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RESEARCH

Vulnerability, Relocation and Resilience: Narratives of Older Widows in Not-For-Profit Old Age Homes in Karnataka (India)

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Abstract

Widowed women constitute a majority of India's older female population. Increasing numbers seek shelter in institutional homes. This qualitative study examines the relocation of older widows into not-for-profit old age homes in India, focusing on their motivations for moving and on resilience practices they employ in the new environment. The research took place in Mangalore, Karnataka, involving in-depth interviews with 15 widows (aged 60 and above) residing in four homes, along with interviews with five staff members and a focus group with ten ageing experts. Findings reveal that financial scarcity, accompanied by multi-level neglect by family and community emerged as the primary trigger for widows' relocation – a pattern rooted in specific gendered vulnerabilities towards existing social structures, economic conditions and cultural commitments. The decision to relocate was often initiated by the widows themselves as a means to escape severe neglect. Post-relocation, the widows experienced improved living conditions and expressed deep appreciation for the care, routine, and companionship available in the homes. These institutional environments, despite limited resources, provided safety and social support that mitigated loneliness and enhanced the women's emotional resilience to experienced stress and trauma. The study's insights underscore the importance of viewing free of charge old age homes as a potential supportive environment for vulnerable older women, especially in the context of a rapidly ageing population, decreasing social support and rising numbers of older widows. It also highlights the need for further examining how older, vulnerable women maintain a sense of functionality and dignity in later life.

Keywords Older widows · Institutional care · Population ageing · Vulnerability · Resilience · Neglect

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Introduction

Population ageing in India has a strong gendered dimension: older women are far more likely to be widowed and economically dependent compared to older men (Bharati, 2011; Mohindra et al., 2012; Mohanty & Patra, 2017). According to the Longitudinal Ageing Study in India (LASI) first wave (Bloom et al., 2021), 54% of women over 60 were widowed, versus only 16% of men, and among those women over 80, nearly 87% were widowed. This imbalance is partly due to women's greater longevity and the cultural pattern of women marrying older men. The proportion of India's population over 60 is projected to double from 10.5% in 2020 to 20.8% by 2050, reaching about 320 million people (International Institute for Population Sciences & United Nations Population Fund, 2023). As a result, the number of widows is expected to rise sharply, making widowed older women an increasingly significant demographic group and leading thus partly to a "feminization of ageing" (Kalavar & Jamuna, 2011, p.204; Cauhan, 2021). Indeed, it has been noted that "the increasing proportion of elderly women, especially widows, is a characteristic feature of India". This demographic trend raises critical questions about the well-being, care, and social support of older widows in India's rapidly ageing society.

Widowhood and Economic Security

Growing old as a woman often involves difficulties through financial insecurities, economic dependence, limited access to healthcare as well as to care (Westwood, 2018; ADB, 2024; WHO, 2025). For many older widows in India, the situation looks particularly precarious (Pandey, 2022; HelpAge India, 2023). Typically, after a husband's death, a woman's economic security is undermined because husbands are often the primary earners (Mohindra & Haddad, 2012; Ranjan, 2001). Often, the loss of the male income can plunge families into poverty (Mohanty & Patra, 2017; Bharati, 2011). As Bharati (2019) notes, most widows in India live in poverty or poor economic conditions. Financial insecurity frequently begets emotional insecurity. A recent report by HelpAge India emphasizes that financial dependence can leave widows feeling helpless and neglected (HelpAge India, 2023). Legal protections exist in theory – for example, under the Hindu Succession Act (1956) a widow is entitled to a share of her husband's property – but in practice many widows do not receive these assets, due to lack of awareness and deeply entrenched gender biases in inheritance practices (Aggarwal, 2024).

For older women, even more so for economically weak widows, family support is crucial. As a HelpAge India study on women and ageing in the country (2023) states, 81% of older women live with their families. The remaining ones live with either their spouse, with their relatives, or alone (9%). Those living alone are mainly women, in rural and in urban areas (Mohanty & Patra, 2017; Pandey, 2022). Reasons for living alone are childlessness, poverty (including lack of property), dysfunctional relationship to children and relatives, children being abroad or living far away in India and not least widowhood (Bharati, 2011; Mohanty & Patra, 2017; Pandey, 2022).

Family also plays a vital role for feeling financially secure in old age. Amongst the 47% of older women, defined as 60 years and above, who do feel secure, 80%

are dependent on their children for finances (HelpAge India, 2023). Even though 31% of older adults need to continue to add to the workforce due to lack of resources (Mohanty & Patra, 2017), the HelpAge India study found out that most of them are men. Only 25% of women continue working full or part-time in old age (HelpAge India, 2023) because the family cannot back them up. One reason for women of being poor but not being able to be engaged outside the home is health (Bharati, 2011).

Widowhood, Health and Social Security

Widowhood in India entails profound health challenges. Widows often experience deteriorating health, partly because they are older but also due to cumulative neglect. LASI data indicate that about half of the women over 75 have at least one Activity of Daily Living (ADL) limitation, double the rate of same-aged men (Agrawal et al., 2014). Widows also report significantly higher depression levels than their male counterparts (Ahmed-Gosh, 2009; Agrawal & Keshri, 2014; Perkins et al., 2016) . Agrawal and Keshri (2014) found that widows had higher prevalence of chronic health conditions than widowers.

Social support systems like pension or health insurance for widows are insufficient and lack awareness. For instance, 44% of widows 60 + surveyed in LASI were uninformed about the Indira Gandhi National Widow Pension Scheme, which currently provides a pension of 1,500 Indian Rupees (around 15 Euro in 2025) to widows living below the poverty line (BPL) in the age group 40–79 years (Social Justice and Special Assistance Department, 2025). As per LASI results (2020), 25% of eligible poor widows received any pension. Besides, only 21% of the LASI age-eligible households (with members of 45 years and above) are currently covered by health insurance; the percentage decreases with age and gender (60 years and higher: 18.2% of older persons; females: 16.9%).

Widowhood and Institutional Old Age Care

Given the situation of those who have no family to rely on, whose children are living abroad or far away, who have limited or no financial resources, accompanied by health-related challenges and the increase in life expectancy, institutional care for older adults is emerging in India as a pragmatic solution (Gupta, 2025). Historically, sending parents to an 'old age home' was stigmatized and institutional capacity was scant (Brijnath, 2012; Pandey, 2022). However, with modernization, urbanization and smaller families, formal care homes have expanded (Johnson et al., 2018). In 2018, an estimated 1,150 senior living facilities existed nationally, with states like Kerala, West Bengal, and Tamil Nadu leading (Tata Trusts et al., 2018). There are two types of old age homes: free of charge homes and paid homes. Most free of charge homes are run by Non-Governmental Organizations (NGOs), charitable trusts or religious groups (e.g., ashram), with relatively few state-run facilities (Issac et al., 2021). Importantly, many of the free homes cater to the poor and marginalized, amongst them often destitute widows, who have no family willing or able to care for them (Nag, 2021). Paid homes (pay-for-stay) are largely private and for-profit targeting middle-class seniors (Johnson et al., 2018). The number of pay-for-stay homes is

sharply increasing, also due to many children who are often absent, unable or unwilling to provide personal care for their parents (Pandey, 2022). Government policy also began to acknowledge the need of care for older adults: the Maintenance and Welfare of Parents and Senior Citizens Act (2007) mandates at least one old age home per district for indigent seniors (Ministry of Law and Justice, 2007).

Widowhood, Institutional Care and Old Age Vulnerabilities

Strong evidence to the above-mentioned discussion on ageing women in India and their manifold challenges in growing older when losing their spouse is the increasing scientific literature around this topic. Amongst the various aspects that have been researched over the past fifteen years in India are the quality of life in institutions (Mishra, 2012; Gupta et al., 2014; Jaswal & Singh, 2014), the emergence and quality of long-term care (Johnson et al., 2018; Burholt et al., 2022), preferences for family versus institutional care (Brijnath, 2012), family caregiving burdens (Kadoya & Yin, 2015), health and gender disparities (Sreerupa & Rajan, 2010; Perkins & Subramanian, 2016), and widows' health and morbidity (Agrawal, 2014). Only a few qualitative studies have focused on the experience of widows in old age homes. Kalavar and Jamuna (2011) offered insights into older women's experiences in care homes, noting that childlessness was a common reason for entry, given the lack of familial support . Their study looked at fee-based homes with primarily middle-class residents and included all older women, not specifically widows. Mallick (2008) studied narratives of widows in Kolkata's old age homes, focusing on women who entered due to family abuse and on the extent of the abuse itself prior to relocation. Nag (2021) looked at shelter homes and elderly women in Varanasi district of Uttar Pradesh, analysing the interplay of socio-cultural norms and family for moving into an Ashram. While recognizing that widows are the most deprived ones amongst older women from poor socio-economic backgrounds, the focus of the study is on all older women, not specifically on widows. One recent qualitative study of Gupta (2025) conducted in one single old age home in Uttar Pradesh centered around how institutional living influences the social connections and sense of well-being of its residents. It primarily looks at all residents, not specifically at older widows, and challenges associated with widowhood in India.

Our study attempts to go beyond prior research by explicitly exploring narratives of older widows who relocated to not-for-profit old age homes in India. Our analytical lens centers on the concept of old age vulnerability (Schröder-Butterfill and Marianti 2006a, b) and capacities that anticipate, mitigate or prevent it. Vulnerability in later life can be viewed as arising from deficits in personal resources, social networks and formal support (Flaskerud & Winslow, 1998; Hilhorst & Bankoff, 2004). Widowhood is often identified as a major risk factor enhancing vulnerability, due to loss of spousal support and the associated social devaluation of widows (Chen, 1998; Eeuwijk, 2006). We also consider resilience, which in this context refers to the ability of the older women to adapt to and recover from the adversities of widowhood and relocation (Mlinac et al., 2011; Alburn et al., 2016). Factors like social support (even within an institution), activity (Havighurst, 1961; Liu et al., 2024) and faith are considered as meaningful resilience resources for coping with change. Correspond-

ingly, this article is guided by the research question how older widows experience vulnerability and resilience through relocation to old age homes.

By situating the widows' personal stories within these frameworks, we aim to draw connections between individual experiences and the broader societal patterns of population ageing and family change.

Methodology

We conducted a qualitative study in Mangalore, Karnataka (South India), using semi-structured interviews and focus group discussions. The study design was approved by relevant institutional ethics committees, and we obtained informed consent from all participants. Our methodology mainly draws from sociology and gerontology, focusing on narrative accounts.

Study Setting and Sample

The town of Mangalore was selected as a field site because the federal state of Karnataka has one of India's highest proportions of older adults (11.5% aged 60+in 2021) and the city has multiple old age homes (Statista, 2023). We focused on *not-for-profit old age homes* (sometimes called 'charitable' or 'free' homes) that provide housing and care to older people without charging fees, as they commonly cater to poorer seniors including financially weak widows with hardly any social and financial support. Through preliminary mapping, four old age homes in Mangalore met our inclusion criteria: not-for-profit, having at least 15 residents (to ensure a community environment), willingness to participate and open to all religions. Three homes were run by Christian organizations (Catholic mission), and one by a secular charity trust. Each home housed between 15 and 150 residents; women comprised the majority in each.

Our primary participants were older widows residing in these homes. Inclusion criteria for widows were: age 60 years and above; widowed; resident of the home for at least two months; cognitively able to participate in an interview; and informed consent provided. Grounded on convenience sampling technique, those eligible were approached and asked to participate. We reached high data saturation after semi-structured interviews with 15 respondents. All names were replaced with codes to protect anonymity (W1-W15). For triangulation and additional perspectives, we also interviewed five staff members (caregivers or managers) from the homes (coded HP1-HP5). Furthermore, to capture broader contextual insights, we convened one focus group discussion with 10 local experts in ageing and eldercare (such as academics, doctors, NGO workers, coded E1-E10). These experts provided external viewpoints on issues raised by the widows' experiences.

Data Collection and Procedure

The PI (Principal Investigator) and a female research assistant conducted the interviews. The widows were interviewed individually on-site at their respective homes,

in a private setting (usually their room or a quiet corner). Interviews followed a semi-structured guide covering topics such as personal background, circumstances leading to entering the old age home, changes experienced after relocation, daily routine and activities in the home, relationships with other residents and staff, ongoing contact (if any) with family, and reflections on their current life versus previous life. Culturally sensitive prompts were used to discuss potentially difficult topics (e.g., experiences of neglect or abuse, feelings about widowhood). Conversations were held in the participants' preferred language (Tulu/Konkani, Kannada, Malayalam, Hindi). The research assistant translated questions and answers in real-time between English and the local language as needed. All sessions were audio-recorded with permission. Each interview lasted 45–90 min.

We also interviewed key healthcare/care staff at the homes (caregivers, doctors). Their interview guide focused on observations of widows' adjustment, common issues faced, and staff perceptions of residents' well-being and desires (e.g., do widows express wanting to go home?). The staff interviews were conducted in English or Kannada (with translation as required) and lasted about 60 min each.

The focus group discussion was held at a conference room in a local college. It included geriatricians, social work professors, NGO activists, and an operator of various private care services in Karnataka. The discussion centered on broader questions: the changing role of family in caring for older women, the societal attitudes toward widows in institutions, and suggestions for policy or community interventions. The focus group discussion lasted about two hours, conducted in English (the common language for these professionals), and was facilitated by the PI.

Data Analysis

Interviews were transcribed verbatim and translated into English (i.e., professional translators were employed for transcripts to ensure accuracy beyond the on-the-spot translation). We used the Framework Analysis (Ritchie & Spencer, 1994), appropriate for applied qualitative research that starts with specific questions and allows new themes to emerge. Coding was assisted by MAXQDA, a qualitative data analysis software. Initially, the PI read the transcripts to familiarize with the data and identify preliminary themes, which were then reviewed by the other team researchers. A coding scheme was then developed combining deductive codes (derived from our research questions and the vulnerability/resilience conceptual framework) and inductive codes (new insights from the data). For example, deductive codes included 'reasons for relocation', 'health changes', 'family relationships', 'emotional well-being', while inductive codes consisted of finer categories such as 'role of religion', 'sense of purpose in home', and 'experiences of abuse'. We applied the coding framework to all transcripts, meeting frequently to reconcile any differences in code application. Next, we charted the data into matrices corresponding to key themes, summarizing each widow's perspective under each theme. This allowed us to compare experiences across participants. Finally, we interpreted the data by identifying patterns and relationships between themes, guided continuously by our main research question. For instance, we examined how vulnerability factors like 'neglect by family' linked to 'decision to relocate', and how resilience resources such as 'practicing religion'

and 'embedding routines' related to 'well-being' and 'future outlook'. We also paid attention to exceptions or negative cases. The focus group discussion and staff interviews were analysed in a similar way and were used to contextualize and cross-verify information from the interviews with widows.

Results

The age of the 15 interviewed widows ranged from 60 to 88 years. Most of them had lost their former spouse already years back. Some of them had no school education, half of them had finished primary school (4th grade), and the remaining few attended school until 10th grade. Five women were Hindu and ten were Christians. Prior to relocating to the old age home and/or retiring, the majority had worked as household servants, two described themselves as housewives. Except for one, all of them had already spent many years at the old age home. Aside from two widows who had no children, the rest had one to four children. Based on their educational status and their former occupation, in combination with being widowed, all women had a poor financial status prior to moving into the home. Two out of 15 received support through the Indira Ghandi National Widow Pension Scheme. The big majority did not obtain any financial support from the government and received only minimal support from their family (Table 1).

Emerging Themes

Three major themes were distilled from the data analysis: (1) Triggers of relocation: multifactorial vulnerability; (2) Adjustments to new home and resilience resources; (3) Shifts in well-being and appreciation of care. These themes collectively encapsulate the trajectory from relocation causes to life in the home to outcomes and outlook for the widows. We selected representative quotes for each theme to illustrate key points; we edited them lightly for clarity while preserving the original meaning and tone.

1. Triggers of Relocation: Multifactorial Vulnerability.

Every widow interviewed experienced several forms of vulnerability. Most pronounced were social, environmental and economic vulnerability, reflected in some form of acute neglect, abuse, or exclusion by family members and community in the period leading up to her relocation. This neglect was the primary trigger that pushed them to seek refuge in an old age home. The narratives revealed several common patterns:

Stigma, increased workload and financial scarcity: Most widows included in the study were widowed at a relatively early stage in their live. They described manifold challenges around widowhood, including financial challenges, the burden of bringing up children on their own, the lack of help from family members and society, and the constant need to work hard, without sufficient rest. One widow shared: *"No, we arranged it ourselves, not even from my brother's house. They did not lend any help. I used to have children and go to work. Once my son was grown up, he started working. He quit the school and started working." [W10]*.

Table 1 Older widow's population by age, education, religion, former profession, family background, date of relocation and previous home

S.NO	Age	Education	Religion	Former profession	Family background	Date of moving into old age home	Home prior to relocation
WI	72	10th grade	Christian	Tailor; social activist (in women empowerment)	Widow (husband died in 2012);1 child (died)	2010	Hassan, Karnataka
WII	85	No education	Christian	Household servant	Widow (husband died around 2017);no children	1989	Uppala, Kerala
WIII	76	Primary education (4th grade)	Hindu	Beedi worker	Widow (husband died long time ago);no children	2005	Udupi, Karnataka
WIV	60	12th grade	Hindu	Housewife	Widow (husband died in 2008; separated prior to his death);2 children	2016	Mangalore, Karnataka
WV	79	10th grade	Christian	Household servant	Widow (husband died in 2007);3 children (2 died, 1 not well)	2019	Mangalore, Karnataka
WVI	80	No school education	Christian	Household servant	Widow (husband died ten years after the marriage);4 children (2 live in Bombay, 1 died, 1 is with her at old age home)	2015	Udupi, Karnataka
WVII	83	Primary education (3rd grade)	Christian	Cook; cleaner	Widow (husband died in 2010);3 children	2019	Karnataka, town unknown
WVIII	85	Primary education (4th grade)	Hindu	Fruit vendor	Widow (husband died in 2002);1 child (died because of Covid-19)	2021	Mangalore, Karnataka
WIX	Unknown	Primary education (3rd grade)	Christian	Household servant	Widow;1 child	2021	Mangalore, Karnataka
WX	62	5th grade	Hindu	Household servant	Widow (husband passed away long time ago); 3 children	2012	Town in North Karnataka
WXI	74	10th grade	Christian	Household servant (Oman); product manager	Widow (husband passed away in 2018);1 child	2022	Bangalore, Karnataka
WXII	75	No school education	Hindu	Housewife	Widow (husband died in 2018);4 children	1992	Town in Kerala
WXIII	88	5th grade	Christian	Housewife	Widow (husband passed away long time ago);4 children (1 with her at the old age home)	2016	Border village, Kerala
WXIV	72	5th grade	Christian	Cleaner	Widow (husband was killed in 1984);3 children (1 in Delhi, 1 mentally disabled, 1 lives closer by)	2008	Mangalore, Karnataka
WXV	66	No school education	Christian	Household servant	Widow (husband died in 1992);3 children (1 died, 2 live abroad)	2021	Bangalore, Karnataka

Source: Field Study

Some widows worked until exhaustion stating that they were too proud to ask for help as assistance from relatives was not offered voluntarily. One widow narrated: *"Difficulty means I had to do everything alone. I had to clean the dishes*, *wash the clothes*, *mop the floor*, *clean the portico*, *mop the entire house*, *I had to do everything. I would not get a moment's rest." [W9]* The only help some women received was offered by members of the church, either in form of financial support for the household or in the form of free education for the children. One widow who had no work experience and had three young children to bring up found shelter in an Ashram – a place of religious retreat for Hindus – and only left after her children got married. For most interviewees, talking about times of being alone with their children, working hard and having had hardly any support prior to relocating to the old age home caused severe discomfort. This was reflected in the women's facial expressions, crying or wanting to not talk about the topic.

The widow's statements on widowhood were supported by the experts in the focus group discussion. Based on their observations, dependencies and obligations of many women in India are causing a strong urge for them to be 'functional'. These dependencies are caused by the strong male-controlled influence (i.e., depending on sons and their decisions, especially in the North of India), limited decision-making capacity of women, their limited funds and the lack of technical skills. As one expert said: *"And because in a patriarchal society*, *the woman grows up thinking that her needs are secondary. So that spills over even into the old age too." [E5]*.

Emotional neglect by children: Two-thirds of the widows had a weak or non-existent relationship with their family members including their children and other relatives from both their side of the family and from their former husbands. Many of them were severely affected by dysfunctional family relationships and expressed deep sorrow and pain about these. One widow underlined: *"It has been 1 year 4 months since my elder brother passed away. They don't want me. Brother's children are there*, *my sister's children are there*, *they are living like I am somebody else and they are somebody else (no way connected). I am a stranger to them*, *and they are strangers to me." [W2]*.

They also described their disappointment about their family members stopping to provide support once they knew the widows were experiencing health issues and lost their functionality. This was even more painful for those widows who lost their spouse at an earlier age and had to bring up the children all on their own, without much money and support structures. After life-long battles of survival, they felt that when they finally needed someone to take care of them, no one was there, as it is also reflected in the statement of one widow: *"Yes*, *my daughter-in-law is there but of no use. She was the one who sold the house. I had a house*, *she sold it.* [Son died because of Covid-19] *Husband's family stays far away; it is a big family. Nothing*, *even when my husband was there*, *they would not help*, *they would just come and go." [W8]* This disappointment was further intensified in cases where the widow already suffered during their marriage. Only two interviewees described positive memories of their previous marriage, and all others talked of abusive behaviour.

Lastly, their severe disappointment about not being cared for by family was expressed in talking about the lack of visiting them in the new home. Half of the interviewees are visited rarely or occasionally, whereas nearly just as many stated

that nobody comes to visit them at the old age home. One said: *"As a mother I will say one thing, as a mother I took all the efforts to bring them up since childhood, give them good life, got them married, everything. They don't even have a courtesy to do a phone call and talk to their mother." [W15]* Only one single interviewee mentioned that she receives regular visits.

Health care professionals were aware of the many dysfunctional relationships of the residents. Some even saw it as their role to encourage them to forgive their relatives and look forward. The frequent dysfunctional and non-existent relationship with family members that the health care professionals observed with the widows is a representation of a more general breakdown of the joint family system that is growing across India. As one health care professional underlined: *"Earlier, joint families were there, always call in the morning, call in the afternoon, call in the evening. Nothing of that now." [HP IV]* The few interviewees that had a functional relationship with their family members, and especially to their children, immediately showed happiness and positivity when talking about them. Overall, talking about their children was extremely stressful for the widows, just as it was stressful to talk about their widowhood. This could be seen from their crying, losing focus of the discussion or becoming bitter towards the topic or the interviewer.

Lack of social security: The fact that many women in India do not receive any form of formal social security, even though they are considered vulnerable, complicates their life even more. Except for two of the widows included in the study, no one had ever received any means of formal social security throughout their life. Even though all interviewees qualified for a widow's pension, the majority stated they did not currently receive any financial support from the government and had also never received any in the past. In addition, health insurance is still rarely available in old age. This is in line with a HelpAge India report (2022), which says that about 67% of respondents did not have any health insurance. Only 13.1% were found to have had the Ayushman Bharat card, which is a health insurance coverage from the state government. As a result of the lack of health insurance, all interviewed widows stated that they had been in constant fear throughout their lives that losing strength to work would be the beginning of their end.

Lack of alternative support structures: The interviews showed that the decision to relocate to an old age home was often based on a lack of alternatives. Even though most interviewees had children, the children were not able or willing to take care of their mothers, due to work-related issues, being overwhelmed with their mother's deteriorating health condition, or because they were not in contact with their mother anymore. Those who did not have children and could not work due to frailty had therefore no money to survive and were left with no other option than to move to a home. One health professional described this in the following words: *"Not they are forced, the situation is such that they have nobody to care; as long as they are able to work outside in the world, they work and earn some money and when they are no longer able to work, they have to come here." [HP3].*

In essence, the widows framed relocation as an act of self-preservation – often a choice they made themselves when conditions became unbearable. Many of these widows actively sought out the institution or agreed to suggestions by community members or clergy to go there. Neglect and mistreatment eroded their well-being to

the point that the old age home appeared as a safer alternative. This theme underscores how multi-faceted vulnerability factors (for example economic dependency, frail health, lack of social network, and gendered stigma) converged to make continued living in the community untenable.

It is noteworthy that while poverty was a backdrop (as stated above all widows were of low socio-economic status), it was the relational aspect of neglect – particularly being unloved and uncared for by a family – that was cited as most painful and decisive. This aligns with the concept of social vulnerability (Schröder-Butterfill and Marianti 2006a) where the breakdown of family support is a critical element.

2. Adjustments to New Home and Resilience Resources.

The adjustment period differed for different people. According to the health professionals interviewed, it took a few days for some, for others it could take several months. Based on narratives, particular factors influenced the capacity of widows to cope with change, to adjust to the new environment and to build resilience towards the new situation:

New residents and rules: In contrast to being in their own homes, they are suddenly surrounded by other residents at the old age home, they must follow new rules as well as dealing with being separated from their family. Some participants needed medication to calm down after relocation, especially those whose life had been extremely challenging prior to the move. One remembered: *"In the beginning, I did not understand anything, and my heart was getting suffocating and crying. I was getting afraid to tell anyone because here, they listen to one thing and then narrate/convey the other thing over there, which I don't like. Many people here are not married, most of them are single. If you tell anyone, they will not understand. They don't understand anything." [W6]*.

Nature, company and attention: Half of the widows interviewed coped well with the relocation, stating that it was a positive experience where they were not alone anymore and were receiving the care they needed. Several reasons seemed to contribute positively to the adjustment and to the overall acceptance of the new home. For many widows, the environment of the old age home had a calming effect on them. Two of the four old age homes were somewhat remote, away from busy city life, with no cars honking or people talking loudly, and instead surrounded by animals and trees, providing protection from the sun. The moment the residents stepped out of these homes, they had the space to walk freely in the surrounding environment. In addition to these benefits, they enjoyed being visited by doctors or medical students from close-by hospitals.

Despite initial challenges for some, it was striking that none of the widows regretted their decision to relocate to the home in hindsight. Even those who cried for weeks noted that they eventually found peace. The staff played a crucial role in this adjustment period by providing a family feeling for their residents. One stated: *"Yes, sisters are very nice and affectionate towards me. They just came early in the morning and provided tea to everyone. Now, again they would come in the evening and give me my medicine and injection and everything else." [W7]*.

After the initial adjustment, widows established new routines within the old age home. This shows how daily life in the institution provided both structure and dignity that the widows used to cope with their past trauma and present ageing challenges.

Embedding routines: Adjustment and acceptance of the old age home is established through a daily routine which all residents must follow. Daily routines in the case of the interviewees included getting up early, having breakfast at a given time, helping with cleaning, mopping, ironing, kitchen and outdoor work, having prayers at a given time, followed by lunch at noon, going for a nap, having tea in the afternoon at a given time, supporting housework again, having dinner at a given time, watching TV after dinner, going to bed. These daily routines could be considered as formalized rituals for adjusting to their new lives at the old age home. Routines also allowed for an active ageing process within institutional confines. The widows in this study reported that contributing to these activities helped them to find peace in their new surroundings. They stated that life became more difficult for them once they were not able to perform these daily routines anymore due to health issues. This aligns with strengthening of individual resilience, as contributing to the activities and being active restores a feeling of competence and belonging.

Practicing religion: Another major reason which was found to contribute positively to the well-being of the widows and to serve as resilience resource was religious belief. Most interviewees felt strongly connected to God, whether they were Hindu or Christian. Only two interviewees, both Hindu, found strength in other ways, for example through physical work. Praying as an integral part of the daily routine provided strength to many of them and helped them to cope with past and present stressors in their life. As one widow said: *"I do prayers very happily. If there are Hindus, they will go and sit aside, we will not force them. All the sorrows that we have will go away with prayers. […] We get to do prayers and worshipping every morning, that gives immense happiness to me. Praying to God is peace." [W1]* Christian prayers and symbols were prominent at all old age homes. One of the homes had their chapel situated in the middle of the home, making it a central focus. At two other homes, the chapel was situated next to the entrance of the building, so that whenever people entered or left the home, they would see the chapel. During hours of prayer, the old age homes seemed to be deserted and silent, with hardly anyone to be seen.

Receiving health care: The widows especially enjoyed the care and attention they received at the old age homes, mostly from the sisters and caretakers. All old age homes provide regular medical check-ups through physicians from close-by hospitals. In case of an emergency, residents are taken to affiliated hospitals. Except from Covid-19 times, medical students from these hospitals drop by on a regular basis to look after the old age home residents. This contributed to a general reduction in feelings of anxiety and improved health stability and thus psychological resilience of many widows. Some even saw improvements in health due to regular meals and rest. Overall, only two widows expressed some dissatisfaction with the quality of health care at the home, one about the quality of the food and the other one about being unfairly treated by the care providers.

3. Shifts in Well-Being and Appreciation of Care.

As the widows settled in and developed or regained social agency and cultural dignity, they experienced also notable shifts in their overall well-being. The overwhelming sentiment expressed was one of gratitude and appreciation for the care and environment of the old age home, especially when contrasted with their previous life circumstances.

Physical security and mental health improvement: Almost all widows described feeling physically safer and less anxious about the satisfaction of basic needs. Having regular meals, a place to sleep, and assistance available gave them a sense of security that had been lacking. Initially, many widows suffered depression or grief, but over time they reported improvements in mood. The companionship of peers and involvement in daily activities helped them to alleviate feelings of sadness and anger.

Greater appreciation for care and empathy: A striking theme was how prior vulnerability in form of neglect made the widows highly appreciative of even modest levels of care provision (for example receiving food and basic medicine). Many widows in the interviews frequently praised the home's staff. Even though these homes were not luxurious – some lacked many amenities – the widows compared it favourably against neglect. This dynamic is somewhat paradoxical but understandable: having experienced being uncared for, they deeply value being cared for. From a resilience perspective, this attitude of gratitude can further reinforce positive mental health and old age.

Despite the ability of many older women to adapt to and recover from the adversities of widowhood and subsequent relocation, one major challenge remained, after all: the desire for family reconciliation. This was reflected in most of the widows wishing to be with their children again, leaving the home, being in employment or simply being visited by their families. Those who were still struggling from past trauma expressed wishes of dying, as clearly reflected in the narrative of one widow: *"It is enough if I die*, *I don't want this life. I don't want a life in which no one is there. I would feel happy if the person who got me here visits me. Even they don't come. If I want to go*, *these people won't let me go out. They won't allow me to go to town." [W8]* Resilience, thus, could not be built in all spheres of life.

Discussion

Our findings provide an intimate glimpse into the intersection of population ageing, family change, and gender in India by describing the relocation experiences of older widows from their former homes to not-for-profit old age institutions in Mangalore, Karnataka. They illustrate how macro-level demographic shifts and social transformations manifest in the personal lives of marginalized older women. In discussing these findings, we relate to the concept of old age vulnerability and resilience and draw implications for theory and practice in the context of global ageing.

First, this study reinforces the notion that widowhood is a critical juncture of multiple vulnerability in male-dominated societies. The widows' experiences confirmed that the death of a husband often triggers a cascade of adverse events: loss of income, loss of status in the household and in the community and, consequently, neglect[1] by family. The lack of social support outside of the family and kin such as through

[1] Neglect is understood as the failure to provide the basic needs for a person who is in need of care, may it be emotional needs (e.g., rejection, apathy), material needs (e.g., withholding food or clothing), or service-oriented needs (e.g., depriving of education or medical attention) (Forum on Global Violence Prevention, 2014).

friends, neighbours or acquaintances accompanied by the weak and insufficient social security system in India exacerbated the life of the widows and left them even more vulnerable towards declining health and financial constraints. Adding to these stressors and being most harmful for their degree of vulnerability was the widow's rejection by their own children. Often, this rejection had already started years before the mothers relocated to the old age homes. This was especially the case in situations where the mother's health deteriorated so that she needed more support and was no longer functional in her expected roles, as confirmed in previous studies by Sreerupa and Rajan (2010), Perkins and colleagues (2016) and Gupta and Sekher (2018). Thus, poverty, neglect and marginalization on various levels and degrees have been the catalyst for an increased vulnerability towards inequality and exclusion and, finally, for the widows' relocation to an old age home. These findings align with older research such as Bharati (2011) and Mohindra and colleagues (2012), who strongly highlight the accumulation of challenges combined with widowhood, such as limited resources, high levels of restrictions and lack of legal entitlement, and complement findings of Kalavar and Jamuna (2011) who found out that widowhood is one important consideration in the decision to relocate to an old age home. They are also in congruence with recent findings of Gupta (2025) who revealed that economic instability and disrupted family relationships are triggers for moving of many older adults into old age homes, and of Batra (2024) who discovered that almost all women staying in a free of charge homes were financially weak. Our findings also align with more general research findings that see older, marginalized and vulnerable women at a higher risk of experiencing isolation, poverty and neglect (Westwood, 2018; ADB, 2024; WHO, 2025).

Secondly, our findings highlight agency within a high degree of vulnerability. Despite severe hardships across her life-course, each widow in our study consciously took the initiative (or agreed when offered the opportunity) to relocate to an old age home (Emirbayer & Mische, 1998; Magni, 2020). This can be interpreted as a practice towards a higher degree of resilience – they actively and knowingly sought an environment where their needs would be met rather than passively accepting further marginalization, abuse or neglect. In a sense, these widows exercised a distinct form of bargaining with male hegemony: when the expected old age support from the patrilineal family failed, they 'bargained' by exiting – but not undermining – that kindred system and entering a non-related institutional one. This is consistent with Kabeer's notion of disempowerment and choice: the women made a constrained and risky but crucial choice to improve their situation (Kabeer, 1999). For ageing research, this indicates we should not consider older widows in institutionalized old age care only as passive and submissive victims of circumstances; yet it is in most cases a rational, deliberate and empowered response to an insupportable and undeserving situation.

Third, the role of old age homes as protective niches and institutional buffers that reduce and mitigate certain dimensions of vulnerability – notably of material, social and emotional nature – and increases resilience clearly emerges. Within the home, widows accessed psychological resources and social capital they increasingly lacked outside. Communal living provided emotional support (peer companionship) and a semblance of social networks which allowed most of the widows to reach a ripe old age (see Table 1). In terms of our employed vulnerability framework (Schröder-Butterfill and Marianti 2006b), the homes enhanced some kind of agency: social capital

was built through new friendships, mutual help and feelings of solidarity among residents, effectively creating a new kin-like network of peers. The lack of a strong social protection system was softened through the structured care services (food, healthcare, supervision) within the homes. Both dimensions contributed to improved individual resources (the women's own health, skills), which allowed participation in daily routines. These routines kept the widows active and helped them to partially overcome their emotional burdens and find a sense of usefulness and belonging. This resulted in most cases in improved self-esteem, confidence and resilience. This is in line with a study conducted by Mishra (2008) on old age home residents of Orissa, where re-engagement in various activities in the homes kept many residents mentally and physically well and supports Gupta's observations on older adults in Uttar Pradesh (2025) on the importance of engagement while being institutionalized. Overall, the findings correlate with Winstead and colleagues' revised activity theory (2014) articulating that there is a positive correlation between activity and mental and social adjustment and that these activities can help replace lost life roles and combat loneliness and isolation.

Fourth, our findings underline the critical role of religion in daily activities for improving individual resources of the widows and strengthening resilience. In our Christian old age homes, for instance, prayers help to absorb sorrow and mitigate pain. The embedding of prayers into the daily structure of life at the old age homes helped the widows to use this time for venting negative thoughts. These insights are in line with the findings of Kalavar and colleagues (2013) regarding Indian seniors in 'pay-and-stay' homes, as well as Kaur and colleagues (2019), who concluded that lived spirituality substantially enhanced the quality of life of older persons in India. They also support findings from Batra (2024) who compared the life of older women in pay-for-stay care systems with those in not-for-profit care systems and found out that practicing religion helped diverting the minds of those women residing in free of charge old age homes.

Implications for theory and practice

When provided in good quality, institutional eldercare works as an interference improving the older women's health and increasing life expectancy and life satisfaction in a supportive home. Therefore, a national ageing policy should invest in improving the homes' quality and thus their reputation and highlighting their potentiality, especially for vulnerable societal groups. One way of doing so is to work on quality specifications for free-of-charge old age homes. While the need for providing such homes has been recognized by the Indian government some time ago in its Maintenance and Welfare of Parents and Senior Citizens Act (2007) and the mushrooming of old age homes is going on at that (Pandey, 2022), there are hardly any standards relating to the quality of care inside the homes yet (Johnson et al., 2018). The state of Tamil Nadu was the first state in India in 2016 that has developed a set of minimum requirements for old age homes that are delivered by non-for-profit organisations, focussing on physical elements of the facilities such as room size, access to basic services and medical assistance (Burholt et al., 2022). Additional information on communal rooms and recreational facilities would benefit the residents and contribute to a more home-like environment.

Beneficial for improving social capacities could be community-linked models where homes allow reliable visiting and integration with local community events. A good example for such a model is one of the oldest shelter homes for widows in Uttar Pradesh, Ma Dham, located in the City of Vrindavan, established by the Indian Non-Governmental Organization Guild for Service (Merten, 2025). The spacious area does not only include accommodation for women but also a primary school and a training center, where the widows can learn new skills to make a living. Intergenerational living in the form of school children, middle-aged widows and older widows sharing the same compound can be a substitute for the lack of social networks many widows are suffering from.

Moreover, encouraging family involvement (through visits, calls) even after institutionalization can be beneficial. It also suggests that societal narratives positioning old age homes as a complement to family rather than its full replacement, might ease widows' emotional burden. Some of our participants' own reframing of the home as a new family or kin is enhancing their emotional and social resilience to deal with that loss.

Additionally, certain support structures need to be in place to reduce the pressure on widows' children who frequently seem to face financial, physical and mental stressors as well: one support mechanism is to ensure that social pension schemes reach widows, which is currently not always the case. Another mechanism is to provide local day care or support groups for older widows in their community so that even when living on their own, some assistance is available (i.e., enhancing ageing in place). Strengthening promotive activities in families about elder abuse and neglect would also address the vulnerabilities of many older widows and their families.

Lastly, multiple vulnerabilities of the widows interviewed occurred across the entire life-course and not only as late-life events in institutionalized old age homes. The current dataset does not allow insights into common patterns regarding the reasons and causes of vulnerabilities among women before moving into the old age home (such as education, occupation, income, number of children, urban/rural, etc.). However, supportive interventions should start from the transitional moment when the woman and wife turns into a widow. Resilience-building mediations can be financial support programs for economically precarious widows (e.g., access to micro-loans), educational initiatives for those being less educated (e.g., providing vocational training workshops) or community engagement activities (e.g., peer networks for older widows having no family or dysfunctional relationships to their family members).

From a theoretical standpoint, our findings underscore the utility of combining micro-narratives with macro-frames. The concept of old age vulnerability is multidimensional, and our study concretely shows how physical, psychological, social, economic, political and health vulnerabilities intersect in older widows' lives. It also manifests the older widows' agentic resources for the development of higher degrees of individual resilience: leaving abusive environments, forming new social bonds, finding meaning in routine and faith, and cognitive reframing when many widows adjust their situation from one of victimhood to one of relative fortune within the home. This interplay of vulnerability and resilience in very late life is an area for further research, as it questions the general notion that older adults are only on a trajectory of multiple decline and dysfunctionality; even in their 70–80 s, these women are still capable to adapt to their new living environments and find new sources of strength.

Conclusion

In rapidly ageing India, the existing support system for older widowed women is increasingly strained. The narratives of ageing widows in our study show both the plight and the resilience of this vulnerable group of society. Family neglect propelled these women into the search for institutional care, where many found a renewed sense of security and communality. Their stories make a compelling case that old age homes – often culturally rejected by Indian families (Lamb, 2007; Brijnath, 2012; Pandey, 2022) – serve in fact as crucial resorts that restore dignity and well-being to those marginalized by society. However, the mere relying on formal institutions alone is not sufficient and leads to new dependencies; rather, these findings call for a all-inclusive approach. This encompasses the strengthening of formal social protection schemes for older widows, the fostering of more compassionate and supportive family and community attitudes across the life-course of a woman, and the recognition of institutional care as a valid complementary component of elder care infrastructure in India's rapidly changing demographic landscape. For India, a society for all ages and genders must ensure that older widows who represent the disadvantaging intersectionality of gender, marital status, wealth, health and growing old are not left in isolation, despair and finally in neglect.

Limitations and Future Research

Our study is rather region-specific (coastal South India) and the sample is relatively small in scope, which may limit a broader generalizability. Cultural contexts in other parts of India might yield different patterns and findings. Additionally, since our sample was entirely from private not-for-profit homes, corresponding results might differ in private pay homes or public institutions.

Future research should further investigate reasons behind older widows' children not able or willing to look after their parents and also expand the religious scope, for instance, looking at widows from Muslim families. Longitudinal follow-ups within the old age homes could also reveal how the end-of-life phase is handled and experienced – an important aspect as all these narratives may conclude with the widows' life within the institution that manages the final years of their life including dying and death.

From a macro-perspective, exploring the economic feasibility and models of scaling up the quality of old age homes in India's poorer and rural areas is urgently requested, as most current home facilities are both inadequate and inappropriate to the growing need – a fact that our participants indirectly pointed out through their awareness of being part of a larger demographic transformation and societal trend.

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Author Contributions M.M. conceived the study and developed the research proposal, with input from P.vE. M.M. developed the research materials and collected the data, with significant contributions from V.V. M.M. undertook the qualitative analysis. P.vE., T.B. and V.V. provided topic-related expertise during the whole research process. All co-authors provided input to the manuscript and feedback on drafts. All authors read and approved the final manuscript.

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Data Availability The data of this study are available on request from the corresponding author. The data (i.e., interview transcripts) are not publicly available due to ethical restrictions as it contains identifying data that could compromise the privacy of the research participants.

Declarations

Ethics Approval The study was approved on December 9, 2021, by the Ethics Committee of Charité Universitätsmedizin Berlin (EA1/297/21), and on April 28, 2022, by the Ethics Committee of Yenepoya (deemed to be University), Mangalore (YEC-1/2022/047). Informed consent was requested and provided by all study participants.

Competing interests The authors declare no competing interests.

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