Review of Literature and Related Studies
Review of literature is summarizing the current status of research including major findings, related to the problem of research. One will get an insight into the problem and thus will be able to formulate a correct plan for his investigation. This helps to eliminate duplication of what has been done and provides helpful suggestions for significant investigation. The literature pertaining to the study is discussed under the following headings.

2.1. Aging
2.2. Status of elderly in India and in Kerala
2.3. Characteristics of old age
2.4. Causes and consequences of aging
2.5. Problems of the aged
2.6. Quality of life of the elderly
2.7. Contributions of the Central and State for promoting the welfare of the aged
2.8. Related studies
2.1 Aging

Aging is a continuous process that begins with conception and ends with death. The process of aging is physiological and is assessed by comparing biological age with chronological age (Dhaar and Robbani, 2006).

Aging is a steady and gradual process which has always been regarded as unfortunate but inevitable part of the cycle of life. It is a relentless process in life leading to its extinction (Gowri and Sukumaran, 2003). Aging is a phase with the developmental task integrity versus despair (Bansod and Paswan, 2006).

Aging brings in its wake a host of changes in body and mind with consequent impact on the life style different hue. The people who live past sixty years of age or so are commonly known as aged or elderly (Devi and Murugesan, 2006). Old age is the closing period in the life span. It is a period when people 'move away' from previous, more desirable periods or times of 'usefulness' (Modi, 2001). A person's usefulness in the society diminishes because of aging. Since aging is a process, it is very difficult to define the term 'aged' (Reddy, 2006).

Aging is a natural and irreversible life process. Aging is generally associated with fatigue decline in functional capacity of the organs of the body, decreased ability to cope with stress of disease or trauma. Disabilities
that impair daily living activities are common in the very old; though aging is a multi dimensional process (Muttagi, 1997).

Aging is a period when people move away from the earlier periods of their lives, and they often look back on them, usually regretfully, and tend to live in the present, ignoring the future as much as possible. Age sixty is usually considered as the dividing line between middle and old age (Hurlock, 1998). All elderly persons with same age do not exhibit, similar physical signs nor do all aged persons feel "old". Being 'old' is a psychic perception while being labeled 'old' is a social ascription. Values and ethics vary with social traditions. Economic security always remains a matter of concern for the elderly (Maulik, 2004).

Aging as defined by Jerry and Jarry (1995) in Collins dictionary of Sociology as "the chronological process of growing physically older. However, there is also a social dimension in which chronology is less important than the meaning attached to the process. Different cultural values and social expectations apply, according to gender and age group and therefore there are socially structured variations in the personal experience of aging."

According to Devadas and Jaya [1996], old age is a period of feeling of inadequacy, rejection, self pity, apathy, negativism, rigidity and regressive tendencies. They also pointed that;
1. It is a period of decline
2. There are individual differences in the effects of aging
3. Old age is judged by different criteria
4. It is a period of loss of general attractiveness, productivity, mental functioning and decline in social contacts
5. It is characterized by loneliness, ill health, feeling useless, cautions, conservative, religious followed by financial crisis and poor adjustment.

WHO defines those aged 60-74 years as 'elderly' and those older as 'aged'. In 1980, the United Nations recommended 60 years as the age of transition for the elderly segment of the population. Bagchi (2002), categorized the senior citizens as follows:

- Young - Old between 60-75 years
- Old - Old between 76-85 years
- Very - Old 86 years and above

2.2 Status of elderly in India and in Kerala

India is on the threshold of aging society. A growing aging population can heavily affect a society's socio-economic development potential, particularly where real dependency ratio among the elderly is high (Singh, 2005). According to Help Age India (2007) there are 76 million senior citizens in India.
One of the many challenges facing India is its parabolically growing elderly population—growing much faster than the overall population itself. As two-thirds of the elderly population live in the rural areas, and more than half of the population is on the margin of poverty, poor health and unhygienic conditions, the care and wellbeing of the elderly will be an arduous task.

Every human being passes through various stages in his life—birth, infancy, childhood, adolescence, adulthood and old age. This biological transition through different stages has cultural and human overtones. Age definition and differentiation carry significance to the society and the individual.

Indian society was having traditional informal support system such as joint family, kin and community. The primary responsibility of the joint family was to protect its dependent members for instance, elderly children, disabled, by providing basic needs such as food, clothing, shelter, health and psychological support (Dube, 1999).

The elderly were consulted for guidance by the younger generation because of their experience and maturity in providing appropriate decisions (Sandhu and Arora, 2001). In traditional joint families, senior citizens lived with their children and grand children and were affectionately looked after, and in their turn they played specific role in raring up the grand children and transmitting family traditions to the posterity.
Due to the rapid industrialization and urbanization, the joint family system has been losing its importance and gradually disintegrating in India. The spontaneous respect and regard accorded to the aged out of sincerity and emotional attachment are absent (Bansod and Paswan, 2006).

In the past, family relations were strong and so the status and living conditions of the aged were different. The aged today feel neglected, helpless and unwanted, and old age homes are increasing everywhere (Patel, 2000).

Though the proportion of the elderly population is more in developed countries, majority of the old people, live in developing countries (Dhaar and Robbani, 2006). The number of aged is steadily increasing over time. India is also passing through a transitional phase where we are witnessing a gray revolution (Kohli and Varma, 2000).

The improvement in life expectancy and the disintegration of the joint family have created problems for the aged. Respect for the elderly is on the decline. The youth want change and often see parents and grandparents as an obstacle to this. Fundamental virtues of family life such as caring and sharing, giving and forgiving, respect and love are on the decline and so are all moral and spiritual values. This is primarily responsible for the neglect of the aged (Sundaram, 1999).
The status of older person in any country squarely rests on the level of the manipulating power of the persons. In most countries of the world, the older persons do not enjoy a decent status in society. This is all the more so in developing countries such as India which are economically poor and have been subjected to the ravages of demographic transition, migration, modernization, dwindling joint family, market economy, poor public health and hygiene and low social and income securities (Ramamurthy, 2003).

In India, the trends in demographic transition are alarming. There are 70 million people above 60 years of age constituting 6.5% of the total population. This is likely to touch 179 million by 2026. The percentage of female population aged 60 years and above constitutes 8.9% as against 8.0% of male population.

There are certain factors that affect the life status of the elderly. They are modern education and modernization, elderly sons and marrying daughter in later life, technical changes that are influenced by urbanization, materialistic and individualistic outlook, the break down of the joint family system and also common ownership of the property, high cost of living, scarcity of accommodation, migration of younger generation to urban areas, employment of women, neglecting children, additional economic responsibility of the eldest etc (Modi, 2001).
The traditional Indian value system used to place a heavy emphasis on prestige associated with old age. The elderly were the centers of authority and the most respected members of the family. These days, due to change in family structure, the elderly were not given adequate care and attention by their family members. This trend is fast emerging partly due to growth of "individualism", in modern industrial life and due to the materialistic thinking among the generation. These changes lead to their greater alienation and isolation of the elderly from their family members and from society at large (Desai and Raju, 2000).

In India, the family is the most important institution that has survived through ages. The joint family system has always been an integral part of Indian culture. The family transmits cultural standards to next generation. Despite forces of industrialization and urbanization, which have had significant impact on the traditional Indian family, the most modern nuclear family in contemporary time has deep-rooted links in various structural and functional aspects (Sharma, 2007).
### Table No. 2.2.1
**Growth of elderly population aged 60 and above by gender in India**
*(in millions)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Persons</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>1901</td>
<td>12.06</td>
<td>05.50</td>
<td>06.56</td>
</tr>
<tr>
<td>1911</td>
<td>13.17</td>
<td>06.18</td>
<td>06.99</td>
</tr>
<tr>
<td>1921</td>
<td>13.48</td>
<td>06.48</td>
<td>07.00</td>
</tr>
<tr>
<td>1931</td>
<td>14.21</td>
<td>08.94</td>
<td>07.27</td>
</tr>
<tr>
<td>1941</td>
<td>18.04</td>
<td>08.89</td>
<td>09.15</td>
</tr>
<tr>
<td>1951</td>
<td>19.61</td>
<td>09.67</td>
<td>09.94</td>
</tr>
<tr>
<td>1961</td>
<td>24.71</td>
<td>12.36</td>
<td>12.35</td>
</tr>
<tr>
<td>1971</td>
<td>32.70</td>
<td>16.87</td>
<td>15.83</td>
</tr>
<tr>
<td>1981</td>
<td>43.98</td>
<td>22.49</td>
<td>21.48</td>
</tr>
<tr>
<td>1991</td>
<td>55.30</td>
<td>28.23</td>
<td>27.07</td>
</tr>
<tr>
<td>2001</td>
<td>75.93</td>
<td>38.22</td>
<td>37.71</td>
</tr>
</tbody>
</table>

*Source: Economic Review, 2007*

Kerala, the southernmost state of India is unique in more than one way in terms of its social, political and geographical characteristics. Geographically the state is one of the most densely populated state and politically the state stand unique as the people of this area is more aware of state and national politics. Socially, the state stands different as the female population is different from the rest of the country. Kerala, which is having the highest literacy rate for men and women, is having a higher life span also.
Plate 1

Exerts from Newspapers - 01

State urged to set up tribunals for the elderly

The Senior Citizens' Friends Welfare Association has urged the State government to constitute special tribunals under the central Act for the welfare of elderly persons and parents.

A press note quoting Manjula Ramakrishnan Nair, general secretary of the association, said the special tribunals that were supposed to receive complaints from senior citizens and parents and find solutions to their grievances were yet to be formed even though the act came into force seven years ago.

"The government is yet to allocate an amount of Rs. 1.1 lakh to be spent on the preparation of an annual report, which is crucial for the proper functioning of the tribunals," the note said.

The association said the government was yet to issue an annual report which was necessary for the proper functioning of the tribunals.

The government was also urged to allocate an amount of Rs. 1.1 lakh to be spent on the preparation of an annual report, which is crucial for the proper functioning of the tribunals.

The association said the government was yet to issue an annual report which was necessary for the proper functioning of the tribunals.

It also requested the government to take steps to ensure that the tribunals were functioning properly.

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It also requested the government to take steps to ensure that the tribunals were functioning properly.
The state along with the rest of the country has driven off most of the contagious diseases like small pox, cholera etc and evolved a health scheme on the basis of the socio-economic status of the people. The maternal and infant mortality rate of the state are also lower than the national rates which is also considered by the experts as the reason for the highest standard of living (Rajan, 2003).

Table No. 2.2.2
Age Wise Population of India and Kerala

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>India (Crore)</td>
<td>Kerala (Lakhs)</td>
<td>India (Crore)</td>
</tr>
<tr>
<td>1</td>
<td>0-14</td>
<td>31.96 (37.76)</td>
<td>86.64 (29.78)</td>
<td>39 (37.3)</td>
</tr>
<tr>
<td>2</td>
<td>15-59</td>
<td>47.03 (55.57)</td>
<td>178.84 (61.42)</td>
<td>57.0 (55.6)</td>
</tr>
<tr>
<td>3</td>
<td>60+</td>
<td>5.64 (6.66)</td>
<td>25.61 (8.8)</td>
<td>07.00 (6.7)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>84.63 (100)</td>
<td>290.99 (100)</td>
<td>103 (100)</td>
</tr>
</tbody>
</table>

Figures in parentheses denote percentages.
60 വയ്സ്ത്തി എണ്ണം

ശിഷ്യങ്ങൾ 59%

DEEPAM NEWS, 21/10/2010

60 വയസ്സിൽ നിന്ന് എണ്ണം വരേണ്ണമാണ് ഇന്ത്യയിലെ. ഇത്, ഒരു കാലാവധിയിൽ നിന്ന് എണ്ണം വരേണ്ണമാണ്. അത് വ്യക്തികൾ 60 വയസ്സിൽ ദേശീയരെയും വ്യാപകമായി വെള്ളച്ചാട്ടം നിർമ്മിക്കുന്നു. ഇതിനായി ഒരു കാലാവധിയിൽ നിന്ന് എണ്ണം വരേണ്ണമാണ്. ഇത് വ്യക്തികളുടെ ആയുസ്സും കാലത്തൻ കാലാവധി ഉറപ്പുള്ള കാലമാണ്. വ്യക്തികളുടെ ആയുസ്സും കാലാവധി ഉറപ്പുള്ള കാലമാണ്. ഇത് വ്യക്തികളുടെ ആയുസ്സും കാലാവധി ഉറപ്പുള്ള കാലമാണ്.

2020ലെ ദേശീയ കാലാവധി തിരക്ക്. 60 വയസ്സിൽ നിന്ന് എണ്ണം വരേണ്ണമാണ്. 

<table>
<thead>
<tr>
<th>വയസ്സ്</th>
<th>എണ്ണം</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-64</td>
<td>0.63</td>
</tr>
<tr>
<td>65-69</td>
<td>12.67</td>
</tr>
<tr>
<td>70-74</td>
<td>14.68</td>
</tr>
<tr>
<td>75-79</td>
<td>15.71</td>
</tr>
<tr>
<td>80+</td>
<td>16.12</td>
</tr>
</tbody>
</table>

Exerts from Newspapers - 02

Plate 2
Among the Indian states, Kerala has the largest proportion of the elderly population and the growth rate among the aged is becoming higher and higher. It is growing much faster than the over all population itself. High female life expectancy in Kerala increases the population of older women (Beevi, 2008).

The demographic transition brought about by decline in birth and death rate has resulted in population aging in Kerala. This phenomenon is inevitable and irreversible and is experienced by all populations that are in the final stages of demographic transition. Ranking second in terms of population and seventh in terms of area, those above 60+ years contribute about 7% today in Kerala (Kohli and Varma, 2000).

Average life expectancy in Kerala has reached 68.8 years for males and 74.7 years for females, and this kind of longer life span is associated with worsening health condition. The gender gap in aging in the State is well documented with the consequences of aging more pronounced for females because they not only out number men, but also out live men (Gulati, 1997).
Table No. 2.2.3

<table>
<thead>
<tr>
<th>Age group (in years)</th>
<th>1991 census</th>
<th>2001 census</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Persons</td>
<td>Male</td>
</tr>
<tr>
<td>60-64</td>
<td>871572</td>
<td>41704</td>
</tr>
<tr>
<td></td>
<td>(33.95)</td>
<td>(35.02)</td>
</tr>
<tr>
<td>65-69</td>
<td>698734</td>
<td>324559</td>
</tr>
<tr>
<td></td>
<td>(27.22)</td>
<td>(27.28)</td>
</tr>
<tr>
<td>70-74</td>
<td>431280</td>
<td>199223</td>
</tr>
<tr>
<td></td>
<td>(16.8)</td>
<td>(16.73)</td>
</tr>
<tr>
<td>75-79</td>
<td>276932</td>
<td>121978</td>
</tr>
<tr>
<td></td>
<td>(10.78)</td>
<td>(10.24)</td>
</tr>
<tr>
<td>80+</td>
<td>288847</td>
<td>128057</td>
</tr>
<tr>
<td></td>
<td>(11.25)</td>
<td>(10.75)</td>
</tr>
<tr>
<td>Total 60+</td>
<td>2567365</td>
<td>1190862</td>
</tr>
<tr>
<td>Total population</td>
<td>29098518</td>
<td>14288995</td>
</tr>
</tbody>
</table>

Figures in parentheses denote percentages.

According to Chakraborti (2004), Kerala had the highest proportion of urban female (9.4%) and male (7.8%) elderly in the entire nation. Kerala is the only state in India having feminine sex ratio in both the rural and urban areas for all the three categories of elderly. Female predominance in sex ratio was the highest in Kerala in old-old category in rural and urban areas.
Old age blues and the dil factor in the Valley

It took months for the two desi families to reconcile their differences. Eventually they had to simply agree to disagree. The bone of contention was not money or property but a simple suggestion that complicated their lives completely. "Why don't you put your parents in a retirement community?" There are excellent ones in the country these days." The smoldering look from the other couple told their well-wishing friends they had strayed past the LOC. Needless to say, the suggestion started a war of words between other techic friends present too. How should NRI couples manage ageing parents and the ensuing old age problems?

Disintegration of the joint family has had a downside for several desi families who now face the dilemma of just how they should care for their aged parents. Do they step out of their comfort zone to care for them the old-fashioned way, akin to the manner in which their parents did when they were toddlers?

Exerts from Newspapers - 03
### Table No. 2.2.4

The Elderly Population in the Districts of Kerala, 2001

<table>
<thead>
<tr>
<th>Districts of Kerala</th>
<th>Population 60+</th>
<th>Population %</th>
<th>Population 70+</th>
<th>Population %</th>
<th>Population 80+</th>
<th>Population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerala</td>
<td>3335675</td>
<td>10.5</td>
<td>1401524</td>
<td>4.4</td>
<td>389013</td>
<td>1.2</td>
</tr>
<tr>
<td>Thiruvananthapuram</td>
<td>337184</td>
<td>10.4</td>
<td>135224</td>
<td>4.2</td>
<td>37044</td>
<td>1.1</td>
</tr>
<tr>
<td>Kollam</td>
<td>281616</td>
<td>10.9</td>
<td>117709</td>
<td>4.6</td>
<td>32710</td>
<td>1.3</td>
</tr>
<tr>
<td>Pathanamthitta</td>
<td>180018</td>
<td>14.6</td>
<td>84296</td>
<td>6.8</td>
<td>25539</td>
<td>2.1</td>
</tr>
<tr>
<td>Alapuzha</td>
<td>271910</td>
<td>12.9</td>
<td>118763</td>
<td>5.6</td>
<td>32000</td>
<td>1.5</td>
</tr>
<tr>
<td>Kottayam</td>
<td>251835</td>
<td>12.9</td>
<td>117030</td>
<td>6</td>
<td>35105</td>
<td>1.8</td>
</tr>
<tr>
<td>Idukki</td>
<td>102560</td>
<td>9.1</td>
<td>43437</td>
<td>3.8</td>
<td>12717</td>
<td>1.1</td>
</tr>
<tr>
<td>Ernakulam</td>
<td>352743</td>
<td>11.4</td>
<td>155098</td>
<td>5</td>
<td>44415</td>
<td>1.4</td>
</tr>
<tr>
<td>Thrissur</td>
<td>346943</td>
<td>11.7</td>
<td>148470</td>
<td>5</td>
<td>39862</td>
<td>1.3</td>
</tr>
<tr>
<td>Palakkad</td>
<td>265758</td>
<td>10.2</td>
<td>105561</td>
<td>4</td>
<td>27667</td>
<td>1.1</td>
</tr>
<tr>
<td>Malappuram</td>
<td>263551</td>
<td>7.3</td>
<td>96878</td>
<td>2.7</td>
<td>26412</td>
<td>0.7</td>
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<tr>
<td>Kozhikode</td>
<td>277870</td>
<td>9.7</td>
<td>114260</td>
<td>4</td>
<td>30954</td>
<td>1.1</td>
</tr>
<tr>
<td>Wayanad</td>
<td>58097</td>
<td>7.4</td>
<td>22957</td>
<td>2.9</td>
<td>6507</td>
<td>0.8</td>
</tr>
<tr>
<td>Kannur</td>
<td>246752</td>
<td>10.2</td>
<td>103391</td>
<td>4.3</td>
<td>28091</td>
<td>1.2</td>
</tr>
<tr>
<td>Kasargode</td>
<td>98838</td>
<td>8.2</td>
<td>38450</td>
<td>3.2</td>
<td>9990</td>
<td>0.8</td>
</tr>
</tbody>
</table>

*Source: Rajan, 2009*

### 2.3 Characteristics of old age

According to Hurlock (1998), old age is a period of decline. This period is characterized and judged by different criteria. There are individual
differences in the effects of aging. There are many stereotypes and social attitudes towards old age. The elderly people have a minority – group status and aging requires role change. Poor adjustment is the characteristics of old age and the desire for rejuvenation is widespread in old age.

Aging is a process of climbing upward in kinship status for women as well as men. The characteristics of old age are:

1. Loss of general attractiveness
2. Loss of productivity in the matter of work and money.
3. Feeling useless
4. Loneliness
5. Ill health
6. Financial crisis
7. Decline in mental functioning
8. Decline in social contacts
10. Demanding attention and unwillingness to do one's share of work.
11. Cautious, conservative and religious.
12. Feeling of inadequacy, rejection, self pity, apathy, negativism, rigidity and regressive tendencies

(www.ageing.oxfordjournals.org).
Although individuals age at different rates, certain broad generalizations about the aging process are relevant to the law. Aging is inevitably accompanied by physical decline. Muscles atrophy, bones become brittle, vision weakens, and hearing becomes less acute. Many older individuals have chronic health conditions such as arthritis. As a consequence of physical decline, many elderly persons are unable to care for themselves. And because of dementia or other mental disabilities, many also suffer a loss of mental capacity and some lose the ability to care for themselves. In response to these declines in physical and mental ability, most industrialized nations have adopted social benefit programs for the elderly and have created legal institutions and laws to confront the legal problems associated with the physical and mental consequences of aging (www.law.jrank.org).

There is habitually a lack of self-confidence in old age, particularly if the old people can’t take care of themselves monetarily. Their children are in the hight of their lives and repeatedly the children’s plans do not include them. Old age may bring a lack of ability to concentrate, forgetfulness, inability to speak, to hear, to see etc. So the old individual gets used to sitting in a chair as pensiveness, vegetating, saying nothing.

Old age is characterized by decline in health status, increased diseases, morbidity, mortality and physical deterioration. Old age is viewed as an unavoidable, undesirable, problem-ridden phase of life that we all are
compelled to live, marking time until our final exit from life itself. Perceiving old age with fear is actually a rather recent phenomenon. It seems to increase as each day passes and the world become more complex and less comprehensible (www.squidoo.com).

2.4 Causes and consequences of aging

Aging is a process of climbing upward in kinship status for women as well as men. A person may be old when the body loses vigour to the extent that it takes either the strength or mobility required to do adult work. Thus old age can also be defined in formal terms often dependent upon taking on new roles or losing old ones.

Aging is a natural period of change and development, corresponding in several ways with puberty. Hence it can be called as a second puberty in human life. It is a period of anxiety, of worry about bodily changes, of concern over the loss of physical, muscular, vigour and of nervous and muscular co-ordination, become rather depressed by the signs of aging and begin worrying about putting on weight or getting fat, about dieting and exercise and the disease of stress (www.disabilityindia.org).

Aging is a steady and gradual process, which has always been regarded as an unfortunate but inevitable part of the life cycle. The term old is associated with loneliness, low profile life, ill health and even in sanity (Neelima, 2000).
The last stage in the life span is frequently sub divided into early old age, which extends from age 60 to age 70, and advanced old age, which begins at seventy and extends to the end of life. People during the sixties are usually referred to as ‘elderly’, literally meaning advanced far in years of life and having lost the vigour of youth (Haas, 1999). The United Nations defines a country as ‘aging’ where the proportion of people over 60 reaches seven percent (Sharma, 1999).

The definition of aged officially accepted in India was 55 years or age of super annuation when the employees retired from service and subsequently it was raised to 58 years. In the Western countries however, a person is considered aged if he reaches the age level ranging between 60 and 65 years (Guruswamy, 2001).

In old age changes take place rather more or less suddenly and many persons are not prepared to face them. Therefore to an extent these changes are viewed as normal and are accepted with grace and without protest, decide on individuals adjustment (Patil, 2000).

According to Nayar (2000), survival and healthy old age are directly related to one's degree of independence. The loss of independence and usefulness are the factors that contributed to troublesome aging.
The aging process progressively decreases organ reserves. In elderly persons most organs function at or near capacity during ordinary activities. During stress, the aged experience inadequacy and it contributes to an overall difficulty in handling stressful situations (Prakash, 1999).

The process of aging and occurrence of diseases are linked to environmental factors. Living in calm and quiet surroundings, avoiding polluted water, air and noise can step up the quality of life. Aging needs to be prepared for and planned properly and judiciously (Natarajan, 1998).

Aging of population is a by-product of a demographic revolution, which is usually called the demographic transition. It has commonly been viewed as a consequence of the industrial revolution, but it is much more closely related to changes in public health and education than to changes in modes of production (Kapoor and Kapoor, 2000).

A growing aging population can heavily affect a society's socio-economic development potential, particularly where real dependency ratio among the elderly is high (Singh, 2005).

The aged are slowly being marginalized and being pushed aside from the mainstream of development. Because of the socio-economic changes and migration of younger people to the cities have left elderly to fend for themselves. In other words, the elderly have lost their roles as
head of the families with the shift from extended to nuclear families. They have lost control over the family economy and have not much decision-making power. In spite of these rapid socio-economic changes, the elderly continue to remain in the family because of strong emotional bonds (Philip, 2003).

Elderly persons have now become vulnerable and their social security and care has become a problem on account of the changing family composition, structure and values. In the modern world families started gradually withdrawing from the responsibility of looking after the aged; consequently, exploring the possibility of providing security through social institutions originated as an urgent need of the day (Syamakumari and Kumari, 2004).

Many elderly people, upon accepting the label of 'aged', do indeed change their style of dress. Those who are reluctant to alter their appearance or prefer the fashionable arouse derision or surprise. Many older persons seek what they now regard as appropriate forms of social activity, they join old-age clubs and day centers or the club houses of the park benches; where they engage in seemingly aimless conversations. All these types of behaviour bolster the image of the aged as needy, hopeless, sick and incapable of social involvement – in short, people whose lives are no longer worth living (Ramachandran, 2004).
Aging of populations and extension of life are significant by products of the demographic transition. Aging of population is primarily the result of two factors—reductions in fertility and mortality. The reduction in mortality rates implies a longer life span for the individual and the reduction of fertility implies a decline in the proportion of the young in the total population (www.oxfordjournals.org).

According to Ramamurti and Jamuna (1992), the significant determinants of successful aging include self acceptance of aging changes, self perception of health, perceived functional ability, perception of social support, inter—generational amity, belief in Karma and their life, flexibility, range of interests, activity level, marital satisfaction, religiouusity, certain value orientations and economic well-being.

2.5 Problems of the aged

Human development and aging are important in the Indian context. It is said that the most common cause of fear of old age is associated with possibility of poverty. The situational assessment of the aged and their socio-economic and health disparities to bring out an important though some what neglected fact that the aged are mostly heterogeneous group (Dilip, 2001).

Old age, in general, is associated with multi dimensional problems. The problems which are associated with old age and the care of elderly are not exclusively the problems with social, cultural and economic ramifications,
rather they include health and medical problems also that affect the life of the community as well (Saraswathi, 1998).

The problem of aging among the senior citizens has a special significance in contemporary societies. In the traditional society of the past in India, old age was no problem at all. Elderly persons were respected more than the younger ones. They were the chief patrons of the family. The stable joint family system in traditional Indian society was definitely a guarantee for the protection of the age. Initially under the regime of 'laissez faire' the elderly people had to struggle hard to take care of their welfare and face the hazards of old age individually with their own efforts. There was no one to look after their health and comfort due to acute non-availability of social security measures for the elderly people (Dandekar, 1996).

Aging is a toilsome treadmill grinding to a tragic halt as years pass by. The problems of the senior citizens in India and for that matter in most of the third world countries are different from the problems of the old persons in the developed and western countries. The social institutions, cultural milieu customs, traditions, religion, community controls and individuals as well as group psychology of the two worlds are quite different.
The above model shows that family provides different types of support to aged, at the same time change in the family structure leads to various problems for the aged in the contemporary society.

The different aspects of aging according to Kapoor and Kapoor (2004), is as follows:
1. Biological and physiological problems: it includes problem of mobility, problem in following routine work, dependency, senescence and senility.

2. Health care and medical services: It includes minor health problems due to negligence and lack of care, such as; defective eye sight, general weakness, pain in joints, cough and cold, defective hearing, blood pressure, digestive complaints, breathing trouble, tumbling of limbs, etc., chronic diseases, accidents, non-adoption of preventive measure and lack of health scheme for the aged.

3. Nutritional problems: It includes lack of awareness, education and non availability of nutrients.

4. Psychological problems: It includes mal-adjustment, lack of regard, affection, love, feeling of isolation, loneliness, neglect, insecurity, humiliation and frustration, inter-generational relations and generation gap, rigidity, dissatisfaction with life, socio-cultural problems, role diffusion, change on status, disintegration of joint family system, non participation in decision making, increasing materialism, individual orientation in place of family, urbanization, industrialization, displacement from rural to urban areas, changes in values, norms and culture.
5. Occupational and financial problems: It includes problems in arranging suitable part-time job in supplement their income, to involve them in some productive and creative work that is useful for them and society, thereby creating economic independency.

6. Environmental hazards susceptible to environmental change (heat and cold), pollution (noise and air, etc.,) and ecological imbalances.

7. Housing problems.

8. Social security measures for aged.

9. Communications and transportation.


2.5.1 Physical problems

Old age is a state of life, as childhood and youth. Age is recognized as a factor which indicates social life. The difference between old age and other states of life is that in the childhood, the child is looked after and treated with great care and in the middle age people reach a period of maximum capacity and vigour. After middle age the capacities and abilities of man show a slow but sure decline. In every field of life there are problems there is difference in the physical and mental strength to adjust with the problems and situations (www.scotland.gov.uk).
Old age is accompanied by a decline in physical fitness and an increasing experience with body aches and pains. Each person makes his own accommodation to his changing body. Some people become preoccupied with their bodily state, and each ache and pain is magnified while other people seem to ignore physical discomfort (Sivaraju, 2002).

Suffering from age based diseases, lack of treatment and nursing facility by the household members etc are the major issues in this period. Old age is a period of decline. Some are physically and mentally more active and sensible. Some are not. For some, decaying starts early, for some, it is late. The problems of old age are not same for all (Muthaya and Anneesudhin, 1997).

Physical changes that come about in old age actually shrink their world. Mobility gets reduced and walking becomes slower. Fractures on big bones can be caused by even gentle falls. Diabetes and hypertension may trouble them (John, 1999). Infection and illness are common problems of elderly people (Squire, 2000).

Some of the physical problems encountered during old age are reduced vision, dental decay, body weakness and pain, body cramps, problems related to diseases, slow movements, indigestion, sleeplessness and loss of hearing (Mehrotra and Batish, 2009).
2.5.2 Psychological problems

Aging indicates a type of process which, manifested by accumulation of adverse changes that decreases the ability of a person for carrying out various specialized functions. Aging processes, though, are inherent and inevitable, they are independent of stresses, trauma or diseases and are neither identical nor do they progress at the same pace in all persons (Natarajan, 1998).

The aging process itself is seldom the major cause of problems in Old age. The effect of disease and the social problems of growing old are often more psychological than material. He is constantly exposed to personal and emotional insecurity as well, which follow from his alienation from the nuclear family (Shabeen, 1995).

Aged suffer from both physical and mental health problems. Role due to retirement or loss of spouses and resultant loneliness emerges as another major socio – psychological problem. One writer states “Nothing could be more damaging to the human spirit than the feeling that one is no longer useful to anybody”. With the ‘social’ retirement aging quickens and the anxiety psychosis starts working feverishly (Singh, 1997).

Psychological changes accompany the passing of year’s slowness of thinking, impairment of memory, decrease in enthusiasm, increase in cautiousness, alternation of sleep patterns are well known features.
Emotional disorders in elderly occur as a result of social maladjustments. Failure to adapt can result in bitterness, inner withdrawal, depression, weariness of life and even suicide. After the age of 40, there is cessation of reproduction by women and diminution of sexual activity on the part of men. As a result, physical and emotional disturbances may occur when age increases. This may sometimes lead to certain common and frequent emotional changes like jealousy, irritability etc (Bose, 1998).

Anxiety is reported to be at a higher level among the elderly in general and symptoms such as feelings of loneliness and emptiness, economic uncertainty, general unhappiness or distress or general despair, meaningless and hostility are experienced by them (www.sciencedaily.com).

Old age is often accompanied with mental health problems. Among the elderly, anxiety states, depression, phobia, senile dementia and several other symptoms and diseases are reportedly pervasive. The longer one's life, the greater the risk of developing physical disabilities and mental impairment.

Psychological aspects of aging are much significant in assessing the morbidity of an individual. As age increases the sense of loss of status, loss of role, loss of economic security and independence lead to loss of self esteem and frustration. In the modern setup, the younger generation usually becomes more individualistic and forgets the responsibility towards their parents leaving them to loneliness.
Elderly people are highly prone to mental morbidities due to aging of the brain; problems associated with the physical health, cerebral pathology, socio economic factors such as break down of the family support systems, and decrease in economic independence. The mental disorders that are frequently encountered include dementia and mood disorders. The rapid urbanization and societal modernization has brought in a break down in family values and the frame work of family support, economic insecurity, social isolation, and elderly abuse leading to a host of psychological illnesses (www.thehindubusinessline.com).

Stress is important in triggering, psychological disturbances among the elderly than it is in the case of younger people. Progressively declining resistance to stress has been considered the most important biological characteristic of aging.

Men traditionally have a higher propensity than women to act out aggressively. Women on the other hand, suffer disproportionately from a variety of emotional ailments, such as depression and anxiety attacks. Approximately two out of every three cases are females. At present, World Health Organisation ranks depression as the world’s fourth most devasting illness (Foote, 2001).

Elderly people themselves are reluctant to seek psychological help, even when they believe they need it, because they grew up in an era
when doing so would be a sign of personal weakness. The twilight years of the elderly are ridden with a sense of neglect and loneliness (Varma, 2002). Their desires and wishes are not allowed to flower and they feel the pinch of loneliness, even voicing their likes and dislikes is prohibited (Vijayalakshmi, and Shoba, 2002). Added to this is the attitude of the younger generation which makes them isolated. The aged face psychological problems like lack of protection and supervision.

Old age is associated with decline in intellectual skills. Older people are not by virtue of their age, expert at dealing with problems of disability. Some of the negative consequences include; interrupted continuity in way of life, more need for more extreme coping methods, reduced capacity to use defenses such as selective interaction, difficulty in identifying new possible selves, de-personalization of the social environment, changes in reference groups, rusty skills in using feedback from others to fashion new self-conceptions (Woods, 1999).

2.5.3 Health problems

Aging is an index of deteriorating health. It may be fast or slow depending on the stage of social and physical health of the citizen. It becomes a problem in respect of certain senior citizens, if it becomes fast. The reasons for slow and fast aging relate closely to the social scenario (Rajan, Mishra and Sharma, 1999).
Old age in general is associated with multi-dimensional problems. The problems which are associated with old age and the care of elderly are not exclusively the problems of social, cultural and economic ramifications, rather than they include health and medical problems also that affect the life of a community as well (Dave and Mehta, 2008).

Health issues and medical care are considered to be a major concern among the large majority of the elderly. It is obvious that people become more and more susceptible to chronic diseases, physical disabilities and mental incapacities in their old age. It is generally noticed that the diseases of the elderly are multiple and chronic in nature (Gore, 1990).

Health needs problems of the aged are many and varied. With advancing age there is decreased vitality and increased vulnerability to common diseases, acute as well as chronic. Several diseases, such as cancer, heart ailments, diabetes mellitus, joint diseases, mental sub functions, chest complaints and disabilities of vision and hearing are particularly common in the aged. Nutritional problems are especially prevalent in the aged (Kapoor and Kapoor, 2004).

In old age health may begin to decline. Prior to old age many persons enjoyed good health. But in old age, many suffer from a variety of ailments. There is also a decrease in the resistance to various ailments. So
an old man is more likely to catch some infection and he is also likely to require more time to recover from these (Muthaya and Aneesudhin, 1997).

In some respects, aging is more difficult in a rapidly changing materialistic society. Modernization, urbanization, and consequent mobility play a vital role in the aging process of an individual. However, the intensity of their effects may vary from one individual to another. When compared to urban elderly, those living in rural areas tend to have more chronic health impairments, higher number of medical conditions, more functional limitations and a greater number of performance difficulties in activities of daily living and instrumental activities of daily living (Coward, 1991).

Health in old age is greatly determined by the pattern of living, exposures and opportunities for health protection over the life course. Those who worry the most tend to be those in the poorest health (Kalache, 1999). Aged, along with neonates are the most vulnerable high risk groups in terms of health care. Current trends towards nuclear families, urbanization, participation of women in the workforce and the development process all contribute to the erosion of traditional forms of care (Kalache and Sen, 2000). Ill health leads to dependency, discomfort and the feeling that time is running out bringing in more stress than pain (Joseph, 1994).

The elderly suffer from health problems like senile- cataract, glaucoma, nerve deafness, musculo-skeletal changes affecting locomotion,
failure of special senses and poor reflexes due to aging process (Park, 1999). Elderly people in low socio-economic groups or among those living alone are at higher risk of poor dietary intake (Wadhawa, Sabharwal and Sharma, 1997).

Not only are the elderly persons at risk of particular age-related diseases, they may suffer from a combination of several diseases and senescent changes. In addition to the multiple disabilities caused by the diseases themselves, complications may arise due to the complexity of drug treatment prescribed. Poor health is repeatedly cited by the aged as one of their most serious problems. Though the fact that many of the aged are more susceptible to sickness is neither denied nor disputed, the society generally considers old age as synonymous with illness. Further, much of the disability and ill health of old people is the result of both family and medical negligence (Bond and Peace, 2000).

Examples of the common age related disorders are arthritis, diabetes mellitus, dementia and depression, muscular weakness, easy fatigability etc. With increase in age there is a decrease in disease immunity and slowing of repair or recovery processes that increase the frequency of illness and prolonged convalescence (Birren and Schaie, 1997).

The elderly also suffer from poor sight, joint pain and stomach upset, rheumatic complaints, diabetes, hypertension etc. Many elderly suffer from malnutrition. Malnutrition affects not only the general health of the person
but also makes them more susceptible to disease and infection. A majority of the elderly, due to lack of teeth may not be able to munch and take hard and semi hard foods. This restricts the quality and quantity of food intake. Some of the elderly also suffer from gastro-intestinal problems like hyper acidity and mal absorption which affect the health (Sivaraju, 2002).

Other special consideration in the elderly relate to meeting energy needs in special populations, such as those suffering from Alzheimer’s and Parkinson’s disease, which frequently can lead to malnourished states and a diminishing of body weight. These conditions are often associated with reduction in food intake, probably due to a loss in functionality (Gibney, Horster and Kok, 2003).

The problems associated with aging are primarily related to health, economic aspects, housing and leisure time activities. The aged especially from the lower income groups often suffer from ill health and prolonged illness, mainly due to malnutrition, which in turn adds up to pressures on the economic front (Tandon, 2001).

Lens of eye undergoes opacification leading to progressive loss of vision due to cataract. Gradual impairment in the sense of hearing due to age related changes and slow decline in calcium content of bones which therefore become less dense and more brittle leading to osteoporosis (Goyal, 1999). The Indian Council of Medical Research (ICMR) has
attempted to compile data on morbidity from different sources. The total number of blind persons among the older population was around 11 million in 1996; eighty percent of them were due to cataract (Angra, Angra and Gupta 1997). Nearly 60 percent of older people are said to have hearing impairment in both urban and rural areas. The hearing loss and resultant communication problems adversely affect the well-being of older people (Kacker, 1999). The 1997 World Health Report clearly initiated that by 2020, over two third of death in developing world would be caused by aging related non-communicable diseases (Cohen, 2001).

Due to increase in life expectancy, which is the direct result of the better health care, the number of the aged in the society is on the increase. The proportion of the aged in the society is on the increase. The proportion of the aged in the total population is also becoming steadily greater. Demographic and socio-economic characteristics of the elderly are very important, to understand the problems among the elderly (Yogendra, 1997).

The process of aging of an individual is assessed by comparing biological age corresponds a chronological age. If biological age lags behind chronological age, aging is described as delayed or retarded. And if the biological age has advanced read of the chronological age, aging is described a precocious or premature. The "biological age" of a person is not identical with his "chronological age". Nobody grows old merely by living a
certain number of years. Years may wrinkle the skin, but worry, doubt, fear, anxiety, tension, and self-distrust wrinkle the soul. With the passage of time, certain changes take place in an organism (Dhaar and Robbani, 2006).

In India, the elderly people suffer from communicable as well as non-communicable diseases. The medical problems of the elderly can be categorized into three: a) problems due to the aging process b) problems associated with long term illness and c) psychological problems. Disabilities like senile cataract, glaucoma, nerve deafness, osteoporosis affecting mobility, failure of special senses, bronchitis, alzheimer's, rheumatism etc are considered as incident to old age (Thapar, 1996).

Certain chronic diseases are more frequent among the older people than in the younger people. It includes Cancer, diabetes, certain degenerative diseases of heart and blood vessels, diseases of locomotor system, genitourinary system etc followed by visual impairment, loss of hearing, psychiatric problems and skin diseases (Ingle and Nath, 2008).

2.5.4 Socio-economic problems

One of the major concerns of people growing old is income security, to pull them through the years when their health and family might fall them; though there are formal and informal ways of dealing with this biggest challenge of old age (United Nations, 2002 in www.un.org).
Old age is generally accompanied by a number of problems that the elderly have to face and adjust with in varying degrees. These problems are mainly: insufficient income to support themselves and their dependents; ill health; no creative use of free time; less social security; lack of love and recognition; decreasing social participation; less dignity and self respect; loss of economic independence; declining physical vigour and the emergence of various types of degenerative diseases. All these consequences of aging change the elderly from the independent self-supporting individual to one who is now in need of help and shelter and requires help from his children, members of the family and the society in general (Saxena, 2006).

Socio-economic status of the individual at this age is a major factor that decides if the person is likely to be a satisfied or unhappy one, with the physical decline in performance. The determining factors, here are, mental maturity, the realization that the end is drawing closer and is inevitable, the educational status, the occupation and the financial status (Kapoor and Kapoor, 2004).

The socio-economic problems of the elderly are aggravated by factors such as the lack of social security and inadequate facilities for health care, rehabilitation, and recreation. Also, in most of the developing countries, pension and social security is restricted to those who have worked in the public sector or in the organized sector of the industry. This is another reason for the poor socio-economic status of the elderly.
The social adjustment may be noted that qualities like adaptation to changed situation, positive communication pattern, optimism, healthy outlook towards life, initiative to take up-roles and realistic expectations are among some of the essential components of the ability to adjust harmoniously. It seems that social adjustment has a direct and strong hearing on the life satisfaction (Bose, 1998).

The loss of status of the age is primarily attributed to lack of positive, creative role in society after retirement. The reduction in income and inability to adjust with modern living standards due to retirement creates undue hardship and resentment to elderly (Alam, 2006).

Economic conditions have a significant influence on the depression level of the elderly. Depression is an emotional state characterized by exaggerated feelings of sadness, rejection and helplessness. The elderly have a much higher risk of depression than the young, because major losses tend to take place in the later stages of life like illnesses, change in physical status, loss of income on retirement, death of friends, loss of a life partner and changes in accommodation arrangements (Doron, 2001).

Along with birth and death rates, migration is yet another factor that affects changes in the number and distribution of population. However, in terms of its socio-economic effect on societies both, of origin and host, it
has far greater importance, more so with regard to the quality of life of older people (Prakash, 2001).

The aged feel a sense of social isolation because of disjunction from work relationships, demise of relatives and friends and mobility of children to far-off places for jobs. The situation worsens when there is physical incapability and financial stringency. The senior citizens are highly vulnerable to attack diseases. Increase of a stroke, no one may come to their rescue in time (Rajan and Kumar, 2003).

Living with spouse is a major factor in determining the social status of an elderly. The spouse is the only person who truly understands the needs of the individual and is a psychological support (Rao, 1994).

The retired persons experience fast aging if they are deprived of the continuity to work. The senior citizen who remain actively involved in social interaction even after their retirement, do not experience fast aging problems (Dhillon, 1992).

A vast majority of older persons have no social security at the age of 60. They live below the poverty line and have no part in the decision making processes of the family. They are not respected and the family neglects them. They depend upon their families for economic support and feel insecure (Goel, 2004).
Financial problems add to the misery of the aged. Having spent all their hard earned money on children's education and marriage, they are giving them shelter (Sundaram, 1999).

2.6 Quality of life of the elderly

Quality of life analyses began to be developed in the 1970's in order to describe and measure the impact of different conditions on people's daily lives, taking in to account emotional and social functions as well as purely physical ones (Aaronson, Ahmedzai and Bergman, 1993).

Quality of life refers to a person's subjective well-being. It reflects the difference, the gap, between the hopes and expectations of a person and their present experience. It is the measurement to measure the extent to which people's "happiness requirements" are met – ie those requirements which are a necessary condition of any one's happiness – those without which, no member of the human race can be happy (www.isqols.org).

World Health Organization defines, the quality of life, as the conditions of life resulting from the combination of the effects of a complete range of factors such as those determining health, happiness, education, social, economical and intellectual attainments, freedom of action, justice and freedom from oppression. The WHO Quality of Life Group (1995) explicitly identifies the subjective perceptions of individuals as a defining attribute of quality of life. According to them, it is a multidimensional...
approach, which involves the individuals perceptions of both positive and negative dimensions (www.who.int).

Quality of life can be defined as a composite means of physical, mental and social well being as perceived by each individual or by a group of individual – i.e. happiness, satisfaction and gratification as is experienced in such life concerns as health, marriage, family, work, financial situation, educational opportunities, creativity, belongingness and trust in others (www.calresco.org).

Goel and Gupta (2008) and Ferrans (1996) views that quality of life is a person's sense of well being that stems from satisfaction and dissatisfaction with the areas of life that are important to him / her. It is a systematic frame work which aims towards improving the lives of individuals.

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Quality of life is a descriptive term that refers to people's emotional, social and physical wellbeing, and the ability to function in the ordinary tasks of living. Quality of life analysis are particularly helpful for investigating the social, emotional and physical aspects of a person's daily life and also for determining the need for social, emotional and physical support during illness and on certain vulnerable groups (www.hayward.co.uk).

Quality of life is the product of the interplay among social, health, economic and environmental conditions which affect human and social
development. Quality of life aspects of an individual’s personality or temperament as the determining factor may result in fewer resources being invested in improving the material circumstances of vulnerable individuals (www.scotland.gov.uk).

Thirteen areas have been identified as the major indicators of quality of life by Malgavkar, (1996). It includes – food, health care, clothing, housing and supporting construction needs, education, transport – air, road, rail, sea. Communications, women population, growth, water, energy, ecology and global independence. Thus quality of life refers to ensuring basic infrastructural support leading to self – fulfillment and to creative partnership in the use of a nations productive forces and its human potential.

According to Baldwin, Godfrey and Protter (1990), the concept of quality of life has four dimensions. They are health and functioning, psychological or spiritual, social and economic and family living.

According to Nagchandhuri (1992), the concept of quality of life is connected with physiological well being, which includes the perception of personal health, adequate nutritious food, shelters and adaptation to the environment, including the perception of the environment by each individual and group, not only as a resource, but also as a source of aesthetic satisfaction.
Sen and Nussbaum (1993) addresses quality of life as a person's level of activity in daily living, specifically measuring the presence of related behaviours in the relevant areas; and is focused on the parameters like activity, daily living, health, support, outlook, mobility, physical activity and social participation.

Elderly persons quality of life is defined first and foremost by the respect they have for themselves something over which they have power and secondly by the respect the outside world shows them. It is easy to identify seniors who are excited about life. They are active and are well groomed, they watch what they eat and do not sleep their days away. They do not seek to isolate themselves at home or in nursing homes. Those who continue to cultivate their minds and pass on their life experience enjoy a superior quality of life (Jayashree, 2000 and Grouix, 1990 in www.vac.acc.gc.ca).

Elderly people also enjoys better quality of life and status with in the family. But the love and respect given to the elderly parents who are the partners in the development of family has almost vanished in the modern society at the dawn of the century (Ousepparampil, 2004).

Quality of life is concerned with evaluation of the 'wellness', of the person's state of being as well as with the goodness of his/her contribution to the country, to the success in achieving his/her over all goals.
In this context, the quality of life of elder people is of much concern (Gubrium and Holstein, 2000).

According to Hurlock (1998), Old age is the closing period in the life span. It is a period when 'people move away' from previous, more desirable periods or times of usefulness. Old age is associated with a series of stressors, and threatening events that may create physical and psychological problems as well as disengagements for older people, affecting their quality of life.

Studies have shown that there are a number of domains affecting quality of life of a person. Some of them are – income, food, health, shelter, inter-personal resources, education, socio-economic status, political system, standard of living and living arrangements, family life, total environment etc. These indicators are more or less same among individuals irrespective of their age group. In India also, these are some among the several factors which acts as impediments in bringing about a better quality of life of their senior citizens (Alberto, 2001).

The concept of quality of life is a quantitative measurement to evaluate the standard of life of the population. It evaluates the basic needs of people – security of food, shelter, drinking water, access to health care and education, right to employment, psychological security, peace, compassion and togetherness, whether human rights are respected and
investigate whether there is any disparity between races, classes or gender (Wailson, 2000).

Quality of life is often defined as the absence of health threatening hazards from the environment or as the absence of disease or medical problems. It is a multidimensional set of values, unique to each organism, person and context (www.evidence-based-medicine.co.uk).

Quality of life can also be defined as a systematic framework through which to view work aimed towards improving the lives of individuals (Bowling, 1991).

The approach to the measurement of the quality of life derives from the position that there are a number of domains of living. Each domain contributes to one's overall assessment of the quality of life. The domains include family and friends, work, neighbourhood (shelter), community, health, education and spiritual (The University of Oklahoma, 2001 in www.ou.edu).

Quality of life is the product of the interplay among social, health, economic and environmental conditions which affect human and social development. So is in the case of elderly people as well (Prasad, 1995).
Wong (2003) has identified 17 domains of life to evaluate the quality of life of elderly. He found that apart from personal health conditions, family ties, public safety, transportation, arts and culture, leisure, recreation,
facilities available to them were found to be more significant to determine the quality of life of the elderly.

In contrast with prevailing myths and stereotypes, older adults are an asset to our community. By meeting their needs and preferences, older adults remain a vital segment of our population – aging in a place for as long as possible. No older adults should ever have to choose between a meal and medications, remaining at home or moving in to unfamiliar surroundings, spending time with others or being alone. The longer older adults remain among us, the longer we retain an important part of our local heritage and economy. Higher levels of depressive symptoms are associated with higher rates of physical illness, higher health care resource utilization, and greater functional disability, all of which may compromise the quality of life and independence of older adults (Joyce, McGhee and Boyle 1999).

2.7 Contributions of the Central and State for promoting the welfare of the aged

The Central and the State Governments must first recognize the fact that the senior citizens are in need of much help. As far as the Indian Government is concerned it has begun awakening to the needs of the aging population, but the efforts need to be speeded up (Singh, 2001). The Government of India is fully sponsoring the National Old Age Pension Scheme. The eligibility criteria is that the age of the applicant should be 65
years of age or more, the applicant should be destitute in the sense of having little or no regular means of subsistence from his/her own source of income or through financial support from family members (Government of India, 1998).

2.7.1 National Policy for the Elderly in India

In view of the demands and expectations of the elderly people, the Government of India adopted the National Policy for the Elderly, in 1999. The macro and household implications of this phenomenon both economic and social were considered. The policy seeks to assure older persons that their concerns are national concerns and that they will not continue to live unprotected, ignored or marginalized. Under the policy, the state is to:

♦ Extend support for financial security, health care and nutrition, shelter, education, welfare and other needs of the older persons.

♦ Provide protection against their abuse and exploitation.

♦ Make available opportunities for development of the potential of the elderly, and

♦ Seek their participation and offer for their services so that they can improve the quality of their lives (Ponnuswamy, 2003).
2.7.2 National Council for Older Persons

A National Council for Older Persons (NCOP) has been constituted by the Ministry of Social Justice and Empowerment to operationalise the National Policy on Older Persons. The basic objectives of the NCOP are to:

◆ Advice the Government on policies and programmes for older persons.
◆ Provide feedback to the Government on the implementation of the National Policy.
◆ Advocate the best interests of older persons.
◆ Provide a nodal point at the national level for redressing the grievances of older persons which are of an individual nature.
◆ Provide lobby for concessions, rebates and discounts for older persons both with the Government as well as with the corporate sector.
◆ Represent the collective opinion of older persons to the Government.
◆ Suggest steps to make old age productive and interesting.
◆ Suggest measures to enhance the quality of inter-generational relationships.
◆ Undertake any other work or activity in the best interest of older persons.
There are 39 members in the council. A seven member working group has also been constituted from amongst the members of NCOP.

2.7.3 Old Age and Income Security

The Ministry has also launched a project called "Old Age Social and Income Security (OASIS)". An expert committee is constituted under the project. The first reports of the committee and the existing income security instruments available to older persons have been comprehensively examined. The report also contains detailed recommendations for qualitative improvement in the customer service of Public Provident Fund, the Employees Provident Fund, the Annuity Plans of LIC, and UTI etc.

The recommendations of the Committee are being examined by the Ministry of Finance for further action. Meanwhile, phase II of the project is looking at the pension and gratuity schemes of the Central Government and Old age Pension provided under National Social Assistance Programme (NSAP). At the core of the second phase of project OASIS, however, lies the designing of a new, fully funded, contributory pension programme for the balance (uncovered) workers including casual / contract workers, self employed farmers etc (http://www.disability.org/oldage.cfm).

2.7.4 National Old Age Pension (NOAP) Scheme

Under National Old Age Pension Scheme, central assistance is
available on fulfillment of the following criteria:

- The age of the applicant (male or female), should be 65 years or more.
- The applicant must be a destitute in the sense that he/she has no regular means of subsistence from his/her own sources of income through financial support from family members or other sources.

The amount of old age pension is Rs 75 per month. This scheme is implemented in the State and Union territories through panchayats and municipalities. Both panchayats and municipalities are encouraged to involve voluntary agencies as much as possible in benefiting the destitute elderly for whom the scheme is intended.

2.7.5 Widow Pension in Kerala

Widow pension is Rs 110 per month. The person must be a destitute and her income per year must be below Rs 12000. There is no age bar.

2.7.6 The Voluntary Organizations and Older Persons

Voluntary Organizations are expected to assist Government in dealing with the demographic revolution successfully through concerted efforts and sustainable solutions (United Nations, 1999). Today a number of organizations are working for the welfare of the elderly in the country.
2.7.6.1.1  Bharat Pensioner's Samaj

It has its headquarters in New Delhi and was established in 1960. It functions as a nodal point for pensioners belonging to central and quasi-state government organizations. It highlights the difficulties faced by the aged pensioners and other senior citizens at various forums and strives to solve the grievances of its member by negotiating with appropriate authorities. The Samaj helps the needy pensioners through a benevolent fund created through contributions from its well-to-do pensioner members.

2.7.6.2  Caritas India

It is a member of CARITAS International. It is the official national level organization of the Catholic Bishops Conference of India. It aims to promote care for the sick, crippled, handicapped, destitute and the aged.

2.7.6.3  The Indian Association of Retired Persons

Having its headquarters in Bombay, it is funded through membership fees, donations, grants-in-aid from the government and undertakes a variety of programmes for the welfare of retired persons. Organizes regular talks and discussion with the authorities to project the problems faced by retired persons in society. It open its membership to all retired persons those who are above 60 years of age. It brings out a quarterly bulletin and has a well-equipped library in Bombay. It is now working in a project for providing socio-medical and financial help to its members.
2.7.6.4.1 Age-care

It was initiated by Founder-Secretary N.L. Kumar as a non political, non-profit secular charitable, educational, cultural and social welfare society for the care of the aged. With a current membership of 1500 volunteers, it focuses on helping older persons to lead a healthy and dignified post retirement life. Membership is open to all physically fit persons 21 years of age and above, irrespective of caste, creed or sex. It reviews patronage from the government and is recognized by the United Nations in the U.N handbook of Organizations active in the field of aging.

A disability relief fund has been created at Age Care head office for rendering immediate financial assistance (up to a maximum limit of Rs.500 to the needy elderly during emergencies, accidents and sudden physical disability). It has set up day care center's, holds regular weekly lectures on topics of aging and allied interests, also seminars and conferences, creates awareness about problems of older persons among school and college students, and organize yoga and nature-cure training for the elderly. An innovative new project, day center on wheels, provides service like medical consultations, BP check-up, spots counseling and collates information pertaining to available facilities and services for senior citizens. The organization brings out a monthly publication, Age-care News, for the general reader and celebrates Elder’s Day on 18th November every year to honour senior citizens above 80 years as part of its annual day function.

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2.7.6.4.2 The Age Well Foundation

Formally launched on 6th April, 1999 at Delhi with support from the Ministry of Social Justice and Empowerment, it operates like a club by offering a life membership of Rs.5000 to an individual or an elderly couple. Children, especially NRIs can sponsor their parents to the club, which is chiefly concerned with the problems of the privileged elderly otherwise lacking organized help. The services arranged for elderly range from legal assistance, financial advice, ambulance service, help with pension problems, property tax notice, wealth/income tax assessment orders, and so on. The foundation levies a fixed tax on the subscriber, to be billed every month depending on their frequency of use. It runs on the employment exchange for older persons, helpline, involves elders as volunteers for social work and provides a platform to interact with other fellow senior citizens. The Age well Foundation, while charging costs for professional services, acts as a bridge in helping members access the 'right' sources to alleviate their specific problems.

2.7.6.6 Help Age India

It was set up by the Help the Aged of U.K in 1980. M.M. Sabharwal has been the chairman of both Help Age India and Help Age International. It started with the school education cum-fund-raising programme as the major fund raising effort. This becomes the mainstay of the resource mobilization activity which includes the use of video films, audio-visuals, advertisements, sponsored events and so on.
It is the country's largest voluntary organization with 23 regional offices, getting nominal grants from the central government. It runs on charity funds collected through motivating students and youth organizations, from private and public sectors, and through selling flags and greeting cards. The primary focus is to provide financial support to other voluntary organizations in the welfare of the aged. Research and Development centers also exist, where it trains its personnel in age care. It is accredited to the U.N and closely associated with Help the Aged, U.K. It is a founder member of Help age International. Its Mobile Medicare Units (MMUs) enable older people to assume an active role in looking after their own health while encouraging others to do same. 95 MMUs are at present servicing lakhs of older persons residing in slums, resettlement colonies and adjoining rural areas providing medicines, counseling and health care free of cost (Vankayalapati, 2008).

2.8 Related studies

Crandall (1980) in his study on "Gerontology-a behavioural science approach," identified that arthritis, hearing impairments, heart problems, high blood pressure, visual impairments, digestive disturbances, chronic sinusitis, mental and nervous conditions, genito-urinary problems and circulatory problems were found to be most frequent medical problems of the aged.

Kaur and Kaur (1987) in a study emphasized the fact that the
present generation treated the old people as a burden and their presence in the family troubles and irritates most of the family members. The study also observed that about one third of the aged experienced difficulty in spending their free time.

Soman (1992) in his study measured the health status of the elderly population, on the basis of morbidity and disability. He found that, though population of Kerala is low, there is an improved health level especially among the aged.

An examination of intra-family relations of urban elderly by Shah (1993) found that satisfactory intra family relations were somewhat higher among the widows than the widowers and somewhat lower among those living in joint families. Further, elderly having no substantial assets or fairly good source of income and who were economically dependent, found the attitude and behaviour of their family members as unsatisfactory.

Katyal and Hector (1998) made a study to compare the quality of life of old people living with their families and those living in institutions in Chandigarh. The results showed that old people living with their children considered themselves self-sufficient and had a positive frame of mind in contrast to their counterpart living in institutions.

Chandrasekhar and Bhooma (1998) conducted a study on the
nutritional profile of the elderly in Tamil Nadu, in terms of their background and life style information, food nutrient intake, body measurements, prevalence of diseases, haemoglobin, and trace mineral profile. The result of the study indicates that in general there is need to care for the nutrition and health status of the elderly. The fact that when familial care and security couple with conductive psycho-social environment brought about a better nutritional profile in the random sample studied is a definite indication of the need to look in to these factors while establishing institutions for the welfare of the elderly.

The prevalence of nuclear family was found among the upper class elderly and predominance of joint family system among the economically weaker poor elderly in a study by Sonia, Subha and Tyagi (1999) in Delhi.

A study by Nayar (2000), in Kerala, observed, spouses whenever available were the main source with whom the old interacted most in the family. Most of the respondents had friends outside the family with whom they frequently interacted. It was also found that more than half of the elderly expressed that they are dependent on others for money. They were considered burden financially and health wise, they were unadjustable, and there was nobody to look after them in the family.

The study by Jayasree (2000) on the living arrangements and exchange patterns of elderly in Mangalore revealed overwhelming majority
of the respondents strong aversion to reside with married daughters and overwhelming joy and tendency to live with married sons. The traditional norm of living with sons during old age was clearly evident in the study. The study also revealed that non-resident children maintains higher intensity of contacts with their parents.

A study on the aged was conducted by Dasgupta and Ray (2000) among the Santal tribals of Belkuli in Burdwan district, West Bengal. It was found that the break up of the joint family system is the major cause for many of the problems of the elderly. Almost all the elderly people in the area do some work and are therefore less burden to others. As a result they “consider a person old when a person loses his or her capability to work and earn for the family”.

Gaur and Kaur (2001) studied aged from Chandigarh, Panchkula and Mohali. The sample was divided in to institutionalized and non-institutionalized groups. A likert type scale was used to evaluate life satisfaction. The non- institutionalized elderly had a higher score for life satisfaction than those who had been institutionalized; the males had higher scores than the females. The non- institutionalized males had a higher range of activity and had more autonomy and independence. Males were also financially more independent and involved in outdoor activities than females.

Himabindu (2002) in her study in rural Andhra Pradesh observed
that rural aged women continue to enjoy their traditional status at various life cycle ceremonies and social gatherings. The hardworking nature imbibed, from early childhood in a marginal economy was observed to facilitate their better adaptation to old age, but for the minor exceptions here and there.

A study conducted by Help Age India (2003) in three metropolitan cities in the country among elderly people observed that among elderly females there was nobody to share their grievances. It was also found among elderly females that lack of work, lack of facilities for utilization of leisure time, and general feeling of loneliness, lack of emotional support, lack of money and lack of time by others for the elderly persons, where the major constraints that are faced by them.

Rajan (2003) in his study on 'Aging in Kerala' revealed that women are having a higher status during the old age and thus their health and nutritional status are higher than the men. He also analyzed the young old people and their position in Kerala in the context of demographic variables.

Royce and Elizabeth (2005) conducted a study on the Kottayam district of Kerala State on the 'views of home makers on living arrangements of elderly', revealed that home makers had a positive as well as negative attitude towards care giving to elderly. The study also revealed that elders spent most of the time by chatting with others, watching TV, taking rest, playing with children and indulging in many other activities of their interest.
Besides these elderly women were helping in household activities too. The company of pet animals while 'going for a walk' was enjoyed by men, while sewing and knitting were preferred by women who never had problems with eye-sight.

According to Sandhya (2005), women outnumber men in the oldest old age group (80+) and among women the vast majority are widows. At this age, most people would have retired completely from active life and most of them were economically depend upon their kin and this is in a higher degree than their younger age mates. This age is also characterized by a multiplicity of disease; some are acute and most of them chronic.

Alam (2006) in his study; an analysis relating to the living arrangements of the elderly is often promised on the notion of growing nuclearisation of families and declining trends in multi-generational living. As a fall out of growing urbanization and industrialization, younger couples are living in nuclear households, affecting the overall living arrangements of the elderly.

In a study conducted by Gunasekaran and Muthukrishnaveni (2006) on the 'living condition and health status of elderly in old age homes', the findings were as follows:- Most of the elderly staying in the old age homes were driven out of their homes by their family members. Majority of them are from poor families and are staying free of cost. As they were poor, not having any support from their families they found old age homes as the only
source of living arrangements for their rest of the life. Eye problems, blood pressure, arthritis, back pain and neurological or mental problems found major among the elderly. As most of them were not having adequate source of income they were passing the days with difficulty.

In a study conducted by Beevi (2008), in two districts of Kerala Alappuzha and Kottayam, the findings were – aging is predominantly a women's problem. Not only do women live longer, but most of them are widows. Most women do not work during their younger years. Certainly they cannot save anything for the rainy day and they are condemned to lead the last years of life in privation and misery. Majority of elderly women suffer deficiency of love, emotional support and care.