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AGEING & SOCIETY : THE INDIAN JOURNAL OF GERONTOLOGY

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- ★ Social Gerontology
- ★ Biology
- ★ Medicine
- ★ Behavioural Science

In addition we welcome Abstracts, Book reviews & Interviews with senior citizens

STATUS OF LIVING ARRANGEMENT OF ELDERLY PEOPLE IN EASTERN UTTAR PRADESH

Anand Bihari*
Alok Kumar**

ABSTRACT

The increase in life expectancy over the years has resulted in an increase in the population of the elderly. This situation could be attributed to a combination of factors such as increase in age, longevity and decreased death rates due to advancement in the field of medicine, improvement of life expectancy at birth, and enhancement in the average span of life. We find that the main factor that has contributed to the change in the living arrangements has been the increase in the migration. Population ageing is an unavoidable and irreversible change which comes through demographic transition in all societies. India is in the third stage of its demographic transition. The age structure of the country reveals that it has been ageing rapidly. The issue of living arrangement of the elderly especially in the context of India is a challenging subject to study. There had been no serious thoughts and acts on the issues of the elderly with respect to their health, morbidity pattern, disease pattern isolation, adjustment within the family, abuse. insecurity and living arrangements before the 20th century. The traditional Indian culture emphasizes that the elderly should be respected in the society and treated as the heads of the family with dignity and respect. So, the living arrangements of the elderly were never an issue two decades ago and it was assumed that the family would take the responsibility of proper care and treatment of the elderly in such a way that they could live in peace and with dignity.

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INTRODUCTION

The UN defines a country as "Ageing" where the proportion of people over 60 reaches 7 percent to total population. By 2011 India has exceeded that proportion (8.3 percent) and is expected to reach 12.6 percent in 2025. In India, as a result of the change in the age composition of the population over time, there has been a progressive increase in both the number and proportion of aged people. The Indian population has increased from 361 million in 1951 to 1.027 billion in 2001 and further to 1.21 billion in 2011. Simultaneously, the number of older people has increased from 19 million (i.e. 4 percent of total population) to 77 million and further to roughly 93 million (i.e, 7.5 percent of the total) during the same time span (Registrar General of India, SRS Statistical Report 2011).

Living Arrangements in India

In India, elderly parents co-residing with their children can serve a dual purpose: children can take care of their parents' health and daily needs, while parents can provide childcare for young grandchildren. These are non-financial aspects of co-residence that typify a joint living arrangement. Other benefits include elder health, particularly in terms of relationship between co-residence and self-rated health, chronic and short-term morbidity (Sudha et al. 2006). In a move to alleviate the financial cost by co-residence, the Indian Government introduced the National Policy on Older Persons in 1999. This policy has provisions for tax rclief or children who co-reside with their parents, allowing rebates for medical expenses and giving preference in the allotment of houses (MOSJE 1999). This policy however, is yet to be adopted and enforced by a majority of states, the locus of such policy execution in India.

There exist several living patterns for the elderly such as living with the spouse, living with children and living with others. Living alone or with the spouse is the most stable living arrangement for people who are not too old yet. (Wilmoth1988). Researchers have put in a lot of effort to investigate the determinants leading to a specific living

arrangement. Living arrangement are influenced by variety of factors including the number and availability of children and other relatives, kinship pattern of society, location of household. marital status, financial status, availability of services and physical and mental well-being of elderly (Schafer, 1999, kan, poark and Chang, 2001). Attitude towards and perception about the living places is another important component that decides where they should live (Chen 1998).

Material & Methods

The specific objectives of the study are -

- to study about the pattern of living arrangements of elderly in eastern UP
- to mark the differences in living arrangements according to important socio-economic & demographic characteristics.

Operational Definitions

The following terms were used in the study as per the definitions given below.

Older person: One who has attained the age of 60 years or above at least 6 months prior to the date of the study.

Living arrangements: Living arrangement is the type of household / family setting in which the elderly live, the headship they enjoy, the place they stay in and the people they stay with, the kind of relationship they maintain with their kith and kin, and on the whole, the extent to which they adjust to the changing environment.

a) Living alone: The household is comprised of the elderly person who is staying alone.

b) Living with spouse only: The household is comprised ofthe elderly married couple.

c) Co-residence with children: The household is comprised of the

elderly person or couple who are living along with son (s) or daughter (s) (married or unmarried)

d) Living with relatives: The household is comprised of the elderly person living along with siblings/grandchild (ren) or other relatives of the family (paternal! maternal).

Sampling Procedure

Multistage stratified random sampling procedure was adopted to collect information from the area under study. The 27 districts in eastern Uttar Pradesh were divided into three strata's based on the criteria including the dominance of rural and SC/ST population. By applying simple random sampling procedure, one district was selected from each category i.e., from low, middle and high dominance categories. Further, a block is chosen from each selected district using SRS procedure and list of villages in each selected block were prepared according to population size. The villages with less than 50 households were taken from the sampling frame. Further a village was selected using SRS procedure from each selected block and using probability proportional to population size (PPS) technique, the households were selected. Finally the required elderly was selected through circular systematic sampling procedure. The selection of individual was done so that only one elderly was interviewed from each household. The mechanism to maintain gender balance in the number of elderly is, if a female respondent was selected from a household, a male had been selected from the next household. In case of those households where male has completed 60 years but female does not due to age gap between husband and wife, male respondent was interviewed even though a female was supposed to be interviewed from such households.

Sample size formula

To determine the sample size, the proportion of elderly having solitary living, but having at least one adult child, is considered as the key variable in sample size determination.

The required number of sample households would be

$n_h = m*n = m*\{p(1-p)(z^2/e^2)*f\}$

Thus, as an approximation, suppose that about 6 percent of the elderly living alone, has at least one adult child, in rural areas (Central Region, NFHS III); then

$n = p(1-p)(z^2/e^2) * f = 241*1.5 = 362$ (approx.)

The sample had to be increased by 15% to account for contingencies such as non-response or recording error.

$n+15\% = 362 * 1.15 = 416.3 = 417$

As per government reports (census. NFHS), from 3 households III a village of eastern UP, one can get at least one elderly person.

Thus,

$n_h = 417 * 3 = 1251$ households

Therefore, 1251 households were chosen from the rural areas to get the required number of elderly sample. At least 3 villages were needed for getting the expected elderly sample in the proposed research, after considering the average no. of households in a village was 500 with mean household size is around 6 (Census, 2001).

Data Collection

The data collection took approx 4 months i.e. from 15 May 2014 to 20 September 2014. On an average it took one hour to one and a half hour conduct the interview schedule (Median: 1 hour).

Data Processing and Statistical Analysis

For the purpose of Quantitative data analysis, first a suitable data entry module in the coded form was created for its rapid computerization. An electronic structured data sheet in Cs-Pro-10 version considering suitable width for each field was made. Validity of the whole data was checked by running the validation

programmed prepared by the investigator himself for this data set as well as manual crosschecking as needed. The Cs-Pro-10 version data sheet was then exported to SPSS trial version 16.0 and the grouping of values was made into meaningful, dichotomous, nominal or ordinal categories following the scientific logic and accordingly these were numerically coded.

Result & Discussion

Table 1: Current inter-generational living arrangement by some background characteristics of the elderly

Background Characteristics	Current living arrangement of elderly					
	Alone	With spouse only	With spouse & adult children	With adult children only	With other relatives	χ^2 value
Gender						
Male	10 (3.57)	18 (6.43)	159 (56.79)	51 (18.21)	42(15.00)	82.25***
Female	6 (4.60)	3 (2.31)	31 (23.85)	81 (62.31)	9 (6.92)	df = 4
Caste						
General	9 (4.92)	9 (4.92)	82 (44.81)	63 (34.33)	20 (10.93)	5.85
OBC	4 (3.17)	7 (5.56)	65 (51.59)	37 (29.37)	13 (10.32)	df = 8
SC / ST	3 (2.97)	5 (4.95)	43. (42.57)	32 (31.68)	18 (17.82)	
Educational Status*						
Illiterate	13 (5.99)	17 (7.83)	112 (51.61)	60 (27.65)	45 (6.91)	18.54*
Primary	2 (3.39)	2 (3.39)	27 (45.76)	20 (33.90)	8 (13.56)	df = 9
Secondary	1 (1.54)	0 (0.00)	23 (35.38)	27 (41.54)	14 (21.54)	
High School	0 (0.00)	2 (6.06)	12 (36.36)	13 (39.39)	6 (18.18)	
Intermediate	0 (0.00)	0 (0.00)	9 (45.00)	7 (35.00)	4 (20.00)	
Graduate & Above	0 (0.00)	0 (0.00)	7 (43.75)	5 (31.25)	4 (25.00)	
Type of Card						
BPL	11 (7.19)	17 (11.11)	74 (48.37)	37 (24.18)	14 (9.15)	31.06**
Other	5(1.95)	4 (1.56)	116 (45.14)	95 (36.96)	37 (14.40)	df = 4

Background Characteristics	Current living arrangement of elderly					
	Alone	With spouse only	With spouse & adult children	With adult children only	With other relatives	χ^2 value
Type of House						
Kachcha	2 (3.08)	3 (4.62)	42 (64.62)	12 (18.46)	6 (9.23)	32.18*** df = 8
Semi Pucca	3 (2.75)	8 (7.34)	64 (58.72)	27 (24.77)	7 (6.42)	
Pucca	11 (4.66)	10 (4.24)	84 (35.59)	93 (39.41)	38 (16.10)	
Marital Status						
Currently Married	6 (2.52)	21 (5.81)	181 (45.40)	0 (0.00)	30 (12.61)	1.92 df = 4
Other	10 (5.81)	-	9 (5.23)	132 (76.74)	21 (12.21)	
Social Status**						
Low	10 (3.56)	10 (3.56)	121 (43.06)	92 (32.74)	48 (17.08)	22.17*** df = 4
Middle	4 (3.85)	11 (10.58)	54 (51.92)	32 (30.77)	3 (2.88)	
High	2 (8.00)	0 (0.00)	15 (60.00)	8 (32.00)	0 (0.00)	
Economic Status						
Low	5 (3.68)	5 (3.68)	70 (51.47)	47 (34.56)	9 (6.62)	13.27 df = 8
Middle	6 (4.92)	8 (6.56)	60 (49.18)	34 (27.87)	14 (11.48)	
High	5 (3.29)	8 (5.26)	60 (39.47)	51 (33.55)	28 (18.42)	
Total	16 (3.90)	21 (5.12)	190 (46.44)	132 (32.50)	51 (12.44)	410

Note: + χ^2 value calculated by merging the high school, Intermediate & Graduate and above level categories; + χ^2 value calculated by merging the middle & high social status categories.

Figures in parentheses represent the percentage.

*p<0.05; **p<0.01; ***p<0.001

The living status of the elderly is determined by the basic parameters / background characteristics such their living arrangement in the categories-alone, with spouse, with spouse and children, and living with relatives; gender, caste, educational status, marital status, social and economic status. These are the fundamental parameters which affect their current living arrangement as alone, wilh spouse, spouse and adult children, adult children only and living with relatives. The data shows that 3.57% male and 4.60% female elderly lived alone, 6.43% male and 2.31% female with spouse, 56.79% male and 23.85% female with spouse and adult children, 18.25% male and 62.31 female with adult children only and 15.00% male and 6.92% female with their relatives. Caste-wise living of elders was similar in alone and with spouse living in general caste. But the number living with spouse and adult children was high or 44.81% in comparison to living with adult children (34.43%) and other relatives (10.93%). In OBC also the higher proportion was of living wilh spouse and adult children (51.59%), 3.17% alone, 5.56% with spouse and 29.37% with adult child, 10.32% with other relatives. For the SC/ST caste this propertis is similar to the other categories. The proportion of educational study of elderly in the categories of living with their spouse and adult children was simultaneously 51.61% in illiterate, 45.16% in primary, 35.38% in secondary, 36.36% in Junior high, 45.00% in high school/ intermediate and 43.75% in graduation and above. the given data also depicts that the proportion of elderly living with spouse and children is the highest, compared to other categories. The proportion of living alone and with spouse is very low compared to others. It light in the fact that 7.19% BPL holder live alone, 11.11% with their spouse, 48.37% with spouse and adult children and 24.18% with their adult children and finally 9.15% with relatives. Among other card holders, 1.95% live alone, 1.56% with spouse, 45.14% with spouse and adult children, 36.96% with adult children and 14.40% with their relatives. The Kaccha semipucca and pucca house holders current living arrangement with spouse and adult children. This percentage was statistically high (64.62%, 58.72%, 35.95%), was simultaneously in Kaccha, semipucca and

pucca house, other categories were with adult children only, and other relatives which deposits 18.46%, 24.33% and 39.41% and 9.23%, 6.42% and 16.10%.The currently married elderly's proportion of living with spouse and adult children was high (45.40%). After that the relatives were 12.61% in other than married, the proportion of living with adult children was high 76.76%. In social status signifier the data shows that low status elderly preferred to live with spouse and adult children and adult children only. The major proportion was 43.06% and 32.74% subsequently middle class elderly also lived with their spouse and adult children and adult children in 51.92% and 30.77% high class elders lived with spouse and adult children and adult children only that was 60% and 32% simultaneously.

Economically weak and strong elderly sumilarly lived alone but the highest proportion is seen living with spouse and adult children was 51.47% in low status,49.18% in middle and 39.47% in high economic status , other living arrangement was someday approximately similar the characteristics to live with their spouse and adult children together.

Care of the elderly has always been the responsibility of the family in most of the Asian countries including India, However, with rising modernization, with the increase in education and urbanization, there is an increase in women work force (working women) and in turn migration from rural to urban areas. All these changes are likely to alter the living arrangements of the elderly. Not only the actual living arrangement but also the preference for a particular living arrangement may also be dependent on the family structure. An attempt is made here to see how the family characteristics influence the present living arrangement of the elderly. Another important variable that determines the living arrangement pattern was the education of the elderly. Clearly, a higher proportion of the better-educated elderly was staying alone in eastern Uttar Pradesh as compared with the elderly who are not so educated.

Living condition of elderly

Figure 1: Distribution of the elderly according to separate room availability for them to sleep

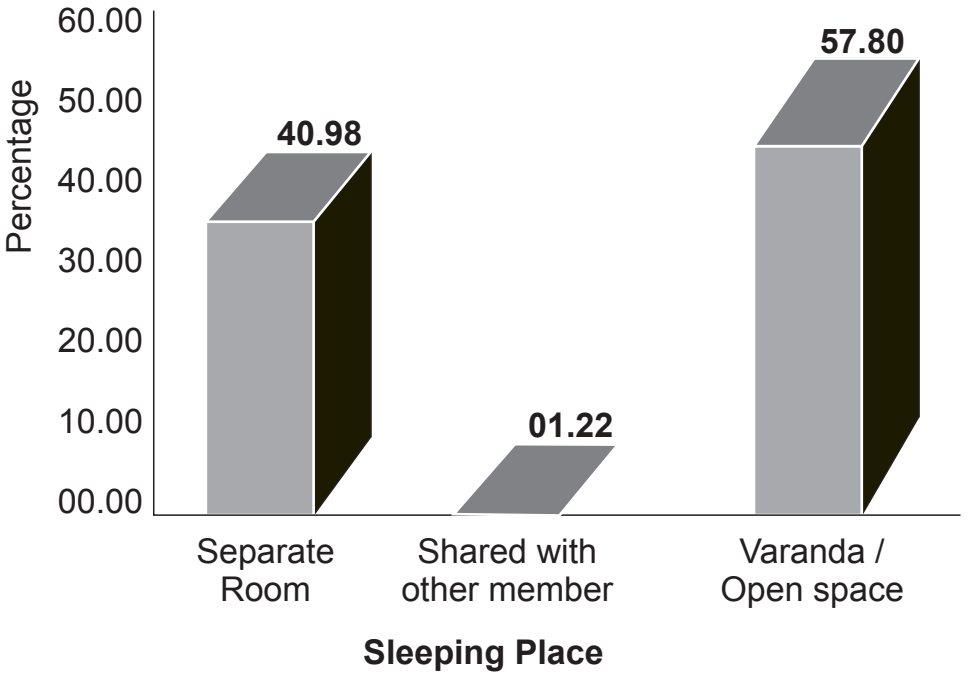

Figure 1 shows that 40.98 percent of elderly people have separate rooms in the house and about 60 percent do not a separat room. About 60 percent elderly sleep in the same room as their child or at the veranda,or at other places. Only 1.22 percent of elderly shared the room with other members for sleeping. The above figure indicates that sleeping place for elderly was not adequate in the study area.

Table 2: Distribution of elderly according to separate room availability and satisfaction about overall living condition with socio-economic & demographic variables

Variables	Separate room and Present living condition			
	Available	χ^2 value	Satisfied	χ^2 value
Gender				
Male	126 (45.00)	5.90*	212 (75.71)	9.63**
Female	42 (32.31)	df = 1	79 (60.77)	df = 1
Age				
60 - 69	111 (43.19)	1.48	180 (70.04)	0.29
70 - 79	44 (37.93)	df = 2	84 (72.41)	df = 2
80 +	13 (35.14)		27 (72.97)	
Marital Status				
Currently Married	101 (42.44)	0.04	168 (70.59)	0.50
Others	67 (38.95)	df = 1	123 (71.51)	df = 1
Caste				
General	81 (44.26)	2.28	147 (80.33)	19.48***
OBC	45 (35.71)	df = 2	72 (57.14)	df = 2
SC / ST	42 (41.58)		72 (70.59)	
Education				
Illiterate	76 (35.02)	21.71**	136 (62.67)	15.56**
Primary	19 (32.20)	df = 5	41 (69.49)	df = 5
Secondary	35 (53.85)		55 (84.62)	
High School	17 (51.52)		26 (78.79)	
Intermediate	12 (60.00)		18 (90.00)	
Graduate & Above	09 (56.25)		15 (93.75)	
Social Status				
Low	98 (34.88)	19.93**	176 (62.63)	35.17***
Middle	51 (49.04)	df = 2	90 (86.54)	df = 2
High	19 (76.00)		25 (100.00)	
Economic Status				
Low	54 (39.71)	2.93	92 (67.65)	10.76**
Middle	44 (36.07)	df = 2	77 (63.11)	df = 2
High	70 (46.05)		122 (80.26)	
Total	168 (40.98)		291 (70.98)	

Note : Figures in parentheses represent the percentages; *p<0.05, **p<0.01, ***p<0.001

It is assumed that deviation in living arrangement, of the elderly, may vary with different characteristics. In the following analysis gender, age, marital status, social status, economics status types of family and education are considered as affecting variables of living arrangement.

Table 2 presents the distribution of variables and deviations in living arrangement condition among the elderly in eastern U.P.. More than half of the elderly reported no separate room tor sleeping. Here a difference between male and female, age group wise, married, widow, widower, caste- based, illiterate & literate, social status based & economic status based could be seen.

Less than half of elderly reported that they have a separate room for sleeping, more than half the elderly reported that sleeping place is comfortable. The table shows 29.23% female compared to 24.29% male reported the living arrangement to be uncomfortable. Age factor and marital status is not affected by the living arrangement condition. The table clearly indicates that social and economic status, educational status of elderly affected their living arrangement and condition. The chi-square test statistics also satisfies living arrangement condition as per the variables gender, social and economic status, education & caste.

Increase in social status and economic status increases the avaibility of separate room for sleeping. Similar pattern shows that the satisfaction level of present living condition in both categories. In case of caste, avaibility of separate room for sleep OBC category is very low compared to other categories, Avaibility of room is not statistically significant but satisfaction condition is. Social and economic status are statistically significant on satisfaction level and separate room for sleep is not statistically significant incase of economic status.

Table 3: Results of logistic regression analysis for living with adult child and satisfaction with actual condition

Variables	Living with adult child			Satisfaction about actual living condition		
	B (S.E)	Exp (B)	CI (95%)	B (S.E)	Exp (B)	CI (95%)
Gender (Ref: Male)						
Female	0.78(0.31)	2.17*	1.19-3.97	-0.71(0.24)	0.49**	0.30-0.79
Caste (Ref: SC/ST)						
OBC	0.48(0.35)	1.62	0.82-3.19	-0.70(0.30)	0.50*	0.28-0.89
General	0.42(0.32)	1.53	0.82-2.85	0.43(0.30)	1.54	0.85-2.77
Age (Ref: 60-69)						
70 - 79	0.75(0.32)	2.11*	1.13-3.95	0.00(0.27)	1.00	0.59-1.68
80+	0.80(0.52)	2.23	0.80-6.23	-0.17(0.42)	0.84	0.37-1.91
Marital Status (Ref: Married)						
Others	-0.02(0.28)	0.98	0.57-1.68	0.13(0.25)	1.14	0.70-1.85
Education (Ref: Illiterate)						
Primary	0.21(0.40)	1.23	0.56-2.70	0.54(0.37)	1.72	0.84-3.53
Secondary	-0.07(0.39)	0.93	0.44-1.99	0.48(0.36)	1.62	0.79-3.31
Highschool & Above	-0.08(0.38)	0.92	0.44-1.95	0.15(0.35)	1.16	0.59-2.28
Type of House (Ref: Kachha)						
Semi pucca	-0.02(0.44)	0.98	0.41-2.32	0.30(0.36)	1.35	0.67-2.71
Pucca	-0.73(0.41)	0.48	0.22-1.07	0.35(0.34)	1.42	0.73-2.75
Social status (Ref: Low)						
Middle	0.83(0.33)	2.29*	1.19-4.37	0.37(0.29)	1.44	0.81-2.57
High	1.76(0.78)	5.78*	1.26-26.62	-0.04(0.49)	0.96	0.37-2.54
Economic status (Ref: Low)						
Middle	-0.67(0.35)	0.51	0.26-1.02	-0.04(0.30)	0.96	0.53-1.74
High	-0.87(0.35)	0.42*	0.21-0.83	-0.22(0.31)	0.80	0.44--1.46

Dependent Variables :
Living with adult children '1' if yes, otherwise '0'
and Satisfaction about actual living condition '1' if yes, otherwise '0'
Explanatory Variables :
Sex: Male=0, Female=1
Caste : SC/ST=1, OBC=2, General=3

Age group: 60-69=1, 70-79=2, 80 and above = 3
Marital Status: Currently married=1, otherwise=2
Levels of education: No education=0, Primary=1, Secondary=2 High and above=3
Type of house: Kachha=1, Semi pucca=2, Pucca=3
Social status: Low=1, Middle=2, High=3
Economic status: Low=1, Middle=2, High=3

Table 3 shows the result of binary logistic regression analysis to assess the impact of various socio-economic and demographic indicators on self rated health status of the elderly in the study population. The above table, depicts the results of binary logistic regression analysis for predicting the likehood of the elderly living with adult child or not on the left side of the table and the likelihood of being satisfied with actual living condition or being dissatlsfied with that.

The results of the table revealed that the elderly female are significantly 2 times more likely to living with adult child as compared ill maleelderly. Whereas the evidence indicates that the percentage of aged people, higher caste group and higher social status found to be more likely living with adult child significantly. As, the type of house are changing towards *semi pucca* or *pucca* with respect to kachha with betterment of economic status as well as educational status, people are less likely to live with adult children.

For the satisfaction about actual living condition, females reported being significantly 50% less satisfied with respect to male. In caste group, OBC is signiificantly 50% lesser satisfied and General is 50% higher satisfied about actual living than the SC/ST group. Age group above 80 has lesser chance to being satisfied with current living condition. The unmarred group is 14% more satisfied with current living condition. Educational status-wise, Primary and Secondary education group are more than 50% satisfied with current living condition with respect to Illiterate group. People living in *Kaccha* house have lower satisfaction with current living condition. People with Middle class social status have high chance of being satisfied

with current living condition. Higher the economic status, lower the chance of being satisfied with current living condition.

SUMMARY

Living arrangements and family relationships are important determinants of the quality of life of the elderly. The result shows significant proportion of the elderly living alone. Migration of children for seeking education, job, and other causes has emerged as the most important reasons for elderly living alone. Apart from that,family confliets and the desire to live independently have influenced their current life arrangcmen to a great extent; social and mental impact of this has affected the elderly living alone .

The fair living arrangement of elderly people is an important part. The traditional co-residential family living arrangement is the most common practice across all research areas, The majority of the elderly in the selected area has no separate room to sleep. Availability of separate room depends on different factors like gender, age, marital status, social status, economic status, caste, and education. The living arrangement of the elderly is further disaggregated by their background characteristics; the dominant type of living arrangement across all categories remains living with spouse, children and grandchildren.

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Senicide in India: A Sociological Study

Satish Kr. Gupta*
Anirban Mukherjee**

ABSTRACT

Family occupies a key position in the Indian social structure. However, the forces of globalisation, modernisation and urbanization is affecting the structure and functioning of the Indian family system. People are increasingly having apathetic attitude towards the elderly. Children are ignoring their responsibilities towards the elderly and the elderly are perceived as a liability. Further, they are subjected to physical and mental abuse. For instance, in Bridhnagar, Tamil Nadu, people practice Thalaikoothal, a traditional practice of senicide. The study is secondary in nature and explores the practice of Thalaikoothal from sociological lens.

Keywords: Globalisation, Thalaikoothal, Bridhnagar, Senicide

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INTRODUCTION

Ageing is a universal process and it affects each human being in the world. People can be considered old because of certain changes in their activities or social roles. Old age and the problems associated with it are emerging as the most pressing social problems of the 21st Century. The words 'elderly', 'older persons', and 'senior citizens' are often used synonymously as if they refer to a homogenous group. Old age is typically differentiated into two categories: those who are between 60 and 74 years old are termed as 'younger-old' and others who are 75 or more years are referred to as 'old age' (Mishra & Patel, 2013). Besides, if age of retirement is taken as an indicator of old age, for the developed nations it is 65 years; whereas for India it is 55 years. The current retirement age in India falls between 58 to 60 years, it varies across states and occupations (Bhatt & Dhruvarajan, 2001). According to the National Policy of Education (1999), Government of India, a senior or elderly person is someone aged 60 years and above. However, in the agricultural and informal sectors, people continue to work as long they are physically able and retirement is closely associated with physical incapability (Dandekar 1996). Thus, it is difficult to have a universally accepted definition of old age.

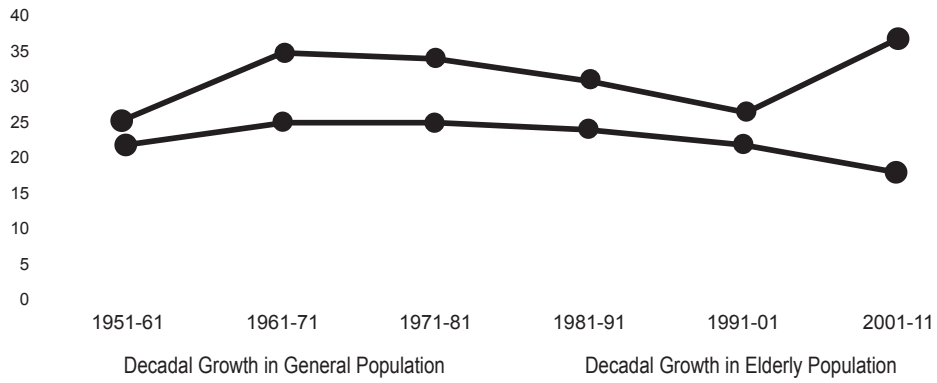
The forces of urbanization, globalization, and modernization have heavily affected the socio-economic structure of the society, social values, and institutions such as the family (Bhatt & Dhruvarajan, 2001). This study focuses on the challenges and discrimination that the aged face in Indian society and specifically attempts to develop sociological insights about Thalaikoothal, the practice of senicide in Tamil Nadu.

Size and Growth of Elderly Population in India

India currently has the second largest elderly population in the world. One in eight among older persons in the world now lives in India (Bhatt & Dhruvarajan, 200 l). The population of the aged people in India is rapidly increasing and this is evidenced from the fact that the

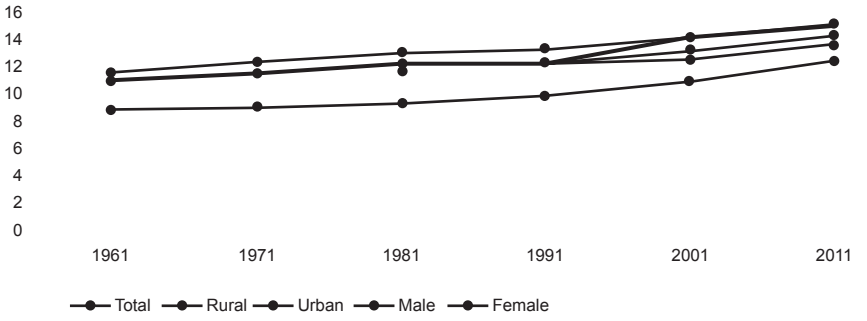
elderly population in 1901 was 12.1 million and it expanded to 103.2 million in 2011. Out of 103.2 million elderly, 53 million were females and 51 million were males (Situation Analysis of the Elderly in India, 2011). If we see in percentage then the population of seniors has grown from 5.6 percent in 1961 to 8.6 percent in 2011 (Elderly in India, 2016). It is predicted that by 2050, 15.1 percent of the total population will be 65 years and older (United Nations, 1998; United Nations Population Division, 1999). The increased population of the elderly may be attributed to medical advancement, higher living standards, better food availability etc.

Decadal growth of elderly population as copmared to general population (In Percentage)



Source: Population Census Data, 2011

The decadal growth rate of India's elderly population and of the general population, for the period 1951 to 2011, as shown in the fig. above, reveals that the decadal growth rate for elderly population between 1951-61 was 24 percent as against 22 percent of the general population. The decadal growth rate of the elderly population in 1961-71 and 1971-81 was 34 and 33 percent respectively. However, the Census of India 2011 reports that the decadal growth (2001-11) rate of the elderly population was 36 percent as against 18 percent for the general population. The reason for the growth of elderly population may be attributed to the availability of better medicinal facilities and rising standards of living.



Source: Population Census Data, 2011

The dependency ratio is defined as the ratio of those who are not in labour force generally defined as those between 0-14 years of age and those in the labour force (typically defined as those between 15-64 years of age) (Pettinger, 2016). The old age dependency ratio reveals that the percentage of dependant elderly people have risen from 10.9% in 1961 to 14.2% in 2011. The above figure also reveals that females are more dependent than the males and their dependency is related to the prohibition placed on their economic independence in society. There exist considerable difference between the rural and urban areas in terms of dependency ratio; while the old age dependency ratio 15.1 in the rural areas, it is 12.4 for urban India (Census of India, 2011). This is related to the fact that urban areas have a higher concentration of working age population.

The Indian context

India is a country comprising of varied cultural, linguistic, racial and ethnic groups. The traditional social structure of India may be characterized by the predominance of patriarchy, joint family and caste system. Modernization, globalization, and urbanization, has had a significant impact on various institutions of India such as the family. We can see change in the family structure, both in rural and urban environments. The joint family system is an extended family arrangement, who live under the same roof and are tied by the common relationship. In the words of Karve (1965:8), *"A joint family is a group of people who generally live under one roof, who eat food*

cooked in one kitchen, who hold property under common ownership and who participate in common worship and are related to one another as a particular type of kindred." The functionality of the system can be realized from the emotional help, social support, physical security, and protection it offers to its members including the old, frail, and weak (Ramamurti, 2002). But due to dearth of jobs in the rural areas, children are moving out from the extended family and establishing their own nuclear families in the urban areas. The tradition of joint family in the culture of Indian society is disappearing rapidly. Now-a-days people are increasingly preferring nuclear family over joint family. Nuclear family typically consists of husband, wife, and children (Murdock, 1949) and the arrangement is based on convenience rather than on emotions. The outmigration of the working age population from the families increases the helplessness of the elderly. Elderly people thus have no other choice but to reside in the old age homes.

Thalaikoothal-The Senicidal Practice

Being a traditional society, respect for the elderly used to be an indigenous practice in India. India is perhaps the only country in the world, where people touch the feet of the elders as a way of showing respect. In other words, elderly people occupy a very revered position in the society. India has experienced rapid modernization in the recent years, so it is shocking that senicide is still practiced in certain parts of the country.

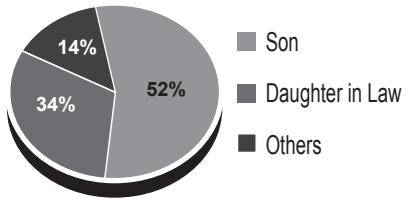
In Tamil language, word 'thalaikoothal' refers to senicide. Bridhnagar, for instance is a place in Tamil Nadu where senicide is practiced from ages. It is a practice in which elderly are put to sleep with the knowledge of all the family members. Relatives are sometimes invited to participate in the practice and to be present in parting occasion. Thalaikoothal is mainly practiced on the bed-ridden and terminally ill person and it involves giving a ceremonial oil bath to the person in early morning, followed by feeding the person with tender coconuts that cause high fever. This generally results in the death of the person in a day or two. The alternative method is to

give head massage with cold water, which lowers the body temperature sufficiently to cause heart failure. Senicide is also practiced by forcefully feeding cow's milk to the person while plugging his/her nose, thereby suffocating the person to death. Sometimes, the elderly are made to consume poison, pesticides, sleeping pills when the customary practice does not work (Sanso, 2010 The Hindu Report; Mathew, 2016). In fact, reports reveal that there exist as many as 26 methods of senicide (Jesudasan, 2016,- The Hindu Report).

Financial issues and terminal illness may not be the only factors why Thalaikoothal is practiced. People resort to this heineous practice when they perceive the elderly as a hurdle towards their future prospects. For instance, Thalaikoothal is practiced when parents voice their reluctance about leaving the ancestral place for better life in the city (Chatterjee, 2017)

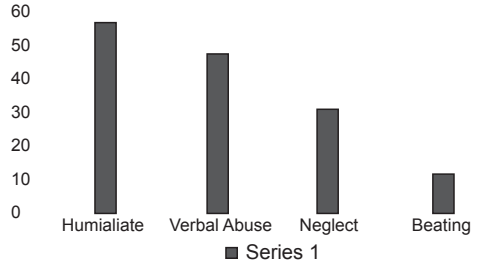
The most concerning part of Thalaikoothal is that the practice does not have social stigma attached to it. It is disturbing to note that the practice has some degree of societal approval. Such cruelty is not restricted to Tamil Nadu per se, it is evidenced throughout the country. According to the report of Help Age India, every fourth elderly in the country is a victim of misbehavior. The perpetrators of such misbehavior and abuse are none other than the son, daughter, daughter-in-laws. Such crimes are seldom reported (about 82% of the elderly do not report) because the perpetrators are mostly the family members. Astonishingly, more than half of such attrocities are committed in the well-educated families (Report of the Help Age India).

Culprits of misbehaviour



Source: Hindustan News Paper, 2018

Type of Misbehaviour (In Percentage)



CONCLUSION

Sociologically speaking, the practice of 'Thalaikoothal' can be interpreted from the Disengagement theory. The people engaging in the act perceive the elderly to be a liability and no longer functional for society. So, their disengagement from societal roles appear to be the only acceptable solution. We, thus witness, dissolution of family values, rise of individuality, and increasing "radius of distrust" (Fukuyama,). The problem can only be countered by narturing and inculcating empathetic attiudes among the youths and not by building old age homes. After all, as Stanislaw Jerzy remarked, *"Youth is the gift of nature, but age is a work of art.*"

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SOCIO-ECONOMIC DETERMINANTS OF PHYSICAL HEALTH STATUS OF THE URBAN AGED PERSONS IN ASSAM: A MULTIVARIATE ANALYSIS

Anita Baruwa*
Nayanmoni Borgohain Baruah**

ABSTRACT

The urban aged persons seem to be at a greater risk than their rural counterparts at present. So it is necessary to highlight their health situation and identify the determining variables of their physical health condition. Data collected randomly from the urban aged population of six urban centres in Assam is used for the purpose. Health deteriorates as age increases and good health is positively associated with a socially, economically and physically active lifestyle. There is the need for ease of access to health facilities to them well before the onset of twilight years.

Keywords:
Aged Population, Elderly, Elderly Health, Health Status Score.

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INTRODUCTION

The population of the world is ageing at a fast pace. Between 1950 and 2000, the world population aged 60 years and above tripled and it will more than triple between 2000 and 2050 and will total up to 2 billion (22 per cent of world population). In absolute terms, the aged population of the world is over 962 million (2017), i.e. about 11 per cent of the total world population. The proportion of persons aged 60 years and above in India rose from 5.6 per cent in 1961 to about 8 per cent in 2011. According to the "India Ageing Report 2017" by the United Nations Population Fund, the share of population over the age of 60 years could increase from 8 per cent in 2015 to 19 per cent in 2050 (Economic Times, 2018).

There are wide variations among the different states, with the highest percentage of aged population (12.6 per cent) in Kerala and the lowest (5.4 per cent) in Delhi. In case of Assam it stood at 6.1 per cent (Census, 2011).

Ageing and deteriorating health go side by side. It is very rare that an aged person is without any ailment. In India the various reports of the National Sample Surveys conducted during the past years confirm the vulnerability of the aged persons to both chronic and acute multiple diseases with variations in gender and area of residence.

In Assam, the percentage of chronically ill aged persons was 62.8 in 1986-87, which rose to 69.5 in 1995-96 in rural areas. The same increased from 59.1 to 76.7 in urban areas (Alam, 2006). Thus, there is an increasing incidence of chronic ailments over the years with the share shifting from the rural to urban areas (Baruwa, 2015). Such a dismal health situation is further aggravated because of the fact that there are neither any assured provisions for the aged persons in terms of medical facilities, benefits or social security schemes in the country nor a steady source of personal income for majority of the aged persons. Whatever government schemes are floated is piecemeal in nature. This is confirmed by the NSSO report (2004-05) that in urban Assam the expenditure on treatment in private hospitals has risen sharply (Dutta and Bawari, 2007).

RATIONALE OF THE STUDY

Unlike yesteryears when the wisdom of the old was revered, the aged segment of the population is being increasingly side-lined and thrown to the corners in the globalisation-fed consumerist world of today. The predicament for the urban aged persons is riskier than their rural counterparts because of nuclearisation of the family structure. In such a context, and keeping in mind the gradual increase in the growth rate of the aged persons over the years, it has become necessary to highlight the health situation of this marginalised segment of the population. The essence of this paper is to focus on health status of the aged persons in order to prescribe health improvement measures for this vulnerable and marginalized section of the population.

AREA AND SCOPE OF THE STUDY

Macro-level survey data tends to mask the heterogeneity that exists among different sets of population groups residing in the same state. Hence an attempt has been made in this paper to study a cross section of the aged population residing in six district headquarters of Assam, viz. Dibrugarh, Golaghat, Jorhat, Sivasagar, North Lakhimpur and Tinsukia. The rationale of selection of the study area is that the urban elderly population is placed in a very vulnerable position, specifically after the 1990s. No extensive specific socio-economic and health study on the aged population has so far been conducted in the Upper Assam region.

Though “health” refers to “a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity”, as per the World Health Organisation (1948) definition, the present study is confined to the study of selected physical health aspects of the aged sample persons. A clinical examination and study of the mental health aspect of the respondents are outside the purview of the study. This delimitation might be a constraint to the study since generalisation of the results is not possible.

OBJECTIVES OF THE STUDY

i. To understand the overall physical health condition of the aged persons of the sample area.
ii. To identify the socio-economic variables associated with the physical health of the sample aged persons.

METHODOLOGY OF THE STUDY

A total of 657 aged persons, selected randomly, consisting of 362 males (55.1 per cent) and 295 females (44.9 per cent) comprise the sample of the study. The criterion of selection of the sample urban centres was that all six are district headquarters with municipal boards. No other district headquarters have municipal boards. The study of elderly health is confined to the physical health of the elderly population. The collected data was analysed with the help of the suitable statistical package. Physical health status indicator was prepared to get an idea about the health condition of the sample elderly. Multivariate logistic regression analysis was done to determine the association of the various socio-economic variables with the physical health condition of the sample aged persons.

FINDINGS

The findings of the study are arranged according to the objectives set earlier. Accordingly, an overall physical health status indicator has been prepared to understand the health condition of the sample elderly respondents. Thereafter, the results of the multivariate logistic regression are analysed to examine the socio-economic determinants of health status of the elderly persons of the study area.

Physical Health Status Indicator

An attempt has been made in this section to derive health status indicator of the sample elderly persons which further serves as the dependent variable in the regression model fitted in order to examine the determinants of the physical health condition of the sample elderly persons. The physical health condition of the aged respondents has been determined on the basis of this health status indicator

prepared after taking into account the health ratings (1 to 5) as submitted by the aged respondents during the interview, based on their feelings about their own health. The indicator also includes scores derived from 19 other health related questions. Thus the health score is based on 20 points by linearly adding up the responses of the elderly individuals with regard to questions put to them on various health related matters. Scoring was done in reverse order, i.e. the presence of a disease was scored "0" whereas the absence of the same was scored "1". Presence of fit habits was marked "1" and its absence marked "0". Thus, higher score indicates better health status.

The composite Activities of Daily Living (ADL) score is linearly added in the total score. This framework for ADL was used by Srivastava (2010) in her study on the urban elderly women in Rajasthan. The score was derived from 9 three-point likert scale based questions which were then further assigned numerical values in the following manner: Perfect – 4, High – 3, Moderate – 2 and Low – 1. Reliability between the items was found to be sufficiently good (Cronbach's alpha = 0.7298, Standardized alpha = 0.7205). The numerical summaries of the Health Status indicator are shown in Table 1.

Table 1: Numerical Summaries of the Health Status Indicator

Mean	S.D.	S.E. (mean)	IQR	C.V.	Skewness	0%	25%	50%	75%	100%	n
19.41	4.05	0.16	5	0.21	-0.34	6	17	20	22	27	657

Thus, the health status indicator shows that the score is approximately symmetrical; the negative value suggesting that the number of low health status scores is few.

Determinants of Health Situation of the Respondents

To examine the physical health situation of the urban elderly population of the study area, a multivariate logistic regression model was fitted by taking the health status Indicator as the dependent variable. The results are shown in Table 3.

Table 3: Logit Estimates of Regression of Health Status Indicator

Variables	B	S.E.	Wald	Df	Sig.	Exp(B)	95% C.I.for EXP(B)	
							Lower	Upper
AGE (1)	-.989	.189	27.506	1	.000	.372	.257	.538
HWK (1)	.761	.204	13.971	1	.000	2.140	1.436	3.189
WST (1)	.904	.240	14.247	1	.000	2.470	1.544	3.949
FIT (1)	1.155	.220	27.475	1	.000	3.173	2.060	4.886
GEN (1)	.808	.209	14.912	1	.000	2.243	1.489	3.380
PEN (1)	.747	.204	13.372	1	.000	2.111	1.414	3.150
FRN (1)	.786	.259	9.235	1	.002	2.195	1.322	3.644
Constant	-2.423	.338	51.406	1	.000	.089		

The associations between health status score and all the socio-economic variables considered in the logistic model, viz. AGE (age), HWK (household work), WST (work status), FIT (fit habits), GEN (gender), PEN (pension) and FRN (meeting friends regularly) are found to be statistically significant. The dependent variable is the health status indicator derived in the previous section. It can be seen that for the sample elderly, there is significant negative association between age and health status and for the rest of the variables, there is a significant positive association.

A good health status score is 63 per cent less likely for the aged elderly persons (70 years and above) in the sample (Odds Ratio 0.372). Having fit habits (like regular walking, exercising, gardening and so on) is found to be the most important predictor (Odds Ratio 3.173) of a good health status score of the sample elderly followed by work status (Odds Ratio 2.470).

Among the other factors considered, the determinants of a good health index for the sample urban elderly population in order of their comparative importance are gender (being male), meeting friends in the neighbourhood regularly, participating in household work, receiving regular pension and age respectively.

DISCUSSION

While biology, genetics and a host of other factors are undoubtedly associated with health of a person, nonetheless, associations between good health and different socio-economic and demographic variables have been empirically established in many earlier studies conducted elsewhere in India and abroad. The overall results of the regression analysis show that fit habits have a fairly positive relation with good health, thereby validating the fact that a moderate regular amount of physical activity is essential for maintaining good health in the later ages.

Age has a negative relationship, thereby confirming the fact that health problems are compounded as one gets older. This negative association between the health indicator and age might be interpreted by the fact that the older old and oldest old (70-79 years and 80+ years) elderly tend to experience sharp reduction in their physical capabilities and morbidity sets in at advanced ages, compared to the young old (60-69 years) elderly persons.

As far as the positive association between gender and the health status indicator is concerned, without making any clinical surmises, it can be broadly argued that the entire life cycle events of a female elderly, particularly that of a married female person in a patriarchal set up, go against her physical health in general; the effect of which are more prominent in the older ages.

Further, the healthier aged persons are those who have a higher level of higher frequency of the opportunity to meet friends. Regular social interaction with friends is good for health and so is doing household chores. Those who receive regular pension report better health than those who do not. This clearly follows from the fact that with pension a steady flow of money for the elderly means they can spend on their health expenses easily and frequently, either for curative or preventive purposes.

Though it is not possible for each aged person to be economically active either during the prime years of their lives in general and

more specifically after attaining the age of 60 years and above, it has been found that those who are engaged in some or the other economic activity, have better health condition than those who are not earning. While the straightforward implication of this association between good health and economic activity is that the aged person has sufficient funds of his/her own to spend on health, the other plausible explanation might be the physical activity involved during working hours which also keeps them mentally fit. Many studies have confirmed the need for active ageing.

Being only physically and economically active alone does not connote "active" ageing. Continuing participation in all-round activities which encompasses social, economic and community participation will lead to an aged person remaining "active" in the true sense (Kalache, 2009). Keeping physically fit regularly both by means of moderate physical exercise, yoga, walking, gardening as well as participating in household work will help in proper bodily and mental functioning. At the same time, the sense of confidence that comes from being able to be physically (and for some economically) independent is an added booster to overall health. Eventually, this works both ways, i.e. being healthy will lead to lesser medical expenses and having an income stream will make it easier to spend on one's own health, without having to depend on others.

CONCLUSION

The deterioration in health as age increases is inevitable. However, the overall health status indicator for the sample is fair. A socially, economically and physically active lifestyle can abate illnesses to a great extent. Moreover, a regular flow of income helps people of this age group to tackle not only existing diseases but also incur precautionary health expenses to keep fit and fine. At the same time and more importantly, keeping in mind the dismal health scenario in case of this marginalised section of the population, there is an urgent need in Assam for ease of access to health facilities to them through joint government, non-government and individual efforts well before the onset of their twilight years.

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COMMUNITY CARE : INTEGRATION AND SUSTENANCE OF THE ELDERLY IN THE INDIAN SOCIETY

Indrani Chakravarty*

ABSTRACT

In our traditional society the older people always held a respectful and dignified position. Care & Protection of the elderly was integrally embedded in the value system. They are considered as God in Hindu Shastra—"**MATRU DEVO BHAVA PITRU DEVO BHAVA**". At the heart of the Joint Family, a system of Intergenerational reciprocity exists. But the advent of Modernity, Globalization and accompanying phenomena has put strains on the social institutions which are changing fast. This paper primarily aims to identify the nature of care available to the Senior citizens in the context of changing Socio-economic scenario.

India, the world's second most populous country, has experienced a dramatic demographic transition in the past 50 years, entailing almost a tripling of the population over age of 60 years (Government of India, 2011).[1] Population ageing is a global phenomenon and it is common all over the world, India is no exception. Shrinking fertility rates and longer lives are changing the demographic landscape of countries worldwide.

According to 2011 census, India has 104 million elderly people and it will rise to near 140 million by 2021. The future projection shows the number will reach 177 million by 2025. But several social changes, such as industrialization, urbanization, modernization and

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globalization weakened the Indian traditional social structure and the number of care providers to the aged in the family set up is also diminishing. In a changing socio-demographic and socio-cultural perspective both the meaning and connotation of care have been changed.

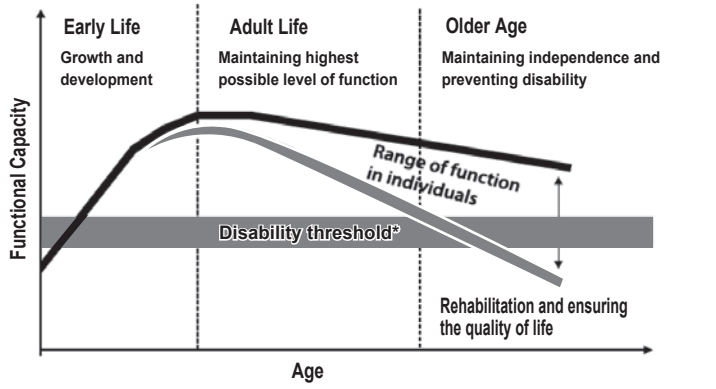
WHO, in 2000 defines 'Care' as “the system of activities undertaken by informal & formal caregivers (family, friends, neighbors, professional) to ensure that a person who is not fully capable of self care can maintain the highest possible quality of life according to his/her individual preferences with the greatest possible degree of independence, autonomy, participation, personal fulfillment & human dignity.

The concept of care is traditional in the country, providing care to seniors in Indian families connotes moral obligation to family members. The prevalent cultural model is that at the heart of the joint family, a system of intergenerational reciprocity exists. However, rise of the middle class and rapid disintegration of the family system augmented by complex reforms of economic liberalization in the 1990s caused severe erosion in the tradition of intergenerational reciprocity and elder care in Bengali families in both rural and urban settings.[2] A survey by Calcutta Metropolitan Institute of Gerontology (CMIG) in 2012, shows that eighty per cent of senior citizens in Kolkata prefer to stay with their children and feel that the family is still the best place to live in. The study further reveals that dependence on kin has been the dominant way of living and a major source of support for the elderly. The BKPAI (2011) survey also gathered information regarding support system for the elderly in their old age.

However, Socio-economic changes, along with demographic transition lead to dwindling family support and inadequate availability of resources. These factors necessitate Formal, Social and Community care be in place for the elderly to meet the multidimensional challenges of older persons.

The essence of care giving is embedded in the fact that the functional capacities—the abilities of ADL, IADL decline with age.

Figure 4. Maintaining functional capacity over the life course



**Changes in the environment can lower the disability threshold, thus decreasing the number of disabled people in a given community.*

This is the functional capacity and disability threshold graph. It reveals that during adulthood functional capacity reaches its peak – then it starts declining. Beyond the threshold point senior citizens need rehabilitation to ensure quality of life.

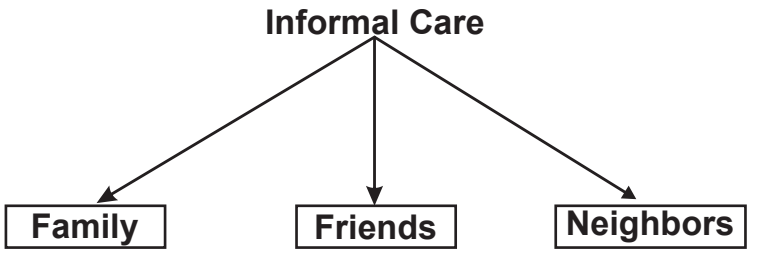
Formal or institutional care means care given by Institutions – Old Age Home, Hospice, Nursing Homes or a hired and trained person. British System of poor laws which evolved throughout 17th & 18th century defined older person as deserving poor citizens who are lacking the means to support themselves. For them poor house or Old Age Homes were set up in Great Britain in the 18th century. That was the first mandate of formal care for the elderly citizens.[4]

But with increasing lifespan, pressure on primary caregivers, women empowerment; formal care became a necessity of the twenty first century. A formal caregiver is paid for his or her service. Hiring a formal caregiver to continuously support for an elderly is exorbitantly expensive, even if convenient for the family members. But at the same time, such services are mostly unwelcomed by the elderly in question. Being expensive, formal care is neither the ready solution, nor a prospective answer to the question of care of the older people of a country like India. A care during the sunset years should be affordable and accessible for all irrespective of their social, financial

or familial condition, since it's only humane.

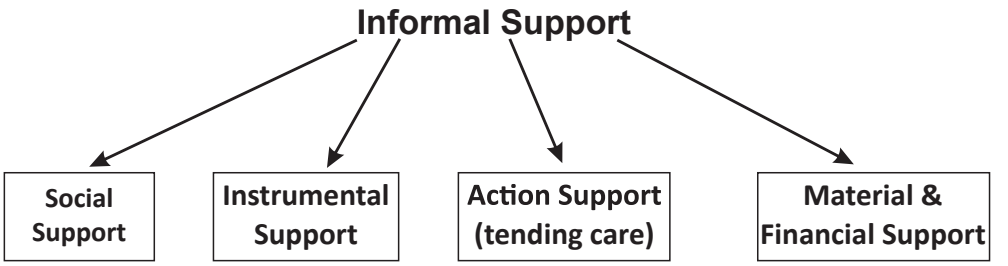
The difference between Formal sector and informal one according to Froland (1980)[5] is, the former encompasses Govt. mandate or sponsored services which State-administrators provide through Chartered intermediaries such as private non-profit organizations. The formal Sector also includes private market-based services as well as services provided by Voluntary Organizations that receive Governmental Financial support. Froland (1980) refers to the informal Sector of care as those sources of care and assistance provided by family members, kin, friends and neighbors. (Ngan: Social Care & Older Person).

Informal care is based on three pillars.



Ngan- Social Care and Older Person: an introduction to Gerontology

Barnes in his 1954 study of class and committees in a Norwegian island parish, defined and classified informal support network based on the nature of support. (R. Ngan: Page-130)



1) Social Support: This has three components: emotional support, esteem support and network support.

2) Instrumental or Informational Support: This involves guiding persons to better coping or adaptation.

3) Active support or tending Care: This support is being spontaneous and attentive to the needs of the recipients. (Parker, 1981)

4) Material Support: The provision of goods, financial and material aids, and tangible aids.[7]

Social Care --- a new concept

Social care is typically provided by home-based support services arranged by formal organizations and the bulk of tendering care by family caregivers. Social care describes functional (task-oriented) and effective (emotional support) assistance in daily living. Social care is a combination of both formal and informal care. (R.Ngan)

Recent research done by the Scholar of CMIG (Dynamics of elder care: an published Ph.D. thesis),[8] reveals that large number of senior citizens in the city residing in the family, are dependent on Social Care, where both the near-kin and hired trained professional looks after the sick elderly.

Community Care- An Emerging Concept:

In order to promote the concept 'Ageing in Place' (Sheila Peace), in addition to formal and social support, more and more community support is needed. The concept emphasizes keeping older and frail elderly in their home for as long as possible via the provision of home-based community services. Community care means indigenous or natural helpers, informal self-help or mutual aid activities found within network or groups, usually on an unorganized or spontaneous basis. Community care is referred to as the natural support system to include local informal caregivers not directed by caregiving professionals trained by voluntary welfare organizations. Student and housewives are the two main potential sources of community

caregiving. Those who can spend quality time with the elderly in the community. Thus community care is mainly based on informal social relationship and altruism. In promoting ageing- in place strategies aimed at reducing social isolation are needed. Some of the examples of community care are Voluntary Day Centres, emergency helpers, doctors on call, meals on wheels programme by youth etc. With increasing numbers of elders living alone, their emotional needs can also be well catered to by community volunteers. Policy should be directed in this direction.

Indian Scenario

1999 was declared as IYOP. The NPOP was announced by the Govt. of India in the same year. This was formulated keeping in view the provisions enshrined in the Constitution of India regarding the wellbeing of senior citizens.

The NPOP, 1999 is a perceptive document. It takes into consideration the challenges emerging out of transition in the society and the population size, documenting and treating these as the rationale for the National policy. It assures older persons that their concerns are national concern; and they will not be left unprotected, ignored or marginalized. Therefore, the goal of the national policy is basically the well being of older persons, which aims to strengthen their legitimate place in the society and help older persons to live the last phase of their life with purpose, dignity and peace.[9]

There are various areas of intervention in the policy like Financial Security, Health Care including expansion of mental health services, protection of life and property, promotion of voluntary organizations through grants, awareness generation regarding various ageing issues, strengthening family bond etc.

The first step of implementation of National Policy is the training of manpower. The basic objective of the Govt. is to produce a group of trained manpower (named as Geriatric Animator), who will look after the elderly in different institutional and non-institutional settings.

In the domain of Ageing, the Project National Initiative on Care for

Elderly (NICE) came in vogue, under National Institute of Social Defence (NISD). The project NICE is a pioneering effort to create a core group of skilled persons, who can care for the elderly in the family & community setting. NISD organizes the following courses:

- Three Month Training Programme for bedside attendants
- Six Month Certificate Course (Geriatric Animator)
- One Year Post-graduate Diploma Course in Gerontology and Age Management

Our organization, Calcutta Metropolitan Institute of Gerontology (CMIG) has been working for the elderly over three decades with the focus- Community Development (CD) through intensive research & action oriented programmes. The institution is the Regional Collaborating Agency of NISD, a Regional Resource & Training Centre on Ageing (RRTC) of Ministry of Social Justice & Empowerment, Govt. of India and runs various Training Courses throughout the year.

So far CMIG has produced 1130 trained geriatric animators who are engaged in providing domiciliary services to the frail and home bound elderly. In addition to helping the seniors to do ADL, IADL, Escorting and Companionship, they also help them promote successful Ageing by connecting them spiritually, culturally and productively.

CONCLUSION

The genesis and unfolding of this new dimension of care provision, i.e., community care, has opened a vista of possibilities for the elderly population across the world. The existing triad of care infrastructure (Formal, Informal, Social) entails large-scale mobilization of human as well as financial resources on part of the Govt. as well as other sectors. It was imperative that in order to meet the demands of the increasing prominence of elderly citizens across the global demographic landscape, an augmentation of the existing care structure be done. Community care, in this respect, has been a radical intervention. India, being a collectivist society, with a rich spiritual heritage, and highly valued familial ties, the spontaneity of the masses in helping and caring for the elderly comes as a natural outcome of our culture. With increased awareness in society, community care will gradually gain prominence, thus forming an integrated and holistic framework of Geriatric Care. The burden of eldercare, we feel, will then be relieved and the dream of graceful ageing, in our society as a whole may finally be realized.

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NOTES FOR CONTRIBUTORS

All Contributions and correspondence should be sent to Dr. Indrani Chakravarty, Calcutta Metropolitan Institute of Gerontology, E-1, Sopan Kutir, 53B, Dr. S. C. Banerjee Road, Kolkata-700 010. Contributors are requested to conform to the following norms and those articles that do not conform may not be considered.

Journal articles that deal with the biological, medical, psychosocial, service or other aspects of ageing are welcome.

Articles should be original contributions. Redundancy is discouraged. The articles should be written in English, free of grammatical or spelling errors, repetitions etc.

Articles shall contain: A brief introduction (reflecting the context, the review of relevant work and why the present study was planned) : relevant details of plan methodology, sample, (including standardization properties of tools) etc., the results or findings and their discussion and conclusions arrived at. At the beginning of the article the title and names of authors shall be mentioned. (Their affiliation may be given at the bottom of the page). This shall be followed by a brief abstract of the article (not exceeding 100 words) in single space, bold and set off the margins (inset by two spaces). Two or three key words of the article should be provided at the end of the abstract separately.

Articles may be computer generated. Two hard copies, double spaced in A4 size (one side only) with wide margin may be sent. The articles would be adjudicated by referees and the result would be communicated. When the article is accepted contributors are requested to send 2 corrected versions of the article (hard copies) and the same in an electronic version in CD, press ready.

(a) References as below in international style (e.g. journal of Gerontology) arranged in alphabetical order in the Text : (Altekar, 1973, Birren, 1959, Tyson 1983 ....). End list of references:

Baltes, P. B. (1987). Theoretical propositions of life-span developmental psychology: On the dynamics between growth and decline. *Developmental Psychology*, 23,611-626.

Baltes, P. B. Reese, H. W., & Nesseiroade, J. R. (1988). *Life-span Developmental Psychology*: Introduction to Research Methods. Hillsdale, NJ : Eribaum.

(b) Footnotes should be avoided unless absolutely essential.

(c) Tables and figures should be clearly laid out, typed in standard format, numbered consecutively, and designed to fit on the page of the journal “AGEING & SOCIETY” of CMIG.