ELDERLY WELLBEING AND INTERGENERATIONAL BONDING

Dr. K. Sathyamurthi

Contents

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Foreword

Greetings!

I am delighted to present this collection of articles on Elderly Wellbeing and Intergenerational Bonding in India. Situation of elderly and the care services and intergenerational bonding available to them have been a matter of concern in the recent years. With a burgeoning population of citizens above 60 years of age of whom many are productive, the country is yet to recognize the potential of the elderly. Most elderly are left to fend for themselves after their productive years, which is the situation in even rural and tribal areas. There is a marked absence of elderly in some tribal areas.

However, the State and civil society organizations have come up with solutions as per their own reading of the situation. Maintenance and Welfare of Parents and Senior Citizens (Amendment) Act, 2018 were a landmark in the State's response to elder abuse and neglect. Civil society has come up with several models of care and intervention with elderly worth scaling up and replicating. Several papers in this book speak about such intervention models. It is heartening to note that more interventions for elderly are coming up in the "gerontological" domain in a space dominated by the "geriatric" domain. This has to move further to a rights perspective to enable elderly to gain their due place in the society.

We express our sincere gratitude to the University of Madras and National Institute of Social Defence for supporting the seminar in which these papers were presented. We appreciate the authors who presented the papers and made them suitable for publication. The Department of Social Work (Aided) has always been in the forefront in academic publications. This adds another feather in their cap.

Dr. S. Raja Samuel, PhD
Principal cum Secretary, MSSW

Acknowledgement

I take this opportunity to immensely thank the authorities of University Grants Commission, New Delhi, Old Age Care Division, National Institute of Social Defence, New Delhi and the Management of Madras School of Social Work (Autonomous), Chennai for providing me an opportunity to organize and publish a book titled as Elderly Wellbeing and Intergenerational Bonding.

I wish to place on record my sincere thanks to Dr. S. Raja Samuel, PhD., Principal cum Secretary for his continuous encouragement, motivation, dynamic leadership and professional zeal with moral values.

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I thank all the contributors and the research scholars for their tireless and timeless assistance co-operation and continued support.

I owe sincere thanks to all the contributors for their timely submission and professional commitment making this conference a successful one and extended their help to bring out a book of this kind.

Finally, I thank Today Publication for their skillful work and support in publishing the book with professional zeal and rightness.

Dr. K. Sathyamurthi PhD.,

Preface

One eighth of the Worlds Elderly Population lives in India. In today's developing countries, aging population tends to have a higher prevalence of physical disabilities, mental illnesses and co-morbidities. With continuous decline in death rates among the older peoples and the limits of life expectancy and life span are not obvious. As per 2011 Census report, total population of senior citizens (60+) is 10.38 cores which is 8.6% of the total population of the country. It is projected that the population of senior citizens in India would be around 19% of total population by 2050. Elderly is the critical stage of life and there is a need to negotiate the issues and challenges of the elderly such as dependency, quality of life, care and support, old age homes (OAH),etc.

The health needs and related problems of elderly people cannot be viewed in isolation. There is a wide gamut of determinants such as social concerns, ill treatment towards elderly, food and nutritional requirements, economic constraints, health care systems etc. The proportion of the population aged 60 years or more has been increasing consistently over the last century, particularly after 1951. According to official population projections, the number of elderly persons will rise to approximately 140 million by 2021. As a development concern, the projected increase of the elderly population in India may pose mounting pressures on various socio-economic fronts. Also, elderly population faces a myriad of challenges - social, physical, psychological and economic which are unique to them.

Intergenerational practice has emerged as one general approach for bringing young people into closer contact with others in their community. There is a large range of outcomes from intergenerational practice for young people, old people and the broader community. For individuals, these included increases in self-worth, less loneliness and isolation, new connections and friendships, academic improvements and more positive perceptions of other generations.

In this context, the book titled on "Elderly Wellbeing and Intergenerational Bonding" complied as an edited volume of consists of various academicians, researchers and practitioners which will help the reader to understand the positive attitude and approach towards the elderly population with a special focus of involving inter-general bonding. Prevention and control of health problems of elderly necessitates a multifaceted approach incorporating active collaboration of

health, social welfare, rural/urban development and legal sectors. Provision of quality assured health-care services for the elderly population is a challenge that requires joint approach and innovative strategies. Failure to address the needs of elderly today could develop into a costly problem tomorrow for the entire society at large.

Dr. K. Sathyamurthi, PhD.,

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1

Delving into the Problems Faced by Elderly specifically Physical Illnesses and influencing Factors : Prospects and Possibilities

Anitha S

ABSTRACT

Aging is a natural process for each human being and it is an incurable disease and inevitable biological process. Old age is viewed as an unavoidable, undesirable and problem ridden phase of life. Problems of aging usually appear after the age of 60 years. The physical condition depends partly upon hereditary constitution, the manner of living and environmental factors. Vicissitudes of living, faulty diet, malnutrition, infectious, intoxications, gluttony, inadequate rest, emotional stress, overwork endocrine disorders are some of the common causes of physical decline. In this context, this study is to assess the Common Physical illnesses of elderly people and to study the socio-economic and environmental conditions influence on physical illnesses. The Present study is based on a Librarial research design and based on secondary data. Secondary data was collected through various books, journals, previous studies, suggestions and discussions with experts and academicians. The study confine to elderly people aged 60 years and above. This paper is to understand the social work perspectives to address the issues of physical illnesses of elderly and identify the role of social workers while working with elderly people. Outcome of the study will focusing on creating awareness among the elderly people about common physical illnesses for the sake of prevention and about the maintenance of their physical fitness to lead contempt full life. We should use multidisciplinary approach to break the generational gap and supporting the elderly socially, economically and to lead a healthy life.

Keywords: Elderly People, Physical Illnesses, Socio-economic status, Environmental Conditions

Introduction

Health has been estimated that among people over 60 years old 80% of people suffer from at least one physical illness. According to Ministry of Statistics and

Programme Implementation in India in the year 2016, in Rural Area consisting 36 Million elderly male, 37.3 Million elderly female and in Urban Area consisting 15.1 Million elderly male , 15.5 Million elderly female. So, overall 73.3 million elderly people are living in rural area and 30.6 million elderly people living in urban areas.

Table -1 : Distribution of Elderly People in Total Population of India

Source	Persons (In Millions)	Female	Male	Rural	Urban
Census 1961	24.7	12.3	12.4	21.0	3.7
Census 1971	32.7	15.8	16.9	27.3	5.4
Census 1981	43.2	21.1	22.0	34.7	8.5
Census 1991	56.7	27.3	29.4	44.3	12.4
Census 2001	76.6	38.9	37.8	57.4	19.2
Census 2011	103.8	52.8	51.1	73.3	30.6

Source: Population Census Data,1961- 2011

The above data shows the growth of elderly population is due to the longevity of life achieved because of economic well-being, reduction in fertility rates, accessibility and availability of health care facilities.

The old age dependency ratio shows an increasing trend and the ratio has risen from 10.9% in 1961 to 14.2% in 2011. According to 2011 Census the old age dependency ratios are 15.1 and 12.4 for rural and urban areas respectively. Among the major states the overall old age dependency ratio varied from 10.4% in Delhi to 19.6% in Kerala. The ratio has increased over time for all these states but the rate of increase was relatively higher in Kerala, Andra Pradesh and Karnataka as compared to 2001.

Both in Rural and Urban areas the proportion of the aged without sickness who felt that they were in a good or fair condition health remains the same for men and women and the figure being 75% and 73% in urban and rural areas respectively. Among the elderly persons it is observed that despite illness more men seemed to be feeling that they had a better health condition compared to the women. In urban areas more elderly men and women felt to have good health as compared to their counterpart in the rural areas.

The Prevalence of heart diseases among elderly men and women was much higher in urban areas than in rural areas. Urinary problems were more common among aged men while more aged women reported from problem of joints.

Table - 2: Number of persons aged 60 and above years reporting a chronic illnesses sexwise per 1000 persons

Chronic Illness	Rural			Urban		
	Males	Females	Persons	Males	Females	Persons
Whooping Cough	8	6	7	4	2	3
Ulcer	37	54	44	30	24	27
Joints/ bone problems	30	40	34	26	45	35
Hypertension	23	53	36	50	59	54
Heart diseases	95	59	80	165	162	164
Urinary Problems	78	28	57	89	33	63
Diabetes	30	52	40	68	36	53
Cancer	18	36	26	25	25	56

Source: National Sample Survey 60th Round (2004)

Population Census 2011 Data reveals that Locomotor disability and visual disability are the most prevalent disabilities among elderly persons. Almost half of the elderly disabled population was reported to be suffering from these two types of disabilities.

Statement of the Problem The Sample Survey conducted by National Sample Survey data reveals that elderly people were suffering from many chronic illnesses due to their age, socio-economic conditions and physiological changes in their body due to age factor. Spreading of chronic physical illnesses is due to lack of health education. In this regard, the present research paper assists to find out the common chronic physical illnesses to prevent and find out precautionary measures to increase the longevity of the elderly people with a healthy lifestyle.

Objectives of the Study

To assess the common physical illnesses of elderly people and to study the socio-economic and environmental conditions influence on their illnesses

Scope of the Study

This study was conducted based on the librarial/secondary data collected through books, publications, journals and previous studies. In addition to this, had a detailed discussion with the Geriatricians and Medical Social workers who works closely with elderly people and taken their guidance and suggestions during the study.

Limitations of the Study

This Study is confined to India and elderly people who were aged 60 years and above.

Review of Literature

It includes various opinions of different authors and their research findings. International Journal of Health Sciences and Research Issue 11 November 2018(Yogesh Sahu & S.P Singh) reports reveals that among 11 Old age homes, half of the elderly were suffering from Hypertension, Joints problems, walking and vision problems. According to The National Academy of Sciences – Aging in Asia – Findings from New and Emerging Data Initiatives edition of 2012(Subhojit Dey & Devaki Nambiar) suggest that Older Indians are subject to a wide range of health, social and financial insecurities affecting their physical and psychological health. Journal of Health Management 2017 Edition(Renu Tyagi & Tattwamasi Paltasingh) reveals that gender, advancing age, living conditions, educational status are influencing the health status of elderly. Journal of Aging Science 2014 edition (V.M.Sarode) Suggests that The high prevalence of risk factors for non-communicable diseases across all age groups (60+) and even illiteracy in this urban slum community indicates the high risk of chronic illnesses in future.

According to Better Palliative care for Older People – WHO 2004(Elizabeth Davies & Irene J Higginson) edition reveals that Most of the developed countries facing the

shortage of palliative care staff and lack of Palliative skills for home care and nursing homes may increase hospital admissions for care at the very end of their life.

According to Krishna Institute of Medical sciences University Journal (Jul-Dec 2012) Ms. K. Lalitha's Article on Health Aspects of elderly – A Global Issue suggested that the health goal could be maintaining physical, psychological and social well being of elderly. There are certain guidelines to the care givers/family members of elderly about aging and life course. To preserve physical health of geriatric people it is essential to provide a well balanced diet, assist them to practice regular exercise, protect them from falls, and facilitate to maintain healthy sexuality. Malaysian Journal on Medical Sciences (Jan 2004) "Physical and Mental health problems of the elderly in a Rural community of Sepang, Selangor by Sherina Mohd. Sidik, Lekhraj Rampal and Mustaquim Afifi reflected in the study that they assess the chronic illnesses such as Hypertension, Diabetes Mellitus, Respiratory diseases and Heart diseases including major mental disorders and functional dependence are mostly influenced by low socio-economic status, environmental factors and their standard of living. Merck Institute of Aging and Health journal (2004) The state of Health and Aging in America 3rd Annual Volume reveals that to reduce the prevalence of chronic illnesses spreading due to aging includes their balanced diet, increased physical activities and proper medication.

Operational Definitions: According to **Phelps & Henderson** "**Old age** is a natural and normal condition. Its pathologies are same as those that occur as any other age period, but they are intensified by illness, family disorganizations, unemployability, reduced income and dependency."

Socio-economic status (SES) – Hierarchical ranking of the elder persons based on education, occupation, present income along with movable and immovable assets.

Physical Illnesses –"A Physical Illnesses is a particular abnormal condition that negatively affects the structure or function of part or all of an organism, and that is not due to any external injury."

Research Method: The present study is based on a historic research design. The study is based on secondary data. Secondary data was collected through books, journals, previous studies, suggestions and discussions with the expertise in this area. This paper is to understand the social work perspectives to address the issues of physical health of elderly and identify the role of social workers working with elderly people.

Major Findings of the study: Various earlier studies and the analysis of data collected by national and international institutions clearly indicate that, elderly people in India and other developing countries are facing the same challenges related to their physical and psychological illnesses or in the field of Geriatrics.

Elderly people 60 years and above suffering from one or the other or multiple chronic physical illnesses and moreover these illnesses are closely associated with psychological factors too.

Common physical illnesses were whooping cough, respiratory illnesses, Hypertension, heart problems, diabetes mellitus, thyroid, Obesity, Cancer, urinary problems, Ulcer and joint problems are the major health issues.

Major causes for these illnesses were dealt with their living conditions, sanitation, health and hygiene issues and environmental factors make a major difference in their health. As per National Sample Survey 2004 data reveals that rural area elderly were healthier than urban area based elderly people.

In addition to this, elderly were lacking nutritious food, adequate physical activities and the family support and positive relationships because of inter generational gap in the current society.

Moreover, elderly were completely depending on their children, especially single/ widow elderly and they were subject to verbal abuse and sometimes they will become the victims of physical abuse too.

During the course of episodes of chronic illnesses, they were undergoing through physical pain, lacking emotional support and lacking the accessibility to healthcare facilities.

Suggestions: Social workers will play a crucial role in working with elderly people in various responsibilities as given below.

Social workers may provide clinical services through providing counseling services and psychotherapies to overcome from their chronic illnesses and for psycho-social problems.

Social workers can assess their socio-economic support, their illnesses, and accessibility to healthcare services and provide referral services to support their medical services.

Social workers can become bridge between the elderly and the public or private individuals or institutions that can support for elderly people for supporting their health conditions.

A Geriatric Social Worker is mandated by law to advocate elderly people with suspected verbal or physical abuse report to Adult Protective Services.

Social workers will play an essential role in elderly with chronic illnesses from their admissions to discharge from the hospital and their follow up treatment. They will also educate the care givers or the family members of the client who will provide homecare services.

Social workers will assist the elderly at old age homes also through providing clinical services as well as providing vocational training to elderly to improve their socio-economic status and to reduce the dependency on their family members.

Social workers assist while providing palliative care for the elderly people with life threatening illnesses and completely bedridden to spend their remaining days peacefully through providing psycho-social support.

Social workers will play various roles while providing multidisciplinary approach in psychiatric and medical hospital settings and even in rehabilitation centers.

Conclusion: Various earlier studies and the analysis of data collected clearly indicate that, most of the elderly people in India and other developing countries were suffering from common chronic illnesses such as whooping cough, ulcer, heart diseases, hypertension, joints pain, diabetes mellitus and obesity. In addition to these illnesses, they were also dependent on their children for their health care and life care. From their family, most of the elderly people were not getting adequate support as they were giving more prominence for their personal life and they didn't even bother about their children. Because of Intergenerational gap, today's adults were neglecting their parents at their elderly age. So, educating the adults, their children and elderly people and providing healthcare services is very essential for social workers and other Para professionals working with elderly people.

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2

Risky Health Behaviours among Elderly in India

Sameen Rafi & Shyna Saif

ABSTRACT

Over the years the population of elderly substance users is gradually increasing in India. There is a larger proportion of elderly substance users with time. This review paper aims to provide an overview of the substance use frequency in the elderly with a focus on the Indian population. The current frequency of substance use in the elderly is discussed. However, information gathered from surveys studies point to the high prevalence of several risky behaviors, such as tobacco and alcohol use. Social efforts are important to create social conditions (social participation, social cohesion and social support) that facilitate healthy behaviors among the seniors. The present paper examined the frequencies of cigarette smoking, alcohol consumption and chewing of tobacco. The survey posed questions to both elderly men and women (urban and rural) about ever-use of any substance related to smoking, consumption of alcohol and chewing of tobacco. The results can be utilized to inform appropriate intervention programs to policymakers and to improve health and reduce disease burden of the elderly.

Keywords: Elderly population, alcohol consumption, substance abuse, risky health behavior.

Introduction

India, the world's second most populous country, has experienced a dramatic demographic transition in the past 50 years, entailing almost a tripling of the population over the age of 60 years (i.e., the elderly) (Government of India, 2011). This is the reason health of the ageing individuals has become a rising concern, particularly due to unpreparedness, lack of responsiveness and negligence to this specific population group and ignored status of geriatrics in India. The geriatric population is defined as the population aged 60 years and above. As the age advances, there is a high chance of having both physical, mental and social

impairment. One of the important factors that influence the severity of disease among elderly is their health seeking behavior.

Health-risk behavior can be defined as any activity undertaken by people with a frequency or intensity that increases risk of disease or injury (Steptoe & Wardle, 2004). The health risk behaviors have possibilities to clump into a risky lifestyle. Health risk behaviors also influence cognitive performance, emotions, and the overall quality of life (Hawkins & Anderson, 1996).

According to WHO, behavior and exposure to health risks such as smoking, alcohol consumption and physical inactivity can have long-term health implications and thus, negatively influence health in older age.

Therefore, understanding these risky behaviors and some linked factors among older people is essential for developing effective prevention programs to improve health and reduce disease burden of the elderly.

Literature Review:

Cigarette smoking is one of the most serious and widespread form of addiction in the world. Tobacco has been called the single greatest cause of non-communicable disease likely to produce a World pandemic unless urgent preventive action is taken. The United States Surgeon General has determined that cigarette smoking is addictive and that the pharmacological and behavioural processes that determine tobacco addiction are similar to those that determine addiction to other drugs, such as heroin and cocaine. Nicotine is the psychoactive drug in tobacco that reinforces its continued use. (Whelan, 1996).

Cigarettes contain cancer causing, tumor initiator and toxic agents, such as tar, arsenic, ammonia, carbon monoxide, hydrogen cyanide, formaldehyde, asbestos, P0210. cyanide, lead, DDT and acetaldehyde (Rust and Maximin, 1997).

Tobacco use was reported as the primary preventable cause of disability and death in older adults (Cataldo 2003; Tait et al., 2007). Mortality rate was reported to be

double among elderly who smoked tobacco compared to those who did not (Donze et al., 2007). A Chinese cohort study among elderly aged 70 years and above found significant association between current smoking and mortality (Ho et al.,1999). Tobacco use was a cause of significant morbidity and mortality, including cardiovascular disease, peripheral vascular disease, cerebro-vascular disease, cancer and chronic obstructive pulmonary disease among elderly population (Little, 2002). Smoking was associated with higher risk of cognitive impairment and dementia, muscular degeneration, cataract and hearing changes (Huadong et al., 2003; Anstey et al., 2007; Bernhard et al., 2007; Nicita-Mauro et al., 2008; Gons et al., 2011). Other factors like loss of function, mobility, independence and fire related fatalities were also associated with smoking among elderly (Schmitt et al., 2005). Smoking was the most important risk factor and squamous cell carcinoma, the most common histological type of lung cancer (Hajmanoochehri et al., 2014).

Tobacco use among elderly was well studied in different settings (Liu et al., 2013; Lugo, et al., 2013; Yawson et al., 2013). In the year 2010 India was the second largest consumer of tobacco products, third largest producer of tobacco (IIPS, 2010) and had the second largest number of elderly people in the world. Global Adult Tobacco Survey India (IIPS, 2010), found that 49% of elderly (>60 years) in India as a whole used some form of tobacco. Earlier research on tobacco use among elderly in India reported marked difference in socio-demographic differentials in tobacco prevalence (Goswami et al., 2005, Gupta et al., 1995; 2005).

Although two-third of alcohol use disorders have an early adult onset as many as one-third also had onset of alcohol use later on in their age. This late-onset category first develops the drinking problems at 40–50 years of age. In contrast to early-onset group, they tend to be more educated, have a stressful life event frequently precipitates or exacerbates their drinking, and tend to be better responsive to treatment.

Elderly alcohol users are more likely to have “at-risk drinking” compared to the prevalence of alcohol abuse or alcohol dependence.[20] This at-risk drinking puts them at risk of physical harm to the health and well-being. Guidelines by the

National Institute for Alcohol Abuse and Alcoholism recommend that older adults drink no more than 7 standard drinks per week. However, about 16% older-adult do engage in at-risk drinking (defined as more than 3 drinks on one occasion or more than 7 drinks per week).[22] In addition, binge drinking may also occur in a substantial proportion of the older-adult population. Alcohol-dependent use is also present in a relatively smaller but significant subset of elderly patients using alcohol.

From the available studies on adults, the trends show a decreasing consumption with increasing age, which may possibly be attributed to an aging effect (i.e., drinking less due to physiological effects), cohort effect (i.e., older cohorts may consume differential or less alcohol), or the mortality hypothesis (i.e., heavy users may die younger).[23]

Objectives:

The objectives of this study are following:

- To understand the status of elderly about ever-use of any substance in India.
- To examine the differential in the pattern of elderly in current risky health behavior by age group.

Data Source:

This study has been based on data from the research project "Building a Knowledge Base on Population Ageing in India (BKPAI)" which was carried out in seven states in India simultaneously conducted during the period May to September 2011.

Specific questions were asked to elderly (60 and above) respondents about the substance use. The survey posed questions to both elderly men and women about ever-use of any substance related to smoking, consumption of alcohol and chewing of tobacco.

Methodology:

After reviewing the data and studies on the elderly, a national survey was launched in seven states of India. All major demographically advanced states with a regional representation were selected for the survey. BKPAI used the interview schedules.

The questionnaires for each state were bilingual, with questions in both the primary language of the states and English. Interviewed method is used for data collection of all those aged 60 and above. A total of 8,329 household interviews and 9,852 elderly interviews were conducted in rural and urban areas. To analyze the data CSPro software package used.

Sample size and its techniques:

This study using probability proportional to population size (PPS) technique, the PSUs (Primary Sampling Unit) were selected and within each selected PSU, elderly households were selected through systematic sampling. A similar procedure was applied in drawing samples from urban areas. The sample for each state was fixed at 1,280 elderly households. Households having at least one elderly member aged 60 years or above formed the set of sample households and all the elderly in the selected households were interviewed.

Result and Discussion:

Present ever and current use of select substances among elderly by gender and place of residence. It can be seen that chewing tobacco was more common than smoking or alcohol consumption; over one-fifth of the elderly respondents had chewed tobacco, about one-sixth smoked cigarettes/bidis and about one-tenth had consumed alcohol. Ever-use of all the three substances were found to be higher among rural elderly in comparison to their urban counterparts.

Furthermore, substance use was found to be more among men than women and ever-use of all the three substances were higher among rural women than urban women. **(See Figure 1)**

Type of Substance	Rural			Urban			Total		
	Men	Women	Total	Men	Women	Total	Men	Women	Total
Current use									
Smoking	24.2	1.2	12.3	14.7	0.6	7.0	21.8	1.1	10.9
Alcohol consumption	8.7	0.2	4.3	6.4	0.1	3.0	8.1	0.2	3.9
Chewing tobacco	21.6	19.5	20.5	12.9	13.4	13.2	19.4	17.8	18.6
Any of the three risky behaviours	44.8	20.7	32.4	28.2	13.7	20.3	40.7	18.8	29.2
Ever use									
Smoking	32.5	1.9	16.6	24.4	0.7	11.5	30.5	1.5	15.2
Alcohol consumption	15.8	0.5	7.8	14.0	0.4	6.6	15.4	0.4	7.5
Chewing tobacco	24.9	22.4	23.6	15.1	16.9	16.1	22.4	20.9	21.6
Number of elderly	2,453	2,685	5,138	2,219	2,495	4,714	4,672	5,180	9,852

Figure 1: Percentage of Risky Health Behaviors According to Place of Residence and Sex, 2011

Mostly the elderly respondents who had ever-used one of the aforesaid substances were continuing to chew tobacco and smoke, while their alcohol consumption had reduced by more than half. Age-wise analysis shows an inverse relationship between age and smoking and alcohol consumption; while in case of tobacco chewing, it increases from 60-69 years to 70-79 years and decreases thereafter. **(See Figure 2)**

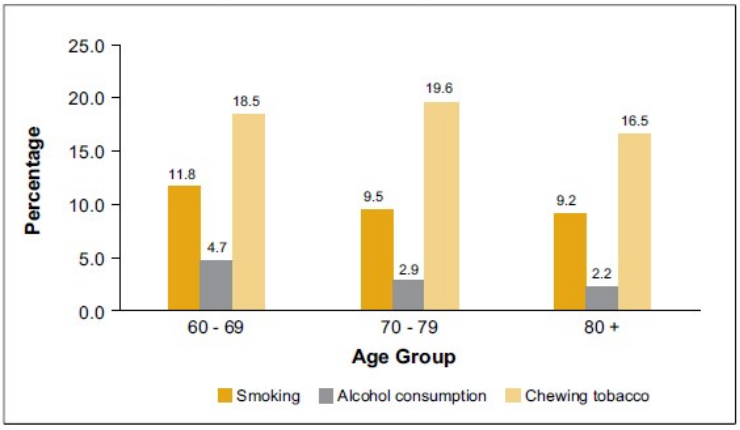

Figure 2: Current Risky Health Behavior by Age Group

Major Findings:

- Preponderance of risky health behaviours is quite high among the elderly. Around 30 per cent of the elderly are currently smoking, chewing tobacco or drinking alcohol.
- The prevalence is particularly high among males then females in both urban and rural area.
- The oldest-old age (80+ and above) were seen to be reduced in consumption of substance as compared to 60-69 years and 70-79 years.
- The 29 per cent of the elderly indulged in risky behavior by consuming all the three substances and similar to the overall trends.

Suggestions:

Most of the existing literature was on nutritional status, dietary intake, role of antioxidants, etc. but there is limited data available on risky health behavior of elderly which hardly deals with the root causes of using these substances as well as other socio-economical hurdles they experience in the life span of elderly. Thus, there is to be need to research and create awareness among elderly and caregivers particularly on risky health behaviours and finally the health problems of the elderly need to be addressed from a life-course perspective than in isolation.

Conclusion:

Thus, on the whole, substance abuse and its frequency of use seem to be high among elderly. With a higher proportion of rural elderly using one or the other substance, there is a need to work on preventive aspects of health care and educate them about its adverse consequences. Not only it affects the physical environment as well as social environment of individual well-being. It is important to create public health awareness, particularly on risky health behaviours. The need for development of geriatrics and sensitization towards the psycho-social needs of the elderly also needs to be raised among the government, health care providers and individual citizens. To change the behavior among elderly the holistic and integrated approach should be used to minimize the falls. India has to create better health systems management for

the elderly. The existing laws should be strictly enforced regarding harmful substance uses and its distribution all over the country.

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3

Tuberculosis and Elderly: Challenges on Diagnosis, Treatment and Prevention

P.Murugesan & K.Sathyamurthi

ABSTRACT

Tuberculosis is emerging as a significant health problem in the elderly. The symptoms are often non-specific and may be attributed to changes related to age. This often leads to a delayed diagnosis and more advanced disease at presentation. Diagnosis, Treatment and Preventive strategies among the elderly population, continues to be a challenge. The World Health Organization (WHO) declared TB to be a global health emergency. Ending the TB epidemic by 2030 is among the health targets of the Sustainable Development Goals. The geriatric population among all ethnic groups and both genders, represent the largest reservoir of TB infection, particularly in developed nations. Clinical features of TB in older adults may be atypical, non-specific, and confused with concomitant age-related diseases. Underlying acute or chronic diseases, malnutrition, and the biological changes with aging, can disrupt integument barriers. Diagnosis of TB can be difficult and consequently overlooked; this treatable infection may unfortunately be recognized only at examination. Furthermore, therapy of TB in the elderly is challenging because of the increased incidence of adverse drug reactions. Optimal treatment of associated chronic diseases, limitation of polypharmacy, and adequate nutritional support are essential for this vulnerable population. The control of TB in this group is essential for the overall success of TB control programmes. This article reviews the current global epidemiology, clinical characteristics, diagnosis, management, and prevention of Mycobacterium tuberculosis infection in community-dwelling and institutionalized aging adults.

Keywords: *Tuberculosis, MDR TB, Elderly, Challenges.*

Introduction: Tuberculosis (TB) is one of the top 10 causes of death worldwide. In 2017, 10 million people fell ill with TB, and 1.6 million died from the disease (including 0.3 million among people with HIV). Multidrug-resistant TB (MDR-TB) remains a public health crisis and a health security threat. WHO estimates that there

were 558 000 new cases with resistance to rifampicin – the most effective first-line drug, of which - 82% had MDR-TB. Ending the TB epidemic by 2030 is among the health targets of the Sustainable Development Goals. (*WHO-2018).*

Population ageing is an inevitable and irreversible demographic reality that is associated with welcome improvements in health and medical care. With longevity and declining fertility rates, the population of older persons (60 years and above) is globally growing faster than the general population. *(India Aging Report-2017).*

India is undergoing a demographic transition while 8 percent of its population was recorded 60 years and above in 2011 Census, The percentage of elderly people is expected to go up in India from 8% in 2015 to 19 % in 2050. The country now faces the major challenge of how to take care of such a large population of senior citizens – whose number is set to grow three-fold from around 100 million at present to 300 million by 2050 *(Help Age India Report – 2018).*

With this kind of an ageing scenario, there is a pressure on all aspects of care for the older persons-be it financial, health or shelter. As the age of a person increases, be it male or female the old age health problems increase too. Weaker immune systems make the elderly more susceptible to tuberculosis (TB). However, it is not incurable. Along with the elderly population's growth in numbers, there has been an increase in the number of tuberculosis (TB) cases among elderly. Around the world there is a lack of data on the health of older people in low and middle-income countries. From India, not much data on the problem of tuberculosis in the elderly are available. With changing demography of the population, and increase in the number of elderly, more and older individuals are being diagnosed as suffering from tuberculosis. However, the problem of geriatric tuberculosis has not received the attention it deserves. It is evident from the dearth of literature on this common problem affecting the elderly.

Elderly are the more susceptible to tuberculosis (TB): In most people, their healthy immune system is able to fight off bacterial infections. But this is not so in the elderly who have weakened immunity, TB isn't always fatal, even when it infects old people. Fatalities in the elderly are usually not caused by TB itself.

Rather, they tend to occur because of other conditions such as ischaemic heart disease or renal failure, for that reason, it's not just the old who are at greater risk of contracting the disease. People suffering from cancer, HIV, diabetes or end-stage renal failure are among those who can easily catch TB because of a weak immune system. Older people are more likely to be under-diagnosed and are more likely to die unscreened and untreated. The factors that put older people at such high risk are tobacco use, low socio-economic status, and previous disease, longer delays in seeking medical attention and very high rates of adverse reactions during treatment, an estimated 16% die without being cured [3].

Mode of Infection: Tuberculosis in old people may be either exogenous or endogenous in origin. Over 90% of cases in the elderly represent endogenous tuberculosis, i.e., reactivation of dormant infection in the lungs or elsewhere in the body. In the remainder, it may be exogenous, i.e., acquired from an outside source, usually a sputum positive case. In individual cases, it is rarely possible to be sure which of these two mechanisms has been responsible, but there are theoretical reasons to believe that in old people, endogenous reactivation is more important. (*Rita Sood-2000).*

Challenges on Diagnosis among elderly: Some of the problems that are encountered in the diagnosis of tuberculosis apply to any disease in old people. Perhaps the biggest problem is their inability to give an accurate account of their symptoms. The contributory factors may be poor memory, deafness, mental confusion or impairment of speech. Old people, and sometimes also their family members wrongly attribute their symptoms to the effect of old age. The presence of other chronic diseases may confuse the clinical picture, both for the patient and the doctor. In particular, concomitant malignant disease can mask the symptoms of tuberculosis since the two conditions may coexist at this age. (*Rita Sood-2000).*

Challenges on treatment among elderly: The main cause of failure of treatment in tuberculosis, whatever the age, is poor patient compliance, and in the elderly this problem is accentuated. Old people especially the very old are unreliable about taking tablets regularly, at the right time or in the right dose, particularly if several

drugs are to be taken concurrently. Poor memory, poor eyesight and mental confusion may be contributory factors. Old people often become apathetic about their treatment and lack the determination required to complete a course of treatment of six months. Many countries, therefore, prefer to use supervised intermittent chemotherapy for such patients. Side effects of certain drugs may also lead to poor compliance with the treatment. A careful watch must be kept for the side effects of drug treatment because the old persons. In a retrospective review, it has been reported that elderly people were nearly three times more likely to have reactions to anti tuberculous drugs as compared to younger patients *(Teale C-(1993), Pande JN - (1996).*

Prevention of tuberculosis among Elderly: In older people, the immune system undergoes a gradual weakening with age, a condition known as immune senescence they also tend not to be as fit and healthy as younger people, especially if they are living alone. Keeping fit and ensuring good nutrition is probably the best way for the elderly to make sure their immune system is up to scratch. Fatalities can occur if the disease is not caught early. Early and adequate access to health care through their primary care physicians is therefore crucial for the elderly[4].

Research studies on Tuberculosis and Elderly: A retrospective cohort study conducted in 12 selected districts of Tamil Nadu, India. Patients aged 60 years and above reported that among older TB patients, the risk for unfavourable treatment outcomes was higher for those aged 70 years and more (RR 1.5, 95% CI 1.2–1.9), The results of this study showed that a major proportion of the elderly were out of the work force, partially or totally dependent on others, and suffering from health problems with a sense of neglect by their family members. *(Ramya Ananthakrishnan - 2013)*

Another retrospective cohort study conducted in Taminlnadu among elderly (Age above 60 yrs) and younger (15–59 yrs) reports that, among a total of 352 elderly and 1933 younger new smear positive pulmonary TB, the elderly had higher loss to follow-up (15% vs. 11%; p = 0.03) and death rates (9% vs. 4%; p,0.001). Side effects related to anti-TB drugs were reported by a higher proportion of elderly patients (63% vs. 54%) (p = 0.005). The Research's recommended that there will be

a need for geriatric counselling centres that can take care of their physical and psychological needs. *(Banu Rekha V V- 2014).* Various studies done in India, Hong-Kong, Ethiopia have shown that TB patients aged 60 years and above are one such sub-group with poor treatment success owing to poor treatment adherence, poor tolerance to therapy, higher mortality rates and co-morbidities *(Teale C-1993, Arora V K-1989, Stead W W –1965)*

Conclusion: Unlike many other diseases seen in the elderly, tuberculosis is potentially curable if treated early. It is, therefore, extremely important that all those who care for the elderly are alert to the diagnosis and treatment of Tuberculosis. There is a growing need for interventions to ensure the health of this vulnerable group and to create a policy to meet the care and needs of the disabled elderly. Further research, especially qualitative research, is needed to explore the depth of the challenges of the elderly especially to address on the diagnosis, treatment and prevention of tuberculosis control programme.

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4

Elderly Well-being: Contribution of socio-emotional selectivity theory

Sreelekha N & Surendra Kumar Sia

ABSTRACT

In this study, the researcher reviewed the last fifteen years of the scientific literature review on well-being of the elderly. The literature review primarily focuses on the role of socio emotional selectivity theory, a life span developmental theory in the elderly well-being. According to socio emotional selectivity theory, aged people's motivation is more concentrated on deriving emotional meaning from life than to fulfill future goals or develop social contacts, as their perceived time in life is limited. One's prioritization of personal goals is influenced by the perceived amount of time remaining in life. As they aged, older adults' goal geared more towards to regulation of emotion and social selection. Through this study researcher try to find out how the socio emotional selectivity theory and elderly well-being is related. The conclusion and recommendations for further research are discussed in the paper elaborately.

Keywords*: Elderly, Wellbeing, Socio emotional selectivity theory*

INTRODUCTION

Aging, an inescapable reality of human existence on earth, plays a crucial role in the global demographic transition. According to the UN population division, there will be two elderly people for every child in the world by 2050. This implies the age category of 60 and above. They currently constitute less than 20 percent of the population, but will turn to 32 percent of the population by 2050.

Family serves as a fundamental structure for living intimately and sharing economic, social and emotional responsibilities. Out of 100, 43 elderly people in India are suffering from psychological problems due to loneliness, depression and other related issues. Almost half of the elderly populations were not taken care of by

their families. It observed that more than 45 percent of the elderly claimed that their family members do not care for their needs and interests (Agewell foundation, 2017).

Elderly Well-being

Well-being is the experience of health, happiness and prosperity. Good mental health, high life satisfaction and a sense of meaning are major components of well-being. Wellbeing classified into different types, mainly subjective well-being, physical well being, psychological well-being, emotional well-being, social well-being and so on.

Subjective wellbeing is a complex construct made up of various dimensions such as happiness life satisfaction and positive affect.

A state of physical well-being is not just the absence of disease. It includes lifestyle behavior choices to ensure health, avoid preventable diseases and conditions, and to live in a balanced state of body, mind, and spirit.

Psychological well-being is a state of attaining a sense of autonomy, self-acceptance, personal growth, purpose in life and self-esteem. Ryff (1989) developed six dimensions of psychological well-being, self-acceptance, positive relation with others, autonomy, environmental mastery purpose in life and personal growth.

Emotional well-being is an experience of generating emotion that lead to positive feelings. Through improving emotional well-being from the earliest stages of life, helps build a foundation for overall health and well-being.

Social well-being is the sense of feelings of belongingness and social inclusion. Social well- being can be obtained through good relationships, social stability and peace.

The subjective well-being and self-concept of elderly women are more negative than those of men. This condition is due to women are more ill, dependent, alone, poor and suffer more medical complaints than men, and have lower expectations; they tend to be considered less attractive and less valued than men. (cachioni et al., 2017).

Perceived loneliness has been a critical condition in the context of well being among elderly (Singh &Misra, 2009). Furthermore, loneliness and lack of social support have been associated with adverse mental and physical outcomes in elderly. Loneliness accounted for the excess risk of depressed mood and hopelessness that adversely affect their satisfaction with life (Golden, 2009). Older people appear to handle social relationships and use social regulation particularly social selection to maintain relatively higher level of well-being (Charles & Carthensen, 2014). Perceived satisfaction with social among elderly is more strongly related with their well-being.

Socio-emotional selectivity theory

Socio-emotional selectivity theory is a life span theory of motivation proposed by Laura L. Cartensen on 1999, grounded in the unique human ability to monitor time. As one's age increases, a person's time horizon, social preference, and composition of the social network vary.

Socio emotional selectivity theory is an alternate model of aging. It highlights the capacity of old people to regulate their emotions effectively.

As one grows older, the social spectrum begins shrinking, and the perception of time undergoes a paradigm change, that is it starts shifting from being an unlimited entity to a limited entity. This is experienced during middle adulthood, when the social interactions and the frequency of new acquaintances and friendships start declining. This decline is accompanied by the strengthening of relationships with siblings, family members, marital partners, and close friends. The quality replaces the quantity of relationships.

Socio-emotional selectivity theory emphasizes age as an significant moderator of relationship changes and age effects on relationships are moderated by relationship type (Finn,2017).

In the late-adulthood and old-age stages, time is perceived as a limited and fast-exhausting entity, and this prompts the complete shift of social goals from being knowledge-oriented to becoming emotion-related, and hence only those

relationships are maintained that are rewarding and positive, while all other types of relationships are discarded.

Socio-emotional selectivity theory also states that one's attention, memory, decision making, and emotional experiences are influenced by their perception of time. This theory does not emphasize on experience but for future changes.

Age differences in emotional memory might reflect more effective emotion regulation strategies. Anticipation of an endings leads to decreased attention to negative stimuli among college students (Pruzan & Isaacowitz, 2006).

Moreover, socio-emotional selectivity theory emphasize that encouragement for social activities among elderly people is difficult because individual preferences in activities differ. In case of elderly people who are residing in institution may feel low motivation for activities with other residents because these social contacts cannot substitute missed intimate relationships (Zank, 2001).

Therefore, socio-emotional selectivity theory carries out a significant role in predicting behaviors of human beings across their life span. In addition, it predicts elderly peoples' behavior in better perspective.

Need for review analysis:

Elderly represents a problem-ridden face of human life especially due to their physical infirmity and cognitive decline, which will stand as a barrier for elderly well being. Even though proper care and support for elders might make their livings better. This study will shed light on to understand how extend socio-emotional selectivity theory help in recognizing various contributors of elderly well-being. Through which factors leads to elderly well-being can be identified and based on these, awareness programs be conducted and implemented in the field of elderly people.

REVIEW OF LITERATURE

The Researcher reviewed last fifteen years of literature on elderly well-being in consistent with socio-emotional selectivity theory and research review more focused upon subjective, emotional and psychological well-being of the elderly people.

Lockenhoff and Cartensen (2004) examined the balance between regulating emotion and making tough choices among the elderly in which socio- emotional selectivity theory has the focus. When perceived time is limited, young adult as well as an older adult prefer emotion-focused coping strategies over problem-focused coping strategies. In addition, they prefer emotionally gratifying social contacts and not novel social partners. These will help them to meet emotional wellbeing, also their feeling of satisfaction from social network become high. The study stressed that older people are more likely to prefer familiar social partner, because familiar social partner is related with an emotionally meaningful goal, by the time novel social partner, represent future-oriented goals related to information gathering and finding new relationships.

Isaacowitz (2005) aimed to test whether optimism has a role in the well-being among adults of different ages, consistent with socio emotional selectivity theory. The study involved 100 young, 86 middle and 94 older adults. Six optimistic measures are mainly tested in this study, which are explanatory style, dispositional optimism, depressive symptoms, life satisfaction, negative and positive effect and perceived health. Results showed that elderly people showing a higher level of dispositional optimism, more optimistic affiliation explanatory style and lower level of dispositional predicts which will lead to better well-being among them. In addition, the study also found out that an individual may become more optimistic as they age, also they are very keen to regulate their socio-emotional world.

Dudley and Multhaup (2005) conducted two experimental studies on younger as well as older adults to generalize past research to new familiar and novel social partner options. In support with socio-emotional selectivity theory, which predicts that novel social partners are preferred in open-ended situations, whereas familiar social partners are preferred in future limited situations.The first study involved 72 younger adults and 72 community living older adults. In the second study 97 young, 185 middle–aged and 54 older adults participated. The study found that young and older adults in the future limited situation preferred familiar partners. In addition, study explained the power of emotion regulation better when time perceived was

limited. Therefore, socio-emotional selectivity theory predicts older adults' choice well.

Burnett-Wolle and Godbey (2007) investigated the role of socio-emotional selectivity theory in leisure behavior among older adults. In addition, the study addresses mechanisms used by elderly people to adapt to changes in later life and their sources of social support. Companionship and social support act as an important motivation for leisure participation in later life.

Kalavar and Jamuna (2008) conducted a study on interpersonal relationships of the elderly in selected old age homes in India to find out the well-being and social network among elderly who are residing in old age homes. The study showed that the absence of family members was often cited as a source of dissatisfaction when evaluating old age homes in India

Hawkley and Cacioppo (2010) examined that loneliness leads to various health problems in young adult as well as older adults. Perceived loneliness influences the health and well-being of the elderly. Perceived social connection or isolation has a modulating effect on age-related decline in physiological regulation and resilience. The study also addresses loneliness, which causes hypervigilance for social threat, and it exerts high influence on perception, cognition, and behavior of an individual and that influence morbidity and mortality through their impact on genetic neural and hormonal changes. This study also emphasizes the reduction in loneliness, which will enhance the sense of connectedness and social adhesion.

Hicks, Trent, Davis, and King (2012) conducted four studies to find out the relationship between positive effect and meaning in life consistent with socio-emotional selectivity theory. In the first study, 360 adults were included and it found that positive effect strongly related to meaning in life among elderly people. In study two and three, 514 adults included and study addresses that participants who perceived themselves having limited time left to live, have stronger meaning in life. In the fourth study 94 participants were tested and found out positive effect is strongly linked to meaning in life, for those who believed they had fewer opportunities to pursue their goal.

McLaughlin, et al. (2012) aimed to explore the effect of social support on later disability among a group of community-dwelling older men and women. This observational cohort study tested social support with the help of Duke social support index and main outcome measure of the study was activity of daily living (ADL) and Instrumental activities in daily living (IADL). The study found that the aspects of social support associated with lower risk of subsequent disability in both older men and women after controlling the presence of the chronic condition. The main interest in this study was elderly women reporting larger networks and more social engagement than men do. Socio-emotional selectivity theory identifies older adults as active participants in regulating their social environment, particularly utilizing social selection to maintaining well-being.

Penningroth and Scott (2012) examined whether the goal of younger and older adults differed in ways predicted by life span developmental theories of socio-emotional selectivity theory and selection, optimization and compensation theory. The study included forty older adults aged 65 to 87 and 69 young adults of age 18 to 29. By the assistance of personal goal questionnaire, it was found that when compared to younger adults, older adults reported more goals related to maintenance, loss prevention, emotion focus, generativity, and social selection and less goal focused on knowledge acquisition and future.

Huxhold, Fiori, and Windsor (2013) conducted a longitudinal study among adults of age 40 to 85 to look at the interacting dynamics of different aspects of social networks such as network structure, social activity engagement, and emotional support. The study involved home interviews with semi-structured self-administered questionnaires. Through maximizing the size of the social network or by actively engaging in social activity may help older adults to meet successful aging. In addition, the study also states that how different social network influencing the health and well-being of elderly people.

Uzer and Gulgoz (2014) aimed to compare the phenomenological properties of young and older adults' memories for the emotional event. The study examined 32 younger and 31 older adults, asked them to recall recent and remote memories associated with six emotional categories and completed the memory characteristics

for each study with the help of memory characteristics questionnaires (MCQ) and Turkish version of mini-mental state examination (MMSE). It Discusses the results in the context of socio-emotional selectivity theory, which helps to understand that older adults tend to reduce to express, think or talk about their angry experiences to meet emotional well- being and keep up harmony among close relationship.

Carpenter and Yoon (2015) states that older adults are more prone towards information that are positive but young adults are more biased on negative ones. These kinds of socio emotional changes of goals may influence decision-making strategies of the elderly, which are emotionally satisfied.

Barber, Opitz, Martins, Sakaki, and Mather (2016) compared young adults and older adults to find out their relative preference to attend to negative and positive information through two separate experiments. In which older adults have a greater tendency to attend and remember positive information over negative ones. The study explains this positive effect with the help of socio-emotional selectivity theory, as people get older, the perceived period in life is limited so that elderly people have a priority to achieve emotional gratification and increased positivity in the cognitive process like attention and recall.

Luhmann (2017) found that stability, as well as changes in the subjective well being of the elderly, can be explained with the help of age-related changes in motivation and goal settings. As one ages, one's intentional activities of daily needs varies, which will help support the subjective well being among the elderly.

SUMMARY AND CONCLUSION

From the analysis of recent reviews, it was found that the social network of the elderly adult generally declines in size with advancing age. The major reason for this condition of a decrease in social support might be due to the loss of members of the networks to illness and death.

Social support has a major role in influencing the well-being of the elderly. Social contacts make them physically and mentally active in daily activities. In addition, older people are more likely to prefer familiar social partner, like spouse, children or others, to whom they attached closely. Elderly living in the family may feel better

position than that of elderly in institution, may be due to better social relations, regular social interaction with family members, chance of expression of feelings and support from the family.

As the number of old age homes are increasing in India, this study will be help in finding the problem facing by the elderly people in old age home, which affect their well-being.

Older people value their limited time in life. They always give importance to present-oriented goals, make them maximize emotional well being. In addition, with age, people focus on appreciating their life and give deep meaning and consideration in their existing relationship. (Cartensen, 2006).

Socio-emotional selectivity theory provides a framework for deriving predictions about the difference in goal representations for younger and older adults. When compared to younger adults, older adults are more focused on emotions, generativity, and social selection. Their goal related to future orientation and knowledge acquisition is very less. Older adults are more likely to select goals such as remaining healthy and avoiding illness over acquiring knowledge about a topic.

Moreover, elderly physical inability to maintain contact or decreased motivation related to perception of a low remaining lifetime also lead to a decline in the social network among them.

In the context of socio-emotional selectivity theory, when perceived time in life is limited, elderly people more focused upon emotion-based coping strategies than problem-focused coping strategies. Moreover, their experience of positive effect becomes highly associated with experience of positive meaning in life.

Implications of the study

The study indicates the need for a healthy relationship, care and support for the elderly. Study will help to shed light on investigation of coping strategies that followed by the elderly in various situations. Proximity with near ones and active engagement with life will help the elderly stand away from loneliness, depression and other related issues, which will encourage them to meet well-being.

Limitations and Recommendations

Most of the studies are from the western countries. There are very less published Indian studies in this area.

As increasing old age homes in India, It remains an open question whether institutions could encourage emotional satisfying relationships between residents.

Programs and workshops to enhance the relationship between elderly people and their family members can be organized in various social institutions.

Empirical studies can be done like the extension of research on the aspects of area.

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5

Happily Ever After: Factors Influencing Emotional Intimacy of Elderly Couple

N.Shenbakam & K. Sathyamurthi

ABSTRACT

Existing in almost all societies, marriage is an important contributing factor to health and well-being. Through this union, new familial dynamics are configured and indelible bonds formed between individuals (Larson and Holman, 1994). However, due to the aging, there is a significant change and there is growing complexity in the marital relationship. There is abundant literature on marital relationships and an emerging understanding of how marriage might influence the health and well being of an individual. Over the past three decades, researchers have begun to investigate emotional intimacy as an essential feature of martial relationships. This study, with a focus on the marital relationship of the elderly couple, examined the emotional intimacy within an elderly couple in the trajectory of marital relationship and the factors that influence the emotional intimacy. It also considers the marital satisfaction in older spouses, in the trajectory of ageing.

Keywords: Elderly, Marital intimacy, Ageing

INTRODUCTION

Marital stability usually indicates increased well-being, whereas marital changes are amongst the most stressful life events (Carr & Springer, 2010; Hughes & Waite, 2009). It was found that deficiencies of marital intimacy were significantly associated with the presence of symptoms of non-psychotic emotional illness in one or both spouses (Waring et al., 1981). Abundant of literature on physical and mental health and mortality by marital status has consistently identified that unmarried individuals generally report poorer health and have a higher mortality risk than their married counterparts (James Robards, 2012) which clearly states marital relationship aids in the wellbeing of the individual. However, it depends primarily on the quality

of the marriage and not on marital status per se (Carr, Freedman, Cornman, & Schwarz, 2014). Even thought there is enough literature which examines that the marital satisfaction is important for health and well-being, although determinants of such marital satisfaction among older couples are unclear. (Ruth Walker, 2013)

Despite its importance, intimacy in older age has been neglected by gerontological researchers. Gerontologists have made considerable progress in the study of sexual intimacy in elderly couple (Gurvinder Kalra et al, 2011; TS Sathyanarayana Rao, 2016), but relatively little in understanding romantic love and intimacy in later life. By neglecting this area of research, we are potentially missing an important link in building the health and well-being of individuals and communities in this context. The understanding marital relationship is also very timely given the changes the institution of marriage has been witnessing over the last several decades.

LITERATURE REVIEW

In older age, developmental and role changes due to the limited future time horizon and the decline of contact with friends and former colleagues may contribute to a convergence in the salience for marital quality for well-being (Carr et al., 2014).

It is also important to note that the relationship satisfaction follows a curvilinear pattern over the life course, declining in the earlier years of marriage and increasing through the later years (Charles & Carstensen, 2002).

A study states that intimacy is associated with marital satisfaction. This proved to be the case with each dimension (emotional, intellectual, sexual, social, recreational, physical, and love) of intimacy. Specific intimacy dimensions proved to be differentially predictive of marital satisfaction for women and men. Emotional intimacy (the ability to share feelings and to be understood) and recreational intimacy (mutual involvement in any leisure activity) significantly predicted marital satisfaction for women. For men, sexual intimacy (the experience of sexual activity and closeness), and emotional intimacy were the most important predictors of marital satisfaction (Jennifer A. Volsky, 1998). According to another study, emotional intimacy was an important predictor of marital satisfaction for both sexes

(Schaefer and Olson, 1981). However Ageism, a negative attitude towards older people is present and the process of ageing permeates our personal and cultural expectations of elderly people. Its impact on the romantic possibilities of late life is not always readily apparent, which also fuels self imposed myths on the elderly.

METHODOLOGY

Objectives of the study:

- To assess the marital adjustment score
- To find out the factors that influences the emotional intimacy of the elderly couple in the trajectory of ageing.

The study uses a descriptive form of research design. The non probability – Snowball sampling method was used. To better understand the factors that influence emotional intimacy in married couples, mixed methods were adopted. The data were collected from the participants through in depth case studies; the qualitative data were analyzed and interpreted with the objectives of this study. The data are collected using two methodologies: self-report measures and personal narratives from the participants. The respondents will be chosen from the sampling frame. To be included in the study, the respondent had to fulfill the following criteria:

A) Participants should be living with a heterosexual partner.

B) Either of the Couple Participants has to be completed minimum 60 years.

C) Participants who don't suffer from clinical psychiatric conditions.

Instruments:

Marital Adjustment Test (MAT) Locke & Wallace (1959)

MAT is a 15 item scale which widely used self-report measure that includes the following: one item that assesses a partner's overall happiness in marriage (a seven-point Likert scale is used); eight items that assess the amount of agreement between the two spouses on several domains of family life; and six items that assess the type of conflict outcomes in their negotiations, levels of intimacy, and the desire to marry the same person again. The MAT has a high reliability in discriminating non distressed couples from couples who have documented marital problems, a high test–retest reliability, and wide use in other studies (Gottman & Levenson, 1992).

Case Study 1: Mrs. R

Demographic Details:

The Hindu couple got love Marriage, and now married for 29 years. Husband is 60 years old and the wife is 51 years, with 2 sons, staying as a nuclear family. Before marriage, the couple was courting for 5 years. Husband is retired and wife is a freelancer. The couple is staying together.

Lived Experience:

The wife perceives that she is extremely close to her partner, able to confide in to the partner and has a **Perfectly Happy marriage.** The couple's Mat Score was found out to be 85.

She finds that Communication, Trust/ Loyalty, Honesty, Sacrifice for the other, investing time in the relationship, Acceptance/Tolerance, Making the relationship a high priority, Mutual respect, Appreciation, Being Together, Presence are the factors that influences her relationship.

Case Study 2: Mrs. S

Demographic Details:

The Hindu couple got love Marriage, and now married for 33 years. Husband is 62 years old and the wife is 59 years, with 2 sons, staying as a nuclear family. Before marriage, the couple was courting for 4 years. The couple is staying in a nuclear family with one son.

Lived Experience:

The wife perceives that she is not close to her partner, not able to confide in to the partner and has a **very unhappy marriage.** She reported, if she wants to do live over again, she will choose a different partner. The couple's Mat Score was found out to be 25.

She finds that making the relationship a high priority influences her relationship.

Case Study 3: Mrs. K

Demographic Details:

The Hindu couple got arranged Marriage, and now married for 38 years. Husband is 68 years old and the wife is 61 years, with 2 children, staying as a nuclear family. Before marriage, the couple knew each other for 1 month. Husband is into Business and staying abroad and wife is a homemaker. The couple is staying apart.

Lived Experience:

The wife perceives that she is very close to her partner, able to confide in to the partner and has a **happy marriage.** The couple's Mat Score was found out to be 98. She finds that Communication, Trust/ Loyalty, Transparency, Investing time in the relationship, Acceptance/Tolerance, Appreciation, Being Together, Presence influences her relationship.

Case Study 3: Mrs. K

Demographic Details:

The Hindu couple got arranged Marriage, and now married for 37 years. Husband is 60 years old and the wife is 51 years, with 1 son, staying as a nuclear family. Before marriage, the couple was courting for 3 months. Both of them retired. The couple is staying together.

Lived Experience:

The wife perceives that she is close to her partner, able to confide in to the partner and has a **happy marriage.** The couple's Mat Score was found out to be 86. She finds that Transparency, Investing time in the relationship, Mutual respect influences her relationship.

DISCUSSION

This study aimed to explore the factors that influence the emotional intimacy in the elderly couple. It was found out that ccouple, irrespective of the age wants to be intimate with their partner. Communication is seen as important factor in the couple's emotional intimacy. Presence and Availability for each other is another important predictor influencing the emotional intimacy. All the 4 participants interviewed seem to jointly enjoy very few of the occasions outside. This seems to impact the recreational intimacy of the couple, one of the dimensions of marital intimacy. Cultural factors are prohibiting the elderly couple to be intimate

emotionally, physically and sexually. Marital conflicts get reduced as you understand about each other. Even though the participants seems to have opinion that the couple are in perfectly happy marriage, Martial adjustment score assessed using the MAT scale shows all the four couples interviewed are in distress (MAT score less than 100). This further state that the as the relationship ages, the couples seem to be satisfied with the quality of existing marital relationship.

CONCLUSION

Despite the demographic differences among the couple, certain factors were found to be very important such as Communication, Common interests, Trust, Honesty, Sacrifice for the other, Acceptance, Making the relationship a high priority, Mutual respect, Presence (Being Together). Availability and presence of the spouse together is very important for the marital relationship. Privacy though not elicited from the case studies, found to be important for emotional intimacy. Hence the joint family and extended families were found to negatively influence the emotional intimacy between the married couple. Sexual intimacy between the couple is important but it doesn't affect the emotional intimacy. It was found that for the individuals to be happy and have perfect life Emotional Intimacy is very important which influence the Happiness in Marriage, which the individuals perceive to be a happily married life. The participants who have high Emotional Intimacy are found to have good Marital Adjustment among the couple.

RECOMMENDATION:

The couple should take efforts to communicate. Among the couple, shared activity will enhance the relationship quality and hence the emotional intimacy of the elderly couple. The joint activities could be as simple as taking a walk together, gardening or discussing the daily news. The family should have better understanding and respect that there emotional intimacy in elderly couple and helping them to enhance the quality of the relationship.

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6

Factors Contributing For Psychological Problems of Older Adults

Lakshmi . J

ABSTRACT

Aging is the process of becoming older and it an inevitable, irreversible process. According to WHO, the ageing population is rapidly increasing worldwide. The increase in life expectancy over the period of time has resulted in an increase in the population of the elderly. The statistics says that the world's population over 60 years will nearly double and from 12% to 22% between 2015 and 2050. Psychological problems and well-being are as important in older age as at any other time of life. There are various factors are contributing for the increase of psychological problems such as existence of more nuclear family system, poor interaction among family members, increases in chronic diseases, medication and changes in environment and so on. Approximately 15% of adults aged 60 and over suffer from a mental disorder. Apart from the above factors the social exclusion is also has impact on psychological problems of older person. The social exclusion is widely practised by the service provider in the society. The service providers are Institutions such as elder home and day care centre and non-institutionalized is characterized, the services rendered by immediate family members and financial services are rendered by the government of India in-terms of providing pension. Hence the present study attempts to understand psychological problems such Depression, Anxiety and Stress faced by older adults in day today life.

Keywords: Older adults, family type, mental health and social exclusion.

Introduction

Greying India

India is in a process of demographic transition. There is a downward shift from a high mortality/high fertility scenario to a low mortality/low fertility scenario. The expectancy of life at birth has almost doubled from 32 years in 1947 to 63.4 years in 2011. (Government of India) Irudaya Rajan (2003) the elderly population

accounted for 7.1 % of total population in 2001 and it is projected to increase its share to more than 10 % by the year 2021. The demographic profile depicts that in the years 2000–2050, the overall population in India will grow by 55 % whereas the aged population of 60 years and above will increase by 326 % and those in the age group of 80+ by 700 %. This has resulted in an increased proportion of older people in the total population, termed as the "greying of population" (United Nation).

The traditional Indian society and the age-old joint family system have been instrumental in protecting the social and economic security of the elderly people in the country. However, with the quick changes in the social scenario and the emerging occurrence of nuclear family set-ups in India in recent years the elderly people are likely to be exposed to emotional, physical and financial insecurity in the years to come. This has drawn the notice of the policy makers and administrators at central and state governments, voluntary organizations and civil society. (Central Statistics Office Ministry of Statistics & Programme Implementation Government of India).

In view of the increasing need for intervention in area of old age welfare, Ministry of Social Justice and Empowerment, Government of India adopted 'National Policy on Older Persons' in January, 1999. The policy provides broad guidelines to State Governments for taking action for welfare of older persons in a proactive manner by devising their own policies and plans of action. The policy defines 'senior citizen' as a person who is 60 years old or above. It strives to ensure well-being of senior citizens and improve quality of their lives through providing specific facilities, concessions, relief, services etc. and helping them cope with problems associated with old age. It also proposes affirmative action on the part of Government Departments for ensuring that the existing public services for senior citizens are user friendly and sensitive to their needs. It provides a comprehensive picture of various facilities and covers many areas like financial security, health care, shelter education, welfare, protection of life and property etc. (Central Statistics Office Ministry of Statistics & Programme Implementation Government of India).

Definitions - Depression

Defined in psychology, a mood or emotional state that is marked by feelings of low self-worth or guilt and a reduced ability to enjoy life. A person who is depressed usually experiences some of the following symptoms: feelings of sadness, hopelessness, or pessimism; lowered self-esteem and heightened self-depreciation; a decrease or loss of ability to take pleasure in ordinary activities; reduced energy and vitality; slowness of thought or action; loss of appetite; and disturbed sleep or insomnia.

Stress

According to Gaurave Akrani Stress is defined as "a state of psychological and physiological unevenness resulting from the disparity between situational demand and the individual's ability and motivation to meet those needs."

Anxiety

According American psychological association, Anxiety is an emotion characterized by feelings of tension, worried thoughts and physical changes like increased blood pressure. People with anxiety disorders usually have recurring intrusive thoughts or concerns. They may avoid certain situations out of worry. They may also have physical symptoms such as sweating, trembling, dizziness or a rapid heartbeat

Methodology

The study adopted descriptive cum diagnostic research design and selected 30 as a sample size for the study by adopting convenient sampling methods. To understand the socio- demographic variables the researcher used a set of self prepared questions and to analysis the psychological problems such as depression, anxiety among respondents the investigator used standardised DASS Scale. The interview schedule method adopted to collect data from the respondents. To analysis the difference between the independent and dependent variable the chi-square test and f-test was used.

Objectives

- To know the socio-demographic details of the respondents

- To find out the level of depression, Anxiety and stress among the respondents
- To analyse the independent and dependent variables

Results and Discussion

Findings on socio-demographic data:

Twenty seven percent of the respondents were between the ages of 66 and 70 years, 30 percent between the ages of 61 and 65 years. The majority (80%) of the respondents had completed primary level education, only 20 percent of the respondents had completed middle school level education. a vast majority of them were married but only 43.3 percent of the respondents were supported by the spouse. More than half of the respondents had a habit of watching TV.

Fifty percent respondents were from semi-urban. the Majority (73.3%) of the respondents were from Nuclear family system. those days the joint family systems were supported the elderly population and care is given by the families, but the trend has changed everyone is preparing to go for nuclear families and indirectly the elderly population is neglected to live with their own children. This condition is developing lot psychological problems among the elderly population, such as anxiety, depression, and so on. Ather M TaquiFunctional (2007) disorder was found high in old age subjects living in nuclear family and living alone.

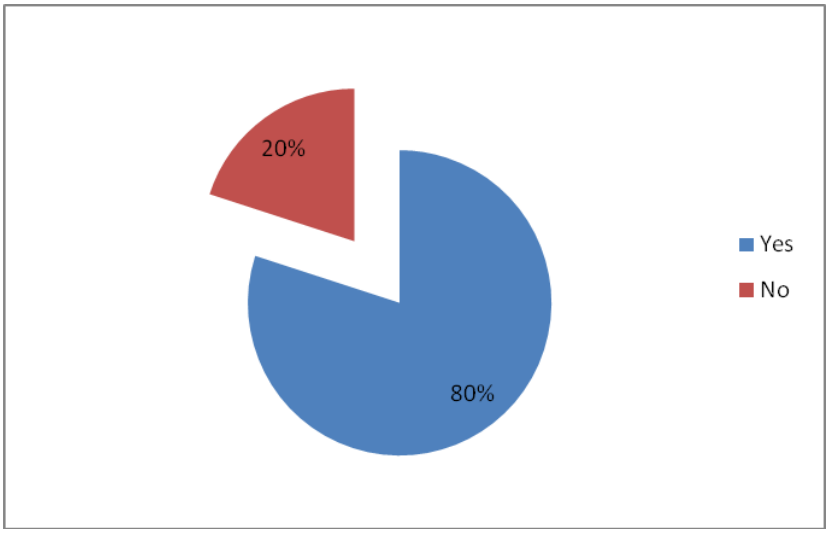
Table 1 Distribution of the respondents with Select variables

Variables	Frequency	Percent
Family is not Supported	22	73.3
Property	22	73.3
Pension	20	66.7
Family Concern	23	76.7

The majority (73.3%) of the respondents was not supported by the family members. The majority (73.3%) of the respondents did not have property, 66.7 percent of

respondents were receiving the government pension and the majority (76.7%) of the respondents' families were not concerned about the elderly population.

Figure 1 - Distribution of the respondents with their sleeping disorder



The figure 1 says that, a vast majority (80%) of the respondents had sleeping disorder. Sleeping disorder is also another important factor for psychological problems. Research reviews also proves, problems with sleep, which could include insomnia or hypersomnia, is one of the diagnostic criteria for major depressive disorder As such, it is not surprising that some type of sleep difficulty occurs in as many of 90% of major depressive disorder patients. The type of sleep difficulty experienced by those with major depressive disorder can include difficulty falling asleep, difficulty staying asleep, insufficient sleep quality, nightmares and daytime sleepiness. (J.Clin psychiatry 1999)

The feeling of loneliness is the major factor for all psychosocial problems. With regard to the lonely feeling of the respondents, 50 percent was sometimes felt very lonely. This is due the decrease of joint family system in our society. This finding also supports Alya and Knawal study, conducted 2018, the result found that loneliness level is higher in the nuclear family system as compare to the joint family system. Mean value of loneliness level (M=38.10) is greater in the nuclear family system as compare to a joint family system that is (M=24.79).

With regard to health problems more 50 percent of the respondents had acute disease, 23.3 percent of the respondents had cancer disease. The researcher also investigated how to control the increase of old home in the present scenario. The respondents were felt that, more than half (66.7%) of the youngsters should inform about the problems faced by older people in society and 33.3 percent of the respondents were felt that, the values of taking care of the elderly have to be taught properly among the younger generation.

Finding related to the level of depression, Anxiety and Stress among the elderly population:

Table 2

Depression	Frequency	Percent
Normal	2	6.7
Moderate	12	40.0
Severe	11	36.7
Very Severe	5	16.7
Total	30	100.0

With regard to the depression, 40 percent of the respondents had moderate level depression, less than half (36.7%) of them had severe level of depression. Therefore, we understand that, as age grows the psychological problems of the elderly is also increasing due to changes in the family system, interaction pattern with the family members and behaviour changes among youngsters. This finding supports the finding of Rizal Abdul Manaf, Madihah Mustafa (2016). The results showed that the prevalence of depression, anxiety, and stress among the elderly respondents was 27.8%, 22.6%, and 8.7%, respectively.

Table 3

Anxiety Level	Frequency	Percent
Mild	1	3.3
Moderate	8	26.7
Severe	8	26.7
Very Severe	13	43.3
Total	30	100.0

With regard to the Anxiety level of the respondents, majority 43.3 percent of the respondents had a very severe level of anxiety and equal no of respondents had moderate and severe level of anxiety. This finding supports **S.C. Tiwari, Nisha** Forty five elderly inhabitants who had given their consent to participate in the study been interviewed. Depression (37.7%) was found to be the most common mental health problem followed by anxiety disorders (13.3%).

Table 4

Stress	Frequency	Percent
Normal	4	13.3
Mild	15	50.0
Moderate	10	33.3
Severe	1	3.3
Total	30	100.0

It is seen from the above table that, 50 percent of the respondents had a mild level stress and 33.3 percent of the respondents had moderate level of stress.

Table 5 :ANOVA -difference among the depression and lonely feeling among the respondents

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	409.333	4	102.333	4.355	.008
Within Groups	587.467	25	23.499		
Total	996.800	29			

It is observed from the above table that there is a significant different among the loneliness of the respondents and their depression. As age grows the elderly are left out in homes irrespective of which family they belong. This finding supports Dhara RD, Jogsan YA (2013) Depression and Psychological Well-being in Old Age, study that "Forty-three per cent older persons are facing psychological problems due to loneliness, relationship issues. It was also observed that more than 45 percent elderly claimed that their family members do not care for their needs and interests,"

There is no significant different among the different age group of the respondents and their psychological problems such as depression, Anxiety and stress. From this we can understand that, as they come to old age, irrespective of older age group everybody faces the same problems and sense the same sort of feeling.

Table 6: Distribution of the respondents' Happy feeling at home

Variable	Frequency	Percent
Agree	3	10.0
S. Agree	1	3. 3
Uncertain	6	20.0
Disagree	5	16.7
Strongly disagree	15	50.0

Table 7: Different among the respondents' Depression and Happy feeling

		Sum of Squares	df	Mean Square	F	Sig.
Depression	Between Groups	9.467	4	2.367	2.973	.039
	Within Groups	19.900	25	.796		
	Total	29.367	29			
Anxiety	Between Groups	428.667	4	107.167	6.860	.001
	Within Groups	390.533	25	15.621		
	Total	819.200	29			
Stress	Between Groups	202.167	4	50.542	2.617	.059
	Within Groups	482.800	25	19.312		
	Total	684.967	29			

It is inferred from the above table that, the majority (50%) of the respondents were not felt happy at home and F test also found that that there is a significance difference between the happy feeling of the respondents and their depression, anxiety and stress of the respondents.

Finding related to independent variable and dependent variables

- There is no significant association between the spouse support and depression of the respondents. Research hypothesis is rejected .Chi-square P value > 0.05
- There is no significant association between the support extended by their children and the respondents' depression and stress. P value 0.99 P value > 0.05
- There is a significant association between the stress and feeling of loneliness of the respondents. Null hypothesis is rejected P < 0.05
- There is a significant association between the Anxiety and feeling of loneliness of the respondents. Null hypothesis is rejected P < 0.05

- There is high level of significant association between the interaction pattern and stress of the respondents. Chi-square value 0.016, Null hypothesis is rejected P < 0.05

Table 8: Association between the Marital Status and Stress

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	30.000[a]	13	.005
Likelihood Ratio	8.769	13	.790
Linear-by-Linear Association	2.167	1	.141
N of Valid Cases	30		

a. 27 cells (96.4%) have expected count less than 5. The minimum expected count is .03.

It is inferred from the above table, that there is a significant different between the marital status and stress of the respondents.

Table 9: Significant relationship between variables

		Depression	Anxiety	Stress
Depression	Pearson Correlation	1	.690**	.870**
	Sig. (2-tailed)		.000	.000
	N	30	30	30
Anxiety	Pearson Correlation	.690**	1	.729**
	Sig. (2-tailed)	.000		.000
	N	30	30	30
Stress	Pearson Correlation	.870**	.729**	1
	Sig. (2-tailed)	.000	.000	
	N	30	30	30

**. Correlation is significant at the 0.01 level (2-tailed).

It is understood from the above that there is a positive correlation between the depression and anxiety & anxiety and Stress.

Conclusion

The study reveals that, the failure of family system, unstable economic condition, poor interaction and communication pattern are causing for the psychological problem such as depression, anxiety and stress among elderly. The majority of the respondents had a severe and moderate level of depression, anxiety and stress and study also found that more than 60 percent of the respondents had a lonely feeling and that there is a significant difference among the loneliness and psychological feeling. The decline of the joint family system was a major cause for the issues related to psychological problems. Therefore, strengthening the family system and improving the communication pattern among family members are the key factor to change the present scenario. The success of an individual depends upon the happiness of an individual, if happiness increase in society there is no problem in society, even in present the researcher found that, more than half of the respondents were not happy wherever they live. Due to modernization and globalization everybody in the world goes behind the material world rather focusing on human relationships. The study found that more than 60 percent of the respondents' grandchildren are also not ready to spend time with their own grandparents instead children are going behind the technology. Slowly we are excluding elderly population which is not positive development and its going to be affects the next generation growth. Hence, it's a necessity to transform the world from materialistic to a spiritualistic to make a fruitful society and sustainable society. And countries around the world talking about the sustainability in resources for making developed nations but sustainable in resources alone is not going to solve the societal problems along with that sustainable relationship should be build in our society to change permanent change in the society its not only in the context of safeguarding older adults even to solve each and every problems. Therefore the relationships have been focussed and should make necessary revolution to strengthen those relations in terms making changes in primary institutions.

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7

Role of Social Support on Psychological Well-Being of the Elderly: Review

Athira Aneesh E K & Surendra Kumar Sia

ABSTRACT

The percentage of elderly people, classified as those above 60 years of age, is likely to go up in India from 8% in 2015 to 19 % in 2050. People in the developed countries have greater life spans than less developed countries, and that life expectancy increased significantly in these centuries due to improvements in public health, medicine and nutrition. People in old age generally experience a decline in their physical and cognitive abilities making them more inactive and dependent on other people's support to keep their life healthy. Researches show that among other factors, social support is the most important in increasing psychological well-being in elderly. The objective of the study was to review the previous literature to examine the role of social support on psychological well-being of the elderly. 14 research articles were selected and reviewed from different data base. Findings indicate that social support is a significant predictor of psychological well-being and mental health of elderly. Lack of social support and social engagement is associated with depression, loneliness, low levels of physical and psychological health and psychosocial well-being. Assessment of social support and other predictors of psychological well-being among institutionalized elderly is also recommended.

Keywords: social support, psychological well-being, elderly

INTRODUCTION

The percentage of elderly people, classified as those above 60 years of age, is likely to go up in India from 8% in 2015 to 19 % in 2050. People in the developed countries have greater life spans than less developed countries, and that life expectancy increased significantly in this century due to improvements in public health, medicine and nutrition.

Ageing is an unavoidable developmental phenomenon fetching along a number of changes in the physical, psychological, hormonal and the social conditions. In terms of biology, aging van be defined as “the regular changes that occur in mature genetically representative organism living under critical environmental conditions as they advance in chronological age.” Compared to other stages of life, after childhood, old age is the period which needs special care and support for the better living conditions of a person. This stage of life is viewed as a complicated one and should address with all possible resources. This phase of life is considered as potentially vulnerable and highly important. The aged become highly dependent on others for their functioning and daily life activities in at least some cases. As man grows, his reduced activities, physical health, income and resulting decline in the position of the family and society makes his life more vulnerable. All these factors contributes to the well-being of the person in many aspects including psychological, emotional and social and resulting in poor mental health. A sense of happiness and well-being is significant in old age as any other stages of life for a better living. Psychological well-being is about lives going well. It is the combination of feeling good and functioning effectively in emotional as well as social aspects. The concept of feeling good includes not only the positive emotions of happiness and satisfaction, but also such emotions as interest, engagement, confidence, hope and affection. The concept of functioning effectively comprises the development of one’s potential, having some control over one’s life, having a sense of purpose, and experiencing positive relationships.

For a better life pattern in the old age, there are several factors involved such as social and emotional support, financial and informational assistance, better health care facilities and engagement in any kind of activities which promote physical and mental health. A positive environment can gradually create enhancement in mental health and psychosocial well-being. When compared to young adults, old age is the period which needs increased support in all dimensions especially after retirement. Psychological well-being of the elderly thus have a greater important. According to Ryff, psychological well-being consists of achieving human potential as a goal that

develops throughout the life cycle of each individual (Ryff,2014). Hence, psychological well-being includes six dimensions that make it promising to fulfill this goal (Ryff & Keyes, 1995). The six dimensions of psychological well-being includes self-acceptance (having positive view of oneself), positive relations with others (having warm, satisfying relationships with others), autonomy (being independent and determining one's own life), environmental mastery (being able to manipulate, control and effectively use resources and opportunities), purpose in life (having goals in life and a sense of direction in one's life) and personal growth (feeling a need for continued personal improvement). In recent years, there has been an increasing concern in the study of well-being. This interest is specifically important for older adults because they have a greater likelihood of facing difficulties such as health difficulties, loss of loved ones, economic difficulties or lack of social participation.

Now a day the elderly population is the fastest growing population in our Indian societies. They generally experience a decline in their physical and cognitive abilities making them more inactive and dependent on other people's support to keep their life healthy. They require love, emotional and social support and more care in this phase of life. Researches show that among other factors, social support is the most important in increasing psychological well-being in elderly. Social support can be considered as one of the most effective resource by which people can deal with stressful events. Social relations helps to create networking and enhance communications with others which is an effective predictor of better mental health and well-being. Social support includes not only the structural characteristics of the social network, but also the functional aspects of the networks which includes the interactions between the elements of the networks that means the people. Studies affirm that social support promotes health and hence psychological well-being.

Lack of social interaction with others among the elderly can lead them to negative emotional states and depression. Such conditions can be occurred due to their age

related health problems, retirement, etc. Any kind of support such as emotional, psychological or informational can be directly reflect in their positive state of mind well-being. Old age is undoubtedly a difficult period and the elderly is faced with several health and social challenges across the world. Providing resources to manage their challenges can be helpful in restoring their hopes and happiness thus their mental health and well-being. Like any other age groups old age also need to be psychologically fit and productive as they can make it. While looking into the protective factors of psychological well-being of elderly, some researches highlighted the role of social support. They show significant positive correlations between social support and psychological well-being.

A survey conducted during May-June 2018 revealed that a large majority of the elderly in India are not getting long-term and palliative care. More than 10,000 participants across India were participated in this particular survey, and the result shows only 37.9% of the elder population is getting such care and rest of the 62.1% of the elderly did not get such care. More than half of these people, 52.4%, said they primarily need traditional family support, says a study by Agewell Research and Advocacy Centre. Older people in India often face problems such as disability, restricted mobility, loneliness, poverty and lack of awareness on accessing old-term care. With a fast growing population of older people, the ever-increasing gap between generations and the fast and demanding lifestyle of young people, for a majority of older people, life is still a struggle for independence. It is important to assess the level of social support (of any types) receiving by elderly and their psychological well-being because it will help us to assist them for improving their physical and mental health as well as enhancing their sense of psychosocial well-being. The present study aimed to examine the role of social support on psychological well-being of the elderly.

OBJECTIVE

The objective of the study is to review the previous literature to examine the role of social support on psychological well-being of the elderly.

METHOD

A literature search was conducted in different data base. Data base such as APA PsycNET, Google Scholar, Google and Science direct were searched for potentially relevant articles from 2000 to 2018. For all the data bases, the key words, “social support”, “well-being”, “psychological well-being” were used. Relevant articles were retrieved for more detailed evaluation.

RESULT AND DISCUSSION

On the bases of the study objective, 14 articles were examined. Among the 14 research articles, 3 were qualitative in nature which used interview as the method of data collection and 10 were quantitative in nature, which includes correlational and descriptive studies and 1 article was a review of previous literature. A large majority of the studies revealed a positive association between social support and psychological well-being or social support as a predictor of psychological well-being among elderly, except one which reported that perceived friendliness of residents and staff appeared to have a greater influence on psychological well-being of the elderly than perceived social support and social activities (Sook,N.P.,2009).

This study found that among 14 literatures which are reviewed, only one study was comparative in nature. Their study revealed that elderly who living alone are experiencing less satisfaction and well-being when compared to the group which is living with children or living in old age homes (Mao,X. and Han,J.W., 2018). It is also found a lack of research in India in this area. Only two studies were found and one was a review based on previously published data. But both results were supporting to the idea that social support has a major role in enhancing psychological well-being in elderly. Almost in all the studies, the participants were aged 60 and above.

MAJOR FINDINGS

- Social support is a significant predictor of psychological well-being among elderly.
- Companionship has a significant effect on the psycho-social well-being of the elderly.
- Loneliness and social networks both independently affect mood and well-being.
- Social support not only important to psychological well-being but also plays a mediating role through receiving formal financial support in old age.
- Family is the source of fundamental support in the elderly.
- Emotional support from children is significantly associated with well-being in elderly.
- Widowhood is the most important predictor of loneliness that reduces the psychological well-being and life satisfaction.
- Having social support helps elderly to consider stressful events less threatening and controllable and acts as a facilitator of stress compliance which is considered as one of the factor that affect the promotion of mental health.
- Higher levels of social engagement are significantly associated with a broad spectrum of health and well-being.
- Socially isolated elderly are less likely to be able to receive informal or formal support and more likely to be depressive.

CONCLUSION

The role of social support on the psychological well-being and mental health is clearly evident from the previous literatures. Having any kind of social support not only increases the psychological well-being but also enhances stress tolerance, positive affectivity, better physical health and overall life satisfaction and promotes other resources like formal and informal financial support.

Based on the findings, it is hereby recommended that:

- More awareness should be given to the family and care givers of the elderly regarding the role of social support in their well-being.
- Comparative studies can be done among institutionalized and non institutionalized elderly in order to understand whether there is a difference in perceiving social support and psychological well-being.
- There is a need for studying the psychological well-being and it's predicting factors among elderly, especially in Indian context because elderly is the fastest growing population and its need to be addressed seriously.
- Risk of depression and lack of social interaction among elderly who living alone or apart from family is also need to be addressed.

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8

Depression among Elders

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ABSTRACT

Ageing is the glorious stages in the life of a person ever have. Unfortunately, our present stipulation changed this concept in reverse form. Even though ageing is an inevitable part of our life, we are trying to avoid ageing and elderly. According to Population Census 2011, there are nearly 104 million elderly persons (aged 60 years or above) in India; 53 million females and 51 million males. A report released by the United Nations Population Fund and Help Age India (2016) suggests that the number of elderly persons is expected to grow to 173 million by 2026. The current share of the elderly in the state's population is 12 per cent, compared to the national average of eight per cent. Kerala has a population of 3.30 crore, according to the latest figures. While Kerala has the highest population of senior citizens in India, it is set to increase to 20% in the next decade. Recent striking news reveals the problems of ageing and the changing attitude of the new generation. (Indian Express, October 1st2018) Globalization, Modern family system, Industrialization, Urbanization, Migration, westernization, and Poverty, have rigorously affected the lifestyle of the people. These social transitions severely affect the protection of care and love of the elderly within their families. Most common penchant is to avoid the obstacle for our pleasure. Old age Homes provide food, shelter, and recreation to avoid loneliness to the destitute elders. This study focused on the depression of institutionalized elders and elders in the family. This research intends to understand the level of Depression through the Geriatric Depression Scale (GDS).

Keywords: Depression, Elders, Mental Health

INTRODUCTION

The new era is an age of technological growth and development and also demonstrates the turn down of values and good traditions. Diseases, decreasing memory and hearing, psychological and emotional imbalances decomposed the glorious stage of an individual. In old golden days, the joint family took care of the children and the elders with much mind and concern. These lend a hand to transmit and inculcate values within the family. Now the nuclear family system and 'instant' culture compel the new generation to be busy and to work without rest. Economic, Health problems and Lack of human resources were badly affecting the structure of the family. So that they cannot take care of the elders in the family and fulfill their needs as they like. Many of the social researchers studied about social problems and the well being of the elders. The government and nongovernmental organizations took many initiatives to work for the welfare of elder generations. To get more care and facilities some of them are in aged Homes and other care homes. Most of the studies revealed that depression is the most common mental disorder which we take less initiative for treatment. This study mainly focused on the depression level of elders.

LITERATURE REVIEW

Ageing which changes the different aspects of human beings that in biological, psychological and social. If we work for the well being of the old citizens we have to concentrate on these important domains. Kaplan and Beckman (2011) discussed the role of social worker for the betterment of the senior citizens in their topic on Gerontological social work. Social workers skill and values were very helpful to provide supportive and therapeutic, and educational services to older adults. James Lubben and JoAnn Damron Rodriguez(2015) in their paper Social and Health Perspectives on family care giving focused, urbanization which caused migration from rural areas to urban centres by the younger generations. This social transition disrupts the old caregiving patterns and this leads the rural elders to poverty. Older people have less financial support from their younger people in less developed countries. In the developed countries the parents have the pension, they are retired, but they are busy within their family by caring for their children and

grandchildren.Rajendra Prasad (2017) in his study on Senior citizens in India discussed the different problems of elderly people. According to his study, common psychological problems are feeling of powerlessness, feeling of inferiority, depression, uselessness, isolation and reduced competence. Elders are facing the problem like lack of care, emotional and economic support from the family. Rajendra Prasad in his paper' Problems of senior citizens in India' discussed the various challenges of elders. He stated that elders are victims of Health problems more than the younger age groups. Besides the physical illness, the senior citizens suffer poor mental health. Financial problem is one of the most important challenges in the life of the senior citizens, According to the National Institute of Mental Health (2000), Depressive symptoms in older people are often missed and undiagnosed and untreated. Diagnosis and treatment with medication and psychotherapy are highly effective in reducing symptoms in older depressed persons. Efficacy studies show that late-life depression can be treated with psychotherapy. Saraswathi Mishra (2009) in her case study of the inmates of old age home focused on the institutionalized elders and the role of family and society. Through this study, she convinced that people do not like to stay in the old age home but circumstances compel them to do so. A comparative study of emotional problems in old and middle-aged men revealed that depression is frequent among elders but not seriously treated. (Rathore.S 2009).V. Sethuramalingam(2013) denotes in his study on Mental Health and Quality of life among elderly women described the depressed elderly problems such as cognitive impairments, lack of concentration and memory. Loneliness and isolation are the most common trend that most of the elders have to face according to the study on ageing: status and problems related to elderly people. (SrivastavaMadhushika, 2013).

SIGNIFICANCE OF STUDY

Elders are the most significant group in the community. They need emotional, psychosocial and economic support from the family and the society. Their boundless experience, wisdom and values are great asset to the society. But unfortunately due to busy life and lack of interest we can't make use of their productiveness. Ageing caused to decrease strength and energy. The active man

became powerless due to ill health and cognitive problems. The joint family system replaced by nuclear family and rapid changes in social values creating unexpected problems in the lifestyle of people. So elders are facing mental and emotional problems. According to the World Health Organization (2018), mental disorders affect approximately 15% of the population over the age of sixty. Depression affects up to 5% of older adults, but that number jumps to around 13.5% for those requiring home healthcare. This study focused on the depression level of elders in the home and old age home. This study tries to understand the level of Depression among elders according to age, gender and living place. Most of the elderly are economically dependent on others for their pecuniary needs. Health problems create the biggest challenge on the elderly to get a hold from others. So it is very essential to study depression, the health problems and financial insecurity of the elders.

RESEARCH METHODOLOGY

OBJECTIVES

- To assess the depression level of Male and Female
- To identify the depression level of elders
- To compare the level of depression among institutionalized elders and elders living with the family.

HYPOTHESIS

There is an association between Place of living and Depression level, Depression and State of Economic Independence and Physical illness is the major cause for depression among elders.

RESEARCH DESIGN

This study attempts to bring focus and attention on depression level. The present study used a descriptive design to study the level of depression among elders. A statistical technique, the chi-square test was applied to test the significance of variables. The data collected is processed and analyzed using SPSS version 20.

SAMPLING SIZE AND SAMPLING TECHNIQUE

The researcher used Simple Random Sampling Technique for collecting the data. For this study, the researcher took 30 samples from Male and Female Old age Homes and 15 from elders living in Home. The total sample size was 45 elders.

RESEARCH TOOL

The researcher used the Geriatric Depression Scale (Long Form), developed by Yesavage JA, Brink TL, and Rose TL in 1983. This scale is a 30 item questionnaire and scoring classified into 0-9 - normal; 10- 19 mild depressives and 20-30 severe depressives.

RESULTS AND DISCUSSIONS

This paper tries to understand the level of depression among elders. Through this study, the researcher analyzes the correlation of gender, age, living place and depression among elders. This study viewed that there was a relationship between the state of Economic Independence and Physical illness. The researcher observed that religious life helped them to accept their suffering and to be happy.

TABLE.1.1

SOCIODEMOGRAPHIC PROFILE OF THE RESPONDENT

Profile	Category	Frequency	Percent	Valid Percent	Total
Family	Nuclear	41	91.1	91.1	100%
	Joint Family	4	8.9	8.9	
Marital Status	Married	32	71.1	71.1	100%
	unmarried	13	28.9	28.9	
Education	Primary	21	46.7	46.7	100%
	Secondary	18	40.0	40.0	
	Higher	6	13.3	13.3	

This table indicates the socio-demographic profile of the respondent. 91.1% of the respondents are from the Nuclear family. This shows industrialization and rapid changes in the society caused to replace the joint family into Nuclear family system. This affects the lifestyle and caring culture of the people. This table value points out 71.1% of respondent are married and 28.9% are unmarried. Most of the respondents are physically ill and having medication. Educational statuses of the respondents, 46.7% have Primary, 40% have Secondary and 13.3% have Higher education.

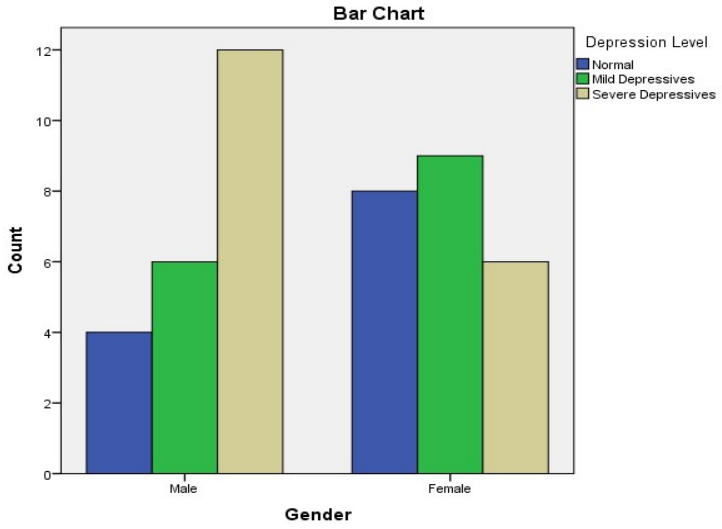

FIGURE.1

GRAPHIC REPRESENTATION OF DEPRESSION LEVEL AND GENDER

This cross-tabulation figure shows the Depression-level among Male and female elders.33.3% Male are Normal, 40% have Mild Depressives and 66.7% have Severe Depressives. 66.7% Females are Normal, 60% have Mild Depressives and 33.3% have Severe Depressives. Male have Severe Depressives than Females.

TABLE.1 GENDER AND PLACE OF LIVING

Gender		Place of Living		Total
		Old Age Home	Family	
Male	Count	15	7	22
	% of Total	33.3%	15.6%	48.9%
Female	Count	15	8	23
	% of Total	33.3%	17.8%	51.1%
Total	Count	30	15	45
	% of Total	66.7%	33.3%	100.0%

Among these male respondents 33.3% are from old age home and 15.6% are from family. Among the female respondents 33.3% are from old age home and 17.8% are living in family.

TABLE.2 DEPRESSION LEVEL

Depression Level	Frequency	Percent	Valid Percent	Cumulative Percent
Normal	12	26.7	26.7	26.7
Mild Depressives	15	33.3	33.3	60.0
Severe Depressives	18	40.0	40.0	100.0
Total	45	100.0	100.0	

This table shows the level of depression among elders. On the basis of the scores, 26.7% of the elders are Normal, 33.3% have Mild Depressives and 40% have Severe Depressives. Depressive elders are not active and they are hard to start a new project. They have the feeling of unhappy, restlessness and fidgety. They are living in the past and more anxious to future.

TABLE.3 AGE AND DEPRESSION LEVEL

		Depression Level			Total
		Normal	**Mild Depressives**	**Severe Depressives**	
Age	60-69	6	6	1	13
		50.0%	40.0%	5.6%	28.9%
	70-89	6	8	15	29
		50.0%	53.3%	83.3%	64.4%
	90-100	0	1	2	3
		0.0%	6.7%	11.1%	6.7%
Total		12	15	18	45
		100.0%	100.0%	100.0%	100.0%

This table indicates the Age and depression level of the elderly. Among the Normal respondents 50% are under 60-69 age group and 50% are under 70-89 age group. Among Mild Depressives persons 40% under are 60-69, 53.3% under are 70-89 and 6.7% are under 90-100 age group. The persons who have Severe Depressives 5.6% under are 60-69, 83.3% are under 70-89 and 11.1%are under 90-100 age group.

TABLE.4 PLACE OF LIVING AND DEPRESSION LEVEL

Depression Level	**Place of Living**		**Total**	**Chi-square value**	**P Value**
	Old Age Home	**Family**			
Normal	8	4	12	.550	.760
	17.8%	8.9%	26.7%		
Mild Depressives	9	6	15		
	20.0%	13.3%	33.3%		
Severe Depressives	13	5	18		
	28.9%	11.1%	40.0%		
Total	30	15	45		
	66.7%	33.3%	100.0%		

This table indicates the depression level of elders within the family and old age Home. Elders within old age home, 17.8% are Normal, 20% have Mild Depression and 28.9% have severe depression. Elders within the Family 8.9% are Normal, 13.3% have Mild depressives and 11.1%% have Severe Depression.

HYPOTHESIS: 1. There is an association between Place of living and Depression level.

This presents the relationship between Place of Living and Depression level. In this Chi-square test P value (.760) is higher than 0.05. There is no strong evidence for the relationship between Place of living and Depression among elders.

TABLE.3.2

DEPRESSION LEVEL AND STATE OF ECONOMIC INDEPENDENCE

Depression Level		State of Economic Independence			Total	Chi-square value	P Value
		Not dependent on others	Partially dependent on others	Fully dependent on others			
Normal	Count	5	3	4	12	13.360	.010
	% of Total	11.1%	6.7%	8.9%	26.7%		
Mild Depressives	Count	1	4	10	15		
	% of Total	2.2%	8.9%	22.2%	33.3%		
Severe Depressives	Count	0	3	15	18		
	% of Total	0.0%	6.7%	33.3%	40.0%		
Total	Count	6	10	29	45		
	% of Total	13.3%	22.2%	64.4%	100.0 %		

Among the persons who fall under the normal category, 11.1% are not dependent, 6.7% are partially dependent and 8.9% are fully dependent. Persons with mild depression are 2.2% are not dependent, 8.9% are partially dependent and 22.2% are fully dependent. Among the persons who are severely depressive, 6.7% partially dependent and 33.3% are fully dependent others for their financial needs.

HYPOTHESIS: 2 Depression and State of Economic Independence are closely related.

This table shows the P value (.010) is less than 0.05. So there is evidence for the relationship between Depression Level and State of Economic Independence

TABLE.3.3

DEPRESSION LEVEL AND PHYSICAL ILLNESS

Depression Level		Physical Illness				Total	Chi-square value	P Value
		Healthy	Minor Physical Illness	Chronic Illness	Bedridden			
Normal	Count	6	6	0	0		16.938	.010
	% of Total	13.3%	13.3%	0.0%	0.0%	26.7%		
Mild Depressives	Count	2	9	3	1	15		
	% of Total	4.4%	20.0%	6.7%	2.2%	33.3%		
Severe Depressives	Count	0	9	6	3	18		
	% of Total	0.0%	20.0%	13.3%	6.7%	40.0%		
Total	Count	8	24	9	4	45		
	% of Total	17.8%	53.3%	20.0%	8.9%	100.0%		

Among the persons who fall under the normal category, 13.3% are healthy and 13.3% are minor physically ill. Among the persons with mild depression, 4.4% are healthy, 20% are minor physically ill, 6.7% are chronically ill, 2.2% are bedridden. Among the persons who are severely depressive, 20% are minor physically ill, 13.3% are chronically ill, 6.7% are bedridden.

HYPOTHESIS: 3 Physical illnesses is the major cause for depression among elders.

This statistical test presents the P value (0.010) is less than 0.05. So there is evidence for the relationship between Depression Level and State of Economic Independence

FINDINGS

- On gender basis, the male Depression level is higher than females.
- 70-89 age groups have high Depression level
- There is no relationship between the Place of Living and Depression Level
- There is a relationship between the State of Economic Independence and Depression Level
- There is an association between Physical illness and Depression Level

SUGGESTIONS

- ☞ Counseling and Therapeutic Interventions through community health centers will help to strengthen mental health of both institutionalized and home based elders.
- ☞ Interaction of children and adult with the elders will help to enhance their emotional balances. Old aged day celebrations in schools and community will help to increase their self esteem.
- ☞ Proper treatment for Depression and Health problems will help to diminish the Depression Level among elders.

CONCLUSION

Even though, the elderly people facing many problems they are the 'powerhouse' of the family, community and the nation. The experience of the aged is real knowledge and that guides the individual in the right path. The new generation has a profound duty to give care concern and protection to the elder people. This study focused on the level of Depression among elders. Through this study, the researcher understands the aged people are waiting for the presence of youth and children. Most of them are anxious about their future and fed up with their physical and emotional problems. The new generation has the duty to understand the elders and work for the well being and happiness of the elders through support and presence.

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9

Mental Well- Being of the Elderly

Harini M & Lakshmi J

INTRODUCTION

Ageing is a normal inevitable and universal phenomenon. The population of elderly in India, over 60 years, ranks second in the world. The absolute population of the aged over 60 years was about 76 million in the year 2001, and expected increase to 137 million by 2021(According to US Bureau of Census, 2000). It is obvious that as then umber of elderly grows the number of those who fall into the various high-risk categorie such as physically ill and disabled, emotionally distressed, cognitively impaired, financially disadvantaged, physically and emotionally abused and socially isolated- also grows. It also remains the biggest risk factor for developing mental health problems, one important reason could be lder slacking in their social relationship sespecially in their familie sand longing for love, care and affection, which results in mental health problems like depression, lonelinessetc. The term mental health is a said to be a state of mind characterized by emotional well- being, relative freedom from anxiety and disabling symptoms, and capacity to establish constructive relationships to cope with the ordinary demands and stressors of life (Goldenson, 1984). The elderly can become more vulnerable for mental health problems when they become of advanced age and they are nomoreable to perform many of the daily activities they used to do independently. The prevalence of aging population is increasing not only in developed countries, but also in the developing countries like India. The problems of the aged which mainly constitutes to mental health problems can be psychological, psychosocial and environment and health problems. At the psychological level it causes impairment of intellectual functioning, difficulty in adjustment with the changes, decrease or slow in learning process , decrease in

self-confidence and motivation, rigid/ inflexible attitude. At the psychosocial and environment level, it causes feeling of neglect and loss of importance in the family, loneliness and feelings of unwantedness, feeling of inadequacy of skills education and expertise. The aim of this study was to understand the factors contributing to affect the mental health of the elders and to measure the mental well-being of the elders in the institutionalized and non-institutionalized sectors in urban community.

REVIEW OF LITERATURE

The review of literature for the present study was on the following topics, Elderly Mental Health, the Needs of Older People with Mental Health Problems, Mental Health Disorders in Elderly People Receiving Home Care, Prevalence of mental illness in a rehabilitation unit for older adults and Geriatric mental health: The challenges for India.

Shubhangi R. Parkar (2015) study highlights the mental health needs of the elderly. It tackles the issues of their institutionalization and community care. Rapid urbanization in Indian society throw sups special problems in elderly care. There is great evidence o f a raise in morbidity, mortality, hospitalization and loss of functional status related to common mental disorders in the elderly patients. Over lap of depression and anxiety is very common with up to almost half of the elderly patients reporting significant depressive and anxiety symptoms. Also, depression is the most common psychiatric disorder in late life. Growth in the elderly population means a direct increase in age related diseases such as dementia and poor mental health outcomes such as depression, anxiety, suicide and serious constraints on the quality of life among elderly individuals.

Joaquim Passos, Carlos Sequeira, and Lia Fernandes (2015) The problems and needs of older people are often associated with mental illness, characterized by a set of clinical manifestations, which constitute important domains for investigation and clinical practice. This paper presents the results of a pilot study whose main purpose was to identify met and unmet needs and to analyze their relationship between those needs, psychopathology and functionality in older people with mental health problems. A sample of 75

patients aged 65 or over, of both sexes, diagnosed with mental illness using ICD-9. The main diagnoses were depression (36%) and dementia (29.3%). The main unmet needs found were daytime activities (40%), social benefits (13.3%), company (10.7%), psychological distress (9.3%), and continence (8%). The majority of these unmet needs occur with dementia patients. Findings also reveal that a low level of functionality is associated with dementia diagnoses. The association analyses suggest that dementia is an important determinant of the functional status and needs.

Wang, Jinjiao; Kearney, Joan A.; Jia, Haomiao; Shang, Jingjing (2012) The final analysis was conducted on records from 28,475 elderly patients with an average age of 79 (range 65–110). Patients were primarily female, White, Medicare beneficiaries, referred from short-stay acute hospitals, and living with others at home. Prevalence of MHDs was approximately 40%; depression (28.0%) and anxiety (18.9%) were common. Factors associated with MHDs were younger age, female, smokers, frail, living alone, referred from psychiatric hospitals, cognitively or sensory impaired, poorer health status, recent history of falls or multiple hospitalizations, and insufficient social support. Only about one third of patient side notified with MHD received mental health services during the 60-day home care episode, including psychiatric nursing services and depression interventions.

Shaha, M Evansb and Kinga (2016) the prevalence of psychiatric disorders was studied in 78 elderly people in are habilitation unit for older adults. The patients were assessed using the Evans Liverpool depression rating scale, Hospital Anxiety and Depression scale and Mini-Mental State Examination. Twenty-eight (35.9%) patients were found to be depressed, 15 of these also had raised anxiety. Thirty-one (41.0%) patients had significant cognitive impairment and 14 of these had associated depression. Only 33 (42%) had no evidence of either cognitive impairment or mood disorder. On discharge, 20 (25.6%) patients were on antidepressant treatment but higher prevalence of depression in this situation compared with the reported prevalence of 20–30% in the acute hospital setting. We recommend that all patients

undergoing rehabilitation should be routinely screened for depression as it is common and treatment will improve the overall outcome.

Pragya Lodha, Avinash DeSousa (2018) This article says that the social factors also plays a major role geriatric mental health problems, it extends saying multiple social, psychological, and biological factors determine the level of mental of a person at any point of time. Along with the typical life stressors common to all people, many older adults lose their ability to live independently because of limited mobility, chronic pain, frailty, or other mental or physical problems. In addition, older people are more likely to experience some events characteristic of the phase of the life they are in such as bereavement, a drop in socio economic status with retirement, or a disability. Other challenge is that the heterogeneity of clinical presentations in geriatric mental health.

METHODOLOGY

OBJECTIVES OF THE STUDY

1. To know the socio-economic condition of the respondents.
2. To understand the factors contributing to affect the mental health of the elders
3. To measure the mental well-being of the elders.

RESEARCH DESIGN

Descriptive research includes surveys and fact-findings enquires of different kinds. The major purpose of descriptive research is description of the state of affairs as it exists at present. The methods of research utilized in descriptive research are survey methods of all kinds, including comparative and correlational methods. This study follows descriptive research design, Descriptive research studies are those studies which are concerned with describing the characteristics of the research problem, and here the research problem taken into account is mental well-being of elders. This research tries to understand the factors contributing to affect the mental health of elders and to measure the mental well-being of the elders.

UNIVERSE OF THE STUDY

The universe for the research is located in Ayanpuram; it includes elders from institutionalized and non- institutionalized background.

SAMPLING TECHNIQUE

The researcher used convenient sampling technique, because the sample was selected based on the availability.

SAMPLE SIZE

30 respondents were taken as a sample size by the researcher.

TOOLS OF DATA COLLECTION

Interview schedule and the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was used to collect the data from the respondents.

MAJOR FINDINGS

- 23% of the respondents are in the age group of 61-65.
- 97% of the respondents have studied till primary education.
- 83% of the respondents were in joint family system.
- 100% of the respondents are female.
- 53% of the respondents were residing in rural places.
- 93% of the respondents have no job experience.
- 7% of the respondents have worked as a domestic worker.
- 100% of the respondents were married.
- 80% of the respondents have no support from their spouse.
- 100% of the respondents have children.
- 67% of the respondents have no support from their children.
- 90% of the respondents not owning any property.
- 53% of the respondents do not get old age pension.
- 67% of the respondents mentioned their family does not have concern on them.

- 87% of the respondents mentioned their grandchildren are not affectionate to them.
- 90% of the respondents are having sleeping difficulty.
- 73% of the respondents have agreed that they are feeling happy in the institution.
- 70% of the respondents mentioned sometimes they feel lonely.
- 93% of the respondents feel they are being accepted by the society.
- 80% of the respondents have willingly joined the institution.
- 60% of the respondents have mentioned that prepared for old age is needed.
- 53% of the respondents have acute disease.
- 67% of the respondents mentioned watching television as their hobby.
- 100% of the respondents mentioned that the organization is addressing their health problems.
- 80% of the respondents mentioned sometimes they will interact with others in the home.
- 60% of the respondents mentioned that elders should adjust and understand to prevent the increasing number of elderly home.
- 73% of the respondents are ranging in the level of 31-40 in Warwick-Edinburgh Mental Well-being Scale.

SUGGESTION

- Older people may be supported to **"adjust" to the circumstances"** that they are in. it is necessary to focus on "need" while understand assessment of people rather than the strengths and the contribution that an individual can make.
- It is important to prepare health providers and societies to meet the specific needs of older populations, like **prevention and management** of age associated chronic disease including mental, neurological and substance use disorders.

- Promoting mental health like **social support** for elderly populations and their caregivers, especially for the vulnerable groups like those who live alone, from rural populations, those who suffers from chronic diseases.
- The**awareness**onelderlycareandtheirmentalwell-beingcanbetaughtintheschools and colleges.
- The **workshop, seminars** can be conducted in the **workplace** for the working men and women in order to make them understand the role of elder sin their families that they will be to handle their elders with love, care and affection by spending time with them.
- **Socialization** with elders can be motivated among youngsters, and adults.
- The **community counselling centre** can be established for the elders at free of cost in order to help the elders in strengthening their self- esteem and self-confidence.
- Every individual should always inculcate the habit of **extend their hands to help** the needy elders.
- The government can conduct **awareness on the legal provision** for the elders to prevent themselves from elder abuse and other benefits provided by the Indian constitution.

CONCLUSION

The present study showed that elder people in the institutional care are having low mentalwell-beingthancomparedtotheelderpeopleinthenon-institutionalsetup.The mental well-being of the elder are mainly affected because of lack of love, care and affection from their intimate relationship (family, son, daughter, grandchildren, friends etc.), and the stigma is which attached to them by the society makes them more reluctant to became socialize with others. There is a need of multi-dimensional approach to solve the problem. There should be community level primary health care, government should strive through its schemes and legislations to give a dignified life to older people.

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10

Attitude of Youth towards the Elderly

Jeena Joby, Teresa John, Bijo B Jose & Siju Thomas

ABSTRACT

Diversities and contradictions in the family ties have led to significant changes in the attitude of youth towards the elderly. Inevitable changes in the social life and institutions had taken place as a part of social development and evolution. Even though the constitution and legislative mechanisms put forward some solutions in this regard, this issue is not yet resolved. As it is a troublesome issue, the researcher hypothesized as attitude towards elders, which was evolved from the incidents reported in newspapers. Reports on incidents of neglecting and abandoning elders are increasing day by day. For this the researchers selected 100 students in the age group of 18-25 years, studying at Mar Augusthinose College Ramapuram, consisting of both male and female, as the population. Systematic random sampling was used. A standardized tool named Attitude Towards Elderly Scale (ATES-ss) was found suitable for the data collection. Statistical techniques were applied to analyze the data. Qualitative and quantitative techniques were used to analyze the data. In qualitative data analysis, convergent techniques such as in-depth interview was conducted for supporting the qualitative data analysis and conclusion. In quantitative research analysis central tendencies and standard deviations were used. For further analysis, inferential statistics such as T-test and Kruskal-Wallis test were used. As a whole, this study found that there is a progressive unfavorable tendency towards the elders. Here it is clear that in this fast moving and technological world, proper care, support, social security and humanitarian consideration should be given to this vulnerable section. The elders can be rehabilitated in a more convenient and supportive atmosphere, such tendencies are emerging. The social worker can work as a catalyst by utilizing the existing facilities for elders with new approaches, such as common rehabilitation centers on each place, where family members are working in different places as bread winners.

Key words: Elderly, Attitude, Youth

Introduction

Diversities and contradictions in the family ties have led to significant changes in the attitude towards the elderly. Attitude is an individual's predisposed state of mind regarding a value and it is precipitated through a responsive expression toward a person, place, thing, or event which in turn influences the individual's thought and action.("Attitude (psychology)," 2019). The present generation views the elderly as a burden rather than an asset. Some parents do not want to 'burden' their families and knock at the doors of government homes.(Roshni, 2019) It is from the family that an individual learns the basic values of respect towards the elderly. But nowadays the number of nuclear families has increased which has led to fewer opportunities to live with the elder citizens. In this mechanical word the younger generation fails to show enough courtesy towards the elderly. This has become a disturbing social phenomenon. So, it is very important that the younger generation must learn the importance of respecting the elders and find time to spend with them.

Review of literature

According to Ms. Tanya Sharma (April 2016) there are similarities as well as differences in the ways the young and the elderly perceive ageing. The World Health Organization considers an age of 65 and above as old age. Ageist attitudes and prejudices about old age are reflected in many ways in our present world scenario. The negative attitudes towards elderly is a result of some myths and stereotypes about old age("(PDF) Conception of Ageing," n.d.). A research conducted on Contact, Anxiety, and Young People's Attitudes and Behavioral Intentions Towards the elderly showed that the attitude towards elderly depend largely on the stereotypical views, whether it is positive or negative and that the quality of contact with the elders is more important than the contact frequency.(Bousfield & Hutchison, 2010). The Logical Indian reports cases on a heinous custom called 'Thalaikoothal', which is the traditional practice of senicide, observed in some parts of Southern districts of Tamil Nadu state of India. The main reasons behind this evil practice as understood till date is that nowadays the youth considers elderly as a burden rather than an asset, which is a result of greater employment, modernization and industrialization.("Thalaikoothal," 2015).Negative attitudes of elders about themselves and the adverse attitudes shown by others towards can equally affect the well-being of elders.Therefore in order to have a healthy ageing one must develop positive attitude towards the twilight of life. Bless Retirement Living,is a new

practice in different parts of india especially Bangalore, Delhi,and Ernakulam.Bless retirement living is a space for those aged above 55,after their retirement could explore the possibilities of ageing gracefully and with dignity("Bless Retirement Living," n.d.).

Significance of the study

In this era of increasing number of old age homes, there is a question what leads to this trend. A growing body of research and global data collected and analyzed by Orb Media shows a strong connection between how we view old age and how well we age. Individuals with a positive attitude towards old age are likely to live longer and in better health than those with a negative attitude. Older people in countries with low levels of respect for the elderly are at risk for worse mental and physical health and higher levels of poverty compared with others in their country. A shift in attitude, the research shows, could improve a lot. Hence healthy ageing is increasingly important (Terry, 2018).

Method

Descriptive Research Design was the perceived method for describing the attitude towards elderly among the youth.

Objectives

1. To study the attitude of youngsters towards elders.
2. To study the attitude towards elders among male and female.
3. To study the attitude towards elderly with respect to cla

Hypothesis

$H_0$1.There is no significant difference between the attitude towards elderly among male and female.

$H_0$2.There is significant difference between the class and attitude towards elderly

Tool

The researcher used Attitude Towards Elderly Scale (ATES-ss) developed by Dr. (Mrs.) Sunita Singh. There were 20 questions all together. The scoring was done using the manual.

Data analysis

After collecting the data, the researcher went through the process of editing coding and tabulation as per the directions given in the manual. Here qualitative and quantitative data analysis was done. In qualitative data analysis, researcher went through abstracts, journals and newspapers for depicting the background and present status of the research topic. In quantitative data analysis descriptive and inferential statistics were used. In descriptive statistics average and standard deviation were taken. In inferential statistics higher forms of statistical analysis such as T-test, Kruskal-Wallis test were used to find out the mean differences of gender and class. For this process SPSS (version 16) had been used.

Analysis and Interpretation

Table 1

Attitude Towards Elderly Score of the Students

Sl. No.	N	Grade	%	Interpretation
1	0	A	0	Extremely favorable
2	13	B	13	Highly favorable
3	15	C	15	Above average
4	42	D	42	Moderately favorable
5	18	E	18	Unfavorable
6	8	F	8	Highly unfavorable
7	4	G	4	Extremely Unfavorable

The above table shows a general picture of attitude towards elders. 42%, majority of the respondents have moderately favorable attitude towards elders. While 15% of respondents showed above average attitude, 13% have highly favorable attitude. Around 30% of respondents have unfavorable attitude towards elders, which means a changing attitude is clear.

Table 2:

T- test for Attitude Towards Elders Among Male and Female

	Gender	N	Mean	Std.de tion	t	df	Signific e
Attitude towards elders	Male	50	72.10	8.340	4.088	98	.000
	Female	50	78.56	7.437			

As it is clear from the above T-test, for 50 males and 50 females, the mean values of the obtained data are 72.10 and 78.56 with a standard deviation of 8.340 and 7.437 respectively. Calculated t- value is 4.088 and the corresponding significant value is .000 with 98 degrees of freedom. That means the researcher rejects null hypothesis, as the calculated value is not coming in the normal distribution. So alternate hypothesis is accepted, which means attitude towards elderly significantly deviates.

Table 3:

Kruskal-Wallis test for Class Vs. attitude towards elders

Variables	N	Mean	Std. Deviation	Chi square	df	Significance
Attitude towards Elders	100	75.33	8.506	6.738	3	.081
Class	100	2.40	1.025			

The Kruskal-Wallis test for Class Vs attitude towards elders shows that for 100 students, the mean value of the data obtained is 75.33 and 2.40 with a standard deviation of 8.506 and 1.025 for attitude towards elders and class respectively. The calculated Chi square value is 6.738 and the corresponding significant value is .081 with 3 degrees of freedom. From this it is clear that as age increases there is no corresponding change in the attitude towards elderly, i.e., attitude towards elderly is equally distributed among the population. Thus, we accept the null hypothesis that, there is no significant difference between class and attitude towards elders.

Result and discussion

There is approximately the same attitude i.e., favorable and unfavorable attitude though, the unfavorable attitude towards elderly is coming closer to the unfavorable attitude. Even though the respondents who responded unfavorably have an attitude that, they think elderly should be with them, yet they have an uncertainty that how it should be. In the age of industrialization, they have to go for work. So, by whom the elderly will be taken care of is a significant question. The researcher got the same when conducted an in-depth study among the selected respondents. They said "they *must live with their family and must be taken care of by their children. The children instead of taking it as a burden must take it as a responsibility. But I can't predict the future."*

When we studied the second objective i.e. the attitude towards elderly among male and female, there is a clear picture of a much more favorable attitude towards elderly among female than that found among male. This change in attitude can be the result of many reasons like educational, economic and cultural background.

Again, when the researchers took into consideration the third objective i.e. there is no significant relation between age and attitude towards the elderly and proved the research hypothesis true. The same trend is almost equally distributed in the population.

Suggestions

In future there will be a grey revolution, by about 2050, if the population growth continues. To tackle this issue, the existing facilities should be utilized properly and novel ventures such as 'Bless' in New Delhi has to be put forward. More researches for probing multifaceted aspects of this issue has to be undertaken. Geriatric social work should be promoted. More social workers should be trained and encouraged for social entrepreneurship.

Conclusion

To finish off this study, the researchers mainly covered up attitude towards the elderly among youth. For these 100 youngsters were included by probability approach. The information regarding the subject matter was collected through a

standardized tool and was analyzed with scientific ways. The study supports the existing trends, growing negetive attitude towards elders. Social work is a profession to make a better and healthy generation. They can do remarkable professional services for this vulnerable section of the society.

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11

Programmes for Intergenerational Bonding : A Community Social Work Perspective

Mini Pradeep K.P & K. Sathyamurthi

ABSTRACT

Relationships between generations have been one of the most important social bonds in all societies. The chains of relationships between different generations are known as intergenerational relationships. Due to fast changing lifestyle, globalization, migration of young and influence of diverse ideologies the gap between generations is widening. Bringing together generations to understand each other is an essential part of developing a sustainable society. Intergenerational programmes or practice has emerged as a general approach for bringing young people into closer contact with others in their community. Intergenerational practice can be seen as a way to encourage meaningful and productive 'engagement' between the young and old in order to improve and enhance the quality of life for the young, old and general community. This paper is based on the analysis of different intergenerational programmes initiated in Kerala from a community social work perspective. The concept and attributes of community social work, the concepts of generation and intergenerational programme or practice, and theoretical foundations for intergenerational programming constitute the basis for analysing the qualitative data generated through key informant interviews.

Key Words: Community Social Work, Intergenerational Programmes, Qualitative study

INTRODUCTION

The term 'generation' is generally used to indicate different age cohort in the society Relationships between generations have been one of the most important social bonds in all societies. The chains of relationships between different generations are known as intergenerational relationships. The gap between generations is widening due to fast changing lifestyle, globalization, migration of young and influence of diverse

ideologies. Generation gap as stated by definition is considered as a difference between personal choices, opinions and perception of different generations which leads to conflicts and gap between family members (Aggarwal et al, 2017). To fill the generation gap, United Nation International Plan of Action on Ageing (UN 2002) suggests to encourage mutual relations pointing to the need of strengthening solidarity between generations, to promote strengthening of intergenerational bonds in family settings, to undertake initiatives aimed at promotion of cooperation between generations, and to increase the opportunities for maintaining and improving intergenerational relations in local communities (Mackowicz, 2014). Bringing together generations to understand each other is an essential part of developing a sustainable society, where young and old can live together with some appreciation of each other's needs and aspirations (Sturdy, 2008).

Intergenerational practice has emerged as one general approach for bringing young people into closer contact with others in their community. There is a large range of outcomes from intergenerational practice for young people, old people and the broader community. For individuals, these included increases in self-worth, less loneliness and isolation, new connections and friendships, academic improvements and more positive perceptions of other generations. For the broader community, benefits include the building of social networks, greater diversity of contact, breaking down of stereotypes, and enhancing of culture in particular communities. In particular, intergenerational programs attempt to reduce many of the physical and social barriers between seniors, children and young people. As Granville (2002) puts it, intergenerational practice brings together “two generations who have become separated from each other through changes in social structures, and enable the strengths of each age group to enhance the life experiences of the other” (p. 24). (Judith MacCallum et. al, 2006).

Intergenerational practice has a role to play in facilitating face to face contact between younger and older members of communities. Community development which "supports networks that foster mutual learning and shared commitments"

(Gilchrist, 2009, p.21) is well positioned to address the decline in social capital and intergenerational practice has a contribution to make in this regard. Intergenerational practice can become a significant aspect of community development work. One of the greatest benefits of intergenerational practice, according to Granville (2002, p.4) "has been to release the potential of older people to contribute positively to their community". Intergenerational practice can have a positive impact on communities where community development and education intersect. Many literatures on intergenerational practice has been linked to community development (Hatton-Yeo et al., 2004; Keuhne, 2003a, Murphy, 2012). This paper presents a qualitative study of planned intergenerational programmes initiated in Kerala namely 'Age Friendly College' undertaken by MAGICS (Managing and Generating Income for Community Services), an NGO based at Ernakulam District and the 'Intergenerational Programmes under Vyomithram Project' of Kerala Social Security Mission, Govt. of Kerala.

THEORETICAL BACKGROUND OF THE STUDY

Generation

The term 'generation' received little research attention till 1923, when the concept was first introduced by Karl Mannheim, in his essay, "the Problem of Generations" (Eyerman & Turner, 1998). It is conceptualised in different dimensions viz *genealogical, pedagogical* and *historical-sociological*. Genealogically it refers to the genetic succession of family members and its meaning goes back to the Latin origin *generare* meaning to generate or to originate. A micro-sociological perspective is preferred in the concept and from that point of view, generations are related family members: grandparents, children, and grandchildren. *Pedagogically* it characterizes generations as learning connections. Generations come together for learning purposes. One generation takes over a teaching role, while the other generation acts as learners. This idea is connected with the German philosopher Friedrich Schleiermacher. Today, every generation can learn from another. As a *historical-sociological* concept, it refers to different groups in a society as generations. (Franz and Scheunpflug 2016).

There are four main assumptions about generations:

- Generations exist at both societal and family levels and are intersecting.
    - At the societal level, generation has three components: shared temporal location, shared exposure to common historic events and shared socio-cultural location (Gilleard and Higgs, 2002).
    - Family generation has structural, temporal and emotional components.
- Generation is both objective and subjective; it can be determined by birth year or kinship relationship; equally generation is the social construction of a set of shared characteristics or familial obligations.
- Generation is related, but not equivalent to, age.
- Generations are not static but change and evolve over time. (Keating, Kwan, Hillcoat-Nalletamby and Burholt, 2015)

Intergenerational Programmes/Practice

There is no clear distinction between intergenerational projects, intergenerational programmes and intergenerational practice in the literature. Granville (2002) in a review of the literature found that intergenerational practice, projects, initiatives and activities are used to describe the practical application of intergenerational ideas. However, McConnell *et al.* (2009, p.2) recognising the "*confusion over terminology when using the terms"* differentiated between a project and a programme, with a project being a single initiative and a programme a number or series of projects. McConnell *et al.* (2009), introduced the concept of "lifetime" projects which take place over a significant number of years, although not necessarily with the same participants. The Beth Johnson Foundation suggests that intergenerational practice is a continuum and proposed seven levels of contact between the generations ranging from low level to high level. (Beth Johnson Foundation, 2011as cited in Murphy, 2012).

Intergenerational practice is a broad and at times ambiguous term used to describe interactions between younger and older people in diverse projects with different

aims and involving different activities, diverse settings and different groups of participants (Granville, 2002; Springate et al., 2008). It is not just about one group helping the other but about reciprocity between the generations, bringing generations together to engage in mutually beneficial activities aimed at resolving a social, economic or cultural issue (Bernard, 2006; Granville, 2002) (Murphy, 2012). According to the International Consortium for Intergenerational Programs (established in 1999) Intergenerational practice is best understood as "social vehicles that create purposeful and ongoing exchange of resources and learning among older and younger generations" (Kaplan et al., 2002, p. xi).

The US National Council on Aging (NCA) describe intergenerational programs as those interventions that aim to "increase cooperation, interaction, or exchange between any two generations" through the "sharing of skills, knowledge, or experience between old and young" (National Council on Aging, cited in Duggar, 1993, p. 5). Angelis (1992) defines intergenerational programs as "activities that bring old and young together for their mutual benefit" (cited in Barton, 1999, p. 625). Newman et al. (1997) define intergenerational programs as being "designed to engage non-biologically linked older and younger persons in interactions that encourage cross-generational bonding, promote cultural exchange, and provide positive support systems that help to maintain the well-being and security of the older and younger generations" (p. 56).

Indeed, a key element in most definitions of intergenerational programs is that they involve face-to-face interaction between young and old. In most cases, those advocating intergenerational practice see it as a way to encourage meaningful and productive 'engagement' between the young and old in order to improve and enhance the quality of life for the young, old and general community.

Types of Intergenerational Practice

There are four types of intergenerational practice (Whitehouse 2000, p. 768):

- The first type involves organisations arranging activities for the young and old in the same premises

- The second type involves partial interaction in programs with a small level of contact,
- The third type involves young and old forming working groups or pairing off, and
- The fourth type of interaction involves the young and old creating a mutual learning and/or work environment where outcomes are negotiated and shared.

Manheimer (1997, p. 81) focuses on the direction of interaction and suggests programs range from a human services model of 'doing for' to a community development model of 'learning with'. 'Doing for' programs involve young people undertaking service-related activities for older people, whereas 'Learning with' programs involve young people collaborating with, or being instructed by, older people in educational or artistic endeavours. Kaplan's (2004) suggests to focus on the "depth of intergenerational engagement". (Judith Maccallum et. al., 2006)

Theoretical Foundations for Intergenerational Programming

- ***Social identity theory*** (e.g., Tajfel, 1978; Tajfel & Turner, 1986) considers personal and social identities as central to the way we view ourselves and others. Personal identity refers to the way we see ourselves as compared with others in our own social group; for example, a woman among women. Social identity is the result of comparisons between social groups in our society–for example, between younger persons and older persons.
- ***Social network theory*** (e.g., Zippay, 1995) emphasizes the benefits to youth of a large and diverse social network as opposed to a small and intimate one. According to this theory, broad social networks provide access to resources that can help young people to 'get ahead' through ideas, skills, approaches, and goals that they would not otherwise discover.
- ***Intergenerational contact model*** formulated by Fox and Giles (1993) is based on the concept that intergenerational exchanges are really of the 'intergroup' and

'intercultural' variety (e.g., Giles & Coupland, 1992; Hewstone & Brown, 1986), with persons from (at least) two cultural age groups communicating with one another in program settings.

- ***Fundamental concepts and theories inherent in community development and community building*** literature seem to have great potential application to intergenerational programmers and researchers (e.g., Kretzman & McKnight, 1993; Spruill, Kenney & Kaplan, 2001 as cited by Kuehne, 2003). Kuehne (2003a) draws attention to the potential of community development literature and theory to be applied "in application to intergenerational programmers and researchers" while Hatton-Yeo and Watkins (2004, p.5) observed an increasing interest in approaches to community and community development "that acknowledges the need to build intergenerational connections and understanding".

COMMUNITY SOCIAL WORK

The concept 'community social work' is adopted in the study to indicate 'the professional social work practice with communities incorporating micro, meso and macro practices'. The major attributes of community social work are: Preventive in nature; Simultaneous emphasis on community, and the individuals & groups within the community; Tapping, developing or sustaining formal and informal local networks in communities; Partnership between community, statutory services and voluntary agencies; Encouraging mutual aid; Collective responsibility; Attempt to harness community resources; Interventions at micro, meso and macro levels; and Promoting social justice and inclusive development. (Mini and Sathyamurthi, 2017a)

In community social work the concept of community can have many dimensions: Spatial, Social, Relationship, Virtual, Civic, Commonality, Identity and Intentional. While the spatial dimension of a community focuses on the geographical divisions like urban or rural in which the community social work is practiced, the civic dimension can be understood from the political divisions such as panchayat or municipality. The social system, social networks and social interactions among the people creates the social dimension of a community. Relationship dimension of the

community can be understood in terms of affiliations or associations among the people. The unity or we feeling among the people based on their common features indicates the commonality dimension of community. The virtual dimension of community involves technologically enabled relationships and networks. The groupment of people, based on functional or emotional identity give rise to the identity dimension and that based on particular interests for specific actions or purposes indicates the intentional dimension of community in community social work. (Mini and Sathyamurthi, 2017b)

LITERATURE REVIEW

The literature provides some evidence of the potential benefits of intergenerational practice to younger and older participants and to the community. Aside from the enjoyment experienced by the participants in projects, research indicates that for both younger and older participants, increased understanding of the other age group from the experience often leads to a more positive opinion and thus a reduction in negative stereotyping for both age groups (Bales, Eklund and Siffin, 2000; Epstein and Boisvert, 2006; Gilbert and Ricketts, 2008; Kuehne, 2003b; Meshel and McGlynn, 2004; Pain, 2005). For older people, intergenerational projects provide a means to transmit culture, traditions and skills (Butts *et al.*, 2007) and to acquire new skills (Martin, Springate and Atkins, 2010). Participation can reduce the sense of isolation experienced by some older people and provide them with opportunities to socialise and network often leading to participation in a wider range of activities (Beth Johnson Foundation, 2011; Kuehne, 2003b; Martin *et al.*, 2010). These benefits often result in increased sense of well-being being experienced by the older participants (Butts, 2007; Butts *et al.*, 2007; Hernandez and Gonzales, 2008; Martin e*t al.*, 2010; Newman and Larimer, 1995; Pinazo *et al.*, 2007; Slaght *et al.*, 2006).

The benefits for young people include advice, wisdom, support and practical skills which older people have to offer, together with a more positive perception of older people which can help increase tolerance and understanding of the ageing process (Pinazo *et al.*, 2007). Intergenerational projects can provide opportunities for younger people to develop qualities such as initiative, flexibility, openness, empathy

and creativity and to understand the value of lifelong learning (Goff 2004). Greater participation in positive intergenerational activities results in increased sense of worth, self-esteem and self-confidence and an enhanced sense of social responsibility.

Research suggests that intergenerational projects can lead to increased social cohesion and active citizenship with both younger and older participants taking on other activities and voluntary roles (Beth Johnson Foundation, 2011; Granville 2002; Hatton-Yeo, 2007; Martin *et al.*, 2010; Pinazo *et al.*, 2007). Research also suggests that intergenerational projects can result in positive outcomes for the wider community with better use of public space and facilities, particularly when projects have been established to resolve conflict over public space and to plan shared spaces for all ages (Beth Johnson Foundation, 2011; Pain, 2005) (Murphy, 2012).

The results of study on age friendly college intervention (Susan and Sebastin, 2017) undertaken at MAGICS (Managing and Generating Income for Community Services) based at Ernakulam District in the state of Kerala indicate positive impact on the well-being of those who underwent the experience. Age friendly college is an intervention with the aging section of the society by student volunteers for three months covering 45 hours. One-to-one teaching-learning method is followed. Other programmes like arts-sports days, picnics, and festival celebrations were organised to help the participants to express their talents, ideas and interests. The intervention was meant to (i) help the senior citizens to use social media to build relationships (ii) to introduce to them the facilities of e-governance, e-banking, online payments and purchase which make them feel more independent and capable in their old age.

METHOD

The study is qualitative in nature. It is conducted in the Ernakulam district of Kerala, situated in the central part of the State. The intergenerational initiatives namely ‘Age Friendly College’ undertaken by MAGICS (Managing and Generating Income for Community Services), an NGO based at Ernakulam District and the ‘Intergenerational Programmes under Vyomithram Project’ of Kerala Social Security Mission, Govt. of Kerala were considered for the study. The concept and

attributes of community social work, the concepts of generation and intergenerational programme or practice, and theoretical foundations for intergenerational programming constitute the basis for analysing the qualitative data generated through key informant interviews.

Overview of the Programmes Considered

Age Friendly College

Age Friendly College is an intergenerational learning programme based on the concept 'University of Third Age' undertaken by MAGICS (Managing and Generating Income for Community Services), an NGO founded in May 2015 by a group of four likeminded Youth who are social work professionals. 'The University of Third Age' is an international concept aiming at education and stimulation of mainly retired members of the community - those in their third 'age' of life. It is commonly referred to as U3A. U3A membership is not related to a specific age but to a period in one's life (the third age) after the second age of full-time employment and parental responsibility. Anybody in their third age can join U3A and this includes people who are working part-time. There is no lower age for membership. U3A provides educational opportunity for all ranging from those who are uneducated to those who wish to pursue a PhD in a subject of their interest. Typical courses include, educationally, Art, Classical Studies, Conversation, Computers, Crafts, Debate, Drama, History, Languages, Literature, Music, Sciences, Social Sciences, Philosophy, etc. There also are other activities - Games, Health, Fitness & Leisure', together with Picnics, Theatre/Concert Clubs, Travel Clubs, Dance forms etc.

The broad long-term objective guiding of U3A is to mobilize, organize and empower elderly so as to enable them to continue learning and working for leading healthy, active, productive and self-fulfilling life in later years. The main task of U3A can be, bringing elderly together in mutual interest and respect and to impress upon them the value of later life learning. In specific terms, the U3A can work in the following specific objectives:

1. To offer elders learning opportunities which they could not avail of during early years for whatever reason.
2. To provide elders opportunities for sharing experiences through interchange of mails and participating in discussions with similar active ageing groups registered all over the world under the main concept U3A.
3. To create conditions for the elderly that help them to continue learning and working in later years thereby remain self-relevant and independent.
4. To undertake & encourage study and research into the state of elderly in Kerala, their needs and problems, measures that may keep them healthy and active.
5. To educate and sensitize society, community and family about the roles and contribution of the elderly and to motivate them in their care.
6. To identify skills and talents of the elderly and to design and implement programs for their utilization in social and national development.
7. To launch special programs for early retirees, disabled and unemployed elders to facilitate them to lead later years productively and joyfully.
8. To help create and arrange learning opportunities, facilities for learning new technologies and stimulate the elderly to acquire skills in vocations, arts, culture, yoga, meditation etc. for successful ageing.
9. To collect and publish information useful for the present and prospective elders and to act as a clearing-house to disseminate information.
10. To pay special attention to prospective third agers in 50+ age group and to provide them exposure, through modern communication techniques, for successful and active ageing.
11. To promote interaction among national and international U3A to share experiences and to learn about effective Third Age programs through joint exchange visits and U3As international network.
12. To liaison with national and international government and NGOs to understand and appreciate the needs and problems of third agers and to make them to respond to the demands and contributions of the elderly.

13. To ensure representation of the U3A in national, international and multi-national organizations directly or indirectly through securing representation on committees / sub groups for pursuing effectively the cause of the elderly.
14. To persuade universities and institutions for evolving a framework for lifelong non-award bearing open learning with research for, by and with the third agers.
15. To organize periodical meetings, workshops, and seminars to share experiences, research findings and to plan collaborative endeavours among U3As.
16. To promote inter-generational understanding and support between the young and old through dialogues and joint activities.
17. To develop database of themes and programmes pursued by U3As in Kerala

Age-friendly colleges are such education institutions which offer conventional education while opportunities for adults to access these institutions for continuing education, vocational trainings and obtaining other life skills. Teaching and knowledge sharing between generations is given prime importance. For example, a student with an aptitude for teaching may get an opportunity to teach an older person how to use a computer, smart phone or a gadget to access a bank account. Visits to other colleges, picnics and flight tours with support of college and student volunteers are organized, where older persons get an opportunity to tour with younger generations.

The Guiding Principles are:

1. To involve older persons in educational and research programs.
2. To promote personal and career development in the third age and to support those who wish to pursue careers at that any age.
3. To recognize the educational needs of older persons of any age (from those who un-educated through to those who wish to pursue Master's or PhD qualifications).
4. To promote inter-generational learning and reciprocal sharing of expertise between learners of different age groups.

5. To widen access to online educational opportunities for older adults to ensure a diversity of routes to participation.
6. To ensure that the college's research agenda is informed by the needs of an ageing society and to promote public discourse on how higher education can better respond to the varied interests and needs of older adults.
7. To increase the understanding of students of the longevity dividend and the increasing complexity and richness that aging brings to our society.
8. To enhance access for older adults to the college's range of health and wellness programs and its arts and cultural activities.
9. To engage actively with the college's own retired community.
10. To ensure regular dialogue with organizations representing the interests of the aging population.

Now, the programme is there in four colleges of Ernakulam District in Kerala namely, St. Teresa's College, Sacred Heart College, Rajagiri College of Social Sciences and Bharatmata College. Professional social workers are undertaking the initiation and implementation of the programme.

Intergenerational Programmes under Vyomithram Project

Vayomithram Project was launched in 2011 exclusively for the elderly in Kerala under Kerala Social Security Mission (KSSM), Government of Kerala. The project is the first of its kind in India providing health care and support to elderly above the age of 65 years residing at Corporation/Municipal areas in the State. The main objective of Vyomithram project is to provide free health care to the old age people. Services provided under the Vayomithram are Mobile Clinics Service, Palliative Care Service, Counselling Service, Help Desk to the old age. Other services include Special Medical Camps, Special entertainment programmes like Sallapam, Snehayathra mainly for the destitute in old age home and Vayomithram beneficiaries, sponsorship programmes with the help of NGO's or institutions in the project area, special day programmes (related to health and welfare) in the area and active involvement of Vayomithram in social issues related to old age in the area. (www.socialsecuritymission.gov.in). Professional social workers are working as the

Coordinators of the project in all the municipalities and corporations and as District Coordinators in all the districts of the State.

Student Police Cadets' Weekly Elderly Meeting Programme

The Project in collaboration with the Student Police Cadets (SPC) under Kochi City Police conduct a weekly elderly meeting programme. SPC is the student wing of Janamaithri Police introduced in Kerala. 9^{th} and 10^{th} standard students are the members of SPC. They are provided with classes on law, traffic, social welfare etc with opportunities to practice. SPCs meet the members of Vyomithram Clubs in the area and interact with them on every Saturdays. They make elders aware of their privileges and identify their problems. If there is any issues of exploitation or harassment are identified, it will be handled to local police and necessary actions will be taken if needed. SPCs also help to conduct cultural programmes and tours for elderly.

Adolescent Club Members and Elderly

There are clubs of adolescent girls under each Anganawadi centre in Kerala. Vyomithram Project provides opportunities for these club members and Vyomithram club members to interact and work together. They conduct programmes and activities like organic farming which foster interactions and develop emotional attachment between them.

DISCUSSION

Age Friendly College focuses on the societal generation in its pedagogical and historical-sociological conceptualization. As an intergenerational programme it is a type that involves organisations arranging activities for the young and old in the same premises. It enables sharing of skills, knowledge and experience between youth and elderly through face to face communication. The programme is sustainable as the colleges are owning the programme. This programme is a responsive opportunity structure for the aged at the community level.

Intergenerational learning involves conceptual approaches to the learning process between different generations (cf. Meese, 2005). First, it is possible that generations learn from each other. This approach highlights the fact that one generation is able

to inform and support another generation. Second, generations can learn with each other. The participants are working and learning together on topics that are new to the whole group. Third, generations can learn about each other. Learning about each other means focusing on the historical and biographical living conditions and experiences of another generation. (Franz and Scheunpflug, 2016)

'The Third Age' is a theoretical perspective on ageing introduced in 1989 by Peter Laslett. The third age and fourth age replace the generic term 'old age'. The third age occurs post retirement and is a period of fulfilment, free from paid work and parenting when a person is still active and able to engage in leisure activities (Coleman *et al.*, 2004; Gallagher, 2008; Hunt, 2005). This is followed by the fourth stage, a time of dependency. However, Laslett assumes that life is about development and learning and that people post retirement are actually interested in education and intellectual pursuits (Coleman *et al* 2004; Gallagher, 2008) (Murphy, 2012).

Intergenerational Programmes under Vyomithram Project focus on the societal generation in its historical-sociological conceptualization. As an intergenerational programme it is a type that e involves young and old forming working groups or pairing off. It enables change in attitudes and emotional attachment between adolescents and elderly through interactions and activities. These programmes are effective intergenerational contact models at community level. As cited by Canedo-García, García-Sánchez, and Pacheco-Sanz (2017), participation in interventions of this type yields benefits in terms of improving older adults' health and well-being by facilitating continued intellectual or physical activity in the elderly, and it simultaneously contributes to the encouraging of values and behaviours in children and to the construction of identity among adolescents. The nature of both the programmes correlates with all the attributes of community social work emphasising the social, relationship and identity dimensions of community.

CONCLUSION

Planned intergenerational projects were first introduced in the United States in the 1960's and 1970's, initially to bridge the perceived gap between the generations but have since developed to seek to resolve many social issues for younger and older

people and society at large (Murphy, 2012). Creating age-friendly society is vital in responding to population aging. Professional social workers have the responsibility to make communities age-friendly. Through the analysis of the programmes initiated for intergenerational bonding in Kerala the study ascertains the scope and need for community social work interventions for the well-being of elderly. It also demands the professional social workers to think beyond the existing models of practice with communities.

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12

Bonding Towards Grandparents among Young Adults

Angeline Vinitha. J & A. Enoch

ABSTRACT

In Indian families, grandparents play a vital role in bringing up of their grandchildren. With their most valuable experience and wisdom, they act as a role model, guide, counsellor, support system etc. But the growing trend of nuclear family system has decreased their participation in grandchildren's life. This study focuses on the bonding between grandparents and grandchildren. Data collected from 31 respondents between the age group of 18 to 35 show their experience as children when nuclear family system flourished (in 1990's) and current bonding levels. The results will bring to light the perception of the grandchildren about their relationship with their grandparents with suggestions for the wellbeing of the elderly with regard to the same in a family environment.

Keywords: Intergenerational bonding, Grand parenting, Young adults.

INTRODUCTION

As there is still a common notion that the nuclear family system has broken the love, bonding and responsibility of the family members towards each other, Grandparents have made their mark in the lives of grandchildren in the society which is rapidly shifting to nuclear family system. Allen D. M (2011) points out that there has been a dramatic increase in the number of grandparents taking care of grandchildren in the last years (para.1). This shows that the bond between grandparents have not decreased due to various reasons such as working parents, unreliable external caregivers, trust in the wisdom and experience of the caregivers etc. Studies show that the increasing life expectancy due to developing medical facilities and remedies, have increased their opportunities for multigenerational contact and bonding. (Watkins et al, 1987). Hence, intergenerational or multigenerational bonding is

becoming more important than nuclear family ties for continued support and well-being throughout the course of life. (Bengston, 2001).

REVIEW OF LITERATURE

Nasreen (2004) lists commercialization, industrialization and modernization of the Indian Society which is replacing joint family system with nuclear family system as one of the factors which sharpens intergenerational differences. However, A study on the diversity of grandparents living with grandchildren in Canada by Milan A et al (2015) shows that among 600000grandparents living with grandchildren Sikhs were 38.6% and Hindus were 17.7% which can be generalized to the Indian society in which most of families with children tend to retain grandparents due to their religious & social values and also for support in child rearing.

Abernaz (2015) states that the close emotional ties between grandparents and grandchildren decrease depressive symptoms in both groups with extended longevity on grandparents. Abernaz also argue that grandchildren experience lesser behavioral and emotional problems and fewer difficulties with the peers. They are able to deal with the adverse effects of parental breakup and bullies at school. She quoted an Australian study which showed that grandparents who spent time with grandkids performed well in comparison to those who didn't.

Canfield (2016) puts forth that grandparents have special window to their grandchildren's heart and acts as natural transmitters of values for their grandchildren. He argues that the child may find it hard to forget things that a loving authoritarian member of the family has taught.

Brubaker & Brubaker (1999) illustrates that intergenerational bonding is characterized and can be enhanced by the Four 'R's namely: Respect, Responsibility, Reciprocity and Resilience. Young adults develop respect towards elders when they take up crucial roles in the family through work, marriage, child bearing, child rearing etc. He highlights the way college students and young adults indicate that relationships with grandparents are important to them. They feel responsible to ensure the well being of older generations by making calls, visiting often, and by providing financial assistance whenever required or on an regular

basis. A classic example of Reciprocity would be the way grandparents take care of their grandchildren and the emotional support they receive in return. The relationship becomes interdependent. Resilience can be observed by ways in which families are able to cope with positive and negative such as work, marriage, parenting, divorce, child care etc., with the support of older generations. He concludes that families which have responded to life situations or crisis with respect, responsibility, reciprocity and resilience will be able to apply the same coping mechanisms in future for smooth functioning of the family.

OPERATIONAL DEFINITIONS

Intergenerational Bonding is refers to the emotional closeness and connectedness that the grandchildren share with their grandparents.

Young Adults are persons between the age group of 18 – 35 living in Chennai who were with their grandparents in childhood days.

Grandparent is a parent of father or mother of young adults in Chennai.

OBJECTIVESOF THE STUDY:

The following are the objectives of the study:

- To understand the bonding between the grandparents and grandchildren who are currently young adults.
- To suggest ways for stronger Intergenerational bonding

HYPOTHESIS

1. Area of residence and Levels of bonding are interrelated.
2. Levels of bonding is associated with the type of family
3. Currently living with grandparents and Level of Bonding are associated to each other.

METHODOLOGY

The Study was conducted among the residents of Chennai in the age group of 18 – 35 years who had the experience of living with their grandparents in childhood. The design of the research is descriptive in nature. The sample size is 31and the

researcher used Random sampling technique to collect data. The data collected from the selected samples were analyzed using SPSS.

TOOL

Mailed Questionnaire was used to collect data which comprised of details on demographic profile and a standardized tool to measure the levels of bonding among the young adults. After discussions with experts, Intergenerational Relationship Quality Scale – Aging Parents (IRQS–AP) adopted from a study by Dr. Xue Bai (2018) conducted in China to assess Intergenerational bonds between young adults and Aged parents. Question no. 2.6 – 2.8 must be reverse scored. The sum of the score for each item will reflect the level of bonding. As per the scale, the scoring key is 13 to 30 – Low levels of bonding, 31 to 47 – Moderate levels of bonding, 48 to 65 – High levels of bonding. The tool also includes a space for the respondents to give their suggestions towards better bonding between grandparents and grandchildren.

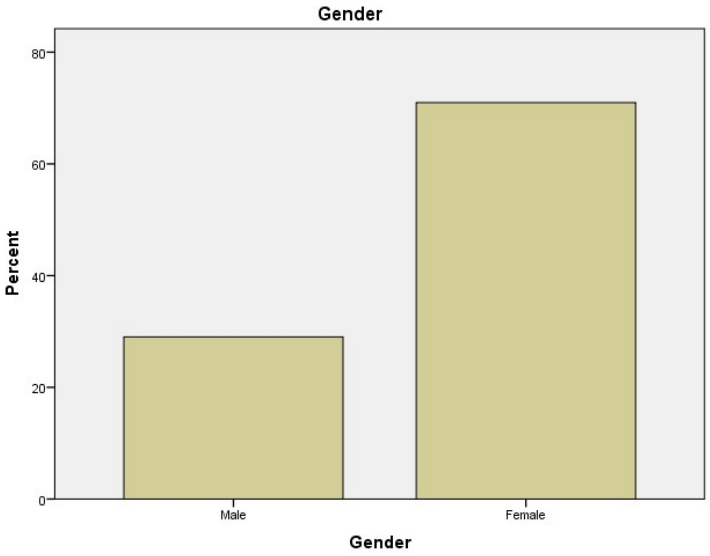
RESULTS

Table 1.1 – Age of the respondents

		Frequency	Percent
	18 - 25	13	41.9
	26 - 30	16	51.6
	more than 30	2	6.5
	Total	31	100.0

The respondents in the age group of 18-25 years were 41.9%. Around half of the respondents were between 26-30 years. Very few (6.5%) of the respondents were more than 30years.

Figure 1.1 – Gender of the Respondent



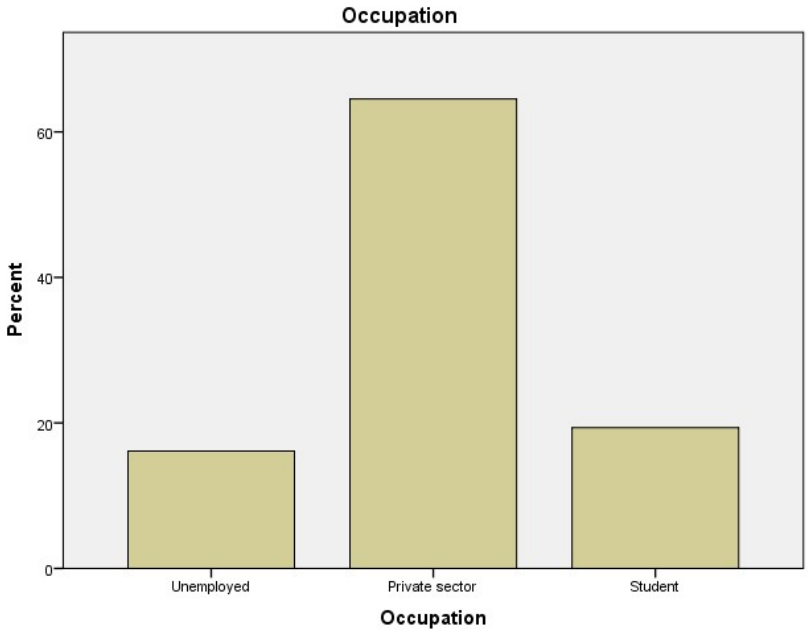
Female respondents contributed to 71% of the data and males respondents contributed to 29% percent of the data.

Table 1.2: Educational Qualification of the respondents

		Frequency	Percent
Valid	Higher Secondary	2	6.5
	Undergraduate	18	58.1
	Post Graduate & above	11	35.5
	Total	31	100.0

The above table shows that 35% of the respondent's educational qualification was postgraduate and above. A majority of 58% was undergraduate and 6.5% had completed their schooling.

Figure 1.2: Occupation of the respondents



The above chart shows that 64.5% of the respondents worked in private sector, 19.4% were students. 16.1% were Housewives.

Figure 1:3 shows that the 93.5% of the respondent's father was working and 6.5% of the respondent's father was unemployed. More than half (64.5%) of the mothers were homemakers and 35.5% were employed.

Figure 1:3 – Employment of Respondent's parents

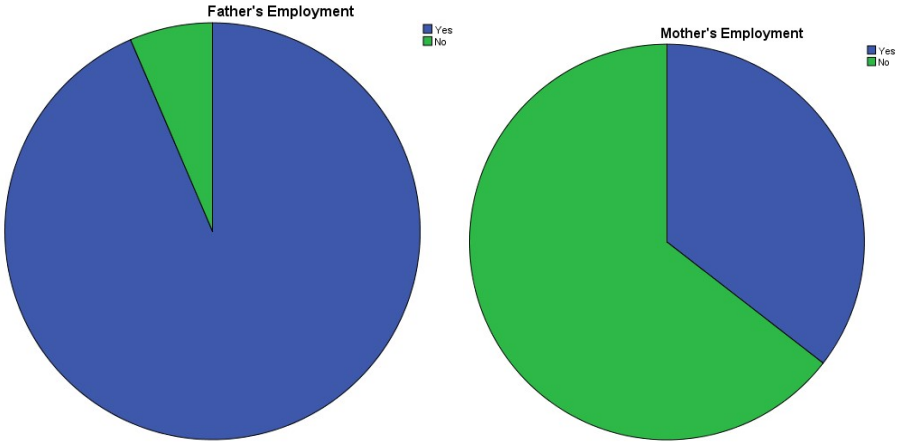


Table 1.3 – Levels of Bonding of Young Adults towards Their Grandparents.

Levels of Bonding		Frequency	Percent
Valid	Moderate Level of Bonding	14	43.8
	High level of Bonding	17	53.1
	Total	31	96.9

None of the respondents in the study had low level of bonding with their grandparents. Though there is a general notion that the grandchildren have low level of bonding with their grandparents, in this study it shows that 43.8% of the respondents had Moderate level of bonding and 53.1% of the respondents had high level of bonding with their grandparents. Table 1.4 shows that among the Urban residents (61.3%), 25.8 % have moderate level of bonding and 35.5% have high levels of bonding with their grandparents. In the rural residents (38.7%), 19.4% have moderate levels of bonding and 19.4% have high levels of bonding with their grandparents.

Table 1.4 - Place of Residence * Levels of Bonding Crosstabulation

		Level of Bonding Interpretation		Total
		Moderate	High	
Place of Residence	Urban	25.8%	35.5%	61.3%
	Rural	19.4%	19.4%	38.7%
Total		45.2%	54.8%	100.0%

Table 1. 5 – Cross tabulation between Area of Residence and Frequency of Help in Household Chores

Area of Residence	Frequency of helping in Household Chores			Total
	Sometimes	Most of the times	Always	
Urban	19.4%	32.3%	9.7%	61.3%
Rural	12.9%	19.4%	6.5%	38.7%
Total	32.3%	51.6%	16.1%	100.0%

The above data shows that out of the 61.3% of the respondents living in Urban areas, most of the times the grandchildren have helped their grandparents and among the 38.7% respondents from rural areas, 19.4% of the respondents have mostly helped their grandparents. It is worth to be noticed that none of the respondents have chose rarely or never options in the questionnaire. From the table below, it can be observed that though a majority of 48.4% respondents lived with their grandparents, 22.6% contacted them only once per week which shows that considerable amount of poor communication.

Hypothesis 1 – Place of residence and Levels of bonding are interrelated.

Table 1.5 – Testing of Hypothesis - 1

Chi-Square Tests					
	Value	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.185[a]	1	.667		
Continuity Correction[b]	.004	1	.952		
Likelihood Ratio	.185	1	.667		
Fisher's Exact Test				.724	.475
N of Valid Cases	31				
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 5.42.					
b. Computed only for a 2x2 table					

Since P value is greater than 0.05, the null hypothesis is accepted. Hence concluded that there is no association is found between Place of residence and Levels of Bonding. ($X^2(2)>=0.185$, P=0.665)

Hypothesis 2: Levels of bonding is associated with the type of family

Chi-Square Tests					
	Value	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.203[a]	1	.138		
Continuity Correction[b]	1.226	1	.268		
Likelihood Ratio	2.268	1	.132		
Fisher's Exact Test				.258	.134
N of Valid Cases	31				
a. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 4.97.					
b. Computed only for a 2x2 table					

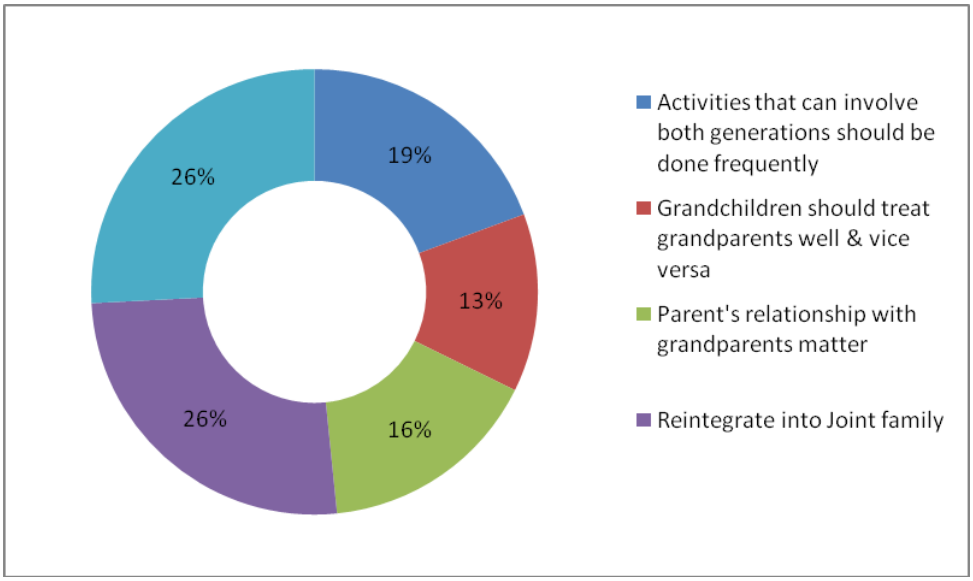
As the P value is greater than 0.05, the null hypothesis is accepted. Therefore no association is found between Type of family and Levels of Bonding. ($X^2(2) = 2.203$, P=0.138)

Hypothesis 3: Currently living with grandparents and Level of Bonding are associated to each other.

Chi-Square Tests					
	Value	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.806[a]	1	.016		
Continuity Correction[b]	4.190	1	.041		
Likelihood Ratio	6.062	1	.014		
Fisher's Exact Test				.029	.019
N of Valid Cases	31				
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 6.32.					
b. Computed only for a 2x2 table					

Null Hypothesis is rejected as the P value is lesser than 0.05. Based on the result, the level of bonding is related to whether or not the grandparents are living with the young adults. ($X^2(2) = 5.806$, P=0.016)

Figure 1.4: Suggestions by Respondents to improve intergenerational bonding



The above figure shows that 26% of the respondents prefer to be reintegrated into the joint family system which may be simply impossible for many. 16% have insisted that the relationship of parent's with grandparents is crucial. 19% have suggested that activities that interests both generations such storytelling in childhood etc. must be done frequently to build on the bonding level from childhood. 26% state the quality time between the both generations is important. 13% say that both the groups must treat each other well.

MAJOR FINDINGS

The following are the findings of the study:

- The respondents in the age group of 18-25 years were 41.9%.51.6% respondents were between 26-30 years. 6.5% of the respondents were more than 30years.
- Female respondents contributed to 71% of the data and males respondents contributed to 29% percent of the data.

- 35% of the respondent's educational qualification was postgraduate and above. 58% were undergraduate and 6.5% had completed their schooling.
- 64.5% of the respondents worked in private sector, 19.4% were students. 16.1% were Housewives.
- 93.5% of the respondent's father was working and 6.5% of the respondent's father was unemployed. 64.5% of the mothers were homemakers and 35.5% were employed.
- Among the Urban residents, 25.8 % have moderate level of bonding and 35.5% have high levels of bonding with their grandparents. In the rural residents, 19.4% have moderate levels of bonding and 19.4% have high levels of bonding with their grandparents.
- Out of the 61.3% of the respondents living in Urban areas, most of the times the grandchildren have helped their grandparents and among the 38.7% respondents from rural areas, 19.4% of the respondents have mostly helped their grandparents.
- Though a majority of 48.4% respondents lived with their grandparents, 22.6% contacted them only once per week which shows that considerable amount of poor communication.
- There is no association is found between Place of residence and Levels of Bonding.
- No association is found between Type of family and Levels of Bonding.
- Level of bonding is related to whether or not the grandparents are living with the young adults.

SUGGESTIONS

Apart from the suggestions of the respondents, in the family level frequent get-togethers, visits, family dinner time etc must be done. It is important to teach children the family traditions and lineage, which can be done best by grandparents which will help in bonding between the two generations and also strengthen the family ties. Schools can bring in the concept of 'Grandparent's day' to celebrate their huge contribution to their children's life by being readily available to transfer

their wisdom, experience, fun and love. The celebration may include activities such as storytelling, coloring, solving puzzles etc. that both these different generations can do together (Rajpal, 2017). Grandparents can also volunteer in schools, orphanages etc to teach, engage and influence children positively especially if there are no children at home. This, as read earlier, can help in maintaining mental health and gain emotional support.

LIMITATIONS OF THE STUDY

- The study was carried out with a very small sample size
- It didn't focus on the bonding in terms of grandparent's financial status.

CONCLUSION

With modernization and development in various aspects of life, the world has become increasingly busy to live life to the fullest with values, respect, love and bonding. As charity begins at home, when generational bonds are strong at home, elders in the society can enjoy their rights to live and to be respected. When grandchildren respect grandparents, they reciprocate the values taught by their elders at home to others. Hence it is essential to focus on family based and community based interventions and well-being of the elderly.

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13

Kinship and Trans-Generational Bonding: A Study of Hijra Communities in West Bengal

Sampurna Sarkar & Manoj Joseph

ABSTRACT

Kinship relations and Trans-generational bonding in non-normative families, such as Transgender families, are likely to differ from heteronormative families. This paper is an outcome of a study on the kinship structure among Hijra communities in West Bengal. The study also attempted to comprehend the nature of existing kinship relations and trans-generational bonding among the Hijra communities. Using a phenomenological approach, this study presents the experience of transgender persons in their family of origin .i.e. biological family and family of choice i.e. *Hijra* family.

Keywords: Kinship, Hijra Community, Trans-generational Bonding.

Introduction

The study on kinship predominately underscores theoretical assumptions of heteronormative family. The family centred practices in general uphold theoretical assumptions of heteronormative families, such as, family is essentially a caring system. The professional services are often directed towards strengthening the family system. Theoretical assumptions and practice directions based on heteronorative families can be misleading and make it problematic to work with diverse family types such as Hijra families (Nanda,1999; Lal, 1999; Reddy, 2005; Reddy,2006; Dutta, 2012; Kalra, 2012).

The study on families and kinship structure is an important arena of inquiry among anthropologists and sociologists (Levine, 2008). It is assumed that the systems of families and kinship shape the opportunity structure and destiny of a person. The systems of family and kinship perform many important social roles. It provides identity to the individual, access to property, and rights of inheritance and

entitlements. It assigns rights and responsibilities to members in the family and kinship structure. It regulates sexual freedom and intimacy amongst the members. It aims at facilitating solidarity among siblings, unity among collateral relatives and integration among different generations.

Context and Scope of Inquiry

The studies on families in the past predominantly focused on the families of dominant social groups. It focuses on the nature and structure of family and kinship structure. The concepts and framework employed in the theorization of family and kinship among the dominant social groups can be said to be inadequate to understand Trans-families and its kinship structure. There is a dearth of understanding about non-normative families and its kinship structures. This study is an attempt to understand and interpret the nature, structure and function of systems of families and kinship among Hijra communities in West Bengal.

Research Methodology: Design, Method and Participants

The central question of the research was how kinship relations and trans-generational bonding among transgender communities operate. The study used a phenomenological approach and phenomenological three stage interview process (Seidman, 2006). Ten research participants were recruited with the help of an organization working with Hijra communities in West Bengal. An In-depth Interview Protocol was developed to elicit narratives about the kind of experience the research participants had from their family of origin and family of choice. The interviews were translated and transcribed. The interview transcripts were thematically analyzed with the help of Atlas.ti. Some of the key insights stemmed from the thematic analysis are presented here.

Being in a Family: Experiences of Transgender

The experiences of being in a family for the research participants were found to be diverse. All the participants in the study moved from their family of origin i.e. biological families to their family of choice i.e. Transfamilies. We will look at the experience of the research participants in their families of origin first and their

transition to the families of choice. Then, we discuss their experience of being in transgender families

The experience of Being in Family of Origin

The experiences of the research participants indicate that their family of origin was rarely a space of caring except during their early childhood. It was noted that many of the research participants tried to distance themselves from their family of origin and their blood relatives. It may be because of the rejection and neglect that they might have experienced. For instance, Sana, one of the research participants, expressed the experience of being in the family of origin in the following words;

> *Since my childhood, I understood that I was different. ... I have been discriminated against, by the society, all my life due to those differences. My parents too discriminated against me and had also harassed me. They were ashamed of me. They spent every hour of their lives telling me that I was a disgrace to them. You might judge me but I do not care anymore. I am happy that they are dead now*
>
> *Research Participant_3_Sana.txt - 3:1*

Sana shared that she was expecting that her parents will act as a protective shield from the stigmatization from the wider society. But according to her 'the protector becomes the perpetrator'. The experience of Jyoti is not different. She shared her experience with her parents which forced her to subscribe to the view that her life is worthless. She expressed her experience with her family in the following words

> *I have been discriminated against, by the society, all my life. My parents too discriminated against me and had also harassed me. They were ashamed of me. The look, the glare directed at me continues to remind me how unwanted and undesired I am. The people around me should understand that I too am a person.*
>
> *Research Participant_4_Jyoti.txt - 4:1*

Many of the research participants shared that they experienced a sense of rejection from their parents. The transition to adolescence, a period of realization and affirmation of their gender identity, might have been the cause. The research

participants shared that the transition to adolescence was the most traumatising experience. It was during this period, the family of origin tuned into a space of negation, rejection, torture, assault, and oppression.

Family of Origin as a space of identity suppression

Irrespective of the socio-economic backgrounds of the research participants, it was noticed that their family of origin was a space of control which constantly tried to negate the expression of their non-normative sexual identities. The members in the family of origin and their extended relatives employed many strategies to intimidate the expression of non-normative sexual identities. The intimidating strategies ranged from mild emotional abuse to severe physical assault and abandonment. For instance, Bitton, one of the research participants, narrated how she was expelled out from her family of origin when she disclosed her gender identity. She shared the experience in the following words;

> *My parents had kicked me out of their house when I had expressed my gender identity. After 7 months had passed, I had visited my parents. When I had asked my mother for food, it was not given to me. She gave me water though. The glass that was used to serve me was then given to me. They had called me an untouchable.*
>
> *Research Participant_6_Bitton.txt - 6:4*

Amit, another research participant, narrated the outcome of her disclosure of desire to undergo sex alignment surgery with her mother and maternal uncle.

> *I was so blinded by my desire to turn myself into a woman that I was even ready for a sex change operation. However, when my family heard about the plan, they simply abandoned me. My mother gave me her own death ultimatum. My uncles began torturing my family after my revelation. I had no other choice then but to subdue all my desires. I then realised that I was a transgender person but I could do nothing to live my truth. I was prohibited by my family to socialise with any transgender person*
>
> *Research Participant_10_Amit.txt - 10:1*

While some of the research participants of the study had tried to ascertain and negotiate their gender identity with their family of origin, the fear of abandonment forced a few to suppress their gender identity. For instance, Surajit, one of the research participants expressed her apprehensions in ascertaining her gender identity in the following words.

> *I believe that when a male child is born and starts developing a feminine character, she is already a transgender person... Many of us do not have the courage to confess to the world proudly that we are transgender persons. I am a part of the programmes and events of the community. However, I am not a direct part of the community (I do not practice their profession). I have short hair and there are some rules which have to be followed in order to be a part of that community. I am ashamed of myself. I do not have the courage to admit my own identity. I gravely fear people's abandonment. I still care, unlike many of my friends, about the opinion of the society, about the opinion of my family*
>
> *Research Participant_7_Surajit.txt - 7:*

As we see in these cases, the family members and relatives act as oppressors who deny any expression of the third gender identity. Such reaction needs to be treated as an outcome of the stigma experienced from the society. This can be noticed in the experience of Amit.

> *My family has not been able to accept me and my gender identity...My family is afraid of the society and of the bad name that will be attached to our family. They think it is something that I can change. I think that at some point in my life, I will be able to make them understand who I am and that I could not change.*
>
> *Research Participant_10_Amit.txt - 10:2*

It was noted that the research participants felt that their biological mothers were unlikely to understand and connect to their lives as they lacked the experience of being a transgender person. Shalni, one of the research participants, shared how she

experienced a sense of rejection from her mother and unconditional acceptance by the Guru in her family of choice.

> *For me, my Guru is another mother for me. A mother who understands me and knows my motivations. She has supported me for years. She scolds me at times and then loves me at other times. I respect her a lot. In fact, she understands me better than my birth mother. I do not blame Maa (birth mother) for that. How will she understand if she herself has not been through that pain?*
>
> *Research Participant_2_Shalini.txt - 2:5*

The experiences of the research participants in this study reveal that their family of origin was a space of gender suppression. The experience of the courtesy stigma i.e. stigma by association experienced family indicates that the structures and process of gender suppression in family space is very much connected to the macro structures and process such as patriarchy, transphobia, and genderism. Now we will look at how third gender identity in biological families alters the kinship roles and family bonding.

Inauthentic Identity and the Burden of Masculinity

The research participants in the study expressed that their family of origin often imposed a pressure to perform socially ascribed masculine roles. Many of the research participants consider that they are 'women but trapped in a male body'. For instance, Shibesh, one of the research participants shared the pressure faced from her mother in the following words.

> *I am 50 years old. I was born at a time when the third gender was nothing short of a taboo. Since my childhood, I have had womanly characteristics. My mother would often tell to 'be a man' but that was simply not possible.*
>
> *Research Participant_9_Shibesh.txt - 9:6*

Some of research participants shared that though they accepted the socially ascribed masculine role, they were hesitant to negate their Hijra identity. For instance, Amit, one of the research participants shared the expectation that her family had after the death of her father.

I lost my father at the age of six and I am the only son in my family. I have five sisters. My family had certain expectations from me. They expected me to act as their saviour, their breadwinner. And I realised that I had no other choice but to give in to their demands. However, nobody has been able to separate me, since my childhood, from my feminine essence

Research Participant_10_Amit.txt - 10:1

It was noted that being inauthentic to their gender identity and acting on the expectation of others is a compromise on the agency and autonomy in their life. Now, we will look at how the experience of transgender person in their family of choice.

The Experience of Being in a Family of Choice

The transition to Hijra families was a choice that research participants made in lieu of the stigma, rejection and trauma that they experienced in their family of origin. Despite the fact that they have been rejected by their family of origin, a few of them expressed their concern for their biological family. They have been maintaining a relationship with them even after the transition to their Hijra families. This aspect will be discussed at later.

Trans Family: A Space of Acceptance, Socialization, and Gender Assertion

The transition from family of origin to family of choice was pictured as a major turning point in the life of the research participants. It was partly because of their gender identity being accepted and acknowledged in their family of choice. For instance, Pinky, one of the research participants, stated that acceptance and rejections were part of the social norm. According to her, society operates on some rules and the members of that society had to adhere to its norms. Similarly, biological families too have certain norms and deviations from those norms are likely to be objected. She thinks that Hijra household is the only space that affirms the identity of the transgender person.

The society runs on some rules. Each household has its own rules. Like in my house, there was an unsaid rule that my father would be the first one to have

his meal and then the rest of the house could have. Similarly in this house, there exists only one rule and that is, you have to believe that you are a woman and that there is nothing that can stop you from being a woman.

Research Participant_8_Pinky.txt - 8:3

Surajit shared the resistance that she had from her parents to accept her third gender identity. And she also shared the acceptance and support that she received from her family of choice. She shared that

My parents have never acknowledged my gender identity but my Guru does. I can say that she is like a mother to me. She encourages me and knows how important it is for me to come to that household. ... I will always be indebted to her. ... she tells me how to handle people in my professional life but she does not comment on the work.

Research Participant_7_Surajit.txt – 7

Trans Family: A space for being authentic and liberated

The research participants viewed the family of choice to be a space where they could live uninhibitedly. After having faced discrimination from their biological families and the surrounding environment, the Trans households have provided them with an opportunity to express their gender identity. The point of realisation varied for each individual. Robin shares her experience with folk theatre and the route to self-discovery.

I have been a part of the Hijra community since 1989... I was also an active Jatra participant. It was through the medium of Jatra that I began my association with other transgender persons and members of the Hijra community. The mere associations soon turned into friendship. A number of people who belonged to the community would also participate with me in theatre. I would see Hijra persons applying cosmetics and I would envy how beautiful they looked. I discovered that I loved dressing- up. After several conversations with them, I discovered that I liked learning about their traditions, I discovered that I could live as a liberated person. And that is how I began identifying with the community.

Research Participant_1_Robin.txt - 1:2

For some of the research participants like Bitton, the liberty to express her gender identity was most important. Despite being harassed, she continued to be a part of the *Hijra* household.

> *I had understood that I was a transgender person very early during my childhood. However, I wanted to be a part of the Hijra community for entirely different reasons. ... The members of that house would beat me, abuse me but I still remained. At least I was getting the opportunity to wear a Saree, to express my gender, to express my sexuality. I have been associated with the Hijra community for the past 19 years.*

Research Participant_6_Bitton.txt - 6:1

Trans Families Kinship Continuity with discontinuity

The experiences of some of the research participants indicates that they have been betwixt in between family of origin and family of choice. Despite the hostile reactions and rejections from the family of origin, a few respondents sustain their bonding with their biological parents. For instance, Jyoti, one of the research participants in the study shared that her family of origin was ashamed of her third gender identity and excluded her from family events. However, over a period of time, she managed to reconnect with her mother.

> *My family was very ashamed of me initially. And to extent, I think they still are. When we understood that I was a transgender person, they stopped associating with me. They did not support me when I needed them the most. There were also times when my father hit me because he was embarrassed. My mother too did not indulge in any conversation with me for a long time. But a mother can never stay away from her child for very long. Later, she did embrace me.*

Research Participant_4_Jyoti.txt - 4:5

It is further noted that some of the research participants feel that they have responsibilities towards their biological parents. For instance, Bitton, one of the research participants shared that she was thrown out of her house.

> *My parents had kicked me out of their house when I had expressed my gender identity..... If I wanted, I could have told them a lot of things and not taken care of them. But then what would be the difference between them and me? I hope that all people like me are able to make their parents understand the reality of themselves and are able to blend with them. It has taken 20 years to convey to them. Through this fight, I have been able to achieve recognition and success. The fight must continue. I have learnt to win, not loose.*
>
> *Research Participant_6_Bitton.txt - 6:4*

Shibesh, another research participant, shared that she was expelled from her family by her father. She was kept in abeyance from family functions. But she feels that she has the moral responsibility to support her aged mother.

> *My family has been very displeased with my choices and we have not been in talking terms for around 26 years. I too understand that parents too are a part of the society and if the society does not accept us, how will they? My father had passed away and I was not able to perform his last rites. ... I still continue to contribute, monetarily, towards my family. I do not think that I should run away from my responsibilities.*
>
> *Research Participant_9_Shibesh.txt - 9:6*

The experience of a few research participants reveals that they were disconnected from their family of origin and family of choice. The kinship relationships remain by and large reduced to functional and impersonal. For instance, Bitton, shared her association with both the families in following words.

> *It was during the time when my family had abandoned me that I took refuge in a Hijra household. The members of that house would beat me, abuse me but I still remained. At least I was getting the opportunity to wear a Saree, to*

express my gender, to express my sexuality. I have been associated with the Hijra community for the past 19 years. ... Now I am no longer a part of that household anymore... When I was a part of the household, I have follow the traditions and rules of the community. I had no choice but to follow it. I might sound very offensive and petty to you but the truth is that relationship had never mattered to me. I had a motive of my own behind seeking admission in that house. I wanted to feel liberated, I wanted to fulfil my desires, I wanted to live my life keeping my gender identity intact. That was the only reason as to why I associated myself with them. That relationship was not significant. My Guru had mattered to me when my family had rejected me but now she no longer does.

Research Participant_6_Bitton.txt - 6:2

Discussion

The kinship relationship existing between a Guru and a Chela is found to be significant as it helps each of them to validate their own identity and existence. Having faced rejection from family and society, the acceptance of the Guru is pivotal to the Chela. The Guru, who has faced neglect and has been attributed to discriminatory attitudes, does not wish the same for the future generations. The experience of the courtesy stigma i.e. stigma by association experienced family indicates that the structures and process of gender suppression in family space is very much connected to the macro structures and process such as patriarchy, transphobia, and genderism. Hill (2003) argues that examining these structures and process can be a useful framework for interpreting anti-gender violence.

The age and the circumstance through which one discovers oneself, discovers their gender identity varies for each individual. The Guru is associated with the role of a friend, mother and father. The Guru is expected to take care of them, guide them, support them and when appropriate, admonish them. It is evident that in that relationship, there exist unequal power relations like in any parent- child relationship. The reasons for attachment might be different for each individuals, however, the Guru- Chela relationship continues to be important for several reasons.

Apart from personal support, the Guru also provides professional advice and support.

Conclusion

This study found that the kinship relations and bonding that transgender persons experience are embedded beyond the biological family system. The Guru- Chela relationship is a very integral part of their life. The Guru- Chela relationship provides a space of acceptance and assertion of their third gender identity. It also enables them to exert their agency and autonomy to engage in a self-governed life. The cultural heritage of India prescribes a child to look after the parents at their old age. The same obligation is felt by some community members towards their Gurus and also their biological parents, despite their rejection. However, there are also instances where the structure of trans kinship has dissolved after the death of the Guru. It is noted that there is continuity with discontinuity in the kinship relation and trans-generational boding.

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14

Attitude and Attachment of Adolescents towards Elderly

Anjali U S & K.Sathyamurthi

ABSTRACT

The wide gap in the ideology of living, feeling and thinking particularly among young children and older persons is one of the reasons for transition from intergenerational bonding to intergenerational gap. At the point of Intergenerational gap, the attitude and attachment towards the elderly may widen. The present study is a descriptive research method which focuses on how the attitude and attachment of adolescents towards elderly differs. Inventory of parent and peer attachment scale and Kogan's Scale Attitude towards Older People was used to collect data from 40 adolescents. Data was analyzed using SPSS 20 version. The study focused on the attitude and attachment of adolescents with respect to their gender and living status with elderly. It also studied the difference in attachment to their grandparents and attitudes to the older people.

Keywords: Attitude, Attachment, Elderly, Intergenerational Bonding

Introduction

The elderly, being less able to independent; need the care and support of others in several respects. Taking care of the elderly refers mainly to the emotional support; on the other hand, support given to the elderly refers to the financial and material support. The former type of support is expected from the families or persons closer; whereas the latter is supposed to be a joint effort of the immediate family and society. The care and support enjoyed by the elderly is linked to their residence. Family is the safest form of security and rates living alone removed from their immediate relatives (spouse and child) as the biggest form of deprivation for the elderly. Further, Indian elderly live in extended multigenerational households and rely primarily on their adult children for financial support and personal care. It is the family members and neighbors who provide the bulk of the support and care to older

adults who need assistance. However, these traditional families are now showing signs of breaking due to demographic, economic and social change, there is no replacement for the family as a source of support for the elderly (Parikh, 2011). The traditional family structure is rapidly becoming nuclear. So, the base for the care of the elderly is crumbling for three reasons: (1) caregivers are migrating away from the places where the elderly reside, (2) values related to elderly care are deteriorating and (3) the concept of individualism is growing and the sense of community is declining. A large number of people living in the mega cities without a strong family base and with modern lifestyles are desperately in need of someone who can perform the job of caregiver for the elderly.

Intergenerational gap may exist between older people and young age due to several reasons:-

- Psychological
    - Exclusion by other generations. “you are old”
    - Self Exclusion by older generation, who feel rejected by other people: “I am old”
- Sociological

  In the present scenario, the idea “youth first and foremost” is predominating. On March 10, 1982, a discussion was organized by UNESCO as part of youth day for human rights. In the discussion, it was quoted that the consumer society equates productivity with usefulness and non-productivity with uselessness. This itself blooms a feeling of low self esteem among elders. Break down of joint family system into Nuclear family system and migration of young generation in search of job and higher studies brings gap among younger and older generation.

Review of literature

Rush K.L, Hickkey, Epp and Janke have done a systematic integrative review on nurses attitude towards elderly. The objective of the study was to examine hospital nurses’ attitude towards caring for older adults

Positive Attitudes towards Older People and Well-being among Chinese Community older adults were studied by Luo Lu, Shu-Fang Kao and Ying Hui Hsieh. A total of 316 samples were taken to measure their own attitude towards aging and to examine whether positive attitude is associated with social support, community participation and well being.

In a study on Adult Children's Attachment and Helping behavior to elderly parents:A path model, Cicirelli(1983) reviewed model of intergenerational solidarity proposed by Bengtson, Olander and Haddad. As per that model, there would be more helping behavior when the parents' dependency needs became greater, when the adult child felt a greater sense of filial responsibility, when the adult child lived closer and when the adult child was a daughter. Cicirelli in their study found that stronger feeling of attachment lead to increased attachment behavior as do dependency and filial obligation. (Cicirelli, 1983)

A study on "Attitude towards population ageing and older people" revealed that there are a greater number of citizens having positive than citizens with a negative attitude toward the elderly. (Ronald C. Schoenmaeckers, 2008). A study on Socialization outcomes "A study on Intergenerational agreement and disagreement in Catholic American family was done by Partha (1972). In the study, the catholic adults and adolescents are viewed as persons maintaining distinct position for interaction in the socialization process. The study found that "on all attitudes for which intergenerational agreement is found, adolescents are more likely to agree with their parents if their parents hold a view that is in agreement with the majority view. This predictive ability is sustained when intergenerational .agreement are examined, controlling for content and social structural influences. The intergenerational differences found are more likely to occur on social attitudes rather than on moral or religious attitudes. (Pratha, 1970)

The literature shows that frequent and meaningful direct contacts between cohorts of different generations can help overcome ageism, improve attitudes towards the other generation, and create intergenerational solidarity (Lisbeth Drury, 2017)

Saraswathi Nandhini in her study on "Elderly as health promoting factors in adolescent girls – an Introspective study", it was found that the food patterns and practices which elders follow as customs has remedial measures in the health of adolescents. The study concluded that rather looking elders as needy population, they could be appreciated as remedial resources in the family and community could provide mutual benefits in the society. (Saraswathi Nandhini, 2018)

Research Methodology

Objectives

- To know the demographic profile of adolescents
- To study the level of attachment of adolescents towards elderly.
- To understand the attitude of adolescents towards elderly.
- To know the relation between attitude and attachment of adolescents towards elderly.

This study employs a descriptive research method to understand the attitude and attachment of adolescents towards elderly. Simple Random Sampling is used to collect data from 40 adolescents from Kerala and Tamil Nadu. Attachment of Adolescents towards Elderly was assessed using Inventory for Parent and Peer Attachment. From the scale, parent attachment alone was taken for the study. Cronbach's Alpha Internal Reliability for grandmother and grandfather domain is 0.87 and 0.89 respectively. Inventory for Parent and Peer Attachment has three domains namely Trust, Communication and Alienation. The results reveal whether the adolescents were having more secure or less secure attachment towards their grandparents. The Kogan's Scale for Attitude towards Older Adults was used to know the nature of attitude of adolescents towards elders. The analysis was done using Statistical Package for Social Sciences version 20.

Findings

From the analysis, it was found that 66.7 percent of the respondents were having less secure attachment towards their grandmother and 83.3 percent less secure attachment towards their grandfather. 57.5 percent are living with their grandparents in home. Among Males, 36.4 percent is having more attachment to their grandmother and 32 percent of females have more attachment towards their grandmother. But in the case of attachment towards grandfather, it was found that 9.1 percentage of males are having more secure attachment while 20 percentage of females are having more attachment towards grandfather. Even higher percent of adolescents is living with their grandparents in home, 85 percent is having less secure attachment.

From 40 respondents, 42.5 percent shows positive attitude towards older adults while 57.5 percent has negative attitude. While analyzing the gender, it was found that more than half of both male and female have negative attitude towards older adults. More than 60 percent of adolescents living with their grandparents have negative attitude towards the older adults. Chi-square test revealed that 50 percent of adolescents of more securely attached have negative attitude. Similarly, 50 percent of adolescents of less securely attached have positive attitude.

Discussion

David Jeremiah quoted that every parent knows that children look at their grandparents as a sources of wisdom and security. This study has attempted to find the attitude and attachment of adolescents towards elderly. It was found that highest percentage of respondents has less attachment towards their grandparents even if a relatively high number of samples are living with them in home. Girls have more secure attachment towards grandfather while boys have more secure attachment towards grandmother. It is supported by Freudian theory which stressed the Oedipus complex and electra complex. Even high percent of adolescents is living with their grandparents in home, lesser their attachment towards their grandparents. Adolescents have more negative attitude towards older adults.Kallio-puska (1994). Radical change occurred in the family structure value system, adoption of western culture, busy life style and independent views resulted in deteriorating the

relationships between grandparents and grandchildren. Gender difference is not seen in the attitude towards older adults. The present study contradicts Nischalla (2010) study which found that boys have less intimate and unfavorable relationship with their grandparents. Adolescents living with elderly have more negative attitude towards older adults than those who are not living with elderly. There has been no significant difference found in the attitude and attachment of adolescents towards elderly. According to a study involving 1,151 Belgium kids aged 7 to 16, kids who are close to their grandparents are are less likely to show bias towards older adults. Kids who had a poor relationship (not necessarily in terms of quantity of contact, but rather the quality of it) were more likely to have ageist views.

Scope for future research

The researcher attempted to study the attachment and attitude of adolescents towards older adults using only limited number of variables. Attachment of adolescent's parents and their grandparents can be one of the reasons for the attachment type. It will give an in-depth view on the intergenerational bonding from three generations. Number of researches in the field of Intergenerational bonding and well being of elderly is relatively low. This is a field which is yet to be explored further.

Conclusion

Attachment and Attitude are two constructs which is having an interconnection. The study tried to trace out its interconnection among adolescents and elderly. But there was no relation found in the attachment of adolescents towards their grandparents and their attitude towards elderly. And it was revealed that majority of the adolescents are having less secure attachment and negative attitude towards elderly. This showed that the bonding and attachment among the coming generation is seemed to be limited and respect and value towards senior citizens are diminishing.

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7

Prevalence of Depression among Elderly Patients in a Tertiary Care Hospital in Central India

Nidhi M

ABSTRACT

Background: Elderly are an integral part of a population of any country and their mental health and emotional well-being is an important point of concern towards their growing age. Depression is a significant public health issue and is identified as a common and serious mental health problem particularly among the older adult population. **Objective of the study:** The study aims to assess the prevalence of depression among the elderly patients attending the outpatient department in Mure Memorial hospital (MMH), Nagpur, India and other factors associated with higher prevalence of depression in these patients. **Methods:** A study was done on 100 randomly selected elderly patients attending OPD in MMH, Nagpur. A structured tool Geriatric Depression Scale (GDS), short version was used to collect data. Data entry was done using Epi data version 3.1 and analysis was done using SPSS statistics 17.0. **Results:** 52% of the respondents were male. 68% of the respondents were between 60 and 70 years, (mean age 68 years) 34% of the respondents resided with their children and 59% of the respondents are financially dependent. 58% of the respondents have less than two diseases while 57% of the respondents were on more than two medicines. 52% of the respondents were independent for their activities of daily living. We found that a total of 68% of the respondents are suggestive to depression i.e. 18% were mildly depressed, 21% were moderately depressed and 29% were severely depressed We found that elderly suffering from financial dependence seemed to be subjected more to depression (p value= 0.017). Limitations include the small number of patients studied and possible bias is given that this was a hospital-based study.

Key words: Elderly, Depression, medication, and diseases

Introduction

The government of India, National policy on older persons defines an elderly or senior citizen as a person who is of age 60 and above. Globally the world's population is rapidly aging and according to WHO, between 2015 and 2050, the number is expected to increase from 900 million to 2 billion people aged 60 and above. In India, there were 98 million senior citizens in 2011 and is expected to increase to 143 million by 2021 with 51% being females. [1] Age is an important determinant of mental health. Old age is a period of transition when one has to deal not only with the physical aging, but also with the challenges affecting the mental and social well-being. Due to the normal aging of the brain, deteriorating physical health and cerebral pathology, the overall prevalence of mental and behavioural disorders tends to increase with age. Disability arising due to various illnesses, loneliness, lack of family support, restricted personal autonomy and financial dependency are other important contributing factors for a higher prevalence of mental and behavioural disorders. [2] The overall proportion of the elderly population in the world was 5.8% during 2000 and it is expected to increase to 8.7% by the year 2025 and 15.0% by the year 2050 [3]

Depression is both the most common and most treatable/reversible mental illness in old age, affecting one in five older people in the community. Depression is not a normal part of aging for the majority of people. The term depression is commonly used to mean the temporary emotional experiences of "the blues", sadness, loneliness, grief, and negative reactions to loss and pain that are normal. Clinical depression, however, is much more serious. [4]

Depression is a most common psychological disorder which is characterized by lack of interest in life, day to day activity, pleasure, guilty feeling, low self-esteem, sadness, poor memory, disturbed sleep pattern, poor appetite and tiredness. 20% of the geriatric population is facing mental or neurological problem, depression and dementia are the most common problem. [5] Symptoms of depression in elderly are often overlooked and untreated because many people think that depression is a normal part of aging—a natural reaction to chronic illness, loss and social transition.

Elderly people do face noteworthy challenges to their connections through loss, and also face medical vulnerability and mortality. For the elderly population, depression can come in different sizes and shapes. Many elderly people and their families don't recognize the symptoms of depression, aren't aware that it is a medical illness and don't know how it is treated. Others may mistake the symptoms of depression as signs of:

- Dementia
- Alzheimer's disease
- Arthritis
- Cancer
- Heart disease
- Parkinson's disease
- Stroke
- Thyroid disorders

Late-life depression increases risk for medical illness and cognitive decline. Depression is the single most significant risk factor for suicide in the elderly population. Tragically, many of those people who go on to die by suicide have reached out for help— 20 percent see a doctor the day they die, 40 percent the week they die and 70 percent in the month they die. Yet depression is frequently missed. Elderly persons are more likely to seek treatment for other physical ailments than they are to seek treatment for depression. [6]

Material and method

The study was conducted on 100 randomly selected elderly patients attending the Outpatient department of Mure Memorial Hospital, Nagpur. Consent was obtained from all subjects. A structured tool was used to collect the socio-demographic details, functional assessment and activities of daily living. A standardized questionnaire Geriatric Depression Scale (GDS) was used to assess the level of depression.

Inclusion criteria: Elderly patients of age 60 years and above and willing to participate in the study

Exclusion criteria: Patients who have issues related to memory and those who are terminally ill and not willing to participate

Results - Baseline Characteristics of the Respondents

Characteristics	Percentage
Age group (mean age 67)	**N=100**
60-70	68%
71-80	21%
above 80	11%
Gender	**N=100**
Male	52%
Female	48%
Residential status	**N=100**
Lives alone	4%
With spouse	22%
With spouse and children	26%
With children	34%
Old age home	14%
Education	**N=100**
No education	13%
Primary	11%
Secondary	26%
Higher secondary	18%
Graduate	22%
Post graduate	10%
Financial Status	**N=100**
Dependent	59%
Partially dependent	10%
Independent	31%
Number of diseases	**N=100**
Less than 2	58%
More than 2	42%
Number of medicines	**N=100**
Less than 2	43%
More than 2	57%

Functional assessment	
Vision	**N=100**
Normal	84%
Decreased	16%
Hearing	**N=100**
Normal	82%
Decreased	18%
Bowels	**N=100**
Continent	84%
Occasional accident	13%
Incontinent	3%
Bladder	**N=100**
Continent	62%
Occasional accident	35%
Incontinent	3%
Activities of Daily living	**N=100**
Independent	52%
Dependent	48%

52% of the respondents were male. 68% of the respondents were between 60 and 70 years, (mean age 68 years). 58% of the respondents had less than two diseases while 57% of the respondents were on more than two medicines. 34% of the respondents resided with their children and 56% of the respondents were financially dependent. 84% of the respondents have continent bowels and 62% of the respondents have continent bladder. 52% of the respondents were independent for their activities of daily living.

Level of Depression	Percentage
Normal	32%
Mildly depressed	18%
Moderately depressed	21%
Severely depressed	29%

The above table explains the level of depression among the respondents. 32% have no depression, 18% are subjected to mild depression, 21% are moderately depressed and 29% are severely depressed. The level of depression is calculated according to the scoring of Geriatric Depression Scale.

Financial status	Frequency (%)	Level of depression	Frequency (%)
Dependent	59%	Normal	32%
Partially dependent	10%	Mildly depressed	18%
Independent	31%	Moderately depressed	21%
P value: 0.017		Severely depressed	29%

A significant association is found between financial status and the level of depression. We found that patients who are financially dependent are subjected to higher level of depression.

Average money spent on medications (Rs)	N=100
0 to 500	54%
600 to 1000	20%
More than 1000	26%
Number of diseases	**N=100**
Less than 2	58%
More than 2	42%
Number of medicines	**N=100**
Less than 2	**43%**
More than 2	**57%**

Discussion

The study has analyzed the level of depression being experienced by the elderly. A total of 68% of the respondents were subjected to at least one level depression. There was no significant relation found between gender and depression. 52%of the respondents were male and 68% of the respondents were in the age group of 60-70years (mean age: 68years). 59% of the respondents were financially dependent on their children and therefore may feel burdened. The study found out that there is a significant relation between their financial dependency and depression. (p value=0.017). Possible reason for this may be their residential status as 34% of the respondents resided with their children and 26% resided with their spouse and children. A few of the respondents revealed that being financially dependent is such a pain. They have to ask their children for every single thing and most of the time they are not attended of their needs.

58% of the respondents have less than two diseases and 57% of the respondents are on more than two medicines. Some of the respondents said they found it difficult to recollect the timing of their medications and that consuming more than two medicines was a great task for them. We found that elderly suffering from more diseases and on higher number of medications are subjected to depression. (p value=0.00).

According to a study done by kartik sudhakar patil et al. on depression among elderly people in the slum of central India, 39.5% of the respondents found out to be on depression according to Geriatric Depression Scale where as our study shows 68% depression in the study population. The difference may be because the present study was done on an outpatient department setting. Another study done by kshatrapal prajapati on assessment of depression among elderly population in a tertiary care hospital shows that 49.5% study participant belong to moderate depression, whereas the present study shows 21% of the respondents as moderately depressed. This possibly would be due to the range of scale chosen for depression. This study reveals that the elderly patients suffer from a wide range of depression levels and their associated factors can be mainly their present state and residence of living, their financial status and the disease or their medical condition they experience at this phase of life.

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National Alliance on Mental Illness

16

Level of Cognitive Impairment and Its Impact on Functional Disability, in Elderly Women under Respite Care in Chennai

Preenu Ashok

ABSTRACT

There is a significant gap in the knowledge of the frequency and determinants of Behavior and Psychological Symptoms in those cognitively preserved elderly with multiple health problems India is all set to see tripling of those over 60 years of age from 71 million in 2001 to 173 million in 2026. The purpose of the study were (i) to screen for cognitive impairment using Mini-Mental Status Examination among three old-age groups based on dwelling types in Chennai, India i.e. residential paid old-age homes, residential free (charitable) homes and home-based community-dwelling residents; (ii) secondly to investigate factors (demographic, psychological, medical and disability) associated with cognitive impairment in the these old-age;This is an ongoing Cohort study of health and wellness in the elderly from the Institute of Neurological Sciences, Voluntary health Services Multispeciality Hospital and Research Institute, Chennai. The study proposal has been approved by the Institutional Ethical Research Committee of the VHS Hospital. The study is to find out the prevalence of BPS in an urban elderly population that has within it several nested case control studies that examine the relationship between BPS, Medical, Neurological And Psychiatric comorbidity, cognitive decline, quality of life and disability, psychosocial factors including socio-economic status The burden of cognitive impairment was high in all aged-care dwelling types in urban India; with free charitable home residents being worse affected. Cognitive impairment was associated with disability and poor health-related QOL in these age-care settings

Key words: Elderly, Cognition, Quality of life, Respite care

Background of the Study

As the world's population ages, there is growing interest in the prevalence and significance of depressive symptoms and disorders in the elderly. Mental health is a fundamental need which contributes to the overall well being. It needs to be recognized and treated to all human beings, including the greying population with the same urgency as physical health. India Ageing Report 2017" by the United Nations Population Fund (UNFPA) says the share of population over the age of 60 could increase from 8 per cent in 2015 to 19 per cent in 2050. Approximately 15% of adults aged 60 and over suffer from a mental disorder .Nearly half of older adults report difficulty initiating and maintaining sleep. **Roepke, S.k. (2010)** With age, several changes occur that can place one at high risk for sleep disturbance including increased prevalence of medical conditions, environmental and lifestyle changes. It is important to focus on the cognition as impairment due to the mental health issues among elders. Not many studies are available on the effect of cognitive impairment on the quality of life, common mental health problems and disabilities in elderly population in India. At the community level the study hopefully creates a better understanding on the greying population among all the stake holders the policy makers.

Review of Literature

Cognitive impairment adversely affects wellbeing and is a form of intellectual disability. Cognitive impairment is a strong predictor for chronic disease progression, and subsequent mortality. A number of reports have focused on cognitive impairment of community-dwelling elderly in well-defined cohorts, but only limited information is available for charitable and paid home facilities. **(Das, S.K., 2007)**Many studies have not defined specifically, whether the aged home care was home based, charitable or fee paid in their cognitive screening studies. Understanding the cross-sectional prevalence of cognitive impairment in aged people living in different residential settings will help to predict requirements for allocation of health services and resources. There have always been traditionally associated with dementia. There is a significant gap in the knowledge of the frequency and determinants of BPS in those cognitively preserved elderly with

multiple health problems India is all set to see tripling of those over 60 years of age from 71 million in 2001 to 173 million in 2026. And hence the need to assess BPS in a community dwelling elderly across medical, neurological and psychiatric diagnoses

That could help us in

1. Aid in early diagnosis and intervention that could lead to decreased morbidity and mortality
2. Understanding the problem better at the community level.
3. This will probably give an impetus to governmental policy making for elder care, thus improving their quality of life.

Methodology

Hypotheses

Ho-There is no significant association between Cognition and Physical disability

H1-There is a significant association between Cognition and Physical disability

Research Design :

This is a cohort study of prevalence of BPS in an urban elderly population that has within it several nested case control studies that examine the relationship between BPS –

- Medical, neurological and psychiatric comorbidity
- Cognitive decline
- Quality of life and disability
- Psychosocial factors including socio-economic status

This is an ongoing study of health and wellness in the elderly from the Institute of Neurological Sciences, Voluntary health Services Multispeciality Hospital and Research Institute, Chennai. The study proposal has been approved by the Institutional Ethical Research Committee of the VHS Hospital.

Tool used for data collection

In the present study two important variables Cognition and Disability is measured with the use of following tools.

1. cognition is assessed using Mini Mental status examination : Cognitive screening of elderly was performed using a pen- and paper-based MMSE evaluation. MMSE is a cognitive screening instrument, which is widely used for research and clinical community settings in India.
2. Disability is assessed using the WHO-DASS scale : World Health Organisation Disability Assessment Schedule (WHODAS): WHODAS 2.0 to access the level of disability among the elderly. The 12 items WHODAS scored on a 5-point Likert scale and assesses the difficulty experienced by the elderly in performing an activity.

Inclusion Criteria : All community living elderly (above 65 years) living with an Informant who has stayed with the patient for at least 3 months

Exclusion Criteria : Those who refuse to give consent for the study and the absence of a reliable informant

After obtaining written informed consent, consenting subjects were included in the study, 256 subjects were approached, out of which 198 met the inclusion criteria and consented for the study

Duration of the study : 5 years

Old Age Home	**Number of residents approached**	**No of residents having consented for study**
Vishranthi	110	109
Senior Citizen's Home	20	17
Anbagam	60	47
Nandhini	26	6
Mother Josephine	40	19
Total	256	198

Analysis and Interpretation

Table 1

S.No	Demographics	N=198
1	Mean Age(years)	77.4
2	Gender Male / Female	Female= 145 and 45 Male
3	Marital Status	86 % Married
4	Education	37.5 % > 5 years of education
5	Socio economic Status	38.9% middle socio-economic condition.

Of the 198 subjects included in the final analysis, most of them were female. Most of the subjects were in the age group of 65 to 90 years, with 10 subjects between 90 to 100 years of age The mean age was 77.4 +_ 8.72 years (N = 198). 37.5 percent had less than 5 years of education, 31.1 percent had 5 to 10 years of education, 23.3 percent had 11 to 12 years of education The percentage of undergraduates and postgraduates was 3.9 percent respectively in the study sample 10.5 percent belonged to low Socio Economic Status (SES), 38.9 percent belonged to middle SES, 48 percent belonged to high SES.

Table 2:

Particulars		Total Score of WHO Disability Assessment Scale
Mini Mental Status Examination	Pearson Correlation	-.347**
	Sig. (2-tailed)	.000
	N -198	1

International Classification of Functioning, Disability and Health (ICF) categories included: under the understanding and communication domain, 68% of the respondents had mild disability , because of the auditory issues. The Getting around domain which focused on functional disability (42%) of the elders had moderate disability, These respondents needed assistance for walking and picking up things. It was found that most of the 39% had severe difficulty in doing their self care activity and 63% of the elders has moderate difficulty in Getting along with their inmates because of various social factors (caste, Class etc).The Mental Status Examination negatively correlated significantly (r=-.347,p<.01) with the Disability Assessment Scale, where nearly 1/3rd (m=63) of the population falls under the mild disability level in WHO-DAS. The functional disability may have an impact but on the cognitive status of the individual. However, Many such studies indicates otherwise, A large scale cohort is require for further generalisation.

Discussion

Around 1/4th of the subjects with a mean age between (70-75 yrs) . As aging progresses, individuals tends to develop cognitive decline and become susceptible to various mental health problem, as suggested by data nearly 100% subjects in age group 70-89 years showed some level of mental health problem. This study indicates that half of the population (mean= 54,±.71) belong to a high socio-economic strata in the respite care facility, however only 8 subjects had 14 years of formal education. Despite of high Socio economic Status, elementary education might be the factor contributing toward higher prevalence of mental health problem. The Mini Mental Status Examination negatively correlated (r=-.347,p<.01) with the Disability Assessment Scale, where nearly 1/3rd (m=63) of the population falls under the mild disability level in WHO-DAS. This indicates that there is strong correlation between cognitive impairments and the quality of life and physiological state.

Conclusion

This study needs to be applied to a larger cohort including both genders to identify the relationship between cognition and psychological co-morbidity.and disability Regardless of the direction of causality between these functional factors in old age homes, the burden of cognitive impairment and functional

disability in elderly remains particularly at a much higher rate in free charitable homes compared with paid homes and remaining living within an extended family. Government and non-governmental organizations will find our study useful to predict the required resources to manage the growing burden of cognitive impairment, poor Quality of Life and functional disability among elderly in India. Further research should investigate Optimizing physical and psychological health which includes identifying and treating; accompanying physical illness, increasing physical and cognitive activity can optimize well-being. homes in India that include cognitive stimulation programmes, activities that improve social interactions, health screening for chronic conditions, and innovative psycho-social approaches to improve Quality of life.

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A Retrospective Cohort Study to Evaluate the Impact of Elderly Day Care Centers in the Quality of Life of the Elderly of a Secondary Care Hospital in Rural South India

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ABSTRACT

Background: The phenomenon of population aging is becoming a major concern for the policymakers all over the world, both for developed and developing countries. There is an emerging need to pay greater attention to aging-related issues and promote holistic policies and programs for dealing with aging society. A study was conducted by Lokhare P. O et al, on 'assessment of quality of life among elderly population in old age homes or elderly care centers' stated that there is a need to conduct comparative study of quality of life between elders attending elderly care centers or old age homes and elders not attending elderly care centers or old age homes. **Objective:** To assess the impact of elderly day care centers in the quality of life of the elderly of a secondary care hospital in rural south India. **Materials and Methods:** A retrospective cohort study was done on elderly population attending and not attending elderly care centers with WHOQOL-BREF questionnaire. All learned data was entered using Epi-data version 3.1 and outcomes were analyzed using SPSS statistics 17.0. **Result and Conclusion:** 96% of the elderly respondents from elderly care centers have rated their quality of life as good, 80% of them rated their health satisfaction as good, 72% of them rated their physical domain as good, 95% of the rated their psychological domain as good, 93% of them rated their social domain as good and 90% of them rated their environmental domain as good whereas 64% of the elderly respondents not attending elderly care centers have rated their quality of life as poor, 88% of them rated their health satisfaction as poor, 97% of the rated their physical domain as poor, 99% of them rated their psychological domain as poor, 72% of them rated their social domain as poor and 64% of them rated their environmental domain as poor. The literature and few studies done alone on the quality of life of elders in old age homes suggest that

the quality of life is better of those not staying in old age homes or elderly centers: where as this study shows the quality of life of elders who are parts of the elderly care centers is better.

Keywords: Quality of life of elders, elderly care centers

INTRODUCTION

Worldwide, the proportion of people age 60 and over is growing faster than any other age group. As people age, their quality of life is largely determined by their ability to maintain autonomy and independence. Aging is a process of deterioration in the functional capacity of an individual that results from structural changes, with the advancement of age (Harman, 2003). [1]

According to Population Census 2011, there are nearly 104 million elderly persons (aged 60 years or above) in India; 53 million females and 51 million males. With age comes disability and Most common disability among the aged persons was a locomotors disability and visual disability as per Census 2011. [Elderly in India – Profile and Programmes, 2016]

As the more numbers of people are entering in old age, the problems arising among them cannot be overlooked. There is increased risk of morbidity leading to limitation of movements due to pain and discomfort. This is superadded by the financial burden and difficult to access health services. The further young generation has less time in busy lives to take care of the elderly population and there is a rising trend of nuclear families where priorities are given to spouse and their children. [1]

Hence, most of the older people are obliged to stay in old age homes. Thus, unconditional respect, power, and authority that elder people used to enjoy in extended traditional families are being gradually eroded in India in recent years (Mahajan, 2013).

The aged population faces the problem of poor health status along with social cut off, economic dependence and loss of emotional support affecting their quality of life. Access to high quality, long care which is particularly important in later life is somewhere losing its importance.

In a survey of elderly 65 and above, respondents were aware of the term quality of life and talked both in positive and negative terms. This comparison was done on the basis with others, social interactions especially with family and children, material circumstances and activities. In negative evaluations, they stressed dependency and functional limitations, unhappiness and reduced social contacts through the death of friends and family members. In a national survey done by Bowling and colleagues of 999 individuals aged 65 years or more, living in England and Scotland, identified constituent factors of quality of life as social relationships, social roles and activities, solo activities, health, psychological, home and neighborhood, financial circumstances, independence, miscellaneous and society/politics in the order frequency of mentioning. The same order stood for factors constituting good quality of life while health and home and neighborhood came on the top as factors that can take away the quality of life.

A study was conducted by Lokhare P.O et al, on _assessment of quality of life among elderly population residing at old age homes' stated that there is a need to conduct comparative study of quality of life of elderly residing at old age homes with elderly residing with their family for better understanding of difference in Quality of life.

LITERATURE REVIEW

Human resource is considered as an asset for a country. It plays an important role in economic development and growth. The global demographic trend, however, shows that, with the passage of time, the countries have experienced ageing of population. The population ageing that started in the last century in developed countries, is now encompassing developing countries too and India, by no means, is an exception to this phenomenon. Over the years, structure of the population has changed and will further change in the time to come. The proportion of older persons in the population will increase. [2]

The world population continues to grow and it reached 7 billion in 2012, 562 million (or 8.0 percent) were aged 65 and over. In 2015, 3 years later, the older population rose by 55 million and the proportion of the older population reached 8.5 percent of the total population. [3]

Over the next 15 years, the number of older persons is expected to grow fastest in Latin America and the Caribbean with a projected 71 per cent increase in the population aged 60 years or over, followed by Asia (66 per cent), Africa (64 per cent), Oceania (47 per cent), Northern America (41 per cent) and Europe (23 per cent). The older population is growing faster in urban areas than in rural areas. At the global level between 2000 and 2015, the number of people aged 60 years or over increased by 68 per cent in urban areas, compared to a 25 per cent increase in rural area. [5]

According to Population Census 2011 there are nearly 104 million elderly persons (aged 60 years or above) in India; 53 million females and 51 million males. Both the share and size of elderly population is increasing over time. From 5.6% in 1961 the proportion has increased to 8.6% in 2011. For males it was marginally lower at 8.2%, while for females it was 9.0%. As regards rural and urban areas, 71% of elderly population resides in rural areas while 29 % is in urban areas. [6]

The elderly population has increased in size across all the states in the country. Figure 2.1 shows the percentage of the population aged 60 years and above for the years 2001 and 2011. Tamil Nadu has one of the highest proportions of elderly persons in the country, next only to Kerala and Goa. According to the 2011 Census, the elderly constitute 10.4 per cent of the total population of the state while the figure for the country as a whole is 8.6 per cent. Of the approximately 7.5 million persons in Tamil Nadu who were 60 years of age or above in 2011, there are marginally more women than men (about 3.85 million women and about 3.66 million men). On the other hand, slightly more elderly persons live in rural areas compared to urban areas (about 4.03 million to about 3.48 million). [8]

In today‘s developing countries, the rise of chronic non communicable diseases such as heart disease, cancer and diabetes reflects changes in lifestyle and diet, as well as aging the potential economic and societal cost of such diseases rise sharply with age. Morbidity being a function of the socio economic conditions of a given population varies widely in different parts within the country, which is why different studies conducted in different parts of the country are bound to yield non-uniform results.

A study done by Dr. S.Chandrika et.al among elderly population aged 65 and above 65 years residing in old age homes and in the community of Visakhapatnam city showed that the social and psychological domains of QOL were better in the people living in the community. Another study done by Lokhare et.al to assess the quality of life among elderly population residing at old age homes concluded that there is a need of age friendly communities that provide their citizen with more opportunities for social activities and worthwhile leisure time pursuits

The improvement in quality of life of the elderly calls for a holistic approach and concerted efforts of the entire health sector with strong backing by the government and other stakeholders to be worked up aggressively towards the targets we need to achieve for the health of our elderly

MATERIALS AND METHODS

Study setting

The present study was conducted among elders from different villages of a state in rural south India

Study design and sample

It was a retrospective cohort study ran between February and May 2018. We retrospectively reviewed the prospectively collected learning data of 112 elders at elderly day care centers. Taking the cut-off value for good and poor quality of life to be a score of 60, using the formula $n = \frac{z^2_{\alpha/2} * [\frac{1-P_1}{P_1} + \frac{1-P_2}{P_2}]}{[\ln(1-\varepsilon)]^2}$ the minimum sample size was 54, including all the eligible participants from the exposed group, total sample size was 128. Elderly population from 6 elderly day care centers and 4 villages were selected by Participatory Rural Appraisal method.

Inclusion and exclusion criteria

Elders with 90% attendance in the exposed group were enrolled in the study. Elders with impaired hearing and those who are mentally impaired were excluded from the study. This was done assuming that only regular participants in the exposed group have received proper benefits from the elderly day care centers.

Ethical consideration

Approval of Institution was obtained before the commission of the study. Informed written consent was taken from all the participants for voluntary participation. All information collected was kept private and confidential.

Outcome variable

The primary outcome of this study was the quality of life, which was classified as either “good” or “poor”.

Data collection

Interview was conducted with eligible participants using interviewer administered questionnaire at a mutually convenient time. Anonymity of the study participants was maintained to enhance the participation rate and to ensure confidentiality. Details about age, gender, education, marital status, family type, occupational status health issues were collected. Interview schedule included questions to assess the physical health, psychological, social relationships and environmental domains.

Statistical analysis

Data were analyzed using Statistical Package for the Social Sciences (SPSS) for Windows, version 17.0. Results were expressed as frequencies and proportions for domains and outcome variables. Pearson’s Chi-square test was applied to assess the difference in knowledge across various study variables. Two sided $P<0.05$ was considered as statistical significance.

RESULTS

Demographic data

There were 112 elders enrolled in 2016. The male to female ratio was 1:4 and almost equal in elderly centers and community respectively. Most of the elders were in age group of 61-70. 63% and 81% of the elders were uneducated respectively. 68% are widowed in centers whereas 71% are married in the community. Almost all the elders were unemployed.

Baseline characteristics of the respondents

Characteristics	**Percentage in Elderly Center**	**Percentage in Community Villages**
Age Distribution	n=69	n=69
=60	17%	23%
61-70	42%	60%
71-80	35%	13%
81-90	6%	4%
Gender Distribution	n=69	n=69
Male	20%	42%
Female	80%	58%
Education	n=69	n=69
No education	63%	81%
Primary	33%	18%
Secondary	4%	1%
Marital Status	n=69	n=69
Married	26%	71%
Unmarried	6%	1%
Separated	0%	1%
Widowed	68%	26%
Divorced	0%	1%
Occupational Status	n=69	n=69
Employed	7%	12%
Unemployed	93%	88%

Receiving Pension	n=69	n=69
Yes	86%	88%
No	14%	12%
Monthly Income	n=69	n=69
No Income	7%	10%
<Rs. 4000	84%	87%
Rs. 4000- Rs. 8000	9%	3%

Learning outcomes

Physical domain was 72% good in centers while 97% poor in community.

	Poor (Percentage)	Good (Percentage)
Elderly Center	28%	72%
Community Villages	97%	3%

Psychological domain was 95% good in centers while 99% poor in community.

	Poor (Percentage)	Good (Percentage)
Elderly Center	5%	95%
Community Villages	99%	1%

Social relationship domain was 93% good in centers while 72% poor in community.

	Poor (Percentage)	Good (Percentage)
Elderly Center	7%	93%
Community Villages	72%	28%

Environmental domain was 90% good in centers while only 64% in community.

	Poor (Percentage)	Good (Percentage)
Elderly Center	10%	90%
Community Villages	36%	64%

Quality of life was 96% good in elderly centers while only 67% in community.

	Poor (Percentage)	Good (Percentage)
Elderly Center	4%	96%
Community Villages	33%	67%

Health satisfaction was 80% good in centers while 88% poor in community.

	Poor (Percentage)	Good (Percentage)
Elderly Center	20%	80%
Community Villages	88%	12%

DISCUSSIONS

96% of the elderly respondents from elderly care centers have rated their quality of life as good, 80% of them rated their health satisfaction as good, 72% of them rated their physical domain as good, 95% of the rated their psychological domain as good, 93% of them rated their social domain as good and 90% of them rated their environmental domain as good whereas 64% of the elderly respondents not attending elderly care centers have rated their quality of life as poor, 88% of them rated their health satisfaction as poor, 97% of the rated their physical domain as poor, 99% of them rated their psychological domain as poor, 72% of them rated their social domain as poor and 64% of them rated their environmental domain as poor.

The literature and few studies done alone on the quality of life of the elderly in old age homes suggest that the quality of life is better of those not staying at old age homes or elderly centers, whereas this study shows that the quality of life of elderly who are beneficiaries of the elderly centers have better quality of life.

CONCLUSION AND RECOMMENDATIONS

This study demonstrates the impact of elderly centers in the quality of life of elders. Moreover we found that elderly centers offers better quality of life for elders than community. We suggest that this idea should be spread worldwide to improve the quality of life of elderly as aging is an inevitable phenomenon and a great deal for the countries' development.

Limitation

There are no limitations.

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Conflicts of interest

There are no conflicts of interests.

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Quality of Life of Senior Citizens Residing at the Home for Aged

S.Sudarmathy & M.Kannan

ABSTRACT

Quality of life of senior citizens residing in the old age homes was studied using the Quality of Life Brief scale WHO. Descriptive research design was chosen and the samples of 50 male senior citizens and 50 female citizens were selected through random sampling method. It was found their quality of life is in the moderate level. Respondent's quality of life does differ with regard to the educational qualification, the type of domicile and the present of income. Psychological quality of life, social relationship and the overall quality of life do differ for the respondents having children around 3-4.

Keywords: Quality of life, Senior citizens, Old age homes

INTRODUCTION

Old age consists of ages nearing of surpassing the average life span of human beings and thus the end of the human life cycle. Old age is the closing period in the life span. The term old age defines not only an individual's appearance, but also refers to a loss of power, role and position. Loss of full possession of the faculties and a proneness to physical diseases causes an individual to become more dependent on others. In such this state caring an elderly becomes a problem by their children as a result they are dumped in old age homes. When son/daughter in family is not in position to take care of the elderly Quality of the life becomes questionable.

REVIEW OF LITERATURE

- **Eric. J. Lenze (2006)** reported in his study that "the constant state of worry and anxiousness may seriously affect older people's Quality of life by causing them to limit their daily activities and have difficulty in sleeping
- **Easwaramoorthy and Chanda, (1999)** studied 580 aged respondents (305 men, women 275) from five districts of Tamil Nadu. The findings of study suggest that the women old group and the rural elders are disadvantaged in items of economic, physical, psychological and social indication, indicating that they are having comparatively poor quality of life than their counterparts
- **David Blane, Richard Wiggins, Paul Higgs and Martin Hyde. (2000),** conducted a research to find out the factors influencing the quality of life in early old age. Most of our sample report reasonably good quality of life although there are those who still suffer poor quality of life. Men had a slightly higher quality of life than women in this age group. Those under 70 years had a higher quality of life than those over 70 years
- **Predictors of quality of life in old age: A cross-validation study was conducted by Gail Low' Anita E. Molzahn Faculty of Nursing, University of Alberta (2006)** a replication study was undertaken to validate a model of quality of life (QOL) generated in an earlier study on a random sample of 202 older adults. Pathways found to be significant were retested using QOL data from a convenience sample of 420 older adults. Using path analysis, we found that financial resources, health, and meaning in life directly and positively influenced QOL. Health, emotional support, and the physical environment indirectly affected QOL through purpose in life. All but one pathway were replicated, explaining 50.5% of the variance in QOL. Further explorations of the influence of spirituality, emotionally close ties, and opportunities for active engagement on QOL in older age are warranted.

RESEARCH METHODOLOGY

AIM : To study the quality of life of the senior citizens in the home for the aged.

OBJECTIVES

- To study the socio-demographic factors of the senior citizens.
- To measure the level of quality of life of the senior citizens in the home for aged.

RESEARCH DESIGN

- Descriptive research design was used to describe the quality of life of senior citizens in the home for aged.

SAMPLING METHOD

- Randomly selected seven homes for aged at Madurai.
- Using Lottery method 102 senior citizens have been selected for this study.

INCLUSION

✓ Senior citizens who are able to co-operate.

✓ Senior citizens who are institutionalized.

EXCLUSION

× Senior citizens who are above the age of 90 years.

× Senior citizens who are undergoing psychiatric treatment.

× Senior citizens who are unmarried.

TOOLS OF DATA COLLECTION

× Semi-structured interview schedule and WHO Quality of life Scale

HYPOTHESES

- Quality of life of the respondents do not differ with regard to the gender
- Quality of life of the respondents do not differ with regard to educational background
- Quality of life of the respondents do not differ with regard to the types of domicile
- Quality of life of the respondents do not differ with regard to the total number of children

- Quality of life of the respondents do not differ with regard to the present source of income

DATA ANALYSIS: The collected data were edited, coded and entered in the computer and using SPSS – ver 16.0 spread sheet researcher had made an attempt to test the formulated hypotheses.

DATA ANALYSIS AND DISCUSSION

- GENDER AND AGE: Out of 50 per cent of male respondents 26.5 per cent come under the age group of (60 – 70) years, 23.5 per cent come under the age group of(70 & above). Also it shows that out of 50 per cent of female respondents 22.5 per cent are in the age group of (60 – 70) years, 27.5 percent are in the age group of 70 & above years. Almost equal numbers of male and female respondents are in the younger older and older older age group.
- EDUCATIONAL QUALIFICATION: It is found that out 50 per cent of male respondents 6.9 per cent are illiterates, 11.8 per cent perused primary education and one third of the respondents (31.4%) studied higher secondary and above. It is also found that out of 50 per cent of female respondents 19.6 per cent are illiterates, 12.7 per cent perused primary education and 17.6 per cent studied higher secondary and above. It is inferred that majority among male respondents studied higher secondary and above, whereas majority among females are illiterate.
- DOMICILE: More than half of the respondents (52.9%) are from urban area. Nearly half of the respondents (47.1%) are from rural area. Almost equal number of male and female senior citizens are sent to old age homes from both urban (male: 28.4%; female: 24.5%) and rural area (male: 21.6%; female: 25.5%).
- TOTAL NO. OF CHIDREN: More than one third of the respondents, 39.2 per cent (Male: 24.5%; Female: 14.7%) have three to four children. More than one fourth of the respondents, 26.5per cent (Male: 10.8%; Female: 15.7%) have one to two children. Respondents having five to six children (10.8%) also residing in old age home. Nearly one fourth of the respondents

(23.5%) do not have children residing in old age home since nobody is there to take care of them.

- REASON FOR THE STAY IN OLD AGE HOME:. Nearly half of the respondents (40.2%, 23.5% male & 16.7% female) are residing at old age homes due to disagreements with sons and daughter in law. For one third of the respondents (35.3%) no body is there to take care so they came to old age home. Where as few respondents who's (11.8%) children are willing but the respondents couldn't adjust with them was the reason to come to old age home. For few respondents (12.7%) nobody is willing to take care of them so they came to old age home. From the above table it can be concluded that the major reason for which the senior citizens residing in old age home is disagreement with their sons and daughter in law.
- PRESENT SOURCE OF INCOME: More than half of the respondents (52.9%) did not receive any money as pension or gifts from family members or visitors. Nearly one fourth of the respondents (25.5%) received pension. Less than one fourth (21.6%) of the respondents received gifts from their family members or visitors. Thus majority of the respondents didn't even receive old age pension.
- QUALITY OF LIFE: More than two third of the respondents (68.6%) have moderate level of quality of life. More than one fourth of the respondents (26.5%) have low level of quality of life. Only few (4.9%) have high level of quality of life. Thus the majority of the respondents residing at old age homes have moderate level of quality of life. This may be due to the high level of anxiety and depression experienced by the senior citizens at the old age homes. It was supported by the findings of Ann Bowling, Emily Grundy, et.al.., (1993), they found out that the anxiety and depression were consistently associated with poor or deteriorating levels of anxiety to perform routine tasks. Another reason may be the poor health condition of the senior citizens affects the quality of life.

"t "TEST RESULTS FOR QUALITY OF LIFE BASED ON SEX

Factors	Male (51)	Female(51)		" t " Value	Statistical Result
	Mean SD	Mean	SD		
Quality of life QOL Physical	47.82 7.528	47.25	6.483	0.409	P > 0.05 N S
QOL Psychological	39.88 7.199	35.80	6.086	3.090	P < 0.05 Sig
QOL Social Relationship	53.86 10.032	52.25	7.177	0.931	P > 0.05 N S
QOL Environment	44.20 12.326	42.43	9.468	0.811	P > 0.05 N S
Total QOL	46.44 7.693	44.44	4.976	1.563	P > 0.05 N S

The above table shows the "t" test results of quality of life of the senior citizens based on the sex.

QOL - Physical:

Physical quality of life of the male senior citizens (Mean= 47.82; S.D. = 7.528) is high when compared with the female senior citizens (Mean= 47.25; S.D = 6.483). The t value is 0.409. The observed difference is statistically not significant, since the t value is not significant at 0.05 level. Thus it is inferred that the senior citizens of different sex do not differ with regard to their physical quality of life.

QOL - Psychological:

Psychological quality of life of the male senior citizens (Mean= 39.88; S.D. = 7.199) is high when compared with female senior citizens (Mean= 35.80; S.D.= 6.086). The t value is 3.090. The observed difference is statistically significant, since the t value is significant at 0.05 level. Thus the senior citizens of different sex do differ with regard to their psychological quality of life.

QOL - Social Relationship:

Social relationship of the male senior citizens (Mean= 53.86; S.D.= 10.032) is high when compared with female senior citizens (Mean= 52.25; S.D. = 7.177). The t value is 0.931. The observed difference is statistically not significant, since the t value is not significant at 0.05 level. Thus it is inferred that the senior citizens of different sex do not differ with regard to their social relationship (quality of life).

QOL – Environment:

Environmental quality of life of the male senior citizens (Mean= 44.20; S.D. = 12.326) is high when compared to female senior citizens (Mean= 42.43; S.D.= 9.468). The t value is 0.811. The observed difference is statistically not significant, since the t value is not significant at 0.05 level. Thus the senior citizens of different sex do not differ with regard to their environmental quality of life.

Total QOL:

Total quality of life of the male senior citizens (Mean= 46.44; S.D. = 7.693) is high when compared to female senior citizens (Mean= 44.44; S.D.= 4.976). The t value is 1.563. The observed difference is statistically not significant, since the t value is not significant at 0.05 level. Thus the senior citizens of different sex do not differ with regard to their total quality of life.

QOL - Physical:

While comparing the physical quality of life of the senior citizens with their educational background it is found that the senior citizens who studied up to fifth standard (Mean= 48.80; S.D.= 6.000) have high physical quality of life when compared with illiterate (Mean= 46.44; S.D.= 6.471) senior citizens and the senior citizens who perused high school and above (Mean= 47.50; S.D.=7.718). The F ratio is 0.733. The observed difference is statistically not significant at 0.05 level. Therefore the senior citizens belong to different educational background do not differ with regard to their physical quality of life

ANOVA RESULTS FOR QUALITY OF LIFE BASED ON THE EDUCATIONAL QUALIFICATION

Quality of Life	Illiterate (27)		Primary (25)		High School & Above (50)		Total (102)		" F " Ratio	Statistical Result
	Mean	SD	Mean	SD	Mean	SD	Mean	SD		
QOL Physical	46.44	6.471	48.80	6.000	47.50	7.718	47.54	6.996	0.733	P > 0.05 N S
QOL Psychological	35.00	7.894	37.24	4.603	39.68	6.915	37.84	6.942	4.384	P < 0.05 Sig
QOL Social Relationship	50.44	7.648	53.84	4.200	54.08	10.573	53.06	8.716	1.680	P > 0.05 N S
QOL Environment	36.48	7.648	42.92	6.396	47.20	12.483	43.31	10.972	9.859	P < 0.05 Sig
Total QOL	42.09	5.100	45.70	3.395	47.12	7.696	45.44	6.525	5.707	P < 0.05 Sig

QOL - Psychological:

Psychological quality of life is high for the senior citizens who studied high school and above (Mean= 39.68; S.D.= 6.915) compared to illiterate (Mean= 35.00; S.D.= 7.894) and the senior citizens who perused primary education (Mean= 37.24; S.D.=4.603). The F ratio is 4.384. The observed difference is statistically significant at 0.05 level. Therefore the senior citizens of different educational background do differ with regard to their psychological quality of life.

QOL - Social Relationship:

Social relationship of the senior citizens who perused education above high school (Mean= 54.08; S.D.= 10.573) is high when compared with illiterate (Mean= 50.44; S.D.= 7.648) senior citizens and the senior citizens who perused primary education (Mean= 53.84; S.D.=4.200). The F ratio is 1.680. The observed difference is statistically not significant at 0.05 level. Therefore the senior citizens belong to different educational background do not differ with regard to their social relationship.

QOL - Environment:

Environmental quality of life is high for the senior citizens who studied high school and above (Mean= 47.20; S.D.= 12.483) compared to illiterate (Mean= 36.48; S.D.= 7.648) and the senior citizens who perused primary education (Mean= 42.92; S.D.=6.396). The F ratio is 9.859. The observed difference is statistically significant at 0.05 level. Therefore the senior citizens of different educational background do differ with regard to their environmental quality of life.

Total QOL :

Total quality of life of the senior citizens who studied high school and above (Mean= 47.12; S.D.= 7.696) is high compared to illiterate (Mean= 42.09; S.D.= 5.100) and the senior citizens who perused primary education (Mean= 45.70; S.D.=3.395). The F ratio is 5.707. The observed difference is statistically significant at 0.05 level. Therefore the senior citizens of different educational background do differ with regard to their total quality of life.

“t “TEST RESULTS FOR QUALITY OF LIFE BASED ONTHE DOMICILE

Quality of life	Rural (48)		Urban (54)		“ t “ Value	Statistical Result
	Mean	SD	Mean	SD		
QOL Physical	46.65	6.353	48.33	7.491	-1.231	P > 0.05 N S
QOL Psychological	37.02	6.828	38.57	7.024	-1.131	P > 0.05 N S
QOL Social Relationship	50.46	7.240	55.37	9.313	-2.990	P < 0.05 Sig
QOL Environment	40.81	9.684	45.54	11.642	-2.236	P < 0.05 Sig
Total QOL	43.73	5.636	46.95	6.927	-2.585	P < 0.05 Sig

QOL - Physical:

Physical quality of life of the urban senior citizens (Mean= 48.33; S.D.= 7.491) is high when compared to the rural senior citizens (Mean= 46.65; S.D.= 6.353). The t value is -1.231. The observed difference is statistically not significant, since the t value is not significant at 0.05 level. It is inferred that the senior citizens from different type of domicile do not differ with regard to their physical quality of life.

QOL - Psychological:

Psychological quality of life of the urban senior citizens (Mean= 38.57; S.D.= 7.024) is high when compared to the rural senior citizens (Mean= 37.02; S.D.= 6.828). The t value is -1.131. The observed difference is statistically not significant, since the t value is not significant at 0.05 level. It is inferred that the senior citizens from different type of domicile do not differ with regard to their psychological quality of life.

QOL - Social Relationship:

Social relationship of the urban senior citizens (Mean= 55.37; S.D.= 9.313) is high when compared with rural senior citizens (Mean= 50.46; S.D. = 7.240).The t value is -2.990. The observed difference is statistically significant, since the t value is significant at 0.05 level. It is inferred that the senior citizens from different types of domicile do differ with regard to their social relationship.

QOL – Environment:

Environmental quality of life of the urban senior citizens (Mean= 45.54; S.D.= 11.642) is high when compared with rural senior citizens (Mean= 40.81; S.D. = 9.684).The t value is -2.236. The observed difference is statistically significant, since the t value is significant at 0.05 level. It is inferred that the senior citizens from different types of domicile do differ with regard to their environmental quality of life.

Total QOL:

Total quality of life of the urban senior citizens (Mean= 46.95; S.D.= 6.927) is high when compared with rural senior citizens (Mean= 43.73; S.D. = 5.636).The t value is -2.585. The observed difference is statistically significant, since the t value is significant at 0.05 level. It is inferred that the senior citizens from different types of domicile do differ with regard to their total quality of life.

The social relationship, environmental quality of life and total quality of life is better for senior citizens from urban area when compared to rural area. It is known that the urban people have all the facilities for their livelihood when compared with rural people thus their quality of life is better when compared with the rural people. It is supported by the view of Easwaramoorthy and Chanda, (1997), in their study they found that the rural elders are disadvantaged in terms of economic, physical, psychological and social indication, indicating that they are having comparatively poor quality of life.

QOL - Physical:

Physical quality of life is high for the senior citizens having two children (Mean= 48.68; S.D.= 6.498) when compared with the senior citizens having one (Mean= 48.48; S.D.= 6.653) , three (Mean= 46.7; S.D.= 10.864) and none (Mean= 44.96; S.D.= 5.607). The F ratio is 1.687. The observed difference is statistically not significant at 0.05 level. It is inferred that the physical quality of life do not differ with regard to the total number of children of the senior citizens.

QOL - Psychological:

Psychological quality of life of the senior citizens having one children (Mean= 39.63; S.D.=5.699) is high when compared the senior citizens having two (Mean= 39.50; S.D.=6.917), three (Mean= 35.91; S.D.= 8.514) and none (Mean= 33.96; S.D.= 6.018). The F ratio is 4.587. The observed difference is statistically significant at 0.05 level. So it can be inferred that the psychological quality of life do differ with regard to the total number of children of the senior citizens.

ANOVA RESULTS FOR QUALITY OF LIFE BASED ON THE TOTAL NO.OF CHILDREN

Factors	No Children (24)		One (27)		Two (40)		Three (11)		Total (102)		" F " Ratio	Statistical Result
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD		
Quality of Life QOL Physical	44.96	5.607	48.48	6.653	48.68	6.498	46.73	10.864	47.54	6.996	1.687	P > 0.05 N S
QOL Psychological	33.96	6.018	39.63	5.699	39.50	6.917	35.91	8.514	37.84	6.942	4.587	P < 0.05 Sig
QOL Social Relationship	45.88	8.523	54.26	5.050	55.20	8.004	58.00	10.545	53.06	8.716	9.504	P < 0.05 Sig
QOL Environment	40.50	11.669	41.59	8.391	45.80	11.395	44.64	12.628	43.31	10.972	1.508	P > 0.05 N S
Total QOL	41.32	6.303	45.99	3.984	47.29	6.552	46.32	8.590	45.44	6.525	4.901	P < 0.05 Sig

QOL - Social Relationship:

Social relationship of the senior citizens having three children (Mean= 58.00; S.D= 10.545) is high compared to the senior citizens having one (Mean= 54.26; S.D.= 5.050), two (Mean= 55.20; S.D.= 8.004) and none (Mean= 45.88; S.D.= 8.523). The F ratio is 9.504. The observed difference is statistically significant at 0.05 level. Thus it can be inferred that the social relationship (quality of life) do differ with regard to the total number of children of the senior citizens.

QOL – Environment:

The senior citizens having two children (Mean= 45.80; S.D.= 11.395) have better environmental quality of life when compared with the senior citizens having one (Mean= 41.59; S.D.= 8.391), three (Mean= 44.64; S.D.= 12.628), and none (Mean= 40.50; S.D.= 11.669). The F ratio is 1.508. The observed difference is statistically not significant at 0.05 level. It is inferred that the environmental quality of life do not differ with regard to the total number of children of the senior citizens.

Total QOL:

The total quality of the senior citizens having two children (Mean=47.29; S.D.= 6.552) is high when compared with the senior citizens having one (Mean= 45.99; S.D.= 3.984), three (Mean= 46.32; S.D.= 8.590) and none (Mean= 41.32; S.D.= 6.303). The F ratio is 4.901. The observed difference is statistically significant at 0.05 level. Thus it can be inferred that the total quality of life do differ with regard to the total number of children of the senior citizens.

ANOVA RESULTS FOR QUALITY OF LIFE BASED ON PRESENT SOURCE OF INCOME

Factors	Pension (26)		Gifts from Family members/Visitors (22)		No (54)		Total (102)		" F " Ratio	Statistical Result
	Mean	SD	Mean	SD	Mean	SD	Mean	SD		
Quality of Life QOL Physical	48.19	7.653	49.18	6.752	46.56	6.728	47.54	6.996	1.260	P > 0.05 N S
QOL Psychological	39.88	7.056	40.00	5.398	35.98	7.022	37.84	6.942	4.406	P < 0.05 Sig
QOL Social Relationship	54.31	11.390	54.09	4.297	52.04	8.602	53.06	8.716	0.789	P > 0.05 N S
QOL Environment	49.85	11.688	41.14	7.298	41.06	10.759	43.31	10.972	6.909	P < 0.05 Sig
Total QOL	48.05	7.856	46.10	3.669	43.91	6.383	45.44	6.525	3.908	P < 0.05 Sig

QOL - Physical:

Physical quality of life of the senior citizens is high for those who receives gifts from family members or visitors (Mean= 49.18; S.D.= 6.725) when compared with the senior citizens who gets pension (Mean= 48.19; S.D.= 7.653) and who do not have any income (Mean= 46.56; S.D.= 6.728). The F ratio is 1.260. The observed difference is statistically not significant at 0.05 level. The respondent's based on present source of income do not differ with regard to their physical quality of life.

QOL - Psychological:

Psychological quality of life of the senior citizens is high for those who receives gifts from family members or visitors (Mean= 40.00; S.D.= 5.398) when compared with the senior citizens who gets pension (Mean= 39.88; S.D.= 7.056) and who do not have any income (Mean= 35.98; S.D.= 7.022). The F ratio is 4.406. The observed difference is statistically significant at 0.05 level. So the respondent's based on present source of income do differ with regard to their psychological quality of life.

QOL - Social Relationship:

Social relationship is high for the senior citizens who gets pension (Mean= 54.31; S.D.= 11.390) when compared with the senior citizens who receives gifts from family members or visitors (Mean= 54.09; S.D.= 4.297) and who do not have any income (Mean= 52.04; S.D.= 8.602). The F ratio is 0.789. The observed difference is statistically not significant at 0.05 level. The respondent's based on present source of income do not differ with regard to their social relation (quality of life).

QOL – Environment:

Environmental quality of life of the pensioner's is high (Mean= 49.85; S.D.= 11.688) when compared with the senior citizens who receives gifts from family members or visitors (Mean= 41.14; S.D.= 7.298) and who do not have any income (Mean= 41.06; S.D.= 10.759). The F ratio is 6.909. The observed difference is statistically significant at 0.05 level. So the respondent's based on present source of income do differ with regard to their environmental quality of life.

Total QOL:

Total quality of life of the pensioner's is high (Mean= 48.05; S.D. = 7.856) when compared with the senior citizens who receives gifts from family members or visitors (Mean= 46.10; S.D.= 3.669) and who do not have any income (Mean= 43.91; S.D.= 6.383). The F ratio is 3.908. The observed difference is statistically significant at 0.05 level. So the respondent's based on present source of income do differ with regard to their total quality of life.

The senior citizens who do not have income have high level of anxiety it is quite natural people who earned for years and suddenly they become resentful will affect their mental health there by they feel as unproductive and unwanted which may lead to depression in turn affect their quality of life. In the same hand the senior citizens who are pension earners have better psychological, environmental and total quality of life.

FINDINGS

- Almost equal numbers of male and female respondents are in the younger older and older old age group
- Majority of the male senior citizens studied higher secondary and above and majority of female senior citizens are illiterate
- Almost equal number of male and female senior citizens are send to old age homes from both urban (male:28.4%; female:24.5%) and rural area (male:21.6%; female:25.5%).
- More than one third of the senior citizens (39.2%, Male: 24.5%; Female: 14.7%) having three to four children are residing in old age homes.
- More than half of the senior citizens (52.9%) they don't receive any money as pension or gifts from family members or visitors
- 68.6% of the respondents have moderate quality of life. Also there exists difference based on the respondent's educational qualification, type of domicile, total no. of children and source of income.
- Psychological Quality of life of the respondents do differ with the gender, educational qualification, total no. of children and source of income.

- Environmental domain of Quality of life of the respondents do differ with regard to educational qualification, type of domicile and source of income.
- Social Relationship domain of Quality of life of the respondents do differ with regard to type of domicile and source of income.

SUGGESTION

- Old age is an inevitable stage of human life with many challenges, which need to be faced with help of family. Instead family consider it as burden and transforms that responsibility to old age home.
- Quality of life of the senior citizens was largely depend on their physical, psychological, social and environmental factors. The people at this stage needs lot of love care and affection for their loved ones. But in reality due to various reasons they are sent to home for aged.
- Though they have moderate level of quality of life the psychological domain is largely differ with gender, educational qualification, total no. of children and the source of income.
- Instead of Spending on old age the children can spend time with the older parents, which improves the quality of life. Since the elderly people are very much a part of our society and family and hence it is our duty to take care of them and respect them.
- The major cause for dumping the senior citizens in old age homes is the disintegration of joint family system. In this research it is reported that more than half of the senior citizens are from nuclear family. Its is the right time for the younger generation to rejuvenate the system of joint family.
- Elders should also be prepared to adjust with the younger generation especially with their own family members.
- They should be prepared for their old age gracefully and should secure their old age economically. In this research it is found that more than half of the senior citizens they don’t receive any money as pension or gifts from family members or visitors. Since economic security will also enhance their decision-making power in the family.

- Parents are a treasure that children should guard zealously putting them into old age homes must never be the first but always the last option. Treat your parents as assets not liability. Let them feel wanted and not a burden.

CONCLUSION:

Quality of life which includes the physically, psychological, social relationship and environment. When a person being satisfied in the entire above domain will have good quality of life. Especially during old age good quality of life is not easy. More than that problem in old age is an inevitable one. Lots of changes that to physically, mentally as well economically will take place during this stage. It is important to take care of them at this stage rather than putting them in old age home and detetoriating their quality of life.

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Health Care Services for Elderly Persons in India

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ABSTRACT

Health is determined by various economic, social, psychological and physiological factors. Health has been declared fundamental rights that imply the state to have the responsibilities for the health. According to the World Health Organization (WHO), health is a state of concept physical, mental and social well- being and not merely an absence of disease or infirmity. Health care service is to improve the health status of the population, its main goal is to achieve in terms of mortality and morbidity reduction, increase in expectation of life span, decrease in population growth rate, improvements in nutritional status, provisions of basic sanitation etc. (K.Park, 2015). Aging is defined in terms of chronological age with a cut of 60 or 65 years while older adults are those about age 65 years and above. Health care for the elderly persons is a burning issue since a decade, the directive principles of state policy has envisaged the state to provide public assistance to older persons within the limits of its economic capacity; hence the social welfare has included old age pension and shelter. The national policy on older persons was adopted in 1999 by the ministry of social justice and empowerment, with the commitment of India in framing the national policy on older persons. United Nation declared 1999 as the international year for the older persons, and India declared 2000 as the year for the older persons. The National programme for Health care for elderly (NPHCE) was launched by the ministry of health and family welfare during financial year 2010-11 (MoHFW, 2011). Its aim is to provide dedicated health care facilities to the elderly through primary, secondary and tertiary health care delivery systems consisting of district hospitals with regional medical institutions providing a firm referral backup. The programme builds a capacity of medical and Para-medical professionals as well as family based caretaker for providing health care to the older persons. It has convergence with National Health Mission, Ministry of social justice and empowerment and Ministry of AYUSH. The Census 2011 shows that there were 98 millions of older persons in India. In which chronic diseases was the leading cause of death, the

common chronic ailments are arthritis, hypertension, cataract and diabetes and mostly among women of older persons. Therefore, with increase in age the disability becomes common major issues hence it creates increasing burden to the care givers and family members, As per 2011 census there are about 51.8 per 1000 for elderly population and 84.1 per 1000 for 80 plus elderly population (India ageing report, 2017).

Keywaords: Health, Health care services, ageing, elderly persons.

Demographic Ageing in India

The population of India is 1.31 billion globally the second largest nations with 17% of world's population (UN 2015); by 2028 it will take over china's population. Ageing is a burning issue in today's century; it is defined in terms of chronological age with a cut off age of 60 or 65 years and above. The three demographic changes are declining fertility, reduction in mortality and increasing survival at older age. Population of ageing is an inevitable and irreversible demographic reality that is associated with welcome improvements in health and medical care. Globally 60 plus population constitutes about 11.5 % of total population of 7 billion by 2050 it will increase to about 22% (UNFPA, 2017). Ageing population in India will increase to 19 % in 2050. According to sample registration system life expectancy of 60 years old has increased from 14 years in 1970 – 1975 to 18 years in 2010 – 14 with women living about two years longer than men. As per 2011 census 71 % of elderly lives in rural areas, except two states Goa and Mizoram a higher proportion lives in rural areas. It is fact that most of the rural areas have poor mass communication, poor transport access, income security, inadequate access to quality health care. 83 million people in India are 60 years of age and older representing 7% of the nation's total population (world health statistic, 2011). In fact geriatric health issues are identified as one of the most five challenges that primary health care will face in the days to come. The older population specially the 75 + is the largest growing segment in the population of India. It will definitely rise by 2050 and the number of 60 + people will rise to 360% and older persons will rise to 323 millions in 2050 (UNFPA & Help Age international).

Demographic trend:

	Years (numbers in millions)				
Age	2011	2021	2031	2041	2051
60 +	98	132	184	233	298
70+	43	52	75	104	131
80+	11	16	20	29	41

Source: Dr. A B Dey: Health and long – term care of older persons in India

Health Status of Older persons in India:

Health is determined by various economic, social, psychological and physiological factors. The quality of life and well being of older persons is determined by poor health and morbidity. Elderly persons mostly suffer from dual medical problems that are communicable and non communicable diseases. It also includes impairment of special sensory functions like vision and hearing (Gopal K, 2008). TB is mostly found in older persons than younger generations. A study conducted on elderly persons in Himachal Pradesh found that most of the patients came from a rural background. Common chronic in older persons includes Diabetes, hypertensions, cardio vascular, disorders, depression, dementia, visual and hearing impairments and infections like TB (Abhay, et al, 2014). Declined in health status due to ageing depends on heredity, lifestyles and nutritional quality of food consumed daily. In 2014 the prevalence of acute morbidity increased from 30% in the age group of 60-69 years, 37% in 80 plus years of group and mostly among women elderly persons. NSSO 71st round shows that rate of hospitalization belongs to elderly persons than the general population. 47% were admitted to government hospitals and the rest to private hospital, which shows that the preference of private hospital was higher in urban than the rural areas. The cost of health care is very high and increases out of pocket in private facilities. Half of the medicines spent were towards the cost of medicines (BKPAI, 2011) this shows that increased in health expenditure add economic and psycho burden on the family and its income. According to a study

conducted by (SAGE, 2007) chronic condition was the leading cause of disease among the older persons. Chronic ailments are higher among women as compared to men, 674 women per 1000 men in rural areas. The common chronic ailments of the elderly as reported are arthritis, hypertension, cataract and diabetes which are more among women while Asthma and heart disease are prevalent mostly in men, out of seven states surveyed in India, Arthritis 478 women per 1000 men in Punjab, 390 women per 1000 men in Himachal Pradesh and 351 women per 1000 men in Maharashtra. For chronic ailment treatment most of the elderly prefer private hospital than government hospital. Regarding mental health BKPAI did a survey on 12 items general health questionnaire and 9 subjective well being inventory (general health questionnaire is to quantify subjective well being (SUBI) that can indicate mental health while SUBI is to measure feelings of well being or ill being as experience by individual or group. The general questionnaire show that half of the older persons have psychological distress who came from rural areas and lower educational background while SUBI indicates poorer health among women who are from the rural areas.

Disability is very common in older persons, with the increased in age disability becomes very common or major issues among the elderly persons. Hence, it increases a burden to the care giver, family and society. Census 2011 indicates that 51.8 women per 1000 men for elderly and 84.1 women per 1000 men for 80 plus. It is also shown in the 2011 census that mobility and vision related are higher among women while mobility disabilities are higher among men. 4 percent of both men and women suffer from disabilities with respect to mental health. Use of disability aids such as spectacles, hearing aids and walking stick there is significant unmet needs among older persons (BKPAI, 2011). Activities of daily living (ADL) such as feeding, bathing, dressing, mobility, toilet and continence are vulnerable among older persons that indicate there is huge care burden in the society as a whole. Elder abuse like verbal abuse, disrespect and neglect are very common in older persons, mostly it is abused by family members, relatives, friends, or trusted care giver.

Health Determinants of older persons:

Ageing is a process that converts fit adults into frailer adults with a progressively increased risk of illness, injury and death (AB Dey 2016). The health determinants of elderly are social, economic, environment, individual characteristics and behavior. And the factors of older person's health condition associated with the determinants are as follows: higher income and social status are linked to better health, wider the gap in income there is greater differences in health. Lower education level also leads to poor health, more stress and low self esteem. It is also fact that safe water, clean air, healthy workplace, safe hours, communities and roads contributes to good health. It is found that older persons who are employed are much healthier. Greater support from families and friends and communities are linked to good health. However due to customs, traditions and beliefs of the family and communities it certainly affects the health of the older persons. It is also true that our personal behavior and coping skills like balanced eating, keeping active, smoking, drinking and how we deal life's stress and challenges all affect the health of older persons.(K S Shay|)

Health Problems of the elderly:

The health problems of the elderly can be grouped broadly into Ageing process, problems associated with long term illness and psychological problems. It is fact that declined in health status and decreased in functionality due to aging process primarily depends on heredity, lifestyle, and mutational quality of foods consumed daily by the older persons. An average older person in India suffers from dual sets of communicable and non communicable diseases. The most common health problems of the Indian older persons are diabetes, hypertension, cardiovascular disease, multiple disabilities, visual and hearing impairment, respiratory disorders, depression and infections. Many surveys have reported that retired older persons are confronted with financial insecurity and loneliness problems. It is also found that there is a rise on the conflict between the mother in-law and daughter in-law mostly in our Indian culture. Therefore due to various conflicts the older persons are not spare from abuse in the families, institutions settings, and other places which includes physical, psychological and sexual abused.

National Program of Health Care for the Elderly (NPHCE):

National program for health care of the elderly is an articulation of the international and national commitments of the government as envisaged under (UNCRPD), National policy on older persons (NPOP) adopted by the government of in 1999 and section 20 of the maintenance and welfare of parents and senior citizens Act, 2007 dealing with provisional for medical care of senior citizens. Ministry of Health and Family welfare (MoHFW) has taken appropriate steps in this regard by launching the national programme for health care of elderly as a centrally sponsored scheme under the initiatives in the XI five year plan. The well being of senior citizens is mandated in the constitution of India under article 41. " the state shall within the limits of its economic capacity and development make effective provision for securing the right to promote assistances in cases of old age.

The vision for the national program of health care for the elderly is to provide accessible, affordable and high quality long-term; it also creates a new architecture for the Ageing. It is to build a framework in order to create an enabling environment for a society for all ages and to promote the concept of active and healthy ageing. (Verma R. Khanna, 2013)

Specific objectives of NPHE:

- To provide an easy access to promotional, preventive, curative and rehabilitative services through community based primary health care approach.
- To identify health problems in the elderly and provide appropriate health interventions in the community with a strong referral backup support
- Build capacity of the medical and para- medical professionals as well as the care taker within the family for providing health care to the older persons
- Referral services to the older persons through Sub divisional hospital, district hospital and regional medical institutions
- Convergence with National Health Mission, AYUSH and other line departments

Strategies of NPHCE:

- Community based PHC approach and visits by trained health care workers
- Dedicated services at PHC/CHC and provisions of essential equipments and needs
- 10 beds at district hospital, additional manpower, equipments and drugs
- Strengthening 8 regional medical institutions and introductions of PG course in geriatric medicines
- IEC materials and mass media to reach the target community
- Continuous monitoring and independent evaluations
- Promotions of public private partnerships in geriatric health care
- Mainstreaming Ayush- revitalizing local health traditions and convergence with programs of ministry of social justice and empowerment
- Reorientating the medical education to support geriatric issues.

Package of services under NPHCE for elderly person:

At sub centre: Healthy education related to healthy ageing domiciliary visits for attention and care to home bound bedridden elderly person and provide training to the family care providers in looking after the disabled elderly persons arrange for suitable calipers and supportive devices from PHC to the disabled older persons to make them ambulatory

At PHC: Weekly geriatric clinic managed by trained doctor and maintain the records of the elderly by using standard format. Conducting a routine health assessment based on simple clinical examination relating to eye, BP, blood sugar etc. Provide medicines and proper advice on chronic ailments public awareness on Promotive, preventive and rehabilitative aspects of geriatric during Village health nutrition and sanitation day or health camps. Referral services to CHC/SDC/DH needing further investigations.

At CHC: First referral unit for the elderly from PHCs and Sub centres, twice in a week for geriatric clinic, Rehabilitation unit for physiotherapy and counseling.

Domiciliary visits by the rehabilitation worker for bed redden older persons, counseling of family members on their home based care, referral of difficult cases to DH/ Higher health care facilities.

At District Hospital: Geriatric clinic for regular dedicated OPD services to the elderly, laboratory facilities for investigation and diagnosis, provisions of medicines, existing specialties such as orthopedics, ophthalmology, ENT, etc. conducting camps at PHCs/CHCs and referral services for major cases to tertiary levels.

At RGC (Regional geriatric centres):

Special Geriatric clinic, 30 bedded geriatric ward for in-patients care, specialties like surgery, orthopedics, psychiatry, urology, ophthalmology and neurology etc. laboratory facilities with special sample collection centre in the OPD block, tertiary health care to the cases referred from Sub centres, Primary Health Centres, Community health centres, Sub divisional hospital, District Hospital, medical colleges etc.

Health Challenges posed by older persons:

By 2020 ageing related deaths is projected to three quarters in developing countries, 16% of elderly population will be in India. It is fact that with the increased in age there is always visual impairment and vision loss, cataract is consider being the most related ageing ailments. Over 10% older persons suffers from depression and 40 – 50 % requires psychiatric or psychological interventions (HelpAGE India,).

Health Security: to provide the health security for the older persons the health facilities should be accessible, available and affordable. Trained personnel and adequate infrastructure should be provided. The facilities at health centres should be develop and public private partnership should be explored and encourage. Special attention should be given to rural, women, poor, disabled, dalits and destitute.

Health insurance: health insurance schemes should be improve and uniform policy on all insurance companies to be owned by government.

Disabled elderly: provisions of facilities at all health centres like physiotherapy, psychological and counseling etc. rehabilitation process should begin during

treatment of disability. Social workers are being inducted in hospitals therefore proper guidance and direction should be given to assist and help the older persons.

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Policies and Programmes for Elderly

Sonia Rajoria

ABSTRACT

This paper mainly has to intentionally based on the elderly related issues which is now-a-days because of modernization, urbanization, industrialization did negotiate its issues and challenges such as dependency, quality of life, care and support, old age homes (OAH) etc. Their health related issues , psychological problems, isolation problems also there is such a very large gamut of which like their social concerns, ill treatment, care, food , need of healthy diet, economic constraints, etc. of which we really focused on these issues on elderly. In this paper we have three main objectives to acquire the main aim of the present paper. Firstly, this paper mainly helps to promote the positive attitude and approaches towards the elderly population with a special focus of involving inter-general bonding. Secondly, to address the problems faced by the elderly and third but not least objective is to understand and strengthen the existing intergenerational bonding through the policies and programmes being run by the Government of India also to address the issues of senior citizens. Therefore, this study on elderly are most significant for understanding the problems related to elderly care, which is an urgent need in the 21st century.

Keywords: Elderly, Issues, Welfare Schemes, Policies and Programmes.

INTRODUCTION

The system of family has undergone qualitative changes because of Industrialization Modernization, education, influence of urbanization, changes in marriage system migration, revolution in the field of transport and communication, increasing influence of the state and the influence of the individualization philosophy of life. Awareness among women has changed the social capital, or the dependence and sustainability among family members. The changes have been so fast in some parts

of the world. With the advent of industrial civilization with modern technology the structure and functions of the family fatedly changed. It is essential to understand that how family relates the social capital and how this term is useful for the family members and as well as in society. Family is particularly considered as a system where the actual interactions among members have constituted the layer of reality and trust in it. Another term social capital is a composition of the family which gives the quality of life within the family relationships which has included the parameters such as trust, family co-relation, solidarity, family participation, family cohesion, etc. which they have also strengthen the family relationships in a family. From this point of view the family is an "impulsive social subjectivity" along with the extraordinary memories and the identity. Therefore, family as a social capital is considered as a characteristic of relationships relatively than entities or structures: it is developing the belongings and to control the abnormal family relations and to engender the dimensions of social capital parameters. Couples are the bases of a family association and their relations effects on other aspects of the society. Good Relations between the husband-wife along with their children have good adjustment are deemed as social capital. Classical sociologists were interested in paying the attention into the quality in social relationships within the various types of families which were subjected. In this up-bringing we should keep in mind that Indian families have changed from the traditional form to the new form because of urbanization, globalization, industrial economy, developing of transportation systems, expanding bureaucracy, established educational systems and universities and developed mass media (Azad Armaki, 2007: 69). An Indian family is entirely different from the western unit. It has greater cohesion and greater continuity. Even when sons are forced to get separated from the parental family because of their job, education, etc., their bonds with the parental unit remains unbreakable in most of the cases. The ties among the members remain more tenuous, subtle and slender. But before analyzing that family as a social capital in especially in the metro cities, we must know about the general concepts of this structure.

OBJECTIVES

In this paper we have three main objectives to acquire the main aim of the present paper. Firstly, this paper mainly helps to promote the positive attitude and approaches towards the elderly population with a special focus of involving inter-general bonding. Secondly, to address the problems faced by the elderly and Thirdly, but not least objective is to understand and strengthen the existing intergenerational bonding through the policies and programmes being run by the Government of India also to address the issues of senior citizens.

Data Collection

For this paper gathered data from secondary sources through books, Government of India journals, use of Internet, taken websites, etc. to acquire and to accomplish these paper objectives.

CONCEPTUALIZATION

Family

According to Irawati Karve (1953), joint family as "a one hearth, hold property in common, participate in common family worship, and are related to each other as some particular type of kindred. "According to I.P. Desai (1956), a traditional joint family as one which consists of three or more generations. M.S. Gore (1968) has said that a joint family should be viewed as "a family of co-parceners and their dependents" instead of viewing it as a multiplicity of nuclear families. He holds that in nuclear family, emphasis is on conjugal relationships while in a joint family, emphasis is on filial and fraternal relationships. Burgess and Locke has defined that "Family is a group of persons united by ties of marriage, blood or adoption constituting a single household interacting and intercommunicating with each other in their respective social roles of Husband and wife father and Mother, son and daughter, brother and sister, creating a common culture".

Social Capital

Bourdieu (1977) has initially defined in his first published in 1973 that social capital is „Capital of social relationships which will provide, if necessary, useful „supports": a capital of honorability and respectability which is often indispensible

if one desires to attract clients in socially important positions, and which my serve as currency, for instance in a political career". Robert Putnam (2000) defines social capital as „connections among individuals– social networks and the norms of reciprocity and trustworthiness that rise from them". We find the existence of social capital in many families because it gives the quality of life as well as develops the society. The term 'Social Capital' is a way of defining the intangible resources of community, shared values and trust upon which is evident in daily life; it is a relationship between human beings. Riddell, Baron and Wilson (1999) indicated that there have been mainly two frameworks where they have brought the understanding that how social capital arises and their effects on the family. As Riddell, Baron and Wilson (1999: 55) within that of this perspective of social capital „it is the social network of which engage the family relations or the community relations which mainly liable their ability to get engage in education, training and work and also prolonged a healthy civic community or the family relations. Coleman's had mainly focused on how an individual's" attainment of human capital demonstrated by recognizing the significance level of family and also inter- family relations which develops the Coleman's framework to develop the more account that influences the social structure. Critical theorists have been concerned about the other things, of which mainly focus on to develop the power relationships. It is the work of Bourdieu (1979, 1986, 1987, and 1989) that has been most influential terms while doing critical analysis in the study of Social Capital. The main base of Bourdieu's work was to express that how social advantage and their disadvantage are based on historically and maintained. He also identified four types of capital these are cultural, social, economic and symbolic. He refers to social capital as a way of connections, to link or to build the relationships and maintain as well as. He suggests that such type of connections is very useful when understanding the society and families is the main point of to build up and broadcast of social capital.

Social capital has some characteristics and the main determinants that are as follows:

1. Family trust
2. Family co-relation and solidarity
3. Family participation

4. Family reciprocity

5. Family cohesion

Society has accepted the transition period from a traditional set-up to a modern one. This means both conformity and modernity has their roots in the society and they have the negative or positive effects in both set-ups. So, in the first objective in this paper mainly helps to promote the positive attitude and approaches towards the elderly population with a special focus of involving inter-general bonding through understanding the concepts of social capital and its values which strengthen the family values in a positive manner.

Elderly

Elderly and old age consists of ages nearing or surpassing the average life span of human beings. The boundary of old age cannot be defined exactly because it does not have the same meaning in all societies. However, despite a number of commonly used definitions of old age, there is no general agreement on the age at which a person becomes old. Though most of the developed countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person, but like many westernized concepts, this does not adapt well to the situation in developing or underdeveloped countries. At this moment, there is no by the United Nations has defined the standard numerical criterion, but its agreed cutoff is 60+ years to refer to the older population.

According to the Wikipedia, elderly is a change in an organism over time. It refers to a multidimensional process of physical, psychological and social change (Hultsch and Deutsch, cited in Parikh, 2011).

In the Indian context, the National Policy on Older Persons, 1999 defines 'senior citizen' or 'elderly' as a person who is of age 60 years and above.

In brief, biological and psychological deteriorative changes that occur in genetically matured organism. Indeed these changes are irreversible, weaken the organism's ability for survival and adjustment, and eventually cause the organism's death.

PROBLEMS FACED BY THE AGED OR ELDERLY

In general, the following problems are faced by an elderly person:

1. ***Failing Health***: to address the issue of failing health, it is of prime importance that good quality health care to be made available and accessible to the elderly in an age-sensitive manner. Health services should address preventive measures keeping in mind the diseases that affect- or are likely to affect- the communities in a particular geographical region. In addition, effective care and support is required for those elderly suffering from various diseases through primary, secondary and tertiary health care systems. The cost of health has to be addressed so that no person is denied necessary health care for financial reasons. Rehabilitation, community or home based disability support and end-of-life care should also be provided where needed, in a holistic manner, to effectively address the issue to failing health among the elderly.
2. ***Economic insecurity***: the problem of economic insecurity is faced by the elderly when they are unable to sustain themselves financially. Many older persons either lack the opportunity and/ or the capacity to be as productive as they were. Increasing competition from younger people, individual, family and societal mind sets, chronic malnutrition and slowing physical and mental faculties, limited access to resources and lack of awareness and lack of awareness of their rights and entitlements play significant roles in reducing the ability of the elderly to remain financially productive, and thereby, independent.

   Economic security is as relevant for the elderly as it is for those of any other age group. Those who are unable to generate an adequate income should be facilitated to do so. As far as possible, elderly who are capable, should be encouraged and if necessary, supported to be engaged in some economically productive manner. Others who are incapable of supporting themselves should be provided with partial or full social welfare grants that at least provide for their basic needs. Families and communities maybe encouraged

to support the elderly living with them through counseling and local-governance.

3. ***Isolation***: means a deep sense of loneliness, is a common complaint of many elderly is the feeling of being isolated. Where there are a few who impose it on themselves, isolation is most often imposed purposefully or inadvertently by the families and or communities where the elderly live. Isolation is a terrible feeling that, if not addressed, leads to tragic deterioration of the quality of life.

   It is important that the elderly feel included in the going-on around them, both in the family as well as in society. Those involved in elder care, especially NGOs in the field, can play a significant role in facilitating this through counseling of the individual, of the families, sensitization of community leaders and group awareness or group counseling sessions. Activities centered on older persons that involve their time and skills help to inculcate a feeling of inclusion. Some of these could also be directly useful for the families and the communities.

4. ***Neglect***: the elderly, especially who are weak/ or dependent, require physical, mental and emotional care and support. When this is not provided, they suffer from neglect, a problem that occurs when a person is left uncared for and that is often linked with isolation. Changing lifestyles and values, demanding jobs, distractions such as television, a shift to nuclear family structures and redefined priorities have led to increased self-neglect of the elderly by families and communities. This is worsened as the elderly are less likely to demand attention than those of other age groups.

   The best way to address neglect of the elderly is to counsel families, sensitize community leaders and address the issue at all levels in different forums, including the print and audio-visual media. School, Institutions and work places offer opportunities where younger generations can be addressed in groups. Government and non-Government agencies need to take this issue up seriously at all these levels. In extreme situations, legal action and

rehabilitation may be required to reduce or prevent the serious consequences of the problem.

5. ***Abuse***: the elderly are highly vulnerable to abuse, where a person is willfully or inadvertently harmed, usually by someone who is part of the family or otherwise close to victim.

   The best part of protection from abuse is to prevent it. This should be carried out through awareness generation in families and in the communities. Information and education of groups of people from younger generations is necessary to help prevent abuse. The elderly should also be made aware of their rights in this regard. In addition, to follow legal action needs be taken against those who willfully abuse elders, combined with counseling of such persons so as to rehabilitate them and to ensure that they are able to recover with minimum negative impact.

6. ***Fear***: Many older persons live in a fear. Whether rational or irrational this is a relevant problem face by the elderly that needs to be carefully and effectively addressed.

   Elderly who are suffer from fear need to be reassured. Those for whom the fear is considered to be irrational need to be counseled and if necessary, may be treated as per their needs. In this case adhere preventive measures needs to be followed by appropriate action where and when possible.

7. ***Boredom (idleness)***: boredom is a result of being poorly motivated to be useful or productive and occurs when a person is unwilling or unable to do something meaningful with his/her time. A person is mainly who is not fully occupied tends to physically and mentally decline and this will turn to become the negative emotional impact.

   Most of the people who have reached the age of 60 years or more have previously led productive lives and would have general several skills during their life-time. Identifying these skills would be a relatively easy task.

   Motivating them and enabling them to use these skills is a far more challenging process that requires determination and consistent effort by dedicated people working in the same environment as the affected elders.

Manly elderly can be trained to carry out productive activities that would be useful to them or benefit their families, communities or environment; activities that others would be unable or unwilling to do. Recreational activities can be devised and encouraged at little or no additional cost and being meaningfully occupied, many of the elderly can be taught to keep boredom away.

8. ***Loss of control***: this problem of older persons has many facets. While self-realization and the reality of the situation is acceptable to some, there are others for whom life becomes insecure when they begin to lose control of their resources-physical strength, body systems, finances, social or designated status and decision making powers.

   Early intervention, through education and awareness generation, is needed to prevent a negative feeling to inevitable loss of control. Finally, motivating the elderly to use their skills and training them to be productive will help gain respect and appreciation.

   Therefore the majority of Indians are unaware of the rights and entitlements of older persons.

INDIAN SCENARIO

According to *Population Census 2011*, there are nearly 104 million elderly persons in India; 53 million females and 51 million males. It is interesting to note that up to Population Census 1991, the number of elderly males exceeded the number of females. In the last two decades, however, the trend has been reversed and the elderly females outnumbered the elderly males. This is also a major concern for policy makers as elderly women are more vulnerable on all fronts compared to elderly men. As regards rural and urban areas, more than 73 million persons i.e. 71 per cent of elderly population reside in rural areas while 31 million or 29 per cent of elderly population are in urban areas. The tremendous growth of the elderly population is not unique to the industrialized or developed societies. By 2025, the 60-plus world population is expected to approach 1.2 billion people. In most nations, the older population is growing faster than the population as a whole.

POLICY AND PROGRAMME INITIATIVES FOR ELDERLY

The Ministry of Social Justice & Empowerment, which is the nodal ministry for this purpose focuses on policies and programmes for the senior citizens in close collaboration with state governments, non-governmental organizations and civil society. The programmes aim at their welfare and maintenance, especially for indigent senior citizens, by supporting old age homes, day care centers, mobile Medicare units, etc.

Constitutional Provisions

Article 41of the constitution provides that the state shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.

Further, **Article 47** provides that the state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.

Legislations

General improvement in the health care facilities over the years is one of the main reasons for continuing increase in proportion of population of senior citizens. Ensuring that they not merely live longer, but lead a secure, dignified and productive life, is a major challenge, the Government of India enacted the Maintenance and welfare of parents and senior citizens guaranteed and recognized under the Constitution and for matters connected therewith or thereto. This Act provides for:

- Maintenance of parents/senior citizens by children/ relatives made obligatory and justiciable through tribunals;
- Revocation of transfer of property by senior citizens in case of negligence by relatives;
- Penal provision for abandonment of senior citizens;
- Establishment of old age homes for indigent senior citizens; and
- Adequate medical facilities and security for senior citizens.

The maximum amount which may be ordered for maintenance of a senior citizen by the tribunal shall be as prescribed by the State Government which shall not exceed Rs. 10,000 per month.

Section 19 of the Act also envisages a provision of at least old age home for indigent senior citizens with 150 capacities in every district of the country.

National Policy on Older Persons, 1999 envisages

The National Policy on Older Persons (NPOP) was announced in January 1999 to reaffirm the commitment to ensure the well-being of the older persons. The policy envisages state support to ensure financial and food security, health care, shelter and other needs of older persons, equitable share in development, protection against abuse and exploitation and availability of services to improve the quality of their lives. Its primary objectives are as follows:

- To encourage individuals to make provision for their own as well as their spouse's old age.
- To encourage families to take care of their older family members;
- To enable and support voluntary and non-governmental organizations to supplement the care provided by the family;
- To provide care and protection to the vulnerable elderly people;
- To provide adequate healthcare facility to the elderly;
- To promote research and training facilities to train geriatric care givers and organizers of services for the elderly ; and
- To create awareness regarding elderly persons to help them lead productive;
- Independent live.

The implementation strategy adopted for operationalization of national policy envisages the following:

- Setting up of separate Bureau for Older Persons in Ministry of Social Justice & Empowerment.
- Setting up of Directorates of Older Persons in the states.
- Three yearly public review of while implementing the policy.

- Setting up of a National Council for Older Persons headed by Ministry of Social Justice & Empowerment from Central Ministry, states, non-official members representing NGOs, academic bodies, media and experts as members.
- Establishment of an autonomous National Association of Older Persons.
- Encouraging the participation of local self-government.

National Council for Older Persons

It was constituted in 1999 under the chairpersonship of the Minister for Social Justice and Empowerment to oversee implementation of the policy. It is the highest body to advise the government in the formulation and implementation of policy and programmes for the aged. The council was re-constituted in 2005 with members comprising citizens' groups, retired persons' association and experts in the field of law, social welfare, and medicine.

The National Social Assistance Programme (NSAP)

The National Assistance Programme is a welfare programme being administered by the Ministry of Rural Development. The programme is being implemented in rural areas as well as in urban areas. The Government of India launched NSAP as a centrally sponsored scheme w.e.f. August 15, 1995. It included three schemes:

1) National Old Age Pension Scheme: Under the scheme, destitute aged 65 years and above were entitled to a monthly pension of Rs.75.
2) National Family Benefit Scheme: The benefit under the scheme to below the poverty line household was lump sum amount of money on the death of primary breadwinner aged between 18 and 64 years. The ceiling of the benefit was Rs. 5000/- for death due to natural causes, and Rs. 10,000/- for accidental death.
3) National Maternity Benefit Scheme: Under the scheme, lump sum cash assistance of Rs.300 per pregnancy was provided as maternity benefits to women of BPL households up to 2 live births.

Old Age Pension Amount under NOAPS

Under NOAPS, Rs.75 per month was being provided to each destitute who was of 65 years and above. The amount of pension was increased to Rs.200 per month w.e.f. 1-4-2006 and the states were requested to top up with another Rs.200 from their own resources so that a destitute pensioner could get at least Rs 400 per month. At present, 18 states/ U.Ts are providing Rs. 400 as old age pension.

Inter-Ministerial Committee on Older Persons

An Inter-Ministerial Committee on Older Persons comprising 22 ministries/ department, and headed by the Secretary, Ministry of Social Justice & Empowerment is another coordination mechanism in implementation by various ministries/ department concerned is considered from time to time by the committee.

Central Sector Scheme of Integrated Programme for Older Persons

An Integrated Programme for Older Persons (IPOP) is being implemented since 1992 with the objective of improving the quality of life of senior citizens by providing basic amenities like shelter, food , medical care and entertainment opportunities and by encouraging productive and active ageing through providing support for capacity building of government/NGOs/ PRIs/ local bodies and the community at large.

Under this scheme, establishing and maintaining old age homes, day care center and mobile Medicare units. The scheme has been made flexible so as to meet the diverse needs of older persons including reinforcement and strengthening of the family, awareness generation on issues pertaining to older persons, popularization of the concept of lifelong preparation for old age, facilitating productive ageing, etc.

This scheme has been revised from April 2008. Besides increase in amount of financial assistance for existing projects, several innovative projects have been added as being eligible for assistance under the scheme. Some of these are as follows:

- Maintenance of Respite Care Homes and Continuous Care Homes;
- Running of Day Care Centers for Alzheimer's disease/ Dementia patients;
- Physiotherapy clinics for older persons;

- Helplines and counseling centers for older persons;
- Sensitizing programmes for children particularly in schools and persons;
- Regional resource and training centers for caregivers to the older persons;
- Awareness generation programmes for older persons and caregivers;
- Formation of senior citizens Associations etc.

During 2007-08, the government has spent more than Rs. 16 crore for assisting 660 such programmes around the country which covered around 50,000 beneficiaries.

Apart from the above, various central ministries such as Health & Family Welfare, Rural Development, Railways, Finance, Civil Aviation, Pensions and Pensioner Grievances, etc., have also launched their own schemes for the benefit of their retired employees. For examples, while Indian Railways provides a discount of 40 percent and 50 percent to male (60+) and female (58+) senior citizens respectively, the national carrier, Air India, provides concession up to 50 percent for male senior citizens of 65 years and above, and for female senior citizens of 63 years and above.

CONCLUSION

To conclude, it is difficult to pen-down the drastic changes under which Indian families are going. The system was never completely static of course, and slowly changes throughout the twentieth century. Until the end of the third decade of the twentieth century, however there was no political, social or industrial power that could successfully break Indian Families‟ self-imposed isolation from the fourth decade of the twentieth century, particularly after the independence.

With the continuous development of modernization and urbanization, the development is not limited to these fields only rather we get the evidences of development in family relations for, we find most of the young married couples opting and establishing a nuclear family being departed from their parental families. Neo-local residence is, therefore, becoming more common. Sometimes these neo-local families eventually return to their stem (parental) families, but often they do not". The values are the core of the Social Capital which have exists trust, responsibility, family cohesion, family participation, understanding, reciprocity etc.

are the main determinants/or values and these values are existed in the families but if these values are not present in the families it may cause that weakens or might be disorganized the Family Social Capital and if they are present it may raise the growth of the family social capital.

To conclude this with last Para that the implications of the elderly for India are many and far-reaching. The numbers are increasing, the resources are limited and the priorities lie elsewhere. Hence, the response to this social problem has to be well-orchestrated, multi-sectoral and based on systematic planning. The first step is advocacy, to raise policy makers' awareness of the multiple issues related to the old age or elderly in the country. Professionals, politicians, voluntary workers, NGOs and the general public should come forward for this worthy cause.

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Reforming Elderly Care through Corporate Social Responsibility

Arun V & Rubini V E

ABSTRACT

As per the Population Census in the year 2011 there are nearly 104 million elderly persons (aged 60 years or above) in India; 53 million females and 51 million males. Out of which 30 million are living alone, and 90 per cent work for livelihood. According to the report released by the United Nations Population Fund and Help-Age India, the number of elderly persons is expected to grow to 173 million by 2026. This is a very critical stage of life as the individual undergoes a series of drastic changes - physical, psychological and social. Starting from problem related to health deterioration, neurotic 'wear and tear' leading to deviations in 'psyche' and 'empty-nest syndrome'. All of the above is a part and parcel of old age and a very few get the access to necessary support and care in India. Due to increase in nuclear family & employment opportunity in overseas and other part of the country, Senior Citizens at home are indirectly forced to live alone. Due to aging and health condition it has become challenging for them to take care of themselves. Corporate Social Responsibility (CSR) of those companies fulfilling the said provisions under Section 135 of Companies Act (2013) is also prescribed to encourage and support the welfare of the elderly in the country (Schedule VII). Many companies have adopted the same and have designed unique projects to provide care and support for the senior citizens in the country. This study is a qualitative research and presents a particular CSR model that addresses elderly care in the form of case-study. Providing Elderly-care through Corporate Social Responsibility of private companies paves way to complete reformation in the field of Elderly-care. It benefits many senior citizens and proves to be a secure option for the individuals.

Key words: Senior Citizens, Elderly-care, CSR

Introduction

In Indian Context **Senior Citizen**' has been briefed as an individual who attains the age of 60 years at any time during a financial year, while an individual who is 80 years or more is categorised as 'Very **Senior Citizen**'. This is a very critical age as the individual undergoes a series of drastic changes - physical, psychological and social. Starting from problem related to health deterioration, neurotic 'wear and tear' leading to deviations in 'psyche' and 'empty-nest syndrome'. All of the above is a part and parcel of old age and a very few get the access to necessary support and care in India.

Senior Citizen Population in India:

As per the Population Census in the year 2011 there are nearly 104 million elderly persons (aged 60 years or above) in India; 53 million females and 51 million males. Out of which 30 million are living alone, and 90 per cent work for livelihood. According to the report released by the United Nations Population Fund and Help-Age India, the number of elderly persons is expected to grow to 173 million by 2026.

A recent report states that the United Nations Population Fund has said the population of elderly people in India will triple by 2050. The percentage of elderly people, categorized as those above 60 years of age, is expected to go up in India from8% in 2015 to 19 % in 2050.

In 2018, the Government declared in Parliament that India will have 34 crore people above 60 years of age by 2050 that would be more than the total population of the US. The numbers are expected to be even higher than projected by other international agencies like UN and Help-Age India. These agencies have predicted the 60-plus population in India to rise to by nearly 32 crore by 2050

Top 5 states in India with Senior Citizen Population in 2001

S.No	State/UT	Population 2001 (In crore)		
		Total Population	Senior Citizen	Senior Citizen %
1	Utter Pradesh	16.6	1.2	7%
2	Maharashtra	9.6	0.9	8.9%
3	Bihar	8.2	0.6	6.7%
4	West Bengal	8.0	0.6	7.1%
5	Andhra Pradesh	7.5	0.6	7.7%

Top 5 states in India with Senior Citizen Population (%) in 2001

S.No	State/UT	Population 2001 (In crore)		
		Total Population	Senior Citizen	Senior Citizen %
1	Kerala	3.1	0.3	10.6%
2	Manipur	0.2	0.02	10.0%
3	Himachal Pradesh	0.6	0.06	10.0%
4	Goa	0.1	0.01	10.0%
5	Punjab	2.4	0.2	9.2%

Senior Citizen Identity Card in India:

The Indian Government provides a set of schemes and programmes inorder to benefits to senior citizens. An identity card called Senior Citizen ID Card can help

the individual to avail facilities like various tax benefits, travel and health care facilities etc.

Elder Care Services In India :

Due to increase in nuclear family & employment opportunity in overseas and other part of the country, Senior Citizens at home are indirectly forced to live alone. Due to aging and health condition it has become challenging for them to take care of themselves.

The Social Defence Bureau of the Ministry mainly assists the requirements of Senior Citizens. The programmes and the policies of the Bureau aim at equipping this group to sustain a life of respect and honour and to become contributing citizens. The State Governments, NGOs, autonomous bodies and even the corporate world are constantly involved in formulating and implementing the policies. All these programmes are meant to aid, prevent neglect, abuse and exploitation and provide assistance to those deprived and mainstream them to the maximum, thus including them in the society.The senior citizen who need these kind of support and companion services to meet their daily and health need has increasing drastically day by day. The private companies understood the market for those needs and developed different modules to meet the need.

Thus this specific Elder care service for the senior citizens aims to provide an eco system that enables senior citizens to pursue an active life while being accorded the utmost care and comfort. With the support of technology and manpower the private oganizations has been rendering fee services and commercial services as well for the Senior Citizens. The services include their basic home needs, regular services and household essentials along with focusing on their active and healthy lifestyle. and the service providers would also ensure proper functioning of household equipments, Electronics, LPG gases etc.Escort services to Senior Citizens to accompany them to attend social events like marriage, festivals etc., meditation or yoga session, and most importantly accompanying them to regular check-ups to hospitals, collection of reports, on time-medications, purchasing medicines.

Corporate Social Responsibility (CSR) of those companies fulfilling the said provisions under Section 135 of Companies Act (2013) is also prescribed to

encourage and support the welfare of the elderly in the country (Schedule VII). Many companies have adopted the same and have designed unique projects to provide care and support for the senior citizens in the country.

Research Methodology:

This study is a qualitative research and presents a particular CSR model that addresses elderly care in the form of case-study.

Objective:

- To understand the importance of intervention of CSR in elder care services
- To know the current trend of CSR model that provides elderly-care.
- To analyse the various provisions made under that particular CSR model.
- To comprehend the process of services provided by the CSR project.

CSR Model Addressing Elderly Care:

The given CSR model aims to provide a home care service that helps seniors to get love and care in the absence of their children. It ensures an eco system that enables senior citizens to pursue an active life while being accorded the utmost care and comfort. With the socio-cultural shift in the society triggered by increasing popularity of nuclear families coupled with individuals venturing away from their native for career opportunities, there is a vacuum created in the life of parents/senior citizens. This void creates a big question mark on – who takes care of the day-to-day needs (not restricted to medical care) that may not require skilled support but are generally catered to by own children. The CSR projects under the said model aims at bridging this with the help of technology and a skilled team of individuals who believe in this cause. It focuses on building a technology platform that supports the team of "Specialists - Elder Care" and empowers them to do the best job possible, at the same time creating transparency for families so that they can see what 's happening real time in home. The services are done through trained/skilled care specialist for a better quality of care. These are first hand approaches experimented by some companies that practice CSR. Senior citizen contributes 8.6% of india's population which is projected to climb to 19% by 2050 (UN 2011). Elderly Care an initiative project through CSR of companies looks forward to bridge this with the help of technology and a skilled team of individuals at the same time creating transparency for the families so that they can see what is

happening in the house at the same time holds responsibility for the satisfaction of senior citizen.

Few services that are included in the project are;

- Services related to Acquaintance care - General inspection about the condition of the home/household activities/equipments to ensure its proper functioning. - Share the images and information about wellbeing of senior citizens with request of senior citizen & their
- Services related to Social Care -Home visits for meeting purpose. - Accompanying the care recipient for outings/social/daily/spiritual activities.
- Services related to Health Care -Fixing up appointment with doctor/diagnosis center as per the choice of senior citizen - Accompanying the client to hospital/diagnosis center - Montoring the health status of the senior citizen. - Medicine purchase and collection of reports from diagnosis center. - Arrange for transportation for doctor visit/diagnosis.(Ola, Uber, etc)
- Services related to Home Care -Create and monitor of list for household activities/equipments as per the request of senior citizen. - Arrange vendors for any repair works at home(Electrician, Plumber, etc),Arrange vendor/maid services if required. - Provide physical support to pay all kinds of bill in online/cheques.
- Services related to Leisure Care -Accompanying for shopping/Cinema/Outings. -Bookings for Shows / Travel/ Emergency - Emergency contact storage – personal/medical.

Few Case Studies on the interventions of Elder Care Services by Private Companies in India.

Case Study - 1

The Senior Citizen couple living at Porur, Chennai, their two children are working in United states, they are financially well balanced they can even hire the person to take care of their daily needs, but the only problem is the reliability. The couple had few bad experiences with their housekeeping and maintenance staffs in the past.

They registered them self with one of the private health care services. Their regular health checkups, medicine purchase, escorting them to Hospitals, temples, social events like marriages, spending quality time with them are all taken care by the qualified employees appointed by the private elder care service.

Nobody can replace the family, but the kind of support with skills and professionalism by the Specialist – Care-giver under the CSR Project made the senior citizen couple feels that some reliable people are there for us to support and comfort us in all our challeging situations.

Case Study - 2

The retired employee over 73 years, residing at Vadapalani, after their children marriage he was living alone after lost her wife. He has the eye sight problem. doctors advised him to go for cataract. But most sad thing is no is there to look after him for even 15 days. Then he came to know about the private elder care services through his friend. With the support of Specialist – Care-giver appointed under the CSR Project, he has successfully undergone the cataract and now completely fine after one month of rest and continuous check up and follow up. Care giver extended all his possible support to the senior citizen during his treatment and surgery process. " I felt like my family member is supporting me, I am really thankful for this elder care service" it is the voice of that Senior Citizen.

Case Study - 3

The Senior Citizen couple living at Chennai aged above 75, both of them are retired Government employees. Both of them have the health issues, the husband has no mobility because of ageing, and the wife is suffering with the fractured legs which not allows her to go out of the home for any work. The care giver from elder care services supported in every aspects of their work from handling bank work, producing life certificates at bank for pension, accompany them for the treatment at hospital, purchasing medicine, booking train tickets for accompanying to railway station, etc.

" I personally feel, the intervention by the private companies in the field of elder care really add value to the life of aged people " is voice of the senior citizen couple.

Major Findings:

Due to raise in nuclear family system, senior citizens are very much in need of care and assistance. With regards to the age factor and physical condition they are the most vulnerable group in nature. Hence the accompanying services are more in need when compared to other needs. The percentage of senior citizens in overall country's population is increasing every year. So the need for supporting/service institution especially for senior citizens is the need of the hour.

Corporate Companies which are obliged to contribute for the community in order to meet the statutory requirements under the provisions of Companies Act (2013); Section 135 for CSR , are coming up with different modules to support the various needs of senior citizen community. These CSR projects have benefitted a wide range of senior citizens especially those belonging to the elite group. It still remains impossible for the senior citizens from poor and downtrodden communities to access these facilities as these projects exclusively target the upper-class and upper-middle class of the society.

The increase in demands create a market for any product/service likewise we can assume that corporate companies' with the understanding of the needs of senior citizen's that they gained by supporting them under their CSR project, can sooner or later develop the same into a business module and render the same service under commercial banner. There are high chances that the CSR funds of a company can be misused to do a pilot/trial project of a major business model.

Suggestions and Recommendations:

In-depth level of scrutinising of the utility of CSR funds by the concerned Government Officials is highly recommendable inorder to prevent misuse of funds by the company. In this case the funds can be used for the benefit of senior citizen population who are elite and capable to afford a paid service rather than for the benefit of underprivileged and downtrodden. Hence those senior citizens in real need of care and support who cannot afford to benefit from a paid service should not be excluded from the basic care and support.

Conclusion

The current trends in Elderly-care are under constant change and are being consistently improvised by both commercial and non-profit organisations. Providing Elderly-care through Corporate Social Responsibility of private companies paves way to complete reformation in the field of Elderly-care. It benefits many senior citizens and proves to be a secure option for the individuals. Though the Private Companies provide those services at free of cost under their CSR project and also in commercial basis, a strong law is required to protect the social and financial security of the Senior Citizens. Today law makers are tomorrow's senior citizens, today's children are tomorrow's senior citizens. Responsibility to look after the senior citizens in secured way is lies with the hands of everyone in the society.

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Policies and Programmes for Elderly In India : An Overview

Parishmita Dutta

ABSTRACT

Aging is a process where an individual experience a decline in performance, productivity and health over time. It is the natural stage of human life, which brings innumerable problems with it which makes elderly population vulnerable and dependent. As a vulnerable and dependent section of the society, the elderly population needs special care and protection. The objective of the paper is to write about Policies and Programmes meant for the elderly population of the country. This paper discusses about who is elderly, constitutional and legal provisions available for the elderly population in India along with certain loopholes in the existing policies as well as challenges in implementation of the policies and programmes.

Key Words: Elderly, Vulnerable, Welfare.

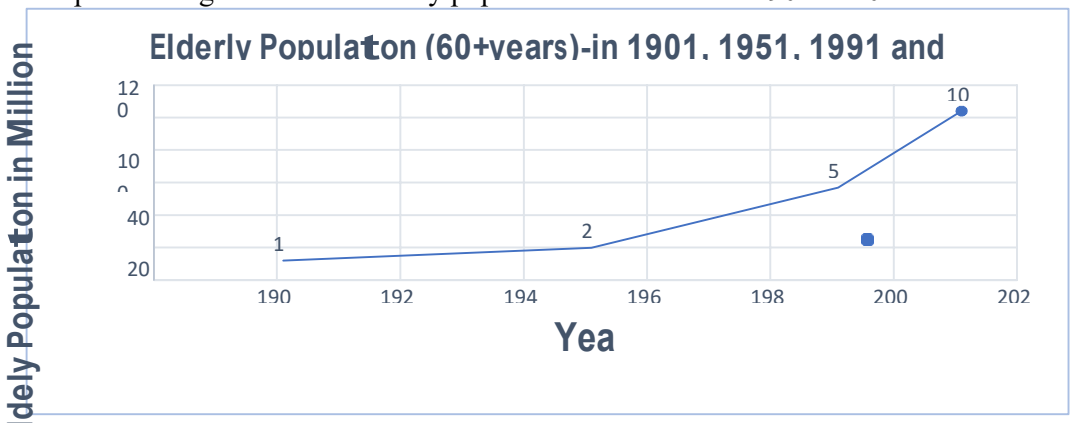
1.Introduction

Elderly or old age consists of ages nearing or surpassing the average lifespan of human beings. The boundary of old age cannot be defined exactly because it does not have the same meaning in all societies. Government of India adopted 'National Policy on Older Persons' in January 1999. The policy defines 'senior citizen' or 'elderly' as a person who is of age 60 years or above.[1]

An increase in proportion of ageing population has emerged to be a global phenomenon and the same has hit the shores of India as well. The improved life expectancy in India- (cause) has contributed to an increase in the number of persons who are 60+ years- (effect). The number of elderly persons has increased from 12 million in 1901 to 20 million in 1951, 57 million in 1991, and 104 million in 2011. As regards rural and urban areas, 71% of elderly population resides in rural areas

while 29 % is in urban areas. The sex ratio among elderly people was as high as 1028 in 1951, subsequently dropped and again reached up to 1033 in 2011.

Graph showing increase of elderly population in India from 1901 to 2011



2. UN and Elderly People-

- Vienna International Plan of Action on Ageing,1982.
- On 14 December 1990, the United Nations General Assembly (by resolution 45/106) designated 1 October the International Day of Older Persons.
- In 1991, the General Assembly (by resolution 46/91) adopted the United Nations Principles for Older Persons.
- Madrid International Plan of Action on Ageing,2002
- The Shanghai Plan of Action,2002 and the Macau Outcome document,2017.

The Government of India is a signatory to all these documents demonstrating its commitment to address the concerns of the elderly

3. Constitutional Provisions and Policies and Programmes of Government of India

Recent times have witnessed considerable discussion and debate on the various impacts of demographic trends as well as changes in society and economy about

elder persons. The constitution of India recognises the vulnerability during the old age and addresses the same through mandating wellbeing of the older persons via Article 41, a directive Principle of State Policy, wherein the state has been directed to make effective provision for securing the right of public assistance in cases of old age within the limits of its economic capacity and development. Moreover, right to equality embodied in the Indian constitution also encompasses elderly people. Besides these constitutional provisions, the following legal provisions are pertained to senior citizens

Legal Provisions

S No	Legal Provision Law/Procedure	Brief Details
1	Part IX- Personal Law (Hindu)	**Section 20 (1)--**a Hindu is bound during his or her life-time, to maintain his or her legitimate/illegitimate children **and his or her aged or infirm parents.** **Section 20 (3**)- The obligation of a person to maintain his or her
2	Code of Criminal Procedure, Chapter IX Order for maintenance of wives, children and parents	**Section 125(1)** (d): If any person having sufficient means neglects or refuses to maintain his father or mother, unable to maintain himself or herself, a Magistrate of the first class may, upon proof of such neglect or refusal, order such person to make a monthly allowance for the maintenance of his wife or such child, father or mother, at such monthly rate not exceeding five hundred rupees in the whole, as such Magistrate thinks fit, and to pay the same to such person as the Magistrate may from time to time direct. **Section 125(3):** If any person so ordered fails without sufficient cause to comply with the order, any such Magistrate may, for every

Based on the above mentioned constitutional and legal provisions Government of India has enacted various policies and Programmes for the elderly.

Legislations

THE MAINTENANCE AND WELFARE OF PARENTS AND SENIOR CITIZENS ACT, 2007

The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 was enacted in December 2007, inter alia, to ensure need-based maintenance for parents and senior citizens and their welfare. The Act shall come into force in a State on such date as the State Government may, by notification in the Official Gazette, appoint. So far, all the States and UTs have notified the Act. The Act does not extend to the state of Jammu and Kashmir.Himachal Pradesh has its own Act for welfare of Parents and Senior Citizens.

Policies and Programmes for the Welfare of Elderly Persons

Administrative setup -

The Ministry of Social Justice and Empowerment is the nodal Ministry for the welfare of senior citizens.

The Ageing Division in the Social Defence Bureau of the Department of Social Justice and Empowerment develops and implements programmes and policies for the senior citizens in close collaboration with State Governments, Non-Governmental Organisations and civil society. The programmes for senior citizens aim at their welfare and maintenance, especially for indigent senior citizens, by supporting old age homes, day care centres, mobile medicare units, etc. These programmes are implemented through providing support for capacity building of Government /Non-Governmental Organizations (NGOs) /Panchayati Raj Institutions (PRIS) /local bodies and the Community at large.

NATIONAL POLICY FOR OLDER PERSONS, 1999

The National Policy for Older Persons (NPOP) was announced in 1999 to reaffirm the commitment to ensure the well-being of the older persons. The policy envisages State support to ensure financial and food security, health care, shelter

and other needs of older persons, equitable share in development, protection against abuse and exploitation, and availability of services to improve the quality of their lives. The primary objectives of the policy are:

- To encourage individuals to make provision for their own as well as their spouse's old age
- To encourage families to take care of their older family members
- To enable and support voluntary and non-governmental organisations to supplement the care provided by the family
- To provide care and protection to the vulnerable elderly people
- To provide adequate healthcare facility to the elderly
- To promote research and training facilities to train geriatric care givers and organisers of services for the elderly.
- To create awareness regarding elderly persons to help them lead productive and independent life.

NATIONAL POLICY FOR SENIOR CITIZENS, 2011

The foundation of this new policy is based on several factors. These include the demographic explosion among the elderly, the changing economy and social milieu, advancement in medical research, science and technology and high levels of destitution among the elderly rural poor (51 million elderly live below the poverty line). All those of 60 years and above are senior citizens. This policy addresses issues concerning senior citizens living in urban and rural areas, special needs of the ''oldest old" and older women.

For the implementation of the Policy, it focuses on the establishment of Department of Senior Citizens and National Council for Senior Citizens under the Ministry of Social Justice and Empowerment, Directorates of Senior Citizens in states and Union territories and National/State Commission for Senior Citizens

INTEGRATED PROGRAMME FOR OLDER PERSONS (IPOP)

The Ministry of Social Justice and Empowerment is implementing a Central Sector Scheme of Integrated Programme for Older Persons (IPOP) since 1992 with the objective of

improving the quality of life of senior citizens by providing basic amenities like shelter, food, medical care and entertainment opportunities etc. through providing support for capacity building of Government/ Non-Governmental Organizations/Panchayati Raj Institutions/ local bodies etc. The Scheme was revised with effect from 01.04.2008 and 01.04.2015.

INTERNATIONAL DAY FOR OLDER PERSONS (IDOP) AND NATIONAL AWARDS : VAYOSHRESHTHA SAMMAN

The Ministry of Social Justice and Empowerment observes the International Day for Older Persons (IDOP) on 1st October every year in a befitting manner by organizing a series of events and programmes dedicated to the senior citizens.

In order to recognise the efforts made by eminent senior citizens and institutions involved in rendering distinguished services for the cause of elderly persons, especially indigent senior citizens, the Ministry started in 2013 the Scheme of National Award for Senior Citizens ('Vayoshrestha Sammans'). The Scheme showcases the Government's concern for senior citizens and its commitment towards senior citizens with the aim of strengthening their legitimate place in the society. It also provides an opportunity to the younger generations to understand the contribution of the elderly in building of the society and the nation.

Vayoshrestha Sammans are conferred every year in thirteen categories on 1st October on International Day of Older Persons (IDOP). The Award in each category carry a Citation, a Plaque and also cash award in some of the categories as decided from time to time.

Schemes/Programmes of Other Ministries

Ministry of Rural Development

The Ministry of Rural Development is implementing the Indira Gandhi National Old Age Pension Scheme (IGNOAPS) under which Central assistance is given towards pension 200 rupees per month to persons above 60 years and 500 rupees per month to persons above 80 years belonging to a household below poverty line, which is meant to be supplemented by at least an equal contribution by the states.

Ministry of Health and Family Welfare

The Ministry of Health and Family Welfare provides the following facilities for senior citizens:

- Separate queues for older persons in government hospitals.
- Geriatric clinic in several government hospitals.
- National Programme for the Health Care for the Elderly (NPHCE) from the year 2010–11

Ministry of Finance

The Insurance Regulatory Development Authority (IRDA) in 2009 issued instructions on health insurance for senior citizens to CEOs of all General Health Insurance Companies which, inter-alia, includes:

- Allowing entry into health insurance scheme till 65 years of age.
- Transparency in the premium charged.
- Reasons to be recorded for denial of any proposals etc. on all health insurance products catering to the needs of senior citizens. Likewise the insurance companies cannot deny renewability without specific reasons.
- The Ministry provides the following tax benefits for senior citizens:
- Income tax exemption for Senior Citizens of 60 years and above up to 2.50 lakh per annum.
- Income tax exemption for Senior Citizens of 80 years and above up to 5 lakh per annum.
- Deduction of 20,000 under Section 80D is allowed to an individual who pays medical insurance premium for his/her parent or parents, who is a senior citizen.
- An individual is eligible for a deduction of the amount spent or 60,000, whichever is less for medical treatment of a dependent senior citizen.

Ministry of Home Affairs

The Maintenance and Welfare of Parents and Senior Citizens Act,2007 provides for protection of life and property of senior citizens. The State Governments are required to prescribe a comprehensive action plan for providing protection of life and property of senior citizens.

The Ministry of Home Affairs in 2008 issued advisory to state governments to ensure that the life and property of senior citizens is fully protected.

Ministry of Railway

The Ministry of Railways provides the following facilities to senior citizens:

- Separate ticket counters for senior citizens of age 60 years and above at various PRS(Passenger Reservation System)centres if the average demand per shift is more than 120 tickets;
- Provision of lower berth to male passengers of 60 years and above and female passengers of 45 years and above.
- 40% and 50% concession in rail fare for male and female senior citizen respectively of 60 years and above respectively.
- Wheel chairs at stations for old age passengers.

Ministry of Civil Aviation

The Ministry of Civil Aviation provides air fare concession up to 50%for male passenger aged 65 years and above and female passenger aged 63 years and above in the National Carrier, Air India.

Challenges/Loopholes in the implementation of the Policies and Programmes

The success of any Programme or Scheme depends on its proper implementation, however many situations/circumstances /factors stand as a huge challenge

- Power Dynamics within the Villages: PRI members or any other government officials on the onus of their power misuse these Schemes and hence the most vulnerable

  elderly sections are deprived. As a result, many vulnerable elderlies do not extract or obtain the benefits due to lack of transparency which is a causal

factor of power dynamics within the villages.

- Mobility: It is a well-known phenomenon that the mobility of a person is being abated with age. Population Census 2011 data reveal that loco motor disability and visual disability are the most prevalent disabilities among elderly persons and 6% of elderly population was reported as disabled in rural areas whereas, in urban areas 4% of elderly population was disabled. Though the Policies and Schemes in India promises a lot for the elderly, the location or distance of resources such as banks, post offices etc. make it very hard for many rural elderlies to obtain benefits out of these Policies and Programmes.
- Lack of Awareness: Illiteracy among rural population of India is widely prevalent. There is a huge gap between literacy rates among elderly persons in rural and urban parts of the country. Around 30% of elderly persons in urban areas were having educational qualification metric/secondary and above but the proportion is comparatively much less (7%) in rural areas. These results in unawareness among the rural elderly about the social safety net and the social securities, they are entitled to.
- Lack of Proper Implementation: Implementation of Policies and Programmes need a proper communication between the right holders and the agencies responsible for ensuring the same. Lack of such proper flow of communication stands to be a huge challenge.
- Lack of a Robust Monitoring system: There has been no monitoring system being devised which would ensure that the most vulnerable elderly is being included or not.

Along with the above mentioned challenges, certain loopholes exists within the Programmes/Policies for elders in India. Some of them has been discussed below:

- Under the Indira Gandhi National Old Age Pension Scheme, 200 Rupees and 500 Rupees assistance are provided to BPL people above 60 years and 80

years consequently which are not sufficient to fulfill their needs

- The Insurance Regulatory Development Authority (IRDA) in 2009 instructed all Health Insurance Companies to allow people to entry into the Health Insurance Schemes till 65 years of age, but there is no any Health Insurance Schemes available above 65 years of age.
- Not any single Scheme/Programme focuses on long term solution of the problems of Elderly People.
- The effort for providing psychological support or reunion of family members is not made by existing Schemes/Programmes which also important for Elderly People.
- With an estimate that 74% of the elderly living in the rural areas, any initiative with the objective of benefiting the rural elderly should incorporate adequate budgetary provisions. There is heavy criticism on allocation of budget to the voluntary organizations for programmes relating to the aged by Ministry of Social Justice and Empowerment.

Conclusion

Ageing is a natural process, which inevitably occurs in human life cycle. It brings with a host of challenges in the life of the elderly, which are mostly engineered by the changes in their body, mind and thought process and the living patterns. Ageing refers to a decline in the functional capacity of the organs of the human body, which occurs mostly due to a physiological transformation. The elderly people constitute a precious reservoir of such human resource as is gifted with knowledge of various sorts, varied experiences and deep insights to the evolution of a phenomenon. They may be formally retired from their Government services or any other services, yet an overwhelming majority of them are physically fit and mentally alert. Hence if appropriate opportunities are given to them and proper care and attention is paid, they can also survive a happy life like all other sections of the society also they can also make a significant contribution to the socio economic development of the country.

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