Changing perceptions of elderly living in care homes

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SUBMITTED BY

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DECLARATION

I, **Ms. Akshaya krishnan,** do hereby declare that the Dissertation titled

"Changing perceptions of elderly living in care homes"

Is based on the original work carried out by me and submitted to the University of Kerala during the year 2015-2017 towards partial fulfillment of the requirement s for the Master of Arts Degree Examination in Sociology. It has not been submitted for the award of any Degree, Diploma, Associateship, Fellowship or other similar title of recognition before any University or anywhere else.

Thiruvananthapuram **Ms. Akshaya Krishnan**

18th August, 2017

CERTIFICATE OF APPROVAL

This is to certify that the work embodied in this dissertation entitled **"changing perceptions of elderly living in care homes."** has been carried out by Ms. **AKSHAYA KRISHNAN.** of Fourth semester, Master of Sociology student of this college under my supervision and guidance, and that it is here by approved for submission.

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18/08/2017 ***Ms. AKSHAYA KRISHNAN.***

MA SOCIOLOGY

CONTENTS

ABSTRACT

Changing age structure is one of structural change that witnessed in the last century. Population ageing is one of its consequences, which emerges as a global phenomenon in the present day. It is generally expressed as older individuals forming large share of the total population. This process is considered to be an end product of demographic transition or demographic achievements with a decline in both birth and mortality rates and consequent increase in the life expectancy at birth and older ages

In large joint families, our grandparents always enjoyed centre-stage; they were consulted by their adult children, loved and respected by their grandchildren. however, today much of this respect for elders have withered away. Today, as the number of elderly in India touches 100 million, this figure, gives us no reason to celebrate. Even in rural areas the changing family patterns with younger people migrating to cities in search of work, a large number of elders are being left alone, ill-equipped to meet the debilitating effects of advanced age. The lives of many older people are more frequently negatively affected by the social and economic insecurity that accompany the demographic and developmental process (World Bank, 2000). The growth of individualism and desire for the independence and autonomy of the young generation (Serow, 2001) affect the status of the elderly in the country. This is one of the many reasons for large number of old age homes in the country.

The paper highlights the changing perception of elderly of being in care home. From the five cases researcher can concluded that there is change in the concept of elderly being in care home.

INTRODUCTION

INTRODUCTION

Changing age structure is one of structural change that witnessed in the last century. Population ageing is one of its consequences, which emerges as a global phenomenon in the present day. It is generally expressed as older individuals forming large share of the total population. This process is considered to be an end product of demographic transition or demographic achievements with a decline in both birth and mortality rates and consequent increase in the life expectancy at birth and older ages

The Indian aged population is currently the second largest in the world to that of china with 100 million of the aged. The absolute number of the over 60 population in India will increase from 77 million in 2001 r of the over 60 population in India will increase from 77 million in 2001 to 137 million by 2021(Syam Prasad 2013)

This ever increasing number of elderly in the country is a concern for both academicians and policy makers. There are numerous problems that need to be addressed urgently with this changing demographic structure

STATEMENT OF THE PROBLEM

In large joint families, our grandparents always enjoyed centre-stage; they were consulted by their adult children, loved and respected by their grandchildren. however, today much of this respect for elders have withered away. Today, as the number of elderly in India touches 100 million, this figure, gives us no reason to celebrate. Even in rural areas the changing family patterns with younger people migrating to cities in search of work, a large number of elders are being left alone, ill-equipped to meet the debilitating effects of advanced age. The lives of many older people are more frequently negatively affected by the social and economic insecurity that accompany the demographic and developmental process (World Bank, 2000). The growth of individualism and desire for the independence and autonomy of the young generation (Serow, 2001) affect the status of the elderly in the country . This is one of the many reasons for large number of old age homes in the country.

The percentage of the aged in Kerala was 5.83 in 1961. In 1991, this rose to 8.82 per cent - higher than the national figure - and became 9.79 per cent in 2001. Going by this trend, the aged in Kerala will constitute 16 per cent of the total population by 2021 and 20 per cent by 2026. a recent study by Help Age India conducted in the year 2014 concluded that Kerala, among all the States, has the maximum number of old-age homes. Generally Misbehaviour of children, financial crisis often lead to feeling of ignorance and lack of emotional support in elderly which often compel them to opt other places for living a problem free life. And, in present scenario along with other reasons Old Age Homes are being considered as a better alternative to reside. (Tiwari,1994).

Many studies which was published in the early 20th century has generally pointed out to similar reasons for elderly living in a old age home. Recently, the researcher while in a visit to an old age home could observe that there are certain contradictions in this convectional existing images of reasons of elderly living in old age homes. Some of the inmates volunteerlily left there home to be in the old age home , which has shocked the researcher. This has stimulated the curiosity in the mind of researcher for a contemporary analysis of how elderly view about living in an old age home. What are the variations from the convectional reasons identified ?What are the reasons for this variations? Sothrough thisstudy the researcher proposes to look at What are the Changes in perceptions of elderly for being in care homes today?

SIGNIFICANCE OF THE STUDY

The theme ageing is as old as human life span. Old age was a themein stories, myths and cultures of societies. Plato argued that the wisest men should serve as guardians of societies, since education would not bring its 'full harvest' until the age of fifty. Aristotle also iscussed the subject of age; it was a theme in Shakespeare's sonnets as well. According to Hindu mythology, the Lord Krishna advised The Gīta to Arjuna at the age of 125 years. The Bible says that Adam lived for 930 years and Noah for 950 years. Moses could see well, even at the age of 120 years. Between the sixteenth century and the third quarter of the twentieth century, western ideas about ageing underwent a fundamental transformation spurred by the development of modern society. Ancient understandings of ageing as a mysterious part of the eternal order of things gradually gave way to the secular, scientific and individualistic tendencies of modernity. Old age was redefined as a problem to be solved by science and medicine.8 This scientific attitude to the theme proclaims it as a twentieth century phenomenon. The British Society of Gerontology provided a multidisciplinary forum for the researchers in the field of ageing.

Gerontology was the scientific approach to all aspects of ageing; and geriatrics was the branch of gerontology and medicine concerned with the health of the elderly in all its aspects preventive, remedial and rehabilitative. According to Nathan W. Shock,

"Gerontology is a scientific study of the phenomenon of aging. By aging, we mean the progressive changes which take place in cell, tissue, and organ system, a total organism,or a group of organisms with the passage of time. All living things change with time in both structure and function, and the changes which follow the generaltrend constitute aging".Gerontology is a multi disciplinary field of investigation, which has three core components: the biological, the psychological and the social. The biological seeks the impact of physiological systems, psychological about mental function and the social covers the social aspects of ageing. The study of social dimensions of ageing is usually referred to as social

gerontology, to which the present study belongs. Three distinct approaches to the study of social aspects of ageing (social gerontology) are discussed by Ward.10 The firstone examines ageing as an individual experience by investigating such topics as changes

in perceived age identity as the individual progresses through the life course. The second approach examines the social context that defines ageing and seeks to understand the position of the elderly within society. The third one is the examination of societal consequences of ageing. The present study belongs to the second approach which says that ageing occurs within a social context that ranges from the micro scale of the family to the macro scale of the society. It considers ageing as a social phenomenon taking place within a social context and exerts various constraints upon the individual. And the social context that defines ageing allocates the position of the elderly in a particular society. It would be the result of the interaction between the individual and the society where he/she exists and what the conception of old age in that society was. The study does not neglect the other approaches of social gerontology, for example, it considers societal consequences like demographic transition as factors for the changed concepts of old age.

Social gerontology does not possess an extensive theoretical frame work in its own right. This failure to formulate a systematic theory of social ageing is explained by Christina R. Victor. According to her, social gerontology has not been immune from the broader sociological paradigms such as social interactionism, exchange theory and functionalism. While not a specific theory as such, the consideration of old age as a social problem was first carried out in Britain.12 The reason behind this consideration is explained in terms of three interrelated factors: old age as a contributing factor to poverty, economic difficulties and changes in methods of production combined to drive many older workers into retirement, and concentration of the elderly in rural location by the migration of youngerpeople.13 In short, sociologists say that old age as a social problem or a prejudice against the old did arise as a result of societal changes due to the modern growth.

In the present scenario of ageing population ,elderly and old age are heated topic for policy makers, academicians,and general public. How to cop up with this transformation of social structure is a question that is not answered properly even today. With changing values and the emergence of new ones a contextual analysis of a social situation has its relevance. Within this frame this study trying to sketch out the variations from the conventional idea of ageing has a lot of relevance. Findings of this study may contribute to the disciplines of Sociology,

Gerontology,Geriatrics etc.It may also help the general public in gaining a better understanding about elderly in the state and the changes.

RELATED THEORIES

Disengagement Theory

One of the earliest theoretical perspectives used by gerontologists was disengagement, which was originally formulated by Cumming and Harry. In the simplest form, this perspective states that independent of other factors such as poor health or poverty, ageing involves a gradual but inevitable withdrawal from interaction between the individuals and their social context. Here the individuals prepare themselves for death; the society also prepares them for the later phases of life, by withdrawing the pressure to interact. The end result is that the elderly person plays fewer social roles and experiences deterioration in relationships. Central to this theory is the assumption that the disengagement of elderly is a necessary condition for both successful ageing and the orderly continuation of the modern society.

Activity Theory

Opposed to the notion of disengagement is activity theory developed by Havighurst. It says, normal and successful ageing involves preserving, for as long as possible, the attitudes and activities of middle age. To compensate for the activities surrendered with ageing, substitutes should be found. Central assumptions of activity theory are: life satisfaction, which is related to social integration, and role losses such as retirement which are inversely co-related with life satisfaction.

Development Theory

Developmental theorists argued that rights of the aged are not with disengagement or activity theories. Rather, a diversity of approaches and adaptations to the problem of ageing will be displayed, depending upon the history of the older person. Central assumption to this theory is that old age is the time of summing up of one's life: what he/she achieved and not achieved during his/her life .So for a successful ageing, current life style must be in terms of earlier history.

Continuity Theory

This theory does not assert that one must disengage, or become active, in order to cope with ageing. Rather, the decision regarding which roles are to be disregarded and which are to be maintained will be determined by the individual's past and preferred life style. Those who prefer to be active will do so and those desire lower levels of interaction may do so.

These theories appear to be prescriptive recommendations about how to live old age in a modern society. Besides them, the theories like symbolic interactionism, labelling theory, exchange theory and age stratification approaches are for viewing ageing by more positive attitudes and overcome the negative stereotypes of old age.

Later, Cowgill and Holmes stated modernization theory15 in 1972, in order to explain that there is a tendency for the status of the aged to decline when a society's degree of modernization increases. As the societies become more complex and technically sophisticated, the status of the elderly declines. In 1974 Cow gill16 began an inquiry into the factors that cause such a phenomenon. His theory asserts that certain aspects of modernisation are more important than others to place elderly at a disadvantage. These factors are:

(a) the development of modern health technology, (b) modern economictechnology, (c) urbanization, and (d) education.17 So the influence of an increasing degree of modernization on the status of the elderly can be known by assessing such factors of the particular social context. This is what the present study is aiming for. While considering the traits of modernization, India is a fast developing country. One of its smallest states, Kerala is ahead of the rest of the country in fertility transition by 25 years. The modernization theory is applicable to this situation in such a way that, as the society of Kerala becomes more complex and technically sophisticated, there is likelihood for the status of the elderly to decline. This is the hypothesis that the present study holds as the reason behind the changed conception of old age in Kerala today.

Chapter 2

LITERATURE REVIEW

Old age is not a new phenomenon; it is as old as human society. Theterm ‘age’ means the length of time for which a person has existed and if that existence is for a long time, the society considers him as ‘aged’. The aged is defined in various ways. According to internationally acceptеddefinition; an aged is one who is sixty five year of age or above. In India,however, all persons who are sixty years or above are included among the aged. This study refers the Indian definition and included those who aresixty years or above at the time of the survey as aged. Ageing is thebiological process of getting old. It is the terminal stage of one’s life cycle,accompanied with decreasing energy and body resources with infirmitiesdue to the decaying and weakening of one’s bodily organs. According to thehuman growth and developmental chart, old age starts from sixty years tilldeath. But being sixty years old today is different from what it was beingsixty years old a century back. In earlier times, ageing as a social problemdid not preoccupy the society. The few who lived over sixty years wereconsidered as the repositories of wisdom and sole authorities to the familyand the community. The notions of vānapṛasta and sanyāsa were the socialmechanisms that encouraged the aged to move away from the managementof everyday concerns. The joint family easily accommodated the old and thedisabled. The economy that was organized around agriculture provided therole differentiation in the community, which offered a respectful space forthe older generation. This situation changed by the intervention of moderninstitutions in the everyday affairs of human life.

systems are different in some ways from each other. A widely acceptedThe benefit of western medicine and the advancement of scienceand technology created tremendous changes in social living. Increase in lifeexpectancy resulted in an increase of greying population making it a socialissue to the present society. Commercialized agriculture and marketoriented economy provided fewer roles to the aged. The break-up of jointfamily into nuclear family made it incapable to accommodate the old dueto the pressures created by the demands of a modern urban andindustrialized lifestyle. Accommodating and providing greater recognitionfor the distinctive interests and needs of the old was difficult in thissituation. Emergence of old age homes thus became an alternatearrangement for the care of the elderly. And the availability of the homenurses was of increasing importance in this situation. By 2030, when thelast of the baby boomers--the generation born between 1946 and 1964will become the senior citizens, people over 55 will constitute one third of the population3, and the issue of old age will turn out to be a crucial one forthe society.

By considering these changes, it can be said that the 'shift in socialconception of old age' lies somewhere in between the two systems ofliving--traditional and modern--where the values and world views of thethesis of Stearns4 says that in preindustrial societies the aged weregenerally better provided for, and given a more central and active role infamily and community life. As one moves from this type of society throughthe transitional stages of modernization, a consistent decline will occur intheir social well-being. Thesocial,economic, cultural and political aspectsof tradition and modernity created impacts on the social conception of oldage. In both the situations, old age is a socially constructed reality, which can be justified by the fact of their social relativity to specific socialcontext. The sociology of knowledge is concerned with the relationshipbetween human thought and the social context within which it arises5. Inorder to understand the concept of old age in each of the system of living,various aspects such as social, economic, cultural and political of therespective contexts need to be studied in detail. thesis of Stearns4 says that in preindustrial societies the aged were generally better provided for, and given a more central and active role in family and community life. As one moves from this type of society throughthe transitional stages of modernization, a consistent decline will occur intheir social well-being. The social, economic, cultural and political aspectsof tradition and modernity created impacts on the social conception of oldage. In both the situations, old age is a sociallyconstructed reality, whichcan be justified by the fact of their social relativity to specific social context. The

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As more people grow into old age, the field of gerontology become an area of inquiry of increasing importance. The British Society of Gerontology established in the year 1973, provided a multi disciplinaryforum for researchers in the field of ageing. Since then, there is no dearthof articles and books on gerontology, which covers the contributions of biological, psychological and social perspectives of ageing. As the presentstudy belongs to the social aspects of ageing, the literature on socialgerontology is of particular interest here. Most of those literatures are about the western society and is reviewed here.

India is a developing country where the degree of modernization,specifically the number of old people is increasing day by day with betterhealth, medical facilities and reduction in death rates. This increasing trend imposes the need for studies and surveys about this particular group. Thereview of literature, which belongs to social gerontology from Indiancontext, is also important for this study. It is projected that by the year2025, one in every five persons would be a senior citizen in Kerala. But it has only been a short time since the issue of old age has become a majortopic of discussion; and hence, the studies are less in number. However theavailable writings are reviewed here.

Literature of Western Context

The study of the social dimensions of ageing is incorporated withthree distinct approaches: ageing as an individual experience, ageing withinthe social context, and the societal consequences of ageing. The literaturefrom the western social context has either covered all the three approaches in one study or in separate studies. However, the field is advanced with agood number of studies in the social aspects of ageing. The studies thatexamine ageing as an individual experience are investigating them from alife course perspective. Some of them relate the psychological impact on anindividual to the social aspects of ageing. The literature survey is arrangedhere in such a way that the first portion is covered by the literature onindividual approaches of social ageing, then the societal consequences ofageing and lastly to the social aspects of ageing.

Sheila M. Peace in Researching Social Gerontology (Concepts,Methods, and Issues) says about the dependency, support and construction of ageing in its social aspects. The relationship of chronological age anddefinition of social and biological age is described here. One of thedifferent concepts of age explained is 'social age', which means that theage of an individual must be something that can be measured at a point intime. Social age may increase from stage to stage as time goes by whereasother social measures may fluctuate. The distinction between quality of lifeand standards of living suggests that quality of life is a multidimensionalconcept, which cannot be defined in a single way. Peace highlighted thecomplexity of the concept that both are constructed and perceived, and theimportance of considering both subjective and objective forms ofmeasurement.

Irene M. Hulicka conducted an empirical study in the Psychologyand Sociology of Aging. It is purely a quantitative analysis, which clearlyanalyzes demography, intellectual functioning, perceptual functioning,learning, memory, problem-solving and creativity, life satisfaction and adjustment to ageing, work and retirement. This book discusses how theprocess of ageing and behaviour of older people are connected. There are surveys, which showed the impact of environment on old people. Theinfluence of improved physical and social environment appeared not only in the increased satisfaction of residents with their living situation but alsoin more favourable attitudes about themselves and towards others, in moreactive and social patterns of life, and in signs of improved physical andmental health. About the

attitudes of the aged towards euthanasia, Irenepointed out that their religious faith is an important consideration.

The need of casework with the ageing is emphasized by Edna Wasser in Creative Approaches in Case Work with the Aging. It views ageing as part of the continuum of life-long, interconnected experiences.Most elders are coping with and adapting to the changes of advanced years within the range of their capacities and resources while many do not. This creates the need of a caseworker. The concepts of the individual life cycle, individual development, developmental tasks and the interrelatedness of the various stages offer a substantial framework for the caseworker inunderstanding and relating to the ageing person. The role of the familyagency is to specify the need of elders to give proper guidance. Theservices rendered by the volunteers, homemakers and supplementaryservices are also well defined. Marriage counselling for the aged client andthe treatment of marital conflict are fruitful. The central concept used hereis to prepare them to have a marital balance, which can be disrupted bymany factors such as retirement and lowered income, inevitable organic,

sexual and psychological changes of old age. Group approaches are alsofound useful if it can be done by a trained social worker. The client who issuffering due to various reasons can be empowered to strengthen hiscapacity to cope with his environment and regain his sense of control and mastery. The affirmative approach to old age is the theme, which runs throughout in Aging and Mental Health: Positive Psycho-Social Approacheswritten by Butler and Lewis. Here, the elderly give three messages to thesociety. The first one is that they want to take their own decisions about theirlives, the second is that they want to continue to be involved in life, and thirdly, they want to be treated with dignity. Old people need freedom, encouragement to move in new directions, autonomy and independence, and they treat these as precious commodities for them. The authors conclude the book by saying that the physical, cultural, social and economic aspects of old people's lives will be considered as intricatelywoven into their mental conditions.The book, Becoming and Being Old-Sociological Approaches to Later Life by thewayand others set the study in three approaches:becoming old, being old, and old age. It is to promote the study of the aged which relates to both 'the realities' and 'the ideologies' of ageing experience. The title, 'Becoming and Being Old' means that in the course of life, people become old and thereafter remain old. The process of becoming and the status of being old is described in the book. It analyzes how the people who are approaching pensionable age handle the process of ageing and face the transition from work to retirement. The book also discusses how they cope with the negative

connotations of retirement and part leisure in their response. Relating different life styles in old age in different social classes concerns the process of being old. Defining concept of old age is another aim of the study, and the concept is placed in the complex interplay between institutions, belief and personal experience. In his book, The Aging Experience- An Introduction to SocialGerontology, Russell A. Ward says that though human behaviour is multifaceted, a multidisciplinary approach can only satisfy the gerontological studies. Growing old is not and cannot be the sameexperience in different societies, or even in the same society. There are many factors that shape happiness and unhappiness in old age. Two major ideas conveyed in the book are: first, all societies can be characterized by their age stratification systems, which result in age-differentiatedexpectations, sanctions, and rewards. Second, ageing person interprets the experience according to the symbolic meanings available to him or her. Jayconsiders 'sociality' as a major component to the meaning of good old age, which consists of five themes- social connectedness, state of mind, leisure, confidence and enjoying life, which are socially positive.

The book Gender and Later Life-A Sociological Analysis of Resources and Constraints by Sara Arber and Jay Ginn25 aims to provide a better understanding of gender differences among the aged. The high proportion of elderly women who live alone is a historically unprecedented situation. The book examines the position of elderly women and thecultural stereotypes, which affects older women where the 'compassionate ageism' gives way to 'conflictual ageism'. The resources preventing dependencies are analyzed at four levels: resources possessed by the individual elderly person, elderly person's household, available from the community (family members, friends, neighbours etc.), provided by thestate in response to need. Comparisons are drawn between U.K. and U.S. for differences in their personal income in terms of their earlier roles in production and the labour market. Gender differences in life expectancy,health, disability and institutional care are also examined.Rosemary Bleisner and Victoria Hilkevitch Bedford in Aging and the Family analyze both traditional topics such as marriages, parent-child bond, and sibling relationship and newer topics such as feminist analysis offamily relationships, nonmarital partnerships and the interface between the family and long-term care institutions. It also points out that family relations in old age are shaped by the intersecting influences of individual life experiences, historical events and social and economic conditions. The nature and timing of life transitions (marriage and retirement) affect relationships within and between generations may also vary across time. Family development theory, family stress theory, and critical

theory are used as fruitful approaches to studies of ageing. Bedford has analyzed the theme of life course continuity, as it is echoed with special reference to sibling relationships. Julia Johnson and Robert Slater in Aging and Later Life 27 consider themselves as the part of an ageing society. According to Britain's census report, elders will cover 18 per cent of the population in 2031. Not a matterof statistics, but the experience of ageing and old life is highlighted in thebook through a collection of personal accounts. They included first handaccount of older people, because those who are younger have not had the same experience of age. How the images are created and how far the behaviour in later life influenced by the labelling and stereotype is included under the heading 'Images and Identity'. The authors have also dealt with topics such as ill health and well-being, intervention and therapy policy and politics etc. They formulate a concept of ageism and the essential feature ofit is the contrast between 'us' and 'them'. The quality of life and life satisfaction is also well described. They documented some of the many changes currently affecting the lives of older people: the privatization of welfare, the development of markets and changing patterns of retirement. It is a multidisciplinary work and covers many aspects which are notcommon, but relevant to practice. Ingrid Arnet Connidis, in Family Ties and Aging28 has attempted to weave the vast range of information about the many facts of family relationships and ageing into a critical, comprehensive and integrated whole. The life experience of any age group are so closely tied to the family that the examining of such ties can lead to a better understanding of later life. Most relationships in old age are a continuation of those begun in earlier life; however, changes also occur in response to other changes associated with ageing. Connidis made five theoretical assumptions to explain the family ties in later life. First, the family ties of later life are best understood in the life course perspectives; they represent both continuityand change. Second, understanding the family ties of older persons require examining relationships, not only families, but also both older and younger persons to give and receive in their familial relationships. Third, family membership should be defined broadly and not restricted to a traditional notion of what constitutes family. Fourth is the arrangement of social life. The fact behind this search is the importance of individual persons who have the ability to act on their own behalf and the influence on one's position within the social structure. Fifth, the meaning of family at both the cultural and individual level is an important facet of understanding how ties are both negotiated and evaluated by family members and by others. The impact of divorce and remarriage on intergenerational relations is also well treated by Connidis. The study about sibling ties in middle and later life shows that it has significance ties for women, especially those who are

not married and the childless. Among divorced adults, the absence of a spouse may lead to re-establishing sibling bonds earlier than usual. Connidis also recommended a need for greater recognition of the obligations of family members caring for older persons. Jon Hendricks, in The Ties of Later Life30, says that having ties with children or grand children are important sources of support and affirmation. It pronounces that families are responsible for the needs of the elderly. In reality the responsibility falls on the shoulders of the family's femalemembers. With longer lives come more extensive kinship networks, and more grand children know their grand parents while all those in the middle try to balance obligations to both generations. In later years, there is need for mutual accommodation. The interaction between grand parents and grand children is a significant source of emotional satisfaction for both generations. But three types of styles and strategies of grand parenting that have been noted are: detached, passive and active. The interaction between step grand parents and step grand children may need to be dealt with counselling or educational settings which include role clarity, relationshipquality, behavioural expectations and contact.

In the book, Family Care Of the Elderly-Social and Cultural Changes, Jordan refers to Cowgill and Holmes in order to show that the dependence of the aged has shifted from the family to the State in modern societies. This dependence covers other areas of life such as housing, transportation, nutrition, health care and so on. According to Jordan, we are moving toward a 'world community' and so no country is immune to the impact of other countries, however close or far away. So the study about the family care of the elderly in sixteen countries is a great revelation as a means of adaptation. Ellen Rhoads Holmes and Lowell D. Holmes, the authors of the book, Other Cultures, Elder Years are anthropologists who are interested in gerontology say that it is a discipline that must take all people and all cultural traditions into consideration if we are to contribute to an understanding of the process of human ageing. The authors concerned the modernization influences in developing countries and its effect on the status and role of the elderly. Because change is an on going process in all societies, the impact of cultural change on the elderly is clearly noted. The book explains how the cultural tradition shapes the needs and roles of seniors. The other concern is with change, especially modernization and accompanying demographic change, and its effect on the status and wellbeing of the elderly. James A.Thorson, in Aging in a Changing Society tries to figure out the massive population shift, which the world is experiencing, as a revolution unprecedented in human history. Until the 20th century, the worldwide pattern showed women bearing many children, a few of whom lived adulthood, and fewer lived up to

old age. Not only the number of older people has been increasing, but the ways in which different generations see the world have been changing as well. The physical as well as the psychological process of ageing and the health care system is well explained in the book. The topics are more applied than theoretical.

Old age in Modern Society by Christina R. Victor35 presents ageing in modern society as a richly diverse experience. This book covers the social aspects of ageing by incorporating three distinct aspects of ageing. Ageing is considered as an individual experience, by investigating such topics as change in perceived identity as the individual progresses through life. The second aspect is the social context that defines ageing and seeks to understand the position of the elderly within the society. Third, the author examines the societal consequences of ageing. So the book finds the factors such as age, sex and social class contribute to make the elderly a heterogeneous segment within the total population. The author suggests that the main goal for an ageing society must be to replace notions of independence and dependence with a social framework, which emphasizes interdependence between generations.

Gail Wilson, Understanding Old Age-Critical and Global Perspectives36 aims to look more critically at knowledge of old age and to consciously correct some biases, which inform current discourses on ageing. This book provides a comprehensive overview of ageing as seen from a global perspective. The elders themselves see health as the main determinant of the quality of their lives. The present situation considers older men and women as consumers and providers of services. This book society and the author proposes an increase in equality in ageist society. Exposing the ageist and sexist assumptions lying mainstream demography and economics, the author presents a more balanced view of ageing of world population. Wilson also explains how a shrinking world in terms of communication has changed the lives of older migrants. There are different forms of migration in later life as a challenge to dominant discourses—the conservative, passive and unadaptable.

Indian Literature

India is a fast developing country where the degree of modernization and rapid economic growth affect the status of the elderly. India has the second largest number of old people in the world as the elderly are the fastest growing age group and their population will reach 179 million by 2026. Recent books and articles are evidence of this. The main focus of Indian literature consists of suggestions to cope with the ageing scenario. Some of them are creative approaches towards understanding problems of the aged and planning for their rehabilitation. The review of Indian literature is provided here to check what the main agenda from the area of social gerontology. Most Indian writings are on the population explosion of the greying generation, which is also a global issue of the present century. In Aging in Indian Perspective-International Conference on Aging in India, Vinod Kumar compiled different sessions of the seminar on epidemiology, demography, and ecology of ageing. It gives an overview of conditions prevailing in different parts of India, both urban and rural and highlights important geographic differences. Methods and provision of care and services for elderly from different parts of India also have been mentioned. The influence of socio-economic status on various type of morbidity is clearly mentioned. Different coping mechanisms and resources are described as that may help the individual in various settings. The book has emphasizes the need to consider the age-old traditional wisdom, while making patterns of leisure and recreational activities as the new approaches towards coping with problem of the elderly. The problems of aged women, who are currently regarded as a vulnerable group, are well described. Section on biological gerontology includes papers on mechanism of ageing and development and the biological basis of anti-ageing agents as investigated inside well-equipped laboratories. This publication may be regarded as a rare collection of numerous multidisciplinary observations from different parts of India and from other countries like U.S., U.K, Sweden, Zimbabwe, Egypt, and Romania etc.

Srivastava in his book, The Aged and the Society compiled the outcome of a socio-economic study conducted in some selected areas of Delhi, covering a wide socio- economic spectrum. The study was carried out in order to identify programmes, services and assistance needed for utilizing the skills and experience of the aged so that they become more useful to society. Much has indeed been written on the humanitarian aspects of the elderly, such as Medicare, old age homes, counselling and community centres.

In The Rural and Urban Aged, Maninder Singh Randhawa has attempted to scientifically investigate the various sociological aspects of ageing in both the rural and urban areas. In the rural communities of India, the joint family system is still prevailing to a large extent and such families do not throw the aged to the mercy of the society. There the aged participate in productive activities as much as they can. So the elders in rural communities still enjoy a high status and play a major role in decision making. According to Singh, the aged in the urban area also enjoy a fairly high status in their families and the so-called problems are only a trend. The major problems arise due to the abrupt retirement from an occupation, which is considered as a normal phenomenon of modern industrial society. He quotes Burgess, who points out that the increasing problems of ageing in an urbanized society are: difficulty in finding satisfying and substitute activities, economic security, loss of status, decreasing social participation in organization, greater unhappiness and maladjustment, loss of health and illness. Singh concludes that the aged with higher education and economic status enjoy a leadership position in their families in both rural and urban areas. Pati and Jena in Aged in India, have attempted a multidisciplinary approach towards understanding of the problems the aged and planning for their rehabilitation. The social concepts include transition in social positions, roles, status and characteristics of person. Mohanty says, to know how to grow old is the masterwork of wisdom and one of the most difficult chapters in the great art of living. Jamuna44 likes to make use of the rural elderly women as resource persons to the communities around and consider them as assets rather than liability. Counselling is also an important measure to the +older individual to minimize ruptures with children or younger members and to keep their social relationships in constant repair. The book gives guidelines to planners and social workers for developing action programmes for the cause and care of the elderly population both in rural and urban areas of the country.

Aging in India is research conducted by Kirpal Singh Soodan pertaining to the aged in the city of Lucknow. His demographic analysis shows gradual increase in number of aged. He compares the educational level, the age of migration to the city and their economic dependence. He found that the majority of the aged spend their free time doing odd jobs connected with household work, looking after children and ‘doing nothing’. Free time pursuit of men was solitary in nature, while women spent free time in interpersonal activities. Information about the available welfare services was also a major concern of this study. Shrinivas Tilak46 in his study Religion and Aging in the Indian Tradition has emphasized the traditional Indian views on ageing and collected the rich reflections of human experiences.

He has analyzed this through the dialectical relation of Vedic religion, Buddhism and Hinduism and the concerns of various genres of texts İndia's Elderly- Burden or Challenge? by Rajan et.al. explores the widespread feeling that the elderly are becoming a burden in Indian society. It is a demographic survey that cautions us about the implications of increasing elderly population in a developing country like India. The statistics of social conditions, economic conditions and the available social policies are meticulously presented in the book. For the authors, the situation in general is worse for the female elderly compared to their male counterparts. This is substantiated by several case studies and group studies in this direction. The book will enlighten policy makers and researchers about the needs of the elderly. A Study of Some Related Factors Related to Adjustment of Urban Aged Men, a doctoral dissertation by Ramamurti studies the impact of socio-economic status on the adjustment of elderly. It reveals that the higher income group people are better adjusted than the lower income group people. Family jointness, family and social integration among the elderly by Venkoba Rao studied psychiatric illness of the aged in the context of different living arrangements. It concludes that living within the family does not ensure a healthy integration. In No Aging in India- Modernity, Senility and the Family, Lawrence Cohen puts forward a post modern approach. It is an ethnographic study, which freely draws upon post modern social theory and helps one to understand how social theory brings to bear on how field work is conducted. It offers views on current debates on old age in India. By adding 'No' to the title 'Aging in India', Cohen suggests certain differences in approach towards old age. The reason behind such a title is to inform that the aged too can cause radical transformations and can articulate collectivities and polities in society. Dependent person also possesses power in a particular space, or silence too speaks. By presenting this type of argument the book says there is no ageing in India, aged too have power in their own space, a postmodern argument.

Understanding graying people of India by Arun P.Bali is the edited work of many articles on social aspects of ageing. Among them, the study by K.D Gangarade deals with the emerging conception of ageing in India. It is a micro study that deals about the historical shift of Indian

tradition towards modernization. The study analyses the social factors of tradition and modern settings. It is an effort to find out the conceptions of ageing in respective contexts. It explains the importance of traditional Indian value system, which can support the authority of elders and sanctity of tradition. There the individual life span was encircled by the concentric

zones of family, caste, village community and the social control being exercised by religion. Indian society has been undergoing rapid transformations under the impact of several forces like industrialization, urbanization, education etc. This situation encourages the nature of rationality and the right of individual conscience. It encourages the task of national insurance, guaranteeing the basic subsistence to all: the orphans, the disabled, the aged, and the widows as well as temporarily unemployed. This study is very similar to the present study because it tries to define the concepts of ageing from the social context.

Literature from the Context of Kerala

Even though, one of the smallest states of the country, Kerala is ahead in the awareness about old age as a serious social problem. Ever since development planning was initiated in independent India, the state has recognized older persons as a priority target group for social welfare action. Here the literature on gerontology is mainly about guidelines to face old age graciously. It does not examine the social context which defines ageing as a social problem today. Most of the available literature in Kerala covers the societal consequences of ageing, and is reviewed here.

A survey of the old age homes in Kerala by Irudaya Rajan considers population ageing as the ultimate consequence of demographic transition. It assesses the ageing scenario in Kerala by districts and the profile of existing old--age homes in Kerala. Needs and Problems of the aged: A Study in Kerala by Nayar studies the problem faced by the aged parents in Kerala. It states that the isolated parents due to the migration of younger generation are the present social problem here. The articles in Kerala Sociologist by Jacob John Kattakayam, S.Saraswathy, Pushpa Mary Rani, Merlin J.N and Abraham Vijayan studied the various aspects of elderly population in Kerala, mainly the impact of modernization, institutional care, elderly abuse, health aspects and the challenges of ageing in the twenty-first century. Another study about the Pattern of Living Arrangement of Elderly Women in Kerala by Kattakayam has compared the anticipatory socialization of elderly women between those institutionalized and those living in families. It argues that the elderly of today do a lot of mental exercises on various patterns of living arrangements and choose the best according to their socio-economic conditions. But it has been done only by a section of the society. Adjustment and Its Correlates in Old Age: A Study in Relation to Living Arrangement, a doctoral Dissertation by Cherian, is the study on adjustment and its correlates in old age, it provides information regarding the differences in adjustment of the elderly living in varied (home) living arrangements.

Vṛuddhasadanam, a novel in Malayalam, by T.V.Kochubavaprovides good evidence about the development of old-age homes in the social context of Kerala. It says, the Vṛuddhasadanam(old-age homes) were the immediate need of the society then. In the novel, society is pictured in such a way that the ‘old’ has no role in the family or in the society.

They get marginalised, and are becoming a burden to the rest of the society. The novel says, the old age homes for the old are not the idea of old, but of the rest of society who take decision for the old. It gives the impression that the modern world is not for the 'old'. But when we read the novel with a reflexive mind, it gives certain post modern concepts of uncertainty towards the reality. Dynamics of Migration in Kerala: Dimensions, Differentials and Consequences by Zachariah, Mathew and Irudaya Rajan is a book about the relatively new development in Kerala: the migration that began to take place mostly since the 1960s. After independence of India, out-migration increasingly became a way of life for the educated youth of Kerala. Hence, an emerging problem is the care of the elderly in families from which the youth and the middle-aged have migrated, leaving their parents alone to take care of themselves. The year 1999 was the year of the elderly, and since then the problem of the elderly received considerable attention in the Government circles and by the academicians. The section of the book 'Migration and the Elderly' is about the elderly population of Kerala. It provides information about the impact of migration on the elderly.

SOCIAL DETERRMINANTS

Social determinants means the circumstances, in which people are born, grow up, live, work and age as well as the system put in place to deal with illness. In India as in the other oriental and developing countries, the family has been a well knit social institution that met the social, economic, and emotional needs of its members. Older people enjoyed a sense of honour and authority, had the responsibility of the decision making in family and community. The family with its extended structure considered sometimes of three generations parents, children, and grand children - a stable unit. In India, where the family has an obligation to care for the elderly, the consequences of rapid declines in fertility and mortality on elderly makes living arrangements an important issue in the field of population and development. A study of Yi.Z et al., [2002]38 revealed that lower fertility, higher mobility, change in attitude about family structure and function, increase in life expectancy, especially mortality declines in later life. The population of China, which consists of more than two fifths of the world total, is ageing at an extraordinarily rapid pace. There are important interactions between population ageing, hanges in the living pattern of the elderly and the need for long-term-care service. Such interactions are directly related to community and family support systems and public policies.

Changes in dietary and sleeping habits, perception of adequacy of food intake, and the food items consumed in a meal, opinion on worries, feeling of depression, experience of a loss of interest etc. contributes detritions of health of the elderly. To maintain good health a person should be free from habits like tobacco smoking, chewing, excessive alcohol consumption etc. Such habits are not only expensive to maintain but also results in various psycho social health problems. People are able to withstand the effects when they are younger but as age advances there is a deterioration of the capacity of the body to resist their ill effects. The elderly face a lot of health problems which many arise out of their past and present addictions.

Murphy‟s [1995] research on old age revealed that at an advanced age due to restricted physical activity the majority of elderly change their living habits especially their dietary intake and duration of sleep. There is a general perception in the community that since the old led a sedentary life they should eat less food, have more rest and develop more religious interests to occupy them. Nutritional status of a person significantly influences his/her health status and more so in the case of the elderly. The subjective perception of the sampled elderly on their nutritional status while assessing almost all the total elderly irrespective of their group responded that their intake of food was nutritionally adequate. No wide sex differentials in the perception on nutritional status were observed. Marriage contributes to health through emotional, financial and behavioural factors and singles scored worse than married on most self-reported health dimensions. The exception was married persons aged less than 25 years. Married and single persons had the largest differences in psychological measures. The smallest differences were in physiological measures. The married state was more protective for men than women. Formerly, married people scored poorly on psychosocial, stress, smoking and drinking factors. Among the institutional population, long term illness was greater. There was a long term association between marital disruption by spouse, death or divorce and limiting long-term illness. This relationship was stronger for divorced women than widowed women. People living without a nuclear family had the highest long term illness rates.

Analysis of data of Martin [1998]from survey of the elderly conducted on the socioeconomic, cultural and demographic determinants of living arrangements of the elderly in Fiji, Korea, Malaysia and the Philippines revealed that the availability of kin, spouse and children plays an important role in determining the living arrangements of the elderly. Living in an urban area in Philippines is positively associated with living with children, but home ownership and being self supporting are negatively associated with living with children in several countries. Education and health of the respondent have little effect on living arrangements.

A study conducted by Indira Jai Prakash [2001]41 showed that older women are likely to have more health problems, are less likely to be financially independent and have less power and status compared to old man. In India because of the migration and urbanization, rural areas will become pockets of poverty, where living arrangements also change, leading to problems in providing for security to elderly.

A study on the living arrangements of elderly reveled that except a few (7%), almost all elderly live with their children. These few are living by themselves in single household because of not having any children. Among the others, 73% live with their sons whereas 20% live with their daughters [Dharmalingam et al., 2001].

More elderly are now living in joint households, with one or more married sons and some other relatives. However, the rest of the older persons either live alone or with a spouse and also in pilgrim centers and old age homes [Shah et al., 1997]. The results of a study conducted in Tamil Nadu in elderly revealed that only 9.16%of respondents lived alone and 18.33% lived with their spouse only. Majority of respondents (77.50%) lived with their children (38.34% were couples and 34.17% were single) and 95% lived in their own house [Sundhar et al., 2004]44. It is generally reported that the respondents have maintained friendly relations with their grown-up-children [Jayashree, 1999]45. More elderly female (3.49%) are living alone compared with males (1.42%). In other words, only 6% of elderly in India are living in a family where their immediate kinship is not present in the household [Irudaya Rajan et al., 2003]46. A study conducted by National Sample Survey Organization revealed that there is no significant difference in the living pattern in both rural and urban areas. Elderly mostly stay with their adult children and about 7% of men and 11% of women were supported by their spouses. Approximately three-fourths were supported by their own children and about 8%and 12% of elderly men and women, respectively were supported by others [National Sample Survey Organization, 1991]. A study on the level of life satisfaction among the elderly people according to their age and type of family found that the younger respondents had greater life satisfaction and those who were living separately from their children were more satisfied than those who were living with their married or unmarried children [Hosmath et al., 1993]47. Older people generally have lower incomes than their younger counterparts, with women who are unattached (e.g., as a consequence of divorce or bereavement) being particularly vulnerable to poverty. However, improvements in women‟s educational and employment opportunities may result in improved financial circumstances for older women in the future.

MENTAL HEALTH AND SOCIAL WELL-BEING

From a population health perspective, the health status of individuals, subgroups within the population and the population as a whole is the result of complex interplay among various factors. These factors include determinants of health like, individual characteristics, the physical environment, and social and economic factor. And also the changes that occur as part of the natural ageing process, such as retirement, changes in income, physical changes and changes in social support networks, which includes care giving, spousal bereavement, social isolation etc. Some older people may welcome retirement as an opportunity to engage in activities that had been set aside while working and / or raising a family. For others, retirement may signal things like significant reduction in income, narrowing of their social network and support system, negative change in self image and identity, and the recognition of their mortality.

Mental Health of the elderly is an important area in understanding their overall health situation, it is generally expected that the elderly should be free from mental worries since they have already completed their share of tasks and should lead a peaceful life but often the unfinished familial tasks like education of children, marriage of daughters etc becomes a source of worry for a period of time. According to Siva Raju [2002] a very high proportion of the elderly had to worry over a lot about their problems [63.3%], the poor elderly comprised a very good proportion [70%] of those with worries. However based on Sudha Katyal‟s [1999] old age suggested that successful treatment of loneliness in life reduces the research on the old people living with their families have cordial relation with their children and spouse, their social interactions are good and they have a positive frame of mind. But this cannot be said about people living in institutions as they do not have cordial relations with their children and spouse, they do not feel good about themselves and they do not have peace of mind. Older people are often victims of mental disorders on account of their fear about death, feelings of dependency, anxiety, boredom, loneliness and helplessness. The treatment and the diagnosis of psychological problems are not yet prioritized. Many old people suffer from mental illness, which their families may not even be aware of. Every human being has emotional attachment to their own kin‟s and creed‟s. The sociobiological view considers the phenomenon of social support to be deeply rooted in our biological inheritance, providing a central influence in our success as a life form [Richard E. Pearson‟s 1999]. One of the major psychological problems of elderly women is loneliness as most of them are widowed and also due to mobilization. The concepts of loneliness with particular reference to risk of more serious complications,

such as feelings of meaninglessness, decrease in social contacts, low self esteem and trust [Asgarali patel et al., 2000]

In Kerala, wherein the highest proportions of elderly is found to be present and has several social security schemes, 73.6% of the rural females and 76% of the urban females are fully dependant on others. This shows that vulnerable elderly women are even in Kerala known for its high order of social investments. The aged face psychological problems like decreased vitality, loss of works, reduced income, isolation, age associated disability, lack of supervision, deteriorating mental function which often leads to psychological problems [Sunil goyal et al., 1999]. The rural aged were found to suffer from anxiety, alienation, maladjustment, fear, tension, feeling of insecurity, worthlessness dependency, loss of memory, vision, hearing, giddiness and body pain [Selvi 2001].

Successful treatment of loneliness in old age reduces the risk of more serious complication such as feeling of meaninglessness, decrease in social contacts, self contacts, self esteem and trust. Loneliness among the aged can be reduced by acceptance, reflection, social interaction and increased activity. Loneliness has been conceived as a problem for everyone and the elderly experience more loneliness because their spouse might be deceased, their friends might have either removed away or died. Their children might be in distant places and they themselves might be subject to physical disabilities. Industrialization and urbanization have weakened the traditional joint family setup in India and elderly persons are least or not wanted in the social set up of a family or society at large resulting in loneliness and anxiety about death [Weeks, 1994]54. An old person begins to feel that even his children do not look upon him with that degree of respect which he used to get some years earlier. The old person feels neglected and humiliated. This may lead to the development of psychology of shunning the company of others, loneliness in turn may give rise to depression and may eventually lead to worsening of sickness [Chowdhry, 1992].

A study on the psycho-social problems of the retired revealed that age had a significant positive relationship with psychological distress and significant negative relationship with attitude towards physical changes [Prema B. Patil, 2000]. The retirement process may involve passing through a series of phases, the precise nature of which is influenced by a person's reason for retirement and the age of retirement. Older people who have inadequate income and are in poor health, or need to adjust to stress such as the death of a partner have the most difficult time adjusting to retirement. Retirement also impacts a person's partner and may

require both people to adjust to changing roles and expectations. Majumdar [1985] states that during old age there is a feeling of loneliness, perception of void in life, financial problem, loss of social status accompanied by a sense of alienation and helplessness. Loneliness increases gradually with age, is more common in women and is highly correlated with physical health. Other risk factors include low economic status and a lack of security and social networks. The absence of supportive friendships appears to be a major determining factor for loneliness. Further, widowed men and women report higher levels of loneliness and depression than their married counterparts. However, in older adults who are married vs. those who are single and among those who have children vs. those who are childless, perceptions of well-being are reported as similar. Psychological problems such as loss of job, anxiety, depression, loneliness, loss of social support, neglect, abuse and exploitation were faced by the elderly [Hema Nalini et al., 2002]. In a study conducted in Tamil Nadu among the aged population, the per capita income was found to have negative and significant relationship with depression and the number of children was found to have positive and non significant relationship with depression [Patil et al., 1998]59. Gradually elderly people develop a feeling of uselessness and purposelessness. Opportunities should be made available to the aged to fulfill their varied kind of needs adequately in the opinion of Surendra Singh [1997].

In a study on the physiological problems of elderly, it was found that 88 percent of old people were suffering from mental tension. A good majority 74.5 percent were found suffering from fear of death and 71.7 percent were found suffering from the feeling of dependency, 70 percent were found suffering from anxiety, 62.5 percent were found suffering from the feeling of loneliness, 60 percent were found suffering from the feeling of helplessness, 52.5 percent of old people were found suffering from depression, 52 percent were found suffering from the feeling of uselessness. A study conducted among old people showed that 70 percent of old people did not know whether they were suffering from any whims. 16 percent said that they were not suffering from any whims while 14 percent of old people said that they were suffering from whims [Hitesh Patel, 1997]. Depression is increased with age among elderly people [Prema.B.Patil, 2000]

.It is widely believed that depression is common in older adults, but in fact prevalence rates vary widely. Mild depression and situational depression (i.e.,depression in response to physical or social losses) are more frequent than major depression. Depression is more frequent in older women and people over 85. Depression in older adults may manifest

differently than in younger people, requiring different approaches to identification and treatment. For example, signs and symptoms are often physical rather than emotional, and may include changes in sleep patterns, decline in appetite, weight loss, constipation and minor aches and pains. Depression in older adults is associated with increased morbidity and mortality. This requires care, because symptoms of depression in older people may overlap with the symptoms of other conditions or may be seen as a normal part of ageing, resulting in the depression's being overlooked [Centre for addiction and mental health-CAMH-Practice guidelines for mental health promotion programme, Older adults 2010-2011].

A study on the psycho-social problems of aged in the Indian perspective from central and state services belonging to urban and rural area highlighted that elderly people are facing a multitude of problems. As people grow older, they usually become less interested in life and more concerned about death. When health deteriorates, they tend to concentrate on death and become pre-occupied with it. This is in contrast with the perception of life by younger people. The study found that habit, gender and caste play significant role in the adjustment of aged people. It was also found that rural aged were more adjusted than urban aged [Rafique Alam et al., 1997]. A study on the role of adjustment and status in aged conducted among the Bengali Population, has brought out that feeling of isolation was high in female and they had poor life satisfaction. Income seems to be a very important factor influencing adjustment. Widowed older women being dependant on families, face several problems in adjusting to others [Bannerjee Mrinmayi Tyagi et al., 2001]. Further research carried out to estimate the prevalence of dementia, one in a rural and other in an urban area of Madras, India found that the prevalence of dementia was 3.5 percent in the rural and 2.7 percent in the urban sample and the same increased exponentially with age. Rural prevalence estimates were higher than the urban estimates. Though gender differences were negligible in the rural setting, dementia rates were significantly higher among urban males in contrast to urban females [Rajkumar et al., 1998].

HEALTH PROBLEMS

Physical changes and increased vulnerability to chronic health conditions are often seen as the hallmark of ageing, and can significantly impact older people's psychological and social well-being. Health problems may limit older people's mobility, thereby narrowing their social contact and potentially precipitating mental health problems. In addition, studies about ageing shows that, most health problems were associated with lower education, lower income, less knowledge about health, poorer health practices, lower perceived health status and lower self efficacy. By contrast, older people who felt they were healthy and self-sufficient had fewer health problems, greater knowledge of health issues, and better health practices. Human organs gradually diminish in function over time although not at the same rate in every individual by itself, this gradual diminution of function is not a real threat to the health of older people unless they fall prey to some disease. Diseases are the chief barriers to extend health and longevity and when they accompany normal changes associated with logical ageing maintaining health and securing appropriate health care becomes especially problematic for older person. Health in simplest term is defined as the absence of disease or illness. Health is not only a biological or medical concern, but also a significant personal and social concern. In general, with declining health, individuals can lose their independence, lose social roles, become isolated, experience economic hardship, be labeled orstigmatized, change their self-perception and some of them may even be institutionalized [Ketshukietue Dzuvichu, 2005]. Morbidity pattern among the elderly varied from country to country. Chronic conditions which produced infirmity and disability became more common in old age.

The major ailments reported by the elderly are visual impairments, nerve disorders, hearing impairment, diabetes, heart diseases and hypertension, skin diseases, cataract, asthma etc. Many of the elderly are suffering from more than one combination of ailments. These diseases prevent many of the elderly from attending to their normal work and even affect the movement within as well as outside the house. Some chronic diseases like visual, hearing impairment can be limiting their movements but is not life threatening, whereas diseases like heart disease, hypertension, stroke, etc can lead to fatal diseases. The demographic picture of the population in any country is changing very rapidly. The problem of old age is a significant human and social problem in recent times. The problem of ageing is found in almost all the countries of the world. A study carried out by Hitesh. N. Patel [1997] revealed that 88% of old people were found suffering from mental tension, because of the ill health of

self or their life partner, bedridden self or life partner, conflict with other members of the family, contradictory life values, economic dependency on others, lack of adjustment in old age and trouble in passing time. Not only this, but social factors like widowhood and poor income may also intervene to change the diet of the elderly, there by leading to potential health problems. The changes like greying of hair, loss of hair, vision and hearing impairment, wrinkling of skin with loss of elasticity and dryness of skin etc are not strictly chronologically age related. In other words these changes might appear in individuals who might be 50 or they might not appear in an individual who is 70. Their appearance varies from one person to another. Old age in general is associated with multi-dimensional problems. The problems which are associated with age and the care of elderly are not exclusively the problems of social, cultural and economic ramifications, rather they include health and medical problems also that affect the life of a community as well paradoxically, it is the advance technology of medicine, which in turn facilitating contraception and reducing morbidity during the second half of life has eventually increased the prominence to the needs of the elderly. Health status is an important factor in deciding the quality of life of the rural elderly along with certain related factors such as service availability, awareness and accessibility [Vijaya Kumar, 1998].

The extension in life expectancy has been accompanied by an increase in the level of chronic diseases, including heart disease, diabetes, hypertension and arthritis. Also of concern is the weakening of traditional informal support systems, both community and family and the marginalization and elimination of the elderly's social and economic roles [Elderimire, 1997]. Analysis of the data on persons 65 and over years of age drawn from National Sample Survey, Sample Registration System and Censes of India revealed that, gender is a very important variable that influences quality of life at all ages. Of the population over 70 years of age, more than 50 percent suffer from one or more chronic conditions. Lack of social support, breaking up of joint family system, changing life-styles, all aggravates health and nutritional problems in the elderly age group. While elderly people in India may have reasonable access to family care, they are inadequately covered by economic and health security [Susuman, 2005]71. Understanding the various factors that determine the perceived and actual health status will help in evolving suitable and effective measures for improving the health status of the elderly in our country. Important factors like age, marital status, educational status, perception on living arrangement, perception on economic status, degree of feeling idle, addictions, type of health care received during ill health and the habit of

taking medicines etc. Have an important role in the assessment of the health status. As age advances, a person becomes more vulnerable due to psychological changes. Sex wise data showed that males of different age groups vary considerably in the perception of their health status. Those who perceived their health condition as good constituted as high as 54% among the age group of 60-64 years and such a positive perception of health status was represented by only 35% of the elderly in the 65-69 years and this proportion further came down to 25% among the 70+ years [Siva Raju, 2002].

Based on the study of ageing and health conditions in rural India conducted byYadava et al. [1996], 267 persons over 60 years old from Uttar Pradesh, Varanasi district were interviewed, Overall 37 percent of men and 70 percent of women rated their health condition as "bad". The incidence of illness after age 60 years was 77 percent among women and 61 percent among men. Most common were chest problems such as asthma, tuberculosis and bronchitis. The percentage of unhealthy persons was slightly lower among illiterates and those with a university education than men and women with primary or middle school educational levels. These educational differences are presumed to reflect class-based occupational histories. In general, those with middle levels of education were employed in household industry or businesses with high exposure to disease. Men and women with unsatisfactory, conflictual family relationships also experienced increased health problems.

Regarding the condition of exposure of old age to disease of any kind, the situations are quite different in various backgrounds. The prevalence of the disease increased significantly with age among the males and was related to socioeconomic status or smoking. Chronic bronchitis was also more common among males. While the incidence of the disease was not related to marital status, it was inversely proportional to economic status and significantly related to smoking. More men are generally smokers [Purohit et al., 1974].

In most situations in society compared to the young old [60-69 age] middle old[70-79 age], the oldest old [80 years and over] suffer more from at least the following major ailments. 1- Majority of them having more than a disease like rheumatism, arthritis, diabetes, hypertension, cardiac problems. 2- They are having less mobility, many of them are bedridden and are suffering from terminal illness and physical disabilities. 3- Depression at best and dementia at worst. 4- They are more likely to be the victims of accidents or falls and consequent bone fractures. 5- Nutritional deficiency is found more among them. 6- Many of them having problems in getting adequate care giving. 7- Loneliness, isolation and being cut

off from social bonds. 8- Abuse and neglect and even abandonment, especially if they are unhealthy, physically disabled, mentally handicapped and are poor [Nair.P S.1989]. The findings of the study conducted by Nath D.C [2000] revealed that socioeconomic, demographic and ecological factors have an important role in the health of old people. Most elderly people could have better health if they received better health care and followed healthy life styles. A study on the socioeconomic and health status of the aged in the rural areas of Karnataka revealed that the incidence and prevalence of chronic as well as non-chronic diseases is obviously high among the elderly. The major chronic diseases include respiratory diseases, loco-motor illnesses and hypertension. The duration of illness is comparatively longer among males. The majority of the aged have been treated by private physicians. Since the social and health problems of the elderly are peculiar and considering their growing population size, a huge infrastructural development will be necessary to take care of their health and social needs. This is even more important in view of the reduction in family size, the nuclearisation of families and the erosion of family kinship ties even in rural areas of the country [Nair, 1989].

There are more women than men at any elderly age group. Depression and osteoporosis are the commonest problems in elderly subjects. Some problems specific to males are hypogonadism, erectile dysfunction and enlargement of prostate and in females are post-menopausal disturbances, urinary incontinence and breast or lung cancer. However, problems of special concern in both male and female elderly are malnutrition, falls and cognitive dysfunction. The impact of old age on women is different from that of men because of differences in their status and role in society. This is specially so because proportion of widows in 60+ age group is considerably higher than of widowers. Sexuality is often overlooked as a health status particularly in elderly women. Clinicians should recognize the importance of sexual functions to the overall health of older persons particularly women. Religious participation and involvement are associated with positive mental and physical health. Family life is the key to the health of elders, especially older men. Lack of social support increases the risk of mortality and supportive relationships are associated with lower illness rates, faster recovery rates and higher levels of health care behaviour [Dhar, 2001].

In a WHO study it was revealed that morbidity due to cancer, coronary heart disease, diabetes, hypertension and arteriosclerosis had increased while there was a decline in morbidity among the elderly from conditions like skin diseases, visual and hearing handicaps and multiple orthopedic problems. In addition a study of 658 elderly in a rural area in

Trivandrum found 20.15 percent of males and 68.1 percent of females widowed. The women were found to be poorer and suffering a lot more morbidity than men, in spite of their greater life expectancy. The diagnosed illness included hypertension, arthritis and joint complaints, chronic bronchitis, diabetes and coronary heart disease. Chronic bronchitis and diabetes were more among the males whereas hypertension was more prevalent among the females [Vijayakumar 1994].

From the point of view of Pappathi et al. [2005] on psycho-social perspectives, problems and strategies for the health and welfare of the rural aged females, it is generally felt that a majority suffered from joint pain, hypertension and chest pain.

A study on the nutritional and health problems of the aged found that the rural aged suffered from nutritional, psychological and other problems, when compared to urban aged. The aged employed privately and those self-employed had more health problems than not gainfully employed persons. In general, the male members were found to be literate, economically independent and had less physiological and nutritional problems when compared to their female counter parts, when the literacy level, income level and employment status improved, they seemed to have better health [Vasantha et al., 1998]. The most prevalent illness among the aged are loss of eye sight, arthritis, tuberculosis, asthma, skin diseases, urinary infections and general body pain. Very few have reported that they are living in good health [Lalitha, 1998].

It is generally perceived that general intake of medicines by the elderly make them feel that their health status is at a lower level. It is observed that among the total elderly, that those who are regular in their intake of medicines perceived their health status at a lower level (72%) as compared to those who are not taking medicines. Problems of joint pain are a common feature among the elderly in Kerala while disease like cough and hypertension was also reported by a sizable section of elderly population. The prevalence rates are 480, 204 and 170 for joint problems, cough and hypertension respectively. The chronic disease such as piles (53%), heart disease (40%) and urinary problem (37%) are also prevalent in the population. The age wise differential showed that the chronic diseases such as cough, joint problem are common in the oldest old aged category. Heart disease and hypertension are more frequent among the young old. Sex wise differentials are clear with the burden of joint problems and hypertension being more among economically dependent persons than their

counter parts who are independent or partially dependent on others for their livelihood [Dillip, 2001].

Another study found out that joint pain as the number one problem followed by failing eyesight and cardiac problems. It is interesting to note that in spite of high level of prevalence of various diseases among the elderly 63% of them reported that their overall health status was good [Hema Nalini et al., 2002].

In a different context, health condition of the aged population of Allahabad city was found that the health of the aged male is better than that of the females. Most of them suffer from more than one health problem. The most common illnesses are abdominal problems, cold, cough and fever. Almost all the respondents of this study have gone for allopathic treatment for their major ailments, more than half the patients obtained treatment from private hospitals, three fourth from government hospitals and only a very small minority from other sources [Tripathi, 2001].

However, it is true that the attitude, both professional and general seems to be that the illness was an essential part of old age and most of the illness of the old have no cure but only palliative [Nayar, 2000].

The health problems of elderly tend to increase with advancing age and very oftenthe problem aggravated due to neglect, poor economic status, social deprivation and inappropriate dietary intake. Large majority of landless rural aged are suffering from one or the other health problem and physical disabilities. Indigestion, anemia, hypertension, skin diseases, poor eye sight, respiratory problems, urinary / kidney troubles and diseases of joints with varying degrees of affliction were some of the physical ailments they were suffering [Chandra Paul Singh, 2005].

Seriously considering the disease pattern of the retirees, hypertension is rated the highest, diabetes is rated second highest and problems with ears and eyes as third highest. These in most situations are followed by muscular pain, frequent colds, insufficient sleep, dental, throat and heart problems [Jayashree, 2004]88. Another study on the health status of elderly revealed that only 20% of senior citizens did not suffer from any diseases, 22.5% of each were suffering from hypertension and arthritis, 7.5% each were suffering from asthma and diabetes mellitus, 5% were found to have heart disease and anemia and 10% of elderly were suffering from other diseases [Suresh, 2002].

The Indian Council of Medical Research (ICMR) has attempted to compile data on morbidity from different sources. The total number of blind persons among the older population was around 11 million in 1996, eighty percent of them due to cataract [Angra et al., 1997] 90. The consequences of blindness are not limited only to physical disability that ensues, but also impinge on economic, social and psychological domains of the affected individual's life. Nearly 60 percent of older people are said to have hearing impairment in both urban and rural areas. The hear of older people [Kacker, 1997]91. An estimated five million were diabetic and the prevalence rates were about 177 per 1000 for urban and 35 per 1000 for rural elderly people. Crude prevalence rate of strokes is estimated to be about 200 per 1,00,000 persons. Older persons surviving through peak years of stroke (55-65 years) with varying degrees of disability are already a major medical problem [Dalal, 1997].

Finding on disabilities and death surveys in rural areas, shows that the elderly suffer from conditions specific to this population that are accumulated over the life cycle. The major causes of death for persons aged over 50 years are respiratory diseases (18%), diseases of the circulatory system (10%), disorders of the central nervous system (12%), senility (almost 50%) and other causes (12%). 75% of respiratory deaths are due to bronchitis and asthma. Air pollution causes chronic respiratory damage. The most vulnerable people are the elderly, children, smokers and those with chronic respiratory problems. Almost two-thirds of circulatory system deaths are due to heart attacks. Paralysis is a common cause of central nervous system culminating in ultimate deaths. Cancer accounts for almost 50 percent of other diseases. Medically certified deaths among those aged over 55 loss and resultant communication problems adversely affect the well being years show the major causes as heart attacks, ill-defined conditions, infectious and parasitic diseases, respiratory system diseases and neoplasms. Compared to mortality among the working-age population, the elderly suffer more from respiratory diseases and paralysis, especially men. 45% of the elderly have some chronic disease. 80% of the chronically-ill suffer from joint problems, coughs and high blood pressure. Elderly morbidity follows a residence and gender pattern.

Around 10 percent suffer from disabilities. Blindness is highest among the elderly, especially women. Women experience conditions related to menopause [Rao et al., 1998]. Meena et al. [1995] have reported from their research that health problems of the elderly are subjected to a kind of shift from communicable and infectious diseases to non-communicable disease. Poor nutrition and lack of clinical care are known to be important factors explaining the health profile of the persons. The health conditions of elderly are making a great demand for

geriatric services. There is an unmet need for health care and social security services for elderly. Hence there is a need for a community based health care strategy to care and protect the welfare of the aged in the country. Old age manifests different diseases and these diseases have a compound effect with each other. Hence there isa need to assess the living conditions of the older population and the care and support available to them in order to develop appropriate social security and health care measures for the vulnerable elderly population.

The dimension of the problems of the elderly and enormous increase in their absolute numbers in India, warrants study of their health and medical needs to formulate strategies at various levels to improve functional independence and quality of life through reduction/alleviation of morbidity, by recognition of the multiplicity of problems, atypical presentations, rapid deterioration, irregular or erratic intake of medicine and medication practices by the elderly and the possibility of iatrogenic diseases complicating further the clinical picture.

Chapter 3

METHODOLOGY

TITLE

changing perceptions of elderly living in a care homes.

GENERAL RESEARCH QUESTION

What are the change in perception of elderly for being in care homes today?

SPECIFIC RESEARCH QUESTIONS

1) What are reason for them to come to the care home?
2) what is the socio-economic back ground of the respondent?
3) How it varies from the existing accepted reasons?

RESEARCH DESIGN

The researcher is using case study design since the study demands intensive examination of selected case.

SELECTION OF THE CASES

The researcher propose to select the cases purposively.

NUMBER OF CASES- 5

DATA COLLECTION

Both the primary and secondary data are to be collected. The primary data will be collected directly from the respondents by conducting interviews. Secondary data will be collected from books, journals, magazines and web resources.

METHODS OF DATA COLLECTION

Unstructured interview, Non- participant observation.

TOOLS OF DATA COLLECTION

Interview guide.

Chapter-4

DATA ANALYSIS & INTERPRETATION

INTRODUCTION

Researcher selected two institution Pulayanarakotta care home and Kripalayam old age home for the study. These two care homes are situated in Thiruvananthapuram. Researcher collected five cases for the study with help of interview tool.

Pulayanarkotta Care Home

The Government newly built care home for the elderly under the social justice Department home to nearly 110 peoples, previously sheltered at the Chakka care home.The care home at chakka was previously a rehabilitation centre for prisoners, started in 1956 by the Travancore King, which at a later stage became an old age home to rehabilitate the increasing number of abandoned elderly people . Now there is difficulty in running the home with the limited number of staff members appointed by the government and the temporary staff appointed through social security mission,13 additional staff members have been brought in by the managing committee. The care home has also received support from the public, who have contributed various product for the care home.

Kripalayam Old Age Home

Kripalayam is a private old age home located at Ulloor in Thiruvanathapuram has seven years of service in this field. They provide physical and spiritual assistance. They also giving opportunities to continue all relationships of inmates. The common festivals like Onam,Christmas,Ramzan are being celebrated in a special way with inmates. They carry out cultural events for inmates.

CASE-1

First study is on Bhavaniyamma (77) . she is form Trissur district of kerala. She had been here for twelve years(ie in 2005) she came here by herself . she got married to a station master and they had one child who is working in bank and got married to a girl who is his collegue. Bhavaniyamma's husband died when their son in college. After marriage of her son, she faced some ignorance from her son. Her son started alligating her for no reason by hearing his wife's words. This became common .

One day she the news about this old age home in a newspaper. She herself came by train with the help of some police officer she came here. At first police officers told her they will talk with her son and will take her to her home. But she didn't agree she sternly stick on to her decision . for police officers there no choice other than supporting her decision. Finally she joined to this old age home with the help of police officers. Now she is living there. She also will get her pension amount. Her son or daughter-in-law won't to visit there to see her. She had been living this life since November 2005.

CASE-2

Next study is on prabhakaran (80) a retaired Govt: officer . he was an officer in income tax. He came to this old age home 5 years back. He came here by himself . he had 2 son . one is settled in America and his another son is working in Australia . both of them will come twice in 2 year to see their parents.

After the death of his wife he faced solitude and was also in mental stress of being lonely . so he himself took decision to join in an old age home so that his state of mind will change . he don't blame his children because he know their work tension. His two son and their wife and children will came twice every year to see him and to spend time with him.

CASE-3

Ponnamma (90)got shelter her seven years back ie, when she was 83 years of old . she came here with the help of some people . she had ten children all are male child. For many year she had been staying with her younger son . His wife don't like her staying with them. Every day there was problem between ponnamma and his sons wife . ponnamma's health condition started getting worse . one day his son left her in a chair infront of a temple . Then with the help of some local party members and some people of that area she got shelter here. Now she is very happy to live with same age people and she don't blame her children and she said that every one live for their children runs towards for making money for their future at that time we will forget to live for ourself. Really we should live for ourself then only we can enjoy our life.

CASE-4

Fourth study is on valsala (74) she had been in pulayanarakotta old age home since 2003 ie , 14 years.She came here with the help of her sister puspa. Valsala is born and brought up at

Trivandrum. She got married to vijayan at the age of 19. They had one daughter. They lived around twenty people. Valsala's daughter Remya got married to farmer and had two children Rajesh and Reshmi.

Problems arosed in the family the death of valsala's husband Vijayan. He died at the age of 54. Heart attack was the cause of death . valsala is unemployed, she then lived with the measly amount of money which her daughter gives. But again give valsala a deep wound the death of her daughter Remya. That was an accident after this incident she went into a state of desolation. So don't have anyone to share her worries etc she had two grand children. Resmi is married to a man from another district of kerala Alapuzha and is she there. She will come once in a blue moon to see her granny. She is busy with her granny. She is busy with her life and often will forget about her granny. Another grandson Rajeh, who is an auto driver wont take care of valsala . he even don't enquire whether she exist or not . he is living in his own world another life style.

In this situation Puspa, had no other way but to make her sister join an old age home named as pulyanarkotta old age home. Another reason is that pushpa's health condition is also not good . so, in the cause of time it will be difficult for her to look after her sister also. Now valsala is happy in old age home. But when she was narrating her whole story memories made her shead tears. The death of her husband and her only daughter is still remaining as a scar in her heart.

CASE-5

It was eight years ago that his sons left K.Rajappan (70) at the government care home at Chakka. He is retired government officer in health department. His sons promised to take him back after one week. But weeks passed his sons didn't come to the old age home to take him. Rajappan already partitioned his properties between his two sons. Now he is getting his pension. Rajappan's health condition is not good. He is suffering from arthritis and heart problem.

Though his sons left him there and he never his blame sons for doing so. He always supports his sons, in all his talk through out he support both his sons. He is of the statement that both his children are busy with their job. After the death of his wife he was alone in his house. So its better to be here with lots of company than to be alone at home. Now he was really happy in care home he had lots of friends and there is so many activities are conducting in care

home. Every once in a week his sons come to see him. He know about the busy works of his sons so he is not complaining about his sons what they done with him and also he is supporting his sons in each and every words.

Analysis

Traditionally, the Kerala family was joint and matrilineal, with the eldest male member of the consanguinal family (called *Tharawad)* functioning, as head *(Karanavar).* The system prevailed among the dominant *Nair* community and among some *Ezhava* and Muslim groups. Unlike other joint families elsewhere in India, a woman in the *Tharawad* did not lose her status and privileges on the death of her husband because of her right over family property. In this sense an old woman, including widow, enjoyed better position in the family in Kerala than her counterpart elsewhere in India who usually loses her status in the family on the death of her husband, more so if he happened to be the family head. However, the *Tharawad* system broke down in the early decades of the last century due to dissensions from within and consequent government intervention through legislation, legalizing partition *of Tharawad.* Thus, the joint family system in Kerala broke-up due to endogenous rather than exogenous factors. However, the old in these families did not face immediate neglect or lack of care because the Kerala family, even after the break-up of the *Tharavuad, w*as comparatively large. As per the 1981 census the average household size in Kerala was 5.75, the third largest among the major states in India; 48.05% of the families had more than 6 members. In India 6+ member families constituted only 44.56%. The census of 1991 showed that large sized families continued to be popular in Kerala. The 1991 census data also showed that around 90% of all old people were living with their sons/ daughters or relatives.

However, there are signs that this situation is fast disappearing and the small-family norm is receiving wide acceptance in Kerala. Its impact in terms of reduced family size is bound to show up soon. There are also other factors at work in the state which are not so friendly for older people and which are different from those operating in other parts of India. One is the changing role of women in the family which pulls them increasingly away from the role of care-givers to the old. This operates much more strongly in Kerala than in other parts of India because of the higher level of education of women and their

better control over pregnancies due to the easy availability of family planning techniques. The longer life span of women vis-a-vis men has reversed women's care-giving role and this has even pushed many of them to be at the receiving end. This is also a phenomenon existing only in Kerala at present.

Perhaps a major factor undermining the care of the old in Kerala is the large-scale migration of young male workers to the Gulf countries and the United States. Available statistics show that there are over a million emigrants from Kerala, of whom around one-half are working in other parts of India and the rest abroad, mainly in the Gulf Countries. Emigration of young workers (who include a significant number of women) leaves behind the old to look after themselves, other younger members and the family property if any. This is an unenviable situation for the old who want to spend their last years in peace and in the midst of their near and dear ones.

A large proportion of the 60+ population in Kerala, like their counterparts elsewhere in India, are illiterate, notwithstanding the very high literacy of the state's people as a whole. Literacy figures in the 30d age group are presented in Table 7. The three lower age groups have been included because, by 2020, these groups will be in the 60+ age and adding the burden of their illiteracy to their old-age problems.

In Kerala the process of urbanization has been virtually stagnant in the last two decades and the urban population has remained around 25%. Actually, this need not be a problem for the old like in other states because in Kerala the rural-urban divide is very hazy. The peculiar ecological and settlement configuration of Kerala is partly responsible for this phenomenon. Consequently, most of the villages are linked with towns by good roads and buses and many urban civic amenities such as schools, hospitals, recreation grounds, post offices, electricity, cable TV and even STD booths are available in most villages.

The predominant pattern of the elderly living is with their children. Those living alone and living in old-age homes are negligible, even though women in both rural and urban settings number more than men who are living alone. The maintenance pattern of the old

in the 1991 data shows that, out of every 1000 elderly persons, 473 men and 873 women in rural areas and 523 men and 880 women in urban areas were partly or fully dependent on others for their survival. The disadvantaged position of the vast majority of women in this respect is once again evident from this picture.

The role of the family in the care of the old assumes great importance in any programme for care and rehabilitation. Fortunately, the link between the old and their kin is still strong in Kerala, though one cannot take it for granted for all time to come. It has been shown in Table 8 that more than 90% of older people are staying with their families - either sons or daughters or relatives. Research studies have revealed that both the older person and his/her relatives want to live together in the family and when a suggestion for putting the old kin in an old age home comes up, it is either due to destitution and the consequent inability of the kin to maintain the old or because there is no person to look after him/her in the family. An analysis of the intergenerational relationships also showed that, by and large, the old and the young (children and grandchildren) get along well in the family. This trend should be buttressed with supportive measures.

Kerala has the largest number of old-age homes in India even though they admit less than 1% of the old. As per Help Age India's directory of the old-age homes published in 1995, Kerala accounted for 93 (27%) out of the 347 homes, and 3,386 (22%) out of the 15,471 inmates in these homes countrywide. Of late, there has been a spate of old age homes in Kerala. Statistics made available by Help Age India office, Thiruvananthapuram, and the Government of Kerala's Department of Social Welfare, show that in 2001, there were 164 old-age homes in the state which provided accommodation to around 5,200 old persons. Forty per cent of the inmates of these homes were men and 60% women. Old-age homes are of various types - destitute homes which are totally free of charge to inmates, pay-and-stay homes and a combination of the two where some optional payments are collected from those who can afford and are willing to pay. Thirty-six homes are for women only and all of them are destitute homes. The vast majority of the homes are run by Christian managements and very few by Hindu and Muslim communities. To be sure, a number of the homes are run by secular agencies and their number is increasing. The government is running a few homes; they have plans to establish old-age homes in all the 14 districts of the state

and these are at various stages of implementation. All government homes are free of charge for inmates and are open to both sexes.

Old-age homes are becoming popular in Kerala among both the destitute and affluent sections. In the prevailing context, they are necessary and the trend is desirable. But there are many inadequacies in most of these homes - absence of trained counsellors or social workers, adequate space for indoor and outdoor activities, medical services, and good management. These lacunae have to be removed to improve the quality of life of the inmates of those institutions. There is need for a regulatory authority for old-age homes at the state level and monitoring authority at the district, block and *panchayat* (rural self-government unit) levels. At present, old-age homes provide accommodation only for the healthy older people. This keeps out a large number of needy and deserving older persons, especially among the destitute, on grounds of ill health. Actually, this segment needs high priority because destitution compounded by illness makes their lot doubly miserable.

There will be need for more old-age homes in the coming decades because of the nuclearization of families and dwindling of the number of care-givers. The need is equally high among both the poor and not-so-poor. In view of the increasing life expectancy and old-age morbidity there is need for geriatric care homes and hospices. It will be very appropriate that each *panchayat* or block in Kerala has an old-age home. These could be established by community initiative, sponsorship and support with the *panchayats* acting as promoters and catalysts. The government and NGOs could give them the needed initiative, patronage, support and leadership:

Social security is the crux of old-age security and social security presupposes a sound economic base. In this sense Kerala's economic structure cannot be considered as supportive of a sound social security net. The striking characteristics of the state's economy are a stagnant industrial sector and widespread unemployment. Industrial development in Kerala has remained virtually at a standstill with around 5% growth in the past several decades, creating general poverty and large-scale unemployment. Latest estimates place around 30% of the people of the state below the poverty line. Using an IRDP survey the Kerala State Planning Board has calculated

the number of older persons below the poverty line in Kerala in 1992 as 666,124(Kannan,2000).Around two-thirds of the labour force is outside the productive system. Unemployment has assumed enormous proportions in recent years. The figure for 1997 was 3,701,222, of which 3,305,444 were the backlog of the previous years and 395,778 were new entrants. During that year 75.7% of the unemployed were Secondary School Leaving Certificate holders and higher qualified.

There is a need to revamp the entire pension and welfare fund schemes and to rationalize and unify the rules and to bring all pension and welfare funds under one or two independent boards. Currently, huge amounts of money are accumulated under several funds because the government has not been able to identify beneficiaries or finalize the rules for distributing them. If the rules are made uniform and payments standardized and if the different schemes are integrated and streamlined, the administrative and organizational costs in having to run several parallel establishments could be avoided. This itself could result in huge savings which would permit the amounts of pensions to be enhanced considerably and payments made more regularly without any additional burden on the state's exchequer.

Kerala is known for its highly developed health care system. With a good track record in education and public heath dating back to the days of the princely rule, Kerala was able to forge ahead of other states in India when national programmes in health and family planning were initiated. Kerala's overwhelming success in fertility control is attributed mainly to the high level of education of its women, and health care measures were able to succeed because of the well-developed infrastructure. Kerala's remarkable performance in family planning, infant mortality rate (IMR) reduction and increased life expectancy has become models for other states in India. However, the state has not been able to make any substantial headway in morbidity control, especially the control of communicable diseases. At the same time new diseases, mainly lifestyle-related illnesses such as coronary heart diseases, hypertension, stroke, diabetes and cancer have made inroads into the state's burden of morbidity. As a matter of fact, Kerala has the double burden of having to combat simultaneously with short duration acute and communicable diseases and long duration chronic and non-communicable diseases. The National Sample Survey 28th Round in 1973-74, the Kerala Sastra Sahitya Parishad survey (KSSP-I) in 1987,the Kerala Sastra Sahitva Parishad survey

(KSSP-II) in 1996and the NSS 52nd Round, 1995,all listed major communicable diseases like diarrhea diseases and fevers of all kinds as the principal elements in Kerala's morbidity. The annual reports of the Kerala government's Health Services Department also continue to list them as principal diseases during the last several decades. The KSSP I study in 1987 found that 66.7% of the state's total acute morbidity was contributed by communicable diseases and 33.3% by noncom in unica.ble diseases. In the KSSP II 1996 study, the corresponding proportions were 57.9% and 42.1%. The magnitude of the principal communicable diseases will be clear from Table 12.

At the same time non-communicable diseases like heart diseases, diabetes, hypertension, stroke, cancer and mental illnesses which are directly related to lifestyle, are on the increase in the state. Some of these are also old-age diseases in the sense that their prevalence and the mortality due to them are more among the 60+ age group.

The rate of increase was the highest in the case of cancer, closely followed by hypertension. The major forms of cancer in Kerala are oral cancer (17%) and cancer of the respiratory system (16.5%) among men and breast cancer (25.7%) and. uterine cervical cancer (12.7%) among women. Cancer morbidity increases more progressively from age 40-44 among both men and women, while the mortality rate moves faster at ages 60-64 and beyond, reaching its peak at ages 70-74.

Dementia-related disorders which are mainly diseases of old-age are also making their appearance. A study in rural Kerala found that among the 60+ population, dementia, including both vascular dementia and Alzheimer's disease, was prevalent in 3.2% of the persons with cognitive impairment (male 2.8%, female 3.5%). It increased more rapidly from age 80 onwards. This gives an additional dimension to old-age diseases in the state.

The NSS morbidity study showed that among the 60+ category 88 out of 1000 persons (male 98, female 86) reported acute ill-ness during the 15 days preceding the survey and 246persons out of 1000 (male 267, female 228) reported chronic illness during the 365 days preceding their survey. 874 out of 1000 ailing persons (male 90S, female 842) reported as having received medical treatment for their ailments. The number

of hospitalization cases per 1000 sick persons among the 60+ during the 365-days period was 159 (male 194, female 131).

By all calculations the morbidity rate is very high in Kerala. The proportion of old-age morbidity will be naturally higher in the overall morbidity. Oldage is characterized by long periods of illness though not of a very serious nature. A corollary of this is that the longer a person lives the longer he will live with his illness. The incidence of morbidity among the old is higher and its prevalence longer. A characteristic of old-age illness is its multiple and/ or chronic nature. Treatment is expensive and prolonged. Also, effective treatment requires expertise in geriatrics which is an undeveloped field even in Kerala where specialty and super-specialty hospitals are coming up very rapidly. However, hardly any of these hospitals has geriatric wards or doctors specially trained in geriatrics. Even when wards are designated as geriatric, the treatment does not differ much from that given in non-specialty wards. The geriatric wards in government hospitals can become a dumping ground for destitute old patients suffering from all sorts of terminal illnesses.

The primary health centres (PHCs) in Kerala are losing much of their usefulness today. Only the poorer sections of society are making use of them. They were originally designed for promoting family planning programmes, then shifted to maternity and child health and presently take care of the medical needs of the local community. Even so, in spite of the fact that each PHC caters only to a small population, their general utilization is limited to only 40% of the population. Inadequacies attributed to government hospitals are relevant here also but there is also the lack of dedication of PHC health workers in making visits and monitoring the needs of present and potential clients.

There were 956 PHCs including reproductive and child health centres, and another 95 community health centres in Kerala in 1996. Since family planning programmes are losing their relevance today in view of the state population fast moving towards the replacement level and zero growth rate, 75% of the couples protected and 80% of them sterilized, it is high time that emphasis should shift from population control to old-age care and family welfare should include a large input of old-age welfare. This will go a long way in taking care of the health problems of the poor sections of the community

without committing heavy expenditure on old-age health care. The district and state-level hospitals could then follow up the work of the PHCs in a better manner. In fact the PHC should be made the primary unit for old-age health care.

Another requirement in the sphere of health is to make health service affordable to all, especially to the lower segments of society. The cost of health care, including doctors fee, hospital charges, clinical charges and drug prices, has gone up manifold (what the authors of KSSP II call "mediflation") and this is keeping health care beyond the reach of even the middle class.

But the lower classes are the worst victims of this malady. The KSSP II study showed that the lower classes spent proportionately larger amounts of their income on medical expenditure. The per capita expenditure on medicine incurred by the socioeconomic class I (lowest) was as much as 39.6%., class II 16.1%, class III 5.1% and class IV (highest class) 2.4%. Certainly, ill-health robs the poor of not only their vitality but their hard-earned money as well.

Chapter 5

FINDINGS AND CONCLUSION

FINDINGS

The study title “Changing perceptions of elderly living in care homes” it meant changes of understanding or realization of elderly being in care home. For this study researcher collect five cases from both the care homes. Researcher use interview tool for the data collections.

The result of this study shows that elderly in both the institution have changed their concept about being in care home. In previous days, elderly people thought that their children leave them because they were worst and useless for them and they used to blame them. But today its seems that they are happy for where they are now. At present they are not ready to blame their children for what they are done and they realized that their children leave them because of personal issues and they also realizing that their children are not leaving them in care homes not forever.

CONCLUSION

The paper highlights the changing perception of elderly of being in care home. From the five cases researcher can concluded that there is change in the concept of elderly living in care homes. They realized that they are not burden for their children and they left them in care home because of personal issues and busy schedule of their life. For the better care and concern their children left them in care home.

Demographically, the 60+ population is going to rise in number progressively in the coming decades, with the 70-79 and 80+ groups increasing more rapidly than the 60-69 age group. Society will have to reckon with a new category of the old, viz. the oldest-old or what Peter Laslett would call the "Fourth Age". According to him, "the third age is the age of active, fulfilling retirement while the fourth age is the age of incapacity and dependence". The proportion of the 80+ in the older population will rise from 11.25% in 1991 to possibly as high as 16% in 2020. The population distribution will change from its pyramidal shape to one with a narrow base and a broader apex. Expectation of life at birth will rise from the present 72 years to 75 years in 2020 with a smaller difference between the sexes. Expectation of life at 80 will move from 12.6 to 16 years or more. There will be need for more geriatric care hospitals and trained home nurses to care for the octogenarians, nonagenarians and centenarians as also those in bad health in the lower age categories among the old.

In the social sphere a striking development in the coming two decades will be the further nuclearization of families, increase in the role of women outside the family and their non-availability as old-age carers. Thanks to the feminization of ageing (poverty, widowhood, longer life span and consequent "compression of morbidity" at the end period), more women than men will need carers and this, will call for more home nurses.

Nuclearization of families will also affect the living arrangements of older people. Currently, the majority of the old are staying with their children. The nuclear family, especially in urban settings, will give rise to situations which will compel the old to opt out of this arrangement or push more of them away from their kins. Already signs of inter-generational conflicts, especially between grandparents and grandchildren, are reported in major cities in India and this is bound to happen in Kerala sooner than later. The worst-affected group in this situation will be the fourth-age people, especially widows, the sick and the disabled. The rising tide of globalization and liberalization will sweep away many of the elderly-friendly social values and promote individualism and commodity culture. These, in turn, will create cleavages in intergenerational harmony. It is very difficult to insulate the Kerala society (or for that matter any other open society) from the ill-effects of such trends. The cult of consumerism, which is at a high pitch in Kerala, and the ubiquitous satellite television will bring in waves of the new ethos right into the living room of the common man. Hence, the strategy should be to protect and preserve as much of the country's values in whatever way possible. The school curriculum and mass media and, more importantly, child socialization, should contain heavy doses of traditional values. Since the old themselves are the best spokesmen and the strongest bulwark of traditional values, they should be pressed into service for the preservation and protection of these values instead of dismissing them (the old) as spent forces and retrogrades. The "grand parenting role" of the old is especially relevant in this context. A "society for all ages" will be possible only if all the different generations live together under one roof in an atmosphere of mutual love, understanding, confidence and cooperation.

The unique position of Kerala in the matter of old-age homes has been pointed out in an earlier paragraph. Of late, there has been a spate of new old-age homes, mainly as a response to the rising need. This trend is worth encouraging in view of the great need and demand for this facility. New homes could be sponsored by non-resident Indians, commercial banks, industrial houses, residents' associations, charitable trusts and the local community

panchayat. Where appropriate, the buildings and infrastructure now being made redundant by the fall in student enrolment in Kerala's state-run primary schools could be made available by the government for the purpose.

Old-age homes in Kerala are not functioning on healthy lines. They lack many things that would contribute to the quality of life of the inmates. The government should lay down fresh norms and guidelines for the establishment and management of these homes. Currently, old-age homes are under the control of the State Orphanage Control Board which also controls 475 orphanages and 22 fondling homes. There should be a separate authority for the control of old-age homes and there should also be welfare committees at district and lower levels to exercise vigil on the good running of these homes. There should be model old-age homes which will admit not only the able-bodied old as is the case with existing homes but also the disabled, the sick and the infirm. In view of the growth of the "Fourth Age" older persons, there is need for geriatric homes and terminal care centres or hospices at the sub-division level.

In the economic sphere, unemployment is rampant among the majority of the labour force (15-59 yrs). The worst hit is the currently 40-59 age group, many of whose members are illiterate (22%, Table 7). In fact, 25% of the below Secondary School Leaving Certificate-holder unemployed group belongs to this category. They are not easily amenable to learning any new skills and the information technology revolution which promises huge job opportunities will bypass them. Without any savings or social security this group, of necessity, will have to depend on destitute pension. This would mean that in the coming two decades, old-age pension will have to be continued for an increased number of beneficiaries.

All pension schemes should be brought under one autonomous board with freedom to run on commercial lines. Government payment to the board should be made mandatory and as committed expenditure. All welfare fund schemes should be handed over to the General Insurance Corporation of India (GIC) which should open a new wing exclusively for their operation. All contributions will be collected by this wing of the GIC and all payments and settlements of claims will be made by this agency. The benefits will cover health insurance besides other social security payments. All the boards administering the

respective welfare fund programmes will cease to exist. Their main role at present is to act as paymasters of the board employees much more than as service-providers to their clients.

The most impressive fact about the health of the 60+ is that the majority of them are keeping reasonably good health and one-fourth of them are still working. This is a good sign of healthy and active ageing. This trend is likely to continue for quite some time with perhaps less number of the old in the workforce (due to market conditions than due to their own option). But the morbidity scene is characterized *by* a high incidence of acute communicable diseases which deplete not only the health of the victim but also his pocket. They are also diseases of poverty. The trend is likely to continue with some fall in the rate over time. At the same time there will be a rise in the prevalence of non communicable diseases, especially lifestyle diseases. But there is no facility for geriatric treatment in the state. With the liberalization policy of the government, there will be more medical colleges and hospitals in the private sector but geriatric facilities may take a back seat unless the government takes a positive stand. The state government could take up the task through its medical colleges and hospitals without incurring heavy expenditure. The first thing is to include geriatrics in the curricula of the state's medical colleges. The offices of the Director of Medical Education and the Director of Health Services could devise a programme of training the staff (doctors and nurses) of all government hospitals in geriatric treatment and care and, as a first step, train a set of trainers in different medical colleges run by the state. These trainers will, in turn, train staff in the PHCs and district hospitals within a time frame. Training modules already prepared could be appropriately modified to suit the needs of the state.

In view of the enormous need for trained home carers, the state should also assume the leadership in encouraging competent agencies, including selected government and private hospitals and NGOs, to offer courses for them. The state should also exercise control over the agencies which recruit home nurses and supply them to families. Progressively, the state should also open geriatric outpatient departments and wards in its hospitals in a phased manner.

Nutrition of the older person is a comparatively neglected area in health care. Ignorance about old age nutrition exits even among the affluent and the educated. Nutritional anaemia is widely prevalent among older people, especially among the poor elderly.

According to government statistics, 56% of deaths due to anaemia in 1995 were among the 60+ group. To overcome nutritional deficiency among the poor, a supplementary noon meal programme could be instituted and operated through the over 25,000 Anganwadis of the state's Integrated Child Development Scheme. The Anganwadi worker could, during her home visits or during the visit of the older person to the Anganwadi, give instructions on the nutritional aspects of diet.

Lifestyle, an important element of healthy ageing and healthy lifestyle should be cultivated early in life. The state mass media and education departments and health and family welfare training centres should be pressed into service besides the school system and the private print and electronic media to propagate the message of healthy ageing, nutrition, exercise, abstention from hazardous health habits and the like.

Solutions to ageing problems require a multidimensional approach and coordinated effort of all concerned: the family, the community, the government and, above all, the ageing individual. If all these constituents put their heads together and evolve a sound policy and plan of action, ageing can be made healthy, happy and graceful and the aged can function as valuable members of society.

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APPENDIX

Changing perceptions of elderly living in care homes

Interview Schedule

- Name
- Age
- Place
- Family
- How long you have been in this care home?
- What is the reason to come in elderly home?
- Are you satisfied with the facilities and the care taker of this old age home?
- Whether you have any routine in this old age home?
- Do you have any worries in this care home?
- Do you have a room for your own or do you share?
- Do you have any medical issues ?
- Do you get proper treatment ?
- What are activities provided for you in this old age home?
- Whether you celebrate any festivals here?
- Do you have any picnic?
- Is there any visiting day for you to see your family members?
- How often your family members visit you?
- Are you happy being in care home?
- Are you adjusted with this environment?
- What you feel now about being in care home?