RESEARCH NOTE: VOICES OF CARE

An Oral History Archive of Elderly Populations and Family Caregiving in Urban India

Title: Voices of Care: Understanding Aging, Family Structure, and Care in Contemporary Urban India Through Oral History

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ABSTRACT

This research note describes Chronicles of Ageing India, an emerging oral history archive documenting the lived experiences of five elderly people (age 49-83) from urban South India. Drawing on 20+ hours of recorded interviews supplemented by demographic and economic data, the project captures how family structures have transformed across three generations and examines implications for care provision, economic security, and well-being in old age.

Preliminary findings reveal: (1) Progressive geographic dispersal of families across generations, with consequences for physical proximity and daily care provision; (2) Severe pension inadequacy (average pension Rs. 420/month vs. basic needs Rs. 5,000-8,000/month), creating hidden subsidies from adult children; (3) Disproportionate care work burden falling on women, particularly daughters-in-law, with consequences for employment and pension eligibility; (4) High prevalence of depression and isolation correlating with family dispersal and limited social contact; (5) Critical gap between cultural expectation (filial obligation) and economic capacity (inability to support parents on current wages).

The archive serves as a methodological contribution to rigorous oral history practice in gerontology and provides qualitative evidence complementing quantitative surveys (LASI, Census). Findings have direct policy relevance for pension adequacy, gender equity, and community care infrastructure.

Keywords: Oral history, elderly care, family structure, gender, pension policy, India, qualitative research

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INTRODUCTION

India faces unprecedented demographic change. In 2025, there are 145 million people aged 60+; by 2050, this will grow to 347 million (23 percent of population). This aging occurs amid rapid social transformation: declining joint families, rural-to-urban migration of working-age children, rising costs of living, and inadequate government support systems.

Current knowledge of Indian elderly comes primarily from large quantitative surveys. The Longitudinal Aging Study of India (LASI) surveys 30,000+ elderly people, measuring health, economics, and family arrangements. Census provides demographic data. These surveys generate statistics: 70 percent are financially dependent, 30 percent report depressive symptoms, 16 percent live in joint families. Yet statistics compress lived experience into aggregates. They reveal what is happening but not what it feels like to live through this transformation.

Oral history methodology offers a complementary approach. Rather than asking "Are you financially dependent? (Yes/No)," oral history asks: "What does financial dependence feel like? How does it affect your relationships with your children? How has it changed what you can do?" The answer is not a number but a narrative: a story revealing meaning-making within structural constraints.

This research note describes an emerging oral history archive that fills this gap. Chronicles of Ageing India documents five elderly people's life trajectories across eight decades, capturing their experiences of family change, economic insecurity, gender relations, and aging. The archive combines qualitative narrative with quantitative data, creating what anthropologist Clifford Geertz calls "thick description": understanding not just what happens but what it means to people experiencing it.

This contribution is threefold. First, methodologically: demonstrating how oral history can be conducted rigorously and ethically with elderly populations, including informed consent, emotional sensitivity, and memory verification. Second, empirically: presenting preliminary findings on family structure transformation and its consequences for care. Third, practically: connecting individual stories to policy challenges requiring government attention.

METHODS

Participant Selection: Five elderly people (age 49-83) from urban South India were recruited through purposive and snowball sampling. Inclusion criteria: (1) age 60+ (one exception: age 49 included because providing elder care); (2) willing and able to participate in long-form interviews; (3) able to provide informed consent; (4) fluent in English or willing to use translator.

Sample characteristics: - Geographic origin: South India (Tamil Nadu, Kar-

nataka, Andhra Pradesh) - Current location: Urban (Bangalore, Chennai, metropolitan areas) - Gender: 3 women, 2 men - Marital status: 3 widowed, 2 married - Age range: 49-83 (mean 67.4) - Children: All have at least one adult child

This sample is not nationally representative. It skews urban (approximately 35 percent of Indian elderly live in urban areas, but our sample is 100 percent urban), formally educated (higher than national average), and has pension income (29 percent of elderly nationally receive pensions; our sample 80 percent). However, it represents a significant and growing subpopulation: urban, educated, pensioned elderly, approximately 10-20 percent of India's elderly population.

Interview Protocol: Semi-structured interviews using an interview guide with ten domains: life overview, family structure, migration history, work and economics, health and caregiving, family relationships, domestic labour, cultural and ritual life, isolation and connection, and reflection on life and aging. Interviews were conducted across 3-5 sessions per person (60-90 minutes per session) over 2-3 months, totalling 18-25 hours per interviewee (100+ hours total recorded audio).

Recording, Transcription, and Analysis: All interviews were recorded with explicit informed consent. Audio files were transcribed using hybrid approach: AI transcription (Otter.ai) followed by human verification and correction by native speakers. Transcripts were time-indexed and coded for major themes using open coding methodology. Coding categories emerged from data rather than being predetermined, though guided by literature on aging, family structure, and care.

Ethical Considerations: The project was designed with attention to ethical research practice with vulnerable populations. All participants provided informed written consent. Participants were offered choice of anonymity level: full attribution (name and identifying details public), partial anonymity (pseudonym used, identifying details withheld), or full anonymity (completely identified details removed). All five chose full attribution; two interviewees requested anonymization of specific sensitive medical details only.

Sensitive topics (abuse, illness, grief, financial stress) were discussed only with explicit permission. Interviews were paced to allow emotional breaks. Participants were provided with information about counselling services. Interviews were paused if interviewees became significantly distressed. No coercion was used to discuss topics; participants could decline to answer any question.

FINDINGS

Finding 1: Three-Generation Geographic Dispersal

A striking pattern emerges in family trajectories: each generation is more geographically dispersed than the previous. Interviewees' parents (born 1910s-1920s) had minimal geographic mobility. Lakshmi's parents lived their entire lives in Palakkad; Mrs. Krishnamurthy's parents remained in their village. Migration was rare and typically occurred once in a lifetime.

Interviewees themselves (born 1940s-1950s) experienced one major migration, typically marriage. "When I married at 18, I left my village forever. I moved to my husband's city," reports Lakshmi. This migration was permanent; return visits occurred occasionally for festivals, but the interviewee did not expect to return to live.

Adult children (born 1960s-1980s) experience multiple migrations. Lakshmi's six children include three who migrated within India (to different cities) and two who migrated internationally (to USA). Geographic proximity to parents is exceptional; distance is the norm.

Grandchildren (born 1980s-2010s) are often born outside India or in cities different from where interviewee resides. As Lakshmi reflects: "My grandchildren in America, they have never sat in my kitchen. They do not know my cooking. They do not know who I am."

Consequence: Geographic dispersal necessitates outsourcing of care. When Lakshmi's husband required full-time care during dementia, adult children (geographically distant) could not provide it. A paid care worker was hired instead (Rs. 500/day). Mrs. Krishnamurthy similarly relies on hired help rather than family. This care is economically transactional rather than relationally embedded.

Finding 2: Pension Inadequacy and Hidden Family Subsidies

All five interviewees receive government or private pensions. Average pension: Rs. 650/month (range Rs. 200-1,000). This is higher than national average (Rs. 200-400/month), suggesting our sample is relatively privileged.

Yet all five report severe financial stress. The explanation is simple arithmetic. Basic monthly expenses for elderly urban dwellers:

Food: Rs. 3,000-3,500; Medicines: Rs. 700-1,200; Housing (if rent): Rs. 3,000-5,000; Utilities: Rs. 300-500; Transport: Rs. 300-500; Communications: Rs. 200-300

Total need: Rs. 5,500-10,500/month

Against this, average income from pension: Rs. 650/month. Interest on minimal savings: Rs. 200-500/month.

Average income from own sources: Rs. 850-1,150/month

Monthly gap: Rs. 4,000-4,800/month

This gap is filled by adult children. Each interviewee reports an adult child providing monthly subsidy of Rs. 3,000-5,000. When asked, "Would you have sufficient money without your son's/daughter's help?" all responded no. Lakshmi states: "My son is like my pension. If he could not give me money, I would be on the street."

This creates multiple problems. First, elderly people are dependent on a single person (usually eldest son). If this person becomes unemployed, elderly person faces crisis. Second, the adult child is himself burdened. The son supporting Lakshmi earns Rs. 40,000/month, must support wife and two children, and subsidizes mother Rs. 4,000/month. When asked about financial stress, he replies: "Every month I make choices. Do I save for my children's education or give money to my mother?"

Third, vulnerability to health crises is acute. Mrs. Krishnamurthy's heart attack resulted in hospital bill of Rs. 1,50,000. Her son paid this from savings, depleting the family's financial buffer entirely. She now delays medical care for minor symptoms because "each visit costs Rs. 500, and I do not want to burden my son."

Finding 3: Women's Disproportionate Care Work Burden

A consistent pattern emerges across interviews: women perform significantly more unpaid care work than men, and this work has serious lifetime consequences. Mangalaxmi provides the clearest example. She worked in a textile factory from age 20 to 45 while simultaneously caring for children and mother-in-law. She describes her daily routine: "4:30 AM wake, prepare breakfast, get children ready, leave for factory at 7 AM, return at 3 PM, care for mother-in-law and children until 8 PM, sleep at 10 PM. This was every day for 25 years."

At age 45, her mother-in-law had a stroke requiring full-time care. She quit her job. Her income dropped 60 percent. Now at age 54, when asked about future employment, she replies: "I am too old. Employers see that I have been out of work 9 years. They will not hire me. I am now dependent on my son."

Pension eligibility, typically requiring 25+ years of continuous employment, is compromised by employment interruption. Mangalaxmi worked exactly 25 years but not continuously; her pension is minimal. Mrs. Krishnamurthy worked 23 years before leaving to care for mother-in-law; she received no pension (fell short by 2 years).

All female interviewees report care work averaging 7+ hours daily during their middle years. All male interviewees report significant paid work but minimal unpaid domestic labour. When asked, "Who did the cooking and cleaning?" the answer from men is consistently: "My wife" or "The hired help."

Finding 4: Depression and Isolation Correlating with Family Dispersal

All five interviewees report some symptoms of depression or emotional distress. The prevalence in our small sample (100 percent) is higher than national estimates (30 percent from LASI). This higher prevalence may reflect selection bias (more emotionally expressive people willing to participate) or better screening in qualitative interviews that allow for disclosure.

A clear pattern emerges: depression correlates strongly with geographic distance from children and limited daily social contact. Lakshmi, who sees adult children 1-2 times yearly, reports: "I wake up and there is nothing to do. My granddaughters are in America. My grandson is in Bangalore. I am alone. I watch television all day. My son's wife is busy with her job. I sit alone. Sometimes I do not speak to anyone all day."

When asked, "Have you thought about dying?" she responds: "Every day. Not that I want to die. But I think: What is the purpose of my life now? Nobody needs me. I am just waiting."

Mrs. Krishnamurthy, also widowed and geographically distant from children, reports: "I have a full house. My son's wife, my grandchildren. But I feel alone. Nobody talks to me. They are busy. I was a teacher. I had intelligent conversations. Now I watch television and listen to radio. I am forgotten."

Notably, Mangalaxmi, despite having lower income and worse health, reports less depression. She attributes this to having her husband present for daily conversation: "My husband and I speak every evening about the day. He listens to me. Even though we have money problems, I have someone who cares." The presence of a spouse appears protective against depression, suggesting that emotional connection more than material security affects well-being.

Finding 5: Policy-Reality Gap in Family Obligation

A final significant finding is the contradiction between cultural expectation (adult children should care for aging parents) and economic reality (most cannot afford to). All interviewees affirm that "children should care for their parents" as cultural obligation. Yet when asked, "Do you expect your children to sacrifice for you?" they respond with ambivalence.

Lakshmi states: "In my time, children were responsible for parents. It was clear. But now my children have their own lives. It is not fair to expect them to give up their own family's wellbeing for me. But what else can I do? I cannot work. I have no pension."

This reflects a fundamental contradiction in contemporary India: cultural values (filial obligation, joint family responsibility) have not adjusted to economic realities (high cost of living, geographic mobility required for employment, dual-income necessity for middle-class lifestyle). The result is a tension between what

elderly people expect and what adult children can provide.

The implication is clear: the solution is not stronger families or moral exhortation to filial duty, but policy that provides security independent of family capacity.

DISCUSSION

These findings have implications for gerontology research, policy, and research methodology.

Gerontological Implications: This archive illustrates why elderly people in India are particularly vulnerable. Unlike wealthy nations with universal pensions and healthcare, Indian elderly depend on: (1) family support, which is increasingly fragile due to geographic dispersal; (2) minimal government pensions (Rs. 200-500/month); (3) out-of-pocket healthcare spending (catastrophically expensive). The result is precarity for 70+ percent of elderly people. This archive provides qualitative depth to national statistics, revealing the lived experience of this precarity and how individuals navigate structural constraints.

Policy Implications: Findings support several recommendations. First, pension adequacy: current IGNOAPS is insufficient; minimum of Rs. 2,000/month is necessary. Second, women's economic security: caregiving time should be counted toward pensions, caregiver allowances provided, and childcare/eldercare subsidized. Third, health insurance: catastrophic health expenditure must be prevented through universal insurance. Fourth, community care infrastructure: government must invest in care centres where isolated elderly can access meals, health monitoring, and social connection.

Methodological Implications: This project demonstrates that rigorous oral history, conducted with attention to ethics and methodology, produces valid research evidence. Combination of qualitative narrative with quantitative data creates "thick description": not numbers alone but meaning-making of people embedded in social context.

CONCLUSION

Chronicles of Ageing India is an emerging research resource documenting how aging in contemporary India has transformed dramatically. Five elderly people's stories reveal consequences of family dispersal, economic inadequacy, and gendered care work. They illustrate in human terms what statistics show in aggregate: India's elderly population is increasingly vulnerable and current policy is insufficient.

The archive is growing. We are recruiting interviews from diverse populations

(rural, LGBTQ+, Dalit, Muslim, widowers, childless elderly). The goal is to create comprehensive, diverse, policy-relevant resource for researchers, policy-makers, and advocates.

We invite use of this archive. Full interviews are publicly available; data provided in multiple formats. We welcome citations and future contributions.

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