Indian Journal of
GERONTOLOGY

(a quarterly journal devoted to research on ageing)

Vol. 40 No. 4, 2026

Special Issue on Ageing with Dignity

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Indian Journal of Gerontology

(A quarterly journal devoted to research on ageing)

PEER REVIEWED JOURNAL
ISSN : 0971-4189
Approved by UGC – (CARE List Group B – Science, 121)

This Journal Does Not Charge Any Publication Fee

SUBSCRIPTION RATES
Annual Subscription
US $ 80.00 (Including Postage)
UK £ 50.00 (Including Postage)
₹ 1200.00 Libraries in India

Subscriptions are for Calendar year only
Claims for missing issues can be made within two months of publication of the issue.

Financial Assistance Received from :
ICSSR, New Delhi

Printed in India at :
Aalekh Publishers
M.I. Road, Jaipur

Typeset by :
Rajeev Kumawat
Jaipur

Contents

	Editorial	i– vi
1.	Healthy ageing among rural elderly: A model of health services *Anand P. Ambali, Kokilodayachandra, D. and Bhupathi Tabusum*	431–446
2.	Emerging Nursing Care Challenges for the Ageing Population in India: A Narrative Synthesis *Devnarayan*	447–454
3.	Ageing, Healthcare Access, and Care Practices among Tribal Elders in Fifth Schedule Areas of Odisha *Saswat Kumar Pradhan*	455–469
4.	Addressing Social Isolation and Loneliness in Rural Older Adults: Early Outcomes from a Community-based Group Intervention *Neha Muralidharan*	470–493
5.	Solo Ageing as Necessity or Choice? *Medhavi Gupta*	494–518
6.	The 'Empty Nest' phenomenon and Well-Being among Older Adults in India: Evidence from Longitudinal Ageing Study in India *Ravina Ranjan and Bhaswati Das*	519–536
7.	Gender Differences in Socioeconomic Vulnerability and Their Impact on Well-being of Older Adults in India *Ravi D. Prasad and Anjali Radkar*	537–564
8.	Old-Age Pensions as a Right or Policy Grace? An Evaluation of Old-Age Social Assistance Schemes in India *Taniya Malik,*	565–590
9.	Religion, Health Perceptions, and Ageing: Is India in need of reforms? *Kshipra Jain and Manish Sinsinwar*	591–605
10.	Outstanding Loans, Social Pension and Life Satisfaction : An Analysis Using Longitudinal Ageing Study in India (LASI) Data *Rakhi Jangir*	606–633
11.	Labour Market Vulnerability Among Older Adults in India: An Intersectional Analysis Using PLFS Data *Neha Paliwal*	634–658
12.	Ageing, Vulnerability and Dignity: Looking Through the Lens of Mental Health Challenges *G. C. Pal*	659–686
	Contributors	687–688

NEWS & VIEWS

SCOPE OF THE JOURNAL

Indian Journal of Gerontology (ISSN : 0971-4189) is a peer-reviewed and UGC Approved Journal, and is indexed by - the Indian Ctation Index, Google Scholar, CNKI Scholar, EBSCO Discovery, and UGC Group 1. Started in the year 1969, is the first in India, and 18th in the world. It publishes papers related to the Biological aspects of Human ageing, animal ageing, and ageing of plants. It also publishes papers on geriatrics, geriatric nursing, and geriatric physiotherapy (Clinical aspects). The social aspects of ageing cover, Sociology, Social work, Anthropology, Psychology, Economics, Demography, and other Social Sciences.

The publishers and authors who contribute their publications on gerontology are essential to advancing knowledge and help shape our community. You may send two copies of your work for review by scholars and potential publication in our journal, Indian Journal of Gerontology.

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Call for papers for special Issue (April 2027) on "5 MS" of Geriatric Medicine.

Last Date 1st March 2027

EDITORIAL

In recent years, the United Nations has introduced themes for the International Day of Older Persons that highlight key aspects of ageing, helping society and governments understand the global evolution of ageing issues. It reminded us that dignity in later life is a collective duty, requiring strong care systems, inclusive policies, and social solidarity and encouraged healthcare professionals and citizens to see their role in shaping ageing support.

In 2024, the UN's theme for World Older Persons Day was *"Ageing with Dignity: The Importance of Strengthening the Care and Support System for Older Persons Worldwide"*. It emphasised society's and the state's responsibilities. It reminded us that dignity in later life is not a gift of circumstance but a collective duty, requiring strong care systems, inclusive policies, and social solidarity.

In 2025, the theme *"Older Persons Driving Local and Global Action: Our Aspirations, Our Well-Being and Our Rights"* shifted the lens to agency and participation. Here, older persons were not only recipients of care but were also recognised as leaders, advocates, and contributors shaping the world around them. And in 2026, the theme *"Resilience of Older Persons in a Changing World"* highlights the inner strength and adaptability of older persons themselves. It acknowledges that in a rapidly changing social, technological, and environmental landscape, resilience is not merely survival, it is the capacity to transform, to remain rooted yet flexible, and to continue offering wisdom in times of uncertainty.

Understanding the UN themes as a journey from protection to empowerment and resilience can inspire policymakers and professionals to see ongoing progress and potential for positive change in ageing policies.

Dignified ageing involves policies that ensure older persons live with respect, autonomy, security, and inclusion, especially as India's elderly population grows rapidly. A holistic approach to ageing

emphasises respect, independence, healthcare, financial security, and social inclusion. The UN highlights ageing as a human success story, but warns that without strong support systems, dignity can be compromised. In India, as longevity rises, dignified ageing is central to welfare policies and healthcare reforms. When we look at accessible, affordable geriatric care, we find that geriatric-trained doctors are in short supply and healthcare is very costly. Pensions, savings, and insurance give financial security in old age. Only 29% of the elderly receive pensions. The gradual breakdown of joint families has reduced seniors' active participation in family and community life, leading to loneliness. Elder abuse and neglect are increasing due to weak enforcement (or lack of publicity) of laws like the Maintenance and Welfare of Parents and Senior Citizens Act 2007. Ageism and reduced autonomy and respect for seniors are reflected in families and society because seniors lack decision-making power and recognition of their contributions.

The government has taken some initiatives in this direction. For example, Ayushman Bharat PM-JAY expansion (2024) provides free health coverage for citizens above 70 years. The National Programme for Health Care of the Elderly (NPHCE) provides specialised geriatric services. Similarly, the Indira Gandhi National Old Age Pension Scheme (IGNOAPS) provides financial support for BPL seniors. But these initiatives are not sufficient because India has over 149 million seniors today, and nearly 350 million are projected by 2050. As the number of seniors grows, India must take immediate steps to address these challenges by strengthening *care and Support Systems* so that seniors may *age with Dignity*

Dignified ageing requires urgent policy reforms in healthcare, pensions, social inclusion, and legal protections to inspire policymakers and professionals to act decisively for seniors' well-being and dignity.

Institute of Development Studies Jaipur (Rajasthan) organised a two-day National Seminar on Ageing with Dignity from February 26-27, 2026 with financial support from Indian Council of Social

Science Research (ICSSR) New Delhi, Government of India. Participants presented 25 papers. Out of those papers, 12 were selected for this special issue of the Indian Journal of Gerontology on the theme of the seminar.

A Summary of Papers: Studies on Ageing, Vulnerability, and Well-Being in India

Across diverse contexts in India, recent studies converge on the urgent need to make elder care more accessible, culturally sensitive, and sustainable. Ambali and colleagues documented a five-year community camp in Arjunagi village that brought healthcare directly to the doorsteps of 237 elderly individuals. By overcoming mobility barriers and offering free medicines, screenings, and follow-ups, the camp achieved measurable improvements in blood pressure, blood sugar, and weight, while also identifying new cases of non-communicable diseases. Its steady growth in beneficiaries shows how affordable, community-based models can reach rural elderly who are otherwise hard to reach.

Devnarayan's work highlights the indispensable role of nurses in elder care across hospital, community, and home settings. Yet workforce shortages and gaps in geriatric-specific training limit care quality. The literature synthesis points to escalating clinical complexity, ethical responsibilities, and organisational constraints, underscoring the need for structured geriatric nursing training, culturally responsive strategies, and alignment with national programmes such as the NPHCE to strengthen equity and responsiveness in elder care.

Saswat Kumar's study of tribal elders in Orissa reveals systemic barriers that force reliance on traditional medicine, which remains inadequate for chronic and life-threatening conditions. The lack of linguistic and cultural sensitivity among providers further alienates tribal elders, while poverty and isolation deepen their vulnerability. To ensure dignity and healthy ageing across India's diverse regions, policies must incorporate culturally sensitive healthcare models, tailored outreach programs, and community engagement strategies that respect regional

traditions and languages, thereby promoting equitable elder care in tribal and rural areas.

Neha Murlidharan's early findings from a community-based group intervention in Tamil Nadu show promise in addressing loneliness and social isolation among socioeconomically vulnerable elders. Structured activities such as chair yoga, cognitive games, and creative exercises fostered participation and peer interaction, while on-site healthcare consultations added value. Despite attendance challenges, the intervention demonstrates feasibility and contextual appropriateness, with long-term evaluation needed to assess sustainability and integration into public health systems.

Together, these studies illuminate a shared vision: elder care in India must be affordable, accessible, culturally attuned, and integrated across health and social domains. Whether through doorstep medical camps, strengthened nursing education, culturally sensitive outreach in tribal areas, or community-based social interventions, the path forward lies in holistic strategies that uphold dignity, health, and inclusion for the ageing population.

Recent scholarship on ageing in India reveals a complex interplay of autonomy, vulnerability, social protection, and cultural influences shaping the lives of older adults. A case study, Autonomy and Solo Ageing by Madhavi Gupta, of five widows aged 70-80 shows that financially secure female solo agers exercise autonomy in everyday life. They choose alternative living arrangements (senior living facilities, apartments, pay-and-stay homes), sustain social networks beyond family, and engage in active ageing practices. This micro-level narrative highlights resilience and independence among urban elderly women. Using LASI Wave I data (30,000+ respondents), the study, Empty Nest Households- by Ravina Ranjan & Bhaswati, finds that 26.8 per cent of older adults live in empty nest households. While these elders report better economic status, they face higher risks of poor physical and social well-being. The findings underscore the need for policies that strengthen healthcare access, community support, and social protection to offset disadvantages of solitary living. In his study,

Gendered Socioeconomic Vulnerability, Ravi D. Prasad analysed LASI Wave I findings (72,250 respondents), which show that 32 per cent of older adults experience high socioeconomic vulnerability (SEV). Women are over three times more likely than men to face SEV, with widowhood, caste, religion, rural residence, and poor housing compounding risks. Vulnerability peaks among women aged 80+, showing cumulative disadvantages across the life course. The study calls for inclusive, gender sensitive policies to address structural inequalities. Taniya Malik's study, Social Assistance and Rights, examined old age pensions, the paper questions whether non-contributory social assistance is welfare or a rights-based entitlement. While contributory pensions are constitutionalised as rights, tax-financed social pensions remain framed as welfare schemes with executive discretion. Jurisprudence, however, offers doctrinal hooks for recognising social pensions as part of the right to live with dignity under Article 21, signalling scope for incremental rights-based reform. Using ISSP 2021 data (27,958 respondents), the study, Religion and Health Perceptions, by Kshipra Jain & Manish Sinsinwar, explores how religious beliefs shape perceptions of health systems. Findings show the elderly are more just in their views compared to younger cohorts, while *Hindu respondents are least progressive*. Though religion's explanatory power is modest, it remains significant, suggesting that inclusive ageing policies must account for religiously shaped worldviews. In her study on Life Satisfaction, Rakhi Jangir used LASI Wave 1 data (31,320 respondents) and found that 89 percent of older adults report life satisfaction, though loans and limited pension coverage remain concerns. Education, health, and family co-residence are strong positive predictors, while poor health, disability, food insecurity, and living alone reduce satisfaction. Regional differences (higher satisfaction in the West, lower in the Central region) highlight the role of cultural norms and community support. In her study, Labour Market Vulnerability, Neha Paliwal used PLFS 2023-24 data (40,748 older adults) and constructs a Labour Market Vulnerability Index. Gender, education, expenditure, social group, and household

size are key determinants. Older women face cumulative disadvantages, while older adults often work out of necessity rather than choice. The findings stress the need for inclusive labour market policies and stronger social protection to ensure dignified ageing, aligning with SDG 8 on decent work. G.C. Pal, in his paper, highlighted that India's rapidly growing elderly population faces not only health and economic challenges but also significant mental health burdens. The paper emphasises that implementing integrated healthcare, targeted interventions, and community outreach can make a meaningful difference in upholding elders' dignity and well-being.

In brief, while some elderly, especially financially secure widows, demonstrate autonomy and resilience, structural vulnerabilities persist for women, marginalised groups, and those in empty nest households.

Women, particularly widows and those aged 80 years and above, face compounded disadvantages across health, social, and economic domains. Social pensions remain framed as welfare rather than rights, labour markets lack equitable opportunities, and cultural and religious perceptions shape healthcare systems. Life satisfaction and vulnerability differ across regions and communities, pointing to the need for context-sensitive interventions. The urgent need is for inclusive, rights-based, and gender-sensitive policies to ensure dignity, security, and well-being for India's ageing population.

We hope readers and policymakers will benefit from these studies in understanding the issues faced by senior citizens and in planning to better support for older adults.

Indian Journal of Gerontology
2026, Vol. 40, No. 4, pp. 431-446
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI : 10.5958/0971-4189.2026.00001.2

Healthy ageing among rural elderly: A model of health services

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ABSTRACT

The elderly in rural areas often face difficulties accessing healthcare services, resulting in poor health and overall well-being. This Reaching the Unreached camp for the elderly was conducted to address unmet needs, such as transportation and mobility barriers, and to provide continuous healthcare services. This study aimed to present the health profile of elderly individuals residing in rural areas and evaluate the impact of regular healthcare services, including measurable improvements in blood pressure, blood sugar, and weight. This ongoing community-based field study was conducted over five years in the village of Arjunagi. A total of 237 elderly individuals voluntarily enrolled to access healthcare services. Services included symptom assessment, vital sign monitoring, blood sugar and haemoglobin estimation, and clinical examination.

Medicines were provided free of cost. Improvement in blood pressure and blood sugar levels, weight, and regularity of follow-up were used as indicators of positive impact. Universal sampling was used for analysis, and systematic random sampling was applied to assess weight gain. The findings of showed that, among 237 elderly individuals, males predominated (54%), and most (80%) were aged 60–74 years. Common prevalent diseases were musculoskeletal disorders (30%), hypertension (23%), and diabetes (13%). Regular Screening identified 51 patients newly diagnosed with non-communicable diseases. Multimorbidity was observed in 23 elderly individuals. Disabilities such as hearing loss and partial blindness were noted in 29 elderly individuals, and polypharmacy in 12. The number of beneficiaries at the camp has doubled over the past five years. There were 9 mortalities in the last 5 years. Based on these findings, the camp delivers affordable, accessible healthcare to older people in rural areas who are differently abled, poor, and living alone at their doorstep, thereby reaching the unreached.

Keywords : Rural elderly healthcare, Community-based health camp, Non-communicable diseases, Multimorbidity in ageing, Accessible healthcare services, Health profile of the elderly

The elderly in India currently comprise a little over 10 percent of the population, translating to about 104 million, of whom 71percent reside in rural areas (NSO 2021). Moreover, many seniors, especially women and those residing in rural areas, face challenges in accessing healthcare due to the limited availability of geriatric specialists and services, high out-of-pocket costs, and a lack of awareness about age-related health issues (Help Age 2022; NITI Aayog 2024). Elderly people residing in rural regions are more vulnerable to health inequities than other age groups in India.

Rural health status in developed countries like the United States is in crisis. Decades of hospital closures, clinician shortages, and the loss of essential services have left millions of people without reliable access to care and with worse health outcomes. The government has announced scoring methods to determine award amounts for organisations providing rural health care. (Heather, and Carmel, 2026). In India, the rural population is large and growing; hence, there is a dire need for a policy to ensure that health services reach them.

On October 21, 2020, we at the Department of Geriatric Medicine received an emergency call amid the COVID-19 pandemic: elderly people in and around Arjuangi village had exhausted the medicines they needed for chronic diseases, and most lacked access to health services. Our department, along with the medical college administration, geared up for the occasion and, with a team of doctors from the geriatrics department, nurses, and interns, sent a team to the village on 23 October 2020 to provide healthcare services to all in need. Clinical examination, basic blood tests, and electrocardiography were performed, and medicines sufficient for one month were provided to all needy elderly individuals. This led to the formation of the 'Reaching the Unreached' health service camp exclusively for the elderly of the village. Since then, the geriatrics department faculty has been visiting the same village on the fourth Sunday of every month. The services are provided by a team comprising Anand Hospital (NGO), Shri B M Patil Medical College Hospital, the National Program of Health Care for the Elderly (NPHCE) Vijayapura, and the Gram Panchayat of Arjunagi village.

This camp has been ongoing and has completed 62 months of non-stop health services as of November 2025. This study presents a ground report on the health status of the elderly in a village from the geriatrician's perspective.

A total of 237 elderly people, irrespective of caste or sex, have registered for the camp and have been seeking health services over

the last five years. Every year, the cumulative number of beneficiaries is increasing. These camps not only address existing diseases among the elderly but also help detect new-onset diseases through regular screening. Consistent availability of medicines and regular monthly visits by the team have improved overall well-being among the elderly. Home services are provided for older people who are bedridden in the village. The elderly who require additional medical tests or surgery receive extended services at the medical college hospital.

The elderly with age-related diseases are most prevalent in rural areas. They are economically insecure and lack access to, or cannot afford, quality health care. There is a lack of early diagnosis and access to regular medications. Older adults in rural areas face difficulties accessing adequate healthcare services. (Banerjee, 2021).

Over the last five years, this camp has addressed unmet needs in health services for the elderly, such as affordability, accessibility, consistency, and inclusiveness. In addition to health services, awareness talks are organised for the elderly. This camp also provided a platform for the unique Government of Karnataka program, the Karnataka Brain Health Initiative (KaBHI), to conduct dementia screening camps for the elderly rural population. (AFPI Karnataka 2025). Our team was also part of the national program 'Swasth Nari Sashakt Parivar Abhiyan' at Arjunagi Village on 28/09/2025.

The impact of the camp is such that the elderly from nearby villages are also seeking health services. This activity has been endorsed in the United Nations Decade of Healthy Ageing report published in 2023 (Decade of Healthy Ageing 2023). The villagers have honoured the team members during their annual fest as a token of gratitude.

These ongoing camps have made a lot of positive impact among the elderly who are differently abled, staying alone, frail, below the poverty line, and cannot afford to reach the health care facilities.

Method

The health check-up camp has been organised every month for the last five years in the village of Arjunagi. 237 elderly people have registered voluntarily to seek health services as of November 2025. This is ongoing fieldwork. The registration process is free and open to all elderly people, irrespective of sex, caste, religion, or socio-economic status. Every month, one to two new elderly people get registered to avail health services. The elderly seeking health services are provided with a one-time, unique registration number. Written consent in the local language is taken from all elderly people attending the camp at the time of initial registration. Demographic data such as age, sex, and marital status are collected, and existing diseases are noted in the proforma.

Some people elderly seek services as needed, while those with non-communicable diseases visit regularly. A few elderly people often leave the village for various reasons, such as helping their families with farming, serving as caregivers for their grandchildren, or migrating for work, and they return after a few months. During these months of absence, they are lost to follow-up.

Health services include recording new symptoms, monitoring vital signs, measuring blood sugar and haemoglobin levels, and conducting detailed clinical examinations. The required medicines are provided free of cost and are sufficient for one month. A record is maintained of the examination findings and medications provided, and a copy is provided to the elderly patient. Improvements in blood sugar and blood pressure levels, weight gain, and regularity in follow-up are used as indicators of positive impact.

Most elderly people are living with chronic health diseases, their complications and disabilities. For older people who are bedridden or unable to reach the centre, a service is available to visit them at home. Elderly persons who require additional medical tests or surgery are referred to the medical college hospital for detailed evaluation and treatment.

Data from all 237 elderly patients so far have been analysed and presented in tabular form. The universal sampling method was

applied. The systematic random sampling technique was used to assess weight gain, evaluating the weight of every tenth elderly patient at registration and comparing it with the most recent available record. Details of elderly patients who have died in the last five years have also been included.

Results

Age and sex distribution (Table 1)

Among two hundred and thirty-seven elderly participants, one hundred and twenty-seven are male, and one hundred and ten are female. The majority of patients (80%) were aged 60 to 74 years, i.e., young-old. The oldest patient is a 100-year-old female for whom a home visit was conducted.

Table-1
Age and Sex Distribution

Age in years	Male	Female	Total	%
60 to 74	99	92	191	80
75 to 84	21	16	037	16
>85	07	02	009	04
Total	127 (54%)	110 (46%)	**237**	**100**

Diseases present in the elderly population (Table 2)

The most common diseases were non-communicable diseases. The disease that already existed among the participants is identified through medical history, previous records and examination. Musculoskeletal system disorders like osteoarthritis of the knee, cervical and lumbar spondylosis, and post-fracture neck and femur constituted 30 per cent of the elderly, with a female predominance. Hypertension is the next most common disease seen in 23 per cent, with female dominance, while Diabetes mellitus was the third most common, with 12 per cent, again with female predominance. The other diseases were Chronic Obstructive Pulmonary Disease, Stroke, Anaemia, Parkinsonism, Cancer, Acid Peptic Disease, Heart Failure, Cardiac Arrhythmias, Ischemic Heart Disease, Cataract, Benign Prostatic Hypertrophy, Chronic Kidney Disease, Dementia and

Epilepsy. Interestingly, 28 per cent of elderly participants had no diseases. The high prevalence of disease among elderly females is a concern.

Table 2

Disease(s) present in elderly population

Disease Name	Male	Female	Total	%
Musculoskeletal	30	40	70	30
Hypertension	19	37	56	23
Diabetes Mellitus	13	17	30	12
Cataract	11	9	20	8.5
COPD	11	6	17	04
Ischemic Heart Disease	5	10	15	6.3
Anaemia	6	5	11	4.6
Stroke	5	1	06	2.5
Parkinsonism	5	0	05	02
Cancer	2	2	04	1.6
Acid Peptic Disease	2	2	04	1.6
Benign Prostatic Hypertrophy	4	0	04	1.6
Depression	0	2	02	0.8
Heart Failure	1	0	01	0.5
Cardiac Arrhythmias	0	1	01	0.5
Chronic Kidney Disease	1	0	01	0.5
Dementia	1	0	01	0.5
Epilepsy	0	1	01	0.5
No diseases	43	24	67	28

This study has the added advantage of identifying new diseases over a 5-year period through screening (Table 3). The diseases detected through the camp are hypertension in 13, anaemia and osteoarthritis in 10 each, diabetes in 8, cataract in 4, thyroid disorders in 3, and ischemic heart disease, Alzheimer's disease, and brain tumour in 1 each. The number of diseases and persons vary because

multiple diseases may be diagnosed in the same elderly patient. This was possible because our camp regularly visited the same village, and elderly participants came for follow-up and were screened for diseases. This camp helped detect diseases in 51 elderly participants who were unaware of their conditions and were diagnosed during screening. This emphasises that regular screening for non-communicable diseases helps identify elderly individuals with these conditions, enabling early treatment. This prevents complications and delays disabilities.

Table 3

Newly detected Diseases

Disease Name	Male	Female	Total	%
Hypertension	8	5	13	6
Anemia	2	8	10	4
Osteoarthritis	3	7	10	4
Diabetes Mellitus	4	4	08	3
Thyroid Disorders	2	2	04	1.5
Cataract	2	2	04	1.5
Ischemic Heart Disease	1		01	0.5
Brain Tumor	01	-	01	0.5
Alzheimer's	01	-	01	0.5
Acute illness (Bronchitis, Urinary Tract Infection, Typhoid fever, viral fever, Flu)	30	40	70	

Osteoarthritis and anaemia were common in females, while hypertension was common in males. Acute illnesses such as viral fever, urinary tract infection, bronchitis, diarrhoea, and typhoid fever were treated on an outpatient basis with short-course antibiotics and supportive treatment.

Multimorbidity

Among 237 elderly participants, 23 (9.7%) are living with more than two comorbidities.

Functional capacity

Sixty-six elderly patients (28%) have low to moderate dependence as identified by the Instrumental Activities of Daily Living scale. This camp has been accessible to them.

Disabilities

The common disabilities found were blindness or partial blind in 20(8%) and Hearing loss in 09(3.7%) elderly participants

Medications

The elderly patients using four or more medicines regularly (Polypharmacy) are 12, while twenty-one are using three medicines. This is alarming as twentyone elderly people will shift to the polypharmacy category in the near future.

Year-wise beneficiaries (Table 4)

The number of beneficiaries of the camp has steadily increased over the last five years. A total of 185 elderly participants availed of the camp's health services in 2021, which rose to 365 in 2024. This rising trend in the number of patients seeking health services indicates that the elderly in rural areas are now aware of and making the best use of such camps. Our commitment to making health care reach the unreached is gaining momentum.

Table 4

Year-wise beneficiaries

Year	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
Total camps organised n = 62	03	12	12	12	12	11
Beneficiaries	122	185	278	331	365	348 (Nov 25)

Healthy elderly people

Among 237 health camp-seeking participants, 28 percent of the elderly had no diseases. They visit our camp regularly to get screened for Non-communicable Diseases.

Mortality

The number of elderly patients who died in the last five years was nine.

Discussion

One positive aspect of the camp's gender distribution is that women are taking advantage of it, as their male counterparts do. In fact, women have been more regular with follow-up than men in the last five years, as this camp is accessible and affordable.

This camp has helped with the timely diagnosis of diabetes, hypertension, cancer and chronic obstructive pulmonary disease has also ensured regular medications and appropriate monitoring every month for the last five years. This indirectly helps delay complications like heart disease, renal failure and stroke.

In this study, males accounted for 54 per cent, whereas in Suman & Sinha (2025), males accounted for 51.9 per cent and females for 48.1 per cent. In a study by Radjasegarane *et al.,* (2021), a female predominance of 66.4 per cent was seen.

The prevalence of disease patterns among rural elderly in various studies is presented in tabular form. (Table 5). The common non-communicable diseases in this study were musculoskeletal diseases, hypertension, and diabetes. There are substantial differences in disease prevalence among rural elderly across studies (Ghosh *et al.,* (2015), Vidyashree *et al.,* (2020), Radjasegarane *et al.,* (2021), Kapri, and Yadavannavar (2023), Das and Kar, (2024), Flage *et al.,* (2025), Suman and Sinha (2025). This difference may be attributed to the diseases identified by the consultant varying from those identified by the survey method. It is indeed clear from all the studies mentioned that non-communicable diseases are now common among the elderly residing in rural areas as well. Our camps have also identified more diseases than other studies. Three elderly individuals have been diagnosed with cancer, treated and are on therapy. In contrast, one older male was diagnosed with a brain tumour and was operated on at the Medical College Hospital, but later succumbed to it.

Table 5
Disease patterns among rural elderly across various studies

Disease Name	Radjase-garane (2021)	Das and Kar (2024)	Vidyashree *et al.*, (2020)	Ghosh *et al.*, (2015)	Flage *et al.*, (2025)	Kapri and Yadavann-avar, (2023)	Suman, and Sinha (2025)	Our study %
Musculoskeletal (%)	08	11	37	49	11	52	38	30
Hypertension	42.5	71	35	41	34	32	42	23
Diabetes Mellitus	29.6	33	39	9.5	25	21	32	12
Cataract	4.3	-	-	-	-	3.4	34	8.5
COPD	7.9	30	32	29	04	3.4		04
Ischemic Heart Disease	2.9	21	3.3	41	-	0.6		6.3
Anaemia	-	-	22	-	-	9.7	14	4.6
Stroke	1.2	14	2.3	3				2.5
Parkinsonism				1				02
Cancer		2.8	0					1.6
Acid Peptic Disease								1.6
Benign Prostatic Hypertrophy						1.7		1.6
Depression		15						0.8
Heart Failure								0.5
Cardiac Arrhythmias								0.5
Chronic Kidney Disease								0.5
Dementia								0.5
Epilepsy								0.5
No diseases						15.4		28
Acute diseases	4%							29%

This camp is also helping the elderly with multiple comorbidities. The elderly living with two or more comorbidities in the study population were 9.7 per cent, while in a study by Flage *et al.,* (2025), there were 35 per cent participants with at least two chronic illnesses, 4 per cent participants with at least three chronic illnesses and 22 per cent in a study by Kapri and Yadavannavar (2023).

These are the elderly who require a larger number of medicines and are at risk for polypharmacy as well. Our camp is ensuring an adequate supply of medicines for this set of patients. The number of elderly patients with multimorbidity is low; hence, rational polypharmacy is also not observed in our patient population.

The most common disabilities in our study population are blindness and hearing loss, while Velayutham *et al.* (2016) reported that the disability rate is higher in the elderly residing in rural areas (5,593 per 100,000) than in urban areas (4,181/100,000).

The elderly with mental health issues are very few in our camp, as the elderly do not wish to attend such camps due to stigma and fear of discrimination associated with them. One elderly person living with Dementia has lost follow-up in our health care services since the diagnosis was made. In most of the villages, the family members of the elderly with mental health issues seek alternative therapies (Jadhav *et al.,* 2007).

According to the study by Suman and Sinha (2025), the primary reasons for not seeking treatment were "lack of money and family support" (57.9%) and "not feeling it was necessary to go to the doctor as the conditions were age-related" (32.3%). Our monthly camp has helped older adults overcome this barrier by providing medicines free of charge and on a regular schedule.

Healthy elderly people accounted for 28 per cent of our study population, while 15.4 per cent had no diseases, according to Kapri and Yadavannavar (2023). The reason is that a few of the elderly who do not have diseases still come for regular check-ups and screening for diabetes and hypertension.

This camp not only helps the elderly in rural areas access primary care but also serves as a gateway to secondary and tertiary care at the medical college hospital. The elderly, for whom additional tests or surgical intervention are required, are directed to the medical college hospital, to the department of geriatrics, where our team consults with them and then refers them to the required specialists. The emergency contact number is also printed on the health cards. The elderly of the village have access to the geriatric care team round the clock and during emergencies.

Strengths

- The study is based on physician-assessed data, documented through examinations and medical records, rather than relying solely on interviews.
- Inclusion of healthy elderly (28%) highlights that rural populations seek preventive health services, not only treatment.
- Regular screening methods enabled the detection of non-communicable diseases that are often overlooked in similar studies.
- The ongoing nature of the camp allowed the provision of extended secondary and tertiary care to those in need.
- Consultant visits and repeated examinations ensured accurate identification of specific diseases among the elderly.
- Continuous screening facilitated new case detection over time, including conditions like anaemia that are frequently missed.
- Meticulous follow-up and mortality recording provided longitudinal insights absent in many comparable studies.

Limitations

- Some elderly participants were irregular in follow-up, limiting continuity of data collection.

- Healthy elderly attending only for routine screenings were not tracked longitudinally, leading to gaps in follow-up.
- Seasonal migration of elderly resulted in loss to follow-up, making it difficult to maintain complete longitudinal data for all participants.

Conclusion

The Reaching the Unreached camp has successfully addressed unmet health needs among rural elderly by bringing affordable and accessible services directly to their doorsteps, especially benefiting widows, widowers, people with low incomes, those living alone, and the differently abled. Sustained for five years in the same village, with growing participation, the camp exemplifies dedicated teamwork supported by the gram panchayat of Arjunagi, the medical college hospital, Anand Hospital, and NPHCE Vijayapura. Its reliance on real, clinically identified health data enhances its credibility and usefulness for policymakers. If replicated nationwide, with each private medical college hospital adopting one village, this model could extend affordable geriatric care to around 400 villages, ensuring that elderly populations who cannot reach health facilities are instead reached with compassion and inclusivity.

Acknowledgements : Our sincere gratitude to the office bearers of Gram Panchayat, Arjunagi, for providing their office for conducting the monthly camp. My sincere thanks to the postgraduate students, namely Dr Santosh BT, Dr Sandeep Kumar, Dr Vigneshwaran S, Dr Kushal Bhangale, Dr Harini T, Dr Karthik S, Dr Kokilodayachandra, and Dr Bhupathi Tabusum, for volunteering to provide health services to older people in rural areas. Also, thanks to the nursing staff and public relations officers for their active involvement in the camp process over the last five years.

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Indian Journal of Gerontology
2026, Vol. 40, No. 4, pp. 447-454
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI: 10.5958/0971-4189.2026.00002.4

Emerging Nursing Care Challenges for the Ageing Population in India : A Narrative Synthesis

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ABSTRACT

Nurses play a pivotal role in delivering elder care across hospital, community, and home-based settings. However, workforce shortages and gaps in geriatric-specific training continue to constrain the quality and accessibility of care. Existing literature highlights the need for structured training programmes, particularly in home care nursing and geriatric mental health nursing, to address workforce limitations and caregiver burden. Themes that emerged from this narrative synthesis include escalating clinical complexity due to multimorbidity, increased workload associated with functional dependency, evolving geriatric nursing competencies, emotional engagement and ethical responsibilities, organisational and system-level constraints, and culturally responsive care in diverse and tribal communities. These findings underscore the need to strengthen geriatric nursing education, culturally sensitive care strategies, and integrated

workforce planning. Aligning nursing professional development initiatives with national programs such as the National Programme for Health Care of the Elderly (NPHCE) can enhance the quality, equity, and cultural responsiveness of nursing care for the ageing population.

Keywords : Ageing population, Nursing care challenges, Multimorbidity, Functional dependency, Home care nursing

India's demographic landscape is undergoing a profound shift, with a steady increase in the proportion of adults aged 60 years and above, driven by rising life expectancy and declining fertility rates (MoSPI, 2016). Projections indicate that the older adult population will nearly double by 2036, placing significant pressure on the healthcare system to deliver accessible, coordinated, and sustainable elder care services (NITI Aayog, 2024). Older adults commonly experience multiple chronic illnesses, disabilities, and socioeconomic vulnerabilities, which complicate care delivery and intensify demand for health and social services (Bone *et al.,* 2024).

Evidence shows a high prevalence of supportive and palliative care needs among older adults in India, highlighting the growing clinical complexity healthcare providers face (Bone *et al.*, 2024). In this context, nurses occupy a central role in clinical management, chronic disease monitoring, psychosocial support, health education, and community engagement. Despite their critical contribution, nursing care for older adults is constrained by geriatric workforce shortages, uneven distribution of skilled personnel, and limited access to structured geriatric training, particularly in-home care nursing and geriatric mental health nursing (Saini & Gambhir, 2025).

Home care nursing literature emphasises the need for specialised competencies to manage complex health conditions, reduce caregiver burden, and navigate systemic barriers inherent in community-based

care settings (Joshi & Purohit, 2025). To address these challenges, the Government of India introduced the National Programme for Health Care of the Elderly (NPHCE), which aims to integrate geriatric care into primary healthcare systems and strengthen training capacity across healthcare cadres (Directorate General of Health Services n.d.). While the NPHCE reflects a strong policy commitment to elder care, further examination of nursing workforce challenges, including competency gaps, emotional demands, and organisational constraints,remains essential to inform future education and workforce planning.

Method

This narrative synthesis examines emerging challenges in nursing care associated with India's ageing population. Evidence was drawn from peer-reviewed journal articles, policy documents, and relevant grey literature accessed through Dimensions.ai and Google Scholar up to 15 November 2025. Titles and abstracts were screened for relevance, followed by full-text review of selected sources. The researchers included studies addressing nursing workload, staffing shortages, geriatric competencies, emotional and ethical aspects of care, home-based nursing, and culturally responsive practices. Sources focusing exclusively on nursing students, non-ageing populations, or purely theoretical discussions were excluded. Thematic synthesis, yielded core themes reflecting the multidimensional challenges and opportunities in geriatric nursing care.

Results

Escalating Care Complexity Due to Multimorbidity

Multiple chronic conditions, such as diabetes, cardiovascular disease, respiratory disorders, and mobility impairments, significantly complicate clinical management and care planning, and are frequently present among older adults. (Bone *et al.*, 2024). Polypharmacy, overlapping symptom profiles, and age-

related physiological changes further intensify clinical complexity, requiring comprehensive assessment and coordinated nursing interventions. National data suggest that multimorbidity will continue to drive demand for chronic, supportive, and palliative care services, necessitating advanced competencies among nursing professionals (WHO, 2020).

Increased Workload from Functional Dependency

Functional dependency, manifested as the need for assistance with activities such as feeding, bathing, dressing, and mobility, substantially increases nursing workload, particularly in home-based and community settings (Joshi & Purohit, 2025). In many cases, families assume primary caregiving responsibilities, often with limited training or support, thereby increasing reliance on nursing guidance. Workforce planning strategies that incorporate structured support systems, task-sharing, and workload management are critical to preventing nurse burnout and ensuring continuity of care (Saini & Gambhir, 2025).

Evolving Geriatric-Specific Skills

Effective geriatric nursing requires a broad set of specialised competencies, including comprehensive geriatric assessment, dementia and mental health care, chronic disease management, palliative care, and culturally competent communication (Ramawat & Soni, 2025). Studies assessing nursing competence in acute and community settings highlight gaps in geriatric knowledge and skills, underscoring the need for targeted education and continuing professional development (Joshi & Purohit, 2025; Ramawat & Soni, 2025).

Emotional Engagement and Moral Responsibility

Nurses caring for dependent older adults frequently encounter ethical dilemmas related to autonomy, dignity, informed decision-making, and end-of-life care. Sustained emotional engagement with patients and families can contribute to moral distress and

psychological strain (WHO, 2020). Institutional support mechanisms, including resilience training, ethical reflection forums, and access to counselling services, are essential for promoting nurse well-being and maintaining quality of care (Saini & Gambhir, 2025).

Organisational and System-Level Factors

Organisational determinants such as staffing adequacy, infrastructure, service integration, and policy support significantly influence the delivery of nursing care for older adults (NITI Aayog, 2024). Although national and state-level initiatives aim to strengthen geriatric services, workforce shortages and inconsistent implementation persist across regions (Saini & Gambhir, 2025). Integrating geriatric content into undergraduate curricula and expanding continuing education opportunities are increasingly recommended to enhance workforce preparedness (Ramawat & Soni, 2025).

Ethical and Cultural Considerations in Tribal Elder Care

In tribal and remote communities, culturally responsive nursing care is essential to address traditional health beliefs, linguistic diversity, geographic isolation, and limited access to healthcare (Deb *et al.,* 2023). Understanding local cultural contexts fosters trust, supports ethical practice, and enhances the relevance and acceptability of care services. Studies emphasise the importance of culturally sensitive palliative and chronic care models for Indigenous older adults to reduce health inequities (Yadav *et al.*, 2025).

Discussion

Nursing care for India's ageing population is shaped by increasing clinical complexity, workforce shortages, educational gaps, emotional demands, systemic constraints, and cultural diversity. The literature consistently highlights the need for structured geriatric training programs, competency frameworks, and expanded nursing roles in home care and mental health services. To providestrengthened elder

care, gaps in geriatric workforce preparedness and specialised training remain evident.

Shortages in geriatric mental health nursing limit early identification and management of conditions such as depression and dementia, reinforcing the need for dedicated specialisation pathways within nursing education. Similarly, challenges in home-based nursing care, including inadequate geriatric training and limited institutional support, underscore the importance of competency-based workforce strategies that prioritise caregiver support and nurse retention. Organisational readiness, policy alignment, and investment in age-friendly health systems will be critical to advancing equitable and sustainable geriatric nursing care delivery.

Conclusion

Nurses are fundamental to meeting the evolving healthcare needs of India's ageing population. Challenges include managing multimorbidity and functional dependency, addressing workforce shortages and training gaps, and navigating the emotional, ethical, and cultural dimensions of care. Strengthening geriatric nursing education, enhancing workforce preparedness, expanding integrated care models, and promoting culturally sensitive practices offer significant opportunities for improvement. Aligning national initiatives such as the NPHCE with targeted professional development efforts can enhance equitable, high-quality, and person-centred nursing care, with dignity, autonomy, and quality of life at the core of geriatric care services. Nursing professionals specialising in community health nursing can be effectively utilised in community-based geriatric care.

Statement and Declaraton

AI disclosure : The authro used chatGPT by Open AI for text paraphrasing and grammatical refinement during drafting of this manuscript.

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Indian Journal of Gerontology
2026, Vol. 40, No. 4, pp. 455-469
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI: 10.5958/0971-4189.2026.00003.6

Ageing, Healthcare Access, and Care Practices among Tribal Elders in Fifth Schedule Areas of Odisha

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ABSTRACT

The present study examined the challenges faced by 51 elderly individuals (31 males and 20 females), aged between 60 and 80 years, from tribal regions, particularly the 5th scheduled areas, of Odisha state in accessing and utilising government healthcare facilities during periods of illness. The primary data were collected through in-depth interviews and field observations. Case studies were also collected to capture a range of experiences related to healthcare practices, financial struggles, and systemic barriers. Observations of living conditions, healthcare access, and traditional practices enriched the understanding of their daily challenges. The secondary data were collected from government reports, research studies, and census data to contextualise the findings. The findings revealed that tribal elderly persons face healthcare Access Challenges. Tribal elders often rely on traditional medicine because modern health care

facilities are limited and hard to access. Traditional practices preserve cultural heritage but are insufficient for chronic and life threatening conditions (e.g., cancer, hypertension, tuberculosis). A lack of linguistic and cultural sensitivity among healthcare providers alienates tribal elders reduces and care effectiveness. Documenting traditional health knowledge fosters cultural pride, while training providers in cultural sensitivity bridges gaps in service delivery. Based on present findings, strengthening primary healthcare, expanding outreach in remote areas, and improving social security support are vital. Combining modern healthcare with culturally appropriate, community based interventions ensures healthy ageing and dignity for tribal elders. Multiple chronic illnesses among tribal elderly populations demand integrated, age sensitive healthcare services.

Keywords : Tribal elderly, healthcare access, ageing, long-term care, traditional health knowledge, Sundargarh, Odisha.

The growing elderly population in India faces an increasing burden of illness and health-related challenges. However, access to healthcare is often hindered by social inequalities such as caste, gender, religion, and economic status. Many older adults also struggle with limited mobility, limited access to healthcare facilities, and financial constraints, making it difficult for the elderly population to obtain timely and affordable healthcare (Bhatta *et al.*, 2022). Authors here also observed that illnesses among rural community older adults are high, while their healthcare-seeking behaviours are inadequate. The most common and visible reasons are poor accessibility, a lack of healthcare professionals and facilities, belief in spiritual healers, and the high cost of healthcare. Rural areas should imporve the availability, accessibility, and affordability of public healthcare facilities in rural areas to enable disease prevention, timely diagnosis, and cure (Ibid.).

Sinha *et al.* (2023) cited reports indicating that tribal people comprise nearly 8.6 per cent of the total Indian population, with most living in rural areas and relying on subsistence economies. Indigenous populations possess distinct sociocultural beliefs and traditions, which encompass a higher prevalence of alcohol and tobacco consumption, rendering them more susceptible to various non-communicable diseases (NCDs). Moreover, lifestyle changes have led to multimorbidity energing as a significant public health concern in these communities. Most data on NCDs among indigenous populations come from studies focused on individual tribes or regions, with few nationwide investigations. Nevertheless, to achieve universal health coverage, it is imperative to generate national evidence on NCD multimorbidity among indigenous populations, to inform existing programmes and policies aimed at reducing healthcare disparities within this demographic (Ibid.).

The authors also stated that multimorbidity is more likely among older adults aged 80 years and older, consistent with previous studies showing that multimorbidity increases with age. Chronic conditions begin to appear in midlife, at 40-45 years of age, and tend to accumulate with advancing age, which may help explain the significant association with multimorbidity among adults aged 80 years and above in the present study. However, this elderly population requires special care as they tend to be more socially and economically dependent on the younger age groups for treatment. Moreover, in deprived sections of society, percent these individuals' health is often neglected as priorities shift toward the family's earning members (Ibid.). Together, prominent tribal areas account for approximately 15 per cent of the country's geographical area. Scheduled Tribes are the poorest section of India's population in terms of ecological, economic, and educational conditions. They account for a quarter of the country's population. It is an unfortunate reality that social injustice and exploitation of Scheduled Tribes and other weaker sections continue to exist in India, despite the extensive provisions of the Indian Constitution and other laws

(Ashifa, 2022). Traditionally, elder tribes have served as catalysts for cultural transformation within their respective tribal communities. Today, many tribes remain largely illiterate and socially isolated from the rest of society (Ibid.).

The Ashifa found in her study that, among scheduled tribes, one member of that group is over the age of sixty. They are essentially shut out of society, the economy, politics, and the legal system. These individuals are in poor health and use health care facilities infrequently, indicating they are underserved. Their economic dependence on uppercaste members affects their lifestyle, access to food, and access to health care. Beyond that, older adults are already more susceptible to health problems such as arthritis, lung ailments, back pain, poor vision, and hearing loss, as well as concerns about family adjustment. Adjustment is measured in terms of the home, social, emotional, self, and health, with gender and age significantly influencing the results (Ibid.).

Objective of the Study

This study examined the challenges faced by elderly individuals in tribal regions, particularly in accessing and utilising government healthcare facilities during illness, with an emphasis on the relevance of these findings to improving tribal health policies and services.

Method

Sample

51 elderly respondents, 30 males and 20 females, aged 60 years and above, were selected through purposive sampling from tribal-dominated villages in Sundargarh district, Odisha. The majority of respondents belonged to the ST category (42), while 6 were from Other OBC and 3 from SC. The sample included diverse tribal communities, including Oraon, Kisan, Munda, Bhuiyan, Gond, Kumbhar, and Khadia, as well as a few respondents from the Barik, Thodia, Pan, and Harijan communities. Regarding religion, 41 of the respondents followed Hinduism, while 10 followed Christianity. Most respondents were engaged in their own cultivation, agricultural labour,

daily wage work, livestock rearing, forest-based activities, or homemaking, while several elderly individuals were not working due to age-related limitations. A few respondents were retired government employees or involved in small businesses.

Tools Used

Two case studies in the Bonai and Lathikata blocks illustrated the realities of elderly tribal life, focusing on healthcare practices, financial struggles, and systemic barriers, and enriched understanding of their daily challenges.

Findings and Discussion

In line with the study objective, the case study below highlights the challenges faced by elderly tribal individuals in accessing and utilising government healthcare services. Financial insecurity, delayed pension benefits, visual impairment, language barriers, and dependence on traditional medicine collectively limited the couple's interaction with formal healthcare systems. The case also demonstrates how socio-economic and institutional barriers create healthcare-seeking behaviour among elderly populations in 5th schedule areas.

Demographics and Challenges

As discussed above, India's tribal population constitutes approximately 8.6 per cent of the total population as per ORGI (2011). Within this demographic, the proportion of elderly individuals is growing, reflecting broader national and global ageing trends.

In their research, Dey *et al.* (2012) highlighted several significant aspects of India's elderly population. The findings indicate that amongst the 7.5 per cent of Indians who are elderly, approximately two-thirds reside in rural areas, with nearly half experiencing poor socioeconomic conditions. Approximately 50 per cent of the elderly in India are dependent on others, often due to being widowed, divorced, or separated, with women comprising the majority of this group. Although only a small fraction (2.4%) of the elderly live alone, this percentage is higher among women (3.49%) than among men. Consequently, the research concludes that most elderly individuals

in India live in rural settings, come from low socioeconomic backgrounds, and rely on their families for support (Ibid.). A significant portion of this demographic resides in rural and tribal regions, where they encounter unique challenges. Tribal elders often live in remote areas with limited access to healthcare and basic amenities (ibid.).

Cultural and linguistic barriers further hinder effective healthcare delivery. Social isolation and the erosion of traditional support systems, exacerbated by the urban migration of younger generations, compound these issues. Addressing these challenges necessitates culturally sensitive policies, improved healthcare access, and programs to strengthen community-based support systems for tribal elders.

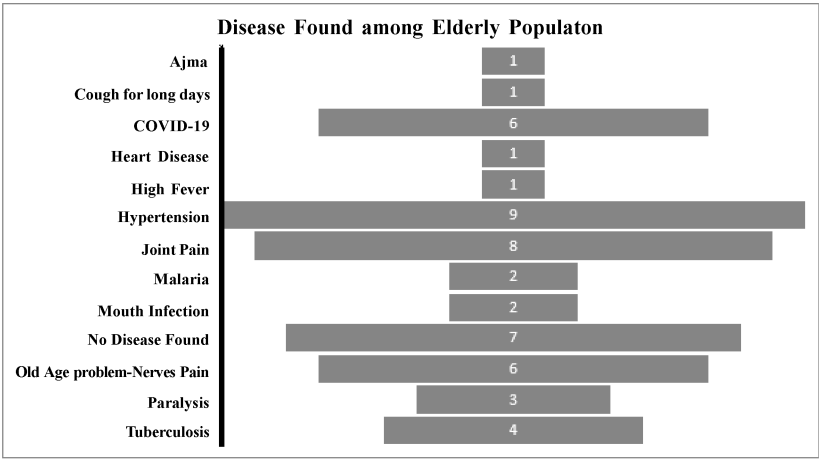
However, the elderly in tribal areas often encounter challenges that multiply their vulnerabilities, including poverty and economic insecurity, geographical isolation, cultural barriers, limited awareness, and limited healthcare infrastructure.

Figure 1 offers a comprehensive view of the health issues faced by the elderly population. The data highlight a mix of chronic, communicable, and age-related ailments, reflecting the diverse healthcare needs of this vulnerable demographic. Below are detailed analyses and interpretations of the data:

Most prevalent health issues like hypertension (9 cases): Hypertension is the most common condition, accounting for a significant portion of the elderly population's health concerns. This underscores the rising burden of non-communicable diseases (NCDs) among ageing individuals. Hypertension can lead to severe complications like heart attacks, strokes, and kidney disease if not managed properly. Joint Pain (8 cases): Joint pain is another prominent issue, highlighting the impact of degenerative conditions such as arthritis and osteoporosis. These conditions are common in older adults due to ageing bones and joints and often require pain management and orthopaedic care.

Figure 1

Different Diseases Found among Elderly Population in the Study Area of Sundargarh District, Odisha



Source : Primary Field Data Collected by Author

Morbidity among tribal elderly

The findings from the respondents indicate a high burden of morbidity among the tribal elderly population. The findings show a substantial burden of morbidity among the elderly respondents. Of the 51 participants, 80.4 Per cent reported at least one health condition, while only 19.6 Per cent reported none. Nearly half of the respondents (49.0%) suffered from a single morbidity. Multimorbidity, defined as the coexistence of two or more health conditions, was observed among 31.4 Per cent of the elderly population. Specifically, 25.5 Per cent reported two morbidities, and 5.9 Per cent reported three. The findings indicate that a considerable proportion of older adults experience multiple chronic and infectious health conditions simultaneously, highlighting the need for integrated geriatric healthcare and long-term care services in tribal and rural communities. The study further reveals that multimorbidity is a major health concern among the tribal older population, with a substantial proportion experiencing two chronic

conditions simultaneously. The higher prevalence of multimorbidity among older age groups highlights the need for regular health screening, early diagnosis, and continuous medical care. The results also underscore the need to strengthen geriatric healthcare services in tribal areas, where elderly populations often face barriers to accessing timely and appropriate treatment.

Long-Term Care Needs

Long-term care encompasses a range of services and support required by individuals who can no longer perform daily activities independently. For tribal elders, long-term care needs include:

Tribal regions in India present unique challenges for their elderly population, necessitating comprehensive long-term care strategies. A primary concern is the growing incidence of non-communicable diseases amongst older tribal individuals, which has led to heightened levels of disability and dependence. Whilst the National Programme for Health Care of the Elderly (NPHCE) has been established, significant gaps remain in the provision of consistent and culturally appropriate healthcare services for these tribal communities (Vaishnav *et al.,* 2022). For tribal elders, long-term care needs include home-based care, community support, financial assistance, palliative care, and rehabilitative care.

Traditional family support systems, which have historically provided care for the elderly, are weakening due to urban migration and socioeconomic changes. This erosion underscores the need for formal long-term care services tailored to the unique cultural contexts of tribal communities. However, the availability of such services is limited, and there is a pressing need for policies that address these specific requirements (Alam, 2023).

NITI Aayog (2024) stated that to effectively meet the long-term care needs of tribal elders, it is imperative to develop and implement culturally sensitive policies, enhance healthcare infrastructure, and

promote community-based support systems. Collaborative efforts between government agencies, non-governmental organisations, and tribal communities are essential to ensure that the elderly in these regions receive the care and support they require.

Role of Traditional Health Knowledge Systems

Traditional Health Knowledge Systems are integral to the well-being of tribal communities, with elderly members serving as primary custodians of this knowledge. These systems encompass a wide range of practices, including herbal medicine, spiritual healing, and community-based therapies, all tailored to the specific cultural and environmental contexts of their communities.

In many tribal areas, access to modern healthcare facilities is limited, making THKS the primary source of medical care. Elderly individuals draw on their extensive knowledge of local flora and fauna to treat various ailments. For instance, the use of animal parts and other biological materials is pivotal in the local medicinal systems of certain tribal communities (Ahmad *et al.,* 2021).

However, Traditional knowledge systems (TKS) have the potential to provide benefits in healing, comfort, and support for elderly people as needed. Traditional knowledge can benefit the country's elderly population in selected areas, such as health care, nutritious food, stress management, and artisanal skills. The nature-friendly healing methods, affordable costs, simplicity, and robust operations are fringe benefits of traditional knowledge that are useful for elderly people. Activities and knowledge systems useful from the elderly people's viewpoint have been discussed in this paper. Elderly people are generally aware of the traditional knowledge practised in their own region. There might be many TKS from other regions of the country that can benefit them if applied appropriately. Knowledge sharing of traditional systems for the mutual benefit of elderly people across different regions is not difficult in modern times, with vast opportunities available through the internet, radio, and other channels (Dixit & Goyal, 2011).

Case Study : 1

This case study examines the lives of (MM (pseudonym), a 63-year-old male, and BM, a 68-year-old female) who reside in Bhadimara village in the Bonai Block of Sundargarh district, Odisha. The couple, known as the Munda couple, belonging to the Munda tribe, which is classified as a scheduled tribe, offer a poignant illustration of the adversities and tenacity exhibited by elderly tribal individuals in a scheduled area. Despite confronting numerous socio-economic and health-related obstacles, the pair demonstrate remarkable self-sufficiency and ingenuity. This analysis explores their living circumstances, approaches to healthcare, financial hardships, and the barriers they face in accessing essential services.

Living Conditions : The Munda couple lives in an ancient mud dwelling, featuring a traditional design and a "Khapra" roof. Their residence has no electricity connection, exacerbating the hardships of their daily routine. The household contains minimal furnishings, with the occupants utilising a rope-woven bed for rest. To prepare meals, they employ timber as fuel, which they procure from the adjacent forest.

Financial Status : The couple has no children and relies solely on MM's old-age pension for sustenance. Mrs BM, however, is not receiving her pension despite having applied several times at the Bonai block office. She was born in Jharkhand and has faced administrative challenges due to her birthplace. Despite offering a monetary bribe to local authorities, including the sarpanch and a ward member, her pension application remains unresolved. To supplement their limited income, they sell "Mahula" (a forest product) and utilise "Tula" oil to meet daily needs.

Health Practices and Challenges : Both husband and wife demonstrate a significant reliance on traditional herbal medicine for their healthcare needs, procuring medicinal herbs from the forest. During an episode of tuberculosis, MM initially utilised allopathic medication but subsequently reverted to employing traditional

remedies. He attributes his recovery from TB to the efficacy of medicinal herbs. This dependence on traditional medicine emphasises their connection to indigenous knowledge and self-sufficiency.

The couple encounters substantial impediments in accessing contemporary healthcare services. BM's visual impairment significantly hinders her capacity to seek medical attention autonomously. Furthermore, they experience a linguistic barrier when engaging with healthcare providers because medical practitioners cannot understand their local Sundargari dialect, a tribal language. Despite their limited resources, the Munda couple's ability to manage their household and documents demonstrates their resilience and adaptability.

Their case study underscores the pressing need for social welfare programmes to ensure elderly tribal individuals receive their rightful benefits without corruption or discrimination. Their reliance on traditional knowledge for healthcare, their organised approach to managing their lives, and their efforts to overcome systemic barriers reflect a deep resilience. It also highlights the importance of promoting cultural and linguistic sensitivity among service providers to bridge the gap between tribal communities and essential public services. *(Excerpt from MM couple)*

It also shows a higher prevalence of disabilities among tribal elders, highlighting challenges such as limited access to healthcare services and socioeconomic disadvantages. These disparities underscore the need for targeted interventions that consider the unique cultural and environmental contexts of tribal communities.

Case Study : 2

SM (62 years) and MM (59 years) reside in Fikodchundi village in Lathikata block and belong to the Bhuiyan (Hindu) tribe, classified as a Scheduled Tribe (ST). They reside in a Katcha house with a khaprail roof and depend primarily on forest resources and

small-scale employment such as cow grazing, chowka work, and job card labour under MGNREGA. Nonetheless, employment through job cards offers only 100-120 workdays per annum, with daily remuneration ranging from ₹ 200 to ₹ 250, resulting in uncertain, fluctuating income. MM has been battling breast cancer for the past three years. Initially, they opted for allopathic treatment but later switched to traditional medicine, relying on locally sourced herbs. SM also prepares medicines himself, utilising forest products and unique items such as silkworms, which he has preserved for two years for medicinal purposes. Meanwhile, access to healthcare remains a significant challenge for the couple. When MM experiences severe pain, they visit the Birkera Community Health Centre or the local drug store situated 14 km away. Frequently, they are compelled to walk the distance due to a lack of transportation, or they utilise shared conveyance in a local auto-rickshaw. Despite the physical and financial burden, the couple continues to seek healthcare when necessary. The CHC's remote location and lack of transportation options pose significant barriers to accessing timely medical care.

SM has become a local healer in his community. Drawing on his knowledge of traditional medicine, he collects herbs and prepares remedies, which he provides to other villagers for a nominal charge of ₹ 100-150 per patient. His practices, though rooted in traditional values, serve as a vital resource for those in the village who cannot afford or access modern healthcare facilities. While SM's traditional medicine serves the community, it highlights the lack of access to modern healthcare services for chronic illnesses like cancer. *(Excerpt from SM couple)*

This case highlights the double role of traditional health knowledge in tribal areas. On the one hand, it serves as an accessible and culturally accepted source of healthcare in areas where modern medical services remain limited. Similarly, the dependence on traditional medicine for serious illnesses such as cancer reflects the persistent barriers to accessing specialised healthcare facilities. Case

study 2 further reveals how tribal elders act as custodians of indigenous medical knowledge, preserving practices that continue to support community health. However, the gradual loss of the traditional way of life, the migration of younger generations, and the lack of methodological documentation create hurdles in the transmission of this knowledge.

Limitations of the Study

This study has certain limitations that should be acknowledged. First, the findings are based on a relatively small sample of elderly respondents from selected tribal-dominated villages of Sundargarh district, which may limit the generalizability of the results to other tribal regions. Second, the morbidity information was largely self-reported and may be subject to recall bias or underreporting of health conditions. Finally, the cross-sectional nature of the study captures health conditions and healthcare experiences at a single point in time. It does not allow for the examination of changes in health status over time.

Conclusion

Access to healthcare remains a significant challenge, with tribal elders frequently relying on traditional medicine due to the unavailability or inaccessibility of modern healthcare facilities. While traditional practices possess considerable value and reflect cultural heritage, they are inadequate in addressing chronic illnesses and life-threatening conditions such as cancer, hypertension, and tuberculosis. Moreover, the absence of linguistic and cultural sensitivity among healthcare providers further alienates tribal elders, creating barriers to effective healthcare delivery. Documenting and preserving traditional health knowledge systems can promote cultural pride and ensure tribal elder's wisdom continues to benefit future generations. Training healthcare providers to be culturally and linguistically sensitive will bridge the gap between tribal elders and essential services. By implementing inclusive policies and utilising innovative solutions, it is possible to ensure that tribal elders experience healthy, dignified, and fulfilling lives. Continued efforts in this direction will not only benefit

the elderly population but also contribute to the overall well-being and resilience of tribal communities.

The findings also highlight the rising burden of multiple diseases among tribal elderly populations, which requires integrated and age-sensitive healthcare services. Strengthening primary healthcare, expanding outreach services in remote tribal areas, and improving social security support can significantly enhance the health and well-being of older adults. A holistic approach that combines modern healthcare with culturally appropriate community-based interventions is essential for promoting healthy ageing in tribal regions.

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Indian Journal of Gerontology
2026, Vol. 40, No. 4, pp. 470-493
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI: 10.5958/0971-4189.2026.00004.8

Addressing Social Isolation and Loneliness in Rural Older Adults : Early Outcomes from a Community-based Group Intervention

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ABSTRACT

This study presents early findings from a community-based group intervention (CBGI) designed to address social isolation and loneliness among 115 community-dwelling adults aged ≥60 years, who were predominantly female, socioeconomically vulnerable, and characterised by low educational attainment and high levels of widowhood, belonging to seven villages of the Villivakkam block, Tiruvallur district, Tamil Nadu. The intervention integrates structured cognitive and motor activities with informal social engagement and on-site primary healthcare. A substantial burden of chronic conditions was observed, alongside high levels of loneliness, social isolation, and depressive symptoms, indicating significant psychosocial vulnerability. Process observations from the initial three months of implementation demonstrated that structured group activities, including chair yoga, cognitive games, and creative exercises, facilitated participation, peer

interaction, and engagement. Integrating of on-site clinical consultations addressed unmet health needs and increased the perceived value of participation. However, attendance remained variable due to health limitations, competing responsibilities, and contextual constraints. Overall, the findings suggest that a multi-component, community-based intervention is feasible and contextually appropriate for addressing social isolation and loneliness among older adults in rural Tamil Nadu. Continued implementation and endline evaluation are needed to assess long-term effectiveness, sustainability, and potential integration within existing public health systems.

Keywords : Older adults, Social isolation, Loneliness, Community-based intervention, Rural health, India

Social isolation and loneliness have emerged as significant public health concerns among older adults globally. Social isolation refers to abscence of social relationships and limited participation in social activities, while loneliness is the subjective distress from a lack of meaningful social connections (Goldman *et al.,* 2024). A WHO study (2007–08) reported a loneliness prevalence of 16 per cent among older men and 20 per cent among older women (Srivastava *et al.,* 2021). The Longitudinal Ageing Study in India (LASI) Wave 1 (2017–18) further documented high levels of isolation and loneliness, with strong associations between loneliness and depressive symptoms (Hossain *et al.,* 2022). The study also reported an overall prevalence of loneliness of 13.4 per cent, with higher levels among individuals who were unmarried, physically inactive, experiencing multimorbidity, or lacking supportive networks (Srivastava & Srivastava, 2023). Community-based findings mirror this burden, with studies reporting prevalence estimates of 40 per cent in Gujarat and 34 per cent in Raipur (Kumar *et al.,* 2022; Damor *et al.,* 2024).

Loneliness and isolation are associated with adverse physical and mental health outcomes, including higher rates of depression, anxiety,

somatic complaints, and reduced psychological well-being (Grover *et al.*, 2018; Mishra *et al.,* 2023). A panel study in Tamil Nadu (2014) found that 9 per cent of adults aged 55 years and above lived alone, reporting elevated loneliness and depressive symptoms, with women and individuals in poverty disproportionately affected (Banerjee *et al.,* 2023). These findings underscore the need for targeted interventions, particularly in low- and middle-income countries (LMICs) such as India, where formal systems that address the social and emotional well-being of older adults remain limited and fragmented.

Globally, researchers have explored several intervention models, including community groups, recreational programs, peer support initiatives, and technology-based approaches, to reduce social isolation among older adults (Fakoya *et al.,* 2020). Physical activity–based models have also been shown to promote connectedness and well-being (Hoang *et al.,* 2022). However, much of the available research comes from high-income countries, with limited high-quality evidence from LMICs (Madani *et al.,* 2022). In India, there is a scarcity of structured, community-based social engagement programmes specifically designed to address social isolation and loneliness among older adults, particularly in rural settings. Given contextual constraints such as low literacy, limited digital access, gendered mobility restrictions, and socioeconomic barriers. Simple, low-cost, socially engaging, community-based interventions offer a feasible and contextually relevant approach. Generating evidence on such interventions is critical to inform policies and programmes that improve the well-being of older adults in India.

Structured social and leisure activities have shown growing evidence in promoting cognitive and emotional well-being in older age. Building on this, community-based group interventions offer a promising approach to reducing loneliness and social isolation while strengthening social networks among older adults. This study aims to develop and implement a community-based group intervention to address social isolation and loneliness among older adults in the

Tiruvallur district of Tamil Nadu and to assess early outcomes from the initial phase of implementation.

Method

This study adopts a mixed-methods design, integrating quantitative baseline assessments with qualitative process documentation to examine the early implementation of a community-based group intervention (CBGI) aimed at reducing social isolation and loneliness among older adults. As the intervention is still ongoing, this paper focuses on the first three months of implementation, which had been completed at the time of analysis.

Setting

The study was conducted in the Villivakkam block of Tiruvallur district, Tamil Nadu, in the state's north-eastern part, which is known for its high level of industrialisation. Tiruvallur district houses major industrial establishments, including the Avadi Tank Factory, and is characterised by rapidly changing socio-economic patterns that influence family structures and support systems for older adults. Within this district, the Villivakkam block comprises a mix of semi-rural and agrarian villages, seven of which were selected for the intervention. The intervention is being implemented at the Omayal Achi Community Health Centre (OACHC), a central health and community resource within the block. The OACHC plays a key role in supporting participant mobilisation, providing accessible spaces for group meetings, and facilitating coordination across the villages. Strong informal social networks characterise the selected villages, but also increase vulnerabilities among older adults due to the migration of younger family members and shifting household responsibilities. These contextual factors informed CBGI's design and implementation.

Participants

Participants were community-dwelling older adults aged 60 years and above residing in the seven selected villages. Individuals with cognitive or mental disabilities that limited their ability to engage meaningfully in group activities, as well as those with serious illnesses

that substantially restricted participation, were excluded. The sample size was calculated to inform the full evaluation of the one-year intervention, including pre–post comparisons of depressive symptoms measured using the Patient Health Questionnaire–9 (PHQ-9).

As there were no prior interventions in LMICs to address social isolation and loneliness, we used the MANAS trial conducted in Goa to calculate the sample size (Patel *et al.*, 2010). In this study, community volunteers delivered psychological interventions to improve mental health. There was a mean difference of 7.6 points in the PHQ-9 score before and after the trial. The standard deviations before and after the trial for the PHQ9 score were 5.2 and 4.8, respectively. The sample size calculated for a 95 per cent confidence level and 80 per cent power is 15. Since we are doing cluster sampling and expect a high intra-cluster correlation, we are applying a high design effect of 4. We will also account for a 10 per cent loss to follow-up over the 1-year trial period. Therefore, the sample size was 66, rounded off to 70.

Each village was defined as a cluster, with a target of approximately ten older adults per village. However, actual recruitment varied across clusters, with some villages enrolling more than ten participants and others fewer, depending on local availability and willingness to participate. Participant identification followed a structured, community-led purposive sampling approach. Community Health Volunteers (CHVs) in each village, who were oriented to the intervention objectives, procedures, and eligibility criteria, conducted household visits and consulted primary caregivers to identify eligible older adults. Particular attention was given to vulnerable subgroups, including widows and widowers, older adults living alone, and those managing chronic health conditions.

Intervention Process

The intervention is ongoing, with three months completed to date, during which participants from each of the seven villages participated in one group session per month. During the first week of each month,

the facilitators finalised the activity plan and confirmed the session schedule for all villages. Each session lasted approximately 4–5 hours, allowing time for sustained engagement across multiple structured and informal activities. Sessions were facilitated by the author and another physician at the centre, with support from CHVs who assisted with mobilisation, coordination, and translation as needed. Participants were transported to the centre by being picked up from a central point in each village and were safely dropped back after the session. A simple, freshly prepared, nutritious hot meal was provided during each session. Throughout all sessions, facilitators sought to maintain participant comfort and adapt activities to participants' mobility levels, chronic health conditions, and energy on the day of the meeting. Each session began with a meet-and-greet interaction and concluded with a brief reflection.

Cognitive and Motor Group Activities

Cognitive and motor activities were conducted in each monthly session to engage older adults in structured group-based activities. This included bingo, mandala colouring, a memory card game, chair yoga, and short walks. In Month 1, sessions primarily involved bingo and introductory interactions to familiarise participants with the group setting. In Month 2, chair yoga was introduced along with group discussions on daily routines and village life. In Month 3, mandala colouring and a memory card game were added as creative and cognitively oriented activities. These activities were implemented consistently across villages with adaptations based on participants' mobility and comfort levels.

Primary Care and Clinical Consultation

A primary care component was integrated into the intervention to ensure continuous clinical support for participants. During each monthly session, the clinical team conducted routine assessments, including measurement of weight, heart rate and blood pressure. Minor ailments were managed on-site, and participants with chronic conditions such as hypertension and diabetes received monitoring and medications as required. Clinical interactions during sessions also

provided insights into participants' existing health conditions and healthcare access. Brief health education sessions were also delivered, focusing on chronic disease management and lifestyle modification.

Entertainment

Informal entertainment elements were organically incorporated into each session. Participant-requested songs and short movie clips were played in the background or during transition periods between activities. Although unstructured, these elements formed a consistent part of the session environment across villages.

Baseline Assessment and Measures

Baseline assessments were conducted at the start of the intervention to capture participants' sociodemographic characteristics, clinical profiles, and initial levels of mental health and social well-being. The number of participants exceeded the minimum target sample size, and descriptive analyses were conducted using Excel, with missing values handled appropriately. Sociodemographic data included age, gender, marital status, household income, education level, occupation, family type, and living arrangements. Clinical information comprised self-reported chronic morbidities and current medication use. Standardised tools were used to assess mental health and social well-being, namely, the Patient Health Questionnaire–9 (PHQ-9) for depressive symptoms (Howren *et al.*, 2023), the UCLA Loneliness Scale (Version 3) for perceived loneliness (Russell, 1996), and the Lubben Social Network Scale–6 (LSNS-6) for social connectedness (Gray *et al.*, 2016). These measures provided a baseline profile against which changes in mental health, social isolation, and loneliness will be examined at the end of the one-year intervention.

In addition to the quantitative baseline data, processes were documented during each monthly session to capture participants' engagement, group dynamics, and practical implementation insights. This included attendance records, brief observational notes on participation behaviours, facilitator-participant interactions, and logs of clinical assessments and primary care consultations. Photographs

were also taken during sessions and were maintained as supplementary material. These qualitative records provide context for understanding participation trends, engagement patterns, and implementation challenges observed during the intervention.

Ethics

The study protocol was reviewed and approved by the ICCR – Ethics Committee (EC No.: ICCR-EC 01/07/2025; Approval Date: 11 July 2025). The study was prospectively registered with the Clinical Trials Registry of India (CTRI) (Registration No.: CTRI/2025/09/094878, dated 16 September 2025). All participants were informed about the purpose and nature of the CBGI. Written informed consent was obtained from all participants prior to recruitment. For participants who were unable to read or write, the participant information was read aloud in the local language (Tamil), and consent was documented through a left thumb impression. An impartial witness also signed the informed consent form to attest to this process.

Participation in the study was entirely voluntary, and participants were free to withdraw at any time without any consequences. The group intervention followed a covenant of confidentiality, whereby participants periodically committed to maintaining the confidentiality of all information shared within the groups. Privacy and confidentiality were ensured during both baseline and endline data collection. All village names and participant identifiers were anonymized in the dataset and in this paper. Study data were stored in encrypted, password-protected files accessible only to the principal investigators and the research team.

Results

This section presents findings from the baseline assessment and observations of the CBGI intervention process conducted across seven villages. A total of 115 community-dwelling older adults were assessed at baseline. Quantitative results describe participants' sociodemographic characteristics, clinical profiles, and baseline levels of depression, loneliness, and social isolation. Qualitative findings

complement these data by examining participation patterns, engagement processes, healthcare-related insights, and implementation challenges observed during the intervention sessions.

A. Quantitative Findings

1. Socio-Demographic Characteristics

Participants were predominantly in the 60–69-year age group, followed by those aged 70–79 years, with relatively few aged 80 years and above. The sample was largely female, reflecting a marked gender imbalance. Educational attainment among participants was low, with a high proportion reporting illiteracy and very few having completed secondary education or higher. The economic profile suggested substantial financial vulnerability, with most participants reporting very low or no monthly income. In terms of occupational status, most participants were unemployed or engaged in unpaid domestic roles, indicating limited economic independence. Family structure and living circumstances varied, with joint families and single-person households being most common. A large proportion of participants were widowed, and many lived either alone or with their children, while none reported residing in institutional care settings (Table 1).

Table 1

Socio-Demographic Characteristics of Participants (n=115)

S.	Variable	Category	Frequency (n)	Percentage (%)
1.	Age (years)	60–69	60	52.2
		70–79	47	40.9
		80+	8	7.0
2.	Sex	Male	19	16.5
		Female	96	83.5
3.	Education	Illiterate	85	73.9
		Primary School	22	19.1
		Secondary School	7	6.1
		Higher Secondary School	1	0.9

4.	Monthly Income (n=114)	≤ ₹ 5,000	109	95.6
		₹ 5,001–10,000	0	0.0
		₹ 10,001–15,000	1	0.9
		No income	4	3.5
5.	Occupation	Farmer	1	0.9
		Daily Wage Labourer	5	4.3
		Retired	7	6.1
		Housewife	29	25.2
		Unemployed	71	61.7
		Other	2	1.7
6.	Family Type	Nuclear	22	19.1
		Joint	48	41.7
		Single Person	45	39.1
7.	Marital Status (n=114)	Married	31	27.4
		Widowed	80	70.8
		Divorced/Separated	1	0.9
		Never Married	1	0.9
8.	Living Arrangements (n = 114)	Living with Spouse	19	16.7
		Living with Children	49	43.0
		Living with Other Relatives	6	5.3
		Living Alone	40	35.1

Total sample size was n = 115. Data were complete for all variables except monthly income, marital status, and living arrangements, for which one response was missing (n = 114).

2. Clinical Characteristics

A high burden of chronic conditions was observed among participants, with hypertension and diabetes being the most reported conditions. In contrast, heart disease and other chronic conditions were reported by smaller proportions. As chronic conditions were assessed using a multiple-response item, several participants reported more than one condition. Most participants reported currently taking medication for chronic illnesses; however, a notable proportion reported not taking any medication, despite reporting at least one chronic condition. Diagnosed mental health conditions were reported by only a small proportion of participants (Table 2).

Table 2

Clinical Characteristics of Participants (n=115)

S.	Variable	Category	Frequency (n)	Percentage (%)
1.	Chronic Conditions	Diabetes	59	51.3
		Hypertension	72	62.6
		Heart disease	8	7.0
		Other conditions	18	15.7
2.	Currently taking medication	Yes	90	78.3
		No	25	21.7
3.	Diagnosed mental health condition	Yes	5	4.3
		No	110	95.7

3. Mental Health Status

Depressive symptoms were assessed using the Patient Health Questionnaire–9 (PHQ-9), and depression severity categories were derived using standard cut-off scores. The distribution of PHQ-9 scores indicates a high burden of depressive symptoms in the sample. More than half of the participants fell within the severe depression category, while a substantial proportion reported moderately severe symptoms. In contrast, only a small proportion of participants reported minimal or mild depressive symptoms (Table 3).

Table 3

Distribution of Depression Severity (n = 111)

Severity Category	Score Range	Frequency (n)	Percentage (%)
None / Minimal	0–4	6	5.4
Mild	5–9	10	9.0
Moderate	10–14	13	11.7
Moderately severe	15–19	24	21.6
Severe	≥ 20	58	52.3

Total sample size was n = 115; complete data for depression severity were available for 111 participants.

4. Loneliness

Loneliness was assessed at baseline using the three-item UCLA Loneliness Scale, and total scores were categorised as low (3–5), moderate (6–8), or high (9–12) levels. All participants provided complete responses. The distribution of scores indicates a high prevalence of perceived loneliness among participants at baseline. More than half of the sample (56.5%) reported high levels of loneliness, while an additional 23.5 per cent experienced moderate loneliness. In contrast, only 20.0 per cent of participants fell within the low loneliness category. Overall, high levels of loneliness were commonly reported in the sample (Table 4).

Table 4

Distribution of Loneliness Levels Among Participants (n=115)

Loneliness Level	Score Range	Frequency (n)	Percentage (%)
Low	≤ 5	23	20.0
Moderate	6–8	27	23.5
High	≥ 9	65	56.5

5. Social Isolation

Social isolation was assessed at baseline using the Lubben Social Network Scale–6 (LSNS-6), and participants were categorised as socially isolated or not socially isolated using standard cut-off scores. The distribution of LSNS-6 scores shows that social isolation was common among participants at baseline. A majority of participants were classified as socially isolated, while a smaller proportion were not. Overall, limited social networks and reduced social connectedness were frequently reported in the sample (Table 5).

Table 5

Social Isolation Status among Participants (n=113)

Social Isolation Status	Score Range	Frequency (n)	Percentage (%)
Socially isolated	< 12	67	59.3
Not socially isolated	≥ 12	46	40.7

Total sample size was n = 115; complete data for social isolation status were available for 113 participants.

B. Qualitative Findings

1. Participant Trends

Across the seven villages, participation in the CBGI varied over time, with attendance fluctuating across sessions. Most villages demonstrated an initial period of moderate engagement, followed by either gradual decline or intermittent attendance in later rounds. A small core group of older adults continued to attend sessions regularly, while new participants joined occasionally. Female participation predominated across all villages, with men attending infrequently and, in several cases, discontinuing participation after the initial sessions.

Irregular participation and non-attendance across sessions were commonly attributed to health-related limitations, including chronic illness and mobility challenges. Competing social and household responsibilities, such as participation in important family or community events, ration distribution days of Public Distribution System and engagement in Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA)- related work, also influenced attendance. Environmental and logistical factors, including adverse weather conditions, further constrained participation in some instances.

Participation patterns varied across villages and were shaped by a range of facilitating and constraining factors reported by participants and observed during sessions. Access to medical consultations, opportunities for social interaction, and support from community health volunteers and facilitators were commonly cited as factors encouraging attendance.

"If I visit the centre, I also get to see the doctor, and at the same time I also have a good time with the others. I also get a good meal. So, I like to attend." – an elderly woman.

"X (mentions the name of the community health volunteer) lives near my home. She comes and informs me about this meeting and reminds me. So, it is easy for me to attend."

– an elderly woman

In contrast, health-related limitations, mobility challenges, competing village responsibilities, scheduling conflicts, emotional strain, and environmental factors such as weather were frequently reported as barriers contributing to irregular or declining participation.

"In the first week, the public distribution system comes door to door to the houses of elders to distribute rations. If we are not at home, we will miss the opportunity. So, if the meeting is scheduled on that day, we may have to miss it." – an elderly man

"That old man keeps having difficulty in breathing. So, it is challenging to bring him to the centre. His sons and daughter are also worried about sending him to the centre. So, we do not bring him." – a community health volunteer

2. Engagement Patterns

Elders' engagement with the intervention was assessed through observable participation behaviours during sessions, including verbal interaction, willingness to participate in activities, attendance duration, and continuity across rounds. Across villages, engagement patterns varied by round and village context. Structured activities involving clear instructions and tangible outputs were associated with higher observable participation across villages, as reflected in sustained involvement during sessions and near-universal uptake of activities such as chair yoga, mandala colouring, and bingo.

"The games and activities are enjoyable. We get to do all these activities together. The togetherness and interesting activities make us forget all our troubles" – an elderly woman.

"After doing the chair yoga, my mind and body feel relaxed." – an elderly woman.

"I do not usually do exercises at home, but I will include them in my routine from now on." – an elderly woman.

"I want to continue colouring." – an elderly woman.

Informal interactions, including shared meals and music-based activities, were associated with increased peer-to-peer interaction and participation among elders who were initially less vocal.

"We used to play kabaddi as young girls in our village. Now we are playing again here at the centre in our old age. We never thought we would get such an opportunity" – an elderly woman.

"If you play old Tamil songs, we will surely dance to them." – an elderly woman.

"Even though we live very close to each other, we hardly get any chances to socialise in the village.This program helped us come together and feel connected."- an elderly woman.

Factors associated with reduced engagement included fatigue, health-related discomfort, mobility limitations, competing responsibilities, and adverse weather conditions. Despite these constraints, most villages showed increases in participation over successive rounds, indicating growing familiarity with the intervention structure and facilitators.

"We enjoy coming here. We keep asking the community health worker when we have to come again. We will never miss an opportunity. – an elderly woman

3. Healthcare Access and Health-Related Insights

Across all seven villages, participants reported a high burden of chronic conditions, most commonly hypertension, diabetes, joint pain, chronic body aches, mobility limitations, and age-related fatigue. Several elders also reported sleep disturbances and symptoms related to low mood or anxiety. Limited access to regular healthcare services was evident across villages, particularly among participants with longstanding chronic conditions.

Participants across all villages utilised clinical consultations conducted during intervention sessions. A substantial proportion of attendees reported existing diagnoses of chronic non-communicable diseases, particularly diabetes and hypertension. Some participants also reported more complex conditions, including chronic kidney disease and coronary artery disease, and indicated gaps in regular access to treatment prior to the intervention. During on-site consultations, acute and unmanaged health concerns were identified, including gastrointestinal complaints, missed antihypertensive doses, respiratory symptoms, and elevated blood pressure readings. These issues were identified during the sessions and managed or referred where feasible.

Discussion

The present study implemented a community-based group intervention to address social isolation and loneliness among older adults in rural Tamil Nadu, integrating structured cognitive and motor activities with informal social engagement and primary healthcare. Baseline assessments revealed a high prevalence of psychosocial vulnerabilities, consistent with national and regional evidence, including LASI Wave 1 and community studies from Gujarat and Raipur. The purposive sampling strategy specifically targeted older adults at heightened risk of social isolation and loneliness, reflecting evidence that these groups often experience overlapping psychosocial and physical vulnerabilities. The high prevalence of loneliness and depressive symptoms observed in this study is consistent with findings from other rural Indian settings, indicating widespread psychosocial vulnerability among ageing rural populations, and aligns with global evidence identifying social isolation as a significant risk factor for depression and anxiety (Grover *et al.*, 2018). This relationship is further supported by evidence from previous studies indicating that loneliness among older adults is linked not only to poorer mental health outcomes but also to adverse physical health outcomes. Loneliness has been shown to predict both higher levels of depressive symptoms and an increased number of poor physical health days per month,

suggesting that limited social connections may contribute to a reinforcing cycle of psychological distress and declining physical wellbeing (Akinyemi *et al.,* 2025). These findings underscore the interconnected nature of social, psychological, and physical vulnerabilities in older age.

The intervention leveraged several strengths to engage this vulnerable population. By situating sessions within local villages and involving community health volunteers, the program enhanced accessibility, trust, and local participation. In rural Indian village settings, strong social ties, community involvement, and trust within local networks significantly influence older adults' health and wellbeing, shaping both their willingness and ability to engage in group activities. Evidence from a nationally representative Indian study indicates that personal community involvement and having someone to trust are positively associated with psychological and physical health outcomes among older adults (Joe *et al.,* 2019). Designing the intervention within this social context was therefore critical to its acceptability and relevance.

The integration of on-site clinical consultations addressed chronic conditions, minor ailments, and health education needs, reinforcing the perceived value of participation while linking social engagement to health support. Structured cognitive and motor activities, including chair yoga, bingo, mandala colouring, and a memory card game, were implemented to stimulate cognition, memory, creativity, and physical mobility. These activities were designed to be simple, low-cost, and adaptable to varying levels of physical and cognitive ability among participants. Chair yoga was modified to accommodate mobility limitations, allowing even frail elders to participate safely, while cognitive games were paced slowly and facilitated to ensure inclusivity. Activities were adjusted over time based on participant comfort, attention span, and expressed preferences, reflecting a flexible and responsive intervention design. Informal feedback from participants suggested enjoyment of group-based activities, appreciation for opportunities to interact with peers, and a sense of

routine and anticipation associated with session days, indicating that the activities were both acceptable and engaging in this rural context. These findings are consistent with evidence that cognitively and physically stimulating group-based activities enhance wellbeing, cognitive functioning, and social connectedness among older adults (Bassuk *et al.*, 1999; Hughes, 2010; Taibi & Vitiello, 2011; Duong *et al.,* 2018; Wang *et al.*, 2022). Informal elements, such as participant-requested songs and shared meals, further fostered peer-to-peer interaction and a relaxed atmosphere, potentially contributing to improved mood, reduced feelings of loneliness, and a greater sense of purpose among participants.

Despite these strengths, participation and engagement were variable, reflecting challenges commonly observed in community-based interventions with older adults. Factors such as health-related limitations, mobility constraints, competing household and village responsibilities, scheduling conflicts with ration distribution or MGNREGA work, and adverse weather conditions contributed to inconsistent attendance. Similar barriers, particularly physical health limitations, mobility challenges, and competing social and household responsibilities, have also been associated with reduced social participation among older adults in prior research (Townsend *et al.*, 2021). In response, strategies such as flexible scheduling, rapport-building, and inclusive activities were implemented to help maintain engagement among a core group of participants.

Overall, the findings demonstrate that a multi-component, community-based intervention integrating structured cognitive and motor activities, informal social engagement, and on-site primary healthcare is both feasible and contextually appropriate for older adults in rural Tamil Nadu. The intervention addressed intersecting social, psychological, and physical vulnerabilities while fostering meaningful engagement and social connection. Its design shows strong potential for scale-up and adaptation within the public health system, including integration into existing Anganwadi and village-

level outreach programs. Leveraging local health workers, community volunteers, and low-cost, accessible activities, such interventions offer a sustainable approach to reducing social isolation, loneliness, and psychosocial distress among ageing rural populations.

Implications

This study contributes to the limited evidence on community-based interventions addressing social isolation and loneliness among older adults in rural India. It highlights the need for more research to assess sustained impacts on social isolation, loneliness, mental health, and quality of life, as well as to examine barriers to participation and the cost-effectiveness of such models. From a practice perspective, the findings support integrating multi-component, low-cost group interventions that combine cognitive, physical, and social activities into routine community-based care, with an emphasis on flexibility, local adaptation, and the active involvement of community health volunteers to enhance accessibility, trust, and sustained engagement. Embedding basic health services within these interventions may further improve participation and perceived value. At the policy level, there is a need to recognise social isolation and loneliness as public health priorities and to incorporate structured social engagement interventions into existing systems such as primary healthcare and village-level platforms, supported by training of frontline workers and dedicated programmatic guidance to ensure scalability, sustainability, and equitable access for vulnerable older populations.

Acknowledgements: This study was supported by the MR Omayal Achi MR Arunachalam Trust, which generously provided meals, transport, salaries for research staff, intervention materials, medical supplies, and technical and administrative support for organising and coordinating the intervention. The author gratefully acknowledges the invaluable guidance of Dr. Vijayaprasad Gopichandran (Principal Investigator) and Co Investigators Dr S. Kanchana, Prof. C. Jayasree, and Dr. Hemavathy J, whose

central roles in the study's conception, design, planning, and implementation were vital to the study's success. Sincere appreciation is extended to Ms. Ambika R., Staff Nurse In Charge, and the dedicated team at the Omayal Achi Community Health Centre for their coordination of community engagement activities, training of community health volunteers, and facilitation of participant recruitment. The author also warmly acknowledges the Community Health Volunteers, whose essential contributions in identifying participants and supporting mobilisation, coordination, and translation were integral throughout the intervention.

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Indian Journal of Gerontology
2026, Vol. 40, No. 4, pp. 494-518
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI: 10.5958/0971-4189.2026.00005.X

Solo Ageing as Necessity or Choice?

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ABSTRACT

This study, conducted as a case study, involved five elderly widows living alone, aged between 70 to 80 years, from diverse urban settings. Of the five, two lived in senior living facilities, two in Delhi apartments, and the fifth in a pay-and-stay home. These respondents were selected using a non-probability sampling technique. These respondents were interviewed independently. Most of the interviews and conversations were recorded and transcribed, and common themes emerging from the narratives were identified to present the results. The findings revealed that these widows were financially secure, which may reassure readers about the stability of their circumstances, and that these female solo agers exercise autonomy in everyday life: from choosing alternative living arrangements to maintaining social networks beyond their families and engaging in self-care through active ageing.

Keywords : Active Ageing, Ageing in Place, Bridge Employment, Ideal Ageing, Kitty Party

The elderly in India are projected to constitute 20 per cent of the entire population by 2050, underscoring the need for targeted

social policies (UNFPA, 2023). As people live longer and grow older, the nation's population is ageing. "But while ageing will touch everyone, it is already a distinctly female story. Women outlive men, yet they do so with fewer savings, weaker pensions, and far less social security" (Gopal & Gopal, 2025). The current scenario and the experiences of countries that have already undergone this demographic shift highlight the imperative of elder policymaking and initiatives to shape our collective future.

Scholars also emphasised the need to plan for this impending feminisation of ageing over a decade ago (Jadhav, 2013). While ageing comes with a set of challenges for everyone, women tend to be more vulnerable due to a lifetime of discrimination through gendered norms (Chauhan, 2021). This includes higher widowhood rates than among men (due to large spousal age gaps) and associated stigma, higher rates of abandonment (due to property and inheritance rights) in later years, and a greater likelihood of being left or of choosing to live alone (Lamb, 2000; Ugargol, 2024). This means that successful ageing standards and end-of-life care for women require special attention to meet their distinct needs.

The primary reasons for solo ageing are migration of adult children, desire to age in place in a familiar setting with a social network of relatives and neighbours rather than moving abroad, dependence anxiety, stigma associated in living with married daughters in case of lack of male heir, desire to stay in a home with deceased spouse's memories and so on (Gangopadhyay, 2021; Shankardass, 2021). Eldercare is widely understood to comprise four major providers of care, as per the care diamond theory – the family, state, private sector, and community/not-for-profit (Razavi, 2007). Familialist state policies have long dominated the elder care paradigm in India, disproportionately putting the bulk of elder care on families. This can be seen through policy-making trends indicative of the state's reliance on familialism, such as the enactment of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007, which legally necessitated the provision of

maintenance to elder family members by adult children, failing which they could be imprisoned (Agrawal, 2021). However, urbanisation and migration patterns over the past few decades have had significant impacts on household and living arrangements. One consequence has been the outsourcing of care to the silver economy by those who can afford it, typically the middle and elite classes. In this scenario, we find elderly women who choose to live away from their families in accordance with their own ideas of ageing with dignity. This paper investigates these very perceptions of ideal ageing of female solo agers as they actualise it. Many respondents reported finding companionship among their peers and socialising more as they aged solo. This was because they were free of the domestic and household duties they had performed for their families during their productive years. They also engaged in self-care and active ageing through group exercise, travelled in groups, used social media to stay connected with their families and much more.

Method

Sample

The present study was conducted on five elderly widows living alone, aged between 70 and 80 years, from diverse urban settings. Out of five, two resided in senior living facilities, two in Delhi apartments, and the fifth in a pay-and-stay home. These respondents were selected using a non-probability sampling technique.

Tool Used

An interview technique was used to gather detailed information about the solo living of these respondents. Interview questions for female solo agers often took the form of life histories to understand the social and economic factors leading to their transition to solo ageing. Some common questions were about their working lives (homemakers or period of service and retirement for professionals), marital status (all widows), living arrangements of children (many living abroad or in different cities and when they migrated), sources of

income supporting solo ageing (savings, pensions, remittances), and their social networks (neighbours, friends, elder home co-residents). The testimonies of other stakeholders involved in ageing and elder care were also recorded.

These respondents were interviewed independently. Most of the interviews and conversations were recorded and transcribed, and common themes emerging from the narratives were identified to present the results. The findings revealed that these widows were financially secure and that these female solo agers exercise autonomy in everyday life: from choosing alternative living arrangements to maintaining social networks beyond their families and engaging in self-care through active ageing.

Findings and Discussion

The respondents of the study were grouped into three categories based on their living arrangements: women residing in single-person households, those living in senior living facilities, and one respondent residing in an intergenerational multi-purpose shelter without her direct descendants (where residence for elders was on a pay-and-stay basis). The respondents hailed from a variety of contexts,including luxury retirement communities such as Vardaan Senior Living in Delhi and Bhavans Ashray in Amritsar (a home for senior citizens, abandoned girls, and persons with disabilities), as well as women living alone in their own homes. Although the sample size was limited and the majority of respondents hailed from Hindu upper-caste and upper-class backgrounds, this proved to be a limitation of the study. Moreover, most respondents shared the view that their solo living arrangements were their choice and that they were satisfied with them. They often cited many other people they knew who chose to age solo to add weight to their narrative and gave examples of more luxurious senior living homes that their friends, relatives, or colleagues were residing in. Snowball sampling often led me to the intended beneficiaries of solo ageing, meaning I could not

access respondents with testimonies that opposed this view, such as those who may have tried it. However, they then returned to earlier living arrangements or those dissatisfied with living in a senior home. Pseudonyms have been used throughout the paper to maintain the anonymity of the respondents and their families.

Moreover, the researcher draws on the testimonies of other stakeholders involved in the domain of ageing and elder care. This entailed staff at Vardaan (a nurse, a care worker and an administrative employee), family members of some respondents (Vidhu Mittal's father and Kiran Sachdeva's daughter), gig workers (a paramedical home aide who cares for elderly women and Rashmi Sehgal's domestic helper) and a physician working in geriatric care. These interviews gave me additional insight into respondents' living arrangements, daily lives, and what constituted successful ageing and ageing with dignity for them.

The study revealed that there exists a subsection of older women who are choosing to age away from family or children, even as that choice may be shaped by cultural expectations, gendered norms (not wanting to reside with married daughters), anxieties of being burdensome and wanting to grow old in their own country or region and not migrate. Most of these women come from middle- and upper-middle-class backgrounds and derive income from savings, bridge employment, pensions, rent, and so on, while simultaneously receiving financial support through remittances and subsidies. A recent study based on the first wave of LASI data also found that, among women aged 45 and above living in single-person households (73 per cent were aged 60 and above), most were widows and resided in rural areas. Of these, a significant percentage belonged to the wealthiest quintile, while almost one-third were on the opposite end of the financial spectrum (Anjana & Bindu, 2026, pp. 279-280). This reflects the varied socioeconomic distribution of female solo agers and the limited segment this study seeks to examine.

Table 1
Basic profile of respondents

S.N.	with (Pseudonyms) Respondent and Age (in years)	Marital Status	Distance from Children	Living Arrangements
1.	Vidhu Mittal (70)	Widowed at 66	Son residing in the USA with his family	Resides in a senior living facility with her father in Delhi; lived with her son for some time before transitioning.
2.	Shashi Chaudhary (86)	Widowed at 61	Son resides in Delhi-NCR with his family	Resides in a senior living facility in Delhi and visits her son from time to time. Lived both by herself in an apartment for many years and then with her son before transitioning.
3.	Kiran Sachdeva (80)	Widowed at 76	Elder daughter resides in the USA; younger daughter resides in Delhi-NCR	Resides in a three-in-one living facility in Amritsar and has relatives in the city whom she visits, as well as her own children.
4.	Rashmi Sehgal (78)	Widowed at 49	Both daughter and son reside in the USA with their families	Lives in her apartment in a gated society in Delhi. Lived with her children in the USA and in a religious township for some time.
5.	Asha Lalwani (79)	Widowed at 35	One Daughter resides in the USA, and the other two daughters reside in different cities in India.	Lives in her apartment in Delhi. Had a full-time care aide reside with her for some time.

Consider the case of Vidhu Mittal (female, 70) residing at Vardaan with her widowed father (94). She decided to move here after her husband passed away during the COVID-19 pandemic. Saying she made the right decision by moving here, she also pointed out how many older adults cannot afford this choice and called it "money-based ageing" as "money is the first requirement". Her reasons to transition to a senior living facility were manifold: she did not enjoy living in the USA with her only son and his family, as she felt she was dependent on them for everything. She also did not want to migrate, as when her son and daughter-in-law went to work, and her grandchildren went to school during the day, she felt lonely despite living with family. She describes her present living arrangement and relationship with her son as "you live happily, we live happily", pointing to her being able to maintain her independence and her son's family having their privacy. At Vardaan, she spends her day engaged in various activities with other elders (music therapy, yoga, Zumba, communal meals, card and board games, prayer, etc.). She chose senior living over her own home in Hisar because living there entailed similar loneliness, fears about security (particularly at night), and the burden of managing a household, which she found extremely cumbersome despite having domestic help. While looking at senior living facilities before she finally chose Vardaan, Ms Mittal says she visited various facilities built on huge premises with multi-storey buildings and so many rooms and residents that you cannot even get to know everyone living on your floor. At Vardaan, which is limited to about 80 residents, she finds that the staff, daily routine, and small size promote a sense of community. She describes it as being made to feel "we are with you". At Vardaan, she lives in a two-bedroom with her father, Jagdish Mittal (94). She is his primary caregiver as both her sisters reside with their families, and her adoptive brother severed ties with the family many years ago. Mr Mittal had adopted him from a relative in hopes of having someone to care for him in his old age, as he had no sons of his own. Ms Mittal's case showcases her agency not only in choosing to live away from her son but also

in choosing to be a caregiver for her father, going beyond traditional ideas of adult sons and daughters-in-law as the primary caregivers of elder parents in multigenerational households.She urged that government financial investment for the elderly is the need of the hour, as not all elders can afford market-based forms of living.

Another respondent at Vardaan, Dr Shashi Chaudhary (86), an academic and educationist who has authored several books, chose to reside in a senior living facility despite the disagreement of her son and daughter-in-law. She previously resided in Meerut and lived by herself for many years after her husband passed away in 2000. Dedicated to her profession and intellectual calling, she continued working and did not retire until age 75. She then moved to Delhi-NCR to live with her son, daughter-in-law, and their children. She felt lonely during the day when everyone in the family left for work or school, and she was left alone at home in the care of servants. As she desperately tried to settle into her new routine, she realised she did not connect with the other elderly ladies in the vicinity and did not enjoy being part of their get-togethers in the form of 'kitty parties'. Kitty parties are rotating savings associations run by middle- and upper-middle-class women in India, where this group of friends holds gatherings or parties regularly to draw the 'kitty' or sum of money collected over time (Waldrop, 2011, p. 162). Dr Chaudhury felt as if she did not fit in anywhere. Over time, she decided to explore other living options for herself, something beyond living alone in her own apartment, seeking more companionship throughout the day, compared to when everyone in her family left home for the day. She explained, "Seniors nowadays take hold of their lives". She started searching for and visiting senior living facilities in Delhi-NCR and Dehradun, and even visited a facility where 4 of her friends had moved. However, she did not like the various facilities spread across the huge estates, similar to Ms Mittal's comment, "I like this place because it is not huge and massive". Even after she decided to transition to senior living, it took Dr Chaudhary 3 years to convince her family of the change, as they vehemently resisted it (indicating

that family members may not always support the choice to age solo and may even be opposed). Finally, she said to them, "I have decided to take the plunge, whether you like it or not". She says that after her transition, she has recommended these living options to many people. She spends her time playing games, chatting and celebrating occasions with the other residents in the *Chaupal* (community gathering space). She became particularly close to Mr. Mittal, whom she refers to as 'Bhaiya' (literally, elder brother), and in turn Ms Mittal calls her '*Bua*' (father's sister). These relationships can be seen as signifying fictive kinship and Kath Weston's (1991) concept of families we choose. This concept (although originating from fieldwork amongst queer people) highlights the role of friends and non-biological kin in care work and support, which are usually expected from one's family. Weston argues that these families are meaningfully constructed and imitative of biogenetic relations that comprise actual kinship bonds. Weston points to the subjective agency implicit here as "families we choose" and "families we create". Fictive kinship as a significant element of non-kin sociality in later life has been studied in other contexts. For instance, Sae Nakamura (2021) has focused on fictive kinship among the elderly and care workers in her study of later-life'kinning' in Sri Lanka. She has shown that the formation of fictive kin amongst the elderly consists not only of intimate moments and acts of sharing but also of an interpretive aspect, in which discursive practices of creating fiction around kin enable connections and help navigate confusion and ambivalence surrounding these relationships.

Kiran Sachdeva (female, 80) transferred to the Bhavans Ashray old-age home in Amritsar while visiting a relative already residing there. She owned a home in Delhi and even resided for some time with one of her daughters there after her husband passed away. She chose to move here because she felt it would improve her quality of life and day-to-day satisfaction. She chose to transition to a senior living facility after visiting a relative at Bhavans Ashray and finding it a better alternative. She mentioned that most of the elders residing

here were those whose children had migrated abroad, which some scholars have termed PICA, that is, "parents in India and children abroad" (Rao, 1986; Brijnath, 2012). Although she had explored various living facilities in Delhi, she ultimately chose Ashray. She mentioned that because her home was on the second floor and lacked an elevator, she had to move away due to mobility issues. Moreover, while living alone, she could not maintain a healthy routine or exercise daily due to domestic work and household responsibilities. At Ashray, she exercises daily with encouragement from her peers and enjoys the company of other residents by playing board games, celebrating festivals and occasions, and more. She also has relatives residing in Amritsar to take care of any immediate needs and feels spiritually content living in a vegetarian facility and being close to the Golden Temple. Another reason Ms Sachdeva chose Ashray over other luxury senior living homes is that Ashray is a "Three-in-one Shelter". It is not only a senior living facility but also rehabilitates abandoned girls and provides vocational training to young persons with disabilities (mentally challenged). Ms Sachdeva's case brings to the fore the mutual benefits of intergenerational living arrangements and how they can aid healthy ageing. Various studies have shown positive impacts of intergenerational interaction between elders and children for both groups, including evaluations of Foster Grandparent Programs (FGP) in the USA (Saltz, 1971; Schulhoff & Dukehart, 2025). The three-in-one project at Bhavans Ashray not only provides shelter to multiple vulnerable groups but also brings them together, enabling them to benefit emotionally and mentally from interacting with one another. Ms Sachdeva mentioned a deep sense of satisfaction in spending time with and guiding the young girls and intellectually disabled children rehabilitated at Bhavans Ashray. This arrangement gives her a sense of purpose and makes her content with actively contributing to society. Parallels of such arrangements being mutually beneficial can be found across the world, including FGPs in the USA, the student-senior home-sharing model in France, intergenerational collaborative housing in Germany (Labit & Dubost, 2016), and advocacy for

mixed-use residential centres over age-specific housing enclaves in Australia (Judd, 2011).

Through a personal contact, I visited the home of Ms Rashmi Sehgal (78) and participated in a kitty party she had hosted for her friends. There, I observed how a kitty party unfolds from start to finish and interviewed two elderly female solo agers: Ms Sehgal and Ms Lalwani. Kitty parties are popular among middle-class housewives in urban North India and amongst diaspora communities residing abroad (Srinivasan, 1995; Kumar, 2023). Although kitty parties are derided in common parlance for their association with gossip and conspicuous consumption, studies also point out the important role they play in many women's lives. Kitty parties provide opportunities for socialising, entertainment, leisure, exposure to the outside world for housewives, status production and serve as extra-familial social networks on the one hand. On the other hand, they provide participants with autonomy over control and ownership of financial assets (Kumar, 2023, p. 203) and have even helped women launch businesses and achieve economic independence by accumulating money (Sethi, 1995, p. 175). Ms Sehgal lost her husband in 1997, after which she became the sole caregiver and breadwinner for her two children. By 2005, both her children had migrated abroad permanently, having been in India from time to time as they pursued higher education and advanced in their careers in the years prior to 2005. Since then, Ms Sehgal has been living alone in her apartment, choosing not to move abroad to live with her children. Having visited her children in the USA, she cited reasons similar to those of other respondents for not wanting to migrate there permanently. She says that in order to be successful in the USA, her children cannot spare her much time during the day. Her motto in life is "Be on your own; do not be dependent". She can live comfortably on her own in her apartment for several reasons: financial security, a vast social network of neighbours and friends, and a reliable domestic worker who has worked for her for a long time. She receives a monthly pension and aid through remittances from her

children, which ensures her financial well-being. She mentions three groups of people that are central to her well-being. First, her neighbours in the gated society complex in which she has been living for many decades are her immediate support system: "Anytime, any moment I call *ke aa jao* (come), without any delay [they say], *haan ji aunty aa rahe hain* (yes, aunty, we are coming)". Second, her kitty party friends, whom she met on a trip to Goa, have been holding monthly kitty parties at restaurants or their homes, where they play games (such as tambola, antakshari), sing and dance, have feasts and more. Third, she has a group of friends from her *satsang* whom she meets three times a week. *Satsang* typically entails a gathering of devotees for worship and/or discussions of religious practices, often moderated by a Guru (Desai, 2010). Elaborating on the role of the *satsang seva* (*seva* literally means service but has connotations of selfless action or social service) in her life, she says, "My Guru is my anchor". After her children migrated to the USA, on the advice of her elder sister and brother-in-law, Ms Sehgal went and stayed at the religious-spiritual township of Radha Soami Satsang Beas (RSSB), hoping to reside there permanently and spend her remaining years engaged in *seva* and meditation. She could not stay there permanently because of knee issues and decided to move back to her apartment in Delhi. Now she attends a nearby RSSB centre for *satsang-seva* and has found a community of like-minded elderly women who have become her very dear friends. Her trusted part-time domestic helper, whom she depends upon for cooking, cleaning and general upkeep, was also introduced to her through the RSSB centre. She says that engaging in *seva* and meditation keeps her spiritually content. She also indulges in hobbies to keep herself occupied, such as knitting, acupressure and writing *bhajans* (devotional religious songs).

Asha Lalwani (79) has been living by herself since 2000, when her third and youngest daughter got married. She was widowed in 1982, while her daughters were still in school. At that time, they were part of a joint family household, because of which she suffered a lot.

After her spouse's passing, she began working as a teacher and set up a tuition centre to support her daughters' upbringing. She wanted her daughters to be well educated and supported all three of them in getting master's degrees. Her daughters got married in 1990, 1995 and 2000, respectively. Since then, she has been living all alone. When asked whether she chose to live alone after her daughters' marriages, Ms Lalwani replied, "*Nahi maine choose kya kara? Mere paas to aur koi option hi nahi tha*" (No, what did I choose? I did not have any other option). When asked whether she could live with her daughters, she explained that one of her daughters lives abroad with her parents-in-law, and that another had previously been her neighbour and would visit her regularly. She also noted that she raised their children, implying she cared for them from infancy until they started school. She also mentioned that now she is accustomed to living alone and has fulfilled all her responsibilities. After retirement, she began *seva* as a *satsangkarta* (preacher) under her Guru. Things were going well until 2010, when she had a heart attack and fell severely sick. During that time, she resided with her daughter, and was under her care, until she recovered. Although she still engages in *seva*, she retired from the post of preacher after turning 70 in 2017. After 2017, she faced severe health issues once again, this time related to her kidneys and eventually her knees and mobility. Her daughters stayed with her for months to care for her until recovery. After this incident, her daughters "forced her to hire a 24-hour nurse" as they were not willing to leave their mother all alone. The carer she hired was a teenage girl of around 18 years and did not do much work: "Ek jane ka kya kaam hoga?" (What work will be there for one person?). This arrangement continued for about 3-4 months, and eventually Ms Lalwani had to let her go, as she did not feel cared for at all. The carer she hired would spend her time on her phone, take frequent days off to go home, or indulge in other activities such as applying makeup and nail polish. Ms Lalwani got fed up with her behaviour and found it unsuitable to continue working with her. Afterwards, she reverted back to simply hiring part-time domestic helpers. Ms Lalwani

says she finds this arrangement much better; now she is free from responsibilities, spends her time with her friends and does *seva* as she likes. She also does not want to be bound by anyone nor interfere in her daughters' lives. After living on her own, she prefers this unrestricted way of life and does not wish to transition to a senior home. However, a conversation with a doctor working in geriatric care who opposed elders' solo living arrangements revealed another perspective on the very values Ms Lalwani claimed were the positive outcomes of her living arrangement. He stressed the need for family members to be around to respond to medical emergencies. He vehemently criticised values such as independence, privacy and freedom as justifications for choosing to age alone. He argued that such narratives often ignore or downplay the disadvantages of living alone and the benefits of residing with families, specifically the regulatory role children play in monitoring daily health-related activities, ensuring dietary restrictions are followed, and encouraging exercise, which greatly impacts the outcomes of chronic illnesses associated with old age.

Thus, these testimonies reveal the complex spectrum of choices surrounding solo ageing. The choice is not always made individually, and familial acceptance is key to the transition. For most respondents, the transition was also not sudden but marked by a period of ambivalence as they first explored various other living arrangements before finally deciding on one. Most respondents visited multiple senior living facilities (and rejected them for several reasons, such as a preference for a vegetarian residence or cost). At the same time, Ms Sehgal first moved to a religious township. Ms Sachdeva's daughter mentioned how her mother initially wanted to move out of Bhavans Ashray and went back and forth on her decision before she got used to it. For some, ageing solo is not a choice but rather a consequence of gendered norms, as in Ms Lalwani's case. In still other cases, living arrangements might be flexible, such as Dr Chaudhary visiting and staying with her family regularly. Her son and his family also visit her every weekend, and she calls this arrangement

"The best of both worlds: I have my children's care as well as my own space and company of the same age group".

What factors enable successful solo ageing among older women? Some of the common themes emerging through the present fieldwork are as follows:

Daily Routine: Various respondents and elder care workers emphasised the importance of a healthy, structured daily routine. Keeping the elders engaged throughout the day with a variety of activities and hobbies was essential to their mental well-being. This was ensured by the staff and activity centres at senior living facilities, as well as by regular meet-ups with friends through kitty parties and spiritual gatherings for elderly women residing in their own apartments. Respondents who transitioned from their homes to living facilities mentioned the resulting exercise, varied meals, social interaction with co-residents, and, most importantly, freedom from the stress of managing a household as essential to achieving a healthy daily routine. A structured daily routine has been shown to have countless health benefits for the elderly, such as better sleep quality and circadian rhythms, reduced stress and anxiety and better self-management of chronic diseases (Chifu *et al.*, 2022, p. 2). Data gathered from the daily routines of the elderly have been used to better inform elder care, especially to address complex healthcare issues. Many researchers are developing models to collect data on the daily routines of the elderly to design solutions specifically geared towards older adults living at home and living alone (Susnea *et al.*, 2019; Alia & Lago, 2024).

Exercising and Active Ageing: The WHO's Ageing and Life Course Programme developed the concept of Active Ageing (AA) for the Second UN World Assembly on Ageing held in April 2002 (Kalache & Gatti, 2003).They defined AA as a dynamic process of optimising opportunities for participation, security and health of older people to increase their Quality of Life (Van Malderen *et al.*, 2013, p. 930). AA has garnered wide recognition in gerontology globally, and many countries have established active ageing centres to fight

social isolation of older people and combat loneliness and related mental health issues. Examples include HelpAge India's AA centres spread across the nation. While AA is measured along 7 determinants (with sub-items under each), physical activity is listed as an important behavioural determinant of AA. Many respondents reported that after transitioning to senior living, they began exercising regularly, encouraged by staff and other residents. These facilities also have gyms, Zumba classes, physiotherapy, yoga sessions, and other physically engaging activities organised regularly. Ms Sehgal's gated apartment complex has a park where she goes for regular walks with her neighbours, thereby meeting multiple active ageing criteria, such as physical activity and social interaction.

Financial Security: Most respondents have several sources of income, including a mix of pensions (own and deceased spouse's), rental income, monetary aid from children residing elsewhere, and remittances from those settled abroad. Some respondents continued to work post-retirement, such as part-time work for their former workplaces, consulting within the same industry or monetising their hobbies such as acupressure and palmistry. These working arrangements can be seen through the lens of bridge employment. Bridge employment refers to people working for pay post-retirement from their long-term or major job, although exact definitions may vary (Beehr & Bennett, 2015, p. 112). Bridge employment may offer retirees and elders benefits such as financial advantages, a structured daily routine, increased social contact, a sense of belonging and identity, and a collective purpose. These benefits for older populations have been observed across the globe (Kim & Feldman, 2000; Alcover *et al.*, 2014; Mazumdar, Warren, and Brown, 2021).

Travelling and Leisure: Many respondents mentioned feeling "free from responsibilities" after their children had been educated and married. Having achieved these major milestones, they felt a sense of relaxation and satisfaction at having fulfilled their child-rearing duties. Since the majority of the respondents belong to the middle

and upper-middle classes, retirement and old age also present opportunities for travel and leisure; those residing in senior living facilities were privy to monthly excursions and annual trips, with assistance from care workers to manage any health issues or mobility needs. They also had ample access to a range of recreational equipment, activities, and workshops (for example, music therapy and water therapy) within the residence. Respondents living in their own apartments, like Ms Sehgal and Ms Lalwani, also travelled with their kitty party friends and for religious purposes, such as preaching and pilgrimage. Most respondents mentioned travelling to meet their relatives for weddings and festivals as well as visiting their children abroad.

Community Feeling: "It has almost become a truism that people prefer to age in their own homes and communities" (Stone, 2016, p. 67). The testimonies of many respondents in this study who chose to age alone rather than migrate abroad or even move to another city within the country to live with their children can be seen as a choice not only of solo ageing but also of ageing-in-place. One of the recurring themes throughout the interviews was a sense of community and the companionship of peers. Dr Chaudhary's comment about having the best of both worlds – her family and elderly peers at Vardaan- highlights the need and significance of contact with same-aged peers in the post-retirement phase. In the case of Ms Lalwani and Ms Sehgal, this companionship was provided by their *satsang* and kitty party groups. At the same time, studies have shown repeatedly that social isolation and loneliness among the elderly are significantly associated with all-cause mortality (Zhou, *et at.*, 2023). These conditions and the occurrence of depression amongst older adults are also found to be higher in low- and middle-income countries, with symptoms worsening especially after the age of 70. In a recent survey of older adults in Tamil Nadu, 81 per cent of widowed women living alone had at least one child. The respondents had three major reasons for solo ageing: they could not reside with their sons-in-law (50 per cent), they did not wish

to be a burden (40 per cent), and/or they did not wish to leave their homes (20 per cent). The study also highlighted the need to foster social interactions among elders as a key driver in preventing social isolation and related issues (Banerjee *et al.*, 2023, p. 189).

Social Network for immediate needs: A recent survey by HelpAge India (2026) found that community participation among the elderly in India is often very limited, with almost three-quarters of elders not having membership of any formal association or organised group. Even then, community participation of elders decreases as they age, and three groups of elders tend to have even lower rates, namely those who are widowed, those living alone and those having minimal or no formal education. Never-married and solitary-living respondents reported receiving the least support despite being more heavily dependent on community networks due to weaker familial support. This study reflects how community support amongst elders is very unevenly accessible and distributed (pp 61-62). One of the major considerations for solo agers when choosing their living arrangements is the availability of a social network or group of people to meet immediate needs, handle medical emergencies, or provide support in any emergency. For those not having such a network beyond their children and families, this need is often met by transitioning to senior living. Many respondents chose senior living homes in a particular region because of the availability of a social network in that city and the staff. Ms Sachdeva moved to Bhavans Ashray after visiting her cousin, who was already residing there. She could choose a senior home in Amritsar despite her daughter residing in Delhi, because she had young relatives and extended family there to take care of any immediate needs. In the case of Ms Sehgal, her neighbours provide her with this support, and she emphasises in her testimony that their response time is always immediate.

Safety and security : Ms Mittal highlighted her concerns regarding safety and security while living alone in her apartment at times when there were no domestic helpers around. Her fears for

safety were particularly heightened during nighttime, as there would be no one to defend her in case of an attack or robbery. This was also one of the push factors in her case that made her move to Vardaan. Conversely, Ms Sehgal feels very safe in her own apartment, as she lives in a gated complex surrounded by trustworthy, reliable neighbours and with various security measures in place, including 24-hour guards at the complex entrance. Ms Lalwani chose not to continue with the 24-hour care worker employed by her daughters for various other reasons, and a concern about safety and security was one of them.

Independence: Both recent and older studies have shown dependence anxiety among older adults as a major issue for the elderly across cultures (Vatuk, 1990; Banerjee *et al.*, 2023). For some, ageing alone proves to be an opportunity to maintain independence and live with dignity and high self-esteem. Most respondents felt "dependent" on their children when they visited them abroad due to a lack of an extra-familial social network in those countries and loneliness during the day while being alone at home. They also mentioned that their children needed their own privacy, and that by living independently, they did not feel like a burden or be ignored when their children could not spend sufficient time with them. Dr Chaudhary commented that when her son and daughter-in-law, or her grandchildren, were invited to social gatherings, she did not want to attend; they often felt guilty about not being able to include her and for staying out late at night. This was another reason she chose to age solo, as she "did not want to weigh them down".

Spirituality and Religiosity: The names of various old-age homes and senior living residences reflect the Hindu conceptions of ageing spiritually and indicate the third and fourth stages in a person's life as per the *Varnashramdharma,* which entailed retreating to forests and individual spiritual quests, respectively (Lamb, 2009). Many of these residences portray themselves as following spiritual values and aligning with religious ideas of morality and ageing. Both

Vardaan and Bhavans Ashray have temples on their premises and advertise themselves as "pure vegetarian facilities". These were also key considerations of the respondents while choosing these facilities over others. This is also the reason why such senior homes have residents predominantly hailing from Hindu upper castes. Solo agers living in apartments, like Ms Lalwani and Ms Sehgal, emphasised the role of their religious duties, gatherings, and meditation as a major factor in their emotional and mental well-being. Studies have also revealed the role of faith spaces as social infrastructure in creating age-friendly communities across several religions (Ellor, 2004; Lang, 2025). These spaces are particularly important in providing support to older adults from marginalised communities but have been overlooked in policymaking.

Conclusion

Solo female agers are not a homogeneous group; reasons for solo ageing and socio-economic conditions differ widely. Older women should be seen as individual subjects exercising autonomy, not just as kin keepers or peripheral family members. They act as economic agents (consumers, bridge employees), shapers of discourse, and changers of family/household patterns. Rising numbers of ageing individuals living alone increase demand for outsourced elder care, requiring both private-sector services and government subsidies/investments. Well-being is strongly tied to financial status; many lament the lack of state support, leaving poorer women reliant on family or community (non-profit) care. Solo ageing reflects the classic structure-agency debate—sometimes necessity, sometimes choice. For upper-class women, solo living can be a positive choice and a tool for ideal ageing, enabled by financial security. As one staff member at Vardaan noted, *"This [solo ageing] is the future of ageing… for subsequent generations.*" Solo ageing is not simply abandonment—it can be a path to autonomy and dignity. Policy must recognise older women's agency, diversity, and economic roles, while ensuring inclusive support for elder care.

Acknowledgement : The author is grateful to Dr. Mala Kapur – Shankardass.

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Indian Journal of Gerontology
2026, Vol. 40, No. 4, pp. 519-536
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI: 10.5958/0971-4189.2026.00006.1

The 'Empty Nest' phenomenon and Well-Being among Older Adults in India: Evidence from Longitudinal Ageing Study in India

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ABSTRACT

This study, based on LASI Wave 1 data of over 30,000 older adults in India, finds that about 26.8% live in empty-nest households, where children are absent though spouses may co-reside. Empty-nest elders show a higher prevalence of poor physical (30.2% vs. 27.1%) and poor social well-being (28.7% vs. 26.0%) than their non-empty-nest counterparts, though they report relatively better economic status (33.4% vs. 21.7%). Multivariable analysis confirms that empty-nest status is significantly associated with increased odds of poor physical well-being (AOR 1.21) and social well-being (AOR 1.18), but not emotional well-being. The findings highlight that, while economic independence may be greater, empty-nest living arrangements pose disadvantages in health and social domains, underscoring the need for policies that strengthen healthcare access, community support, and social protection for India's ageing population.

Keywords: Empty nest households, Demographic change, Family structure shifts, Methodological approach, and Policy relevance

Population ageing is increasingly a defining demographic trend worldwide, with significant implications for social structures, economic systems, and public policy (United Nations, 2020). In the Indian context, this shift unfolds alongside rapid socio-economic changes, urbanisation, child migration, and evolving family dynamics, which have gradually altered traditional intergenerational joint-family arrangements (Rajan *et al.,* 1999). Estimates by the United Nations (2020) indicate that the proportion of older persons in India is expected to rise steadily, underscoring the need for a deeper understanding of their living conditions and well-being.

Within this changing landscape, the phenomenon of the "empty nest" has gained increasing relevance (Kumar & Pradhan, 2019). Broadly used in Western gerontological literature to describe the life-cycle stage where adult children have left home but older adults still reside with a spouse, the term requires deliberate contextual adaptation in non-Western, developing contexts (Chen & Short, 2008; Hartanto *et al.*, 2024). In India, where multi-generational co-residence has long functioned as the primary informal system of old-age security, the departure of children represents a profound structural disruption (Rajan *et al.*, 1999).

To capture the full spectrum of this transition, this study conceptualises "empty nest status" as the condition of older adults living without any co-resident children (Kumar & Pradhan, 2019). This definition encompasses both older couples residing exclusively with each other and widowed or single elderly individuals living completely solo (Thapa *et al.,* 2018). By maintaining this terminological framework, the paper captures the socio-emotional reality of child absence while recognising that the legal and practical vulnerabilities of empty-nesting in India overlap heavily with those of solitary living (Srivastava & Muhammad, 2022).

A substantial body of research has emphasised the importance of living arrangements in shaping the well-being of older adults (Singh *et al.,* 2013). Co-residence with family members is generally associated with improved access to care and financial stability (Rajan *et al.,* 1999). In contrast, older adults in empty nest environments may face challenges such as economic insecurity, limited physical care, and social isolation (Cornwell & Waite, 2009; Srivastava & Muhammad, 2022).

Despite growing interest in ageing-related issues, there remains a lack of comprehensive empirical evidence in India examining the relationship between empty-nest living and well-being across multiple dimensions simultaneously (Kumar & Pradhan, 2019). The availability of nationally representative data from Wave 1 of the Longitudinal Ageing Study in India (LASI) provides an opportunity to address this gap.

Three key questions guide the analysis:

1. To what extent does empty nest status affect the overall well-being of older adults?
2. Which specific dimensions of well-being are most sensitive to empty nest living arrangements?
3. Do empty nest older adults exhibit signs of adaptation or resilience despite potential disadvantages?

Review of Literature

Living arrangements have long been recognised as a critical determinant of health and quality of life in later life, particularly in societies where family-based support systems play a central role (Singh *et al.,* 2013). In developing countries like India, the traditional norm of intergenerational co-residence has historically functioned as an informal system of old-age security, ensuring economic stability, physical caregiving, and emotional support for older adults (Rajan *et al.,* 1999; Lloyd-Sherlock, 2010). However, ongoing demographic and socio-economic transitions are reshaping these traditional living arrangements, leading to a noticeable

diversification of household patterns among the elderly population (Bongaarts & Zimmer, 2002).

According to Government of India reports (2021), the proportion of older adults living alone or exclusively with a spouse has been rising steadily. This structural shift is closely linked to macro-level processes such as the outward migration of younger generations for employment, declining fertility rates, and evolving family norms (Bloom *et al.,* 2011; Government of India, 2021). While these changes reflect broader processes of modernisation, they simultaneously raise significant public health concerns regarding the structural adequacy of informal family support systems for a rapidly ageing population (United Nations, 2020).

Empirical research suggests that these non-co-residential structures, often described under the umbrella of the "empty nest" phenomenon, significantly influence multiple dimensions of well-being (Kumar & Pradhan, 2019). Several studies have documented that elderly individuals living without their children are more likely to experience adverse physical health outcomes, including higher rates of chronic morbidity and reduced access to immediate healthcare services (Alam *et al.,* 2012; Singh *et al.,* 2013). Similarly, non-co-residential living arrangements have been consistently associated with lower levels of subjective life satisfaction and poorer self-rated health outcomes (Kumar & Pradhan, 2019). Conversely, when older adults live alone or lack close familial support, they face a heightened risk of economic hardship and limited access to functional care (Srivastava & Muhammad, 2022).

The socio-emotional dimension of the empty nest is equally complex. The structural absence of immediate family members frequently leads to reduced daily social interactions and increased feelings of loneliness, which are heavily linked to negative psychological outcomes (Chen & Short, 2008). This lack of regular intergenerational contact can reduce emotional bonding and elevate the risk of depression and social isolation in later life (Cornwell & Waite, 2009).

However, the gerontological literature also emphasises that the empty-nest experience is not entirely negative or homogeneous (Marshall, 2015). Some scholars argue that independent living arrangements can foster greater autonomy, personal dignity, and decision-making capacity among older adults, thereby contributing positively to their overall life experience (Sen, 1999; Duflo, 2003). Furthermore, certain subgroups of older adults, particularly those who maintain better baseline health, possess higher educational attainment, or command independent financial resources, often experience a sense of control and resilience that helps preserve their emotional well-being (George, 2010; Marshall, 2015). Wealth and assets can act as a crucial buffer against the negative effects of child absence by enabling independent access to paid healthcare, household services, and comfortable living conditions (Bongaarts & Zimmer, 2002).

Finally, gender differences structurally shape how the empty nest transition is experienced. Women face a disproportionately higher likelihood of experiencing empty nest setups and subsequent solitary living due to a combination of higher life expectancy and widespread widowhood in later life (Crimmins *et al.,* 2011). The absence of a spouse often compounds the vulnerabilities associated with the absence of a child, stripping the individual of both practical and emotional support structures (Srivastava & Muhammad, 2022).

Despite this rich body of literature, a significant gap remains: most existing studies focus on isolated outcomes, such as physical health, economic status, or mental health, independently, without integrating these interconnected aspects into a broader, multidimensional framework (Kumar & Pradhan, 2019). Furthermore, limited empirical attention has been given to how vulnerability and adaptive resilience coexist among elderly individuals within the Indian context. By utilising nationally representative data from the Longitudinal Ageing Study in India (LASI), this study addresses these gaps, offering a comprehensive and nuanced analysis of how the

empty nest phenomenon relates to the multi-domain well-being of older adults.

Method

Data Source and Analytical Sample

The study utilises data from Wave 1 of the Longitudinal Ageing Study in India (LASI), conducted during 2017–18 by the International Institute for Population Sciences (IIPS) in collaboration with the Harvard T.H. Chan School of Public Health. For this study, the sample is restricted to individuals aged 60 years and above (N = 31,164).

To handle missing values transparently, a listwise deletion approach was employed. A total of 790 cases (2.53%) with missing values on primary well-being indicators or background characteristics were excluded. Characteristics of the excluded sample were compared with those of the included sample using chi-square tests, revealing that missingness was completely at random and did not systematically bias the sample toward lower socioeconomic or less-educated cohorts. The final analytical sample consists of 30,374 older adults.

Definition of Key Variables

• **Empty Nest Status (Primary Independent Variable):** In classical family sociology and life-course developmental frameworks, the "empty nest" stage represents a distinct post-parental transition occurring when adult children launch from the parental home, leaving the parents behind to navigate a shifting domestic and emotional landscape (Duvall, 1985; White & Edwards, 1990). While Western literature historically limits this definition to households where the adult children have left but *both spouses continue to co-reside*, demographic and cultural research in non-Western, developing contexts widely adapts this term to capture a broader structural reality (Chen & Short, 2008; Zimmer *et al.,* 2016).

In developing regions characterised by low levels of formal institutional support, traditional norms of intergenerational co-residence

serve as the primary mechanism for old-age security. Consequently, international scholars studying Asian ageing dynamics recognise that the absence of co-residing children constitutes an "empty nest" scenario regardless of the parents' marital status, as it signals the critical loss of proximate, informal familial care (Silverstein *et al.*, 2006; Cong & Silverstein, 2012).

Aligning with these globally validated, culturally adapted frameworks, this study operationalises Empty Nest Status as a binary variable based on household composition:

Empty Nesters (Yes): Older adults aged 60 years and above who reside without any co-resident biological, step, or adopted children. This includes both married older couples living independently with each other (the traditional, post-parental empty-nest phase) and widowed, divorced, or single older individuals living completely solo (in which the empty-nest transition has culminated in solitary living due to the absence of both a spouse and children). It is essential to clarify that, while the term 'empty nest' originates in Western gerontological discourse and often implies a post-parental stage in which couples retain their home, our operationalisation is specifically adapted to the Indian demographic landscape. In India, where multi-generational co-residence is the bedrock of informal old-age security, the departure of children is not merely a change in household size; it is a profound structural disruption of the primary social safety net. Thus, by grouping both independent couples and solitary elderly under the 'Empty Nest' umbrella, this study captures the functional loss of intergenerational support that defines the transition from joint-family security to independent living.

Non-Empty Nesters (No): Older adults residing with at least one child, child-in-law, grandchild, or extended family unit.

Construction of Well-Being Measures

Well-being is conceptualised as a multidimensional construct incorporating four key domains derived from specific LASI items:

Construction of Well-Being Measures

To ensure transparency and replicability, four distinct, binary well-being domains were constructed using specific LASI items:

Well-Being Domain	Component LASI Survey Items Included	Operational Threshold for "Well-off" vs. "Not Well-off"
Physical Well-Being	• Self-rated health (SRH) • Objective chronic condition count • Activities of Daily Living (ADL) limitations	Classified as **"Well-off"** if respondent reports good/very good/excellent SRH, possesses <2 chronic conditions, and reports zero ADL limitations. Otherwise classified as "Not well-off".
Economic Well-Being	• Monthly per-capita consumption expenditure • Asset ownership score • Subjective financial security	Classified as **"Well-off"** if composite score falls into the top three wealth quintiles and indicates independent financial security.
Social Well-Being	• Frequency of community meeting attendance • Interaction with extended family/friends • Social participation index	Index scored 0 to 10 (alpha = 0.76). Classified as **"Well-off"** if score age 6, representing active social integration.
Emotional Well-Being	• Short-form Centre for Epidemiological Studies Depression (CES-D) scale	Scores aggregated; respondents scoring below the validated threshold for clinical depressive symptoms are classified as **"Well-off"**.

- **Multidimensional Well-Being Index :** Created by combining the four domains. Older adults classified as "Not well-off" in three or more individual domains are categorised as having poor overall multidimensional well-being.

Analytical Approach

The analysis is executed in two stages:

1. Descriptive Analysis: Weighted percentages and chi-square (chi^2) tests were performed to map the background characteristics of older adults by empty nest status.

2. Multivariable Analysis: Separate binary logistic regression models were estimated for each domain and the composite index. Critically, Empty Nest Status is explicitly modelled as the primary independent variable, alongside all socio-demographic covariates, to estimate Adjusted Odds Ratios (AORs). Given the cross-sectional nature of the LASI Wave 1 data, all regression coefficients are interpreted as associations rather than causal effects.

Results

Descriptive Profile of Older Adults by Empty Nest Status

Out of the 30,374 older adults in the sample, 8,135 (26.78%) are classified as empty nesters, while 22,239 (73.22%) live in non-empty nest arrangements (Table 1).

Table 2 presents the distribution of empty-nest status by background characteristics. Broadly, 31.94% of individuals aged 71–80 are empty nesters, compared with 27.40% of those aged 60–70 ($p < 0.001$). A clear economic gradient is visible: the proportion of empty nesters rises steadily from 21.96% in the poorest wealth quintile to 41.49% in the richest quintile ($p < 0.001$). This indicates that financial asset security is strongly correlated with independent empty-nest arrangements. Rural areas show a significantly higher proportion of empty-nest arrangements (30.94%) than urban centres (21.80%; $p < 0.001$).

Crucially, the cross-tabulation between marital status and empty nest status highlights why the term "empty nest" is preserved:

- Among older adults "Currently in Union" (married), 34.77 per cent are empty nesters. This represents the traditional empty-nest life-cycle phase: the couple lives independently yet together because their adult children have moved out.
- Among older adults "Not in Union" (widowed/ divorced/ separated), 98.10 per cent are empty nesters. Because they have no co-residing children and no living spouse, their empty-nest transition has structurally culminated in living completely alone.

Bivariate Associations with Well-Being

Table 3 details significant differences in well-being outcomes based on empty nest status:

- **Physical Well-Being:** 30.18 per cent of those classified as physically "not well-off" are empty nesters, compared to 27.09 per cent among the "well-off" ($p < 0.001$).
- **Economic Well-Being:** 33.39 per cent of economically "well-off" older adults are empty nesters, while only 21.65 per cent of the "not well-off" fall into this category ($p < 0.001$).
- **Social Well-Being:** 28.68 per cent of individuals with poor social well-being are empty nesters, compared to 26.04 per cent among those with high social well-being ($p < 0.001$).
- **Emotional Well-Being:** Shows no statistically significant difference at the bivariate stage (28.81% vs. 28.01%, $p = 0.214$).

Multivariable Logistic Regression Results

Table 4 presents the complete multivariable logistic regression results, showing the primary independent variable (Empty Nest Status) modelled alongside control covariates.

After adjusting for demographic factors, empty-nest status is significantly associated with higher adjusted odds of poor physical well-being (AOR = 1.21; 95% CI: 1.12–1.31) and poor social well-being (AOR = 1.18; 95% CI: 1.09–1.27). Conversely, empty-nest status is strongly associated with a lower likelihood of poor economic well-being (AOR = 0.74; 95% CI: 0.68–0.81), indicating a clear financial advantage. The association between empty nest living and poor emotional well-being is not statistically significant (AOR = 1.03; 95% CI: 0.94–1.13).

Advanced age (71+) substantially increases health risks, dramatically increasing the odds of poor physical well-being (AOR = 1.98; 95% CI: 1.88–2.09). Educational attainment remains a powerful, consistent protective mechanism; individuals holding a

graduate degree or higher show significantly lower adjusted odds of poor physical, economic, social, and overall multidimensional well-being.

Table 1

Distribution of Elderly by Empty Nest Status

Empty Nest Status	Frequency (N)	Percentage (%)
Non-Empty Nesters (Reside with Children)	22,239	73.22
Empty Nesters (Reside without Children)	8,135	26.78
Total	**30,374**	**100**

Notes:

a. Data derived from LASI Wave-1 (2017–18).

b. Percentages are weighted estimates.

c. Empty nest refers to elderly (60+) living without co-residing children.

Table 2

Background Characteristics of Elderly by Empty Nest Status (%)

	Characteristics	Empty Nest (Yes)	Empty Nest (No)	p-value
Age Group	60–70	27.4	72.6	< 0.001
	71–80	31.94	68.06	
	81+	24.05	75.95	
Sex	Male	28.32	71.68	0.842
	Female	28.26	71.74	
Education	No Education	29.89	70.11	< 0.001
	Primary	27.06	72.94	
	Secondary	23.47	76.53	
	Graduate & Above	26.46	73.54	
Marital Status	Currently in Union	34.77	65.23	< 0.001
	Not in Union (Widowed/Divorced)	98.1	1.9	

Wealth Quintile	Poorest	21.96	78.04	< 0.001
	Poorer	21.34	78.66	
	Middle	28.38	71.62	
	Richer	31.92	68.08	
	Richest	41.49	58.51	
Residence	Rural	30.94	69.06	< 0.001
	Urban	21.8	78.2	

Notes:

a. *Wealth Quintile is constructed using household asset ownership and housing characteristics in LASI.*

b. *p-values are based on chi-square tests for association.*

c. *Percentages are row-wise and weighted.*

Table 3

Distribution of Well-Being Domains by Empty Nest Status (%)

Well-Being Domain	Category	Empty Nest (Yes)	Empty Nest (No)	p-value
Physical Well-Being	Well-off	27.09	72.91	<0.001
	Not well-off	30.18	69.82	
Economic Well-Being	Well-off	33.39	66.61	<0.001
	Not well-off	21.65	78.35	
Social Well-Being	Well-off	26.04	73.96	<0.001
	Not well-off	28.68	71.32	
Emotional Well-Being	Well-off	28.81	71.19	0.214
	Not well-off	28.01	71.99	

Notes:

a. *p-values indicate statistical association between empty nest status and well-being domains.*

b. *Classification of well-being is based on composite indices constructed from LASI indicators.*

c. *Emotional well-being shows a non-significant association ($p > 0.05$).*

Table 4
Multivariable Logistic Regression Results (Odds of Poor Well-Being Outcome)

Explanatory Predictors	Physical Well-being AOR [95% CI]	Economic Well-being AOR [95% CI]	Social Well-being AOR [95% CI]	Emotional Well-being AOR [95% CI]	Multidimensional Index AOR [95% CI]
Empty Nest Status (vs. Non-Empty)	1.21 [1.12–1.31]***	0.74 [0.68–0.81]***	1.18 [1.09–1.27]***	1.03 [0.94–1.13]	1.16 [1.08–1.25]***
Age Group (71+ vs. 60–70)	1.98 [1.88–2.09]***	0.94 [0.89–0.99]*	1.37 [1.28–1.47]***	1.05 [1.00–1.11]*	1.48 [1.40–1.55]***
Sex (Female vs. Male)	1.24 [1.18–1.31]***	0.80 [0.75–0.84]***	1.34 [1.25–1.44]***	1.13 [1.07–1.19]***	1.10 [1.04–1.16]***
Marital Status (Not in Union vs. Married)	1.24 [1.18–1.32]***	1.17 [1.11–1.24]***	1.22 [1.12–1.31]***	1.06 [0.98–1.14]	1.22 [1.16–1.29]***
Primary Education (vs. None)	0.99 [0.94–1.05]	0.67 [0.64–0.71]***	0.57 [0.53–0.61]***	1.12 [1.06–1.19]***	0.79 [0.74–0.83]***
Secondary Education (vs. None)	0.77 [0.70–0.84]***	0.38 [0.34–0.41]***	0.43 [0.38–0.48]***	1.45 [1.33–1.59]***	0.52 [0.48–0.58]***
Graduate+ (vs. None)	0.56 [0.49–0.64]***	0.18 [0.15–0.21]***	0.32 [0.28–0.37]***	1.74 [1.52–1.99]***	0.34 [0.29–0.39]***
Residence (Urban vs. Rural)	1.05 [0.99–1.11]	1.51 [1.43–1.59]***	1.02 [0.95–1.09]	1.12 [1.06–1.18]***	1.25 [1.19–1.32]***

***Notes**: Adjusted Odds Ratios (AOR) derived from separate multivariable logit frameworks. Reference categories: living with family, age 60–70, male, currently married, no education, and rural residence. Statistical significance: ***p < 0.001, p < 0.01, *p < 0.05.*

Robustness and Subgroup Variations

To add nuance to these findings, stratified analyses were performed across sub-samples:

- **Gender:** The negative association between empty nest status and poor physical health is significantly stronger for

elderly men (AOR = 1.34) than for women (AOR = 1.14). This highlights a gendered vulnerability, as older men in India are traditionally less accustomed to managing independent health and domestic care without a co-resident family network.

- **Residence:** The social well-being penalty of empty nest living is more pronounced in urban environments (AOR = 1.29) than in rural settings (AOR = 1.11). This indicates that dense, localised rural communities can help mitigate the isolation of child absence more effectively than urban neighbourhoods (Bailey *et al.,* 2018).

Limitations and Causal Design

A key limitation of this study is its reliance on the cross-sectional data of LASI Wave 1. Because these variables are observed simultaneously, it is not possible to establish a definitive causal direction. For example, a decline in physical health could prompt changes in living arrangements (such as moving closer to medical resources), meaning that health status can influence living patterns rather than the empty-nest arrangement itself causing poor health. Future research using upcoming longitudinal data from LASI Wave 2 will be valuable for establishing clear causal pathways.

Discussion

The findings reveal that empty nest living arrangements are not a uniform state of vulnerability. Instead, they interact dynamically with socioeconomic factors to produce contrasting outcomes across physical, economic, and social domains.

The higher prevalence of empty-nest status in the richest wealth quintile (41.49%) suggests that economic independence enables older adults to maintain independent households. Financially secure older individuals are often better positioned to maintain autonomy over co-residence (Bongaarts & Zimmer, 2002). Conversely, the lower prevalence among poorer cohorts reflects an economic dependence on multi-generational family structures out of financial necessity.

The multivariable association between empty nest status and poor physical well-being (AOR = 1.21) highlights a crucial vulnerability. This relationship likely reflects an associational dynamic in which the absence of co-resident caregivers can compound functional limitations. At the same time, pre-existing health constraints may also influence household separation decisions over time (Srivastava & Muhammad, 2022). Social well-being is similarly compromised among empty nesters (AOR = 1.18), highlighting the risks of social isolation associated with the absence of daily intergenerational engagement (Cornwell & Waite, 2009).

The non-significant association with emotional well-being suggests potential adaptive resilience among older adults in empty-nest households, who may turn to alternative social networks or community engagement to maintain stability (George, 2010; Hartanto *et al.*, 2024).

Conclusion and Policy Implications

This study demonstrates that the empty nest phenomenon in India is a multifaceted experience. While empty-nest living arrangements are associated with poorer physical and social well-being, they are also associated with greater economic security.

These findings suggest several targeted policy interventions:

- **Localised Social Inclusion Programmes:** Because empty-nest older adults often enjoy better economic status but face lower social well-being, policymakers should prioritise social inclusion programs (such as senior day centres and community peer groups) over direct income transfers for this group.
- **Targeted Geriatric Home-Care Interventions:** Given the higher odds of poor physical well-being among empty nesters, local public health services should establish home-based care and telemedicine support tailored specifically for households without co-resident family caregivers.

- **Subgroup Protections:** Support services should prioritise highly vulnerable subgroups, particularly older men living alone in rural areas and widowed women, ensuring they have access to localised protection networks.

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Indian Journal of Gerontology
2026, Vol. 40, No. 4, pp. 537-564
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI : 10.5958/0971-4189.2026.00007.3

Gender Differences in Socioeconomic Vulnerability and Their Impacton Well-being of Older Adults in India

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ABSTRACT

This study aims to examine the gendered dimensions of socioeconomic vulnerability among older adults in India and its implications for their well-being, using data from the Longitudinal Ageing Study in India (LASI) Wave 1 (2017–18), which surveyed a nationally representative sample of 72,250 individuals, including 31,464 aged 60 years and above. The research highlights how intersecting factors such as gender, caste, religion, education, location, and housing conditions shape disparities in later life. Findings reveal that 32% of older adults experience high socioeconomic vulnerability (SEV), with older women more than three times as likely as older men to face such conditions (OR=3.11). Widowed or divorced individuals have 37% higher odds of vulnerability, while Muslims (OR=1.52) and rural residents (OR=1.33) are significantly more at

risk. Regionally, Odisha, Jammu & Kashmir, and Uttar Pradesh report the highest SEV prevalence. Vulnerability is especially pronounced among women aged 80+, underscoring the cumulative disadvantages faced over the life course. The study situates old age as a marginalised phase, particularly for women, and argues that vulnerability in later life is structurally embedded. It contributes to the discourse on gender, ageing, and livelihood security by advocating for inclusive, age- and gender-sensitive policies that enhance social protection, healthcare access, and well-being among India's elderly population.

Keywords : Gender differences, Older adults, Socioeconomic vulnerability, Well-being, India

The rapid ageing of India's population brings with it critical challenges, particularly for marginalised elderly groups who face compounded socioeconomic vulnerabilities. The vulnerability is not limited to economic indicators but also includes limited access to food, healthcare, housing, and social participation. Research indicates that socioeconomically vulnerable elderly individuals are more likely to experience food insecurity and poor psychological and physical health outcomes (Keshari & Shankar, 2021), especially among women and the uneducated elderly population, who often face greater barriers to accessing resources and social support systems.

Socioeconomic vulnerability in old age, rooted in unequal access to education, lifelong employment opportunities, and gendered care roles, acts as a critical barrier to achieving wellbeing and dignity. In terms of social vulnerability, the ageing transition has significant implications for family structures, social networks, psychosocial dynamics, living arrangements, life satisfaction, and the overall well-being of older individuals. In India, the family system has traditionally served as the prime source of support for aged people, with sons

responsible for caring for their parents (HelpAge, 2021). Around three-fourths of the elderly co-reside with their spouse, children and grandchildren (Rajan & Kumar, 2003).

Economic vulnerability among the elderly is a multifaceted issue influenced by various factors, including wealth quintile, employment status, financial support, and other factors (Alam, 2009; Dhar, 2014; Goli *et al.*, 2019). The study by Singh & Sharma (2022) highlights that economic activity helps to mitigate some aspects of financial hardship. However, this study also notes that informal and low-wage employment often lacks sufficient benefits and social protection. Moreover, the financial burden associated with age-related dependency and medical conditions is substantial and projected to rise as the number of older adults continues to increase (Rao, 2006). Thus, this trend underscores the need for targeted strategies to address the economic impact of ageing in India (Banerjee *et al.*, 2023). Economic vulnerability is based on the fact that elderly people are in a position to maintain a minimum living standard in terms of access to economic resources (Chakraborty, 2017), which is measured in either income or subsistence poverty in terms of basic needs (Rao, 2006).

Socio-Economic Old-Age Vulnerability in India

India is undergoing a significant demographic transition, with the elderly population projected to reach nearly 14.9% by 2036 (Government of India, 2020). Therefore, socioeconomic old-age vulnerability in India is a significant issue that affects various aspects of well-being and quality of life, including physical and mental health, as well as overall life satisfaction (Muhammad *et al.*, 2022; Bhat & Sahoo, 2023). A study conducted in Assam found that elderly individuals with lower socioeconomic status exhibited poorer physical and mental health outcomes. The research highlighted that factors such as limited income, lack of education, and unemployment were significantly associated with chronic illnesses and depressive symptoms among the elderly population.

Additionally, cognitive impairment was more prevalent among socioeconomically disadvantaged older adults, with illiteracy, poor economic status, and lack of social support being significant risk factors (Sarma & Bardoloi, 2024). Further, a study analysing life satisfaction among older adults revealed that individuals from SCs and STs reported lower life satisfaction scores compared to their counterparts from other caste groups. Additionally, poor childhood health and low socioeconomic status were significantly associated with depressive symptoms in later life, underscoring the importance of early-life socioeconomic conditions in shaping the mental health of the elderly (Muhammad, 2022). Furthermore, elderly individuals living alone or in non-nuclear households are more prone to neglect and economic vulnerability, exacerbating their vulnerabilities (Keshari & Shankar, 2021). The compounded effect of poor income, deteriorating health, and lack of institutional support puts elderly individuals at heightened risk of social exclusion.

Moreover, many older individuals, particularly in rural or informal sectors, lack savings or occupational pensions, resulting in lifelong dependency on family or continued labour in advanced age, often under exploitative or low-paying conditions (Prasad, 2011). This precariousness is compounded by inadequate access to healthcare, poor housing, and food insecurity, particularly among women and those from marginalised communities (Keshari & Shankar, 2021). As institutional support remains weak, elderly individuals often experience vulnerability not only in terms of income but also in access to essential services and social participation, further heightening their vulnerability. Even though welfare schemes like the National Social Assistance Programme aim to provide financial relief, Prasad (2011) notes their limited reach and sufficiency, rendering them ineffective at addressing the deeper structural roots of poverty among the aged. The absence of comprehensive old-age security mechanisms and limited coverage of pension schemes have heightened the economic dependence of the elderly on family or informal sources (Ibid.). These conditions

collectively contribute to the social marginalisation and economic vulnerability of older people, particularly women in rural and low-income settings. Therefore, the study aims to determine the gender differences in socioeconomic old-age vulnerability and its associated factors for overall well-being among older adults in India.

Method

Data Source and Sample Selection

The study uses secondary data from the Longitudinal Ageing Study in India (LASI) Wave 1 (2017–18), conducted by the International Institute for Population Sciences (IIPS), Mumbai. LASI is India's first and the world's largest longitudinal study focused on ageing, designed to inform the development of policies and programmes to improve the social, health, and economic well-being of older adults. The survey targeted individuals aged 45 and above, along with their spouses, regardless of age. The LASI survey adopted a multistage, stratified, area probability cluster sampling design across all states and union territories (UTs), using a three-stage method in rural areas and a four-stage method in urban areas.

LASI Wave 1 collected information from 43,584 households and 73,396 individuals across the selected households. After merging the household and individual datasets, the final matched sample comprised 72,270 individuals, including 31,464 aged 60 years and above and 6,749 aged 75 years and above, across all 36 states and UTs of India.

Study Variables

Outcome Variable : The outcome variable of this study is "Socioeconomic Vulnerability" and it was constructed to measure the socioeconomic aspects of vulnerability among the older population using eight socioeconomic indicators (education level, satisfaction with living arrangements, social participation, whether living in a safe locality/areas, MPCE Quintile, working status, receiving financial support from family or friends, and having the burden of loan/debt). All these socioeconomic variables were recorded as '0' (vulnerable/

disadvantaged category) or '1' (otherwise), and the sum of socioeconomic variable responses was generated (see Table 2). The newly constructed variable is continuous, with higher scores indicating lower levels of socioeconomic vulnerability. Then, the final score variable has been normalised and divided into three categories corresponding to different levels of socioeconomic vulnerability: high, moderate, and low.

Explanatory Variables : The study contains a range of explanatory variables to assess vulnerability levels across different background characteristics. These covariates include sex (male/female), age groups (45–59 years, 60–69 years, 70–79 years, and 80+ years), and educational attainment (no education, primary, middle, secondary, and higher education and above). Marital status is classified as currently married or widowed/divorced/separated/never married. Living arrangements are categorised as living alone, living with others, living with a spouse, living with a spouse and children, or living with children (without a spouse). Religious affiliation includes Hindu, Muslim, Christian, and others. In contrast, social category includes Scheduled Castes (SC), Scheduled Tribes (ST), Other Backwards Classes (OBC), General (none of the above), and missing/not reported. Employment status is grouped into never worked, currently working, or currently not working but previously worked. Economic status is represented by wealth quintiles (poorest to richest). Other variables include place of residence (urban/rural), geographical region (North, South, East, West, Central, and North-East), and state classification (Empowered Action Group [EAG] vs. non-EAG states).

Statistical Analysis

The present study employed a combination of statistical techniques to examine gender differences in socioeconomic vulnerability among older adults and their associated factors. Descriptive statistics were used to summarise the frequencies and percentages of outcome variables and key demographic and socioeconomic indicators. Bivariate analysis was used to explore the

distribution of socioeconomic vulnerability across India, including variations at the state and background group levels. Spatial analysis helped identify geographical patterns in vulnerability across states and UTs. Finally, ordered logistic regression models were applied to determine the key factors associated with socioeconomic vulnerability in old age.

The ordered logit regression model is appropriate when the response variable is ordinal (Grilli *et al.*, 2014). This model estimates the cumulative probabilities of the response categories, linking them to the covariates through a regression framework.

$$Pci = Pr (Yi = yc| xi), c = 1, \ldots\ldots , C \quad \ldots\ldots\ldots\ldots\ldots \quad (1)$$

Let Yi be an ordinal response variable with C categories for the ith subject, and let xi denote the corresponding vector of covariates. Ordinal regression models are typically not formulated directly in terms of category probabilities; instead, they use one-to-one transformations such as the cumulative probabilities $gci = Pr (Yi \leq yc \mid xi)$, c = 1, ..., C. Since the final cumulative probability is always equal to 1, the model only needs to define C–1 cumulative probabilities.

The ordered logit model for an ordinal response Yi with C categories is specified through C–1 equations, each relating the cumulative probability $gci = Pr(Yi \leq yc|xi)$ to a linear predictor $\beta'xi = \beta0 + \beta1x1i + \beta2x2i + \ldots..$ via the logit link function:

$$Logit (gci) = \log (gci / (1-gci)) = \alpha c - \beta'xi, c = 1, 2 , .. , C - 1 \quad \ldots\ldots\ldots\ldots (2)$$

The parameters αc, known as thresholds or cut points, are ordered such that $(\alpha1 < \alpha2 < \ldots < \alpha c\text{-}1)$. It is not possible to estimate both the overall intercept β0 and all the C–1 thresholds simultaneously, due to an identification issue: adding a constant to β0 can be offset by adding the same constant to each αc, leaving the model unchanged. To address this problem, one common approach is to omit the overall intercept from the linear predictor (i.e., β0 = 0) or to fix the first threshold (i.e., α1 = 0).

Results

Profile of the Study Respondents

The percentage distribution of the sample by background characteristics used in this study is presented in Table 1. The sample comprises 42 per cent males and 58 per cent females. In terms of age distribution, 55 per cent of respondents were aged 45–59 years, 27 per cent were 60–69 years, about 14 per cent were 70–79 years, and only 4 per cent were aged 80 years and above. Regarding marital status, 76 per cent were currently married, while 24 per cent were widowed, separated, or never married. The majority of respondents identified as Hindu (82%), followed by Muslims (12%). By social category, 45 per cent belonged to Other Backwards Classes (OBC), 20 per cent were Scheduled Castes (SC), and 9 per cent were Scheduled Tribes (ST). In terms of housing, 55 per cent of older individuals lived in kutcha/semi-pucca houses, and a significant majority (91%) owned their houses, with only 9 per cent living in rented houses. Geographically, 70 per cent of respondents resided in rural areas, and 30 per cent lived in urban areas. The regional distribution shows that 24 per cent of respondents were from the Eastern region, followed by 23 per cent from the Southern and 20per cent from the Central region, and only 4 per cent from the North-Eastern region. Lastly, around 60 per cent of the respondents were from Empowered Action Group (EAG) states, and 40 per cent were from non-EAG states.

Appendix T1 presents the percentage distribution of socioeconomic indicators used to construct the outcome variable, i.e., Socio-economic Vulnerability (SEV). These indicators include no formal education or only minimal educational attainment, dissatisfaction with current living arrangements, lack of participation in social activities, not residing in a locality perceived as safe from crime or violence, poor wealth status, never having worked in one's lifetime, not receiving financial support from family or friends, and carrying a burden of loans or debts from banks or other financial institutions. For instance, the majority of respondents (67%) had either never attended school or completed only primary education, while

33 per cent had attained middle school, secondary, or higher education. Regarding satisfaction with living arrangements, 78 per cent of respondents reported being satisfied or strongly satisfied, whereas around 22 per cent expressed dissatisfaction or remained neutral.

Table 1

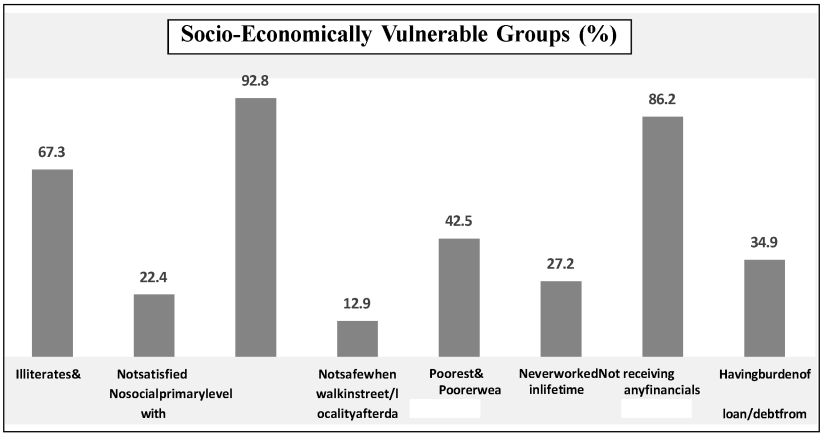
Percentage distribution of the study respondents by explanatory variables, India, LASI Wave-1, 2017-18

Variable	Variable Category	%	N
Sex	Male	42.1	29546
	Female	57.9	39822
Age group	45-59 years	54.6	39526
	60-69 years	27.1	18224
	70-79 years	13.6	8582
	80 years & above	4.7	3036
Marital status	Currently married	76.0	53442
	Widowed/Separated/	24.1	15924
	Never Married		
Religion	Hindu	82.1	50719
	Muslim	11.5	8133
	Christian	2.9	7004
	Other religious groups	3.5	3512
Social group	Scheduled Castes	19.6	11527
	Scheduled Tribes	8.7	12258
	Other Backward Classes	44.9	26325
	None of the above	24.1	16764
	Missing & not reported	2.7	2494
Household type	Kutcha/semi-pucca	54.5	37262
	Pucca house	45.5	31768
House Ownership	Own house	91.4	62089
Status	Rented house	8.6	7275
Place of residence	Urban	30.2	24212
	Rural	69.8	45156

Geographical	North	12.1	12219
region	Central	20.4	9031
	East	24.2	12405
	North-East	3.8	10426
	West	16.5	8974
	South	23.0	16313
Status of EAG/	EAG States	59.5	48207
Non-EAG	Non-EAG States	40.5	21161
	Total	**100.0**	**69368**

Note: Dropped 2902 missing cases to make a unique dataset from all variables for accurate analysis; Applied weights for '%' and 'N ', which are considered without weights.

Fig. 1 Percentage distribution of socioeconomic indicators of vulnerability, India, LASI Wave-1, 2017-18



The vast majority of older individuals (93%) were not active in any form of social activity. Regarding perceived safety, 87% of respondents felt safe walking alone after dark, while about 13 per cent did not. Slightly over half of the sample (58%) fell into the middle-to-wealthiest quintiles, and 42 per cent were in the poorest or poorer categories. Most older individuals (73%) had worked or were currently working, but about 27 per cent had never worked in their lifetime. Only about 14 per cent of

respondents received financial support from family or friends, while a significant 86 per cent received none. Lastly, approximately 35 per cent reported carrying a burden of loans or debts from banks and other financial institutions (Fig. 1).

State-wise variations in socioeconomic indicators of vulnerability among older adults in India reveal notable disparities across regions (Appendix T2). For instance, a large proportion of individuals in states such as Chhattisgarh (79%), Andhra Pradesh (76%), and Madhya Pradesh (76%) have low educational attainment, with most having only primary education or being illiterate. Dissatisfaction with living arrangements is relatively higher in states such as Karnataka and Tamil Nadu, where about 31% of older individuals reported being dissatisfied with their current living conditions. Social participation is particularly low in the Andaman & Nicobar Islands (96%) and Delhi (98%), showing very high non-participation in social activities. Perceptions of safety also differ across regions; for instance, in Jammu & Kashmir (60%) and Odisha (41%), a significant proportion of older individuals feel unsafe walking alone after dark.

On the economic front, poverty is widespread in states like Bihar (56%), Odisha (55%), and Jharkhand (52%), where large shares of the older population fall into the poorest or poorer wealth quintiles. Additionally, a notable proportion of individuals in Jammu & Kashmir (61%) and Punjab (51%) reported never having worked in their lifetime. Access to financial support varies across states, with West Bengal (92%) and Assam (91%) showing high percentages of individuals receiving help from family or friends. Lastly, the burden of loans and debts is considerable among older adults in states like Uttar Pradesh (51%) and Telangana (45%) in India.

Concomitant Socioeconomic Indicators of Vulnerability

The percentage distribution of concomitant socioeconomic indicators of vulnerability among older adults in India is presented in Table 2. The level of SEV among older adults has been categorised

into three groups: high, medium, and low. High vulnerability, defined as experiencing five or more indicators of disadvantage, was observed among 30 per cent of the older population. A majority of respondents had a moderate level of vulnerability (57%), indicating exposure to three or four vulnerable conditions. Only 13 per cent of older individuals fell into the low vulnerability category, with just one or two indicators present (Appendix F1). It is important to note that 116 respondents who reported no vulnerability on any of the selected indicators were excluded from this analysis.

Table 2

Percentage distribution of concomitant socioeconomic indicators of vulnerability among older adults in India, LASI Wave-1, 2017-18

No. of Indicators	N	%	% Contribution	Vulnerability Level
All Eight	42	0.1	**29.7**	**High**
Seven	727	1.4		
Sex	4233	7.6		
Five	12963	20.7		
Four	21558	31.4	**57.1**	**Moderate**
Three	18381	25.8		
Two	9598	11.4	**13.2**	**Low**
One	1750	1.7		
Total	**69252**	**100.0**	**100.0**	**-**

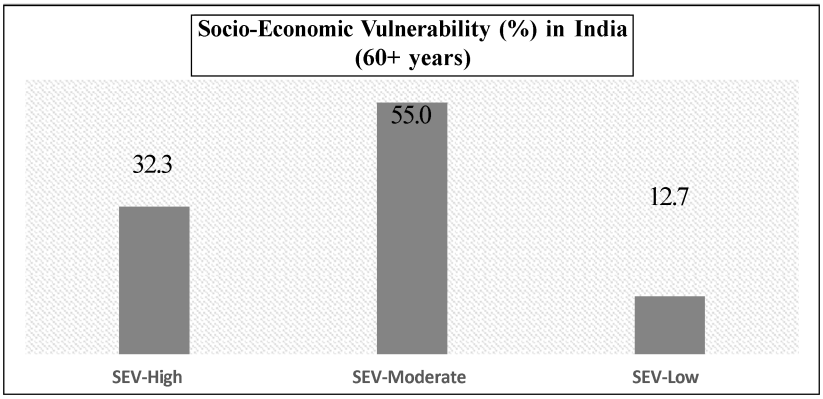
Note: Respondents who were not vulnerable (n=116) have not been considered.

• Socio-Economic Vulnerability among Older Population

Fig. 2 shows the percentage distribution of socioeconomic vulnerability among older adults (aged 60+ years) by age group. For instance, almost one in every three individuals falls under high-SEV. Notably, a larger share of the older population (60+ years) experiences high vulnerability (32%) compared to their younger counterparts (28%). Overall, a significant majority (87%) of older

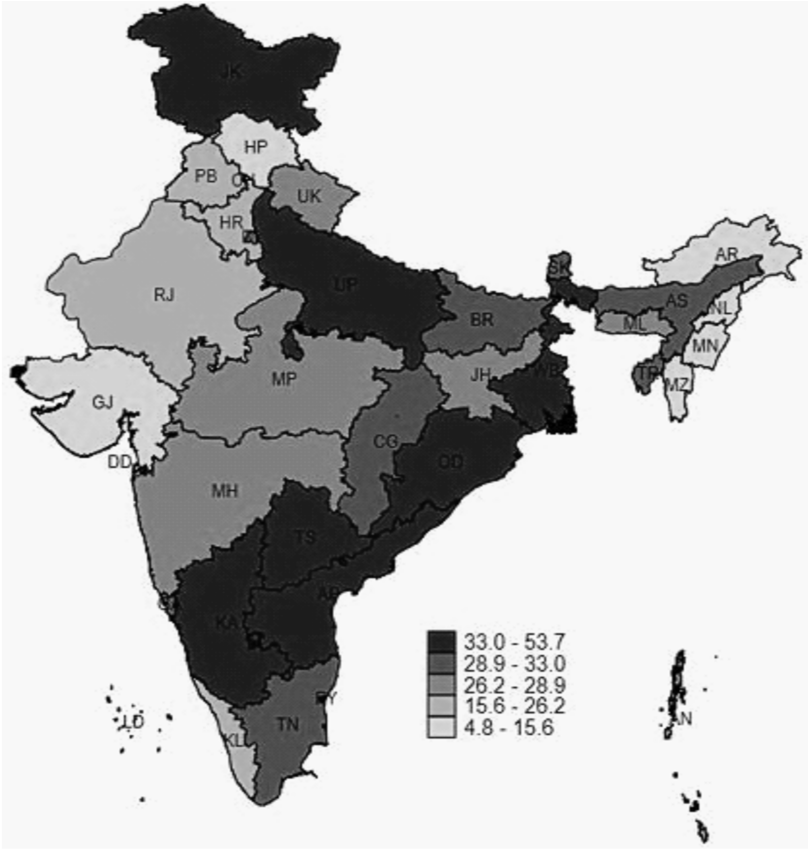
persons experience either moderate or high levels of SEV, indicating they are slightly more vulnerable in India.

Fig. 2 Percentage distribution of socioeconomic vulnerability among older population (60+ years), LASI Wave-1, 2017-18

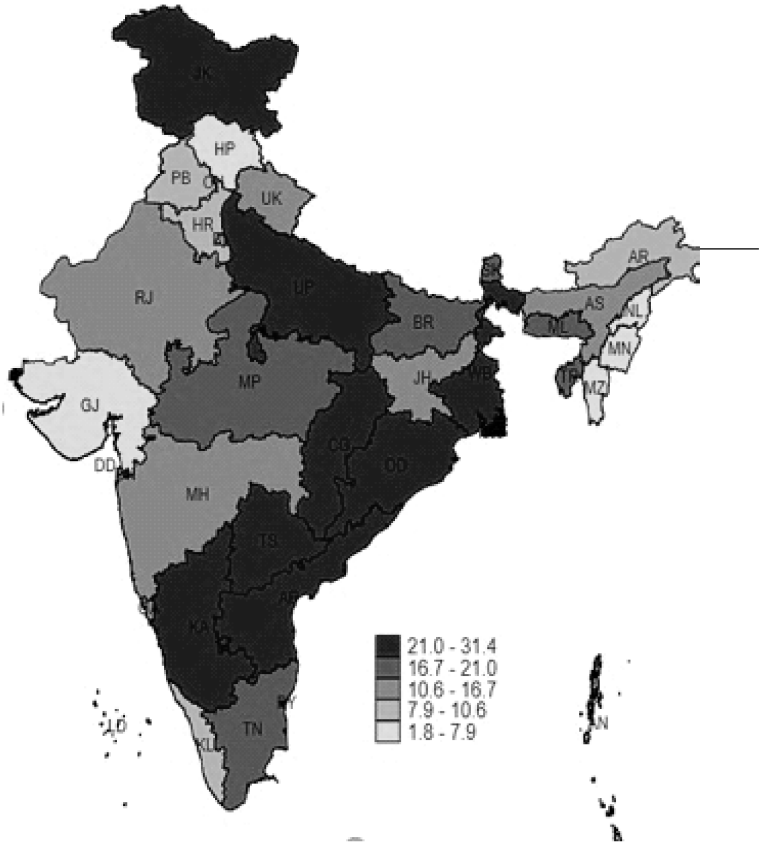


Further, Map 1 presents the age distribution of socio-economically highly vulnerable (high-SEV) older adults in Indian States/UTs. For instance, states with the highest levels of high-SEV among those aged 60 years and above are Odisha (54%), Karnataka (45%), and Jammu & Kashmir (43%) (Appendix F2). There is a huge gender disparity found, i.e., 37 per cent of females are in high-SEV compared to 19 per cent of males in India (see Map 2). Particularly striking is the gender gap in several regions; for instance, in Jammu & Kashmir, 60 per cent of older women are highly vulnerable compared to 21 per cent of older men, which shows a 39 per cent difference between older males and females. Further, Delhi, Uttar Pradesh, and Bihar also show significant gender gaps in India. Therefore, these discrepancies suggest that, in many areas, older women were disproportionately disadvantaged in socioeconomic terms, possibly due to the cumulative effects of limited education, limited social participation, lower economic status, and limited financial support from family and the state over their lifetimes.

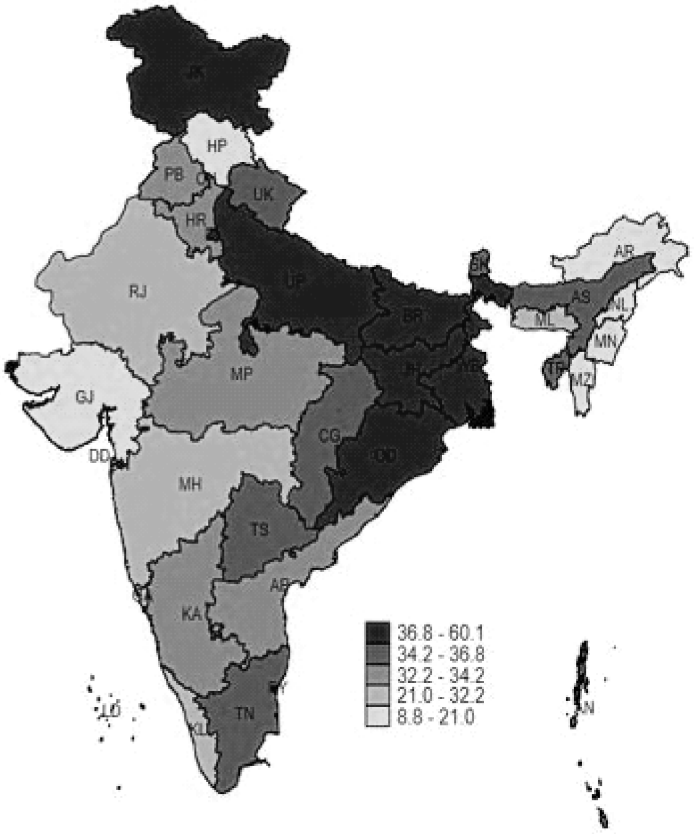
Map 1: Percentage distribution of socioeconomically highly vulnerable (high-SEV) older population (60+ years) in Indian State/UTs, LASI Wave-1, 2017-18



Map 2: Percentage distribution of socioeconomically vulnerable (high-SEV) older population in Indian State/UTs by Gender, LASI Wave-1, 2017-18



(A) SEV among Older Males



(B) SEV among Older Females

Factors Associated with Socio-Economic Vulnerability in Old Age

Table 3 presents the ordered logit regression results explaining factors associated with socioeconomic old-age vulnerability, categorised as high, moderate, and low, among the older population in India. Keeping all other variables constant, older females are over three times more likely to experience high SEV (OR=3.11, 95 per cent CI: 2.96–3.27) than older males, highlighting a sharp gender gap. Widowed, divorced, or separated older individuals had 37 per cent higher odds of vulnerability (OR=1.37, 95% CI: 1.30–1.44) compared to those who were currently married. By religion,

Muslims had 52 per cent higher odds of experiencing SEV (OR=1.52, 95% CI: 1.41–1.64), and Christians were 30 per cent less likely to experience high SEV (OR=0.70, 95% CI: 0.61–0.81) compared to Hindus. Older individuals from OBCs had 28 per cent lower odds (OR=0.72, 95% CI: 0.67–0.76), and those from other social groups had nearly half the odds (OR=0.51, 95% CI: 0.48–0.55) compared to SCs.

Table 3

Ordered Logit Regression Results: Factors associated with socioeconomic vulnerability among older population (60+ years) in India, LASI Wave 1, 2017-18

Background Characteristic	SEV among 60 years & above	
	Odds Ratio	95% CI
Sex		
Male ®	1.00	
Female	3.11***	(2.956 3.272)
Marital Status		
Currently married ®	1.00	
Widowed/Divorced/Separated & Others	1.37***	(1.299 1.438)
Religion		
Hindu ®	1.00	
Muslim	1.52***	(1.408 1.644)
Christian	0.70***	(0.611 0.811)
Others	0.76***	(0.668 0.859)
Social Group		
Schedule Castes ®	1.00	
Schedule Tribes	0.84***	(0.762 0.925)
Other Backward Classes	0.72***	(0.671 0.764)
None of the above	0.51***	(0.478 0.553)
Missing/not reported	0.65***	(0.554 0.761)

Household type		
Pucca house®	1.00	
Kutcha/semi-pucca	1.65***	(1.568 1.735)
House Ownership status		
Own house ®	1.00	
Rented house	1.06	(0.966 1.167)
Place of residence		
Urban ®	1.00	
Rural	1.33***	(1.258 1.409)
Geographical Region		
North ®	1.00	
Central	1.27***	(1.155 1.388)
East	1.28***	(1.182 1.395)
North-East	0.60***	(0.516 0.704)
West	0.73***	(0.666 0.804)
South	1.17***	(1.065 1.294)
Status of EAG/Non-EAG		
EAG States ®	1.00	
Non-EAG States	0.92**	(0.849 1.000)
N	**29,647**	-

Note: ***p<0.01; **p<0.05; * p<0.10; CI: Confidence Interval; ® Reference Category

Living conditions were a strong predictor of the socioeconomic well-being of the older population. The elderly persons living in kutcha/semi-pucca houses were 65 per cent more likely to face high SEV (OR=1.65, 95% CI: 1.57–1.73) than those in pucca houses. By place of residence, rural residents had about one-third higher odds of vulnerability (OR = 1.33, 95% CI: 1.26–1.41) than their urban counterparts. The Central and Eastern regions showed 27 per cent and 28 per cent higher likelihood of vulnerability, respectively, compared to the Northern region (reference category), whereas those in the North-East had 40 per cent lower odds (OR=0.60, 95% CI: 0.52–0.70). Older individuals from non-EAG states had about 8 per

cent lower odds of vulnerability (OR = 0.92, 95% CI: 0.85–1.00) than those from EAG states. Overall, these patterns reveal deep-rooted socioeconomic inequalities shaped by gender, social group, religion, place of residence, and regional development in India.

Gender Differences in Socio-Economic Vulnerability in Old Age

Table 4 presents the ordered logit regression results explaining gender-specific factors influencing socioeconomic vulnerability among the older population in India. Keeping all other variables constant, among older males, age significantly increased the likelihood of vulnerability–those aged 80+ years had nearly 49 per cent higher odds of experiencing greater SEV (OR=1.49, 95% CI: 1.33–1.67) than those aged 60–69 years. On the other hand, for older females, the effect of age was even more pronounced than for older males; i.e., those aged 80+ years had 61 per cent higher odds (OR=1.61, 95% CI: 1.44–1.80) compared to the reference category (age group 60-69 years). Older widowers/divorced/separated males had 29 per cent higher odds of SEV (OR=1.29, 95% CI: 1.19–1.41), whereas for females it was slightly lower at 22 per cent (OR=1.22, 95% CI: 1.14–1.30). Further, religious affiliation showed similar figures across genders—Muslims were about 50–60 per cent more likely to experience high SEV compared to Hindu counterparts, while Christians and other religious groups had significantly lower odds, by approximately 28–32 per cent.

Table 4
Ordered Logit Regression Results: Factors associated with socioeconomic vulnerability (60+) among older males and females in India, LASI Wave 1, 2017-18

Background	Older Males		Older Females	
Characteristic	**Odds Ratio**	**95% CI**	**Odds Ratio**	**95% CI**
Age group				
60-69 years ®	1.00		1.00	
70-79 years	1.14***	(1.056 1.223)	1.36***	(1.267 1.466)
80 years & above	1.49***	(1.333 1.670)	1.61***	(1.439 1.797)

Marital Status				
Currently married ®	1.00		1.00	
Widowed/Divorced/ Separated & Others	1.29***	(1.186 1.409)	1.22***	(1.138 1.304)
Religion				
Hindu ®	1.00		1.00	
Muslim	1.60***	(1.434 1.793)	1.5***	(1.349 1.676)
Christian	0.72***	(0.577 0.891)	0.72***	(0.592 0.866)
Others	0.68***	(0.569 0.818)	0.80**	(0.669 0.952)
Social Group				
Schedule Castes ®	1.00		1.00	
Schedule Tribes	0.91	(0.787 1.045)	0.81***	(0.709 0.924)
Other Backward Classes	0.60***	(0.551 0.664)	0.81***	(0.743 0.889)
None of the above	0.41***	(0.365 0.450)	0.61***	(0.554 0.677)
Missing/not reported	0.53***	(0.420 0.673)	0.70***	(0.559 0.867)
Household type				
Pucca house®	1.00		1.00	
Kutcha/semi-pucca	2.31***	(2.141 2.487)	1.25***	(1.167 1.342)
House Ownership status				
Own house ®	1.00		1.00	
Rented house	1.16**	(1.004 1.335)	1.03	(0.903 1.164)
Place of residence				
Urban ®	1.00		1.00	
Rural	1.72***	(1.581 1.866)	1.04	(0.961 1.123)
Geographical Region				
North ®	1.00		1.00	
Central	1.28***	(1.119 1.458)	1.27***	(1.120 1.445)
East	1.12*	(0.997 1.266)	1.49***	(1.331 1.675)
North-East	0.50***	(0.401 0.632)	0.71***	(0.573 0.881)
West	0.98	(0.853 1.122)	0.59***	(0.514 0.667)
South	1.37***	(1.187 1.576)	1.03	(0.899 1.176)
Status of EAG/Non-EAG				
EAG States ®	1.00		1.00	
Non-EAG States	0.96	(0.857 1.083)	0.87**	(0.774 0.973)
N	**14,277**	-	**15,647**	-

Note: ***p<0.01; **p<0.05; * p<0.10; CI: Confidence Interval

® Reference category

Social group, housing, and regional disparities also varied by gender. Among older males, those from OBCs were 40 per cent less likely to experience high SEV (OR=0.60, 95% CI: 0.55–0.66), while for older females, the reduction was smaller at 19 per cent (OR=0.81, 95% CI: 0.74–0.89). Notably, older males living in kutcha/semi-pucca houses had higher odds of SEV than double (OR=2.31, 95% CI: 2.14–2.49), compared to only 25 per cent higher odds for older females (OR=1.25, 95% CI: 1.17–1.34). Rural residence had a strong effect on older males (OR=1.72, 95% CI: 1.58–1.87), increasing their odds of SEV by 72 per cent, whereas the effect was not statistically significant for older females. The regional variation was also notable, i.e., older males in the South had 37 per cent higher odds of SEV (OR=1.37). In contrast, older females in the West and North-East were about 29 per cent and 41 per cent less likely to experience high SEV, respectively.

Conclusion

The study highlights that socioeconomic vulnerability (SEV) among India's older population is both widespread and deeply unequal, shaped by age, gender, caste, religion, geography, and living arrangements. Nearly onethird of individuals aged 45 and above face high SEV, with vulnerability intensifying after age 60 due to cumulative disadvantages across the life course. Older women are disproportionately affected, being over three times more likely than men to experience high SEV, largely due to widowhood, low education, unpaid caregiving roles, and financial dependence. Structural inequalities further compound vulnerability: marginalised groups such as Scheduled Castes, Scheduled Tribes, and Muslims, as well as those living in rural areas, kutcha/semipucca housing, and Central or Eastern regions, face significantly higher odds of exclusion, while states like Odisha, Jammu & Kashmir, and Uttar Pradesh report especially high SEV. These findings underscore the need for intersectional, regionsensitive policies that address the compounded effects of gender, caste, religion, and socioeconomic status, ensuring that older adults—particularly women and marginalised groups—can age with dignity, security, and inclusion.

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Annexures

Appendix T1

Percentage distribution of socioeconomic indicators of vulnerability, India, LASI Wave-1, 2017-18

S. no.	Variable name	Label Code	Label Categories	%	N
1	Education Level	0	No schooling & Primary level of education	67.3	44450
		1	Middle, Secondary, Higher & above level	32.7	24918
2	Satisfaction with living arrangements	0	Strongly dissatisfied, dis-satisfied & neither satisfied nor dissatisfied	22.4	13923
		1	Strongly satisfied & Satisfied	77.7	55445
3	Member of any social organisations, religious groups, clubs or societies	0	Not a member	92.8	62799
		1	Yes member	7.2	6569
4	Feeling safe when walking down your street/locality alone after dark	0	Not very safe & Not safe at all	12.9	8201
		1	Completely safe & Safe	87.1	61167
5	Wealth Quintile	0	Poorest and Poorer	42.5	27586
		1	Middle, Richer, and Richest	57.5	41782
6	Working Status	0	Never worked in a lifetime	27.2	20595
		1	Currently working/Worked in the past	72.9	48773
7	Receiving financial support from family or friends	0	Not receiving any financial support	86.2	60310
			Receiving financial support	13.8	9058
8	Having a burden of loan/debt from banks or other institutions	0	Having loan/debt	34.9	20095
		1	Not having any loan/debt	65.1	49273

Note: Dropped 2902 missing cases to make a unique dataset from all variables for accurate analysis; Applied weights for '%' and 'N ', which are considered without weights.

Appendix T 2

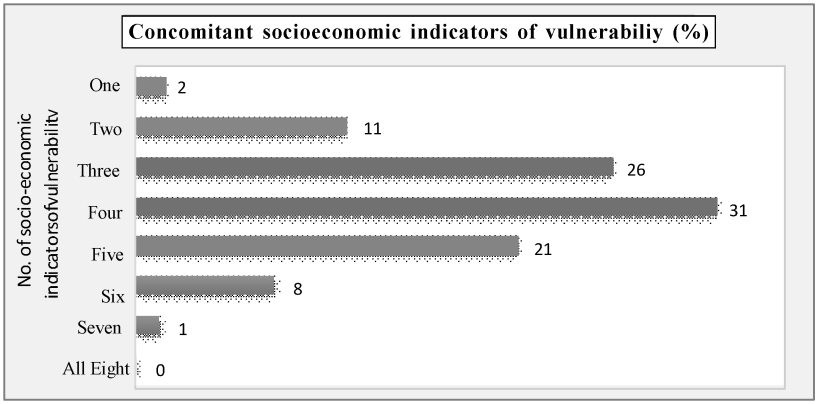
Percentage distribution of the socioeconomic variables of vulnerability among the older adults by States, LASI Wave 1, 2017-18

State/UT	Illiterates (or) Primary level	Not satisfied with current living arrange-ments	Not parti-cipating in any social activities	Not safe when walking in your street/ locality	Poorest (or) Poorer wealth quintile	Never worked in lifetime	Not receiving any financial support	Having loans/ debt from banks and others	Sample (N)
A & N Islands	67.3	15.9	95.8	18.1	30.1	47.8	97.3	5.8	1189
Andhra Pradesh	76.1	27.6	86.5	16.5	27.2	18.9	88.1	49.1	2476
Arunachal Pradesh	68.9	23.4	86.6	5.6	27.1	34.7	80.5	5.8	1195
Assam	57.0	26.3	84.4	9.4	47.4	34.9	91.6	23.1	2302
Bihar	74.9	19.1	94.5	4.3	56.1	33.6	72.5	42.1	3437
Chandigarh	39.6	12.3	96.0	6.2	17.1	44.0	96.2	15.7	930
Chhattisgarh	79.4	17.1	85.7	9.2	70.1	13.4	87.0	31.2	1936
Dadra and Nagar Haveli	72.0	14.2	93.6	9.5	51.7	10.5	88.7	17.1	900
Daman and Diu	54.8	12.2	93.4	3.9	33.5	19.7	84.8	12.3	836
Delhi	50.8	19.8	98.0	7.0	44.9	43.2	94.8	8.1	1256
Goa	48.6	13.5	88.6	25.0	14.0	44.2	92.4	32.9	1336
Gujarat	64.0	11.9	91.2	5.6	38.9	14.5	87.4	22.3	2079
Haryana	69.0	11.8	98.2	4.8	33.5	37.3	93.8	21.1	1785

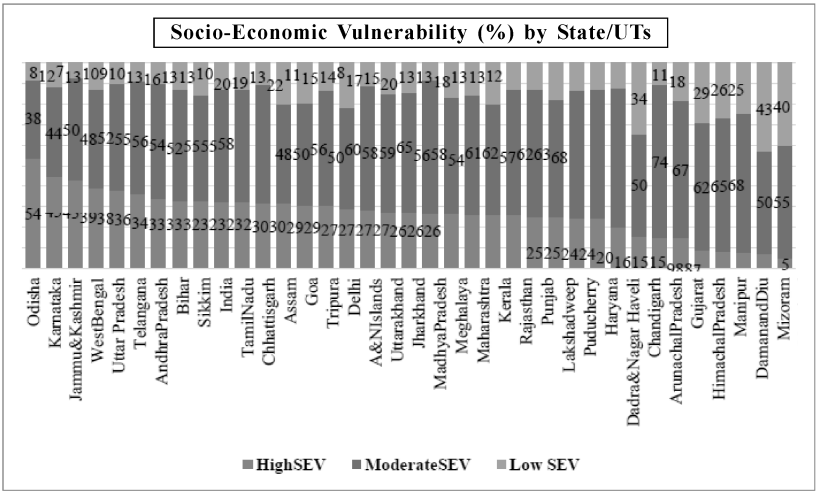
Himachal Pradesh	56.2	2.9	89.2	3.5	20.9	14.5	84.6	36.1	1290
Jammu andKashmir	67.7	33.4	98.4	60.3	12.7	61.6	77.5	15.4	1549
Jharkhand	70.3	17.9	95.7	13.4	52.1	26.2	85.3	23.9	2382
Karnataka	53.8	30.7	88.1	30.1	25.2	24.9	82.1	48.4	2224
Kerala	33.9	18.7	81.5	13.5	40.8	43.9	86.7	32.3	2268
Lakshadweep	50.1	4.6	95.3	0.6	59.9	57.2	86.0	2.7	1045
Madhya Pradesh	76.1	19.4	96.3	4.7	42.7	20.7	92.3	36.5	2773
Maharashtra	59.8	13.2	96.5	20.1	43.9	16.9	77.8	38.6	3823
Manipur	46.2	39.9	84.2	9.3	22.2	9.7	81.2	15.7	1324
Meghalaya	67.6	17.0	90.1	29.3	47.1	24.8	81.2	5.6	941
Mizoram	53.9	4.1	33.8	3.6	44.4	21.6	97.4	9.3	1170
Nagaland	62.9	14.5	77.4	0.4	26.0	24.6	74.5	8.0	1281
Odisha	71.7	13.3	82.6	41.4	55.2	33.1	88.8	45.4	2833
Puducherry	52.5	12.1	93.8	2.2	53.2	36.5	86.9	29.0	1384
Punjab	65.7	17.3	95.8	2.0	15.1	50.6	93.6	28.0	1931
Rajasthan	79.3	14.5	97.0	4.2	39.6	21.0	87.9	29.8	2148
Sikkim	68.1	20.2	76.3	4.1	41.8	57.6	87.8	6.6	1094
Tamil Nadu	66.6	30.9	94.9	1.9	43.0	24.4	89.5	37.8	3450
Telangana	79.8	31.9	84.0	18.6	32.2	13.5	91.7	44.7	2277
Tripura	63.6	29.4	93.0	1.3	31.4	30.5	96.0	37.1	1119
Uttar Pradesh	72.1	30.2	99.0	10.7	51.3	34.1	87.7	26.1	4322
Uttarakhand	65.1	12.2	97.1	6.4	39.7	29.5	94.6	27.5	1330
West Bengal	64.5	30.4	90.7	9.8	42.4	33.8	92.3	36.7	3753
India	**67.3**	**22.4**	**92.8**	**12.9**	**42.5**	**27.2**	**86.2**	**34.9**	**69368**

Note: Dropped 2902 missing cases to make a unique data set for all variables and get a more accurate analysis.

Appendix F1. Percentage distribution of concomitant socioeconomic indicators of vulnerability, India, LASI Wave-1, 2017-18



Appendix F2. Socio-Economic Vulnerability among older population (60+ years) by State/UTs, LASI, Wave-1 (N=30,804)



Indian Journal of Gerontology
2026, Vol. 40, No. 4, pp. 565-590
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI: 10.5958/0971-4189.2026.00008.5

Old-Age Pensions as a Right or Policy Grace? An Evaluation of Old-Age Social Assistance Schemes in India

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ABSTRACT

The paper examines whether non-contributory old-age social assistance in India is better understood as a matter of governmental grace or as part of a rights-based framework grounded in constitutional and statutory obligations. The paper assesses this question through three markers of a rights-based framework: statutory entitlement, a benefit standard linked to subsistence, poverty-line, or minimum-consumption benchmarks and judicial enforceability against arbitrary denial or non-payment. Using doctrinal methods, the paper analyses the legal architecture of central and state-level old-age social pensions, with a focus on the Indira Gandhi National Old Age Pension Scheme (IGNOAPS) under the National Social Assistance Programme (NSAP)and a purposive sample of state schemes. It reads scheme guidelines and government notifications alongside constitutional text and key decisions on pensions and the rights of elderly persons, including D. S. Nakara v. Union of India (1983) and

Dr Ashwani Kumar v. Union of India (2019). The paper finds that while Indian courts have strongly constitutionalised contributory employee pensions as a right rather than a bounty, analogous recognition for tax-financed social pensions for the poor elderly remains partial and indirect. Social pensions are typically framed as welfare schemes, with wide executive discretion in design, coverage and adequacy. Existing jurisprudence and policy documents, however, provide doctrinal hooks for an incremental shift towards recognising old-age social assistance as part of the right to live with dignity under Article 21, read with Article 41.

Keywords : Old-age social assistance, Rights-based framework, Judicial enforceability, Governmental grace vs entitlement, Constitutional obligations (Article 21, Article 41)

Ageing is a natural stage in the human life course, and population ageing has emerged as a global demographic phenomenon. Ongoing demographic transition, marked by rising life expectancy and declining fertility in most countries, is reshaping age structures and increasing both the proportion and the absolute number of older persons worldwide. India is no exception. In 2022, the country had an estimated 149 million people aged 60 and above, accounting for about 10.5 per cent of the total population. Projections indicate that by 2050 this share will nearly double to 20.8 per cent, with the older population reaching approximately 347 million (United Nations Population Fund [UNFPA] & International Institute for Population Sciences [IIPS], 2023). This steep rise in the older population is expected to have wide-ranging implications for health systems, labour markets, intergenerational relations, and social protection arrangements in India (UNFPA & IIPS, 2023).

Ageing has long been regarded as a normal part of life, with older people often respected for their experience and judgment. In

recent decades, however, ideas about ageing have shifted. Ageing is increasingly associated with weakness, dependence, and decline, and older adults may be treated as less important or even as a burden. Global media and consumer culture can reinforce this shift by celebrating youth, appearance, and "anti-ageing" ideals (World Health Organization, 2021). These attitudes can harm older people by increasing loneliness, stress, and depression and by reducing opportunities for meaningful social participation and community engagement (UNFPA & IIPS, 2023; World Health Organization, 2021).

These changes matter in India because population ageing is occurring alongside significant social and economic transformation. Urbanisation, migration, and new forms of employment have altered family life and living arrangements. Many households are smaller, and adult children frequently reside far from their parents for work or education. Everyday support within families can therefore become harder to sustain. The family remains the primary source of care for many older persons, especially when chronic illness or disability reduces their ability to manage daily activities. At the same time, the weakening of joint-family structures tends to reduce shared responsibilities, routine contact, and intergenerational learning (UNFPA & IIPS, 2023).

There are also important economic concerns. As the number of older adults grows, the share of the population in working ages shrinks, which can affect growth and public finances if labour-force participation and productivity do not adjust. At the same time, older persons contribute substantially through unpaid work, including care for grandchildren, support to household enterprises, and voluntary activities in communities. These contributions are valuable, but they are rarely counted in official economic indicators, thereby reinforcing a narrative of older persons as dependants rather than contributors (UNFPA & IIPS, 2023; NITI Aayog, 2024).

Recent evidence indicates that India is ageing in a context where most work is informal, pension coverage is limited, and family

support is uneven (NITI Aayog, 2024). Many older persons have spent their working lives in informal employment or self-employment and therefore have not accrued contributory retirement benefits. Public sector jobs and formal private employment account for only a minority of the labour force, so contributory pensions reach only a relatively small segment of the elderly population (Singh & Kumar, 2019). With the older population expected to rise sharply, non-contributory public income support in old age becomes central to policy debates on ageing with dignity and on the design of a basic floor of social protection (UNFPA & IIPS, 2023; NITI Aayog, 2024).

Constitutionally, old age support in India occupies a hybrid and evolving normative space at the intersection of enforceable fundamental rights and aspirational Directive Principles of State Policy. Article 21, which guarantees the right to life and personal liberty, has been expansively interpreted by the Supreme Court to encompass not only survival but a life with dignity. Through a series of socio-economic rights decisions, particularly those concerning the right to food, shelter, health care, and livelihood, the Court has read into Article 21 a positive obligation upon the state to protect vulnerable populations, including older persons (People's Union for Civil Liberties v. Union of India, 2001). In this interpretive framework, social security and basic subsistence are not treated as acts of charity but as components of a dignified existence. For indigent senior citizens, therefore, access to minimum income support, health care, and shelter can be viewed as flowing from the constitutional promise of dignity embedded in Article 21 (UNFPA & IIPS, 2023; Gund, 2025).

At the same time, Articles 41 and 46 in Part IV of the Constitution articulate a more explicit social welfare vision. Article 41 directs the state, within the limits of its economic capacity and development, to make effective provision for securing the right to work, education, and public assistance in cases of unemployment, old age, sickness, and disablement. Although

conditional and programmatic, this provision clearly recognises old age assistance as a constitutional responsibility rather than a purely discretionary policy choice. Article 46 further obliges the state to promote the educational and economic interests of weaker sections and to protect them from social injustice and exploitation. Older persons, particularly those who are poor, widowed, disabled, or socially marginalised, frequently fall within this category of weaker sections, which strengthens the normative basis for targeted support. While Directive Principles are formally non-justiciable under Article 37, the Supreme Court has consistently held that they are fundamental in the governance of the country and must inform legislative and executive action. Over time, the Court has sought to harmonise Part III (Fundamental Rights) and Part IV (Directive Principles), using the latter as interpretive tools to expand the content of the former. In this way, Directive Principles, though not directly enforceable, operate as moral and interpretive guides that shape the scope of rights under Article 21 and legitimise state intervention in the field of social security (UNFPA & IIPS, 2023; Gund, 2025). Article 41's phrase "within the limits of its economic capacity and development" should not be read as a complete escape clause. It undoubtedly recognises that social assistance depends on public resources and administrative capacity. However, it does not convert the obligation into pure discretion. A better reading is that Article 41 qualifies the pace, scale, and design of implementation, not the existence of the obligation itself. Courts may be justified in avoiding direct fixation of pension amounts. However, they can still require governments to justify prolonged non-revision, arbitrary exclusion, and pension levels that bear no rational relationship to subsistence needs.

On the policy front, these constitutional commitments have translated into a series of targeted welfare schemes, most notably the National Social Assistance Programme (NSAP). Introduced in 1995 and subsequently revised, NSAP represents a centrally

sponsored framework for providing social assistance to poor households. Within it, the Indira Gandhi National Old Age Pension Scheme (IGNOAPS) serves as the primary income-support mechanism for elderly persons living below the poverty line. Under IGNOAPS, the central government contributes 200 rupees per month for beneficiaries aged 60 to 79 years and 500 rupees per month for those aged 80 years and above, with states expected to supplement this amount from their own resources (Ministry of Rural Development, 2014). In practice, the total pension amount varies considerably across states depending on fiscal capacity, administrative priorities, and political choices (Singh & Kumar, 2019; Press Information Bureau, 2025). While NSAP reflects an institutional acknowledgement of the state's obligation towards older citizens, the modest central contribution and restrictive Below Poverty Line eligibility criteria have prompted persistent debates about adequacy, universality, and the extent to which existing measures fulfil the broader constitutional vision of dignity and social justice for older persons (Singh & Kumar, 2019; NITI Aayog, 2024).

In parallel, Indian pension jurisprudence has evolved along two related lines. In the landmark judgment of D. S. Nakara v. Union of India (1983), the Supreme Court held that pension is a right rather than a bounty and framed pension as a measure of socio-economic justice in old age, rejecting arbitrary classifications among pensioners as violative of Article 14. This and related decisions emphasise that contributory pensions of retired employees are protected entitlements, closely linked to equality and dignity under Articles 14 and 21. More recently, in Dr Ashwani Kumar v. Union of India (2019), the Supreme Court addressed the situation of older persons more broadly, directing the Union and the states to strengthen pensions, shelter, and geriatric care, and calling for review and revision of existing policies such as NSAP and the National Policy on Older Persons. The Court treated old age pension schemes as one of the instruments through which the right to live with dignity under Article 21 is realised, while stopping

short of declaring a freestanding fundamental right to a particular pension amount.

Despite this rich constitutional and policy landscape, non-contributory old age social pensions remain relatively under-theorised in doctrinal legal scholarship. Available economic and policy studies indicate that pension amounts are often below state poverty lines and that a significant proportion of older persons are excluded from coverage (Singh & Kumar, 2019). However, these works rarely foreground questions of justiciability, entitlement language, and constitutional status. The present paper addresses that gap by asking whether old age social assistance in India is conceptualised in law as a matter of governmental grace or as a right grounded in the Constitution and in statutory or scheme-based obligations. To make this inquiry analytically clear, the paper treats three indicators as moving old-age social assistance toward the rights end of the spectrum: first, statutory recognition of the pension as an entitlement rather than a revocable executive scheme; second, a determinate benefit standard linked to subsistence, poverty-line, or minimum-consumption benchmarks; and third, judicial recognition of an enforceable claim against arbitrary denial, non-payment, or manifest inadequacy. Conversely, the continued use of executive schemes, discretionary revision powers, and absence of a defined income floor would indicate that social pensions remain closer to policy grace.

Method

The paper adopts a doctrinal research design that treats legal and policy texts as its primary material. It proceeds in three steps. First, it analyses the central framework of old-age social assistance through a close reading of NSAP and IGNOAPS guidelines, circulars and official manuals issued by the Ministry of Rural Development, along with the National Policy on Older Persons and related documents on social security for the elderly. This step maps how the Union government formally describes the objectives, eligibility conditions, quantum and administrative features of old-age pensions,

and how frequently constitutional or rights language appears in official texts.

Second, the paper undertakes a comparative analysis of state-level schemes. Drawing on national surveys and comparative policy studies, it constructs a typology of state schemes along three axes: eligibility (strict Below Poverty Line criteria versus broader residency or income tests), benefit levels (very low, low, and relatively higher in relation to poverty lines) and legal form (executive scheme, government resolution, or statutory basis). A purposive sample of states is then selected to represent contrasting positions in this typology, and the relevant scheme notifications, rules and administrative orders are examined to identify the language used to define entitlements, discretion and grievance redress.

Third, the paper analyses judicial decisions concerning pensions and elderly rights. It begins with classic employee pension cases such as D. S. Nakara v. Union of India (1983) and related judgments, then moves to decisions that directly or indirectly concern old-age social assistance, including the Dr. Ashwani Kumar v. Union of India (2019) litigation and High Court decisions on delays, denials or revisions of social pensions. Judicial decisions are read for how courts characterise pensions (as a right, a benefit, or a policy), the constitutional provisions invoked, and the remedies granted.

Across these steps, doctrinal interpretation is supplemented by selective use of secondary literature in economics and social policy on coverage, adequacy and exclusion in pension schemes. These sources do not provide the primary data, but they inform the assessment of whether the legal design of schemes plausibly sustains dignified old-age living. The method is interpretive rather than statistical, and the contribution is primarily conceptual and normative, although grounded in positive legal materials.

Results

The doctrinal analysis yields three main findings.

Finding 1

A doctrinal reading of central policy documents on old-age social assistance in India suggests that old-age pensions occupy a hybrid space between programmatic welfare and constitutional aspiration. The National Social Assistance Programme (NSAP) Operational Guidelines describe NSAP as a centrally sponsored scheme that provides social assistance to Below Poverty Line (BPL) households in cases of old age, widowhood, disability, and death of the primary breadwinner (Ministry of Rural Development, 2014). Within this framework, the Indira Gandhi National Old Age Pension Scheme (IGNOAPS) serves as the primary instrument for non-contributory old-age support, with the Union government contributing a modest monthly amount and state governments expected to supplement it (Government of India, n.d.). The guidelines explicitly present NSAP as an expression of constitutional values, describing key principles as non-negotiable and "based on the Constitutional provisions," and identifying beneficiaries as members of the "most vulnerable" groups whose protection is a moral and public duty (Ministry of Rural Development, 2014, pp. 3–6). At the same time, the legal form remains that of an executive scheme rather than a statutory right.

On eligibility and quantum, the central framework is tightly targeted and fiscally restrained. IGNOAPS applies to persons aged 60 years and above in BPL households, with different benefit levels for two age bands, and substantial discretion left to states to expand coverage and increase pension amounts (Ministry of Rural Development, 2014; Government of India, n.d.). Under the scheme, central contributions are specified as follows: for persons aged 60–79 years, 200 rupees per beneficiary per month; and for persons aged 80 years and above, 500 rupees per beneficiary per month (Ministry of Rural Development, 2014). NSAP as a whole targets "destitutes," defined as any person with "little or no regular means of subsistence from his/her own source of income or through financial support from family members or other sources," to be identified by state governments (Ministry of Rural Development, 2014, p. 6). Nothing

in the Union guidelines guarantees a particular income floor or directly links the pension amount to poverty lines or minimum consumption standards. This supports the interpretation that the Union contribution is conceived as a partial supplement rather than a complete realisation of a right to income security in old age, with the responsibility for enhancement and expansion largely shifted to state governments (Government of India, n.d.; Singh & Kumar, 2019).

Where the NSAP documents are relatively strong is in their articulation of procedural and governance guarantees. The guidelines emphasise proactive identification of beneficiaries, stating that the onus should not rest on the elderly applicant to prove eligibility, and call for simple, people-friendly application procedures, regular monthly disbursement, preference for electronic transfers, social audits, and periodic verification (Ministry of Rural Development, 2014). Local self-government institutions are envisaged as central to implementation, supported by an information technology-based management information system for sanction, disbursement, and monitoring (Ministry of Rural Development, 2014). These provisions indicate a significant concern with administrative fairness and transparency. However, they are framed as programme principles and administrative instructions to implementing agencies, not as justiciable procedural rights in themselves.

The National Policy on Older Persons (NPOP) reinforces this pattern of strong normative commitment coupled with legal softness. The policy highlights the fragile financial situation of a large majority of older persons. It states that some level of income security in old age will be given high priority (Ministry of Social Justice and Empowerment, 1999). In its section on financial security, NPOP describes existing old-age pensions as a source of "some succour" and commits to significantly expanding coverage to include all older persons below the poverty line, with periodic revisions of pension amounts to protect against inflation (Ibid.). The policy also refers to existing legal duties of maintenance under criminal and family law. However, these commitments remain at the level of policy

declarations. The document does not characterise old age social pensions as legal entitlements enforceable in a court of law. The language of "will be ensured" and "will be expanded" conveys an expectation of action but does not specify justiciable standards, thresholds, or remedies.

Thematic work on social security for the elderly by scholars associated with the United Nations Population Fund treats NSAP and NPOP in a similar manner. Kulkarni, *et al.,* (2016) describe NSAP as a non-contributory social assistance scheme for poor elderly persons, widows, and persons with disabilities, rooted in the Directive Principles and in the vision set out by NPOP, but still constrained by low benefit levels, limited coverage, and substantial inter-state variation. Their analysis underlines the gap between policy commitments and actual pension adequacy, as well as the continued reliance on executive discretion for key aspects of scheme design. Taken together, these documents support the conclusion that central legal and policy texts consistently treat old age social pensions as welfare schemes informed by constitutional and rights language, yet they stop short of recognising them as enforceable individual rights to a defined level of income security. The doctrinal materials provide a strong normative foundation and several interpretive hooks for a rights-based reading. However, they leave substantial space for governments to decide whom to include, how much to pay, and how quickly to revise benefits in response to changing needs (Ministry of Social Justice and Empowerment, 1999; Ministry of Rural Development, 2014; Kulkarni *et al.*, 2016; Singh & Kumar, 2019).

Finding 2

For the second research objective, a comparative analysis of state-level schemes is carried out. It is worth noting that comparison of state schemes must not be limited to the amount of pension paid. While the benefit level is important, it does not by itself determine whether a pension operates as a right. A relatively high pension granted through an executive order may remain vulnerable to revision, suspension, or

withdrawal. Conversely, a lower pension embedded in statutory rules, supported by notice, hearing, appeal, and periodic revision, may have a stronger rights-like character. For this reason, the state schemes are examined not only by quantum but also by legal form: whether the scheme rests on a statute, rules or notifications, government orders, or departmental guidelines; whether the beneficiary is described as entitled to receive the pension; and whether cancellation or denial is subject to reasoned decision and appeal.

In the comparative analysis of state-level schemes, the first step is to distinguish states that provide relatively high per capita pension income from those that provide relatively low per capita pension income. Recent information on state old-age social pensions confirms very large differences across the country in what older persons actually receive each month. A cross-section of recent government orders, state portals and news reports suggests that some states now provide relatively high pensions, while others continue to pay very small amounts. Andhra Pradesh enhanced its Social Security Pensions under the NTR Bharosa Pension Scheme to 4,000 rupees per month for older persons, effective from April 2024, with payments at the new rate starting from July 2024 (Government of Andhra Pradesh, 2024). Himachal Pradesh has expanded social security pensions, with recent statements indicating monthly amounts of 1,150 to 1,700 rupees for most older beneficiaries, depending on age and category (Department of Social Justice and Empowerment, Government of Himachal Pradesh, 2022). Odisha has announced a pension of 3,500 rupees per month for the oldest elderly and certain highly vulnerable groups (Deccan Herald, 2024). Haryana has raised its Old Age Samman Allowance to 3,200 rupees per month from November 2025 (Times News Network, 2026). In Delhi, the Old Age Assistance scheme continues to provide 2,000 rupees per month for those aged 60 to 69 and 2,500 rupees per month for those aged 70 and above, with additional support for disadvantaged groups (Department of Social Welfare, Government of NCT of Delhi, n.d.). These five states

illustrate the upper end of current pension levels. At the other end, several states still offer very modest amounts: Assam provides 250 rupees per month to all senior citizens with APL or BPL ration cards (MyScheme, Government of India, n.d.). Madhya Pradesh pays 600 rupees per month under its Social Security Old Age Pension Scheme in at least some districts (Government of Madhya Pradesh, n.d.). Jharkhand's universal old-age pension pays 1,000 rupees per month (Jharkalyan, 2026). Uttar Pradesh continues to pay 1,000 rupees per month to eligible older persons, covering more than 60 lakh beneficiaries (Outlook Money, 2025). Bihar raised the amount of its Mukhyamantri Vriddhjan Pension Yojna to 1,100 rupees per month in June 2025 (Directorate of Social Security, Government of Bihar, n.d.). Table 1 summarises these ten illustrative states.

Table 1

Top five and bottom five states by monthly social pension for older persons

Group	State	Latest monthly pension (approx.)	Relevant Policy Initiative	Legal form
Higher	Andhra Pradesh	4,000 rupees	NTR Bharosa Social Security Pensions, raised to 4,000 rupees per month for the old-age category from April 2024 (Government of Andhra Pradesh, 2024).	Executive scheme
Higher	Odisha	3,500 rupees (80 plus and some groups)	Enhanced old-age pensions to 3,500 rupees per month for the oldest elderly under Madhu Babu Pension Yojana (Deccan Herald, 2024).	Executive scheme
Higher	Haryana	3,200 rupees	Old Age Samman Allowance raised from 3,000 to 3,200 rupees per month from November 2025 (Times News Network, 2026).	Executive scheme

Higher	Delhi	2,000 to 2,500 rupees	Old Age Assistance pays 2,000 rupees (60–69) and 2,500 rupees (70 plus) per month (Department of Social Welfare, Government of NCT of Delhi, n.d.).	Executive scheme
Higher	Himachal Pradesh	1,150 to 1,700 rupees	Social security pensions range from 1,150 to 1,700 rupees per month for seniors, with higher amounts for older age groups (Department of Social Justice and Empowerment, Government of Himachal Pradesh, 2022).	Executive scheme
Lower	Assam	250 rupees	Assam's Swahid Kushal Konwar Sarbajanin Briddha Pension Achonipays 250 rupees per month to all senior citizens with APL or BPL cards (MyScheme, Government of India, n.d.).	Executive scheme
Lower	Madhya Pradesh	600 rupees	The Social Security Old Age Pension Scheme pays 600 rupees per beneficiary per month (Government of Madhya Pradesh, n.d.).	Executive scheme
Lower	Jharkhand	1,000 rupees	Mukhyamantri Rajya Vridha-vastha Pension (universal) pays 1,000 rupees per month via DBT (Jharkalyan, 2026).	Executive scheme
Lower	Uttar Pradesh	1,000 rupees	State old-age pension pays 1,000 rupees per month to eligible seniors (Outlook Money, 2025).	Executive scheme
Lower	Bihar	1,100 rupees	Mukhyamantri Vriddhjan Pension Yojna pays 1,100 rupees per month (Directorate of Social Security, Government of Bihar, n.d).	Executive scheme

The state-level materials show that the dominant legal form remains administrative rather than legislative. Haryana's Old Age Samman Allowance is presented on the official departmental page of the Directorate of Social Justice and Empowerment, Government of Haryana (2024) as a "scheme," with eligibility, exclusion, rate revision and disbursal rules shaped through notifications and amendments issued from time to time. The official page also records repeated rate changes and lists separate notifications governing income criteria and sanctioning procedure, indicating executive control over the scheme's design. Delhi is somewhat stronger in form because the Department of Social Welfare lists "Old Age Assistance Rules, 2009" under its notifications, acts and rules, but the operational page of the Department of Social Welfare, Government of NCT of Delhi (n.d.) still describes the benefit as financial assistance, subject to application scrutiny, verification, and scheme conditions. The Rajasthan state portal (Jan Soochna Portal, Government of Rajasthan, n.d.) provides beneficiaries with access to eligibility, beneficiary details, payment details, and pension status, thereby improving transparency. However, it remains a portal-based governance mechanism rather than a statutory income guarantee. These examples support the broader conclusion that state schemes may vary significantly in generosity and transparency, but they rarely transform old-age pension into a legally determinate social right.

A 2025 press note from the Ministry of Rural Development observes that once the small, unchanged central IGNOAPS amount is added, state top-ups range from about 50 to roughly 3,800 rupees per month, with average pensions in many states clustering around 1,000 rupees (Press Information Bureau, 2025). This snapshot already suggests that even in the "generous" states, many older persons do not receive an amount that could reasonably be considered a full income guarantee. The doctrinal analysis of scheme texts helps explain why.

Across both central and state schemes, pension is almost always described as financial assistance provided under a scheme, not as a

matter of legal right. The central Indira Gandhi National Old Age Pension Scheme, the core of the NSAP, is a non-contributory pension for persons aged 60 and above who live below the poverty line (National Social Assistance Scheme, n.d.; Press Information Bureau, 2025). State scheme texts follow the same pattern. The Andhra Pradesh government order that raised Social Security Pensions to 4,000 rupees per month explains that the pensions are being enhanced "to extend financial security" to vulnerable groups and explicitly notes that categories, amounts and conditions may be revised by government decisions (Government of Andhra Pradesh, 2024). Haryana's Old Age Samman Allowance guidelines present the pension as social security for those who "are unable to sustain themselves with their own resources" and state that the rate is fixed by the government "from time to time" (Dorectprate of Social Justice and Empowerment; Haryana, n.d.). Delhi's Old Age Assistance scheme is similarly framed as financial assistance, with the Directorate of Social Welfare emphasising that support is given "subject to" fulfilment of eligibility and verification by the administration (Department of Social Welfare, Government of NCT of Delhi, n.d.). In all these cases, the careful wording preserves executive discretion, rather than creating an explicit, enforceable entitlement.

Eligibility rules are drafted as administrative filters, not as recognition of older persons as a rights-bearing class. Central IGNOAPS restricts eligibility to BPL households, using poverty lists that many studies have found to be inaccurate and outdated (National Social Assistance Scheme, n.d.; Singh & Kumar, 2019). Jharkhand's universal pension is a relative outlier, because it covers older residents without a BPL requirement, although a minimum age threshold and offline or CSC-based application process still create some entry barriers (Jharkalyan, 2026). Assam's scheme has universal coverage in principle. However, it requires an APL or BPL ration card and an annual income below a fixed ceiling, and the benefit is very low at 250 rupees per month (MyScheme, Government of India, n.d.). Haryana's more generous pension still hinges on a family income

ceiling of three lakh rupees per year and excludes anyone already receiving a government pension. These conditions turn access to a pension into a matter of documentary proof and administrative verification, rather than a simple declaration of age and residence.

Scheme texts usually retain broad clauses that allow revision, suspension, and termination with modest procedural safeguards. Government orders commonly state that future government decisions may modify pension rates, categories and eligibility criteria, and that benefits may be stopped if the beneficiary is found to be ineligible, deceased or non-traceable, often without laying down detailed appeal procedures beyond a general grievance process (Directorate of Social Justice and Empowerment, Haryana, n.d.; Government of Andhra Pradesh, 2024). A few states have strengthened grievance redress mechanisms, as in Rajasthan, where online platforms allow beneficiaries to track applications and submit complaints. However, these are still framed as internal review measures rather than as acknowledgement of a legally enforceable right to the pension. Therefore, appeal and grievance procedures are primarily tools for correcting implementation errors, not indicators that schemes understand pensions as rights.

Taken together, the legal language of state pension schemes and the actual amounts and coverage they deliver support a cautious but clear conclusion. State schemes are diverse and, in a few cases, substantially more generous than the national floor. However, almost all of them are framed as executive welfare schemes that can be adjusted, expanded or cut according to policy choices and budgetary space. Eligibility is defined through administrative criteria, often linked to BPL lists or income ceilings. Revision and suspension powers are broad. Appeal channels exist, but they are designed as administrative correctives. Empirical evidence on benefit levels shows that these pensions function as modest supplements, not as full realisation of a right to income security in old age (Singh & Kumar, 2019). A court could still interpret Article 21, and the Directive Principles to move closer to a rights-based model, and some high-benefit states offer

hints of that normative direction. However, the current doctrinal and empirical configuration remains closer to policy grace than to a clearly justiciable social right.

Finding 3

This part of the paper uses doctrinal analysis of Indian case law to ask whether courts have moved from viewing pensions as discretionary welfare to treating them as rights, and how far that shift extends from employee pensions to old-age social assistance for the poor. The pattern that emerges is layered. In service pension jurisprudence, courts have steadily constitutionalised pension as a form of property and as part of a dignified livelihood. In litigation concerning elderly persons and social pensions, courts acknowledge the centrality of income security for a dignified life. However, they stop short of articulating a clearly enforceable, rights-based entitlement to an adequate social pension.

The starting point is the classic employee pension cases. In Deokinandan Prasad v. State of Bihar (1971), the Supreme Court held that the right to pension of a public servant is "property" protected by the Constitution and cannot be taken away by mere executive order. The Court located the pension within Articles 19(1)(f) and 31(1) (as they then stood), emphasising that once a pension is earned, its withdrawal or reduction must follow "due process of law" and not administrative whim. Later decisions have reiterated this understanding, citing Deokinandan Prasad v. State of Bihar (1971) for the proposition that pension is a vested right, not an ex gratia payment, and linking it to the later right to property under Article 300A.

This line of reasoning is consolidated in D. S. Nakara v. Union of India (1983), where the Supreme Court famously rejected the idea that a pension is a "bounty" payable at the State's pleasure. Instead, the Court described a pension as a "deferred wage" and applied Article 14 to strike down an arbitrary cut-off date that denied a revised pension to a segment of retirees within a homogeneous class. Read doctrinally, D. S. Nakara v. Union of India (1983) does two things.

First, it firmly anchors pension within the architecture of constitutional equality, rather than charity. Second, it frames pension as integral to a dignified post-retirement life, which later decisions fold into Article 21's protection of livelihood and dignity. Recent High Court pronouncements echo this tone: for instance, the Calcutta High Court has described pension as a "legal right" earned through service, not an act of charity, and held that delay in payment violates principles of equity and justice (Lakhotia, 2025). Courts have also treated extreme delay in disbursing retiral dues as arbitrary and unconstitutional, warranting compensation in the form of interest.

However, it should be kept in mind that the doctrinal strength of employee pension cases rests on the idea of prior legal earnings. Service pension is treated as deferred compensation for work already performed. It is therefore easier for courts to characterise it as property, accrued entitlement, and a component of equality under Article 14. Social pensions stand on a different footing. They are not linked to an employment relationship or a prior wage bargain. They arise from vulnerability, indigence, age, and the constitutional promise of dignified existence. This makes the moral claim very strong, but the legal form less determinate. Courts can protect an elderly beneficiary against arbitrary exclusion from an existing scheme, but they are more hesitant to prescribe the scheme's amount, coverage, or fiscal design.

Against this background, the paper examines whether an analogous rights-based logic is extended to non-contributory old-age social assistance for people experiencing poverty. The pivot here is Dr Ashwani Kumar v. Union of India (2019), a public interest litigation under Article 32 seeking enforcement of elderly persons' rights under Article 21, with specific prayers on pension, shelter, geriatric healthcare and implementation of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007. The Court took cognisance of the Indira Gandhi National Old Age Pension Scheme (IGNOAPS) under the National Social Assistance Programme, noting that the Union government provided only ₹ 200 per month for persons

aged 60–79 years and ₹ 500 per month for those above 80 years, and that these amounts had not been revised for more than a decade. The judgment acknowledged that these sums were "a pittance" in relation to the constitutional promise of a dignified life under Article 21.

Doctrinally, Dr Ashwani Kumar v. Union of India (2019) is significant because the Court explicitly connects elderly persons' needs for income, shelter and healthcare to Article 21, reading the right to live with dignity in old age into the fundamental rights framework. At the same time, the Court is cautious about stepping into fiscal and policy domains. It stops short of declaring a justiciable right to a particular quantum of social pension or of universal coverage. Instead, it issues directions: requiring status reports on the implementation of the 2007 Act, asking governments to make pensions "realistic", and insisting on an effective monitoring mechanism. The constitutional language here is strong, but remedies remain supervisory rather than rights-specifying. The Court repeatedly invokes the constraint of "economic capacity and development" when speaking of social assistance, signalling deference to executive assessment of fiscal space.

High Court litigation on old-age pensions adds an important layer. Cases such as H. Mariyam Beevi v. Secretary to Government, Government of Tamil Nadu (2011) concerned denial or delay of pensions under the National Old Age Pension Scheme. The Madras High Court treated non-payment as unlawful and directed authorities to release arrears and ensure timely payment by a fixed date each month. Commentators have read this as a move towards recognising old-age pensions as enforceable entitlements under existing schemes, grounded in Article 41 and Article 21, even though the schemes themselves are executive in form.

More recent litigation from other states shows a similar pattern. In Mudroboyina Suseela v. State of Andhra Pradesh (2023), a 66-year-old widow challenged administrative inaction that denied her a rice card, thereby blocking her access to the

old-age pension and other welfare benefits. The Andhra Pradesh High Court intervened and directed authorities to regularise her access to food rations and related entitlements once technical obstacles with Aadhaar were resolved. While the Court framed the case primarily as one of arbitrary administrative exclusion, the reasoning implicitly acknowledges that social pensions and linked benefits are central for the survival of below-poverty-line elderly persons.

Similarly, in Assam Public Works v. State of Assam (2016), the Gauhati High Court monitored the implementation of state schemes for widows and old-age pensioners. It directed that selected beneficiaries under specified schemes should not be deprived of assistance due to changes in political dispensation or budgetary rearrangements. The focus here is on continuity and non-arbitrary withdrawal of benefits, rather than on defining an underlying constitutional right to adequate income in old age.

Some quasi-judicial bodies have gone further in their use of rights language. A recent order of the Kerala State Human Rights Commission, dealing with the cancellation of an old-age pension and the refusal to pay arrears, described the retrospective withdrawal of benefits by executive order as illegal and directed the government to release several years of arrears within a specified time (Times News Network, 2025). The Commission emphasised that once granted, pension benefits cannot be taken away retroactively by administrative fiat. Although the order speaks in human rights terms rather than constitutional doctrine, it fits with the broader judicial trend of protecting existing entitlements against arbitrary curtailment.

Taken together, these strands suggest a differentiated doctrinal landscape. In the service pension cases, courts have clearly articulated pension as a right: property protected against arbitrary deprivation, a deferred component of wages, and an element of dignified livelihood under Articles 14, 21 and 300A. Non-payment or delay attracts strong remedies, including writs and interest. In the elderly-rights PIL

and social pension cases, courts recognise the centrality of income security to Article 21, especially for older persons in poverty, and they are willing to supervise implementation of statutory and scheme-based entitlements. However, with the partial exception of some High Court orders that treat old-age pensions as "legal rights" under the scheme, they generally do not re-characterise social pensions as full-fledged constitutional rights with determinate content (for example, a pension benchmarked to poverty lines).

Instead, courts appear to adopt a hybrid position. Social pensions are no longer seen as mere charity; they are essential components of the State's obligation to ensure a dignified life for elderly citizens, and arbitrary denial or cancellation can be challenged. At the same time, decisions remain tethered to the existing statutory and scheme framework, and the judiciary is reluctant to prescribe minimum pension levels or universal coverage as enforceable constitutional baselines. For this paper, the doctrinal finding is that Indian courts have travelled partway towards a rights-based conception of old-age income security, but predominantly in the context of employee pensions. In the specific domain of non-contributory social pensions for the poor, the case law supports a more cautious reading: courts protect participation in existing schemes and condemn arbitrary exclusion, yet they leave significant discretion with governments over the design, quantum and coverage of those schemes. This provides both a foundation and a limit for any argument that old-age social assistance in India has already crystallised as a justiciable right.

Conclusion

Old-age social assistance in India sits uneasily between constitutional right and policy grace. Article 21, read with Article 41, and the jurisprudence on food, shelter, and health provide a strong normative basis for treating minimum income in old age as part of the right to live with dignity. Yet the design of NSAP and state schemes frames pensions as welfare programmes: low, uneven benefits, targeted eligibility, and wide executive discretion. Courts have

constitutionalised contributory employee pensions as vested rights, but social pensions remain treated as welfare entitlements mediated by fiscal capacity. This doctrinal divide—exchange-based versus need-based entitlement—explains why employee pensions are firmly protected while social pensions remain legally unstable.

Judicial caution, often expressed through deference to "economic capacity," risks freezing pension amounts at subsistence defying levels. A rights-based approach would not require courts to dictate budgets but would require governments to justify non-revision and ensure transparency. The counterfactual is clear: had courts or legislatures established indexed statutory entitlements with appeal rights, social pensions would have shifted decisively toward rights. Instead, constitutional pressure exists, but institutional design preserves executive control.

A reform path lies in enacting a statutory minimum pension law. Such a framework could require states to set pension floors linked to poverty lines, consumption thresholds, or minimum wages, with annual indexation. Procedural safeguards—notice, reasons, appeal rights, and protection against arbitrary suspension—would convert pensions from discretionary welfare into rule-governed entitlements. While fiscal debates would remain, this shift would anchor social pensions in enforceable rights, ensuring that the constitutional promise of dignity in old age has practical meaning for those who depend on public support.

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Indian Journal of Gerontology
2026, Vol. 40, No. 4, pp. 591-605
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI: 10.5958/0971-4189.2026.00009.7

Religion, Health Perceptions, and Ageing: Is India in need of reforms?

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ABSTRACT

A consistent shift in population structure towards an older population, driven by advances in medical science, has made ageing a global concern. In developing countries, particularly India, which has a large absolute number of elderly people amid significant unmet developmental needs, ageing remains a low priority. This becomes critical for the health sector, as the needs of the elderly differ substantially. Indeed, service delivery is at the state level; individuals' perceptions of the health policy will be insightful for understanding how accommodating we are, and this paper argues for the role of religious beliefs, given religion's deep-rooted impact on shaping worldviews. Using the ISSP 2021 module on Health and Health Care, the study examined major religious beliefs and their impact on perceptions of the health system, measured through beliefs about allopathic medicine, immunisation, fairness, and accessibility across two age groups: working-age and elderly. Using appropriate statistical tools, the study constructed a composite

perception index and conducted bivariate and multivariate analysises on a population of 27,958. Results reveal two broad findings: the older generation is more just compared to the younger; and the Hindu religion is the least in reporting progressive perception. In fact, the elderly population amongst Hindus are doing better than their younger counterparts, which raises a critical concern for India. Indeed, religion's impact, in terms of explained variation, is low yet significant, suggesting it as a route to more inclusive ageing societies.

Keywords : Elderly care, Health sector, Religious beliefs, Healthcare perceptions, Progressive vs regressive views

With declining fertility and mortality rates worldwide, countries are increasingly experiencing the final stage of the demographic transition (Kirk, 1996). Indeed, the shift is inevitable, but the pace has led to an unprecedented increase in the elderly's share of the population. Globally, the proportion of people aged 65 and older is expected to increase from one in eleven in 2019 to one in six by 2050 (United Nations, 2019). Moreover, this increase is largely coming from developing countries, which are in the midst of multiple transitions. On the one hand, while fertility levels are declining, the base is so huge that maternal and child health care still carries the major share in the allocation of health care resources amidst an increasing elderly population. Unlike in developed countries, infrastructure is insufficient and the government cannot prioritise the ageing population. The traditional caregivers such as the joint family, are also breakdown due to globalisation-led changes and increasing urbanisation and migration. Ageing brings an array of challenges. Amongst them, healthcare, well-being, and financial security are often discussed in policy decisions concerning the elderly population.

India, home to the second-largest elderly population, has enacted multiple policies and rules to protect and care for its elderly, including the Maintenance and Welfare of Parents and Senior Citizens Act 2007. However, whether these provisions are enough remains an issue

to be addressed. Beginning with financial security, social security provisions are very limited, and the pension cover, which is largely confined to the population working in the organised sector, is also changing in nature (Jain, 2023). In place of the monthly regular pension, the government has now introduced the New Pension Scheme, under which a lump-sum amount will be given to the person at superannuation. With rising life expectancy and limited financial literacy, it is not advisable to be overly optimistic about individuals' ability to ensure their own financial well-being by using their financial resources optimally. Regarding health care and well-being, the elderly population are not only susceptible to various infections and shoulders the burden of non-communicable diseases, but there is also an increase in feelings of isolation and depression (Raja *et al.*, 2010; Pilania *et al.*, 2013). Further, India, which is still struggling with issues such as malnutrition and poor body mass index (Nguyen *et al.*, 2021), is likely to experience serious repercussions in old age.

With this background, ageing, along with the epidemiological transition and changes in living arrangements and care mechanisms, mandates a multi-stakeholder response to celebrate the triumph of medical science. Indeed, governments across the globe are taking initiatives to ensure a successful second innings, while recognising the role of the individual in ensuring their own well-being. One factor that has been rarely studied is the role of an individual's belief system in shaping responses to these transitions. Often defined as the guiding principles, categorised into four as Religious; Philosophical; Political; Personal, the belief systems provide direction and meaning in life. This understanding of right and wrong is critical in deciding how an individual lives their life and in shaping expectations across various sections of society. In any religious country, including India, a land of multiple religions dominated by Hinduism, this understanding is often shaped by religious beliefs. In the simplest terms, religion describes the relationship of human beings to what they regard as holy, sacred, spiritual, or divine, as well as their attitudes towards the broader human community (Britannica, 2026). It influences

matters of everyday affairs. It is a phenomenon that cannot be explained by any particular aspect of human society, culture, or thought, though it interacts with all of them (Stefon, 2025). Studies have shown salutary benefits of religious involvement across several health outcomes (Seeman *et al.*, 2003; Hummer *et al.*, 2004; Koenig *et al.*, 2012). Nie (2021) emphasised the role of innovative ethical visions in effectively addressing population ageing and developing adequate eldercare. Moreover, regarding elderly care, healthcare infrastructure is extremely critical. At the outset, medical science is an area of scientific intervention; however, the association between religion and science has been far from straightforward, and, as a result, perceptions of modern science are influenced by an individual's belief systems. In this context, the present study aims to examine the perceptions of people belonging to different religious beliefs regarding various health-related parameters. Also considering the ubiquitous phenomenon of population ageing, the study aims to investigate whether there are differences in the perceptions of people who share the same religion but belong to different age cohorts, and across religions.

Method

Given the objectives of the study, it has used the 2021 module of the International Social Survey Program (ISSP) Health and Health Care II. It is a cross-national collaborative program that has conducted annual surveys on a range of social science topics since 1985. The 2021 module covered 32 countries, with information collected about individual health and health care systems. For the first time, the survey has included India and collected data during July 2023. It essentially covers the population aged 18 years and above, with a few countries collecting information from those aged 16 years, for a total sample size of 44,549 individuals. Also, the module includes information not just about religion but also about practising it; therefore, it allows for analysis of those who practice it. The study has used the following variables for its analysis as presented in Table 1.

Table 1

Definition of variables

Religious beliefs	Population	Health perception
Hindu,	Elderly population: Aged 60	Access to publicly funded
Islam,	years and above	health care for non-citizens
Buddhist;		
Jewish;	Working age population	Immunisation does more
Orthodox Christian;		harm than good.
Catholic;		Alternative medicine is
Protestant;		better than conventional medicine.
		Fairness that rich people have better health care

The study has used bivariate and multivariate analytical tools. A composite index has been constructed that defines an individual's perception as "progressive" if there is support for modern medicine, accessibility for non-citizens, and equal access irrespective of economic status. The study has applied appropriate weights when assessing the bivariate associations. Also, the chi-square test of significance has been used to examine the significance of associations.

Furthermore, logistic regression has been used to predict the probability of progressive perception, given the dichotomous nature of the dependent variable. The study ran multiple models, beginning with unadjusted odds ratios (ORs), followed by adjusted ORs, and then two separate models for the working-age and elderly populations. The unadjusted ORs examined the association between progressiveness and each explanatory variable without accounting for other variables. In contrast, the adjusted ORs assessed the impact of religious beliefs on progressiveness while controlling for other explanatory variables. The following model is used for calculating adjusted ORs:

$$\ln(P / (1 - P)) = \beta_0 + (\beta_1 * X1) + (\beta_2 * X2) + (\beta_3 * X3) + (\beta_4 * X4)$$

where β_0: Intercept coefficient

β_1, β_2, β_3 and β_4 : coefficients for each categorical independent variable

X1, X2, X3 and X4: independent variables, i.e. age, religious beliefs, gender, and place of residence

Further, the study ran the following model separately for the working-age and elderly population to specifically identify if the contribution of religious beliefs in shaping the perception changes with age:

$\ln(P / (1 - P)) = \beta0 + (\beta1 * X1) + (\beta2 * X2) + (\beta3 * X3)$

where β0 : Intercept coefficient

β1, β2 and β3 : coefficients for each categorical independent variable

X1, X2, and X3: independent variables, i.e. religious beliefs, gender and place of residence

Results

Bivariate associations across all four indicators by religious beliefs revealed significant associations among younger and older populations. Compared with Hinduism, other religions performed better, and this pattern remained consistent across age groups,with the older age group performing better.

Regarding access to publicly funded health care for non-citizens (Table 2), there is growing acceptance among the younger generation; however, among Hindus, the elderly were more accepting. Compared to 64 per cent of elderly Hindus who agreed, the percentage reduced to 52 per cent for the younger population; in fact, there is no change in the percentage of the population with a neutral stance, whereas, compared to 14 per cent of the elderly, it increased to 24 per cent amongst the working-age population who disagreed. For every other religion, agreement for accessibility increases, even slightly. For instance, compared with 49 per cent of older Protestants, 55 per cent of the working-age population reported agreement. The highest percentage of the population in agreement is among Orthodox

Christians (71%), and 67 per cent among the working-age and elderly populations, respectively. In the case of Jews, irrespective of age group, approximately 45 per cent of them disagree; however, despite being the lowest percentage (31%) of agreement, there is still improvement in the younger population compared to the elderly. It is indeed an irony that on the one hand, the Hindu religion is moving away from science and towards religion. However, it's believers do not support providing health care to non-citizens (which reflects a humane approach), a principle that is increasingly widely accepted across other religious beliefs.

Table 2
Percentage distribution of population according to access to publicly funded health care to non-citizens, 2021

Religion	Younger population				Elderly population			
	Agree	Neutral	Disagree	N	Agree	Neutral	Disagree	N
Hindu	52.21	22.55	25.24	1411	64.28	21.21	14.50	176
Islam	66.35	16.76	16.89	724	63.05	22.36	14.59	111
Buddhist	60.94	16.56	22.50	976	58.19	19.07	22.74	473
Jewish	31.01	23.90	45.09	474	29.74	25.34	44.92	100
Orthodox Christian	71.21	11.47	17.32	394	67.03	12.34	20.63	152
Catholic	55.51	17.24	27.25	4050	53.13	17.50	29.37	2251
Protestants	54.99	20.16	24.86	1617	49.50	21.15	29.35	1148

Analysing the Acceptance of Immunisation results reveals that, irrespective of belief system, a lower percentage of the younger population, compared to the elderly, disagreed that immunisation is doing more harm than good (Table 3). Indeed, except for younger Hindus (43%) and Orthodox Christians (41%), more than 50 per cent believed in the use of immunisation, but this drop compared to the elderly population still needs attention. Also, the percentage of the younger population with a neutral stand is consistently higher than that of the elderly population, which is also not a great sign. Immunisation is clearly an advancement in medical science that the population has well accepted. However, a substantial percentage of

the population not believing in it is to some extent, indicative of a greater reliance on religion than on science regarding health. Retreating attention at the time of the survey could explain this phenomenon as an instance rather than a general tendency.

Table 3

Percentage distribution of younger and elderly population according to their opinion about immunisation doing more harm than good, 2021

Religion	Younger population				Elderly population			
	Agree	Neutral	Disagree	N	Agree	Neutral	Disagree	N
Hindu	29.34	27.53	43.13	1355	31.25	15.69	53.06	163
Islam	24.99	25.60	49.41	683	23.54	19.52	56.93	103
Buddhist	21.52	19.47	59.02	965	11.45	12.37	76.18	474
Jewish	9.21	16.82	73.97	466	#	14.43	78.45	98
Orthodox Christian	30.71	28.23	41.06	377	23.43	24.57	52.00	146
Catholic	19.43	22.09	58.48	3973	17.26	18.45	64.30	2196
Protestants	17.80	22.02	60.18	1578	10.39	14.98	74.62	1135

About the percentage of individuals those who considered alternative medicine, i.e., Ayurvedic/Ayurvedic/yoga/Naturopathy, provide better solutions for healing problems than Allopathic medicine; the results reveal that this is higher amongst Hindus, i.e., 52.56 per cent in the working age group, which reduces slightly to 49.64 per cent amongst the older (Table 4). The lowest percentage is observed among Jews, with approximately 13 per cent across both age groups. What is interesting here is that while the difference between the younger and elderly Hindus in terms of agreement is not huge, this increase is simultaneously accompanied by a decrease in the percentage of the working-age population having a neutral stand (26% amongst the elderly and 22% amongst the younger) and an increase of only one percent in disagreement. Indeed, across all the beliefs, a shift in alternative medicine is evident, but the highest percentage, being more than 50 per cent, is reported amongst Hindus. While the preference for alternative medicine is not well

aligned with the scientific temperament, this finding should be read with the survey's time period in mind, which was soon after the pandemic. Until treatment for COVID was discovered, there was an inclination toward preventive methods, and since alternative medicine also includes yoga and naturopathy, the level of disagreement with these practices decreased.

Table 4

Percentage distribution of allopathy and conventional medicine, 2021

Religion	Younger population				Elderly population			
	Agree	Neutral	Disagree	N	Agree	Neutral	Disagree	N
Hindu	52.56	21.80	25.63	1372	49.64	25.76	24.60	169
Islam	35.45	35.12	29.44	688	34.30	32.80	32.91	103
Buddhist	27.13	27.50	45.37	916	20.07	41.64	38.29	438
Jewish Orthodox	13.59	36.80	49.62	459	12.74	23.89	63.37	100
Christian	25.11	31.82	43.07	379	11.02	34.78	54.20	152
Catholic	22.49	36.87	40.64	3901	15.28	35.19	49.53	2121
Protestants	20.85	38.63	40.52	1550	16.70	36.64	46.66	1110

The study further analysed people's perceptions of the availability of healthcare facilities (Table 5). While the 1946 Constitution of the WHO, and Article 25 of the Universal Declaration of Human Rights (1948) established the international recognition of health as a basic right. It has been increasingly observed that people with higher incomes often have access to better healthcare. Since receiving health care may be a matter of need, what is more critical is understanding how religious beliefs influence people's perceptions of fairness regarding the affordability of health care. Consistent with the pattern emerging from the tables above, followers of the Hindu religion have different perceptions from those of other religious groups. Across both age groups, the highest percentage of respondents who believe it is fair for the rich to have better access to health care is among Hindus: 45 per cent in the working-age population and 32 per cent in the elderly. Overall, there is indeed a higher percentage of younger people who

agree that the rich have better access, but that percentage is still well within 25 per cent; however, a change in the influence of religion is evident.

Table 5

Percentage distribution of younger and elderly population according to their opinion about the extent of fairness that people with higher income can afford better health care, 2021

	Younger population				Elderly population			
	Fair	Neutral	Unfair	N	Fair	Neutral	Unfair	N
Hindu	45.19	23.08	31.73	1410	31.95	31.75	36.30	172
Islam	24.84	21.17	53.99	723	24.86	23.85	51.30	112
Buddhist	26.19	21.97	51.84	972	24.79	23.06	52.15	475
Jewish	21.43	25.59	52.99	476	24.11	17.07	58.82	100
Orthodox Christian	25.32	20.56	54.12	385	19.02	16.79	64.19	154
Catholic	23.90	16.42	59.68	4102	19.26	20.09	60.64	2293
Protestants	23.65	21.84	54.51	1511	18.05	27.41	54.54	1132

Overall, it presented a contrasting picture of the nature of the Hindu religion with a less inclination toward modern medicine and humanism. With a strong presence in the working-age population, the disaggregated scenario still needs to be built collectively to understand the situation. Therefore, the study constructed a composite categorical variable based on the above-analysed indicators to examine the aggregated picture of individuals' progressiveness across different religious beliefs. Consistent with the previous results, Table 5 shows a weaker position for Hindus than for others, with the gap worse among the working-age population. The lowest percentage of the population having the progressive perception, i.e. 45 per cent amongst the elderly population, is for Hindus, followed by 55 per cent of Buddhists and Jews, with the highest percentage reported amongst Orthodox Christians. A similar pattern is reported for the working age group; however, the highest drop of 11 per cent in having a progressive perception is reported for Hindus, with 34 per cent being the lowest reported percentage amongst them across all the religious beliefs. The highest percentage is again reported for

Orthodox Christians, at 68 per cent. While Hindus reported the least progressiveness, even globally, except for Buddhist and Protestants, all the religious beliefs have seen a drop in the percentage of having a progressive perception amongst the younger population compared to the elderly. Further, regarding neutral and non-progressive perceptions, while there is a decline in the percentage of the population having a neutral stand across all beliefs from the elderly to the younger population, the percentage of the population having a non-progressive perception increases, with the maximum increase for younger Hindus, i.e. from 33 per cent amongst the elderly population, it increases to 49 per cent for the younger population. Overall, the study reveals that the present generation is less inclined towards being progressive, irrespective of their belief system, yet the position of Hindus is most worrisome.

Table 6
Percentage distribution of population according to perception towards health policy, 2021

Belief System	Younger population				Elderly population			
	Progressive	Neutral	Non progressive	N	Progressive	Neutral	Non progressive	N
Hindu	34.00	17.44	48.56	976	45.14	22.04	32.82	166
Islam	60.21	17.67	22.12	563	63.68	19.59	16.72	90
Buddhist	56.02	18.94	25.04	792	54.94	25.80	19.26	398
Jewish	49.40	27.39	23.20	311	55.76	26.66	17.58	95
Orthodox Christian	68.29	14.53	17.18	312	75.84	16.05	8.11	152
Catholic	62.20	16.86	20.94	3051	65.08	19.90	15.02	1856
Protestant	59.28	21.80	18.92	1153	59.74	26.21	14.04	863

Results from bivariate analysis reveal findings : 1. Overall, the older population is becoming progressively less active than the younger population, irrespective of their belief system; 2. Religious beliefs govern those who follow Hinduism more than a scientific temperament does. However, to confirm the results, the study conducted multivariate analyses by running multiple logistic

regressions for the whole sample and separately for the working-age and elderly populations (Table 7). For the overall sample, results confirmed that the elderly expect a more progressive health policy than younger generations (Adjusted OR: 1.16), and that the Hindu religion is the least inclined among religions. The adjusted ORs across all the beliefs are positively associated with progressive perception compared to Hindu religion, for instance, Orthodox Christian are 4.19 times more likely to report progressive opinion in their perception followed by Catholic (Adjusted OR: 3.38), Islam (Adjusted OR: 3.12), Protestants (Adjusted OR: 2.79), Atheists (Adjusted OR: 3.52), Buddhist (Adjusted OR: 2.57) and Jews (Adjusted OR: 1.98). This finding should also be read alongside the idea that belief systems need reform to become more progressive. Indeed, all of them are doing better than the Hindu religion, which makes this religion most in need of reform; however, the elderly population being more progressive compared to the working-age population is where the major concern lies. Further, regarding gender, males are less likely to have a progressive perception of healthcare than females (Adjusted OR 0.88), whereas place of residence is not significantly associated.

While the overall elderly population has performed better, the study has further analysed these two population subgroups separately to examine the impact of religious beliefs. Comparing the ORs for the working-age and elderly populations, the latter reported smaller ORs, though the association remained significant and positive with reference to the Hindu religion. This reflects a worrisome situation for Hindus. The gap between the Hindu religion and other belief systems is smaller amongst the elderly population compared to the younger ones, which implies younger Hindus are drifting away from the scientific temperament at a much faster pace compared to their counterparts belonging to different belief systems. For instance, younger Muslims are 3.32 times more likely to be progressive in their perception about healthcare, which reduces to 2.15 times amongst older Muslims. Similar to the overall sample, in the working-age group and the elderly, males are less likely to have a progressive perception [OR: 0.87], while place of residence remained insignificant across both age groups.

Table 7

Unadjusted and adjusted Logistic regression estimates predicting the impact of characteristics on just perception amongst overall, working-age and elderly population, 2021

Character-istics	Overall sample							
	Unadjusted		Adjusted		Working age		Elderly	
	Odds ratio	[95% CI]	Odds ratio	[95% CI]	Odds ratio	[95% CI]	Odds ratio	[95% CI]
Age								
Working age [R]					NA	NA	NA	NA
Elderly population	1.10***	[1.051, 1.152]	1.16***	[1.093, 1.249]	NA	NA	NA	NA
Religion								
Hindu [R]								
Islam	2.92***	[2.396, 3.550]	3.12***	[2.539, 3.843]	3.32***	[2.664, 4.139]	2.15***	[1.185, 3.891]
Buddhist	2.30***	[1.950, 2.701]	2.57***	[2.170, 3.059]	2.80***	[2.312, 3.397]	1.38	[0.912, 2.080]
Jewish	1.97***	[1.577, 2.471]	1.98***	[1.575, 2.506]	2.08***	[1.609, 2.681]	1.43	[0.814, 2.515]
Orthodox	4.19***	[3.336, 5.271]	4.53***	[3.578, 5.756]	4.47***	[3.415, 5.855]	3.03***	[1.813, 5.049]
Catholic	3.19***	[2.801, 3.643]	3.38***	[2.949, 3.894]	3.47***	[2.980, 4.037]	2.12***	[1.466, 3.075]
Protestant	2.70***	[2.329, 3.121]	2.79***	[2.388, 3.263]	2.86***	[2.391, 3.418]	1.73***	[1.181, 2.539]
Atheist	2.46***	[2.176, 2.791]	3.52***	[3.082, 4.024]	3.59***	3.111, 4.146]	2.29***	[1.585, 3.304]
Gender								
Female [R]								
Male	0.87***	[0.836, 0.912]	0.88***	[0.833, 0.939]	0.87***	[0.807, 0.929]	1.00	[0.898, 1.116]
Place of Residence								
Urban [R]								
Rural	0.92***	[0.878, 0.967]	0.99	[0.928, 1.058]	0.95	[0.881, 1.029]	1.02	[0.912, 1.148]

Note : R is reference category; [ ] Confidence Interval.

Conclusion

The study highlights how ageing societies reveal surprising contrasts in healthcare expectations shaped by belief systems. ISSP survey data show that elderly populations, often stereotyped as orthodox, actually favour more inclusive, science-based, and temperament-driven healthcare policies across religions. At the same time, younger generations—especially younger Hindus—display lesser progressive tendencies, leaning toward traditional medicine and showing less concern for equitable access to public healthcare. This reversal challenges assumptions about generational progress, and raisens questions about whether religious practice itself is shifting. In India, where Hinduism's liberal ethos of *Vasudev Kutumbkum* is historically celebrated, the findings suggest a troubling neglect of inclusivity among the youth, making it urgent for policymakers and researchers to reconsider how religious beliefs and democratic expectations intersect with health policy in an ageing world.

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Indian Journal of Gerontology
2026, Vol. 40, No. 4, pp. 606-633
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI : 10.5958/0971-4189.2026.00010.3

Outstanding Loans, Social Pension and Life Satisfaction: An Analysis Using Longitudinal Ageing Study in India (LASI) Data

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ABSTRACT

The study used the first wave of the Longitudinal Ageing Study in India (LASI), conducted during 2017-18, and analysed a sample of 31,320 individuals aged 60 years and above. The study used descriptive, bivariate, and multivariate logistic regression analyses and controlled for socio-demographic, health, economic, household, and geographical variables. The study found that while 89% of respondents reported being satisfied with their lives, 25% carried outstanding loans, and only 39% received pensions. Satisfaction was significantly higher among those aged 60–74 years than among those aged 75 years and above. Both education and health significantly shaped life satisfaction: satisfaction was higher among more educated individuals and lower among people with poor health or disabilities. Regression models confirmed that higher educational attainment, being female, and living with family were positive predictors. In contrast,

age, poor health, food insecurity, disability, living alone, and outstanding loans were strong negative predictors of life satisfaction. Geographically, the Western region reported the highest satisfaction, while the Central region reported the lowest. Cultural norms, regional social support systems, and community engagement may influence these regional differences, suggesting that region-specific policies could further enhance elderly well-being.

Keywords : Elderly, Life Satisfaction, Social Pension, Outstanding loans, Social Security, LASI India

Population ageing is rapidly reshaping the socioeconomic and demographic composition of nations worldwide, and India is no exception. India has a large and rapidly ageing population, with around 100 million individuals aged 60 and above, and this number is expected to increase sharply in the coming decades (Choudhary *et al.,* 2024). This rising older population has major impacts on society and the economy. The focus is now shifting from mere survival of elderly persons to ensuring a higher quality of life, such as a healthy and satisfying life, commonly referred to as "successful ageing". Although longevity is a positive outcome of development, it also increases the cost of care for elderly individuals. Most older people face economic insecurity, dependence on households, and a heightened risk of poverty, especially in developing economies where formal social safety nets remain poorly organised, fragmented, and insufficient (Pandey *et al.,* 2025).

In India, retirement is often considered a difficult stage, as it is not an easy and comfortable phase of life. Unlike developed countries, where older individuals receive effective social security support, a significant proportion of senior citizens in India face rigid credit constraints and inadequate government support. As a result, most elderly people are forced to keep working into old age, not by choice but because of financial or economic necessity (Sahadevan, 2021). In this situation, social pensions like the Indira Gandhi National Old

Age Pension Scheme (IGNOAPS) play a crucial role. These pensions are non-contributory and act as a major source of protection or support for poor and vulnerable older people. Beyond reducing poverty, research shows that pensions also improve mental well-being by lowering the risk of stress, depression, and anxiety and giving elderly people a sense of financial independence and dignity (Guimbeau & Menon, 2024).

Discussions of financial well-being among elderly individuals remain incomplete if they ignore debt. Indebtedness is now widely recognised as a critical source of stress that can harm psychological well-being in old age. Studies show that the subjective debt burden - worry and mental pressure related to repayment of loans often has a greater impact on mental well-being than the real amount of debt itself (Tay *et al.,* 2016). Older adults who have high financial debt relative to their assets are more likely to experience higher depression, stress, and poor subjective health status, making debt a distinct socioeconomic factor influencing well-being. Thus, to understand life satisfaction in later life, it is essential to consider both sources of financial security (such as social income) and financial liabilities (such as debt) that significantly affect psychological well-being.

Life satisfaction is a widely used indicator of subjective well-being among older adults. It reflects not only individuals' living conditions but also how they personally appreciate, evaluate, and feel about their lives. While existing studies have examined pensions and debt separately, they need to integrate these factors to understand their combined effects on India's ageing population. To address this gap, the current study analyses data from the Longitudinal Ageing Study in India (LASI) Wave-I (2017-18). By using descriptive, bivariate, and multivariate regression methods, this paper analyses how financial variables, specifically the receipt of social pension and the presence of outstanding loans, are related to the life satisfaction of elderly persons. This analysis provides a more comprehensive understanding of how financial security and financial burden relate toolder adults' well-being.

Literature review

Socio-Economic Conditions, Pension Coverage, and Older Adults' Well-Being in India:

India's demographic transition has led to a crisis of economic security for older adults. This stems from the absence of a strong social support system; as a result, many older individuals are forced to keep working even after retirement age. Several studies show that when older persons lack financial independence, they are forced either into the labour market or to depend on family members. Hence, this underscores the urgent need for universal old-age pension schemes to improve older adults' well-being (Goli *et al.,* 2019). This economic insecurity is further supported by Sahadevan (2021), who states that access to social pensions significantly increases the likelihood that elderly people withdraw from the labour force, as pensions provide financial security and allow them to "purchase" their retirement and enjoy leisure in later life.

The mere presence of pension schemes or programmes does not guarantee the well-being of elderly people. Pandey *et al.* (2025), using LASI data, highlighted major gaps in social protection coverage, showing that many older people do not receive employer-funded pensions because of administrative hurdles, corruption, and delays, which limit pensions' positive impact on overall quality of life. Despite these implementation gaps, financial pensions clearly provide psychological well-being. Mendiratta *et al.* (2022) highlight that older adults who receive pensions have higher life satisfaction and resilience than those who do not, and note that a regular income buffers against later-life stress. Conversely, lack of financial security among older adults is closely linked to poor health outcomes; Muhammad, *et al.,* (2021) show that older persons who feel their income is inadequate are more prone to cognitive impairment. In addition, Maurya *et al.* (2025) argue that engagement in work during old age does not necessarily result in better life satisfaction; rather, older individuals who continue working by their personal choice, especially those with wealth and

asset ownership, report higher life satisfaction, whereas those who are working due to economic compulsion often report lower well-being.

Economic Security, Living conditions, and Psychological Health:

However, Financial resources and living arrangements jointly have greater consequences on the psychological well-being of older persons. Analysing LASI data, Guimbeau and Menon (2024) present convincing evidence that access to social pensions reduces the risk of depression by approximately 8.6 to 10.1 percentage points, with a stronger effect, especially among widowed women, as social pensions provide them with greater financial autonomy. Similar evidence from international studies by Lu and Wang (2025) suggests that pension-based economic security enhances life satisfaction, and that this positive impact is stronger among older people with greater financial literacy.

Financial security in later life depends not only on income but also on the source and stability of that security. Hansen *et al.* (2008) argue that life satisfaction does not necessarily decline with ageing. They also indicate that accumulated assets and lower liabilities contribute more to financial satisfaction than regular income alone. The stress process model used by Fan and Ryu (2023) further explains that debt is a major source of stress that reduces elderly people's subjective well-being. However, strong social resources can reduce this negative effect. In India, economic conditions are closely connected with living arrangements in later life. Boro *et al.* (2021) suggest that changes in living arrangements are often caused by financial conditions, which can harm the mental health of older people. Likewise, Seo and Kim (2022) found that home ownership influences how living with household members affects life satisfaction. Charles and Kulandai (2020) further highlight that pension income and social support together play an important role in shaping older people's overall life satisfaction.

Indebtedness, Debt Stress, and Mental Health Effects:

Also, indebtedness among older people is increasingly seen as a main reason for poor mental health, and it is separate from general poverty. A critical review by Tay *et al.* (2016) examines how debt-related stress, pressure, and worry affect mental well-being more than the amount owed. This distinction is essential for understanding well-being in old age. Asok (2025) supported this, showing that a study in rural Kerala found debt-related stress differs by gender (affecting males and females differently) and is a major contributor to older adults' overall well-being.

The impacts of indebtedness among the elderly are very serious. Evidence from Brazil shows that many older people are increasingly vulnerable to "payroll deductible" loans and financial scams that weaken their retirement security (De Souza *et al.,* 2025). This type of financial vulnerability is different from over-indebtedness. Jamaluddin *et al.,* (2025) highlight that financial fragility refers to broader household-level vulnerabilities and argue that researchers should measure it properly to understand the real burden of debt. In India, research based on LASI data supports similar conclusions. Mohsin and Ahmad (2025) and Roopani *et al.,* (2022) show that economic factors like wealth status strongly determine life satisfaction among older people. In many cases, these financial indicators affect well-being more than other social or demographic factors.

Key factors of Life Satisfaction: Income, Pensions, and Social Support:

The link between government and family support for older people is complex. Kim (2012) examined the "crowding out" hypothesis and found that government pensions in Korea greatly improved the life satisfaction of older individuals. At the same time, these pensions also reduced the financial support elderly parents receive from their adult children. Overall, however, social pensions still positively affectelderly well-being. Similarly, Esser and Palme (2010), drawing on findings from a cross-national European study, highlight that "Basic security" pensions play an essential role in improving the well-being and health of older persons, especially women.

In India, Choudhary *et al.,* (2024), applied hierarchical regression models using LASI data to show that social security coverage plays an important and foundational role in improving quality of life along with health and social relationships; Mehrotra *et al.,* (2018) also supported this and found that though family support is very essential, economic factors like home ownership and socio-economic status also largely impact the overall life satisfaction and cannot be replaced by household or family support alone. Taken together, these studies suggest that pensions provide limited financial protection, but they are most effective when they complement family-based social capital rather than replacing it.

Economic Vulnerability, Rotational Living, and Mental Health effects of financial Stress

The most vulnerable older persons are those who are trapped in a cycle of loans, insecure housing conditions and are excluded from any pension support. Muhammad and Srivastava (2020) explain the concept of "rotational living," which means older parents move from one child's home to another. This situation negatively affects their mental health and mainly happens due to a lack of independent financial resources. Due to this, older persons are forced to depend on informal family support systems, which are often insufficient.

Research shows that financial stress harms not only physical health but also the psychological health of older adults. Sweet *et al.* (2013) found that people with large financial debt compared to their assets tend to have higher "diastolic blood pressure" and feel more stressed, highlighting that debt can act as a biological health risk indicator. A systematic review by Turunen and Hiilamo (2014) supports this and found that indebtedness is linked to depression and suicidal thoughts, indicating that unpaid financial loans are not economic issues only but also regarded as serious public healthcare concerns. In contrast, Kaushal (2013) emphasises that pensions play a buffering role. The expansion of pension schemes or programmes in India has increased household expenditure on healthcare and

education, highlighting that pensions help households meet essential needs and reduce reliance on high-interest loans.

Research gap

Although a substantial body of literature exists, several crucial research gaps remain unexplored. Using LASI data, the current study aims to address these gaps. Most studies examine the effects of pensions and debt separately. Hence, limited research investigates how both (pensions and debt) work together. International studies highlight differences between the actual amount (Objective debt) and the stress individuals feel due to debt (Subjective debt) worldwide. In India, several LASI-based studies have primarily focused on objective economic indicators like MPCE, income, and assets. Limited research compares how different loan types affect quality of life, particularly among elderly people receiving pensions. Also, there is little understanding of whether informal loans (from family members/ moneylenders) are more harmfulto life satisfaction than formal bank loans, especially for older persons who receive pensions. Finally, in India, several earlier studies on life satisfaction among elderly people use cross-sectional data (mainly from wave-1 of LASI/BKPAI), which limits conclusions about cause-and-effect relationships. Future research could apply causal inference strategies such as Regression discontinuity as used by Guimbeau and Menon, 2024, to examine the debt-life satisfaction relationship, which remains largely unexplored in the Indian socio-economic context.

Method

Data Source

For the current study, Wave I of the Longitudinal Ageing Study in India (LASI) survey, conducted during 2017-18, has been utilised. LASI is nationally representative data (IIPS, *et al.,* 2020). The LASI survey used multi-stage stratified random sampling to select the sample households. The selection criterion for the household was that it should have a member aged 45 or older. From the selected households, the survey interviewed individuals aged 45 and above. In addition, spouses of individuals aged 45 and above, irrespective

of their age, were interviewed across India's states and Union Territories. The LASI survey collected information on household income, consumption, assets, loans, health and well-being, social networks, and coverage of various welfare schemes targeted at individuals aged 45 and older. Given LASI's rich information on these subjects and its national representativeness, these data have been widely used in research on the population aged 45 and older in India. For the current study, we considered individuals aged 60 and older.

Variables

Outcome Variable

The current study's main outcome (dependent variable) is individuals' perceived life satisfaction level. In the survey, the information on this indicator was collected using the following question:

"Please think about your life as a whole. How satisfied are you with it? Are you completely satisfied, very satisfied, somewhat satisfied, not very satisfied, or not at all satisfied?" and its responses were recorded on a one-to-five-point scale, one representing completely satisfied and five representing not at all satisfied. The original five-point life satisfaction variable was dichotomised into two categories (satisfied and not satisfied) to facilitate binary logistic regression and to simplify interpretation of the findings.

Intermediate Variables:

In this study, two main intermediate variables have been considered: a) receipt of any social welfare pension, and b) whether the individual's household has any outstanding loan that is not yet paid. In this study, we also examined the effect of outstanding loan amount, but because of its reporting distribution, we did not include it in the analysis.

Both variables, pension status and outstanding loan status, have been dichotomised; 0 means no and 1 means yes.

Socio-demographic, economic and other variables:

Individual characteristics such as age, gender, marital status, and education variables were been considered in the analysis.

Furthermore, Purposes for taking loans and household economic status, such as overall economic status and BPL card availability, were considered. In addition, social and religious status have been taken into account. The analysis also controlled for the presence of grandchildren, economic support receiving/giving status, and place of residence and geographical region.

Method

The univariate and bivariate analyses were conducted to fulfil the current study's objective. In univariate analysis, we calculated the mean and standard deviation, along with the maximum and minimum values, for all study variables. In the bivariate analysis, we compared the distribution of outcome and intermediate variables across background characteristics, including individual demographic and economic characteristics, household social and economic characteristics, and geographic characteristics.

Moreover, multivariate logistic regression analysis was used to identify factors affecting the outcome variable, that is, perceived life satisfaction level. In the multivariate regression models, all study variables (background characteristics) have been controlled for to estimate the net effect of each background characteristic on an individual's life satisfaction.

Result

Summary Statistics

Tables 1 and 2 present the summary statistics for all variables used in the current study. Table 1 presents the summary statistics of the outcome, outstanding debt-related indicators, loan purposes, and pension receipt status. About 89 per cent of respondents reported being satisfied, while 25 per cent had outstanding loans. Health and living expenses (76%) were the leading purpose for outstanding loans, followed by agriculture and business (34%), and home/construction (24%). Approximately 39 per cent of respondents were currently receiving various social pensions.

Table 1
Summary statistics of study sample (N= 31,320).

Variable	Mean	Std. Dev.	Min	Max
Outcome indicator: satisfaction with life	0.89	0.32	0	1
Debt-related indicators				
Outstanding loan	0.25	0.43	0	1
Loan purpose (First loan):				
Home/Construction	0.24	0.43	0	1
Agriculture & business	0.34	0.48	0	1
Education	0.03	0.18	0	1
Health & living expenses	0.76	0.27	0	1
Consumer durables, marriage & others	0.19	0.39	0	1
Loan purpose (Second loan):				
Home/Construction	0.20	0.40	0	1
Agriculture & business	0.29	0.45	0	1
Education	0.04	0.20	0	1
Health & living expenses	0.26	0.44	0	1
Consumer durables, marriage & others	0.20	0.40	0	1
Loan purpose (Third loan):				
Home/Construction	0.19	0.39	0	1
Agriculture & business	0.24	0.43	0	1
Education	0.07	0.25	0	1
Health & living expenses	0.32	0.47	0	1
Consumer durables, marriage & others	0.19	0.40	0	1
Status of pension (social security)				
Receiving	0.39	0.45	0	1

Table 2 shows the summary statistics of the socio-demographic, health, economic, household, social, and geographical factors of the study sample. About 79 per cent of the respondents were aged 60-74 years, while 22 per cent were aged 75 and above; 52 per cent were female. Further, 38 per cent, 16 per cent, 17 per cent, and 30 per cent of older adults belonged to the OBC, SC, ST, and other caste categories, respectively. Around 73 per cent belonged to Hinduism; 37 per cent were widowed/separated/ divorced, and 54 per cent had no schooling. However, 41 per cent were economically poor.

Approximately 5 per cent of the sample reported living alone, while 89 per cent lived with family. The study found that 7 per cent of households faced some level of food insecurity. About 46 per cent reported poor healthconditions, while 10 per cent had a disability. About 13 per cent received social support from other family members, while 5 per cent provided social support to other family members. About 30 per cent were working, while 55 per cent of households had five or more members. About 88 per cent used a ration card; 72-84 per cent of older adults played a significant role in intra-household decision-making, and 67 per cent lived in rural areas. Approximately 26 per cent and 18 per cent of the older population resided in the Southern and Eastern regions of the country, respectively.

Table 2
Summary statistics of socio-demographic characteristics of study variables.

Variable	Mean	Std. Dev.	Min	Max	Variable	Mean	Std. Dev.	Min	Max
Age group: 60-74	0.79	0.41	0	1	Other family members	0.05	0.22	0	1
75 & above	0.22	0.41	0	1	Non-relatives	0.00	0.07	0	1
Gender of respondent: Female	0.52	0.50	0	1	Not receiving	0.94	0.25	0	1
Caste: Schedule castes (SC)	0.16	0.37	0	1	Household size:1 member	0.05	0.22	0	1
Schedule tribes (ST)	0.17	0.37	0	1	2 members	0.18	0.39	0	1
Other backward classes (OBC)	0.38	0.49	0	1	3-4 members	0.22	0.41	0	1
Other castes	0.30	0.45	0	1	5 & above members	0.55	0.50	0	1
Religion: Other religions	0.28	0.44	0	1	Use ration card	0.88	0.33	0	1
Hindu	0.73	0.44	0	1	Role in decision making: Marriage of son/daughter (Yes)	0.79	0.41	0	1
Marital Status:	0.63	0.48	0	1	No	0.06	0.23	0	1

Currently married	0.37	0.48	0	1	Not applicable	0.16	0.36	0	1
Widowed/ separated/ divorced/ unmarried									
Education: No Schooling	0.54	0.50	0	1					
Upto primary level	0.31	0.46	0	1	Buying and selling of property (Yes)	0.83	0.38	0	1
Up to secondary & higher secondary level	0.11	0.31	0	1	No	0.07	0.26	0	1
Up to Graduate & above	0.04	0.20	0	1	Not applicable	0.10	0.30	0	1
Working Status: Currently working	0.30	0.46	0	1	Gifts to children and others (Yes)	0.84	0.37	0	1
Not working	0.70	0.46	0	1	No	0.07	0.26	0	1
Economic status: Poor	0.41	0.20	0	1	Not applicable	0.09	0.28	0	1
Self-rated health: Poor	0.46	0.50	0	1	Education of family member (Yes)	0.72	0.45	0	1
Disability	0.10	0.30	0	1	No	0.11	0.31	0	1
					Not applicable	0.17	0.38	0	1
Food insecurity	0.07	0.27	0	1	Arrangement of religious events (Yes)	0.81	0.39	0	1
Living arrange-ment: Living with family	0.89	0.31	0	1	No	0.08	0.27	0	1
Living with others	0.06	0.23	0	1	Not applicable	0.11	0.31	0	1
Living alone	0.05	0.22	0	1	*Geographic indiators*				
Have grandchildren	0.90	0.30	0	1	Residence: Rural	0.67	0.47	0	1
					Geographical region: North	0.18	0.39	0	1
Receive social support: From spouse/partner	0.01	0.10	0	1	Central	0.13	0.34	0	1
Other family members	0.13	0.34	0	1	East	0.18	0.39	0	1
Non-relatives	0.01	0.07	0	1	West	0.11	0.32	0	1
Not receiving	0.85	0.35	0	1	South	0.26	0.44	0	1
Social support given: To spouse/ partner	0.01	0.10	0	1	Northeast	0.13	0.34	0	1

Bivariate Analysis

Table 3 Column (A) presents the distribution of Outstanding loans by socio-demographic, health, economic, and household characteristics. Overall, about 25 per cent of respondents had outstanding loans, while 75 per cent had no outstanding loans. The prevalence of loans was high among working people, those with low educational attainment, poor self-rated health, disabled people, and those living in rural areas. At the regional level, the South had the highest loan prevalence (36.30%), compared with 17.64 per cent in urban areas. Loan prevalence was higher among non-poor (32.43%) than among the poor (27.11%). Among household characteristics, respondents who received financial support from non-relatives had the highest loan prevalence (59.52%), whereas people living alone had the lowest (10.57%). Overall, the results show considerable variation in outstanding loan status by socio-economic, health, and household characteristics.

Table 3 column (B) shows the distribution of pensions among the selected variables. It was found that 39.20 per cent of respondents were receiving a pension, while 60.80 per cent were not. The pension rate was higher among respondents aged 75 years and above (43.68%) than among those aged 60-74 years (32.82%). Pension coverage was higher among respondents with a graduate education level and above (45.66%), those living alone (50.76%), and those with disabilities (43.92%). Geographically, pension receipt was highest in the North (57.64%) and lowest in the West (14.01%). Pension receipt varied considerably across factors such as age, education, living arrangements, region, and socio-economic characteristics.

Column (C) in Table 3 shows life satisfaction by selected variables. Overall, about 89 per cent of the respondents reported being satisfied with their lives. The level of life satisfaction was low among people aged 75 and older, living alone, and having poor health conditions or disabilities.The largest differences were in health and food security: satisfaction was 79.03 per cent for individuals with poor health status and 76.59 per cent for individuals with disabilities,

compared with 93.82 per cent and 87.78 per cent for their healthier counterparts. Food insecurity was also associated with lower satisfaction (63.41% versus 88.87%). Geographically, satisfaction was reported highest in the Western region (93.62%), while the Central region showed the lowest (82.84%).

Table 3

Results from bivariate analysis: (A) individuals with outstanding loan status, (B) receiving pension status; (C) satisfaction by background characteristics.

Variables	Outstanding loan (%) (A)	Receiving any pension (%) (B)	Satisfied with life (%) (C)	N
Age				
60-74 years	30.08	32.82	87.40	24,248
75 years & above	30.18	43.68	83.99	6,629
Gender of respondent				
Male	31.97	35.97	87.70	14,925
Female	28.39	34.61	85.70	15,952
Caste				
Schedule caste	32.48	41.65	80.86	5,034
Schedule tribe	23.25	41.14	86.72	5,162
Other backward class	32.32	34.84	87.33	11,761
Other castes	26.88	29.75	89.53	8,920
Religion				
Other religions	26.72	34.56	85.64	8,343
Hindu	30.81	35.41	86.87	22,534
Marital Status				
Currently married	31.30	30.31	88.97	19,586
Widowed/Separated/Divorced/ Unmarried	28.14	43.32	82.83	11,291
Education				
No schooling	30.98	38.23	83.75	16,682
Up to primary level	32.98	29.46	88.37	9,566
Up to secondary & higher secondary level	21.90	31.56	94.44	3,366

Up to graduate & above	15.84	45.66	95.79	1,263
Working status				
Working	35.48	27.69	87.49	9,167
Not working	27.62	38.70	86.26	21,710
Self-rated health status				
Good	27.78	33.03	93.82	16,300
Poor	32.53	37.49	79.03	13,975
Disability				
No	29.08	34.19	87.78	27,734
Yes	38.43	43.92	76.59	3,143
Food insecurity				
No	30.22	35.13	88.87	28,608
Yes	28.80	36.65	63.41	2,269
Economic status (MPCE quintile)				
Non-poor	32.43	34.22	88.55	18,160
Poor	27.11	36.59	84.22	12,717
Place of residence				
Urban	17.64	30.40	91.43	10,283
Rural	34.87	37.16	84.77	20,594
Region				
North	22.58	57.64	89.46	5,589
Central	26.03	29.00	82.84	4,156
East	34.04	39.55	84.16	5,675
West	29.80	14.01	93.62	3,414
South	36.3	40.43	85.27	7,906
Northeast	15.3	34.09	91.11	4,137
Household size				
1 member	10.60	50.71	68.52	1,631
2 members	22.24	34.76	82.97	5,725
3-4 members	28.36	34.81	87.01	6,621
5 & above members	35.59	33.95	89.72	16,900
Use ration card				
No	21.19	25.86	88.92	3,827
Yes	31.48	36.84	86.27	26,947
Have grandchildren				
No	22.28	31.85	81.73	2,940
Yes	30.74	35.79	87.08	27,654

Living arrangement				
Living with family	31.67	33.78	88.40	27,569
Living with others	26.02	42.30	78.40	1,684
Living alone	10.57	50.76	68.42	1,624
Financial support received from				
Spouse/partner	33.26	17.96	93.56	292
Other family members	33.39	35.56	84.19	4,076
Non-relatives	59.52	40.04	78.50	152
Not receiving	29.34	35.36	87.03	26,357
Financial support given to				
Spouse/partner	32.50	36.35	93.98	307
Other family members	39.51	42.07	90.47	1,556
Non-relatives	50.97	34.70	94.41	138
Not giving	29.52	34.92	86.36	28,876
Role in decision-making				
Marriage of son/daughter				
No	30.85	38.16	82.50	1,749
Yes	30.61	34.99	88.58	24,266
Not applicable	27.47	35.31	79.36	4,862
Buying and selling of property				
No	32.45	35.71	81.12	2,274
Yes	29.99	34.98	88.47	25,558
Not applicable	28.95	37.00	76.89	3,045
Gifts to children, grandchildren, other relatives				
No	32.53	37.95	80.02	2,194
Yes	30.27	34.89	88.05	25,996
Not applicable	26.18	35.93	80.01	2,687
Education of the family member				
No	35.59	37.17	81.67	3,391
Yes	29.30	34.71	89.11	22,132
Not applicable	29.14	35.86	81.22	5,354
Arrangement of social or religious events				
No	33.71	36.15	81.52	2,465
Yes	29.82	35.03	87.96	25,069
Not applicable	28.90	36.01	82.00	3,343

Factors Affecting the Individual's Satisfaction: Findings from Multivariate Regression Analysis

Table 4 presents the results from multivariate logistic regression models predicting individual's life satisfaction. Model 1 examines the association between outstanding loan status and life satisfaction, Model 2 analyses the relationship between pension receipt and life satisfaction. Model 3 incorporates both outstanding loan status and pension receipt, while Model 4 is an adjusted model that combines allsocio-demographic, health, household, economic, andgeographical characteristics.

The findings show a statistically significant negative relationship between outstanding loans and life satisfaction. Those with outstanding loans were less likely to be satisfied than those without outstanding loans. The relationship remained statistically significant in Models 1, 3, and 4, but the coefficient's significance decreased slightly after adjustment (from -0.27 to -0.20). Pension receipt showed a negative and significant association with life satisfaction in Model 2 ($\beta = -0.17$, $p < 0.001$) and remained significant in Model 3 ($\beta = -0.16$, $p < 0.001$). However, after controlling for other factors such as socio-demographic, health, economic, household, and geographical characteristics in Model 4, the relationship became statistically insignificant ($\beta = 0.03$). This suggests that other characteristics related to pension recipients largely account for the correlation between receiving pensions and life satisfaction.

In Model 4, age was non-significant, as people aged 75 years and above did not differ significantly in life satisfaction from those aged 60-74 years. Female respondents had significantly higher odds of being satisfied with their lives than men. Significant differences were also observed by caste, marital status, and education. More educated respondents had higher odds of being satisfied with their lives than those with no education. Economic and geographic factors were also critical. Poorer individuals had lower chances of reporting life satisfaction, while rural respondents had lower chances than urban

Table 4

Results from multivariate logistic regression models, predicting the individual's life satisfaction, controlling for socio-economic, demographic and geographical characteristics.

Variable	Model-1 Coeff. (SE)	Model-2 Coeff. (SE)	Model-3 Coeff. (SE)	Model-4 Coeff. (SE)
Outstanding Loan (Ref: No outstanding loan)				
Outstanding loan	-0.27***(0.040)		-0.27***(0.04)	-0.20***(0.0452)
Pension Receipt (Ref: No pension)	-			
Receiving pension		-0.17(0.036)	-0.16 (0.037)	0.03(0.041)
Age Group (Ref: 1 = 60-74 years)				
75 years & above				0.02(0.048)
Gender (Ref: Male)				
Female				0.14**(0.046)
Caste (Ref: Scheduled caste)				
Scheduled tribe				0.31***(0.074)
Other backward class				0.169**(0.053)
Others				0.15*(0.060)
Religion (Ref: Other religions)				
Hindu				-0.07(0.050)
Marital Status (Ref: Currently married)				
Widowed/Separated/Divorced/Unmarried				-0.25***(0.051)
Education (Ref: No education)				
Primary				0.34***(0.048)

Secondary and higher secondary				0.82***(0.091)
Graduate and above				1.04***(0.164)
Work Status (Ref: Working)				
Not working				0.03(0.047)
MPCE Quintile (Ref: Non poor)				
Poor				-0.26***(0.042)
Place of Residence (Ref: Urban)				
Rural				-0.13**(0.048)
Region (Ref: North)				
Central				-0.41***(0.070)
East				-0.16*(0.065)
West				0.53***(0.093)
South				-0.14*(0.064)
Northeast				0.32***(0.090)
Living Arrangement (Ref: Living with family)				
Living with others				-0.23**(0.081)
Living alone				-0.89 (1.120)
Self-rated health (Ref: Good self-rated health)				
Poor self-rated health				-1.21***(0.043)
Disability status (Ref: No disability)				
Has disability				-0.47***(0.055)
Food insecurity (Ref: Food secure)				
Food insecure				-1.03***(0.055)
Source of financial support received (Ref: Spouse/partner)				
Other family members				-0.29 (0.241)

Non-relatives				-0.78*(0.331)
Not receiving				-0.24 (0.236)
Source of financial support given (Ref: Spouse/partner)				
Other family members				0.09 (0.285)
Non-relatives				0.34 (0.487)
Not giving				-0.33(0.267)
Household size (Ref:1 member)				
2 members				-0.29 (1.120)
3-4 members				0.01(1.120)
5 and more members				0.35 (1.120)
Ration card status (Ref: no ration card)				
Has ration card				-0.05(0.063)
Constant	2.13*** (0.021)	2.13***(0.024)	2.19***(0.026)	3.53**(1.171)
Observations (N)	30326	30758	30326	30169

Note: Standard errors in parentheses; $^{*}p< 0.05$, $^{**}p< 0.01$, $^{***}p< 0.00$; Ref: Reference Category.

respondents.There were significant regional differences, especially between the Central, East, West, South, and Northeast regions and the North region.

Health-related characteristics had one of the strongest correlations to life satisfaction. Poor self-rated health, disability, and food insecurity were all found to be significantly and negatively associated with life satisfaction. Marital status was also significant, with those who were widowed/separated/divorced/unmarried being less likely to be satisfied with their lives than married people. Overall, the fully adjusted model indicates that outstanding loans, rather than pensions, still significantly affect life satisfaction.

Conclusion

Late adulthood in India is shaped by changing demographic, economic, health, and social conditions. It is not only about increased longevity but also about the struggle to live with dignity and a good quality of life. Using data from LASI Wave I, this study goes beyond basic population figures to understand the psychological and financial conditions of older individuals in India. The findings reveal that life satisfaction among older persons is closely associated with real-life factors such as financial independence, access to healthcare, and social relationships.

Our multivariate analysis shows that financial security and socio-economic conditions are the main determinants that affect subjective well-being in later life. Descriptive and bivariate results indicated lower life satisfaction among older adults. Although pension recipients appeared to report higher life satisfaction in the descriptive and bivariate analyses, the association became statistically insignificant after controlling for socio-demographic, health, economic, household, and geographical characteristics. Hence, this suggests that life satisfaction among older adults is influenced more strongly by broader socio-economic and health conditions than by pension receipt alone. In contrast, outstanding

loans remained negatively associated with life satisfaction, which indicates that financial burden continues to play an important role in shaping subjective well-being. The pressure of outstanding loans and the need to repay debt can create psychological strain, which negatively affects mental well-being and undermines the conditions necessary for healthy ageing.

This study clearly shows that financial conditions alone do not determine older adults' overall well-being. The results demonstrate the continued importance of the Indian family system. Older persons living with family reported higher life satisfaction than those living alone. Despite this, significant inequalities remain. The findings reveal a "satisfaction divide" based on gender, caste, and place of residence. Women, widowed older adults, Scheduled Castes, and older individuals living in rural areas experience comparatively lower levels of well-being. These inequalities emphasise the need for an increased focus on the health of marginalised sections within India's elderly population.

Policy Implications and Way Forward

To help older people move from "just surviving" to living a fulfilling and dignified life, it is important to shift from fragmented welfare schemes to a more holistic, well-coordinated social protection system.

First, although social pensions were not independently associated with life satisfaction after adjustment, strengthening their coverage, adequacy, and timely delivery remains important for improving older adults' financial security. These pensions should be regularly adjusted to keep pace with inflation, so they maintain their real value and provide meaningful financial support rather than mere nominal assistance. Second, debt among senior citizens needs urgent policy attention. Major efforts should improve financial literacy among older persons and regulate informal lending practices, which often charge exorbitant interest rates and trap poor or

disadvantaged older people in long-term debt. Third, policies or programmes must recognise the "feminisation of ageing." Older women, especially widows and those living alone, often face a "double burden," namely economic insecurity and social isolation. Thus, targeted interventions are required to address their specific vulnerabilities.

Lastly, a strong support system for older people should combine family-based care with community services. While encouraging inter-generational living arrangements, the government should also develop community-oriented geriatric care networks to support older persons without family support.

In the long run, ensuring life satisfaction for India's more than 100 million older persons is not only a moral duty but also important for sustainable development. As the population ages, the focus should shift beyond extending life expectancy to improving the quality of life in later life. Additional years of life should be lived with dignity, financial security, and overall well-being, so that older people can truly enjoy their "silver years" in a meaningful way.

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2026, Vol. 40, No. 4, pp. 634-658
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI: 10.5958/0971-4189.2026.00011.5

Labour Market Vulnerability Among Older Adults in India: An Intersectional Analysis Using PLFS Data

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ABSTRACT

The study investigates labour market vulnerability among older workers in India using unit-level data from the Periodic Labour Force Survey (PLFS) 2023–24. This study treats vulnerability among 40,748 older adults (aged 60 years and above),20,058 (49.2 per cent) older males and 20,688 (50.8 per cent) older females, as a multi-dimensional phenomenon. To study this phenomenon, the authors constructed a Labour Market Vulnerability Index using binary indicators of employment quality and tetrachoric factor analysis. The study also used binary logistic regression to identify socio-economic and demographic determinants. The study found that gender, sector, education, monthly per capita expenditure, social group, and household size determine vulnerability. Older women face cumulative disadvantages from earlier life stages, making their vulnerability more severe. A higher odds ratio for older

men does not imply better opportunities for women. Vulnerability is especially acute among socio-economically marginalised groups. Employment among older adults is often driven by necessity rather than choice, reflecting inadequate social protection. These findings show that older adults lack adequate and economically beneficial work opportunities. Inclusive labour market policies and stronger social protection systems are urgently needed. Ensuring dignified ageing without gender bias aligns with SDG 8 (Decent Work and Economic Growth), which emphasises not just employment but the quality of work. Thus, this study highlights that living with pride in old age requires more than just jobs—it requires decent, equitable, and secure work opportunities, especially for women and marginalised communities.

Keywords : Labour Market, Vulnerability, OlderAdults, Ageing, Employment, PLFS

With better health facilities and rising longevity, healthy ageing is observed globally (Gruss *et al.*, 2026). Along with this, the rising trend of nuclear families and the out-migration of young people for jobs have worsened the economic and social conditions of older adults aged 60 above. Many older adults have to earn money to survive and live with pride. Many others want to work to be fit and healthy. They want to participate in the labour market and join the labour supply. International Monetary Fund (IMF) and International Labour Organization (ILO) studies state that in advanced countries, older people work longer by choice or policy support, such as raising the retirement age (Grigoli *et al.*, 2018; Aitken, 2025), but in developing economies, older people's higher participation rate is due to economic necessity along with weak social safety nets (ILO, 2018). The loss of income and increased health expenditure are the reasons for higher economic dependency with ageing in India (International Institute for

Population Sciences & United Nations Population Fund, 2023). This has made older people work more in developing economies like India. However, the policy provisions (such as a low retirement age, age-related eligibility criteria for jobs, etc.), physical and mental health conditions, and society's mindset make them mostly available in informal and low-profile jobs. Within the older population, older women face a double disadvantage: being older and being women (Dias, 2017). While the participation of the older age group in the labour force has attracted scholarly attention earlier, the focus has remained largely on aggregate trends, and the ageing population is generally treated as a homogeneous group (Srivastava & Mohanty, 2012; Sinha *et al.*, 2021; Saravanakumar *et al.*, 2022; Ahmad *et al.*, 2024). The experiences of older women in the labour market are painted with the dark colours of cumulative disadvantages faced by them across the life cycle, including gender discrimination at every phase, low educational attainment at an early age (Kingdon & Unni, 2001), wage discrimination in the job market, interrupted work history due to marriages and childbearing, unpaid household and care responsibilities (Singh & Pattanaik, 2019), and limited asset holdings. These could lead to high economic vulnerability among them in old age.

Labour market participation among the older population is of high economic importance and should be thoroughly analysed. The present study examines the labour market participation and vulnerabilities of older adults in India using an intersectional framework. It asks: who ages worse in the labour market, and how do intersecting identities, such as gender, caste, education, marital status, and location, shape labour outcomes in old age? Rather than a single-axis analysis, this study brings multiple social intersections into interaction to elucidate the differentiated ageing experiences of older adults in India.

Objectives

The major objectives of this study are as follows:

- To analyse the labour market vulnerability among older adults in India, and to see gender differences in labour market ageing.
- To determine the factors affecting the labour market vulnerability of older adults in India.

Hypothesis

- H_0: Older women are as vulnerable as older men.

  H_a: Older women are less vulnerable than older men in India.
- H_0: There is no statistically significant association between labour market vulnerability and socio-economic and demographic characteristics.

  H_a: There exists a statistically significant association between labour market vulnerability and socio-economic and demographic characteristics.

Conceptual Framework of Labour Market Vulnerability for Older People

Labour market vulnerability is conceptualised as a multi-dimensional concept by academicians. Rodgers (1989) relates vulnerability to unstable employment, irregular work, lack of social security, and inadequate earnings. Similarly, the International Labour Organisation (ILO), in one of its publications, reported that generally own-account workers and family contributors are regarded as having a vulnerable employment status since they lack basic elements of decent work; on the other hand, paid employees have better job security and working conditions along with social security coverage (Gammarano, 2018).

Labour market vulnerability refers to a condition of precarious employment, i.e., unstable employment, high job insecurity, harsh working conditions, lack of social benefits, inadequate earnings, inappropriate working hours, etc. When the labour market vulnerability is to be examined in context of older people factors like age-specific constraints and heath related issues make them prone to mandatory official retirements, low availability of stable jobs, sensitive to harsh working conditions, low skill upgrading,lack

of adequate social security measures, under employment and their increased needs of self-dependency with changing social conditions such as nuclear family trends should be well considered. Labour market vulnerability among older adults refers to the instability of jobs and income insecurity they face in accessing and sustaining gainful employment due to age-related, structural, and institutional constraints. For older people, both entry and retention in the labour market, as well as adequate and stable earnings, are great challenges.

Therefore, this research paper analyses labour market vulnerability amongolder adultsand considers precarious employment conditions to be a form of vulnerability, characterised by informality, instability, insecurity, and limited social security coverage. It measures the degree of vulnerability faced by those who were actually employed. It is assessed using the usual principal and subsidiary activity status. It is related to structural insecurity and was measured by constructing a labour market vulnerability index (LMVI) based on seven indicators of the nature, scale, and security of employment.

Method

This study is analytical research based on secondary data. It used first-visit unit-level data of the Periodic Labour Force Survey (July 23-June 24) for the analysis conducted by the National Statistical Office of India. Since PLFS mainly covers economic and labour market-related dimensions, the survey data were used to study the labour market vulnerability of 40,748 older persons (aged 60 year older); 20,058 (49.2 per cent) were older males and 20,688 (50.8 per cent) were older females. The unit-level data files for person (first visit) and household (first visit) were merged (many-to-one), with the person file as the master. Survey weightswere applied before the analysis.

The Labour Market Vulnerability Index (LMVI) was constructed using 7 indicators. In the development of LMVI, various indices constructed by different agencies (ILO, 2009; Bazillier,

Boboc, and Calavrezo, 2014; OECD, 2019; and CEE, 2025) were used. Each indicator is coded as a binary variable for computing the vulnerability index. Table 1 presents the indicator name, the corresponding PLFS variable,its encoding and its details. Since the PLFS 2023-24 does not provide information on earnings and working hours for UPS and UPSS, these indicators were excluded from the analysis.

Table 1

Description of indicators used for the construction of LMVI

Indicator	PLFS Variable	Values	Detail
Employment Type	Usual Principal Status (b5pt1q3 _perv1)Usage of produce (b5pt1q14_ perv1)	1 = Not stable employment and earnings, 0 = Regular salaried/ wage employed	If a casual worker/unpaid family helper or OAW/ employer of a very small or mainly for consumption, not for selling HH enterprise, then vulnerable, else non-vulnerable
Subsidiary Work Engagement	Whether engaged in anywork in a subsidiary capacity? (b5 pt1q7_perv1)	1 = Yes, 0 =No	If engaged in subsidiary activity (assuming insufficiency of income from principal activity), considered as vulnerable; else non-vulnerable
Social Security Coverage	Social Security Benefits (b5pt1q13_ perv1)	1 = Not any social security benefit, 0=else	If not eligible for any social security benefit, then vulnerable; else non-vulnerable
Employment Stability	Type of Job Contract (b5 pt1q7_perv1)	1=No written job contract, 0 = else	If there is no written job contract, then vulnerable; else non-vulnerable
Enterprise Size	Number of workers in the enterprise (b5 pt2q9_perv1)	1= Number of workers less than 6, 0 = else	If the number of workers in the enterprise is less than 6, then vulnerable; else non-vulnerable
Enterprise Type	Enterprise Type (b5pt	1 = Not formal/ organised/	If proprietorship (Single owner-ship), Employer's household,

	1q10_perv1)	registered enterprises 0 = else	partnership with same household (HH) members or other HH members and others, then Vulnerable, else (Government/local body, Public Sector Enterprises, Autonomous Bodies, Public/Private limited company, Co-operative societies, trust/other non-profit institutions) non-vulnerable
Workplace location/	Location of workplace (b5 pt2q7_perv1) Usage of product of economic activity (b5 pt1q14_perv1) Or Number of workers in the enterprise (b5 pt2q9_perv1)	1 = No proper, separate or fixed structure 0= else (For those not coded here, having NIC division 01 (Crop and animal production, hunting and related services activities): 1= very small or mainly for consumption, not for selling economic activities, else = 0)	If the workplace is located in: own dwelling unit, open area adjacent to own dwelling unit, employer's dwelling unit, street with fixed location, construction site, no fixed workplace andothers, then vulnerable; else (separate proper structures/ buildings/ shops) non-vulnerable. Persons, not coded here, having NIC division 01, are considered vulnerable if the produce (all or more than 50%) from economic activity is used for own consumption or the number of workers is less than 6;otherwise, non-vulnerable

Source : Derived from PLFS 2023-24

Note: All indicators except the 'Subsidiary Work Engagement' indicator are related to the usual principal activity.

As all indicators are binary, the vulnerability index is constructed using the factor analysis technique based on tetrachoric correlations. 'Iterative Principal Factor method' is used toextract the factors and to compute factor loadings. This analysis is performed using Stata 17 software.

The composite index 'LMVI' is constructed using those factor loadings with the following formula:

$$LMVI = \frac{\Sigma W_i X_i}{\Sigma w_i}$$

Here, w_i = Weight (Factor loading) of the ith indicator

X_i = Value of the ith indicator

Based on LMVI values, older persons are classified into two groups -vulnerable (1) and non-vulnerable (0), with the help of the two-way cluster technique and a binary variable 'LMV_Group' is created using SPSS 21. This binary variable is used as the dependent variable in Binary Logistic Regression Analysis.

Binary Logistic regression on survey data was applied using Stata 17 to examine the association between labour market vulnerability and socio-economic and demographic predictors. The logit form of the model is:

$$\text{Log}\left(\frac{P}{1-P}\right) = \beta_1 X_1 + ... + \beta_B X_B$$

Here, P = Probability of 'Vulnerable' and $\frac{P}{1-P}$ = Odds of 'Vulnerable'

X_1.....X_2 =Predictors (Sector, Gender, MPCE, Household Size, General Education Level, Age, Social Category, Marital Status)

Among the predictors, only Household Size is continuous; the others are categorical. Model fit was evaluated using the F-value. Since the survey design violates the assumption of simple random sampling, it does not use the usual likelihood ratios; instead, it uses the F-value (the design-adjusted Wald test statistic) for the overall model fit, which is equivalent to the Omnibus test. The Hosmer-Lemeshow test generally becomes sensitive to sample size. It can yield significant results, indicating a poor model fit, in large surveys (Paul *et al.*, 2013), so it is not evaluated here.

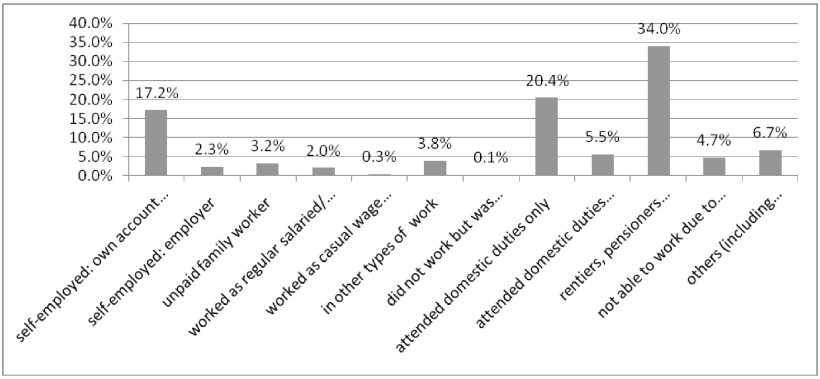
Parameters (β_1 to β_8) were estimated, and their significance was verified using a Wald-type test with survey-corrected standard errors at a 5 per cent level of significance. Stata 17 was used for the analysis.

Employment Status of the Older Population in India

The population of older persons was estimated as 11.51 crore based on PLFS 2023-24, of which 49.43 per cent were male, 50.56 per cent were female, and .01 per cent were transgender. Of the total older population, 3.31crore (28.7 per cent) were employed, 36.47 thousand (0.1 per cent) were unemployed, and 7.76 crore (71.2 per cent) remained out of the labourmarket under the usual principal activity status (UPS) in India, according to unit-level data of the PLFS 2023-24 (Figure 1). Two major reasons identified for not being part of the labour supply were receiving pensions, rent, or other income (34 per cent) and being engaged in domestic duties (20.4 per cent). The majority of employed old adults were self-employed own-account workers in household enterprises (Figure 1).

Figure 1

Usual Principal Activity Status of Older Persons (2023-24)

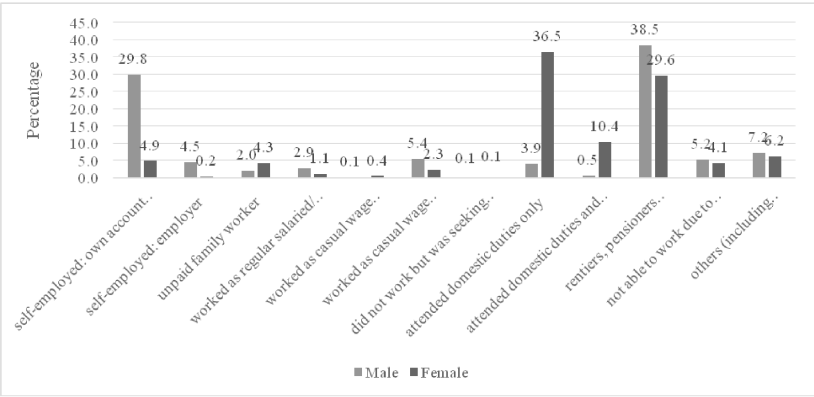


Source : PLFS Unit Level Data - 2023-24

The gender-wise percentage distribution of people in the principal activity status is shown in Figure 2.

Figure 2

Gender-wise distribution of Usual Principal Activity Status of Older Persons (2023-24)



Source : PLFS Unit Level Data - 2023-24

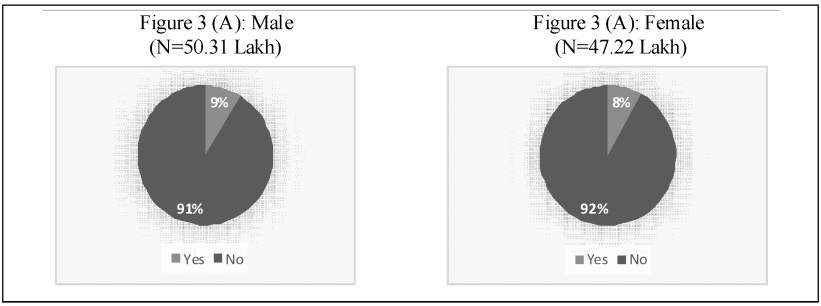
Note : N (Older Male) =5.69 Crore, N (Older Female) = 5.82 Crore

Figure 2 shows that the majority of all older persons identified as rentiers, pensioners, or remittance recipients included 38.5 per cent of older males, 29.6 per cent of older females, and all older transgender people (100 per cent). The major activity identified for older females was attending to domestic duties, and the highest proportion of females (36.5 per cent) engaged in that activity. In contrast, only 3.9 per cent of males did so. Overall, 71.2 per cent of older persons remained out of the labour force; of them, 38.40 per cent were males, 61.59 per cent were females, and .01 per cent were transgender individuals. Only 0.1 per cent of both the older males and females were unemployed and seeking or available for work. Although the ratios of males and females vary widely, among employed older adults, the majority of males and females were self-employed, especially as own-account workers. Of all older males, 29.8 per cent were own-account workers, but only 4.9 per cent of women were in this status. The ratio of older women who worked

as unpaid family helpers was 4.3 per cent, less than half (2 per cent) of that for older men. A very small proportion of older men were regularly salaried employees (2.9 per cent), which was almost half that of females (1.1 per cent). Almost 5.5 per cent of older men and 2.7 per cent of older women worked in all types of casual work. A total of 86.7 per cent of older women remained out of the labour force, whereas this ratio for the men was comparatively less, i.e., 55.3 per cent under the UPS. These facts emphasised that a smaller proportion of older females had the opportunity to work than older males, and those who were employed held lower-paid or unstable jobs.

Figure 3

Engaged in any work in a subsidiary capacity?



Source : PLFS Unit Level Data - 2023-24

The PLFS asked about engagement in any work in a subsidiary capacity, and overall, 97.53 lakh (8.5 per cent) older adults were found to be engaged in subsidiary activities. Figure 3 represents the gender-wise estimated responses for the older population. A smaller proportion of older females (8.1 per cent) engaged in subsidiary activities compared to their male counterparts (8.8 per cent). Figure 3 presents the percentage distribution of older persons for their activity status in a subsidiary capacity. Of the 50.31 lakh older males, the majority, i.e., 45.5 per cent, were own-account workers, whereas the corresponding ratio for older females was 21.9 per cent. The majority of older females (40.9 per cent) worked as unpaid family workers; the corresponding figure for their male counterparts was

19 per cent. Across all types, 71.1 per cent of older males and 64.1 per cent of older females were self-employed. Other than self-employment, the second major work done by older persons in subsidiary activity was casual wage labour. Very few of them worked as regular salaried or wage employees.

Figure 4

Usual Subsidiary Activity Status of Older Persons (PLFS -2023-24)



Source : PLFS Unit Level Data - 2023-24

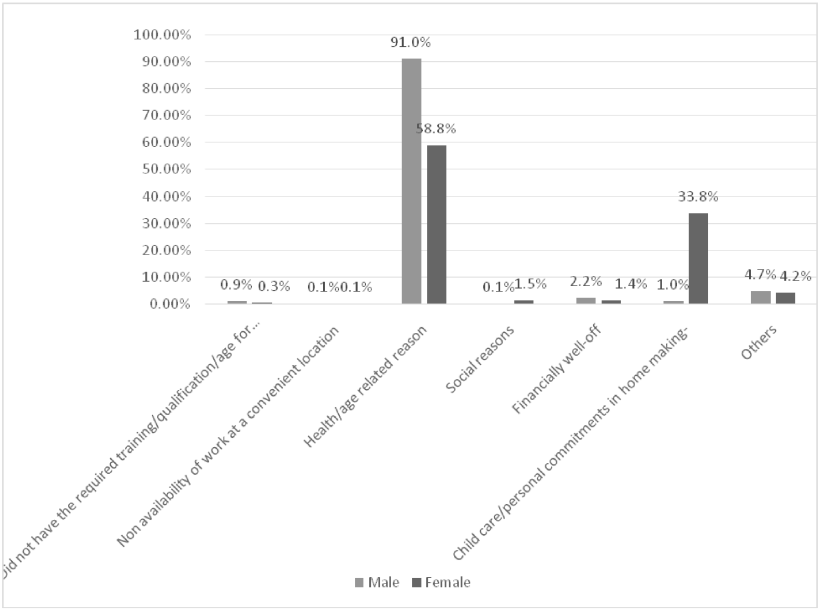
Note : N (Older Male) = 50.31 Lakhs, N (Older Female) = 47.22 Lakhs

Both the Usual principal activity and Subsidiary activity engagements show that a smaller proportion of the older female population was engaged in work than of the male population, and those who worked had a more precarious job profile than males. Those older women who were not part of the labour force were less blessed than older men, as a smaller proportion of them were recipients of pensions, rents and other remittances, and most of them performed domestic duties.

The persons who remained out of the labour force as per UPS and never engaged in subsidiary activity during the reference period accounted for 67.40 per cent of the total older population; of them, 39.13 per cent were male, 60.86 per cent were female, and 0.01 per cent were transgender individuals. The reasons given by respondents during the PLFS 2023-24 were: not having the required training/ qualification/age for work; non-availability of work at a convenient

location; health/age-related reasons; social reasons; being financially well-off; child care/personal commitments in homemaking; and others. The main reason 58.8 per cent of older women reported for remaining out of the labour force without engaging in any subsidiary work was health and age-related reasons, similar to older men (91 per cent), but with a large difference in proportions (Figure 5). Another important reason was 'child care and personal commitments in homemaking' reported by 34 per cent of older women, compared to only 1 per cent of older men. Here, the question arises whether the activity status of older women was a matter of personal choice or compulsion. The older women who did not suffer from health issues or age-related problems andwere not burdened with child care or housekeeping responsibilities might have worked and become self-reliant.

Figure 5
Main reason for remaining out of the Labour Force and not engaging in Subsidiary Activity



Source : PLFS Unit Level Data - 2023-24

Note: N (Older Male) = 3.04 Crore, N (Older Female) = 4.72 Crore

Table 2

Vulnerability Status of Older Adults based on Indicators

Status	Indicator						
	Employment Type	Subsidiary Work Engagement	Social Security Coverage	Employment Stability	Enterprise Size	Enterprise Type	Workplace location
Vulnerable (%)	41.6	16.1	98.8	98.4	88.9	96	71.8
Non-vulnerable (%)	58.4	83.9	1.2	1.6	11.1	4	28.2
Total (%)	100	100	100	100	100	100	100

Source: Computed using PLFS Unit Level Data - 2023-24

Note: N(Female)=25.38 Crore, N (Male)= 7.69 Crore, N (All)=33.07 Crore

Labour Market Vulnerability for the Older Population in India

This section examines the Labour Market Vulnerability among employed older adults in India. A person who appears to be employed but does not have regular and adequate earnings, works under harsh conditions, lacks social security benefits, faces job insecurity, works in precarious environments, or is engaged in informal or unregistered employment is considered to be experiencing labour market vulnerability. Based on the available variables in the PLFS 2023-24, seven indicators of labour market vulnerability: employment type, subsidiary work engagement, social security coverage, employment stability, enterprise size, enterprise type, and workplace location were computed as explained in section 3, and respondents were coded 0 (non-vulnerable) and 1 (vulnerable). Table 2 presents the percentage distribution of all older persons in vulnerable and non-vulnerable categories based on the seven indicators of labour market vulnerability.

Table 2 shows that based on five of the seven indicators, more than 70 per cent of older adults were classified as vulnerable, and for three of these five indicators, this percentage exceeded 95 per cent.

To complete the picture of labour market vulnerability among older adults, the researcher constructed the Labour Market Vulnerability Index (LMVI) using the seven indicators described above. Since these indicators are binary, the index is constructed via factor analysis using tetrachoric correlations. Lower correlation coefficients were also accepted to ensure that all indicators important for measuring labour market vulnerability were included in the analysis.

The factor analysis was conducted using this tetrachoric correlation matrix to estimate a single factor's loadings, which were then used to construct a composite index. Table 3 presents the factor

loadings thus computed. Subsidiary engagement, social security coverage, and enterprise size have the top three loading values, whereas enterprise type has the lowest.

Table 3

Factor Loadings for Labour Market Vulnerability Index

Indicator	Factor Loadings
Employment Type	0.3934
Subsidiary Engagement	0.9715
Social Security Coverage	0.9503
Employment Stability	0.7893
Enterprise Size	0.8902
Enterprise Type	0.0913
Workplace location	0.8104

Source: Computed using PLFS Unit Level Data - 2023-24

Note: In the Iterative Principal Factor method, the tetrachoric correlation matrix is used to compute factor loadings.

Using these loadings, the LMVI is constructed for all employed older persons. This index ranges from 0 to 1, where values closer to 0 indicate non-vulnerability and values approaching 1 indicate increasing vulnerability. After constructing the labour market vulnerability index, the employed older adult population is classified into two groups: vulnerable and non-vulnerable. Table 4 presents the distribution of members among all employed older persons and the cluster centroids. The mean value of the LMVI index for the vulnerable cluster is much higher than that of the non-vulnerable group, and the standard deviations of clusters show a greater dispersion in index values for the non-vulnerable group than for the vulnerable group. The ratio of vulnerable older persons is estimated to be 75.1 per cent, and that of non-vulnerable persons is 24.9 per cent.

Table 4

Cluster Centroids and Member Distribution for Clusters based on Labour Market Vulnerability Index (LMVI)

Clusters	Mean	Std. Deviation	N (In crores with Survey Weights)	% of Combined
Vulnerable	.9303	.05071	2.48	75.1
Non-vulnerable	.6435	.17247	0.82	24.9
Combined	.8457	.16642	3.31	100.0

Source: Computed using PLFS Unit Level Data - 2023-24
Note: The two-step clustering method is used to classify the respondents.

After classifying persons into vulnerable and non-vulnerable groups and taking the cluster membership variable (LMV_Group) as the dependent variable, Binary Logistic Regression for survey data is employedto examine whether various socio-economic and demographic factors- such as sector, gender, MPCE level, household size, general education level, age, social group and marital status- have any influence on labour market vulnerability in India. Here, the regression is run three times- for all employed older persons, and for sub-populations of employed older females and males. Table 5 shows the results of the Regression analysis.

Table 5
Results of Binary Logistic Regression on Survey Data

Variables	Model 1 (All Persons)			Model 2 (Female)			Model 3 (Male)		
	Exp(B)	Std. Error	t-value (p-value)	Exp (B)	Std. Error	t-value (p-value)	Exp (B)	Std. Error	t-value (p-value)
Sector (Rural)	3.963***	0.290	18.81 (0.000)	1.656***	0.245	3.4 (0.001)	4.973***	0.404	19.72 (0.000)
Gender (Female)	0.588***	0.055	-5.7 (0.000)						
MPCE (<=30th Percentile)	1.223**	0.123	2.0 (0.045)	1.431**	0.239	2.14 (0.032)	1.196	0.144	1.48 (0.139)
Household Size	1.069***	0.021	3.38 (0.001)	1.156***	0.043	3.86 (0.000)	1.044	0.023	1.92 (0.055)
General Education Level (Below Primary)	2.019***	0.166	8.53 (0.000)	1.533**	0.302	2.17 (0.03)	2.055***	0.187	7.93 (0.000)
Age (71Yrs and Above)	0.883	0.095	-1.15 (0.250)	1.071	0.251	0.29 (0.768)	0.824	0.099	-1.61 (0.107)
Social Category (ST)									
Social Category (SC)	0.472***	0.080	-4.41 (0.000)	0.518**	0.150	-2.27 (0.023)	0.443***	0.090	-4.02 (0.000)
Social Category (OBC)	0.514***	0.078	-4.38 (0.000)	0.441***	0.116	-3.12 (0.002)	0.525***	0.096	-3.53 (0.000)

Social Category (Others)	0.596***	0.095	-3.24 (0.001)	0.803	0.232	-0.76 (0.448)	0.538***	0.104	-3.22 (0.001)
Marital Status (Currently Married)									
Marital Status (Never married)	1.113	0.455	0.26 (0.793)	0.938	0.503	-0.12 (0.905)	1.064	0.514	0.13 (0.897)
Marital Status (Widowed)	1.042	0.105	0.41 (0.684)	0.815	0.120	-1.38 (0.168)	1.324**	0.188	1.98 (0.048)
Marital Status (Divorced/ Separated)	1.319	0.660	0.55 (0.580)	1.361	0.978	0.43 (0.668)	0.956	0.623	-0.07 (0.945)
Constant	0.963	0.184	-0.19 (0.846)	1.089	0.385	0.24 (0.808)	0.938	0.217	-0.28 (0.783)
Number of Observations	11,117			2763			8354		
Population/Sub-Population Size	33,068,817			7,688,800			25,380,017		
F-value (p-value)	50.93*** (0.000)			5.89*** (0.000)			56.24*** (0.000)		

Source: Computed using PLFS Unit Level Data - 2023-24

*** Significant at 1 per cent level ($p < .01$), **Significant at 5 per cent level ($p < .05$)

Note: a. Dependent Variable (LMV_Group) encoding: Vulnerable-1, Non-vulnerable- 0.

b. Constant estimates baseline odds.

c. Reference categories for all independent variables are as follows: Sector- Urban, Gender- Male, MPCE>30th Percentile, General Education Level- Primary and above, Age- 60< and <=70 Yrs, Social Category- ST, Marital Status -Currently Married.

When binary logistic Regression is run in Stata on survey data, it reports an F-value, which is the design-adjusted Wald test statistic for the overall model, with the null hypothesis that all predictors have no effect. It evaluates whether the model with predictors fits significantly better than a model with only the intercept. For all three models, the F-values were significant, so the null hypothesis that all regression coefficients were zero and that the predictors did not improve the model was rejected.

The exponential values of the binary logistic regression coefficients [Exp (B)], their standard errors (survey design-adjusted), t-statistics, and p-values for all three models are shown in Table 5.

For model 1 (all persons), all variables except age and marital status were significant. For the variable Gender, the value of Exp (B) was 0.588 (<1), indicating that older females who were employed had 41.2 per cent lower odds of being vulnerable in the labour market compared to older males, controlling for other variables. Older females usually worked in better locations than older males. Older males mainly worked as self-employed own-account workers and had unstable income and full risk with no social security. In rural areas, they worked more in open fields or in unstructured settings.

Persons from rural areas have 3.96 times higher odds of being vulnerable compared to persons from urban areas. If we compare model 2 with model 3,we can state that rural residence was more strongly associated with vulnerability among older males than among older females. According to the 2011 Census, almost 71 per cent of older adults live in rural areas (International Institute for Population Sciences & United Nations Population Fund, 2023), thereby exacerbating their vulnerability.

If a person belongs to a household with MPCE below or equal to the 30th percentile, the odds of being vulnerable are 1.22 times higher compared to a person from a household with MPCE above the 30th percentile. This variable is not significant among older males, but the association between MPCE level and vulnerability is stronger

among older females than among all older adults. This indicates that older persons with poor backgrounds suffer more in the labour market, too, especially women. They bear the double burden of being poor and having precarious job conditions in the labour market.

For household size, each additional household member increases the odds of vulnerability by 1.069, and this association is stronger for females than for males. So, it can be stated that older females from larger households were more prone to labour market vulnerability, as they had to work even under harsh conditions to earn more income.

If a person has acquired a general education below the primary level, the odds of being vulnerable are 2.019 times higher than for a person with a general education above the primary level, and the association between this predictor and vulnerability is stronger among males than among females. The older adults below the primary level had inadequate regular income opportunities in the labour market and were more engaged in subsidiary activities. They worked under harsher conditions at construction sites, in open areas, and on streets.

An older person of any category other than the ST category, no matter whether male or female, has lower odds of being vulnerable compared to an older person of the ST category. Overall, 88.8 per cent of employed older persons fromthe ST category were found labour market vulnerable, whereas this percentage was 76.1 per cent for SCs, 74.3 per cent for OBCs, and 70.8 per cent for Others.

The marital status predictor was not significant across all reference categories in any of the three models, except for widowed in model 3 (males). A widowed older male had higher odds of being vulnerable in the labour market compared to a currently married male. The widowed older male had low requirements, and if he had to do care work himself, he got less time for paid jobs. Otherwise, it can be concluded that marital status was not an important predictor for labour market vulnerability of employed older adults.

Conclusion

In conclusion, the study underscores that labour market vulnerability among older adults in India is a layered and intersectional phenomenon shaped by gender, socio-economic background, education, household structure, and rural–urban divides. While older men often endure harsh and precarious working conditions as sole proprietors or own-account workers, older women remain largely excluded from the labour market due to unpaid caregiving and household responsibilities, with those engaged often confined to unpaid family-helper roles. This apparent lower statistical vulnerability of older women compared to men masks deeper structural disadvantages and long term economic sacrifices. Ageing amplifies pre existing inequalities accumulated over the life course, leaving those from marginalised groups, low expenditure households, and with limited education most exposed to precarious employment. The findings reject simplistic interpretations based on age or gender alone and call for nuanced, targeted policy frameworks that provide universal, gender sensitive pensions, flexible, decent work opportunities; and recognition of the heterogeneity of older adults' work experiences. Ultimately, ensuring secure income sources and dignified employment for older persons—especially women—can offset entrenched disadvantages, promote financial independence, and enable ageing with dignity in India's evolving socio economic landscape.

Acknowledgement : The author acknowledges the constructive suggestions from the faculty members of the Institute of Development Studies, Jaipur, which helped enhance the clarity and rigour of this study.

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Indian Journal of Gerontology
2026, Vol. 40, No. 4, pp. 659-685
ISSN : 0971-4189, UGC No. – List B, Science –121
DOI: 10.5958/0971-4189.2026.00012.7

Ageing, Vulnerability and Dignity: Looking Through the Lens of Mental Health Challenges

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ABSTRACT

With the unprecedented growth in the elderly population, the challenges of ensuring their overall well-being have changed considerably. While age-related health and economic problems are unequivocal, other social disabilities and mental health burdens often make many elderly people vulnerable to deprivation of fundamental human rights, including the right to social security and life with dignity. The promotion of their mental health issues has, however, been a neglected aspect in the public healthcare systems in India. This paper attemptsto comprehensively examine the complex interplay between ageing and mental health challenges among elderly people. The paper draws evidence from a variety of sources– macro-level databases on the status of the elderly population in India, recent large-scale surveys on the problems of the elderly population in India, a scoping review on psychological well-being of elderly people, psychosocial theories on ageing, empirical evidence on mental health

challenges among elderly people in India, macro level data and relevant literature on various forms of abuse and violence against elderly people, and vulnerabilities to age-related problems due to intersection of ageing and other identities. The paper argues that age-related mental health challenges among many elderly people are linked to familial and social circumstances. The dependent position, coupled with the socio-economic shifts in traditional family and community structure and changing social perceptions of elderly people, often makes them subject to deprivation of caretaking and emotional support. These have greater implications for many substantive aspects of meaningful life, leading to low life satisfaction and mental health challenges. The paper underscores the need for targeted interventions, integrated healthcare, and community outreach services to enable elderly people to enjoy the right to life with dignity.

Keywords : Elderly, Vulnerability, Well-being, Meaningful life, Life with dignity

Ageing is an inevitable reality of human life. Physical and mental changes are a natural, irreversible part of ageing. These changes are very often interconnected. Elderly people are more likely to experience several physical and mental conditions at the same time. As a result, they have well-being disadvantages compared with other age groups. The faster growth of the ageing population in recent decades, driven by increased life expectancy and declining birth rate, raises global concerns about healthcare services, social protection, and the overall well-being of elderly people. As countries recognise ageing-related challenges, most are reformulating action plans to support the welfare and well-being of senior citizens.

Although India's policy initiatives on elderly people have largely been guided by the constitutional mandate on the well-being of senior citizens and their 'right to life with dignity' (Article 41), in recent times,

other driving forces have reasonably influenced and strengthened them. From a broader perspective, India's commitment to global conventions on population ageing, and the Sustainable Development Goals (SDGs) related to healthcare, social security and social inclusion of vulnerable groups, including older people (United Nations, 2015), has encouraged the government of India to incorporate various principles into its national policies and programmes on senior citizens. In recent years, recommendations from the World Health Organisation (WHO, 2021, 2023) and other United Nations entities (United Nations, 2025) on promoting the economic and social security of older persons have also influenced the Indian government's policy responses and action plans.

In pursuance, in pursuance of the constitutional rights of elderly people, India formulated its first National Policy on Older Persons (NPOP) in 1999 (MoSJE, 1999) and laid down a specific support system to address the various challenges faced by older persons. In line with the NPOP, the National Council for Older Persons (NCOP) was established in 2005 to serve as an advisory body for formulating policies and programmes. Later, the NCOP was reconstituted as the National Council for Senior Citizens (NCSC) to work in association with the Ministry of Social Justice and Empowerment (MoSJE). However, for the first time, the government of India enacted the 'Maintenance and Welfare of Senior Citizens Act' (MWSCA) in 2007 (MoLJ, 2007) to provide more effective provisions for the protection of the rights and interests of senior citizens, and to ensure need-based maintenance to enable them to lead a life of dignity and respect.

Recognising the rapid growth of India's elderly population, their greater dependence on children, and rising social deprivation and exclusion, the government of India introduced the National Policy for Senior Citizens (NPSC) in 2011 to create mechanisms to support their diverse needs (MoSJE, 2011). In a similar vein, keeping in view the increased complexity in addressing a variety of challenges faced

by elderly people, and the limitations of the MWSCA, 2007, the Amendment Bill in 2019 was brought to expand the scope of the Act to ensure healthcare, safety, and security for senior citizens to lead a life with dignity (MoSJE, 2019). Subsequently, an Amendment Bill was introduced in 2023 to strengthen the legal protection, maintenance, and welfare of elderly individuals in India, leading to the 'Maintenance and Welfare of Senior Citizens (Amendment) Act' (MoSJE, 2023).

Aligned with national legislation and policies on elderly people, various umbrella schemes have been implemented over the years under different ministries to improve their quality of life (PIB, 2025). However, most focus specifically on health and economic needs. Despite the fact that national policies recognise mental health issues to ensure a meaningful life for elderly people, there has been an overriding impression that provisions for economic support and healthcare services will take care of their mental health issues, leading to limited targeted interventions for the promotion of their mental health. In the discourse of social science research, while many studies examine the healthcare and economic problems faced by elderly people in India, the issue of mental health challenges is commonly discussed in the margins.

Other than health and economic conditions, psychological changes in adulthood and changes in the social lives of elderly people significantly affect many substantive aspects of their lives. Given that the overall well-being of elderly people is affected by many social and familial factors, such as interpersonal relationships in the family, sense of belongingness, social relationships, social engagement, and so on, an understanding of the mental health challenges of elderly people can help develop a holistic view of the extent of disadvantages suffered by elderly people in India. WHO (2023) recognises that understanding the mental health challenges of elderly people, helping them manage and improving their quality of life is key to 'healthy ageing'. This paper aims to enhance understanding of ageing-related

risk factors and to comprehensively examine the mental health challenges elderly people in India commonly encounter and their likely implications for their lives. This would advance understanding of ageing-related risk factors that make elderly people vulnerable to the deprivation of many fundamental human rights, including the right to life with dignity.

The Focus and Methodological Approaches

Recent studies on ageing in India affirm that most elderly people depend on others for everyday care (Agewell, 2021; IIPS, NPHCE and MoHFW, 2021; NSO, 2021; IIPS and UNFPA, 2023; NITI Aayog, 2024). With the increased social dependency of elderly people, the situation becomes complex because of changes in family norms and traditional social values, and the decline of traditional support systems. Many elderly people live with their families and receive care and support. However, there are many elderly people who either experience neglect and discrimination within their families or live alone and look after themselves. These situations are more likely to affect psychological well-being, raising the question of mental health challenges.

It is reported that anxiety and depression are the most prevalent mental health issues among many older persons (WHO, 2020; Verma & Chaudhary, 2026). According to the WHO (2020), nearly 15 per cent of elderly people worldwide struggle with some form of mental health problems, and this is more so in developing countries like India, where one in every five elderly people experiences mental health concerns that are not a normal part of ageing. It is expected that the number of elderly people suffering from mental health problems will continue to increase in most of the countries, including India. It is estimated that up to 63 per cent of older persons with mental health problems do not receive the services they need.

Mental health is a state of psychological well-being that enables people to cope with life stresses (WHO, 2020). The recent idea of promoting 'healthy ageing' recognises that psychological well-being

becomes a protective factor in physical health and has intrinsic and instrumental value (WHO, 2020, 2023). The global well-being framework (OECD, 2024) also provides a powerful lens for the same, which maintains that for a meaningful life, there is a need to move beyond narrow output measures (material well-being) toward frameworks that value what truly counts– freedom, security, dignity and agency.

This paper revolves around a few assumptions. *Firstly*, welfare and well-being are relevant to the quality of life in old age. In line with the ideas of Netuveli and Blane (2008), there is a need to consider the framework that combines 'objective conditions' (health status, economic aspect and living conditions etc.) along with 'subjective experiences' (life satisfaction, emotions, and sense of purpose etc.); and 'relational/social aspects' (sense of belongingness, resilience, motivation to thrive, etc.). *Secondly*, when the fundamental demographic shift in ageing is 'adding years to life', the most critical question relating to 'healthy ageing' (WHO, 2023) is 'does it add life to years?' *Thirdly*, in line with the global well-being framework (OECD, 2024), 'human well-being encompasses not only the ability to live but also the kind of lives they value'. Thus, mental health among elderly people is critical to enabling positive adaptation to changes in the ageing process.

This paper is an attempt to provide a comprehensive examination of ageing-related mental health issues that elderly people in India commonly encounter and likely impact of these on their lives. The specific objectives include— (i) reflecting on the salient features of ageing in India and mental health concerns for the elderly people; (ii) providing empirical evidence of mental health problems of elderly people in terms of feelings of mental stress, worries about future life, and overall life satisfaction, besides the experiences of neglect, abuse and discrimination; (iii) examining patterns of abuse and violence against elderly people and its likely mental health consequences; (iv) understanding the intersection of ageing and other identities and

vulnerabilities to social disabilities and mental health problems of elderly people.

Evidence draws on an eclectic approach that incorporates different data sources. Macro-level databases such as the Census, 2011, National Sample Survey (NSS), 2018, the Periodic Labour Force Survey (PLFS) 2018-19, the National Health Profile (2019) and the National Commission on Population Report, 2020 are used to reflect on the status of the elderly population in India. These are supplemented by recent large-scale survey reports on ageing and the problems faced by elderly people in India. While a scoping review of literature on psychological well-being and mental health issues among elderly people is used to provide a context for discussion, empirical evidence is used to reflect the experiences of neglect, abuse, and discrimination among elderly people in India and the mental health challenges encountered by them. Data on various forms of crimes against senior citizens of India, provided by the National Crime Record Bureau (NCRB), is used to reflect on the increased vulnerability of elderly people in India to various forms of abuse and violence. Lastly, the National Sample Survey data and relevant literature are used to examine the intersecting disadvantages among elderly people and their adverse effects on mental health.

The following sections deal with the key features of aging in India, an overview of mental health challenges among elderly people, empirical evidence of various aspects of psychological well-being among elderly people in India, human rights violations in the forms of abuse and violence against elderly people in India and poor access to social justice, which is likely to have a significant impact on the mental health of elderly victims as well as other elderly people, and intersecting disadvantages among elderly people, exacerbating the vulnerability to r mental health challenges.

Ageing in India: Macro-level Reflections

Like many developing countries, India is witnessing faster growth in its elderly population. According to the Census data, the percentage

share of elderly persons (aged 60 years and above) in India increased from 7.5 per cent in 2001 to 8.6 per cent in 2011. The projected share of the elderly population in 2021 was 10.5 per cent, and it is expected to increase to 15 per cent in 2036 and to 21 per cent in 2050 (United Nations, 2022; IIPS and UNFPA, 2023). This is mainly attributed to increased life expectancy; for example, it rose from 50 in 1970-1975 to 69 in 2014-18 (National Health Profile, 2019; National Commission on Population, 2020). With higher life expectancy among elderly females in India, they are expected to constitute a disproportionately larger share of the elderly population in the coming decades.

With the significant increase in the elderly population, undoubtedly, old-age dependency has increased. A majority of elderly people in India are dependent on others in everyday maintenance and live without any financial security, putting many elderly people in a vulnerable situation. According to census data, the dependency ratio for older persons in India increased from 11.8 per cent in 1991 to 14.2 per cent in 2011. The National Commission on Population Report, 2020, projected the dependency ratio of 16.1 per cent in 2021 and expected it to increase to 20.1 per cent in 2031. The dependency ratio varies for elderly males and females, indicating higher dependency among elderly females.

Old-age dependency can be understood through the participation of elderly persons in economic activities. According to the Periodic Labour Force Survey (PLFS) data for 2018-19, about 65 per cent of elderly men and 18 per cent of elderly women in the 60-64 age group participated in economic activities. Participation declined among elderly men and women aged 65 years and above. The data on old age vulnerabilities (IIPS, *et al.*, 2021) revealed that while 24 per cent of older persons faced restrictions in activities of daily living, almost a similar percentage had multiple morbidities, and about 19 per cent had no income, leading to living with poverty.

These data suggest that caregiving for older family members is vital. However, rapid modernisation and changing family norms have significantly altered the traditional family structure and function in India, leading many young and adult members to adopt a modern lifestyle of living alone, valuing privacy and freedom, and adopting an individualistic mindset. Many leave their families for better opportunities and a decent life. This sometimes creates a lack of caregivers for older family members. In many cases, must take care of themselves and adjust to their lives, creating alienating living conditions for older persons and deeply affecting their emotional well-being. Thus, the growth of the elderly population in India has significant implications for the healthcare, economic, social and psychological aspects of elderly life.

Ageing and Mental Health: Conceptual and Theoretical Frameworks

Conceptual frameworks on ageing recognise it as a multidimensional process. At the individual level, physiological ageing is associated with a decline in the functional capacity of the body's organs, while psychological ageing is a process in which a person loses mental ability, primarily due to deterioration of bodily systems. Mental health problems can sometimes deteriorate in response to physical health issues. In other words, poor physical health, chronic illnesses and lack of access to quality healthcare services can affect mental health. The most common idea is that mental health problems in old age stem mainly from physical decline and loss of economic independence. Conversely, psychological trauma or mental pressure can cause poor physical health, which is often reflected in the body as an unnatural process.

Elderly people also experience social ageing, in which they take up responsible roles depending upon their age status in society (Muttagi, 1997; Sahu & Subudhi, 2019). It is commonly used to determine the demographic classification of individuals for social security, welfare measures, or other age-group decisions. Socially,

many traditional aspects of elderly people's lives sometimes erode, leaving them without a meaningful role within the family or community. This limits social connectedness and often makes them feel alienated. The relationship between ageing and mental health can thus be understood through physiological, psychological, and social effects. According to WHO (2023), a diverse set of individual, community and structural factors can protect or undermine the mental health of elderly people. Besides the health-related changes, community-related factors such as limited social interactions and community support, and structural factors such as exposure to adverse social environments, including stigma, ageism, discriminatory treatment, and violence, are the key risk factors that shape the mental health of elderly people.

However, the mental health challenges that come with age, often due to cumulative and cyclic effects of physical, economic, and social problems, can be minimised by 'healthy lifestyles' (WHO, 2023). Social connection and meaningful social activities can improve mental health, life satisfaction and quality of life (WHO, 2025). According to the OECD (2024), social and human capital can strongly determine resilience and enable positive adaptation to physical, economic, and social changes, as well as support positive mental health. Psychologists interested in the human ageing process identify various adaptive changes that help people cope with mental health challenges. Psychosocial theories explain how a positive outlook on self and subjective perceptions of cognitive changes, social interactions, community attachment, and social roles can influence the ageing process and help older adults adapt successfully (Bengtson & Settersten, 2016).

Among the key psychosocial theories on ageing, the activity theory (Havighurst & Albrecht, 1953) explicates that engagement of older individuals in fulfilling activities (beyond routine physical or personal maintenance) and patterned actions that provide a feeling of being part of society or social life can enable them to better adjust to old age, greater life satisfaction and healthier lives. The

disengagement theory (Cumming and Henry, 1961), however, emphasises the interaction between elderly people and others in the social system one belongs. The continuity theory of ageing (Havighurst, Neugarten and Tobin, 1963) posits that ageing is not viewed as a terminal or final part of life separated from the rest of life. It is a continuation of earlier life and should be an integral part of the entire life cycle. Accordingly, elderly people need to try to maintain or continue previous habits, preferences, values, beliefs, relationships and other issues that have contributed to their personalities. However, because older persons vary in age and background, theories in both physiological and psychosocial categories may not always fully explain the ageing process and successful ageing.

Elderly and Mental Health Challenges: Empirical Insights

Undoubtedly, mental health of the elderly is an important issue in understanding their overall health situation. According to WHO (2020), untreated mental health problems can lead to diminished functioning, slow healing of physical illness, poor quality of life, and increased premature mortality. Mental health is often understood in terms of psychological well-being, which is affected by many risk factors beyond physical health problems. Psychological studies have shown that mental health problems are much more serious among the elderly, even when they have good physical health and economic security. These are often exacerbated by reduced emotional support from their own people and perceived discrimination, which affects how they cope with life challenges (Singh & Upadhya, 2014; Singh & Kaur, 2025). Unmet developmental needs and expectations can lead to inappropriate social behaviours and psychological problems (Sathyanarayana & Shaji, 2007; Singh & Kaur, 2025).

Although the age-related inequalities reflect how older people differ from other adults in several indicators of quality of life, they have unique mental health challenges. The feelings of loneliness and social isolation have been widely recognised as a contributing factor

to mental health decline in the elderly (Bashar, Begam and Gnansekaran, 2025). However, these are not merely a reflection of being alone but a deeper sense of emotional isolation and suffering, which act as key risk factors for mental health conditions (WHO, 2023). HelpAge India (2024) recognises that elderly loneliness is an emerging public health challenge.

Evidence suggests that elderly loneliness in India is caused mostly by vulnerability to indifference, neglect, discrimination, abuse and negative perceptions, and these result in psychological distress, worries, and feelings of helplessness (Singh & Misra, 2009; Halder, Das, and Samajdar, 2026; Verma & Chaudhary, 2026). Moreover, social isolation is linked to the risks of physical and emotional abuse, which often go underreported or unreported due to stigma (HelpAge India, 2014). As a result, mental health issues are very often underdiagnosed and unaddressed, having adverse effects on overall well-being.

In a recent study (Mamgain, 2025), data collected from more than one thousand elderly respondents in the state of Uttarakhand, India revealed that about one-third reported poor psychological well-being. While one-fourth of the elderly respondents reported mental stress, one-third of them were worried about their own life, suffering from an incurable disease in future due to old age and a fear of death, indicating a negative status of mental health. These were further reflected through poor emotional well-being, with the social experiences of the death of other elderly persons. More than half of the elderly respondents worried about their families' future after their death. Data on life satisfaction revealed that about 40 per cent of the elderly were not satisfied with their present life.

As mentioned earlier, physical and economic problems of elderly people, along with other social disabilities (living alone, ageing-prejudice, differential treatment, neglect, conflicts with family members, abuse, and so on), often cause mental health problems. The above study revealed that 10 per cent of elderly respondents reported the

experience of physical abuse, whereas 14 per cent reported verbal abuse, and another 11 per cent reported mental abuse. While 18 per cent of elderly respondents reported that family members disobeyed their suggestions, a similar percentage reported restrictions on social interactions. Notably, 12 per cent of the elderly experienced perceived uselessness and 14 per cent experienced neglect of medical care. A relatively higher percentage of the elderly in rural areas, as compared to the elderly in urban areas, reported the experiences of verbal abuse, disobedience of their suggestions and restrictions on social interactions. These experiences are linked to a life of dignity and self-respect. The study revealed that about half of the elderly had access to mental health support at the time of need. About 11 per cent of the elderly reported needing such support but not receiving it; the remaining did not need it.

Evidence thus showed that while a relatively higher percentage of elderly persons in India reported poor psychological well-being in terms of mental stress, anxiety over their own life and the future of families and life satisfaction, a smaller percentage of the elderly reported the experiences of neglect, abuse, and discrimination. The latter should be viewed in light of the elderly's subjective experiences within the family, which may not reflect reality, given their dependence on others and the traditional value system of not speaking about family matters that could disgrace the family's social status.

Elderly and Vulnerability to Abuse and Violence

The issue of various forms of abuse and violence against older persons is a global problem. These take place in all types of settings– families, communities, care institutions and public spaces. These violations of human rights can have severe consequences. The Human Rights Council Resolution identifies combating them as a priority area under international law (OHCHR, 2025). Many countries have specific legal provisions addressing different forms of human rights violations against older persons. The World Health Organisation estimates that one in six people over the age of 60

years experienced some forms of abuse– physical, verbal, psychological, financial and neglect- in community settings (WHO, 2020). These can lead to serious, long-lasting mental health consequences. However, manifestations of the abuse and violence often go unnoticed or unreported for various reasons. The underreporting of experiences of abuse and violence by older persons, presumably due to fear of the abusers/perpetrators, is an important issue. The lack of reliable data often remains a major obstacle in developing action plans and addressing abuse and violence against older persons effectively. In India, the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 (MWPSCA, 2007) requires State governments to develop action plans to ensure the safety and security of senior citizens and eliminate all forms of abuse and violence, enabling them to live with freedom and dignity. It is critical to understand the magnitude and patterns of abuse and violence against older persons, as these are important risk factors for mental health consequences.

The National Crime Victimisation Survey of the National Crime Record Bureau (NCRB) provides data on crimes against vulnerable groups, including senior citizens or older persons. Crimes against older people involve intentional acts by others, including caregivers, family members and acquaintances. The NCRB data reveals that common offences against the elderly include abuse, mistreatment, physical harm, economic offences, harassment, intimidation and intentional isolation. However, the NCRB does not report the reasons for these crimes (PIB, 2021). While much is written about violence against socially marginalised groups, women and children, the incidents of violence committed against older persons have, however, not drawn similar attention. Many forms of abuse against elderly people are sometimes recognised as types of domestic violence. Moreover, while a variety of circumstances are considered abuse against older persons, it does not include criminal activities or acts of violence against them.

However, evidence shows that abuse and violence against elderly people lead to severe consequences and long-term psychological consequences, such as distress, generalised anxiety, loss of dignity and respect, and other mental health problems. Studies in India show that elderly people remain vulnerable to a variety of abuses and violence, and these have a significant impact on the well-being of elderly victims (Mishra & Patel, 2013; HelpAge India, 2014; Patel, 2020; Patel & Mishra, 2025; Shankardass, 2025). Social experiences of crimes and violence inflict fear in the minds of many older persons and affect their way of life and overall well-being.

Drawing evidence from the NCRB data on crimes against senior citizens in recent years, this section provides insights into the magnitude, patterns and trends of various forms of crimes or violence against elderly people, to reflect on their vulnerabilities to human rights violations. The NCRB data revealed that, on average, more than 26.5 thousand cases of crimes against senior citizens (aged above 60 years) were registered annually between 2018 and 2023. This rose from 24.4 thousand in 2018 to 28.5 thousand in 2022 and 27.9 thousand in 2023, an increase of about 15 per cent over the six years. Interestingly, in line with global reports of higher incidence of crimes against elderly people during the COVID pandemic (HelpAge International, 2021; WHO, 2023; OECD, 2024; OHCHR, 2025), NCRB data showed a sharp increase in the number of crimes in India between 2018 and 2019.

Data on the yearly average number of different registered crimes during 2018-2023 indicated that physical hurt constituted the highest share of total crimes (7.8 thousand), of which most cases were simple hurt (86.5 per cent), leaving 13.5 per cent as grievous hurt. The yearly average of economic crimes such as theft and robbery constituted the second-highest number (4.8 thousand). On average, about 2.8 thousand social crimes, such as forgery, cheating, and fraud, and 2.4 thousand psychological crimes, such as criminal intimidation (42 per cent) and trespass (38 per cent), were registered. On average, about

1.6 thousand elderly remained vulnerable to the heinous crime of murder (73 per cent) and attempt to murder (27 per cent). Although data showed a small percentage share of assaults on elderly women to outrage their modesty, it still suggests that many elderly women remain vulnerable to violence in public spaces. The trend of various crimes showed that the highest percentage increase was for forgery/ cheating/fraud (69.2 per cent), followed by criminal intimidation and trespass (49.4 per cent), assault on a woman to outrage her modesty (46.7 per cent), physical hurt (36.9 per cent) and murder and attempt to murder (17 per cent) whereas the economic crimes such as theft and robbery showed a declining trend.

Given the limitation in the absolute number of registered crimes to understand the magnitude of crimes, the rate of crimes (indicating the number of cases reported per one lakh elderly persons), commonly taken as a realistic indicator, showed an annual average rate of 25.6 and an increase from 23.4 in 2018 to 26.9 in 2023. However, the registered cases of various forms of crimes against elderly people can be an underestimation of the actual prevalence. As mentioned earlier, many elderly people do not intend to report abuses due to the fear of its negative ramifications or are forced not to register. Notwithstanding this, data helps in promoting an understanding of the patterns and trends of different forms of crimes and the vulnerability of elderly people to human rights violations.

Given the rise in crimes or violence against elderly people, the critical question is what has been the response of the state machinery? Police disposal of registered cases indicated that, on average, 41.5 per cent of cases remained pending annually at the police station during 2018-23, meaning many cases could not be charge-sheeted. Importantly, of the charge-sheeted cases, on average, over 90 per cent remained pending for trial in courts at the end of each year. Despite the obligation of the criminal justice system to ensure justice for the elderly victims of crimes, on average, in less than one-third of cases, the perpetrators of crimes against elderly people were

convicted. The critical issue is that the conviction rate declined considerably, from 38.3 in 2018 to 23.4 in 2023. Thus, many elderly people continue to remain vulnerable to the various forms of oppressive behaviours, and they have poor access to social justice. All these deprive them of many human rights and create social environments that have long-lasting mental health consequences.

Ageing and Mental Health Challenges: Intersecting Issues

This section reflects on how the positions in which elderly people experience marginalisation, deprivation and mental health problems are likely to differ based on the interplay of ageing with social perceptions and other identities. It is the fact that at the core of the marginalisation of many elderly people is not simply age, but other intersecting forms of discrimination (Sorinmade, Elugbadebo and Peisah, 2025). The UN Human Rights Council recognises that 'human rights violations against older persons are often rendered invisible due to the pervasiveness of 'ageism' (age-based avoidance, discrimination and inaccurate stereotypes and prejudices)' (United Nations, 2019). Ageism acts as a systemic barrier that limits access to older people's rights (United Nations, 2020; HelpAge International, 2021; WHO, 2021; Soares, 2025). Discrimination also takes place based on perceived physical or cognitive limitations, known as 'ableism'. Besides, discrimination occurs based on mental illness or perceived incapability, known as 'mentalism'. This can compound the other two—ageism and ableism —leading to severe marginalisation (Rabheru & Gillis, 2021).

The interlinkages among these social and behavioural manifestations can be understood from the framework of 'layering'. An older person with poor health or complex health needs (for example, with chronic conditions, i.e. severe physical and mental illness and mobility issues), can face multiple layers of discrimination and social prejudices— ageist bias and being dismissed as 'too old' (ageism), perceived functional inabilities (ableism), and perceived as 'incapable' (mentalism). These layers are rooted in widespread

societal ignorance and a lack of understanding of the ageing process (Failde Garrido *et al.*, 2019). These often hinder access of elderly people to fair healthcare and treatment, and affect their quality of life.

Within the ageing population, certain groups such as elderly women, single elderly individuals, the elderly from socio-economically disadvantaged groups, and the elderly with disabilities are more likely to face particular intersectional issues. Interestingly, among older persons, many of those reporting mental health issues are in the 60–70 age group (Verma & Chaudhary, 2026). This suggests that the early phase of elderly life, especially when adjusting to living alone, may be particularly vulnerable to psychological problems. Elderly women often experience more mental health issues than their male counterparts. Mamgain (2025) found that elderly women were more vulnerable to perceived uselessness and restrictions on interactions and had lower life satisfaction and poorer psychological well-being than elderly men. Elderly women also live at a higher risk of abuse and violence (Patel, 2020). According to Victor *et al.,* (2005), the primary mental health challenges among elderly women stem from emotional distress, a sense of helplessness, difficulties in social adjustment, isolation, and the perception of being undervalued by both family and society. Mental health problems among elderly women have been found to be highly true for the single elderly women.

Given that elderly women constitute a disproportionately higher share of older persons, especially at advanced ages due to the higher life expectancy (IIPS and UNFPA, 2023), they are more likely to live alone due to higher levels of widowhood and face an emotional void in their lives. The absence of a partner can create numerous daily challenges because of a lack of mutual emotional and financial support, along with the stigma often associated with living alone. Most studies indicate that elderly individuals living alone, especially widowed women, are more vulnerable to depression and loneliness because of being deprived of a long-term emotional bond compared to women those living with others (Verma & Chaudhary, 2026).

Similarly, Srivastava *et al.* (2021) found that widowed elderly women living alone were 56 per cent more likely to experience depression compared to their married co-residing counterparts. They also found that widows report higher levels of anxiety and depression, the most common manifestations of mental health problems, compared to widowers. Consistent with the findings that elderly women experience higher mental health problems, it is found that a higher percentage of elderly women than men seek support for mental health issues (Mamgain, 2025), with widows forming the majority (Verma & Chaudhary, 2026).

The social and economic concerns and the status of economic dependence very often affect the well-being of older persons, resulting in poor mental health. Many elderly persons from socio-economically disadvantaged households, particularly in rural areas, are found to be more vulnerable to mental health issues (Mamgain, 2025). A higher percentage of elderly people in rural areas reported experiences of verbal abuse. It is reported that the intersection of ageism, ableism, and socio-economic marginalisation contributes to disabled older persons having limited access to routine and preventative healthcare (Branco, Ramos and Hewstone, 2019), often exacerbating the vulnerability to other mental health problems.

The UN Convention on the Rights of Persons with Disabilities (EHRC, 2009) ensures that disabled people enjoy full human rights, equality, non-discrimination and dignity. The age-disability matrix suggests that disability prevalence is closely linked to age (Agewell, 2021; IIPS and UNFPA, 2023). With the onset of ageing, people become more susceptible to physical disabilities due to chronic diseases, sometimes leading to multiple disabilities. According to the National Sample Survey data (NSS, 2018), more than half of elderly persons in India suffer from a physical disability and have undergone treatment. Since the majority of the elderly with disabilities (EwD) are unable to work, many of them are sometimes neglected by their own people because of the caregiving burden and many times, they

are left on their own. The intersection of ageing and disability thus increases economic vulnerability and other social disabilities, such as neglect and abuse, and they find themselves in a helpless situation, often leading to other psychological problems. The identity of the elderly with disabilities is further affected when they are not in a position to fight their disability economically. They become helpless, depend on public charity to survive, and resort to begging. Evidence shows that a substantial proportion of elderly people who are found begging are persons with disabilities (Verma, 2020). The interface of ageing, disability, and begging suggests that it is not always physical conditions like disability or elderliness, but also the emergence of individualistic considerations, neglect by primary caretakers, and lack of access to adequate public support services. These underscore the critical need for targeted interventions for vulnerable subgroups within the ageing population.

Conclusion

The faster growth of the elderly population unquestionably poses several challenges for healthcare services and social and economic security systems. Although the mental health of elderly people is an important issue in understanding their overall health situation, it is frequently overlooked in the discourse of public healthcare systems. This paper offers insights into the complex interplay between ageing and mental health challenges among elderly people. It is evident that mental health problems among the elderly are not only age-related but also linked to other social circumstances. Many elderly people are vulnerable to neglect, abuse, discrimination, negative perceptions, and human rights violations. These result in lower levels of life satisfaction and mental health challenges. The interplay of ageing and other identities underscores the need for special support systems that recognise the diverse challenges faced by the intersecting elderly minorities. Diverse issues related to the mental health of elderly people discussed in the paper can be useful for developing measures for the promotion of positive mental health among elderly people in India

and ensuring the 'rights to live with dignity'. This aligns closely with Sustainable Development Goal 3 (SDG 3), which aims to ensure healthy lives and promote well-being for all at all ages, and with the Report on the Decade of Healthy Ageing, 2021-2030, which focuses on 'changing how people think, feel and act about age and ageing'.

This paper proposes targeted strategies to rethink healthcare reforms that support integrated health services and person-centred care, enabling elderly people to enjoy a meaningful life and live with dignity. Policy initiatives and action plans for the elderly in India need to ensure the support and care they deserve, either by involving family members in caregiving or by making alternative arrangements that provide a quality of life. Special efforts are needed to inculcate sensitivity in young children and restore the social value of caring for the elderly. This could be possible through sensitivity training programmes at school and college levels and by incorporating elderly issues into curricula. Increasing public awareness about elderly mental health problems needs to be a priority in the course of providing healthcare services, as they are rarely brought to the attention of healthcare professionals and policymakers. This would raise sensitivity to the mental health needs of the elderly among health professionals and the public at large.

Emphasising relational and social well-being can strengthen the ability to find a renewed sense of purpose in life. Community-level action can strengthen social connectedness and build social capital, which in turn fosters better mental health. Given that institutional care for mental health problems is limited in most places and is costly, and the existing community outreach services are not equipped to support home-based care of older people, alternative care services without economic costs can be a better support mechanism. The National Initiative on Care for the Elderly (NICE) aims to improve care delivery for the elderly in community settings. In this regard, specialised training in integrated geriatric care can build a stronger workforce, and trained health workers can play a

critical role in providing outreach mental health services in rural areas. Promotion of mental health programmes for the elderly, which have been a neglected dimension in healthcare service delivery systems, can be addressed through outreach programmes with the help of trained health workers. This can further be complemented with community-based initiatives such as neighbourhood support groups and elder self-help collectives. Promoting inclusive and sustainable well-being is essential to restoring the dignity of the ageing population.

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