**CHAPTER – I**

**INTRODUCTION**

Family occupies a unique position in the human society. Its significance, however, varies from society to society and, within the same society among different groups and individuals occupying various positions and statuses that are placed at ' different stages of growth in their passage of life. As a social Institution, family fulfils the needs and interests of the large number of individuals as compared to any other social institution, In general, an individual is born in the family, brought up in the family, grows old in the family, and in normal course dies in the family

With the passage of life towards the old stage, an individual's mental and physical capacity, to perform certain roles gradually gats declined, and when he retires from bread-winning stage he has to experience several socio-economic and psychological problems within the family and society.

Since time immemorial, in traditional Indian society aged people enjoyed better st;atus and authority in the family when joint family system was quite prevalent, The joint family system in India has often been used to illustrate the status of the aged in rural societies. Education of children, changes in the marriage institution, importance given to conjugal relations and emancipation of women have brought changes in the joint family system and consequently challenged the authority of the aged people.

In all industrialized societies of the West, one can find a process of the slow transpiration of multi-generation families, and small core family becoming more and more popular especially in the urban areas. This process is, at present,, slowly occurring in India in tune with the culture changes resulting in me changes in the norms and values as well as in the behavior of an individual, Very often old people are slower to change or Co accept, new traditions #an the young, as a result, the old are looked upon as obsolete or old fashioned.

Aging of the population also known as demographic aging, and population aging is a summary term for shifts in the age distribution (i.e., Age structure) of a population toward older ages. A direct consequence of the, ongoing global fertility transition (decline) and of.; mortality decline at older ages, population, aging is expected to be among the most prominent: In global demographic trends of the 21st century. Population aging is progressing rapidly in many industrialized countries, but those developing countries whose fertility declines began relatively early also are experiencing rapid increases in their proportion of elderly people. This pattern is expected to continue over the next few decades, eventually affecting the entire world. Population aging has many important socioeconomic and health consequences, including the increase in the old-age dependency ratio. It presents challenges for public health as well as for economic development.

There is of course some uncertainty with any forecast, but it is important to note that previous population forecasts underestimated rather than overstated the current pace of population aging. Before the 1980s the process of population aging was considered as an exclusive consequence of fertility decline and it was predicted that the pace of population aging would decrease after stabilization of fertility rates at some low levels. Population ageing is the most significant result of the process known as demographic transition.

Rapid decline in old-age mortality observed in developed countries in the last decades of the 20th century significantly accelerated population aging. Now the old-age mortality trends are becoming the key demographic component in projecting the size and composition of the world's future elderly population. The future uncertainties about changing the mortality may produce widely divergent projections of the size of tomorrow's elderly population

**AGEING SCENARIO**

Population ageing, the process by which older individuals come to form a proportionately larger share of the total population, is one of the most distinctive demographic events of the contemporary world. Initially experienced in the more developed countries, the process is now rapidly approaching the developing world. Although not a global phenomena yet, various predictions indicate that population ageing is going to become a major global issue in the years to come (Chakraborti, 2004). For most of the nation, regardless of their geographic location or developmental stage, there are two notable aspects of the global ageing process: one is progressive demographic ageing of the elderly people and the other is about the feminization of ageing. The rapid growth of the older population has an identical importance in public policy.

By 2050, India will be home to one out of every six of the world‘s older persons, and only China will have a larger number of elderly, according to estimates released by the United Nations Population Fund (UNPF). Thirty years ago, there were no ―aged economies,‖ in which consumption by older people surpassed that of youth. In 2010, there were 23 aged economies. By 2040, there will be 89. Japan is today the only country with more than 30 per cent of its population aged 60 or above. By 2050, there will be 64 countries where older people make up more than 30 per cent of the population. In simple terms, within a decade there will be one billion older persons worldwide. And by 2050, nearly 80 per cent of the world‘s older persons will live in developing countries — with China and India contribute to over one-third of that number (The Hindu, 2012).

**RESEARCH PROBLEM**

Old age or elderly consists of ages nearing or surpassing the average life span of human beings. As per National Policy on Older Persons, 1999, elderly or senior citizen is a person who is of age 60 years or above. The era of urbanization, nuclearisation of family, industrialization, education, dual career in families, modernization, and rise of individual philosophy have diminished the traditional values of India society that earlier had vested authority with elderly.

**IMPORTANCE OF THE STUDY**

The aged were significant in terms of stabilizing the personalities within the family. Their experience and expertise have been doing matchless jobs for the younger generation and in turn, the members of the families could provide care for the aged significantly. The aged contribution cannot be measured qualitatively and they deliver their best whenever the families require crucial supports which are qualitative in nature. The dimension is when the age is increasing the problems are also joining with them resultantly the aged need the different kinds of support for their survival. This is a cause for the present study which has been carried out in the Mayyil Panchayath in Kannur district. The solitary reason for the researcher to select the rural area is the rural elderly are contributing their best when compared to the elderly of urban areas even though their working hours are less, since the agriculture and allied activities are in a position to provide the work to the aged.

**OBJECTIVES OF THE STUDY**

1. To study health and economic status of aged in Mayyil Panchayath
2. To study the problems and challenged faced by aged people in Mayyil panchayath
3. The socio-economic issues involved and the types of problems faced by the elders in the study area.
4. To study the adjustment of the aged in the families on parameters like physiocological, Economical and social

**RESEARCH METHODOLOGY**

The researcher has used descriptive research design for this study. The study described the problems of the elderly regarding their physical, economical and social problems as well as the available social supportive systems

The researcher has used observation and interview as the methods of data collection apart from the interview schedule, as a tool for data collection

**PROFILE OF THE RESPONDENTS**

The age factor is a matter of Universal concern. Here in this study 60 years of age has taken as beginning of becoming aged. Some of the demographers distinguish young old (60-69 Years), old (70-79 Years). Oldest old (80-89 Years) and the extreme old (90 + above years).The National Policy on Older person (NPOP) in India classifies and categories this demographic group into young old, (60-69 years) who are usually active vital and vigorous, old(between 70-75 Years) the old-old (between 76-84 Years) and oldest old(85+ above years ). The last in this category is more likely to be frail and infirm and generally face difficulties in managing activities of daily living.

**LIMITATIONS OF THE STUDY**

1. The major limitation of the study is time constraint; therefore, the study had to be confined to a sample size of 50.
2. Random sampling method was used for taking respon se from the respondents. So the limitation s of thi s method are relevant in this study.
3. Any false /wrong disclosure from them will destroy the truthfulness of the study.
4. The study is confined to a finite period. Time and cost constraints are the important limitation s of the present study.

**SCHEME OF THE STUDY**

The contents of the study are presented in 5 chapters.

The 1st chapter examines the relevance of the study, presents the research problem, the objectives of the study, the methodology, followed by the limitations of the study.

The 2nd chapter set apart for review of literature related to the present topic of the study.

The 3rd chapter highlights the profile of study area and theoretical aspects of problem s, health status and living arrangements of aged

The 4th chapter contains the analysis of data collected from the 50 samples of aged in Mayyil Panchayath

The last chapter summarizes the major findings of the study and also advances some suggestions for improving the living condition of aged.

The first chapter of this study gives an introd.,uction to the project topic. This chapter also deals with the statement, importance, objectives and limitations of the study.

**CHAPTER - II**

**REVIEW OF LITERATURE**

The notable review of gerontological research which marked the beginning of the 1960's was brought out by end of the decade with 3 volumes edited by Matilda W. Riley and supported by the Russell Sage Foundation. 'Ageing and Society: An Inventory of Research Findings' by Riley and Foner in 1968 organised an enormous body of empirical research on social scientific aspects of human ageing. The other two were - 'Ageing and the Professions' by Riley and Johnson in 1969 and 'A Sociology of Age Stratification' by Riley, Johnson and Foner in 1971. It constitutes an integrated effort to explain the significance of age for the allocation of social resources and opportunities over the life span. These volumes are largely interdisciplinary.

Buendía, J. and Riquelme, A.; Universidad de Murcia, Murcia, Spain. The extraordinary relevance of the depression have provided a greater interest in health professionals about the study of the psychological and social factors implicated in the development and maintenance of depression in elderly. Since the paradigmatic work of Lowenthal y Haven (1986) in which they shown the importance of a confidence in order to improve the well-being and to prevent depression in elderly, an amount of researches have reported about the size of social nets and specially the level of perceived social support as the best predictors in the development of depressive disorders in ageing. Nevertheless, the specific mechanisms implicated in the buffering effects of the social support on depression in elderly go on being one of the main problems in this framework of research.

Atchley in his article- 'The leisure of the elderly', (Atchley, B.C., 'The Leisure of the Elderly' Humanist 37(5), 1977) studied the leisure of the elderly. he noted that the aged made effective use of their leisure times since most of them had a sense of inner fulfilment. Though they had freedom of choice, they were limited by physical, financial and transportational factors. He concluded that the aged found their self-actualization in a sense of personal work rather than in leisure time activities.

Marulasiddaiah (. Old People of Makunti, Dharwar: Karnataka University, 1969 ) found that the old in the village felt that they are neither properly cared for while they are ailing nor well fed and cared by their sons and relatives. Oak and Sharma observe that the authority and prestige of the elderly person in his family and community is decided by his caste and economic position. With advancing age there is a dominant shift from the position of domination to subordination.

Rao, M.K. (2003). 'Health status of the Rural Aged in Andhra Pradesh; A sociological perspective'. Research and Development Journal -The empirical study among 226 elderly persons (120 Males and 106 females) in the coastal districts of Andhra Pradesh highlighted that a greater percentage (88%) of the elderly persons was illiterate – such proportion was more overwhelming among women than men were as the reverse trend was noticed in the case of those studied up to primary school level. Half of the elderly were not working, one-fifth were working as agricultural laborers followed by cultivators and less than one-tenth was working in traditional occupations skilled and unskilled works

Sebastian, Daliya, and T.V. Sekhar, (2011), “Living Arrangements and Satisfaction of Elderly in Rural Kerala” in, Ageing: Some Emerging Issues Profiles, Trends and Policy Perspectives, K N S Yadav and Alok Kumar (Ed). New Delhi: Mana Publication Pvt. Ltd. The study among 300 rural elderly in Kerala revealed that a large number of elderly (83%) were literates and as expected the proportion was higher among males than females. On the other hand, while about half of the sample elderly were widowed, such proportion was large in the case of females than their male counterparts. In the case of their occupation, it was found that slightly more than 65% of the elderly were not working unemployed and around one-tenth each were cultivators and casual labours. 54 The percent of unemployed/not working was higher among females as against males, whereas the reverse pattern was noticed in the case of other two occupational groups

Papiya G. Mazumdar & Sumit Mazumdar,(2009) “ Dynamics of Family Support for the Elderly in Rural India: The Influence of Co-Residence with Children”, XXVI IUSSP, International Population Conference, Morocco. - The considerable light on the pathways that influence of living arrangement patterns of the elderly on the degree of familial 56 support, which can be viewed as a facilitating factor improving the general well-being of the elderly. The findings, which involve examining the effect of co-residence with children on a composite index of familial support indicates that such form of living arrangements, empower the elderly with increased familial support, which, in turn is more likely to lead to improved well-being. The important role of traditional modes of intra-family support systems for the aged in developing country settings that seem to withstand the ongoing process of erosion of joint family norms and the encompassing ‗cultural flux‘ witnessed by many contemporary developing societies. Much of this holds true for rural India, where children still constitute the predominant source of intra-family support for the aged, in a situation marked by a dearth in formal institutional support mechanisms for these sections of the population erosion of joint family norms. and the encompassing \_cultural flux' witnessed by many contemporary developing societies. Much of this holds true for rural India, where children still constitute the predominant source of intra. family support for the aged, in a situation marked by a dearth in formal institutional support mechanisms for these sections of the population

The agricultural economy, the patriarchal joint family. system and traditional values such as reverence for age that bound parents and their adult children are the distinguishing characteristics of the ancient Indian cult. In the patriarchal joint family system, the oldest male member of the joint family is the head .of the family. Property inheritance is matrilineal (from father to son to grandson). In a joint family, all members of the family live, cook and eat together and share the responsibility of managing common land holdings a business. The oldest male member may also ·live with his siblings and their children and grandchildren under the same roof. IQ such a joint family, its elderly members, even if disable.d, e easily taken care of by the other members. Elder care was not a problem.

Brown, et al. 2002; Lee, et al.· 1995; Pal, 2004 Friendly living arrangements are generally associated with better health outcomes. Studies linking health and living arrangement mainly looked at two major dimensions - the impact of t!te health of the elderly on living arrangement and the impact of living arrangement on health of the elderly. The studies linking health and living arrangement has looked at illhealth and disability as a factor for co residence.

Mathews and Mohan (200 I ) also studied the Indian elderly in the demographic perspective. They found that the elderly constituted 7.7 per cent of the populatfon of the country (2001).With their strength of 96 million they constituted 67.6 per cent as the dependants for every l00 economically active population. About 40 per cent of them were below poverty line. Almost 90 per cent of them were not covered by any state security and had no family security either.

Rajan, Mishra, and Sanna (1999), m their book India's Elderly - B.urden or Challenge? noted the increasing trend of ageing in India· and examined how it would have serious implications on the circumstances under whtch the future elderly would live. During. 1981-91, the annual growth rate of the general population was 2.55 per cent, but the annual growth rate of the elderly persons was 3.39 per cent. During 1991-2001, the figures were 2.02 per cent and 3.39 per cent respectively. Based on this trend, they predicted that during 2001- 11, the annual growth rate of the general population would be 1.61 percent and the annual growth rate of the elderly persons would be 3.65 percent. During 2011 – 2021, the figures would be 1.53 percent and 3.94 percent respectively.

The second chapter of this project work deals with the review of literature related with the project topic. There are a number of studies related to the project topic. Most of the studies revealed that the main problems of aged in our society is loneliness.

**CHAPTER – III**

**PROFILE OF THE STUDY AREA**

**THE CONCEPT OF AGED**

The term 'aged' (or alternatively termed 'old age') is difficult to define specifically because of the fact that this complex word is being used differently under diflFerent criteria. Some distinguish and separate age groups on the basis of chronological age, and others do so on the basis of their social, psychological or physiological characteristics.

Much debate is presently going on and much controversy is surrounding on as to who should be considered the aged: those who have completed certain chronological years of age or have become weak, fragile and inactive. This is but natural that as age advances many changes take place in the physical and biological conditions of an individual. This is due to waning of the body tissues and the resultant degeneration process with loss of strength and vigour. As a result, changes also occur in his social and psychological make up of the personality. Since he will not have the required strength, energy and concentration to undertake the roles he has been playing till now, he is expected to relinquish these to younger members of the group to achieve the group interests in a better way. While this was a gradual process in a slow tradition-bound society, the process is more disturbing and problematic for the modern generations. Here old age means physical disability declining mental ability, the gradual giving up of role playing in social activity and shift in the economic status, moving from economic independence to economic decency on others for support.(soodan,1975:U2).

Under normal circumstances the transfer of roles and authority from aged to young is a routine and automatic matter. If the youth refuse to take up these or the aged refuse to give, there will be problems in the group. Similarly, if inexperienced and immature want to take up roles requiring maturity and responsibility, problems arise then also. However, there are special and unusual occasions and circumstances such as the death of a father when his children are still young or an aged father loses his sons by way of death or family partition, assumption of such rotes become inevitable and this is also accepted. A person, who succeeds in discharging his worldly duties properly and at an appropriate time, is not only considered fair minded but also lucky. But all may not succeed in their efforts. The reasons are not difficult to think: firstly, one may not succeed in begetting a son and train him properly to take over the family responsibilities. Secondly, the sons may not come up to the expectation and perform their obligations properly. When these happen, naturally, he continues to shoulder the family burden. It may also bring guilty feeling in him for not doing his parental duties properly. by the society.

**MEASUREMENT OF AGING**

The most popular traditional measure of the extent of aging consists of identifying a critical level of age above which a person will be considered as "aged" and then finding the proportion that is "aged". As noted earlier, the practice is to use 60 or 65 years as the cut-off point for separating aged from the non-aged. But the index, which is an exact analogue of head - count ratio, reflects only the numbers that are old, but does not take into account the extent of oldness (Basu and Basu, 1987). As shown by them, a family of poverty measures in economics offers in developing an idea which captures tiie underlying notion of aging.

**DEMOGRAPHIC TRANSITION OF THE ELDERLY**

Aging of the population also known as demographic aging, and population aging is a summary term for shifts in the age distribution (i.e., Age structure) of a population toward older ages. A direct consequence of the ongoing global fertility transition (decline) and of mortality decline at older ages, population aging is expected to be among the most prominent global demographic trends of the 21st century. Population aging is progressing rapidly in many industrialized countries, but those developing countries whose fertility declines began relatively early also are experiencing rapid increases in their proportion of elderly people. This pattern is expected to continue over the next few decades, eventually affecting the entire world. Population aging has many important socioeconomic and health consequences, including the increase in the old-age dependency ratio. It presents challenges for public health as well as for economic development.

There is of course some uncertainty with any forecast, but it is important to note that previous population forecasts underestimated rather than overstated the current pace of population aging. Before the 1980s the process of population aging was considered as an exclusive consequence of fertility decline and it was predicted that the pace of population aging would decrease after stabilization of fertility rates at some low levels. Population ageing is the most significant result of the process known as demographic transition.

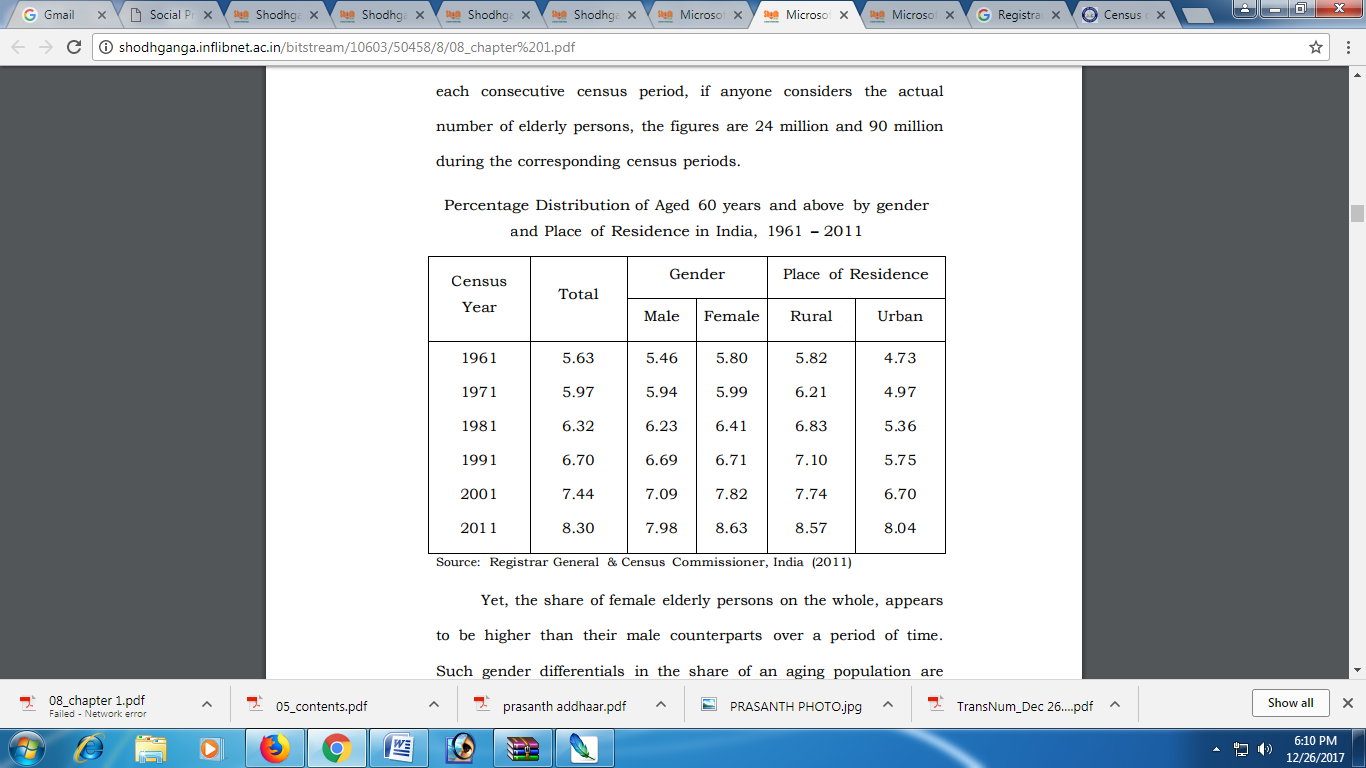
Rapid decline in old-age mortality observed in developed countries in the last decades of the 20th century significantly accelerated population aging. Now the old-age mortality trends are becoming the key demographic component in projecting the size and composition of the world's future elderly population. The future uncertainties about changing the mortality may produce widely divergent projections of the size of tomorrow's elderly population

**AGEING IN INDIA**

India has achieved longevity of its population during the last century, compared to other countries; the proportion of the aged population in India is less, nonetheless in absolute numbers is more. It has already reached this mark and is expected to have 21.3 percent of older people by 2050. At present China has the largest number of elderly persons in the world and India is ageing faster next to China (Jamuna D, 2000). Both the number and proportion of the aged are increasing over a period of time throughout the world including India.

The population of persons aged 60 and above was 12 million in 1901, it reached 24 million in 1951, 57 million in 1991 and 76 million in 2001. It is projected to reach 127 million in 2025, 198 million in 2030 and 326 million in 2050. According to the 2011 census, the old age population has crossed 90 million. As per the United Nations, a country is an ageing country if the proportion of older people reaches 7 percent. According to the population projections till 2016, worked out by the expert committee headed by the Registrar General and Census Commission of India, the number of elderly population 60 years and above are steadily increasing. Such trend is more conspicuous after 1961 onwards mainly because of the significant reduction in death rate and consequent improvement in the life expectancy of persons. In other words, India‘s population above 60 years will be doubled in size between 2001 and 2026, in 2001 elder‘s population was 7.44% and it has increased 8.30% in 2011 and it will account for 12.17% of the elderly population in 2026, it shows nearly one percent has been increased between 2001 and 2011.

**TABLE 3.1**



**POLICIES AND PROGRAMMES FOR ELDERLY**

The Ministry of Social Justice and Empowerment put in place the National Policy on Older Persons in 1999 with a view to addressing issues relating to aging in a comprehensive manner. But the programme failed at the implementation level. The Ministry is now formulating a new policy that is expected to address the concerns of the elderly. The idea is to help them live a productive and dignified life. There is a scheme of grant-in-aid of the Integrated Programme for Older Persons, under which financial assistance is provided to voluntary organisations for running and maintaining 33 projects. These include old-age homes, day-care centres and physiotherapy clinics. While the scheme, indeed the concept, is still alien to India, the Ministry is considering the revision of cost norms for these projects, keeping in view the rising cost of living.

The most recent intervention has been the introduction of the National Programme for Health Care for Elderly in 2010, with the basic aim to provide separate and specialised comprehensive health care to senior citizens. The major components of this programme are establishing geriatric departments in eight regional geriatric centres and strengthening health care facilities for the elderly at various levels in 100 districts. Though the scheme is proposed to be expanded during the Twelfth Five Year Plan, the regional geriatric centres are yet to take off because of lack of space in the identified institutions. The enactment of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007, was a legislative milestone. However, its implementation has been poor.

**PROBLEMS OF AGED PEOPLE**

In general, the elderly are living with many problems. The adaptability of the human organs makes it possible to compensate for many of the physiological impairments of ageing. The life span is influenced to a considerable degree by heredity or susceptibility to major diseases like cancer and heart disease running in the family. Increase in lifespan also results in chronic functional disabilities creating a need for assistance required by the elderly to manage chores as simple as the activities of daily living. With the traditional system the women in the house looking after the aged family members at home is slowly getting changed as the women at home are also participating in activities outside the home and have their own career ambitions. There is growing realization among elderly 14 that they are more often than not being perceived by their children as a burden.

**HEALTH PROBLEMS**

Among the problems of old age, health is among them because it is accentuated by an increasing number of physical handicaps more frequent and serious illnesses, mental disturbances and a general reaction among the aged that ill health is their major burden. In recent times, as a result of changing circumstances due to demographic transition, the rapid pace of industrialization and urbanization, disintegration of joint family structures into unitary ones, and the older people become more vulnerable to physical disabilities because of social, economic and emotional alienation and isolation. Older people usually suffer from chronic illness. The duration of both acute and chronic conditions is longer for the elderly and their chronic conditions are more likely to be lethal. Frequent chronic ailments among the elderly are Diabetes, Mellitus, Hypertension, Cardiovascular diseases, Cancer, Arteriosclerosis, Kidney diseases, Parkinson‘s diseases, Arthritis, Dementia, etc. Most often elderly may suffer from multiple chronic conditions, visual defects, hearing impairment and deterioration of speech which can cause social isolation.

On the positive side, the health status of older people of a given age is improving over time now, because more recent 16 generations have a lower disease load. Older people can live vigorous and active lives until a much later age than in the past and if they're encouraged to be productive, they can be economic contributors as well. Also the possibility should not be excluded that current intensive biomedical anti-aging studies may help to extend the healthy and productive period of human life in the future (de Grey et al., 2002).

**ECONOMIC PROBLEMS**

Economic insecurity in the old age is a feeling of vulnerability due to lack of economic resources. The loss of physical ability to work and thereby to stand on one's own feet and also being laid off the work force due to old age, retirement, leaves the old with little or no revenue for economic sustenance. Around 90% of the elderly are from the unorganized sector which means no social security, no pension, no gratuity and no medical schemes which leaves the old economically insecure and vulnerable. Further, the children/relatives too are either unwilling or unable (due to economic inability) to take care resulting in economic insecurity. The poor have as it has never been in a position to make two ends meet, where would they have been able to amass wealth enough to sustain old age? Those elderly who can work but have no work should be encouraged to work for a wage which would lead them towards economic security. Those elderly who cannot work should be facilitated to access various government schemes on social welfare. It is imperative for society and the government to recognize the potential of the elderly and help them to use their time productively which would generate an income leading them towards security economically.

With poor social security arrangements for the elderly, it is not surprising that around 37 million elderly in India are engaged in productive work, according to NSSO data for 2004-05. A majority of these workers are illiterate or have limited levels of education. Half the women elderly workers are from the two poorest consumption quintiles. This indicates that illiteracy and poverty push them to undertake work outside as a survival strategy, or out of compulsion. For many people, the sunset years of life often turn out to be traumatic. They live alone, handling rising costs, scrambling to find and pay people even to repair.

**SOCIAL PROBLEMS**

Elderly suffer a low self esteem in old age due to their inability to manage on their own. Others in the family or community do not have time. Taunts and barbs from the younger able bodied do little to help. There is a further dip in self esteem when they are unable to do what they could do in their younger days. The old feeling of being useful members of society is replaced with a feeling of total dependency resulting in low self esteem of the elderly. The elderly suffer neglect from their own near and dear ones and from society because of the mind sets that elderly are a spent force and burnt out. Neglect also happens because the younger members in the family are busy with their own concerns or just not motivated or interested enough to include the elderly in their scheme of things or make them participate in their discussions or plans etc.

Many older persons live in fear of the unknown which stems from their overall decline in health, and their economic and social status. Some fears are related to death, loss of their spouses. Elderly who suffer from fear need to be reassured. Those, for whom fear is considered to be irrational, needs to be counseled and, if 19 necessary, treated. In the case of those with real or rational fear, the cause must be identified and preventive measures taken where and when possible. The elderly suffer a low self esteem in old age due to their inability to manage on their own. Others in the family or community do not have time. There is a further dip in self esteem when they are unable to do what they could do in their younger days. The old feeling of being useful members of society is replaced with a feeling of total dependency resulting in low self esteem of the elderly.

Isolation is a state when a person feels cut off from society, and feels they disconnect. The elderly suffer isolation from two front‘s physical and Psychological. Physical isolation happens because children have most likely moved away to earn a better keep. The elderly suffer isolation psychologically because children/relatives are unable to give time because they have to busy themselves in the task of earning their own bread and butter. Their friends, who could be good company, are most likely in similar situations, dependent on others to take care of their needs. All this leads to physical isolation. Psychological isolation among the elderly proves to be lethal for the elderly because they feel unwanted and that works on their psyche. This problem can be resolved to quite an extent if the younger people around the elderly are sensitized that it is not enough to just provide for the elderly it is essential to make them wanted included in the activities of the family

**ADJUSTMENT PROBLEMS**

When caring for an elderly, it‘s easy to become focused on their physical needs. Caring for an elderly requires patience, kindness and hard work from the care giver. Depending on the situation, this work may be physical, mental or both. One who may already be dealing with aging issues of their own may become trapped in a cycle of caring for another, sleeping, waking up, and starting all over again the next day. To avoid this, those senior citizens caring for an elderly relative need to build a support system of helpers, get plenty of rest, take time off when possible, and continue living their own life. If the elderly needs are timeconsuming, they may use all one‘s energy, especially if an elderly is already having physical difficulties of their own such as arthritis or back issues etc. The care giver may often get frustration and it creates a more stress for them so that they need to look at the relaxation as an important part of their care giving. Having a support system of other relatives, perhaps grown children/ grandchildren and maybe a nurse or another part-time caretaker, can be a big help.

Higher costs of housing and health care are making it harder for children to have parents live with them. This is a common fact both in rural and urban areas. As the National Policy on Older Persons (NPOP) puts it, due to shortage of space in dwellings in urban areas and high rents, migrants prefer to leave their parents in native place. Changing roles and expectations of women, their concepts of privacy and space, desire not to be encumbered by caring responsibilities of older people for long periods, career ambitions, and employment outside the home implies a considerably reduced time for care giving. (Government of India, 1999).

**ELDER ABUSE**

The elderly most often are run down again and again with abuse which can be verbal, physical, and psychological .Most often they are abused by their own children and their near and dear ones which leaves them traumatized. . In most cases, elderly are abused by individuals who want to reiterate and display their power and authority. The elderly are also abused because of their lack of awareness of their own rights and entitlements. Sensitization of the younger generation in this regard is of utmost importance.

The aged are abused in the following way Physical elder abuse is the use of physical force that may result in bodily injury, physical pain, or impairment. Physical elder abuse may include acts of violence like striking, with or without an object, hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. The inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any kind also are examples of physical elder abuse. Emotional or psychological elder abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/ psychological elder abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment.

**LIVING ARRANGEMENTS OF AGED**

Living arrangements among the elderly was never an issue a few decades ago in most of the developing countries, including India, because their families were expected to take care of them. However, issues concerning household structure and support for older persons in developing countries are becoming increasingly important because the aging population is making its presence felt in many of these countries. Along with the population ageing, these countries are also experiencing socioeconomic and demographic changes. Economies are growing with literacy levels increasing, urbanisation and modernisation increasing rapidly, women bearing fewer children and people living longer and healthier lives. The effects of these trends on families, households, kin networks and subsequent support of older persons are complex and not well documented. It is generally felt that the size and complexity of the households decrease along with industrialisation and urbanisation. In traditional rural societies, families are more extended than in modern urbanised society where the independent nuclear family is dominant. Extended kinship ties weaken and the nuclear family becomes an independent unit in urban areas. This weakening of filial ties reduces social interaction and financial and physical support for the older generation. As countries develop, the prevalence of separate living arrangements for the different generations gathers momentum. Therefore, in this context, the living arrangement issues among the elderly needs attention because the welfare of the elderly depends greatly on it.

**AGING IN KERALA**

In India, in 1981, the number of persons over age 60 was 42.5 million; this number is expected to increase to 75.9 million in 2001. The avera e proportion of elderly (over age 60) in India as a whole was 6.3% in 1981; for Kerala, the percentage was 7.6%. Kerala's growth rate was always faster than India's as a whole, until 197.l when the annual growth rate declined. Population projections predict that the elderly population in Kerala will increase from 2.2 million in 1986 to 4.6 million in 2011 to 8.3 million in 2026. Factors which contribute to population aging include 1) decreases in fertility and mortality; 2) decline in the infant mortality rates, from 242/ 1000 live births (l911-1920) to 30/l000 live births in 1985;3) from 1971-t 981, a substantial improvement in the mortality rates for ages 0-14, but only a marginal change among youth and a moderate decline in the middle ages and among the elderly; 4) except for ages 35-39, male mortality rates higher for men than for women; 5) the highest life expectancy in lndia, which is also increasing; and 6) a projected total fertility rate of 2.3 for 19861990. Changes in age composition include 1) the percentage of those aged 0- 14 years declined 42.6% in 1961 to 35% in 1981, and the percentage of elderly increased from 5.8% in 1961 to 7.5% in 1981; 2) in all 3 census periods, 1961, 1971, and 1981, the percentage of females aged 0-14 was smaller than males, but larger in all other age groups; 3) over 80%•of Kerala's elderly population reside in rural areas; 4) projections of population by broad age group betWeen 1986 and 2026 show a continuous decline in the age group 0-14 and an increase among the elderly; 5) in 2026, more women will be i n older age groups than men;6) in 2026, the number of men and women in the working•age population will substantially increase; 7) in 2026, there will be a marked decline in the proportion of children; 8) the youth dependency ratios are expected to decrease from 52.9 in 1986 to 3\_7.3 in 2026, while the elderly dependency ratios are expected to increase from 13 in 1986 to 30.9 in 4026. By 2026, Kerala will have 6.3 million people aged 60-74 and 2 million people aged 75 and older.

**CHAPTER – IV**

**LIVING ARRANGEMENT AND ECONOMIC STATUS OF AGED: A CURENT SCENARIO**

In order to examine the ‘living arrangements and economic status of aged in Mayyil Panchayath’, a sample of 50 aged were drawn from the Mayyil Panchayath. The results of the sample survey are presented in this chapter

**TABLE NO.4.1**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **AGE CLASSIFICATION**   |  |  |  | | --- | --- | --- | | **AGE GROUP OF RESPONDENTS** | **NO OF RESPONDENTS** | **PERCENTAGE** | | 60-70 | 13 | 26 | | 70-80 | 15 | 30 | | 80-90 | 11 | 22 | | 90-100 | 11 | 22 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE NO : 4.1**  **AGE CLASSIFICATION** |

From the table 30% of respondents belongs to the age group 70-80, 26% of respondents belongs to the age group of 60-70, 22% of respondents belongs to the age group of 80-90 and 22% of respondents belongs to the age group of 90-100.

**TABLE NO. 4.2**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **GENDERWIE CLASSIFICATION OF RESPONDENTS**   |  |  |  | | --- | --- | --- | | **SEX** | **NO OF RESPONDENTS** | **PERCENTAGE** | | Male | 27 | 54 | | Female | 23 | 46 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE NO : 4.2**  **GENDERWIE CLASSIFICATION OF RESPONDENTS** |

From the table 54% of respondents are male and 46% of respondents are female.

**TABLE NO. 4.3**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **RELIGION**     |  |  |  | | --- | --- | --- | | **RELIGION** | **NO OF RESPONDENTS** | **PERCENTAGE** | | Hindu | 22 | 44 | | Islam | 19 | 38 | | Christian | 9 | 18 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE NO : 4.3**  **RELIGION** |

From the table 44% of respondents are Hindus, 38% of respondents are Islams and 18% of respondents are Christians.

**TABLE NO. 4.4**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EDUCATIONAL STATUS**   |  |  |  | | --- | --- | --- | | **STATUS** | **NO OF RESPONDENTS** | **PERCENTAGE** | | Illiterate | 8 | 16 | | Primary | 13 | 26 | | Middle | 13 | 26 | | SSLC | 11 | 22 | | HSC | 4 | 8 | | Degree & above | 1 | 2 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE NO : 4.4**  **EDUCATIONAL STATUS** |

From the table 26% of respondents are primary level education, 26% of respondents are middle, 22% of respondents are SSLC level, 16% of respondents are illiterate, 8% are HSC level and 2% are degree & above qualification.

**TABLE NO. 4.5**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **OCCUPATION**   |  |  |  | | --- | --- | --- | | **RETIRED OCCUPATION** | **NO OF RESPONDENTS** | **PERCENTAGE** | | Retired Govt..employee | 14 | 28 | | Retired Private employee | 16 | 32 | | Professionals | 15 | 30 | | Others | 5 | 10 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE NO : 4.5**  **OCCUPATION** |

From the table 32% of respondents are retired private employees, 30% of respondents are professionals, 28% of respondents are retired Govt. employees and 10% are others.

**TABLE NO. 4.6**

**DO YOU HAVE ANY OTHER SOURCE OF INCOME**

|  |  |  |
| --- | --- | --- |
| **YES/NO** | **NO OF RESPONDENTS** | **PERCENTAGE** |
| Yes | 18 | 36 |
| No | 32 | 64 |
| **Total** | **50** | **100** |

**(Source : Primary Data)**

**FIGURE NO : 4.6**

**DO YOU HAVE ANY OTHER SOURCE OF INCOME**

From the table 64% of respondents have not any other source of income and 36% have any other source of income.

**TABLE NO. 4.7**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MARITAL STATUS**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | **MARITAL STATUS** | **NO OF RESPONDENTS** | **PERCENTAGE** | | Married | 14 | 28 | | Unmarried | 13 | 26 | | Widow/widower | 14 | 28 | | Separated / Divorce | 9 | 18 | | **Total** | **50** | **100** |   **( Source : Primary Data)**  **FIGURE No : 4.7**  **MARITAL STATUS** | |

From the table 28% of respondents are married, 28% of respondents are widow /widower, 26% of respondents are unmarried and 18% of respondents are separated / divorce.

**TABLE NO. 4.8**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **LIVING ARRANGEMENTS**   |  |  |  | | --- | --- | --- | |  | **NO OF RESPONDENTS** | **PERCENTAGE** | | Son's family | 13 | 26 | | Daughters family | 11 | 22 | | Own family | 17 | 34 | | Alone | 9 | 18 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE No : 4.8**  **LIVING ARRANGEMENTS** |

From the table 34% of respondents are living with their own family, 26% of respondents are living with their son’s family and 22% of respondents are living with their daughters family and 18% of respondents are living alone.

**TABLE NO. 4.9**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SIZE OF THE FAMILY**   |  |  |  | | --- | --- | --- | | **SIZE OF THE FAMILY** | **NO OF RESPONDENTS** | **PERCENTAGE** | | Small(0-4) | 28 | 56 | | Medium(5-7) | 20 | 40 | | Large(8) | 2 | 4 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE No : 4.9**  **SIZE OF THE FAMILY** |

From the table 56% of respondent’s family size is small, 40% of respondent’s family size is medium and 4% of respondent’s family size is large.

**TABLE NO. 4.10**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DO YOU HAVE ANY HEALTH PROBLEMS**   |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | **AGE GROUP OF THE RESPONDEDNTS** | **NO OF RESPONDENTS** | **PERCENTAGE** | | Yes | 34 | 68 | | No | 16 | 32 | | **Total** | **50** | **100** |   **(S (Source : Primary Data)**  **FIGURE No : 4.10**  **DO YOU HAVE ANY HEALTH PROBLEMS** | |

From the table 68% of respondents have any health problem and 32% of respondents have not any health problem.

**TABLE NO. 4.11**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WHAT MAKES YOU SICK**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | |  | **NO OF RESPONDENTS** | **PERCENTAGE** | | Lack of caring | 9 | 18 | | Problems on your health | 25 | 50 | | Family problems | 8 | 16 | | Due to ageing | 4 | 8 | | Smoking / Drinking Alcohol | 3 | 6 | | Others | 1 | 2 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE No : 4.11**  **WHAT MAKES YOU SICK** | |

From the table 50% of respondents says that problems on their health makes them sick, 18% says that lack of caring makes them sick, 16% says that family problems, 8% says that due to ageing, 6% says that smoking / drinking alcohol and 2% says that others.

**TABLE NO. 4.12**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MEET THE DOCTOR**   |  |  |  | | --- | --- | --- | | **MEET THE DOCTOR** | **NO OF RESPONDENTS** | **PERCENTAGE** | | Once a week | 5 | 10 | | Twice a week | 11 | 22 | | Once a month | 21 | 42 | | Twice a month | 12 | 24 | | Any other | 1 | 2 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE NO : 4.11**  **MEET THE DOCTOR** |

From the table 42% of respondents meet the doctor once a month, 22% meet the doctor twice a week, 24% of respondents meet the doctor twice a month, 10% meets the doctor once a week and 2% says that any other.

**TABLE NO. 4.13**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WHO PAID FOR THE MEDICINE AND MEDICAL CONSULTATIONS**   |  |  |  | | --- | --- | --- | | **MEDICAL CONSULTATIONS** | **NO OF RESPONDENTS** | **PERCENTAGE** | | Self | 10 | 20 | | Spouse | 9 | 18 | | Children | 16 | 32 | | Relatives | 10 | 20 | | Others | 5 | 10 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE NO : 4.13**  **WHO PAID FOR THE MEDICINE AND MEDICAL CONSULTATIONS** |

From the table 32% of respondents says that their children paid for the medicine and medical consultations, 20% of respondents self paid for the medicine and medical consultations, 20% says that their relatives paid for the medicine and medical consultations, 18% says that their spouse paid and 10% says that others

**TABLE NO. 4.14**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **RELATIONSHIP WITH FAMILY MEMBERS**   |  |  |  | | --- | --- | --- | | **RELATIONSHIP STATUS(FAMILY)** | **NO OF RESPONDENTS** | **PERCENTAGE** | | Very good | 13 | 26 | | Good | 26 | 52 | | Fair | 7 | 14 | | Worst | 4 | 8 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE NO : 4.14**  **RELATIONSHIP WITH FAMILY MEMBERS** |

From the table 52% of respondents says that the relationship with family members is good, 26% says that very good, 14% says that fair and 8% says that worst.

**TABLE NO. 4.15**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DECISION MAKING**   |  |  |  | | --- | --- | --- | | **DECISION MAKING** | **NO OF RESPONDENTS** | **PERCENTAGE** | | Regularly | 17 | 34 | | Occasionally | 20 | 40 | | Not at all | 13 | 26 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE NO : 4.15**  **DECISION MAKING** |

From the table 40% of respondents says that they participate the decision makings of their family occasionally, 34% regularly participate the decision makings of their family and 26% not at all participate the decision makings of their family.

**TABLE NO. 4.16**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HEALTH INSURANCE SCHEME**   |  |  |  | | --- | --- | --- | | **HEALTH INSURANCE** | **NO. OF RESPONDENTS** | **PERCENTAGE** | | Yes | 24 | 48 | | No | 26 | 52 | | **Total** | **50** | **100** |   **(Source : Primary Data)**  **FIGURE NO : 4.16**  **HEALTH INSURANCE SCHEME** |

From the table 52% of respondents says that they have not any health insurance schemes and 48% of respondents says that they have health insurance schemes.

**TABLE NO. 4.17**

**SPENDING TIME WITH WHOM**

|  |  |  |
| --- | --- | --- |
| **SPENDING TIME** | **NO. OF RESPONDENTS** | **PERCENTAGE** |
| Spouse | 24 | 48 |
| Son | 14 | 28 |
| Daughter | 8 | 16 |
| Relative | 4 | 8 |
| **Total** | **50** | **100** |

**(Source: Primary Data)**

**FIGURE NO : 17**

**SPENDING TIME WITH WHOM**

From the diagram 48% of respondents says that the spouse spend more time with 28% that their son, 16% says that daughter & 8% says that their relatives spend more time with them.

This chapter helps to identify the problems of the elderly. By analyzing the opinion of the aged regard to the various factors it thrown light on the causes of the problem faced by the elderly in day to day life. It tries to understand the effect of these problems on the elderly persons life.

**CHAPTER V**

**FINDINGS, SUGGESTIONS & CONCLUSION**

**FINDINGS**

1. The demographic profile of the respondents shows that majority of therespondents are in the age group of 70-80, majority of the respondents are male, majority of the respondents are Hindu religion, majority of the respondents have primary education, majority of the respondents are retired private employees
2. 64% of respondents don’t have any other source of income
3. majority of the respondents are living with their own family
4. 56% of respondent’s family size is small
5. 68% of respondents are suffering from any health problems
6. 50% of respondents opinioned that problems on health makes them sick
7. Majority of the respondents meet their doctor once in a month
8. Majority of the respondents opinioned that their children pay their fee for medical consultation
9. Majority of the respondents are of the opinion that they are respected by family members
10. Majority of the respondents opinioned that their relation with their family is good
11. According to majority of the respondents they struggle to adjust with the younger generation
12. According to majoirity of the respondents they partipate in decision making of their family occasionally
13. 48% of respondents opinioned that spouse spend more time with them

**SUGGESTIONS**

1. In order to battle loneliness, the elderly should interact with their families, friends and neighbours.
2. Regular exercise and intake of a balanced diet will go a long way towards helping the elderly maintain its physical fitness and mental poise.
3. The elderly should be considered as human resources and their rich experience and residual capacities should be put to optimum use for the benefit of the family as well as society.
4. The aged should not feel that they are isolated, abandoned and neglected by the society
5. The aged may be involved themselves in some kind of activities like decision making process of the family, carry out some domestic works, socialize the grand children etc.,.
6. The aged have to adjust to the younger generation and curb the conflicts from time to time to have a better life.
7. The saving habit is a key factor to get some kind of confidence to the elderly. So maintain better economic condition can also bring the social and psychological support to lead their last phase of life peacefully.
8. The volunteers of NGSs, day care centers, colleges and schools may provide times demanding care for the elderly those who need real help and also who have been abandoned by the kith and kin.
9. The elderly should be involved in the social programmes on a large scale. Those who are fit and fine should work beyond the age of retirement. They should provide help and support, motivation and guidance to the young generation.
10. Those old persons who are physically and mentally fit should be provided jobs by the government according to their likes and dislikes.

**CONCLUSION**

Though the aged are considered by Economist as consumers than the producers from the income point of view the sociologist consider them as important human beings for strengthening the social institutions in general and family in particular. The aged has plenty of experience, expertise, knowledge and patience to generate human infrastructure facilities by motivating the younger generations in the families. If the aged is consistently provide shapes to the others in the family. This process may be considered as institution building assignments. Insipte of constraints many aged across the world contribute significantly.

The major objective of this study is to examine the determinants of living arrangements, health problems of aged people in the study area. From the study it is found that the major problems faced by aged is health problems and most of them participate in the social and family events. Most of the aged people in the study area struggle to adjust with the younger generations Through the study the researcher found that the saving habit is a key factor to get some kind of confidence to the elderly So maintain better economic condition can also bring the social and psychological support to lead their last phase of life peacefully..

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**QUESTIONNAIRE**

Name :

1.Age: 60 – 70 70 – 80

80 – 90 90 - 100

2. Sex : Male Female

3. Religion : Hindu Islam Christian

4. Educational status : Illiterate

Primary

Middle

SSLC

HSC

Degree & above

5. Occupation : Retired Govt. employee

Retired Private employee

Professionals

Others

6. Do you have any other source of income :

Yes

No

7. Marital status :

Married

Unmarried

Widow/widower

Separated/Divorce

8. Are you living with your

Son’s family

Daughters family

Own family Alone

9. Size of the family

Small(0-4)

medium(5-7)

Large (8+)

10. Do you have any health problems?

Yes

No

11. What makes you sick?

Lack of caring

Problems on your health

Family problems

Due to ageing

Smoking/Drinking Alcohol

Others

12. How often you meet the doctor for checkups and for consultation

Once a week

Twice a week

Once a month

Twice a month

Any other

13. Who paid for the medicine and medical consultations?

Self

Spouse

Children

Relatives

Others

14. Do you get respect f from family members?

Yes

No

15. How is your relationship with family members?

Very good

Good

Fair

Worst

16. Do you feel that you have struggled to adjust with younger generation?

Yes

No

17. Do you participate the decision makings of your family?

Regularly

Occasionally

Not at all

18. In your family, who spend more time with you?

Spouse

Son

Daughter

Relatives

19. Do you have any health insurance schemes ?

Yes

No