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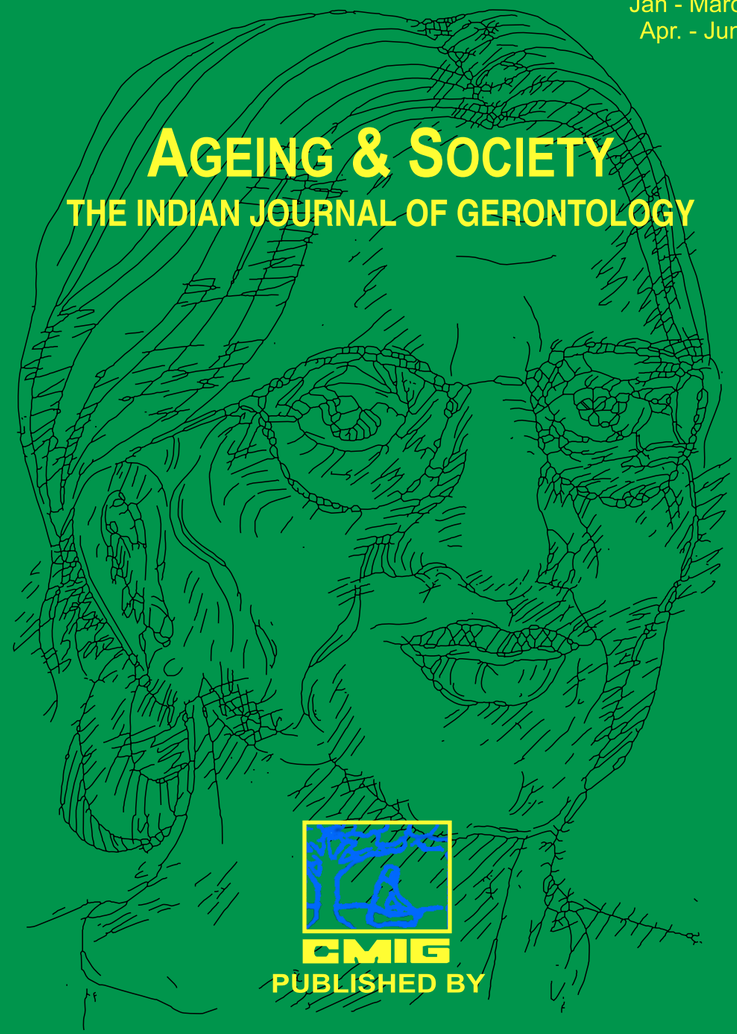

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AGEING & SOCIETY : THE INDIAN JOURNAL OF GERONTOLOGY

Editorial Board

This Journal will be devoted to papers on the following aspect of human ageing

- ★ Social Gerontology
- ★ Biology
- ★ Medicine
- ★ Behavioural Science

In addition we welcome Abstracts, Book reviews & Interviews with senior citizens

NOTES FOR CONTRIBUTORS

All Contributions and correspondence should be sent to Dr. Indrani Chakravarty, Calcutta Metropolitan Institute of Gerontology, E-1, Sopan Kutir, 53B, Dr. S. C. Banerjee Road, Kolkata-700 010. Contributors are requested to conform to the following norms and those articles that do not conform may not be considered.

Journal articles that deal with the biological, medical, psychosocial, service or other aspects of ageing are welcome.

Articles should be original contributions. Redundancy is discouraged. The articles should be written in English are free of grammatical, spelling errors, repetitions etc.

Articles shall contain: A brief introduction (reflecting the context, the review of relevant work and why the present study was planned) : relevant details of plan methodology, sample, (including standardization properties of tools) etc., the results or findings and their discussion and conclusions arrived at. At the beginning of the article the title and names of authors shall be mentioned. (Their affiliation may be given at the bottom of the page). This shall be followed by a brief abstract of the article (not exceeding 100 words) in single space, bold and set off the margins (inset by two spaces). Two or three key words of the article should also be provided at the end of the abstract separately.

Articles may be computer generated. Two hard copies, double spaced in A4 size (one side only) with wide margin may be sent. The articles would be adjudicated by referees and the result would be communicated. When the article is accepted contributors are requested to send 2 corrected versions of the article (hard copies) and the same in an electronic version in CD, press ready.

(a) References as below in international style (e.g. journal of Gerontology) arranged in alphabetical order in the Text : (Altekar, 1973,

Birren, 1959, Tyson 1983.....). End list of references:

Baltes, P. B. (1987). Theoretical propositions of life-span developmental psychology: On the dynamics between growth and decline. *Developmental Psychology,* 23,611-626.

Baltes, P. B. Reese, H. W., & Nesseiroade, J. R. (1988). *Life-span Developmental Psychology: Introduction to Research Methods.* Hillsdale, NJ : Eribaum.

(b) Footnotes should be avoided unless absolutely essential.

(c) Tables and figures should be clearly laid out, typed in standard format, numbered consecutively, and designed to fit on the page of the Journal “AGEING & SOCIETY” of CMIG.

A COMPARATIVE PSYCHOSOCIAL STUDY OF SELECTED ELDERLY GROUPS IN THE CANVAS OF SUCCESSFUL AGING

Nisha Bothra*
Manisha Dasgupta**

ABSTRACT

A sample of one hundred and eighty individuals, sixty each (thirty male and thirty female) of institutionalized elderly individuals without their spouses alive (Group A), their non-institutionalized counterparts having spouses (Group B) and those devoid of them (Group C) were assessed on selected psychosocial variables, namely, generativity, depression, partner bonding and adjustment, to probe into their psychosocial correlates in relation to successful aging. Statistics in the form of two-way analysis of variance (ANOVA) followed by t-test and Pearson's Product Moment Correlation were computed. Results indicated significant profile differences among the three groups with respect to depression and self adjustment. Correlation coefficients also indicated significant extent of associations between the different variables for the three groups. Strategies targeted towards attaining successful aging have also been implicated.

Key words: successful aging, institutionalized elderly, generativity, depression, partner care and control, adjustment.

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Seasons of life are the offerings of the dynamic creation of God. Each developmental phase has its unique characteristic features, developmental tasks, virtues and realization points in the platform of positive psychology. Old age is the final developmental phase which is adorned by folds of wisdom, generativity and ripened meaning of life for successful aged. Since the dawn of civilization, human beings have recognized a progression through the life course, from infancy through old age. One cannot fully understand what old age means unless one understands it as part of the entire course of human life, and this approach is called the life course or life-span perspective (Settersten, 2003). The notion of successful aging is of much importance at this juncture. This study focuses on the measurement of four variables in elderly individuals pertaining to successful aging, namely, generativity, depression, partner bonding and adjustment. It also sees the interaction pattern among these variables in the backdrop of institutionalization or non-institutionalization, and the presence or absence of spouse due to death.

Successful aging: A conceptual overview

The population of seniors in India has grown from 3.3 percent in 1950 to 7.6 percent in 2000. It is predicted that by 2050 a whopping 15.1 percent of Indian population would consist of individuals 65 years and older (United Nations, 1998; United Nations Population Division, 1999). The increase in the number of elderly individuals has led to discussions about health care facilities and social support system in India. Aging is usually associated with physical decline and frailty as well as psychological modifications. A number of research studies focus on structural and functional decrements (Margrain and Boulton, 2005; Solomon, Shock and Aughenbaugh, 1970; Singh, 2004; Ramamurti, 2002). Powerlessness or perception of others in control can be an emotional risk factor in old age too (Kunzmann, Little and Smith, 2002).

The question comes to mind as to what successful aging is and how it can be achieved in the face of such decline and changes. According to Wong (1989; 2000), prolonging life without providing any meaning for existence is not the best answer to the challenge of aging. He defines successful aging as a relatively high level of physical health, psychological well-being and competence in adaptation (Wong, 1989). However, Wong (1989; 2000) notes that the latter two aspects are more important than physical health when determining successful aging. Competence in adaptation emphasizes personal responsibility, implying that an individual has a choice of how she will cope with the challenges and changes that occur with growing older such as retirement, physical decline, personal losses, suffering and impending death. This view is supported by numerous other studies too (Rowe & Khan, 1998; Fisher and Specht, 1999).

Role of family and spouse in successful aging

In our country, the family is the most important institution and one that has been able to withstand the vicissitudes over the centuries (Sinha, 1984). Joint family, kinship and value system in the past ensured emotional help, physical security and social support to the aged (Ramamurti, 2002). However, in the last few decades, researches have specified that the traditional joint family has disintegrated due to forces of urbanization and modernization, and leaves the older people vulnerable and isolated (Raju, 2002). In this context, the role of the spouse has been reported to be very important as a spouse can be the strongest predictor of life satisfaction (Whisman et al., 2006). Individuals at greatest risk of emotional isolation are those without a spouse (Adams et al., 1989). Unavailability of a confidante and death of a spouse have been found to be key predictors of trait loneliness (Taylor and Adams, 1996).

Role of institutions in old age

Many elderly parents due to lack of proper care for them in the family set-up tend to express that given the opportunity, the functional capacity and the finances, most of them would prefer to live by themselves than with their children's family or in institutions for the elderly (Malhotra and Chadha, 2007). Major reasons for institutionalization, as quoted by the inmates participating in a study (Jamuna, 1998) were low economic status, widowhood, destitute conditions, abuse by family members and lack of support by social networks. The relevance of spouse and family in an elderly's life, thus, cannot be negated. In order to outline the importance of this matter, the present sample was assessed to verify the bearing of certain selected personality variables on successful ageing, the conceptual launching of each of them having been done in the following section.

Generativity in relation to successful aging

Erikson (1963) depicted the life course as a series of psychological tasks, each requiring the person to resolve conflicting tendencies. Erikson posited a conflict preponent in middle age as that of **stagnation and generativity** – being trapped by old habit versus going beyond self-absorption to nurture the next generation. In generativity, one comes to accept that he won't live forever, and seeks to leave a positive legacy for the future. Kotre (1984) echoes the idea by defining generativity as “a desire to invest one's substance in forms of life and work that outlive the self”. McAdams and de St. Aubin (1992) proposed a model where they view generativity as a configuration of seven psychosocial features constellated around the personal and societal goal of providing for the next generation, namely, cultural demand, inner desire to be needed, concern for the next generation, belief in the species, commitment, action taken, and narration or the generativity script within the personal life history.

Depression in the parlance of successful aging

Depression refers to a profound feeling of sadness and loneliness, a feeling of monotony and joylessness, a feeling of impending doom, and a self accusatory tendency, even to the extent of feeling the need to commit suicide. According to Beck (1967), depression consists of negative feelings about one's self, one's world and one's future. A triad of feelings of hopelessness, worthlessness and helplessness is often observed. It interferes with an individual's ability to function and causes great distress to him/her (Geist and Jefferson, 1997). Late-life depression has been shown to be influenced by genetic, situational, biological and psychosocial factors.

Specific bearing of partner bonding on successful aging

Relationships play an important role in the life of an individual. During adult life the most common attachment figure is the marital partner or cohabitant. A couple invariably depends on each other for emotional needs which take prime importance especially during old age. Wilhelm and Parker (1988) identified and defined two key dimensions underlying partner bonding namely care and control. The care dimension reflects care expressed emotionally as well as physically. The control dimension suggests domination, intrusiveness, criticism and authoritarian attitudes and behaviors. It could be argued that intimate confiding relationships might produce a protective effect when stressful events are faced (Bowling, 1994). On the other hand, a partner trying to dominate becomes a hazard in daily living and may cause immense suffering (Kraaij and Garnefski, 2002).

Adjustment in relation to successful aging

Adjustment is the behavioral process by which humans and other animals maintain equilibrium among their various needs or

between their needs and the obstacles of their environment (Encyclopedia Britannica, 1987). Several factors influence adjustment in old age, a few of which are health, living conditions, economic conditions, social isolation, loss of physical health, lower income, achieving security and medical care (Hurlock, 1976). Aged individuals, clearly, have to make fresh adjustments in the older years. (Landis, 1942; Jamuna, 1984)

Objectives of the present study

This study purports to assess whether:

1. there exists any significant inter-group difference with respect to generativity, depression, partner bonding and its dimensions, and adjustment and its dimensions, as far as the three selected groups are concerned, namely, institutionalized elderly without their spouse alive (Group A), their non-institutionalized counterparts having spouse (Group B) and those devoid of them (Group C)
2. there exists any significant gender difference in the sample with respect to the selected variables and their respective dimensions
3. there exists any significant intra-group differences in the sample with respect to the selected variable and their respective dimensions
4. To assess the extent of relationship among the selected variables and their respective dimensions with respect to the current sample

METHOD

Sample

- Sample Size: one hundred and eighty individuals divided into three broad groups, each group consisting of thirty males and thirty females:
  - Group A, institutionalized elderly individuals without their partners alive (M=72.85 years, SD=8.67)
  - Group B, home bound or non-institutionalized elderly individuals residing at home with their partners (M=68.35 years, SD=6.19)
  - Group C, home bound or non-institutionalized elderly individuals without their partners alive (M=71 years, SD=7.59)
- Sampling Technique: purposive sampling method

Married, retired Indian nationals, belonging to Hindu religion, from middle and upper middle class, aged between sixty to ninety years residing in Kolkata (India) were selected for the study. Unmarried, remarried, divorced, or separated individuals, or ones who were involved in any job/business after retirement and those who had the presence of any psychiatric, organic or neurological disorder were not chosen.

Tools Used

Information Schedule constructed by the researcher aimed at eliciting basic information, Loyola Generativity Scale (McAdams and de St. Aubin, 1992), Geriatric Depression Scale (Yesavage, Brink, Heersema, Adey and Rose, 1982), Intimate Bond Measure (Wilhelm and Parker, 1988), and Adjustment Inventory for the Aged (Ramamurti, 1968) were used. All the inventories scored high on reliability and validity coefficients.

Procedure of data collection

The participants were selected according to the pre-determined criteria. They were made to understand the nature of the tests, and were assured of the confidentiality of the data and the results. Each individual was administered the tests in isolation, so she could give honest responses. Rapport was established. An interview was carried out before administration of the tools in order to gain an insight into the day-to-day living, hobbies and interests of the individual, and to yield qualitative information about his/her life, in general. The information blank was filled first and then the administration procedure for each questionnaire was followed. All the questionnaires were administered in a single session which lasted for about ninety minutes to two hours. There was no scheduled time gap between administration of the different questionnaires; however, adequate rest was given to the participant when required.

Statistics Used

Descriptive statistics (Mean, Standard Deviation), inferential statistics (ANOVA, t-test) and parametric statistics (Product Moment Correlation) were carried out to analyze the scored and tabulated data.

RESULTS

Table 1: F values obtained by two-way analysis of variance (ANOVA) for the selected variables and their respective dimensions:

Variables	Source of Variance	F-Value
(1) Generativity	Between Group	0.142
	Between Gender	0.009
	Interaction	0.911
(2) Depression	Between Group	8.032**
	Between Gender	0.799
	Interaction	3.005*
(3) Partner Bonding	Between Group	0.126
	Between Gender	0.022
(3a) Care	Interaction	0.041
	Between Group	0.366
(3b) Control	Between Gender	0.568
	Interaction	0.393
(4) Adjustment	Between Group	2.217
	Between Gender	0.024
	Interaction	5.637**
	Between Group	2.881
(4a) Health	Between Gender	1.353
	Interaction	2.59
	Between Group	2.096
(4b) Emotional	Between Gender	0.098
	Interaction	4.388**
	Between Group	3.218**
(4c) Self	Between Gender	0.222
	Interaction	6.537**
	Between Group	1.832
(4d) Home	Between Gender	0.227
	Interaction	2.478
	Between Group	0.451
(4e) Social	Between Gender	0.918
	Interaction	5.89**

* Significant at 0.05 level** Significant at 0.01 level

From Table 1 it is clear that there are significant differences among the three groups with respect to the variables used in the study. Significant inter-group ($p < 0.01$) and intra-group differences ($p < 0.05$) are observed for the variable of Depression. Adjustment is seen to vary significantly ($p < 0.01$) within groups. The dimension of Self Adjustment shows significant inter-group ($p < 0.05$) and intra-group differences ($p < 0.01$), where as, the dimensions of Emotional Adjustment and Social Adjustment both show significant intra-group differences ($p < 0.01$). Inter group differences were assessed by using t-test.

Table 2: t values showing the significance of difference between the means of Institutionalized elderly without spouse (Group A), Non-Institutionalized elderly with spouse (Group B) and Non-Institutionalized elderly without spouse (Group C) for selected variables and their dimensions

Variables	Group A		Group B		Group C		t - VALUE between groups A, B, and C
	M	SD	M	SD	M	SD	
(2) Depression	12.48	7.475	7.03	6.65	10.35	8.52	A - B = 4.22** A - C = 1.458 B - C = 2.377**
(4c) Self Adjustment	6.7	4.84	4.65	3.94	5.72	4.82	A - B = 2.544** A - C = 1.115 B - C = 1.327

* Significant at 0.05 level** Significant at 0.01 level
(Adjustment being reverse scored)

From Table 2, it is evident that Group A shows significantly higher levels of depression (t=4.22, $p < 0.01$) and poorer self adjustment (t=2.54, $p < 0.01$) in comparison to Group B. Additionally, Group C has significantly higher loadings of depression (t=2.37, $p < 0.01$) when compared to Group B.

Table 3: t values showing the significance of difference between the means of males and females of each of three groups of Institutionalized elderly without spouse (Group A), Non-Institutionalized elderly with spouse (Group B) and Non-Institutionalized elderly without spouse (Group C) for selected variables and their dimensions

VARIABLES	GROUP A MALES		GROUP A FEMALES		GROUP B MALES		GROUP B FEMALES		GROUP C MALES		GROUP C FEMALES		t-VALUES for males (M) and females (F) of Groups A, B and C
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
(2) Depression	13.9	7.75	11.07	7.04	5.83	6.97	8.23	6.19	8.63	7.77	12.07	9.01	GROUP A : M-F : 1.483 GROUP B : M-F : 1.41 GROUP C : M-F : 1.581
(4b) Emotional Adjustment	8.4	5.54	5.67	4.1	4.67	4.39	6.1	4.16	5.8	5.16	7.77	5	GROUP A : M-F : 2.17* GROUP B : M-F : 1.298 GROUP C : M-F : 1.499
(4c) Self Adjustment	8.37	5.15	5.03	3.92	4.7	4.57	4.6	3.26	4.47	4.12	6.97	5.21	GROUP A : M-F : 2.82** GROUP B : M-F : 0.097 GROUP C : M-F : 2.062*
(4e) Social Adjustment	7.27	4.25	4.2	3.15	5.97	4.1	5.57	3.71	5.43	3.28	7.23	4.63	GROUP A : M-F : 3.173** GROUP B : M-F : 0.396 GROUP C : M-F : 1.738

* Significant at 0.05 level** Significant at 0.01 level (Adjustment being reverse scored)

Table 3 indicates significantly higher scores indicating poorer adjustment in emotional ($t=2.17$, $p < 0.05$), self ($t=2.82$, $p < 0.01$) and social dimensions of adjustment ($t=3.17$, $p <0.01$) in case of Group A males when compared to the females from the same group. Scores on self adjustment were higher ($t=2.06$, $p < 0.05$) in women from Group C in comparison to men from the same group implying their overall poorer adjustment.

Table 4: Pearson Product Moment Correlation Coefficients showing the inter-relationship among selected variables and their respective dimensions for all the three groups of Institutionalized elderly without spouse (Group A), Non-Institutionalized elderly with spouse (Group B) and Non-Institutionalized elderly without spouse (Group C)

	Dep	Gen	Care	Cont	Hea	Emo	Self	Home	Soc	T
Dep		A- 0.479** B- 0.428** C- 0.623**	A- 0.339** B- 0.311* C- 0.51**	A+ 0.259* B+ 0.127 C+ 0.343**	A+ 0.742** B+ 0.62** C+ 0.694**	A+ 0.872** B+ 0.82** C+ 0.79**	A+ 0.79** B+ 0.813** C+ 0.815**	A+ 0.573** B+ 0.775** C+ 0.68**	A+ 0.657** B+ 0.687** C+ 0.725**	A+ 0.866** B+ 0.867** C+ 0.863**
Gen			A+ 0.373** B+ 0.201 C+ 0.435**	A- 0.092 B- 0.093 C- 0.248	A- 0.461** B- 0.267* C- 0.411**	A- 0.55** B- 0.467** C- 0.66**	A- 0.612** B- 0.505** C- 0.757**	A- 0.489** B- 0.397** C- 0.563**	A- 0.578** B- 0.383** C- 0.72**	A- 0.636** B- 0.47** C- 0.725**
Care				A- 0.15 B- 0.251 C- 0.419**	A- 0.355** B- 0.193 C- 0.398**	A- 0.337** B- 0.221 C- 0.379**	A- 0.393** B- 0.337** C- 0.481**	A- 0.31* B- 0.491** C- 0.612**	A- 0.249 B- 0.267* C- 0.473**	A- 0.391** B- 0.354** C- 0.549**
Cont					A+ 0.138 B- 0.017 C+ 0.166	A+ 0.138 B+ 0.278* C+ 0.231	A+ 0.063 B+ 0.186 C+ 0.279*	A+ 0.381** B+ 0.206 C+ 0.385**	A+ 0.102 B+ 0.043 C+ 0.493**	A+ 0.19 B+ 0.165 C+ 0.359**
Hea						A+ 0.756** B+ 0.641** C+ 0.706**	A+ 0.717** B+ 0.524** C+ 0.658**	A+ 0.471** B+ 0.601** C+ 0.576**	A+ 0.524** B+ 0.559** C+ 0.586**	A+ 0.826** B+ 0.779** C+ 0.814**
Emo							A+ 0.814** B+ 0.777** C+ 0.787**	A+ 0.538** B+ 0.772** C+ 0.616**	A+ 0.71** B+ 0.722** C+ 0.74**	A+ 0.912** B+ 0.914** C+ 0.898**
Self								A+ 0.551** B+ 0.717** C+ 0.644**	A+ 0.761** B+ 0.747** C+ 0.719**	A+ 0.914** B+ 0.874** C+ 0.888**
Home									A+ 0.57** B+ 0.628** C+ 0.692**	A+ 0.732** B+ 0.874** C+ 0.83**
Soc										A+ 0.836** B+ 0.846** C+ 0.863**
T										

* Significant at 0.05 level** Significant at 0.01 level

For Table 4, the following index can be used:

Dep = Depression, **Gen** = Generativity, **Care** = Care dimension of Partner Bonding, **Cont** = Control dimension of Partner Bonding, **Hea** = Health Adjustment, **Emo** = Emotional Adjustment, **Self** = Self Adjustment, **Home** = Home Adjustment, **Soc** = Social Adjustment, **T** = Total Adjustment

(higher scores on adjustment indicate poorer adjustment)

From Table 4 it is seen that for institutionalized elderly individuals without their spouses alive, **significant positive correlations** were found to exist between:

- Ø Depression and Control dimension of Partner Bonding
- Ø Depression and Adjustment, and each of its dimensions
- Ø Generativity and Care dimension of Partner Bonding
- Ø Control dimension of Partner Bonding and Home Adjustment
- Ø Adjustment and each of its dimensions

Where as, **significant negative correlations** were seen between:

- Ø Depression and Generativity
- Ø Depression and Care dimension of Partner Bonding
- Ø Generativity and Adjustment, with each of its dimensions
- Ø Care dimension of Partner Bonding and each of Health, Emotional, Self, Home and Total Adjustment

In case of non-institutionalized individuals with their spouses alive, **significant positive correlations** were found to exist between:

- Ø Depression and Adjustment, and each of its dimensions
- Ø Control dimension of Partner Bonding and Emotional Adjustment
- Ø Adjustment and each of its dimension

On the other hand, **significant negative correlations** were seen between:

- Ø Depression and Generativity
- Ø Depression and Care dimension of Partner Bonding
- Ø Generativity and Adjustment, with its dimensions
- Ø Care dimension of Partner Bonding and each of Self, Home, Social and Total Adjustment

For non-institutionalized individuals without spouses living, **significant positive correlations** were found between:

- Ø Depression and Control dimension of Partner Bonding
- Ø Depression and Adjustment, and each of its dimensions
- Ø Generativity and Care dimension of Partner Bonding
- Ø Control dimension of Partner Bonding and each of Self, Home, Social and Total Adjustment
- Ø Adjustment and each of its dimensions

Significant negative correlations were seen between:

- Ø Depression and Generativity
- Ø Depression and Care dimension of Partner Bonding
- Ø Generativity and Adjustment, with each of its dimensions
- Ø Care dimension and Control dimension of Partner Bonding
- Ø Care dimension of Partner Bonding and Adjustment, with each of its dimensions

DISCUSSION

Inter-group profile differences

The profile of institutionalized individuals (Group A) when compared to that of non-institutionalized individuals, showed greater loadings of depression and maladjustment in them. Again, when non-institutionalized individuals without spouse (Group C) were compared to those with spouse (Group B), it is evident that the former had higher levels of depression and maladjustment (Table 2). There is no sizeable difference among groups with respect to generativity and partner bonding. This trend of result can be

attributed to a number of reasons. During this phase of life, when elderly individuals face many difficulties, family and spouse play a very important role in buffering the effects of these significant changes. As discussed earlier, a major stressful event in this stage of life is a change in one's social network due to the loss of spouse, friends or relatives (Stephens and Hobfall, 1990) and it calls for augmented coping (Feezel and Shepherd, 1987). A study (Malhotra and Chadha, 2007) shows that married individuals draw a sense of social and emotional support from their partners. It is against this background that a bereaved individual feels lonelier and craves for a companion with whom he/she can share the same bonding. Thus, death of a spouse may lead to loneliness and depression (Garrett, 1987), further resulting in impairment in the different dimensions of adjustment, as can be seen in Groups A and C. Group A has even higher loadings of depression and maladjustment owing to addition burden of institutionalization. Many individuals seek institutional care due to feelings of dejection by children (Malhotra and Chadha, 2007). In spite of the help through institutional support, individuals undergo severe emotional and psychological problems. They show lesser life satisfaction (Arora and Chadha, 1995) and lesser adjustment (Anantharaman, 1980) than home-bound individuals. Shifting to institution tends to signify loss of love, care and affection. These factors together appear to contribute to the overall maladjustment of the individuals and can lead to depressive loadings.

Gender-wise profile differences

No significant gender difference on the whole was obtained in the present study. However, definite gender differences are revealed when compared within groups. Greater degree of maladjustment was seen in institutionalized males in comparison to institutionalized females (Table 3). The difference in gender in terms of these adaptive functions can be attributed to the culture and society at large. In India, males are encouraged to become

independent and take the financial responsibility of the family. On the other hand, females are expected to be docile and compliant and are coaxed into being adaptive in different life situations (Rajgopal and Prakash, 1990). Thus, when male individuals are institutionalized, they are “retired” physically and psychologically which involves loss of income, occupational identity, social status, etc and may lead to greater dissatisfaction in life (Nathawat and Rathore, 1996). In Group B, no significant gender difference was revealed. However, in Group C, there is a significantly higher level of maladjustment with respect to self for the females. There is also a trend of greater level of depression in the females (Table 3). This could be owing to the fact that women tend to suffer from 'empty nest syndrome'. When they, who already feel insecure about their relationships, lose their spouse, they feel devastated and become distraught (Sharma and Dak, 1987). They may feel isolated and unloved, and may find it difficult to cope with this sudden loneliness.

Hence, to draw the curtain close, it may be stated that everything in this dynamic world has some advantages and limitations. Old age is no exception. There can be multiple reasons to feel disheartened like retirement, loss of loved ones, physical decline, loss of power and autonomy, and interpersonal conflicts. Successful aging can never be based on the denial of real losses as regards the quality of functioning in the last stage of life. Rather, the idea of successful aging involves graceful acceptance of reality as it is, adopting a generativity-glimmered orientation towards life in general. Successful aging means growing old with good health and functional capacity, self-acceptance, autonomy, and forgiveness, engaging in learning and activities promoting personal growth, prosocial behavior, healthy interactions with the family, deriving a sense of purpose or meaning in life and being satisfied with life. As such, the discourse may end with the notion that elderly individuals need to be accepted, respected, and provided with their requisite

self-respect. As a society it is important to alter our thinking and to recognize the beauty and usefulness of age. Old age is synonymous with wisdom, values and a host of positive things that are desirable in a community. Older adults are more likely than other generations to articulate values that have a social tilt and are geared towards maintaining a balanced social order. Thus, the elderly can be the role models in terms of values and practiced behavior patterns. This is likely to facilitate the elderly individuals to glance at life through the lenses of "experientially-rimmed wisdom" and accept factual realities gracefully, thereby helping them to bask in the "rays" of successful aging.

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PERCEPTION OF SOCIAL CHANGE AMONG ELDERLY

Changing Role-Relations of Younger Generations, Intergenerational Bond and Family Dynamics in Rural Bihar

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ABSTRACT

A qualitative analysis of older person's perception of social change in some north Indian villages reveals that there is little change in terms like family, kinships, care, respect etc. Perception of social change is based on the level of care and respect they get. The notion of care is changing. Earlier it was bodily care with love and affection, today it is material. It varies as per social status of older persons. The better off have a negative perception but among the lower status it is positive. The impact of education, employment and migration of younger generation is not always negative rather contributed positively to their status and respect. A marked difference has been observed in marriage and conjugal lives of the youth.

Key words: Elderly, Perception of Social Change, Intergenerational Bonds, Notion of Care, Conjugal Lives

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INTRODUCTION

Social change and condition of the elderly may be seen in terms of the sophisticated living conditions of the youth of today. There are two important aspects which need to be highlighted in this context. First, youth are the most affected age group by any change in the society and they sustain it, and like a circle carry it forward to their own later phases of life –old age.

They are the carriers of these changes and they are very much adaptive and attracted towards it. This is the youth group, which deliberately or automatically brings changes, or this is the group through which any change takes place. Thus, the youth are the focal point of the sources of change, i.e., media, market, fashion, technology, etc.

The second aspect is that youth are the reference groups for the elderly to see the changes. When we study change or perception of change among the elderly, the youth are the reference group. Elderly locate the changes in terms of their own youth age and youth of today, and compare it. What was the social parameter at that time to evaluate the youth, what are their youth experiences and how the youth of today are different from them? This comparison of after – before is the one of the tools to judge the perception of social change.

The study on change among the youth is important because this group provides care, service, money and respect to the elderly. The elderly have to depend upon the youth for their care and security. All the elderly-power is exercised upon the youth. This youth-elderly relation may be seen otherwise also. The youth of today are also dependent upon the elderly for several things. The elderly provide the security to children and wives of younger people in case of migration. The relation between elderly and youth is quite interdependent.

One can understand the relative change as experienced by the elderly from their perceptions. The perception of change may be different from the actual transformations and happenings in the society but it reflects their life experience. They have travelled through several phases of change since their childhood to their old age. The personal biographical changes and the social changes can get intermingled in peoples' perception. But at a collective level the perceptions will reflect the collective experience.

There are contradictory findings about social change and care of the older persons in Indian society. Some authors found that in the past the elderly had a very strong position in the family and society but in modern times, their condition got deteriorated (Chaudhari 1992; Guha 1992; Kohli 1996; Sati 1996). Supporting this view Sengupta 1973; Satnam Kaur and Malik Kaur 1987; Joseph 1988, 1990; Ambedkar 1990 etc consider that elderly face a lot of problems today than 100 years ago.

Another group of authors maintain that India is still traditionally very strong. Forces of social change have not penetrated Indian society yet as it happened in the west. The joint family system and other institutions such as kinships, neighbourhoods, community bondage are still very robust to take care of older persons, children, women, disables, ill, unemployed etc. The elderly still get respect and hold high status in the family and society (Desai 1981; Dandekar 1991; Hussain 1992; Nayar 1992; Ansari 1997, 2000, 2002; Shah 1998, 1999; Bharat 2003; Singh 2003). As Susan S. Wadley (1994) had found, there is a change in the fashion, lifestyle, houses, food, medicines, and machines, but the original social values and norms are still intact in rural India. However, in the post globalised era there is a chance of disintegration of the traditional system. It requires to be protecting and promoting in the interest of everybody including older persons.

How far the values, norms and customs are significant for the well-

being of elderly in the present scenario? Moreover, whatever changes in the lifestyles of youth are taking place; it is more of an urban phenomenon than a rural one. The changes in the family structure and in terms of care of the elderly are also more of an urban phenomena and among the middle class, but majority of the older and even younger people reside in rural India (Shah 1999; Khan 2000).

Emphasising on the intergenerational bonds and importance of joint family in India, a group of authors (Ree 1970; Desai 1985; Deb 1988; Chadha et al. 1990; Dandekar 1993) hold that mothers become grandmothers and always remain in the company of their children and grandchildren in a practical set-up. By virtue of their age, grandmothers command respect and have come to acquire much power.

This paper will analyse the role and relation of the elderly and younger generation (both male and female) in the present scenario through the eyes of the older persons, through their reminiscences and observations. Certain questions have been tried to be answered through our findings. Such as what are the various changes that have taken place in the society? What is the position of younger persons for the elderly in terms of care and respect? What is the impact of sons' employment on the status of the father in the society? What is the role of daughters and daughters-in-law in terms of care and respect of older persons? How far the roles and relationship of daughters-in-laws and mothers-in-laws have been changed? What is the perception of newly married women regarding their mothers-in-laws? What is the overall perception of older persons about the younger generation?

This paper will also focus on changing conjugal lives of younger people and marriage-related customs, i.e., selection of partner, visiting the in-laws' house (Sasural), wife-husband activities; as well as on impact of migration, higher education and employment of sons on the familial and social status of father and mother; and how

the intergenerational bond can become stronger due to economic and social development.

BACKGROUND

This paper is based on the studies conducted by the author in Gopalganj district of north Bihar during his M Phil and Ph D works in 1995-97 and 1997- 2002 respectively on all 1204 households of all six villages of Kalyanpur panchayat (Ansari 1997, 2002).The total population coverage was 8,911, 694 elderly living in 494 households (7.79 per cent of its population)). Gopalganj district is a rural, backward, agriculture-based area where an upward social and economic mobility has been seen where 16 types of households were found clubbed into 4 types - joint families, extended families, nuclear families and 'only' (single) elderly member. Data were gathered quantitatively and qualitatively. This portion of the paper is based on qualitative data collected through detailed case studies on 69 households and various levels of informal group discussions, interviews and observations.

PERCEPTION OF CHANGE AMONG ELDERLY

There is a general consensus among the elderly of all sections of the society that though they have got better material position now, whatever the service, respect, and obedience they rendered to their parents and grandparents, their children and grandchildren are not rendering the same. Many of the older persons have set the past standard of service by their sons. This is not only bodily care but care with respect and dignity mixed with love and affection. So the notion of care has been changed. Some elderly of well off society had reported that during their time every son had to obey his father, no one could dare to confront his father and were always lying in wait to follow his orders instantly, but today no son likes to do such service today. They further compare themselves to the past norms and say that though all their sons are attentive to them, they have

hardly got time to do 'hands-on' physical care. Daughters-in-law, though, provide food and water at the *thaur* (sitting place), they also do not render the bodily massage as per need, which was done earlier.

The modern era has made people economically more active even in rural areas. Some elderly of the well off society had reported, “These days nobody has free time, everybody is busy with their tasks, how they will tend to their elderly?, "Children go to school, daughters-in-law are busy with cooking and caring for kids, the young people have either migrated or are busy in the agricultural work, so who will attend to us?”. They differentiate between the past and present roles of sons in terms of care and respect towards their father. They consider that earlier people were free from work up till *jawani* and they used to play *guli-danda*, *chika-thari* even in their youth. They had no worry about their livelihood, no strong requirements of work, more people stayed at home, a few had migrated or not migrated, because in those days there were not much requirements at home, so they had enough time and physical proximity to do *sewa* of their elderly.

Beyond these common perceptions, different elderly have various views about the present behaviour of their sons and grandsons. Some reported that new generations of today have become more independent, less caring, less obedient, more fashionable, tending more towards their wives and children and less towards their parents. However, another group of elderly has contradictory views.

Some other elderly people reported that the new generations of today are more responsible, more conscious about their career and livelihood, more careful about their parents, and tend more towards education and migration. This group of elderly is from the poor and middle strata economically, whereas the former was from the better-off and well-off.

Some poor and middle strata elderly of backward castes have a different view from the above two assessments. They consider that though there are some changes in the behaviours of *beta* and *pota* (son and grandson); they have not forgotten their *samskara*. They are proud of their sons and criticise others that they have failed to socialise their children in a proper manner. Nevertheless, a few of these elderly also asserted that whatever, and in whichever manner they served their father and grandfather, they are getting back the same treatment from their sons.

One middle class older person extends this view by saying, “children of today are conscious about their *farz* (duties) towards their parents, if a father is doing physical labour in his *budhapa* (old age), no son can bear this and they stop their father from physical labour for a livelihood even if sons themselves are very poor economically”. Today they provide independence and choice to the father – either to work or rest, which was not possible earlier. Actually, this older person indicates towards the economic betterment and the elderly of today are in a better position than earlier. Therefore, they can survive without work as their sons are earning. He again maintains that sons of today instruct their wives and children to give attention towards their father and mother.

Older people of all sections accept that generally sons of today have become more active, they are more intelligent, more conscious than during their own childhood. One old woman expressed in her own language, “*Aaj-kal ke laeeka janamate chaalak ho jat bare san* …. (The children of today are born clever)”. She further added, "*Pahile ke log jawani tak bewakuf rahat rahe*… (In earlier days, they remained fools till their youth)".

The poorest older persons have a positive view towards their sons. They consider that the sons of today do better service to their parents than earlier. One barber blind elderly belongs to the poorest category said that though his sons are not staying with him, they have separated from each other and from the elderly but they

ensure to care for him and his wife. He experienced that in earlier days the elderly were neglected and left alone in a corner of the house or at *bathan* and not rendered proper attention. Another older man from the poorest category belonging to the SCs, a Chamar caste, supports the above view. He reports that his son left his job of mason from Lucknow and staying home only to take care of him and his ailing wife.

However, the emerging change is in the leadership role within the family. Earlier, the father remained the head and leader. Now he is becoming more of a dependant and has less authority as a real head. Rapid changes in the larger society, particularly in education and migration, make the elderly more diffident while dealing with them; whereas the sons feel that they can deal with them better. However, interdependence between the generations also increases with migration. Hence, a somewhat changed form of the father-son relationship and the joint family continues.

Changing Family Dynamics: Father-Son Relationships

The family in general, is a patriarchal institution where the male member is the head. The family runs in the name of the father, grandfather, sons and the grandsons. It is the practice of the society by which the daughters have to leave their parental family and join the husband's family. In her husband's family, she is the subordinate and that family runs in the name of her husband, not in her name. Likewise, her parental family is named after her brothers, and not hers, so she loses her identity as a *maleek* (owner) in both the places: father's house as well as husband's house.

The second aspect of this system is that the father has to depend upon the sons and not on the daughters. However, the daughters do come to serve their parents in case of *Alath* - not all the daughters, and not at all times, because as a daughter-in-law she has to first follow the restrictions and responsibilities of her husband and his family. So even after having a strong willingness, she cannot render her service to her father and mother on a regular basis. Thus, the importance of sons in terms of care and responsibility is formally institutionalised though very often it is the daughters who actually come and serve the old parents.

Usually, couples lament for a son even if they have many daughters because, by tradition, only sons are considered to be the *lathi* of *budhapa* (supporting stick of old age) and with them the family name continues. Those who have only daughters, feel insecure for themselves and for their future generation.

This system of family still continues. No change has taken place in the case of parent-daughter relationship and parent-son relationship. Sons are still considered to be the supporting pillars and daughters are considered to be the *paraya dhan* (other's property); whatever love and affection one has for one's daughter but one day she has to leave the father's house and this is the *riti* (system, custom) of the society.

It is the societal obligation that every son should respect his father and mother, care for them, and provide adequate food, clothes, shelter even by depriving himself, his children and wife. It is culturally accepted that if any son neglects his parents, he will be criticised and condemned in the society. It is also culturally institutionalised that the service to father, mother or any elderly, is the service to God. Because of these social pressures, sons try their best to serve their elderly but sometimes, due to certain constraints they fail to do so completely, or not up to the level of social expectations. Some sons are perfect in service and care, as it is demanded; they are 'good sons', they are the modern *Sarvan Kumars*.

However, it is the general perception that for the care and security some land and money are necessary in the name of the elderly, so

that others can come to his service. The status of the father in the family is decided by the resources he has and the social values that have been inculcated in his sons. He could be the 'real' head of the family or he could be just a nominal head. Nominal head is one who has no 'say' in decision-making, though he may or may not be the owner of land. The real head is one who has a role in family decision-making and everybody follows his desires no matter whether he is the owner of land or not. It is the social values, customs, *samskar* which make the sons and other members of the family abide by the elderly's decision and respect him/her as being a father, mother, grandfather, and grandmother.

The elderly, who is not the head, has no money in hand, or having no lands, feels insecure even if he has sons. If sons are not *samskarik* (well socialised) they may not respect and take care of their elderly. The other causes of not taking care are the sons' poverty, overburden of their own children and wives, or having no income at all. However, no case was found of such kind where the father or mother has no land or money and left unattended by their sons even among the poorest. However, care with respect is necessary for the elderly and if they have expended the money and have no land at all, they may have to face problems. The father, even after the division of sons, keeps some land in his hand and the son with whom he lives cultivates and avails the product in return.

There are certain cultural and social values, which force the sons to look after their parents even in case the father and mother have nothing in hand. It depends upon the *sanskara*, which the parents inculcated in the sons during socialisation since childhood, whether they do so with respect or only give them enough for subsistence but suffer it as a burden. Hence, even if there would be nothing left in the father's hand, then also the sons take care of them.

Impact of Migration of Sons on Older Persons

It has been seen that even after migration of the younger generations, there is no lack of care for the elderly. Yet the perception about the impact of migration of children differs. A class factor operates behind the perception about migration of the younger generation. The elderly belonging to low socioeconomic status (SES) have a positive impact of migration. It has improved their economic condition. The elderly are in a better position, socially and materially, than in those households whose members have not migrated. The elderly who belong to high SES also receive its benefits because with a declining agricultural economy at rural level they need additional cash income.

The older people of low SES can bear the psychological problems (emotions) of the migration of their sons but cannot bear the deprivation of food and money. Therefore, for them it is good, but the rich worry about their *mukhagni* (pyre) by the sons. If the sons will not migrate, then also they will have a reasonable economy at home and so they have more psychological problems due to migration of sons compared to the poor.

The total (all sons with wife and children) and permanent migration (in case they have settled there) is more problematic for the elderly. One elderly of low SES reports, "The migration of son is not a problem but if *bahu* and *bacha* will go, then I shall feel loneliness and nobody will be left here to look after me". By migration of whole nuclear unit of the family, the son will not be in a position to send money to his parents because savings will be very low. If the elderly is a widow or widower then his/her problems will be multiplied, as they would be left alone.

Senior citizen of well off category have more problems in case of total migration.

If the kids and daughters-in-law would be at home then he would

not face loneliness. Though sons want to keep the parents with them but the elderly do not feel comfortable at the urban centres.

The elderly of lower SES face double loss in case their migrated sons are neither earning nor sending money. The parents feel deprived of the sons' hands for care as well as their daily wages, which they could have earned at home. Migration is good as perceived by the older people of middle SES if the sons earn and send money. However, in all cases money is not every thing, but emotion and respect are very important rather the son should visit home after certain intervals of six months, seven months so that father could see the son to satisfy his affection.

If the single son has migrated, and the daughter-in-law is at home but has no kids, then widowers face problems in communication with the daughter-in-law due to the very custom of *pardah*. Grandchildren are generally the medium of communication between *bahu* and *sasur.* The elderly console themselves by saying that *beta* is of *pardeshi* and *beti* is of the *paraya ghar*. This is the system of society and the parents should bear with it.

Impact of migration depends upon the son's character, nature and his work. If the son is hardworking, sincere to the parent, obedient and successful, then the parents feel for him after his migration. Contrary to this, if the son is not good in behaviour and character, the parents feel relaxed by sending him to *pardesh*. Migration produces love and affection between father and son. The father is fed-up with the son who lives at home with him, due to everyday differences, but when he goes out, he feels affectionate towards him. Geographical distance reduces the distance of hearts.

Migration of sons is the symbol of status for fathers. He is known in the society by how many sons have migrated to how many places. One elderly of middle SES expressed with pride that his three sons had migrated to three different places and he received a good sum of money from all the sons. They used to visit home frequently to

see him, once each - on rotation basis.

The socialisation into the idea of a "joint family as ideal" is helpful for the poorer elderly as well as it ingrains the responsibility of sons towards their parents and siblings. This makes them send remittances home even when they themselves live in poor conditions or in economic hardship in their place of immigration.

Effect of Son's Social Status on the Elderly

Earlier, with little opportunities for mobility, there was hardly any difference in social status of father and son. Now the processes of social change are leading to change in status from one generation to the next. It has been observed that the elderly parents of educated sons and grandsons are well respected in society. The elderly feel proud of high education and well-paid jobs of their sons and grandsons. One elderly retired of Orient Fans, well-off, is well respected in the society not because of his family status but due to the education of his eldest son and grandson. His son is a political activist at local level and has a good influence over the local society and administration.

For the poor elderly, the education of their children is a tool for their own prestige in the society. Despite being poverty-stricken, they somehow try to bear the cost of their sons' education. On finding a government job by the sons, the parents' status gets elevated. Once their sons get government administrative job they come into the upper strata of the society, and get the same treatment as the other upper castes rich elderly get.

However, there is a negative aspect of their sons' higher education and good jobs. After becoming officers, they migrate to the urban centres with their wives and children. Though they make frequent visits to the village to see their parents, as long as they stay at home, the parents feel happy but after their departure they feel lonely and neglected. The situation worsens when there is a total and

permanent migration. Moreover migration is good for economy but not for emotional well-being. Similarly, higher education is good for the economy and social status of the father, but not for the emotional attachment with their sons.

Contrary to the above cases, the negative social images of the sons affect the status of the elderly. If the son indulges in bad habits like drinking, quarrelling, theft and dacoity, then the father has to face embarrassment in the society. His honour and prestige is diminished and they have to face a social boycott and are not called to the village panchayat, other social gatherings, and religious activities.

Family Dynamics: Daughter-Parents Relationship

Daughter and care is synonymous; everywhere care stands for the womankind either in the form of daughter, daughter-in-law, wife, mother, grandmother and mother-in-law.

From childhood, the daughter is trained in such a way so that she can provide care to everybody. In villages, until her marriage, she provides water and food to her father at his *thaur*. She helps in bathing, washing, and massaging her father and grandfather. Generally, daughters-in-law maintain *pardah* from the *sasur* so she hesitates to serve food and water outside the house. She cannot touch the *sasur's* body. Hence, these tasks are well performed by the daughters. Boys are not expected to do these tasks due to their male roles in the family. They go for study and work, but daughters, generally, after primary school does not continue their studies and they are available in the house all the time as their moving outside the house is also restricted. They are expected to do all services to their father and mother. Even after her marriage, she comes to serve the father and mother in case of illness or *Alath*, but by tradition, she cannot be a permanent care provider for her parents.

Role of Married Daughters in Care of Disabled Elderly

In case of illness and disability, the married daughters and sons-in-law come to serve the elderly. One elderly of low SES reported, “I have no son but only one daughter. After marriage she looks after her children and her in-laws, hence she has no time to come here and stay with me. Therefore, my son-in-law stays here to take care of me and he works and earns wages. He also cooks for me.”

There are several other cases of this kind where there are no sons but only daughters. There are also the elderly who have sons but are poor or separated or migrated, and then the married daughters take care of everything. They support their parents in case of bad economic conditions where the older people have to take help of their daughters because sons' conditions are so bad that they are unable to take care of their own wives and children. But this happens only among lower SES groups.

Not only the married daughters take care of their parents, but married sisters also take care of their ill, poor, elderly brothers. One case of the elderly of low SES who has always been ill and has no sons, is very poor and has no land or source of other income, in such condition his married sister came and took him to her house. After a three-month stay there, he came back. Again he felt a sense of emptiness leading to a state of illness and now he has gone to his eldest married daughter's house for treatment. So *beti* and *bahin* are very helpful during the illness to the elderly.

Changing Marriage Pattern and Conjugal Relationship among Younger Generations

The conjugal relationship of the young couples affects the family

dynamics and structure, as well as the elderly's relations with new generations. After marriage of sons, certain changes take place in the house. Their inter-relationships are redefined with father-mother, brother-sister, and *chacha-chachi*. If the son's behaviour does not adversely affect these relations, then he is a good, obedient son; otherwise, he is labelled as *bibi ka gulam* (servant of the wife). Actually, the parents test their sons' roles, behaviour, and their caring tendency after their marriage. If the daughter-in-law does not force the husband to care, she and her children rather instigate to take care for all in the family then she is considered to be a *khandani* and *sanskarik bahu.* Everybody including the elderly bless her. In course of time, elderly perceived certain changes in the conjugal-relationship of the young people. It has acquired greater importance while the responsibility towards other family members also continues.

The respect to the elderly is traditionally shown not only by the service given to them but also by maintaining *pardah* or *laz-lehaz*. The couple should not be so open in front of their elderly. It is seen negatively by the senior elders in the house. Earlier, the newly married men were hesitant to interact with their wives in the daytime. They felt shy even in talking to them in front of the elders. It was revealed by a group of women in the villages that earlier newly married men used to go to their wives secretly at night only and left the house in the morning before anybody woke up. They even abstained from playing with their own children in front of their parents. If they wanted to do so, they took their wives at their immigrated place, so that they could have some independence.

Now this *laz-lehaz* is diminishing. Sons are becoming more open in terms of their marital lives. One old woman of Mathurapur village exclaimed, "*Ab ta dolia par se utarate hi mehararu ke sath ghar mein ghus jat bade san… ab woh laz-lehaz naeekhe*". (Now the young people go to their wives as soon as she arrives - just after getting down from the palanquin…now there is no social constraint

or respect of the kind which was there earlier). She further expressed, "*Ab ta apna mehraru ke rani bana ke rakhat bade san*". (Now they keep their wives like queens). Indication is that earlier, due to the fear or shyness or respect to the parents, the sons did not pay much attention towards their wives. They were hesitant in giving any gifts, clothes, ornaments, cosmetics, etc to their wives. If anyone used to do that, it was without the knowledge of mother and father. But now they give all items openly and are now more attentive towards their wives than earlier. Now, the sons play with their children, take them in their laps, and walk outside with children. In this context the old woman said, "*Aaj-kal ta sauriye main ghus jat bade san*… (Today, they enter the labour room even before the birth of the child)".

The couple can together visit the local markets and towns (though not so openly) which was not at all allowed earlier. Due to certain values, sons did not go outside along with their wives in any public place. If it was necessary to go to the doctor, then any female member of the house would accompany the wife and the son used to go separately. This was due to the standard norms of the society and fear (*lok-laz*) of society. If the couple had a strong desire to go out in the town, market, or see a movie, they used to pretend to go to the doctor; otherwise the elderly would not allow them. Actually, it is related to the *izzat* (prestige) of the elderly. If others who were known to the elderly would see their daughter-in-law and son roaming in the town or market, they would criticise it, as it was considered an act against the norms of the society. This was also considered important to preserve the joint family and collective social values.

Whatever small changes are taking place in the society today, the elderly have accepted them considering these as the result of *naya-zamana* (new era). Now, if the couple go anywhere - to a movie, to town, to market, even if they ride on a motorcycle, nobody looks down upon it and no one criticises it.

Another dimension of conjugal relations and marriage is the visit to the *sasural* (in-law's house) by sons. By custom, young men were not supposed to visit their *sasural* just after marriage but they had to wait for five or seven years otherwise it was against the *izzat* of the father. If the son's wife was staying at her parent's home for some months, then also the son used to visit there on the pretext of visiting someone else so that the father would not come to know. According to the existing custom, one could go to *sasural* only after a certain period of their marriage - generally after five or seven years and with some gifts (*pakwans*) and he had to stay there for seven or nine days. Now this custom is gradually being abolished. One can go to his *sasural* just after marriage and there is no strong convention to take big gifts for the in-laws; rather he can just give some sweets.

The institution of marriage is also changing. Now the sons have become very choosy about their partners. Earlier, sons had no objection to marry any girl, which their father had arranged. Now they demand to see the bride before their marriage. Earlier it was considered very negative and marriage alliances were broken if such a demand was made as the *izzat* of the girl's father was considered flouted by it. One Muslim old man of the poor category of a study village said that today if the bride is not in accordance with the son's choice, he can refuse her, and divorce can take place. Unacceptable matches among young couples produce quarrels in the house, which affect the elderly life and care.

Changing Relationships of Mothers-in-law and Daughters-in-laws:

Contradictory Opinions

Some elderly opined that, the relationships between mothers-in-law and daughters-in-law have changed a lot over time. Some women of the poorest, poor, and middle strata, and many from the extended, joint, and few from nuclear families, contradicted the above views. They opined that there is substantial decline in the service and care of *saas* (mother-in-law) by the *bahu* (daughter-in-law). They said that whatever the service they did to their mothers-in-law, they are not getting the same from their new *bahus*.

However, a few viewed that there is hardly any change. The elderly belonging to the poorest, poor and middle strata reported that not all daughters-in-law were caring towards their *saas*. There were always some who cared, but many did not; even today this is continuing.

Daughters-in-Law are Getting Freedom and Mothers-in-Law are Becoming Liberal

Several case studies show that the daughters-in-law of today can avail more liberty than earlier, vis-à-vis mothers-in-law who had experienced the same restrictions and punishment when they were *bahus*. Earlier, the *bahus* were kept under strict control of the *saas*. They could not touch anything without the permission of the *saas*. The *bahu* could not eat properly because the s*aas* used to provide limited food. Even in the case of having plenty of food, the *saas* restricted the *bahu*. If the *bahu* tried to over-rule the instruction, she was beaten up. But now this system is breaking. Somaria Devi, 70, widow, SES I, a Chamar caste, narrated her story that earlier her *saas* used to beat the daughters-in-law with a *muadi* (thick stick). The *bahus* used to tremble with fear of *saas*. Whenever the *saas* returned from work, the *bahus* served her water and food quickly; if delayed, then there was no "*khairiyat* of *bahu".* They used to wash the hands and feet of the *saas* so that she would not be angry. Somaria Devi further disclosed about her *saas*, "*Hamar saas muadi se maras, kewadi meen band kar des, khana-pani na des. Ab kehu oeesan kari?* (My mother-in-law had beaten me up with a stick, she shut me inside the door, and food and water was not given to me.

But nowadays no mother-in-law can do such cruelty with her daughter-in-law)".

Some adult women of a different *tola* maintained sarcastically that it was the *saas* who used to beat the *bahu,* now the *bahus* do that to their *saas*. They said that the position of *saas* and *bahu* has been reversed.

However, the general perception was in favour of giving more freedom to the daughter-in-law. It was commonly said that the women inherit the character of *saas* from their mother-in-law and try to impose the same upon their *bahu*, and this chain of transmission continues from generation-to-generation. If the mother-in-law is cruel, the *bahu* shall behave in the identical manner with her *bahus*. But many of the elderly opined that this chain should be broken. If the mother-in-law was tortured or kept under strict control by her own mother-in-law due to certain reasons like extreme poverty and crisis, this trend should not be repeated for the present and future daughters-in-law.

One middle-aged woman, SES III, explained that her mother-in-law tortured her, beat her, deprived her of food and clothes not because there was a crisis, but because she had received the same treatment from her mother-in-law. She further pointed out that during the time of her grand-mother-in-law, the family was very poor and every member had to do *banihari.* In that situation to maintain the discipline, and sharing the limited resources, the grand-mother-in-law would have beaten up the *bahu,* but today when there is everything in the house, her mother-in-law produces an artificial crisis to torture the *bahu* and that is not good.

A group of women in Jalpurawan Village said, "*Dono hath se roti pakati hai…* (Both hands are used in preparing roti)". Both *saas* as well as *bahu* are responsible for their good mutual relationships.

In Mathurapur village, a group of Muslim women, SES II, III, of a

Muslim *tola* suggested that the daughter-in-law should not be punished and kept under strong restrictions; rather, they should be given freedom and space to do their own activities. They come from another house, leaving their parents, so they need affection and solace from the *saas*. It is the *saas* who should care for the daughters-in-law in a strange new house and later on, in return, the *bahu* will care for *saas*. These women further expressed that keeping of *bahu* in a proper way is an art and every mother-in-law should learn this and keep away from the misconceptions and misunderstanding about the *bahus*. The best relation of s*aas* and *bahu* is that when the *saas* behaves like a mother and *bahu* like a daughter.

CONCLUSIONS

The elderly have a great role for the family members and the society. They are the safeguards of the family and mainstay of the society. Female elderly have greater role than the male elderly does in domestic matters. She provides all sorts of help to the daughter-in-law, as she (daughter-in-law) was not aware of the family affairs. They also prevent the nuclearisation of the family.

In case of migration of all sons, the elderly have a greater role to take care of children and women at home. The elderly from whose households any one has migrated have a better position in the family and society. The younger generation, in turn provides personal service, *sewa*, and support to the elderly.

The elderly's perception of changing the family structure is based on the notion of respect they get, care- particularly the bodily care, and life styles of the new generation. There is a change in their live styles and behaviours among the new generation. They are more fashionable, more cinema going more independent.

The elderly also perceived that the service of mother-in-law by the daughter-in-law has been reduced. The *Bahus* of today are not rendering as much bodily care to their mothers-in-law as the present mothers-in-law did for their elderly.

The elderly particularly the male perceived that their respect has been reduced in the family in terms of headship. Today, the earning educated migrated sons have more say in family decision making though their fathers are the heads (Ansari 2000).

The sons of today though providing better economic facilities- food, clothing, medical treatment, housing, etc., have less time and willingness to serve the elderly. They don't touch the feet of the father; do not do the massage of legs and body, washing the clothes, helping during the bath etc.

There is a geographical distance between the father and sons due to migration, probably contributed towards the perceptual shifts in the meaning of 'respecting' from 'obedience' to 'courtesy'. It seems there have been reducing notions of *Sewa*, *Adaar* to 'care' and 'looking after'. These can be seen as both reductions in the power of the elderly, as well as a process of accommodation of elderly and younger generation to the changing times.

Within the Asian context the shift in meaning seemed to be pervasive. It might be argued that even in the past obedience toward elders, must have been accompanied by courtesy. It would seem that status and respect could be presumed to be synonymous although there is some degree of overlap. Status as a concept appears to be closely linked with roles and functions whereas respect has a personalised dimension, which explains why people in authority often do not draw respect. On a societal level, whether the Asian values of respect for elders continue to be transmitted will depend on whether the present adult generation takes the effort and time to instil them in the next generation (Mehta 1997).

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LIVING ARRANGEMENTS OF ELDERLY : AN EMPIRICAL STUDY IN ODISHA

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ABSTRACT

Today India is home to one out of every ten senior citizens of the world. Both the absolute and relative size of the population of the elderly in India will gain in strength in future. Approaching 100 million in number, India has the second largest population of elderly people after China. Demographics in India suggest that majority of seniors live with immediate family members, and family continues to be the main provider of elder care. Indian society had traditional informal support systems such as joint family, kin and community. Due to modernization, urbanization and globalization, the capacity of the traditional informal support system is slowly weakening and is not in a position to fulfill the basic needs of the elderly.

The traditional joint family system in India is on the decline and more families are becoming nuclear. Given this background, it is important to explore the current nature of the living arrangements and its determinants. This paper analyses the socio -economic and demographic correlates of the living arrangement choices of older persons in Cuttack and Bhubaneswar of Odisha.

Key words: Ageing. Living arrangements, Social support system.

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Introduction

As per Census 2001, the number of older persons in 2001 was 70.6 million (6.9%) which was projected to be 83.5 million in 2006 (7.5%). According to further projections the percentage of older persons will be 94.8 million in 2011 (8.3%), 118 million in 2016, (9.3%) 143.7 million in 2021(10.7%) and 173.1 million in 2026 (12.4%). The growth of population of the older persons shows upward trend.

With the changing lifestyle of modern society the young generation are migrating from not only rural to urban areas rather from one country to another as well; leading to increase in old age dependency ratio. The old age dependency ratio (number of old persons 60+ years) to the working age group (15-59 years) has increased from 9.8 per cent in 1981 to about 12.6 per cent by the year 2001. (Census of India, 2001)

Living arrangements for the elderly was not an issue a few decades ago in most developing countries, including India, because the elderly are expected to be cared for by the family. However, issues concerning household structure and support for older persons in developing countries are becoming increasingly important. Along with an ageing population these countries are also experiencing socio-economic and demographic changes. Since last few decades, there has been a rise in economic growth, literacy levels, urbanisation and modernization, women bearing fewer children and people living longer and healthier lives. All this brought about significant changes in India. The effects of these trends on families, households, kin networks and subsequent support for older persons are complex and not well documented. It is generally accepted that the size and complexity of the households decrease along with urbanisation and modernisation. In traditional rural societies, families are often more extended than in modern urbanized societies where the independent nuclear family is

predominant. In the process, extended kinship ties weaken and the nuclear family becomes an independent unit. This weakening of ties with family members reduces social interaction and financial and physical support for the older generation. Separate living arrangements are required for them as countries develop. Therefore, in this context, the living arrangement issues of the elderly need attention because their welfare depends on it.

India is still characterized by its traditional ways of living where several generations live jointly within the same household. With improved health infrastructure and increased life expectancy, the elderly are expected to live longer. The joint family system is on the decline and more and more families are becoming nuclear. Apart from this, the elderly in India are facing several other challenges, such as lack of guaranteed and sufficient income to support themselves, absence of social security, loss of social status and recognition, non-availability of opportunities for creative use of their time and persistent ill health. Studies have shown that a higher proportion of the elderly are living miserable lives without any hope. Ensuring a decent and comfortable living arrangement for them continues to be a major challenge. Given this background, it is important to explore the current nature of living arrangements and its determinants.

REVIEW OF LITERATURE

John Bongaarts and Zachary Zimmer (2002) studied the living arrangements of older adults in 43 developing countries around the world using data from Demographic and Health Surveys (DHS). They found that while most of the older adults live in large households, often with adult male children, the elderly were more likely to live alone than people of other ages. Moreover, the average proportion living alone was nearly twice as high for women (11 percent) as for men (6.5 percent), largely because women

experience a higher risk of widowhood than men. There were important regional differences. Older adults in Asia, for example, are more likely than elderly people in Africa or Latin America to be living with children. Roughly two-thirds of Asian men and women aged 65 years and older live with adult children, compared with about half of Africa's elderly and slightly more than half of older people in Latin America.

In Asia, much of the research on elderly living arrangements has focused on countries in East and South East Asia, since they were among the first to experience a decline in fertility and mortality and increased life expectancies in the developing world. Martin (1989) examined the factors that influenced the living arrangements of the elderly in Fiji, Korea, Malaysia and the Philippines and found that while most of the elderly in Asia lived with their children, factors like number of surviving children, home ownership and being male increased the likelihood. On the other hand, survival of a spouse reduced the likelihood of living with children. Similarly, in Thailand a majority of elderly co-reside with their children or live in residences adjacent to them (Sobieszczyk et. al., 2002). Other studies have also reported that a large percentage of the elderly in Asian countries like India, Singapore, Thailand and South Korea co-reside with their children (Hashimoto, 1991). In Bangladesh, even if the married children are not in the same residence, they often reside in a separate household, but within the same compound (Amin, 1998).

The early research in India on the living arrangements of the elderly was actually motivated by an interest in fertility dynamics. Some authors examined whether there is a link between the desired number of children and the security children provide during old age (Cain, 1986; Vlassoff, 1990; Cain, 1991; Dharmalingam, 1994). Though the debate remains unresolved due to the lack of good data on decision making dynamics, it is quite clear that in all the studies of India, most elderly were found to co-reside with their children. In

their paper on living arrangements based on NFHS data, Rajan and Kumar (2003) report that 80% of the elderly live with their adult children. This is even more the case if the elderly are widowed. Just as in other parts of Asia, the currently married status of the elderly does seem to reduce the probability of co-residence with children, while the number of surviving children has the opposite effect (Rajan and Kumar, 2003; Dharmalingam, 1994). Furthermore, Rajan and Kumar (2003) found that males were much more likely to have the status of heads of an intergenerational household than elderly women. Unfortunately, when women are heads, it is often because they are destitute widows or living alone. Both small case studies as well as data from NFHS reveal more elderly women living alone than elderly men in India.

Though the research on the elderly in India is just beginning to gain ground, there is no doubt that their welfare in the foreseeable future depends on their families.

Increasing urbanization, modernization, rising individualism, women's labor force participation and mobility are among the many factors that have been cited as threatening the survival of intergenerational households. This in turn is seen as increasing the marginal and precarious existence of the elderly (Rajan and Kumar, 2003; Visaria, 2001; Planning Commission, 2001). As long as societies have inadequate institutional infrastructure for the well being of the elderly, residence with the family is largely seen as the best arrangement.

What is alarming is the growing number of elderly single female households. They may be widows or never-married women. In most cases, such women have no surviving children to care them and very little if any wealth to fall back on (Sobieszczyk et. al, 2002; Planning Commission, 2001). Increasingly, survival means having to work late into their old age (Vlassoff, 1991; Dharmalingam, 1994). Analysis of gender differences in elderly well being reveals that

these women are not only poorer than their male counterparts, but they are less educated too.

Sen Mitali and Noon James(2007) have studied the living arrangements of the elderly in India basing on the India Human Development Survey-2005(IHDS) data and have reported that short term morbidity given the present institutional environment, the elderly are least prone to short term illnesses when living within a large joint family perhaps being able to share the burden of survival with other adult members as well as partake in all the activity of the younger generation keeps them alert, engaged and healthy compared to elderly in other situations.

Although there are many studies on the type of living arrangements for the elderly, the reasons for seeking a particular type of living arrangement by the elderly remain relatively unknown (Palloni, 2001; Kinsella and Phillips, 2005). These studies have identified a number of factors such as age, sex, occupation, education, place of residence, number of children etc., as the important variables that shape the living arrangement (United Nations, 2005; Yadava, Yadava and Sarma , 1996; Jaiprakash, 1999). Velkoff (2001) found that living arrangements are influenced mainly by financial well being, marital status, family size and structure as well as cultural traditions. However, the relative importance of each of these factors has hardly been examined carefully.

A strong association is usually observed between socio-economic factors and the decision to co-reside among the elderly persons (Chakraborty, 2004; Yadava, Yadava and Sarma, 1996; Jaiprakash, 1999; Sahayam, 1988; Zimmer, Chayovan, Lin and Natividad, 2003). For instance, co-residence is inversely related to the socio-economic background of the family. The decision of the elderly to live alone is often determined by the economic resources available with them. It is generally argued that elders with fewer resources tend to co-reside with their children compared to those with better

resources. If the elderly are provided with some form of social security like old age pension, health insurance etc., the probability of them living alone would systematically go up. But empirical evidence does not support this argument fully (Pal, 2004: Bhattacharya, 2005). The contradictory argument is that if the elderly have some economic independence, the children, particularly the unemployed, will be more inclined to reside with them and take advantage of the available resources. Even the NSSO data reveals a higher incidence of the elderly living alone or with the spouse in rural areas. Various smallscale surveys on the elderly also bring out the dismal conditions in which they live alone in the Indian context (NSS, 1998; Rajan, Mishra and Sarma, 1999b).

The education level of the elderly is yet another important variable determining their living arrangement. It was found that with an increase in the level of education, the pattern of co-residence systematically diminishes (Andrade and DeVos, 2002; Bongaarts and Zimmer 2001; Pal, 2004; Zimmer, Hermalin and Lin, 2001).

Yet another important variable of interest is the number of surviving children and its impact on the co-residence pattern. From a broad range of studies, it is known that co-residence of older parents and at least one adult child is a central feature of the filial support system in most of the developing countries (Bongaarts and Zimmer, 2001). Studies generally supported the view that the number of living children is positively related to the probability of elders living with them (Martin, 1989). With a drastic decline in fertility in many states of India, co-residence with children becomes increasingly difficult. In addition, the educated adult children tend to migrate to urban areas in search of employment leaving behind elderly parents (Rajan, Mishra and Sarma 1999b; Bongaarts and Zimmer, 2001). In the Indian context, it is not merely the number of children available but their gender and marital status that also determines the co-residence pattern. In India, unlike in western societies, sons are more likely to coreside with their parents (Bongaarts and Zimmer,

2001; Chaudhury, 2004; Gulati and Rajan, 1990; Silva, 1994; Zachariah, 2001).

Studies in India also found significant gender differentials in the living arrangements of the elderly, but they are attributed to the higher incidence of widowhood due to the longer life expectancy of women (Chakraborti, 2004; Knodel, 1999; Knodel and Ofstedal, 2003; NSSO, 1998; Rajan, Mishra and Sarma, 2000).

The joint family system that persisted in the country in the past, has given way to nuclear families. As a result, the earlier concept of children providing support to the elderly has also undergone drastic changes. This may also be due to other factors like modernisation, urbanisation and the erosion of traditional cultural values that existed in the country (Bhattacharya, 2005; Mason, 1992; Rajan, Mishra and Sarma, 2000; Sahayam, 1988; Shah, 1999; Sumangala, 2003).

Although it is important to find out the significance of each of these factors in determining co-residence of the elderly, there are certain inherent limitations for such an analysis. The relationship of each of these variables with living arrangements depends mainly upon the cultural context in which such studies are undertaken. For instance, while availability of resources with the elderly may enhance the chances of them living alone in the West, the reverse may be true in the Indian context because the children might be more willing to co-reside with such parents (Pal, 2004).

Panda (1996) have conducted a field study in Orissa in 271 households consisting of 341 elderly persons of 60+ ages. His aim was to examine the living arrangements of the elderly in rural Orissa and the available support and care to them. He has concluded that still the family is the main social institution for care of the elderly in rural Orissa. However, increasingly poverty and economic stress is likely to erode the traditional care and support for the elderly. As regards to living arrangements of the elderly, he has observed that in accordance to traditional cultural norm of a patrilineal and patrilocal society, majority of the elderly co-lived with their elder sons. Also, he had observed that nearly one fifth of the elderly were living alone and further one tenth of the elderly were living only with their spouses without direct support and care from their kin.

Panigrahi (2009) has conducted a study in Orissa and has examined socio-economic, demographic , gender differentials and the regional variations in living arrangements among the elderly in Orissa. Mr. Panigrahi has concluded that as the number of surviving sons increased, significantly fewer elderly lived alone. The presence of sons was an important variable that determined co-residence. Similarly, the likelihood of the elderly with higher education living alone was much higher compared to those who were either illiterate or had a few years of schooling. Economic independence was also an important variable in determining the chances of living alone. There was less likelihood of the elderly living alone when they were fully or partially dependent on others indicating the significance of individual income over household income in determining the living arrangement. Similarly, the region was also a significant variable that determined the chances of living alone. In Orissa, a significantly higher proportion of elderly residing in southern region lived alone compared to their counterparts in the northern and coastal regions.

PURPOSE OF THE STUDY

The living arrangements of the elderly is seen as a parameter in understanding their plight because of the lack of public institutions and social security nets. The twin forces of modernization and urbanization may complicate the matter further since India is not institutionally adapted to handle the transition from traditional social support system for the elderly to more modern ones. The study aims to see the changing pattern of living arrangements of the elderly.

OBJECTIVES OF THE STUDY

The specific objectives of the study were:-

1)To find out the socio-demographic profile of the elderly

2)To study the living arrangements of the elderly.

3)To study the determinants of living arrangements of elderly.

4)To know who will be the best help for the elderly in their old-old age.

METHOD

2001 census, the population of Bhubaneswar was 8,00,000 and in 2011 census (Provisional) it has a population of 10,65,000.

The present study was taken up in Cuttack (old capital) and Bhubaneswar (New capital), popularly known as “Twin-city” of Odisha. According to 2001 census, the city of Cuttack has a population of 5,34,654 and in 2011 census (Provisional) the population is 7,50,000. In 2001 census, the population of Bhubaneswar was 8,00,000 and in 2011 census (Provisional) it has a population of 10,65,000.

SAMPLE

The present study is a recent one. The results reported in this paper are based on the responses of 140 elderly collected during the period from September 2008 to February 2009. Data have been collected from various sources like hospitals, geriatric Health Centres, many informal groups of elderly like Walker's Club, Yoga Centres, Community Centres, Old Age Homes and so on. A quota

sample of 140 elderly (both men and women) was selected for the study. A preliminary survey was conducted to draw a fairly mixed sample of elderly from different socio-economic backgrounds.

INTERVIEW SCHEDULE

A structured Interview Schedule was used to collect data from the sample elderly.

Data Analysis

The data were processed through SPSS package.

ANALYSIS AND DISCUSSION

TABLE-I : Background Characteristics of the Sample Elderly.

Characteristic	Male	Female	Total Percent
Age (in years)	**N = 66 (%)**	**N – 74 (%)**	**N = 140 (%)**
60-63	21 (31.8)	40 (54.0)	61 (43.6)
64-67	15 (22.7)	21 (28.4)	36 (25.7)
68-71	10 (15.2)	10 (13.5)	20 (14.3)
72-75	13 (19.7)	2 (2.7)	15 (10.7)
76 and above	7 (10.6)	1 (1.4)	8 (5.7)
Religion			
Hindu	64 (97.0)	57 (77.0)	121 (86.4)
Christian	2 (3.0)	15 (20.3)	17 (12.2)
Muslim	–	2 (2.7)	2 (1.4)
Caste			
Other Castes	34 (51.5)	14 (18.9)	48 (34.3)
Backward Classes(OBC)	29 (43.9)	46 (62.0)	75 (53.6)
Scheduled Caste	3 (4.6)	12 (16.2)	15 (10.7)
Others (including Muslim respondents)	–	2 (2.7)	2 (1.4)
Marital status			
Married	47 (71.2)	8 (10.8)	55 (39.3)
Widow/Widower	19 (28.8)	63 (85.0)	82 (58.6)
Separated or divorced	–	3 (4.1)	3 (2.1)
Education			
Illiterate	11 (16.7)	56 (75.6)	67 (47.9)
Primary	11 (16.7)	14 (18.9)	25 (17.9)
Secondary	15 (22.7)	1 (1.4)	16 (11.4)
Intermediate	7 (10.6)	2 (2.7)	9 (6.4)
Technical	1 (1.5)	--	1 (0.7)
Graduate & above	21 (31.8)	1 (1.4)	22 (15.7)
Family Income (In Rs. per month)			
Below Rs 10,000/-	6 (9.2)	32 (43.3)	38 (27.1)
Rs 10,001/- - Rs 15,000/-	16 (24.2)	25 (33.8)	41 (29.3)
Rs 15,001/- - Rs 20,000/-	19 (28.8)	13 (17.5)	32. (22.8)
Rs 20,001/- - Rs 25,000/-	10 (15.1)	2 (2.7)	12 (8.6)
Rs 25,001/- and above	15 (22.7)	2 (2.7)	17 (12.2)
Respondents' Income (In Rs. per month)			
No Income	8 (12.1)	33 (46.6)	41 (29.3)
Below Rs 5,000/-	3 (4.6)	19 (25.7)	22 (15.7)
Rs 5001/- to Rs 10,000/-	16 (24.2)	18 (24.3)	34 (24.3)
Rs 10,001/- to Rs 20,000/-	23 (34.9)	3 (4.1)	26 (18.6)
Rs 20,001/- and above	16 (24.2)	1 (1.4)	17 (12.1)

From Table-I it is observed that out of the total 140 elderly persons, 66 were males and 74 were females. The age of the study population ranged from 60 years to 84 years and 55 (39.3%) of them are married, 82 (58.6%) are widows/widower, 3 (2.17%) are separated/divorced. About 47.9% are illiterate and 22 (15.7%) are graduates and above. Only 1 (1.5%) is technically educated. From the total 140 respondents, the family income of 38 respondents (27.1%) are below Rs.10,000/- per month. Hardly 17 (12.2%) of the respondents' family income is of more than Rs.25,000/- per month.

TABLE – II shows the different living arrangements of the elderly.

The elderly are considered to be 'living alone' if they live alone or with the spouse and no other kin. 'Co-residence' or 'not living alone' is when the elderly person lives with any one kin, including children.

TABLE – II shows the different living arrangements of the elderly

Demographic variables	LIVING ALONE		LIVING WITH SPOUSE AND OTHER MEMBERS		LIVING WITHOUT SPOUSE BUT WITH CHILDREN		LIVING WITH OTHERS		TOTAL	
	n	%	n	%	n	%	n	%	n	%
AGE										
60-69	11	7.9	20	14.3	62	44.3	4	2.9	97	69.3
70-79	4	2.9	8	5.7	14	10.0	8	5.7	34	24.3
80 AND ABOVE	1	0.7	1	0.7	6	4.3	1	0.7	9	6.4
	16	11.4	29	20.7	82	58.6	13	9.3	140	100.0
SEX										
MALE	7	5.0	19	13.6	36	25.7	4	2.9	66	47.1
FEMALE	9	6.4	10	7.1	46	32.9	9	6.4	74	52.9
	16	11.4	29	20.7	82	58.6	13	9.3	140	100.0
MARITAL STATUS										
MARRIED	6	4.286	43	30.7	2	1.4	4	2.9	55	39.3
WIDOWED	10	7.143	7	5.0	58	41.4	7	5.0	82	58.6
DIVERSED/SEPARATED	0	0	0	0.0	1	0.7	2	1.4	3	2.1
	16	11.43	50	35.7	61	43.6	13	9.3	140	100.0
SURVIVING CHILDREN										
0	7	70.0	1	10.0	1	10.0	1	10.0	10	7.1
1	3	18.8	5	31.3	8	50.0	0	0.0	16	11.4
2	4	12.5	13	40.6	10	31.3	5	15.6	32	22.9
3+	2	2.4	31	37.8	42	51.2	7	8.5	82	58.6
	16	11.4	50	35.7	61	43.6	13	9.3	140	100
SURVIVING SONS										
0	5	3.6	1	0.7	0	0.0	2	1.4	8	5.7
1	2	1.4	2	1.4	6	4.3	2	1.4	12	8.6
2	2	1.4	8	5.7	8	5.7	4	2.9	22	15.7
3+	2	1.4	21	15.0	33	23.6	1	0.7	57	40.7
	11	7.9	32	22.9	47	33.6	9	6.4	99	70.7
SURVIVING DAUGHTERS										
0	2	1.4	0	0	1	0.7	0	0.0	3	2.1
1	1	0.7	3	2.1	2	1.4	2	1.4	8	5.7
2	2	1.4	5	3.6	2	1.4	2	1.4	11	7.9
3+	0	0.0	10	7.1	9	6.4	0	0.0	19	13.6
	5	3.6	18	12.9	14	10.0	4	2.9	41	29.3

It is clear from this table that 15.6 per cent of the elderly live alone in Orissa and the rest (84.4 per cent) are in co-residence. It is interesting to note that the proportion of elderly persons who live alone in Orissa was slightly higher than the Indian average of 14.5 per cent (Chaudhuri and Roy, 2007). However, studies have shown that the proportion of elderly who live alone in most of the European countries is much higher (Grundy, 2000). Studies in other South East Asian countries too have shown that a much higher proportion of elderly live alone (Martin, 1989).

A majority of the elderly (51.5 per cent), who were in co-residence, live with their spouses and children; roughly, one-third lived without spouse but with children and a small proportion (2.5 per cent) lived with other relatives and non-relatives. These findings were almost in line with the expected behaviour of elderly Indians - most elders lived with their children because of strong traditional value systems. However, the proportion of the elderly living alone is likely to increase in the near future because of the various socio-economic and demographic changes taking place in Indian society. Therefore, it is interesting to analyse the important factors that determine the living arrangements of the elderly in Orissa.

Demographic Determinants of Living Arrangements of the Elderly in Orissa

The major demographic factors considered here that determine the living arrangements of the elderly are age, sex, marital status, and their surviving children.

Age and Living Arrangements

Studies have shown that age of the elderly was one of the important determinants of living arrangements. For the present analysis, the age of the elderly has been categorised as younger old, older old and oldest old, in the age groups of 60-69, 70-79 and 80 and above,

respectively. The corresponding percentage of younger old, older old and oldest old in the sample was 69.5, 24.1 and 6.3 per cent respectively.

TABLE – II presents the association between the age of the elderly and their living arrangements in Orissa. It is quite evident from this table that as they got older, the proportion of elderly living alone decreased. The proportion of elderly living alone was highest in the age group 60 -69 years (17.3 per cent). This proportion reduced to 11.9 per cent when the elderly moved to the age group 70-79 years and it reduced further to 7.3 per cent when the elderly reached 80 years and above, indicating lesser chances of the elderly living alone when they grow older. This may be due to their declining capacity for self-care as they grow older. Studies conducted elsewhere also reported similar findings (Shah et al. 2002; Liang, Gu and Krause, 1992; Ramashala, 2001; Zimmer and Kim, 2002). Further, irrespective of the age, living with spouse and children was the most common living arrangement observed in Orissa. It was also interesting to observe that a positive relationship existed between the age of the elderly and living without spouse, but with children. As their age increased, the proportion of the elderly living without spouse but with children also increased. This could be because of the fact that as they got older there was a higher chance of widowhood. They lived with their children, but without the spouse. Similarly, the proportion of elderly living with others also increased with age. As in many other countries, age turned out to be an important determinant of living arrangements in Orissa also. Higher the age of the elderly lesser was their chance of living alone.

This relationship may however be quite complex because there was a negative relationship between age and living alone; this may not be solely due to age alone, but due to reasons of an economic nature as well. As the elderly grow older they may depend economically on others and therefore they co-reside with others when compared to the younger old who are economically active. Hence, the relationship between age and living arrangements may be due to economic reasons rather than age, per se. Therefore, further analysis was required to deduce the exact relationship between age and living arrangements considering other economic variables.

Gender and Living Arrangements

The gender of the elderly was another important demographic indicator that determined their living arrangements. TABLE – II presents the relationship between the gender of the elderly and their living arrangements. The table shows that in Orissa the proportion of elderly men who lived alone (18.6 per cent) was higher than that of elderly women who lived alone (11.9 per cent). This is in contrast with the pattern observed elsewhere in the world where more elderly women lived alone than elderly men. Nevertheless, it may be quite possible in the Indian context, because traditionally, women were not expected to live alone and therefore this proportion was lower.

Among those who were in co-residence, majority of the males (68.3 per cent) lived with spouse and children; majority of the females (51.6 per cent) lived without spouse but with children. Studies conducted elsewhere have also shown that more males, rather than females, lived with their spouses (Bian, et al. 1998; Chan, 1997; Bongaarts and Zimmer, 2001; Knodel and Ofstedal, 2003; Panda, 1997; Shah, et al. 2002; Zimmer, 2005). As mentioned earlier, this may be due to higher incidence of widowhood among elderly females than among elderly males. (Chan, 1997; Sobieszczyk, Knodel and Chayovan, 2003; Lee and Palloni, 1992; NSS, 1998; 2006, United Nations, 2005; Shah et al. 2002). Here again, it may be difficult to establish the relationship between gender and living arrangements unless the marital status was controlled. The next attempt therefore is to look at the differentials in living arrangements according to marital status.

Marital Status and Living Arrangements

Unlike other countries, the association between marital status and living arrangements may not be very prominent here, mainly because, marriage is almost universal in India. However, an attempt was made to look into the relationship between marital status and living arrangements. The marital status of the elderly was divided into four categories: never married, currently married, widowed, and divorced/separated. In this sample, majority of the elderly were either currently married (66.2 per cent) or widowed (32.9 per cent) while a small proportion was divorced/separated (0.3 per cent). The proportion of never married (0.6 per cent) was negligible in this sample.

TABLE – (IV. 2) also presents the association between marital status and living arrangements of elderly. Since the number of persons who were never married and divorced/separated was very small, comparisons were made only for those who were currently married versus widowed. It can be seen from the table that a relatively higher proportion of currently married elderly lived alone (18.9 per cent) compared to the elderly who were widowed (8.7 per cent). However, majority of the widowed (82.0 per cent) lived with their children. It could be true in the Indian traditional context that the widowed elderly are generally looked after by their children.

Surviving Children and Living Arrangement

Another important demographic factor that determines the living arrangements of the elderly is the presence of surviving children. It is generally believed that, in traditional societies including India, children are considered as security during old age. In this sample, the percentage of elderly, with no children, one child, two children, and three or more children was 4.0, 10.4, 14.0, and 71.6 per cent respectively.

TABLE – II presents the association between number of surviving children and living arrangements of elderly in Orissa. Majority of the elderly with no surviving children either lived alone (50.5 per cent) or with others (24.3 per cent). It was possible that some of them had no

children. As expected, the number of children was negatively associated with living alone. For example, only 12.4 per cent of the elderly lived alone when they had one surviving child whereas 50.5 per cent of the elderly lived alone when they did not have any children. Studies conducted elsewhere also generally supported the view that the number of children positively related to the probability of living with them (Bian, et al. 1998; Burch and Mathews, 1987; Martin, 1989; Rajan and Kumar, 2003; Zimmer and Kwong, 2003). More the number of surviving children better are the chances of the elderly t o co-reside with them. It is possible that when there are more children, at least one of them will take care of the elderly. Migration in search of livelihood may be another reason. The break-down of the joint family system is also a factor.

Surviving Sons and Living Arrangements

Apart from the number of surviving children, the gender composition also determined the living arrangements of the elderly. In India, the son is considered as the most important care provider for parents in their old age. In the study sample, it was found that 12.0 per cent of the elderly did not have a surviving son, 29.6 per cent had only one, 29.7 per cent had two, and 28.7 per cent had three and more.

TABLE – II presents the distribution of the elderly with the number of surviving sons. It is evident from the table that the number of surviving sons is negatively associated with elderly living alone . For example, 42.9 per cent of the elderly with no surviving son lived alone compared with 12.4 per cent of the elderly with one surviving son. The proportion of elderly living alone further declined with an increase in the number of surviving sons. Similarly, the proportion of elderly living with other members also declined with an increase in the number of surviving sons.

Surviving Daughters and Living Arrangements

The number of surviving daughters is also equally important in determining the living arrangements of the elderly. In this sample, 18.6 per cent of elderly did not have any surviving daughters, 28.1 per cent had one, 27.4 per cent had two, and 25.9 per cent had 3 or more. It is interesting to note that only 18.8 per cent of the elderly without any daughters lived alone whereas 42.9 per cent of the elderly with no sons lived alone, indicating the importance of living sons in determining the living arrangements of the elderly. Further, the proportion of elderly living alone did not vary much with respect to number of surviving daughters, indicating the importance of sons in determining their living arrangements.

From the above discussion, it is clear that the demographic variables like age, gender and number of surviving sons affect the living arrangement choices of the elderly. In Orissa, younger olds, males, and elderly with no surviving sons lived alone compared with their counterparts elsewhere.

Table-III Opinion of the elderly regarding who will be the best help in their old-old age

	Men(66)		Women(74)		Total (140)	
	n	%	n	%	n	%
Sons	38	57.6	35	47.3	73	52.1
Daughters	10	15.2	17	23.0	27	19.3
Spouse	12	18.2	16	21.6	28	20.0
Self	4	6.1	3	4.1	7	5.0
God	2	3.0	3	4.1	5	3.6

Table-III shows the opinion of the elderly as regards to be the best help when they become very old. About 52.1 per cent of the elderly

believe that their sons will be the best help where as 19.3 per cent feel that their daughters will be the best help to them when they become very old. 20 percent of the elderly is of the opinion that their spouse will be the best help. Interestingly, 3.6 per cent of the elderly keeps faith on God and 5.00 per cent of the elderly are of the opinion that they may not need any help at the time when they become very old.

From the above analysis, it is clear that the dependency on off sprigs (either sons or daughters or even on both) at the time of old age still prevails in India. Indian society has traditional informal support system such as joint family, kin and community. Though the twin forces of modernization and urbanization has weakened this traditional informal support system to a great extent, but, the other forms of care and social support cannot replace it completely.

From the above discussion, it is clear that the demographic variables like age, gender and number of surviving sons affect the living arrangement choices of the elderly.

The structure in the family refers to the type of family (i.e. joint, nuclear and extended) and functioning denotes the dynamics of interaction, interpersonal relations and communication between family members. Healthy interaction between family members leads to healthy relationships created and reinforced by positive communication. But due to structural changes in the family the relations and the communication patterns have inevitably changed. This transition in all the three components is a serious threat for healthy ageing at the level of the family.

Increasing individualism in youths has resulted in asserting strongly for individual self, and they are in a great hurry to have every source of pleasure ignoring others' consideration totally. Such attitudes may lead to indignity, disgracefulness, embarrassment, dishonor, disheartening, disregard, indifference, injustice, lack of care, psychological torture and unlimited hostility towards elders. The

social and cultural heritage of the family as an institution of care of elders has already entered the risk zone. The dynamics of relations in the family are undergoing unprecedented changes. The emotional bondage, the source of keeping the family intact, united and fully functioning are changing not only in joint families but also in nuclear families.

No institution can replace the family.

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DISEASE PROFILE OF 80+ ELDERLY FROM DIFFERENT SOCIAL GROUPS: STUDY IN METRO CITY OF DELHI

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ABSTRACT

Changing structure of population today, demographic change is a global phenomenon resulting from two almost universal trends: declining fertility and increasing life expectancy. As a consequence in 21st century most parts of the world, there is 'demographic ageing' defined as a rise in median age of populations and a growing share of people above age 65. In fact, mortality declined significantly long before fertility in all populations, but the former decline was not adequate in itself to age the population (Henry, 1976). The ageing process in India has been initiated from the “apex” rather than from the “base” due to improvement of survival first in the old age range. This is reflected in the old age structure of the population in which the proportions of young-old(60-64) have been decreasing and those of 65-69 , 70-79 and 80+ increasing. And it is pertinent to note that 80+ elderly are the fastest growing elderly among the geriatric population leading to increasingly broader “apex” of population pyramid-an indication of the shift of the age structure of elderly from “young- old” to “oldest-old”. As per World Population Ageing, 2007 report: 1.4 percent are 80+ elderly globally; which is 0.7 for SE-Asia; and male, female being 0.6 and 0.9 respectively. The growth rate of 80+ elderly worldwide is 3.9 in contrast to Asian which being fastest

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in World is 4.5.Indian ranking for population of 60 or over is 90, in contrast to Japan's no. 1; median age of India is 24.3 with the rank of 100 and ageing index of India is 26.1 with rank for the same being 94 (UN Dept. of Eco and Social Affairs, Pop Div, 2007). As per Indian census released in October 2004, the elderly population in 1961 was 25 million, in 1971, it was 33 million (increase of 8 million), in 1981 it was 43 million(increase of 10 million),in 1991 it was 57 million(increase of 14 million),in 2001 it was 76 million(increase of 18 million).By 2025, the older is estimated to become 168 million i.e. about 12.7% of the total population. The dependency ratio is projected to increase from the present 9% to over 12% by year 2050. Unique feature of demographic transition is that the population of 80+ is increasing rapidly at present; it has already reached more than12% through out the country of total population of elderly, viz, more than 12 millions are 80+, which is big absolute number.

Health problems of Elderly

As a consequence of several changes in organ systems, most people are afflicted with various diseases and disabilities, as they grow old. Some of these diseases which are quite common include atherosclerosis, arthritis, amyloidosis, cataract, chronic renal failure, diabetes, osteoporosis and senile dementia.

At the same time, various other impairments of bodily functions such as delayed wound healing, slower metabolic clearance of drugs, reduced absorption of nutrients and increased susceptibility to infections and hypothermia are also observed more frequently in old age(Holliday; 1995).The origin, occurrence and manifestations of these diseases depend upon several interacting factors, such as the individual's genetic makeup, environmental conditions and nutritional status. In the case of human beings, factors such as psychological state, loneliness and life style including socio-economic status are also important modulators of health and disease.

The needs and problems of the elderly vary significantly according to their age, socio-economic status, health, living status and other such background characteristics. As people live longer and into much advanced age (say 80years and over), they need more intensive and long term care, which in turn may increase financial stress in the family. So inadequate income is a major problem of elderly in India (SivaRaju; S,2000). The most vulnerable are those who do not own productive assets have little or no savings or income from investments made earlier, have no pension or retirement benefits, and are not taken care of by their children; or they live in families that have low and uncertain incomes and a large number of dependents (Bose; 1996).

There are studies describing the correlates of “successful aging” or the factors which may govern transition from health to disability for the oldest-old (Ross et a1; 1984). The health-related quality of life

(HRQL) of the long-lived elderly is much worse than the quality of life of the people 75-80 years old. The long-lived women have worse health status than men over 90. Self-report of the cause of disability appears to be generally accurate but is influenced by gender, health status, and type of disease (Robbins et al; 1994). Both perceived health and chronic illness are major elements of health status in the elderly, because perceived health declines with age and chronic health problems increase with age. Furthermore, there is a growing body of evidence indicating that older people are at risk for multiple co-morbidities (Gijsen et al; 2001).

Many older persons, however, have more than one chronic illness that may differentially impair health status. Health promotion programs which focus on regular diet, exercise, and regular physical check-ups should be developed to improve independence of everyday life and quality of life among low-income elderly (Lee et al; 2005). A well-targeted comprehensive geriatric assessment (CGA) programme and the control of patients' adherence to recommendations are effective in improving the well-being of elderly patients (Luk et al; 2000).The factors that best explain the greater utilization of health-care services by elderly women versus men are the no. of chronic diseases and HRQL (Aurea et al; 2006). The review in brief reveals: (a) There are not exclusive studies for 80+ elderly in Indian context which can provide empirical data about living arrangement, dependency, health problem, disease profile and health seeking behaviour. There are several research questions which need due attention. In the Indian context,

(a)What are the most prominent health problems at 80+ across three social groups? (b) What are the constraints in availing the health care facility by 80+ elderly in the family? (c) Whether health status of elderly could be assessed by non technical personnel at grass root level. (d) How do they rate their own health? (e) What sort of health care services do they desire ? (f) Whether disease profile of elderly at 80+ onward changes radically? Keeping these

questions into account the study of 80+ elderly was initiated. There is need (i) to study the life profile of 80+ including diseases, (ii) Whether elderly from different sections of society carry same diseases profile or do they have different disease profile of diseases, (iii) There is need to know the facility of health care they are availing. To assess the health status the main issue is how to do it ? Health professionals are not fully available for the hospitals. Their services to the community are the major problem. So there is a need to develop community based rapid screening technique to assess the health status of elderly (Khan; 2001, 2004).

Objectives

a) To find out background detail of 80+ elderly with which they are living.

b) To find out the health problems of 80+ elderly using Rapid Disease Screening Check-list.

c) To identify the constraints in health seeking behaviour of 80+ elderly from different sections of society.

d) To find out how 80+ male & female differ in disease profile.

Methodology

Study Design: The present study is an exploratory, cross sectional in nature.

Study Area: For this study Delhi was chosen, as it is a metropolitan area with a good admixture of different strata of society in terms of socio- economic status. Delhi, is divided into 12 zones; and in each zone, Municipal Corporation of Delhi(MCD) has categorized residential colonies using unit area method (UAM) in which the assessment of the colonies is done on the basis of land values; and these are categorized into A to G grades ranging from very posh colony to very backward colonies (i.e. Jhuggi/Jhompri clusters).

Study area included randomly selected colonies of each type from randomly selected one zone of Delhi. Posh colony to backward colony are categorized here as high socio-economic group **(HSEG)**, middle socio-economic group **(MSEG)** and low socio-economic group **(LSEG)** for the purpose of understanding differences in disease profile across different social environment.

Study Population: Elderly both male and female above the age of 80 years.

Variables: The variables included in this study are: demographic, sociological, economical, psychological, health status, health care, self rating of health.

Sampling Technique: Probability sampling method using multi stage random sampling technique was used as follows: First, one zone of Delhi was selected using random technique. It was further stratified into four areas out of which one was selected using random technique. The second step was to collect the list of colonies and classified it into three social group that is high, middle and low. Since colony of high class was very large therefore only one was selected for collecting data on 80+ elderly both men and women. The size of the middle and lower range colonies was small therefore three colonies of middle and four colonies of lower were selected for the purpose of collecting data on 100 elderly from each categories. Selection of these colonies was done following simple random technique

Research Tool: Study included Rapid Disease Screening Check-List (RDSC) developed by A.M. Khan. (2004) This was developed in different stages. The first stage, following the international classification of 22 diseases, prominent symptoms of each disease was listed out against each disease. This was done by a medical professional and subsequently the same was put up to a group of five medical experts, who were asked to verify whether the symptoms listed by professional are correct or not. All the five

medical experts confirmed that the symptoms listed under each disease are highly correct. In the second stage, one field investigator from medical background was asked to collect data from elderly by asking only the symptoms. Investigator was also instructed to collect the prescriptions of the doctors from the elderly, who were undergoing some treatment at the time of data collection. This process further confirmed that diagnosis based on symptoms listed under checklist was correct to a very high degree when verified from the prescriptions given by treating doctors. In the third stage, in another study conducted on a sample of 384 elderly, the correlation between the disease mentioned in the prescription or symptoms based disease was computed and it was found to have a reliability value of 0.92.

Data Collection:

The contact with representative of resident welfare association and respected senior citizens was established. They were explained the purpose of the study and its utility in developing policies and programme for the health care of elderly. With their help contact was established with individual elderly and appointment for in-depth interview was taken . It was difficult to get time from some elderly; particularly in posh area where elderly were highly suspicious. Therefore, it was decided to collect data in doctor's uniform having medical instrument of measuring the blood pressure, which was taken as a tool of establishing good rapport. In all, time spent on each elderly was between 1 to 1 ½ hours excluding the travel time.

Data Analysis: The data collected was analysed as per the objectives of the study using SPSS 12.0 version by applying statistical tests. Some salient findings are detailed. Findings related to backgrounds are also briefly mentioned.

Results and Discussion

Background Characteristics:

Table (1a): Respondents distribution by area, male and female wise

Residential area	Frequency	Percentage
HSEG	100	33.3
MSEG	100	33.3
LSEG	100	33.3
TOTAL	**300**	**100.0**
Male	140	46.4
Female	160	53.6
TOTAL	**300**	**100.0**

HSEG(High Socio Economic Group) MSEG (Middle Socio Economic Group)
LSEG (Low Socio Economic Group)

Table (1b): Distribution of male and female respondents across different areas of living

Area	Male	Female	Total
HSEG	62	38	100
MSEG	39	61	100
LSEG	39	61	100
TOTAL	**140 (46.4%)**	**160 (53.6%)**	**300**

Table(1a) shows that respondents were equally distributed among three areas; each having 33.3 percent to make it equally representative of each group for the purpose of "comparability" among the groups for different variables. Table1b shows that there is more of females than males (53.6 percent v/s 46.4 percent) It also shows that there are more females than males in middle areas. This finding overall is, in consonance of studies conducted in the

context of feminisation of ageing. However, in HSEG the trend is reverse. It may be due to some local situational reason.

Table 2: Area wise literacy level distribution of the respondents

Literacy	HSEG	MSEG	LSEG	Total	Percentage
Illiterate	022	045	072	139	46.3
Primary	006	024	022	052	17.3
Middle	015	016	000	031	10.3
Higher	030	013	004	047	15.7
Graduate	014	NIL	002	016	05.3
Postgraduate	002	002	000	004	01.3
Professional	011	NIL	NIL	011	03.7
Total	**100**	**100**	**100**	**300**	**100**

Table 2 shows that less than half (46.3%) respondents were illiterate; 17.3% were educated till primary level, 10.3% middle, 15.7 % till higher level and only 10.3 % were graduate and above with no postgraduate and professional were from low income. All the professionals from high area, with 3.7 percent. Eighty years ago, educational accessibility was extremely poor for deprived people. So the distribution of educational status is reflection of reality.

Table 3: Religion and caste wise distribution of respondents (N=300)

Religion	Frequency	Percentage
Hindu	269	89.7
Other than Hindu (Muslim, Christian, Sikh)	31	10.3
Total	**300**	**100**
Caste	**Frequency**	**Percentage**
General	248	82.7
SC or ST	052	17.3
Total	**300**	**100**

Table 3 shows that majority (89.7%) were from Hindu background; and only 6.6 percent constitutes, Muslims, Christians and Sikhs together while others were only 3.7percent. It also shows that 78 % were from general category and 17.3 percent were from SC or ST, which quite matches with national profile.

Table 4: Occupational status, house ownership and current marital status (N=300)

Occupational status (past)	Frequency	Percentage
Self Employed	214	71.3
Govt.	58	19.3
Private	28	09.3
House ownership	**Frequency**	**Percentage**
Self	157	52.3
Son	64	21.3
Spouse	47	15.7
Daughter	4	1.3
Daughter-in-law	5	1.7
other relative	5	1.7
Live as tenant	18	6.0
Marital status	**Frequency**	**Percentage**
Living with spouse	090	29.7
Widow (er)	210	70.3
Total	**300**	**100.0**

Table-4- shows that only 19.3 % had a govt job and 71.3% were self employed.. More than half (52.3%) were having house ownership

in their own names 21.3 percent house owner ship was in the name of sons. 100% respondents were married. The percent of widows and widowers is significantly higher.

Table 5: Widow(er) distribution area wise (N=300)

Type of Area	Widows		Widowers		Total No. of Widow(er)	Percentage
	Frequency	Percentage	Frequency	Percentage		
HSEG	029	9.6	024	08	53	17.7
MSEG	039	13.0	042	14	81	27
LSEG	055	18.3	021	07	76	25.3
Total	**123**	**40.9**	**087**	**29**	**210**	**70.3**

As evident from the table maximum widows, (18.3%) were from LSEG followed by middle (13%) and high (9.6%) Socio-Economic Groups. The highest percent in lower economic group might be explained on the basis of poverty, illness, malnutrition etc. However this pattern is not consistent with the pattern emerged for widowers. Overall the percentage of widows sample of 300 comes to 41% and widowers 29%.

Table 6: Living arrangements and dependency amongst 80+ elderly (N=300)

Living arrangements	Frequency	Percentage
Staying with son	235	78.4
Daughter	5	1.7
Married daughter	14	4.7
with spouse only	28	9.4
Alone	18	6.0
Dependent	**Frequency**	**Percentage**
Yes	51	17.0
No	249	83.0
Total	**300**	**100.00**

Table 6 depicts that close to 2/3rd(73.7%) 80+ elderly live with their sons and only 4.7 percent live with married daughter; indication of strong tradition of not to stay with married daughter. This finding is reflection of social & cultural reality of Indian society. It is interesting to find that amongst 80+ elderly only 17% were dependent and 83% of them feel that they are independent. This somehow indicates that the life of 80+ elderly is not as miserable as it is perceived generally. It also suggests that the concept of dependency perhaps cannot be measured simply by asking a question whether you are dependent or independent.

Diseases Profile of 80+ elderly

Simple percentage was calculated for 22 diseases reported by Elderly people. The percentage less than 25 were put under category 1. Those who reported between 25-50 percent were classified into category II and those who reported above 50% were classified in category III. The categorization is just tentative to find out the prominence of the diseases amongst 80+ elderly.

Table (7a): Disease Profile of 80+ elderly with disease distribution in three different category (n=300)

Sl. No.	Diseases falling under the category I (Less than 25%)	Percentage
1	CVS/IHD/CAD	23.3
2	Chronic Bronchitis	15.3
3	Bronchial Asthma	3.0
4	Pulmonary Koch's	2.3
5	COPD	13.3
6	Genitourinary(Male), Enlargement of Prostate Benign or Malignant	24.7
7	Male and Female - UTI	4.3
8	Prolapsed of uterus	0.7
9	Spondylitis, Cervical, Lumber, Sciatica	20.7
10	Fracture	4.7
11	Accidents	3.0
12	Neoplasia/Cancer, Throat cancer, Genital cancer in female (uterus)	0.3
13	Gastrointestinal	13.0
14	Metabolic Diabetes	16.7
15	Haemorrhoids	5.3
	Diseases under category II (25-50%)	**Percentage**
16	Hypertension	38.3
17	Locomotive arthritis	48.3
18	Centre Nervous System	36.3
19	Gastrointestinal Dyspepsia Constipation, Diarrhoea, GI cancer (upper GI) and Lower GI	35.7
	Diseases under category III (Above 50%)	**Percentage**
20	Eye : Cataract, Glaucoma, Refractory error	84.0
21	ENT (Hearing loss)	53.7
22	Mental - Emotional; Maladjustment, Depression, Inner withdrawing, Sucidal tendency	87.0

Table-7-a-shows that majority of the respondents 87% were having problems relating to mental status such as emotional, maladjustment, depression, inner withdrawing and suicidal tendency (particularly *"emotional blankness)* their functional status. 84 percent of them were having morbidity relating to eye (cataract, glaucoma, refractory error). More than half (53.7%) have problem of hearing loss, 48.7 percent reported gastrointestinal disorders, and close to half (48.3%) of them were having problem of locomotive arthritis affecting their mobility considerably. 33.9 percent reported various disorders related to respiratory system, chronic bronchitis(15.3%), COPD (13.3%) and bronchial asthma and Pulmonary. Koch's) 38.3 % reported suffering from hypertension, 36.3 % reported problems relating to Central Nervous System(CNS) which have more to do with age related degenerative changes particularly Alzheimer's disease,24.7 percent were having problems of prostate, CAD (23.3%), 16.7 percent have diabetes, one in twenty; 5.3 percent reported Haemorrhoids', while the fracture is reported by 4.7 percent, only two females were having prolapsed of uterus while almost non-existent of neoplasia (only one case). Such findings can help in designing health services on priority basis.

Table (7b): Disease Profile of 80+ elderly male & female wise.

Diseases	Male (n=140)	Percentage	Female (n=160)	Percentage
1.CVS/IHD/CAD	38	27.14	32	20.00
2.Hypertension	50	35.71	65	40.63
3.Chronic Bronchitis	35	25.00	11	6.88
4.Bronchial Asthma	05	3.57	04	2.50
5.Pulmonary Koch's	02	1.43	05	3.13
6.COPD	20	14.29	20	12.50
7.Genitourinary(Male) , Enlargement of Prostate Benign or Malignant	74	52.86	--	---
8.Male and Female-UTI	06	4.29	07	4.38
9.Prolapse of uterus	------	-----	02	1.25
10.Locomotive arthritis	73	52.14	72	45.00
11.Spondylitis, Cervical , Lumbar, Sciatica	21	15.00	41	25.63
12.Fracture	07	5.00	07	4.38
13.Eye : Cataract, Glaucoma, Refractory error	129	92.14	122	76.25
14.ENT(Hearing loss)	85	60.71	75	46.88
15.Centre Nervous System	063	45.00	046	28.75
16.Accidents	01	0.71	08	5.00
17.Neoplasia/Cancers , Throat cancer, Genital cancer in female(uterus)	01	0.71	---	----
18.Gastrointestinal	19	13.57	20	12.50
19.Metablic Diabetes	31	22.14	19	11.88
20.Gastrointestinal Dyspepsia, Constipation , Diarrhoea, GI cancer(upper GI) and Lower GI	43	30.71	64	40.00
21.Haemorrhaids	07	5.00	09	5.63
22. Mental-Emotional ; Maladjustment , Depression , Inner withdrawing, Suicidal tendency	135	96.43	126	78.75

Table 9: Graded Self Reported Health (SRH) in three different groups (Frequency)

Area	Poor	Fair	Good	Very good	Excellent	Total
LSEG	12	32	38	11	07	100
MSEG	12	40	37	07	04	100
HSEG	07	28	48	05	12	100
Total	31	100	123	23	23	300

The general belief that old age is synonyms of disease does not hold true. Only 10.3% percent 80+ elderly have reported poor health. 33.3% rated as Fair, and highest percentage have reported their health as good, Around 15.4% have reported their health as very good and excellent. These findings need further validation from similar studies. However, it looks that as the age proceed, there is possibly internalisation of the problems that in medical language is generally known as disease. Older people may visualise this problem as a reflection of particular age. It may not be taken or realise as a disease. These findings have got in-depth implication in designing health care services for older people. The primary health care system as envisaged in National Policy of older (NPOP) people (1999), in the present form would be mockerying if implemented. Doctors need to come out of their medical model mind set of disease and design the treatment plan keeping the characteristics of particular age into account. For example, during old age the felt need for counselling is a very strong and it has to be inbuilt into health delivery system.

Table 10: Comparison of Self-rated health (SRH) among the respondents of three groups

DUNCAN'S MEAN TEST

Variable	S1 (N=100)		S2 (N=100)		S3 (N=100)		S1 v/s S2	S1 v/s S3	S2 v/s S3	F - value
	Mean	SD	Mean	SD	Mean	SD				
SRH	2.69	1.05	2.51	0.94	2.87	1.04	-	-	*	3.16*

*Note:S1=Low area,S2=Middle area,S3=High area, *significant at .05 level*

Therefore it may be inferred from the study that females are having much more problems than males; who were having more problems than females in respect of heart diseases, fracture, hearing loss, CNS and metabolic diabetes only. It is to be further noted that difference was highly significant in respect to CVS/IHD/CAD, Locomotive arthritis, Eye (Cataract, Glaucoma and Refractory error and Gastrointestinal. As evident from above graph no 2 and table 22 that the SRH is best in high class of all the three different socio economic group which is lowest in middle class. Difference among them is significant (F=3.16, significant at .05 level), which is significant between the group belonging to middle class and high class.

Table 11: Status of present self health perception with one year ago (N= 300)

Health in comparison to one year ago	Frequency	Percentage
Much better than one year ago	14	4.7
Some what better now than one year ago	22	7.3
About the same as than one year ago	102	34.0
Some what worse than one year ago	90	30.0
Much worse now than one year ago	72	24.0

The table 11 shows that more than half (54%) respondents perceived their health worse than one year ago. It denotes towards the gradual degeneration of body reflecting into health problems.

Health Seeking Behaviour

Table 12: Distribution for first line of medical treatment (N=300)

First line of medical treatment	Frequency	Percentage
Private	201	67.0
Govt.	89	29.7
Home - based	10	3.3
Reason for avoiding govt. health facility # #		
Distance from residence	91	30.3
Transport cost	67	22.3
Apathy found amongst medical staff	155	51.7
Scattered treatment service	183	61.0
It takes lot of times	201	67.0
No desire to avail govt. facility	149	49.7
Preferred mode of treatment		
Allopathic	286	95.3
Ayurvedic	5	1.7
Homoeopathy	5	1.7
Others	4	1.3
Have undergone medical check up		
Yes	15	5.0
No	285	95

*# # **Note**: It is to be noted that percentages shown will not add to 100 because of multiple responses.*

As evident from the table 12 first line preference for medical treatment is for private (67%) followed by Government (29.7%) and home based. Main preference is for allopathic system (95.3%). medical check-up is fully missing. This is matter of great concern as for as well being of older person is concerned. It also shows the premium for health in this country among 80+ elderly. It is a totally in contrast to Europe, Japan, USA and other countries where longevity is more than our country. (UN Dept. of Eco and Social Affairs, Pop Div, 2007). The matter regarding health check-up, early detection of diseases and premium for oldest old people need special efforts of Health planners particularly in the early of researches related to policy, programmes and provisions.

The Problems faced in seeking medical care

Table 13: Problems faced in seeking medical care (N=300)

Problem	Sever		Mild		Nil	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Cost - wise	60	20.0	52	17.3	188	62.7
Access - wise	70	23.3	62	20.7	168	56.0
Availability - wise	75	25.0	51	17.0	174	58.0

The table 13 shows that every fifth respondent(20.0%) is faced problem in medical care due to cost factor, which requires urgent intervention from the govt. The availability of medical services appears to be more prominent. Since elderly from upper and middle residential areas are relatively well off economically therefore relatively larger percent fall into the category of nil.

Conclusion

Unlike general belief, majority of 80+ elderly (83%) were found to be independent. Male more than female suffer with CAD problem; the difference was significant. The cases of locomotive arthritis were more in female than male; the difference is significant. Similarly women suffer more with the problem of cataract, glaucoma than men; the difference was highly significant. Women more than men suffer with the gastrointestinal problem. The problem related to ancestral health was found more in the women. In all, women profile of health appears to be more critical than men's health. Interventions for 80+ elderly need to take care of male, female differences into account. Possibly early detection of diseases from the community by using Rapid Screening Checklist developed by (Khan 2006) could serve a better purpose of community based diagnosis of diseases amongst elderly of any age group. While combining the rating of good, very good and excellent which comes to 88% , one get impression that health condition of elderly of 80 is not as bad as generally believed. Such findings however do not fully support the findings related to disease profile. Possibly 80+ elderly fully assimilate values generally believed in the society about old age as synonym's of disease. In fact, on the self rated health the difference between lower and middle is normal. However, significant difference has emerged as far all the three groups are concerned, showing the social class effect in rating the health by elderly themselves. The finding also revealed that every year is crucial at 80+, the situation deteriorates fastly, it was reported by 1/4th elderly, possibly they are those who are at the age of 85 and above.

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