Socio-economic and Health Conditions of the Rural Elderly Women in Southern Tamil Nadu

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Abstract: Though India’s vignettes indicate mixed development pattern among women, however, the economic, social and health conditions of rural women has not been significantly improved, especially it is worse in the case of rural elderly women. This study analyses the socio-economic and health conditions among the rural elderly women living in Kannankudi Block in Sivaganga district. This research employed descriptive design. The qualitative technique such as focus group discussion (FGD) was conducted. Most rural elderly women of Kannankudi Block who participated in the FGDs are married and some of them are widows. The rural elderly women are predominantly working as agricultural labourers. However, a section of the rural elderly women are economically dependent on others. Geriatric age, loss of family key roles, economic dependency and ill-treatment by the family members are the key perceived problems by the rural elderly women.

Keywords: Rural elderly women, Socioeconomic, Health, Sivagangai district

1. Introduction

Though India’s vignettes indicate mixed development pattern among women, however, the economic, social and health conditions of rural women has not been significantly improved, especially it is worse in the case of rural elderly women. The normal life of rural elderly women is affected by physical and mental problems that are mostly interlinked with social and economic issues (Pappathi, 2007).

In order to observe the socio-economic and health conditions among the rural elderly women living in Kannankudi Block in Sivaganga district, which is one of the backward districts in Tamilnadu (Ministry of Panchayati Raj, 2017). Ageing has serious socio-economic and health implications (Singh, 2013; Prakash, 2012). It is evidently associated with physical and mental conditions including health and hygiene, morbidity pattern, levels of daily activity skills, emotional aspects, social support system, daily activities, feeling of being respected and problems at geriatric age.

Ageing is a universal phenomenon and a biological process of human life sequence and it is not a disease that can be cured (Hurlock, 1981). Warnick (1995) viewed that ageing is a cascade of life processes that begin with the birth, continue throughout the life cycle and eventually represent the closing period in the lifespan (Warnick, 1995). In the modern epoch, ageing has become a subject that is perhaps uncomfortably recognizable, with its focus on ways to overcome, prevent, oppose, and in a few but budding quarters, embrace, one’s ageing (Pachana, 2016). The human ageing is a phenomenon which has many faces and of which, physical ageing is the most visible face (Marcoen, Coleman, & O’Hanlon, 2007). The aged individuals encounter it in their mirror image and bodily experiences as falling velocity, early fatigue and unwanted sleepiness by day, sleeplessness at night, lack of energy and occasionally waves of indefinite pain (Marcoen, et al., 2007). In another dimension, these authors also strongly viewed ageing as a socio-cultural phenomenon that society and culture co-construct human ageing for better and worse.

Many social scientists have categorised old age into three stages: 1) early old age or young old age which extended from age 60 to age 69, 2) old age or advanced old age which begins at the age 70 and ends at age 79 and 3) older old age which is 80 years and above (Dhara & Jogsan, 2013). The United Nations (cited in Pachana, 2016) disclosed that the aged population of above 65 will swiftly surpass those aged 5 and below, across both the developed and the developing world.
The major observations of this research are:

Out of the total elderly population, two-thirds of them live in rural areas (Jamuna, 2003). Since independence, females are relatively higher than males in the aged population than the general population (Paltasingh & Tyagi, 2015). Tamil Nadu, one of the highest elderly populated States in the country, has averagely one out of every 14 people aged over 60 and comprises of three-fourths of the elderly women in the elderly population (Nagarajan, 2008).

In the social sphere, the rural elderly women are the guardians of the family, the custom and the tradition (Rath, 1996; Pappathi, 2007). Despite the scientific temper, their religious beliefs have not demolished and frequently they trace out some religious causes either for their well being or for their ill being (Rath, 1996). The potentials and the vast experience that older women have acquired area rarely rewarded (Pappathi, 2007). The rural women have full of physical, social, emotional and financial insecurities in their old ages (Paltasingh & Tyagi, 2015).

In general, women have different hormonal and structural constitution than men and indeed, there are differences in their nutritional, functional and emotional aspects that cannot be compared with men (Rajendran, 2008). The quality and distribution of health in the general population ascertain the civilization (Pandya, 2008). The increasing elderly population experiences most common psychiatric illnesses (Prakash & Kukreti, 2013) and non-communicable diseases (Petersen &Yamamoto, 2005). The uprising cost of medical care has caused a serious concern among older people and societies, in general ensuing in constant review and reform of institutions and programmes designed to aid the elderly with these expenses (Singh, 2017).

II. Materials and Methods

This study analysed the socio-economic and health conditions of the rural elderly women. This research employed descriptive design to characterise the socio-economic conditions and the health conditions of the rural elderly women living in Kannankudi Block in Sivaganga district during a period of time respectively and to analyse the potential factors contributing to their current social and health conditions. The qualitative technique such as focus group discussion (FGD) was conducted. Three FGDs respectively were conducted in two rural panchayats of Kannankudi Block. These panchayats were purposively selected considering the thickness of the population. One panchayat has the highest population and another panchayat has the least population among other panchayats. Totally, 6 FGDs were conducted. Of these 6 FGDs, 3 were conducted in Dalit colonies and the other 3 were held in non-Dalit areas having mixed communities. In each focus group discussion, minimum 8-12 rural elderly women ageing above 60 years were present.

The major observations of this research are:

- Most rural elderly women of Kannankudi Block who participated in the FGDs are married and some of them are widows. The rural elderly women are predominantly working as agricultural labourers. However, a section of the rural elderly women are economically depended on others. Since in their young ages, there was not much compulsion on education, thus, they are not in a state to get access to school education. A few women who were in the young old age group have reached up to high school education.
- Owing to the major shift from joint family to nuclear family, the most common dwelling practice among the rural elderly women is that they have no other chance to live in their sons'/daughters’ families. The living houses of the rural elderly women are poor with lack of water and sanitation facilities. The elderly women who are in the older age group experience hardship to live a better life.
- Since most of the rural families have a moderate level of income sources, predominantly the rural elderly women receive food from the families. The women who have regular work have own wages. They often spend these monies for providing cattles for their grandchildren.
- The rural elderly women who are working have physical and mental health than the rural elderly women without work. The most common health problems observed among the rural elderly women are eye defects, arthritis and backache. Some of them have multiple health problems. The most common psychological problem among the rural elderly women is anxiety. However, predominantly the rural elderly women are not feeling depressed.
- Most rural elderly women of Kannankudi Block have moderately received support for healthcare from their families. However, a segment of them have never obtained any physical support from their families. The neighbours play a crucial role by rendering essential support to the rural elderly women.
- The rural elderly women feel that the socioeconomic support of the State has not reached them in the recent periods. The local women groups and the local non-governmental organisations have totally rejected the rural elderly women.
- The government hospitals and primary health centres are the primary health institutions for the rural elderly women, but a section of them are dissatisfied with the healthcare services of those health institutions.
Most rural elderly women are in the physical strength to eat, dress and bath on their own. A few of them have difficulties to walk into the house and to do their household chores. The major routine activities of the rural elderly women are performing prayers, doing household activities or watching television, going for walk or chatting with the family members and engaging in regular occupations if working. The family gives respect to them is highly felt by the rural elderly women that the society respect them. Geriatric age, loss of family key roles, economic dependency and ill-treatment by the family members are the key perceived problems by the rural elderly women.

III. Conclusion

Ageing, indeed, has a greater influence in the lives of the rural elderly women in socio-economic and health spheres. The loss of physical strength and family roles, economic dependency and bombardment in the hands of the family members are the major causes for the problems of the rural elderly women. The social support of the family and the society is a greater demand and need for creating an enabling environment for the rural elderly women to live a better quality of life at their old ages.

References


