Chapter-II

METHODOLOGY
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This chapter aims to describe the research approach, design, methodology, setting, socio-economic background of the respondents as well as the procedures and techniques of data collection and analysis used. On the basis of these findings we have formulated our hypothesis for the present study. This chapter also deals statement of problem, objectives, hypothesis, sample and limitations of the study. This chapter provides a detailed review of the available literature on various aspects of the study.

Statement of the Problem:

The purpose of the present study is know the morbidity profile of the rural elderly. As age advances people are susceptible to many diseases. Though it is a natural phenomenon, elderly people in rural areas are deprived of many medical facilities and other infrastructure facilities. Because of this deprivation, they suffer from sickness. Morbidity profile of rural elderly certainly reveals many facets of their illness. Hence, the study is undertaken to unearth issues concerning the morbidity aspects of rural elderly.

Objectives of the Elderly:

The following are the main objectives of study:

1. To assess the socio-economic status of the elderly.
2. To examine the morbidity profile of rural elderly respondents.
3. To know the health problems faced by the Aged
4. To study the determinants of morbidity
5. To examine the preventive and curative aspects.
**Hypothesis:**

In the light of the above objectives the following hypothesis have been framed, and the same will be tested on the basis of the primary data.

1. A sound educational background of the respondents minimizes the disease.
2. Most of the elderly people have multiple health problems.
3. Women constitute the largest segment of the oldest-old and the vast majority of them are facing multiple problems.
4. Morbidity profile depends on income, awareness, health facilities and life style of the respondents.

**Limitations of the Study:**

Following are the limitations of the study, they are;

1. The study is confined to rural elderly only.
2. The study covers elderly of Guledgudda Town of Bagalkot District.

**Justification of the Study:**

The present study is conducted in Badami Taluk of Bagalkot District. Bagalkot district was selected through lottery method. Bagalkot district consists of Six Taluks. Of these taluks, Badami Taluk was selected through lottery method. Badami Taluk consists of four towns, namely; Badami, Guledgudda, Kerur and Kulageri. Out of four towns, Guledgudda has been taken for the study through lottery method. Guledgudda Town consists of 36 villages. Out of 36 villages, (50%) 18 villages have been taken for the study through simple random sampling method. Voter list of 18 villages have been taken, we got 1509, 60+ elderly in these villages, which constitutes the universe of the study. 25 percent of the elderly in each village was taken.
Table No. 2.1

Sample for the present study

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Name of the Villages</th>
<th>Above 60+</th>
<th>25% of the Total Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
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<tr>
<td>01</td>
<td>Parwati</td>
<td>40</td>
<td>113</td>
</tr>
<tr>
<td>02</td>
<td>Asangi</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td>03</td>
<td>Murudi</td>
<td>31</td>
<td>51</td>
</tr>
<tr>
<td>04</td>
<td>Khazibudihal</td>
<td>23</td>
<td>47</td>
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<tr>
<td>05</td>
<td>Teggi</td>
<td>30</td>
<td>67</td>
</tr>
<tr>
<td>06</td>
<td>Thogunashi</td>
<td>51</td>
<td>51</td>
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<tr>
<td>07</td>
<td>Budinagad</td>
<td>23</td>
<td>57</td>
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<tr>
<td>08</td>
<td>Lingapur</td>
<td>28</td>
<td>56</td>
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<tr>
<td>09</td>
<td>Injanawari</td>
<td>19</td>
<td>23</td>
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<tr>
<td>10</td>
<td>Khanapur</td>
<td>37</td>
<td>26</td>
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<tr>
<td>11</td>
<td>Padanakatti</td>
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<td>63</td>
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<td>Kotikall</td>
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<td>13</td>
<td>Subbalahunashi</td>
<td>16</td>
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</tr>
<tr>
<td>14</td>
<td>Layadagundi</td>
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<td>31</td>
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<td>16</td>
<td>Lakkasakoppa</td>
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<tr>
<td>17</td>
<td>Allur</td>
<td>28</td>
<td>34</td>
</tr>
<tr>
<td>18</td>
<td>Kotnalli</td>
<td>43</td>
<td>77</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>551</td>
<td>958</td>
</tr>
</tbody>
</table>

380 elderly constitute the final sample for the present study. Of them, some of the elderly were not feeling well, their health condition was so critical; they could not answer the research questions. Finally researcher could get information from 350 respondents.
The Method of Study:

A total sample 350 respondents consisting 217 females and 133 males were interviewed. The data was analyzed on the basis of frequencies, percentages and cross tables using the SPSS package. The data is collected from both primary and secondary sources of data.

1. Primary data:

The primary data was collected through the personal interview method with the help of interview schedule.

2. Secondary data:

The secondary source of data was collected through available books, on the aged and Census reports, Journals, Published books and some magazines also referred. Government’s reports of Badami Taluk, Gazetteer are also used.

Review of Literature:

(2007), Venkateshwarlu Vankayalapati (2008), Nirankar Singh, Sujita Kumar Singh, Ashish Yadav, Shailesh Kumar Suman, Shailendra, Kumar and J.V. Singh (2012), and Gopalakrishnan S. (2013) etc., deals with health aspects of elderly. However, studies’ pertaining to morbidity is very, very scanty in nature.

**Socio-economic aspects of elderly:**


Dandekar’s (1996) study of the “Rural aged in Maharashtra”, points out that agriculture is the major occupation of the rural aged. It requires only better physical health and intention to work and there is no age of retirement in this sector. The rural aged owned assets of house, land and cattle but did not cultivate the habit of savings because their earnings were just sufficient to meet their family expenditure. They expected their children to help them in their old age. Old age pension can help the aged to lead a comfortable life.

Vijaya Kumar S. (1999) in his paper on “Elderly in the changing traditional family structure-an Indian Scenario”, highlighted that several disadvantages associated with ageing makes the elderly population as one of the most vulnerable section of the society. He stated that changing traditional joint family structure was one, which had repercussion on the elderly. Due to industrialization, filial responsibilities were weakening and the interpersonal and intergeneration relations were also getting strained.
Chanana H.B. and Talwar P.P. (1987) Study on “Aging in India: Its Socio-economic and Health Implications”, pointed out that majority of elderly workers were engaged in agriculture. Modernization of agriculture in the future (which would require fewer workers than currently) accompanied by increases in the number of young adults seeking employment are factors likely affect adversely future job opportunities for the elderly.

Irudaya Rajan (2004) has brought out the trends in work participation of the Indian Elderly. In rich countries the elderly can afford to retire early because of the availability of pension schemes social security programmes and a minimum of 2 per cent of the elderly are involved in work participation. But in India, where poverty and inadequate social security systems and lack of economic security prevail high, 63 per cent of elderly men and 58 per cent of elderly women continue to work and are economically active beyond the age of 60 and even at the age of 80 and above 22 per cent of men and 17 per cent of women continue to work. In Tamil Nadu, an agricultural labourer at the age of 85 said that there is only one retirement not from work, but from the world.

Renu Tyagi (2008) made a study on “Socio-health Dimensions of Aged Population”. The study was carried in a group of elderly males and females staying with families and another group of comparable age but staying in old age homes of Delhi. Demographic variables, educational status, eating pattern, health status, physical activity level, religious activity status and some leisure time activities were studied among these elderly. The life style of the elderly in the old age homes and those staying within the family set up were quite different in several aspects. The health status also showed some differences like the vision problem, hearing problem and anemia were reported to be higher among the elderly staying in the families.
However, the joint problems were found to be more affecting the residents of old age homes.

The traditional Indian value system used to place a heavy emphasis on prestige associated with old age. Age, today can be related to a period of life with a natural decrease in functional capability of the body and starts around the middle of the perceived life span of 100 years. The rural elderly were the authority and the most respected members of the family.

**Bhatia’s (1983)** study on “Ageing and Society: A Sociological Study of Retired Public Servants at Udaipur”, concluded that most of the people face retirement without any planning and preparation leading to problems in their old age.

**Biswa S. K. and Tripathi T. P. (1990)** study on “A Comparative study of Employment Situation of the Aged”, this study of 286 aged pensioners 60+ from an urban metropolitan area and 1117 villagers near Giridih in Bihar. This study has revealed that among male aged of age 60-70 years 91.6 per cent were working in rural areas and only 15.3 per cent in urban areas. Thus, aged persons are generally working in rural areas but same is not the position in urban areas. This study also showed that, in rural areas, of the non-working males none had the social status of head of the family but in urban areas 95.9 per cent of the non-working males were the head of their families. Similar was the position of working and non-working females.

**Gurumurthy K. G. (1991)** focused on “The Aged in India”, the study in Rural Karnataka; the sample was taken from all the districts of Karnataka excluding the urban and tribal areas. This study had a sample of 600, the study showed that 74 percent of female aged and 88 percent of the male aged lived with their families (wife, sons, grandsons and daughter-in-law) 26 percent of the females and 11.3 percent of the males lived outside their families. About 5.5 percent lived with brother, sister,
daughter, 2.2 percent because none to care for them 1.3 percent because they had a quarrel with son/daughter-in-law and 1.2 percent because there was no room in their house and 0.9 percent for a positive reason that they were wanted by their adopted families a few 8.67 percent of male and 17.6 percent of the females lived independently.

**Reddy K. N. (1996)** in his paper on “Social Security for the Elderly in India: Need for Reform”, rightly said that 53 million of elderly persons are in the unorganized sector, further, a vast majority of elders, belonging to unorganized sector, and particularly those belonging to lower middle income, middle income, upper middle income classes were exposed to misery. In the unorganized sector, there was no health insurance cover at all or any special facilities for priority treatment in government hospitals. They had to depend on private sector only.

**Muthayya and Aneesuddin (1997)** have studied ‘Rural Aged’ Existing Conditions, problems and possible Interventions (A Study in Andhra Pradesh) and suggest interventions of the government and NGO Sectors. They have pointed out the socio-economic characteristics, health condition and dietary pattern, social life, recreation, past activities, hopes and worries of the old apart from pointing out the role and position of some inmates of the old-age-homes.

**Behura N. K and Mohanty R. P. (2005)** conducted study on “Aged in Changing Social System: Their Problems”. The universe of the study includes three broad groups of ‘aged’ who residential fringe multi-caste Hindu Villages located around Bhubaneswar city. These villages belong to two different blocks namely Balianta and Bhubaneswar of the district of Khurda of Orissa. That majority of aged people 60.14% are quite mobile without the help of anybody. They are followed by those who are fairly mobile without the help of walking-sticks 19.59% fairly mobile
with the help of walking-sticks 12.84% and slightly mobile with the help of a person (4.05%). A total number of 5 persons or 3.38 percent are immobile or bedridden.

**Purohit C. K. and Rameshwar Sharma's (1972)** paper on “A study of Aged 60 years and above in Social Profile”, presented that all the aged persons were sick at the time of survey. Average sickness per person was found to be 4.07 and 3.85 in males and females, respectively. The causes of illness at the time of survey were chronic bronchitis (70.05%) anaemia (65.24%), constipation (47.06%) cataract (39.83%), arthritis (25.40%), hypertension (12.56%), avitaminosrs (11.49%), and corneal capacity (10.69%). At the time of survey 85 (22.72%) aged persons were disabled. According to Purohit (1971) the causes of disabilities were recorded as difficulty in walking and standing (7.5%) partial blindness (5.34%) partial deafness (4.01%) abnormal involuntary movements (3.74%) and complete blindness (2.24%).

**Marulasiddaiah (1969)** conducted field work on “Old People of Makunti”, having a population of 1,630 persons with 145 old persons. Study pointed out the declining authority of the elderly in a small village Makunti in Mysore and found that the elderly faced severe health problems and economic adjustments. The purpose of the study was to make a preliminary assessment of the role played and the sort of problems encountered by the older people of the rural community in India. One more study conducted on the living conditions of the retirees have found a mixed situation. While **Mishra (1987)** from his study of the 272 retired government male employees living in Chandigarh found that a majority of them are living in nuclear families.

**Desia and Naik (1972)** “Problems of Retired People in Greater Bombay”, by comparing the pre-and post-retirement situation of health of the retired persons in Greater Bombay, inferred that if a retired person keeps himself/herself fit before and immediately after his/her retirement, he/she continues to be free from illness during
the post-retirement period; but once an illness starts, before or just after the retirement period too. Venkoba Rao (1987) focused on the multiplicity of symptoms of the elderly in his clinical study.

Shabeen Ara (1994) made a study on “Old Age among Slum Dwellers in Hubli city (Karnataka)”, has shown that during illness only 8 percent of aged were not given care by anyone. About 27 percent were looked after by spouse, 21 percent by daughter, 16 percent by daughter-in-spouse, 21 percent by daughter, 16 percent by daughter-in-law, 11 percent by friends 8 percent by son, 6 percent by relatives and 4 percent by grand-children. Only about 28 percent if the aged have friends. About 62 percent of the aged living in families was heads of families. About 70 percent of the aged were living with their children were taking care of them during illness, 80 percent said that the children showed them respect, and 69 percent said that they were a burden and 16 percent said that they were worthless.

The focus of the paper, Anindya Jayanta Mishra (2007) in her paper on “Staying Active and Promoting Well-being among the Elderly”, examines the life-satisfaction of old age home (Home/Homes, hereafter) residents in Orissa within the framework of activity theory of ageing. They investigate the reasons why the elderly shift to homes. They are study also examine the daily activities of the home residents and its impact on their physical and mental health. Conducted personal interviews with 55 residents staying in six homes, of these 55 residents, 32 were males and 23 were females. The majority of the home residents were in the age group of 66-70.

Roles and Status of the Elderly

Harlan (1964) reports on “The status of the aged in rural India”. The marital status, intergenerational relationship, economic status and education play an important
role in getting respect and prestige from the community; widow rations her prestige as long as she is able to aid the family and behaved well towards other family members.

The study of rural aged persons by **B. Raj & B.G. Prasad (1971)** also reveals similar situation. They classified the aged into rich, upper middle, lower middle, poor & very poor and studied the attitudes towards life of the aged persons. The study has revealed that among the rich 25.0 percent feel happy, 66.7 percent are indifferent while 8.3 percent are depressed. As against this among the very poor only 4.7 percent feel happy, 46.5 percent are indifferent while 48.3 percent are depressed.

**D'Souza (1971)** research paper “Changes in Social Structure and Changing Roles of Older People in India”, opined that in the past the structure of society was such that the ageing process did not put any obstacle in the way of older persons filling roles of enchanted status, but in the recent times the structure of the society has been undergoing a fundamental change, under which the older persons are being dislodged from their roles of higher status. Due to the changes in the family structure and the value system, the respect, honour, status and authority which the elderly used to enjoy in the traditional society, gradually started declining and in the process the elderly are relegated to an insignificant place in our society.

**Sharma (1972)** profiled the rural aged 60 years and above in the Indian State of Rajasthan and reported that the male and female aged suffered from a number of physical and mental ailments. **Soodan (1975)** made a study entitled “Ageing in India”. The general purpose of the study was to make a detailed investigation into the conditions, needs and problems of the aged in the city of Lucknow.

**Gokhale (1992)** notes that ageing in India is described as a process of change in human roles throughout life. Culture is transmitted between generations. Social
changes in India have made an impact on the elderly like shifts in life styles and housing shortages. By 2025 the world aged dependency ratio is expected to be 39 per cent. The cost of providing aid shows variation among elderly subgroups. The elderly males aged 60 years and above spend about 33 per cent of their time in production. Women spend 40 per cent of their time at work. In India, retirement means phased withdrawal from productive activity and control over resources. Death is viewed as only the end of a chapter rather than the end of a workbook.

Vimal P. Shah (1993) a “Study of Elderly in Gujarat”, this study was conducted in four localities of Ahmedabad city. The localities were purposively selected, two localities were from the centre of the city, one with preponderant Hindu population and the other with preponderant Muslim population, one locality was with mixed population and the fourth locality was a recently developed area random selection of 800 aged was made with the help of electoral rolls. However, only 482 could be traced and covered and in these 46.3 percent were males and 53.7 percent were females. Among males illiterates were 18.1 percent and among females 52 percent. As the age advanced to 76+, among males the percentage of married was 77.6 and of widowers 20.6 among females these percentages were 20.6 and 73.5 respectively. About 40 percent of the male and 15 percent of the female were engaged in economically gainful activities.

Radha Devi D. (2008) the study conducted on “Work Participation of the Aged in India”. Work participation among older persons and the type of work they do in India, can be revealed using data from census of India publications. The term older persons connote those who are 60 years of age or more. Majority of older persons were illiterate, out of 100 older males 65 were illiterate, and only 4 had matriculation and above level of education. Almost all older women were illiterate (92 %). Rural
male work participation varies from 45 percent in Kerala to 78 percent in Uttar Pradesh. In Andhra Pradesh, Bihar, Madhya Pradesh and Uttar Pradesh more than 70 percent of the older persons were participation in work.

**Psychological aspects of Elderly:**

Psychological changes accompany the passing of years, slowness of thinking, impairment of memory, decrease in enthusiasm, increase in cautionness and alternation of sleep patterns. Social pressure and inadequate resources create many dysfunctional features of old age.

**Sharma (1969)** paper on “Leisure Time Activities of Retired Persons”, found that among the various leisure time activities, reading newspapers, household activities, morning and evening walk, listening to radio, sitting and gossiping with children, son or grandson, chatting and gossiping with friends, talking with wife, kirtan and bhajans, inviting and entertaining friends at home, and day sleeping were reported by a majority of the retired persons.

**Jayashree (2009)** in her article “Retirement and Leisure” applied activity theory to study leisure activities of the elderly. Author also found that hobbies are more prevalent among highly educated respondents and upper income groups. Respondents who belong to lower income group have shown more interest in religious activities.

**Muthukrishnaveni S. (2006)** conducted study on “Co-residence and Well-being of Elderly in Rural Tamil Nadu”. The major psychological problems as reported by the elderly were anxiety (87.4%) unnecessary worry, angry, isolation, easily upset, tension, loneliness and depression. The overall psychological status obtained by combining and scoring all the 24 psychological variables showed that 39.1 percent of
elderly were in good psychological status, 41.1 percent were in moderate psychological status and 19.8 percent were in poor psychological status.

**Sharma M.L. and Dak T.M. (1987)** have edited a book on “Ageing in India: Challenge for the Society”, the purpose of aging in India and the socio-psychological problems attached to this process. The edition contains a total number of 23 short research papers authored by 37 workers. These paper are based on 3 broad categories of problem. They are as follows;

i) Aging and the changing society.

ii) Socio-psychological problems of the aged and 

iii) Health and medical aspects of aging.

**Joseph James (1991)** has conducted a psychological study in terms of “Problems and Personality of the Aged”, in the district of Kottayam in the state of Kerala. For the purpose of his study, he has considered a person of 60 years of age as “Old”. He says that a paltry sum of pension is associated with poor living condition and suffering. Thus, occupational insecurity, lack of training facilities and shortage of psychiatric and psychological services etc., are some of the main inadequacies in some of the advanced social systems of the world.

**Dhillon P.K. and De'Souza S. (1992)** conducted a study “The Effect of age and sex on needs, social adjustment and reactions to frustration”. This is health problems and medical care is the major concern among a large majority of the elderly. It is obvious that people become more and more susceptible to chronic diseases, physical disabilities and mental incapacities as they grow older. In the later years of life, arthritis and rheumatism, heart problems and high blood pressure are the most prevalent chronic diseases affecting the elderly. Majority of them refrain from seeking
medical aid from public hospitals due to many impediments, besides lack of money. Some of the health problems of the elderly can be attributed to social values also.

**Dandekar K. (1996)** focus on “The Elderly in India” analyzed the conditions of the elderly and the efficacy of the old age pension scheme. Ghosh (1997) discusses the demographic aspects of ageing and its socio-economic and psychological implications. There is a great need to create support systems which will meet the varying needs of the elderly.

**Chaturbhuj Sahu (1998)** analyzed “The Socio-psychological problems of the Aged”, which have more relevance in traditional than in developed societies. The veneration shown to the old, the weight given to their advice, the eagerness to have them to mediate in disputes and the unique honour and respect shown to them in social functions in traditional societies have no parallel in modern societies. The erosion of these privileges consequent on the emergence of new values and norms cause not a small amount of despair and anguish in the minds of the elderly.

Issues in Mental Health and psychological well-being of older persons have been noticed by **Indira Jai Prakash (1999)**. Physiological factors particularly chronic disease, play an important part in mental illness among the elderly. Poor hearing and eye sight and reduced mobility affect the kind of interactions one can have with others and thus effect inner experience of sensory stimulation. In addition, the general slowing down of reaction time, associated with ageing itself rather than disease, makes it difficult to think and respond as fast as younger people. Physical changes may make people less sure of oneself and more isolated from others. Such changes when combined with losses that accompany old age and lowering of social status, lead to psychopathology. There is high morbidity of physical illness and disability in those who present psychiatric symptoms in late life (Pitt B. 1993). Life of mentally ill old persons is often complicated by greater vulnerability to co-morbidity.
Sharma K. L. (2009) studied “Elderly Women of Kachhi Basti a Socio-psychological profile”, the focus was on difficulties faced in old age. The physical abilities, psychological capacities decrease with age and habits and personality traits become more rigid. These biological and psychological changes play an important role in determining the adjustment in old age and create difficulties to them in their social adjustment. This study about 43 percent subjects reported that they have problems related to eyesight’s, for 41 percent women physical weakness is common cause of difficulty, personal health 35 percent, housing problem 23 percent, and inability to earn 15 percent, were also reported by these subjects as the cause of difficulties.

According to Ramamurti and Jamuna (1984) paper on “Psychological Research on the Aged in India”, most elderly bear a negative self-image and poor self-concept. Changes in looks and likeability and a feeling that others alienate the elderly greatly contribute to the negative self image.

Dhillan (1992) discusses the psychological and adjustment processes of the aged and examines the effect of age and sex, social class, retirement or institutionalization etc., on the psychological processes of the aged. The Hindu Survey of “A society for All Ages”, indicates that the majority of the older and aged people in rural areas are denied health and social services which are enjoyed by the urban aged.

Economic conditions of the elderly:

Economic conditions are closely related to health of the elderly. Most of the studies conducted to study the economic conditions of the elderly (Sarawathi & Ranjana Dutta, 1988; Easwaramoorthy M. and Chadha N. K. (1999).

Saraswathi T. S. and Ranjana Dutta (1988) made a study “Current Trends in Development; A Life Span Perspective and Problems of Adjustment: Ageing and
Adjustment”. Study purpose are of the view that problems of adjustment are associated with both contemporaneous factors and antecedent life conditions such as retirement, possible reduction in income, loss of spouse and deteriorating health. According to them past studies indicate that well adjusted subjects on the whole enjoyed good physical health, had a positive self concept, had more friends, participated in more leisure and recreational activities and complained less of being lonely.

The National Sample Survey (July 1995-June-1996) classified the elderly into three categories according to their economic dependence; not dependent, partially dependent and fully dependent. The fully dependent elderly needed economic support in old age as they are below the poverty line. In the rural areas, 58 percent of women and 45 percent of men were fully dependent, whereas in the urban areas these percentages increased to 64 and 46 respectively. The economic dependence is the main reason for the elderly to continue to work in old age, in spite of their poor health.

Easwaramoorthy M. and Chadha N. K. (1999) in their paper on “Quality of Life Indian Elderly: A factor analytic approach”, emphasized that the concept of quality of life has gained significance in ageing due to the need for integrated approach towards understanding the aged. Four dimensions of quality of life were assessed, namely-economic well-being and social wellbeing, physical well-being, psychological well-being and social well-being by administering various psychological tools. The result provided a comprehensive understanding of elderly and carries various implications for research and policy.
Health Status of the Elderly:

Health status is an important factor that has a significant impact on the quality of life of an elderly population. The major elements of health status are perceived health especially psychological well being, chronic illness, and functional status. Various studies have shown that perceived health declines with age, and the effects of ill health impact on many areas of daily activity.

Joshi C. K. (1971) conducted a study on the “Medical Problems of Old Age”, through his clinical study of the elderly, opined that the differential ageing phenomena, both physical and mental, appear to depend on environmental and social factors such as, diet, type of education, adjustment to family and professional life, and consumption of tobacco and alcohol.

Djurfeldt and Lindberg (1975) studied “The Issues of Sickness, health behavior and Health Institutions in a Village in Tamil Nadu” in the context of social structure and production relations and modes of production. They conducted a study of introduction of western medicine in the village.

Oktay and Sheppard (1978) discuss “Home-Healthcare for the Elderly”. They present an overview of the good population requiring home-health care and a detailed picture of the development and content of such services in the U.S. They pointed out how the growth of the elderly population has greatly increased the number of persons requiring long term health services. They pointed out that the old person can benefit socially and psychologically if he can avoid the disruption, isolation, and impersonal allocation of institutional placement. One the whole, they conclude that an expansion of home health services is necessary.
Ramachandran et al. (1981) studied the relationship between “Family Structure and Mental illness in Old age”. The subjects were 181 people aged over 60. The families of the elderly subject and their living conditions were studied in detail. The families were divided into ‘joint’, ‘nuclear’ and ‘loosely joint’, based on living arrangements, financial support, and other helps received. Functional disorder was found high in subjects living in nuclear families and living alone. On the whole, it was found that family affecting the mental health of the elderly.

Gore (1990) analyzing the social factors affecting the health of the elderly, concluded that, while there are no data showing direct relationship between income level and health of elderly individuals, one would assume that nutritional and clinical care needs of the elderly are better met with adequate income than without it. If so, the poor countries and the poorer segments of the elderly population within each country would experience greater problems of health and well-being.

Pokarna (1994) has examined “The structured social beliefs and practices in relation to health and disease”. His emphasis was on the understanding of traditional institutions of health practices and sickness. He suggested eliminating the ignorable superstitious dimensions related to sickness which are prevalent among the rural people. He has also studied the modern health system in terms of its role and its impacts, personal hygiene and environmental sanitation and role of community agencies in health and disease.

Vijaya Kumar S. (1998) in his paper on “Health Services for the rural elderly”, examines the health status of the rural elderly, available health services and frequency of getting medical aid, satisfaction of the elderly towards the medical services and the help rendered by family members. This empirical work carried out in selected rural areas on Andhra Pradesh covering 200 elderly men and 200 elderly
women aged 65 years and above. It was found in this study, that though 85.5 percent of the elderly are suffering from chronic diseases, very less number are taking sufficient treatment or advice of doctors regularly.

In a cross-sectional study on health and social problems of 213 elderly persons conducted by Lena A., Ashok K., Padma M., Kamath V., and Kamath A., (2003) The Physiological decline in ageing refers to the physical changes an individual experiences because of the decline in the normal functioning of the body resulting in poor mobility, vision, hearing, inability to eat and digest food properly, a decline in memory, the inability to control certain physiological functions, and various chronic conditions. The most common being hypertension, osteoarthritis, diabetes, or bronchial asthma. Others included cataract, anaemia, and skin problems. Around 73% of the patients belonged to the age group of 60-69 years old. Nearly half of the respondents were illiterate. Around 48% felt they were not happy in life. A majority of them had health problems such as hypertension followed by arthritis, diabetes, asthma, cataract, and anaemia. About 68% of the patients said that the attitude of people towards the elderly was that of neglect. Almost 98% of the respondents felt that old age had affected their day-to-day life and 86.4% of the elderly felt that age had partially affected their daily activities.

Bhardwaj Shaila (2008) conducted a study of the “Health and Ageing among Dhanka and Brahmin of Rajasthan”, this study was undertaken to evaluate the level of literacy, type of family, socio-economic status, health problem, old age diseases and anthropometric and physiological variations among the elderly. Most common complaints reported were cough, joint pain, backache and weakness, loss of appetite, headache and abdominal pain.
Morbidity Pattern of the Elderly:

Morbidity pattern among the elderly varied from country to country. Chronic conditions which produced infirmity and disability became more common in old age.

A study conducted by Anil Jacob Purty et al. (2006) on the “Morbidity Pattern among 320 elderly persons in the rural area of Tamil Nadu”, observed that the average morbidity per person was found to be 2.77%. The most common morbidity in this study was found to be joint pain and stiffness (43.4%), followed by dental problems (42%), visual impairment due to cataract and refractive error (57%) and hearing impairment (15.4%).

A study conducted by Vinaykumar S. Koparde (2010) on the “A-Cross Sectional study of Morbidity Profile in Geriatric Population of Kakati ‘A’ Subcenter of Primary Health Centre of Vantamuri, Belgaum”, observed that among 400 elderly population, the average morbidity per person was 3.13%. Most of the elderly i.e. 32(29.35%) in the age group of 65 to 69 years were having problems of respiratory system, 94(36.71%) elderly in the age group of 60 to 64 years were having musculoskeletal problems, 47(36.71%) elderly in the age group of 60 to 64 years were having problems of circulatory system, 14(44.66%) elderly in the age group of 60 to 64 years were having problems of sensory system. Only 55(13.75%) of senior citizens had any type of Health Insurance. Majority of the elderly 230(57.50%) preferred to take treatment from private practitioners.

Anderson D. R. (1976) conducted study on the “Morbidity Factor In Health Care An International Study”, using a method similar to the surveys conducted in the united states a major international study was undertaken by the World Health Organization in seven countries to analyze health care, among the other things it
measured Morbidity Factors including social dysfunction, bed days, restricted activity days, and sick days, as well as 'perceived morbidity factors' including reported illness its severity, its chronicity and its urgency.

Apte (1982) has mentioned physical problems such as loss of eyesight, loss of hearing and loss of motor co-ordination as common to the process of ageing. Diseases like diabetes and hypertension are common among the aged in higher socio-economic groups. Incidences of accidents due to falls are also common. Crippling diseases like stroke and paralysis make old people completely dependent on other family members and reduce their physical mobility.

Swami H.M. et al. (2002) assessed 362 elderly persons in a community based cross-sectional study in Chandigarh and it was found that females had a higher rate of morbidity than males. The study also observed that a large number of subjects (89%) were suffering from at least one medical problem and 68% of the elderly were taking treatment for their ailments.

Vijayakumar K. et al. (2002) conducted a study “Life and Health of the elderly in a community in transition”, a survey in Thiruvananthapuram City, Kerala to assess the health and functional status of the elderly. Out of the 658 elderly covered 2015 of males and 68.1% of females were widowed. The women were found to be poorer suffering a lot having more morbidity than the men, in spite of their greater life expectancy. The diagnosed illness included hypertension (18.4%) arthritis and joint complaints (12.1%) chronic bronchitis (11.7%) and diabetes (9.5%). Chronic bronchitis and diabetes were more among the males whereas hypertension was more among the females 20.9% of men and 32.8% of women were habituated to chewing of betel leaves. Perceived morbidity was higher among the females than men.
Rao (1994) reported from a rural center in south India that of 603 older persons, only one third utilized services from the primary health centers and sub-centers. Of the remaining persons, 51.1% utilized services from hospitals and private practitioners, and 11.3% preferred indigenous methods of treatment, while the rest did not need services. Health services utilization was also irregular and despite the chronic nature of their illnesses, older persons were not able to visit these facilities on a regular basis.

Joshi K. Kumar R. and Ayasthi A. (2003) study concentrates on “Morbidity Profile and its relationship with disability and psychological distress among elderly in Northern India”. Morbidity profile of rural elderly people were distressed physically, psychologically or both. The most prevalent morbidity was anaemia, followed by dental problems, hypertension, chronic obstructive airway disease, cataract and osteoarthritis. Morbidities like asthma, chronic obstructive airway disease, hypertension, osteoarthritis, gastrointestinal disorders, anemia and eye and neurological problems were significantly associated with greater disability and distress.

Abdulraheem I. S. and Abdulrahman A. G. (2005) they have studied “Morbidity pattern among the Elderly population in a Nigerian Tertiary Health Care Institution: Analysis of a retrospective Study”. This study concentrate chronic disease is a major component of the burden of illness among the geriatric age group. Women had significantly higher mean number morbidities than did men. Joint pain and backache were the most common morbidities.

Vinod Kumar (2005) in his paper on “Health Status and Health Care Services among Older Persons in India”. Age-related disorders include life-threatening diseases such as heart disease, stroke, cancer, diabetes, and infections, as well as
certain chronic disabling conditions affecting vision, mobility, hearing, and cognition. Older persons also complain about various symptoms that may appear non-specific and unrelated to any classic disorder. These include general weakness, sleeplessness, constipation, flatulence, diminished appetite, decreased libido, and so forth.

Ashok Kumar T. Sowmiya K.R. and Radhika G. (2006) conducted a study on “Morbidity Pattern among the Elderly People Living in a Southern Rural India: A Cross Sectional Study”. It was found that 63% of elderly were suffering from one or more eye problems, which is slightly lower than Prakash R. et al. (2004). They found 70% of men sample had one or more eye problems. The present study included only cataract, corneal opacity and refractive errors. This study found that 44% of the elderly were suffered from hypertension. There are few (8.9%) elderly people having more than 6 morbidities. A small number (5.9%) of elderly is free from disease.

Jayashree (2003) in her paper “Improvement in Female Life Expectancy Trends and Implications”, pointed out that health of Indian women is more or less related to their socio-economic status within the household. India being predominately patriarchal society women have lesser share and access to health care. They are discriminated in terms of nutrition, care, recognition, treatment and prevention.

Sharma D. Mazta S.R. and Parashar A. (2013) conducted a study “Morbidity Pattern and health seeking behavior of aged population residing in Shimla hills of North India: A Cross-Sectional Study”, pointed out that a total of 400 elderly people aged 60 years and above were selected from rural and urban areas of Shimla hills in North India by simple random sampling Description Statistics were used to describe socio-demographic and morbidity variables. The most common morbidity identified among them was musculoskeletal problems 55.00 percent followed by
hypertension 40.5 percent. Two third were seeking treatment for their health problems. Among older persons not seeking treatment for their medical condition, most considered these morbidities as an age-related phenomenon. The presence of hypertension among the older persons in urban areas 56.00 percent was about twice that in rural areas 25 percent. Our study observed a significantly higher mean number of morbidities in rural areas.

Nair P.S. (1989) found that “The aged in rural India: A Study of the Socio-economic and health profile”, this paper reports on a study of the socio-economic and health status of the aged in the rural areas of Karnataka, India. The social milieu and setting represent the typical social structure prevalent in Hindu-dominated village India. The problem of economic dependency is accentuated by the fact that the majority of elderly females are widows. The incidence and prevalence of chronic as well as non-chronic diseases is obviously high among the elderly. The major chronic diseases are; respiratory diseases, locomotor illnesses and blood pressure. The majority of the aged have been treated by private physicians. Our study also observed highest treatment visit private hospitals.

Kamble S.V. et al. (2012) in their paper “Health Status of elderly persons in rural area of India”, this paper reported elderly are vulnerable to long term diseases of insidious onset such as cardiovascular illness, CVA, cancers, diabetes, musculoskeletal and mental illnesses. Hence, the study was conducted to assessing the health status and morbidity pattern among the rural elderly. Commonest morbidity observed among the elderly people was depression (31.4%), musculoskeletal disorder (25.5%), hypertension (24.1%), and diabetes mellitus (5.9%). And our study observed among the rural elderly people was depression (17.7%), hypertension (32.9%), diabetes (28.9%), jaundice (14.3%), paralysis (2.3%) affected with hernia problems.
and with other types of issues apart from these major health problems associated with them.

Paul A. Bourne et al. (2007) study is to examine the "Socio-demographic determinants of health status of elderly with self-reported diagnosed chronic medical conditions in Jamaica", the social determinants of poor health status of elderly Jamaicans with at least one chronic disease. Majority (43.2%) of the sample reported hypertension, (25.4%) diabetes mellitus and (13.2%) rheumatoid arthritis. The prevalence of chronic diseases and levels of disability in older people can be reduced with appropriate health promotion and strategies to prevent non-communicable diseases.

Prakash Rahul et al. (2004) "A Study of Morbidity Pattern among geriatric population in an urban area of Udaipur Rajasthan". In his study reported that 14.6 percent elderly persons had musculoskeletal problems in which 8.42 percent males and 17.3 percent females were suffering from arthritis of knee joints problems. In our study the prevalence of high blood pressure 9.7 percent, arthritis 2.0 percent of common diseases which are more prevalent in urban areas are known as deadly diseases in today’s life.

Sekhon H. and Minhas S. (2013) on the study "Psychosocial determinants of morbidity in the aged in a rural area of Punjab, India", this study out of the total 265 study subjects who participated in the study, 53.72% were males and 46.28% were females. The most common morbidities found in the study subjects were those pertaining to the musculoskeletal system. Amongst these, the most common was chronic low back ache. An equal percentage of male and female study subjects had ophthalmic morbidities; with the most common ones were those having depression and dementia.
A cross-sectional study conducted by Kishore S. et al. (2007) in the study “Morbidity Profile of elderly persons”, in which they found that the commonest morbidity was hypertension 41.4 percent, which was followed by musculoskeletal problems 36.8 percent and respiratory problems 36.1 percent. Their study among the elderly in a rural area of Punjab, India has highlighted a high prevalence of morbidity and identified common existing medical problems such as like anaemia, arthritis, cataract, depression, hypertension and diabetes mellitus.

Rao et al. (2003) study on “Health status of the rural aged in Andhra Pradesh: A Sociological perspective”, found that health problems tend to increase with advancing age and very often the problems aggravate due to neglect, poor economic status, social deprivation and inappropriate dietary intake. A high proportion of the total respondents stated that they were suffering from illness seriously. Lack of medical facilities in the village and poor economic conditions might be responsible for the low health status of the villagers.

Rao P.V. et al. (1989) study on “The Eluru Survey: Prevalence of Known Diabetes in a rural Indian Population”. Reported that prevalence of known diabetes was 6.1 percent in individuals aged above 40 years which was unexpectedly high at that time for a rural area with low socio-economic status and decreased health awareness, in our study prevalence of known diabetes was 28.8 percent of the rural elderly.

Ketshukietuo D. (2005) in the paper “Health Problems of aged among the Angaminagas”, mentioned that health is not only a biological or medical concern but also a significant personal and social concern. In general with declining health, individuals can lose their independence, lose social roles, become isolated, experience
economic hardship, be labeled or stigmatized, change their self perception and some of them may even be institutionalized.

Achir (1998) in the paper "Strategies to formulate Family Support System and Community based services for the care of the old", showed although, changes are good indicators of development, and dilemma for support capacity of the family towards the elderly is inevitable.

Pappathi et al. (2005) in the paper "Psycho-social Characteristics and problems of Rural Aged", showed that the psycho-social perspectives and problems and strategies to welfare of the rural female aged found that a majority suffer from joint pain, blood pressure and chest pain. A few complaint of asthma, piles, lose of weight, diabetes and skin diseases only 30 percent among the rural aged where in good health.

Vasantha (1998) in the paper “Nutrition and Health Problems”, found that the rural aged suffered from nutritional, psychological and other problems, when compare to urban aged. The aged employed privately and those self employed had more of health problems then not gainfully employed person. In general, the male members were found to be literate economically independent and had less physiological and nutritional problem when compare to the female counter parts, when literacy level, income level and employment status improve, they seem to have better health.

Balamurugan J. and Ramathirtham G. (2012) study on “Health Problems of Aged People”, aging brings about a number of physiological changes. It not only affects a person’s looks, but also becomes a cause of physical deterioration. This study was undertaken to understand the health status of elderly people and to gather some information about their perceived health needs using the information and over
of Puducherry district. Reveal that majority of the elderly, both male and female, are unhealthy. The most common health problems aged people face include eye sight, hearing, joints pains, nervous disorders, weakness, heart complaints, asthma, tuberculosis, skin diseases, urinary problems and others. More health problems were reported by women compared to men.

**Pilot Study:**

We have conducted the pilot study in order to test the interview schedule. 50 members were taken randomly in 36 villages of Guledgudda town. In the pilot study the interview schedule was administered and the relevance of the schedule was tested. On the basis of this test the schedule has been slightly modified and added few more questions.

**Period of data collection:**

The present study was based on primary data and data collected from the elderly people by using interview method during March-April 2011 and March-April 2012. There were many hurdles, while collecting information from the respondents.

**Statistical analysis of data**

The data collected have been analyzed by using appropriate statistical techniques. The chi-square test has been applied whenever possible. And also collected data have been highlighted with pictorial representation like bar diagrams and pie charts etc.
Chapterization:

The entire thesis has been designed in nine chapters. Each chapter lays emphasis on different aspects pertaining to the morbidity profile of rural elderly. The important issues of these chapters have been enumerated below;

CHAPTER-I, INTRODUCTION

Introduction chapter deals with concept of ageing, definitions of ageing, four aspects of ageing, the meaning and definitions of health, dimensions of health, determinants of health, conceptual framework among health status of the elderly, health and disability among elderly, health challenges of elderly, concept and definitions of morbidity, health and morbidity, how to find morbidity, problems of elderly, health problems, global ageing, global trends of population ageing, ageing-world perspective, population ageing in India, age structure of the population, sex ratio of elderly population, life expectancy of the elderly, trends, and theories pertaining to the morbidity profile of the elderly.

CHAPTER-II, METHODOLOGY

This chapter deals with methodology statement of the problem, objectives of the study, hypothesis, limitations of the study, justification of the study and area sample, method of study, review of literature, pilot study and chapterization.

CHAPTER-III, THE PROFILE OF THE SETTING

This chapter describes the area of study i.e., Guledgudda town of Bagalkot District of Karnataka State, general background of the study area, geographical features, historical background, demographic features, physiographic, rainfall, climate, language structure, religious structure, political structure, economic structure, educational structure, transport and medical facilities etc.,
CHAPTER-IV, SOCIO-ECONOMIC BACKGROUND OF THE RESPONDENTS

This chapter deals with respondents socio-economic perspectives like, age, sex, mother tongue, religion, caste, marital status, age at marriage, educational background of the respondents, sources for daily living of the respondents, living arrangement of the elderly, percentage wise age group and living arrangements, primary occupation, household facilities available to the respondents, economic aspects of the respondents and decisions making in the family matters of the respondents.

CHAPTER-V, MORBIDITY PROFILE OF THE AGED

This chapter deals with morbidity profile of the aged, difference between morbidity and mortality, type of physical disabilities among elderly, pattern of eye check-up, activities of daily living among elderly, ailments of the respondents, usage of physical aids of the respondents, mental fidgetiness of the respondents, mental oblivion and mental stress of the respondents, intensity of loneliness among the elderly, reasons behind mental stress of the respondents, hospitalization of the respondents, types of hospital, respondents preferences of medicine, present health problems of the elderly, percentage wise health and income of the respondents, duration of the ill-health or period of unhealthiness, transmitted diseases etc., sickness and morbidity profile.

CHAPTER-VI, DETERMINANTS OF MORBIDITY

This chapter deals with determinants of morbidity, food consumption of the respondents, type of food intake among elderly, accessibility of drinking water, distribution of households by main source of drinking water facilities, type of consumption of drinking water, cleaning hands before taking food, category and
cleaning up of hands before taking food of the respondents, measure taken to avoid from mosquitoes. Addiction (tobacco smoking, alcoholic addiction) pattern among the rural elderly.

CHAPTER-VII, DISEASE PATTERNS AND SUPPORT SYSTEMS

This chapter deals with disease patterns and support systems among the elderly persons, types of disease, acute and chronic conditions, expectations of the respondents, monthly medical expenditure and income wise distribution of the respondents, receiving health care facilities from government, reasons for not taking health facilities, care taker of the elderly during illness, old age pension and receiving the government facilities of the respondents.

CHAPTER-VIII, PREVENTIVE AND CURATIVE ASPECTS

This chapter deals with preventive and curative aspects of the rural elderly. Available facilities, constipation among respondents, remedial measures taken by the respondents, measures taken to prevent Arthritis, diabetic among the respondents, precautions taken by the respondents, measures taken to prevent paralysis, kidney disease, cancer, asthma etc., recent consultation with doctor’s, follow up doctor’s advice, measure taken by to prevent dysentery, respondents suffering from anaemia disease and measures taken to prevent anaemia.

CHAPTER-IX, CONCLUSIONS AND SUGGESTIONS

This chapter contains the conclusions and suggestions. The conclusion deals with the major findings and some suggestions to the policy makers.