CHAPTER- 5

HEALTH AND ILLNESS AMONG THE ELDERLY: PSYCHOLOGICAL AND PHYSICAL ISSUE

"***Do not cast me off in the time of old age, forsake me not when my strength is spent***"**- Seventy First Psalm**

Introduction

Ageing has always been known to be the final part of the journey in life. Perspective of the 'self' as per the change of time in the given environment is essential for a successful ageing. Adjustment of life in old age is thus a process of development. It is a myth that ageing provides an extended vacation from learning and development. The ancient Indian texts beginning from Rig-Veda and the Puranas have highlighted the importance of essential changes in the persons as one move around in the stream of life (Paramjeet, 1992, p. 15). Life style factors have a greater psychological impact than genetics, which increase longevity, delay illness and improve the quality of life. The change in the family patterns and the variation in social and economic status between generations are reasons of stress. Always it is not a progression from good health and active mental life to chronic illness and senility. Most people remain vigorous and active until the end of long life (Madhu, 2009, pp. 73-77). According to Rowe and Kohn (1998) the way people take the stress and strain of living has something to do with the wearing out of mind and body. They proposed three components of successful ageing; (a) avoiding disease, (b) engagement with life, and (c) maintaining high cognitive and physical function (Rowe & Kohn, 1998).

5.1 Socio-Psychological Relations

The study has tried to analyse the living arrangement among the sample population. The health and illness of an individual is not entirely depended on the biological wear and tear but would largely be influenced by the day to day social and psychological stress and strain as well.

5.1.i Satisfaction and Change of Living Arrangement

Satisfaction is a relative term that can't be measured easily and keeps on changing with time and situation. The study has taken into consideration the self reported satisfaction of the elderly on the basis of the care, support and inclusion they experience in the environment they are currently staying in. The data (Figure 5.1) shows that 76.8% are satisfied with their living arrangement.

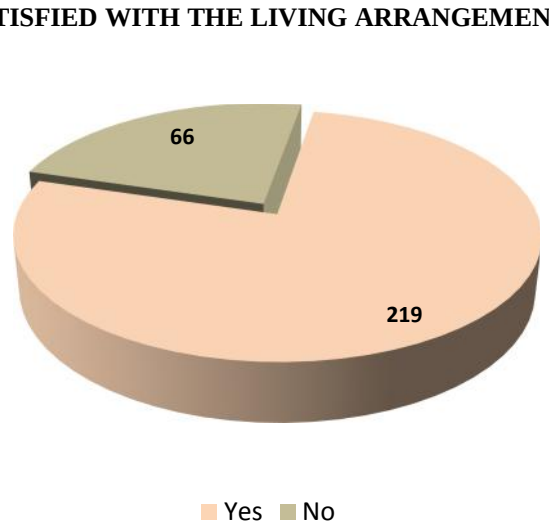

Figure 5.1

Analysis of the sampled data (Figure 5.2) is to understand the level of satisfaction among the respondents staying as single, in nuclear family, joint family, and old age home in relation to their stay and willingness to continue with the present arrangement reveals that 219 sample populations are satisfied with their present living arrangement. Most of the respondents whether in nuclear family or joint family prefer to stay wherever they are as they think that is the best option available to them. At the same time this does not prove that the elderly are happy with their present arrangement, as 88 sample populations in old-age home have wanted no change in their living arrangement. The elderly in Old-age homes were observed to be unhappy and discontent with life but when asked about changing their living arrangement most of them preferred to remain in the institution as the stay with their children or relatives is not better. Four respondents staying in nuclear family has admitted that though the present arrangement is alright, they would like to stay with their children.

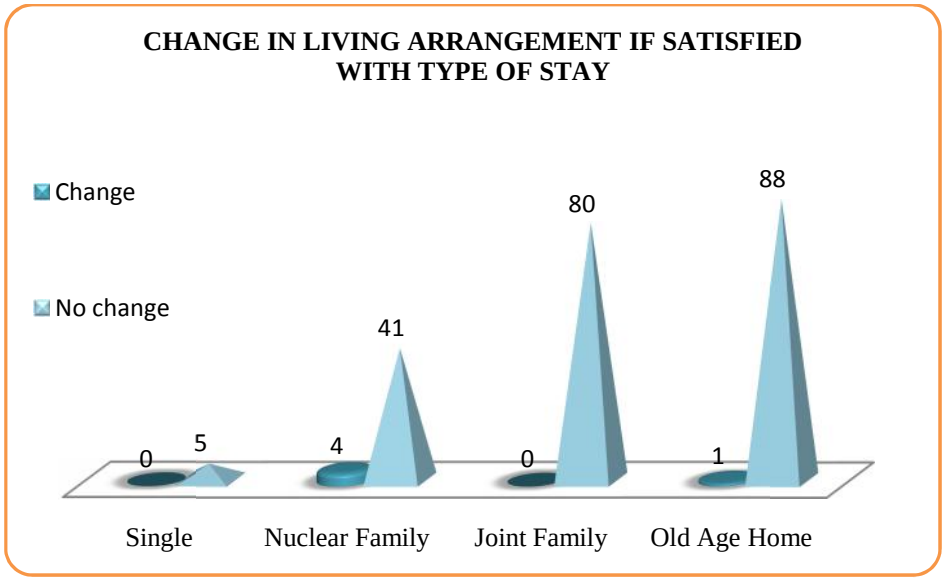

Figure 5.2

The graph (Figure 5.3) shows that the maximum numbers of sample population who are not satisfied with their present arrangement of stay are residents of Old-age homes. Out of 46 Old-age home respondents 27 wish to change their stay if given a chance. In Old-age homes it was observed that the elderly respondents who have no children are comparatively satisfied and consider themselves lucky to be under a roof, while residents with children has a constant disappointment with their condition as their expectations were very different from what they are in.

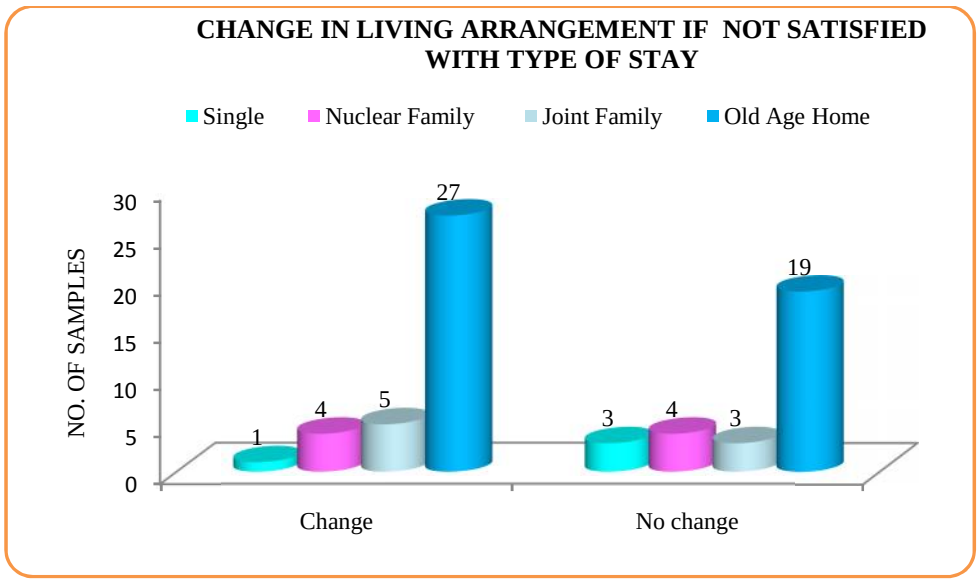

Figure 5.3

The respondents in families and not happy with their staying arrangement are usually those who have some kind of conflict with their family members. One respondent who is not happy with the single living arrangement is a woman who has only a married daughter. She leads a lonely life as the culture does not permit her to stay with her daughter. The respondent admitted that both she and her daughter feel helpless as the daughter is staying in a joint family along with her in-laws. She said that she is helped by her friends and neighbours in time of need.

5.1.ii Relation with Friends and Sharing of Worries

Several studies have proved that greater the social bonding and social relations better the health of an individual, especially in cases of elderly these relations act as a buffering zone for age related stress. The analysis of data (Figure 5.4) shows that 52.1% of men and 58% of women do not maintain any relation with their friends. It has been noticed that as age increases most of the elderly move towards voluntary seclusion, they make minimum effort in socialising.

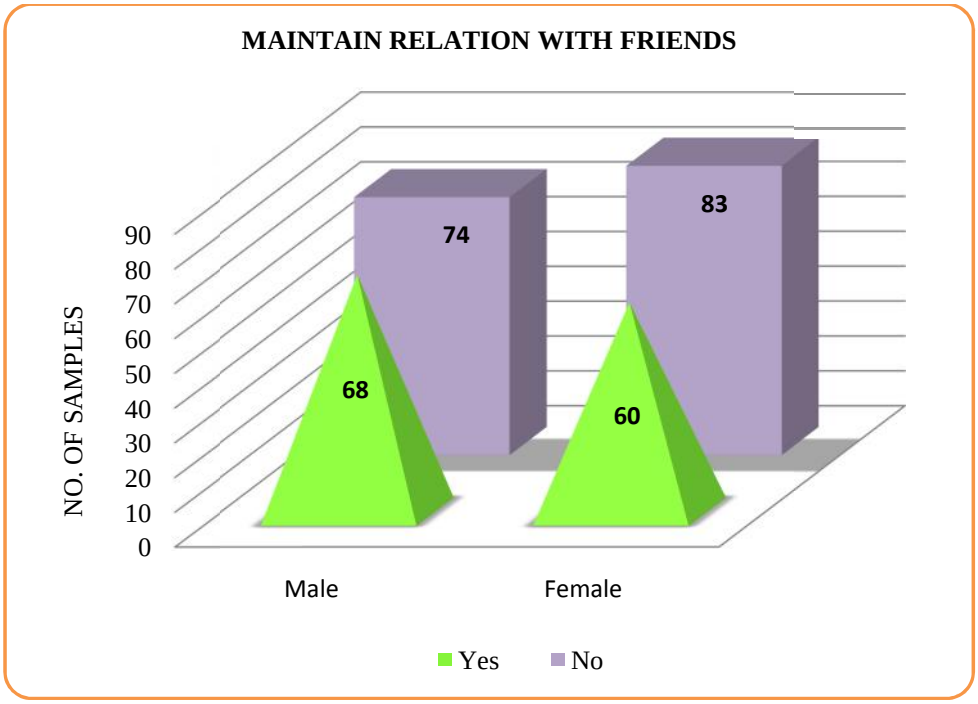

Figure 5.4

The data reveals that in rural location only 11 respondents have been identified as having no relation with friends. It was observed during data collection that in villages the interpersonal relationships are very good. People knew each member of the village and also in most of the villages the immediate families lived nearby or next to each other thus creating a strong social bonding and interdependence among families as well as among other village members.

In urban locations the respondents who did not maintain relation with their friends are found to be slightly higher than the rural respondents. In cities the interpersonal relations with neighbours were found to be very limited and the elderly reasoned that their long-time friends were staying in other localities and it is not possible for them to travel and meet often. The researcher visited a park meant solely for the elderly in Bhuj town in Kachchh district. Casual talk with the visitors of the park revealed that most of them visited it regularly either in the morning or in the evening. The main reason to visit the park is to meet their friends and have a chat. Some of the elderly admitted that all have their share of stress in personal life but a few hours spent in the park refreshes them. But the researcher also noticed that compared to men there were very few women visitors.

In Old-age homes there are 121 sample populations who do not keep any relation with their friends. In Old-age homes the scenario is very different from rural and urban. The data reveals that most of the residents of Old-age homes do not belong to that particular district, they are either from neighbouring districts or they have a relative in that particular district. Most of them prefer to stay in Old-age homes away from their birth place or home town as they feel ashamed of their situation and also to avoid questions from friends and relatives.

On further examination of data it was found that very few respondents share their worries with a friend that is 29.5% of males and 39.8% of females. Friends include long time friends as well as neighbourhood friends and in case of Old-age homes their roommates. The data (Figure 5.5) shows that the majority of the respondents in rural sector that is 24 males and 29 females share their worries, as said earlier the interpersonal relationships are very strong in rural areas. Everybody knows every other persons personal issues, so generally there are bound to be discussions when people meet each other.

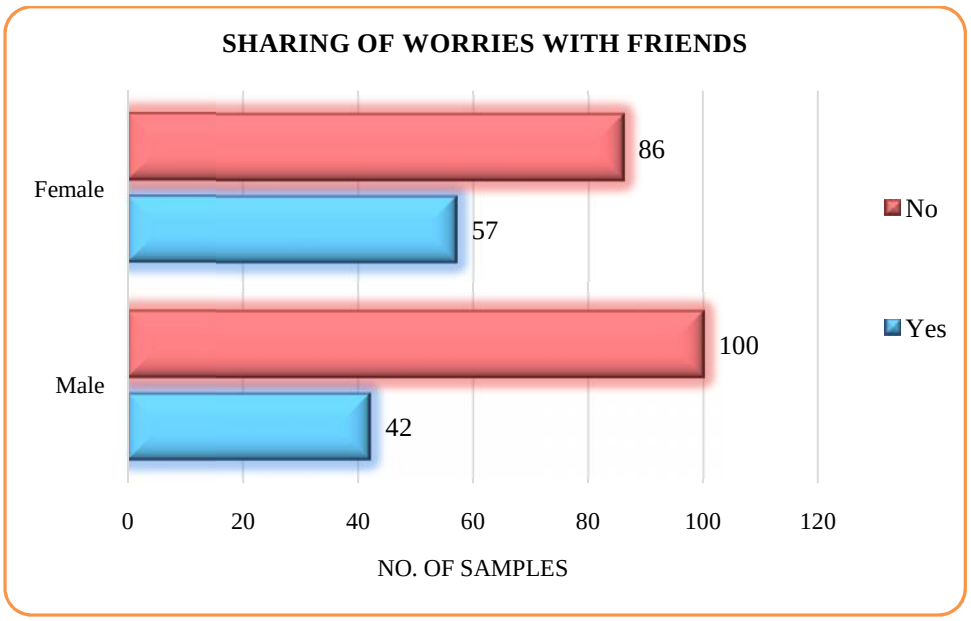

Figure 5.5

In urban locations 12 males and 22 females are found to be sharing their personal worries with their friends. The respondents who do not share their worries argue that sharing wouldn't solve their problems and they wouldn't want others to know about their personal issues. Only 6 males and 6 females in old age homes share their worries with their roommates. Though in Old-age homes people have similar issues and problems that lead them there, it was observed that there are conflicts and groupings between residents which are more common among female residents. Sometimes the conflicts are serious enough that the authorities have to intervene and reach a consensus.

5.1.iii Relation with Children

With the advent of this century Gujarat like any other state has undergone tremendous transition in lifestyle, economic activity and social setting. The fast and modern life style adopted by the younger generation has left little time for family bonding. The competitive work pressure and the secondary sources of entertainment facilities have pushed men and women alike into a world of individualism. But in this scenario the elderly population who are neither into competitive economic activity nor technology savvy entertainment activities is left unattended or uncared for leading them to

depression and senility. The happiness of an elderly depends on the amount of attention and care they receive from their loved ones particularly the children.

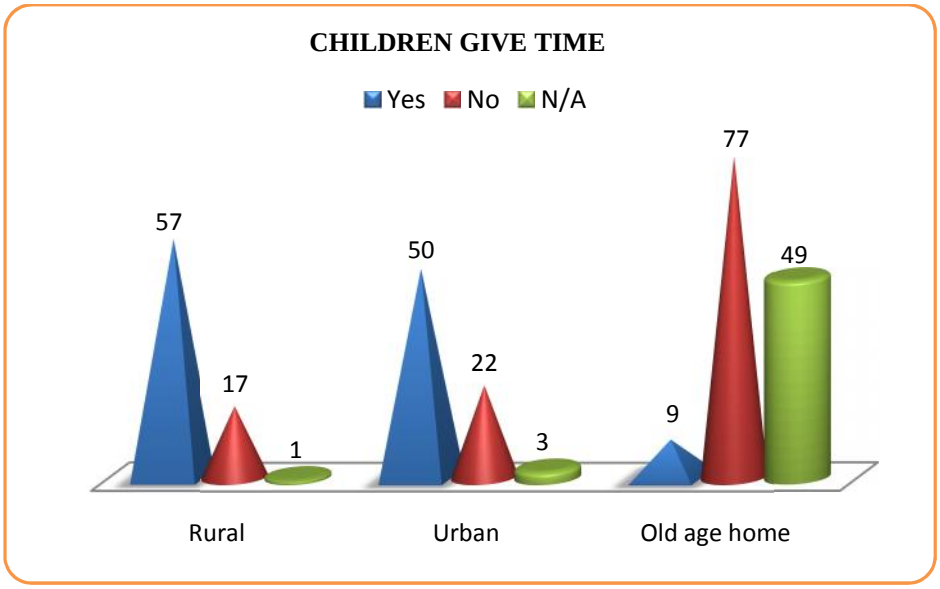

Figure 5.6

The data (Figure 5.6) shows that the elderly in rural location fare better, i.e. 76% of the rural respondents have children who give them enough time. This may be also due to the lifestyle that the rural population lead. They are engaged in agriculture or associated economic activity for a living where all the members in a family actively participate in one form or the other. Life in a rural setting goes forward with mutual dependence of all in a family. In rural areas, the respondents, whose children have migrated to towns or other countries live a secluded life supported by their neighbours and friends in times of need. 22.6% of respondents do not get to spend enough time with their children.

In urban locations 66.6% of the respondents have children who spend time with them. In Gujarat the joint family system is still prevalent in urban locations as well. In such setting it was observed that the elderly is the binding force between the family members. Most of such families are headed and run by the elderly in the family. All decisions whether concerning a particular member or concerning the whole family is made after discussion among the members of the family. 16 respondents in nuclear families said that their children come and spends some time with them during weekends. In some cases it was observed that though the children are staying

separately they regularly visit their parents and help them with their shopping and other works. In urban sample population 29.3% of the respondents have children who do not spend time with them; these are mostly elderly who are staying as a nuclear family. The study has found that the male respondents are the most vulnerable whether in rural or urban.

In Old-age homes 57% of the elderly do not receive any attention from their children. Most of the respondents said that their children visited only to pay the monthly fees. It was observed that daughters visited their parents in Old-age homes more frequently than the sons. A few respondents of Old-age home that is 6.6% have children who visit them regularly and spend time with them. It was observed that some of the respondents stay in Old-age homes because of no adequate space in the house in spite of having good relations with their children.

5.1.iv Emotional Bonding

Every individual has different levels of bonding; the study has made an attempt to assess the closeness between the elderly with that of family members and friends (Figure 5.7). An individual seeks support and understanding from the person with whom he or she is emotionally close with.

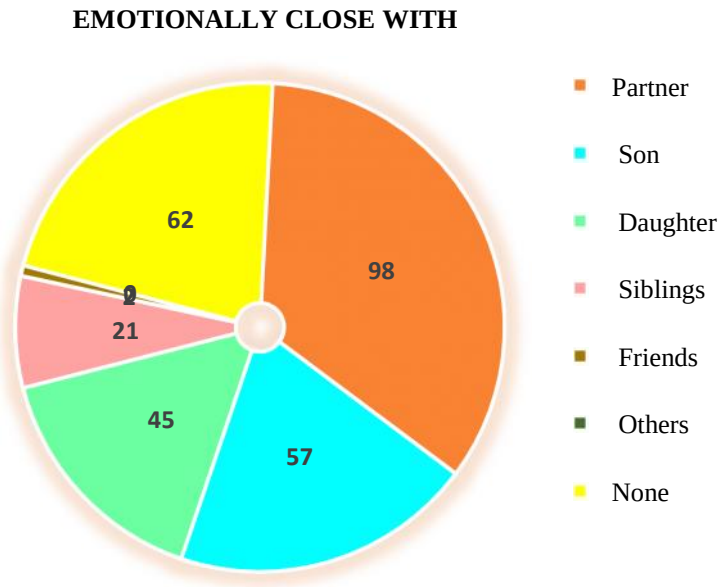

Figure 5.7

The analysis reveals that 34.3% of the respondents are emotionally close with their partners or spouses. Most of the elderly who are married and living with their spouses immediately agreed that the partners have a very significant place in their life. Only in two cases the married partners are found to have no emotional bonding as the male partners are abusive. Gujarat, like other states in India is a patrilineal and patriarchal society, where the family is taken forward to the next generation through a son; and after father, it's the husband and then the son who holds authority in a family. A son is looked as a provider and a protector by the aged parents, 20% of the respondents are emotionally close to their sons.

A daughter is always considered as an outsider in an Indian family, as the daughter goes off to her husband's house after marriage. But in the case of respondents in Old-age homes it has been found that it is the daughters who take time to visit their parents and take care of them when they are sick while the sons visit only occasionally. 15.7% of the respondents are found to be close to their daughters. A small percentage of respondents i.e. 7.3% are found to be close to their friends and the rest that is 21.7% of the elderly are not close to anybody. These are mostly the respondents who lead a very dejected and unhappy life.

5.2 Recreational Activities

The aged like any other age group requires sufficient amount of recreational activities that would deal with some of the stress and loneliness associated with ageing. Depression, senility, inactivity, delirium, dementia are some of the accompaniments of ageing. As an individual age, it is essential to keep one's mind and body active. But usually it is seen that elderly persons restrict their activity when age advances, most of the elderly get inclined towards religious activities as it provides peace and tranquillity which is required to face the ever increasing debility and the ultimate truth of life and the death.

The study has tried to examine some of the parameters related to recreational activities among the sample population. The analysis of the data (Table 5.1) indicates that in rural 61.3% of the respondents engage themselves in religious activities. In rural areas everything starts and ends with some religious ritual, as most of the people are engaged in agriculture which largely depends on the seasonal climates,

dependence on the ultimate power is significant. But at the same time it was also noticed that the people in villages go to temples rarely.

	Parameters	**Rural**	**Urban**	**OAH**	**Total**
A	Participates in spiritual gathering				
	(i) Yes	46	49	92	**285**
	(ii) No	29	26	43	
B	Engaged in recreational activities				
	(i) Yes	5	16	6	**285**
	(ii) No	70	59	129	
C	Go for movies				
	(i) Yes	1	7	0	**285**
	(ii) No	74	68	135	
D	Watch television				
	(i) Yes	25	47	74	**285**
	(ii) No	50	28	61	

Table 5.1

In urban locations 65.3% of the respondents engage in religious activities. The activities include visiting the place of worship regularly and also reading religious books. In Old-age homes the respondents seek religion as a solace to deal their internal pain and suffering. Most of them engage themselves in religious teachings and books, in institutions 68.1% of the respondents are religious and engage themselves in such activities. Some of them have admitted to the researcher that religious thinking has helped them to cope with their disappointment and dissatisfaction in life and have helped them to forgive their children who were responsible for their predicament.

On further examination it was found that very few respondents engage in recreational activities like getting together with friends, going on holiday tours etc. The analysis shows that in rural areas only 6.6% engage in such activities. In rural areas as the economic activity is mainly agriculture it is impossible for them to keep away from their daily routines of farming and cattle rearing which needs constant attention. The other factor is absence of good transport facility. They have to wait for hours for the public transport which is tiresome. In Urban areas 21.3% of the respondents engage in some kind of recreational activities. These elderly go on tours with their families, preferably to religious locations. They are also included in family get-togethers and visits. In Old-age homes 4.4% of the respondents have admitted that they are included in family get-together at the time of some functions like marriage or deaths. Otherwise the organisation organise outings or tours which are usually sponsored by some people or clubs. These outings are usually to religious places or temples, though it has been observed that these are not regular events.

Another parameter of recreational source tested is movies. It has been found that only 1.3% of the rural respondents see movies as there are no movie theatres in most of the villages. The only source through which they can see is television which is also rare. In urban 9.3% of the respondents watch movies either in theatres or on television. In Old-age homes none of the respondents watch movies. It has been observed that all Old-age homes do not have television facility, and in Old-age homes with television facility residents usually watch religious as well as other serials.

Television is the common entertainment source throughout especially for the aged, as they hardly venture out of the house. In rural areas 33.3% of the respondents watch television, during data collection the researcher observed that Television is found only in the better off households in the village. In urban locations 62.6% of the respondents watch television. Hindi serials are the favourite among women while men are more interested in watching news channels and religious serials. It has been noticed that most of the households in urban locations have television. In Old-age homes 54.8% of the respondents spend some time watching television. Most of the organisations with this facility have timings for it. 8 respondents staying in different Old-age homes were found to be keeping personal television in their rooms.

5.3 Abuse in Family

What is elder abuse? It is a subjective term that cannot be defined specifically. It ranges from physical abuse to even avoidance of an elderly person. Though abuse is a taboo word among Indians, it does happen in families whether it's with a female member or with the elderly in the family. In most of the cases the perpetrators of abuse are the family members, the reason can be manifold like dependency, senility, amnesia, illness etc. Several studies have been conducted to assess the situation in our society, but there are chances of misrepresentation of data as most of the elderly do not reveal about abuse if there is any. The researcher of the study had to take into consideration situational behaviours and attitude while interpreting abuse among elderly in families. The respondents of Old-age homes were more forthcoming when asked about abuse in their family (Table 5.2).

ELDER ABUSE Any form of illtreatment / mistreatment that results in harm or loss to an elder person		
TYPES OF ABUSE	**PERPETRATORS**	**CONSEQUENCES**
Psychological	Daughters-in-law	Depression and Dementia
Financial	Son/ Daughter	Increased Dependency
Physical	Sons-in-law	Sense of Helplessness
Sexual	Care takers	Mortality/Morbidity
Verbal	Relatives	Increased Stress
	Partner	Fear

Table 5.2

The data (Figure 5.8) reveals that 24.6% of the male and 23% of the female respondents have faced abuse in one form or the other. Majority of the respondents who have revealed of the abuse are residents of Old-age homes. While interviewing

the elderly in family the question of abuse was mostly ignored by the elderly or refused to answer saying everything is alright or little bit of fights do happen among family members. In rural as well as urban locations only five cases each were identified whereas rest of the abused belonged to the old-age homes. In most of the cases the abusers are sons and daughters-in-law, surprisingly a case was identified where the perpetrator was the elderly female's daughter. She lives in a plastic shed outside the daughter's house and begs for a living. Many elderly have shifted to Old-age homes to get away from the abuse even though they own the house.

Figure 5.8

Abuse of any kind is always kept inside the four walls of the house. Many people do not reveal of their ordeals fearing stigmatisation and decline of status in the society. According to the data (Figure 5.9) only 13 female respondents out of 33 abused has informed others of the abuse in the family, as most of them are dependents and have no other means of livelihood. They also feared that revealing of the abuse would put them in more danger. Among the male respondents only 12 out of 35 abused have shared about their abuse to others, most of the male respondents reported that by revealing the abuse they feel insulted and feared about the family status in the society. At the same time they are also not in a position to take physical abuse.

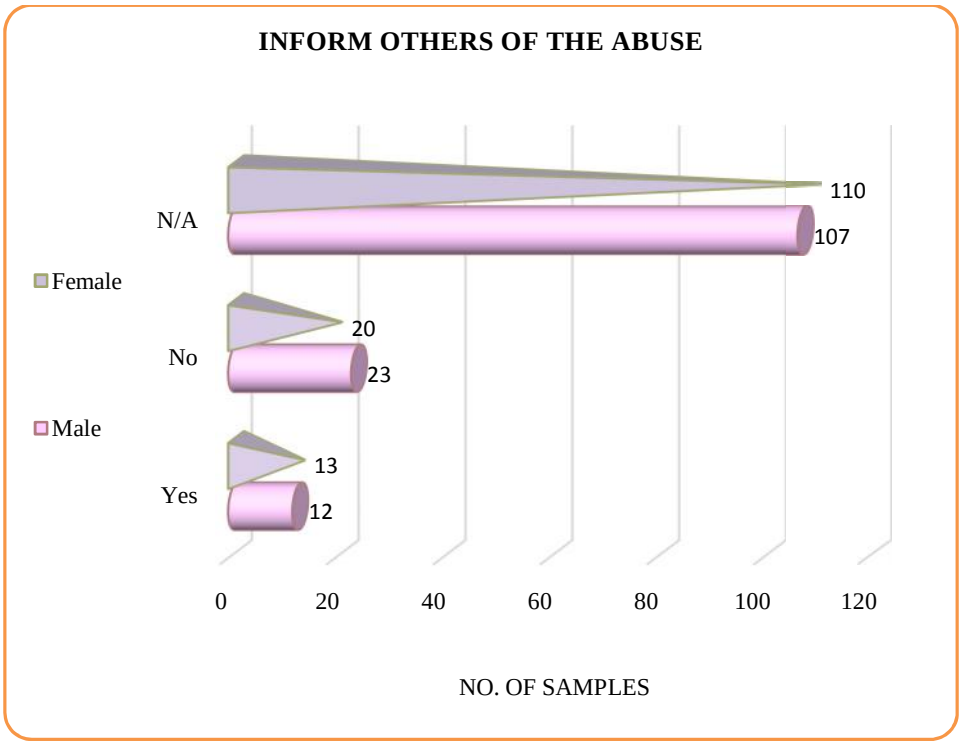

Figure 5.9

Several reasons for not informing about the abuse have come up while analysing the responses (Table 5.3). Among the respondents 10 males out of 23 and 6 females out of 19 who have not informed about the abuse fear their perpetrators, as they know that they would be punished by them or their level of abuse might increase. They also do not want to put their children in trouble as most of the perpetrators are their own children.

In addition 7 males and 2 females feel that they would be stigmatised if they inform as it is always considered that the in-laws are bad towards their daughters-in-law, or that the elderly is very demanding. Every human being tries to make a position in the society and once it is made, closely guards it. Six male and ten female respondents never disclosed about their abuse as they do not want their family status to be tarnished in the society. According to them whatever happens in the house should remain in the house itself.

Some of the respondents i.e. 17 males and 17 females have admitted that they have experienced psychological abuse most of the time. They are neglected and their health

issues are ignored, their movements are restricted citing old age. Some have even admitted of denial of food by their children.

	Parameters	**Male**	**Female**	**Total**
A	Reason for not informing			
	(i) Fear	10	6	**285**
	(ii) Stigma attached	7	2	
	(iii) Family status	6	10	
	(iv) Others	0	1	
	(v) N/A	119	124	
B	Kind of abuse faced			
	(i) Physical	5	3	**285**
	(ii) Verbal	13	13	
	(iii) Psychological	17	17	
	(iv) N/A	107	110	

Table 5.3

There are elderly who had to abandon their own house and take refuge in Old-age homes. Few of the respondents had to undergo verbal abuse mostly from their daughters-in-law i.e. 13 males and 13 females. Almost all the respondents who have experienced abuse though are not happy staying in Old-age homes; think that they get peace of mind in the organisation.

Physical abuse which is considered as the gravest abuse also happens with the geriatric population. The elderly respondents i.e. 5 males and 3 females admitted that they have suffered physical abuse from their children. They said that they were shoved or pushed or even beaten up by their sons and daughters-in-law.

5.4 Incidence of Depression and Treatment

The World Health Organization has estimated the overall prevalence rate of depressive disorders among elderly between 10% and 20% depending on cultural situations. The community-based mental health studies in India have revealed that the prevalence of depressive disorders in elderly Indian population varies between 10 and 25 percent (Ankur & etal, 2011). The study has tried to examine the self-reported incidence of depression among the elderly sample population. In India depression among elderly usually go unreported and untreated as it is looked as a part of ageing process.

	Parameter	**Male**	**Female**	**Total**
A	Incidence of depression			
	(i) Yes	24	30	**285**
	(ii) No	118	113	
B	Taken medication for depression			
	(i) Yes	4	9	**285**
	(ii) No	138	134	

Table 5.4

Analysis of the data (Table 5.4) reveals that 16.9% of the male respondents have been experiencing depression. Majority of these respondents stay in Old-age homes that are 17 men out of 24. In Old-age homes life is more or less monotonous with nothing to look forward to. The remaining 6 respondents stay in a joint family. Though we believe that there is more bonding and affection in a joint family a few feel side-lined or less appreciated for their effort. Whether in rural or urban depression is more associated to religious beliefs thus resulting in avoidance or ignorance in taking medication or medical help.

While analysing women respondents it was found that 20.9% of the elderly women have been experiencing depression. Even among the women respondents' majority of them stay in Old-age homes that is 18 out of the total 30 samples. Most of these women are widows; the death of the partner weakens the women psychologically. Only 2 respondents were found to be staying in a joint family, 7 in nuclear family and three as singles. According to the respondents abandonment by the children; their indifference towards them; and conflict with family members are the main causes of depression as it creates mental stress and pain.

5.5 Conflicts

On further examination the study has tried to assess (Figure 5.10) the level of conflict among the sample population. It shows that 9% females and 4.2% males have conflicts with their sons as well as daughters-in-law. The reasons according to the respondents are mostly dependency of the parents; intergenerational maladjustments; and in some cases love marriage of the son with a girl from another caste or community. Another 5.5% of female and 5.6% of male respondents have conflicts with their relatives. The reasons for such conflicts are either property or dependency of the elderly widow. Among males 6.3% have admitted as having conflicts with their partner, a few of these males have separated from their spouses, The reasons for conflict between partners range from physical abuse of wife and children, health issues to extra marital affairs of the husbands.

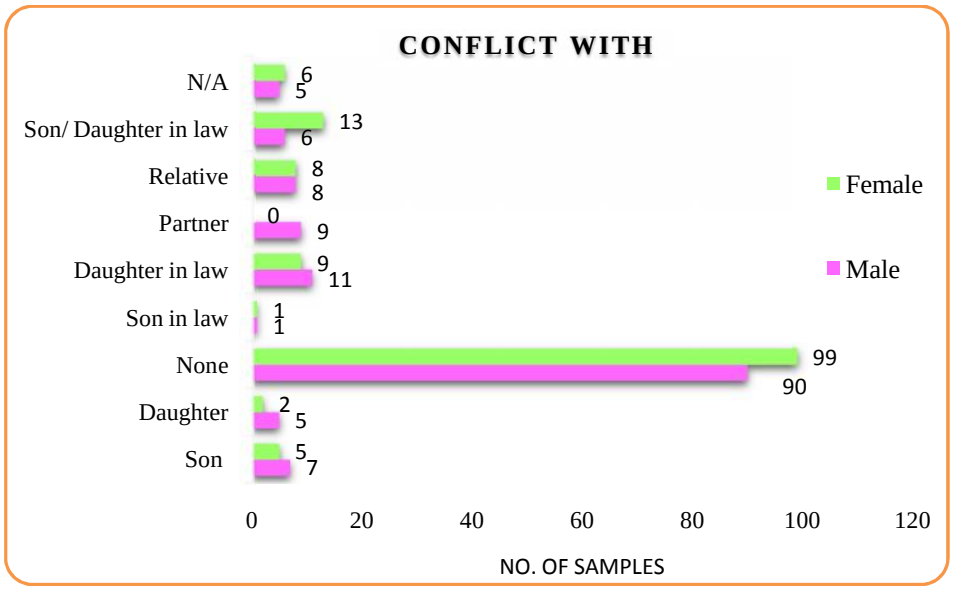

Figure 5.10

Another 6.3% of female and 7.7% of male respondents have conflicts with their daughters-in-law though they maintain a good relation with their sons. Only 0.6% of elderly female and 0.7% of elderly male respondents have some sort of conflicts with their sons-in-law. In one particular case the son-in-law was found to have dumped the respondent in a charity based Old-age home after taking away the respondent's property and pension income by forcefully getting signature on power of attorney. It has been noticed that daughters are not much in conflict with their parents except in a few cases. 1.3% of elderly females and 3.5% of elderly males have some sort of conflict with their daughters; usually the conflict is for the parent's property or money. Some of the parents have issues with their sons and not with their daughters-in-law. 3.4% elderly women and 4.9% of elderly men have admitted of conflict with their sons with regard to money or property.

5.6 Current Status of Health

Health and illness can said to be the most important issues in an individual's life. The study has tried to analyse various aspects of health from a social perspective. India's health programmes and policies have mostly concentrated on issues like population control, infant mortality, maternal mortality, disease control, immunization etc. However the current scenario and statistics on demography is seeking attention towards elderly and issues related to them. The study tries to assess and examine the health of the sample population from rural, urban and Old-age homes. All the parameters of health are self-reported by the sample population.

The data (Table 5.5) shows that 1.4% of the males and 4.8% of the females have severe difficulties in carrying out their basic activities that is the basic daily needs. The majority among this are Old-age home respondents that are 7 out of 9 elderly. Except for one Old-age home in Kutch no other Old-age home has any facility to take care of the residents having severe health issues or illnesses. The residents in such cases sometimes take the help of their roommates or friends in the institution or the supporting staff of the organisation by paying some extra money. In most of the cases such residents are sent off with their guardian but if not taken back by their relatives, they are left unattended and ignored in the Old-age home. Few of the respondents who were not keeping well were seen in soiled clothes and sheets as they did not have the energy to change or wash it and the organisation they were staying in did not have

a helper to help them in such situations. The other 2 respondents are from the rural area where they are assisted by their family members.

	Parameters	None	Mild	Moderate	Severe	Total
A	Difficulty in basic activities					
	(i) Male	101	23	16	2	**285**
	(ii) Female	95	25	16	7	
B	Difficulty in moving around					
	(i) Male	83	31	21	7	**285**
	(ii) Female	72	29	28	14	
C	Difficulty in House hold activities					
	(i) Male	79	30	28	5	**285**
	(ii) Female	67	28	37	11	
D	Difficulty in breathing/ shortness of breath					
	(i) Male	106	22	10	4	**285**
	(ii) Female	100	26	13	4	

Table 5.5

Among the respondents 11.1% of females and 11.2% of males are having moderate difficulty in carrying out their basic daily needs. On further examination it was found that out of 32 respondents 12 are from rural area in which 9 are females and 3 are males. It has been observed that women in rural areas engage in strenuous labour in the field as well as carry out household chores. They give least attention to themselves in matters of food as well as health. Most of the female as well as male respondents in rural areas look older than their age. There are 11 respondents in Old-age homes who experience moderate difficulties in carrying out their basic needs out of which 7 are males and 4 are females.

The analysis of disability among the sample population deals with difficulty in moving around due to problem in the leg, obesity, back pain, paralysis, Parkinson's disease etc. the data reveals that 4.9% of males and 9.7% of females have severe disability that is their movement is restricted to their rooms. They can move with the help of crutches or assistance from family members. On further assessment it was found that out of the total 21 respondents with severe disability 6 are from rural location and all of them are females. In urban locations 5 respondents are identified as having severe problem in moving around, out of which 2 are females and 3 are males. The Old-age homes have the maximum elderly with severe disability that is 10, out of which 6 are females and 4 males.

The study shows 49 respondents who are moderately disabled; though they have difficulty in moving around they are able to go around without much support or assistance. Out of these 49 respondents 11 are from rural locations, in which the females are more than the males. The urban locations show 10 respondents in this category out of which 4 are females and 6 are males. The Old-age home again has the maximum number of respondents that is 28 out of which 15 are females and 13 are males.

The study has tried to assess the difficulty pertaining to household activities or chores which would be more relevant to the elderly women than men. While 55.6% of the men reported as having no problem in carrying out the activities, only 46.8% of the women reported as having no problem. At the same time 3.5% of the elderly men and 7.6% of the elderly women respondents have severe problems in carrying out the household activities. Out of the total 16 respondents in this category 4 belong to the rural sector and all the four are women. In rural areas women who have difficulties abstain themselves from such roles as the role is passed on to their daughters-in-law who manage the whole household chores. Urban locations show only two respondents in the category which has one male and one female. In the Old-age homes' though cooking is done in a common kitchen the elderly are made to help in turns, moreover in most of the Old-age homes there are no facilities for cleaning their rooms and washing their clothes which the residents have to do by themselves. In Old-age homes there are 10 respondents who fall in to this category, out of which 6 are females and 4 are males.

Shortness of breath is common as age advances, they feel fatigued and out of breath when climbing stairs or walking long distances or doing some work. The analysis shows that not many have issues with breathing as the data reveals only 2.8% of men and 2.7% of women as having severe breathing problems. Out of the total 8 respondents 4 are from the Old-age homes, 3 from rural locations and 1 is from urban location.

The data also reveals that 7% of men and 9% of women respondents moderately suffer from shortness of breath. Out of 23 respondents in this category 9 are from the rural locations 8 are from Old-age homes and 6 are from urban locations. It has been found that 8 respondents in moderate category and 2 respondents in severe category have heart problems, which seems to be one of the reasons for breathing issues.

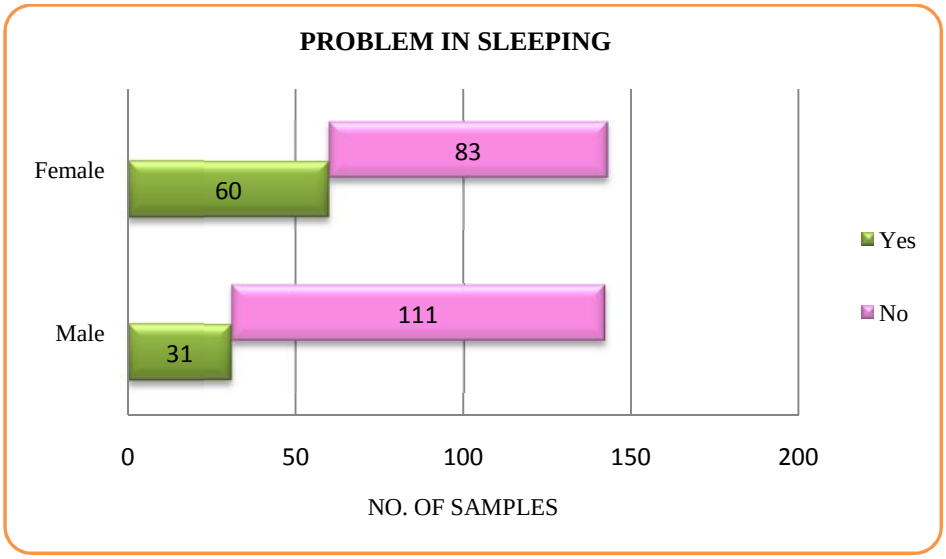

Figure 5.11

The study has made an attempt to look into the sleeping pattern and lack of sleep among the sample population (Figure 5.11). The probe into the data revealed that 41.9% of the female and 21.8% of the male respondents have problem getting proper sleep. Anxiety has been reported as the major cause of sleeplessness. Some of the respondents haves also reported of leg pain which is mainly due to arthritis. In Old-age homes 49 out of 91 respondents have reported sleeping disorder. Most of these respondents 25 in rural areas and 17 in urban areas have complained about getting proper sleep. Most of these respondents have admitted that they are stressed out and

get disturbed because of family problems. It has been observed that in all the three sectors rural, urban and Old-age home the female respondents are the most affected.

5.7 Diet and Health

The geriatric population intrinsically suffer from deficiency of essential vitamins and minerals which leads to weakness in bones, frailty, general weakness, exertion, low resistance to diseases etc. As age advances individuals lose their appetite as there is not much activity which is also ignored by the family relating it to be part of the changes in old age, thus leading to malnourishment. Hence the data is collected to know the food intake pattern to determine whether it has any relation to the health and illness of the geriatric population.

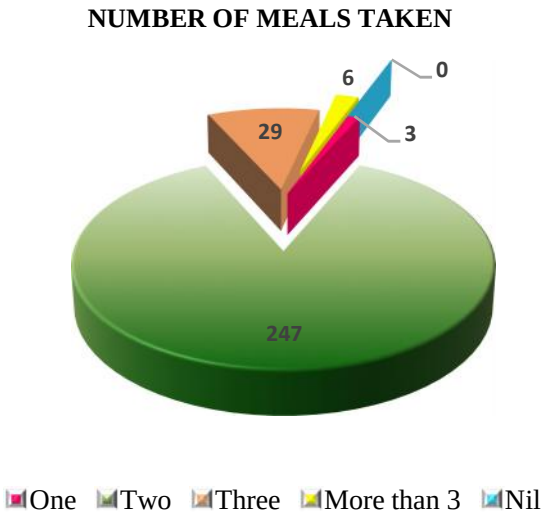

Figure 5.12

The chart (Figure 5.12) clearly indicates that majority of the respondents have only two meals a day. It has been observed that two major meals a day is a cultural habit of Guajarati's throughout the state. The data reveals 86.6% of the respondents fall in this category. The breakfast consists of usually tea with Rusk (Toasted bread) or biscuits, the lunch which is taken around 11:30 AM or 12 PM consists of *bakri* (thick roti made of whole wheat flour) *dal* (Curry made with pulses) and *bhaji* (Dry preparation of any vegetable). Even in Old-age homes only two major meals are served. Dinner is usually kept light with *kichdi* which is a mix of both rice and *dal*. Majority of the respondents are vegetarians except some respondents belonging to Muslim and Christian communities. Some of the respondents who belong to the tribal community

and lower castes are also non-vegetarians but they do not openly admit to it as it may lower their social status. They believe themselves as Sanskritized in order to uplift their social status.

The data also reveals that there are 1% of respondents who hardly have one meal a day. It also shows that all of these respondents belong to the lower class in the rural sector and all of them are females. There are 10.1% of respondents who have three meals a day which is considered as a healthy habit of eating. In Old-age homes the respondents said that they receive huge donations in the form of snacks and biscuits which are stored by them. These snacks are consumed by them in the morning and in the evening. These snacks also cause certain health issues to some respondents as most of these eatables are fried snacks and biscuits which contain sugar and there are no means of control in distributing such items.

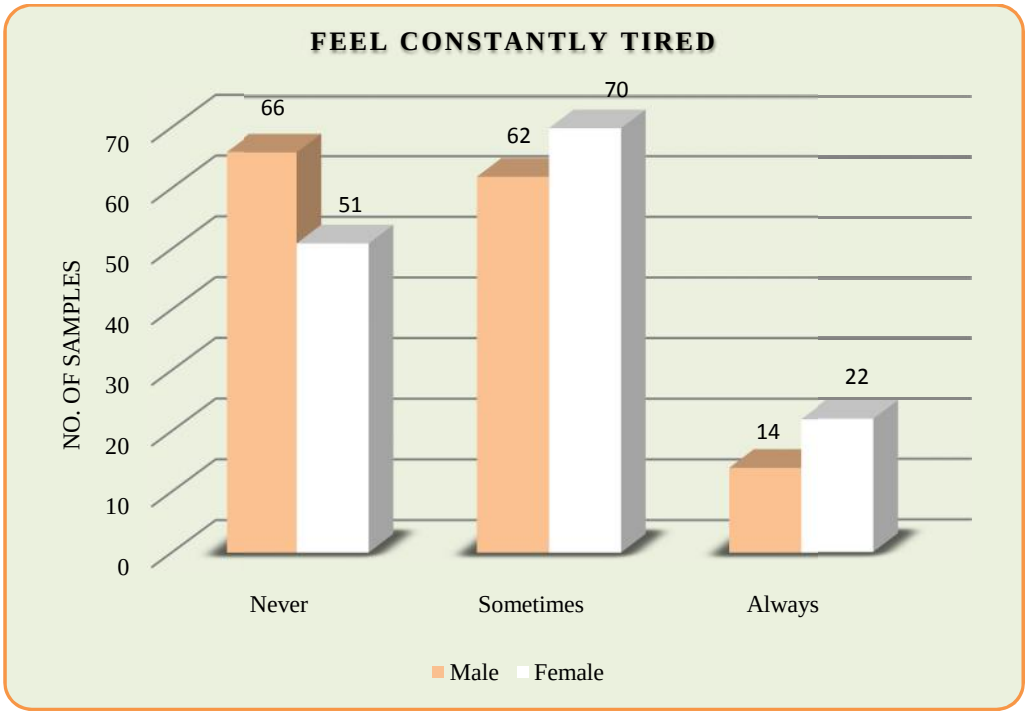

Figure 5.13

According to (Figure 5.13) 9.8% of the male and 15.3% of the female respondents feel constantly weak and tired. Out of the total 36 respondents who reported of constant tiredness 19 are residents of various Old-age homes, 12 are from rural locations and only 5 are from urban areas. It has been observed that in rural locations the people give least attention to health and proper balanced diet. While in Old-age

homes health issues are hardly addressed and most often ignored due to difficulties in finance and travelling. Except for one Old-age home the food provided is reasonably good and balanced in all the other organisations. Most of these elderly suffer from deficiencies and are anaemic, but there are only 3 respondents in this category who are found to be taking supplements in the form of medicines.

5.8 Eye sight and Corrections

Weak eyesight and deterioration of vision can pose a huge impact in the functioning of an individual and his ability to perform tasks efficiently. According to the studies sixty years and above are more prone to vision impairment, it could be due to heredity or general psychological and physiological changes as age advances. Elderly are more vulnerable and has a higher risk of vision ailments, and affected people usually go through trauma and frustration due to the impairment. Timely consultation and treatment of vision impairments could restore the vision to a certain extent.

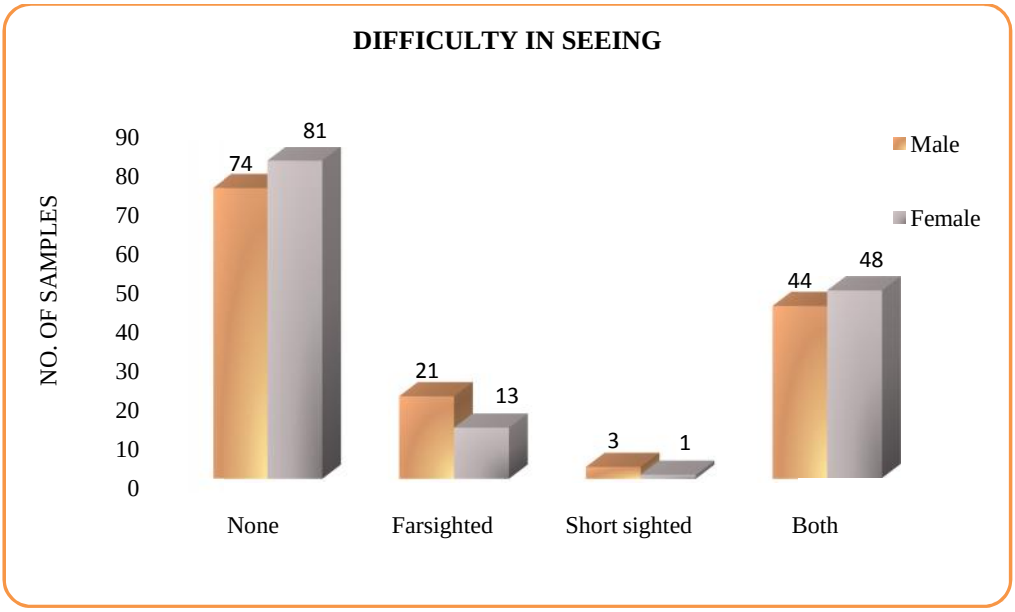

Figure 5.14

According to the graph (Figure 5.14) above there are 30.9% of male and 33.5% of female respondents who are both far-sighted as well as short-sighted. These elderly had been tested for eye sight earlier and had been recommended for glasses by doctors. Further, the data reveals that in this category 32 respondents are from rural areas but out of that only 15 are seen to be using glasses for sight. Out of the rest, 20

are from urban locations in which 16 are using glasses. The remaining 40 are the respondents staying in various Old-age homes, out of which 33 are seen using corrective glasses.

According to the data 52.1% of male and 56.6% of female respondents have claimed as having no problem with vision. It was understood during data collection that some of the elderly have certain myths or phobia regarding going to a hospital for any health issue. Further examination of data shows that 15.4% of the respondents have never gone for an eye check-up.

5.8 i Detection of Cataract and treatment

Cataract is one of the major causes for vision impairment among the geriatric population. Several studies have demonstrated that elderly persons have the highest rate of cataract glaucoma, diabetic retinopathy etc. According to studies approximately one person in three has some form of vision reducing disease by the age of 65 years (Borker, 2010, pp. 50-54).

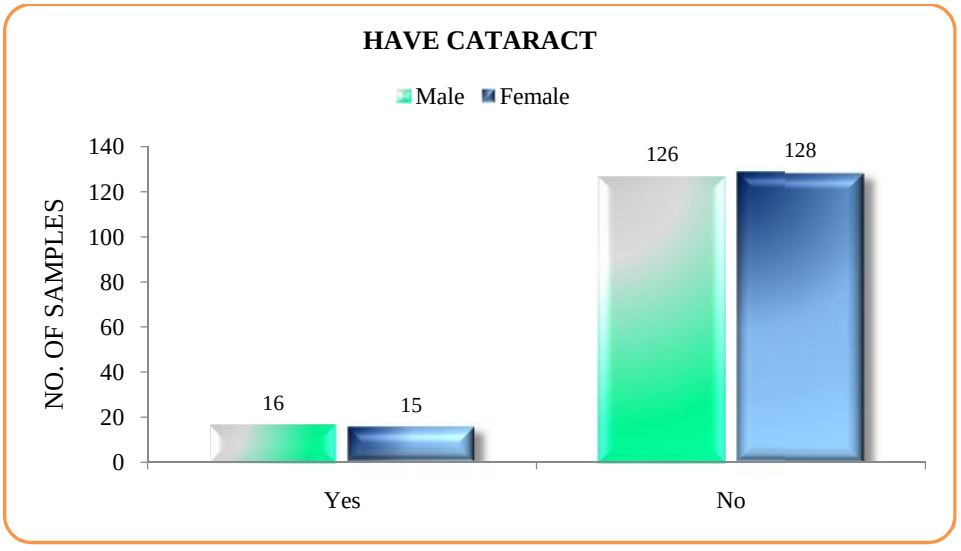

Figure 5.15

The data (Figure 5.15) reveals that 11.2% of the male and 10.4% of female respondents suffer from vision disability due to cataract and have to undergo corrective surgery. The data shows 88.7% of men and 89.5% of women have no cataract; this also includes men and women who have already undergone corrective

surgery as well as a few who have lost sight due to negligence in seeking medical help.

It was also found that 7% of male and 6.2% of female respondents have operated their one eye for cataract and are waiting for the other to be operated. Another 29.5% of men and 37.7% of women respondents have operated on both the eyes. In the not operated category there are 4.2% of men and 4.1% of women who have been identified as having cataract but still have to undergo corrective surgery. No one from this category falls in the urban sectors but of the 12 samples in this category 5 are from rural sectors and 7 from Old-age homes. Except for the upper class and a few middle class respondents all the other elderly who have already had corrective surgeries have done it in charity camps, especially in rural areas people with vision problem wait for eye check-up camps as visiting a hospital in town for the purpose is most often not viable. In Old-age homes as most of the respondents face monetary issues, the elderly wait for free charity camps for eye check-ups and cataract surgeries.

IMPROVEMENT IN VISION

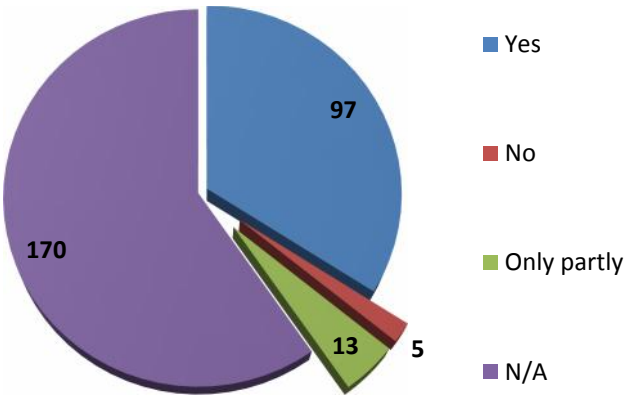

Figure 5.16

The study has also tried to understand the level of success of the corrective surgeries done, according to the acquired data (Figure 5.16) 34% of the sample population have informed that their vision has improved after the surgery. A few of the sample population that is 4.5% have reported that they have not regained complete vision

after the surgery and they have no hope of regaining their lost vision. And a small percentage of the respondents that is 1.7% have reported that there was no improvement at all in their vision. All of the surgeries which were not successful have been done in free charity camps or for a minimal amount of ₹250 - ₹500.

5.9 Auditory Senses

Hearing loss among the geriatric population is very common; this may be due to physiological changes happening with increase in age. Deafness brings about lots of psychological changes as well as it creates a sense of isolation in the affected individual when it becomes difficult to communicate with other people.

	Parameters	**Rural**	**Urban**	**OAH**	**Total**
A	Difficulty in Hearing				
	(i) Yes	10	8	26	**285**
	(ii) No	65	67	109	
B	Using hearing aid				
	(i) Yes	1	3	6	**285**
	(ii) No	74	72	129	

Table 5.6

The study (Table 5.6) identified 13.3% of the respondents in rural locations with difficulty in hearing, Out of the 10 affected 8 elderly are women and the rest 2 are men. In urban locations 10.6% of respondents are identified with this problem. Out of the total 8 respondents in this category 3 are women and 5 are men. The Old-age homes show the maximum number of respondents that is 19.2% have been affected. Out of the total 26 affected respondents 12 are women and 14 are men. Loss if auditory senses among the geriatric population are perceived as natural by the family and the affected persons themselves, though weakness of nerves may also be one of

the many causes. With the advancement in medical science there are measures to correct or arrest hearing loss through surgeries or hearing devices.

The data reveals that only 1 respondent out of 10 affected in rural areas is using a hearing aid. In rural areas health issues like hearing loss or low vision do not pose any threat to life hence mostly ignored. These issues also require specialised consultation with the concerned specialist who is only available in big towns or cities. In urban locations 3 respondents out of 8 are using hearing aids and in Old-age homes only 6 out of 26 are using the device.

In Old-age homes respondents with hearing aids complained that it was proving costly for them to maintain it. So most often they were seen not using it. It was noticed that respondents with auditory issues were reluctant of making any kind of conversation as they felt frustrated when not able to understand the other person. In Old-age homes the roommates of such elderly helped them communicate with others. Most often the affected looked dejected and bored.

5.10 Urinary Problems and Constipation

Ageing gets with it several biological changes in the body like low resistance to infections and diseases. It also changes the appetite and intake of food level leading to gastric issues and constipation in most of the elderly population.

	Parameters	**Rural**	**Urban**	**OAH**	**Total**
A	Urinary Problems				
	(i) Yes	4	5	27	**285**
	(ii) No	71	70	108	
B	Constipation Problem				
	(i) Yes	10	8	40	**285**
	(ii) No	65	67	95	

Table 5.7

The data in the above (Table 5.7) shows that 5.3% of the respondents in rural areas and 6.6% of the urban areas suffer from urinary problems. Since the percentage is low it is assumed that the infection may be due to low hygiene or low resistance level of the individual to infections. But there is an increase in the number of respondents suffering from the problem in Old-age homes. The data shows 20% of them in this category. During the data collection the researcher noticed that not enough cleanliness was maintained in the washrooms which were used by multiple residents. Some of the Old-age homes though had cleaners; the washrooms were not maintained well. This could be one of the reasons for urinary infections and related problems among the residents.

The data reveals that 13.3% of the rural respondents have constipation problem. The rural population give little importance to food and mostly eat whatever is grown by them. It was noticed that most of the elderly in village looked frail and weak. Their food intake was mostly limited to whatever is locally available. Whereas in urban 10.6% of the respondents have constipation problem, though they claim that they have a balanced diet with enough fibres. In Old-age homes 29.6% of the respondents have the problem of constipation. In Old-age homes the respondents are provided with only two meals a day and the quantity as well as quality is limited to an extent. These do not provide enough fibre needed to the elderly for proper digestion. Moreover in all the organisations the respondents receive eatables as charity which is not very healthy.

5.11 Diagnosis of Diabetes and its Treatment

The rapid changes in life style and food habits have given rise to many non-communicable diseases, one of which is Diabetes Mellitus. It is a group of metabolic diseases in which there are high blood sugar levels over a prolonged period. Diabetes is due to either the pancreas not producing enough insulin or the cells of the body not responding properly to the insulin produced ("Diabetes", 2015). The study has tried to analyse the prevalence of the disease among the sample population.

The data (Table 5.8) reveals that in the rural locations the number of affected individuals is less that is only 8%. Out of the total 6 affected respondents 5 are men and only one is a woman. The low rate of prevalence may be due to the lifestyle that the rural population lead. They engage in manual labour which gives a good exercise

to their body, and also eat very limited food. It has been observed that in rural areas everybody does some work or the other thus keeping themselves active.

In urban locations 18.6% of the respondents suffer from diabetes. Out of the total 14 sample in this category 9 are men and 5 are women. In urban locations most of the respondents are inactive and spend time sitting around or watching television. The elderly in urban areas also lead a stressful life due to various reasons. On further enquiry it was found that all the affected respondents in both rural as well as urban are being treated for diabetes.

	Parameter	**Rural**	**Urban**	**OAH**	**Total**
A	Diagnosed with diabetes				
	(i) Yes	6	14	22	**285**
	(ii) No	69	61	113	
B	Treated for diabetes				
	(i) Yes	6	14	20	**285**
	(ii) No	69	61	115	

Table 5.8

The study (Table 5.8) found that in the Old-age homes the prevalence rate of diabetes is 16.2%. Out of the total 22 respondents 11 are women and the rest 11 are men. Most of the affected have got the disease in their middle age that is when they were in their fifties. Further probe revealed that 20 respondents who got affected are seeking treatment for the same. But the respondents also admitted that they are not regular with the medicines, and they sometimes skip it when they cannot afford to buy it. In Old-age homes the medicines are occasionally sponsored by some rich people for charity. So sometimes the residents wait for such sponsors to get their needed medicines.

5.12 Common Illness

It is said that ageing and illness are two sides of the same coin; the study has tried to find out the occurrence of some of the common illness among the sample population. Shah in his 'study of urban elderly in Gujarat' found deteriorating physical conditions among two-thirds of the elderly (Shah, 1993).

Identified Illness	Rural	Urban	OAH	Total
Blood Pressure (B.P)	13	23	45	81
Heart disease	2	3	4	9
Joint pain	7	3	3	13
Tuberculosis (T.B)	0	1	2	3
Cancer	0	0	0	0
Lung Disease	0	0	1	1
Kidney Failure	0	0	0	0
Parkinson's Disease	0	0	0	0
Heart Disease/ B.P	0	9	13	22
Others	19	10	27	56
None	33	25	36	94
Pacemaker	1	1	0	2
Paralysis/ B.P	0	0	4	4
				285

Table 5.9

The detailed examination of data (Table 5.9) reveals that in rural locations the reporting of illness is less. The data shows that there are 17.3% of respondents who are suffering from high blood pressure or hypertension. Of the total 13 affected 8 are females and 5 are males, but it has been found that not all the effected take any medicines. Some have opted for alternative practices like Ayurveda or Homeopathic treatments. The tribal villages are mostly dependent on traditional medicines rather

than allopathic treatments. In urban areas 30.6% are suffering from hypertension, in which there are 12 females and 11 males. And in Old-age homes there are 33.3% of the respondents in this category. Among which 25 are females and 20 are males. In Old-age homes again the residents are not regular in taking their medicines because of economic constraints. But if the Old-age homes are near to a government hospital a difference is seen in the regularity of medicine intake since medicines are given for free in health centres and these hospitals.

Heart ailments are on the rise, it is also known as the rich man's disease as the major cause for it is the lifestyle pattern of the individual. The study reveals that there are only 2.6% of respondents in rural areas in which one is a male and other a female. This low percentage can be attributed to the active and strenuous life style of the rural population as well as the strong social bonding among the family members and the community thus acting as a stress buster. The urban area's 4% of the respondents are suffering from heart ailments. All the three respondents are males and they stay in nuclear families. Among these three, two belong to 71-80 age groups and one in 81-90 age groups. The Old-age home data shows 2.9% of the respondents with heart ailments, in which three are females and one is a male. Further probing reveals that when two of them are issueless the other two has more than one son. The study finds that of the total nine elderly with heart ailments five are from Surat district.

Joint pain due to arthritis or weakness in bones is very common in old age. In rural locations 9.3% of the respondents have some kind of joint pain; among this three are females and four are males. In rural areas the elderly engage in strenuous labour. Age doesn't stop them from doing any work and they continue to work till they are able to. Hence they suffer from joint pains. In urban areas 4% of the respondents have joint pains, in which two are females and one is a male. The elderly in urban locations mostly complained of knee joint pain and a few have reported as taking injection for osteoporosis or weakness of bones due to calcium deficiency. In Old-age homes 2.2% of the respondents have joint pains; this includes two females and a male. The common joint pains reported are knee joints and back pain. In one case the problem is acute and the respondent needs help for day to day activities which is done by her husband.

Tuberculosis or commonly known as T.B is not a very common disease now as there is adequate treatment available which completely cures the patient, unless it is a resistant T.B strain which is a recent development. All the elderly who reported of T.B have been treated for it and have completely recovered from the disease. The analysis brings forth 1.3% of the effected and cured who are from urban locations and 1.4% from Old-age homes. Cancer on the other hand which has become a familiar word was reported by 5.3% in urban areas with three females and one male and 1.4% female respondents reported of cancer from Old-age homes. All these respondents are completely cured of the disease. All the five women suffered had breast cancer. The lung disease shows only 0.7% affected, the single effected respondent is a female staying in an Old-age home. None of the sampled elderly are affected by kidney failure or Parkinson's disease.

The urban locations show 6.6% of the sampled elderly suffering from both heart disease and blood pressure, in which men are more that is seven, while there are only two women. In Old-age homes there is a reversal with more women in this category that is 8 are women and 5 are men. The rural sector shows no one with this illness. Further exploration shows that except for one respondent in urban all the other affected in urban locations belong to either upper class or middle class.

All the other illnesses which are not so prominent have been clubbed under the 'others' category. The illness in this category are skin disease, weakness, paralysis, chest pain or congestion, kidney stone, prostrate, thyroid, leg pain, asthma and osteoporosis. The rural areas show 25.3% of the respondents suffering from at least one of the illnesses mentioned in this category. The affected percentage includes 11 females and 8 males. In urban areas 13.3% of the respondents fall under this category in which 5 are females and 5 are males.

The Old-age homes are showing 20% of the respondents with at least one of the illnesses, out of which 11 are females and 16 are males. The study has identified 1.3% of respondents in both rural and urban areas with all the three illnesses like pacemakers, dialysis and B.P. The Old-age home data reveals that 2.9% of the respondents are partially paralysed, which includes 2 females and 2 males. The affected individuals admitted that paralysis was the reasons for them to move out of their home as their daughters-in-law were reluctant to keep them or look after.

5.13 Addictions and Habits

Gutka (a combination of betel leaf, areca nut and slaked lime), *chikni* (Snuff tobacco), *beedi* (*Tendu* leaf filled with tobacco) and cigarettes are some of the common addictions found throughout Gujarat. The study has tried to analyse the consumption of these tobacco products among the respondents. The analysis of the acquired data pertaining to these habits shows that both males and females alike have these habits.

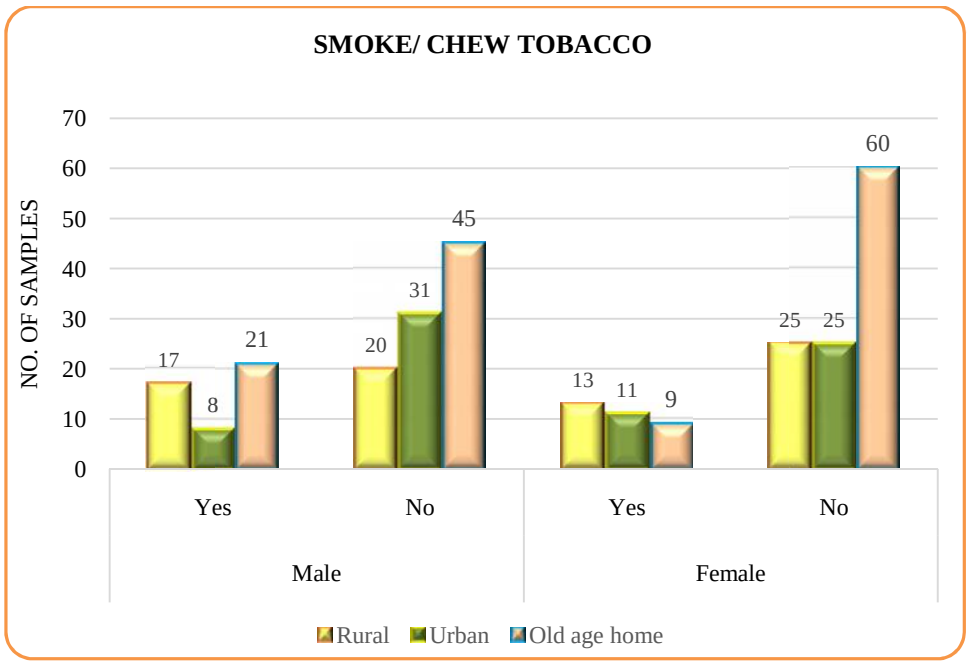

Figure 5.17

Detailed assessment of the data (Figure 5.17) reveals that in rural areas 11.9% of males and 9% of females are in to these habits. In rural areas *chikni* and *beedi* are found to be commonly used. It was observed that few of the female respondents also smoke beedi but otherwise chikni which is either inhaled or rubbed in to the gums seems to be popular. Surprisingly most of them couldn't remember the age when they started using chikni. Some admitted that they have been using it since the age of 12 years. The respondents using it also admitted that it would be impossible for them to stop its usage at this age as they feel disoriented or unwell if they do not have it.

In urban areas 5.6% of males and 7.6% of females are in to these habits. In urban areas *gutka* is popular among the males and chikni among the females. The respondents who use chikni claim that if not taken it causes headache or toothache.

Most of them have started the habit at a very young age as most of their family members were habituated to it and it was considered a normal behaviour or in fact the children were encouraged to try it by their own family members.

The Old-age homes have 14.7% of the males and 6.2% of the females who are habituated to gutkha or chikni. In Old-age homes cigarettes and beedi are not allowed, but still a few were seen using it. Gutkha and chikni are common among both males and females. The study also encountered some of the respondents who had been using these things but stopped it due to health issues. In Old-age homes compared to men there are fewer women who have these habits. It may be because of the non-availability of these things easily and the economic constraints.

5.14 Availability and Access of Health Care

Several studies have mentioned that Gujarat needs to improve on the infrastructure and manpower in the public health sector. The Indian Institute of management research study and publication of Shreekant and Ravindra clearly states that gaps in terms of manpower availability in the public health system of the state is very wide in case of paramedical staff and medical professionals (Shreekant & Ravindra, 2014). The present study tries to assess the health care pattern among the geriatric sample population in rural, urban and Old-age home.

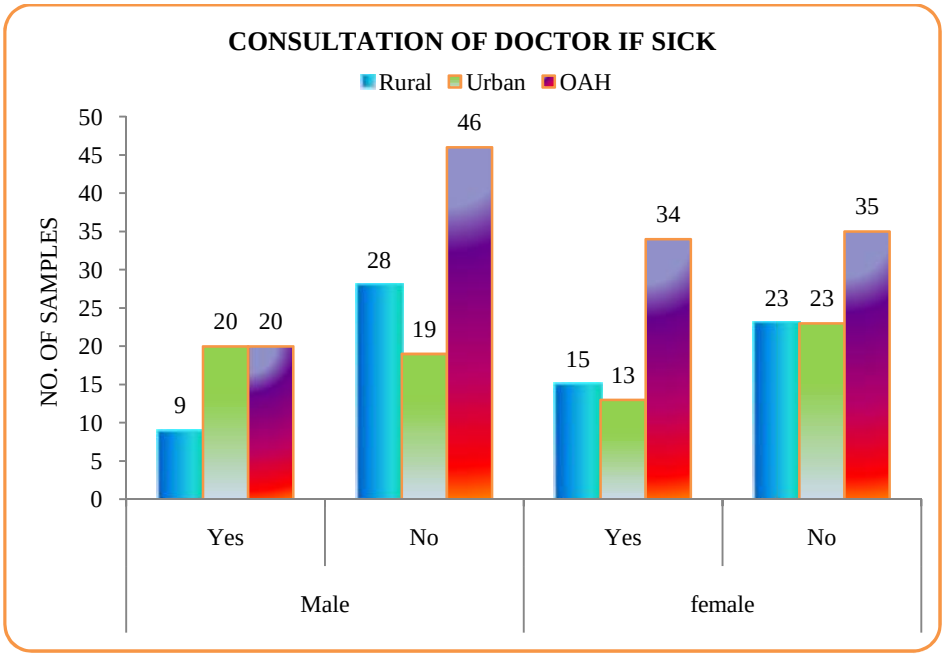

Figure 5.18

The above data (Figure 5.18) indicates that in rural areas 19.7% of the males and 16% of the females do not consult the doctor every time they are sick. Most of the people in rural location either ignore the illness or try home remedies. They approach a medical doctor only if it is a serious illness, some of the respondents also reported that the doctors practising in private clinics in the village are incompetent and most of the time the patient does not get cured. Poor public transport connectivity between villages and towns also deter the rural elderly from seeking medical help.

In urban locations 13.3% of men and 16% of women do not go to the doctor for consultation every time they are sick. In urban locations there is no dearth for doctors and private clinics, but most of these clinics charge anything from ₹100- ₹400 just for the consultation. The study has sampled elderly who have never gone to any doctor in their lifetime. Some of the respondents have some sort of preconceived ideas about doctors and medicines which stop them from taking medical help if needed.

The Old-age homes house 32.3% of men and 24.4% of women who do not take medical help every time they are sick. In Old-age homes money is an important criteria for taking medicines as well as consulting a doctor. None of the sampled Old-age home has any medical or health facility apart from medicines for fever or other minor ailments given in case of emergencies. All the respondents reported that they are supposed to take care of their own medical expenses and needs, which proves to be costly for them. Apart from residents who have some kind of regular income, others wait for charity organisations or sources to come forward to buy their prescribed medicines or consult the doctor.

The respondents (61%) who admitted that they do not consult the doctor every time they fall ill have given numerous reasons for it. A major chunk of this category that is 35% feels that it is not necessary to consult and take treatment every time they fall ill. They believe that it is better to ignore and let the illness take its time to heal. They admitted that they would go to a hospital or consult a physician only if it is unbearable or serious. Consulting a private doctor or going to a private hospital involves money if there are no government run health centres or hospitals. Hence the respondents (19.2%) avoided treatment from a doctor because of monetary issues. This group of respondents cannot afford the medicine cost or doctor’s fee or the travelling cost.

Majority of the respondents who have economic reasons for not consulting the doctors are residents of Old-age homes.

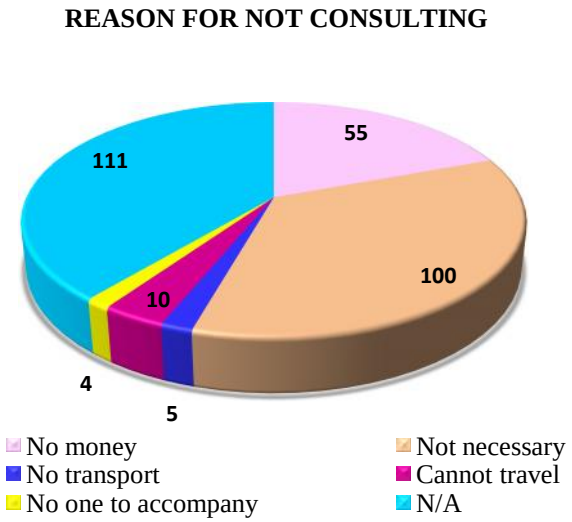

Figure 5.19

According to the data (Figure 5.19) a few of the respondents i.e. 1.7% blame the ineffective transport system connecting villages to towns. In this group out of five, four are from rural locations. In rural areas the public transport is mainly depended on private jeeps or rickshaws which take more people than it is supposed to. The frequency of government run buses is very low. 3.5% of respondents cannot travel due to health issues, and they cannot afford an alternate means as most of these are from rural locations and Old-age homes. Two each from rural locations and Old-age homes i.e. 1.4% have no one to accompany them to the doctor or hospital.

The data (Figure 5.20) shows that 2% of men and 3.4% of women have never gone to a hospital or a doctor. These men and women claim to be perfectly healthy and so never felt the need to go. In case of minor ailments these elderly preferred home remedies to taking Allopathic medicines of any sort. Another 3.5% of men and 3.4% of women have sought medical help more than 4 years ago and 16.1% of men and 13.9% women have gone to a doctor some two to four years back. The rest 78.1% of the elderly men and 79% of elderly women have taken medical help during the year of data collection.

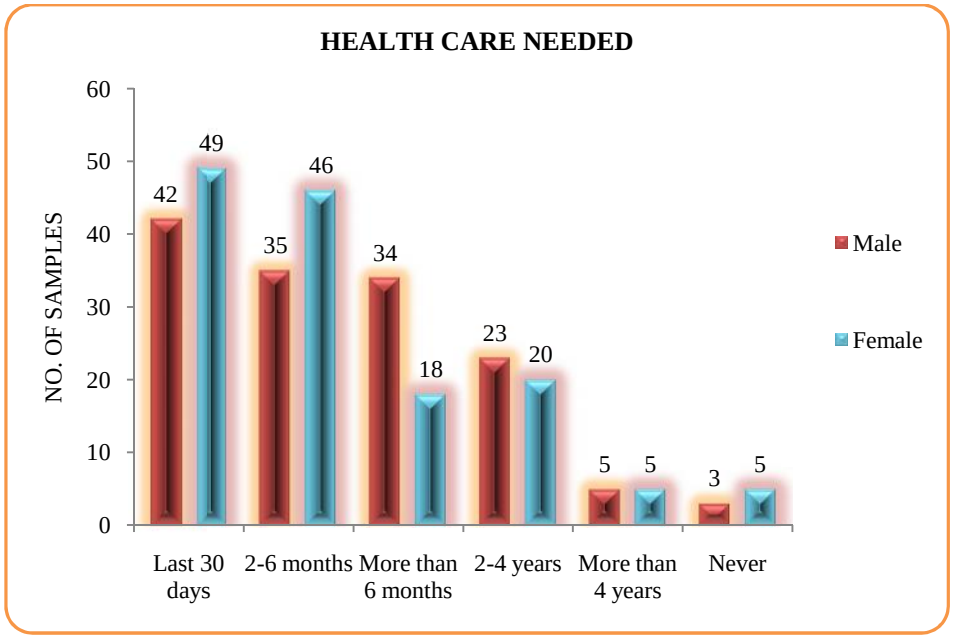

Figure 5.20

The data (Table 5.10) clearly shows that in rural areas the sought after health care facility is private hospitals, which are mostly in nearby towns or cities. The data indicates that 38.6% of the respondents take medical help in private hospitals. Majority of the villagers tend to ignore minor ailments and take medical help only if the illness persists and is serious. So they feel that private hospitals in towns have better doctors and facilities. Another reason for not approaching public facilities in towns are that the procedures are lengthy and time consuming, have to wait for hours to be able to consult and moreover sometimes the treatments/medicines given are not effective. The villagers who do not have a PHC/CHC in their villages are depended on private clinics which are mostly run by incompetent doctors. The villagers admitted that in case of emergencies they have no other alternative but go to these clinics. 20% of the respondents in rural areas go to private clinics in their locality in case of any illness.

The researcher realised while talking to the rural respondents that the attitude towards Primary Health Centres is relative to economic status i.e. it changes with the economic background. While the respondents who are economically fine preferred private health care than public health facility, the respondents who are economically backward feel that the PHCs are good since they provide free of cost medicines. The

rural locations have 20% of the respondents depended on PHCs. The data shows that in tribal villages respondents (12%) are more into traditional medicines.

Health care taken from	Rural	Urban	OAH	Total
Private clinic	15	10	4	29
Private hospital	29	45	57	131
Public hospital/ PHC	15	12	54	81
Charity run clinic	0	2	8	10
Charity run hospital	0	0	2	2
Traditional medicine	9	4	3	16
Self-medication	0	1	4	5
N/A	7	1	3	11
Total	75	75	135	**285**

Table 5.10

The data related to urban areas show that 60% of the respondents attain health care from private hospitals. In urban locations since there are private hospitals at every nook and corner and provides better health care compared to public or government hospitals therefore people opt for these health care system, but it certainly comes with a cost attached on everything. The respondents also visit private clinics if it is not major ailment. 13.3% of the respondents go to a private clinic in their locality as it is more convenient and also charge less for consultation. Public hospitals or government run centres are opted by economically poor people as they cannot afford to spend on health care when their priorities are fulfilling the basic necessities. In urban locations 16% of the respondents are depended on public health care system. Alternative medical practices are also preferred by 5.3% respondents. They opt for traditional medicines particularly Ayurveda or Homeopathic treatments. Self-medication is also opted by a respondent who does not want to make frequent visits to hospitals or clinics.

Further analysis reveals that in Old-age homes also the residents prefer private health care system to public health care. According to the data 42.2% of the respondents go to private hospitals as they believe that it provides quick relief though it is a bit costly. They usually go to those private hospitals which provide them discounts on consultation and medicines on their Old-age home status. The respondents other than who have a regular income admitted that otherwise it would be impossible for them to consult a private physician. Some of them (2.9%) visit private clinics that are there in their vicinity as they are more acquainted to the doctors.

In locations where there are public hospitals near by the Old-age home the respondents opt for these health care systems as it provides medicines and consultation for free. According to the data 40% of the respondents go to public hospitals for any health issue. Since money is a major constraint, 5.9% of the respondents of Old-age homes, identify clinics and hospitals which run for charity and provide treatment for a mere ₹5 to ₹10, and another 1.4% visit charity hospitals which are usually run by Trusts. In the Old-age homes 2.2% of the respondents believe in alternative or traditional medicine for treatment of illnesses. A few i.e. 2.9% prefer to treat themselves and hardly have visited any hospital or clinic, the respondents claim that they do not fall ill and if needed they get medicines from stores for minor ailments.

Access of health care services determines an individual's state of health as well as the quality of life a person could attain by addressing the several health issues. While dealing with elderly population health and health care plays a very important role because gradual gradient of health and mobility is the ultimate truth of life and it is believed that to a certain extent good health care system could bring some quality of life into the ageing body.

The (Table 5.11) shows that 8% in rural areas, 9.3% in urban areas and 5.9% in Old-age homes have consulted a doctor or taken health care from hospitals or alternative practitioners more than ten times in the current year of data collection. These consultations also include visits to the health care practitioners in case of minor ailments like fever or cold. Another 17.3% in rural, 10.6% in urban and 9.6% in Old-age homes have at least made six to ten consultations in the year. The respondents in

these two categories are those who suffer from several health issues and need regular health care apart from the care during ailments like fever, cold etc.

No. of times consultation sought in the current year	Rural	Urban	OAH	Total
1-3	21	25	59	105
3-6	18	18	28	64
6-10	13	8	13	34
>10	6	7	8	21
Nil	17	17	27	61
	75	**75**	**135**	**285**

Table 5.11

In both rural and urban locations 22.6% of the respondents have not consulted any health care practitioners in the current year, like wise in Old-age home as well 20% have not taken any medical help during the year. This also includes elderly who avoid consultations and visits to health care facility because of economic constraints or inability to travel.

5.15 Economic Dependency for Health

In the absence of economic security for the geriatric population, it has to be seen how this section of our society meet their health demands and what are the sources of finance for fulfilling these demands. The study has made an attempt to assess the spending on health and its source among the respondents.

The detailed analysis of the data in (Table 5.12) reveals that 29.3% in rural, 17.4% in urban and 35.5% in Old-age homes spend nothing on medication. This group includes who are healthy and are not on any medication as well as those who visit government hospitals and health care centres. The respondents who are on medication for high blood pressure and other minor ailments spend less than ₹200 a month for medication.

Amount spend on medication in a month (₹)	Rural	Urban	OAH	Total
(i) Nil	22	25	48	95
(ii) Less than 200	29	18	41	88
(iii) 200-600	12	14	29	55
(iv) 600-1000	4	6	9	19
(v) More than 1000	8	12	8	28
	75	**75**	**135**	**285**

Table 5.12

Another 6.6% of the total respondents spend around ₹600- ₹1000 on medication. These consist of respondents who suffer from multiple illnesses like Blood Pressure, heart ailments, joint pain etc. There are also respondents who spend more than ₹1000 a month and are the ones who suffer from heart disease and associated health issues, dialysis, pacemakers etc. Most of these elderly have medicines which are very expensive and needs to be taken regularly.

The (Table 5.13) shows that in rural areas 33.3% of the respondents spend their own earnings on medication and majority of them are males. On further examination it has been found that all these respondents are independent and are earning members. Another major chunk of the rural respondents i.e. 41.3% are depended on the earnings of other family members to fulfil their medical needs. As expected majority in this category are female respondents i.e. 22 out of 31. The rural respondents i.e. 9.3% are depended on their savings. These are the respondents who are either currently employed or have a pension or investment which gets interest on a regular basis.

A 4% of the respondents admitted that they have to borrow money from their friends, neighbours or relatives in case of health problem as they are not in a position to afford additional expenses like medication and hospitalisation. Though the health care centres in the rural locations are not the best option in case of illness as there are no

doctors in most of the health centres, they are mostly run by nurses or attendants who provide with necessary tablets and basic treatments. The data shows that 12% of the respondents in rural locations depend on these health centres for their illness.

Source of finance for medication	**Rural**	**Urban**	**OAH**	**Total**
(i) Earning of self	25	29	15	69
(ii) Income of other family members	31	25	47	103
(iii) Savings	7	8	23	38
(iv) Insurance	0	0	0	0
(v) Sold items	0	0	0	0
(vi) Loan from others	3	0	0	3
(vii) Charity/ Gov. hospitals	9	13	50	72
Total	75	75	135	**285**

Table 5.13

In urban locations 38.6% of the respondents attend to their medical needs with their own income. Males out number females in this category, there are 21 males to 8 females. Almost all the respondents in this category are economically independent. Dependency on other family members is also seen among the urban respondents, 33.3% of the respondents fall in to this category. Out of the total 25 respondents 19 are female dependents.

All the respondents in urban locations who have investments or pension use it for their health needs. They are happy that they do not have to depend on somebody else for their health needs and could make their own decisions regarding access to health care. The study found 10.6% of the respondents fall in this category. The charity hospitals and government civil hospitals in urban locations are much better equipped than the health centres. The data reveals that 17.3% of the respondents meet their health needs from these institutions. Majority of them who avail this facility are the respondents belonging to lower class.

In Old-age homes the respondents who have their own earnings to support their health needs are less compared to rural and urban respondents. The data shows that 11.1% of them use their own income. This category includes 9 males and 6 females. The Old-age homes also have 34.8% of the respondents who are depended on other family members and mostly their children fulfil their health requirements. In Old-age homes the dependency is seen among both males as well as females. The data shows that there are 20 males and 27 females who are dependent. The Old-age home respondents who use their savings like investments for health purpose are around 17%. This category includes 11 females and 12 males. The respondents who take health care from government hospitals and charity clinics are more in Old-age homes since majority of them have economic constraints and are depended on charity or their children. They also prefer these health care institutions rather than putting further burden on their children. The data shows 37% of them in this category.

5.16 Surgeries

Ageing is associated with several health issues and as the age advances the elderly are faced with numerous challenges. The constant and continuous wear and tear sometimes culminates in surgeries to regain or to sustain the biological or physiological system.

The (Figure 5.21) gives a clear idea as to the type of surgeries the respondents have undergone. The data shows that 5.6% of the male respondents have undergone heart operation, while only 2% of the females have undergone heart surgery. Surprisingly seven out of eleven in this category are from the upper class. According to the data 2.8% of the males and 3.4% of the females have removed kidney stones. Some of them have reported that the issue of kidney stone has recurred even after the surgery. Kidney stone problems have been reported more from Banaskantha district.

Hernia has been operated in 2.1% of the males. Knee joint replacement has been done for 3.5% of males and 1.3% of females. In this category four of them are of Old-age homes, two are of urban locations and one belongs to rural location. The study finds that 6.2% of the female respondents have undergone hysterectomy more than ten years back.

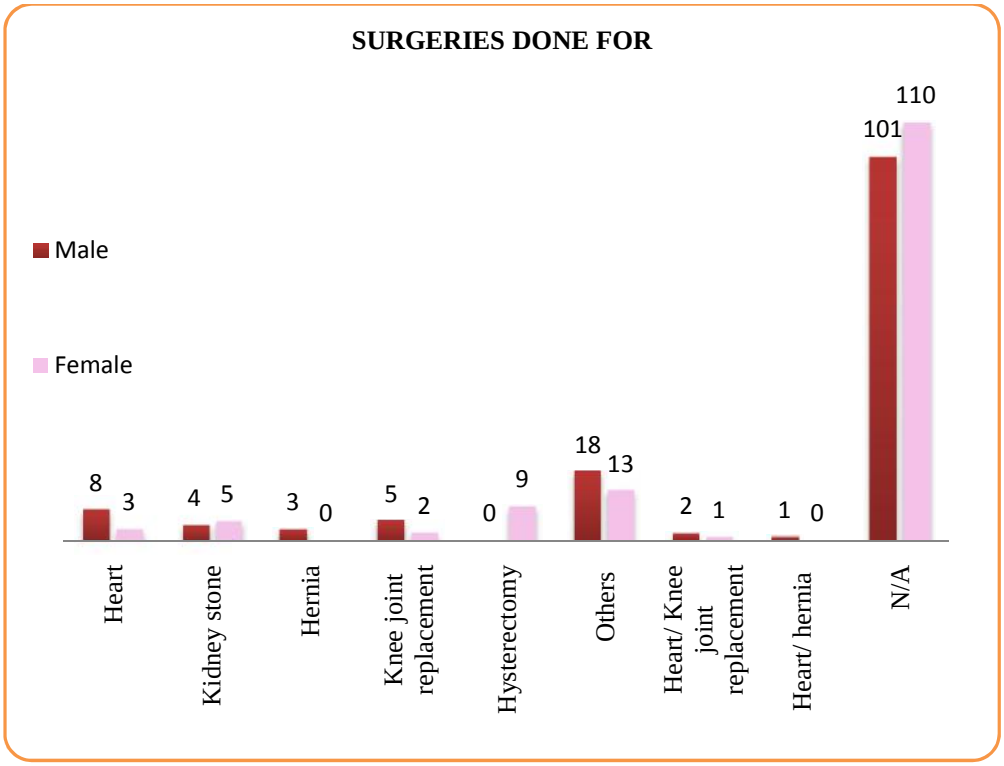

Figure 5.21

In the ‘others’ category the researcher has clubbed several not so common surgeries like cancer/tumour removal, appendix, prostrate, fracture, amputation, backbone, pancreatic surgery, ear grafting, piles. The researcher has identified 12.6% of men and 9% of women have undergone at least one of these surgeries. The graph shows 1.4% of males and 0.6% of females have undergone both heart and knee joint replacement surgeries and 0.7% of males have undergone both heart and hernia operation.

The study tries to assess the amount spent on various surgeries that the respondents have undergone. The data (Figure 5.22) includes all the surgeries discussed above in addition to cataract surgeries. Out of the total respondents 17.8% have undergone surgeries for charity or free. These surgeries are mostly carried out in government hospitals which charge nothing. In case of cataract surgeries, even some private hospitals conduct free camps.

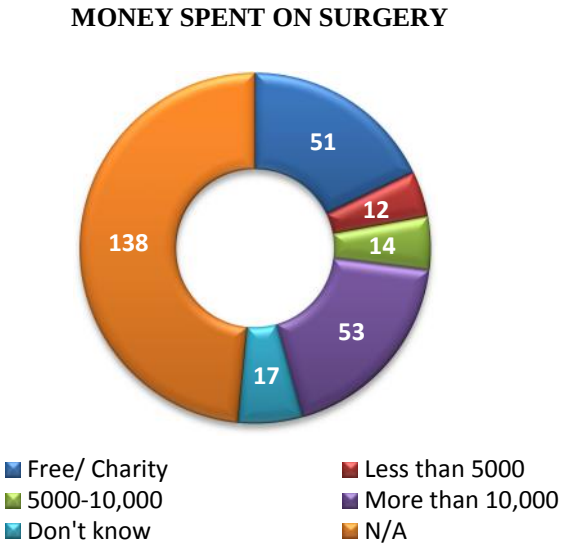

Figure 5.22

Among the sampled elderly 18.5% have spent more than ₹10,000 and they include major surgeries for heart or knee replacement as well as other surgeries like cataract which has been done in private hospitals. Surgeries like bypass for heart ailments, installation of pace makers, knee joint replacement amount to lakhs of rupees. While other minor surgeries can be carried out at a reasonable cost if done in lesser known private hospitals compared to multi-speciality hospitals which charge thrice as much the normal price range.

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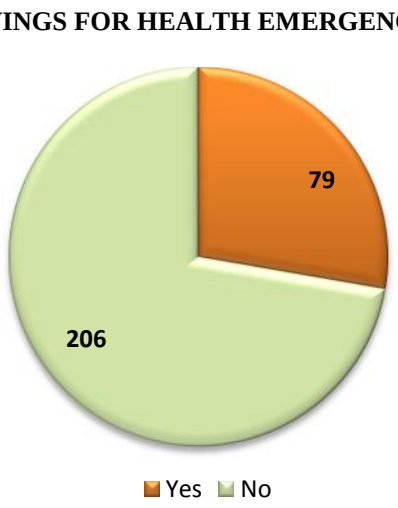

Figure 5.23

Old age throws many surprises like health emergencies, but as the data in (Figure 5.23) the study reveals there are various hardships in the life of an elderly like economic instability, abuse, neglect, access and availability of good and affordable health care etc. The study tries to understand the economic capability of an elderly to meet these health emergencies. Exploration and analysis of the acquired data reveals that only 27.7% of the respondents have some savings that could meet the health emergencies.

5.17 Major Findings and Interpretations

These are some of the major interpretations of the study:

Satisfaction and Change of Living arrangement

- Majority of the respondents are satisfied with their living arrangement as they think that it is the best available option to them.
- The respondents who are not satisfied with their living arrangement consist of mainly Old-age home residents.

Relation with Friends and Sharing of Worries

- In rural the respondents maintain relation with friends, community and relatives thus creating a strong social bonding and support.
- In urban locations the social relations and bonding by the respondents with their neighbours or community was found to be less than the rural locations as a result the respondents lead a lonely and boring life.
- In Old-age homes though the idea is to bring together people of the same age for a better social support, the study found that there is very less cooperation and more conflicts among each other.

Relation with Children

- The children of respondents in rural locations who are in agriculture and associated activities spend enough time with their parents and have better relations with them.
- In rural, respondents with children who have migrated to other countries or towns lead a secluded life but is supported and helped by their neighbours and friends.

- In urban, respondents who are staying in joint families have a good relation with their children as the house is controlled and run by the elderly in the house.
- In urban or rural the respondents who are in nuclear family due to intergenerational conflicts lead a lonely and depressed life as their children do not spend much time with them, in such cases men seem to be most affected and vulnerable.
- In Old-age homes majority of the respondents do not receive any attention from their children.
- In Old-age homes most of the respondents are often visited by their daughters than sons.

Emotional Bonding

- Most of the spouses were emotionally close to each other.
- Most of the respondents are emotionally close to their sons than their daughters.
- Some of the respondents claimed to be not close to anyone as they are unhappy and dejected with life.

Recreational Activities

- In rural locations religious rituals, functions like marriage and rituals related to festivals are the main source of recreation for the respondents.
- In urban locations religious activities like going to the temple, reading religious books, watching television, going on tour to religious places etc. are some of the recreation the respondents engage in.
- In Old-age homes the study found that the respondents lead a monotonous and inactive life as the only recreation available is television in some organisations and tour to religious places takes place only once in a while.

Abuse in Family

- As compared to females the study found more men who have faced abuse in one form or the other.

- Majority of the respondents who have admitted of facing some kind of abuse are residents of Old-age homes.
- In most of the cases the abusers are sons and daughters-in-law.
- Many of the respondents have shifted to Old-age homes due to the abuse in spite of owning the house.
- Most of the abused respondents do not reveal about the abuse to others as they are depended, scared and worried about the family status in the community.
- As compared to physical and verbal abuse most of the respondents have experienced psychological abuse where they are neglected and ignored.

Incidence of Depression

- Compared to men more women have had incidence of depression.
- Most of the women with incidence of depression are widows.
- Majority of the respondents whether male or female who have had incidence of depression are residents of Old-age home.

Conflicts

- Majority of the respondents are not in conflict with anybody.
- Of the few respondents who are in conflict, are with their daughters-in-law and sons.
- Very few respondents have had conflict with their daughters.
- Major reason for conflicts is dependency of the respondents and in some cases inter-generational maladjustment.

Current Status of Health

- Majority of the respondents do not face any difficulties in carrying out their basic daily needs.
- Most of the respondents who have severe difficulty in carrying out their basic daily needs are residents of Old-age homes.
- Most of the respondents who face moderate difficulties in carrying out their basic daily needs are from rural locations and consists of mainly women as they engage in strenuous agricultural labour.

- More women compared to men face severe disability or difficulty in movement.
- Maximum respondents with severe disability are from Old-age homes.
- Most of the respondents who have severe problems in carrying out the household activities are residents of Old-age homes.
- Only few respondents have severe problems related to breathing.
- A few who suffer from shortness of breath have been found to have heart problems.
- More than 50% of the respondents suffer from sleeplessness.
- Anxiety, family problems and leg pain are the major causes of sleeplessness.
- Most of the respondents with sleeping disorder are from Old-age homes.
- Respondents in rural locations compared to urban have more cases of sleeping disorder.
- Female respondents are the most effected with the disorder in all the sectors i.e. rural, urban and Old-age home.

Diet and Health

- Majority of the respondents have only two major meals a day as it is the accepted pattern of diet throughout Gujarat.
- In rural the diet is usually simple, mostly prepared with whatever they produced.
- In rural respondents used ghee in abundance as majority of the households has cattle.
- In urban the respondents used vegetable oil in abundance for cooking.
- In urban the respondents have one full meal for lunch and a light meal for dinner.
- Most of the respondents are vegetarians except for Muslims, Christians and tribal.
- The respondents who complained of weakness and tiredness are mostly elderly in Old-age homes and rural locations.
- The respondents in rural locations gave least attention to health and a proper balanced diet.
- All Old-age homes except for one take care to provide a balanced diet.

- Many respondents reported of deficiencies and low haemoglobin but very few in this took any supplements to combat it.

Eye Sight and Corrections

- Many respondents are seen not using their corrective glasses in spite of doctor's prescription.
- Most of the respondents who avoid using corrective glasses are elderly in rural locations.
- More than 50% of male and female respondents reported as having no problem with their vision.
- Some of the respondents have never gone for an eye check-up as they were found to have certain myths and phobia regarding hospitals and doctors.

Detection of Cataract and Treatment

- Around 50% of both male and female respondents have never had cataract.
- Most of the elderly who have undergone corrective surgery have done it in charity eye camps or government hospitals.
- Most of the respondents in rural depend on eye camps for their vision issues as it is not viable for them to travel to towns or cities for the purpose.
- Old-age home respondents are primarily depended on charity eye camps as they face monetary issues.
- In urban locations the well to do respondents did the cataract surgery in private hospitals, while others mostly did it in government hospitals or eye camps.
- A few respondents have reported of negligence during cataract surgery which has led to vision impairment.
- A small percentage of respondents have reported of no considerable change in vision even after the surgery.
- All unsuccessful surgeries were carried out in charity camps.

Auditory Senses

- Maximum numbers of respondents with impaired auditory senses are residents of Old-age home.

- Out of the effected in Old-age homes, very few use hearing aids.
- Those possess hearing aids in Old-age homes hardly uses it as it is costly to maintain it.
- In rural only one respondent among the effected use a hearing aid.
- The study found that the respondents with weak auditory senses felt frustrated, bored and dejected as it becomes difficult for them to communicate with others.

Urinary Problems and Constipation

- Only a few respondents suffer from urinary infection.
- Most of the affected are respondents in Old-age homes.
- Poor cleanliness of the washrooms of Old-age homes is the primary reason for infection.
- Around 50% of the respondents suffer from constipation.
- Maximum numbers of respondents with constipation problem are residents of Old-age homes.
- In Old-age homes the meals served are to an extent planned according to the seasonal availability and price of the vegetables and pulses thus compromising on fibre intake of the respondents.

Diagnosis of Diabetes and its Treatment

- The prevalence of diabetes in rural locations is found to be very low. Active life style and intake of simple and limited food are the reasons for low prevalence in rural locations.
- Compared to Old-age homes and rural locations urban locations have more respondents suffering from diabetes. The reasons for prevalence of diabetes among respondents in urban locations are inactive lifestyle and stress.
- All respondents affected with diabetes in rural as well as urban locations are taking treatment for it.
- The respondents with diabetes who are staying in old age homes do not take regular treatments due to monetary issues.

Common Illness

- Hypertension is seen to be more among the respondents of urban locations and Old-age homes.
- In rural locations the few respondents with hypertension depended on Ayurvedic and traditional medicines.
- In Old-age homes the respondents skipped medicines depending on affordability.
- Respondents who were in organisations which are closer to government hospitals took medicines regularly as they got it for free.
- Not many cases of heart ailments have been reported by the respondents.
- Only two respondents in rural have reported as suffering from heart ailments. Compared to rural more cases were reported in Old-age homes and urban locations.
- All the respondents in urban locations who reported of heart ailments are men staying in a nuclear set-up.
- Of the total 9 respondents reported with heart ailments 5 are from Surat district.
- Joint pains due to arthritis or weakness of bones is found to be more in respondents of rural locations compared to respondents in urban and Old-age homes.
- A very small percentage of respondents have had Tuberculosis (T.B) earlier, all of them are either from urban locations or Old-age homes.
- Occurrence of cancer among the respondents was reported more in urban locations compared to Old-age homes.
- No case was reported in rural locations.
- Majority of the affected were women, and all were cases of breast cancer.
- Old-age homes have more cases of heart disease along with blood pressure compared to urban locations.
- Rural locations did not report of any case of heart disease along with blood pressure.
- Compared to females more male respondents have been identified with heart disease along with blood pressure. Majority of the effected respondents belong to either the upper or middle class.

- Stress and food habits are found to be two major causes for heart diseases and blood pressure.
- A very small percentage of respondents in urban locations used pacemakers and did dialysis.
- A small percentage of the respondents were identified with partial paralysis, all of the affected are residents of Old-age homes.
- The respondents affected with paralysis had to move out of the family as their children and daughters-in-law were reluctant to keep them.

Addictions and Habits

- Chikni and beedi are commonly used in all the sectors.
- Among females chikni is more popular though a few also smoke beedis.
- In Old-age homes though the rule books restrict the residents from using any addictive substance, compared to urban maximum number of respondents with these habits have been found in Old-age homes and rural locations.

Availability and Access of Health Care

- Rural respondents consult a medical doctor only if it is serious illness and the sickness persists.
- The rural respondents were not happy with the locally available medical treatments as it did not provide much relief.
- Poor public transport facility in the rural sector hamper the access to good health care.
- None of the Old-age homes provided medical facility to its residents.
- Access of health care among the respondents in Old-age homes depended largely on their economic status or availability of free health care facility nearby.
- Accesses of health care by urban respondents are better than rural as there are ample health care facilities that are affordable to all sections of society.
- More than 70% of the male and female respondents have taken medical help during the year of data collection.
- A small percentage of male and female respondents have never consulted a doctor or taken any medicine in their life time.

- Most of the respondents preferred private hospitals to public hospitals as the private hospitals provided much better treatment.
- Many of the respondents in Old-age homes who are economically weaker depend on government health facilities as the treatment and medicines are given free of cost.

Economic Dependency for Health

- 9.8% of the respondents spend more than ₹1000 for medication every month.
- Maximum numbers of respondents depend on the income of other family members for their medication.
- None of the respondents have any medical insurance.
- Compared to Old-age homes more respondents in rural and urban use their own earning for medications.

Surgeries

- Maximum surgeries have been done for heart after cataract.
- Compared to men more female respondents of both have been operated for Kidney Stone.
- Compared to other districts under study Banaskantha district has reported more cases of Kidney Stone.
- 18.5% of the respondents have spent more than ₹10,000 for surgeries.

5.18 Case Study 1

Patel Ganshyam Daya Bhai of Vadara village in Anand district is a 78 year old retired teacher. He is staying in a nuclear family which includes only him and his wife. He has two sons and two daughters. Daughters are married off and sons stay separately as the daughters-in-law cannot get along well with his wife. He has some agricultural land which he looks after just to keep himself occupied.

He and his wife stay in a single story *pucca* house which is furnished well. He has partitioned his properties among his children which include separate houses for the sons as they wanted to stay separately. He receives service pension and some earnings from agriculture which he says is enough for him and his wife. He suffers from diabetes and is taking insulin for the same. When the researcher met the respondent,

he was recovering from a recent surgery of Hernia. When talking about his sons there was evident anger and disappointment in the respondent. According to him his sons do not visit or talk or enquire about him or his wife even though they are aware that he and his wife have health issues. His wife suffers from high Blood Pressure and low haemoglobin which results in frequent giddiness and weakness. He claims that for his hernia pre-operation check-ups, surgery and post-operation check-ups he had to travel 15 kilometres by rickshaws accompanied by his friends or relatives. None of his sons visited him or called him. His daughters call them frequently, and they also visit one of their daughters who is migrated to U.K. He meets his friends and other villagers daily in the evening when all get-togethers near the temple. He claims that he do not believe in God when asked if he is religious. Though he meets his friends often he says he does not discuss his personal affairs with them. He is a chain smoker and smokes at least 25 beedi a day.

He goes to the Primary Health Centre in the village for minor ailments and basic medicines but has to go to Tarapur town which is 15 kilometres away for major illnesses and specialised consultation. He is not happy with how life has turned out as he and his wife is depended on the maids who come for cleaning, cooking and also taking care in case of sickness.

5.19 Case Study 2

Dorothy Rose Samuel is an 82 year old Christian widow in Godhra town of Panchmahal district. She stays in a nuclear family which includes her unmarried son other than her. She has 3 daughters and 3 sons; another son stays in the adjacent house. She retired as the principal of government Primary School, but continued to work as a principal in a private school for almost twelve years. She receives pension which she says is enough to fulfil her needs.

She and her elder son stay in her ancestral house which was given to her. A portion of it is separated and given to her another son and his family. In 1974 she was detected with breast cancer so had to undergo surgery and treatment. She says that she did not have to spend much on her treatment as she always took treatment from government hospitals. The children in her school also collected money and helped her financially in her time of need. She had recurring cyst and lumps so had to undergo at least 7 surgeries to remove them. Earlier she weighed 105 kg but reduced it to 75 kg as it was

becoming difficult for her to move about and her leg was giving problems. She maintains a fixed schedule for herself and has simple and light food. Her son cooks the food and looks after her when she falls ill. She keeps herself occupied by doing crochet work and stitching and is also actively involved in social works connected to the church. She maintains a very good relationship with her children as well as community. She goes and stays with all her children so that she doesn't get bored.

She is a very lively lady who loves to talk and read. She looks happy and content and says she has no complaints about life and tries to live her life to the fullest by spreading happiness and cheer to all she meets.

Conclusions

"The wiser mind mourns less for what age takes away than what it leaves behind."
- William Wordsworth (1770-1850)

According to William Wordsworth There are several layers of wisdom embedded in this quote. One is that as people get older; their wisdom is expressed by focusing on what is most important. Second, those adults who do focus on loss will be less able to maximize their mental powers, even in areas that traditionally seem vulnerable to the effects of aging. Third, by concentrating on your strengths rather than your weaknesses, your more positive mental set will allow you to take advantage of your mental powers, even if they're not quite what they were when you were younger.

In this chapter the study has analysed the different facets of physical and psychological aspects of elderly persons. The study found that there are intergenerational conflicts and abuse in families which are pushing the elderly to take refuge in Old-age homes though it pains them. There is a dyad mode of care taking in families where the actors are mostly daughters-in-law and spouses. The urban areas showed more degenerative illnesses compared to rural. The study shows that while elderly in rural locations abstained from health care due to lack of time and good health care nearby the elderly in Old-age homes abstained from attaining health care due to monetary issues.

ELDERLY WITH ILLNESSES

Photograph 5.1

Kanh Bha is totally depended on her care taker and moves about on a wheel chair- Sree Madhapar Leva-Patel Apnu Ghar (Kachchh)

Photograph 5.2

An old lady with fractured leg at Palanpur General Hospital (Banaskantha)

Photograph 5.3

An old lady admitted due to high fever in Palanpur General Hospital (Banaskantha)

Photograph 5.4

Shanta recovering from a fall has no care taker and is depended on her room-mate-Ambika Niketan Vrudhashram (Surat)

Photograph 5.5

Amrit Lal had infection in his stomach and was operated 4 Yrs back. Still suffers from indigestion and constipation (Khemana, Banaskantha)

Photograph 5.6

Sammu Ben, weakness due to old age and lack of balanced diet (Sadarpur, Banaskantha)

Photograph 5.7

Kesri Ben is undernourished and weak due to utter poverty (Babrol, Panchmahal)

Photograph 5.8

Hitudi Ben lost vision in one eye after the cataract surgery and suffers from skin allergy and weakness (Babrol, Panchmahal)