

FACTORS AFFECTING SOCIAL PARTICIPATION OF ELDERLY PEOPLE: A STUDY IN LAHORE

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ABSTRACT

Social participation is deemed to have strong bearing on the health and life quality of older people. The objective of the present study was to identify major factors associated with social participation of older people. The data for the present paper draws from the survey carried out in 2006 on management of chronic conditions and healthy ageing. The findings of the present study indicated that the older individuals' social participation was significantly associated with their socio-economic positions, presence of severely limiting chronic conditions, widowhood status and gender. Chronological age is largely attributed to the reduced participation in social life. However, we found that socio-economic status and gender of the respondents were significant factors in determining the social participation of the older people.

Key word: Ageing, Chronic Conditions, social participation, spouse.

INTRODUCTION

Social participation in older age is considered to be largely determined by various factors such as increased poverty levels (due to retirement, reduced income generating activities), loss of spouse and physical decrements resulting from the onset of chronic ailments. The lack of participation in social activities is significantly associated with increased morbidity and mortality (Rozanski *et al.*, 1999), while social participation has positive impact on the health of older people (Avlund *et al.*, 2004) and their quality of life (Bowling *et al.*, 2002). Social participation entails both informal and formal roles. Participation of older adults in informal and formal activities is affected by disabilities resulting from certain chronic conditions, such as cardiovascular diseases, arthritis and diabetes (Verbrugge *et al.*, 1989; Guralnik *et al.*, 1993; Fried *et al.*, 1999). Disabilities may result from other factors, such as accidents or congenital deficits. However, disability is largely associated with age related senescence (Albert, 2004). Senescence and disability seem to start at an early age in Pakistan. For example, the 1998 census count of Pakistan (Government of Pakistan, 2000) recorded consistent increase in disability for people aged 50 years and above. Disability exacerbates in the presence of chronic conditions, which in turn might adversely affect elderly people's participation in social activities. In other words, sheer chronological age may not push older people to disengage from social fabric of the society. In addition to age related disability, socio-economic conditions and lifestyle factors are associated with social participation (Stuck *et al.*, 1999). Life events (such as affliction with chronic ailments and widowhood status) and gender are important factor influencing social

participation in old age, as women are generally more socially and economically disadvantaged than older men (Zeng *et al.*, 2006). Various studies demonstrate that social participation is a key element in the strategy to address socioeconomic and public health conditions of the ageing population (Rozanski *et al.*, 1999). The present paper was an attempt to assess the impact of chronological age, socio-economic status, affliction with serious morbidities, widowhood status and gender on the social participation of individuals aged 50 years and above in urban Lahore.

MATERIALS AND METHODS

The present study was based on the household survey conducted in September 2006 to accomplish the 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 (Babar Block, Scotch Corner, Rehman Pura, Mohallah Jalutiyani, Qalanda Pura and Babu Sabu) of City District Lahore. The major objective of the study was to ascertain self-reported prevalence of chronic conditions and their management with a focus upon healthy ageing in the study population. Data about social participation of the older adults were gathered and analyzed. Information was also collected about socio-economic variables of the respondents. A total score index for socio-economic status of each respondent was computed on the basis of educational attainment, occupation, monthly income, availability of consumer durables. On the basis of total score, respondents were classified into three categories representing their socio-

economic status (i.e., low, medium, high) by applying the specific range of scores by using 33, 66 and 67+ percentile ranks.

RESULTS

Socio-economic Profile of the Respondents: This section provides information about the socio-economic and demographic profile of the older people across different localities of city district Lahore. The data in Table 1 shows that a substantial proportion of respondents with slightly greater fraction of females (47.3 percent) compared to that of males (41.6 percent) was aged 50-59 years. Such a gender difference could be expected in societies like Pakistan where women are usually younger than men at the time of marriage. Overall, smaller proportion of respondents was aged 70 + years. It might be attributed to the life expectancy of

individuals in Pakistan which is less compared to that of in developed countries.

Marital status is considered important in determining psychological and emotional health of the people in later years. Availability of spouse might be a significant source of support in later years of life. A marriage relationship can provide affection and a sense of belonging. This valuable support is lost upon widowhood (Victor, 1994). Table 1 shows percent distribution of respondents by gender, age, and marital status. Out of the total 483 male respondents, 86.7 percent were currently married, while only 12.0 percent of them were widowed. Out of total 438 female respondents, 62.1 were currently married and 36.5 percent were widowed. Only tiny proportions (0.2 percent) of male and female respondents were divorced.

Table 1 Percentage distribution of respondents by gender, age, marital status and socio-economic status

		Marital Status					Total
Gender	Age (in Years)	Currently Married	Widowed	Separated	Divorced	Never Married	
Male	50-59	38.7	1.9	0.0	0.2	0.8	41.6
	60-69	29.0	2.1	0.0	0.0	0.0	31.1
	70-79	14.5	3.7	0.0	0.0	0.2	18.4
	80 and above	4.6	4.3	0.0	0.0	0.0	8.9
	Total	86.7	12.0	0.0	0.2	1.0	100.0
	N	419	58	0.0	1.0	5.0	483
Female	50-59	34.7	11.6	0.2	0.2	0.5	47.3
	60-69	16.0	11.0	0.0	0.0	0.2	27.2
	70-79	9.4	8.4	0.0	0.0	0.2	18.0
	80 and above	2.1	5.5	0.0	0.0	0.0	7.5
	Total	62.1	36.5	0.2	0.2	0.9	100.0
	N	272	160	1	1	4	438
		Socio-economic Status				Total	
Gender	Age (in Years)	Low	Medium	High			
Male	50-59	14.1	9.9	17.6		41.6	
	60-69	9.1	7.2	14.7		31.1	
	70-79	6.8	4.1	7.5		18.4	
	80 and above	4.1	1.2	3.5		8.9	
	Total	34.2	22.6	43.3		100.0	
	N	165	109	209		483	
Female	50-59	20.3	13.2	13.7		47.3	
	60-69	13.7	8.7	4.8		27.2	
	70-79	7.8	6.2	4.1		18.0	
	80 and above	4.3	2.7	0.5		7.5	
	Total	46.1	30.8	23.1		100.0	
	N	202	135	101		438	

Source: MCCPHA 2010*

The percentages of female widowed across all age groups were greater than those of males. It indicates that a large proportion of widows may have to face more isolation and ordeal compared to their married

counterparts. Womanhood and widowhood may jeopardize social, economic and psychological status of females more than their male counterparts in later years of life. Widowed demonstrate higher rates of mortality,

morbidity and self reported ill health (Victor, 1994). Percentages of divorced or separated respondents were small. One may argue that people could be less likely to divorce or separate in older ages because they may need their spouses to take care of each other.

Socio-economic status has strong bearing on one's health status in late years of life. Socio-economic status influences many aspects of people's lives, including their access to health and other services. With the increase in age, older adults scored low on socio-economic variables (education, occupation, monthly income and consumer durables). It is understandable that income levels reduce with increase in age due to retirement or less involvement in income generating activities due to physical frailty. It might also be argued that elderly respondents scored low on educational attainments compared to those of young old cohorts due to availability of better educational facilities and increased enrolments in educational institutions.

However, gender differentials indicate that older females were more deprived and scored less on socio-economic variables compared to their male counterparts. It might have implications for their health and well-being.

Self-reported Prevalence of Medically Diagnosed Chronic Ailments: It is usually believed that chronological age largely determines individuals' social participation. But the major life events such as loss of spouse, retirement, affliction with chronic condition(s)

significantly influence life quality of older persons. These life transitions are largely intertwined with socio-economic statuses and gender of older people.

The data collected for the present study showed high prevalence of chronic conditions (such as, poor eye sight, high blood pressure, arthritis, diabetes and Alzheimer's disease) in the sample population across the six urban localities of Lahore at the time of survey. Table 2 shows that out of total 921 respondents, a vast majority of respondents suffered from the listed chronic conditions. Only a tiny proportion of respondents did not report any chronic condition. The data clearly indicate that old age is characterized with the prevalence of chronic conditions.

The data show following order of prevalence of chronic conditions in the study population: 'Poor eye sight (70.5 percent), high blood pressure (51.6 percent), dental or gum problem (44.2 percent), arthritis (43.1 percent), too frail to work (32.6 percent), insomnia (25.5 percent), diabetes (25.4 percent), hearing impairment (22.1 percent), high cholesterol (18.0 percent), obesity (17.9 percent), Alzheimer's disease (16.0 percent), heart attack (12.2 percent) and angina (12.2 percent), hip fracture (9.0 percent), Parkinson's disease (7.7 percent), lung disease (7.2 percent), stroke/paralysis (6.0 percent), cancer (2.7 percent) and other ailments including fever, flu/cough, T.B (2.3 percent) across all the six survey sites.

Table 2 Percent distribution of respondents by self reported diagnosed conditions by survey site

Self-reported medically diagnosed condition	Babar Block	Scotch Corner upper mall	Rehman Pura	Mohallah Jalutiyan	Qalandar Pura	Babu Sabu	Total
Heart attack	2.1	0.9	2.1	3.9	1.3	2.0	12.2
Angina	1.7	1.5	2.9	1.5	2.0	2.5	12.2
Obesity	3.6	2.3	4.1	2.6	1.8	3.5	17.9
High blood pressure	6.1	4.8	10.1	10.1	9.9	10.6	51.6
High cholesterol	3.4	2.7	4.8	2.6	1.7	2.8	18.0
Diabetes	2.9	2.8	5.2	5.6	4.1	4.7	25.4
Arthritis/Joint pain	3.0	4.9	5.9	8.7	10.6	10.0	43.1
Stroke/paralysis	0.1	0.5	1.5	1.0	1.1	1.7	6.0
Cancer (of any type)	0.1	0.2	0.5	0.2	0.3	1.3	2.7
Lung disease	0.4	1.1	1.5	0.8	2.1	1.3	7.2
Hearing impairment	1.7	3.4	4.5	3.9	3.7	5.0	22.1
Vision problem	10.6	9.1	14.0	12.9	11.8	11.9	70.5
Alzheimer's disease	1.8	2.6	3.8	1.5	3.1	3.0	16.0
Dental /gum problem	3.1	5.1	7.6	11.9	8.9	7.5	44.2
Too frail to do daily work	1.6	3.4	6.3	7.6	6.2	7.5	32.6
Insomnia	1.7	2.7	4.8	5.0	5.4	5.9	25.5
Hip fracture	0.1	1.3	2.9	1.1	1.4	2.2	9.0
Parkinson's disease	0.1	0.8	1.7	1.1	1.8	2.2	7.7
Other	00.0	0.5	0.4	0.5	0.5	0.2	2.3

Source: (Ahmad, 2010) N= 921

Overall, poor eye sight/vision was the most prevailing condition in the largest proportion of

respondents (70.5 percent) across all the six localities of Lahore. It is usually believed that vision problem worsens

with increase in age. Although vision problem is non-fatal, it may cause other problems like falling and getting injured (hip fracture) in old age. It is interesting to note that heart attack, angina, obesity and high cholesterol were more prevalent conditions in upper (Babar Block, Scotch Corner) and middle socio-economic neighborhoods (Rehman Pura and Mohallah Jalutiyan) compared to low socio-economic neighborhoods (Qalanda Pura and Babu Sabu).

In developing countries, risk factors for heart diseases increase with rising incomes (for example, obesity), which in part is attributable to changing diet patterns containing high levels of fat, salt and calories. The increasing body weight and less exercise among the affluent people (Leeder *et al.*, 2004) causes several ailments. It may be argued that the availability of personal transportation and labor saving devices could be responsible for declined physical activity in affluent classes. Such a lifestyle leads to high cholesterol, obesity and heart diseases, while genetic influence could partly be responsible for chronic ailments. However, the analysis of genetic factors was beyond the scope of the present study. The data show that high blood pressure, diabetes, arthritis, stroke, lung diseases, hearing impairment, Alzheimer's disease, hip fracture, frailty and vision problems were more prevalent among the respondents of middle and lower socio-economic neighborhoods compared to those from upper socio-economic backgrounds. One may argue that exposure to malnutrition in early life, lack of access to adequate health care, and exposure to unsafe environmental conditions either at work or at home could be among the factors responsible for greater prevalence of these chronic conditions in lower and middle socio-economic strata than in the upper socio-economic neighborhoods. It may also be argued that poor health conditions could also lead to poverty due to medical costs and decreased chances of employment.

Social Participation of the Respondents: Information was gathered about participation in various social activities such as religious behaviors, political participation, and pursuing cultural activities. Table 3 presents Percentage distributions of respondents by gender, age, social participation, leisure time activities, and frequency of visiting friends/relatives. More than one-half of the respondents (52.0 percent males and 58.7 percent females) reported participation in religious activities. Presence of co-morbidities is believed to be responsible for increased religious pursuits. This argument received support from chi-square test of association (χ^2 51.64 df 9 $P \leq 0.001$), which shows a robust association between affliction with multiple chronic conditions and participation in religious activities. Religious activities are the source of spiritual support and provide opportunities to interact with people

having similar values and beliefs (Poloma *et al.*, 1991). Participation in religious activities helps older people to cope with chronic health problems and depression (McFadden, 1996). A significant proportion of respondents viewed illness as a spiritual problem and considered religion as an important tool to manage depression. Religious pursuits help reduce disease related stress (Quadagno, 2002).

A significant proportion of respondents, with relatively greater percentage of males (21.3 percent) compared with that of females (19.6 percent) reported participation in cultural activities. A smaller proportion of females (9.4 percent) compared to that of males (15.7 percent) reported participation in political activities. The chi-square test (χ^2 15.71, df 3, $P \leq 0.001$) showed significant relationship between respondents' gender and participation in political activities. These findings could be expected in a male dominated society like that in Pakistan. It clearly implies gender-based difference exists in all the activities particularly related to public life as opposed to that in domestic affairs.

The data in Table 3 suggest that participation in social activities decreased with age. It might be attributed to the increased frailty due to severely limiting chronic conditions (such as heart diseases, arthritis, Alzheimer's disease, stroke and hip fracture). The widowhood status was another factor constraining the social participation in old age. In a sample of 921 respondents, 36.5 percent constituted female widows compared to 12.0 percent males who had lost their spouses. Widowhood status was significantly associated with less frequent participation in social activities (χ^2 21.58 df 3, $P \leq 0.05$). Age norms might also be responsible for less frequent participation in social activities by the elderly, as normal ageing process involves withdrawal from various activities of the social fabric of the society (Cumming and Henry, 1961).

However, social participation of females was lesser compared to that of males in the study population. Since larger fractions of male respondents scored better on socio-economic variables compared to their female counterparts, the lesser participation in social activities by females could be attributed to patriarchy and domesticity of women in Pakistani culture.

People engage in variety of leisure time activities, for example watching television, listening to radio, reading, just taking rest or relaxing. Chronological age, gender and affliction with chronic conditions are considered important to influence the nature of leisure activities. The data in Table 2 show that a large proportion of respondents (55.1 percent), with slightly greater share of females (58.7 percent) than males (52.0 percent) had reportedly spent their free time as 'rest time'. It implies that women, even in their older age, were expected to carry out household chores. The types of leisure activities respondents were engaged in showed

little variation with regard to age, while gender reflected variation with regard to leisure time activities. It is interesting to note that greater share of young old cohort

compared to that of older old spent their leisure time in watching television and reading. It implies that the younger cohort of respondents might be better informed.

Table 3 Percentage distributions of respondents by gender, age, social participation, leisure time activities, and frequency of visiting friends/relatives

Social Participation							
Gender	Age (in Years)	Religious Activities	Political Activities	Cultural Activities	Non	Total	
Male	50-59	21.1	6.4	9.9	4.1	41.6	
	60-69	14.5	5.2	7.0	4.3	31.1	
	70-79	11.2	3.1	2.7	1.4	18.4	
	80 and above	5.2	1.0	1.7	1.00	8.9	
	Total	52.0	15.7	21.3	10.9	100.0	
	N	251	76	103	53	483	
Female	50-59	25.3	6.4	9.4	6.2	47.3	
	60-69	17.1	0.7	5.9	3.4	27.2	
	70-79	12.3	.9	3.7	1.1	18.0	
	80 and above	3.9	1.4	0.7	1.6	7.5	
	Total	58.7	9.4	19.6	12.3	100.0	
	N	257	41	86	54	438	
Leisure Time Activities							
Gender	Age (in Years)	Resting	Reading	Watching TV	Listening to Radio	Other	Total
Male	50-59	21.1	6.4	9.9	0.2	3.9	41.6
	60-69	14.5	5.2	7.0	0.2	4.1	31.1
	70-79	11.2	3.1	2.7	0.2	1.2	18.4
	80 and above	5.2	1.0	1.7	0.4	0.6	8.9
	Total	52.0	15.7	21.3	1.0	9.9	100.0
	N	251	76	103	05	48	483
Female	50-59	25.3	6.4	9.4	0.2	5.9	47.3
	60-69	17.1	0.7	5.9		3.4	27.2
	70-79	12.3	0.9	3.7		1.1	18.0
	80 and above	3.9	1.4	0.7	0.2	1.4	7.5
	Total	58.7	9.4	19.6	0.5	11.9	100.0
	N	257	41	86	2	52	438
Frequency of Visiting Friends and Relatives							
Gender	Age (in Years)	Not at all	Sometimes	Often	Most Often	Total	
Males	50-59	11.2	13.7	11.8	5.0	41.6	
	60-69	6.6	11.4	8.9	4.1	31.1	
	70-79	4.8	7.9	3.9	1.9	18.4	
	80 and above	1.4	4.1	2.5	0.8	8.9	
	Total	24.0	37.1	27.1	11.8	100.0	
	N	116	179	131	57	483	
Females	50-59	12.6	19.6	9.4	5.7	47.3	
	60-69	6.8	10.3	6.8	3.2	27.2	
	70-79	3.2	8.9	3.7	2.3	18.0	
	80 and above	2.7	2.1	1.4	1.4	7.5	
	Total	25.3	40.9	21.2	12.6	100.0	
	N	111	179	93	55	438	

Source: MCCPHA 2010

than that of older old. A considerable number of respondents had spent their leisure time in 'other' activities mainly grand parenting. The data show gender

based variation with regard to grand parenting, as greater number of female respondents performed the role of grand parenting

Participation in informal activities with friends and relatives had a significant bearing on life satisfaction (Longino and Kart, 1982). Frequent interactions with friends/relatives are considered important to offset the repercussions of ageing and help people stay active and happy. The data in Table 3 show frequency of visiting close friends/relatives by gender and age. The data show that a substantial proportion of respondents across gender and age occasionally visited their friends/relatives. A

smaller proportion of respondents visited their friends and relatives most often. Apart from chronological age, individuals are constrained by economic factors to visit friends and relatives most frequently. This argument was supported by the chi-square test (χ^2 58.65, df 6, $P \leq 0.001$), which indicated robust relationship between elderly people's socio-economic positions and their social contacts (frequency of visits to relatives/friends).

Table 4 Regression analysis- Summary Statistics Dependent variable: Frequency of Participation in Social Activities

Variables	R. Square	β	t-Value	Significance
	0.237*	0.808	5.656	0.000
Socio-economic status of the respondents		0.173	4.280	0.000
Age of the respondents		0.051	1.285	0.199
Gender of the respondents		0.174	2.422	0.016
Affliction with multiple chronic conditions		-0.095	-1.603	0.109
Widowhood Status of the respondents		-0.078	-1.086	0.278

* R. Square value for all variables

Source: MCCPHA 2010

To determine the relative importance of the various independent variables (socio-economic status, age, gender, affliction with multiple chronic conditions, and widowhood status) in predicting the value of the dependent variable (frequency of participation in social activities) multiple regression was applied. This method has the advantage of covariance that enables one to have a quick look at the overall importance of a given variable in the model. Table 4 presents summary statistics about the regression analysis for the social participation of sampled population in urban Lahore. The value of R-square shown in Table 4 indicate that all stipulated variables (socio-economic status, age, gender, affliction with severely limiting chronic conditions, and widowhood status) explained considerable variance in explaining frequency of participation of elderly people in social activities. The results of regression analysis clearly suggest that out of five stipulated variables, socio-economic status, gender and presence of comorbidities were significantly related with the frequency of social participation. Although widowhood status and age were significantly associated with the frequency of participation in social activities, socio-economic status of the respondents, their gender and affliction with multiple chronic conditions turned out important predictors for the frequency of participation in social activities. It may safely be concluded that older females are more likely to face adverse consequences with regard to their health and well-being in later ages compared to that of males.

DISCUSSION

The quality of life and well-being in old age is wedded with older individuals' participation in social life.

The available evidence suggested that older adults' social participation was largely associated with their socio-economic positions and life events (such as widowhood and affliction with multiple morbidities). Socio-economic variables are often confounded with the prevalence of serious chronic conditions (such as heart diseases, arthritis, Alzheimer's disease, stroke and hip fracture) which in turn affect the functional health status of older people. Reduced social participation of older people could be attributed to their poor functional health status. However, the cumulative effect of socio-economic variables and bereavement was more pronounced in older females than among males. In the face of poverty, patriarchy and poor functional health status older females were disadvantaged with regard to their participation in social activities.

The exponents of disengagement theory (Cumming and Henry, 1961) hold that normal ageing process involves withdrawal from social life. Withdrawal from social activities is functional in that both the society and individual mutually withdraw from each other in advance so that the death of the individual may not be disruptive for the social system and older person's role may be filled by young one. The findings of the present study indicated that socio-economic status and gender were significantly related with the social participation of older people. However, cumulative life circumstances and health behaviors affect health and life quality in later years (Emmanuelle, 2006), which may affect the ageing process adversely, in turn withdrawal from social life.

Older males and females, however, shared similarity with regard to increased participation in religious activities; as religion is considered the main source to manage depression. Older adults' participation

in political and cultural domains of life may also help them stay active until late in life. However, the findings of this study imply that older females had fewer opportunities to participate in political and cultural domains of life.

Conclusion: A link between social participation and socio-economic status was found. Gender and affliction with serious chronic conditions in late age largely influence social participation. It is concluded that elderly females are more disadvantageous compared to that of males. The disadvantageous position of older females seems to be the outcome of cumulative effect of life circumstances in childhood and adulthood. In sum, older females' disadvantage results in their social isolation and consequently their marginalization from public life. It may also be concluded that older adults, particularly females face the challenges of increased morbidity and impaired well-being. This situation demands policy intervention to enhance social participation of older adults in community life, particularly that by the older females.

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