COMMUNITY CARE FOR ELDERLY

A SITUATIONAL ANALYSIS OF ELDERLY IN SELECTED LOCALITIES OF MUMBAI

PROJECT LOCATION: LOWER PAREL AND DHARAVI (MUMBAI)

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MARCH 2016

PREFACE

The emerging changes in the age and sex structure of India's population, will have a profound impact on the demographic landscape and are expected to pose multifaceted developmental challenges, especially for older persons. A rapid increase in the number of older persons as well as their proportion in our population has led us to being more conscious of the many social, economic, psychological and health problems of the older population. Several researchers have attempted to focus on issues of the elderly from various surveys commissioned for different purposes. However, data base focusing exclusively on the elderly is very limited. Hence, Tata Institute of Social Sciences (TISS) in collaboration with Family Welfare Agency (FWA), Mumbai and Tata Trusts, undertook a research project on Situational Analysis of Elderly to initiate activities at local level, especially in urban context by strengthening community care services. In this regard, generating scientific and systematic information on the living conditions of the older persons in selected localities by conducting a situational analysis was prime focus of the study. Further, such a study is expected to help in providing information on gaps in the existing services and also provide valuable clues for designing suitable interventions to promote community care for elderly.

The review of the studies conducted so far on Situation of Elderly show that a lot of focus has been centered on these issues in the West, while in India, negligible attempts have been made. Given the complexities involved in understanding the issues and concerns affecting the well-being of elderly, it is very important to initiate the process of understanding their needs and evolve a plan of action to minimize their problems and enhance their quality of life. In this regard, it is increasingly seen that organizations like FWA are focusing on various social activities to improve the condition of the elderly within community, along with the establishment of intervention projects in the areas of their operations.

Both quantitative and qualitative approaches were used in the study as it provides a comprehensive and in-depth understanding of the socio-economic, demographic, housing and health conditions of the elderly in the community. The data collection was carried out during the period November 2015 to January 2016 and altogether 2700 elderly residing in the localities of Lower Parel and Dharavi were covered in the survey. The collected data was analyzed in four clusters forming localities, namely; Matunga Labor Camp, Dharavi, Lower Parel and BDD Chawl.

The successful completion of the survey and this report under the title 'Community Care for Elderly' would not have been possible were it not for the engagement of various individuals and institutions that contributed at different stages of the project. We sincerely thank and convey our deepest gratitude to all of them.

Prof. S. Parasuraman, Director, Tata Institute of Social Sciences (TISS) for granting necessary permission to associate with this major project and for his constant encouragement.

Ms.Sugandhi Baliga, Tata Trusts for conceptualizing the study, entrusting it to us and also for her valuable suggestions at various stages of the study. We are thankful to Mr. Nilesh Yadav, Programme Associate Health, Tata Trusts for his constructive and active involvement in the implementation of this study.

We are thankful to Ms. Alpa Desai, Head (FWA) for her co-ordination, co-operation and administrative support throughout the study. Thanks are due to all the FWA officials, especially; Mrs. Kranti Bhilare, Junior Social Worker, and all the other members who are associated with the field activities.

Our sincere thanks to Dr.Nidhi Gupta, Assistant Professor, TISS for her academic support during the study.

We appreciate all the TISS survey team for their sense of responsibility and commitment in successfully carrying out the various research activities in the assigned field areas. We thank the project staff: Mr. Gandharva Pednekar, Ms. Pranali Panchal, Ms. Shweta Singh and Ms. Rashmee Sharma for their continual involvement in the execution of the project.

Our sincere thanks to the community workers in the respective study areas, various personnel of government and non-governmental agencies and volunteers who assisted indifferent stages of the field work.

Last but not the least, to all the community members of the study areas, who provided us with the requisite information.

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CHAPTER 1: INTRODUCTION

India, the world's second most populous country, has experienced a dramatic demographic transition in the past 50 years, entailing almost a tripling of the population over the age of 60 years (Government of India, 2011). This pattern is poised to continue. It is projected that the proportion of Indians aged 60 and older will rise from 7.5percent in 2010 to 11.1percent in 2025 (United Nations Department of Economic and Social Affairs [UNDESA], 2008). This is a small percentage point increase, but a remarkable figure in absolute terms. According to UNDESA data on projected age structure of the population (2008), India had more than 91.6 million elderly in 2010 with an annual addition of 2.5 million elderly between 2005 and 2010. The number of elderly in India is expected to surpass the population of children below 14 years by 2050(Raju, 2006).

Population ageing is an important emerging demographic phenomenon in India, warranting a strong multi-sectoral policy and programme response to deal with many significant implications for the elderly in particular and society at large. Longevity by itself is to be celebrated but for the increasing vulnerabilities of the elderly arising out of poverty, income insecurity, illiteracy, age related morbidity, feminization, dependency and decreasing support base. In most of the western countries, advanced stages of development preceded population ageing but the same is not true for many developing and middle-income countries, including India. In India with majority of its population aged less than 30, the problems and issues of its grey population has not been given serious consideration. To reap the advantage of demographic dividend, the attention is mainly on the children and the youth and fulfillment of their basic needs for proper development. Also the traditional Indian society and the age-old joint family system have been instrumental in safeguarding the social and economic security of the elderly in the country. With the rapid changes in the social scenario and the emerging prevalence of nuclear family set-ups in India in recent years, the elderly are likely to be exposed to emotional, physical and financial insecurity in the years to come. This has drawn the attention of the policy makers and administrators at central and state governments, voluntary organizations and civil society. Further, India is presently going through a phase of demographic paradox wherein it has to capitalize on the demographic window of opportunity by investing in youth and at the same time focus on an increasing elderly population. The science of gerontology is still in its infancy in India and the interest of social scientists and social work professionals on various issues of ageing is of recent origin. Only recently were older people identified as a priority group in implementation of social welfare policies and government interventions. Population ageing is a matter of concern that requires continued efforts at all levels, but India at present appears to be falling short in its realization and preparedness to deal with major geriatric issues. There are limited scientific literatures that focus on the situational assessment of elderly in India.

Ageing diminishes the capacity to work and earn. "A reduced capacity for income generation and a growing risk of serious illness are likely to increase the vulnerability of elders to fall into poverty, regardless of their original economic status…" (Lloyd-Sherlock.2000) The presence of elderly make its implication on the production function within the household and thus on overall work effort that reflects in income and production (Schwarz, 2003). In other words, in most of the cases, the presence of the elderly creates distortions in the production function as they are physically unfit to work. This can have direct effect on the wellbeing of the households that reflects in the poverty among elderly. The inability in the initial endowment of an individual that deteriorates as they go up in the life cycle make them more vulnerable and puts them a position in which they fail in risk management and maintenance of a cope-up strategy in maintaining the level of living conditions (Zwi, 1993). This makes the elderly more dependent on others for their needs resulting in higher levels of economic insecurity and deprivation. Studies across the globe have revealed a sudden dip in

the life of the elderly after the retirement (World Bank, 1994,Steyn 2000, Bradshaw, 2006). While in the West most of the elderly are under the social safety net, the incidence and magnitude of the economic insecurity are high in the case of developing countries (Helpage International, 2003; World Bank, 2001).

Physical and health risks are very high among the elderly. The precise implications of population aging for future levels of health and health care utilization depend on whether the increases in life expectancy experienced in general are accompanied by an increase or decrease in health problems in later life (Gruenberg, 1977; Kramer, 1980; Manton, 1982). The increased healthcare expenditure in households with elderly in the developing world has led to deprived access to health treatment to the elderly. (Helpage International, 2005). The studies highlight high rates of deprivation of good health and lack of care in the developing and transitional economies (Balkov, 2005; Ferrer, 2002; WHO, 2004).

A few important characteristics of the elderly population in India are noteworthy. Of the 7.5percent of the population who are elderly, two-thirds live in villages and nearly half are of poor socioeconomic status (SES) (Lena et al., 2009). Half of the Indian elderly are dependents, often due to widowhood, divorce, or separation, and a majority of the elderly are women (70%) (Rajan, 2001). Of the minority (2.4%) of the elderly living alone, more are women (3.49%) than men (1.42%) (Rajan and Kumar, 2003). The majority of the Indian elderly work in the informal sector with low levels of wages and deficient working conditions and this has also put the elderly in a state of deprivation, vulnerability and distress in old age in terms of both health and economic security (Helpage International, 2002). Studies have shown a gradual decline in the standard of life of the elderly with high rates of dependency and lack of basic needs (Rajan Mishra and Sarma, 1999; Rajan, 2004; Alam, 2007). The occurrence of economic, health and social insecurities are becoming common (Dey, 2000; World Bank, 2001; Priya, 2003; Alam, 2007).

The belief that children will take care of the parents in the old age is eroding in India where the family size has been cut down as a result of the demographic process (Dandelkar, 1996). The situation in the urban areas shows a rejection of older people by the next generation and this is spreading to rural areas (Desai, 1985). In the nuclear family setting, the position of the elderly become more vulnerable and are treated as a burden to the family (Nayar, 1992). The social negligence of the elderly occurs due to cultural, social and economic relations within the society and its coexistence with demographic development (Achenbaum, 1978). This changing dynamic that starts within the family and society can make the elderly insecure (Alter G Et all 1996) through intergenerational imbalance (Hareven and Adams, 1996). These changing dynamics can affect the living arrangements and social protection system and make the elderly more insecure. The Global Report on Ageing in the 21st Century (2012) maintain that there is multiple discrimination experienced by older persons, particularly older women, including in access to jobs and health care, subjection to abuse, denial of the right to own and inherit property, and lack of basic minimum income and social security (UNFPA & HelpAge International, 2012)

Objectives of the study:

A rapid increase in the number of older persons as well as their proportion in our population has led to us to being more conscious of the many social, economic, psychological and health problems of the older population. One such initiative is to work at locality level especially in urban context by strengthening community care services. In this regard, generating

scientific and systematic information on the living conditions of the older persons in selected localities by conducting a situational analysis is vital. Further, such a study helps in providing information on gaps in the existing services and also valuable clues for designing suitable interventions to promote community care for elderly.

The specific objectives of the study are as follows:

1. Understand the living conditions of the older population in the selected localities of Mumbai, in terms of social, economic, demographical, cultural and health aspects with a view to know their expectations from various stakeholders towards their care,
2. Know the programmes and services for the care of the older population in the city of Mumbai in terms of old age homes, day care centres, senior citizen's clubs, old age pension schemes and other such programmes, and prepare a directory of the same with a view to assist FWA in its networking initiatives,
3. Develop locality level action plan to build enriching community care for elderly in order to strengthen the need based services especially community care for them,
4. Develop strategy to enhance inclusion of senior citizens in the community in order to increase their participation in the management of Elder friendly care and Enrichment Centres (EEC's), prevention of elder abuse and also build a volunteer force for elder care.

The objectives listed above have been framed by keeping in view of the specific activities carried out over a period of time by Family Welfare agency in the study localities, and the experience gained by the agency while addressing the issues related to welfare of elderly and improving their quality of life.

CHAPTER 2: METHODOLOGY

A Descriptive study was conducted using both qualitative and quantitative methods in two localities within Mumbai, namely, Lower Parel and Dharavi. These localities were specifically selected due to the already existing presence of our implementing agency i.e., Family Welfare Agency (FWA) which has been working for welfare of elderly in these communities since more than a decade. The sub-localities that formed the study area of Lower Parel were parts of Delisle Road, Curry Road, Lower Parel west, areas near Chinchpokli station and Lower Parel station, and Arthur Road. Dharavi majorly consisted elderly residing in Matunga Labour Camp and three sub-localities within Dharavi namely: Bhagat Singh Nagar, Nithyanand Nagar and Kunchikurve Nagar.

All elderly members aged 60 years or above were interviewed. The field work was carried out during the period November 2015 to January 2016 and a total of 2700 elderly interviews were conducted. The collected data was analyzed in four clusters forming localities, namely; Matunga Labor Camp, Dharavi, Lower Parel and BDD Chawl.

The tool used for conducting the survey was a closed-ended interview schedule. The interviews were administered on Tablets by a set of trained investigators using the application 'Collect'. The Schedule collected basic information on the Demographic profile, Housing conditions and Living Arrangements of elderly, Economic Conditions, Socio-Cultural Engagement and Subjective Health and Nutrition Assessment. An interviewer's Manual was designed that contained techniques and procedures for conducting and completing the interviews. It explained the questions and procedures for soliciting the responses and quality checks for ensuring consistency of responses. Field investigators involved in data collection were trained to use and administer the questionnaire on tablets. Cross-sectional analysis of data was conducted using Software Package used for Statistical Analysis (SPSS).

Profile of Implementing Agency: The Family Welfare Agency (FWA)

The Family Welfare Agency (FWA) has been established since 1950 in the city of Mumbai, Maharashtra, India. It is a voluntary social organization, registered under the Bombay Public Trust Act of 1950 (E-5(BOM)). The FWA has two centers located in Lower Parel, Mumbai (for the elderly and for the mentally ill) and one center at Dharavi (for the elderly). The agency has developed from working with general community based issues to providing specialized services in the field of Ageing and Mental Health. The FWA has worked at three levels preventive, promotive and curative within the community and nearby areas. The agency has, thus progressed from 'remedial' to 'therapeutic' and has now broadened its approach with a 'social development' perspective, emphasis on integrating approaches. This integrated development approach has been instrumental in enhancing the quality of life along with people's participation to achieve the same.

FWA through the Multi-Service Centers for the senior citizens has been providing direct need based community services such as:

Health care: Physical/ Mental: Health check up camps, Health management support, Nutrition guidance and aid, Medical aid, Provision of Assistive aids, Yoga class, Physiotherapy clinic.

Educational: need based issues and topics, focus on health – physical / mental, social, spiritual, legal, cultural, personal development through lectures, field trips, awareness sessions, discussions and debates, workshops, Interactive Group sessions, Street play on elder abuse: formed and acted by senior citizens

Counseling-individuals/families on issues such as elder abuse, neglect, family relations, stress, health, link up with Government schemes for old age pension etc.

Community outreach: Care of the homebound elderly and those with special needs: stroke, dementia, alzheimers; Home Visits to regular members for need based follow-up; enhance participation of non –members; Family related activities such as Inter-generation dialogues and improving relations are all a part of the FWA intervention agenda in order to create an elder-friendly community.

Recreational activities include hobby groups – bhajan / music activity(men and women), picnics, visits, games – indoor and outdoor, competitions – games, elocutions, singing, dancing, poems, essays, programmes – cultural, music shows, movies, dramas and celebration of important days/ festivals.

Provision of legal aid is also an important pursuit of FWA apart from all the activities mentioned above. It also flaunts a library that is open for use to the elderly.

The FWA has been providing services for the elderly at the grassroot level in certain geographical areas however, its outreach is minimum in terms of the phenomenal growth in the elderly population and the dearth of organizations working for the care of the elderly in the field. Hence, the FWA elder care initiatives, was strengthened by developing the concept of networking and ward level efforts to enhance the outreach in a qualitative manner.

The initiatives to develop elder friendly wards and to develop responsive services for the care of the elderly were undertaken alongwith networking among different organizations which focus on welfare of the elderly and to reach out and sensitise the other organizations towards the needs and issues of the elderly.

Collaboration within and across different systems and service providers such as formal / informal organizations like senior citizens associations(SCA), association of retired persons(ARP), old age homes(OAH), NGO's, Government organizations(GO), Financial institutions, Transportation, Health care institutions (hospitals, labs), Judicial system (laws, police), Emergency services(ambulance, fire brigades, police), media and commercial establishments were made.

These experiences and contributions in the field of elder care is now being strengthened further to gear towards 'community care of the elderly' as a model and fulfil the FWA goal of "Care of the elderly and building elder friendly enriching communities in the city of Mumbai".

CHAPTER 3: DEMOGRAPHIC PROFILE

Age-sex distribution:

The elderly population cannot be considered a homogenous group with similar needs and expectations. Age specific requirements and services are just as important as the varied needs of the males and females. Therefore, the age of the respondents were categorized into three age groups, namely, 60-64 years, 65-69 years and those who were 70 years or above.

Figure 1: Percentage Distribution of Elderly by Sex & Locality

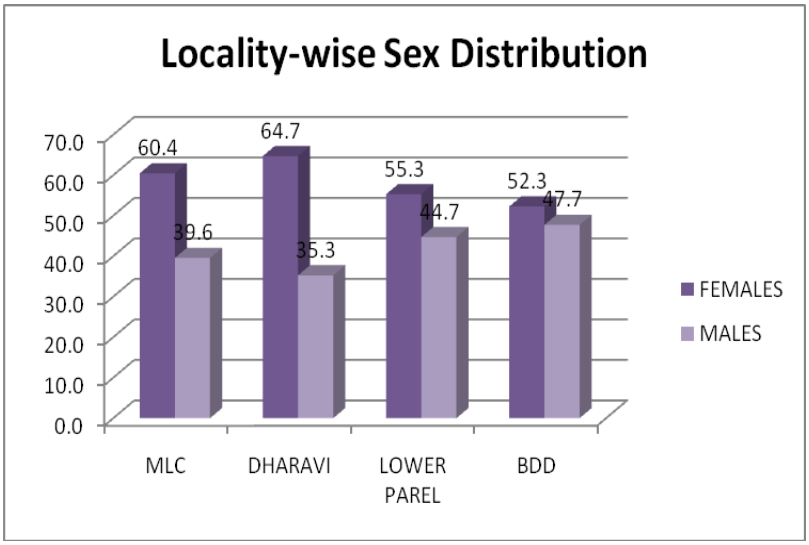


Figure 2: Percentage Distribution of Elderly by Age & Locality

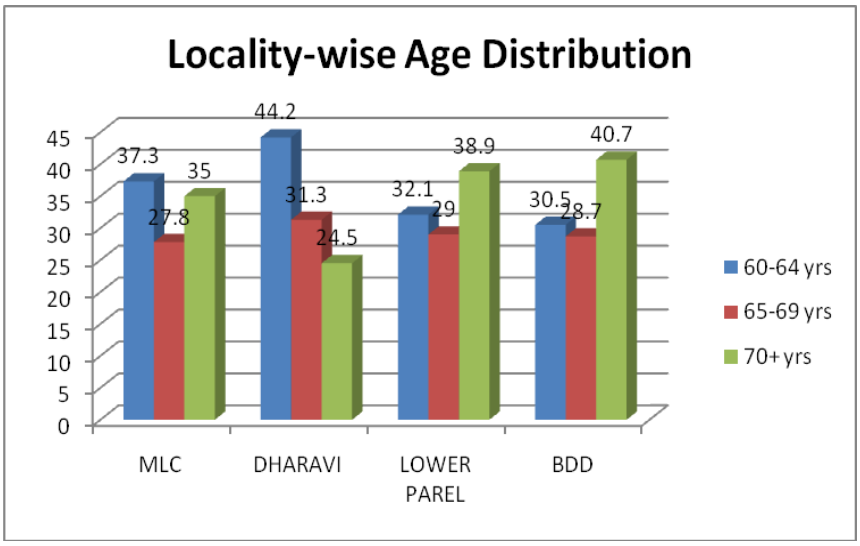


Table-3-1: Percentage Distribution of Elderly by Sex & Age according to Locality

	MATUNGA LABOR CAMP			DHARAVI			LOWER PAREL			BDD CHAWL			TOTAL		
Age groups	Females	Males	Total	Females	Males	Total	Females	Males	Total	Females	Males	Total	Females	Males	Total
60-64 years	283 (41.3)	140 (31.2)	423 (37.3)	73 (50.3)	26 (32.9)	99 (44.2)	173 (34.8)	116 (28.9)	289 (32.1)	55 (23.8)	80 (37.9)	135 (30.5)	584 (37.4)	362 (31.7)	946 (35.0)
65-69 years	174 (25.4)	141 (31.4)	315 (27.8)	35 (24.1)	35 (44.3)	70 (31.3)	132 (26.5)	129 (32.1)	261 (29.0)	76 (32.9)	51 (24.2)	127 (28.7)	417 (26.7)	356 (31.2)	773 (28.6)
70+ years	229 (33.4)	168 (37.4)	397 (35.0)	37 (25.5)	18 (22.8)	55 (24.5)	192 (38.6)	157 (39.0)	349 (38.9)	100 (43.3)	80 (37.9)	180 (40.7)	558 (35.8)	423 (37.1)	981 (36.4)
Total	686	449	1135	145	79	224	497	402	899	231	211	442	1559	1141	2700

The survey covered a total of 2700 elderly (aged 60 years and above), out of which 57.74 percent were women and 42.25 percent men. Thus the overall sex ratio among elderly is 1366 females per 1000 males, more females than males in the enumerated population. The age group distribution of elderly shows that 36.3 percent of elderly are above 70 years of age, 35 percent of elderly lie in the 60-65 years age group followed by 28.6 percent in the 65-70 years group. The sex ratio is uniformly seen to be more than 1000 females per 1000 males in all the three age groups.

Marital status:

Marital status is considered important in determining psychological and emotional health of the people in later years. Availability of spouse might be a significant source of support in later years of life. A marriage relationship can provide affection and a sense of belonging. This valuable support is lost upon widowhood. Table 2 shows percent distribution of respondents by gender, age and marital status.

Table-3-2: Percentage Distribution of Marital Status of Elderly by Sex

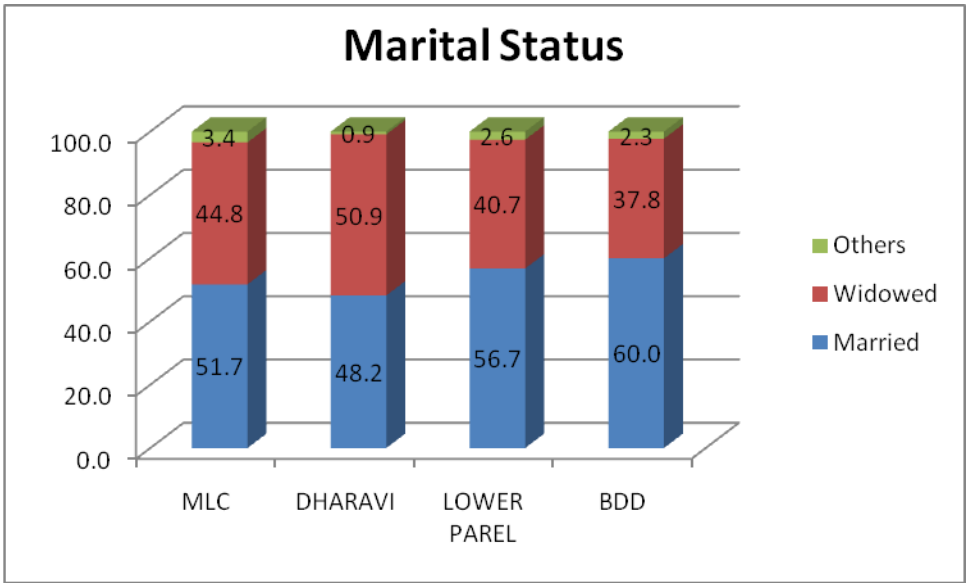
Marital status	Female		Male		GRAND TOTAL	
	No.	percent	No.	percent	No.	percent
Married	556	35.7	914	80.1	1470	54.4
Widowed	971	62.3	185	16.2	1156	42.8
Others	32	2.1	42	3.7	74	2.7

Table-3-3: Percentage Distribution of Marital Status of Elderly by Age

Marital status	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
	No.	percent	No.	percent	No.	percent	No.	percent

Married	626	66.2	438	56.7	406	41.4	1470	54.4
Widowed	290	30.7	310	40.1	556	56.7	1156	42.8
Others	30	3.2	25	3.2	19	1.9	74	2.7

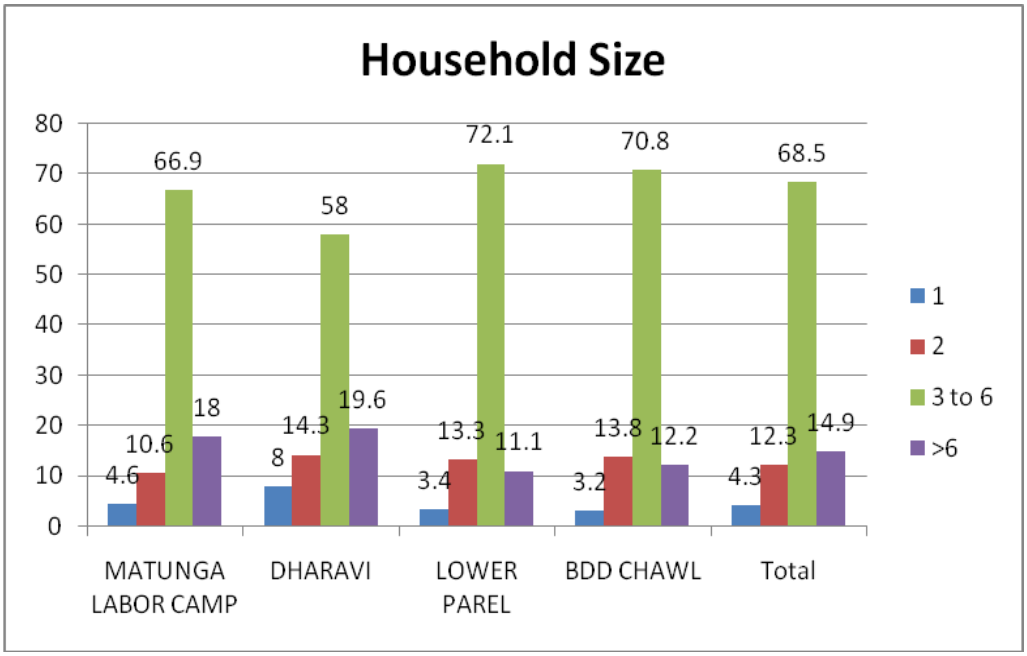
Figure 3: Percentage Distribution of Marital Status of Elderly by Locality



Overall, around 55 percent of the elderly are currently married while almost 43 percent are widowed. The remaining 2.7 percent are either separated, divorced, deserted or never married. The percentage of widows is far higher among elderly women (62.3%) than among elderly men (16.2%). It indicates that a large proportion of widows may have to face more isolation and ordeal compared to their married counterparts. Womanhood and widowhood may jeopardize social, economic and psychological status of females more than their male counterparts in later years of life. The proportion of widowed elderly increases with age as expected. Dharavi showed an opposite trend, with the number of widowed elderly (60%) being higher than married ones (48.2%), as compared to the other three localities.

Household Size:

Figure 4: Percentage Distribution of Elderly by Household Size & Locality



The mean size of the surveyed households was 4.6 persons. The data on number of household members shows that more than 2/3rd of the elderly live in households that comprise of three to six members and almost 17 percent elderly live in one or two member households, followed by the remaining 15 percent who live in households consisting of more than 6 members.

CHAPTER 4: HOUSING CONDITIONS AND LIVING ARRANGEMENTS

The family life of the elderly plays a pivotal role in the quality of later life. To assess their housing conditions and living arrangements is pertinent in order to gauge at the comfort and support that the elderly experience. Variable such as living arrangements, type of dwelling and owner of house, comfort using toilet and bathroom facilities, are discussed in this chapter.

Living arrangements:

Marital status has a direct bearing on the living arrangements of the elderly. This trend has important implications for housing needs and the demand for institutional care. With the decline in the proportion of the elderly living with relatives likely to continue, there will probably be a greater need for the provision of social support and health services by the community or other public sources.

Figure 5: Percentage Distribution of Elderly by Living Arrangement & Sex

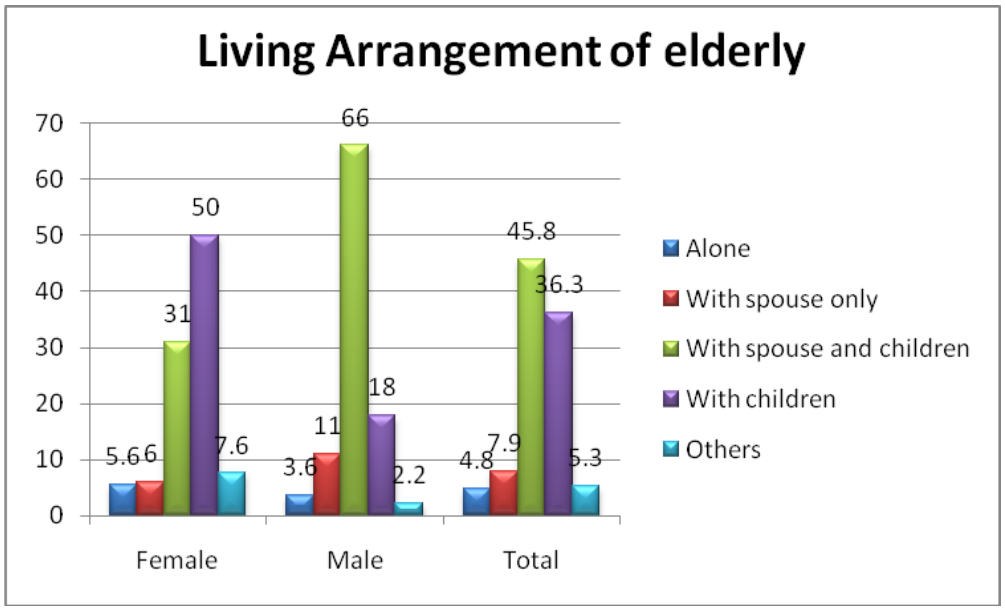


Table-4-1: Percentage Distribution of Living Arrangement of Elderly by Age

Living arrangements	60-64yrs		65-69yrs		70+yrs		Total	
	No.	%	No.	%	No.	%	No.	%
Alone	47	5.0	35	4.5	47	4.7	129	4.8
With spouse only	78	8.2	64	8.3	71	7.2	213	7.9
With spouse and children	504	53.3	381	49.3	351	35.8	1236	45.8
With children	275	29.1	247	31.9	457	46.6	979	36.3
Others	42	4.4	46	5.9	55	5.6	143	5.3

The traditional co-residential family living arrangement is the most common practice across all survey localities. However, a few trends are noteworthy as seen from the profile of elderly men and women by their place of residence and living arrangements. A majority of the elderly are co-residing (more than 83%), and only less than 15 percent of all elderly are either living alone or with their spouse only; and almost 5 percent are living alone. A higher proportion of elderly women (5.6%) than men (3.6%) live alone. This trend is observed in all the four localities.

Type of Dwelling:

Table-4-2: Percentage Distribution of Type of Dwelling of Elderly by Sex

Type of dwelling	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Flat in the building	562	36.0	437	38.3	999	37.0
Tenement with a common toilet	729	46.8	539	47.2	1268	47.0
Others	268	17.2	165	14.5	433	16.0

Table-4-3: Percentage Distribution of Type of Dwelling of Elderly by Age

Type of dwelling	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
	No.	%	No.	%	No.	%	No.	%
Flat in the building	367	38.8	294	38.0	338	34.5	999	37.0
Tenement with a common toilet	402	42.5	360	46.6	506	51.6	1268	47.0
Others	177	18.7	119	15.4	137	14.0	433	16.0

The localities that were selected for this situational analysis, majorly comprised of Middle-income and Lower-income groups of the population. This is clearly reflected in the data on type of dwelling. 47 percent of the elderly lived in tenements with a common toilet (better known as 'chawls'), followed by 37 percent who live in flats in buildings. The remaining 16 percent live either in huts in slum localities (15.7%) or live on the street. Huts in a slum locality are observed to be the most common type of dwelling in Dharavi, with almost 65.2 percent of elderly residing in the same, followed by 22.8 percent living in chawls and 12.1 percent in flats. As for the other three localities, chawls and flats are more common types of dwelling. The percentage of 70+ elderly living in chawls is higher than that of young elderly.

Ownership of Dwelling:

Table-4-4: Percentage Distribution of Elderly by Ownership of Dwelling & Sex

	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%

Ownership of the house						
Rented	115	7.4	80	7.0	195	7.2
Owned	1444	92.6	1061	93.0	2505	92.8
Owner						
Self	794	55.0	870	82.0	1664	66.4
Son	182	12.6	71	6.7	253	10.1
Others	468	32.4	120	11.2	588	23.4

Table-4-5: Percentage Distribution of Elderly by Ownership of Dwelling & Age

	60-64yrs		**65-69yrs**		**70+yrs**		**Total**	
Ownership of the house	No.	%	No.	%	No.	%	No.	%
Rented	90	9.5	45	5.8	60	6.1	195	7.2
Owned	856	90.5	728	94.2	921	93.9	2505	92.8
Owner								
Self	539	63.0	506	69.5	619	67.2	1664	66.4
Son	52	6.1	58	8.0	143	15.5	253	10.1
Others	265	31.0	165	22.5	158	17.2	588	23.4

The survey collected information on ownership of the dwelling in order to gauge at the dependency ratio of elderly for a place to live. Overall, 92.8 percent of elderly live in houses that are owned and the remaining 7.2 percent in rented households. It is observed that more than 2/3rd of the elderly live in houses owned by self, followed by only 10 percent of elderly who live in a house owned by their son. The remaining elderly live in houses owned by their spouse, grandchildren, relatives and others.

Subjective Comfort in existing housing condition:

Table-4-6: Percentage Distribution of Elderly according to their Comfort in existing Housing Condition & Sex

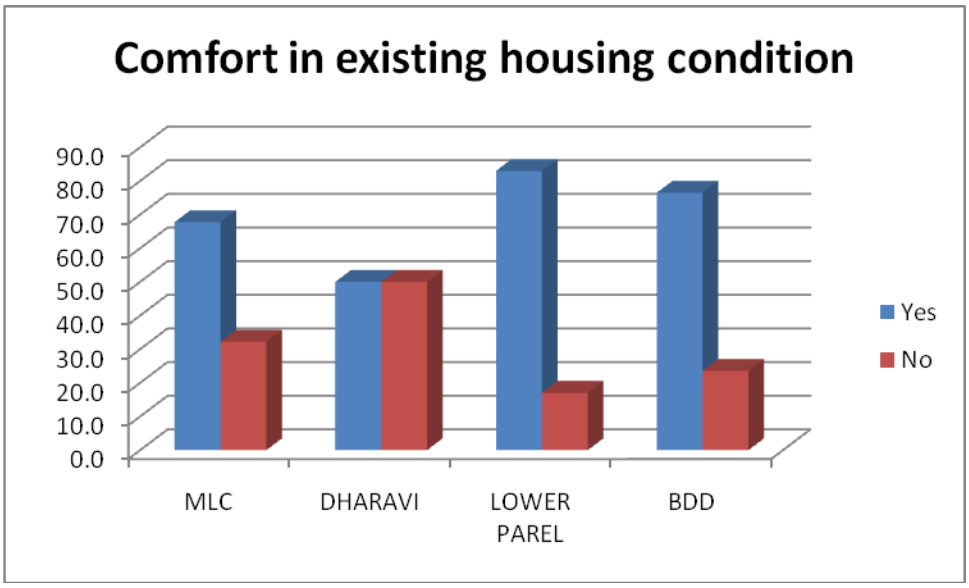
Comfort in existing housing condition	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Yes	1096	70.3	869	76.2	1965	72.8
No	463	29.7	272	23.8	735	27.2

Table-4-7: Percentage Distribution of Elderly according to their Comfort in existing Housing Condition & Age

Comfort in existing housing condition	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
	No.	percent	No.	percent	No.	percent	No.	percen

								t
Yes	701	74.1	568	73.5	696	70.9	1965	72.8
No	245	25.9	205	26.5	285	29.1	735	27.2

Figure 6: Percentage Distribution of Elderly by Comfort in Existing Housing Condition & Locality



More than 1/4th of the elderly stated that they aren't comfortable with the existing housing conditions. In this regard, elderly living in Dharavi and Matunga Labor Camp showed a noteworthy difference, where an overwhelming 50 percent and nearly 1/3rd of elderly respectively, were not comfortable with the existing housing condition. Discomfort in current housing condition increases for elderly with age, but marginally.

Subjective Comfort in Toilet and Bathroom facilities:

Table-4-8: Percentage Distribution of Elderly According to their Comfort of Toilet Facility by Sex

Comfort of toilet facility	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Access to toilet						
Yes	1344	86.2	1004	88.0	2348	87.0
No	215	13.8	137	12.0	352	13.0
Type of toilet						
Indian	1541	98.8	1124	98.5	2665	98.1
Western	18	1.2	17	1.5	35	1.3
Comfort in using toilet facility						
Yes	1299	83.3	979	85.8	2278	84.4
No	260	16.7	162	14.2	422	15.6

Fear of falling in toilet						
Yes	377	24.2	262	23.0	639	23.7
No	1182	75.8	879	77.0	2061	76.3

Figure 7: Percentage Distribution of Elderly by Comfort of Toilet Facility & Age

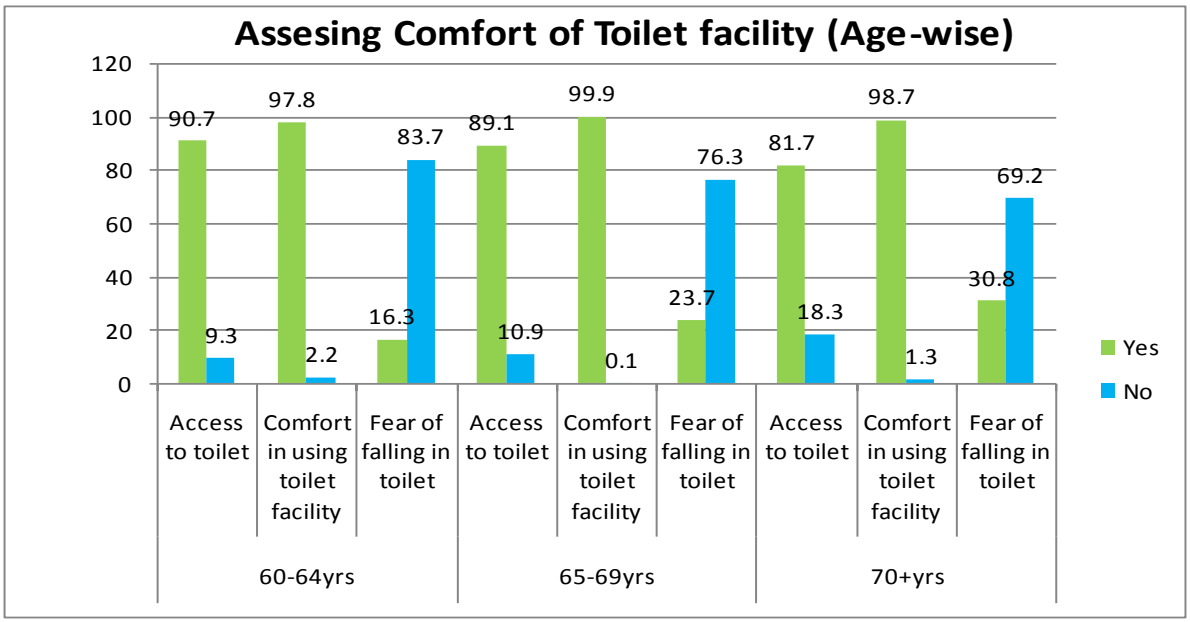
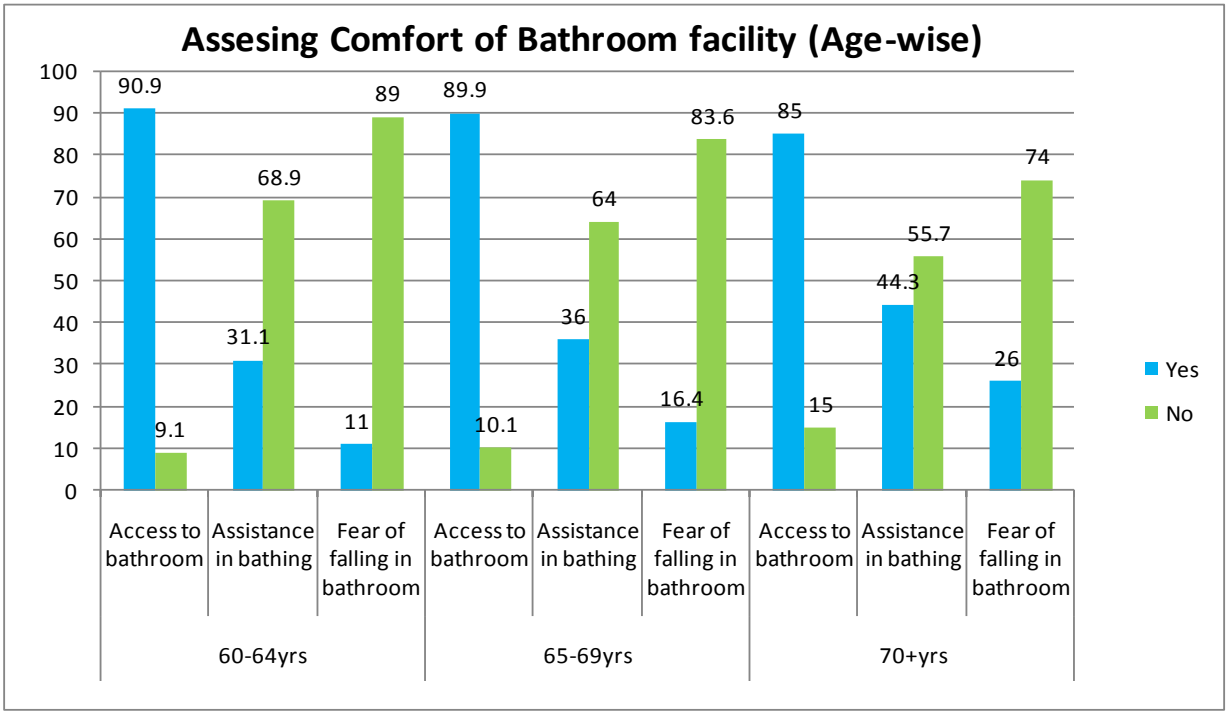


Table-4-9: Percentage Distribution of Elderly According to their Comfort of Bathroom Facility by Sex

Comfort in bathroom facility	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Access to bathroom						
Yes	1365	87.6	1024	89.7	2389	88.5
No	194	12.4	117	10.3	311	11.5
Assistance in bathing						
Yes	592	38.0	415	36.4	1007	37.3
No	967	62.0	726	63.6	1693	62.6
Fear of falling in bathroom						
Yes	282	18.1	204	17.9	486	18.0
No	1277	81.9	937	82.1	2214	82.0

Figure 8: Percentage Distribution of Elderly by Comfort in Bathroom Facility & Age



The access to improved toilet and bathroom facility is also an indicator of the living conditions of the elderly population. Majority of the elderly population (87%) have easy access to toilets and 84 percent are comfortable with the type of toilet facility they use. This trend is common for all the four areas. More than 98 percent of the elderly population use Indian type of toilet facility. Overall, 88.5 percent of elderly have easy access to bathrooms, however the elderly who do not have easy access to bathrooms is significantly higher in Dharavi (21%) as compared to the other four localities. It is observed that more than 1/3rd (37.3%) elderly require some kind of assistance in bathing. The percentage of elderly requiring assistance in bathing is highest in Lower Parel (41.5%), followed by Matunga Labor Camp (39.6%), Dharavi (37.5%) and BDD Chawl (22.6%).

Since falls and other household accidents put elders at risk and are often the reason staying at home independently becomes impossible, the elderly were also asked about their fear of falling in toilets and bathrooms. It is observed that close to 1/4th (23.7%) and 18percent of elderly are scared of falling in the toilet and bathroom respectively and also this percentage is proportional to the increase in age. The number of elderly who fear fall is higher in Dharavi and BDD Chawl as compared to the other two areas.

CHAPTER 5: ECONOMIC CONDITIONS

Among the several problems of the elderly in our society, economic problems occupy an important position. With advancing age and inadequate finances, the elderly start depending on their children economically, especially on their son/s. The economic condition of their offspring has considerable effect on the living conditions of the elderly. Hence, what they could achieve in their own lifetime, for economic stability in their old age, is significant. The following variables such as current and most recent occupation, planning of old age expenses, source of income, perceived income situation and work participation, aim to throw light on the economic conditions of the elderly in the sample so as to develop suitable schemes and services for improving the quality of later life.

Occupation:

Table-5-5: Percentage Distribution of Elderly According to Occupation by Sex

Current Occupation	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Managers	3	0.2	1	0.1	4	0.1
Professionals	6	0.4	5	0.4	11	0.4
Technicians and associate professionals	1	0.1	6	0.5	7	0.3
Clerical support workers	15	1.0	39	3.4	54	2.0
Services and sales workers	14	0.9	40	3.5	54	2.0
Skilled agricultural and fishery workers	7	0.4	10	0.9	17	0.6
Craft and related trade workers	11	0.7	37	3.2	48	1.8
Plant and machine operators	2	0.1	16	1.4	18	0.7
Elementary occupations	32	2.1	48	4.2	80	3.0
Defense and armed forces	0	0.0	5	0.4	5	0.2
Business	40	2.6	76	6.7	116	4.3
Homemaker	807	51.8	107	9.4	914	33.9
Unemployed/ Retired	708	45.4	838	73.4	1546	57.3

Table-5-6: Percentage Distribution of Elderly According to Occupation by Age

Occupation	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
	No.	%	No.	%	No.	%	No.	%
Managers	3	0.3	0	0.0	1	0.1	4	0.1
Professionals	7	0.7	2	0.3	2	0.2	11	0.4
Technicians and associate professionals	4	0.4	1	0.1	2	0.2	7	0.3
Clerical support workers	26	2.7	20	2.6	8	0.8	54	2.0

Services and sales workers	19	2.0	23	3.0	12	1.2	54	2.0
Skilled agricultural and fishery workers	7	0.7	5	0.6	5	0.5	17	0.6
Craft and related trade workers	21	2.2	17	2.2	10	1.0	48	1.8
Plant and machine operators	6	0.6	10	1.3	2	0.2	18	0.7
Elementary occupations	43	4.5	21	2.7	16	1.6	80	3.0
Defense and armed forces	2	0.2	2	0.3	1	0.1	5	0.2
Business	56	5.9	43	5.6	17	1.7	116	4.3
Homemaker	324	34.2	243	31.4	347	35.4	914	33.9
Unemployed/Retired	496	52.4	432	55.9	618	63.0	1546	57.3

The occupational structure also clearly indicates that many currently working elderly are engaged in unskilled, informal low paying occupations like clerical workers , craft and related trade workers, service and sales workers, plant and machine operators and elderly involved in elementary occupations constituting laborers in mining, construction, transport, etc. Also, 4.3percent of elderly currently manage their own business. More than half of elderly women (51.8%) are currently home-makers. More than 55percent of elderly are currently unemployed. Overall, 54.6 percent women elderly (including homemakers) and 26.5percent male elderly are currently working.

Chief earner:

Table-5-7: Percentage Distribution of Elderly According to Chief Earner of Household by Sex

Chief Earner	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Self	432	27.7	618	54.2	1050	38.9
Spouse	264	16.9	61	5.3	325	12.0
Son	652	41.8	398	34.9	1050	38.9
Others	211	13.5	64	5.6	275	10.2

Table-5-8: Percentage Distribution of Elderly According to Chief Earner of Household by Age

Chief Earner	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
	No.	%	No.	%	No.	%	No.	%
Self	362	38.3	339	43.9	349	35.6	1050	38.9
Spouse	179	18.9	81	10.5	65	6.6	325	12.0
Son	324	34.2	281	36.4	445	45.4	1050	38.9

Others	81	8.6	72	9.3	122	12.4	275	10.2

More than half of male elderly (54.2%) but only 27.7 percent female elderly of the total surveyed population are the chief earners of their households. Overall, almost 40percent of elderly are themselves the chief earners of their households, followed by their sons (40%), spouse (12%) and remaining 10.2 percent which comprise of grandchildren, relatives, friends and others. As anticipated, the dependency on sons increases with an increase in age, with 45.4 percent of elderly in the 70+ age group stating that the chief earner of the household is son, followed by 36.4percent (65-69 years) and 34.2percent (60-64 years).

Source of income:

The surveyed elderly were also asked if they had planned to meet their old age expenses before turning 60. Only 22.1percent out of the total elderly agreed to have made plans to meet their old age expenses. Notable difference was observed among the male and female elderly, where, 81.3percent of female elderly and 73.2percent male elderly had made no previous plans for old age.

Table-5-9: Percentage Distribution of Elderly According to their Plan to meet Old Age Expenses and Source of Income by Sex

	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Did they plan to meet old age expenses						
Yes	291	18.7	306	26.8	597	22.1
No	1268	81.3	835	73.2	2103	77.9
Source of income						
Depending on sons	1017	65.2	707	62.0	1724	63.9
Depending on daughters	166	10.6	80	7.0	246	9.1
Depending on grandchildren	42	2.7	9	0.8	51	1.9
Wages/salary	71	4.6	84	7.4	155	5.7
Superannuation/Pension	182	11.7	270	23.7	452	16.7
Old age pension	119	7.6	93	8.2	212	7.9
Others	218	14.0	193	16.9	411	15.2

Table-5-10: Percentage Distribution of Elderly According to their Plan to meet Old Age Expenses and Source of Income by Age

	60-64yrs		**65-69yrs**		**70+yrs**		**Total**	
Did they plan to meet old age expenses	No.	%	No.	%	No.	%	No.	%
Yes	181	19.1	192	24.8	224	22.8	597	22.1

No	765	80.9	581	75.2	757	77.2	2103	77.9
Source of income								
Depending on sons	604	63.8	487	63.0	633	64.5	1724	63.9
Depending on daughters	87	9.2	59	7.6	100	10.2	246	9.1
Depending on grandchildren	7	0.7	9	1.2	35	3.6	51	1.9
Wages/salary	68	7.2	35	4.5	29	3.0	132	4.9
Superannuation/Pension	141	14.9	137	17.7	174	17.7	452	16.7
Old age pension	84	8.9	54	7.0	74	7.5	212	7.9
Others	174	18.4	124	16.0	113	11.5	411	15.2

As a large proportion of elderly (the elderly that are unemployed or retired) are found to be economically dependent on others for their livelihood, it is pertinent to know what is their source of income and who is providing economic support to them. Among elderly men, 62 percent are supported financially by their son, followed by 7 percent and 0.8 percent who are dependent on their daughters and grandchildren respectively. Among elderly women, the trend is followed, where almost 2/3rd of elderly women, 10.6percent and 2.7percent are dependent on their son, daughter and grandchildren respectively. Overall only 16.7 percent of elderly live on superannuation or old age pension as their source of income. Wages/salary are a source of income for only 6percent of the elderly. The remaining 15.2percent are dependent on fixed deposits, income from rent, relief payment, business and agricultural produce.

Income Situation:

Figure 9: Percentage Distribution of Elderly by Income Situation & Locality

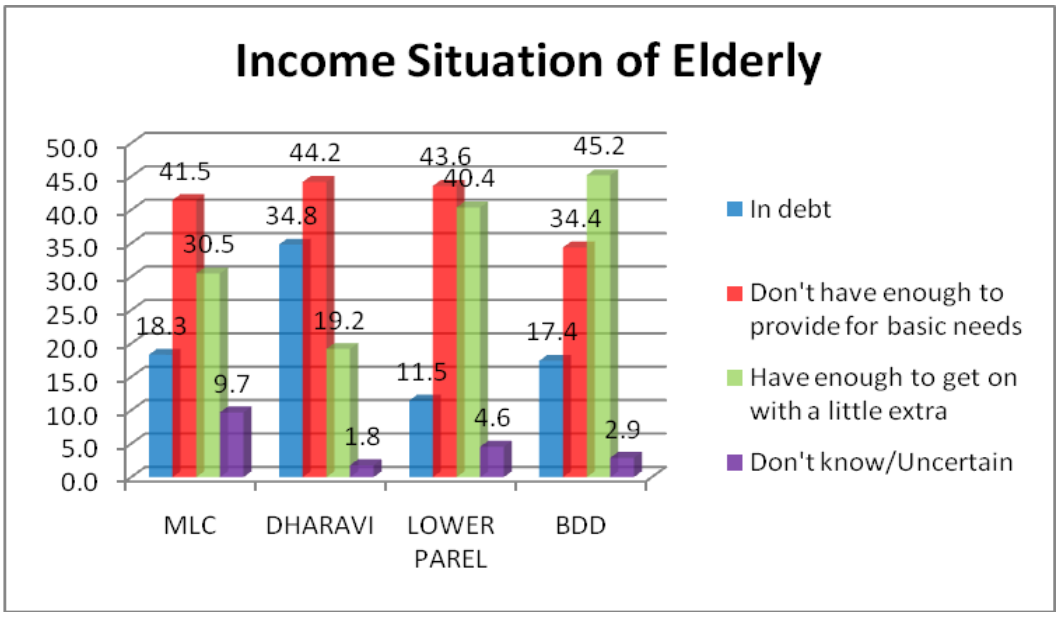


Table-5-11: Percentage Distribution of Elderly According to Income Situation & Sex

Income Situation	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
In debt	286	18.3	180	15.8	466	17.3
Don't have enough to provide for basic needs	654	41.9	460	40.3	1114	41.3
Have enough to get on with a little extra	516	33.1	436	38.2	952	35.3
Don't know/Uncertain	103	6.6	65	5.7	168	6.2

Table-5-12: Percentage Distribution of Elderly According to Income Situation & Age

Income situation	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
	No.	%	No.	%	No.	%	No.	%
In debt	174	18.4	139	18.0	153	15.6	466	17.3
Don't have enough to provide for basic needs	406	42.9	302	39.1	406	41.4	1114	41.3
Just have enough to provide for basic needs								
Have enough to get on with a little extra	304	32.1	287	37.1	361	36.8	952	35.3
Don't know/Uncertain	62	6.6	45	5.8	61	6.2	168	6.2

As already observed in the data on occupation and source of income, the majority of older adults do not work and/or have fewer options for continued income. They are at risk for rising costs of living, which may place them at an economic disadvantage and potentially at lower levels of Socio-economic status. The data shows that an overwhelming 41.3percent of elderly do not have enough to provide for their basic needs and 17.3percent are in debt. 7percent of the total elderly are not aware about the household income situation. There is a significantly high number of elderly in debt in Dharavi (34.8%) as compared to other localities. Not much discrepancy is found on the grounds of gender, since the trend followed is uniform for all kinds of income situation for males and females. As observed in the table against age, the number of elderly in debt is lowest for the 70+ age group (15.6%) and the percentage increases for the young elderly.

Work participation and reasons to work:

The work participation at older ages is often viewed differently in different contexts. For example, many western countries argue that there exists significant unused labor force capacity at older ages. Retirement decisions in European countries are linked with the pension reforms and the work participation ends with retirement (Kalwij and Vermeulen, 2005; Mete and Schultz, 2002). In developing countries like India, however, the scenario is different. Labor force participation of the elderly, and particularly of women, is often driven by poverty (Bhalotra and Umana-Aponte, 2010; Bhalla and Kaur, 2011). India's occupational structure is dominated by informal sector employment where there is neither a retirement age nor a pension (Unni and Revenndran, 2007). According to the NSSO, nearly 84 percent of

workers are employed in the informal sector and this is true even for the senior citizens (Rajan 2004; Selvaraj et al., 2011).

Figure 10: Percentage Distribution of Elderly by Interest in Working & Gender

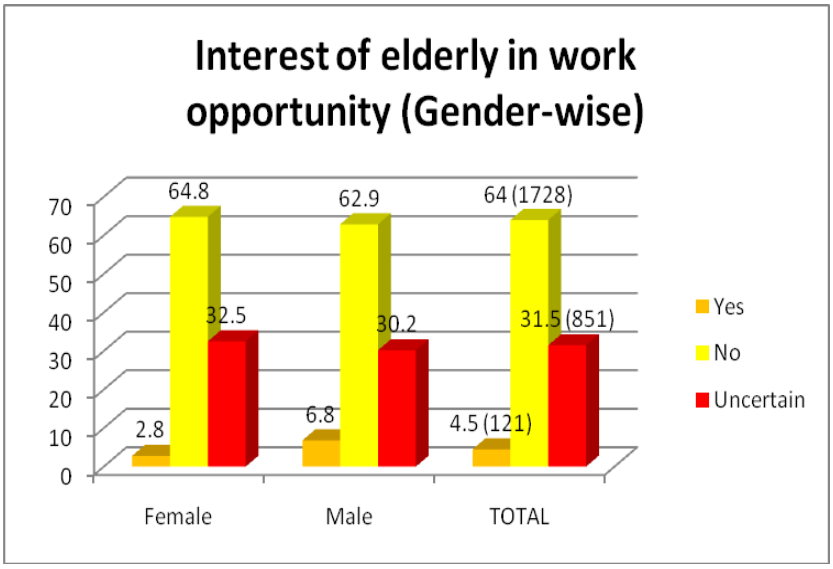


Figure 11: Percentage Distribution of Elderly by Interest in Working & Age

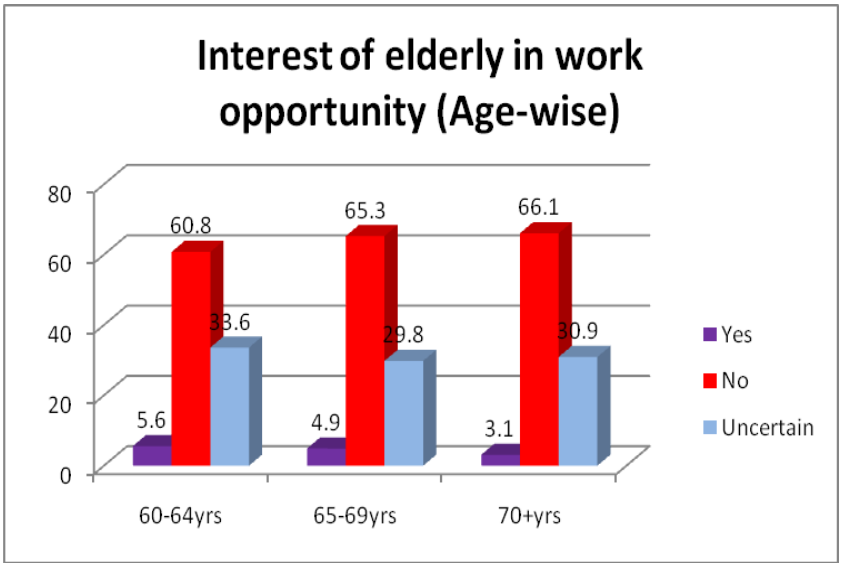


Table-5-13: Sex-wise Percentage Distribution of Elderly According to their Reasons to Explore Job Opportunities at Old Age

Reasons for exploring such job opportunities	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Need money for current expenses	29	5.3	39	9.2	68	7.0
Need money for future financial security	6	1.1	10	2.4	16	1.6
Do not want to be dependent on others for money	0	0.0	5	1.2	5	0.5
No one to depend on for money	0	0.0	2	0.5	2	0.2
Want to lead an active life	0	0.0	10	2.4	10	1.0
Need something to occupy time/keep me busy	2	0.4	11	2.6	13	1.3
Own/family business	4	0.7	1	0.2	5	0.5
Others	3	0.2	6	0.5	9	0.3

Table-5-14: Age-wise Percentage Distribution of Elderly According to their Reasons to Explore Job Opportunities at Old Age

Reasons for exploring such job opportunities	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
	No.	%	No.	%	No.	%	No.	%
Need money for current expenses	34	9.2	22	8.2	12	3.6	68	7.0
Need money for future financial security	5	1.3	7	2.6	4	1.2	16	1.6
Do not want to be dependent on others for money	3	0.8	1	0.4	1	0.3	5	0.5
No one to depend on for money	0	0.0	1	0.4	1	0.3	2	0.2
Want to lead an active life	2	0.5	2	0.7	6	1.8	10	1.0
Need something to occupy time/keep me busy	6	1.6	4	1.5	3	0.9	13	1.3
Own/family business	2	0.5	0	0.0	3	0.9	5	0.5
Others	3	0.3	2	0.3	4	0.4	9	0.3

The survey also found that there is a smaller proportion of the elderly (4.5%) still seeking work, but unable to find it. The percentage of male elderly (6.8%) who would like to work if given an opportunity is higher than women elderly (2.8%). As speculated, it is observed that the interest in exploring work opportunities reduces with increase in age. Only 3.1percent of elderly aged above 70 show interest to work if given an opportunity, followed by 4.9percent (65-69 years) and 5.6percent (60-64 years). It is observed that the reasons for work for the majority of the elderly are economic or

other compulsions such as need money for current expenses or future financial security and to reduce dependency on others financially.

Reasons for not working:

Table-5-15: Sex-wise Percentage Distribution of Elderly's Experiences During Job Search

Experiences during job search	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Employer empathy	32	2.1	49	4.3	81	3.0
Availability of part-time jobs/assignments	6	0.4	14	1.2	20	0.7
Work from home opportunities	9	0.6	15	1.3	24	0.9
Satisfactory monetary support	9	0.6	17	1.5	26	1.0
Age was a barrier	92	5.9	90	7.9	182	6.7
Poor health condition	65	4.2	55	4.8	120	4.4
Under-qualified/don't have skills required	41	2.6	30	2.6	71	2.6
Salary is too low	18	1.2	37	3.2	55	2.0
Jobs available are too physically demanding	5	0.3	11	1.0	16	0.6
Undesirable/unsuitable working hours	17	1.1	18	1.6	35	1.3
Jobs available are too far away from home	18	1.2	26	2.3	44	1.6
Others	55	3.5	35	3.1	90	3.3
No response	1276	81.8	808	70.8	2084	77.2

Table-5-16: Age-wise Percentage Distribution of Elderly's Experiences During Job Search

Experiences during job search	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
	No.	%	No.	%	No.	%	No.	%
Employer empathy	23	2.4	20	2.6	38	3.9	81	3.0
Availability of part-time jobs/assignments	8	0.8	7	0.9	5	0.5	20	0.7
Work from home opportunities	15	1.6	5	0.6	4	0.4	24	0.9
Satisfactory monetary support	13	1.4	6	0.8	7	0.7	26	1.0
Age was a barrier	73	7.7	46	6.0	63	6.4	182	6.7
Poor health condition	29	3.1	35	4.5	56	5.7	120	4.4
Under-qualified/don't have skills required	35	3.7	20	2.6	16	1.6	71	2.6
Salary is too low	30	3.2	13	1.7	12	1.2	55	2.0

Jobs available are too physically demanding	4	0.4	8	1.0	4	0.4	16	0.6
Undesirable/unsuitable working hours	13	1.4	15	1.9	7	0.7	35	1.3
Jobs available are too far away from home	24	2.5	13	1.7	7	0.7	44	1.6
Others	24	2.5	35	4.5	31	3.2	90	3.3
No response	713	75.4	586	75.8	785	80.0	2084	77.2

The study also focused on experiences elderly came across while job search and their reasons for not taking up jobs. Age barrier (6.7%) and poor health conditions (4.4%) were the main reasons stated. Some elderly (2.6%) face the problem of being under-qualified while searching for a job, and some feel the compensation is too low to support their needs (2%). Employer empathy is also experienced by 3percent of the total elderly. This can be presumed to be a sign of discarding pre-conceived notions about hiring older people for work.

CHAPTER 6: SOCIAL PROFILE

Like the family support, the social factors concerning the elderly are also important in determining the quality of later life. The social support system of the elderly enables them to remain integrated within the community and also encourages them to be active members of the society. Therefore variables such as the activities elderly normally engage in, participation in social activities, involvement in decision making, volunteering, issues faced by them, awareness of day care and hobby centres and old age homes and willingness to join them, and awareness and utilization of old age social security schemes were included to gather information about the social interaction of the elderly.

Engagement in daily activities and social Interactions:

Figure 12: Percentage Distribution of Elderly by Activities they normally Engage in

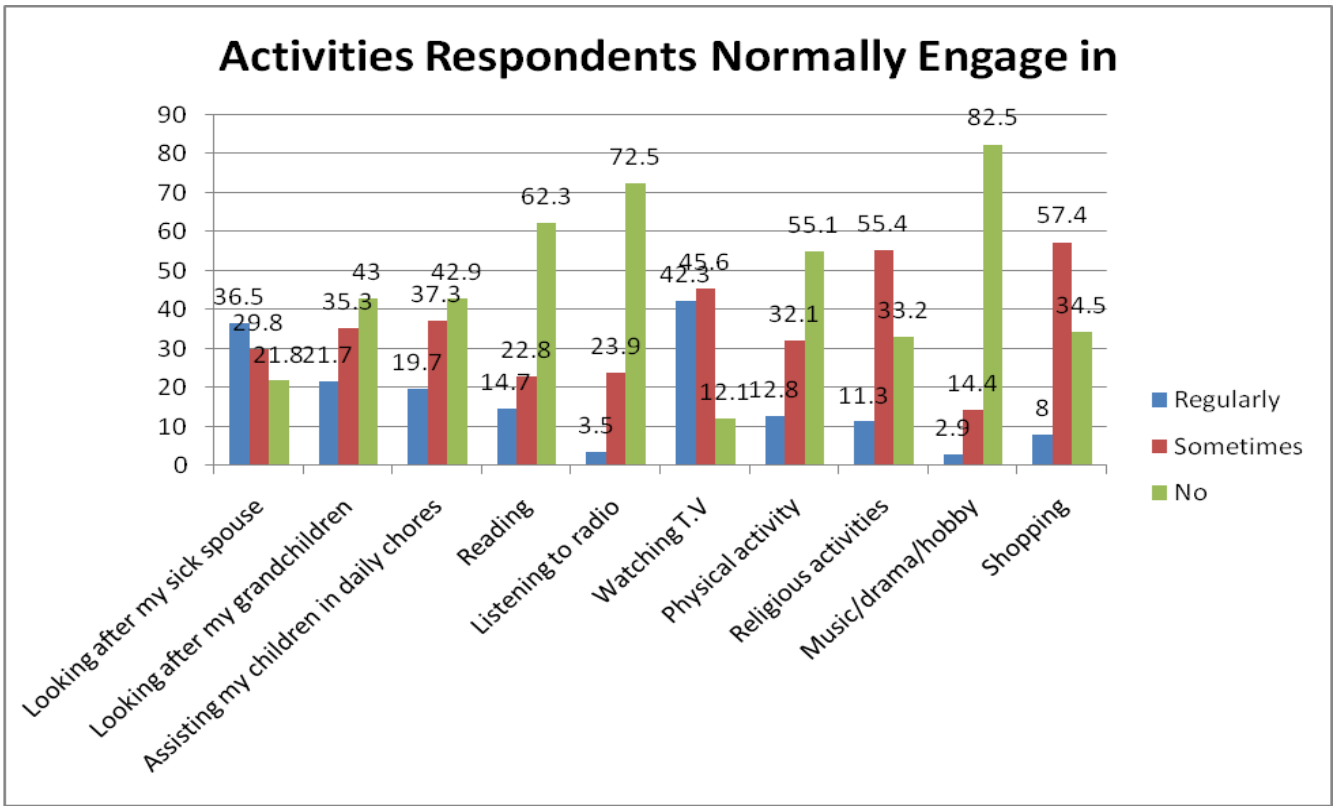


Table-6-17: Sex-wise Percentage Distribution of Elderly According to the Activities they normally Engage in

Activities respondents normally engage in	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Looking after my sick spouse						
Regularly	454	29.1	532	46.6	986	36.5
Sometimes	275	17.6	372	32.6	647	29.8
No	830	53.2	237	20.8	1067	21.8
Looking after my grandchildren						

Regularly	339	21.7	246	21.6	585	21.7
Sometimes	575	36.9	377	33.0	952	35.3
No	645	41.4	518	45.4	1163	43.0
Assisting my children in daily chores						
Regularly	337	21.6	194	17.0	531	19.7
Sometimes	602	38.6	405	35.5	1007	37.3
No	620	39.8	542	47.5	1162	42.9
Reading						
Regularly	105	6.7	293	25.7	398	14.7
Sometimes	272	17.4	344	30.1	616	22.8
No	1182	75.8	504	44.2	1686	62.3
Listening to radio						
Regularly	30	1.9	64	5.6	94	3.5
Sometimes	286	18.3	360	31.6	646	23.9
No	1243	79.7	717	62.8	1960	72.5
Watching T.V						
Regularly	612	39.3	531	46.5	1143	42.3
Sometimes	731	46.9	499	43.7	1230	45.6
No	216	13.9	111	9.7	327	12.1
Physical activity						
Regularly	152	9.7	194	17.0	346	12.8
Sometimes	442	28.4	424	37.2	866	32.1
No	965	61.9	523	45.8	1488	55.1
Religious activities						
Regularly	146	9.4	158	13.8	304	11.3
Sometimes	858	55.0	638	55.9	1496	55.4
No	555	35.6	345	30.2	900	33.2
Music/drama/hobby						
Regularly	23	1.5	56	4.9	79	2.9
Sometimes	170	10.9	220	19.3	390	14.4
No	1366	87.6	865	75.8	2231	82.5
Shopping						
Regularly	100	6.4	117	10.3	217	8.0
Sometimes	886	56.8	663	58.1	1549	57.4
No	573	36.8	361	31.6	934	34.5

Table-6-18: Age-wise Percentage Distribution of Elderly According to the Activities they normally Engage in

ACTIVITIES RESPONDENTS NORMALLY ENGAGE IN	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
Looking after my sick spouse	No.	%	No.	%	No.	%	No.	%

Regularly	412	43.6	288	37.3	286	29.2	986	36.5
Sometimes	246	26.0	192	24.8	209	21.3	647	24.0
No	288	30.4	293	37.9	486	49.5	1067	39.5
Looking after my grandchildren								
Regularly	207	21.9	175	22.6	203	20.7	585	21.7
Sometimes	335	35.4	258	33.4	359	36.6	952	35.3
No	404	42.7	340	44.0	419	42.7	1163	43.1
Assisting my children in daily chores								
Regularly	206	21.8	149	19.3	176	17.9	531	19.7
Sometimes	384	40.6	284	36.7	339	34.6	1007	37.3
No	356	37.6	340	44.0	466	47.5	1162	43.0
Reading								
Regularly	137	14.5	144	18.6	117	11.9	398	14.7
Sometimes	254	26.8	172	22.3	190	19.4	616	22.8
No	555	58.7	457	59.1	674	68.7	1686	62.4
Listening to radio								
Regularly	27	2.9	33	4.3	34	3.5	94	3.5
Sometimes	246	26.0	207	26.8	193	19.7	646	23.9
No	673	71.1	533	69.0	754	76.9	1960	72.6
Watching T.V								
Regularly	431	45.6	354	45.8	358	36.5	1143	42.3
Sometimes	452	47.8	347	44.9	431	43.9	1230	45.6
No	63	6.7	72	9.3	192	19.6	327	12.1
Physical activity								
Regularly	109	11.5	108	14.0	129	13.1	346	12.8
Sometimes	319	33.7	289	37.4	258	26.3	866	32.1
No	518	54.8	376	48.6	594	60.6	1488	55.1
Religious activities								
Regularly	118	12.5	101	13.1	85	8.7	304	11.3
Sometimes	584	61.7	434	56.1	478	48.7	1496	55.4
No	244	25.8	238	30.8	418	42.6	900	33.3
Music/drama/hobby								
Regularly	29	3.1	19	2.5	31	3.2	79	2.9
Sometimes	148	15.6	140	18.1	102	10.4	390	14.4
No	769	81.3	614	79.4	848	86.4	2231	82.6
Shopping								
Regularly	107	11.3	73	9.4	37	3.8	217	8.0
Sometimes	624	66.0	464	60.0	461	47.0	1549	57.4
No	215	22.7	236	30.5	483	49.2	934	34.6

The most common activities that respondents normally engage in regularly are watching T.V (42.3%), looking after their sick spouse (35.7%), looking after grandchildren(21.7%) and assisting in daily household chores (19.7%). 57.4percent of the total elderly engage in shopping sometimes that includes shopping for small household items. It is observed that only 12.8percent of elderly regular take up physical activity like walking, exercise and yoga. The number of elderly engaging in these activities gradually decreases with age.

Figure 13: Percentage Distribution of Elderly by Social Activity Engagement

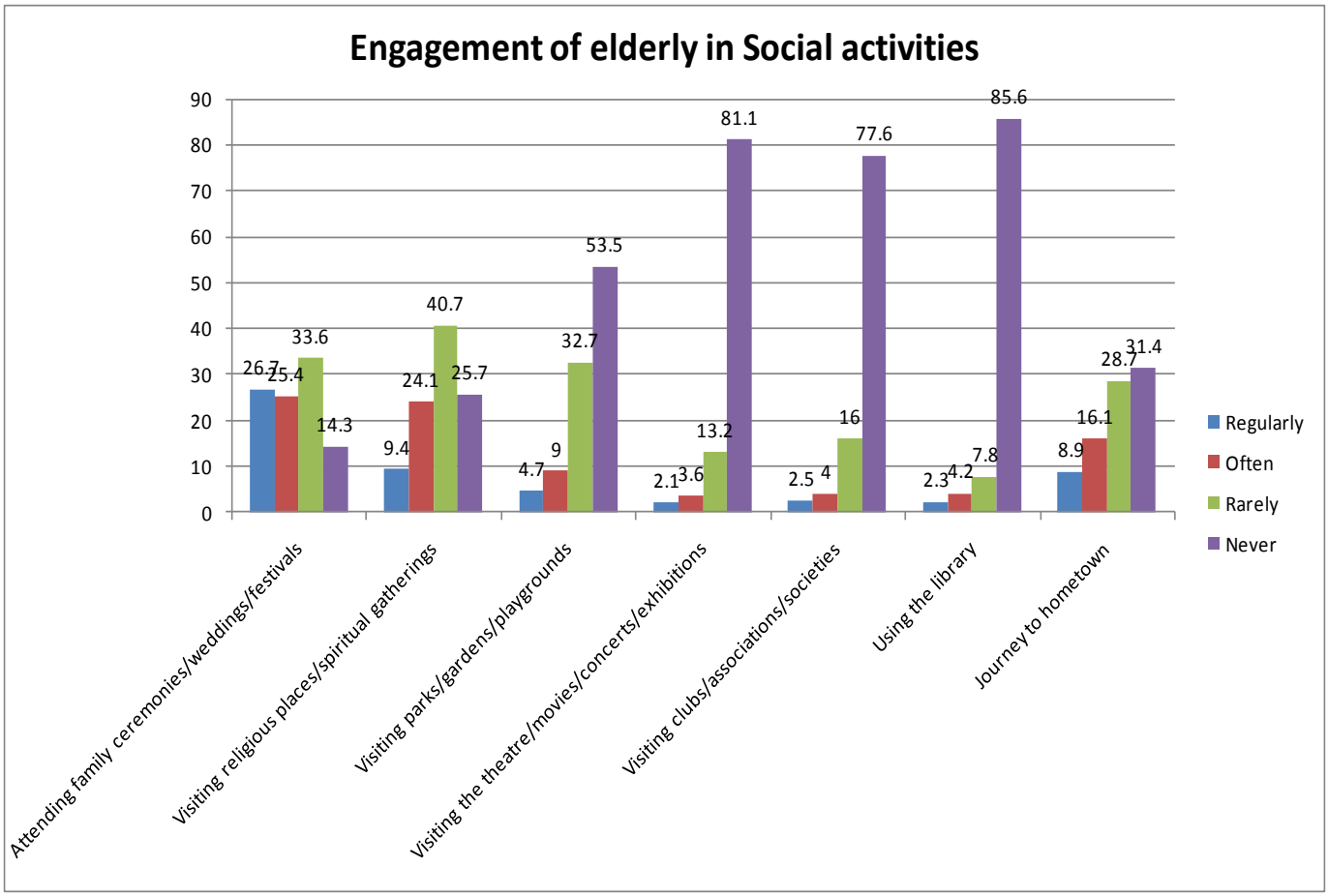


Table-6-19: Sex-wise Percent Distribution of Elderly According to their frequency of participation in Social Activities

Social Activities	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Attending family ceremonies/weddings/festivals						

Regularly	367	23.5	355	31.1	722	26.7
Often	390	25.0	296	25.9	686	25.4
Rarely	557	35.7	349	30.6	906	33.6
Never	245	15.7	141	12.4	386	14.3
Visiting religious places/spiritual gatherings						
Regularly	113	7.2	141	12.4	254	9.4
Often	344	22.1	308	27.0	652	24.1
Rarely	676	43.4	423	37.1	1099	40.7
Never	426	27.3	269	23.6	695	25.7
Visiting parks/gardens/playgrounds						
Regularly	40	2.6	87	7.6	127	4.7
Often	124	8.0	120	10.5	244	9.0
Rarely	459	29.4	424	37.2	883	32.7
Never	936	60.0	510	44.7	1446	53.5
Visiting the theatre/movies/concerts/exhibitions						
Regularly	18	1.2	39	3.4	57	2.1
Often	41	2.6	56	4.9	97	3.6
Rarely	169	10.8	187	16.4	356	13.2
Never	1331	85.4	859	75.3	2190	81.1
Visiting clubs/associations/societies						
Regularly	17	1.1	51	4.5	68	2.5
Often	44	2.8	63	5.5	107	4.0
Rarely	195	12.5	236	20.7	431	16.0
Never	1303	83.6	791	69.3	2094	77.6
Using the library						
Regularly	19	1.2	43	3.8	62	2.3
Often	47	3.0	67	5.9	114	4.2
Rarely	86	5.5	125	11.0	211	7.8
Never	1407	90.3	906	79.4	2313	85.6
Journey to hometown						
Regularly	111	7.1	130	11.4	241	8.9
Often	218	14.0	218	19.1	436	16.1
Rarely	690	44.3	485	42.5	1175	28.7
Never	540	34.6	308	27.0	848	31.4

Table-6-20: Age-wise Percent Distribution of Elderly According to their frequency of participation in Social Activities

SOCIAL ACTIVITIES	60-64yrs	65-69yrs	70+yrs	Total

Attending family ceremonies/weddings/festivals	No.	%	No.	%	No.	%	No.	%
Regularly	309	32.7	227	29.4	186	19.0	722	26.7
Often	248	26.2	212	27.4	226	23.0	686	25.4
Rarely	303	32.0	250	32.3	353	36.0	906	33.6
Never	86	9.1	84	10.9	216	22.0	386	14.3
Visiting religious places/spiritual gatherings								
Regularly	111	11.7	78	10.1	65	6.6	254	9.4
Often	250	26.4	205	26.5	197	20.1	652	24.1
Rarely	410	43.3	320	41.4	369	37.6	1099	40.7
Never	175	18.5	170	22.0	350	35.7	695	25.7
Visiting parks/gardens/playgrounds								
Regularly	39	4.1	36	4.7	52	5.3	127	4.7
Often	84	8.9	90	11.6	70	7.1	244	9.0
Rarely	350	37.0	272	35.2	261	26.6	883	32.7
Never	473	50.0	375	48.5	598	61.0	1446	53.6
Visiting the theatre/ movies/ concerts/ exhibitions								
Regularly	22	2.3	12	1.6	23	2.3	57	2.1
Often	41	4.3	34	4.4	22	2.2	97	3.6
Rarely	151	16.0	109	14.1	96	9.8	356	13.2
Never	732	77.4	618	79.9	840	85.6	2190	81.1
Visiting clubs/associations/societies								
Regularly	24	2.5	20	2.6	24	2.4	68	2.5
Often	41	4.3	31	4.0	35	3.6	107	4.0
Rarely	178	18.8	126	16.3	127	12.9	431	16.0
Never	703	74.3	596	77.1	795	81.0	2094	77.6
Using the library								
Regularly	20	2.1	20	2.6	22	2.2	62	2.3
Often	37	3.9	34	4.4	43	4.4	114	4.2
Rarely	86	9.1	62	8.0	63	6.4	211	7.8
Never	803	84.9	657	85.0	853	87.0	2313	85.7
Journey to hometown								
Regularly	80	8.5	80	10.3	81	8.3	241	8.9
Often	164	17.3	127	16.4	145	14.8	436	16.1
Rarely	466	49.3	342	44.2	367	37.4	1175	43.5
Never	236	24.9	224	29.0	388	39.6	848	31.4

The study shows that involvement of the elderly in social life, whether in attending family ceremonies like marriages, public meetings, organizational meetings or religious programmes is very limited. It is found that men are more active in

collaborating with other people compared to women though the frequency varied. The attendance of elderly in religious programmes or services and weddings and funerals, is highest among all social activities the respondents were asked about.

Involvement in Decision Making:

Figure 14: Sex-wise Percent Distribution of Elderly According to their Involvement in Matters of Decision Making

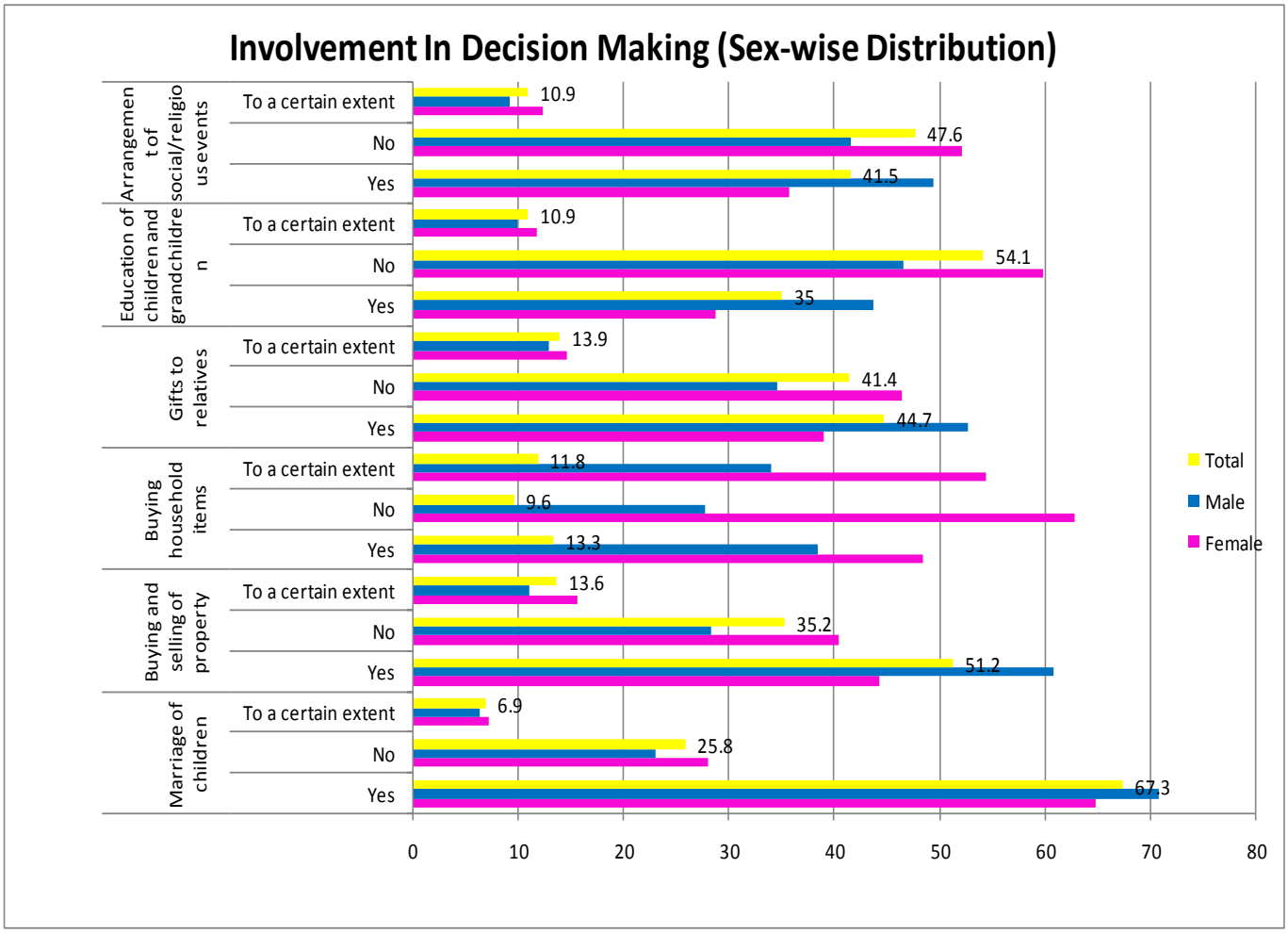


Table-6-21: Age-wise Percent Distribution of Elderly According to their Involvement in Matters of Decision Making

INVOLVEMENT IN DECISION MAKING	60-64yrs		65-69yrs		70+yrs		Total	
Marriage of children	No.	%	No.	%	No.	%	No.	%
Yes	643	68.0	522	67.5	653	66.6	1818	67.3
No	231	24.4	205	26.5	261	26.6	697	25.8
To a certain extent	72	7.6	46	6.0	67	6.8	185	6.9
Buying and selling of property								
Yes	491	51.9	429	55.5	462	47.1	1382	51.2

No	310	32.8	241	31.2	400	40.8	951	35.2
To a certain extent	145	15.3	103	13.3	119	12.1	367	13.6
Buying household items								
Yes	567	59.9	448	58.0	453	46.2	1468	54.4
No	275	29.1	236	30.5	403	41.1	914	33.9
To a certain extent	104	11.0	89	11.5	125	12.7	318	11.8
Gifts to relatives								
Yes	469	49.6	379	49.0	360	36.7	1208	44.7
No	346	36.6	296	38.3	475	48.4	1117	41.4
To a certain extent	131	13.8	98	12.7	146	14.9	375	13.9
Education of children and grandchildren								
Yes	356	37.6	298	38.6	291	29.7	945	35.0
No	485	51.3	395	51.1	581	59.2	1461	54.1
To a certain extent	105	11.1	80	10.3	109	11.1	294	10.9
Arrangement of social/religious events								
Yes	433	45.8	356	46.1	332	33.8	1121	41.5
No	408	43.1	340	44.0	536	54.6	1284	47.6
To a certain extent	105	11.1	77	10.0	113	11.5	295	10.9

Table18 shows the decision-making role of the elderly in different instances: marriage of children, buying and selling property, buying household items, giving gifts to relatives, education of children and grandchildren, and arrangement of social and religious events. Elderly opinion and advice is taken usually on matters on marriage of children (74.2%), buying household items (66.2%) and buying and selling of property (64.8%). A common trend of male elderly being involved more than females in making decisions is observed in the data.

Issues of Elderly:

Late life is commonly a period of transitions (eg, retirement, relocation) and adjustment to losses.With aging, the ability to do daily activities (functional ability) declines to some degree in every person. Also, older people, on average, tend to have more disorders and disabilities than do younger people. But the changes that accompany aging are more than just changes in health. Social issues (such as living arrangements or type of work) influence an older person's risk and experience of illness. The data captures a few issues that the elderly feel are serious to be dealt with.

Figure 15: Percentage Distribution of Elderly by Issues faced

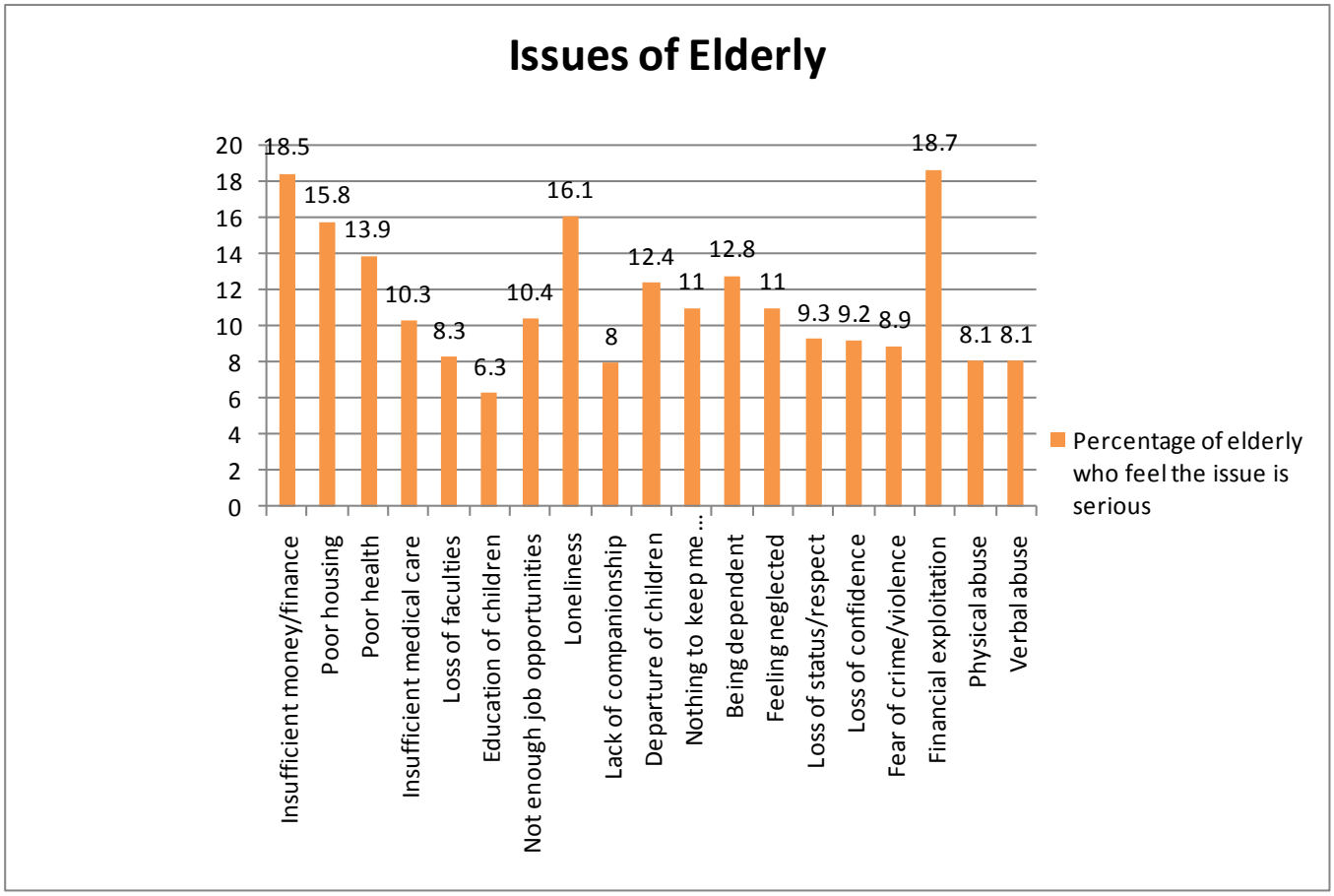


Figure 16: Percent Distribution of Elderly by forms of Health Issues faced

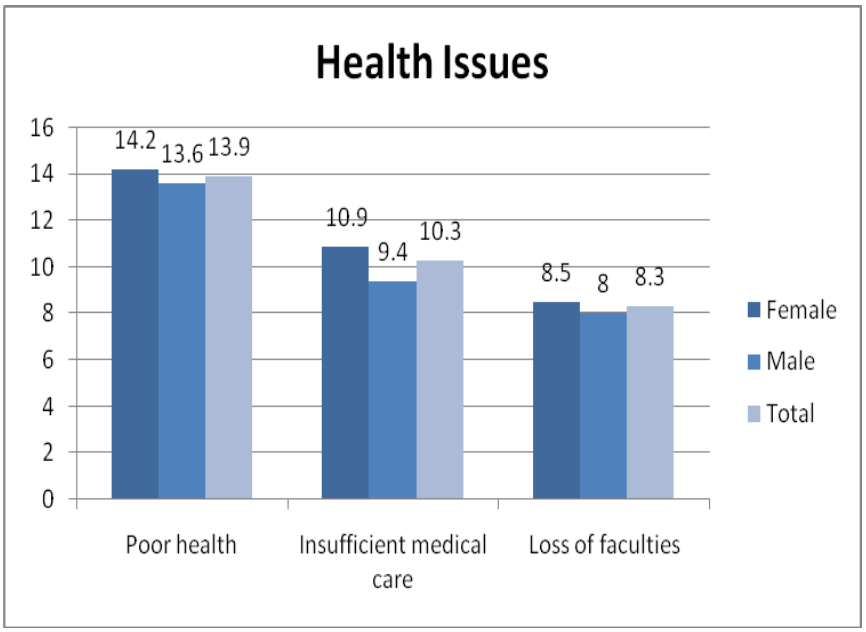


Figure 17:Percent Distribution of Elderly by forms of Economic Issues faced

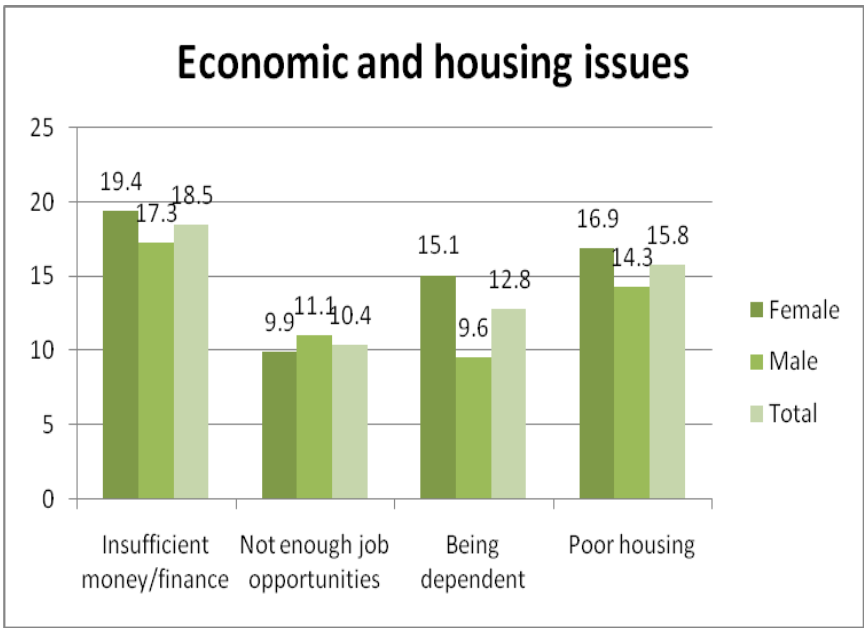


Figure 18: Percent Distribution of Elderly by Experience of Abuse & Sex

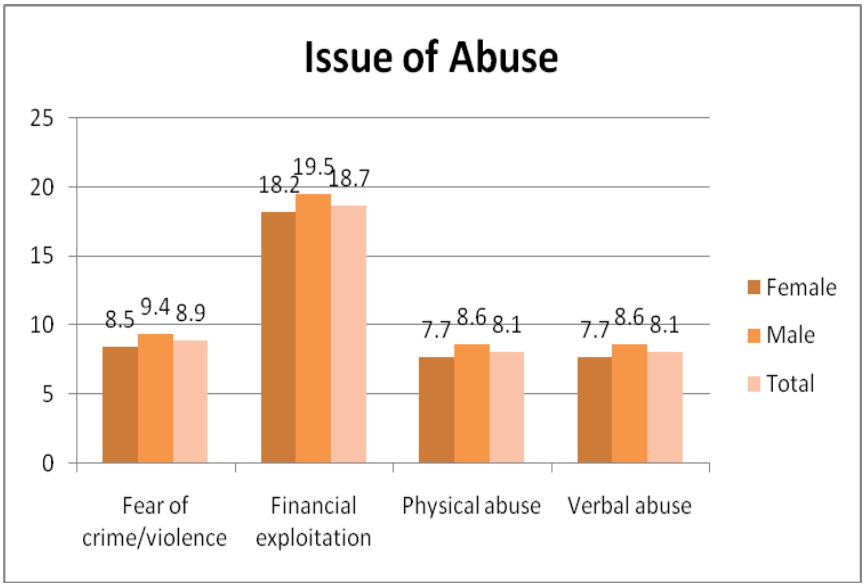


Figure 19: Percent Distribution of Elderly by forms of Psycho-social Issues faced

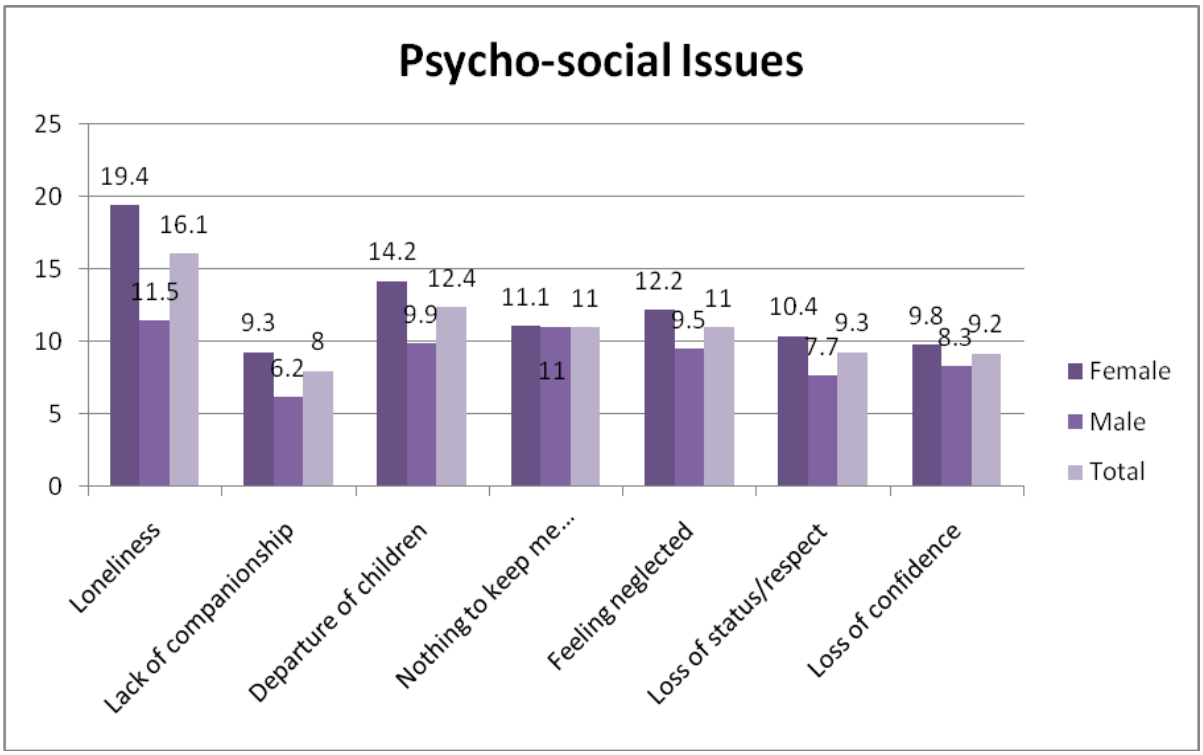


Table-6-22: Age-wise Percentage Distribution of Issues that Elderly face

ISSUES OF ELDERLY	60-64yrs		65-69yrs		70+yrs		Total	
Insufficient money/finance	No.	%	No.	%	No.	%	No.	%
Serious	193	20.4	131	16.9	175	17.8	499	18.5
Hardly a problem	638	67.4	548	70.9	656	66.9	1842	68.2
No specific opinion	115	12.2	94	12.2	150	15.3	359	13.3
Poor housing								
Serious	164	17.3	111	14.4	151	15.4	426	15.8
Hardly a problem	565	59.7	487	63.0	590	60.1	1642	60.8
No specific opinion	217	22.9	175	22.6	240	24.5	632	23.4
Poor health								
Serious	107	11.3	78	10.1	191	19.5	376	13.9
Hardly a problem	718	75.9	592	76.6	690	70.3	2000	74.1
No specific opinion	121	12.8	103	13.3	100	10.2	324	12.0
Insufficient medical care								
Serious	84	8.9	68	8.8	125	12.7	277	10.3
Hardly a problem	659	69.7	559	72.3	673	68.6	1891	70.0
No specific opinion	203	21.5	146	18.9	183	18.7	532	19.7
Loss of faculties								

Serious	65	6.9	49	6.3	109	11.1	223	8.3
Hardly a problem	663	70.1	565	73.1	669	68.2	1897	70.3
No specific opinion	218	23.0	159	20.6	203	20.7	580	21.5
Education of children								
Serious	62	6.6	47	6.1	60	6.1	169	6.3
Hardly a problem	529	55.9	454	58.7	517	52.7	1500	55.6
No specific opinion	355	37.5	272	35.2	404	41.2	1031	38.2
Not enough job opportunities								
Serious	100	10.6	87	11.3	94	9.6	281	10.4
Hardly a problem	553	58.5	476	61.6	562	57.3	1591	58.9
No specific opinion	293	31.0	210	27.2	325	33.1	828	30.7
Loneliness								
Serious	147	15.5	102	13.2	185	18.9	434	16.1
Hardly a problem	528	55.8	479	62.0	562	57.3	1569	58.1
No specific opinion	271	28.6	192	24.8	234	23.9	697	25.8
Lack of companionship								
Serious	59	6.2	60	7.8	97	9.9	216	8.0
Hardly a problem	650	68.7	543	70.2	666	67.9	1859	68.9
No specific opinion	237	25.1	170	22.0	218	22.2	625	23.1
Departure of children								
Serious	112	11.8	90	11.6	132	13.5	334	12.4
Hardly a problem	530	56.0	453	58.6	542	55.2	1525	56.5
No specific opinion	304	32.1	230	29.8	307	31.3	841	31.1
Nothing to keep me busy/feeling of redundancy								
Serious	89	9.4	78	10.1	131	13.4	298	11.0
Hardly a problem	576	60.9	485	62.7	594	60.6	1655	61.3
No specific opinion	281	29.7	210	27.2	256	26.1	747	27.7
Being dependent								
Serious	100	10.6	67	8.7	178	18.1	345	12.8
Hardly a problem	582	61.5	520	67.3	561	57.2	1663	61.6
No specific opinion	264	27.9	186	24.1	242	24.7	692	25.6
Feeling neglected								
Serious	89	9.4	69	8.9	140	14.3	298	11.0
Hardly a problem	602	63.6	516	66.8	602	61.4	1720	63.7
No specific opinion	255	27.0	188	24.3	239	24.4	682	25.3
Loss of status/respect								
Serious	77	8.1	59	7.6	114	11.6	250	9.3
Hardly a problem	588	62.2	512	66.2	598	61.0	1698	62.9
No specific opinion	281	29.7	202	26.1	269	27.4	752	27.9
Loss of confidence								
Serious	80	8.5	56	7.2	112	11.4	248	9.2

Hardly a problem	626	66.2	531	68.7	616	62.8	1773	65.7
No specific opinion	240	25.4	186	24.1	253	25.8	679	25.1
Fear of crime/violence								
Serious	86	9.1	58	7.5	95	9.7	239	8.9
Hardly a problem	525	55.5	455	58.9	542	55.2	1522	56.4
No specific opinion	335	35.4	260	33.6	344	35.1	939	34.8
Financial exploitation								
Serious	187	19.8	134	17.3	185	18.9	506	18.7
Hardly a problem	468	49.5	404	52.3	485	49.4	1357	50.3
No specific opinion	291	30.8	235	30.4	311	31.7	837	31.0
Physical abuse								
Serious	78	8.2	55	7.1	85	8.7	218	8.1
Hardly a problem	395	41.8	380	49.2	452	46.1	1227	45.4
No specific opinion	473	50.0	338	43.7	444	45.3	1255	46.5
Verbal abuse								
Serious	74	7.8	55	7.1	89	9.1	218	8.1
Hardly a problem	437	46.2	409	52.9	496	50.6	1342	49.7
No specific opinion	435	46.0	309	40.0	396	40.4	1140	42.2

The most common issues that elderly complain of are insufficient money (18.5%), loneliness (16.1%), poor housing (15.8%) and poor health (13.9%). 11percent of elderly feel that being neglected is a serious problem, where a higher percentage of women (12.2%) complain of neglect than men (9.5%). The above table also provides the extent of abuse that the respondents have faced after they have turned 60 years of age. Overall a staggering 18.7percent of elderly have reported of being financially exploited, and the percentage of elderly reported having faced physical and verbal abuse is 8.1percent. Where abuse is reported, it is marginally higher for men in comparison to their female counterparts. Poor health, insufficient money, financial exploitation, feeling of neglect and loss of confidence are some issues that are observed to disturb higher percentage of elderly in the 70+age group as compared to the young elderly.

Volunteerism:

Research has shown that for older adults, volunteering can be an important mechanism for meeting new people and extending connections. Whilst there are undoubtedly many social opportunities for older people in which they can interact, volunteering is able to provide a much broader and more diverse network of interactions than other types of social activities. One of the other positive benefits of volunteering is that there is also scope for older people to engage in physical activities, to experience themselves in productive roles and to increase social contacts. But unfortunately, our survey data shows that 95.6percent of elderly do not volunteer for any kind of social activities, and out of these, a negligible 1.5percent are ready to volunteer in future. 3.3percent of the total elderly are currently involved in volunteering, where the number of male elderly involved is higher than females.

Table-6-23: Sex-wise Percentage Distribution of Elderly who Volunteer or are willing to in the future

Volunteering	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Do they volunteer for social activities						
Yes, at present	22	1.4	66	5.8	88	3.3
Yes previously, but not at present	7	0.4	14	1.2	21	0.8
Ready to volunteer, but not aware	4	0.3	5	0.4	9	0.3
No	1526	97.9	1056	92.6	2582	95.6
Willingness to volunteer						
Yes	11	0.7	23	2.2	34	1.3

Table-6-24: Age-wise Percentage Distribution of Elderly who Volunteer or are willing to in the future

VOLUNTEERISM	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
Do they volunteer for social activities	No.	%	No.	%	No.	%	No.	%
Yes, at present	28	3.0	28	3.6	32	3.3	88	3.3
Yes previously, but not at present	6	0.6	6	0.8	9	0.9	21	0.8
Ready to volunteer, but not aware	3	0.3	3	0.4	3	0.3	9	0.3
No	909	96.1	736	95.2	937	95.5	2582	95.6
Would they like to volunteer?								
Yes	15	1.7	11	1.5	8	0.9	34	1.3

Awareness and interest in hobby and day care centers and old age homes:

Day care centers are facilities for the supervised care of older adults, providing activities such as meals and socialization one or more days a week during specified daytime hours. The participants, primarily persons with physical and/or mental limitations who need socialization, physical assistance, and/or psychological assistance, return to their homes each evening. The program is often used by family members caring for an older person who cannot be left alone safely in the home.

Old age homes are a multi-residence housing facility intended for senior citizens. Typically, each person or couple in the home has an apartment-style room or suite of rooms. Additional facilities are provided within the building. This can include facilities for meals, gatherings, recreation activities, and some form of health or hospice care. These old age homes can either be a free facility or a paid facility.

Table-6-25:Sex-wise Percentage Distribution of Elderly According to their Awareness and Interest in Hobby Centers, Day Care Centers and Old Age Homes

	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Awareness of day care centers, hobby centers and old age homes						
Yes	391	25.1	361	31.6	752	27.9
Interest in joining hobby center						
Yes	42	2.7	61	5.3	103	3.8
No	1272	81.6	932	81.7	2204	81.6
Uncertain	245	15.7	148	13.0	393	14.6
Interest in joining Day care center						
Yes	28	1.8	36	3.2	64	2.4
No	1281	82.2	960	84.1	2241	83.0
Uncertain	250	16.0	145	12.7	395	14.6
Interest in joining Old age home						
Yes	19	1.2	42	3.7	61	2.3
No	1290	82.7	954	83.7	2244	83.1
Uncertain	250	16.0	144	12.6	394	14.6

Table-6-26: Age-wise Percentage Distribution of Elderly According to their Awareness and Interest in Hobby Centers, Day Care Centers and Old Age Homes

	60-64yrs		**65-69yrs**		**70+yrs**		**Total**	
Awareness of day care centers, hobby centers and old age homes	No.	%	No.	%	No.	%	No.	%
Yes	296	31.3	212	27.4	244	24.9	752	27.9
Interest in joining hobby center								
Yes	28	3.0	35	4.5	40	4.1	103	3.8
No	769	81.3	639	82.7	796	81.1	2204	81.6
Uncertain	149	15.8	99	12.8	145	14.8	393	14.6
Interest in joining Day care center								
Yes	24	2.5	21	2.7	19	1.9	64	2.4
No	772	81.6	650	84.1	819	83.5	2241	83.0
Uncertain	150	15.9	102	13.2	143	14.6	395	14.6
Interest in joining Old age home								
Yes	24	2.5	16	2.1	21	2.1	61	2.3
No	778	82.2	655	84.7	811	82.7	2244	83.1
Uncertain	143	15.1	102	13.2	149	15.2	394	14.6

The survey data shows that the level of awareness regarding hobby centers, day care centers and old age homes is low. Only about 30percent of elderly are aware of one or more of these facilities for elderly. When asked about their interest to join these facilities, majority of the overall elderly are not interested in joining. Where interest is shown to join, the percentage of male elderly is higher than that of female elderly, with varying frequencies. At odds, the proportion of elderly who are interested in joining old age homes is higher in the 60-64 age group (2.5%) as compared to the 2.1percent elderly in 65-69 and 70+ age group each.

Awareness and Utilization of Schemes for Welfare of Elderly:

The term social security refers to programmes established by state that insure individuals against interruption or loss of earning power (International Social Security Association, 2003). The main function of social security is to provide income security, access to health care and basic social services and thus reducing poverty among the elderly. International Labour Organisation (2006) defines social security as the "set of institutions, measures, right and obligations whose primary goal is to provide income security and medical care to individual members of the society". Unlike developed countries India does not have a universal pension system. There is no comprehensive social security system in India as a whole. Pension policy adopted by the country is restricted to the workers in organised sectors leaving 90 percent of the workers in the unorganized sector.

Some of the existing social assistance programmes for the poor in India are state and national pension schemes, Integrated Programme for Older Persons (IPOP), National Policy for the Health Care of the Elderly (NPHCE), Indira Gandhi National Old Age Pension Scheme (IGNOAPS), Annapurna Scheme and Maintenance and Welfare of Parents and Senior Citizens Act (MWPSC Act), 2007. It is but important to assess whether these social security schemes were actually reaching the intended beneficiaries, namely, the targeted elderly.

Figure 20: Percent Distribution of Elderly by Awareness of Social Security Schemes

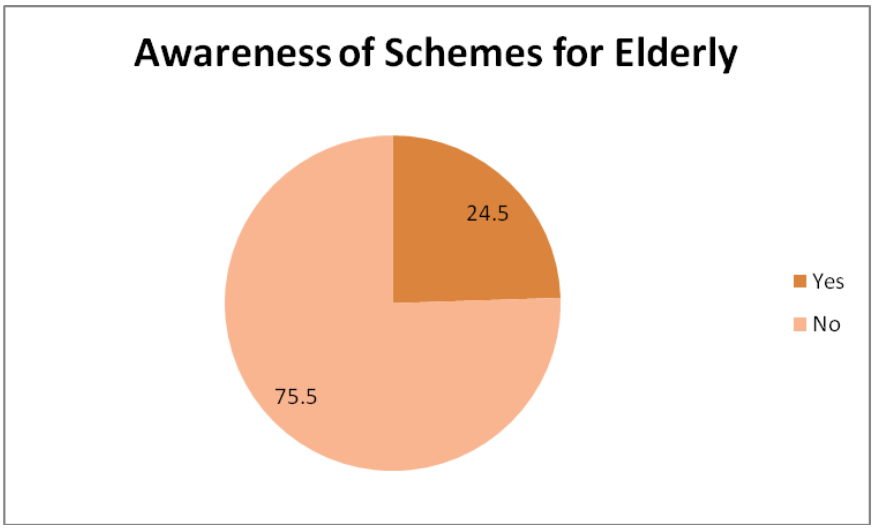


Figure 21:Percent Distribution of Elderly Registered for Scheme(s)

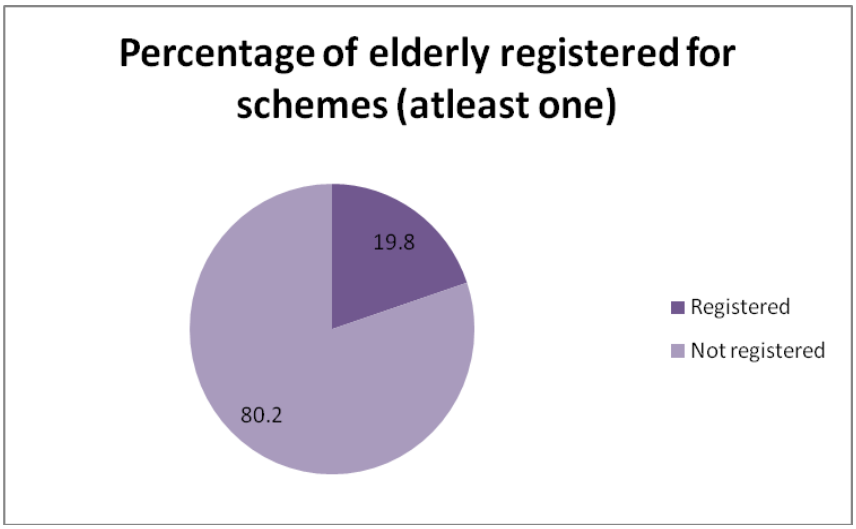


Table-6-27: Sex-wise Percentage Distribution of Awareness and Utilization of Social Security Schemes by the Elderly

	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Scheme awareness						
Yes	296	19.0	365	32.0	661	24.5
No	1263	81.0	776	68.0	2039	75.5
Registered for schemes						
Yes	56	18.9	35	9.6	91	19.8
Schemes benefiting from						
Annapurna scheme	3	0.2	2	0.2	5	0.2

IGNOAPS	5	0.3	4	0.4	9	0.3
IGNWPS	1	0.1	1	0.1	2	0.1
IGNDPS	0	0.0	1	0.1	1	0.0
National Family Benefit Scheme	2	0.1	3	0.3	5	0.2
Sanjay Gandhi Niradhar AnudanYojana	9	0.6	3	0.3	12	0.4
Shravan Bal Seva Rajya Nivrutti VetanYojana	0	0.0	1	0.1	1	0.0

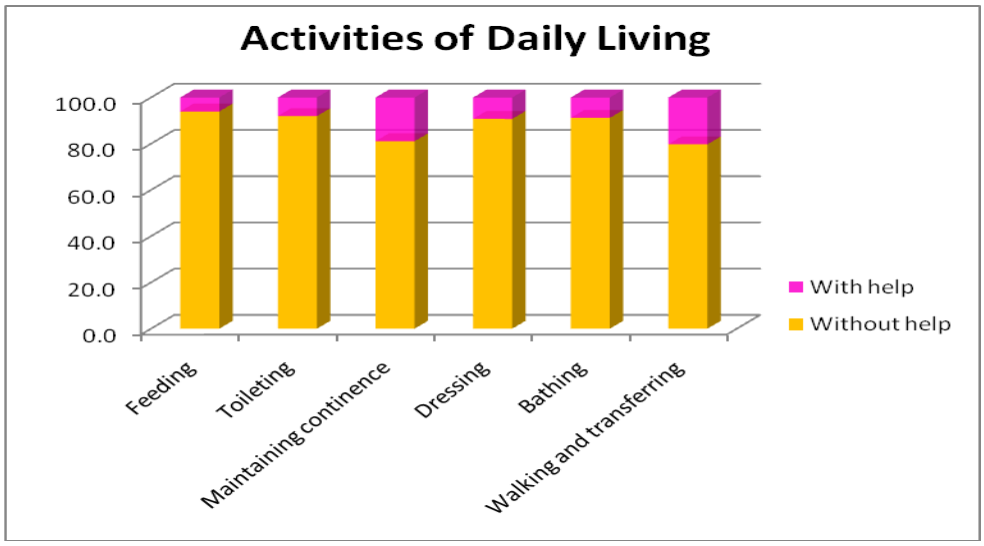
Only about 1/4th of the total elderly are aware about Social Security Schemes like Indira Gandhi National Old Age Pension Scheme, Indira Gandhi National Widowhood Pension Scheme, Annapurna Scheme, National Family Benefit Scheme, Sanjay Gandhi Niradhar Anudhan Yojana and Shravan Bal Seva Rajya Nivrutti VetanYojanafor senior citizens. The level of awareness regarding schemes is higher in males (32%) in comparison to females (19%). A mere 20percent of the elderly who are aware of the schemes, are registered for the same. The registration rate is observed to be higher in female elderly (18.9%) than males (9.6%).

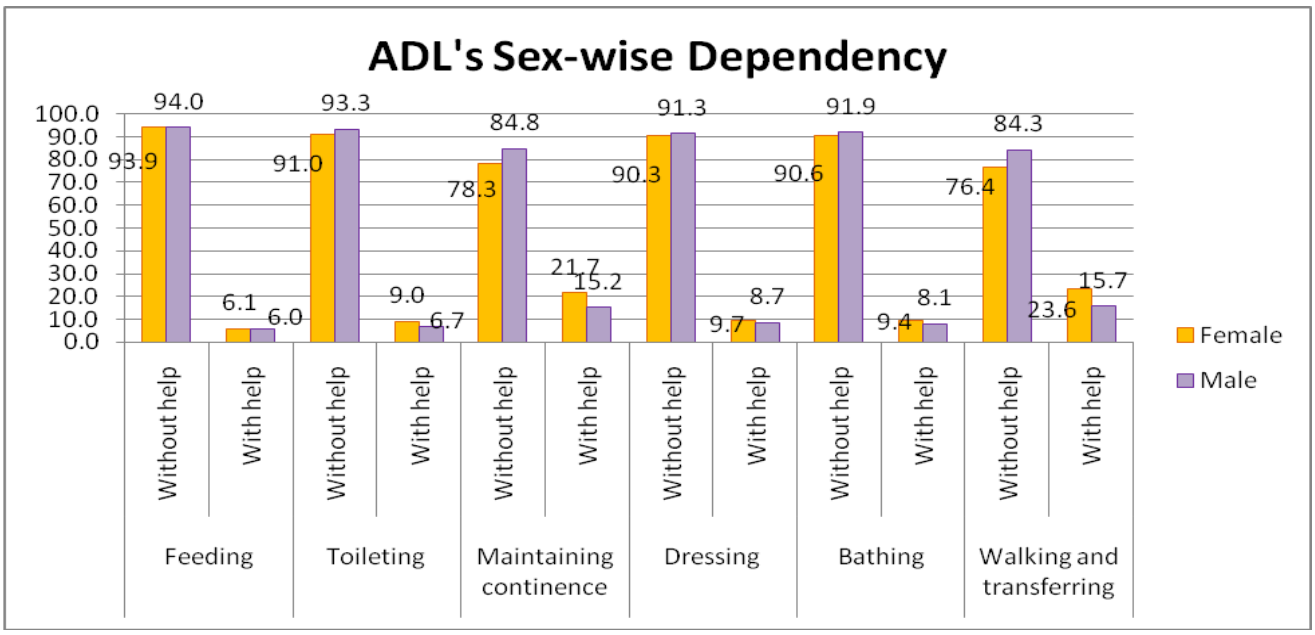
Having examined the levels of awareness regarding the social security schemes, it is imperative to understand the coverage of the schemes so as to find out how far the schemes are reaching the targeted beneficiaries. It can be seen that the utilization of the schemes is very low. The utilization of Sanjay Gandhi Niradhar Anudhan Yojana is 0.4percent, followed by IGNOAPS (0.3%) and Annapurna Scheme and National family Benefit Scheme at 0.2percent each. The purpose of such schemes is defeated as they are not reaching the targeted beneficiaries. Therefore, it is necessary to understand the bottlenecks, ranging from documentary proof and application procedures, problems with BPL listing or database and local politics and favouritism. It has been observed that accessing the bank is difficult; disbursement is also irregular. Another major concern is that the amount of pension is not adequate. At times, funds are not released or get delayed because of administrative procedures. Applications remain pending in offices. A proper strategy is required to target the beneficiaries. The application procedure needs to be simplified.

CHAPTER 7: ACTIVITIES OF DAILY LIVING (ADL) AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL):

The **'activities of daily living'** or **ADLs** are the basic tasks of everyday life, such as feeding, bathing, dressing, toileting, mobility (i.e., getting in and out of bed or chair) and continence (controlling bladder and bowel movement). When people are unable to perform these activities, they need assistance either from others or from mechanical devices or both. Apart from providing objective assessments of the ability of the elderly to execute basic daily activities and the level of difficulty in executing such tasks, ADLs have been found as an important predictor of home or institutional care, living arrangements, health expenses and mortality (Palmer and Harley, 2012). Functional disabilities in terms of ADLs, when assessed also provide understanding of socio-economic and demographic disparities in such functional limitations; the extent of familial support to those unable to execute the ADL functions gives an idea about how such informal arrangements can be expected to address the care needs. (Refer Annexure part A.3 for classification of level of dependency for each ADL)

Figure 22: Percentage of Elderly Requiring Full/Partial Assistance in ADL Activities





The survey focused to assess the level of independence of elderly to carry out six different types of ADL activities covering physical domains of functionality viz., feeding, toileting, maintaining continence, dressing, bathing and mobility, under the categories of 'without help' and 'with help'. Also, there were different categories provided for those who require help, to gain information on who provides help viz., family members, friends, neighbors, community care givers or others.

Majority of the respondents are able to perform ADLs without any help. Maintaining continence (18.9%) and Mobility (transferring and walking) (20.3%) are the two ADLs which show a significant percentage of elderly that require help for functioning of the same. Also, a gender difference is observed for these two ADLs, where the percentage of male elderly requiring help is more than their female counterparts.

Figure 23: Percent Distribution of Elderly by Katz Independency Index & Sex

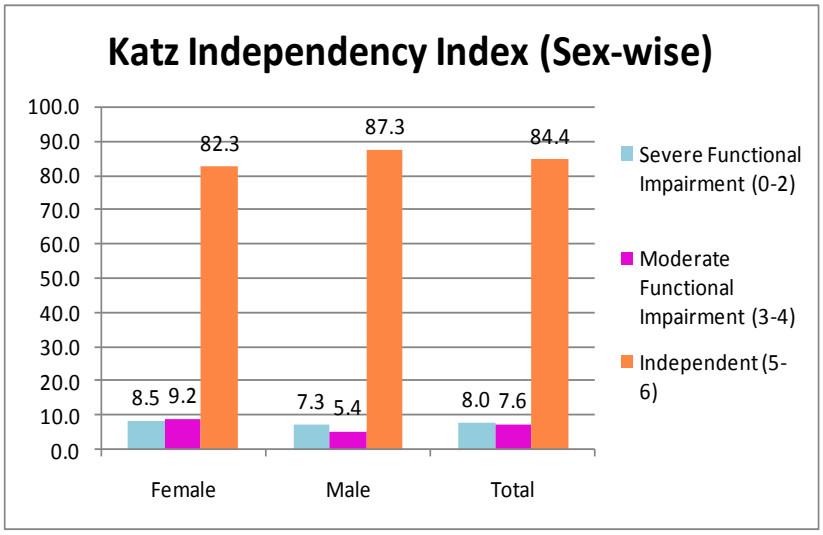
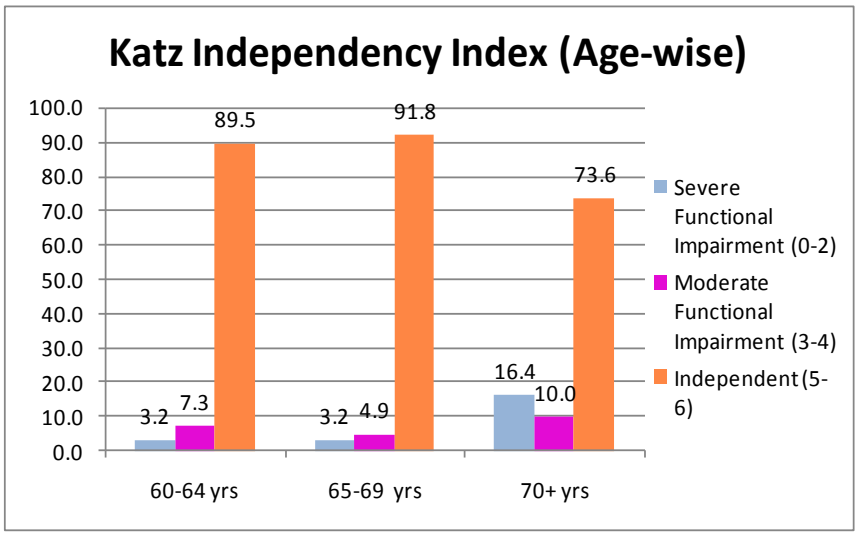


Figure 24: Percent Distribution of Elderly by Katz Independency Index & Age



Normal aging changes and health problems frequently show themselves as declines in the functional status of older adults. Decline may place the older adult on a spiral of iatrogenesis leading to further health problems. One of the best ways to evaluate the health status of older adults is through functional assessment which provides objective data that may indicate future decline or improvement in health status, allowing the care-takers to intervene appropriately

The Katz Index of Independence in Activities of Daily Living, commonly referred to as the Katz ADL, is the most appropriate instrument to assess functional status as a measurement of the client's ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The Index ranks adequacy of performance in the six functions of bathing, dressing, toileting, transferring, continence, and feeding. Elderly are scored yes/no for independence in each of the six functions. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment.

The study observed that overall 8percent elderly face severe functional impairment, followed by 7.6percent who face moderate functional impairment. Majority of the elderly (84.4%) carry out ADL's independently, with least functional impairment issues. A higher number of female elderly (9.2%) face moderate functional impairment than their male counterparts (5.4%). As anticipated, Severe functional impairment is seen to be higher with increasing age, with almost 16.4percent elderly ageing 70 yrs or more being severely impaired.

Apart from ADLs, the **'instrumental activities of daily living' (IADLs)** constitute an important dimension of functional limitations or disability among the elderly. IADLs are designed to involve a more complex set of functioning than the ADL-based functional disability measures; they require more skill, judgment and independence than the ADLs (Kovar and Lawton, 1994). The eight domains, all of which were covered in the survey, included the ability to telephone, go shopping, food preparation, housekeeping, doing laundry, travelling, responsibility for own medication and ability to handle finances. The table presents the percentage of elderly with difficulties in executing different IADL tasks under the

categories of 'without help', 'with help' and 'unable to do'. (Refer Annexure part A.4 for classification of level of dependency for each ADL)

Figure 25: Percent Distribution of Elderly Needing Full/Partial Assistance for IADL Activities

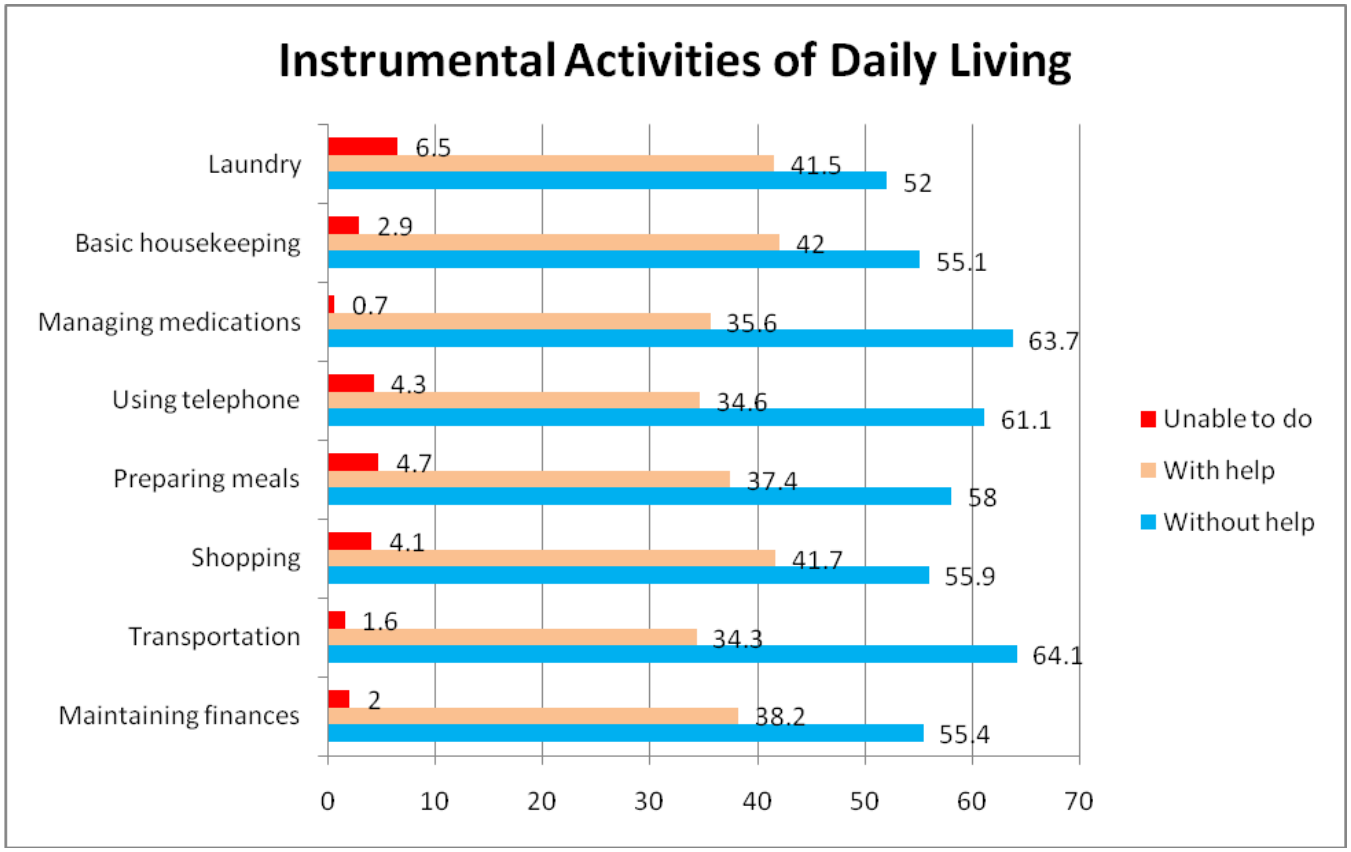


Figure 26: Percent Distribution of Elderly Needing Full/Partial Assistance in IADL Activities by Sex

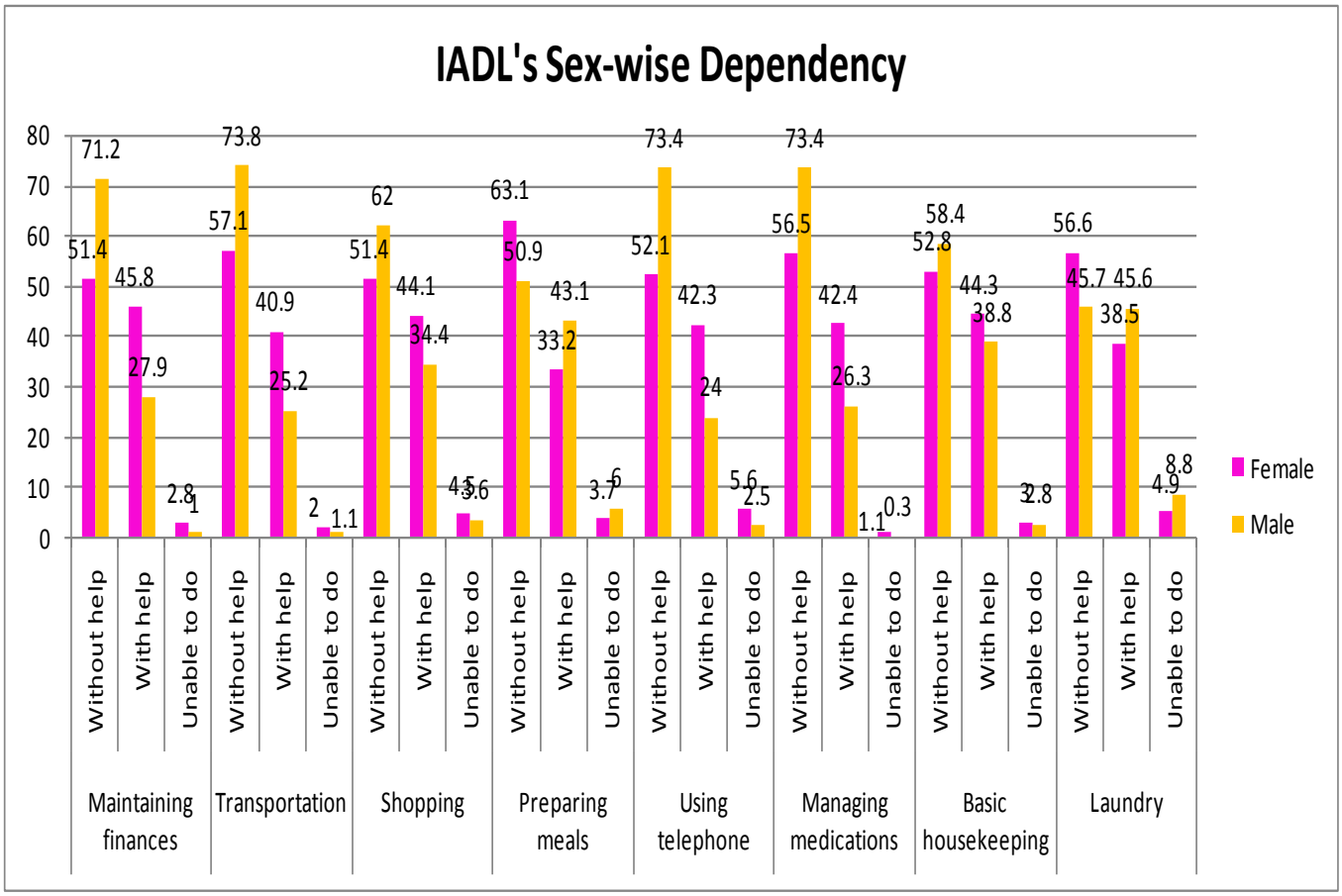


Table-7-28: Age-wise Percentage Distribution of Full/Partial Assistance Required by Elderly in IADL Activities

INSTRUMENTAL ACTIVITIES OF DAILY LIVING	60-64yrs		65-69yrs		70+yrs		Total	
Maintaining finances	No.	%	No.	%	No.	%	No.	%
Without help	616	65.1	537	69.5	461	47.0	1614	59.8
With help	324	34.2	227	29.4	481	49.0	1032	38.2
Unable to do	6	0.6	9	1.2	39	4.0	54	2.0
Transportation								
Without help	690	72.9	560	72.4	482	49.1	1732	64.1
With help	250	26.4	208	26.9	467	47.6	925	34.3

Unable to do	6	0.6	5	0.6	32	3.3	43	1.6
Shopping								
Without help	592	62.6	517	66.9	399	40.7	1508	55.9
With help	350	37.0	244	31.6	487	49.6	1081	40.0
Unable to do	4	0.4	12	1.6	95	9.7	111	4.1
Preparing meals								
Without help	626	66.2	494	63.9	445	45.4	1565	58.0
With help	305	32.2	252	32.6	452	46.1	1009	37.4
Unable to do	15	1.6	27	3.5	84	8.6	126	4.7
Using telephone								
Without help	638	67.4	525	67.9	487	49.6	1650	61.1
With help	286	30.2	234	30.3	414	42.2	934	34.6
Unable to do	22	2.3	14	1.8	80	8.2	116	4.3
Managing medications								
Without help	679	71.8	559	72.3	483	49.2	1721	63.7
With help	264	27.9	214	27.7	481	49.0	959	35.5
Unable to do	3	0.3	0	0.0	17	1.7	20	0.7
Basic housekeeping								
Without help	588	62.2	496	64.2	405	41.3	1489	55.1
With help	351	37.1	264	34.2	518	52.8	1133	42.0
Unable to do	7	0.7	13	1.7	58	5.9	78	2.9
Laundry								
Without help	566	59.8	461	59.6	377	38.4	1404	52.0
With help	348	36.8	264	34.2	508	51.8	1120	41.5
Unable to do	32	3.4	48	6.2	96	9.8	176	6.5

The table presents the percentage of elderly with difficulties in executing different IADL tasks. About 43percent of elderly need help in maintaining finances, 42percent in basic housekeeping activities, 41.7percent in shopping and 37.4percent in preparing meals. Unlike ADLs, the IADL domains reveal that difficulty in carrying out IADL tasks is significantly higher among elderly women than elderly men for all but the following two domains- preparing meals and laundry. This means that the prevailing gender norms in the society are significantly influencing who does or is primarily responsible for what type of tasks.

(Please refer to annexure for detailed explanation on the levels of functionality for all the ADL and IADL Activities.)

CHAPTER 8: PRIMARY CARE GIVER

Caregiving, simply, is the regular provision of care to someone. The nature of care depends on the specific needs of the recipient. An older person, for example, may need help with household tasks such as cleaning, preparing meals, and arranging medical services or transportation. Those who are more disabled may need assistance with daily living activities such as dressing, bathing or toileting. Older people may require help with thought-related tasks: making decisions, managing money, and getting from place to place. An elderly may also need care due to loss of health, loss of memory, the onset of illness, an incident (or risk) of falling, anxiety or depression, grief, or a disabling condition.

Relationship with Primary care giver:

The care giver may be a family member, a trained professional or another individual. Depending on culture there may be various members of the family engaged in care. Family caregivers are a varied group. Many are spouses of the older person and are, themselves, often limited in the activities they can perform. Another large group of caregivers are the children of older people, particularly daughters and daughters-in-law, and, on occasion, sons. Caregivers also include other relatives — sisters and brothers, nieces, nephews, cousins and grandchildren — as well as friends and acquaintances.

Table-8-29: Sex-wise Percentage Distribution of Elderly According to their Relation with Primary Care Giver

	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Primary care giver						
Spouse	325	20.8	707	62.0	1032	38.2
Children	764	49.0	304	26.6	1068	39.6
Grandchildren	118	7.6	29	2.5	147	5.4
Others	228	14.6	51	4.5	279	10.3
NA*	124	8.0	50	4.4	174	6.4

Table-8-30: Age-wise Percentage Distribution of Elderly According to their Relation with Primary Care Giver

Primary care giver	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
	No.	%	No.	%	No.	%	No.	%
Spouse	436	46.1	320	41.4	276	28.1	1032	38.2
Children	330	34.9	282	36.5	456	46.5	1068	39.6
Grandchildren	32	3.4	42	5.4	73	7.4	147	5.4
Others	91	9.6	78	10.1	110	11.2	279	10.3
NA*	57	6.0	51	6.6	66	6.7	174	6.4

The table above represents data on who act as primary care givers for the elderly, thus providing with information on the involvement of members of the family or community. The survey shows that children and spouse of elderly form

majority of primary care givers (more than 3/4th). Other primary care givers include relatives, friends, neighbors and community care-givers. A noteworthy difference is observed on a gender perspective, where children are the primary care givers for almost half of the female elderly but only 26.6percent of male elderly. Majority of male elderly are taken care of by their spouse (62%). Overall, 6.3percent of the elderly do not have any primary care giver and are responsible for self-care. The primary care giver vs. age data shows that the role of spouse as the care-giver reduces gradually with age, whereas that for the children and grandchildren increases. This can be attributed to the higher proportion of widows in later years, due to loss of life.

Availability of Primary care giver:

Table-8-31: Sex-wise Percentage Distribution of Elderly According to Availability and Sufficiency of care provided by Primary Care Giver

	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Availability of Primary Care giver						
Full time	802	55.8	789	72.3	1591	62.8
Only during the day	42	2.9	26	2.4	68	2.7
Only during the night	313	21.8	103	9.4	416	16.4
Only when called	279	19.4	172	15.8	451	17.8
Manage in Primary care givers absence						
Able to manage by myself	1012	70.5	801	73.4	1813	71.6
Someone else comes in	235	16.4	157	14.4	392	15.5
No special arrangements made	158	11	103	9.4	261	10.3
Helper seldom goes out	31	2.2	29	2.7	60	2.4
Care giver time sufficient						
Yes	958	66.7	834	76.4	1792	70.7
No	291	20.3	176	16.1	467	18.5
Uncertain	187	13	80	7.3	267	10.6

Table-8-32: Age-wise Percentage Distribution of Elderly According to Availability and Sufficiency of care provided by Primary Care Giver

	60-64yrs		**65-69yrs**		**70+yrs**		**Total**	
Availability of Primary Care giver	No.	%	No.	%	No.	%	No.	%
Full time	559	62.9	461	63.9	569	62.2	1589	62.9
Only during the day	20	2.2	20	2.8	28	3.1	68	2.7
Only during the night	138	15.5	112	15.5	166	18.1	416	16.5
Only when called	171	19.2	129	17.9	151	16.5	451	17.9

Manage in Primary care givers absence								
Able to manage by myself	673	75.7	538	74.5	599	65.5	1810	71.7
Someone else comes in	104	11.7	95	13.2	193	21.1	392	15.5
No special arrangements made	101	11.4	72	10.0	88	9.6	261	10.3
Helper seldom goes out	10	1.1	17	2.4	33	3.6	60	2.4
Care giver time sufficient								
Yes	642	72.2	523	72.4	624	68.2	1789	70.8
No	153	17.2	136	18.8	178	19.5	467	18.5
Uncertain	93	10.5	63	8.7	111	12.1	267	10.6

After knowing the proportion of various members who are responsible for taking care of elderly, it is pertinent to analyze different aspects such as their availability and how the elderly manage in their absence. The data shows that 62.8percent of the elderly have their care giver available for support full-time, with a variation on the gender front, where a higher percentage of male elderly have full-time care givers as compared to female elderly. This trend is common for all the four localities. The care-giver is available for 17.8percent of the elderly only when called, for 16.4percent only during the night and for 2.7percent only during the day. Almost 72percent of elderly can manage in the absence of their primary care giver. 15.5percent of the elderly require someone else to come in and help in the absence of care-giver. More than 10percent of elderly complain of not having any special arrangements made even though required to help them, in care giver absence.

More than 18percent of elderly feel that the care giver time provided to them is not sufficient. The percentage of elderly in this category is higher in Matunga Labor Camp and Dharavi as compared to the other two localities.

CHAPTER 9: HEALTH AND NUTRITION

It is usually believed that chronological age largely determines individuals' social participation. But the major life events such as loss of spouse, retirement, affliction with chronic condition(s) significantly influence life quality of older persons. These life transitions are largely intertwined with socio-economic statuses and gender of older people. Given the deterioration that comes with ageing, health problems among the elderly have not yet received widespread attention; and, health care resources are insufficient for meeting their health care requirements. Problems related to health are more serious among the many problems faced by the elderly, in view of the fact that their entire functioning is closely linked with their health condition. Due to deteriorating physiological conditions with age, the body becomes more prone to illnesses which are multiple and chronic in nature. The association of old age with ailments and infirmities is deep-rooted and many of the sufferings, even when curable, are accepted as natural and inevitable by the elderly and society.

Self-rated health:

The self-rated health is considered as a strong predictor to understand the health status of people in general and the elderly in particular. The self-rated health was assessed in the survey using a 5-point scale (1) excellent, (2) good (3) average (4) poor (5) worse.

Table-9-33: Sex-wise Percentage Distribution of Self-rated Health of Elderly

Self-rated health	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
Good	726	46.6	621	54.4	1347	49.9
Average	704	45.2	456	40.0	1160	43.0
Poor	129	8.3	64	5.6	193	7.1

Table-9-34: Age-wise Percentage Distribution of Self-rated Health of Elderly

Self-rated health	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
	No.	%	No.	%	No.	%	No.	%
Good	528	55.8	428	55.4	391	39.9	1347	49.9
Average	389	41.1	319	41.3	452	46.1	1160	43.0
Poor	29	3.1	26	3.4	138	14.1	193	7.1

The survey found that almost 50percent of the elderly rated their current health as excellent (4.5%) or good (45.4%). However, around 7.1percent rated their health as poor (6.7%) or worse (0.4%). Nearly 43percent rated their health as average. Thus, self-rated health of the elderly is relatively good. In general, self-rated health is better among elderly men than among elderly women. The self-rated health worsens with increasing age. Only about 40percent of the elderly in the age group of 70+ have rated their current health as excellent or good as against more than 55percent in the age

group 60-64 years. 14percent of the 70+ elderly consider their condition to be poor or worse as compared to a mere 3.1percent and 3.4percent of elderly in the 60-64 and 65-69 age group.

Acute Morbidities:

Morbidity is a state of ill health caused by any disease. Acute morbidity is defined as any elderly person reporting any event of sickness or ill health during the 15 days prior to the survey. The reporting is based on the responses of the elderly persons and has therefore been termed as self-reported morbidity. Depending upon the duration of any illness during this reference period, there could be four possibilities: (i) morbidity or illness episodes that started more than fifteen days ago and are continuing during the reference period, (ii) illness or morbidity episodes that started more than fifteen days ago and ended during the reference period, (iii) illness or morbidity episodes that occurred during the reference period and were continuing on the date of survey, and (iv) illness or morbidity episodes that both started and ended during the reference period.

Figure 27: Percentage Distribution of Last Episode (within past 15 days) of Acute Morbidities Pattern among Elderly by Sex

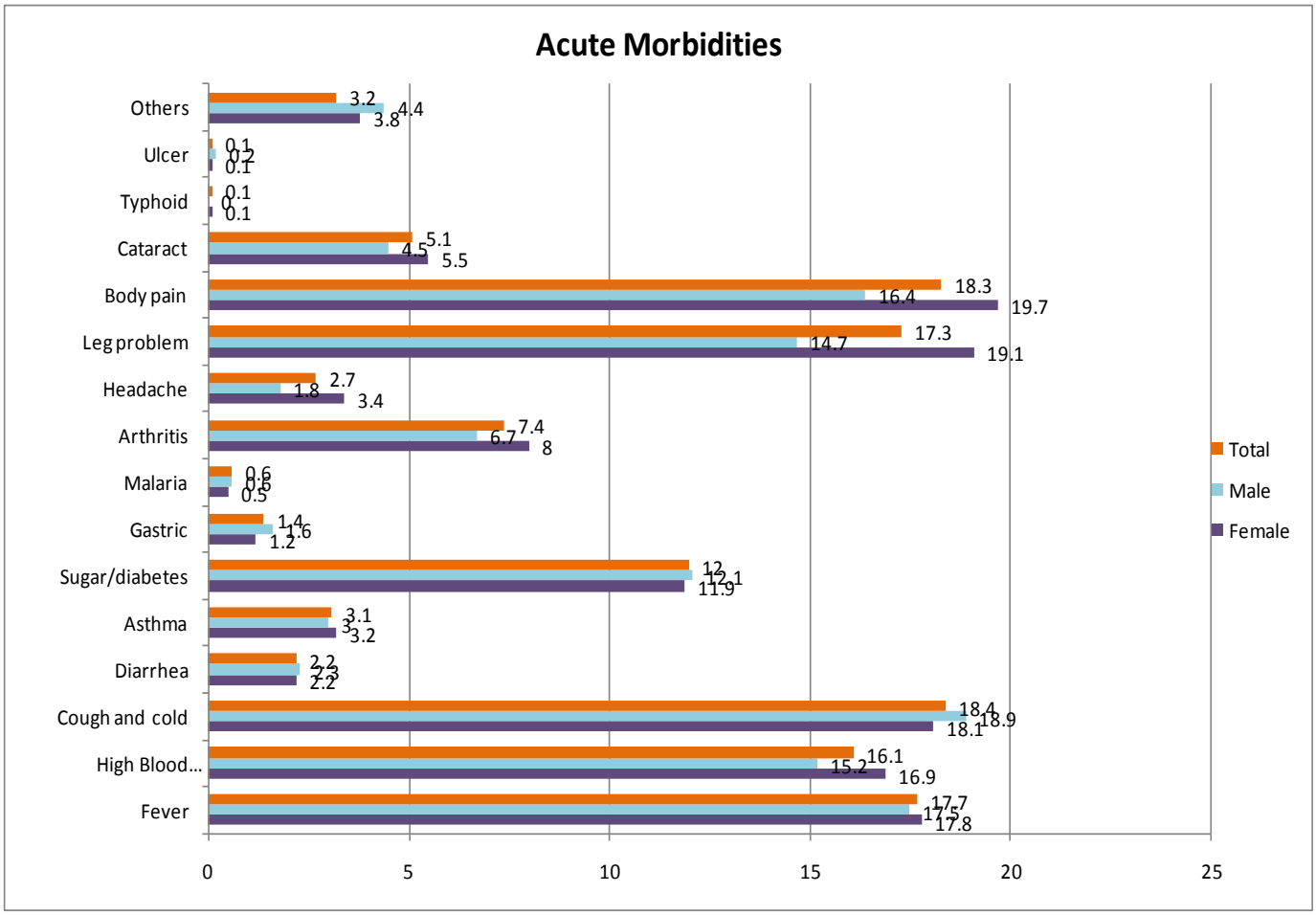


Table-9-3: Percentage Distribution of Last Episode (within past 15 days) of Acute Morbidities Pattern among Elderly by Age

Acute morbidities	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
	No.	%	No.	%	No.	%	No.	%
Fever	172	18.2	122	15.8	184	18.8	478	17.7
High Blood pressure	152	16.1	116	15.0	168	17.1	436	16.1
Cough and cold	162	17.1	135	17.5	201	20.5	498	18.4
Diarrhea	25	2.6	14	1.8	21	2.1	60	2.2
Asthma	15	1.6	22	2.8	47	4.8	84	3.1
Sugar/diabetes	101	10.7	100	12.9	123	12.5	324	12.0
Gastric	13	1.4	12	1.6	12	1.2	37	1.4
Malaria	7	0.7	5	0.6	3	0.3	15	0.6
Arthritis	86	9.1	53	6.9	61	6.2	200	7.4
Headache	23	2.4	22	2.8	28	2.9	73	2.7
Leg problem	146	15.4	127	16.4	193	19.7	466	17.3
Body pain	167	17.7	132	17.1	195	19.9	494	18.3
Cataract	46	4.9	32	4.1	59	6.0	137	5.1
Typhoid	1	0.1	1	0.1	0	0.0	2	0.1
Ulcer	1	0.1	0	0.0	3	0.3	4	0.1
Others	43	4.5	32	4.1	35	3.6	110	4.1

The most commonly prevailing acute morbidities among surveyed elderly are cough and cold (18.4%), body pain (18.3%), leg problem (17.3%), fever (17.7%) and high blood pressure (16.1%). A significant 12percent have diabetes followed by 7.4percent suffering from arthritis. A common trend is observed, where the prevalence of these morbidities is higher in females than males; especially for leg problem and body pain. The above table also helps us differentiate the prevalence of these acute morbidities locality-wise.

Chronic Morbidities:

Non-communicable diseases (NCDs), including mental health, are being acknowledged as major contributors to the disease burden in India. The burden of chronic diseases has been rising, keeping pace with the demographic transition and the increasing numbers of senior citizens. Accordingly, it is important to examine the prevalence of chronic ailments. The survey collected information from the elderly on various types of chronic ailments suffered by them that are medically diagnosed by a doctor or a nurse.

Figure 28: Percent of Elderly Reporting Chronic Morbidities by Sex (with a reference period of one year)

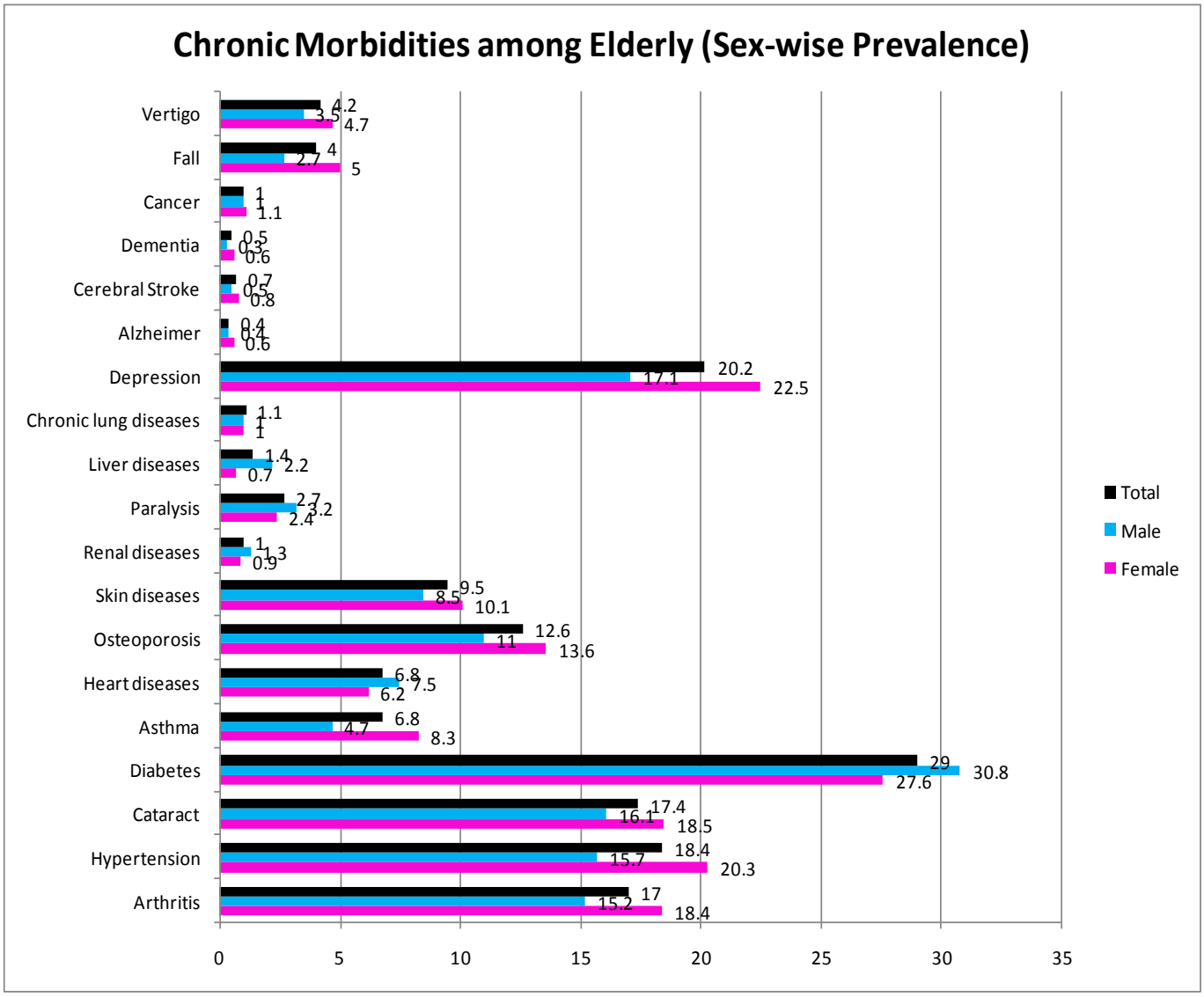


Table-9-4: Percentage Distribution of Prevalence of Chronic Morbidities among Elderly by Age

Chronic morbidities	**60-64yrs**		**65-69yrs**		**70+yrs**		**Total**	
Arthritis	No.	%	No.	%	No.	%	No.	%
Yes	134	14.2	112	14.5	171	17.4	417	15.4
Hospitalized	18	1.9	10	1.3	15	1.5	43	1.6
Hypertension								
Yes	123	13.0	110	14.2	190	19.4	423	15.7
Hospitalized	28	3.0	18	2.3	26	2.7	72	2.7
Cataract								

Yes	79	8.4	87	11.3	159	16.2	325	12.0
Hospitalized	42	4.4	39	5.0	64	6.5	145	5.4
Diabetes								
Yes	206	21.8	203	26.3	296	30.2	705	26.1
Hospitalized	23	2.4	26	3.4	28	2.9	77	2.9
Asthma								
Yes	33	3.5	36	4.7	82	8.4	151	5.6
Hospitalized	4	0.4	8	1.0	20	2.0	32	1.2
Heart diseases								
Yes	36	3.8	34	4.4	83	8.5	153	5.7
Hospitalized	8	0.8	5	0.6	16	1.6	29	1.1
Osteoporosis								
Yes	121	12.8	84	10.9	118	12.0	323	12.0
Hospitalized	7	0.7	2	0.3	6	0.6	15	0.6
Skin diseases								
Yes	80	8.5	63	8.2	102	10.4	245	9.1
Hospitalized	3	0.3	3	0.4	4	0.4	10	0.4
Renal diseases								
Yes	3	0.3	3	0.4	13	1.3	19	0.7
Hospitalized	3	0.3	2	0.3	3	0.3	8	0.3
Paralysis								
Yes	11	1.2	19	2.5	35	3.6	65	2.4
Hospitalized	1	0.1	3	0.4	5	0.5	9	0.3
Liver diseases								
Yes	7	0.7	8	1.0	12	1.2	27	1.0
Hospitalized	3	0.3	4	0.5	3	0.3	10	0.4
Chronic lung diseases								
Yes	1	0.1	7	0.9	7	0.7	15	0.6
Hospitalized	8	0.8	2	0.3	3	0.3	13	0.5
Depression								
Yes	178	18.8	135	17.5	222	22.6	535	19.8
Hospitalized	3	0.3	5	0.6	3	0.3	11	0.4
Alzheimer								
Yes	1	0.1	2	0.3	3	0.3	6	0.2
Hospitalized	1	0.1	0	0.0	5	0.5	6	0.2
Cerebral Stroke								
Yes	4	0.4	3	0.4	3	0.3	10	0.4
Hospitalized	2	0.2	3	0.4	3	0.3	8	0.3
Dementia								
Yes	4	0.4	1	0.1	4	0.4	9	0.3
Hospitalized	2	0.2	0	0.0	5	0.5	7	0.3

Cancer								
Yes	6	0.6	6	0.8	6	0.6	18	0.7
Hospitalized	6	0.6	3	0.4	8	0.8	17	0.6
Fall								
Yes	36	3.8	42	5.4	100	10.2	178	6.6
Hospitalized	10	1.1	5	0.6	11	1.1	26	1.0
Vertigo								
Yes	44	4.7	37	4.8	81	8.3	162	6.0
Hospitalized	3	0.3	1	0.1	6	0.6	10	0.4

Table presents the prevalence rates of various chronic ailments classified by sex. Diabetes is the most common type of ailment reported by the respondents followed by Orthopaedic/musculoskeletal ailments involving arthritis and osteoarthritis. Other ailments with relatively higher prevalence levels include hypertension, cataract, paralysis and asthma. Ailments related to the respiratory system and cardiovascular system have lower prevalence rates. The most common chronic ailments are more prevalent among elderly women as compared to elderly men, except for Diabetes, to which men are more susceptible. Hypertension and Diabetes are two lifestyle diseases that are more prevalent in Lower Parel as compared to other localities. This is in lines with socio-economic differentials, since Lower parel consists of more Middle-income group residents and the standard of living is higher than the other three localities.

Nutrition Checklist:

Older people are vulnerable to malnutrition for many reasons including physiological and functional changes that occur with age, lack of financial support and inadequate access to food. The functional status of the elderly is their ability to carry out their day to day activities including preparation of food and intake, thereby affecting nutritional status. In India, the problem of the health of the elderly is compounded by poor nutrition together with medical issues, including both communicable and noncommunicable diseases. Malnutrition and morbidity create a vicious cycle.

The nutrition and health of the elderly is often neglected. Most nutritional intervention programs are directed toward infants, young children, adolescents, and pregnant and lactating mothers. However, nutritional interventions could play a part in the prevention of degenerative conditions of the elderly and an improvement of their quality of life. A timely intervention can stop weight loss in those at risk of malnutrition. Unfortunately, not much explanation has been given for the precise estimate of under-nutrition in this age group in research. An evaluation of nutritional status is important for the creation of a database to assist with the initiation of important programs and formulation of policies.

Table-9-5: Percentage Distribution of Elderly Answering Yes for the Nutritional Checklist by Sex

Nutrition screening Checklist	Female		Male		GRAND TOTAL	
	No.	%	No.	%	No.	%
I have an illness or condition that made me change the kind and/or amount of food I eat	712	45.7	519	45.5	1231	45.6
I eat fewer than two meals per day	630	40.4	445	39.0	1075	39.8
I eat few fruits, vegetables or milk products	871	55.9	719	63.0	1590	58.9

I chew tobacco, smoke or drink alcoholic beverages almost every day.	381	24.4	466	40.8	847	31.4
I have tooth or mouth problems that make it hard for me to eat.	416	26.7	291	25.5	707	26.2
I don't always have enough money to buy the food I need.	664	42.6	469	41.1	1133	42.0
I eat alone most of the time.	525	33.7	288	25.2	813	30.1
I take three or more different prescribed or over-the-counter drugs per day.	377	24.2	254	22.3	631	23.4
Without wanting to, I have lost or gained 5kgs. in the last six months.	181	11.6	118	10.3	299	11.1
I am not always physically able to shop, cook, and/or feed myself	495	31.8	353	30.9	848	31.4

Figure 29: Percent Distribution of Elderly by NSC Score & Sex

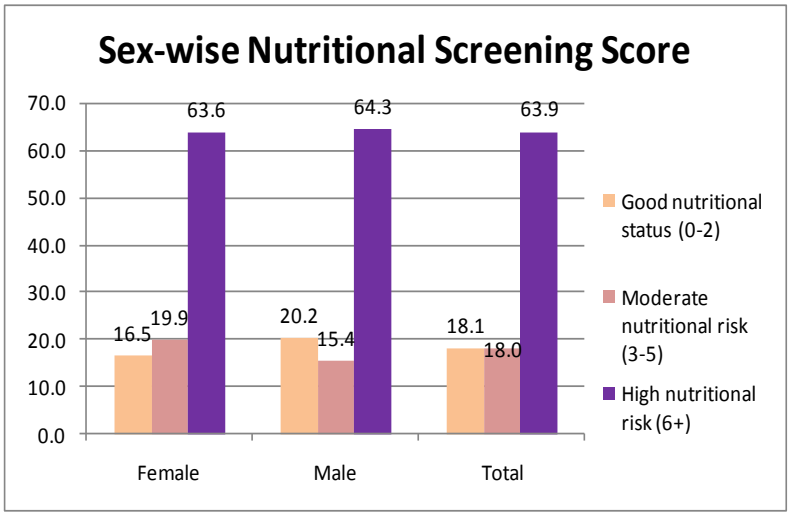
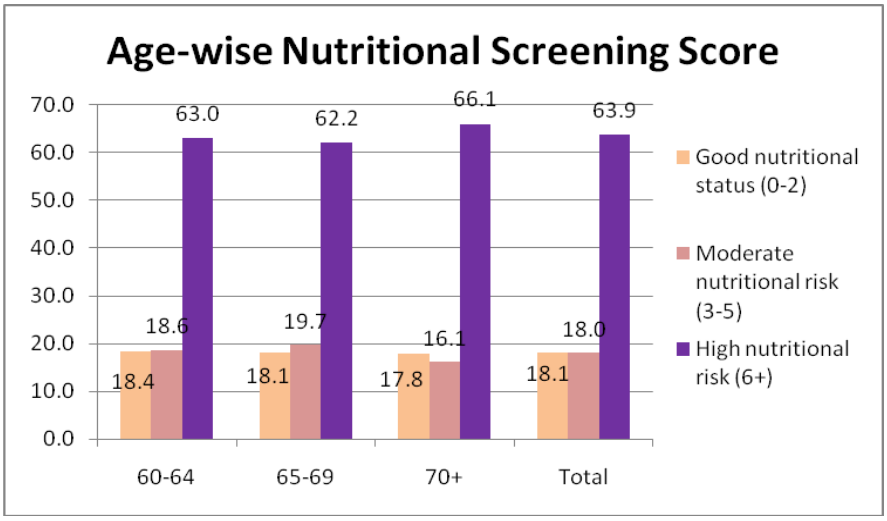


Figure 30: Percent Distribution of Elderly by NSC Score and Age



A Nutritional Checklist was used to assess the risk of elderly to malnutrition. The checklist has a score system where in pre-determined points are allotted to each question. The respondent is supposed to select the statement that applies to them. The nutritional scores finally obtained are categorized into three sections; Score0-2: Good, Score 3-5: Moderate Nutritional Risk, Score 6 or more; High nutritional risk. Each case can be individually analyzed to assess their nutritional scores.

Overall, It is observed that nearly 60percent elderly do not eat fruits, vegetables and dairy products on a regular basis, wherein the elderly male are in greater number than the females. Almost 45percent stated that they have an illness or condition that has led to a change in the amount and kind of food they consume. Unfortunately 42percent of the elderly do not have enough financial resources to buy food every day. Nearly 40percent elderly eat less than two meals per day. It is observed that 40.8percent of male elderly chew tobacco/drink alcohol/or smoke almost everyday, which is significantly higher than nearly 25percent of females who do the same. The nutrition checklist factors that are listed are observed to worsen with age for almost all the factors except for the number of meals being less than 2 per day. Dental problems are staggeringly high in the 70+ age group (34%) as compared to the young elderly.

Based on the scores evaluated, it is observed that overall 64percent of the elderly face high nutritional risk, 18percent are at moderate nutritional risk and the remaining 18.1percent show good nutritional status. Gender and Age Distribution show marginal variation in terms of nutritional risk.

Mid Upper Arm Circumference (MUAC) range:

MUAC is used as an indicator for the assessment of acute adult undernutrition. The indicator is useful for both screening acute adult undernutrition and for estimating prevalence of undernutrition at a population level.It is an easy and inexpensive way to detect nutritional status and is used in developing countries for rapid and extensive nutrition surveillance and screening programs. MUAC is the circumference of the upper arm measured at the midpoint between the tip of the shoulder and the tip of the elbow (olecranon process and the acromium). MUAC greater than 23cm is considered normal, and less than 23cm can be considered as a warning for undernutrition.

Figure 31: Percent Distribution of Elderly by MUAC & Sex

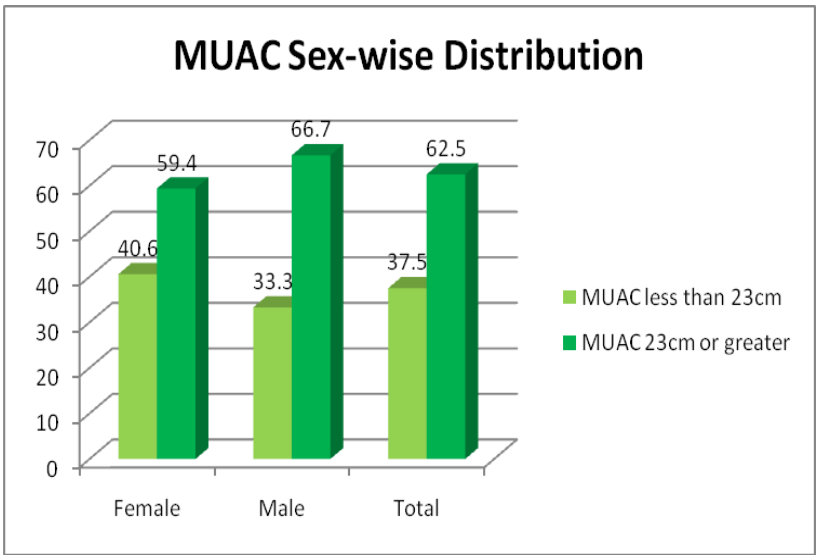
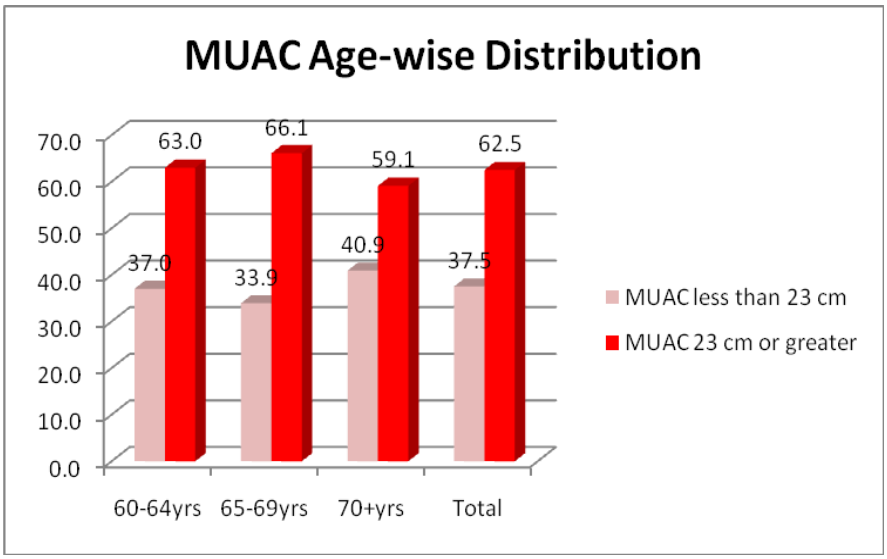


Figure 32: Percent Distribution of Elderly by MUAC & Age



The survey data shows that a significantly high percentage (almost 37%) of elderly fall in the risk of undernutrition category. Elderly living in Dharavi show a distinctively higher percentage (more than half i.e., 51.3%) in the less than

23cm range. Females are observed to be at a higher risk of undernutrition as compared to male elderly. This trend is common in the localities except for Dharavi, where males are at a higher risk than females. As observed, the proportion of elderly facing risk of malnutrition is increasing with age, where more than 40percent of the 70+ age group elderly, followed by 37percent of the 60-64 years and 33.9percent of the 65-69 years age group are at risk.

CONCLUSION

In developing countries, including India, increasing longevity is not necessarily a result of improved socio-economic status of the elderly, as is the case in much of developed world. The pace of population ageing is faster than overall population growth and the level of preparedness is very limited. The most recent global report on Ageing in the 21st Century by UNFPA and HElpAge International (October 2012) appropriately calls the ongoing demographic phenomenon a cause for celebration as well aqs a significant challenge. The focus therefore is to reduce vulnerability and enhance the quality of life of our senior citizens.

To achieve community integration and home care for elderly, this study generated primary data from 2700 senior citizens from four cluster localities- Matunga Labor Camp, Dharavi, Lower Parel and BDD Chawl- on the following specific areas that are associated with their well-being and quality of life: (a) living arrangements and familial relationships (b) workforce participation and income situation of the household (c)social engagement (d) awareness and utilization of schemes meant specially for senior citizens (e) Activities of Daily Living (ADL's) & Instrumental Activities of Daily Living (IADL's) and (f) health status.

Health is both at the level of (a) one's own perception of well-being and (b) medically determined status. It also means that health is a life cycle experience in the sense that healthy younger years are essential for healthy later years. At the perception level, the analysis shows that around 7.1 percent of the elderly rated their current health as poor and another 43 percent as average. Acute morbidities (within a span of past 15 days) and chronic morbidities (time span of 1 year) were inquired. Diabetes was the most common type of ailment reported by the elderly, followed by Orthopaedic/musculoskeletal ailments involving arthritis and osteoarthritis. Other ailments with relatively higher prevalence levels included hypertension, cataract, paralysis and asthma. Ailments related to the respiratory system and cardiovascular system had lower prevalence rates. The most common chronic ailments noted were more prevalent among elderly women as compared to elderly men, except for Diabetes, to which men were observed to be more susceptible. Programmes that promote healthy lifestyles, assistive technology and supportive environments are required to foster healthy and active ageing. Further, good health behaviours should be promoted so that diseases and disability can be prevented and/or delayed. It is also important to focus on preventive aspects by introducing multi-phase screening. The assessment of ADL's provides and encouraging picture which shows that there are large potentials among the elderly population that can be tapped. For this a change in social attitudes is necessary. Ill health is closely linked with malnourishment. The present survey tried to cover this risk by measuring the Mid-Upper-Arm Circumference (MUAC) as well as pulling together data on selected factors that affect nutritional status through the Nutrition Screening Checklist. The survey data shows that a 37percent of elderly fall under risk of undernutrition, wherein, female elderly are observed to be at a higher risk as compared to male elderly. Efforts to ensure a proper diet for the elderly will have to be made.

The current living arrangements and the contribution of elderly to family expenditures suggest that the family is the first source of support. The survey also confirms that the elderly view children as their most preferred source of support, institutional care being the last option. Efforts are therefore necessary to strengthen inter-generational bonds by promoting and training family care-givers in care for the elderly. Further, the existing local community organizations, NGO's, elected representatives, need to be sensitized to evolve and work in cohersion on community-based care mechanisms. A pool of trained caregivers will have to be made available and different mechanisms of service provision through private entities and civil society organizations will have to be evolved. It is important to note that 46.4 percent of

the elderly feel that the government should provide support during old age. With institutions being the last option, community-based day-care centres focusing on the elderly could provide services such as skill up-gradation and training, financial and legal advice, as well as entertainment and activities such as yoga, exercise, etc. by linking up with the public health system.

The findings of the study clearly highlight that income insecurity, age related morbidity, and physical and economic dependency are factors that tend to make the Indian elderly, and particularly elderly women, vulnerable. The survey found that only about one-fourth of the elderly are aware of existing social welfare schemes, and more so the reach is presently negligible. As most of the elderly are/were working for low paid informal sector with no pension or retirement benefits, the access to and the amount of social pension must increase and have to specifically be extended for BPL families and all elderly women. Better targeting of national flagship programmes and special schemes meant only for the elderly and addressing special needs of older women would be required.

The information emanating from the study has impotant policy and programmatic implications for improving the well-being and quality of life of the elderly. The approach needs to be holistic and multidimensional; at the individual, family, community, governmental and non-governmental levels. Therefore approaches to understand these issues from a multi and inter-disciplinary perspective need to be initiated. Studies on nutritional aspects, impact of migration on the elderly, strengthening of community-based institutions, family support systems like care-givers and social networks should receive greater attention. There is not enough efforts made to bring multiple stakeholders to the table to hear and respond to the voices and demands of senior citizens. There is a need to engage institutions for more focused interventions relating to home-based and community-based care for the elderly. First and foremost, it is important to extend social pension and health insurance, especially to women. At the family level, stronger intergenerational bonding needs to be encouraged and at a community level, greater participation of elderly has to be ensure by active involvement in decentralized bodies. Effective implementation of national policy and programmes for older persons in line with the international instruments is imperative.

ACTIONABLE POINTS FOR INTERVENTION:

- Considering the living conditions of elderly, the **toilet and bathroom facilities** for those living in BDD chawl and Dharavi could be improved.
- Majority of the elderly are not beneficiaries of any **social security scheme**. This can be changed by awareness generation programmes and the utilization of government schemes for welfare of elderly can be increased by engaging communities to register for these schemes.
- A major disinterest can be observed for volunteering and **engagement in social activities**. The agency can play a role in community mobilization to increase elderly participation in social and cultural activities.
- A very few elderly who are interested in working can be tapped and given **work opportunities** to support economic development and reduce their dependency.

- The field observations indicate that many elderly living in Lower Parel and Dharavi **do not have enough money** to afford medical expenses and they need to be prioritized in the intervention by the agency.
- **Risk of malnutrition** is high among elderly living in Dharavi. The agency can focus on clinically assessing the nutritional status of these elderly and monitored monthly. Nutrition specialists can be consulted to prepare minimum standards for providing nutritional supplements to the worse affected.
- The elderly suffering from **diabetes, arthritis and hypertension** can be screened and given proper medical attention to avoid further deterioration in health. Those suffering from arthritis and osteoporosis can be advised by physiotherapists and enrolled for regular sessions.
- Elderly complaining of **depression** is very high as compared to other chronic morbidities. These elderly need to be further clinically assessed for signs of depression. Interventions to keep them socially engaged and mentally fit can be designed for such respondents.
- The percentage of **tobacco chewing/smoking/drinking** elderly is high in Dharavi. These elderly can be identified and interventions to reduce this number need to be designed.

SOCIAL MAPPING

Background

Social Mapping of utility agencies in an area is important as it helps not only the elderly who are in need of various services from such agencies, but also for the agencies to interact with other agencies around them. The present effort in social mapping will also be useful for Non-Governmental organizations, researchers and academicians who are involved in the field of ageing. An innovativeness of the present effort is that agencies present in each of the study areas are plotted in specially prepared maps with help of geographical information system (GIS). Such a effort will greatly help in understanding the spread of agencies and their accessibility in the particular study area.

All the agencies which are required by the elderly for their day to day activities are considered for social mapping. A list of organizations covered under social mapping is attached herewith.

Methodology

The methodology adopted was to identify various utility organizations in the study areas and physically verify these organizations on a census basis. Given the physical verification of the agencies by the trained field workers, we may assume that the social mapping covered all the listed agencies in the study areas. The agencies are plotted on a road network map and detailed list is given subsequently. The location of an agency in each study area can be observed by an identification number given to that particular agency in the map.

Social mapping technique which is adopted while creating the maps is very informative. It acts as a important tool to assess locational aspects and focus on relevant needs. As mobility is a major issue for the elderly; utilization of services, provided by the agencies, depend on ease of accessibility. Prior to the physical identification of agencies, a list of probable agencies for their inclusion in the social mapping was shared with the nodal agencies in both the study areas.

A total of 403 agencies were identified across study areas (Dharavi &Matunga Labour Camp:144; Lower Parel:259). This was a time consuming exercise as many of the organizations were located on internal roads or between housing structures. Field checking helped in reducing the error in plotting, yet there is a possibility of margin of error of 5-10 meters in plotting of agencies. Due to limited geographical extent of the study area, use of global positioning satellite (GPS) to pinpoint exact location of an agency proved unsuitable.

Dharavi and Matunga Labour Camp, Mumbai -

It was observed that out of the 144 utility agencies, medical shop (29) followed by grocery shops (17) and hospital/clinic (13) constitute nearly one third. It is significant to note that there are nine religious places in the study area. There are six common toilet in the study area. Health related facilities also include three diagnostic centres. There are equal number of schools(4), NGOs(4) and political party offices(4) in the area.

Lower Parel, Mumbai -

As the study area lies in the heart of Mumbai city, it is observed that the concentration of various utility agencies is very high. Nearly one fifth of the agencies are hospitals/clinics (49), other health related agencies include medical shops (28), diagnostic centre (2) and physiotherapy centre (1). Among the social development related agencies, we can observe that community centre/mandal (38) occupy a much larger share, compared to NGOs (4) and senior citizen associations(3). Infrastructure related agencies are limited to common toilets (10) and parks/ground (3). Due to vast spread of the study area , it has twenty six bus stops and three railway stations identified. It is also important o note that there are fifteen banks/ATMs and thirty mobile repair recharge shops in the study area.

Lower Parel				Matunga Labor Camp and Dharavi			
Bank & ATM	15	Medical Shop	28	Bank & ATM	2	Police Chaoky	1
Bus Stand	26	Mobile Recharge Repair Shop	30	Common Toilet	6	Police Station	1
Bus Stop	2	NGO Centre	4	Community Centre/Mandal	9	Political Party Office	4
Common Toilets	10	Others	14	Day Care Centre	1	Post Office	1
Community Centre/Mandal	38	Parks & Grounds	3	Diagnostic Centre	3	Provision Store	2
Diagnostic Centre	2	Physiotherapy Centre	1	Grocery Shop	17	Public Distribution System	3
Grocery Shop	6	Police Chowki	2	Hospital & Clinics	13	Religious Places	9
Hospital & Clinics	49	Police Station	2	Medical Shop	29	School	4
Library	2	Political Party Office	3	Mobile Recharge Repair Shop	2	Senior Citizen Assocaition	1
Religious Place	1	Post Office	1	NGO Centres	4	Shop	1
School	1	Provision Store	1	Others	24	Taxi Stand	2
Senior Citizen Assocaition	3	Public Distribution System	1	Parks & Grounds	1	Telephone Booth	1
Taxi Stand	2	Ward Office	5				
Telephone Booth	7						

MUMBAI : DHARAVI MATUNGA LABOUR CAMP

POI	NAME
2	New Royal Medical Stores
3	Kusum Medical Stores
4	Priya Medical Stores
5	Amita Nursing Hom
6	Prem Sagar Medical Store
7	HDFC Bank ATM
8	Shree Ram Medical Store
9	Nitish Farma Medical Store
10	Mahadev Medical Store
11	Jasin Shopping Centre
12	Avni Health Clinic Centre
15	Shaarda Kirana General Store
16	Mumbai Medical And General Store
18	Indian Post Office
19	Mahavir General stores
22	Shahu Nagar Play Ground
23	Mahavir General Stores
25	Shahu Nagar Clinic
26	Shifa Orthopedic Clinic
27	Bhur bakery General Stores
28	Sunny ESLQM Shahu Nagar
30	Neelam Bakery

POI	NAME
33	Maharana Stores
35	Ambika General Stores
36	Rehmat Stores
37	Wel Come Stores
39	Balmurgan Shop. No-13
40	New Khetlaji Sobhars
43	Bhaskar Shehi Jansampark Office
44	Madarsa Masjid, Ali Ahmad
45	Dr. Mohammad Afapu Faaski Hospital
46	Sunni Gousiya Masjid
47	Health Care
48	Sai Hospital
49	Sai Hospital
50	Ayush Hospital
51	Kamaran Memorial School
52	Dental Clinic
53	Bhartiya Janta Party Office
54	Bhartiya Janta Party Office
55	Shivsena Branch No 178 Sai Baba Nagar
56	Hari Medical Shop
57	Kailash Dairy
58	Solanki Medical Stores
59	Sai Medical Stores
60	Sudhir Patil Clinic And Diagnostic Centre
61	Janta Dairy Farm
63	H. S Medical Stores
64	Asirfaya Medical Store
65	Citizen Centre
66	vijay Medical Store
67	Baba Medical Store
68	Resham Diagnostic Centre
69	S. T. M Medical Stores
70	Maharashtra (Shashan) Milk Dairy Centre

POI	NAME
71	varn Sanerarium Stores
72	Maharashtra (Shashan) Milk Dairy Centre
73	Dharavi Police Station
74	Maharashtra (Shashan) Milk Dairy Centre
76	Cemeteny
77	Health Medical Stores
78	Health Medical Stores
79	Rajaram Medical Stores
82	Signal Police Beat
83	makdoom Mobile Shop
84	V. M Raaj Milk Centre
85	M. I Medical Stores
86	Shripal La Jain Clinic
87	Anjuman Cemetery
88	Kalpatru Public Toilet
89	Young Star Group
90	Shree Krishna Medical And General Stores
91	Ayyub General Stores
94	Abhijit Communication
96	Tata Power dharavi
97	B. M. C School Mumbai 19
98	Pimpleshwar Temple
99	Family Welfare Agengy Citizen Centre
100	Jasmeen Masjid
102	HIV Advice Centre
103	Siddharth Seva Sangh
104	Sulabh Toilet
105	Shree Siddhi Vinayak Medical Stores
106	Sneha Office
107	Adhar Vikaas Samajik Sanstha
108	Nasheman General Store
109	Sarvajanik Ekta Vikas Agamma
110	Sulabh Toilet Mhada
111	Asharfiya Jama Masjid School
112	Dr Sanjay Hospital
114	Cent Pourl Church
115	Vardhman Chemist & Drugist
116	BOI ATM
118	Sangam Milk Centre
119	Lucky Mobile Service
120	Taxi Stand
120	Taxi Stand
121	Om Sai Medical Store
122	Sai Baba Mandir
123	Sulabh Toilet
125	Play Group Nursery
126	NGO Ekta Mitra mandal
127	Panchshil Toilet
128	Jay Bharat Medical Stores
129	Mehta Medical Stores
130	Murgan Temple Taxi Stand
131	Ayappa Temple
132	chemist General Stores
133	Young Man Welfare Association
134	Labour camp Chemist And Drugist
135	P. G Diagnostic Centre
136	R.S General Stores
137	Runanubandh Sulabh Toilet
138	Mourya Mitra Mandal
139	The Children education Society
140	Drop Un Centre Jaldip Krida & Mahila Mandal
141	Health Clinic
142	Gandhi Memorial English Highschool
143	Bhartiya Boudhya Mahasang Karyalay
144	Janseva Majur Sahkari Sanstha
145	CORP
146	SHILD
147	World Vision
148	Ashok Samrat Mandal
149	Runanubandh Samajik Sanstha
150	Samaj Mandir Hall
151	Morya Mitra Mandal
152	Ranveer Krida Mandal

LOCATION MAP OF
DHARAVI MATUNGA LABOUR CAMP

Legend

ROAD

60 30 0 60 120 180 Meters

MUMBAI : LOWER PAREL

POI	NAME AND ADDRESS
1	BMC OFFICE (WATER SUPPLY)
2	S BRIDGE BUS STOP
3	BMC POPERTY OFFICE
4	BMC OFFICE (MADHYAVARTI KHATE)
5	BMC (KALYAN CENTRE)
6	GOMTIBAI CHAWL
7	NUTAN RAMDEV MANDAL
8	SANT DNYANESHWAR MANDAL
9	SIDDHIVINAYAK MEDICAL STORE
10	KURSWAMY KHURDERAY SEVA MANDAL
11	BOI ATM
12	DR. RUPA & PANCHAL CLINICS
13	BMC BEAT OFFICE
14	S BRIDGE BUS STOP
15	S BRIDGE BUS STOP
16	ICICI BANK ATM
17	VODAFONE 3 G
18	KALPANA GRAIN STORE
19	UNIQUE MOBILE CENTRE
20	DR. M. S. SHASHTRE BUDDHE CLINIC
21	BADHRI MEDICAL SHOP
22	GULAB RAO G CHOWK SIGNAL
23	GULAB RAO G CHOWK BUS STOP
24	SRI RAMDEV MEDICAL STORE
25	TAXI STAND
26	MAHARASHTRA MEDICAL
27	UJWAL TOILET BMC
28	KASTURBA HOSPITAL
29	KASTURBA BUS STOP
30	SIGNAL
31	TADA COURT
32	B.M.C YAANGRAHA ARTHUR ROAD
33	GULABRAO G JAGTAP BUS STOP
34	NEW BOMBAY LABORATORY
35	SANE GURUJI MARG SIGNAL
36	MAHAVEER MEDICAL STORE
37	DR.SANDHYA R GUPTA SAI CLINICS
38	DR.R.D.GAZDAR
39	SHUBHAM MOBILE REPAIR SHOP
40	ARIHAT MEDICAL STORE
41	SWATHI GROCERY SHOP
42	AGREEPADA POLICE STATION
43	SITARAM MILL COMPOUND B.M.C SCHOOL
44	JAY RENUKA GRAIN STORE
45	LODHA EXCELLS TAXI STAND
46	SECURITY OFFICE
47	SENIOR CITIZEN KATTA
48	DR.NIRAMAL HOSPITALS
49	LG CUSTOMER SERVICE
50	BUS STAND
51	KINJAL MOBILE SERVICE
53	NEW DELACU MEDICAL STORE
54	AREY CENTRE
55	BAVLA MASJID
56	DR.MANALI MATERNITY HOSPITAL
57	SRI RAJARAM MEDICAL STORE
58	MAHAVEER MOBILE SHOP
59	AMIT MEDICAL STORE
60	OM MEDICAL STORE
61	SIDDHI SAI CLINIC
62	PRAGATI INDUSTRIAL ESTATE
63	SAKUBAI MOHTEMURY VODAFONE 3 G
64	VODAFONE SERVICE
65	AMBAR SPORTS CLUB
66	BAJRANG VACHNANLAYA
67	SWAPNA PURTI MAHILA MANDAL
68	B.M.C PLAY GROUNDS
69	JHUNKA BHAKAR CENTRE
70	SATTYAM KREEDA MANDAL
71	SENIOR CITIZEN KATTA
72	N.M.JOSHI POLLICE STATION
73	NURSING HOME
74	CHETNA MEDICAL STORE
75	N.M JOSHI P.S BUS STOP
76	NAUKAAR MEDICAL STORE
77	YOUNG BHARAT KREEDA MANDAL
78	BHARAT KREEDA MANDAL
79	S BRIDGE BUS STOP
80	MASHKAR HOSPITALS
81	GRECE SPORTS CLUB
82	GARUD JAP MANDAL
83	DR. SUDHIR KAMBLE
84	MATOSRI CLINICS
85	BANDAYA MARUTHI SEVA MANDAL
86	AMIT MEDICAL STORE
87	DR.SANKOP S.S
88	DR.NIRMAL C JAIN
89	AZARA URBAN OPP A.T.M
90	N.M.JOSHI MARG P.S
91	RAJESH P.C.O CENTRE
92	SAUKALP EYE CLINIC
93	SAI MOBILE SERVICE
94	SUVIDA PROVISIONS STORES
95	MAHAVEER MOBILE SERVICE
96	VODAFONE SALES & SERVICE
97	DR.SHASHIKANT KHATE
98	RAJARAM MEDICAL STORES
99	BANK A.T.M
100	MANSI MATERNITY NURSING HOME

POI	NAME AND ADDRESS
201	AVRS MOBILE SERVICES
202	MAHAVEER MOBILE
203	BMC TOILETS
204	SHIVAM SALES SERVICE
205	DURGESHWARI MEDICAL SHOPS
206	9 TO 9 MOBILE SHOP
207	DAWN MILL BUS STOP
208	GANESH MOBILE SERVICE
209	SRI MOBILE SERVICES
210	NEW KAMGAAR MANDAL
211	SENIOR CITIZEN KATTE
212	SULABH TOILET
213	DR.RAM BOAL C
214	GANESH MEDICAL STORES
215	YOUNG VIJAY KRIDA MANDAL
216	BABUBHAI GROUP MOBILE
217	N.M JOSHI POLICE BEAT
218	B.M.C SAMAJ KALYAN
219	RAJESH PCO CENTRE
220	RAGINATH RAHIVASI SANG
221	MANOHAR SEVA MANDAL
222	M.N.S JAN SAMPARKA SEELA COMMUNICATION CENTRE
224	011 K MOBILE REPAIR SHOP
225	DR D K CHAUCHARY
226	PHOENIX MILL BUS STOP
227	BHARTIYA KREEDA MANDAL
228	HDFC & C BANK
229	CORPORATION BANK ATM
230	PHOENIX
231	KARMAVEER YADAV
232	ADINATH MOBILE SERVICE
233	SUGAM TOILETS
234	PRAVEEN TELECOM SERVICE
235	SAILEELA MOBILE SERVICE
236	SIDDHIVINAYAK STD & PCO
237	ADARSH KREEDA MANDAL
238	DR.ANIL KUMAR CLINIC
239	BHAIRAV MEDICAL SHOP
240	LOWER PAREL JAIN HOSPITALS
241	RABV CLINICS
242	NIKHIL MEDICAL STORES
243	RAM DENTAL CLINICS
244	LAXMI METRA MANDAL
245	MAHARASHTRA SHASHAN YOJANA
246	GANPATI SALES & SERVICE
247	ICICI BANK ATM
248	ASHOK V KAMATE PHSIOTHERAPY CENTRE
249	DR M K SAWLA CLINICS
250	KOTAK MAHINDRA BANK ATM
251	GANESH MOBILE SALES CENTRE
252	SIDDHARTH SEVA MANDAL
253	SRI GAJANAN MEDICAL STORES
254	STATE BANK ATM
255	MATHADI UNION
256	BANK OF MAHARASHTRA
257	DENA BANK
258	INDIAN POST OFFICE
259	HANDYCAP PCO

POI	NAME AND ADDRESS
101	MEENA PAPER STALL
102	NEW DILASA MEDICAL STORE
103	AMBAJI PHARMACY CLINICS
104	KINJAL MOBILE REPAIR SHOP
105	JAY SHREE KRISHNA MOBILE SERVICE
106	BALAJI MOBILE SERVICE CENTRE
107	DR SUDHAKAR DESHPANDE MEMORIAL POL
108	BAWALA MASJID
109	DR HRISHIKESH NAIK
110	DR BHARTI SHAH CLINIC
111	DR MALTI ADSULE CLINIC
112	DR DNYANESH J HERUKAR
113	DR KAMAT CLINIC
114	DR SAKSHI HEALTH CARE
115	SAI MEDICAL STORE
116	RASHTRAIWADI CONGRESS PARTY OFFICE
117	HANUMAN SEVA MANDAL
118	ASHA DIAGNOSTIC CENTRE
119	SIDDHI VINAYAK MITRA MANDAL
120	YUVAK KRANTI MANDAL
121	B.M.C PARKS & GROUNDS
122	SENIOR CITIZEN BUS STOP
123	YUVAK KRANTI READING ROOM
124	FAMILY WELFARE OFFICE
125	ANJALI SEVA MANDAL
126	AJIKYA KRIDA MANDAL
127	ROHIDAS SAMAJ MANDIR
128	DR PALLAVI NARKAR
129	DR SHILPA R SAVLA FAMILY PHYSICIAN
130	ATHARVA MEDICAL SHOP
131	DR SUNITA GAITONDE
132	KAMARAN MEDICAL STORE
133	COMMON SULABH TOILETS
134	MAHADEV PALV MARG
135	SAI MOBILE SERVICE
136	SHRI GANESH MOBILE SERVICE
137	MAHADEV PALV MARG
138	SRI KESHRIYA GRAIN STORE
139	CURREY ROAD RAILWAY STATION
140	VINAYAK MEDICAL STORE
141	SUSHRUSA CLINICS
142	DR.MOHAN GADE HOSPITAL
143	KOTAK MAHINDRA BANK
144	SAFALYA SANG NGO
145	CARE DENTAC CLINIC
146	PIMPLESHWAR KRIDA MANDAL
147	GOOD HEALTH DIAGNOSTIC CENTRE
148	CURREY ROAD PLAY GROUNDS
149	CURREY ROAD B.M.C HOSPITAL
150	INDIAN BANK ATM
151	ASHIRWAD MEDICAL STORE
152	RAILWAY UNION OFFICE
153	KURSAN STATION
154	VISHWABHARATI SEVA MANDAL
155	DR D.B ADSULE
156	VISHNAV KREEDA MANDAL
157	TELEPHONE EXCHENGE
158	DR.AMOL KADAM CLINIC
159	HANUMAN MANDIR TRUST
160	KHAPARDEV MANDAL
161	DAU PARAB SABHA GRAHA
162	SHIVSENA SHAKHA
163	HANDYCAP TELEPHONE BOOTH
164	LOWER PAREL BUS STOP
165	SAI MANDIR MANDAL
166	DEEPAK TALKIES BUS STOP
167	MODERN HOSPITAL
168	SULABH TOILET
169	LOWER PAREL BUS STOP
171	GOPI KRISHNA HOSPITAL BUS STOP
172	DR RAJEEV SUKHTANK HOSPITAL
173	SRI SIDDHIVINAYAK MEDICAL
174	DR PRAKASH BORANE
175	DR P SOLANKI CLINIC
176	DR BARKHA Y JAIN C
177	SUGAM TOILETS
178	SRI RAM MILL BUS STOP
179	BALSANSKAR CENTRE
180	SHIVASAKTI GRAIN STORE
181	GANDHI NAGAR RAHIVASI SEVA SANSTHA
182	BMK SAHYOG SEVA COMMON TOILET
183	DAINIK BHIVNER BUS STOP
184	SAI CLINIC
185	PUBLIC TOILET
186	D.S BUS STOP
187	SAHYADRI SEVA MANDAL
188	P.C.O / S.T.D
189	SRI RAM MILL BUS STOP
190	RAVI POLICE BIT NO 3
191	M MEDICAL STORE
192	DR GUPTA CLINICS
193	G P BUS STOP
194	APNA SAHAKARI BANK
195	SHENOY NURSING HOME
196	KUMAR BROTHERS CHEMIST
197	ICICI BANK ATM
198	JAY BHAVANI MANDAL
199	DAWN MILL BUS STOP
200	HARIOM MOBILE SERVICES

LOCATION MAP OF LOWER PAREL

Establishing Linkages between Nodal Agency &Utility Agencies

The study clearly revealed that there is ample scope to establish linkages between nodal agency and utility agencies through various programmes over a period of time, which will have a positive impact on the elderly community in the study area. Besides stressing about the importance of linking programmes with other stakeholders, the following points are listed for the consideration of the agency.

- The agency can involve other NGOs and Senior Citizen Associations to increase awareness about social security schemes for the elderly.
- It can organize counseling sessions by doctors from hospitals/clinics in the vicinity to create awareness about ill-effects of tobacco chewing/smoking/drinking.
- Religious places in the area can be used as the venue in case of limited options and to attract elderly to attend such sessions.
- Similarly it can also tie up with the doctors for routine health check-ups, health camps, as many of the elderly have health issues like diabetes, arthritis and hypertension.
- Tie-ups can also be made with few medical shops in the study areas, from where the agency volunteers can get discounted medicines for the elderly and distribute it at the agency/ arrange for home delivery.
- There are several community centre/mandals in the study area which can engage elderly in their social activities. The agency can act as a bridge between the elderly and the community centre/mandals in this regard.
- Agency can tie up with specific mobile shop / service provider to enable elderly to get special tariff plans and cost-effective simple handsets.
- Food security of the elderly is a major concern in study areas. Grocery shops/provision stores can be made partner to purchase items of day to day diet at wholesale rates and make it available to elderly at a retail rate.
- It was observed that the study areas are close to business districts which can facilitate the agency to explore opportunities of involving corporate partnership/funding in its programmes as part of their CSR initiatives.

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ANNEXURE

A.1 INTERVIEW SCHEDULE

SITUATIONAL ASSESSMENT OF THE ELDERLY

I. **IDENTIFICATION**

Name	Tenement Number	Name and number of building	Locality	Contact No. (optional)

II. **DEMOGRAPHIC INFORMATION**

Sr No	Question	Response	Code
1.	Gender	Male Female	Male = 01 Female =0 2
2.	Age (completed years)/ Date of birth		
3.	Marital Status (present)		Married =01 Widowed=02 Separated =03 Deserted =04 Divorced=05 Never married=06
4.	How old were you when you got married (age in completed years)	Age:	Age NA= 00
5.	Duration of widowhood/ divorce/ separation OR Age when widowed/ divorced/ separated		Age NA= 00

6.	Chief owner of the house		Self = 01 Spouse =0 2 Son = 03 Daughter =04 Grandchildren = 05 Relatives= 06 Others = 07 (Specify)_____

III. **HOUSING CONDITION**

Sr no	Question	Response	Code
1.	Type of dwelling		Flat in the building= 01 Tenement with a common toilet= 02 Others= 03 (Specify)_____
2.	Ownership of house		Rented= 01 Owned= 02

	If, owned by whom		Parents= 01 Self= 02 Son= 03 Daughter =04 Grandchildren= 05 Relatives= 06 Others= 07 (Specify)_____
3.	Living arrangements		Alone =01 With spouse only =02 With spouse and children =03 With married daughter= 04 With relatives= 05 Others =06 (Specify)_____
4.	Any room exclusively for your (and your spouse's) use		Yes =01 No=02
5.	Are you comfortable using the existing housing condition?		Yes=01 No=02

6.	Comfort and utilization of Toilet and Bathroom Facility		
	- Do you have easy access to toilet?		Yes=01 No=02
	- Type of toilet		Indian=01 Western =02
	- Are you comfortable using the present type of toilet facility		Yes=01 No=02
	- Are you scared of falling while using the toilet?		Yes=01 No=02
	- Do you have easy access to bathroom?		Yes=01 No=02
	- Do you need assistance in bathing?		Yes=01 No=02
	- Are you scared of falling while using the bathroom?		Yes=01 No=02

IV. **ECONOMIC CONDITIONS**

Sr no	Question	Response	Code
1.	Occupation	Most recent Current	Managers= 01 Professionals = 02 Technicians and associate professionals =03 Clerical support workers =04 Services and sales workers =05 Skilled agricultural, forestry and fishery workers =06 Craft and related trade workers =07 Plant and machine operators and assemblers= 08 Elementary occupations= 09 Defense and armed forces= 10 Unemployed=11 Retired=12
2.	Individual monthly income (from all sources)		NA= 00
3.	Family monthly income (from all sources)		NA=00
4.	Did you plan to meet your old age expenses		Yes= 01 No= 02

5.	What plans did you make previously to meet your old age expenses and at present what is your (and your spouse's) source of income? (Multiple answers possible)	Previous Present	Depending on sons=01 Depending on daughters =02 Depending on grandchildren= 03 Depending on relatives=04 Wages/ salary= 05 Superannuation/ pension=06 Old age pension= 07 Fixed deposits=08 Investment= 09 Business= 10 Rent= 11 Interest or dividend= 12 Agriculture= 13 Relief payment= 14 Others= 15 (Specify)_____

6.	Present income situation		In debt= 01 I don't have enough to provide for basic needs= 02 I have just enough to provide for basic needs=03 I have enough to get on with a little extra= 04 I always have money left over= 05 Don't know/ uncertain= 06 No response=07
7.	Are you aware of any schemes for the elderly?		Yes=01 No=02
8.	Have you registered for any schemes for senior citizens?		Yes=01 No=02
8.	Which are the schemes that you're benefiting from? (refer annexure)		
9.	Some elderly do not have the resources to meet all their expenses. Who according to you should take this responsibility		Self=01 Family=02 Community=03 Government= 04 Non-governmental organizations =05 Others= 06 (Specify)_____

V. HOUSEHOLD CHARACTERISTICS

1. Household Composition:

No.	Name	Relationship with head of household (HH)	Sex (M/F)	Age	Marital Status	Educational Status	Occupation	Disability
1	SELF							

(Relationship with HH: 01= self,02= spouse, 03=son, 04= daughter, 05= father, 06= mother, 07= grandchild, 08= son-in-law, 09= daughter- in-law, 10= others)

(Sex: 01=male, 02= female)

(Marital status: 01= married, 02= widowed, 03= separated, 04= deserted, 05= divorced, 06= never married)

(Educational status: 01= illiterate, 02= primary, 03= secondary, 04= higher secondary, 05= graduate/ diploma, 06= post graduate, 07= M.Phil/PhD)

(Occupation: 01= managers, 02= professionals,03= technicians and associate professionals, 04= clerical support workers, 05= services and sales workers, 06= skilled agricultural and fishery workers, 07= craft and related trade workers, 08= plant and machine operators and assemblers, 09= elementary occupation, 10= armed forces/defense, 11=Unemployed, 12=retired)

(Disability: 01= visual, 02= hearing, 03= speech, 04= loco-motor, 05= mental, 06=multiple disability)

2. Information on adult children.

	Total No.	No. of children alive	No. of children living in the household	No. living in Mumbai/Pune	No. living outside Mumbai/Pune
Son					
Daughter					

Sr. no	Question	Response	Codes
3.	What are your plans for the future?		Continue in the same HH=01 Plan to shift to another HH=02 Plan to go back to place of origin (village/native place)=03 Not yet decided/uncertain=04

VI. ACTIVITIES OF DAILY LIVING

Sr. no	Question	Response	Codes

1.	Which are the following day to day activities that you carry out on your own or with others help? ADL: - Feeding - Toileting - Maintaining continence - Dressing - Bathing - Walking and transferring IADL - Maintaining finances - Transportation - Shopping - Preparing meals - Using telephone IADL:		Without help=01 With help=02 Without help=01 With help=02 Unable to do=03 Without help=01 With help=02 Who provides help (familial=03, neighbors=04 friends=05

2.	- Managing medications - Basic home maintenance/housekeeping - Laundry Activities you normally engage in - Looking after my sick spouse - Looking after my grandchildren - Assisting my children in daily chores - Reading - Listening to radio - Watching T.V - Physical activity - Religious activities - Music/drama/hobby - Shopping		Regularly=01 Sometimes=02 No=03

VII. FAMILY AND PRIMARY CARE GIVER

Sr no	Question	Response	Code

1.	Who is your primary care-giver		Spouse=01 Children=02 Grandchildren=03 Relatives=04 Others=05 (Specify)_____ NA=00
2.	Availability of the primary caregiver		Full time(day and night)= 01 Only during the day=02 Only during the night=03 Only when called=04
3.	If primary caregiver is away for sometime (4-8 hrs a day) how do you manage		Able to manage by myself=01 Someone else comes in=02 No special arrangements made=03 Helper seldom goes out=04
4.	Is the caregiver time provided sufficient to meet your daily needs		Yes=01 No= 02 Uncertain=03

5.	With whom do you spend most of your time		Spouse=01 Children=02 Grandchildren=03 Relatives=04 Neighbors=05 Friends=06 others= 07 (Specify)_____
6.	Involvement in decision making - Marriage of children - Buying and selling of property - Buying household items - Gifts to relatives - Education of children and grandchildren - Arrangement of social/ religious events		Yes=01 No=02 To a certain extent=03

VIII.SOCIAL ACTIVITES

Sr No	Question	Response	Code

1.	How frequently you engage in following activities - Attending family ceremonies/ wedding/ festivals - Visiting religious places/ spiritual gatherings - Visiting gardens/ parks/ playgrounds - Visiting the theatre/ movies/ concerts/ exhibition - Visiting clubs/ associations/ societies - Using the library - Journey to hometown		Regularly=01 Often=02 Rarely=03 Never=04
2.	Volunteer for social work activities		Yes, at present=01 Yes previously, but not at present=02 Ready to volunteer, but not aware=03 No=04
3.	If no, would you like to voluntarily participate in such activities		Yes=01 No=02

4.	What kind of volunteer work would you like to do or are already involved in or have done previously? (Multiple choice possible) With children (5-15 years) With adolescent (15-20 years) With adults (21-59 years) With older persons (60+) In the area of health In the area of education Work with marginalized groups (destitute women, disabled, poor, etc.) Work related to your own occupation Organizing events/programmes Any other (Specify_____)		Yes=01 No=02 Can't say=03 If yes, describe the kind of activity=04
5.	Awareness of day care centers, hobby centers and old age homes for elderly		Yes=01 No=02
6.	Interest in joining such centres/ facility - Hobby center - Day care center - Old age homes		Yes=01 No=02 Uncertain=03 (applies to all three facilities)

7.	If yes, specify the type of facility you expect in it. (To be asked to only those respondents who have said 'yes' for old age homes in the previous question) - Independent room with medical support - Dormitory with medical support - Others, specify		Yes=01 No=02 (applicable to all three options)

IX. ISSUES FACED BY THE ELDERLY

1. Issues faced by elderly

Sr No	Question	Response	Code
1.	Insufficient money/ finance		Serious=01 Hardly a problem= 02 No response= 04
2.	Poor housing		
3.	Poor health		
4.	Insufficient medical care		
5.	Loss of faculties		
6.	Education of the children		
7.	Not enough job opportunities		
8.	Loneliness		
9.	Lack of companionship		
10.	Departure of children		

11.	Nothing to keep me busy		
12.	Being dependent		
13.	Feeling neglected		
14.	Loss of status/ respect		
15.	Loss of confidence		
16.	Fear of crime/ violence		
17.	Financial exploitation		
18.	Physical abuse		
19.	Verbal abuse		
20.	Others		

Sr. no	Question	Response	Code
2.	(For those who feel they do not have enough job opportunities) Are you aware of income generation programmes for elderly?		Yes=01 No=02
3.	If given an opportunity, would you like to work?		Yes=01 No=02 Uncertain=03

4.	If yes, what are the reasons for exploring such job opportunities?		Need money for current expenses=01 Need money for future financial security=02 Do not want to be dependent on others for money=03 No one to depend on for money=04 Want to lead an active life=05 Need something to occupy time/keep me busy=06 Own/family business=07 Others=08 Specify _____

5.	What were your experiences during job search?		Employer empathy=01 Availability of part-time jobs/assignments=02 Work from home opportunities=03 Satisfactory monetary support=04 Age was a barrier=05 Poor health condition=06 Under-qualified/don't have skills required=07 Salary is too low=08 Jobs available are too physically demanding=09 Undesirable/unsuitable working hours=10 Jobs available are too far away from home=11 Others (specify_____)=12
6.	Would you like to enroll in skill enhancement activities if required for a job?		Yes=01 No=02

X. HEALTH AND NUTRITION ASSESSMENT

Sr No	Question	Response	Code

1.	Rate your present health		Excellent= 01 Good= 02 Average=03 Poor=04 Worse=05
2.	In past 15 days, did you suffer from any health issue? If yes, specify (No probing) - Fever - High Blood pressure - Cough and cold - Diarrhea - Asthma - Sugar/diabetes - Gastric - Malaria - Arthritis - Headache - Leg problem - Body pain - Cataract - Typhoid - Ulcer		Yes=01 No=02 Others=03 (Specify)_____

3.	Chronic ailments (in the last 1 year) - Arthritis - Hypertension - Cataract - Diabetes - Asthma - Heart diseases - Osteoporosis - Skin diseases - Renal diseases - Paralysis - Liver diseases - Chronic lung diseases - Depression - Alzhiemers - Cerebral stroke - Dementia - Cancer - - - Fall - Vertigo - -F - Others (specify) _____		Yes=01 No=02 Hospitalized=03

	-Fall -Vertigo		

NUTRITION ASSESSMENT

Sr. no	Nutrition Screening Checklist	Yes
i.	I have an illness or condition that made me change the kind and/or amount of food I eat	2
ii.	I eat fewer than two meals per day	3
iii.	I eat few fruits, vegetables or milk products	2
iv.	I chew tobacco, smoke or drink alcoholic beverages almost every day.	2
v.	I have tooth or mouth problems that make it hard for me to eat.	2
vi.	I don't always have enough money to buy the food I need.	4
vii.	I eat alone most of the time.	1
viii.	I take three or more different prescribed or over-the-counter drugs per day.	1
ix.	Without wanting to, I have lost or gained 10 lbs. in the last six months.	2
x.	I am not always physically able to shop, cook, and/or feed myself	2

ANTHROPOMETRY

Sr No.	Measurements	Value	Code

1.	BMI ***OR*** Calf circumference (CC)	Height: ____ (m) Weight: _____ (cm) CC : _____ (cm)	BMI Classification >18.5 (underweight)=1 18.5-24.99 (normal)=2 <25-29 (overweight)=3 <30 (obese)=4 CC less than 31cm=1 CC 31 cm or greater=2
2.	Mid arm circumference (MUAC)	MUAC : _____ (cm)	MUAC less than 23 cm=1 MUAC 23cm or greater=2

A.2 SCHEMES

1. Annapurna scheme
2. Indira Gandhi National Old age Pension Scheme (IGNOAPS)
3. Indira Gandhi National Widow Pension Scheme (IGNWPS)
4. Indira Gandhi National Disability Pension Scheme (IGNDPS)
5. National family benefit scheme
6. Sanjay Gandhi Niradhar Anudan Yojana
7. Shravan Bal Seva Rajya Nivrutti Vetan Yoajana
8. Others (Specify)_____

A.3 ACTIVITIES OF DAILY LIVING (ADL)

Question no.	**Activity**	**Without help (independence)**	**With help (dependence)**
1	Feeding	Gets food from plate into mouth without help. Preparation of food may be done by another person.	Needs partial or total help with feeding or requires parenteral feeding.
2	Toileting	Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	Needs help transferring to the toilet, cleaning self, or uses bedpan or commode.
3	Continence	Exercises complete self-control over urination and defecation.	Is partially or totally incontinent of bowel or bladder.
4	Dressing	Gets clothes from closets and drawers and puts on clothes and other garments complete with fasteners. May have help tying shoes.	Needs help with dressing self or needs to be completely dressed.
5	Bathing	Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
6	Walking and transferring	Moves in and out of bed or chair unassisted. Mechanical transferring aids are acceptable.	Needs help in moving from bed to chair or requires a complete transfer.

A.4 INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

Question no.	**Activity**	**Without help (independence)**	**With help (dependence)**	**Unable to do**
1	Maintaining finances	Manages financial matters independently (budgets, writes checks, pays rents and bills, goes to bank, etc)	Manages day-o-day purchases, but needs help with banking, major purchases, etc.	Incapable of handling money.
2	Transportation	Travels independently on public transportation or drives own car. Arranges own travel via taxi or auto rickshaw, but does not otherwise use public transportation.	Travels on public transportation when assisted or accompanied by another. Travel limited to taxi or automobile with assistance of another.	Does not travel at all.
3	Shopping	Takes care of all shopping needs independently or shops independently for small purchases.	Needs to be accompanied on any shopping trip.	Completely unable to shop.
4	Preparing meals	Plans, prepares and serves adequate meals independently or prepares meal when supplied with ingredients.	Heats and serves already prepared meals.	Needs to have meals prepared and served.
5	Using telephone	Operates telephone on own initiative, looks up and dials numbers, or dials a few well-known numbers.	Answers telephone but does not dial, or requires assistance in using telephone.	Does not use telephone at all.
6	Managing medications	Can take medicines in the right doses at the right time by self.	Takes responsibility if medication is prepared in advance in separate dosages.	Is not capable of dispensing own medication.

7	Basic home maintenance/ housekeeping	Maintains house with occasional assistance (for heavy work), performs light daily tasks such as bed making, dishwashing, etc.	Needs help with most of the home maintenance tasks such as cleaning, be making, dishwashing, etc.	Does not participate in any housekeeping tasks.
8	Laundry	Does personal laundry completely.	Launders small items, rinses socks, stocking, handkerchiefs, etc.	All laundry must be done by others.