Chapter – 2

Review of Literature
2.1 Introduction

Interest in ageing among the western social scientists started in the early 1940s and 1950s. Linton (1942), Cottrell (1942), Anderson (1960), Burgers (1960), Tibbitts (1960), Aries (1962), Maddox (1970) and Riley et al., (1972) have made remarkable contributions to the studies on ageing by covering many issues, for example, demographic aspect of ageing, health, income, changing roles, work patterns, retirement, leisure time activities, family life of the aged, ageing and the economy, living arrangements, special housing arrangements, psychological problems, morale, self-concept, isolation and loneliness, government and ageing, and ageing and voluntary association. But, gender ageing, as an area of research, did not get due recognition even in developed countries till late nineties and issues of the aged women had been dealt by the aforesaid scholars along with the aged men (Srivastava, 2010).

In India, researches in the field of ageing and the aged started in the sixties. Most of the researches identified have been conducted after seventies, which show the growing concern for the problems of the aged during this time. One of the reasons could be attributed to the demographic factors. The elderly population has been increasing at an alarming rate. As of now, there is a considerable amount of writing and research on gerontology in India. A series of annotated bibliographies on ‘Elderly in India’ published by TISS (1999 and 2001), and a bibliographical study by Ruprail (2002) are significant contributions and give insights about the literature on gerontology.

However, the following is an attempt to cite a few important foreign and Indian studies conducted after eighties that have specifically dealt with the aged. In India, volumes of research on diversified aspects of aged have been well established from the literature. But as it is very difficult to cover up all these aspects in this review section, few relevant cases with a heterogeneous dimension of situation are presented. Moreover, aged are by no means homogenous groups. Their needs and problems vary according to their age, family background, health condition, economic status and living arrangements (Swaminathan, 1996). Therefore, the findings from these studies are presented under the
following headings; Socio-economic aspects, Living Arrangements, Health and Related aspects, Disability Status and Studies Related to Care and Support of the Elderly in India.

2.2 Socio-economic Dimensions of elderly

Old age is a universal phenomenon. The numbers of old people are increasing all over the world, both in absolute terms and in proportion to the population (Hobman, 1979). In India research on ageing and problems of the aged is in its infancy. Social surveys on the life and problems of the aged population in India have been conducted by a few sociologist, anthropologist, psychologist and demographers (Bhatia, 1983). Hence, it is observed that the increase in scientific concern for the old age is a result of rapid increase in the population of elderly persons above 60 years (Bhatia, 1983).

Irudayarajan et al., (1999) made an attempt to obtain the view and perceptions of Indian elderly from different socio-economic settings on issues pertaining their needs and expectations from the family, the state and the society at large. The results from the five different group discussions carried out among elderly in Kerala and Tamil Nadu, highlight the differential needs and expectations depending on the familial, educational, occupational and residential background of the individual elderly. It was found that the perceptions of the elderly on their unmet needs depend on sex, education, occupation and residential background. And the female elderly favoured co-residence with children, which they felt was the best security in old age. But the males seemed to differ on this count. On the level of satisfaction in old age, the study revealed that there was more dissatisfaction among the elderly in a nuclear family set-up and among those who were financially dependent. Regarding old age homes, rural elderly favoured the concept of the old age home as alternative to home environment. But urban elderly, never approved of old age homes as a replacement for home environment.

In general it is seen that the concerns of the elderly are seen as a low priority since they are a relatively smaller proportion of the population. They are also a low priority from individual, family as well as societal point of view. Generally it is believed that the potential of contributing to the future by the elderly is limited (Karkal, 2000). Therefore
the socio-economic conditions show those of the elderly, who have all along been poor, constitute the most vulnerable section of the population. The women among them are in a worse condition than men (Sureender et al., 1996). Similarly those in rural areas are worse off than those in urban areas. Sandhya (1996) observes that the changing socio-economic scenario of our traditional groups particularly of the aged. At this juncture, most of the rural aged who are increasingly less active and resourceless feels insecure. As a result, the aged as a group has become socially vulnerable and need immediate attention of the society.

A considerable literature has now emerged regarding the nature of emotional, logistical and care giving support that families provide their older members (Brody, 1985). Rosow (1962) noted that marital status, health status, work and income are crucial factors for continued social integration. Younger elderly, those who are employed, well-educated and own homes, those who provide economic transfers to children, and those in more frequent contact with children (although not actually living with children) tend to be influential in family decisions than older elderly, who are not home owners, those who are not highly educated, those who are no longer in the labour force, those who do not provide economic support to their children, and those with infrequent contact with children (Williams and Domingo, 1993).

The role of marital status in the socio-economic conditions of elderly, as shown by that Johnson and Donald (1981), who identified from their study that marital status was found to be the major determinants of the quality of support the elderly received. It is also found that widow reported lower levels of psychological wellbeing and both men and women elderly who are without spouse are found to be considerably in a lower level of social support. A large number of elderly women are widowed (Asian women normally used to marry men 10 to 15 years older and consequently they had to have a longer period of widowhood). Their conditions are further precarious as they are unable to feed for themselves. “Abandonment of elderly widowed women, even from educated families is rapidly on the rise” (Chakraborti, 2002) as women did not have any income of their own. Illiteracy and socio-cultural practices such as ‘Udyogam purusha lakshnam’ (job is the duty of man) etc., made her dependent on male members of family for her
livelihood. In the younger age, the gender based social, cultural inequalities and differential role attributed to men and women become the root cause for the vulnerability in old age (Sen, 1994). Thus in the family, the elderly couple must be given proper care and respect in order to lead a happy life. Hence, there are large gender differences, however, in the individuals available to the elderly as assessed by marital and household status that shows that significantly fewer men live alone, one-tenth of younger group and two-tenth of older men, proportions one-third that of women (Soldo, 1980).

Studies conducted in North India and South India revealed the socio-economic conditions of elderly against the gender background depicting cases from Haryana state conducted by Goswami et al. (2004) and Singh (2005) they found that female elderly are economically dependent compare to male and the female illiteracy level is higher than male in term of livelihood female are more dependent. More numbers of female elderly are widows. In South India a study conducted by Audinarayana et al. (2002) found that the proportion of widowed, illiterates, non-working and thereby, not earning any income were significantly higher among females compared to males. Data from a multi-ethnic rural setting of Nadai district in West Bengal state (Chakrabarti, 2006) highlighted that, there was preponderance of widows over widowers particularly in the adult-old (70-79 years) and old-old (80+ years) age groups. In the case of literacy status, most males were literate as against females. The proportions of female elderly belonging to poor households engaged mostly in daily labour and cultivation as well as very economic categories as against male elderly who belonged to business and poor & middle economic categories. Hence, the situation of older women appears to be particularly precarious. Research in eight settlement colonies in India indicates that more older women than men consider their status with the family to have deteriorated with age (Gibson, 1985).

The socio-economic conditions of elderly with regard to gender differentials in education shows that studies like Rao (2007) found that a greater percentage (88 percent) of the elderly persons was illiterates such proportion were overwhelming among women than men, whereas the reverse trend was noticed in the case of those who studied upto primary school level. Half of the elderly were not working, one-fifth were working as agriculture labourers followed by cultivators and less than one-tenth were working in
traditional occupations, skilled and unskilled works. Gender differentials in this regard were on the expected lines. Venkateswarlu and Raju (2007) observed that literacy is much higher among males as against females. More than half of the elderly were widowed followed by currently married, whereas the proportion of widowed was more than two-thirds among females as against males. Study in Tamil Nadu (Pappathi, 2007) highlighted that a greater proportion were illiterates, half of them were working in agricultural and related occupations, slightly more than fifty percent were in widowhood status, getting low and moderate personal income as well as belonged to low and average monthly family income brackets. Another study (Swarnalatha, 2008) in Andhra Pradesh state (at Chitoor district among 400 rural elderly women) revealed that a greater proportion of women (88 percent) were illiterates, whereas one-tenth had primary level education. Followed by 71 percent of elderly who were widowed, more than two-fifths were working as agricultural labourers and a greater percent of them were women whose annual income was less than Rs.11,000 (below poverty line), belonged to low socio-economic status and spend their leisure time activities mostly with peer group. The study by Sebastian and Sekher (2011) in Kerala revealed that a large number of elderly (83 percent) were literates and as expected the proportion was higher among males than females. On the other hand, while about half of the sample elderly were widowed, such proportion was large in the case of females than their male counterparts. In the case of their occupation, it was found that slightly more than sixty five percent of the elderly were not-working and around one-tenth were cultivators and casual labourers.

There is a contrasting issue of rural urban socio-economic conditions of elderly. The debate encircle the arguments with regard to the support from these studies conducted in India which shows it is possible that rural elderly need more assistance from family members than do urban elderly because of relatively fewer formal support services in rural areas (Scott and Roberts, 1987). Poverty in rural areas as well as greater geographic dispersion exacerbates problems for rural older adults. It is generally recognised that rural elderly have fewer economic resources, greater chronic health problems, transportation problems and more substandard housing than their urban counterparts (Youmans, 1977 and Kimmel, 1974). Older persons who live in small towns
have been found to have lower incomes and poorer health than those in cities, where more than half have incomes near the poverty level (Lawton, 1980). Compared to their counterparts living in urban settings, elderly in sub-urban communities tend to have higher incomes, are less likely to live alone, and report themselves to be in better financial and health status (Logan and Spitze, 1988).

Most people in India live in rural areas and the proportion of elderly is higher in rural areas than in urban areas (Chadha and Easwaramoorthy, 1993). Rural society with its strong folk tradition is often distinguished from urban life by its emphasis based on strong bonds of kinship, neighbourliness and informal friendship ties developed as a consequence of the lengthy shared experiences of its members (Wirth, 1938 and Redfied, 1947). Herbert and Wilkinson (1979) report that elders in rural areas have good support systems such as friends, neighbours which are enviable in comparison to the apparent anonymity of the urban centres. However, the deprivations of rural elderly have also been well documented. For example, Chadha and Eswaramoorthy (1993) with research evidences have illustrated that rural elderly have less income, poor health, poor housing, poor access to health care and transportation. Thus the findings of studies have revealed many merits and demerits associated with living in rural areas. In rural areas elderly had contrasting views on their societal role as against their counterparts in urban areas. Again, they differed on the problems and constraints of life. The findings also reflected on the different concerns in old age between sexes. For instance, the female elderly favoured co-residence with children, which they felt was the best security in old age. But the males seemed to differ on that count, for they felt that the younger generation would ignore their role (Irudhayarajan et al., 1999).

Rural-urban differences in social relations are particularly critical for the elderly population because social interaction has been shown to be related to a variety of measures of adjustment and emotional wellbeing among older persons (Larson, 1978 and Longino & Kart, 1892). Several studies have indeed found higher levels of social integration among older rural residents than among their urban counterparts (Lawton et al., 1975 and Donnerworth et al., 1978). Rural elders are stereotyped as having large and supportive friendship networks in contrast to stereotyped depictions of urban elders who
rarely even know their neighbours (Stoller and Lee, 1994). Primary caregivers in rural areas are, in fact more likely to be spouse, but they are also more likely to provide care with fewer personal, financial and community resource when compared with urban caregivers (Stone, 1991).

There is a debate which shows that the elderly in traditional family were given respect and care but under modern society the elderly are seen to be in a vulnerable situation. Population research does not shown particular concern of the elderly due to small numbers. A micro level study found that the conditions among the elderly poor followed the deteriorating pattern of economic conditions. Rural-urban migration results in the abandonment of the elderly in rural areas. Those without close relatives and widows/widowers are the most in need of social supports. At present, most of the aged still live in joint families. Social changes are expected to reflect a decline in the high status given to the elderly in society. Researchers have recommended that Government address some problems of the elderly by establishment of health care units for the aged in general hospitals country-wide (Kabir, 1994).

Mahajan (1992) expressed that the lower segments of society, the working generation is not able to extend social and economic support to the aged, not because they do not want but because they cannot afford to it. It is this segment which becomes most vulnerable with increasing age. In Asian societies, the traditional norms and values laid stress on providing care and respect for the aged and elderly person. The traditional value system where age is to be respected and parents are to be obeyed is supported by religion, by the agrarian economy and by the institution of property in which elderly males continue to regulate/control the hereditary property of the family. In an average Indian household, it is usually the oldest male member of the family who is the head of the household and his decisions are rarely questioned. He owns the property, decides where and how to educate his children gets his children married when they grow; in fact, he brings under his umbrella his entire family, regardless of the age of the individual members and considers it his duty to direct, advice and guide till will the moment of his death (Ramani, 2002).
Although the traditional family values of respect and acceptance of responsibility for the elders still persist, the changing social and economic context due to modernisation and industrialisation have raised questions about the enduring role of the family as a source of support for its elderly. This process of nuclearisation of the family may have also affected the traditional bond of relationship between parents and children. Increasing rates of divorce, high rate of mobility among young adults, and increase in the labour force participation of women, the prognostication is that future elderly cohorts will have less opportunity for family support than present and previous generation of older persons (Fletcher and Stone, 1982). To understand the elderly situation in India, it is essential to know how the elderly lead their life under particular living arrangements. The second part of the review connects this idea and shows the living arrangements of the respondents, giving importance to the first part i.e. socio-economic conditions.

2.3 Living Arrangements of the Elderly

It is seen that family plays a much lesser role in the country today on account of the structural changes taking place in Indian society and the concomitant disintegration of joint family leading to rejection of the aged (Planning Commission, 1963). Younger couples due to industrialization are displaced and live in nuclear household affecting the daily living of the elderly (Irudayarajan, 1992). Hence, living arrangement of the elderly originates from the assumption of declining joint family in the Indian society (Irudayarajan, 1993). There arises the elderly support differentials based on the family constitutional members and their living arrangements. The different living situation causes elderly to be valued most comprehensively (Burch and Mathews, 1987). What consists of the differential treatment of the elderly in variety of living arrangement depends upon the “component” of household goods including physical shelter, personal care, companionship, independency, power and authority (Martin and Perston, 1994). Living arrangements are influenced by variety of factors including marital status, family size, and cultural tradition. The changing household structure translates into a decline in support for the elderly (Muthukrishnaveni, 2010).
With regard to declining support of elderly in transition in living arrangements, studies show that in the living arrangement of houses in relation to elderly problem majority of elderly in rural areas expect to rely on children when they become old (Arnold, 1975), specially mothers are likely to depend on their sons for old age support (Sharma, 2002). Elderly living with family and living with spouse are the most popular destinations of transition. It also suggests that attitudes toward living arrangements may also be an important factor for other developing countries in analysis of transition in living arrangements. It could be especially true for those countries which traditionally have a favorable attitude toward living with children and recently have experienced a rapid increase in the proportion of living either alone or with spouse only due to structural change (Chen, 1998).

Such structural change makes the elderly conditions vulnerable. D’Souza (1989) observes that change in living arrangements, family structure and mode of sudden retirement adversely affect the old and further, that the old people are in increasing proportion losing the status and security which they enjoyed in the traditional Indian society. There is a debate over the mindset of the elderly in traditional and modern family system. It is seen that in the traditional societies the older people have higher status and authority so they prefer to stay with their married children. Most often parents will continue to look after their children even after the children themselves have become parents. Thus, parental love and affection towards children is perpetual (Sung, 1992). Also on account of the value system of traditional society, the youth productivity and efficiency do not occupy the same important position as they do in modern societies (Clark, 1969). On the other hand the ethnographic studies the differences in values between the generations make it easier for parents and children to stay separately, thereby to avoid disagreement and tension (Clark and Anderson, 1967).

An overview of living arrangement and support reveal that both older men and women in developing countries usually live with adult children. And the use of non family institution for care of the frail elderly varies widely around the world but is relatively low everywhere (Kinsella and Velkoff, 2001). Elderly mostly stay with their adult children and more women than men were supported by their spouse. A study on the
level of life satisfaction among the elderly people according to their age and type of family found that the younger respondents had greater life satisfaction and the respondents who were living separately from their children were more satisfied than those who were living with their married or unmarried children (Hosmath et al., 1993).

There is existence of differentials in living arrangement with result to demographic variables such as sex, marital status, education, caste etc. An Analysis of data from Audinarayana and Kavitha (2006) revealed that among widowed, majority lie with children (with married sons to a large extent) and a substantial percent as alone. On the other hand, a large majority of the currently married co-reside with children (mostly with married sons) and by themselves. Venkateswarlu and Raju’s (2007) study among rural elderly in Andhra Pradesh revealed that Gender wise analysis showed that females were mostly living with son, alone and sister as against their male counterparts, whereas made mainly living with spouse and unmarried and with brother. A study among rural elderly in Amaravati district, Maharashtra (Bansod, 2009) revealed that one-fourth of the elderly were living with spouse and married sons(s) followed by with married son(s). The proportion of living with married son(s) and alone was significantly higher among females than males. More females reported their living conditions as satisfactory compared to males. By and large, it may be concluded that change in perception of living situation tended to occur in the elderly lives when their sons(s) get married. Sebastian and Sekher (2011) in their empirical rural study the proportion of living with sons were higher among schedule caste/schedule tribe communities, who had more number of children and sons (conspicuously, the proportions of living alone were also higher in the case of those who had children and sons), fully dependent and confined to bed/house.

With regard to elderly living alone, a recent study by Muthukrishnaveni (2010) showed that the chance of living alone was 2.5 times higher for females as against their male counterparts. It was also found that elderly who had served in government had three times more chances of living alone compared to those who had no work. Ghosh and Husain (2010) revealed that, the percentages of female elderly are significantly higher in co-residing with children (but not with spouse) and few as alone/old-age home as well as other relatives/non-relatives than among their male counterparts. Panigrahi (2010)
highlighted that significantly, fewer older persons live alone if they had up to a secondary level of education compared with those who were illiterates, whereas a significantly higher proportion of elderly persons live alone when they have beyond secondary level of education. Further, significantly, a higher proportion of elderly who were economically independent live alone compared with those who were partially or fully dependent on others.

Gurumurthy (1988) found a large number of aged who have houses of their own and live independently. He shows that elderly live in houses where they were permitted to stay in one corner or portion. Among such houseless aged, female aged are more. They also come from OBC and SC groups and are also poor. Apart from becoming aged and widowed they are also abandoned by their migrating family and reduced to the status of total destitute. It is these age who need institutional care. But they are not willing to move into homes for the aged owing to lack of information about them and their workings and also because of their traditional outlook. Mathew (1997) compares the life satisfaction of institutional and non-institutional elderly. Results revealed that life satisfaction was higher among the non-institute living elderly group when compared to the institutional living elderly. Further, life satisfaction was found to have a significant positive correlation with education, age at marriage, number of living children, and number of friends. A negative correlation was noted between age and life satisfaction. Hence, Sinha (1999) expressed that our primary focus should be to provide space for elders in the family because that is their ideal home and their children are the ideal support system. And we have to seek solutions for the problems of the aged at family, social and state level. Therefore, the living arrangement also depends upon how the elderly are treated in the family which makes one understand the living conditions and familial support of the elderly. Hence, the third part of the review deals with social adjustment and decision making role in their family.

2.4 Social Adjustment and Decision Making Role of the Elderly

Rural society has its own folk tradition with strong bounds of kinship and informal friendship ties which have been developed as a consequence of the lengthy
shared experience of its members (Wirth, 1938 and Redfied, 1947). Subjective social interaction exerts a relatively stronger effect on the adjustment of the rural elderly and hence the social relationships are more personal within rural communities (McGhee, 1984). Moreover, certain variables found to influence the adjustment of the urban elderly may be relatively less important to the rural aged (Lee and Lassey, 1980). Those who were better educated, had better income, whose spouse were living and those who were living in joint families are found to be better adjustment (Ramamurthy, 1970).

Dak (1991) reported that the loss of status and decision-making role was suffered more by ageing women than by men as the arrival of daughter-in-law and death of spouse have affected the women more than the men in this respect. The arrival of daughter-in-law is often followed by the erosion in the status and respect for old women, while the mother does not like him paying exclusive attention to his wife, the daughter-in-law with an intent to position in the family, poisons her husband’s ears and seeks favour from him quite often against her mother-in-law.

Migration process also involves the reduction of care for the elderly, with modernization accompanies industrialisation and urbanisation. Migration involves the physical separation of the senior and younger generations; the number of once multigenerational households is consequently reduced. It is common for industrialization to increase the rate at which young individuals leave their rural houses and migrate to urban areas to take up employment. Because the more senior generations frequently, although not inevitably, remain behind, there is increased physical separation of the elderly and their adult children. In this situation, physical care of the elderly by their children is likely to be especially problematic. Even remittances may suffer if the emotional ties between parents and children weaken because of absence (Pramualratana, 1991).

Chakravarty (1998) feels that the family still plays a major role in elderly care, but the sign of change are now becoming more visible. Mohanty (1997) from a study observed that care of the elderly, considered as a sacred duty in the past is breaking down in nuclear families. Due to socio-economic, political, psychological and physical changes
coupled with changes in the family system and life style, the aged need specify Medicare besides other support. Case studies from rural areas reflect that, though the joint family system does look after the elderly there are, however, some emerging stresses and strains which in varying degrees, tend to increase the vulnerability of the aged (Upadhyay, 1992). Lakshminarayanan (1993) found that rural aged male are better adjusted and better education is associated with a greater ability to adjust. Female elderly who live in rural areas perhaps lack of social interaction and hence would have poor adjustment in their life widowhood could also be a factor in which social isolation plays a vital role. In addition, there is a negative stereotyped attitude towards older persons.

Singh et al., (1983) studies the adjustment problems of elderly using the technique of well adjustment inventory. It was found that older people have significantly more adjustment problems in the emotional, social, wealth and home areas than young people. It was also found that among old individuals, the non working persons had more adjustment problems in the home area than the working persons. On the whole, the findings indicate that engagement in some purposeful and productive takes contributed significantly to old age adjustment.

The breakdown of the joint family system was one of the most important factors responsible for changing authoritarian position of elders in the family. In a majority of cases the son occupied the position of head of the family (Madhu and Darshan, 2003). Decline in respect was felt by a majority of elders. The reasons stated for this decline in respect were breakdown of joint family deterioration of moral values and modernization. Significant value of chi-square established association between respect and income of the elders. Respect of elders in the family increased with the increase in the income of elders. A majority of elders were not getting respect in the family irrespective of their occupational status. Relatively more elders who were doing farming and business work at present get respect from their family members. The variances in levels of respect may be to the financial contribution the elderly make to the family.

A majority of elders were performing prestigious and income generating roles in the family earlier in life but at present the majority of aged respondents were currently
helping in agriculture and household work. More than one fifth of the elderly were caring for animals. A majority of elders who were performing less important roles in the family at present, consequently, also reported a low status in the family. The study further revealed that a greater number of males were helping in agriculture work and caring for animals while females were performing daily household chores and caring for grandchildren. The status of the elderly in the family depends upon the economic contribution the elderly make to the family. If the elderly continue to contribute financially to the family, they enjoy the same status, otherwise their status deteriorates after around sixty years of age. High and significant value of chi-square established and association between the status of elders and their educational level, occupational position and those in between 60-70 years of age were enjoying a higher status than other groups. A majority of both male and female elderly felt their status in the family deteriorating after reaching 60 years of age. Economic dependency of elders amidst poverty is one of the most important factors responsible for reducing the respect and status of elders in the family (Madhu and Darshan, 2003). Martin’s (1989) finding says that the elderly in many Asian countries are less likely to reside with children when they have fewer of them. Co-residence and support appear to be less common among more modernized sectors of the population including those with an higher education, modern sector occupations and high income as mentioned in the review of Mason (1992).

Analyzing the conditions of the elderly in terms of their family, socio-economic activities, occupation, daily activities, headship/ownership, migration of younger generations, the level of caring and respects, in rural Bihar, Ansari (2000) found that the elderly are not a burden in the society and family. They are valued for their economic activity, and moral support for the family and society. They take part in family decision making, managing the home, in agricultural and other works, participate in matrimonial alliances, in village Panchayats and in other social activities (Bose and Gangrade, 1989 and Selby et al., 1985). The family members need them and the elderly need their family members too. Those households in which there is no elderly, either male or female, feel themselves to be orphans. The male elderly provide safeguards from outside whereas the female elderly provides support inside the house. So the elderly should be given care and
support in the family, also proper care in terms of health services mainly as elderly seek health care support first from the family. There comes the next part of the review health status of the elderly which is relevant to understand the elderly living condition.

2.5 Health Status of the Elderly

Many feel that old age and ill-health are synonymous. Such type of association mainly arises because human organs increasingly diminish in functioning overtime, although not at the same rate in every individual, through which elderly persons fall prey to some disease. This tends further accelerate due to the adverse life styles, viz., drinking alcohol, smoking cigarettes/beedis, and using tobacco/snuff powder, adopted during their adult ages. In the Indian context, some studies conducted among rural elderly had brought out several types of illness mostly based on perceived health status, in addition to chronic morbidities and lab-tested health problems as well as their differentials and determinants. Respondents tend to describe their own health in relation to other persons of their age in term of the category poor, good and excellent. There is a significant relationship between network size and health status. Persons who rated their health status in the poor category had significantly smaller social network (Willigen et al., 1996).

Health of the elderly is determined by several factors. Normal ageing and disease ageing interact with each other. The socio-economic, social and environmental factors all affect elderly health status. Moreover, factors such as gender, economic status, marital status, living arrangements, availability of social support etc. influence health during old age (Ramamurti, 1989; Anantharaman, 1990 and Weller and Bates, 1992). In a study Pandey (2009) stated that lower income level is an important determinant of poor health among elderly. The same positive strong relationship was found in the case of all the three samples under consideration. Among the other findings the noted ones were: compared to female elderly the health status of male elderly was much better. Increased age was associated with lower level of health status and the association between health and age was non-linear. Education level of elderly had showed mixed net effects on their health status. Number of children was also positively associated with the higher health longevity, however, found to be significant only for the 1995-96 and polled data.
A study conducted on a sample of Assamese and Bengali speaking populations of the Hindu and Muslim religions in Assam found that due to lower education, poor economic conditions and rural backgrounds, the scheduled caste people reported poor access to health care facilities. The aged employed privately and those self-employed had more of health problems than not gainfully employed persons. In general, the male members were found to be literate, economically independent and had less physiological and nutritional problems when compared to the female counterparts, when the literacy level, income level and employment status improved; they seemed to have better health (Vasantha and Premkumar, 2000).

Therefore, health is not only a biological or medical concern, but also a significant personal and social concern. In general with declining health, individuals can lose their independence, lose social roles, become isolated, experience economic hardship, be leveled or stigmatized, change their self perception and some of them may even be institutionalized (Ketshukietuo, 2005). Men and women with unsatisfactory, conflictual family relationships also experienced increased health problems (Yadava et al., 1996) where lack of social support, breaking up of joint family, changing life style; all aggravates health and nutritional problems in elderly age group. While elderly people in India may have reasonable access to family care, they are inadequately covered by economic and health security (Susuman, 2005).

It is basically seen that environmental and social factors play a very important role in ageing process and the health conditions of the elderly. Joshi (1971) conducted a study on the medical problems of the aged. He states that differential ageing phenomena both physical and mental appear to depend on environmental and social factors such as diet, type of education, occupation, adjustment to family, professional life and consumption of tobacco and alcohol. The results show that the elderly persons suffer from ineffective and parasitic diseases, diseases of respiratory system, symptoms of ill defined similarity arthritis and rheumatism, hyper-tension, congestion, heart failure and diabetes mellitus. Bansod and Paswan (2011) expressed elderly widowed/widowers and economically independent elderly were more likely to suffer from one or the other health problems than those living with family members. Disabled elderly were more likely to
suffer from more ill health problems compared to others. Devi (2008) in a study in Kerala found that large percent of elderly were healthy in urban areas than the rural counterparts. Moreover, good health status was higher among financially strong familial groups.

Elderly health is also significant to understand in slum areas and non-familial institution. Elderly populations among the slum dwellers constitute a small percentage. As most of the populations of the slums are drawn to work in the unorganized sectors, one finds most of the people working in the informal sector earning a very meager amount which is not sufficient to maintain the family. A majority of the elderly are working at present to meet family expenditure. Daksha Barai (2000) conducted a study on slum dwellers in Bangalore, where majority express health problems like poor eyesight, weakness and body ache. The quality of life depends on living condition and type of relationship they are maintaining with their family members. Katyal and Bector (1999) found the living condition of old people and quality of life revealed cordial relationship with the children in the family have a positive frame of mind in contrast to their counterparts living in institutions.

Every society usually takes for granted that it is normal for the elderly to suffer from some illness or the other. It is a fact that many of the elderly are more susceptible to disease and sickness at this stage in their lives. Yes, it is quite surprising that society considers old age to be synonymous with sickness. There is no such disease as ‘old age’. Some old people are severely restricted in their mobility while others are able to maintain themselves in the ordinary activities of daily living. The variation among the elderly in their physical health and their degree of impairment is vast (Shanas, 1968). In addition to the multiple disabilities caused by the diseases themselves, complications may arise due to the complexity of drug treatment prescribed (Bond et al., 1994).

The present section which deals with the health status of the elderly is divided the review into 3 categories like physiological, mental and disabled elderly. Ageing is associated with fatigue and decline in functional capacity of the organs of the body due to physiological transformation the elderly are one of the high-risk groups in terms of health (Jayakumar and Stantley, 1992). Dilip (2003) found that in India in both rural and urban
areas certain major chronic ailments same. He found that the rate was comparatively higher in case of joint problems and blood pressure than in the case of piles, health disease, urinary problems and diabetes. The nutritional food intake by the elderly depends on their socio-economic conditions. Awareness of the importance of nutrition food is also another important factor.

Jayanthi et al., (1996) explored the effect of economic pressures, disabling diseases, and social neglect on the nutritional status of the elderly. It was hypothesized that all these variables could lead to nutritional problems. Information on dietary habits, socio-economic conditions, and anthropometric and medical status of 30 men and 30 women in the age group of 55-65 years was obtained. It was found that the old were aware of the importance of nutrition. These were no negative effect of any of three variables in the sample studies. Lena (2010) in Karnataka observed, it was noticed that the percentage of elderly suffering with osteoarthritis was much higher among females as against males, but in the case of other health problems such gender differentials were negligible.

The extension of life expectancy has been accompanied by an increase in the level of chronic diseases, including heart diseases, diabetes, hypertension and arthritis. Also of concern is the weakening of traditional informal support system, both community and the family and the marginalization and elimination of the elderly social and economic roles (Eldermire, 1997). A study on the socio-economic and health status of the aged in the rural areas of Karnataka, Indian revealed that the incidence and prevalence of chronic as well as non-chronic diseases is obviously high among the elderly. The major chronic diseases are 1) respiratory diseases, 2) loco-motor illness and 3) blood pressure. The duration of illness is comparatively longer among females.

Hence, health status is an important factor in deciding the quality of life of rural elderly along with certain related factors such as service availability, awareness and accessibility (Vijaya Kumar, 1998). According to Shah (1993) the high prevalence of chronic conditions among the elderly, and the functional limitations that result, generate a high demand on the health services. Often health services provided are ill equipped and
ill trained to provide adequate diagnostic, therapeutic and rehabilitative support to the elderly. Loss of respect, authority, status, interaction, effective roles and social relation of elders are the root cause of other psychological and health problems. As a result a majority of elders had multiple health problems and were also found depressed (Madhu and Darshan, 2003). Muthukrishnaveni (2010) it was noted that almost all elderly, irrespective their gender, who had health problems were in need of treatment and the main source of treatment was Government Hospital followed by Private Hospitals. Poverty (no money), lack of family support and no one to help them to go to the hospital were stated to be the main reasons for not availing treatment.

Ending of physiological and starting of mental – inter-relationship between physical and mental illness becomes more prominent in old age, many of the elderly’ behavioural disorders go unrecognised and untreated. Many suffer physical and mental discomfort because of lack of knowledge and resources (Harper, 1991). According to Durairaj and Kalarani (1999), “apart from physical problems, old people have mental problems also. They suffer from tension because of ill health of self or their life partners and feel their loneliness very strongly. Thus, emotional insecurity of the age is a serious problem. Family care is still considered to be the main source of social protection for the elderly. Because the aged expect not only economic support from the younger generation but more of social and emotional support also”. There are more women than men at any elderly age group. Depression and osteoporosis are the commonest problems in elderly subjects. Some problems specific to males are hypogonadism, erectile dysfunction and enlargement of prostate and to females are post-menopausal disturbances, urinary incontinence and breast and lung cancer. However, problems of special concern in both male and female elderly are malnutrition, falls and cognitive dysfunction (Muthukrishnaveni, 2010).

Among all the problems faced by the elderly, loneliness is a serious problem which leads to psychological disturbances like depression, withdrawal, etc. The psychological problems result from a feeling of neglect and humiliation by the family members. Thus, they may be facing depression and sickness (Chowdhry, 1992), which can be alleviated through social intervention and other alternatives. Rao and
Parthasarathy (2000) discussed some of the negative attitude towards the elderly like, elderly people are not willing to discuss their emotional problems, talking about death and sickness, poor memories, and their disability. Due to ill health, loss of the loved one and limited income the elderly will face stress and strain. In this situation, social support plays a very important role which affects not only the physical but also the mental health. The importance of the relationship between social support and depression was also pointed out in the clinical observation among the aged (Hange, 1989).

Involvement in religious activities is more in old age. Religious belief plays a crucial role in avoidance of loneliness among the elderly as has been found by Patel and Broota (2000) who conducted a study on the role of family setup and religious belief in the experience of loneliness in later life. The result revealed that there were no significant differences between older people from joint family and nuclear family in experiencing loneliness and health anxiety. However, religious elderly experience significantly less loneliness than non-religious elderly. Thus, participation in religious activities builds positive framework towards life in the elderly.

Mellor (1989) from his study found that neither age nor place of residence was related to loneliness and availability of social support rather than the quality of social support. He also discussed some important conditions contributing to happiness and stressed the need to develop favourable attitudes old age like a realistic attitude towards physical changes, continuing participation in interesting and meaningful activities, a feeling of satisfaction, enjoyment of recreational and social activities.

Disability of the Elderly shows that during old age, many elderly, in addition to ill-health, suffer with disabilities. While the most common disability among elderly is reported to be the eyesight, hearing problems, joint problems, teeth problems also cannot be ruled out. Further, it is of general propensity that elderly may not be able to perform certain Activities of Daily Living (ADL) as well as Instrumental Activities of Daily Living (IADL) mainly because of the less functioning/malfunctioning of selected organs in the body like, head and neck, hands and forearms, hip, knee and ankle, tongue, etc. Though biological causes are the main reasons for such ailments, the lifestyles followed
by the elderly persons during their adult ages also would cause damage to a few body organs. In the Indian context, few studies related to these aspects have been carried out at different settings.

Based on the 2001 census data analysis of disabled elderly population for India, Audinarayana (2010) came to the conclusion that the elderly were suffering with different disability conditions. Among the disabled elderly, persons with visual impairment constitute more than fifty percent followed by movement disability and hearing. The magnitudes of all the five disability under consideration were much higher in rural areas (hearing and seeing are still more large, about 82 percent) than their rural counterparts, whereas gender differentials were marginal in the case of all disabilities. However, the magnitudes of majority of the disabilities were much higher among married men as against women; the reverse pattern was true in the case of widowed women as compared to elderly men. Likewise, among main workers the levels of majority of the disabilities were higher among men than their women elderly counterparts. All these findings lead to the conclusion that aged persons who belong to lower strata of the society (rural and scheduled castes/tribes) as well as socially disadvantaged (widowed) were more vulnerable to various types of disabilities.

The number of older people is projected to increase in both developed and developing countries. The incidence and prevalence of functional disability are higher among older people and is higher at older ages (Kovar, 1991). Elderly persons who live in urban areas have significantly lower proportion of physical disability as compared to their rural counterparts. It was also observed that elderly people who belong to the higher socio-economic class were found to have lesser disabilities. It is seen that majority, however, will have multiple disabilities, while a sizeable group will have difficulties with instrumental activities of daily living (Zarit et al., 1993). By Dillip (2001) in Kerala found that visibility was the most prominent form of disability among elderly followed by locomotors, hearing, senility and speech disability. Sex wise differentials showed that the conditions like visual, hearing and speech disabilities were predominant for females than males.
Dilip (2003) noticed the prevalence of different physical disabilities in the following order: visual, locomotor, hearing, amnesia and speech. With a few exceptions, the prevalence rates of physical disabilities were higher among old-old (70-79 years), females, currently unmarried, rural areas, belonging to less monthly per capita consumer expenditure of households and economically fully dependent on their counterparts. Rao’s (2007) study in rural Andhra Pradesh showed that slightly more than one-third of the respondents had reported having difficulty in seeing and one-fourth with hearing problems; women’s proportions were significantly more than men in both these difficulties. In the case of their ability to perform certain physical work, they had difficulty in bathing, dressing and going to toilet. However, these proportions were slightly higher among women as compared to men elderly in the case of latter two activities, whereas the opposite pattern was noticed in the case of bathing.

Goswami et al. (2005) in their rural study observed that a large majority of the elderly had vision related disabilities closely followed by other disabilities. Large number of aged, though not using, felt the need for the respective aids. Further, the most common reason for not using these aids was non-availability followed by carelessness, especially in the case of vision, hearing and walking. The other reasons mentioned were fear, wrong belief and shyness. An examination of mental status (cognitive impairment) among the rural elderly in Faridabad district, Haryana by Goswami et al. (2006) highlighted that about one-fifth of sample respondents had cognitive defect. On screening, such proportion was found to be higher among females than among males.

Studies undertaken in different parts of India revealed that the perceived health status of the elderly were Charkrabati’s (2006) in a study in multi-ethnic rural setting, West Bengal state revealed that the proportion of self-assessed health status as ‘good’ and ‘moderate’ was higher among male elderly as against females. With regard to prevalence of chronic diseases, majority elderly were suffering from gastro-intestinal, blood pressure, asthma and respiratory followed by eye complaints and joints pain. Conspicuously, while the prevalence of blood pressure did not vary much by their gender background, asthma and respiratory disease was higher among males as against females, the opposite pattern was observed in the rest of the chronic diseases. Bansod’s (2009)
rural study in Amaravathi district, Maharastra highlighted that elderly living with spouse and sons perceived health status as ‘good’ as compared to those who lived alone; a higher percent of the elderly living alone perceived that their health as ‘not good’. It was also noticed that those living either with spouse or children had better health than those elderly living alone.

Venkateswaralu (2003) in Andhra Pradesh observed the perceived health status were perceived their own health as ‘good’, whereas slightly more than half reported as ‘serious illness’ and about around three-tenth stated to be suffering with ‘minor illness’. He found that while the role of the son and to some extent the daughter appear to be more for middle-old and old-old than the young-old, the opposite trend was noteworthy is the case of ‘no help’, wife/husband and neighbours. The study by Goswami et al. (2004) among rural aged belonging to Haryana state revealed that a large majority of males and females rated their health status as ‘not healthy’. It was also observed that men were more likely to report their health status as ‘very healthy’ and ‘quite healthy’ compared to women and these differences were found to be moderately significant. Moreover, the respondents ‘poor self rated health’ was analysed and found that dependence, a dissatisfied life, sleep problems, feeling sad or depressed and disability were all linked. Consumption of alcohol was associated negatively with ‘poor self related health status’.

Health and functional status are major factors affecting the social involvement of older people (Shanas and Maddox, 1985). Those elderly with declining capacities are more likely to experience shrinkage of their social environment; healthier and functionally active individuals are more likely to have a functioning social network. In their social interaction, not only is their increased preference of contacts with age-peers in old age over younger individuals, but also interactions with age-mates has been associated with higher levels of life satisfaction (Rosow, 1967 and Laing et al., 1980). Parents who are older and have greater needs and worse health are expected to be more likely to live with children and to receive help (Stoller, 1983) although health may not affect levels of contact. Relatives were first turned to in case of a health crisis; friends and neighbours were helpful in relieving relatives of care (Johnson, 1971 and Hochschild, 1973).
Due to the multiple and chronic health problems associated with ageing, the need for a systematic action by health care practitioners, administrators and policy makers becomes urgent. Their challenge is to provide a wide range of health care services in a manner that reflect current state of knowledge about the cost-effectiveness and health benefit of these services. “Providing health care to the elderly is increasingly complex. The number of older people is growing; particularly within the oldest age groups, where a large proportion of individuals have significant health care needs” (White, 1989).

Clinicians should recognize the importance of sexual functions to the overall health of older persons particularly women. Religious participation and involvement are associated with positive mental and physical health. Family life is the key to the health of elders’ especially older men. Lack of social support increases the risk of mortality and supportive relationships are associated with lower illness rates, faster recovery rates and higher levels of health care behaviour (Dhar, 2001). The financial and social resources necessary to provide health care services are already strained. Hence, there is a need for the Government to improve the health services (Suneetha, 2010). Through this discussion it is seen that, like social support is a central factor in determining psychological adaptation to old age (Mellor, 1989), so there comes the next issue of care and support provided to the elderly.

### 2.6 Care and Support of the Elderly

The problems of the aged are multi dimensional and ever increasing in the modern era and one undergoing a transition from rural agrarian economy to urban non agrarian economy. It is not only the destitute who needs economic support and care through institutinalisation today, but the large proportion of the economically sound and physically fit aged also require social support and emotional and psychological security for wholesome wellbeing. In developing countries like India, the household is a critical institution for older adults, who often require social, economic and physical support. As in developing countries less public support is available and hence, they heavy rely on household members and family for their wellbeing (Population Brief, 2001).
The forces of modernisation particularly geographical mobility and erosion of values associated with family responsibility for elders – have compromised the willingness of the contemporary family to care for its older members and a demand for extra familial support is created by deficits in family functioning. These issues are particularly pertinent to developing countries where worries are voiced about the viability of the traditionally strong system of family care for the elderly (Glenn and McLanahan, 1982; Tout, 1989 and Choi, 1996). In fact, current elderly seems to have been deprived of the familial care in the wake of nucleation and displacement of children from parental homes. And hence, the economic security becomes essential in the absence of co-residence with children. Besides economic security, universal social security for all elderly to adapt with changing social environment becomes the challenge of the time. Alternative arrangement for elderly, living other than living with their own children seems to be a partial solution (Irudayarajan et al., 1995).

In the Indian context, some studies have been conducted on different types of dimensions of care and support extended to the elderly in different settings (rural and urban). While analysing the socio-economic problems of Santhals of Mayurbhanj, Orissa, Mohanty (1997) found that large mass of elderly sought economic support from their children. Moreover, receiving care from daughters was more among females. Sushma et al., (2004) in Haryana state, exhibited that in majority of cases sons were financially supporting their aged parents. Sudha et al., (2007) children were the chief sources of economic support to the elderly followed by spouse.

Audinarayana (2005) in his study found that the role of spouse in providing physical care when they were chronically ill to a higher extent closely followed by self and conspicuously, caste background of the elderly had shown a significant negative effect on the likelihood of getting physical care by the elderly during sickness. Bhingradiya and Kamala (2007) in their rural Maharashtra study, observed that majority of the aged women and aged men perceived their spouses as caretakers during illness, whereas all the sons and daughters-in-law from all households were perceived as caretakers of aged women and aged men during illness. Muthukrishnaveni’s (2010) study in Tamil Nadu exhibited that the main sources of money for the elderly was their son.
Higher proportions of females were not getting the required help compared to male elderly.

The patriarchal joint family system and traditional values such as reverence for age that bound parents and their adult children are the distinguishing characteristics of the Ancient Indian culture (Muthukrishnaveni, 2010). The care and support of the elderly specially women is in stake as less importance has been assigned to socio-religion ceremonies and her experience in child rearing is not of much value due to greater reliance on modern medicine, technology and information.

Ramamurti et al., (1992) “care giving is a emotional relationship that expresses caring and concerning for the care receivers and it cannot be so if it is were just mechanical and non-humanist”. Therefore such caring by children and families is beset ingrain in the cultural and familial norms as a valued practice which is handed down from generation to generation. However, there are argument which states that one of the features of the nuclear families is reduced commitment towards older parents and relatives.

The recent social and economic changes in the society brings about a decline in the ideas of children has the main source of support (Dharmalingam, 1994). Hence, urbanization and large scale migration for economic reason are changing society and family system. However on the other side traditionally in Indian society the elderly in rural areas are found to be provided with familial and community support which rested in the hands of younger generation of individual families as a duties. Hence, studies in India found that the elderly consider their own family as the major support system because they prefer to approach the family in case of any problems and only in absence of family did they seek help from neighbours. The relatives were approached least because it is not easy to reach out to them (Bhamini Metha et al., 2002).

Neglect of the older people by the younger generation is increasingly becoming common and the underlying reasons may vary. Generation gap, family dynamic in the present and past results in friction which ultimately leads to disrespect and humiliation.
Lees et al. (1994), indicated that the prosperity of adult children to provide instrumental support and emotional support was indirectly affected by the influence of the early parent child relationship. Generally the elderly like to stay with their Kith and Kin and give suggestions to the younger generation. They enjoy authority with economic independence. But now a days due to emergence of nuclear families the elderly are missing the opportunity of being independent and authoritative. The increased life expectancy of men and women finds a long survival time ahead, which increases the physical disabilities of elderly with advancement in age (Shanas, 1979).

With regard to the care and support of the elderly in the family, there are emerging literatures which concern perception of reciprocity in supportive relation. Older parents expect a reciprocal care from the younger family members which they had once given them in their childhood. So, evidence for the importance of equity in social relation is considerable (Adams, 1965), specially in supportive relationship (Kahn and Antonucci, 1980). This reciprocity in care and support relationship varies by culture (Aksymama et al., 1995), resources (Dowd, 1984) and by the nature of relationship (Wentowski, 1981).

However, the trends toward smaller families and increasing number of labour market suggest that the availability of daughters as caregivers may become more limited in the future and the sons may be increasingly called upon to act as caregivers. Horowitz (1985) examines how sons differ from daughters as caregivers and addresses three issues; under what conditions sons take on the care-giving role, differences in the extent of care-giving provided by sons, and sons differences in their perceptions of the social and emotional consequences of care-giving. Jones et al., (1983) observe daughters in South Wales to be three times more likely to be identified as carers than sons.

Receiving a good social support by the elderly depends on the understanding between the elderly and other younger family members. The elderly must be in a position to understand well the care givers and share a good cooperation level within the family members (Indira, 1999-2000) as family in the immediate source of social support at the time of needs (Shanas’, 1979).
Apart from the family members, the wellbeing of the aged is taken care of by society especially by friends and neighbours. Friends and neighbours are more sympathetic towards the aged and extend help in needy times. Mutual understandings between the same age group will be more appropriate than different age groups because most of the needs and attitudes will be common in the same age group (David, 1985). The family takes care of the needs of the elderly like providing food, bathing and providing medicine. The aged depend on community people for activities of instrument such as shopping, bank work, work at post-office and paying of bills (Branch and Jette, 1983).

According to Biegal et al., (1984) the elderly have greater need for social support than other population groups. Because social support for the aged provides a sense of security, confidence in their ability and competence in them, is vulnerable. It also gives satisfaction in life and reduces victimization of them. For that purpose the family member must improve their social support networks. Moreover, the neighbours also support these oldest old groups. Bould (1990) explained that the distinction between care giving and social support is especially critical for the oldest old.

According to Dak (1981) elders to not favour isolated life, old age homes do not offer solution to the problems of aged. There is need to strengthen, through some mechanism, the traditional kinship and family bond, to ensure continuity in the flow of income to survive and to keep the aged to engage some constructive activities of their own choice. Hence, the family members must provide care and freedom to the elderly in the family. Carretch et al., (1997) and O’Cormnor (1995) both found from their study, that the quality of relationship with family and friends was important to the life satisfaction of older generations. For elderly subjects, the quality of their relationships with friends was more important to life satisfaction than relationship with children. However, relationships with friends were not perceived as more positive than relationships with children. Thus, there is a need for motivating the people for meeting the needs of the elderly. This must be realized not only as giving care to the elderly but also in creating equitable alternatives to family care (Kosberg, 1992). The stress management techniques of the elderly can be
overcome by performing any busy tasks. The need for the care may occur for most of us in the last years of our lives as elderly are more dependent on family for care and support.

2.7 Perception of Elderly about Ageing

Nalini (1993) in her study of retired persons in Madurai found that the ageing process is associated with a number of factors like, i) traditional culture that recognize the position of the old, ii) health status, iii) economic independence and iv) their role expectations in the family. Hence people exhibit different potentials for maintaining actively. Retirement reduces social involvement but family responsibilities fill in the vacuum thus created. Old people are active within the similar circle of family. Family is still the core of the society protecting the old. Anticipatory socialisation before retirement would enable the old to adjust in society and also a venue to channel their social activities.

The study by Asharaf (2007) in Kerala found there were elderly who think that youth today are disrespectful to elderly, consider elderly as a burden, as a hindrance to taking outings, do not give importance to their feelings and who physically abuse the elderly’ feeling, these respondents were more likely to feel that being aged is a problem. A higher proportion of elderly without financial/religious engagement perceived ageing as a problem. Similarly the likelihood of perceiving ageing as a problem was found higher among those who did not have frequent contact with relatives, no contact with friends, were forced to handle depression all alone, did not have the status as head of the household and those who are not considered in decision making of the family.

2.8 Research Gaps and Need for the Present Study

The review of studies conducted in India at different rural settings portrays some of the major research related to ageing and its related issues. The need of the hour arises, as the elderly with regard to modernisation are found in destitution because they are left behind alone in village, where they feel socially helpless and economically unsecured and thereby they are compelled to lead a life of uncertainty and difficulty (Behara and Mohanty, 2005). On the whole, in Indian context, though the research relating to ageing
and its related issues was of the recent phenomenon, a number of studies are conducted with related to the size of elderly population and differentials in their demographic and socio-cultural sub-groups, viz., age, gender, rural-urban settings, marital status, etc., Moreover, the focus of the research themes also vary extensively since the researchers had diverse specialisations from different disciplines, like Sociology, Anthropology, Social Work, Psychology, Economics, Population Studies, etc. In this process, the size of the sample of elderly, the methods of data collection and the instruments of data collection vary from study to study, and thereby, the findings too may not be strictly comparable.

But the social aspects of studying elderly situation are neglected. Hence, while looking at the existing literature it was found that there is lack of studies in India on the social issues of elderly like, social adjustment, role, status and decision-making power. In this context, the present study aims to full-fill some of these research gaps by considering substantially large sample size of elderly and focussing on wide-ranging features like, socio-economic background, personal life style, living arrangement, participation in familial concerns, health status, chronic diseases, disability status, knowledge about old-age homes and maintenance of older persons act. Furthermore, the studies related for a holistic understanding of the different domains of care and support of aged persons. It also examines the issue such as how the aged and their subsequent generation (their children) perceive ageing. The study also tries to understand the overall opinion of the elderly regarding their expectation from children, society and also from government.

Keeping all these in mind, in this study it is aimed to full-fill some of these research gaps by considering substantially large sample size of elderly and focussing on wide-ranging features like, different dimensions of care and support from elderly’ perspective, viz., emotional, physical and financial. Under these circumstances, it is felt that this type of study would be more useful for policy formulation for the well-being of the elderly in general and that of those residing in rural settings in particular.