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REVIEW OF RELATED RESEARCH

A review of related research fosters familiarity with the studies undertaken hither to in the field of investigation. It provides an opportunity to understand the methods and approaches employed in the earlier studies. The functions of the review of literature according to Stevens et.al. (1993) are: to give reasons why the topic is of sufficient importance for it to be researched; to provide the researcher with a brief up-to-date information and discussions of literature on the issue relevant to the topic; to provide a conceptual and theoretical context in which the topic for research can be suited; and to discuss relevant research carried out on the same or similar topics. A review of the available literature in the area of social gerontology has been presented in this chapter. Themes concerning the perspectives and the problems of the aged, their socio-economic conditions and the status of the aged have been examined in a number of researches. The life of the elderly in rural sector, the role of governmental and non-governmental agencies, policies and programmes for the welfare of the aged are the areas which have attracted the attention of scholars.
1. Social Scenario

1.1 Population ageing

Rural urban differentials among the aged in India have been noticed by Jayarami Reddy (1999) in some of the South Indian states. South India ranks second in proportion of the rural elderly. Among the South Indian states, Andhra Pradesh has a high proportion of the rural elderly (7.3 per cent males and 7.4 per cent females) accounting for larger rural-urban differentials. South India has more female sex composition of the elderly population, Kerala being the first state, followed by Andhra Pradesh, Karnataka and Tamil Nadu. Tamil Nadu is the only state in India which has shown gradual increase in masculine sex ratio and a rise in the age of its rural population. Nair, et al. (1997) analysed the socio-economic conditions and health profile of the aged in Trichur District of Kerala. The aged population in Kerala is growing faster than in the rest of India and the female aged population is more than that of males. The Government of Kerala has implemented a number of social welfare schemes to provide social security to the elderly. The study points out that lack of publicity to old age homes draws attention and accounts for the majority of (he elderly opting to live with their children rather than seek shelter in old age homes. Seal and Talwar (1994) have predicted that India will reach the threshold
level of Net Reproductive Rate (NRR) of one child per family within a
decade or so. If the model family situation appears then there will be less
children but more number of elderly people to take care of. This will create
the likelihood of neglect and abuse of the elderly. Pankajam Sundaram
(1998) states that the myth that elderly population is a problem of the West
and not of the East has exploded and the factors such as stress and strain of
modernization, financial constraints, migration, inadequate housing and
structural changes in the family system have made the population of the
elderly vulnerable.

John van Willigen (1998) denoted that India’s population is ageing
rapidly because of a progressive increase in life expectancy and a decline in
fertility and that the situation of older women is quite different from that of
older men because of cultural patterns associated with inheritance and the
gendered nature of the distribution of property, control of wealth, education,
employment and mobility.

The World Health Organisation (WHO) 1998 launched the
"International Year of Older Persons" on October 1, 1998, and announced
that the theme of the 1999 World Health Day in April would be "Active
Ageing". Both initiatives seek to draw attention to the necessity of creating
policies dealing with ageing in the light of the demographic ageing
throughout the world. Physically, ageing reduces the body’s capacity for self-regulation and self-healing. Socially, old age may be a period of increasing isolation as children migrate and companions die. The increase in older population has been fueled by declining mortality rates and an increase in average life expectancy from 41 years in the early 1950s to 62 years in 1990. By 2020, the number of elderly people is projected to reach more than 1000 million, with 70 per cent living in developing countries, particularly in China, India, Indonesia, Brazil, and Pakistan. More than 20 developing countries currently have a life expectancy at birth of 72 years or more. It is expected that by 2020, 75 per cent of mortality will be age-related. Also, the number of people with mental health disorders, such as senile dementia, will increase the incidence of visual impairment and general morbidity. All the above factors urge that it is very important at this juncture to create a reliable database for the aged, improve the quality of life in old age and provide more care for the elderly.

Nair (1997) conducted a study on the old age people in Trichur District of Kerala State and concluded that, the mean number of children among the aged was 4.4.; 37 per cent of the aged in the sample were illiterate, despite the advances made in literacy; 17.8 per cent of the elderly males and 50 per cent of the elderly females were illiterate; about 56 per
cent had education beyond primary school; 33 per cent of the elderly women were dependents; 79 per cent lived with other members of the family; one in 20 had no living children; about 16 per cent had no living male children to support them during old age; elderly males had more income than elderly females; 60 per cent of the elderly women were engaged in household activities, which did not yield wages; 75 per cent were not employed in any capacity; 13.2 per cent of the gainfully employed elderly worked in agriculture; 50 per cent of elderly females were housewives and 33 per cent were dependents; and about 69 per cent desired to work but were constrained by health conditions. The most common illness among the elderly was muscular pain. Most suffered from multiple illnesses and 5 per cent were mentally ill. The highest incidence of death was from heart attacks, affecting 18 per cent. The second greatest cause of death was bronchitis and asthma, followed by cancer. Over 50 per cent of the elderly males smoked, and 65.1 per cent of the females chewed tobacco. The need for the implementation of a single policy formula to meet the economic needs of the aged has been recognised. The roles allotted to the public, private and informal sectors have to be reviewed for provision for the welfare of the elderly. Long-term financial sustainability and quality of protection should be ensured for the welfare of the aged.
Economic and Social Commission for Asia and the Pacific (1996) recommends that continuing education for the elderly ensures the welfare of the aged. The family members of the aged should support the steps taken by the local-level planners in organising programme for the elderly. International Agencies, National-level Organizations, Non Governmental Organizations and Media can also extend their support to the local organizations for conducting this type of programmes. The complexities of the problems faced by the elderly should be assessed periodically through National Sample Surveys, Regional Studies, and Focus Group Discussion. The ESCAP (1996) report aims at enhancing awareness of the multiple problems faced by the increased proportion of the elderly in Asia and the Pacific. The population processes, changes in population structure, dependency ratios and changing patterns of “old-old” and “young-old” should be analysed through a survey of the aged population. Discussion proceeds to focus on the elderly in terms of living arrangements and the family life cycle in Japan. The current issues identified are economic security, health and health care, family care, the large elderly female population, community supports, and elderly potential. Asia and Oceania are projected to have the largest growth in the elderly population, followed by Africa. The most rapid growth in Asia is expected in East Asia. China
and India will be major contributors to the increase in the elderly population in the Asia-Pacific region. Life expectancy is increasing in all countries of the region. The share of the economically active elderly ranges from 6 per cent to 40 per cent. The most economically active elderly are engaged in agriculture and live with their children. The family remains a central support for the elderly. Mortality and morbidity patterns of the elderly are changing. Health expenditures on health care for the elderly are likely to increase considerably.

Nayar (1996) suggests that the socioeconomic conditions of the elderly, their health and nutritional status, disabling conditions, economic dependence, personal safety and family integration are the most crucial factors in gerontological analyse.; The impact of the size and growth of the elderly population, the issue of healthy life expectancy, urbanisation and the concentration of the elderly in rural areas should be considered for policy-making decisions. Elderly women widows have less family support, employment opportunities and socio cultural interactions.; Respect for the aged is deeply rooted in Asian cultures. Ancient traditions encourage individuals to care for the old, infirm, and the disadvantaged. Industrialization, urbanization, and modern technology have weakened the traditional joint and extended family structures in Asia. Changes have
occurred in the size, composition, and living arrangements of families, ownership of property, and the focus of power. The patterns of inter-generational and intra-generational support between members of the extended family have changed over the past four decades. Trends indicate a shift to nuclear families, erosion of kinship ties and weakening of the family as a support system. China and India account for over 50 per cent of the elderly in less developed regions. Evidence suggests that the poor elderly in Asia have no access to health facilities. Many of the elderly depend on their traditional belief systems for diagnosis and treatment of illness and disease. It is likely that nutritional deficiencies among the aged are due to poverty and related problems. Physical disability often leads to anxiety, depression, and social isolation. Housing should be designed to meet the needs of the elderly.

1.2 Social status of the aged

Harlan (1964) reports on the status of the aged in rural India. The marital status, intergenerational relationship, economic status and education play an important role in getting respect and prestige from the community. A widow retains her prestige as long as she is able to aid the family and behaved well towards other family members. Kimmel (1980), from an international perspective concludes that there is no convincing evidence that ageing was
better in pre-industrial societies. There is a great diversity around the world in the pattern of ageing. In some societies, the aged with power and money have very good life experience. In other societies, the condition of those who are no longer productive, and with have sound family is very poor.

D'Souza (1971) mentions that the problems of the aged in India have arisen as a result of changes in the family and the social structure of Indian society. The status and the role of elderly people have also undergone drastic changes. In the family, the aged who possess health and higher degree of education get respect and better treatment. Desai and Nailec (1971) conclude that the majority of retired people are protected by their families. Ranade (1974) conducted a sample survey of the aged population of Delhi and noticed that nearly 90 per cent of the elderly female respondents were widows and more than 87 per cent suffered from certain ailments. Bose (1982) asserts that in spite of the various processes of social change that have been transforming Indian society, the elderly have continued to enjoy respect and the dominant position in the family. Prasad (1983) studied the welfare needs of the elderly in the context of the changing family structure and he points out that the elderly do enjoy respect in the Indian family. They are consulted on domestic and educational matters. Their socio-economic status depends upon education, occupation and continued employment.
They participate in community activities and political programmes. Hale (1982) reports that physical health, interpersonal relationship and depression depend upon the financial status of the individuals. Gillis Samualsson et al. (2001) stress the role of children, which is the primary factor for informal social support next to spouse. The number of children, grand children and siblings are the indicators of potential social support resources for the aged.

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

Shah et al. (1995) observe that elderly women are more vulnerable, neglected and abused by their sons and daughters-in-law because of illiteracy, lack of remunerative occupation and lack of awareness about legal and economic rights. Soodan (1975), in his study found that almost half of the aged were fully dependent upon others and nearly one third were the chief bread winners of the family. The majority did not have any income of their own and one fourth were still worried about the education and marriage of their children. Income maintenance, medical and health care, adjustment to changing roles and status and proper use of leisure time are the four major areas of hardships faced by the aged. Kumar (1991) highlights the family problems of the aged and their interpersonal relations due to modernization and urbanization. Kasthoori (1996) explores different areas of old people’s life like interpersonal relations with family members, loneliness and health. The study reveals that income is a critical factor in the life of an old person and its influence was multi-dimensional. Prasad and Bould (2001) examined the status of elderly people in a foreign land. They observed that the aged are often worried about not being independent and not being able to meet people because of economic dependence. Ramamurti (1968) reports that old people generally desire to work because it gives them a better status in society and
contributes to economic independence.

Bill Von Hippel (2004) observed the genetic relationship of mother and daughter. The attention of a mother’s mother towards a child is high compared to that of mother’s father, a father’s mother or a father’s father. It shows paternal uncertainty and maternal certainty and denotes grandma’s favorites are the children of her daughter than those of her son. In India, the relationship between grandma and daughter’s children is the closest. The mother is the happiest person in welcoming the grand children from her daughter and taking care of them from conception and socializing them effectively.

1.4 Economic conditions

Dandekar’s (1996) study of the rural aged in Maharashtra points out that agriculture is the major occupation of the rural aged. It requires only better physical health and intention to work and there is no age of retirement in this sector. The rural aged owned assets of house, land and cattle but did not cultivated the habit of savings because their earnings were just sufficient to meet their family expenditure. They expected their children to help them in their old age. Old age pension can help the aged to lead a comfortable life.
Chronister and Kellamas (1987) report that blue-collar workers prefer retirement while the white-collar professionals resist retirement. Rowe Alon (1976) and Uhlig (1952) support this point by pointing out that managers, proprietors, officials, academicians (professionals) and semi-professionals are interested in prolonging their career compared to unskilled workers. Gandotra (1986) examined the money management practices among the retired low and middle income groups among Post and Telegraphs and the Indian Air Force employees. The study found that the majority of them were able to save well before retirement. According to Mishra (1993) one third of the aged respondents often favoured re-employment after retirement. Galen observes that employment is nature’s best physician and is essential for human happiness.

Lalitha (1998) studied the health problems and economic insecurity of the rural aged in four villages of Athoor Block in Dindigul District. The study revealed that disengagement from work is very rare among the young aged (60-70 years) males. The most prevalent illness among the aged are loss of eyesight, arthritis, tuberculosis, asthma, skin diseases, urinary infections and general body pain. Very few have reported that they are living in good health. The rural aged feel that their children should take care of them in their old age. The village community is strictly following and
safeguarding this attitude. This may be the reason why the rural aged are not willing to join old age homes.

Mirunanjali (1999) prepared the socio-economic and health profile of the tribal aged of Pannaikadu in the Kodai Hills. The old women practised the habit of savings in the form of chit funds. The tribal aged are productive by nature and visit the land, take care of young children, collect interest and repayments of money lent and milk the cattle. Though they are less educated their dependency level is also low because of their hard work which needs only physical health. They suffer from impairment of vision and hearing and locomotor disability. Hypertension, heart problem, asthma, tuberculosis and arthritis are other common health problems among the aged. She points out psychological problems such as insomnia, excessive anger and anxiety. Embarrassment, distress, forgetfulness, fatigue, feeling of insecurity, isolation, loneliness and lack of confidence are experienced by the tribal aged. It is observed that the female aged are considerably low in proportion in the study area.

Balakrishnan and Yogananthan (1998) analysed the socio-economic problems of the rural aged in Achampatty and Appanampatty Villages in Dindigul District. The study revealed that the problems of the aged from the two villages were almost identical and were mostly related to
economic, social, health and psychological factors. Lack of nutrition and inadequate medical attention were found to affect the old age people. Many male aged were found to be in the habit of drinking and there were instances of alienation from the family. However, the study acknowledged that the rural aged preferred to stay with their kith and kin rather than stay in old age homes.

Gokhale (1994) conducted a case study of the living and economic conditions of the aged in India. Industrial areas, developed agricultural areas and tribal areas were selected as study sites. The study found that the rural elderly aged faster than the urban elderly due to malnutrition, lack of medical care and hard physical labour. Saving for the future is not possible. Many rural elderly persons were eager to seek retraining and were aware of their lower productivity compared to the young. The elderly preferred to live with their sons or daughters.

Guha Roy, S. (1989) reports that the immediate impact of the growth of the old-old segment of the population and its changing composition is the mobilisation of greater public funding for the aged, which includes social security and pensions, health care, and housing.
Goyal (1989) analysed the problems of ageing in India the major problems are related to health care and economic considerations. A large majority of India's aged are in the lower socioeconomic classes. Poor health and poverty are their major problems. Elderly persons from the upper strata of society expressed more concern for social problems and a significantly large proportion of the elderly rural males are economically active. But, there is a declining trend, which will add further to the economic hardship of the aged and would make them more dependent on their children. Sharma (1987) emphasizes the demographic changes leading to a rapid increase in the elderly population and the consequent impact on Indian society. Particular attention is to be paid to the breakdown of traditional kinship and family organisations, which leave the elderly helpless, isolated and economically dependent.

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

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

India stands second in accommodating senior citizens (75 million) next to China. By considering the economic, health and social security conditions of the elderly social scientists and policy makers are able to plan national policies and programmes.

1.5 Cultures Fostering Long Living

People in some parts of the world enjoy a longer span of life because of their culture and food habits. Leaf (1973) found that long-living people were generally held in high esteem in their communities because of their wisdom; they worked hard, enjoyed sex and had very moderate diets.
Benet (1974) reported that the Abkhasians remained active as long as possible and that retirement was unknown to them. Old people were given increased status, avoided over eating and experienced a high degree of integration in their lives within the society. Beauvoir (1977) noted that in several societies high status was granted to the elderly. The Navajo in North America, the Jivaro in South America, the Lile and Tiv in Africa, and the Mende in Sierra Leone revered the aged. The Japanese and Chinese cultures provided high status to the elderly and this is still being maintained. In Japan, in spite of the dramatic industrialization, the country is bestowed with large number centenarians. Myerhoffs (1979) anthropological study of the elderly Jewish community pointed out that the younger generation often see the ageing from outside so that it appears to be a tragic series of losses. The anthropological perspective provides a view of ageing from the older person’s own frame of reference as a challenge that has meaning in itself. Koring (1990) suggests that religion is a powerful cultural force in the lives of older patients and is integrally related to both mental and physical health.

1.6 Growing old in a changing world

The aged population is increasing steadily due to improved health care, better nutrition and decline in fertility and mortality. The image and attitude about ageing has also changed and they are perceived in a more
positive way than earlier. Even at 75 years, they are active with good health status and self-respect. Michaelangelo and Picasso created their masterpieces when they are in their 8th and 9th decade of life. In rural areas where agriculture, animal rearing and hunting is predominant, the aged with higher socioeconomic conditions have a positive experience, but the status of women is lower than that of men. During old age the physical changes in the brain cause intellectual and personality deterioration. Due to advanced medical facilities there is a possibility of controlling the physical development to a great extent which was a dream of the past.

1.7 Old age and religious beliefs

Broota (2000) concludes that the religious elderly experience less loneliness than the non-religious ones. This finding is supported by Mullins (1989) who reports that greater involvement in religion is found related better adaptation at old age with less loneliness and more peace of mind. Loss of religious belief, on the other hand, may produce uncertainty among the aged. Mishra (1987) mentions that the religious minded aged are generally happier and well adjusted. A good educational background, a positive attitude towards social change and a non-interfering attitude regarding the personal affairs of grown up children generally lend themselves to good adjustment in later life (Dandakar, 1996). Bhusan (1978)
holds that the religious elderly are significantly better adjusted than the non-religious at home, in health, social and emotional aspects.

1.8 Studies on rural aged

Ramnath (1998) indicated that the rural aged love their village and do not want to leave their village. They are inextricably integrated with the life of the village. They believe that it is their village community which will look after them in helpless situations. Generally, the aged are well treated, fed and helped by the village community in India. This attitude and trust are very significant for being contented and happy in life.

Bajpai (1998) stated that the older people are the custodians of our rich cultural heritage. They adhere to universal values and their treasure of practical knowledge and experience guides them to wisdom. They are conservative, firm in ideas, slow to adopt new ideas, meticulous in observing rituals and following traditions. They are dogmatic in their approach. There is always a gap between the young and the old. To bridge the gap the parents should socialize their children to promote psychological bonds with the old, particularly the traits of love, compassion and obedience towards the elderly. A constructive reciprocity between the aged and the young can mould their attitude and perception in restoring their love and concern for each other and bringing about personality and mental development. Social services by the
aged have to be promoted, making use of them as an asset of the society (Bajpai, 1998). This will increase their self-esteem and satisfaction, promoting better interpersonal adjustment among the aged. They need more recreation and social attention than care and treatment. Sivaraju (1999) holds the view that to solve the emerging problems of the elderly effectively, a holistic approach has to be followed considering the social, economic, cultural changes that have taken place in Indian society.

2. Psychological Scenario

2.1 Psycho-Social problems of the aged

The major psychological factors found related to old age are disrespect, death of dear ones, strained in-house relations, disappointment, mental tension, loneliness and lack of freedom. Senility, dementia, sexual problems and emotional disorders arise due to hormonal changes. Reduction in income and change in social status due to retirement and lack of employment also affect the aged. Hussain (1997) analysed the psycho-social problems of the rural aged in India and identified lack of adjustment, restlessness, sleeplessness and anxiety as problems. Srinivasan (1998) studied the elderly of Mumbai who worked in a project “Cleaning Mumbai with Dignity” in collaboration with the Bombay Municipal Corporation (BMC). The aged wanted to live with dignity rather than fame, name, money
or fortune. Productive ageing gives enormous value addition to their sense of self-importance. The younger generation, children and grandchildren, feel happy and proud of having such productive parents and grand parents. The productive senior citizens look after themselves well and are found to be busy and active. Selvi (2002) examined the socio-economic conditions, psycho-emotional characteristics and social problems faced by the rural aged of Theni district. The breakdown of the joint family system and socio-economic changes through modernization, urbanization and industrialization deprived the aged of the care and the support of the family, which are traditionally given to them. The rural aged were found to suffer from anxiety, alienation, maladjustment, fear, tension, feeling of insecurity, worthlessness, dependency, loss of memory, vision, hearing, giddiness and body pain.

2.2 Loneliness

Weeks (1994) reviewed the concept of loneliness with particular reference to old age and suggested that successful treatment of loneliness in life reduces the risk of more serious complications, such as feelings of meaninglessness, decrease in social contacts, self-contacts, self-esteem and trust. Loneliness among the aged can be reduced by acceptance, reflection, social interaction and increased activity. Loneliness has been conceived as a
problem for every one and the elderly experience more loneliness because their spouses might be deceased, their friends might have either moved away or died, their children might be in distant places and they themselves might be subject to physical disabilities. Industrialization and urbanization have weakened the traditional joint family setup in India and elderly persons are least or not wanted in the social setup of a family or society at large resulting in loneliness and anxiety about death (Mullins et al, 1996; Roth, 1978). According to Alexandm Ciua (1979) the rural elderly have strong intergenerational relationship with their offspring through mutual help, visits and contacts over phone, though they no longer share the same household.

2.3 Depression

Depression is a disorder in which the individual is deeply unhappy, demoralized, self-derogatory and bored. The individual with acute depression does not feed well, loses stamina easily, has a poor appetite, is restless and is often found demotivated. It has been called the common cold of mental disorders. Persons who are in extreme depression exhibit loss of interest, weight changes, sleeplessness, feeling of worthlessness, loss of memory, inability to concentrate and fear of death. The sadness may be because of loneliness, pains and aches or chronic illness. It may also be due to lack of siblings, friends, children, fear about future, effect of medicines
and a feeling of helplessness with no control over their lives. Prema (1998) states that depression is related to lack of health, economic status, social interaction, religious activities and family background. Absence of abnormal children, proper health, education, occupation, marriage of children and settling children as desired by the parents and family can prevent mental depression. The depressed people are involved in religious activities like visits to holy places (pilgrimages) doing meditation, reading philosophical books, attending bhajans, reciting puranas and kirthanas and attending rituals organized at various religious centers. A strong family network and friends can prevent depression among the aged. The ‘empty nest’ syndrome leads to loneliness. When the rural youth experience the generation gap, i.e., differences of opinion, attitude, interest, values etc., it may affect the family solidarity and make the aged in rural areas unhappy. Gurumurthy (1999) analysed the ego problems in old age. It is reported that the ego remains strong and powerful in individuals who integrate, although the memory fades and strength is lost. Vijayalakshmi et al, (2000), in a study conducted in Chittoor District, of Andhra Pradesh, found that when the family members gave the aged attention, their pains and aches vanished. Their major concern was not physical health but mental happiness. So, they were constantly on the lookout for attention, love, reassurance and genuine concern from their
family members. Prema (2000) observed that age had a significant positive relationship with psychological distress and a negative relationship with attitude towards physical changes. Subsequently, a positive relationship was observed between per capita income and social relationship, leisure time utilization and social security.

2.4 Ageing and retirement

Bhatia’s (1983) study of retired employees at Udaipur concluded that most of the people face retirement without any planning and preparation leading to problems in their old age. Ranjan (1986) reiterates the feeling of neglect and frustration amongst the elderly. Dhillon (1992) discusses the psychological and adjustment processes of the aged and examines the effect of age and sex, social class, retirement or institutionalization, etc. on the psychological processes of the aged. Leether (1964) reports that more than the half of the retired peoples in Los Angeles work full-time or part-time after their retirement. Studies by Barmash (1982), Ginger, Dispenzier and Eisenber (1983) and Atchley (1985) reports that the productivity and the attendance record of the aged workers are superior to those of younger age groups.
2.5 Adjustment and social ageing

According to Ruth Jacob (2001) sociologists have noted that social disintegration is pathogenic, which predisposes peoples to depression and in extreme cases to suicide. Many elderly women living in foreign countries do not have outside contacts and must make special efforts to maintain themselves well. This study brings out the fact that from the biological perspective ageing is predictably progressive. There is universal deterioration of various physiological systems-mental and physical, behavioural and biomedical. It concludes that elders in foreign countries are not dependent on their children. In fact they are helping as much as they can at home and take care of the grand children.

According to Schneider (1965) adjustment is “a process involving both mental and behavioural responses by which an individual strives to cope with inner needs, tensions, frustrations and conflicts and to bring harmony between the inner demands and those imposed upon him by the world in which he lives”. Persons who are physically fit, active, mentally alert, with high morale, confident, relaxed and satisfied with the things going on will be effective in overcoming frustrations, resolving conflicts and achieving success in life. Golden (1982) has identified ‘confrontation’; ‘denial’ and ‘avoidance’ as three main coping styles in stress situations.
Powell (1979) observes that gardening is very useful to engage elders in regular activities. A person who is active in life has better adjustment and high life satisfaction.

Chaturbhuj Sahu (1998) analysed the socio psychological problems of the aged, which have more relevance in traditional than in developed societies. The veneration shown to the old, the respect given to their advice, the eagerness to have them mediate in disputes are unique honours. The regard shown to them in social functions traditionally has no parallel in modern societies. The erosion of these privileges consequent on the emergence of new values and norms has caused despair and anguish in the minds of the elderly. The anxiety and insecurity caused by poor health, diminishing income and the constant threat of death as one advances in life are other factors contributing to emotional impairment among the old (Nayar, 1990). Marjatta Marin (2001) observed that successful ageing is possible if the wrong age-images or the negative features of ageing are changed. Their capacities and potentialities have to be recognised and society must support them providing necessary technological education. This can equip them to become independent and not a burden to their family. There should be a source of care, psycho-social and moral support for the aged.
2.6 Ageing as a curse

Beauvoir (1972) describes some of the cultures in which old people were killed or allowed to die when they were no longer productive. These events usually involve a ceremony of some kind and sometimes are seen as a way to enhance the old person’s life after death, or sometimes as a sacrifice for the well-being of the community. In Siberia, the Chukchee tribe respect the elders who can carry on trade and amass a little capital and regard the others as a burden and persuade them to prefer death. Among the Hopi, the Creek and the Crow Indians, and the Bushmen of South Africa, it was customary to lead the aged person to a hut specially built for the purpose away from the village and abandon him leaving very little food and water. The Eskimos, whose resources are meagre and most uncertain, persuade the old to go and lie in the snow and wait for death. ‘They leave them on an ice-floe when the tribe is out fishing or shut them into an igloo, where they die of cold. In Uganda a tribe kills or abandons the aged who are unable to care for themselves. Simmons (1945) points out that there are tribes who kill the aged violently where they live in a severe climate, with semipermanent residence and an irregular food supply. However, the tribes who are engaged in agriculture, having property and codified laws never mete out such harsh treatment to elders.
2.7 Respect for the aged

The elderly are respected to a great extent in all cultures. They have an important role in all ceremonies and rituals. They are the repository of ancient myths or cultural history. Among the Miao, who live in the high forest and bush country in China and Thailand, the elderly are respected for their experience and memories. The Miao, who run large patriarchal families takes care of women, children and the grand parents. The elderly are protected by the head though they are burden to him. They think that the dead soul is living in the house and guards it and they believe that the newborn are the reincarnation of the dead persons. They are the community’s guides and counsellors (Beauvoir, 1972). Reddy and Usha (1996) have urged to plan appropriate developmental strategies and then implementation to make the life of the aged happier and comfortable with dignity and self-respect. The aged have contributed their mite (hard work) for the prosperity and development of the society in their adulthood.

Deborah Moggach (2004), a British novelist, appriciated Indian society for its friendly and tolerant attitude to the follies of the elderly. The addressing system is so endearing such as grandma, grandpa which attracts the old, who hanker after affection. In England though the children are living in nearby locations they do not see them for years. They are polite but
distant. There no one respects the elderly, no one has time for them and their life span is increasing but their pension money is dwindling. English society is too stiff and cold for the elderly and they prefer to come to India where things are cheap, people are helpful, family ties strong and the elderly respected. But in England the elderly are often sent off to live in old age homes in the countryside or by the sea.

2.8 Happy ageing

According to Bromley (1974) life satisfaction is a composite index of one’s adjustment, attitude towards life and events, perception of experience and problems of interactional events. Active life and high socioeconomic status are related to the life satisfaction of the individual. Alberta Hunter, an American who was a jazz and blues singer, switched over to the nursing profession after her retirement and returned to her earlier profession at the age of 82, appearing in television and films. Her 83 year old voice remained a strong, flexible instrument and as authoritative as ever and she performed even better than her junior artistes. The complete or partial loss of income after retirement causes a lot of changes in the economic status of the aged and in their social status (Kapadia, 1990), The issue of economic dependency is more relevant to elderly females (Prakash,1996). Those with financial problems experience a diminished
feeling of the control over their lives which increases stress (Karur, 1996). Health, old age and poverty are intimately linked. In most societies, a disproportionate number of the ‘poorest poor’ are very old. This has profound implications for countries where social inequalities are severe. Daksha (1997) analysed the impact of modernization to improve the status of the elderly population in society. Promotion of joint family system, family support, geriatric health care, health promotional education programmes, convenient pilgrim trips, recreational support, gainful employment can integrate the elders with the family and enable them to lead a happy life. Pinto and Prakash (1996) found that reading life reviews of others can enhance the quality of life give higher life satisfaction, higher cognitive ability, lower psychological distress and ensure loneliness, good morale, positive effect and increased daily activities in their life.

The characteristics of old age narrated by Alexander (1977) enunciates experience, wisdom, declining health and emotional insecurity. Growth through life is not inevitable, but depends on the presence of a balanced community that can sustain the give and take of growth. Persons at each stage of life have something irreplaceable to give and to take from the community. It is just these transactions which help a person to solve the problems that beset each stage. Architectural and physical changes in public
places should suit the elderly with facilities such as ramps, non-slip surfaces, wide doors for wheel chairs, hand rails along corridors for support, coloured surface in all public places, particularly in railway stations, auditoriums, banks and bus stops. The changes in family system and family interaction result in the decline of care for the elderly. New systems and facilities can enable older persons to be less dependent on their family for their well being.

3. Health Status

The Hindu survey of “A Society for All Ages” indicates that the majority of the older and aged people in rural areas are denied health and social services which are enjoyed by the urban aged. Except a limited population the majority of the elderly belong to the unorganised sector and live below the poverty line. They are not getting old age benefit. India being a developing country, the Government can not consider ageing as an acute problem in the context of child labour and women’s empowerment. However, more attention and resources have to be provided for the welfare of the elderly in rural India. Dandekar’s (1996) analysis of the NSS data also shows that, though women live longer than men, elderly women always suffer from poorer health as compared to men of the same age.

D’ Souza (1982) analysed the health problems of the aged and advocated the
establishment of special geriatric wards in hospitals to care for the elderly in India. Darshan et al. (1987) reported that among the older persons the most common impairment was visual handicap (62 per cent). Many suffered from paralysis of the lower limbs and hearing impairment. There is a positive correlation between age and ailment. The study concluded that the incidence of disease tends to go up with the advancement in age. Sharma (1972) profiled the rural aged (60 years and above) in the Indian State of Rajasthan and reported that the male and female aged suffered from a number of physical and mental ailments. Mental disorders were prevalent among persons advanced in age in India according to Khan (1997).

The atmosphere in terms of friendliness, cordiality, affection, sharing of meals, eating together, preparation of food liked by the elders, keeping regular meal timings and serving of food by family members have all been found to affect the food consumption and satisfaction. Meals when shared with family members was more enjoyable which also kept them in a happy frame of mind and satisfaction, whereas when they had to eat alone or at late hours, they experienced poor appetite and imaginary ailments. Bagehi (2000) recommended food items having more micronutrients, minerals and vitamins. Intake of more fluid and avoiding of food items with cholesterol and fat content are required. Smoking and drinking habits are not good for
the aged. Physical exercise, social interaction and better family care for the ailments, prevention from falling can promote better health during old age. Nutritional vulnerability is higher in a person eating a diet of only a few food items. People who eat the same food items day after day are likely to lack some important vitamins and minerals. It is important to find out the different types of food the person or group eat and how often they eat each food. Dhannalingam (2001), in his study, noted that the aged received adequate food, clothing, shelter and health care in Indian families, but they complained that the food was not served in time and as per their wish. They expect from family members a feeling of being wanted, and respected. Vijayalakshmi (2000) also observed that the eating atmosphere in terms of timings, choices, likes or dislikes, health state and food preferences are likely to affect the food intake of the elderly.

Apte (1982) has mentioned physical problems such as loss of eyesight, loss of hearing and loss of motor coordination as common to the process of ageing. Diseases like diabetes and hypertension are common among the aged in higher socioeconomic groups. Anemia is common in the lower socioeconomic groups. Incidence of accidents due to falls are also common. Crippling diseases like stroke and paralysis make old people completely dependent on other family members and reduce their physical mobility.
Christine Doyle (2004) found that the ability to remember deteriorates with age. Food items such as berries, oranges, spinach, onions and broccoli, and avoiding alcohol are bound to improve their memory power. Games such as crossword puzzles, scrabble, computer games, yoga and exercises enhance mental alertness and memory. They can also improve their physical health. They stimulate their zest for life.

Asim Ranjan Das (2004) explains that the withdrawal of calcium from the skeletal system caused osteoporosis, osteo-arthritis, spondylitis, loss of muscle-tone and ossification of bones. The reduction of blood corpuscles and blood platelets can lead to anaemia and reduce the immunity power. Respiratory epithelium gets atrophied resulting in poor breath-holding capacity and reduced breathing movements. A fall in the metabolic activities and lesser oxygen intake and oxygen utilization, leads to a fall in the normal body temperature. Elastic tissues are replaced by fibrous tissues caused lesser functioning of the arteries leading to atherosclerosis and myocardial infraction, coronary heart diseases and strokes. The practice of healthy life style and balanced diet help the aged to overcome most of the diseases. A study of the health practices among the elderly in Faridabad by Kaur and Simon (1998) revealed that the rural elderly males performed regular exercise which was absent among the females. The urban males
performed regular exercise, yoga, walking, jogging and weight lifting practices and the females adhered to regular exercise and walking practices. Health consciousness was found to be poor among the rural female aged as compared to their urban counterparts.

4. Welfare Programmes

4.1 Welfare schemes for the aged

The Volunteer Inter-faith Care-givers Programme launched with technical assistance and training to look after the needs of the aged living in their own homes and to help the persons who care for their elders in their homes (The Hindu 1999) has become very popular. The volunteers render services like counselling, helping to pay electricity bills, buying groceries, getting old age pension and medical aid. Arranging functions and cultural programmes helped the aged to show their skill like singing and acting (Aravind, 1999).

The action plan aims to provide assistance to Panchayat Raj Institutions for rendering institutional and non-institutional services to older persons. Assistance will also be given for setting up resource centres on ageing across the country. Multipurpose identity cards are issued to senior citizens. The Old Age Social and Income Security scheme (OASIS) aim at providing a safety net to workers, particularly of the unorganized sector, in
their old age with the small contributions made during their days of employment. This is the first time that such an effort has been made to provide investments for the aged as an economic security. Low-cost old age homes should be constructed in the countryside without removing the old people from their social and cultural environment. The broad areas of concern for the welfare of the aged are financial security, health care and nutrition, education and shelter, concession in transportation and earmarking of seats in local public transport. These have been recommended in the National Policy for the welfare of the Aged (1999).

While the Government’s role is significant, the monitoring and evaluation of activities and even their implementation could at best be carried out by voluntary agencies and other grassroot organizations. Helpage India, in two decades of service has supported more than 1,400 welfare projects. Through the income generation programme, it assists older people who are poor to undertake activities like dhurrie making, envelope making, rearing of goats and pigs. The main aim is to make them self-dependent. Similar programmes undertaken on a wide scale are needed for the welfare of the aged in India. Organizing mass cataract operations in the interior rural areas, running mobile medicare units in urban slums and sponsoring the destitute under "Adopt a Granny" scheme are a few of the other programmes supported by
Help age India. Voluntary organizations can in fact provide a large measure of help to older people in the financial, psycho-social and health spheres. Financial attachment and emotional security can eventually ensure a better life for the elderly, particularly in rural India. Sivakumar (1999) points out that in Canada a daughter, son or a member of the family who cares for the aged is provided full salary and allowances at the place of care if she or he is employed. Special leave or duty leave with wages can be granted for the period of care for the aged. Government intervention will weaken the family’s responsibility. So a negative effect on the well-being of older adult is envisaged.

Subramanian (2001) stresses that the elderly can spend their leisure time in a challenging way by imparting their experience, knowledge and skills, helping the children, engaging literacy classes and involving themselves in organizing or participating in the activities of NGOs. This will give satisfaction, life stability and self-respect that should pave way for happy ageing.

There is a great need to create support systems which will meet the varying needs of the elderly.

Thattil (2003) points out that most of the developed countries have good social security schemes, guidelines on care of the aged and run a network of homes for senior citizens. In Singapore, a part of the income tax goes towards social security schemes for the aged and it is available to all the aged. But, in India because of lack of political will and proper direction, there is no social security for them. The traditional joint family in India had taken better care of the aged members. The problem of caring for the aged emerges when the children migrate to cities or abroad for education and employment. The high growth rate of senior citizens compelled India to formulate a national policy on older people for the welfare of the aged. The main requirements of the old people are social, health and financial security. Decreasing income, loneliness and insecurity compound their problems and they face an uncertain future,

Sonaimuthu (2003) points out that Helpage India is providing financial assistance to NGOs to empower the rural female elders through income generating programmes, petty trade or business and skills development considering the local requirements and resources. Training is given in basket weaving, broom and rope making. The trained persons
produce thatch sheets for roofs, readymade clothes and the NGO helps them in keeping accounts. The NGO recommends suitable trades after analyzing the local resources and the needs of the village.

Bose (1992) points out the need for an integrated national policy to protect the elderly. The emerging issues identified are the decline in the joint family, changing values which emphasize the need for the care of the elderly and the economic dependence of the elderly. The number of voluntary organizations providing oldage services has increased. Health services are viable and care for the health needs of the elderly. Housing for the low income elderly is a particularly neglected sector. The healthy elderly should be provided with employment opportunities. NGOs can adopt innovative approaches to meet the needs of the elderly.

Many elderly people also view themselves as healthy and so the need for elderly physical exercise and recreational facilities for maintenance of good health will increase. Families are subject to great pressure and adjustments due to rapid social and economic changes. Long-term development planning should strengthen the capacity of the family and the community to provide housing for the elderly through co-residence or old age homes. The stereotype of old age dependency can be changed by fostering self-sufficiency and involvement of the elderly in economic and
social activities. Development planning must integrate population ageing into programmes in order to ensure a humane and loving society.

The National Old Age Pension scheme (NOAP), one of the components of the National Social Assistance Programme (NSAP), came into effect from 15th August 1995. By this scheme the aged above 65 years who are destitute and do not have regular income from their own sources or support from family members are benefited. The States and Union Territories implemented this programme under the full sponsorship of the Ministry of Rural Development, in accordance with the norms, guidelines and conditions laid down by the Central Government. According to the source of Ministry of Rural Development, in 2001, 55,45,414 beneficiaries got OAP in India. The Old Age Pension scheme was first implemented in Uttar Pradesh in 1957, providing Rs. 100/- to destitute poor and infirm in the age group of 60 and above. In 1962, Tamil Nadu started with a pension of Rs. 35/- but now it has been increased to Rs. 200/-. The Annapurna scheme was launched on April 2000 by the Ministry of Rural Development for providing food security to those indigent senior citizens getting old age pension. It provides 10kg of food grains per month free of cost. For that the aged have to get a certificate from the Taluk office certificating to their eligibility to get benefit from this scheme.
4.2. Old age homes

Reena et al. (2000) conducted a comparative study of the institutionalized and non-institutionalized aged. The study concluded that the institutionalized aged had more problems than the non-institutionalized aged in physical, social and financial aspects. Ara (1995) points out the type of old age homes available in India. Old age homes are secular by nature and provide accommodation to the needy aged irrespective of caste, creed, or religion but there are homes belonging to particular communities too. FS Parekh Dharam Shala in Maharashtra admits only Parsi Zoroastrians, Vridhashram of the Voluntary Health Education and Rural Development Society of Tamilnadu accepts only Brahmins, whereas Ashanivas in Madhya Pradesh is meant for tribes, Mary (1998) surveyed the old age homes in Madurai and Dindigul districts of TamilNadu. According to her findings, the inmates are provided with all basic facilities for lodging, boarding and recreation in these old age homes. Regular medical checkup is given. Medical treatment is also provided to the initiates in all the old age homes. The oldest home (Inba Illam, established in 1979) in Madurai is nearly 25 years old and receives funds from Helpage India. The majority of the inmates in charitable old age homes are former casual workers and labourers. They have no income at present. Most of the inmates reported that
their spouses were not alive and their children have discarded them. Prakash Rao (1998) examined the pattern of decision making in joining the old age homes. The main findings are that the perception, values and experiences of old people do not differ significantly even if the aged stay in different old age homes. The inmates, both males and females came to know about the old age home through their friends. The main reason mentioned for joining the old age home was that the aged were all discarded by their family members. Premalatha (1998) examined the “third age attitudes of institutionalized aged” among the inmates of various homes in and around Madurai and found out the reasons for taking shelter in the old age homes. The reasons were the quarrel among the children, who should look after the aged, no offspring ready to take care of them, lack of adjustment and the poor economic condition of the family.

Katyal and Bector (1999) made a comparative study at Chandigarh and found that the quality of life of the elderly living with their families is better, with cordial relations with their children and has positive frame of mind, compared to that of their counterparts at old age homes. This is so because the institutionalized elderly had smaller networks and lesser contentment in life and now suffer from severe emotional and psychological problems. The quality of life depends upon group cohesiveness, helping
altitude, understanding, ensuring good relations among members, absence of physical and mental illness, sense of belonging and feeling of well being. The major reasons for seeking shelter at old age homes are low economic status, widowhood, destitution, abuse by family members and lack of support from social networks. The institutionalised aged face more problems than the non-institutionalised aged. In the institutions, no one advises the aged to take care of their health and for getting medical treatment. The chronic diseases like asthma, diabetes, ulcer, hypertension, arthritis and breathing problem need not only regular medical checkup but also strict dietary regulations which can be provided only in their home by their family members (Reena, 2000). The personal care, moral support and warmth which the aged received at home can in no way be provided in the institution. Though the institutions have medical facilities there is a lapse in proper nursing and timely medical treatment. These findings are supported by Strain and Laurel (1991). Jayaseelan (2001) examined the reasons for the inmates taking shelter in old age home in Madurai and their status in the old age home. The study pointed out that many of the institutionalised elderly were treated badly by their daughters-in-law. There is no cordial relationship between daughter-in-law and mother-in-law. Negligence and careless treatment by the family members were reported and most of the inmates are
not willing to reintegrate with their family members even during sickness. They are satisfied with the facilities, treatment and security provided by the institution. Gurusamy (2002) explains that the existing socio-psychological atmosphere within the family such as alienation, domination of daughter-in-law, loss of social status, neglect, improper accommodation, limited social participation and ill-treatment by family members forced the rural aged to take refuge in old age homes. The aged from broken families, those with lack of adjustment with family members and low socio-economic condition also take shelter in old age homes. The aged living in the old age homes wished to get back to their families prior to death. The aged who are receiving survival assistance of 15 kgs of rice, 1 kg pulses and Rs. 50 per month from an NGO (Gandhi Seva Sangam) are treated better by their family members when compared to their other counterparts.

Counselling plays a positive role among the elderly, especially widows, which provides better adjustment, minimize the generation' gap and reduce tensions in life, develop healthy mental attitude towards life and ensure happy ageing. The services of voluntary social welfare organizations help to bring about a spirit of joy, hope and happiness in their life. Agarwal (2003) ascertained the opinion of inmates (widows) and found that the majority (80 per cent) of them had taken shelter because of lack of adjustment with
family members and due to a feeling of unwantedness at home and economic dependence. Very few (10 per cent) stated that their children are outside India but supported them financially. The remaining 10 per cent do not have children or close relatives to live with and so they took shelter in the old age home. In a home called Swami Satyanand Sevadham Viradhesram all the inmates are satisfied with the socio-economic conditions, medical care and recreational avenues. They have meditation, kirtan (group religious songs), self-study (jap satsang) and listened to the inspiring talk of the founder ‘Sant’. These activities and counselling often help them in developing a feeling of self-satisfaction and self-esteem.

Jasmeet Sandhu (2003) points out the reasons of the inmates who took shelter in the old age home at Khalsa Peharak Vidyalaya. She states that they had no sons and did not want to live with their married daughters (8 per cent). Conflicting relations with sons or in-laws (44 per cent) were also the other reasons expressed by them. Independent and peaceful life (18 per cent), feeling of loneliness (16 per cent), and empty nest feeling (14 per cent) also forced them to the old age homes.

Hina Sharma (2004) highlighted the role of micro-credit in reconstructing the livelihoods and empowering the elderly in psycho-social status. The self-help group “Shree Thakar Mahila Bachat” in Chapredi
village in Gujarat was run by fifteen elderly women for their survival after the earthquake in 2001. With the help of Helpage and Kutch Vikas Trust they revived the micro credit and its benefits. The group organized Bhajans and got rid of all their mental worries. By these activities they become more confident in life.

Conclusion

The review of literature indicates that a number of studies have been carried out in the field of social gerontology in India. Problems of the aged, their socioeconomic conditions and rehabilitation strategies have been analysed in most of the studies. However, empirical studies pertaining to psycho-social perspectives and problems of the rural aged are conspicuous by their absence. Further, there is a specific need to study the problems of the female aged in the rural areas. This is especially required in the context of the tremendous social changes and the technological advancement taking place in India and since their impact is felt on the social institutions, The care of the growing number of the rural aged in the new millennium depends on the policies and programmes implemented for them. Against this background the present study examines the welfare measures undertaken for the elderly in rural India and how best the female aged are benefited by them.