CHAPTER TWO

REVIEW OF LITERATURE

2.0.0 INTRODUCTION

Review of related literature is an important pre-requisite for actual planning and execution of any work. Review of related literature implies locating, reading and evaluating the reports of research as well as reports of casual observations and opinions that are related to an individual’s planned area of work. Review provides a better understanding of the problems, which helps the investigator in gaining new insight and to formulate new approaches to the problem that has been selected.

A literature review gives an overview of the field of inquiry: what has already been said on the topic by great investigators what the prevailing theories and hypotheses are, what questions are being asked, and what methodologies and methods will be appropriate and useful. A critical literature review shows how prevailing ideas fit into your own thesis, and how your thesis agrees or differs from them (Harper Rowena, 2011).\(^1\) (Best, 2000) “Familiarity with the literature in any problem area helps the students to discover what is already known, what others have attempted to find out, what methods of attempt have been promising or disappointing and what problems remain to be solved.”\(^2\) “A literature review is a critical summary of research on a topic of interest, often prepared to put a research problem in

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1 Harper Rowena, Paper Presentation on defining Gerontology, Accademic skills center, Canbarra.
context. A literature review helps to spot the foundation for a study and can also inspire new research ideas” (Polit and Hungler, 1998).³

### 2.1.0 Gerontology and Geriatrics

The size of India’s adult population is greater than the total population of many developed and developing countries. According to World Health Statistics 2011, 83 million persons in India are 60 years of age and older, representing over 7% of the National total population. Geriatrics is the study of health and disease in later life and emphasizes comprehensive care for older persons as well as the well-being of their care-givers. Gerontology is the study of the ageing process and involves the study of the physical, mental and social changes that occur as people age (WHO, 2011).⁴

The study of the physical and psychological changes which are incident to old age is called gerontology. The care of the aged is called clinical gerontology or geriatrics. Social gerontology which was born on the one hand out of the instincts of humanitarian and social attitudes and on the other out of the problems set by the increase number of old people (Park, 2011).⁵ Gerontology is the field of study that focuses on understanding the biological, psychological, social and political factors that influence older people’s lives. Geriatrics deals with clinical study and treatment of older people and the disease that affect them (Nancy, R. Hooyman et al. 2005).⁶

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Gerontology is study of the aging process and individuals as they grow from midlife through later life including the study of physical, mental and social changes; the investigation of the changes in society resulting from our aging population; the application of this knowledge to policies, programs, and practice (Quadagno, 2008). Geriatrics is the study of health and disease in later life; the comprehensive health care of older persons; and the well-being of their informal caregivers (Butler, 2008). Gerontology is the study of the social, psychological and biological aspects of aging. It is distinguished from geriatrics, which is the branch of medicine that studies the diseases of older adults. Gerontologists includes researchers and practitioners in the fields of biology, medicine, nursing, dentistry, social work, physical and occupational therapy, psychology, psychiatry, sociology, economics, political science, architecture, pharmacy, public health, housing and anthropology (Nancy, Hooyman R. 2011).

Geriatrics is a branch of medicine and it deals with gerontology and ageism. According to National Associations of Social Workers, (NASW) “the geriatric social work is a profession, which provides specialized service and opportunities for the elderly and their family to enhance problem solving and coping skills of the elderly and their care-givers and to help develop a social policy”. Geriatrics is a profession, which deals with the physical, mental, social, and medical aspects of old age. It stands for the over all development of the elderly (Elizabeth, B. Hurlock, 1992).

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Butler, 2008. AGHE Executive Committee.
Geriatrics derived from two Greek words, “Geras” means old age and “Iatro” relating to medical treatment. Thus, geriatrics is the medical specialty that deals with the physiology of ageing and with the diagnosis and treatment of diseases affecting the aged. It is the branch of medicine dealing with the problems of ageing and the diseases of the elderly (Stephanie Nancy, 2010).

With rapid advancement in scientific developments, improved health practices and better standards of living, the life expectancy in many countries including India has gone up considerably. In developed countries, many people live up to the age of seventy years and over. In England, twelve percent of the people are over sixty-five years of age, whereas in India it is 3.8 Per cent. Life expectancy is affected by various factors such as the historical period in which one lives, his family background, nationality, sex, life style, etc.

The rapid urbanization and societal modernization has brought in its wake a breakdown in family values and the framework of family support, economic insecurity, social isolation, and elderly abuse leading to a host of psychological illnesses. In addition, widows are prone to face social stigma and ostracism (Jamuna, D. 1997). The socio-economic problems of the elderly are aggravated by factors such as the lack of social security and inadequate facilities for health care, rehabilitation, and recreation. In addition, in most of the developing countries, pension and social security is restricted to those who have worked in the public sector or the organized sector of industry. (Karthikeyan, 1999).

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surveys have shown that retired elderly people are confronted with the problems of financial insecurity and loneliness. (Bhatia, 1983).\(^{14}\) In the recent times individualism, independence, and achieved position in the family are becoming part of family culture in India. The aged would now prefer to live independently as long as possible and the children do not feel guilt of being away from the parents. Nevertheless there is no total societal acceptance to deserting parents by their children. Living arrangements for the elderly are influenced by several factors such as gender, health status, disability, socio economic status, societal tradition and cultural heritage (Madhav Rao, 2002).\(^{15}\)

The 60\(^{th}\) National Sample Survey (January–June 2004) collected data on the old age dependency ratio. It was found to be higher in rural areas (125) than in urban areas (103). With regard to the state of economic development, a higher number of males in rural areas, 313 per 1000, were fully dependent as compared with 297 per 1000 males in urban areas. For the aged female, an opposite trend was observed (706 per 1000 for females in rural areas compared with 757 for females in urban areas). National survey (2006).\(^{16}\) Overall 75\% of the economically dependent elderly are supported by their children and grandchildren. Despite this, the elderly still tend to suffer from psychological stress as was found in a survey conducted for a middle class locality in New Delhi. (Bose, 1997).\(^{17}\) Over 81\% of the elderly confessed to having increasing


stress and psychological problems in modern society, while 77.6% complained about mother-in-law/daughter-in-law conflicts being on the increase.

The elderly are also prone to abuse in their families or in institutional settings. This includes physical abuse (infliction of pain or injury), psychological or emotional abuse (infliction of mental anguish and illegal exploitation), and sexual abuse. A study that examined the extent and correlation of elder mistreatment among 400 community-dwelling older adults aged 65 years and above in Chennai found the prevalence rate of mistreatment to be 14%. Chronic verbal abuse was the most common followed by financial abuse, physical abuse, and neglect. A significantly higher number of women faced abuse as compared with men; adult children, daughters-in-law, spouses, and sons-in-law were the prominent perpetrators. (Chokkanathan, 2005).

2.2.0 Ageing Process and Accompanying Changes

In advanced countries, the care of the aged is provided mostly in institutions, unlike in India where the elders are still-some what respected and cared for by the family members and support is given mostly in the homes. There are also few institutions, which provide care for the aged. Yet the status of the elders and the quality of the care provided are satisfactory. The increased proportion of the elderly segment in the community necessitates the services of community health workers who can be of use to the family as a whole. A trained home nurse knows the needs and problems of the aged and their families better and meets them more efficiently. The care of the aged is a part of clinical gerontology and geriatrics. Besides the superior competency to meet the needs and problems

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concerned with the psychology and physiology of ageing, the social aspects of ageing offers a great challenge to the caring profession. Aged people are more vulnerable to illnesses such as bronchitis, arthritis, avitaminosis, gastro-intestinal disorders, rheumatism, diabetes and skin disorders etc. Their vision and hearing can be impaired to an extent that their social activates are greatly restricted.

It is clear from the above review of earlier studies on health of the elderly that the health and wellbeing of the elderly are affected by many interwoven aspects of their social and physical environment. Family support is found to be an important factor for socio-psychological well-being of the elderly (Devi and Murugesan, 2006).19

2.2.1 Social Aspects of Ageing

Some of the sociological changes that come with increasing life span include reduced income, negative impact on in the life style, loss of other family members and friends, which results in social isolation and loneliness. The ageing population place greater demand on community health services. They impose additional responsibilities on the younger generation and the other family members. With a reduced income, retirement and with very few companions their life style is considerably altered, especially when they are affected with some illness (Keshav Swarnkar, 2010).20 Many of the aged are reluctant to go to institutions for the care of the aged. Thus, family care-giving is encouraged and promoted. In some countries besides financial help, social workers, nurses and


professionals provide supervision of care in the family in order to lessen the strain in the family members. Many hospitals are now having geriatric units for the care of the aged both in the in-patient and outpatient departments. Specialized training is given to medical, nursing and other health professionals for this purpose. Health promotional and ailment prevention measures such as health examination for early diagnosis and treatment are provided.

A man's life is normally divided into five main stages namely infancy, childhood, adolescence, adulthood and old age. In each of these stages an individual has to find himself in different situations and face different problems. The old age is not without problems. In old age physical strength deteriorates, mental stability diminishes; money power becomes bleak coupled with negligence from the younger generation. There are 81 million older people in India -11 lakhs in Delhi itself. According to an estimate, nearly 40% of senior citizens living with their families are reportedly facing abuse of one kind or another, but only 1 in 6 cases actually becomes known. Although the President has given her assent to the Maintenance and Welfare of Parents and Senior Citizens Act, which punishes children who abandon parents with a prison term of three months or a fine, situation is grim for elderly people in India (Yuman Hussain, 2010).

Living in Old Age Homes has also become common among the elderly in Kerala. As per the Kerala Aging Survey done in 2009, Kerala topped the country with 204 old age homes, and one out of every 5 old age institutions in India is located in Kerala. And more such centers that provide residential facilities for senior citizens are coming up in the state. and Ernakulam has the highest percent of

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elderly living in old age homes (23) and Kasargod has the lowest (0.8 percent). More women are living in old age homes, and reports say that the aged have a negative perception about such institutions and majority of them prefer to stay in their homes. But with more youngsters making their living in faraway places, the living conditions of the elderly are undergoing a drastic change (Kerala Ageing Survey, 2009).22

Maintenance of Health and Independence: Health education is imparted on a three-tier basis — primary, secondary and tertiary education. Primary education is provided for the prevention of disease or injury and the promotion of positive health. The elders are encouraged to participate in activities that are beneficial to health and to avoid those that are injurious. Secondary education is concerned with early detection of signs of ill health and timely intervention and care. Tertiary education is given following disease or injury to encourage the individual return to independent existence as far as possible. They are encouraged to reduce excessive intake of alcohol and to give up smoking. The opportunities for health promotion are many, and include good housing, balanced diet or education to adapt to the home environment to counteract disability if any (TNAI, 2008).23

It is observed in many of the elders especially the very old that there they are unable to manage their own physical needs (washing, dressing, toilet, eating). There is also the loss of ability to fulfill their psychological needs (security, status, social interacting). In an institution or community, an initial assessment of the elderly person can identify his abilities and limitations, with to direct personal needs (toilet, washing, cleaning feeding), and extended

personal care (shopping, cooking, housework and socializing). The care should be planned according to individual’s strength and limitations with frequent reviews of the situations. It is important wherever possible to involve the relatives in the planning and providing of care. The teaching role of the social worker should be directed towards the practical aspects of promoting knowledge concerning health, and adaptation to disability, teaching basic skills and an acquisition of positive attitudes. In their scheme an assessment of ‘readiness to learn’ and the coping ability of the family are essential. Besides the capability of the person concerned and his relatives to learn should be ascertained. The individual’s interest in the problem and the incapacitation of any intellectual ability that may have been caused due to illness should also be identified in advance.

(Park, 2011) Practical skills, (such as testing urine, changing appliances, drawing up and giving injections, inhalations) are best taught by demonstration with accompanying explanation. Opportunity should be given to the person and or his relatives to handle the equipments and clear doubts by questioning. Regular supervision with encouraging praise, reinforcing success will help the teaching.  

There is an adage: attitudes are caught and not taught. The social workers have the responsibility of promoting positive attitudes to health, aging and the management of disability. The right attitude of the nurse promotes desirable attitudes in others. The family is a unit through which maximum satisfaction is obtained through mutual sharing and a genuine show of concern. But in old age a person’s family status often undergoes a negative change. A father, who was the chief of the family till then, may suddenly turn a dependent on his children. A mother may have to

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subject herself to the rule of daughters-in-law. If one of the partners is dead, the other is prone to feel lonely. The decision making process in the family changes and the control is transferred.

Under such circumstances, the best thing to do is that the old person to eschew the desire for power and to avoid unnecessary interferences. They may give advice, when needed. They should also try to adjust their own needs and daily living activities to the routine of family. By adjusting with the generation gap and modern trends as far as possible, old age can be made pleasant. Though the ashram system is not possible in modern times, an old person can adopt the attitudes of a vanaprastha and make his own life more congenial and rewarding (Keshav Swarnkar, 2010).

2.2.2 Biological Aspects of Ageing

Biological ageing, or senescence, is defined as the normal process of changes over time in the body and its components. It is a gradual process common to all living organisms that eventually affects an individual’s functioning vis-à-vis the environment but does not necessarily result in disease or death. It is not, in itself, a disease. However, aging and disease are often linked in most people’s minds, since declines in organ capacity and internal protective mechanisms do make us more vulnerable to sickness. Because certain diseases such as Alzheimer’s, arthritis, and heart conditions have a higher incidence with age, we may erroneously equate age with disease. However, a more accurate concept of the aging process is gradual accumulation of irreversible functional losses to which the average person tries to accommodate in some socially acceptable manner. People can continue to maintain an

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active lifestyle as they experience age-related changes in their biological and physiological systems. In order to achieve active aging, people may alter their physical and social environments by reducing the demands placed on their remaining functional capacity (Nancy, 2005). This is consistent with the person-environment model of ageing; as their physical competence declines, older people may simplify their physical environment to re-establish homeostasis or their comfort zone.

Popular culture, as reflected in books and magazines, is full of stories about “anti-ageing hormones,” “fighting ageing,” and “preventing death.” The problem with these optimistic projections is that no single scientific theory has yet been able to explain what causes ageing and death. Without a clear understanding of this process, it is impossible to prevent, fight, or certainly to stop this normal mechanism of all living organisms. The process of ageing is complex and multidimensional, involving significant loss and decline in some physiological functions and minimal change in others. Scientists have long attempted to find the causes for this process. A theme of some theories is that ageing is a process that is programmed into the genetic structure of each species. Others theories state that ageing represents an accumulation of stimuli from the environment that produce stress on the organism. Any theory of ageing must be based on the scientific method, using systematic tests of hypotheses and empirical observations (Nancy, R. Hooyman).

Successful ageing means a positive approach to ageing. “Successful ageing refer to modification of behavioral diet exercise

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and attaining/retaining autonomy and social support. This concept provides an access to achieve the best possible outcomes of ageing” (Krishna Kumari, 2005).28

The successful ageing is thus an active process in which an individual has to make choices to age in a healthy manner. For successful ageing such factors as diets, exercise, lifestyle, social support and maintenance of personal autonomy need to be accepted as part of the philosophy of health promotion in old age. The ageing population needs to be encouraged to adopt healthy lifestyle and a congenial environment to live long and have quality in life. The study of ageing process and its effect on older person is known as gerontology. The study approaches can be cross-sectional or longitudinal or both (Krishna Kumari, 2005).29

The various changes that occur in the natural process of ageing are classified as physical, mental and psychological, sociological and spiritual. Physical changes are usually noted first. These include degeneration of bone tissues and muscle tissues which result in changed body structure and posture, weakening of muscles, graying of hair, loss of teeth retraction of gums and difficulties in mobility. There is a weakness in the circulatory and cardiac efficiency, slowing of digestive process, alteration in the functions of endocrine system, decrease in the size of kidneys a marked reduction in reduced lung capacity etc. which let loose numerous problems to the ageing individual.

2.2.3 Psychological Aspects of Ageing

The major psychological factors found related to old age are disrespect, death of dear ones, stained in-house relations,

disappointment, mental tension, loneliness and lack of freedom. Senility, dementia, sexual problems and emotional disorders arise due to hormonal changes. Reduction in income and change in social status due to retirement and lack of employment also affect the aged (Pappathi, 2007). Hussain analysed the psycho-social problems of the rural aged in India. Psychological changes of normal ageing include loss of self-esteem, acceptance of physical changes, coping with personal loss, slower process of information and possible depressions. Mental changes include gradual mental dysfunction due to gradual decline in intelligence, memory, sensory changes resulting in inaccurate communication, disruption of sleep, etc. The psychosocial changes occurring in old age cannot be separated from physical changes. Because of decreased activity of sensory organs, a person is not able to work with full efficiency in his environment. Due to this, psychosocial state is affected. The person feels a sense of ‘uselessness’. Social and psychological changes of old age are as follows: Because of the experiences and happenings of life, a person’s personality is affected. However, in old age no remarkable changes occur in the basic personality structure.

Changes may occur in the personality due to the death of the life partner, loss of self-dependence, loss of source of income, incapacity, etc. Memory power may decrease with increases in age. Recalling of less frequently used information is difficult. In some old people, the tendency to repeat facts and information increases and a confused memory may manifest in disconnected utterances. If the old person is not sick, usually his intelligence is not affected. Old age does not make a person more intelligent, or less intelligent; yet because of the increase in knowledge and experiences, the person’s status of intelligence becomes more fertile.

2.2.4 Spiritual Aspects of Ageing

The spiritual changes are both internal and external. The religious attitude and feelings tend to increase. While attendance in religious services tends to decrease with increasing age for reasons such as functional disabilities, lack of company, shortage of funds and related means and facilities, etc. All these changes may cause feelings of rejection, hopelessness, depression, powerlessness, loneliness, anxiety and insecurity.

Some believe modern medicines and artificial limbs can help senior citizen cope with ageing. But in the Indian context, ageing is not just about adding years. And while Indians do not consider death as the end of the chapter, it is spirituality that is the answer for most of us. We have a right to live life with dignity and spirituality does show a way said Gokhale (Anuradha Mascarenhas, 2012).31

A sense of psychological loss decreases vitality and increases vulnerability to psychophysical problems. Most of the elder people fears these changes, as they grow older, whereas they are not afraid of death many are fully satisfied with their life, lived fully, and are thus ready for the ultimate experience of life. Often they are willing to die. This does not imply that they are depressed. Similarly, some of the old people may be tired of life because of the impact of bitter experiences in their life. They are fed up with life and express their desire to die, for which they are ready (Krishna Kumari, 2005).32

Self-concept can be enhanced in older persons by communicating respect and demonstrating caring behaviours, reinforcing health-promoting behaviours, encouraging activities of

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31 Anuradha Mascarenhas, (2012), Spirituality to assist healthy ageing, April, 7 WHO New Delhi.
daily living that contribute to independence, and by avoiding a focus on self-care deficits.

The level of self-care practice among the elderly is high. Universal self-care requisite scores are high in the areas of maintenance of sufficient intake of air, water and food, the provision of care associated with eliminative process and excrements, the prevention of hazards to human life, human functioning and human well-being and the promotion of normalcy. The score are moderate in the maintenance of a balance between, going for walks and caring for children - 20% each.

Senility is greater in people who are introverts than in those who lead a normal life. Loneliness can lead to depression. One should be involved in indoor games, social activities and reading. Developing an attitude of “thinking outside oneself” is what an elderly person should aim at. According to researchers, people who participate in cultural activities are more likely to live longer because they follow a more leisurely, low risk life style.

(Vijaya Kumar 1991) conducted a study on the family and the health of the aged. For this study, 200 aged respondents (60+years) with gastro intestinal, heart and circulation and muscular skeletal disorders. The samples were randomly selected, 491 community dwelling older adults were selected. In the area of psychological health, women tended to show greater anxiety than men did. Gender differences in self-assessed health, body awareness of health problems or symptoms were. Men reported greater body awareness than women. Men were found to fatal illness such as strokes and heart attacks. Women regarded higher rates of depression than men, but men showed more personality and
substance misuse disorders than women. The goal of health care reform for the elderly must be to evolve a service delivery system test ensuring a comprehensive, continuous care for the older adults in diverse setting (Clare Callins, 1997).

Preventive health care services should play a significant role in the program. The two most important means of promoting health and preventing chronic diseases in the elderly are health education and regular health check up (The Hindu, 1998).

(Pankajam, 2004) was also of the opinion that surface signs of ageing are obvious in their appearance. The skin wrinkles, hair loses color, muscle strength diminishes, the shoulders become stooped and a reduction in height characterized the elderly persons. As regard to physical health and mental activity, as Pankajam said that persons over 60 might lose 50 percent of their power, which forces them to lose interest in personal life and family responsibility.

2.3.0 National Policy on Older Persons (NPOP) 1999

National Policy on Older Persons (NPOP) 1999 was announced by the Government of India in the year 1999. It was a step in the right direction in pursuance of the UN General Assembly Resolution 47/5 to observe 1999 as International Year of Older Persons and in keeping with the assurances to older persons contained in the Constitution. The well-being of senior citizens is mandated in the

35 The Hindu Magazine, Adding Life to Years, October 18, 1998
Constitution of India under Article 41. “The state shall, within the limits of its economic capacity and development, make effective provision for securing the right to public assistance in cases of old age”. The Right to Equality is guaranteed by the Constitution as a fundamental right. Social security is the concurrent responsibility of the central and state Governments.

Subsequent international efforts made an impact on the implementation of the National Policy on Older Persons. The Madrid Plan of Action and the United Nations Principles for Senior Citizens adopted by the UN General Assembly in 2002, the Proclamation on Ageing and the global targets on ageing for the Year 2001 adopted by the General Assembly in 1992, the Shanghai Plan of Action 2002 and the Macau Outcome document 2007 adopted by UNESCAP form the basis for the global policy guidelines to encourage Governments to design and implement their own policies from time to time. The Government of India is a signatory to all these documents demonstrating its commitment to address the concerns of the elderly.

The policy and plans were put in place by Central and State Governments for the welfare of older persons. The State Governments issued their policies and programmes for the welfare of older persons. While some States and Union Territories implemented their policies with vigour, most States, particularly the big ones were behind perhaps due to financial and operational deficiencies.

Pensions, travel concessions, income tax relief, medical benefit, extra interest on savings, security of older persons through an integrated scheme of the Ministry of Social Justice and Empowerment as well as financial support was provided for Homes, Day Care Centres, Medical Vans, Help Lines etc are extended
currently. The Ministry of Social Justice and Empowerment coordinates programmes to be undertaken by other Ministries in their relevant areas of support to older persons. The Ministry of Social Justice and Empowerment piloted landmark legislation the "Maintenance and Welfare of Parents and Senior Citizens" Act 2007 which is being promulgated by the States and Union Territories in stages.

The Government of India announced the National Policy on Older Persons in 1999 to reaffirm its commitment to ensure the well-being of the older persons in a holistic manner. Reiterating the mandate enshrined in Article 41 of the Constitution of India, the Policy placed the concern for older persons on top of the National Agenda. The NPOP while promising to safeguard their interest in terms of financial security, health, legal, social and psychological security, also envisages a productive partnership with them in the process of development by creating opportunities for their gainful engagement and employment. The Policy also appreciates the special needs of older persons and therefore lays emphasis on empowerment of the community as well as individuals to adequately meet the challenges of the process of ageing.

The NPOP broadly provides for the following to fulfill these objectives: Financial security through coverage under Old Age Pension Scheme for poor and destitute older persons, better returns on earnings/ savings of Government/Quasi-Government employees’ savings in Provident Fund, etc., creating opportunities for continued education/skill up-gradation ensuring thereby continued employment/self-employment and income generation and provision for Pension Scheme for self-employed, employees of the non-formal, and non-Governmental sector.
Health Security: The NPOP recognizes the special health needs of the older persons to be met through strengthening and reorienting the public health services at Primary Health Care level, creation of health facilities through non-profit organization like trust/charity, etc., and implementing health insurance.

Recognizing Shelter as the basic human need, the NPOP provides for earmarking 10 percent of the houses/housing sites in urban as well as rural areas for older persons belonging to the lower income groups, special consideration to the older persons falling in the category of Below Poverty Line (BPL) and destitute in housing schemes like Indira Awas Yojana, loans at reasonable interest rates and easy repayment installments with tax relief for purchase of houses etc.

Education/information needs of older persons too have been adequately reflected in the National Policy. Education/information material relevant to the lives of older persons should be developed and made available through mass media. Education, training and information being the important human requirement, the NPOP provides for proactive role in ensuring the same by disseminating knowledge about preparation of Old Age. It is also emphasized for schools to have programme on inter-generational bonding.

Welfare and Institutional Care: Institutional Care has been provided for in the NPOP as the last resort. The care in a non-institutional set up i.e. within family and the community needs to be strengthened and encouraged. This apart, the State should also create infrastructure in partnership with voluntary organizations to provide for poor, destitute and neglected older persons whose care cannot be ensured within the family. This is to be ensured through Old Age Homes and other such institutional facilities that would be needed. Voluntary efforts needs to be encouraged for creating
facilities for day care, outreach services, multi-service citizen centers, etc.

Protection of Life and Property of Older Persons: The State is made bound to gear up the security network to save older persons from criminal offences and the police is required to keep friendly vigil. Early settlement of property/inheritance disputes is to be done, safeguards to protect them from fraudulent dealings in transfer of property through sale/‘Will’ are to be put in place and free legal aid and toll free helpline services are to be placed across the country. Maintenance of elderly within family resorting to the provisions of law viz. Criminal Procedure Code, (Cr.P.C.) 1973, Hindu Adoption and Maintenance Act. (HAMA) 1956 etc., whenever needed is required to be ensured.

Training of Human Resource to care for Older Persons: The Policy lays emphasis on the need for trained personnel/care givers. This envisages the training of human resource in the areas like specialization in Geriatrics in medical courses, special courses on Geriatric Care in nursing training, training of social workers especially for geriatric care and professional caregivers.

Media: The Policy enjoins the media to take up a special responsibility for the care of older persons. Media is to play a role in identifying emerging issues and areas of action, dispelling stereotypes and negative images about the old age, maintaining restraint from creating fear psychosis by responsible reporting, promoting intergenerational bonds and informing individuals/families/groups with appropriate information on ageing process.

2.3.1 Available Support Services

National Social Assistance Programme (NSAP) The National Social Assistance Programme came into effect on 15th August,
1995. NSAP is a social assistance programme for the poor households and represents a significant step towards the fulfillment of the Directive Principles enshrined in Article 41 and 42 of the Constitution of India, recognizing the concurrent responsibility of the Central and State Governments in the matter.

**2.3.2 The National Old Age Pension Scheme (NOAPS)**

The Scheme covers older persons/destitutes having little or no regular means of subsistence from his/her own source of income or through financial support from family members or other sources. The age of applicant must be 65 years or above. At present 50% of the older persons under Below Poverty Line (BPL) destitutes are covered under NOAPS. The Central Government contributes Rs.200/- per month per beneficiary. The State (Provincial) Governments are advised to add matching amount or more as their contribution in the federal set-up. During the Tenth Five Year Plan (2002 – 07), 110,793,860 elderly people were covered and US $ 1002.20 million (approximately) was incurred on this count.

**2.3.3 Annapurna Scheme**

Annapurna Scheme covers all the other elderly below poverty line, who are not covered under the NOAPS. A provision of 10 k.gs. of rice or wheat is provided to the needy elderly. Under this scheme US $ 56 million was expensed and 43, 03,491 elderly were covered in the Tenth plan (2002-07)

**2.3.4 Concessions/Tax Rebate/Other Incentives**

Presently persons of 60 years and above are entitled to 30% concessions in train fare in all the classes. There are airlines providing 45% to 50% concession in air journey to senior citizens.

Older persons who are above 65 years of age also enjoy income tax rebate up to 15,000 of actual tax with provision for
deduction of Rs.20,000 spent on account of medical insurance premium and Rs.40,000 spent on account of medical treatment, from taxable income. Senior citizens are exempted from Income Tax up to 1.95 lakh as per the union Annual Budget, 2007. Banks are providing 0.5% - 1% additional interest to older persons of 65 years and above, on fixed deposits. The public facilities for the elderly, initiated by the Government, include reservation of seats for the elderly in the public transport, railways and airways.

2.3.5 Insurance Coverage

Some of the public sector insurance companies provide life insurance coverage up to 75 years of age and many private insurance companies have 55 years as the last entry age. The Insurance Policy Schemes announced for older persons include Jeevan Dhara (18-65 years), Jeevan Akshay (30-75 years), Jeevan Suraksha (25-60 years), Senior Citizen Unit Plan (18-54 years). In addition, Health Insurance Schemes covering Mediclaim Policy and other individual and Group Mediclaim Policies are also offered by Nationalized as well as private insurance companies. The Government is taking steps to enforce a uniform policy on all Insurance Companies as regards entry age of Senior Citizens.

The Government has launched a Reverse Mortgage System for senior citizens to extract value out of their property and lead a hassle free life by securing a regular income as loan against their existing property.

2.3.6 Integrated Programmers for Older Persons

Ministry of Social Justice & Empowerment, Government of India, is implementing an Integrated Programme for Older Persons with an aim to empower and improve the quality of life of older persons. The basic thrust of the programme is on older persons of
60 years and above, particularly the infirm, destitute and widows. Under the scheme, financial assistance is provided to Non-Governmental Organizations, Autonomous Bodies, Educational Institutions, Cooperative Societies, etc., up to 90 per cent of the project cost for the setting up and maintenance of Day Care Centers, Mobile medi-care Units, Old Age Homes and Non-Institutional Service Centers. During the Tenth Five Year plan, Ministry provided financial assistance to voluntary organizations to the tune of US $ 18.6 million.

2.3.7 Construction of Old Age Homes

The scheme for Assistance to construction of Old Age Homes provides one time grant to Local Bodies, NGOs etc. for construction of Old Age Homes or Multi-Service Centers for older persons. The Ministry also incurred an expenditure of US $ 70,000 for construction of Old Age Homes during the Tenth Five-year Plan. Growing old is also marked by failing health and advancing age may bring with it innumerable health complications. Restricted physical mobility, coupled with crippled health, makes it difficult for older persons to have access to the health facilities if they do not enjoy the support of the family or have a care institution within their easy access. Realizing the real situation wherein the older persons live, Para 36 of the National Policy envisages covering of health insurance and financial security towards essential medical care and affordable treatment process. Some of the initiatives by the Government provide for a separate counters/O.P.D. in hospitals and free medical services in Central Government Health Scheme, Government Hospitals to facilitate easy accessibility to the elderly including Geriatric Units in the Hospitals.
2.3.8 Care of Alzheimer’s Disease and other Forms of Dementia

Dementia due to Alzheimer’s disease and other causes is one of the most serious degenerative diseases that affect the older persons. The loss of memory with advancing age is a common phenomenon. However, dementia, which is a progressive disease of the brain, affects the memory, intellect and personality. Of all the categories of the dementia, Alzheimer’s disease is the commonest and the severest.

Many of the Government and public hospitals have started Memory Clinics, Mental Health Programmes to facilitate proper diagnosis of Dementia to achieve the slowing down in the process and for preparing the care-givers and the family to manage Alzheimer’s and Dementia Care. The National Institute of Social Defense under the Ministry of Social Justice & Empowerment has initiated training of care-givers and functionaries as a special initiative apart of the centenary observances of Alzheimer’s. Covering all the districts to ensure that facility to accommodate 150 needy elderly in each of them.

Helpline Services for Older Persons: The State Governments and Office of the Commissioner of Police in collaboration with NGOs have initiated special protective measures for safeguarding the elderly and one such innovative approach is “Helpline Services” in some big cities.

Training & Human Resource Development for Home Care In the changing family context, role of professionally trained home carers have become very crucial. Therefore, preparing a frontline cadre of care-givers to ensure quality care at home as well as in the institutions is one of the important strategies. In the wake of disintegration of Joint Family System, it is ensured that professionally trained carers are available to meet the demand. In
order to meet this objective, Ministry of Social Justice and Empowerment launched the Project ‘NICE’ (National Initiative on Care for Elderly) through National Institute of Social Defense (NISD) an autonomous body of the Ministry of Social Justice and Empowerment in 2000. The NISD organizes one year P.G. Diploma Course and Six Month Certificate Courses under Project NICE to meet the demand for care-givers. In addition, Short Terms Courses varying from 5 days to One Month are also organized for skill upgradation of Service Providers working in Old Age Homes, etc. In the X Five year plan, NISD has so far organized 85 training programmes and 2535 care-givers and service providers have been trained.

A general plan of action for the elderly persons has to take into account (a) the rapid demographic changes taking place in the country in favor of the increasing number (1901:1.2 crore/1951:3.2 crore/ 2001: 6.6 crore/2025: 14.6 crore) and proportion of persons above the age of 60, (b) declining labor-participation rates of elderly in economy, (c) increasing financial strains on account of early retirement trends, slow economic growth, spiraling medical costs and inflation, (d) a slow, but, marked withdrawal of family support due to weakening of joint family ties and migration of children to cities and developed regions, and (e) the special biological, social and emotional needs associated with the old age.

Policy formulation concerning the aged persons should also draw on developments in the international field, beginning with the World Assembly on Ageing (1982), the Vienna International Plan of Action (1982) and its two subsequent reviews in 1985 and 1989, the United Nations Principles for Older Persons (1991) and finally the Global Targets on Ageing for the Decade 1991-2001 adopted by the U.N. General Assembly (1992). As an instrument of Government policy, the plan of action for the aged persons has to take into
consideration the broad constraints of resources of developing country and the limited income-base of the taxpayers/persons paying insurance premium. It is also required to take cognizance of the fact that, unlike the developed countries, aged population in India has a high proportion of destitute elderly living primarily in rural areas and working in the unorganized sector of economy without any reasonable prospect of pension of job security. It can, however, draw its strength from the strong family ties and the overall respect the aged persons still command in Indian society as a reservoir of socially useful talent and experience. It can also build up a framework based on the promise shown by the voluntary organizations in providing health, shelter and daycare services to the aged persons. It can improve upon the initiatives taken by the State Governments and Union Territories in introducing old age pension scheme for the destitute elderly.

2.3.9 The Objectives of the Old Age Policy may be Summarized as follows:

1) Providing increasing employment options and evolving mechanisms for assisting elder persons seeking work after retirement.

2) Providing (a) family support, (b) mutual benefit societies, (c) income security through personal savings policies, (d) social insurance, (e) occupational pensions, (f) provident funds, and (g) public and private social assistance.

3) Social and economic support to the old age persons living without families (on account of childlessness, death of spouses, migration of children, destitution, etc.).

4) Re-evaluating healthcare priorities and providing access to health services, 5) Reorienting housing and area planning to suit the special needs of the elderly.
A review of current approaches and programmes reveals the status of the existing legal, economic, policy framework, and the areas requiring special attention.

2.3.10 Legislative Framework

Article 41 of the Constitution recognizes the needs of the elderly and enjoins upon the state the responsibility of making effective provision for public assistance in case of unemployment, old age, sickness and disablement and in other cases of undeserved want. While the welfare of the aged is a state subject, the nodal responsibility of the Centre is assigned to the Ministry of Welfare. Under the section 20(1) of the Hindu Adoption and Maintenance Act, 1956, an aged and infirm parent, if unable to maintain him or herself, is entitled to maintenance. Muslim law also imposes an obligation to support needy parents, subject to certain conditions. Independent of the personal Law, the Code of Criminal Procedure 1973 (section 125(1) (d)) makes it incumbent upon a person, having sufficient means to maintain his father or mother, who is unable to maintain himself or herself and on getting proof of neglect or refusal, a first class magistrate may order such a person to make a monthly allowance, not exceeding Rs. 500.

2.3.11 Social Security Acts

(a) The Workmen’s Compensation Act, 1923.
(b) The Employee’s State Insurance Act, 1948.
(c) The Employees’ Provident Funds and Miscellaneous. Provisions Act, 1952.
(e) The payment of gratuity Act, 1972.
(f) The Pensions Act, 1871.
2.3.12 Tax Concessions to Elderly Persons Under

(a) Income Tax (Amendment Acts), and
(b) Finance Acts passed each year in favor of
   (i) Pensioners (reduction allowed on pension) and
   (ii) Taxpayers (below the age of 70 years on health insurance).

2.3.13 Old Age Pension Scheme for the Destitute Elderly

All the State Governments and Union Territories are currently implementing old age pension schemes to the destitute/poor elderly. There are schemes, drawn up for the purpose by each State/Union Territory according to their financial resources though they are under statutory obligation to do so. These benefits cannot be claimed as a matter of right. The first old age pension scheme was started in U.P, in 1957. Rate of pension, eligibility criteria, domicile conditions and coverage vary from State to State. The quantum of pension ranges from Rs. 50 to Rs. 100 per month. In Tamil Nadu, old age pensioners are eligible for free meals at the nutrition meal programme centers. In 1987-8, Rs. 227 crore were spent by the States/Union Territories to give pension to 49 lakh beneficiaries. Another scheme in the State Sector which is catering to the needs of a large number of destitute aged is that of homes for the aged. Some States provide grant to voluntary organizations for maintenance of the aged in these homes. In some places the old age pension due to the inmates is paid to the voluntary organizations for the upkeep of the aged. Besides, there are homes run by Voluntary organizations without Government assistance. Since 1983-84, the Ministry of Welfare is providing general grant-in-aid for assistance to voluntary organizations in the field of social welfare for (i) rendering welfare services to the aged and (ii) for constructing homes for the aged. A scheme called the Welfare of the
Aged has been launched under the Eighth Five Year Plan (1992-97), marking the entry of the aged in Indian planning.

### 2.3.14 Welfare of the Aged (Under the Eighth Five Year Plan)

The scheme aims at encouraging voluntary organizations/organizations of the elderly to provide old age homes, day care centers, Medicare and non-institutional services for the aged by assisting through grant-in-aid. Under the Old Age Home Programme, assistance is available for both maintenance and construction of such homes. Old age homes are expected to be residential units of the aged persons of 60 years and above. Old age homes are expected to take care of the physical and psychological well-being of their inmates with the help of trained social workers/counselors and medical staff. Assistance for the building construction/extension of old age homes is also available under the programme in the form of grant for construction.

In addition to the old age homes, the scheme aims at providing assistance to voluntary organizations for setting up day care centers for the aged. A day care centre should at least have 150 aged persons in its list so that even after dropouts and absenteeism, its daily attendance does not fall below 50. Day care centers should aim at gainful utilization of the spare time of the elderly, living in the neighborhood and should appoint a part-time qualified physician each for medical check-up and a full-time trained social worker. A day care centre is required to establish links with the medical, welfare and local institutions and services available in the area. Under the Mobile Medicare Service Programme of the scheme, grants are available to voluntary organizations possessing experience and expertise in Medicare services to the aged. Likewise, programmes can also be taken as under the scheme for setting up or maintaining a foster care unit.
of 25 aged persons. National Housing Policy has given due recognition to the special needs of the aged and the handicapped and has recommended construction of dwelling units with designs formulated to meet the specialized requirements of these categories. A large number of housing finance schemes has been formulated to subsidies the cost of housing for the priority groups. Government employees are encouraged to avail of house building loans at concessional rates during their service career.

**2.3.15 Health Care System**

Providing a minimum package of primary health and medical services through the expansion of health care infrastructure has been our country’s first priority. Being an integral part of the overall population, the aged in rural, tribal and urban slum areas have been benefited by the expansion of health care infrastructure. In addition to these activities, voluntary organizations are being assisted to run special programmes for the health of the aged. Health insurance schemes such as Bhavishya Arogya and Med claim (by the General Insurance Corporation of India) also exist. The Central Government Health Scheme facilities are now available to the retired Central Government pensioners.

**2.3.16 Travel Concessions and Facilities**

The Indian Railways provide 20 per cent concession in second-class railway fare to every person, aged 65 years and above for travel beyond 500 km. Free wheel-chairs are provided at all important and ‘junction’ stations to the aged and priority is given in the allotment of lower berths to passengers above 60 years of age. At large computerized reservation offices, a separate reservation counter is earmarked for the aged and handicapped persons. Some State Transport Corporations have provided for seat reservation in their buses for the aged persons. In most state
transport buses, entry for the aged is allowed from the exit door. Karnataka State Road Transport Corporation gives 50 per cent travel concession to the citizens aged over 60 years in city/sub-urban services during restricted hours. The Inter Ministerial Committee, set-up to formulate policy for the aged welfare was set-up by the Government under the Chairmanship of a Secretary (Welfare) with the representatives from the Ministry of Labour, Department of Pensions, Ministry of Urban Development, Ministry of Rural Development, Ministry of Human Resource Development, Health Directorate, Department of Economic Affairs, Railway Board and Planning Commission.

The terms of reference of this committee were: To examine the recommendations of the Round Table discussions for the care of the elderly, sponsored by the Indian Council of Medical Research and other medical and family planning bodies and suggest ways and means of implementing them. To consider the draft national policy on care of the elderly suggested by the Round Table discussions and suggest a policy frame for adoption. To suggest programmes for the care and protection of the elderly in keeping with the changing socio-economic conditions as for utilization of their services and experiences with a view to supplement the income as also channelize their energies in community support activities. (Park, 2010).

2.4.0 National Policy on Senior Citizens 2011

National Policy on Senior Citizens 2011\textsuperscript{38}: the large increase in human life expectancy over the years has resulted not only in a very substantial increase in the number of older persons but in a major shift in the age groups of 80 and above. The demographic profile depicts that in the years 2000-2050, the overall population

\textsuperscript{38} National Health Policy for Senior Citizens, 2011.
in India will grow by 55% whereas population of people in their 60 years and above will increase by 326% and those in the age group of 80+ by 700% - the fastest growing group (see table and graph).

<table>
<thead>
<tr>
<th>Years</th>
<th>Total Population (millions)</th>
<th>60+ (millions)</th>
<th>80+ (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>1008</td>
<td>76</td>
<td>6</td>
</tr>
<tr>
<td>2050</td>
<td>1572</td>
<td>324</td>
<td>48</td>
</tr>
</tbody>
</table>

Problems in any of these areas have an impact on the quality of life in old age and healthcare when it is needed. Increase in life span also results in chronic functional disabilities creating a need for assistance required by the Oldest Old to manage simple chores. This policy looks at the increasing longevity of people and lack of care giving.

**Elderly Women Need Special Attention**

Women and men age differently. Both have their concerns. The problems of elderly women are exacerbated by a lifetime of gender based discrimination, often stemming from deep-rooted
cultural and social bias. It is compounded by other forms of discrimination based on class, caste, disability, illiteracy, unemployment and marital status. Patriarchal hierarchy and access to property rights are also discriminatory. Burdened with household chores for a longer span of time compared to older men, older women don’t have time for leisure or recreational activity. Women experience proportionately higher rates of chronic illness and disability in later life than men. Women suffer greater non-communicable diseases and experience lower social and mental health status, especially if they are single and/or widowed. Over 50% of women over age 80 are widows.

Elderly women and their problems need special attention as their numbers are likely to increase in the future and, given the multiple disadvantages they face in life, they are likely to be grossly unprepared to tackle these issues.

**Rural Poor Need Special Attention**

Many households in rural areas at the bottom of the income distribution in India are too poor to save for their old age. Available resources are used to meet daily consumption needs. Even at slightly higher income levels there is likely to be little demand for savings and pension instruments that require a commitment of several decades. Instead, the savings of households in the lower deciles of the income distribution are likely to be earmarked for self-insurance against emergencies; or perhaps, in short term investments that increase their own productivity or the productivity of their children. Liquidity is highly valued. The absolute poor in India cannot be expected to participate in long term savings schemes for old age and they do not. The poverty in rural areas for older persons is increasing and needs attention. Hence rural poor would need social security in large measure.
Increasing Advancement in Technology

There have been several advancements in medical technology, medicine and in technology for assistive living (and technology) for elderly that have prolonged life for senior citizens and this needs to be factored in the policy that not only for the eighty plus but rural poor, women and disadvantaged seniors will have longer years and will need many of the policy interventions.

Policy Objectives

The foundation of the new policy, known as the “National Policy for Senior Citizens 2011” is based on several factors. These include the demographic explosion among the elderly, the changing economy and social milieu, advancement in medical research, science and technology and high levels of destitution among the elderly rural poor (51 million elderly live below the poverty line). A higher proportion of elderly women than men experience loneliness and are dependent on children. Social deprivations and exclusion, privatization of health services and changing pattern of morbidity affect the elderly. All those of 60 years and above are senior citizens. This policy addresses issues concerning senior citizens living in urban and rural areas, special needs of the „oldest old” and older women.

In principle the policy values an age integrated society. It will endeavour to strengthen integration between generations, facilitate interaction between the old and the young as well as strengthen bonds between different age groups. It believes in the development of a formal and informal social support system, so that the capacity of the family to take care of senior citizens is strengthened and they continue to live in the family. The policy seeks to reach out in particular to the bulk of senior citizens living in rural areas who are
dependent on family bonds and intergenerational understanding and support.

2.4.1 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**

   - Old age pension scheme would cover all senior citizens living below the poverty line.
   - 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.
   - 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**
   - The public distribution system would reach out to cover all senior citizens living below the poverty line.

3. **Income Tax**
   - 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**
   - 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

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

- 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.

- 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.

- 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.

- Public private partnership models will be developed wherever possible to implement healthcare of the elderly.
Services of mobile health clinics would be made available through PHCs or a subsidy would be granted to NGOs who offer such services.

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.

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.

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

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

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.

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.

Protective services would be established and linked to help lines, legal aid and other measures.
IV. Housing National Policy on Senior Citizens 2011

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.

- 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.

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

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

- 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.

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

V. Productive Ageing

- The policy will promote measures to create avenues for continuity in employment and/or post retirement opportunities.
Directorate of Employment would be created to enable seniors find re-employment.

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

VI. Welfare

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.

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.

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 Adhaar scheme on priority.

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

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

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

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

Natural disasters/ emergencies

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

- 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 agency.
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 a National Policy on Senior Citizens 2011.

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 and Family Welfare, Rural Development, Urban Development, Youth Affairs and Sports, Railways, Science & Technology, Statistics and Programme Implementation, Labour, Panchayati Raj and Departments of Elementary Education and Literacy, Secondary & Higher Education, Road Transport and Highways, Public Enterprises, Revenue, Women and Child Development, Information Technology and Personnel and 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.

2.5.0 Gandhian Concept of Family Systems

A mother who does not listen to her daughter’s complaints is no mother, similarly a daughter who feels shy in opening her heart to her mother, thinking that she is too busy to listen to her, is no
true daughter. It is the vital role of all parents that they should train their children for character formation and to serve the country. They should be self-reliant. The aim and motto of the children should be the welfare of all the people. The beauty of the things lies in the fact that by serving the world, one does not cease to serve one's family is included in the service of the world.\textsuperscript{39}

According to Gandhi, “I believe that whatever I have achieved is due to my devotion to my parents who have been given the place of a teacher and of God, who have been thought of as perfect beings, so that to their offspring they are perfect.”\textsuperscript{40}

All parents should give, according to Gandhi, the prime importance to develop the character formation of their children. They should not give costly ornaments, clothes, and palatal food and give money only for their needs. The family is the center of human preparation for the social life, that is to say, all preparation for responsibility, sympathy, self-control and mutual tolerance.

\textbf{2.6.0 Scriptural Teachings Related to Old Age}

Show respect for old people and honour them reverently obey me, I am the Lord.\textsuperscript{41} Old men have wisdom and old men have insight. green and strong.\textsuperscript{42}

Long life is the reward of righteous: gray hair is a glorious crown.\textsuperscript{43} Respect your father and your mother so that you may live a long time on the land that I am giving you.\textsuperscript{44} He was then almost

\textsuperscript{40} op.cit.pp.373-374
\textsuperscript{41} Leviticus 19/32
\textsuperscript{42} Psalm 92/14
\textsuperscript{43} Proverb 16/31
\textsuperscript{44} Exodus 20/12
one hundred years old: but his faith did not weaken.\textsuperscript{45} Is there any one who is ill? He should send to the church elders, who will pray for him and rub olive oil on him in the name of the Lord. Gray hair is a crown of splendor; it is attained by a righteous life.\textsuperscript{46} if a man curses his father or mother, his lamp will be snuffed out in pitch darkness.\textsuperscript{47} The glory of young men is their strength, gray hair the splendor of the old.\textsuperscript{48} Listen to your father, who gave you life, and do not despise your mother when she is old.\textsuperscript{49}

\textbf{2.7.0 Chavara Kuriakose Elias Message to Families}

Kuriakose Elias (founder of CMI, CMC and CTC) wrote his famous book, \textit{oru nalla appante chavarul}, to the families of Kainakari village. According to him a good family resembles the heavenly abode. All the members in the family, who are either related by birth or bonded in nuptial relations, shall regard the elders in high esteem and live together in unity and solidarity. Every person shall maintain the highest dignity and self-realization in all his words and deeds. It is the sacred duty of the children to respect their parents diligently. They shall be taken care of as a treasure in their old age and sickness. Such children are eligible for the grace of God.\textsuperscript{50}

All the members in a family shall have a deep-rooted love for one another. This underlying love can bring in peace and friendship in the family which, in turn, enables them to face the trials and tribulations with utmost calm and, thereby overcome all the tragedies in life. Your children are divine instruments; they shall be

\begin{itemize}
\item \textsuperscript{45} Jacob 5/4
\item \textsuperscript{46} Proverb 16/31
\item \textsuperscript{47} Proverb 20/20
\item \textsuperscript{48} Proverb 20/29
\item \textsuperscript{49} Proverb 23/22
\end{itemize}
brought up in the best way possible, and you shall extend to them all kinds of protection.\textsuperscript{51}

\textbf{2.8.0 Subjective Well-Being of the Care-Givers of the Victims of Dementia}

In a study by (Nygaard, 1988) 46 patients with senile dementia and their primary care-givers were studied. Eighty-five percent of the care-givers felt despair and anger and 75\% complained of chronic fatigue. There was significant correlation between care-givers’ strain on one hand and the duration of symptoms, degree of dementia and deviation of behaviour on the other hand.\textsuperscript{52} (Morris, et al.1988) found that care-givers who experienced lower levels of marital intimacy, both currently and before the onset of dementia, were found to have higher levels of perceived strain and depression.\textsuperscript{53} (Brown, et al.1995) found that caregivers predominantly used problem-focused strategies. Further analysis demonstrated that employing more positive coping strategies did not necessarily result in a reduced sense of burden.\textsuperscript{54}

Care-giver’s commitment or lack of commitment constituted a superior level that determined whether the patient was seen as a subject or as an object. Subcategories that were found were knowledge of the patient’s disease and personal history, intuition, identification, empathy, generalization and reutilization. (Athlin,\textsuperscript{55} et al.1990). (Hooker, et al.1992) reported that neuroticism and

\begin{itemize}
\item \textsuperscript{54} Brown, P.J. et al. (1995) Copying Strategies of Care-givers of Family members with dementia, Journal of Mental Health Nurses.
\item \textsuperscript{55} Athlin, E. et al. (1990) Members Caring for an Elderly Person with Dementia, Journal of clinical Epidemiology, 45:61-70.
\end{itemize}
optimism were significantly related to mental and physical health.\textsuperscript{56} (Carcoran, 1992) reports that husbands and wives have different approaches to care-giving; each approach has consequences. Male care-givers adopt a task-oriented approach to their duties and carry out their activities in a linear fashion; female care-givers use a parent-child approach and nest activities inside one another in a constant stream of work.\textsuperscript{57} Family members of demented elderly people have narrated their feelings toward their care recipient as mothering, grieving, feeling guilty, distancing and objectifying. When the family members expressed mothering thoughts, there were no expressions of guilt; objectifying or distancing and prior relationship was narrated as good.

\textit{\textsuperscript{58} \textbf{(Norberg, et al.1993)}} Face to face interviews with 50 older women caring at home for a husband with dementia revealed that gratification was associated with greater well being and frustration with more distress. Wives who perceived continuity in marital closeness since the illness had greater gratification than those who perceived change. Frustrations in disrupting life plans are apparently greatest at the onset of symptoms and as routines are developed, diminish despite the need to provide more care.\textsuperscript{58} (Gilhooly et al.1988), in his study, expressed emotion care-givers of the demented elderly revealed significant correlations between expressed emotion and care-givers psychological well-being, contact with friends and the quality of the relationship between the care-givers and demented relative.\textsuperscript{59} (Leiberman, et al. 1995) found

\textsuperscript{56} Hooker, K. et al. (1992) Mental and Physical Health of Spouse Care-givers: the role of Personality, Psychology of Ageing, 7: 367-375.
that severity was significantly associated with health and well-being for spouses, offspring and in-laws, regardless of the amount of caregiving, demonstrating the potential cascading effect of the illness through the family. \(^{60}\)

(Majerovitz, S.D. 1995) found that greater memory and behaviour and depression. For care-givers who were lower in adaptability, longer hours of care were related to greater depression. For care-giver higher in adaptability, hours of care were unrelated to depression. \(^{61}\)

(Asada, 1991) pointed out that social activity, individual free time and familial interaction, as well as many emotional and physical aspects were more severely affected in the subject carers. Many of carers reported recurrent falls by the patients. \(^{62}\) (Parmelee, 1983) studied two care groups who did not differ in self-rated depression or in feelings of dependency upon care providers. \(^{63}\)

### 2.8.1 Cognitive and Behavioral Interventions

(Kahan, et al.1985) examined the effect of 8-session group intervention based on cognitive and behavioral approach to provide information about dementia care and improve problem solving skills. Experimental group consisted of 22 and control group 18 care-givers of demented elderly. Using outcome measure as burden and depression, they found that there was a decrease in family

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burden and depression in experimental group while the control
group revealed increased burden and depression.\textsuperscript{64}

(Haley, et al. 1987) conducted 10 session of support group
including skills training and problem solving methods and found no
difference between experimental and control group on outcome
measures (Beck Depression Inventory, Negative Family Impact,
Health and Daily living form), but the care-givers reported support
groups as helpful.\textsuperscript{65}

(George, et al. 1988) did a cross-sectional comparison of
support group attendees and non-attendees. Sample consisted of
510 care-givers providing home or institutional care. Results
revealed that support group participants had higher knowledge of
disease and community services, higher use of counseling and part
time paid help and lower loneliness scores.\textsuperscript{66}

(Farran, et al.1994) divided 139 care-givers in 3 groups: 62 in
educational support; 19-Alzheimers Association support group and
58 did not receive any treatment. Outcome measured coping styles,
burden, care-givers concerns and symptom profile in caregiver.
Results revealed that the distress increased in educational support
group after intervention; high participant satisfaction with groups;
support group members reported higher distress and life impact

\textsuperscript{64} Kahan, J. Kemp, B. et al. (1985) Decreasing the burden in families caring
for a relative with a dementing illness: A controlled study. Journal of
American Geriatric Society, 33, 664-670.

\textsuperscript{65} Haley, W. E. Levine, E. G. Brown, S. L. Berry, J. W. and Hughes, G. H.
(1987). Psychological, social and health consequences of caring for a
relatives with senile dementia, Journal of American Geriatrics society,
35: 405-411, Population-based study, Scandinavian Journal of Social
Medicine, 21 : 247 – 255.

multidimensional examination of family care-givers of demented adults,
Gerontologist, 26: 253-259.
and lower anxiety. Control group had lowest distress and lower care-giving satisfaction.\(^{67}\)

(Herbert, et al. 1995) in randomized controlled trial conducted structured program of 8 weekly sessions of 3 hour each, which focused on providing information on dementia, role playing and relaxation training. Total of 45 patient-care-giver pairs participated in the study with 24 in the experimental group and 21 in control. Control group referred to informal meetings of Alzheimer’s society for care-givers of dementia. Results through 24 months survival analysis showed no significant difference in institutionalization.\(^{68}\)

(Bass, et al.1998) in a randomized control trial over 12 months provided computer link based support to 102 primary care-givers of Alzheimer’s disease patients. The program included 24 hours access to communication network, encyclopedia of AD, and monthly phone call on service use. The control group received 90-minute placebo training session on identifying local services and resources. The participants were assessed at baseline (T1) and 1 year (T2) to see effect on emotional, physical and relationship strain. Results showed that participation in the intervention did not alter the relationship between T1 and T2 care-giver strain. Computer link access led to significantly greater reduction in emotional strain for care-givers with more informal support.\(^{69}\)

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(Hosaka, et al. 1999) conducted group intervention on 20 family care-givers, having series of 5 weekly sessions using educational approach, psychological support, and ventilation. Pre-post measures were Profile of Mood States (POMS) and General Health Questionnaire (GHQ-30). Results indicated significant improvement in depression, anxiety, fatigue, confusion in POMS and physical symptoms-anxiety, sociality-depression on GHQ-30.70

(Hepburn, et al. 2001) tested role-training intervention as a way to help family caregivers appreciate and assume a more clinical belief about care-giving. The group training programs were conducted for 2 hours for the period of 7 weeks. Standard measures were used for depression, burden and reaction to the care receiver behaviour. Total of 94 care-givers participated in the study and they reported that group participation was helpful. There was significant change in their reaction to the behaviour of the patient, decrease in depression and burden.71

These studies provide evidence to support the potential of family group intervention in improving the psychological well-being and the knowledge about dementia care among their care-givers. However, the efficacy of these researches has been limited. Despite this, care-givers value their participation in these groups and indicate high levels of satisfaction with them. These approaches have been wide ranging, and have focused on teaching specific behavioural skills to the care-giver along with problem solving, relaxation training, self improvement and combination of these techniques.

(Lovett, et al. 1988) in their psycho educational program included problem solving skills and techniques for improving self-efficacy. 107 care-givers participated in the study and were randomly divided in experimental and control group. 10 sessions were conducted, once a week and the results showed that there was decrease in depression and increase in morale overtime. However, perceived stress remained unchanged. Control group did not reveal any changes.72

(Brodaty, et al.1989) examined the effectiveness of training programme to reduce stress in care-givers of patients with dementia. Eligible patients were less than 80 years old, had mild to moderate dementia, and lived at home with their care-giver. Of the 96 patient-care-giver pairs in the study, 33 were in the dementia care-givers programme group who received training in coping with the difficulties in looking after the patients with dementia and memory training. 31 were in the memory-training group who also received 10 days of respite and 32 were in the waitlist group who waited for 6 months before undertaking the care-givers programme. At 12 months follow-up the care-givers programme had resulted in significantly lower psychological stress among the care-givers than memory retraining group. In the waitlist group the distress scores remained stable even after the care-givers and patients had undertaken care-givers programme.73

(Chiverton et al. 1989) conducted three 2-hour group discussions taking equal number of subjects (20) in experimental and control group. After four weeks, post assessment was done and

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it revealed that the care-givers in experimental group found the program beneficial to feelings of competence related to disease and to function with greater independence.\(^6\)\(^7\) (Mittleman, et al. 1994) examined the effect of family education and counseling session followed by weekly support group in reducing burden of care-givers of dementia patients. Care-givers in the treatment group showed increased satisfaction with the social network and no effect on burden, mental or physical health was seen in early stages but was evident at the end of 12 months. Control group placed patients 2 times more in nursing homes.\(^7\)\(^4\)

(Teri, et al.1997) in their randomized controlled trial designed 60 minute weekly sessions for 9 weeks. 72 care-giver-patient pairs participated in a program they were divided into 3 groups: first group provided pleasant events schedule used by the care-giver to generate and plan pleasant activities for the patient (BT-PE). The second group was taught problem solving strategies (BT-PS). The third group was given typical advice and support through community services (TCC). The stress was on care-giver depression (P<0.01). BT-PE & BT-PS care-givers depression improved more significantly than the other group on Hamilton Depression Rating Scale (HDRS). This improvement maintained at six months.\(^7\)\(^5\)

(McCurry, et al. 1998) in a randomized controlled trial provided active treatment in two phases to the care-givers of patients with dementia-six weeks (Phase 1) and four weeks (Phase 2). Phase 1 comprised of 7 patient-care-giver pairs who were provided 6 weekly small group sessions focusing on sleep hygiene, stimulus control,

\(^{64}\) Mittelman, M. S. Ferris, S. Shulman, E. et al. (1994) Efficacy of multi component individualized treatment to improve the well-being of Alzheimer's disease care-givers, New York

relaxation, community resource information and behavioural techniques. Phase 2 included 14 patient-care-giver pairs who received the same as in phase 1 but condensed into four weeks individual sessions. Wait list control consisted of 10 patient-care-giver pairs. Outcomes measures were care-giver sleep, caregiver mood, reactions to behavioural problems of the patients and sleep diary. Results indicated that overall sleep quality was significantly better for care-givers in the active conditions at post treatment and follow-up than for control care-givers. There were no significant differences in care-giver mood, burden or patient behaviours at post treatment and follow up but there was tendency for depression scores to decline at post treatment in both conditions. 60% of the care-givers were judged to have demonstrated clinically significant improvements.76

(Zannetti, et al.1998) in a non-randomized controlled trial, conducted six weekly 1-hour behavioural management technique and group discussion. Control group did not receive any specific intervention, outcome measures were care-givers depression, perceived stress, knowledge of disease and functioning of the patient. They found that care-givers in the experimental group showed an increase in disease knowledge from baseline to post, while control showed none. After 3 months experimental caregivers showed a significant decline in perceived stress relating to patient’s disturbances, even though the behavioural disturbances of the patient did not change significantly. There was no reduction in emotional symptoms such as depression or anxiety.77

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(Ostwald, et al. 1999) tested the effect of interdisciplinary psycho educational family group intervention in decreasing caregivers' perceptions of the frequency and severity of behavioural problems in demented elderly and their reactions to their problems and decreasing care-giver burden and depression. They conducted 7 weekly, 2-hour multimedia training sessions including education, family support and skills training. Repeated measures ANOVA was used to test the significance differences between the experimental and control group. Intervention group showed decreased burden and depression over time and diminished negative reactions to disruptive behaviour of the patients.  

(Haupt, et al. 2000) examined the effect of psycho educative group intervention on the behavioural and psychological symptoms of the dementia patients in a 3-month, expert-based and conceptualized group intervention with care-giving relatives of dementia patients. The 3-month group intervention yielded a significant improvement in agitation and anxiety of the dementia patients.

(Marriott, et al. 2000) studied the effectiveness of cognitive behavioural family intervention in reducing the burden of care in care-givers of patients with Alzheimer's disease. The intervention included care-giver education, stress management and coping skills training spread over 14 sessions with 2 weekly intervals between each session. Experimental group received family intervention and was compared with two control groups. There were significant

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reductions in distress and depression in intervention group at post treatment and follow up. Positive outcomes of studies using cognitive and behavioural approaches have been reported in most of the studies which include increased social support, decreased depression, decreased burden and increased knowledge about dementia care. Research indicates that combination of behavioural and cognitive components in the therapeutic program is effective in reducing the behavioural problems of patients and decreasing the burden of care-givers.\textsuperscript{80}

Studies have also examined the effectiveness of combinations of different types of interventions for care-givers of patients with dementia. It includes cognitive and behavioural approaches, psycho education, support, and community and respite care services. The above therapeutic approaches have been tried out in different combinations.

(Mohide, et al.1990) investigated the effect of randomized controlled trial of family care-giver support in the home management of dementia patients. Total sample was 60 care-givers (30 in experimental and 30 in control group). Patients were having moderate to severe dementia. The experimental group received education about dementia, assistance in problem solving, care-giver focused health care, 4 hour block of weekly and on demand in-home respite and 2 monthly support group. Control group received conventional nursing care for the patient. Outcome measures were depression, anxiety, quality of life ‘and life satisfaction of the care-givers. Assessment was done at baseline, 3 months, 6 months and follow-up at 12-18 months to assess service needs. Results revealed

clinically significant improvement in quality of life of care-givers in the experimental group by 20%.\(^1\)

(Hinchliffe, et al. 1995) examined the effect of multimodal intervention on care-giver psychological distress and behavioural problems of the patient with dementia. 40 patient-care-giver pairs participated in a program (experimental=22, control=18). Individualized plan was generated by multidisciplinary team derived to reduce most distressing problem behaviours in patient (medication, psychological techniques and social measures). Group 1 - received immediate intervention and Group 2 - received delayed intervention. Assessment was done at baseline 16±2 weeks (phase 1), 38 weeks (phase 2). Blind raters were used. Results showed statistically and clinically significant reduction in care-giver General Health Questionnaire (GHQ) score for the immediate intervention group. Behaviour problem of the patients improved in Group 1 compared to Group 2 at phase 1, which was maintained at phase 2.\(^2\)

(Mittelman, et al. 1996) provided family intervention to delay nursing home placement of patients with Alzheimer’s disease. In the randomized controlled trial of four months of individual and family counseling, support ongoing, total of 206 patient-care-giver pairs participated. Control group did not receive any active intervention or counseling. It was found that the patients in the treatment group remained at home significantly longer than those in control groups,


using the same Module.\textsuperscript{83} (Mittleman, et al. 1993) found that within one year of intake, the treatment group had less than half as many nursing home placements as the control group.\textsuperscript{84}

Studies reveal the greater effectiveness of a combination of different types of interventions for care-givers. Care-giver interventions have the capacity to improve care-giver's psychological well-being and delay admission in nursing homes and can reduce behavioural problems of patients with dementia. Interventions with dementia patients and their care-givers in India are now at its initial phase. The investigator did not come across any published study on intervention with this population in India. The studies have focused more on the behavioural problems of the patients with dementia and the psychiatric morbidity in Care-givers, which suggest that care-givers experience significant distress, care-giving burden and their quality of life is poor (Sunanda, 2000).\textsuperscript{85} In a study on behavioural problems of dementia patients and care-givers stress, (Srinivas, 2002) found significant correlation between the severity of the disease and care-givers stress. Two third of the care-givers had GHQ scores indicating psychological problems, which they were unable to cope with.\textsuperscript{86}

2.8.2 Need of Social Support to the Dementia Patients and Care-Givers.

Investigating the experiences of care-givers in looking after chronically ill and impaired elderly persons, one topic of increasing


interest has been the effect of social support on care-giver’s well being. While there is a consensus that social support is important, little attention has been paid to the factors that affect the provision of support. The available literature on social support and social networks provides inconsistent findings regarding the relative importance of various sources of support.

(Suitors, et al.1993) Community surveys have established that the great majority of dementing elderly people are cared for at home. This is to say that the burden of caring for such patients falls specifically on those relatives and friends who are generous enough to support them. There is reason to believe that these supporters of the demented elderly are themselves under considerable strain and have to be treated as hidden patients.87 (Fengler, et al. 1979). (Bergmann, et al.1979) found that family support was more important than other indicators in achieving home care of the demented patient.88 (Zarit, 1980) found that the lowest burden ratings were reported from families receiving most frequent visits from others.89

(Cohen, 1983) identified one of the greatest burdens of the care-givers to be lack of free time; other investigators have identified the sense of guilt felt by the closer relations in handing over the burden of care to someone else.90

(Pratt, C.1985) found that burden in Alzheimer’s care-givers was reduced by coping strategies of problem solving, through support from the family and the church.91 (Scott, et al. 1986) found socio-emotional support from the family members was positively associated with more effective coping styles in care-givers. The instrumental and social emotional support provided by the families to the primary care-givers of Alzheimer’s patients were examined. Ratings of instrumental assistance, social emotional support, adequacy of support and coping effectiveness were made on 23 primary care-givers. Also a second family member, who was closest to the kin of the care-giver was interviewed with a view to elicit another perspective of the support, the family provided.92

The majority of the care-givers felt a high degree of support from their families and reported low levels of emotional stress and strain in consequence. The most common family problems reported were lack of visits, disagreement over the level of patient’s mental and physical condition and lack of consensus over the type of care required. Overall, the data indicated that family support is an effective resource that improves a person’s capacity to meet stressful events.

(Engles, 1587) found that care-givers who are suffering from high stress levels tend to receive more support from services. Informal supports from family and friends have been shown to reduce levels of stress and depression.93

(Morris, et al. 1987) found that care-givers expressed less satisfaction with their social networks than did controls but the groups did not differ in objective size of social network or number of network contacts. However, they do express more dissatisfaction with the adequacy of their support network. The importance of social supports in the care-giving role has been documented by (Aronson, et al.1984) and Cantor (1983). This relationship has been further clarified by Fiore, et al. (1983) who separated perceived network support from upset in Alzheimer’s care-givers with the latter found to be a stronger predictor of depression. In a study by (Quayhagen, et al.1988) 58 care-givers of dementia were interviewed. They found that the most commonly identified source of emotional support across groups was a blood relative (87%), followed by support group (43%). Information support was primarily from books and magazines (51%) and secondarily from health professionals (31%).

In a study made by (Pruncho and Resch,1989) based on traditional gender role theory, women were found more capable than men in exhibiting skill and confidence in helping the spouses in trouble. Social support was more effective than drugs and antidepressants in retrieving a demented person from the clusters of dementia. This was true in the case of care-givers too. More than half the number of care-givers felt they needed greater support in caring for the patients than they were currently receiving room family and

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friends. These findings have been reported by (Clipp and George, 1990) in their study of care-givers in order to determine the correlate on between psychotropic drug use and family support.

(Suitor, 1993) in their study in which they interviewed 95 care-givers found the relative importance of friends and siblings as sources of support and means of reducing stress. Siblings provided about the same amount of support as did friends. While siblings were a greater source of instrumental support than friends, they played a far less important role than friends in providing emotional support. In fact, friends were clearly the greatest source of emotional support for these care-givers. Persons who care for family member with dementia experience high levels of psychological distress and clinical depression. (Brodatay, 1996).

(Clipp and George, 1993) found that facilities for social life and recreational participation revealed a similar negative scenario for dementia care-givers in comparison with cancer spouses. Overall satisfaction with social activities was significantly lower for the dementia care-givers, who also reported feeling more alone and in need of more help from friends and family than did cancer care-givers. This apparent need for outside contact also was reflected in support group membership. Over half of dementia care-givers were support group members compared with 4% of the cancer group. Finally, two indicators of financial resources revealed that in comparison with cancer care-givers, dementia care-givers reported

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significantly lower incomes and perceived themselves as less economically secure.\textsuperscript{101}

(Hannapel, et al.1993) studied 93 family care-givers. Contrary to most other findings the care-givers who received more support were found more depressed.\textsuperscript{102} In a survey of those involved in the care of the frail elderly, (Temstedt, 1983) found that 60\% of secondary care-givers were women and that the proportion of men who were secondary care-givers were greater than those who were primary care-givers. Often several secondary care-givers provide assistance by performing a wide range of activities including washing and shopping. All these studies indicate that social support availability decreases the burden felt by the family care-givers. Care-giving should not be solely and individual duty, but a group work. Even these studies have primarily focused on the individual care-givers support system and its effect on stress, burden and other impact on health.\textsuperscript{103}

2.8.3 Family Burden on the Care-givers of Dementia

(Orford, et al.1987) made a study on the expressed emotion and perceived family interaction in the key relatives of elderly patients with dementia and reported the protective behaviors, hostile- dominance with little loving care.\textsuperscript{104}

(Orford, et al.1987) reports that the level of patient’s depression is significantly correlated with the extent of care-givers

\begin{thebibliography}{99}
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depression and burden. The study reveals that care-givers of chronically ill, elderly men cope better with physical and cognitive incapacity than with affective symptoms, because the care-givers support is the most important factor in safeguarding the well being of disabled elder in the community.105

(King, 1995) explored the barriers in using home health aide services as perceived by family care-givers of relatives with dementia. The major findings included the high cost of the resources, often recurring and prolonged made them beyond the reach of the common man. Care-givers in many cases indicated that the price paid for services outweighed benefits.106

Another serious problem experienced by most of the care-givers is that owing to the weakening of the patient’s memory, all sorts of accusations are heaped on the care-givers, which cause a drift in the relationship between patient and the care-giver.

(Shyu, et al.1996) reported that incontinence was identified by 36% of 184 care-givers as a problem in their care of older community dwelling patients with dementia. Such dementia patients had greater impairment of cognitive function and more frequent behavioural problems than those who live a sober, disciplined life. Burden scores were higher among care-givers of incontinent patients;107 (Robinson, 1990) studied predictors of burden among wife care-givers. He reported that past marital adjustment was a significant predictor of subjective burden. Socio-

economic status and attitude toward asking for help were the significant predictors of objective burden.\textsuperscript{108}

(Macmillan, 1960) pointed out that the emotional relationship between an elderly patient and the relative, responsible for him determines whether family care will be a blessing or a curse. As to the problems faced by those following some careers, an appreciable number had been forced to give up their jobs to devote them to patient care. In general, female care-givers with husbands younger than 65 years reported economic distress.\textsuperscript{109}

The adverse impacts of dementia on the patient’s family’s economy, relationship among family members and social life are well recognized. The majority of people have only a vague understanding of dementia. Medical insurance may helps the family in caring for the demented patients, financially but it cannot meet the emotional and social needs of the patient and the care-giver (Liu, et al.1991). The association between care-giving and the health variables was found to be stronger when the patient is the spouse than when it was the child. Greater behavioural disturbance in the demented patient was associated with higher levels of morbidity in the care-givers.\textsuperscript{110}

(Baumgarten, et al.1992) Twenty-six family members in the case-group reported abusive behaviour in the care of the elderly at home. These family members were compared with 154 family members in the control group, applying other coping strategies than abusive. In the abusive group most of the elderly were in a mild


\textsuperscript{110} Liu, H.C. et al. (1991) “Impact of demented patient on their family members and care-givers in Taiwan”. Neuro epidemiology, 10: 143-149.
stage of dementia, and the family members expressed greater strain in the caring situation. The family members were older, judged their health as deteriorated, and were mostly living together with the dependent elderly.111

(Graftstrom, et al.1993) A higher level of behavioural disturbance in the patients with dementia were indicators of the worsening of the care-givers depression and physical symptoms during the study period. The magnitude and direction of changes in the care-givers health varied considerably.112  (Baumgarten, et al. 1994 and Hinrichsen, et al. 1994) reports that dementia management strategies accounted for a significant variance in the family members’ burden, which most often induced them to institutionalize the patient.113

(Suwa-Kobayashi, et al. 1995) reported that the difficulties faced by care-givers could be divided into five categories: incomprehensible situations, strange behaviour, deterioration of dementia, trouble or inconvenience caused by demented behaviour, remarks and support network.114

Looking back, there is a need to study the specific deficits in the profile of subjective well-being of the care-givers of the demented. Most studies have taken into account only the impact of burden on care-givers. It would be interesting to study the specific


care-givers’ deficits and the quality of life and the relationship between the subjective well-being of and the burden on care-givers. It is for this reason that the researcher felt it necessary to explore the area of subjective well-being and the factors co-related to it.

2.8.4 Psycho-Social Problems of Family Care-Givers

(Coombs, 2007) conducted a study on “Spousal care-giving for stroke survivors’. Van Mane’s approach was used for examining the spousal care-givers. Data were collected through audiotapes from semi structured interviews. Six inter-related themes emerged from data analysis: experiencing a profound sense of loss. Feeling the demands of care-giving, adjusting to a relationship with a spouse, the reluctance to take up new responsibilities, feeling belittled in having to depend on the support of others and the struggle for maintaining hope and optimism. Eight spouses who met the inclusion criteria participated in the study.115

(Larson, et al. 2007) conducted a study on ‘The impact of gender on the psychological well-being and general life situation among spouses of stroke patients during the first year after the patient’s stroke event’. This study was conducted with three assessments regarding the psychological well-being and the general life situation. 20 female and 20 male spouses of stroke patients, admitted to a stroke unit, participated in the project study. The findings: there are gender differences among spousal care-givers of stroke patients and females are more adversely affected in the unwelcoming development.116

(Blake, et al. 2006), conducted a research on care-giver strain in spouses of stroke patients”. The study was conducted on 400

care-givers of whom 276 had an identifiable co-residence spouse. The result was that the carers at risk of later strain could be identified for further follow up. Services to provide emotional support to carers could affect considerable in the reduction of caring strain.\textsuperscript{117}

(Thommessen, et al. 2002) conducted a study on ‘Psychosocial burden on spouses of the elderly with Stroke. Dementia X-Parkinson’s disease’. They studied 36 couples who were victims of stroke. They concluded that spouses caring for patients with stroke experience a similar type and level of psychosocial burden, independent of the disease.\textsuperscript{118}

(Forsberg, 2002) conducted a study on care giving strain and care giving burden of primary care-givers of stroke survivors with and without aphasia. They examined the relationship between stroke and care-giver burden and strain. The results spotted that there is a lack of research in this area and pointed to need for determined initiatives, including the development of an instrument with psychometric properties, capable of assessing the burden, and strain on the care-givers of stroke patients.\textsuperscript{119}

(Smith, 2005) conducted a Randomized trial to evaluate the education programme for patients and carers after stroke. The study was conducted on 170 patients admitted to a stroke rehabilitation unit and the care-givers of the patients. They found that the education programme did not result in improved knowledge about stroke and stroke service but there was a significant


reduction in patient anxiety and carer anxiety at six months post stroke onset.\textsuperscript{120}

(Bethoux, et al.2004) Conducted a study on the ‘Quality of life of the spouses of stroke patients’. They assessed stroke patients and their spouses using Barthel index. A 10cm visual analogue scale was used to evaluate the spouse’s quality of living. This study confirms the constant impact of stroke on the quality of living of spouses resulting from the patient’s physical disability.\textsuperscript{121}

(Lincoln, et al. 2004) conducted a study on the ‘Evaluation of a stroke and family support, organizing a randomized controlled trial’. They noted that care-givers in the intervention group were significantly more knowledgeable about whom to contact for information on stroke, reducing the risk of stroke and the need for community services and emotional support. Care-givers were more satisfied with stroke information.\textsuperscript{122}

(Jo S, et al. 2003) conducted a study titled ‘Care-giving at the end of life: perspectives from spousal care-givers and care recipients’. Spousal care-givers identified many negative reactions to care-giving such as fatigue or weariness, depression, anger, sadness, financial difficulties and lack of time. Additional positive results of care-giving, reported by spouses included strengthened relationship with their spouses and enhancement of emotional strength and physical abilities in managing care.\textsuperscript{123}

\textsuperscript{120} Smith, et al. (1986). The Older Patient Introduction to Geriatric Nursing, (14\textsuperscript{th} ed).U.S.A., Hodder Stoughton Company


(Mant, 2003) conducted a study on ‘Family support for stroke: a randomized control trial in the department of primary care and general practice, University of Birmingham’ which revealed family support significantly increased social activities and improved the quality of life of careers, without any adverse effects on patients.124

(Van den Heuvel, et al.2002) Conducted a research on the “Short term effects of a group support program and individual support for care-givers of stroke patients’. The research was conducted on 2/4 primary care-givers in order to examine the impact of care-giving stressors. Their conclusion was that higher levels of both objective and subjective stressors were associated with all three dimensions of care-giver health, power self reported health more, negative health behaviors are greater.125

(Bugge, C.1999) ‘Conducted a study on Stroke patient’s informal care-givers, patient, care-giver and the service factor that affect care-giver strain’. Some of care-givers were experiencing considerable strain. The amount of time a care-giver spent on helping a stroke patient, the amount of time the care-giver spent with the patient and the care-givers health were associated with the level of strain experience.126

(Larson, et al.2004), conducted a study on ‘the impact of a nurse led support and education programme for the spouses of stroke patients’ it was a randomized controlled trial. 100 spouses were randomly assigned to intervention. The result was that no

significant differences found between intervention and control groups over time.\footnote{127}

**Conclusion**

The investigator thoroughly went through some of the previous studies related to the topic under investigation with a view to get an insight into the theoretical background of the subject of study and to gather ideas. The knowledge secured from such reading helped the investigator to define the exact problem and select suitable methodology and make correct interpretations of the findings. Looking back, the need to study the specific deficits in the profile of subjective well-being of the care-givers of the demented has been detected. Most studies have taken into account only the impact of burden on care-givers. It would be interesting to study the ageing process, specific care-givers’ deficits and the quality of life and the relationship between the subjective well-being of and the burden on family care-givers. It is for this reason that the researcher felt it necessary to explore the area of their subjective well-being and the factors co-related to it.