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Appetite Assessment of the Older Adult Women of Kolkata and Finding its Relationship with Protein-energy Intake and Nutritional Status

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ABSTRACT

Decreasing appetite is found among older people living in the community care homes or even in the hospitals. Appetite loss has both psychological and non-psychological reasons. Loss of appetite leads to decrease in food intake and malnutrition. Therefore, the objectives of the study were to assess the appetite of both the free living older women and the residents of old-age homes and to find out the relationship of appetite with protein – energy intake and nutritional status. A cross sectional study was performed among 365 older women (age = 60 years) living both in the community (free living) and old-age homes of Kolkata. An eight items Council

on Nutrition Appetite Questionnaire (CNAQ) was used to assess appetite among the participants. Self-structured Food Frequency Questionnaire (FFQ) was used to assess protein and energy intake. Mini Nutritional Assessment (MNA®) was used to assess the nutritional status. 44.7 per cent older women were found to have anorexia. No significant difference ($p = 0.05$) was found between free living and old-age home residents in terms of anorexia. Protein and energy scores were found significantly ($p < 0.05$) correlated with appetite scores of both free living and old-age home groups. Significant association ($p < 0.05$) of appetite and nutritional status was also observed for both free living and old-age home participants. Therefore it was found that older women participants for the study, both free living and residents of old-age homes, were suffering from anorexia and no statistically different picture was found in this regard. Their protein-energy food intake and nutritional status were also associated with their level of appetite.

Key words: Older adult women, Appetite, Old-age home, Free living, Food intake, Nutritional status

Unintentional decline in food intake followed by involuntary weight loss in old age is enunciated as anorexia in ageing. Poor appetite and loss of motivation to eat is often observed in old age (Soenen, S., *et al.*, 2013; Pilgrim, A., *et al.*, 2015). Decreasing appetite is found among the free living elderly, hospital inpatients and even among people living in care homes. Women were found to suffer more than men (Soenen, S., *et al.*, 2013). Anorexia in old age has many causes some of them are physiological and some are non-physiological; like social, financial and medical conditions. Any single cause or multiple causes result in anorexia (Pilgrim, A., *et al.*, 2015). Physiological anorexia is age associated decline in appetite. Older adults, even the healthy, feel less hungry than younger people. This results in less intake of energy (Hao, R., *et al.*, 2012). Appetite regulation is a complex process and not yet clearly understood (Soenen, S., *et al.*, 2013). Psychological parameters like depression, dementia also play important role in non-physiological development of reduced appetite (Hao, R., *et al.*, 2012). Anorexia related weight loss finally leads to protein energy malnutrition in old age (Champion, A., *et al.*, 2011). Anorexia alters quality of life and has increased mortality and morbidity (Ikeda, M., *et al.*, 2002)

Objectives of the study were to assess the appetite of the elderly women participants living in their houses (free living) and old-age homes, to find out the relationship of appetite with protein – energy intake and nutritional status.

Materials and Methods

Study design: A cross sectional study was performed among 365 elderly women. Out of them 169 were selected randomly from the community while196 women were randomly selected from different old-age homes of Kolkata, India.

Inclusion criteria: Women aged 60 years and above, free from any severe disease and willing to participate in the study were included.

Ethical clearance: Ethical clearance of the study was obtained from Bioethics committee for Animal and Human Research Studies, University of Calcutta (No. BEHR/1099/2304). The study was explained thoroughly to all the participants and their signature was obtained in a consent form.

Appetite assessment: Eight items Council on Nutrition Appetite Questionnaire (CNAQ) was used to assess appetite among the elderly participants (Wilson, M. M. G., *et al.,* 2005). The questionnaire was administered through interview and participants were asked to answer eight questions related to their appetite. Low scores indicate loss of appetite. About 10 minutes was spent for the interview in each case

Protein and energy intake assessment: Self-structured Food Frequency Questionnaire (FFQ) was used to assess weekly food consumption. From this data protein and energy scores were calculated to find out the total scores of energy and protein from seven days food consumption of the older adult women (Maity, B., *et al.*, 2018).

Assessment of nutritional status: Nutritional status of the participants was assessed by using long version of Mini Nutritional Assessment (MNA®) tool (Vellas, B., *et al.*, 2006).

All information from the participants was obtained through interview mode and anthropometric measurements were done using standard methods.15–20 minutes time was spent to administer MNA.

Statistical Analysis

Collected data were entered in Microsoft excel worksheet (Microsoft, Redwoods, WA, USA). Normality of distribution was checked by Kolmogorov-Smirnov test. Distribution was found skewed (significant p value). Continuous data were expressed in median values and dispersion was expressed in inter quartile range (IQR). Degree and direction between two variables were calculated by Spearman's rank correlation coefficient (rho). Binary logistic regression model was used to predict the effect of independent variables on dependent variables. Chi-square test was done to test the association between categorical variables. All statistical analysis was done using SPSS software, version 19.0 (Statistical Package for the Social Sciences Inc, Chicago, IL, USA). p value <0.05 was taken as statistically significant.

Results

Previous study, among the same participants, revealed that according to MNA 54.5 per cent free living and 53.6 per cent old-age home participants were at risk of malnutrition, while 17.2 per cent free living and 21.9 per cent old-age home participants were malnourished. Significant positive correlation ($p < 0.05$) was found between nutritional status and protein and energy scores (Maity, B., *et al.*, 2018).

Table 1

Distribution of older adult women according to appetite

Appetite	*Free living participants (N=169)*	*Participants from old-age homes (N=196)*	*Total (N=365)*
No anorexia	86 (50.9)	116 (59.2)	202 (55.3)
Anorexia	83 (49.1)	80 (40.8)	163 (44.7)
Median ± IQR	28.0 ± 6.0	29.0 ± 6.0	28.0 ± 6.0

(Figures in parenthesis indicate percentages)

Pearson's chi-square ($\chi 2$) = 2.53, df= 1, p = 0.11

Table 1 shows distribution of older adult women according to their appetite. 44.7 per cent of the total participants had anorexia and were in 'at risk of weight loss' group according to CNAQ scale. 49.1 per cent free living participants and 40.8 per cent old-age home residents were found to have anorexia and 'at risk of weight loss'. Median values of appetite for free living, old-age home residents and

total participants were 28.0 ± 6.0, 29.0 ± 6.0 and 28.0 ± 6.0, respectively. No significant difference was found between free living and old-age home groups ($p = 0.05$).

Table 2

Association of appetite according to CNAQ scores with protein scores and energy scores of the older adult women

Appetite According to CNAQ	*Protein scores Median ± IQR*			*Energy scores Median ± IQR*		
	Free living (N= 169)	*Old-age home (N= 196)*	*Total (N= 365)*	*Free living (N = 169)*	*Old-age home (N= 196)*	*Total (N= 365)*
No anorexia	63.0 ± 26.8	47.0 ± 15.2	55.0 ± 22.8	67.5 ± 23.7	48.0 ± 17.0	55.0 ± 22.5
Anorexia	55.0 ± 22.7	42.5 ± 13.3	48.0 ± 22.0	62.0 ± 18.0	44.0 ± 10.0	52.0 ± 23.0
Spearman's rho	0.216* (p = 0.005)	0.263* (p = 0.000)	0.161* (p = 0.002)	0.215* (p = 0.005)	0.189* (p = 0.0008)	0.107* (p = 0.042)
Mann-Whitney U test	Z = –2.26* (p = 0.043)	Z = –2.815* (p = 0.005)	Z = –2.205* (p =0.027)	Z = –2.012* (p = 0.044)	Z = –2.019* (p = 0.043)	Z = – 1.364 (p = 0.173)

* Significant

Table 2 shows association of appetite with protein scores and energy scores of free living, old-age home residents and total older adult women participants. Significant correlation between appetite with protein and energy scores ($p < 0.05$) for free living and old-age home participants were found. According to Mann-Whitney U test, significant difference ($p < 0.05$) was observed between protein and energy score, both for free living and old-age home participants.

Table 3

Association of nutritional status and appetite of the older adult women

Nutritional status according to MNA	*Appetite according to CNAQ Median ± IQR*		
	Free living (N=169)	*Old-age home (N= 196)*	*Total (N= 365)*
Normal nutritional status	30.0 ± 4.0	31.0 ± 2.0	30.0 ± 4.0
At risk of malnutrition	27.5 ± 6.0	28.0 ± 6.0	28.0 ± 6.0
Malnourished	22.0 ± 6.2	26.0 ± 9.0	26.0 ± 9.0
Spearman's rho	0.436* (p = 0.000)	0.466* (p = 0.000)	0.435* (p = 0.000)
Kruskal Wallis H test	22.116* (p = 0.000)	44.921* (p = 0.000)	63.759* (p = 0.000)

* Significant

Table 3 shows association of nutritional status and appetite of the older adult women. Significant difference was found among the median values of CNAQ in the three levels of nutritional status ($p < 0.05$). Significant positive correlation was found between nutritional status and appetite ($p < 0.05$).

Table 4

Binary Logistic regression coefficients of CNAQ with respect to MNA for free living and old-age home participants

	MNA	B	S.E	Wald	df	p value	Expected (B)
Free living (N= 169)	CNAQ	1.307	0.373	12.257	1	0.000	3.695
Old-age home (N=196)	MNA	B	S.E	Wald	df	p value	Expected (B)
	CNAQ	2.789	0.619	20.332	1	0.000	16.268

Table 4 displays binary logistic regression coefficients of CNAQ with respect to MNA. Positive significant ($p< 0.05$) beta coefficients were observed for both free living and old-age home groups.

Discussion

Appetite assessment revealed that out of the total 365 participants 44.7 per cent participants had anorexia and they were at risk of weight loss within six months. 49.1 per cent free living and 40.8 per cent residents of old-age home were also identified with anorexia [Table1]. This means more than 40.0 per cent participants had poor appetite and had risk for anorexia related weight loss. Median values of CNAQ score were 28.0 ± 6.0, 29.0 ± 6.0 and 28.0 ±6.0 for free living, old-age home residents and total participants, respectively [Table 1]. All median values obtained, fall under no anorexia range of the CNAQ tool.

Earlier studies (Landi, F., *et al.,* 2010, Nakamura, S., 2008) reported, prevalence of anorexia among about 25 per cent community dweller elderly and 87.5 per cent elderly patients, respectively. Some suggest that women are more susceptible to anorexia than men (Pilgrim, A., *et al.,* 2015). In the present study 49.1 per cent free living elderly women and 40.8 per cent women from old-age homes had anorexia. This also indicates that many women suffer from anorexia in old-age.

Age related anorexia is often found in old age even among the healthy elderly, hence people feel less drive to take food which usually results in less intake of energy (Sonen, S., *et al.,* 2013). Anorexia therefore leads to involuntary weight loss (Donini, L. M., *et al.,* 2003) and finally protein-energy malnutrition among the older adults (Champion, A., 2011). Mortality and morbidity also found to be associated with anorexia (Landi, F., *et al.,* 2012).

In the present study significant correlations of appetite was found with protein scores and energy scores for both free living and old-age home groups ($p < 0.05$). Significant decrease of protein and energy scores were observed in the 'anorexia' group in comparison to 'no anorexia' group, for both free living and old-age home participants ($p < 0.05$) [Table 2]. These findings revealed that protein and energy rich food intake decreased significantly with anorexia. Generally, it can be stated that food intake decreased with loss of appetite or anorexia in the older adult women under study.

Donini *et al.,* (Donini, L.M., *et al.,* 2013) found that elderly with reduced food intake were suffering from anorexia and their consumption of certain foods like; meat, fish and egg was significantly lower than others. Loss of appetite or reduced craving for food in old age has multiple reasons. Apart from physiological anorexia; social causes, financial causes, medical conditions and psychological states play important roles in the development of non-physiological anorexia (Donini, L.M. *et al.,* 2003). Psychological reasons like depression and dementia are truly sensitive parameters in this regards (Ikeda, M., *et al.,* 2002). However, anorexia and related weight loss are potential causes of developing protein energy malnutrition in old age (Champion, A., *et al.,* 2011)

In this study nutritional status assessed by MNA was found to have significant association with appetite ($p < 0.05$) for both free living and old-age home participants [Table 3]. Both significant positive correlation coefficient [Table 3] and significant positive regression coefficient ($p < 0.05$) [Table 4] between nutritional status and appetite indicate that when appetite was good then nutritional status was also good. Appetite scores were found to decrease significantly ($p < 0.05$) from normal to poor nutritional groups [Table 3] for both free living and old-age home groups [Table 3].

Hence, it can be concluded that–

- Anorexia was present in higher percentages among both free living older women and old-age home residents
- No statistically significant difference was observed between the two groups in terms of anorexia prevalence
- Protein and energy intake as well as nutritional status of the participants of both the groups were significantly correlated

References

Maity B, Chaudhuri D, Saha I and Sen M (2018): Dietary practice of elderly women and its association with their nutritional status. *Indian J Gerontol*, 32 (1), 62–77.

Champion A (2011): Anorexia of Aging. Annals of Long-Term Care. *Clin Care Aging*, 19(10), 18–24.

Donini LM, Savina C and Cannella C (2003): Eating habits and appetite control in elderly. The anorexia in ageing. *Int Psychogeriatr*, 15(1), 73–87.

Donini LM, Poggiogalle E, Piredda M, Pinto A, Barbagallo M, Cucinotta, D. and Sergi, G. (2013): Anorexia and Eating Patterns in the Elderly. *PLoS One*, 8(5), e63539.

Hao R and Guo H (2012): Anorexia, undernutrition, weight loss, sarcopenia, and cachexia of aging. *Eur Rev Aging Phys Act* 2012, 9, 119–127.

Ikeda M, Brown J, Holland A, Fukuhara R and Hodges J (2002): Changes in appetite, food preference, and eating habits in frontotemporal dementia and Alzheimer's disease. *J Neurol Neurosurg Psychiatry*, 73, 371–376.

Landi F, Liperoti R, Lattanzio F, Russo A, Tosato M., Barillaro C., Bernabei, R., and Onder, G. (2012): Effects of anorexia on mortality among older adults receiving home care: an observation study. *J Nutr Health Aging*, 16(1), 79–83.

Landi F, Russo A, Liperoti R, Tosato M, Barillaro C., Pahor, M., Bemabei, R. and Onder, G., (2010): Anorexia, physical function,

and incident disability among the frail elderly population: results from the ilSIRENTE study. *J Am Med Dir Assoc*, 11(4), 268–274.

Nakamura S, Yanagihara K, Mihara T, Izumikawa K, and Seki M (2008): Clinical characteristics of pneumonia in the oldest old patients. *Nihon Kokyuki Gakkai Zasshi*, 46(9), 687–692.

Pilgrim A and Sayer AA (2015): An overview of appetite decline in older people. *Nurs Older People*, 27(5), 29–35.

Soenen S and Ian M. Chapman IM (2013): Body Weight, Anorexia, and Undernutrition in Older People. *J Am Med Dir Assoc*, 14, 642–648.

Vellas B, Villars H, Abellan G, *et al.*, (2006). Overview of the MNA® – Its History and Challenges. *J Nutr Health Aging*, 10, 456–465.

Wilson MMG, Thomas DR, Rubenstein LZ, Chibnall JT, Anderson, S., Baxi, A., Diebold, MR., and Morley, JE. (2005): Appetite assessment: simple appetite questionnaire predicts weight loss in community-dwelling adults and nursing home residents. *Am J Clin Nutr*, 82, 1074–1081.

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Assessment of the Nutritional Status of Elderly and its Correlates

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ABSTRACT

The primary objective of the study was to evaluate the nutritional status, based on BMI of elderly men and women (aged 60 and above) living in the urban and rural area of Patna. Out of 300 elders, 150 each were selected from five villages of the rural area and five wards of urban area of Patna district. Data on anthropometric measurements including weight and height were recorded using standard equipment and techniques. Information on socio-economic status was collected using interview schedule. Results of the study shows that the normal elderly were more in well-to-do families than in those with poor socio-economic status. The proportion of normal elderly was the highest for BC/OBC caste category when compared with other social categories like SC/ST. Caste, income, religion and type of diet were strongly associated with nutritional status of elderly people. The service and business holder elders were found more normal in comparison to agriculturist elders. The employment status had some effect on the nutritional status of the elderly people.

Key words: Body Mass Index, Malnutrition, Elderly, Urban

The elderly are one of the most vulnerable and high risk groups in terms of health status in any society. Nutrition is an important

determinant of health in persons over the age of 60 years. Malnutrition in the elderly is often under diagnosed, therefore careful nutritional assessment is necessary for both the successful diagnosis and development of comprehensive treatment plans for malnutrition in this segment of population. Evaluation of nutritional status and chronic morbidity status is important for any health action plan for the elderly persons.

Demographic ageing is a global phenomenon. Ageing is accompanied by a variety of physiological, psychological, economic and social changes that compromise nutritional status and/or affect nutritional requirements (Munro and Danford, 1989). Globally it is estimated that there are 605 million people aged above 65 yrs. WHO has predicted that ageing population will present new challenges to the health care (World Health Organization, 2008). The older population faces a number of problems ranging from absence of ensured and sufficient income to support themselves and their dependents, ill health, absence of social security, loss of social role or recognition and non-availability of opportunities for creative use of time (Srivastava, R.K. 2007).

Since nutrition of the elderly affects immunity and functional ability, it is an important component of elderly care that warrants further attention. The few studies that have been done, show that more than 50 per cent of the older population is underweight and more than 90 per cent have an energy intake below the recommended allowance (Natarajan, V.S. *et al*., 1993 & 1995).

Anthropometric measurements are often used to assess the nutritional status of individual and community. Anthropometry plays good indicator of nutritional status of adults (WHO, 1995). The Body Mass Index (BMI) has been recognised as an indicator of overall adiposity and is most established indicator for assessment of adult nutritional status (Lee and Niemann, 2003). Although adult nutritional status can be evaluated in many ways, the BMI is most widely used because of the technique being economical, non-invasive and very practical (James *et al.,* 1988; Lohman *et al.,* 1988 and Ferro-Luzzi *et al.,* 1992). The BMI has been widely used as a practical measure of chronic energy deficiency (Khongsdier, 2005). In general, the elderly peoples of India are recognized as socially and economically vulnerable. Recent

reports have advocated that height may be particularly useful as an index of socioeconomic conditions in developing societies because populations which are poorly fed and subject to repeated infections rarely grow well in either childhood or adolescence and fail to achieve an adult stature which is commensurate with their full genetic potential (Gopalan, 1987).

Objectives

- to assess nutritional status of rural and urban elderly people of Patna district.
- to find out how far factors like age, income, caste, type of family, religion, education, family size and occupation affect nutritional status of elderly people.

Methodology

The present study was undertaken in the urban and rural areas of Patna. 300 elderly people (aged 60 years and above) mentally receptive and who were willing to participate in the study were selected using stratified random sampling method equally from rural as well as urban area. Five villages from one Block of Patna and five wards from Municipal area of Patna were randomly selected. The subjects were randomly selected from the list of older people prepared from each selected village and ward. The list was prepared with the help of voter's lists and ration cards of the villagers. One hundred and fifty elderly were selected from the five villages of the rural area and the same number of elderly persons were selected from the five wards of urban area of Patna district. It means 30 elderly people were selected from each of these identified villages and wards of the sample.

An interview schedule was used to gather information. Demographic indicators such as age, income status, caste, type of family, educational status, number of family members and occupation were ranked and compared against nutritional status of elderly people in the study. Nutritional status of the elderly people was assessed by Body Mass Index (BMI). Weight and height were measured by using standardized spring balance and measuring tape respectively. Weight was measured to the nearest 0.1 kg and height to the nearest 0.1 cm.

The BMI was computed using the following standard equation: BMI = Weight (kg)/height (m2). BMI were categorized into four groups–

< 18.5 = Underweight

18.5–24.9 = Normal

25–30 = Overweight

> 30 = Obesity.

(Source: Adapted from WHO, 1995).

Chi-square test for independence of attributes was used to see the association of variables.

Results and Discussion

Table 1

Nutritional status of elderly according to body mass index (BMI) by age group

Age (years)	*Nutritional status according to Body Mass Index (BMI)*								*Total*
	=18.5 (Under Weight)		*18.5–24.9 (Normal)*		*25–30 (Overweight)*		*> 30 (Obesity)*		
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*
Upto 65 Years	28	17.0	77	46.7	46	27.9	14	8.5	165
66 to 75 Years	16	17.8	39	43.3	28	31.1	7	7.8	90
76 to 85 Years	4	10.8	15	40.5	16	43.2	2	5.4	37
More than 85 Years	4	50.0	4	50.0		0.0		0.0	8
Total	52	17.3	135	45.0	90	30.0	23	7.7	300

$\chi^2 = 12.075$; $df = 9$, $p > 0.10$

Nutritional status of the elderly people by age group was assessed by Body Mass Index (BMI). It is clear from Table 1 that 17.3 per cent of the elderly have low body mass index (less than 18.5) reflecting underweight and chronic energy deficiency. 30 per cent of the elderly are overweight (25–30) and only 7.7 per cent have obesity. 45 per cent of the elderly have normal weight. Large number of elderly of 76–85 years age group (i.e. 43.2%) are observed to be overweight.

Chi-square test for independence of attributes was carried out for age versus BMI of elderly people. ($\chi^2 = 12.075$; df = 9, $p > 0.10$) Thus, values were found to be insignificant and there was no association between age and BMI of the elderly people.

Table 2

Distribution of elderly by nutritional status (BMI) vs. socio-economic status

Socio-economic status	Nutritional status according to Body Mass Index (BMI)								Total	
	=18.5 (Under Weight)		18.5–24.9 (Normal)		25–30 (Overweight)		>30 (Obesity)			
	No.	%	No.	%	No.	%	No.	%	No.	%
Low Income Group	33	27.7	44	37.0	30	25.2	12	10.1	119	39.67
Middle Income Group	11	12.4	37	41.6	36	40.4	5	5.6	89	29.67
High Income Group	8	8.7	54	58.7	24	26.1	6	6.5	92	30.67
Tota	52	17.3	135	45.0	90	30.0	23	7.7	300	100.0

$\chi^2 = 24.593$ $df = 6$ $p < 0.005$

Table 2 have shown that the economic status of the family was directly proportional to the nutritional status of the elderly. In low income group out of 119 elderly 27.7 per cent were underweight, 25.2 per cent and 10 per cent had overweight and obesity respectively. While among the elderly belonging to middle income group out of 89 elderly 12.4 per cent were underweight, 40.4 per cent and 5.6 per cent had overweight and obesity respectively. In the high income group out of 92 elderly 8.7 per cent, 26.1 per cent and 6.5 per cent had underweight, over weight and obesity. In the whole out of 90 overweight, maximum percentages (40.4) of overweight were found in middle income group and maximum number of under weight 27.7 per cent were found in low income group.

The results clearly showed that higher the economic status lower was the percentage of malnutrition and vice versa. As for the high income group, the socio-economic affluence permitted fulfilment of nutritional requirements of elderly, thus the cases of normal were highest in this category.

Chi-square test was applied to find out the effect of socio-economic status on the nutritional status of the elderly. The association between economic and nutritional status was found to be significant. Value of χ^2 being 24.593, df = 6, $p < 0.005$. The result showed that there was a massive variation in prevalence rates of under weight between low and high socio-economic groups. Normal elderly were more in well-to-do families than in those with poor socio-economic status.

Table 3

Nutritional status vs. Caste

Caste	*Nutritional status according to Body Mass Index (BMI)*								*Total*	
	=18.5 (Under Weight)		*18.5–24.9 (Normal)*		*25–30 (over weight)*		*>30 (Obesity)*			
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
General	48	19.3	109	43.8	72	28.9	20	8.0	249	83.00
BC/OBC	4	9.3	24	55.8	14	32.6	1	2.3	43	14.33
SC/ST	0	0.0	2	25.0	4	50.0	2	25.0	8	2.67
Total	52	17.3	135	45.0	90	30.0	23	7.7	300	100.0

$\chi^2 = 12.748$, *df*= 6 $p < 0.05$

Nutritional status vs. caste of elderly was analysed in Table 3. Out of 52 under weight elderly people, 19.3 per cent underweight were found in general caste category whereas, 9.3 per cent under weight elderly were found in BC/OBC and none had in SC and ST category. About 29 per cent overweight elderly were found in general caste category. The proportion of normal was the highest for BC/OBC caste category when compared with other social categories.

The finding was further substantiated by χ^2 test for the independence of attributes (social category and nutritional status) and it was found to be significant showing association between nutritional status and caste of the elderly persons.

Table 4

Nutritional Status vs. Type of Family

Type of family	*Nutritional status according to Body Mass Index (BMI)*								*Total*	
	=18.5 (Under Weight)		*18.5–24.9 (Normal)*		*25–30 (over weight)*		*>30 (Obesity)*			
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Nuclear family	24	19.2	53	42.4	39	31.2	9	7.2	125	41.67
Joint family	28	16.0	82	46.9	51	29.1	14	8.0	175	58.33
Total	52	17.3	135	45.0	90	30.0	23	7.7	300	100.0

$\chi^2 = 0.916$ *df* = 3 $p > 0.50$

The effect of type of family on the nutritional status of the elderly was analysed according to Body Mass Index (BMI). The normal elderly in nuclear families and joint families were 42.4 per cent and 46.9 per

cent respectively, while elderly suffering from malnutrition in these two types of families were 19.2 per cent and 16 per cent under weight and 7.2 per cent, 8 per cent over weight respectively (Table 4).

When we tried to find out the effect of type of family on the nutritional status of the elderly, we arrived at a unique finding that no significant effect of family type in determining the nutritional status of the elderly was found.

Therefore, this is in contradiction to the general belief that elderly in joint families are less cared or not cared for their nutrition as compared to the elderly in the nuclear families. Chi-square test for independence of attributes was carried out for the type of family versus nutritional status of elderly people ($\chi^2 = 0.916$, $p > 0.50$) but no significant association was found.

Table 5

Nutritional status versus Religion

Religion	*Nutritional status according to Body Mass Index (BMI)*								*Total*	
	=18.5 (Under Weight)		*18.5–24.9 (Normal)*		*25–30 (over weight)*		*>30 (Obesity)*			
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Hindu	48	19.3	109	43.8	72	28.9	20	8.0	249	83.0
Muslim	4	9.3	24	55.8	14	32.6	1	2.3	43	14.33
Sikh		0.0	2	25.0	4	50.0	2	25.0	8	2.67
Total	52	17.3%	135	45.0	90	30.0	23	7.7	300	100.0

$\chi^2 = 11.478$ *df* = 6 $p > 0.05$

The nutritional status of elderly was examined on the basis of their religion in Table 5. The normal elderly in Hindu, Muslim and Sikh religion were 43.8 per cent, 55.8 per cent and 25 per cent respectively, while elderly suffering from malnutrition (under weight) in these religions were 19.3 per cent and 9.3 per cent respectively, though percentage of malnutrition was less among Muslims in comparison to other religions. In Sikhs problem of under weight was not found. On the other hand Sikh elderly respondents were more obese (25%) in comparison to Hindus (8%) and Muslims (2.3%).

According to chi-square test it appeared that religion had no marked effect on the nutritional status of the elderly. Least level of under nutrition in terms of BMI was found for Muslim elderly in comparison to other religious categories.

Table 6

Nutritional status versus education

Education	*Nutritional status according to Body Mass Index (BMI)*								*Total*	
	=18.5 (Under Weight)		*18.5–24.9 (Normal)*		*25–30 (over weight)*		*>30 (Obesity)*			
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Illiterate	22	31.0	28	39.4	17	23.9	4	5.6	71	23.67
Primary School	4	10.3	21	53.8	12	30.8	2	5.1	39	13.00
Secondary School	7	21.2	11	33.3	10	30.3	5	15.2	33	11.00
High School	7	11.1	30	47.6	21	33.3	5	7.9	63	21.00
College	9	12.2	34	45.9	25	33.8	6	8.1	74	24.67
Professionally qualified	3	15.0	11	55.0	5	25.0	1	5.0	20	6.67
Total	52	17.3	135	45.0	90	30.0	23	7.7	300	100.0

$\chi^2 = 19.342$ *df* = 15 $P > 0.10$

The nutritional status of elderly with respect to education was analysed on the basis of BMI (Table 6). On the whole, the discussion supported the fact that higher percentage of elderly who were professionally qualified, were found normal and the data show that maximum percentage (55) of normal elderly fell into this category.

The chi-square test did not reveal any significant relationship between BMI and education of the elderly people.

Table 7

Nutritional status versus family size

No. of family members	*Nutritional status according to Body Mass Index (BMI)*								*Total*	
	=18.5 (Under Weight)		*18.5–24.9 (Normal)*		*25–30 (over weight)*		*>30 (Obesity)*			
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Up to 4 members (Small)	28	23.1	53	43.8	32	26.4	8	6.6	121	40.33
5–8 members (medium)	15	14.2	45	42.5	.37	34.9	9	8.5	106	35.33
Above 8 members (Large)	9	12.3	37	50.7	21	28.8	6	8.2	73	24.33
Total	52	17.3	135	45.0	90	30.0	23	7.7	300	100.0

$\chi^2 = 6.439$ *df = 6* $p > 0.10$

The nutritional status was examined with respect to family size in Table 7. It was observed that larger the number of the family higher was the level of nutrition (or normal status). The small and medium type of families had the highest percentage of 43.8 per cent and 42.5 per cent respectively of normal elderly. However, with increase in the numbers of family members there was increase in the percentage of normal elderly i.e. highest being 50.7 per cent, for a family with 8 and above members. As for malnourishment grades, the percentage of malnourished elders in respective grades decreased with an increase in the number of members in the family i.e. 23.1 per cent and 12.3 per cent of underweight elders were found in small family (four members in the family) and large family (8 and above members in the family) respectively.

Chi-square test for independence of attributes was carried out for family size versus BMI of elderly people ($\chi^2 = 6.439$, df. = 6). The association was found not to be significant.

Table 8

Nutritional status versus occupation before age 60

Occupation	*Nutritional status according to Body Mass Index (BMI)*								*Total*	
	=18.5 (Under Weight)		*18.5–24.9 (Normal)*		*25–30 (over weight)*		*>30 (Obesity)*			
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Agriculture	12	25.5	21	44.7	14	29.8		0.0	47	15.67
service	16	13.0	61	49.6	36	29.3	10	8.1	123	41.0
Business	4	12.5	16	50.0	11	34.4	1	3.1	32	10.67
House wife	20	20.4	37	37.8	29	29.6	12	12.2	98	32.67
Total	52	17.3	135	45.0	90	30.0	23	7.7	300	100.0

$\chi^2 = 13.425$ $df = 9$ $p > 0.10$

The occupations of elderly (before 60 years) were seen with respect to their nutritional status as presented in Table 8. It was observed that the service and business holder elders had more normal elderly in comparison to agriculture. Maximum percentage (44.7%, 49.6% and 50%) of normal elders were seen in agriculture, service and business sectors respectively. From the above study, it may be inferred that occupation of elders have an important role to play as far as their nutritional status was concerned. The percentage of normal was found lower in housewife elderly. However, the chi-square test was not

significant to show any association between BMI and occupation of the elderly.

Table 9

Nutritional status versus type of diet of elderly

Type of diet	*Nutritional status according to Body Mass Index (BMI)*								*Total*	
	=18.5 (Under Weight)		*18.5–24.9 (Normal)*		*25–30 (over weight)*		*>30 (Obesity)*			
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Vegetarian	29	18.7	59	38.1	51	32.9	16	10.3	155	51.67
Non vegetarian	23	15.9	76	52.4	39	26.9	7	4.8	145	48.33
Total	52	17.3	135	45.0	90	30.0	23	7.7	300	100.0

$\chi^2 = 7.630$ *df* = 3 $p > 0.05$

The type of diet was examined with respect to their nutritional status in Table 9. It was observed that the percentage of underweight (18.7%) and overweight (32.9%) elderly was found higher among vegetarians, Normal was more common (52.4%) in non vegetarian elderly.

When we tried to find out the effect of type of diet on the nutritional status of the elderly, we arrived at a unique finding that much of an effect of non vegetarian foods in determining the nutritional status of the elderly was found. However, the association between type of diet and BMI was found not to be significant as revealed by chi-square test.

Cnclusion

The results clearly showed that there was a massive variation in prevalence rates of underweight between low and high socio-economic groups. Normal elderly were more in well-to-do families than in those with poor socio-economic status. The proportion of normal was the highest for BC/OBC caste category when compared with other social categories like SC/ST and percentage of malnutrition was less among Muslims as compared to Hindus and Sikhs. Service and business holder elders had more normal weight in comparison to agriculture. A unique finding that much of an effect of non vegetarian foods in determining the nutritional status of the elderly was found. Family income,

caste and religion and type of diet were strongly associated with nutritional status of elderly people.

Recommendation

Geriatric nutritional centres have to be established in the rural areas like that of ICDS to provide adequate nutrition to the elderly. Old age pension scheme has to be implemented especially in the rural area for the elderly people to make them financially independent. It has to be revised frequently based on consumer price index. Geriatric health care services be made a part of the primary health care services and mandatory training for all health care providers in the primary and secondary health care services has to be ensured for better delivery system.

References

Ferro-Luzzi, A., Sette, S., Franklin, M., and James, W.P.T. (1992): A simplified approach of assessing adult chronic deficiency. *Eur. J. Clin. Nutr*., 46:173–186.

Gopalan, C. (1987): Heights of population – an index of their nutrition and socio-economic development. *Bull. Nutr. Found. Ind*. 8: 1–5.

James, W.P.T., Ferro-Luzzo, A. and Waterlow, I.C. (1988): Definition of Chronic Energy Deficiency In Adults, Report of a working party of the international dietary energy consultative group. *Euro. 1. Clin. Nutr*., 42, 969–981.

Khongdier, R. (2005): BMI and morbidity in relation to body composition: a cross-sectional study of rural community in north east india. *Br. J. Nutr.,* 93:101–107.

Lee, R.D. and Nieman, D.C. (2003): *Nutritional assessment*, McGraw Hill, New York.

Lohman TG, Roche AF, Martorell R (1988): *Anthropometric Standardization Reference Manual.* Human Kinetics Books, Chicago.

Munro H, and Danford D. (1989): *Nutrition, Aging and the Elderly, Human Nutrition, A comprehensive treatise.* New York: Plenum Press

Natarajan VS, Shanthi R, Shiva Shanmugam, *et al.* (1993): Assessment of nutrient intake and associated factors in an Indian elderly population. *Age Ageing,* 22: 103–108.

Natarajan V.S., Shanthi R., Krishnaswamy B., *et al.* (1995): High prevalence of nutritional disorders and nutrient deficits in elderly people in rural community in Tamil Nadu, *Ind. JHK Geriatric Society*, 6: 40–43.

Srivastava, R.K. (2007): *A multicentric study to establish epidemiological data on health problems in elderly.* A WHO collaborative programme: 9–10.

World Health Organization (1995): *Physical status: the use and interpretation of anthropometry.* Technical Report Series No. 854. World Health Organization, Geneva.

World Health Organization (2008): *The world health report 2008: Primary health care now more than ever*. http://www.who.int/whr/2008/en.

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Productive Ageing: Insights from an Action Research Dealing with Senior Citizens' Engagement with an E-Learning Platform to Educate Underprivileged Children

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ABSTRACT

The paper presents the insights and observations of the interventions where fifteen retired senior citizens were trained in using an online learning platform to get productively engaged by utilising their dormant knowledge resource to impart quality education from their home to rural underprivileged school students for three years. This Action Research programme demonstrates that use of Internet and Web 2.0 Technologies by senior citizens not only helps them to get involved in a productive activity but also directly engage themselves in the development process of improving the learning outcomes of underprivileged school children in rural India.

Key words: Productive ageing; Internet and Web 2.0 Technologies; Online e-learning platform.

United Nations Report on Madrid International Plan of Action on Ageing (MIPAA) indicates that ageing will be the dominant and most visible aspect of world population dynamics in the 21st century (UN, 2002). In this context, MIPAA has urged the governments and

society at large to adopt innovative mechanisms to promote participation of elderly/senior citizens as citizens with full rights, and to assure that persons everywhere are able to age with security and dignity. The objective is to create an inclusive society for all ages characterised by independence, participation, care, self-fulfilment and dignity.

Since Independence, India has recognised senior citizens as a priority target group for social welfare interventions and rarely as resource or as active participants in mainstream productive activities. The Central Government Policies (Ministry of Social Justice and Empowerment, 1999) and various gerontological social services focus on various welfare schemes that secures only financial and health issues of elderly in the country. This subscribes to the disengagement theory of ageing that constructs age as a process of economic, social, and physical decline (Turner, 1995) and therefore need support in those aspects. However, to create an inclusive society for all ages, the focus must shift to constructive engagement of elderly in society rather than on supporting them. Rejecting the disengagement theory of ageing and current focus of Indian gerontological social services, the action research programme presented in the paper demonstrates the potential of Internet-based social technologies in providing productive engagement opportunities to elderly through enhancement of virtual social connectivity.

Until Industrial Revolution, elderly had honored roles in society; they were the nurturers, guardians of the traditions, teachers, mentors and initiators of the young. However, in modern society, the mainstream visions of ageing have largely seen the senior years as a time for withdrawing from making contribution to the larger community, a time for winding down. However, this is a group that has acquired a lifetime of skills, knowledge and wisdom which can be shared with the younger generation, contributing to the knowledge capital of the society. In this context, the paper proposes the action research programme where a group of knowledgeable senior citizens, using their vast pool of knowledge and experiences, redefine their role as teachers and mentors and get engaged in disseminating quality learning to the underprivileged students in rural India using an online e-learning platform.

Children in rural India continue to be deprived of quality education owing to factors like 'teacher absenteeism, inadequately trained teachers, non-availability of teaching materials, inadequate supervision, and little support' (Kumar, 2010). Children from rural schools often drop out due to factors like an 'unattractive classroom environment, teacher absenteeism, teacher-centered teaching, and a stagnant daily routine' (Dreze, 2013). Retired senior citizens, who have the required knowledge base but are not involved in any productive engagement, can act as remote teachers using computer assisted distance learning to these students leading to enhancement of quality education for such children and their own improvement in quality of life after retirement.

Objectives

The action research programme has focused on the current nature of subjective wellbeing among a group of senior citizens in the city of Kolkata and further explores the need of productive ageing through utilisation of dormant knowledge capital in disseminating quality education to underprivileged rural students using digital technologies. The overall objective is to study the effectiveness of digital technologies as an enabler to promote a better quality of life for the senior citizens who can be active participants in the process of social change.

Background

In India, several NGOs such as Agewell Foundation, Calcutta Metropolitan Institute of Gerontology, Help Age India Deep Prabin Parisheba, Nightingale Medical Trust are at present working on providing assistance to elderly in their everyday life which includes affordable medical care at home, improved access to institutional health care, home-based rehabilitation services and social support. Though many such gerontological social services have started to focus on social engagement of elderly, efforts are much less in comparison to assistive health related support given to the senior citizens of India. Governmental policies in India are now keen on providing opportunities for elderly that will guarantee independence and dignity in society in terms of main-stream engagements in social activities. This brings us to the discussion on the need towards *productive ageing*. The concept of productive ageing is not restricted to earning a living in old

age (Raje, 2012). According to Butler and Gleason (1985) 'the principal concept of productive ageing is to remain constructive in relationship to the larger society and immediate environment as long as possible. I think the downside to productive ageing is if it is only seen as work'. Gokhale (1995) explains: 'Productive ageing implies the participation in action-oriented policies and programmes aimed at guaranteeing social and economic security for the elderly as well as providing opportunities for them to contribute to and share in the benefits of development'. In this context, the paper focuses on mechanisms of disseminating elderly knowledge and wisdom as a means towards productive ageing. Indigenous elder knowledge sharing traditions have the potential to address some of the mentoring and knowledge transfer needs within a community.

Role of Internet and Web 2.0 Technologies in Productive Ageing

Use of information and communication technologies (ICT) as assistive technologies are quite common in providing assistive care to the elderly which helps people stay healthy and live independently at home for a long time (Siegel & Dorner, 2017). However, in this context, the focus shifts from assistive means of technology to the wider scope of the cyber-world that provides productive opportunities for enhancing the social connectivity of older adults through various social technology tools and platforms. ICT can play an important role in helping older adults to stay independent as long as possible and stay socially included by way of interacting with others. Digital technology has the potential to bridge barriers as online social networks and online discussion forums can be used to engage in social contact regardless of geographical or temporal location. Senior citizens' participation in social media ranges from passive engagements such as reading posts and online discussions to active engagements of writing blogs, creating content, connecting online with family and friends, etc. (Sims, *et al.*, 2016), which has positive impact on the physical and mental well-being of older adults.

Intergenerational solidarity and family support is an important component of ageing gracefully in later life and social networking platforms can play a significant role in this regard. Grandparents can also serve as mentors, historians, wizards or nurturers (Kornhaber &

Woodward, 1981). Different initiatives have used the virtual spaces in building online communities among old and young. NGOs, gerontological societies and individuals all across the world, believing in the positive impact of connecting younger generations with elderly, have taken number of initiatives in connecting them using social media. FCB Brazil, an advertising agency based out of Brazil has initiated 'Speaking Exchange' project for CNA language schools where young Brazilians learn English from American elderly using video conferencing meeting room. A group of retired elderly in old age homes and own homes in America help the youth in Brazil with speaking and communicating in English (Nudd, 2014). 'Cyber Seniors' initiative centred on senior citizens based out of San Francisco, USA focuses on connecting generations using Internet. This initiative focuses on a group of senior citizens getting trained in using Internet through computers or smart phones by young volunteers for three months. The seniors eventually start using Facebook, youtube, Gmail, etc. and connect with loved ones using video conferencing software. These seniors engage themselves by uploading their videos, watching others' videos through youtube. All these initiatives through digital technologies aims at making the elderly actively engaged after retirement and intend to alleviate loneliness and social isolation in old age. But the paper questions as to whether elderly can use this avenue of connecting with the younger generations in solving the burgeoning social problem of poor quality of education.

Aiming towards redefining the roles of elderly in society as mentors to the younger generation, the action research programme has focused on the capacity of knowledgeable elderly in solving problems of education in rural India using social technologies. Underprivileged students in rural areas lack holistic growth because of inexperienced rural teachers and poor content. Thus, the paper reflects potential of a group of retired senior citizens to disseminate quality formal and non-formal education to the rural underprivileged students through online e-learning platforms.

The action research reflected in this paper has two parts. In the first part, an attempt has been made to prove the hypothesis that engagement with productive activities and social interactions facilitates overall subjective wellbeing of senior citizens. The main findings

of the study have been mentioned. In the second part, some observations and insights from interventions have been presented where an attempt has been made to create an opportunity for knowledgeable senior citizens to get involved in productive engagements and social interactions using Internet and web 2.0 technologies. 15 retired senior citizens were trained to get engaged in an online e-learning platform to impart quality education from their home to rural underprivileged school students for three years. The e-learning platform was developed by the research group to conduct the action research. The objective is to demonstrate that use of Internet and Web 2.0 Technologies by senior citizens not only helps them to get involved in a main-stream productive activity but also improves the well-being and learning outcomes of underprivileged school children in rural India.

Effect of Productive Engagements and Social Interactions on Subjective Wellbeing

The paper will now discuss briefly the main findings of a subjective wellbeing study that was conducted in the action research programme where 98 middle class elderly from city of Kolkata, India was selected using snowball sampling to investigate the factors responsible for increasing one's subjective wellbeing in old age. The independent variables of this study are: (i) physical wellbeing, (ii) companionship, (iii) involvement in paid services, and (iv) involvement in voluntary services. These variables are scored in a 1–3 scale and can be defined as follows:

Physical well-being: It assesses the ability to perform basic activities of daily living and to live independently. Health and physical wellbeing is an important parameter to determine subjective wellbeing of older adults.

Companionship: This variable comprises of component of social and family interactions, relationship with off-springs and grand-children at home. This parameter gauges the presence and support of spouse, offsprings and grandchildren as well as social engagements in old age.

Involvement in Paid services: This variable is one component of productive ageing. This parameter defines engagement of elderly in any work that yields economic return.

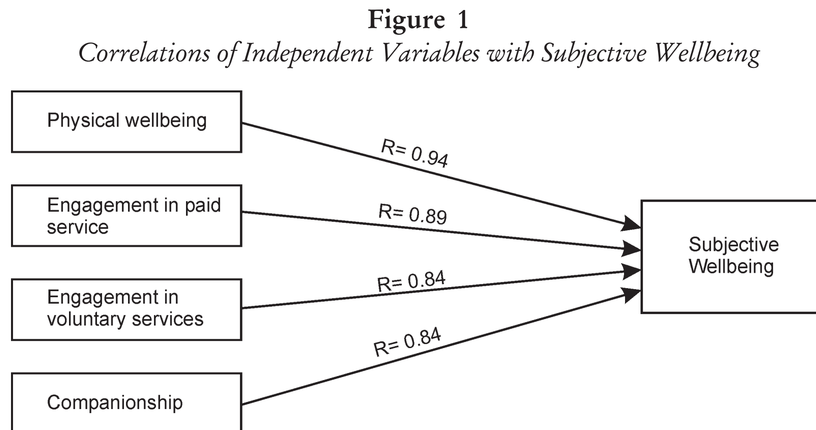
Involvement in Voluntary services: This variable indicates extent of productive participation in voluntary services such as helping underserved communities, working in NGOs, taking part in local community activities, etc.

The dependent variable taken in this study is *subjective wellbeing* of elderly in old age. Subjective measures of wellbeing, scored in a 1–5 scale, capture people's feelings or real experiences, explores people's perceptions on their life, their happiness, sadness, satisfaction, etc. (McGillivray and Clarke 2006). McGillivray and Clarke state that 'subjective wellbeing involves a multidimensional evaluation of life, including cognitive judgments of life satisfaction and affective evaluations of emotions and moods.' Subjective wellbeing is measured using Life Satisfaction Index, Morale Scale and Affect (Positive and Negative). The Life satisfaction measurements have been conducted using the Diener Scale, the Morale scale has been conducted using Philadelphia Geriatric Morale Scale (PGC Morale Scale) and the Affect scale measurements are conducted using The PANAS-X: Manual for the positive and negative affect schedule (Watson & Clark, 1999).

The correlations of independent variables with the dependent variable are presented in Figure 1.

Figure 1

Correlations of Independent Variables with Subjective Wellbeing



As shown in figure 1, the independent variables show high positive correlation with subjective wellbeing. The first relationship indicates that older adults with low *physical wellbeing* will have low

subjective wellbeing. The primary reasons behind this are confinement at home and inability to participate freely in social/productive engagements. It implies that digital technology has the potential to improve their wellbeing through improved access to social/productive engagement opportunities using Internet and web 2.0 technologies, even if they are confined at home.

The second and third relationships indicate that increased *engagement in paid services* and increased *engagement in voluntary services* increases feelings of subjective wellbeing among the older adults. This implies that increased subjective wellbeing of an older adult depends only on active engagements in mainstream social activities, even if it is unpaid. This analyses that to ensure increased subjective wellbeing, an older adult needs to be active participants in social change.

The final relationship between companionship and subjective wellbeing shows positive correlation at 0.84. People tend to have higher subjective wellbeing when they stay connected with their spouse or offsprings. Intergenerational solidarity is considered to be a factor influencing subjective wellbeing among older adults where interaction and relationship between two generations especially alternate generations are taken.

To summarise, this quantitative study of subjective wellbeing emphasizes the need for *productive* and *meaningful social engagements* after retirement. The derivations of a positive relationship between activities and subjective wellbeing can be further explained from the Activity theories of ageing (Havighurst, 1961) that has emphasized on the importance of work with categorisation of age.

Creating Productive Ageing Opportunities using Internet: Insights from the Action Research

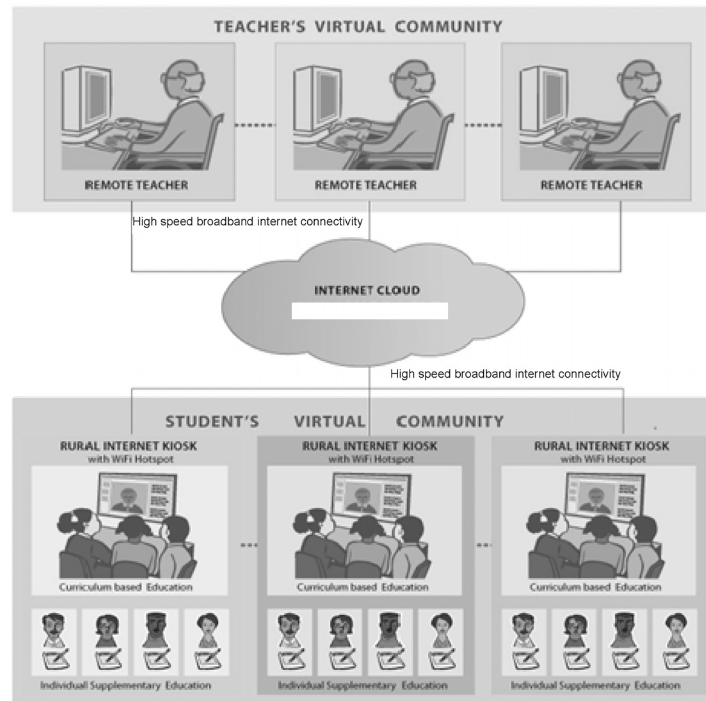
As indicated in the last section, productive and meaningful social engagements play an important role in improving subjective wellbeing among retired senior citizens. In the second part of the paper, we present some insights from interventions where the primary objective is to exploit the potential of Internet-based social technologies in providing productive and meaningful social engagement opportunities to elderly through enhancement of virtual social connectivity.

15 knowledgeable retired senior citizens were selected from an initial sample of 98 using convenient sampling. These 15 senior citizens were previously not involved in any productive activities after formal/informal retirement. Since elderly knowledge and wisdom is the primary asset of retired senior citizens, we focused on creating an online e-learning platform (Figure 2) where the knowledgeable elderly would get connected online with young underprivileged learners in rural India from the comforts of their homes.

These retired senior citizens from Kolkata connected with the underprivileged students located in rural regions of Burdwan, Birbhum, South 24 Parganas, Nadia, Murshidabad and Kolkata in West Bengal, India through this online e-learning platform. The elderly teachers have taught them academic subjects such as English, Mathematics and Science and a non-formal subject termed 'Grand-parenting', comprising of story-telling, recitation, art and crafts, exposure to world knowledge, etc. It focuses on holistic development of children. The purpose of such interventions was to engage knowledgeable senior citizens in a productive activity of knowledge dissemination.

All of the 15 elderly are within the age group of 65 to 80 years and were not involved in any meaningful activity after formal/informal retirement from work. Five out of the 15 elderly teachers were retired professors, three of them were retired Montessori trained teachers, three of them were retired secondary school teachers and rest of the four elderly had retired from corporate offices. The four elderly who were into formal services have prior experience of teaching students privately at home or in tuition centres. Out of these fifteen elderly, eight were male and seven were female. Three out of seven elderly women were predominantly home-makers but no longer involved in nurturing own children and were now spending less time to take care of the households. They felt lonely with the sudden reduction of activities. The men too after retiring from formal employment felt the need to be engaged in an activity that would give meaning to their life.

Figure 2
Elderly teachers teaching underserved students using an online e-learning platform



The e-learning platform

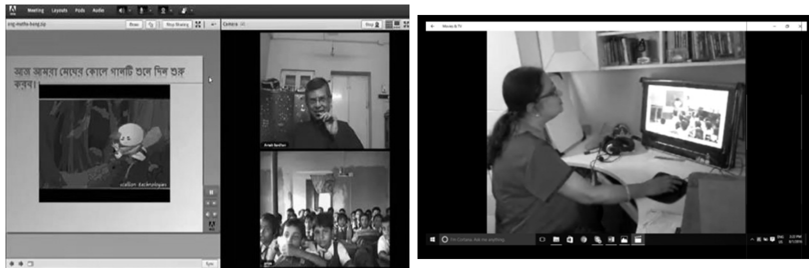
The online e-learning platform (Fig 2) has an in-built video conferencing system that also has a provision to share digital content on the computer screen or to use in-built digital white board for diagrammatic explanations. These elderly teachers teach from their homes, where they have an ICT setup (laptop/desktop, speakers, camera, and headphones) along with high speed internet connectivity.

During the initial stage of the intervention none of these elderly knew the use of computer/laptop and Internet. 10 young volunteers started training the interested elderly teachers at their residence and it took them more than a month to complete the training. The objective of the training was to connect them with the cyber-world. After the

training, the teachers could operate Youtube, Facebook, Gmail, Whatsapp and the online teaching learning platform (Figure 3).

Figure 3

Elderly teachers teaching underserved students online: two snap-shots



The rural underprivileged students are located in remote class-rooms, which are also equipped with an ICT setup (desktop/laptop, large monitor/screen or projector, camera, speakers and microphone) and high speed internet connectivity. The classes are conducted at scheduled times, using the above platform. Individual student can also get connected with on-line teacher on a one-to-one basis, using his/her smart-phone or tablet. An on-site teaching assistant/class coordinator appointed at this rural classroom would schedule classes, coordinate the teaching process via this platform, manage the classroom and mediate the interactions with students and the online teachers during classroom sessions.

The effectiveness of these classes conducted by elderly teachers (Figure 3) can be briefly described highlighting the following aspects:

- Bridging the barrier: The underserved students from the rural communities were not exposed to the world outside. The elderly teachers used to talk about their urban environment, urban experiences to the students located in distant villages of West Bengal, India. One of the teachers, who went to her daughter's place in Boston, USA for a vacation, conducted online classes from USA. She showed, for example, the snow-fall and streets & buildings of Boston from the window of her room, while inter-acting with those rural children online. Through the online e-learning platform, a teacher showed short films of Charlie

Chaplin and Disney, making students familiar with the world outside. Thus, the senior teachers focused on holistic development of each student by introducing a world that was earlier unknown to them.

- Explanation of concepts: The underserved students had difficulty in understanding basic concepts in Mathematics and Science. They were weak in English grammar and pronunciations. The online classes focused on clarification of the concepts where the elderly teachers used colourful e-whiteboard, audio-visuals as well as real life examples while explaining those concepts. While teaching English, the elderly teachers focused on pronunciation.
- Engagement in cultural activities: Unlike the existing rural school teachers, the elderly teachers encouraged students to read story books, poems, sing and dance in class to make the classroom environment learner-centric yet devoid of the monotonousness of a regular classroom. One of the elderly teachers had asked the students to organise a cultural function where all of the students rehearsed online and staged a play scripted by the teacher himself.
- Encouraging participation: Existing rural school teachers, having low interest level in teaching a class, never encourage students to participate. On the other hand, the elderly teachers, having the interest and desire to impact the lives of the underserved students, payed more attention on communication, reciprocation and peer-to peer learning using the online learning platform.

Assessing the Impact on Elderly Teachers

The impact of the interventions on elderly teachers engaged in online teaching can be illustrated using certain themes derived from first-hand accounts of the teachers:

1. Intergenerational solidarity: While teaching students, one of the elderly teachers shared his childhood memories with the students online. He used to show videos of Laurel Hardy, Indian Epics and various cartoons to make learning fun. Students too shared their fears and happiness with the elderly teacher, resulting in the usage of the term 'Dadu' or grandfather for the elderly teachers. These moments have impacted deeply in the minds of the elderly teachers who too considered the students as their own

grand-children, contributing in their holistic development. The elderly teachers have said in interviews that they feel closer to these students than their own grand-children who do not stay with them.

2. Socio-economic contribution: Teaching the underserved rural children was the primary motivation of majority of teachers to become a part of the social experiment. One of the elderly teachers is a retired school teacher and had 40 years of experience in teaching students from decent socio-economic backgrounds. After retirement she was looking for opportunities where her expertise in teaching can be used to impact those who are in need of good teachers. She was in need of an activity that will satisfy her as a human being. As a result, teaching the underserved rural children with low learning achievement levels was the driving force for her to be a part of the social experiment. After teaching for three years, she expresses her extreme satisfaction in contributing to the problem of education in India. She constantly looks for better study materials for the students to make them at par with the urban students. Apart from contributing in mitigating a social problem, financial reward, although insignificant, was another factor that attracted the elderly teachers to this initiative where they can also earn from the comfort of their home. All the teachers have expressed extreme satisfaction in contributing to the problem of education in India.
3. Reduction of physical problems: One of the elderly teachers has said that the lively and engaging interactions with students help her forget her health problems. Two hours of engagement everyday through the online learning platform energises the elderly teachers to such an extent that they feel more positive and socially included. One of the teachers had a brain surgery and he couldn't teach students for two months and was in a state of depression. He regained his spirit after joining back the classes after two months.

Assessing the Impact on Rural Children

79 students from three rural schools in districts of Nadia, Burdwan and South 24 Parganas in West Bengal took part in the online

learning interventions. Most of the students from underserved rural communities are first generation learners. They receive little or no help at home. The elderly teachers have tried to bridge the rural-urban education divide by catering to each students, addressing individual problems and clarifying basic concepts using relevant examples. The students receiving less attention at home and schools feel included when the elderly teachers force them to talk about themselves. The impact on the students can be illustrated as follows:

1. Academic Impact: Students are now enjoying their studies and want to learn more. They started interacting and communicating more with the online teachers.
2. Holistic Development: The underserved students were now more enlightened because of the constant knowledge sharing by the elderly teachers. The students enjoy listening to the stories narrated by the elderly teachers. These stories, poems and real life experiences of the elderly teachers help students go beyond their microcosmic locale.

We have tried to measure students' improvement with two variables: *Students' Wellbeing* and *Learning Achievement.* It can be stated that learning and wellbeing are inextricably related, as students learn best when their wellbeing is optimized, and eventually they develop a strong sense of wellbeing when they experience success in learning. In this context, it has been observed that students themselves identify schooling as a significant influence on their wellbeing: 'be it the positive impact of a great teacher, an inspirational and engaging classroom lesson or that extra support provided at just the right time' (Student Learning And Wellbeing Framework, 2018). It is stated that 'more learning occurs in a joyous classroom where children feel safe, secure and accepted, and where they feel the teacher sees them for who they really are' (Diamond, 2010). The learning achievement of the students have been measured using competency based grade level questionnaire that have been formulated keeping in mind the heterogeneity of school boards and geographical locations.

Before the students were engaged in this social experiment, a preliminary study was conducted to assess their wellbeing and learning achievement. After the intervention, the students have shown considerable improvement. Figure 4 and 5 show the improvement on

Wellbeing score and Learning Achievement score of those 79 under-privileged students at an individual level. It is to be noted that the improvement is noticeable for each individual student in their Wellbeing scores. It must be also stated that there has been a stark improvement in Learning Achievements among the students indicating a positive shift towards quality of education.

Figure 4

Improvement of 79 students in Wellbeing after Intervention

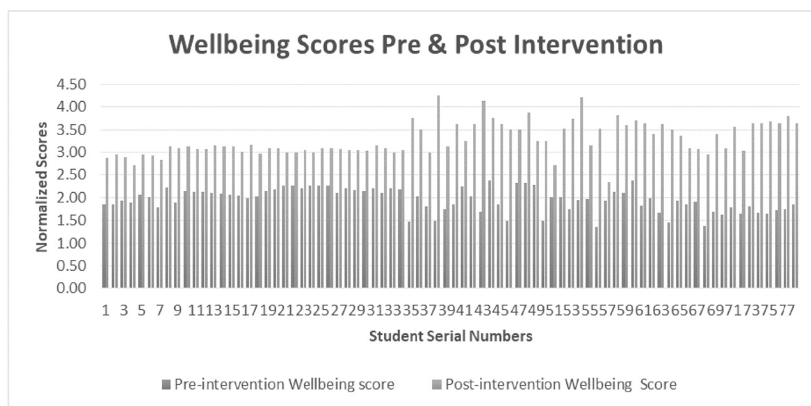
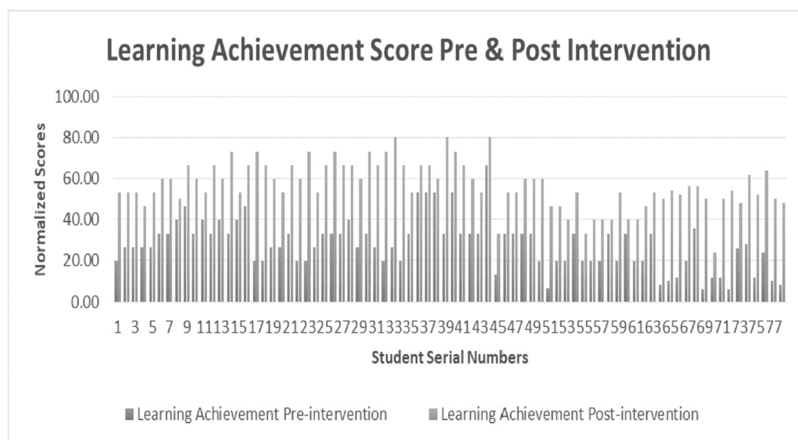


Figure 5

Improvement of 79 students in Learning Achievement Score after Intervention



Conclusion

The paper has focused on the importance of productive and meaningful social engagements in old age which is positively correlated with subjective wellbeing. The paper also suggests the use of Internet-based social technologies in providing productive engagement opportunities to the senior citizens through enhancement of virtual social connectivity. Though the scope of the term 'Productive ageing' ranges from paid services to voluntary activities, Robert Butler has focused on remaining constructive in relation to the larger society. In other words, productive ageing implies contribution to economic growth and social development of a nation in old age (Butler and Gleeson, 1985). The action research mentioned in the paper has focused on productive ageing where the dormant knowledge capital of knowledgeable elderly can be mobilized using Internet and web 2.0 technologies, contributing to improvement in the rural education system of the nation. At the same time, this enhances the subjective wellbeing of the senior citizens. The positive experiences gained by the elderly teachers through the proposed online e-learning platform prove that intergenerational solidarity plays crucial role in benefitting both the age groups. The positive experiences of the students assert the fact that knowledgeable elderly have the potential to mentor younger generations.

The action research programme proposes not only active involvement of elderly after retirement but also their meaningful engagements in society. The policy implementation thus proposed is realisation of the definition of productive ageing characterised by autonomy and independence in old age. The paper critiques the primary focus of majority of gerontological social work organizations and governmental policies of India that focus primarily on health care services, social security, and financial stability of elderly and ignore the issues related to promoting independence and productive engagement of older adults in the society. Along with financial and health related securities, there is dire need for recognition of the roles and expertise of elderly in society by the government and gerontological services. This would be possible if all such organisations come together and envision a platform for the elderly where they can find their own agencies to contribute and play important roles in society. This paper

has demonstrated the importance of productive ageing and suggested an online e-learning platform as an example of creating a robust mutually benefitting community where retired senior citizens can feel socially included and independent.

Acknowledgement

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References

Butler, R.N. & Gleason, H.P. (1985): *Productive Ageing: Enhancing Vitality in Later Life*. New York: Springer Pub.

Diamond, A 2010: The Evidence Base for Improving School Outcomes by Addressing the Whole Child and by Addressing Skills and Attitudes, Not Just Content. *Early Education and Development*, Vol. 21, No. 5, pp 780–793.

Dreze, Jean and Amartya Sen (2013): *An Uncertain Glory: India and its Contradictions.* Princeton University Press, 2013.

Gokhale, S.D. (1995): Community experiences in active ageing: An NGO perspective. Population Ageing and Development. *Asian Population Studies*. Series No.140.

Havighurst, R.J. (1961): Successful ageing. *The Gerontologist*. 1: 8–13. doi:10.1093/geront/1.1.8

Kornhaber, A. & Woodward, K.L. (1981): *Grandparents, grandchildren: the vital connection.* NewYork: Anchor Press/Doubleday.

Kumar, A.K. & Rustagi, P. (2010): Elementary Education in India: Progress, Setbacks, and Challenges. *Oxfam India Working Papers Series,* OIWPS–III

McGillivray, M., & Clarke, M. (2006): Human well-being: Concepts and measures. In M. McGillivray, & M. Clarke (ed.), *Understanding Human Wellbeing* (pp. 3–16). New York: United Nations University Press.

Ministry of Social Justice and Empowerment (1999): *The National Policy on Older Persons.* New Delhi: Government of India.

Nudd, T. (2014): Brazilian Kids Learn English by Video Chatting With Lonely Elderly Americans. Https://www.adweek.com/creativity/perfect-match-brazilian-kids-learn-english-video-chatting-lonely-elderly-americans–157523/

Raje, A. (2012): Productive Ageing: An Indian Perspective. In I. Holmerova, M. Ferreira, & P. Wija, (eds.), *Productive Ageing: Conditions and Opportunities: A Monograph* (pp. 71–78). Prague: The Ministry of Education, Youth and Sports –Charles University, Faculty of Humanities.

Siegel, C., & Dorner, E. (2017): Information technology for active and assisted living influences to the quality of life of an ageing society. *International Journal of medical informatics,* 100, 32–45.

Sims, T., Reed, A.E., & Carr, D.C. (2016): Information and communication technology use is related to higher well-being among the oldest-old. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences.* 72(5) 761–770.

Student Learning and Wellbeing Framework. (2018): State Of Queensland (Department Of Education) 2018. http://education.qld.gov.au/schools/healthy/docs/student-learning-wellbeing-framework.pdf

Turner, B. (1995): Ageing and Identity. In M. A. Featherstone (eds), *Images of Ageing*. London: Routledge.

United Nations, Department of Economic and Social Affairs. (2002): *Madrid International Plan of Action on Ageing 2002*. New York: United Nations.

Watson, David & Anna C. Lee. (1999): *The PANAS-X: Manual for the positive and negative affect schedule-expanded form*. Psychology Publications.

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Perceived Challenges Associated with Care of Older Adults by Family Care-givers and Implications for Social Workers in South-east Nigeria

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ABSTRACT

The present study sought complex, comprehensive understanding and insight on challenges of care-giving to older adults by using qualitative approach. Forty care-givers aged 23 and above living in Nnewi, south-east Nigeria participated in the study. Focus Group Discussion was used to collect data from the participants. The collected data were analysed in themes and the results revealed that family care-givers undergo stress, lack of finance, insufficient time for themselves and negative attitudes of older adults towards them. Social work professionals are required to teach family care-givers essential social skills in providing care and support for older adults.

Keywords: Family care-givers, Care of older adults, Perceived challenges, Social work practice in Nigeria

Older people represent an increasing percentage of the global population (Bagheri-Nesami, Rafii, *et al*., 2010). Estimates in the world population of people who are 60 years old and above was 11 per cent in the year 2000, and this population is projected to constitute 22 per cent

of the world population by year 2050 (World Health Organization, 2014). In Nigeria therefore, the experience of ageing is currently undergoing what Palloni and cohort described as 'silent ageing process' (Palloni, *et al*., 2006), which implies swift declines in fertility and infant mortality, as well as a continuing increase in life expectancy (Abdelmoneium & Alharahsheh, 2016). In the year 2012, number of Nigerians aged 60 years and above was 8.8 million, meanwhile this figure is projected to be 28 million by the year 2050 (United Nations, 2012). The implication is that Nigeria's population will continue to age rapidly in decades to come resulting in increase in the number of older adults to be cared for by both professional and personal care-givers in Nigerian society.

Although care-giving can be perceived as rewarding opportunity for many care-givers, it could also contribute to substantial stressors and poor health outcomes, financial, physical, and psychological draining (Pinquart & Sörensen, 2003; Elmore, 2014; Goren *et al*., 2016). For instance, care-givers devote themselves assisting older people, with little or no time for their own cares and needs. In some cases, they may not recognize or may ignore the signs of illness, exhaustion or depression that they are experiencing (Okoye & Asa, 2011). This strain of care-giving demands has been linked to poor health outcomes including depression, physical illness, anxiety, and poor sleep habits (Schulz, *et al*., 1997). Scholars have also expressed that it is common for care-givers to feel anger, frustration, guilt, isolation, unhappiness in marriage, anxiety, depression, a diminished social life, loss of self-esteem from time to time and dissatisfaction with life (Gonyea, *et al*., 2008; Macneil, *et al*., 2010). In most cases, this has been attributed to care-givers resorting to maltreatment and neglect of the older adults (Gupta & Chaudhuri, 2008); and equally forming them to negative health behaviours such as smoking, over eating, lack of physical exercise which results in high mortality rate of both the caregiver and the care receiver (Okoye & Asa, 2011).

Social scientists and other scholars have acknowledged two broad types of home care-givers for older persons as professional care-givers such as nurse, physical therapist, occupational therapist, speech therapist or social worker; and personal care-givers including family members or workers at home (United Hospital Fund, 2014; Abdelmoneium & Alharahsheh, 2016). However, for this study,

personal care-givers in the domain of family care-givers will be considered, and this entails people who provide care to older adults within their family confinement such as family members, neighbors or friends based upon feelings of affection or personal obligations toward the older adults. The choice for considering family care-giver in this study was informed by the prevailing traditional system of support in the study area. In south-east Nigeria, family members, friends, community members provide greater proportion of care-giving to older adults (Okumagba, 2011; Oladeji, 2011; Osamor, 2015). According to Okunola (2002) older adults usually abode either in their own residence or the residence of their care-givers to receive care. Ajala (2006) stated that provision of care to older adults by family care-givers was considered to be a moral imperative and material bliss. While Okoye (2012) revealed that care-giving from families was not as a result of the emotional connectivity which emerges out of blood or marital relationship but by the influence of routine behavioural practices enshrined in traditional values and norms.

The role of family care-givers in care of older adults in our society cannot be trivialized. Some of the essential roles played by family care-givers to older adults ranges from providing significant proportion of health and long-term care (Elmore, 2014) to financial assistance and emotional support (Abyad, 2001; Koh & MacDonald, 2006). As the strengths and abilities decline, older adults may require support and care in their activities of daily living, including feeding, transportation, dressing or using the bathroom, lifting, turning in bed, cooking, shopping, paying of bills, running errands, giving medicine, keeping company and so many other things (Iecovich, 2008; Gray, *et al.*, 2016;). In submission to accomplishing these tasks, several challenges usually occur which often hamper the quality of services provided to older adults.

Certainly, providing care to older adults in any form takes a huge toll, both, financially, socially, physically and emotionally. Most often only a few people are reportedly prepared for the responsibilities and tasks involved in caring for their older adults (Okoye & Asa, 2011). In some cases, family care-givers are not endowed with the necessary skills and knowledge required for meeting the complex needs of their older adults (Economic and Social Commission for Western Asia [ESCWA], 2008; Given, *et al.*, 2008). Hence, human professional

services in the field of social work are of immense importance. The primary role of social workers entails integrating the care-givers into the mainstream of care-giving with proficiency. Amid proficiency in care-giving to older adults, some likely challenges are reduced. Social workers develop appropriate intervention and educational programmes for care-givers and would be care-givers (Okoye & Asa, 2011). With its strengths-based, person-in-environment perspective, social workers are well positioned to advocate for support to family care-givers of older adults (National Association of Social Workers [NASW], 2009). Essentially, social workers can support family care-givers in making informed decisions, modify and fulfilling care-giving roles to improve or maintain their own health and well-being, also identify and address the stress related to care-giving responsibilities (NASW, 2010).

Several studies have emerged on the challenges associated with care for older adults utilizing quantitative approach (Okoye & Asa, 2011; Reinhard, *et al.*, 2011; Lai, 2012; Abdelmoneium & Alharahsheh, 2016), none has explored on this issue with qualitative approach especially in the study area. This study aims at filling the gap by examining perceived challenges experienced by family care-givers in caring for older adults. In doing so, the following questions were raised: (1) Do care-givers experience stress while taking care of older adults? (2) To what extent do care-givers experience financial challenges in care of older adults? (3) To what extent do attitudes and behaviours of the older adults affect their family care-givers? (4) What is the implication of findings to social work practice in Nigeria?

Methods

Participants

Forty participants (twenty-four female and sixteen male care-givers) were selected by purposive sample technique for this qualitative study. They were providing care to either a male older adult or female older adult or both. The researchers intentionally permitted the number of female participants to exceed the number of male participants because in traditional Nigerian society, women more often than not bear the brunt of support and care of older adults. This implies that they are usually exposed to challenges more than their male counterparts. They therefore constitute veritable assets for the

needed information regarding the topic under study. The participants were purposively selected and were aged between 18–49 years.

Data Collection

Data for the study were collected through qualitative method. Total of five FGDs were conducted with eight discussants in each group. The participants of three FGDs were females and discussants of remaining two FGDs were male. Discussion session for the female care-givers was conducted in three different locations including a restaurant, village and primary school hall; meanwhile the sessions with male care-givers were conducted at the village square and youth hall. The discussion guide contained unstructured questions in order to stimulate supplementary questions but within the scope of the study. Three researchers conducted the discussion sessions; while one of the researchers was moderating the discussion sessions; other researchers were recording the discussions. Observations were performed during the discussion sessions and field notes were compiled systematically immediately after each discussion session. The duration of each discussion session lasted between 60 and 90 minutes according to lenience and willingness of the participants. All discussions were tape-recorded and transcribed verbatim.

Data Analysis

The inductive thematic analysis developed by Braun and Clarke (2006) was adopted in the analyses of the transcripts and field notes. All the responses and observations were transcribed manually onto a personal computer bearing in mind the emerging themes which served as illustrative quotes. Data from notes and observations included the non-verbal cues from the participants, comments about tone of voice, and recurrent themes. The data were transcribed first in the local Igbo language and translated verbatim into English language to ensure that English and local language versions carried the same meanings. The researchers independently read and re-read the analysis of transcripts for familiarity with the data and also to generate initial codes. The researchers identified the emerging recurrent themes while going through the transcripts. The emerged themes including the experience of stress, financial challenges, lack of time and negative attitudes sufficiently answered the questions raised in the study.

The participants' demographic background was discussed while the data collection progressed. The findings revealed that majority of participants were married (*N* = 34, 85%), while a small proportion of them was widowed (*N* = 4, 10%). Only two participants indicated they were single as at the time of this study. Majority of participants (*N* =22, 55%) were traders; while (*N* = 9, 22.5%) indicated they were farmers. A few identified as public servants, artisans and one participant stated that she is unemployed. The data also show that majority of the participants have completed their secondary education (*N* = 25, 62.5%), other participants (*N* = 7, 17.5%) had higher education, still other participants (*N* = 5, 12.5%) had primary education while a handful of the participants (*N* = 3, 7.5%) had no formal education.

Results

Several important themes emerged from this analysis and findings which relate to the experiences of family care-givers in supporting and caring for their older adults. The participants narrated their experiences regarding the prevailing challenges associated with taking care of older adults. This section presents themes on participants' views regarding the issue under study.

Experience of Stress in the Care of Older Adults

The findings of the study revealed that majority of the participants found caring for the older adults stressful. However, the associated stresses experienced by the caregivers vary as a result of the health condition and frailty of some older adults. One of the female caregivers stated that 'taking care of older adults is stressful especially the feeble ones'. Also, a male caregiver said that 'the stress in taking care of my mother is much because of her health challenge'. From the responses of the participants, although some of these older adults could still attend some of the functions in the community such as going to market, church, village meetings, etc. they are usually assisted by their care-givers to do so. Also, findings revealed that some other older adults were home-bound while others were ill, bedridden and handicapped. Almost all the participants indicated they were faced with stress in their efforts to make their older adults happy, transporting them and cooking different types of foods. Some other participants also indicated they experienced stress in their effort to

keep the rooms of older adults clean. One of the participants' views was reflected in the following quote;

> The stress in taking care of older adults is much. Sometimes I have to suspend where I was about to go or I may be late to engagements in a bid to ensure that my mother was in good condition before I consider my schedules. (Male care-giver, Age 39)

The findings also reveal that some family care-givers are faced with stress in transporting their older adults. Transporting them in this regard entails assisting those older adults to where they want to go. Some of the older adults may want to be transported to the markets to sell their wares; some would want to be taken to the village meeting whereas others may want to be transported to hospitals for medication. Also, some of the older adults are assisted to walk to the toilet either to urinate or to defecate, some other older adults are assisted to their rooms or outside their rooms. A male caregiver stated:

> I have to transport my mother to wherever she wants to go in spite of my personal engagements. Sometime she would want me to take her to the village meetings, visit her relatives. Many a times, I take her to markets in the morning and equally come around in the middle of the day or towards evening to take her home. Even when you are busy with customers in the shop; you don't have any option other than leaving the customers, and rush to transport her. (Age, 42)

Also, another male caregiver stated:

> Of course, it poses a challenge to us. For instance, my mother would want that her request must be granted before considering others. In the morning, especially on the market day, she would pack her wares that may not amount up to 3 USD and insist I must take her to the market at all cost. In the afternoon when she must have been through, she will still call me to come and take her home not minding where I am or what I am doing, she insists that I take her home. (Age, 44)

The study equally revealed that some of the older adults are frail; they usually defecate uncontrollably on themselves and on their sleeping materials. This condition has made the family care-givers to be always busy in keeping the older adults and their environments

neat, thereby experiencing some stress. A female participant stated, 'some of them are frail and bedridden; this is the case with my father, I bathe him while he is confined in a place. I always wash his clothes which he usually defecates on, and I always clean the room he stays to avoid foul smell'. Also, another female care-giver stated, 'my mother cannot walk, she usually defecates on her sleeping materials; I have to clean them up to ensure the environment is neat'. Another male care-giver also said:

> Taking care of the older adults especially the home bound ones is stressful. The stress therein is enormous on me as I try to make my mother happy and keeping her and her room neat. To be honest, someone without a good heart cannot do it. (Male, Age 42)

Some of the older adults are afflicted with some illnesses, resulting in their preference to some diets over others which most often differ from common diets meant for the entire household. The findings of the study reveal that as some of the older people are placed on special diets as recommended by their physicians, the care-givers are compelled to be preparing special diets which often differ from the food the entire family members may want to eat at a particular point in time. One female participant stated:

> I equally spent much time cooking different types of food to enable my mother-in-law adjust to the doctor's recommendation. The food we always give her is quite different from what I, my husband and my children eat. Often time, I have to prepare our food separately. (Age, 40)

Financial Challenges in Care of Older Adults

The researchers sought to find out if finance can amount to a challenge the care-givers are faced with while providing care to older adults. The findings revealed that care-givers always have problem of finance as they provide care to their older people. Majority of the participants indicated that they often spend lots of money in buying foods and drugs for the older adults. This is as a result of the health conditions of some of the older adults of which many are suffering from terminal illnesses such as diabetes, high blood pressure, stroke, etc. These terminal illnesses have caused the older adults to be allergic

to some foods. Also, older adults who are hypertensive and diabetic are placed on costly routine drugs. Other participants stated that rarely will their older adults spend one week or two without developing an illness that may result in taking them to hospital. Other respondents equally stated that they always buy expensive supplements for their older adults to ensure they are in stable health condition. One of the female caregivers stated thus, 'you have to spend so much money buying their foods, drugs, especially all these supplements for their health'.

A male caregiver who participated in our discussion reflected:

> Taking care of older adults require money. You have to buy their drugs regularly especially the hypertensive ones; you equally buy food recommended by the doctors especially for older adults who are diabetic. You will also buy disinfectants to make sure their environments are well taken care of. (Age, 36)

One participant also stated:

> In this their old age, a lot of things are happening in their lives. You cannot compare this stage with their youthful age, they are always sick. In fact, I hardly stay for a week or two without taking my mother to hospital either for treatment or medical check-up. (Male, Age 40).

The findings further revealed that one of the major attributes to early demise of older adults is unavailability of money. Most of the participants indicated that some older adults would not have died if there were enough money to take care of them. The participants also disclosed that some older adults would have outlived their years if their families had enough money for their proper medical services and better nutrition to enable them live optimally and also age gracefully. One of the male participants in the FGD stated:

> Some older adults died because their families lacked adequate money to give them proper medical attention. I know of many of them that died because their children do not have the wherewithal to take them to good hospital. Some of them even died of starvation because of lack of food and money. (Age, 42)

Equally, a female caregiver in the discussion stated:

> Nobody would want either the parents or close one to die because of money. Sometimes, it means spending the money you have saved for some important projects on them. *'Nye onye ?b? mgbe ? d? nd?'* [provide for the person while he or she is still alive]. (Age, 46)

Lack of Quality Time for Personal Life and Family

The findings revealed that family care-givers have little time for themselves and their own family as they make every effort to care for their older people. A male participant in the FGD stated that 'taking care of them is time consuming'. The responses from other participants revealed that the married children especially the female children and daughters-in-law are more burdened with this. They will always devote ample time supporting and caring for their aged parents and mothers-in-law while their immediate families will be forsaken.

One of the male participants in the discussion stated:

> The immediate family, especially the married children, is challenged on this aspect. To be sincere with you, I have experienced this as the case with my father because he is frail; he always depends on us for everything he wants to do. This has made us especially my wife to spend ample time taking care of him, thereby forsaking her own personal pursuit and that of my immediate family. (Age, 38)

Also, a female caregiver stated:

> My mother is in this category; taking care of her consumes a lot of time. Do you know I spent quality time visiting her although; I am fortunate to have my brothers' wives around who assists me in taking care of her. (Age, 46)

The findings of the study revealed that taking care of older people usually limits the care-givers to wherever they want to go. Some of the participants indicated that they can neither go to where they want to go nor stay as long as they would want to any time they go out. The participants reiterated that they have to continually stay close to the older adults to know when they need assistance. One of the female caregivers stated, 'while you are taking care of them, you cannot go out as you desire, I cannot stay outside the home as long as I want because I must keep a constant check on my mother-in-law'.

Interestingly, one of the female participants was in a rush to leave the discussion exercise because of the condition of her mother-in-law. According to her:

> Taking care of my mother-in-law gives me less time for myself and my family. Even when I go to market or church, I will always be in a hurry to leave. For instance, you know we just dismissed from church before joining this discussion exercise, I am still here because it is you (one of the researchers), and I would have rushed back home before now to see how she (mother in-law) is faring. (Age, 44)

Views on Attitudes and Behaviors of the Older Adults

The study sought to find out if attitudes of older adults can constitute a challenge to their care-givers while supporting and caring for their older adults. The findings indicated that some of the attitudes and behaviors of older adults constitute some challenge to them in their bid to support them. While some of the participants reflected that their older adults shout at them for no just cause, others stated that their older adults often lay some false allegations against them. Equally, others stated that older adults talk to them in a hurtful and derogatory manner. One participant, a male care-giver stated, 'my father can also talk to you in a manner that hurts and irritates you'. Another female caregiver also said 'my mother-in-law often times behaves like a child; she changes her mood and appetite often'. Also, a participant who is a female care-giver stated, 'my mother-in-law always lay allegations on me especially when she is looking for any of her belongings such as money'.

One of the participants in our discussion stated:

> My mother shouts at us for just no cause. Also whenever she is visited by someone, she will tell the visitor how we have been maltreating her. Initially, I was not finding it easy with her until I realized it was as a result of old age and I am no more disturbed by such attitudes (Female, Age 32).

Discussion

Perceived challenges associated with providing care to older adults by family care-givers were discussed in this study. The findings from the study revealed that family care-givers have less adequate time

for themselves and their own family in order to take proper care of their older adults. Most often, the family care-givers have to postpone their appointments or tend to be late to engagements in order to ensure that their older adults are in better condition before putting their own schedule into consideration. This is consistent with other findings such as that of Okoye (2014) who noted that most often; caregivers spend a substantial amount of time interacting with their care recipients, while providing care in a wide range of activities. Reinhard *et al*., (2008) found in their study that four out of ten caregivers spend five or more hours providing care, while more than half of family caregivers provide eight hours of care or more every week. Nixon (2008) reported that care-givers may have to make changes in the workplace sometimes depending on the intensity of the care-giving work or giving up their work entirely.

The present study found that care-givers are faced with financial challenges as they care for the older people especially in buying foods, supplements, drugs and going to hospital for medical treatment or medical check-up. In conformity Okoye (2014) who noted that care-giving imposes considerable direct financial costs on caregivers and their families such as medical services, medical devices, drugs, food, clothing, and personal items for the older adults. Abdelmoneium and Alharahsheh (2016) in their study noted that the finances of family care-givers can also be affected by the daily costs of care-giving and other related care-giving expenses.

This study found that providing care to older adults is stressful on the family care-givers especially when they are trying to make them happy; transporting them or cooking different types of foods, and ensuring neat environments. Collaborating with other studies such as study by Elmore (2014) which reveals that taking care of older adults may often include assistance with activities of daily living such as bathing, dressing, eating, and transferring; these care-giving tasks usually put a great deal of strain on caregiver's health. Gray *et al*., (2016) found that caregivers usually feel emotional stress from witnessing their relatives suffering, as well as from having to deal with the unpredictability of day-to-day life. Gallagher-Thompson *et al*., (2006) noted that care-givers may experience direct and indirect physical health consequences, including higher levels of stress hormones.

Findings by Okoye and Asa (2011) and Gupta, *et al*., (2009) show that assistance rendered by care-givers are socially, emotionally, physically and psychologically draining especially when the care-givers lack the necessary knowledge and skills required for effective care-giving. This conforms to finding of this current study which shows that family care-givers undergo several challenges. This then calls for professionals who are endowed with such knowledge and skills essentially required to buffer the challenges associated with care for older adults. Social workers therefore are the most appropriate professionals that can assist the family care-givers to overcome these challenges. One of the roles expected of social workers is to educate the care-givers and potential care-givers through adult literacy and public enlightenment. This will provide the care-givers the opportunity to acquire needed information that will enhance their skills and knowledge regarding care for older adults. Scholars have found that social workers provide educational programs that expose the family care-givers to the issues and challenges involved in care-giving for the older adults when the need arises (Aua *et al*., 2010; Chena, *et al*., 2010). In the same vein, Marim, *et al*., (2013) stated that educational and support programs have a positive impact on the reduction of caregiver burden.

Conclusion

This paper examined the perceived challenges associated with care of older adults by their care-givers in their activities of daily living. The study reveal that providing care to older adults take a huge toll on social, financial, material, emotional and physical health of family care-givers. Findings from the study added to the knowledge of care-giving and the challenges therein especially in the area of research, field of gerontology and other human service providers. The results will add to the body of researches that advocate for educational and financial policies as well as community-based support that furnish incentives for the family care-givers in Nigeria. Purposeful education policy equips current care-givers and would-be care-givers with competence and knowledge regarding care-giving for older adults and challenges therein. Financial incentives in the form of monthly stipend will to a large extent reduce financial burden faced by the family care-givers. Similarly, community-based support and care will ease the family care-givers some stress, and also afford them time for themselves and their immediate families.

Counseling and therapeutic social work activity was perceived to be effective in reducing stress and burden on care-givers (Kerr, *et al*., 2005). To this regard, social workers in south-east Nigeria should engage in effective interface with the family care-givers through counseling programs that meet the bio psychosocial needs of family care-givers. This must be conveyed with recognition of the principle of confidentiality as enshrined in the NASW Code of Ethics (2008). Finally, the numbers of female participants in this study exceeded that of male participants as a result of the perceptions that explain the belief of more women involvement in care-giving role of older adults. Therefore, the researchers suggest that further study should be conducted to ascertain men's attitudes and perception to care-giving of older adults especially in south-east Nigeria.

References

Abdelmoneium, A.O., & Alharahsheh, S.T. (2016). Family home caregivers for old persons in the Arab Region: Perceived challenges and policy implications. *Open Journal of Social Sciences*, *4,* 151–164. Retrieved from http:/dx.doi.org/10.4236/jss.2016.41019

Abyad, A. (2001). Health care for older persons: A country profile – Lebanon. *Journal of American Geriatrics Society*, *49,* 1366–1370. Retrieved from http://dx.doi.org/10.1046/j.1532–5415.2001.49268.x

Ajala, M. (2006). 'The changing perception of ageing in Yoruba culture and its implications on the health of the elderly', *Anthropologist*, 8(3), 181–8.

Aua, A., Lib, S., Leeb, K., Leungb, P., Panc, P..., Gallagher-Thompsone, D., (2010). The coping with caregiving group program for Chinese caregivers of patients with Alzheimer's disease in Hong Kong. *Patient Education and Counselling, 78,* 256–260.

Bagheri-Nesami, M., Rafii, F., & Oskouie, H.S.F. (2010). Coping strategies of Iranian elderly women: A qualitative study, *Educational Gerontology, 36,* 573–591.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101.

Chena, Y., Hedrick, S.C., Young, H.M., (2010). A pilot evaluation of the family caregiver support program. *Evaluation and Program Planning, 33*, 113–119.

Chorn-Dunham, C., & Dietz, B.E. (2003). 'If I'm not allowed to put my family first: Challenges experienced by women who are care-giving for family members with dementia'. *Journal of Women and Aging, 15,* 55–70.

Economic and Social Commission for Western Asia (ESCWA) (2008). Situational analysis of population aging in the Arab countries: The way forward towards implementation of MIPAA. E/ESCWA/SDD/2008/Technical Paper. 2, United Nations, New York. Retrieved from http://www.globalaging.org/elderrights/world/2008/situation.pdf

Elmore, D.L. (2014). The impact of caregiving on physical and mental health: Implications for research, practice, education, and policy. In R. C. Talley *et al.,* (eds), *The challenges of mental health caregiving,* (pp. 15–21). New York: Springer Science+Business Media. Retrieved from https://www.springer.com/.../9781461487906-c1.pdf?...

Feinberg, L., Reinhard, S.C., Houser, A., & Choula, R. (2011). Valuing the invaluable: 2011 update – The growing contributions and costs of family caregiving. Retrieved from http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf.

Gallagher-Thompson, D., Shurgot, G.R., Rider, K., Gray, H.L., McKibbin, C.L., Kraemer, H.C., Sephton, S.E. and Thompson, L.W. (2006). Ethnicity, stress, and cortisol function in Hispanic and non-Hispanic white women: A preliminary study of family dementia caregivers and non caregivers. *American Journal of Geriatric Psychiatry, 14,* 334–342.

Given, B., Sherwoon, P., & Given, C. (2008). What knowledge and skills do caregivers need? *Journal of Social Work Education*, *108,* 115–123. Retrieved from http://dx.doi.org/10.5 175/JSWE.2008. 773247703.

Gonyea, J.G., Paris, R., & de Saxe Zerden, L. (2008). Adult daughters and aging mothers: The role of guilt in the experience of caregiver burden. *Aging and Mental Health, 12,* 559–67.

Goren, A., Montgomery, W., Kahle-Wrobleski, K, Nakamura, T. and Ueda, K. (2016). Impact of caring for persons with Alzheimer's disease or dementia on caregivers' health outcomes: findings from a community based survey in Japan. *BMC Geriatr., 16,* 122. doi:10.1186/s12877–016–0298-y.

Gray, R.S., Hahn, L., Thapsuwan, S., & Thongcharoenchupong, N. (2016). Strength and stress: Positive and negative impacts on caregivers for older adults in Thailand. *Australasian Journal on Ageing, 35,* E7–E12.

Gupta R, Chaudhuri A, 2008. Elder abuse in a cross-cultural context: Assessment, policy and practice. *Indian Journal of Gerontology, 22,* 373–393.

Gupta, R., Rowe, N., & Pillai, V. (2009). Perceived caregiver burden in India: Implications for social services. *Journal of Women and Social Work, 24,* 69–81.

Iecovich, E., (2008). Caregiving burden, community services, and quality of life of primary caregivers of frail elderly persons. *Journal of Applied Gerontology, 27,* 309–330.

Kerr, B., Gordon, J., MacDonald, C., & Stalker, K. (2005). *Effective social work with older people.* A paper prepared for the Scottish executive by the social work research centre, University of Stirling as part of the 21st century social work review. Scottish Executive Social Research.

Koh, S.K., & MacDonald, M. (2006). Financial reciprocity and elder care: Interdependent resource transfers. *Journal of Family and Economic Issues*, *27*, 420–436.

Lai, D.W.L. (2012). Effect of Financial Costs on Caregiving Burden of Family Caregivers of Older Adults. *SAGE Open, October-December, 2012.*1–14. Retrieved from http://journals.sagepub.com/doi/pdf/10.1177/2158244012470467

Macneil, G., Kosberg, J.I., Durkin, D.W., Dooley, W.K., Decoster, J., & Williamson, G. M. (2010). Caregiver mental health and

potentially harmful care-giving behavior: The central role of caregiver anger. *Gerontologist, 50,* 76–86.

Marim, C.M., Silva, V., Taminato, M., & Barbosa, D.A. (2013). Effectiveness of educational programs on reducing the burden of caregivers of elderly individuals with dementia: A systematic review. *Rev. Latino-Am. Enfermagem, 21*(Spec), 267–75. Retrieved from www.eerp.usp.br/rlae

National Association of Social Workers. (2008). *Code of ethics of the National Association of Social Workers*. Washington, DC: NASW Press. Retrieved from http://www.social workers.org/pubs/code/default.asp]

National Association of Social Workers. (2009). Aging and wellness. *Social work speaks: National Association of Social Workers policy statements, 2009–2012* (8th ed., pp. 14–21). Washington, DC: NASW Press.

National Association of Social Workers. (2010). *Social work practice with family caregivers of older adults.* Washington: National Association of Social Workers.

Nixon, D.C. (2008), *Tax incentives for family caregivers: A cost-benefit analysis*. Retrieved from http://www.publicpolicycenter.hawaii.edu/documents/paper003.pdf

Okoye, U.O. (2014). Financial incentives to support family care-givers of older adults in Nigeria: A policy consideration. *Research on Humanities and Social Sciences, 4(4),* 55–62.

Okoye, U.O. (2012). Family care-giving for ageing parents in Nigeria: Gender differences, cultural imperatives and the role of education. *International Journal of Education and Ageing, 2(2),* 139–154.

Okoye, U.O., & Asa, S.S. (2011). Caregiving and stress: Experience of people taking care of elderly relations in South-eastern Nigeria. *Arts and Social Sciences Journal, 29,* 1–9. 1

Okumagba, P.O. (2011). Family support for the elderly in Delta State of Nigeria. *Studies on Home and Community Science, 5(1),* 21–27. Retrieved from http://www. Krepublishers. com/.../HCS-05-1-0211-146

Okunola, M.I. (2002). *Old age care. A hand book for Nigerian social workers*. Ibadan: Daybis Ltd.

Oladeji, D. (2011). Family care, social services, and living arrangements factors influencing psychosocial well-being of elderly from selected households in Ibadan, Nigeria. *Education Research International, 2011,* 1–6. Retrieved fromhttp://www. hindawi.com/journals/edri/2011/421898/.

Osamor, P.E. (2015). Social support and management of hypertension in South-West Nigeria. *Cardiovascular Journal of Africa, 26(1),* 29–33. Retrieved from http://www.ncbi.nlm .nih.gov/pmc/articles/PMC4392208/

Palloni, A., Peláez, M., & Wong, R. (2006) Introduction: Aging among Latin American and Caribbean Populations. *Journal of Aging and Health*, *18,* 149–156. Retrieved fromhttp://dx.doi.org/10.1177/0898264306286766

Pinquart, M., & Sörensen, S. (2003). Differences between caregivers and non caregivers in psychological health and physical health: a meta-analysis. *Psychol Aging, 18,* 250–67.

Reinhard, S.C., Given, B., Huhtala, N.P., & Bemis, A. (2008). Supporting family caregivers in providing care, family caregiving-caregiver assessment. In: R. G. Hughes (ed.), *Patient safety and quality: An evidence-based handbook for nurses* (pp. 1–64). Rockville: Agency for Healthcare Research and Quality.

Reinhard, S.C., Feinberg, L., & Choula, R. (2011). *The challenges of family caregiving: What experts say needs to be done.* AARP Public Policy Institute. Retrieved from http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2011/ib194.pdf

Schulz, R., Mittelmark, M., Burton, L., Hirsch, C., & Jackson, S. (1997). Health effects of caregiving: The caregiver health effects study: An ancillary study of the cardiovascular health study. *Annals of Behavioral Medicine, 19,* 110–116.

United Hospital Fund (2014) Home care: A family caregiver guide. Retrieved from http://www.nextstepincare.org/uploads/File/Guides/Home_Care/Guide/Home_Care.pdf

World Health Organization (2014). *Facts about ageing.* Geneva: World Health Organization. Retrieved from http://www.who.int/ageing/about/facts/en/

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Living Arrangements and Quality of life of Nepalese Elderly in Rural Nepal

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ABSTRACT

The purpose of this paper was to examine the elderly people's perception towards quality of life according to their living arrangement in rural setting of Nepal. This is a cross-sectional study carried out in 2017 in Kailali district, western part of Nepal. Total sample size for this study was 547. This study used a single item Likert scale QOL question to assess the quality of life of elderly. An overwhelming majority (85.15%) of respondents lived with their son/daughter in law while a small number of cases (2.74%) reported to live alone. According to the study results, a little over one-third of the respondents (35.4%) were living with their son/daughter rated their QOL as good while nearly half of the respondents (46.7%) living alone rated their QOL as poor. In this study, elderly people's perception on quality of life as good or poor was rated on the basis of their standards, hopes, pleasures and concerns. This study is relevant to the agendas of human rights and social justice which are the burning issues and cry of the present world.

Key words: Elderly people, Ageing, Senior citizen, Living arrangement, Quality of life

Issues concerning older adults are recognized as a research priority in developed countries, evidenced by a growing body of

research in the area of psychological, social and health needs of the aged. Despite attracting less attention, there is also great need for research in the different aspects of elderly people in developing as well as the least developed countries (Chalise *et al.*, 2007). Living arrangement is the residential arrangement and care and support that the elderly receive in the family or non-family context. It is seen as an important area for research because of its influence on the well-being of the elderly. Living arrangement is a basic determinant and an indicator of the care and nature of informal supports available to the elderly within the family, and therefore of their quality of life (Domingo & Casterline, 1992). Still, in the developing countries the data collection for obtaining the statistical profile of the current living arrangements of the elderly, and an investigation into how they influence their well-being was not examined in depth.

Living arrangement of elderly people is a significant determinant of their economic security and quality of life. The issue is critical for poor elders in the developing world, where formal welfare systems are less extensive. Although co-residence benefits the younger as well as the older generation, in many societies living together with adult children has been 'a fundamental means of ensuring that the day-to-day needs of the older population would be met' (United Nation, 2005, p. 75). In Nepali culture, elderly generally prefer to stay with their children and living in old age home is not very common (Chalese & Ghimere, 2018).

Aging is a natural and universal phenomenon and human concern about it is old age. It is an inescapable part of human destiny and comes to every one of us. Ageing is a process which takes place during the entire life span of the organism and is the final phase of human development (Cumming & Henry, 1961), it must be seen as part of a continual process of change. Population aging is a global issue that draws attention from academic, political, and economic fields. It is not only characterized as a social issue in developed countries where it has been most prevalent but also recognized as a social problem faced by more and more developing nations. The United Nations declared the year 1999 as the international year of the aged with the theme 'Towards a society for all ages' and 1st October as the 'World Elders

Day'. This focus could be attributed to the burning problems of the aged.

Quality of life is a multidimensional concept, which cannot be explained in medical terms alone. Quality of life is a key concept in environmental, social, medical and psychological sciences, as well as in public policy and in the minds of the population at large; nevertheless, there is no consensus regarding the definition of quality of life. Moreover, when quality of life is referring to old age it must be required to address the broad diversity of ways of ageing; that is, from successful ageing through usual aging to aging with disability and dependency (Fernández-Ballesteros & Santacreu, 2010). It is one of the central concepts in ageing research.

The World Health Organization's Quality of Life (WHOQOL) Group (1993) defined the concept of QOL as: An individual's perception of their position in life, in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment (Ibid).

This research paper focuses on analysing the sample survey data with a focus on living arrangements and quality of life of elderly people. Various dimensions of *living arrangements like:* types of living arrangement, reasons for living alone, perception about their current living arrangement, and relationship between living arrangement and quality of life have been discussed. The main objective of this research paper is to evaluate the perception of elderly people towards quality of their life according to their living arrangement in rural setting of Nepal.

Material and Methods

This is a descriptive and explanatory study based on primary data collected from a cross sectional survey carried out in 2017. Multi stage sampling design was adopted for this study. At the first stage, conveniently two VDCs named (Hasuliya and Basauti (now renamed as Kailari Rural municipality) of Kailali districts which represent the highest proportion of elderly population were selected as sampled

area. At the next stage, all the wards of selected VDCs were sampled. All the wards of selected VDCs were considered as cluster. So, there were 18 clusters in this study. All the sampled clusters were considered as primary sampling units (PSU) for this study. At the last stage, 22 households with at least one elderly 60 years and above were selected from each sampled cluster. Systematic random sampling method was used for the selection of 22 households from each cluster. The sample size of the study was 396 households. Yamane formula was used to determine sample size. However, in the survey a total of 396 households were visited and 547 elderly people aged 60 + were successfully interviewed. All the elderly persons in the sampled households were enumerated.

Likert scale tool was used to assess the quality of life (QOL) of elderly. A question was asked to the respondents i.e. How do you rate your quality of life? The response of the respondents was collected in five point scale. Data was collected using face-to-face interview method through structured interview. Respondent's right to refuse and withdraw from the interview at any time was accepted with the maintenance of confidentiality. Respondents were assured of the confidentiality. Thereafter the study sought for the informed verbal consent of respondents before the interview which is already in use in Nepal due to some problem in the written informed consent Data was analysed using SPSS version 20.0. For the statistical analysis, tools like simple frequency table, percentage, mean and chi square test were used.

Results

Types of Living Arrangement

Gee (1999) suggested a relation between living arrangements of older women and their quality of life and its dimensions. In this study, older women staying with their families have a better QOL as compared to older people living alone. Very few of the total respondents (2.74%) reported to live alone and only less than10 per cent respondents reported to stay only with their spouse without children (7.86%). About four-fifth (85.15%) of them lived with their son/daughter in law and about two per cent (2.19%) lived. with their grandchildren (Table 1).

Table 1
Per cent distribution of respondents according to their living arrangement and sex.

Living with (Living arrangement)	*Sex of the respondents*			*N*
	Male	*Female*	*Both*	
Spouse	10.2	6.2	7.86	43
Son/daughter in law	84.4	85.7	85.19	466
Daughter/son in law	0.9	1.9	1.46	8
Grand children	1.8	2.5	2.19	12
Other family member	0.4	0.6	0.55	3
Alone	2.2	3.1	2.74	15
N	225	322	–	547
	χ^2 (P–value) = 4.350 (0.500)			

Source: Field Survey, 2017

By sex disaggregation, the proportion of female respondents living alone is slightly higher than male respondents (3.1% and 2.2% respectively) while on the other hand, the proportion of male respondents, who lived with their spouse only without children, is higher than female respondents (10.2% and 6.2% respectively). The data shows that the proportion female respondents are slightly higher than male respondents (1.9% and 0.9% respectively) lived with their daughter/son in law.

Reason for living alone

As per the traditional Nepalese cultural system, children provide support system to older parents in the house, however a few respondents were living alone without their children. In the present study, the respondents living alone were questioned to elicit the reasons for living alone. Over half of the total respondents (60%) living alone reported that they have to live alone as their children are living in other areas (Table 2).

The other main reasons listed by the respondents included having no children (alive/born) (20%) and a few others had no support from children (20%) so were living alone. The findings on reasons for living alone suggest that older people want to live with their children however, due to reasons like children living in other areas or no own children, they are forced to stay alone.

Table 2

Per cent distribution of respondents living alone (without children) according to reasons for living alone and sex.

Reasons for living alone	*Sex of the respondents*			*N*
	Male	*Female*	*Both*	
No support from children	20.0	20.0	20.0	3
Children living in other areas	20.0	80.0	60.0	9
No own children	60.0	0.0	20.0	3
N	5	10	–	15
	χ^2 (P–value) = 8.00 (0.018)			

Source: Field Survey, 2017

By sex disaggregation, the proportion of female respondents living alone due to children living in other areas was about 80 per cent while the corresponding figure for male respondent was only 20 per cent. On the other hand, the proportion of female respondents living alone due to no own children was only 20 per cent while the corresponding figure for male respondents was about 60 per cent.

Perception about their current living arrangement

It is important to understand older people's perception about their current living arrangement to elicit their satisfaction with the current living arrangement. In the present study, more than three fourth of the respondents (75.68%) reported satisfied with their living arrangement (Table 3). About one-tenth (10.24%) of the total respondents reported not satisfied with their living arrangement and a little over one-tenth of the total respondents (11.52%) perceived their current living arrangement to be neither satisfied nor dissatisfied.

Table 3

Per cent distribution of respondents according to their perception about their current living arrangement gender wise

Satisfied with living arrangement	*Sex of the respondents*			*N*
	Male	*Female*	*Both*	
Satisfied very much	1.3	1.2	1.28	7
Satisfied	76.4	75.2	75.68	414
Neither satisfied nor dissatisfied	7.6	14.3	11.52	63
Not satisfied	12.9	8.4	10.24	56
Not satisfied very much	1.8	0.9	1.28	7
N	225	322	–	547
	χ^2 (P–value) = 8.612 (0.072)			

Source: Field Survey, 2017

By sex disaggregation, the proportion of female respondents was less than male respondents (8.4% and 12.9% respectively) who have perceived not satisfied with their living arrangements while the percentage of female respondents was greater than male respondents (14.3% and 7.6% respectively) who have perceived neither satisfied nor dissatisfied with their living arrangements.

Perception of Elderly people about their Quality of life (QOL)

Older people's own rating of their quality of life provides important insights about their perception of their quality of life (QOL). Subjective QOL was understood by directly asking about respondents rating of their QOL. The information about quality of life of the respondents was collected by asking a close ended question (i.e., How would you rate your quality of life?). The information was reported on the basis of his/her responses as he or she feels about his/her quality of life.

Nearly half (45.9%) of the total respondents took a neutral position while rating their QOL i.e. neither poor nor good, while about one-third of them (34.4%) reported their QOL to be good and nearly one-sixth (15.9%) reported their QOL to be poor (Table 4).

Table 4

Gender wise per cent distribution of respondents according to their perception about their quality of life

Quality of life	*Sex of the respondents*			*N*
	Male	*Female*	*Both*	
Very poor	3.1	3.1	3.1	17
Poor	15.6	16.1	15.9	87
Neither poor nor good	40.0	50.0	45.9	251
Good	40.0	30.4	34.4	188
very good	1.3	0.3	0.7	4
N	225	322	–	547
	χ^2 (P–value) = 8.336 (0.080)			

Source: Field Survey, 2017

However, there was a significant difference between respondents rating of their QOL according to sex. About half of the female respondents (50.0%) rated their QOL as neither poor nor good compared to

forty per cent of male respondents (Table 4). About forty per cent of male respondents (40.0%) rated their QOL to be good, while only about less than one third of the female respondents (30.4%) reported their QOL to be good

Type of Living Arrangement and Quality of Life

Older people's living arrangement is an important factor that influences their QOL. In the present study, a little over than one-third of the total respondents (35.4%) living with their son/daughter rated their QOL as good while the corresponding figure those elderly living with spouse only was more than forty per cent (41.9%). (Table5). Nearly half of the respondents (48.7%) took a neutral stand suggesting that they rated neither good nor poor with their QOL.

Table 5

Per cent distribution of quality of life of respondents according to their current living arrangements.

Quality of life	*Type of Living Arrangement*						*N*
	spouse	*son/ daughter in law*	*Daughter/ son in law*	*Grand Children*	*Other family members*	*Alone*	
Very poor	7.0	2.1	0.0	16.7	0.0	13.3	17
Poor	23.3	13.1	25.0	33.3	100.0	46.7	87
Neither poor nor good	25.6	48.7	50.0	33.3	0.0	33.3	251
Good	41.9	35.4	25.0	16.7	0.0	6.7	188
Very good	2.3	0.6	0.0	0.0	0.0	0.0	4
N	43	466	8	12	3	15	547
	χ^2 (P–value) = 60.056(0.000)						

Source: Field Survey, 2017

Further, nearly half of the respondents (46%) living alone rated their QOL as poor while all the elderly people living with other family members (i.e., nephew/nice in law) rated their quality of life as poor. One-third of the respondents living with grand children rated their quality of life as poor and another one sixth proportion of respondents living with grand children rated their quality of life as very poor.

Reason for living alone and Quality of life

Reason for living alone is an important factor that influences their QOL. In the present study, about two-third of the total respondents (66.7%) living alone due to no support from children rated their QOL as poor while the corresponding figure of elderly living alone due to children living in other areas and having no own children was less than 45 per cent (44.4% and 33.3% respectively)(Table 6). Further, more than half of the respondents who live alone due to the children living in other areas (55.6%) took a neutral stand suggesting that they rated neither good nor poor with their QOL.

Table 6

Per cent distribution of quality of life of respondents living with alone

Quality of life	*Causes of living alone*			*N*
	No support from children	*Children living in other areas*	*No own children*	
Very poor	0.0	0.0	66.7	2
Poor	66.7	44.4	33.3	7
Neither poor nor good	0.0	55.6	0.0	5
Good	33.3	0.0	0.0	1
N	3	9	3	15
	χ^2 (P–value) = 15.714(0.015)			

Source: Field Survey, 2017

One-third of respondents (33.3%) who live alone due to no support from children rated their quality of life as good. Two-third of the respondents living alone due to no own children rated their quality of life as very poor.

Perceptions about their Current Living Arrangement and Quality of life

Perception about living arrangements is an important factor that influences the quality of life of older people. The data on perception of older people about their QOL thus clearly reveals that almost all the respondents (100%) perceived their current living arrangements as satisfied very much also rated their quality of life as good. Less than half of the respondents (39.4%) perceived current living arrangements as satisfied also rated their quality of life as good.

Table 7

Per cent distribution of quality of life of respondents with their perception on current living arrangement.

Quality of life	*Perceptions about their current living arrangement*					*N*
	satisfied very much	*satisfied*	*Neither satisfied nor dissatisfied*	*not satisfied*	*not satisfied very much*	
Very poor	0.0	1.7	1.6	3.6	100.0	7
Poor	0.0	10.6	36.5	35.7	0.0	87
Neither poor nor good	0.0	47.3	41.3	51.8	0.0	251
Good	100.0	39.4	20.6	8.9	0.0	188
Very good	0.0	1.0	0.0	0.0	0.0	4
N	7	414	63	56	7	547
	χ^2 (P–value) =291.773(0.000)					

Source: Field Survey, 2017

Almost all respondents (100%) perceived current living arrangements 'not satisfied very much' rated their quality of life as very poor. Slight more than forty per cent respondents (41.3%) perceived their current living arrangements as neither satisfied nor dissatisfied rated their quality of life as neither poor nor good. The result is statistically significant.

Discussion

The questions posed for discussion are: what are the current living arrangements of the elderly? Are older persons living arrangements associated with perceived quality of life? Does this relationship differ by gender? How does the quality of life of the elderly living in the different types of living arrangements vary? First, an attempt is made here to discuss the relationship between the types of living arrangements of the elderly and their quality of life. From the findings, it is observed that those who live with the spouse, followed by those who live in parent-child co-residence fared better in terms of quality of life. Those who lived in parent-child co residence reported the lowest degree of loneliness and a better adaptation to old age. Moreover, the results also showed that the levels of quality of life differed according to types of living arrangements. More specifically, those living with other family members (i.e., nephew/niece in law) and alone fared the

worst. In this context, Gee (1999) found that living alone significantly reduces quality of life among Chinese-Canadian elder people. More specifically, Chinese elderly widows live alone at risk of low well being. On the other hand, Huang & Liu (2016) concluded that living with children may generate negative effects on elders' wellbeing. The elders who do not live with children may have more time and opportunities to participate in community activities and develop their network, which may help them achieve better quality of life. Mckillop (2016) found that quality of life in those who live with family is statistically significantly better than among those who live alone. It was observed that the respondents living alone due to no support from children rated their QOL as poor compared to those elderly living alone due to children living in other areas and having no own children

Gender differences in perceived well-being may be more or less prominent depending on the social setting and living arrangement. However, there was a significant difference between respondents' rating of their QOL according to sex. About half of the female respondents (50.0%) rated their QOL as neither poor nor good compared to forty per cent of male respondents. About forty per cent of male respondents (40.0%) rated their QOL to be good, while only about less than one third of the female respondents (30.4%) reported their QOL to be good. Studies investigating perceived well-being in rural South African settings have found gender effects; however, the strength of the relationship is contested. In several studies, older women report worse quality of life evaluation than older men (Gómez-Olivé *et al.*, 2010; Nyirenda *et al.*, 2012; Schatz *et al.*, 2012). In addition, in rural samples there is also evidence that differing gender expectations may be influencing affective well-being, with older women reporting worse affective well-being (Schatz *et al.,* 2012). Both gender and age of an individual may influence quality of life of older people. In this context, Kofi Annan (1999), the former United Nations Secretary-General, pointed out that, 'women comprise the majority of older persons in all but a few countries. They are more likely than men to be poorer in old age, and more likely to face discrimination.' The current study also found that about 1.3 per cent older male respondents rated their QOL as very good while the corresponding figure for female respondents was only 0.3 per cent.

The current study found significant difference between perception of older people with their current living arrangements and their perception towards quality of life. Older people who perceived their current living arrangements as satisfied very much also rated their quality of life as good and older people who perceived current living arrangements not satisfied very much rated their quality of life as very poor.

Limitations of the study

The limitations of the study are as: This study is limited on the selected households of rural area of Kailali district and focused only on the elderly people aged 60 years and above. This study has adopted simple statistical tools such as frequency, percentage, average, rate, ratio, etc. Most part of the research is based on descriptive approach. The study has used the responses of elderly to understand about their living arrangement and their perception on quality of life from themselves.

Conclusions

Majority of older respondents (85.65%) irrespective of sex live with their son/daughter in law. More than half of the total respondents (60.0%) living alone reported that they have to live alone due to the reason that their children are living in other areas. Almost three quarters (75.68%) of the total respondents reported to have a satisfied life with their living arrangement. Near about one-third of them (34.4%) reported their QOL to be good and nearly one-sixth (15.9%) reported their QOL to be poor. By sex disaggregation, forty per cent of male respondents (40.0%) rated their QOL to be good, while the corresponding figure for female respondents was less than one third (30.4%). Two-thirds of the total respondents (66.7%) living alone due to no support from children rated their QOL as poor while the corresponding figure of those elderly living alone due to children living in other areas and having no own children was less than 45 per cent (44.4% and 33.3% respectively). Almost all the respondents (100%) perceived their current living arrangements as satisfied very much also rated their quality of life as good.

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References

Chalise, H.N. & Ghimire P.K (2018). Does population ageing affect the least developed country like Nepal? *OAJ Gerontol& Geriatric Med. 2018; 3(4): 555618. DOI:10.19080/OAJGGM.2018.03.555618*

Chalise HN, Kai I, Saito T (2007). Significant variables of self-reported health: A study of older adults from a developing country – Nepal. BioScience Trends 1: 102–107.

Chalise HN (2010). Social support and its correlation to loneliness and subjective well-being of Nepalese older adults. Asian Social Work and Policy Review 4: 1–25.

Chalise HN (2012). Socio-demographic and health status of Nepalese elderly. Indian Journal of Gerontology 01/2012/26: 151–160.

Chalise HN Rai SL (2013). Prevalence and correlates of depression among Nepalese Rai older adults Journal of Gerontology and Geriatric Research 2: 1.

Chalise HN, Basnet M (2017). Abuse of older adults residing in the community of Nepal. J Gerontol Geriatr Res 6: 415.

Cumming, E; &, Henry, W.E. (1961). *Growing Old: The process of disengagement.* New York: Basic Books

Domingo, L.J., &Casterline, IJB. (1992). *Living arrangements of the Filipino elderly.* Michigan: Population Studies Center.

Fernández-Ballesteros R. &Santacreu I. M. (2010). *Ageing and quality of life*. In JH Stone, M Blouin.(eds). International Encyclopedia of Rehabilitation. Available online: http://cirrie.buffalo.edu/encyclopedia/en/article/296. (Accessed on 08 May 2018).

Gee, E. (1999). Living arrangement and quality of life among Chinese Canadian elders. *Social Indicators Research*. 51(3): 309–329. Retrieved from: http://www.ncbi.nim.nih.gov/.../Pmc5664. Dated on Sep 16, 2000. (Accessed on 24 February 2018).

Gómez-Olivé, F. Xavier, Margaret, T, Benjamin, C. Kathleen & Stephen, T. (2010). Assessing health and well-being among older people in rural South Africa. *Global Health Action 3(Supplement 2).* Retrieved from www.globalhealthaction.net. (Accessed on 24 February 2018).

Huang. X, & Liu, J. (2016). Living arrangement and quality of life among older adults in china: how does social cohesion matter?. *The Gerontologist. 56 (3):589–603.* Retrieved from https://doi.org/10.1093/geront/gnw162.2375. Dated on 1 November 2016 (Accessed on 24 Feb 2018).

Jestha Nagarik Ain, 2063 and Regulation, 2065. Kathmandu: Government of Nepal.

Kofi Annan (1999): *UN press release SG/SM/6893.* New York: United Nation. Retrievedfrom www.un.org/press/en/1999/19990920.sgsm7136.html. (Accessed on 16 March 2018).

McKillop, M. (2016). *Household living arrangement and quality of life in adults with mental illness.* (Unpublished doctoral dissertation). The University of Western Ontario. Retrieved from https://ir.lib.uwo.ca/etd/4293. (Accessed on 26 February 2018).

Nyirenda, M. *et al.,* (2012). An Investigation of Factors Associated with the Health and Well-Being of HIV-Infected or HIV-Affected Older People in Rural South Africa. *BMCPublic Health* 12(1):259–72. Retrieved from http://www.globalhealthaction.net/index.php/gha/article/view/19201. (Accessed on February 11, 2018

Nyirenda, M. *et al.*, (2013). Health, Wellbeing, and Disability among Older People nfected or Affected by HIV in Uganda and South Africa. *Global Health Action 6(0).* Retrieved fromhttp: //www.globalhealthaction.net/index.php/gha/article/view/19201. (Accessed on February 11, 2018).

Schatz, E., Xavier, Gómez-Olivé, Margaret R., Jane M.& Stephen T. (2012). The impact of pensions on health and wellbeing in rural

South Africa: Does Gender Matter? *Social Science & Medicine* 75(10):1864–73. Retrieved from https://www.ncbi.nlm.nih.gov /.../22884944. (Accessed on February 05 2018).

United Nations. (1991). *Ageing and Urbanization*. New York: United Nations.

United Nations. (2005). *Living arrangements of older persons around the world.* New York: Department of Economic and Social Affairs, Population division, United Nations Secretariat. Retrieved from www.un.org/.../population/publications/livi...(Accessed on 19 March 2018).

WHOQOL-Group. (1993). Study protocol for the World Health Organization project to develop a quality of life assessment instrument (WHOQOL). *Quality of Life Research,* 2: 153–159. Retrived from http://www.who.int/msa/mnh/mhp/ql1.htm. (Accessed on 19 March 2016).

WHO, (2002). *Active ageing a Policy Framework*. World Health Organization to the Second United Nations World Assembly on Ageing, Madrid, Spain, April 2002. Retrived from http://www.who.int/msa/mnh/mhp/ql1.htm. (Accessed on 09 May 2016).

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To Disclose or not to Disclose? The Benefits and Risks of Person with Dementia: A Journey Through Research Literature

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ABSTRACT

Disclose or not to disclose is a matter seriously debated today. Opinions differ. Books and journals have expressed varied view points on this matter in favour of or against. This paper makes an attempt to assess this fact with a critical perspective. It is found that disclose or not to disclose has different dimensions, that is, the age of the person with dementia, the severity of the disease, family support system, etc. are factors that influence these dimensions. The fact that the available literature and books are yet to find scientific findings to disclose or not disclose is to be seriously considered. Disclose or not to disclose becomes a challenge when the rights and dignity of a person with dementia is pitted against the attitude of family and the society around him. This paper has found that disclosure definitely helps the person with dementia and his family. But, unfortunately, under certain circumstances disclosure did not have the effect that was expected. This paper is a serious journey to discover the pros and cons of 'disclose or not to disclose' based on available literature and practical experience.

Key words: disclose, not to disclose, person with dementia.

The diagnostic disclosure in dementia has been debated extensively in professional journals, books, Media, etc. Bamford C., *et al.*, (2004) tried to review empirical data regarding diagnostic disclosure in dementia. They found that the impact of disclosure indicates both negative and positive consequences of diagnostic disclosure for people with dementia and their carers. Existing evidence regarding diagnostic disclosure in dementia is both inconsistent and limited.

Even experienced physicians find it difficult to disclose a diagnosis of dementia. Studies during the past decade suggest that diagnostic disclosure in dementia is inconsistent, with up to 50 per cent of clinicians routinely withholding a diagnosis of dementia (Carpenter B., and Dave J., 2004). Current guidelines state that the issue is no longer one of whether or not to disclose the diagnosis of dementia, but rather how and when to do so. Disclosure should take a patient-centred approach that maintains personal integrity and instil a sense of hope. (Fisk J.D., *et al.,* 2007) If the person with dementia is in a position to understand the situation then disclosure can help him prepare for eventualities.

Discussion

Yet most elderly patients would wish to be told of a diagnosis of dementia in order to plan, settle family matters, and pursue travel (Carpenter B., and Dave J, 2004). The need for sensitivity cannot be overstated. Dementia is a progressive, terminal disease, but unlike many other terminal illnesses, there are often social implications. Making a diagnosis of dementia has been described as both a medical process and a social act that moves the patient to a new social group, one that is highly stigmatized.

Persons with dementia in the early stages of Alzheimer disease describe experiencing shame, discrimination, rejection, social isolation, loss of the sense of control, and altered self-image (Aminzadeh F, *et al.,* 2007). Also there is a big difference in acceptance between educated society and uneducated society due to the cultural differences. Lanting, S., *et al.,* (2011) argues that there is a close relationship between the degree of acceptance and socio cultural conditions. However it is possible to enable persons with dementia to live normally with dignity.

Cassell (2004) lists the 3 goals of medical care that are applicable to any chronic disease: 1) make diagnostic or therapeutic plans in terms of the sick person, not the disease; 2) maximize the patient's function; and 3) minimize the suffering of the patient and the family. These goals are very much applicable to dementia care. This is not applicable to older primary care persons with dementia. They seem to perceive themselves as having no cognitive symptoms and refuse dementia diagnostic assessment despite their positive screening results. (Boustani, M *et al.*, 2007.)

A diagnosis of dementia can be devastating for patients and family who grieve progressive losses of functioning and independence and face an uncertain future. A caring, committed relationship with the family physician can help to reduce suffering and facilitate healing as patients and family members come to terms with this demoralizing terminal illness.

As Buckman (1992) notes, 'The task of breaking bad news is a testing ground for the entire range of our professional skills and abilities. If we do it badly the patients or family members may never forgive us; if we do it well, they will never forget us.'

The mind set of the person with dementia can greatly be influenced by the person who primarily breaks the unpleasant news to the person with dementia and the family. Considerable study need to be done to determine the benefits and risks of disclosure.

Disclosure

Debate has always raged about disclosure or not of the conditions of a person with dementia. There is no doubt that disclosure of the state of health of a person with dementia is important for him to tackle the course of his future life. Steeman E *et al.*, (2006) pointed out that in the early stages, dementia may challenge quality of life. Research on early-stage dementia is mainly in the domain of biomedical aetiology and pathology, providing little understanding of what it means to live with dementia. Knowledge of the lived experience of having dementia is important in order to focus pro-active care towards enhancing quality of life.

Relevance of disclosure

Diagnostic disclosure of dementia is a process and it should include many things. Fisk, J.D., *et al.,* (2007) recommend that a progressive disclosure process be employed to address issues including: remaining diagnostic uncertainty, treatment options, future plans, financial planning, assigning power of attorney, wills and 'living wills', driving privileges and the need for eventual driving cessation, available support services, and potential research participation. Diagnosis can be beneficial for both the persons and their care givers (Bond, 2001) and Cayton (2004) goes as far as claiming that diagnosis is essential as it gives meaning to a person's illness.

However, some research suggests that early diagnosis is the preferred option among person with dementia and their families (Jha *et al.,* 2001 and Elson, 2006). There are a number of benefits for a person with dementia arising from a diagnosis (Pratt & Wilkinson, 2001), including a sense of relief, because it allows for planning and provides an explanation for troubling behaviors and emotional responses within a medical framework that attributes cause to a physical factor outside the patient's control (Smith & Beattie, 2001). It may also mark the end of a difficult stage of confusion and uncertainty and allows for legal protections such as power of attorney to be awarded to next of kin.

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals (Rosenstock, I. 1974). It is important to focus on goals of management when disclosing a diagnosis of dementia; each plan should accommodate the specific needs of the patient, maximize functioning (e.g., through lifestyle and pharmacologic interventions), and minimize suffering to ensure the highest quality of life for the longest period of time.

Robinson *et al.,* (2011) say after review of 35 papers of dementia disclosure 'The vast majority of people with dementia wished to know their diagnosis. The key challenges for the person with dementia were coming to terms with losses on multiple levels''. The long term suffering in dementia seems to be more for the family and carers than the person with dementia.

We have to consider the familial perspective of dementia including the carers. So, this process should involve not only the affected individual but also their family and/or other current or potential future care providers (Fisk, J.D., *et al.,* (2007) by telling the truth, we are respecting the right to know what is happening in person with dementia and acknowledging his or her potential to face the challenges of life. It is essential to help the person to make preparations for dealing with the gradual decline in memories. Ultimately, we are giving the person an opportunity to fight with his destiny.

From the study of relevant research papers consideration has to be given to other relevant factors that influence the disclosure to the person with dementia.

Age Differences and Disclosure

There is a major difference in the effect of disclosure in younger people with dementia and older people with dementia. Rossor, M, *et al.,* (2010) emphasise that the diagnosis of dementia is devastating at any age but diagnosis in younger patients presents a particular challenge. The differential diagnosis is broad as late presentation of metabolic disease is common and the burden of inherited dementia is higher in these patients than in patients with late-onset dementia. At early stages of memory loss, individuals use self-protecting and self-adjusting strategies to deal with perceived changes and threats. However, the memory impairment itself may make it difficult for an individual to deal with these changes, thereby causing frustration, uncertainty and fear (Steeman E., *et al.,* 2006).

So, particular care has to be taken for disclosure to younger persons with dementia and their caregivers. Even the carers' age also plays vital role in this process. However, some research suggests that early diagnosis is the preferred option among PWD and their families (Jha *et al.,* 2001 and Elson, 2006).

The author worked with Alzheimer's and Related Disorders Society of India and interacted with younger persons with dementia whose young carers were distressed at the disclosure but later were thankful for the disclosure which helped them handle the situation and give quality care. The younger care givers were significantly more likely to feel that such an opportunity would have been useful. Most

of the care givers who had informed the sufferer said that the sufferer had wanted to know, or needed a meaningful explanation for their difficulties, rather than giving more practical legal or financial reasons. In the author's follow-up sessions with these young carers and persons with dementia I have noticed substantial improvement in their quality of life.

A study (Beattie, A., *et al.,* 2004) draws on the findings from 14 qualitative in-depth interviews with younger people with dementia conducted in the South-west of England, and considers some of the issues involved in interviewing people with dementia My experience with younger people with dementia corroborates well with the above study in that younger people manage their problems better than older people and analysis is that age plays a major role in persons with dementia and their carers.

Benefits of Disclosure

Considering all the findings in our analysis and available research literature it can be surmised that disclosure has benefits to the persons with dementia and their carers. The awareness of the disease is the beginning of quality life through quality care.

Carpenter and Dave (2004) say that in gaining knowledge and developing a treatment plan, individuals may realize that they can take an active role in managing the illness, enhancing a sense of self-efficacy where before they might have felt helpless.

Clare, L. *et al.,* (2005) suggests that expression of awareness interacts with coping style, illustrating the need to consider both factors in combination in order to better understand individual expressions of awareness of change. Disclosure will help the person to engage in cognitive exercises that will slow down the decline process and it will help the person to plan his day-to-day activities. Also disclosure process helps the person to complete his or her commitments and it is easy to get full enjoyment in remaining life in a wise manner. The analysis based on this has similar comparisons in my experience with person with dementia and carers.

Glaser, B.G. (1992) and Clare, L. *et al.,* (2008) made a study based on grounded theory model and argued that awareness in people with moderate to severe dementia who still communicate verbally proposes

that demonstration of awareness involves a set of analytic and behavioural processes, a scope or timescale, and a focus. This awareness may create a sense of clarity in their life. Clare (2008) again mentions that awareness is demonstrated in relation to a given focus and scope through the involvement of cognitive processes of varying degrees of complexity, ranging from registering through appraising and interpreting to reflection. This finding by Clare goes well with the person with dementia in my areas who have accepted the reality and have focus on planning their future life.

It is important to consider the points made by Bamford, C., *et al.*, (2004) and this state of knowledge seems at variance with current guidance about disclosure. There is no doubt that the focus of attention should be the person with dementia care whether it is disclosure or not disclosure.

The author met persons with dementia and their carers who have indicated the need to take family members of the person with dementia in to confidence to make ongoing assessment of persons with dementia. Robinson L, (2011) claims that there is still little empirical research observing the process of diagnostic disclosure in dementia and studies exploring the views of patients and their families suggest this should be an ongoing process with the provision of support and information tailored to individual needs. There are benefits of disclosure but it must be admitted there are certain risks in it.

Risk of Disclosure

Disclosure of life affective problem is disconcerting to anyone creating anxiety; depression, etc. This is true also for persons with dementia. Gilmour, J. (2005) show that the understanding of the reality for people is essential given that representations of the catastrophic impact of dementia generate high levels of anxiety and depression.

Disclosure could be considered by person with dementia as a Damocles' sword, not knowing what is going to happen. Iliffe & Manthorpe (2004, p. 103) rightly raise the question of hazards of the early recognition of dementia, the demand for assessment based upon the 'Alzheimerization' of older age, demand to meet the needs of those

traumatised by the diagnosis and the resource pressure of supporting more people for longer; a view upheld by others

Disclosure could upset his mental makeup and leave him with little hope. It can create confusion and instil a sense of incapability to handle his future and that of his family.

Process of Disclosure

The author remembers the relief of the family members of a friend's father who was diagnosed with Alzheimer's disease when an explanation of the disturbing changes that had been happening over the years was explained to him and his family. Robbie Foy**,** *et al.*, (2007) suggests that for people with dementia, patient-centred care should involve timely explanation of the diagnosis and its implications. I believe that person with dementia and his or her family members have the right to know the diagnosis as early as possible.

Journey to Disclosure

On the basis of this analysis of the research literature and the meta analysis (Greenland S, 2008) available and personal experience with persons with dementia and their care givers the author believes that disclosure should be a phased out process rather than a hasty disclosure.

This process of Disclosure could be Phased Out as Suggested Below:

Phase 1: Explain the changes in the behaviour as well as cognitive pattern. It is advisable to explain in detail social issues as well. Clare, L. *et al.*, (2005) claim that, the onset of dementia may be viewed as a threat to self-occasioning attempts to regain control through a range of psychological strategies, which are likely to affect the ways in which people communicate an account of their experience and hence the extent to which they may be considered 'aware'.

Phase 2: Explaining the clinical reasons of this change including the changes in cognitive function, memory, orientation, etc.

Phase 3: Explain what dementia is and how it can be dealt with. It is the time to discuss the common symptoms and management of dementia

Phase 4: The changes of the brain should be explained. Also inform the neurological issues of dementia, if the person with dementia is mildly affected.

Phase 5: Inform the final prognosis and give person with dementia the confidence to carry on with the assurance that a person with dementia can live.

Phase 6: Explain to the person with dementia how this unexpected challenge can be managed and how systematic planning can be done for symptomatical control. Help of family members will go a long way.

Phase 7: Explain how grief can be reduced and also how to reduce risk. Awareness of memory clinics, day care centres, respite centres, etc. should be given. Encouragement to become positive ambassadors can be given. Spiritual awakening can also be used.

Conclusion

Understanding the reality of the situation is vital for a person with dementia to deal with life and its intricacies. He can plan his life and understand the situation early enough to take steps to put things in perspective and act accordingly. The freedom to understand one's state of health is a fundamental right of any person. It is therefore the right of every person with dementia to fully understand his state of health and not disclosing it to him is a violation of human rights. All through the analysis of the research literature it is clearly understood that the early disclosure of the state of health of a person with dementia gives him the opportunity to make a properly binding will. It helps him leave a legacy. Information about the state of health frees a person with dementia from uncertainties. To prevent the shock of a sudden disclosure it would be advisable to use the services of doctors, councillors and interdisciplinary team to break the news in a gentle but professional manner. They will help plan a healthy life style.

References

Aminzadeh, F., Bysgewski, A., Molnar, F.J. and Eisner, M. (2007): Emotional impact of dementia diagnosis: exploring persons with dementia and caregivers' perspectives; *Aging Ment Health*, 11(3) 281–90.

Bamford, C., Lamont, S., Eccles, M., Robinson, L., May, C. & Bond. J. (2004): 'Disclosing a diagnosis of dementia: a systematic review', *International Journal of Geriatric Psychiatry,* Vol. 19, No. 2, pp. 151–169.

Beattie, A., Daker-White, G., Gilliard, J. & Means, R. (2004): 'How can they tell? A qualitative study of the views of younger people and their dementia and dementia care services', *Health and Social Care in the Community,* Vol. 12, No. 4, pp. 359–368. (online journal)

Bond, J. (2001): 'Sociological perspectives' in Cantley, C (ed.) *A Hand Book of Dementia Care*. Buckingham; Open University Press. pp. 44–61.

Boustani, M., Cathy, S., and Yonceb, S. (2007): The Challenges of Supporting care for dementia in primary care, *Clin Inter Aging,* 2(4), 631–636.

Buckman R., (1992): *How to break bad news. A guide for health care professionals. Baltimore, MD: Johns Hopkins* University Press.

Carpenter B., and Dave J. (2004): Disclosing a dementia diagnosis: a review of opinion and practice, and a proposed research agenda. *Gerontologist;* 44*(2):*149–58.

Cassell, Eric, J. (2004): *The Nature of Suffering and the Goals of Medicine,* Oxford Scholarship online.

Cayton, H. (2004) 'Telling Stories; Choices and Challenges on the Journey of Dementia' *Dementia*, Vol. 3 (1) pp. 9–17.

Clare, L., Roth, I. & Pratt, R. (2005): 'Perceptions of change over time in early-stage Alzheimer's disease', *Dementia,* Vol. 4, No. 4, pp. 487–520.

Clare, L., Rowlands, J., Bruce, E., Surr, C. & Downs, M. (2008): 'I don't do like I used smoderate to severe dementia living in long term care', *Social Science and Medicine,* Vol. 66, No. 11, pp. 2366–2377. (Online journal)

Elson, P. (2006): Do older adults presenting with memory complaints wish to be told if later diagnosed with Alzheimer's disease? *International Journal of Geriatric Psychiatry*, 21, pp. 419–425.

Erde EL, Nadal EC, Scholl TO. (1988): On truth telling and the diagnosis of Alzheimer's disease. *J Fam Pract*; 26*(4):* 401–6.

Fisk, J.D., Beattie, B.L., Donnelly, M., Byszewski, A. & Molnar, F.J. (2007): 'Disclosure of the diagnosis of dementia', *Alzheimer's and Dementia,* Vol. 3, No. 4, pp. 404–410. (online journal)

Gilmour, Jean (2005): Finding the Balance living with memory loss, *International Jr. of Nursing Practice.,* 11(3) 118–124.

Glaser B.G., (1992): *Basics of Grounded Theory Analysis: Emergence vs. Forcing*, California: Sociology Press.

Greenland S, O' Rourke K. (2008): Meta-Analysis. in *Modern Epidemiology*, 3rd ed. Edited by Rothman KJ, Greenland S, Lash T. Lippincott Williams and Wilkins; Page 652.

Iliffe, S. and Manthorpe, J. (2004): 'The Hazards of early recognition of dementia: a risk assessment', *Aging and Mental Health*, Vol. 8, No. 2, pp. 99–105. (Online journal)

Jha, N. Tabet, M. Orrell. (2001): To tell or not to tell-comparison of older patients' reaction to their diagnosis of dementia and depression. *International Journal of Geriatric Psychiatry*, 16 (9), pp. 879–885

Lanting, S., Crossley, M., Morgan, D. & Cammer, A. (2011): 'Aboriginal experiences of aging and dementia in a context of sociocultural change: Qualitative analysis of key informant group interviews with aboriginal seniors', *Journal of Cross Cultural Gerontology,* Vol. 26, No. 1, pp. 103–117. (Online journal)

Pratt, R., Wilkinson, H. (2001): 'Tell Me the Truth' – The effect of being told the diagnosis of dementia from the perspective of the person with dementia. Mental Health Foundation, London.

Robbie, Foy, Jillian, J.F., Marie, J., Martin, E., Jan, E., Claire, B. and Jeremy, G. (2007): The Development of the thoery – based intervention to promote appropriate disclosure of a diagnosis of dementia, *BMC Heal Services Research* 7: 207.

Robinson, L., Gemski, A., Abley, C., Bond, J., Keady, J., Campbell, S., Samsi, K. & Manthorpe, J. (2011): 'The transition to dementia –

individual and family experiences of receiving a diagnosis: a review', *International Psychogeriatrics,* Vol. 23, No. 7, pp. 1026–1027.

Rosenstock, I. (1974): Historical Origins of the Health Belief Model. *Health Education Monographs.* Vol. 2, No. 4.

Rossor, M., Mummery, C., Schott, J. & Warren, J. (2010): 'The diagnosis of young-onset dementia', *The Lancet Neurology,* Vol. 9, No. 8, pp. 793–806. (online journal)

Smith and Beattie, (2001): A. Smith, B. Beattie, Disclosing a diagnosis of Alzheimer's disease: patient and family experiences, *Canadian Journal of Neurological Sciences,* 28, pp. S67–S7

Steeman E., De Casterles′ B. D., Godderis, J. & Grypdonck, M. (2006): 'Living with early-stage dementia: a review of qualitative studies', *Journal of Advanced Nursing*, Vol. 54, No. 6, pp. 722–738. (Online journal)

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The Nature of Retirement: Factors Responsible for Affecting Retirement Decision

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ABSTRACT

The present study focuses on the core factors of the human life during retirement decision which influences their timing of retirement. Retirement is a crucial part of officially working people. They have to face it once in a lifetime but between pre-retirement and post-retirement some of the factors always influence them. They struggle with the questions of why and how they can take retirement decisions which can make their future secured. This research paper is based on a descriptive research design by secondary data method to describe the nature of retirement and tried to explore major factors which influence it. Family obligation, Education of children, pre-planning for retirement, fear of financial insecurity in term of reduced income, physical disability during the work time are some of the social and economic issues which may influence the timing of retirement decision of working people during pre-retirement phase of life.

Key words: Retirement decision; Obligation; Insecurity; Pre and post-retirement.

Old age is a biological and natural process in which people face many challenging stages throughout their lives and retirement is one of them. Retirement initially is a new feeling of freedom from hectic

schedule of life and job work, competitions with colleagues, some obligations and some commitments. From the role strain perspective, retirement from the demands of a career job may reduce the role strain (i.e. felt difficulty of managing overload and conflict) (Kim J.E. & Moen P., 2001). Sometimes retirement is a chance to create new opportunities for self-chosen activities which a retiree used to do or wish to do earlier. Now there is no wake-up alarms and hurries early in the morning, no publication dead line to meet and no daily schedule to follow. It may be a reunification of relations or time to build a strong or balanced relation within the family and peer groups. Now there is more time to spend with them, sufficient time to meet with relatives and make travelling plan anytime with spouse or family but in many cases the situation is totally opposite, that means, after retirement life becomes stressed and painful which leads to depression and tension inside the family. Retirement is not an easy phase to cope with many dimensions of life i.e. social, psychological and emotional, that's why it is stressful for many.

The most obvious effect of retirement is insufficient and inadequate income, especially for those who had low salary during the job. After retirement, there is an erosion of authority of the elderly due to transition from the role of a provider to dependent, and this results in lack of respect for the elderly as well as neglect too. In our country, when the employee is in service, various health & medical facilities are provided to him/her, but these facilities are suddenly stopped after their retirement. While such medical facilities are needed more during this crucial time, especially for those people who have low salaries and pensions coverage. Finance and expenditure planning, health care facilities, involvement in various social and traditional activities, better access to life in the retirement years, would have been more effective if planning had started earlier.

If we see in the context of India, it is difficult to understand how long parents need to look after their children and take their responsibility? Economic factor is the most important one to determine it. Ultimately it is the economic condition of the young that determines the actual retirement from active life and makes parents relieved of their children's responsibility. In India, parents consider their child 'settled', till the time they become financially strong to run their household on their own. Young children depend totally on their

parents and have little opportunity to use resources to influence parents (Malhotra & Chadha, 2007). Bad financial condition of the family is one of the basic reasons behind familial tension in the household after retirement. The chain is long but it can be understood by a simple fact that not having a career till late age lead to depression and to overcome it, an individual behaves rudely to everyone else in the family, which ultimately leads to breakdown of anger and tension among all the members of the family. Parents can look after their children till a definite age, after that the dependency of the child on them remains insecurity of future which ruins their old age. This fact is mostly seen among the families in which a person gets pension but it is not enough to run a family. Problems of retirees get aggravated with an entry in old age due to financial dependency. At present, in India old age, specially for those who are not financially secure during their crucial stage of life is difficult. They have to depend on their children or on interest of their savings which is a very nominal income for them at this period.

Retired/Old age is usually discussed in connection with the different types of problems encountered by the aged and the welfare measures associated with providing them a better quality of life. Unfortunately, far too many retirees evaluate their life in terms of only one or two criteria, such as material wealth or health. Retirement is assimilated with old age which means reduced physical ability, declining mental ability, the gradual giving up of role playing in socio-economic activities and a shift in economic status from economic independence to economic dependence upon others for support when social security or pension is not adequate. Urbanization, modernization and globalization have led to a change in the economic, social and cultural structure, the erosion of societal values, weakening and disinterest of social values and social institutions such as the joint family. As per the Census, the average size of household in India fell to 4.9 in 2011 from 5.4 a decade ago, and as per the National Sample Survey Organization estimates, in fiscal 2012; nearly 40 per cent of the urban household had 3 people or less.

Nature of Retirement

The classification and exact meaning of retirement may not be considered in one framework due to multi-dimensional feature of retirement. Several authors have defined its meaning through the

nature of retirement, criteria of job, withdrawal efficiency from the current job, physical capacity and more. Retirement is a new feeling of freedom from hectic schedule of life & job work, competitions with colleagues, some obligations and some commitments. Sometimes retirement is a chance to create new opportunities for self-chosen activities. Strieb G.F. (2002) has tried to give a suitable definition of retirement, he revealed that 'A retired person is one who has relinquished his mid-life job or position for a life of greater freedom and leisure and who relies on other sources than wages, salary or profit for the major portion of his current living'. Retirement may be a reunification of relations to build a strong or balanced relation with family members and peer groups to spend more time with them, sufficient time to meet relatives and make travel plan anytime with spouse or family. Retiring from a job is likely to be the beginning of another career, so retirement from one job is just another type of career transition (Kim N., & Hall D.T., 2013). The convergence of several demographic and economic trends have created a great interest among the financial community and the general population alike in planning for that period of life called retirement (Greninger S.A. & *et al.,* 2000). Retirement often means changes in income, health, residence, friends, and the division of household labour (Kim, J.E. & Moen, P., 2001). The main problems of retirees may include: fear of being physically weak, psychological tension, fear of social negligence, shortage of friend circle and peer group, empty time and fear of widowhood. We have acquired some perspectives of life and learned how to deal with some stresses (Hepner, W., 1969). Many studies reported retirement as a stressful life event, due to certain circumstances of the event itself as well as the specific personal characteristic of the retiree (Sharma K.N., *et al.,* 2015).

Most of the definitions of retirement do not give clear, comprehensive and precise picture which may be universally acceptable definition of retirement. Gustman, *et al.,* 1995), revealed in their study that there is no consensus in the literature regarding the definition of retirement. Many studies focus on the condition of retirement in any particular age. Retirement is mostly considered when anyone withdraws from his current position or job completely. But many questions come in mind on this definition of retirement. Firstly, elderly persons who at the age of 60+ years retired from their current job and are enjoying/adjusting the rest of their life with family members or visiting/spending their leisure time anywhere, is it the

real meaning of retirement? Secondly, a person who gets enough of money (from EPF, GPF and other retirement benefits) after his retirement and invests that money in starting a business with the help of his family member or members or with other friend or known person. At this age (above 60 years) he works continuously and earns good amount of profit from business. Can he be considered a retired person? Thirdly, a person who gets good amount of money from his retirement benefit schemes and he invests all his savings to build a new home, for children's marriage, their education and other functions. After all these expenses he again starts doing job in an unorganized sector for his own requirements, in spite of the fact that his body doesn't allow him to work. Is he a retired person in a real sense? Fourth, a person who retired happily and wants to spend rest of his life with his children but so called urban life style of his children due to their busy life schedule or urban life style are unable to give time to him or his father (parents). In turn the children send him to 'Old Age Home' without any pre information or support. Is life of 'Old Age Home' retirement in real sense? These are some questions which evaluate the nature of retirement in gerontological perspective. Hepner H.W. (1969) also point out that some people whose careers call for creative talents i.e. artist, musician, writers, singers, researcher, philosopher and more never really retire and they continue to contribute in their knowledge, skills and guidance to others.

Factors Influencing the Period of Retirement

Family Obligation

Family obligation is not considered as a responsibility, it depends on family's authority, status and inter-relation between various family members. Usually when people are in service they take major and most of the decisions with the assent of family members or with consultation of family members. But after retirement, erosion of authority gradually increases and it happens normally due to physical disability and not remaining the bread earner of family. Now most of the educated children (or present generation) take family decisions without consulting their parents. Parents may wish to continue to control their children's behaviour while younger generation wishes to establish own autonomy (Malhotra & Chadha, 2007). Although a healthy relation and communication between family members after

the retirement leads to a psychological satisfaction of their well being. Close family relationship involve high level of attachment and affection built up over the entire life (Ibid).

Family is a primary unit of society where members of the family depends on each other for financial, social and psychological support. The basic function of the elderly/parents is the tension/problems management of their children. The children also help the parents/elderly family members in solving their problems. Three factors that contribute to retirees subjective well being are: a) Economic resources, b) Social relationship, c) Personal resources (Kim J.E. & Moen, 2001).

India is a land of traditional and spiritual values and heritage where elder people are always the most reliable source of knowledge. The elderly persons in the family brought up children through their own life's experiences. Indian people still believe that by the blessings of elder people they get four types of fortunes; Long Life, Wisdom, Fame and Power. Caring after the retirement, when elderly persons become old-old (very old 80+), had never been a problem in India because a value-based joint family system was supposed to prevail. Indian culture had originally been well formed and supportive to elders under *'Ashrama Vyavastha'*. Joint family structure in our society and intergenerational understanding in family, as well as values attached to it provided emotional strength, security and adjustment to old person in the family.

Education

Education always influences individual's income and income influences economic condition before and after retirement. Having a higher education and higher prestige job prior to retirement has been linked to greater satisfaction after retirement (Palmore *et al.,* 1984). As we know that education is always a good weapon to explore the limits of mind. So it provides better opportunities to again start an active life to earn that happiness by doing the desired job. Education determines the economic condition of individuals through their salary level or their expenditure level. Low paid salary workers face many economic challenges before and after retirement and they are not able to fulfil family obligation accordingly while high paid salary workers always

increase their economic condition as well as psychological satisfaction level which is beneficial for them after retirement.

Pre-planning for Retirement

It has been revealed in most of the studies that majority of retirees indicated that retirement is not the end of one's working activity. More than three-fifths both male and female claimed that retirement was not the end of life or one's working activity (Ogunbameru O.A. & Bamiwuye, 2007). This statement indicates that working for salary or money only is not the complete aim of our life. Living or working for the cause of society or doing some social work, etc. may enhance the ultimate aim of life. After all a mechanized life is not a life in real sense. A human's life always is a life of happiness he or she desired, for which he earned like machine. Retirement policies rely on the predictability of individuals' retirement behaviour (Szinovacz *et al.*, 2015). In the pre-retirement phase, the role of HR in helping employees to prepare for retirement is discussed, focusing primarily on financial planning and other retirement related benefits (Rau, *et al.*, 2012).

Fear of Financial Insecurity

Working people probably assume during the stage of pre-retirement that after retirement their income (in the form of pension) will be decrease and that will be affected my monthly expenditure and family obligation. Some literature also reveal that reduced income of retirees after retirement tends to make them feel insecure financially. People might say they would like to retire earlier, but they probably would not be willing to reduce current income even further in order to do it (Atchley R.C., 1976). People often prefer mandatory retirement as compared to voluntary retirement if they are physically and mentally fit. Because they want to get enough retirement benefit coverage like pension, Gratuity fund over as many years as possible till the minimum service requirement or minimum age retirement. Continued financial liabilities, even for adult children who have left the household, may render retirement economically more difficult (Szinovacz *et al.*, 2015). Early retirement is usually a system under which employees are allowed to retire before they become eligible for a social security retirement pension. Too early retirement usually affects their pension coverage as well as other retirement benefits

(ibid). Especially those in low paid or physically arduous job, the unavoidable obligation of being expected to work for longer may be viewed much less positively (Loretto W., 2010). Physical disability influences retirement life of retiree. His children become busy in their own life (job, family) and they don't give enough time to properly take care of him. Such problems may get worse when both (son & daughter-in law) are engaged actively in working sector. With increasing age and decreasing health, the older person begins to depend unknowingly physically and psychologically on either the kinship or the existing Social Support Network (Shettar, S.C., 2013).

Most of the study also revealed that financial crisis is not a major problem for those who get retirement from public sectors. They face less economic challenges as compared to non-public sector retirees. Economic dependency would be higher among the groups who have retired from unorganized sector (Mane, 2016). Public sector gives their employees better facilities like social assistance and social insurance after retirement as a form of pension, life coverage, and relaxation in tax, health care and more things. The earning of workers in the unorganized sectors is not only relatively lower than their counterpart in the organized sectors but many times are too low to provide the minimum subsistence level of living (Sirohi, A., 2005). Parents in this circumstance cannot always count on financial support from their children and may have to take care of themselves (Shettar S.C., 2013).

Physical Disability

Ogunbameru and Bamiwuye (2007) indicate the attitude of retirees towards retirement in their study. They found out that higher percentage respondents disagreed with the assertion that when a person gets retired his health is affected. Sometimes it is also seen that a retiree desires to explore more to contribute to family or society but his illness and weak body doesn't allow him. Physical disability may be one of the reasons for voluntary retirement to working people from their work or designation. Good physical along with mental health of retiree leads to the decision of retirement. Working people wish to continue his job for the retirement benefits but physical disability becomes a barrier for that. Some of the areas may be considered for such things but where physical activities are more important (i.e.

defence, force, police, etc.) for the job may not allow an employee to continue work. Besides physical ailments, psychiatric morbidity is also prevalent among large proportion of elderly (Shettar, S.C., 2013). One of the study of Pollman (1971) reveals that about 25 per cent of the respondents cited health as primary reason for the retirement.

Life Satisfaction

Retirement promotes marital satisfaction by reducing competition from other roles; thereby increasing opportunities for marital companionship and intimacy (Kim J.E. & Moen, 2001). Unfortunately, far too many retirees evaluate their life in terms of only one or two criteria, such as material wealth or health (Hepner W., 1969). In the term of individual's life satisfaction, expectancy theory suggests that motivation to employees for a good reward and pays lead to them a good satisfaction before and after retirement. Satisfaction of retirement life depends on how they nourished their family requirements, how much economic independence they have before and after retirement, what type of relationship with colleagues and family members before retirement. Due to rapid advanced development and changing socio-economic scenario retired people may have to face many challenges to get the satisfaction in their lives. Changing traditional values among youth lead negligence to them, reduced saving level due to family obligation, expensive health care expenditure, breakdown of social institution like joint family system may also affect their satisfaction of life after retirement. Women with children were more prone to retire, whereas childless married women and childless non-married men were less inclined to retire (Szinovacz *et al.*, 2015). Every person has two types of personal goal which give the individual a strong sense of personal worth or satisfaction. First, involve learning to respond to life by developing certain personal qualities like; honesty, ambition, cheerfulness, kindness and so on. While second types of goals are materialistic and involve achieving ownership of property like; land, house, car, etc.

Conclusion

Satisfaction of life is one of the most important goals of every individual but all these willing and unwilling desires may not be possible in every situation. People either adjust with some desire or try

to find out the way of satisfaction through appropriate strategies or not. *Psychoanalytical theory* of Sigmund Freud illustrates that people's desire which is controlled by Id part of mind, always try to fulfil their willing or unwilling desire if he gets successful he gets satisfied but if he fails the frustration becomes high. In this situation, people always push their unwilling desires into unconscious mind with the help of Ego part of mind. *Maslow's Need of Hierarchy Model* also indicates that every people's ultimate goal is to get self-actualization which directly means to achieve satisfaction of life. Above sixty years of age when people's health ability, mental capacity, and psychological process gradually decrease then they start becoming conscious about their health and opt for yoga and exercises. Through *Indigenous Therapies* which is basically a form of Yoga can engage and improve retired people's over all fitness that also promotes physical, psychological as well as spiritual growth to them through different modes like; *Asanas, Pranayam* (breathing exercise) and *meditation* for their inner strength and peace. Such kind of practices will decrease their physical as well as psychological problems and maintain their expenditure on health which is very expensive in the present context. Due to less health problems the expenditure done on medication can be saved and they can utilize this amount for family obligations and other things. Some studies need to focus on the issue that in pre-retirement stage retirees can make appropriate strategies for their retirement.

References

Atchley R.C., (1976). *The Sociology of Retirement*, Schenkman Publishing Company, Cambridge.

Greninger, S.A., Hampton, V.L., Karrol A. Kitt, and Susan Jacquet (2000): Retirement Planning Guidelines: a Delphi Study of Financial Planner and Educator, *Financial Service Review* (9), 231–245.

Gustman, A.C., Mitchell, O.S., and Steinmeier, T.L., (1995). Retirement Measure in the Health and Retirement Study, *Journal of Human Resources*, 30, 57–83.

Hepner, H.W., (1969). *Retirement – A Time to Live A New*, McGraw-Hill Book Company; VBVB.

Kim J.E., and Moen, P., (2001). Is Retirement Good or Bad for Subjective Well-being?, *Current Directions in Psychological Science,* 10(3) pp. 83–86.

Kim, N. & Hall, D. T., (2013). Protean Career Model and Retirement, in Mo Wang (ed.) *The Oxford Handbook of Retirement*, Oxford University Press, New York, pp. 102–116.

Loretto, W., (2012). The Domestic and Gendered Context for Retirement, *Human relations*, 66(1), 65–86

Malhotra, R., & Chadha, N. K., (2007). Family Relations of the Elderly after Retirement and Widowhood, In K.L. Sharma (ed.) *Studies in Gerontology*, Rawat Publications, Jaipur, New Delhi, pp. 117–130.

Mane, A.B. (2016): Ageing in India: Some Social Challenges, *Jr. of Gerontology & Geriatrics* 5(2), 136.

Ogunbameru, O. A., & Bamiwuye, (2007). Attitude of Nigerian Retirees towards Retirement, *Indian Journal of Gerontology*, 21(4), 415–424.

Palmore, E.B., Fillenbaum, G.G. and George, L.K. (1984): Consequences of Retirement, *Jr. of Gerontology,* 39 (1) 109–116.

Pollman, A.W. (1971): Early Retirement: A comparison of poor health to other retirement factors; Jr. of Gerontology, Vol. 36 (1), 41–45.

Rau, B. L., and Adams, G. A., (2012). Aging, Retirement and Human Resources Management: A Strategic Approach, in Mo Wang (ed.) *The Oxford Handbook of Retirement,* Oxford University Press, New York.

Sharma, K.N., Karunanidhi, S., & Chitra, T., (2015): Determinants of Psychological Well-being among Retirees, *International Research Journal of Social Science*, 4(3), 19–26

Shettar, S.C. (2013): Problems of Aged in Changing Indian scenario, *Yojana,* August 01.

Sirohi, A., (2012): *Social Policy and Administration: The Challenges of Poverty and Equality*, Wisdom Press Delhi.

Streib, G.F. (2002): An Introduction to retirement communities, *Research on Aging*, 24: 3–9.

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Existence of Senior Citizen in Election Manifesto in India

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ABSTRACT

The present study has done a comparative descriptive analysis of manifestos on senior citizen issues released by national political parties (NPPs). Authors have taken all national political parties' manifestos except CPI and Nationalist Congress Party (NCP) since authors could not find these two national political party's manifestos while searching. All the manifestos were taken from respective national political party's website. Assessment of manifesto was designed by a group of scholars who are doing their research in the field of ageing (and extensive literature review), and it was agreed that each statement related to senior citizens published in the manifesto would be assessed for five sections of senior citizen issues. After download, the manifestos were shared between authors for assessment (each assessment done by sitting together) of mentioned five areas, and authors given points from manifesto's attention on selected five domains of senior citizen issues. The range of point was between 0 and 10, where least attention means 0 and highest attention means 10. The analysis revealed that in 2014, three out of four parties discussed a solution on financial problems faced by the elderly. Except for BJP, no other party discussed the healthcare of the elderly. Even when the major part of the elderly population is in distress, no vital importance was

given by the political parties to the elderly population in their manifestos. In 2009, INC didn't mention the topic of the senior citizen in its manifesto, but in 2014 the party mentioned the financial security problem in its manifesto. Similarly, in 2009, BJP only mentioned about pension in its manifesto, but in 2014 the party gave more importance to financial security and also mentioned the healthcare of elderly and old age homes in its manifesto. So we can say that increasingly parties are giving importance to the problems of the elderly population in their manifestoes.

Key words: Senior citizen, India, manifesto, National political parties.

India is the largest democratic country which functions through the multiparty parliamentary representative system and the second most populous country in the world. The world's population has continued to pass through the remarkable demographic transition from high birth and death rate to one characterized by low birth and death rates. At the heart of this transition has been the growth in the number and proportion of older persons. Such a rapid, large and ubiquitous growth has never been seen in the history of Civilization (Norman & Henderson, 2003). The hefty increase in human life expectancy over the years results in not only in unprecedented growth in the number of older persons but in a major shift in the age groups of 80 and above. As per the estimation of United Nation in the years 2000–2050, the overall population growth will be approximately 55 per cent whereas 60 years, and above (younger elderly) would rise by 326 per cent, and age group of 80 and above (oldest older) will grow by 700 per cent which is the quickest growing group (U.N. 2002). As per the definition given by the ministry of social justice and empowerment, 'a senior citizen means any person being a citizen of India, who has attained the age of sixty years or above' (ministry of social justice and empowerment). One in every eight of the world's elderly population lives in India and most of them never retire in the usual term (Ministry of Social Justice and Empowerment, 2011). Though the number of elderly population is tremendously increasing overall welfare programs are not growing to support the quality of life of elderly in India.

There are seven national political parties (NPPs) in India (Kumar *et al.*, 2017). In a democracy, there is an old saying that 'government of

the people, by the people, for the people'. Historically issues related to senior citizen (ageing population) have been the political campaigns during several elections held in developed countries, but in India elderly population issues are yet to take political centre stage. Election manifesto plays a crucial role in party competition as well as party standing (Eder *et al.*, 2017). The manifesto is nothing but the commitment of political parties which has a great influence on national policy (Kumar *et al.*, 2017). Vision and intentions of National Political Parties (NPPs) can be known with the help of mature promises in the manifesto (Ibid). A political party publishes its manifesto as a reference document to the people which tells that, once. The party forms a government documented services and benefits that would be provided. According to election commission of India, 'a manifesto usually defines a published declaration of the intentions, motives, or views of an individual, group, political party or government or whosoever issues it' (Ibid). Election manifesto consists typically of an ideology of the political party and its policies and programs for the country, which is then placed for electors to cast their vote in favor of the party (Ibid). The present study has focused on the comparative analysis of senior citizen issues in different political party manifestos.

Methodology

There are seven national political parties in India based on election commission notification issued on 13 December 2016. The present study has done a comparative descriptive analysis of manifestos on senior citizen issues released by NPPs. The seven national political parties are Indian National Congress (INC), Bharatiya Janata Party (BJP), All India Trinamool Congress (AITMC), Communist Party of India-Marxist (CPI-M), CPI, Nationalist Congress Party (NCP), and Bahujan Samaj Party (BSP). Authors have taken all national political parties' manifestos except CPI, BSP and Nationalist Congress Party (NCP) since authors could not find these three national political parties' manifestos while searching. All the manifestos have been taken from respective national political party website. Assessment of manifesto was designed by a group of scholars who are doing their research in the ageing field (and extensive

literature review), and it was agreed that each statement related to senior citizen published in the manifesto would be assessed for five aspects of senior citizen issues. These are Pension & financial security, Healthcare, Old age home, Difficulties in transportation, and Elderly abuse. After download, the manifestos were shared between authors for assessment (each assessment done by sitting together) of mentioned five areas, and authors gave points for manifesto's attention on selected five domains of senior citizen issues. The range of point was between 0 and 10, where least attention means 0 and highest attention means 10. The present study has done four national political parties' (Indian National Congress, Bharatiya Janata Party, All India Trinamool Congress, Communist Party of India-Marxist) manifestos assessment for 2014 Lok Sabha (People's House) elections of India, and two national political parties' (Indian National Congress, Bharatiya Janata Party) manifestos assessment for 2009 Lok Sabha election.

Objectives

1. To know the importance or existence of senior citizen issues in different political party manifestos.
2. To study the changes of various political party manifestos in light of senior citizen issues.

Results

In 2014 most of the parties included the topic of pension in their manifestoes, as Congress stated in its manifesto that our Nation's citizens, and particularly our senior citizens, deserve greater security with regard to their pension funds, but it didn't discuss any plan, scheme or goal in its manifesto so 6 points were given to INC, on the other hand, BJP mentioned this issue in its manifesto by stating 'will provide financial support, exploring ideas like additional tax benefits and higher interest rates. ', BJP also gave special importance to the problem of financial security in old age by stating 'Devise schemes and programs to engage the Senior citizens as volunteers/part time workers in various development programmes of the government, in urban and rural areas. This will not only help in utilizing their time, but also it would be an effective utilization of their experience and

may add an additional source of income for them', so 9 points were given to BJP. CPI(M) gave impressible attention to elderly pension in its 2014 manifesto. AITMC didn't state anything about the elderly in its manifesto.

INC didn't mention any vision, goal, strategy or scheme for the health of elderly in its 2014 manifesto, so no points were given to INC. BJP, on the other hand, put a spotlight on this issue by stating 'Senior Citizens BJP is committed to the welfare of senior citizens, especially their security and health care' and 'Senior Citizens healthcare would be a special focus area', so 7 points were given to BJP. CPI(M) didn't mention anything about the healthcare of the elderly in its 2014 manifesto

Similarly, INC didn't discuss old age homes, BJP stated in its 2014 manifesto that they would invest in setting up and improving old-age homes, but they didn't mention any scheme or strategy, so 5 points were given to BJP. CPI(M) in its 2014 manifesto stated that they would Build a network of old-age homes/daycare centres with State support. No party discussed anything about the solution of elderly abuse and problems faced by elderly in transport.

In 2009 INC didn't mention anything about the elderly population of India, and BJP only discussed financial security by stating 'Income of all senior citizens by way of pension will be exempt from Income Tax' (BJP Manifesto, 2009).) and 'Women and senior citizens will receive an additional exemption benefit of Rs 50,000', but they didn't discuss pension for the elderly so only 4 points were given to BJP.

We can see from Table 2 that in 2009, INC didn't mention the topic of the senior citizen in its manifesto, but in 2014 the party mentioned the financial security problem in its manifesto, so we can say that there was a slight improvement. Similarly in 2009 BJP only mentioned about pension in its manifesto, in 2014 the party gave more importance to financial security and also mentioned the healthcare of elderly and old age homes in its manifesto. So we can say that slowly parties are giving importance to the problems of the elderly population.

Table 1

Assessment of statements made in manifestos of National Political Parties for 16th Lok Sabha (people house) elections in the year 2014, India

Domains of senior citizen issues	*2014*			
	INC	*BJP*	*AITMC*	*CPIM*
Pension & financial security	7	9	0	9
Healthcare	0	7	0	0
Old age home	0	6	0	7
Difficulties in transportation	0	0	0	0
Elderly abuse	0	0	0	0

Note: where least attention means 0 and highest attention means 10.

Table 2

Assessment of statements made in manifestos of National Political Parties for 15th Lok Sabha (people house) elections in the year 2009, India

Domains of senior citizen issues	*2009*	
	INC	*BJP*
Pension & financial security	0	4
Healthcare	0	0
Old age home	0	0
Difficulties in transportation	0	0
Elderly abuse	0	0

Note: where least attention means 0 and highest attention means 10.

Discussion and Conclusion

Currently, a large proportion of the elderly population in the country is spending its life in soreness, when they are most dependent on others for support. An NGO, Agewell Foundation, conducted a study across the country that revealed that about 71 per cent of the elderly population suffers from health-related problems, 65 per cent from financial distress, 63 per cent from social problems and 43 per cent from psychological issues like loneliness and marginalization (Bhatnagar, 2017). We all know that it is government's responsibility to provide a conducive living environment to all the citizens of the country and elderly are an integral part of the society and their problems are as important as other problems. It was estimated that less than 10 per cent of the Indian population has Health Insurance (either public or private) and roughly 72 per cent of all Healthcare spending is

out of pocket. The ageing population is facing more problems, as the Health Insurance Scheme for the poor covers only those aged 65 or younger. Another important problem for the elderly concerns their economic well-being. There is no official data on the income of the elderly in India. Mass poverty is the Indian reality, and vast majorities of families have an income far below a level that would ensure a reasonable standard of living. India's Ministry of Social justice and empowerment (2011) in its document on the national policy for older persons, has relied on the figure of 51 million elder living below the poverty line. Studies on the wellbeing of the elderly in developing countries show that there is a high degree of dependency in old age in term of both economic and physical support (Barrientos *et al.*, 2003). It was found that 54 per cent and 20 per cent of elderly males and females respectively had some source of income of their own, a higher proportion of the elderly depend on their family (Berkman *et al.*, 2012). Inadequate income is a major problem for the elderly in India (Raju, 2002).

Why a party's manifesto is important is because it displays the ideological direction of the party, so it becomes very important to assess the manifestoes of the NPP's to analyse how much they care about the elderly population of the country. Financial dependence is one of the significant effects that disturb the life of older persons; to deal with this, pensions are provided to needy elderly persons. We saw that in 2014, three out of four parties discussed a solution on financial problems faced by the elderly. BJP and CPI(M), seemed serious about this problem as they comprehensively mentioned this issue in their manifesto.

Economic development and population ageing have contributed to an emerging non-communicable disease trend, such as cardiovascular disease and obesity, previously thought to be a concern mostly for affluent or developed countries (Mahal *et al.*, 2010). According to World Health Organization (WHO, 2009), standardized age mortality due to cardiovascular disease among adults 60 years old or older was 1978 for 1,00,000 persons in India, Compare to 800 per 1,00,000 in the United States. In just 20 years the number of people suffering from diabetes increased from 30 million to more than 177 million. By 2,030, as many as 366 million people worldwide will be diabetics and the

fastest growth will be in developing countries (WHO, 2007). Old age is the age of physical decline, the immune system becomes weak, hereupon the whole body becomes weak and the chances of becoming diseased increases manifold, so healthcare of the elderly becomes an important issue. Sadly, in 2014 except BJP none of the other parties gave attention to this problem in their manifesto.

According to a survey conducted by 'Help Age India' in 2018 half of India's elderly (50%) reported experiencing abuse. About 77 per cent lived with their families and most of the times abuser was a relative (Help Age India). This abuse and financial problems make the life of an old person at home very difficult. In such a situation old age home becomes the only support of an old person. None of the parties gave any special attention to old age homes in their manifesto; two parties didn't even discuss anything about it.

We all know that in India there is a scarcity of resources in transportation, due to over-crowding and lack of infrastructure, aged persons, especially those who are financially weak and cannot afford expensive category travelling, face a lot of problems during travelling. Sadly, there is no discussion about this problem in any party's manifesto.

As mentioned earlier the prevalence of elderly abuse is high in India, the national crime records bureau in 2014 reported 18,714 incidences of crimes against senior citizens, and as a whole, the rate is 18.3 per cent in India. Agewell-India's report displayed that one in every fourth elderly admitted that their family members are exploiting them. In this type of scenario, the elderly section of the population needs a policy, scheme or any programme to spread awareness against elder abuse so as to detract its severity. Sadly, no party mentioned its severity anything about this in its manifesto. Even when the major part of the elderly population is in distress, no vital importance is given by the political parties to the elderly population in their manifesto. Lastly, we can say that slowly parties are giving importance to the problems of the elderly population in their manifestoes.

Strength and Limitation

In Web of Science, authors searched several terms (Election Manifesto and elderly OR senior citizen OR Ageing OR Aging) to

have relevant published literature, but authors could not find any documents. In the same way, in Pubmed, authors used terminologies like election manifesto AND elderly OR senior citizen OR Ageing OR Aging and got two pieces of literature, but both were not contextual. Finally, authors had done targeted literature review but could not found the mention of these terms. So, as per the knowledge of authors, probably the present study is going to be the first study which is combining both senior citizen and election manifestoes (Though there is numerous literature which relates several aspects with election manifesto except senior citizen). So, it will play a pioneering role for further research in this field. In spite of authors' profuse desire, they could not show the trend of selected national political partys' manifestoes on the importance or existence of senior citizen issues since authors did not find sufficient documents of selected parties. The present study is only focusing on the importance or existence of senior citizen issues in different political parties' manifestoes. But there are many sentences in the manifestoes which are describing the overall population's problems, but authors did not consider them. So only from the present study's findings, one cannot generalize how much good or bad a manifesto is since authors did not consider any aspect other than senior citizens' plight.

References

All India Trinamool Congress Manifesto. (2014). People will have their say Its Mamata all the way. [Last accessed on 16–01–2019]. Available from: http://aitcofficial.org/wp-content/uploads/2016/03/Manifesto-English-for-web.pdf.

Barrientos, A., Gorman, M., & Heslop, A. (2003). Old age poverty in developing countries: contributions and dependence in later life. *World Development*, 31(3), 555–570.

Berkman, L.F., Sekher, T.V., Capistrant, B., & Zheng, Y. (2012). *Social networks, family, and care giving among older adults in India.* National academies Press (US)

Bhatnagar, Gaurav Vivek. *The wire*. 07 28, 2017. [Last accessed on 16–01–2019]. Available from: https://thewire.in/politics/india-elderly-population-distress.

BJP Manifesto. (2009). Good governance development security. [Last accessed on 16–01–2019]. Available from: https://www.bjp.org/images/pdf/election_manifesto_english.pdf.

BJP Manifesto: (2014). Sabka Saath Sabka Vikas: Ek Bharat Shreshtha Bharat. [Last accessed on 16–01–2019]. Available from: http://www.bjp.org/images/pdf_2014/full_manifesto_english_07.04.2014.pdf.

CPI(M) Manifesto. (2014). [Last accessed on 16–01–2019]. Available from: https://cpim.org/elections–2014/manifesto.

Eder, N., Jenny, M., & Müller, W. C. (2017). Manifesto functions: How party candidates view and use their party's central policy document. *Electoral Studies*, *45*, 75–87.

Help Age India (2018): 'Elder Abuse In India https://www.helpageindia.org/elder-abuse.

Indian National Congress Manifesto. (2009). Aam Aadmi ke Badte Kadam Har Kadam Par Bharat Buland. [Last accessed on 16–01–2019]. Available from: http://incmanifesto.a-i.in/manifesto09-eng.pdf.

Indian National Congress Manifesto. (2014). Your Voice Our Pledge. Lok Shabha Elections. Manifesto: [Last accessed on 16–01–2019]. Available from: https://www.inc.in/images/Pages/English%20Manifesto%20for%20Web.pdf.

Kumar, D., Kumar, R., Chauhan, R., Chander, V., & Raina, S. K. (2017). Pattern of health promises for Indian democracy: A qualitative review of political manifestos. *Journal of family medicine and primary care*, *6*(3), 455.

Ministry of Social Justice and Empowerment. (2011). National Policy on Senior Citizens. [Last accessed on 16–01–2019]. Available from: http://socialjustice.nic.in/writereaddata/UploadFile/dnpsc.pdf

Ministry of social justice and empowerment. Department of Social Justice and Empowerment. Government of India. [Last accessed on 16–01–2019]. Available from: http://socialjustice.nic.in/Home/SiteSearch?Search=senior%20citizen

Norman, R. A., & Henderson, J.N. (2003). Aging: an overview. Dermatologic therapy, 16(3), 181–185.

Raju, S. S. (2002). Health Status of Urban Elderly: A Medico-social Study. BR Pub.

World Health Organization. (2007). Ten statistical highlights in global public health. World health statistics, 9420.

World Health Organization. (2009). Disease and injury country estimates.

United Nations (2002): World population Ageing: 1950–2050. Department of Economic and Social affairs, Population Division,. New York.

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