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ELDERLY IN RURAL INDIA: A SOCIOLOGICAL ANALYSIS

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Abstract

India is the second largest country in terms of aged population. Statistics reveal that 80% of India's elderly live in villages. With the technological breakthrough and the advancement in the_medical field the life expectancy of elderly has increased by four to five years. But a longer life does not mean a necessarily a happier one. Studies show that despite the growing numbers among the elderly rural people almost all the economic social and health indicators point to the rural being far poorer and less healthy than that of their urban counter parts. This paper makes an attempt to study the process of ageing in rural India. It also highlights the triple jeopardy faced especially by the women in rural India. The author has also emphasized on how quality life can be ensured to these groups of people by following the emancipation perspective. This would rightfully guarantee that the aged are not excluded from society.

Keywords: *aging, elderly, India, rural*

Introduction

The multifarious dimensions in India can sociologically thought to be a series of transition from one set of social roles to another and such roles are structured by the social system. According to Bhatia (1983), "age and ageing are equally related to role-taking, value orientations and modes of behaviour of a person, the expectation of which varies at different age-

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stages of members of a society". It may be mentioned that the process of ageing is not uniform for all individuals in the society. Thus, a change in the life of the aged, which is considered to be the *sanyas ashram* of the Hindu a*shram* theory, is influenced by the biological as well as the social and cultural systems. However, in recent times, the status and role of the old age population have been diminished due to the technological developments that have colonized the outlook of the youths.

According to Mishra (1987), the technological breakthrough due to industrialization, westernization and urbanization had neglected the ascribed statuses by weakening the unity and integrity of the joint family and caste group that leads to the negligence of the elderly persons and the diminishing of their role and status. Moreover, the emergence of achieved properties like wealth and education in distorted forms, has affected the state of mind of the youths by adopting the individualistic value of the West. According to Ambedkar (1990), the issue relating to old age is a result of the conflict between the traditionalism of the old individuals and the uncritical eagerness of youth towards the Western values (Raju 2002). Modernization theory of aged, propounded by Cowgill and Holmes (1972), portrays a sense of abandonment of the role of the elderly in the modern society. After engaging in a series of qualitative and quantitative observations on older people in pre-industrial and industrial societies, Cowgill and Holmes advocate that modern societies have less use of older persons than that in the pre-modern societies. Modern societies have failed to give due recognition to the elderly. According to them, the older you become, the more you experience a sense of relative deprivation. In the words of Baum and Baum, as promulgated by Cogwill and Holmes, "modern societies abandon their older people economically, socially, and culturally more so than did pre-industrial social orders".

India lives in her villages. Furthermore, Indian economy is primarily an agrarian-based economy. It is characterized by the existence of longstanding variations, such as rural-urban dichotomy, rich and poor differences and the unequal distribution of updated technological facilities. The situation of the elderly living in rural India is worse when compared to the urban aged. It is against this backdrop that the present paper makes an attempt to understand aging in rural India.

Aging in India: Some reflections

The aged population in India is currently the second largest in the world. In modern times, for all practical purposes the individuals who are above sixty years of age are considered to be aged or 'senior citizens' of the State. In academic research, retirement age is often taken as an index of aged status. Chronological age of fifty-eight or sixty is considered the beginning of old age. While the population of children below the age of 15 has considerably decreased, there is a tremendous explosion in the population of the elderly. In 1951 we had only 19 million elderly people which increased to 77 million in 2001 and by 2025 we will have 177 million elderly persons. Table 1 shows the gradual rise in the elderly population in India. From 5.4 percent in 1951, the proportion of 60+ people grew to 6.4 percent in 1981 and closed at 9.2 percent in 2011.

In the case of rural elderly, in Asia their number is projected to double or quasi double between 1995 and 2025 (UN Population Division, 1996). In absolute terms, the number of rural elderly in Asia can be expected by 2025 to be 337 million. The statistical dimension of senior citizens (2001) reveals that in India 80 % of the aged over 60 years live in rural areas. The percentage of aged in rural areas was 7.22 compared to 5.22 in urban areas. The figures indicate that the states and territories have shown a similar type of rural urban pattern. Over the last 20 years, the rural share of elderly has increased steadily—four-fifths of Indian elderly are found in rural areas. Of the 193.1 million households, 30% have reported the presence of rural elderly. Number of households without elderly population is 134.9 million (Rural 94 million + Urban 40.8 million). The percentage of households without elderly population is 69.8 % (Rural 68.4 % Urban 73.4 %). (Irudaya Rajan et al., 1999).

There are significant socioeconomic differences between the urban and rural elderly in India. More than 80% of those aged over 60 live in rural areas. The rural elderly are older than the urban elderly, but have little access to tertiary care services. In the rural areas 6% of the women are elderly, in the urban areas 5.1 %. While 78.2% of the elderly men are currently married, thus having the support of the spouse, 64.3% of elderly women are widowed,

and most of them are dependent. A large workforce exists in the rural informal sector: 70% of rural elderly men work, as against only 48% of urban elderly women. The health care services also differ significantly in rural and urban areas, with emphasis on primary health care in the rural areas, and tertiary care in the urban areas (Shah, 1994).

Social Problems of the Rural Elderly

Despite the growing numbers, the older rural people, by almost all the economic, health and social indicators are poorer and less healthy than their non-rural counter parts. A significant difference exists in the familial structure and economic system of the rural and urban elderly.

The joint family system is a typical feature of the rural sector and is found mainly among the affluent and landowning families. They live together because this ensures greater economic returns to the family (Shah, 1994). In this setting, reciprocal obligations felt by family members for one another arise from strong kinship bonds. The aged enjoy high prestige as custodians of village lore and morality and as persons standing nearest to their departed ancestors. As family headsmen, landowners and bearers of vital information about agriculture, artisan skills, folk medicine, child care and warfare, the elderly enjoy honor and exercise some degree of authority over younger family members. As long as they are physically able, they contribute to productive work in farming. The chances of the individual remaining employed for a longer period of time in rural areas are greater than in towns and cities (Jamuna, 1999). Continuity in occupational activity ensures a steady income and a sense of being autonomous and socially involved. Two of the major problems of aging, namely, losing one's sense of worth and boredom for lack of anything to do are overcome to a great extent. Continuity in an occupational role and income is also important in supporting the familial authority of the male. This continuity strengthens the status and rule of the farmer who has greater experience. Activity theorists like Lemonan Bengston (1972) say that continuation of life style which they had during middle age helps to minimize society's withdrawal from the elderly. The strongest predictor of quality of relationship of such affluent rural elderly is

the geographic proximity. Farm residents tend to have greater proximity and interaction with children and grandchildren than the rural non-farm residents and urban residents (Bose, 1988). This affords them more opportunity for social contact and support. This factor, in turn, is believed to have some degree of influence on the health profiles of rural elderly farmers. Research in this area demonstrates that rural elders still engaged in farming are among the healthiest of all elders, while rural non-farmers show the worst health profiles (Coward. et al., 1990). The farm advantage is particularly evident among men, indicating that instrumental ties, probably involving access to land, frequently link the male members to adjacent generation of farm families.

The Indian rural family is thus supportive of age, provides a formal location, a role and a status for the aged in which they are respected, are expected to guide and counsel the young (Jamuna & Ramamurti, 1999). While no elder individual can escape the physical consequences of aging in terms of failing health and decreasing physical capacities, he is well supported in his social, familial status, his sense of worth and the sense of being wanted. The status of the elderly within the family seems to be affected by gender differences, by rural–urban location and by the degree of economic self-sufficiency of the elder.

But the number of land owning families is small compared to the landless. In most developing countries about 15 to 20 percent of the population are landless and another 15 to 20 percent are very small farmers owning half a hectare or less (D'souza, 1990). They are not found to live in joint families. Many of the rural poor often live in isolated or remote areas in arid regions or mountain valleys. These rural elderly occupy a greater share of nation's substandard and dilapidated housing (Clark, 1991). They have poor housing, fewer options in personal and public transportation and significantly more limited access to health professional and community based programmes and health services (Coward and Lee, 1985). These people subsist from the meager out put of their small holdings or from the agricultural labor they perform under highly unfavourable tenancy or sharecropping arrangements. The children of such rural non-farm residents are most likely to migrate to urban areas in search of jobs.

Nayar (1996) says that the rural old are beset with an important set of problems— flight of young able bodied to distant places for jobs and establishment of household there. Sometimes they take the elderly along with them. But in most cases, the aged are left behind and sometimes they are even forced to destitution. More elderly women when compared to men live alone (Census, 2001).

In some states like Kerala, the migration of young is very high, resulting in a crisis of caring for older people (Sooryamoorthy, 1997). According to Rao (1994) in rural India people are losing their control and authority and are forced to depend on other kin due to migration of sons. There is evidence to suggest that migration of the young is leading to nucleation of the family and thereby adversely affecting intergenerational support (Gangadharan, 1999). The greatest complication for the parents arises when an only child chooses to migrate. Even if there are other children, the loss of support can be substantial because it is generally the most dynamic and the most educated of adults who want to migrate. Caring of the aged by the family who has immigrated is thereafter from a distance. Distance, time and expense separate children and parents. This is especially the case, if they have no other children. Due to migration of young people, either permanently or seasonally, instead of multi-generational coexistence, only older persons with a son and his family are living in the so-called joint family. In such circumstances older people are either subjected to neglect or are deprived of even basic minimum needs such as proper living space, required nutrition and timely health care. Though information in these areas is limited, an analysis of the existing literature reveals that the dwelling unit, family typology and inter-personal and inter-generational relations are important factors deciding the socioeconomic status of older people in India. In addition, personal autonomy, dependency, functional ability, life satisfaction and social integration are some of the issues that affect life considerably.

The activity theory of Havighurst (1958) predicts that a vacuum in life lessens the total activity which reduces opportunities for others to validate one's specific role identities and a general self concept. As a result positive self-concept wanes and general contentment with life decreases. Even if the remaining siblings care for the parents sometimes there is resentment (Prakash, 2003).

Table 1: Living Arrangement of the Elderly in India, 2001

Type of living arrangement	Rural Male (%)	Rural Female (%)
Living Alone	1.7	5.1
With spouse only	13.7	7.7
With spouse and other members	61.3	31.3
With children but without spouse	17.9	48.1
With other relations without spouse	3.4	5.5
With non-relations	0.4	0.4
Living alone in old age home	0.8	1.0
Not recorded	0.8	1.0
Total	100.0	100.0

Source: Ashish Bose, Population of India, Census 2011.

Economic Problems

Majority of the rural elderly depended on agriculture for the source of income. Nearly 90% of the total work force is employed in the unorganized sector. Rural elderly when compared to the urban elders also tend to have lower level of formal education especially with regard to high school education and beyond. Seventy-three percent of the rural aged are illiterate and can be engaged only in physical labor (Statistical Dimension of senior citizens, 2001). Seventy-eight percent of males and 84 % females work in rural India. Older men are predominant in the cultivator category (76.5%) and women in agriculture labor category (51.5%). Sixty percent of older widows worked even after 60 years and 2 % males and 3% females are engaged in household industry.

The rural elderly are more disadvantaged as both quantity and quality of educational facilities in rural areas has been quite inferior compared to those in urban areas. This predominant rural character of the population, coupled with opportunities for an insufficient wage and salaried employment, compel people to prolong their working lives as long as it is physically possible,

although perhaps at a reduced pace. Analysis of the employment pattern of the working elderly shows that, on the whole, work participation of the elderly continue to be significantly higher in rural areas compared to urban areas (Rajan et al., 1999). In many situations the rural elderly continue to work, though their number of working hours decreased with increasing age (Singh et al., 1987). Coupled with this are natural calamities, less rainfall, lack of productive assets and inaccessible and unaffordable financial support (Kumar, 2003).

Sample surveys conducted in rural India reflect a greater degree of financial insecurity among the rural aged. Inadequate financial resources have been indicated as one of the major problems of the elderly living in rural India (Desai, 1985). Agricultural labour requires physical capability but does not provide old age income security. Most of the rural elderly do not have a concept of saving money for their future security and they think that their old age will be taken care of by their children (Kumar, 2003). They might have spent their earnings on the education of children and on the daily needs of the family. Low wages, job insecurity and lack of legal and governmental provisions to protect their rights, make this group vulnerable to economic hardship. They do not own productive assets, have little or no savings or income from investments made earlier, and have no pension or retirement benefits, and are not taken care of by their children or they live in families that have low and uncertain income and a large number of dependents (Bose, 1996). For elderly living with their families—still the dominant living arrangement—their economic security and well-being are largely contingent on the economic capacity of the family unit. In rural area, most families suffer from economic crisis, as their occupations do not produce income throughout the year. The tendency is to spend more on their growing children, while minimizing expenditure on aged parents; thus, financial security for the elderly in rural families is very limited (Bali, 1995; Kumar, 1990). Punia and Sharma find economic insecurity to be the sole concern of the elderly in barely sustainable households in rural India. They worry about what will happen to them in case of sickness or disability.

The above factors, to varying degrees, influence the stress level, well-being and quality of life of rural elderly. It is perhaps no surprise to find

rural elders vulnerable to experiencing a greater number of health problems such as hypertension, arthritis and rheumatism. A study by Coward et al. show that the majority of the rural elderly (55 percent) had visual problems (cataract), followed by orthopaedic problems. Chronic respiratory disorders were significantly more in men while orthopaedic problems were more in women. Of these 15.6 percent were hypertensive, 8.6 percent (mainly widows) needed assistance in physical activities like bathing, toilet, dressing, walking and eating. Rural elderly tend to experience more functional limitation and greater difficulty in performing tasks of daily living than all other resident categories (Coward et al., 1993). Housing is a determinant of the well-being of an individual. In rural areas, the majority of older people live in semi-concrete houses, followed by mud houses where the surrounding sanitation is not maintained. Keeping proper ventilation, flooring and hygiene is problematic for families, which always depends upon their economic and cultural status. Under such circumstances, older people with arthritis, neuromuscular diseases and visual impairment are in danger of having accidents and falls that may result in partial or total disability. As the system of modern toilets is not in place in most rural households, people use agricultural/barren lands for easing themselves. For older people with locomotor disability this is a difficult function, especially during the rainy season. Living space within the house may be limited as part of the house may be utilized for storing agricultural implements and products. This may cause restriction on space for the movement of older people within the house. In general, older people are provided space and shelter in the outer part of the house under the veranda to allow privacy to younger members of the family. Older people may thus be exposed to climatic variations often resulting in ailments. Even in newly-built houses under various housing schemes, older persons spend much of their time under extended roofs (Rajan et al., 2000). Studies also show that certain diseases are less prevalent in the rural areas. The low prevalence of osteo-arthritis in rural elderly could be due to differences in their life style. Rural elderly are usually more mobile, (in the present study also limitation of movements in rural elderly was significantly less than in urban elderly) have less obesity compared to urban elderly and have better social interactions. The last factor makes rural elderly to divert their minds away from symptoms.

Table: 2 Percent of 60 + rural Male and Female by Type of Disability in India

Type of Disability	Rural Male (%)	Rural Female (%)
Visual	24.9	29.1
Hearing	13.9	15.6
Locomotor	3.2	3.8
Amnesia / Senility	9.6	11.3
Any Disability	38.0	42.5

Source: Ashish Bose, Population of India, Census, 2011.

Table: 3 Per cent of 60 + Rural Male and Female Having Chronic Diseases in India

Type of Chronic Disease	Rural Male (%)	Rural Female (%)
Cough	25.0	19.5
Piles	3.3	1.6
Problem of Joints	36.3	40.4
High / Low Blood Pressure	10.8	10.5
Heart Disease	3.4	2.7
Urinary Problem	3.8	2.3
Diabetes	3.6	2.8
Cancer	0.2	0.3
Any	52.7	51.4

Source: Ashish Bose, Population of India, Census 2011.

The health care services also differ significantly in rural and urban areas, with emphasis on primary health care in the rural areas and tertiary

care in the urban areas. In a rural community, as showed in a survey made by the Indian Council of Medical Research, only 20% of those interviewed said they had no medical problems. Owing to illiteracy, majority of the aged are not even aware of their ailments at the stage where prevention is possible. Disease and physical ailments, in the view of society are nothing but a natural phenomenon of aging. Some of the aged, though they are aware of the ailments fail to consult or take regular treatment due to non availability of mobilization and lack of personal care (Kumar, 1996).

The provision of health security is one of the most neglected areas in rural India. The primary health centres (PHC) and sub-centres (SC) are designed to cater to the basic health needs of the rural population along with upgraded PHCs and hospitals at sub-division and district headquarters. However, rural health services in India are poorly maintained with scarcity of drugs and lack of health workers. In this scenario older people with a greater sickness load are at risk of not receiving care at the time of need. In addition, health workers, irrespective of their status, do not have adequate training in geriatric medicine. Tertiary and private sector health services are beyond the reach of older people or rural India, while general hospitals at district and sub-division levels are not I a position to provide quality referral care. From the care-giver's perspective, treatment of a sick older person in a government hospital is a big task as it involves transportation over a considerable distance, getting a hospital bed and cost of treatment in addition to loss of wage for the daily wager.

Ageing vs. Rural Women

Unlike the trend in most other countries, in India the sex ratio pattern is in favour of women, particularly in rural India statistics. In the 21st century, women in developing countries may be expected to gain 7 to 10 years in their life expectancy. Ageing women in rural India today face a triple jeopardy. First of all, the jeopardy of aging in a society, where old people are increasingly being perceived as a burden to a shaky economy. Old traditions of filial respect and family networks are rapidly vanishing. Rapid urbanization and industrialization deprive older women of several roles

that they automatically used to assume in the pre-industrial societies. In addition, elderly women are burdened by a higher rate of widowhood (Kattakayam, 1998). Seventy-eight percent of women in 70+ age group as compared to only 27% of men would have lost their spouse in old age (D'Souza, 1990). Widowhood for a rural elderly women throws her into an ambiguous position as her status has been dependent principally on her husband's work and status. The elderly female frequently play a dominant role in running the household, until the death of the spouse, when they suffer a rapid and extreme decline in their status. An elderly widow is unlikely to be able to hold an extended household together. Such a person depends on one of her sons and their on daughter in-law as well. In either instance, the role transition that an elderly female and her care-giver suffers give the wide spread belief that only a daughter in-law can really serve her parents with all her heart. Not only does the death of the husband bring about fundamental disruption in a female's social environment, but also removes a key relationship in her emotional life (Jamuna & Ramamurti, 1999).

In addition to emotional loss and loss of status, it may involve economic dependence, mobility and lack of opportunity for social interaction. Simultaneously, it tends to disrupt the established interpersonal and support network that one may have come to depend on for guidance and support in many matters. Sharma and Agarwal (1996) observe, "The death of the spouse, particularly of the husband brings serious consequences for the elderly female; particularly those of the rural area. She is cared for and looked after, as long as her husband is alive. This death renders their positions very vulnerable. According to Role theory losing a role and a relationship disrupts established pattern of behaviour, produces differential treatment from others and modifies one's self identity.

She is often bereft of possessions, jewellery or fine clothes and eats sparingly. In fact widowhood in the lower socio-economic groups condemns elderly female to beg for their food and are left without a meaningful life pattern or social function (Dandekar, 1996). Stress theory treats widowhood as a role loss typical of old age. This unpleasant and overwhelming role loss acts as a stressor that reduces life satisfaction. Role

losses of old age reduces coping resources such as income, health and social support and indirectly weaken life satisfaction. According to Jamuna et al. (1995), financial and emotional problems, negative self concept, feelings of normalcy and powerlessness, high intensity of survival needs, moderate to high physical and psychological distress are significant among the elderly widows.

The second source of jeopardy is that of being a female in a male dominated predominantly patriarchal society, where femaleness is devalued. Examining sex difference in sustenance and survival, using India as example, Basu et al. (1986) report persistent pattern of discrimination and female deprivation in rural areas. Selective discrimination against females at levels is well documented (Dasgupta, 1987). Most disheartening news for humanist is the report that anti discriminatory approach based on legal and educational opportunities has failed to bring out meaningful improvements in the status of rural women. She does not get the best of education. In most cases, even access to education is denied. As Bose (1982) points out, elderly women are likely to encounter age related diseases as health status is influenced usually by quality of past life, environment and social situation. For a large majority of rural women their reproductive period consists of too early pregnancies, too frequent pregnancies with short birth intervals and too late pregnancies. Thus poor nutrition, unsatisfactory reproductive care, dangerous working condition and physical violence, limited access to preventive care and inadequate medical services enhance the problem of ageing women (Kumar, 1997). Kumar (1996) reports that in rural India, primary health centers and subcentres are catering to the health needs of the people. However they neither have geriatric wards nor specialists. Here also no separate wards are provided for the services of the elderly.

The third jeopardy is due to the existing conditions in which most women live. A large majority of women living in rural areas are under the grip of poverty or are dependents in urban areas. Only 33% of the older people live just marginally over the poverty line (Statistical Dimension of Senior Citizens, 2001). Chronic poverty seems to be disproportionately high among historically marginalized groups such as SCs, STs, elderly women

and the disabled. The multiple deprivations suffered by these groups make it harder for them to escape poverty as different forms of disadvantages tend to be mutually re-inforcing (Mehta, 2001). The main reason for rural poverty in spite of women, working all the year round has to be traced to the way women's 'work' is defined. In rural India, where most production is family based and for some consumption, women's contribution is not quantified. Structural inequalities coupled with a narrow definition of what constitutes value ensure that women's work is largely in the informal and subsistence sectors which invariably remain undervalued and uncounted. No monetary value is attached to women's work at home and in the field. Consequently, they lack the savings and monetary resources to secure relative self sufficiency in old age, at a stage in life when they are in most need. The limited economic security experienced in old age by such elderly females is the result of their longer life expectancy, the lifetime impact of limited employment opportunity, society's assumption of women's economic dependency and the bias against women both as workers and as dependents. Thus there is "Graying Feminization of poverty" with women being poor and elderly rural women being poorer.

In their old age they have to depend on their kith and kin for their survival while their contribution throughout their active life is discounted. Amtee (1990) comments that it is economics rather than human rights and dignity that tend to run the world to a great extend. This being so, the prospects of rural aging women appears bleak. Poor rural women face all the obstacles that poor men face, plus many more. These include lack of access to land ownership, limited land use rights, greater difficulty in obtaining bank loans, less technical assistance and training from extension service, restricted employment opportunity, higher rates of illiteracy, and widowhood, to name a few (IFAd, 1992).

Ensuring Quality of Life for the Rural Elderly

The old people are not to be viewed as new social phenomenon as they were participants in the management of affairs of the family, community and larger society. Thus they have the right of power, and every welfare state as Gransci puts it has a popular consciousness where all categories of

people are to be treated as societal partners. The neo-Marxian group lead by Gransci, Georg Lukacs and Althusser refer that the class struggle of the next century will be between the various groups holding different ideology. Here it will be the clash between the cultural ideologies where groups of people, either biological group i.e. gender groups or age groups or ethnic groups become the classes.

India is a poor country belonging to the traditional eastern cultures where family ties continue to be strong. To provide even a semblance of social security to the 60 million elderly would need at least 60,000 million rupees per annum, an amount that would eat into the very vitals of our national budget. Hence, state care is just out of question and should not be encouraged.

The government should come out with wide ranging schemes of supporting family care through subsidies and incentives and by encouraging self-help schemes of income generation and security for the elderly to make them financially viable. Voluntary agencies and community support for elderly should be re-in forced. Support for the destitute should be easily available. Opening day care centers in every villages and ward become a useful adjunct to the family. Also community-run neighborhood caring networks, (necanets) and community elder homes need to be organized (Ramamurti, 1996). They can be served by hospital staff and organized around hospital areas with a mobile van to go round the homes extending medical services. The elderly of the next century will become a conscious and powerful group from the point of view of political participation. Indeed they will be one of the largest groups who will decide the destiny of the state. The group which wields power in the informal and primary institutions will be one of the most sought after groups politically. This becomes more visible when they are under the care of institutions. As Habermas puts forward in his theory of rationalization of culture in the light of Marxian and Weberian theories, the old age culture will be twisted in favour of the state whenever it is required by them. This process is to be watched and taken care of by the policy makers who are interested in the welfare of the old. Dandekar (1996) argues that the thrust of government programmes and policies should be directed at providing old-age pensions. This is not only because the rural old are both well-integrated

with their social milieu and not favourably disposed towards living in old-age homes, but also because pension schemes are a cheaper alternative Gerontological and geriatric research should become complementary to each other and the Government and the Universities concerned should make a serious attempt to break the wall which stands between them. The study of the aged may be viewed from a holistic perspective, keeping in mind longitudinal and cross-sectional diagnosis of the issues concerned. Here, Women's Studies and Gerontological studies should move away from the traditional methodology and should not shun away from experimenting with interdisciplinary and multidisciplinary approaches. Researchers, academicians, scientists, policy makers and administrators should seriously take it as a challenge to promote study and research in this area, so that the results can be applied universally to understand the various dimensions of aging and to evolve scientific and systematic solutions for them.

While implementing the NPOP (National Policy on Older Persons) the welfare of the rural elderly needs to be viewed with all its characteristics: poverty, widowhood and varied distribution of income in families. The crumbling rural economy is also a major determinant of their vulnerability. Already the State is following the "womb to tomb" social security policy with "inadequate funds" and "inappropriate coverage". The demographic projections of a large older population can upset the existing fragile social security system and will definitely tax the nation's resources tremendously. At the same time, neither the family nor the community alone would be able to provide a harmonious atmosphere to older people; and when the economic pressure increases on each of these institutions, India may have to witness hundreds of thousands of older people left out on their own. A radical transformation from a welfare state model social policy to a welfare society is necessary. This can become possible only by active partnership and participation among all stakeholders. Political will, effective implementation of welfare schemes and providing full social security to older people can be realized only if all of us are able to "give the aged a home in our hearts".

The family and above all the elderly themselves could go a long way towards ensuring a good quality of life. Death of spouse and migration

of children are the major breakdowns for the rural elderly and from these points there should be a social reconstruction. The social reconstruction theory by Kuypers suggests that the person who is adjustable can rebuild his society taking into account the social and physical environment. The social reconstruction takes place by interaction with family members. The elderly could play a valuable role in the socialization of young children and in transmitting social and cultural heritage. Their wisdom could be sought by the present day generation for solving problems and during a crisis. The elderly has considerable knowledge in plants and their various uses. In order to protect biodiversity, which is an essential element of sustainable agriculture, such knowledge should not be lost. Though they are driven to the background of the respective social institutions, often their services are exploited by their kin. Here, one has to explore the possibilities of pooling out the resources of the old people for the development of the country, so that they are absorbed into the mainstream and complementarily their ego will be satisfied.

One could rightly follow the emancipation perspective. It gives priority to the liberation of the aged from the exclusion of social, economic and political participation in the society. In fact, the emancipation perspective is defined as creation of a sense of social identity of aged in one extreme, and, as an instigate to social, economic, political welfare of the aged individuals on the other extreme. In essence, the liberation perspective provides relative privilege in socio-economic, political and psychological aspects of aged through the construction of a sense of age consciousness, which leads to the provision of social security. Elderly women have to be treated as a special category as the labor they have put in during their younger years as it cannot be compared to any of equivalence today so that they can have and feel a a sense of contribution and-satisfaction. Dialectical materialism is derived from emotional and materialistic struggle. Social engagement fulfills the mind and body of the aged and thus we could bring an improvement in the life of the elderly of today and tomorrow.

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