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L 614 Dr. M. Varalakshmi
Assistant Professor
School of Medical Sciences,
University of Hyderabad
Gachibowli, Hyderabad
Telangana

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Intergenerational Living Arrangements and Depression among the Elderly in Rural Eastern Uttar Pradesh

Alok Kumar, Anand Bihari[1], Subhi Srivastava[1] and Sangeeta Kansal[1]

Department of Statistics, Institute of Science,
Banaras Hindu University, Varanasi – 221005
and
[1]Department of Community Medicine,
Institute of Medical Sciences, Banaras Hindu University,
Varanasi–221005

ABSTRACT

Living arrangements with the family members play an important role in the life of the elderly. An unpleasant situation in the family creates a number of physical health and mental stress-related problems. An attempt was made in this study to find out the relation between the living arrangements and Parent-child relationship and depression level in 410 elderly, age varying from 60 years and above, living in rural area of Eastern Utter Pradesh (India). The sample (410 elderly respondents) was drawn by applying multistage random sampling technique from the different parts of eastern Uttar Pradesh, a northern and most populous state of India. Geriatric Depression Scale (GDS Long Term) was used to measure the level of depression of these elderly people. High depression level was reported with increased age of the elderly persons ($r = 0.23$; $p < 0.001$). Severe depression was found more among female elderly persons than males ($z = -6.15$; $p < 0.001$)

and more among widow/widower ($z = -8.083$; $p < 0.001$). Elderly who felt that their present living conditions were uncomfortable were more depressed than elderly living in comfortable or satisfactorily home environment ($\div 2 = 19.36$; $p < 0.001$). Interestingly, the elderly who were living with their married child were found more/severely depressed compared to those whose married children were not living with them and migrated to other states ($z = -2.95$; $p < 0.01$). It may be due to the fact that the migrated working children often send remittances to their elderly parents left behind in rural areas. Depression level of the elderly was found to be comparatively high when they were not satisfied with their offspring irrespective of the fact that the children are living with them or separately. It was suggested that proper social security measures for the elderly, especially the health and monetary needs of the elderly parents who had no other source of income for their basic needs, should be looked after by the family and society to overcome their physical and mental health.

Key Words: Geriatric Depression Scale (GDS), Living Arrangement, Parent–Child Relation, Elderly.

Increasing elderly population is a growing concern in almost all the developing countries. In India, living with children, spouse and other family members during old age is a common cultural practice. Low social and economic status, high rate of illiteracy, and a general lack of basic amenities constitute a major problem for the elderly population particularly in rural areas. Family is the great single source of support and the centre of activity for most elderly people, but the decrease in the number of children, and their dispersion owing to migration and urbanization, reduced the care of dependent old parents.

In India, a decline in the prevalence of multigenerational households and the migration of young adults especially adult married sons from rural to urban areas have geographically separated many adult children from their elderly parents, altering and arguably undermining traditional patterns of support to rural elders. Scholars have expressed similar concerns about other Asian nations such as the China, Philippines, Thailand, Indonesia, and Bangladesh, where researchers have observed sharp reductions in co-residence rates between elderly parents and adult married children (Knodel and Ofstedal, 2002;

Schroder, 2003). However, it is not certain whether these changes have adversely affected the psychological and mental well-being of the elderly.

The elderly need certain amenities such as health care, nutrition, and a sense of belonging, but the type and amount of treatment they receive mainly depend on the culture of the family. Life becomes increasingly stressful during ageing process and elderly people become a liability, rather than an asset, to the families and communities involved (Yadava *et al.,* 1996). Usually, elderly parents are neglected by their children unless they are well-to-do, or still earning members (Patel, 1997; Kumar *et al.,* 2005). An unpleasant situation, especially the social and the quality of relationship with their children, especially sons residing with them, creates a number of physiological and stress-related problems, which in turn cause various health problems. Although, the descriptive studies on patterns and changes of inter-generational living arrangements are not exclusively new in India (Rajan and Kumar 2003; Rajan, 2006; Agarwal, 2012; Sathyanarayana *et al.,* 2012), a systematic assessment of inter-generational living arrangements and mental health status has been missing.

An attempt has been made in this paper to discuss the association and effect of intergenerational living arrangements and Parent-child relationship on depression/psychological well-being among elderly people. The central hypothesis of this study was that the elderly living with their married child in the same house would not be found more depressed compared to those whose married children are not living with them and migrated to other places.

Methodology

A sample of 410 elderly people taken from the districts in rural Eastern Uttar Pradesh (India) The sample was drawn by applying a multistage random sampling technique. The selection of block, village and households from a district formed different stages of sampling technique. The data at both the household level and at the individual level (elderly person concerned) was collected individually. The basic instruments of data collection were an Interview Schedule and Geriatric Depression Scale (Long Form). Detailed information regarding the socio-economic status, living arrangements, health and

other old age problems, familial relations, etc. of the respondents was collected by using Interview schedule.

Depression level (Dependent Variable) of the respondents was measured by using the translated Hindi version (Ganguli M. *et al.*, 1999) of Geriatric Depression Scale (Long Form) The GDC-H is a self report 30 items scale. The elderly were asked about thirty depressive symptoms that they might have experienced in the seven-day period preceding the interview. The thirty items were scored on a standard 2-point scale from 0 to 1, and the score was the un-weighted sum of the thirty component items, with a potential range of 0 (least depression) to 30 (severe depression).

Independent Variables

Demographic and Socio-economic Variables

The demographic and socio-economic information related to concerned elderly consisted of gender (1 = male, 2 = female), age (in years), and education (in years of schooling completed), marital status (1 = married, 2= others), caste (1= SC/ST, 2 = OBC, 3= Others), type of family (1= Nuclear, 2= Joint), currently working for cash income (1 = yes, 2 = no) and source to fulfill the basic economic needs (1 = self earning, 2 =service pension, 3 = govt. old age pension, 4 = dependent on others).

Health Condition

Measures of health condition included self-rated current health status (1 = excellent, 2 = very good, 3 = good, 4 = fair, 5 = bad) and asked if the concerned elderly was suffering from any major disease (1= yes, 2 = no).

Living Condition

The quality of living condition was assessed by asking if the elderly has a separate room to sleep (1= yes, 2= no), current living arrangement (1= alone, 2= with spouse only, 3 = with spouse and adult children, 4 = with adult children only, 5= with other relatives), preferred living arrangement (1= alone, 2= with spouse, 3= with children, 4 = with other relatives) and satisfaction about present living condition (1=comfortable, 2= satisfactory, 3 = uncomfortable).

Findings and Discussion

Table 1

Association of Demographic, Socio-economic and Health Condition with GDS-H Score among Elderly People (n=410)

Elderly Characteristics	*(%)*	*GDS Score Median (Range)*	*Group diff.*
Demographic & Socio-economic Variables			
Gender			
Male	(68.3)	13.00 (1–29)	Z* = –6.148 (p < .001)
Female	(31.7)	21.00 (4–29)	
Age	(60–100)		R** = .232 (p < .001)
Year of Education	(0–17)		R** = –.329 (p < .001)
Marital Status			
Married	(58.0)	12.00 (1–29)	Z* = –8.083 (p < .001)
Others	(42.0)	21.00 (4–29)	
Caste			
SC/ST	(24.6)	19.00 (2–29)	$\chi 2^{***}$ = 9.103 (p < .05)
OBC	(30.7)	14.50 (3–28)	
Others	(44.6)	14.00 (1–29)	
Type of Family			
Nuclear	(29.3)	20.00 (3–29)	Z* = –5.285 (p < .001)
Joint/Extended	(70.7)	13.00 (1–29)	
Currently Working for Cash Income			
Yes	(44.9)	12.00 (1–29)	Z* = –5.006 (p < .001)
No	(55.1)	18.00 (4–29)	
Source to fulfill the Basic Economic Needs			
Self earning	(45.4)	12.00 (2–29)	$\chi 2^{***}$ = 25.757 (p < .001)
Service pension	(12.9)	13.00 (4–28)	
Govt. Old age pension	(3.4)	19.50 (1–27)	
Dependent on others	(38.3)	19.00 (3–29)	
Health Condition			
Suffering from Any Major Disease			
Yes	(30.2)	20.00 (4–29)	Z* = –4.494 (p < .001)
No	(69.8)	14.00 (1–29)	
Current Health Status (Self rated)			
Excellent	(5.6)	11.00 (4–28)	$\chi 2^{***}$ = 58.464 (p < .001)
Very Good	(19.3)	11.00 (2–27)	
Good	(35.4)	15.00 (1–29)	
Fair	(28.8)	16.50 (4–29)	
Bad	(11.0)	24.00 (9–29)	

Note: In this study the Hindi version (Ganguli, M. *et. al*., 1999) of the Geriatric Depression Scale (GDS) was used. ; *Mann-Whitney U test, **Spearman Rank Correlation, ***Kruskal-Wallis test.

The association of GDS-H score with demographic, socio-economic and other health conditions variables of the elderly was discussed and results are given in table 1. The table reveals that the age of elderly ranged from 60–100 and education covered from 0 to 17 years both being significantly associated with the depression level i.e., higher depression level was reported with increasing age and with declining the year of education. Females, not currently married and elderly belonging to SC/ST were significantly found more depressed than their counterparts. The elderly who were residing in nuclear family system and currently not working for cash income were significantly found more depressed. So far as the health condition of the elderly according to their GDS-H score is concerned, it was found that older peoples who experienced bad health conditions were more depressed than those in good health and showed significant positivity associated with the GDS score having a significant group difference ($p < 0.001$). Also, the elderly who were suffering from any major disease experienced more depressive life as per GDS-H score than the healthy ones. Similarly, elderly people who were dependent on others for fulfilling their economic needs were found to be more depressed as per the given criteria.

It was observed that the depression level of the elderly, to some extent, depended on their living conditions and their satisfaction with living arrangements in the house. Attitude and behaviour of family members towards their elderly play important role in the life of elderly during ageing. An unpleasant living condition, of course, creates a number of stress related problems which in turn cause various health problems. A lack of felicity regarding living arrangement intensifies the feelings of the elderly causing them mental agony. Table 2 shows that the elderly who had separate room to sleep were scored less on GDS-H scale compared to those where were not having the separate room, although the difference was not statistically significant ($p = 0.842$). The findings reveal that the satisfaction about living condition has a strong relationship with the level of depression among elderly ($p < 0.001$). The elderly who believed that their present living conditions are uncomfortable were found highly depressed and significantly associated with GDS-H score as compared to those whose living conditions were comfortable or even satisfactory. In the study, there is

significant association between the intergenerational living arrangements and respective GDS-H score of the elderly. The elderly currently living with their spouse and children were scored almost half of the median GDS-H score compared to those living either alone or with their spouse. Interestingly, the elderly who preferred to stay alone, with spouse or with other relatives were more depressed than those who gave preference to stay with their children.

Table 2
Association between Living conditions and GDS-H Score of the Elderly (n = 410)

Elderly Living Condition	*(%)*	*GDS Score Median (Range)*	*Group diff.*
Separate Room to Sleep			
Yes	(41.0)	14.00 (2–29)	Z* =-.199 (p=.842)
No	(59.0)	16.00 (1–29)	
Satisfaction about Living Condition			
Comfortable	(7.1)	12.00 (2–27)	
Satisfactory	(63.9)	14.00 (1–29)	$\chi 2^{**}$ = 19.360 (p < .001)
Uncomfortable	(29.0)	26.00 (3–29)	
Current Living Arrangement			
Alone	(3.9)	22.50(7–29)	
With spouse only	(5.1)	24.00(7–29)	$\chi 2^{**}$=78.22 (p < 0.001)
With spouse and adult children	(46.3)	11.00(2–29)	
With adult children only	(32.2)	20.00(4–29)	
With other Relatives	(12.4)	15.00(1–28)	
Preferred Living Arrangement			
Alone	(9.3)	23.00 (6–29)	
With spouse	(12.2)	20.50 (4–29)	$\chi 2^{**}$=29.808 (p < .001)
With children	(77.6)	13.00 (1–29)	
With other relatives	(1.0)	23.50 (21–26)	

Note: *Mann-Whitney U test, **Kruskal-Wallis test

Table 3 displays the results of multiple regression analyses taken the demographic and socio-economic variables in model I, and in subsequent models II and III, a block of other exposure variables i.e.,

the health and living conditions are separately included to measure their influence for scoring high or low score on GDS-H scale. Age, marital status, years of education and type of family of the elderly are significantly associated with the GDS score in all three models. Model II accounted an additional five per cent of the variance explained, after taking the health conditions of the elderly into account, compared with the model 1. This model shows that the elderly who were having good health status reported significantly lower levels of depression score on GDS-H scale. After adding the variables associated with the living conditions of the elderly into the Model 3, the model gave better representation and explained additional six per cent of the variation (Adjusted $R^2=0.38$) compared to model II. Satisfaction about the present living condition and preferred living arrangement as desired by the elderly significantly influenced their depression level.

Table 3

Summary of Multiple Regression Analysis for Variables Predicting GDS score among Elderly

Variables	*Model I*			*Model II*			*Model III*		
	B	*SE B*	β	*B*	*SE B*	β	*B*	*SE B*	β
Demographic & Socio-economic Characteristics									
Gender	0.46	0.92	0.03	0.61	0.89	0.04	0.34	0.86	0.02
Age	0.13	0.05	0.13**	0.11	0.05	0.11*	0.12	0.05	0.11*
Years of Education	–0.25	0.08	–0.16**	–0.23	0.08	–0.15**	–0.19	0.08	–0.12*
Marital Status	3.77	0.78	0.25***	3.51	0.76	0.23***	3.89	0.81	0.26***
Caste	–0.82	0.43	–0.09	–0.67	0.42	–0.07	–0.74	0.40	–0.08
Type of Family	–3.62	0.71	–0.22***	–3.18	0.69	–0.19**	–2.07	0.69	–0.13**
Currently working for Cash Income	1.64	1.03	0.11	0.94	1.01	0.06	1.10	0.99	0.07
Fulfill the economic needs	0.13	0.36	0.02	0.05	0.35	0.01	0.24	0.34	0.04
Health Condition									
Suffering with Any Major Disease				–0.62	0.80	–0.04	–0.61	0.76	–0.04

Cont'd...

Cont'd...

Current Health Status				1.49	0.36	0.21***	1.47	0.34	0.21***
Living Conditions									
Having Separate Room							–1.09	0.69	–0.07
Satisfaction about Living Arrangement							2.73	0.61	0.20***
Present Living Arrangement							–0.54	0.38	–0.07
Preferred Living Arrangement							–1.88	0.49	–0.16***
Constant	6.91	3.57		4.77	4.14		4.25	4.23	
	F(8,401) = 19.98***			F(10,399) = 19.91***			F(14,395) = 19.20***		
R2	0.29			0.33			0.41		
Adjusted R2	0.27			0.32			0.38		

Note: *p < 0.05; **p < 0.01: ***p < 0.001

Figure 1

Elderly GDS-H Score and their Opinion regarding benefits and difficulties of Living together with Married Children

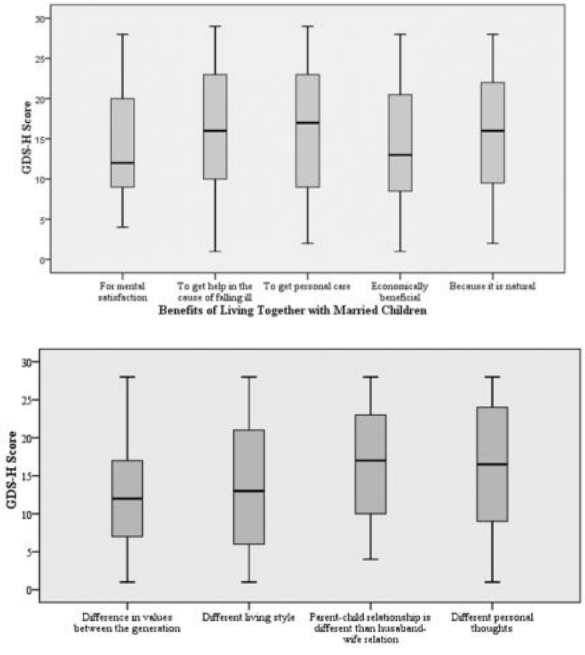
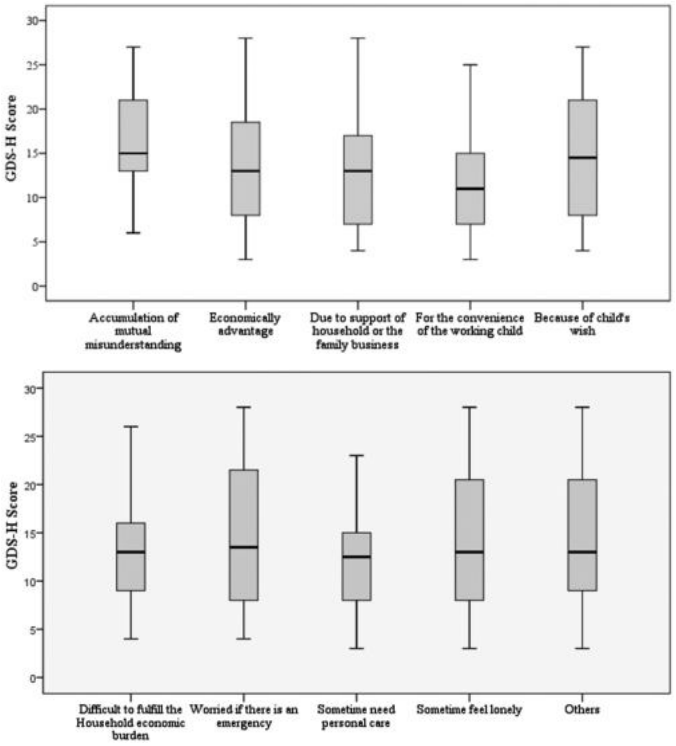


Figure 1 shows the box plot graphs representing the GDS-H score of the elderly and elderly's opinion regarding the benefits and difficulties of living together with their married children. The elderly who felt that living together with their married children was economically beneficial and provided mental satisfaction were found less depressed i.e., having less median GDS-H score as compared to those who were seeing benefits of living together with married children for getting personal care and expecting help at the time of sickness. On the other side, the elderly who believed that the 'parent-child relationship is different than the husband-wife relationship' and having difficulty living with their married children were found more depressed i.e., scored higher median score on the GDS-H scale.

Figure 2

Elderly GDS-H Score and Benefits and Difficulties of Living Separately with Married Children



The box plot graphs given in Figure 2 represent the summary of GDS-H score for those elderly who gave opinion regarding benefits and difficulties of living separately with their married children due to various reasons. Those elderly who had the opinion and seeing benefit that they were living separately with their married children just 'for the convenience of the working child' were found on an average less depressed. The elderly who were facing difficulty of living separately with their married children and often worried 'if some kind of emergency happens and the children are not with them', they were scored at higher side on GDS-H scale i.e., little bit more depressed than their counterparts.

In traditional rural societies like India, intergenerational living arrangements with the children, particularly with married son(s) are supposed to be a source of economic support and security during distress, sickness and for personal health care, but such base support of elderly has been shaken because of rising inflation and pauperization. An unpleasant situation, of course, creates a number of stress related problems which in turn cause various health problems. Social and the quality of relationship with sons and daughters largely decide the economic factors, which, in turn, determine the health of the elderly people. The median GDS-H score of the elderly residing and not residing with their married children according to their financial dependency and the kind of relationship with married children are given in table 4. It was found that the elderly parents who were residing with their married children and were not at all financially dependent on children scored almost half of the median score on GDS-H scale i.e., considered to be in less depression than those who were fully or partially dependent on their children for financial support. Interestingly, those elderly parents not residing with their married children, their average GDS-H score were almost same, irrespective of, if they are fully or not at all financially dependent on their children. Also, there was no significant difference between the median GDS-H score of self stated good and bad kind of parent-child relationship by those elderly not residing with their respective married children.

Table 4

GDS-H score of the elderly as per their living arrangements and financial dependency & kind of relationship with their married children (n=288)

	GDS-H Score					
	Residing with Married Children (n = 203)			*Not Residing with Married Children (n = 85)*		
	(%)	*Median (Range)*	*Group diff.*	*(%)*	*Median (Range)*	*Group diff.*
Financially dependent on children						
Fully	(32.0)	21.00 (6–29)	$\chi 2^{**}$= 38.41 (p<.001)	(19.8)	13.00 (4–28)	$\chi 2^{**}$= 1.67 (p=.557)
Partially	(26.6)	17.00 (4–28)		(67.4)	13.00 (3–27)	
Not at all	(41.4)	12.00 (2–28)		(12.8)	11.00 (6–22)	
Relationship with children						
Good	(75.4)	15.00 (2–29)	Z*= 7.91 (p<.01)	87.2	11.00 (3–28)	Z*= 2.44 (p=.119)
Bad	(24.6)	19.00 (4–28)		(12.8)	14.00 (4–26)	
Total	(70.5)	16.00 (2–29)		(29.5)	12.00 (3–28)	Z*= –2.95 (P < 0.01)

Note: *Mann-Whitney U test, **Kruskal-Wallis test

Conclusion

Findings of this study revealed statistically significant differences in GDS-H scores among different measures of demographic, socio-economic and health condition variables of the elderly. This study found strong significant differences in GDS-H scores among different categories for predictors variables related to inter generational living arrangement, i.e., current and preferred living arrangements, satisfaction level for current living condition; except the availability of a separate room for elderly to sleep. The variables age, years of education, marital status, type of family, current health status, satisfaction about living arrangement, preferred living arrangement have significant contribution in explaining the depression among elderly. The study revealed that there are significant differences in GDS-H scores among the levels of financial dependency and relationship status of the elderly residing with their married children. Overall, the median GDS-H score is significantly high of those elderly residing with their married children compared to their counterparts.

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Use of Public Transport by Older Women in Semi-urban West Bengal, India

Tulika Bhattacharya

Centre for Research on Ageing
Faculty of Social, Human and Mathematical Sciences
University of Southampton (U.K.)

ABSTRACT

In this exploratory study 33 older women, age varying from 60 to70 years, residing in a semi-urban community in Kharagpur, West Bengal were selected by purposively sampling method in order to obtain detailed data that can link their location and travel behaviour. For the present study, primary in-depth semi-structured interviews were conducted. It was found out that these subjects have to face challenges in availing public transport but it has not significantly affected their use of public transport, due to lack of alternatives and limited financial capacity. The study reveals that the older women have developed multiple strategies for accommodating themselves within the existing public transportation system.

Key words: Older women, Public transport, Quality of life

Adequate infrastructure for transportation of older people facilitates them to maintain autonomy, manage self-care and provides them the capacity to age independently, and thereby enhances their quality of life. The need for age friendly transportation facilities has increased worldwide with the proportional as well as absolute increase of the older population. There has been some studies on the transportation

needs/behaviours of the older people in the developed nations like United Kingdom (Schmocker *et al.,* 2008), United States of America (Clarke *et al.,* 2009), Japan (Arai *et al.,* 2011), Austria (Cole *et al.,* 2010), Canada (Newbold *et al.,* 2005), etc. and some studies in developing nations like China (Zhang *et al.,* 2007), Philippines (Petterson and Schmoker, 2010). However, these studies were conducted in the urban areas and the needs of the older people remain underexplored in semi-urban/rural areas.

Information about transportation needs/behaviours of the older people in India remains unexplored. India has more than 104 million older people – 53 million older females (Census Report of India, 2011). Seventy-one per cent of the older population in India resides in semi-urban/rural areas (The Hindu, 2016). Adequate studies on the transportation needs/behaviours of the older people in sub-urban India were not identified. Even though a few studies have been conducted on the transportation needs of the younger women in India (Srinivasan, 2004;. But there has been a knowledge gap about the transportation needs/behaviours of the older women in sub-urban India.

Prior studies in other countries have shown that the older women make shortest and least number of trips (Boschmann and Brady, 2013). However transportation behaviour of the older women in semi-urban India is not known and therefore the study was conducted in a semi-urban part of West Bengal – a rapidly ageing state in India (SRS Statistical Report, 2013) with 24,73,564 aged women residing in semi-urban/rural areas (Alam *et al.,* 2014). Public transport is the most common mode of transport used in semi-urban West Bengal. The study attempts to understand whether the experiences in public transport affect the use of public transport by older women in semi-urban West Bengal.

The study may provide some evidence of the factors facilitating/inhibiting the use of public transport by older women in semi-urban areas. The study aims to understand the transport behaviours and experiences of the older women in semi-urban West Bengal, while using public transport. The findings may help to address practical challenges through inform policy.

Methodology

Sample

Out of 65 identified elderly women residing in a semi-urban community in Kharagpur, West Bengal, who had adequate experience of using the public transport within the last two years, 33 Older women, age varying from 60 to 70 years, were selected by purposive sampling technique, which ensures the maximum utilisation of limited resources – in terms of time, energy and money (Black, 2010) in this study. This sampling technique was used with the aim to identify i) cognitively coherent older women participants (within the age group of 60–70 years), ii) who have been residing in the community for at least five years, iii) with experience of availing the public transport in the last two years, iv) could make themselves available during the interview period v) participate in in-depth semi-structured interviews and vi) provide permission to audio-record the interviews.

For the present study, primary in-depth semi-structured interviews were conducted – between September 2017 – April 2018 in order to obtain detailed data that can link their location and travel behaviour.

The place and time of the interview were decided with the participant over the telephone, based on their convenience. Out of the thirty – three interviews, twenty-six interviews were conducted at participant's home and seven interviews were conducted in a neighbourhood Park.

Locale of the Study and Research setting

Data was collected from a semi-urban community in Kharagpur, Medinipur district in West Bengal, located in eastern part of India. The semi-urban community neighbourhood, where the interviews were conducted, is located in-between two major cities of eastern India, Kolkata and Bhubaneshwar, each of which is approximately 135 kms away. It is surrounded by rural hinterland and forest areas. There is a government funded primary health centre within the community which provides emergency facilities round the clock, basic consultations with physicians, medicines and diagnostic services to its indoor and outdoor patients. There are also a few specialized private clinics of

the physician and diagnostic centres within/adjacent to the community. There are two big government hospitals within 15 kilometres from the community. However, these local hospitals and medical facilities are not held in high esteem by the community residents, especially in comparison to the bigger hospitals in the neighbouring cities. As a result, most of the community residents travel to the hospitals in the neighbouring cities for availing better medical treatment.

There is a market within the community where locally grown vegetables and daily amenities are available. The community is served locally by the unskilled formal caregivers and domestic helpers. The community residents regularly visit larger markets outside their community, including those in larger cities, for accessing better goods and services.

Bus services are available from the community to nearby important bus stations, although direct buses are not available to the major cities. *Auto* (a three or a four-wheeler motorized vehicle, which is a common mode of public transport in many parts of West Bengal) services are available for local transportation. The *auto* services are also available to the railway station, which in turn is connected with all major cities in India. The nearest airport is 145 kilometres away from the community. Auto and bus services are the modes of public transport which are directly available from the community. However, these services are mostly available during the daytime and early evening hours. Transportation is a major challenge for the community residents during odd hours.

Many young people, i.e. – the children and grand children of these older people, left the community to work in the city in different parts of India or abroad due to lack of job opportunity and poor transportation facilities. However, at the same time, many old people working in neighbouring communities and institutions (like academic institutions – schools and colleges, banks, post office, railways, etc.) bought houses in this community after their retirement, primarily due to their familiarity with the community along with the facilities in the community, such as primary health care facility and market-place within the community, safety concerns, peaceful neighbourhood and access to bus and auto facilities.

It should be noted here that the community is a registered housing society and it only allows 'Bengalis' to purchase houses within the community and therefore the community is more or less homogeneous in nature consisting of middle class and upper-class aged people.

Method of data collection

A semi-structured interview guide (Brymman, 2016) was developed through a systematic literature review. The theme list of the semi-structured interview guide (see Box 1 for theme list) was revised after consultation with two subject matter experts and translated into the Bengali language by the researcher (a native Bengali speaker) and the Bengali questionnaire was back-translated into English (by another expert with knowledge of Bengali and English). The discrepancy in the translation was adjusted by the researcher and the expert. More Open-ended questions were included to encourage the participants to provide detailed responses, and thereby obtain richer data. The interview guide was prepared in order to have some control over the flow of the interview (Ibid.).

Box 1

- *Theme list of the semi-structured interview guide*
- Demographic Information
  - Describe all incidents that you could recall while using public transport in the last two years
  - including both positive and negative incidents as well as
- repeated and occasional incidents.
- Has these incidences,
  - altered your use of public transport?
  - brought any other change that you would like to share?
- Do you think because of your present physical condition you have any functional limitation? Can you describe it a bit?

Before initiating the interview, the details of the research, the interview process and the rights of the participants was provided. The

semi-structured interview theme list in Bengali that was prepared earlier was used while conducting the interviews. The interviews were conducted in Bengali and all the interviews were audio recorded in a password-protected personal mobile phone of the researcher. Interjections like 'sure', 'interesting' 'right' and 'yes' were used by the researcher during the interview and thereby the participants were encouraged to illustrate their personal experiences to fully clarify their responses. In order to deduce maximum information about the interesting components of the participants' experiences related to the research question, adequate follow-up questions, probes and prompts were used by the researcher, but the order in which the questions/probes were asked was altered/varied, according to the flow of each interview (Ibid.).

During the interview, precaution was taken to avoid double-barrelled questions (Lavrakas, 2008). Any issue raised by the participant was pursued by the researcher. All the interviews lasted for more than 34 minutes (46 minutes, on an average) to 62 minutes, depending on how much the participant was willing to talk and share. After the interview, data was backed up in a password protected file in a password protected personal laptop of the researcher, in order to protect against accidental loss or corruption.

The audio recorded interviews were transcribed, translated into English and backed up in password protected device. Adequate blinds were used to protect the participants' identity/privacy and the anonymised data was prepared for further analysis. A computer software for qualitative data analysis called NVivo was used for data management and facilitating the data analysis.

Reflexivity

Data collection was done by a female researcher in her early thirties, with a post-graduate degree in Sociology and Psychology, who has been residing in the same community for more than four years for her research work. Prior to re-locating to the community, the researcher was residing in the neighbouring city of Kolkata and was teaching in an undergraduate degree college. She identifies herself as Indian Bengali, the same way as all the research participants identified themselves. All the interviews were conducted in the

Bengali language, the locally spoken language in the community. She has also been involved with organising *Yoga* and *Ayurveda* Camp for the older people and older people's family caregivers' workshop in the community. She has also been involved with raising awareness about Palliative Care in the community and with assisting cancer patients' family caregivers in procuring Palliative Care services from outside the community. The spouses of the participants were acquainted with the researcher for at least two years, prior to conducting the study. The researcher and the spouses of the participants practise *Yoga* together. Initially the researcher found it very strange to find that only old males practised Yoga in the community as a group, which was contradictory to her experiences in many Yoga shibirs (assemblies) in Kolkata and other parts of India and Nepal, where people of both genders and all age groups practice yoga together. The researcher has seen similar pictures in the television, which telecasts live Yoga sessions from different parts of India. The researcher's father who resides in a semi-urban locality in a different district of West Bengal told her that seventy per cent of the yoga practitioners in his community were actually women, roughly in the age group of forty-five and sixty-five years.

So the researcher asked her male acquaintances in the community why their spouses do not come to practise Yoga and found that it was difficult for the women to come to the place where Yoga was practised by walking as many had joint-pain, knee pain, leg pain, waist pain, etc. and they had to do other household and religious works in the morning. The male (in the age group of 55–82 years) came by cycling and walking. The researcher did not see older women cycling/co-riding a cycle in the community.

Limitations or Biases

It should be noted that the findings from the study is based on the interview with thirty-three participants, and therefore cannot be generalised to the larger population due to the smaller sample size.

Probing, prompting during the interview, might have introduced some error, as it was not possible for the interviewer to probe in a consistent manner throughout all the interviews. Therefore interviewer's effect was not adequately controlled in the study and

therefore the characteristics of the interviewer might have an impact on the response of the participants (Groves *et al.,* 2009).

Research Ethics

The study involved voluntary participation. The present study is based on the same method that ordinary people use in their everyday life, i.e. – asking questions (Dingwall, 2008) and therefore the study design does not involve any harm or distress to the participants beyond those experienced in day-to-day life.

At first, the prospective participants were contacted over the telephone and informed about the aim of the study, a brief overview of the study and the interview process – including what taking part in the interview would involve, like – the duration of the interview would be around one hour, interview would be audio-recorded, etc. They were told that – other than the researcher – the detailed information provided by them will not be made available/disclosed to anybody. They were also informed that if any information provided by them, is used in the final report, then adequate blinds will be used to protect their identity/privacy and it will be presented in an anonymised way. They were informed that even if they agreed to participate, they may choose not to respond to any particular question and/or if they feel uncomfortable at any point, they can inform the researcher and terminate their consent (Heath *et al.,* 2009) within two weeks after the interview. It was mentioned that the study was conducted as part of a research degree (Ph.D.) project and it was not part of any developmental program, and therefore they may not have any direct benefit from participating in the study.

After providing all these information, the prospective participants were asked for their permission to participate in the study. Verbal informed consent was obtained from the participants, as written consent is difficult to obtain in sub-urban areas. Previous researches have shown that signing any document is treated with suspicion in sub-urban contexts. According to the socio-cultural norms of the community in which the data was collected, the older women are generally expected to take permission from their family members before putting their signature in any document. Therefore asking for written consent might have reduced the willingness as well

as the possibility of the appropriate prospective participants to take part in the study, and thereby might have led to truncated/biased sampling. So, verbal informed consent was chosen over written consent in order to i) minimise the social/formal distance between the researcher and the respondent and ii) maximise the willingness of the prospective participants to participate in the study. Before initiating the study, verbal consent was obtained twice, from each participant – i) over the telephone prior to the visit and ii) during the visit before initiating the interview, for a) participating and b) audio-recording the interviews. All interviews were audio recorded, stored and backed up in password encoded data files in password protected devices, in order to ensure the confidentiality of the participants. While transcribing the interviews, specific details about the participant which could make them identifiable were altered, but it was ensured that it did not change the meaning of the participant's expressions in any way (Bryman, 2016). All participant information and identifiers were removed before data storage, in order to protect the identity and privacy of the participants. Only anonymised soft data was prepared for storage and used throughout the study. Printed data was not prepared in order to save paper and reduce costs; which in turn eliminated the risks outside the researcher's control, such as theft of the printed data. All research ethics guidelines were followed during data collection and storage, in order to protect participants from any harm due to their research involvement and also to protect their rights and interests.

Data Analysis Strategy

Thematic Analysis technique (Braun and Clark, 2006), a qualitative analysis approach that uses coding was used to interpret the patterns and themes emerging from the interviews. The six phases of thematic analysis (Clarke & Braun, 2013) were followed for the analysis of the interview transcripts. At first, the researcher got familiarized with the interview transcripts through 'data immersion'. Then NVivo software – was used for coding the interview transcripts. Conceptual matches were made between the codes and the transcript segments. The interview transcripts were coded through open coding process (see box 2 for examples of open coding) and then similar codes were clustered together into coding trees. The initial codes were

constantly compared and the analogous codes were appropriately renamed or merged (Mason, 2002), e.g. – three separate but similar codes were clustered into one code (Code applied: Unsafe, unhealthy and unhygienic-see appendix). The transcripts were coded at the descriptive level as well as at the interpretive level of analysis.

Box 2

Example of open coding

- Code applied: Bus Numbers are not visible
  - Like if we have to board a bus, the bus number is written but those are not clearly visible. If [name of her daughter] is with me, then she helps me to read it. It becomes easier. Otherwise I have to ask other people.

The codes and the meanings of the codes were prepared in a codebook (see Appendix) and discussed with a field expert and revised. Codes were assigned to the interview transcripts in order to create i) meaningful patterns, ii) connections between different aspects of the data (Hansen, 2006). Then the themes were generated on the basis of build on codes identified in the transcripts (Bryman, 2016) and the coherent and meaningful patterns emerging from the codes (Clarke & Braun, 2013). The themes were indexed through a systematic process of analysing/reading and re-analysing/re-reading the transcripts. Then the name and a brief description of the themes were finalised.

The research focus was adapted in accordance with the findings from the collected data. Thematic Analysis involved a fluid and ongoing process of data collection, transcription, coding, analysis and identification of themes and sub-themes, reflection, discussion; and therefore the study was not guided by any pre-established hypothesis.

Results

It should be noted that the findings from the study are based on the findings from the interview with thirty-three participants. The findings from the present study are discussed below:

Reason for Transportation

The study revealed that the older women used public transport for attending social gatherings – like family members' weeding; formal work – like collecting pension, paying the utility bills, going to the post office and bank; personal work like purchasing goods and availing services; medical or health care related factors like regular check-ups with the Physician, going to Physiotherapists, purchasing medicines and for religious/spiritual visits. None of the participants reported availing the public transport on a daily basis, e.g. – for going to work, or picking up grandchildren from school, etc. The frequency of their travel varied between eight to fourteen trips per month on an average.

Mode of Transportation

All the participants reported using private transportation on a regular basis. Only one participant reported rarely using private vehicle, riding in her son's scooter when her son is free. None of the participants reported having their personal private vehicle or a driving licence or driving their family owned vehicle (although sixteen participants had a private family owned vehicle).

The participants reported that they use different modes of public transport like bus, auto, train or rickshaw etc., depending on the availability of the public transport, their travel destination, their health condition and whether they had an accompanying family member or not.

Use of Multiple Modes of Transport

The participants expressed their difficulty as they had to use multiple modes of transport e.g. – train or bus followed by auto, etc. to reach the destination, thereby making the travel experience cumbersome. Even for going to the nearest railway station they had to take an auto or a bus.

Lack of Alternative Modes of Public Transport

All the participants expressed their concern about the limited number of modes of transportation options and lack of direct transportation options, though the degree of dissatisfaction varied widely between the participants. However nineteen participants also

expressed that availing alternate modes of transport, like booking a car or taxi was beyond their budget. All the participants said that they have heard about ola/uber facilities but they were not sure whether such facilities were available in their community and they were not acquainted with the technology involved with availing those services. Four participants said that they have availed such facilities when they visited other cities and those services were remotely booked for them by their children/spouses of children/nephew/niece.

Challenges in Purchasing Tickets

The participants reported various challenges in purchasing tickets, like difficulty in standing in the queue for purchasing tickets for long hours, because of their health problems, lack of computer knowledge for purchasing online tickets, etc. They also expressed their lack of trust in making online payments, as they were scared of being cheated and losing money in the online process. As a result the participants expressed that they had to often take help from their spouse or children or young tech-savy neighbours for purchasing bus or railway tickets.

Challenges Associated with Availing the Public Transport

The participants reported various challenges related to using public transport like – the bus numbers are not clearly visible, the abusive and strong Union of the bus and the auto drivers, the fear of being ostracised by the bus drivers, auto drivers, etc. They also reported various health problems as a result of which they face difficulty in using the public transport, e.g. – inadequate time at each stoppage. Lack of sign-posts in big railway stations was reported as a serious concern. The issue of lack of toilets in local trains leading to unsafe, unhealthy and unhygienic ambience inside the local train compartments was raised. They also reported issues arising due to overcrowding and inadequate sitting space. Pick-pocket in public transport also emerged as a serious concern. Difficulties arising from lack of sitting space in bus stands – for the older people to sit and wait for the bus – were also reported.

Unavailability of public transport at night was raised as a serious concern, with special focus on medical emergency. Various problems

in availing the auto services were recorded, including over-charging, reckless driving, and uncomfortable sitting arrangement for female passengers. The participants reported that they experienced double marginalization because of age and gender.

Public Transportation as a Mode of Entertainment

Only one participant reported a positive incident where she recalled that while travelling on a local train she had observed another older woman travelling with her grandchildren as a mode of entertainment.

Strategies for Accommodating Oneself and having Control Over the Journey

The participants reported that they had brought multiple behavioural changes and changes in their way of dressing in order to continue to use the public transport. E.g. – using special closed shoes, opening gold jewellery so that it does not get snatched, tying hairs, wearing convenient clothing, etc. Besides they have taken co-travelling – with spouse, children, family, friends as another strategy for their safety and convenience. Other strategies like not drinking water or consuming food due to lack of toilets in the local trains/buses and paying extra in public transport for availing additional facilities, e.g. – so that the bus stops for a longer duration in a stoppage, were also reported. The women used various psychological defences to rationalise their behaviour.

Impact of Critical Incidents on the use of Public Transport

The participants reported that although they would like to avoid public transport but there is no other alternative available to them. Therefore they continue to use public transport. As a result of the critical incidents the participants reported that they have tried to minimise their travels and do not avail public transport unless it is necessary. This finding is similar to that of Boschmann and Brady (2013) who found that older women make shortest and least number of trips.

Outmigration

Participants reported that they have seen many of their older neighbours to relocate to bigger cities owing to lack of adequate public transport to suit their travel needs and limited health care facilities. This reveals that poor public transport system in semi-urban areas is leading to outmigration.

Conclusion

The study reflects that even though the older women in semi-urban West Bengal face a number of challenges in availing public transport, it has not significantly affected their use of public transport, due to lack of alternatives and limited financial capacity. The study reveals that the older women have developed multiple strategies for accommodating themselves within the existing public transportation system.

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Elderly Abuse: A Study Based on the Eldelry Living in Old Age Homes of Assam

Bikash Deka and Basobi Patir
Department of Sociology,
Dibrugarh University, Assam

ABSTRACT

In India, the Old Age Homes are increasing an evidence of break of Indian family system, values, loss of respect, love and bonding between the parents and offspring. There are estimates that elder abuse and neglect in India is on the rise. Therefore, the present study was an attempt to know the nature, extent of abuse and also the reasons of elder abuse which forced the elderly to join the old age homes in Assam. 130 elderly were randomly selected from 7 old age homes located in six districts of Assam. Out of these 130 respondents only 35 respondents (10 males and 25 females), 60 years and above, who reported that they were abused, were selected for this study. The subjects were interviewed individually to identify symptoms and types of abuse and were also asked about the issues of abuse and their experiences. In the analysis of findings both qualitative and quantitative data was used. It was found out that majority of respondents faced physical, psychological/emotional abuse from their family members. Poverty, economic dependence, property/money were the main reasons of abuse.

Key words: Old Age Home, Elderly Abuse, Elderly Care, Reasons of abuse

Elder abuse and neglect is now recognized as a global social problem threatening older or aged people. Elder abuse refers to

intentional or neglectful acts by a caregiver or trusted individual that lead to or may lead to harm of a vulnerable elder. According to WHO (2002), elder abuse is defined as a single or repeated act or lack of appropriate action, occurring within any relationship where there is an exception of trust, which causes harm or distress to an older person. Elder abuse and neglect are usually committed by a person known to the victim and with whom they have a relationship implying trust. A person who abuses an older person usually has some sort of control or influence over him or her (Peri *et al.*, 2009).

For years in India, it was believed that elder abuse was not a problem in India. Infact, it may be that elder abuse actually goes unreported and remained hidden from public in India for a variety of reasons linked to culture and circumstance. Cultural reasons linked to elder abuse generally evolve around the complicated factors of pride, fear, shame and the need to protect one's family (LTSS, 2015). Although family ties in India are still strong and majority of the old live with family members, nevertheless, the position of an increasing number of older persons is becoming vulnerable. Growing urbanization, modernization, westernization, changes in the joint family, changes in the value system, migration of people to urban areas in search of work, participation of women in income generating activities are the factors responsible for the changes in the condition and decline in the role and status of the old people. In the present scenario, they cannot take it for granted that their children will look after them when they need care in their old age in view of longetivity, which implies an extended period of dependency (Tareque *et al.,* 2008).

In India, the Old Age Homes are increasing as a proof of break of Indian family system, values, loss of respect, love and bonding between the parents and off springs. The material aspirations have taken over the need for parental bonding, a long established tradition (Bora, 2018). Increasing individualism in youths has resulted in asserting for individual self, and they are in great hurry to have every source of pleasure ignoring other's consideration totally. This life style does not allow them to care for the personal, physical and emotional needs of elders. Such attitudes may lead to indignity, indifference, and disregard, lack of care, psychological torture and unlimited hostility towards elders (Jain, 2008). This has led not only to ill treatment of

parents at home but also to children forcing their old parents to stay in the old age homes, which is now being called Elder Abuse.

Review of Literature

Elderly abuse is an unreported and hidden issue. In a study conducted by Balambal (2012) among three different social classes – upper, middle and lower, found that though abuse is found in the society the degree, expression and method vary from one stratum to the other. The elderly belonging to lower class express openly all sort of abuses they experience, the middle class elderly bear it with patience and the upper class elderly do not expose the abuser as they feel that the prestige of the family should not be affected.

Soneja (2002), in his study, conducted among the urban society in Delhi, found that although the elderly talk about emotional problems and lack of support, neglect, insecurity, loss of dignity, maltreatment and disrespect by their family members yet they never use the word abuse. They all considered abuse to be abnormal which does not exist in the society.

However, the growing literature in elder abuse indicates that elder abuse is no longer a hidden issue. The study conducted by Help Age India, an N.G.O (2018), reported that 50 per cent of the elders have experienced abuse at national level. 83 per cent of the elders reported that abusing is prevalent in the society. Female (53%) faced more abuse than male elderly (48%). They found that elderly from the age-group 60–69 years (72%) experience more abuse than the age-group from 70–79 years (25%) and 80–89 years (3%). The main reasons of abuse are emotional and economic dependence and changing ethos. Verbal abuse (41%) is the most common abuse and the daughter-in-law and son were the common abusers of the elderly.

Mishra *et al.,* (2016), conducted interviews of 3578 elderly widows in 7 states in India. They found that in India more than 90 per cent of elderly widows experienced verbal abuse, 53 per cent of the elderly were neglected, 35 per cent experienced physical abuse within their family and 14 per cent of elderly widows reported such act of abuse from outside the family. Mostly children and also the domestic helper and relatives in the family were the main perpetrators of abuse against widow in India.

Sebastian and Sekhar (2010), in their study found that neglect and verbal abuse were the common forms of mistreatment against the elderly people. Widows and elderly in advanced ages experience more abuse. The abusers were mostly children, especially sons, daughter-in-law and son-in-law.

Choi and Mayer (2008), points out that elderly in the age group of 70 years and above who were frail and cognitively impaired faced abuse. Self neglect and neglect was the most prevalent form of abuse among the elderly. They found that elders who are in the habit of taking alcohol or other substances were more likely to self neglect as these substances diminish frail elder's ability to care for themselves. They also found that the major perpetrators of physical abuse were spouses and adult children and the abusers of financial exploitation were unrelated to the victims.

Kumar and Bhargava (2014) collected cases of elder abuse from the various newspapers and analysed the data by content analysis technique They found that health related abuse were common forms of abuse prevalent among the elderly. They also found that older women are at risk of financial abuse, physical abuse and sexual abuse. Women become victims of rape and physical assault even at older ages and also due to their physical weakness, the caretaker like servants and maids take the advantage of abusing them.

Gupta (2016) conducted a cross-sectional survey in Mumbai. She studied 450 older women of 60 years and above from 3 socio-economic classes, poor, middle and well to do. The study revealed that older from poor class and who were illiterate, experienced more abuse. The elderly from economically well off classes faced verbal abuse from within the family. They also found that older women experiencing any form of abuse had poor physical health, hampered social relations in comparison to those elderly women who did not experience any form of abuse.

Rufus and Beulah (2011) conducted a study about 300 victims of elder abuse from the old age homes in Tirunelveli. They found that most of the elderly were from the age group of 75+ years (38.3%). The elderly were generally abused by the combination of more than one type of abuse such as physical, financial emotional and neglect. Dependency of the elder is the major cause of abuse for the elderly

because lack of financial and physical strenght made them dependent on their family members.

Reviews have expanded the knowledge of elder abuse in India. However, the literature of elderly abuse in Assam is not available. Although in Assam the caring of the elderly continues to be practised in the family but still the provision of care giving of older people is increasing under the institutional care in the form of old age home, which depicts that the elderly were not free from being abused. Therefore, the present study was an attempt to know the nature, extent and also the reasons of elder abuse which made the elderly to join the old age homes in Assam.

Methodology

The present study was conducted in seven old age homes located in six districts of Assam. They were situated in Lakhimpur, Tinsukia, Nagaon, Kamrup (Metro), Moran (Dibrugarh) and Jorhat. The total inmates of the seven old age homes were 130. The elderly living in Old Age Homes were interviewed to identify symptoms of abuse. These 130 respondents were interviewed first. In this process it was found that 35 respondents were subjected to some form of abuse in the family. These 35 elderly were further interviewed in depth to findout their experiences and the reasons of abuse.

The present study is a mixture of both qualitative and quantitative approach. For qualitative approach, semi structured interview schedule with both open and closed questions was used to collect data. Moreover, in depth interview, focus group discussion was conducted with the respondetns. The respondents were questioned about the various issues of abuse they experienced and also some questions were asked relating to their family matters. At the same time, necessary care was taken not to hurt the aged and also make them comfortable while asking some personal and sensitive questions needed for the study.

Results and Discussion

Socio-economic Characteristics of the Respondents

Data in Table 1 reveals that out of 35 respondents, 71.5 per cent were female and 28.5 per cent were male. This reveals that more female

elderly face abuse as compared to male elderly. These findings are similar to Tarreque *et al.,* (2008), study which shows that because of higher life expectancy the female live longer than men, therefore, they are more subjected to abuse.

As regards to age, of respondents 42.8 per cent respondents were from the age-group of 80 and above years (oldest-old), followed by 70–79 years old-old (37.2%) and 60–69 years young-old (7.20%). This shows that with the increase of the age, the elderly experience more abuse. Tareque *et al.,* (2008) reported that the abused elderly were young old between 60–69 years. But in the present study it was found that most of the abused elderly belonged to the age group between 80 and above, followed by 70–79 and 60–69 years. Respectively. However, these findings were in line with Sebastian and Sekher (2010). This is because as people grow older, they become physically and mentally weaker and more dependent on others which ultimately made them vulnerable to abuse.

Data on marital status reveals that majority of the aged (77.2%) were in the category of widow/widower and the percentage of widows (57.3%) were higher than the widower. 11.4 per cent were in the category of unmarried and 5.7 per cent were separated/divorced. Widows were more frequently victims of abuse. The findings of this study were similar to Achhhapa *et al.,* (2016) who also found that widows experienced more abuse. This study was also on abused respondents living in old age homes.

Table 1
Socio-economic Profile of the Respondents

S. No.	*Socio-economic Characteristics*	*Sex*		*Total*
		Male	*Female*	
1.	**Sex**	10(28.5%)	25(71.5%)	35(100%)
2.	**Age**			
i.	60–69(young old)		7 (20%)	7 (20%)
ii.	70–79(old-old)	6 (17.2%)	7(20%)	13(37.2%)
iii.	80 and above (oldest-old)	4 (11.4%)	11 (31.4%)	15 (42.8%)
3.	**Marital status**			
i	Married	1(2.8%)	1(2.8%)	2(5.7%)

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ii	Unmarried	2(5.7%)	2(5.7%)	4(11.4%)
iii	Widow/Widower	7(20%)	20(57.3%)	27(77.2%)
iv	Separated/Divorced		2(5.7%)	2(5.7%)
4.	**Caste**			
i	General	8(22.8%)	11(31.5%)	19(54.3%)
ii	OBC	2(5.7%)	9(25.7%)	11(31.4%)
iii	ST		1(2.8%)	1(2.8%)
iv	SC		4(11.5%)	4(11.5%)
5.	**Religion**			
i	Hindu	8(22.9%)	24(68.7%)	32(91.5%)
ii	Christian	1(2.8%)		1(2.8%)
iii	Islam	1(2.8%)	1(2.8%)	2(5.7%)
6.	**Place of residence**			
i.	Rural	3(8.5%)	12(34.3%)	15(42.8%)
ii.	Urban	7(20%)	13(37.2%)	20(57.2%)
7.	**Educational Qualification**			
i.	Illiterate	3(8.6%)	17(48.7%)	20(57.2%)
ii.	Primary (I-V)	1(2.8%)	3(8.6%)	4(11.4%)
iii.	Middle school (V-VII)	1(2.8%)	2(5.7%)	3(8.6%)
iv.	High School (VIII-X)	2(5.7%)	3(8.6%)	5(14.3%)
v.	Matriculation	1(2.8%)		1(2.8%)
vi.	Higher secondary			
vii.	Graduation	2(5.7%)		2(5.7%)
8.	**Occupation**			
i.	Skilled labourer (Police, Worker in office)	2(5.7%)		2(5.7%)
ii.	Unskilled labourer (Business, Agriculture, labourer in factory, tea garden, Artisan, Daily wage earner)	7(20%)	10(28.7%)	17(48.6%)
iii.	Own household work/Other's house hold work	1(2.8%)	15((42.8%)	16(45.7%)
9.	**Monthly Income**			
i.	< 5,000	6(17.2%)	9(25.7%)	15(42.9%)
ii.	<10,000	1(2.8%)		1(2.8%)
iii.	<20,000			
iv.	<30,000			
v.	40,000& above	3(8.6%)		3(8.6%)
vi	No Income		16(45.7%)	16(45.7%)
10.	**Economically dependent**			
i.	Own pension/savings	5(14.4%)	1(2.8%)	6(17.3%)
ii.	Husband pension/Savings		5(14.4%)	5(14.3%)

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iii.	Son& Daughter-in-law	3(8.5%)	13(37.3%)	16(45.7%)
iv.	Daughter& Son-in-law		3(8.5%)	3(8.5%)
v.	Brother & Sister-in-law	1(2.8%)	3(8.5%)	4(11.4%)
vi.	Unrelated	1(2.8%)		1(2.8%)
11.	**Living Arrangement**			
i.	Spouse	1(2.8%)	1(2.8%)	2(5.7%)
ii.	Living with only son	1(2.8%)	1(2.8%)	2(5.8%)
iii.	Son &Daughter-in-law	6(17.4%)	13(37.3%)	19(54.3%)
iv.	Daughter & Son-in-law		3(8.5%)	3(8.5%)
v.	Brother & Sister-in-law	1(2.8%)	3(8.5%)	4(11.4%)
vi.	Living with unrelated persons	1(2.8%)		1(2.8%)
viii.	Alone		4(11.5%)	4(11.5%)
	Total	10 (28.5%)	25 (71.5%)	35 (100%)

Regarding the elderly who are living in old age homes it was found that 57.2 per cent respondents belonged to urban areas and 42.8 per cent were from rural areas which indicates that people from urban areas experience more abuse. However, despite a slight difference it is also clear from the data that both the elderly from rural and urban areas experienced abuse.

In terms of caste and religion, it is evident from the study that majority of the general caste (54.3%) and the elderly who follow Hindu religion experienced more abuse than those who are from other religion and castes. This is because Hindu religion is the dominant religion in Assam.

Data on educational qualification reveals that majority of the respondents were illiterate (57.2%), 14.3 per cent of the respondents had education up to high school, 11.4 per cent had education up to primary level, 8.6 per cent had education up to middle school, 5.7 per cent respondents had education up to graduation and 2.8 per cent respondents had education up to matriculation. It was found in the study that female elderly were more illiterate than the male elderly. This study revealed that the aged who were illiterate experienced more abuse than the elderly who had formal education.

In regards to occupational status it is evident from the data that most of the aged were engaged in unskilled labour (48.6%), followed

by 45.7 per cent were engaged in their household work. Only a few were engaged in skilled labour (5.7%). From this data it is clear that the aged who were engaged in unskilled labour experienced more abuse than the skilled labour. It is also found in the study that female elderly (42.8%) were mostly engaged in their daily household activities and had no income of their own so they experienced more abuse.

In regards to monthly income and economic dependence of the elderly, it was found that most of the female elderly (45.7%) had no income and they were the worst sufferer of abuse. The female elderly were more dependent on their sons and daughters-in-law. This is because women are not sent to school in childhood for education, so they had to depend on their husband and after the death of their husband they have to depend on their sons, therefore they faced more abuse than the male elderly.

Data on living arrangement shows that majority of the respondents (54.3%) co-resides with son and daughter-in-law. This is because in the patriarchal societies it is the tradition to reside with the sons. Since the elderly of the present study mainly resides with the sons therefore, they were the main abusers of the elderly people.

The association between socio-economic characteristics and abused shows that the female elderly who were widows, aged from the age group of 80 and above, elderly who were illiterate and engaged in unskilled labour, who had no income of their own and were economically dependent on others and who were living with their sons and daughters-in-law were the most vulnerable of abuse in Assam.

Table 2

Nature, Types and Reasons for Abuse of Elderly in Assam

1.	*Physical Abuse*	*Male*	*Female*	*Total*
i	Hitting by son	1(2.8%)	1(2.8%)	2(5.7%)
ii	Hitting by daughter		1(2.8%)	1(2.8%)
	Total	1(2.8%)	2(5.7%)	3(8.5%)
2.	**Psychological/Emotional Abuse**			
i	Disrespect/Verbal abuse by son		4(11.5%)	4(11.5%)
ii	Mistreatment/Verbal abuse by daughter-in-law	4(11.5%)	4(11.5%)	8(22.8%)

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iii	Disrespect by son-in-law		2(5.7%)	2(5.7%)
iv	Verbal abuse by sister-in-law		2(5.7%)	2(5.7%)
v	Mistreatment by villagers		1(2.8%)	1(2.8%)
	Total	4(11.5%)	13(37.4%)	17(48.5%)
3.	**Financial Abuse**			
i	Taking away the property without her consent		3(8.5%)	3(8.5%)
ii	Demanding money by the children for addicted substances	1(2.8%)	1(2.8%)	2(5.7%)
	Total	1(2.8%)	4(11.5%)	5(14.2%)
4.	**Neglect**			
i	Not giving any attention in regard to food and medicine	1(2.8%)	1(2.8%)	2(5.7%)
	Total	1(2.8%)	1(2.8%)	2(5.7%)
5.	**Abandonment**			
i	Leaving the elderly in the station/unknown places	1(2.8%)	1(2.8%)	2(5.7%)
ii	Leaving the old parents to live on their own	2(5.7%)	4(11.5%)	6(17.4%)
	Total	3(8.5%)	5(14.2%)	8(23.1%)
6.	**Abuser**			
i	Son	4(11.5%)	10(28.5%)	14(40%)
ii	Daughter-in-law	4(11.5%)	5(14.4%)	9(25.7%)
iii	Daughter		3(8.6%)	3(8.6%)
iv	Son-in-law		2(5.7%)	2(5.7%)
v	Sister-in-law	1(2.8%)	3(8.6%)	4(11.5%)
vi	Relatives		1(2.8%)	1(2.8%)
vii	Unrelated	1(2.8%)	1(2.8%)	2(5.7%)
	Reasons for Abuse			
i	Poverty	1(2.8%)	3(8.6%)	4(11.5%)
ii	Economic dependence	3(8.6%)	14(40%)	17(48.5%)
iii	Property/Money	1(2.8%)	4(11.5%)	5(14.4%)
iv	Burden	5(14.4%)	3(8.6%)	8(22.8%)
v	Accused of Witch		1(2.8%)	1(2.8%)
		10 (28.5%)	25 (75.5%)	35 (100%)

Data on Table No. 2 reveals that the respondents mostly face psychological/emotional abuse (48.5%), followed by abandonment (23.1%), financial abuse (14.2%), physical abuse (%) and neglect (5.7%). The psychological abuse includes mistreatment by daughter-in-law (22.8%), disrespect/verbal abuse by son (11.5%), disrespect by son-in-law, verbal abuse by sister-in-law (5.7%) and mistreatment by villagers (2.8%). Abandonment includes leaving the old parents to live on their own (17.4%), leaving the parents in the station and unknown

places (5.7%). The financial abuse includes taking away the property without the elderly's consent (8.5%) and demanding money by the children for addiction (5.7%). The physical abuse includes hitting by son (5.7%) and hitting by daughter (2.8%) and Neglect includes not giving enough food and not paying any attention when the elderly get sick (5.7%). Most of the male elderly face psychological abuse/emotional abuse, i.e. mistreatment by their daughter-in-laws. Among the female elderly, they face psychological abuse/emotional abuse that is mistreatment/verbal abuse by son and daughter-in-law and abandonment, i.e. leaving the old parents alone without informing them.

Who were abusers It was found in the study that most of the abusers were sons (40%), followed by daughters-in-law (25.7%), sisters-in-law (11.5%), daughters (8.6%), sons-in-law (5.7%), unrelated persons (2.8%) and relatives (2.8%). From the study it is evident that both the male and female elderly were abused by their sons and daughters-in-law.

Regarding the reasons for abuse, it is evident from the study that most of the elderly faced abuse due to economic dependence (48.5%), considered as burden by their family members (22.8%), property/money (14.4%), poverty (11.5%) and due to accused of witch hunting (2.8%). From the study it was found that the reasons behind abuse of male elderly was that they were considered as a burden by their family members due to economic dependence and the reasons behind the abuse of female elderly was also economic dependence, property, poverty, burden and were also accussed of witch hunting.

The following case studies will give a better explanation of the reasons of abuse faced by the elderly that forced them to take shelter in old age homes in Assam.

Mrs. X is a widow aged 76 years; she hails from urban area, belongs to general category and stays in one of the old age homes in Guwahati. She is illiterate and had no income of her own. Her husband was a rich businessman. Her family comprised of two sons and two daughters. After the death of her husband, she lived with her two sons and was dependent on them, who were handling the business of their deceased father. Because of her ignorence about family business and property she had to face financial abuse from her sons and

psychological/emotional abuse from her daughters-in-law. She stated that "My daughters-in-law were very rude to me and they didn't treat me well. My sons also betrayed me and transferred all the land and properties in their name and left me out of the house. My grandson, 9 years old, who loved and cared for me, committed suicide after my ousting from the house. My daughter informed me about this sad news. Now, I have also heard that my two sons were dead, because they were in the habit of taking alcohol, but my daughter-in-laws never informed me about this. My elder daughter kept me here and my son-in-law bears all the expenses of keeping me in the home. I am the only unlucky Mother, who will never see again the face of my sons and grandson".

Mr. Y, a widower, aged 83years, belongs to general category and comes from urban area. He studied upto matric level and is a rich businessman and has two daughters and only one son. He was living with his only unmarried son. He feels ashamed and now blames himself for his son's character, who physically abused him. He said that he loved his son more than his daughters and fulfiled all his demands from the childhood onwards and now his son is in the habit of taking alcohol and some addiction substances. He doesn't even listen to his words and doesn't give any respect to him. He always demands money and whenever refused he abuses him physically. So, he said that it is difficult to live with him and therefore, he told his elder daughter to keep him in the old age home where he could have some peace.

Mrs. Z is a 80 years old widow, belongs to OBC category and she hails from urban area. She is illiterate, has no income of her own and was dependent on her only son who works as a driver. She belongs to the poor class and lived only with his son and daughter-in-law. She felt very sad and depressed at the behaviour of her son. She was abandoned by her son and daughter-in-law. She said that a few years after the marriage her son along with his wife left her alone without giving his address and he even doesn't keep contact with her. One of the neighbours brought her to the old age home by seeing her pitiable condition. She also stated that "If my own son whom I have given birth did not take care of me then why should I care for him. For me,

he is dead, I am all alone and there is no one to care for me and no one to perform my rituals after my death".

Mr. A, is a 76 years old widower. He belongs to general category and a resident from an urban area. He is a graduate and a retired pensioner. He worked in the department of health and retired at the age of 60 years. He belongs to the upper class. He stayed with his 2 sons and daughter-in-laws who were all well established. He was psychological/emotionally abused by his daughter-in-laws. He stated that, "No respect is given to me by my daughter-in-laws. They are very rude to me and always abused me verbally. They forced my sons to keep me in the old age homes, so they kept me here, Though, I have got pensions but my son never allows me to use my money, because they said that it will be needed at the time of my death to perform my rituals. Though food is not good here in the old age home still I am happy because I can stay here peacefully instead of listening harsh words from my daughter-in-laws".

Mrs. B, a widow, aged 81 years, belongs to a rural area and she comes from ST category. She was a cultivator by profession and is illiterate. She has no children and was living alone. She experienced psychological/emotional abuses from the villagers. She was mistreated by her villagers who accussed her as a witch. She stated that "My husband was a pandit in the village. He was in the habit of taking alcohol, so he passed away. I had 3 sons and they all died in jaundice, I had no money for their treatment. I was left all alone and no one is there to take care of me. I have a temple in my house and since all of them died, therefore, the villagers suspected I was a witch and they all drove me out of my village. Some policemen brought me in the home and now I am happy here".

Mrs. S is 75 years old married woman, who came from rural area, belongs to OBC category and is living with her spouse in the old age home. She is illiterate and had no income of her own. Her husband was a daily wage earner. They were very poor and somehow managed their daily expenses before coming to the old age home. She has 3 sons and 4 daughters. They lived with their sons. But their sons abandoned them to live on their own and moved to the cities in search of work leaving them alone and her daughters were all married. They were growing old and her husband also cannot search any work. So, by

knowing their conditions, the Old age home supervisor brought them to this home.

Mrs. C, came from rural area, is a widow aged 70 years and she belongs to SC category. She is an illiterate. She was a cultivator and worked on other's agriculture land. She had 2 sons and was staying with her sons. She stated that, 'it is my fortune that I am residing in the Old age home'. She was always mistreated by her sons. She said that she is very poor and her house is very small. When her son's friends come she has to go out of her house even in night also. Her sons felt ashamed of her because she can't talk properly. So she told her nephew, who stays in the city, to take her to his home but he kept me here in this old age home. She has come to the is oldage home without informing his sons and daughters-in-law. Now, she is longing to go back to her own home. She felt very depressed because after knowing that she is staying in the old age home, her sons and daughter-in-laws never came to visit her.

Mr. R is a bachelor, aged 75 years; he came from rural area and belongs to OBC category. He was living with his younger brother and sister-in-law. He is an illiterate. He belongs to poor class and was a daily wage earner. But unfortunately he suffered from paralysis and could not work and earn any more. He lived in a joint family which comprised of his brother, sister-in-law and their children. He was neglected by his family members. He said that he was burden on them. Her sister-in-law didn't pay any attention to him. She also didn't give him enough food and sometimes he had to remain empty stomach. He was admitted to the civil hospital by his friend. From there, the Old age home supervisor brought him to the old age home and they bear all the expenses of his treatment.

Mrs. F is a 80 years old widow. She comes from urban area and belongs to general category. She studied upto primary level. Her husband worked as a teacher and she received the pension of her deceased husband. She belongs to the middle class group. She has only one daughter who continued to stay with her after marriage. She was financially exploited by her own daughter and son-in-law. She stated that, "Not only the sons but also the daughters are becoming greedy now-a-days. My only daughter and son-in-law whom I trusted, illegally

took my properties and didn't care me, so this old age home became only option for me".

Mrs. S.D, a widow, aged 62 years, who came from rural areas and belongs to OBC category. She studied upto class 6. She has no income and was dependent on her only one son and daughter-in-law. She belongs to the poor class. She stated "My daughter-in-law, who is a teacher, is the only earner of my family. They stay outside home and my only son stays with her because he does not earn. She was abandoned by her son and daughter-in-law and was living all alone in the home. She also said that she can't stay with them because there is no room (space) for her in my house. Therefore, they dropped me in this old age home.

Mrs. S.B is a 83 years old aged widow, who comes from urban area and she belongs to general category. She is an illiterate. She belongs to the lower class and was working as a daily worker in a hotel. She lived with her only son and daughter-in-law. Her son does nothing but her daughter-in-law also worked as a labourer in a hotel. She was abandonned by her son and daughter-in-law on station. She said with grief that as long as she was working everything was fine but when she is not capable to earn anymore she became burden for her son and daughter-in-law. They took her in the train and dropped her in the Guwahati railway station. She stayed in the station for 1 month. She started begging in the station and even lives with an empty stomach. Some people from N.G.O have saved her life and brought her to the old age home.

These voices of the elderly people clearly depict the various kinds of abuse they faced in their own homes. Most of the elderly from the age group 70–80 years and above face more abuse because as the age advances, they are rendered unable to perform even the activities of daily living and become dependent and considered as a burden by their family members. These conditions forced them to reside in the old age homes. These case studies clearly show that people from both rural and urban areas experienced abuses in various forms. Elderly from the upper and middle classes faced various kinds of abuse by their family members. But there is little difference in the forms of abuse they face. The upper and middle class elderly experienced financial abuse, psychological/emotional abuse and the poor class elderly experienced

abandonment and neglect. The elderly who were widow, illiterate, had no income and who were economically dependent on others faced more abuse. Most of the abusers of the elderly were their sons and daughter-in-laws with whom they lived and were economically dependent. The elderly who had no children faced abuse from other persons and relatives.

These case studies also clearly depict the selfish motives of the children. When the elderly were growing older and could not earn sufficiently they start facing abuse and are considered as a burden by their own children. From this study, it can be said that the elderly were not safe in their own homes; they face abuse at the hands of their own blood whom they trusted and were financially, physically and emotionally dependent on them. These various forces made them choose Old Age Homes as their only option, which they had never dreamt of.

Among those who experienced abuse, 80 per cent did not report their abuse to anyone. Only 10 per cent aged made an attempt to complain but finally decided not to complain for the fear of being thrown out from home by their children and also for the fear of social stigma. When the elderly were asked why they were not interested to report their miseries to the concerned authorities almost all the elderly were of the view that they can't take such a step against their family members. Majority of them stated that they wanted "to maintain confidentiality of family matter". A few of the respondents did not know how to deal with the problem. Due to illiteracy they have lack of confidence also. Only 3 per cent of victims had the awareness about redressal mechanisms. There was not much difference in the opinion of the victims on this issue. The effective measures identified were: 'increase economic independence of the victim' (elderly) and 'sensitize the younger generation' about the problems of elderly.

Conclusion

Elderly abuse is now-a-days becoming a major factor for the elderly to join the old age homes in Assam. Old age homes cannot be a substitute to protection from elder abuse though it is of great advantage for those who are alone and poor. As long as older people are looked down upon and marginalized by society they will suffer

from loss of self-identity (Madhurima, 2008). Therefore, Positive attitude should be developed towards the older people instead of writing them off as a burden. The elderly people deserve peace, life of dignity and well being in their last phase of life.

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Physical and Mental Health Status of Elderly People in Urban Setting of Nepal

Mahendra Raj Joshi
Kailali Multiple Campus, Dhangadhi, Kailali (Nepal)

ABSTRACT

The objective of the study was to explore the physical and mental health status of elderly people in urban setting of Nepal. 353 elderly respondents (Male = 149 and female = 204) age varying for 60 yrs. and above were selected from 280 households. Cross sectional descriptive study method was used with structured questionnaire and some qualitative survey tools such as FGDs, key informant interviews were used to collect information. The study revealed that about three fourth (73%) of respondents perceived at least one health problem. The perceived health problems were found to vary among respondents according to sex. Near around half (48%) of respondents reported that they had of physical pain (joints, knee, back, stomach etc.) as a major physical health problem. The prevalence of types of major health problems were found to vary according to sex. Majority of the respondents consulted the physicians for their health problems. About half of the respondents (50%) reported at least one mental health problem. Sex differences were noticed in mental health problems.

Keyword: *Elderly people, Ageing, Jestha Nagarik Aein, World Assembly on Ageing,* mental health, Physical health.

The simplest meaning of the word 'health' is the condition of being hale. WHO (1948) defined health as: "Health is a state of complete physical, mental and social wellbeing and not merely an

absence of disease or infirmity." Albert and Cattell (1994) stated that the term 'old age' is a multi-faceted and multi-disciplinary concept (cited as Weeks: 2005: 368). It can be conceptualized on chronological, psychological, biological/physiological and socio-cultural and demographic points of view.

All persons age 60 and above were taken as the elderly in the World Assembly on Ageing held at Vienna (Austria) in 1982 (cited in Weeks, 2005: 367). Similarly, in the United Nations International Conferences on Ageing and Urbanization in 1991, the term elderly was defined as the population aged 60 years and above (UN, 1991). For international comparison, the population aged 65 years and above is categorized under the ageing population. But in the case of developing countries like Nepal, the population aged 60 years and above is categorized under elderly population. In the case of Nepal, *Jestha Nagarik Aein, 2063* BS and *Regulation 2065* BS, clearly defined that the person aged 60 years and above are placed under elderly or old person (MoLJPA, 2065).

The world's population is ageing rapidly. Between 2015 and 2050, the proportion of the world's older adults is estimated to almost double from about 12 per cent to 22 per cent. In absolute terms, this is an expected increase from 900 million to 2 billion people over the age of 60 (UNESA/PD, 2015). Older people face special physical and mental health challenges which need to be recognized. Mental health has an impact on physical health and vice versa. For example, older adults with physical health conditions such as heart disease have higher rates of depression than those who are medically well. Conversely, untreated depression in an older person with heart disease can negatively affect the outcome of the physical disease (Snowdon, 2002: 42).

In Nepal, information on elderly population is very scant to provide a basis for formulation of a sound policy to meet the needs of growing older population. The present study is the partial attempt to fill this gap. The research will be good reference and clues for NGOs, INGOs, CBOs which are working for the enhancement of elderly people. This research will be thought to be relevant to the agendas of human rights and social justice which are the burning issues and the cry of the present world.

The main objective of this study was to access the health status of elderly people in urban setting of Nepal. The specific objectives were to find out the physical health condition, mental health condition and to analyze the diagnosis status of elderly in urban setting of Nepal.

Material and Methods

Sample

All the elderly people (aged 60+) of the Dhangadhi Municipality area constituted the population of the study. In the survey a total of 280 households of the area were visited and 353 elderly (Male = 149 and female = 204) aged 60 years and above were interviewed individually. For getting quantitative information, structured interview was employed and qualitative information was collected through Focus Group Discussions (FGDs), Case studies, Key Informant Interview (KII) were also used in this study.

The data was statistically analysed by using SPSS version 16.0.

Results

Physical Health Condition

The information about physical health condition of the respondents was collected by asking a close ended question about physical health condition (i.e. how is his/her health condition?). The information was reported on the basis of his/her responses as he or she feels about his/her physical health condition.

Table 1

Percentage distribution of elderly aged 60 years and above reporting at least one health problem according to age and sex.

Background characteristics	*Yes*		*No*		*Total*	*N*
	Per cent	*Number*	*Per cent*	*Number*	*Per cent*	*Number*
Sex						
Male	69.8	104	30.2	45	100.0	149
Female	76.0	155	24.0	49	100.0	204
Age group						

Cont'd...

Cont'd...

60–64	62.9	56	37.1	33	100.0	89
65–69	81.4	70	18.6	16	100.0	86
70–74	67.9	53	32.1	25	100.0	78
75+	80.0	80	20.0	20	100.0	100
Total	73.4	259	26.4	94	100.0	353

Source: Field Survey, 2012

Table 1 shows the percentage distribution of respondents reporting their physical health problems in the study area. About three fourth (73%) of respondents reported that they perceived at least one health problem. The perceived health problems were found to vary among respondents according to sex. It was found that more female respondents suffered (76%) from at least one health problem compared to male respondents (70%) in the study area. There was found curvilinear relationship between perceived health and age group of respondents. It was found highest (81%) among the respondents aged 65–69 and the lowest (63%) for the age group 60–64.

Major Physical Health Problems

Table 2 shows the percentage distribution of respondents with major health problems according to sex. Near around half (48%) of respondents reported that they had physical pain (joints, knee, back, stomach etc.) followed by gastric (27%), respiratory disease (22%) and eye problems (19%). None of them reported prostate glands problems, HIV/AIDS, cholesterol, cancer. The prevalence of types of major health problems were found to vary according to sex of the respondents in the study area. About thirteen per cent reported in 'others' category which includes skin disease, ulcer, cough, leg swelling, headache, jaundice, stone, hernia, babasir, tuberculosis, polio, thyroid, deafness, bone decay, delivery/pregnancy related problems. More female respondents reported physical pain, gastric, respiratory disease, blood pressure, bath, uric acid and heart diseases compared to male respondents in the study area. On the other hand, more male respondents reported eye problems, sugar and kidney/urinary compared to female respondents in the study area.

Table 2

Percentage distribution of elderly aged 60 years and above with major health problems according to sex.

Diseases	*Male*			*Female*			*Total*		
	Yes	*No*	*N**	*Yes*	*No*	*N**	*Yes*	*No*	*N**
Physical pain (Joints, knee, back, stomach, etc.	42.3	57.7	104	51.6	48.4	155	47.9	52.1	259
Gastric	22.1	77.9	104	31.0	69.0	155	27.4	72.6	259
Respiratory diseases	22.1	77.9	104	21.3	78.7	155	21.6	78.4	259
Eye problems	19.2	80.8	104	18.7	81.3	155	19.3	80.7	259
Sugar	10.6	89.4	104	7.7	92.3	155	8.9	91.1	259
Blood pressure	8.7	91.3	104	9.0	91.0	155	8.9	91.1	259
Bath	4.8	95.2	204	9.0	91.0	155	7.3	92.7	259
Heart diseases	2.9	97.1	104	6.5	93.5	155	5.4	94.6	259
Kidney/urinary	3.8	96.2	104	1.3	98.7	155	3.1	96.9	259
Uric acid	0.0	0.0	104	1.3	98.7	155	1.2	99.8	259
Others	14.5	85.6	204	11.0	89.0	155	12.5	87.5	259

Note: * These are the respondents among those who have any physical health problems at present

: Others includes Skin disease, ulcer, Cough, Leg swelling, Headache, Jaundice, Stone, Hornia, Babasir, T.B., Polio, Thyroid, Deafness, Bone decay, delivery/pregnancy related.

Source: Field Survey, 2012

Key Informant of Seti zonal hospital (Krishna B. Bohara) said that most of the elderly who visited the hospital had respiratory and gastric problems. The same tendency was also reported by another Key Informant Hem Raj Upadhyaya of Rosan Medical Hall (Private clinic) of Dhangadhi Bazzar.

The study also analyzed information about major health problems according to age group of respondents in the study area. Key Informant of Seti zonal hospital (K.B. Bohara) said that most of elderly who visited hospital fall in the age group 60–70. Only a small numbers of elderly aged 75 years and above visited the hospital. They visit hospital only in very serious condition. The same tendency of elderly was also reported by another Key Informant Hem Raj Upadhyaya of Rosan Medical Hall (a private clinic).

Diagnosed by Health Personnel

This type of information was collected only from those respondents who reported feeling of physical health problems. They were asked "did you consult the physician for your aliment?" Did the doctor diagnose the same disease or not? Table 3 shows the percentage distribution of respondents who were feeling physical health problems and were diagnosed by health personnel. Majority of the respondent reported that they were diagnosed for their health problems by health personnel. It was found that highest percentage (91%) were diagnosed for high blood pressure and blood sugar and the lowest (53%) for bath disease in this sample. The percentage of respondents with physical health problems and who were diagnosed by health personnel varied according to sex.

Table 3

Distribution of percentage of elderly aged 60 years and above who were feeling physical health problems and were diagnosed by health personnel according to sex.

Diseases	*Diagnosed by health personnel*								
	Male			*Female*			*Total*		
	Yes	*No*	*N**	*Yes*	*No*	*N**	*Yes*	*No*	*N**
Physical pain (Joints, knee, back, stomach, etc.)	70.4	29.6	44	65.0	35.0	80	66.9	33.1	124
Respiratory diseases	87.0	13.0	23	87.9	12.1	33	87.5	12.5	56
Blood pressure	88.9	11.1	9	92.9	7.1	14	91.3	8.7	23
Sugar	90.9	9.1	11	91.7	8.3	12	91.3	8.7	23
Gastric	78.3	21.7	23	81.3	18.8	48	80.3	19.7	71
Bath disease (Rog)	60.0	40.0	5	50.0	50.0	14	52.9	47.4	19
Heart diseases	75.0	25.0	4	90.0	10.0	10	85.7	14.3	14
Eye problems	76.2	23.8	21	79.3	20.7	29	78.0	22.0	50
Kidney/urinary	50.0	50.0	6	100.0	0.0	2	62.5	37.5	8
Uric acid	0.0	100.0	1	100.0	0.0	2	66.7	33.3	3
Others	86.7	13.3	15	82.4	17.6	17	84.4	15.6	32

Note: *Only those who felt having a disease
: Others includes Skin disease, Ulcer, Cough, Leg swelling, Headache, Jaundice, Stone, Hernia, Babasir, T.B., Polio, Thyroid, Deafness, Bone decay, delivery/pregnancy related.

Source: Field Survey, 2012

The diagnosed percentage of physical pain and bath rog (disease) was reported higher by males (i.e. 70 and 60 per cent respectively) as compared to females (65 and 50 per cent respectively) in the study area. On the other hand, the diagnosed percentage of rest of the diseases was reported higher for females as compared to male respondents.

Most of the participants of FGDs (Focus group discussion) said that elderly people usually go to private hospital/clinic (or for some serious cases to India) for taking treatment of diseases. They do not want to go to government hospital (Seti zone hospital) because they think that government hospitals do not provide good treatment and the physicians also do not treat them well. Key Informant of Seti zonal hospital expressed his disagreement about such complaints. He said that about 30 per cent of the total patients who visited the hospital were in the age group 60 years and above. He further said that the hospital had provided the facility of free treatment and medicine for those elderly whose economic status is poor.

Mental Health Problem

Table 4 shows the percentage distribution of elderly who had mental health problems. Out of total 353 elderly, 176 respondents (50%) reported at least one mental health problem (table 4.1). Sex difference in mental health problem was noticed in this study. Female respondents (56%) in comparison to male respondents (49%) reported at least one mental health problem. Among the respondents who had mental health problems, about half (47%) of them reported that they were feeling insecurity, followed by boredom (14%), loneliness (11%), anxiety (5%), neglect (5%) and sadness (2%).

Female respondents reported anxiety/stress as the major mental health problems (56%), followed by insecurity (46%), boredom (17%), loneliness (15%), neglect (6%) and sadness (2%). On the other hand, male respondents reported insecurity as the major health problem (49%), followed by anxiety (43%), boredom (9%), loneliness (5%), neglect and sadness (3% each). (see Table 4).

Table 4
Agewise distribution of mental health problems in male and female elderlies.

Age and sex	*Feeling of*							*At least one mental health problem*
	Insecurity	*Boredom*	*Loneliness*	*Anxiety*	*Neglect*	*Sadness*	*N**	
Sex								
Male	49.3	9.0	4.5	43.3	3.0	3.0	67	49.3
Female	45.9	17.4	14.7	56.0	5.5	1.8	109	56.0
Age group								
60–64	47.8	15.2	10.9	50.0	2.2	2.2	46	51.7
65–69	53.1	10.2	8.2	44.9	2.0	2.0	49	57.0
70–74	35.7	21.4	14.3	46.4	10.7	3.6	28	46.4
75+	47.2	13.2	11.3	60.4	5.7	1.9	53	60.4
Total	47.2	14.2	10.8	5.1	4.5	2.3		49.9
N	83	25	19	90	8	4	176	

Note: * They are the respondents who reported at least one mental health problem

Source: Field Survey, 2012

Agewise differences in mental health problems were noticed in this study. At least one mental health problem was reported by the (60%) elderly belonging to age group of 75 and above and (51.7%) elderly belonging to age group of 60–64 years. Anxiety was reported as the major health problem (50.0%) followed by insecurity (48%) and boredom (15%) in age group 60–64 in this study. Same pattern was found in other age groups. In the age group of 65–69 majority of respondents reported that they were suffering from insecurity (53%) followed by anxiety/stress (45%) and boredom (10%).

One elderly woman aged 65, reported in FGC that she is having a problem of *night movement*. She usually moves from her bed in unconscious state. At the time of night, when she is in the state of deep sleep she moves from home to a long distance. Her family members are aware of her condition. The keep themselves alert all the time. She has been suffering from this problem since last 5 years after the death of her young son who expired in a jeep accident.

Discussions

The findings of the study have revealed that majority of elderly people perceived at least one health problem. It was found that more female elderly suffered from at least one physical health problem as compared to male elderly. Among the various physical health problems, the most common problem was found physical pain (e.g., joints, knee and stomach). The prevalence of physical pain, gastric and respiratory diseases were found more in female respondents as compared to male elderly. On the other hand, eye problems, sugar and kidney problems were found more in male elderly as compared to female elderly. Over the past decades, epidemiological research has shown complex trends in the health status of ageing and old individuals. While the prevalence of (self-reported) chronic diseases has increased in the past, disability and limitations in functional health have decreased over time (Freedman *et al.,* 2004: 431). In the literature several explanations for the improvement in functional health have been discussed: "Increases in education and in income, changes in life styles, improvements in nutritional intake, reductions in occupational stress, declines in infectious disease rates, and improvements in medical care are all related to each other, have lagged effects, and all changed dramatically within a very short period of time" (Costa, 2004: 30). With respect to individual life-style and health behaviour, there are ample empirical evidences for the positive effects of physical activity and adequate nutrition – and for the negative effects of smoking, sedentary behaviour, obesity, and alcohol abuse (Ferrucci *et al.,* 1999: 649).

The result of mental health status of elderly shows that approximately 50 per cent of elderly respondents suffered from at least one mental health problem at the time of survey. Watts's *et al.,* (2002) reported psychiatric morbidity of 48 per cent among older persons by GHQ–12 method. Similar results (53%) were also obtained by Berardi *et al.,* (2005). In this study the mental health was associated with lower educational status of the respondents. Kim *et al.,* (2002), in their study revealed that 54.2 per cent psychiatric patients were illiterate and 29.4 per cent were educated up to primary level only. Rao and Madhvan, (1982); Satija *et al.,* (1984) and Ramachandran *et al.,* (2008) also reported similar results. As age advances there is a need for change in

one's life style, and attitude. For literate persons it is easy to accept this change as compared to illiterate ones. The mental health was poor among females than males. Majority of female elderly had at least one mental health problem as compared to male elderly. Anxiety and insecurity was found higher in the female as compared to male respondents. Widowhood was a significant cause for poor mental health in female respondents. Tellez Zento *et al.*, (2002) also reported the same observations. In Nepal, life expectancy of females is higher and culturally they marry with a man who is older to them. So in this age group the widowhood is more common among females than males. Widowhood may lead to poor mental health of elderly women. Widowed or divorced or unmarried state leads to the feeling of loneliness, lack of purpose and dissatisfaction in life coupled with loss of income and changes in living arrangements. Ramchandran *et al.*, (2008) also revealed that separated or divorced respondents were associated with late life depression.

Limitations of the Study

The study has used the responses of elderly themselves to understand their health status. Health status of elderly persons would have been better understood if the study had been accompanied by their medical examination by the researcher himself.

Conclusions

Poor economic condition was found to be the main barrier to good health status of elderly in the area of study. The other barriers were illiteracy among respondents, lack of safe drinking water facility, large family size, and non availability of a geriatrician in Seti zonal hospital (local hospital). The author is of the view that health programmes for elderly should give more emphasis on the health programmes for elderly women.

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Health Status of Elderly Population: An Empirical Evidence from India

Sonali Chakraborty
Sociological Research Unit,
Indian Statistical Institute Kolkata, India

ABSTRACT

This study aims to capture the socio-economic and demographic predictors that can explain the self-rated health status or well being categorized as 'poor' and 'good/excellent', the socio-economic inequality presents, gender differential in health exists among the elderly Indian in most recent past (NSS, 2014). The unit level data of survey on 'Health in India' conducted by National Sample Survey Organization has been used to assess this situation. As Poor health is generally thought to be the outcome of poor economic and social status a binary logistic regression has been done to explain the health status of an individual. Some comparison of descriptive statistics with previous year survey has also been made. Results show that chronic and other diseases along with poor health status by self rating are significantly higher among the women than men. The self rated poor health is also high among the socially backward classes and among the Muslims. Rural urban differentiation in self rating process is not so profound.

Key words: Self rated health status, Elderly population, Socio-economic inequality, Physical mobility.

Elderly or old age consists of ages approaching the average life period of human beings. People are considered being old due to certain

changes in physical, mental and some social roles. They need special humanitarian and developmental aspects as per the United Nations World Assembly on Ageing, held at Vienna in 1982. The problem of aging population is a serious issue all over the world. India is also facing a rapid demographic transition, resulting in a high enhancement of elderly population. According to UN (2015), India is the second largest country after china to bear elderly population (60+). The growth rate of this population is also in an alarming state, three per cent per annum, far higher than the growth rate of the children and younger age cohort (which is two per cent per annum from census 1991 to census 2001). Decreasing trend of fertility and mortality rate and increase in life expectancy are the leading determinants of population aging (Alam, 2006). In 1961, the older population at age 60 and above was only 24 million; it increased to 100 million (Census 2011). The older population has increased four times during the last five decades. The United Nations statistical projection indicates that the size of India's population aged 60 and above is expected to increase to 117 million in 2015, 193 million in 2030, and further to 335 million in 2050(United Nations Population Division, 2006).

The proportion is 7.7 in the year 2014 (NSS, 2014) likely to reach 13 per cent of the population in 2030 and 20 per cent in 2050 (United Nations Population Division, 2006). So population aging becomes a serious problem in India as in other countries like Asia, Caribbean, and Latin America etc. The needs and problems of the elderly vary significantly according to their age, socio-economic status, health, living status and other such background characteristics (Raju, 2011). Fast growing elderly population in an economy is a kind of threat as it needs to increase special intervention like medical and health care facilities, pension, and social security. On the other hand shrinkage of workforce will lead to loss of active workers. Coupled with these, there has been a great change in the family structure that reduces informal family support towards the elderly care now a days in India. Traditionally, in India, the most common form of family structure was a joint family structure. But the emergence of nuclear family, weakening of kinship and community relations, migration of youth for better livelihood, increasing participation of female workforce, all are the direct and indirect causes that forced the elderly to be

marginalized. Moreover Indian society has faced discrimination against gender line, caste divisions, religion difference, income profile, educational attainment, rural urban residence, getting provision of minimum sanitation level etc. All these issues also are warning signs towards elderly population for leading a civilized life. However educational endorsement of this grey population is also disappointing. According to the 71st round, 51 per cent of the elderly in India were found to be illiterate. This is likely to have a bearing on their economic activities. Poverty and loneliness further add to the problem of elderly care, rendering senior citizens even more vulnerable.

Review of Literature

The impact of socio-economic structure on health status of old people has been well documented across various nations. They have documented an inverse relationship between socio-economic status and different health parameters like mortality, morbidity and disability (Alam, 2006). Evidences from different settings have shown higher rates of poor self-rated health and lower rates of excellent or good self-rated health in women, as compared with men (Benyamini, *et al.*, 2003; Idler, *et al.*, 2000; Kowal *et al.,* 2010; Phaswana-Mafuya *et al.,* 2013). Recently three different approaches (1) Socio economic status, (2) Family structure (3) social support are jointly interesting issues for elderly populations (Rueda, 2009). Social indicators based on occupations are not plausible for elderly. The impact of occupational attributes for aged population gets faded, as being away from the labour market for long time. Rather educational endowment has more impact throughout the life span. In our country most of the population is below 30 and all the developmental initiatives are pin pointed toward children and youths. Very few studies focus the issue of this grey population in our county. Here it is an attempt to document an over view of this less focused section of the society with available data structure which are nationally representative.

Objective of the Study

Present study aimed to capture the socio-economic and demographic predictors that can elicit the self-perceived health status or well-being of an elderly individual categorized as poor/good/excellent.

The socio-economic inequality also presents gender differential in health among the elderly. The socio-economic status is determined by educational attainment, economic independence and monthly per capita expenditure (MPCE) which is proxy to income. Family structure was measured through living arrangement, i.e household size, marital status, number of dependants, number of sons and daughters living with etc. Social support was measured through the number of persons helping, economic supports coming from etc.

Methodology

This paper used the data from the 71st round of National Sample Survey (NSS) conducted by National Sample Survey organization (NSSO) during 2014. The 71st round of NSS focused on 'morbidity and health care' includes several questions related to key health indicators like the problems of aged persons. However, in this study, we are using the questions related to key socio-economic and health attributes to estimate the socio-economic status based health inequalities among the older population of India. Data provide information on various aspects of the older population, including living arrangement, number of living sons/daughters, the state of economic independence, person/persons financially supporting the aged, loans, and so on. Information on physical mobility, ailment on the date of inquiry, own perception about the current state of health, and own perception about the relative state of health are also provided. Unit level data has been used here from the schedule 25, from the survey "Health in India' by developing software.

In this survey, the question posed to them was "What is your own perception about your current state of health?" The question had three categories (excellent/very good, good/fair, and poor). Researchers categorized the response categories into two groups, "Poor" which includes only *poor* and "Good" which includes *excellent/very good* and *good/fair*.

Information on the following demographic and socio-economic variables such as sex, age, marital status, education, work status, monthly per capita consumption expenditure (MPCE), economic independence, religion, social group, living arrangement, place of

residence, and region of residence. The variables were categorized as follows.

a. Sex: male, female.

b. Age is categorized as "youngest-old" elderly (age group 60–69), "old-old" elderly (age group 70–79), and "oldest-old" elderly (age group 80 and above).

c. Marital status: currently married, widowed, never married/divorced/separated.

d. Education: illiterate, primary, secondary, higher and above.

f. MPCE: The level of living is highly related with the general health of the household members as well as to the extent of medical care received by them. Thus, as the background information, the distribution of households and population by income level is necessary for a correlative study on morbidity and health care. However, the NSSO collects data on Monthly per capita expenditure (MPCE*)*, which provides a reasonable proxy for relative ranking of the households according to level of living. The standard of living is measured by the MPCE. The entire population is divided into 12 groups by the expenditure class. For studying income distribution of the population twelve MPCE classes may be formed after arranging the entire population by value of MPCE. The upper limits of these classes correspond broadly to the MPCE level of cumulative proportions of poorest 5 per cent, 10 per cent, 20 per cent, 30 per cent, 40 per cent, 50 per cent, 60 per cent, 70 per cent, 80 per cent, 90 per cent, 95 per cent and 100 per cent of the population. From the data on NSSO Consumer Expenditure Survey, these MPCE classes are obtained separately for rural and urban part of the country (GOI). MPCE has been then finally grouped into 5 classes 0–20, 20–40,40–60,60–80,80–100.

g. Economic independence: independent, partially dependent, fully dependent.

h. Religion: Hindu, Muslim, Others.

i. Social groups: Scheduled Castes (SCs), Scheduled Tribes (STs), Other Backward Classes (OBCs), and Others.

j. Living arrangement: alone, with spouse only, with spouse and others, without spouse and with children, other relation, and other non relation.

k. Place of residence: rural, urban.

(2) *Mobility:* Physically immobile, Confined to bed or home, Able to move outside with help of wheel chair, physically mobile.

To see the effects of the determinant of health condition Binary logistic regression has been done. The dependent variables are (1) Self rated Health status: Poor self-rated health status=0, good/excellent=1.

(2) *Mobility:* Physically immobile (Confined to bed or home, Able to move outside with help of wheel chair) and physically mobile.

Socio-economic variables/independent variables: Place of residence: Rural/Urban, Sex: Female/Male, Economic status (based on Monthly Per Capita Consumption Expenditure [MPCE]): Education, Religion, Caste: Scheduled Castes/Scheduled Tribes/others, Marital status, sanitation facilities received, age group, presence of son and daughter, living condition like living in old age home, with family, with spouse only, with other members etc.

Results

Descriptive Analysis Show

The sex ratio among the 60+ has gone from 930 to 1033from census 1981 to census 2011. In case of rural it is more (1036) and in urban it is 1027(Census 1981, 2011). The sex ratio indicates that female population has outnumbered the males.

Table 1

Proportion of ailing persons (per 1,000) during last 15 days for different age group separately chronic and short duration ailment

Age Group	*Per 100 # ailing persons*					
	Rural			*Urban*		
	Chronic	*Short Duration*	*All*	*Chronic*	*Short Duration*	*all*
60–64	175	79	254	302	48	350
65–69	203	61	264	305	57	362
70+	235	71	276	320	53	373

Source: NSS

Table 2

Percentage of cases of hospitalization on account of ailments of different broad ailment categories reported during the last 365 days

Broad ailment categories	*Rural*				*Urban*			
	Male		*Female*		*Male*		*Female*	
	60–69	*70+*	*60–69*	*70+*	*60–69*	*70+*	*60–69*	*70+*
Infections	1.44	1.56	1.38	1.58	1.16	1.79	1.29	2.09
Cancers	0.42	0.23	0.17	0.35	0.70	0.61	0.62	0.46
Blood disease	0.23	0.15	0.15	0.21	0.08	0.17	0.15	0.32
Endocrine metabolic and nutrition	0.25	0.54	0.33	0.55	0.56	0.88	0.76	1.00
Psychiatric &neurological	0.61	1.36	0.47	1.33	0.99	1.96	0.52	1.12
Eye	0.80	1.08	1.69	1.28	0.82	1.17	1.49	1.03
Ear	0.00	0.02	0.03	0.02	0.00	0.00	0.01	0.00
Cardiovascular	1.34	2.87	1.05	1.70	2.35	4.89	1.78	3.09
Respiratory	0.69	1.60	0.48	0.93	1.17	1.58	0.54	1.79
Gastrointestinal	0.80	1.24	0.82	0.65	1.04	1.92	0.67	1.01
Skin	0.06	0.20	0.05	0.09	0.08	0.18	0.08	0.12
Musculo-skeletal	0.49	0.64	0.86	0.60	0.34	0.84	0.75	1.34
Genitor-urinary	0.58	1.48	0.27	0.32	0.75	1.45	0.43	1.66
Injuries	0.73	0.79	0.38	0.81	1.16	1.17	0.85	1.42
others	0.22	0.41	0.26	0.40	0.26	0.41	0.11	0.54

Source: NSS

1. An over view of ailment situation for elderly population has been displayed in Table 2. Different types of ailments increase with increasing age of the person. Most likely Infections, endocrine metabolic and nutrition, psychiatric and neurological problem, cardiovascular, respiratory or gastrointestinal are profoundly increased among the above 70 age group. There are rural urban differences of occurring those ailments. The people of urban are more prone to suffer from Respiratory or Cardiovascular problems. From Table (1) it is found that chronic disease increases also with age.

2. Most of the elderly population belongs to the youngest old group. The share of female aged group is more than their counter part up to primary level of education. But this has been dropped to half in the upper spectrum of educational profile (Table 3).
3. During 2014 about 96 per cent of the aged had at least one surviving Children. Families are mostly male headed (82%). So Extended family system and patriarchy remains dominant as 84 per cent elderly are living with their spouse and other family member (Table 3).

Table 3

Crude Share of Sociodemographic factors by Gender in the Older population in India

	Male	*Female*
Residence		
Rural	50.99	49.01
Urban	49.01	50.64
Educational Attainments		
Up to Primary	25.07	38.96
Middle School	17.75	9.18
Higher Secondary and above	6.9	2.05
Age in years		
60–70	36.87	37.23
71–80	10.62	9.3
80 and above	2.76	3.15
Sanitation		
(1) latrine with flush/septic tank	26.37	25.68
pit/no latrine/others	23.88	24.06
(2) Covered/pucca drainage	16.15	16.56
No drainage/open kuchha drainage	34.1	49.74
(3) Safe drinking source of water	5.7	5.8
Unsafe drinking source of water	44.46	43.8
(4) LPG/Gobor gas for cooking	23.5	23.5
Other hazardous source for cooking	26.67	26.23
Household headed by	82.35	18.01
Marital Status		

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Married	42.11	23.76
Never married/widowed/divorced	8.14	25.98
Living arrangement		
(1) With spouse	6.1	3.9
(2) Spouse & Children	42.6	42.15
(3) Not with family members	1.54	3.66
Status of economic independence		
(1) not depending on others	21.29	5.02
(2) fully/partially depending on others	28.98	44.69
Number of dependants on elderly		
(1) No dependants	28.33	23.17
(2) Have dependants	21.92	26.57
Financial supports coming from		
(1) Spouse	1.35	10.07
(2) Others	38.02	60.65
Religious affiliation		
(1) Hindu	39.96	39.91
(2) Other minority	10.26	9.88
Caste		
(1) lower	11.8	11.7
(2) upper	38.39	38.03

Author's calculation from unit level data of NSS survey Health Situation India 2014.

4. However elderly people living alone have gone up from 2004 to 2014, probable reason of this is increased life expectancy (Central Statistical Organisation, GOI, 2011)
5. The economic dependency of females on other both in case of rural and urban is about 90 per cent (Central Statistical Organisation, GOI, 2011). The economic provider is mainly their children and spouse. However from Table 3 it is noticed that economic dependency of the female is almost double than the male. Females still depend on spouse and other and the share of these two factors are far above than male.
6. About 8.4 per cent of aged person in rural and 7 per cent in urban are confined to bed and this percentage is also higher among the female (Central Statistical Organisation, GOI, 2011).

7. A gender line difference is coming from the distribution of Table (4), it is noticed that females were admitted to hospital less frequently than males, they are more immobile than male, are more prone to *chronic diseases*, receive less health coverage facilities.

Table 4

Share of selected independence factors, physical mobility and Health factors by Gender in the Older population in India

	Male	*Female*
Whether Hospitalized before		
(1) yes	13.97	11.96
(2) No	36.27	37.71
# time hospitalized		
(1) Once	45.96	39.9
(2) More than once	7.9	6.22
Having Chronic disease		
(1) Yes	12.04	13.16
(2) No	37.3	36.55
Suffering from any other disease 15 days before the survey		
(1) yes	3.22	3.49
(2) no	47.13	46.2
Physical mobility		
(1) immobile	4.11	5.96
(2) mobile	46.14	43.78
Whether having any Health coverage		
(1) yes	9.03	8.72
(2) No	41.22	41.02
Reporting about health		
(1) Self reporting	28.3	30.51
(2) Proxy reporting	21.92	26.57

Author's calculation from unit level data of NSS survey Health Situation India 2014

Results from Regression analysis

This analysis has been done separately for rural and urban sector). When Self-reported health status was used as dependent variable the observations are as follows.

1. The relationships with the independent variables are almost similar trend in case rural and urban settings.
2. Chances of reporting good health status reduces in case older or oldest elderly i.e age is strongly related to poor health condition factor. Person who lives alone i.e either divorced or separated or never being married is also likely to report poorer health status than those who are ever married both in urban and rural, except widowed in rural perceived good health status. Significant negative relation of self-rating good health has been noticed for Muslims as compared with Hindus, absence of male child, physically immobile individuals and those who are living only with spouse against living with spouse and children also.
3. The likely hood of reporting a good health status has increased with educational up gradation in urban area
4. Economic independence both fully and partially also has positive impact to self-rate good health condition. Among the several troubles faced by the senior citizen in India, economic issues are the most important. In reality mass poverty and huge section of families lying far below the poverty level are required to ensure a reasonable standard of living. Nearly 92 per cent of the country's total workforce is employed in the unorganised sector, where poor people often have to give up work unwillingly on account of poor health. Moreover, they have to do so without any monetary refuge like pension, and post retirement benefits.
5. Chances of rating good health reduces in case of nuclear or small sized household in comparison to medium sized, where as bigger house hold size has increased the likelyhood of rating good health.
6. The chances of living with sons increase the likelyhood of better health condition, in contrast to living with daughter.
7. The person belonging to the house hold type of casual labour are more likely to self-rate as poor health condition as compared to person from self-employed family.
8. Sanitation also plays a vital role to put up with a sound heath. Improper latrine facilities, drainage system, hazardous ways of

using energy for fuel and having no provision of safe drinking water lead to poor health.

9. Females are more likely to self-rate as good health status than male, almost 1.5times more in urban and 1.2 more in rural areas.

Table 5
Results (Odds Ratios) of Logistic Regression
(Dept Variable poor health status = 1, 0 otherwise)

Independent Variables	*Exp (B) Urban*	*Exp (B) Rural*
Constant	4.99	5.949***
Age (60–69) ref		
70–79	0.638***	0.576***
80 and above	0.555***	0.470***
Marital Status (Ref: currently married)		
never married	0.448**	0.752
Widowed	0.728**	1.139
Divorced/separated	0.612*	0.828
Education (Ref: below primary)		
Up to secondary	1.021**	1.146*
H.S and diploma	1.529***	0.893
Graduate and above	1.533***	1.157
Sex Ref: male		
Female	1.49**	1.1798***
House hold size Ref: med (4–6)		
small (1–3)	0.949	0.908
Large (6+)	1.046	1.032
Social group Ref: OBC and others		
SC	0.836**	0.984
ST	1.643***	1.114*
Religion Ref: Hindu		
Muslim	0.687***	0.634***
Others	1.088	1.125***
Economic independence Ref: Fully dependent on others		
No dependent	1.905***	2.162***
Partially dependant	1.438***	1.729***
	Exp(B)	Exp(B)

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Drainage sys Ref: proper drainage		
Improper drainage system	0.741***	0.885*
Drinking water Ref tap+ tube well		
Other sources	0.718***	0.694***
Primary source of energy for cooking Ref: LPG+ Gobor gas		
Other sources	0.864*	1.23**
Latrine Ref flash/Septic tank		
Others	0.857***	1.042
House hold type Ref: Self employed		
Salaried	0.95	0.908
Casual workers/others	0.847**	891
Mobility condition: Ref: Mobile		
Confined to bed	0.31***	0.04***
Confined home	.122***	0.105***
Move with wheel chair	.140***	0.168***
Living Ref: with spouse & children		
Living old age home/other	1.101	0.564***
Living with spouse only	0.810*	0.813***
Without spouse but children	1.217	0.819**
Other relations	1.358	0.932

Author's calculation from unit level data of NSS survey Health Situation India 2014
*p < 0.1, **p < 0.05, ***p < 0.01

Mobility condition of a person was considered as a dependent variable then following results were found:

1. It was seen that age is the most significant factor that increases the immobility of an individual. It increases more than twice the chance of immobile condition of older elderly and six times more with the oldest elderly.
2. Person living never married or divorced than married one, belonging to smaller or very big household size than medium one, coming from Muslim community, lack of proper sanitation also make an individual confined to home or bed ridden earlier
3. Economic independency shows positive association with physical mobility.

4. Index of dissimilarity (ID) shows about 44 per cent gender inequality in health.

Table 6

Results (Odds Ratios) of Logistic Regression
(Dept Variable mobility condition Physically mobile = 1, 0 otherwise)

Independent Variables	*Exp(B) Urban*	*Exp(B) Rural*
Constant	0.057***	0.069***
Age (60–69) ref		
70–79	2.714***	2.674***
80 and above	6.033***	5.845***
Marital Status (Ref: currently married)		
never married	0.998	1.17
Widowed	1.625***	1.594***
Divorced/separated	0.638	3.720***
Sex Ref: male		
Female	1.052	0.854*
House hold size Ref: med (4–6)		
small (1–3)	1.331**	1.184*
Large (6+)	1.014	0.97
Social group Ref: OBC and others		
SC	0.994	0.901
ST	1.202	1.087
Religion Ref: Hindu		
Muslim	1.319	1.22
Others	0.932	1.148
Economic independence Ref: Fully dependent on others		
No dependent	0.398***	0.222***
Partially dependant	0.583***	0.478***
Drainage sys Ref: proper drainage		
Improper drainage system	0.983	1.104
Drinking water Ref tap+ tube well		
Other sources	1.063	1.258**
Primary source of energy for cooking Ref: LPG+ Gobor gas		
Other sources	1.044	0.945

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Latrine Ref flush/Septic tank		
Others	1.081	1.078
House hold type Ref: Self employed		
Salaried	1.179**	0.932
Casual workers/others	1.125*	1.071

Author's calculation from unit level data of NSS survey Health Situation India 2014 *p < 0.1, **p < 0.05, ***p < 0.01

Discussion

The study documents the impact of socio-economic and demographic factors on self-perceived health status among the older men and women in India. The self rated health status and the mobility condition of men and women were taken as response variable. The process of data collection may get affected by subjectivity and also the consciousness and perception of an individual about health. Despite all these well-recognised problems and difficulties of measurement, the reported information of morbidity obtained in large scale surveys would be extremely useful, especially in the absence of clinically validated surveys [Ghosh and Arokiasamy, 2009]. Rather Several earlier studies have shown that self-reported health among older men and women is a valid measure of the respondent's objective health status, an important predictor of survival in old age and a strong predictor of healthy longevity (Husain, and Ghosh 2010; Idler *et al.*, 2000; McCallum, *et al.,* 1994). The study doesn't confirm the results from the previous studies that older women's poor self-rated health status is more than men (Agrawal & Arokiasamy, 2010). Rather female both in urban and rural areas are reporting good health compared to male. It is common phenomenon in Indian society that female are less bothered about their personal health, and preferential allocation of care and recourses goes towards the male members of the household, result of the survey may have reflected this criteria. There is a strong age effect on poor self-rating, that goes with many other previous studies. Education and economic independence has a positive association of reporting good health. That indicates the economic wellbeing is positive indicator of sound health. This is probably because wealthy and educated households have adequate resources and afford a good proportion of their earning on food and health care awareness.

Preference of living with son is also a positive indicator of good health condition. Still now, in Indian society, the elderly relies more on son rather daughter. Persons living only with spouse are not reflecting good health, rather complete family system is more effective to hold good health status. It is also supported from the result that in nuclear family health gets more deteriorated as the sharing of household chores are not applicable here. Rather person belonging to medium or big sized household comparatively bear good health status.

Economic dependency has higher odds to poor health as persons economically dependent on others have to rely for medical and other health care on their immediate caregivers. In so far as the social groups or religious communities are concerned the Muslims and SC (Schedule Caste) reported more poor health condition than the reference group. Actually Muslims and SC and ST are more in disadvantageous position than upper class or Hindus in terms of education and economic status in Indian social structure. Improper sanitation System i.e lack of safe drinking water, conventional cooking arrangement, poor surroundings of household having open drainage system may increase the risk of disease and eventually led to vulnerable health condition. Still women in the village are engaged to collect fire woods, fetch drinking water from faraway places in their daily schedule that ultimately make them physically immobile in old age.

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Integrating Elderly into Community: A Socio-Economic Model

Anoop C Choolayil and Laxmi Puthran
Department of Social Work,
Central University of Kerala. Kasargod, Kerala–671531

ABSTRACT

The thrust area of this study was the possibility of integrating skilled elderly population into the economic workforce in their own terms. The study tried to focus upon skilled elderly who could contribute to the community and thus realize their potential while being economically active. The data was collected via secondary sources in the first place from studies that have dealt with the questions pertaining to the recent past. The findings show that economic participation of elderly in developing nations is far higher than that of the developed nations and India tops the list but the trend is gradually declining in India. The average participation of urban elderly in economic activities has fallen considerably during the period from 1983 to 2010. Further, data show that higher the rate of literacy, quality of life and social security the economic participation of elderly lowers. It is assumed that elderly are unable to seek jobs on their own terms or there is an atmosphere where economic participation by elderly is not favourable owing to multiple factors that are social in nature. It is argued that social level interventions are required along with economic level interventions to facilitate meaningful economic participation of elderly. To address this special need an attempt was made to reconcile the

ideas of developmental psychology, motivation theory and valued roles into the realm of economic participation.

Keywords: Economic roles of elderly, Integrating elderly into workforce, Economic participation for healthy ageing, Population ageing and economy, Dignifying economic contributions of elderly, Promoting work-culture among elderly

The greatest mystery that has always baffled human minds throughout the history of human civilization is nothing but life. The key to life is considered to be the ultimate quest of human species. This quest has naturally been exploring the anti thesis of life as well viz. death. The deeper the themes of life and death were fathomed myriad were the corollaries that arouse. Ageing was one such corollary that has always been portrayed as a theme with close bindings to the antithesis of life. Ageing as a phenomenon has almost always been portrayed in negative light till the recent past. Aristotle from Greek philosophy in his work *Rhetoric* opined that elderly under-do everything and they tend to be distrustful and cynical in life (Aristotle, trans. 1991). However, this idea of old age as an age of decline was not arbitrary as there were others like Cicero who drew similarities between elderly and the captain of a ship in his work titled *On Old Age*. While others do a lot of energetic work in the ship the captain's job may not seem that pompous but what he does is far more important. Hence he opines that it is not physical dexterity that counts but reflection, force of character and judgement; characters that are intertwined to old age. (Cicero, trans. 1887). Understanding the nature and possibilities of old age has thus always been a matter of discourse from times immemorial.

The theme of old age has been gaining importance in the past few decades due to some unprecedented events; population ageing being one of the major reasons for this reappraisal of old age. "Aging of population (also known as demographic aging, and population aging) is a summary term for shifts in the age distribution (i.e., age structure) of a population towards older age." (The Encyclopedia of Population, 2003). One out of every eight individuals in the world is above 60 years old. (UNFPA, 2018). Since the modern world is practicing birth control measures to control population and at the same time life span of people are on a rise owing to medical progresses

the trend of population ageing will be on a rise in the years to come. In India 8.6 per cent of the population belong to age group above 60 (Ministry of Statistics and Programme Implementation Government of India, 2016) which is expected to rise to 12.45 of the population by 2026 (Subaiya and Bansod, 2011).

Old age is often portrayed as a negative phase of life as it is associated with declining economic productivity, physical weakening and ultimately death. One of the major reasons for a negative outlook towards old age is the misconception that elderly people can't fit into economic roles in the community i.e. they are not active economic contributors. However, the idea of "successful ageing" as propagated by Rowe and Khan (1997) stands in stark contradiction to the idea of old age being a period of economic unproductivity. The concept places "active engagement with life" as one among the three components of successful ageing and productive activity, especially economically productive activity, is considered as a key factor in this regard. However, in a world were ageism still pertains, the elderly often end up sacrificing their aspirations; once retired they are forced to withdraw themselves from the workforce often due to the stereotyping associated with ageing as the end of productivity. The thrust area of this study was the possibility of integrating skilled elderly population into the economic workforce in their own terms i.e. the highlight was upon the subjective aspects that the skilled elderly considered important to engage themselves in the economic force and objective means to help them achieve the realization of economic roles. The study tried to focus upon skilled elderly who could reflect upon the possibilities of contributing to the community and thus realize their potential while being economically active so that the situation that might emerge in India in a decade viz. skilled and zealous but economically unproductive elderly population could be anticipated and thus an effective action plan could be drawn through assumptions from current researches.

Methods and Materials

This study is exploratory in nature in so far as it attempts a historical analysis of how elderly population has been integrating themselves into economic roles of the society; through an analysis of

available secondary data and thereby trace the trend of participation of the elderly in the economic force as a whole. The aim is to assess how effective the economic participation of elderly in the social context is and how the perception of economic participation could pave way to a dignified status of the elderly in the society as a whole so that it leads to a triple benefit of realization of the socio-economic potential of the elderly, elevation of the social status of the elderly and a boost to the economy in general. This appraisal in turn could be beneficial in so far as population ageing is concerned too as the induction of the elderly population into the workforce successfully while contributing to their healthy ageing could be beneficial to the economy, the community as well as the individual.

For this purpose, the data regarding participation of the elderly enumerated in the sources like research papers, statistical data compiled by organisations and other valid sources in the past few decades have been reviewed. The keywords used in obtaining this compilation included 'elderly in workforce' 'economic roles of elderly', 'integrating elderly into workforce', 'economic contribution of elderly' 'economic participation for healthy ageing', 'population ageing and economy', 'social integration through economic roles', 'economic participation as a social role', 'dignifying economic contributions by elderly', 'promoting work-culture among elderly', 'impediments to economic participation of elderly', 'developmental tasks of economic nature' etc. From the articles and resources thus obtained relevant data was further sieved as per the time period of the study and its nature of integrating both economical and social roles. Further theoretical aspects were drawn from developmental psychology and gerontology.

The data thus compiled is further assessed to identify the nature of the integration of elderly into economic roles. Once the data is analysed, the findings are further assessed to amalgamate the idea of economic participation with social and individual concerns of the person in the realization of such a participation. For this purpose concepts from developmental psychology, gerontology and life span approach theories are drawn with the purpose of of transcending the

idea of economic participation of the elderly into the level of valued social role from a theoretical perspective.

Results and Discussion

Elderly in the Workforce: Global Scenario

In the global scenario participation of elderly in the economic force shows flickering trends. India tops the list when it comes to active economic participation of elderly men. 74.2 per cent of elderly men in India in the age group of 60–64 participate in contribution to the economy and the per cent is 58.5 and 34.4 respectively when it comes to the age group of 65–69 and 70+. (ILO, LABORSTA, 2017). This rate is considerably high compared to many developed nations and even higher than most developing nations. (Table 1). However, the participation rates of elderly in the economic force has steadily been increasing in the past decade in the advanced economies. The rate of participation of elderly has increased by 9 and 4 percentage respectively in the age group of 55–64 and 65+ during 2006–2016 and women participation has considerably contributed towards this growth. (Brown and Guttmann, 2016). The situation of elderly participation in the economic workforce of India on the other hand is not promising in the past decade.

Table 1
Elderly Men in Workforce: Global Scenario

Nation	*India*			*Brazil*			*US*		
Age Group	60–64	65–69	70+	60–64	65–69	70+	60–64	65–69	70+
Participation Rate (men)	74.2	58.5	34.4	63.8	47	25.5	60	36.5	14.7

Source: ILO, LABORSTA, 2010.

Economic Participation of Elderly in India

The higher rate of elderly participation in economic participation of India could not absolutely be counted as a positive sign as this could be the outcome of poverty, lack of social security measures and even the nature of work the elderly are engaged in might be different; particularly in rural areas. (Rajan, 2010). It is evident from the data of population census 2011 that participation of elderly in economic

activity varies according to area and gender. 66 per cent of elderly men and 28 per cent of elderly women in rural area participate in economic activity in the capacity of main or marginal worker whereas only 46 per cent and 11 per cent of elderly men and women respectively participate in urban areas (Ministry of Statistics and Programme Implementation Government of India, 2016) (Table 2).

Table 2
Place of Residence, Sex and Participation in Economic Activities

Place of Residence	*Sex*	*Main Worker*	*Marginal Worker*	*Main + Marginal Workers*	*Non Worker*
Rural	Male	53	13.5	66.4	33.6
	Female	16.3	12.1	28.4	71.6
Urban	Male	41	5.1	46.1	53.9
	Female	8.3	3.0	11.3	88.7

Source: Office of the registrar General, India.

It is evident that the rate of participation of elderly in economic activities stands tall in rural areas. However, the stark reality is that the rural elderly are unable to reap the economic benefits that their urban counterparts do. Though it is only a minority of urban elderly that are economically active compared to rural elderly 38 per cent of them earn a better income of Rs 10,000–25,000 compared to 23 per cent among rural elderly. The income brackets are lower for rural elderly.

Furthermore the rate of literacy could also have some form of influence on the rate of participation as the CSO data based on 2011 census shows that literacy rate among elderly in the urban area is 66 per cent which is higher compared to 34 per cent in that of rural area. (Ministry of Statistics and Programme Implementation Government of India, 2016). Further it is found that the rate of unemployment is higher among literate and educated elderly than those among the illiterate possibly because the latter engage in economic activities that involve lesser skills associated with education.

The lack of availability of work that suits the nature of education and skill of the educated elderly might thus be a factor leading to lower rate of economic participation in urban areas. The average

participation of urban elderly in economic activities has fallen considerably during the period from 1983 to 2010 (Employment and Unemployment Surveys of NSSO of India, 1983 and 2010–2011) further strengthening the idea of slow declining of elderly participation in economic participation with the improvements in life situation. (Table 4). This trend could also be seen in developed nations in relation to job satisfaction; as people with low satisfaction levels at work tend not to work during old age and those with a higher rate of job satisfaction tends to work even after regular retirement age (Von Bonsdorff, 2009) (Aristovnik, A. and Jaklic, K., 2013). This trend could be interpreted along the lines of Maslow's 'hierarchy of needs' theory of human motivation. (Maslow, 1943). Elderly are not too much obsessed with physiological and safety needs if they enjoy a good quality of life, they rather tend to seek belonging, esteem and self actualization opportunities in life. The case could be the same when they consider participating in economic force. What could motivate them in such a participation can't be economic remuneration alone but things that transcend mere economic gains in the first place; it could more be social and personal factors that contribute to the positivity of individual psyche. Hence it could be assumed that better the life situations of the elderly, they are to engage in economic activities that suits their skill and provides them satisfaction as an individual; not just monetary benefits. Thus old age economic participation could be associated more with better work environment, job satisfaction and other social and personal factors which favour the particular age of the individual.

Table 3

Variation across Years in Economic Participation of Urban Elderly

Year			*Age*		
1983	60+	60-64	65-69	70-74	75+
Participation (in per cent)	31.26	41.53	32.71	21.96	14.02
Year			Age		
2011-12	60+	60-64	65-69	70-74	75+
Participation (in per cent)	21.8	29.9	122.54	17.29	5.95

Source: Employment and Unemployment Surveys of NSSO of India, 1983 and 2010–2011

It could hence be inferred that the rate of economic participation among the elderly in India fluctuates under the influence of variables like gender, level of education, area of residence, level of income etc. There is an inverse relationship in general between education, economic security and better living conditions and non participation in economic activities.

Kerala: A Case Study as the Pre Cursor of Future India

The state of Kerala is one of the most advanced states in India. It has HDI indices at par with many developed nations and the elderly in Kerala enjoy better standard of living than mos of the other states in India. Kerala has the maximum number of elderly population in India viz. 12.6 per cent. It also enjoys the highest life expectancy, i.e. 71.8 years, in India. (Ministry of Statistics and Programme Implementation Government of India, 2016). The normal age for retirement in Kerala ranges from 55–65 years. Pension payments from the state's own revenue was as high as 28.5 per cent in Kerala – the highest revenue expenditure for the same in India – during 2004–05. (Rajan, 2010). It hence could be assumed that Kerala could be a miniature of what India could look like in the future regarding standard of living and human development indices. However one of the alarming trends shown by the elderly community of Kerala is in fact regarding active economic participation. The old age dependency ratio among the elderly of Kerala is as high as 19.6 per cent – the highest in India. (Ministry of Statistics and Programme Implementation Government of India, 2016). It could be argued that this could be due to the high life expectancy in Kerala and associated health issues of advanced old age (70+). But the data from the National Sample Survey – 68th round proves it otherwise. The Worker Population Ratio (WPR) for both the age group 60–64 and 65+ are much lower for Kerala when compared to the national average. The WPR for Kerala is only 584 and 384 per thousand persons for the age group 60–64 and 65+ respectively compared to the national average of 810 and 523 respectively. (NSSO 68th Round, 2011–2012).

This trend could be identified as a precursor of what could happen to India in the decades to come if India progresses in a steady rate in Human Development Indices. Once the quality of life and

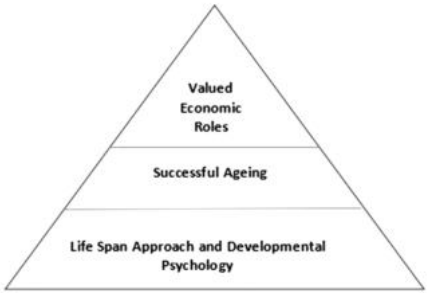
standard of living of the elderly improve and they attain social security they tend not to carry out the economic roles. This could be a major blow to the economy of the nation and active ageing of the individual himself/herself; as well as a poor strategy of integrating the elderly into economic roles. Setting apart ill health as a reason for this reluctance to participate in economic activities, the possible reasons could be poor job satisfaction, absence of jobs that suit the skill, lack of social acceptance, ageism, inability to adjust with the schedule and poor availability of job opportunities from a subjective point of view (Von Bonsdorff, 2009; (Aristovnik A. and Ksenja J., 2013) and competition from youngsters, unfeasible work schedule and dearth of opportunities from an economic point of view. The trends that favour the economic participation of elderly in economic roles from a social perspective are not encouraging in the current scenario. This could not be tackled from a mere economic perspective; but requires social re-engineering as well.

Towards a Socio-Economic Model of Integrating Elderly into Community

The analysis of the empirical data suggests some interconnections between the variables identified and the participation of elderly in the economic activities. It is evident that there are factors other than economic nature that leads to non participation of elderly in economic roles. The standard of life of elderly in India, especially the urban elderly, is steadily improving which is a great achievement; the quality of life of rural elderly will also see significant improvements in the decades to come. On the flip side, this rise in some particular aspects of the standard of living is seen to be somehow associated with a decline in elderly participation in economic activities. This could be an indicator of how our economy is unable to create job opportunities that suits the strengths and weaknesses of elderly on one hand and on the other the elderly are unwilling to take up economic roles that do not satisfy, suit or embrace their strengths and weaknesses. Hence a dual approach of creating economic roles that suit the elderly and making these roles socially valued and respected is necessary.

Valued Economic Roles: A New Paradigm to Integrate Economic and Social Aspects towards Successful Ageing

With the aim of successfully integrating the individual and social realms of the elderly concepts are drawn from life span approach, developmental psychology and successful ageing to propagate a socially valued and individually beneficial model of economic participation. The framework could be conceptualised as a pyramidal structure.



Life Span Approach and Developmental Psychology: The Foundation for Integration of Elderly into Economic Workforce

Life span approach is one of the major themes in developmental psychology and life is divided into different phases based on age categories in this approach. Life span approach in developmental psychology stresses on the importance of developmental tasks that are crucial in promoting healthy development of an individual across different life spans. The idea of developmental task was introduced by Havighrust (1953) which he defined as one that arises predictably and consistently at or about a certain period in the life of the individual attaining which is important in progressing to the next stage of life. It is the midway between an individual need and a social demand; an integrating factor between personal motivation and social requisites. (Ibid.). Two of the tasks that are specific to old age as enlisted by Havighrust relevant in the context of economic participation are 'adjusting to retirement and decreased income' and 'meeting social and civil obligations'. With the changing global scenario of improvements in standard of living and the trend of population ageing these tasks should be reinterpreted as per the need of the times. Adjusting to retirement could positively be interpreted as not a cessation of work but a rescheduling of the work patterns and working in one's capacity

to remain active during the process of ageing. The rescheduling of work and working as per one's capacity will facilitate a counter mechanism to sudden cessation of income and thus help the individual to compensate the reduction in income to a great extent. The other developmental task viz. Meeting civil and social obligations should be reinterpreted in the changing global scenario of population ageing. The elderly constitute a considerable portion of the population and the economy and consequently the development of the nation look forward to its workforce. The participation of able elderly in the economic force could contribute to better status of the nation. Hence it would turn out that emancipating the nation is a social as well as civil obligation in the wider picture.

Successful Ageing: The Model to Integrate Subjective and Objective Aspects of Integrating Elderly into Economic Roles

Having placed economic participation as an obligation as well as an activity contributing to the welfare of the individual elderly as the foundation we look into models for successfully carrying out the same. It is then that the concept of successful or active ageing comes into play. Successful ageing as put by Rowe and Khan (1997) includes " ... three main components: low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life ... successful ageing is more than absence of disease, important though that is, and more than the maintenance of functional capacities, important as it is. Both are important components of successful ageing, but it is their combination with active engagement with life that represents the concept of successful ageing most fully." Successful ageing was reappraised as active ageing by WHO and it was defined as " ... the process of optimising opportunities for health, participation and security in order to enhance the quality of life as people age" (WHO 2002). The idea of successful ageing has three domains and each of the domains are crucial in ageing successfully. However, in the context of economic participation the domain of 'active engagement' turns out to be quite important. Active engagement with life has two major elements viz. 'maintenance of interpersonal relationships' and 'productive activity' (Rowe, and Kahn, 1997). The latter could be instrumental in helping elderly perform economic roles while feeling personally staying healthy in the process of ageing. It is found that contrary to the

popular belief the elderly make productive contributions; often as unpaid voluntary work. (Americans Changing Life Survey, 1994). Further it was found in a 2007 study among working elderly that 48.1 per cent of the working elderly in the USA show low likelihood to involve in paid work, 35.4 per cent of them showed very low likelihood of participation in economically productive activities, 14.9 per cent showed a moderate likelihood of engaging in paid work and only 3.6 per cent were actively involved in economically productive activities. (Jeffrey *et. al*., 2007). It is clear that elderly engage in productive activities but the number of elderly working in economically productive activities comparatively less. If the productive activity of elderly could be used in such a manner that they are economically productive as well it could be a great boost to the economy while contributing to healthy ageing and improved life standards of the elderly. It is at this point that the concept of 'valued economic roles' comes into play.

Valued Economic Roles: The Means to Integrate Elderly into Economic Roles

'Valued social roles' was a holistic term introduced by Wolfensberger through the framework of 'Social Role Valorization' which involves bringing about positive changes in the lives of disadvantaged population. (Wolfensberger, W., 1983). The fundamental notion behind role valorising is that better life is accessible to people who enjoy valued social roles and those with devalued social roles find it tough to attain a better life. In short if a person is in a valued social role he/she could experience a positive integration into the community. There is a triad of opportunities that valued social roles offer viz. acceptance, belonging and contribution. (Schultz, B. and Held, R., 2014). These three opportunities help the individual to attain personal satisfaction and at the same time can contribute to the progression of the community. Old age is often associated with 'devaluation'; often ascribed with negative social roles like senility, dependency etc. (Ibid.) which could lead to lesser 'active engagement with life' which would in turn be an impediment to active ageing. However, if we are able to promote the idea of valued social roles in our community we could easily integrate elderly into the mainstream of the society successfully while benefiting them personally, as well as bringing about larger community welfare as well.

Within the framework of valued social roles we could formulate the idea of 'valued economic roles' wherein elderly are able to perform economic roles in such a manner that they are able to engage in economically productive activities which provide them the triad of benefits viz. acceptance, belonging and contribution. By valued economic roles what is envisioned is a set of economic roles newly formulated or already existing economic roles that are reformulated in such a framework that the elderly are able to participate in economic roles in their own terms without being devalued. The contribution of elderly should be dignified as real contribution to the economic framework of the community. Hence the subjective aspects that elderly consider important for participating in economic roles should be given due importance for promoting valued economic roles; this would involve flexibility in working hours, working pattern, nature of work, job satisfaction, dignity and decent pay. 'Valued economic roles' should not be confused with mere 'economic participation'; it is not just making elderly participate in labour force but it involves creating an atmosphere where the community facilitate a 'fully belonging' feel to the elderly by making them actively involve in productive activities including economically productive activities. In short 'valued economic roles' can help the elderly to transform from mere passive clients to active contributors which can positively influence their psyche and hence facilitate successful ageing of the individual as well as facilitate growth of the community. Interventions at policy level, community level and individual level are required in order to facilitate valued economic roles for elderly so that integration of elderly into economic force may be possible.

Conclusion

The study analysed the trends in participation of elderly in the economic workforce against the background of population ageing and it was found that elderly participation in economically productive activities is on a decline as the level of education, area of residence, standard of living and other positive amenities rise. This trend could adversely affect India as the standard of living of the elderly and population ageing are on a rise in India which is expected to attain many bigger feats in the decades to come. The elderly population that forms a large chunk of the population and those with the potential and

zeal should be successfully integrated into the economic picture of the nation without compromising the quality of life they enjoy. Such a task could be attained through a framework wherein the subjective demands of the well being of elderly should holistically be met while making them active economic participants in the society. This task of integrating both the subjective and objective aspects is attempted to be conceptualised by integrating approaches from developmental psychology, life span approach, successful ageing and social role valorisation. Having placed life span approach and developmental psychology as the objective foundations to attain the aim, the concept of successful ageing is adapted as a model wherein elderly can subjectively seek their well being while actively contributing to economic productivity. This model could be realised through the means of 'valued roles' which involves providing opportunities to the elderly citizens to make contributions that are valuable to society through means that are dignified and are in unison with their special requirements. This conceptual framework requires further studies to explore more possibilities of integrating elderly into economic roles through policy level, community level and individual level interventions. Further, studies are also required to categorically analyse the nature of economic participation across genders, trends in this framework could possibly serve as a platform for transcending the nature of economic roles of elderly while contributing to successful ageing of the individual; as well as tackling the challenges raised by population ageing and thus contribute to personal and community well being.

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Developing Healthy Defence Mechanisms as Effective Coping Strategies in Elderly

Devshree
Indian Institute of Psychology and Research, Bangalore

ABSTRACT

The focus in this paper is on the effective coping strategies which can be used for healthy functioning (or positive ageing) of the elderly without undergoing stress and inner conflicts. It also discusses coping strategies and suggests effective coping strategies by means of healthy defense mechanisms, i.e., humour, intellectualization, sublimation etc. Understanding and developing these healthy defence-mechanisms will contribute to mental well-being and successful ageing in elderly.

Keywords: Healthy ageing, Coping strategies, Defence-mechanisms, Problem-focused coping strategy

Gero-psychology, a branch of psychology, addresses the concerns of elderly. It is the specialized field of psychology which examines the biological, psychological, behavioural, and social aspects of ageing. It applies the knowledge and methods of psychology to better understand and help older adults and their families in maintaining well-being, overcoming problems and achieving maximum potential during later life. The science of gero-psychology further presumes that these ageing processes are iterative and interactive; taking form within a context/environment that influences outcomes and experiences (APA, Committee on Ageing, 2009). Geriatrics, being the study of old

age (age 60 and above), studies the preventive measures, diagnosis and treatments of disorders affecting old age people. Ageing is a multidimensional process and refers to the process of "...accruing maturity with the passage of time." It begins with conception and continues throughout life until death occurs. Ageing is progressive, ubiquitous and inevitable to all living beings (Misiaszek, 2008). It consists of at least three different processes: primary, secondary and tertiary ageing. Primary ageing is referred to normal, disease-free development during adulthood. Secondary ageing is related to developmental changes that are related to disease, lifestyle, and other environmentally induced changes that are not inevitable. Tertiary ageing is about the rapid losses that occur shortly before death. Ageing can bring on significant physical and psychological changes in an individual, the way these changes are dealt with determines the good or poor personal and social adjustments in elderly. The physical changes or the medical needs can be taken care of up to a good extent, what seeks more attention are the psychological changes a person goes through.

Developmental Tasks

As every human being is a part of society, there are social expectations for every stage of development. Every cultural group expects from its members to master certain essential skills and acquire certain patterns of behaviour at various ages during the life span. Havighurst (1972), has labeled them as developmental tasks. He defined these developmental tasks as "a task which arises at or about a certain period in the life of the individual, successful achievement of which leads to happiness and to success with later tasks, while failure leads to unhappiness and difficulty with later tasks." These tasks enable individuals to know what society expects of them at given ages, and motivate individuals to do what social group expects them to do at certain ages during their lives. The developmental tasks which Havighurst gave for old age includes the following:

- Adjusting to retirement and reduced income
- Adjusting to death of spouse
- Adjusting to decreasing physical strength and health
- Establishing satisfactory physical living arrangements

- Establishing an explicit affiliation with members of one's age group
- Adapting to social roles in a flexible way

Any cause or factor which interferes with individual's mastery on these developmental tasks may be regarded as potential hazard. These potential hazards can lead to inappropriate expectations and crises due to tension and stress of mastering these developmental tasks.

These developmental tasks given by Havighurst are crucial determinants of individual's adjustment in old age, the ability of an individual to master these tasks successfully can bring happiness or vice versa. The major consequence of unsuccessfulness on these developmental tasks is unfavourable self-judgments, which in turn lead to unfavorable concepts of self.

Coping Strategies

As we focus on the aging process through a cultural lens, this changing racial and ethnic minority population will represent unique groups of individuals. As culture has affected their lifetime experiences, it will also affect their aging experiences (Jackson, *et al.*, 2004). During the old age, older adults undergo numerous problems which influence their mental and emotional well-being, they tend to have negative outlook towards self and other people. These unfavorable attitudes toward self, other people, work and life in general can increase the likeliness of an individual to become depressed and disorganized. As a result, decline in their physical and mental health can be observed. How the individual strategize to cope with the stressors will also affect the rate of decline. Motivation becomes one of such important factors which plays significant role in decline. This intensity of decline varies by the method used for handling the distress causing factors, it can give positive and healthy outcome as well as negative and deteriorating outcomes in an individual's life. When physical, personal, social, cultural factors increasingly affect the mental well-being in old age, the psychological state is extremely deteriorated and people tend to find alternatives to fight such factors. Accepting the failure of weak alternatives is then replaced by developing coping strategies which can help the person in dealing with the problems/issues/situations without harming the self and hurting the

emotional well-being of self. Lazarus and Folkman (1984) suggested that there are mainly two types of coping strategies, namely, problem focused coping strategy and emotion-focused coping strategy. Problem-focused coping strategy deals directly with the problem which causes the distress, and the effective coping enables the person to get rid of the problem or helps in minimizing the effect of the problem. On the contrary, emotion-focused coping strategy works in a very different way. In emotionfocused coping strategy, the person actually avoids the factors/stressors/situations which cause the problem and try not to respond to these problems. It is found that emotion-focused coping strategy is ineffective as it does not deal with the root cause of the problem and merely avoids the problem (Penley *et al*., 2012). Gender differences have also been reported; women tend to use more emotion-focused strategies than men (Billings & Moos, 1981). The problem-focused coping strategies are found to be more beneficial and highly effective. Problem-focused strategies work well when the source of stressor is in control. Optimistic people who tend to have positive expectations of the future are more likely to use problem focused strategies, whereas pessimistic individual are more inclined to use emotion-focused strategies (Nes & Segerstrom, 2006). The defense mechanisms used by people across different age groups are actually coping strategies. These defense mechanisms, either immature or mature, both work unconsciously to satisfy the ego of the individual, eventually helping the person to survive life's complex situations and problems.

Defence-Mechanisms

A very common coping strategy people opt for satisfying their complexes, idiosyncrasies, thoughts and emotions, is the so called defense mechanisms. Defense mechanism is any enduring pattern of protective behaviour that functions to provide a defense against the awareness of anxiety producing stimulant. Sigmund Freud introduced the concept of defense mechanisms and initially gave seven defense mechanisms, Projection, Reaction Formation, Undoing, Displacement, Isolation, and Denial. Later, Freud added sublimation to this given list of defense mechanisms. These defense mechanisms were then mainly outlined and studied by Freud's daughter, Anna Freud, who was a psychoanalyst (Freud, 1946; Benjafield, 1996). It is

the process by which ego unconsciously defends itself against undesirable thoughts, feelings, or impulses. These psychological defense mechanisms are ways of dealing with stress through unconsciously distorting one's perception of reality.

Also, the notion behind the use of defense mechanisms is to reduce the anxiety and guilt. (Freud, 1946). According to the psychoanalytic theory of Sigmund Freud, there are three components of structure of personality, namely, id, ego and superego. Id is the instinctual drive; works on pleasure principle and always seeks fulfillment of desired things. Ego, the rational part of personality; works on reality principle and tries to maintain balance between id and the superego. Superego is the conscience, ethical or moral attitudes and the sense of should, striking a balance between different dimensions of personality and working on morality principle. The theory firmly states that id's unconscious demands are instinctual, infantile, and amoral, they must often be blocked by the ego and the superego. Due to the rising conflict and persistence of unsatisfied demands, anxiety and guilt are aroused. The person then finds ways to shield the ego from this anxiety and guilt by setting up defenses. The basic role of the ego is in perceiving and adapting to reality, and is called the ego strength, which refers to an individual's capacity to acknowledge reality, even when it is extremely unpleasant, without resorting to primitive or immature defense mechanisms (Bellack, *et al.*, 1973). Freud has given several defense mechanisms by which the ego disguises, hides, redirects, and copes with the id's urges. However, a good number of psychologists hold the view that these mechanisms account for some of the ways people cope with their problems. Thus, these defense mechanisms are generally accepted as a useful way of looking into how people handle stressful situations and conflicts. The perceived controllability of situations is believed to influence the types of coping strategies used, and thus is important in adaptive processes. Elderly individuals are widely perceived to have less control over their environment than other adults. This lack of perceived control should have adverse effects on how they cope with stressful situations. Aldwin *et al.,* (1996) reported that there are no age differences in perceived stressfulness of the problem, appraisals of harm/loss, or helpless appraisals, number of emotions reported, or coping efficacy in

different age groups considering from adolescents to older adults. The major issue they found is that even after probing, nearly a quarter of the old adults reported having no problems and they expended less coping efforts even when they did have problems. It can be interpreted from these results that the nature of stress changes with age, from episodic to chronic, which in turn affects appraisal and coping processes in people.

Older adults are more likely to describe a co-occurrence of positive and negative emotions, but less likely to describe the simultaneous experience of multiple negative emotions (Lockenhoff, *et al.*, 2008). A study by Diehl *et al.,* (1996), based on age and sex differences in the use of coping and defense strategies examined a sample of 381 participants. It was found that

Older adults used a combination of coping and defense strategies indicative of greater impulse control and the tendency to positively appraise conflict situations. Women used more internalizing defenses than men and used coping strategies that flexibly integrated intra- and interpersonal aspects of conflict situations. Thus, it suggests that men and women may face different developmental tasks in the process toward maturity in adulthood as per their choice of coping strategies and defense mechanisms.

Hunt *et al.,* (2003), conducted a comparative study among older adults and younger adults to study nature and intensity of worry along with their coping methods to worry. They found that on the individual subscales of health, family concerns, and world issues older adults expressed significantly more worries than younger adults. The results support the notion that older adults report relatively low levels of worrying when compared with the younger population. It is also being witnessed that locus of control is directly associated to the perception of problems and coping strategies used by people. Several researches provide evidence for the role of locus of control in determining the nature of coping strategy or defense mechanism used by people. People who attribute what happens to them to internal and controllable causes use more coping strategies focused on the problem than people who put forward external causes. In a study on locus of control and coping behaviour in elderly, the results showed that advancing age, contrary to the main intercultural injunctions, was

linked to an increasing belief in external factors regulating life events and with an emotion-focused coping of avoidance type when facing any stressor. It is the adaptation of the self to the world by managing the feelings, which seems gradually to prevail during aging and could contribute to difficulties in adjustment of the elderly (Denoux, and Macaluso, 2006).

Defense mechanisms are cognitive processes that function to protect the individual from excessive anxiety or other negative emotions. They also protect the person from loss of selfesteem and, in the extreme, the loss of self-integration. Recent research by (Cramer, 2008) has supported seven basic tenets regarding defenses. These include:

1. Defenses function outside of awareness;
2. There is a chronology of defense development;
3. Defenses are present in the normal personality;
4. Defense use increases under conditions of stress;
5. Defense use reduces the conscious experience of negative emotions;
6. Defense function is connected to the autonomic nervous system;
7. Excessive use of defenses is associated with psychopathology.

It has been evident from the several research studies that the perception of controllability, effective coping strategy and defense mechanism employed are all age based and are developed differently in different age population. Generally, elderly tend to use immature or negative or unhealthy defense mechanisms, which works on escapist approach and only provide distress and emotional vulnerabilities. Most of the classical defense mechanisms described in the psychoanalytic literature represent a form of cognitive distortion with some containing strong elements of dissociation. It has been observed that reaction formation, isolation, and denial have been amply shown in studies, and they do seem to serve defensive functions. Undoing, in the sense of counterfactual thinking, is also well documented but does not serve to defend against the threat. Projection is evident, but the projection itself may be a by-product of defense rather than part of the defensive response itself. Displacement is not well supported in any

meaningful sense, although emotions and physical arousal states do carry over from one situation to the next (Baumeister, 1998). It is seen that increase in ego level are associated with increased use of the defense mechanism intellectualization and decreased use of the defense mechanisms of doubt and displacement.

Kimsey *et al.*, (2006), in an indirect questioning with two dissimilar elderly groups found that they reported little fear of death or dying. In producing Thematic Apperception Test stories, however, respondents who were well and autonomous used less denial and expressed more affect than did those who were sick and dependent. Thus, it provides the evidence that aging per se does not result in psychological regression. But denial and constriction of affect are used by the elderly when awareness of their deterioration and dependency compels them to face the dying process.

Defense mechanisms as above mentioned do not give any healthy effect to individual if overly used, it is essential that healthy defense mechanisms also should be used to a certain limit. Mature, higher order or intellectual defense mechanisms are considered to be healthier as compared to the one's mentioned before. They are socially adaptive and useful in the integration of personal needs and motives, social demands, and interpersonal relations. They can underlie seemingly admirable and virtuous patterns of behavior. These mature defense mechanisms are healthy and adaptive throughout the life cycle (Sadock, *et al.*, 2015). These include intellectualization, rationalization, moralization, reversal, identification, sublimation and humour.

Intellectualization is a mature and healthy defense mechanism and it controls the affects and impulses by way of thinking about them instead of experiencing them. It is a systematic excess of thinking, deprived of its affect, to defend against anxiety caused by unacceptable impulses. The individual who uses intellectualization as a defense mechanism talks about feelings in a way that strikes the listener as emotionless. The persons accept the idea of what s/he is feeling and inhibits the expression of those feelings. Intellectualization handles ordinary emotional burden, and shows considerable ego strength to think rationally in an emotionally overloaded situation. As long as the affective aspects of that circumstance are eventually processed with more emotional acknowledgement, then the defense is operating

effectively. It is a healthy defense mechanism as the person who uses intellectualization actually is able to behave in a mature way under stress rather than giving an impulsive, kneejerk response. Thus, it can be used as a healthy defense mechanism by elderly to overcome the problems of old age and leading towards a successful life.

Rationalization is a justification of attitudes, beliefs, or behavior that might otherwise be unacceptable by an incorrect application of justifying reasons or the invention of a convincing fallacy. It may come into play either when a person fails to get something he desired, and concludes by retrospection that the thing was actually not so desirable. The more intelligent, and creative people are able to wisely use rationalization as a healthy defense mechanism. It works best when an individual is able to make the best out of a difficult situation with minimum resentment. It becomes a poor coping strategy if the individual starts rationalizing anything and everything. Hence, if used appropriately, rationalization is considered a most mature defense mechanism across all age groups.

Moralization, is similar to rationalization with a little distinction of working principle involved. Rationalization works on ego principle and moralization is dominated by superego. A moralizer, who uses moralization as a defense mechanism tends to feel that it is his/her duty to do the thing. He categories it into the morally justified deed and pursues his way towards its accomplishment. These mechanisms are well portrayed in theories and require wise adaptation to function properly, over usage of these defense mechanisms can be troublesome for the individual as it will only intensify the problem behavior.

Altruism is the vicarious but constructive and instinctually gratifying service to others, even to the detriment of the self. This is different from altruistic surrender, which includes a masochistic surrender of direct gratification or of instinctual needs in favour of fulfilling the needs of others to the detriment of the self, with vicarious satisfaction only being gained through introjections. It can precisely be called an act of goodwill towards another person, and mainly used as a way of diffusing a potentially anxious situation.

Anticipation as a healthy defense mechanism is found to be very effective, if used appropriately. The realistic anticipation of or planning for future inner discomfort, it implies overly concerned

planning, worrying and anticipation of dire and dreadful possible outcomes. The anticipation of a potentially stressful event is one way a person might mentally prepare for it. It might also involve rehearsing possible outcomes in one's mind or telling oneself that it will not be as bad as they imagine. It is evident that people tend to do better at highly anticipated events. The mind is actually preparing hard to lower down the anxiety and it actually works in a healthy way, if used in a mature way.

Asceticism is the elimination of directly pleasurable affects attributable to an experience. The moral element is implicit in setting values on specific pleasures. It is directed against all basic pleasures perceived consciously and its gratification is achieved through renunciation. It has its origin from religious traditions from Hinduism and Buddhism, and it has been divided in 'Natural asceticism' which consists of utmost simple lifestyle with least materialistic aspects but without maiming the body or harsher austerities that make the body suffer, and 'unnatural asceticism' which is defined as a practice that involves body mortification and self-infliction of pain. Max Weber made a distinction between innerweltliche and ausserweltliche asceticism, which means (roughly) "inside the world" and "outside the world", respectively. 'Inner – or Other-worldly' asceticism as practiced by people by withdrawing from the world to live an ascetic life. 'Worldly' asceticism refers to people who live ascetic lives but do not withdraw from the world. It can be commonly seen in elderly; majority of elderly population adopt this mechanism as a coping strategy to attain successful aging and peaceful end to their life.

Sublimation allows instincts to be channeled rather than diverted or dammed up. The gratification of an impulse whose goal is retained but whose aim is changed from a socially objectionable one to a socially valued one. This libidinal sublimation involves a desexualisation of drive impulses by placing value judgment which substitutes what is valued by superego or society, that is, the primitive libidinal impulses are redirected and refined into new, learned and non-instinctive behaviours. Freud himself suggested that there was one positive defense mechanism, and that is sublimation. It acknowledges the feelings, modifies and directs them toward a relatively significant person or goal so that modest instinctual satisfaction can be obtained.

Sublimation is the most successful defense mechanism because it channelizes the instinctual energy into socially acceptable endeavors without blocking the energy (Fenichel, 1945). Freud also believed that creativity is actually a sublimated form of sexual impulses. As sublimation is considered the most positive and successful defense mechanism among all, it can be easily and successfully adopted or developed for a healthy sustenance of life.

Suppression is the conscious or semiconscious decision to postpone attention to a conscious impulse or conflict. It is the effort made by the individual to hide and control unacceptable thoughts or feelings. Suppression of thoughts and emotions is something which happens consciously and people may be entirely aware that they are attempting to suppress their anxieties. It involves successfully attempting not to think about a memory or feeling – a person may try to think of another subject when an uneasy thought enters their mind or they might preoccupy their minds by undertaking an unrelated task to distract themselves.

Humor is the overt expression of feelings without personal discomfort or immobilization and without unpleasant effect on others. George Vaillant described the use of humor as a "mature" defense mechanism – a primarily adaptive technique to help us to cope with tense or stressful situations. Looking for a funny aspect in an environment in which people lack control can help them to endure it, and can even be an altruistic act in helping others to better cope as well. It allows the individual to bear, and yet focus on, what is too terrible to be borne, in contrast to wit, which always involves distraction or displacement away from the affective issue. It can actually be called as a subtype of sublimation; it maximizes the individual's capacity to tolerate psychological pain. The extreme version humor is called 'gallows humor' which is used by people as a mechanism to survive life's grimmest realities. Humor is a positive defensive and a little sense of humor in acknowledging harsh realities of life, transforming the sorrow and pain in pleasure, capacity to laugh at one's own idiosyncrasies, is the core element of mental and emotional well-being. Humor, along with abovementioned mechanisms can be considered a most healthy defense mechanism.

Hence, practice of the abovementioned defense mechanisms like intellectualization, rationalization and moralization requires more care. The other healthy defense mechanisms like suppression, sublimation, altruism, anticipation, asceticism and humor can be wisely used by geriatric population for effective coping and successful aging. Further empirical data can also be obtained to provide support to mature or healthy defense mechanisms and coping strategies.

Limitations

Coping strategies are widely used by people across all age groups, and defense mechanisms are the most widely employed coping strategy, but there are certain limitations to its successful use. Firstly, there is vast research evidence about negative defense mechanisms in elderly, but evidence for healthy defense mechanisms adopted in geriatric population is very low. The lack of empirical support to the vast and renowned literature of defense mechanisms is the major limitation. Secondly, healthy defense mechanisms act as effective coping strategies unless over used.

Conclusion

The geriatric population undergoes immense complexities of old age which involves biological, psychological, and social problems. These concerns eventually affect their mental and emotional well-being to such an extent that it becomes tough to maintain personal and social relationships and affects their personal as well as social adjustments. To overcome these issues, they tend to use coping strategies in order to function well. By settling for immature defense mechanisms as coping strategy they eventually end up in creating more complexities for themselves. The need of developing healthy defense mechanisms is prominent and various healthy defense mechanisms are discussed in reference to their meaningfulness to geriatric population. The importance of such defenses is underlined in this study and need for further research in this area is required to gain stronger evidence to show the importance of healthy defense mechanisms as effective coping strategies in elderly.

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A Comparative Study of Health Problems and Disease Pattern among Elderly in Urban and Rural Areas

KumKum Kumari Sharma

Post Graduate Deptt. of Home Science,
J.D. Women's College, Patna (Bihar)

ABSTRACT

The paper describes the results of a comparative study to examine the health and related problems faced by elderly in urban and rural areas. Data was collected from representative sample of 300 elderly from both the areas. 150 elderly were selected from five villages of the rural area and similar number of respondents were selected from five wards of urban area of Patna district. The results revealed that in rural area, elderly men suffered more from heart trouble, stroke, depression, tuberculosis, kidney disease and nervous disorders. On the other hand rural elderly women have more of hypertension, diabetes, arthritis, gastro-intestinal disease, respiratory disease and skin disease. Gender wise differences were observed among the problems relating to physical health reported by the respondents. Similarly hypertension/B.P., arthritis, gastro-intestinal disease, skin disease were more commonly mentioned by elderly women both in urban and rural areas. It was also found that a very large number of them were getting medical assistance from their sons both in urban and rural areas respectively. Some of them also got medical assistance from daughters both in urban and rural areas respectively. Elderly men have more ability to perform

their routine physical works on their own as compared to their women counterparts in urban as well as rural areas. Most of them preferred to spend their old age in their own home. Least preference was given to old age home or similar institutions.

Keywords: Ageing; Problems; Urban and Rural areas.

Old age is a universal phenomenon. With varying degrees of probability, individuals survive childhood, grow to maturity and become old, in all societies. In the Indian context, people who have attained 60 years and above are considered old. With the passage of time, particular changes take place in an organism, leading to morbidities, disabilities, and even death (Kishore S., *et al*., 2007). The needs and troubles of the elderly vary notably according to their age, socio-economic status, health, living arrangements, and background characteristics (Ramakrishna Reddy N., *et al*., 2014). Ageing of a population is an issue of great concern for the health segment. The elderly, as a whole, are less healthy than the non-elderly (Karim H.A., 1997). The health problems are acknowledged to increase with age, and this demographic trend may lead to enhance the absolute number of health conditions in the population.

The aged population has unique health problems that are different from those of adults or young. The majority of diseases in aged are chronic in nature such as cardiovascular diseases, arthritis, stroke, diabetes, cataract, deafness, cancer, and chronic infections. Most often, elderly may undergo multiple chronic situations, visual defects, hearing impairment, and deterioration of speech which can cause social isolation. In addition, because there is a growing body of evidence that older people are at risk of multiple morbid conditions, health-care seeking will probably also increase (Kumari R., 2001).

Objectives of the Study

1. to find out the health problems commonly faced by elderly people.
2. to trace the common socio-economic and psychological problems of the aged people in urban and rural area.
3. to find out elderly's preferences in spending their time (leisure time activities).

4. to find out the problems commonly faced by elderly women.

Methodology

The sample consisted of 300 elderly people (aged 60 years and above) selected by using stratified random sampling method, equal in number from rural and urban areas. Five villages from one Block of Patna and five wards from Municipal area of Patna city were randomly selected. For the selection of the respondents lists were prepared from the voter lists of these rural and urban areas.150 elderly from each area were selected randomly. Questionnaire/interview schedule was prepared to collect information from the respondents. The questionnaire contained the questions regarding the financial assistance for medical care, ability to perform physical work, preference in spending old age and various health problems faced by them. Simple arithmetic mean was calculated to interpret the results.

Findings and Discussion

Table 1

Prevalence of medical illness of elderly people by urban-rural residence

Medical illness	*Urban*		*Rural*	
	No.	*Percentage*	*No.*	*Percentage*
Hypertension/B.P.	69	46.0	36	24.0
Diabetes	47	31.3	30	20.0
Arthritis	47	31.3	34	22.7
Heart trouble	54	36.0	34	22.7
Gastro intestinal disease	37	24.7	39	26.0
Respiratory disease	22	14.7	42	28.0
Skin disease	17	11.3	34	22.7
Stroke	3	2.0	21	14.0
Depression	17	11.3	25	16.7
Tuberculosis	01	0.7	22	14.7
Kidney disease	05	3.3	24	16.0
Nervous disorders	17	11.3	28	18.7

Table 1 'A'
Prevalence of medical illness of elderly people by sex

Medical Illness	*Urban*				*Rural*			
	Male		*Female*		*Male*		*Female*	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Hypertension/B.P.	30	37.5	39	55.7	21	22.8	15	25.9
Diabetes	26	32.5	21	30.0	18	19.6	12	20.7
Arthritis	15	18.8	32	45.7	18	19.6	16	27.6
Heart trouble	25	31.3	29	41.4	23	25.0	11	19.0
Gastro intestinal disease	12	15.0	25	35.7	20	21.7	19	32.8
Respiratory disease	12	15.0	10	14.3	24	26.1	18	31.0
Skin disease	08	10.0	09	12.9	19	20.7	15	25.9
Stroke	03	3.8	–	–	14	15.2	07	12.1
Depression	14	17.5	03	4.3	16	17.4	09	15.5
Tuberculosis	01	1.3	–	–	16	17.4	06	10.3
Kidney disease	04	5.0	01	1.4	15	16.3	09	15.5
Nervous disorders	07	8.8	10	14.3	18	19.6	10	17.2

Table 1 shows the details of health problems of urban and rural elderly. In urban area 46 per cent of the elderly suffered from hypertension, percentage of urban females having hypertension was 56 per cent. 31.3 per cent elderly (both sexes) were reported with Diabetes and 32.5 per cent male elderly suffered from diabetes. 45.7 per cent female elderly were suffering from arthritis. 36 per cent of all urban elderly had heart trouble, whereas 41.4 per cent female elderly and 31.3 per cent male elderly in urban setting had Heart problems. 41.4 per cent urban elderly suffered from gastro intestinal disease in which 35.7 per cent female elderly reported with this problem. 15 per cent elderly were suffering from Respiratory disease. 10 per cent male and about 13 per cent female elderly were suffering from skin disease, the problem was almost equal among both sex, and only 3.8 per cent and 1.3 per cent male were reported stroke and tuberculosis. 17.5 per cent elderly were reported with depression the problem being more widespread among male compared to female elderly, and only 5 per cent male and 1.4 per cent female had kidney problem. 8.8 per cent male and 14.3 per cent female were suffering from nervous disorder. Beside among urban elderly 11.3 per cent suffered with tuberculosis, 11.3 per cent have skin problems and 3.3 Uri-nary infection cases respectively.

Among rural area, male elderly who suffered from Heart trouble, stroke, depression, tuberculosis, kidney disease and nervous disorders constituted 25 per cent, 17.4 per cent, 16.3 per cent and 19.6 per cent respectively. On the other hand rural females having hypertension, Diabetes, arthritis, gastro intestinal disease, Respiratory disease and skin disease constituted about 26 per cent, 20.7 per cent, 27.6 per cent, 32.8 per cent, 31 per cent and about 26 per cent respectively.

The overall analysis shows that Hypertension, Diabetes and Arthritis were more common among urban elderly, while Hypertension, Arthritis, Gastro intestinal diseases and Nervous disorders were more prevalent among the urban and rural female elderly. Gender wise differences were observed among the problems relating to physical health reported by respondents. Hypertension/B.P., Arthritis, Gastro intestinal disease, and Skin diseases were more commonly mentioned by females in both urban and rural areas.

Table 2

Showing the financial assistance for medical expenses received by urban-rural respondents

Financial assistance for medical expenses	*Urban*		*Rural*		*Total*	
	No.	*Percentage*	*No.*	*Percentage*	*No.*	*Percentage*
No help	47	31.3	50	33.3	97	32.3
Son	57	38.0	61	40.7	118	39.3
Daughter	42	28.0	35	23.3	77	25.7
Siblings	1	0.7		0.0	1	0.3
Neighbour		0.0	2	1.3	2	0.7
Govt. Doctor	3	2.0	2	1.3	5	1.7

Table 2 'A'

Showing the financial assistance received for medical expenses by sex

Financial assistance for medical expenses	*Urban*				*Rural*			
	Male		*Female*		*Male*		*Female*	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
No help	33	41.3	14	20.0	38	41.3	12	20.7
Son	14	17.5	43	61.4	27	29.3	34	58.6

Cont'd...

Cont'd...

Daughter	29	36.3	13	18.6	26	28.3	9	15.5
Siblings	1	1.3		0.0		0.0		0.0
Neighbour		0.0		0.0	1	1.1	1	1.7
Govt. Doctor	3	3.8		0.0		0.	2	3.4
Total	80	100.0	70	100.0	92	100.0	58	100.0

The elderly who suffer from various ailments and physical disabilities do need medical assistance. What type of medical assistance and care they avail is another important area, which needs to be explored. Keeping in mind this the respondents were asked about the major source of medical assistance they received. It was found that a very large number of the them (38%) and (40.7%) were getting assistance from their sons in urban and rural areas respectively. 28 per cent and 23.3 per cent got medical assistance from daughters in urban and rural areas respectively.

Thus, the majority of the respondents in rural and urban area were getting assistance from their sons and daughters. In both the areas, elderly men got more help from daughters; on the other hand elderly women received more help from their sons. One third of the elderly men and women of urban and rural areas did not get any financial assistance from any source.

Table 3

Showing respondents' ability to perform physical work

Ability to perform physical work	*Urban*		*Rural*		*Total*	
	No.	*Percentage*	*No.*	*Percentage*	*No.*	*Percentage*
Can do without any difficulty	121	80.7	100	66.7	221	73.7
Can do with difficulty	26	17.3	42	28.0	68	22.7
Cannot do without help	3	2.0	8	5.3	11	3.7
Grand Total:	150	100.0	150	100.0	300	100.0

Table 3 'A'
Ability to perform physical workUrbanRural

	Male		*Female*		*Male*		*Female*	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Can do without any difficulty	67	83.8	54	77.1	69	75.0	31	53.4
Can do with difficulty	11	13.8	15	21.4	18	19.6	24	41.4
Cannot do without help	2	2.5	1	1.4	5	5.4	3	5.2
Grand Total	80	100.0	70	100.0	92	100.0	58	100.0

It is evident from table 3 that majority (80.7%) of urban and 66.7 per cent of the rural elderly can perform their physical work without any difficulty. However, there is also a significant percentage (17.3 per cent in urban area and 28 per cent in rural area) of elderly who reported that they are able to perform these tasks with difficulty. The elderly, who are not able to attend to their personal tasks such as, ablution, dressing, etc., are usually helped mostly by their family members such as grandchildren, sons, daughters, daughters-in-law and spouse. The data show that the elderly respondents are helped to attend to these needs by their grandchildren, daughters, and spouse in that order. Elderly men have more ability to perform their routine physical works on their own as compared to their women counterparts both in urban and rural areas.

Table 4
Showing number of diseases which are prevalent in the respondents

Age group (years)	*Unit*	*Upto 65 Years*		*66 to 75 Years*		*76 to 85 Years*		*More than 85 Years*		*Total*	
		Male	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
No disease	No.	27	19	9	2	9		1		46	21
	%	34.2	22.1	15.8	6.1	27.3	0.0	33.3	0.0	26.7	16.4
One disease	No.	14	8	10	9	5	1	1	3	30	21
	%	17.7	9.3	17.5	27.3	15.2	25.0	33.3	60.0	17.4	16.4
More than one disease	No.	38	59	38	22	19	3	1	2	96	86
	%	48.1	68.6	66.7	66.7	57.6	75.0	33.3	40.0	55.8	67.2
Total	No.	79	86	57	33	33	4	3	5	172	128
	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

The above table reveals that majority of the male and the female elderly persons have more than one disease among them. Female elderly are more afflicted with these diseases as compared to male elderly. The percentage of elderly having no disease is 26.7 per cent among male and 16.4 per cent among female elderly respectively. It seems that males have less number of prevalent diseases (55.8%) in comparison to female respondents (67.2%). Among males, the prevalence of more than one disease was highest (57.6%) in the age group of 76 to 85 years and among females highest percentage (75%) was in the same age group. The percentage of elderly males and females with no disease was higher in the initial age groups of 60 to 75 years as compared to upper age group of more than 75 years. Thus, younger (among elderly) were more disease free than those with advanced age. Among sexes elderly males were more disease free at advance ages than their female counterpart who start suffering more with the advancement in age.

Table 5

Showing number of respondents having membership in old age clubs and Club activities

Particulars	*Urban*		*Rural*		*Total*	
	No.	*Percentage*	*No.*	*Percentage*	*No.*	*Percentage*
Respondents having membership in Old age clubs	12	8.0	6	4.0	18	6.0

Regarding the respondent's membership in old age clubs and similar organizations, it was found that only 8 per cent of elderly had membership in such organizations in urban and 4 per cent in rural areas respectively.

Table 6

Showing respondents' preferences in their living arrangements

Preference in living arrangements	*Urban*		*Rural*		*Total*	
	No.	*Percentage*	*No.*	*Percentage*	*No.*	*Percentage*
Old age homes	2	1.3	–	–	2	0.7
With sons	40	26.7	49	32.7	91	30.3
With daughters	11	7.3	5	3.3	16	5.3
Own home	97	64.7	94	62.7	191	63.7
Grand Total	150	100.0	150	100.0	300	100.0

The study revealed that majority of respondents from urban (64.7%) and 63.7 per cent from rural area prefer to spend their old age in their own homes. About 27 per cent elderly in urban area preferred to spend their old age with their sons and 7.3 per cent with daughters and in rural area 33 per cent elderly wanted to live with sons and only 3.3 per cent with daughters. It was also found that 1.3 per cent of respondents from urban elderly preferred living in old age homes whereas in rural area no respondents preferred to live in old age home (Table–6).

The preference for living in old age homes (pay and stay homes) among the respondents from urban areas could be due to the higher standard of services and care these institutions provide to elderly people or they have dissatisfaction with their family members.

In India old age care in care houses and old age homes is not a common feature. The preference for living in one's own home could be due to the Indian tradition of people's love for ownership possession as well as for sentimental reasons. Traditionally people in India love to live in their own homes.

Table 7

Showing the problems faced by elderly (respondents)

Problems Faced by Elderly women	*Urban*		*Rural*		*Total*	
	No.	*%*	*No.*	*%*	*No.*	*%*
Rude behavious of Children	20	13.3	33	22.0	53	17.7
Children do not care	29	19.3	40	26.	69	23.0
Children do not visit as often	38	25.3	44	29.3	82	27.3
Economic exploitation by Children	11	7.3	30	20.0	41	13.7
Fear of Death	32	21.3	37	24.7	69	23.0
Feal Dejected	53	35	59	39.3	112	37.3
Feeling lonely	46	30.7	53	35.3	99	33.0
Financial difficulties	36	24.0	54	36.0	90	30.0
Health Problems	84	56.0	94	62.7	178	59.3
Ill treatment in Public places (Buses, queues, hospitals etc.)	31	20.7	48	32.0	79	26.3
Lack of caring attitude by daughter in law	26	17.3	40	26.7	66	22.0

Cont'd...

Cont'd...

Lack of good friends to share feelings	42	28.0	53	35.3	95	31.7
Lack of recreational facilities at home	39	26.0	66	44.0	105	35.0
Lack of emotional support from the spouse	27	18.0	37	24.7	64	21.3
Lack of time to take rest	15	10.0	29	19.3	44	14.7
Nobody to help when sick	36	24.0	46	30.7	82	27.3
Nobody to talk	41	27.3	41	27.3	82	27.3
Physical abuse by Children	12	8.0	22	14.7	34	11.3
Physical abuse by husband	5	3.3	12	8.0	17	5.7
Not able to move around	39	26.0	36	24.0	75	25.0

As many as 20 problems, which are commonly faced in varying degrees by the respondents in their day to day life were identified by the researcher. Old age seems to be very problematic for elderly. The elderly among rural suffer more than their urban counter parts on all the 20 identified problematic issues. Majority of them (60%) suffer from health problems associated with old age. Other important problems faced by them are more of psychological nature such as dejection, feeling loneliness, lack of recreational facilities at home, lack of friends and other company to take care and share their feelings. Some of them also complained about the financial difficulties they are facing and lack of help during their sickness. It is necessary to avoid, mitigate or compensate for the adverse effects of these problems so that elderly, both in urban and rural settings, may lead quality life in their last phase of life.

Suggestions

To address the low intake of calcium, foliate and vitamin C, daily consumption of menu items containing fresh fruit and vegetables (especially green leafy vegetables), whole grains, milk and milk products, should be emphasised. Older people should be encouraged to spend their time in outdoor activities regularly and also increase their physical activities.

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A Study of Health Challenges and Activities of Retired Government Servants of Lucknow City

Neetu Batra
GIRI Institute of Development Studies, Aliganj, Lucknow–226024

ABSTRACT

The paper deals with the health status of retired government servants and its co-relation with their daily activities. Randomly selected 240 retirees (200 male and 40 female retirees) from different colonies of Lucknow city were interviewed individually with the help of standard structured questionnaire. Sex differences were found out in the morbidity pattern and time spent in physical activities. The respondents also reported weak grip strength, exhaustion and slow gait speed. These frailty indicators are the symptoms of ageing. The findings of the study also revealed that status of health of the elderly is positively related with their daily activities.

Keywords: Health, Retiree, Daily activities

The concept of retiree in India is generally associated with the government job. The age of retirement varies in different parts of India from 58 to 65. The event of retirement is a crucial external factor which affects the old people physically, mentally, economically and socially. Changes in social values and norms are causing gradual transformation of social structure and are creating various problems for the senior members of the society. Because of job and education, generally

children are settling in other than home town, giving rise to emergence of more nuclear families. As a sequel, the aged have to depend on their resources rather than depending on family care. Hence, the situational factors which determine the resources of the aged individual to satisfy his needs play an important role in his life.

Health of the aged is a major concern of the society as old people are more prone to morbidity than the young age groups. It is often claimed that ageing is accompanied by multiple illnesses and physical ailments. Besides physical illness, the aged are more likely to be victims of poor mental health, which arises from senility, neurosis and the absence of life satisfaction. Female retirees were less concerned about their health in young age and are now suffering more than their male counter parts. Working outside and managing house hold responsibilities make toll on their health.

Fast social and cultural changes have placed elderly in a highly vulnerable state. Declining social support and failing health expose the aged to various socio-economic problems. Apart from the changes in values, the spurt in the number of elderly is posing economic challenges too before the society. Given this, the problem of ageing appears to be a major issue in present day society. Age-related degenerative changes at social, physical and economic level have an important bearing on adjustment in old age. The situation is further complicated by rapid changes in the social matrix of the society. A healthy lifestyle is also required during old age. But in the Indian context, there exist three different trends that are seriously threatening the chances of meeting such needs. These are a rapidly growing elderly population, the gradual erosion of the traditional joint family system and the inability of the government to sustain the incremental burden of pension expenses for its own employees. Health is the single most important determinant of the quality of life among elderly. The health status of the elderly is determined by a host of economic, social, psychological and physiological factors. With advancing age, ill-health becomes a major hindrance for the well-being of the elderly. Therefore, not only physical but even perceived health is an important predictor for their living happily (Kivinen *et al.,* 1998).

Another important dimension of health is positive personal health behavior. Undoubtedly, personal as well as preventive health

behaviour can ameliorate the health problems among all segments of the population and particularly among the elderly. Some life style behaviours such as smoking, alcohol consumption and chewing tobacco have a direct link with ill-health.

Aged who are living in poverty in India don't have luxury to get adequate health care which is an important determinant of active ageing. Getting good treatment in old age depends upon many factors like socio-economic conditions and public policy.

In this study, the researcher, attempted to know the health condition of the respondent (retirees) through primary sources. Information was collected regarding the perceptions of their own health conditions, their physical ailments and the degree of seriousness of their suffering from ailments and the time spent due to illness after retirement. It was also studied as to how retirees' day to day activities help them to trounce their health hazards of age.

Methodology

In order to approach the retirees to be included in the sample the investigator took the record of pensioners from the treasury office and sorted out retirees of Malviya Nagar, Chowk, Alambagh and Raja Ji Puram of Lucknow city's areas and the addresses of selected retirees were noted down. After investigation the researcher came to know that the total number of retired government servants, age varying from 60 and above, was 1200 in these selected colonies. Finally 240 retirees (200 male and 40 female) were selected as sample of this study.

The tool of the investigation was interview schedule. Other than general questions regarding age, sex, income, more focus was given to their living arrangements, relationship status, health status, and their daily routine in special mention to time spent in activity. Most of the questions were structured and some were open ended. The retirees were interviewed individually.

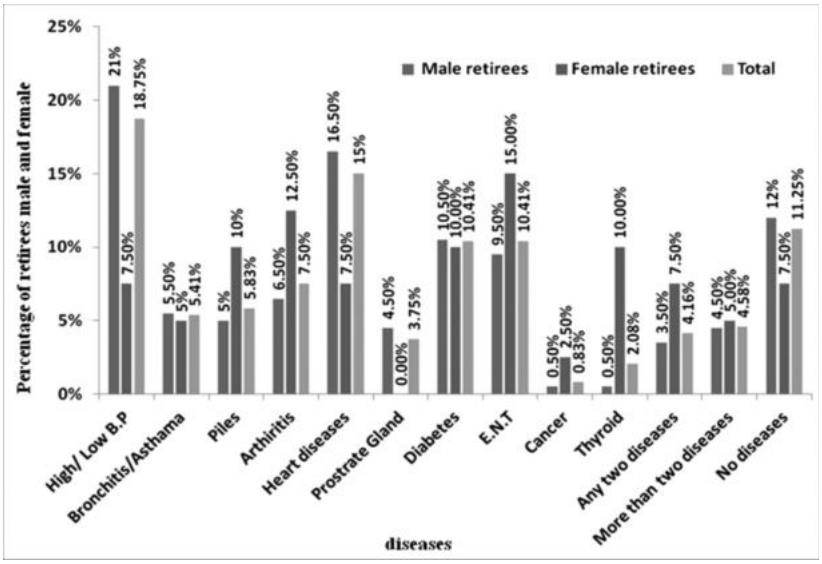
The data was analyzed and percentages and averages were calculated to find out the differences between the respondents.

Findings and Discussion

Old age brings with it a number of health complications for the elderly. Females are more at risk on account of their biological

features. In, females, the crucial periods of their lifecycle are adolescence, childbearing and menopause but for working women it's not possible to take proper care in these crucial periods of their life. Diet and care, which they requires at these special stages of their life, are ignored due to work pressure resulting in bad health in old age. Though working women contribute significantly to the household income, they have to face the burden of household work along with childcare. Such women put in more hours of work to fulfill their numerous responsibilities and have less leisure time causing deterioration in their health.

Figure 1
Disease Profile of Retirees



Disease Profile of Retirees

In order to have first hand information about the respondents' health, they were asked to name the specific disease/s they are suffering from. Figure 1 indicates their disease profile as reported by themselves.

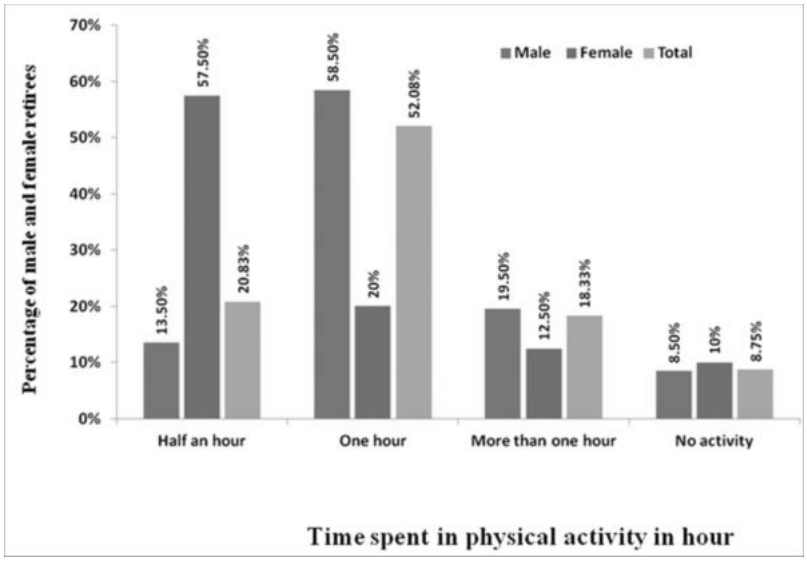
It is clearly evident from the Fig.1, that diseases like blood pressure (21%), heart diseases (16.5%), and prostate gland (4.5%) were

usually found more in male retirees as compared to female retirees. However, arthritis (12.5%), thyroid (10%), piles (10%) and cancer (2.5%) are the most common diseases found in female retirees. Bronchitis and diabetes were found almost in equal measure in both sexes. Only 12 per cent of respondents were found to be disease free whereas this percentage in women was a meager 7.5 per cent. The adverse health condition of female could be explained due to their sex specific complications as childbirth, lactation, menopause etc.

Relationship between Health Status and Physical Activity

Figure 2

Time Spent in Physical Activity in Hour



Physical activity has been found to be effective in the treatment of depression bringing psychological improvement in the health status of aged. As age of retirement itself gives an emotional set back to elderly in feeling unwanted for the society, the physical activity attains greater value in later year adjustment. The self-image hypothesis (Kirkcaldy *et al.,* 2002). suggests that the positive association between physical activity and mental health is (partly) due to the favorable effects of physical activity on body weight and body structure,

resulting in more positive feedback from peer groups, which in turn improves adolescent's self-image, thereby resulting in better mental health The same can be applied for other age groups. The social interaction hypothesis suggests that it is not the physical activity itself but the social aspects of physical activity—that is, the social relationships and mutual support among team members—that contribute to the positive effects on mental health (Vilhjalmsson & Thorlindsson, 1992). It is also well established that physical activity has a protective role on cardiovascular morbidity and mortality, which is thought to be mainly attributable to its favorable effects on traditional risk factors (Skoumas J, *et al.,* 2003). Physical activity, high density lipoprotein cholesterol and other lipids levels, in men and women from the ATTICA study (Ibid).

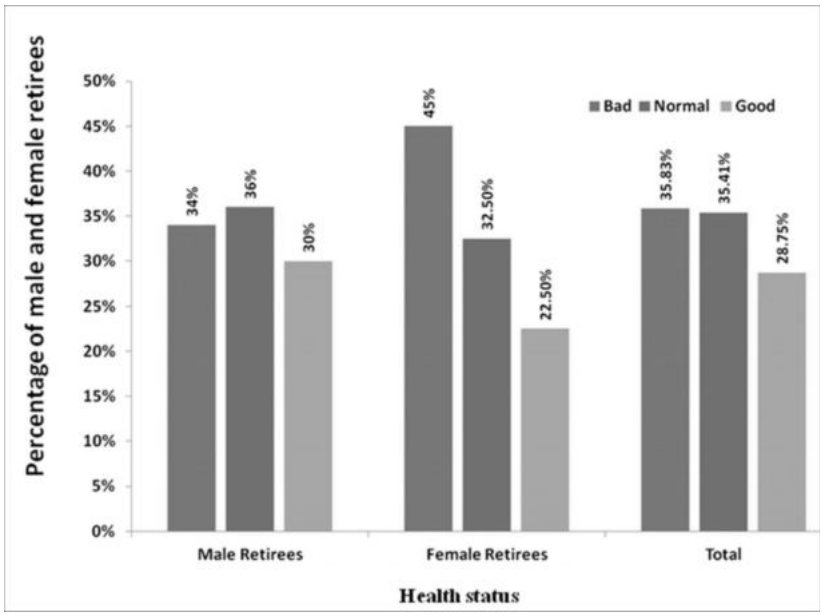
With a view to establish correlation between physical activity and health status of the elderly, the investigator attempted to get from the respondents as to how much time they spend on varied physical activities like exercises, yoga, walk/cycling, meditation, and playing their favorite sport and other common physical activities. To find out their degree of involvement in these physical activities, the time spent daily in these physical activities, is taken into consideration. It was subdivided into four slots/categories, viz; half an hour, one hour, one to two hour and no activity. The respondents were asked how much time they spent in different activities.

Analysis of data in Fig.2 shows that 20.83 per cent of total respondents spared half an hour for outer physical activity like walking etc. Among them, females constituted 46 per cent and males 54 per cent.

On the contrary in the next time slot total 52.08 per cent respondents spared about one hour for physical activity. Among them male and female participation was 93.6 per cent and 6.4 per cent respectively. Slot of physical activity of more than one hour had only 18.33 per cent in all with male 88.6 per cent and female 11.4 per cent, and about 8.75 per cent respondents were found to be not involved in any physical activity. Among them females respondents comprised about 19 per cent and males comprised nearly 81 per cent.

Self Perceived Health Status

Figure 3
Self Perceived Health Status of Retirees



Well being is an important factor in the adjustment of the aged. We cannot deny the fact that biological aging gets aggravated with age related diseases like low vision, poor hearing, fluctuations in blood pressure etc. But it is no less related with the own perception about health. The respondents were asked to explain their health in their own eyes. For this they have given three options –bad, normal and good. Figure 3 gives the respondents distribution according to perception of their health. Data analysis in the table presents interesting picture.

Out of total aged, approximately 28.75 per cent were enjoying good health and 35.41 per cent stated their health condition as normal. Among the male respondents, as many as 36 per cent reported their health as normal and 30 per cent of the male respondents perceived the same as good. At the same time 32 per cent female respondents were leading a normal health and 22.5 per cent reported it as good. It is also

noteworthy that 34 per cent male respondents and 45 per cent female ones perceived their health as in bad condition. Cross analysis of the data for outdoor activities and perceived health of elderly reveals that there is positive correlation between the degree of involvement in outdoor physical activities and self perception about health condition. Regular walkers of both sexes were leading relatively good and normal state of healthy life.

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Government Policies and Programmes for Elderly Women Living in Slum Areas of Aligarh

Sana Hashmi

Centre for Women's Studies,
Aligarh Muslim University, Aligarh (U.P.)

ABSTRACT

The aim of this study was to gather information about the implementation of old age pension scheme for elderly women living in slum areas of Aligarh city and the behaviour of the employees of the concerned departments towards them. 40 elderly women were selected randomly from slum areas for this study. Interview schedule was used for data collection. The findings revealed that there were a number of impediments in the way of receiving the pension and in approaching the concerned authorities.

Keywords: Elderly women, Government policies and programmes, Slums

The elderly women residing in slum areas*, are the most vulnerable section of the society. Most of the time people live in these areas because they have no other options of living. These people migrate from their native places to urban areas in search of livelihood. Most of the time, these people have to face pathetic conditions where it is extremely difficult to survive. The condition of the elderly women becomes miserable beyond imagination in these dingy and dirty areas. They don't have access to the most basic amenities like food, shelter,

clothing and even fundamental demands like sanitation, hygiene, access to potable water are not properly met. Elderly women of these areas are mostly dependent on others for their aforementioned basic needs, as slums are totally deprived of them.

A number of schemes and policies were implemented by the government of India for the benefit of elder people. The government has launched schemes aimed at the promotion of health, well-being and independence of senior citizens around the country. Some of them have been designed keeping the women in prime focus for e.g. the "VIDHWA PENSION YOJANA" and to strengthen the primary health care system through the "NATIONAL HEALTH POLICY" and many more.

The National Social Assistance Programme (NSAP) was set up in 1995, and has undergone various modifications over time. Currently five schemes come under this scheme; the Indira Gandhi National Old Age Pension Scheme (IGNOAPS), the Indira Gandhi National Widow Pension Scheme (IGNWPS), the Indira Gandhi National Disability Pension Scheme (IGNDPS), the National Family Benefit Scheme and ANNAPURNA Scheme. The National Social Assistance Programme was implemented in all the States/Union Territories by the respective social welfare and other related departments. In terms of geographical coverage, the NSAP extends to both the urban as well as rural areas. Under this scheme 100 per cent central assistance was extended to the States/Union Territories to provide the benefits in accordance with the norms, guidelines and conditions laid down by the Central Government. Under this scheme a number of programmes are being run by the Government for the upliftment of the social status of the Indian population. A special programme has been introduced for the betterment of the older people named "Indira Gandhi National Old Age Pension Scheme" widely known as "Vridhdha Pension". For getting benefits of this scheme, there are some criteria prescribed by the Government of India which must be fulfilled by the applicant. For example. the applicant must belong to a BPL (Below Poverty Line) family. There is also a provision in this scheme for getting the pension i.e. a new beneficiary will be identified from BPL list prepared by the States/Union Territories as per guidelines issued by the Ministry of Rural Development (MoRD) for the BPL Census

2002. Further, the age eligibility for this pension was reduced to 60 years from 65 years with effect from 1st April, 2011. There is also a revision in the scheme which has increased the sum of pension from Rs 200 to Rs 500 per month. The Delhi Government has a provision of Rs 1,500 as pension for those who cross the age of 70years and above, and Rs 1,000 per month for those persons who are in the age group of 60–69.

There is no doubt that the government has implemented a number of programmes for the betterment of elderly people. But the question arises – "Are these policies and programmes really benefiting the elderly women?"

Review of the Literature

Chopra *et al.,* (2014) highlighted the role of Social Security Pension Scheme in India. The study highlighted the irregularities in the payments of the pension for older persons in various States of India.

The elderly are always facing different types of health, financial, physical and mental problems that is why their care has to be the prime concern for the policy makers, authorities and voluntary organizations. Elderly people are considered as a burden on the family due to their non-economic status. According to Ayanendu *et al.,* (2015) about 50 per cent of elderly are fully dependent on others and the ratio is higher among women as compared to men. ANNAPURNA scheme (it is a sub scheme of NSAP), which is meant for only those elderly who are eligible for the IGNOAPS is not being properly implemented Unfortunately elderly are not benefited by this scheme due to various reasons. They also foundout that IGNOAPS, which ensures the economic security for the elderly, covers only a miniscule proportion of the needy population of the country.

Kulkarni (2017) focused on the growing elderly population in India and its problems. The condition of elderly people is becoming worse day by day due to continuous changing structure of the society. Approximately, two-fifth of the elderly population has no personal income. Taking their financial status into consideration, it was observed that most of the time the elderly are fully or partially dependent on others for their basic requirements. Government has

taken a few initiatives so as to provide financial and social security to the elderly people. These policies provide some kind of financial assistance to the elderly and widows for the betterment of their lives on the basis of certain criteria. Around 6 million elderly people in India are benefiting from the old age pension scheme and around 3 million are benefiting from the widow pension scheme. The author also focused on the issue of lack of access to these programmes by most of the elderly men and women. It was obsereved in the study by Kulkarni that 81 per cent men and 71 per cent women were aware of this scheme and only a dismal 22 per cent among them were being benefited by these programmes. Similarly 70 per cent of BPL elderly widows were aware of IGNWPS but hardly 20 per cent were benefited by this scheme.

Significance of the Study

Elderly women are always marginalized and neglected in all spheres of their lives as compared to elderly men. The situation, of elderly women who live in slums is becoming worse day by day. After reviewing some literature the researcher found that hardly any studies hsve focused on government policies and programmes for the elderly women. The present study tries to analyse the economic condition of elderly women who live in slum areas of Aligarh city and also to understand in what way IGNOAPS is being implemented in slums of Aligarh city among elderly women. This study also focuses on the attitude of employees of various related departments towards these needy women.

Objectives of the Study

a. To study the problems of elderly women in slum areas of Aligarh City regarding the various beneficial Government policies for them.

b. To study the behaviour of the people of the concerned departments towards elderly women.

c. To suggest measures to improve the condition of elderly women in slum areas of Aligarh City.

Methodology

All the elderly women living in slum areas of Aligarh City were constituted in the universe of study. 40 elderly women were randomly selected for this study.

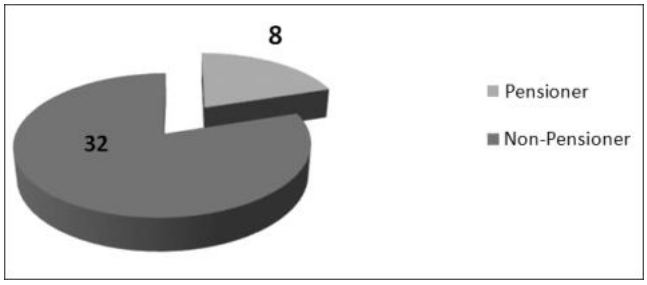
Interview schedule was prepared for data collection. These respondents were interviewed individually.

Findings and Discussion

The data collected for the present study revealed that only 08 elderly women out of 40 who are living in slum areas were being benefitted with the old age pension while the rest are not getting any type of assistance from the government though they deserve it. Only one respondent used to get SAMAJWADI PENSION, run by the SAMAJWADI PARTY LED-UTTAR PRADESH GOVERNMENT. Now the policy has finished with the tenure of the aforementioned government.

Figure 1

Showing the Distribution of Pensioners and Non-Pensioners



As it is seen that only 08 elderly women were getting this pension while the rest i.e., 32 were deprived of this beneficiary policy of the government. The reasons differs from case to case. While some are not getting it because of lack of proper documents or because of non-access to the concerned authorities. It was found that mostly elderly women of such vulnerable section were illiterate. They were not able to complete their documents and paper-work and their children do not take care of them. It is needless to say that in the later years of age, parents are the responsibility of their children but their children do not fulfil even the basic daily requirements of their parents. To be

précise, 21 elderly women could not benefit from the policy due to absence of a valid ID proof. 08 women have applied for it two or three times but could not obtain the same. 07 elderly women had ID proofs and wanted to apply for the scheme, but due to incomplete documents they were unable to proceed with the formalities. There was a case in which the respondent got the pension for a period of three months and suddenly it was stopped. After a lot of struggle she was informed that because of improper address this assistance from the government was stopped. The researcher found that 02 elderly women who had a valid Aadhar card were she was not able to apply for the old age pension or any other pension because their Aadhar Cards contained the addresses of their native places. and it did not match with their current residential addresses. The author has also found one case in which the elderly woman was unable to fill the application form of Aadhar Card as her right hand was amputated. Thus, she did not have an ID proof and could not apply for any type of pension. 02 cases were found in this study who paid Rs 200–300 to the broker for applying for the old age pension scheme but, till date of data collection, they have not received any amount of pension.

Table 1
Showing the Problems in getting the Oldage Pension

No id card	21
No proper document	07
Applied but did not get it	08
Got only 3 months	08
Address Problem	02
Adhar Card problem	01
Total	40

The dependency ratio of these elderly women shows that 05 elderly women out of 40 of the slum areas in Aligarh City were dependent upon pension while 13 elderly women out of them were partly independent because some of them were working as domestic labourer while others were having their own "khokhas" (a kind of small shop) and still others were collecting wood and grass and selling it out. This is the plight of these women who have to engage in such petty occupations in order to arrange for two square meals. 09 elderly women were dependent on their sons while only 01 on her husband.

Because of a large age difference, most of the elderly women, during this phas, of life were found to be widows. One of the reasons of it may be higher life expectancy among elderly women as compared to men. It was seen that 03 elderly women were dependent on their daughters while rest of the elderly women i.e., 09 on others.

Most of the elderly women said that the attitude of people of the concerned departments is absolutely arrogant and uncompassionate towards them. Most of the time, these people did not explain to them the process of applying for such schemes. Every respondent who was getting this pension told that "they never get pension in time. They have to make several trips to the banks for getting their pension".

The above data shown through the following table and charts:

Table 2
Showing the Dependence of Elderly Women

Depend on pension	05
Depend on son	09
Depend on themselves	13
Depend on husband	01
Depend on daughter	03
Depend on others	09
Total	40

The present discussion is based on the information collected from the respondents belonging to the lower strata of society. During this survey, the researcher not only came to understand the problems of elderly women of this vulnerable section but also analysed the causes of it.

The data shows that out of 40 respondents only 08 elderly women were being benefited by the old age pension scheme run by the Central Government. Though there are schemes for the betterment of the elderly population, still the majority of the deserving population is deprived of these programmes. There are a number of reasons of it such as:

- *Migration:* In search of work, the lower strata of the society have to move from one place to another. It was found during data

collection that the majority of the population in the slum is the migrated one. The is one of the main reasons of not getting benefits of the policies and programmes run by the Government. To be specific, according to our survey, two of our respondents originally belonged to Bihar and migrated to Aligarh City in search of their livelihood. Their Aadhar Cards were issued by Bihar Government and they are of no use here in Uttar Pradesh for the purpose of applying for any sort of the previously discussed pension schemes.

- *Awareness and Access:* One of the main reasons of not being benefited by this policy is lack of awareness and access to these programmes and concerned departments. Most of our respondents are deprived of these schemes because of lack of access to the concerned persons or the departments. The main reasons of it are illiteracy and dependency on others. Illiteracy leads to the problem of not understanding the process of applying for the particular scheme. Due to illiteracy or lack of the knowledge of online processes, the process laid down by the government is hard to understand by the elderly persons.
- *Others:* There are number of reasons behind the fact that the elderly women cannot obtain access to the hugely beneficial policies and schemes introduced for them. One reason is not being in possession of proper documents. During the data collection process, the researcher came across a shocking reason – "physical disability" of the respondent. Due to some kind of infection the fingers of right hand of one of our respondents – amputated by doctors and just because of that she couldnot put her fingerprints on the application of the Aadhar card and thus failed to procure a valid ID proof. This resulted in the deprivation of pension.

Conclusion

Elderly women who reside in the slum areas constitute one of the most deprived and vulnerable sections of our society. They are the ones who strongly need social security. Pension can help to enhance their financial status. This particular group of elderly women of society are unable to approach various beneficial programmes of

government. There are some who struggle a lot to receive old age pension and finally obtain it. A number of issues are associated with it, such as delay in the time of the pension, the attitude of the bank employees and the employes of the departments. There is a need of change in the system of government as well as the society, so that such needy elderly women can get social security.

Limitations of the Study

a. The study was limited to only 40 elderly women in slum areas of Aligarh city.

b. The study was limited to only one scheme i.e., IGNOAPS for elderly women in slum areas of Aligarh City.

Notes and References

* As per Slum Areas (Improvement and Clearance) Act, 1956, the definition of a slum is: Any predominantly residential area, where the dwellings, which by reasons of dilapidation; overcrowding; faulty arrangement of design; lack of ventilation; lack of light or sanitary facilities; or any combination of these factors, are detrimental to safety, health or morals. Keeping in mind all these problems, the government took initiatives for the betterment of the lives of elderly people.

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