Contents

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Articles

005 Aging with Dignity: Financial Planning for Retirees
A. V. Jose

014 Students towards the Old : the Graduated in Groups
Stella Antonio

021 Senior Citizens: as Food Shoppers
Vimal Chandra Verma and Devashish Das Gupta

029 Spiritual Involvement and Beliefs: Mental Health of Widows and Widowers
R.S. Mhaske

035 Nutritional Intake of the Elderly : a Cohort Study
Sithara Balan V. and V. Girija Devi

046 Assessment and Management : Dementia
Lebia Gladis

051 Nightingale Medical Trust : Case Study
Joy Mukhoupadhay and Malavika (Dola) Chatterjee

Overview

The International Conference on Aging Well (ICAW2014) passed off with great éclat. We are pleased to record that the Conference was well accepted by the International academic community. Association of Gerontology of Indian Council of Social Science Research associated themselves with and shared the toil of the organizational initiative for the conference. The message from the UN Secretary General on the World Aging Day had kindled in us the resolution and determination to organize the Conference. There are currently 810 million persons aged 60 or more worldwide. It is estimated that by 2050 the number will be more than double to 2 billion. When the entire world is thinking in terms of sustainable development and long term planning for welfare and development, taking care of the needs and rights of elderly persons becomes essential. Their issues have diverse dimensions - social, political, managerial and those related to welfare and health. The Conference in detail discussed many major issues involved, with special reference to the themes: Social Challenges of Aging and Managerial issues of Aging.

Prof.Sarah Harper, Professor of Gerontology and Director, Oxford Institute of Population Aging, Oxford University inaugurated the Conference.

We feel it a privilege to publish a few papers presented during the Conference as a Supplementary Issue of *SCMS Journal of Indian Management*. I hope the academic community interested in socially relevant questions and issues will receive the Supplement with pleasure.

Dr. Radha Thevannoor

Director, SCMS Group of Institutions and
Convener, ICAW 2014

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Aging with Dignity: Financial Planning for Retirees

A. V. Jose

Abstract

India is holding the first position among all the nations with maximum population in the working age group. This demographic dividend is going to fetch rich returns to the country as an emerging economy. But, this advantage will gradually transform itself to be a challenge with the number of aging people set to increase in the next decades. It is time to think aloud, how to tackle the issues related to aging. In this article, an attempt is made to approach this issue in a different perspective i.e. the role of finance and need for financial planning well in advance of retirement to have a smooth transition to the post-retired life. This article is an attempt to explain how the retired people can convert their accumulated wealth to a perpetual source of income/ cash flows to provide safety, security, peace of mind and wellness. Care has been taken to include a few financial options to suggest a good plan /model for retirement planning. It tries to integrate health care sector, insurance sector and banking sector to provide an umbrella protection taking care of all the requirements of the retirees in a cost effective manner, which can provide a happy retired life. This comprehensive model also includes a special scheme for protection from financial problems that may emanate from the dreadful disease of cancer, if affected. It also throws some light on health insurance for the old, reverse mortgage etc. for making the retired life peaceful.

Keywords: *Reverse mortgage, demographic dividend, financial planning, retirement planning*

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India's demography is changing. At present, India is known worldwide for its demographic advantage on account of the young population. This "demographic dividend" will continue for a few more decades. The 'veterans' group born before 1946 had already retired. The baby boomers born between 1946 and 1964 have started retiring. Retirement and life after retirement will be a big challenge in our country also. It is inferred that one out of every five Indians will be above sixty, by the year 2050. During retirement supply is limited and demand is unlimited. The only solution for this is to adapt to the changes, psychologically, physically and also financially.

During the times of our previous generation, retirement was not much of a problem. There were three reasons for this. First, "l**ife expectancy."** Fifty years ago, when retirement age was 55, the life expectancy was only 60 years. Studies have revealed that

very few people enjoyed pension for more than five years at that time. Most people died before sixty and obviously, spending five years after retirement did not pose any major problem. Today, life expectancy at retirement age of 58/60 is 75 years, which means half of our working life is still left after retirement. The second reason is the change in the "**family structure."** Half a century ago, most people were members of joint families. The day you laid down office, you still had a large family around you. Surely, in a large family you could do something meaningful and make you feel that you were contributing to the family. Today the family has become nuclear—husband, wife and children. By the time one retires, the children might have gone away for employment or settling down in different parts of the globe. This is not particularly easy to accept and adjust to, after retirement. The third reason is the problem of "r**oots."** In olden days, people used to have a "native place" and an "ancestral home" with a big battalion of relatives and friends around. They looked forward to going there and settling down after retirement. People today are often confused as to where to settle down as they have lost their connections with the native place. And also their relatives and friends might have moved to different places for various reasons.

Need for Retirement Planning

The retirees can be grouped into different categories according to their financial position: Fortunate people build up a corpus for retirement. They have a peaceful retired life without any financial worries. They may have done proper investments for health care and related contingencies. Some people do not build up a corpus for retirement due to various reasons and compulsions, and therefore they are not fortunate. Some put up a corpus for retirement during their long service, but spend all the savings and investments for family functions, like marriage of children, without any planning. Some retirees leave all their investments and assets to the children, due to compulsions. The financial position of this group will be quite vulnerable. This group will be desperate on their ill-fate. This despair leads to their physical and mental health. They may be neglected by their own family members. And some retirees who are financially weak due to unplanned spending habits during their earning period. They are financially weak with limited income sources and unlimited financial requirements. Each category of retirees may have different perspectives regarding dependency on their children for their financial requirements during the retired life.

After retirement, generally the retirees are worried about the financial matters than anything else for the following reasons: The ever increasing medical bills during the retirement period will be a big threat for all the categories of retirees, even though some of them have made a provision. Some people nurture the interests of travelling to different places of interest, which they were not able to do when they were in active service, mainly due to busy schedules. They generally prefer to go for the leisure journey or pilgrimage when they are healthy, i.e. immediately after retirement. Some people will be interested in cultivating or developing hobbies and that also may involve the money factor. Some people will be interested in involving in social activities and charity, which also may require money. Mostly all the retirees will be requiring a regular income for funding different activities to make their retired life tension-free and active. If there is a regular cash flow during their retired life, half of the mental worries can be driven away and they will remain healthy with less worries.

Literature Review:

Rapidly changing demographics worldwide towards increased proportion of the elderly in the population and increased life-expectancy have brought the issues, such as "why we grow old," "how we grow old," "how long can we live," "how to maintain health," "how to prevent and treat diseases in old age," "what are the future perspectives for healthy aging and longevity," and so on, in the centre stage of scientific, social, political, and economic arena (**Rattan**, Suresh I.S.2013).

A generation of "tomorrow's pensioners" is plagued by worries about money, with one in four people in their fifties is afraid that he/she will lose his/her home because he/she is falling behind on payments (Charity Age UK, 2013).

Planning for your old age can be difficult if you are young but the sooner you get started the quicker you can retire. We all want to retire early and stop work as soon as we can but, unfortunately, it is hard to do unless you have a lot of money. So what are some strategies for better planning for your retirement? Set financial goals to achieve. Insure yourself against any possible disasters, Look after your health now (cpmcc /planning age 2013).

Aging is not a positive experience for everyone, and yet some people still manage to look at it as a rewarding experience. Those who think the latter are the people who have learned to age with dignity. No matter how you look at it, aging is inevitable – so if it's going to happen to you anyway, why not embrace it (cmpcc/ planning retirement).

The " House " where a retiree has been living for the past so many years is an object of sentiments to the majority of people and this article is focusing this aspect, in the financial planning agenda discussed in detail. Timmerman, Sandra in her article " Financial Gerontology" observes," A very small percentage of

people over age 65 relocate, and remaining in the same home is a popular choice for the vast majority. One might think that staying put is akin to inertia, an easy way to avoid decisions, but in fact the house is centered on our emotional attachment or lack of it. It reflects a lifetime of memories and experiences. Our clients may love the community they live in, have good friends in the neighbourhood, and their children and grandchildren may live nearby. Or they may have plans to remodel or update their houses once their children leave the nest."

Financial Planning for Retirement

For those retirees who believe that the assets they had created out of their hard work should be available for them for funding their retired life also, have an option to approach the Banking System to avail themselves of an innovative loan product, "Reverse Mortgage Loan" which was introduced in India in the year 2007. This concept was originated and soon gained popularity in the West. It is gaining momentum in India also because of the changing family equations and living standards. This article is an attempt to throw some light on the various options available to the retirees to make retirement life peaceful.

Reverse Mortgage

In our country absence of social security measures is one of the reasons for the desperate state of affairs of the senior citizens. They are helpless during their old age as they do not have much savings for their living expenses. The concept of Reverse Mortgage is considered to be an option to the financial needs of " house owning senior citizens." Reverse mortgage is a financial product that seeks to monetize the residential property as an asset and specifically render liquidity to the owners equity in the property. In simple terms, to provide a source of additional income for senior citizens who own self acquired house property in India. The product generically involves the senior citizen borrower(s) mortgaging their residential property to a lender, usually a Banker, who then makes periodic and /or lumpsum payments to the borrower(s) during the latter's lifetime, generally fixed for a particular number of years. The senior citizen borrowers are not required to service the loan during their lifetime and therefore, do not make monthly repayments of principal and interest to the lender. On the borrower's death, the loan is repaid along with the accumulated interest, through sale of the house property. The borrowers and/ or their heirs can also repay or pre-pay the loan with accumulated interest and have the mortgage released without resorting to sale of the property.

Reverse Mortgage is an agreement by which a home owner borrows against the home and receives regular tax- free payments from the lender. It is a source to borrow against one's house to create a regular stream of income while continuing to live in that house. With this scheme, all that is required is to pay property tax and insurance and maintain the house so that its value is retained. Repayment is not required till the owner continues to live in the house and the full amount becomes due only on the death of the surviving spouse, or when the house is sold, whichever is earlier. Reverse Mortgage is so called because instead of paying the monthly installments, the borrower actually receives money from the lender. The details of the scheme is furnished below.

Table 1: Reverse Mortgage-Salient Features

Objective	To provide a source of additional income for senior citizens who own self acquired House property in India		
Eligibility	**a**	No. of borrowers	Single or jointly with spouse
	b	Age of the first borrower	Above 60 years
	c	No. of surviving spouses on the date of sanction of loan	Should not be more than one. Borrowers will have to give an undertaking that they will not remarry during the currency of the loan.
	d	Age of the spouse	Above 58 years
	e	Residence	Borrower should be staying at SELF ACQUIRED and SELF OWNED house/flat against which loan is being raised, as his permanent primary residence.
	f	Title of the Property	Borrowers should have clear and transferable title in their names.

<table>
<tr><td rowspan="4">Eligibility</td><td>g</td><td>Title of the property and number of borrowers</td><td>If the property is in single name and the loan is availed jointly with spouse, the borrower should make a Registered Will in favour of the spouse.</td></tr>
<tr><td>h</td><td>Encumbrances</td><td>The property should be free from any encumbrances.</td></tr>
<tr><td>i</td><td>Residual life of property</td><td>Should be at least 20 years in case of single borrower and 25 years in case of spouse below the age of 60.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Security</td><td colspan="3">The loan will be secured by residential property.</td></tr>
<tr><td>Period</td><td colspan="3">Age of the younger borrower:
Between 58-68 years ----------15 years
Above 68 years----------10 years
OR till death of the borrower(s) whichever is earlier.</td></tr>
<tr><td>Disbursement</td><td colspan="3">Directly to the joint account of the borrowers with E or S clause.</td></tr>
<tr><td>Periodicity of availing loan</td><td colspan="3">1. Monthly/quarterly payment
2. Lump sum payment.</td></tr>
<tr><td>Quantum of loan</td><td colspan="3">The loan amount would be 90% of the value of property. Loan amount would include interest till maturity. The loan installment payable to the borrower(s) would be as under (for a loan amount of Rs.1 lac) (interest calculated at 10.75% p.a.)
<table>
<tr><th>Loan Tenor</th><th>10 yrs</th><th>11yrs</th><th>12yrs</th><th>13yrs</th><th>14yrs</th><th>15yrs</th></tr>
<tr><td>Monthly installments</td><td>468</td><td>399</td><td>343</td><td>297</td><td>258</td><td>225</td></tr>
<tr><td>Quarterly installments</td><td>1423</td><td>1215</td><td>1045</td><td>905</td><td>787</td><td>687</td></tr>
<tr><td>Lump sum payment</td><td>34294</td><td>30813</td><td>27686</td><td>24876</td><td>22351</td><td>20083</td></tr>
</table>
Qualifying loan amount (90% of property value) Rs.9 lacs

Tenor----------15 years
Monthly installment Rs.225 X 9 = Rs.2025
Quarterly installment Rs.687 X 9 = Rs.6183
Quantum of monthly installment/quarterly installment will change whenever there is change in the rate of interest.</td></tr>
<tr><td>Loan amount</td><td colspan="3">Minimum Rs.3 lacs & Maximum Rs 100 lacs</td></tr>
<tr><td>Pre closure of loan</td><td colspan="3">The borrower(s) will have option to repay the loan at any time during the loan tenor. There will be no pre closure penalty.</td></tr>
</table>

A SWOT analysis of Reverse Mortgage Loan (RML) will be beneficial for a better understanding of the scheme:

Strengths:

- Normally a retired person is not eligible for any loan from the banking system as his income is very limited. But Reverse Mortgage loan is given for senior citizens without looking at the income, just to give/ supplement income.
- It is a great relief to the borrower and his spouse that loan servicing is not required during their lifetime.
- If the borrower dies during the period of the loan, the spouse will continue to get the loan for the remaining period of the loan.
- Income tax is not payable on the loan amount even though it is an income flow.
- The borrower and the spouse can live in the house till both die.
- Heirs of the borrower will be entitled to get the surplus of sale value of property. Heirs are not liable for any shortfall in the loan amount when it is settled.
- Borrower /Heirs can at any time prepay the loan and get back the property without any penalty.

Weaknesses:

- Reverse Mortgage is extended usually for a period of 15 to 20 years, depending on the Bank which sanctions the loan. If the borrower or spouse outlives this period, the regular cash flows will stop, leading to an embarrassing situation.
- Basis of property valuation may differ from person to person.
- Requirement of self acquired property without encumbrances to get the loan.

Opportunities:

- It will act as a partial substitute for a social security scheme for senior citizens.
- It Satisfies ever increasing medical expenses at a time of increased longevity.
- There is a strong tendency on the part of the senior citizens to live in their own homes acquired by them. For them this facility will be a blessing.

Threats:

- Property valuations are ambiguous.
- Rate of interest is floating and is reset after every five years which may increase the burden on the loan.
- Bank has the right to foreclose the loan on violation of conditions by the borrower.
- Availing of this loan may lead to disputes in the homes of the borrower and relationship between the parents and the children may be stained.

The main weaknesses of the scheme is the stoppage of cash flows after the tenure of the loan for 15/20 years depending on the terms of sanction by individual banks. This feature may lead to a vulnerable situation where the borrower and the spouse will be left with nothing forthcoming for the uncertain future. The only consolation to the borrower is the permission to live in their own houses till their death. Understanding this peculiar situation, where periodical payment is stopped at a time when more funds are required for the senior citizens during the advanced age, especially for medical / healthcare, National Housing Bank(NHB) in association with insurance companies has come up with another innovative scheme which is better than the Reverse Mortgage already in existence.

Reverse Mortgage Loan enabled Annuity (RMLeA)

With increasing longevity, the segment of senior citizens is growing in the Indian society. While dependency in old age is incremental, the cost of health care facilities is spiraling, there is a felt need for senior citizens to be supplemented with regular cash flow stream for meeting, increased **living expenses till death**.

National Housing Bank (NHB) in association with Star Union Daichi Life Insurance Company Ltd., (SUD Life) and Central Bank of India (CBI), has now conceived an extension of the ***RML value chain*** to ensure life-time annuity payments to the senior citizens, a significant improvement over the existing Reverse Mortgage Loan (RML) product variant which limits the loan disbursement tenure to a fixed term of 15/20 years causing considerable inconvenience to the borrowers.

RMLeA will facilitate the Senior Citizen borrowers to receive assured life-time payments even after completion of the fixed term of 15/20 years, with a better amount of annuity as compared with earlier product variant. Individual borrowers need to approach Primary Lending Institutions (PLI). PLIs will source Life-time Reverse Mortgage Loan enabled Annuity (RMLeA) from a Life Insurance Company on behalf of borrowers. PLIs shall make RMLeA payments directly to borrower on behalf of Life Insurance Company. Married couples will be eligible as joint- borrowers for the scheme. In such cases, age criteria for couple would be at

the discretion of the PLI, subject to at least one of them being above 60 years of age and other not below 55 years. In such cases, the owner of the house property shall be regarded as first borrower and his/her spouse shall be the second borrower. In case of joint-ownership, the joint-owners shall have the options to decide their status as first or second borrower. The residual life of the property should be at least 20 years. The prospective borrowers should use that residential property as permanent primary residence. This new variant is gaining momentum with more tie ups with different insurance companies by various banks. The salient features of the scheme are given below:

Salient features:

- This is a Reverse Mortgage Loan enabled Annuity Product.
- A senior citizen above the age of 60 years, individually or with spouse of 55 years (minimum age) can avail the loan. Blood relatives of above 60 years are also eligible.
- RMLeA is sanctioned against mortgage of self acquired, self occupied and self -owned residential property by eligible borrower. Loan against ancestral property with clear and marketable title can also be considered at the discretion of the Bank.
- Reverse Mortgage Loan limit shall be ranging from 60% to 75% of the value of property depending upon the age.
- Tie-up with Life Insurance companies assures life-time annuity till the demise of the last surviving borrower.
- Option of 25% lumpsum and rest in annuity OR higher annuity on 100 % Reverse Mortgage Loan.
- Option of return of premium i.e. principal loan OR without return of premium but with higher annuity assured product.
- Despite premature adjustment of Reverse Mortgage Loan flow of annuity continues for lifetime.

There are two options for periodic payment, which the borrower has to choose initially. They are.

RMLeA (without return of purchase price): Life-time Annuity payment till demise of the borrower. In case spouse is made a co-borrower, the Annuity can be procured separately in their respective individual names on a proportionate basis that they may decide.

RMLeA (with return of purchase price): Life-time annuity payment till demise of the borrower. After demise of borrower, purchase price (initial net premium amount) will be returned. In case of Joint borrowers under this option, the Annuity shall first be sourced in the name of the primary borrower. On death of the primary borrower, PLI shall use the returned purchase price to re-purchase Annuity in the name of the second borrower at annuity rates applicable for his/her age at time of re-purchase, so that the flow of Annuity continues to the surviving second borrower.

An indicative table showing both options are given below :

Table 2: Indicative monthly payments under RMLeA Scheme

	Indicative RMLeA Payments			
			Net Monthly RMLeA*	
Age	Property Value	LTV	Option-1	Option-2
60-64	10,00,000	60%	3209	2191
65-70	10,00,000	60%	3737	2267
70+	10,00,000	70%	5452	2904

Taxation : All payments under reverse mortgage loan are exempt from income tax under Section 10(43) of the Income-tax Act, 1961. However, periodic annuity payments are subject to tax under Section 17, 56 and 80CCC of the Income Tax Act and taxable in the hands of the annuity recipients (borrowers). But considering the upper exemption limit available to senior citizens it is estimated that in the case of majority of borrowers, the annuity amount per annum will be tax free.

Healthcare Planning for Retirees:

Next most important area which needs attention for the retirees is the availability of medical insurance at affordable costs. Healthy body, a must for all, irrespective of age becomes a major concern once age advances. A major reason for this is that once a person crosses retirement age steady income stops and any expenses due to health problems eats into the savings. This is where a Health Insurance Policy comes into assistance by extending

reimbursement of hospitalization costs incurred due to an unfortunate health problem, subject to terms and conditions. There are many Non Life Insurance Companies who provide such Health Policies for senior citizens with entry age 65 years and above.

Table 3: List of Insurance Companies and their respective policies for the aged

Name of Insurance Company	***Name of Policy***
The New India Assurance Company Ltd.	Senior Citizens Mediclaim Policy
National Insurance Co. Ltd.	Varishta Mediclaim for Senior Citizens
The Oriental Insurance Co. Ltd.	Individual Mediclaim Health Insurance
United India Insurance Company Ltd.	Senior Citizens Health Insurance Policy
Apollo Munich Health Insurance Company Ltd.	Optima Senior
Bajaj Allianz General Insurance Company Ltd.	Silver Health Plan
Future Generali India Insurance Co. Ltd.	Future Health Suraksha-Individual
ICICI Lombard General Insurance	Complete Health Insurance
L & T General Insurance Company Ltd.	My: Health Medisure Classic Insurance
Religare Health Insurance	Care Health Insurance
Star Health Insurance Company Ltd.	Senior Citizen Red Carpet
Max Bupa Health Insurance Company Ltd.	Heartbeat Health Insurance Policy
Max Bupa Health Insurance Company Ltd.	Health Companion Health Insurance Policy
Max Bupa Health Insurance Company Ltd.	Health Assurance Policy
The following policies are ordinary Health policies with entry age upto 65 years	
Bharti AXA General Insurance Company Ltd.	Smart Health Insurance
Cholamandalam MS Insurance Co. Ltd.	Individual Health Line
HDFC ERGO General Insurance	Health Suraksha
IFFCO-TOKIO General Insurance	Individual Medishield Insurance Policy
Reliance General Insurance Company Ltd.	Reliance Health Wise Insurance Policy
Raheja QBE General Insurance Co. Ltd. *	Cancer Insurance
Royal Sundaram Alliance Insurance Company Ltd.	Health Insurance
TATA AIG General Insurance	Mediprime
SBI General Insurance Company Ltd.	Group Health Insurance
Universal Sompo General Insurance Co. Ltd. *	Individual Health Insurance

Notes: *Entry age up to 55 years

It is clear from the above list that all the Public Sector General Insurance Companies have special schemes for the senior citizens along with the Private Sector counter parts. The amount of cover, the rate of insurance premium and of course some of the diseases covered will be different from company to company.

A person whether he opts for a Reverse Mortgage or not, may join for a medical /health insurance for a reasonable amount along with the spouse. Most of the companies are providing cashless option, which may be preferred. It will be advisable to join for health insurance immediately after the retirement to save a good amount in premium.

It may be advantageous to join for health insurance at an early age during the period of employment itself if the employer is not providing any medical benefits so that the premium fixed at an early age will be substantially low. The annual medical insurance premium payment will provide tax benefits also to the insured.

Apart from health insurance, senior citizens can join for specific medical care at a very affordable cost. There is another dimension for this particular scheme. It is a mutual help initiative. You will be blessed if you are not contracting the particular dreadful disease, but definitely your contribution will be benefiting others who are also enrolled in the same scheme. One such scheme very popular in India, particularly in Kerala is Cancer Care for Life.

Cancer Care for Life

The common ailments which take away money as well as life are different variants of Cancer. Anyone can contract cancer at any

time. From diagnosis onwards, cancer treatment can be extremely expensive. For this critical illness, some of the above mentioned policies (Table:3) give insurance cover. Another option for the senior citizens is that when they have enough income before retirement or even after retirement, they can join hands with Regional Cancer Centre, Trivandrum for their life long protection cover - popularly known as Cancer Care for Life.

Cancer Care for Life is an initiative of RCC (Regional Cancer Centre , Trivandrum) which offers an opportunity to contribute from your side as part of individual social responsibility and also enjoy the benefits of complete medical treatment for the contributor if he/ she contracts cancer at any time. The cover will be based on the contributions made by the member. By this the member of the scheme is helping others as well as getting protection against very costly treatments in case he/ she contracts the disease. Normally the financial position of every family will be affected if somebody from the house is affected by cancer. By joining the scheme, up to a certain extent, an element of security can be felt by the family members and senior citizens, particularly at least in the financial perspective. Main features of the scheme are briefly given below:

Who is eligible?

- Open to all Indian citizens who are not already cancer patients.
- Member is eligible for benefits after completing 2 years of enrolment.

Benefits

Under the current scheme which is the 3rd series, the benefits include:

- Membership fee will be once in a life time payment with no annual premium.
- In the event of getting cancer, re-imbursement of expenses (both in-patient and out-patient treatment, expenses of investigations, surgery, chemotherapy and radiotherapy) during treatment at Regional Cancer Center, Thiruvananthapuram after approval from CCL Medical Board as per the rules of the Regional Cancer Centre.
- Membership is non - refundable, non - transferable and valid for life.
- Applicants will not be subjected to any medical check up.

Table 4: Schemes available under Cancer Care for Life

Plan A

Membership fee	Benefit
Rs. 500/-	Rs. 50, 000/-
Rs. 1000/-	Rs. 1, 00, 000/-
Rs. 1500/-	Rs. 1, 50, 000/-
Rs. 2000/-	Rs. 2, 00, 000/-

Discount for Family *

Family of three persons	:	Discount Rs.100/-
Family of four persons	:	Discount Rs.300/-
Family of five persons	:	Discount Rs.500/-

** Family include spouse and children under 18 years.*

Plan B

Membership	Benefits
Rs 10,000	Upto Rs 5,00,000
Discounts not applicable in Plan B	

Conclusion:

It is better to start financial planning when we are in active service. Structured planning with the help of experts in this area can guide us through various investment opportunities. Experts in financial planning will provide the risk factors and related information to select ideal investments. Tax planning and wealth management services are popular with almost all the private sector banks and leading public sector banks. There are various Non-Banking Finance Companies also, engaged in wealth management and related services. Senior citizens can take advantage of these facilities for a better financial planning of their retirement life.

The main problem of retirement is that people refuse to plan in advance. They follow the mantra "let us cross the bridge when we come to it." This is not correct. During your active service you are contributing to Value. Think of Transfer Value. After retirement you can think of Leisure Value.

We live in three "Boxes." First is the "Box of Learning," which starts from birth and goes on till 20 plus. Second is the "Box of Work," which commences at 20 plus and goes on up to 58 or 60. Third is the "Box of Leisure." When we are in the Box of Work, what is significant is status , prestige, power- all these we aspire for and it is what we get from life. The more we get, happier we are. The day we retire we move into Box No: 3- the one of leisure.

Try to enjoy the life in Box No: 3. Develop good hobbies which incorporate your creativity, autonomy, and integrity with a pre-planned financial security. If you are financially secure you will be able to lead a peaceful life. We have to consider Retirement as "not adding Years to your Life but adding Life to your Years." Retirement is to be considered as an opportunity and not as a calamity. To make this opportunity productive, eventful, peaceful and joyful, we have to lay a strong foundation on financial planning at an early age itself.

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Students towards the Old: the Graduated in Groups

Stella Antonio

Abstract

The paper presents some of the results from the research (i) to assess the attitudes of Portuguese University students, (ii) to analyze which variables were associated with attitudes towards old people, and (iii) to identify the preferred group to work after graduation. The study was cross-sectional in design. A convenience sample was used. It Comprised six hundred Portuguese university students enrolled in degrees in medicine, nursing, social work, and physiotherapy. They filled in self-questionnairse, which were analyzed using contingency tables and student's t-test for group comparison. The affective components of attitudes were measured through Kogan's Old People scale (1961).

Social workers, doctors, nurses and physiotherapists and Portuguese University students, who participated in this study, displayed positive attitudes towards old people, but their preferred group to work with after graduation is "children." The less preferred are "young adults" and "old people." Attitudes to older people were significantly related to gender and preference to work with the elderly.

Key words: *Attitudes towards old people, older people, grandparents, university students.*

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Portugal has an aging population structure. It was among the ten oldest countries in the World (PRB, 2013 World Population Data Sheet). Today, the elderly represents 19% of Portugal's population and the Portuguese Bureau of Statistics estimates that the population aged 65 years and over will reach almost 32% of the total population by 2050. The demographic aging trend observed in the last few years persists, as a result of a decline of both young and working age population, and there is a rise in the elderly population. This trend reflects the continuing decrease in birth rates, the increase in life expectancy and, most recently, the increase of emigration flows (INE, Statistics Portugal (2012), (for more information see table 1 – Portugal's present demographic situation).

The aging population combined with changes on the epidemiological pattern, and on family and social structure will determine a greater demand for professionals in the areas of health

and social support (Bleijenberg et al., 2012; Gonçalves et al., 2011; Hweidi and Al-Obeisat, 2006). According to Söderhamn et al. (2000) attitudes toward old people are thought to influence actual and potential caregivers in choosing career possibilities and also how they carry out their work.

So, the increase of older population could represent two important implications for doctors, nurses, social workers, and physiotherapist students in Portugal: (1) an increased demand for social workers and health care professionals - doctors and nurses; (2) the need of social workers and health care professionals to be prepared for working with old people and dealing with the changes and challenges that aging will bring to all settings and fields of practice. Consequently, the attitudes of social workers, doctors, nurses, and physiotherapists toward old people can have a significant impact on the quality of the services they render.

The aim of this paper is to present some of the results from the research: (i) to assess the attitudes in a sample of Portuguese University students enrolled in degrees in nursing, medicine, physiotherapy, and social work, (ii) to analyze which variables were associated with attitudes towards old people, and (iii) to identify the preferred group to work after graduation.

In this paper the expressions "old people," "older adults," or "elderly" are defined as a person aged 65 years and older.

Table 1 – Portugal's present demographic situation (2012)

Indictors	Data
Population	
Resident (thousands)	10,487,289 persons
- Growth rate	-0.52%
- Natural growth rate	-0.17%
- Migration growth rate	-0.36%
Structure	
- Young people (0 to 14 years of age	14.9%
- Working age population (15 to 64 years of age)	65.8%
- Old people (65 years of age and older)	19.4%
Aging index (old people per 100 young people)	
	131
Fertility	
- Live births	89.481
- Birth rate (births per thousand inhabitants)	8.5
-Total fertility rate (average number of children per woman of childbearing age 15-49 years)	1.28
Mortality	
- Crude death rate (deaths per thousand inhabitants)	10.2
- Infant mortality rate (deaths per thousand live births)	3.4
Life expectancy at birth (2010-2012)	
	Men = 76.6 years Women = 82.5 years
Life expectancy at 65 years old (2011)*	
	Men = 16.9 years Woman = 20.3 years
Migration	
- Emigrants	51.958
- Immigrants	14.606

Source: INE – Demographic Statistics 2012 – www.ine.pt; * www.pordata.pt

Research conducted in several countries has shown that medical, nurses and social work students exhibit negative attitudes towards the elderly - that they are reluctant to work with the old people as they do not consider this their priority area. They do not have prestige in terms of status and occupation. They gradually gain only professional expertise in geriatrics and gerontology. They gain experience by living with elderly relatives, including grandparents (Gonçalves et al., 2011; Edward & Aldous, 2009; Cummings et al., 2003; Menz et al., 2002; Mehta et al., 2000; Weiss et al., 2002; Dunkle & Hyde, 1995).

In the review of the literature, the factors identified are : age (Furlan & Fehlings, 2009; Hweidi & Al-Obeisat, 2005); gender (Heycox & Hughes, 2006); educational level and courses (Cheong et al., 2009); family and intergenerational ties (Roff et al., 2002); degree and type of relationships with old people and grandparents (Haight et al., 1993).

About the lack of interest in working with older people, international literature seems to indicate the existence of three significant factors: (1) the manifested attitudes facing the age variable and a hypothetical scenario of working with the elderly; (2) the prejudice and stereotypes associated with the aging processes and the elderly, and also the performing of professional functions in this sphere; and (3) the gaps in factual knowledge (Fonseca et al., 2009). For others, it seems to be explained by four interrelated factors: (1) attitudes towards aging, (2) previous contact with older adults; (3) technical knowledge about aging, and (4) gender and age (Gonçalves et al., 2011).

In a comparative study of first year social work students' preferences in the UK, USA and Israel, the most preferred service user groups to work with, were children and adolescents, while the least preferred agency setting was an old age home (Weiss et al., 2002).

The most common tool used in research to measure students' attitudes towards old people is Kogan's Attitudes towards Old People scale (1961). This measure was translated to many other languages, used in various countries. For example, Netherlands (Bleijenberg et al., 2012); China (Yen et al., 2009); Sweden (Söderhamn et al., 2001); Italia (Matarese et al., 2012); Greece (Lambrinou et al., 2009); USA (Lookinland & Anson, 1995); Lithuania (Roff et al., 2002).

To assess respondents' attitudes towards old people, we use the Kogan's Attitudes toward Old People Scale (KAOP, 1961). Kogan's scale consists of one set of 17 statements expressing negative sentiments about old people and a second set of 17 statements the reverse positive sentiments. That permits the researcher who uses the instrument to avoid answering prejudices that means some people tend to agree (or disagree) with the content of all items and also allow to the researchers to examine the extent that these prejudices pass through the scale (Kogan 1961, Sachini-Kardasi 1997 quoted by Lambrinou et al., 2005). The manifest contents of the statements are concerned with: The residential aspects of old people's lives, special reference to segregation, maintenance of home, character of neighbourhood, the degree to which vague feelings to discomfort and tension are experienced in company of old people, the extent to which old people vary among one another; the nature of interpersonal relations across age generations – conflict or benign, dependence of old people, the cognitive style and capacity of old people, qualities of old people with respect to personal appearance and personality and the power of old people in business and politics (Kogan 1961). The scale is designed as summed Likert attitude scale with six response categories provide for all of the items: "strongly disagree," "disagree," "slightly disagree," "slightly agree," "agree," and "strongly agree." These categories were scored 1, 2, 3,4,5,6, and 7, respectively, with a score of 4 assigned in the rare case of failure to respond to an item (Kogan 1961). Scores on the negatively worded items had to be reversed to obtain a total score. The possible score was between 34 and 238 (Yen et al., 2009). A higher score indicate favourable attitudes toward old people (Kogan, 1961). The questionnaire was distributed to all the students, who have volunteered, by the author in the end of classes after informed consent was asked. The survey took approximately 15 minutes to complete.

Data Analysis

Data was analyzed using SPSS for windows v.19 (Statistical Package for the Social Sciences). Descriptive statistics were used to explore the characteristics of the sample. For statistical tests, the level of significance considered appropriate for this study was a value for P of d" 0.05. Differences in mean attitude scores between groups were in this study tested with *Student's t-test* for independent samples (two-tailed probability).

Results

Table 2 - Demographic characteristics

Degree	Medicine		Nursing		Physiotherapy		Social Work		Total	
	n	%	n	%	n	%	n	%	n	%
	193	31.1	164	26.5	95	15.3	168	27.1	620	100.0
Gender										
Female	131	21.1	141	22.7	77	12.4	152	24.5	501	80.7
Male	62	10.0	23	3.7	18	2.9	16	2.6	119	19.3
Age										
18-23	179	28.8	156	25.2	88	14.2	133	21.5	556	89.7
24-29	12	2.0	5	0.8	4	0.7	25	1.1	46	7.4
> 30	2	0.3	3	0.5	3	0.5	10	1.7	18	2.9
Have lived with Maternal Grandmother										
Yes	77	12.4	91	14.7	44	7.1	86	13.9	298	48.1
No	116	18.7	73	11.8	51	8.2	82	13.2	322	51.9
Have lived with Maternal Grandfather										
Yes	64	10.3	71	11.5	37	5.9	71	11.5	243	39.2
No	129	20.8	93	15.0	58	9.4	97	4.0	377	60,8
Have lived with Paternal Grandmother										
Yes	67	10.8	59	9.5	34	5.5	67	10.8	227	36.6
No	126	20.3	105	16.9	61	9.8	101	16.3	393	63.4
Have lived with Paternal Grandfat her										
Yes	56	9.0	56	9.0	27	4.4	57	9.2	196	31.6
No	137	22.1	108	17.4	68	10.9	111	17.9	424	68.4
Contact with older adults										
Yes	172	27.7	153	24.7	74	11.9	134	21.6	533	85.9
No	21	3.4	11	1.8	21	3.4	34	5.5	87	14.1

Table 3-Preferred group to work after graduation by degree

	Medicine		**Nursing**		**Physiotherapy**		**Social Work**		**Total**	
	n	%	n	%	n	%	n	%	n	%
Children	31	5.0	54	8.7	22	3.5	48	7.8	155	25.0
Adolescents	18	2.9	12	1.9	14	2.3	20	3.2	64	10.3
Adults	65	10.5	32	5.2	20	3.2	20	3.2	137	22.1
Old people	5	0.8	31	5.0	5	0.8	27	4.4	68	10.9
Indifferent	50	8.1	24	3.9	29	4.7	42	6.8	145	23.4
Don’t Know	24	3.8	11	1.8	5	0.8	11	1.7	51	8.2

Table 4 - Kogan’s attitudes Old People scale, means and standard deviation by degree

	Mean	SD
Medicine	4,41	0.611
Nursing	**4,69**	**0.625**
Physiotherapy	4,33	0.615
Social Work	**4,64**	**0.639**

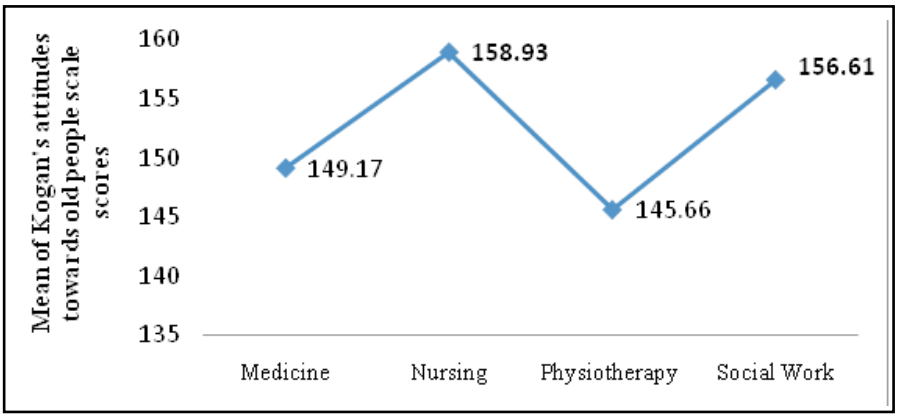

Figure 1 – Kogan's attitudes towards Old People scale scores by degree

Table 5 – Summary of Kogan's attitudes towards Old People scale mean scores by gender, have lived with grandparents and have contact with older adults

	n	mean	SD	t	p-value
Gender					
Male	119	4.37	0.606	-4.172	0.000*
Female	497	4.57	0.452		
Have lived with Maternal Grandmother					
Yes	270	4.54	0.519	0.397	n.s
No	294	4.52	0.461		
Have lived with Maternal Grandfather					
Yes	175	4.55	0.546	0.716	n.s
No	306	4.52	0.454		
Have lived with Paternal Grandmother					
Yes	174	4.54	0.480	0.923	n.s
No	340	4.50	0.499		
Have lived with Paternal Grandfather					
Yes	113	4.59	0.497	1.622	n.s
No	338	4.50	0.504		
Contact with Older Adults					
Yes	530	4.53	0.487	-0.159	n.s
No	87	4.54	0.509		
Preference to work with old people					
Yes	68	4.69	0.488	-2.907	0.004*
No	548	4.51	0.474		

*p<0.005; n.s: not significant.

Summary of Results

- **Sample characteristics**

Six hundred and twenty students participated in the survey. Most of them (31.1%) are from medicine degree; one hundred and sixty four (26.5%) are from nursing degree; one hundred sixty eight (27.1%) are from social work degree; ninety five (15.3%) are from physiotherapy degree and twenty four (3.9%) are from Social Policy. Mostly were female (80.7%). The mean age of the sample was 21.4 years; the median age was 21 years; with the youngest being 18 years and the oldest 38 years.

Most of the students did not live with their grandparents. However, it was with maternal grandmother with whom they have lived more (48.1%) and it was with paternal grandfather with whom they have lived less (31.6%). Most of the students have regular contact with older people (85.9%). The preferred group to work

with after graduation is the "children" (25,0%) and the less preferred are "young adults" (10,3%) and "old people" (10,9%). The results show that Portuguese students of medicine, nursing, physiotherapy, and social work have positives attitude toward old people (Table 4). The most positive attitudes towards older people are to be found among nursing and social work students (Figure 1).

There was a significant difference between the mean total score for the males in comparison with females and between the individuals who preferred work with old people and the others who don't, which are displayed in Table 5. No differences related to have lived with grandparents and among contact with old people are noted.

Discussion

Previous studies have presented several independent variables that influence students' attitudes towards old people such as age, gender, educational level and courses, family and intergenerational ties, degree and type of relationships with old people and grandparents, preferred group to work after graduation (Gonçalves et al., 2011; Hweidi andAl-Obeisat, 2006; Furlan & Fehlings, 2009; Heycox and Hughes, 2006; Cheong et al., 2009; Roff et al., 2002; Haight et al., 1994; Fonseca et al., 2009).

In this study, the most significant variables that were found to influence attitude towards old people were gender and group preferred to work after graduation. Female students have had more positive attitude towards old people (M = 4.57 ± SD =0.452) than male students (M= 4.37 ± SD = 0.606). These results are consistent with previous studies (Dunkle & Hyde, 1995; Söderhamn et al., 2001; Lambrinou et al., 2009).

The students who preferred work with old people after graduation displayed more positive attitudes toward them (M = 4.69± SD = 0.488) than the students who prefer not to work with this group (M = 4.51±SD = 0.474). This result is similar to previous findings (Hweidi and Al-Obeisat, 2006; Fonseca et al., 2009).

Conclusions

The study has shown that Social workers, Doctors, Nurses, Physiotherapists and Portuguese University students, who participated in this study hold positive attitudes towards old people. However, only 10.9% preferred to work with them after graduation.

Considering that: 1) the Portuguese aging population is a fact, 2) there are changes in the epidemiological pattern and on family and social structure with important implications for future social workers and health professionals, and 3) the importance that professionals have in the way they treat the elderly and the services they provide to them, further research should analyze the reasons for the lack of interest to work with old people among the Portuguese future professionals-doctors, nurses, physiotherapists and social workers.

Recommendations for further research

Further research is, however, needed to identify the students' reasons for lack of preference to work with old people after graduation.

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Senior Citizens: as Food Shoppers

Vimal Chandra Verma and Devashish Das Gupta

Abstract

Aging occurs naturally. With the advent of progress in research as well as health practices, percentage of senior citizens is on the rise in almost all countries especially USA, UK, and Germany. India is one among them. Life expectancy has gone up considerably. With the growth of retail in India, it has become a challenge for marketers of food products. However, all products and strategies are broadly focused to youth and children. Does Senior segment have affordability to consume? Can they be segmented further? Can we go into studying their shopping behaviour especially for food products? This study explores into the existing work done internationally with general reference to India.

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The worlds' silver population is increasing rapidly. The average age of population is increasing and this segment has turned out to be the largest in the world. By the year 2050, it is projected that the total elderly would be 1.5 billion and will constitute over 16% of the population. India being the second country having largest elderly population is no exception to this trend. The changing needs of senior citizens create a vital issue for retailers of food items. Food is the fundamental need of man. Consequently food shopping becomes vital and frequent activity for all consumers. As per the USDA Foreign Agriculture Service, Global Agricultural Information Network (GAIN), retail food sales in India are estimated at $270 billion which equates 60% of total retail sales and a $225 per capita annual expenditure on food. This estimate indicates that modern grocery retailers managed to carve out an estimated one percent of share of food retail sales in 2005. This share has increased to two percent in 2011 or $5.4 billion. Demographic factors are vital in determining decision in regard to food choice (Shepherd, 1999). They have been considered as significant influence on consumer's food behaviour. As an individual moves towards aging, he/she feels different changes in terms of appetite, food intake and dietary adequacy (Hughes et

al., 2004; Simpson et al., 2005) and there is also decrease in their ability to taste, chew, smell and handle food (Popper and Kroll, 2003).

As per international literature adults in the age group 65 plus years are classified an senior citizens while in India the people who have completed 60 years are considered to be senior citizens. According to the maintenance and welfare of parents and senior citizens Act 2007, "Senior citizen has been defined as any person being a citizen of India, who has attained the age of sixty years and above." However, it is evideny form the literature that there is no single accepted way of defining the people of this segment. There exists a wide variation in terms of the consideration of where one should draw the line. Many studies and articles have taken people above the age of 50/ 55 as to be forming the relevant segment for the analysis.

Global Scene - According to new US Census Bureau population projections, by mid century most world regions and the United States will resemble Europe.

Region	Year	65 Years& Over	75 years and Over	80 Years and Over
EUROPE.	2000	15.5	6.6	3.3
	2015	18.7	8.8	5.2
	2030	24.3	11.8	7.1
NORTH AMERICA.	2000	12.6	6	3.3
	2015	14.9	6.4	3.9
	2030	20.3	9.4	5.4
OCEANIA/AUSTRALIA/NEWZEALAND.	2000	10.2	4.4	2.3
	2015	12.4	5.2	3.1
	2030	16.3	7.5	4.4
ASIA.	2000	6	1.9	0.8
	2015	7.8	2.8	1.4
	2030	12	4.6	2.2
LATIN AMERICA/CARIBBEAN.	2000	5.5	1.9	0.9
	2015	7.5	2.8	1.5
	2030	11.6	4.6	2.4
NORTH EAST/NORTH AFRICA.	2000	4.3	1.4	0.6
	2015	5.3	1.9	0.9
	2030	8.1	2.8	1.3
SUB -SAHARAN AFRICA.	2000	2.9	0.8	0.3
	2015	3.2	1	0.4
	2030	3.7	1.3	0.6

Source: United Nations, 2000

Figure 1: Percent of World Population by Age: 2000 to 2030

US in 2005 became the first major world region where the population 65 and older outnumbered those younger than 15. In the United States, the senior citizen population - those age 65 and older - is projected to grow by 104.3% between mid-year 2012 and 2050. At that point there will be 80.5 million Americans under age 15 and 86.8 million seniors over age 64.

Indian Scene - In the next decade, India would add 150 million to its population, a growth of 14%. During the same period, the age group 60+ would grow by 30 million at 35%. 'Older' Indians may yet account for a quake in life-cycle spending patterns.

	1990	1995	2000	2005	2010	2012f	2015f	2020f
0-4 years	13.9	13.02	11.98	11.07	10.45	10.21	9.73	9.03
5-9 years	12.61	12.24	11.63	10.85	10.12	9.9	9.63	9.06
10-14 years	11.45	11.3	11.09	10.66	10.01	9.75	9.41	9.04
15-19 years	10.13	10.28	10.25	10.16	9.83	9.62	9.3	8.83
20-24 years	9.1	9.06	9.29	9.35	9.33	9.26	9.11	8.71
25-29 years	8.02	8.12	8.17	8.45	8.56	8.6	8.63	8.51
30-34 years	7.15	7.15	7.31	7.42	7.72	7.8	7.9	8.04
35-39 years	6.3	6.35	6.42	6.62	6.77	6.89	7.11	7.35
40-44 years	4.75	5.57	5.68	5.8	6.02	6.09	6.22	6.6
45-49 years	4.01	4.16	4.94	5.09	5.24	5.33	5.5	5.74
50-54 years	3.56	3.45	3.63	4.37	4.55	4.6	4.74	5.03
55-59 years	2.95	2.98	2.94	3.13	3.82	3.93	4.03	4.24
60-64 years	2.29	2.36	2.44	2.44	2.64	2.89	3.27	3.5
65-69 years	1.65	1.72	1.82	1.92	1.96	2	2.16	2.71
70-74 years	1.09	1.13	1.21	1.32	1.43	1.45	1.49	1.67
75+ years	1.05	1.1	1.2	1.35	1.54	1.67	1.76	1.96

F= BMI forecast, Source: World Bank UN BMI

Figure 2: India' Population by Age Group, 1990-2020(% of Total)

Their spending is expected to rise faster than in any other age group, fuelled by a more educated and affluent generation turning older (Euromonitor, 2004). Although India is still younger than US and Japan from a demographic standpoint, that aging has begun in the country. It is anticipated that the elders in India would increase both in absolute numbers and relative strength, indicating a gradual swing to a senior population. As per Census of India projections, the percentage of elders as a percentage of total population in the country would jump from 7.4% in 2001 to 12.4% in 2026 and touch 19.7% in 2050. In 2011, India had about 76 million seniors above the age of 60 years and it is expected that this figure will grow to 173 million by 2025, further increasing to about 240 million by 2050. This marked increase in elderly population would involve a change in an important sociological aspect, the 'old age dependency ratio.' Interestingly, by 2050, it is estimated that the number of dependent adults in India will be on a par with the number of dependent children. This change in senior citizens population has far reaching implications, for public policy, marketing and health care. Since the number of older consumers and their composition in total population has not been substantial enough to attract their attention. The knowledge in this regard is vital to craft such a strategy which is focused to them.

Psychographic Segmentation

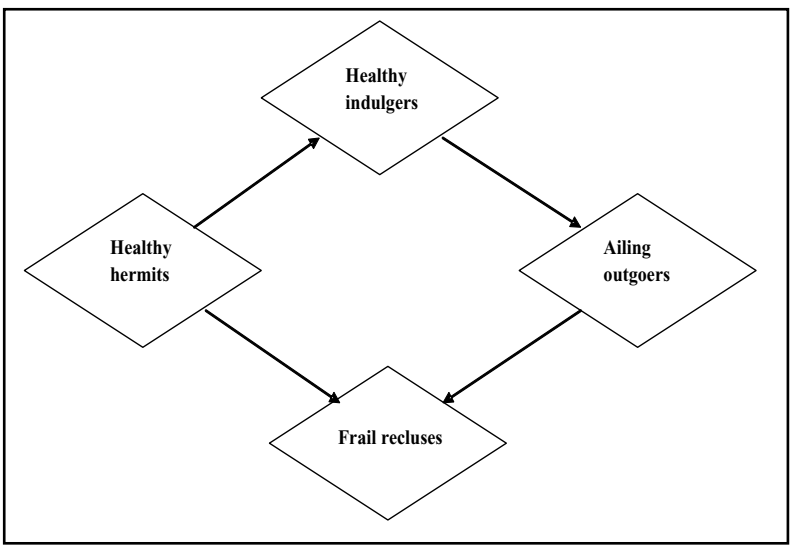
Psychographics is basically the study of personality values, attitudes, interests and lifestyles, and psychographic factors are also called as AIO (Attitude, Interest, and Opinion) variables. In his study Bone (1991) indicated that the use of different demographic characteristics for segmentation such as age, discretionary income, and employment status, can prove to be misleading. While segmenting on the basis of discretionary income, it can have flaw of not considering factors such as activity levels, personal interest, health, or discretionary time (Burnett and Wilkes, 1985-86; Moehrle, 1990, Bone, 1991). However, the common method of segmentation on the basis of chronological age, does not consider behaviour as psychological age (Bartos, 1980; Barak and Rahtz, 1989).

Oates et al. (1996) in their study on psychographically segmenting older customers say that demographics alone do not give complete information about the customer and can be misleading, therefore hampering the marketer in segmenting the market to its full potential (Cooper, 1984). Considering psychographic information with demographics, the marketer will be able to understand the wants and needs of the consumer in a better way. Moschis (1993) and Lambert (1979) concludes that buying behaviour, desires, and needs of elderly must be unique.

The conflicting research on the elderly has given rise to many questions for the wisdom of using age alone to segment the market. Oates et al., 1996 also suggested in their study that other variables as lifestyle or psychographics have been tested and proved to be very excellent techniques of identifying distinct categories of buyer behaviour.

Gerontographic Segmentation

As per the model developed by Centre for Mature Consumers in Atlanta, Georgia- they can be placed in four different groups such as (a) Healthy indulgers- who are socially engaged, active and independent, healthy and wealthy and behave like younger consumers, (b) Healthy hermits, who are socially and psychologically withdrawn, healthy, and have very little interest in staying active, (c) Ailing outgoers- Consumers of this segment are health conscious, socially active, unlikely to change their lifestyle because of chorological age and are considered as active consumers having strong self-esteem with financial security, and (d) Frail recluses who are inactive individuals with chronic ailments, spiritually strong stay in isolation and most conscious about their physical and financial security (Moschis, 1996).



Source: Moschis (1996)-Specific arrows indicate that people may move to next stage in life due to psychological and social aging; arrows pointing to left indicate psychological aging:; arrows pointing to the right indicate biophysical aging.

Figure 3: Life stage segments of mature consumers

The model in Figure 3 indicates that consumers in these four segments are likely to switch over time in their gerontographic segment due to aging processes such as life circumstances and life changing events they experience over the duration of their life (Moschis, 1996).

Understanding elderly consumers, lifestyle and shopping behaviour

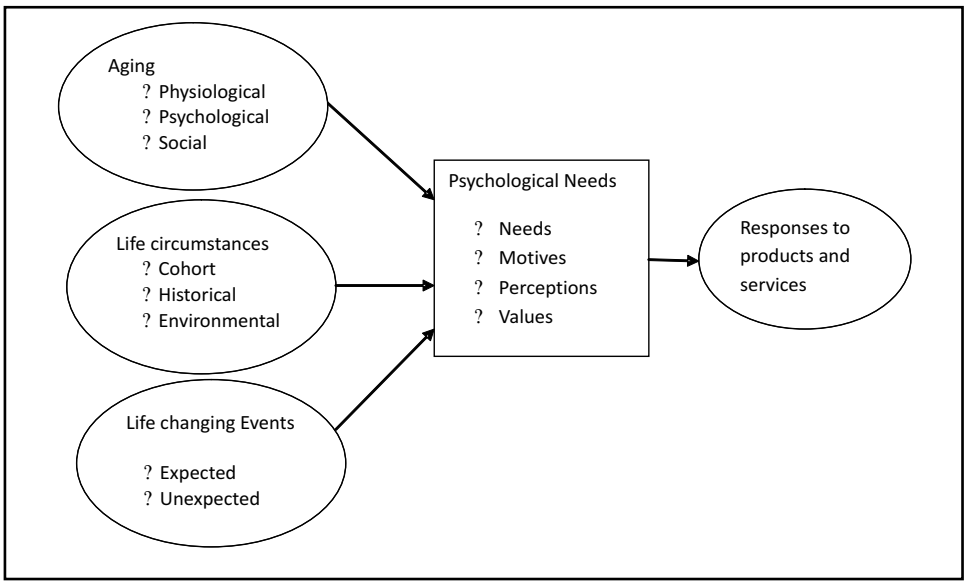
For developing effective food retail strategy to appeal to elderly consumer market, requires a deep understanding of the needs of diverse elderly market. Marketer needs to analyze and understand psychological states of the elderly consumers and what differentiates them from their younger counterparts. As people approach towards aging, it results in certain changes in biophysical, psychological, and social aging (Moschis,1996). There are various changes in bodily system such as decline in ability to hear and vision and certain diseases cause different rates of physiological decline. They also become sensitive to glare of the light and it consequently takes more time in getting adjusted to light conditions and faces difficulty in opening of cans, bottles, packets etc. Therefore, as people move towards aging they also loose ability of taste, reason being the loss of taste buds due to medication. People also differ physiologically while aging. Senior consumers prefer to buy same products to avoid risk of buying new and unknown products and are considered as loyal consumers (Moschis, 1992). Quality plays a crucial role in creating trust among senior consumers (Jahn et al., 2012). Seniors stick to the existing choice of product and service and showing their higher loyalty (Lambert- Pandrued and Laurent, 2010). Le Clerc and Thornbury (1983) found that women's diet was more in proportion with fat, protein and carbohydrate.

Elderly consumers and their retail buying behaviour

According to Wilson et al. (2004) shopping behaviour of older consumers is very complex and they concluded that a store usage does not affect dietary variety. Age also has a negative impact on

the number of stores patronized (Baltas et al., 2010). Repeated purchase intention is positively affected by perceived service quality (Lu and Seock 2008).

Different factors such as aging, life changing events, life circumstances affect psychological needs of mature consumers and in respect to all these factors they respond to various products and services.



Source: *George P. Moschis, Jodie L. Ferguson, Meng Zhu, (2011) Mature Consumers' selection of apparel and footwear brands and department stores.*

Figure 4: Factors affecting consumption habits of mature consumers

Food Shopping Behaviour

Sherman and Brittan (1973) in their study on food shopping habits of the elderly find that mobility and transportation is very vital in choosing a store and has direct impact. Relationship of products quality and its price is very important criteria for selecting a particular store Lambert (1979) and Lumpkin et al. (1985). They seek for attractive products having attractive price value for the money instead going for lower prices. Elderly consumers prefer to have fashionable clothing and enjoy the ability to return goods they are not satisfied with (Lumpkin et al., 1985).

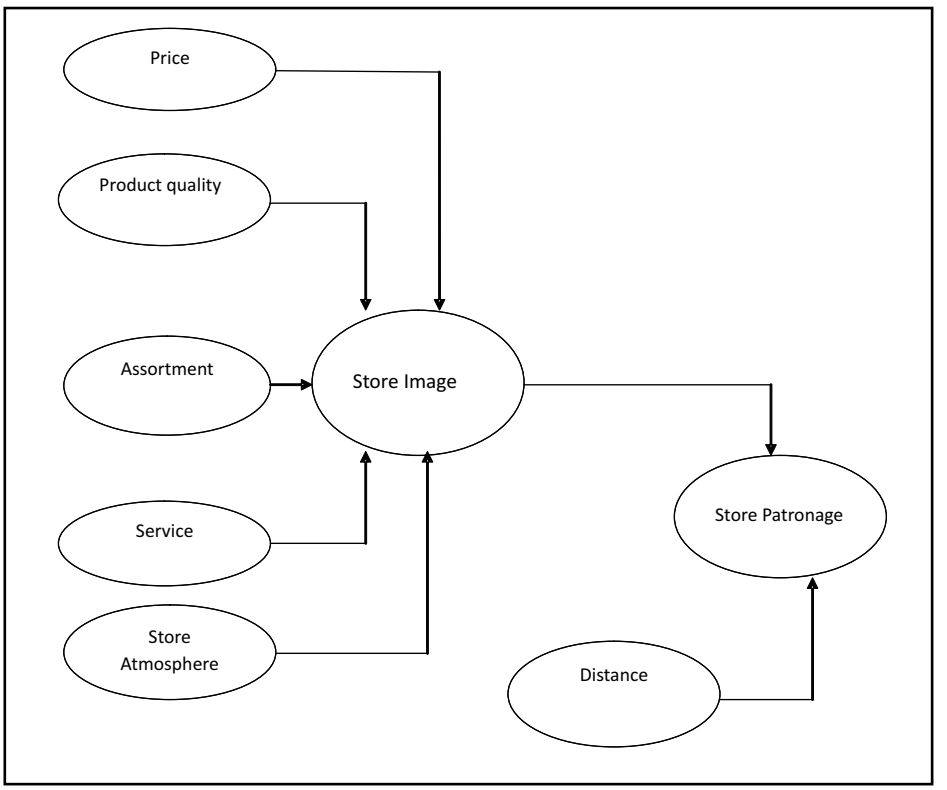
Mature consumers shop primarily at specialty and department store that have a greater concern about product quality, well known brands, store reputation, readable labels, knowledgeable sales persons and offer discount for senior citizens (James R. et al., 1992). Product relocation causes confusion and anxiety among older people. In some cases, it is given as a reason not to shop in supermarket stores. Hence the issue of product relocation has the possibility for either encouraging continued store patronage or losing customers. Overcrowding is vital concern for older people when shopping food and they feel it as a burden. They also do not go easily for online shopping, since to them it is too technical (Lisa Meneely et al., 2009). In a research on food choice (Herne 1995) found that the older people who face a great deal of difficulty in food shopping are at the highest nutritional risk. Shiffman (1971; 1972; 1973) finds in his study of elderly consumers, that both internal and external communication have effect on their decision making and the more perceived risk. The less chances of product trail, socially active elderly consumers, are more active as compared to social isolates.

According to Lambert (1979), Lumpkin *et al*. (1985) and Mason and Bearden (1978) store attributes and shopping pattern of elder consumers are based on retailers are going to fulfill their wants and needs. It is found out by Mason and Bearden (1978) that elderly consumers generally shop for other different reasons than buying goods and they are interested in purchasing experience than goods (Dychtwald and Flower 1990).

As per the study conducted by Meulenberg and Steenkamp, price, product quality, assortment, service and store atmosphere have an influence on store image and all these factors as well as distance, have effect on food store patronage decision.

Patronage behaviour is the decision process with regard to where consumers shop, how they shop, and what they purchase (Moschis, 1992). Consumers patronize retail stores for several different reasons, which may include some factors such as store prices and values, merchandise selection, purchasing convenience, services offered, merchandise quality, treatment by store personnel, and store reputation and status.

Accessibility of stores is very vital for older consumer cohorts due to deterioration in personal mobility with increase in age (Moschis, Curasi, and Bellenger 2004). Shelf management helps the consumer in locating and comparing the products and therefore facilitates shopping process inside a store. The whole process of locating and picking the products is very challenging for the older consumers (Goodwin and Mcelwee 1999).They also feel difficulty in proper reading and identification of the products which they are looking for due to lack of eyesight (Hare 2003).



Source: *Meulenberg and Steenkamp (1963) -The role of store image in food store patronage behaviour*

Figure 5: Model of food store patronage behaviour

Findings

Antecedents and factors influencing senior citizens food shopping behaviour

Genderwise differences

Women are consistent in their decision to make healthier food choices: fruits, lean meat, and whole meal breads and salads and follow nutritional guidelines to prevent coronary heart disease and various types of cancers. It was found that women's diet was more of high quality than men's diet.

Agewise differences

Elderly consumers tend to own somewhat limited mobility, to use large quantity of market information, to engage in shopping for more than just buying reasons such as entertainment, fun and leisure. They require more information in taking a food purchase decision as compared to their younger counterparts. They prefer to buy repeated purchase of the same products since they try to avoid the risk associated with buying new and unknown products. Mature consumers avoid going for online shopping because they feel that it is too technical. They avoid shopping in stores which are overcrowded.

It is also found out that mature consumers shop primarily at specialty and department stores which carry the image and offerings in terms of product quality. Well known brands have good store reputation, readable labels, knowledgeable sales people and offers of special discount for senior citizens. Elderly consumers have a reason to buy goods because they are interested in purchasing experience rather goods. Senior consumers prefer to buy same products to avoid risk of buying new and unknown products and are considered to loyal consumers. They prefer new products which offer less perceived risk and are innovative if they are socially active. While going for shopping they do not only go to buy products but are interested in having buying experience.

Conclusion

The elderly consumer segment requires greater attention as a population segment which will offer great potential for profit in the time yet to come. It is vital that their particular needs within the food segment are met. This study has shown that there is scope for food retailers to enrich their retail offering for better serving the elderly consumers. Different issues have been found to be important such as relationship with product quality and price. They also primarily go for food shopping to get dietary variety with buying experience. New products and online shopping are not easily accepted by them because they avoid the risk associated with technicality involved in it. In order to overcome different problems faced by elderly consumers and improving their food shopping, they must go in deeper understanding for the improvements targeting the needs of older people, such as changes to pricing strategies, good store layout, and design of store lighting which makes them feel comfortable in the glare.

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Spiritual Involvement and Beliefs: Mental Health of Widows and Widowers

R. S. Mhaske

Abstract

the purpose of this study was to examine the relationship between spiritual beliefs and mental health with regard to widows and widowers in Institutions. The sample for the study consisted of 100: fifty each, widowers and widows from Institutions: different old age homes from Pune city. Spiritual involvement and beliefs were compared with problem-focused coping and emotional-focused coping in mental health. The tools used for this study were Spiritual Involvement and Beliefs Scale (Hatch et al., 1998), Ways of Coping (Folkman and Lazarus, 1985), and General Health Questionnaire – 28 (GHQ-28) (Goldberg and Hiller, 1979). A t-test was carried out to see if males and females differ significantly on spiritual involvement and beliefs, ways of coping, and mental health in institutional widow and widower. The mean for widower on spiritual involvement and beliefs was 94.74, SD = 16.85, and for widow 62.92 and SD = 29.64 and t value was 6.60 (p >0.001). The mean for widower on emotional-focused coping were 24.02, and SD = 4.83, and for widow 30.46, and SD = 5.71 and t value was 6.27, (p >0.001), which found significant. The mean for widower on problem-focused coping was 39.30 and SD = 8.48, and for widow 31.60, and SD =10.86, and t value was found 3.91, (p >0 .001) which was significant. The mean for widower on mental health was 13.38, and SD = 7.97 and for widow 21.84, and SD = 4.56, and t value was found 6.16, (p > .001) which found significant. The product-moment correlation showed positive and negative correlation in concern areas, results were discussed in the light of previous studies.

Key words: *Ways of coping, Institutionalized aged and coping, Spirituality and Ways of coping, Gender and spirituality.* **Conference sub-theme:** *Residential aged care.*

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Aging is a universal phenomenon. As per 2011 census, India's current population is 1.21 billion, and out of that 60+ population of India is 100 million, and the estimated population of Indian aged 60 would be over 174 million in 2026 (www.censusindia.gov.in/2011), and estimated population of the Indian aged (65+ years) would be 14 per cent by 2050.

There is an increasing need for care of older people in both physical and mental health problems. Considering these statistics with the aging population growing rapidly under institutional care is becoming a necessity in India.

In terms of prevalence of widowhood, India ranks highest in the world. Approximately 7% widows are living alone in India. Population of widows in India is 34 million, out of that 8% population is female, and 50% of the female population is over

the age of 50. Only 2.5% of Indian men are widowers (www.nativeministeriesindia.org).

There are 728 old age homes in India (Directory of Old Age Homes India, Help Age India) (www.dadadadi.org).

Old-age homes have been characterized as "an essential private place which is the center of domesticity, a place of intimacy and sometimes a place of solitude" (Peace, 1988, 1993; Sixsmith, 1986; 1990). It is often linked to the idea of family (Peace, 1988, 1993; Willcocks et al., 1987).

Widowhood refers to an ongoing and frequently long-term state, which has both social and personal consequences and meanings (Bennett et al., 2005). Most people feel distressed and depressed following the loss of a loved person (Stroebe & Stroebe, 1987). The death of a spouse is rated as among the most stressful life event that humans experience (Amster & Krauss, 1974; Holmes & Rahe, 1967). Major life events such as widowhood are also associated with a disturbance in one's normal routine (including participation in health behaviours) and an increase in stress (Holmes & Rahe, 1967). Older women are three times more likely than their male counterpart to be widow (cited in, Michael et al., 2003).

Several cross-sectional studies have suggested that marriage is protective and that widowhood, divorce, and separation are detrimental to health behaviours (Rosenbloom & Whittington, 1993; Schone & Weinick, 1998; Venters et al., 1986) and cardiovascular disease risk factors (Kushnir & Kristal-Boneh, 1995; Venters et al., 1986). Studies have shown that widower were found more socially and emotionally isolated than widow and this may have dire consequences for their health (Ferraro et al., 1984; Lazarus & Folkman, 1984).

Several studies have reported a relationship between religious coping and outcomes of negative life events, including health problems (Levin et al., 1989; Pressman et al., 1990; Idler et al., 1992; Larson et al., 1992; Matthews et al., 1998; Musick et al., 1998, cited in Bosworth et al., 2003). According to Hayman and Gianturco (1973) older widows and widowers maintain higher level of religious activity after their loss.

Spirituality defined as "a set of beliefs or attitude," (Ellison et al., 1988), but the terms religion and spirituality have been used interchangeably. Some of the researchers tried to define these two terms separately. Spirituality tends to increase during late adulthood and old age population (Moberg, 2005).

Researchers examined the impact of widowhood on the lives of older women and how religion and spirituality may be used as coping methods in loss; researcher found that older women use religious coping as well as spiritual beliefs and behaviour to facilitate positive adjustment to the loss of a spouse (Michael et al., 2003). Study found a moderate correlation between happiness and involvement in religious activity (Myers, 2000).

Many studies indicated that people used religion/spirituality in situation of bereavement. Widowed individuals scored high on life satisfaction before than after the loss, and widowed individuals used less problem-focused and less emotion-focused coping than non widowed individuals (Michael & Ben-Zur, 2007). Research indicated that many older adult used personal or private activities related to their spiritual beliefs and practices as a means of coping (cited as in Kaplan, 2001), and another study reported that spiritual beliefs and practices were frequently perceived as active and effective means to cope with stressors (Paloutzian & Kirkpatrick, 1995, cited as in Kaplan, 2001).

When 17 Chinese widowers were asked to share strategies to adopt and achieve healthy adjustment in spousal loss, it was, revealed that loss orientation coping, consisting of emotion-focused coping, social coping, and meaning focused coping were found key strategies in dealing with challenges. By the past restoration-orientation coping consisting of problem-focused coping, social coping, future-focused coping and meaning focused coping was found key to managing challenges for present and future challenges (Woo et al., 2009). With respect to gender differences in coping, women are found more confrontive and expressive of their emotion than men (Strobe, 2001).

In one study, (Cramer, 1993) higher rates for psychological distress were found among widowers compared with married men, than for widows compared with married women. On the basis of extensive review, Gove (1972) reported that widowers had relatively higher rates of mental illness than widows, compared with their same gender controls. A recent meta-analysis found that total life events as well as the death of significant others were associated with higher levels of depressive symptoms in older adults (Kraaij et al., 2002). Older women were reported to have higher levels of depression than men (Kessler et al., 1997; Palsson et al., 2001), but it was found reversed in widowhood, that depression was found higher amongst widowers (Stroebe & Stroebe, 1983, cited in Bennett et al., 2005). In one study Lee et al. (2007) reported that widowed elderly have lower level of well-being than elderly couples their socioeconomic status and self-perceived health were found positively associated with well-being in them, and frequency of prayer was found negative relationship with well-being.

A number of studies have shown that depressive feelings are elevated in widowed people (Bennett, 1997, 1998; Gallagher, Breckenridge, Thompson & Peterson, 1983; Zisook, Paulus, Shuchter & Judd, 1997, cited in Bennett, 2005). Choulagai et al. (2013) conducted a study to determine the prevalence and associated factors of depression among inmates of geriatric homes and result showed high prevalence of depression (51.3%), severe depression (15.4%), and mild depression was found 35.9%, in geriatric homes, and most of the (75%) widow/widowers found severely depressed.

Williams et al. (2005) compared mental health with non-widowed participant and found that widow reported higher proportion of mental health in comparison with non-widowed participant. Several years after their husbands' death many widows reported a significantly lower sense of coherence, diminished social support and lower level of mental health as compared with married women (Ungar & Florian, 2004). Bebbington (1987) concluded that being widowed increased the risk of developing an affective disorder more in men than in women. Widowed women are reported to have more physical and mental health problem than married women aged 50–79 years (Wilcox et al. 2003). One study (Lee et al., 1998) reported that widowhood had a substantially stronger effect on depression for men than women.

In gender differences, Chen et al. (1999) found higher level of depression in general widows than widowers. Monteso et al. (2012) evaluate the prevalence of depression in rural area in the south Catalonia, and research found high risk of depression in rural community and widowers suffer more than widows. In another study, Gallagher et al. (1983) found that widows had higher levels of distress than widowers.

Aims and Objective of the study

The purpose of this study was to find out differences in spiritual beliefs, ways of coping and mental health among the institutionalized widows and widowers.

Hypothesis

1. Widowers show higher spiritual involvement and beliefs than widows.
2. Widows use more emotion-focused coping than widowers.
3. Widowers use more-problem-focused coping than widows.
4. Widows show poor mental health than widowers.

Methodology

- **Sample**

The sample for the study consisted of 100 institutionalized widows and widowers (50 widows and 50 widowers), who were staying in old age home since last three years in Pune city, and had been widowed between 3 years to 7 years, aged between 60 to 80 years from middle-class socioeconomic status, and all were free from any psychopathological conditions, and free from major physical ailment.

The Product-moment correlation is used to examine the relationship between spiritual belief, and ways of coping, mental health, and t-test is used to measure gender differences in spiritual involvement and belief and ways of coping, and mental health.

Details of the tools used for study

1. *Spiritual Involvement and Beliefs Scale (Hatch et al., 1998)*

   It is a 24-item questionnaire that assesses spiritual beliefs and actions across religious traditions. The SIBS total score has test-retest reliability of 0.92 over 7 to 9 months and construct validity in that it has been found to correlate (r = 0.79) with the SIBS. Alpha in this study was 0.91 for mothers and 0.70 for fathers.

2. *Ways of Coping Questionnaire (Folkman & Lazarus, 1985)*

   It measures eight ways of coping, namely, Confrontive Coping, Distancing, Self-Controlling, Seeking Social Support, Accepting Responsibility, Escape-Avoidance, Planful Problem-Solving, and Positive Reappraisal. Test-retest reliability and alpha coefficients for the scales range from 0.61 to 0.79.

3. *General Health Questionnaire-28 (Goldberg and Hillier, 1979)*

   It consists of 28 items with four subscales: *Somatic Symptoms, Anxiety and Insomnia, Social Dysfunction, and Severe Depression.* The Cronbach's alpha coefficients of reliability of the sub-scales range from 0.83 to 0.92. The scoring procedure of test states that the higher the scores the poorer the health, and low scores indicate good (well-being) mental health.

Results

Table-1.1 shows means, standard deviation and t-test result for widowers and widows on spiritual involvement and beliefs, ways of coping and mental health (Widowers, N = 50, Widows, N = 50).

Table 1.1

Variables	Widowhood	Mean	SD	t-test
Spiritual beliefs and Involvement	Widowers	94.74	18.85	6.60**
	Widows	62.92	29.64	
Problem-Focused Coping	Widowers	39.30	8.48	3.91**
	Widows	31.50	10.86	
Emotion-Focused Coping	Widowers	24.02	4.83	6.27**
	Widows	30.46	5.71	
Mental Health	Widowers	13.38	7.97	6.16**
	Widows	21.84	4.56	

** Significant at 0.01 level

As table 1.1 shows, the mean for widower on spiritual involvement and beliefs was 94.74, SD = 18.85, and for widow 62.92 and SD = 29.64 and t value was 6.60 ($p < 0.001$) which was significant. The mean for widower on problem-focused coping was 39.30 and SD = 8.48, and for widow 31.60, and SD =10.86, and t value was found 3.91, ($p < 0.001$) which was significant.

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Discussion:

As table 1.1 shows that widowers were higher on spiritual involvement and beliefs than widows, therefore, the first hypothesis stated that, 'widowers show higher spiritual involvement and beliefs than widows' was accepted and previous findings did not show the exact findings but showed that men and women appeared to understand and experience spirituality in a similar manner (Gomez & Fisher, 2005, cited in Brown et al., 2013), but older women used more religious coping as well as spiritual beliefs and behaviour to facilitate positive adjustment to the loss of a spouse (Michael et al., 2003), and study showed that women consistently scored higher than men on spirituality and religious involvement (Maselko & Kubzansky, 2006; Wink & Dillon, 2002, cited in Brown et al., 2013). In the present study, widowers did not have any family support and support from their own male group because they were less in number and because of that widower were found more involved in spiritual involvement and belief than widows.

Second hypothesis widow's used more emotion-focused coping than widowers, was accepted. But the present findings is similar to some extent with previous findings which showed that females showed more social support, emotion-focused, and avoidant coping compared to males (e.g. Billings & Moos, 1981; Pearlin & Schooler, 1978; Ptacek et al., 1992; Stein & Nyamathi, 1999; and Stone & Neal, 1984, cited in Mhaske & Ram, 2009). But the study also showed that widowed individuals used less problem-focused and less emotion-focused coping than non widowed individuals (Michael & Ben-Zur, 2007). As third hypothesis stated that widowers used more-problem-focused coping than widows was accepted in present study, and some previous findings also showed that male elderly used more problem-focused coping than females (Brems & Johnson, 1989; Stone & Neal, 1984), and widowers also used problem-focused coping in challenging situation (Woo et al., 2009), and previous findings showed that elderly people did not use only problem-focused and emotion-focused coping in stressful situation, but they also used religious and spiritual coping to a large extent (Cox and Hammonds, 1988).

Last hypothesis, 'widows show poor mental health than widowers' was accepted in present study, and previous study also supported the present findings. Chen et al. (1999) found higher level of depression in general widows than widowers. In bereavement, women not only have higher distress and depression but they also show higher rates of physical illness, whereas men have higher mortality rates (cited in, Stroebe, 1998). Another study showed that older women reported to have higher levels of depression than men (Kessler et al. 1997; Palsson et al. 2001). One study supported the present findings and said that after the husbands' death many widows reported a significantly lower sense of coherence, diminished social support and lower level of mental health as compared with married women (Ungar & Florian, 2004).

In another study, Gallagher et al. (1983) found that widows had higher levels of distress than widowers.

Conclusion

The present study found the following conclusions:

1. Widower elderly found higher in spiritual beliefs and involvement than widow elderly.
2. Widow elderly used more emotion-focused coping than widower elderly.
3. Widowerelderly used more problem-focused coping than widow elderly.
4. Widow elderly showed poor mental health than widower elderly.

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Nutritional Intake of the Elderly: a Cohort Study

Sithara Balan V. and V. Girija Devi

Abstract

A sample of eighty numbers was selected from a total population of 800 elderly for dietary pattern and bio clinical assessment. The nutritional intake and dietary pattern of the samples were taken and bio clinical assessment was done. The nutritive value of the diet was calculated using Food Composition Tables. Bio clinical assessment was also done. Serum glucose level, serum cholesterol level, hemoglobin level and blood pressure of the samples were estimated. The study revealed that women elderly have lower nutritional intake and poor clinical assessments when compared to their male counterparts. A cohort study has also been carried out in order to find whether any feasible options are available to improve the quality of life of the elderly. It includes an intervention programme comprising diet counseling, yoga and meditation. The results obtained have been much impressive and hopeful.

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Aging is a natural process, spanning the life period from conception through birth - infancy - childhood-adolescence-adulthood-old age – to death. Each of these stages has unique characteristics and vulnerabilities requiring special attention to ensure optimum health during each stage. Aging is a steady and gradual process which has always been regarded as unfortunate but inevitable part of the cycle of life. It is a relentless process in life leading to its extinction.

India has the second largest number of elderly persons after China. As of 2011 Census reports, South India has the highest number of elderly persons above 60 years and will maintain its lead in the next 40 years. The highest proportion of elderly people is found in Kerala. In Kerala the elderly constituted 7.5 percent of population in 1987, 9 per cent in 2001, and 11 percent in 2011. One of the notable facts is the greater number of elderly women than elderly men. Kerala has 15 per cent more old women than any other state. The main reason for this is that Kerala is ahead of the rest of the country in fertility transition by 25 years. Decrease in fertility and mortality, a decline in the infant mortality rates,

and a continuing rise in life expectancy (currently the highest in India) have helped to create this situation. As the number of aged people increases, the main area of concern is regarding their quality of life.

The quality of life available to the majority of citizens of any country is a direct indicator of its state of economy. Quality of life can be interpreted as a person's sense of well being that stems from satisfaction or dissatisfaction with the areas of life that are important to them. Quality of life is a general feeling of happiness which is not a momentary experience but a long term sense of well being. It consists of experiences that cause a person to express his happiness. The condition of happiness and satisfaction clearly depends upon ability to survive, reasonable state of health and multiplicity of things that permit and cause the achievement of desires and aspirations.

Nutritional status of the elderly population is a major criterion in determining their better quality of life. Many elderly suffer from malnutrition. Malnutrition affects not only the general health of the person but also makes them more susceptible to disease and infection. A majority of the elderly, due to lack of teeth may not be able to munch and take hard and semi hard foods. This restricts the quality and quantity of food intake. This itself shows the relevance of conducting an in depth study on the nutritional intake of the elderly people.

Aims and Objectives:

The aim of the present study is to find out the nutritional intake of the elderly with the following objectives: to assess the nutritional intake of the elderly, to find out the relation with nutrient intake and selected variables along with their quality of life of the samples selected, and to develop and evaluate the effect of an intervention programme to improve the quality of life of the elderly selected for the study.

Methodology:

Thiruvananthapuram district, has been selected as the area for the present study. A total of 800 elderly people were selected as the sample for the study. The elderly people were identified using the voter's list. From this entire list, the samples were selected using systematic random sampling method. Equal considerations were given to both the genders. Even though, the rural – urban difference is hazy in Kerala (Nayar, 2000), proportionate sampling was done in order to get the proportionate number of samples from rural and urban areas.

Thiruvananthapuram district comprises 84 grama panchayats, 120 villages, 4 municipalities, 4 taluks, 1 district panchayat, 1 corporation. The district is divided in to four taluks, viz: Thiruvananthapuram, Neyyattinkara, Nedumangadu and Chirayinkeezhu. Almost all the urban areas come under the Thiruvananthapuram taluk. The four taluks comprise a total of 120 villages, which include urban and rural areas. Out of these villages, every third village (41)has been selected as the area for study. A detailed interview scheduled was prepared to find out the personal and socio economic details of the sample. A quality of life assessment scale was used to identify the level of quality of life enjoyed by the samples. 24 hour recall method and bio clinical analysis were used to find out the nutrient intake of the elderly. An intervention programme was chalked out in the form of a cohort study to find out the possible measures in improving the quality of life of the elderly. In order to check the effect of the intervention programme developed, clinical assessment were done before and after the study. The results of the data collected were statistically analysed using appropriate tools.

Personal background of the samples:

The personal background regarding the subsamples is given in table no:1.

Table no:1 - Age wise distribution of the sub samples

Particulars	Male (n=40)	Female (n=40)	Total (n =80)
Age (in years)			
60 :69	21 (52.5 %)	27 (67.5%)	48(60%)
70:79	11(27.5%)	9 (22.5 %)	20(25%)
80 +	8(20%)	4 (10%)	12(15 %)

A sub sample of eighty numbers was selected in order to study the nutritional intake of the samples in detail. It consists of equal number of samples from both the genders (40 nos each). From the above table, it was found that 60 % of the sub samples belong to the age group of 60 to 69 years of age, 25 percent belongs to the age group of 70 to 75 years of age and 15 percent of the sub samples belong to the age group of 80 years and above.

Sub sample study:

The present article deals with the nutritional intake of the elderly that was carried out on the sub samples of the main population. It includes dietary pattern and bio clinical assessment of the samples. A twenty-four hour recall method was planned to find out the nutritional intake and dietary pattern of the samples and bio clinical assessment was done to understand the health profile of the elderly. With the help of these data, nutritive value of the diet was calculated using Food Composition Tables. The eight nutrients thus calculated were energy, protein,calcium, iron, vitamin A, thiamine, riboflavin and vitamin C. The nutritive values obtained were then compared with the RDA suggested by ICMR, 1998 (www.icmr.nic.in). Bio clinical assessment was done among the sub samples to find out the health conditions of the elderly. Serum glucose level, serum cholesterol level, hemoglobin level and blood pressure of the samples were estimated with the help of a qualified nurse. The results obtained were compared with the standard values.

Dietary pattern of the elderly

Malnutrition among the aged is caused by a number of factors such as conditioning of the family, poverty, ignorance, superstition, inability to chew, increased incidence of diseases and disabilities which lead to alteration in the dietary intake, lack of interest in eating and misconception concerning diet (Dave and Mehta, 2008).

Table no: 2 : Nutrients present in the daily diets of the elderly

Nutrients	Gender	RDA	Mean	SD	t	p
Energy (Kcals)	Male	1973	1822	351.1	2.71**	0.01
	Female	1704	1793	351.1	1.55	0.13
Protein (gms)	Male	55	72.7	116	0.97	0.34
	Female	45	64.8	38.4	3.14**	0.003
Calcium (mg)	Male	880	518.4	201.1	11.37**	0.00
	Female	865	612.2	237.2	6.48**	0.00
Iron (mg)	Male	40	13.5	4.6	36.74**	0.00
	Female	40	22.2	54.3	2.00	0.054
Vitamin A(µg)	Male	998	2530.5	2710	3.58**	0.001
	Female	996	2569.3	2650.3	3.61**	0.001
Thiamine (mg)	Male	1.2	1.00	0.3	4.54**	0.00
	Female	1.2	1.1	0.3	3.09**	0.004
Riboflavin (mg)	Male	1.1	0.82	0.3	5.7**	0.00
	Female	1.1	0.9	0.4	3.1**	0.004
Vitamin C (mg)	Male	42	81.5	63.6	3.93**	0.00
	Female	38	73	67	3.18**	0.003

*** Significant at 0.01 percent level; N= 80*

A 24 hour recall method was used to assess the dietary pattern of the elderly. With the help of the data, nutritive value of the diet was calculated using food composition tables. The eight nutrients thus calculated were energy, protein, calcium, iron, vitamin A, thiamine, riboflavin and vitamin C. The nutritive values obtained were then compared with the RDA suggested by ICMR (1998). The mean intake of the eight nutrients is presented in table no.2.

The mean energy intake of elderly women was higher than the RDA, unlike in the case of elderly men. The mean intake of protein, vitamin A, and vitamin C were higher than that of the RDA in both the cases, while the mean intake of calcium, thiamine and riboflavin presented as different picture. The mean intake of iron is found to be very low among both the genders. The mean intake of protein and energy by elderly men were found to be statistically significant at one percent level, while in the case of elderly women, the mean intake of protein, calcium, iron, vitamin A, thiamine and riboflavin were found to be significant at one percent level.

Mehta, Chauhan and Khurana (2008) reported that elderly women were more likely to consume calcium and iron supplements as soon as they attained the age of fifty. Moreover elderly women were observed to prefer to eat more leafy vegetables than elderly men (Soman, 1992).

These may be the factors responsible for the high intake of calcium, iron, vitamin A and riboflavin among the elderly women in the study.

Influence of selected socio – economic variables on the nutrient intake of the elderly:

The nutrient intake of the elderly was also compared with certain selected variables to depict a clear picture on the nutrient intake of the sub samples. The variables selected for the study were gender, age, place of residence and quality of life.

While comparing the nutrient intake of the elderly with gender, it was found that the intake of nutrients like energy, protein and vitamin C were found to be comparatively higher among elderly men, where as the intake of the nutrients like calcium, iron, vitamin A and riboflavin were higher among elderly women. Thiamine intake was found to be equal among both the genders. How ever, the deviation was not statistically significant.

Comparison of the nutrient intake of the elderly based on age:

Table 3 shows the comparison of the nutrient intake of the elderly based on different age groups.

Table no: 3 : Comparison of the nutrient intake of the elderly based on age

Nutrients	Age	Mean	SD	F	p
Energy (Kcals)	60-69	1818	371.4		
	70-79	1729	317.7	1.35	0.266
	80+	1957	324.2		
Protein (gms)	60-69	62.4	35.6		
	70-79	80.1	138.3	0.4	0.674
	80+	60.2	15.7		
Calcium (mg)	60-69	599.3	207.3		
	70-79	493.6	239.8	2.32	0.106
	80+	623.1	184.4		
Iron (mg)	60-69	21.2	49.2		
	70-79	12.3	4.3	0.53	0.593
	80+	14.1	3.8		
Vitamin A(µg)	60-69	2625.7	2496.2		
	70-79	2258	2370.8	0.6	0.55
	80+	3459.2	4298.7		
Thiamine (mg)	60-69	1	0.3		
	70-79	1	0.3	0.09	0.916
	80+	1	0.2		
Riboflavin (mg)	60-69	0.9	0.4		
	70-79	0.8	0.3	1.21	0.302
	80+	0.7	0.2		
Vitamin C (mg)	60-69	75.2	53.7		
	70-79	72.6	63.2	0.85	0.433
	80+	106.8	116.1		

Results show that the intake of the nutrients like energy, calcium, vitamin A and vitamin C were found to be higher among the age group of above 80 years, when compared to the other two groups; whereas the intake of iron, riboflavin were found to be higher among the age group 60-69 years of age. Thus it was found that there is no significant difference in the nutrient intake of the elderly based on age.

Comparison of the nutrient intake of the elderly based on place of residence:

The nutrient intake of the elderly based on their place of residence was compared and is depicted in table 4.

Table no.4 : Comparison of the nutrient intake of the elderly based on place of residence

Nutrients	Locale	Mean	SD	t	p
Energy (Kcals)	Rural	1781	300.3		
	Urban	1877	526	0.95	0.345
Protein (gms)	Rural	71.3	94.7	0.63	0,530
	Urban	55.7	15.7		
Calcium (mg)	Rural	554.9	219.3	0.8	0.427
	Urban	605.6	232.6		
Iron (mg)	Rural	18.2	41	0.36	0.718
	Urban	14.3	6.2		
Vitamin A(µg)	Rural	2384.8	2382.5	1.3	0.191
	Urban	3372.4	3484.9		
Thiamine (mg)	Rural	1.00	0.2	2.06*	0.043
	Urban	1.2	0.4		
Riboflavin (mg)	Rural	0.8	0.3	1.15	0.253
	Urban	0.9	0.6		
Vitamin C (mg)	Rural	71.2	58.1	1.71	0.092
	Urban	102.1	82.3		

** Significant at 0.05 percent level; N= 65 (rural), 15 (urban).*

On comparing the nutrient intake of the elderly with respect to their place of residence, it was evident that the intake of almost all the nutrients except protein and iron were found to be high among those respondents residing in urban areas. The difference in the thiamine intake (t value = 2.06) among the rural and urban elderly was found to be statistically significant at 5 percent level.

Comparision of the nutrient intake of the elderly based on quality of life

A comparison was also done on the nutrient intake of the elderly based on their quality of life.

The quality of life of the elderly was assessed using a "Quality of life assessment scale". Consisting of 80 statements under eleven attributes such as physical well being, family life satisfaction, friends, living arrangement, economic well being, psychological well being, recreational activities, religious activities, social network, health and decision making. The samples were grouped into three categories, like low, medium, and high, based on the over all scores obtained by them from the assessment scale. Those who obtained scores less than 160, out of the total score 400, were grouped under "low" quality of life status; those having the scores between 160 and 320 were grouped under "medium" quality of life status, and those who obtained scores above 320 were grouped under "high" quality of life status.

It was interesting to note that no sub samples were having low level of quality of life. Among the eighty samples selected, forty four samples enjoyed medium level of quality of life and thirty six samples enjoy high level of quality of life. The above table 5 clearly reveals that the intake of almost all the nutrients except protein, thiamine and vitamin C were found to be higher among

those elderly who enjoy medium level of quality of life; where as the intake of thiamine remains same among both the groups and the intake of protein and vitamin C were found to be higher among those elderly who enjoys better quality of life. This means that there is no significant difference in the nutrient intake of the elderly based on their quality of life.

Table no:5: Comparison of the nutrient intake of the elderly based on their quality of life

Nutrients	QOL	Mean	SD	t	p
Energy (Kcals)	Medium	1863	320.1	1.82	0.072
	High	1721	376.1		
Protein (gms)	Medium	63.3	35.8	0.58	0.565
	High	74.5	122.2		
Calcium (mg)	Medium	599.4	234.4	1.58	0.118
	High	521.6	198.8		
Iron (mg)	Medium	21.4	49.7	1.06	0.294
	High	12.7	4.2		
Vitamin A(µg)	Medium	2910.7	2776.9	1.29	0.202
	High	2153.5	2403.9		
Thiamine (mg)	Medium	1	0.3	0.3	0.767
	High	1	0.3		
Riboflavin (mg)	Medium	0.9	0.4	0.8	0.425
	High	0.8	0.3		
Vitamin C (mg)	Medium	76.8	69.1	0.04	0.966
	High	77.6	57.9		

Bio clinical assessment was done among the sub samples to find out the health conditions of the elderly. The sub samples were randomly selected from the total sample size. Bio clinical assessments like serum glucose level, serum cholesterol level and blood pressure of the samples were estimated with the help of a qualified nurse.

Details regarding the serum glucose level are presented in figure 1.

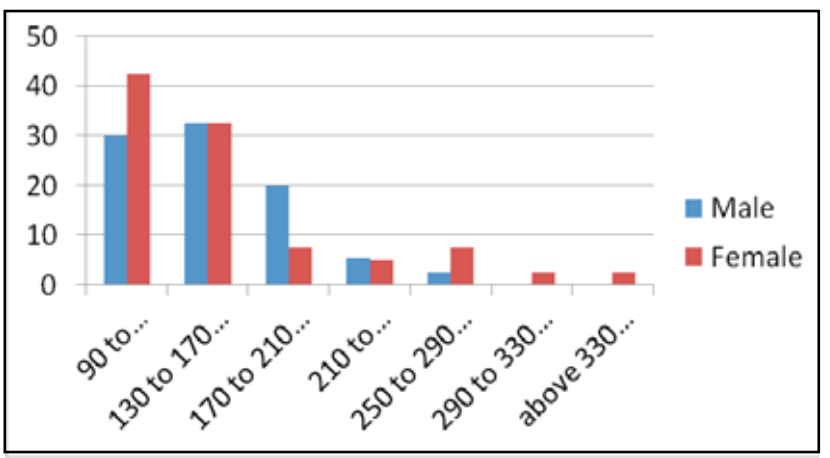

Figure no.1 Serum glucose level of the samples

Random serum glucose level of the elderly was taken for the bio clinical assessment. The normal range is between 90- 130 mg/ 100ml. It was found that 42.5 percent of the elderly women and 30 percent of the elderly men were having their glucose level in the normal range. About 32.5 percent of both men and women respondents were having their glucose level between 130- 170 mg/ 100ml. Another twenty percent of the elderly men and 7.5 percent of the elderly women were having their glucose levels between 170-210 mg/100ml. Serum glucose levels of 2.5 percent of the elderly men and 7.5 percent of the elderly women were between 250-290 mg/100ml. Further higher levels of glucose levels were observed among elderly women only. About 2.5 percent each of the elderly women were having their glucose levels as 290-330 mg/100ml and above 330 mg/100ml. This clearly indicates that glucose levels is found to be higher among elderly women when compared to elderly men among the sub samples, which is a direct indicator for the occurrence of higher number of diabetes mellitus among the aged persons.

The normal range of cholesterol level is up to 200 mg/ 100ml. The cholesterol level of about 67.5 percent of the elderly men and 75 percent of the elderly women was in the range of 120-200 mg/100 ml, which was found to be normal. About 32.5 percent of the elderly male and 22.5 percent of the elderly women were having their cholesterol in the range of 200- 280 mg/100ml. Another 2.5 percent of elderly women were having their cholesterol level above 280 mg/100ml and there was no elderly men coming under this category. To sum up, the data shows that the high level of cholesterol was found to be more common among elderly men than elderly women.

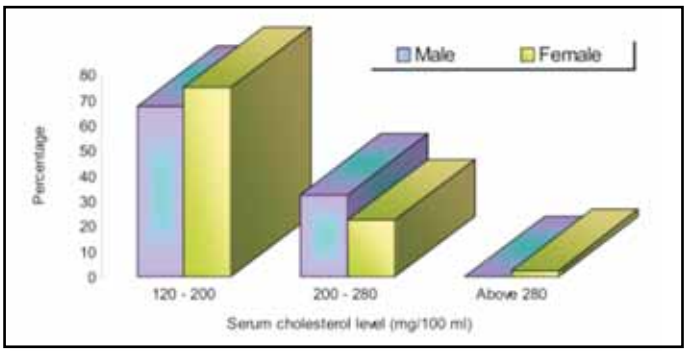

Figure no:2 - Serum Cholesterol Level

According to Dhaar and Robani (2006), the normal range of blood pressure level for the people above 60 years of age is in between 90/ 140 mm of Hg. It was found that about sixty five percent of the elderly men have normal blood pressure, whereas it was 47.5 percent among the elderly women. Hypertension was found to be high among elderly women (52.5 percent), when compared to elderly men (35 percent).

Durnin (1994), in his study observed that about 66.3 percent of the elderly women suffer from hypertension, and the reason he cited for the high prevalence of blood pressure among elderly women is that, women in older ages tend to have more psychological problems, which lead to depression and related mental disorders there by affecting a sudden rise in their blood pressure level.

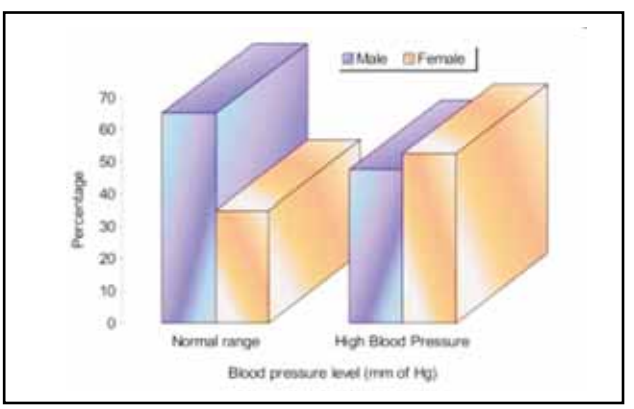

Figure no: 3 - Blood pressure level of the elderly

The normal level of haemoglobin among adult female is between 11.5 – 16gm/ 100 ml of blood and 13- 18gm for adult male. The results of the laboratory investigation shows that half of the elderly women (50 percent) and 45 percent of the elderly men had normal haemoglobin content in their blood, whereas the remaining samples show the prevalence of anaemia. High prevalence of anaemia was found among elderly men than elderly women, which seems to be different from other studies.

According to Shetty and James (1994), the prevalence of anaemia among elderly men may be due to multifactorial with aetiology as nutritional, physiological and pathological problems. Anaemia among elderly women is related to multiple pregnancies, nutritional imbalances, menstruation and other gynaecological problems.

The anthropometric measurements such as height and weight of the sub samples were taken. With the help of the weight and height measurements the Body Mass Index (BMI) was calculated as per Srilekshmi (2006). The sub samples were then further categorised according to BMI. The details regarding the grading of the sub samples are given in table no.6.

Table no.6 – Categorisation of the BMI of the sub samples

BMI Grading	Male (40)	Female (40)	Total (80)
Normal	32 (80)	13 (32.5)	44 (55)
Grade I	5 (12.5)	20 (50)	25 (31.5)
Grade II	2 (5)	3 (7.5)	5 (6.5)
Grade III	--	--	--
Underweight	1 (2.5)	5 (13)	6 (7.5)

Figures in parentheses denote percentages.

Among the sub samples, 80 percent of the elderly men had normal BMI, whereas it was only 32.5 percent among elderly women. About 50 percent of the elderly women lies in Grade I obese category, but it was only 12.5 percent among elderly men. Grade II obese category comprises 7.5 percent elderly women and 5 percent elderly men. No subsamples were found in Grade III obese category. But it was interesting to note that 13 percent of the elderly women and 2.5 percent of the elderly men were under weight.

Cohort Study

A cohort study is a study in which subjects who presently have a certain condition and or receive a particular treatment are followed over a time period. A cohort is any group of individuals who are linked in some way or who have experienced the same significant life event within a given period. A cohort group may preferably be from a minimum of 5 to a maximum of 15 members. Smaller the group, the effectiveness, feasibility and evaluation of the study will be greater. Four cohort groups were identified with twenty elderly people, from both the genders. Each group comprising five members each. They were selected based on their preference and willingness to undergo a six months programme without any hesitation. The groups were asked to meet on every weekends. The cohort group has been under observation for a period of six months. During this period, an intervention programme was charted out for them in order to find out whether any improvements can be made possible in the quality of life of the elderly. The intervention programme consisted of diet counseling, yoga and mental counseling. Bioclinical analysis of the cohorts was done before and after the intervention programme. It was felt that, lack of knowledge about the role of nutrients, superstitions and wrong selection of food were the major factors contributing to over weight among the elderly. Hence, with the help of a registered dietician, the cohorts were given diet counseling and were given a thorough knowledge about the importance of maintaining the body weight as per the ideal standards. Further, modifications were made on the diet of the cohorts and were advised to follow the same. An evaluation book was maintained with the cohorts to record their daily diet. The evaluation was made on every two weeks and was continued for six months. The cohorts were given a pamphlet showing the importance of diet during old age with a sample.

Table no: 7 Cohort study results of group one- Pre intervention results

Age (in years)	Gender	Height (in cms)	Weight (in kgs)	BMI (kg/m²)	Grade
61	Female	153	65	27.77	Obese I
65	Female	150	59	26.22	Obese I
69	Female	150	64	28.44	Obese I
78	Male	171	80	27.39	Obese I
68	Male	152	58.5	25.32	Obese I

Particulars			Pre Intervention			
Sample	Age (in years)	Gender	BP (mm of Hg)	BS (mg/100ml)	CH (mg/100ml)	Hb (gm/100ml)
1	61	Female	150/90	270	195	10.9
2	65	Female	150/110	117	240	13
3	69	Female	140/89	125.1	187.5	11.7
4	78	Male	150/90	202.5	196.5	12.4
5	68	Male	165/90	196	160.4	11.2

BP: Blood Pressure; BS: Blood Sugar; CH: Cholesterol; Hb: Haemoglobin

The healing power of yoga is well known to get quick relief from stress and strain for the people of all age groups. With the help of a trained yoga master, the cohorts were given a fifteen day crash programme on yoga, which dealt with a basic course in yoga. During this session, the cohorts were given psychological counseling also, in order to get rid off from the psychological disturbances in their life. There after, the cohorts were instructed to continue yoga with the help of the pamphlet distributed to them. Anthropometric measurements and bio clinical analysis were done before and after the intervention programme.

Table no:8 Post intervention results

Age (in years)	Gender	Height (in cms)	Weight (in kgs)	Post BMI (kg /m²)	Deviation	Bio clinical assessments			
						BP (mm of Hg)	BS (mg/100ml)	CH (mg/100ml)	Hb (gm/100ml)
61	Female	153	59	25.21	-2.56	140/90	195	197	11.4
65	Female	150	53	23.55	-2.67	130/90	115	204	13
69	Female	150	60	26.66	-1.78	140/90	125	160.5	10.2
78	Male	171	79	27.05	-0.34	142/90	198	198.4	13
68	Male	152	50	21.64	-3.68	130/90	181	171.5	13.2

BP: Blood Pressure; BS: Blood Sugar; CH: Cholesterol; Hb: Haemoglobin

It is clearly evident from their results that the intervention programme definitely had an impact on the health status of the elderly under observation. Diet modification had definitely helped to control the blood sugar and cholesterol level of the cohorts. Visible changes in the weight loss were also noticed among the cohorts; which itself is a positive sign towards the intervention programme. Psychological counseling, yoga and regular exercise helped a great deal to reduce stress and tension among the cohorts. This is clearly evident from their blood pressure level of the cohorts after the intervention programme. An elderly camp was also organized for a day, so that these elderly could meet together and can share their experiences. Dieticians, counsellors and yoga master took classes and were given a better insight on their results.

Conclusion

From the present study it can be concluded that the occurrence of under nourishment and over nourishment are more among elderly women. The higher ranges of glucose levels and blood pressure

levels were found to be higher among elderly women than elderly male, which is a direct indicator for the occurrence of higher number of diabetes mellitus and hyper tension among the elderly women. Elderly women suffer from various nutritional problems when compared to their male counterparts. Diet counseling, yoga, meditation etc can definitely help the elderly to improve their quality of life at large.

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Assessment And Management: Dementia

Lebia Gladis

Abstract

This research paper attempts to assess the conditions of dementia patients, their symptoms, after effects, their mental and physical short comings and process of management in handling them. This paper is based on a study that attempted to find out the social conditions of dementia patients. The study also aimed to find out the changes that take place in the personality of the dementia patients due to the loss of several capacities that they had earlier. This study also investigated the nature of interaction pattern and the burden of caring experienced by the families of persons with dementia. The research design used in this study is descriptive cum explorative. The universe of the study was dementia patients at 'Alzheimer's and Related Disorders Society of India,' Palarivattom. Simple random sampling was used in this study. Interview schedule was used to collect the data. The perspective of 'Activity and Disengagement' theories provide theoretical base to the study.

Keywords: ***Dementia***

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Dementia is the state when the brain loses the capacity to function properly. Dementia is not a single disease in itself, but a general term to describe symptoms such as impairments to memory, communication and thinking. All dementias are caused by progressive brain cell death that happens over a period of time. While the likelihood of having dementia increases with age, it is not a normal part of aging. Minor cognitive impairments such as poor short-term memory, can occur as a normal part of aging. This is known as age-related cognitive decline, and not dementia.

Common problems associated with dementia

A person with dementia may demonstrate any of the following problems, mostly due to memory loss - some of which they may notice themselves, while others may only be singled out by carers as a cause for concern. The signs used to compile this list are published by the American Academy of Family Physicians (AAFP) in the journal *American Family Physician* (2001).

- Recent memory loss - a sign of this might be asking the same question repeatedly, forgetting about already asking it,
- Difficulty completing familiar tasks - for example, making a drink or cooking a meal, but forgetting and leaving it,
- Problems communicating - difficulty with language by forgetting simple words or using the wrong ones,
- Disorientation - with time and place, getting lost on a previously familiar street close to home, for example, and forgetting how they got there or would get home again,
- Poor judgment - the AAFP says: "Even a well person might get distracted and forget to watch a child for a little while. People with dementia, however, might forget all about the child and just leave the house for the day,"
- Problems with abstract thinking - for example, dealing with money,
- Misplacing things - including putting them in the wrong places and forgetting about doing this,
- Mood changes - unlike those we all have, swinging quickly through a set of moods,
- Personality changes - becoming irritable, suspicious or fearful, for example,
- Loss of initiative - showing less interest in starting something or going somewhere.

Dementia – The Indian Scenario

'Dementia in Indian perspective' the first national seminar conducted by K.R.Chadda, gives us a lot of information regarding the significance of dementia in Indian context. It was the personal traumatic experience of caring his father late Rev. O.C. Kuriakose Kor Episcopal that led Dr. Jacob Roy, a pediatrician by profession, to turn zealously to form a society for the care and support of people affected with dementia. It is estimated that there are three million dementia patients in India and the number of them will be increasing shortly. The available data shows that by 2020 India will be the most affected country in the world with vast number of dementia patients.

Taking care of a person with dementia takes a big toll on the family. Institutions are needed to take care of them and also to relieve the caregivers, in particular, from stress. However, for quality care that is cost- effective, there is nothing like home care. There is a need for good support systems, which are woefully lacking in India.

In urban setting, due to the rapid nuclearisation of families, the parents are often found living alone as their children have set up their own independent homes in places away from their home town. In such cases, when one of the spouses develops the dementia, the strain on the other spouse will be tremendous. The absence of external support in the form of community dementia services or day care facility for the demented elderly is acutely felt in this situation.

Also in modern times, very often both the husband and wife have jobs. The family do not have any other option but, to lock up the demented person inside the house when they are away at work. This severely affects the quality of life of the demented and causes intense feeling of guilt in the care givers.

In the initial stage of dementia, the affected are often misunderstood by their families and are met with their antagonistic stance. This exacerbates the distress of the demented individuals and caregiver's interpersonal problems in the families.

Methodology

This research paper is based on a study undertaken in Kochi to find out the socio demographic profile of dementia patients, to disclose the warning signs of dementia, to study the changes in dementia patients which had led to loss of their selfhood and of competence, and to find out different management strategies for the care of dementia patients. The universe of the study was dementia patients at 'Alzheimer's and Related Disorders Society of India,' Palarivattom. Lottery method of random sampling was used to select the respondents. Interview schedule and key informant interview were used to collect the data. Some of the respondents were met at the centre and others at their respective homes. Each interview with care givers as well as the dementia patients took an average of 30 minutes each.

Theoretical Framework

Activity Theory by Lemon Bengston & Peterson and Disengagement theory by William Henry and Elaine Cumming formed the theoretical base for the study. This theory emphasizes that continuing activity through social roles is required for every person in order to attain high life satisfaction in life. It is argued that in order to be happy in later life, people should remain active in their role relationship as far as possible. The theoretical perspective of activity theory is used in the study. Disengagement theory is a model originally proposed in 1961 by William Henry and Elaine Cumming, two social scientists interested in studying aging and the way interactions with other people change as people grow older. Disengagement theory refers to an inevitable process in which many of the relationships between a person and other

members of society are severed and those remaining are altered in quality. Withdrawal may be initiated by the aging person or by society, and may be partial or total. It was observed that older people are less involved with life than they were as younger adults. As people age they experience greater distance from society and they develop new types of relationships with society.

The high level of deterioration of mental capacities in dementia patients, withdraw them from social relationships and activities. In the case of dementia patients, engagement in activities and social interaction can bring about lot of changes and improvement in their personality. Hence these form an essential part of management of dementia cases.

Socio-demographic Profile of the respondents

Particulars	Respondents	Number	Percentage
Sex	Male	11	22
	Female	39	78
Age Group	60-70	2	4
	70-80	6	12
	80-90	42	84
Marital Status	Married	36	72
	Un Married	13	26
	Unwed mother	1	2
Religion	Hindu	16	32
	Christian	31	62
	Muslim	3	6
Place of living	Rural	8	16
	Urban	42	84
Family System	Nuclear Family	35	70
	Joint Family	10	20
	Single life	5	10

Findings

An analysis of the personal profile of the respondents is necessary in any study because through it alone would the reader get to know the respondents of the study. It was seen that females out number males. 78 % of the respondents were females. It may be due to the fact that generally women outlive men. In the case of their marital status, most of the respondents are married. Although all the respondents were aged sixty years and above, it was seen that 84%percent of the respondents were above 80 years of age. With regard to religion the number of Christians is greater than any other religious group (62%). Also, since the study was conducted in a Christian institute there is more possibility that Christians had a special preference to join this particular institute. The study was conducted in an urban area and naturally most of the respondents belonged to nuclear families. Among the respondents, 84%belonged to urban area and 70% belonged to nuclear families. Urbanisation would also have brought about changes in the family structure that led to a loss of status of the elderly.

A specific objective of this study was to find out the initial signs or warning signals of dementia. These were studied from different perspectives like, physical, social and psychological. The findings regarding this are discussed below. With regard to physical aspects, it was found that respondents had already lost or were in the process of losing their cognitive abilities like memory, listening capacity, language, judgment and orientation. It was seen that they lost their capacity to manage their affairs and even simple skills of personal care. The details are as follows: 98%of the

respondents were not able to remember their phone numbers, date, month and year. 50% of the respondents had difficulty in coordinating time, and, in understanding day and night. 64% of the respondents misplaced objects frequently.62% of the respondents failed to recognize relatives and bystanders.

With regard to socio-psychological signals of dementia, previous studies have shown that persons with dementia become unusually emotional and experience rapid mood swings for no apparent reason. This study however proved otherwise. Mood swings and sudden outbursts of anger or frustration were absent among the respondents. It was seen that 82% of the respondents did not express signs of fear, and 74% were not afraid of being alone. It is inferred that this is due to the strong family tie that exists in Kerala and the place and honor given to the elderly in our culture.

Another objective of the study was to assess the difficulties faced by the respondents. Studies reveal that people with dementia often find it hard to complete everyday tasks that are routine tasks. It was seen that 38% of the respondents had difficulty in performing daily tasks. 96% of the respondents felt that they were not confident to visit a bank and discharge business there as they used to do earlier, they were also unable to do shopping for themselves or for their family as earlier.78% of the respondents needed help and assistance in brushing teeth, taking bath etc. 90% of the respondents expressed their inability to take any decision.72% of the respondents had difficulty in expressing themselves properly and so hesitated to interact with people.

Management Strategies

Taking care of demented individuals needs specialized skills, which are not usually possessed by caregivers. Consequently, the quality of life of the demented elderly are very low and their families experience severe burden generated by the long care- giving process. The study analysed how to handle these patients and found few management strategies which are helpful to cope with the dementia patients- adjustments, love and care, patience and understanding their feelings.

Family members caring for dementia patients must often contend with a complex set of behavioural problems evidenced by their demented older relatives. In this study we examined how strategies to manage dementia problems in older people were associated with the adjustment of family members while providing assistance to the patient. Four Dementia Management Strategies were identified. After controlling for the influence of family member and patient background characteristics and family member coping, Dementia Management Strategies accounted for significant and unique variance in family members' burden and desire to institutionalize the patient.

Taking care of a person with dementia takes a big toll on the family. Institutions are needed to take care of them and also to relieve the caregivers, in particular, from stress. However, for quality care that is so effective, there is nothing like home care. There is a need for good support systems, which are woefully lacking in India. Some organisations such as Alzheimer's Disease international (ADI), an umbrella body of national Alzheimer's associations around the world, is creating an awareness and managing people with dementia., particularly in developing countries. Just as with mental illnesses, a stigma is attached to dementia. Families are reluctant to admit that they have someone with dementia problem for fear of social consequences. This is why awareness about dementia is urgently needed.

Conclusion

Data analysis reveals that the interaction pattern in the majority of these families was categorized as being low particularly with regard to leadership, role, cohesion and communication. Family burden experienced was high in terms of disruption of family interaction leisure and routine family activities. Dementia causes tremendous psychological strain on the patient and his family. Legal and financial disputes often become complicated when an individual is no longer competent to manage his own affairs. Socially the family may find it hard to sustain the same life style when the patient is unable to act responsibly. The family faces many difficult decisions as the disease progresses. Often the most difficult decision is whether or when to place the patient in a nursing home during the later stages of the illness.

To conclude, the study has made an attempt to examine and find out the various factors of dementia and its impact on the victim as an unbecoming self of the person. With the help of more researches and investigation in this area the treasure of the society the elderly may have a better treatment and care. It is amazing to know that many people who are engaged in activities promote awareness of the disease and give instructions to the family members how to take care of them. As long as we love our older generation as phrase goes "Old is Gold," let us continue to love and care them.

No doubt awareness about dementia is slowly but steadily increasing in country. But in a large country like India we still need to do a lot of hard work before dementia gets included in the national health agenda. There is still lack of understanding about the suffering of the affected person and the families. We need to inform a national net work to work for the dementia patients, thus all of us can make a difference in the lives of people with dementia. The problem of the elderly must be addressed to urgently and with utmost care. There is urgent need to amend the Constitution

for the special provision to protection of aged persons and bring it in the periphery of fundamental right. With the degeneration of joint family system, dislocation of familier bonds and loss of respect for the aged person, the family in modern times should not be thought to be a secure place for them. Thus, it should be the Constitutional duty of the State to make an Act for the welfare and extra protection of the senior citizen including palliative care. We hope several studies will impact on policy makers, and offer relief to people with dementia and to their families.

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Nightingale Medical Trust: Case Study

Joy Mukhopadhyay and Malavika (Dola) Chatterjee

Abstract

India has the largest population of young people in the world. But in western countries there is the concept of social security. There is no indication that India will have a system of social security in near future. There are many organizations working for the elderly. One such organization, Nightingale Trust, has been doing yeomen service in this field. The Trust, established in Bangalore in the year 1996 with the primary objective of taking care of the elderly people, in the last two decades, has grown rapidly with different services and received many accolades from the stake holders and government. This is a case study on the said trust. It gives the details about the Trust, its history, organization and details of service activities. The case study also includes interviews with the management and beneficiaries. This case study proves that proper management of resources along with a compassionate attitude can work wonders.

Key words: *Senior Citizens, Elderly Care, Charitable Trust*

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Populations in Western countries are now skewed with higher percentage of senior citizens. In India, the situation is just opposite. India has the largest population of young people in the world. But there is a glaring difference, in Western countries there is the concept of social security. That is totally absent in India and there is no indication that India will have a system of social security in near future. Under these circumstances, it is imperative that we should take care of our senior citizens.

Care for senior citizens popularly called as Aged care or Elderly care, or simply Eldercare can be broadly defined as fulfillment of the special needs and requirements unique to senior citizens. This encompasses such services as assisted living, adult day care, long term care, nursing homes, hospice care, and home care. In India, the traditional way of life takes it for granted that the children

take care of the elderly. However lately, because of transformation of joint families to nuclear families, change in lifestyle, children going to far-off places (including abroad) for employment, hectic urban life etc. traditional eldercare by children may not always be possible. Hence a systematic approach of eldercare by third party is becoming relevant.

Background

There are many organizations working for the elderly. They are typically run by religious organizations and mostly urban based. A partial list of such organizations is given in the Appendix. There are a few organizations in Bangalore city which is becoming a busy metropolis and getting the symptoms of hectic life schedule. One such organization, Nightingale Medical Trust, has been doing yeomen service in this field. The Trust was established in Bangalore in the year 1996 with the primary objective of taking care of the elderly people. In the last two decades, it has grown rapidly with different services and received many accolades from the stake holders and Government. This is a Case Study on the said trust. It gives the details about the Trust, its history, organization and details of service activities. The Case Study has been developed from information given by the trust and by personal detailed interview with Mr Prem Kumar Raja, one of the founders and Administrative Head of the Trust.

Nightingale Medical Trust

Establishment

Dr Radha Murthy and Mr Prem Kumar Raja started Nightingales Home Health Services (NHHS). This was after realization that there was an acute shortage of eldercare service in India. Soon enough the founders realized the greater scope of eldercare, it was not only medical attention, but also emotional and societal fulfillment. Thus Nightingales Medical Trust was established in 1998 with a vision of fulfilling all the needs of senior citizens. Over the years the Trust has increased its activities to a great extent and extended its service to larger areas including some nearby villages. The Trust was particular about one thing that it did not want to start yet another old age home. The major milestones in the history of the Trust are detailed below:

1999

Nightingales Elders Enrichment Centre (NEEC), a unique daycare centre for senior citizens was started. It is a place where elders gather and engage in a wide range of activities designed to meet their physical, emotional and social needs. With a registered membership of over 300, nearly 50 of them are regular visitors. The beneficiaries are mostly from the middle class. The benefits of the program are:

Health & Medicare: Services include medical checkup, lab investigations, injections, wound care, ECG and other health-related support. Counselling: We support individuals and groups as they face the emerging challenges in the changing environments of family and society. Practical guidance for enjoying old age and counselling on health, fitness, diet and nutrition are also provided.

Memory Exercises: Memory exercises help keep elders alert and mentally active.

Physiotherapy and Fitness Programmes: This programme promotes regular guided exercises based on individual needs. Exercises include yoga, pranayama (breathing) sessions for relaxation and special exercises for Parkinson's and Arthritis.

Total Daycare and Respite Care Facility: This programme is mainly for elders who are left alone at home during the day while family members are away. In situations where family members leave for a short period, a short-term stay facility is also available. This package includes bed facility, lunch and nursing aid assistance in addition to the use of other facilities at the centre. Both members and non-members can avail of these facilities.

Recreational, Cultural, Creative and Social Activities: Above activities are carried out. Newspapers, magazines, a good library, television and computers are available. Special sessions are held in music, literature and art display. Women's hour caters to the special needs and interests of female members. Talks and interactive sessions on topics of interest such as the essence of different religions, health and age-related issues, current affairs, etc. are also conducted. Members get to learn new languages, arts, crafts and games. We also celebrate birthdays, special days and national & religious festivals. Elders participate in tours, in visiting old age homes and undertaking community welfare schemes for underprivileged elders.

2000

Nightingales Lifesaving Services (NLS) was introduced in 2000. It was launched with the objective of increasing awareness about Cardio-Pulmonary Resuscitation (CPR) and creating a community of trained and confident lifesavers who can save precious lives during emergencies.

Till date, over 16,000 people including elders' family members, medical professionals, students, auto drivers, security personnel, policemen, corporate staff, industrial workers, etc. have been

trained in CPR. Additionally, about 17,000 people have been trained in first-aid. Having covered about a hundred organisations, NLS services have now been extended to other cities as well. The team of trainers comprises professional doctors and trained healthcare workers. NLS also conducts the following training: AED (Automated External Defibrillator), IV techniques, and

Medical Emergencies on Dental Chair (MEDC).

2002

Elders Helpline, a joint venture between the Bangalore City Police and the Trust was established. It is a pioneering service providing assistance to all senior citizens living within city limits. The Helpline propagates Nightingales Medical Trust's vision of ensuring a life of dignity and security to all elders, by combating harassment and abuse. All the services at this project are free. Till date about 1150 cases have been successfully resolved by Elders Helpline.

2004

A Day Care Centre for disadvantaged elders named Sandhya Kirana was set up in 2004. It was an initiative in partnership with the BBMP (Greater Bangalore Civic Corporation), with the intention of providing daycare facilities to economically disadvantaged senior citizens, where they can spend their day time with a range of services and facilities to fulfill their social, physical, financial and emotional needs. It ensures a better quality of life for disadvantaged elders. All the services are provided free. All senior citizens are eligible for registration. Over 50 elders avail of these services every day.

Health and Hygiene: Basic medical check-up, treatment for minor ailments, referral services, physiotherapy, yoga and fitness programmes, health education, counselling and health camps.

Skill Development and Income Generation: Identifying and utilising elders' skills and interest, different articles like greeting cards, paper bags, dolls, candles, mats, etc. are made and sold by the Trust.

2006

Rural Mobile Medicare Program

Under this project, the Nightingales Medicare van equipped with medical supplies, a doctor, a nurse and a volunteer attend to the health complaints of the elderly living in the outskirts of Bangalore. The team visits three centres on a pre-determined schedule, dispensing basic care and free medicines wherever required. Cases requiring specialised services are referred to nearby hospitals. Till date more than 26,000 cases have been attended to by this programme. On an average, nearly a thousand health complaints are attended to every month. Most of the complaints are of general body aches, weakness, cough, cold, fever, etc. A few of the cases also include those typical of old age like diabetes, hypertension, stroke and bronchial asthma.

2010

The Nightingale's Centre for Ageing and Alzheimer's was established.

Services offered for Dementia Patients

Memory Clinic for Screening & Assessment: The services include multidisciplinary specialist assessment, diagnosis and follow-up, information and education. These are valuable to the patients and caregivers who attend this clinic. The importance of early diagnosis and education can never be underestimated, particularly in dementia as this provides recognition of the disease itself and a tangible point of contact for carers who can be alleviated from burden of caregiving early and the patient can be rehabilitated early.

Long Term Care – In advanced stages of Dementia, the patients become totally dependent on care givers and need round the clock care. Difficult behaviours may also set in. Providing the care they need at home becomes almost impossible. The decision to move a loved one into long term care is difficult, but in the best interest of the patient it becomes essential. At the center, we have staff trained in dementia care and who have the ability to manage the difficult behaviors without having to resort to sedating medication. A therapeutic and secure environment is also provided. Non-pharmacological interventions are given priority.

Short Term / Respite Care: This is a great relief to the caregiver, particularly when they need to go out of station or just want a break from caring for a short period. You can rest be assured that your loved one will be well cared for.

Day Care: If looking after the person with dementia during the day is a problem due to work constraints, you can avail of day care service. We will provide patients activities to keep them occupied and entertained. This also provides us an opportunity to assess them in a different environment and gives them a platform to interact socially with our other patient.

Acute assessment: Sometimes dementia presents with very challenging behaviours. The reasons for this could be many, but it is important to assess and treat those behaviours if possible so that you can continue to care for your loved one at home. This

would be a short term admission just until the patient is more settled.

Fitness and Rehabilitation – The importance of physical fitness cannot be overruled at any age. Hence this centre which focuses on holistic approach for the elderly provides range of physiotherapy exercises as well as therapies for management of issues related to ageing. The concept of healthy ageing in reinforced through our fitness and rehabilitation centre which is open both for dementia patients and needy elders. Additional consultations with neurologist and physiotherapist can also be arranged. In addition to the above the center will also offer· short term admission for rehabilitation following stroke, fractures and for Parkinson's disease.

Training: Training is provided to caregivers (professional as well as family members), with hands on practice. Training of trainers is a specialty of this programme. There is a technical collaboration with Alzheimer's Australia.

Elders Enrichment Centre: Besides Alzheimer's Care, the Centre has an Elders Enrichment Wing with planned facilities and activities, addressing the physical, medical, emotional, economic and social needs of the elderly. The purpose of the Enrichment Center is to keep elders active both mentally and physically for their overall wellbeing.

Activities: Patients coming to the centre enjoy a range of meaningful and enjoyable activities in a therapeutic environment. The range of activities include art, music, pet, reminiscence, out-door and in-door games, and movement. Occupational-therapy based activities enhancing their day-to-day functioning are also incorporated. These activities are individualized and in accordance to the care-plan which is formulated by the multidisciplinary team upon admission.

Snoezelen Room: For people who have Alzheimer's disease or other types of dementia, over stimulating their senses—touch, sound, smell, taste, and sight—can help them reconnect with their environment. Snoezelen or multisensory stimulation provides sensory stimuli to stimulate the primary senses through the use of lighting effects, tactile surfaces, meditative music and the odour of relaxing essential oils. This allows them to react better to their environment and to the people who are part of it, and to experience inner peace and contentment.

Jobs 60+

A unique service offered by this centre is imparting skills and finding remunerative jobs for senior citizens. Elders, 60 to 70 years of age, in dire need of jobs are identified. Their functional and intellectual capabilities and needs are assessed and classified. Training is provided in computer literacy, accountancy, physical fitness and soft skills to adapt them to the present day changed working environment. An employment bureau functions at the Centre to liaison with potential employers and assist the trained elders get suitable placements. A 40 seater computer based data processing unit undertakes simple back office operations, outsourced by business establishments. The Centre offers a platform for elders with special skills to offer consultancy services. For those, who cannot work in offices, the Centre imparts vocational training in tailoring, making of candles, greeting cards, eco products such as paper bags, areca nut plates and cups, eatables like chocolates, pickles etc.

Nightingales Dementia Care: Dementia is a brain disorder and the most devastating illness of old age. Although there is no prevention or cure, systematic care coupled with sympathy and understanding alone can make a difference in the lives of those suffering from dementia. The services offered are:

Public Education: In view of the stigma attached to this disease in India, the dementia cases are pushed under the carpet and untold suffering within the family is the result. Attributing the symptoms to old age, early detection and systematic care are often neglected. Through public education we create awareness that dementia is only a disease that can happen to anyone and early detection and proper care could make an improvement in the lives of the patients. This programme includes interpersonal contacts, group meetings in senior citizens organizations, old age homes and educational institutions, display of posters in hospitals and publicity through media.

Community Screening: Elders are screened for symptoms and potential risks for developing dementia. A team of experts will conduct special camps using scientific tools anywhere in Bangalore for a minimum of 20 elders. For individuals, this facility is available at our centres.

Online Self Assessment: NMT, along with the Bangalore Chapter of ARDSI has launched a website *www.dementiabangalore.in* to enable elders and family members to have a self assessment of symptoms leading to dementia. The Website becomes significant as it helps people who hesitate to go out seeking help, and also as screening facilities are very few in Bangalore.

Counseling and Guidance through Helpline: In most cases, initial symptoms are ignored and attributed to age. Family members need to be educated about the nature and seriousness of the disease and about the do's and don'ts while handling the patients. A

Dementia Helpline is open 9 am to 9pm and operates on all days to provide information on dementia management

Support Group: The purpose of this group is to provide support to caregivers and thus allow them to cope better by:

Sharing their feelings and experiences, learning more above the disease and giving care, helping others through sharing of ideas and information and providing mutual support, encouraging caregivers to take care of themselves, knowing that they are not alone, and presently the group meets second Saturday of every month between 3 pm to 5 pm.

Training of Caregivers: Caregivers' job is very stressful and often leading to a breaking point. Besides sympathy and patience they need to have a good knowledge of the disease and understanding of the victims unpredictable behaviour. Periodical training is arranged for caregivers both professionals and family members at various levels.

Rehabilitation: Rehabilitative care in the different stages of dementia is a vital need in managing the behavioural symptoms and other associated physical limitations. The programme focuses on the patient's abilities and aims to promote independence in daily living. Experts provide rehabilitative care through physiotherapy, occupational therapy and speech therapy with prior appointment.

In-home Service: Cognitive and memory training can be carried out at patient's home to solve families' escort problem. Our Occupational Therapist or Physiotherapist design comprehensive care plans and home training to maintain patient's abilities in daily functioning. We also advise on home care management, behavioural management techniques and environmental safety and modification. Home Medical Services such as doctors visit, nursing care, diagnostic services etc could be arranged.

Day Care Centres: There are centres at Kasturinagar and Shanthinagar operating during day time. This provides respite service for families with dementia patients to have a break from the intensive care giving task. The persons with dementia can also benefit from a series of cognitive training and activities including reality orientation, reminiscence, memory training, music therapy, ADL training, art and craft operation.

Memory Clinic / Early Detection Centre: Early dementia and Mild Cognitive Impairment (MCI), a preclinical stage of Alzheimer's Disease, can be identified through screening tests and assessment by a Neurologist. Early intervention in this stage through medication can effectively help to delay the progression of clinical symptoms. Referral for medical investigations will be made when necessary. This service is provided with appointment

Elder Security Initiative

NightingalesTrace: Elderly persons suffering from Alzheimer's and other forms of Dementia are likely to go wandering and sometimes missing too. Responding to these challenges, Nightingales Centre for Ageing and Alzheimer's (NCAA) has launched Nightingales Trace for the safety of the Alzheimer's patients. This is a 24/7 service for elders with Dementia.

Dementia patient is to wear an ornamental bracelet. An identification number of the elder and the phone number of the NCAA are inscribed on it. On registration, the family has to furnish all relevant details of the patient. With the bracelet on, whenever the patient goes missing, easy identification is possible. Any concerned public spotting the person can contact NCAA and inform the ID number. At once, the Centre will inform the family about the whereabouts of the patient enabling easy rescue

Mobile Memory Screening: It is common to seek medical attention for physical discomforts. However, very little attention is given to mental problems. People hesitate in seeking help from psychiatric clinics and mental health institutions due to the fear and stigma attached to mental illnesses. Problems such as memory loss are ignored as a sign of increasing age and help is sought only when the condition has reached a more advanced stage. Hence to identify memory loss at an early stage, people should be encouraged to undergo screening and this service needs to be made available in a non threatening atmosphere, in the comfort of their community set up. Hence the mobile memory screening service was conceptualized to provide awareness and screening services for people in their community settings. The objective of this screening unit is to detect dementia early and to provide further help and assistance for persons found positive through the screening, and also to provide memory screening services to elderly persons (high risk age group for Dementia) at their doorstep in a comfortable atmosphere.

Steady Steps – a Fall Prevention Program: The Steady Steps programme aims at restoring elders to their highest possible level of functional capacity. It helps older adults and elders advance into old age with maximum mobility and fitness. This is an exercise-based approach that uses advanced training equipment. Health conscious elders and those suffering from problems like Arthritis, diabetes, heart ailments and other disabilities benefit from this programme. Individuals with mobility impairments, pain, musculoskeletal disorders, Parkinson's, chronic obstructive

pulmonary disease & coronary artery disease and those who need post- cerebrovascular accident/stroke, post-fracture or post-surgical care also find it useful. Interestingly, some elders who believe that drugs are not the only answer to their physical disabilities also make good use of this facility. The main focus of this programme is guided-physical exercise to correct all aspects of fall including causes, prevention, remedial measures and rehabilitation. Exercises are personalised and individually tailored.

The services include: Geriatric Assessment, Health Education, Counselling and Guidance, Guided Exercises, Balance and Fall Prevention Training, Post-fall Management, Strength and Flexibility Training, Physical Conditioning, Yoga and Pranayama, Rehabilitation, Special Exercises for Parkinson's, Incontinence and Arthritis, and

Domiciliary Service.

Training in Geriatric Care

Nightingales Medical Trust is conducting the following courses in Geriatric Care:

A. Certificate Course in Geriatric Care

This is a six-month long course conducted in association with the National Institute of Social Defense. The aim of this programme is to develop skilled professionals to take care of senior citizens, who need nursing care and assistance.

The subjects covered are: Social Gerontology, Basic Geriatrics, Applied Geriatrics, and Geriatric Nursing.

The trainees get practical hands-on experience at old-age homes, geriatric care centres, and hospitals. A stipend of Rs. 600/- is paid during the training period to all the admitted students.

B. Training in Home Nursing

This is a one-month training course that covers all aspects of bedside assistance. The course includes a one-week hands-on practical experience at the bedside of a patient. All students who successfully complete the course are guaranteed jobs through Nightingales Medical Trust.

C. Three-month Bed-side Nursing Course

This course is aimed at youth who wish to pursue work in home health service. This course is spread over a period of three months with more emphasis on hands-on experience.

Govt. Authorized Senior Citizen ID Cards

Nightingales Medical Trust has been authorised by the Government of Karnataka to issue ID cards to senior citizens above the age of 60 years. This card contains all the necessary details regarding the identity of the holder. This card, endorsed by a government authority, is an authentic proof of the date of birth and address of the card holder. The ID card enables elders to utilise the various benefits available to them, in hospitals, labs, medical shops, buses, railways, airways and other places. It is also helpful in times of emergencies, for easy identification.

Advocacy & Awareness

Nightingales Medical Trust makes consistent efforts to uphold the rights and privileges of older people, and to influence the government and decision-makers to focus on the well-being of the elderly. We regularly organise awareness and advocacy programmes through rallies, walks, exhibitions, seminars, talk shows, public hearing, workshops and by the issue of handbooks. These programmes have, over the years, led to tangible benefits for senior citizens. Some of the issues focused on so far, have been elder's security, bridging generation gap, finance planning, legal precautions, regulatory body for old age homes and setting-up of fast track courts.

The Trust has also been active in publication. It publishes a Newsletter. It has also published a series of Handbooks: Be a Cautious Senior Citizen, Seven Steps to Senior's Security, Old Age Homes In and Around Bangalore, The Elders Protection of Rights and Redressal of Grievances Act, and Concessions & Related Information to the Senior Citizens.

Findings and Conclusion

The trust is offering yeomen service and many of them are of unique nature. The main challenges faced by the trust are in the areas of finance and human resource management. The Trust has been successful enough in facing these challenges so far. The trust gets donations from different sources and some of the services offered are fee-based. There is always a need for more fund for widening the scope of services. The trust should approach big business houses who donate for social cause. For this, the trust needs to carefully document its activities and make presentation to gain attention of potential donors. There is need for a dedicated research and marketing team who can take up this challenge.

The other important area is human resource management. Any additional human resource is always welcome for sustaining and furthering the trust's activities. The trust must enlist more volunteers. It may approach educational institutes and offer internships to students who are inclined towards social service.

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Sumit, Mazumdar; Ulf-Goran Gerdtham (13). "Heterogeneity in Self-Assessed Health Status Among the Elderly in India." *Asia-Pacific Journal of Public Health*

www.nigtingalebangalore.com

www.nightingaleseldercare.com

Appendix:

Partial List of Eldercare Providers in Karnataka

1. Aid The Aged, 1492, 17th A Main Road, II Phase, J.P.Nagar, Bangalore-560078.
2. Arogya Matha Kendra, St.Lawrence Garden, Pademale PO, Mangalore-575005.
3. The Bangalore Friend-In-Need Society, 3, Colonel Hill Road, Bangalore-560051.
4. Canara Bank Relief and Welfare Society, 27th Cross, Banashankari II Stage, Bangalore-560070.
5. Eventide Home, St.Joseph's Convent, Whitefield, Bangalore-560066.
6. Human Relations and National Integration Trust, 'Shanti Bhavan', 10, Jayalakshmipuram, Mysore-570012.

Sl. No.	Name of the States/UTs	Grant Released (Figures are in Lakhs Rs.)					
		2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
1	Andhra Pradesh	458.51	412.12	454.26	423.82	478.74	
2	Arunachal Pradesh	0	0	0	1.49	0	4.08
3	Assam	79.22	87.29	94.58	102.32	77.48	18.16
4	Bihar	2.76	2.76	4.88	1.73	2.44	10.68
5	Chhattisgarh	1.18	5.97	5.08	7.76	9.03	4.88
6	Delhi	14.99	20.83	17.88	25.29	18.76	30.04
7	Haryana	35.7	29.1	74.4	56.73	50.73	11.56
8	Himachal Pradesh	3.42	0.6	0	9.51	4.99	1.22
9	Jammu & Kashmir	0.58	0	0	0	0	0
10	Karnataka	190.73	196.47	213.1	233.4	237.03	23.66
11	Kerala	2.22	0	0	21.07	6.9	0
12	Madhya Pradesh	8.02	9	13.2	7.25	14.79	7.72
13	Maharashtra	31.99	49.92	47.07	99.05	133.32	84.74
14	Manipur	98.99	120.16	118.74	140.73	121.67	65.67
15	Mizoram	0.99	3.87	1.29	0	6.18	0
16	Nagaland	1.38	0	0	0	0	0
17	Orissa	243.29	293.92	330.19	355.5	356.9	96.1
18	Puddhucherry	3.98	0	0	0	0	0
19	Punjab	13.66	10	17.47	15.87	31.62	5.79
20	Rajasthan	13.15	7.48	16.66	14.89	8.89	0
21	Tamil Nadu	205.67	209.62	260.32	263.8	242.14	38.95
22	Tripura	20.71	4.3	10.85	13.75	10.81	0
23	Uttar Pradesh	53.52	40.31	87.09	118.68	39.29	43.38
24	Uttarakhand	3.63	5.54	0	12.01	5.87	9.31
25	West Bengal	124.43	261.85	205.04	142.82	141.43	27.98
	Total	**1612.72**	**1772.1**	**1972.1**	**2067.47**	**1999.01**	**559.31**