Old Age in an Indifferent Society

Old Age in an Indifferent Society

T.K. Nair (Ed)

Old Age in an Indifferent Society
By T.K. Nair (Ed)

Publisher : Ramesha M.H. for Niruta Publications, # 244, 3rd Main, Poornachandra Road, MPM Layout, Mallathahalli, Bangalore-560056, Ph : 080-23212309, Mob : 9980066890
Email: ramesha.mh@gmail.com, nirutapublications@gmail.com
www.niratanka.org

Printed at: Niruta Print Solutions, # 244, 3rd Main, Poornachandra Road, MPM Layout, Mallathahalli, Bangalore-560056, Ph: 080-23212309, Mob: 9980066890
Email: ramesha.mh@gmail.com, nirutapublications@gmail.com
www.niratanaka.org

First Edition : 2013
ISBN : 978-81-923326-3-5
Pages : 146
First Impression : 1000 copies
Paper : NS Maplitho 70 GSM
Price : 200/-
Size : 1/8th Demy
Cover Page Design : Premnath M
Cover Photo : M.Nadarajah
Typeset : Shivakumar

Dedicated to
Millions of Elderly Men and Women
Who Toil Day and Night for
Survival

Contents

Preface

Ageing is an inevitable, natural phenomenon. From nearly hundred million in 2011-2012, the estimated sixty-plus population of India will be around three hundred and twenty million in 2050. This phenomenal increase poses many challenges and provides many opportunities depending on the perception and preparedness of the central and state governments. This edited book, a collection of articles, aims at addressing some issues.

The first article discusses the concept of old age. One of the earliest studies was by Marulasiddaiah. Old people of Makunti, published after a long gap, was based on a village study conducted by him more than fifty years ago. His findings are relevant even today. A significant feature is with regard to the partition of the family property. Often the parents, along with the land, house, utensils, ornaments, grains, money, and other trivial things, are also divided. Visweswara Rao's article on the rural elderly analyses the situation of the older people in Indian villages. He also reviews the relevant policies and programmes.

Devi Prasad, as the title of his article suggests, narrates the struggles of the elderly victims of abuse and neglect in the Indian families. The stories of elder abuse reveal two main angles according to Devi Prasad. One is that the patterns of elder abuse reflect the prevailing negative stereotypes towards the elderly and their roles in the society. The other is how we are explaining the phenomenon of ill-treatment of the elderly in the larger context of socio-economic realities.

The role of traditional medicines as well as the close link between the health of the ageing population and Ayurveda are examined by Unnikrishnan. He observes "approach to elderly care should be based on the vision of reinforcing family and community-based care in a locally driven process harnessing

locally available resources and knowledge". Siva Raju outlines the research priorities in the field of aging. He quotes from the Research Agenda on Ageing for the 21st century adopted by the Second World Assembly on Ageing at Madrid 2002 : "There is a need to assess the 'state of the art' of existing knowledge, as it varies across countries and regions, and to identify priority gaps in information necessary for policy development".

Nair has added four articles. In State and the Elderly, he analyses the weaknesses of the existing social security measures. The indifferent attitude of the state towards the elderly has been discussed as seen from the lack of proper implementation of the National Policies since 1999. In the article on Eldercare Services, he suggests community-based services. Life Satisfaction in Old Age is a field study-based article. Mean life satisfaction score of the elderly is found to be low. Life satisfaction score of the urban elderly is double that of the rural elderly. Life satisfaction level is also associated with health status, economic condition, and belief in re-birth. The last article is on issues concerning neglect of the older persons in a society of indifference.

Elder care in India meant homes for the aged till 1979, when Helpage India and the Centre for the Welfare of the Aged (CEWA) pioneered non-institutional services in Madras city. Ajith presents a case study of CEWA and its contribution to a new approach in promoting participatory elder care services which can be replicated in different parts of the country with region-specific adaptations. Nightingales Medical Trust (NMT) in Bengaluru has taken initiative to "take health care to the elderly at their door". Many family-based health support systems for the senior citizens belonging to different socio-economic groups are initiated by NMT. Of particular significance is the unit for therapy and rehabilitation of patients affected by Dementia and Alzheimer's disease. KalpanaSampath developed the case study

of NMT based on repeated visits and discussions with the important functionaries.

I thank Prof H.M. Marulasiddaiah, Chief Adviser, and M.H. Ramesha, Editor of SamajaKaryadaHejjegalu (Social Work Foot-Prints) for their love and support. I also thank NIRUTA Publications for publishing this book.

T.K.Nair
September, 2013

Acknowledgment

SamajaKaryadaHejjegalu (Social Work Foot-Prints), a bilingual social work journal (Kannada and English) in Karnataka with a national readership, brought out a special issue on Ageing India in April, 2013. Prof.T.K.Nair was the guest editor. The readers appreciated the articles. Hence Prof.H.M.Marulasiddaiah, our Chief Adviser, suggested the publication of the articles as a book with the addition of some more articles. Prof.Nair accepted our request. The present volume is the outcome of the suggestion of Prof. Marulasiddaiah.

We are indebted to Prof. Nair for his enthusiastic co-operation. I am grateful to Prof. Marulasiddaiah,our mentor, who is ever willing to guide us. I am very much thankful to our Niratanka team for their hard work.

M. H. Ramesha
Publisher
September, 2013

Contributors

K. N. Ajith: Vice-President and Head (HR and FMS), Mytrah Energy (India) Ltd. After his Master of Philosophy degree, he is pursuing research on Human Resource Practices. His book Corporates & Social Responsibility published in 2011 was well-reviewed and well-received.

Dr.B.Devi Prasad : Professor at the Centre for Equity for Women,Children and Families at the School of Social Work at the Tata Institute of Social Sciences.Earlier he was Director of the Centre for Social Studies at Surat and Professor of Social Work at Andhra University.

Dr. H.M.Marulasiddaiah : A senior social work educator in India. Was Professor and Chairperson at the Department of Social Work at the Bangalore University. A popular Kannada scholar he has authored many books. He is also a prolific writer on social work and his books in English are equally popular. He has been in the forefront of cultural, literary and social welfare activities for many decades in Karnataka.

Dr.T.K.Nair : Chairman of the Centre for the Welfare of the Aged. Was Professor and Principal at the Madras School of Social Work. Authored many books on social work and ageing.

Dr.Kalpana Sampath : Director of Arpitha Associates. Is a well-known HR Professional and organisational development consultant. A Masters' degree holder in classical dance, she is a versatile behavioural science and education consultant to many organisations.

Dr.S.SivaRaju : Professor and Chairman at the School of Development Studies at the Tata Institute of Social Sciences. A

specialist on research issues on ageing, he has been active on UN-sponsored studies on old age and eldercare.

Dr.PayyappallimanaUnnikrishnan :Research Co-ordinator at United Nations University-IAS at Tokyo. A graduate in Ayurvedicmedicine,he holds a Masters degree in Medical Anthropology and a PhD degree in International Development.

Dr. K.VisweswaraRao : Professor of social work at Andhra University. His book on Ageing in Rural India is a popular book based on village studies.

Old Age

T.K.Nair

Aging is a long term process of change for both individuals and populations. However, the concept and process of aging are surrounded by considerable controversy and suspect evidence. Human aging is a process of differentiation and individualization. Aging has two integral elements – intrinsic and extrinsic. Intrinsic aging means those age-related processes that are internal and specific to the individual, while extrinsic aging comprises those age-related changes that are brought about by external factors related to the physical and social environment of the individual (United Nations,1982). Older persons, who were born at a particular historical time, and in a particular region and society, belong to a cohort sharing similar social and historical experiences, life-styles and other characteristics which differentiate them from other older persons born at different historical periods in diverse social situations. Individuals derive social meanings and develop expectations regarding themselves, their families and their society as they grow older from these processes of aging and within the context of social, historical, cultural and economic situations.

Old age is a relative concept which varies from society to society. In fact, there are several explanations of old age and we are likely to slip unknowingly from one to another. Though aging is a universal process, identifying the chronological threshold to old age is not possible. Depending on the expectation of life, the definition of old age is found to vary from about 40 in some developing countries to 70 and beyond in some developed countries.

The common assumption is that the passage of time , as measured by the chronological age , is a reliable index of changes in our minds and bodies, and in our abilities and limitations. But

this assumption is highly erroneous which is well illustrated by the example of compulsory retirement (Kastenbaum, 1979). The age of 65 is still the most frequent cut-off point for compulsory retirement in developed countries although more diversity has been shown lately. It is the institution of retirement which clearly labelled a section of persons old. Social historians contend that the social constructs of 'youth 'and 'old age' have in fact grown up after the industrial revolution (Aries,1962). There is no scientific support for retirement at any particular chronological age. These age markers have no foundation in any biological reality. Instead, political and economic reasons have been responsible for the age-based retirement practice. In India, the mandatory age of retirement of most of the personnel in government service ranges from 55 to 60. Only a small section could work till 65.

The World Assembly on Aging held in 1982 under the auspices of the United Nations adopted the definition of aging population as persons 60 years and older without obscuring the great individual, societal and temporal differences in actual and perceived characteristics of the elderly population. The United Nations (1985) report adds that such a demarcation is convenient only for statistical analysis .The Census of India has been adopting the age of 60 years to classify a person as old. Gerontologist Neugarten (1974) points out that, with increased survival ratesand improved health, it is becoming apparent that there are two, rather than one, strata of aging population, which she has distinguished as the young-oldupto 74 years) and the old-old (75 years and above) . **Ayurveda**, the traditional system of Indian medicine, divides human life span into ten stages and categorizes the aging persons into two broad groups :**Vriddha** (60 to 80 years) and **Jaratha** (above 80 years) .

The definition of old age is dependent on the cultural norms and social context of any society. In India, **Shashtiabdapurthi**, which means the completion of 60 years, is traditionally celebrated as a significant milestone, while the completion of 70 years is celebrated as **Sapthadi**, which is an achievement in

the life span of an individual. It is the duty of the offsprings to celebrate these milestones. But these are observed only by the well-to-do and those belonging to the upper castes. In most of the societies under the influence of Chinese culture, the sixty-first birthday has been associated with the beginning of old age (Maeda 1978). In ancient China, the calendar year was named with the combination of two sets of Chinese characters – one consisted of twelve characters and the other five characters. Therefore, on becoming sixty-one years old, the name of that year becomes same as that of the year of birth. Hence the sixty-first year after birth is called **Kanreki** (return of the calendar) which is often regarded as the beginning of second childhood. In Japan many people used to hold a passing rite to mark **Kanreki**. At the time of the ceremony of **Kanreki**, the person becoming sixty-one used to be presented by the children and relatives with a red vest designed to signify the coming of second childhood. Generally speaking, people of sixty years of age and over are not obliged to work to earn money. In other words**, kanreki** signifies the social sanction permitting entry into **Inkyo,** meaning retired life, though most Japanese elderly people continue to work. But now the concept of old age is changing greatly in Japan. Age sixty marks a universally accepted point in time for entry into the oldest generation in China (Friedmann, 1983). Consequently, in terms of social functioning, the years between fifty and sixty are a transition period in which Chinese men and women come increasingly to be seen by others and by themselves as old, while the years after sixty mark a clearcut turning point and are virtually always designated as the years of old age.

The marriage of one's children –particularly of one's sons – marks the beginning of old age in Indian society far more clearly than does the passing of a specified number of years. This is especially so for women (Vatuk, 1975). The arrival of grandchildren is strongly associated with the onset of old age in Indian and many other societies. The birth of a first grandchild also encourages self identification as an old person. For those persons who had their child at about eighteen and whose first

born also had a first child at eighteen, grandparenthood can come as early as age thirty-five or thirty-six. The effects of the family life cycle may have different implications for people living in different cultures. In societies, where marriage and child bearing occur at young ages, persons may achieve the "old age" status of grandparent while in their thirties as discussed earlier. In other contexts, where childbearing is delayed because of the desire of young women for education and work experience, persons attain this status at more advanced ages. Thus, even if persons are defined as "elderly" with reference to similar social roles, there are great differences among societies in the chronological age at which such roles are attained (United Nations, 1985).

Society has another way of classifying people by age. Anthropologists refer tothis as age-grading. It has been the most important basis of age distinction in many societies. Age is a very important element of social organization that anthropologists are convinced that age-grading is a universal feature in the assignment of social roles, rights and responsibilities in modern as well as pre-industrial societies though the nature of the criteria used in the distribution of roles varies. As people encounter the sequence of age-graded roles, rites of passage are one of the mechanisms used by society to indicate their movement from one phase of the life cycle to the next. Originally such rites were celebrated by highly ritualized ceremonies and had as their function the provision of an institutionalized means for facilitating the cessation of certain behaviour and the introduction of a new set of expectations (Hendricks & Hendricks, 1977).

Age-grading can be as powerful as chronological age in shaping a person's life. The rules of behaviour are often quite different for the various grades. This means that moving from adulthood to old age can have different implications, according to the rules that characterize a particular society's age-grading. Age-grading establishes guidelines as to who should do what kind of work and who owes what kind of obligation to whom, and so on. In a thoroughly age-graded society, everybody has a

pretty good idea of what he or she is supposed to be doing at a particular time of life. Kastenbaum (1979) observes that becoming an elder is often an improvement in status for the woman in age-graded societies.

A contribution towards an integrated concept of age was made by Birren (1959), in differentiating the concepts of biological, psychological and social age. Biological age refers to the position of an organism with respect to its remaining potential longevity. Psychological age refers to an organism's level of adaptability, that is, the state of those capacities which permit the individual to adapt to external and internal environmental demands. Social age is the individual's position in expected age-graded social roles and social habits. The concept of functional age has been added to these three different concepts of age.

A person's functional age is viewed as a composite index of his potential biological, psychological and social capacities, and his current or manifest ability to adapt competently and efficiently to environmental demands of working or living conditions. In other words, the more these three dimensions of an individual's functioning enable him to adapt successfully, the "less old" he or she is.

There is a plethora of terms in gerontological literature to refer to persons as they grow older, indicating the uncertainty prevailing in all societies towards the later years of life. 'Old', 'aged', 'elderly', 'mature' , 'senior citizens' , 'old old' and 'older people' are the commonly used terminologies. Some prefer to use the adjective 'older' to 'old' which (whether as noun or adjective) is falsely suggestive of the existence of a group clearly distinctive from the not-old. The same objection applies to the terms 'aged' and 'elderly' whereas the word 'older' does not have such dichotomous reference as we are all older than some and younger than some others. Even 'older' is extremely vague as far as chronological precision is concerned; so are the other age-terms (The Open University, 1979). The World Assembly on Aging preferred the term "the aging" as it highlights

the process of continuous aging of individuals even when they are already "aged" or "elderly"(United Nations, 1985).

Lesnoff-Caravaglia (1986) is vehemently critical of such terms. She observes that not only do meaningless euphemisms abound, but researchers adopt confusing labels such as the young old, the old old, the oldest old, the mature, the elderly, the very old, the aged, senior citizens, or the "risky" versus the "frisky" built upon their own characterizations of aging. She offers the following categorization scheme (developed jointly with Marcia Klys) : septuagenarians (70 to79 years old), octogenarians (80 to 89 years old), nonagenarians (90 to 99 years old), centenarians (100 to 109 years old), and centedecianarians (110 to119 years old). Yet the difficulties in finding a satisfactory terminology of "old age" continue. Perhaps this reflects the general unease in all societies about old age.

The Hindu scriptures divide the life of a man into four stages or **asramas** :**brahmacharya, grihastha, vanaprastha** and **samnyasa**. The first is the stage of study, discipline and celibacy, and the second that of the householder. The third stage, **vanaprastha**, starts when the hair of the householder turns white and he sees his son's son. He should relinquish his responsibilities to his sons and retire from the active pursuit of material life. He should leave the family (**kula**), the home (**griha**), and the village (**grama**), and go to the forest (**vana**) to live there as a hermit leaving his wife to the care of the sons. Though the presence of wife was permitted in the forest, he should withdraw from sexual relations and bring under control his senses of enjoyment. **Vanaprastha** is the preparatory stage for the final separation from the pains and pleasures of human life. In the final stage, the individual leads the life of an ascetic casting off all attachment (**samgam**)

with the world striving for the attainment of his spiritual goals and the final salvation (**moksha**). A staff, a begging bowl, and a few rags of clothing are his only belongings. A **samnyasin** or an ascetic is a person who has made complete **(sam)** renunciation (**nyasa**)of everything; a totally detached person

(Prabhu, 1961,). This, however, has been the scriptural ideal, but not the usual social practice. It is unlikely that the scriptural prescriptions of detachedness were ever practised to any significant extent. Even in the remote past, only a negligibly small number, that too belonging to the higher castes, would have adhered to the scriptural norms. In fact, observance of the four **asramas** was expected only of those who were born into the twice-born castes – **brahmans** (priests), **kshatriyas** (rulers) and **vaishyas** (merchants).Further, the scriptures do not articulate whether the women should observe the four **asramas**. The woman, according to the laws of Manu, should remain under the control of her father in childhood, under that of her husband in youth, and on the husband's death under that of her son. The **vanaprastha and samnyasa** stages, though not followed by most persons, have, however, a profound influence on the thinking and behaviour of people.

To sum up, it is evident that old age defies any specific definition. It is not a mere statistical categorization or fact. The social definition of old age depends on the norms of a particular society. Ageing and being an older person are essentially social and cultural phenomena.

References

1. Aries, Philippe. (1962). **Centuries of Childhood: A Social History of Family Life**. Translated by Robert Baldick. New York: Alfred A.Knopf.
2. Birren, J.E. (1959). "Principles of Research on Aging". In, J.E.Birren (ed.).**dbook of Aging and the Individual**. Chicago: University of ChicagoPress, pp.3-42.
3. Friedmann, D. D. (1983). **Long Lives**: **Chinese Elderly and the Communist Revolution.** London: Harvard University Press.
4. Hendricks, J., & Hendricks, C.D. (1977). **Aging in Mass Society: Myths andRealities**. Cambridge, Massachusetts: Winthrop Publishers.
5. Kastenbaum, Robert. (1979).**Growing Old: Years of Fulfilment. The LifeCycle Series**. Holland: Multimedia Publications Inc.
6. Lesnoff – Caravaglia, Gari. (1986). "Realistic Expectations For Long Life ". (Conference Report**). Ageing International**, 13 (1): 10-11, 21.

7. Maeda, Daisaku. (1978). "Ageing in Eastern Society". In, David Hobman (ed.). **The Social Challenge of Ageing**. op. cit., pp. 45 - 72.
8. Neugarten, B.L. (1974). " Age – groups in American Society and the Rise of the Young – Old ". **Annals of the American Academy of Political and Social Sciences,** 415 : 187 – 198.
9. Open University. (1979). **An Ageing Population, Block 1 , Ageing in Society.** Walton Hall , Milton Keynes : The Open University Press.
10. Prabhu, P.H. (1961). **Hindu Social Organization: A Study in Socio –Psychological and Ideological Foundations.** Bombay: Popular Prakashan.
11. United Nations (World Assembly on Aging). (1982). "**Introductory Document: Humanitarian Issues, Report of the Secretary General**. A/CONF. 113/9. New York: United Nations.
12. United Nations. (1985). **The World Aging Situation: Strategies and Policies.** New York: United Nations.
13. Vatuk, Sylvia (1975). "The Aging Woman in India: Self-Perceptions and Changing Roles". In, Alfred de Souza (ed.). **Women in Contemporary India: Traditional Images and Changing Roles.** Delhi: Manohar, pp. 142-163.

Old People of Makunti

H.M.Marulasiddaiah

Makunti is a small, multi-caste, kin - oriented village located in the Malnad track of Karnataka. The people are generally following their traditional occupations according to their caste. The population of the village was 1,630 (850 males and 780 females) and the total number of households was 315.For the study, persons aged 55 and above were defined as old. Accordingly, there were 154 elderly persons (81 men and 73 women) in the village.

Makunti people use different terms to identify the elderly or old persons: Yajamana, Hiriya, and Muduka; Yajamani, Hiriyalu and Muduki are terms for women. The term Hiriya means the elder, the leader, the husband and the older person. The term Yajamana means, in addition, the owner and the employer. But Muduka means older person only. Every Muduka is not considered asYajamana or Hiriya. For, the younger people also occupy the seats of Yajamana or Hiriya. These are the terms of title. But the convention requires the Makunti people to address all the older persons with the term Hiriya. When a person becomes a grand- father of his son's child he is known as Ajja or Tata in relation to the newborn. For a grandmother the terms used are Ajji or Avva. The terms are used not only to identify one's grandfather or grandmother but also used for addressing any old person by any one.

Normally the eldest son leaves the family after his marriage. Owing to the departure of the eldest son the family suffers changes, no doubt. But it is welcomed by the family as well as by others, as it is considered to have averted the major disaster for the family, i.e., the partition of it. The eldest son, however, would allege that his younger brothers, their wives and children are always helped and supported by the parents, and not his

wife and children. The departure of the first son, though it averts a major crisis, does not cease to create a series of tensions in the family. It is, in a way, the beginning of the family break-up and it is a clear indication of the declining authority of the elderly persons.

An interesting point is to be noted here with regard to the partition of the family. If both the parents are alive, and if they desire to live together, they may do so. The parents would be given a portion of the house, a piece of land or whatever that is decided by the village elders who sit in judgement on such occasions. But often the parents, along with the land, house, utensils, ornaments, grains, money and such other trival things, are also divided. It is found that if the choice is left to the sons to choose between the two parents, they would prefer the mother to the father and if the choice is given to the daughters- in- law they would prefer the father-in-law to the mother- in-law. The son probably thinks that the mother would work in the house and look after him and his children well; while the daughter-in-law probably feels that the father-in-law would not interfere in domestic matters, unlike the mother- in- law who would always pass critical remarks, pointing out the "defects" of the daughter-in-law. This type of choice has psychological implications. If the parents are given the choice, they would prefer to stay with the youngest son if he is unmarried or has married their granddaughter. Otherwise, they would prefer to stay independent of their sons.As has already been stated, the partition of the family takes place during the advanced age of the older parents. The persons, who are relatively young, say between the years of 55 and 64, are actively engaged in the organization of their family. Those who are above 64 years are mostly widowed and have lost interest in their life and they are removed from the sphere of controlling and co- ordinating the threads of family life.

Family life in Makunti is shaped mainly by the agrarian economy, and even those who are not agriculturists are also influenced by that economy as they play complementary roles to those of the agriculturists. There are rich young men of

agricultural occupations who have brought new things from the urban communities to be used in their homes. Changes, therefore, are found in the types of vessels, kind of dishes and in the mode of eating. Otherwise the traditional way of family life continues to influence the members.

The kinship and the sub-caste are the wider spheres for the activities of the older persons. In the family the elderly person, the father or the grandfather, may be ignored. But the kinsmen do not disregard the elderly person unless they have special reason to do so. The older person is either a grandparent, or a relative-in-law (a near relative always), and he or she is on the periphery of the kinship world. The person is consulted on various domestic, marital, religious and legal matters. The older is the one who is spared to attend to the relatives whenever the latter is in need of such help. Sometimes the old man is seen guarding his relative's house when the owner is gone on urgent business.

During various rituals, the older persons are specially invited by the relatives, and especially on the ceremonies connected with the child, and of marriage and death. In Makunti, on the third year of the child, a ceremony called ChettigavvanaVara is performed. Chettigavva is the deity of children's diseases. The deity is to be propitiated or appeased, so that she will not trouble the child, and in addition, she is said to prevent any evil spirit from attacking the child. It is the maternal grandparent who is very much interested in attending such functions.

Settling marital alliance of the partners is still in the hands of the elders; there are deviations in the village of course. Some young men have tried at selecting their own partners against the desires of their parents. There are also instances of divorce. Apart from attending ceremonies, the elders are associated with solving disputes that arise between kinsmen; of course the elders of the Lingayat caste are also the elders of the village. That way there cannot be much distinction in their case between the two spheres (caste or community) of activities. But the relatives prefer the elderly persons of their group to take the major role in the solution of their problems.

Though the older persons in Makunti are playing still their traditional roles in their families, among kinsmen and caste fellows and in the village as a whole, they are losing their grip on the younger persons. Much against their desire, their sons get the property and family divided, try to get brides of their liking, spend money on things which the older persons consider it to be a waste, oppose their decisions and even at times beat them. Formerly, the kinsmen and caste people, it is said, used to consult the aged, follow their advice in a number of matters and rarely went against their decisions. But now the elders are not consulted on certain important matters. In the case of village administration, it is quite visible that the younger persons have replaced the elders, and the earlier actions of the latter with regard to the developmental activities in the village are severely criticized by the former. The replacement of the aged by the young, how-ever, has not led to the improvement of village conditions. Disputes between the villagers, the kinsmen and even between the brothers are nowadays taken to court of law instead of to the elders for solution.

The changes taking place in the community are not welcomed by the aged. They show their distress in a number of ways. Their declining authority has added another dimension to their age- old problems. They feel they are not sufficiently fed and clothed by their sons and relatives. The aged attribute all this to the play of Kali, the Lord of Kaliyuga. Some feel it may be their bad fate or their action in their past life (Karma). However, the neglect of the aged by the young and immoral actions committed by the people are clear indications, according to them, of the onset of Adharma (unrighteousness). Similarly, the failure of rains, frequent visits of famine, low rate of agricultural yield and the rampant poverty are, they believe, due to the neglect of virtuous ways of living by the people in modern days. And some young people also agree with them.

According to the villagers, a virtuous person is one who respects and obeys the elders, protects the parents, is polite and speaks always the truth, does not deceive others, does not think

in terms of breaking away from their parents and brothers, marries the girl selected by the elders and lives with her for life, looks upon all women (excepting of course, his wife) as his mothers and sisters, earns his living honestly, does not flaunt his wealth, does not look down upon the poor and the depressed, and does not break the traditional practices set by his caste and forefathers.But these ideals of behaviour are not always found in all the persons, even including the aged. People quarrel for trival matters, elope with girls, divorce wives, steal from fields, deceive the kin and the aged, beat the parents, run away from home leaving their wives and children to starve, and speak lies. It is insisted by the aged that the number of violators of Dharmic norms and the incidence of sinful actions are increasing these days.

The Rural Elderly in India

K. Visweswara Rao

Introduction

In demographic terms, the 20th century was a century of population growth and the 21st century would be century of aging. The composition of age structure has been changing in India after independence and there is a steep increase in the elderly population. The percentage of child population below 14 years showed a substantial decline from 38.9 % to total population and would further decrease to 19.7 % by 2050 whereas the population of the elderly (60 +) will grow sizably from 5.6 %, in 1950 to 20.6 % by 2050. However, regional variations are found in population of elderly as in 11 states/union territories of India such as Andhra Pradesh, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu and others have more than the national average (7.5%). With the rapid changes in the social scenario and the emerging prevalence of nuclear family set-ups in India in recent years, the elderly people are likely to be exposed to emotional, physical and financial insecurity in the years to come. This has drawn the attention of the policy makers and administrators at central and state governments, voluntary organizations and civil society (Central Statistics Office, 2011).

Growth of Elderly population In India

The Indian elderly population is currently the second largest in the world. The decadal growth rate of elderly in India shows that in 1951, the number of elderly (60+) was 20.190 million and this has increased to 24.712 million (1961), 32.700 million (1971), 43.172 million (1981), 54.685 million (1991) and 77 million in 2001. Thus, the population of the aged has increased about three fold during the period from 1950 to 2001. Further, the absolute number

of the elderly increases from 77 million in 2001 to 137 million by 2021, and by 2050, India will be home to one out of every six of the world's older persons. The major reasons for the phenomenal growth of the elderly is due to the increase in life expectancy at birth as well as at 60+ years. The expectation of life at birth in India has increased from 41.9 for males and 40.6 for females during 1951-61, to 64.1 to 65.6 for females, respectively by 2000. Life expectation at age 60 increased from 13. 8 years in 1971 to 16.29 in 2011 for males and 14.75 years to 18.18 for females. Similarly, life expectation at age 70 also increased during this period for both males and females; in future also it is going to be increased.

During the years 2000 – 2050, the overall population in India will grow by 55 % whereas population of the elderly (60 +) will increase by 326 % and those in the age group of 80+ by 700 % (Government of India, 2011). Projections for the immediate future include further improvement in life expectancy, accelerated pace of growth of old population, gradual tracking of gender ratio in favour of females (especially among the older old), and altered patterns of morbidity, disability and mortality (Kumar, 1997). Ensuring that they not merely live longer, but lead a secure, dignified and productive life is a major challenge (Planning Commission , 2012).

Profile of the Indian Rural Elderly

Of the total population of 77 million elderly in 2001, the population of the older women was 39 million, whereas men were 38 million. Literacy status indicates that 53 % among elderly males are literate and female literacy is only 20 %.

Further, the majority of the elderly (75 %) are living in rural areas and the rest (25 %) are in urban areas (Census of India, 2001). The census data and the NSS Surveys 43rd round (1987-88), 50th round (1993-94), and 52nd round (1995-96) also found the rural urban differences, where a large percentage of the older people lives in villages. The NSSO study indicates the elderly

are concentrated in rural India and there is also a movement of the elderly from urban to rural areas. The report says the number of elderly women is more than that of elderly men. Nearly three out of five single older women are very poor, and two out of three rural elderly women are fully dependants. There is an increasing proportion of elderly at 80-plus ages, and this pattern is more pronounced among women.

The data on work status of the elderly (NSSO, 2006) revealed that 36 % are still in the labour force and two-thirds (64 %) of them are out of the labour force. Over a quarter of elderly (26.9 %) are self – employed and the casual labourers among the older population are to the extent of 7.4 %. Only 1.5 % of them are in regular salaried employment. Elderly males are more economically active as compared to elderly females. According to NSSO (42nd round), there were 654 widows and 238 widowers per 1,000 old persons in rural areas. The respective figures were 687 and 200 for urban areas. More than 65 per cent of Indian women live without a spouse as compared to 29 per cent of older men.

Research (Marulasiddhiah, 1969; Vijaya Kumar, 1991,) conducted on the rural elderly in various parts of India found that majorities of the elderly were living with married sons(s). The study, undertaken in seven states of India by HelpAge, found that one-fifth of the elderly live alone. This proportion has registered a sharp increase in the past two decades and is more evident in the case of elderly women. The housing data from Census 2011 also point out that the number of households has increased substantially in the last decade, and the number of persons per household has come down substantially. Declining fertility, migration and nuclearisation of families are three possible reasons for such reduction in household size. Across the States, there is a substantial variation in the type of living arrangement, particularly in the proportion of elderly persons living alone. The percentage of those living alone or with spouse

is as high as 45 % in Tamil Nadu, Goa, Himachal Pradesh, Maharashtra, Punjab and Kerala.

The data on old age dependency ratio revealed that it was higher in rural areas (125) than in urban areas (103). Further, it was observed that a higher number of males in rural areas, 313 per 1000, were fully dependent as compared to 297 per 1000 males in urban areas (NSSO, 2004). About 70% of the older people depend on others for their day to day maintenance and 85.87% of the elderly women are dependent on others.

Policies and Programmes for the Elderly

In pursuance of Article 41 of the Indian Constitution, government of India and state governments have initiated policies and programmes for the elderly in India. The National Policy on Older Persons (NPOP) was announced in January 1999 to reaffirm the commitment to ensure the well-being of the elderly. The Policy envisages State support to ensure financial security, health care, shelter and other needs of older persons to improve their quality of life. Subsequently, a Committee was set up to draft a new National Policy on Senior Citizens and the Committee submitted its report on 30th March 2011. The new draft Policy has been placed on the Website of Ministry of Social Justice and Empowerment for comments from the general public and circulated to State Governments for their response.

The Maintenance and Welfare of Parents and Senior Citizens (MWPSC) Act was enacted in December 2007, to ensure maintenance for parents and senior citizens and their welfare. The Act contains 7 Chapters – maintenance of parents and senior citizens, establishment of old age homes, provision of medical care, protection of life and property of senior citizens, offences and procedure for trial etc. As on March 31, 2011 the Act had been notified by 23 States and all UTs and they are required to frame rules such as appointment of maintenance officers; Constitution of maintenance and Appellate Tribunals etc. So far, 12 states including Gujarat, Haryana, Kerala, Madhya Pradesh,

Tamil Nadu, West Bengal etc. have taken the steps for implementation of the Act.

The Scheme of Integrated Programme for Older Persons (IPOP) is the major programme implemented by the Ministry of Social Justice and Empowerment since 1992 and was revised in 2008. Under the Scheme, financial assistance is provided to NGOs, Governments, Panchayati Raj Institutions/ Local Bodies for running and maintenance of old age homes, day care centres, mobile medicare units, day care centres for alzheimer's disease/ dementia patients, physiotherapy clinics, regional resource and training centres, etc. Currently, 3 Regional Resource and Training Centres (RRTCs) have been supported under the Scheme of IPOP. The Ministry of Rural Development is administering the Indira Gandhi National Old Age Pension Scheme (IGNOAPS), under which Central assistance is given towards pension @ Rs. 200/- per month to persons above 60 years belonging to a household below poverty line, which is meant to be supplemented by at least an equal contribution by the States so that each beneficiary gets at least Rs.400/- per month as pension.

The most recent intervention has been the introduction of the National Programme for Health Care for Elderly (NPHCE) in 2010, with the objectives of providing preventive, curative and rehabilitative services to persons at various levels of health care delivery system of the country.The major components of the programme are to establish geriatric department in all the existing 8 Regional Geriatrics Centres; strengthening healthcare facilities for elderly at various levels of 100 identified districts in 21 States of the country. Programme was initiated in 30 districts of 21 identified States during 2010-11 and during 2011-12 the programme is to be initiated in another 70 districts of 21 identified States. National Non Communicable Diseases (NCD) Cell has been established at the Centre to monitor the implementation of NPHCE.

The Ministry of Railways provides facilities such as separate ticket counters for senior citizens at various Passenger

Reservation System (PRS) centres; provision of lower berth to male passengers of 60 years and above and female passengers of 45 years and above; 40% and 50% concession in rail fare for male passengers aged 60 years and above and female passengers aged 58 years and above respectively to senior citizens. The Ministry of Finance provides income tax exemption for the elderly (60 +) up to Rs. 2.50 lakh per annum and for elderly of 80 years and above up to Rs. 5.0 lakh per annum and the National Carrier, Air India, under the Ministry of Civil Aviation provides air fare concession up to 50% for male passenger aged (65 +) and female passenger aged (63 +). The Ministry of Road Transport and Highways has taken initiatives for providing reservation of two seats for elderly in front row of the buses of the State Road Transport Undertakings. Some State Governments are giving fare concession to elderly in the State Road Transport Undertaking buses. Besides these programmes, various state governments have introduced old age pension schemes for the elderly and however, the eligibility criteria, quantum of amount, etc. vary from state to state. NGOs like HelpAge India and associations of older people are also rendering their services for the older people in India.

Issues of the Rural Elderly

The unconditional respect, power and authority that older people used to enjoy in rural extended traditional family is being gradually eroded in India in recent years. Some of the main problems of senior citizens are related to security, healthcare, need for care and maintenance. As early as in the mid fifties, Dube (1955) had highlighted the gap between the ideal norms and actual practices in intra family relation in a village of Andhra Pradesh. It was found in a study that when the persons approached to old age, they gradually receded to the background and the control of the household as well as village affairs had passed on to middle aged persons (Marulasiddaiah, 1969). The problems are economic, health, social, psychological,

dependence, widowhood among elderly women, restriction in their mobility, verbal and physical abuse, besides habits such as smoking, consuming alcohol, chewing tobacco etc. (Nair, 1980; Punia and Sharma, 1987; Himabindu, 1990; Rao, 1995; Vijaya Kumar, 1991; Avatharamu, 2003)

About 64 per thousand elderly persons in rural areas and 55 per thousand elderly persons in urban areas suffer from one or more disabilities. Most common disability among the aged persons was loco motor disability as 3% of them suffer from it, next are hearing disability (for about 1.5%) and blindness (1.7% in rural areas, and 1% in urban areas) (Central Statistics Office, 2011). Findings of a study conducted in Karnataka showed that a major proportion of the elderly were out of the work force, partially or totally dependent on others, and suffering from health problems with a sense of neglect by their family members. There is a growing need for interventions to ensure the health of this vulnerable group and to create a policy to meet the care and needs of the disabled elderly (Lena, 2009).

The prevalence of the chronic diseases among the aged is quite high. While the elderly poor largely describe their health problems, on the basis of easily identifiable symptoms, like chest pain, shortness of breath, prolonged cough, breathlessness/ asthma, eye problems, difficulty in movements, tiredness and teeth problems, the upper class elderly, in view of their greater knowledge of illness, mentioned blood pressure, heart attacks, and diabetes which are largely diagnosed though clinical examination (Siva Raju, 2002; Mutharayappa and Bhat, 2008).

Elder abuse is another major problem of the elderly in India and has been reported in many studies. The elderly were more frequently subjected to verbal abuse (91.5 %), material abuse (78.7 %) and physical abuse (74.4 %) and women were subjected to abuse more frequently as compared to men. The elderly of advanced age, less education and poor financial status were more prone to abuse (Mahajan, 1987; Avatharamu, 2003; Devi, 2006; Rao, 2007; Sebastian and Sekher, 2011).

Conclusions and Suggestions

The Ministry of Social Justice and Empowerment, Government of India (1999), in its document on the National Policy for Older Persons, has relied on the figure of 33 per cent of the general population below poverty line and has concluded that one – third of the population in the 60 plus age group is also below that level. Though this figure may be understood from the older people's point of view, even at this estimate, the number of poor older persons comes to about 23 million. As per the Policy, the coverage under the Old Age Pension Scheme for poor persons is only 2.76 million. The scope, coverage, eligibility criteria and the quantum of pension vary from state to state. The combined national budget allocation for the NOAPS comes to 0.6 per cent only as compared to 6 per cent of Central Government revenue expended on pension for its employees (Irudaya Rajan, 2001). Therefore, the Government should increase the monthly pension amount to at least a minimum of Rs. 1000/-per beneficiary and for senior citizens above 80 years of age, the amount provided should be further enhanced. There is a need to establish State Resource Training Centres in each state as it can monitor and strengthen the programmes for the elderly.

In order to meet the health needs of the rural elderly of BPL category,there is a need to strengthen the existing health care facilities in primary health centres and district hospitals by setting up more geriatric centres, expansion of geriatric wards under the NPHCE, etc. Lifestyle habits such as alcohol consumption, regular smoking and tobacco chewing have adverse effects on one's ability to control diseases and increases morbidity among elderly (NFHS-2). Alzheimer's disease has now become a major public health and social problem that is seriously affecting 3.7 million elderly and their families. This number is expected to double by 2030 (ARDSI, Dementia India Report, 2010). There is a lack of diagnostic and simple screening techniques to detect early onset of Dementia due to inadequate knowledge and basic awareness about the disease. Short-term

and long term training programs on dementia management need to be evolved to benefit various categories of care givers.

The implementation of MWPSC Act, 2007 has been very poor. Further, the stakeholders - elderly and their family members, NGOs, government functionaries etc. are not completely aware of such legislation. Therefore, there is a need to make special efforts in creating awareness about the provisions of the Act among public through media campaign, organizing workshops/ conferences, etc.

Greater involvement of Panchayats at the village level, in dealing with the policies, programmes and problems of the elderly and also to create awareness and sensitization programme regarding the needs for ensuring the well being, safety and rights of elderly**.** Helpline services for elderly should be set up in all districts of the country to provide services for the elderly in difficult circumstances.There is a need for setting up Commissions for senior citizens at the national and state levels to address the various complaints and grievances in a time bound and effective manner. Also there is a need for establishment of a National Institute of Ageing which will carry out the task of evaluation of various programmes for the elderly, human resource development, research studies and documentation, etc.There is an urgent need for professionally trained caregivers to meet the growing demands of the elderly especially of above 70 years of age to ensure quality care at home as well as in the institutions. Both print and electronic media should focus on various issues viz. healthcare, security, need for care and maintenance, etc. relating to elderly. There should be uniformity defining the aged person in India as 60 years and above. Provision of free legal services to the elderly of low income groups; Issue of Special Identity Cards for the elderly, as most of them are illiterate, so as to enable them to avail various facilities provided by the government as well as NGOs are needed. Further, special attention to address the needs of the single, widowed, abused, poor, disabled and elderly of 80 years and above, be given. Whatever the programmes, concessions, benefits that are being

implemented are mostly concentrated / addressed to the needs of the urban elderly. Therefore, there is a need to have a comprehensive development policy to address various issues for rural older people in India.

References

1. Alzheimer's and Related Disorders Society of India. (ARDSI). (2010). The Dementia India Report.
2. Bose, A.B. 1996: Economic and Social Conditions of the Elderly, with a Special Focus on Women: Needs and Capabilities of the Elderly. Implications of Asia's population future for older people in the family (ESCAP Asian Population Studies Series # 145). Bangkok: ESCAP, cited in Vijay Kumar, S. 2003: "Economic Security for the Elderly in India: An Overview", An Aging India: Perspectives, Prospects and Policies, The Haworth Press p.45-65, New York.
3. Central Statistics Office. (2011). *Situation Analysis of The Elderly in India*. New Delhi: Ministry of Statistics & Programme Implementation.
4. Das, N.P and U. Shah. (2001). The Social and Health Status of the Elderly in India: Evidence from Recent National Level data, Population Research Centre, M.S. University of Baroda. A Special Report prepared by the Ministry of Health and Family Welfare, Government of India, New Delhi.
5. Devi, K.R.(2006). Elder abuse in the family. In Aravind, K. Joshi (Ed.). Older persons in India. New Delhi, Serial Publications
6. Dube, S.C. (1955). Indian Village, London, Routledge and Kegan Paul Ltd.
7. Gopal N.N. (1987). Welfare Services for the Aged.,Encyclopeadia of Social work (Vol.3), New Delhi, Government of India, Publication Division,.
8. Government of India. (1999). The National Policy on Older Persons. New Delhi. Ministry of Social Justice and Empowerment.
9. Government of India. (2000). Elderly in India: Profile and Programmes. Central Statistical Organization, Ministry of Statistics and Programme Implementation New Delhi.
10. Government of India. (2011). Draft National Policy on Senior Citizens 2011. New Delhi. Ministry of Social Justice and Empowerment.
11. Himabindu, M. (1990). Aged women in rural Andhra Pradesh: An Anthropological Study. Unpublished Master's thesis, Andhra University, Visakhapatnam.

12. Irudaya Rajan, S. (2001, February 24): Social Assistance for Poor Elderly: How Effective? Economic and Political Weekly, 613-617.
13. Krishakumari&Sudeva. (1996). Population ageing in Kerala. In Kumar V (ed) Ageing; Indian perspective and global scenario. New Delhi: All India Institute of Medical Sciences. Pp 32-35.
14. Kumar.V, (1997) Ageing in India – An overview. Indian journal of Medical Research, 106, pp 257 – 264.
15. Lena, K. A. (2009). Health and Social Problems of the Elderly: A Cross-Sectional Study in Udupi Taluk, Karnataka.*IndianJournal of Community Medicine* , http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2781120/.
16. Marulasiddaiah, H. M (1969) old people of Makunti, Dharwad, Karnataka University
17. Mutharayappa and Bhat (2008), 'Is lifestyle influencing morbidity among elderly?', Journal of Health Management, 10 (2),: pp.203 – 17.
18. Nair, T.K.(1980). Older People in Rural Tamil Nadu. Madras, Madras School of Social Work.
19. National Sample Survey Organisation 1998 Morbidity and Treatment of Ailments July, 1995- June, 1996 (NSS 52nd Round) Report No. 441, New Delhi, Government of India.
20. Omashram. (n.d.). *Old age care*. Retrieved Feb 19, 2013, from The Elderly in India: http://omashram.wordpress.com/2009/06/18/the-elderly-in-india-1/
21. Planning Commission. (2012). Report of the Working Committee Group. Hyderabad: Ministry of Social Justice.
22. Prakash, I.J. (2004) ,Ramamurti, 2005 'Perspective of research on ageing in India', In Phoebe S Liebig and S. Irudaya Rajan (Eds.) An Ageing India: Perspectives, Prospects and Policies. New Delhi, Rawat Publications.
23. Punia D. and Sharma, M.L. (1987). Family life of rural aged women. In M.L. Sharma and T.M. Dak. (Eds.). Aging in India. Delhi, Ajantha Publications.
24. Rao, K.V. (2007). Ageing in Rural India. AmbalaContt. The Associated Publishers.
25. Sebastian, D. and Sekher, T.V. (2011). Extent and Nature of elder abuse in Indian Families: A Study in Kerala. Research and Development Journal. Vol. 17(3).
26. Siva Raju, S. (2000). Ageing in India: An Overview", in 'Gerontological Social Work in India', Murli Desai and Siva Raju (Eds.), Delhi, B. R. Publishing Co.
27. Siva Raju, S. (2002). Meeting the Needs of the Poor and Excluded in India, Situation and Voices, The Older Poor and Excluded in South Africa and India, UNFPA, Population and Development Strategies, No. 2, 93-110.

28. Siva Raju, S. (2004) "Profile of Elderly and Organisations Working for their Care: A Study in Mumbai", Family Welfare Agency, Mumbai (Mimeo)
29. Siva Raju. (2006). Ageing in India in the 21st Century: A Research Agenda. Harmony – Mumbai, Celebrate Age.
30. Sonali Public Shiksha Samiti. (n.d.). A Study Report on A study of effectiveness of Social Welfare Programmes on Senior Citizen in rural Rajasthan, Chhatisgarh, Gujarat. Retrieved Feb 19, 2013, from Planning commission:
31. Suvalaxmi, Ch. and Sarkar, A (2011). Pattern and Trend of Population Ageing in India. The Indian Journal of Spatial Science. Vol. II (2).
32. Vijay Kumar, S. (2003). "Economic Security for the Elderly in India: An Overview", An Aging India: Perspectives, Prospects and Policies, The Haworth Press p.45-65, New York.
http://pib.nic.in/infonug/infyr2000/infoaug2000/i010820001.html
http://planningcommission.nic.in/reports/sereport/ser/ser_shikshasamiti.pdf

Struggle for Survival: Narratives of Abuse and Neglect of the Elderly in Indian Families

B. Devi Prasad

Introduction

Many of those who work with older people know that cases of elder abuse and neglect not only exist but abound. Elder abuse is the most pervasive yet an under recognized human rights violation in the world. It is also a profound health problem that saps energies of the elderly, compromises their physical and mental health, and erodes their personal dignity and self-esteem. Despite the high costs of abuse against the elderly, till two decades back, public institutions in almost every society seemed to lack an awareness in assessing the enormity of the problem.

What is elder abuse? It was defined as '*a single or repeated act or lack of appropriate action occurring in any relationship where there is an expectation of trust, which causes harm or distress to an older person*' (Action on Elder Abuse, 1995). The abuse can take on different forms - physical abuse, emotional abuse, financial exploitation and neglect or even self neglect if the elder person is forced by depression to that state. While these forms may occur simultaneously in the life span of an older person, they may manifest in extreme expression of one form at a particular stage in their life. Often, the abuse is so subtle that it may get hidden under the normal interpersonal stress.

In the context of changing demographic scene and social values, the situation of the elderly world over and particularly in India, has become critical in the recent years and the maltreatment of the elderly in the family context is emerging as a significant problem. Elder abuse does constitute a separate category of abuse requiring special attention for three important reasons. Firstly, The elderly, especially those over 75 years,

become more and more vulnerable to abuse and neglect. This is more so because of their devalued social status and dependency on family, which increases as they advance in age. Secondly, it is learnt from many preliminary studies both in the West and in India, that elder abuse exists. It is estimated that in USA alone, an estimated 4 million elderly are subjected to physical, psychological and other forms of violence and neglect annually (American Psychological Association (APA), 2012). Quite a few Indian studies also gave strong indications as to the existence of maltreatment of elderly in the family context (see Sebastian and Sekher, 2011 and Devi Prasad, 2000 for a comprehensive review). It was revealed that nearly 50 per cent of the elderly faced some form of abuse in their lives and that the incidence of physical abuse varied between 10 to 12 per cent for the previous year. In one of the community studies (Devi Prasad and Vijayalakshmi, 2008), nearly 48 of 100 older adults reported overall abuse while it was 9 per cent for physical abuse i.e .nearly one out of every ten elderly in rural A.P. was physically abused during the past year by one of their intimate family members. Further, an attempt was made in this study to project the incidence rate of physical abuse to the rural populations (as per Census 2001) of the state of A.P and the country. Accordingly, the projections showed that in absolute numbers, it is nearly 4,11,107 rural elderly who are physically assaulted, every year, by their family members. One caveat is that in view of the sensitive nature of the problem, elder abuse is largely hidden and underreported. Disclosure of abuse is difficult because the victim may be frightened, unable or embarrassed to tell anyone, or it may happen 'behind closed doors'. Therefore, estimates based on the studies need to be considered with caution. And lastly, the maltreatment of the elderly significantly undermines the quality of their life, leads to lower self-esteem, greater occurrence of depression and loneliness among them and may have a profound effect on the moral fiber of the society.

Studies have indicated that more than 95 per cent of the abuse of elderly takes place at home. A majority of the elderly

live with their spouses, children and grand children, and other relatives. That is why son, daughter-in-law, spouse and the daughter are frequently reported to be the abusers. While the typical profile of an elderly victim of abuse, whatever be the form of abuse, is found to be a 'woman, widowed, of advanced age, poor and assetless'; a typical abuser is - middle aged, a principal caregiver, and usually the offspring of the older person. With slight variations, this is the scenario we get through a review of the studies in the field.

If we look more closely at the question of why women have a higher risk for victimization, one of the reasons that comes out clearly is their gender which makes them vulnerable for greater social and emotional harm as compared to men (Prakash, 2000). Generally, more women are illiterate, poor and assetless, unemployed, not receiving any family support and are mostly staying alone. These factors, in addition to the cultural factors, put women in India at clear disadvantage and higher vulnerability for abuse and neglect than men. Further, studies have consistently showed, age and dependency of the victim, gender, widowhood, and economic status as the potential risk factors for the abuse of the elderly (APA, 2012; Devi Prasad, 2000).

Let us see how these factors are played out in the lives of the abused elderly as narrated in the following tales.

The Tales Of Woe And Abuse

These narratives are part of the field data of research studies on older people. An attempt is made here to capture their narratives under each theme relating to abuse to see how the story unfolds highlighting the relationship between the particular theme and type of abuse of the older person. These cases are selected from two different settings - rural and urban - and two states i.e Andhra Pradesh (A.P) and Gujarat (Devi Prasad and Vijayalakshmi, 2008; Smita, 2012) to show that irrespective of geographical location, the phenomenon of abuse and neglect continues to be the same. In the narratives, the names of the elderly are changed to ensure confidentiality.

Economic Dependency And Advanced Age

When economic necessity more than affection forces the elderly to co-reside with children, they are likely to be subjected to abuse. Thus, co-residence may not always mean that the needs of the elderly are adequately met. If property is owned by the elderly and is at their disposal, then care may be provided primarily in the hope of inheritance (Bali, 1999). Therefore, given the poverty and enormity of deprivation faced by most of the people in rural India, it is not surprising if issues of abuse and neglect of the elderly revolve around matters of money or inheritance (Mander, 2008).

Satyavathi's life story showcases the situation of widowed dependent elderly women in many of the rural households. She is a frail 72-year-old widow from Potnuru, a village in A.P. Two months prior to this interview, her husband suddenly fell ill and died. She has two daughters and one son, and all got married. She is completely dependent upon her son. Satyavathi owns a house in which she is currently staying with her son who is an alcoholic and wants the house to be transferred on his name so that he can sell it. She tried to explain to him that if the house was sold she would be without shelter. It became a major issue of conflict between the mother and the son and he started regularly abusing her verbally and even resorted to physical abuse. He threatened to kill her and beat her up 6-7 times during the last two months. Once, the neighbors came to her rescue and took her to the doctor for treating the bruises. The daughter-in-law, though being her niece (brother's daughter) says to her, "*You did not give us any property hence we don't have any obligation to take care of you*". She did not have respite even from her daughters' side. Her son-in-law demands money or a share in the house. She has no source of income and cannot go for work due to her frail health and advanced age. Drinking tea is her only luxury which she buys from the amount she secures by selling a portion of rice she gets through *Annapurna* Scheme - a government programme for the poor elderly. She often laments, '*there is no happiness in my life since marriage. Even my husband used to come home*

drunk and beat me'. She recollects that the only happy moments of her life were during her childhood and says "*I was happy only during my childhood when I was with my parents*".

Gender And Widowhood

Saritaben's story shows how elderly women after loss of their spouse and having some property in their name which they refuse to part with would be vulnerable to abuse and exploitation. She is a 67 year old Hindu widow who migrated with her husband to Vadodara 35 years ago and started living in a slum settlement. She had been working as a domestic help in a household. She had two sons who were both married and were living in the same house.

Saritaben's husband built a small 3 roomed house on an encroached land in the slum. After her husband's death, for some time, she lived amicably with her married sons. However, within two years they started demanding that the house be registered in their name. One day, her elder son hit her, threw all her belongings on the street and told her to leave the house. She filed a police complaint in order to protect herself and the son was arrested. However, she took back the complaint as she did not want her son to be in trouble. When he was released from custody, he had a fight with her and dumped all her belongings on the small verandah in the front portion of the house, while her younger son looked on in silence. They told her that from then on that verandah would be her place to stay.

"I am their mother. Yet, they do not want me in the house that belongs to me; they bully me every day; they wish to abandon me and don't seem to care that I have nowhere to go. My family is against me for the small property. No one is trying to stop this injustice and who would support me? I feel helpless".

After her son dumped her belongings in the verandah and warned her not to enter the house, she put up a small stove, arranged the belongings she possessed -a few utensils, a small bed, a tattered mattress and some clothes - and started cooking

on her own. From then on she considered herself as living alone. In her own words,

"Yes, I live here alone. They treat me as if I am invisible, they avoid me. They do not seem to realize, even now, that their actions are wrong".

She often worries that her belongings would be tampered with or thrown away by her sons or daughters-in -law when she was away at work. She had put a small barricade of cardboards against her bed and belongings. This chronic stress has affected her physically and emotionally.

Multiple Manifestations Of Abuse

Often the patterns of abuse do not come in neatly cut forms. Instead, they mesh with one another, subtly or explicitly, and get reflected in how the older people are engaged, valued, sheltered, entertained or neglected.

Narasinga Rao, 67 has been facing constant abuse from his sons and even his minimum needs were neglected. He has three sons and two daughters. He lives separately with his wife and his eldest daughter who is deserted by her husband. Narasinga Rao hails from B.Tallavalasa in A.P., owns a piece of land (half an acre), works as a casual labourer in others' fields, and runs a bullock cart on which he earns Rs.50 per day. His sons want him to transfer the land and house on their name. They beat him several times when he tried to convince them that the land was the only source of his livelihood and hence he cannot part with it. But they did not budge and even labeled him as mad.

At one time, he sold away the bullocks and cart as the bullocks grew old and the cart needed repairs, and kept the money in the house with plans to buy a new cart and a pair of healthy bullocks. As his sons took away this money forcibly, he could neither buy a cart nor could exert himself in manual work thus finding it difficult to make both ends meet. The sons kept on threatening him to hand over the documents of the land so that they can sell the land. During last year, he was beaten up more than 10 times and once he was also thrown out of the house. His

wife joined the sons and abuses him verbally which made him all the more an easy prey to the violence of his sons. Though he sought help of the village elders and the sarpanch of the gram panchayat, nothing was done to contain the adamant behaviour of his sons.

Though generally his daughter gives him food twice a day, she taunts him often with the remark : "*Why should I look after you old man! Go to your sons and get beatings from them*". Many a times, he was given a meager meal and there were times when he went without food. He smokes and loves to have tea twice a day. As he didn't have money, he could not fulfill these trivial pleasures even one time a day.

Denying Place Attachment - A Form Of Neglect?

The meaning of place and attachment to place assumes greater relevance in old age. As people grow older, they form affective, cognitive and behavioral ties to their immediate surroundings – home, close neighborhood, and support networks where most of their daily activities take place. Therefore, forced relocations during old age involves deconstruction and reconstruction of social networks, engagements, and identities in the new place. Also, the common aspects of place attachment such as 'safety, rootedness, privacy, joy, togetherness, recognition and control' would get disturbed (Bond et al, 2008). So, if older people are not allowed to age in place because of circumstances beyond their control, does it come under neglect or disguised abandonment?

Krishnakant is a 79 year old Hindu married man belonging to the Patel caste. His wife is about the same age. They have two sons and three daughters who were married and settled abroad. Their source of income is the remittances received from children. For the past 19 years only he and his wife have been staying together at their own house in Vadodara, Guajarat. His house is well-kept and comprised of three spacious bedrooms, a well furnished hall and a kitchen.

He narrated how his home brings him a lot of memories and attachments. He said that his grandmother used to stay with him till her death in the year 1976. Later his father and stepmother moved in and stayed with him and eventually, in the year 1980 his father passed away, followed by his stepmother in the year 1992. During the period between 1978 and 1990, all his five children one by one, moved abroad for studies. Krishnakant was 58-year old when his youngest child moved abroad, and he felt it was a great achievement for him and his family that all his children settled abroad.

Between the years 1990 and 1999, he and his wife regularly visited their children abroad for varying periods. While abroad, they were confined to the home and had to abide by a lot of restrictions so that they did not fall ill. Over a period of time, their excitement for going abroad had faded away and the frequency of their visits reduced.

In the year 2011, his children asked him and his wife to shift permanently to the U.S to live with them, as they will not be able to come down to India if either or both the parents passed away. Though Krishnakant partly agreed to this, his wife who is attached to their house felt that she would lose her autonomy and would feel out of place abroad. So, she was opposed to this decision. She felt that if the children were not able to come here, they might arrange for their funeral through some relative who lived here. However, after a great deal of persuasion by her husband she had agreed, though half-heartedly, to go abroad. But Krishnakant was still apprehensive of the kind of life that awaited them there.

Conclusion

The stories reveal different angles of the abuse of the elderly. One angle is that the patterns of elder abuse and neglect reflect and reinforce the prevailing negative stereotypes toward the elderly and their roles in society. The other angle is how we are constructing and explaining the phenomenon of maltreat-

ment of the elderly in the larger context of socio economic realities.

Butler (1975) defined ageism as "a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this for skin colour and gender". He argues that 'underlying ageism is the awesome dread and fear of growing older and, therefore, the desire to distance ourselves from older persons who are a proxy portrait of our future selves. We see the young dreading ageing and the old envying youth. Ageism not only reduces the status of older people but of all people'. As in the case of West, in contemporary Indian society, when youth is romanticized and marketed with great fervor in media and family spaces, old age will be perceived as a non-productive and dependent existence in the context of increasing poverty and competition for resources. These negative attitudes tend to dehumanise old people and make it easier for an abuser to victimize them without feeling remorse.

Another perspective we need to acknowledge is about the selective way in which the whole discourse on elder abuse had come to be framed and how the analyses often ends up as a 'conflict between 'innocent' elders and 'bad' families. Phillipson (1997) observed:

> 'On the one side, we have a stereotyped view of the old as relatively powerless, undemanding and invariably blameless… On the other side, there are families, for whom various 'risk factors' can be identified, ranging from psychopathology on the part of the abuser to various forms of stress (p.9)'

Thus, in the process, we fail to "acknowledge the extent to which abusive situations themselves are socially constructed (italics mine) through low-incomes, inadequate community care, and ageism" in our society. Consequently, if we disproportionately highlight the role of individual families ignoring the wider socio-economic context, the broader issues will be ignored in the debates on elder abuse.

References

1. Action on Elder Abuse (1995). *What is Elder Abuse?*London:Author.
2. American Psychological Association. (2012). *Elder Abuse and Neglect: In Search of Solutions*. Retrieved on February 14, 2013 from, www.apa.org/ageing/elderabuse.html.
3. Bali, A.P. (1999). Well being of the elderly, *Social Change, 29*(1&2): 64-76.
4. Bond, J., Peace, S., Dittmann-Kohli and Westerhof, G.J (Eds) (2008). *Ageing in society (3rd edn).* New Delhi: Sage.
5. Butler, R.N. (1975). *Why Survive? Being Old in America,* New York: Harper & Row
6. Devi Prasad, B. (2000). Elder abuse and neglect: A review of research and programmes. In M. Desai, and P. Sivaraju (Eds.) *Perspectives for Gerontological Social Work in India*(pp.219-239), New Delhi: B.I. Publications.
7. Devi Prasad, B., &Vijayalakshmi, B. (2008). *Psychosocial consequences of elder abuse and neglect: A study of the implications of elder abuse to mental well-being among rural elderly of north costal Andhra Pradesh*. (ICMR Project report). Vishakhapatnam: Department of Social Work, AU.
8. Mander, H. (2008). Living with hunger: Deprivation among the aged, single women and people with disability, *Economic and Political Weekly*, XLIII (17), 87-98.
9. Phillipson, C. (1997). Abuse of older people: Sociological perspectives. In P. Decalmer and F. Glendenning (Eds). *The mistreatment of elderly people* (Second edition) (pp.102-115). London: Sage.
10. Prakash, I.J. (2000). Adult women and the aging process, *Ageing & Society, 10* (3&4):31- 42.
11. Sebastian, D., &Sekher, T.V. (2011). Extent and nature of elder abuse in Indian families: A study in Kerala. *Help Age India- Research and Development Journal,17 (3),* 20-28.
12. Smita, B. (2012). *Living Arrangements and the Quality of Life of the Elderly in Vadodara City: Implications for Social Work Practice*. Unpublished doctoral dissertation, Vadodara: M.S. University of Baroda, Faculty of Social Work.

Aging Population in India: The Health System Role of Traditional Medicine

Unnikrishnan Payyappallimana

Introduction

India has experienced a major demographic transition in the past few decades resulting in a substantial increase in the aged population. Consequently there is increasing burden on the health system. Neither the current healthcare infrastructure nor the professional capacity is equipped to handle this situation. This is further challenged by the fact that there is no social security system in the country and over 80 percent of the health care is accessed through out of pocket expenditure. Changing social support systems, rapid urbanization, deteriorating environment further complicate the situation.

In this context, the article explores the relevance of traditional systems of medicine in the country for improving healthcare for the elderly population. The article briefly highlights certain unique principles and features of traditional systems of medicine in geriatric care by focusing on Ayurveda, the most popular traditional medical system in the country. The article takes two fold approaches to address the challenges i.e. from the point of view of individual care what measures are desired and from a health system focus what policy directions are needed to integrate these systems into geriatric care.

Indian life expectancy has increased by 25 years in the last 5 decades. This has resulted in tripling of elderly population in the country. India is going to become the second largest country in the number of elderly in the world. It is expected that by 2026, 12.4 percent of the population will be in the above 65 age category (Patwardhan 2012, Dey et al. 2012). Extrapolated figures indicate that elderly population (60+ age group) will be

100 million in 2013 and will raise to 198 million by 2030 (Government of India 2011). Two thirds of the elderly population live in rural areas and around half of them have poor socio economic status thus making health service a major challenge (Dey et al. 2012). Due to the diverse stages of social, political and economic development there is considerable disparity among Indian states in the demographic transition and their consequences. It is anticipated that the South India will face a faster transition as compared to the North owing to this. Another critical fact to take note of is that around half of the elderly population is dependent and 70 percent of elderly are women (Dey et al. 2012). It is estimated that 51% of Indian elderly will be women by 2016 and compared to males, women have poorer health status (Government of India 2011).

Health Systems Challenges in an Aging Society

International instruments such as the United Nations Human Rights Commission, Millennium Development Goals (MDGs) and the World Health Organization (WHO) have increasingly acknowledged access to appropriate healthcare as a human right. At the same time the situation of the aging population in the country is challenged by the fact that the health system is not adequately equipped to take care of these emerging needs. There is a huge out of pocket expenditure of almost 83% for outpatient care which is not covered by any insurance at all (Duggal 2007; 2009). Availability, accessibility and affordability of health services continue to be major issues. Declining social support systems, reduction in disposable income post-retirement, family nuclearization, lack of appropriate social security policies, increasing chronic disease morbidity, high diversity and heterogeneity in different regions in the country, reduction in post retirement earning, gender, caste and religious based inequities are some of the key contributing factors. Elderly health is also dependant on several other factors such as marital status, education, economic freedom, sanitation and so on (Dey et al. 2012). According to the 2004-2005 National Family Health Survey,

only 10% of the households had atleast someone in a family covered under any type of health insurance. Only the privileged groups of the society avail insurance coverage and most needy are left out. Often elderly are excluded from insurance coverage due to certain age limits or based on their previous health status (Dey et al. 2012). Due to reduction in income postretirement most are unlikely to be able to pay the insurance premium regularly.

Being a transition economy with huge diversity and disparity, the pattern of morbidity has been quite unique in the country. While infectious diseases continue to exist, chronic diseases have already reached epidemic proportions. This places a huge stress of the health system. According to the 60th round National Sample Survey around 8% of the elderly population is confined to home or bed and 27% of those aged 80 years are bedridden (NSSO 2006).

Traditional Health Systems and Their Role

The following section gives an overview of traditional systems of medicine and examines their role in addressing healthcare challenges of elderly. Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being." (WHO 2002) Further the term complementary and alternative medicine (and sometimes also non-conventional or parallel) are used to refer to a broad set of healthcare practices that are not part of country's own tradition, or not integrated into the dominant healthcare system. This is a broad and inclusive definition which makes it difficult to find a region or a country without any form of traditional medicine. It is often known through a variety of names such as traditional medicine, alternative medicine, complementary medicine, natural medicine, herbal medicine, phyto-medicine, non-conventional medicine, indigenous medicine, folk medicine, ethno

medicine etc., based on the context and the form in which it is practiced. Chinese medicine, Ayurveda, Herbal medicine, Siddha, Unani, Kampo, Jamu, Thai, Homeopathy, Acupuncture, Chiropractic, Osteopathy, bone-setting, spiritual therapies, are some of the popular, established systems (Payyappallimana 2010).

There is an emergent interest in both developed and developing countries to integrate traditional medicine/ complementary and alternative medicine (TCAM) in public health systems. Diversity, flexibility, easy accessibility, broad continuing acceptance in developing countries and increasing popularity in developed countries, relative low cost, low levels of technological input, relatively low side effects and growing economic importance are some of the positive features of traditional medicine (WHO 2002, Payyappallimana 2010).

Though these systems differ in their approach to clinical principles or management methods they share a common worldview. According to this the macrocosm (outside universe) and microcosm (living being) are inherently related and have common elements. These systems also have similar perspectives such as ecological centeredness, an inclusive approach to non-material or non-physical dimensions, and holistic approach to health management considering physical, mental, social emotional, spiritual, ecological factors in health and wellbeing. "Fundamental concept is that of balance - the balance between mind and body, between different dimensions of individual bodily functioning and need, between individual and community, individual/community and environment, and individual and the universe. The breaking of this interconnectedness of life is a source of dis-ease,"(Bodeker 2009: 37).Other unifying attributes are their popular and public domain character and orientation to prevention and self help. Mostly these systems focus on the functional aspects of health and diseases, whole system approach to health, multi-causality, subjective, qualitative, individualized and personalized management and consider both physician and patients both as active agents in healing.

According to WHO between 60-80% of the population in developing countries and a growing percentage in developed countries continue to avail services of traditional medical systems (WHO 2002). However the slow official response shows the lack of correspondence between public choice in health seeking behavior and the policy processes in different countries. Proof of efficacy, quality, safety and rational use continue to be major challenges in the sector. Increase in chronic diseases, better awareness about the limitations of conventional medicine, growing interest in holistic preventive health, increasing evidence of clinical efficacy, better clinical care, easy access especially in rural areas and cost efficacy are some of the key reasons for the resurgent interest in traditional medicine. In countries like India the per-capita ratio of practitioners of TCAM is higher compared to conventional medicine. In rural areas easy access, availability and cost are key aspects of utilizing traditional medicine whereas in urban areas it depends on concerns about chemical drugs and interest in natural medicines, limitation of conventional medicine, greater information access are some of the reasons for accessing traditional medicine. Thus in a public health context availability, accessibility, affordability, utility, quality, efficiency and equity become relevant in accessing healthcare (Payyappallimana 2010).

Indian Context of Traditional Medicine

In the subcontinent varied forms of codified medical systems such as Ayurveda, Siddha, Unani or Tibetan medicine (Gso-wa-rigpa) have long coexisted along with a rich non-codified folk form of knowledge. There are also several allied disciplines of traditional medical knowledge such as yoga and several newly introduced knowledge streams. The codified knowledge systems like Ayurveda have evolved in last 3-4 millennia and have unique worldviews, conceptual and theoretical frameworks for health management. The current available oldest Ayurveda literature is codified in 300 BCE which

shows its antiquity. These systems have their distinctive understanding of physiology, pathogenesis, pharmacology and pharmaceuticals which are different from Western medicine. These systems have been institutionalized through national councils, uniform syllabus and education systems. In India there are around 800,000 licensed practitioners belonging to these medical systems, a huge human resource for any public health intervention. Much more diversity is available in the folk knowledge traditions otherwise known as local health traditions which are community specific and ecosystem specific. They use locally available medicinal plants and other resources for healthcare. They include an array of practices such as household level health practices (home remedies, food and nutrition, health related rituals and customs etc.) to specialized healers treating fractures, poison, pediatric ailments, skin disorders, mental health and so on. They are mostly orally transmitted, and highly dynamic. Though they differ substantially based on the ecosystem in which they are practiced they share common value systems and similar modes of transmission in communities. These are not legally recognized and often considered invalid yet continue to exist in communities due to social legitimacy and patronage.

Apart from these native traditions there also exists an extensive machinery of homeopathy practitioners which has been institutionalized in India and comes under the department of AYUSH[1], the Ministry of Health and Family Welfare. The traditional medical resources also include allied disciplines such as yoga, various approaches of meditation, breathing, martial arts, *marmachikitsa*, massage techniques which contribute to health and wellbeing. There are also new forms of complementary and alternative medical (CAM) knowledge which have been imported from other countries in the recent

1. AYUSH department under the Ministry of Health and Family Welfare is the apex body for regulating Ayurveda, Yoga, Unani, Siddha and Homeopathy systems in the country.

decades and have become popular like acupuncture, phytomedicine or herbal medicine, osteopathy, reiki, shiatsu, and so on which do not have formal recognition yet practised in India.

Life, Health and Aging in Ayurveda

This section examines how Ayurveda, a major Indian traditional medical system views aging and what healthcare response is feasible from the point of view of Ayurveda. CarakaSamhita, the olderst traditional treatise available today starts with a chapter on long life (*deerghamjeeviteeyam*). The mythological origins of ayurveda according to this chapter is that great ascetics disturbed by diseases in their religious observances due to worldly indulgence, gathered in the abode of Himalayas to seek a solution to the problem. Wishing for a long and healthy life they sent Bharadvaja as their representative to Indra, the king of devas, who had received the knowledge through a lineage originating from Brahma. Brahma in turn revealed this knowledge of life to the ascetics through Bharadvaja. Whereas the mythical origins and anecdotes may have layers of meanings intertwined in the cultural context what is most interesting is Ayurveda's pursuit for healthy and long life imprinted in these lines.

The term Ayurveda is comprised of two words Ayu (longevity of life) and veda (knowledge), the word Ayu is further explained as *sukhaayu* (happy life), *hitaayu* (sustained happiness), and *deerghayu* (long life) thus extending the definition of longevity to include a holistic approach to health and wellbeing. This perfectly signifies the role of Ayurveda in geriatric care. Health according to Ayurveda is a balance of structural and physiological principles (*dosa*s and *dhatus*) of the body, excretory mechanism (*mala*), and a balance of self (*atman*), sense organs (*indriya*) and mind (*manas*). Ayurveda has primarily a predictive and preventive approach to healthcare management with self awareness and self reliance as its focus. From this perspective health is a state when one is established oneself (*svastha*). This is

based on the understanding that each individual is born with a specific constitution and predisposition for health and disease. Maintaining the balance of one's constitution (which is unchangeable though tendencies can be modified to certain extent) is healthy state while promoting a positive approach to health and wellbeing.

Though the exact cause of aging is not discussed in detail, it is mentioned that it is a natural state of 'disease' (*svabhavabalaroga*) among other such six other states such as hunger, thirst, sleep, and death. Describing that no cause is needed for natural decay, Caraka says that the growth or deterioration depends on two factors such as *daiva* (effects of the past) and *purusakara* (efforts of present life). By stressing the importance of time (*kala*) Caraka says growth depends on place and time of birth; quality of seed and soil; diet; mind; natural mechanism; physical exercise; cheerfulness etc., which are essential for growth (Tiwari and Upadhyay 2009).

According to most Indian traditional medical systems there are three *dosas* (roughly correlated as humors) in the body namely *kapha* (nourishment principle), *pitta* (transformation), *vata* (movement and destruction). Starting from early stage of life, nourishment, transformative and movement and destruction factors will be strong respectively. In other words towards late stages of life *vata* principle manifests strongly in the body thus leading to diseases of neuromuscular and musculoskeletal conditions. Apart from this, each individual by birth acquires either singular or a combination of the characteristics of these *dosas* known as *prakriti* (physical and mental constitution). Similarly every factor such as seasons, geographical regions, tastes, food items, medicinal plants and so are classified on the basis of the relative preponderance of these *dosas*. These are cardinal principles in understanding the predispositions of health or disease, diet, lifestyle or suitable medicines for an individual. Equilibrium of these principles is the desired state of health.

Geriatrics is one of the eight core branches of Ayurveda since its written history. *Rasayana* or *jarachikitsa* mainly deals with

rejuvenation, improving growth and reducing deterioration of the body. Jara indicates a process of reduction in lifespan due to changes in the body (Tiwari and Upadhyay 2009). This encompasses concept of *vayasthapana* (stabilizing or regulating aging), rejuvenation, regeneration, immunomodulation and so on. There are different approaches to rasayana (Patwardhan 2012). Early aging which is an unnatural state can be prevented by this treatment, at the same time it can slow down the process of natural aging. *Rasayana* also encompasses other topics such as healthy living and social conduct. Treatment regimens and medicines have effects on promoting longevity, strength, stabilizing and regulating aging, promoting intellect, memory, alertness and minimizing fatigue (Badithe and Ali 2003).

There is also a systematic approach to social and community health involving an intricate psychosomatic approach. *Svasthavrita* (healthy regimen or preventive care) a central tenet of ayurveda reinforces this approach through elaborate daily and seasonal practical advices.

Coming to the curative dimension, some of the major diseases encountered during old age are arthritic conditions, rheumatic and neurological conditions, dementia, Alzheimer's disease, psychiatric disorders, physical disabilities due to injury and slow healing, skin disorders, impairment of sense organs (chiefly visual and hearing impairment), mental morbidities like anxiety or depression due to social isolation and feeling of alienation, lack of immunity and infections like pneumonia, tuberculosis (multidrug resistance), dietary problems of the aged mainly due to teeth loss, low backache, chronic bronchitis, hypertension, digestive disorders, aneamia etc. Additionally for those who already suffer from chronic conditions like diabetes, cardiovascular disease the secondary effects during old age can be challenging. In stages of conditions with syndromic nature, conventional symptomatic medications like those for pain, antidepressants, anti-inflammatory agents, laxatives cannot address the basic cause, may create dependency on these medicines and chronic after effects. This can also lead to loss

of autonomy, inactivity and so on. In such stages there is a definite preventive, curative, promotive and palliative role that traditional management regimens can contribute to. Apart from these ayurveda advice on diet which is constitutionally and seasonally planned, physical exercises based on yoga or other exercise forms especially sensitive to brittle bones and joints have an important function. Spiritually oriented meditative exercises, breathing techniques, daily and seasonal diet and lifestyle modifications based on traditional medical principles, personal and social behavior and so on also have key contributions to make.

Panchakarma therapy consisting of major purificatory and rejuvenative management methods as per ayurveda also has an important role in geriatric care. For instance regular oil application based on the individual constitutional specificities and health condition requirements is a good support for maintaining health. This would help reduce the healthcare costs. Early monitoring and surveillance can also produce good results.

Apart from the formalized, institutionalized traditional medical systems, local health traditions also has a lot to offer in rural healthcare and especially in areas like gender specific interventions due to the fact that public health facilities are often not used by women.

Need for Policy Support

The approach to universal health coverage and health system development in India is predominantly based on modern medical approach. In the National Health Mission programs traditional medicine is integrated marginally and mainly in the form of dispensable medicines and not as a holistic health care approach. In most national programs traditional medicine appears in the form of inclusive, politically correct, tail-end statements. Why are Ayurveda and other traditional medical systems not called for to address the healthcare challenges of the elderly? There is a lot that TRM can offer in terms of preventive care, healthy lifestyles, early detection of likely

manifestation through methods such as *prakriti* analysis, treatment methods such as *panchakarma* particularly in the case of chronic, debilitating conditions. National program for Health Care of the Elderly is a comprehensive health strategy by Ministry of Health and Family Welfare. Such programs should integrate holistic practices of AYUSH systems and their infrastructure not as pilot schemes but as large scale interventions across the country. This requires creation of traditional medicine resource centres, capacity building for medical and paramedical professionals with special focus on the strengths of TRM in chronic care. This also requires continuous generation and updation of evidence base for the TRM management. This would enhance the confidence among AYUSH professionals on their relevance in gerontology. This is important as public health today is an unfamiliar terrain for AYUSH professionals. It is a welcome move that AYUSH department has promoted Centres of Excellence in Geriatrics in the recent past. These centres should actively engage in research and capacity development in the sector. It is also important to promote geriatrics focused education in undergraduate and postgraduate AYUSH programs in the existing academies of traditional medicine in the country.

In policy discussions on traditional medicine multilateral bodies have given broad guidelines on how to systematize traditional knowledge with due consideration to quality, safety, efficacy and rational use. These issues will have to be addressed for any traditional medicine based public health intervention. One of the hurdles with respect to traditional medicine is the widespread quackery and cross system practices that exist in the guise of TRM. Continuous surveillance systems need to be established for monitoring safety of these practices. Inorder to assure quality, rational drug use and cost efficiency, essential drug lists with region specific requirements are a must.

An important dimension that any traditional medical intervention should create is self reliance in management of primary healthcare problems of the elderly. It should also promote a positive approach to health and wellbeing as well as

improve resilience of elderly population. As a rural community based self reliant healthcare model, India as a biodiversity rich region of the world has immense potential in developing a locally driven healthcare and nutrition development model particularly for regions where health access poor, yet are natural resource rich in the country. Such an approach is especially important for reducing healthcare costs while assuring self reliance among communities. This also requires enormous commitments from the professional medical fraternity for planning, implementing and monitoring of such community centred health delivery programs.

Finally, elderly population requires long term, regular care which calls for systems of care of a longer term basis. In a country like India which is based on family care taking, home care givers have a significant role to play. Home care workers need special training in geriatric care through traditional medicine in particular in the area of neuromuscular, musculoskeletal and other degenerative conditions. Many studies show also that family continues to be primary care giver in the country. This calls for better awareness among households about the various management approaches of elderly care among family members. There should be capacity both for family members and care givers for systematically giving feed back to the health system. This will help develop a need based primary healthcare approach. Adequate knowledge and awareness of health conditions, their prevention or treatment, healthy lifestyle are necessary for implementing such public health interventions.

Conclusion

It is clear that informal care is far important than formal care in the area of geriatric care chiefly in countries where family care has been the norm, and as no government can provide for the demands of a fast aging population. Approach to elderly care should be based on the vision of reinforcing family and community based care in a locally driven process appropriately harnessing locally available resources and knowledge. One of the rich resources that the country possesses is the strength of

its traditional knowledge systems and the abundant natural resources in the form of medicinal plants and nutritional resources. The traditional systems have different and unique approaches to healthcare. Methods like *rasayana* which are means to revitalize ailing and aging bodies have not been adequately studied and thus needs due research consideration. As Patwardhan (2012) notes, going by the recent statement of the World Health Organization, integrating such a holistic health care approach is definitely likely to yield 'not just years to life but life to years'.

References

1. Badithe, T.K. and Ali, R. 2003. Aging Research in India. Experimental Gerontology 38: 597–603.
2. Bodeker, G. 2009. Traditional Medicine. In Manson's Tropical Diseases, 22nd Edition, eds. Cook G.C., Zumla A.I., 35-45. Saunders Elsevier.
3. Dey. S., D. Nambiar, J. K. Lakshmi, Kabir Sheikh, and K. S. Reddy. 2012. Health of the Elderly in India: Challenges of Access and Affordability In Aging in Asia: Findings from New and Emerging Data Initiatives,Smith.J.P and Malay Majumdar, Eds., Washington.D.C: The National Academy Press.
4. Duggal, R. 2007. Poverty and Health: Criticality of Public Financing. Indian Journal of Medical Research126:309-317.
5. Duggal, R. 2009. Sinking Flagships and Health Budgets in India. Economic and Political Weekly XLIV(33): 14-17.
6. Government of India. 2011. National Programme for the Health Care of the Elderly (NPHCE), Operational guidelines. New Delhi: Government of India.
7. NSSO 2006. Morbidity, Health Care and the Condition of the Aged. National Sample Survey, 60th Round, Report no. 507 (60/25.0/1). New Delhi: Ministry of Statistics and Programme Implementation, Government of India.
8. Patwardhan 2012. Adding Life to Years with Ayurveda, Journal of Ayurveda and Integrative Medicine, 3(2): 55-56.
9. Payyappallimana, U. 2010. Role of Traditional Medicine in Primary Health Care: An Overview of Perspectives and Challenges, Yokohama Journal of Social Sciences 14(6): 57-77.
10. Tiwari, B.G. and Upadhyay, B.N. 2009. Concept of Aging in Ayurveda, Indian Journal of Traditional Knowledge, 8(3): 396-399.
11. WHO 2002. WHO Traditional Medicine Strategy 2002-2005, Geneva: World Health Organization.

Life Satisfaction in Old Age

T.K.Nair

(A study of 104 elderly persons aged 60 and above participating in a community care programme of CEWA)

Life satisfaction, "in the sense of a subjective feeling of well- being, depends both on external, material factors, as well as the internal dispositions of the ageing person " (Brearley, 1978). The concept of satisfaction is, therefore, closely linked to the idea of adaptation to aging. Satisfaction in later years of life is dependent on being able to see a total pattern in life, which will not always be easy in the light of the past and present deprivations, hardships and problems that many older people experience. Life satisfaction is the outcome of self-comparison of what one desired with what one got.

Life Satisfaction Index (LSI)

Several studies have been reported on the life satisfaction of individuals. Of particular relevance is the study of Neugarten, Havighurst and Tobin (1961). They have developed two scales to measure life satisfaction: life satisfaction idex A and life satisfaction index B, which have been clinically validated. The scales measure the happiness and satisfaction of an individual with his present life. Life satisfaction index A has been used in the present study to measure the life satisfaction of the elderly respondents (vide appendix). An individual is regarded as being at the positive end of the continuum of psychological well- being to the extent that the person (a) takes pleasure from the round of activities that constitutes his or her everyday life; (b) regards his or her life as meaningful and accepts resolutely that which life has been; (c) feels that he or she has succeeded in achieving the major goals in life ; (d) holds a positive self - image; and (e)

maintains happy and optimistic attitudes and mood. Conceptually, the components are zest, resolution, congruence, self-concept, and mood tone. (Neugarten, et al., 1961).

Life satisfaction index A contains twenty items, each having a simple statement with two response categories of 'agree' and 'disagree'. The individual has to choose either of the two responses which is true for him or her. Of the twenty items in the scale, twelve are positively worded and eight are negatively worded. As regards the scoring procedure, " agree" response to a positive item or "disagree" response to a negative item has a score 1. Similarly no score is given for "disagree" response to a positive item or "agree" response to a negative item. Thus the possible scores on the life satisfaction scale range from 0 to 20; higher the score greater will be the life satisfaction on the part of the individual. As the original scale is in English, a Tamil version was prepared for the study. In order to ensure the aptness of the Tamil translation of the life satisfaction scale, the English and Tamil versions were compared and examined separately by two scholars in Tamil and two psychologists. The final Tamil version had the consensus of these four specialists.

Reliability of the Tamil version of the index was determined by both split-half and test- retest methods. In all, 104 elderly persons were administered the life satisfaction scale. The items of the life satisfaction index were divided into groups on odd-even criteria and the product moment correlation coefficient (r) was computed between the scores obtained on the two halves of the scale. Half of the elderly persons (104), who had responded to the test earlier, were chosen on simple random sampling basis (that is, every alternate person commencing from the random start of 2) for the retest. There was a gap of four weeks between the first test and retest. The product-moment correlation coefficient (r) calculated between the test and retest scores of the 52 elderly respondents gave the index of temporal stability. The coefficient of internal reliability of the scale was computed using Spearman- Brown formula (2r/1+r) to correct for attenuation in the split-half test.

Table 1
Reliability of the Tamil Version of LSI A

	N	r	Reliability coefficient
Split-half method	104	0.625	0.769
Test-retest method	52	0.786	

The reliability coefficient shows that the Tamil version of the life satisfaction scale is valid for measuring life satisfaction of the elderly participants. Sinha (1989), who has used a Hindi version of the life satisfaction scale for an earlier study, has also arrived at the same conclusion. The index of reliability of the Hindi version was 0.84.As young (1966) says, a reliable scale "agrees with itself" and measures consistently that which it is supposed to measure.

Analysis of Results

The LSI scores of the 104 elderly persons on whom the scale was administered range from 0 to 18. As the group selected for administering the scale was not based on the probability sampling method, chi – square test has been preferred for analysis. Individual scores have been grouped into two categories: below 10, and 10 and above. Scores less than 10 are considered to indicate low level of satisfaction, and scores of 10 and above denote satisfactory level.

In general, life satisfaction of the elderly participants of the community care programme is low as seen from the mean score of 7.89. However, the scores of 39 per cent of the elderly participants are 10 and above indicating that a substantial proportion of the older persons in the community care programme have life satisfaction to a reasonable extent. The life situations of two elderly persons at the two extremes of the life satisfaction index continuum are presented below.

Govindammal (score 18) is a widow. She has a married daughter, settled in Bangalore. She works as a house maid and earns a meagre wage every month. She lives alone in a tiled

house .She says that since she does not have a son, she toils even at the age of 75. But she is very happy that her daughter is settled in life. She does not worry that her daughter is not visiting her often because of high railway fare, which her daughter cannot afford. Govindammal is active and healthy. She does not suffer from any disease. She says that with the money she gets regularly from CEWA through the family assistance programme, she is able to eat good food; her relationship with her relatives has improved; and she need not have to depend on anybody now.

Kamakshi (score 0), aged about 85, lives in Parivakkam village. She is a widow. She earns her livelihood by working as an agricultural coolie. She started working only after her husband's death. She did not give birth to any child. Now she lives all alone, in a thatched hut, feeling very depressed and "waiting for the final hour". She has neither a sister nor a brother. She has no other relative also in the village. She suffers from chronic backache and is very weak. Recently, she had undergone hysterectomy operation. She staggers as she is not able to walk properly.

Sex

Men and women have different problems as well as different life perspectives. Yet they derive satisfaction in life depending upon the way each one achieves ego integrity.

Table 2
Elderly by Sex and LSI
(Percentage Distribution)

Sex	Life Satisfaction Score		N	Mean Score
	0 – 9	10 +		
Men	56.14	43.86	57	8.77
Women	64. 86	35.14	74	7.20

Chi -square = 1.03

Note: In all tables, Chi – square has been computed using the cell frequencies.

Though the mean score of elderly men is greater than that of elderly women, there is no significant difference in the life satisfaction level between older men and women participants in the community care programme.

Age

Table 3

Elderly by Age and LSI

(Percentage Distribution)

Age Group(Years)	Life Satisfaction Score		N	Mean Score
	0 – 9	10 +		
60 - 64.	54.84	45.16	31	8.65
65 - 69	62.79	37.21	43	7.79
70 - 74	65.85	34.15	41	7.54
75 +	56.25	43.75	16	7.56

Chi-square = 1.10

A study of life satisfaction of older persons between the ages of 50 and 70 was made by Ramamurthi (1970) by administering both the indexes A and B on a sample of 250 educated elderly men in Madras city. The results indicated a decline in life satisfaction around the 55th year and also beyond the 61 st year, and an improvement in between these two ages. He explains that the first decline may be due to retirement effects and the second due to psychological and physical effects of " old age ". The data for the present study also show a decline of the mean scores of the first three age groups from 60 to 74 years. But there is no statistically significant association between age and life satisfaction.

Marital Status

Becoming a widow or a widower is a traumatic experience. It can be a process that may begin before the event occurs, or it

may be an event without any anticipation. Marriage is a very intimate human relationship and loss of spouse deprives the individual of deep emotional relationship. For men, the death of the wife, the principal caregiver, causes dependence on other relatives for care, particularly in times of illness. Older persons, who are married and widowed, differ in the life satisfaction scores, with higher mean score for the married. But the difference is not significant probably because the individual slowly learns to cope with the effects of being widowed as the years advance.

Table 4
Elderly by Marital Status and LSI
(Percentage Distribution)

	Life Satisfaction Score			
Marital Status	0 – 9	10 +	N	Mean Score
Married	55.32	44.68	47	8.74
Widowed/divorced	63.86	36.14	83	7.40

Chi- square = 0.92

Children

Table 5
Elderly by Number of Children and LSI
(Percentage Distribution)

	Life Satisfaction Score			
No of Children	0 – 9	10 +	N	Mean Score
No children	68.00	32.00	25	6.92
One or more children	59.43	40.57	106	8.11

Chi- square = 0.62

Elderly persons with neither children nor close relatives may experience isolation than those with close familial ties. However, too much emphasis should not be placed on the existence of children as close relatives can compensate for the care and affection which an older person may get from his or her children. Further, even if a person has children, it need not follow automatically that the relationship is satisfying. Value lies in the existence of close family ties more than in the mere fact of having children. According to the data for the present study, there is no significant variation in life satisfaction between the elderly who have children and those who do not have.

Health Status

Table 6
Elderly by Self- Estimate of Health and LSI
(Percentage Distribution)

Self – Estimate of Health	Life Satisfaction Score		N	Mean Score
	0 – 9	10 +		
Very poor / poor	80.43	19.57	46	6.17
Fair	48.39	51.61	62	8.94
Good/ very good	56.52	43.48	23	8.48

Chi – square = 11.65

Good health normally has positive bearing on the individual's attitude towards life in general. Self - estimate of health and level of life satisfaction show significant association. Many elderly respondents experience varying degrees of discomfort and impairment related to general health, vision or hearing. This may be the reason for the significant relationship between these two variables.

Economic Situation

Table 7
Elderly by Opinion on Financial Situation and LSI
(Percentage Distribution)

Opinion on Financial Situation	Life Satisfaction Score		N	Mean Score
	0 – 9	10 +		
Difficulty even for subsistence	73.02	26.98	63	6.75
Enough to make ends meet	46.34	53.66	41	9.17
Satisfactory/ comfortable	55.56	44.44	27	8.59

Chi – square = 7.87

Poverty and life satisfaction are mutually exclusive phenomena under normal circumstances. A large number of elderly participants belong to families without adequate means for subsistence. Therefore it is natural to find significant association between the reaction towards the harsh economic situation in life and the unfavourable attitude towards life as seen from the data.

Place of Residence

Table 8
Elderly by Place of Residence and LSI
(Percentage Distribution)

Place of Residence	Life Satisfaction Score		N	Mean Score
	0 – 9	10 +		
Urban	49.46	50.54	93	9.22
Rural	89. 47	10.53	38	4.63

Chi- square = 18.16

The idyllic description of the Indian village as an important social support system for the elderly has been found to be at variance with the real situation in the rural areas. The mean life satisfaction score of the rural elderly respondents is only 4.63 in sharp contrast to the mean score of their counterparts in the city, which is double that of the former. Consequently, the association between place of residence and life satisfaction level is very high.

Belief in Re-birth

Table 9
Elderly by Belief in Rebirth and LSI
(Percentage Distribution)

Belief in Re-birth	Life Satisfaction Score		N	Mean Score
	0 – 9	10 +		
Yes	73.58	26.42	53	6.75
Doubtful	65.22	34.78	46	7.70
No	34.38	65.63	32	10.03

Chi- square = 13.40

Philosophic acceptance of old age and death is advocated in the religious scriptures. It is widely held that the sufferings in the present life will be compensated in the next birth; it, no doubt, is a weak consolation. The elderly respondents were, therefore, asked whether they believed in re- birth. Two in five elderly persons are certain that there is no re-birth; a third are in doubt; and a fourth firmly believe that they would be born again. Quite strikingly, the non – believers are more among the rural elderly. The data show that if a person believes in re-birth, he or she is likely to be satisfied with the present life despite the problems in living.

Summary

Analysis of the life satisfaction level of the elderly participants has been done in relation to a limited number of

variables only. Life satisfaction score of the elderly participants in the community care programme is generally low. Statistically valid association does not exist between life satisfaction, and the variables such as sex, age, marital status and number of children. On the other hand, significant association exists between life satisfaction, and the variables such as place of residence, economic situation, self-estimate of health and belief in re-birth. Social work is concerned with issues of alleviation, prevention and enrichment. The community care programme operates under considerable financial and personnel constraints being an experimental low cost effort. Therefore, its contribution towards the enhancement of the quality of material life of the elderly with regard to adequate and nutritious food, sufficient clothing, decent shelter and some personal income is only small, though significant.

References

1. Brearley, P.(1978). "Ageing and Social Work". **In**, David Hobman (ed.). **The Social Challenge of Ageing.** London :Croom Helm : 172-196.
2. Neugarten, B.L. ,Havighurst, R.J., & Tobin, S.S. (1961). "Measurement of Life Satisfaction". **Journal of Gerontology**, 16(2):134-143.
3. Ramamurthi, P.V.(1970). "Life Satisfaction in the Older Years". **Indian Journal of Gerontology**, 2(3&4) : 68-70.
4. Sinha, J.N.P. (1981). **Problems of Ageing**. New Delhi: Classical Publishing Company.
5. Young, P.V. (1984). **Scientific Social Surveys and Research**. New Delhi: Prentice Hall.

Appendix

LIFE SATISFACTION SCALE

1. As I grow older, things seem better than I thought they would be.
2. I had got more of luck in my life than most of the people I know.
3. This is the dreariest time in my life.
4. I am just as happy as when I was young.
5. My life could be happier than it is now.
6. These are the best years of my life.
7. Most of the things I do are boring or monotonous.

8. I expect some interesting and pleasant things to happen to me in the future.
9. The things I do are as interesting to me as they ever were.
10. I feel old and somewhat tired.
11. I feel my age, but it does not bother me.
12. As I look back on my life I am fairly satisfied.
13. I would not change my past life even if I could.
14. Compared to other people of my age I have made a lot of foolish decisions in my life.
15. Compared to other people of my age I make a good appearance.
16. I have made plans for things I will be doing a month or year from now.
17. When I think back over my life I did not get most of the important things I wanted.
18. Compared to other people I get into low spirits too often.
19. I have got very much of what I expected out of my life.
20. In spite of what people say, the lot of the average man is getting worse not better.

State and The Elderly

T.K.Nair

Social services are organized societal approaches to the amelioration or eradication of those conditions which are viewed at any historical point of time as unacceptable and for which knowledge and skills can be applied to make them more acceptable (Beattie, Jr., 1976). The emergence of social security systems throughout the world gave impetus to social responsibility for the provision of different social services for the elderly depending on the resources available to the countries and the level of awareness as well as acceptance of the needs of older persons. The term "Social Security" was first used in the title of the United States legislation, the Social Security Act of 1935. It was used in 1941 in the wartime document known as the Atlantic Charter. The ILO adopted the term. It adopted a Convention of Minimum Standards of Social Security in 1952 which has influenced many social security measures all over the world.

Social Security is included in List III of the seventh schedule of the Indian Constitution. Social Security is the concurrent responsibility of the central and state governments. Item 9 of the state list, and items 20, 23 and 24 of the concurrent list relate to "social security and social insurance"; and "welfare of labour including conditions of work, provident funds, employers' liability for workmen's compensation, invalidity and old age pensions, and maternity benefits". The Directive Principles of State Policy concerning social security in the Constitution are Articles 38, 39, 41, 42 and 47. Article 41 states as follows: "The state shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want". The Employees' State Insurance Act (1948),

the Employees' Provident Funds and Miscellaneous Provisions Act (1952), and the Payment of Gratuity Act (1972) are the major social security legislations since Independence for the benefit of the organized labour. The Provident Funds Act was supplemented in 1971 with a family pension scheme and in 1976 with a deposit-linked insurance scheme.

Social Insurance

Social insurance is one of the principal measures of social security designed to provide income security for the elderly in many countries. In India, government and quasi-government employees are eligible for pension, provident fund and gratuity. The system of government pension flows from the Pension Act of 1871. Pension is based on the principle of "pay-as-you-earn"which, in effect, means that the present working population pays for the old age security of the elderly generation. A separate Department of Pension and Pensioners' Welfare was set up by the government of India in 1985. The lot of the government pensioners has been improving through pensioners' associations, collective bargaining, political lobbying, litigation and government-appointed pay commissions. The employees in the organized sector of industries and business establishments are entitled to provident fund and gratuity. However, some organizations in the private sector too give pension to their managerial, supervisory and secretarial personnel.

In 1999, a significant report of the project OASIS (Old Age Social and Income Security) was presented to the government of India by an expert committee chaired by Surendra Dave. The government of India launched a New Pension Scheme (NPS) in April 2008 on the recommendation of the OASIS project report and extended it to all citizens from May 2009. This is the first government-designed pension product for citizens other than government and quasi-government employees, who are covered by various old age benefit schemes. According to a survey by the Invest India Economic Foundation, which was reported in "The Week" of March 22, 2009, the protected Indian work force

comprises 22 million people who are government employees and another 15 million people who are covered by various retirement saving schemes. NPS aims to cover 80 million people who are capable of saving and investing at least Rs. 6,000 per annum. The New Pension Scheme is claimed to be a government initiative to help the "common man" tide through the twilight years. But large sections of the population cannot afford to avail of the NPS due to poverty or low income.

The provident fund system follows the principle of "save-as-you-earn". Coverage under the Employees' Provident Funds and Miscellaneous Provisions Act is presently restricted to establishments employing 20 or more persons. The minimum rate of contribution under the act is either 8.33 or 10 per cent of the employee's salary depending on the industries to be notified by the government of India. Employers are required to make a matching contribution. The savings are accumulated over the working life of the workers in a trust fund, and the sum collected will be released in total together with interest at a predetermined age or at retirement.

In contrast to the provident fund which is a contributory scheme made up of contributions by the employer and the employee, gratuity is a lump sum paid by the employer alone as a benefit on retirement, resignation, death or disablement. The Payment of Gratuity Act is applicable to factories, mines, oilfields, plantations, ports, railway companies, shops and other establishments employing 10 or more persons. The payment of gratuity is subject to the completion of a minimum continuous service of five years. It is payable at the rate of 15 days' wages based on the wages last drawn by the employee for every completed year of service subject to a maximum permissible amount of gratuity of Rs 3,50,000,which has been enhanced to Rs.one million recently.

Social Assistance

Social assistance in the form of means-tested old age pension (OAP) has been introduced in all the states and union

territories for the destitute elderly persons in the below poverty line (BPL) households, that is, those who have no source of income or have only nominal income which is inadequate for survival, and who have no adult carers. Uttar Pradesh was the first state to initiate the scheme in 1957. The minimum age of eligibility for old age pension is 60 , while many states have prescribed lower age limits for women, widows and the disabled. The amount paid as pension ranges from state to state.

On August 15, 1995 the government of India launched the National Social Assistance Programme. For the BPL (below poverty line) elderly aged 65 years and above , Indira Gandhi National Old Age Pension Scheme (IGNAOPS) with a central assistance of Rs 75 per month was introduced. In the 2011 budget, the age was reduced to 60. In the 2006-2007 budget, the government of India increased the central assistance to Rs.200. The state governments can match this amount with additional grant. In Tamilnadu, the amount of old age pension was enhanced to Rs.1,000 per month in May 2011 by the newly elected government. In Tamilnadu, the recipients of old age pension are also given 4 kg of rice every month and clothes (dhotis for men and sarees for women) twice a year. OAP is also a populist measure for electoral gain. In Haryana, increase in the old age pension amount was an electoral slogan in 1987. Implemented in 1987 with great enthusiasm by the government after election, the political commitment has become a "fiscal burden" to the state government and payments were discontinued in February 1990.The implementation of the old age pension scheme is unsatisfactory because of stringent eligibility provisions, procedural formalities, bureaucratic delays, corruption, and unhelpful attitude of the officials. Payment of the OAP amount was normally delayed by the postmen. In Chennai city many received OAP during the third or last week of the month. The long wait was often compounded by the corrupt practices of the postmen who almost always deducted 10 per cent of the OAP amount as their "service charge" before handing over the amount to the beneficiaries. In many instances the OAP recipients were

made to stand in long queues while the OAP was required to be delivered at the residence. In September 2010, the Central Bureau of Investigation (CBI) raided three post offices in Chennai and arrested eleven postmen for misappropriation of OAP amount.

In Tamilnadu, the Revenue Department is the implementing office of OAP and the Special Tahsildars (Distress Relief Schemes) are the sanctioning authorities who are overloaded with many responsibilities. OAP beneficiaries have to be prepared for a major hurdle by way of abrupt stopping of OAP. Getting the OAP benefit back is not easy. Added to this strain is the denial of OAP amount for the period of suspension.

Sidhammal, a destitute widow of Swaminathapuram village in Tamilnadu, was denied old age pension by the concerned officials on the ground that she was making a living by begging and hence she had a source of income. It was in September 1979. Left with no other option, she filed a writ petition before the Madras High Court in 1984. Following admission of the writ petition by the High Court, the Revenue Divisional Officer of Salem district sanctioned the pension with effect from November 1984. While passing the final orders in 1988, the High Court observed that the woman was 69 years old and blind, and therefore could not earn for her living. As she has been unjustly deprived of pension, the High Court directed the Revenue Divisional Officer to pay the arrears of pension to her from September 1979 to October 1984 within three months.Though justice was meted out to her, it was a long wait after laborious efforts for the inane interpretation of the rules by the officials.

A strange example of the cumbersome and unfriendly social assistance delivery system is the arbitrary action of the lower level personnel in some Tamilnadu villages resulting in the deprivation of family ration cards to many widows as reported in the New Indian Express of 19 October, 2009.

When Lakshmi had gone to the public distribution system (PDS) outlet at her village, she was told that she was not entitled to a ration card as she was receiving the government's widow pension. The card was taken away from her, rendering her

unable to avail of its benefits.Lakshmi is one of the many women in Mullipallam and other neighbouring villages of Vadipatti taluk who say that their ration cards have, for unknown reasons, been confiscated by the PDS staff. Under the pension scheme, Lakshmi receives Rs.400 a month and four kg of rice. Twice a year, she is also given a saree.While the money helps her pay the house rent, not being able to buy sugar, wheat and dhal at the PDS shop adds to the burden of daily expenses, she said. But the Vadipatti taluk tahsildar said that women getting the widow's pension could also use their ration cards for PDS benefits and there was no rule against this.

The government of India initiated the Annapurna Scheme in 1999, which was implemented in 2001 by the Ministry of Rural Development. Under this scheme, free food grains (wheat or rice) up to 10 kg per month are provided to older persons who are otherwise eligible for old age pension under the Indira Gandhi National Old Age Pension Scheme. Target for each state is fixed by the central government. The Commissioner of Civil Supplies and Consumer Protection is the Nodal Officer for implementation of the Annapurna Scheme. Funds are allocated to the nodal office which, in turn, allocates the needed funds to the District Collector whose office selects NAOP recipients. Separate ration cards in different colour from the other ration cards with the identification mark "Annapurna" printed on the cards are given to the recipients. At present, only a small proportion of the OAP beneficiaries could receive the Annapurna benefit and the criteria for selection are unclear to the elderly.

The OAP scam unearthed by the CBI prompted the Tamilnadu government to explore alternate methods to ensure disbursement of several social security pensions. That led to the door delivery of pension amounts through banks by retaining "business correspondents". Bank accounts are opened for the pension recipients, who are given biometric smart cards. Despite use of hand-held device, biometric authentication equipment and issuance of a printed receipt, newspapers brought to light the

demanding of "service charge" by business correspondents for door delivery. The government has been acting on the media reports as promptly as possible.

A landmark legislation of the government of India is "The Unorganised Workers' Social Security Act",2008.The statement of objects states that the Act aims to provide for social security and welfare of the unorganized sector workers, who constitute more than 94 per cent of the total workforce in the country. The Act provides for a National Social Security Board and State Social Security Boards for unorganized workers as well as workers' facilitation centres under the auspices of the state governments. In the 2010-2011 budget, the Finance Minister announced the creation of a National Social Security Fund for unorganized sector workers with an initial allocation of Rs.1,000 crore. But this is only an enabling Act without specifying any specific social security measure. In 2010, the government of India amended the Employees' State Insurance Act, 1948 to provide medical facilities to unorganized workers in ESI Corporation hospitals and recognized private hospitals under the Rashtriya Swasthya Bima Yojna (RSBY), a cashless health insurance scheme for the BPL households , the size of which is arbitrarily fixed by the Planning Commission. There are serious instances of corruption in the implementation of the RSBY scheme by the doctors and hospitals with the support of the officials.

In India, social security arrangements have evolved over the years in a piecemeal fashion. Among all sections of the elderly, government and quasi-government employees are served best, or rather have ensured that they are best served. Other sections in the organized sector are also well protected in retirement. JairamRamesh , a prominent economic commentator, observes that India's organized sector has become a parasite, an oasis of relative prosperity in a desert of destitution (**India Today**, March 8, 1999).

National Policy on Older Persons

The long-felt need for a national policy for the welfare of the elderly was realized in 1999 with the formal announcement of a detailed National Policy on Older Persons (NPOP) by the government of India. The Ministry of Social Justice and Empowerment (MSJE), earlier the Ministry of Welfare, is the nodal agency for the implementation of the national policy. The main objectives of the NPOP are to encourage families to take care of the older members, to support NGOs to supplement family caregiving, to provide healthcare to the elderly, to ensure income security in old age, and to enable the older persons to function independently.

The NPOP has the following thirteen functional areas:

i. Financial security which includes income security through hassle-free old age pension for the destitute elderly; and pension schemes in the public, private and other sectors.
ii. Health care and nutrition with focus on strengthening primary health care system and orienting its services to older persons also; expanding geriatric care at secondary and tertiary facilities; health education; health insurance for low income groups; and mental health services for older persons.
iii. Shelter : Earmarking 10 per cent of government housing schemes for allotment to older persons
iv. Education :Programmes to meet the educational and training needs of the elderly.
v. Welfare :Prioritising the needs of older persons; encouraging non-institutional services by voluntary organizations; and providing assistance to voluntary agencies for a variety of services.
vi. Protection of life and property: Protecting older persons from physical, emotional and financial abuse; and protecting the life and property of the elderly with the involvement of the police and neighbourhood associations.

vii. Other areas of action which include concessions in all modes of transport, and priorities in various public services .
viii. Non-governmental organizations : Networking NGOs; and promoting self-help groups and associations of the elderly.
ix. Realising the potential of the elderly
x. Family : Strengthening family support and promotion of values.
xi. Research
xii. Training of manpower
xiii. Media : Involving media with issues related to aging.

Apart from the Ministry of Social Justice and Empowerment, 22 ministries are to be involved in the implementation of the NPOP. Each of the 23 ministries is expected to prepare five-year and annual action plans. The MSJE would review the implementation of the NPOP in a detailed manner every three years. In July 2005, the MSJE made a review of the NPOP and added some more areas of action such as involvement of the private sector in elder care by providing tax benefits, and creation of a national federation of organizations caring for the elderly.

The NPOP mentions the intention to set-up a bureau of older persons under the MSJE. The national policy is committed to the formation of a national association of older persons (NAOP) with state level and district level associations. TheMSJEhas created a National Council for Older Persons (NCOP) with 36 official and non-official members to advise the MSJE. The National Council for Older Persons is the third national council to be set up by the government of India. The Ministry of Health created a National Council on Ageing and Older People in 1997 to advise the Minister on all aspects of aging to promote the health of the older people superseding an earlier National Council for the Elderly. The NCOP is a meeting body and the nomination of non-official members is not based on any objective criteria.

The 1999 national policy document included almost all possible areas of action for the well-being of the older persons.

It appeared like a 'dream policy'. But as dreams often do not materialize, the first decade of the implementation of NPOP was far from cheerful for the elderly. The NPOP recognizes the need for affirmative action for the welfare of the elderly with their productive involvement. The policy stresses on an age-integrated society. But the implications of these stated goals are not clearly internalised by those who are responsible for action. There is a clear conviction deficiency. Panchayati Raj institutions are crucial for the implementation of the NPOP along with the associations and forums of the older persons at the panchayat, block and district levels. But even after ten years since the launching of the NPOP, no worthwhile step was initiated by the central and state governments. A policy sans effective action is no policy at all. Though MSJE is the nodal ministry, the absence of a functioning secretariat made the NPOP ineffective. In January 2010, the MSJE constituted a committee to review the NPOP and to draft a new policy. A policy called the National Policy on Senior Citizens (NPOS) was drafted by the committee and submitted to the government in 2011 (vide Appendix). It is a summarized version of NPOP and the government has not yet notified it till recently. A policy of this nature needs to be drafted on the foundation of reliable database. A time-bound action plan needs to be drafted. The elderly, who constitute about 14 per cent of the voting population, should not be treated as mere objects of state benevolence. They have a right to state support and to participate in policy formulation and programme implementation. What is needed is a paradigm shift in policies concerning the older persons.

Eldercare Legislation

Aware of the failure of children to perform their filial responsibility in caring for the elderly parents, the state has initiated legislative action to protect them against neglect. The Criminal Procedure Code, 1973 has made statutory provisions to mitigate the hardships of neglected elderly parents. Under section 125 of the Criminal Procedure Code, a magistrate of the

first class can order any person having sufficient means to maintain his father or mother, who is unable to maintain himself or herself, by paying allowance at the rate not exceeding Rs. 500 per month to the parent. If the person fails to pay this amount without sufficient cause, the magistrate can issue a warrant for levying the amount, and if the amount still remains unpaid, he can sentence the person to imprisonment and fine. The magistrate may make such alteration in the amount of monthly maintenance (which means food, clothing and lodging) as he thinks fit on proof of a change in the circumstances of the person receiving or paying the allowance. The magistrate may also cancel or vary the order as he thinks fit in consequence of any decision in a competent civil court relating to the parties. The relief given by the Criminal Procedure Code is available to persons belonging to all religions.

Hindus and Muslims have, in addition to the protection of the general law, their own personal laws of maintenance. The personal laws of both the Hindus and Muslims enable an indigent member of either of these two communities to claim maintenance from a wider circle of relatives than the general law which limits claims of parents to children. Under section 20 of the Hindu Adoptions and Maintenance Act, 1956, a Hindu son and daughter are bound to maintain their aged or infirm parents who are unable to maintain themselves out of their own earning or other property. An adopted son or daughter is also bound to perform this duty to the same extent as a natural born child.

When section 125 was incorporated in the Criminal Procedure Code, there was skepticism as to its effectiveness and whether the parents would seek legal remedy to redress their grievances. But, with growing awareness of their legal rights, elderly parents in distress have started seeking legal remedy.

A pertinent question that arose from the Criminal Procedure Code, 1973 was the legal obligation of daughters. A Supreme Court judgement in 1987 in the case involving a married daughter and her indigent father made it mandatory for the offspring,

irrespective of sex, to give financial support to the parents, who have no other source of income. The daughter, a medical practitioner in Maharashtra, tried to prove that section 125 of the Criminal Procedure Code said "his" father or mother and therefore was applicable only to sons. "We do not see why the daughter is to be excluded from such obligations" to the parents, declared the Supreme Court. The court also observed that in case the contention of the daughter is accepted, then the parents having daughters only and who are unable to maintain themselves would go destitute unless the daughters, provided they have independent and sufficient means of their own, help them.

Himachal Pradesh Maintenance of Parents and Dependants Act of 2001 is a significant state legislation. But it was not applicable to the Muslims. The Maharashtra government enacted a similar law. In 2007, the government of India passed "The Maintenance and Welfare of Parents and Senior Citizens Act", which was notified on 31 December, 2007. It extends to the whole of India except the state of Jammu and Kashmir, and also covers Indian citizens living outside India.

Salient Provisions of the Act

i. The Act provides for entitlement for maintenance by a senior citizen, including a parent, who is unable to maintain himself / herself from his / her own earning or out of the property owned by him / her against one more of his / her children not being a minor and in the case of a childless senior citizen against his / her relatives who would inherit his / her property.
ii. The state governments would constitute one or more Tribunals for each sub-division and the Tribunal shall be presided over by an officer not below the rank of a Sub-division Officer. The Tribunal will have the powers of a first class judicial Magistrate for securing the application, refer the same to Conciliation officer for amicable settlement.

iii. The application for maintenance may be made by a senior citizen or a parent and if he / she is incapable, by any other person or organization authorised by him / her. The Tribunal may also take cognizance **suo motu**. An application for monthly allowance shall as far as possible be disposed of within ninety days and definitely within 120 days from the date of the service of notice of the application. The Tribunal is empowered to sanction monthly allowance during the pendency of the proceedings.

iv. If children or relatives neglect or refuse to maintain a senior citizen, the Tribunal may order such children or relatives to make a monthly allowance for the maintenance of such senior citizen which shall not exceed rupees ten thousand.

v. A senior citizen or a parent aggrieved by the decision of the Tribunal has a right to prefer an appeal to the Appellate Tribunal within sixty days from the date of the order of the Tribunal. The Appellate Tribunal shall be presided over by an officer not below the rank of a district magistrate, and it shall try to decide the appeal within one month from the date of filing of appeal.

vi. Legal practitioners are prohibited from participating in the proceedings before the Tribunals and Appellate Tribunals. The state governments shall designate the District Social Welfare Officer or an officer not below the rank of a District Social Welfare Officer as Maintenance Officer who shall represent a parent if he / she so desires before a Tribunal or Appellate Tribunal.

vii. An important provision in the Act is that if a senior citizen, after the commencement of this Act, transfers his / her property by way of gift or otherwise, the said transfer of property can be declared void by the Tribunal at the option of the senior citizen. It also provides that where any senior citizen has a right to receive maintenance and if he / she is incapable of enforcing

the rights, action may be taken on his / her behalf by any voluntary association.

viii. A person who intentionally abandons a senior citizen under his /her care shall be liable for punishment of imprisonment up to three months or with fine which may extend to five thousand rupees.

ix. The Act also stipulates that the state governments should ensure that beds be provided for all senior citizens in government hospitals or hospitals funded by the government, and geriatric facilities in all district hospitals should be arranged.

x. For the indigent elderly, the Act contemplates establishment of old age homes by the state governments in a phased manner with at least one in each district to accommodate a minimum of one hundred and fifty poor senior citizens.

Comments

The older adult protection legislation of 2007 is a welcome measure. But there are hurdles in its implementation. Though the Act stipulates wide dissemination of information by the officials of the state governments, this is seldom reflected in action so far.

The Act appears to exclude the poor elderly as they do not own property. However, provision for setting up old age homes by the state governments has been made. This does not appear to be a sound proposition. Old age homes, however well-maintained, cannot be emotionally satisfying to most of the elderly. Instead of considering different community-based options for the well- being of the poor elderly, setting up old age homes in all the districts of thecountry for the indigent elderly may cause large scale segregation of older persons. The way residential institutions for destitute children and students from socially disadvantaged communities are run by the governments would not enthuse even a liberal optimist to welcome government-run old age homes. Further, identification of the indigent elderly to

be eligible for admission to old age homes is to be made by the government official which gives scope for corruption.

Fixed time limits for disposal of petitions and prohibition of legal practitioners are two positive features of the Act. But the ceiling of Rs 10,000 as maintenance allowance is questionable and lacks rationale. There is a widespread ignorance among the elderly, particularly women, of their rights. Even among those who have knowledge of the legal provisions, there will be reluctance to seek legal recourse from their children unless compelling situations drive them to that remedy for what is considered as essentially a family matter and a moral obligation. Another weakness of the Act is that a neighbour or a well-wisher cannot file a complaint of elder abuse or neglect.

The Act makes provisions for geriatric services and research by the state governments. So also are there directives for life and safety of the elderly who are often soft targets. But these clauses appear to be mere tokenism. A law by itself cannot mitigate the hardships of the elderly unless there is a political will, and elderly-friendly bureaucratic and judicial procedures.

Reference

1. Beattie,W.M.Jr.(1976). "Aging and the Social Services". **In**, R.H. Binstock& Ethel Shanas (eds.). **Handbook of Aging and the Social Sciences**. New York: Van NostrandReinhold : 619-642.

Appendix
National Policy on Senior Citizens 2011

Policy Objectives

The focus of the new policy:

1. Mainstream senior citizens, especially older women, and bring their concerns into the national development debate with priority to implement mechanisms already set by governments and supported by civil society and senior citizens associations. Support promotion and establishment of senior citizens associations, especially amongst women.

2. Promote the concept of "Ageing in Place" or ageing in own home, housing, income security and homecare services, old age pension and access to healthcare insurance schemes and other programmes and services to facilitate and sustain dignity in old age. The thrust of the policy would be preventive rather than cure.

3. The policy will consider institutional care as the last resort. It recognises that care of senior citizens has to remain vested in the family which would partner the community, government and the private sector.

4. Being a signatory to the Madrid Plan of Action and Barrier Free Framework it will work towards an inclusive, barrier-free and age-friendly society.

5. Recognise that senior citizens are a valuable resource for the country and create an environment that provides them with equal opportunities, protects their rights and enables their full participation in society. Towards achievement of this directive, the policy visualises that the states will extend their support for senior citizens living below the poverty line in urban and rural areas and ensure their social security, healthcare, shelter and welfare. It will protect them from abuse and exploitation so that the quality of their lives improves.

6. Long term savings instruments and credit activities will be promoted to reach both rural and urban areas. It will be necessary for the contributors to feel assured that the payments at the end of the stipulated period are attractive enough to take care of the likely erosion in purchasing power.

7. Employment in income generating activities after superannuation will be encouraged.

8. Support and assist organisations that provide counselling, career guidance and training services.

9. States will be advised to implement the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 and set up Tribunals so that elderly parents unable to maintain themselves are not abandoned and neglected.

10. States will set up homes with assisted living facilities for abandoned senior citizens in every district of the country and there will be adequate budgetary support.

Areas of intervention

The concerned ministries at central and state level as mentioned in the Implementation Section would implement the policy and take necessary steps for senior citizens as under:

I. Income security in old age

A major intervention required in old age relates to financial insecurity as more than two third of the elderly live below the poverty line. It would increase with age uniformly across the country.

1. Indira Gandhi National Old Age Pension Scheme

1. Old age pension scheme would cover all senior citizens living below the poverty line.

2. Rate of monthly pension would be raised to Rs.1000 per month per person and revised at intervals to prevent its deflation due to higher cost of purchasing.

3. The "oldest old" would be covered under Indira Gandhi National Old Age Pension Scheme (IGNOAPS). They would be provided additional pension in case of disability, loss of adult children and concomitant responsibility for grand children and women. This would be reviewed every five years.

2. Public Distribution System

4. The public distribution system would reach out to cover all senior citizens living below the poverty line.

3. Income Tax

5. Taxation policies would reflect sensitivity to the financial problems of senior citizens which accelerate due to very high costs of medical and nursing care, transportation and support services needed at homes.

4. Microfinance

6. Loans at reasonable rates of Interest would be offered to senior citizens to start small businesses. Microfinance for senior citizens would be supported through suitable guidelines issued by the Reserve Bank of India.

II. Healthcare

With advancing age, senior citizens have to cope with health and associated problems some of which may be chronic, of a multiple nature, require constant attention and carry the risk of disability and consequent loss of autonomy. Some health problems, especially when accompanied by impaired functional capacity require long term management of illness and nursing care.

7. Healthcare needs of senior citizens will be given high priority. The goal would be good, affordable health service, heavily subsidized for the poor and a graded system of user charges for others. It would have a judicious mix of public health services, health insurance, health services provided by not-for-profit organizations including trusts and charities, and private medical care. While the first of these will need to be promoted by the State, the third category given some assistance, concessions and relief and the fourth encouraged and subjected to some degree of regulation, preferably by an association of providers of private care.

8. The basic structure of public healthcare would be through primary healthcare. It would be strengthened and oriented to meet the health needs of senior citizens. Preventive, curative, restorative and rehabilitative services will be expanded and strengthened and geriatric care facilities provided at secondary and tertiary levels. This will imply much larger public sector outlays, proper distribution of services in rural and urban areas, and much better health administration and delivery systems. Geriatric services for all age groups above 60— preventive, curative, rehabilitative healthcare will be provided. The policy will strive to create a tiered national level geriatric healthcare

with focus on outpatient day care, palliative care, rehabilitation care and respite care.

9. Twice in a year the PHC nurse or the ASHA will conduct a special screening of the 80+ population of villages and urban areas and public/private partnerships will be worked out for geriatric and palliative healthcare in rural areas recognizing the increase of non-communicable diseases (NCD) in the country.

10. Efforts would be made to strengthen the family system so that it continues to play the role of primary caregiver in old age. This would be done by sensitizing younger generations and by providing tax incentives for those taking care of the older members.

11. Development of health insurance will be given priority to cater to the needs of different income segments of the population with provision for varying contributions and benefits. Packages catering to the lower income groups will be entitled to state subsidy. Concessions and relief will be given to health insurance to enlarge the coverage base and make it affordable. Universal application of health insurance – RSBY (Rashtriya Swasthya Bima Yojana) will be promoted in all districts and senior citizens will be compulsorily included in the coverage. Specific policies will be worked out for healthcare insurance of senior citizens.

12. From an early age citizens will be encouraged to contribute to a government created healthcare fund that will help in meeting the increased expenses on healthcare after retirement. It will also pay for the health insurance premium in higher socio economic segments.

13. Special programmes will be developed to increase awareness on mental health and for early detection and care of those with Dementia and Alzheimer's disease.

14. Restoration of vision and eyesight of senior citizens will be an integral part of the National Programme for Control of Blindness (NPCB).

15. Use of science and technology such as web based services and devices for the well being and safety of senior

citizens will be encouraged and expanded to under-serviced areas.

16. National and regional institutes of ageing will be set up to promote geriatric healthcare. Adequate budgetary support will be provided to these institutes and a cadre of geriatric healthcare specialists created including professionally trained caregivers to provide care to the elderly at affordable prices.

17. The current National Programme for Health Care of the Elderly (NPHCE) being implemented in would be expanded immediately and, in partnership with civil society organizations, scaled up to all districts of the country.

18. Public private partnership models will be developed wherever possible to implement healthcare of the elderly.

19. Services of mobile health clinics would be made available through PHCs or a subsidy would be granted to NGOs who offer such services.

20. Health Insurance cover would be provided to all senior citizens through public funded schemes, especially those over 80 years who do not pay income tax.

21. Hospices and palliative care of the terminally ill would be provided in all district hospitals and the Indian protocol on palliative care will be disseminated to all doctors and medical professionals.

22. Recognize gender based attitudes towards health and develop programmes for regular health checkups especially for older women who tend to neglect their problems.

III. Safety and Security

23. Provision would be made for stringent punishment for abuse of the elderly.

24. Abuse of the elderly and crimes against senior citizens especially widows and those living alone and disabled would be tackled by community awareness and policing.

25. Police would be directed to keep a friendly vigil and monitor programmes which will include a comprehensive plan for security of senior citizens whether living alone or as couples.

They would also promote mechanisms for interaction of the elderly with neighbourhood associations and enrolment in special programmes in urban and rural areas.

26. Protective services would be established and linked to help lines, legal aid and other measures.

IV. Housing

Shelter is a basic human need. The stock of housing for different income segments will be increased. Ten percent of housing schemes for urban and rural lower income segments will be earmarked for senior citizens. This will include the Indira Awas Yojana and other schemes of the government.

27. Age friendly, barrier-free access will be created in buses and bus stations, railways and railway stations, airports and bus transportation within the airports, banks, hospitals, parks, places of worship, cinema halls, shopping malls and other public places that senior citizens and the disabled frequent.

28. Develop housing complexes for single older men and women, and for those with need for specialized care in cities, towns and rural areas.

29. Promote age friendly facilities and standards of universal design by Bureau of Indian Standards.

30. Since a multi-purpose centre is a necessity for social interaction of senior citizens, housing colonies would reserve sites for establishing such centres. Segregation of senior citizens in housing colonies would be discouraged and their integration into the community supported.

31. Senior citizens will be given loans for purchase of houses as well as for major repairs, with easy repayment schedules.

V. Productive Ageing

32. The policy will promote measures to create avenues for continuity in employment and/or post retirement opportunities.

33. Directorate of Employment would be created to enable seniors find re- employment.

34. The age of retirement would be reviewed by the Ministry due to increasing longevity.

VI. Welfare

35. A welfare fund for senior citizens will be set up by the government and revenue generated through a social security cess. The revenue generated from this would be allocated to the states in proportion to their share of senior citizens. States may also create similar funds.

36. Non-institutional services by voluntary organizations will be promoted and assisted to strengthen the capacity of senior citizens and their families to deal with problems of the ageing.

37. All senior citizens, especially widows, single women and the oldest old would be eligible for all schemes of government. They would be provided universal identity under the Aadhar scheme on priority.

38. Larger budgetary allocations would be earmarked to pay attention to the special needs of rural and urban senior citizens living below the poverty line.

VII. Multigenerational bonding

39. The policy would focus on promoting bonding of generations and multigenerational support by incorporating relevant educational material in school curriculum and promoting value education. School Value Education modules and text books promoting family values of caring for parents would be promoted by NCERT and State Educational Bodies.

VIII. Media

40. Media has an important role to play in highlighting the changing situation of senior citizens and in identifying emerging issues and areas of action.

41. Involve mass media as well as informal and traditional communication channels on ageing issues

Natural disasters/ emergencies

42. Provide equal access to food, shelter, medical care and other services to senior citizens during and after natural disasters and emergencies.

43. Enhance financial grants and other relief measures to assist senior citizens to re-establish and reconstruct their communities and rebuild their social fabric following emergencies.

Implementation Mechanism

There will be efforts to provide an identity for senior citizens across the country and the ADHAAR Unique identity number will be offered to them so that implementation of assistance schemes of Government of India and concessions can be offered to them. As part of the policy implementation the Government will strive for:

I. **Establishment of Department of Senior Citizens under the Ministry of Social Justice and Empowerment**

The Ministry of Social Justice and Empowerment will establish a "Department of Senior Citizens" which will be the nodal agency for implementing programmes and services for senior citizens and the NPSC 2011. An inter-ministerial committee will pursue matters relating to implementation of the national policy and monitor its progress. Coordination will be by the nodal ministry. Each ministry will prepare action plans to implement aspects that concern them and submit regular reviews.

II. Establishment of Directorates of Senior Citizens in states and union territories

States and union territories will set up separate Directorates of Senior Citizens for implementing programmes and services for senior citizens and the NPSC 2011.

III. National/State Commission for Senior Citizens

A National Commission for Senior Citizens at the centre and similar commissions at the state level will be constituted. The Commissions would be set up under an Act of the Parliament with powers of Civil Courts to deal with cases pertaining to violations of rights of senior citizens.

IV. Establishment of National Council for Senior Citizens

A National Council for Senior Citizens, headed by the Minister for Social Justice and Empowerment will be constituted by the Ministry. With tenure of five years, the Council will monitor the implementation of the policy and advise the government on concerns of senior citizens. A similar body would be established in every state with the concerned minister heading the State Council for Senior Citizens.

- The Council would include representatives of relevant central ministries, the Planning Commission and ten states by rotation.
- Representatives of senior citizens associations from every state and Union Territory.
- Representatives of NGOs, academia, media and experts on ageing.
- The council would meet once in six months.

V. Responsibility for Implementation

The Ministries of Home Affairs, Health & Family Welfare, Rural Development, Urban Development, Youth Affairs & Sports, Railways, Science & Technology, Statistics &Programme Implementation, Labour, Panchayati Raj and Departments of Elementary Education & Literacy, Secondary & Higher Education, Road Transport & Highways, Public Enterprises, Revenue, Women & Child Development, Information Technology and Personnel & Training will setup necessary mechanism for implementation of the policy. A five-year perspective Plan and annual plans setting targets and financial allocations will be prepared by each Ministry/ Department. The annual report of

these Ministries/ Departments will indicate progress achieved during the year. This will enable monitoring by the designated authority.

VI. Role of Block Development Offices, Panchayat Raj Institutions and Tribal Councils/Gram Sabhas

Block Development offices would appoint nodal officers to serve as a one point contact for senior citizens to ease access to pensions and handle documentation and physical presence requirements, especially by the elderly women.

Panchayat Raj Institutions would be directed to implement the NPSC 2011 and address local issues and needs of the ageing population.

In rural/ tribal areas, the tribal council or gram sabha or the relevant Panchayat Raj institution would be responsible for implementation of the policy.

The provisions of the 13th Finance Commission for special funding to them would be made applicable.

Elder Care Services

T.K.Nair

Social services for the elderly all over the world would fall into two broad categories: institutional care and community-based services.

Institutional Care

Institutional care in 'homes for the aged' emerged as a favoured form of care of the elderly by the state, and the religious orders and voluntary organizations when the family was unable, negligent or unwilling to provide care to the older members. Institutionalization isolates the elderly from their homes and the community, and hence is an undesirable form of care of the elderly.

The **dharmasalas, ashrams, maths and sadavartas**, that have been in existence in India, are quite different from the 'old age homes'. These are rest homes and retreats established by the religious institutions, erstwhile rulers, and pious individuals for the benefit of persons who wish to spend time in a religious atmosphere and to devote themselves to spiritual pursuits. They are numerous at pilgrimage sites and at other places of special religious significance to Hindus. Most such retreats are open to persons of all ages and both sexes, and many cater mainly to temporary visitors or pilgrims. But some are specifically designed for the longer term needs of older persons who intend to retire from active participation in worldly affairs and to concentrate on spiritual matters. Most of these retreats are supported by charitable donations, and provide accommodation and food to the residents free of charge, though some are intended for older people with means. Some accept an older person's remaining wealth and property in return for life-time shelter and care. Elderly persons, who have no family or who opt to live

among other older people in a religious atmosphere, are also looked after by these institutions.

In the 1500s and 1600s, those who were not part of the domestic work force in England were considered to be "problems" ; these included vagrants, criminals, prostitutes, paupers, beggars, lunatics, orphans, the aged, and the sick. Estes and Harrington (1981) are of the view that the development of social control systems such as institutionalization to handle those who could not or would not work was the response of capitalism to deal with these "problems" . The Poor Law of 1601, often referred to as "43 Elizabeth", confirmed the responsibility of the parish (the local community) for the maintenance of the poor who were not supported by their relatives. The law distinguished three classes of poor: the able-bodied poor, the impotent poor and children. The able-bodied poor, called "sturdy beggars", were forced to work in the "house of correction" or "workhouse". The impotent poor were people unable to work : the sick, the old, the blind, the deaf-mute, the lame, the demented, and mothers with young children. They were placed in the "almshouse" where they were required to help within the limits of their capacities. If the impotent poor had a place to live and seemed less expensive to maintain them there,the overseers of the poor could grant them "outdoor relief", usually in kind, sending food, clothes, and fuel to their homes (Friedlander, 1963). The Colonies adopted the Elizabethan Poor Law. However, in the United States of America, most of the almshouses and workhouses were established in large cities. In addition to outdoor relief in kind, the paupers were "farmed out" or "sold out" to the lowest bidder. A special type of farming out was the placement of widows, and infirm and aged paupers, for short periods, from house to house (Friendlander, 1963).The almshouse was the progenitor of the "home for the aged". Many almshouses were, in course of time, converted into or rechristened as homes for the aged. Initially religious and voluntary organizations have started "old age homes". The almshouse finally became a "home", achieving a "new status in the philosophy of scientific charity" (Haber,

1983). In the second half of the nineteenth century, organizations such as the "New York Association for Improving the Condition of the Poor" and their successors advocated institutionalization for all aged paupers. Their volunteers actively attempted to place every needy elderly person, including even those who resisted their charitable assistance, in institutions. By the beginning of the twentieth century, the segregation of the elderly into "homes" and "asylums" had begun to assume institutional form. Proprietary homes with high profit motives also began to flourish.

Most of the developed nations have a type of residence that can be described as a home for the aged, which houses older people in need of assistance and provides help with meals and housekeeping as well as with bathing, dressing, and other self-maintenance functions. People with needs for daily medical or nursing care are not ordinarily placed in homes for the aged, but are put in nursing homes. Another common form of institutional care for the elderly is the mental hospital. The fourth type of institutional care for the elderly is the geriatric hospital, which is a central feature of the British care system (Lawton, 1982).

Institutionalization represents the ultimate personal failure for the elderly and their family. "In fact, two-thirds of the elderly view institutions as the least desirable alternative possible, a sort of confession of final surrender, a halfway stop on the route to death" (Hendricks and Hendricks, 1977). There is adequate empirical evidence to prove that institutionalization is deleterious to the emotional health of the elderly, though some may have the benefit of a sheltered environment. The spectacle of older people living collectively, awaiting death away from family, is the ultimate tragedy of life (Puner, 1974).Townsend (1962), who made a well-known survey of residential institutions and homes for the aged in England and Wales, provides a mass of empirical data to portray the misery of many elderly residents in such institutions. His observations on the effects of institutional life on the residents are very disquieting.

> In the institution people live communally with a minimum of privacy, and yet their relationships with each other are slender. Many subsist in a kind of defensive shell of isolation. Their social experiences are limited, they lack creative occupation and cannot exercise much self-determination, and they are deprived of intimate family relationships. The individual has too little opportunity to develop the talents he possesses and they atrophy through disuse. He may become resigned and depressed and may display no interest in the future or in things not immediately personal. He sometimes becomes apathetic, talks little and lacks initiative.

Townsend based on the strength of his survey data, asserts in an unambiguous manner that homes for the aged are not necessary.

Ideology of Deinstitutionalization

Two ideologies responsible for segregation of the elderly, according to Estes and Harrington (1981), are separation and medicalization. The first is predicated on the belief that older people are special and different, with needs requiring special and different old age policies and services; and the second is based on the premise that old age is a process of inevitable physical decline that is best treated by medical interventions. The ideology of separatism as the best way to approach the "old-age problem" has justified age-segregated programmes such as congregate housing, residential care and nursing homes for the elderly. The medicalization ideology, with its orientation toward individual rather than structural aspects of aging, has obscured an understanding of aging as a socially generated problem.

The highly visible and growing economic costs of institutionalization, and the individual as well as the social costs of stigmatization resulting from segregated care led to a global trend towards deinstitutionalization. In the West, the pressure for moving mental patients "back to the community" in 1950s was so strong that it has become an important ideology, around

which a diverse number of interest groups and professional bodies have converged. Social scientists have concluded that the institutions themselves were obstacles to the treatment of the mentally ill and urged community mental health programmes instead. Critiques of mental institutions such as Goffman's (1961) "Asylum" brought about a consensus that mental hospital care was simply custodial care, and not therapeutic.

The emergence of the deinstitutionalization ideology has profound influence in the advocacy for shifting the elderly from nursing homes and residential institutions back to the home and the community. Estes and Harrington (1981) are of the view that the pressures for deinstitutionalization of the elderly and the new ideology of "alternatives of institutionalization" in America are influenced by a combination of factors such as the growing concern of aging advocates, fiscal crisis in government, the powerful interests of the health care industry, and the efforts of health and social services agencies to command a large share of policy dollars. They warn that in the enthusiasm for deinstitutionalization and community-based services, the focus should not merely be on services. The political, economic and social factors that disenfranchise the elderly in society should not be lost sight of.

Community Care of the Elderly

Community care of the elderly in simple words is any form of care of persons outside of an institution by means of health and other social services based in the community. A number of research experiments have shown that it is possible to keep elderly people with very high levels of disability in the community (Means and Smith, 1985). Since there is not a better substitute for the family as a source of support for the elderly, community-based programmes have the advantage in facilitating the involvement of the families in enhancing the well-being of their elderly members and integration of the elderly in society. Community-based services in the Western countries include home-helps (also called homemakers, home-health aides), portable meals (or meals on wheels), friendly visitors, day care (also called geriatric day hospitals), respite services, and

substitute family care (foster homes) (Beattie, Jr., 1976). Bell (1973) identifies five basic components of a community care programme in a given geographic region: health maintenance, home-help, mobile meals, transportation services, and counselling, crisis intervention, and advocacy.

Community is an area in which a group of people live, or a group of people living in an area, or a group of people who have close ties or common interests. It is more than a physical place, it is a vehicle for social participation and collective action (Checkoway, 1988). "Care" does not mean something given by an active younger person to a passive older person. The word can also mean a service which is given to a person by an organization. It also includes something which elderly people can actively take part in. Similarly, community care programme for the elderly does not at all imply that everything is done for them and they remain as passive recipients. On the other hand, the programme envisages the active participation of the older persons in decision-making and implementation.

Checkoway's Five Models of Community Practice

	Goals	**Strategies**	**Examples**
Community Planning	Set goals; solve problems	Plan programmes at the community level	District planning councils, area aging agencies, municipal aging offices, elderly resident councils
Community Advocacy	Represent interests in established institutional arenas	Legislative lobbying, administrative advocacy, judicial representation	Elderly advocacy groups, legislative lobbyists, agency consumer repres--entatives, legal services attorneys

Community action	Alter power relations; reallocate resources; create change	Identify issues, and organize people for social and political action	Retired persons' associations, elderly consumer groups, elderly residents' organizations
Community education	Develop knowledge, skills, and attitudes ; increase confidence, competence, and capacity	Raise conscious--ness and develop capacity around awareness of problems and causes	Adult learning, self-help, Education and training progra--mmes, media campaigns
Community service	Design programmes; deliver services	Develop community-based programmes and services	Churches, voluntary associations, neighbourhood organizations

Social work, according to the National Association of Social Workers (1973), is the "professional activity of helping individuals, groups, or communities to enhance or restore their capacity for social functioning and to create societal conditions favorable to their goals". "Community care" has been a slogan in social work for about five decades. Probably the most clear element in the origins of community care is the movement for deinstitutionalization of the social services. Community care is also referred to as social care in the community. It is defined as "those aspects of social work concerned with enabling resources, which are or might be available, to be used more effectively in the provision of social services to clients" (Payne, 1986). Community care is concerned with all kinds of resources: personal, economic, social and political. Social workers are a significant part of the provision of community care because they help people to make effective use of their own personal resources

and at the same time, they help community resources to provide for those in need. Community care rests on two basic premises: first, care is better provided by services organized in the community, rather than those based on institutions; and secondly, in enabling people to help themselves, dealing with the family as a unit is more important rather than its individual members' problems (Payne, 1986).

Eldercare Services in India

Founding of Helpage India in 1978, and the World Assembly on Aging in 1982 have been responsible for creating greater awareness of the needs of the growing number of older persons in the country. Helpage India and its founding organization Help the Aged (United Kingdom) have made signal contribution towards the development of a variety of services for the elderly in India. Help the Aged was founded by a group of British businessmen, headed by the late Cecil Jackson-Cole, who was closely associated with the general development agency Oxfam since its origin as the Oxford Committee for Famine Relief during the Second World War. In 1960, the group had noted that no agency existed to meet the needs of elderly people in disaster situations, and discussions with the United Nations confirmed this lack of service (Tout, 1989). Thus Help the Aged came into being in 1960. In 1978, Help the Aged took the initiative to start an independent agency to work for the cause of the elderly in India which resulted in the formation of Helpage India as a registered society with Indian and overseas members in the organization. It mobilizes substantial resources in India for supporting various programmes for the welfare of the elderly through non-governmental organizations.

Monegar and Rajah of Venkatagiri Choultries was the first institution for the care of the elderly in India. It has its beginning in the early 18th century, though the records about the Choultries are available only from 1782. Formation of Helpage India in

1978 marked the beginning of professional fund-raising and project advisory services, thus accelerating non-governmental efforts in promoting services for the elderly. The partnership between Centre for the Welfare of the Aged (CEWA), Helpage India and Help the Aged, UK, led to the development of a pioneering project at Chennai under the auspices of CEWA in 1979 to experiment with alternate elder care models to help strengthen the integration of the elderly in the communities in which they live through day centres, domiciliary care, family counselling, social work with elderly patients in hospitals, and income maintenance through assistance for self-employment, skill upgradation and group income-generating activities. The first day centres for the elderly in India were set up during 1979-80 at Chennai (Centre for the Welfare of the Aged), Mumbai (Family Welfare Agency) and Hyderabad (Association for the Care of the Aged).

The role of the state in organizing welfare programmes for the elderly is marginal though some homes for the aged are run by the state governments. Welfare services for the elderly in India are mainly under the auspices of religious bodies and voluntary organizations. The Christian missionaries, particularly those belonging to the Catholic denomination, have been responsible for starting a large number of homes for the aged. "Little Sisters of the Poor", a well-known religious order of nuns with its headquarters in France, maintains many homes for the aged in different states. Of late, the Hindu religious and secular groups are also starting residential care programmes for the elderly.

References

1. Bell, W.G. (1973). "Community Care for the Elderly : An Alternative to Institutionalization". **The Gerontologist**, 13(3):349-354.
2. Beattie, W.M.Jr. (1976). "Aging and the Social Services". **In**, R.H.Binstock& Ethel Shanas (eds.). **Handbook of Aging and the Social Sciences**. New York: Van Nostrand Reinhold: 619-642.

3. Checkoway,B. (1988). "Community-based Initiatives to Improve Health of the Elderly". **Danish Medical Bulletin: Gerontology Special Supplement Series**, No.6: 30-36.
4. Estes, C.L., & Harrington, C.H.(1981). "Fiscal Crisis, Deinstitutionalization, and the Elderly". **American Behavioral Scientist** , 24(6) : 811-826.
5. Friedlander, W.A.(1963). **Introduction to Social Work**. New Delhi: Prentice Hall.
6. Goffman, E.(1961). **Asylum: Essays on the Social Situation of Mental Patients and Other Inmates**. Gardencity, New York: Double day.
7. Haber,C. (1983). **Beyond Sixty Five: The Dilemma of Old Age in America's Past.** Cambridge: Cambridge University Press.
8. Hendricks, J. & Hendricks. C.D (1977). **Aging in Mass Society: Myths and Realities**. Cambridge, Massachusetts : Winthrop Publishers.
9. Lawton, M.P. (1982). "Environments and Living Arrangements". **In**, R.H.Binstock, et al. (eds). **International Perspectives on Aging: Population and Policy Challenges**. New York: UNFPA: 159-192.
10. Payne, M. (1986). **Social Care in the Community**. London: Macmillan.
11. Puner, M. (1974). **To the Good Long Life: What We Know About Growing Old**. New York: Universe Books.
12. Tout, K. (1989). **Aging in Developing Countries**. Oxford: Oxford University Press.
13. Townsend, P. (1962). **The Last Refuge: A Survey of Residential Institutions and Homes for the Aged in England and Wales**. London :Routledge& Kegan Paul.

Research Priorities in the Field of Ageing in India: Some Suggestions

S. Siva Raju

Background

The large scale social, economic and technological changes, which are taking place in the society have significantly transformed the pattern of formal and informal support systems available to the older people. With the growth of "Individualization" in modern industrial life and materialistic thinking among the younger generation, there is greater alienation and isolation of the elderly from their family members and from society at large. Given the changes, the elderly face a number of problems and adjust to varying degrees. These problems range from absence of ensured and sufficient income to support themselves and their dependents, to ill health, absence of social security, loss of social role and recognition, to the non-availability of opportunities for creative use of free time. Given the constraint of resources, care of elderly has received a low priority so far in planning and programming social security provisions and services.

Issues of the older persons

The issues of the older persons in India are many and complex. They have become increasingly vulnerable not only due to their physical disabilities, but also due to social, economic, psychological and health related issues.

For elders living with their families-still the dominant living arrangement-their economic security and well being are largely contingent on the economic capacity of the family unit. Particularly in rural areas, families suffer from economic crisis, as their occupations do not produce income throughout the year.

Inadequate income is a major problem of elderly in India (Siva Raju, 2002). Nearly 90 percent of the total workforces are employed in the unorganised sector. They retire from their gainful employment without any financial security like pension and other post retirement benefits. The Ministry of Social Justice and Empowerment, Government of India (1999) in its document on the National Policy for Older Persons, has relied on the figure of 33 percent of the general population below poverty line and has concluded that one-third of the population in 60 plus age group is also below that level. Though this figure may be understated from the older persons' point of view, still accepting this figure, the number of poor older persons comes to about 23 millions. As per the Policy, the coverage under the Old Age Pension Scheme for poor persons, which is 2.76 million (as on January 1997) will be significantly expanded, with the ultimate objective of covering all older persons below the poverty line.

These days, due to change in family structure, the elderly are not given adequate care and attention by their family members. This trend is fast emerging partly due to growth of "individualism" in modern industrial life and due to the materialistic thinking among the younger generation. These changes lead to greater alienation and isolation of the elderly from their family members and from society at large. Due to the changes in the family structure and the value system, the respect, honour, status and authority, which the elderly used to enjoy in the traditional society, gradually has started declining and in the process the elderly are relegated to an insignificant place in our society (D' Souza, 1971). Though the young generation takes care of their elders, in spite of several economic and social problems, it is their living conditions and the quality of care, which widely differs from society to society.

As older people become aware of their incompetencies, they begin to revise their ideas about themselves. They also have to start coping with reduced income, change of status, loss of friends and spouse and lastly, their waning physical health. Psychological changes accompany the passing of years,

slowness of thinking, impairment of memory, decrease in enthusiasm, increase in cautionness and alternation of sleep patterns. Social pressure and inadequate resources create many dysfunctional features of old age. Further, it is well known that the incidence of mental illness among old people is much higher than among the young. The psychological problems encountered by retired persons are much wider and its impact on the individual is entirely different as compared to those in the unorganised sectors. Reduced health, reduced income and a sudden break with a particular kind of professional life results in various socio-psychological problems for the retired. The attitude of family members towards retired persons changes and his attitude towards his family members also changes in this period of life. Attitudes towards old age, degradation of status in the community, problems of isolation. loneliness and generation gap are the prominent thrust areas resulting in socio-psychological frustration among them (Mohanty, 1989).

Most elderly are reported to bear a negative self-image and poor self-concept (Ramamurti and Jamuna, 1984). Changes in looks and likeability and a feeling that others alienate the elderly greatly contribute to the negative self-image. It was noticed that after the age of 50, people gradually manifest more problems and display poor adjustment and life satisfaction till the age of retirement. However, after the retirement they slowly and gradually find adjustment and as such their life satisfaction and adjustment show higher index until the age of 70 when the negative effects of ageing again become more pronounced (Ramamurti, 1978). The significant determinants of Successful Ageing, according to some studies (Ramamurti and Jamuna, 1992, Niharika, 2004, Siva Raju, 2006), include self-acceptance of ageing changes, self-perception of health, perceived functional ability, perception of social support, inter-generational amity, belief in karma and after life, flexibility, range of interests, activity level, marital satisfaction, religiosity, certain value orientations and economic well-being.

Health problems and medical care are the major concerns among a large majority of the elderly. The majority of them refrain from seeking medical aid from public hospitals due to many impediments, besides lack of money. Some of the health problems of the elderly can be attributed to social values also. The idea that old age is an age of ailments and physical infirmities is deeply rooted in the Indian mind and many of the sufferings and stresses within curable limits are accepted as natural and inevitable by the elderly.

The existing medical facilities in India are inadequate and their utilisation by the public is very meagre. The problem is more acute in the remote areas, where, whatever meagre facilities have been made available, are not optimally utilised by people (Siva Raju, 1991). Instead, people go to private practitioners of indigenous medicine who live among them and who may not be qualified. Getting proper medical aid is beyond the reach of the elderly, which may be due to their poverty, illiteracy, general backwardness and adherence to superstitious beliefs for curing illnesses and diseases. Poor people spend larger proportion of their income on medical bills than the rich. Since medicines and consultations are very expensive, they take medicines only until the symptoms go away, and as a result, most of the leading ailments become chronic in nature.

Research on Ageing in India

The Research Agenda on Ageing for the 21st Century which was jointly developed by the United Nations Office on Ageing and the International Association of Gerontology, was adopted by the Second World Assembly on Ageing at Madrid, Spain in 2002. It aimed to elaborate and implement public policies on ageing and influence the direction and priorities for scientific gerontology in the coming decades. According to UN (2002), "There is a need to assess the 'state of the art' of existing knowledge, as it varies across countries and regions, and to identify priority gaps in information necessary for policy development." Accordingly, attempts are made recently to

review the body of knowledge in the field of ageing and to identify the priority areas of research in the field of ageing in India (Prakash, I.J., 2004, Ramamurti, 2005, Siva Raju, 2006).

The science of gerontology is still in its infancy in India. The interest of social scientists and social work professionals on various ageing issues is of recent origin. At present academic institutions like Tata Institute of Social Sciences and SNDT University in Mumbai, International Longevity Centre in Pune, M.S. University in Baroda, Centre for Development Studies and Centre for Gerontological Studies in Trivandrum, Council for Social Development in Hyderabad, Sri Venkateswara University in Tirupati and Bangalore University in Bangalore have been actively engaged in research on ageing. The Census, National Sample Survey Organisations, Central Statistical Organisation and others collect and compile data on various ageing related issues like age and sex structure, rural urban residential patterns, literacy, martial status, work status dependency status, disability and health status and related information. Further organizations like ICSSR, ICMR, Planning Commission, Ministry of Social Justice and Empowerment and International Agencies like UNFPA, UNESCO, WHO and ESCAP sponsor projects that focus on issues related to ageing. These organizations also sponsor programmes and organize seminars conferences and workshops on ageing related issues.

The research on Ageing in India as on today was primarily focused on socio-economic and demographic profiles, living arrangements, problems of and services to the aged, interpersonal relationships especially of the urban elderly. No doubt concerted efforts made by researchers have so far led to a better understanding of ageing issues. However the diversity that has emerged in the ageing process necessitates our research efforts to focus on different ageing issues in society. This in turn is expected to promote a development of effective age-related policies and programmes. The review of the earlier studies reveal that most of them view the elderly as passive receivers of care. Further the problems of vulnerable elderly like widowed

females, disabled, fragile older persons and those from the unorganized sector are inadequately covered. Most studies conducted to assess various issues of the elderly are exploratory and descriptive. Ageing needs a multi and inter-disciplinary perspective. The development of social gerontology reveals that disciplines like sociology, demography, psychology, anthropology, geography, law, social policy and administration, management, economics, nutrition, as well as varied professional training like social work, nursing, counseling and clinical psychology, focus on various ageing issues. However, no single disciplinary focus gives a holistic understanding. A combination of qualitative and quantitative approaches are also required for a more comprehensive understanding of ageing issues. Also wide variation in levels of development and socio-economic status of people living in different geographical regions make national level studies on elderly essential. Analysis of both secondary and primary data need to be attempted, wherever necessary, which in turn will help to focus on ageing issues, both at macro and micro levels.

Research Priorities

Some of the areas of research on elderly which needs our attention on priority basis are:

- Assessment of the impact of globalization on the living conditions of the elderly.
- Study of vulnerability of elderly women, disabled, fragile older persons and those from the unorganized sector.
- Focus on the rural and tribal elderly living conditions.
- Effect of rural - urban migration of young members on the living conditions of their elderly.
- Need assessment studies on establishment of day care and interactive centres for elderly in the community.
- Impact of health problems on the quality of life of the elderly.
- Study of linkages between nutritional and health status of the elderly.

- Primary Health Care for the rural and tribal elderly.
- Factors contributing for different forms of elder abuse.
- Determination of 'successful' ageing, 'healthy' ageing, 'productive' ageing and 'active' ageing
- Assessment of quality of life of elderly on the basis of life span approaches.
- Assessment of family relations and social networks of elderly living in different socio-economic settings.
- Issues and implications of networking of organizations working on ageing issues.
- Assessment of areas for collaboration between Public and Private sector for enhancing the living conditions of the elderly.
- Assessment of issues related to the promotion of ageing in place.
- Study of linkages between spirituality and ageing
- Study of role of technology in the quality of life of elderly.
- Assessment of voluntarism among the elderly living in different socio- economic settings
- Study of opportunities and facilities that are required for enhancing the contribution of elderly to the family, community and society.

The focus of social gerontology is not only concerned with people in later life but also the social institutions which particularly affect that period such as retirement, pensions and welfare policy. Given the changes in the socio-economic profile of the elderly, there is a need to recognize them as the resource group and to develop suitable policies and programmes for their integration into the development process.

References

1. D'Souza, V.S. 1971 Changes in Social Structure and Changing Roles of Older People in India. Sociology and Social Research 53 (3), 297-304.
2. Government of India 1999 National Policy on Older Persons. Ministry of Social Justice and Empowerment, New Delhi.

3. Mohanty, S.P 1989 Demographic & Socio-Cultural Aspects of Ageing in India:Some Emerging Issues. In R.N.Pati&B.Jena (Eds.) Aged in India:Socio-Demographic Dimension. New Delhi: Ashish, 37-45.
4. Niharika, Gupta, 2004. Successful Ageing and Its Determinants, Ph.D. thesis, TISS, Mumbai (Mimeo)
5. Ramamurti, P. V. 1978 The Sixth decade and after. Tirupathi: S. V. University Press.
6. Ramamurti, P.V. &Jamuna, D. 1984 Psychological Research on the Aged in India. Journal of the Anthropological Society of India, 19, 3.
7. Ramamurti, P.V. &Jamuna, D. 1992 Markers of Successful Ageing Among Indian Sample, Basle, Switzerland, Sandoz Project Report.
8. Prakash , I.J., 2004, Ramamurti, 2005, Siva Raju, 2006, Identify the priority areas of research in the field of ageing in India
9. Siva Raju, S. 1991 "Health care system in India: Need for comprehensive evaluation", in `Primary Health care', Yesudian C.A.K. (ed.) Tata Institute of social Sciences, Bombay.
10. Siva Raju, S. 2002: "Health Status of the Urban Elderly: A Medico-Social Study", Delhi, B. R. Publishing Co.
11. Siva Raju, S. 2002: "Meeting the Needs of the Poor and Excluded in India", Situation and Voices, The Older Poor and Excluded in South Africa and India, UNFPA, Population and Development Strategies, No. 2, 93-110.
12. Siva Raju, S, 2006, Ageing in India in the 21st Century : A Research Agenda, Mumbai: Harmony- Celebrate Age
13. UN (2002): http://social.un.org/index/Ageing/Resources/MadridInternationalPlanofActiononAgeing.aspx

Towards A Community of Concern for the Elderly

K.N.Ajith

Studies on ageing conclude that institutional care of the elderly is not desirable for their emotional well - being, though their basic needs of food, clothing and shelter are met by the homes for the aged. Further, such an approach for the welfare of the elderly would legitimize the segregation of the elderly from their homes and familiar surroundings. In financial terms, homes for the aged are costly propositions while the number of beneficiaries is very small. As an elder care service, institutionalization should be considered only as the last resort.

At a time when home for the aged was the only form of service for the elderly in India, Centre for the Welfare of the Aged (CEWA), formed in 1979, pioneered community-based elder care services in association with Helpage India.

Vision

A society where people of all age-groups living together without discrimination of age, gender, religion, caste and social class in an environment of security and mutual respect.

Mission

CEWA works with and for older persons in general, and the poor and the disadvantaged among them in particular, with their active involvement in partnership with their families and the communities in which they live so as to enable them to lead their lives with self-respect, dignity and usefulness to others.

Major Objectives

- To promote community - based services for and by the elderly so as to enable the older people to function as

active participants in the families and communities, and in the larger social context.

- To serve as a centre for research, documentation, training and communication on ageing, welfare of the elderly and related issues.
- To influence social policy formulation on the welfare of the elderly through conferences, seminars, workshops, and collective action by the elderly.

CEWA's Convictions

- The best place for the well - being of the elderly is the family.
- Services to the elderly should be extended where they live or as near as possible.
- Elderly are resources of the community. Their talents and resources are unlimited which should be identified, recognised, developed and utilised.
- The elderly themselves will be able to manage programmes for their well - being with necessary support from social welfare personnel as facilitators.
- There must be continuous educational campaigns to create awareness in society of the problems, needs and capacities of the elderly. It is also necessary to enhance the positive self - image of the older persons.

Community – Based Services

CEWA is the first organisation in the country to operationalize the concept of community - based services for the elderly in partnership with Helpage India and Help the Aged, UK. The Annual Report of Helpage India (established in 1978) observes:

> "We are particulary pleased to be acting in partnership with the new Centre for the Welfare of the Aged, Madras, to undertake an entirely non - residential service to the aged of that city. This project is pioneering a new field of social service for the elderly which we hope others will follow".
>
> (Annual Report, 1980)

Day Centres

As the vast majority of the elderly in India are not benefited by any service, it is necessary to have less expensive, easily replicable, community - based services for the elderly. On these premises, CEWA started day centres in the communities in which the elderly live.

CEWA started day centres at a time when voluntary organisations and social workers considered homes for the aged as the only one type of elder care service possible. There was scepticism among social welfare and religious organisations, which were running homes for the aged, about the feasibility of organising day centres successfully. But once the day centres started functioning with the active involvement of the elders, keen interest was shown by the media, social workers, welfare agencies and the government.

Copac, Manual on Cooperatives for the Aging, a joint publication by the Copac Secretariat at Rome, and the United Nations Office at Vienna, Centre for Social Development and Humanitarian Affairs, published the following about CEWA's day centres:

The Centre for the Welfare of the Aged (CEWA) works to foster self-help among the aged who do not benefit from any age care services. CEWA regards 'care' not as a treatment to be 'given' to passive objects, but as the attention to all the needs of the person. CEWA believes that the best place for the well-being of elderly people is within their families and communities. This is in contrast to widespread assumptions that the best 'care' of the elderly is 'given' by professionalised and specialised institutions. The elderly themselves are in large measure capable of attending to their own needs and the needs of their peers. At times, expert consultation may be needed and the services of doctors, legal advisers, ophthalmologists, and physiotherapists may be required, but the process of mutual 'caring' and self-help cannot be professionalised.

Because CEWA is confident that the elderly can help themselves, its work is the forging of links amongst the elderly

themselves and between the elderly in need of a few specialised services and the trained personnel who can help them. Beginning in the early 1980's it organised meetings for the elderly in low - income neighbourhoods of Madras in southern India to explain the concept of self-help through local day centres and it conducted a household survey with the dual aim of spreading the idea of community care for the elderly through day centres and of collecting basic information on the families of the elderly people in the neighbourhood.

The first day centre was established in a small hut in a low - income neighbourhood. A weekly clinic was arranged by CEWA. Because the centre is near their homes, the elderly can attend the day centre clinic with much less difficulty than the state hospital. Because the elderly gather in one place, the attending medical officer can see them all in much less time than would be the case were it necessary to visit each person at his or her home. Special trips are made to bed-ridden elderly while serious cases are referred to the geriatric department of the state hospital. CEWA has also arranged for a physiotherapist to treat cases referred by the medical officer and all the elderly may have their vision tested at regular intervals by a specialist who comes to their centre.

Bringing professional health service into the community was a priority of CEWA and a task particularly well-suited to an outside agency. However, by no means was it envisaged by CEWA that the care of the elderly ended with specialised professional services. Other aspects of care also need development and the people best equipped to identify those needs and develop responses to meet them are the elderly themselves. Therefore, the elderly have the responsibility of managing the centre through the Association of the Elderly. The CEWA social workers serve as facilitators.

The day centre remains open not only for clinics, but as a social centre where the elderly can meet to discuss current events and take tea. An elderly volunteer convenes regular meetings in order to collect information on the problems and needs of the

older people. The association also organises outings, family counselling, and the celebration of festivals. All of these provide the opportunity for the elderly to make a contribution to their community and to maintain social contacts in a supportive environment. The association addresses strictly material needs by organising a daily meal for the poorest elderly. However, this also provides useful work for the elderly who help out in all aspects of its preparation. Some members of the association work producing incense and paper bags. The proceeds are divided among these members according to the contribution of each one.

The Chairman of the Tamilnadu Social Welfare Advisory Board (Mrs. Tara Cherian), who led a Committee of the Central Social Welfare Board in January 1985, made the following observations:

> "The members very much appreciated the day centres run by CEWA. They wanted to run such centres all over the country and I am very happy that this programme of yours is very much appreciated."

Economic Support For Self – Employment

Elderly persons, despite age, prefer to be on their own and would like to be contributors to the family income, unless serious illnesses or handicaps restrict their capacity. Most of the elderly in self-employment are in marginal occupations with meagre returns. They borrow money from money - lenders at daily or weekly rates of interest which are exorbitant. Though the weaker sections are eligible for loans from nationalised banks at differential rates of interest the poor elderly find it difficult to avail of loans as they are not in a position to guarantee security. Advanced age itself is a disincentive for the banks to consider loans to the elderly.

CEWA stood guarantee for elderly men and women, and arranged bank loans for self - employment. The Social Workers of CEWA would make home visits and discuss the self-employment project in detail. The details of the loan assessment

were then sent to the bank with CEWA's recommendation. Regular follow - up visits were made. In the cases of day centre members, the respective associations recommended the applications. The elderly persons were generally prompt in repayment of loans unless some unexpected events like sickness of self or members of the family, visits to villages for urgent purposes, rain and loss in business took place.

Social Work With Elderly Patients

The Geriatric Unit of the Government General Hospital, Madras, established in 1978, is the first of its kind in India. The Unit came forward to collaborate with CEWA in 1982 to improve the quality of geriatric care to the elderly. This unique collaboration between the leading government institution and CEWA, a non-governmental organisation, was very beneficial to the elderly patients.

The services extended by the CEWA team of social workers were as follows:

- Interviewing and preparation of case histories.
- Listening to the problems in the family, financial difficulties and worries, which were closely related to their state of health; and extending emotional support and counselling service.
- Helping the elderly patients who sought clarifications about their diseases and medical treatment, guiding elderly patients to the different departments and helping them with tests.
- Providing information on old age pension, loans for self-employment, sources of help for the members of the family, etc.
- Rehabilitation services such as arranging financial assistance, loans for self - employment, spectacles and other aids. Often the elderly persons remarked that "half of my sickness is over when I talk to Amma" (referring to CEWA Social Worker).

Elder Care Volunteer Programme

While the number of older people has been on the increase, the services and opportunities for their well - being have been highly inadequate. CEWA, therefore, launched an Elder Care Volunteer Programme in 1993. CEWA had sensitized 182 persons till December 1999 for elder care volunteer service: 126 of them were women and girls. The vast majority of the volunteers were younger persons. A beginning effort was also made to reach out to the impressionable group of school students in the 15-16 age group. Initial training of volunteers was followed by regular review sessions once in two months. The volunteers, who had undergone the training, were unanimous in their appreciation of the exposure on ageing and elder care. Many of them stated that they took the elders for granted and often ignored their needs and problems.

Training and Elder Care Consultancy

CEWA has encouraged many organisations in the country, particularly in the southern states, to start community - based elder care services as well as to improve the quality of care in residential institutions. CEWA also had the privilege of giving guidance to a Bangladesh organisation in initiating a community care programme for the elders.

In collaboration with the National Service Scheme (NSS) Unit of the Madras University, a training seminar was organised in March, 1983 by CEWA for the Programme Officers of NSS for the development of a plan for involving the college students in programmes for the welfare of the elderly. The seminar was attended by Professors and Assistant Professors from the Madras city colleges.

A ten - day training programme for the personnel of voluntary organisations from the four southern states caring for the elderly was organised by CEWA in collaboration with Helpage India in August 1985. It was sponsored by the Department of Social Welfare, Govt. of India. A five - day training

in organising day centres was arranged for the personnel of non-governmental organisations in February 1993.

A three - month certificate programme in elder care was organised in 1995 in collaboration with the Tamilnadu Slum Clearance Board. The trainees were women from slum communities. They were trained to work as Home Nursing Aides.

Non-governmental organisations, developmental and welfare, have been working in different spheres of social life and with different sections of the population. Perhaps there is no aspect of human life which is not the concern of NGOs. These organisations have extensive reach and resources. But most of the NGOs concentrate on their "target groups and areas"; and the elderly often go unnoticed. Many developmental NGOs have the mistaken notion that working with the aged will dilute their organisational fervour and thrust. For example, there are many NGOs working with the Dalits ; they mobilise the Dalits for collective action; but they often ignore the needs of the elderly among the Dalits who are, in fact, doubly deprived because of socio-economic oppression and age-related debilities. Developmental organisations working with the slum communities and women are other examples. An organisation may vociferously be fighting for gender justice and mass mobilisation of women without showing any interest in the well - being of elderly women. In order to strengthen the integration of the elderly with the vibrant community life and to promote the well - being of a large number of older persons, if not all, with minimum financial requirements, NGOs have a crucial role. Hence workshops for NGOs were organised by CEWA. During the period 2000-2002, seven workshops were organised to sensitize the NGOs from Chennai city and the districts of Tamilnadu; 96 NGOs participated in the workshops.The government agencies, the Tamilnadu Social Welfare Board and the Tamilnadu Slum Clearance Board, actively collaborated in organising the workshops.

Elder Abuse Awareness

The prevalence of elder abuse in different forms is a painful reality in the Indian society. A survey of older people in Chennai city conducted by CEWA about ten years ago indicated disturbing findings. Nearly three-fourths of the elderly agreed with the statement that "these days old parents are neglected by children" . They mentioned many types of elder abuse prevalent in the city : shouting, making them wait for food, delaying or even denying medical treatment, leaving the sick elderly in soiled clothes, discarding the personal belongings of parents as junk, not taking them to social functions, preventing them from visiting neighbours for fear of gossiping, not consulting them on family matters, not introducing them to visitors, denying elderly couples privacy, and assaulting physically. On the occasion of the first World Elder Abuse Awareness Day on 15th June 2006 CEWA conducted a survey of older persons in five urban poor settlements in Chennai ; 71% men and 76% women reported that they experienced ill- treatment in the families.

A national workshop on elder abuse, organised in March 1996, was the first effort in the country to focus attention on this serious issue. The workshop brought together a group of social workers working with the elders, academics engaged in gerontological research and legal practitioners. Various aspects of elder abuse and case studies were discussed by the group.

As elder abuse has been on the increase in families, irrespective of social class, CEWA has initiated an awareness campaign to sensitize children in schools on elder abuse and its prevention through a variety of programmes.

Advocacy

The elderly segment of the population is not a homogeneous group; they are highly heterogeneous in terms of capabilities, problems and needs. However, broadly speaking, they could be divided into two categories. The first category consists of elderly who have independent income from employment pension, property, investment, or other sources. They have organizational

support too in the form of pensioners' associations, senior citizens' groups, etc. The second category comprises older persons who are deprived of even basic necessities of human existence. Without a viable social security programme for the elderly, the only alternative support at present is the social assistance of the state government for the older persons who are aged 60 and above, without an adult son / grandson, and without any means of sustenance. But securing old age pension is not an easy task because of procedural bottlenecks and delay in sanctioning the pension. Most often external support is needed. While employment pensioners have strong associations, the old age pension recipients do not have any forum. Though the middle and higher sections have associations of senior citizens or clubs, the poor elderly do not have any organization of their own. In the absence of planned welfare and development programmes, it is necessary to mobilise the poor elderly into self-help associations to enable them to improve their quality of life.

CEWA believes that community - based services create strength among the elderly and in course of time enable the elders' associations to function as social action groups capable of influencing Government policies. So since 1984, CEWA has been organising Elders' Days to bring together elderly people from different parts of the city and even outside to discuss common issues.

In 1985, CEWA organised a national workshop on ageing and care for the elderly in India. Social workers in the field of elder care, social scientists, and government representatives participated in the workshop. The workshop had drafted a national plan of action for the welfare of the elderly which received national attention.

The incidence of Alzheimer 's disease (AD) is on the increase in India. But most of the families are ignorant of its symptoms and progression. Services for AD and other types of dementia are scarce. Hence an article titled "Silent Killer of Minds" by Dr.T.K.Nair, Chairman, was published by The Hindu on 2008 World Alzheimer's Day (September 21).

Recognition

In 1988 CEWA was invited to be in an International Panel discussion on "Coming of Age" at London, which was telecast for global viewing by Channel 4 in London.

The United Nations (ESCAP) invited CEWA to participate in two workshops on ageing in 1996 and 1997 at Bangkok and Macau, respectively.

An observation made by a representative of the globally famous organisation GRAY PANTHERS, USA:

"The most unique aspect of your work was your belief in the need to organise people to exercise their own power. This seems to be the sine qua non of CEWA".

Nightingales Medical Trust: An Innovation in Health Care

Kalpana Sampath

Every country strives to provide the best way of life for the children, youth, and the senior citizens. If there was a section that was just not in the purview of the Indian mind a few decades back it was the senior citizens. They came under the family structure as a natural process of aging and weren't considered the responsibility of the community or the state. But in the recent past, the issue of elderly care in India is gaining attention with an unimaginable speeding the cities as well as the rural areas. With the increasing pace of life and the process of globalization, this issue has gained importance. Factors like the increase in the average age of the population, migration into cities thus leaving the seniors to fend for themselves, the impetus given by the government regarding healthcare services have all led to the emergence of this situation and demand immediate solutions. The private institutions and NGOs play a vital role in providing sincere and excellent services. One such institution which has made its mark is the Nightingales Medical Trust (NMT). I am very glad to share the journey and wonderful contributions of NMT through this article.

Nightingales Medical Trust (NMT) is a registered, non-profit, voluntary organization working for the well-being of the elderly in and around Bangalore since 1998 through various innovative, family-based support systems for the senior citizens of different socio-economic groups. It is a professionally managed organization that benefits over 800 senior citizens every day. Some of Nightingales' projects have emerged as models and are being replicated in other parts of the country. Besides involving the community in all the programmes, Nightingales

Medical Trust is successfully partnering with government agencies. A founder member Dr.Radha Murthy says, "When we started it was difficult to convince people that we can provide health care to elderly at their door. But over time, with our sincere effort our organization took off well and now we are recognized for our efforts, both at national and international levels. The reason for such success could be the fact that our services look at assurance of personalized care for elderly with the comfort of home and it's cost effective".

Personalized care is not so easy. In every nuclear household with two or three siblings, when people in the family begin to age, they move from actively managing the household to becoming senior citizens and it is an uphill task to recognize the reality that they're aging. Usually, until there is a medical condition, the concept of aging is not recognized. When the health issues hit the family, most of them get caught in triviality rather than the priority.

The priority should be to see how the elderly can be provided with care. It is indeed a significant achievement to build an institution par excellence in elderly care. Nightingales Home Health Services (NHHS) was set up in January 1996 and led to the establishment of Nightingales Medical Trust in 1998. For any institution to be on the path of excellence it should be guided by a powerful vision. NMT's vision is **to build a society where elders are happy, healthy and secure, living with dignity as an integral part of the family and the community with appropriate care and support systems**. NMT not only focuses on giving medical attention, but also emotional and societal fulfillment. To achieve this vision the key projects of NMT include the following:

- **Nightingales Elders' Enrichment Centre** , a centre where senior citizens gather to interact with one another, discuss issues, learn and enjoy their sunset years.
- **Sandhya Kirana** started in February 2004 is a day care centre for impoverished elders, some of whom are destitute. It is a joint project of Bangalore MahanagaraPalike and NMT.

- **The Elders' Helpline-1090** was set up in partnership with the Bangalore City Police to address issues relating to exploitation and abuse of the elderly.
- **Nightingales Jobs 60+** launched in October 2011 aiming at ensuring economic security and independence to non-pensioned elders with necessary training and assistance to get suitable placements.
- **Centre for Ageing and Alzheimer's** provides comprehensive services and facilities for elders suffering from Alzheimer's and related disorders. With a facility of 70 in-patients' care as well as out-patient facility, as a part of its outreach activities, the centre runs mobile memory screening and tele-dementia care.

Nightingales Centre for Ageing and Alzheimer's

Currently, in India, there are about 3,20,000 elders affected by Alzheimer's and in Bangalore alone, the estimated number is about 30,000. The centre gives priority to therapeutic treatment with less or nil priority to non-pharmacological interventions rather than resorting to sedating medication. Dr. Soumya says, *"We try to maintain the treatment very culture - specific and don't try to copy the western treatment models"*. The best part of the centre is its dedicated team of psychiatrists, physiotherapists and psychologists who take care of the elders along with educating the family on the support required from them while dealing with Dementia or Alzheimer's patients. Dr. Soumya opines that not all patients require institutionalization. It is best for the patient if they can live with the family. Therefore, they provide training, and check on them and maintain their medication and treatment from time to time. NMT also provides short term or respite care for the family having dementia person with them. This service is like a boon for the family members when they have to go out of station or just want a break from caring for a short period. They can drop the patient at the centre for the period they are away with the assurance that in their absence, the family member is well cared for by the dedicated staff of the centre. The short

term care also helps in understanding their behavioural pattern, and prescribing treatment and medicines. Appropriate feedback is given to the family so that they can follow the actions required when the patient behaves in a particular manner at home.

The patients are seen experiencing a higher level of comfort at the centre. Dr. Soumya points out that "*as many live in apartments where mobility is restricted and they can only see other people when someone visits the family, people feel more comfortable here because of the infrastructure which is so open and spacious. The open secured environment to meet and interact with other people and personal care by the staff add to the comfort. Also, aggressive behaviour of the patients is dealt with deftly by observing and understanding the behavioural pattern and solutions are identified to manage them*."

The centre has patients from all over India. But majority of them are from southern states of India. NMT also provides referrals to other institutions doing similar work in the respective states when the patients cannot be accommodated in Bangalore.

In addition, the centre has corporate partnerships and a lot of people volunteer in various activities. The centre also provides internships for psychology students interested in the study of senior citizens. Dr. Soumya says that media attention plays a large role in spreading the work. Besides media, the mouth to mouth publicity also enables people to access help and services.

The other services are:

- **Day care**
- **Training** : Training for both professionals as well as family members with hands on practice is a specialty in this programme. NMT has technical collaboration with Alzheimer's Australia,
- **Research:** Special focus on the efficacy of indigenous medicines for managing age-related ailments and Alzheimer's.
- **Awareness:** NMT has recently launched the Mobile Memory Screening Unit withscreening facility which proposes to visit places where there are groups of elderly people such as old age homes, senior citizen

clubs,and interested individuals with a minimum of 20 people to be screened. If screening indicates a problem, a more detailed assessment will be arranged to rule out dementia.

- **Activities**: Patients who come to the centre can enjoy a range of activities -individualized and in accordance to the care-plan in a therapeutic environment which includes art, music, pet,reminiscence, out-door and in-door games, and movement. Occupational-therapy based activities enhance their day-to-day functioning.
- **Snoezelen Room**: For Alzheimer's and dementia patients, over stimulating their senses of touch,sound, smell, taste, and sight can help them reconnect with their environment. Snoezelen or multisensory stimulation provides sensory stimuli to stimulate the primary senses through the use of lighting effects, tactile surfaces, meditative music and the odour of relaxing essential oils. This allows them to react better to their environment and to the people who are part of it, and experience inner peace and contentment. This also helps in dealing with destructive behaviour ofpatients.

Nightingales Elders' Enrichment Centre

Nightingales Elders Enrichment Centre (NEEC, 1999) is a unique daycare centre for senior citizens. With a registered membership of over 300, nearly 50 of them are regular visitors. The beneficiaries are mostly from the middle class. There are different programmes.

- **Health and Medicare**: Services include medical check-up, lab investigations, injections, wound care, ECG and other health-related support.
- **Counselling:** The centre provides counselling support to individuals and groups with practical guidance for enjoying old age and tips on health, fitness, diet and nutrition.

- **Mental Exercises**: Memory exercises, physiotherapy and fitness programmes such as yoga, pranayama (breathing) sessions for relaxation and special exercises for Parkinson's and Arthritis.
- **Total Daycare and Respite Care Facility**: For the elderly who are alone at homeduring the day, this programme is very useful. In situations where family members leave for a short period, a short-term stay facility is also available. Women's hour caters to the special needs and interests of female members. Talks and interactive sessions on various topics such as the essence of different religions, health and age-related issues, current affairs and others are also conducted. Members get to learn new languages, arts, crafts : and to celebrate birthdays, special days and national and religious festivals. Elders participate in tours, in visiting old age homes and undertake community welfare schemes for underprivileged elders.

Gunny Talgery, a beneficiary, says, "*In a desert of loneliness, NEEC is an oasis for rejuvenation. Here, you are reminded that now is the time to do many of the things you never found the time for earlier. The centre provides the opportunity to meet and mix with people having common interests and wavelengths, apart from age. While doing so, we build relationships that are lasting and enriching*."

Rural Mobile Medicare Programme

The innovation in health care is not just for the people in the city but also for the rural community. The Nightingales Medicare van equipped with medical supplies, a doctor, a nurse and a volunteer attend to the health complaints of the elderly living in the outskirts of Bangalore. The team visits three centres on a pre-determined schedule, dispensing basic care and free medicines wherever required. On an average, nearly a thousand health complaints are tended to every month. Cases requiring specialized services are referred to nearby hospitals. The Rural

Mobile Medical Programme has made a great impact on the health of the elderly in the villages. Since the services are regular, the team is now well-received by the elderly in the villages.

Conclusion

Nightingales Medical Trust is professionally managed by a Board of Trustees consisting of dedicated people from different fields of expertise and elders themselves on the managing and co-ordinating committees at various levels. The team also consists of medical professionals, lawyers, counsellors, social workers and committed staff.

According to Dr. Radha, the challenges faced by NMT are in terms of:

- Educating public about the concept and making them accept and use the same.
- Funding, especially for elderly care.
- Retaining staff who are willing to care for the elderly, inspite of low paying jobs.
- Documentation of the daily interventions.

Dr. Radha reports that "the people working with us have steadily increased. We started with an urge to do something for the elderly, but never imagined that we will reach so far. At the end of the day I am very much satisfied. In the coming years, the time has come to broaden the horizon. A different model is envisaged to implement health care for the rural old with the participation of local community. We look forward to individuals or organizations to associate with us and replicate our models in their own place," Dr. Radha adds that "it's high time to shift our perception of elders and think of empowering them Elders' productivity has multiple outcomes and will also instill a life of dignified independent status. Also, at the same time the elderly should understand the changing social scenario. So it is important to initiate steps to fill the gaps from both sides – children as well as elders."

Old Age in an Indifferent Society

T.K.Nair

Demography of Aging

Longevity is a triumph of humanity. It is the result mainly of declining fertility and mortality rates, and increasing survival at older ages. The global population of persons aged 60 years or over is projected to increase to one in five by 2050 according to the estimates of UNFPA and Helpage International (2012). The demographic profile of India in the UNFPA report poses great social, economic and political challenges to the central and state governments, families and non-governmental organizations.

	2012	2050
Number of persons aged 60 and above (in million)	100.213	323.092
Percentage of persons aged 60 and above	8.0	19.1
Number of persons aged 80 and above (in million)	9.249	44.218
Sex-ration :2012 (Men per 100 women)	92 (60+) 82 (80+)	
Life expectancy at birth: 2010-2013	64 (Men) 68 (Women)	
Life expectancy at age 60 : 2010-2015	16 (Men) 18 (Women)	
Percentage of currently married : 2011-2012	83 (Men) 40 (Women)	

Internationally comparable statistics on population aging for 195 countries enable countries to be ranked according to life expectancy at birth, life expectancy at age 60, and healthy life expectancy at birth. Japan ranks first in all three categories: life

expectancy at birth of 84 years ,life expectancy at age 60 of 26 years, and healthy life expectancy at birth of 75 years (average figures for men and women) . This provides the norm against which other countries can be ranked. The report card for India shows:

- Life expectancy at birth : 66 years. World ranking :143/ 195
- Life expectancy at age 60: 17 years. World ranking : 141/195
- Healthy life expectancy at birth: A newborn can expect to live 53 years free from disability. World ranking : 122/177

In less than four decades, India will witness more than a three-fold increase in the elderly segment (60+) of its population, and quite strikingly, nearly a five-hold increase among the "old old" from 9 million to 44 million. Gender-wise, there is a distinct feminization of old age with life expectancy more skewed for women than for men. More significantly, widowhood is a serious reality as women grow older. Theirs is a life time of gender-based discrimination. As the number and proportion of the elderly grow faster than any other age group, there are serious concerns about the capacities of the central and state governments to address the social, economic and other challenges associated with the demographic transition. In the developed countries, economic development preceded population ageing. But in India, the reverse trend is being witnessed. The steadily increasing elderly population in India raises many questions. How will we, and the future generations, deal with the challenges posed by the aging of our population? Can it be ensured that growing old will not mean, for the majority, a further sliding down into poverty, starvation and dependency? How can families be supported so that they will be able to provide satisfactory quality of care for older members? How can the elderly themselves be empowered to look after themselves effectively?

Family and the Elderly

Indian family has been undergoing changes in its structure and functions. Some sociologists assert that the joint family is breaking down, while some other social scientists are of the view that joint family with joint residence was not the norm. They say that joint family values are not to be interpreted as joint residence.

Joginder Kumar (1974) observes from his study of families from TamilNadu, Delhi, Uttar Pradesh and Rajasthan :

> There is considerable evidence that in North India, the general pattern of the establishment of a nuclear family is the result of the breakage of existing joint families. In contrast to this, in the southern part of India, the tradition appears to be the establishment of a separate home, shortly after marriage.

The first large scale rural study of the elderly was carried out by Nair (1980) in 200 villages selected on a probability sampling basis in Tamil Nadu state, and the findings were as follows:

Type of Family*	Per Cent of Families
1. Single person household, subnuclear, supplemented subnuclear.	22.63
2. Nuclear, supplemented nuclear	59.95
3. Lineal joint, supplemented lineal joint, collateral joint, supplemented collateral joint, lineal collateral joint, supplemented lineal collateral joint.	15.22
4. Others	2.20

*Classification by Kolenda, Pauline.(1987). **Regional Differences in Family Structure in India.** Jaipur :Rawat Publications.

Even in tribal societies, the joint families are in a minority. A study of Kota tribe (Varadharajan, 1982) in Tamilnadu indicated that only 10 per cent were joint families.

In the book "No Aging in India: Alzheimer's, the Bad Family, and Other Modern Things", Cohen shows that old age is a cultural construct participating in other forms of knowledge

and power: biomedical, sociological, colonial, and historical. Through these imbrications and excesses, the old person is no longer seen as himself or herself, but instead as a metaphor for the moral decay of the family and the nation. Cohen initially went to Benares looking for the etiology of senile dementia, but to his surprise, he found a set of languages and ideologies that denied the very existence of the plaques and tangles he was searching for. There was no aging in India – at least not until Western ideologies had seeped into the fabric of the nation. Alzheimer's was not a disease of the brain, but a disease of the family. The decay of family ties, and not some etiologic agent of disease, was seen as the causative factor of particular forms of dementia. Increasingly, Cohen became aware that Alzheimer's was not a fixed, ontologically secure entity but a "set of local and contingent practices rooted in culture and political economy". What began as a simple anthropological study became a much larger exploration of how modernity and discourse shape the treatment and alienation of aging people.

The family in India continues to be the provider of care for the elderly though the quality of care often is not satisfactory. The capacity of the family to provide care to the older members depends on three factors: the social and economic situation of family; whether it comes within the ambit of a social security system or not; and the nature and structure of the family itself (Chawla, 1988). In many families, though the elderly and other dependants are taken care of, they are "looked upon sometimes as people who do not have legitimate claims for their support by the family" which affects the emotional security they need (Devanandam& Thomas, 1966).

Income Security

Most of the elderly persons, having worked in agricultural and other unorganised sectors, have no source of income in their advanced years. Since a large number have always started their life in poverty, they have not saved anything during their working

years. The social security benefits are available only to a small section of the population and the quantum of social assistance to the destitute elderly is meagre. Hence "to be elderly under conditions of poverty can only spell continuous vulnerability, and a life devoid of even the most rudimentary human dignity" (Chawla, 1988).

Djurfeldt and Lindberg (1980), two Swedish scholars, undertook an intensive study of the introduction of western medicine in a village (Thaiyur) situated near Chennai city, and they observed that death is often an undramatic "natural event" in old age for the under and malnourished villagers who spent many years in hard labour.

> We remember that "old age" is the most common cause of death among adults. We now understand part of the reality behind that classification. Sometimes death in old age is a euphemism for death due to starvation.

Currently available old age pension schemes for the poor, which are being implemented by the states, are grossly inadequate in scale and coverage, and illiberal in their qualifying criteria. Social assistance for the elderly has been premised on the assumption that only the destitute older persons need state support. Thus, old age pension schemes seem to be aimed at substituting the family rather than strengthening it by enlarging its capacity to look after the needs of the elderly members. A major reform of these schemes should be topmost in the social security agenda.

Corruption is rampant at different stages of the OAP scheme across the Indian "bribe republic". For instance, the unholy nexus between the taluk office officials at Coimbatore and the document writers operating outside charging Rs.3,000 as bribe for speeding up action on the old age pension application was reported in the newspapers.

India need not wait until it becomes affluent to evolve an effective social protection floor. In our context, social security has to be integrated with anti-poverty programmes. While anti-

poverty strategies seek to reduce the number of people living in poverty, social security should be targeted towards the poorest deciles who fail to be reached either by the growth process or by the anti-poverty programmes so as to prevent them from regressing into destitution. This will necessitate formulation of measures for a blend of social insurance, social assistance and social welfare. A national old age pension scheme through an appropriate legislation is needed instead of the present non-legislated measures. The social security programme in India is devoid of respect, compassion and above all gratitude to the elderly. A large number of older persons are deprived of basic support to prevent poverty in old age. Social security should encompass services that the elderly require to live with dignity.

All over the world there is a growing demand for the institutionalization of a publicly-funded, universal, non-means-related, non-contributory pension scheme for the elderly. For the first time, a five day "dharna" at JantarMantar in Delhi was organized by the Pension Parishad in May 2012 for a universal pension of Rs.2,000 for all persons aged 55 years and above at current rates. The monthly pension amount should be indexed to inflation once in six months and it should be revised every two or three years. The BPL-APL criteria should not be adopted for exclusion, while income tax payees and recipients of pensions from other sources which exceed the universal pension amount can be excluded. The elderly poor are "overlooked increasingly by the ruthless inroad of investment and profit which sees them as an expendable commodity" according to Aruna Roy, one of the organisers of the JantarMantar protest (The Hindu, August 4, 2013).

Age-ism

The consequences of old age in American society are devaluation, stereotyping, exclusion from equal opportunities for social participation and rewards enjoyed by younger persons, role loss, role ambiguity and struggle to preserve self-esteem

through youthful self-images (Rosow, 1977). Older people experience alienation from major family and work roles because of widowhood, retirement, lower income and ill-health. The elderly persons are commonly viewed in invidious stereotypes, as are other devalued minority groups and various negative characteristics are attributed to them. Currently, the mass media in western countries have identified old age as a social problem, and have sensitized the public conscience to its existence. As the media excel in concrete description and pictorial representation, there is the very real danger that they may "define the problem largely in terms that can readily provide a picture, very often in terms of the social problems such as poverty, homelessness, hypothermia, isolation or squalor" (Gaine, 1978).

Butler (1989) has coined the term "age-ism" to refer to the pejorative image of someone who is old simply because of his or her age. Like racism or sexism, it is a form of discrimination against all members of a category based on age-criterion and is as dangerous as racism and sexism.

> Ageism can be seen as a systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender. Old people are categorized as senile, rigid in thought and manner, old-fashioned in morality and skills……Ageism allows the younger generation to see older people as different from themselves ; thus they subtly cease to identifywith their elders as human beings.

Older persons are portrayed as sick, helpless and useless in television programmes in India. The image and language used by the visual media regarding older people are often degrading.

Apathy of Governments

A National Policy on Older Persons (NPOP) with many promises was announced in 1999 raising hopes to millions of older people. But the elected political leadership has shown least interest in implementing the policy, possibly because the older

voters have not yet become a vote bank. The implementation or non-implementation of the policy is left to the discretion of the bureaucracy. The priority for the elderly is low and there is serious conviction deficit among those who matter in implementing the NPOP. The NPOP contains pro-family rhetoric and promises of health care initiatives for the elderly. Non-governmental organizations were assured of transparency, simplification of procedures and timely release of grants. But a policy document cannot alter the bureaucratic practices of decades. A revised policy called the National Policy on Senior Citizens (NPSC) was drafted by a committee and submitted to the government in 2011. The NPSC is yet to be notified by the government, which appears to be complacent on the issues concerning the elderly.

A government that watches millions starve while tonnes of food grains rot cannot be expected to respond effectively to the needs of the elderly whose collective voice is feeble. Exasperated by the continued apathy of the state and central governments, a joint action committee of senior citizens observed August 16, 2010 as the National Protest Day to "stir up the conscience of our rulers and the society", taking a cue from the warning of the former UN Secretary General Kofi Annan: "Senior citizens, in spite of their number, collective wisdom and experience, will continue to be ignored and marginalized unless they unite".The Protest day has now become a Protest Fortnight.

Times of India (September 18, 2012) has observed that " India does not seem to be a country for senior citizens" as a review conducted by the Union health ministry has found that most states have failed to honour or execute the much-touted National Programme for Healthcare of Elderly (NPHCE).Of the 91 districts expected to start a geriatric clinic by now, only 22 have managed to do so. Worse, just a dozen districts have set up a 10-bed geriatric ward. Only three districts – two in Haryana and one in Jammu & Kashmir – have started running a bi-weekly geriatric clinic in community health centres. And, only two districts in these two states have started a weekly geriatric clinic

in primary health centres. Ministry officials say none of the steps – setting up a geriatric clinic, ward or holding bi-weekly clinics – have been rolled out in states like Andhra Pradesh, Assam, Bihar, Tamilnadu, West Bengal, Kerala, Karnataka, Jharkhand and Chhattisgarh. A ministry official said, "We have released funds under the NPHCE for creating the stipulated wards and running the clinics in 91 districts across 21 states. However, very few states have done any work. "States haven't woken up to putting in place systems or infrastructure to take care of its elderly". This situation is despite India recently joining ten other South East Asian countries to adopt the Yogyakarta Declaration on Ageing and Health, committing to improving national response to the health of the aging population.

As of today the elderly population in India had not become a strong social action force with capability to influence the electoral fortunes of political parties, though there is a simmering protest among various elderly segments over governmental apathy. A National Commission for Older Persons should be constituted by the government of India with statutory powers and the state governments should take steps to form state commissions for older persons. Directorates of aging need to be created both at central and state levels with adequate budgetary support.

The guiding principle of the government till now has been to rely on the family and voluntary organizations regarding care for the elderly rather than to initiate appropriate programmes with the exception of the old age pension scheme. The idea of a golden age, a time of rest with loving family care and a secure income, is the cultural ideal. But the reality should not be harsh. Elderly persons have the right to maintain their dignity and independent social functioning. While family care is vital for the physical and emotional well-being of the elderly, the family unit alone can no longer attend to the different needs of the elderly. Caring for the elderly is the collective responsibility of the family, the community and the state.

An Indifferent Society

Hundreds of thousands of elderly men and women have been living on the foot paths of Indian roads for years. For example, at least 60 senior citizens have been abandoned on the streets of Chennai in June alone, reported The Hindu (July,2013). "Nagarunissa, who is in her seventies has been living on the pavement along Sydenhams Road in Periamet for several years." Her son lives in Bangalore, but she has been here for the past twenty years.

Under the title "Grave Truth", the New Indian Express (January 7, 2013) reported a heartrending incident of a 90-year-old man who was found abandoned at a graveyard in Salem district. The nonagenarian Kuppusamy, a former weaver, was a widower. He was living alone at Perumalkoilmedu after his wife passed away several years ago and was surviving on food given by some of his relatives as he had no children. Kuppusamy had bequeathed a house and a barren land which he owned to his grandson. He met with an accident and was in need of others' help to meet even his basic needs. Feeling burdened by him, his relatives brought him in an auto rickshaw and abandoned him at the graveyard in Ramayan Nagar near Seelanaickenpatti. He was found struggling to help himself amidst the bushes in the graveyard premises. Taking pity on him, some residents living nearby had given food packets and water to Kuppusamy for four days. Finally, a local leader rescued him along with some volunteers and enrolled him in an orphanage run by Salem Corporation. The volunteers provided him with a set of clothes, blankets and a cot. Kuppusamy told his rescuers that he had earlier given Rs.2000 to his grandson to perform his last rites, but he abandoned him.

An editorial in The New Sunday Express in December 2002 observes as follows:

> In an already impoverished nation, it is the aged and the young who tend to suffer the most – the old because the breadwinners come to look upon them as useless mouths to feed

and the young because poor families cannot afford to provide them the nourishment they need. Whether they live in the cities or in the villages, many of the older people are condemned to a miserable existence. They live in unhygienic surroundings, lack even the most elementary health care and have little by the way of social protection.....With increasing privatization and the changing of social mores, the old cannot be sure that their children will look after them in the evening of their old lives. A simple indication of this is the number of older people who are abandoned by their families during festivals like the Kumbh Mela in Allahabad.

References

1. Butler, R.N. (1969). "Age-Ism: Another Form of Bigotry". **The Gerontologist**, 9(4 Part 1):243-246.
2. Chawla, Sandeep. (1988)." The Participation of the Elderly in Development". Paper prepared for the United Nations for the **International Seminar**, Organized by the UNCSDHA,2-5 ebruary,1988.Valletta, Malta.
3. Cohen, Lawrence. (1998). **No Aging in India : Alzheimer's, the Bad Family, and Other Modern Things.** Berkeley: University of California Press.
4. Devanandam, P.D., &Thomas,M.M. (1966). **Changing Pattern of Family in India**. Bangalore: Christian Institute for the Study of Religion and Society.
5. Djurfeldt, Goran.,& Lindberg, Staffan. (1980). **Pills Against Poverty: A Study of the Introduction of Western Medicine in a Tamil Village**. Delhi: Macmillan.
6. Gaine, Paul. (1978). "Ageing and the Spirit". In, David Hobman. (ed.). **The Social Challenge of Ageing.** London :Croom Helm , 222-248.
7. Kumar, Joginder. (1974). "Family Structure in Hindu Society". In, George Kurian (ed.). **Family in India – A Regional View**. The Hague: Mouton: 43-74.
8. Nair,T.K., (1980). **Older People in Rural Tamil Nadu**. Madras : Madras School of Social Work.
9. Rosow, Irving. (1977). **Socialization to Old Age**. Berkeley: University of California Press.
10. UNFPA and Helpage International. (2012**). Ageing in the Twenty-First Century: A Celebration and a Challenge**. London:UNFPA.
11. Varadharajan, D. (1982). **A Demographic Study of the Kota Tribe of the Nilgiris District, Tamilnadu**. PhD Thesis. Madras: Madras University.

Appendix

Global Response

The first World Assembly on Ageing held at Vienna in 1982 was a landmark global response to the concerns of the elderly ; and the International Plan Of Action on Ageing guided member states to take appropriate steps. In 1991, the United Nations General Assembly adopted the United Nations Principles for Older Persons. The 18 UN Principles aim at ensuring that priority attention will be given to the situation of older persons on five areas: independence, participation, care, self-fulfillment and dignity of older persons. The Second World Assembly on Ageing, held in Madrid, Spain in 2002 produced a rights-based Political Declaration and Plan of Action on Ageing

Ten Priority Actions

UNFPA and Helpage International report recommends ten priority actions to maximize the opportunity of aging populations:

1. Recognise the inevitability of population aging and the need to adequately prepare all stakeholders (governments, civil society, private sector, communities, and families) for the growing numbers of older persons. This should be done by enhancing understanding, strengthening national and local capacities, and developing the political, economic and social reforms needed to adapt societies to an aging world.
2. Ensure that all older persons can live with dignity and security, enjoying access to essential health and social services and a minimum income through the implementation of national social protection floors and other social investments that extend the autonomy and independence of older people, prevent impoverishment in old age and contribute to a more healthy aging. These actions should be based on a long-term vision, and

supported by a strong political commitment and a secured budget that prevents negative impacts in time of crisis or governmental changes.

3. Support communities and families to develop support systems which ensure that frail older persons receive the long-term care they need and promote active and healthy aging at the local level to facilitate aging in place.
4. Invest in young people today by promoting healthy habits, and ensuring education and employment opportunities, access to health services, and social security coverage for all workers as the best investment to improve the lives of future generations of older persons. Flexible employment, life-long learning and retraining opportunities should be promoted to facilitate the integration in the labour market of current generations of older persons.
5. Support international and national efforts to develop comparative research on aging, and ensure that gender- and culture-sensitive data and evidence from this research are available to inform policy making.
6. Mainstream aging into all gender policies and gender into aging policies taking into account the specific requirements of older women and men.
7. Ensure inclusion of aging and the needs of older persons in all national development policies and programmes.
8. Ensure inclusion of aging and the needs of older persons in national humanitarian response, climate change mitigation and adaptation plans, and disaster management and preparedness programmes.
9. Ensure that aging issues are adequately reflected in the post-2015 development agenda, including through the development of specific goals and indicators.

10. Develop a new rights-based culture of aging and a change of mind-set and societal attitudes towards aging and older persons, from welfare recipients to active, contributing members of society. This requires, among others, working towards the development of international human rights instruments and their translation into national laws and regulations and affirmative measures that challenge age discrimination and recognise older people as autonomous subjects.