promotes access to medical services. Table 3 shows percent distribution of respondents by financial support received from the close ones during the last one year by gender and age. The data show that about 36.2 percent respondents (38.9 percent men) and (33.3 percent women), received occasional financial support form their close ones. It is important to note that the 41.1 percent women reported receiving financial support frequently as compare to their 27.1 percent male counterparts. It suggests that females were financially more dependent on their close ones than the males. It also indicates greater economic deprivations in females than the males, which is largely rooted in the socio-cultural system of Pakistani society.

Only a tiny proportion of respondents (3.7 percent males and 3.4 percent females) reported that they never had received financial support from their close ones during the last one year. Overall, large fraction of respondents received occasional financial support from their close ones. Since larger fractions of respondents were either non-working or engaged in low paid informal activities or were widowed, their dependence on financial support might be attributed to their poor socio-economic conditions. Although the close ones were supporting older persons financially, they were constrained because of the financial resources needed for the better education of their children and their own health needs. This situation may pose serious challenge for the government to initiate social protection programs for older people in the years to come.

Table 3:
Percent distribution of respondents by financial support received from close ones during last one year by gender and age

Gender	Age (years)	Frequency of financial support received during last one year				
		Never	Rarely	Occasionally	Frequently	Total
Male	≤ 60	2.3	15.9	19.7	14.7	**52.6**
	61-69	1.0	7.2	7.5	4.3	**20.1**
	≥ 70	0.4	7.0	11.8	8.1	**27.3**
	Total	**3.7**	**30.2**	**38.9**	**27.1**	**100.0**
	N	**18**	**146**	**188**	**131**	**483**
Female	≤ 60	2.3	13.5	17.8	25.8	**59.4**
	61-69	0.5	3.0	6.6	5.0	**15.1**
	≥ 70	0.7	5.7	8.9	10.3	**25.6**
	Total	**3.4**	**22.1**	**33.3**	**41.1**	**100.0**
	N	**15**	**97**	**146**	**180**	**438**

Source: MCCPHA 2010

c) **Support Received to Visit Friends and Relatives**

Friends are considered as an important source of support because they provide emotional support through advice and exchange relations (Dykstra, 2007:90). The frequency of contacts with friends/relatives has a great impact on the well-being of older people (Quadagno, 2002:251). Contacts with friends/relatives may not only decrease substantially with the age but the pattern of visiting friends may also vary. Those who maintain their contacts with their friends/relatives are less likely to be socially isolated than those who are not. Table 4 presents percent distribution of respondents by support received in visiting friends/relatives by gender and age. The data show that 33.7 percent of the respondents (34.2 percent women and 33.3 percent men) received occasional support from close ones to visit their friends and relatives. It is important to note that 17.6 percent women and 14.3 percent men reported receiving support to visit their friends and relatives. It is argued that females are more likely to see friends than males (Victor, 1994: 185) and women's social networks are stronger than those of men (Grundy, 2006:189). But the data showed that women's contacts with friends and relatives decreased with age. It might be due to the reportage of severely limiting chronic conditions (such as stroke, hip fracture, arthritis and vision problem) by women in the study population. A significant proportion of respondents (21.3 percent) reported that they never received support to visit friends/relatives by their close ones. It implies that likelihood of retaining contacts with friends and relatives decreases with age and poor health status.

Table 4:
Percent distribution of respondents by extent of support received in visiting friends/relatives by gender and age

		Frequency of support received by close ones to visit friends/relatives during last one year				
Gender	**Age (years)**	**Never**	**Rarely**	**Occasionally**	**Frequently**	**Total**
Male	≤ 60	12.2	14.7	19.5	6.2	**52.6**
	61-69	5.6	6.6	4.8	3.1	**20.1**
	≥ 70	5.8	7.5	9.1	5.0	**27.3**
	Total	**23.6**	**28.8**	**33.3**	**14.3**	**100.0**
	N	**114**	**139**	**161**	**69**	**483**
Female	≤ 60	12.3	16.4	20.1	10.5	**59.4**
	61-69	3.7	5.5	3.9	2.1	**15.1**
	≥ 70	3.0	7.3	10.3	5.0	**25.6**
	Total	**18.9**	**29.2**	**34.2**	**17.6**	**100.0**
	N	**83**	**128**	**150**	**77**	**438**

Source: MCCPHA 2010

d) **Emotional and Psychological Support**

Emotional support is considered important in making individuals feel cared and comforted. Those individuals who have some support to share their problems/worries with their close ones are considered less likely to be affected by tensions or anxiety compared to those who do not have some support to share problems/worries. Table 5 presents percent distribution of respondents by source of support to share problems/worries by gender and age. About 38.9 percent men as compared to 24.9 percent women reported spouse with whom they shared their worries/problems. This was expected in a patriarchal structure where women could have lesser liberty to discuss their problems with their husbands. Since greater percentage of females (36.5 percent of the total 438 females) compared to males (12.0 percent of the total 483 males) was widowed, it was possibly another reason that they did not report sharing their problems with their spouses.

Table 5:
Percent distribution of respondents by source of support to share problems/worries by gender and age

Gender	Age (years)	Source of support in sharing worries/problems						
		Spouse	Son	Daughter	Friend	Neighbor	Other	Total
Male	≤ 60	22.8	11.4	3.9	4.8	1.4	8.3	**52.6**
	61-69	9.5	3.9	1.9	1.2	00.0	3.5	**20.1**
	≥ 70	6.6	9.3	4.6	1.2	00.0	5.6	**27.3**
	Total	**38.9**	**24.6**	**10.4**	**7.2**	**1.4**	**17.4**	**100.0**
	N	**188**	**119**	**50**	**35**	**7**	**84**	**483**
Female	≤ 60	18.7	15.3	12.6	2.7	0.9	9.1	**59.4**
	61-69	3.0	5.0	3.2	0.2	0.2	3.4	**15.1**
	≥ 70	3.2	10.5	4.8	1.8	00.0	5.3	**25.6**
	Total	**24.9**	**30.8**	**20.5**	**4.8**	**1.1**	**17.8**	**100.0**
	N	**109**	**135**	**90**	**21**	**5**	**78**	**438**

Source: MCCPHA 2010

The data also show 30.8 percent women reported son with whom they shared their problems and worries. With increase in age, relatively fewer female respondents reported male spouse as a source to share problems/worries. It is probably due to the loss of male spouse in later years. These findings imply that women in advanced ages face the challenges of bereavement and deserve more care.

The data show that greater fraction 20.5 percent women compared to 10.4 percent men reported 'daughters' with whom they shared their problems and worries. It is understandable that older females were more comfortable to share their problems with their daughters than sons. However, sons were also a source of emotional support to their mothers. Very few respondents reported friends and neighbors as a source of support in sharing problems or worries. Overall, close family members seem to be the important source of support in sharing problems and worries.

e) Source of Social Support

Another question was asked about the major source of support during the last one year. Table 6 presents percent distribution of respondents by source of support by gender and age. Greater fractions of male respondents, compared to those of females, across all age groups reported their 'spouses' as the main source of support followed by 'sons' and 'daughters'. Relatively greater percentage of male respondents aged 70+ years reported 'son' as the main source of support. It might be one of the factors that male births are cherished in Pakistan. It is also possible that when daughters get married, they move away to their in-laws and could not attend to the needs of their elderly parents.

Table 6:
Percent distribution of respondents by source of social support by gender and age

		Source of social support						
Gender	**Age (years)**	**Spouse**	**Son**	**Daughter**	**Friend**	**Neighbor**	**Other**	**Total**
Male	≤ 60	22.6	14.9	4.6	0.8	1.7	8.1	**52.6**
	61-69	7.5	7.2	2.5	00.0	00.0	2.9	**20.1**
	≥ 70	7.0	10.1	5.6	0.6	0.2	3.7	**27.3**
	Total	**37.1**	**32.3**	**12.6**	**1.4**	**1.9**	**14.7**	**100.0**
	N	**179**	**156**	**61**	**7**	**9**	**71**	**483**
Female	≤ 60	16.7	24.9	10.3	0.5	0.2	6.8	**59.4**
	61-69	3.0	5.9	3.2	00.0	00.0	3.0	**15.1**
	≥ 70	3.2	13.5	3.4	0.2	0.9	4.3	**25.6**
	Total	**22.8**	**44.3**	**16.9**	**0.7**	**1.1**	**14.2**	**100.0**
	N	**100**	**194**	**74**	**3**	**5**	**62**	**438**

Source: MCCPHA 2010

Several respondents reported 'other' as the source of support. The category 'other' included daughters-in-law or grandchildren. However, family networks were the major source of support for older people. It might be due to this reason that state has not yet assumed the responsibility of taking care of older people in Pakistan.

f) Satisfaction with the Support

Satisfaction with support is considered important aspect in continuity of the support. Table 7 presents percent distribution of respondents by their satisfaction with the support received by gender and age. A little more than one-half of the respondents (54.5 percent) reported high satisfaction with the support they received. A significant proportion of respondents (30.8 percent) expressed moderate satisfaction with the support they were receiving. Overall, slightly greater fractions of females, compared to those of males, expressed more satisfaction with the support they had received. Since most of the support was provided to females by their male spouses, it might be difficult for female spouses to express dissatisfaction with the support they had received.

Table 7:
Percent distribution of respondents by satisfaction with the social support by gender and age

		Satisfaction with the social support received				
Gender	**Age (years)**	**Not at all**	**Slightly satisfied**	**Moderately satisfied**	**Highly satisfied**	**Total**
Male	≤ 60	2.9	4.6	15.5	29.6	**52.6**
	61-69	1.4	1.4	6.8	10.4	**20.1**
	≥ 70	0.8	3.9	8.3	14.3	**27.3**
	Total	**5.2**	**9.9**	**30.6**	**54.2**	**100.0**
	N	**25**	**48**	**148**	**262**	**483**
Female	≤ 60	1.6	6.6	18.5	32.6	**59.4**
	61-69	1.1	2.1	5.3	6.6	**15.1**
	≥ 70	0.5	2.3	7.3	15.5	**25.6**
	Total	**3.2**	**11.0**	**31.1**	**54.8**	**100.0**
	N	**14**	**48**	**136**	**240**	**438**

Source: MCCPHA 2010

However, a considerable number of respondents, with relatively greater share of males aged 61+ years were less satisfied with the support they had received. It is understandable as considerable number of respondents were unable to manage

relationships with their family members, particularly with their female spouses. Since management of relationship with family members is considered important for continuity of support and subsequent satisfaction, it might be due to this factor that a considerable number of respondents were less satisfied with the support provided to them. Sometimes receiving less support than one gives leads to distress and feeling of guilt (Dykstra, 2007:89), which might in turn result in dissatisfaction.

Overall, the findings indicate that a little more than one third of the respondents (36.7 percent) received average social support, whilst a little less than one third of the respondents received high and low social support during the last one year (see Table 8).

Table 8:
Percent distribution of respondent by the level of Support received by close ones

Level of Social Support	Frequency	Percent
Low social support	294	31.9
Average social support	338	36.7
High social support	289	31.4
Total	921	100.0

Source: MCCPHA 2010

2) Social Support and Everyday Self-maintenance Activities

a) Impairment in Everyday Self-maintenance Activities

According to Disabled People's International (1982), impairment refers to the functional limitation within the individual caused by physical, mental or sensory loss. Disablement model explains disability in terms of self-reported difficulty in performing every day tasks because of functional limitation (i.e., impairment) [Albert, 2004].

WHO (2001) in its revised model (International Classification of Functioning, Disability and Health) explained disability in terms of activity limitation and participation restriction. It clearly indicates that functional limitation (impairment in everyday self-maintenance activities) is widely used indicator of disability. Table 9 provides information about impairment in everyday self-maintenance (ADL and IADL) tasks. Out of the total 921 respondents, 48.8 percent had no difficulty in performing ADL tasks; 21.7 percent of the total respondents had one difficulty in ADL domain, while 29.5 percent of the total respondents had 2+ difficulties in ADL sphere. It is necessary to mention here that 2+ difficulties in ADL capabilities were more prevalent in the respondents from lower and middle socio-economic neighborhoods of city District Lahore. Table 9 shows that 43.2 percent of the total 921 respondents reported no difficulty in any activity under

reference in IADL capabilities, while 15.4 percent of the total respondents had difficulty in one of the tasks of IADL domain. It is interesting to note that greater proportion of respondents (41.4 percent) reported 2+ difficulties in IADL domain compared to that of respondents (29.5 percent) who had 2+ difficulties in ADL competencies. Over reportage of difficulties in IADL capabilities might partly be attributed to culture and gender specific responses to the items covered in IADL sphere (such as going out for shopping, preparing meals, washing clothes and cleaning floor). However, significant proportions of respondents were impaired in both ADL and IADL capabilities. The effect of older adults' social support on their everyday self-maintenance activities was tested by applying univariate analysis of variance.

Table 9:
Percent distribution of respondents by impairment in everyday self-maintenance activities

Impairment in ADL Domain	**Frequency**	**Percentage**
No difficulty in ADL activities	449	48.8
Difficulty in 1 ADL activity	200	21.7
Difficulty in 2+ ADL activities	272	29.5
Total	**921**	**100.0**
Impairment in IADL domain	**Frequency**	**Percentage**
No difficulty in IADL activities	398	43.2
Difficulty in 1 IADL activity	142	15.4
Difficulty in 2+ IADL activities	381	41.4
Total	**921**	**100.0**

Source: MCCPHA 2010

b) **Effect of Social Support on Everyday Self-maintenance Activities**

I. **Effect of Social Support on ADL Capabilities**

To examine the effect of older adults' social support on their ADL capabilities, the following null hypothesis was tested.

Ho: There is no significant effect of respondents' social support on their ADL impairment.

Table 10 presents descriptive statistics and univariate analysis of variance for the effect of social support on ADL impairment. The data show that respondents with high social support had low ADL impairment mean (0.9066) than those with low social support (high ADL impairment mean i.e. 1.2041). The standard deviations indicate variability of ADL impairment on the basis of respondents' social support ranging from a

low of 1.2283 (high social support) to a high of 1.3822 (low social support). The results of univariate test (F=3.861, P≤0.05) rejected the null hypothesis that there was no significant effect of respondents' social support on their ADL impairment and it is concluded that respondents' social support has significant effect on their ADL impairment. Respondents who received high social support were less impaired in their ADL competencies compared to those who received less social support.

II. Effect of Social Support on IADL Capabilities

The following null hypothesis was tested to examine the effect of older adults' social support on their IADL capabilities:

Ho: There is no significant effect of respondents' social support on their impairment in IADL competencies.

Table 11 presents descriptive statistics and univariate analysis of variance for the effect of respondents' social support on their impairment in IADL competencies. Respondents with high social support have low impairment mean in IADL competencies (1.3910) compared to those with low social support (1.6973). The standard deviations indicate the variability of impairment in IADL competencies on the basis of respondents' social support ranging from a low of 1.5307 (high social support) to a high of 1.6566 (low social support). The null hypothesis that there is no effect of respondents' social support on their IADL impairment was rejected for univariate test (F=2.754, P=0.064). However, there is slight mean impairment difference in IADL capabilities for the respondents with high social support Vs respondents with low social support. It implies that there might be other confounding factors which offset the impairment in IADL capabilities of the older adults or it might be due to gender and cultural sensitivity to the responses covered in IADL domain.

Table 10:
Descriptive statistics and univariate analysis of variance for the effect of respondents' social support on their ADL impairment

Social support	Mean			SD	
Low social support	1.2041			1.3822	
Average social support	1.0503			1.2660	
High social support	0.9066			1.2283	
	Univariate Analysis of variance				
Source of Variation	**Sum of squares**	**df**	**Mean Square**	**F**	**Significance**
Social support	12.908	2	6.454	3.861	0.021
Error	1534.378	918	1.671		
Total	**2571.000**	**921**			

Source: MCCPHA 2010

Table 11:
Descriptive statistics and univariate analysis of variance for the effect of respondents' social support on their impairment in IADL competencies

Social support	Mean	SD
Low social support	1.6973	1.6566
Average social support	1.5621	1.5496
High social support	1.3910	1.5307

Univariate Analysis of variance

Source of Variation	Sum of squares	df	Mean Square	F	Significance
Social support	13.731	2	6.865	2.754	0.064
Error	2288.070	918	2.492		
Total	**4519.000**	**921**			

Source: MCCPHA 2010

Discussion

Social support is a powerful predictor of living a healthy and long life (Dykstra, 2007). Social support in old age, regardless of individuals' socio-economic status, health risk behaviors and use of health services, has strong bearing on the health status of older people (Uchino, 2004). Social support acts as a buffer and alters recovery patterns (Zink, 1994). Population ageing is becoming one of the serious issues in developing countries like that of Pakistan. Family structures and living arrangements of elderly people also seem to be changing in the wake of population ageing in Pakistan.

Although older people are embedded in family net works, changing family structures may affect the pattern of support in future. Availability of spouse in later ages is major source of support in matters relating to sickness and emotional support. Widowhood, which is largely the experience of women in societies like Pakistan where women are less likely to remarry in old age, may yield adverse consequences for functional health status of older adults due to lack of instrumental and emotional support. Although male children are major source of instrumental support, daughters-in-law shoulder support in matters of sickness. It could be one of the important factors for son preference in societies like Pakistan. Older people afflicted with multiple morbidities (such as arthritis, heart diseases, paralysis, hip fracture and vision problems) expect more support. However, class differences are important in determining the types of social support older people

receive. Supports in sickness and financial matters were needed more by the older people from lower socio-economic neighborhoods compared to those of middle and upper socio-economic neighborhoods. The older adults from middle and upper socio-economic neighborhoods reported less than needed support in visiting friends and sharing their problems/worries. It is interesting to note that large proportion of older adults showed moderate to high satisfaction with the support they received from their close ones, particularly family members during the last one year. It is understandable as people may not want to reveal the complaints about family members or in the face of poverty, absence of governmental support mechanism people may not complain about inadequate social support by their family members out of the fear of losing social support. However, descriptive statistics and univariate analysis of variance supported the assumption that social support in older age has significant effect on the everyday self-maintenance activities of the older adults. Those who had high social support had less mean impairment scores both in ADL and IADL capabilities compared with those who had low social support from their close ones during the last one year.

Conclusion

Although older people are enmeshed in their families and command respect from their families, changing socio-economic structure may mar the availability of support to older people by their respective families in future. It warrants the need of devising formal strategies to cater to the social protection demands of the growing older population of Pakistan. Poor and marginalized families should be assisted to support their older adults.

References

Ahmad, K. (2010). "Management of Chronic Conditions as Predictor of Healthy Ageing: An Analysis of Urban Population, Lahore, Pakistan". An unpublished PhD thesis submitted to the University of Punjab, Lahore.

Afzal, M. (1999). Study on the Situation of Elderly People in Pakistan. New York: United Nations.

Albert, S.M. (2004). Public Health and Aging, An Introduction to Maximizing Function and Well-being. New York: Springer Publishing Company, Inc.

Ali, S.M., and Kiani, M.F.K. (2003). Ageing and Poverty in Pakistan. Isalmabad: Pakistan Institute of Development Economics. MIMAP Technical Paper Series No. 18.

Clark, G., Zaman, H. and Chaudry, A.G. (2002). Pakistan Aging Study, Preliminary Report on Six Sites in Punjab: Testing Traditional Assumptions about Family Support. Islamabad: Government of Pakistan, Ministry of Women Development, Social welfare, and Special Education. National Council of Social Welfare (NCSW).

de Vaus, D.A. (1995). Surveys in Social Research. London: Routledge.

DPI (1982). Proceedings of the First World Congress. Singapore: Disabled People's International.

Dykstra, P. (2007). 'Aging and Social support'. In The Blackwell Encyclopedia of Sociology, Volume (I), G. Ritzer, ed. Pp. 88-92. Malden: Blackwell Publishing Ltd.

Government of Pakistan (2000). 1998 District Census Report of Lahore. Islamabad: Statistics Division, Population Census Organization (PCO).

Grundy, E. (2006). "Gender and Healthy Aging." In Longer Life and Healthy Aging, Z. Yi, E.M. Crimmins, and Y. Carriere, eds. Pp. 173-199. Dordrecht, The Netherlands: Springer.

Nasir, Z.M. (2003). 'Economically Active Population, Employment, and Unemployment'. Pp.285-311 in Population of Pakistan: An analysis of 1998 Population and Housing Census. Islamabad: Pakistan Institute of Development Economics.

Penninx,B.W., Tilburg, T., Kriegsman, D.M., Boeke, A. J., Deeg, D. J., and Eijk, J.T. (1999). Social Network, Social Support, and Loneliness in Older Persons with Different Chronic Diseases. Journal of Aging and Health, 11(2): 151-168.

Quadagno, J. (2002). Aging and the Life Course, An Introduction to Social Gerontology. New York: McGraw Hill.

Rukanuddin, A.R. (2003). "Disabled Population of Pakistan." In Population of Pakistan: An Analysis of 1998 Population and Housing Census. Islamabad: Pakistan Institute of Development Economics, pp.327-348.

Shippy, R.A. and Karpiak, S.E. (2005). Perceptions of Support among Older Adults with HIV. Research on Aging, 27 (3): 290-306.

Uchino, B.N. (2004). Social Support and Physical health: Understanding the Health Consequences of Relationships. New Haven: Yale University Press.

United Nations (2002). World Population Ageing 1950-2050. New York: Economic and Social Affairs, Population Division.

Victor, C.R. (1994). Old Age in Modern Society. London: Chapman and Hall.

WHO (2001). International Classification of Functioning, Disability and Health. Geneva: World Health Organization.

Wolf, D.A. (1994). "The Elderly and Their Kin: Patterns of Availability and Access." In Demography of Ageing, G.M. Linda and H.P. Samuel, eds. Pp. 146-194. Washington DC: National Academy Press.

Zeng, Y. (2006). "The Family and Healthy Aging." In Longer Life and Healthy Aging, Z. Yi, E.M. Crimmins, and Y. Carriere, eds. Pp. 235-237. Dordrecht, The Netherlands: Springer.

Zink, M.R. (1994). Social Support Systems in Elder Homebound Clients. Home Health Care Management & Practice, 6 (3): 1-10.

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