International Journal of Community Medicine and Public Health
Verma NK et al. Int J Community Med Public Health. 2026 Sep;13(9):4954-4962
https://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20263172

Original Research Article

Comparative assessment of the awareness and utilization of government-initiated geriatric health and welfare schemes among the elderly population of urban and rural communities of western Maharashtra

Neha Kumari Verma*, Soniya Saklani

Department of Community Health Nursing, College of Nursing, Armed Forces Medical College, Pune, Maharashtra, India

Received: 24 April 2026
Revised: 29 July 2026
Accepted: 01 August 2026

***Correspondence:**
Dr. Neha Kumari Verma,
E-mail: neha031217@gmail.com

ABSTRACT

Background: India is experiencing a rapid demographic transition, leading to a growing elderly population with increasing health and social welfare needs. Although the Government of India and the Government of Maharashtra have introduced several geriatric health and welfare schemes, limited awareness and poor utilization continue to hinder their effective implementation. This study assessed and compared the awareness and utilization of government-initiated geriatric health and welfare schemes among elderly individuals residing in urban and rural communities of western Maharashtra and examined their association with selected socio-demographic variables.
Methods: A descriptive comparative cross-sectional study was conducted over six weeks from October to November 2024 in selected urban and rural communities of western Maharashtra. A total of 200 elderly individuals (100 urban and 100 rural) were recruited using non-probability consecutive sampling. Data were collected using a validated structured interview schedule and analyzed using descriptive statistics, the Chi-square test, and the Mann-Whitney U test.
Results: Rural participants demonstrated significantly higher awareness scores than urban participants (6.97±2.61 versus 5.41±2.15; $Z=4.20$, $p<0.001$). Utilization scores were also significantly higher in the rural group (2.66±1.05 versus 0.48±0.81; $Z=10.74$, $p<0.001$). However, overall utilization remained low in both groups. The major barriers reported were lack of awareness, procedural complexity, and limited access to information.
Conclusions: Rural elderly demonstrated greater awareness and utilization of geriatric health and welfare schemes than urban elderly, although utilization remained low overall. Targeted awareness programmes, simplified enrolment procedures, and improved accessibility are essential to promote equitable utilization and support healthy ageing.

Keywords: Awareness, Elderly, Geriatric welfare schemes, Rural and urban population, Utilization, Western Maharashtra

INTRODUCTION

India is undergoing a rapid demographic transition, with a steadily increasing proportion of older adults resulting from improved healthcare, declining fertility rates, and increased life expectancy.[1] According to the Census of India 2011, older adults constitute approximately 8.6% of the total population, and this proportion is projected to increase substantially in the coming decades.[1] As the ageing population expands, ensuring healthy ageing and social security has become a major public health priority.[2]

Older adults commonly experience multiple chronic illnesses, functional limitations, financial dependency,

and social isolation, which adversely affect their quality of life.[3] Recognizing these challenges, the Government of India has introduced several health and social welfare schemes, including the National program for Health Care of the Elderly (NPHCE), Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (PM-JAY), Indira Gandhi National Old Age Pension Scheme (IGNOAPS), Mukhyamantri Vayoshri Yojana, Sanjay Gandhi Niradhar Anudan Yojana, and travel concessions for senior citizens.[4-8] These program aim to improve healthcare access, provide financial assistance, and enhance the overall well-being of elderly individuals. Despite the availability of these initiatives, evidence suggests that the awareness and utilization of geriatric welfare schemes remain sub-optimal, particularly among socio-economically disadvantaged populations.[9]

Factors such as limited health literacy, inadequate dissemination of information, administrative barriers and geographical disparities contribute to under-utilization of these benefits. Rural and urban populations differ considerably in terms of healthcare infrastructure, educational status, socioeconomic conditions, and accessibility of services, which may influence awareness and utilization of Government welfare schemes.[10,11]

Although several studies have assessed awareness or utilization of selected geriatric welfare schemes, comparative evidence between rural and urban elderly individuals in western Maharashtra remains limited.[12] Understanding these differences is essential for planning targeted interventions and strengthening program implementation. Therefore, the present study was undertaken to assess and compare the awareness and utilization of geriatric health and welfare schemes among elderly individuals residing in selected urban and rural communities of Western Maharashtra. The findings of this study may help policymakers and healthcare administrators develop targeted strategies to improve awareness and utilization of geriatric health and welfare schemes among the elderly.

Need of the study

Population ageing has emerged as one of the most significant demographic transitions worldwide, and India is experiencing a rapid increase in the proportion of older adults.[17,29] Ageing is associated with an increased burden of chronic diseases, functional limitations, financial insecurity, and greater dependence on health and social care services. To address these challenges, the Government of India and the Government of Maharashtra have implemented several health and welfare schemes aimed at improving healthcare access, financial security, and the overall quality of life of older adults.[13-15]

Geriatric health and welfare schemes

In the present study, these refer to government. Despite the availability of these programs, evidence indicates that awareness and utilization of geriatric health and welfare schemes remain sub optimal among many elderly individuals. Limited health literacy, inadequate dissemination of information, administrative complexities, socioeconomic disparities, and geographical differences contribute to the under-utilization of these services.[18,22] Furthermore, rural and urban communities differ considerably in terms of healthcare infrastructure, educational status, accessibility of services, and socioeconomic conditions, which may influence awareness and utilization of Government welfare schemes.

Although previous studies have assessed awareness or utilization of individual geriatric welfare schemes, comparative evidence between urban and rural elderly individuals in western Maharashtra remains limited. Understanding these differences is essential for identifying existing gaps, planning targeted awareness programs, strengthening service delivery, and informing policy decisions to improve equitable access to Government welfare schemes. Therefore, the present study was undertaken to compare the awareness and utilization of geriatric health and welfare schemes among elderly individuals residing in selected urban and rural communities of western Maharashtra.

Operational definition

Elderly

In the present study, elderly refers to individuals aged 60 yrs and above residing in the selected urban and rural communities of western Maharashtra who fulfilled the eligibility criteria and participated in the study.

Awareness

In this present study, awareness refers to the participants knowledge regarding government-initiated geriatric health and welfare schemes, including their objectives, benefits, eligibility criteria, application procedures, and sources of information-initiated health and social welfare programs implemented by the central and state government to improve the healthcare, financial security, and social well-being of elderly individuals. The Schemes assessed in this study included NPHCE, PM-JAY, MJ-PJAY, Mukhyamantri Vayoshri Yojana, IGNOAPS, IGNWPS, IGNDPS, Sanjay Gandhi Niradhar Anudan Yojana, and MSRTC travel concessions.

Primary objective

To assess the level of awareness and utilization of geriatric health and welfare schemes among the elderly individuals residing in selected rural and urban communities of western Maharashtra.

To compare the level of awareness and utilization of geriatric health and welfare schemes between elderly

individuals residing in rural and urban communities of Western Maharashtra.

Secondary objective

To find the association between level of awareness and utilization of geriatric health and welfare schemes with selected socio-demographic variables.

METHODS

A quantitative research approach using a descriptive comparative cross-sectional study design was adopted. The study was conducted in selected urban (Pune Cantonment Board) and rural (Zila Parishad) communities of western Maharashtra over a period of six weeks from October 2024 to November 2024. The study population consisted of elderly individuals aged 60 years and above residing in the selected urban and rural communities.

The sample size was calculated based on the findings of Tripathy et al, considering a 95% confidence level, 12% absolute precision, and an anticipated non-response rate of 5%. The calculated sample size was 190 participants, which was increased to 200 to compensate for possible non response. Accordingly, 100 National Program for the healthcare of elderly-National Programme for Health Care of the Elderly (NPHCE): A Government of India programme providing comprehensive geriatric healthcare services elderly participants each were recruited from the selected urban and rural communities.

A non-probability consecutive sampling technique was employed. Eligible elderly individuals who fulfilled the inclusion criteria and provided written informed consent were recruited consecutively until the desired sample size was achieved in each study setting.

Data were collected using a validated self-structured interview schedule developed after an extensive review of literature and relevant government guidelines on geriatric health and welfare schemes.

Inclusion criteria

Elderly individuals aged 60 years and above. Elderly individuals who were willing to participate and provide written informed consent.

Exclusion criteria

Elderly individuals who were severely ill. Elderly individuals who were not cooperative. Elderly individuals diagnosed with cognitive impairment or severe neuro-sensory deficit that prevented effective communication. Individuals covered under the ex-servicemen contributory health scheme (ECHS) or central government health scheme (CGHS).

Data collection instrument

Data were collected using a validated self-structured interview schedule administered through the structured interview method. The instrument consisted of three sections: (i) socio-demographic characteristics, (ii) awareness of government-initiated geriatric health and welfare schemes, and (iii) utilization of these schemes. The schemes assessed include the following:

Health related schemes

Through primary, secondary, and tertiary healthcare facilities.[30]

MJ-PJAY-Mahatma Jyotirao Phule Jan Arogya Yojana (MJ-PJAY)

MJ-PJAY is a Government of Maharashtra health insurance scheme that provides financial protection for eligible families requiring hospitalization for specified medical and surgical conditions.[30]

Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY)

Ayushman Bharat-PM-JAY is a flagship health insurance scheme of the Government of India that provides cashless health coverage for eligible beneficiaries requiring secondary and tertiary healthcare services.[31]

Welfare related schemes

Mukhyamantri Vayoshri Yojana-Mukhyamantri Vayoshri Yojana is a Government of Maharashtra welfare scheme that provides financial assistance to eligible senior citizens for purchasing assistive devices and supporting healthy ageing.[30]

Indira Gandhi National Old Age Pension Scheme

IGNOAPS is a social assistance programme under the National Social Assistance Programme (NSAP) that provides monthly financial assistance to eligible elderly individuals belonging to economically disadvantaged families.[30]

Shravan Bal Seva Rajya Nivruttivetan Yojana

It is a Government of Maharashtra pension scheme provides monthly financial assistance to eligible elderly individuals belonging to economically weaker sections of society.[30]

Indira Gandhi National Widow Pension Scheme (IGNWPS)

IGNWPS provides monthly financial assistance to eligible widowed women belonging to below poverty line

households under the National Social Assistance Programme.[30]

Sanjay Gandhi Niradhar Anudan Yojana (SGNAY)

SGNAY is a Government of Maharashtra social welfare scheme that provides financial assistance to economically disadvantaged individuals, including eligible elderly beneficiaries.[30]

Indira Gandhi National Disability Pension Scheme (IGNDPS)

IGNDPS provides monthly financial assistance to eligible persons with disabilities belonging to Below Poverty Line households under the National Social Assistance Programme.[30]

Maharashtra State Road Transport Corporation (MSRTC) Travel Concession Scheme

MSRTC provides travel concessions for eligible senior citizens to promote accessible and affordable public transportation.[32]

Pilot study

A pilot study was conducted after obtaining approval from the institutional ethics committee and permission from the concerned authorities. The pilot study included 20 elderly individuals (10 each from selected urban and rural communities of western Maharashtra), representing 10% of the calculated sample size. Participants were selected using a non-probability consecutive sampling technique, and written informed consent was obtained from all the participants. Data obtained during the pilot study excluded from the final analysis.

The pilot study confirmed the feasibility of the study design, adequacy of the sampling technique, clarity of the interview schedule, and suitability of the data collection procedure. Internal consistency of the instrument was assessed using Cronbach's alpha. The unstandardized (α=0.8201) and standardized (α=0.8209) coefficients indicated good reliability of the instrument.

Data were entered into Microsoft Excel and analysed using IBM SPSS Statistics for Windows, version 23.0. Descriptive statistics including frequency, percentage, mean, and standard deviation were used to summarize the data. The Man Whitney U test was used to compare awareness and utilization scores between urban and rural participants. The Chi square test was used to compare categorical variables. ANOVA and the Mann-Whitney U test were used to determine associations between awareness/utilization scores with selected socio-demographic variables, as appropriate. A p value of <0.05 was considered statistically significant.

Ethical approval was obtained from the institutional ethics committee before commencement of the study. Administrative permission was obtained from the concerned authorities. Written informed consent was obtained from all the participants before data collection. Confidentiality and anonymity of the participants were maintained throughout the study, and participation was entirely voluntarily.

RESULTS

Table 1 shows the socio-demographic characteristics of the study participants. A total of 200 elderly individuals participated in the study, comprising 100 rural and 100 urban participants. The distribution of age groups was comparable between the two groups. Rural participants were predominantly male (76%), whereas females constituted the majority in the urban group (55%). Rural participants had lower educational attainment and were mainly engaged in farming, while homemakers formed the largest occupational group in the urban community.

Table 1: Comparison of socio-demographic data between rural and urban samples (n=200).

Parameters		Rural (nr=100)		Urban (nu=100)	
		Frequency	%	Frequency	%
Age (years)	60-69	54	54	54	54
	70-79	38	38	36	38
	80 and above	8	8	10	10
Gender	Male	76	76	45	45
	Female	24	24	55	55
Education level	No formal education	46	46	22	22
	Primary	40	40	48	48
	Secondary	12	12	28	28
	Higher secondary	1	1	2	2
	Graduate and above	1	1	0	0
Occupation	Unemployed	16	16	22	22
	Farmer	53	53	0	-
	Labourer	14	14	18	18

Continued.

Parameters		Rural (nr=100)		Urban (nu=100)	
		Frequency	%	Frequency	%
	Pvt Job	9	9	19	19
	Homemaker	6	6	41	41
	Others	2	2	0	-
Type of family	Nuclear	39	39	36	36
	Joint	61	61	64	64
Marital status	Currently married	68	68	40	40
	Never married	0	-	5	5
	Divorced/separated	2	2	2	2
	Widow/widower	30	30	53	53
Monthly expenditure on health (Rs)	Up to 1000	49	49	50	50
	1001-5000	33	33	37	37
	5000	18	18	13	13
Do you have a ration card	Yes	98	98	100	100
	No	2	2	0	-

Table 2: Comparison of awareness scores on government welfare schemes between rural and urban elderly using Mann-Whitney U Test (n=200).

Parameter	Rural (nr=100)		Urban (nu=100)		MW test Z value	P value
	Mean	SD	Mean	SD		
Awareness score	6.97	2.607	5.41	2.147	4.20	<0.0001

Table 3: Compare the level of utilization of geriatric health and welfare schemes between elderly individuals residing in rural and urban community group (n=200).

Parameter	Rural (nr=100)		Urban (nu=100)		MW test Z value	P value
	Mean	SD	Mean	SD		
Utilization score	2.66	1.047	0.48	0.810	10.74	<0.0001

Most participants in both groups belonged to joint families and possessed an orange ration card.

Table 2 shows the comparison of awareness scores between rural and urban elderly participants. The mean awareness score was significantly higher among rural participants (6.97±2.607) than urban participants (5.41±2.147) (Mann-Whitney U test, Z=4.20, p<0.0001). Most participants in both groups demonstrated poor to average awareness, with only one rural participant (1%) exhibiting good awareness. The difference in awareness levels between the two groups was statistically significant (χ^2=15.789, p=0.001).

Table 3 shows the comparison of utilization scores between rural and urban elderly participants. The mean utilization score was significantly higher among rural participants (2.66±1.047) than urban participants (0.48±0.810) (Mann-Whitney U test, Z=10.74, p<0.0001). Nevertheless, utilization of government geriatric health and welfare schemes remained poor in both groups, with 99% of rural participants and all urban participants demonstrating poor utilization levels.

Table 4: Association of awareness and utilization scores with selected sociodemographic variables among urban and rural elderly.

Variables	Group	Awareness mean±SD	Test	P value	Utilization mean±SD	Test	P value
Gender (urban)	Male	5.53±2.201	MW	0.38	0.33±0.739	MW	0.033
	Female	5.31±2.116			0.60±0.852		
Education (urban)	No formal education	4.68±2.2555	ANOVA	0.046	0.77±1.020	ANOVA	0.13
	Primary	5.29±1.890			0.35±0.729		

Continued.

Variables	Group	Awareness mean±SD	Test	P value	Utilization mean±SD	Test	P value
	Secondary	6.13±2.300			0.47±0.730		
Occupation (rural)	Unemployed	6.31±2.522	ANOVA	0.79	3.06±1.181	ANOVA	0.005
	Farmer	7.13±2.849			2.60±0.947		
	Labourer	6.64 +2.274			2.57±0.938		
	Pvt Job	7.67±2.121			2.89±0.601		
	Home maker	7.33±2.338			2.83±1.329		
	Others	6.00±2.828			0.00±0.000		
Family type (rural)	Nuclear	7.62±2.662	MW	0.045	2.79±1.031	MW	0.11
	Joint	6.56±2.507			2.57±1.056		
Monthly health expenditure (rural)	Up to 1000	6.76±2.586	ANOVA	0.72	2.57±1.041	ANOVA	0.038
	1001-5000	7.15±2.819			2.48±0.972		
	>5000	7.22±2.340			3.22±1.060		

Table 4 shows the association between awareness and utilization scores and selected socio-demographic variables. Among urban participants, awareness was significantly associated with educational status (p=0.046), while utilization was significantly associated with gender (p=0.033). Among rural participants, awareness was significantly associated with family type (p=0.045), whereas utilization was significantly associated with occupation (p=0.005) and monthly health expenditure (p=0.038). No significant associations were observed for the remaining variables.

DISCUSSION

The present study assessed and compared the awareness and utilization of Government-initiated geriatric health and welfare schemes among the elderly individuals residing in selected urban and rural communities of Western Maharshtra. A significant difference was observed between the two groups, with rural participants demonstrating higher overall awareness and utilization scores than their urban counterparts. However, despite these differences, the overall utilization of most Government schemes remained low in both settings indicating that awareness alone does not necessarily translate into effective utilization of available services.

Rural participants demonstrated significantly greater awareness of the NPHCE and Mukhyamantri Vayoshri Yojna, whereas urban participants were more aware of MJ-PJAY, Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and Indira Gandhi National Disability Pension Scheme (IGNDPS). These differences may be attributed to variations in program implementation, the stronger presence of frontline healthcare workers such as accredited social health activists (ASHAs), Anganwadi workers (AWWs) and primary healthcare staff in rural communities, and differences in the dissemination of information through community based health services, Conversely, urban participants appeared to rely more on electronic media and institutional sources for information, which may explain the higher awareness of insurance-based schemes.

The present findings are partially consistent with those reported by Devi et al, who observed that awareness was highest for old age pension schemes among senior citizens.[28] Similarly Agrawal et al reported that only 31% of elderly participants were aware of any social security scheme, with the highest awareness observed for IGNOAPS.[19] Goswami et al, also reported high awareness of IGNOAPS (I85.5%) among the rural elderly individualss, with 41% of eligible participants utilizing the scheme.[23] Collectively these studies suggest that pension-related schemes are generally more widely recognized than healthcare-specific schemes.

Despite moderate awareness of certain schemes, utilization remained poor in the present study. Almost all participants demonstrated poor overall utilization scores, although rural participants utilized significantly more services than urban participants. These findings are comparable with those of Agarwal et al, Goswami et al, and Kohli et al, who also reported low utilization despite reasonable levels of awareness.[19,23,25] Similarly Goel et al found that a large proportion of elderly individuals in rural Meerut were unaware of available welfare schemes, and the majority had never utilized them.[26] The persistently low utilization observed across studies may be explained by inadequate dissemination of information, procedural complexity, limited guidance during enrolment, and difficulties in accessing Government services.

In contrast, Nivedita et al, reported a substantially higher utilization rate (66.6%).[24] Bartwal et al and Srivastava et al documented comparatively lower utilization rates of 19.7% and 27.8%, respectively.[20,21] These variations may reflect regional differences in program implementation, accessibility of healthcare services, socioeconomic characteristics, literacy levels, and the effectiveness of community outreach activities.

The present study further demonstrated that the awareness was significantly associated with educational status among urban participants and with family type among rural participants, suggesting that education and family

support may influence access to information regarding Government welfare schemes. In addition, utilization was significantly associated with occupation, monthly health expenditure in the rural group, and gender, with female participants demonstrating higher utilization scores than males. Aggarwal et al, similarly reported significant associations between awareness and educational status, religion, caste, whereas gender, marital status, age, family type, and financial dependency were not significantly associated with awareness or utilization.[19] These findings indicate that socio-demographic characteristics continue to influence access to and utilization of government welfare programs.

The barriers reported by the participants provide further insight into the low utilization observed in the present study. Rural participants primarily cited inadequate information and procedural complexities, whereas urban participants additionally reported difficulties in completing documentation and administrative formalities despite relatively better awareness of some schemes. Similar barriers have been reported by Agarwal et al, Goswami et al, Goel et al, and Retnakumar et al, who identified inadequate awareness, procedural complexity and limited guidance as major obstacles to effective utilization of government welfare schemes among older adults.[19,23,26,27]

The findings of the present study emphasize the need for targeted community-based awareness programs, strengthened involvement of frontline healthcare workers, simplified enrolment procedures, and improved dissemination of information regarding available geriatric welfare schemes. Regular outreach activities, community counselling, and integration of welfare services with primary healthcare may enhance awareness and improve equitable utilization of Government initiatives among the elderly individuals.

The present study has certain limitations. The cross-sectional study design limits the ability to establish casual relationships between the socio-demographic factors and the awareness and utilization of geriatric health and welfare schemes. The study was conducted in selected urban and rural communities of western Maharashtra using a non-probability consecutive sampling technique therefore the findings may not be generalizable to the entire elderly individuals of Maharashtra or India. Information on awareness and utilization was obtained through self -report, which may be subject to recall bias and social desirability bias. In addition, the study focused on selected Government health and welfare schemes and did not assess all programs for older adults.

CONCLUSION

The present study demonstrated significant urban-rural differences in the awareness and utilization of Government initiated geriatric health and welfare schemes among the elderly individuals in western Maharashtra. Although the rural participants exhibited higher awareness and utilization than the urban participants, the overall utilization of most schemes remained low despite varying levels of awareness. Inadequate dissemination of information, procedural complexity, and administrative barriers were the major factors limiting effective utilization.

The wellness and welfare awareness campaign highlighted the potential of targeted educational interventions to improve awareness. Strengthening community-based awareness programs, simplifying enrolment procedures, and enhancing the involvement of frontline healthcare workers are essential to improve equitable access and utilization of geriatric health and welfare schemes among the elderly.

Recommendations

Based on the findings of the study, the following recommendations are proposed:

Community-based awareness program should be conducted regularly to improve knowledge regarding Government and geriatric health and welfare schemes among the older adults.

Front line healthcare workers, including ASHA, Anganwadi workers, and Primary healthcare personnel, should be actively involved in disseminating information and facilitating enrolment into eligible schemes.

Administrative procedures and documentation requirements should be simplified to improve accessibility and utilization of welfare services.

Digital assistance and counselling support should be made available for elderly individuals who face difficulties in accessing online government services.

Similar multicentric studies with larger representative samples and longitudinal designs should be undertaken to validate and expand upon the present findings.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. Census of India. Provisional Population Totals, Maharashtra, 1. Census 2011. New Delhi: Office of the Registrar General and Census Commissioner, India; 2011. Available from: https://censusindia.gov.in/. Accessed on 19 March 2025.
2. James KS. India's demographic change: opportunities and challenges. Science. 2011;333(6042):576-80.

3. Bloom DE, Mahal A, Rosenberg L, Sevilla J. Economic security arrangements in the context of population ageing in India. Int Soc Secur Rev. 2010;63(3-4):59-89.
4. Government of India. The Constitution of India. New Delhi: Ministry of Law and Justice; 1949. Available from: https://www.indiacode.nic.in/bitstream/123456789/16124/1/the_constitution_of_india.pdf. Accessed on 19 March 2025.
5. Government of India. National Policy for Older Persons 1999. New Delhi: Ministry of Social Justice and Empowerment; 1999. Available from: https://socialjustice.gov.in. Accessed on 19 March 2025.
6. Ministry of Rural Development, Government of India. National Social Assistance program (NSAP). New Delhi: Ministry of Rural Development; 2022. Available from: https://nsap.nic.in. Accessed on 19 March 2025.
7. Ministry of Health and Family Welfare, Government of India. National program for Health Care of the Elderly (NPHCE). New Delhi: Ministry of Health and Family Welfare; 2011. Available from: https://main.mohfw.gov.in. Accessed on 19 March 2025.
8. Government of India. Senior Citizens' Benefits and Schemes. New Delhi: Ministry of Social Justice and Empowerment; 2023. Available from: https://socialjustice.gov.in. Accessed on 19 March 2025.
9. Shankardass M. Awareness and utilization of social welfare schemes among elderly in India: challenges and opportunities. Indian J Gerontol. 2018;32(4):456-72.
10. Prasad S. Social security for the elderly in India: a critical review of the existing schemes. J Aging Soc Policy. 2019;31(2):176-92.
11. Government of Maharashtra. Maharashtra State Action Plan for Senior Citizens. Mumbai: Department of Social Justice and Special Assistance; 2021. Available from: https://sjsa.maharashtra.gov.in. Accessed on 19 March 2025.
12. Shah AM, Patel V, Kumar S. Challenges of aging in India: Health, social, and economic aspects. J Geriatr Ment Health. 2020;7(2):85-92.
13. United Nations. Department of Economic and Social Affairs, Population Division. World Population Prospects 2022: Summary of Results. New York: United Nations; 2022. Available from: https://population.un.org/wpp. Accessed on 19 March 2025.
14. Government of India. National Old Age Pension Scheme. New Delhi: Ministry of Rural Development; 1995. Available from: https://rural.nic.in. Accessed on 19 March 2025.
15. National Health Mission. Strengthening Community Health Systems in Rural India. New Delhi: Ministry of Health and Family Welfare, Government of India; 2021. Available from: https://nhm.gov.in/. Accessed on 19 March 2025.
16. World Health Organization. World report on ageing and health. 2015. Available from: https://www.who.int/publications/i/item/9789241565042. Accessed on 19 March 2025.
17. Srivastava AK, Kandpal SD. Awareness and utilization of social security scheme and other Government benefits by the elderly: a study in rural area of district Dehradun. Indian J Community Health. 2014;26(4):379-84.
18. Agrawal D, Tyagi N, Dhakar JS, Chaturvedi M. Awareness and utilization of Geriatric Welfare Schemes among urban elderly individuals of District Gautam Budh Nagar. Indian J Community Health. 2019;31(3):315-21.
19. Srivastava AK, Srivastava A, Tiwari SC, Tripathi RK, Singh B. Geriatric social security and welfare services in Gwalior, India: a cross-sectional study of awareness, utilization, concerns, and solutions. Int J Community Med Public Health. 2018;5(3):1037-42.
20. Bartwal J, Rawat CS, Awasthi S. Awareness and Utilization of Geriatric Welfare Services among Elderly in Nainital District of Uttarakhand. Nat J Community Med. 2016;7(9):727-31
21. Maroof M, Ahmad A, Khalique N, Ansari MA. Awareness of geriatric welfare services among rural elderly individuals. Int J Res Med Sci. 2016;4(3):809-13
22. Goswami S, Singh M, Ranjan P, Dhaka R. Awareness and utilization of social security schemes among the elderly individuals of District Faridabad, Haryana, India. J Compr Health. 2020;8(1):27-32.
23. Nivedita BM, Mangala S, Subrahmanyam G. Utilization of social security schemes among elderly in Kannamangala, Bengaluru. Int J Sci Study. 2015;3(7):82-5.
24. Kohli C, Gupta K, Banerjee B, Ingle GK. Social security measures for elderly individuals in Delhi, India: Awareness, utilization and barriers. J clin Diagn Res. 2017;11(5):LC10.
25. Goel P, Garg SK, Singh JV, Bajpai S. Unmet needs of the elderly in a rural population of Meerut. Indian J Community Med. 2003;28(4).
26. Retnakumar C, George LS, Chacko M. A qualitative analysis of awareness and utilization of social security measures among the elderly in Kochi Corporation. Int J Med Biomed Stud. 2020;4(5):1-7.
27. Devi TS, Kaur R, Thakran A, Gudwalia B, Kumari M, Gurjar IS, et al. Awareness and utilization of various schemes launched by the Government of India for the welfare of senior citizens. Int J Community Med Public Health. 2021;8(4):1809-16.
28. Jeyalakshmi S, Chakrabarti S, Gupta N. Situation analysis of the elderly in India. Central Statistics Office, Ministry of Statistics and program Implementation, Government of India; 2011.
29. Government of Maharashtra. Social Justice and Special Assistance Department. Mumbai: National Informatics Centre, Ministry of Electronics and

Information Technology, Government of India; 2025. Available from: https://sjsa.maharashtra.gov.in/. Accessed on 19 March 2025.
30. Government of India. Pradhan Mantri Jan Arogya Yojana (PM-JAY). New Delhi: National Health Authority; 2024. Available from: https://pmjay.gov.in/. Accessed on 27 March 2025.
31. Maharashtra State Road Transport Corporation. Official Website of MSRTC. Mumbai: MSRTC; 2023.

Cite this article as: Verma NK, Saklani S. Comparative assessment of the awareness and utilization of government-initiated geriatric health and welfare schemes among the elderly population of urban and rural communities of western Maharashtra. Int J Community Med Public Health 2026;13:4954-62.