INTRODUCTION

India’s population of 1.31 billion, the second largest globally, comprises 17% of the world’s total (United Nations 2015), and the United Nations Population Division estimates that India’s population will in fact overtake China’s by 2028. As India’s population grows, its expanding share of older adults is particularly notable. Currently, the growth rate of the number of older individuals (age 60 and older) is three times higher than that of the population as a whole (Giridhar et al. 2014).

Population Aging in India

Three dominant demographic processes drive the growing share of older Indians: declining fertility rates due to improved access to contraceptives, increasing age at marriage, particularly among women, and declining infant mortality; increasing longevity because of advances in medicine, public health, nutrition, and sanitation; and large cohorts advancing to older ages (Bloom et al. 2014). India’s total fertility rate has decreased from 5.9 in 1950 to 2.3 in 2013 and is projected to drop further to 1.88 by 2050, which is below the replacement level. Life expectancy at birth has improved vastly over the last few decades, increasing from 36.2 years in 1950 to 67.5 years in 2015 and projected to rise to 75.9 years by 2050.
Even more significant in its implications for population aging, life expectancy at age 60 has also increased dramatically, rising from about 12 years in 1950 to 18 years in 2015 and projected to rise further to more than 21 years by 2050.

Average Indian life expectancy at age 80 has likewise increased significantly, from about 5 years in 1950 to more than 7 years at the present time. By the middle of this century, it is predicted to rise to 8.5 years (United Nations 2015).

However, the progress that increasing life expectancy represents comes with the challenge of a burgeoning older population. In India, the population share of adults 60 and up grew from 5.4% in 1950 to 9% today. In absolute number of individuals, this represents an almost six-fold increase, from 20.3 million in 1950 to more than 116 million today.

Meanwhile, the proportion of the “oldest old” adults aged 80 and older has more than doubled over the past 65 years, from 0.4% of the total population in 1950 to 0.9% in 2015, and is projected to reach nearly 3% of the population—almost 48 million individuals—by 2050 (United Nations 2015). The dramatic and massive nature of these current and ongoing demographic shifts indicates that the population-aging challenges India faces are sure to occur on an enormous scale.

As India’s population structure changes, so does its health profile. This is especially true for noncommunicable diseases (NCDs). NCDs include cardiovascular diseases, cancers, chronic respiratory diseases, diabetes, and eyesight conditions, the prevalence of which all increase with age (Agarwal et al, 2016).
Gender Variations in Population Aging

Accompanying the aging of the Indian population is increasing feminization in older age groups, which brings its own unique issues and challenges. Although average life expectancy has increased dramatically in India, it has not risen equally for males and females.

The life expectancy gender gap has been widening in India. In 1950–1955, Indian women’s life expectancy at age 60 exceeded men’s by 0.07 years; by 2010–2015, this gap had doubled to 1.4 years; and by 2050–2055 it is projected to reach 2 years. This growing longevity gap between the sexes implies that India’s older adult population is growing increasingly female.

One of the most important implications of an increasingly female older adult population in India - including variations in the extent of this trend across states—will be the prevalence of widowhood among women. Higher female life expectancies and higher average male age at first marriage are sharply increasing India’s population of widowed females.

In 2012, for example, only 8% of Indian males aged 60 to 64 were widowed, compared with 35% of females in this age group. Among adults 80 and older, a majority of females, more than 60%, had been widowed, compared with just 27% of males (Desai, Dubey et al. 2015). This is highly significant because in many Indian communities, and particularly under traditional Hindu law, widowed women have historically suffered from social stigmatization and discrimination, although evidence exists for improvement in the treatment of widows in the country as a whole (Kadoya and Yin 2012). Most notably, widowed females may suffer from income insecurity due to inheritance traditions that favor sons over daughters and insecurity in their living arrangements (Dey, Nambiar et al. 2012, Sathyanarayana, Kumar et
Evidence also indicates that Indian female widows aged 60 and up suffer from morbidity due to communicable and noncommunicable diseases at a significantly higher rate—13% more—than do male widowers in the same age group. Despite this, however, older female widows are also significantly less likely to engage in health care seeking behavior (Agrawal and Keshri 2014).

In addition to the perils of widowhood, older women in India are significantly disadvantaged in terms of education and literacy relative to both their male contemporaries and to women and men in younger age groups. According to the IHDS-II, as of 2012, only about 22% of Indian women aged 65 or over were literate, compared with 55% of men in this age group. This disparity is especially striking compared with literacy rates for adolescents and adults aged 15 to 64: a nearly equal 63% for females and 64% for males, which reflects more recent improvements in educational access and opportunity. The education gap in older age groups also bears out in years of schooling. While men and women aged 15–64 have nearly identical average years of schooling -- with females’ years of education actually slightly higher than males’ (females averaged 2.8 and males 2.7) -- a pronounced disparity exists among those aged 65 and up. Among older Indian adults, women average only one year of education compared with four for their male counterparts (Desai, Dubey et al. 2015). Because of these disparities in education, older Indian women may be less able to learn about issues such as health risk factors and government benefits and less able to advocate for themselves effectively.

Economic security for older Indian women—particularly widowed and unmarried women, but also for women in general—is also a major concern. Labor force participation among women is very low, and a majority of women depend on their families for economic support.
Moreover, women in India have historically not owned assets due to the nation’s patriarchal inheritance system in which assets and property are kept within a family’s male lineage. Not until a 2005 amendment to national property law have women been entitled to equal property inheritance rights (Government of India 2005). Policy that strives to ensure financial security for both older men and women must be committed to promoting and defending these newly legalized inheritance rights.

Because of ongoing age and gender demographic shifts; considerable heterogeneity in sex-based life expectancy gaps; and prevalence of widowhood across Indian states, aging- and gender-related issues will likely converge as India’s population continues to age over the next several decades. Policy changes and programs must pay attention to the special needs and situations of older women, particularly widows, to ensure the wellbeing of all of the country’s older population.

**Workforce Participation and Income Security**

Another major challenge of population aging in India is income and housing security for older adults. This is due in part to a changing social and economic landscape in which the traditional family support system is breaking down in the households of many older adults. In India, as in many East and South Asian countries, family has traditionally served as the prime source of support for aging adults, with sons responsible for caring for their parents. However, evidence indicates that this support system has been declining due to factors such as increased urbanization and mobility; a 2011 United Nations Population Fund (UNFPA) survey carried out in selected states revealed that about a fifth of 60+ respondents lived alone or solely with a spouse. The main reasons cited for living without children were having no
children, or children living in a different locality due to education, work, or marriage, rather than due to personal preference. Furthermore, only 14% of these single-generation, older-adult households received financial support from friends or relatives (Alam, James et al. 2012).

Workforce participation patterns and employment sectors among older Indian adults are also significant for multiple reasons. First, employment and workforce attachment data give information about income and income security for India’s aging population. Estimates from India’s most recent census indicate that 42% of adults 60 and up and 22% of adults 80 and up still participate in the workforce (Government of India, 2011). The UNFPA survey of older Indians found that about 24% of India’s nearly 10,000 respondents aged 60+ remained in the workforce and that a large proportion of these respondents were working at a relatively high intensity level of at least six months out of the year or more than four hours a day. Rates of workforce participation among older adults were markedly higher in rural (47%) than in urban areas (29%); were much higher for males than for females (Agarwal et al, 2016).

As many Indian individuals experience longer life spans and better health, an increasing number may choose to continue to work, full time or part time, beyond traditional retirement ages for reasons of enjoyment and intellectual stimulation, or to share their knowledge and experience with younger workers. At the present time, however, more than 70% of older Indian workers surveyed cited economic necessity, rather than personal preference, as their main reason for remaining in the workforce, indicating a high level of income insecurity (Alam, James et al. 2012).
The second major reason that workforce participation is significant is because only individuals who have worked in the “organized” labor market—that is, those who have had official employment with employers such as government organizations or private corporations—are eligible to receive pensions after their retirement. An estimated 83% of India’s working population, however, is in the unorganized sector and therefore not entitled to receive any pension or retirement benefits in their old age. In total, less than 10% of the population currently receives a pension of any kind (Uppal and Sarma 2007). India faces an urgent need for social safety net measures that are available to all individuals, regardless of work history.

Income security takes on extra significance with older adults due to rising health care consumption and expenditure. As discussed previously, the prevalence of noncommunicable diseases increases with age, and so, accordingly, does health care spending. Moreover, only 17% of the population is covered by health insurance (Bloom, Mahal et al. 2010). Indeed, the 2011 LASI pilot survey found that of about 1,600 adults aged 45 and older, 87% reported “family” as their primary payment mechanism for health care costs, while only 1% reported having insurance (Arokiasamy, Bloom et al. 2012). In the absence of health insurance and quality health care infrastructure, catastrophic health care expenditures can easily push older adults into poverty. Health insurance and comprehensive health care policies will also be a crucial component of any national action designed to ensure the income security of India’s older adults.
Deprivation in Old Age

The lives of many older people are more frequently negatively affected by the social and economic insecurity that accompany the demographic and developmental process (World Bank, 1994). The growth of individualism and desire for the independence and autonomy of the young generation (Serow, 2001) affect the status of the elderly. The studies show that the socioeconomic condition of older women is more vulnerable in the context of the demographic and sociocultural change (Tout, 1993). The condition of elderly poverty has been a consistent phenomenon in the Third World as the older population is deprived of the basic needs (Keyfitz and Flieger, 1990). Chambers (1995) described the eight diminutions of deprivation among the elderly as poverty, social inferiority, social isolation, physical weakness, vulnerability, seasonality, powerlessness and humiliation of the aged. Poverty is thought to be a major risk of ageing in developing countries (Sen, 1994) and study by the World Bank reveals that in the most of the developing countries, older people are vulnerable (World Bank, 1994).

The health risk of an aged person in a household can result in a catastrophic shock in the family that can make households more exposed to poverty. The increased cost of the medical treatment makes large chunks of the elderly in the developing world deprived of access to health (Prasad, 2011).

The data on living arrangements of the Oldest Old in rural areas suggests that most of them live with the families of their adult children (HelpAge India, 2015). They depend on their children to take care of them during ill health. However, the children are almost never helpful.
and, in many cases, the Oldest Old have to depend on their spouses. As a result, many of them face insufficient food intake and many report economic abuse by their family members.

The health problems faced by the Oldest Old include asthma, poor eyesight, cold and cough, joint pains, and problems related to general physical weakness. Most of them depend on a private doctor/clinic, community health centre and primary health centre in the area for treatment. The Oldest Old in rural areas are not covered by any health insurance scheme, and therefore find it difficult to access healthcare. In most cases, there are no dependable community support systems that the Oldest Old can depend on. Moreover, there are no government welfare schemes for their benefit, except for the Indira Gandhi National Old Age Pension Scheme.

The belief that children will take care of the parents in the old age is eroding in India where the family size has been cut down as a result of the demographic process (Dandekar, 1993). The situation in the urban areas shows a rejection of older people by the next generation and this is spreading to rural areas (Desai, 1985). In the nuclear family regime, the position of the aged becomes more vulnerable and is treated as a burden to the family (Nayar, 1992). The social negligence of the aged occurs due to cultural, social and economic relations within the society and its coexistence with demographic development (Achenbaum, 1978). This changing dynamic that starts within the family and society can make the elderly insecure (Alter et al, 1996) through intergenerational imbalance (Hareven and Adams, 1996). These changing dynamics can affect the living arrangements and social protection system and make the elderly more insecure. In most of the countries in the West the shift in the living arrangements to a state of living alone has made the elderly more insecure (World Bank, 2001). The scenario is almost emerging to high levels of insecurity in the Asian countries.
with shift in the living pattern and increase in the social exclusion (Zeng, 2005; Yoko, 2000; Moregami, 2003). The majority of the elderly are deprived of the basic necessities and are thus in chronic poverty (Rajan, 2001).

Decline in health, though, is just one of the possible risks associated with old age apart from a prospective fall in income, dependency and loneliness, and it remains one of the dominant concerns among the aged (Prakash, 1999). This is not surprising, as studies have shown that health is one of the crucial factors that determine the quality of life among the elderly (Wiggins et al., 2004). Moreover, poor health would be a cause of worry among the elderly since illness episodes in general have the potential to cause economic shock, leading to financial dependency, loss of autonomy, reduced social contact and loneliness. Literature on health clearly shows that a positive relation exists between age and morbidity among the adults, i.e., at old age there is higher prevalence of morbidity implying that the risk of illness and morbidity is higher among the aged (Crystal et al., 2000; Duraisamy, 2001). Some studies have shown a grim picture as most of the elderly in the world are deprived of health care and protection and these deprivations get aggregated in the developing countries (HelpAge International, 2005). Studies across the globe attributed that aspects of health insecurity are conditioned by economic and social conditions (Zick and Smith, 1991; Sengupta and Agree 2003). In India, issues of health insecurity and deprivation are a chronic problem among the aged (Alam 2007; Rajan et al, 1999).

In India, people generally respect the aged and take care of them in a respectful manner. Conventionally, the family system has a main responsibility of the taking care of the elderly. In most cases, the elderly live with their son or daughter (Nayar 1992; Desai, 1985; HelpAge International, 2005)). Recent years have witnessed a redefining in the relations as the social
and economic transformation has resulted in the disintegration of the joint family system and the rapid decrease in the family size has put the elderly in the isolated units. A study by Dak and Sharma (1987) highlights a decline in the role of the aged in the family, as they get isolated in urban India. High incidence of migration and urbanization has put the elderly in stress (Rajan, 2004; Alam, 2004).

**Theories of the Aged**

For those who seek understanding of the elderly, there are some social theories that might help to understand the elderly and their later-life experiences.

Continuity theory claims that older adults maintain patterns in their later years which they had in their younger years. The elderly adapt to the many changes which accompany aging using a variety of effective personal strategies they developed earlier in their life. For example, those who participated in outdoor activities in their younger years tend to continue to do so as older adults—although they tend to accommodate their health and fitness limitations as they deem appropriate.

Activity theory claims that the elderly benefit from high levels of activities, especially meaningful activities that help to replace lost life roles after retirement. The key to success in later-life is staying active and by doing so resist the social pressures that limit an older person's world.

Disengagement theory claims that as elderly people realize the inevitability of death and begin to systematically disengage from their previous youthful roles, society simultaneously
prepares the pre-elderly and elderly to disengage from their roles. This was the first formal aging theory that fell short of credibility because the scientific data did not support its assumptions.

Modernization theory claims that industrialization and modernization have lowered the power and influence which the elderly once had which has lead to much exclusion of elderly from community roles. Even though this theory is not as well established and is somewhat controversial, it has made a place in science for understanding how large-scale social forces have impacted the individual and collective lives of the elderly. In our modern societies, the economy has grown to a state that has created new levels of prosperity for most, the new technologies have outpaced the ability of the elderly to understand and use them, and the elderly are living much longer and are not essential to the economic survival of the family as was the case for millennia. Modernization can help us to understand why the elderly have become stigmatized and devalued over the last century (Harmond, 2010).

**Social Support**

As they age, older adults may experience a reduction in functional capacities such as walking, hearing, seeing, and cognition. This makes them more vulnerable to a variety of different contextual conditions. Social networks and neighbourhood characteristics may change substantially as adults age in in their own home and community. Their social participation and independence may be enhanced or limited as their surrounding contexts are modified.
Durkheim's contribution to the study of the relationship between society and health is immeasurable. Perhaps most important is the contribution he has made to the understanding of how social integration and cohesion influence mortality. Durkheim's primary aim was to explain how individual pathology was a function of social dynamics.

In Suicide, Durkheim challenges us to understand how the patterning of one of the most psychological, intimate, and, on the surface, individual acts rests not upon psychological foundations but upon the patterning of "social facts." Durkheim illustrates suicide is triggered by the erosion of society's capacity for integration. Durkheim's theories related not only to the patterning of suicide but easily extend to other major outcomes ranging from violence and homicides to cardiovascular disease, claim Berkman et al (2000).

Societal factors like social integration and cohesion influence health. They form – in Emile Durkheim’s words – a social reality *sui generis* that is unique to itself and not reducible to the parts of which it is composed, i.e., the single individuals. Emile Durkheim analysed suicides not purely in terms of psychology and individual circumstances but conceptualized suicide rates as a social product. It seems likely that much of the disease burdens of modern societies reflect social and economic circumstances that vary between societies. It is likely that diseases can in parts be considered to be as much a social product such as suicides can. Wilkinson (1999) has shown that cohesive and socially integrated societies tend to experience better health outcomes compared to less integrated societies. Neighbourhood social cohesion represents one central aspect of the social environment of a neighbourhood that has the potential to influence physical activity. Social cohesion refers to two interrelated features of society: (1) the absence of latent social conflict and (2) the presence of strong social bonds that are often measured by levels of trust and norms of reciprocity (Berkman et al., 2000).
Berkman et al (2000) argue that networks operate at the behavioural level through four primary pathways: (1) provision of social support; (2) social influence; (3) on social engagement and attachment; and (4) access to resources and material goods. These micro-psychosocial and behavioural processes then influence even more proximate pathways to health status including (1) direct physiological stress responses, (2) psychological states and traits including self-esteem, self-efficacy, security, (3) health-damaging behaviours such as tobacco consumption or high-risk sexual activity, health promoting behaviour such as appropriate health service utilization, medical adherence, and exercise, and finally to (4) exposure to infectious disease agents such as HIV, other sexually transmitted diseases (STDs) or tuberculosis.

Social institutions shape the resources available to the individual and hence a person’s behavioural and emotional responses to the related aspects of their environment. For example, older adults’ attachment to an environment is not only a function of familiarity with their physical surroundings, but also of the social relations available to them, which are created by the interpersonal behaviour of others in their particular surroundings. By assessing actual ties between network members, one can empirically test whether community exists and whether that community is defined based on neighbourhood, kinship, friendship, institutional affiliation, or other characteristics. A deficiency of these relations – which is social isolation – has continually been reported as harmful to health and has been associated with mortality in epidemiological research since the late 1970s and 1980s (Brummett et al., 2001).

One of the earliest theoretical frameworks that focused on interpersonal relationships was proposed by Kahn and Antonucci (1980). Their “convoy model” takes a life-course
perspective and presents a framework for understanding how social networks are formed and developed over time. The convoy model proposes that from childhood to old age people move through life together with other people (Antonucci & Akiyama, 1987). This personal social network accompanies a person over time and across different contexts, serving a number of functions (e.g., emotional, and instrumental support). A person’s “convoy” is organized in a hierarchical fashion, with family members and friends being among those who are most often asked for assistance. Neighbours and other people with whom a person interacts on a regular basis follow one level below in their importance.

Although small variations exist across populations, studies indicate both qualitatively and quantitatively that individuals can be consistently classified into four basic network types based on their social relationship characteristics (Li & Zhang, 2015; Litwin, 2003). Individuals with a diverse network type maintain a broad range of supportive relations with family, friends, and neighbours, and frequently participate in various social activities. In comparison with other network types, these networks generate more resources that can be accessed and potentially mobilized. In other words, such networks are richer in social capital than other types of networks (Lin, 2001). Those with a friend-focused network type have frequent interactions with friends or neighbours, but fewer interactions with family members. In contrast, people with a family-focused network type arrange their social life exclusively around families and have few active relationships with other people. Finally, those with a restricted network type have limited engagement in all kinds of social relations. Older adults with restricted networks have been found to be more physically inactive in comparison with people with the other three network types (Shiovitz-Ezra & Litwin, 2012).
Although family is a major resource of support for the elderly, not much is known about the actual supportive relationship within the families. Researchers who have investigated support for older adults traditionally have used living arrangements as indicators of family support. However, living arrangement in itself does not indicate whether elderly parents are receiving care and support. Living arrangement is the structural aspect whereas the actual transactions of support carried out refer to the functional aspects of support. Structural aspects of support are concerned with integration of the person within the support network, while functional aspects of support are concerned with the function or role served. Functional aspects of family support may vary across cultures because norms of intergenerational contact affect the meaning the respective culture attaches to family and care responsibilities.

The structural aspect of social support is the actual physicality of the support and includes quantitative elements such as size of social network, frequency of social interaction, whether or not people are married, whether or not people live alone, and how often they take part in social activities. The functional aspect refers to the type or content of support. Social support theory suggests that structural social support is a necessary antecedent of functional support (Queenan et al., 2010). The evidence suggests that the structural features of social support such as the availability of support (Henderson, 1981), size of the support network (Jang et al., 2002; Underwood, 2000), and frequency of social contacts (Jang et al., 2002; Conner et al., 1979) are less significant predictors of mental health than the functional aspects.

Assessment of family support is crucial, since it would provide information to guide the government in developing policies regarding support for the elderly, as well as the provision of effective services and programs. Understanding the multidimensionality of the family
support construct is useful when identifying specific kinds of family support that may be beneficial for the elderly.

An individual's social support system comprises multiple networks. These networks comprise various relationships (such as family, relatives, friends and neighbours). The ageing experience of older people is largely influenced by the degree they are embedded in social support networks (Victor, 1994). Social support becomes significant source of help for older people, particularly those living with chronic illnesses (Shippy and Karpiak, 2005) and acts as a buffer and alters recovery patterns (Zink, 1994). Given the increasing prevalence of frailty and disability with age (Albert, 2004), social support, particularly instrumental and emotional support, offsets disability.

Family structures and living arrangements of elderly people have changed considerably in the past few decades in developing countries (Zeng, 2006). The issue of changing family household structures in our country has been documented by many studies. But the actual support rendered to the elderly has not been researched widely in different populations. Social support has always been assumed to be present when the elderly are living with others. There have been many studies conducted on the living arrangements of the elderly and there are many still being conducted. Studying the living arrangement of the elderly, researchers assume about the support they receive. However, living arrangements in itself does not indicate whether elderly parents are receiving care and support.

Social support is a complex and multi-faceted concept, which has been conceptualised and operationalised in a range of different ways. This lack of consistency is one of the most common criticisms of social support research (Williams et al., 2004). Nevertheless, there is a
consensus among researchers that social support has positive and health promoting effects.

According to Shumaker & Brownell (1984), social support is an exchange of resources between at least two individuals which is perceived by the provider or the recipient to be intended to enhance the well-being of the recipient. Cohen et al. (2000) also defined it as a process whereby health and well-being is promoted.

Some scholars have considered social support as a basic human need and defined it as a way that a person's basic social needs—for affection, esteem, approval, sense of belonging, identity and security—are satisfied through interaction with others (Thoits, 1982; Cobb, 1976). However, others have suggested that the benefits of social support arise only because it acts as a buffer to stress, and have thus conceptualised it as social interactions that are perceived by the recipient to facilitate coping and assist in responding to stress (Letvak, 2002). A third group views social support as a multiple construct which operates both as a means of meeting basic needs and a means of buffering stress (Kessler & McLeod, 1985; Cohen & Wills, 1985).

Weiss (1974) outlined six major functions of perceived social support, encompassing most of the functions proposed by other investigators: (a) Provision for attachment (emotional closeness giving one a sense of security); (b) Social integration (a sense of belonging to a group); (c) Opportunity for nurturing behaviour (the sense that others rely on one for their well-being); (d) Reassurance of worth (recognition of one's value, skills, and competence by others); (e) Guidance (the availability of information and advice); and (f) Reliable alliance (the assurance that someone can be depended on for tangible support).
Social networks could be considered as a measure of structural aspects of social support which include the following characteristics: size (the number of people in a network); geographic proximity or dispersion (the extent to which network members live near the focal person); density and complexity (the extent to which members of an individual's network know and interact with one another); homogeneity (the extent to which network members are similar, in terms of for example age, social class, religion); symmetry or reciprocity (the extent to which supports and obligations are equal among members); accessibility (the ease with which the focal person can contact other network members); composition and membership (who are the members of the network); and frequency of contact and durability over time and strength of ties (Bowling, 1994; Berkman, 1984).

Broadly defined, social support allows an individual to feel cared for and loved, provides a feeling of self-worth, and allows people to see themselves as part of a network of communication and mutual obligation (Cobb, 1976). More specifically, Wortman and Dunkel-Schetter (1987) described several distinct types of support. First, support can mean conveying that one is cared for, loved, or esteemed. Second, it can mean acknowledging the appropriateness of a person's beliefs or feelings. Third, support can encourage the open expression of beliefs and feelings. Fourth, it can mean offering advice or information. Fifth, it could mean providing aid or assisting with tasks. Sixth, support can mean that the person feels he or she is part of a system of mutual obligation. Cohen and Hoberman (1983) added a seventh dimension of support to their list: social companionship, which can distract people from worrying too much about their problems.

Social support's impact on health has been hypothesized to occur in two different ways: the buffering hypothesis and the direct effect model. The buffering hypothesis posits that social
support "buffers" people from potentially stressful events in two ways. First, support may reduce the harm from a stressful event by preventing the person from perceiving a situation as stressful. Second, support may decrease the impact of the stressful event by eliminating the event itself or by directly influencing the physiological processes or illness behaviours (Cohen and Wills, 1985; Cohen and Syme, 1985).

In contrast to the buffering hypothesis, social support in the direct effect model is thought to be beneficial to health irrespective of stress. The perception that others are willing to help may result in elevated self-esteem and a sense of control over the environment. This in turn influences physical health through the effects on neuroendocrine or immune system functioning (Jemmott and Locke, 1984) or through health promoting behaviours such as decreased smoking, increased exercise, or medical health seeking (Cohen and Wills, 1985; Cohen and Syme, 1985). In a comprehensive review of the epidemiologic evidence of the association between social support and health, Broadhead et al. (1983) concluded that poor social support precedes adverse psychological outcomes and mortality.

Social support to the elderly can be formal or informal. Formal support was defined by Litwak (1985) as formal medical services, physician advice and other forms of help from health care personnel, while informal was defined as support given by family members, friends and other close associates.

Informal support is extensive and can take many forms, including advice, affection, companionship, helping older family members with transportation and nursing care (Kane & Penrod, 1995). Informal support has been held to play a significant role in providing instrumental support (e.g. communications of affection) to older persons, which can involve
increasing an older person’s self-esteem, competency, and/or autonomy. The informal support networks of older persons are very important as these networks give residents a sense of belonging. These networks provide older persons with the opportunity to spend time and share activities, with others and the absence of these can contribute to loneliness and depression.

Social support is the result of the interplay between individual factors and the social environment. Characteristics such as age, gender, socioeconomic status, marital status, and family size may be associated with the probability of receiving social support.

Self Esteem

We have noted earlier that good social networks and social support can have positive influences on self-esteem and self-efficacy (Berkman et al, 2000). As mentioned by Cobb (1976), social support allows an individual to feel cared for and loved and provides a feeling of self-worth. Wortman and Dunkel-Schetter (1987) have also specifically stated that social support can mean conveying that one is cared for, loved or esteemed. The perception that others are willing to help may result in elevated self-esteem and a sense of control over the environment.

Self-esteem can be characterized as the feeling, appreciation and consideration that people have for themselves, namely how much they like themselves, how they see and what they think about themselves (Tavares et al, 2016).
Possessing positive self-esteem is often considered important because it has been found to be associated with higher levels of psychological health and functioning (Glaus, 1999). Low levels of self-esteem are considered negative and undesirable because it is often associated with poor psychological health and functioning (Glaus, 1999). A strong sense of self-esteem should be encouraged and promoted in today’s elderly population. Billipp’s research indicates that computers may be key to enhancing an aged individual’s self-esteem (Billip, 2001).

The way people evaluate themselves is widely accepted as important by health and mental health care professionals. People who have relatively high self-regard tend to be better students, are bothered by less anxiety, are less depressed, display better physical health, and enjoy better social relationships (Gilberts, 1983).

Self-esteem, unfortunately, is vaguely defined, says Bogan (1988). Wells and Marwell (1976) commented on the expansive number of terms and vast range of settings in which self-esteem constructs were used. They claimed that the same term might take on widely different meanings in the hands of different theorists, to refer to apparently the same construct. In this study, self-esteem is defined as the overall affective evaluation of one’s worth, value, and importance (Blascovich & Tomaka, 1991). High self-esteem is considered important because it is associated with higher levels of psychological health and functioning, and low levels of self-esteem are undesirable because it is associated with lower levels of psychological health and functioning (Glaus, 1999). A strong sense of self-esteem is surely needed among today’s elderly population. Every day is a struggle for many of these individuals. Decreased mobility, disabilities, and failing health can certainly affect one’s sense of self-esteem. Adults at any
age need intellectual stimulation, development, and self-esteem, to be useful and to have a sense of achievement (Eilers, 1989).

Self-esteem, a quiet confidence and acceptance of one’s own worth regardless of shortcomings or deficiencies (Rosenberg, 1979; Sonstroem, 1984), encompasses the affective and evaluative components of self-concept (Sonstroem & Morgan, 1989). Self-acceptance and competence are two dimensions of self-esteem (Sonstroem, Harlow, Gemma, & Osborne, 1991).

Old age involves a number of other changes that might contribute to declines in self-esteem, including spousal loss, decreased social support, declining physical health, cognitive impairments, and a downward shift in socioeconomic status (Baltes & Mayer, 1999). The elderly, like all people, want to feel recognized and appreciated for their ideas, abilities and talents. The aging often lose their sense of worth when illness, disability or frailty limits them. The loss of self worth is devastating to an elder’s well being and can be linked to depression and increased mortality. Caregivers need to add to their loved one’s quality of life by working together on project that boost self-esteem. Enjoying hobbies or pursuing projects such as writing memoirs, or constructing a legacy album or recording family stories can elevate self-esteem.

For older adults, even in the absence of a quality lifestyle, attitude often determines life satisfaction. Unfortunately, attitudes and stereotypes toward older persons are often negative, and these negative societal perceptions become internalized. These attitudes, combined with frequent losses (i.e., job, spouse, home), contribute to lowered self-esteem among older individuals as well as to an increasingly external locus of control and lack of self-efficacy.
Efficacy expectations are important to one’s actions (Bandura, 1997); therefore, older persons may need help in finding a sense of control over their lives and in realizing the strengths and competencies that they possess. This is an underlying assumption of the process of empowerment (Myers, 1991).

Plenty of studies have been conducted on the elderly in India focusing on various kinds of issues and still are being conducted. However, it still remains wanting for the elderly in our country are wide spread across various geographical regions and belonging to various social groups based on ethnicity, language, religion, caste and class. We need more studies on the elderly to understand their problems and needs. Generalizations with few studies cannot be made in such a pluralist society like ours. Moreover, the changes happening nowadays are rapid and their impacts are not immediately apprehensible. We need more studies on the elderly and it is with this conviction that the present study has been conducted with a view to add to the existing body of knowledge on the elderly population in our country. The focus of the present study is to know about the living arrangement of the rural elderly, the various kinds of social support they get and the extent of self-esteem they possess in the later stages of life.