CONCLUSION AND SUGGESTIONS

Ageing is a universal phenomenon. On the global level, the phenomenon of ageing was first highlighted in 1982 when the United Nations organized the first World Assembly on ageing in Vienna. Since then, ageing population is not only the sole concern of developed countries; rather it becomes a critical policy issue in developing World as well. There is no escape to ageing; however, different countries are facing its impact differently based on their socio-cultural and economic characteristics. The Projections of the United Nations Population Division showed a massive demographic shift being taking place in both the developed and developing countries. For instance, the population aged sixty and above in the developed countries will projected to see the percentage of the old people in their population rise from an average of seven percent to over eleven percent by the year 2015. China and India, alone accounts for over fifty percent of the elderly in the less developed regions.

Presently, the developing countries are not emphasizing much on ageing and related problems as compared to the developed World. This is because the problem is not seen as serious in developing countries as compared to the developed nations. But in years to come, it will definitely throw some serious challenges to developing nations and especially to India as because of having the larger share of younger generation at present. India is also heading towards the similar demographic pattern like others. Today every sixth person in the World is an Indian and every fifteenth Indian is likely to be an older person. The population of older persons in India ranks fourth highest in the World and by the end of the present century it will be second only to China.

According to an estimate there are at present 76 million aged persons in the country. Thus India can not only boast of being the highly populous country, it can also claim a place among the “Aging nations”. The U.N has already declared India to be an “ageing society” where the aged accounts for more than seven percent of the total population of the World. Thus to experience ‘Delayed and Healthy ageing’ understanding of the implications of population ageing is must. In fact, this is the right time to think for these missing dimensions both at the micro and macro level. At the micro level, it implies the ways in which person adopt their lives to the important transitions that occur across the life course. It also implies coping with new issues arising from the adjustment on the part of the individuals. At the macro-level, it
implies the challenges of growing ageing population based on the economy, education, health, family and welfare concerns of a nation. It impacts on family structures and individual life-styles which, in turn, influence the quality of life of the elderly. In a nutshell, it becomes imperative to look into the various aspects of their social, economic, psychological and emotional problems.

The present study is a minor initiative in the field of ageing research to identify the needs and socio-economic problems of senior citizens in an urban context. It further outlines the coping practices as required for coming out of these socio-economic problems. Hence, the focus of the study was on both: the problem identification as well as on problem solving which further puts this study under the domain of Social Work.

The study basically focuses on the senior citizens of Aligarh city of U.P. The basic purpose of research is not merely identification and description, but also prediction and control of the problem in the present context. In this light, the present study was a modest attempt to understand socio-economic and health problems among the elderly along with their possible interventions. The study in hand is entitled as “A study on identification of socio-economic problems, coping practices and possible interventions for senior citizens of Aligarh (U.P.)”. Keeping this broader objective in mind the following research objectives have been formulated:

- To study the socio-economic profile of senior citizens of Aligarh city.
- To identify the socio-economic and health problems observed by the senior citizens of Aligarh.
- To analyze the coping practices adopted by senior citizens in coping with their socio-economic and health problems.
- To suggest interventions in dealing with the problems as identified in the present study.

‘Diagnostic cum Descriptive’ research design was adopted to realize the above objectives. The data for present study was collected from both the primary as well as secondary data. For primary data, interview schedule and case study method was adopted, whereas various journals, refereed books, articles, magazines and websites were scanned for locating studies relevant to the topic under study. This exercise helped not only in finding gaps in the studies but also helps in developing better
comprehension about different dimensions of the present study. Further, the Chi-Square test of significance was applied to test the association between background characteristics of respondents and socio-economic problems. Inferences were drawn from the statistical findings so arrived. Some important findings emerged from the analysis of statistical data which are discussed as follows:

First is the age-wise distribution of respondent covered under the study. The findings reveals that majority of respondents (54 percent) falls within the age group of young-old (60-69 years) followed by the old-old (70-79 years) 32.8 percent and the oldest-old (80+) 13.2 percent age group respectively. This shows that the sample covers senior citizens of almost all age groups falling within the different age categories. In addition, the composition of male and female respondents was found to be almost similar as it includes 50.6 percent males and 49.6 percent females respectively.

In order to study the age-specific gender differences, the gender-wise composition of respondents within the three age categories, namely, young-old, old-old and the oldest-old has been determined. The findings reveal that females outnumber males in the oldest-old age group which in turn indicates the vulnerability of oldest-old female elderly as it raises their chances of widowhood and financial dependence. These results go substantially in line with the observations of P. S. Anklesaria et.al.

In order to check the impact of religion on the life style and coping practices of senior citizens; religion as a variable has been introduced. The findings reveal that majority of respondents were Muslims (280) followed by Hindus (220).There was no respondent belonging to any other religious community. This shows the dominance of two religions in the sample. The above findings also matches with the religious distribution of the total population of Aligarh (Census,2011) which shows 81.49 percent share of Hindus followed by 17.78 percent Muslims and 0.73 percent population following other religions( e.g. Sikhism and Christianity).

Education directly affects an individual’s source of earning. Hence, an attempt has been made to diagnose the educational status of the respondents. Further the education is responsible for bringing improvement in the Quality of Life of respondents. The present study assumes that higher the level of education better will be his/her standard of living. The findings clearly reflects that although majority of respondents 327 (65.40 percent) were literate, but they were educated only up to
primary or secondary level (40.6 percent). For instance, there were 76 respondents (15.2 percent) who were educated till primary level, followed by 48 respondents (9.6 percent) till middle class, 59(11.8 percent) till high school and remaining 20(4.0 percent) respondents till the level of Intermediate. In addition, 12.8 percent respondents were totally illiterate. However, the percentage of respondents who were holding some higher degree was also significant i.e. 46.6 percent. Out of them, graduate and post graduate degree holders were 6.8 and 7.0 percent respectively. Besides, 29 respondents (7.0 percent) hold some professional degree (e.g. B. Tech, M. Tech, M.B.A, LL.B etc.) and about one-fourth (25.8 percent) of the respondents were holding the degrees of Ph.D or D.Lit. This shows that the sample comprises of a good mix of respondents holding lower as well as higher education.

Along with education, the present study also assigned an equal weight age to the marital status of respondents because imperative roles and responsibilities have been assigned to an individual on the basis of his/her marital status. Marital status is also important in case of determining the care giving and social interaction experienced by the elder generation. The present study reflects that majority of senior citizens (66.2 percent) were married and used to live with their spouse. This was followed by the number of widow/widower (32.2 percent).

It was further observed that higher percentage of married and living together respondents were from ‘young-old’ and ‘old-old’ age groups, whereas, majority of widow and widower belongs to the ‘oldest-old’ age category. This finding therefore suggests that with increase in age, the chances of living together with spouse decreases, hence increases the problem of care giving and social isolation.

In old age, care receiving and pattern of social interaction also depends upon the type and nature of family in which the respondents used to live. In the present study, the family has been classified into two broad categories, namely, nuclear and joint. Nuclear family is one where an aged person stays with his/her spouse and/or unmarried children or is living alone in a single household, whereas, joint family is one where the senior citizens are living together with their spouse and married children and grandchildren. The finding clearly reflects that overwhelming majority of respondents 280 (56 percent) were living in a joint family, whereas, remaining 280 (44 percent) respondents preferred living in nuclear families. The prevalence of joint
family over nuclear clearly reflects the fact that Aligarh is a traditional city which carries its own values and societal obligations of respecting elders. Hence, care receiving is not an issue for the senior citizens of Aligarh.

But the rapid pace of urbanization and better employment opportunities available outside the city has initiated the process of migration in the city. In old age, migration to any unfamiliar place becomes a social threat, as migration affects the life of senior citizens in many ways e.g. it develops the feeling of isolation and boredom, puts elderly into stress and depression and reduces their level of confidence. It also affects their eating habits, social and psychological health. In the present study, there is found no such impact of migration in the life of elderly as out of 500 respondents, only 63 (12.6 percent) had reported their shift to the city within the spell of last ten years, whereas, 435 (87.0 percent) respondents had never face such problem as they were either born in Aligarh or had shifted many years back.

Out of the small number of the cases of migration; the reasons as to why the respondents migrated were also studied and the reasons found were the retirement from work, considering Aligarh as a nice place to live in, employment of children in Aligarh and their financial dependence on them, loneliness due to the death of spouse, treatment of their chronic illnesses, shifted after communal riots etc. Findings also indicate the problems associated with migration of senior citizens. Out of those who migrated (63 respondents); ‘adjustment’ was found to be the most frequent problem observed by the majority followed by the problem of loneliness and reduced social interaction.

Moreover, the size of family and the proximal distance of children were studied in order to determine the extent of care giving available during old age. Size of family is related to the savings and probability of care received by the elders. Those with less income and larger family size were facing economic hardship. The findings reveal that majority of respondents 197 (39.4 percent) were living in a medium size family (having members between three to six) followed by 130 respondents (26 percent) residing in small family (husband-wife only). However, 92 respondents (18.4 percent) belong to the category of ‘larger’ family size (between seven to nine) and a significant number; 57 respondents (11.4 percent) belong to ‘very large’ family size (i.e. above 10). There were only 24 (4.8 percent) respondents who were living alone.
The findings also reveal that overwhelming majority of respondents 403 (80.6 percent) had at least one of their children living near them or within the same city to take care of the respondents. Out of remaining; 46 (9.2 percent) respondents had their children living in different cities, 41 (8.2 percent) had children settled abroad and only 10 (2 percent) had no siblings. This clearly suggests that overwhelming majority of respondents 476 (95.2 percent) had at least someone to look for. Hence, they do not need any formal type of formal care giving. The only need is to motivate the family as a caregiver.

In the present study, ‘Housing condition’ was also introduced to know the financial and health status of the respondents. For the sake of simplicity, the housing conditions have been classified into three categories as poor, average and good. The poor housing is one where total sanitation is absent, there was no drainage system, no toilet and bathing facility within their house premises and houses were even Kutcha i.e. made of straw, tin, and mud etc. An average house means semi-pucca house with one or two rooms along with toilet and bathing facility available inside the house. But the drainage system was not proper. In contrast, the good housing includes the well furnished pucca houses with three to five rooms, hygienic toilets; bathrooms and good drainage system. The findings reveal that overwhelming majority of respondents (70.20 percent) were living in good housing conditions followed by average houses (17.6 percent) and poor housing (12.2 percent) respectively. In terms of financial status; it was found that generally the labour class is living in poor or average houses whereas the middle and high income groups enjoyed living in pucca houses equipped with all modern facilities.

Along with housing, elderly needs some privacy. In old age, the people want to do their work in their own ways and that too without mood swings. They required private space for doing their Activities of Daily Living e.g. for doing prayers, taking rest, watching T.V. and for chatting with peers etc. The findings indicates that majority of respondents 313 (62.6 percent) had got a separate room for performing their personal activities, whereas, a significant number of respondents 187 (37.4 percent) either shared their room with someone else (other than spouse) or lives in Veranda, lobby or in some common place. Further, it was found that those who were living in nuclear families and had a good source of income were all having privacy whereas, those who were belonging to larger families and had lower income were generally shifted to
shared and congested spaces. Hence, in joint families the senior citizens got social
security but the extent to get privacy reduces, whereas, in nuclear families they
generally face the problem of social isolation and loneliness. Further, in joint family;
they generally face the problem of disrespect and lack of privacy, whereas in nuclear
family they hold the decision making power and experienced the problem of care
giving. Therefore, respondents belonging to any of the socio-economic class, they had
their own problems and needs.

Since the study aims at identifying the socio-economic problems of senior citizens,
many problems were identified in this regard. Loneliness is found to be one such
problem. The present findings indicate that almost all respondents felt loneliness in
old age. However, the intensity and reasons of getting lonely may varies. For
example, there were 368 respondents (73.6 percent) experiencing loneliness
sometimes, whereas, 132 respondents (26.4 percent) felt loneliness always. The
reasons they cited for feeling loneliness were their spouse’s death, children’s
indifferent attitude towards them and the poor health status.

In old age, the senior citizens do have a plenty of spare time and spending that in a
favourable manner is a biggest challenge. The findings revealed that majority of
respondents used to spend their leisure time in non fruitful activities e.g. 323 (64.6
percent) respondents spend their leisure time in gossiping, 275 (55.0 percent) in
watching T.V. and listening radio, 179 (35.8 percent) in pursuing religious cults, 166
(33.2 percent) in doing household jobs, and 108 respondents (21.6 percent) in doing
grand parenting. However, a very few respondents 42 (8.4 percent) showed their
interest in other gainful activities including gardening and joining senior citizens club,
participation in social and political events 56 (11.2 percent) respondent, visiting
public places 124 (24.8 percent) respondents etc. The findings further highlighted that
the respondents belonging to middle and higher income group generally adopt playing
(68 respondents; 13.6 percent) and reading 82 respondents (16.4 percent) as their
favourite time pass.

Moreover, the reasons behind the improper utilization of leisure time were studied.
The respondents complaint of having lack of facilities, improper channels of
communications and physical and financial dependence etc as the basic reasons
behind the follow up of leisure activity. They reported that Leisure activities in which
they were indulged were generally based on forced choices. Hence, they were either partially satisfied or totally dissatisfied with the leisure time activities. In this regard, the findings reveals that almost half of the respondents 249 (49.8 percent) were partially satisfied, whereas, 119 (23.8 percent) respondents were not satisfied with their activities of living. However, only 132 (26.4 percent) respondents were fully satisfied with their leisure time activities. Those who were fully satisfied belong to higher income group and to the young-old age group. This shows that the majority of respondents were not having facilities to choose their preferred life style. Hence, need is to provide for more fruitful ways of passing leisure time for the elderly.

Another significant variable linked to the socio-economic problems of senior citizens is the social status. Social status plays a significant role in the life of senior citizens as it not only affects their social position but also determines their mental and psychological well being. The present study indicates that a large number of respondents (55.2 percent) shared the same position within their family as they earlier used to share. However, a very small percentage (10.2 percent) reported that their social status has enhanced in old age. Those who reported increase are mostly belonging to higher income groups. However, almost one-third of the respondents (34.6 percent) reported decline in their social status. This was due to their poor health and financial dependency. They were generally belonging to the oldest-old age category. This shows that with increase in age and with more financial dependence, the social status generally declines.

Another component affecting the social position is the decision making power. The findings reveals that 47.2 percent respondents had shifted their decision making power to someone else. However, 264 (52.8 percent) respondents were still in a position to take decisions. On getting specific into the area where they used to take decisions it was found that out of 264 decision makers; 56 percent takes decision in financial matters, 71 percent in the matter of marriage and children’s education, 46 percent in household work and 83 percent in matters related to religious activities etc. The majority showing its share in decision making is just because of the traditional practice of giving love and respect to their parents. This shows that although Aligarh is in a rapid pace of urbanization but its’ cultural practices are still pertinent.
The findings of R.K. Punia et.al. in Hissar also supported the present observations and highlighted that 74 percent urban and 65 percent rural elderly were still treated as the head of their family. P. Mohanan et.al and S.Kaur and M. Kaur observes that majority of senior citizens enjoyed authority in making familial decisions and had no share in decision making in financial and other important issues.

In another study by Tulika Sen in Calcutta, the impact of ‘gender’ as a variable in taking familial decision was analyzed. The findings revealed that in rural areas, males play a dominating role in financial management (55 percent males), whereas, females (59 percent) play significant role in religious activities. In addition, the study of M. Jain and A. Sharma found that half of the aged men were consulted for matter related to education, festival, and social ceremony; three-fourth for marriage, land and property matters, 20 percent for societal work, 83.23 percent for occupational matters and remaining 36.6 percent participated in social activities. However, female’s opinion was sought for social functions and religion based activities only. Similar is the findings of present study as in most of the cases females are not involved in decision making (143 females) whereas, males (160 respondents) participation is more. However, females (104) who have reported their involvement in decision-making also complaint of having partial share i.e. they got involved in the discussions only but had given no choice to alter or take final decision.

In the present study the reasons for lost in decision making power was diagnosed. The findings suggest that those who lost their share either belong to oldest-old age group or gets financially dependent on family members. However, those who are living in nuclear families and belong to higher income group are the decision makers of their own affairs. S.K. Ghosh and Maulik in their study based on identification of family authority in old age depicted education, death of spouse and age of respondent as responsible for making decision in old age. For instance, the findings reveal that 82.44 percent urban and 73.14 percent rural aged were retaining authority in the family up to the age of 64 years only. Moreover, with the death of spouse only 26.4 percent rural and 42.1 percent urban retained their family authority.

This shows that the problems of senior citizens are interconnected. For instance, the problem of elder abuse is somewhat related to decline in social status. Elder abuse although is more prevalent but elderly considered it as a sign of disrespect and decline
in their social status and hence they hesitate in reporting abuse. The more severe the form of abuse, the least reported the case would be. Similarly in the present study, majority of senior citizens 350 (70 percent) denied to have any form of abuse. Out of remaining, 17.2 percent reported the cases of verbal abuse, 7.6 percent reported emotional abuse and neglect, whereas, a very small percentage of respondents 26 (5.2 percent) reported physical abuse. Similar findings have been reported by U. Bambawale in Pune, A.M. Khanin in Delhi and R.K. Punia et.al while comparing ageing problems among rural-urban areas and A. K. Panda in M.P. Hence, from above findings it can be concluded that elder abuse is very common phenomenon of present.

In case of abusers, family members were found to be the most frequent abusers or the primary abusers of elderly generation. The present study also reveals that out of the total number of reported cases of abuse; primary abuser was their son (56 percent) followed by daughter-in-law (29.34 percent), spouse (7.34 percent) and daughter (0.66 percent) respectively. This shows that senior citizens generally shared more healthy relations with their daughters and spouse as compared to their son and daughter-in-law.

In case of reporting of the cases of elder abuse, it was found that seventy respondents (14 percent) had never reported the case of abuse to any one, not even to their spouse. However, 28 respondents (5.6 percent) discussed it with their friends, 5.0 percent discussed it with spouse, 3.0 percent with neighbours, 1.8 percent with other family members and 0.6 percent with relatives. The reasons they cited for non-reporting of the cases of elder abuse were the maintenance of family honour and self respect and financial and physical dependency on others etc. In this regard, Shubha Soneja in her country report for W.H.O. outlined lack of emotional support, neglect by family members, and feeling of insecurity, loss of dignity, maltreatment and disrespect by the family members as the common forms of abuse experienced by the senior citizens.

But the basic problem with elder abuse lies in the recognition of these acts as abuse because the elderly person did not recognize these acts as abuse and linked it to only severe acts of violence e.g. battering and throwing out of house. Thus, it can be concluded that elder abuse is something which is more prominent but least reported phenomenon which needs more awareness and sensitization.
In old age, elder abuse also brings the feelings of disrespect and loss of self esteem. Elderly on getting abused from their family started feeling isolation and loss of self esteem. Thus identifying coping ways to combat abuse is a much needed intervention. In this regard, an attempt has been made to identify the coping practices adopted by the senior citizens themselves. For sake of simplicity, these have been classified into Emotion Focused Coping and Problem Focused Coping. The findings revealed that majority of respondents 379 (75.8 percent) adopted Emotion focused coping in case of disrespect and abuse. However, the problem focused coping was adopted by only one-fourth of the respondents (24.2 percent). The findings also revealed that the respondents in the age group of old-old (70 to 80 years) and oldest-old (80 plus) mostly followed emotion focused coping, whereas, problem focused coping was adopted by the young-olds (60 to 70 years) only. This pattern shows that with advancement of age, the practice of adopting emotion focused coping increased.

While looking into other alternatives through which the senior citizens can cope effectively against the psychological and emotional problems; Susan L. Hutchinson et.al reported that joining any social group e.g. Red Hat society may serve as an effective strategy for coping as it provides social support, emotional regulation, sustaining coping efforts and meaning focused coping rather than emotion focused coping. Similarly, E. Gunnarsson in his study carried out in Sweden and on the ‘oldest-old’ age group reported that both men and women respondents pointed towards the need of being active; positive thinker, remaining stress free and not good to take things easier as some of the qualities required in maintaining the self-esteem.

In this regard, religion was found to be as another alternative; as in old age people develop more faith in God. They even opted for religious practices as a means of coping against distress. Out of 500 respondents; almost half of the respondents 229 (45.8 percent) were using religion as a means of coping against psychological and emotional problems, whereas, 144 (28.8 percent) respondents followed it sometimes. Remaining one-fourth of the respondents (127) were not in a habit of adopting religion as a means of coping, however, they too had deep faith in God.

These people commented that religion is for the peace of mind and if they want to get out of some problems than their hard work will pay and not the prayers. In this regard, P.K. Muttagi also identified the practice of religion as a common trend among the aged men and women. He further reported that the senior citizens were using religion as a weapon against the management of psychological stress, alienation and loneliness. This all shows that religion is also playing a significant role in coping with difficult life-situations especially at the time of distress, psychological and emotional problems.

Media can also be used as an effective strategy for improving the quality of life of elderly as everyone is connected with media today. Keeping this in mind, the opinion of senior citizens regarding the role of media in reducing the intergenerational gap between the aged and the younger generation has also been identified. The findings revealed that majority of respondents 179 (35.8 percent) holds the view that media is responsible for enhancing the generation gap. However, 100 (20.0 percent) respondents believed that it all depends on an individual that how he takes the things. On the other hand, there were 35 (7.0 percent) respondents who believed that media has no role in either enhancing or reducing the intergenerational gap. For remaining 142 (28.4 percent) respondents, the question has no significance as they don’t have regular access to media. In addition, they were either illiterate, financially poor or were physically dependent.

Next alternative in providing effective life styles to the aged is to make them separate from their family members and provide all essential facilities to them. Government has made many efforts in this regard in terms of old age homes. But the problem lies in the psyche of individuals as they consider Old Age Home as a symbol of isolation, neglect, and deprivation. In the present study, an attempt has been made to understand the perception of respondents regarding the living of themselves and that of the dependent elderly in Old Age Homes. Do they prefer living in old age home over their present living or think that some other alternative may work more effectively instead of living in old age homes? The findings revealed that a large number of respondents 413 (82.60 percent) considered old age home as the right place for needy and dependent elderly. However, 85 respondents (17 percent) considered it as a wrong choice as nobody wants to get separated from their family. However, a very small percentage (0.40 percent) did not respond to these questions as they had no idea of
living in old age homes. In contrast, a large majority, 469 respondents (93.80 percent) totally denied their living in old age homes, whereas, twenty-nine respondents showed interest in shifting to old age home. Those who said ‘yes’ to old age home were generally belonging to the poor families and were getting abused frequently by their near ones.

This shows that life is full of necessities. Some needs are general whereas others are specific and based on individuals’ desires. But no life is possible without fulfillment of these basic needs. In old age when body shows decline e.g. in physical, mental and biological sphere; the life becomes difficult. In a situation like this, when deprivation to basic necessities was also added, the life becomes totally miserable. Hence, the variable ‘availability of basic services’ has been introduced to diagnose the basic problems of senior citizens. The findings clearly highlighted the deprivation of basic services in almost half of the cases.

As regards the occupation, it was found that 27.2 percent of the respondents belong to service class and were getting pension, 18.4 percent belong to labour class and another 10.6 percent belongs to business class. It was also observed that very few respondents (3.4 percent) in the young-old age group were doing some private jobs, 11.2 percent had their agricultural lands and cattle, 6 percent were getting rent, 6.8 percent were dependent on interest coming from their fixed deposits and only one percent were receiving old age and widow pensions. Besides, 15.4 percent of the respondents were dependent entirely on their family and friends.

The monthly income is also an important variable to determine one’s quality of life. The findings shows that that the monthly income of 112 respondents (22.4 percent) was below Rs.1000, followed by 82 respondents (16.4 percent) earning between Rs.1000 and Rs.5000 per month respectively i.e. considered as ‘low’ in the present study. There were 194 respondents (38.8 percent) belonging to lower income group. However, 106 respondents (21.2 percent) and 161 respondents (32.2 percent) were getting their income in the range of 5,000 to 10,000 and between Rs.10,000 to 20,000 respectively and were put in the category of ‘moderate’ income. However, the remaining 39 respondents (7.8 percent) belongs to the high income group as getting Rs. 20,000 and above on monthly basis. Out of these, many (11 respondents) reported that their monthly income was even more than Rupees one lakh. Thus in total
61.2 percent of the respondents were getting sufficient income to fulfill their basic needs.

The monthly income is also related to the extent of saving. In old age saving becomes even more significant as it reflects the senior citizen’s access to basic services including health, food, water and shelter. Those who had savings were able to utilize the best practices of health, food and housing etc. An overwhelming majority, 206 (41.2 percent) of respondents reported that whatever they earn is just equal to their expenditure and they had nothing in the name of saving. Further, they informed that whatever savings they had was all utilized in the upbringing, education and marriage of their children.

I.Rajan also brings forth similar results in his study based on Tamil Nadu, Kerala and Orissa. The above findings are also in line with the findings of Saraswati Mishra, who conducted her study on the retirees of Chandigarh and Jabalpur and found that both the Chandigarh and Jabalpur based respondents reported inadequacy of monthly income. The reason cited was the lower amount of Pension which is not sufficient to meet their basic requirements of life.

This shows that even the provision of pension does not bring quality to the life of senior citizens. This even put them into trouble at the time of emergencies and makes them dependent on their family and friends. This observation is fully supported by the findings of Moneer Alam who undertook his study in the nine districts of Delhi and found that two-third of the respondents were completely dependent on their respective families. The findings of R. Bakshi et.al, A. K. Panda and L. S. Talunkar and John A. Menachery also support this finding as majority of respondents in each study were found to be dependent on their family for their subsistence. Hence, in old age financial stability is must and which is generally found missing in present senior citizens. In a nutshell, it can be concluded that the younger generation must plan for having some savings for their old age and the elderly should keep some financial asset with them, if possible.

Keeping financial asset in old age is both a boon and a curse. It becomes a boon when it helps in maintaining the quality of life of senior citizens. It changes the attitude of family members towards them. Those who own some financial assets lead more satisfied life as they got all their requirements fulfilled. The financial assets turn out to
be a ‘curse’ when it leads to family conflicts and became a threat to social security. In the present study, the financial asset signifies the ownership of property, household, gold ornaments, vehicles, savings and animal resources etc.

The findings reveals that a very small percentage (27.2 percent) of the respondents kept two or three financial assets of good value with them, whereas, a large majority (38.6 percent) had either transferred it to someone else or left with the ownership of single household in which they were living. However, the remaining respondents 171(34.2 percent) did not hold any such asset and they were mostly females and males belonging to lower income groups. The present findings were fully supported by the findings of A. K. Panda as in her study only 11 percent were holding some property and 13 percent had jewellery, whereas, the remaining respondents were having no financial asset of their own.

Similarly, the findings of A.M. Khan partially support the present findings as study reported almost half (40.9percent) of the elderly holding some personal property whereas, 31 percent had property on the name of their spouse and 11.2 percent on their son’s name. However, observation of P.N. Sati goes in contrast with the above findings as his study shows that majority (95.7 percent) of the respondents were holding some assets. L. S. Talunker and John A. Menachery also found that 74.3 percent of the respondents had not transferred their immovable property to anyone, even in their old age.

In addition to above findings, the study diagnoses a significant relationship in between ownership of financial assets and gender as chi-square value comes out to be 28.19 which is more than the actual value( 5.99) at P=0.05 level of significance. The present findings suggests that majority of females (106) either do not owe any financial asset or have ancestral home as the only asset. However, a small number (65) of male respondents reported to have low financial assets. In general, a large majority of respondents (193) reported that they owe moderate level (one or two assets of good value) of financial assets on their names, whereas, 136 respondents reported to have financial assets of good value including few male (93) and more (43) females. Similarly, R. Chakroborty reported that 70 percent of the aged depends on others for their subsistence and females were highly vulnerable than males as only 31 percent of female respondents had an independent source of income. Similar findings
have been reported by Usha Bambawale in Pune. This shows that elderly females are more dependent on others for their basic necessities as compared to their male counterparts.

Along with gender, the finding suggests a significant relationship in between ownership of financial assets and level of education as chi-square value is more than the actual value at P=0.05 level of significance. Out of 500 respondents; 155 respondents either holding any financial asset or having ancestral home belongs to lower education group, whereas,10 respondents from moderately educated group and 6 respondents from highly educated group does not possess ownership of any financial asset. This shows that in old age mostly the ownership of financial assets decreases, but with higher education; the chances to retain more assets would have increased.

Economic hardship is a cause behind many socio-emotional problems. In old age, it adds up with physical dependence and liability to make the life of senior citizens more vulnerable. The Government, therefore has launched various schemes and policies meant to promote the well-being of senior citizens. But to gain the full benefits of these schemes requires the awareness, correct usage and accessibility of these schemes. To check this usage the variables ‘awareness of welfare schemes’ and ‘the extent of utilization’ of these schemes by the respondents have been introduced. For the sake of simplicity, focus would be given on those schemes which are commonly used by the respondents. First to analyze is the Old Age Pension Scheme (OAPS). It was found that out of 500 respondents; majority 394 respondents (78.8 percent) were knowing the benefits and correct usage of OAPS, whereas, a significant number of respondents 106 (21.2 percent) were even unaware of the procedure of making application.

While examining the reasons for not getting Old Age Pension (OAP); it was found that 291 (58.2 percent) respondents were not in a need of getting such help.130 (23.0 percent) respondents never tried for pension, whereas, 56 (11.2 percent) respondents found the procedure for application as difficult and the amount as meager. Out of those who had already applied for old age pension; 23(4.6 percent) would not receive it because of corruption. They reported that those who had to verify the application either demanded something in return or leave application unattended. They generally
signed the application of their close ones. This clearly shows the loopholes present in the implementation of social security measures.

Hence, the present need is to make the process of distribution flexible and transparent. Like the Right to Information Act; the procedure to submit application should be made easier as many of the senior citizens are still uneducated and dependent. Similarly, in case of Widow Pension (WP), a large number of respondents, 421 (84.2 percent) were found to be aware of the pension, whereas, a small number 79 (15.8 percent) shows their unawareness regarding the scheme. Further on looking into the access to other benefits, it was found that only educated respondents 182 (36.2 percent) were aware of financial benefits including tax reductions and high interest rates available for senior citizens on fixed deposits followed by 177 (35.4 percent) respondents who were aware of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007.

Similarly, I. Rajan also found the significance of education in the knowledge of various welfare schemes. His study reveals that most of the elderly were showing ignorance towards the welfare schemes just because of their lower education or illiteracy. Similarly, the findings of P. Mohananand Sajjan B.S. in Mangalore city of Karnataka based on senior citizens of old age home noticed that out of 1026 respondents, hardly 10 percent of the respondents were enjoying old age pension and 30 percent were enjoying retirement benefits. It was also found that male respondents were more aware about these advantages as compared to females, again showing the vulnerability of females. Similarly, P.N Sati in his study based on needs and problems of aged in Udaipur and Ajmer found that 53.4 percent knows about the welfare schemes. The present findings therefore suggest that majority of older people were not knowing the schemes meant for their welfare.

Since the study aimed at identifying the possible coping mechanisms, the question related to the perception of respondents regarding the best coping practices against financial hardship was examined. Basic aim was to check the respondent’s use of rational thinking and attitude towards handling of the financial problems. The findings clearly indicates that more than half 325 (65 percent) of the respondents were in a favour of saving something in earlier stages of life. However, 73 respondents (14.6 percent) hold the view that one should try to get engaged in work till his/her health
permits as savings get utilized before the time of old age. However, forty-one respondents (8.2 percent) were in favour of keeping some immovable assets, fifty-five respondents (11 percent) gave priority to socialization of children towards giving love and respect to their parents in the final stage of life, whereas, six respondents did not reply. The findings therefore suggest that majority of respondents support of having some savings for old age but the circumstances did not permit them to do so.

The study also highlighted the actual practices adopted by senior citizens in order to cope with financial crisis. The findings revealed that a large number of respondents 137 (27.4 percent) were depending entirely on their children for financial support. However, ninety six respondents (19.2 percent) used to cut down their expenses and try to manage within the available limits. Further if needed, they ask their children for help and if the crisis still exists, they left everything on god. Out of remaining, five percent reported that they sold out their assets if they had, whereas, others were in a habit of borrowing money from someone as 77 (15.4 percent) respondents borrowed money from their friends, 28 (5.6 percent) from their relatives and 43 (8.6 percent) from money lenders. Moreover, five respondents (1 percent) used to take loan on their pension and other assets whereas, only one respondent reported that he used to search for some better employment. However, only eighty eight respondents reported that they never faced any kind of financial crisis in their old age. This is because of their good earning and some earlier savings. Hence, from above findings it can be concluded that in old age the expectations to receive help, increases and majority did not think of making any serious effort for solving their financial problems. The present findings were fully supported by the findings of M. S. Randhwa.

While looking into the impact of education on coping practices it was found that those who are highly educated were mostly facing no crisis, 37 respondents (41.11 percent) and if so, they used to ask children, 29 respondents (32.22 percent) and sold assets, 8 respondents (8.88 percent). In contrast, the lower educated respondents ask children for help; 94 respondents (26.40 percent), cut down expenses; 79 respondents (22.19 percent) and borrow money from friends, relatives and money lenders; 131 respondents (36.79 percent) respectively.
Socio-economic problems had no significance if the health aspect has not been considered. Although health is the concern of every stage of life, but the level of concern rises as one enters the last stage i.e. old age. This is due to the fact that in old age; physical strength deteriorates and mental stability diminishes, which in turn leads to many health problems.

Hence after socio-economic problems, attempt has been made to diagnose the health problems of senior citizens. In this regard, first the perception of their present health status has been determined. A large number of respondents (40.4 percent) reported their health status as ‘poor’. Those who reported poor health status were either belonging to the oldest-old age group or to the labour class. Similarly, 27.2 percent of the respondents reported their health status as ‘average’ followed by 25.2 percent respondents, considering them as ‘good’ as they had no major ailments instead of B.P. and lower vision etc. However, 36 respondents (7.2 percent) considered them as bearing ‘very good’ health status. They were mostly belonging to the young-old age group.

This shows that the ‘age’ as a variable has a significant impact on the health of senior citizens and with increase in age; the health problems generally increases. Similar findings have been reported by L. S. Talunker and John A. Menachery in a micro-level study conducted in Rural Vidarbha where significantly large number (57.1 percent) of respondents opined that their health status was ‘bad’. Similarly, T. C. Joshua and D. T. Fiasta in their study observed that out of 231 respondents; 140 were suffering from various kinds of diseases and only 99 respondents promised of keeping good health. However, 42 respondents said that their health status is neither good nor bad. Dr. Saraswati Mishra in her study related independence with the health perception and determines that fully independent elderly (68.42 percent) are having a good perception of their health, whereas very few respondents who are partially dependent (4.24 percent) holds the similar view.

Sleep is the basic requirement of healthy body and peaceful mind. In old age, the body gets tired very frequently and requires more time for rest. The findings shows that majority of respondents 317 (63.4 percent) were in a habit of sleeping for more than eight hours a day. They mostly belong to the young-old age group. In addition, there were only 19 (3.8 percent) respondents who used to take a sleep of around five
to eight hours. In total, 164 (32.8 percent) respondents had expressed this kind of behaviour. This shows that with age, the pattern of sleep also gets affected. Similar findings have been reported by R.K. Punia et.al. where majority of rural (75.64 percent) as well as urban aged (55.38 percent) did not sleep properly. This shows that with age, the pattern of sleep also gets affected.

In addition to proper sleep, eating habits do have an impact on the health of senior citizens. Healthy eating practices make one feel healthy and energetic throughout their life. For instance, the American Psychological Association, highlighted that the diet rich in folate can help mitigate the feelings of depression, Dementia and mental impairment in senior citizens. The present study revealed that almost two-third of the respondents 385 (77 percent) were in a habit of having meals thrice a day and filled with essential nutrients as their diet includes all the basic vegetables, milk, curd, egg or/and meat and seasonal fruits. However, eighty six respondents (17.2 percent) reported that they used to take some light snacks and fruits in the evening along with three times meals. In addition, they take some energy giving health drinks and dry fruits etc. The findings also suggest that a very small percentage used to take meal twice 24 (4.8 percent) and once 10 (5 percent) in a day. They were generally belonging to lower income group and were not having access to nutritional meals. Whatever they had as food is to fill their hunger.

Further, it was found that gender plays no significant role in the intake of food habits as the chi-square value comes out to be 4.054 which is lesser than the expected value of chi (5.991) at 0.05 level of significance. The findings reveal that only a small number of respondents (11) were in a habit of taking ‘below average’ diet i.e. meals once in a day. The habit was almost similar in both the genders as 8 females and 3 males reported the similar pattern, whereas, a large majority of respondents (297), irrespective of gender (152 females and 145 males) used to take meals thrice.

Activities of Daily Living (ADL) is another variable which determines the individual’s status and role within the family. Health professionals even use the ability to perform ADL as a measurement of the functional status, particularly with regard to people with disabilities and the elderly. Activities of daily living (ADL) refers to the things elderly normally performed in doing daily living such as feeding, bathing, dressing, grooming, homemaking, and leisure etc. The findings clearly
reveals that a large number of respondents 434 (86.8 percent) were doing their ADL by their own. They all belongs to the young-old and the old-old age group, whereas, sixty-six respondents (13.2 percent) either falling in the oldest-old age group or were seriously ill used to take help of others in doing their ADL. This shows that lower the age of the respondents, higher will be the ability to perform their ADL by their own. This is generally due to decrease in health with age. Similarly, A. Bose and M. S. Kapoor in Delhi found that majority of respondents were able to do their ADLs by their own. In contrast, Moneer Alam in his study in Delhi reported that a large number of respondents were suffering from curtailed functional abilities in physical (eating, bathing, dressing, walking, climbing stairs, etc.) as well as in sensory health domains (hearing and vision). This makes them dependent on formal or informal help in doing their ADL. This dependency is acute in lower income group as compared to higher income group. It was also highlighted that females were doing their ADL more as compared to their male counterparts.

The study also outlines the number of ailments found among the senior citizens and reported that out of 500 respondents; majority 353 respondents (70.6 percent) were suffering from major health problems, whereas, 92 (18.4 percent) respondents undergo some minor illnesses. However, 55 (11.0 percent) respondents were not facing any kind of serious health issue. Among the major health problems, more than half of the respondents (56.8 percent) were facing the problem of arthritis/joint pain followed by T.B (21 percent), Cancer (27 percent) and Asthma (23.8 percent). In addition, Osteoporosis was reported by 84 (16.8 percent) respondents followed by Kidney failure/Paralysis 78 (15.6 percent), Diabetes; 68 respondents (13.6 percent), heart and lung related disorders; 45 (9 percent) respondents and severe memory loss by 6 respondents (1.2 percent) respectively. Among the minor health problems; the problem of high/low B.P. was reported by 356 (71.2 percent) respondents followed by lower vision or hearing 312 (62.4 percent) respondents and cataract by 225 (45 percent) respondents. Almost similar nature of health problems were reported by M.S. Randhwa, R.K. Puniaet al., T.C. Joshua and Diengdoh, T. Fiasta and Menachery et al.

Therefore, the above findings clearly reveal that with increase of age, the severity towards health problems increases. In addition, it was found that a significant relationship exists in between health problems and gender as chi-value comes out to be 13.435 which is greater than the actual value (5.991) at 0.05 level of significance.
The finding further indicates that majority of respondents (353) were facing one or the other major ailment.

On looking into the gender differences, it was found that females were suffering more from major diseases (193 respondents) as compared to minor (33 respondents) and no health problems (34 respondents). Similar pattern was observed in the male respondents with having 160 suffering from major health problems, 59 from minor and remaining 34 with having no health issues. The reason why the majority of females undergo severe health problems is their careless attitude towards self. Similarly, P. Mohanan et.al. in her study based on Mangalore city compared the gender differences in health and found that males had more number of chronic illnesses as compared to females e.g. Cataract (30.6 percent M, 19.7 percent F), Diabetes (40.2 percent M, 21.8 percent F), Hypertension (24.6 percent M, 12.8 percent F), Arthritis (5.4 percent M, 6.4 percent F), Asthma (1.9 percent M, 8.8 percent F). Thus it can be concluded that with advancement of age; the number of diseases increases and it was more in case of females.

Ignorance is generally the cause behind many health problems of senior citizens in India. In many cases, ignorance even leads to death. The present findings therefore indicates that a large majority of respondents 402 (80.4 percent) were in a habit of ignoring their health problems; whereas, only 98 (19.6 percent) respondents had shown their concern towards the treatment and care of their health as they never forget to take treatment in the case of any illness (either minor or major). Further, there is found no significant relationship in between the increasing age (young-old, old-old and oldest-old) and the ignorance of health problems as chi value comes to be 3.255 which is lower than the actual value of chi (5.991) at 0.05 level of significance. This shows that ignorance of health problem is a common characteristic in old age.

Along with self ignorance, the senior citizens experience the problem of ignorance by their family members and the problem of 'grand dumping'. 'Grand dumping' signifies the ignorance of parent’s or grandparent’s health by their children and finally dumping them into old-age homes or somewhere else. The findings reveal that a significant percentage (27 percent) were facing the problem of ignorance of health by their children, whereas a large majority of respondents 365 (73 percent) had never been ignored by their family in terms of health and other related matters. The basic
reason behind the concern of family was the prevalence of joint family system and social obligations of giving love and respect to their parents.

In urban areas, care receiving at the time of poor health is also amongst the basic challenges of old age. Urban cities are more influenced by nuclear family system. In the present study the informal care giving has been considered where caregivers include son, daughter, spouse, relatives, friends or someone who help them in doing their activities of daily living. About half of the respondents 269 (53.8 percent) reported the primary caregiver as their spouse. However, many reported their son 91 respondents (18.2 percent) and daughter 41 (8.2 percent) respondents as their primary caregiver. In addition, the other caregivers were identified as daughter-in-law; 62 respondents (12.4 percent), neighbours and friends; 12 respondents (2.4 percent) and relatives; 9 (1.8 percent) respondents respectively.

The findings further revealed that the senior citizens who are living alone have been cared of by their servants; 5 (1.0 percent). There were very few respondents (2.2 percent) who reported no caregiver. The findings of P. Mohanan et.al. fully supported the present findings as it was found that spouse (148; 120M, 28F) was the primary caregiver followed by self care (140; 22M, 118F); son or daughter-in-law (130; 20M, 110F), grand-children (72; 12M, 60F) and others (57; 18M, 39F). Similar is the findings of Anne Gray in Great Britain which suggested that with increasing age, care giving was restricted to spouse or adult children than to non-kin and relatives. Those who are living alone are cared by their friends. Hence, the primary caregiver in old age is the spouse and other family members.

On looking into the impact of gender on care giving it was found that females play the role of care giving more as compared to the males (286 females over 214 males).The findings are totally in agreement with the findings of N. Bano and C. Mayuri where majority of caregivers were females (73 percent) in age the group of 36-40 years and half of them were housewives. Similarly, the findings of C. J. Thomas and F. T. Diengdoh also supported the present findings. Further, the study highlighted no significant relationship in between the number of siblings and the amount of care giving provided by them as out of those who had been cared by their servants, relatives and friends do reported the presence of two or more siblings. Hence, the presence of children either less or more does not guarantee care in old age.
Intake of unhealthy substances; like alcohol, drugs, cigarette, bidi, tobacco etc. also affects the health of senior citizens. Although the intake of unhealthy substances is found less prevalent in the elderly age group, but its usage brings significant health hazards. The findings suggest that a large number of respondents; 302 (60.4 percent) were not in a habit of taking any unhealthy substances but a significant number of respondents; 198 (39.6 percent) still consumed unhealthy substances. Out of them, 56 respondents (11.2 percent) were addicted to cigarette followed by bidi 41 (8.20 percent) respondents, pan with tobacco 28 (5.6 percent) respondents, gutka 23 (4.6 percent) respondents and alcohol 15 (3 percent) respondents respectively. Remaining thirty five respondents (7 percent) used to take two or more substances together like bidi and alcohol, cigarette and alcohol, bidi and tobacco etc.

Similarly, L. S. Talunker and J. A. Menachery in Nagpur found the consumption of tobacco as the most frequent (68.5 percent) unhealthy practice adopted by senior citizens followed by the consumption of alcohol (14.3 percent); chillum (51.4 percent) and bidi (14.3 percent). Similarly, R.K. Punia et al. compared unhealthy practices in rural and urban areas and noticed smoking (61.53 percent in urban and 52.17 percent in rural areas) and drinking alcohol (urban; 4.61 percent and rural; 6.08 percent) as the two most common practices. However, the consumption of bhang 17.39 percent and opium (2 percent) was also prevalent in rural areas. This shows that elderly people do search for unfair means in order to get relief from their tensions and stressors.

The health problems would not affect senior citizens adversely if the proper treatment would be given to them. In India we had many healthcare systems consisting of Ayurveda, Yoga, Siddha, Unani, Homoeopath, Allopath, and Naturopath. Although each system has its own significance but the need is to check the access and availability of each with regard to the elderly care and usage. In this regard, it was found that majority (73 percent) of respondents were in a habit of utilizing Allopath as a means of healthcare followed by Homeopath; 62 (12.4 percent) respondents, Ayurveda; 50 (10 percent) respondents and Unani; 23 (4.6 percent) respondents. However, none of the respondent follows Yoga, Naturopathy and Acupuncture. This shows that ‘Allopath’ is the most frequent choice of medicine among the senior citizens. This is due to its easy access and faster healing ability. Dr. Saraswati Mishra also identified Allopathy, Homeopathy and Ayurveda as the three major systems of medicines adopted by senior citizens at the time of any health crisis.
Out of these; 61.67 percent preferred allopath, 7.07 percent preferred ayurveda and remaining (2.33 percent) preferred homeopath. This shows that allopath is the most frequent choice of medicine among the senior citizens and needs more promotion and access.

Further an attempt was made to diagnose the source of treatment adopted by the senior citizens and reason for its adoption. The present findings revealed that more than half of the respondents 279 (55.8 percent) were taking the help of private doctors, whereas, government hospitals were approached by only 104 (20.8 percent) respondents. The findings also suggests that mostly upper and middle income group were utilizing the services of public hospitals, whereas, those who had lower income followed the treatment from Quacks; 42 respondents (8.4 percent), Chemist shop; 38 respondents (7.6 percent), Vaid / Hakim; 27 respondents (5.4 percent) and free health camps; 4 (0.8 percent) respondents respectively. Private and expensive services were bare by only 6 (1.2 percent) respondents. This shows that the government health services are still serving as a lifeline to many senior citizens.

In order to check the reason behind the utilization of specific system; the question as to what extent they were utilizing and why has been asked. In response to this, the majority of respondents 249 (49.6 percent) reported the reason for utilization of such system as the availability of good services and effective results. However, another 194 (38.8 percent) respondents reported the reason behind their utilization of such services was the availability at lower cost. The remaining respondents (10 percent) preferred the reported system of medicine just because of its easy access. A very small group of respondents (1.6 percent) had no other choice, except to follow the available system. This shows that older people are not utilizing health care services as per their need rather they make forced choices.

Presently, the government is providing health care services at three levels, namely, primary, secondary and tertiary level. The primary level includes Health Centre (HC) with basic facility; secondary level includes Community Health Centre (CHC) and District Hospitals, whereas, tertiary level includes medical colleges, Hospitals and research institutions. The findings reveal that more than half of the respondents 289 (57.8 percent) were not utilizing the government services because of overcrowding. This was followed by negligence of staff 77 (14.4 percent), transport problems 50
(10.0 percent) and financial shortages 45 (9.0 percent) respondents respectively. However, 44 (8.8 percent) respondents did not have any problem in utilizing the government hospitals because of having their own relatives and friends working as a staff in the hospitals.

Thus, overcrowding in government hospitals was found to be the basic cause behind the non-utilization of government services. Similar is the findings of Dr. Saraswati Mishra where government hospitals were preferred by 29.25 percent, nursing homes by 6.85 percent and private doctors by almost half of the respondents (50 percent). Higher proportion preferring private doctors are mostly due to negligence they found in the government hospitals. In addition, L. S. Talunker and J. A. Menachery in Nagpur observed that 77 percent of the respondents did not prefer PHC services in villages due to dissatisfaction from services. Similarly, M.S. Randhwa observed that 52.8 percent rural and 47.2 percent urban did not get proper care in the hospitals. In similar line, A. K. Panda assessed that 27 percent elderly faces inappropriateness in services of government hospitals. In addition, C. J. Thomas and F.T. Diengdoh in their project on ‘Ageing in Meghalaya’ also came up with similar results by stating that those who want to access government hospitals expressed dissatisfaction over services (40 percent) followed by complaints of waiting for a long time (16 percent), doctors do not attend them (10 percent), doctors do not provide proper medicine (9 percent) and does not receive attention from other staff members (8 percent). Hence, need is to provide more hospitals and dispensaries with having special geriatric wards.

It’s true that with age body shows decline. But it’s also true that the preventive measures like regular exercise, walking, yoga, nutritious diet, remaining busy, managing stress, regular health checkups etc. can help in reducing the ill effects of ageing. It further makes one feel energetic, fit and at reduced risk of disease. In terms of healthy life styles; majority of respondents; 207 (41.40 percent) were in a habit of following one or two healthy life styles, followed by 201(40.20 percent) respondents following between three to five life styles, whereas, 70 respondents (14 percent) followed between six to eight life-styles on a regular bases. However, a very small number of respondents 22(4.4 percent) denied to follow any such activity. It was also found that those who were not following any healthy life styles were either bed ridden or belongs to oldest-old age group (80+ yrs).
Further, the individual life styles followed by the respondents were studied and it was found that 226 (45.2 percent) respondents used to go for a morning walk, 45 (9.0 percent) respondents does yoga or exercise, 125 (25.0 percent) visit their near ones and 32 (6.4 percent) respondents went on tours respectively. However, a very few respondents were in a habit of having their regular health checkups 27 (5.4 percent), taking balanced diet 80 (16.0 percent) respondents and gaining knowledge on old age issues 49 (9.8 percent) respondents respectively. Moreover, a significant number of respondents (37.2 percent) spend their leisure time in participation of social and political events. Keeping pets, cycling and swimming etc. was also reported by 55 (11 percent) respondents. The above findings clearly highlighted that majority of respondents are not in a habit of following healthy life styles.

The study further assessed the impact of education on the healthy lifestyle followed by an individual as majority of the respondents (190) having lower education were in a habit of following only one or two healthy life styles followed by the highly educated group (10 respondents) and moderately educated group (7 respondents) respectively. However, 123 respondents from the lower educated group are in habit of following three to five healthy life styles followed by highly educated (41) and moderately educated (37) respondents. Similar is the case for more than six healthy practices. This shows that highly educated groups are practicing healthier life style more as compared to the respondents having lower and middle education.

In addition to healthy life styles, the use of helping aid can also make the life of senior citizens simpler. Helping aid for senior citizens generally includes digital monitor for diabetes, walker, spectacle, hearing aid, B.P monitor, oddly shaped reading material, portable magnifier, wheel chairs, notebooks etc. The present study indicates that out of the total of 500 respondents, only 176 (35.2 percent) respondents were not utilizing any helping aid, whereas majority of respondents 324 (64.8 percent) were using one or the other helping aid to make their life simpler. The most common aid used by the respondents comes out to be spectacles and walker.

It was further identified that age has a significant relationship with the use of helping aid. Amongst the users; 54.07 percent were from 60 to 70 age group,73.17 percent falls in 70 to 80 age group and remaining 87.87 percent respondents belongs to the age group of 80 years and above. This shows that in old age, people generally
depends on helping aid as their means of coping against their health problems and this dependency increases from young-old to old-old and to the oldest-old age group.

Health Insurance can also be used as an effective tool in meeting the expenses of health of senior citizens. In this regard, it was found that majority of senior citizens 381 (76.2 percent) were not covered under any insurance. However, the remaining 119 (23.8 percent) respondents having health insurance are either from higher income group or belong to public sector undertakings. While checking the age-wise distribution of the use of health insurance; it was found that 75 respondents (26.78 percent) from 60 to 70 age group, 32 respondents from 70 to 80 age group and remaining 61 respondents in the age group of 80 years and above were covered under health insurance scheme. In total, 23.8 percent respondents were utilizing health insurance. This clearly shows that with increase in age of respondents; the utilization of health insurance as a means of coping against the health problems decreases.

On looking into their own choice of utilizing health insurance as a means of coping; it was found that 102 (20.4 percent) respondents denied for having such access. The reasons they gave for their denial includes their religious belief that insurance is against their religion, insurance cover is wastage of time and money and creates problem at the time of refund etc. However, a large majority of respondents 389 (77.8 percent) opined that health insurance is a good thing and every one must try to have it. However, the remaining respondents, 9 (1.8 percent) did not replied as they were totally unaware of the concept of health insurance.

In the final analysis; the respondents own perception of their old age has been considered. The findings indicate that out of 500 respondents, 210 were considering their old age as a normal experience, whereas , 206 (41.2 percent) respondents considered it as a ‘curse’. However, a handful of respondents 55 (11.0 percent) evaluated their old age as a ‘period of freedom from responsibilities’ and only 29 (5.8 percent) respondents considered it as an ‘achievement’. Those who considered it as a ‘curse’ were either belonging to lower income group or were physically dependent, whereas, those who considered it as a period of freedom from responsibilities were having sufficient income and proper caregivers. Similarly, that who earns very good income and share high social status considers their old age as an achievement.
In addition to above findings; the case studies were also conducted. The case studies reflected few interesting findings: First, senior citizens belonging to lower income group or were totally dependent considers their old age as a ‘curse’, whereas, those belonging to higher income group or were able to do their activities of daily living were still enjoying their old age. For them, old age is a period of freedom from responsibilities, whereas, others consider it as a period of struggle. Second; senior citizens, irrespective of their income, preferred living in their own home and with their close ones rather than living in any old age home. Third, health is the most common sector which affects almost every senior citizen and hence needs special concern and focused interventions. What is needed most is the attitudinal change towards the aged. Once the senior citizens started feeling their importance in the family and society, they started enjoying their life. For this, all the stakeholders including the media, the younger generation, the educational institutes, the NGOs, the policy makers, the politicians and the bureaucrats; all needs to join hands and work in a positive direction towards making the old age successful and healthy.

**Hypotheses Testing and Results:**

The present study purposes to test the following hypothesis:

* Females are more vulnerable than males in terms of their social status, decision making power, nutritional intake, ownership of assets and health status.

In order to test this hypothesis; the following sub- hypotheses have been assessed:

**Females are more vulnerable than males in terms of their social status.**

The chi-square test on gender and social status of elderly has materially significant relationship as the calculative value (23.44) is more than the actual value (5.99) at 0.05 level of significance. Hence, the present null hypothesis is accepted i.e. females are more vulnerable than males in terms of their social status.

**Females are more vulnerable than males in terms of their decision making.**

The chi-square test on gender and decision making was found to be significant at 0.05 percent level of significance as chi-value (12.403) comes out to be greater than the
actual value (3.841). This shows that there is a significant relation in between the gender and decision making and further checking the gender differences it was found that decision making in important matters was generally shared by the males. Hence, the present hypothesis is accepted.

**Females are more vulnerable than males in terms of their nutritional intake.**

The chi-square test on gender and nutritional intake of elderly has no materially significant relationship as the calculative value is lesser (4.054) than the actual value of chi (5.991) at 0.05 level of significance. The findings shows that there is no relation in between the gender and the dietary intake in old age as both the genders were showing the similar patterns of diet. Hence the present hypothesis is rejected.

**Females are more vulnerable than males in terms of ownership of financial assets.**

The chi-square test on gender and ownership of financial assets was found to be significant at 0.05 percent level of significance as chi-value comes out to be 18.19 which is more than the actual value (5.99). The findings highlighted the dominance of males over females in possession of financial assets. Hence, the present hypothesis is accepted.

**Females are more vulnerable than males in terms of health problems.**

The chi-square test on gender and health status was also carried out and the findings revealed a significant relationship in between the nature of health problems and gender as chi-value comes out to be 9.435 which is greater than the actual value (5.991) at 0.05 level of significance. Females were affected more by the major diseases as compared to the males. Hence, the present hypothesis is accepted.

Thus on the basis of the testing of above mentioned hypothesis it could be inferred that females are more vulnerable than males in terms of social status, decision making power, ownership of assets and health status. However, they were not differentiated on the grounds of dietary intake. But still the quality of diet reduces in old age. Hence the primary hypothesis was tested and found true and objective one and two are therefore achieved.
• Socio-economic problems increase with age. It is highest in oldest-old age group than in old-old and young-old age group.

In order to test this hypothesis; the following sub hypotheses have been assessed:

With increase in age of the respondents; social status decreases
The chi-square test on age of respondents and social status has materially significant relationship as the calculative value (17.325) is more than the actual value (7.82) at 0.05 level of significance. Hence the present hypothesis is accepted.

With increase in the age of the respondents; decision making power decreases
The chi-square test on age of the respondents and decision making was found to be significant at 0.05 percent level of significance as chi-value (16.715) comes out to be greater than the actual value (5.99). Hence the present hypothesis is accepted.

With increase in the age of the respondents; ownership of financial assets decreases
The chi-square test on gender and ownership of financial assets was found to be significant at 0.05 percent level of significance as chi-value comes out to be 12.329 which is more than the actual value (7.82). Hence, the present hypothesis is accepted.

With increase in the age of the respondents; severity of health problem increases
The chi-square test on gender and health status was also carried out and the findings revealed a significant relationship in between the nature of health problems and gender as chi-value comes out to be 23.27 which is very much greater than the actual value (7.82) at 0.05 level of significance. Hence, the present hypothesis is accepted.

Thus on the basis of the testing above mentioned hypothesis it could be inferred that with increase in age of an individual from 60 years to seventy or to the eighty and above age group; his/ her body started to show decline in almost all spheres making the individual vulnerable. Hence, the primary hypothesis was tested and found true. Thus objectives one and two are achieved.

• Social security increases with education. Those with higher education may have more ownership of assets and awareness towards the government schemes.
Higher education leads to more ownership of financial assets.
In old age the ownership of financial assets generally decreases, but with education it keeps on increasing. The chi-square test on education and ownership of financial assets was found to be significant at 0.05 percent level of significance as chi-square value comes out to be 18.02 which is more than the actual value i.e. 9.48. Hence the present hypothesis is accepted.

Higher education leads to more awareness of Government Schemes (especially Old Age Pension).
The chi-square test on education and awareness of Government Schemes was found to be significant at 0.05 percent level of significance as chi-square value comes out to be 12.389 which is more than the expected value (5.991) at 0.05 level of significance. Hence the present hypothesis is accepted.

• Religion serves as an effective tool for coping against distress.
The present findings suggest the dominance of two religious groups in the sample only e.g. Muslims and Hindus. An attempt has also been made to diagnose whether religion makes an impact on the nature of old age problems. Whether it serves as an effective tool for coping against difficult life-situations e.g. at the time of distress, psychological and emotional problems etc or not. It was also found that Out of 500 respondents, almost half of the respondents 229 (45.8 percent) were using religion as a means of coping against psychological and emotional problems, whereas, 144 (28.8 percent) respondents reported to follow it sometimes. Further females were more involved in religious practices as compared to their male counterparts. This shows that religion serves as an effective tool for coping against distress. Thus second objective was achieved.

• Migration after the age of sixty may leads to more socio-economic problems.
The present findings indicate that only 63 (12.6 percent) respondents had reported migration to Aligarh within last one decade. Out of those who migrated, ‘adjustment’ was found to be the most frequent problem associated with migration (44.46 percent) followed by the problem of loneliness (30.15 percent) and reduced social interaction (25.39 percent). Hence, from the above findings, it can be inferred that majority of senior citizens were settled in Aligarh from a long time and hence, they were not
affected by the impact of migration. But those who experienced migration, used to face some problems. Hence the present hypothesis is accepted and the second objective of research was achieved.

• **Elder abuse is the least reported phenomena in old age.**

Out of the total of 500 respondents, 70 percent refused to have any form of abuse, whereas, only 30 percent reported it. Almost two-third of the respondents did not reply on the question of getting abused at home or outside the family. Similarly, there were seventy respondents (14 percent) never reported to any one, not even to their spouse, 28 respondents (5.6 percent) felt free to discuss the incidences of abuse with their friends, 5.0 percent discussed it openly with their spouse, 3.0 percent with neighbours, 1.8 percent with family members and very few (0.6 percent) discussed it with their relatives. Hence, on the basis of above findings, the present hypothesis is accepted leading to the achievement of research objective as well.

• **Primary caregivers in old age are the spouse and the family members.**

In the present study, it was found that in most of the cases, a single individual carries the burden of care giving. The findings also indicates that about half of the respondents 266 (53.2 percent) were taken care by their spouse followed by siblings including son (18.2 percent) and daughter (8.2 percent) as their primary caregivers. Similarly, the other caregivers include daughter-in-law, 62 respondents (12.4 percent); neighbours and friends, 12 respondents (2.4 percent); relatives, 9 respondents (1.8 percent) and servants 5 respondents (1.0 percent) respectively. However, very few respondents 11 (2.2 percent) reported no caregiver at the time of their illness. Hence, on the basis of above findings, the present hypothesis is accepted.

• **Senior citizens are in a habit of ignoring their health problems.**

Ignorance of health problems is very common among the senior citizens. The findings indicates that a large majority of respondents 402 (80.4 percent) were in a habit of ignoring their health problems; whereas, a small number of respondents 98 (19.6 percent) have shown serious concern towards their health as they never ignored their ailments either minor or major. Hence, on the basis of above findings, the present hypothesis is accepted.
The ability to cope decreases with age and hence the old age needs more assistance and support.

The present study indicates a significant relationship between the coping practices adopted by the respondents and the age of respondents as the chi value comes out to be 17.325 which is greater than the actual value at 0.05 level of significance. The findings revealed that majority of respondents 379 (75.8 percent) adopted for Emotion Focused Coping. The Problem Focused Coping was found to be the choice of only one-fourth of the respondents (24.2 percent).

The findings also revealed that the problem focused coping has been showing decreasing trend as 26.27 percent respondents from the age group of 60 to 70 years, followed by 25 percent from 70 to 80 age group and 13.63 percent in above 80 years age group used to follow the problem focused coping. This pattern clearly shows that with advancement of age; the capacity to solve any problem decreases and hence they adopted the easier way to come out of it in terms of emotion focused coping.

Coping against health problems indicates that majority of respondents 381 (76.2 percent) were not having any kind of health insurance. It was also found that 119 (23.8 percent) respondents who are having health insurance are either belonging to higher income group or to the public sector.

Further, on looking into the age-wise distribution of the use of health insurance it was found that the age of respondents has a significant relationship with the use of health insurance (chi value = 12.931 > 5.991 at 0.05 level of significance). The findings further reveal that 205 (73.21 percent) respondents from 60 to 70 age group, 115 (78.23 percent) from 70 to 80 age group and remaining 61 (83.56 percent) respondents in the age group of 80 years and above are not utilizing the benefits of any kind of health insurance. Thus on the basis of these findings, the above hypothesis is accepted and hence the third objective is also achieved.

**Implications of Socio-economic and Health Problems**

There are wide ranging implications of socio-economic problems of senior citizens. Some of which are discussed as follows:

- Socio-economic problems may increase with age
- Problems of senior citizens are interconnected in nature.
• Females are more vulnerable than males in terms of socio-economic problems.
• Education directly affects an individual’s source of earning.
• Significant number of people suffers from elder abuse.
• Females were more vulnerable than males in terms of abuse.
• There will be an ascendance in the abuse as the age of senior citizens increases.
• Elderly will suffer more from a variety of health problems.
• With increase in age; the health problems generally increases.
• Ignorance of health problem is a common characteristic of old age.
• With increase in age, the pattern of sleep gets affected.
• A healthy eating practice makes one feels healthy and energetic.
• An Activity of Daily Living determines the individual’s status and role.
• Care giving in nuclear families will continue to be a problem.
• More nuclear families in cities will generate the problem of social security for elderly.
• Older people will make forced choices in the utilization of health care services.
• Primary care giver in old age is the spouse.
• Lesser proportion of married elderly will have care giving problem as compared to single and widows/widower.
• Migration in older years will bring the feeling of isolation and boredom.
• With advancement of age, the capacity to deal any problem decreases and hence the elderly will adopt emotion focused coping.
• With advancement of age, the interest towards following healthy life-styles may decrease.
• Economic hardship is a cause behind many socio-emotional problems.
• Financial hardship increases with the advancement of the age of elder generation.
• Females are more vulnerable than males in terms of ownership of financial assets.
• Financial independence in old age is a must.
• Elder women will witness erosion of authority and decline in the participation of decision making.
• Elderly widows need to be given special assistance along with pension.
• In absence of social security; elderly perceive themselves as burden.
• Old age brings a feeling of loneliness.
• Religion will play a significant role in coping with difficult life-situations.
• Need for Old Age Home is going to increase in the near future.
• The amount of Old Age Pension needs to be revised and made flexible.
• Geriatric health care services are positively required for bringing quality of life to the elderly.
• Loopholes present in the implementation of social security measures needs to be checked.
• Other than familial support, NGOs and other formal organizations will have to take responsibility of providing formal care giving to the elder generation.

Policy recommendations and suggestions

The old age problems are multi-dimensional ranging from social, psychological, emotional, economic and health aspects to that of neglect, social security and isolation. In India, the senior citizens belong to various localities (e.g. rural, urban and tribal) and had different socio-economic needs. This is because of the individual differences experienced by them in their living conditions, cultural practices, religious
institutions and social and personal beliefs. What is applicable in urban areas is having no significance in rural areas. What seems to be the policy issue for one (oldest-old) age group may not be relevant for the other age group (young and middle-old elderly).

Considerable differences were also observed in case of their emotional, biological, financial and health needs. Hence, the elderly constitutes a homogenous group comprising of individual differences. These differences clearly pointed towards the need of taking the individual differences into consideration while planning any development programme for the welfare of aged. For this, differential planning is needed both at formulation and implementation level. Emphasis should be given on need based interventions rather than on making any attractive policy document.

Geographical Information System (G.I.S) should be implemented for aged data base, which will help in information management, monitoring and updating of information.

Courses on ageing and related issues should be included in the University, college and school curriculum level. Hence, for the overall well being of senior citizens, a multi-pronged approach is needed. This requires the joint efforts of government as well as of private organizations.

Moreover, the need is to make our elder generation organized because majority of senior citizens resides in rural areas with having no access to basic services and had negligible share in decision-making. Thus, first emphasis should be on making the ‘grey power’ visible and effective so that they can easily build pressure on the policy makers for developing effective programmes. For this, the government must initiate the formation of some associations for senior citizens both at the State and National level. These associations should also be given some financial assistance to make their work effective.

Further, on making an in-depth analysis into the problems of senior citizens, it was found that majority of senior citizens reported health problems, financial hardship, neglect and social isolation as their common problems. Out of these problems; ‘health’ needs special concern as majority of old age problems begins with poor health only.
No doubt, India’s healthcare system is amongst the world’s best health care systems. But in case of elderly population, it too needs modifications. This is because in urban areas; the overcrowded hospitals, long queues, far reaching hospitals and high cost of medicines and in rural areas; unavailability of services has all made it difficult for senior citizens to avail basic health care services. Many times the senior citizens did not approach to clinics and hospitals just because of their dependence on others. Thus, mobile elder care units should be provided in every district. Moreover, this service will be made available on elderly help lines. In addition, special geriatric wards may be introduced in every hospital so that elderly can get special care and attention.

For rural elderly, regular and well equipped health camps must be organized. Furthermore, an effective health insurance system with having transparency and easy affordability is required. There must be a provision on behalf of every State to fund for those elderly who are frail and had no caregiver. If possible, the government must provide free and compulsory health services to all its senior citizens.

Every hospital must be provided with all modern facilities and a medical team comprising of geriatricians, social workers, psychologists, gerontologists and geriatric nurses etc. The urgent need is to focus on ‘age-specific’ and ‘area-specific’ health needs. In this line, a specific policy on health of senior citizens should be promoted.

NGOs, especially the foreign donors must be encouraged to invest for the well being of senior citizens. Moreover, healthy life styles like early detection of disease, regular health checkups, doing meditation or yoga/exercise and taking nutritive diet etc. must be promoted.

In addition to health, ‘income’ was reported as another variable which affects the quality of life of senior citizens in a similar way as it affects the other age groups. Financial problem was also among the major causes against the vulnerability of aged. Although in India, family provides maximum care giving and caters all the needs of elderly, but in case of those elderly who are either single or are neglected by their family members, special concern is needed. The replacement of age-based status by the function-based status further aggravated the problem. In old age, elderly shifted their functional responsibility to someone else. Those who had savings and some source of income felt good, but those who had no earnings wouldn’t found any space
in decision making. This further lead to the feeling of reduced social status and loss of self esteem. Hence, financial security in old age is a must.

But few important questions arises that who will provide financial security to aged? Whether India’s financial status permits for providing income security to every household containing elderly? If not, does our government can offer some incentives to the families caring senior citizens e.g. tax reduction in salary, reduction in electricity and water bills, priority in house allocation to caregivers, special leave with pay for fix days etc.

As we know that there are two groups of senior citizens; one who are physically active and another who are dependent on others for doing their activities of daily living e.g. disable destitute and frail elderly. Those who are capable of doing some work should be engaged in some light jobs. Those who are unskilled should be given some vocational training for income generation. The introduction of micro credit and easy loan availability can also be helpful in improving the quality of life (QOL) of such elderly.

For dependent elderly, the need is to introduce adoption programmes like ‘Adopt a grandparent scheme, ‘Adopt a dependent aged’ etc. Along with this, the Old Age Pension Scheme should need to be revised and raised periodically in accordance with the cost of living index. Further, the delivery mechanism requires simplification and easy accessibility as many elderly didn’t register themselves because of the complexity of procedure. Further, those who are getting old age pension complained of not getting the amount on a monthly basis. Comprehensive social security system is the desired solution to this problem.

In addition, the elderly generation needs to learn that retirement from job does not signify the end of an active life. They had many more years to stay and remain active. The only thing needed is their positive thinking in the direction of beginning new interests and avenues. They may even think of work participation as it would bring not only the financial stability, but also reduces their stress of social isolation and loneliness.
In addition, the older people could be engaged in the management of crèches, orphanages, play schools, day care centre or in doing some light natured job. They can also be trained for participation in various counselling services, maintenance of public relations, managerial work, accounting and management of inventories etc. Hence, the need is to map all the resources (tapped or untapped) and develop the strategy accordingly. For this, the NGOs are required to come forward and make conscious efforts at national and international level.

Furthermore, the availability of limited funds at national and state level demanded us to promote the traditional family support system. Living in family not only saves national income but it also provides proper care, protection and emotional support to senior citizens. But this is not an easy task. It requires planning from the very initial stage i.e. at school and home level.

Emphasis should be on the reduction of intergenerational gap. For this, the youth need to teach healthy and encouraging attitudes towards aged. Simple gestures of sharing a cup of tea, passing a smile, offering love and respect are enough to change the life of senior citizens. In addition, the elderly need to be educated regarding their changing roles rather than sticking on the traditional role of care receiver. This requires the opening up of counselling and welfare centers in every district.

In this regard; the role of media is equally important because today’s world is media driven and media has all the power to change the mindset of individuals. Today media has emerged as a weapon of mass mobilization. Media, either printed or electronic, can be used as a medium for spreading positive messages like ageing is a natural phenomenon, we must give love, care and support to our elderly generation, aged people are equally valuable as other age groups etc.

Hence, media can be used as an effective tool for strengthening intergenerational bonds. Media can also be used in sensitizing senior citizens towards their own rights and welfare measures. In addition, media can be used to generate awareness regarding the benefits of practicing healthy life styles e.g. exercise, nutritive diet, maintenance of personal hygiene, preventive health checkups etc.
In addition to above problems; the problem of social adjustment was also reflected in case of elderly living in cities. This is because of the housing shortage. The problem became more pressing in those families which are living in small houses as many senior citizens have been thrown out of their houses just because of small living space. Some have been shifted to old age homes whereas others had given no privacy. Hence, those elderly who are facing humiliation within their families must be offered chance to live in old age homes, whereas, those who are self sufficient and are capable of buying their own flats should be offered old age apartments equipped with all modern facilities.

Conclusions

From the findings some pertinent conclusions emerge which are as follows;

Senior citizens in India are having multifarious needs. But these needs require serious thinking on the part of the government and the civil society. Unless we find proper solutions to mitigate such problems; the elder generation will face more and more hardships both socially and economically. Thus, to address their problems an interdisciplinary and holistic approach is needed. The efforts should always be directed in improving the overall quality of life. In this regard, the government must commit some qualitative and need based research along with the provision of free services.

The Government should ensure free legal aid to all its senior citizens so that they can feel secure and enjoy healthy ageing. Since no government can provide all the facilities to every senior citizen, hence, individual efforts either of senior citizens or of younger generation should be promoted.

Aged women living in both economically urban areas and staying in nuclear families are facing enormous socio-economic and health problems. Ageing for women bring with it dependence, insecurity, poor health and declining care during illness. In an inadequate social security system in India, where abuse of the elderly women, financial hardship, economic independence are quite rampant, aged women constitute a vulnerable group which is often subjected to insult, injury, exploitation, inequality and injustice. Majority of elderly women are less educated, their public participation
is strictly limited. Therefore, it is of urgent need to make an intervention plan for the aged women which incorporates all the disadvantageous conditions of women and promotes the social upliftment along with generating some financial security.

The senior citizens must also change their mind sets regarding the new values imbibed by the younger generation. They should learn adjustment with new roles and focus on the limitations of old age, whereas, the younger generation could learn the lesson of love, respect and care towards the elder generation. They should recognize their elders as heir of experience and a valuable resource rather than being a burden of responsibilities.

In this regard, the role of NGOs can never be ignored. There are many NGOs e.g. Help Age International, Age Care foundation etc. which are working very efficiently for the welfare of elderly. They are helping senior citizens through a plethora of activities like training programmes, counselling services, family and group therapy, mobilization of resources; fund raising, running of welfare centre and day care centre etc. Hence, the public-private partnership is needed to improve the situations of elderly in India.

Further, it can be concluded that joined efforts of all the stakeholders including politicians, policy makers, youth, aged and other government departments is required for making the life of senior citizens healthy. All these stakeholders must look for the possible ways through which the position of aged will be improved.

For this, efforts like coordination of resources, avoidance of duplicity of services, development of database containing the socio demographic and economic profile of senior citizens is needed. Moreover, the government must promote qualitative, need based and policy oriented research following which the policy makers would develop some effective programmes. This requires the extensive participation of young minds in identifying the ageing issues. Need is to open some apex institutes like National Centre for Ageing Research etc. For this, the government as well as donor agencies must release funds.
In a nutshell, it can be concluded that unless old age problems are understood in totality, clearer picture of those problems is unlikely to emerge. Better comprehension of socio-economic, health and psychological problems along with appropriate and timely measures will go a long way in ensuring active and healthy ageing for senior citizens. One must not forget that older people are the reservoir of our wisdom and traditional values. So must be given full care and respect. It is the responsibility of everyone to make senior citizens realize that becoming “old” is an achievement of life and a blessing of god rather than a curse or a burden.
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Appendix

‘Annexure -1’
‘Annexure -2’

Interview Schedule

(For the purpose of the award of Ph. d. Degree in Social Work)

Age: _______yrs

Address (including ward): ______________________________

Sex: M ( )/ F ( )

Religion:


Socio-Demographic Profile:-

Q3. Are you a Literate? (Read and Write both)
   1. Literate
   2. Illiterate.

Q 4. What is your Highest Qualification?
   1. Primary
   2. Madarsa education
   3. High School
   4. Intermediate
   5. Graduate
   6. Post Graduate.
   7. G Ph.D or Higher degree
   8. Professional courses of PG level.

Q 5. What is your current Marital Status?
   1. Married and Living with Spouse.
   2. Married but not living with Spouse.
   3. Widow or Widower.
   4. Divorcee.
   5. Single.

Q6. Type of your family?
   1. Joint.
   2. Nuclear.

Q7. In which type of dwelling are you living?
   1. Pucca House
   2. Semi Pucca
   3. Kachcha
   4. Tin-shed
   5. Jhuggi
   6. Any Other_____
Q8. Total Family members (family size) of your Household? (Only with whom you are living)
1. (1 to 2)
2. (3 to 6)
3. (7 to 9)
4. (10+)
5. Alone.

Q9. Where do you sleep?
1. Separate Room
2. Common Room
3. Lobby/Verandah
4. Kitchen
5. Other ______

Q10. How many years do you have in Aligarh?
1. 0-5 yrs
2. 5-10 yrs
3. 10-15 yrs
4. 15-20 yrs
5. 20+ yrs
6. By Birth

Q11. Why do you come here?
1. Children shifted here
2. Retirement
3. For treatment and Services
4. Natural Calamity
5. Any Other (Job, marriage, Education______________)

Q12. Problems associated with migration?
1. Loneliness
2. Reduced Social Interaction
3. Difficulty in adjustment
4. Compact living space
5. Any Other____________________
6. No. Problem

Q13. How many children do you have? (M and F both)
1. Living with you.
2. Living near you in the same city.
3. Living in another city.
4. Living Abroad.
Q 14. Nature of Help provided by the siblings in various matters

(mention a, b and c) {(a) frequently ; (b) sometimes; (c) never}

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<tr>
<th>Matter of help given</th>
<th>Status of living of siblings</th>
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<td>Others</td>
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Q 15. How often do you have conflicts with your family members?
1. Frequently  2. Sometimes  3. Never

Q 16. What was the main reason behind the conflict?

__________________________________________________________________________

Q 17. Do you felt abused in the family?  [YES ( ) / NO ( )]

A) If yes, what is the extent and nature of abuse?
1. Physical { frequently/ sometimes/ never}
2. Verbal { frequently/ sometimes/ never}
3. Financial { frequently/ sometimes/ never}
4. Psychological and Emotional { frequently/ sometimes/ never}
5. Sexual { frequently/ sometimes/ never}

Q 18. Who is the Frequent Abuser?
1. Spouse  2. Son  3. Daughter

Q 19. Whom do you report the incidence of abuse?
1. NGO  2. Police  3. Friends
7. Spouse  8. No One

If No One, Why?______________________________

Q 20 (a) Is Old Age Home a right place for the elderly people in need?
1. YES  2. NO  3. NO OPINION

(b) Do you prefer Old Age Home over your present living?
1. NO  2. YES  3. NO OPINION

If Yes, Are you able to pay for it?
1. Yes  2. Partially Pay the charges  3. No
Q 21. How you spent your Leisure Time? (Please Rank as 1,2,3,_______ )

1. In Social/Political Participation  
2. Performing Religious Duties  
3. Visiting Somewhere  
4. Doing Household Jobs  
5. Reading books etc.  
6. Playing (Cards etc.)  
7. Grand parenting  
8. Watching T.V. / Listening Radio  
9. Gossiping  
10. Any other________

Q 22. Are you satisfied with your LTA?  
1. Satisfied  
2. Not satisfied  
3. No Opinion

Q 23. How often do you feel lonely and loss of interest in life?  
1. Always  
2. Sometimes  
3. Rarely  
4. Never

Q 24. Please specify whether your family has sought your opinion or not in the following :  
(1. Always  2. Never  3. self capable to take decisions)

1. Financial Matter  
2. Education of Children  
3. Marriage of Children  
4. Religious Practices  
5. Any Others____________

Q 25. What do you think about your current role and status in the family? Does it  
1. Decline  
2. Remain the same  
3. Enhances  
4. Not Sure

Q 26. Do you think media (T.V / Papers) is playing any role in changing the perception of younger generation towards the Aged?  
1. Plays a positive role  
2. No Role  
3. Negative ve Role  
4. No opinion  
5. Depend on individual  
6. Not applicable

Q 27. How often you use religion as a means of coping against Old Age Problems?  
1. Always  
2. Sometimes  
3. Rarely  
4. Never

Q 28. What would you do to overcome the problem of disrespect and loss of Self esteem?  
1. Left everything on God  
2. Involved more in religious cults  
3. Went in Isolation  
4. Get engaged in Household work  
5. Discuss with friends and relatives  
6. Try to solve  
7. Seek professional Help  
8. Any other _______
ECONOMIC PROFILE:

Q 29. Please specify which facilities do you have along with their nature?
   (A) Independent  (B) Common with Family  (C) Public
   1. Toilet  2. Bathing  3. Drinking Water
   4. Telephone  5. Transport  6. Recreation

Q 30. Do you own any of these Assets? (specify Amount or value)
   1. No Assets  2. Vehicles/ Jewellery  3. House/Flat

Q 31. What is your main source of Income?
   1. Retiree-pension  2. Old Age Pension  3. Interest from Savings

Q 32. Range of your Monthly Income (from all your sources)?
   1. 0-1000  2. 1001-3,000  3. 3001-5,000
   4. 5,001-10,000  5. 10,001-20,000  6. More than 20,000.

Q 33. What major responsibilities do you share?
   1. Fooding of Self and Spouse  2. Treatment of Illness
   3. Upbringing of children  4. Education of Children
   5. Marriage of Children  6. Others________
   7. No Responsibility

Q 34. Whether your Income is less, same or more than your monthly expenditure?
   1. Less  2. Same  3. More

Q 35. Who provides financial support to you?

Q 36 Frequency of providing support by them?

Q 37. Are you aware of Old Age Pension Scheme/Other Government Schemes?
   a. From which source do you know? ______________________

Q 38. Out of following which Scheme is Known to you?
   1. Old Age Pension  2. Widow Pension
   3. Tax Reduction on Loans etc.  4. Travelling Discount
   5. Old Age Homes  6. Others________
Q 39. Do you know about Parent’s Maintenance Act of 2007?
   (a). If aware; Source of awareness __________________________
   (b). Are you availing the benefits of this Act?   A. Yes    B. NO    C. No Need

Q 40. Please give reasons for not utilizing the benefits of following welfare schemes?
   1. Procedure is difficult  2. Illiteracy  3. Dependence on others
   4. Never try  5. Ineligible  6. Others (No need, Corruption,
   A. Old Age Pension __________________________
   B. Widow Pension __________________________
   C. Tax Reduction on Loans etc. __________________________
   D. Travelling Discount __________________________
   E. Old Age Homes __________________________
   F. Others __________________________

Q41. What according to you is the best way of dealing with financial crisis in old age?
   1. Saving while earning  2. Doing job till health permits
   3. Investment in Insurance  4. Borrow money from friends
   7. Cut down expenses  8. Take Loan on property or pension.
   9. Search for job or work  10. Any other ________________

HEALTH PROFILE:

Q 42. How do you evaluate your present health status as?
   5. No Response
Q 43. How many hours do you sleep?
   1. Difficulty in sleeping  2. 0-4 hours  3. 5-7 hours
   4. 8-10 hours  5. More____
Q 44. How many meals do you have in a day? ________________
   (a). What are these?
Q 45. What does your meal consists of?
   __________________________
Q 46. How often do you take the following things?
   (A. Frequently  B. Often  C. Never)
   1. Bidi(A/B/C)  2. Tobacco(A/B/C)
3. Pan Masala (A/B/C) 4. Gutka(A/B/C)
5. Alcohol(A/B/C) 6. Drugs(A/B/C)
7. Pan(A/B/C)

Q 47. Which health problem do you have in last two years?
4. T.B./ Cancer 5. Heart and Lung Problems
6. Arthritis 7. Diabetes
8. Cataract 9. Low vision and Hearing
10. High and Low B.P. 11. Any Other (asthma, skin problems etc.)

Q 48. Are you able to do ADLs on your own?
1. Totally depend on others
2. Depend for few activities
3. Yes

Q 49. Who cares you the most during illness and in doing ADL?

Q 50. Reason why your family ignores your health problems?
1. Give priority to self and children’s need
2. Busy schedule
3. Consider poor health as a normal sign of old age
4. Living very far and are unable to come
5. Do not ignore.

Q 51. Give the frequency and reason of self ignore of health, if any?
(A. Frequently B. Often C. Never)
1. Financial crisis 2. Transport problem
3. Considering as a normal sign of Old Age
4. Feeling guilt in distributing others 5. Carelessness

Q 52. What system of medicine do you prefer most during illness?

Q 53. From which source are you getting treatment most of the time?
1. private Hospitals 2. Private Practitioners 3. Government Hospitals
4. Local Hakim/ Vaid 5. Quacks 6. Home Remedies
(a). What was the main reason for utilizing these services?
   1. No other alternative  
   2. Cheaper  
   3. shorter distance  
   4. Provide good services  
   5. Any other________________

Q 54. What problem do you face in the utilization of government health services?
   1. Financial problem  
   2. Transport problem  
   3. Overcrowding  
   4. Discrimination  
   5. Others  
   6. No problem

Q 55. Are you using any Helping Aid?
   1. Yes  
   2. No; but needs  
   3. No and do not need

Q 56. Which one are you using?
   1. Hearing Aid  
   2. Walking Stick  
   3. Spectacles  
   4. Dentures  
   5. Wheel Chair  
   6. Foot Wear  
   7. Any other_______

Q 57. Is health insurance needed in old age?
   1. Must  
   2. Good to have and Important  
   3. Not needed  
   4. Don’t Know about Insurance

Q 58. Do you have any health Insurance?
   1. Yes  
   2. No  
   3. Don’t knows about it.

Q 59. Out of these practices; which ones do you follow regularly?
   1. Going for a Walk  
   2. Doing Yoga / exercise  
   3. Visiting near ones  
   4. Organising tours  
   5. Regular check-ups of health  
   6. Balanced diet  
   7. Participation in social/ political activities  
   8. Gaining knowledge by reading on Old Age.

Q 60. How could you see your Old Age as?
   1. Curse  
   2. Normal Experience  
   3. Period of freedom from responsibilities  
   4. Achievement  
   5. No opinion

Q 61. Can you prioritize your problems which you have shared with me?
   1. Health  
   2. Financial  
   3. Psychological abuse  
   4. Adjustment  
   5. Food  
   6. Housing  
   7. Others (Loneliness, isolation, depression etc-----------------------------)