Gender, Caste and Health Conditions of Aged: A Study of Rural Areas in Haryana

Dr. Preeti
Assistant Professor in Sociology,
M.D.U. Centre for Professional and Allied Studies,
Gurugram-122001.

Abstract

Health is condition of physical, psychological and social well being. Health is a grave concern for individual as well as for the family members especially in old age. Longevity and life expectancy has increased due to medical advancement but quality of life is adversely affected in modern times. Psycho-social pressures are also increasing on individuals in modern life style. Hence, health has become a serious concern in the society. Old age is more prone to adverse affects of environment. The present study analyses the health conditions of the aged and impact of gender and caste on their health condition. Providence of care to the aged by the family members in illness and in routine has also been analysed. This study shows that health of aged is better in the village which undergoes transformation due to urban influences than the village where traditional social structure is deep rooted. Gender and caste category has a direct impact not only on health condition but also on treatment taking patterns as well as care providence by the family members.

Keywords: Ageing, Old Age, Health, Care Providence and Rural Society.

Introduction:

Though longevity and life expectancy has increased in recent times due to medical advancement but quality of life is adversely affected in modern times. Treatments are available for almost all the diseases but number and frequency of diseases has increased multiple times. Moreover, psycho-social pressures are also increasing on individuals in modern life style. Hence, health has become a serious concern in the society. Old age is more prone to adverse affects of environment on physical and psycho-social aspects of individual. Health issues of aged are a major concern in developing societies which strive to assure quality life besides facing various economic and social constraints. Moreover, healthy ageing signifies the physical, psycho- social well being of an individual and society at large.

Many studies have been undertaken on the various aspects of the aged's life. One dominant issue and theme discussed pertain to health conditions of the aged. Rao (1975) states that some of the common somatic diseases of the aged found in India are high blood pressure, heart disease, accidental injuries, strokes, cancer, diabetes, respiratory and lung diseases, kidney infections and diseases of the joints and bones. Decline in vision, hearing and sensitivity to taste and other common deficiencies of old age are also widespread. Nair (1989) reveals that the incident and prevalence of chronic as well as non- chronic disease are more in rural aged that is 1) respiratory diseases, 2) loco-motor illnesses and 3) blood pressure. Pappathi and Sudhir (2005) reveal that physical disabilities like impairment of vision, hearing and loco motor ability are common among the rural aged. Majority suffer from joint pain, blood pressure and chest pain. Asthma, piles, loss of weight, diabetes and skin diseases are also seen among few aged.

Gupta (1968) has shown that old age presents a number of problems and some of the most important among them are the problems which are purely social and psychiatric in nature such as mania, depression, senility, psychosis and senile dementia. Beckman (1973) reports that the aged men and women suffered from rolelessness, powerlessness, and depression. With ageing, there is decline in many physical functions which leads to a feeling of inadequacy.

Kumar (1995) states that increase in life expectancy at birth and enhanced age is accompanied by an enormous magnitude of diverse problems such as- decreased health, finance, housing and an array of socio-psychological issues faced by the aged (like loss of power and status, loneliness, depression and dependence on others etc.). Patel (1997) has shown the mental problems of ageing and the care taken of aged by their families. Old people and their family members are less vigilant about mental illness as compared to physical illness and are often not prepared to accept certain mental diseases as a disease and take little initiative in the treatment and diagnosis of psychological disorders.

Joshi (1971) states that differential ageing phenomenon both physical and mental appear to depend on environment and social factors such as diet, type of education, occupation, adjustment to family, professional life and consumption of tobacco and alcohol. Rao (1975) has mentioned that while improved health has improved longevity in India, but it's typical socio-economic conditions like poverty, breaking up of joint family system and poor services for the aged pose a psychiatric threat.

Pati and Jena (1989) focus on the problems of the aged in rural areas stating that low economic status reduces not merely the social status but the health status of the aged also. An economically dependent life spoils interpersonal relation, reduces/adjusts the personal needs of aged and further leads to psychological depression among them. Bhatia (1983) has shown higher chances of dependency among aged, the incidence of dependency being higher in the higher age groups. Women are found in a disadvantageous position as compared to men.

Reddy (1989) examines that the aged staying in joint families have high expectations of old age support and only few get the support up to their expectations. The aged having few children are better assured for the quality of old age support having greater reliance on daughters in the time of crisis. Kumar (1995) also states that the breaking down of the joint family system due to changes in human values, migration of youth in search of jobs, inflationary trends and growth of individualism, further, compounds the problems of the aged and leaves them vulnerable and unattended.

Vasantha and Premakumar (2000) reveal that the aged members are confronted with various nutritional, physiological and other general problems which are directly related to their education, income etc. When the literacy level, income level and employment status improve, they seem to be more comfortable with their health conditions and living status.

Banerjee (2002) examines the status and problems of the aged in rural areas. Majority from rural areas agreed that they are not facing much problems in different fields of life. A small sense of frustration and depression is seen among aged and they are capable to maintain themselves independently irrespective of getting help from their family. Instead, support is extended to the family members.

Rao et al. (2003) and Singh (2005) mention that health problems tend to increase with advancing age and often the problems aggravate due to neglect, poor economic status, social deprivation and inappropriate dietary intake. Lack of medical facilities and poor economic conditions might be responsible for the low health status of aged in rural areas (Rao et al.,2003; Pappathi and Sudhir, 2005) . Majority of the landless rural aged are suffering from one or the other health problems and physical disabilities.

Pappathi and Sudhir (2005) reveal that aged female have to engage in agricultural work or in daily wages for their livelihood besides being physically weak. Their contribution to up keep of the family and

involvement in decision making is recognised but worry about future is still seen among them. For happy ageing, women need better health status, fulfillment of basic needs like food, clothing and shelter, love and affection, and economic security.

Shankardass (2009) suggests that increasing incidences of material exploitation, financial deprivation, property grabbing, abandonment, verbal humiliation, and emotional and psychological distress in India, all of which compromise the mental and physical health of the aged. National Sample Survey Organisation (2006) analysis of morbidity patterns by age clearly indicates that the aged experience a greater burden of ailments (which NSSO defines as illness, sickness, injury, and poisoning) compared to other age groups across gender and residential locations. World Health Organization (2002) states that the stigma of aging as well as the health and social conditions of the aged (such as dementia, depression, incontinence or widowhood) is another social barrier to access of health in India in unique ways.

Patel and Prince (2001) reveal that despite being frequently observed in the aged population, certain mental health deficits are not acknowledged as health needs. Conditions like dementia are viewed as normal aging and depression construed as the result of neglect by family. Many data collection procedures (National Sample Surveys, Census data, or death certificates) do not capture pathological progression nor do they disaggregate morbidity and disability outcomes among the aged (Alam and Karan, 2010).

In the light of the findings of above studies, the present study attempts to analyse the health status of aged in selected rural areas across gender and caste. Impact of gender on the health of aged has been seen. Caste identity and land ownership are the center of rural structure. How caste identities affect the health of the aged?

Objectives:

The present study has been conducted to accomplish the following objectives:

- To analyse the health conditions of the aged in rural setup.
- To find out the impact of gender and caste on the health conditions of aged.

Methodology:

The design of study is descriptive in nature. The study is intended to find out the health status and patterns of taking treatment among the rural aged across gender and caste status. The aged is accepted as who has already completed 60 years. The present study has been carried out in rural setup of Sonepat district of Haryana. The villages are selected on the basis of their location. One village is selected from the interior areas and the other village from the exterior areas of Sonepat. In the interior village (Sargthal), there are 658 aged while in the exterior village (Kundli), there are 261 aged. A proportionate sample of 33% is taken through systematic random sampling from both the villages. An interview schedule and observation are used as tools of data collection. Questions are framed on socio- economic status, health conditions, treatment taking patterns and care extended by family members etc.

Result and Discussion:

Health Status of Aged:

Good health is not the sole factor but one of the most important factors in determining the quality of life of the aged. The presence of physical ailments may often create problems in leading a comfortable routine life especially in old age where already the body capacity starts diminishing which in turn affects the aged negatively.

The presence of specific physical ailments varies according to gender due to different biological requirements and adaptation of human body along with the social conditions. The physical ailments are different across caste categories as their working conditions and nutritional intake may be varied. Hence, it is

important to analyse the general health status of the aged along with the presence of physical ailments across gender and caste categories.

Though satisfaction of health is completely self-perceived; the aged who are not suffering from any physical ailment or with petty health issues have accepted their health as highly satisfactory; the aged who could combat their routine lifestyle besides having one or few ailments have accepted their health as satisfactory and others stated their health as unsatisfactory. The mean scores are calculated by giving a score of 3 to highly satisfactory health status, a score of 2 to satisfactory health status and a score of 1 to unsatisfactory health status. Higher the value of mean score means the better health status of the aged group.

Table 1.1

Health Status of the Aged by Gender and Caste Category in Interior and Exterior Villages

Sr. No.	Variables		Mean Scores of Health Status	
			Interior Village	Exterior Village
1.	**Gender**	Men	1.89	1.98
		Women	1.56	1.79
2.	**Caste Category**	General	1.81	2.03
		SC	1.85	1.86
		OBC	1.54	1.79

A cursory look at table 1.1 shows that the mean score for health status is found more satisfactory almost in all the groups of aged of the exterior village. The reason for this high score is mainly due to the awareness of medical problems and checkups among people and especially the aged in the exterior village. Though there are Government Medical College, Government Ayurvedic Hospital and Government Physiotherapy Hospital available near 8-10 kilometers from the interior village, and one Primary Health Centre within the village, but due to lack of awareness and taken for granted attitude towards health issues, the mean score for health status of the aged is found low in this village.

The aged in the exterior village are having better health status as compared to aged in the interior village.

Table 1.2

Physical Ailments of the Aged by Gender in Interior and Exterior Villages

Sr. No.	Physical Ailments (Type)	Interior Village			Exterior Village		
		Men (N=97)**	Women (N=121)**	Total (N=218)**	Men (N=49)**	Women (N=38)**	Total (N=87)**
1.	Weakening of eye sight	26 (26.8%)	28 (23.1%)	54 (24.8%)	20 (40.8%)	17 (44.7%)	37 (42.5%)
2.	Joint pain	33 (34.0%)	36 (29.8%)	69 (31.7%)	12 (24.5%)	19 (50.0%)	31 (35.6%)
3.	Hypo/ hypertension	14 (14.4%)	23 (19.0%)	37 (17.0%)	9 (18.4%)	10 (26.3%)	19 (21.8%)
4.	Shortness of breath	17 (17.5%)	17 (14.0%)	34 (15.6%)	11 (22.4%)	4 (10.5%)	15 (17.2%)
5.	Upset stomach	14 (14.4%)	27 (22.3%)	41 (18.8%)	6 (12.2%)	4 (10.5%)	10 (11.5%)
6.	Frequent loss of consciousness	15 (15.5%)	22 (18.2%)	37 (17.0%)	4 (8.2%)	2 (5.3%)	6 (6.9%)
7.	Decreased body stamina/ Body	16 (16.5%)	18 (14.9%)	34 (15.6%)	8 (16.3%)	0 (0.0%)	8 (9.2%)

	ache						
8.	Chest pain	6 (6.2%)	12 (9.9%)	18 (8.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
9.	Severe heart problem	2 (2.1%)	8 (6.6%)	10 (4.6%)	9 (18.4%)	0 (0.0%)	9 (10.3%)
10.	Cough	0 (0.0%)	11 (9.1%)	11 (5.0%)	0 (0.0%)	4 (10.5%)	4 (4.6%)
11.	Head ache	5 (5.2%)	9 (7.4%)	14 (6.4%)	2 (4.1%)	0 (0.0%)	2 (2.3%)
12.	Loss of hearing	7 (7.2%)	2 (1.7%)	9 (4.1%)	0 (0.0%)	3 (7.9%)	3 (3.4%)
13.	Diabetes	3 (3.1%)	2 (1.7%)	5 (2.3%)	0 (0.0%)	4 (10.5%)	4 (4.6%)
14.	Paralysis	3 (3.1%)	4 (3.3%)	7 (3.2%)	3 (6.1%)	0 (0.0%)	3 (3.4%)
15.	Urinary problems	0 (0.0%)	12 (9.9%)	12 (3.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
16.	Other kidney problems	0 (0.0%)	3 (2.5%)	3 (1.4%)	4 (8.2%)	0 (0.0%)	4 (4.6%)
17.	Worsening memory	0 (0.0%)	6 (5.0%)	6 (2.8%)	3 (6.1%)	0 (0.0%)	3 (3.4%)
18.	Cancer	3 (3.1%)	0 (0.0%)	3 (1.4%)	0 (0.0%)	1 (2.6%)	1 (1.1%)
19.	Any Other (specify)	6 (6.2%)	15 (12.4%)	21 (9.6%)	3 (6.1%)	8 (21.0%)	11 (12.6%)
20.	No Ailment	28 (28.9%)	7 (5.8%)	35 (16.1%)	7 (14.3%)	7 (18.4%)	14 (16.1%)

*Figures in brackets indicate percentages.

**Multiple responses.

***Any other (specify) includes obesity, frequent fever, nazla, allergy and nerve problems.

As indicated in table 1.2, 'weakened eye sight' is common among the aged. The proportion of the aged suffering from 'weakened eyesight' is almost double in the exterior village, that is, 37 (42.5%) as compared to the interior village, that is, 54 (24.8%). The reason found for this difference in the proportion is due to the more awareness towards health problems among the aged in the exterior village. The awareness is due to guidance provided to the aged/ their family members through two recent medical camps organized in the village. 'Joint pain' is also common physical ailment in old age. There is a high proportion of the aged suffering from 'joint pain' in both the interior village, that is, 69 (31.7%) and the exterior village, that is, 31 (35.6%). The proportion of the aged women suffering from 'joint pain' is little higher in the exterior village, that is, 19 (50.0%). 'Hypo/ hypertension' is found more among the aged women, that is, 23 (19.0%) and 10 (26.3%) in both the interior and exterior village than the aged men. 'Frequent loss of consciousness' is found more among the aged in the interior village, that is, 37 (17.0%) and especially women, that is, 22 (18.2%). The main reasons are the lack of nutrition, over work load and age factors alone or combination of both reasons. 'Chest pain' is found only among the aged in the interior village, that is, 18 (8.3%). The frequency of some ailments like 'cough', 'allergy' and 'urinary problems like frequency of urination, irritation during urination etc.' is more among women than men. However, the proportion of men, that is, 28 (28.9%) who are 'not having any ailments' is

much higher than women, that is, (5.8%) in the interior village. It is also evident from the mean score values of health status of the aged men and women (calculated in the table 1.1).

It also shows the poor health conditions of women, though their life expectancy is higher than men at the age of 60, that is, at attaining the age of 60 years, there are more chances of women to live longer than men. It can be seen in the light of low status of women which not only affects their health status negatively but, itself also gets negatively affected by it. This is mainly due to higher presence of multiple ailments among women. No specific difference is found across gender for chronic diseases at large.

Table 1.3

Physical Ailments of the Aged by Caste Category in Interior and Exterior Villages

Sr. No.	Physical Ailments (Type)	Interior Village				Exterior Village			
		General (N=100)**	SC (N=62)**	OBC (N=56)**	Total (N=218)**	General (N=31)**	SC (N=28)**	OBC (N= 28)**	Total (N= 87)**
1.	Weakening of eye sight	22 (22.0%)	25 (40.3%)	7 (12.5%)	54 (24.8%)	12 (38.7%)	11 (39.3%)	14 (50.0%)	37 (42.5%)
2.	Pain in joint	33 (33.0%)	18 (29.0%)	18 (32.1%)	69 (31.7%)	11 (35.5%)	12 (42.9%)	8 (28.6%)	31 (35.6%)
3.	Hypo/ hypertension	21 (21.0%)	10 (16.1%)	6 (10.7%)	37 (17.0%)	7 (22.6%)	2 (7.1%)	10 (35.7%)	19 (21.8%)
4.	Shortness of breath	14 (14.0%)	17 (27.4%)	3 (5.4%)	34 (15.6%)	3 (9.7%)	12 (42.9%)	0 (0.0%)	15 (17.2%)
5.	Upset stomach	17 (17.0%)	14 (22.6%)	10 (17.9%)	41 (18.8%)	0 (0.0%)	6 (21.4%)	4 (14.3%)	10 (11.5%)
6.	Frequent loss of consciousness	10 (10.0%)	21 (33.9%)	6 (10.7%)	37 (17.0%)	4 (12.9%)	0 (0.0%)	2 (7.1%)	6 (6.9%)
7.	Decreased body stamina/ Ache	19 (19.0%)	4 (6.4%)	11 (19.6%)	34 (15.6%)	4 (12.9%)	0 (0.0%)	4 (14.3%)	8 (9.2%)
8.	Chest pain	3 (3.0%)	9 (14.5%)	6 (10.7%)	18 (8.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
9.	Severe heart problem	8 (8.0%)	0 (0.0%)	2 (3.6%)	10 (4.6%)	5 (16.1%)	2 (7.1%)	2 (7.1%)	9 (10.3%)
10.	Cough	5 (5.0%)	3 (4.8%)	3 (5.4%)	11 (5.0%)	3 (9.7%)	1 (3.6%)	0 (0.0%)	4 (4.6%)
11.	Head ache	4 (4.0%)	6 (9.7%)	4 (7.1%)	14 (6.4%)	0 (0.0%)	2 (7.1%)	0 (0.0%)	2 (2.3%)
12.	Loss of hearing	6 (6.0%)	3 (4.8%)	0 (0.0%)	9 (4.1%)	0 (0.0%)	3 (10.7%)	0 (0.0%)	3 (3.4%)
13.	Diabetes	2 (2.0%)	3 (4.8%)	0 (0.0%)	5 (2.3%)	0 (0.0%)	0 (0.0%)	4 (14.3%)	4 (4.6%)
14.	Paralysis	0 (0.0%)	6 (9.7%)	1 (1.8%)	7 (3.2%)	2 (6.5%)	0 (0.0%)	1 (3.6%)	3 (3.4%)
15.	Urinary problems	10 (10.0%)	2 (3.2%)	0 (0.0%)	12 (3.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
16.	Other kidney problems	3 (3.0%)	0 (0.0%)	0 (0.0%)	3 (1.4%)	0 (0.0%)	2 (7.1%)	2 (7.1%)	4 (4.6%)
17.	Worsening memory	6 (6.0%)	0 (0.0%)	0 (0.0%)	6 (2.8%)	2 (6.5%)	0 (0.0%)	1 (3.6%)	3 (3.4%)
18.	Cancer	3 (3.0%)	0 (0.0%)	0 (0.0%)	3 (1.4%)	1 (3.2%)	0 (0.0%)	0 (0.0%)	1 (1.1%)
19.	Any other (specify)	15	2	4	21	7	4	0	11

		(15.0%)	(3.2%)	(7.1%)	(9.6%)	(22.6%)	(14.3%)	(0.0%)	(12.6%)
20.	No Ailment	21 (21.0%)	9 (14.5%)	5 (8.9%)	35 (16.1%)	7 (22.6%)	4 (14.3%)	3 (10.7%)	14 (16.1%)

*Figures in brackets indicate percentages.

**Multiple responses.

***Any other (specify) includes obesity, frequent fever, nazla, allergy and nerve problems.

As indicated in table 1.3, there is a great difference in the proportion of the aged suffering from 'hypo/ hypertension' in OBC of the interior village, that is, 6 (10.7%) and of the exterior village, that is, 10 (35.7%). No reasons are observed for this specific pattern of difference. But urban way of life style and younger women entering into work force has definitely put a little more pressure on the aged women. A significant proportion of SC aged is suffering from 'shortness of breath' in the interior village, that is, 17(27.4%) and in the exterior village, that is, 12 (42.9%) as compared to general category and OBC aged. The reason is extra work burden as well as harsh work done by the SC aged than general or OBC aged as well as dreadful working environment of the aged in the past. The proportion of the aged suffering from 'heart problem' is almost more than double in general caste, that is, 8 (8.0%) and 5 (16.1%) than SC or OBC aged respectively in both the villages. The main reason is the lack of awareness of SC and OBC aged as well as to some extent unhealthy food consumption by general caste and especially in the exterior village. 'Loss of consciousness' is mainly observed among SCs of the interior village. 'Worsening memory' is observed mainly in general caste aged in both the villages. 'Urinary problems' are reported mainly by general caste aged in the interior village, that is, 10 (10.0%) only. It is reported by most of the aged above 85 years with other multiple diseases. The proportion of the aged 'not suffering from any ailment' is higher in general caste, that is, 21 (21.0%) and 7 (22.6%) followed by SC, that is, 9 (14.5%) and 4 (14.3%) and OBC, that is, 5 (8.9%) and 3 (10.7%) both in the interior and exterior village respectively. Occupational working conditions and nutritional differences are the main reasons observed for this difference.

Treatment taking Patterns:

Majority of the aged are taking treatment for one or multiple physical ailments. The most often treatment taken for the ailments like weakening eyesight, hypo/ hypertension, asthma, heart problem, cancer and diabetes are allopathic without any difference of gender and caste category. However, place of treatment varied with all these factors that ranges from local physician to big hospitals such as P.G.I., A.I.I.M.S. etc. The preferred treatment taken for joints pain, shortness of breath, urinary problems, allergy and upset stomach is ayurvedic. For paralysis and chest pain both allopathic and ayurvedic treatments are preferred by different individuals. In case of nazla, allergy and nerve problems both ayurvedic and homeopathy medicines separately or in combination are taken by the aged.

Reasons for not taking Treatment:

There is a small proportion of the aged which is not taking treatments for their physical ailments. Hence, it becomes really important to find the various reasons given by these aged for not taking treatment. However, the reasons vary across gender and caste category as these factors played an important role in determining the attitude of an individual in dealing with their health issues.

Table 2.1

Reasons for not taking Treatment among the Aged by Gender in Interior and Exterior Villages

Sr. No.	Reasons for not taking	Interior Village			Exterior Village		
		Men	Women	Total	Men	Women	Total

	Treatment						
1.	No need/ Already taking treatment	77 (79.4%)	98 (81.0%)	175 (80.3%)	45 (91.8%)	30 (78.9%)	75 (86.2%)
2.	Age Factor	14 (14.4%)	10 (8.3%)	24 (11.0%)	4 (8.2%)	8 (21.1%)	12 (13.8%)
3.	Financial	2 (2.1%)	10 (8.3%)	12 (6.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
4.	Discontinued treatment	4 (4.1%)	3 (2.5%)	7 (3.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total		97 (100.0%)	121 (100.0%)	218 (100.0%)	49 (100.0%)	38 (100.0%)	87 (100.0%)

*Figures in brackets indicate percentages.

As indicated in table 2.1, in the exterior village, a significant proportion of the aged men, that is, 45 (91.8%) is 'already taking treatment' as compared to women, that is, 30 (78.9%). However, no significant difference is found among the aged men and women already taking treatment in the interior village. It is mainly due to more awareness of medical problems as well as better financial conditions of the aged men in the exterior village. The proportion of men, that is, 14 (14.4%) not taking treatment due to 'age factor' is high in the interior village and vice versa in the exterior village, the proportion of women is high, that is, 8 (21.1%). The clear reasons cannot be found out. The proportion of the aged not taking treatment due to 'financial constraints' is very high in women, that is, 10 (8.3%) than men, that is, 2 (2.1%) in the interior village. It is due to existing gender differences in terms of poverty. No specific difference is seen between the aged men and women who have 'discontinued treatment (as no significant improvement was obtained in their health conditions)' due to various reasons.

Hence, the aged women are in vulnerable position and have to face more problems than the aged men regarding the treatment taken by them for various physical ailments indicative of poor health status.

Table 2.2

Reasons for not taking Treatment among the Aged by Caste Category in Interior and Exterior Villages

Sr. No.	Reasons for not taking Treatment	Interior Village				Exterior Village			
		General	SC	OBC	Total	General	SC	OBC	Total
1.	No Need/ Already taking treatment	82 (82.0%)	49 (79.0%)	44 (78.6%)	175 (80.3%)	31 (100.0%)	20 (71.4%)	24 (85.7%)	75 (86.2%)
2.	Age Factor	8 (8.0%)	11 (17.7%)	5 (8.9%)	24 (11.0%)	0 (0.0%)	8 (28.6%)	4 (14.3%)	12 (13.8%)
3.	Financial	3 (3.0%)	2 (3.2%)	7 (12.5%)	12 (6.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
4.	Discontinued treatment	7 (7.0%)	0 (0.0%)	0 (0.0%)	7 (3.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total		100 (100.0%)	62 (100.0%)	56 (100.0%)	218 (100.0%)	31 (100.0%)	28 (100.0%)	28 (100.0%)	87 (100.0%)

*Figures in brackets indicate percentages.

A cursory look at table 2.2 reveals that a large proportion of the aged, that is, 175 (80.3%) and 75 (86.2%) 'already taking treatments' for their medical problems in the interior and exterior village respectively. The proportion is a little higher in general category aged, that is, 82 (82.0%) and 31 (100%) than SC and OBC

aged in both the interior and exterior village. It is mainly due to better paying capacity of general caste aged as well as less forbearance of the aged and their family members towards their health problems. The most important reason for not taking treatment is that the aged felt that these ailments are normal in old age and there will be no benefit of taking treatments. There are mainly SCs only, that is, 11 (17.7%) in the interior village and SCs, that is, 8 (28.6%) and OBCs, that is, 4 (14.3%) in the exterior village who are not taking treatment due to 'age factor'. It is due to more negligence of SC and OBC aged towards their health problems. 'Financial constraints' are felt by a small proportion of aged, that is, 12 (6.5%) and mainly OBC, that is, 7 (12.5%) in the interior village. This is mainly due to extreme poverty of not only these aged but of their families also. There is no aged in the exterior village, who is not taking treatment due to 'financial constraint'. It is due to comparatively a little better financial condition of the aged/ their family in the exterior village than the interior village. Only 7 (7.0%) general caste aged of the interior village have 'discontinued their treatment' as they did not find it beneficial.

Caste category has an impact on treatment taking patterns by them for various physical ailments.

Care Providence in Ill-health to Aged:

The aged are expected to be taken care of not during illness but in routine as well. Primarily spouse, daughters-in-law and grown up grand children are the primary care providers. Care is provided in terms of timely providence of sufficient and fresh food, clean clothes, helping them in taking bath, proper medication (if required), involving them in conversation etc.

Care providence in ill-health is completely self-perceived; the aged who are taken care of by family members all the time have perceived their care as highly satisfactory; the aged who are getting care during illness, perceived it as satisfactory and others stated the care providence as unsatisfactory. The mean scores are calculated by giving a score of 3 to highly satisfactory care providence, a score of 2 to satisfactory care providence and a score of 1 to unsatisfactory care providence. Higher the value of mean score means the better care providence in ill-heath to the aged group.

Table 3.1

Care Providence in Ill-health to Aged by Gender and Caste Category in Interior and Exterior Villages

Sr. No.	Variables		Mean Scores of Health Status	
			Interior Village	Exterior Village
1.	Gender	Men	1.62	1.31
		Women	1.43	1.32
2.	Caste Category	General	1.92	1.74
		SC	1.81	1.67
		OBC	1.54	1.52

A cursory look at table 3.1 reveals that care providence by family members during illness to the aged is comparatively better in the interior village than the exterior village. It shows that the family ties are still strong in the interior village. Aged men are provided with better care than aged women in the interior village. The reason may be deep rooted patriarchal structure especially in rural setup. However, no gender differences are seen in the exterior village in terms of care providence to the aged. General and SC aged are provided with better care than OBC aged in both the villages. No reasons are observed for this specific pattern of difference.

Hence, gender and caste have a direct impact not only on health status of the aged but also on their care providence patterns.

Conclusion:-

To conclude, health is condition of physical, psychological and social well being. Health becomes a serious concern for individual as well as for his/her family members especially in old age. In the present study, health status is found better of the aged in the exterior village than the interior village due to the more awareness of health issues. Men have better health status than women. Further, the aged belonging to general and SC groups than OBC are observed to be healthy. The common physical ailments found among the aged are weak eyesight, joint pain and hypo/hypertension and upset stomach etc. The preferred treatments are allopathic and then it is followed by ayurvedic. Though more than four-fifth aged are already taking treatments but the main reasons (who are not taking treatment) for not taking treatment are mainly lack of finances and age factor. Women aged have given financial reasons whereas SC aged consider of age factor for not taking treatment in both the villages.

Care providence to the aged is primarily by spouse, daughters-in–law and grown up grand children. Care providence is found better of aged in the interior village than the exterior village due to their poor health status and strong traditional family ties there. Women are provided with less care than men. Further, the aged belonging to general and SC groups than OBC are having better care providence. Care is provided in terms of timely providence of sufficient and fresh food, clean clothes, helping them in taking bath, proper medication (if required), involving them in conversation etc.

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