INTRODUCTION

Ageing is an inevitable process in human life. It is primarily considered as a physiological phenomenon but an individual's economic, psychological and social areas can affect by the ageing process. It is true that people live longer because of improved nutrition, sanitation, medical advances, health care, education and economic well-being. A population is classified as ageing when the elderly people are proportionately larger in the total population. The challenges of population ageing need innovative planning and substantive policy reforms. The developing countries are facing with the challenge of graying population due to the absence of effective policies and programmes. Developed nations, on the other hand, have already implemented strategies to overcome the problems related to population ageing. It is a fact that industrialized countries became rich before they became old, while developing countries will become old before they become rich (Kalache et.al, 2005). While population ageing is a success story of socio-economic development and good public health practice, it also denotes economic crisis due to increased demand and progressive deterioration of functional status. The breakdown of traditional joint family system, the massive employment of women and the rapid rates of rural-urban migration have posed challenges in the care and protection of elderly population. The challenges such as double burden of diseases, increased risk of disability, formal and informal long term care and feminization of elderly leads to an increased demand for quality elderly care services. As population age, the balance among support for self-care, informal support and formal care should be ascertained. It is clear that most of the

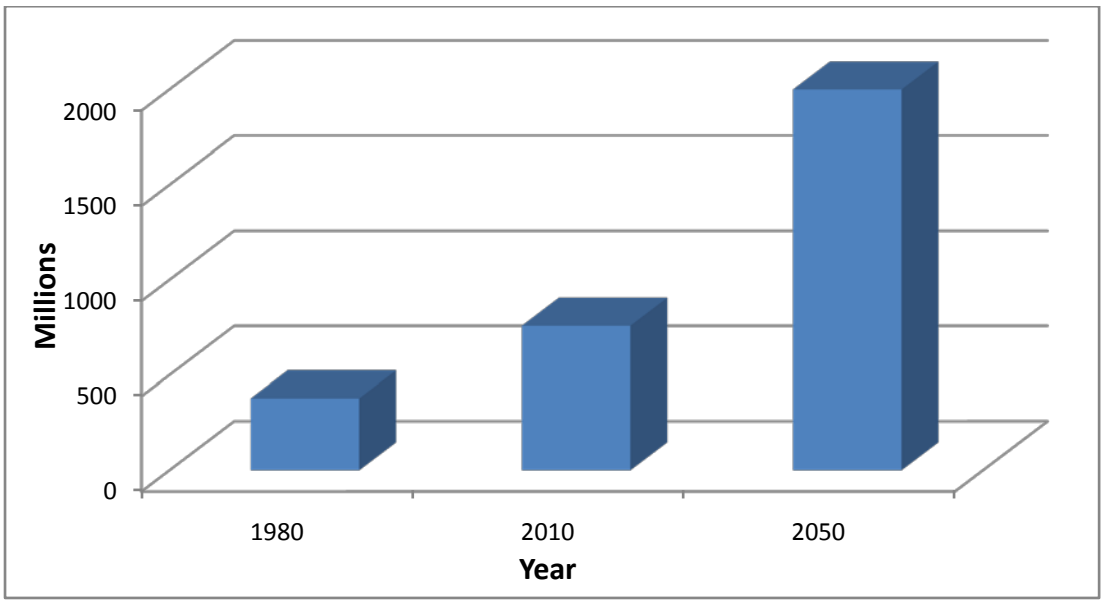
elderly care is provided by themselves or by their informal caregivers. Formal care through health and social service systems need to be equally accessible to all. The elderly who are poor and live in rural areas have limited or no access to the health care facilities. Elderly in need of care prefer to be cared within their own homes. Assistance of informal care giving should be available to the needy elderly and innovative models of care should come to practice in a comprehensive way.

1.1. Population Ageing

The elderly population has been growing at an unprecedented rate all over the world. In 2012, elderly represent 11.5 per cent of our total global population. Figure 1.1 depicts the actual and projected global population aged 60 years and over.

Figure 1.1

Actual and Projected Global Population Aged 60 Years and Above



Source: United Nations World Population Prospects:Population Database 2008

In 1980 there were 378 million elderly people in the world and that figure has risen to 759 million over the past three decades and is projected to jump to 2 billion by 2050. Asia accounts for more than half of the total elderly population of 414 million, followed by Europe, Northern America, Latin America, Caribbean, Africa and Oceania (UNFPA & Help Age International, 2012). It is estimated that the rate of population ageing in developing countries is dramatically high with an increase of 140 percent during 2006 and 2030 (National Institute on Aging, 2007). India is the second largest population of elderly after China (Bhatra & Agnimitra, 2010 & Economic Review Kerala, 2010). Table 1.1 illustrates the size and percentage share of elderly population in India during the period of 2001 to 2016.

Table. 1.1 Size and Percentage Share of Elderly Population in India (2001-2016)

Year	Males	Females	Persons
2001	34.94 (6.10%)	35.75 (7.10%)	70.69 (6.90%)
2006	40.75 (7.10%)	42.83 (8.00%)	83.58 (7.50%)
2011	48.14 (7.70%)	50.33 (8.70%)	98.47 (8.30%)
2016	58.11 (8.10%)	59.99 (9.80%)	118.10 (9.30%)
2021	70.60 (10.20%)	72.65 (11.30%)	143.24 (10.70%)
2026	84.62 (11.80%)	88.56 (13.10%)	173.18 (12.40%)

Source: Office of the Registrar General of India

According to population projections published by the Office of the Registrar General of India, the size and percentage share of India's elderly population is expected to increase from 98.47 million (8.30 percent) in 2011 to 118.10 million (9.30 percent) in 2016. An increase in longevity and decline in

fertility have contributed in people living much longer today than ever. Mortality rates have declined virtually due to progress in preventing infectious diseases and improved living standards. The life expectancy at birth for both males and females has doubled during the last half century from 32 in 1951 to 65 years in 2002 (Singh A P, 2010). The oldest old (80+) among the elderly in India is expected to grow faster than any other age group in the population and is expected four-fold from 8 million in 2001 to 32 million in 2051 (Rajan & Johnson, 2010). The old-age dependency ratio climbed from 10.9 percent in 1961 to 13.1 percent in 2001. The south Indian states have shown steady increase in elderly population during the last decade and Kerala is leading with a tremendous increase of 10 percent in 2001. The state and district wise population of elderly is stated in table 1.2.

Table 1.2

District wise Elderly Population in Kerala – 2001-2051

Districts	**2001**	**2011**	**2021**	**2031**	**2041**	**2051**
Trivandrum	10.62	12.17	15.92	19.93	23.48	25.63
Kollam	11.01	13.96	17.49	21.04	23.93	24.02
Pathanamthitta	14.66	15.47	17.57	20.00	22.35	23.80
Alappuzha	12.79	14.18	16.92	20.14	23.25	24.29
Kottayam	12.93	13.85	16.80	20.34	23.26	24.51
Idukki	9.31	11.34	15.36	20.33	24.00	24.37
Ernakulam	11.44	12.62	16.27	20.46	24.00	25.59
Trissur	11.64	12.78	15.57	19.52	23.21	25.53
Palakkad	10.23	11.47	14.33	17.75	22.17	26.38
Malappuram	7.37	08.15	11.02	14.92	20.70	27.28
Kozhikode	9.77	10.93	14.37	18.34	23.02	26.33
Wayanad	7.57	10.34	12.76	17.75	23.31	27.28
Kannur	10.33	11.64	14.81	18.49	22.86	25.55
Kaseragod	8.33	10.35	12.71	16.81	22.14	27.44
Kerala	**10.56**	**11.93**	**15.09**	**18.89**	**22.92**	**25.63**

Source: Economic Review Kerala, 2011

It revealed that the percent share of elderly population is expected to increase from 11.93 percent in 2011 to 15.09 percent in 2021. It further revealed that Pathanamthitta district has the highest percentage of elderly population during 2011. The group of old-old (70-79) is the fastest growing group and a significant increase is evident among the group of women and men in oldest old (80+). The age composition of the elderly population is being altered because of the tendency of the old age groups within the elderly population is expected to expand more rapidly. While the facilities in living standard, health, literacy and education of Kerala are being appreciated, the social security and welfare measures for elderly are not up to the mark (Rasi R.A & Sudhir M.A, 2010). The care of elderly has turned out to be a major developmental issue in Kerala. The increase in life expectancy can also cause a prolonged state of morbidity and disability. Kerala has a life expectancy of above 70 years and an infant mortality rate of 16 per 1000 live births. It is comparable to many upper middle income countries such as Argentina and Mauritious (World Bank, 2001). Estimates show that the expectation of life at birth has been consistently higher among females in the state. In the period 1951-61, the expectation of life at birth was 44 years for males and 45years for females. During 1991-2001, on an average a man of 60 years survived for another 18 years and his woman counterpart to another 20 years. The ageing in Kerala is disproportionately skewed to female and Table 1.3 presents the proportion of women in the elderly population.

Table 1.3 - Sex Ratio of Elderly Population in Kerala per 1000 Male - 1961-2001

Year	60+	60-64	65-69	70-74	75+
1961	1089	1071	1060	1118	1138
1971	1101	1055	1110	1116	1165
1981	1130	1056	1150	1174	1207
1991	1156	1090	1153	1165	1263
2001	1229	1105	1169	1248	1445

Source :Kerala Calling,2004

Table shows that sex ratio among the 60+ category was 1089 in 1961 and has been increased to 1229 in 2001. Highest sex ratio has been occurred among the 75+ category during the period of 2001, 1445 females for 1000 males. It is further noticed that majority of old age people in Kerala are widows. In 2001, 42 percent are widows in the range of 60-64 and 74 percent are in the range of 70-75 (Census, 2001).The National Family Health Survey (NFHS) of 1998-99, also indicated that 46 per cent of women elderly 50 and above are widowed, on the other hand only seven percent of men in this age group are found to be widowers. The elderly women are marginalized due to the combined effects of ageing and widowhood in the state of Kerala. The population of 0 - 15 age group has decreased from 40 to 23 per cent during the period of 1961-2001. The Old Age Support Ratio (number of working age population between15-59) was 7 in 1991 and projected to fall 4 by the year 2021(Centre for Development Studies, 2005). According to the current

estimates, 11 per cent of elderly population is supported by 61 per cent of working age population in 2001. At the same time the old age dependency ratio (ODR) increased from 11 in 1961 to 16 in 2001 and is projected to increase to 26 in 2021. This may adversely affect the care of elderly population in Kerala. The accelerated growth of elderly population demands the need for changes in health care and welfare activities.

1.2. Elderly in Kerala: Concerns and Issues

The concerns and issues of elderly in Kerala are multi-faceted and can be broadly classified under five categories such as care and support, increased risk of disability, double burden of diseases, feminization of ageing and economics of ageing population. The care and support discuss the formal and informal care systems and the support offered to elderly. The different type of disabilities among elderly and the remedial measures are explained in the second classification. The double burden of diseases discuss about the shift from communicable to non-communicable diseases and the feminization of elderly discuss the longer life span of elderly women and their issues and problems. The economics of ageing population comprehensively refers to the health cost and long term care treatment expenses faced by elderly and care givers.

1.2.1. Care and Support

As population age, the balance among support for self-care, informal support and formal care should be ascertained. It is clear that, in Kerala, most of the elderly care is provided by themselves and by their informal caregivers.

It is a fact that most elderly are cared by their adult children (Jamuna, 2005). A series of factors such as weakening of traditional joint family system and more chance in women employability created new challenges in the care of elderly in Kerala. It weakened the filial obligations and mutual ties, considered as the hall marks of the traditional family. The unavailability of younger generation due to demographic transition and national and international migration have affected the elderly. It is a fact that the ability to extend care is constrained due to geographical distance between the children and parents. In this situation, the Activities of Daily Living (ADL) and personal safety of elderly become more strainful which in turn limit their ability to interact with family and friends. The high rate of longevity among the elderly is another phenomenon which leads to the expansion of morbidity and prevalence of chronic diseases and the prolongation of the period of care. The higher incidence of morbidity and immobility among the elderly will cause an increasing burden to their families. The high cost of rearing and education of children putting pressure on the families and struggling to meet the needs of elderly in Kerala. As a cause of this new trend the elderly are ignored and left lonely. There is a feeling of unwantedness as they are deprived of social, economic, physical and emotional supports. The survey conducted by Help Age India, reveals that twenty percent of the oldest old faces abuse at household level in major cities of India (Help Age India, 2010). The accelerated growth of elderly demands the needs for special attention in informal and long term care. Formal care through health and social service systems needs to be equally accessible to all. The elderly

who are poor and live in rural areas have limited or no access to health care facilities. Limited primary health care services in many areas have put increased financial and intergenerational strain on elderly and their families. It is evident that elderly in need of care prefer to be cared in their own homes. In this scenario, the importance of extending community based programmes for elderly is the need of the hour in Kerala.

1.2.2. Increased Risk of Disability

The independence of elderly is threatened when their physical and mental disabilities make it difficult to carry out the activities of daily living. Many people develop disabilities in later life related to the wear and tear of ageing. Significantly, elderly over the age of 80 are the fastest growing age group among Kerala. The disabilities associated with ageing and the onset of chronic disease can be prevented or delayed. Five types of disabilities are usually reported among the elderly such as sensory impairment, hearing problem, locomotors problem, problems in speech and senility. It is reported that 75 percent of the elderly are afflicted by at least one of these disabilities. Among the disabilities, joint problems or mobility disability have significant percent (72 percent) among the elderly (NSSO, 1998). The NSSO 2006 data also showed that visual and mobility impairment as the most common among the elderly. Supportive changes in the community are also important, both in terms of preventing disabilities and reducing the restrictions. The increasing use of aids such as canes, walkers, handrails, mobile phones may reduce dependence among disabled people. Common age-related disabilities include

vision and hearing losses are increased sharply with old age. The major age-related causes of blindness and visual disability are cataracts, glaucoma, macular degeneration and diabetic retinopathy (WHO, 1997). Disability and impairments leading to immobility among the elderly is a cause of concern for ageing individuals as it adversely affects their quality of life increasing risk of dependence and loss of autonomy. There is an urgent need for policies and programmes designed to prevent visual impairment and to increase appropriate eye care services.

1.2.3. Double Burden of Diseases

The shift from communicable to non communicable diseases is a fast phenomenon among the elderly. The NCD are emerging as a main cause of ill-health in South Asia and contribute 53 percent of death and 44 percent of disability-adjusted life-years (Reddy et.al, 2005). The chronic illnesses such as heart disease, cancer and depression are quickly becoming the leading causes of morbidity and disability among the elderly. Morbidity, which has higher incidence among the aged, will cause an increasing burden to the elderly themselves and to their families also. The problems of Sensory Impairment, Orthopedic hazards, Dementia, Depression, Alzheimer's along with other lifestyle diseases exacerbate the situation even more deeply. As a result of double burden of diseases, only 6 percent of the elderly reported good health, 69 percent had moderate health, 20 percent has poor health and 5 percent had poor health (Nayar, 2000). It is critical to put policies, programmes and

intersectoral partnerships into place that can help to halt the massive expansion of chronic NCDs. While not necessarily easy to implement, that focus on community development, health promotion, disease prevention and increasing participation are often the most effective in controlling the burden of disease and the support for relevant research is most urgently needed.

1.2.4. Feminization of Ageing

Women are having a longer life span than men and the number of elderly women in the state is higher when compared to men. There are significant differences in the life expectancy of women and men. It is notable that the women in Kerala are expected to live 20.62 years as against 18.08 years by her male counterparts. The factors such as higher female life expectancy at the age of 60 -70 and the universal factor of women marry men older than themselves lead to high incidence of widowhood. (Gulati & Rajan 1997). The widowhood creates void in their familial life, and noticeable deterioration in the mental health such as loss of status, sense of insecurity and economic crises. It adds the sufferings from discrimination and abuse from the family members (Nair, 2011). Women are more likely than men to be poor and suffering from disabilities in older age. It is a fact that, due to their second-class status, the health of older women is often neglected. They often tend to disclose their health problems to family members because of high treatment expenses.

1.2.5. Economics of an Ageing Population

The rapid population ageing will lead to an unmanageable explosion in health care and social security costs. Inefficiencies in care delivery systems, long hospital stays due to excessive numbers of medical interventions and the inappropriate use of high cost technologies are the key factors in escalations in health care costs. The costs of long-term care can be managed if the health policies and programmes for elderly are implemented properly. Policies and health promotion programmes that prevent chronic diseases and lessen the degree of disability among elderly enable them to live independently longer. The expenditure of health care in Kerala is higher for the elderly both in out-patient and in-patient care. This goes in line with higher prevalence of long-term chronic illness among the elderly (Mukherjee & Levesque, 2010; Alam 2006). Another major factor is the capacity and willingness of families to provide care and support for elderly family members. The situation varies according to the economic condition and the social status of the elderly in the family and society. The elderly who have adequate financial resources are looked after well by the family members. On the contrary, in many cases, where the elderly are resource poor, family members neglect them intentionally and refuse to fulfill a care-taking obligation (WHO, 2002). The elderly are forced to work and to do odd jobs despite their physical condition and poor health for economic cause.

1.3. Initiatives for the Welfare of Elderly

The *Ministry of Social Justice & Empowerment*, which is the nodal Ministry for the purpose focuses on policies and programmes for the elderly and in close collaboration with State Governments, Non-Governmental Organizations and civil society. *Article-41* of Indian Constitution deals with the State's role in providing social security to the elderly. The Government of India has implemented various social security and welfare measures for senior citizens. The *Senior Citizen (Maintenance, Care and Protection) Act-2007*, seeks to have provisions for the maintenance and welfare of parent and senior citizens, guaranteed and recognized under the Constitution. The objective is to ensure the maintenance of parents and senior citizens by their children. The act provides that a senior citizen including parent who is unable to maintain himself from his own earning or out of the property owned by him, shall be entitled to make an application for claiming maintenance. It enabled them to get maintenance by moving the Tribunal constituted under the act. *National Policy on Older People (NPOP)*- 1999 recommends to extend comprehensive support for financial security, health care and nutrition, shelter, education, welfare and protection of life and property of elderly. It seeks to provide protection against abuse and exploitation, make available opportunities for development of the potential of older persons by enlisting their participation and providing services to improve their quality of life. Speedy disposal of complaints of older persons relating to fraudulent dealings, cheating and other matters will be ensured by the policy. Research activity on ageing will require to be strengthened. Universities, medical colleges and research institutions will

be assisted to set up centers for gerontological studies and geriatrics. The policy recognizes the importance of trained manpower. Assistance will be provided for development of curriculum and course material. Schools of Social Work and University Departments need to give more attention in their organization of services for them. The NPOP is under revision and a new policy entitled *National Policy on Senior Citizen 2011* has been drafted for the welfare for the elderly. A *National Council for Older Persons (NCOP*) was constituted in 1999 under the chairpersonship of the Minister for Social Justice and Empowerment to oversee implementation of the Policy. The NCOP is the highest body to advise the Government in the formulation and implementation of policy and programmes for the elderly. The Council was re-constituted in 2005 with members comprising Central and State governments representatives, representatives of NGOs, citizen's groups, retired person's associations, and experts in the field of law, social welfare, and medicine. An *Inter-Ministerial Committee on Older Persons* comprising twenty-two Ministries/ Departments, and headed by the Secretary, Ministry of Social Justice & Empowerment is another coordination mechanism in implementation of the NPOP. Action Plan on ageing issues for implementation by various Ministries/ Departments concerned is considered from time to time by the Committee. *Vayomithram*, first of its kind in India launched by Kerala Social Security Mission in 2011 is intended to give welfare services such as free medicine, palliative home care, help desk facilities to persons above 65 years. During 2011-12, the programme assisted 62588 persons.

The National Old Age Pension Scheme has been renamed as *Indira Gandhi National Old Age Pension Scheme (IGNOPS)* and formally launched on 19th November, 2007. The central contribution of pension under the Indira Gandhi National Old Age Pension Scheme is Rs. 200/- per month per beneficiary up to 79 years and Rs.500/- per month per beneficiary from 80 year onwards and the State Governments may contribute over and above to this amount. At present old age beneficiaries are getting anywhere between Rs. 200/- to Rs. 1000/- depending on the State Contribution. The eligibility criteria under Indira Gandhi National Old Age Pension Scheme is the applicant (male or female) should be 60 years or above and should belong to a household living below the poverty line according to the criteria prescribed by the Govt. of India. During the Tenth Five Year Plan (2002 – 07) a total of 110,793,860 elderly were covered and US $ 1002.20 million approximately was incurred on this count. *Annapurna scheme* aims at providing food security to meet the requirement of those Senior Citizens who though eligible have remained uncovered under the Indira Gandhi National Old Age Pension Scheme (IGNOPS). Under the Annapurna Scheme, 10 Kg. of food grains per month are to be provided 'free of cost' to the Beneficiary. Under the scheme US $ 56 million was incurred and 43,03,491 elderly were covered in tenth plan (2002-07). *Integrated Programmes for the Older Persons* basic amenities like shelter, food, medical care and entertainment opportunities and by encouraging productive and active ageing through proving support for capacity building Government/ Non-Governmental Organization/ Panchayat Raj Institution/ Local Body and Community at a large.

1.3.1. Concessions and Incentives

The *Ministry of Railways* has given concession of 40 percent for male senior citizens and 50 percent for female senior citizen. *Ministry of Social Justice & Empowerment* is implementing an *Integrated Programme for Older Persons (IPOP)* with an aim to empower and improve the quality of life of older persons. The basic thrust of the programme is on older persons of 60 years and above particularly the infirm, destitute and widows. Under the scheme, financial assistance is provided to non-governmental organizations, autonomous bodies, educational institutions and cooperative societies up to 90 per cent of the project cost for setting up and maintenance of day care centres, mobile medi-care units, old age homes and non-institutional service centres. The scheme for assistance to construction of old age homes provides one time grant to local bodies and NGOs for construction of old age homes or multi-service centers for older persons. Some of the public sector insurance companies provide life insurance coverage up to 75 years of age and many private insurance companies have 55 years as the last entry age. The Insurance Policy Schemes announced for older persons include *Jeevan Dhara* (18-65 years), *Jeevan Akshay* (30-75 years), *Jeevan Suraksha* (25-60 years), *Senior Citizen Unit Plan* (18-54 years). In addition, Health Insurance Schemes covering *Mediclaim Policy* and other individual and Group Mediclaim Policies are also offered by Nationalized as well as private insurance companies. The government is taking steps to enforce a uniform policy on all Insurance Companies as regards entry age of Senior Citizens.

1.4. Community Based Programmes

Community based programmes are increasingly being applied in a range of different contexts, both as part of an idealized model of decentralized government and also in the absence of effective government. Community based programmes can be pursued in areas where traditional forms of aid are not yet possible. It has been considered as a possible means to bridging the gap between relief and development (Cliffe et al., 2003). The community based programmes have significant role in the elderly population. Income generation, microcredit, awareness programmes, living arrangements and social services are the community based programmes for the welfare of elderly. Most of the developed countries have launched their own community based programmes for the welfare and protection of elderly. Kerala can envisage impending challenges which will be posed by enormous increase in elder's population. For handling such a situation, the current social security schemes for the welfare of elderly by the government is inadequate and community based approaches should be evolved for enhancing long term quality care for elderly in Kerala. The different community based programmes like Elders Self Help Group (ESHG), Senior Citizen Clubs, Pensioner's Union and Community Policing provides care and support to the elders. Elders Self Help Groups (ESHGs) can be understood as community based organizations of elderly, aimed at improving living conditions for older people and ensuring a mechanism for social support in the community as well as for facilitating activities and delivering services and achieve sustainable livelihoods. The groups engage in

saving and credits, advocacy and awareness raising and membership facilitate easier access to government services. An ESHG has the features of 10-20 elderly in a group, completely male or female members or mixed members, common geographical boundaries primarily from the village, contribute a fixed amount towards group saving and regular meetings at every month. Presently, these ESHGs are on par with the Self Help Groups promoted by the Government. The senior citizen clubs promote psycho-social solidarity at the local level and use it as a common platform to discuss elderly problems and issues. These clubs occasionally organize medical camps, mobilize resources to social assets and become centers for cultural and recreational activities. It also ensures the nutritional and psychological welfare of the elderly. The Kerala State Service Pensioners Union (KSSPU) focuses on the welfare and rights of pensioners those who are retired from government services. They are working for the rights and can even extend the services to the Senior Citizens for their socio-economic welfare. The concept of Community Policing introduced in Kerala one of the main objective envisages to protect the life and wealth of the elderly who are living alone as well as those are in distress. The resources of the local community and security help the elderly in distress and fear. The Government of Kerala has planned to extend this programme to all police stations in the state. Apart from this the Legal Service Forum, Mobile medical Units and Help Line offered by Non-governmental organization like Help Age India and Age Care International help the needy elderly.

1.5 Life Satisfaction among the Elderly

Life-satisfaction closely related to morale, adjustment and psychological well-being of elderly. Five components such as zest, resolution and fortitude, congruence between desired and achieved goals, positive self-concept and mood tone comes under the life satisfaction. Zest vs. apathy relates to an enthusiasm of response to life in general and was not related to any specific type of activity, such as social or intellectual engagements. Resolution and fortitude related to the active acceptance of personal responsibility for their lives rather than passively accepting or condoning what has happened to them. Congruence between desired and achieved goals is the another components which relative difference between desired and achieved goals caused one to be satisfied or dissatisfied with life. The Self-concept is based on elderly's present emotional, physical, and intellectual dimensions. Past successful living may be contribute to this component indirectly. Mood tone is the final component, which relates to optimism and happiness and other positive affective responses. Depression, sadness, loneliness, irritability, and pessimism are comes under this component.

1.6 Need and Significance of the Study

The ageing process has already begun in Kerala at a much faster rate than anticipated. There are certain demographic aspect which leads to population ageing such as declining fertility level, increased rate of life expectancy and low level of mortality rate. The projected score of 12 percent elderly population (UNDP & Planning Commission, 2009) reveals the need for

special attention to this particular group. In the mean time, the emergence of nuclear family system, increasing longevity, high rate of migration, the changing attitude towards the older ones and traditional caregivers, mainly women, are increasingly taking jobs have been affected the lives of older generation. The morbidity, which have higher incidence among the elderly, will cause an increasing burden to the elderly themselves and to their families. So these two vulnerabilities, natural vulnerability due to health problem and imposed vulnerabilities due to social background will turn out to be a major cause for concern in Kerala. The Kerala model of development has been appreciated all over India. The standard of living, health, literacy and education are compared to the development world. At the same time our social security and welfare measures for the elderly are not par with the developed countries. As the number of older people continues to increase compared to the pool of available caregivers, and as traditional social structures break down, families and policy-makers will increasingly need to look for other options. In this context there is a felt need to develop new strategies to ensure the welfare and need of the old age population. Such situation community based programmes which are easily accessible to elderly community can lend a hand for the welfare and long term care of elderly.

1.7. Statement of the Problem

The present study attempts to analyze the role of community based programme in an active ageing process. One of the community based programmes, Elders Self Help Group has been thoroughly examined.

A theoretical framework has been developed to assess the active ageing process through the Elders Self Help Group. The three pillars of active ageing such as health, participation and security has been assessed and the life satisfaction levels of ESHG members were studied. As such the study is entitled "***COMMUNITY BASED PROGRAMMES FOR ACTIVE AGEING: STUDY OF ELDERS SELF HELP GROUPS IN KERALA***"

1.8. Objectives

1. To study the origin and organizational set-up of elders self help groups(ESHGs) in Kerala
2. To examine the health, security and socio-economic conditions of ESHG members
3. To assess the level of life satisfaction and living arrangements of ESHG members
4. To highlight the role of elders self help groups in promoting welfare programmes
5. To suggest strategies for strengthening community based programmes for active ageing

1.9. Definition of Key Terms

1.9.1. Community Based Programmes

Community based programme enables the process of sustainable improvement in the present situation of elderly with the active support and assistance from the members themselves in the community. Income generation,

microcredit, awareness programmes, living arrangements and social services have been the programmes undertaken for the welfare of elderly.

1.9.2. Active Ageing

Active ageing refers to the process of optimizing opportunities for health, participation and security in order to enhance the quality of life as people age. Active ageing applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental well being throughout the life course. The word active refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force.

1.9.3. Elders Self Help Group (ESHG)

Elders self help group (ESHG) is a community based organization of older people above 60 years aimed at improving living conditions for elderly. It is a group of 10 to 20 active elderly who organize themselves. These groups have office bearers who were elected its members to look after the day to day activities of the group. The groups meet four times every month and unite for the care and support of its members. ESHG ensures the mechanism for social support in the community through facilitating activities and delivering services for sustainable livelihood.

1.9.4. Living Arrangements

Living arrangements are influenced by a variety of factors, including marital status, financial well-being, health status, and family size and structure, as well as cultural traditions such as kinship patterns, the value placed on living independently or with family members, the availability of social services and social support, and the physical features of housing stock and local communities.

1.9.5. Life Satisfaction

Life Satisfaction is closely related to morale, adjustment and psychological well-being of elderly. Five components such as zest, resolution and fortitude, congruence between desired and achieved goals, positive self-concept and mood tone are comes under the life satisfaction.

1.10. Scope and Limitations of the Study

This investigation conducted in elders self help groups of Kerala tried to identify the active ageing process among elderly. The aspects of health, participation, security and life satisfaction level of elderly were analyzed. Descriptive design was used to study the elderly group. The three pillars of active ageing process were thoroughly examined. The life satisfaction level of elderly was constructed and administered to elderly working in Elders self Help Groups. Case studies were conducted with the office bearers of the group members. The formations of ESHGs and back ground details were gathered from field level animators and office bearers through focus group discussion.

1.11. Organization of Research Report

The back ground of the study, its significance, scope and limitations were stated in chapter I. Chapter II presents the three pillars in active ageing with determinants. Theoretical approaches in gerontological aspects were discussed and a frame work for community based programme has been developed in this chapter. Chapter III presents a review of the related studies based on ageing in India and abroad. Studies on health, participation, security, life satisfaction, active ageing and community based programmes were also reviewed and presented in this chapter. Chapter IV deals with the research design and procedure of the study. The collection of data using survey method, preparation of interview schedule, development of life satisfaction scale for elderly and components of focus group discussion format have been explained in this chapter. Chapter V deals with the different community based programmes in Kerala. The profile of Elders Self Help Groups and its activities have been presented in this chapter. Chapter VI analysis and interpret the socio-economic condition, health, security and life satisfaction level among the elderly. The summary, findings of the study, suggestions and social work intervention in gerontological perspectives have been presented in chapter VI. The bibliography and the research tools used for data collection have been appended at the end of the thesis.