ACTIVE AGEING: A COMMUNITY BASED APPROACH

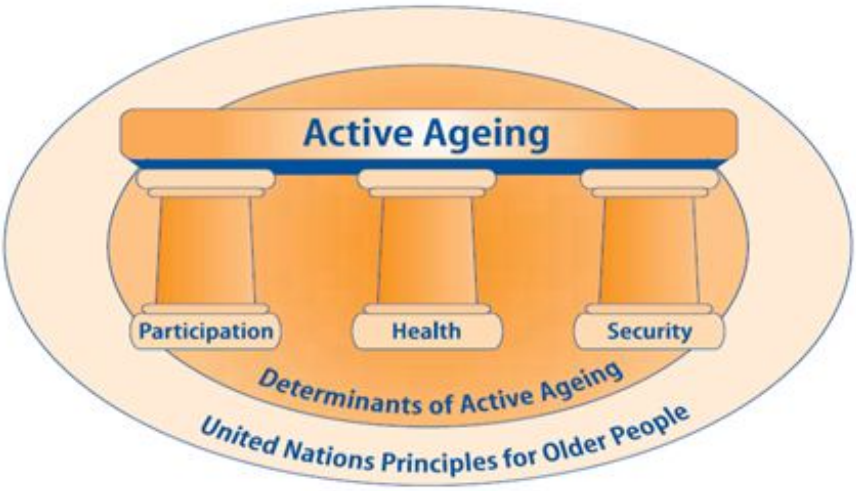
2.1. Introduction

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. The term active ageing was adopted by the World Health Organization. It is meant to convey a more inclusive message than healthy ageing and to recognize the factors in addition to health care that affect how individuals and populations age (Kalache and Kickbusch, 1997). Active ageing applies to both individuals and population groups which allows people to realize their potential for physical, social, and mental well being throughout the life course. The term '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 (Active Ageing Policy Frame work, 2002). The essence of emerging modern concept of active ageing is a combination of the core element of productive ageing with a strong emphasis on quality of life, mental and physical well-being (European Commission, 1999).The active ageing approach is based on the recognition of the human rights of older people and the United Nations principles of independence, participation, dignity, care and self-fulfillment. It shifts a needs-based approach to a rights- based approach that recognizes the rights of people to equality of opportunity and treatment in all aspects of life as they grow older. It supports their responsibility to exercise their participation in the

political process and other aspects of community life. Policies and programmes recognize the need to encourage and balance personal responsibility, age-friendly environments and intergenerational solidarity. Three pillars have been ensured for the process of active ageing such as participation, health and security based on United Nations principles for older people. These pillars are determined by variety of factors such as behavioral, personal, social, physical, economic, health and social sciences. The United Nations Principles and determinants of active ageing are depicted in Figure 2.1.

Figure 2.1

Active Ageing: Policy Framework



2.2. Participation

The active participation of elderly in socioeconomic, cultural and spiritual activities are envisaged the basis for active ageing. The components for participation comprises of education, learning and participation in community life. Participation involves education and training, economic and involvement development activities, formal and informal work, voluntary

activities and involvement in community life. Education and life long learning envisages opportunities throughout the life course to promote health literacy and health education in a comprehensive way. It helps the elderly to care for themselves and each other as they get older. The active participation of elderly held through economic and development activities, formal and informal work and voluntary activities. It is a fact that implementation of income generation programmes for elderly will reduce the poverty and would get the access to development grants and credit. At the same time the hiring and retention of older workers may allow them to participate in meaningful work as they grow older. The facility of affordable public transportation services in rural and urban areas may allow the elderly to participate fully in family and community life. Elderly women whose support to familiy through informal care also can contribute to the economy. The active participation of elderly in political life enables them in the decision-making process in the family as well as community. It can definitely helps them to advocate, promote and enhance the health, security and full participation of elderly in all aspects of community life.

2.3. Health

Active ageing promotes the level of health required for elderly to continue as productive members of society. It helps to reduce the factors for chronic diseases and enables the elderly remain healthy. Age friendly health services and reduction of risk factors are the main components of health in active ageing process. The age friendly health services help to develop

affordable, accessible, high quality services that address the needs and rights of elderly. It provides care includes health promotion, disease prevention, treatment of chronic diseases, long-term and palliative care through all stages of life. The support from informal caregivers through home care and respite care may be provided with special attention to the needy elderly. The improvement in health and social services for elderly through elimination of age discrimination, developing policies, programmes and services between the public and private sectors. The reduction of risk factors focus to develop guidelines on physical activity for elderly men and women. It gives recommendation for improved diets, safe medication and locomotor activities. Education in elderly health care and awareness can optimize the active ageing process among the individuals. This can also be achieved through educating the 'care givers' and community health workers in geriatric care.

2.4. Care and Security

Elderly are ensured of protection, dignity and care by the families and communities. The availability of steady and adequate income may ensure a social safety net during the old age period. At the same time independency and autonomy with appropriate shelter and security for a longer period is the prime concern for elderly. The programmes such as housing assistance through rent subsidies, cooperative housing initiatives and support for housing renovations should be implemented for the welfare of elderly. There is a felt need of action by law enforcement officers, social service providers and advocacy organizations for the protection and safety of elderly. The involvement of media is a major factor to increase the awareness level on injustice and abuse

of the elderly. There is a felt need to enact legislation and enforcement of laws that protect elderly widows from theft of property and domestic violence as they age. Measures should be taken to provide income security for elderly women who have no pensions.

2.5. Determinants of Active Ageing

Active ageing depends on a variety of determinants that surround individuals and their families. More research is needed to clarify and specify the role of each determinant, as well as the interaction between determinants, in the active ageing process. There is a need for understanding the pathways that explain how these broad determinants actually affect health and well being. Moreover, it is helpful to consider the influence of various determinants over the life course so as to take advantage of transitions and "windows of opportunity" for enhancing health, participation and security at different stages. Figure 2.2 depicts the determinants of active ageing.

Figure 2.2

Determinants of Active Ageing

2.5.1. Health and Social Service Systems

To promote active ageing, health systems need to take a life course perspective that focuses on health promotion, disease prevention and equitable access to quality primary health care and long-term care. It enables the people to take control over and improve their health. Health and other social services need to be integrated, coordinated and cost-effective. The importance of curative services and long-term care should be ensured by the health and social service system. The present acute care models of health service delivery are inadequate to address the health needs of rapidly ageing populations (WHO, 2001). As the population ages, the demand will continue to rise for medications that are used to delay and treat chronic diseases, alleviate pain and improve quality of life. The need for a long-term care is the need for the hour. The system of activities undertaken by informal caregivers and professionals to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfillment and human dignity (WHO, 2000). Long-term care includes both informal and formal support systems. The latter may include a broad range of community services (e.g., public health, primary care, home care, rehabilitation services and palliative care) as well as institutional care in nursing homes and hospices. It also refers to treatments that halt or reverse the course of disease and disability. Mental health services, which play a crucial role in active ageing, should be an integral part of long-term care. Particular attention needs to be paid to the under-diagnosis and lack of attention to mental illness and to alarming suicide rates among older people.

2.5.2. Behavioural Determinants

The adoption of healthy lifestyles and taking care of oneself is important at all stages of the life course. One of the myths of ageing is that it is too late to adopt such lifestyles in the later years. On the contrary, engaging in appropriate physical activity, healthy eating, refrain from smoking and consuming alcohol and medications wisely in older age can prevent disease and functional decline, extend longevity and enhance one's quality of life. The effects of smoking are cumulative and long standing (Doll, 1999). Active living improves mental health and often promotes social contacts. Being active can help elderly remain as independent as possible for the longest period of time. It can also reduce the risk of falls. There are thus important economic benefits when older people are physically active. Regular moderate physical activity reduces the risk of cardiac death by 20 to 25 percent among people with established heart disease (Merz and Forrester, 1997). It can also substantially reduce the severity of disabilities associated with heart disease and other chronic illnesses (U.S Preventive Services Task Force, 1996). Medical costs are substantially low for older people who are active (WHO, 1998). Individuals who are often engaged in strenuous physical work and chores that may hasten disabilities, cause injuries and aggravate previous conditions, especially as they approach old age. This may include heavy care giving responsibilities for ill and dying relatives. Health promotion efforts in these areas should be directed at providing relief from repetitive, strenuous tasks and making adjustments to unsafe physical movements at work that will decrease injuries and pain. Older people who

regularly engage in vigorous physical work need opportunities for rest and recreation. In older people, malnutrition can be caused by limited access to food, socioeconomic hardships, a lack of and knowledge about nutrition, poor food choices , disease and the use of medications, tooth loss, social isolation, cognitive or physical disabilities that inhibit one's ability to buy foods and prepare them, emergency situations and a lack of physical activity.

2.5.3. Personal Factors

There is evidence in human populations that longevity tends to run in families. But, all things considered, there is general agreement that the lifelong trajectory of health and disease for an individual is the result of a combination of genetics, environment, lifestyle, nutrition, and to an important extent, chance (Kirkwood, 1996). The influence of genetics on the development of chronic conditions such as diabetes, heart disease, Alzheimer 's disease and certain cancers varies greatly among elderly. For many people, lifestyle behaviours such as not smoking, personal coping skills and a network of close kin and friends can effectively modify the influence of heredity on functional decline and the onset of disease. Psychological factors including intelligence and cognitive capacity are strong predictors of active ageing and longevity (Smits et al., 1999). Self-efficacy (the belief people have in their capacity to exert control over their lives) is linked to personal behaviour choices as one ages and to preparation for retirement. Coping styles determine how well people adapt to the transitions (such as retirement) and crises of ageing. Men and women who prepare for old age and are adaptable to change make a better adjustment to life after age sixty.

2.5.4. Physical Environment

Elderly in an unsafe environment with multiple physical barriers are less likely to get out and therefore more prone to isolation, depression, reduced fitness and increased mobility problems. Urbanization and the migration of younger people in search of jobs may leave elderly isolated in rural areas with little means of support and little or no access to health and social services. Accessible and affordable public transportation services are needed in both rural and urban areas so that people of all ages can fully participate in family and community life. This is especially important for elderly who have mobility problems. Hazards in the physical environment can lead to painful injuries among elderly. Injuries from falls, fires and traffic collisions are the most common during the old age. Safe, adequate housing and neighbourhoods are essential to the well being of young and old. The elderly are forced to migrate cities to join younger family members who have already moved there are at high risk for social isolation and poor health. Falls among elderly are a large and increasing cause of injury, treatment costs and death. Environmental hazards that increase the risks of falling include poor lighting, slippery or irregular walking surfaces and a lack of supportive handrails are preventable through proper attention and care.

2.5.5. Social Environment

Social support, opportunities for education and lifelong learning, peace and protection are key factors in the social environment that enhance health, participation and security as people age. Loneliness, social isolation and abuses greatly increase older people's risks for disabilities and early death. Inadequate

social support is associated not only with an increase in mortality, morbidity and psychological distress but a decrease in overall general health and well being. Elderly are more likely to lose family members and friends and to be more vulnerable to loneliness and social isolation. Elderly who are frail or live alone may feel particularly vulnerable to crimes such as theft and assault. Elder abuse is a common form of violence against elderly committed by family members and institutional caregivers who are well known to the victims and it commonly occurs in families at all economic levels. According to the International Network for the Prevention of Elder Abuse, elder abuse is "a single or repeated act, or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" (Action on Elder Abuse, 1995). Elder abuse includes physical, sexual, psychological and financial abuse as well as neglect. Older people themselves perceive abuse as including the following societal factors: neglect (social exclusion and abandonment), violation (human, legal and medical rights) and deprivation (choices, decisions, status, finances and respect) (WHO, 2002). Confronting and reducing elder abuse requires a multi-sectoral, multidisciplinary approach involving justice officials, law enforcement officers, health and social service workers, labour leaders, spiritual leaders, faith institutions, advocacy organizations and older people themselves. Illiteracy and high rates of unemployment are associated with increased risks for disability and death among people as they age. If people are to remain engaged in meaningful and productive activities as they grow older,

there is a need for continuous training in the workplace and lifelong learning opportunities in the community (Organization for Economic Co-operation and Development, 1998). Like younger generation, elderly need training in new technologies, especially in agriculture and electronic communication. Self-directed learning, increased practice and physical adjustments can compensate for reductions in visual acuity, hearing and short-term memory.

2.5.6. Economic Determinants

Three aspects of the economic environment have a particularly significant effect on active ageing: income, work and social protection. Many elderly women live alone in rural areas do not have reliable or sufficient incomes. This seriously affects their access to nutritious foods, adequate housing and health care. In fact, studies have shown that older people with low incomes are one third as likely to have high levels of functioning as those with high incomes (Guralnick and Kaplan, 1989). The most vulnerable elderly are those who from low income families with no assets, savings and pensions. Particularly, those without children or family members often face an uncertain future and are at high risk for homelessness and destitution. Families provide the majority of support for elderly who require help. However, as societies develop and the tradition of generations living together begins to decline, countries are increasingly called on to develop mechanisms that provide social protection for elderly who are unable to earn a living and are alone and vulnerable. In developing countries, older people who need assistance tend to rely on family support, informal service transfers and personal savings.

Social insurance programmes in these settings are minimal and in some cases redistribute income to minorities in the population who are less in need. Elderly often take prime responsibility for household management and childcare so that younger adults can work outside the home. In all countries, skilled and experienced elderly act as volunteers in schools, communities, religious institutions, businesses and health and political organizations. Voluntary work benefits elderly by increasing social contacts and psychological well being while making a significant contribution to their communities and nations.

2.5.7. Culture and Traditions

Cultural values and traditions determine to a large extent on how a given society views older elderly and the ageing process. There is enormous cultural diversity and complexity within countries and among countries and regions of the world. When societies are more likely to attribute symptoms of disease to the ageing process, they are less likely to provide prevention, early detection and appropriate treatment services. Culture is a key factor in which co-residency with younger generations is the preferred way of living. In India, the cultural norm is to value extended families and to live together in multigenerational households. The diverse in culture and tradition brings different values and attitudes towards the care and services to the elderly with in the country. It is a fact that culture predominantly influences all the other determinants of active ageing.

2.5.8. Gender Determinants

Gender is a *lens* through which the appropriateness of various policy options and how they will affect the well being of both men and women. In many societies, women have lower social status and less access to nutritious foods, education, meaningful work and health services. Women's traditional role as family caregivers may also contribute to their increased poverty and ill health in older age. 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. 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 among the female elderly (Gulati & Rajan 1997). The widowhood creates void in their familial life, even if are in the midst of all other kith and kin. Women are more likely than men to be poor and suffering from disabilities in older age.

2.6. Theoretical Approaches in Gerontology

The field of gerontology has accumulated vast amount of data over past several decades by creating enourmous potential knowledge. There has been an increase in empirical analysis but a decrease in efforts at theoretical explanation concerning population ageing and status of elderly in society (Johnson, 1996). The search for solutions without theory can lead to unchecked assumptions, lack of evaluative criteria and the inability to build upon previous

effort. Contemporary theories of ageing differ in several respects like assumption about human behaviour, matter of subject, epistemological approach and methodological approaches. The theories of ageing have been classified under biological, behavioural and social perspectives. Researchers widely accepted that theoretical progress in social gerontology has been more challenging when compare to biological and psychological theories as the social phenomena are considerably more complex and fluid (Bengtson et.al, 2005). As the framework for the study focus on sociological point of view the researcher mainly on focused social gerontological theories. There are some pioneering efforts by Hall (1922), Cowdry (1939), Linton (1942), Parson (1942) and Havinghurst (1943) to integrate empirical findings into theoretical insights became the formulations of gerontology (Bengtson et al., 1997). These empirical findings were instrumental for the development of role theory by Cottrell (1942), disengagement theory by Elaine Cumming and William Henry (1961), activity theory by Robert Havinghurst (1963) and continuity theory by Nuegartan, Havinghurst and Tobin (1968).

2.7. Role Theory and Disengagement

Role theory is one of the earliest attempts by social gerontologists to explain how individuals adjust ageing process. People play a variety of social role in their lifetimes. Such roles identify and describe a person as a social being and are the basis of self concept. They are organized sequentially and each social role is associated with a certain age or stage of life. Every society

conveys age norms through socialization and thereby become integrated into society. We are constantly adjusting to new roles throughout our lives. The elderly faces number of role dilemmas and tend to become more ambiguous. Since roles are the basis of an individual's self-concept, role loss can lead to social identity and self-esteem (Rosow, 1985). Although old age is a role loss, it can also encompass role gains and continue it throughout the life course. Role changes experienced by the elderly underlie two of the most widely debated theories of successful ageing such as activity theory and disengagement theory. Both theories postulate not only how individual behaviour changes with ageing, but also imply how it should change. Disengagement theory proposes that gradual withdrawal of elderly from work roles and social relationships is both inevitable and natural process. The theory proposes that the process of disengagement is inevitable and an adaptive behaviour. The theory argued that it was beneficial for both the ageing individual and society that such disengagement takes place in order to minimize the social disruption caused at an ageing person's eventual death (Neugarten,1996). Retirement is a good illustration of disengagement process, enabling the elderly to be freed from responsibilities and there by allowing to pursue other roles. Through disengagement, Cumming and Henry argued, society anticipated the loss of ageing people through death and brought new blood in to full participation within the social world (Powell, 2001)

2.8. Activity Theory

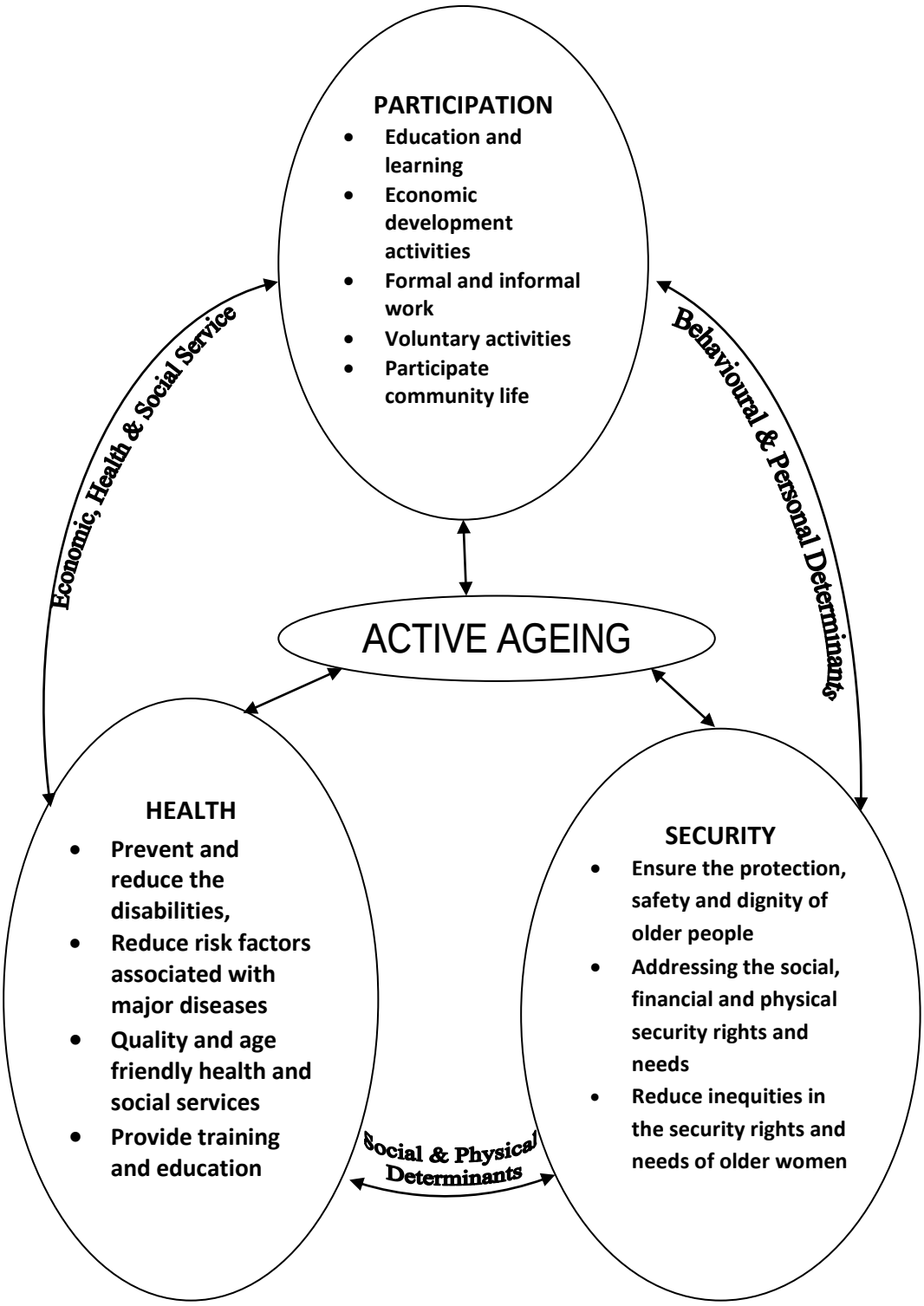
Activity theory insisted ageing can be lively and creative experience. It assumes that older people who are active will be more satisfied and better adjusted than less active elderly. Any loss of roles, activities or relationships within old age, should be replaced by new roles or activities to ensure happiness, value consensus and well-being. In order to minimize society's withdrawal from the elderly, they must deny the existence of old age by remaining active. This perspective is consistent with our society's value system, which emphasize work and productivity. The activity theory rejected the disengagement theory and stating that disengagement is not a natural process and such theory does not promote in any form of positive ageing. Thus activity was seen as an ethical and academic response to the disengagement thesis which re-casted retirement as joyous and mobile. Kastenbaum (1993) claims disengagement theory represented a threat to the promotion of a positive and involved lifestyle for ageing persons across the life course. Based on the activity theory researcher developed a theoretical framework for active ageing process. The development of multi and interdisciplinary theoretical frameworks not only better reflects the complex nature of ageing process but also represents major process in gerontology's advancement as a unique of inquiry (Alkema & Alley, 2006). The study analyzed the active ageing process in a community based organization with the help of activity theory.

2.9. Theoretical Framework of Active Ageing

Activity theory is a dominant theoretical perspective in gerontology and considered as a commonsense theory. The theory was developed from Robert Havinghusrt's (1963,1968) analyses of the Kenas City study of 300 old age people over a period of six years. The theory assumes that older people who are active will be more satisfied and better adjusted than less active elderly. Since activity theory presumes that a person's self-concept is validated through participation in roles characteristic of middle age, it is seen as desirable for older people to maintain as many middle-age activities as possible and to substitute new roles for those that are lost through widowhood or retirement. Older people must deny the existence of old age by maintaining middle age lifestyle as long as possible. The concept of active ageing and activity theory is somewhat identical and both concepts promote an active life during the period of old age. The researcher tries to assimilate the activity theory in the active ageing process by studying the Elders Self Help Groups activities in three levels such as participation, health and security. The determinants of active ageing such as social, physical, behavioural, personal, economic, health and social service have also been studied. Figure 2.3 explains the active ageing frame work through participation, health and security with the help of variety of determinants.

Figure 2.3.

Theoretical Frame Work – Active Ageing



2.10. Active Ageing and Elders Self Help Group

Several steps have been taken care for the welfare of elderly. National Policy on Older People, Indira Gandhi National Old Age Pension Scheme, Annapurna scheme,National Council for Older Persons, Vayomithram, railway and flight travel concessions, day care centres, mobile medi-care units and toll free numbers were implemented for the welfare of elderly community. Apart from these programmes, different types of community based programmes are functioning all over Kerala for the welfare of elderly. The community based programmes such as Elders Self Help Groups (ESHG), pensioner's unions, senior citizen's association and community policing provides care and support to the elderly. The present study has taken the Elders Self Help Groups to study the community based programmes in active ageing process. An active ageing frame work was developed and the pillars of active ageing have been used as the frame work for the study. The study focuses on Elders Self Help Group and how active ageing has been promoted by the ESHGs based on the components such as participation, health and security. The members in the Elders Self Help Groups were studied under the three components of active ageing. The activities of ESHGs comes under each components have been thoroughly analyzed through the active ageing frame work.

2.11. Life Satisfaction and Active Ageing

Life-satisfaction is a significant indicator to ascertain the quality of life of elderly persons. It is closely related to morale, adjustment and psychological well-being of a human being. Neugarten et al. (1961) have identified five

components of life satisfaction such as zest vs. apathy, resolution and fortitude, congruence between desired and achieved goals, positive self-concept and mood tone. 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.

Though life satisfaction a universal phenomenon, it is not a uniform experience among elderly. Some persons achieve a sense of fulfillment and satisfaction in their old-age, while others turn bitter and lament the decline of their physical abilities and social significance. Erickson (1982) asserts that old people review their past life and if they feel that most goals of their life have been fulfilled, they feel satisfied (ego-integration). Palmore and Luikart (1972) have examined a strong positive correlation between life satisfaction and level of activity among the elderly. On the other hand, Abrams (1991) records that

ageing brings negative changes in self-concept and life-satisfaction, increase in emotionality and rise in frustration tolerance. Kant and Sharma (1996) observe that females more often score low on life-satisfaction. Adelmann (1994) observes that there is a strong positive association between multiple roles and psychological wellbeing among elderly. Multiple roles like spouse, parent, homemaker, grandparent, caregiver, employee and volunteer are associated with higher life-satisfaction and lower depressive symptoms. Chadha, et. al, (1992) maintain that married elderly are found to be low on hopelessness and high on life-satisfaction as compared to their widow/widower counterparts. Ardelt (1997) asserts that wisdom has a profoundly positive influence on life-satisfaction, particularly among aged women. Though these studies provide different aspects of life satisfaction among elderly, it does not pay a focused attention on active ageing and life-satisfaction among elderly. It is evident that certain factors in active ageing are associated with life satisfaction of elderly. The theoretical framework helps to identify the life satisfaction factors associated with health, participation and security in a systematic and scientific way.

2.12. Living Arrangements and Active Ageing

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. As population ageing the living arrangements of elderly have

greater demand for formal and informal support systems. Changing family structures have an impact on the well-being of elderly and the need for well organized support systems is essential. The living arrangements have associated with active ageing components such as health, participation and security. The living arrangement of Elders Self Help Group members have analysed using the active ageing frame work.

2.13. Conclusion

Active ageing refers to the process of optimizing opportunities for physical, social and mental well-being throughout the life span. The aim is to extend healthy life expectancy and quality of life at older ages. In addition to remaining physically active, it is important to remain socially and mentally active. When elderly remain active, negative stereotypes associated with old age begin to fade. The present study developed a theoretical framework with the help of gerontological theories to examine the active ageing process in Elders Self Help Groups. The frame work also provides a close look into the factors of life satisfaction with the association of active ageing components.