RESEARCHING THE HEALTH ISSUES OF ELDERLY IN RURAL SOCIETY: A COMPARATIVE STUDY OF MALE AND FEMALE

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Abstract: Population aging is an obvious consequence of the process of demographic transition. India's elderly population is expected to increase from 76 million in 2000 to 327 million in 2050. The growing number of the aged persons is not in itself a social problem on the contrary, nation's prize longevity and counts it an accomplishment, not a failure, that the increasing number of man and woman is live to old age. The problem is the lack of preparation for the sudden appearance of large number of aged people and lag in adopting social institution to their needs. In our society, utmost regards is paid to the elderly citizens since time immemorial. But due to the increasing process of urbanization, industrialization, modernization and as a result of globalization and economic liberalization structural changes have taken place in the traditional social institutions which works as welfare institution for the aged. In the changing circumstances the aged has to face different kinds of problems such as physical and mental health problems, economic problems and socio-psychological problems. In the present paper an attempt has been made to study the health status of the rural aged in a district of Assam. The study is based on 200 aged people.

Keywords: Aged, Health, Health Care Seeking, Ailments.

Introduction: Population aging is an obvious consequence of the process of demographic transition and it creates an imbalance in the age structure over a period of time (Rajan, Mishra & Sharma, 1999; Rao 2007). The developed regions of the world have already experienced its consequence, while the developing world is facing a similar scenario. The constant increase in number or percentage of the aged has caused short and long term effects on society (Sati, 1988). Various factors can be made responsible for the increasing life span and subsequent high percentage of elderly population in many parts of the world (Rao, 2007). The factors can be identified as increasing birth rate, the control of pre-natal and infant mortality, improvement in nutrition, basic health facilities and control of communicable diseases etc (Sati, 1988, Rao, 2007)

As age advances, lot of physical, mental and social changes take place. Physical condition may restrict movements, social changes may force dependency and mental conditions may lead to depression and anxiety. To worsen the situation, health problems, especially age-related, may lead to major disabilities. Health care of the elderly has not received adequate attention from policy maker in developing countries, like India as they were pre-occupied with maternal and child health, communicable diseases, malnutrition, and increasing population. One of the possible reasons for this could be lack of data on health problems of elderly.

In general the term "Health" refers to the state of being well and free from illness in body or mind. "The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease" (Kumar; 2005). So, whenever we have to talk about a healthy individual it should be noted that along with physical and mental health the individual should be socially well adjusted. Many of us believe that old age is synonymous with sickness or illness. The general belief is that "Old age" is a period of illness, weakness, disability and helplessness. Although most of the time sickness is associated with old age it does not necessarily mean that old age is synonymous with sickness or illness. "Old Age in itself is not a disease. Every living being may have disabilities or weaknesses. With advancement in age these ailments come to the surface. They may be of recent origin or a carryover from the past. The aged are normal people. They may become ill but they are not necessarily sick" (Soodan, 1975). "Physical decline in old age is not identical for all the persons and of the aged group. Some of them are sick while some others are maintaining good health status even in advance age (Sati; 1988).

Although old age is a natural and normal condition and its pathologies are the same as those that occur at any other period, they are intensified by illness, family disorganization, un-employability, reduced income and dependency" (Phelps, et al, 1952). Old people in India, like those in other countries, suffer from a range of

problems, however, of all the problems associated with an aging population, health care demands top priority" (Ory & Bond 1989). "Chronic and degenerative diseases and physical defects are major causes which make the aged dependent, because they continue over a longer time and recovery is slower and less favorable" (Soodan K. S.; 1975).

The scholars like Halder (2006), Adak (2006); Sharma (2006); Ghosh (2006); Sen, (2008); Swarnalatha (2008); Rathi & Radhika (2000); Rao (2007); Singh. & Yesudian (2007) and many others have conducted empirical study on the health status of the aged. These studies clearly reflect that amongst all the problems of old age, the problem of health is a major unsolved problem because it is accentuated by an increasing number of physical handicaps, more frequent and serious illness, more mental disturbances and a general reaction among the aged that ill health is their major burden. "In the existing demographic scenario, the elderly health needs could not be ignored. Life expectancy has sharply risen in the last century and is expected to continue to rise in virtually all populations throughout the world. "As a consequence of longer life and aging process, majority of them will be at a higher risk of developing chronic and debilitating diseases" (Kumar; 1996). Good adjustment in old age is possible only with good physical and mental health. The various health studies conducted in India clearly revealed that there are certain chronic health problems which were directly related to ageing. "India is beset with diverse health problems and has to cope with the traditional disease like tuberculosis, malaria, malnutrition, and poverty related diseases, on the one hand, and more recent challenges like chronic degenerative diseases, substance abuse, HIV/AIDS, mental stress, and environmental pollution on the other (Kumar, 2005). 'Aging is associated with a generalized decrease of efficiency in the body's physiological system and natural defense mechanism. This is association with adverse social and environmental factors leads to increased morbidity. In India, the NSSO survey reported that the proportion of aged persons with chronic disease varied between 443 and 455 per thousand and there were no marked urban/rural and gender differences (Swarnalatha; 2008). One can accept this phenomena by looking at National Sample Survey (1991) which has revealed that 45% of elderly suffer from chronic illness and with increase in age there is an increase in disability and dependency in their activities of daily living (Mishra; 1999).

So, in old age an individual may be subjected to different kinds of physical ailments such as difficulty in seeing, reading and hearing, digestive complaints, general weakness, trembling, sleeplessness, breathless, Asthma, kidney trouble, heart trouble, diabetes etc. irrespective of their sex and settings. "Age-related disorders include life- threatening diseases such as heart disease, stroke, cancer, diabetes, and infections, as well as certain chronic disabling conditions affecting vision, mobility, hearing, and cognition. Older person also complain about various symptoms that may appear non-specific and unrelated to any classic disorder. These include general weakness, sleeplessness, constipation, flatulence, diminished appetite, decreases libido, and so forth" (Kumar, 1996). However, problems may be different for rural dwellers in comparison to their urban counterpart because in urban settings more medical health facilities are available. For example the results of National Sample Survey (1991) indicate a higher rate of joint problems and cough among the rural elderly, while high blood pressure, heart disease, and diabetes were common among the urban elders. Only joint problems were more frequent in females, regardless of location. Chronic illnesses and physical immobility revealed increasing frequency with advancing age among older person" (Kumar, 1996). Therefore old people are vulnerable because of their falling health.

In Assam, people living in both rural and urban areas are deprived of adequate health care facilities; many of them are still far away from minimum health services. In such a situation, aged in rural Assam has faced a lot of problems in the maintenance of their physical health. Keeping in view this aspect, an attempt is made here to analyze the basic problems of the aged related to physical and mental health and also the situational problems in meeting the health needs. With the increase in age it is obvious to have faced some sort of health problems. "It is certainly true that old people are more impaired physically and mentally and less mobile when they are compared with the middle-aged or young people. It is important to know from the aged persons how they evaluate their health, because health condition has subjective and objective evaluations. It may be possible that a person would be self rating one's health almost well, but on the other hand physician may classify him as ill or very ill" (Sati; 1988.). "Self assessed health status is an important indicator of quality life during old age; Elderly people are generally engrossed in existential problems of house hold, so the question of personal health does not seem to find a place in their minds. They suffer from chronic ailments" (Halder, 2006). Therefore, in this study an attempt has been made to resort the subjective evaluation of health by the aged themselves.

Health and Gender Inequalities: Mainstreaming gender perspective in the health sector has to go beyond the feminist view, often construed with patriarchy to include aspects such as socially constructed discrimination, cultural construction of roles and status on the basis of sex, etc. (Piang, 2010). New questions have been raised by the social scientists regarding gender inequalities and health recently. It is reflected in the recent development in social theories. Attempt is made to restructuring the gender related experiences. All these have wide spread implications for mental and physical health of men and women at the start of twenty first century. The search for an explanation of differences in male and female morbidity; alongside interest in relationship between variations in women's social circumstances and their health has been a vital part of feminist's attempt the detrimental effects of patriarchy on women's health. Gender inequalities in health were in the most part socially produced rather than biologically given. As such they could be ameliorated even eradicated through changes in the gender order.

As we know with the changes in employment, educational achievement, and in the household and family the lives of men and women all over the world have changed. It results transformation of gender. Transformation of gender has taken place with the changes in work and employment; changes in education and changes in family and household. In earlier studies gender in equalities in health are not critically addressed but now emerging of 'new agenda' for research on gender in equalities in health at crossroad.

Ellen and Kate (2000) argued that a gender comparative approach is essential to the emerging 'new' approach to gender inequalities in health. To argue this point is not in any way to suggest 'all things are equal 'but rather than in times of significant change it is crucial to consider the operations of the social relations of gender as they impact on the health of men and women. Although poorly articulated within the traditional framework, it is often automatically assumed that the social relations of gender support 'good health for men 'and 'poor health for women'. Thus there is a search for 'what makes women sick' (Annandale and Clark, 1966). The emerging new framework moves away from this, to recognize that the social relations of gender operate in much more complex ways. Thus similar circumstances may render both men and women vulnerable to ill health or good health. Equally similar social circumstances may produce different effects-positive for one and negative for the other (Ellen & Kate, 2000).

Objectives of the Study: In this paper an attempt is made to interpret the 'physical and mental health problems of the male and female aged living in rural settings. The objectives of the study are-

1. To study the incidence of disease and other health related problems of the aged.
2. To study the problems face by the aged in maintaining their physical and mental health.

Methodology: The study is based on 200 aged people living in 10 villages of Podumoni anchalic panchayat of Golaghat district. Here, aged refers to an individual who has attained the age of 60 and above. In India, the attainment of the age 60 has been mostly accepted for the purpose of classifying aged persons because the 'acceptance of this age in a majority of services as a criterion for retiring a person' and secondly, 'it's adaptation in the decennial census operations of the country for enumerations of elderly persons'. The list of retirees was prepared with the help of the statistics available in the District Collector's Pension Office. The list of the sample was prepared in such a way that equal numbers of male and female represent the sample size. So, from the pensioner list available in the pension office, a list of 235 retirees was prepared and from that 200 samples were selected. The selected samples constituted 100 males and 100 females. It was purposefully done so that equal number of samples could represent both the sexes and also for the purpose of easy comparison in the later analysis of the study. The study is mainly based on primary data and for data collection personal interview was conducted with the help of interview schedule. Group discussion method was also adopted for the same.

Result and Discussion: ***Social-Background of the Respondents:*** The analysis of different gerontological literature on health shows that seeking and using health care among older individuals vary according to health status, socio-economic factors and sex and that these three factors are independently related to health care use in later life (Barreto et al, 2006). Here, a brief overview of the study population is provided with respect to several socio-economic characteristics such as age, education, income, size of the family, income of the respondents' family members, marital status, care giving responsibility of the respondents, engagement in income generating activities and living arrangement of the respondents. Results indicate that a higher percentage of women (54%) are belonging to the age group of 65-70 years in comparison to the 34 percent of

their male counterpart. However, as high as 29 percent of women are aged 80 and over which is higher than the male i.e. 16 percent. The vast majority of women are found as widowed (64%), while the incidence of divorce (1%) and unmarried (3%) is a rare occurrence in the study area. On the contrary, majority of the male respondents are found as married (78%) and 12 percent have to live their later life without spouse due to the death of the later and all of them belonging to age group 70 and above. Data reveals that comparatively, more female have to live alone in the later phase of their life due to the death of their partner than their male counterpart. It may be the effect of the prevailing tradition of early age at marriage for females in the study area. This has negative impact on physical and mental health of the elderly women. In the absence of their spouse the elderly are always deprived from the support of their partner in the most vulnerable phase of their life. Majority (78%) of the elderly women have their educational qualification below HSLC. The fraction of the women who have been educated up to HSLC is very small. On the other hand 52 percent of the male have been educated up to HSLC. It may be due to gender discrimination in terms of educational attainment. One of the elderly women stated, *"...In my childhood I was not encouraged to go for schools. I have to engage myself in different household activities like cleaning the house, washing cloth of my brothers and sisters, helping my mother in cooking....it is not only me, girls of my age have to perform the same household activities for their respective families..."* Data reveals that only 12 percent of the elderly women have their engagement in income generating activities, however, vast majority of them (84%) actively engage in household activities which is unpaid. 79 percent of the elderly women stated that care giving responsibility of the family member is bestowed on their shoulder. Against this 18 percent of elderly men have their engagement in income generating activities, 24 percent actively engage in household activities and only 9 percent of them have their care giving responsibility to their family members. Results indicates that elderly women have to continue their roles and responsibility in the family which they used to play in their middle ages, but opposite to this abrupt changes have taken in the role and life style of the elderly men. They are subjected to force disengagement from the role they used to engage in their middle ages. The available gerontological literature shows that force disengagement from the previous role played by the elderly have had its negative impact on their physical and mental health.

In the present study it was observed that the elderly women (54%) with a lot of ailments continue to perform their role they used to play for the family. Due to their poor health although they want to disengage themselves from some of the role, the situational needs and demands of the family members does not allow them to do so. It is not that elderly women are voluntarily engage themselves in household activities or to escape from role less situation in old age but o satisfy the needs of the family members. Therefore, it reflects that elderly men and women are subjected to different physical and mental health problems. When the respondents were asked about the attitude of their family members towards them 68 percent of male and 45 percent of female stated about negative attitude of the members. The study reveals that the women have continued their services for their family members and therefore higher percentage of them receiving good treatment from their family members than their male counterpart. The male elderly who have received positive treatment from their kin members' majority of them have some amount of economic contribution to the family monthly budget. The elderly who have received bad treatment from the family members' majority of them, neither in a position to provide financial support (46%) nor they can support in other household activities irrespective of their sex. The follower of exchange theory of aging stated that the system of social exchange largely responsible for measurable condition of the elderly. They have argued that the aged are systematically deprived of valued resources needed for favorable social exchanges.

45 percent of elderly women and 70 percent of men have dependent members in the family on their income ranging from 2 to 8 numbers. Their income source is the pension which is not sufficient for maintenance of the family. Poor income of the elderly, their forceful engagement in household and income generating activities in spite of the presence of ailments results deterioration of their health. With abrupt changes in their life style after retirement, the male become isolated in the family with role less situation and they become mentally sick. The living arrangements of the elderly population are often considered as the basic indicator of the care and support provided by the family (Munsur, et. al, 2010). A plethora of evidence from the developing world suggest that family is the key institution for elderly care and their living arrangements are a fundamental determinant of their well being (Albert & Cattel, 1994 ;). Data reveals that 8 percent of the respondents irrespective of their sex living alone, 14 percent living only with spouse, 36 percent living with unmarried children and 2 percent with other family members. The elderly those who are living alone and those who are living only with their spouse, their children migrated to the urban centers for the search of better livelihood

and they have a very few visits of their parents and they have almost withdrawn the responsibility of their parents. Similar is the picture of those sons who are living separately in the same locality.

Physical ailments of the aged: From the **Figure-1**, it is evident that total 81.5 % of the respondents had 'Dental problems' and it comprised 36.5% females and 45.0% males. Total 75.0% of the respondents had 'Eye problems' (34.0% female, 41.0% male); 35.5% of the respondents had 'Anemia' ; 52.0% of the respondents had 'Cardio- vascular disorders' (female 22.5%, male 29.5%); 61.5% of the respondents had 'Respiratory disorders' (female 22.5%; male 39.0%); 69.5% of the respondents had 'Muscular-skeletal disorders' (female 39.0 %, male 30.5%), 27.5% of the respondents' had 'Ear problems'; 25.5% of the respondents had 'skin disorders'; 34.5% of the respondents had 'Endocrinal disorders'; 49% of the respondents had 'Genitor urinary diseases' and finally, 9.5% of the respondents had 'Cancer'. In case of 'Cancer', 'Genitor urinary disease', 'Gastro-intestinal diseases' and 'Muscular-skeletal disorders' females outnumbered males. On the other hand in terms of 'Eye Problems', 'Dental Problems', 'Anemia', 'Cardio-vascular disorders', 'Ear problems', 'Oral Cavity diseases', 'Respiratory disorders', and 'Skin disorders' males outnumbered females.

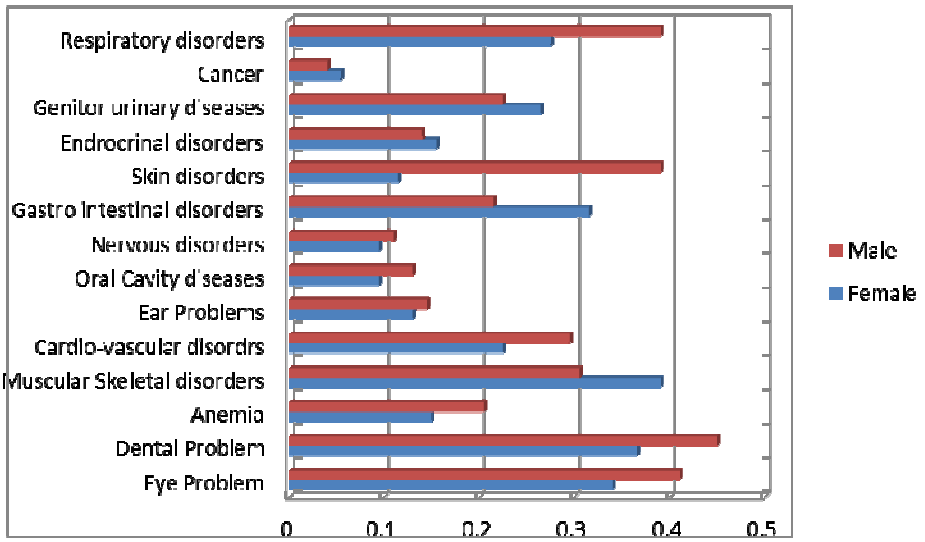


Figure 1: Sex Wise distribution of the Physical Ailments of the Age

The study conducted regarding the ailments of the aged revealed that, in comparison to females greater percentage of the males had Eye problems; Dental problems; Anemia, Cardio-vascular disorders, Ear problems, Oral Cavity diseases, Respiratory disorders, and Skin disorders, Nervous disorders and Endocrinal disorders. On the other hand greater percentage of females had Cancer, Genitor urinary disease, Gastro-intestinal diseases and Muscular-skeletal disorders in comparison to males. Females outnumbered males in case of the Gastro-intestinal disease and 'Muscular skeletal disorders'. Higher percentage of male was suffered from 'Anemia' than female. But the health statistics of Assam reveals that greater percentage of female have to suffer from Anemia in comparison to males. In the present study, regarding Anemia, data contradicts with the report of health statistics.

Many studies worldwide on the health of the elderly found that a greater proportion of elderly women than men had established temporary disabilities. There is good evidence that older women disproportionately suffer from chronic disabling conditions, such as arthritis, that are not life threatening, but increase the need for health care (Barreto et. al, 2006). In the last two or three decades of life elderly females are dominated by two broad categories of health disorders: gynecological disorders accumulated during their reproductive years and compounded by post-menopause morbidities; and the clinical disorders commonly associated with ageing diseases like diabetes, hypertension, osteroposis and cardiovascular disorders (Srivastava , 2010).

In the present study, it was observed that majority of the respondents unable to perform common tasks of daily activities like going to toilet, dressing, getting up from bed etc. Aged women suffer from these infirmities

as compared to the aged men. The elderly women who have more care taking responsibility and who have more dependent members among them rates of morbidity are high. There poor health is a result of life time's inadequate nutrition, hard physical work, repeated pregnancies, systematic gender discrimination and lack of access to primary health care. Older men are subjected to mental illness specially depression as a result of isolation. One of the respondents in the present study reveals –*"I am suffering from pain for last two years. It is very difficult for me to move here and there. I cannot stand continuously for 10 minutes. But, I have the responsibility of my family members living with me. Even I am not getting time to take food on proper time. If I am not going to continue my daily tasks who will take care of them?* "In spite of suffering from ailments majority of the respondents actively engage in household activities. As we know, the rural women are known to shoulder extremely heavy physical workloads, both at home and at work. In spite of their formal jobs women used to provide water and fuel, carrying heavy loads and walking long distances. These constraints can lead to musculoskeletal disorders and reproductive problems. Washing and cooking expose women to water-related diseases such as 'schitosomiasis', malaria and worm. Women cooking on open stoves risk burns and exposure to smoke containing toxic pollutants. An Indian study suggests that the use of biomass fuels increase risk of tuberculosis, particularly in rural areas (ibid). In the present study, higher percentage elderly women have been suffering from cancer, muscular skeletal disorders and gastrointestinal disorder in comparison to the elderly male.

Respondents' Subjective Evaluation of Physical Health Status: In interpreting the respondents' subjective evaluation of health status their responses were categories into three as 'Good', 'Poor' and 'Moderate'. These categories were made on the basis level of difficulty in performing daily living and mobility activities by the respondents. The elderly who reported great difficulties or who were not able to perform one or more daily living activities such as bathing, eating, using toilet and unable to walk at least 100 meters were classified as 'Poor'. Respondents who reported having had to interrupt their routine activities in the previous 20 to 30 days because of health problems were considered as 'Poor' and all others were regarded as having 'Good' health.

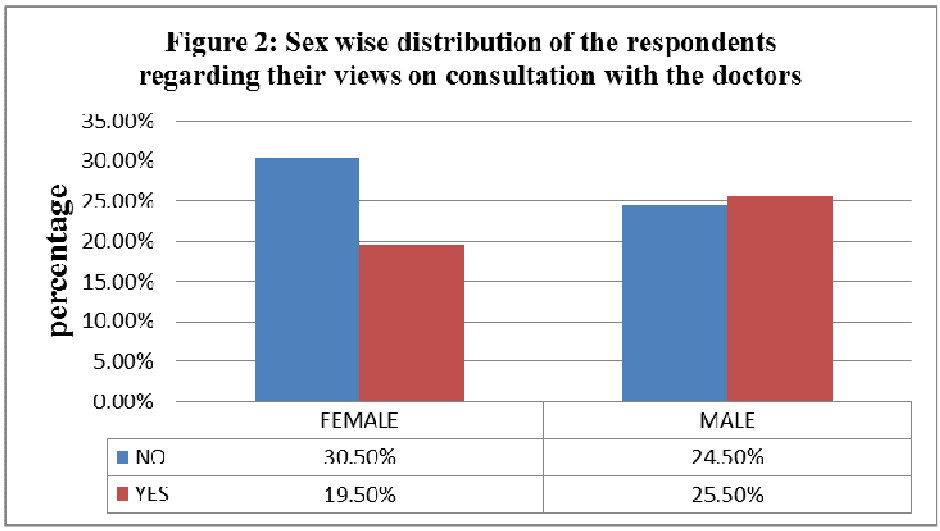
Data in the **Table-1** reveals that 43.5% of the respondents viewed about their 'good' health condition after retirement and the percentage of females (23.0%) outnumbered the percentage of males (20.5%). Again, 35.5% of the respondents stated about their 'moderate' health status which comprised of 18.5% females and 17.0 % males. On the other hand 21.0% of the respondents viewed their poor health condition. 8.5% of the females and 12.5% of the males

Table 1: Health Condition after retirement and Respondents" Sex

Sl. no	Respondents' view	Respondents' view		Total
		Female	Male	
1	Good	46(23.0%)	41(20.5%)	87(43.5%)
2	Poor	17(8.5%)	25(12.5%)	42(21.0%)
3	Moderate	37(18.5%)	34(17.0%)	71(35.5%)
Total		100(50%)	100 (50%)	200 (100%)

Stated about their poor health. The study revealed that in spite of the presence of number of ailments, many aged either regards them to be in excellent condition or were different to their health despite their suffering from illness which are geriatric in nature. Many female respondents, who were suffering from serious illness, evaluated themselves in good health condition. As we know old age is accompanied by a decline in physical fitness and an increasing experience with body aches and pains, many aged had made accommodation to their changing body. Especially, the female aged had developed the habit of making accommodation with the ailments. They were seemed to ignore physical discomfort. It is because of this reason that a significant percentage of the females viewed about their good health condition compared to their male counterparts in spite of their sufferings from a large number of ailments. When any 'old' person becomes seriously sick or disabled, the women of the family continue to look after that senior member. These women themselves may be the middle-aged or elderly. They have to sacrifice much of their comfort to serve their sick senior member. When women grow older they often need special care, still they continue to work hard till functional disability cripples them (Prakash, 1996). Giving of care is viewed in almost all cultures as women's work.

Health Care Seeking Behavior of the Elderly:



As the rural dwellers especially the elderly persons in rural Assam do not receive adequate help from the formal health care services, they mostly depend on informal local health care providers. Patterns of seeking and using healthcare in later life are determined by a number of factors that affect older men and women differently. With regard to health – seeking behavior, data in the **Figure: 2** reveal that 45.0% of the elderly had stated about their consultation with the doctor. Higher percentage of male (25.5%) has access to doctors than the female. On the other hand 55.0% of the respondents had 'no consultation' regarding their physical health. One of the major factors of not consulting with the doctor by the aged was lack of Health Centre in the study area. Many gerontological studies in India consider lack of health centre is one of the major causes of negative attitude towards doctors' consultation.

In the study area medical health centers are far reaching that could provide health treatment for the aged. Although 45.0% of the aged advocated about their consultation with the doctors, interestingly, during interview it was found that majority of them were taking treatment from the village doctors or 'Baidyas'. A few of them have their exposure to clinic and hospitals. Not a single aged irrespective of sex had regular medical examination and who could provide the investigator his or her detailed medical history. Elderly people in the rural society are generally engrossed in existential problems of household, so the question of personal health does not seem to find a place in their minds. A female respondent stated, *"I am a women and it is my responsibility to take care of my family members living with me. My husband, sons and daughters have their right to demand that care from me and it is my responsibility as a women. I am suffering from ailments from the last three months, but I am sincerely engaging myself in household activities and care taking of my family members. For me there is no retirement for a woman"*. The female respondents stated that due to the lack of female doctors in their locality, they are disinterested to go for consultation about their ailments. At many times they refused to consult with the male doctors. Due to this reason mainly the females do not avail treatment for their illness in the rural society.

Access to and use of health services are also related to socio-economic conditions in later life. Many studies reveals that older people both men and women with lower incomes exhibits worse indicators of health status and physical functioning than those having higher incomes. Regarding taking of medicine, data in the **Figure:3** reveals that 84.0% of the respondents advocated about taking of prescribed medicines and it comprised 41.0% females and 43.0% males. On the other hand 16.0% of the respondents were not able to take prescribed medicines. Females outnumbered males in this regard.

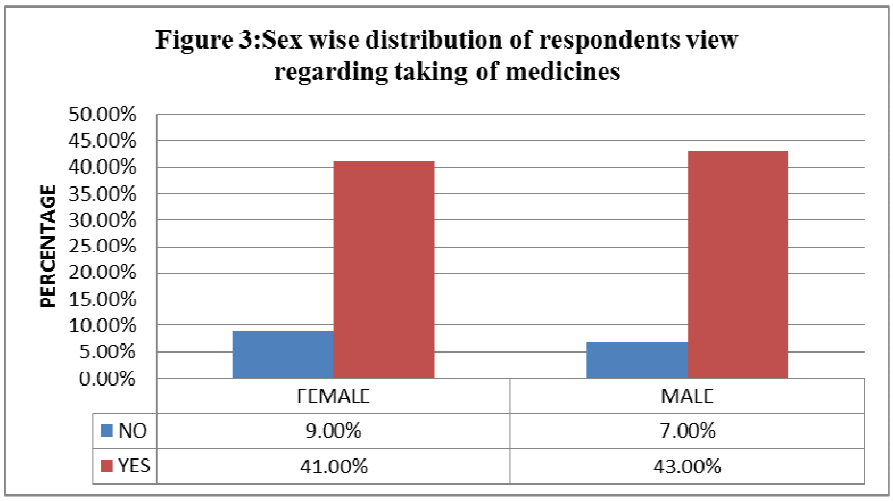
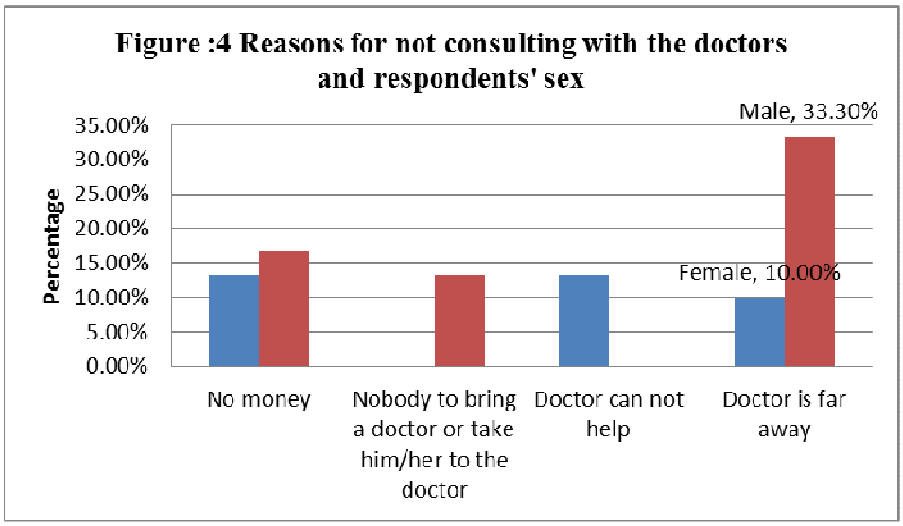
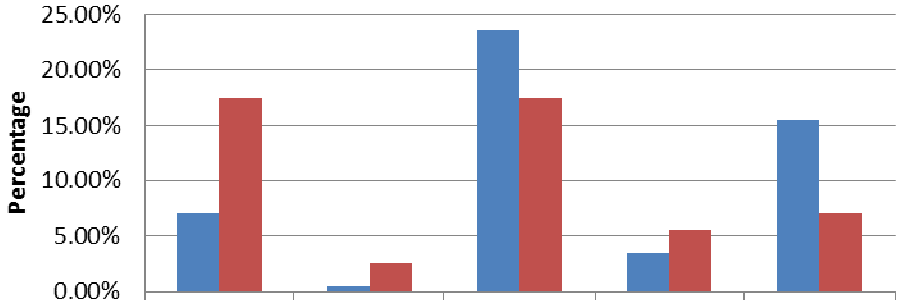


Figure: 4 exhibits the data pertaining to the reasons for not consulting the doctors by the respondents. The study revealed that a significant percentage of the respondents failed to take prescribed medicine due to poor economic condition after retirement. Many of them failed to maintain their family needs in the absence of income source of the family members. Here, 30.0% of the respondents advocated about their poor economic condition and it includes 13.3% female and 16.7% male. 43.33% of the respondents stated that doctor is far away; 13.3% of the respondents viewed that nobody was there to bring doctor or take him to the doctor. Again another 13.3% of the respondents viewed that doctor could not help and it constituted only the female respondents. Due to the poor infra-structure in the rural society, it is difficult for the aged to go for a long distance in their old age to consult with a doctor in the absence of anybody to bring doctor or take him to the doctor. Male aged to some extent can manage the situation but for the female aged it is almost impossible. It is one of the reason for which the female aged are unable to go for a doctor to have consultation about their ailments. Many of the respondents advocated about their common experience that the out – patients departments in every hospital and dispensary in their district head quarters are much over crowded and they have to wait for hours to get their turn to be attended to by the doctor. There are no separate Geriatric units for the aged. Going to these out-patient departments thus proves such a traumatic experience, that the majority of them just refrain from visiting them unless it becomes unavoidable. Some the respondents (13.3%) viewed that doctor could not help and it constitutes only the female respondents. Actually, with the consultation with these groups of female respondents it was come to the light that even after the consultation with the doctor they had not got relief from their ailments and they therefore disinterested to go for the doctor. They also advocated about the absence of female doctors. It is obvious that the rural females dislike consulting with the doctors about the health problems; especially in the study area it was clearly observed. Low educational status is one of the reasons for which elderly women have access treatment from local medical practitioners. One female respondent stated, *"....Whenever I am suffering from pain I use to buy pain killers from a nearby grocery... he acts as medicine provider for many villagers....."*



After retirement aged had received help from their family members for medical consultation. **Figure: 5** depicts that 41.0% of the respondents had paid themselves for medicine and medical consultation. Females outnumbered males in this regard. On the other hand 24.5% of the respondents viewed that their sons paid for their medicine, 9.0% of the respondents advocated about their husband (5.5%) and wife (3.5%); 22.5% respondents stated about their daughters (15.5% females & 7.0% males). Finally, 3.0% stated about the contribution of other relatives. After retirement also a significant percentage of the respondents paid themselves for their medical consultation, followed by sons, daughters, husband/wife, and other relatives respectively. In comparison to male respondents (7.0%) higher percentage of female respondents (15.5%) were paid for medicine and medical consultation by their daughters. Almost equal percentage of sons and daughters are taking the responsibility of medical consultation of their parents and together it comprised 47.0%. Again, 24.5% of the respondents viewed that their sons paid for their medical consultation.

Figure 5: Sex wise distribution of the respondents' regarding payer for medical consultation



	Sons	Other relatives	Self	Husban/wife	Daughters
Female	7.00%	0.50%	23.50%	3.50%	15.50%
Male	17.50%	2.50%	17.50%	5.50%	7.00%

Respondents' Self-assessment of Mental Health: Table - 2 exhibits the data pertaining to the self-assessment of mental health by the respondents. An attempt was made to elicit responses that would throw light on their mental health. 4 statements reflecting mental health status were prepared and exposed to the respondents in order to obtain their reactions. The reactions to each of the four statements were recorded in "quite often", "sometimes", "never" categories. The responses of the respondents taken together indicates that-
35.0% of the respondents quite often, 55.0% of the respondents sometimes, 10.0% of the respondents never worried about their poor health;
18.5% of the respondents quite often, 61.5% of the respondents sometimes, and 20.0% of the respondents never worried of their poor sleep.

And 14.0% of the respondents had stated that fear of death came to their mind quite often, 33.0% of them had stated that fear of death came to their mind sometimes, 53.0% of them had stated fear of death had never come to their mind.

34.0% of the respondents quite often worried due to their poor economic condition, 51.0% of them worried sometimes and 15.0% of the respondents never worried about their poor economic condition.

Regarding 'fear of death' and 'poor economic condition' greater percentage of male are worried than female. The elderly women who have advocated about their anxiety regarding 'poor health, poor sleep, fear of death and poor economic condition, majority of them belong to the widow category and next to them the elderly those who are living alone or only with the spouse. From the field experience it can be said that when an elderly women is a widow, the widowhood stigma gets added to the travails of ageing and compounds her miseries. Similarly elderly men also experience decline in physical and mental health status due to the loss of spouse.

Table 2: Sex wise Distribution of Respondents' self-Assessment of Mental Health (Distribution of frequency and percentage)

Sex Rural

Sl. No.	Statements about health status	Quite often			Sometimes			Never			Total
		Female	Male	Total	Female	male	Total	Female	Male	Total	
1	Worried of poor health	41	29	70	65	45	110	8	12	20	200
		20.5%	14.5%	35.0%	32.5%	22.5%	55.0%	4.0%	6.0%	10%	100%
2	Worried of poor sleep	20	17	37	70	53	123	23	17	40	200
		10.0%	8.5%	18.5%	35.0%	26.5%	61.5%	11.5%	8.5%	20%	100%
3	Fear of death	13	15	28	38	28	66	44	62	106	200
		6.5%	7.5%	14.0%	19.0%	14.0%	33.0%	22.0%	31 %	53 %	100%
4	Worried of poor economic condition	30	38	68	45	57	102	19	11	30	200
		15.0%	19.0%	34.0%	22.5%	28.5%	51.0%	9.5%	5.5%	15 %	100%

The Factors Helps in Remaining Strong at Old Age:

Figure: 6 depicts that 27.0 percent of female respondent and 30.0 of male respondent have had their 'strong feeling at the age of sixty.

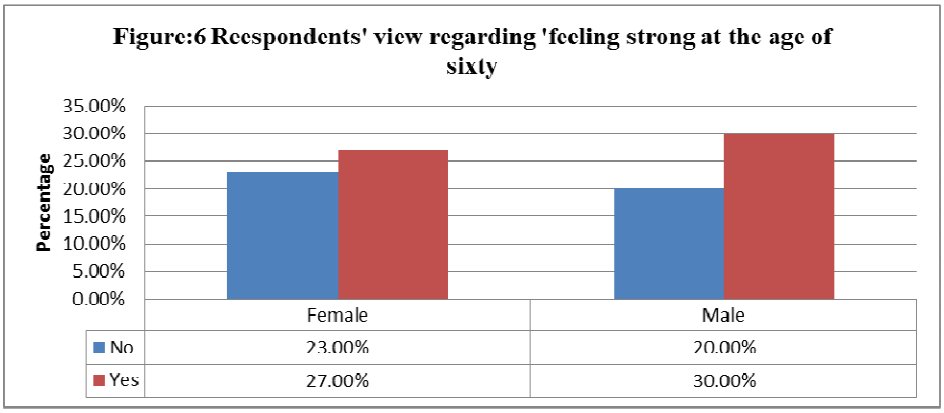


Table 3: depicts that when the respondents were asked about the reasons for remaining physically strong 96.49% stated about their habit of physical activities and 22.80% stated about light exercise; 56.14% stated about the habit of morning walk and 78.07% stated about good eating habits and by 70.17% had stated about the avoidance of alcohol, cigarette, tobacco etc. Again, 24.48% of the male aged, 57.14% of the female aged had stated that they were busy with physical activities. Although higher percentage of elderly women evaluated themselves as strong, majority of them have more than one physical ailment. They are not in a position to manage time for light exercise to maintain their health.

Table 3: Reasons for remaining strong and Respondents' Sex

Sl. No.	Respondents' view	Respondent Sex		Total
		Female	Male	
1	habit of morning walk	24	40	64
		21.05%	35.08%	56.14%
2	busy with physical activities	45	65	110
		39.47%	57.01%	96.49%
3	good food habits	47	42	89
		41.22%	36.84%	78.07%
4	light exercise	6	20	26
		5.26%	17.54%	22.80%
5	avoidance of alcohol, cigarette, tobacco etc.	50	30	80
		43.85%	26.31%	70.17%

(It is calculated from the aged who feels strong enough i.e. from 114 respondents)

Social Isolation and Dissatisfaction: Table - 4 shows that according to 36.0% of the respondent social isolation was the prime cause for dissatisfaction and it comprised 19.5% female and 16.5% male. On the other hand 64% of the respondents negatively viewed and here male outnumbered female. Regarding the life satisfaction after retirement 36.0% of the respondents stated about their isolation problem. However, majority of the respondents were happy with their retired life where males outnumbered females.

Table 4: Isolation as reason for dissatisfaction and Respondents' Sex

Sl. No.	Respondents' view	Respondent Sex		Total
		Female	Male	
1	no	61	67	128
		30.5%	33.5%	64.0%
2	yes	39	33	72
		19.5%	16.5%	36.0%
Total		100	100	200
		50.0%	50.0%	100 %

Calculated X^2= 0.78, d f=1
Here, H_o: "Dissatisfaction due to social isolation does not depend on respondents' sex."
The result obtained from the chi-square test shows that the calculated X^2 value, i.e.0.78 is smaller than the tabulated value (3.84). It accepts the null hypothesis that "Dissatisfaction due to social isolation does not depend on respondents' sex.

Table 5: Happy with the Retired Life and Respondents' Sex

Sl. No.	Respondents' view	Respondent Sex		Total
		Female	Male	
1	no	20	48	68
		10.0%	24.0%	34.0%
2	yes	80	52	132
		40.0%	26.0%	66.0%
Total		100	100	200
		50.0%	50.0%	100 %

Calculated X^2=33.33, d f =1
Mental health of the aged to a large extent depends on the level of life satisfaction. When the respondents were asked about the reasons for their happiness at the age of sixty and above they had given first rank to good physical health, followed by good economic condition, care taking of the family members, sufficient time to spend with friends and family members, more time for reading and working respectively. Regarding respondents' **view about Retired Life, Table – 5** shows the views of the respondents about their life satisfaction. Highest number of the respondents that is - 66.0 of the respondents happy with their retired life. Against 26.0% of the male respondents 40.0% of the female respondents stated that they are happy with their retired life. On the other hand 34.0% of the respondents are not happy with their retired life.

Here, H_o: "There is no association between respondents' happy life after retirement and respondents' sex"
The result obtained from the chi-square test shows that the calculated X^2 value, i.e.17.47 is greater than the tabulated value (3.84).It rejects the null hypothesis that "There is no association between respondents' happy life after retirement and sex" and accepts that "there is association between respondents' happy life after retirement and respondents' sex."

Table 6: Rank Order of Feeling Happiness of the Age

Sl. No.	Indicators of remaining happy	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Total	Rank
1	Good economic condition	28	48	25	20	11	132	2
		21.2%	36.3%	18.9%	15.1%	8.3%	100%	2.53
2	Good Physical &mental health	40	36	20	18	18	132	1
		30.3%	27.2%	15.1%	13.6%	13.6%	100%	2.39
3	Care taking by family members	20	24	60	10	18	132	3
		15.1%	18.1%	45.4%	7.5%	13.6%	100%	2.86%
4	More time for reading and working	30	13	16	34	39	132	5
		22.7%	9.8%	12.1%	25.7%	29.5%	100%	3.78%
5	More times to spend with friends, family	14	11	11	50	46	132	4
		10.6%	8.3%	8.3%	37.8%	34.8%	100%	3.29%

Rank Order of Feeling of Happiness of the Aged: In continuation of the discussion pertaining to the level of satisfaction the researcher further investigated cases of those who expressed the feelings of happiness. The **Table-6** depicts the ranks given by the respondents in order of preference of for indicators of happiness after retirement. On the basis of the individual ranking of the five indicators namely-'good economic condition', Good physical and mental health', 'care taking of family members', more time for reading and working' and 'more time to spend with family'; the ranking of these was made. The rank order calculated regarding rural setting is given below:

1. Good Physical & mental health
2. Good economic condition
3. Care taking of family member
4. More times to spend with friends, family
5. More time for reading and work

Conclusion and Suggestion: The rural aged had 'serious sufferings' from their ailments due to the lack of health awareness among them. Besides this, they achieved less medical health facilities to mitigate their physical and mental health problems. Comparatively higher percentage of the females had 'serious sufferings' from their ailments than their male counterparts. The female in rural society dislike to going for medical consultation due to the lack of female doctors in their locality. It is due to the structural influence that women in India, especially the rural women dislike disclosing about their ailments in front of the male doctors. Again, a significant percentage of rural aged had stated about their 'good health' status in spite of the presence of lots of physical ailments. It is due to the lack of health-awareness that the rural aged had developed the habit of making accommodation with the ailments. The aged who had stated about their consultation with the doctors, during the interview it was found that not a single aged had regular medical examination. 'Health centers' are far reaching for rural aged and in such a situation, it is difficult for the female aged to go for a long distance for health check-up due to very poor transport and communication in some areas. Regarding the reasons for not consulting with the doctors about the physical ailments, the rural aged revealed that poor economic condition, lack of health care institutions, lack of female doctors and disliking of the female aged to consult with the doctors, lack of family support i.e. 'nobody in the family to bring them to the doctor', 'doctor is far away' etc. In spite of their good economic condition, family support, available medical facilities, many of the aged in both male and female aged showed negative attitudes towards health treatment. The older women do have difficulty than older men in accessing public service such as healthcare. For certain conditions such as mental health problems, the gender norms may take it more difficult for women than men to come forward. After retirement, the aged have to live a miserable life with lose of previously enjoyed economic status. In such a situation, it is difficult for them to go for health treatment in the absence of family support. A good numbers of rural aged stated that they themselves paid for their medical consultation. The study reveals that majority of the aged from rural society were free from worries and enjoying relatively good mental health in the post retirement period. Female aged were worried about different aspects of life in comparison to the male aged. The study reveals that higher percentage of male aged advocated about their 'strong feeling' in comparison to female aged. The aged who remains physically and mentally strong at the age of sixty and above stated about the habit of physical activities and light exercise, habit of morning walk, good eating habits and avoidance of

certain habits such as taking alcohol, cigarette, tobacco etc. A significant percentage of the aged irrespective of their sex stated that their active participation in household activities helps them to maintain their physical fitness. Comparatively higher percentage of the male aged stated about their isolation problem than the female aged. The study reveals that dissatisfaction due to social isolation does not depend on respondents' sex. Mental health of the aged to a large extent depends on the level of life satisfaction. When the respondents were asked about the reasons for their happiness at the age of sixty and above they had given first rank to good physical and mental health, followed by good economic condition, care taking of the family members, more times to spend with friends and family members, more time for reading and working respectively. The study also proved that there is association between respondents' happy life after retirement and respondents' sex.

Providing health security to the elderly is one of the most neglected issues in rural India. The present study reestablishes the fact that gender issues affect the health differentially for men and women in any society. Pattern of health and illness in women and men show marked differences. For example, in a society where a women's reproductive function is overvalued, a post-menopausal women is considered old. In cultures, where menopause is equated with loss of vitality, sexuality and felinity, this event may be taken as a marker of ageing (Prakash, 1994). However, menopause is experienced differently by women in different cultures. The ageing is more threatening for women than men because it has more negative implications. Men tend to report more decline in their eyesight and energy as well as in their skin figure. Menopauses markedly accelerate bone loss (Caroline et.al; 1998). It is natural that existing health problems are rather sex specific though many are common to both sexes. In spite of the fact that there are various women specific health problems, it is reported that women as a group, tend to have longer life expectancy than men in the same economic circumstances. Yet despite their greater longevity, women in most communities report more illness and distress than men (Piang, et. al 2010). Especially rural health services in India are poorly maintained and there is no doctor or Para medical Staff trained in geriatric medicine. Corporate health services are beyond the rich of poor rural elderly and the general hospital at district level is inaccessible. Analyzing the life-cycle of women, one observes that the older women are more vulnerable to manage and get treatment as they age. The elderly widows are subjected to multiple- discrimination. 'Gender specific intervention is essential to address the issues of health which focus on biological differentiation as well as socially constructed norms and beliefs. Besides, there are many other issues like access to health services, cost of recovery, distance to health facility etc. have differential connotations and implications on the health of men and women'(ibid).

The aged who are in miserable condition they should be provided medical assistance. It can be suggested that it should be made absolutely free for all old people. In hospitals aged should be given preference in all respects, especially in the outpatient departments. It is generally observed that even if the children want to provide a secured life to their aged parents, they are unable to do so mainly due to financial constraints. And if they are forced by circumstances to keep their parents with them, their relation with parents become unsatisfactory and conflicts take place in the family. In this situation, it can be said that if the governments or welfare agencies share the children's responsibility of looking after the aged by providing them financial and medical assistance, it will encourage them for respectful family living with their children. The solution of the problem of old age will be more satisfactory for the emotional and psychological adjustment of aged people as our traditional society has shown. It will be more economical for society also in long run and suits Indian society as it cannot afford to spend much money on the case of the aged due to its poor economy. Medical attention to the old or the chronic sick is given through services being paid by the National Health Insurance. Membership of a state recognized sickness fund should made compulsory for the aged. This will assured of free medical care in and outside hospital. It is necessary of the setting up of Geriatric Units in hospitals in major towns, manned by medical and paramedical staff including trained social workers and psychologists to stimulate research in degenerative diseases of the ageing and to provide an easy access for the aged to medical aid facilities. Since both nuclear family and joint family fails to provide support for the aged, therefore there is an urgent need for strengthening community based services. The Primary Health Care (PHC system) which is backbone of rural health services should play an increasingly important role in geriatric care. To effectively reach older people, interventions have to take into account on the gender realities. In a society like the one in India, women have been neglected all along. The system of patriarchy subordinates a women right from her birth by controlling her sexuality, reproduction and labor through institutions such as marriage, religion, market and state. Discrimination and devaluation that women are exposed throughout their lives has a major impact on their health and well-being as they go through the process of ageing (Srivasta, 2010). Finally, it can be suggested that the ways in which gender affect the ageing people, their capacities and health seeking behaviour needs to be examined and addressed if interventions are to be truly effective.

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