CHAPTER – 3

CONCEPTUAL FRAMEWORK AND STRATEGY OF INQUIRY

Introduction

Sociology is a theory based subject. In order to understand how societies function or exist, it is necessary to look beyond simple description of a particular phenomenon under research. Sociology consists of a range of competing explanatory paradigms that challenges both naturalistic and individualistic explanations of social phenomena. Sociologists argue that the naturalistic and individualistic understandings arise as a result of socialisation in a particular culture and a set of social structure. People tend to look at certain aspects as natural or have a preconceived notion. At the same time aspects like life-style, behaviour, or lack of motivation are looked as individual characteristics rather ignoring the social factors and structures role in that particular situation, behaviour or belief. There is an epistemological divide within sociological theory who argues that society can be studied objectively by examining the structures of society and others who argue that it has to be approached subjectively by interpreting the social phenomenon through its social actors (Crinson, 2007).

3.1 Theoretical Perspectives

Health or illness are two unavoidable aspects of a living being, it could be understood and explained using different paradigms. Sociology tries to understand and explain these aspects which are dominantly assumed and established as a medical characteristic through social causes (Table 3.1 & Table 3.2).

3.1.i The Functionalist Perspective on Health and Illness

The Functionalist Perspective falls under the ambit of Social Structural approach, and in relation to health it draws quantitative data through social surveys, epidemiological studies and comparative studies to explore the role of societal structures and process in determining health outcomes of social groups. The core concept of functionalism points toward interdependence, functionality and continuity. Thus, society is compared to a biological organism that functions or lives as a result of integrated and continuous functioning of its organs. Likewise social events are explained in relation

to the functions they perform in continuity or existence of a society. Every society has certain rules, norms and values which are imbibed through socialisation and translated into roles. In Medical Sociology the approach is related to 'sick role' and the associated issue of illness behaviour (Crinson, 2007).

Talcott Parsons identified illness as a social phenomenon rather than a physical condition and health as against illness is identified as 'the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he/she has been socialised' (Crinson, 2007). Health therefore is considered as a prerequisite for the smooth functioning of the society, and to be sick is an unmotivated deviance which curtails one from performing his/her role in society. The sickness is thus regulated through the mechanism of 'sick role' concept and the 'social control' by doctors in allowing an individual to take on a sick status. The medical professionals, according to Parson, perform a selfless function by treating diseases using their scientific knowledge which is considered as a non-economic action done in the interest of the whole community (White, 2009, pp. 105-18).

There is an extensive criticism of Parsons' concept of the 'sick role'. According to the critiques Parsons' model best fits those situations in which sickness is acute and it is treated through medical skills. The model cannot be applied in cases of chronic illness like diabetes and physical disabilities in case of pregnancy as diabetes and pregnancy effects only part of the effected persons social roles.

3.1.ii The Marxist Perspective on Health and Illness

Marxist Perspective which is another Social Structural Approach asserts that production is the most basic of all human activities that includes the most basic production like food and clothing to the most advanced technological production in the modern world. Marx argues that any kind of production requires some sort of organisation and appropriate tools which involves social relations in the process (Crinson, 2007). He further argues that in modern industrial societies there is a clear division of labour in social relations of production which has given rise to different social classes. The economic base of a society is formed by these social classes or relations thus determining their superstructure that is the political, legal, educational, health etc.

In Medical Sociology this approach is applied on the social origins of disease. According to this approach health of the population depends largely on the capitalist economic system which operates at two levels. Firstly at the production process itself which can be in the form of industrial diseases, injuries or health issues due to environmental pollution, chemical pesticides or additives etc. secondly at the level of distribution since income and wealth holdings are major factors in determining a persons' standard of living and social patterning of health (Crinson, 2007). The approach argues that both capitalism and capitalist mode of production produce disease and also shape the way these diseases are dealt with by blaming the victim of the disease and controlling access to sick certificate. Medical facilities are profit oriented with high cost and modern technology thus limiting its access reflecting class inequality (White, 2009, pp. 80-104).

3.1.iii The Symbolic Interactions' Perspective on Health and Illness

Symbols and expressions give meaning to any language. In every social setting there are some forms of interaction or communication where symbols and expressions are used. Interactionists argue that the social identity of a person is formed on the basis of reaction of others. According to Aggleton 'People construct understandings of themselves and of others out of experiences they have and the situations they find themselves in. These understandings have consequences in turn for the way in which people act, and the manner in which others react to them' (Crinson, 2007). The approach asserts that an individual constructs his social identity through others perception of him, hence a deviant behaviour or diagnosis of disease can attach him to a label that is prevalent in that particular society which in turn can bring changes in his self-identity.

3.1.iv The Postmodernist Perspective on Health and Illness

Post-modernity refers to the changes in the economic structure from production to consumption. The approach argues that in a post-modern world there would be a decline in industries, working class, unionization etc. thus weakening the rigid distinction between class, public and private sectors and also gender division of labour (White, 2009, pp. 55-59). The social organisation would be based on increased freedom and flexibility which would liberate people from the traditional system of

occupation, class, caste, household division of labour and gender differences thus allowing them to construct their own social identity (ibid, pp. 55-59).

For Beck these changes mean that 'people will be set free from the social forms of industrial society, class-stratification, family and gender status' (Beck, 1992). According to Bauman the world that we live in today is a transformation from a culture of production in which hard work, thrift and self-discipline held sway to a hedonistic indulgence. Rather than hard work resulting in savings and social prestige we are rewarded with free sex, designer drugs and life in the fast lane' (Bauman, 1998). Some theorists interpret that free and week social structures can give way to freedom to construct bodies according to one's own wish. Giddens emphasizing openness of the body and individual freedom to shape it says that 'we have become responsible for the design of our own body' (Giddens, 1992).

Postmodernists see a reversal or change in old social trends, like decentralisation of power and governance. The decentralisation of government functions would bring significant implications in health care as it would give huge subsidies to bring up private companies into the sector and would drive more and more people into private health insurance, thus ironically encouraging and benefitting the capitalist. Post-modernism emphasises increasing options and freedom to shape their own lives to its individuals, in terms of health this means increased options to choose lifestyles and risk behaviours (White, 2009, pp. 55-59).

3.1.v Liberalism & Neo-Liberalism Perspectives on Health and Illness

Liberalism originated in 18th Century and gained importance in the political sphere in the 19th Century. Liberalism became the political arm of the new capitalist class that rose out of the industrial revolution. The consequence of such thought was reduced to governmental intervention in the market. It believed that society should be shaped by individuals striving on their own and pursuing their own interest thus achieving happiness. The major drawback of liberalism was creation of larger inequality in the society as vast majority of society do not start equally; some have more power and resources than the others. The system benefits the capitalist since it allows uncontrolled pursuit of profit and exploitation (White, 2009, pp. 59-61). Henry Mayhew, Booth and Engel argued that the pursuit of profit produces sickness and

disease and in such a social system individuals on their own are powerless to protect themselves (Kevin, 2001). According to Szreter 'health status could be improved only through governmental action and reforms, better food, clean water, housing and better and safe work environment' (White, 2009, pp. 59-61).

Diseases are not randomly distributed; researchers have found a pattern to these diseases with it being more prominent in poverty ridden areas like slums and industrial localities. Epidemiology the study of people's health and distribution of diseases supports that there should be governmental intervention on health at the societal level and individuals cannot be left on their own (White, 2009, pp. 59-61). But now with credits and loans from World Bank and International Monetary Fund (IMF) both developed and developing countries are privatising the health sector with state gradually retreating from the realm. The withdrawal of the state from the public domain was enshrined in the infamous statement by Margaret Thatcher "Society does not exist, only the individual" (ibid, pp. 59-61). Thus the Neo-Liberalism policies are ought to bring changes in the disease rates which could prove to be a reversal of the health status in the modern world. Beaglehole and Bonita argue that 'Public health is a collective action taken by society to protect and promote the health of the entire population' (Beaglehole & Bonita, 1997). However under Neo-Liberalism epidemiology has transformed and the focus has turned to individual risk behaviours rather than social factors.

The most common conceptualisation of Neo-liberalism is as a policy framework marked by a shift from "Keynesian" welfare towards a political agenda favouring operation of markets. The emphasis on markets is directly associated with globalization of capital. This globalized production relations and financial systems are forcing governments to abandon their commitment to the welfare state. Government policies thus become more focused on enhancing economic efficiency and international competitiveness rather than ensuring immediate needs like employment and an inclusive welfare system (Wendy, 2000, pp. 1-2).

According to the Post-structuralism theorist of Neo-liberalism, by invoking individual choice and limiting state functions it encourages both institutions and individuals to conform to the norms of the market. Neo-liberal strategies found in work places,

educational institutions, and health and welfare agencies encourage people to see themselves as individualized and active subjects responsible for enhancing their own well-being. In Neo-liberal government welfare agencies whether it is a health care centre or a Non-governmental Organisation or any civil society establishment are governed through technologies such as budget, disciplines, accountancy and audit (Wendy, 2000, pp. 12-13).

3.1.vi The Feminist Perspective on Health and Illness

The Feminists argue that patriarchy and medicine subordinate and control women by enforcing passivity and dependence which are considered as appropriate feminine traits. The health and illness depends largely on how the people are socialized into masculine and feminine social roles. Feminists argue that medicine plays a vital role in enforcing conformity to these social roles. Controlling women's ability to reproduce is central to a patriarchal society as medical attention is mostly paid to women's reproductive organs and their cycle since it is related to their ability to have children (White, 2009, pp. 132-39).

Feminists assert that women's illness is both a consequence and a response to patriarchal society. Sociologists have made a distinction between 'sex' which is a biological factor in male and Female and 'gender' which is a learned social role through socialization. Feminist argue that medicine labels women who deviate from the approved social roles by branding them as hysteria, chlorosis, anorexia etc (White, 2009, pp. 132-39). Women care for the disabled, elderly and children at home as unpaid labour, often with enormous impacts on their own health and well-being. Women enjoy a very low status in the society, work for long hours which involve more of unpaid labour, have greater social and emotional commitments and get fewer hours of sleep and leisure (ibid, p. 136). Paid work protects women from the stress of nurturing role and helps to enhance their self-image (Lennon & Rosenfield, 1992, pp. 316-27).

3.1.vii Foucault's Perspective on Health and Illness

The French thinker Michel Foucault's perspective is very similar to Parson's. Like Parson Foucault also considers medicine as an institution of social control and sickness as a constructed deviant behaviour. While for Parson 'sick role' is to avoid

social obligation, for Foucault medical profession helps in identifying the deceased (White, 2009, pp. 119-31). He argues that modern medicine is manifestation of an administered society in which there is a need of centralised information for social planning. He focuses on the development of a bureaucratic state in modern societies. Foucault's analysis of modern society moves around three interrelated aspects; body, power and knowledge (ibid, pp. 120-21).

Foucault argues that academic disciplines of psychology, psychiatry, medicine and social sciences define the social role and social functions of the people and establish lifestyles and norms of behaviour. According to him it is enforced through professional groups and is internalised by the people as subjective realities. According to this approach the status of the body is a social accomplishment though it is defined medically (White, 2009, pp. 119-31). The technological advancement in the medical field has changed the concept of natural body as technology is used for restructuring the body and body parts thus highlighting the social shaping of body (ibid, p. 124).

3.1.viii Socio-Psychological Perspective on Health and Illness

Durkheim was the first researcher and sociologist to provide an argument with empirical data that the health and quality of social life are closely related. According to Durkheim, sociologists focus on social networks, social stress and the role of community in preventing or causing illness. He argued that people with weak social ties and relation were at the risk of 'egoistic suicide' as they overvalued their own existence and considered themselves free of any kind of obligation to the community. At the same time he also argued that strong social ties would lead to 'altruistic suicide' as they have a tendency to sacrifice themselves for the cause of the group or community (White, 2009, pp. 67-68).

The approach conceptualises stress at three major areas; Life events, chronic strain and daily existence. Disease and illness can crop up when these stressors accumulate in the body. Life events such as death, unemployment, divorce can result in physical illness or weakness, psychological distress and psychiatric disorders (White, 2009, p. 67). According to Elstad 'Psycho-social perspective is based on three core assumptions (1) Psychological stress is an important cause of health inequalities (2) Psychological stress is socially produced and distributed and is a product of social and

interpersonal relationship and (3) social and interpersonal relationships are mediated by inequality' (Elstad, 1998, pp. 598-618).

Social stress can be conceptualised as any socio-environmental change that prove to be challenging to the individual. Unemployment, poverty or economic instability, homelessness etc. create ongoing negative stress which causes the individual to modify behaviour pattern that can result to physiological and emotional reactions leading to multiple illness. Stressors impact differently on different social groups; long term stressors are distributed unevenly and reflect a wider pattern of inequality (White, 2009, p. 68). Daily life stress can be latent as some of these stressors may be socially initiated and would not be open to introspection (Link, Lennon, & et al, 1993, pp. 1351-87). There are also buffers to stressors like social support network, coping resources etc. Individuals make sense of these stressors and would come up with positive coping strategies thus regaining their health and increasing resilience to similar stressors (White, 2009, p. 69).

3.1.ix Socio-Cultural Perspective on Health and Illness

Socio-cultural perspective is a theoretical thinking used to describe the circumstances and surroundings of individuals and the ways in which it influences their behaviour and health pattern. According to Catherine, A. Sanderson the perspective looks into the behaviour and mental processes as shaped by their social or cultural interaction ("Sociocultural Perspective", 2014). The theory covers a broad area by applying to every sector in daily life, the process of communicating; relating, understanding and coping with different actors are significant to the theory (ibid). In the context of health and illness developing a socially and culturally sensitive understanding is important theoretically as well as practically (Ayse & David, 2009, p. 1). Understanding health from socio-cultural perspective involves deliberating on the importance of religion, tradition, politics, economics, history, ecology, technology and society's view of science in influencing a person's well-being (Alexis & Christie, 2007).

Incorporating culture in to the study of health and illness is important to improve health through promotive, preventive, curative or rehabilitative activities (Ayse & David, 2009, p. 1). A society with vast disparities in health due to prevalence or occurrence of certain diseases can be attributed to discrimination and prejudice in

health care settings and poor accessibility; these can be tackled better by understanding their culture. In social science culture refers to structures, institutions, values, traditions, and ways of engaging with social and non-social world that are shared among members of society and transmitted across generations through social learning. 'Individualism' and 'Collectivism' are two commonly used constructs used to capture the cultural differences and similarities in relation to health and illness (ibid, p. 1). Individualistic culture is characterised by self-defining attributes which fulfils personal independence and uncommitted relationships. But collectivism is defined by interdependence, social relations and membership in groups. They are largely influenced by mutual obligation and fulfilment of in-group expectations while the relationships are more stable and lasting (Adams, 2005, pp. 948-68).

The advances made in medical science in the past few decades have made a mark in prolonging lives, improving health care and lowering disease and death rates. However the improvement in the field of health cannot be completely attributed to the advancement in medicine alone but gradual improvement in the standard of living as well (Dak, 1991, pp. 14-18). While antibiotic drugs are still necessary to control normal diseases many other diseases and health hazards have cropped up due to various social settings and changes. Old epidemiological approaches like bacteria and virus are no longer of much help in controlling the new set of diseases, therefore shifting the attention to aetiology of diseases which lays emphasis on behaviour patterns, life styles, and cultural factors to bring out the cause and their likely control (ibid, pp. 14-15). The socio-cultural approach to the health calls for the identification of whole process for understanding the aetiology of disease so that the events leading to the disease can be traced. Now it has been established that lifestyle, customs and tradition, beliefs and practices, vocation and profession have serious consequences on the health of an individual. With an increasing attention towards prevention rather than therapy, many chronic diseases can be efficiently prevented and controlled by a timely change in behaviour, lifestyle and dietary pattern (ibid, p. 15). Social-epidemiological studies have made efforts to identify socio-cultural factors associated with diseases and also factors associated with preventive and therapeutic care (Suchman, 1965, pp. 2-16).

3.2 Selected Theories Applied for Analysis

The study is being analysed using mainly three perspectives (1) Socio-cultural Perspective for analysing and assessing the social, cultural and economic settings and their effects on health and illness of the sample population (2) Socio-psychological Perspective to analyse and understand the intergenerational relationships and their effect on health and illness of the sampled elderly (3) Neo- liberalism to analyse and comprehend the Institutional and governmental role and interventions and their impacts on the health and illness of the sampled geriatric population. Though there are several theoretical paradigms the study has applied these three approaches to comprehend the various aspects of the study as it aptly applies to it (Table 3.3).

SNAPSHOT OF VARIOUS THEORIES ON HEALTH AND ILLNESS

No	Theorist	Theory	Explanation
1	Talcott Parsons	Functionalist Perspective	'Health' is the optimum capacity of an individual for the effective performance of roles and tasks for which a person is socialized. So to be sick is an unmotivated deviance which curtails one from performing his/her role. The sickness therefore is regulated through the mechanism of 'sick role'.
2	Karl Marx	Marxist Perspective	Both Capitalism and capitalist mode of production produce disease and also shape the way these disease are dealt with by blaming the victim of the disease and controlling access to sick certificate
3	Aggleton	Symbolic Interactions' Perspective	An Individual constructs his social identity through others perception of him, hence diagnosis of disease attach a person to a label that is prevalent in that particular society thus changing his/her self-identity
4	Ulrich Beck; Bauman; Anthony Giddens	Postmodernist Perspective	Freedom from class-stratification, gender status. There would be a transformation from hard-work and self-discipline to hedonistic indulgence. Individual freedom to shape one's own body by increased options to choose life-styles and risk behaviours.
5	Adam Smith; Henry Mayhew; Booth; Engel; Szreter; Beaglehole and Bonita	Liberalism and Neo-Liberalism	Liberalism supports reduced governmental intervention in the market thus allowing uncontrolled pursuit of profit and exploitation. Pursuit of profit produces sickness and disease in which individuals become powerless to protect them.

Table 3.1

No	Theorist	Theory	Explanation
6	Several feminist	Feminist Perspective	The health and illness largely depends on how people are socialized into masculine and feminine social roles. Medicine enforces conformity to these social roles by paying more medical attention to women's reproductive organs and cycle as controlling women's ability to reproduce is central to a patriarchal society.
7	Michel Foucault	Foucault's Perspective	Academic disciplines like Psychology, Psychiatry, Medicine and Social sciences define social roles and social functions of the people and establish lifestyles and norms of behavior. These roles and functions are further enforced through professional groups and internalized by the people. Technological advancement and technology is used to restructure the body parts thus highlighting the social shaping of body.
8	Durkheim; Elstad	Socio-Psychological Perspective	Social networks, social stress and role of family and community prevent or cause illness. Disease crop up when stressors accumulate in the body thus causing the individual to modify behavior pattern that can result in psychological and emotional reactions.
9	Catherine, A. Sanderson	Socio-Cultural Perspective	An individual's behavior or mental process is shaped by his/her social or cultural interaction. The theory calls for understanding the etiology of disease so that the events leading to disease can be traced. Lifestyle, customs, traditions, beliefs and practices, vocation and profession have serious consequences on the health.

Table 3.2

SNAPSHOT OF THEORIES APPLIED IN THE STUDY

No	Theorist	Theory	Explanation
1	Catherine, A. Sanderson	Socio-Cultural Perspective	An individual's behavior or mental process is shaped by his/her social or cultural interaction. The theory calls for understanding the etiology of disease so that the events leading to disease can be traced. Lifestyle, customs, traditions, beliefs and practices, vocation and profession have serious consequences on the health.
2	Durkheim; Elstad	Socio-Psychological Perspective	Social networks, Life events can give rise to social stress and role of family and community can prevent or cause illness. Disease crop up when these stressors accumulate in the body thus causing the individual to modify behavior pattern that can result in psychological and emotional reactions.
3	Adam Smith; Henry Mayhew; Booth; Engel; Szreter; Beaglehole and Bonita	Liberalism and Neo-Liberalism	Liberalism supports reduced governmental intervention in the market thus allowing uncontrolled pursuit of profit and exploitation. Pursuit of profit produces sickness and disease in which individuals become powerless to protect them. It encourages the people in health and welfare agencies to see themselves as individualized and active subjects responsible for enhancing their own well being.

Table 3.3

3.3 Research Methodology

In order to have a holistic approach of the problem and to have a representative data across the state, five districts are selected which fall in different regions of Gujarat. By doing so, the researcher would like to find out whether there is any sub-cultural variation in dealing with the elderly.

The districts selected are Panchmahal from the eastern region of Gujarat, Surat from the southern region of Gujarat, Kachchh from the western region of Gujarat, Banaskantha from the northern region of Gujarat and Anand from central Gujarat. The sample is purposive and consists of randomly selected 285 elderly populations of 60 years of age and above. 60 samples were selected from all the districts except Panchmahal. In Panchmahal district the elderly sampled are 45. The total elderly sampled from households are 150, out of which 75 are from urban and another 75 are from rural. Of the total sampled elderly from both rural and urban 76 are males and 74 are females (3.5 Flow Chart).

To get a representative sample care has been taken to select samples from all strata of the society that is upper, middle and lower classes as well as caste groups. In the household category the elderly staying as single, in nuclear families and joint families have been selected. A total of 135 elderly were also sampled from different Old-age homes of which 66 are males and 69 are females. 30 elderly were sampled from old age homes in each district except for Panchmahal as the district has only one old age home and there are only 15 elderly staying in the institution.

Design of the study is empirical research field work. To collect the required information for the study a structured interview schedule with both open ended and close ended questions were used. The interview was carried out by the researcher on a one to one basis. The interview schedule was piloted and tested in a small sample for its reliability and necessary changes were made. Secondary data has been collected through reviewing literature from various books, research papers, government documents, websites and also census and NSSO data, which was largely used to project the demography of the previous years or to support the findings of the study. The acquired data through survey are analysed using both qualitative as well as quantitative methodology.

3.4 Framework of the Study

The thesis has been presented in four parts:

Part I

It deals with an introduction which gives a description on the evolving issues of 'ageing population' in our country as well as world over. It further goes on to explain what is ageing and who are considered as aged by putting forth several definitions of the key words used in the study to give a clear understanding of the meanings interpreted for those words. The historical development of sociology of health and illness at the global level as well in India gives a clear picture on how the subject has evolved over the years. A brief sketch of the study locations is followed by the aim and focus of the study. The hypothesis formulated gives a definite direction to the research conducted **(Chapter-1)**. A compilation of review of several literatures which gives a clear idea on the issues related to ageing as well as health and illness related to the elderly at the international, national and local level are discussed at length **(Chapter-2)**. Conceptual framework discusses the various theoretical paradigms applicable to study ageing and health. The research methodology give an idea of the sample, tools and techniques applied to collect the required information on the subject and to analyse and interpret it based on the strategy planned for enquiry to achieve the set objectives **(Chapter-3)**.

Part II

It deals with the analysis and interpretations of the various aspects of the study pertaining to the socio-cultural and economic aspects that leads to health and illness of the elderly **(Chapter-4)**. It also deals with the psychological and physical characteristics of the elderly in context of health and illness **(Chapter-5)**. It gives the status of health and illness of the elderly who are staying in several Old-age homes in the study location by assessing several variables **(Chapter-6)**. Further it discusses the role of hospitals and NGO's **(Chapter-7)**.

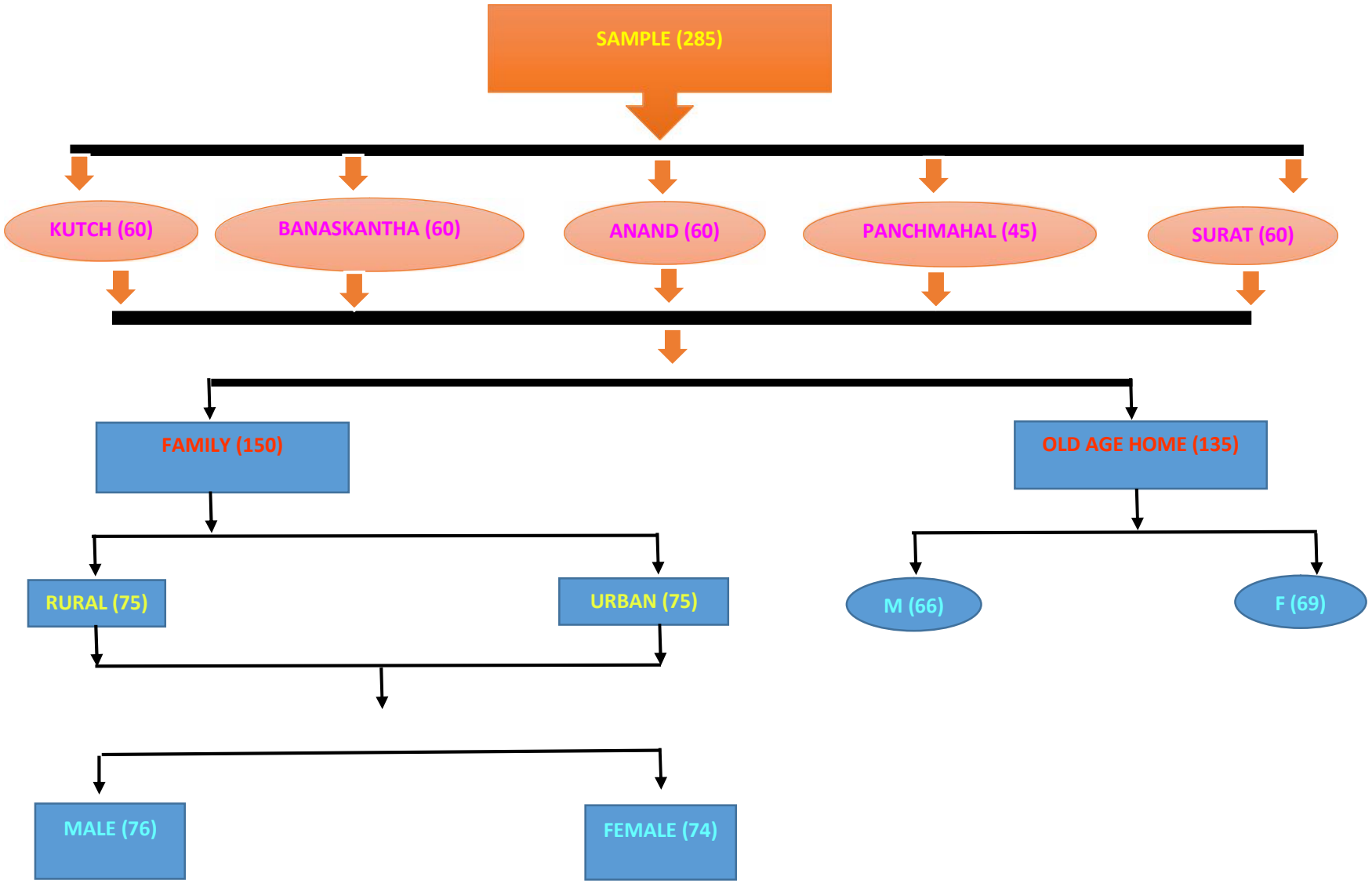
Part III

It deals with the government policies and programmes pertaining to the aged giving a clear idea on the effectiveness of the programmes implemented **(Chapter-8)**.

Part IV

It showcases the concluding reflections of the study with suggesting some recommendations **(Chapter-9)**.

3.5 Sample Flow Chart and Timeline



TIMELINE OF FIELD VISIT		
ANAND		
S.no	**Villages/Towns/City/OAH**	**Date(s) visited**
Anand District (Urban/Town/City)		
1	Anand	26/9/12; 2/2/12; 18/9/12; 22/9/12 ;6/2/12; 20/9/12
2	Karamsad	15/9/12; 16/9/12
3	Borsad	16/9/12; 18/9/12
Anand District (Rural/Villages)		
1	Ambali	11/10/12; 16/10/12
2	Gorel	11/10/12; 16/10/12
3	Bamanva	27/10/12
4	Manpura	8/10/12
5	Vatadara	17/10/12
6	Ralaj	25/10/12;29/10/12
Anand District (OAH)		
1	Jalaram Vadeel Vishram Bhavan	17/11/12; 22/11/12; 15/11/12; 16/11/12; 21/11/12; 19/11/12
2	Anand Dham	27/9/12; 5/12/12; 4/10/12; 30/11/12; 1/12/12
3	Aashra Vrudhashram	30/10/12; 6/11/12; 8/11/12

Table 3.4

TIMELINE OF FIELD VISIT		
PANCHMAHAL & BANASKANTHA		
S.no	**Villages/Towns/City/OAH**	**Date(s) visited**
Panchmahal District (Rural/Villages)		
1	Babrol	20/4/13
2	Suksar	4/5/13; 5/5/13
Panchmahal District (Urban/Town/City)		
1	Godhra	14/7/13
2	Sahera	16/7/13
Panchmahal District (OAH)		
1	Nishat Vrudhashram	23/8/13
Banaskantha District (Rural/Villages)		
1	Sadarpur	23/6/14
2	Khemana	24/6/14
Banaskantha District (Urban/Town/City)		
1	Hanuman Thekadi	23/6/14; 26/6/14
2	Gogri Nagar	2/7/14
3	Sonbath	3/7/14
Banaskantha District (OAH)		
1	Sree Palanpur Hindu Samaj Vadeel Vishranti Bhavan	24/6/14; 25/6/14; 2/7/14

Table 3.5

TIMELINE OF FIELD VISIT		
KACHCHH		
S.no	**Villages/Towns/City/OAH**	**Date(s) visited**
Kachchh District (Rural/Villages)		
1	Dudhai	28/10/13
2	Bhudarmora	28/10/13
3	Thaneti	28/10/13
4	Amrapar	28/10/13
5	Lakhapar	27/12/13
Kachchh District (Urban/ Town/City)		
1	Bhuj	25/12/13; 27/12/13; 28/12/13
2	Mundra	27/12/13
Kachchh District (OAH)		
1	Sree Madhapar Leva-Patel Apnu Ghar	26/10/13
2	Shantiniketan Vrudhashram	28/12/13; 27/10/13; 26/10/13
3	Sree Meghji Sojpal Jain Ashram	30/12/13

Table 3.6

TIMELINE OF FIELD VISIT		
SURAT		
S.no	**Villages/Towns/City/OAH**	**Date(s) visited**
Surat District (Urban/Town/City)		
1	Sree Nivas Vrudhashram	3/3/14
2	Ambika Niketan Vrudhashram	4/3/14;14/5/14
3	Asakthashram	4/3/14
Surat District (OAH)		
1	Vaheval (Mahua)	10/3/14
2	Puna	
3	Bhoriya	
Surat District (Rural/Villages)		
1	Goddaud	16/3/14
2	Surat City	
3	Parle point	
4	Nanpura	14/5/14

Table 3.7

3.6 Demographic Distribution of Sample Population

The data has been collected from three major sectors that is rural, urban, and Old-age home of five different districts in Gujarat. The sample consists of both males as well as females randomly selected from a voters list. In rural and urban sampling, care has been taken to include population from different strata of society on the basis of religion as well as class to get a better representation. In the Old-age home sampling there has been no pre-set criteria of class or religion.

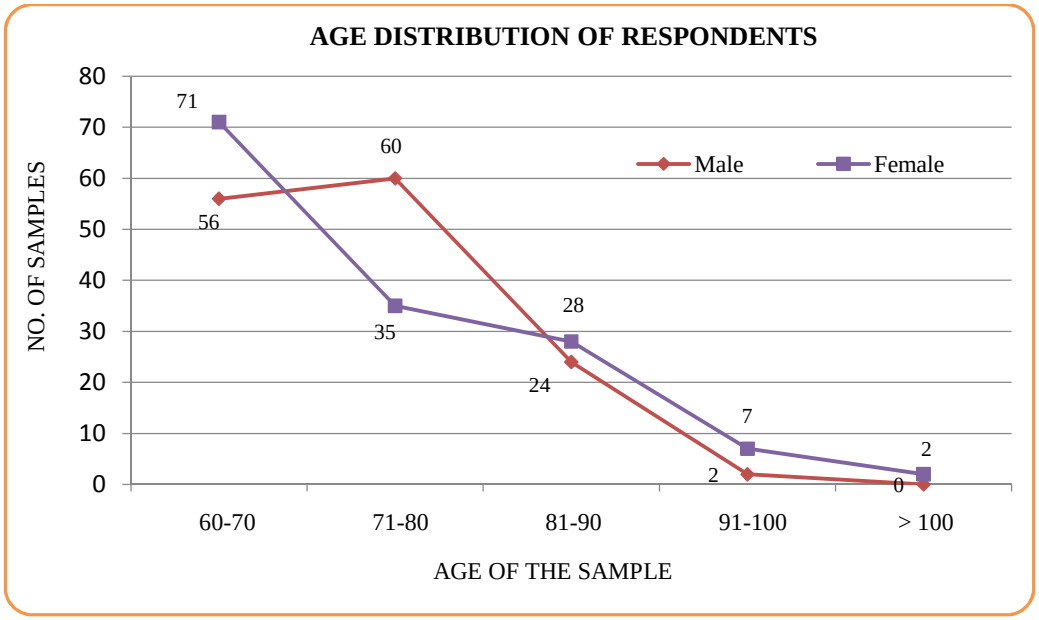


Figure 3.1

The analysis of the data (Figure 3.1) comprising of 285 sample population in which there are 142 males and 143 females, shows not much difference in the distribution of males and females in each age category except for seventy one to eighty category. The 60 to 70 age category has the maximum number of samples that is 49.6% of females and 39.4% of males. In the 71 to 80 years category a slight rise in the number of male sample population has been noticed, which is 42.2% as compared to female sample population that is 24.4%. The data shows that as the age increases the number of females in each category also increases as compared to males. The 81 to 90 age category shows 19.5% of females to 16.9% of males, similarly in 91 to 100 years age group there are 4.8% of females and 1.4% of males. The sample data shows only 1.3% of females but no males in 100+ age category.

An effort has also been made to assess the distribution of sample population in the different age categories on the basis of rural, urban and Old-age homes (Figure 3.2) to understand whether there is any considerable variation in the age distribution pattern.

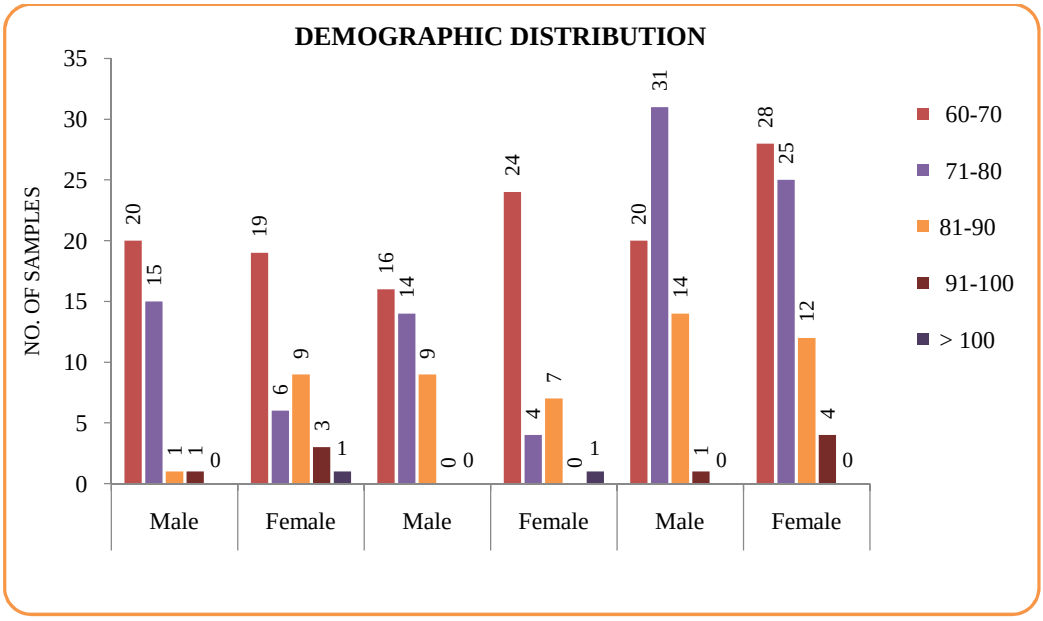


Figure 3.2

The analysis of the randomly selected male and female population in the rural sector shows that the major chunk that is 14% of men and 13.2% of women belong to the 60 -70 age group but in the urban sector this group includes 11.2% of males which is slightly lower than the rural sector, though there is a generalized belief that men and women in urban areas has a longer life span due to the availability of better medical and infrastructural facilities. At the same time the data shows an increase of urban women in this category compared to the rural sector that is 16.7%. The remaining males in the rural sector has 9.1% in 71 - 80 category and 0.7% each in both 81 - 90 and 91 - 100 categories, in 100+ category there are no males in the rural sample population.

In the urban sector there are no male populations in the 91-100 as well as in the 100+ category. In this sector the sample population of women in all the age groups other than 60 to 70 and more than 100 are slightly lower than the rural sector where sampling showed women of all age groups. In Old-age homes the maximum number of male sample population fall in the 71-80 age group that is 21.8% implying that

most of the elderly males are left in these homes as their age increases and disability sets in whereas among the female sample population in Old-age homes maximum number of samples fall in the category of 60 - 70 and 71 - 80 that is 19.5% and 17.4% respectively. Thus the age distribution pattern among the Old-age home women suggests that most of the women opt for Old-age home at an age when they are still healthy and active, the reason being economic dependency and intergenerational conflict.

3.6 Strategy of Inquiry

The Study has made an attempt to examine and understand the status of health and illness among the geriatric population of Gujarat by analysing several aspects. The different parameters examined are categorised under- Socio-cultural and economic issues; Psychological and physical problems and; Institutional functions and support. The interpretations of these categories are carried out using appropriate theoretical approaches that are applicable to the concerned aspects.

The study has viewed health and illness of the sampled geriatric population from the sociological perspective to support and substantiate that health and illness are not merely as a result of biological changes but also largely due to the external environment and living conditions.

3.7 Objectives of the Study

Several objectives have been set to examine and explore the health and illness of the elderly population in Gujarat.

The objectives of the study are the following:

1) **To study the following 'social aspects' effecting the health and illness of the elderly.**
   - To find the variation in health status among the rural and urban elderly respondents.
   - To know the health status of the elderly staying in households and Old-age homes.
   - To understand the relation between marital status and health and illness.
   - To ascertain health status of the elderly in joint families.
   - To know the impact of literacy level on health and illness.

- To examine the availability of basic sanitation facilities.
- To examine whether cultural norms, beliefs and practices affect health and illness.

2) **To study the following 'economic aspects' effecting the health and illness of the elderly.**
   - To examine the relation between health, illness and class.
   - To understand the difference in health and illness of employed and unemployed elderly.
   - To find the health and illness status of the superannuated elderly with pension/investment.
   - To find the health and illness status of the elderly with no income.
   - To find the health and illness status of the elderly who are dependent on their children for sustenance.
   - To find if there is any occupational related health issues.

3) **To analyze the impact of the following 'psychological aspect' on health and illness of the elderly.**
   - To study the effect of spirituality on health status of the elderly.
   - To know the effect of recreational activity on health and illness.
   - To examine the intergenerational relationships and its effect on health and illness.
   - To understand the attitudinal and behavioral changes and their effect on health and illness.
   - To know the impact of elderly abuse on their psychological health.
   - To know the impact of loss of spouse/ partner on the status of health and illness.
   - To examine the occurrence of depression and other psychological problems faced by the elderly.
   - To examine the facilities provided by the Old-age homes and the level of satisfaction and happiness among its residents.

4) **To study the effects of the following 'physical problems' on the health and illness of the elderly.**
   - To examine the health status of aged males and females.
   - To find out the disabilities found among the aged.
   - To know the long term illnesses found among the aged.
   - To examine the morbidity pattern among the aged.
   - To find out the addictive habitual practices.
   - To know whether the elderly are physically abused.
   - To examine the availability of proper health interventions and accessibility to health care centers.
   - To find out the interval of medical examination.
   - To find out the rate of hospital visits.
   - To know the availability of nutritious diet and supplement.
   - To know the type of health care accessed and approached.
   - To relate the health of the elderly who are active with the elderly who are inactive.

5) **To analyze the role and achievement of various organizations and policies for the elderly.**
   - To find whether there are age-friendly hospitals and health care centers.
   - To examine the role of NGO's in elderly health.
   - To understand the various schemes, policies and programs of government and their effectiveness.
   - To examine the infrastructure, manpower and administrative efficiency of old age homes.