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Assessment of Wellbeing of Elders, Family and Community Contributions towards Elderly Care in Selected Districts in Sri Lanka

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ABSTRACT

The aging of population is an unavoidable and irreversible global phenomenon. Aging in developed countries occurred gradually over a relatively long period of life while aging in developing countries including Sri Lanka has been more rapid. Sri Lanka rapidly aging population has important social economic implications and real challenges for government and older population themselves. This research identifies the issues that affect the lives of senior citizens and further matters into the major physiological and psychological problems.

Elders desire a life with good health, dignity, economic independence and finally a peaceful death. They long for care, love and affection. This study looks into the wellbeing of elders in the rural settings and family and community support they received. Furthermore, their satisfaction on available community services were assessed. A descriptive cross-sectional study was carried out in Walasmulla MOH area to assess the family and community assistance for the well-being of elders. A cluster sampling technique was used to select 394 elders. An interview administered questionnaire and an observation check list were used to collect information. Majority of the elders in the sample were Buddhist and Sinhalese. A higher percentage of female elders (56.9%) of whom 63.4% females were without any services of monthly income. The widowhood was also higher among females (66.4%).13.5%of elders have not attended school and 33%. received only primary education. The Physical mental and social wellbeing of the elders were assessed. The functional status was good in 76.9%of the elders. A high proportion of elders in young old category possessed a good functional status for PADL while in the oldest old category the majority were in restricted or in poor functional status. This suggested that the Burden to the care giving family increased as the age advances. The majority of elders were living without psychological distress. Psychological distress level markedly increased above 75 years compared to young old category. A majority of them were involved in effective leisure time activity and religious activities irrespective of their participation in social activities with the family which showed only 50%.

Majority of elders did not get any of the five community care services assessed in the study. Only 13.2% received special clinic service from government hospital and services from special elderly clinics in MOH area. A relatively higher percentage of elders got services from the Grama Sewaka (24.5%) some received the service for getting a monthly income and some got the service for getting spectacles, wheel chair and senior Citizen identity card from the social service department Majority of elders were unaware of the concept of healthy active aging.

The Gramasewaka was the most popular person among elders out of the primary care service providing in the community Unsatisfactory service providers were seen in government hospitals, clinics MOH areas. Most of the community assistance for elders on day-to-day activities revealed that elders experienced poor community assistance. Majority of elders reviewed in lack of awareness of elderly programmed available for them and majority showed their poor level of satisfaction about the community services received.

The importance of the family and community assistance for providing better care for elders should be recognized and prioritized in elderly care.

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INTRODUCTION/BACKGROUND

Population ageing is a significant public health issue, which is observed in both developed and developing countries. The World Health Organization (WHO) launched the “Global movement for active ageing” which includes a worldwide network of partners from both developed and developing countries. Active ageing is defined by WHO as providing maximum opportunities for physical, mental and social wellbeing throughout the entire life course, expecting healthy elderly populations.

Old age is a sensitive phase Elderly people need care and comfort to lead a healthy life without working and anciently. Lack of awareness regarding the changing behavioral patterns in elderly people at home leads to abuse of them by their kin. Hence this research identifies the issues that affect the lives of senior citizens and further complicate into major physiological and psychological problems. Elders desire a life with good health, dignity, economic independence and finally a peaceful death. They long for care, love and affection. Understanding their needs and concerns, will ensure their good health. Landing an emotional support to the elders keep them jovial, which is inevitably the ideal way live a healthy life. However for many people, providing care and attention to elders is not possible due to work priorities.

Justification

Elders must be considered as an asset to the country and this period in their lives should be considered a time for celebrate. They have gone through childhood youth, adulthood, mature parent how stage and have stepped in to a period of an ageing adult. Now they are great senior citizens with a vast knowledge & experience. It is a responsibility of all to make this period more comfortable for them But this maturation of age structure with accumulation of an ageing population crack unexpected problems to society resulting in new issues to be addressed.

Though the old age is not a morbidity state, their physical and mental ability for successful interaction with social life will gradually deteriorates with ageing, unless adequate family & community support are provided. They are susceptible to disabilities and chronic diseases caused by multiple pathology. Chronic health problems are generally associated with ageing. Cardiovascular disease, Neurological disease, Musculo-skeletal disserted, Metabolic, Endocrine and psychiatric disorders are the non communicable disease causing main disabilities in old age. Any of these problems result from physiological changes due to ageing and some are consequences of life style and dietary changes, with the development, urbanization and modernization of the country. But these serious complications caused by these diseases affect elders depriving them physically and mentally. This ultimately leads to old age dependency and social isolation.

Rapid population growth affects in numerous ways to both developed and underdeveloped countries. According to the growth of the world population in recent past, it can be seen that the ageing population has increased rapidly in many countries. Thus in the 21st century, implication of the population ageing is likely to be enormous ever than before. Indeed, the 2151 century has been named as "The Era of Population Ageing" (Kuroda, 1993).

Until the recent past, ageing was a problem in developed countries. But, at present, developing countries too face the same problem. According to UNO reports (1993), people who are over 65 years of age were 20.7% of the world population by 2000. Out of this, 48.2% of the world ageing population belonged to the Asian countries. In the South Asian region, Sri Lanka accounts for the highest rate of increase of ageing population. 6.6% of ageing population in 1981 has increased up to 8.5% by 1995 and by the year2001 it was forecast as 10% (Siddhisena and Rathnayake, 1998). It has been predicted that the Sri Lanka's ageing population would increase up to 6 million, by the mid 21st century. It is nearly 1/4th of the total population of the country (De Silva, 1994). Indeed, this statistical information is a sign of necessity to focus attention on socio economic needs and wants of the ageing population.

According to general social norms, care of the elderly is a family responsibility (Rosenthal, 2010).However, due to rapid social changes, family has been reformed structurally and functionally, and thus its responsibility of elderly care is fading away gradually (Amarasekara, 2011). This implies that another entity such as the

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government has to undertake the responsibility. Presently, Sri Lanka is confronting various forms of social, economic, cultural and political problems and therefore the state alone, can't undertake the full responsibility of caring every elder. In this context, ageing becomes a crucial social problem, which affects in various ways on the whole social structure in the country.

Most of the societal changes in Sri Lanka have been widely connected with the problem of ageing. However, we think is not a too complex problem in rural areas when compared with urban settings because of the existing social values and norms (UNO, 1989). But currently due to the fact that higher literacy rates, increase women employment, rapid urbanization due to various reasons have isolated elders in the rural areas. Inspite of these social values they are isolated in rural sector of Sri Lanka. The lack of welfare services and poor infrastructure facilities in the rural sector also contributes for the poor wellbeing of the elders.

Objective of this study is *to* Identify wellbeing of elders and the participation of family and community in taking care of elders.

METHODOLOGY

This study employed a community-based descriptive cross-sectional design conducted in the Walasmulla Medical Officer of Health (MOH) area, Hambantota District, Southern Province, SriLanka with two main components: assessing the well-being of elders (physical, psychological, and social) and evaluating family and community participation in their well-being, alongside an observational checklist to document elders' status during data collection. The study population comprised individuals aged 60 years or older residing in the area for at least three months, excluding those who had migrated within the last three months. The sample size was determined as 384, calculated based on a 50% prevalence assumption to maximize sample size, accounting for variables such as Activities of Daily Living (ADL) independence, with clusters of 56 households randomly selected from 7 out of 13 Public Health Midwife (PHM) areas using a random number table. Data were collected through an interviewer-administered questionnaire covering physical (ADL), psychological (loneliness, depression), and social well-being (economic independence, religious activities), as well as family and community assistance, supplemented by an observational checklist to assess living conditions during home visits. Interviews were conducted privately after explaining the study's purpose to both elders and family members.

RESULTS

The sample consisted of 394 above 60 years of age selected from the Walasmulla Medical Officer of Health (MOH) area.

01. Socio demographic variable the sample showed proportion of females were higher 57.8% compared to males.

The majority of elders were Sinhalese 99.3%and 0.7% was Muslims. Married elders were 49.2%. those who never married, divorced separated or widowed were 51.3%. 56.9% of elders did not receive any monthly income. Out of the elders who received only less than 10,000 the majority received 5000 – 6000LKR and only 10% received more than 6000. Most of the elders 85.9% were currently unemployed. This included the never employed 65.1% and retired 20.8% category.

Table 1- distribution of the sample by age.

Age category	Percentage	
60-74	283	72%
75-84	85	21.7%
>85	26	6.3%
Total	394	100%

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Wellbeing of elders

physical well being

Eight activities were considered in PADL and level of independence for each activity of the elders was assessed.

Table 2 – distribution of elders according to independence in physical activity of daily living.

	Level of independency				
	Can do independent	**Need some assistance**	**Dependent on others**	**No answer**	**Total**
Feeding alone	380 94.6%	15 4.3%	1 1.0%	-	394 100%
Getting dressed	370 93.4%	18 4.7%	6 1.69%	-	394 100%
Walk <100 yards at home	334 85.4%	44 10.2%	16 4.3%	-	394 100%
Use a toilet at home	311 79.9%	51 13.9%	22 6.3%	-	394 100%
Shaving (male) Combing hair (male/female)	376 93.2%	17 4.5%	8 2.3%	-	394 100%
Bathing alone	342 87.8%	32 8.3%	14 3.6%	8 2%	394 100%
Get in and out of bed alone	366 93.2%	19 4.9%	7 1.9%	-	394 100%

Functional level for PADL was calculated as follows.

Functional level.

Good – all PADL could be done alone.
Restricted – at least one PADL could not be done alone.
Poor – more than one PADL could be done alone

The functional status was good in 76.9% of them. the functional level was restricted in 5.7% and poor in 17.4%.

Level of independence in the instrumental activity daily living (IADL) was looked to assessing physical well-being.

Table 3 distribution of elders according to independence in instrumental activity of delving.

	Level of independence				
	Cando independence	**Need some assistance**	**Depend on others**	**No answer**	**Total**
Going out of home using public transport	244 62.0%	68 16.3%	82 21.7%		100%

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Doing day today activity while at home	295 75.2%	39 10.8%	53 13.9%	7 2%	100%
Going to shops to buy things	267 68.4%	35 9.4%	82 21.0%	10 1.2%	100%
Going for treatment alone during an illness.	299 76.9%	43 11.3%	39 10.9%	13 9%	100%
Perform money transaction alone	196 49.0%	120 30.7%	78 20.3%		100%
Visit homes of children and relations	232 59.7%	66 17.4%	92 21.9%	4 1.0%	100%
Go to places for worship	256 65.6%	59 15.1%	71 18.6%	8 7%	100%

Functional level for IADL was calculated as follows.

Functional level.

Good - all IADL cannot be done alone.
Restricted – at least one IADL cannot be done alone.
Poor – more than one IADL cannot be done alone.

The majority of elders who did not have good functional status had fallen in to poor functional status rather than restricted.

46.4% of elders had good functional status 42.4% had poor function status while only 11.3% had restricted functional status.

Psychological Well Being

Psychological distress level was assessed by using the validated scale of General Health

Questionnaire -12. Twelve questions comprising 4 responses were used in the Questionnaire. The values allocated for each response varied from 0 to 3 . the total score varied from 0-36 assessment score for the psychological distress was taken as follows.

Score

0 – 14 no psychological distress

15-19 some evidence of distress

20-36 severe problem of psychological distress.

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Table 4 – relationship between psychological distress and age category

		Age category			
Psychological distress		60-74	75-84	>85	Total
	No distress	67.7%	44%	33.5%	238
	Some distress	16.9%	21.6%	30.6%	73
	Severe distress	15.4%	34.4%	36.1%	83
Total		100%	100%	100%	394

Chi sqare 38.513 df 4 p <0.0005

The mood of the elders at the time of visit for the interview was assessed by a check list (annexure) the mood observed as happy / normal or depressed according to the instruction given the training of interviews and according to description given in operational definitions.

Social Well Being

13.5% elders of the sample was never attended to school and 33% studied up to grade 5. Majority 36.5% continued their education up to grade 10, while only 5% completed the higher education.

Table 5 – Disturbance of elders according to the income per month by sex.

			Sex
		Male	Female
Any income per month	Yes	85 51.9%	83 36.6%
	No	82 48.1%	144 63.4%
Total		167 100%	227 100%

Chi square 13-27 df 1 p <0.0005

Table 6 - distribution of elders according to the income level and sex.

		Sex	
		Male	Female
Income level	<1000	25 15.9%	78 34.4%
	1001 – 2000	23 13.5%	20 9%
	2001 – 4000	48 28.6%	73 32%
	4001 – 6000	48 28.6%	41 18%
	>6000	23 13.5%	15 6.6%
Total		167 100%	227 100%

Chi square 15.77 df 4 p <0.003

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Table -7 – association between marital status and sex of elders.

		Sex	
		Male	Female
Marital status	Never married	97 58%	118 52.9%
	Currently married	11 6.6%	18 8.1%
	Widowed	35 21.4%	66 29.1%
	Divorced / separated	10 6.2%	7 3.3%
	Others	14 7.8%	18 6.6%
Total		167 100%	227 100%

Chi square 7.218 df 4 p >0.125

Table 8 – relationship between living arrangement and Gender.

Alone	Gender	
	Male	Female
Living with spouse	7 4.5%	2 5.1%
Living with children	33 19.9%	16 6.9%
Living with spouse & Children	114 68.4%	181 19.8%
Living with a relation	10 6.6%	13 5.7%
Other	3 1.6%	15 1.8%
Total	167 100%	227 100%

Chi square 116.648 df 5 p >0.0005

Table 9 -Distribution of elders according to the opportunity to attend to religion places. **Desire to involve in religion activity**

Attendance to religion place	Yes	
	Frequently	175 44.5%
	When necessary	87 22%
	Occasionally	58 14.7%
	Rarely	37 9.5%
	No Opportunity	37 9.3%
Total		394 100%

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Table 10 – Distribution of elders according to the observed response of some personal hygiene measure.

	Observed response					
	Yes		No		Total	
Wearing clean clothes	279	71.2%	115	28.8%	394	100%
Combing the hair neatly	271	69.6%	123	30.4%	394	100%
Nails are clean in hands	204	52.6%	190	47.4%	394	100%
Mouth is clean	220	56.3%	174	43.8%	394	100%

Family assistance in routine Activities

The family involvement for will being of elders and family assistance for will be of them were accessed by the level of assistance in eight activity with four response of each. A score allocated for each response varied from 3 to 0. The total score varied from 24 to 0.

Level of assistance score

Good support 16-24

Some support 9-15

Poor support 0-8

Table 11 – Distribution of elders according to the level of family assistance.

Level of Assistance

	Good	Some	Poor	Total
Help in sickness	278 70.8%	66 16.7%	50 12.5%	394 100%
Help in washing clothes	165 42.5%	55 14.1%	174 43.4%	394 100%
Help in bathing	95 24.3%	39 10.9%	260 64.8%	394 100%
Inquire about meals	330 83.9%	38 10.1%	26 6.1%	394 100%
Provide Money	136 34.5%	122 31.6%	131 33.9%	394 100%
Accompany to religion places	165 42.5%	82 21.2%	147 36.3%	394 100%
Outing for entertainment	95 24.8%	35 9.9%	264 65.35%	394 100%

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Accompany for Trips	110 28.4%	50 12.7%	234 58.9%	394 100%

Community Assistance for elders in the routine activities.

Table 12 – Distribution of the experience of elders in community assistance during past 3 months.

Experience of the elders

	Yes	No	Not involved in last month	No answer	Total
Received a seat traveling by bus	150 38.2 %	146 37.2 %	91 23%	7 1.6%	394 100 %
Got assistance in a shop	105 26.7 %	177 45.8 %	94 24.7%	18 2.8%	394 100 %
Received priority in a hospital	82 21%	236 60.1 %	63 16.5%	13 2.4%	394 100 %
Received assistance in crossing a road	146 37.3 %	165 42.2 %	67 17.2%	16 3.3%	394 100 %
Received priority in bank counter/Post office	56 14.2 %	204 52.6 %	122 31.1%	12 2.1%	394 100 %

Sates faction of elders on assistance received

Table 13 – Level of satisfaction of elders for service received from primary service provider. **Level of satisfaction**

	V. satisfy	Satisfy	Cant decide	Unsatisfied	v. unsatisfied	Total
Service from PHM	36 9.3%	147 37.5%	43 11%	147 37.5%	31 5%	394 100%
Special clinics in MOH area	0%	126 32.9%	98 25%	153 39.5%	15 2.6%	394 100%

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Service from Grama Sewaka	53 13.5%	204 51.8%	35 9.2%	86 22%	16 3.5%	394 100%
Special clinics in government hospitals	0	108 27.6%	98 25%	173 44.7%	15 2.6%	394 100%

Table 14 – relationship of effective leisure time involvement of elder age category. Age category

		60-74	75-84	>85	Total
Leisure time	Involve in useful activity	248 87.7%	64 75.2%	18 72.2%	330 84%
	Not involve in useful activity	35 12.3%	21 24.8%	8 27.8%	64 16%
	Total	283 100%	85 100%	26 100%	394 100%

Description of the participation of elders in social activities.

Table 15 - frequency of participation

	Always	Sometimes	Rarely	Not at all	Total
Outing for entertainment	94 24.8%	35 9.9%	55 14.2%	210 51%	394 100%
Participate in trips and pilgrim	112 28.5%	50 12.7%	68 17.4%	164 41.5%	394 100%

DISCUSSION

Since the Aging is a universal phenomenon many research is done worldwide. Developed as well as developing countries have their own policies and strategies to overcome the age-related problems in their countries. But limited number of studies are available in Sri Lanka on Elderly care.

This descriptive cross-sectional study was carried out to identify the status of Physical, psychological and social wellbeing and to identify the level of family and community care contributed for their well-being in rural area of Hambanthota District (Walasmulla MOH area).

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The elders were separately interviewed after explaining the purpose to the family and to the elder. An observation check list was used to determine the mood of the elders at the time of interview and basic house hold facilities provided to the elder by the family.

Majority (72%) of the sample consisted of young adults (60 – 74 years) category. The oldest old (>85 years) were only 6.3%.

The elders who got married were 49.7% and widowhood was 43.4% in the present study. A study done in Beruwala MOH area in 1995. (Balasooriya 1995) revealed 51.6 were married and 42.5% were widowed. The results of these two studies were compatible with only minor differences.

A higher percentage of elders (56.9%) did not receive any source of income per month. This represented the elders who were never employed and those who were employed and not entitled for a pension. Even out of those who received an income 25% received less than Rs.5000 per month. This obviously contributed to poverty among elders and depending of elders on others for their expenses.

a) Well-being of elders

The degree of assistance required for the daily living activities is an important factor in assessing the physical well-being. The degree of restricted physical activity or depending reveals the disabling status of elders. Out of the eight activities considered in the study, the degree of independence for activities of feeding, dressing, toileting, shaving, combing, getting in and out of bed 90% showed the independency above 90% while walking and bathing showed lower values. The activity of walking more than 100 yards at home was the most affected activity with a degree of independence in only 79.9% of the sample.

The study done in Sri Lanka in 1989 under the project of Emerging issues of the ageing of population (perera 1989) revealed that 87.4% of elders were independent in walking within the home while 9% requiring some assistance and 3.2% were fully dependent on others.

Regarding the activity, bathing alone, present study showed a higher value (87.8%0 compared to the study done in 1988 (perera 1989) the reason for the increased value for bathing in the present study could be due to the availability of new equipments for bathing and also the increased water supply facilities at house hold level compared to the past.

A high proportion of elders in young old category possessed a good functional status for PADL while in the oldest old category the majority were in restricted or in poor functional status. This suggested that the Burden to the care giving family increased as the age advances.

The IADL showed a better functional capacity. The most affected social activity out of seven IADL assessed in the study was the ability to perform money transaction. The majority of elders showed at least one restricted functional level for IADL.

Family participation for well-being of elders.

The level of family assistance for basic eight activities were assessed in the study. The results revealed that good assistance level was shown for elders in sickness and providing an inquiry about meals. A poor family assistance level was shown for help in bathing and washing clothes. These two activities invariable depend on the functional status of the elders but poor assistance in providing money for elders by family members could probably be due to financial instability of the family to provide that services.

The higher frequencies of poor assistance were observed in accompanying them to religion places, outing and trips. This should be addressed in family participants programme after identifying possible underlining factors.

Community assistance for well-being at elders. The study showed that only minority received a seat in a bus and received assistance in crossing the road. These two had been the most common activities which needed frequent assistance. Majority of elders do not get priority in a hospital. The prevailing system for priority is

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still based on the que number. Unless this system in changed the possibility of elders having to wait in long ques to get treatment would remain the same.

Satisfaction of elders regarding the services received.

Majority of elders did not get any of the five community care services assessed in the study. Only 13.2% received special clinic service from government hospital and services from special elderly clinics in MOH area.

A relatively higher percentage of elders got services from the Grama Sewaka (24.5%) some received the service for getting a monthly income and some got the service for getting spectacles, wheel chair and senior Citizen identity card from the social service department.

The level of satisfaction for the services received by elders described that a significant property were dissatisfied regarding the services received by them for unclear reasons. Some elders may not be willing to reveal their view as shown in the study with higher frequencies of 'cannot decide' category except for the services provided by the Grama Sewaka.

CONCLUSION AND RECOMMENDATION

Conclusion

Majority of elders included in to the young old category and functional status of them were either restricted or poor.

More than half of the elders did not receive any income per month Out of those who received an income nearly one forth received less than 5000 rupees per month.

A higher proportion of elders who were becoming more dependent on ADL, ended up in a poor functional status indicating greater depending on others. This was shown in all age category.

Psychological distress level markedly increased above, 75 years compared to young old category.

The majority of elders were involved in useful activity in their leisure time.

Fifty presents of elders did not participate in social activities with their family members.

The elders experienced poor community assistance in their day-to-day activities. Such as crossing the road, receive a seat in a bus, receiving assistance in a shop, waiting in a bank or in hospital.

Majority of the elders were not aware of community care services available to them. Such as day care center programme, Senior Citizens identity cards, priority in Osusala Pharmacy or government and high interest rate for bank accounts.Majority of elders were unaware of the concept of healthy active aging.

The Gramasewaka was the most popular person among elders out of the primary care service providing in the community. Unsatisfactory service providers were seen in government hospitals, clinics MOH areas .

Recommendations

The Government should develop appropriate mechanisms to enhance welfare facilities of the elderly.

In Sri Lanka, similar to most of the developing world, which has experienced the demographic transition, there has been a shift from extended to nuclear families, and an increase in one person households. These changes have important consequences for the welfare and living arrangements of the elderly population. It was found that more than half of the elderly people do not receive any government assistance. Therefore, they have to either depend on income by engaging in some further employment or rely on the support of their adult children or others. The majority of the elderly who co- reside with children receive a pension and provident fund from

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public/private sector employments. In contrast, more than half of the elderly who live in one generation families were on the government's poverty alleviation assistance which was inadequate. Most importantly, the awareness of the facilities provided by the government for the elderly welfare is limited. In this respect, the majority of the elderly are of the opinion that the government must provide a special allowance and increase the current financial assistance, improve income generating opportunities, establishment of elder/care homes with improved facilities and improve free health facilities for the elderly.

Devise an appropriate policy strategy to improve welfare of the elderly who live alone without their spouse or children.

The trend of the elderly living alone is likely to continue and will have important consequences, especially for older women, who are most likely to live alone. Solitary living can result in increasing isolation and makes care-giving by family members more difficult to organize. It increases the need for supplementary support services in order to enable older persons to remain in their own home. Sri Lanka may have difficulties in providing such services. Family changes produced by industrialization, increasing female labour force participation, declining family size, diminishing importance of extended families and increasing internal and international migration and amid other factors have important implications for the well-being of the elderly in developing societies. The rapid changing role of the family is challenging traditional intergenerational support systems, hence there is a need for better integrated policy responses required to meet the well-being of aged population.

However, it was found here that those who live alone are more burdened than their counterparts in other living arrangements. This phenomenon is more likely to occur in the near future and thus, the government has to devise an appropriate policy strategy to accommodate the interests of the elderly living alone in order to improve their well- being. Devise a mechanism of improving healthcare facilities of the elderly including their mental health issues at all levels.

The existing health systems in Sri Lanka are still mainly geared towards providing care for acute episodic conditions and not towards chronic care needs and care that is specific to older persons. Over the years Sri Lanka has seen a trend of obtaining health care through private hospitals whereby people pay for services directly out of their own pocket. Healthcare needs are provided to their elderly parents by both co-residing children as well as those who live independently, although the level differs. The elderly who co-reside with children receive more health care support than those who live in one generation families. Moreover, the healthcare support comes in a way of nonmonetary and moral support in comparison to financial support. Since it was found that healthcare of elderly do not meet expectations, irrespective of their living arrangement status, the government needs to devise a mechanism to attend to the healthcare needs of the elderly.

The majority of aged in Sri Lanka have at least one illness and have been taking medicine for a long time. It is timely to develop geriatric health facilities to which older people have easy access. This can also be done by establishing such facilities in each DS divisions by introducing health clinics for the aged. In this regard, it is essential to integrate primary prevention and primary healthcare for elderly using the Personal Health Care (PHC) network of the Ministry of Health (MOH) for geriatric assessment, prevention and rehabilitation. Furthermore, mental health facilities for the elderly are still not developed properly in Sri Lanka. This service is essential for those who have age related mental health issues. Currently there are no suitable procedures to identify the aged with dementia and issues with family members. Early identification of those issues can enhance the welfare of the elderly.

Create a programme to improve the financial position of the elderly by devising a special programme of income generating activities for the elderly, as well as providing financial support from the government for those who are financially burdened.

The study found that half of the elderly are without financial support from their adult children. At the same time, it was observed that more than fifty percent of elders are economically active. This suggests that the creation of suitable income generating activities for the aged can enhance their well-being. In-depth studies of elders have shown that although they are capable of doing work, it is difficult for them to find suitable

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employment at older ages. Since the majority of aged in Sri Lanka are in the young old category, they still can engage in productive economic activities which will improve their family welfare. This study found that many of them still had dependent adult children. Therefore, the increase in current retirement age from 60 to 65 would allow them to work for another five years and support their young dependents until they become financially independent. This is possible because of improved life expectancy during the recent decades.

The government should take the initiative with the support of the private sector to establish an adequate number of aged homes with satisfactory facilities or encourage private investment like in developed countries.

With a rapid ageing process taking place and especially the accruing of a significant proportion of the elderly in the oldest age group, it will be necessary to expand the supply of formal long-term care for older persons, especially institutional living which can provide the necessary health care and other facilities. Since Sri Lanka still does not have a significant proportion of elderly at oldest ages, the number of institutionalized elderly is relatively small. At the same time, the elderly homes available in the country are just called 'Adult Homes' where only very limited facilities are available. They are just a shelter for those who have been abandoned by children or relatives and contain very limited facilities. These are mostly run by charitable organizations but presently a few private sector companies have started establishing aged homes with improved facilities for the provision of healthcare. There is a necessity from the policy point of view, to establish properly equipped aged homes in order to respond to the rapidly growing ageing population in the country.

The government should ensure a supportive environment in the family and community for the elderly with appropriate legal rights to guarantee their well-being.

Assuring and protecting the human rights of the elderly is an important means of reducing the risk of abuse of older persons and empowering them (United Nations 2014). In this regard, complementary legislation is needed to improve the legal framework in order to protect the rights of the elderly, prevent abuse and neglect and strengthen their opportunities for participating in all aspects of social life. Similarly, there exists a need in Sri Lanka to identify sufficient mechanisms through which to avert age discrimination in labour markets, guarantee intergenerational solidarity through adequate old-age income security systems and to thereby activate the resources needed to supply adequate health and long-term care.

In Sri Lanka, the family and the community are the main supportive groups for elderly. However, it was found that the changing role of the family has significantly altered this supportive environment. This is due to the fact that significant proportion of the elderly live alone with limited material, physical and social support. Therefore it is essential to strengthen the supportive environment in the family and the community with some legality. In this regard, intergenerational supportive systems have to be strengthened by emphasizing mutual gains and support, strengthen community based supportive systems for the aged who have never married and are childless.

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