THE SOCIO-ECONOMIC PROFILE OF THE ELDERLY PEOPLE PARTICULARLY AT CHERANALLOOR GRAMA PANCHAYATH

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A STUDY ON THE SOCIO-ECONOMIC PROFILE OF THE ELDERLY PEOPLE PARTICULARLY AT CHERANALLOOR GRAMA PANCHAYATH

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CONTENTS

SL NO	TITLE	PAGE NO
1	INTRODUCTION	2
2	REVIEW OF LITERATURE	14
3	METHODOLOGY	37
4	FINDINGS AND ANALYSIS	49
5	CONCLUSION AND SUGGESTIONS	96
6	REFERENCES	101
7	APPENDIX	105

LIST OF FIGURES

FIG NO	FIGURE NAME	PAGE NO
4.1	Gender-wise sample distribution across age group	50
4.2	Demographic Composition of respondents	51
4.3	Marital status distribution of respondents	52
4.4	Years of marriage among elderly	53
4.5	Types of residence distribution of elderly	54
4.6	Literacy status of respondents	55
4.7	Education level of respondents	56
4.8	Employment status distribution	57
4.9	Employment history of respondents	58
4.10	Distribution of lifestyle Disease VS others	60
4.11	Support system used by respondent	61
4.12	Medication status of elderly respondents in cheranalloor grama panchayat	62
4.13	Health Insurance coverage among respondents	64
4.14	Distribution of medical support for the elderly	66
4.15	Medical health status of the older adults	67
4.16	Covid-19 impact on the elderly	69

4.17	Access to healthcare government policy among respondent	71
4.18	Beneficiaries of any panchayath healthcare policies	72
4.19	Willingness to join a regional service organization	73
4.20	Participation of panchayathu medical camps at the panchayat and their utilization of services	74
4.21	Respondents view on necessity of medical camps at the panchayath	76
4.22	Most depended hospital type	77
4.23	Phone ownership and type	79
4.24	Connection with family members and friends through the phone	80
4.25	Seeking services at other clinics	80
4.26	Transportation	81
4.27	Opinion on Public Transport	82
4.28	Vehicle ownership and type	83
5.1	Discussion with panchayat president	104

LIST OF TABLES

TABLE NO	TABLE NAME	PAGE NO
1	Showing the medication status of elderly respondents	63
2	Showing the distribution of health insurance coverage among respondents	65
3	Showing the distribution of medical support among respondents	66
4	Medical health status	67
5	Covid-19 Status	68
6	The physical and mental challenges of elderly after covid	71
7	Main source of income	83
8	Internet familiarity	84
9	Categories of pension	85
10	Is your personal spending enough?	85
11	Ration card status	86
12	Assets and property	87
13	Leisure time	87
14	Person residing with	88
15	Primary caregiver	89
16	Grandchildren involvement in caregiving	89
17	How often do you go out / do you attend social function	90

18	Old -Age group membership status and willingness to join	91
19	Major social connection other than family	91
20	Satisfaction in the caregiving received	92
21	Opinion on healthcare availability in panchayath	93
22	Opinion on transportation facilities	94

ABSTRACT

Aging is a critical global concern as rising life expectancy and declining fertility rates reshape population demographics. Older adults contribute wisdom and experience while facing socio-economic and health-related challenges. This study examines the socio-economic profile of elderly individuals in Cheranalloor Grama Panchayat, Kerala, to assess their experiences, caregiving relationships,financial independence, and access to basic needs.

Objectives

1. To examine the availability and profile of caregivers of the elderly in Cheranalloor Grama Panchayat.
2. To assess the health and well-being of the elderly and the accessibility and adequacy of healthcare services.
3. To evaluate transportation accessibility for elderly individuals.
4. To measure digital literacy levels among older adults.
5. To assess the role of the Panchayat in supporting elderly welfare and propose further measures.

Methodology This study was primarily quantitative in nature. The primary data was collected from elderly individuals aged 60 and above in Cheranalloor Grama Panchayat to inform policy interventions.

Theoretical and Operational Definitions

1. **Elderly**: The United Nations defines an older person as someone 60 years or older. For this study, elderly individuals are those aged 60 and above as listed in the Panchayat's voter list.
2. **Literacy**: Theoretical - The ability to read, write, and use these skills in daily life (UNESCO, 1958). Operational - The ability of elderly individuals in Cheranalloor to read signs, labels, and write basic messages.
3. **Digital Literacy**: Theoretical - Understanding and using digital technologies (Gilster, 1997). Operational - The ability of the elderly to use mobile phones or computers for basic communication.
4. **Employment**: Theoretical - Engaging in productive work generating income (Smith, 1776). Operational - Engagement in full-time, part-time, or temporary work in various sectors.
5. **Source of Livelihood**: Theoretical - Activities generating earnings (ILO). Operational - Income sources for elderly individuals, including pensions, family support, or self-employment.
6. **Caregiver**: Theoretical - An individual providing primary care and support to an elderly person. Operational - A person offering paid or unpaid care in Cheranalloor households, including family members and professionals.
7. **Social Groups**: Theoretical - Groups sharing common characteristics and interacting regularly (UN, 2019). Operational - Religious, spiritual, or community groups supporting socialization among the elderly.

8. **Medical Health Camp**: Theoretical - Temporary healthcare services for marginalized populations. Operational - Panchayat-supervised mobile healthcare services offering consultations, tests, and awareness programs.

Research Design

The study universe comprises elderly adults aged 60 and above residing in Cheranalloor Panchayat. A total of 65 individuals were selected using a combination of random and snowball sampling. The lottery method identified wards 10 and 11, and snowball sampling was used to recruit participants within these wards. Challenges such as the geographical spread of wards, unclear address lists, limited local support, and time constraints made it difficult to identify eligible individuals. To address this, snowball sampling was used, allowing initial respondents to help identify others. This approach was especially useful when documents were unclear or individuals were uncertain about their ward affiliation, ensuring the sample remained within wards 10 and 11. Data collection took place from October 15 to December 4, 2024, using an interview schedule and direct observation.

Findings and Analysis

- **Demographics and Living Conditions**: The study revealed a higher female population (40 vs. 25 males), aligning with global longevity trends. Hindus (57 out of 65) formed the majority, with the Nair (42.1%) and Ezhava (31.6%) communities being most represented. Marital analysis showed that 70.77% were married, while 24.62% were widowed. Home ownership was high (87.7%), suggesting financial stability. Literacy rates were 87.7%, with primary education (35.38%) being most common.

- **Health and Healthcare Access**: Lifestyle diseases affected 61.5% of respondents, with obesity (30.8%), hypertension (12.3%), and cholesterol issues (20%) being prevalent. Sensory impairments were common, but most respondents (72.3%) did not require mobility support. Health insurance coverage was 60%, with 83% having access to medical assistance, though 17% lacked sufficient healthcare support.
- **Impact of COVID-19**: The pandemic affected 37% of respondents, with socio-economic disparities evident among affected individuals. While 88% reported no lasting health concerns, 12% experienced lingering effects.
- **Community Engagement and Digital Literacy**: Only 29% showed interest in participating in regional service organizations. Digital literacy varied, with 56 out of 65 owning mobile phones, but only 29 respondents using the internet. Transportation dependency was high, with 43 relying on public transport.
- **Caregiving and Social Participation**: Family remained the primary support system, with 50.77% living with children and 47.69% relying on them for care. However, 9.23% lived alone, raising concerns about social isolation. Professional caregiving was rare (1.54%). Social engagement was low, with 53.85% rarely attending events and only 16.92% engaging daily.

Conclusion and Suggestions

The study highlights both strengths and areas for improvement in elderly welfare in Cheranalloor Grama Panchayat. Strong familial support, high home ownership (87.7%), and relatively good healthcare access were identified as positive factors contributing to elderly well-being. However, financial strain from medical expenses, limited transportation access, and social isolation remain significant concerns. A notable 61.5% of respondents suffer from lifestyle diseases, while 17%

report insufficient healthcare support. Digital literacy is low, with only 29 respondents using the internet, affecting their access to information and services. Additionally, caregiving remains largely informal, with 50.77% relying on family, while professional caregiving remains rare (1.54%).

To improve elderly welfare, the study suggests implementing financial assistance programs to support healthcare and daily expenses, improving transport facilities for better mobility, and increasing community engagement programs to reduce social isolation. Enhancing mental health services, raising digital literacy, and ensuring better implementation of government welfare schemes will further contribute to improving the quality of life for elderly individuals in Cheranalloor Grama Panchayat.

Pursuant to the survey, our research team conducted a follow-up visit to the Cheranalloor Grama Panchayath, on 24 january 2025 under the guidance of Dr. Dora Dominic, in charge of the Teresian Rural Outreach Programme, associated with the Department of Sociology, and presented our compiled, analyzed data and resultant recommendations to the Panchayath President, Mr. Rajesh K.G. The suggestions presented were specifically tailored to inform the implementation of welfare programs benefiting the elderly population within the Cheranalloor Grama Panchayath


GPS Map Camera
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682027, Kerala, India
Lat 10.040135, Long 76.279582
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Note - Captured by GPS Map Camera

CHAPTER I

INTRODUCTION

"The young can walk faster, but the elder knows the road."

- An African proverb

The trajectory of human life is marked by distinct phases, each characterized by unique strengths and vulnerabilities. While youthful energy and vitality enable rapid progress, it is the accumulated wisdom and experience of older adults that provide invaluable guidance and direction. As society ages, it is essential to recognize the value of this accumulated wisdom and to prioritize the well-being, dignity, and contributions of elderly individuals. According to United Nations Principles for Older Persons, an older person is someone who is 60 years or older (United Nations, 1991). According to a notable German-American psychologist Erik Erikson, the elderly stage is referred to as "Old Age" or "Late Adulthood", which typically spans from around 65 years old until death (Erikson, 1982). Renowned American psychiatrist and gerontologist Robert Butler coined the term "ageism" where he defined "elderly" as the individuals aged 65 and older (Butler, 1975). Dr. M. N Srinivas mentions that in traditional Indian society, older adults were considered to be individuals who had reached the stage of "Vanaprastha" or "Sanyasa", which typically occurred around the age of 60 (Srinivas, cited in Butler, 1975, 12). The 21st century has the world's significant challenge because of its vast proportion of elderly population. As the world is going through rapid transformation, the aged population in the world is also affected by this change. There are two key factors responsible for such a transformation. First is the increase in life expectancy and the reduced lifetime fertility. In many developing countries lifetime fertility is less than two children per woman and this results in the low level required for population replacement over a long time. There are three stages in demographic transition, the very first stage is the renewal

of age distribution due to the rise in child mortality. During the second stage, low fertility rates result in the decline in child mortality by rising the working population. In the third stage, there was a decline in both child mortality and working population. This results in the rise of the older population. The demographic transition provides an opportunity to stimulate more economic development (United Nations, 2007). In order to gain more knowledge on aging, it is necessary to look onto the concept of aging.

According to Kinsella, Population aging is the age when fertility rates decline and mortality improvements occur more in old ages than in young ages (Sokolovsky, 2009). The concept of "aging" includes not only the physical changes of getting older but also our perspectives and opinions about the process of aging. One's perception of age may not necessarily align with their actual years. For example; there are sixty-year-olds who see themselves as fragile and old, while there are eighty-year-olds who see themselves as energetic and lively. As people grow older they define “old age” in terms of greater years than their current age. The concept of "old age" is defined by society and is likely to evolve as the population continues to age. Individuals aged 65 and above are generally considered elderly. In the United States, this group makes up about 15.2 % of the population, which is equivalent to 49.2 million people. It is projected that by the year 2060, this number will increase to 98.2 million, making up nearly one in every four U.S. residents. Within this group, 19.7 million individuals will be aged 85 or older. Due to the diverse developmental changes within this population, it is further categorized for comparison by the census into groups of 65 and older, 85 and older, and centenarians (U.S. Census Bureau, 2020).

SUCCESSFUL AGING AND PRODUCTIVE AGING

Successful aging and productive aging are two alternative ways of looking at an ideology. It's critical to realize that success and productivity are highly valued in the United States since they are fundamental to the country's identity. Effective aging emphasizes the important ideas of longevity, mastery, progress, involvement with life, freedom from problems, and independence. The primary goal is to preserve favorable functioning for as long as possible.

The first is vital or active aging, while the second is often associated with retirement**.** Successful aging is about the belief that later life can be a period of enduring health and significance. It is about fulfilling individual aspirations for a healthy and fulfilling life. Productive aging entails the belief that later life is not a time for withdrawal, but rather for making a meaningful contribution to society through work, volunteering, or other roles.

CAREGIVERS

Caregivers are people who provide care for someone who is unable to care for themselves due to illness, disability, or injury. Caregivers can be family members, friends, or neighbors, and most caregiving happens in the home (United Nations, 2002).

CAREGIVERS OF THE ELDERLY

People who look after elderly people who are ill, disabled, or cognitively deficits are known as caregivers for the elderly. They can be paid professionals employed by a formal service system, or they can be unpaid family members, friends, or neighbors. 70 % of older people are receiving care from family, friends, and neighbors (Hooyman & Kiyak, 2011, 393). 80% of caregivers help with three or more IADLs (instrumental activities of daily living), primarily with transportation,

grocery shopping and housework (Hooyman & Kiyak, 2011, 394). Older adults who have informal caregivers are five times more likely to remain in their own homes than those older adults without informal supporters. There are two types of caregivers; informal and formal caregivers. Informal caregivers include friends, neighbors and even acquaintances.

OFFICIAL CAREGIVERS

The caregivers, who can be paid or unpaid, offer care in a structured environment, like a patient's home or a nursing home or assisted living facility. Professionals with licenses, including social workers, doctors, registered nurses, physiotherapists, and occupational therapists are some of them. They could also be temporary trainees who work as unlicensed direct caregivers.

INFORMAL CAREGIVERS

Informal (unpaid) caregivers help individuals with functional limitations with a range of chores so they can go about their everyday lives. These duties include personal care, transportation, basic daily living activities, and obtaining community and healthcare services. Typically, family members—such as the person's adult child or spouse—provide this kind of care. It is often known that persons who are older have a higher chance of developing chronic illnesses, which can include multimorbidity and issues with their physical and mental health. In most developed countries, 90% of older persons have at least one chronic ailment, and about two thirds have multimorbidity. Due to their complicated care demands, elderly individuals frequently need sophisticated treatment and care in a variety of locations.

SOCIAL THEORIES OF AGIN

GERONTOLOGY-STUDY OF ELDERLY

The study of gerontology aims to cover the aging process and the difficulties faced by older individuals. Researchers in gerontology explore the concept of age, the process of aging, and elderly individuals. They examine the experiences of older adults within a community and how aging impacts society members. Gerontology involves the collaboration of medical and biological scientists, social scientists and financial and economic scholars as a diverse field of study.

SOCIAL GERONTOLOGY

Social Gerontology is a specialized field of gerontology that studies the sociological aspects of aging. They focus on developing a wide understanding of the experiences of people at specific ages, such as mental and physical wellbeing, plus age-specific concerns such as the process of dying. Social gerontologists work as social researchers, counselors, community organizers, and service providers for older adult.

In order to investigate the complexities of aging, this study employs various social theories of aging, including Role Theory, Activity Theory, Disengagement Theory, Gerotranscendence Theory, and Age Stratification Theory. By applying these theoretical frameworks to a study of elderly groups in Cheranalloor, we aim to identify the diverse challenges faced by this population, with a particular focus on socio-economic factors.

ROLE THEORY

According to Cottrell , 'role theory' as one of the oldest theories of aging tries to explain how individuals adjust to aging and how change in social roles is associated with a certain age. This theory explores how the conflict of roles, the loss of self-identity, changes in roles, role loss and age norms such as grandparenting impact individuals. Examples: The social roles and expectations from a 30 year old father are different from the same man at the age of 82, role loss of older men and women as drivers, as people are doubtful about the driving skills of the aged. (Hooyman & Kiyak, 2011).

ACTIVITY THEORY OF SOCIAL AGING

Robert Havighurst's attempts to answer how the aged group tries to adjust to age-related changes which includes retirement, various health issues and role loss. Successful aging plays a vital role in bridging the gap between role loss and role conflict by maintaining relationships, status and more activities to find greater life satisfaction in his or her life. For this, age -based programs, communities, policies are needed to develop new roles and activities to encourage socialization and social integration. Activity theory addresses aging as a social problem, which can find solutions by retaining status, roles similar to those of early life stages.

Under our study by using this theory we would like to find whether the aged section of Cheranalloor is having an active, successful aging or not.

DISENGAGEMENT THEORY

The theory holds a vital position among social theory of aging as it treats aging with the help of various tools such as surveys and questionnaire methods. This theory was the first comprehensive

and multidisciplinary theory which is advanced in nature under social gerontology. This theory says disengagement is allowing older people to maintain a sense of self worth while adjusting through withdrawal to the loss of various roles in each stage of life. This theory views old age as a separate period of life not as an extension of early life. The theory raises the argument that aging cannot be understood separately from the characteristics of the social system in which it is experienced. (Cumming & Henry, as cited in Hooyman & Kiyak, 2011).

GEROTRANSCENDENCE THEORY

Gerotranscendence theory represents a shift in the perspective of elders from a materialistic, rational view of the world to a cosmic and transcendent world. The word cosmic world means wisdom, spirituality and one's inner world. Examples: discovering spiritual side after death of partner, prayer group, spiritual communities (Tornstam, 2005).

AGE STRATIFICATION THEORY

Age stratification is a conceptual framework for investigating how people age throughout their lives and how age is viewed in society. Matilda White Riley and her associates established this framework in the 1970s. As a conceptual point of view, age stratification focuses on both the individuals who belong to different age groups in a population and the social institutions that employ age to determine that person’s behavior. It focuses on changes throughout time in aging experiences as well as changes in interactions between age strata. This viewpoint argues that we acknowledge that human aging is, to a considerable extent, a social construct (Riley, Johnson ,& Foner, 1972,).

STATUS OF AGING IN INDIA AND KERALA

According to the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 a senior citizen means any person being a citizen of India, who has attained the age of sixty years or above. In the traditional Indian culture and social arrangements, the social security system that was in place for families was there (Government of India, 2007). The elders were respected and obeyed in their household, neighborhood, and community. However, this has almost reduced with the emergence of nuclear families with very poor arrangements for taking care of the old. The young and physically fit people have left to find employment, studies especially to other countries and states leaving the elderly alone. Kerala is aging faster than the rest of India and has a high rate of widows.

In general, women have a longer life expectancy than men (as is the case throughout India) but in Kerala, it is significantly higher. This is due to the fact that men marry women who are a few years younger, which explains the high number of widows among the elderly.The culture of old age homes and formal care takers are increasing in Kerala. The dependency ratio is a critical metric that measures the economic burden that each worker bears, as it is the ratio of the dependent population to the working age population. The ‘Old' Dependency Rate of India as per 2011 census is 14.2% and in Kerala it is 19.6% due to higher life expectancy at birth. The old age dependency ratio shows an increasing trend in Kerala and is highest among Indian States (Ministry of Statistics and Programme Implementation, Government of India, 2016). The retirement age within the public sector of Kerala is 56 and in most other sectors is 60. The government employees have a state pension and they can live comfortably. But for the elderly who worked under unorganized sectors and poor working sectors do get adequate pension and retirement. Some get a nominal pension from their working area, unfortunately it will not help them to cover their medical expenses. In

developed countries the social security system for elderly is strong. Hence their life needs are fulfilled there.

CHERANALLOOR

Cheranalloor grama panchayath is a rural local body in Edapally panchayat samiti, sixth part of Ernakulam zilla parishad. Cheranalloor is the northern tip of the assembly constituency in Ernakulam. Cheranalloor is one of the beautiful landscapes in Ernakulam along with river sides of Periyar called Varapuzha Kayal. It is a suburb of Kochi city lies near the banks of Periyar river. Earlier this area was ruled by Sakthan Thampuran, who was one of the influential lords around the Cochin area.

The area was named by its earlier inhabitants who saw the land fertile and attractive. In malayalam local language “Cheranalloor” means “good village of Cheras”. Cheranalloor is surrounded by backwaters and brackish lagoons. Before the opening of Varapuzha bridge; Cheranalloor used to have a very busy ferry in NH66 depicting the importance of this place. As per the report published by the department of panchayats government of Kerala, 2025, the population is about 30,594 where male population is 15,157 and female population is 15,437. Cheranalloor used to be a busy ferry in NH66, but the coming of Varapuzha Bridge negated the importance of this place. The arecanut is the only significant trade in this area. The new national highway to the Vallarpadam container terminal from Kalamassery cuts Cheranalloor on NH66 forming a junction in the highway. It is considered as one of the biggest junctions in the city, makes a hotspot as it connects Edapally, Kalamassery, Aravur and Ernakulam. The Cheranalloor has 3 bus terminals such as Eloor, Mannamthuruth and Cheranalloor connecting Cheranalloor through Chittooor, Edapally and Palarivattom as it connects the Edappally. Cheranalloor Panchayat is one

of the closest panchayats to St. Teresa's College, and is also an area that is covered under the Teresian Rural Outreach Program (TROP).

WHY WE WANT TO STUDY AGING AT CHERANALLOOR PANCHAYAT

In the words of Kinsella "The term older population refers to persons ages 65 or older" (Kinsella, 2009, as cited in Sokolovsky, 2009). Older populations are commonly known as dependent age groups as they require support for basic needs such as food, clothing, medicine, shelter mental and physical support from independent groups.

According to gerontologists, aging has at least four dimensions. When we think of age, most of us think of chronological aging, which is the years since a person was born. Biological aging or the physical alterations that "slow us down" as we age and enter middle life, is a second dimension. For instance, blockages in our arteries or issues with our lungs could make breathing more challenging. The third dimension, psychological aging, describes the psychological alterations that come with aging, such as changes in personality and mental functioning. It is important for gerontologists to stress that biological or psychological age and chronological age are not necessarily synonymous.

People will have a more positive and pleasurable social aging experience in a culture that views aging positively than in one where it is viewed negatively. The sociological study of aging is crucial because it enables us to comprehend how social, economic, and political issues influence the aging experience.

The following justifies the significance of researching aging from a sociological angle;

1. Contributing to our understanding of society. Understanding the issues and processes associated with aging, as well as the society in which we live is facilitated by research on aging.
2. Knowing the age distribution of people will help governments and societies in making plans for upcoming social and economic issues.
3. Contributes to our understanding of the individual experience.
4. Numerous social elements, such as social support, health and public policies and programs, all have an impact on how each individual experiences aging.
5. Aids us in comprehending the changing reality.
6. The sociological study of aging helps us comprehend the new realities of aging, such as shifting borders between life stages, altering family relationships and changing retirement habits.
7. Elderly are a vulnerable section, so it was important for us to know whether government schemes like pensions reach all the elderly.
8. To find out the relationship between caregivers and elderly, and to know where the family members are still responsible for the care of the elderly.
9. What were the challenges that the elderly faced?
10. Are they getting basic needs (food, clothes, medicinal needs)
11. To know whether the approach of formal caregivers affects the elderly.
12. Did elderly prefer members of the family or others from formal agencies to be involved in their caring?
13. To find out whether the elderly were financially dependent or independent.

CHAPTER 2

REVIEW OF LITERATURE

Literature review mostly involved studies from the developed western countries therefore this review of literature cannot adequately address social realities in Kerala.

GENDER DIFFERENCES IN LONGEVITY

Women generally live longer than men, resulting in a higher number of grandmothers than grandfathers. Specifically, he highlighted sex differences in mortality rates, with women exhibiting longer life expectancy. This demographic trend is further underscored by the fact that women's longer lifespan contributes to a greater number of grandmothers. The implications of these gender differences in mortality rates and life expectancy are significant, particularly in terms of family relationships and caregiving roles. (Papalia, 2006, 146-240)

HEALTH AND AGING

In the work *ADULT DEVELOPMENT AND AGING* DISCUSSES physical health and aging. Regarding physical health changes with aging; the authors noted that physical health changes with aging are characterized by biological changes, decline in physical strength and endurance, changes in body composition and age-related sensory losses. Additionally, age-related diseases such as hypertension, diabetes, arthritis, and cancer are common among older adults. When it comes to physical activity and exercise; regular exercise is crucial for older adults, and the authors highlighted the importance of physical activity, benefits of exercise for older adults and exercise programs tailored for older adults. Regarding nutrition and aging; the authors discussed the nutritional needs of older adults, common nutritional deficiencies, and healthy eating habits for older adults. Changes in sleep patterns with aging, sleep disorders in older adults, and the

importance of addressing sleep issues were also addressed. The authors emphasized the importance of health promotion strategies, regular health check-ups, health screening tests and healthy lifestyle choices. Disease prevention and screening measures, including preventive care, screening tests, immunizations and vaccinations, were also discussed. With respect to specific physical health issues, the authors highlighted specific physical health issues affecting older adults, including osteoporosis, Alzheimer's disease, arthritis and cancer. (Papalia, 2006, 146-240).

RETIREMENT

That retirement can be a significant life change, requiring an adjustment period. The authors emphasized the importance of pre-retirement planning, including financial preparation and exploration of post-retirement activities. Factors contributing to retirement satisfaction include health and physical well-being, financial security, social support networks and leisure activities and hobbies. Papalia discussed the Disengagement Theory, which suggests that retirement involves gradual withdrawal from social roles, and also explored the Continuity Theory, which proposes that retirees maintain continuity with their pre-retirement lifestyle. Challenges and Opportunities in Retirement; addressed challenges such as ageism and stereotypes, social isolation and physical decline.

The authors also highlighted opportunities for personal growth, learning and exploration. They emphasized the importance of maintaining physical and mental health, building and maintaining social connections, and engaging in meaningful activities. Ageism and Mandatory Retirement; criticized mandatory retirement policies for perpetuating ageism and discriminating against older workers. Research suggests that older workers are often subjected to stereotypes and biases, leading to decreased opportunities and social isolation. Family member’s attitudes and

behaviors can also contribute to the social isolation of older adults. The retirement stage of elderly adults can be categorized into three stages: 1. Pre-retirement stage: This stage involves planning, anticipation and anxiety as elderly adults prepare for retirement. 2. Early retirement stage: During this stage, individuals undergo adjustment, exploration, and redefinition as they transition into retirement. 3. Late retirement stage: In this final stage, elderly adults experience reflection, acceptance, and closure as they come to terms with their life experiences and aging process (Atchley, 2006).

LIFE EXPECTANCY

Life expectancy varies by gender, with females generally outliving males. The life expectancy of females is higher than that of males within the elderly population. This disparity is reflected in the global demographics, where in 2009, elderly women outnumbered elderly men by 66 million worldwide. Furthermore, research has shown that the gender gap in life expectancy exhibits considerable variations between regions and time periods, with the gap narrowing or widening over time within each region.

SHOULD FAMILIES PROVIDE FOR THEIR OWN?

As individuals get older, they face a lot of challenges and most of them seek support from their families and friends. The vast bulk of care for the frail elderly, perhaps 80%, is furnished by families and other private individuals. But the American family is changing at the same time that American society is witnessing changes in the proportion and character of the aging population. To look after the elderly people, families are facing new challenges to give care and help them. Americans have a wealthy and extended family life for elderly people. Most of the elderly people in America are married and have adult children. According to the US Department of Health and

Human Services, Administration on Aging, more than two thirds of older noninstitutionalized people live in a family setting. This information shows an inaccurate image of old people as lonely. In America supporting elderly people is a part of their life cycle. Among married couples, a healthy spouse serves as the primary caregiver. If both the elderly people are weak or one of them has passed away, elderly people seek help from their adult children. Some patterns of caregiving over the lifespan are illuminated by the exchange theory of aging, which is based on the idea that interaction in social groups is based on reciprocal balance. Thus, parents care for children and spouses care for one another because they are motivated by both moral obligation and the knowledge that they can count on reciprocal help in times of difficulty (Moody,2010; Shanas, 1979). Caregiving in this generation has different levels of responsibility: For some it is a support for someone with Alzheimer; for others it is a weekly telephone call. Majority of women who belong to the age group of 45 to 54 years have to spend with caregiving obligation. In case of extreme dependency and frailty, the family members may be exhausted and it affects elderly people. The conditions have led gerontologists to speak of family caregivers as the "hidden victims" of the disease. But many caregivers will be ready to remain in their role for a long time. They never feel “burnt out”.

Moreover, social support, especially informal support to family or friends, can prove helpful for caregivers under stress. In addition, caregivers may benefit from respite care for dependent older people to allow the caregiver some time off (Moody, 2010,196; Klein, 1986). Mutual-aid groups, such as those sponsored by the Alzheimer's Association, have also proved effective for caregivers. In all of these cases, formal support services complement informal care, serving not to replace it, but to support it.

GERONTOLOGY

The population of older people is getting higher. It is necessary to study their mental and physical health in order to understand and differentiate the changes that are related to the aging process (Hooyman & Kiyak, 2010, 3). Gerontology is the study of the biological, psychological and social aspects of aging. Gerontologists study the aspects of aging to find the ways to enhance the life of older people and their families. Gerontologists view aging in terms of four distinctive processes that are examined throughout the book.

Aging can be understood in four distinct ways. Chronological aging is based on a person's years lived from birth, where a 75-year-old is chronologically older than a 45-year-old. Biological aging refers to the changes that reduce the efficiency of organ systems, such as the lungs, heart and circulatory systems. Psychological aging involves changes in sensory and perceptual processes, cognitive abilities (e.g., memory, learning and intelligence), adaptive capacity and personality, where individuals who adapt well to new situations are considered psychologically young. Finally, social aging refers to an individual's changing roles and relationships with family, friends and other informal support, both paid and within productive roles, and within organizations such as religious and political groups.

AGING

The process of aging starts from the moment of birth. Aging refers to the process of physical, aging, an individual has to go through different roles and status in the society. There is an age-grading system in the society which provides role and status to each age group. According to Social Gerontology, the human lifespan can be categorized into distinct stages, including toddlerhood (2-4 years), childhood (4-12 years), young adulthood (18-24 years), and old age (65+ years). Furthermore, older adults can be classified into three sub-groups: the young-old (65-74 years), the old-old (75-84 years), and the oldest-old (85 years and above). Interestingly, the experience of

aging is highly diverse, with most older adults residing with their families, while a small percentage live in institutional setting. In terms of economic security, some older adults receive pensions and investment income, while demographic profiles reveal that men over 65 are more likely to be married, whereas women of the same age group are more likely to be widows, highlighting the unique experiences of individual aging processes.

ACTIVE AGING

Elderly people are considered as weak, non-productive, ill and asexual. These are just stereotypes as most of the older adults actively participate in social activities. Older people pay a higher amount of their income for health care purposes. Less than 5% of the older population resides in old age homes. Gerontologists focus on developing public policies and programs to address their problems and the need for professionals trained in Gerontology is increasing day by day.

LIVING ARRANGEMENTS AND SOCIAL INTERACTIONS

The impact of the environment on human behavior is recognized by various disciplines. The change in characteristics of a person in an environment is modified by individual behavior. The environment affects older people, reducing their capacity to control their surroundings in undesirable settings. This perspective is useful for understanding frail older adult behavior more than healthier adults. As Lawton (1975,7) noted, this concept relates to "the theoretical upper limit of the individual to function in areas of biological health, sensation-perception, motives, behavior and cognition. Moreover, the environment is neither inherently good nor bad for older adults. People with Alzheimer's disease and other forms of dementia face cognitive deterioration, which makes them unable to realize their needs and the environment. Caregivers can adjust these patients'

environments by providing services and orienting devices to help them organize their day. The concept of life-space is the interaction between an elder's competence and their physical environment. It is defined as an individual who is expected to travel to perform an activity (Hooyman & Kiyak, 2011).

DEMOGRAPHIC DISTRIBUTION OF THE OLDER POPULATION.

The population became more urbanized with industrialization, and the percentage of people 65 and older in all population groupings decreased. In the 1960s and 1970s, a large number of people from rural areas relocated to urban development, raising their families and continuing to live in the neighborhoods after retirement. Older individuals are more likely to be left alone since they make more money than those in urban areas. The distance to social and medical services is higher in areas with lower housing densities. Many suburban communities are supporting transit schemes in response to the shifting requirements of their residents, elderly people need to give services such as shopping centers, and retirement housing alternatives.

GLOBAL PERSPECTIVES ON THE DEMOGRAPHY OF AGING

Population aging represents the triumph of public health, medical progress and economic development in overcoming the diseases and injuries that've limited human life expectancy for thousands of years. It is becoming increasingly clear that societal aging poses many problems influencing national security, the sustainability of families and the ability of nations and communities to provide resources for older citizens as well as affecting economic growth. Human population aging refers to an increase over time in the percentage of all existing individuals living at or after a certain age. Projections to 2030 indicate that the growth rate of elderly population in developing countries will continue to be much higher than that of today's industrialized countries.

Many countries will experience a boom in aging populations. In India, the overall population in 2030 is estimated to be 160 percent higher than in 2007. A bunch of studies lately are showing that getting older isn't really the main thing driving up health care costs. It turns out other stuff like how much money people are making, health insurance, new medical technology and even who's working in the healthcare field might actually matter more.Researchers have come to attribute the gain in human longevity since the early 1800's to a complex interplay of advancements in medicine and sanitation coupled with new modes of familial, social, economic and political organization (Sokolovsky, 2009, 13, 14, 23).

GENDER DIFFERENCES

Women tend to live longer than men in almost every corner of the globe. Although we see a higher number of male births compared to females worldwide, men generally face higher mortality rates at every age. This leads to a growing percentage of females at cohorts age, meaning that by the time people reach their forties or mid -forties, women often start to outnumber men in numerous countries. Plus, this female advantage continues to increase.

The differences in gender demographics among older individuals lead to significant variations in marital status. Generally, most older men are married. However, due to factors like women living longer than men, marrying older partners and being less likely to remarry after losing their spouse, a considerable number of older women in various countries find themselves widowed. In places where there isn't a structured social safety net, these older widows - often lacking education and financial reserves - form a particularly vulnerable group, depending on younger family members for their economic needs (Sokolovsky, 2009).

GENDERED NATURE IN CAREGIVING

Primary caregivers are generally adult children. They can also be partners or spouses, other family members, friends. This division of labour is mainly because of the high rates of widowhood among elderly. There is a high number in the male gender roles in caregiving, this shows the change in gender roles. We generally come across the female population who participate in caregiving more than men. Although this is changing gender roles there are still women who are the primary caregivers and kin keepers. An average woman is expected to spend more years in caregiving adults than taking care of her children.

From the feminist theory perspective, women predominate not only because they are socialized to be carers, but also because society devalues a women's responsibility in their homes as well as work. This shows that women earn less than men and comes to a conclusion that they are more willing to give up paid employment to provide care. Widowed women are the primary caregivers and unmarried men are the secondary caregivers in a situation where one of the partners is still alive. The daughters show more participation than the sons. The care recipient involves trust, rapport, compassion, comfort, communication and a sense of psychological responsibility from women caregivers. (Hooyman & Kiyak, 2011).

CHANGING FAMILY STRUCTURE

Changes in fertility and mortality rates impact family dynamics and shape how society organizes care for older adults. As mortality rates decrease, the likelihood of multiple generations living in a family has increased.

Non-married women are less likely than non-married men to have accumulated assets and pension wealth for use in older age: older men are less likely to form and maintain supportive

social networks (Antonucci & Akiyama, 1995). Childlessness has significant implications for future caregiving, yet it remains a largely overlooked topic. Understanding different types of childlessness, such as voluntary, involuntary "coerced", involuntary "natural", and loss of children due to HIV/AIDS, will become increasingly important as current and future cohorts of middle-aged people reach older age (Kreager & Schroder-Butterfill, 2004). Research has highlighted the structural vulnerability of older people in certain societies, such as the Minangkabau of West Sumatra, Indonesia (Indrizal, Kreager, & Schröder-Butterfill, 2004). As the population ages, it is crucial to consider the care arrangements for childless individuals, particularly in societies with limited social support systems.

LIVING ARRANGEMENTS AND SOCIAL SUPPORT

The housing situations of elderly individuals indicate the type of accomodation necessary, whether it is standard or specifically designed or modified. Additionally, they highlight the necessity for other community support or institutional long-term care.

Studies across various wards constantly indicate that older adults, particularly those who live independently, favor staying in their own residences and neighbourhoods. This inclination is supported by several factors, including increased life expectancy, the growth of pension schemes and other social benefits, higher rates of home ownership, the availability of housing suitable for the elderly and a heightened focus in many nations on providing care within the community.

Long-term care for older adults includes a variety of support options. These range from home nursing and helpers to community care, assisted living and residential facilities like long-stay hospitals and similar institutions. (Sokolovsky, 2009, 26-27).

AGEING; A CONCEPTUAL FRAMEWORK

Aging is a complex, lifelong process that involves physical, psychological and social changes. It plays a significant role in human societies, revealing both biological changes and evolving cultural and societal norms. There are different types of aging, including universal aging (common changes experienced by all) and probabilistic aging (changes that may affect some individuals, like diseases). Aging can be viewed through various lenses, such as social aging (cultural expectations of aging) and biological aging (physical changes over time). Furthermore, aging can be influenced by recent experiences (proximal aging) and early life events (distal aging), like childhood illnesses. Importantly, chronological age does not define an individual's mental and physical abilities, as people of the same age can exhibit significant differences. Population ageing can be attributed to three key factors; Migration, increased life expectancy (which has resulted in a lower death rate) and a decline in birth rates. The needs of older individuals often differ from those of the younger population, not only in terms of societal and government support but also in their values and perspectives. Moreover, older adults tend to be more active voters, while in some countries, younger individuals may be prohibited from casting their ballots. As a result, the elderly often wield greater political influence. (Mishra, 2014, 13-14).

EARLY OBSERVATIONS

The first formal studies of ageing appear to be those of Muhammad ibn Yusuf-al-Harawi (1582) in his book 'Ainul Hayat', published by Ibn Sina Academy of Medieval Medicine and Sciences. This book is based solely on ageing and its related issues (Mishra, 2014, 14).

HEALTHCARE DEMAND

The literature suggests that addressing the anticipated surge in demand for long-term care in aging populations requires a multifaceted approach, which can be categorized into four primary areas:

enhancing system performance, reimagining service delivery, providing support for informal caregivers, and adjusting demographic factors. As individuals age, they become increasingly susceptible to a range of health issues, including mental health challenges and physical ailments, with dementia being a particularly significant concern (Mishra, 2014).

COGNITIVE EFFECTS

Early research into how cognitive abilities change with age often indicated a decline in intelligence among the elderly. These studies were primarily cross-sectional, meaning they provided a snapshot rather than following the same individuals over time, which raises questions about whether the results were influenced more by the specific cohorts studied rather than reflecting a genuine aging effect. On the other hand, longitudinal studies may also face complications due to participant's previous experiences with the tests. Intelligence can diminish as we get older, but this decline isn't uniform; it can differ based on the type of intelligence. In fact, some individuals may find their cognitive abilities remain stable for much of their life, with a noticeable drop occurring only as they approach the end of their years. (Mishra, 2014, 20).

COPING AND WELL-BEING

As people age, they face various challenges that can be stressful. However, certain factors can help them cope better. These include having a strong support system, finding comfort in religion or spirituality, staying actively engaged in life and having a sense of control over one's life. These elements can help individuals navigate difficult situations and age more successfully. Social support and the sense of personal control likely stand out as the two most significant factors influencing the well-being, morbidity and mortality rates in adults. Furthermore, aspects such as social relationships and overall health are additional elements that can contribute to enhancing well-being and quality of life among the elderly. Residents in various areas of the retirement home

have shown a decreased risk of mortality, along with improved alertness and self-assessed health, in the section where they had more control over their surroundings. However, it appears that this personal control might have a limited effect on certain specific health metrics. Social control, which encompasses individual's perceptions of their influence on social relationships, serves as a moderator variable, in the relationship between social support and perceived health among the elderly. This dynamic may positively impact coping mechanisms within this demographic (Mishra, 2014, 20-21).

RELIGION

Religion really plays a big role for older folks as they deal with life's challenges in their later years. It seems to pop up way more often than other ways of handling stuff as they get older.

(Mishra, 2014, 21).

SUCCESSFUL AGEING

Successful aging is a concept that combines psychology and sociology to understand how society interacts with individuals throughout their lives. It focuses on the later years of life and involves three key elements: maintaining physical health, staying mentally and physically active, and fully engaging in life's experiences. Some people prefer the terms "healthy aging" and "spiritual aging" instead of "successful aging" because they feel it makes aging seem too competitive. Overall, successful aging is about living a healthy, active and fulfilling life as you age (Mishra, 2014, 22).

POWER OF POSITIVE THINKING

There are two main ways to define successful aging. The first way is about being as healthy and active as possible, avoiding disease and disability and staying engaged with life. This means trying

to stay youthful and healthy for as long as possible.

The second way, defined by Rowe and Kahn, is about delaying illness and disability until the very end of life, and then passing away quickly and without suffering. This perspective is hopeful and realistic, and emphasizes the importance of individual responsibility and initiative in achieving successful aging.

MENOPAUSE AS A BICULTURAL EVENT

This review examines the biocultural perspectives on menopause, focusing on cross-cultural variations in experiences and societal attitudes. The study contrasts menopausal experiences between Western and non-Western cultures, highlighting significant differences in symptom reporting and cultural implications.

MENOPAUSE IN WESTERN CULTURES

Research indicates that women in Western societies often report more symptoms associated with menopause compared to their non-Western counterparts. This heightened symptomatology is partly attributed to the cultural perception of menopause as a negative life transition. In Western contexts, menopause is sometimes linked to a decline in social status and a perception of aging as unfavorable. These societal attitudes can amplify the psychological and physical challenges associated with menopause.

MENOPAUSE IN NON-WESTERN CULTURES

In contrast, non-Western cultures often perceive menopause more positively. For instance, studies on Mayan women reveal minimal reporting of menopausal symptoms. This difference is associated with a cultural shift that grants women greater freedom and elevated social status post-childbearing

years. In such societies, menopause is not viewed as a loss but as a transition to a respected and liberated stage of life. These cultural norms significantly influence women's attitudes, resulting in fewer reported symptoms and a generally more positive experience. (Yewoubdar Beyene, 2007, 94).

BIOCULTURAL INTERPRETATIONS

The literature suggests that the interplay between biological and cultural factors shapes the menopausal experience. While biological changes are universal, their interpretation and impact are mediated by cultural attitudes and societal roles. Western societies often emphasize the biomedical model of menopause, focusing on symptoms and treatments, whereas non-Western cultures integrate menopause into a broader social and cultural framework (Beyene, 2007, 94).

LOSS OF SELF IDENTITY AND WORTH

The study of "Aging in the 21st Century: A Sociological Analysis of Senior Citizens in the ‘Pakalveedu’," investigates the impact of Pakalveedu as a social institution for the elderly, revealing that 99% of participants do not experience a loss of self-identity or worth, viewing it instead as a supportive environment that enhances their social engagement and emotional well-being. Gender and Self-Identity A significant majority (99.3%) of participants assert that Pakalveedu does not detract from their self-identity or self-worth. Only 0.7% (2 respondents) expressed an alternative view, suggesting that Pakalveedu is predominantly regarded as a supportive environment. This perception is consistent across genders, with both male and female respondents largely dismissing the idea that Pakalveedu undermines their self-identity. Education and Self-Identity Among all levels of education, nearly all participants (99.2%) do not perceive Pakalveedu as a setting in which they lose their self-identity. Only 0.8% (2 respondents) raised

concerns regarding a loss of self-worth. The level of education does not appear to significantly affect these perceptions, indicating that Pakalveedu fosters a sense of self-identity irrespective of one's educational background.

CRAMPED AND OVER CROWDED CONDITION

This study explores the experiences of elderly individuals at 'Pakalveedu' (day care centers) during the 21st century, with a particular emphasis on the challenges of limited space and overcrowding. A significant majority of respondents (81%) indicated that Pakalveedu centers do not experience cramped and overcrowded conditions. This points to a general perception that these centers offer sufficient space. Community Engagement is the study that highlights that Pakalveedu centers are frequently established by local community or religious organizations instead of government programs. When services are supplied by beneficiaries, they are more likely to ensure that there is adequate space and proper infrastructure.

LIFE HAS BECOME MORE MEANINGFUL AFTER COMING TO "PAKALVEEDU"

Pakalveedu, an adult day care center, on the lives of senior citizens. The central finding is that 94% of respondents reported their lives became more meaningful after joining Pakalveedu. This suggests the center effectively combats loneliness and provides enriching experiences for its participants through emotional support, activities and peer interaction**.**

RESPONDENTS FEEL MORE INDEPENDENT AT 'PAKALVEEDU' THAN AT HOME.

This segment of the research references a survey published in "The Telegraph" (2016), which revealed that a greater number of individuals express a fear of losing their independence in old age rather than a fear of death. This finding underscores the significance of autonomy and freedom

among elderly individuals. The study subsequently correlates this outcome with their own data, indicating that 91% of participants report experiencing increased freedom and independence at Pakalveedu compared to their homes. This is attributed to the absence of constraints and the presence of a supportive peer community. This literature review adeptly frames the study's conclusions within a broader context of the concerns that seniors have regarding their independence.

RESPONDENTS FEEL SECURE AT 'PAKALVEEDU'

The study explores the sense of security among elderly individuals attending "Pakalveedu" (day care centers). The primary finding indicates that a significant majority (92.9%) of participants report feeling secure in these centers. This sense of security is attributed to the emotional support and understanding they receive from their peers. These results suggest that Pakalveedu offers a vital social environment in which seniors feel acknowledged and comprehended, in contrast to their experiences at home.

RESPONDENTS 'DECISIONS AND FEELING OF COMFORT IN 'PAKALVEEDU'

Elderly residents report feeling empowered to make choices about their routines. Centers don't enforce strict schedules, allowing residents to manage their time. Despite potential cognitive decline, older adults can still make satisfactory decisions in their daily lives. Overall, "Pakalveedu" centers foster a sense of independence and comfort for their residents.

PERSONALIZED LIFESTYLE AT 'PAKALVEEDU'

When it comes to elder care, personalizing the experience at facilities like 'Pakalveedu' is key to improving the lives of senior residents. Research shows that tailored care can boost emotional

well-being, lessen feelings of loneliness, and help with cognitive abilities (Smith et al., 2018). In fact, a survey found that 62.2% of participants strongly believe that individual lifestyles at 'Pakalveedu' should be customized, with regular visitors (65.4%) being the most supportive of this idea. Studies also suggest that connecting directly with seniors helps acknowledge their unique needs (Patel & Gupta, 2021). Looking at global examples from countries like Japan and Sweden, we can see that personalization leads to healthier outcomes (Takahashi ,2020). All in all, these insights highlight how important it is to adapt elder care programs to match personal preferences for a better quality of life**.**

DECISION-MAKING RIGHTS OF SENIOR CITIZENS IN 'PAKALVEEDU'

It's really important for senior citizens to have the power to make choices about their lives; it significantly boosts their well-being. Studies show that when older adults have autonomy in decision-making, they tend to feel happier and healthier (Smith et al. ,2019). Supporting autonomy in senior care facilities not only gives residents a sense of dignity and control but also enhances their overall life satisfaction (Williams & Carter, 2022).

THE IMPORTANCE OF PHYSIOTHERAPY IN 'PAKALVEEDU'

Physiotherapy is essential for keeping our senior citizens healthy and active. Studies have shown that regular physiotherapy can help reduce frailty, manage ongoing pain and enhance overall independence among older adults (Smith et al.,2020). A recent survey revealed that 70% of participants strongly believe there's a need for a physiotherapy center in 'Pakalveedu', underscoring the benefits it could bring to well-being. While yoga is offered at some locations, many see physiotherapy as a valuable supplement that can more effectively address physical challenges. These insights align with other research that highlights the crucial role of

physiotherapy in elderly care, as it promotes longer, healthier lives and improves quality of life (Brown &Taylor ,2021).

‘PAKALVEEDU’ AND QUALITY OF LIFE

Quality of Life (QOL) is shaped by both society and individuals, affecting the well-being of senior citizens. Research shows that living in community settings boosts social connections and mental health for older adults (Smith et al., 2020). In a recent survey, an impressive 97.4% of participants said that ‘Pakalveedu’ has improved their quality of life. Residents are experiencing greater social interactions, higher energy levels and a fresh sense of purpose, even as they navigate the challenges of aging. These findings support previous studies that highlight the importance of social engagement and support from peers in enhancing the mental and emotional well-being of seniors (Brown & Carter, 2021).

UNDERSTANDING THE APPEAL OF THE ‘PAKALVEEDU’ CONCEPT

‘Pakalveedu’ centers help maintain independence and dignity while encouraging community involvement and providing support to alleviate feelings of loneliness and depression (Aday, 2003). One of the most appreciated features of Pakalveedu is its capacity to promote interactions among peers, offering emotional support and meaningful ways to engage. This aligns with earlier research that highlights the importance of social environments in improving the well-being of seniors (Johnson & Walker, 2022).

UNDERSTANDING THE STIGMA SURROUNDING ‘PAKALVEEDU’

The negative views about ‘pakalveedu' often come from general societal attitudes towards institutional care, which many link to feelings of being abandoned or neglected, especially

regarding the elderly (Anderson & Dabelko-Schoeny, 2010). These perceptions are shaped by changes in society that have weakened traditional family roles. Despite these worries, ‘Pakalveedu’ is viewed as a caring environment rather than a place of neglect, helping to challenge the common misconceptions about facilities for the elderly.

‘PAKALVEEDU’ IS ESSENTIAL IN TODAY’S SOCIETY

As family structures start to break down and more elderly individuals depend on others, we face some real challenges (Aday, 2003). Places like Pakalveedu give older adults a chance to stay independent, connect with others and look after their emotional health. The research shows that these centers not only provide purpose but also help reduce feelings of loneliness and support graceful aging. By building a caring community, Pakalveedu allows seniors to adjust to the changes in society while still feeling valued and respected.

The success of ‘pakalveedu' stems from creating a space where seniors can connect with one another, free from everyday stressors. It acts as a powerful means to enhance the quality of life for seniors, bringing them joy, hope and tranquility. Additionally, Pakalveedu is viewed positively and serves as a meaningful and supportive environment for the elderly.This center is designed to encourage learning, social interaction and a sense of self-worth among the elderly. Through a range of programs, Pakalveedu effectively discovers and cultivates talents in singing, drawing, writing, dancing and playing musical instruments, helping seniors stay active and valued within their communities. Research indicates that being involved in activities like debates positively influences seniors' social, mental and physical health (Novek et al., 2013). Although some discussions at the center are scheduled, many happen naturally in everyday conversations, helping seniors stay connected to societal topics.

SCHEMES AND POLICIES OF THE CENTRAL GOVERNMENT FOR ELDERLY

NATIONAL POLICY ON SENIOR CITIZENS 2011

This policy guarantees an honorable final year, as well as physical and financial security, health care and housing. The strategy called for state assistance to guarantee older people's needs for housing, food, and health care as well as their equitable share in development, protection from exploitation and abuse, and access to resources to enhance quality of life.

VAYOSHRESHTHA SAMMAN AWARD FOR THE AGED

Every year on October 1st, the world observes International Day of the Elderly. The Ministry of Social Justice and Empowerment of the Government of India has been celebrating this day by arranging a number of events and providing the Vayoshreshtha Samman Award to notable senior citizens, organizations and Panchayats. This is done in order to honor the contributions made by senior citizens who are older, to raise public awareness of the issues and needs facing older people, and to reaffirm the government's commitment to supporting the needs of the elderly. There are a total of ten awards, divided into several categories.

SOCIAL SECURITY SCHEMES FOR ELDERLY

1. Central govt. in 1999 announced National Policy on Older persons for looking after the wellbeing of older people.
2. Government also brought RASHTRIYA VAYOSHRI YOJANA which aims to fund a senior citizen welfare fund. This provides funds to BPL senior citizens, people with an income of less than ₹1,500 per month, or those with age-related problems.

3. ELDERLINE it's a helpline for senior citizens (14567). This was setup by the ministry for addressing the problems faced by old age in 2021.
4. In 2021, the Government of India also launched the Senior Care Aging Growth Engine to encourage innovative startups focused on elderly care. Under this initiative, innovative programs are identified, promoted and provided with support of ₹1 crore per innovation.
5. Atal Vayo Abhyuday Yojana is another program aimed at providing information and educating families, schools and colleges for a better understanding of the aging process.
6. Rashtriya Vayoshri Yojana is a government scheme that provides free assistive devices like hearing aids, wheelchairs and walking sticks to BPL senior citizens with age-related disabilities, improving their mobility and quality of life.

7. **POLICIES AND SCHEMES OF THE STATE GOVERNMENT FOR THE ELDERLY KERALA STATE OLD AGE POLICY 2013**

One of the first States to implement a policy for elderly people was Kerala. In 2006, the first policy document was released. A new State Old Age Policy was released in 2013 after the government reviewed the Old Age Policy from 2006. Ensuring maximal welfare facilities for all elderly individuals in the State was the policy's goal. The State government will file a police report against individuals who take advantage of the elderly.

AGE FRIENDLY PANCHAYAT SCHEMES

The Kerala Social Justice Department's age-friendly Panchayat is a recent project linked to the State Old Age Policy of 2013. The program's goal is to transform every panchayat in the state into one that is age-friendly in order to guarantee senior citizens' quality of life, participation and good health.

CHAPTER 3

METHODOLOGY

Research is a systematic search for truth. This study focuses on the socio-economic profile of elders particularly at Cheranalloor Grama Panchayat with the focus on their demographic characteristics, economic status, social support systems and access to health care services. The primary data has been collected from older adults above 60 years of age. The purpose of the study is to understand the state of elderly people to inform evidence-based policy and programmatic interventions that address the identified needs and challenges of the elderly population.

TITLE OF THE STUDY

A Study on socio-economic profile of elderly people particularly at Cheranalloor Grama Panchayat

STATEMENT OF THE PROBLEM

Elderly population is a growing demographic worldwide. As people age, they often face significant social, economic and health challenges that can impact their overall well-being. The elderly population in rural areas like Cheranalloor Grama panchayath may face significant social and economic challenges. There is a lack of comprehensive data on the state of elderly individuals in this region making it difficult to design and implement effective policies and programs to support their needs. This study aims to address this knowledge gap and explore the socio-economic profile of elderly community in this region.

OBJECTIVES OF THE STUDY

GENERAL OBJECTIVE;

To investigate and analyze the socio-economic profile of elderly individuals residing in Cheranalloor Grama Panchayat with the focus on their demographic characteristics, economic status, social support systems and access to health care services.

SPECIFIC OBJECTIVES:

1. To examine the availability and profile of caregivers of the elderly in Cheranalloor Grama Panchayat.

2. To understand the state of health and wellbeing of the elderly in Cheranalloor and the availability, accessibility and adequacy of healthcare services at Panchayat.

3. To check the accessibility and availability of transportation systems for elderly individuals, evaluating their overall usability.

4. To measure the level of digital literacy of older adults.

5. To assess the role of Panchayat in aiding the elders and to suggest further welfare measures.

CLARIFICATION OF CONCEPTS

1. ELDERLY:

THEORETICAL DEFINITION-

According to United Nations Principles for Older Persons ‘older person is someone who is 60 years or older’ (United Nations, 1991).

OPERATIONAL DEFINITION;

For the purpose of this study, ‘Elderly’will be defined as individuals included in the voters list of Cheranalloor Grama Panchayath who are aged 60 years and above.

2. LITERACY:

THEORETICAL DEFINITION

Literacy is the ability to read and write with understanding and to use these skills in daily life (UNESCO, 1958).

OPERATIONAL DEFINITION

Ability of older people residing within Cheranalloor Grama Panchayath to read and understand written texts like signs, labels and instructions and the ability to write coherent and legible texts like one's names, address and simple messages.

3. DIGITAL LITERACY:

THEORETICAL DEFINITION

Digital literacy is the ability to understand and use digital technologies, such as computers and the internet. (Gilster, 1997)

OPERATIONAL DEFINITION

Ability of the elderly of Cheranalloor to independently use technological devices like mobile phone, smartphone or computer to some extent to perform basic tasks, including: making and receiving calls, sending and receiving messages, accessing and using social media platforms to engage with others.

3. EMPLOYMENT:

THEORETICAL DEFINITION

Employment is the state of being engaged in productive work, generating income and contributing to economic growth. (Smith, 1776)

OPERATIONAL DEFINITION

Engagement of elderly adults in Cheranalloor Grama Panchayath in any regular or irregular schedule of work hours, including full-time, part-time, temporary or contract work, in the governmental, private, business or non-profit sector and receiving wages, salary or other forms of compensation for work performed.

4. SOURCE OF LIVELIHOOD:

THEORETICAL DEFINITION

Source of livelihood/income refers to the activity or entity that generates earnings, wages, salaries, profits or other forms of compensation for an individual or household. (International Labour Organization, ILO).

OPERATIONAL DEFINITION

Income source refers to the specific origin or means by which elderly individuals residing in Cheranalloor receive financial resources, including pension, retirement benefits, social security, investments, rent/property income, part-time job/self-employment, family support, government schemes and other sources, which collectively enable them to meet their economic needs.

5. POSSESSION OF ASSETS:

THEORETICAL DEFINITION

Anything of value that is owned or controlled by an individual, household or entity, including tangible assets such as land, buildings, vehicles and equipment, as well as intangible assets such as patents, copyrights and trademarks (World Bank,2018).

OPERATIONAL DEFINITION

Any tangible or intangible item of value, whether possessed or not, by panchayath residents, specifically the elders, including immovable assets (land, houses, buildings), movable assets (vehicles, livestock, furniture), financial assets (savings, investments, pensions), intangible assets (patents, copyrights, trademarks) and other assets (jewelry, valuables).

6. MARITAL STATUS:

THEORETICAL DEFINITION

Marital status refers to the legal or social status of an individual in relation to marriage, including never married, married, divorced, widowed or separated. (United Nations, 2015)

OPERATIONAL DEFINITION

The Cheranalloor native elder individual's current legal or social status in relation to marriage, such as; individual who has never been married, individual currently married and living with their spouse, individual previously married but now divorced, individual previously married but now widowed due to spouse's death, individual married but living apart from spouse or cohabiting individual living with partner in committed relationship, but not married.

7. CAREGIVER:

THEORETICAL DEFINITION

Caregiver means an individual who provides primary care and support to an elderly person or a person with disability, including assistance with daily living activities, managing finances and providing emotional support.

OPERATIONAL DEFINITION

A person providing paid or unpaid care for elders in the households of Cheranalloor Panchayath, including assistance with daily living activities, managing finances and providing emotional support and may be a spouse, adult child, family member (other), friend, professional caregiver, senior living staff, or others (e.g , neighbour , volunteer).

9. SOCIAL GROUPS:

THEORETICAL DEFINITION

Social or communal groups refer to a collection of individuals who share common characteristics, interests or identities and interact with one another on a regular basis, often within a specific geographic or cultural context. (United Nations, 2019).

OPERATIONAL DEFINITION

Social or communal groups refer to a social , religious or spiritual group formed either by elders or for elders in Cheranalloor Panchayath , including elderly associations , senior citizen clubs, religious organizations (e.g. , church , temple , mosque), spiritual groups (e.g. , meditation , yoga) community centres, volunteer groups and other groups (e.g. , hobby , clubs , support groups

), where they are able to socialize and form social networks, and may or may not collectively participate in group activities, celebrations or social functions including therapy, counselling, psychiatric care, medication management, support groups, online therapy, and hotline services.

10. SUPPORT SYSTEMS OR ASSISTANCE FRAMEWORK:

THEORETICAL DEFINITION

A support system encompasses the various levels of environmental influences, including microsystems (family, friends), mesosystems (community, organizations), ecosystem (societal institutions), and macrosystems (cultural norms, policies), that provide support and resources to individuals (Bronfenbrenner, 1979).

OPERATIONAL DEFINITION

A network of services, resources, and accommodations that enable older adults to maintain their independence, health, and well-being, including accessibility accommodations like wheelchair accessibility, sign language interpretation, audio descriptions, and social services like home care, transportation, adult day care, respite care, other services such as counselling and support groups within Cheranalloor Grama Panchayath.

11. MEDICAL HEALTH CAMP:

THEORETICAL DEFINITION

A medical health camp is a temporary or mobile healthcare delivery system that provides comprehensive and accessible medical services, including preventive, curative, and promotive

care, to marginalized, underserved, or disaster-affected populations, with the goal of improving health outcomes, reducing health disparities, and promoting health equity.

OPERATIONAL DEFINITION

A temporary or mobile healthcare delivery system conducted within or outside Cheranalloor Grama Panchayath, under the supervision of Panchayath officials, providing comprehensive medical services, including medical consultations, diagnostic tests, medication distribution, and health education and awareness, targeting residents of the same Panchayath.

12. TRANSPORTATION:

THEORETICAL DEFINITION

Transportation refers to the movement of people, goods, or services from one place to another, facilitated by various modes, such as land, water, air, or digital networks, with the goal of connecting individuals, communities, and economies, and promoting social, economic, and environmental development.

OPERATIONAL DEFINITION

A system of moving people or goods from one place to another, accessible and available to residents of the panchayath through various modes such as public transportation (buses, trains, etc. , private transportation (cars, auto rickshaws, etc.) , and non-motorized transportation walking, cycling, etc.) , characterized by type of transportation used, frequency of use (daily, weekly, monthly, or rarely) , accessibility (availability within walking distance or with assistance), and

barriers to use (physical limitations , financial constraints , lack of accessibility , or other reasons), specifically for the elderly .

RESEARCH DESIGN

The study employed a mixed method approach integrating both quantitative and qualitative methodology to provide a comprehensive understanding of the research phenomenon.

UNIVERSE

The universe of this study involves elderly adults, aged 60 years and above, who are permanent or non-permanent residents currently residing in Cheranalloor Grama Panchayath, Kerala, India.

SAMPLE

Sample consists of a total of 65 elderly individuals, aged 60 above residing in Cheranalloor Grama Panchayath for the study.

SAMPLING TECHNIQUES

A random sampling technique, specifically lottery method, was employed to select the wards from the panchayath that would comprise the study sample. In this way, wards 10 and 11 were selected randomly for the purpose of this study. Following this, the study used snowball sampling to recruit elderly participants starting with referrals from ward members of 10 and 11 and expanding through participant social networks.

The study aimed to select elderly individuals from ward 10 and 11 of the panchayath using simple random sampling based on the voters -lists, employing the lottery method for selection of wards. However, challenges such as the geographical spread of the wards, lack of clarity in the

address list, limited support from local contacts, and time constraints made it difficult to identify eligible individuals. To address these issues and ensure the sample remained within ward 10 and 11, snowball sampling was also used, where initial respondents helped identify other potential participants. his approach was particularly useful in cases where ration cards or other documents were unclear, and when individuals were unsure about their ward affiliation. Snowball sampling thus helped overcome the limitations of the sampling frame and facilitated better identification of eligible participants within the target wards.

TOOL FOR DATA COLLECTION

An interview schedule has been utilized for relevant data collection. Primary observation has also been employed.

DATA COLLECTION

Data collection was done from October 15 to December 4,2024. The study's respondents included elderly individuals (aged 60 and above) residing in Cheranalloor Grama Panchayat. either permanently or temporarily, as well as their formal and informal caregivers, who willingly participated and provided relevant information for the research.

The survey revealed insights into the lives of elderly individuals, highlighting both their challenges and sources of happiness. Despite initial hesitation from some participants, particularly those living alone, the majority welcomed the survey and shared their experiences. Key findings included the importance of social and family life, daily life and community support in contributing to their overall sense of contentment and well-being. However, concerns regarding inadequate benefits and reluctance to participate in surveys indicate areas that may require further attention. Our interactions revealed that long-term resident families in the panchayat often exhibited hostility towards newer families, making it challenging for them to establish social connections. This

dynamic can lead to social isolation among elderly individuals, who rely heavily on neighbors for interaction and mobility, highlighting the need for community-building initiatives to foster inclusivity and stronger social ties.

A retired postwoman, living alone after the loss of her son and husband, received formal caregiving support, but struggled to adapt to the varying tastes, attitudes, and behaviors of different caregivers, leading to a deep sense of loss and longing for emotional warmth and personal connection.

The responses received provided valuable insights into the lives of elderly residents, who despite physical limitations, expressed contentment with their lives due to familial connections and friendships. However, concerns over partiality in resource distribution and frustration with government scheme implementation emerged as recurring themes, highlighting systemic issues that need to be addressed.

The survey provided insights into the lives of elderly individuals, their well-being, and experiences with government welfare programs, revealing varied responses that highlighted both positive and negative experiences. The majority of respondents actively participated, sharing valuable insights into their daily lives, with most expressing contentment due to family support and social engagement. However, limitations in data validity arose due to potential influence from family members, and challenges included initial hesitation, misconceptions, and hostile encounters. Despite these obstacles, the survey yielded important findings, emphasizing the need for better communication, trust-building measures, and increased awareness about government policies to improve participation and effectiveness in future surveys.

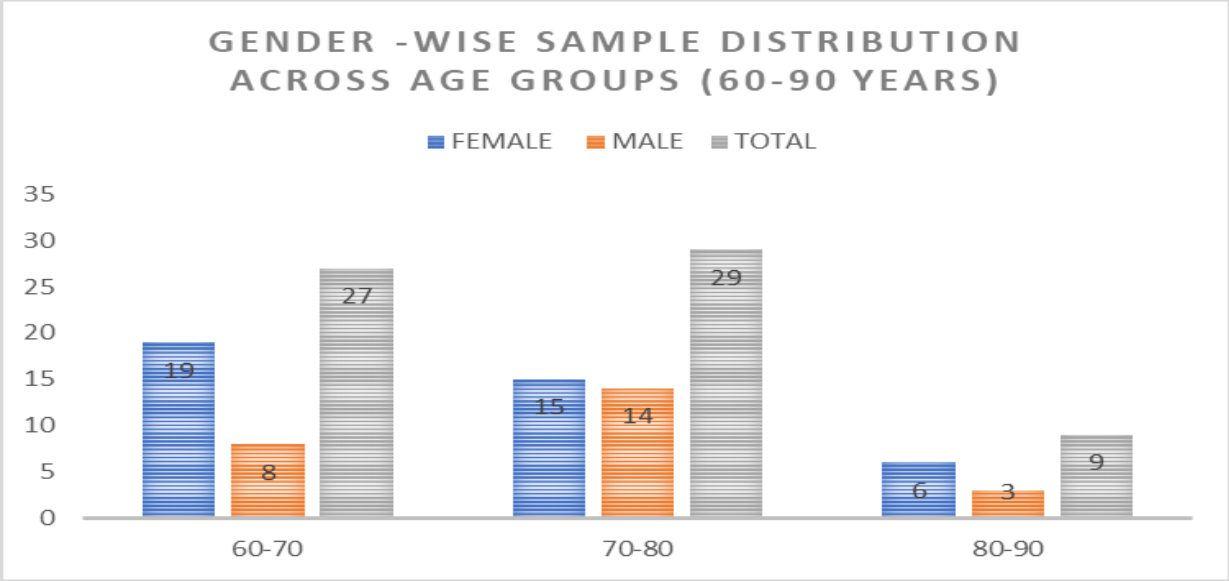
CHAPTER 4

FINDINGS AND ANALYSIS

This section presents the key findings drawn from the investigation into the socio- economic profile of the older adults in Cheranallor grama Panchayath, which explores the demographic, economic and social factors of them and its analysis. Furthermore, implications of these findings for future policy development and elderly welfare are discussed. The findings of this study may provide actionable recommendations that can facilitate continued growth and improvement, which is intended to serve as a model for rural development in their vulnerable community protection, not only within the country but globally, inspiring and guiding other rural communities towards a path of positive transformation and growth.

The sample population for this study consisted of 65 elderly individuals, aged 60 and above, residing in Cheranalloor Grama Panchayat. This sample was selected to gain in-depth understanding of the socio-economic profile, experiences, and challenges faced by elderly individuals within this specific geographic context, thereby providing nuanced insights into the lives of this vulnerable population.

FIG NO 4.1 GENDER-WISE SAMPLE DISTRIBUTION ACROSS AGE GROUPS (60-90 YEARS)



In the surveyed samples of 65 respondents, the number of females is higher than the number of males. The distribution is as follows:

60-70 years: 19 females, 8 males

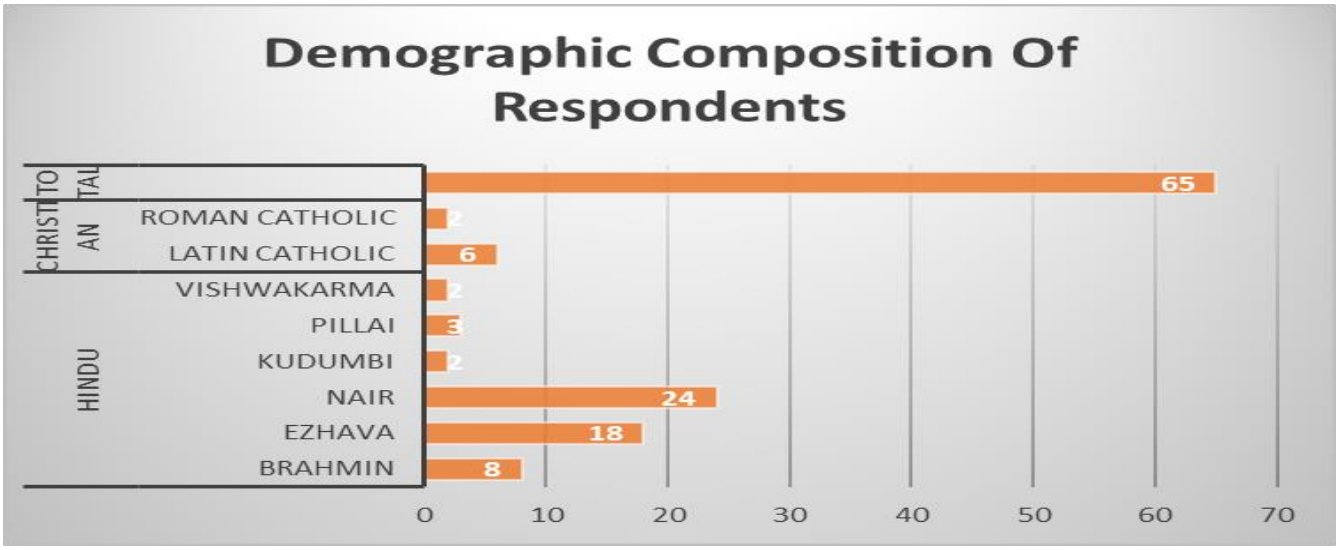
70-80 years: 15 females, 14 males

80-90 years: 6 females, 3 males

Overall, females (40) outnumber males (25) in the total surveyed population. The higher number of females in the elderly population compared to males among our surveyed sample of 65 can be compared to global trends where females have a higher life expectancy than males. This can be attributed to biological factors such as women's generally longer life expectancy, a stronger immune system that makes them more resistant to infections and age-related diseases, and lower risk-taking behaviors such as reduced consumption of alcohol and smoking. Additionally, females

have a lower incidence of certain fatal conditions, such as heart disease and liver disease, which contribute to their longer lifespan.

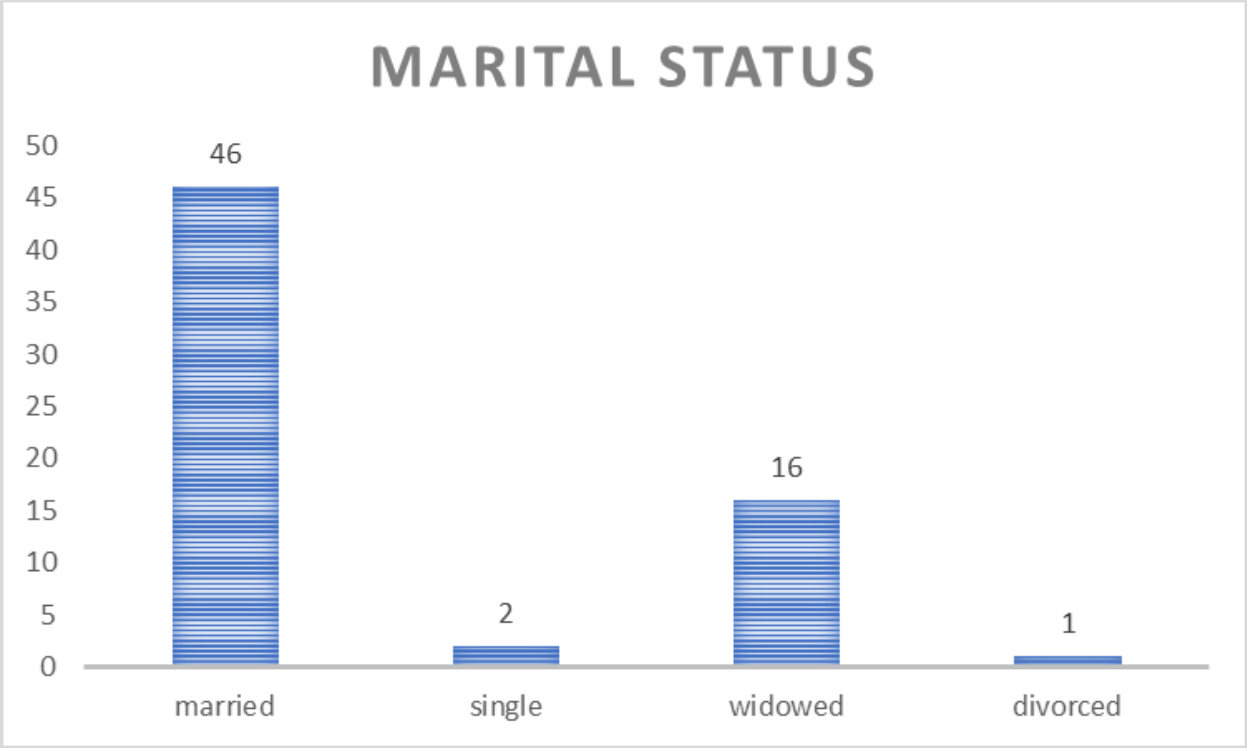
FIG NO 4.2 DEMOGRAPHIC COMPOSITION OF RESPONDENTS



The demographic composition of elderly adults in Cheranalloor grama panchayath reveals that Hindus make up the majority of respondents (57 out of 65). Christians account for a smaller portion (8 out of 65). The Nair community has the highest representation (24 respondents, 42.1% of Hindus). Ezhavas also form a significant portion (18 respondents, 31.6% of Hindus). Brahmins (8 respondents, 14%) and smaller groups like Pillai (3), Kudumbi (2), and Vishwakarma (2) together make up the remaining 12.3%. Among Christians, Latin Catholics (6respondents) are the majority, while Roman Catholics (2 respondents) form a smaller share. The sample is predominantly Hindu, with a strong presence of Nair and Ezhava communities.

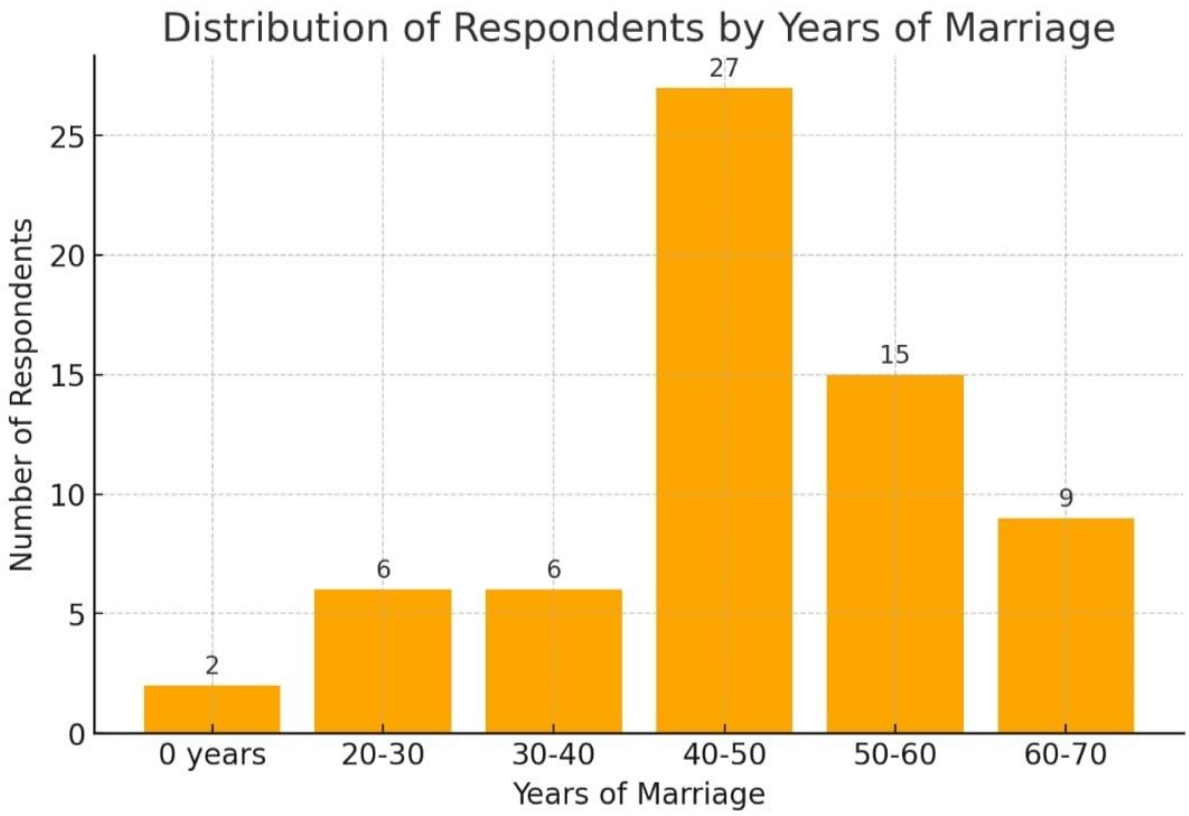
The Christian population is relatively small, and Latin Catholics outnumber Roman Catholics. The Kudumbi and Vishwakarma communities have minimal representation.

FIG NO 4.3 MARITAL STATUS DISTRIBUTION OF RESPONDENTS



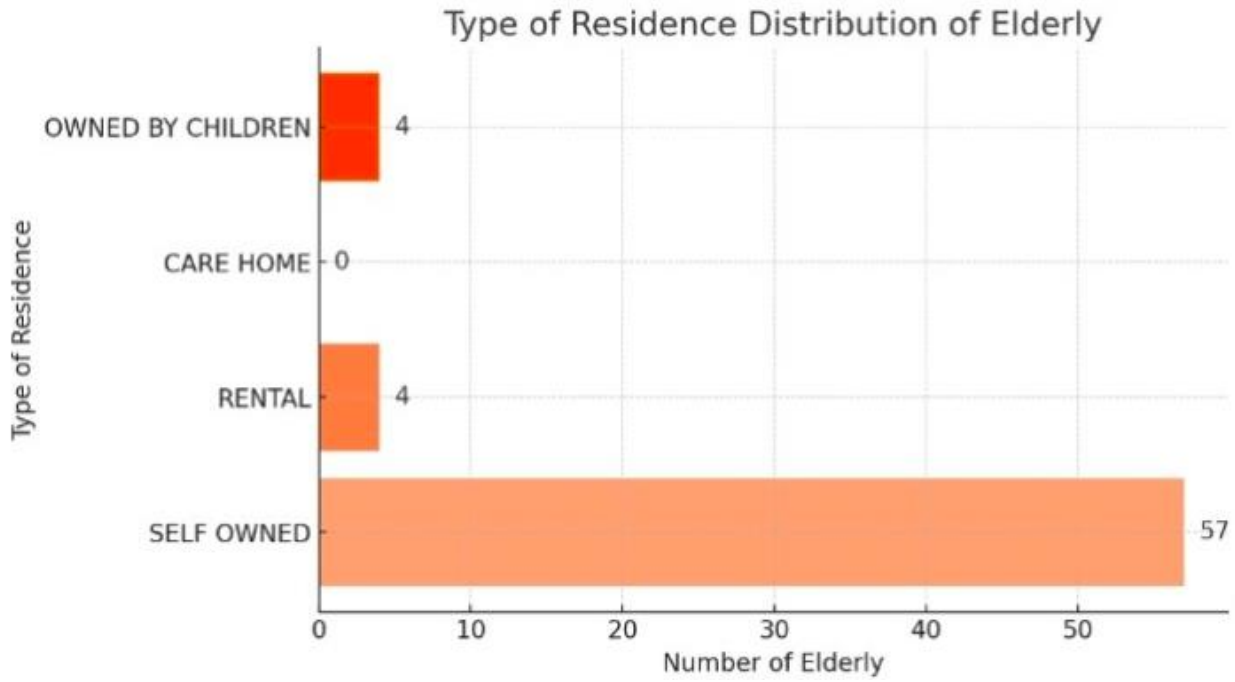
Out of 65 individuals 46 are married, which constitutes 70.77% of the sample. This suggests that marriage is the predominant marital status in this population. 16 individuals (24.62%) are widowed. This is indicating that a significant number of people in the sample have lost their spouses. Only 2 individuals (3.08%) are single, and only 1 person (1.54%) is divorced. This indicates that divorce is rare in this sample. The data suggests a social structure where most individuals marry and remain married. The high number of widowed individuals indicate differences in life expectancy between genders among samples.

FIG NO 4.4 DISTRIBUTION OF RESPONDENTS BY YEARS OF MARRIAGE



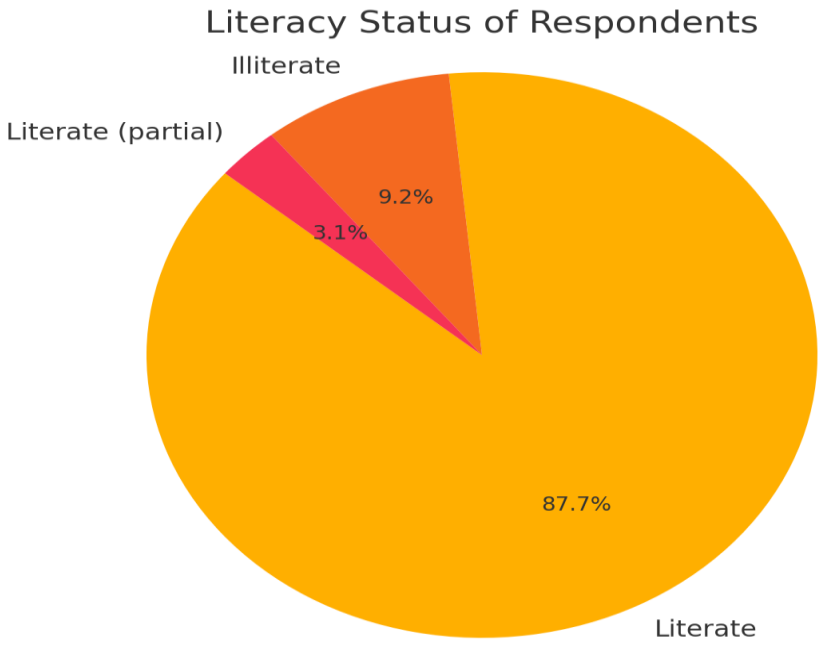
The largest group (27 respondents) has been married for 40-50 years. This indicates that most elderly participants have been in long-term marriages, suggesting a stable marital pattern. 15 respondents have been married for 50-60 years, and 9 respondents for 60-70 years. This shows that a considerable portion of elderly individuals have long-lasting marriages. 2 respondents reported 0 years of marriage, indicating individuals who never married. Most elderly individuals (40-70 years of marriage) have long-term relationships which indicates strong marital longevity.

FIG NO 4.5 TYPE OF RESIDENCE DISTRIBUTION OF ELDERLY



The 57 respondents (87.7%) among 65 were living at their own residence. This indicates a high level of home ownership among the elderly, suggesting financial stability or long-term investment in housing. Only 4 respondents (6.2%) lived in homes owned by their children and 4 other respondents (6.2%) lived in rental properties. The relatively small number in these categories suggests that most elderly individuals in the sample prefer independent living rather than renting or depending on family for housing.

FIG NO 4.6 LITERACY STATUS OF RESPONDENTS

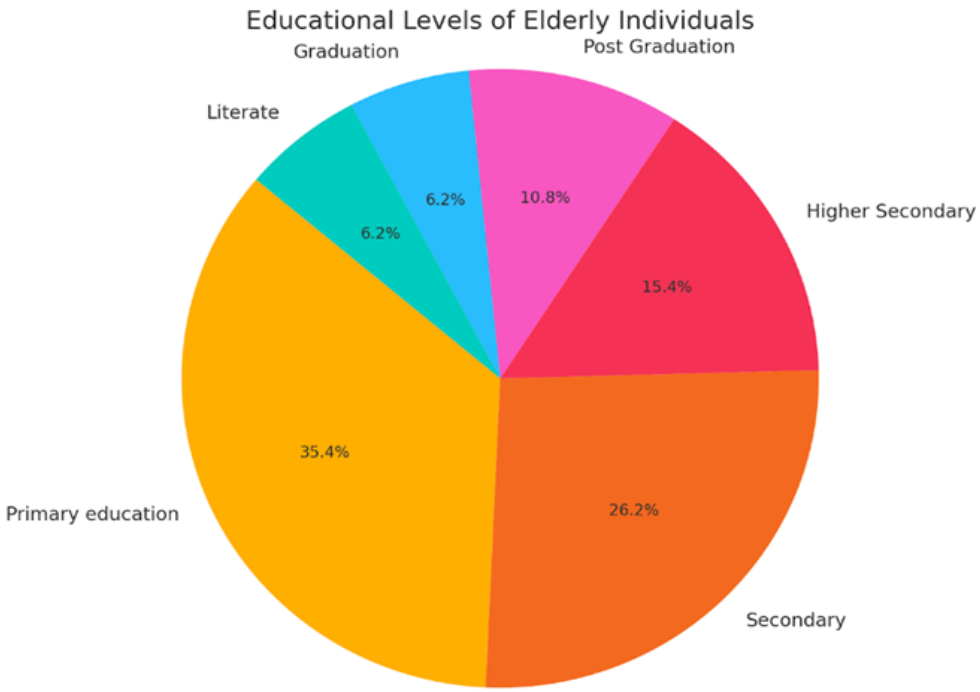


This segment represents the majority of respondents 57 (87.7%), indicating that a significant portion of the elderly population is able to read and write. This high percentage suggests that literacy programs or educational initiatives may have been effective in this community.

Illiterate: This slice accounts for 6 respondents (9.2%) of respondents, indicating a smaller group that lacks basic reading and writing skills. This highlights a potential area for improvement, as addressing literacy could enhance access to information and services for these individuals.

Literate (Partial): Representing 2 respondents (3.1%) of respondents, this category includes those who have some literacy skills but may not be fully proficient**.** This group may benefit from additional educational support to improve their literacy levels.

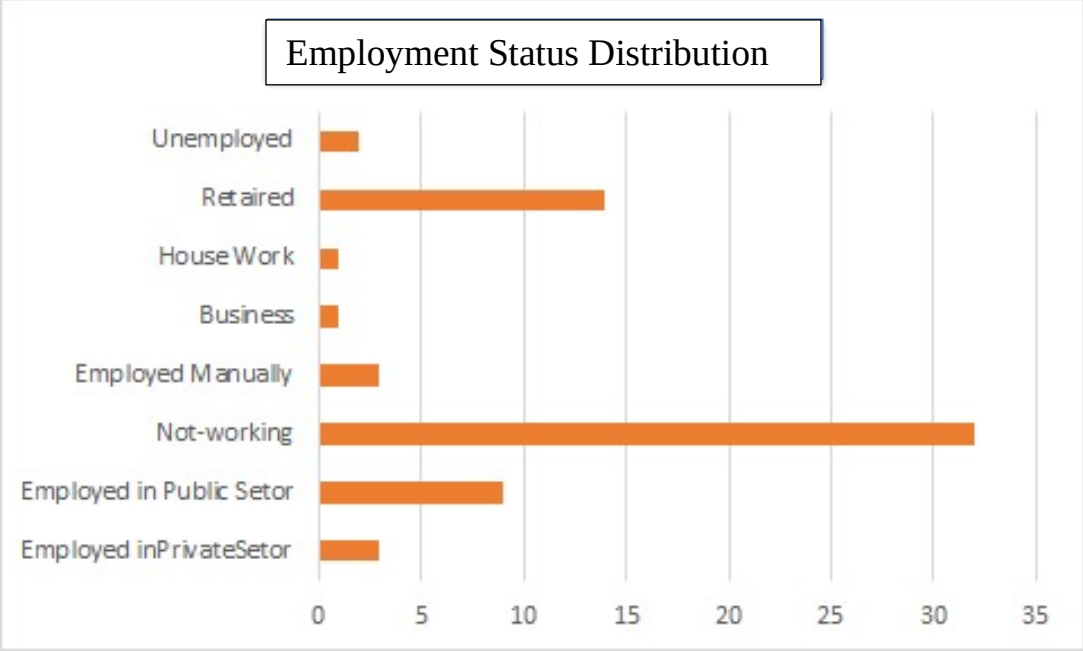
FIG NO 4.7 EDUCATION LEVEL OF RESPONDENTS



The education levels of the literate respondents can be summarized as follows: Primary Education: This segment accounts for the largest portion of the chart, 23 respondents (5.38%), indicating that a significant number of elderly individuals have completed primary education. This suggests a foundational level of literacy and education within this group. Secondary: Representing 70 respondents, (26.15%) of respondents, this category includes those who have completed secondary

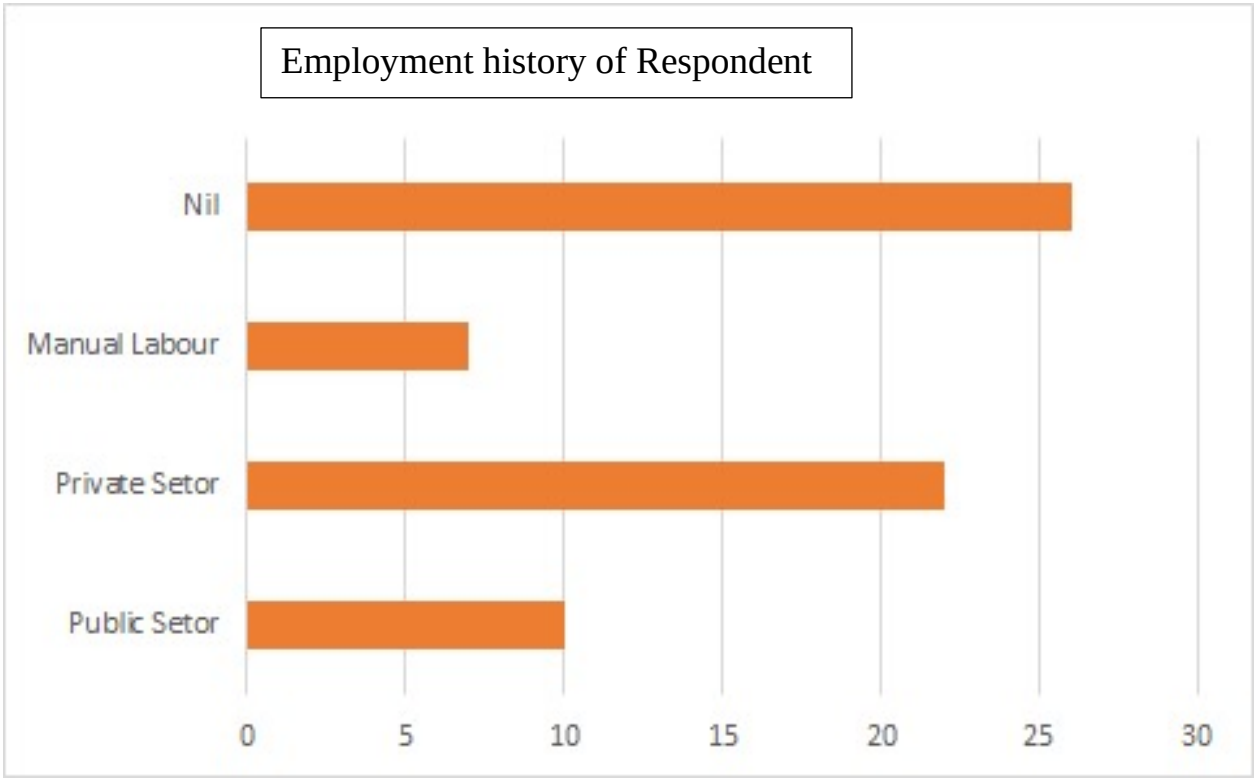
education. This indicates a substantial number of individuals have pursued education beyond primary school. Higher Secondary: This segment makes up (15.38%) of the chart, 10 respondents, showing that a notable portion of the elderly population has completed higher secondary education, which typically includes grades 11 and 12. Graduation: Representing (6.15%), this segment, 4 repondents includes those who have completed a bachelor's degree. Post Graduation: This category accounts for (10.77%) 7 respondents, indicating that a smaller but significant number of elderly individuals have pursued education beyond graduation. Literate: Also making up (6.15%) of the chart, 4 respondents this category includes individuals who can read and write but may not have formal educational qualifications.

FIG NO 4.8 EMPLOYMENT STATUS DISTRIBUTION



Majority Not Working: 32 respondents are not working, which is the largest group. Retired Individuals: 14 respondents are retired, indicating a significant portion of the sample is post-working. Public Sector Domination Public sector employment accounts for 9 respondents, which is more than the private sector and manual labor combined. Low Unemployment \: Only 2 respondents are unemployed, suggesting a relatively low unemployment rate in the sample. Limited entrepreneurship: Only 1 respondent is in business, indicating limited entrepreneurial activity in the sample.

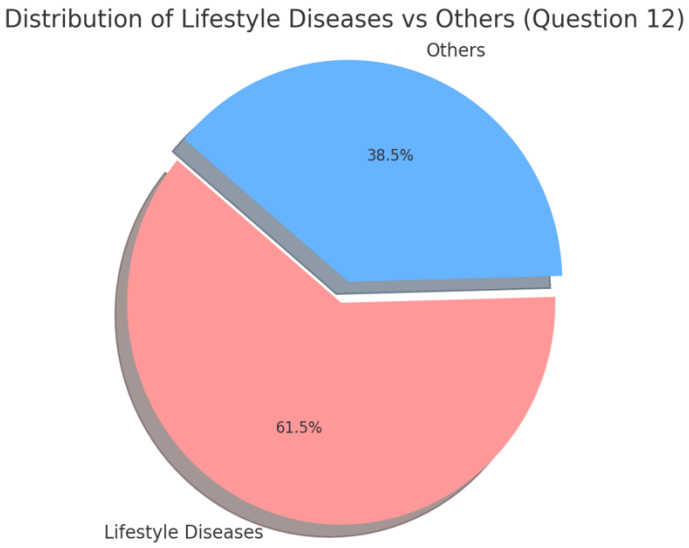
FIG NO 4.9 EMPLOYMENT HISTORY OF RESPONDENTS



Employment History	Count
Public sector	10
Private sector	22
Manual Labour	7
Nil	26

Private Sector Dominance: The private sector has the highest number of people with employment history, with 22 individuals. Public Sector: The public sector has 10 people with employment history, indicating a smaller but still notable presence. Manual Labour Representation: 7 people have employment history in manual labour, showing a relatively smaller representation. Significant Number With No Employment History: 26 people have no employment history, which is a substantial portion of the sample.

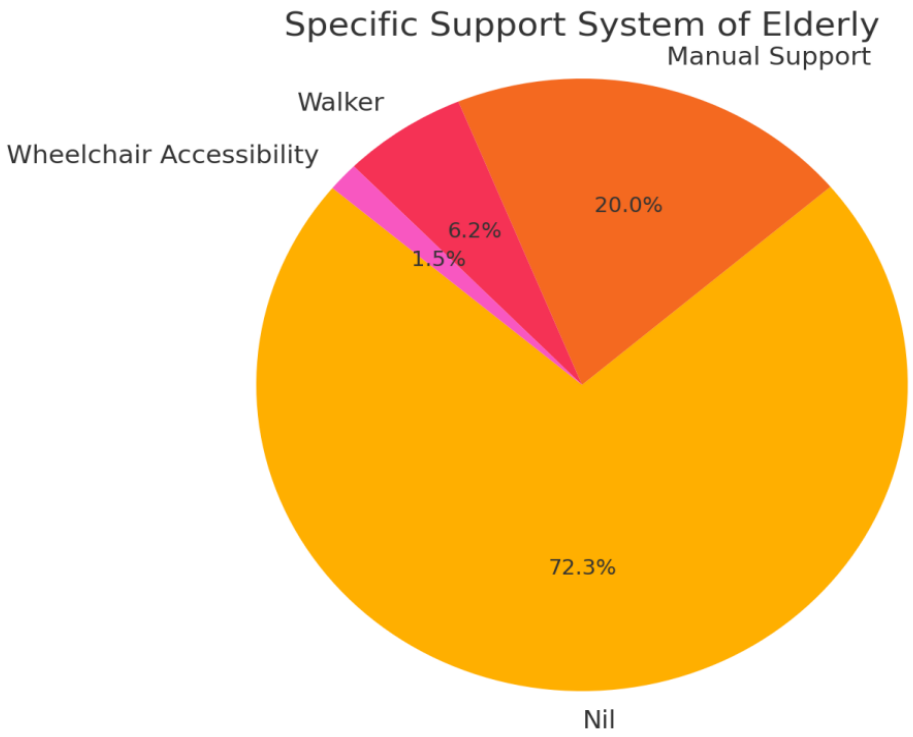
FIG NO 4.10 DISTRIBUTION OF LIFESTYLE DISEASES VS OTHERS



RESPONDENTS PHYSICAL HEALTH PROFILE

Lifestyle Diseases: This category accounts for (61.5%) of the total 40 responses. This indicates that a significant majority of respondents identify lifestyle diseases as a prominent health concern. This could suggest a growing awareness or prevalence of conditions such as diabetes, hypertension, obesity, and other diseases linked to lifestyle choices. The remaining 38.5% of respondents fall into the "Others" category, which includes 25 respondents. This may include various health issues not classified as lifestyle diseases, such as genetic disorder, infectious diseases or other medical conditions. Lifestyle diseases include conditions commonly associated with lifestyle choices, such as diabetes, hypertension (blood pressure), cholesterol issues, and obesity, which is often implied through mentions of movement limitations. Thyroid issues, as well as chronic pain and fatigue, are also frequently linked to lifestyle factors. Obesity is the most frequently reported health issue, with 20 respondents indicating it as a concern. Chronic Pain & Fatigue is also significant, with 16 respondents reporting these issues and thyroid disorders suffered by 6. Hypertension and Cholesterol are notable concerns, with 8 and 13 respondents respectively. Additionally, other medical conditions include genetic disorders like Parkinson's disease with 3 respondents, as well as sensory impairments such as visual impairment suffered by 9 respondents and hearing impairment by 5 of them. These numbers emphasize the prevalence of both lifestyle-related and other health issues among affected individuals.

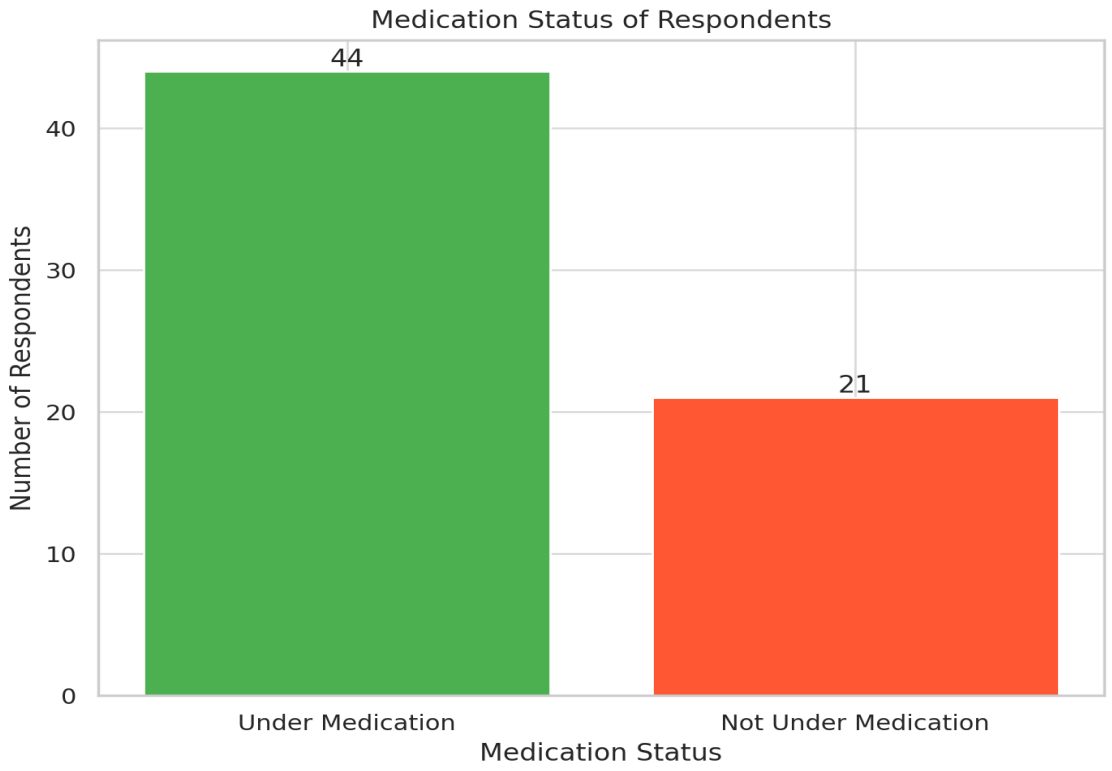
FIG NO 4.11 SUPPORT SYSTEM USED BY RESPONDENTS



A significant majority of the elderly respondents (47 out of 65) indicated that they do not require any specific support system. This suggests a high level of independence among the elderly population in this community, indicating that many are managing their daily activities without assistance. Support (20%): A notable portion of respondents (13 individuals) rely on manual support. This could include assistance from family members, caregivers, or community services. The presence of this group highlights the importance of support systems and resources for those who may need help with daily tasks. Walker (6.15%): Only 4 respondents reported using walkers, indicating that mobility issues are relatively uncommon among this population. This suggests that most elderly individuals are able to move around independently without the need for mobility aids.

Wheelchair Accessibility (1.54%): Just 1 respondent required wheelchair accessibility, which further emphasizes that severe mobility limitations are not prevalent in this group.

FIG NO 4.12 MEDICATION STATUS OF ELDERLY RESPONDENTS IN CHERANALLOOR GRAMA PANCHAYAT



The above graph illustrates the medication status of elderly individuals in the community, which includes two categories: with 44 respondents (68%) who are currently taking medication and 21 respondents (32%) who are not taking any medication.

TABLE 1. SHOWING THE MEDICATION STATUS OF ELDERLY RESPONDENTS

Medication Status	Number of Respondents	Percentage (%)
Under Medication	44	68%
Not Under Medication	21	32%
Total	65	100%

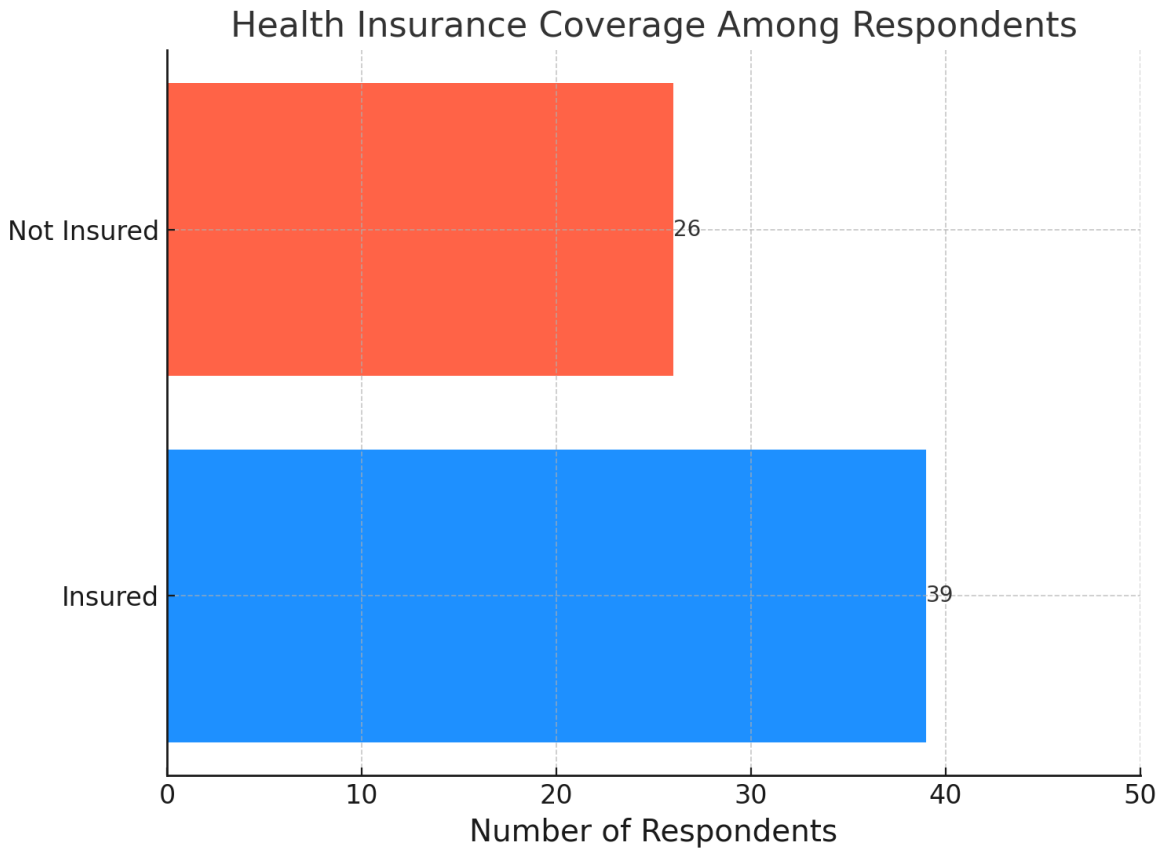
This analysis examines the medication status of 65 respondents, focusing on how demographic, social, and health-related factors influence medication adherence. The average age of respondents under medication is 72.34 years, compared to 68.90 years for those not under medication, suggesting that older individuals are more likely to require medication. Gender analysis reveals that 65.91% of those on medication are female, compared to 34.09% male. Among those not on medication, the gender gap is narrower (52.38% female, 47.62% male), indicating potential gender differences in healthcare access or medication needs.

Most respondents in both groups are married (70.45% under medication, 71.43% not under medication) . However, 29.55% of those on medication are widowed, compared to 14.29% of those not, suggesting that widowed individuals may face additional health challenges or lack support, affecting their medication adherence.

Educational background varies between the two groups. Among those on medication, 40.91% have only primary education, while a higher proportion of those not on medication have secondary or higher education. This suggests that lower education levels may be linked to lower health literacy and medication adherence. Physical difficulties are more common among those on medication,

with conditions like blood pressure issues, chronic pain, and lifestyle diseases being reported. This indicates a stronger need for medical intervention in this group.

FIG NO 4.13 HEALTH INSURANCE COVERAGE AMONG RESPONDENTS



The above figure illustrates the health insurance status which is crucial for understanding the healthcare needs and vulnerabilities of the elderly population at Cheranalloor Grama Panchayath. The "Insured" category shows that 39 respondents have health insurance, while the "Not Insured" category indicates that 26 respondents do not have health insurance.

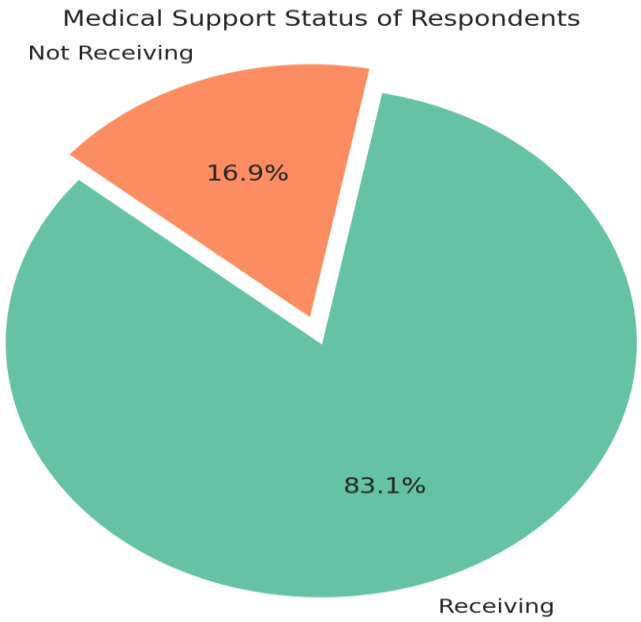
TABLE 2. DISTRIBUTION OF HEALTH INSURANCE COVERAGE AMONG RESPONDENTS

Health Insurance Plan	Number of Respondents	Percentage (%)
Insured	39	60%
Not Insured	26	40%
Total	65	100%

The study revealed that 60% (39 respondents) have health insurance, while 40% 26 respondents) do not. This indicates that the majority of the elderly population in the area is insured, suggesting positive access to health insurance. However, the 40% without insurance represents a significant portion that may face challenges in accessing healthcare and could be vulnerable to high medical costs. While most respondents have health insurance, the 40% uninsured group highlights a gap in coverage. Addressing this gap could involve outreach programs, educating individuals on the importance of health insurance, and providing support for insurance enrollment to ensure more comprehensive healthcare access for the elderly population.

The relation between health insurance coverage and medication status is as follows: Among those on medication, 34.88% have health insurance, while 60.47% do not. In contrast, 47.62% of those not on medication have insurance, and 52.38% are uninsured. This highlights the potential impact of insurance coverage on medication adherence.

FIG NO 4.14 DISTRIBUTION OF MEDICAL SUPPORT FOR THE ELDERLY



The above figure illustrates the proportion of elderly respondents receiving medical support compared to those not receiving it, which emphasizes the importance of medical support for the elderly population in the surveyed area.

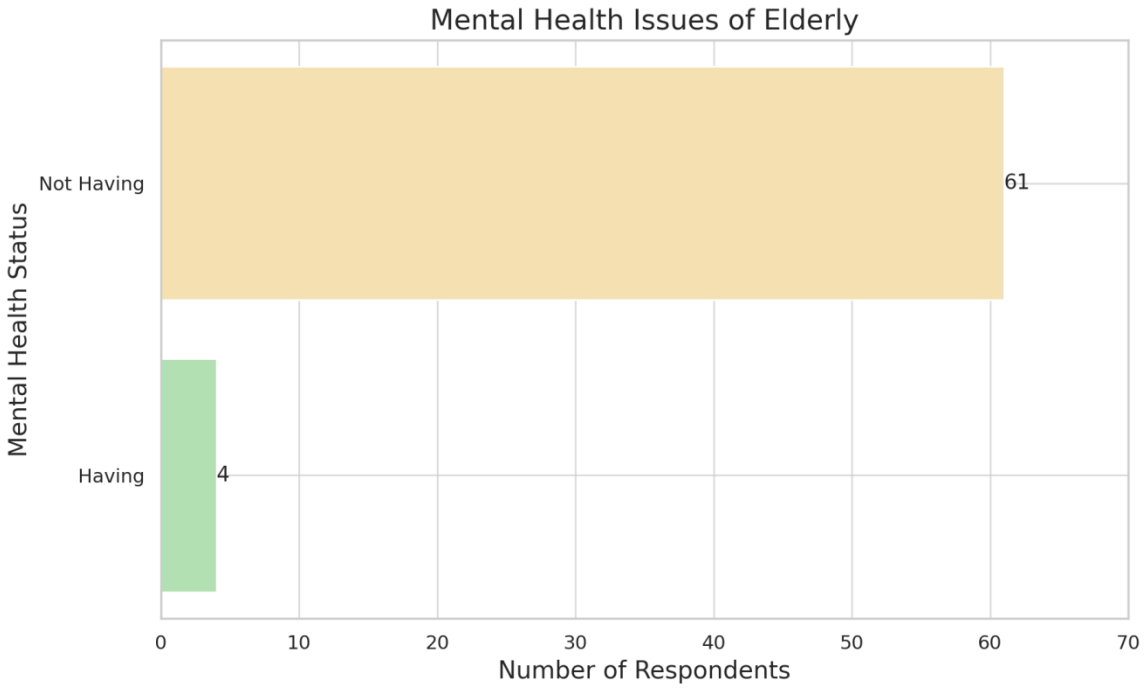
TABLE3. SHOWING THE DISTRIBUTION OF MEDICAL SUPPORT AMONG RESPONDENTS

Medical Support	**Number of Respondents**	**Percentage (%)**
Receiving	54	83%
Not Receiving	11	17%
Total	65	100%

The majority of respondents (54 out of 65) reported that they are receiving medical support, indicating a strong reliance on available healthcare services. A smaller segment (11 out of 65) indicated that they are not receiving any medical support, highlighting a potential area of concern for healthcare accessibility among this group.

The study seeks to identify the extent to which elderly respondents rely on additional medical support services outside of their primary healthcare providers which can include support from NGOs, community health programs, private clinics, or other healthcare institutions. Analyzing the responses reveal the various types of medical support available to the elderly, such as home healthcare, physiotherapy, counseling, or specialized medical services

FIG NO 4.15 MENTAL HEALTH ISSUES AMONG OLDER ADULTS



The above figure shows the mental health status of elderly respondents from the Panchayat. It is categorized into two as elders having mental health issues (4 respondents, 6%) and elders those who are Not Having mental health issues (61 respondents, 94%). The majority of respondents (94%) do not report having mental health issues, while only a small number (6%) do.

TABLE 4. SHOWING THE PREVALENCE OF MENTAL HEALTH ISSUES AMONG OLDER ADULTS.

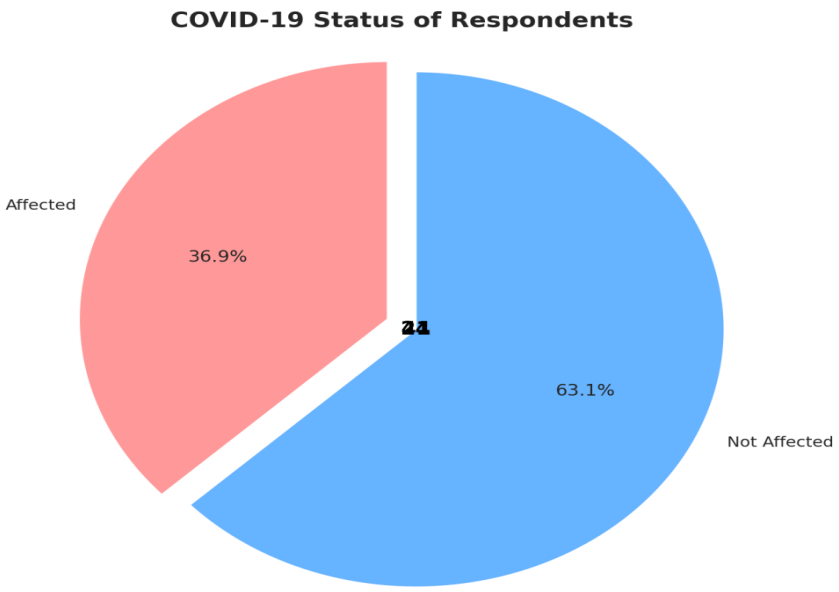
Mental Health Issues	**Number of Respondents**	**Percentage%**
Having	4	6%
Not Having	61	94%
Total	65	100%

The study sought to understand whether the respondents have experienced any mental health issues. From this data, we can observe that out of a total of 65 respondents, a significant majority, 61 elderly respondents (94%) reported not having any mental health issues. In contrast, only 4 individuals, a small fraction (6%) indicated that they do experience mental health challenges. This disparity suggests that mental health issues may not be a prevalent concern among the elderly population in this specific community.

TABLE 5. COVID-19 STATUS

COVID-19 Status	**Number of Respondents**	**Percentage (%)**
Affected	24	37%
Not Affected	41	63%
Total	65	100%

Fig no 4.16 COVID-19's Impact on the Elderly



The above figure titled ‘Covid 19 Status of Respondents’ illustrates how COVID-19 affected the elderly respondents in the dataset, providing a visual representation of the number of individuals who were affected by the virus compared to those who were not affected.

A notable percentage of respondents (37%) report being **a**ffected by COVID-19. This indicates that a significant portion of the surveyed population has experienced the virus, whether through infection, illness, or related impacts (such as quarantine or loss of income). Conversely, 63% of respondents report not being affected by COVID-19, suggesting that the majority of the population surveyed has not experienced direct consequences from the virus. The data suggests that while a majority of respondents have not been affected, a substantial minority has faced challenges related to COVID-19. This highlights the ongoing impact of the pandemic on individuals and communities. The affected group is older on average (Mean: 73.38 years)

compared to the not affected group (Mean: 69.37 years), suggesting that older age is a significant risk factor for COVID-19 severity. In terms of chronic conditions, the affected group reported a total of 18, whereas the not affected group had 40, indicating that the latter may have fewer health issues contributing to their resilience against the virus. Living situations also play a role, with the not affected group predominantly residing in owned homes (34 out of 38), potentially reducing exposure risk compared to the affected group, where only 6 live in owned homes. Health insurance coverage further highlights a disparity, as a higher proportion of the not affected group has insurance (20 out of 38) compared to only 3 in the affected group, which may correlate with better health management. Additionally, the affected group has a higher reliance on medication (7 out of 8), reflecting existing health issues that could complicate their COVID-19 status. This detailed analysis provides numerical proof of the findings and highlights the interconnected factors influencing the respondents' COVID-19 outcomes. Understanding the experiences of those affected can inform public health responses, resource allocation, and support services aimed at mitigating the effects of the pandemic.

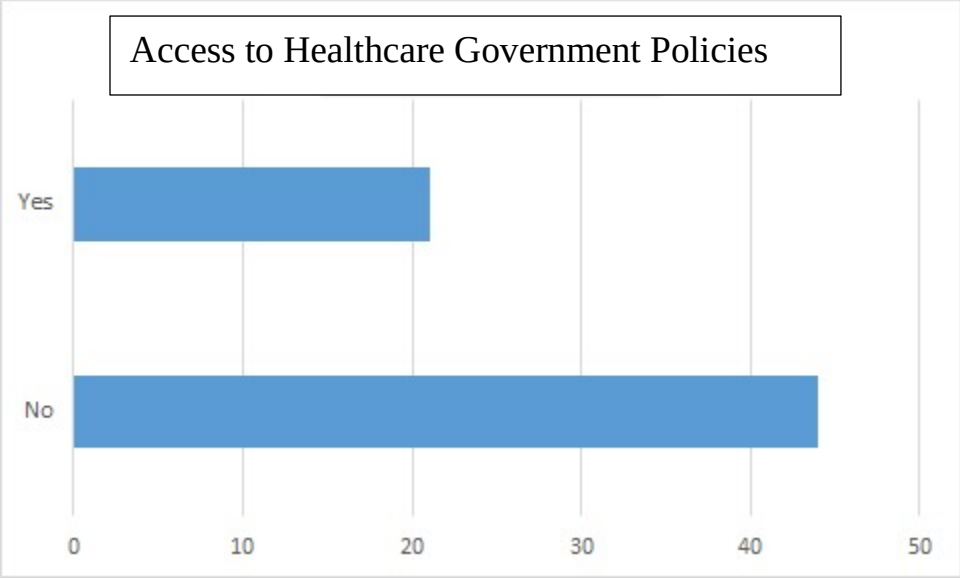
The data on COVID-19 status reveals important trends regarding the impact of the pandemic on the surveyed population. While a majority of individuals report not being affected, the significant percentage of those who have been affected underscores the ongoing challenges posed by COVID-19. This information can be valuable for healthcare providers, policymakers, and community organizations as they continue to address the effects of the pandemic and support those in need.

TABLE 6. SHOWING THE PHYSICAL AND MENTAL CHALLENGES OF ELDERLY AFTER COVID

Health Status	Number of Respondents	Percentage (%)
Having Physical and Mental Challenges	7	12%
Not Having Physical and Mental Challenges	58	88%
Total	65	100%

The above table shows that 88% of respondents did not face physical and mental challenges, while 12% did. This distribution suggests that the population surveyed is predominantly healthy, which could have implications for health services, support programs, and resource allocation.

FIG NO 4.17 ACCESS TO HEALTHCARE GOVERNMENT POLICIES AMONG RESPONDENTS



Among 65 respondents, 21 respondents reported being beneficiaries of healthcare government policies, while 44 respondents said they are not. This indicates that a majority, about two-thirds of the respondents, are not benefitting from healthcare government policies, highlighting a gap in access or awareness of these programs.

Fig no 4.18 BENEFICIARIES OF ANY PANCHAYATH HEALTHCARE POLICIES

A total of 65 respondents shows that 48 respondents benefit from Panchayat healthcare policies, indicating that these policies are effectively reaching and positively impacting most people. However, 17 respondents are not benefiting, which may point to issues like lack of awareness, eligibility criteria, or barriers to access. While the high percentage of beneficiaries reflects the effectiveness of these policies, targeted efforts to support non-beneficiaries could improve inclusiveness and overall impact

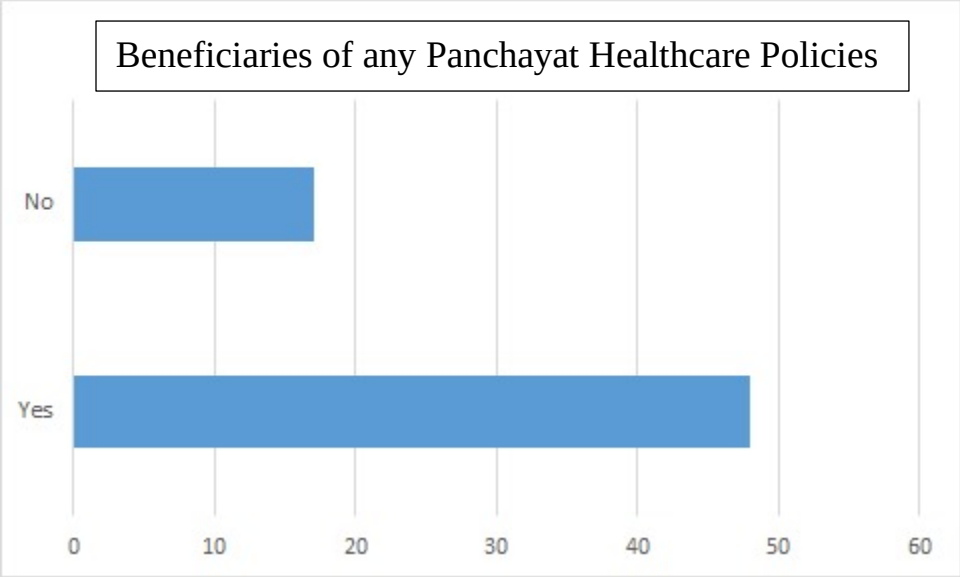
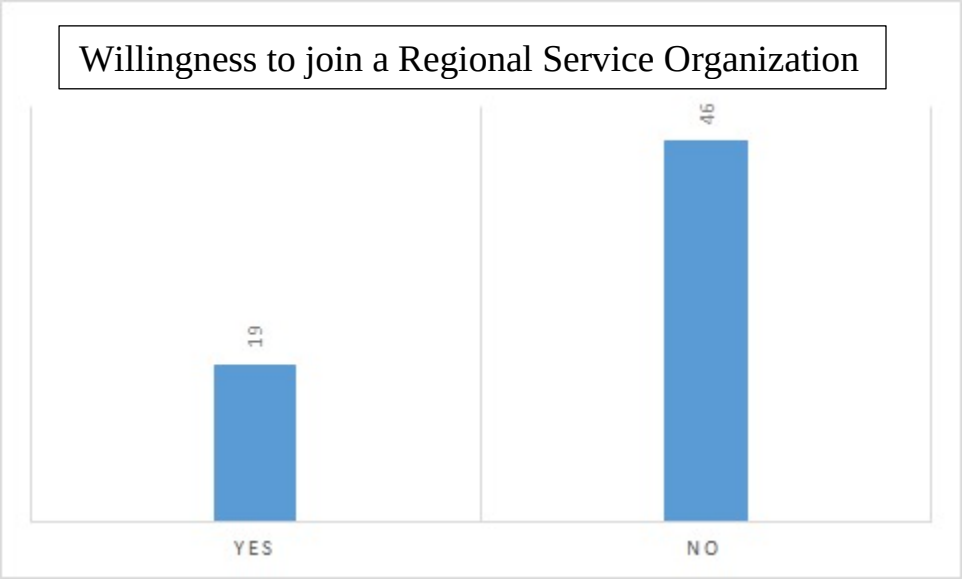


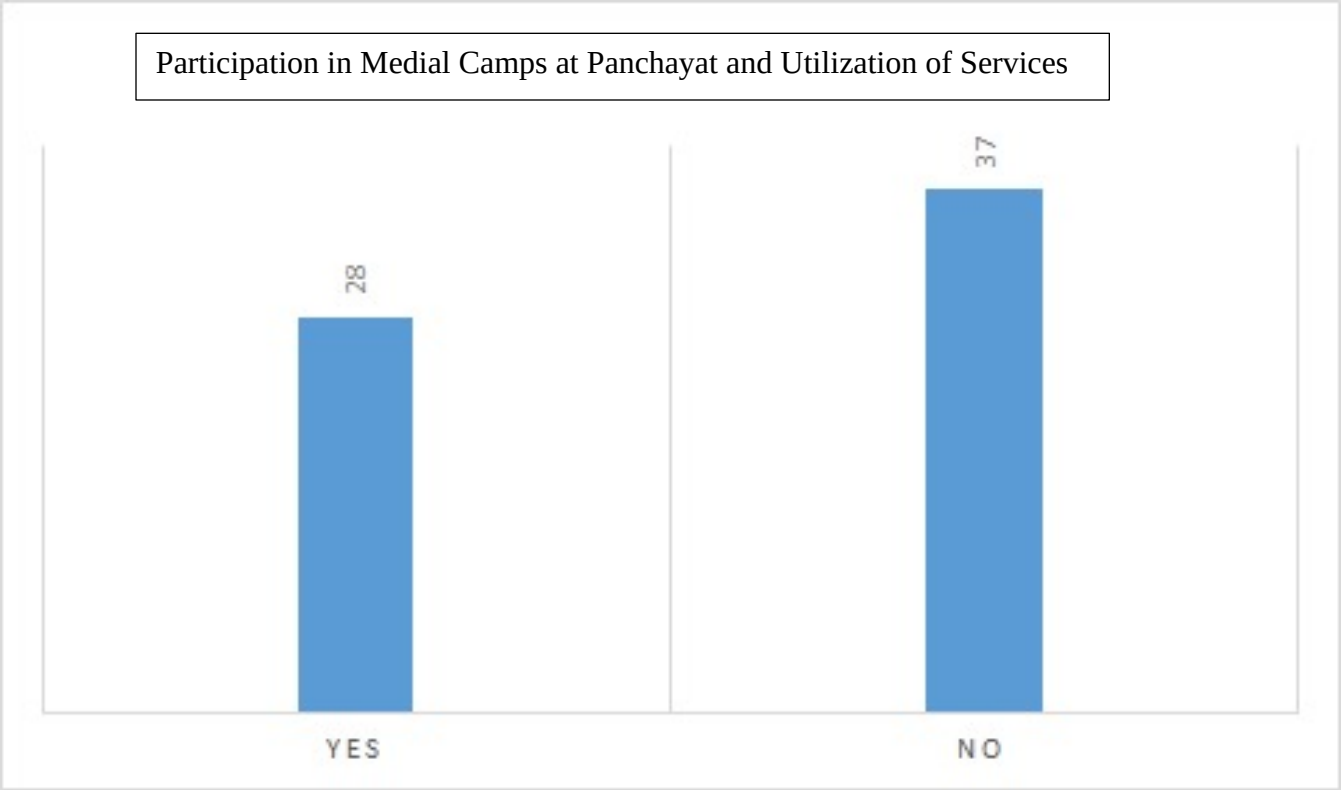
Fig no 4.19 WILLINGNESS TO JOIN A REGIONAL SERVICE ORGANIZATION



Among 65 respondents 19 respondents are willing to join a regional service organization, while 46 respondents are not. The majority's lack of interest could reflect a lack of awareness, perceived benefits, or personal and logistical barriers. The relatively low willingness to join suggests that more effort may be needed to communicate the organization's benefits and purpose to boost participation. Understanding the reasons behind this reluctance such as time constraints, lack of trust, or unclear advantages could help develop more effective outreach and engagement strategies.

awareness, scheduling, and access could help boost participation and ensure that more people benefit from these healthcare services.

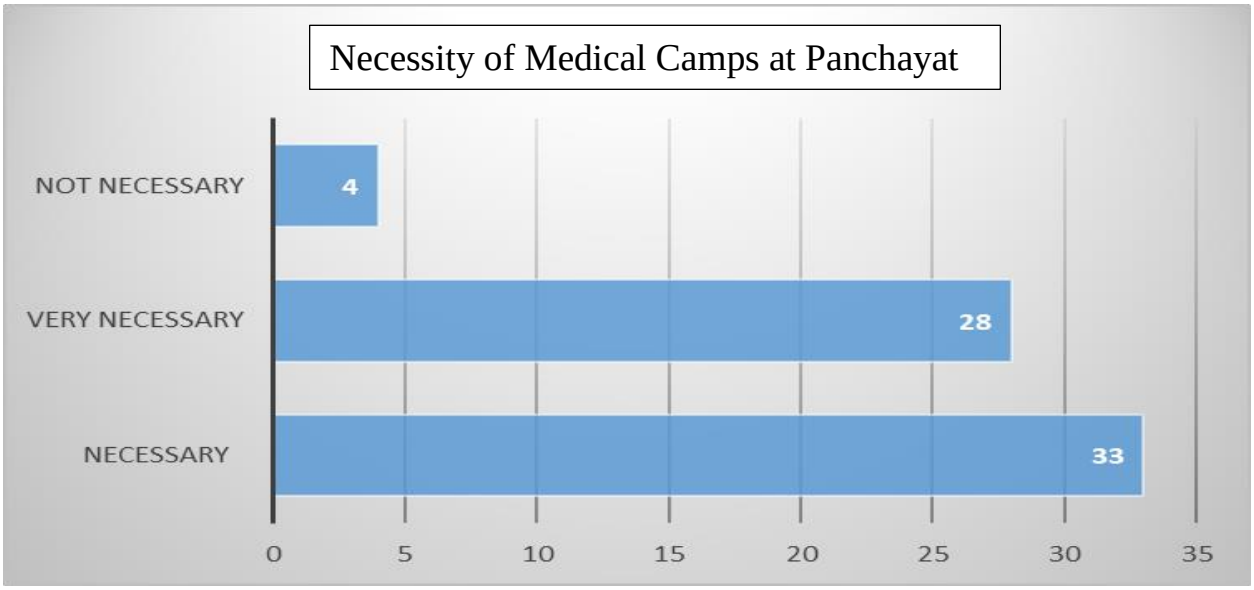
FIG NO 4.20 PARTICIPATION IN MEDICAL CAMPS AT THE PANCHAYAT AND UTILIZATION OF SERVICE.



PARTICIPATION IN MEDICAL CAMPS AT THE PANCHAYAT AND UTILIZATION OF SERVICE.

In total 65respondents 28 respondents have participated in and utilized services at Panchayat medical camps, while 37 respondents have not. This slight majority of non-participants suggests possible barriers such as lack of awareness, inconvenient timing, or accessibility issues. However, the relatively high participation rate indicates that the medical camps are reaching a significant portion of the population, demonstrating some level of awareness and effectiveness. Improving

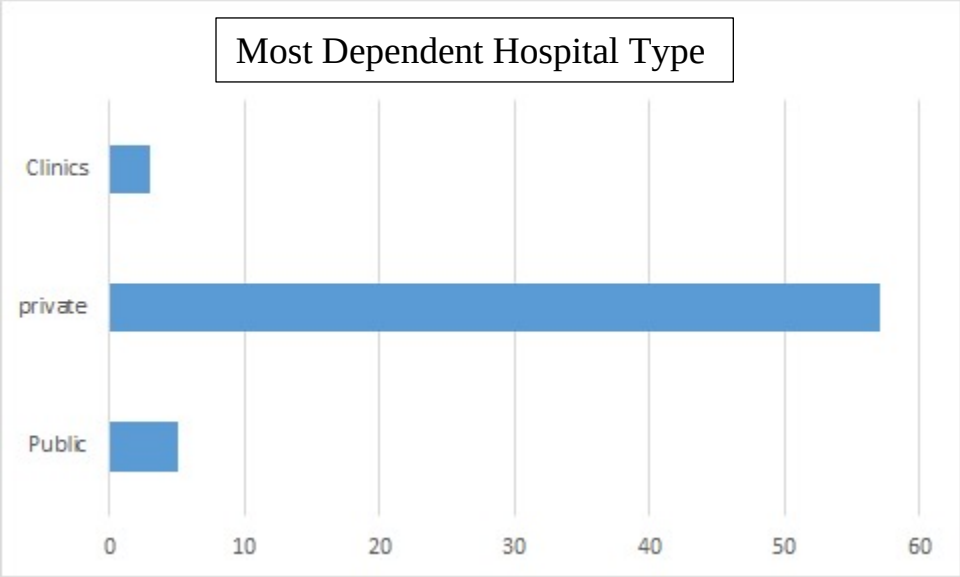
FIG NO 4.21 RESPONDENTS VIEW ON NECESSITY OF MEDICAL CAMPS AT THE PANCHAYATH



Out of 65 respondents, 33 believed medical camps were necessary, 28 considered them extremely necessary, and only 4 thought they were not necessary. The respondents recognize the importance of medical camps, highlighting a strong demand for these services. The minimal percentage viewing them as less necessary suggests that most people value the camps for improving community health. This high level of perceived necessity supports the need for regular organization and potentially increased funding and resources to enhance their reach and effectiveness.

A majority (61 respondents) consider medical camps "Necessary" or "Very Necessary," highlighting a strong demand for healthcare services in the Panchayat. Only a small fraction of respondents find them "Not Necessary," indicating that the general perception favors organizing medical camps. The highest number of responses (33) for the "Necessary" category suggests that while medical camps are important, some may not see them as an urgent need but rather as a beneficial addition to existing healthcare services**.**

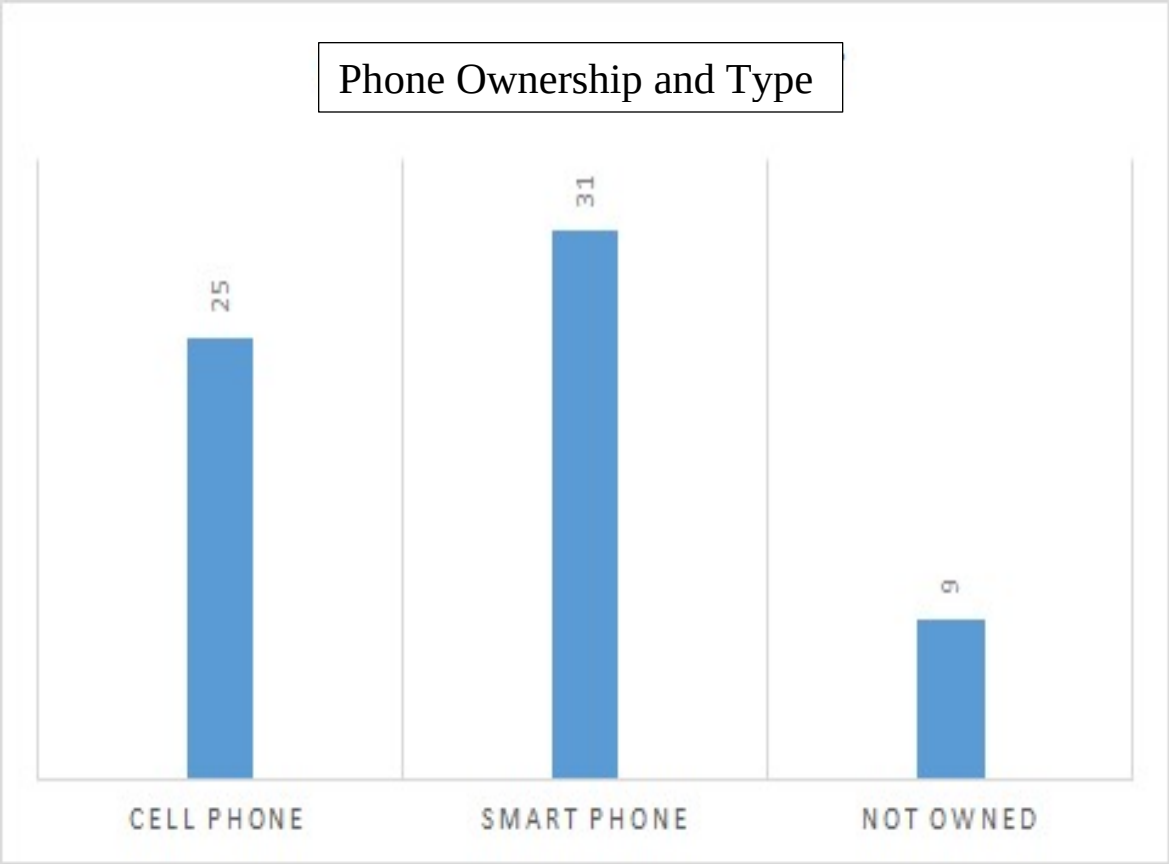
Fig no 4.22 MOST DEPENDENT HOSPITAL TYPE



Among 65 respondents, 57 respondents rely on private hospitals, while only 5 respondents depend on public hospitals, and 3 respondents use other healthcare facilities including clinics. 3 respondents prefer Arya Vaidya Shala, a clinic, over public and private hospitals. Among private hospitals, Lourdes and Renai are preferred because they are nearby, despite being expensive, according to the respondents. Five respondents specifically mentioned preferring Lourdes over other hospitals. The overwhelming preference for private hospitals suggests that public healthcare services may be inadequate, less accessible, or perceived as lower quality. The availability of

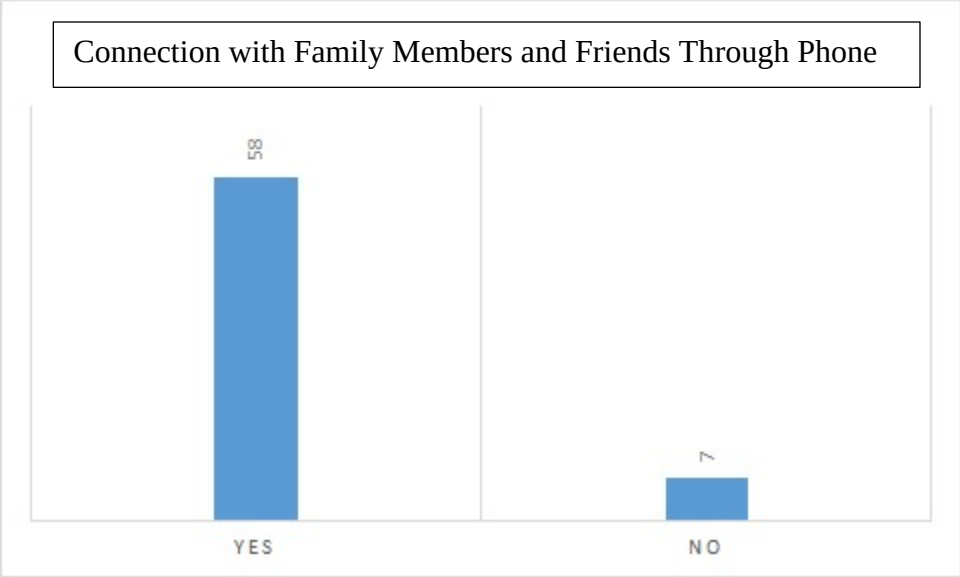
private healthcare at nominal cost may also be a factor. The low reliance on public hospitals highlights potential issues with infrastructure, staff availability, or the quality of care. Improving the quality and accessibility of public hospitals, increasing awareness about available services, and addressing infrastructure and staffing issues could help reduce the financial burden on individuals and encourage greater use of public healthcare.

FIG NO 4.23 PHONE OWNERSHIP AND TYPE



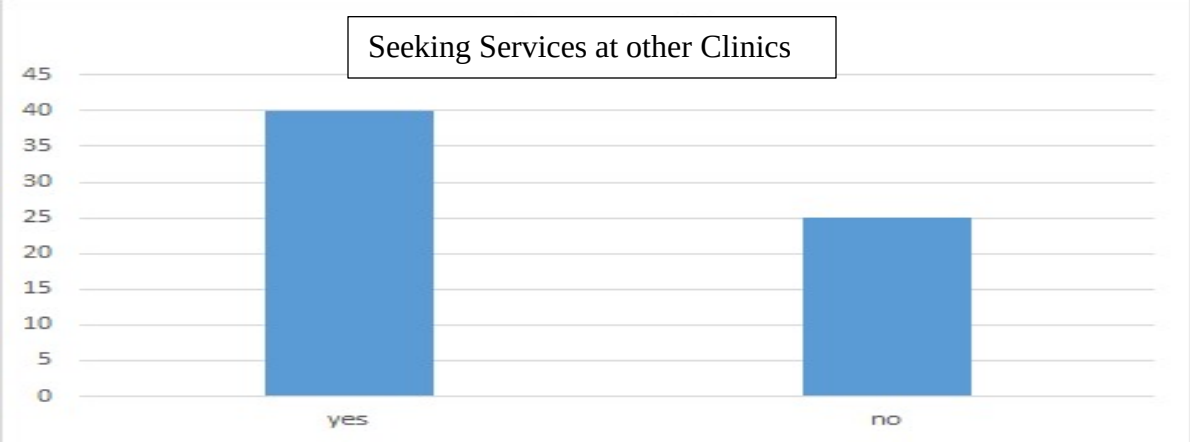
A majority of respondents (56 out of 65) owned a phone, revealing a high level of access to communication devices. Smartphone ownership 31 is higher than basic cell phone ownership 25, suggesting that many people have access to internet-based communication and apps. The 9 without a phone may face barriers to communication, which could be due to economic, technological, or personal reasons.

FIG NO 4.24 CONNECTION WITH FAMILY MEMBERS AND FRIENDS THROUGH THE PHONE



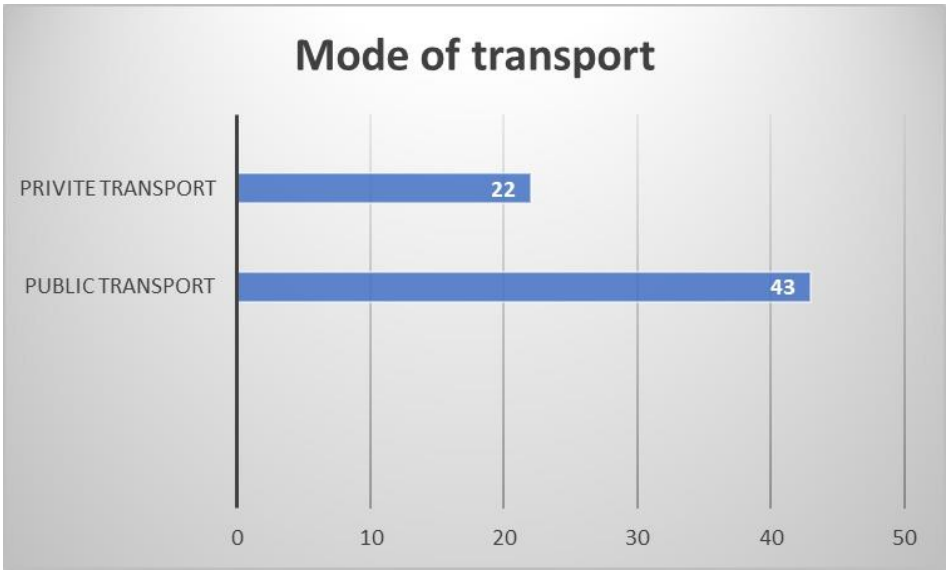
A majority (58 out of 65) of respondents rely on their phones to stay connected with family and friends, while only 7 respondents do not use their phones for this purpose. This highlights the importance of phone communication in maintaining social relationships for most respondents.

FIG NO 4.25 SEEKING SERVICES AT OTHER CLINICS



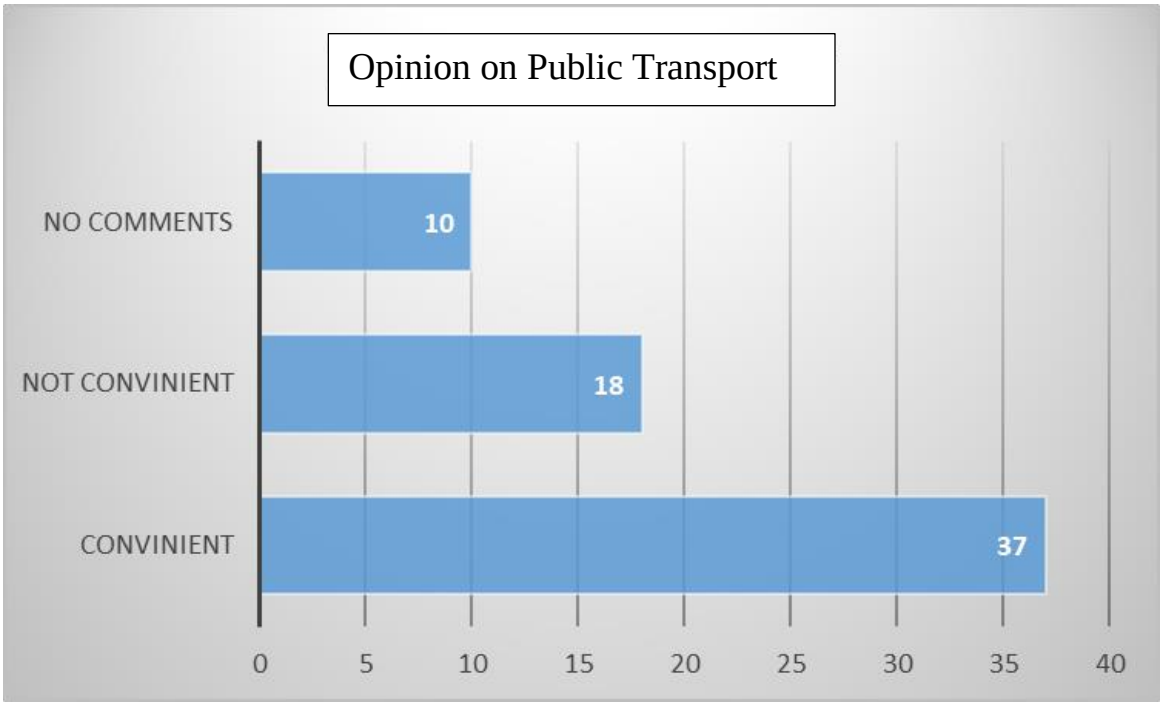
A higher number of respondents 40 reported seeking services at other clinics, suggesting dissatisfaction with their current healthcare providers due to factors like convenience, cost, or better services elsewhere. Fewer respondents 25 said they do not seek services elsewhere, which may reflect satisfaction with their current clinic, limited alternatives, or personal preference.

FIG NO 4.26 TRANSPORTATION



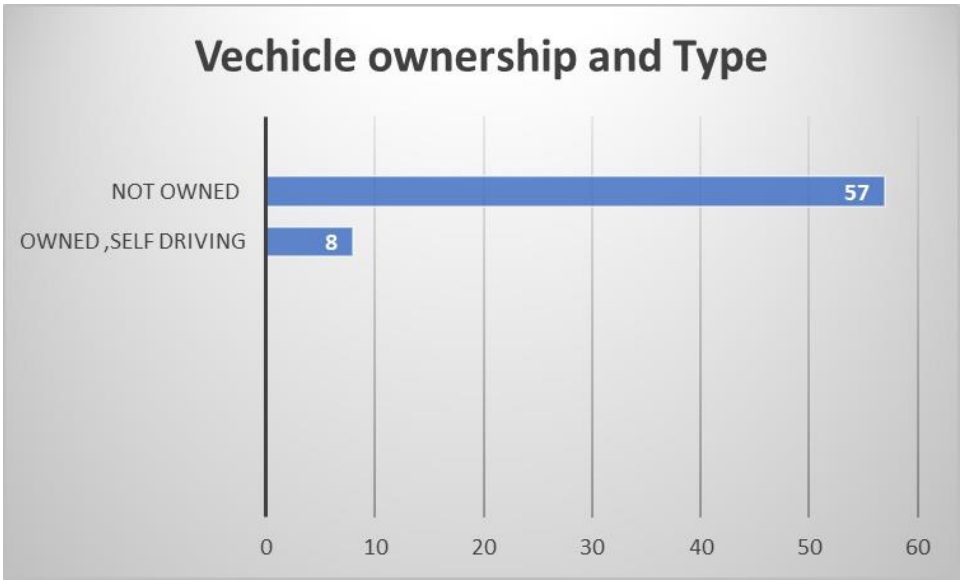
A high number of 43 respondents use public transport, making it the most preferred mode. This suggests that public transportation is more accessible, cost-effective, or convenient for a majority of people. Only 22 respondents use private transport, which is significantly lower than public transport. This could be due to high costs of owning/maintaining a vehicle, traffic congestion, or better public transport facilities.

FIG NO 4.27 OPINION ON PUBLIC TRANSPORT



A higher number of respondents of 37 consider public transport convenient, which indicates a positive perception of accessibility, affordability, or reliability. 18 respondents believe public transport is not convenient, suggesting issues such as delays, overcrowding, lack of routes, or discomfort. 10 respondents chose No comments, possibly indicating indifference, lack of usage, or no strong preference. Since most people find public transport convenient, authorities can focus on maintaining and improving services. The number of dissatisfied respondents suggests areas for improvement, such as better scheduling, increased frequency, or enhanced comfort. Understanding the concerns of the No comments group could provide additional insights into improving public transport.

FIG NO 4.28 VEHICLE OWNERSHIP AND TYPE



The majority of respondents 57 do not own a vehicle, which may suggest reliance on public transportation, shared vehicles, or walking for daily travel. Only 8 of the respondents own and drive their vehicles, which may reflect economic barriers, lack of need due to good public transport options, or preference for other modes of travel.

TABLE 7. MAIN SOURCE OF INCOME

Primary source of income	Responses	Percentage
Pension	43	66.15 %
Familial support	13	20 %
Retirement benefits	3	4.62 %
Work	3	4.62 %
Nil	3	4.62 %

- The majority of respondents (66.15%) rely on pensions as their primary income source,indicating a significant dependence on government or retirement pensions among the elderly population in the dataset.
- A notable portion (20%) also receives income from familial support, suggesting that family plays a crucial role in the financial stability of the elderly.
- Other income sources, such as retirement benefits and work, contribute to the financial landscape, but they represent a smaller fraction of the total responses.

Overall, the data highlights the reliance on pensions and familial support, which may inform policies aimed at improving the financial well-being of the elderly.

TABLE 8. INTERNET FAMILIARITY

Familiarity with internet	Responses	Percentage
Familiar	29	44.62 %
Less familiar	18	27.69 %
Not familiar	18	27.69 %

Among the elderly people surveyed, 29 reported being familiar with the internet, showing a moderate level of online engagement. However, 18 respondents said they were less familiar with the internet, indicating a need for improved digital literacy and access. Additionally, 18 respondents were not familiar with the internet at all, highlighting a wide range of internet usage levels among the elderly.

Overall, the data suggests that while some elderly individuals are familiar with the internet, there is a notable portion that may benefit from targeted educational initiatives to enhance their digital skills and access.

TABLE 9. CATEGORIES OF PENSION

Type of pension	Responses	Percentage
Old age pension	40	61.54 %
Widow pension	5	7.69 %
Welfare pension	1	1.54 %
Kaarshika thozhilaali pension	1	1.54 %
Karshaka pension	1	1.54 %
Sevana pension (for unmarried women)	1	1.54 %
Familial support	1	1.54 %
Not sure	3	4.62 %
Nil	12	18.46 %
TOTAL	65	100%

Most elderly respondents 40 rely on old-age pensions as their main financial support. However, a significant number 12 receive no pension at all. This data highlights the importance of old-age pensions for the elderly, while also revealing a need to improve pension coverage and support for vulnerable individuals.

TABLE 10. IS YOUR PERSONAL SPENDING ENOUGH?

Is the amount spent on yourself adequate?	Responses	Percentage
Not adequate	27	41.54 %
Adequate	26	40 %
Not receiving any pension	12	18.46 %

- 41.54% (27 respondents) receive money but find it insufficient.
- 40% (26 respondents) consider the amount they receive to be enough.

- 18.46% (12 respondents) are not recipients of any pension.

The data shows that opinions are almost evenly split between those who find their financial support adequate and those who do not. However, a slight majority feel that the amount they receive is insufficient. A small portion does not receive a pension at all, indicating they rely on other financial sources. A significant majority of respondents (97.01%) are currently under medication, and 95.52% have a health insurance plan. However, despite this coverage, 43.28% feel that the amount spent on their healthcare is insufficient. This suggests that while most individuals have access to medical treatment and insurance, the financial burden of healthcare remains substantial for many families, highlighting potential gaps in coverage, affordability, or overall healthcare accessibility

TABLE 11. RATION CARD STATUS

Ration card	Responses	Percentage
APL	34	52.31 %
BPL	22	33.85 %
PHH	4	6.15 %
AAY	4	6.15 %
Not sure	1	1.53 %

The survey reveals that a majority of respondents (34) hold Above Poverty Line (APL) cards, indicating economic stability. However, a significant portion (22) have Below Poverty Line (BPL) cards, showing a need for financial support. Additionally, a small percentage of respondents (4) possess Priority Household (PHH) or Antyodaya Anna Yojana (AAY) cards, indicating priority households or extreme economic vulnerability, and (1) respondent is unsure about their ration card status.

TABLE 12. ASSETS & PROPERTY

Assets / property	Responses	Percentage
Yes	33	50.77 %
No	30	46.15 %
Not sure	2	3.08 %

The survey of 65 respondents shows that 33 (50.77%) own assets or property, while 30 (46.15%) do not. A small percentage, 2 respondents (3.08%), are unsure about their ownership status. This reveals a near equal divide between asset owners and non-owners, indicating moderate financial stability among some respondents, while others may face economic challenges.

TABLE 13. LEISURE TIME ACTIVITIES

Leisure time	Responses	Percentage
Rest	6	9.23 %
Gardening	5	7.69 %
Working	5	7.69 %
Watching television	20	30.77 %
Reading newspaper	6	9.23 %
Nothing	5	7.69 %
Travelling	6	9.23 %
Spend with family	12	18.46 %

The data shows that the most common leisure activity is watching television (20) followed by spending time with family (12). Activities like resting, reading newspapers, and traveling each have (6) participation, while gardening, working, and doing nothing are equally less preferred at

(5). This suggests that passive activities like watching TV dominate leisure time, while social and productive activities are less priorities.

TABLE 14. PERSON RESIDING WITH

Person residing with	Responses	Percentages
Children	33	50.77
Life partner	17	26.16
Alone	6	9.23
Home nurse	1	1.54
Siblings	8	12.30

In the respondents, living arrangements of elderly individuals, highlighting that family plays a crucial role in their support system. A majority of 33 elderly individuals reside with their children, followed by 17 who live with a life partner, indicating strong familial ties. However, 6 elderly individuals live alone, raising concerns about potential isolation and the need for community support. Only 1 relies on a home nurse, suggesting a limited preference or accessibility to professional caregiving services. Additionally, 8 live with siblings, possibly as an alternative source of support. These findings emphasize the importance of family in elderly care while also underlining the need for policies that enhance social support systems, particularly for those who live alone or have minimal assistance.

TABLE 15. PRIMARY CAREGIVER

Primary caregiver	Responses	Percentages
Children	31	47.69
Life partner	10	15.39
House wife	6	7.61
Nil	5	12.30
Home nurse	8	6.15

The data shows that the majority of primary caregivers for the group surveyed are children (47.69%), followed by life partners (15.39%). Housewives (7.61%) and home nurses (6.15%) also play a role, but to a lesser extent. A small percentage (12.30%) have no primary caregiver, this suggests that caregiving responsibilities are predominantly taken on by family members, especially children, with professional or external caregiving (home nurses) being relatively uncommon. The presence of a significant Nil category may indicate individuals managing their own care or lacking direct support.

TABLE 16. GRANDCHILDREN'S INVOLVEMENT IN CAREGIVING

Grand children's involvement	Total responses	Percentages
No	37	56.92
Yes, partially	16	24.61
Yes, completely	12	18.47

The data shows that a majority (56.92%) of respondents report no involvement of grandchildren, indicating a significant gap in their participation. A smaller portion (24.61%) are partially involved, suggesting some level of engagement but not full participation. Only (18.47%) of

respondents indicate complete involvement of grandchildren. This suggests that while some grandchildren are engaged, most are either not involved at all or only to a limited extent, highlighting a potential area for improvement in fostering intergenerational connections.

TABLE 17. HOW OFTEN DO YOU GO OUT/ DO YOU ATTEND SOCIAL FUNCTIONS

Involvement in Social Functions	Responses	Percentages
Yes rare	35	53.85
Yes daily	11	16.92
House wife	6	9.23
Yes monthly	10	15.38
Never	3	4.62
Yes	6	7.69
No response	6	9.23

The data shows that the majority of respondents (53.85%) are rarely involved in social functions, indicating limited social interaction. Only 16.92% participate daily, and 15.38% attend monthly, suggesting that regular engagement is relatively low. A small percentage (4.62%) never participated, and 9.23% gave no response. Overall, social involvement appears to be infrequent, with most individuals not actively engaged in regular social activities.

TABLE 18. OLD-AGE GROUP MEMBERSHIP STATUS AND WILLINGNESS TO JOIN

Old Age Group Membership	Responses	Percentages
Not a member, not interested	39	60
Not a member, interested	16	24.61
Already a member	5	7.69
Used to be a member	5	7.69

The majority 60% of respondents are neither members nor interested in joining an old age group, indicating a general lack of engagement or perceived need. However, 24.61% are not members but are interested, suggesting potential for increased participation if encouraged. Only 7.69% are current members, while another 7.69% were members in the past, possibly due to changing needs or circumstances. Overall, there is low participation, but some interest exists, which could be tapped into with the right incentives or support.

TABLE 19. MAJOR SOCIAL CONNECTIONS OTHER THAN FAMILY

Type Connection	Number of Responses	Percentage
Neighbours	20	31%
Friends	18	28%
Others	27	40%

One the basis of responses received from 65 respondents, Neighbours represent a significant portion of social connections, with 20 responses (31%), emphasizing the importance of local communities in elderly social life. Meanwhile, friends make up the smallest percentage (28%) with 18 responses, but they still play a crucial role in maintaining social engagement. The distribution

of responses suggests that elderly individuals do not rely solely on one type of social connection but instead engage with a diverse range of social groups to maintain an active and connected lifestyle. The Others category accounts for the highest proportion (40%), with 27 responses, indicating that many elderly individuals form social ties outside of traditional friend and neighbor relationships. This could include connections through religious groups, community organizations, or other social activities.

TABLE 20. SATISFACTION IN THE CAREGIVING RECEIVED

Satisfaction Level	Total Respondents	Percentage
Very satisfied	47	73.44%
Satisfied	9	14.06%
Not sure	6	9.38%
Not satisfied	3	3.13%

A majority (73.44%) reported being very satisfied with the care they receive, indicating a high level of contentment with their caregivers and the support provided. Additionally, 14.06% of respondents stated they were satisfied, suggesting that while they have a positive view of their caregiving, there may still be areas for improvement. Meanwhile, 9.38% of respondents were not sure, possibly reflecting uncertainty about their caregiving experience or mixed feelings about the quality of care. Only a small percentage (3.13%) reported being not satisfied, indicating that dissatisfaction with caregiving is relatively low. Overall, the data suggests that the majority of elderly individuals feel well cared for, though there is a minor portion that may require additional attention or improvements in caregiving services.

TABLE 21. OPINION ON HEALTHCARE AVAILABILITY IN PANCHAYAT

Opinion	Total Respondents	Percentage
Very impressive	24	37.50%
Impressive	22	34.38%
Not bad	16	25.00%
Very bad	2	3.13%

The majority, 37.50%, rated the healthcare facilities as very impressive, while 34.38% found them impressive, indicating that over 70% of respondents have a positive perception of the healthcare services available. Additionally, 25% of respondents considered the healthcare facilities as not bad, suggesting that while they do not find them excellent, they still see them as functional. However, a small percentage, 3.13%, rated the healthcare services as very bad, indicating dissatisfaction among a few individuals. Overall, the data suggests that the healthcare services in the panchayat are generally well-regarded, with most respondents expressing satisfaction, though there is room for improvement to address the concerns of the minority who are not satisfied. The services in the panchayat are generally well-regarded, with most respondents expressing satisfaction, though there is room for improvement to address the concerns of the minority who are not satisfied.

A significant majority of respondents have provided feedback on healthcare availability, demonstrating a strong interest in the topic. While 73.13% express satisfaction with the caregiving they receive, only 31.34% benefit from governmental healthcare policies, suggesting that many lack access to additional support. Qualitative opinions reveal mixed perceptions, with some respondents finding the healthcare system impressive while others express dissatisfaction. These insights indicate that while existing healthcare facilities are valued by many, improvements are needed to enhance accessibility and affordability. This supports the argument for optimizing

resource allocation and implementing evidence-based practices to better serve the community's healthcare needs.

The analysis of healthcare benefits reveals significant disparities in access and distribution. Only 31.34% of respondents reported being beneficiaries of healthcare governmental policies, indicating that a large portion of the population may be missing out on essential support. Notably, 0% of respondents are members of regional service organizations, highlighting a gap in community structures that could assist in verifying eligibility for benefits. Furthermore, nearly 30% expressed a willingness to join groups aimed at improving eligibility verification, suggesting a community interest in enhancing the system. Qualitative feedback from respondents underscores concerns about inequitable benefit distribution, with some individuals feeling that those in better conditions are receiving support while they are overlooked. These insights collectively point to the urgent need for a more rigorous eligibility verification process to ensure that financial assistance is effectively targeted to those who truly need it.

TABLE 22. OPINION ON TRANSPORTATION FACILITIES

Opinion on transport facilities	Number of respondents	Percentage
Very impressive	34	52.31%
Impressive	14	21.54%
Not bad	12	18.46%
Not sure	5	7.09%

A majority, 52.31%, rated the transportation facilities as very impressive, indicating a high level of satisfaction with the available transport services. Additionally, 21.54% of respondents found them impressive, further reinforcing the overall positive perception. Meanwhile, 18.46% rated the

facilities as not bad, suggesting that while they may not find them excellent, they still consider them adequate. A small percentage, 7.09%, were not sure, possibly indicating a lack of sufficient experience with the transportation system or mixed feelings about its efficiency. Overall, the data suggests that transportation facilities in the area are generally well-regarded, with a majority expressing satisfaction, though there is still room for improvements to enhance accessibility and efficiency further.

CHAPTER 5

CONCLUSION AND SUGGESTIONS

In an era marked by rapid demographic shifts and societal transformations, the elderly population stands at the forefront of numerous challenges and opportunities. Kerala, a state renowned for its pioneering efforts in social welfare and development presents a unique context in which to examine the complexities of aging and elderly care. With a significant proportion of its population above the age of 60, rural Kerala's elderly community face distinct challenges, including physical, mental, social and economic insecurity. Cheranalloor grama panchayat, a rural locale in Ernakulam district, Kerala, presents a unique context in which to examine the intricacies of aging in rural settings. The elderly community there navigates several complexities. Despite the panchayat's commendable Social -welfare initiatives, there remain gaps in service delivery, accessibility and inclusivity. The study undertakes a sociological exploration of the socio - economic profile of the elderly in Cheranalloor grama panchayat aiming to identify areas of concern and recommended targeted interventions to ensure the well -being and dignity of this vulnerable Population.

1. A significant proportion of household expenditure is allocated towards medical costs, thereby imposing a substantial financial burden on certain families, therefore it is necessary that the Panchayat considers introducing a comprehensive benefit scheme to provide additional financial support to these families, alleviating the residents' economic hardship.

2. Access to reliable transportation emerges as a significant challenge for elderly individuals, often hindering their mobility and overall quality of life. To address the Inadequacies in public

transportation, it is imperative that the panchayat considers implementing an enhanced compostation system.

3. Existing healthcare facilities provide a foundation for addressing basic medical needs of the community, yet more accessible, affordable healthcare has to be enhanced with optimising resource allocation, implementing evidence- based practices.

4. Mental health is equally vital as physical health, and it deserves comparable attention, care and support to ensure overall wellness & quality of life. It is recommended that yoga and meditation classes be organized promoting the mental well-being they deserve.

5. Recreational activities options should be inclusive and accessible to all age groups, recognizing the importance of enjoyment for senior citizens. It would be beneficial if the Panchayat consider organizing recreation trips and excursions thereby promoting community engagement among the members.

6. Elderly may experience a range of emotional states in their advanced age, particularly those that stay by themselves. Establishing a community network will provide them with a platform for social interaction, support and collective enrichment.

7. The maintenance and upkeep of roads are a crucial responsibility of the governing authorities. The neglect of Panchayat has severe consequences. It is imperative that this issue is addressed promptly to ensure the safety, mobility and well-being of senior citizens

8. Leakage of scheme benefits to ineligible recipients constitute a pervasive issue, transcending local, national and international boundaries. Therefore it is recommended that the Panchayat should establish a rigorous eligibility verification process to ensure that financial assistance is targeted and provided exclusively

9. Successful implementation of enhanced schemes requires equitable benefit allocation, prioritizing vulnerable populations. To achieve this, the Panchayat must ensure universal awareness and targeted dissemination where relevant information about schemes and eligibility has been articulated to all members facilitating informed access to benefits.

The socio-economic profile of the elderly in Cheranalloor Grama Panchayat reveals key insights across demographics, education, employment, health, social connections, and infrastructure. The average age of respondents is approximately 71 years, with a significant majority being married (46 out of 65), indicating a stable family structure that provides crucial emotional and social support. The gender distribution shows more female respondents (40) than males (25), highlighting potential differences in health and caregiving needs. Education levels vary widely, with primary education being the most common, followed by higher secondary and graduation, emphasizing the need for continued educational resources for the elderly. Employment status among the elderly is diverse, including manual labor, housework, and business, with many continuing to contribute economically, though employment declines with age. Long-term relationships are evident, with the average years of marriage being around 46 years, suggesting strong support networks. Health and caregiving appear well-regarded, as most respondents express satisfaction with the care they receive, with "Very satisfied" being the most common response. Many are under medication and have access to health insurance, indicating awareness and management of health issues. Social connections play a vital role, with many elderly individuals maintaining strong family and community ties, expressing willingness to join social groups and participate in community activities. Healthcare is generally viewed positively, with many describing it as "Very impressive," and transportation facilities are also deemed adequate.

However, challenges remain, such as the need for greater educational support and addressing inconsistencies in the dataset. Future initiatives should focus on enhancing educational opportunities, improving healthcare access, and strengthening social support systems, with programs promoting social engagement and community involvement to further enrich the lives of the elderly. In summary, the elderly population in Cheranalloor Grama Panchayat is largely stable, with varying levels of education and employment. While healthcare and caregiving are perceived positively, further support in education and economic opportunities could enhance their overall quality of life. Understanding these factors and their interconnections can help shape policies and programs aimed at improving elderly well-being.

Pursuant to the survey, our research team conducted a follow-up visit to the Cheranalloor Grama Panchayath, on 24 january 2025 under the guidance of Dr. Dora Dominic, in charge of the Teresian Rural Outreach Programme, associated with the Department of Sociology, and presented our compiled, analyzed data and resultant recommendations to the Panchayath President, Mr. Rajesh K.G. The suggestions presented were specifically tailored to inform the implementation of welfare programs benefiting the elderly population within the Cheranalloor Grama Panchayath.

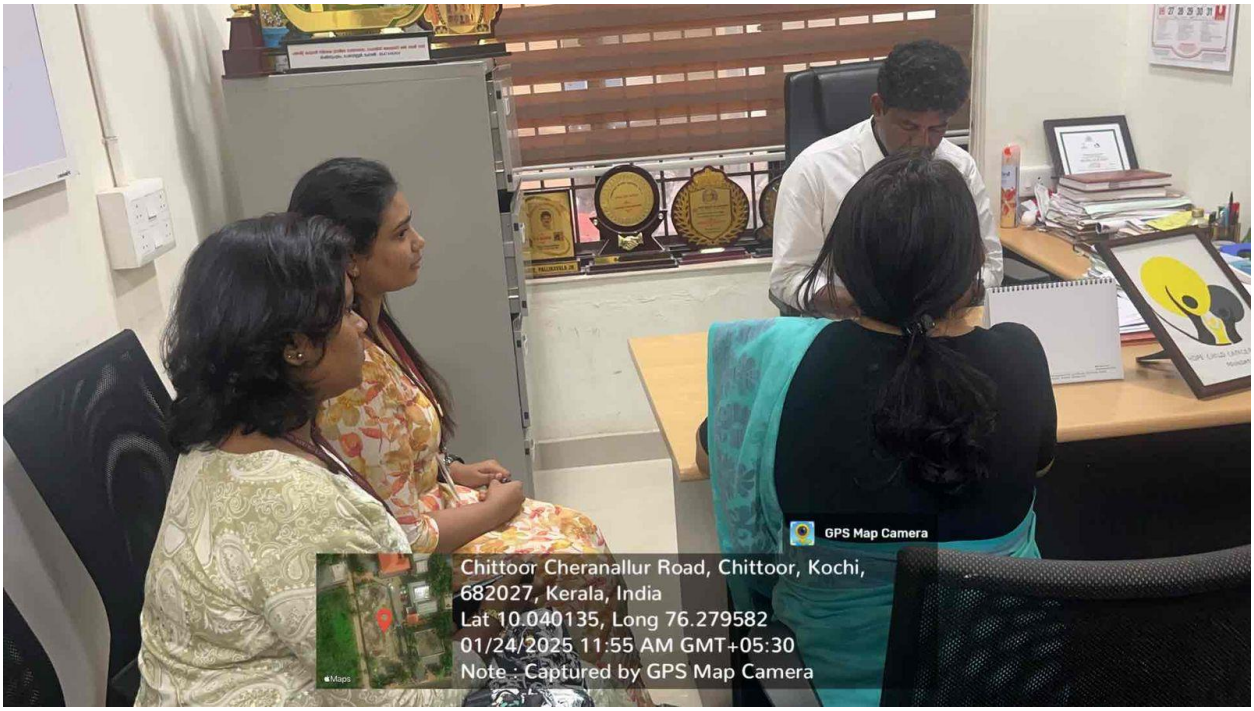


Fig.5.1 Discussion with panchayath president about the findings of the project

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APPENDIX

A STUDY ON THE SOCIO-ECONOMIC PROFILE OF ELDERLY PEOPLE PARTICULARLY AT CHERANALLOOR GRAMA PANCHAYAT

INTERVIEW SCHEDULE

1. Name

2. Gender

3. Age

4. Caste / Religion

5. Address

6. What is your marital status?

7. If married, then how many years of married life?

8. What is your current housing arrangement?

9. Are you literate?

10. What is your educational level?

11. Are you currently working? If yes, what is your job?

12. If not, then what is your employment history?

13. Are there any physical barriers you face? If yes, what sort of difficulties are you experiencing?

14. Is there any specific support / services you require to function daily?

15. Do you have any chronic or ongoing health issues or disease? If yes what kind?

16. Are you currently under medication?

17. Do you have any health insurance plan?

18. Do you recieve any sort of medical assistance? If yes, then what kind of assistance are you receiving?

19. Are you suffering from any mental health disorder? If yes, do you recieve any mental health care or support?

20. Have you been affected by Covid-19 in any way ?

21. Are there any physical or mental changes you experienced after covid -19?

22. Are you a beneficiary of any governmental policy or scheme regarding healthcare of the elderly?

23. Is there any policy or scheme initiated by your panchayat? And are you a beneficiary of it?

24. Are you aware of any NGOs providing support services for elderly individuals in your panchayat or surrounding areas?

25. If yes , are you a member of it ?

26. If not, are you willing to join such a group?

27. Have you heard about any health camp conducted in your panchayat?

28. Have you ever received medical treatment from any medical camps in or outside your Panchayat ?

29. How necessary are medical camps for the health care of your Panchayat residence including senior citizens like you?

30. Which is the nearby hospital that you have access to or which hospital do you depend on the most ?

31. Do you visit other health care facilities like clinics besides hospitals when you are sick?

32. If yes, then why do you opt for a clinic instead of a hospital?

33. How do you describe the medical health accessibility here in this panchayat?

34. Which mode of transportation do you rely on the most?

35. How comfortable do you think public transport is for the elderly individuals?

36. Do you have a vehicle of your own? If yes, what kind of vehicle do you own?

37. Do you drive yourself, if not who usually drives for you ?

38. Do you have a phone? If yes, then what kind of phone do you own?

39. Do you connect with your family or friends with the help of the internet?

40. Are you familiar with any other electronic device?

41. What is your primary source of income?

42. Do you have a pension? If yes , then what kind of pension are you receiving?

43. Is your pension spent on yourself?Is the amount enough to cover your needs?

44. Which is your ration card type?

45. Do you have any property land /other assets in your name? If yes, what sort of asset do you own?

46. Do you have children? If yes, gender and number of children?

47. Whom do you reside with ? Who is your primary care giver?

48. Do you have grandchildren, if yes their involvement in your caregiving ?

49. How often do you go out of your house?

50. Do you attend any functions or family gatherings? If yes, then when was the last time you attended?

51. Are you a member of any organization for elderly?

52. If yes, then in which group are you a member of?

53. If not , are you willing to join any ?

54. How do you spend your free time?

55. Who are your key social connections beyond family?

56. Are you involved in everyday house chores and how often ?

57. How do you describe the caregiving that you receive?

58. What do you think of the healthcare availability here in your panchayat?

59. What is your opinion on the transportation facilities in your panchayat?

60. If any inconvenience is present, do you think there are any changes that can be brought to address these issues ?

Interview Schedule - Malayalam

1. പേര്
2. ലിംഗഭേദം
3. പ്രായം
4. ജാതി / മതം
5. വിലാസം
6. നിങ്ങളുടെ വൈവാഹിക നില എന്താണ്?
7. വിവാഹിതനാണെങ്കിൽ, എത്ര വർഷത്തെ ദാമ്പത്യ ജീവിതം?
8. നിങ്ങളുടെ നിലവിലെ താമസ ക്രമീകരണം എന്താണ്?
9. നിങ്ങൾക്ക് സാക്ഷരതയുണ്ടോ?
10. നിങ്ങളുടെ വിദ്യാഭ്യാസ നിലവാരം എന്താണ്?
11. നിങ്ങൾ നിലവിൽ ജോലി ചെയ്യുന്നുണ്ടോ? ഉണ്ടെങ്കിൽ, നിങ്ങളുടെ ജോലി എന്താണ്?
12. അല്ലെങ്കിൽ, നിങ്ങളുടെ തൊഴിൽ ചരിത്രം എന്താണ്?
13. നിങ്ങൾ നേരിടുന്ന എന്തെങ്കിലും ശാരീരിക തടസ്സങ്ങളുണ്ടോ? ഉണ്ടെങ്കിൽ, നിങ്ങൾ എന്ത് തരത്തിലുള്ള ബുദ്ധിമുട്ടുകൾ അനുഭവിക്കുന്നു?
14. ദിവസേന പ്രവർത്തിക്കാൻ നിങ്ങൾക്ക് ആവശ്യമായ എന്തെങ്കിലും പ്രത്യേക പിന്തുണ / സേവനങ്ങൾ ഉണ്ടോ?

15. നിങ്ങൾക്ക് എന്തെങ്കിലും വിട്ടുമാറാത്തതോ തുടരുന്നതോ ആയ ആരോഗ്യ പ്രശ്നങ്ങളോ രോഗങ്ങളോ ഉണ്ടോ? ഉണ്ടെങ്കിൽ ഏത് തരത്തിലുള്ളത്?

16. നിങ്ങൾ നിലവിൽ മരുന്നുകളുടെ ഉപയോഗത്തിലാണോ?

17. നിങ്ങൾക്ക് എന്തെങ്കിലും ആരോഗ്യ ഇൻഷുറൻസ് പദ്ധതിയുണ്ടോ?.

18. നിങ്ങൾക്ക് ഏതെങ്കിലും തരത്തിലുള്ള വൈദ്യസഹായം ലഭിക്കുന്നുണ്ടോ? ഉണ്ടെങ്കിൽ, നിങ്ങൾക്ക് എന്ത് തരത്തിലുള്ള സഹായം ലഭിക്കുന്നു?

19. നിങ്ങൾക്ക് എന്തെങ്കിലും മാനസികാരോഗ്യ തകരാറുകൾ അനുഭവപ്പെടുന്നുണ്ടോ? ഉണ്ടെങ്കിൽ, നിങ്ങൾക്ക് എന്തെങ്കിലും മാനസികാരോഗ്യ പരിചരണമോ പിന്തുണയോ ലഭിക്കുന്നുണ്ടോ?

20. കോവിഡ് -19 നിങ്ങളെ ഏതെങ്കിലും വിധത്തിൽ ബാധിച്ചിട്ടുണ്ടോ?

21.. കോവിഡ് -19 ന് ശേഷം നിങ്ങൾ അനുഭവിച്ച ശാരീരികമോ മാനസികമോ ആയ എന്തെങ്കിലും മാറ്റങ്ങൾ ഉണ്ടോ?

22.. വയോജനങ്ങളുടെ ആരോഗ്യ സംരക്ഷണവുമായി ബന്ധപ്പെട്ട ഏതെങ്കിലും സർക്കാർ നയത്തിന്റെയോ പദ്ധതിയുടെയോ ഗുണഭോക്താവാണോ നിങ്ങൾ?

23. നിങ്ങളുടെ പഞ്ചായത്ത് ആരംഭിച്ച ഏതെങ്കിലും നയമോ പദ്ധതിയോ ഉണ്ടോ? നിങ്ങൾ അതിന്റെ ഗുണഭോക്താവാണോ?

24. നിങ്ങളുടെ പഞ്ചായത്തിലോ പരിസര പ്രദേശങ്ങളിലോ പ്രായമായ വ്യക്തികൾക്ക് പിന്തുണാ സേവനങ്ങൾ നൽകുന്ന ഏതെങ്കിലും എൻജിഒകളെക്കുറിച്ച് നിങ്ങൾക്ക് അറിയാമോ?
25. ഉണ്ടെങ്കിൽ, നിങ്ങൾ അതിൽ അംഗമാണോ?
26. ഇല്ലെങ്കിൽ, അത്തരമൊരു ഗ്രൂപ്പിൽ ചേരാൻ നിങ്ങൾ തയ്യാറാണോ?
27. നിങ്ങളുടെ പഞ്ചായത്തിൽ നടത്തുന്ന ഏതെങ്കിലും ആരോഗ്യ ക്യാമ്പിനെക്കുറിച്ച് നിങ്ങൾ കേട്ടിട്ടുണ്ടോ?
28. നിങ്ങളുടെ പഞ്ചായത്തിനകത്തോ പുറത്തോ ഉള്ള ഏതെങ്കിലും മെഡിക്കൽ ക്യാമ്പുകളിൽ നിന്ന് നിങ്ങൾക്ക് എപ്പോഴെങ്കിലും വൈദ്യ ചികിത്സ ലഭിച്ചിട്ടുണ്ടോ?
29. നിങ്ങളെപ്പോലുള്ള മുതിർന്ന പൗരന്മാർ ഉൾപ്പെടെ നിങ്ങളുടെ പഞ്ചായത്ത് വസതിയുടെ ആരോഗ്യ സംരക്ഷണത്തിന് മെഡിക്കൽ ക്യാമ്പുകൾ എത്രത്തോളം ആവശ്യമാണ്?
30. നിങ്ങൾക്ക് ഏറ്റവും അടുത്തുള്ള ആശുപത്രി ഏതാണ് അല്ലെങ്കിൽ ഏത് ആശുപത്രിയെയാണ് നിങ്ങൾ ഏറ്റവും കൂടുതൽ ആശ്രയിക്കുന്നത്?
31. നിങ്ങൾക്ക് അസുഖം വരുമ്പോൾ ആശുപത്രികൾ ഒഴികെയുള്ള ക്ലിനിക്കുകൾ പോലുള്ള മറ്റ് ആരോഗ്യ സംരക്ഷണ സൗകര്യങ്ങൾ നിങ്ങൾ സന്ദർശിക്കാറുണ്ടോ?

32. അതെ എങ്കിൽ, എന്തുകൊണ്ടാണ് നിങ്ങൾ ആശുപത്രിക്ക് പകരം ഒരു ക്ലിനിക്ക് തിരഞ്ഞെടുക്കുന്നത്?

33. ഈ പഞ്ചായത്തിലെ മെഡിക്കൽ ആരോഗ്യ പ്രവേശനക്ഷമതയെ നിങ്ങൾ എങ്ങനെ വിവരിക്കുന്നു?

34. ഏത് ഗതാഗത മാർഗ്ഗമാണ് നിങ്ങൾ ഏറ്റവും കൂടുതൽ ആശ്രയിക്കുന്നത്?

35. . പ്രായമായവർക്ക് പൊതുഗതാഗതം എത്രത്തോളം സുഖകരമാണെന്ന് നിങ്ങൾ കരുതുന്നു?

36. നിങ്ങൾക്ക് സ്വന്തമായി ഒരു വാഹനമുണ്ടോ? ഉണ്ടെങ്കിൽ, നിങ്ങൾക്ക് ഏതുതരം വാഹനമാണ് സ്വന്തമായുള്ളത്?

37. . നിങ്ങൾ സ്വയം വാഹനമോടിക്കുമോ, അല്ലെങ്കിൽ നിങ്ങൾക്കായി ആരാണ് സാധാരണയായി വാഹനമോടിക്കുന്നത്?

38. നിങ്ങൾക്ക് ഒരു ഫോൺ ഉണ്ടോ? ഉണ്ടെങ്കിൽ, നിങ്ങൾക്ക് ഏത് തരം ഫോണാണ് സ്വന്തമായുള്ളത്?

39. ഇന്റർനെറ്റിന്റെ സഹായത്തോടെ നിങ്ങൾ നിങ്ങളുടെ കുടുംബാംഗങ്ങളുമായോ സുഹൃത്തുക്കളുമായോ ബന്ധപ്പെടാറുണ്ടോ?

40. മറ്റേതെങ്കിലും ഇലക്ട്രോണിക് ഉപകരണം നിങ്ങൾക്ക് പരിചയമുണ്ടോ?

41. നിങ്ങളുടെ പ്രാഥമിക വരുമാന സ്രോതസ്സ് എന്താണ്?

42. നിങ്ങൾക്ക് പെൻഷൻ ഉണ്ടോ? ഉണ്ടെങ്കിൽ, നിങ്ങൾക്ക് എന്ത് തരത്തിലുള്ള പെൻഷനാണ് ലഭിക്കുന്നത്?

43. . നിങ്ങളുടെ പെൻഷൻ നിങ്ങൾക്കായി ചെലവഴിക്കുന്നുണ്ടോ? നിങ്ങളുടെ ആവശ്യങ്ങൾ നിറവേറ്റാൻ പര്യാപ്തമാണോ?

44. . നിങ്ങളുടെ റേഷൻ കാർഡ് തരം എന്താണ്?

45. നിങ്ങളുടെ പേരിൽ എന്തെങ്കിലും സ്വത്ത് ഭൂമിയോ മറ്റ് ആസ്തികളോ ഉണ്ടോ? ഉണ്ടെങ്കിൽ, നിങ്ങൾക്ക് ഏത് തരത്തിലുള്ള സ്വത്താണ് ഉള്ളത്?

46. നിങ്ങൾക്ക് കുട്ടികളുണ്ടോ? ഉണ്ടെങ്കിൽ, ലിംഗഭേദവും കുട്ടികളുടെ എണ്ണവും?

47. നിങ്ങൾ ആരുടെ കൂടെയാണ് താമസിക്കുന്നത്? നിങ്ങളുടെ പ്രാഥമിക പരിചരണ ദാതാവ് ആരാണ്?

48. നിങ്ങൾക്ക് പേരക്കുട്ടികളുണ്ടോ, ഉണ്ടെങ്കിൽ നിങ്ങളുടെ പരിചരണത്തിൽ അവരുടെ പങ്കാളിത്തം എന്താണ്?

49. നിങ്ങൾ എത്ര തവണ നിങ്ങളുടെ വീട്ടിൽ നിന്ന് പുറത്തുപോകാറുണ്ട്?

50. നിങ്ങൾ ഏതെങ്കിലും ചടങ്ങുകളിലോ കുടുംബ ഒത്തുചേരലുകളിലോ പങ്കെടുക്കാറുണ്ടോ? ഉണ്ടെങ്കിൽ, നിങ്ങൾ അവസാനമായി പങ്കെടുത്തത് എപ്പോഴാണ്?

51. നിങ്ങൾ പ്രായമായവർക്കായി ഏതെങ്കിലും സംഘടനയിൽ അംഗമാണോ?

52. ഉണ്ടെങ്കിൽ, നിങ്ങൾ ഏത് ഗ്രൂപ്പിൽ അംഗമാണ്?

53. അല്ലെങ്കിൽ, നിങ്ങൾ ഏതെങ്കിലുമൊന്നിൽ ചേരാൻ തയ്യാറാണോ?

54. നിങ്ങളുടെ ഒഴിവു സമയം നിങ്ങൾ എങ്ങനെ ചെലവഴിക്കുന്നു?

55. കുടുംബത്തിനപ്പുറം നിങ്ങളുടെ പ്രധാന സാമൂഹിക ബന്ധങ്ങൾ ആരൊക്കെയാണ്?

56. നിങ്ങൾ ദൈനംദിന വീട്ടുജോലികളിൽ ഏർപ്പെടുന്നുണ്ടോ, എത്ര തവണ?

57. നിങ്ങൾക്ക് ലഭിക്കുന്ന പരിചരണത്തെ നിങ്ങൾ എങ്ങനെ വിവരിക്കുന്നു

58. നിങ്ങളുടെ പഞ്ചായത്തിലെ ആരോഗ്യ സംരക്ഷണ ലഭ്യതയെക്കുറിച്ച് നിങ്ങൾ എന്താണ് ചിന്തിക്കുന്നത്?

59. നിങ്ങളുടെ പഞ്ചായത്തിലെ ഗതാഗത സൗകര്യങ്ങളെക്കുറിച്ച് നിങ്ങളുടെ അഭിപ്രായം എന്താണ്?

60. എന്തെങ്കിലും അസൗകര്യങ്ങൾ ഉണ്ടെങ്കിൽ, ഈ പ്രശ്നങ്ങൾ പരിഹരിക്കുന്നതിന് എന്തെങ്കിലും മാറ്റങ്ങൾ വരുത്താൻ കഴിയുമെന്ന് നിങ്ങൾ കരുതുന്നുണ്ടോ?