Organization Profile

Center for Human Progress (CHP)

The Center for Human Progress (CHP) aims to improve the quality of life of individuals and society by supporting, promoting and encouraging knowledge mobilization for sustainable change. As a social change organization we aspire to build knowledge-based leadership and create community empowerment in the process. To achieve these goals we conduct the following activities.

- Life Skills Education & Coaching
- Training & Capacity Building
- Education & Awareness Building
- Communication & Advocacy
- Research & Documentation

Values

- CHP are driven by strong values, including Trust, Commitment and Respect.
- CHP treat all colleagues, partners and individuals with respect and trust, and lead through commitment, competence, creativity and teamwork.

Activity Report

Knowledge-Sharing Activities & Events

- Art for Life project launch on 15 May, 2010 at India Habitat Centre (IHC) and on 16 May, 2010 at Great India Place (GIP) mall, Noida presented by CHP with the support of NACO, UNDP, UNAIDS and MAKE ARTS/STOP AIDS (MASA) (May 2010)

- Children's Voices - An advocacy forum and comics exhibition conducted by PWN+ and Comics Worlds at India Habitat Centre (IHC), New Delhi on 19-20 March, 2010 with the support of UNICEF and CHP. (March, 2010)

- CHP in New Delhi, Kripa Foundation and Prodigal's Home in Nagaland and Care Foundation and Galaxy Club in Manipur conducted Knowledge FAN festival with the support of UNAIDS, India. This festival of youth and communities was held in Imphal, Manipur on 9-10 March, 2010. This first-of-its-kind festival in the north east brought together 300-plus young people and communities from over 30 organizations from the 2 high HIV prevalence states of Manipur and Nagaland to promote dialogue about HIV, health and human rights using various creative forms of expression. (March 2010)

- "Meri Awaaz/My Voice – A Celebration of Voices from the Ground" is a unique festival of voices from the ground which was held on 15 December, 2009 at India Habitat Center (IHC), New Delhi with the invaluable support of UNDP, DSACS and CFAR; and the engagement of NACO and UNAIDS. The festival brought together 1500 people, 60 organizations and every typology of at-risk community from across the geography of the Capital. Meri Awaaz/My Voice is part of a national-level initiative which aims to share knowledge, promote dialogue and support sustainable networking between and across communities and contexts. (December 2009) *Read Report*

- CHP has been awarded a grant by UNAIDS to lead a youth and community knowledge-sharing initiative in the north-eastern states of Manipur and Nagaland. The

project which is called "Knowledge FAN" will engage several hundreds of young people, communities and stakeholders across the two states. (November 2009-ongoing)

- CHP showcased their work at NACO's Red Ribbon Express launch in New Delhi on December 1, 2009. It presented two magnet theatre performances led by communities. One on truck driver's issues and another on MSM issues in collaboration with the Delhi State Training and Resource Center (STRC).

- Project 19 is unique national-level festival which celebrates health and rights and understands HIV in the context of the lives of young people and communities most at-risk and vulnerable to HIV infection. The national-level festival which took place in February 2009 aimed to consolidate CHP's ongoing efforts to create knowledge, promote dialogue and develops sustainable networking among and between young people and communities at-risk of HIV. The Project 19 festival was held at the India Habitat Center and Lok Kala Manch, New Delhi on the 15th and 16th of February, 2009. The festival brought close to 1000 young people and community members from across 50+ organizations and institutions from all over India together in New Delhi for two-days to share knowledge, dialogue and network based on knowledge exchange through use of various forms of expressions (film, music, art, theatre, dance etc.). This is an ongoing initiative and will be followed up with several local- and national-level events and activities to consolidate its goals. (February 2009)

- An expression of Empowerment is a community-led knowledge sharing event which was conducted at Dilli Haat to showcase photo essays developed by truck drivers and helpers of Sanjay Gandhi Transport Nagar (SGTN). They exhibited photographs reflecting their lives and realities and presented a magnet theatre performance on HIV vulnerability reduction which was conducted by the community itself. Nearly 400 audience members joined the event. (March 2009)

Workshops & Capacity Building Activities

- CHP supported NACO's "3-Day National Workshop of Folk Artists for Standardizing Folk Performances and Developing State and Regional Resources" on 18-20 November, 2010. (November, 2010).

- CHP conducted a capacity building workshop on communication skills at a National Consultation on Addressing Youth Concerns and Synthesizing Key Advocacy Issues around Sexual and Reproductive Health hosted by CHETNA in Ahmadabad, Gujarat (August, 2010).

- CHP conducted a capacity building workshop on communication skills for HIV and Human Rights among youth Peer Educator of NAZ Foundation (July, 2010).

- CHP and partners conducted a 3-day youth and community advocacy and knowledge mobilization workshop with 52 young people and community members across the two high prevalence states in the north east, namely Manipur and Nagaland as part of the Knowledge FAN initiative supported by UNAIDS, India (February, 2010).

- CHP conducted a 3-hour HIV awareness and sensitization workshop with truck drivers in Dadri, U.P on 17 December, 2009. The workshop was conducted with the invaluable support of IKEA, APL logistics and Albatross. The goals of the workshop were to engage truck drivers in dialogue-based communication about HIV risks and vulnerabilities and to identify practical techniques to minimize them. The workshop involved using entertainment education to disseminate basic, technical information about HIV and generate a practical understanding about HIV prevention techniques.

- Capacity building workshop for NACO to train State AIDS Control Societies (SACS) consultants on youth issues on youth mobilization. (March 2009)

- Capacity building workshop with youth and at-risk communities in use of photo and video tools to capture issues from the field. (October 2008)

- Capacity building workshop with young community members in implementation of Interpersonal Communication (IPC) tools for HIV/STI risk and vulnerability reduction and sexual and reproductive health issues. (April 2009)

- Capacity building workshop with youth and at-risk communities on identifying issues and scripting them to support knowledge generation. (November 2008)

- Capacity strengthening workshop with youth and at-risk communities in Magnet Theatre methodology. (January 2009)

- Workshop with youth and at-risk communities about music and digital story-telling tools and techniques to capture and share knowledge. (February 2009)

- Workshop for young and at-risk communities on legal literacy training in partnership with the Human Rights Legal Network (HRLN). (May 2009)

- Pre-workshop visit to Ooty for consultation with communities in preparation to launch an IPC initiative for health promotion. (October, 2009)

- Capacity building workshop in Magnet Theatre with the MSM community in collaboration with NACO's State Training and Resource Center (STRC). Magnet Theatre is a mid-media communication method, which unlike conventional stage theatre and some other forms of participatory street theatre, invites the audience to create and re-create scenarios to solve the dilemmas presented in the performance. Messages are not given to the audience through the performance, rather facilitated discussion encourages the audience to generate practical solutions to their barriers (e.g., to HIV prevention, care and treatment) and dilemmas. (November 2009)

- Workshop on student-led knowledge generation and exchange about HIV, Health and rights; and use of creative platforms for knowledge sharing conducted with Vasant

Valley School children of class 8 and 9 with the support of UNAIDS and Vasant Valley School, New Delhi. (November 2009)

Youth and Community-Focused Knowledge Generation Activities

- A photo essay project is being conducted to generate and share knowledge about HIV (and health) issues and to mobilize young and at-risk communities based on knowledge sharing, dialogue and knowledge-based networking. A CHP-trained young helper from Sanjay Gandhi Transport Nagar was awarded the WACC 2009 competition prize for photography. The competition received 1700 photo entries submitted by 950 amateurs and professionals from across the world. Only 6 winners were selected! (December 2008-ongoing)
- A photo project is ongoing to generate and share knowledge about water pollution and its health impacts and mobilize young communities based on knowledge exchange. This project is being conducted under the guidance of renowned, official photographer of National Geographic - Mahesh Nair. (April 2009-ongoing)

- The "Music Initiative" is being conducted to empower young people through music. Young people themselves identify issues related to HIV and sexual and reproductive health and rights and develop songs based on messages they create together with their peers. Young people are trained to develop songs and use technology to create audio casts (to share music online and through mobiles), make CDs and develop music videos (to share online and offline). Overall, the process is extremely empowering for young people and powerful and potentially life-saving for the community. From the programmatic perspective, the Music Initiative creates a powerful platform to mobilize and reach youth with messages they consider critical. (January 2009-ongoing)

- Design of training modules for outreach workers on Injecting Drug Use (IDU) issues. Effort undertaken in partnership with The Communication Hub (TCH). (May-June 2009)

- Design of training modules for STI Counselors Sexually Transmitted Infection (STI) issues. Effort undertaken in partnership with The Communication Hub (TCH). (June-July 2009)

Dialogue-Based Communication Activities

- A Magnet Theatre project is being conducted by and for the community (young and at-risk communities) to create dialogue and promote critical thinking about practical risk reduction strategies. (November 2008)

- A number of Interpersonal Communication (IPC) tools are implemented with communities to stimulate dialogue and find practical solutions to barriers to HIV and other health risks and vulnerabilities. The IPC initiative is being implemented with the Society for Promotion of Youth & Masses' (SPYM) at its de-addiction and rehabilitation center to support clients to identify and reduce risks and vulnerabilities to drug and alcohol dependency. (April 2009)

Research & Documentation Activities

- A research study (SIDA-funded) is being undertaken on transgender health and rights together with Naz Foundation India (Trust). The results of the study will be documented in docu-feature film. (May 2009-ongoing)

- Documented the lives of HIV positive (transgender, male, female) sex workers as case studies which were presented in a book and a film. This project was conducted in partnership with Ashodaya Samithi. The official release of the book was made by Principal Secretary to the Department of Health and Family Welfare, Mr. Madan Gopal and the film was screened as a curtain raiser at the Mysore Positive Habba. (March 2009)

WORK ALLOCATED:

At Centre for Human Progress, New Delhi; based on my Health Management background, I was selected as a Management Trainee (Program Co-ordinator) at Center for Human Progress, New Delhi during internship period of 3 months from 30th January 2011 to 29th April 2011. I started my research work with Proposal writing and till date I have completed my field study. This allowed me to explore research sector and understand different aspects of health care and social sector. During this period I have assigned Following Task/ Responsibilities:

RESEARCH RELATED TASKS:

- **Literature Review**: Literature review for this project has been done for proposal writing and to assess and find out the scenario in India and states also.
- **Questionnaires Design**: Quantitative Questionnaires has been prepared for primary data collection. Then this questionnaire has been translated in Hindi also.
- **Field Study and analysis**: I have been allotted West Delhi for field Survey. The target sample was 242 respondents. Analysis was carried out at SPSS by me.
- **Report Writing**

MANAGERIAL TASKS:

- Play an integral role in organizing and managing resource intensive National and regional level meetings; this involves human resource and logistics issues.
- Oversee overall field operations related to implementation of the program (i.e. invitations, enrollments, workshops, documentation, visit co-ordination and workshop planning etc.).
- Co-ordinate with partners, national and regional NGO's to ensure that critical issues are addressed in a timely manner.
- Attend and participate in various meetings/ workshops ("TRANSGENDER AND THE LAW" organized by UNDP on February 05, 2011 at New Delhi and Reaching Out to Widows of Vrindavan: A National Seminar organized by Maitri India on March 08, 2011 at New Delhi).
- Report on meetings basis to the Director regarding workshop progress and seek timely advice wherever necessary.

- Training of Trainers (TOT) on various issues like HIV/Basic, advocacy, stigma and discrimination etc.
- Contribute to writing documentation reports and papers.
- Any other task as assigned by Director of Center for Human Progress, New Delhi.

REFLECTIVE LEARNING:

It is a great learning experience for me. The assigned work is giving me an opportunity to practice the management and research skills learnt during my course in Public Health Management from International Institute of Health Management Research (IIHMR), New Delhi. After I got selected as a Management Trainee in Centre for Human Progress, New Delhi I had an golden opportunity to work under the guidance of my Director ***Dr. Ash Pachauri*** who taught me all about project activities. These are some reflective learning during my internship:-

- Understanding different aspects of Health care and Social Research.
- Report writings skills.
- Team work and Co-ordination of work.
- Understanding of Various right related issues of Transgender, FSWs and unorganized sector.

1. INTRODUCTION

Ageing is a biological process and experienced by the mankind in all times. It refers to a sequence of changes across a life span of an individual. Though ageing is a multidimensional process, old age is the closing period of the life of an individual. It is a period when people move away from their more desirable period or times of 'usefulness'. According to Kumar (1992)[1] "Ageing is a toil some treadmill grinding to a tragic halt as the years pile up". It can also be defined as a life spanning process of growth and development running from birth to death. It is generally associated with decline in the functional capacity of the organs of the body due to physiological transformation. Though old age is the universal phenomenon with varying degrees of probability, it is overlooked as fundamental aspects of social structure and social dynamics. A person's activities, attitude towards life, a relationship to the family and the work, biological capacities and physical fitness are all conditioned by the position in the age structure of the particular society in which he lives.

Old age term arises scenario like frustration and pity, sickness and poverty, despair and senility, warmth and responsibility. The relationship between ageing and the society's response are complex in the industrial society. Aging is more difficult in the rapidly changing materialistic society. The modernization plays a vital role in the aging process of an individual. It is usually seen that the aged feels a sense of social isolation because of the disjunction from various bonds viz., work relationships, and diminish of relatives and friends, mobility of children to far off places for jobs. The situation of the elderly gets more worsens due to physical incapacity and financial incapacity.

Physical and psychological changes are general characteristics of old age. It is common to associate old age with disability. , We can usually observe extreme losses of physical, mental and social functions in old people. Yet many people continue to maintain high level of function. More health complaints and illness are diagnosed when a young old man moves into old category. The presence and duration of the chronic diseases account for a portion of variation in the functional disability of the aged (Camacho et al., 1993)[2].

The elderly people face number of problems and adjust to them in varying degrees in their old age. These problems range from absence of ensured and their dependents, to ill-health, absence of social security, loss of social role and recognition, and the non-availability of opportunities for creative use of free time.

Today aging is a concern worldwide. Inadequate support from the care givers leads to lack of moral, emotional and physical support for elderly. The living condition of elderly differs in both developed and developing countries. When comparing the world scenario of elderly population, China is not alone with respect to extremely rapid populating aging among developing countries. The proportion of elderly in Korea will climb to a higher level with a large annual increase rate than in China. Mexico and India, two developing countries with large population sizes will also undergo very rapid increase in population aging at annual rates of 2.6 and 2.1 per cent, although the proportion of elderly in 2050 will be substantially lower than in China. The annual increases in the proportion of the elderly between 1990 and 2050 in China, India, Korea and Mexico will be much higher than in European and North American countries. This fact deserves serious attention not only in those developing countries, but also from international organizations and developed countries (Kevin et al., (1992)[3], Linda et al., (1994)[4]).

The crude reality of the ageing scenario in India is that there are 77 million older persons in country, and the number is growing to grow to 177 million in another 25 years. With life expectancy having increased from 40 years in 1951 to 64 years today, a person today has 20 years more to live than he would have 50 years back (Rajan et al., 1999)[5]. With this kind of an ageing scenario, there is pressure on all aspects of care for the older persons – be it financial, health or shelter. As the twenty first century arrives, the growing security of older persons in India is very visible. With older people living longer, the households are getting smaller and congested, causing stress in joint and extended families. Even where they are co residing marginalization, isolation and insecurity is felt among the older persons due to the generation gap and change in lifestyles. Increase in lifespan also results in chronic functional disabilities creating a need for assistance required by the older person to manage chores as simple as the activities of daily living. With the prevailing traditional system in India that lady of the house is used to look after

the older family members at home is slowly getting changed as the women at home are also participating in activities outside home and have their own career ambitions. There is growing realization among older persons that they are more often perceived by their children as a burden. Old Age has never been a problem for India where a value based, joint family system is supposed to prevail. Indian culture is automatically respectful and supportive for elders. With that background, elder abuse has never been considered as a problem in India and has always been thought of as a western problem. However, the coping capacities of the younger and older family members are now being challenged and more often an unwanted behaviour by the younger family members is experienced as abnormal by the older family member.

Population around the world is growing old at high rate with increasing life-expectancy. The challenge ahead for health care in coming years is to ensure the quality of life to a large group of elderly population. However, to address the healthcare needs of this growing numbers of vulnerable and heterogeneous population, reliable information about their health problems from different social settings is still lacking in India. Elders suffer from desires, psychological problems of usefulness and abundant. Women react in different ways in this diminishing role. Those who have not occupied positions previously with little authority or influence perhaps feel it the least those who have occupied positions of authority have considerable difficulty in coping. It should be noted that problems of the old age are highly individualistic in nature. In order to provide better living condition of the elderly women the government of India decided in the year 1983-84 for the first time to give grants to voluntary organization for services to the aged, for health care, income generation subsistence, training and old age homes.

ELDERLY ABUSE AND NEGLECT

Elderly abuse within the community institutional settings is being highly unrecognized. Their ill-health has often been attributed to natural, accidental or undetermined causes when in fact they were the consequences of abusive or neglectful behaviour. Elder women's are more vulnerable to abuse as they usually -financially and emotionally dependent on families than men. Elderly abuse is generally 'hidden', since older persons

find it shameful to admit that they are abused and are ashamed of the stigma. Elderly people on the whole are likely to face both neglect and violence. The difference being that whereas neglect is an act of omission, violence constitutes an act of commission or perpetration. Abuse of the elderly covers physical abuse - infliction of pain or injury, physical coercion or physical drug-induced restraint; psychological or emotional abuse - infliction of mental anguish, illegal or improper exploitation, non-consensual sexual contact (sexual abuse) and refusal or failure to fulfil a care giving obligation (neglect).

Types of Abuse

Elder abuse/ maltreatment include several types of violence that occur among those ages 60 and older. The violence usually occurs from the side of a caregiver or a person whom the elder trusts. There are six types of elder maltreatment:

• **Physical—** This occurs when an elder is injured as a result of hitting, kicking, pushing, slapping, burning, or other show of force.

• **Sexual—** This involves forcing an elder to take part in a sexual act when the elder does not or cannot consent.

• **Emotional—** This refers to behaviors that harm an elder's self-worth or emotional well being. Examples include name calling, scaring, embarrassing, destroying property, or not letting the elder see friends and family.

• **Neglect—** This is the failure to meet an elder's basic needs. These needs include food, housing, clothing, and medical care.

• **Abandonment—** This happens when a caregiver leaves an elder alone and no longer provides care for him or her.

• **Financial—** This is illegally misusing an elder's money, property, or assets.

HEALTH CONSEQUENCES OF ELDERLY ABUSE

For older people, the consequences of abuse can be peculiarly serious. Older people are physically weaker; their bones are more brittle and their recovery takes longer, therefore, even a minor injury can have grave consequences. Mistreatment of older people often occurs within institutional settings such as nursing homes, residential care institutions, hospitals and day care facilities. Various people may be responsible for such

mistreatment – from caregivers to relatives to those within the institution. Evidence from India indicates that in some instances staff often perpetuates institutional abuse when they impose rules or over-protective care in the name of discipline. Some institutions that lack professionally trained management may also end up abusing the elderly. Physical and psychological violence impacts the health of an elderly person. Despite the impact of violence on the elderly, physical and cognitive impairments combined with extensive family ties make it difficult for an elderly person to leave an abusive relationship or to take corrective measures. Displacing the elderly and depriving them of responsibility are potentially harmful cultural norms in many countries. Other forms of abuse are related to the mourning rites of passage for widows (especially those who are childless) in some communities. By custom these widows are either forced to marry their husband's brother or face expulsion from their homes. Accusations of witchcraft are often leveled at elderly (and childless) women in some communities in some regions. Since these practices are firmly entrenched social customs, they may not be considered abuse even by care givers or professionals

The Concern

As a result of the current ageing scenario, there is growing need for elderly care in terms of social, economic, health and shelter. Together with these issues, security of older persons in India is also an emerging come out. With more old people living longer, the households are getting smaller and congested, causing stress in joint and extended families. Even where they are co-residing, marginalization, isolation and insecurity are felt among the older persons due to the generation gap and change in lifestyles. Increase in lifespan also results in chronic functional disabilities leading for a need for assistance required by the older person to manage simple chores as the activities of daily living.

2. REVIEW OF LITERATURE

In India, the elderly account for 7 percent of the total population, of which two-thirds live in villages and nearly half of them in poor conditions. Due to urbanization, migration and rise in existence of nuclear families, care of the elderly has become more of a personal and social problem. In our country, the life expectancy has steadily gone up from 32 years at the time of independence to over 63 in 2001(Rajan et al., 1999)[5]. Change in socio-economic status adversely affects the individual's way of life after retirement. The economic loss is due to a change from salary to pension or unemployment leading to economic dependency on children or relatives. A feeling of low self-worth may be felt due to the loss of earning power and social recognition. During old age change in socio-economic status and various health problems adversely affect an individual's way of life. Ageing is a multidimensional process and it is said that old age is the closing period of the life of an individual. A person's activities, attitude towards life, a relationship to the family and work, biological capacities and physical fitness are all conditioned by the position in the age structure of the particular society in which he lives. Today in India elderly women are living a miserable life, as they are family bonded and not ready to live in old age homes. A study was conducted in Coimbatore to understand the condition of elderly women focusing on socio-economic and health status of them Totally 333 samples were selected by using the simple random sampling method and results of study inferred that the elderly women have psychological problems like depression, isolation, loneliness and irritation. Health problem is the most serious thing that has to be concerned by the society on the whole (J Sheela and M Jayamala, 2006)[6].

The elderly are also prone to abuse in their families or in institutional settings. This includes physical abuse (infliction of pain or injury), psychological or emotional abuse (infliction of mental anguish and illegal exploitation), and sexual abuse. A community based study examined the extent and correlation of elder mistreatment among 400 community- dwelling older adults aged 65 years and above in Chennai found the prevalence rate of mistreatment to be 14 percent. Chronic verbal abuse was the most common followed by financial abuse, physical abuse and neglect. A significantly higher

number of women faced abuse as compared with men; adult children, daughter-in-law, spouses and son-in-law were the prominent perpetrators (Chokkanathan S and Lee AE., 2005)[7].

Household structure and living arrangement is one of the important factors for the status of old. Living suitably with any living arrangement implies good mental status for the successful aging. Results of a research study revealed that out of 986 samples selected by random sampling; eighty one percent (81 percent) of elderly were living with the extended family of their children. Most of the respondents (76 percent) were happy with their current daily life but rests were suffering with social and health negligence by family/relatives/friends (Deka A.K. and Nath D.C., 2009)[8].

The rapid urbanization and societal modernization has brought in its wake a breakdown in family values, family support, economic insecurity, social isolation and elderly abuse leading to host of psychological illnesses. In addition, widows are prone to face social stigma and ostracism. The Socio-economic problems of the elderly are aggravated by factors such as the lack of social security and inadequate facilities for health care, rehabilititation and recreation. It is also found that in most of the developing countries, pension and social security is restricted to those who have worked in the public sector or the organized sector of the industry. A survey was done for middle class society in Delhi mainly focusing on "The condition of the elderly in India". Over 81 percent of the elderly confessed to having increasing stress and psychological problems in modern society, while 77.6 percent complaint about mother-in-law/daughter-in-law conflicts being on the increase (Bose A., 1997)[9].

As found in many developing countries like India health problems and medical care are the major concern among elderly. A person's activities, attitude towards life, a relationship to the family and the work, biological capacities and physical fitness are all conditioned by the position in the age structure of the particular society in which he lives. In the absence of suitable social security policies and meagre income elderly population (60+ years) tend to utilize the public health care services to a large extent when they feel sick from ill-health. A cross-sectional study of 778 people focusing on "Utilization of

Public Health care services among elderly in Coimbatore City of Tamilnadu" revealed that out of total participants only one-third (32 percent) elders used public health facilities when they fell sick. The utilization of government health facility was significantly as lower among elderly who perceived that their families' financial position is good and average, educated up to high school and above. The utilization of Private Health facility was seen more in self earning/ dependent elders in comparison to elders' who dependents on others for their life (Audinarayana N., 2008)[10].

The Cultural and geographic diversity of our country reflects in the heterogeneity of our elderly population. The demographic transition and change in the society and economy are posing challenges to those concerned with the physical and emotional well being of the elderly. Health is precondition of successful ageing. A Pune based research study indicated that maximum share of the health care utilization was incurred by the elderly belonging to the oldest old category (80+ years). Working age group mainly (Son/ daughter) in household responsible for supporting elders for everything (Ex. financially/ morally etc.) (Bawdekar, M. and Ladusingh, L., 2010)[11].

A Cross-Sectional study was carried out on "Health and Social Problems of the Elderly" in Udupi Taluka, Karnataka including 213 elderly patients who attended outreach clinics (60+years). The result of the study stated that around three-fourth (73percent) of the patients belonged to the age group of 60-69 years old and n early half of the respondents were found to be illiterate. It was also found that a round half (48 percent) felt they were not happy in life and majority of them had health problems such as hypertension followed by other health problems. About two-third (68 percent) of the elderly patient reported, negligent attitude towards them. This showed that there is a need for geriatric counseling centers that can take care of their physical and psychological needs. The stringent rules for eligibility to social security schemes should be made more flexible to cover a larger population (Padma M *et al*, 2009)[12].

A Chandigarh based research study stated that out of the total 361 aged persons of Chandigarh, 311 (86.1 percent) persons reported one or more health-related complaints, with an average of two illnesses. The main health-related problems discovered were

disorders of the circulatory system (51.2 percent), musculoskeletal system and connective tissue (45.7 percent). It was also found that loneliness was prevalent more in females (72.8 percent) as compared to males (65.6 percent).and was more prevalent among persons who lived alone (92.2 percent) as compared to those who lived with their spouse (58.9 percent) or when husband and wife lived with the family (61.4 percent). It was higher among the widows (85.2 percent) and widowers (75.8 percent) who lived with the family as compared to the aged who lived with the spouse (58.9 percent) and the aged husband and wife who lived with the family (61.4 percent) (Bhatia V. *et al*., 2007)[13].

The Central and State governments have already made efforts to tackle the problem of economic and social insecurity by launching policies such as the National Policy on Older Persons, National Old Age Pension Program, Annapurna Program, etc. However, the benefits of these programs have been questioned several times in terms of the meagre budget, improper identification of beneficiaries, lengthy procedures, and irregular payment.

3. RATIONALE OF THE STUDY

According to Municipal Corporation of Delhi report (2010) total population of Delhi is 1, 38, 50,157 out of which West Delhi population is estimated to be 21, 28,908 including 5% of elderly population. Hence due to a large population, the absolute size of the aged population is considerable and these older persons, by nature, tend to suffer from multiple physical, psychological, economical, social, and existential problems that collectively contribute to the emergence of suicidal ideations and also completed suicide financial support in Delhi. As it is seen from past decades, that India's health program and policies have been focusing on issues like population stabilization, maternal and child health, and disease control. However, focus on needs and requirements of elderly is still unknown and if a timely initiative in this direction is not taken by the program managers and policy makers then a new set of medical, social, and economic problems could arise for elderly. So there is a need to highlight the medical and socio-economic problems faced by the elderly people in India, and formulation of strategies is needed for bringing about an improvement in their quality of life.

So in order to study the condition of elders the present research study was carried out with the focus on socio-economic and health status of elderly people in West Delhi.

4. OBJECTIVE OF THE STUDY

The main objective of the study is to analyze health and social problems of elderly as well as their family and community support systems in West Delhi.

The specific objectives of the study are:

- To study the socio-economic status of the elderly in West Delhi.
- To study the elder abuse and health problems faced by the elderly in West Delhi.
- To assess the level of knowledge and benefits received from various welfare and health insurance schemes by the elderly in West Delhi.
- To assess the physical and moral support rendered by the family members and community to the elders in West Delhi.

5. DATA AND METHODS

5.1 Study design

The methodology adopted includes quantitative research techniques of data collection. To conduct study on Elderly Needs for Care and Support in West Delhi; quantitative survey was conducted. Data collection was carried out for a period of two months i.e. from February and March 2011.

5.2 Study area

The study was conducted at West Delhi.

5.3 Sample size and Respondent groups

As mentioned above, the target groups comprised the elderly in the age group of 60+ years in West Delhi. . The total sample includes 242 elders, who were in the age group of 60+ years.

Sample size $n = [DEFF*Np\ (1-p)]/\ [(d^2/Z^2_{1-\alpha/2}*(N-1) +p*(1-p)]$

Population size(for finite population correction factor or fpc) (*N*):	110491
Hypothesized % frequency of outcome factor in the population (*p*):	50%+/-5
Confidence limits as % of 100(absolute +/- %)(*d*):	5%
Design effect (*DEFF*):	1

5.4 Sampling Design

Selection of Respondents

Targeting the people aged 60 years and above is challenging, especially in urban areas. Hence I adopted the following strategy to target the sample.

I directly contacted the target groups at household level and collected contact information about the target groups by visiting public places such as parks, temples, churches etc.

5.5 Study Instruments

There was being one type of study instruments which include several sections:

Section 1: Background

Section 2: Social and Economic status

Section 3: Health Status and Care giving

Section 4: Abuse of Elderly and Community Support

5.6 Implemented Plan

Step 1: Selection of Respondents

Step 2: Data Collection

Step 3: Data Entry

Step 4: Data Analysis & Report Writing

All the filled questionnaires that were reviewed in the field were scrutinized before being entered. All open ended questions were also coded scrutinized / edited before starting the data entry.

The data entry was done using CS-Pro package and data cleaning was carried out simultaneously. Then at the end of the data entry work frequency for all variables was checked and the data was cleaned.

Analysis of the quantitative data was carried out with the help of SPSS 13.0 on Pentium 4 machines. Analysis plan and dummy tables were prepared before the ending of Questionnaires.

6. RESULT AND FINDINGS

This chapter gives the socio-demographic and economic profile of the elder. It also gives an understanding of their dependency for various requirements like daily routine and health care, and their needs. It also presents findings pertaining to the welfare schemes and support system available at the community level for the elders.

6.1 Socio Demographic Profile

Table: 1: Socio-demographic characteristics

CHARACTERISTICS	TOTAL
SEX	
Male	104 (43.0)
Female	138 (57.0)
AGE DISTRIBUTION	
60-64 Years	122 (50.4)
65-69 Years	77 (31.8)
>= 70 Years	43 (17.8)
Mean Age (Years)	66.58
MARITAL STATUS	
Currently Married	77 (31.8)
Others*	165 (68.2)
EDUCATIONAL ATTAINMENT	
Illiterate	212 (87.6)
Literate	30 (12.4)
RELIGION	
Hindu	212 (87.6)
Muslims/Sikh/ Christian	30 (12.4)
CASTE	
SC/ST	105 (43.4)
OBC	96 (39.7)
General	41 (17.0)
MEAN NO. OF CHILDREN	
Children	4.46
Son	2.33
Daughter	2.12
TOTAL N	242 (100.0)

* Divorced/ Un-married/ Separate

Table 1 shows that a major fraction (50.4 percent) of the population were lying in the age group of 60-64 years old while a small fraction (17.8 percent) were 70 years old or older. The mean age of the elder varies between 66 and 67 years across the sample. Males (104) and Females (138) formed an almost equal proportion of the study sample. The marital status of the elders is provided in above table; nearly one-third (31.7 percent) of the elders are currently married while rest (68.2 percent) of the elders are respectively single or widow/widower or separated or divorced. A majority (87.6 percent) of the respondents were Hindus. This reflects the true picture of the population based on religion at the local and national level. Literacy was found to be low in the study population. More than five-sixth (87.6 percent) of the elders is illiterate and only one-fifth (12.4 percent) are literate. More than two-fifth of the (43.4 percent) elders in study area belongs to Scheduled caste and Scheduled Tribe while less than one fifth (17.0 percent) elders belong to General Category. Nearly two fifth (39.7 percent) of the elders belong to the other backward category (OBC). Table 1 also gives the mean number of children of the elders. The mean number of children is 4.46, with 2.33 sons and 2.12 daughters.

Characteristics	Male	Female	Total
CURRENTLY LIVING STATUS			
Son/Daughter	67 (64.4)	80 (65.2)	157 (64.9)
Spouse	16 (15.4)	07 (5.1)	23 (9.5)
Alone	19 (18.3)	31 (22.5)	50 (20.7)
Domestic Help workers/Others	02 (2.0)	10 (7.2)	12 (5.0)
TOTAL N	104 (100.0)	138 (100.0)	242 (100.0)
REASONS FOR NOT LIVING WITH SON/DAUGHTER			
No support from children	16 (43.2)	17 (35.4)	33 (38.8)
Children working/living in another place	08 (21.6)	20 (41.7)	28 (32.9)
Have no children	10 (27.0)	09 (18.8)	19 (22.4)
Health problem	03 (8.1)	02 (4.2)	05 (5.9)
TOTAL N	37 (100.0)	48 (100.0)	85 (100.0)

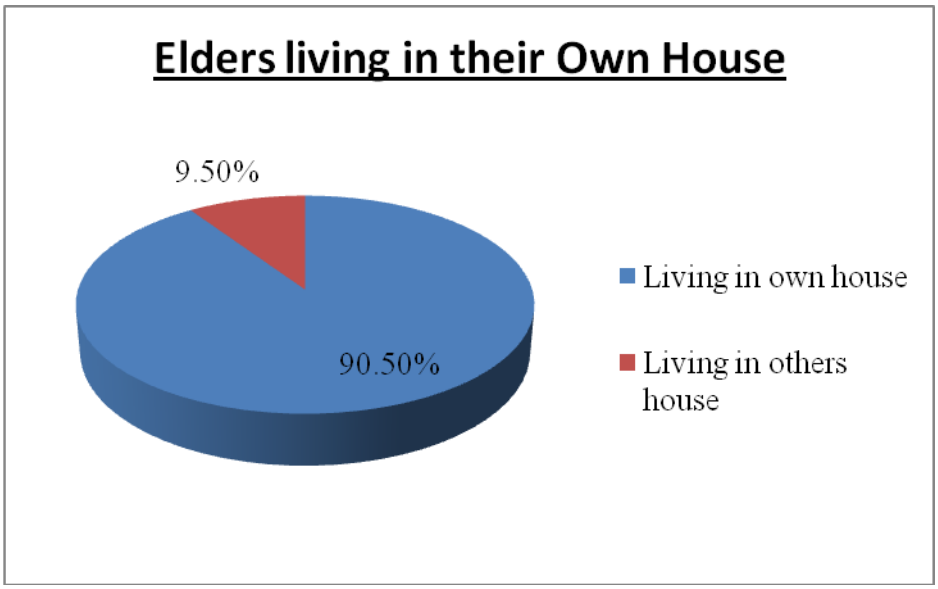
Table 2 currently living status and reasons for living alone

The elders were asked about their current living status. Table 2 shows that nearly two third (64.9 percent) of the elders stay with son or daughter. There is no significant difference found when we analyzed separated in male (64.4 percent) and female (65.2 percent) elders. Also two-fifth (20.7 percent) of the elders is living alone while rests of elders are living respectively with their spouse (9.5 percent) and Domestic Help workers/others (5.0 percent). The elders who reported that they are not living with their son or daughter were further asked about the reasons for not living with them. Nearly two-fifth (38.8 percent) of the elders reported 'no support from children' as a reason. One third (32.9 percent) of the elders reported 'Children working/living in another place' as one of the reasons for not living with their children.

6.2 Economic Profile

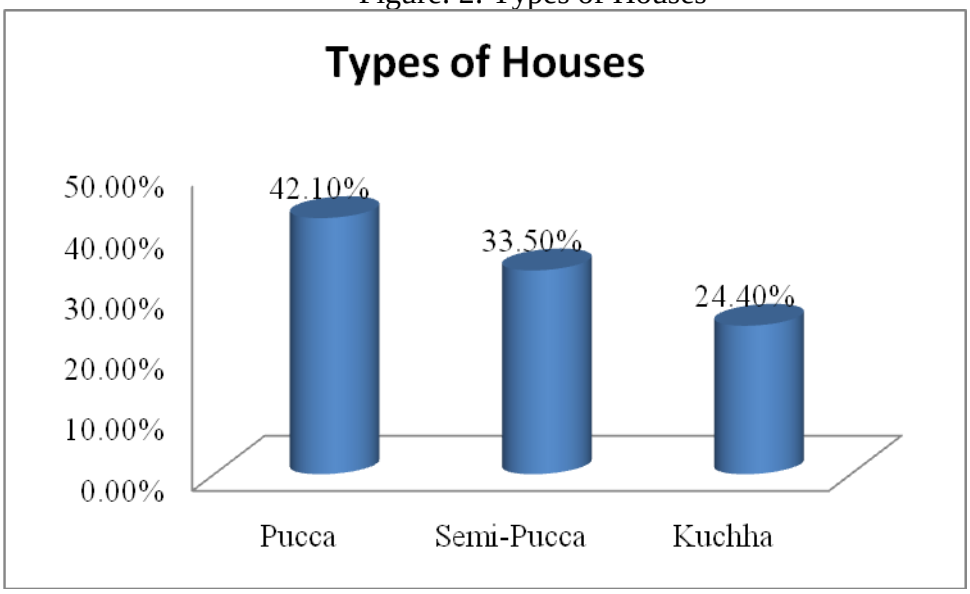
This section deals with the information related to the economic condition of the household and the elders.

Figure: 1: Ownership of House Living in (Percent)



N= 242

Figure: 2: Types of Houses



N=242

Almost all the respondents (90.50 percent) are living in their own homes but very less no. of respondents (9.50 percent) is living in rent houses or relatives' house. About two-fifth (42.10 percent) of the elders live in *Pucca* house, while about one third and one fourth live in semi-*pucca* and *kuchcha* house respectively.

Table: 3: Monthly Household Income

Monthly Household Income	**ALL (%)**
Monthly Income (in Rs)	
Less than 2500	36.1
2501- 5000	32.3
More than 5000	19.1
Can't say/ Don't know	11.0
Mean	4381
Total N	**242**

Table 3 gives the distribution of elders according to monthly house hold incomes. The average monthly household income of the Elders is Rs. 4381. One third (35 percent) each of the Elders have a monthly household income of less than Rs 2500 and between 2500-5000, while one fifth have an income of more than Rs. 5000.

Source of Income

The elders were asked about their source of income. Remittances from children are the main source of income, with 52.1 percent. One fifth (19.8 percent) reported income from contributory pension. One tenth (13.6 percent) of the elders have no income sources.

Table: 4: Source of Income

	Male	Female	Total
Contributory pension	17 (16.3)	31 (22.5)	48 (19.8)
House rent	08 (7.7)	09 (6.5)	17 (7.0)
Business	02 (1.9)	4 (2.9)	6 (2.5)
Remittance from children	55 (52.9)	71 (51.4)	126 (52.1)
Interest on Savings and Fixed Deposits	04 (3.8)	8 (5.8)	12 (5.0)
No Income source	18 (17.3)	15 (10.9)	33 (13.6)
Total N	104 (100.0)	138 (100.0)	242 (100.0)

6.3 Dependency for Various Requirements

An attempt has been made to capture the level of dependency of the elders in urban for three important aspects of life. These are financial dependency, health problem dependency and daily routine dependency. The findings related to these are presented below:

Dependency for financial requirements

The elders were asked whether they are financially dependent on anyone and Table: 5: gives the results.

Table: 5: Dependency on Financial Requirements

	Male	Female	Total
Dependency on Financial requirements	69 (66.3)	88 (63.8)	157 (64.9)
TOTAL N	104	138	242
On whom do you depend?			
Son	76.8	78.4	77.7
Daughter	24.6	33.0	29.3
Son-in-law	5.8	9.1	7.6
Daughter-in-law	30.4	26.1	28.0
Spouse	14.5	9.1	11.5
No Response	7.2	6.8	7.0
TOTAL N	69	88	157

Note: Total adds to more than 100 because of multiple response

Nearby two-third respondent (64.9 percent) are financially dependent on others. Elder male are more financially dependent in comparison to female elders. Table 5 gives the findings on the person whom the elders are financially dependent on. Almost four-fifth (77.7 percent) of the elders is dependent on son. More than one-fourth each of the elders is financially dependent on their daughter-in-law (28.0 Percent) and Daughter (29.3 percent) respectively.

Dependency at Time of Ill Health

Table: 6: Dependency at time of bad health condition

	Male	Female	Total
Son/Daughter	70.2	70.3	70.2
Daughter-in-law	49.0	43.5	45.9
My Self	46.2	35.5	40.1
Spouse	31.7	10.9	19.8
Neighbors/ Other Relatives	8.7	7.2	7.9
Domestic Help Workers	8.7	13.8	11.6
TOTAL N	104	138	242

Note: Total adds to more than 100 because of multiple response

The elders were asked about their health related problems and the person who takes care of them during health problems. More than two third (70.2 percent) of the elders reported that son/daughter takes care of them at the time of health related problems. Though the overall findings suggest that family members are taking care of the elders in case of health related problems, sometimes the children do not care for them. More than two-fifth (40.1 percent) of the elders reported that sometimes they also manage the problem either on their own or nearly one-fifth (19.8 percent) of the elders reported that sometimes with the help of the spouse.

Dependency for Carrying out Daily Routine Activity

The elders were asked about the person who takes care of them in carrying out daily routine activities e.g. washing clothes, timely meals, bringing medicines and materials from market and other routine chores. More Than half (53.7 percent) the elders reported their dependency on Son or Daughter, while nearly half (47.1 percent) reported on the daughter-in-law. Nearly half (49.6 percent) of the elders reported that sometimes they also manage the problem either on their own (Table 7)

Table: 7: Dependency for daily routine activity

	MALE	FEMALE	TOTAL
Son/Daughter	52.9	54.3	53.7
Daughter-in-law	52.9	42.8	47.1
My Self	52.9	47.1	49.6
Spouse	34.6	10.1	20.7
Neighbors/ Other Relatives	8.7	15.2	12.4
Domestic Help Workers	2.9	2.2	2.5
TOTAL N	104	138	242

Note: Total adds to more than 100 because of multiple response

6.4 Elder Abuse at Family Level

Abuse experienced by elders

All the elders were asked whether they have ever faced abuse. As Figure 3 indicates, less than one fifth (16 percent) of the elders have experienced any type of abuse. Female's elders faced more abused in comparison to male elders.

Figure 3 Percentage of elders who Faced Abuse

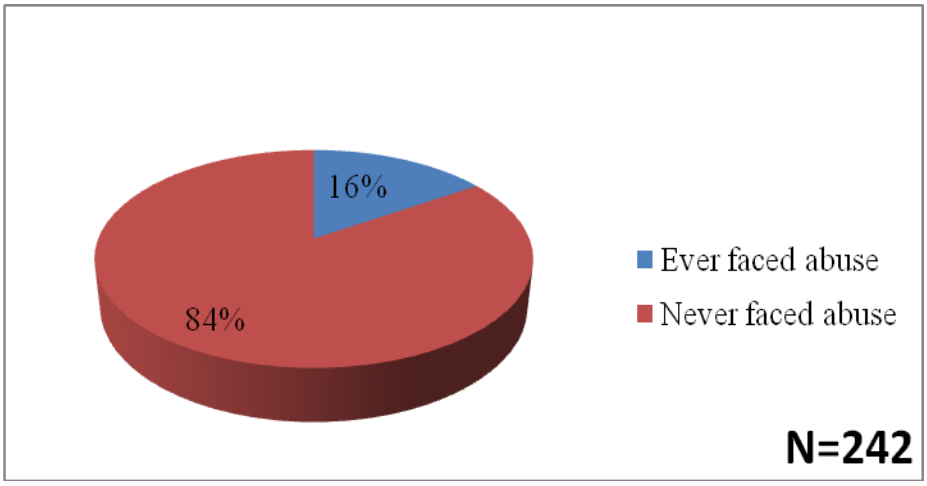


Table: 8: Kind of abuse faced

	Male	Female	Total
Physical Abuse	18.8	9.1	13.2
Emotional Abuse	0.0	18.2	10.5
Verbal Abuse	100.0	77.3	86.8
Economic Abuse	6.2	4.5	5.3
Showing disrespect	12.5	22.7	18.4
Neglect	12.5	22.7	18.4
TOTAL N	16	22	38

Note: Total adds to more than 100 because of multiple response

The elder who reported to have faced abuse were further asked about the kind of abuse faced. The elder reportedly faced various types of abuse with 'verbal abuse' being the most common form of abuse followed by neglect, showing disrespect, emotional abuse and economic abuse (Table 8). The elders who faced abuse were asked about the person who abused them. Son and Daughter-in-law emerge as the major abusers as 73.7 percent and 60.5 percent of the elders respectively reported so.

6.5 Needs

In the present study attempt has also been made to assess the needs and requirements of the elders. Table 9 shows; that all of the elders would like to get 'Health Care/ Separate Hospital/ Free Treatment' and Financial Aid/ Pension Scheme/ Free Travel Pass. Nearly half (46.3 percent) of the elders need 'Social security/ House Facility' while about one fifth (19.0) need 'financial aid'. Nearly two fifth and one third of the elders need pension scheme and separate hospitals for Oldest Old respectively.

Table: 9: Needs of the elders

	MALE	FEMALE	TOTAL
Health Care/ Separate Hospital/ Free Treatment	100.0	100.0	100.0
Free Health Insurance	24.0	15.2	19.0
Financial Aid/ Pension Scheme/ Free Travel Pass	100.0	100.0	100.0
Social security/ House Facility	45.2	47.1	46.3
No Discrimination	2.9	2.2	2.5
Emotional/ physical support	2.9	5.8	4.5
TOTAL N	104	138	242

Note: Total adds to more than 100 because of multiple response

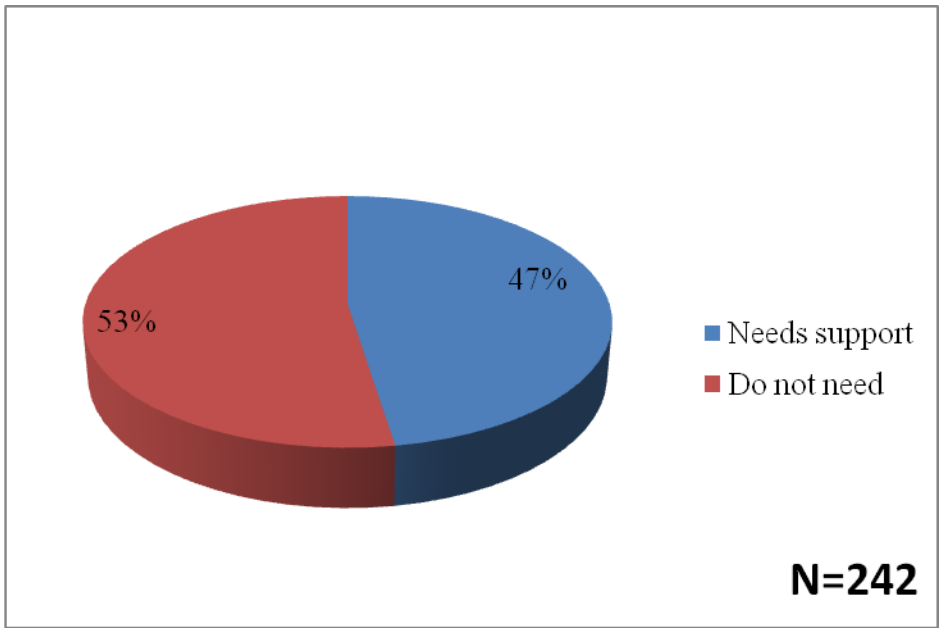
6.6 Support System

This section deals with the support system available at the community level.

Whether Need Support from Community

On being asked; if they need support from community, almost close to half of the elder replied in affirmative.

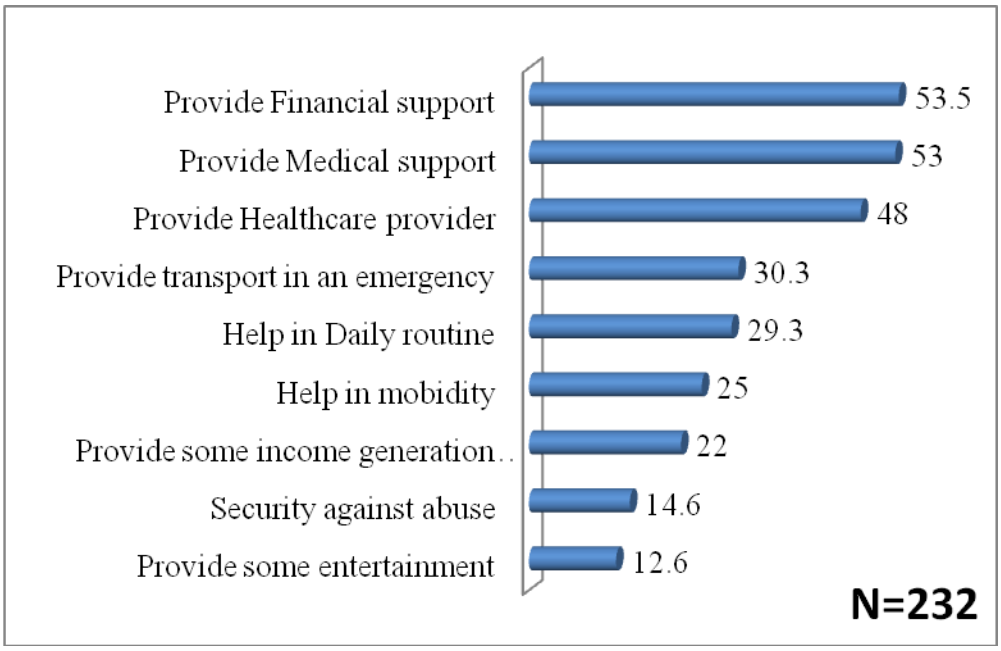
Figure 4 Percentage of elders who Needs Support from Community



Kinds of Support Need from Community

In this study attempt has been made to assess the needs and requirements of the elders at community level. The elders who need support from community were asked about the kind of support they need form community The areas where the elders need support from the community include financial support, provision of medical aids health care provider service, support in emergency, provision of transport in emergency, help in daily routine, help in mobility, provision of income generating activities etc.

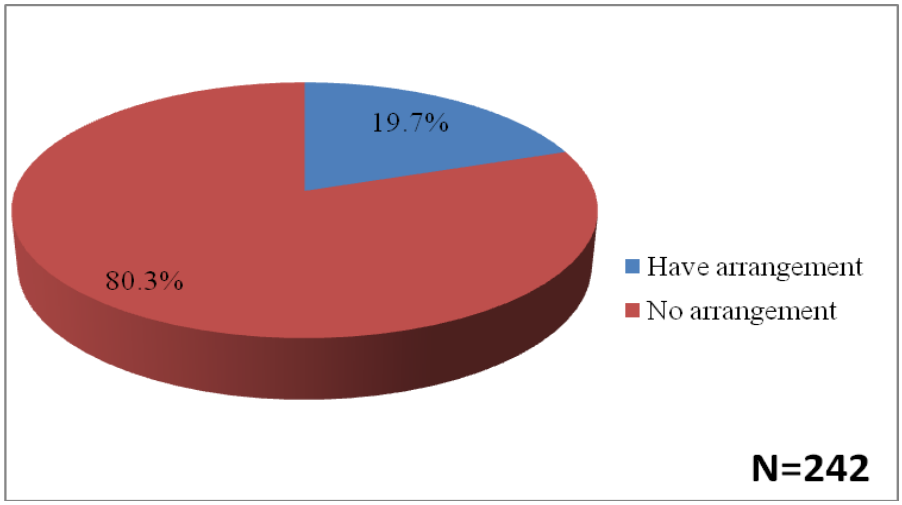
Figure 5 Kind of Support/Help Needed from Community among elders



Note: Total adds to more than 100 because of multiple responses

The Oldest Old who need support from community were asked about the kind of support they need. More half of the respondents want Financial Support (53.5 percent) and Medical Support (53.0 percent) while almost half (48.0 percent) needs Healthcare facility support from the community.

Figure 6 Community have Arrangement for Elderly in Case of Need Reported by elders

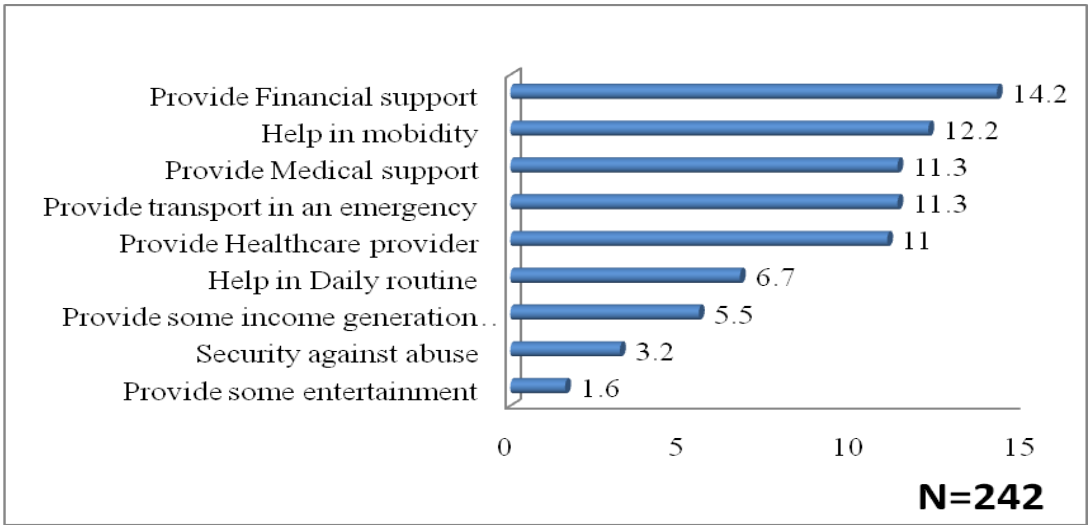


On being asked whether community has any arrangement for them, more than four-fifth (80.3 percent) of the respondents replied that there is no arrangement in the community to support the elders.

Support Provided by Community

The Oldest Old who reported that their community has some arrangement for elder were asked about the kind of support/help provided by the community. The areas where support is provided by the community reported by the elders include financial support, help in mobility, provision of medical aids and transport in emergency etc.

Figure 7 Kind of Support/Help Provided by Community to elders

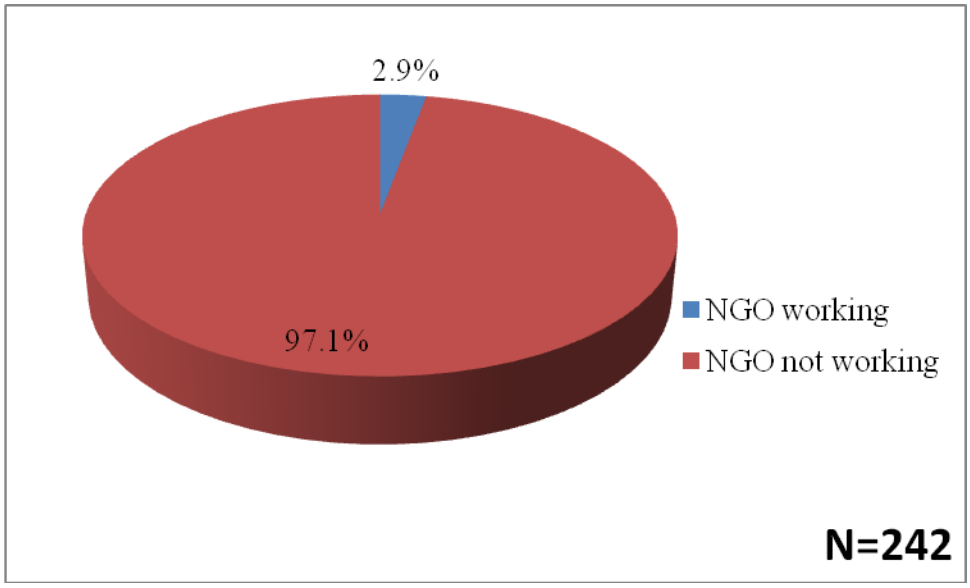


Financial support provided by the community was reported more than one-seventh (14.2 percent) while help in mobility was reported by one in eight (12.2 percent). The other areas where support is provided by the community reported by the elders include provision of medical aids (11.3 percent), transport in emergency (11.3 percent) and Healthcare provider (11.0 percent) etc.

NGO working for elders

On being asked whether any NGO is working for the elders, about 3% of the Oldest Old replied affirmatively. Thus NGO involvement in work related to elders seems to be low.

Figure 8 Percentage of elders who Reported NGO is Working in their Areas for elders



6.7 HEALTH PROBLEMS AND TREATMENT SEEKING BEHAVIOUR

This section deals with the health problems faced by the elders and the treatment seeking behaviour.

6.7.1 Health Status

During the survey an attempt was made to collect information on the health status of the elders.

They were asked to give the response as per the four pre-defined categories as given below:

- **Good:** No such health problems
- **Average:** With seasonal health problems
- **Poor:** With at least one chronic disease like Diabetes, Hypertension and Arthritis
- **Very poor:** With more than one chronic disease like Diabetes, Hypertension and Arthritis

Table 10 Health Status of elders

	Male	Female	Total
Good	17 (16.3%)	19 (13.8%)	36 (14.9%)
Average	35 (33.7%)	42 (30.4%)	77 (31.8%)
Poor	36 (34.6%)	52 (37.7%)	88 (36.4%)
Very poor	16 (15.4%)	25 (18.1%)	41 (16.9%)
TOTAL N	104 (100.0%)	138 (100.0%)	242 (100.0%)

More than half (53.3 percent) of the elders interviewed consider their health status either to be poor or very poor while remaining (46.7 percent) consider the same to be good or average.

6.7.2 Treatment Seeking Behaviour

This section presents the findings on availability of health care facilities and treatment seeking behaviour of the elders. It also presents the analysis of data related to sources for meeting health care expenses.

Availability of Health Facilities

The elders were asked about the various health facilities available for Oldest Old in the area. More than half of the elders reported availability of PHC (55.4 percent), CHC (51.2 percent) and private doctor/clinic (51.7 percent) respectively in their area. Availability of other health facilities like Urban Health Centre, District Hospital, RMP, Traditional Healer and private hospital was reported by 10-35% of the elders.

Table 11 Availability of Health Facility for elders

	Male	Female	Total
Urban Health centre	16.3	13.0	14.5
PHC	49.0	60.1	55.4
CHC	57.7	46.4	51.2
District hospital	23.1	18.1	20.2
RMP	31.7	25.4	28.1
Traditional Healer	33.7	31.2	32.2
Private doctor/clinic	53.8	50.0	51.7
Private hospital	7.7	13.0	10.7
TOTAL N	104	138	242

Utilization of Health Facilities for Common Ailments

Table 12 Utilization of Health Facility for elders

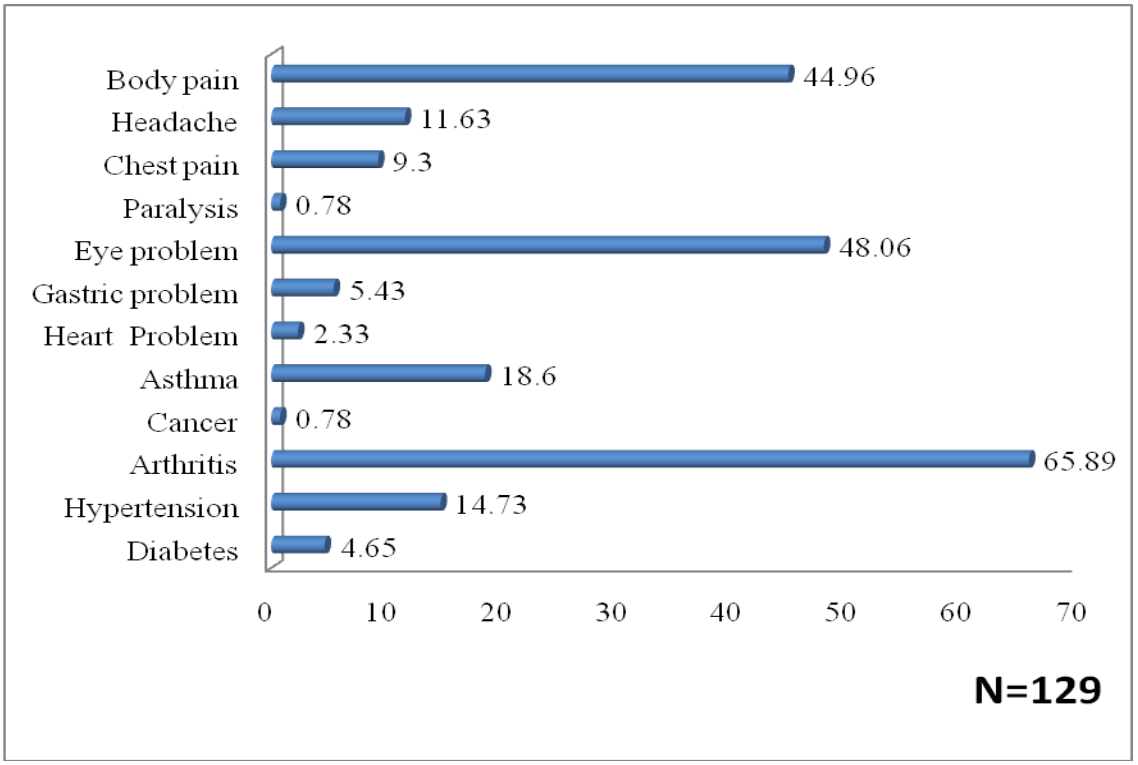
	Male	Female	Total
Govt. Health Facility	49 (47.1)	87 (63.0)	136 (56.2)
Pvt. Health facility	21 (20.2)	28 (20.3)	49 (20.2)
RMP/Traditional Healer	34 (32.7)	23 (16.7)	57 (23.6)
TOTAL N	104 (100.0)	138 (100.0)	242 (100.0)

The findings pertaining to the health care facilities utilized for treatment of common ailments among elders are presented in Table 12. Nearly one fifth (20.2 percent) of the elders reported that, they utilize private doctor/clinic for their treatment and while more than half reported use of Government health facility. Table shows that after so much development and progress; peoples utilize RMP doctors/ traditional healer facility.

Diseases for which Treatment is Sought

Those elders who perceived their health to be poor or very poor at the time of survey (presented in Figure 9) were further asked whether they are undergoing treatment for any health problem. The major health problems reported include body pain (44.96 percent), eye problem (48.06 percent) and Arthritis (65.89 percent). Asthma (18.60 percent) and Hypertension (14.73 percent) were other diseases reported by the elders.

Figure 9 Type of Health Problem for which Taking Treatment



Note: Total adds to more than 100 because of multiple response

Source of Funding to Meet Health Care Expenses

The elders were asked about the source of funding for meeting the health care expenses. The analysis of data presented in table 13 reveals that more than two third (69.8 percent) of the elders are meeting their health care expenses from the money they receive from their children. The second most important source for meeting expenses is their own savings, as more than two fifth of the elders reported so.

Table 13 Sources of Funding to Meet Health Care Expenses

	Male	Female	Total
Savings	50.0	40.6	44.6
Health insurance	7.7	13.0	10.7
Children	69.2	70.3	69.8
Take loan from someone	25.0	24.6	24.8
Relatives/ Friends	17.3	12.3	14.5
TOTAL N	104	138	242

6.7.3 Awareness and Utilizations of Health Insurance Services

An attempt has also been made in this study to understand the awareness and utilization of health insurance among the Oldest Old. This section presents the findings pertaining to this.

Awareness on welfare Insurance

Figure 10 Awareness among elder on welfare Schemes

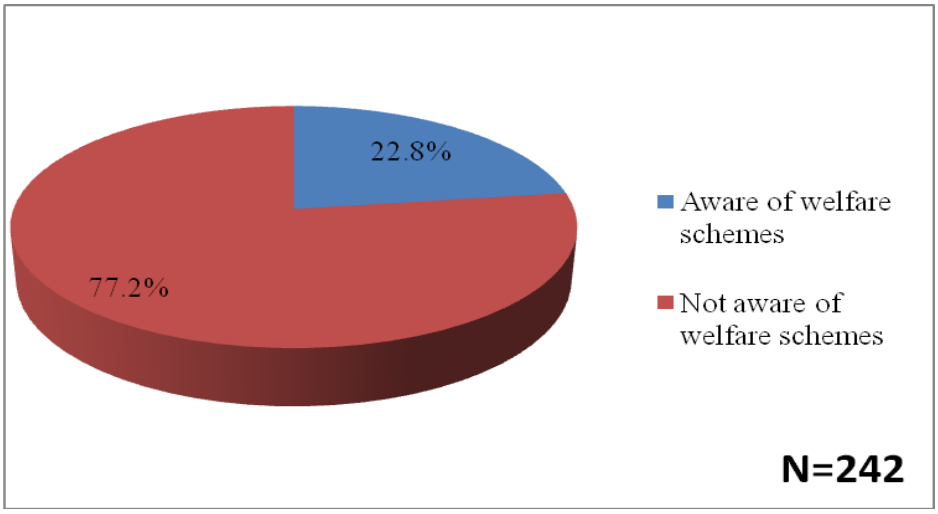


Figure 10 gives the proportion of elder who reported to have heard about any welfare Scheme. About 23% of the elder are aware of any health insurance scheme. Table 14 gives percentage of elders aware any welfare scheme; elders only aware about RSBY (81.8 percent) and Pension Yojana (18.2).

Table 14 Percentage of elders Aware any welfare scheme

	Total
RSBY	45 (81.8)
Pension Yojana	10 (18.2)
TOTAL N	55

Awareness on RSBY

Figure 11 Awareness of Rashtriya Sawsthya Bima Yojana among elders

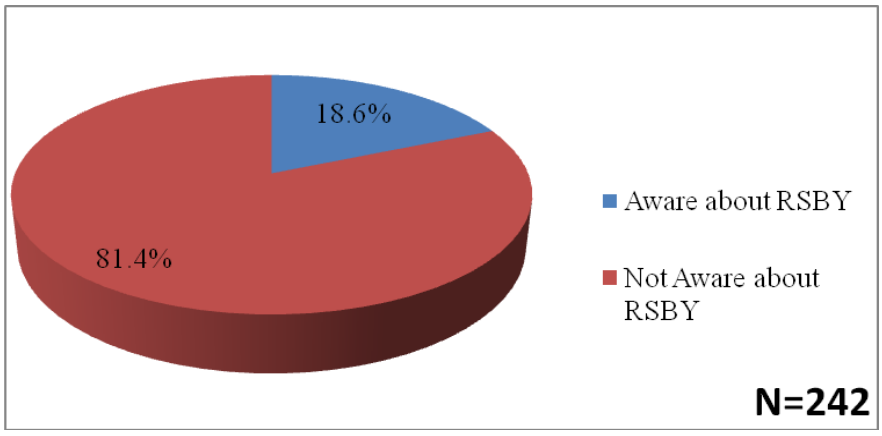
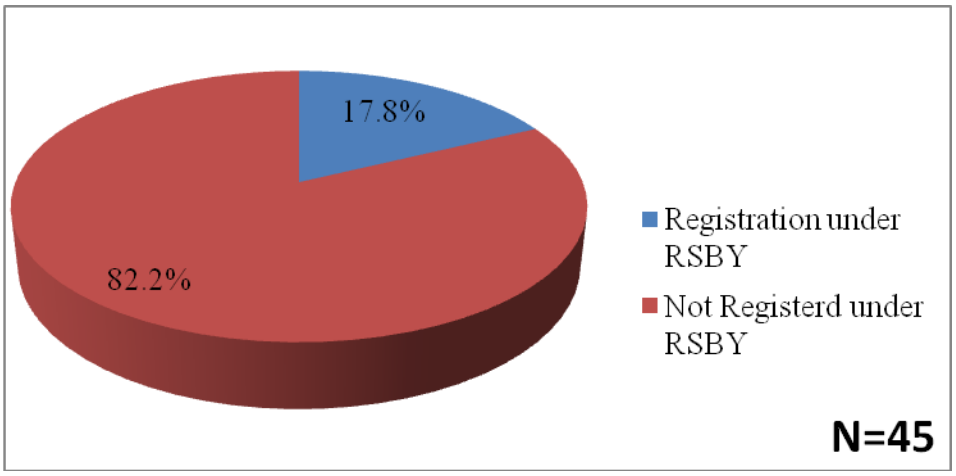


Figure 11 gives the proportion of elders who reported to have heard about Rashtriya Sawsthya Bima Yojana (RSBY). The awareness about the RSBY among the elders is very low as only 18.6 percent reported the same.

Registration under RSBY

Figure 12 Registration of elders under RSBY



Only 0ne-fifth (17.8 percent) elders registered under RSBY scheme but none of registered elder used RSBY card for their treatment.

7. DISCUSSION AND CONCLUSION

India's demographic contours suggest a steep rise in the elderly population in the coming decades as a result of declining fertility, increasing expectation of life at birth and (partly) at later ages. Although the proportion of the elderly population in 2001 may be low, but still India will rank second in the world in absolute numbers. There will be about 75.9 million elderly people in India at that time; one out of every twelve persons will be aged 60 years or more in 2001 (Census data, 2001)(Rajan et al., 1999)[5]. Elders are the growing populations in our country. It is estimated that by the year 2050 elderly population will out reach the youth population and India will be in the first position all over the world.

Due to the change in the social outlook, the elderly populations are not considered in most of the circumstances. This phenomenon, coupled with rapid social changes resulting in the gradual breakdown of the traditional joint family system and ever-increasing financial constraints at the national level, poses serious problems for the elderly.

Among the positive factors which have been sustaining the elderly in India is the strong attachment of family members to the elderly. Social pressure continues to be placed on persons who fail to discharge this responsibility to their elderly family members. Thus it is important to strengthen these values and the capacity of families to cope with the problems of caring for the elderly. The elderly should be considered as human resources and their rich experience and residual capacities should be put to optimum use for the benefit of national development. Their ability to lead healthy and fruitful lives should be ensured by Government.

In the absence of family support, they would expect help from the Government. However, the Government has no old age pension scheme nor has any provision been made for granting aid to the State Governments for this purpose. Although State

Governments and Union Territories have initiated schemes to provide some financial assistance to the handicapped or the destitute, the amount of such pensions ranges from only Rs. 30 to 60 per month. Moreover, owing to the paucity of funds available, the pensions cover only a fraction of the persons eligible.

In India, the government concern for the elderly began with India's participation in the World Assembly Conference in Vienna in 1982, where India adopted the United Nations International Plan of Action on Ageing. This plan focused on the government's role in adopting programmes for the care and protection of the elderly, synchronizing these with the changing socio-economic conditions of the society. The government has begun to recognize the aged as a social category, in need of specialized attention. One of the early interventions was the introduction of pension schemes that were applicable to a minority of the elderly along with other welfare measures. The government has promised to set up an inter-ministerial committee to implement the National Policy on Older Persons which was released by the Government of India in January 1999, in the International Year of Older Persons.

These policy changes comprise a positive step in the right direction. However, the problems of the elderly need to be tackled from both the side: supply and demand. From the supply side, there is a greater need to provide facilities, infrastructure and sensitive handling, to cater to the health of the elderly. But to ensure that treatment reaches those who need it, there is also a need to focus on the demand side of the problem by generating the demand: this would entail focusing on vulnerability factors, and giving special attention to the most vulnerable group.

Since resources are scarce, any programme must be based on prioritizing and targeting. Targeting however should be done carefully, by looking at vulnerability factors first, so that those in need of help the most are not left out. At the same time, planners need to explore the reasons that make a particular group more vulnerable than others, so that these can be tackled in the programme design. At the national level, a mixture of pension schemes, social security systems or insurance need to be funded

and implemented, which would go a long way in helping elderly men and women. In addition, attention must be paid to those factors that impede individuals or groups from taking advantage of these new or even existing programmes like current supply of health services. Education is a key variable that determines who would be better able to express his/her demand. Adult education programmes that already exist in many forms need to be more aggressively targeted, because the benefits spill over from adults to the elderly. Finally, widows, those who are unemployed, as well as those who are below the poverty line need specific intervention and programmes than others. It is precisely these shades in policymaking that are called for if an impact has to be made on the welfare of the elderly in India; rather than focusing on health care interventions based on differentials alone. Vulnerability of the elderly has to be viewed in terms of going much beyond the straight jacket of gender bias.

The results of this study showed that a major proportion of the elderly were out of the work force, partially or totally dependent on others, and suffering from health problems with a sense of neglect by their family members. There is a growing need for interventions to ensure the health of this vulnerable group and to create a policy to meet the care and needs of the disabled elderly. Further research, especially qualitative research, is needed to explore the depth of the problems of the elderly.

8. **RECOMMENDATIONS**

- Firstly we should identify the health care and other needs of the elders and resolve the same on priority basis.

- Abuse at family level is also an issue hence the family members need to be educated about the harms of the elder abuse and Volunteers should also be encouraged to accompany the elderly in seeking health care.

- Since financial dependence on family members and others is a primary issue at this age, the elders should be provided free treatment and medicines or universal health insurance coverage covering all types of health problems of the elders.

- Free health treatment, food, medicines and clothes should be provided and also free vehicles services should be rendered for going to bank, post office, hospital, nursing home and doctors. Number of seats for senior citizens should be increased in the buses.

- Government should initiate some good health related schemes especially for 60+ people and all new and existing schemes should be available at each and every hospital.

- Outreach services should also be provided to the elders. Houses with elderly population should be identified and their health status, issues/ concerns should be registered; this can be done by the local health functionaries.

- To provide an effective mechanism for senior citizens so that they can claim need based maintenance from their children including foster children, adopted children, step children, grandchildren and also from such relatives to whom they have provided financial support.

- Mobilization and community based support towards the elders also needed to be emphasized and worked upon. Efforts need to be made to sensitize the people especially the young generation towards the needs and concerns of the elders.

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For research purpose only

Study on Elderly Needs, Care and Support in West Delhi

Structured questionnaire for interview of oldest of old (60+ Population)

Region	Urban A Rural B
Name of respondent	
Sex of Respondent	Male 1 Female 2
Address	_____ _____

Name of Interviewer: _____

INTERVIEW THE ELDERLY PEOPLE AGED 60 YEARS AND ABOVE

INTRODUCTION/ INFORMED CONSENT

Namaskar. My name is _____. I am from International Institute of Health Research, New Delhi. Our Institute carry out studies on health, nutrition, development etc. Currently I am doing a study on issues relating to elderly people in Urban and rural areas of west Delhi. I shall be grateful if you can spare some of your valuable time and provide the information. Please be assured that the information provided by you will be kept confidential and used only for research and programme purpose.

Respondent willing 1 **Respondent not willing 2**

Signature of interviewer _____

1. BACKGROUND

Q. No.	Questions and filters	Coding categories and codes		Skip to
101	What is your age?	☐☐ (RECORD IN COMPLETED YEARS)		
102	What is your marital status?	Currently Married	1	
		Unmarried	2	
		Separated/ Deserted	3	
		Divorced	4	
		Widow/ widower	5	
103	What is the highest educational level you have completed?	**Level**	**Code**	
		Illiterate	1	
		Primary	2	
		Middle	3	
		Secondary	4	
		Higher Secondary	5	
		Graduate	6	
		Professional/ Post Graduate and above	7	
104	What is the religion of the head of the household?	Hindu	1	
		Muslim	2	
		Christian	3	
		Sikh	4	
		Other (Specify) _____	5	
105	Which social category do you belong to?	Scheduled Caste	1	
		Scheduled Tribe	2	
		Other Backward Castes	3	
		Other (Specify) _____	4	
106.	Type of house?	Kuchha	1	

	(DO NOT ASK. OBSERVE AND RECORD)	Semi-Pucca	2	
		Pucca	3	
107	Does your household own this house?	Yes.....	1	
		No	2	
108	How many children do you have? How many sons? How many daughters?	Sons ☐☐ Daughters ☐☐ **Total** ☐☐		
109	With whom you are staying at present?	With son(s)	1	→ **201**
		With daughter(s)	2	→ **201**
		With spouse	3	
		With domestic help/caretaker	4	
		Alone	5	
		Other (SPECIFY) _____	8	
110	Could you please tell us why are you not living with your son/daughter?	Health problem	1	
		Children working/living at another place	2	
		No support from children	3	
		Has no children	4	
		Other (Specify)_____	5	
		No	2	

2. SOCIAL AND ECONOMIC STATUS

201	What was your last main occupation? SINGLE CODE	Unskilled worker	1	
		Skilled worker	2	
		Petty trader	3	
		Shop owner	4	
		Agricultural labourer	5	
		Homemaker/House wife	6	
		Other (SPECIFY) _____	7	
202	Are you currently engaged in any economic activity?	Yes	1	
		No	2	→ **204**
203	What kind of economic activity are you <u>mainly</u> involved in? SINGLE CODE	Unskilled worker	1	
		Skilled worker	2	
		Petty trader	3	
		Shop owner	4	
		Agricultural labourer	5	
		Homemaker/House wife	6	
		Other (SPECIFY) _____	7	

		Category	**Code**	**Rank**
204	Which are the sources of your income? **CIRCLE ALL RESPONSES RELEVANT AND GIVE RANK**	Pension	1	
		House rent	2	
		Business	3	
		Remittance from children	4	
		Interest on Savings and Fixed Deposits	5	
		No Income	6	
		Other (SPECIFY) _____	7	

205	How much is your monthly household income from all the sources?	_____ (in Rs.) Can't say…….96666 Don't know…….98888		
206	Do you own agricultural land?	Yes	1	
		No	2	
207	Do you depend on anyone for financial requirement?	Yes	1	
		No	2 →	**301**
208	On whom do you depend? **CIRCLE ALL RESPONSES RELEVANT AND GIVE RANK**	**Category**	**Code**	**Rank**
		Spouse	1	
		Son	2	
		Daughter	3	
		Son-in-law	4	
		Daughter-in-law	5	
		Other (SPECIFY) _____	6	

3. HEALTH STATUS AND CARE GIVING

301	Could you please tell us about your health status? READ OUT	Good (no such health problem)	1 →	**303**
		Average (with seasonal health problems like cold,fever etc.)	2 →	**303**
		Poor (with any one of the chronic disease like Diabetes, Hypertension and Arthritis)	3	
		Very poor (with more than one chronic disease like Diabetes, Hypertension and Arthritis)	4	
302	Please tell us for which health problem are you undergoing treatment at present? **CIRCLE ALL RESPONSES RELEVANT**	Diabetes	1	
		Hypertension	2	
		Arthritis	3	
		Cancer	4	
		Asthma	5	
		Heart Problem	6	
		Gastric problem	7	
		Eye problem	8	
		Paralysis	9	

		Chest pain	10	
		Headache	11	
		Body pain	12	
		Can't Say	13	
		Others (Specify) _____	14	
		No Treatment	15	
303	Where do you generally go for your treatment? SINGLE CODE	Sub centre	1	
		PHC	2	
		CHC	3	
		District hospital	4	
		RMP	5	
		Traditional Healer	6	
		Private doctor/clinic	7	
		Private hospital	8	
		Home made remedies	9	
		Others (Specify) _____	10	

304	How do you meet the expenses of health care treatment? **CIRCLE ALL RESPONSES RELEVANT AND GIVE RANK**	**Category**	**Code**	**Rank**	
		Savings	1		
		Health insurance	2		
		Chidlren	3		
		Medical reimbursement	4		
		Take loan from someone	5		
		Other (SPECIFY) _____	6		
305	What kind of health and medical facilities available in your area? **CIRCLE ALL**	**Category**	**Code**	**Rank**	
		Sub centre	1		
		PHC	2		
		CHC	3		

	RESPONSES RELEVANT AND GIVE RANK	District hospital	4		
		RMP	5		
		Traditional Healer	6		
		Private doctor/clinic	7		
		Private hospital	8		
		Others (Specify) _____	9		
306	Are you covered under any health insurance?	Yes	1		
		No	2		
307	In case of any health related problem, who takes care of you? **CIRCLE ALL RESPONSES RELEVANT AND GIVE RANK**	**Category**	**Code**	**Rank**	
		Son/Daughter	1		
		Daughter-in-laws	2		
		Myself	3		
		Spouse	4		
		Neighbours	5		
		Domestic help	6		
		Others (Specify) _____	7		
308	In your daily life, who takes care of you? E.g. washing clothes, timely meals, bringing medicines and materials from market, help in mobility and carrying out routine chores. **CIRCLE ALL RESPONSES RELEVANT AND GIVE RANK**	**Category**	**Code**	**Rank**	
		Son/Daughter	1		
		Daughter-in-laws	2		
		Myself	3		
		Spouse	4		
		Neighbours	5		
		Domestic help	6		
		Others (Specify) _____	7		

4. Abuse of Elderly and Community Support

401	Have you faced any kind of abuse from your family or others because of your (old) age?	Yes	1		
		No	2 →		**405**
402	What kind of abuse did you face? **CIRCLE ALL RESPONSES RELEVANT AND GIVE RANK**	**Category**	**Code**	**Rank**	
		Physical Abuse	1		
		Emotional Abuse	2		
		Verbal Abuse	3		
		Economic Abuse	4		
		Showing disrespect	5		
		Neglect	6		
		Other (SPECIFY)_____ _____	7		
403	From whom did you face the abuse? **CIRCLE ALL RESPONSES RELEVANT AND GIVE RANK**	**Category**	**Code**	**Rank**	
		Son	1		
		Daughter	2		
		Son in law	3		
		Daughter in law	4		
		Domestic help	5		
		Other (SPECIFY)_____	6		

404	What was the context in which it occurred? **CIRCLE ALL RESPONSES RELEVANT AND GIVE RANK**	**Category**	**Code**	**Rank**	
		Due to property issues	1		
		Lack of physical space within the house eg. no place to stay	2		
		Lack of emotional support	3		
		Lack of Health care eg. if I'm unwell I don't have access to medical facilities, don't take me to the doctor, don't give me money to buy medicines	4		
		Lack of basic necessities eg. food, clothing etc	5		
		Over the issue of raising children eg. children's education, their upbringing	6		
		Over the issue of managing the household eg. looking after the house, buying house/ car	7		
		Financial dependence eg. depend on own children for money to buy anything	8		
		Dependence on others due to disability	9		
		Disrespect by/ negative attitude of own children	10		
		Lack of adjustment	11		
		Other (SPECIFY)_____ _____	12		

405	Does your community have any arrangement or facility in case the elderly need any help?	Yes	1	
		No	2	→ **407**

406	What kind of support do they provide? **CIRCLE ALL**	**Category**	**Code**	**Rank**	
		Physical Support	1		
		Economical Support	2		

	RESPONSES RELEVANT AND GIVE RANK	Emotional Support	3		
		Juridical Support	4		
		Others (Specify) _____	5		

407	Is there any NGO in your area working on elderly issues? E.g. health care, providing medical equipment, counselling, legal support.	Yes	1	
		No	2 →	**410**
408	IF YES, have you sought any help from them?	Yes	1	
		No	2	

409	IF **YES IN Q408**, what kind of help have you sought/ IF **NO IN Q408**, then what kind of help generally they provide? **CIRCLE ALL RESPONSES RELEVANT AND GIVE RANK**	**Category**	**Code**	**Rank**	
		Physical Support	1		
		Economical Support	2		
		Emotional Support	3		
		Legal Support	4		
		Others (Specify) _____	5		

410	Have you heard about Rastriya Swasthya Bima Yojana (RSBY)?	Yes	1	
		No	2 →	**413**
411	Are you registered under RSBY?	Yes	1	
		No	2 →	**413**
412	Have you ever used RSBY card for your treatment?	Yes	1	
		No	2	
413	Have you heard of any other welfare schemes available for the elderly?	Yes	1	
		No	2 →	**417**
414	IF YES, what are those schemes?	1_____		

	LIST ALL RESPONSES	2_____ 3_____ 4_____				
415	Have you ever used/using any of these schemes?	Yes	1			
		No	2 →			**417**
416	IF YES, what kind of support/benefit have you received/receiving? **CIRCLE ALL RESPONSES RELEVANT AND GIVE RANK**	**Category**	**Code**	**Rank**		
		Physical Support	1			
		Economical Support	2			
		Emotional Support	3			
		Legal Support	4			
		Others (Specify) _____	5			
417	Please tell us about your need/ requirement or desire at this age? **CIRCLE ALL RESPONSES RELEVANT AND GIVE RANK**	**Category**	**Code**	**Rank**		
		Health Care	1			
		Separate hospital for elderly	2			
		Free treatment	3			
		Free health insurance	4			
		Financial aid	5			
		Pension schemes should be started	6			
		Steps to be taken for security	7			
		Housing facility	8			
		Free travel passes should be provided	9			
		No discrimination	10			

		Emotional Support	11		
		Physical Support	12		
		Others (Specify) _____	13		