Healthy Aging For A Healthy Planet

Edited by

Dr. Pooja Varma | Dr. Pooja Rai | Dr. Alka Ranjan

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The editors would like to record their special appreciation and gratitude for the honourable Vice chancellor of Jain (Deemed to be University), Dr. Raj Singh and his team for his cooperation in taking time out of his busy schedule and contribute towards the Foreword of this book which highlights the importance of healthy ageing from all perspectives in our lives, be it physically, socially, psychologically and cognitively. In addition it brings the attention of the readers towards key content and potent researches covered in the book.

Editors

FOREWORD

The world today, inhabited by more than a billion aged people, is currently witnessing fast rise in proportions of aged people. Projections claim that by 2050 nearly one in five people in developing countries will be over the age of 60. Longer life expectancy, though heartening, this new reality seems impregnated with a host of pressing challenges in view of its failure to guarantee an experience of healthy ageing. This is especially so for those dwelling in the low and middle income countries due to the fact that lack of basic resources and amenities often deprive large numbers of them of a meaningful and dignified life. The COVID-19 pandemic has further exposed glaring disconnects in policies, systems and services. As this global demographic transition remains one of the foremost medical, social and economic concerns of the day, one that impinges upon almost every aspect of society including demographic structure, the phenomenon of 'healthy' ageing is catching the attention of researchers, policy-makers and health professionals alike. Successful or active ageing refutes the stigmatized understanding of age as a mere pathological process and the associated lurking fear that ageing leads to an inevitable decline in the quality of life. Instead it hinges on the non-judgmental concerns relating to physical-mental wellness and cognitive capabilities of aged adults along with their active engagement with life. It is believed that the reduced probability of diseases and debilities will help contain health and social care costs associated with later life. Driven by the growing need to preserve health and vitality and preserve sound lifestyle choices among the older populace, the social policy responses world over seek to foster healthy ageing by largely focusing on the following critical areas of action: social connectedness, nutritious diet and physical activity.

The United Nations Decade of Healthy Ageing (2021–2030) offers a robust platform for concerted decade-long global action on healthy ageing. The initiative intends enhancement of possibilities of engagement with elderly people besides enabling them to realize their potentials, participation and autonomy in a healthy, protective and age-inclusive environment. Resonating with the spirit of UN SDGs, WHO had come forward with its Global Strategy and Action Plan for Ageing and Health for 2016–2020 and its continuation with the WHO programme The Decade of Healthy Ageing 2020–2030. In its ongoing support towards advancement of functional ability and well-being in older age WHO has prioritized country planning and action, research promotion and collection of global data on healthy ageing, aligning health-care systems to the needs of older people, ensuring human resources necessary for long-term integrated care, undertaking a global campaign to combat ageism, and enhancing global network for age-friendly cities and communities.

I am delighted that this publication is on its way to a timely fruition. The critical issue of healthy ageing is multidimensional, influenced heavily by the society and the environment we live in particularly, the people and relationships in our lives together with the attitudes and values we and others around us hold. Successful ageing, therefore, calls for perceptual change among differentiated sets of stakeholders on either side of the spectrum. Set against the backdrop of post pandemic "new" normal the volume contains a rich collection of empirical essays which I am sure will contribute towards a sensitive and nuanced understanding of the phenomenon of ageing from diverse perspectives from an inter-disciplinary approach. The articles reflect a range of rich discussions on value of social support, unconditional self-acceptance and compassion, disciplined spiritual practices, soul-consciousness, emotional intelligence, inner resilience and mindfulness in combating depressive disorder and loneliness syndromes. Contributors candidly spell out simple aerobic exercises, self-care activities and personal hygiene habits for nurturing higher self-esteem, physiological wellness and psychological fitness. The book also has dedicated chapters that elaborate on effective Ayurveda-inspired techniques and smart ICT enablement mechanisms to cope with ageing in the modern world.

Developing holistic and insightful understanding of the problem of 'ageing' is a work in progress and a collective endeavour. The book opens up broader avenues for engagement with our personal journeys of acceptance and adaptations to ageing process both within and without. And, the pieces therein rest on the hope for seizure of these opportunities at its best.

Dr. Raj Singh

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Jain (Deemed to be University), Bangalore

CONTENTS

1 A Roof Over the Head: A Gender Specific Correlation Study

Himanshi Singh* &
Dr. Hema Kumari Mehar**

Abstract

Background: Aging is a progressive physiological changes in an organism that lead to senescence, or a decline of biological functions and of the organism's ability to adapt to metabolic stress. A roof over the head is a critical need of the elder who are destitute, sick and abandoned by family and those uprooted by disasters. The rapid urbanization of communities and nuclearization of families adds to the old age-related difficulties leading to many elderly shifting to Old age homes (OAH) safety and care. Female elderly faces many difficulties in daily life whether they are living in an Old age home or with family. The living environment along with the adjustment, coping and Quality of Life (QoL) are the main focus of this study.

Aim: To assess and compare the relationship of Quality of Life (QoL), Coping, and Adjustment among female elderly living in old age homes and within a family setup.

Methods and Materials: Forty Elderly female living in Old age homes, and forty female elderly living in the family from the community. They were assessed using WHO QoL Scale-BREF (Hindi version) Global Adjustment scale (GAS) and the ways of coping scale.

Result and Conclusion: Findings of this study indicated that female elderly living in old age homes had a better quality of life, coping, and adjustment in comparison to female elderly living within the family setup. It is not possible to conclude if the Old age homes is better than the community for female elderly. However, there is a need to replicate the study as these can have some influence on policy making for female elderly.

Keywords: Aging, Coping, QoL, Mental health

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Introduction

Old age is a challenging period of human life and is associated with many health-related psychological, social, and economic difficulties. Nowadays, Older adults (OA) are highly vulnerable in society (Devi & Roopa, 2013). Their vulnerability increases with age, particularly for females. The elderly female suffer from emotional alienation while living with their son/daughter and grandchildren. Urbanization has caused a drastic change in the socio-economic scenario of the country, leaving the younger generation with no time to interact with the elderly in the family. It is weakening Indian society's traditional bonds between grandchildren and grandmothers thereby making older people more vulnerable due to lack of employment, financial insecurity, ill health and social neglect (Amonkar et al., 2018). The traditional concept of family in India to provide support to the OA is changing with the disintegration of joint families. In past many studies have reported better QOL of the elderly in the family setup as compared to OAH (Roby & Sullivan, 2000). However, with changing social scenario this aspect needs a review.

Elderly female face age-related discrimination, and abuse due to a lack of awareness about their rights and the support system. A typical Indian woman being dependent on others for social, financial, emotional needs is, vulnerable and soft target of wrongdoers. They are forced to lead a life full of distress due to lack of social protection and poverty. Their financial needs are a major concern with the increased life span of elderly female (Neale et al, 1996). Though financial abuse is hard to define, it is reported to be widely prevalent among elderly female. Financial exploitation is the most frequent form of perpetrator-related elder abuse in the US (Jackson, 2017; Sandhu & Arora, 2003).

QoL is widely recognized as an important concept and measure of outcomes in health care, and the concept is emerging more and more often also in connection with long term care. Amonkar et al. (2018) reported higher satisfaction and quality life among elders living in institutional settings than non-institutional settings. Significant differences between the institutional and non-institutional elderly men and women in the area of physical, psychological, level of independence, social relationship, and environment domains of QoL

Adjustment processes in old age are difficult because of the declining physical and mental abilities. Dubey et al. (2011) reported most of the women in OAH were staying there unwillingly. The primary reasons stated for decision to stay in OAH were not having anyone to take care of them at home and not willing to stay with married daughters as per social norms.

Elderly female living in families had a positive attitude towards old age but simultaneously felt it to be a period of dependency. There is yet a lack of consensus about the attitude of the younger generation with their duties towards their older generation is being eroded - and has led to the rapid increase in their institutionalization (Koul, 2015; Singh et al., 2014).

However, there is no consensus about if the family or OAH is a better place to live for the elderly. Kotwal & Prabhakar (2009) found that some of the physical and behavioural symptoms reported by the inmates of OAH are tearfulness and sadness, irritability, social isolation, sleep deprivation, exacerbation of pre-existing pains, and the pains caused by the increase in muscular tension, loss

of appetite, difficulty in sleep, loss of sexual activity, and the loss of interest in daily activities that produce pleasure. Sethi et al. (2013) found that OA who live with family faced more health problems compared to those living with families. Kalavar & Jamuna (2011) reported emotional difficulties of women in OAH. They felt more closeness to their daughters than sons wile staying in OAH However, many felt well away from family in OAH. Thus there is a complex interplay of the social and psychological attributes determine the satisfaction of the Elderly female with living arrangement.

There are lots of gaps in the knowledge regarding the status of elderly female concerning their adjustment, coping, QoL living in families, and OAH. Geriatric health is an upcoming discipline in India. The knowledge is required given the rapidly changing social structure and upcoming need of OAH. The knowledge can be helpful in better designing the psycho-social environment in the OAH for better QOL of elderly female. Hence, we preferred to carry out this study.

Method

Aim: To assess and compare the QoL, coping, and adjustment between elderly female living in OAH and within a family setup.

Methods and Materials: A cross-descriptive research design method was adopted for the study. The study was conducted on OAH and Elderly females residing in families at Rohtak, Haryana. Forty elderly females from authorised OAH and 40 Elderly female from family were selected for this study. Two areas of Rohtak namely, Ram Gopal Colony and Meham were identified for sampling elderly females living in the family. Purposive sampling using the following inclusion and exclusion criteria was followed for collecting the sample. The participants were informed that their participation is purely voluntary and they may withdraw from the study at any stage. They were also assured of confidentiality about the personal information, A written informed consent was taken before enrolling the participants in the study.

Inclusion criteria: The female subjects were considered for inclusion if they were

1. age range between 60-80 years
2. educated up to 5th standard
3. living with family members
4. living in OAH between 2- 5 years (for subjects from OAH)

Exclusion criteria:

1. History of major physical/ psychiatric illness or neurological illness.

Tools:

Socio-Demographic Data Sheet:

It is a semi-structured, self-prepared performa especially drafted for this study. It contains information about socio-demographic variables like age, religion, education, marital status, and domicile.

QoL Scale (WHOQoL-BREF, Hindi version (Saxena et al., 1998)

The Hindi version WHOQoL-BREF Scale was used to assess QoL. This is a short version of the WHOQoL-100 questionnaire contains only 26 items. It can assess QoL in the domains of physical health, psychological health, social relationships, and environment. Higher scores correspond to better QoL. This scale has been widely used for QoL research in India.

Global Adjustment Scale (GAS) (Vohra, 2012)

The adult form of Global Adjustment Scale was used to assess adjustment is valid for subjects aged 20 years and above. The adult form tries to obtain information from the individual regarding Family relationships, Health, Social environment, Emotion, Occupation, Sex-related behaviour, higher scores mean lower adjustment.

Ways of Coping Questionnaire (Lazarus & Folkman, 1988)

It assesses thoughts and actions individual uses to cope with the stressful encounters of everyday living. Ways of Coping Questionnaire has 66 items measuring confronting coping, distancing, self-controlling, seeking social support, accepting responsibility, escape-avoidance, painful problem solving, and positive reappraisal on a 4-point Likert Scale.

Procedure: The subjects were assessed in a single session. The session with each subject lasted for approximately 60-80 minutes.

Bivariate statistical analysis was carried out. Student's t-test and chi-squared test were used for continuous and categorical data respectively.

RESULTS

Table-1

Socio-Demographic Variables between Elderly Females Living in OAH and with Family Setup

Variable		Group		Df	t/x^2
		Old age home	Family		
Age in years (*Mean±SD*)		68.90±6.92	68.37±7.71	79	0.27 NS*
Religion	Hindu	20(50%)	24(60%)	2	1.63 NS*
	Christian	12(30%)	10(25%)		
	Other	08(20%)	06(15%)		
Category	GEN	24(60%)	22(55%)	3	1.27NS
	OBC	6(15%)	6(15%)		
	SC	4(10)	4(10%)		
	ST	6(15%)	8(20%)		
Marital Status	Married	18(45%)	16(40%)	2	1.34NS
	Widowed	6(15%)	4(10%)		
	Other	16(40%)	20(50%)		

Education	Below Metric	24(60%)	26(65%)	2	2.13NS
	Metric	4(10%)	4(10%)		
	Above Metric	12(30%)	10(25%)		
Residence	Rural	18(45%)	16(40%)	1	1.12NS
	Urban	22(55%)	24(60%)		
Family	Nuclear	24(60%)	20(50%)	1	1.28NS
	Joint	16(40%)	20(50%)		

**NS= Not Significant*

Table 1 shows the socio-demographic variable between Elderly females living in an OAH and within a family setup. In socio-demographic variables, there were no significant differences between both groups.

Table -2

Comparison of QoL between Elderly Females Living in OAH and within Family Setup.

Variable	Group		*t*
	OAH (*N*=40) Mean ± *SD*	**Family setup (*N*=40) Mean ± *SD***	
Physical Health	24.85±3.34	18.22±5.014	6.82**
Psychological Health	24.65±4.38	17.67±3.23	8.09**
Social Health	3.05 ±0.87	2.27±1.06	3.56**
Environmental Health	25.50 ± 3.48	19.62±4.96	6.12**
Total QoL	78.05±4.88	57.80±8.52	10.62**

**=significant at 0.05 Level*

***=significant at 0.01 Level*

Table 2 shows the mean scores and comparison of QoL (domain wise) between Elderly females living in OAH and within the family setup. Significant group difference was found in term of social health and environmental health between elderly females living in OAH and within a family setup. It shows that the mean score of social health of elderly females living with the family was better than the elderly females living in OAH. There were significant differences in scores on all domains. Elderly females living with the family were having better social health than those living in OAH. The mean score of environmental health between Elderly females livings in OAH was better than the elderly females living with family. Its indicate that Elderly females living in OAH were better in environmental health than the elderly females living with family. The mean score of QoL between elderly females living in OAH were better than the elderly females living with family. In the physical health domain, the finding suggested that the mean score of persons who live with family was lower than persons who live in OAH.

Table- 3

Comparison of Global Adjustment between Elderly Females Living in OAH and Family Setup

Variable	B		t
	OAH (*N*=40) Mean ± *SD*	Family (*N*=40) Mean ± *SD*	
Emotional Adjustment	14.90±3.90	23.50±6.21	7.41**
Health Adjustment	16.65±6.72	25.17±8.99	4.80**
Social Adjustment	15.95 ±5.63	25.30±7.82	6.13**
Total Adjustment	47.50±9.92	73.97 ±10.48	7.35**

***=significant at 0.05 Level*

Table shows the comparison of Global adjustment (domain wise) between the groups of elderly females living in OAH and within a family setup. Significant group difference were found in terms of health adjustment, social adjustment, and total adjustment between elderly females living in OAH and within a family setup. Elderly females living with family faced more emotional problems. That's the result they faced more emotional problems in comparison to elderly females. Who lived in an OAH.

Table-4

Comparison of Coping and its Domains Among Elderly Females Living in OAH and within Family Setup:

Variable	Group		*t*
	OAH (*N*=40) Mean ± *SD*	Family (*N*=40) Mean ± *SD*	
Confrontive	9.60±=1.79	7.42±2.76	4.18**
Distancing	9.30±1.75	6.90±2.64	4.77**
Self-Controlling	11.80 ±1.18	7.40±2.75	7.06**
Seeking Social Support	7.65 ±2.13	8.52±3.22	1.43
Accepting	7.26 ±1.35	5.67±2.05	4.04**
Escape Avoidance	8.60±3.22	6.72±2.96	2.70*
Plan full Problem Solving	9.25±2.32	7.75±2.67	2.67**
Positive re-appraisal	10.00±2.69	8.60±3.41	2.03
Coping	54.55±6.99	44.67±10.83	4.84**

***=significant at 0.01 Level*

Table 4 shows the mean score and comparison of coping scores (domain wise) between elderly females living in an OAH and within a family setup. Significant group differences were found in term of distancing, seeking social support, escape avoidance, positive re-appraisal, and total coping.

The mean scores for the elderly females in OAH were significantly higher for all coping domains except for domains of 'seeking social support' and 'positive reappraisal'.

Discussion

India is going through a rapid population change due to industrialization and urbanization of the communities. Consequently, the OA are generally left alone to take care of themselves. The situation is particularly tougher for elderly females due to the feminization of the elderly population and more dependency needs of women (Pande, 2020). Therefore, we aimed to assess the QoL, global adjustment and coping among elderly females living in OAH in comparison to counterparts residing in the community.

We didn't found any difference in the sociodemographic characteristics of the women living in family and OAH in this study (Table-1). However, those the living in OAH reported better QoL on all measures of WHOQoL-BREF than those living with family (table-2). As this comparison is not addressed in many studies, we can simply speculate the reasons. The elderly females living with family is likely to face more emotional problems (Brock & Lawrence, 2011; Geo, 2019). This can be troublesome especially if she is the only representative of her elderly age group. Emotional isolation due to younger people not interacting sufficiently may add to her problems, she might also not be able to confide thereby having no vent to her distress. Further, asymmetrical power dynamics are already being perceived as stressful for the spouses (Mehra et al., 2005; Rayirala, 2016). Though the both the groups didn't had any difference in the marital status (Table-1)Though both the groups didn't have any difference in the marital status (Table 1), even then the same may hold for married women in our study. On the other hand, a person living in an OAH with equal relationships with the same age can share her feelings. The study by Mehra (2005) lend support to our findings and reported that females in OAH had better physical health as well as the psychological health of people living in OAH than people lived with the family. They reported stressful family relationships and lack of family care precipitates poor psychological well-being in the family. However, due to small sample of the current study limits the power of study, we would prefer to deal with our findings conservatively despite good support from literature. The other reasons for not attempting to generalise the findings is that many other studies have reported contrary findings too. A study revealed that elderly females who were living alone had a higher level of financial strain, more depressive symptoms and low level of life satisfaction (Chou & Chi, 2000; Dutta, 1989; Top, 2015). Study has shown that elderly females living in community faced many psychological problems. Social health was good for those respondents who were living in the family because of interactions with many people in the family and visiting relatives, neighbours, religious places etc. In OAH social deprivation, negligence, a sense of isolation and poor social health may reduce the subjective social worth of the individual (Jamwal, 2016; Varma, 2010). Poor social health in OAH can be seen because of reduced religious activities and interaction

with community people. They also noticed good environmental health in OAH .This can be attributed to the fact that the management of any authorised OAH has essential responsibilities for maintaining housing, sanitation, electricity, water (Dey, 2012; Lee, 2020; Whitelock & Ensaff, 2018). The QoL women living in OAH were better than those who were living with family. We feel that the environmental attributes may be playing a role in it. Besides that no family burden, having a peer group, and regular cultural activities may also be contributing to it. People often engage the whole day in these types of activities. Goswami and Deshmukh (2018) conducted a study on OAH and rural community people and found that people living in an OAH had higher QoL than people living in a rural community. Dubey et al. (2011) also reported better QoL in institutional settings for the elderly people. However, it was found that poor QoL, more loneliness, and psychological distress can be seen among the inmates of institutions than those living with families in urban areas of Jammu.

We also aimed to study the social adjustment between the groups of FAO living in OAH and within a family setup. The global adjustment scale was used for this purpose. The Table 3 depicts that the elderly females living in the OAH had better adjustment on all domains. The reasons again are speculative as not many studies have touched this aspect of life in OAH. The elderly females living with family faced more emotional problems people living in an OAH had higher QoL than people living in a rural community most of the day when younger members of the family are either at schools or work place during day. This also restricts their movement outside the home due to their physical and psychological dependencies. The findings of Dubey et al. (2011) ruled that people living in OAH had better emotional adjustment than elderly living with a family member also supported this study. The health adjustment was significantly better for those respondents who were living in OAH primarily because of the availability of doctors on the panel to look after their health as a minimum standard is required for an old age home. Otherwise, the elderly are likely to take their health casually (Akbar et al., 2014). In developed countries sufficient resources are available to the elderly living alone and they can manage themselves. However, this is not the situation in the developing countries (Gupta & Kohli, 2011; Kulkarni, 2009). The OAH facilities in that way may be superior than those available to the community residents. We can say this due to the fact that as per minimum requirement guidelines from the department of social welfare, the OAH besides having facilities like food, care, recreation; they must have a visiting doctor to look after the health of inmates. Availability of these essential services facilities should lead to better physical and psychological health.

In current study the elderly females in the OAH had better social QoL and social adjustment (Tables 2 & 3) than those living in community. The reasons can be manifold. Most of the times the elderly deciding to stay in OAH in India find this as the last feasible option for their survival. They generally face multiple socially adverse events compelling them to decide for staying in old age home. Kulkarni et al. (2009) had found a better social adjustment of those respondents living in family than those in old age home. O'Donnell et al. (2008) however reported low social worth, feeling of social deprivation, negligence, a sense of isolation, and poor adjustment among the inmates of old age home. Thus there appears to be discordance between the scientific observations

and media or public opinion. In the family, people certainly participate in many social occasions related to their relatives, neighbours, and community. In our culture, any visitor to the family generally interacts with the elderly persons as a token of regard. But in OAH, the inmates get little chance to attend a social gathering. In old age home, people live with the same age group so they share their feeling with each other easily. They are self-dependent to take decision about themselves. However with urbanisation of communities such trends are not as frequent as in past at any time. Thus, in coming times the social health of FAO in families may decline. Many other studies also supported this study as Singh et al. (2014) found older adults had a poor adjustment in the community.

As evident from table 4 the elderly females residing in OAH had better coping ability in comparison to the family set up. Sandhu and Arora (2003) also reported that seeking social support for coping is more used by a person living in an OAH in comparison to people living in the family. However, the analysis in the current study was not designed to find the predominant ways of coping by the FAO. In OAH, people live alone so they try to take help from different sources including inmates. Choi et al. (2012) reported that persons living in an OAH used full problem solving coping. In OAH people need to manage all alone unlike those living in family who can get help from other members. Somewhat opposite to it Heydari-Fard et al. (2014) reported that OA used positive re-appraisal coping to reduce their stress particularly in the OAH. They hypothesised that the OA live alone in OAH so they try more to cope with the situation emotionally. They further stated those living in OAH tend to take help from others in the OAH thus using social support coping more often. But many times the OA living in the family get all help from family members so they did not do an effort for any work thus having poor coping abilities in case of distress. Scientific studies are yet needed to verify this speculation.

To conclude we found better QoL, coping and adjustment among the FAO residing in the OAH as compared to their community counterparts. These findings though coming from a cross-sectional study with a restricted sample do suggest a need for educating younger generations about aging and their role in keeping the elders healthy and active. Supporting them physically, socially, and environmentally is equally important. Keeping in view poorer coping, adjustment and QoL in the community dwelling OA mental health professionals, researchers and policy makers need to play equal roles for the OA in community and OAH for preventive, therapeutic and rehabilitative health services. The findings are difficult to generalise due to small sample, non-probability sampling technique and involvement of only one OAH. However, these factors seem to provide need base and direction for further research and policy in relation to the well-being of elderly females.

We recommend that larger sample with probability based sampling covering diverse geographic areas should be selected to study the psychosocial aspects of elderly females so that the findings can be generalised and used for policy making.

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