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HelpAge India | Fighting isolation, poverty, neglect

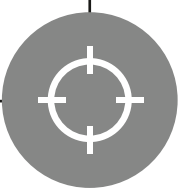
Special Edition

Intersectionality of Gender and Ageing

HelpAge India | Fighting isolation, poverty, neglect

Mission

To work for the cause and care of disadvantaged aged persons and to improve their quality of life



Special Edition

Intersectionality of Gender and Ageing

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Editorial

Nuances of Ageing in India: Experiences of Older Women

Dr Mala Kapur Shankardass *

The intersectionality between gender and ageing raises concerns on many pertinent issues, as certain striking differences are noticeable among men and women in terms of experiences of ageing. Ageing of population across the world indicates that women live longer than men and as life expectancy is rising and the sex ratios favouring women is widening, though there are variations among nations.

On-going research on morbidity patterns, care needs, and coping responses indicates that men and women age differently. It is encouraging that HelpAge India through the medium of this journal is focusing on some aspects that highlight few critical dimensions of intersectionality between gender and ageing. Though the articles included now are limited but we are hopeful of covering more articles in the forthcoming volumes.

Available literature points that many physical, psychological, emotional and social differences can be seen in the lives of older men and women. As compared to men, older women are more likely to have had a lifetime of disadvantage, that impacts on bringing in gender differences in coping mechanisms, using available services for treatment and long-term care, and above all taking into consideration societal responses to address ageing concerns.

The four articles included in this edition point towards the significance of some such aspects and stress on the relevance of taking into account gendered dimensions of ageing. The significance of taking into account vulnerabilities of older women is highlighted by Anu Mohan, Teddy Andrews J, and Lena Ashok in their article published here as it influences how they react to ageing and construct coping responses through spirituality or otherwise. This pivotal dimension can encourage readers to think about how women manage old age and what kind of gender differences exist in ageing experience. This article based on community approach compliments an important contribution by Renny Thomas highlighting aspects of institutional care and issues of quality of life for both older men and women and the differences seen in care provided in paid versus unpaid services. The question which is becoming pivotal in the field of ageing studies is how to improve

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professional services for better quality of life of older men and women and build adequate policy initiatives towards achieving this both at the community and institutional levels.

I am hopeful that readers will think about exploring dimensions of gender and ageing from varied perspectives as there is need to capture data to reflect on various crucial aspects, some more of which will be highlighted in the next edition.

As India is ageing, building responses towards changing demographics, and addressing concerns related to provision of institutional care facilities is growing. The changing family structures, migration patterns, technological developments and expanding care requirements demand rethinking on improving facilities in age care institutions, especially from the perspective of providing quality services that can improve lives of older men and women based on their specific needs defined by gender and other differences. The article by Dr. Sahaja Nagisetty, and Dr. C.T. Anitha makes a contribution towards influencing readers to think about how to provide for holistic and person-centred care that can enhance the well-being and quality of life of older men and women. The last article included in this volume draws attention to the epidemiological transition happening that is leading to rise of diabetes among the older population which requires addressing various public health challenges and especially in the context of improving quality of life. Patlolla Sriram Yadav, Gooty Shirisha, and Dr, Ajitha Katta by keeping focus on intersectionality between gender and ageing throw light on this crucial concern through understanding differences in health disparities between sexes and appealing for appropriate inclusive and effective health care strategies.

Quite clearly, this particular edition of the journal invites attention to critical aspects of gender and ageing intersectionality that can encourage future developments in the field. I am hopeful that readers will think about exploring dimensions of gender and ageing from varied perspectives as there is need to capture data to reflect on various crucial aspects, some more of which will be highlighted in the next edition.

Spirituality and Long-Distance Care: Perspectives and Experiences of Community Dwelling Older Women in Kerala

Anu Mohan* Dr. Teddy Andrews J and Dr. Lena Ashok*****

Abstract

Spirituality is a multi-dimensional construct that extends to achieving transcendence, adding inner meaning, and dealing with life adversities in later years. Spirituality and religious practices are found to have a significant impact on influencing positive aging by providing a source of emotional support in the twilight years in addition to various socio-demographic parameters such as age, gender, living arrangements, health status, and income indicating added vulnerabilities among women who live alone or with their spouse outside multigenerational residence. However nuclearization, urbanization, and youth migration in conjunction with increased widowhood have resulted in the emergence of families where older women are left behind or live with their spouses. Despite the rise in the number of older adults living outside the co-residence, there is a paucity of evidence on the role of spirituality in the context of distance care among community-dwelling older women.

The present study aims to explore how spirituality shapes the experiences of long-distance care received by older women who live alone or with their spouses.

A qualitative approach is used to explore the perceptions of 12 community-dwelling older women above 65 years of age through in-depth Interviews using purposive sampling across three districts in Kerala. Thematic analysis was performed using NVivo to gather insights on the role of spirituality in later life.

Spirituality is found to have a significant impact in fulfilling later years. The companionship of God, the positive influence of religious practices, and firm faith in God's will and non-religious forms of spirituality are crucial in dealing with daily life demands as a distance care receiver. More programs and provisions to foster spirituality among older women are vital in promoting positive aging during later years.

Keywords: Older Women, Spirituality, Long Distance Care, Positive Ageing

Despite the rise in the number of older adults living outside the co-residence, there is a paucity of evidence on the role of spirituality in the context of distance care among community-dwelling older women.

Introduction

Spirituality is regarded as a multi-dimensional concept closely related to life's inner strength, meaning, and

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purpose of life, especially during later adulthood.The South Asian landscape of religiosity and spirituality is pivotal in mediating existential and adaptational patterns where spirituality is expected to grow prominent in its twilight years. (Muhammad 2022; Saleem & Dr. Khan, 2015). According to Miller and Thoreson (2000), spiritual practices, beliefs, and experiences shape spirituality and cultivate inner strength, especially during emotional, and physical stress bereavement, and grief (Saleem and Khan, 2015). Though the impact of spiritual beliefs is subjective, recent studies have established an increase in spirituality with age, owing to the changing perceptions and practices on emotional well-being.. (Jaihind J et al., 2023).

Several programs have been established to support older adults, helping in areas such as healthcare, social security, and caregiving. However, In the absence of social institutions that provide old-age insurance, older adults have to rely on families to sustain their later life.

Spirituality refers to the ultimate meaning in life which is mediated through intimacy and relationship to God or others; religion includes prayer worship, reading of scripture, and meditation in addition to arts, dance music, and poetry. Researchers define spirituality as a dynamic quest for meaning in life, truth, and peace (Zimmer et al., 2016).For many researchers, spirituality encompasses religiosity which involves devotion, practice, and participation in religion. Religiosity involves institutionalised religious participation whereas spirituality is often less structured and more personalised (Iddagoda and Opatha 2017).

Spirituality and religiosity in later life are found to have a significant impact on life satisfaction, emotional well-being, and happiness among older adults in India. (Saleem & Dr. Khan, 2015; Singh, et al., 2020). A cross-sectional survey conducted among 31,464 older adults in India using LASI Data, reveals that religious older adults are less likely to develop cognitive impairment when compared to their nonreligious counterparts. Similarly, the prevalence of depression is found to have a negative correlation with spiritual intelligence implying the significance of spiritual engagement in later life – (Roy et al., 2021). A qualitative exploration by (Malone & Dadswell, 2018) concludes the role of positive spirituality in making adaptations in later life, especially during ill health and distress. Spiritual outcomes in later years are crucial in regulating tolerance, proving self-actualization, and finding inner meaning in later years (Varun 2024).

In India, caregiving for older adults is regarded as a joint effort of core social institutions and families.Though families continue to act as a source of support, Urbanisation, Nuclearisation, and youth migration have catalyzed the emergence of families where older adults live alone or with spouses and receive long-distance care from their children. Several programs have been established to support older adults, helping in areas such as healthcare, social security, and caregiving. However, In the absence of social institutions that provide old-age insurance, older adults have to rely on families to sustain their later life. However, the intersection of solitary living, gendered vulnerabilities, and distance from caregivers significantly shapes the aging process (Powell and Cook, 2021).

Long-distance care is defined as an emerging living arrangement where older adults live outside intergenerational residences due to the out-migration of their adult children and receive distance and virtual care

from their kin settled outside the state or country. Living alone in later years is one of the four vulnerabilities in later life (Banerjee, 2021; Cudjoe, 2020) implying the risk of neglect, loneliness, and isolation associated with solitary living.

As women have a higher life expectancy, the proportion of women who live alone is higher than their male counterparts indicating weak long-term care utilisation, and higher rates of abuse and neglect as well as poor quality facilities (Nair et al., 2021).Though there is no universal intervention to alleviate loneliness, spirituality is found to have a robust impact on defining social connectedness and a sense of purpose in later years. Furthermore, widowhood and dependency add gendered vulnerabilities indicating further complexities associated with ageing.

Existing studies reveal that women possess more spiritual beliefs, composite spirituality, and spiritual involvement when compared to their male counterparts implying the need for a comprehensive investigation into the gendered dimensions of spirituality. Though religion and spirituality are accepted as a unique determinant of well-being among older adults, there is a paucity of research on the same, especially in Kerala, where the estimated projection in the proportion of older adults is higher than the national average (Muhammad, 2022). Hence the present study intends to explore the experiences of spirituality among community-dwelling older women who are living alone or with their spouses due to the out-migration of their adult children.

Materials and Methods

Study Design

A qualitative approach was used to explore the perceptions and experiences of older adults on spirituality in the context of long-distance care by interpreting the meaning of the social reality constructed by the participants '(Jaihind Jothikaran et al.,2023).

Study Setting

Based on the number of migrant households, older adults' population, and the percentage of them living alone, the study was conducted across three geographic zones of Kerala - Pathanamthitta (South Kerala), Thrissur (Central Kerala), and Kannur (North Kerala) using a qualitative approach. Participants within the inclusion criteria across the selected districts were interviewed to gather their insights on spirituality in long-distance care. The participants were recruited across three districts: Koipram Panchayath of Pathanamthitta, Arimpur Panchayath of Thrissur, and Koothuparambu Municipality of Kannur, which were selected purposively. These districts were selected to ensure geographical representation across southern, middle, and northern Kerala, respectively.

Sampling

Twelve older adults above 65 years of age and living alone or with a spouse for a minimum of one year due to the out-migration of their children were identified and recruited using purposive sampling with the help of Local self-government, non-government organisations, and religious groups. Participants were interviewed using a semi-structured interview guide to

the present study intends to explore the experiences of spirituality among community-dwelling older women who are living alone or with their spouses due to the out-migration of their adult children.

explore their experiences and perceptions of spirituality in dealing with distance care. 12 participants between the ages of 65 and 83 across different socio-demographic profiles were interviewed until data saturation to ensure heterogeneity of responses. Older adults with major physical and mental impairments and those with children who have children migrated to other districts of Kerala were excluded from the study.

Data Collection

The tool was developed in consultation with field experts followed by translation into Malayalam (vernacular language)

Data collection was performed from 2023 April to 2023 August. In-depth interview guides were prepared using the insights from previous literature, and pilot study. The tool was developed in consultation with field experts followed by translation into Malayalam (vernacular language) The protocol and tool were approved by the Internal Ethics Committee with IEC1:248/2022. The administrative permissions to conduct data collection across their districts were obtained from the Directorate of Panchayath and respective district directorates.

All the interviews were conducted at the residence of the participants after obtaining permission through prior appointments. All interviews were recorded after obtaining informed consent from the participants.

The in-depth interview guide had the following components; socio-demographic features (living arrangement, annual income, medical conditions, health status, place of migration of their children, and frequency of visits by children), perceptions of long-distance care, dealing with the solitary living, role of spiritual practices, support received from religious and nonreligious interventions, etc. Field notes were prepared to capture additional information along with the interview recordings.

Data Analysis

The audio recordings of the interviews are transcribed and translated into English manually. Coding of the transcribed files was performed using Nvivo version 29. Thematic analysis was performed to derive further insights into the influence of spirituality in distance caring. Data was analyzed and presented using thematic analysis which is a tool to unearth the relationship between themes and subthemes (Mcmanus 2024). Broader themes were generated by clubbing similar themes.

Result

The demographic details of the participants are given in Table 1.

Table1: Socio-Demographic Details of the Participants

Demographics	Number
Age (in years)	
65-69	5
70-79	5
80 and above	2
Religion	
Hindu	5
Muslim	1
Christian	6

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Demographics	Number
Occupation	
Homemaker	5
Retired pvt. employee	3
Retired state/central govt. Employee	2
Returned from Gulf/abroad	2
Marital status	
Married	7
Widow	5
Regular medication	
Yes	8
No	4
Physical mobility	
Healthy and Mobile	8
Assisted Mobility	4
Number of children	
1-2	10
3-4	2
Type of migration of adult children	
Internal	2
Internation	6
Both	4
Availability of paid caregiver	
Full time	3
Part-time	2
No paid caregiver	7

Conceptual Framework: Spirituality and Long-Distance Care

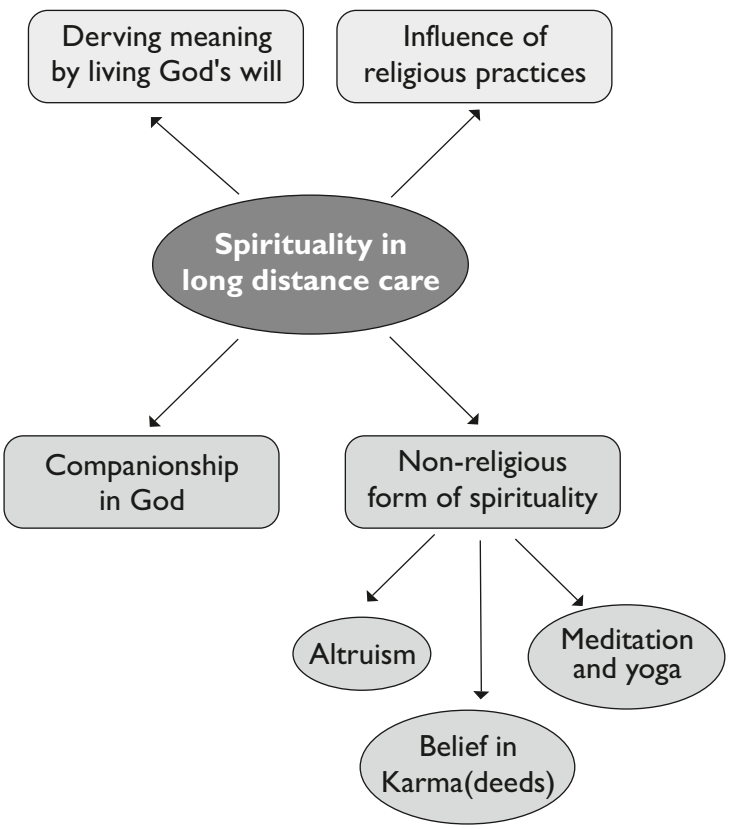

Fig 1: Conceptual Framework

Thematic analysis of the responses of participants on the role of spirituality in dealing with distance care has revealed the following themes: the Influence of religious practices, Living God's Goodwill in later years, Companionship in God, and Non-religious forms of spirituality.

Theme 1: Religious practices in daily life

The Participants believe regular religious practices bring peace and order to the households. These engagements in spiritual activities include prayer, pooja, and attending holy mass improves tranquillity. The religious routines followed in the households were considered a source of inner strength and peace which were crucial when people grew old alone. A 65-year-old female participant shared how the spiritual practices performed by her husband implicitly contributed to the households. She stated her experience as follows

"*My husband wakes up a little early and he visits the temple every day. After 6 pm he will finish with his trading and business followed by evening prayer. He does pooja every morning even though I cannot do it like he does. His way of living brings much peace to our home. He believes in the power of prayer in keeping us safe and well while we grow old all away from our children"* (P1-65-year-old female)

Practising regular habits including prayer, and visits to churches and temples brings stability and order to their lives even when they live away from their children.

These religious practices seem to bring them closer to God, and making prayer a life routine keeps them connected to God. Several participants acknowledged the importance of prayer finding a balance during the twilight years. A 74-year-old female participant stated her view on prayer as follows

"*I Pray for some time. Will read the bible for some time. Reading through the bible helps me to pass time at ease. Also watching prayer ceremonies on Shalom TV makes me feel like I'm closer to God. It is the strength that keeps me moving*" (P3-74-year-old female)

Similarly, a 76-year-old female participant stated the significance of prayer even in her 70s. Going to church either for morning or evening mass was considered a source of support that kept them strong even when they fell sick. When asked about the role of spirituality she stated:

"*I will go to church if possible. If not, I will pray at home. And on the days when I could not go to church in the morning, I would go to mass in the evening. Prayer gives me strength when I feel sick and weak*" (P6-year-old female)

Religious participation was held important by several participants. The participants who could not visit places of worship due to their living arrangements led alternative religious practices such as attending retreats and prayers on TV. A 69-year-old female stated:

I watch prayer and retreats on Shalom TV so that I will not miss prayer services even when nobody takes me to church. I spend most of my day in front of the TV enchanting prayers and attending speeches by eminent priests (P12 69-year-old females)

In general, several participants considered the religion and related rituals including prayer as a source of inner strength irrespective of their age and socio-demographic characteristics. Practising regular habits including prayer, and visits to churches and temples brought stability and order to their lived even when they live away from their children.

Theme 2: Focus on fulfilling God's will

Just like the importance of religious practices, several participants believed that life in later years should follow the will of God no matter with whom we stay. Irrespective of where they were

and with whom reside several participants found meaning in life by seeking to live the will of God. This relationship with God is remarked to have a vital influence in dealing with life adversities while living alone or apart from their children. When asked about the role of spirituality in dealing with long-distance care 81-year-old female stated:

"I am a person who believes that God's will has to be done in our last days no matter who stays with us. The later years of our lives should follow the will of God, the one who created us. I pray to God to fulfill his plans for my end of life more than anything else. Even though my children are far away I have strong faith in the script god has made for me." (P11-81-year-old female)

Faith in God was the source of inner strength and optimism for a few participants. As a couple and family, the firm belief in God has helped participants in navigating life challenges including ill health and distress. A 65-year-old female participant who was a cancer survivor stated how her husband's spirituality influenced them to be hopeful during life adversities. She shared the implied influence of spirituality.

"My husband is a firm believer in God. His faith in God is a great support for me. Even if I am worried about something, he can deal with such situations in a very positive way matter how much I don't believe in God, often his faith seems to influence our lives somewhere. As a couple, his belief and prayer have been instrumental in our lives especially when I was diagnosed with cancer years before. His belief and consistent optimism give us strength to face whatever comes in our lives. He always believes in *Plans God has made for us"* (P2- 65-year-old female)

For several participants, the struggles, and experiences of living apart from their children were regarded as God's plan rather than a choice. They firmly believed in what God has destined for them in their later years and this foundation was crucial in dealing with the demands and crises of day-to-day lives.

Theme 3: Companionship of God

Even when participants grow old alone, many of them derive a sense of fulfilment from the companionship of God. Several interviewed participants acknowledged that the feeling of closeness with God made them feel safer rather than anyone else around. The participants strongly believed that God will lead them through the ups and downs of their lives even when children could not spare time for them. A 76-year-old participant remarked that life in later years should be invested in enchanting God's goodwill rather than complaining over the things that they do not have. She stated:

"I am a person who believes that no matter who is with you, ultimately it is God who should be with you. I thank the almighty for the blessing rather than complaining over the things I do not have now. It is the companionship of God that drives us no matter who all are there for us. Even though my children are far apart I have strong faith that my prayer will be heard and I will be guided even in my darkest days. (P6- 76-year-old female)

Most of the participants did not have futuristic aspirations as they were awaiting God to follow his Goodwill in their lives. Several participants had shown an acceptance of the fact that children could not live with them for long. This acceptance was crucial in

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shaping the relationship and companionship with God. An 80-year-old female admitted that the only companionship she needs is from God stated:

"I want to continue like this for as long as God allows me to live alone. I do not believe that my children can stay around me anymore,All I wish for is the companionship of God until I pass this world"(80-year-old female)

Participants consider old age as a reflection of how they did their lives when they were healthy financially and physically. Most of them consider altruism, Karma(deeds), and self-care practices such as meditation to have far-reaching effects in their later lives.

For several participants, it is God's plan that keeps them moving every day even though they live far from their children. As long-distance care receivers, God has blessed them with health and wellness to date which helped them to live a life without bothering their children. She believed that because of her firm companionship with God, she was able her life alone till now. She shared her perception of spirituality in later after years:

"I Consider it a blessing from God to be able to pass every day without much hassle. When we live alone it is health that matters most and till the moment God has given me the strength to pass each day without bothering my children abroad" (P9: 76-year-old female)

In brief, with age, several participants entrusted in the Goodwill and companionship of God. They felt that even their children can't do much in their later life when they lived miles apart. Companionship and meaningful connection with God are what fulfill them rather than materialistic care and the people around them.

Theme 4 : Non-Religious Spirituality

When most of the respondents had a firm belief in God's plan, several participants also believed in reciprocating deeds. The participants considered old age as a reflection of how they did their lives when they were healthy financially and physically. Most of them considered altruism, Karma (deeds), and self-care practices such as meditation to have far-reaching effects in their later lives.

Altruism

For several participants, helping others was regarded as a way of fulfilling their good will to God and others. These participants derived a sense of fulfilment by doing charity and making regular visits to old age homes where left behind older people lived together. A 77-year-old participant stated that she derived meaning from her life by being kind to others and helping those in need. She believes that deeds were stronger than prayers. Her perception about altruism is stated :

"My everyday wish is to be able to help as much as I can. I find happiness in helping others, even if it is a small help. Being kind to others is the best way to find inner meaning. Deeds go beyond prayers. So, I believe in doing good to feel good" (P4-77-year-old female)

Similarly, a 67-year-old participant stated her positive attitude towards helping others as the only productive thing she could do.

"In these later years, the only thing I can do is to help others in need and I try my best to do it whenever I can" (P8-67-year-old female)

Belief in karma(deeds)

Several participants believed in deeds that come back in one way or the other. Being a distant care receiver who lives apart from their children, several participants believed in the impact of

deeds that reciprocate in life. A 71-year-old participant shared that doing good to others is the only way to get fulfilling rewards in later life. She believed that having alternate sources of support while she lived alone was the result and reward of her past deeds. It is the faith in deeds that pushed her forward over the faith in God. She stated:

"I believe in deeds that come back to us. I have seen my father and ancestors being generous to the people around me. I have tried my best to help others in need when I was able enough to do so. Now when I feel weak, I receive support and love from people around me. I believe that deeds reward more than anything we have. If you do good you will receive good.That is what I believe in. Rather than my faith in God, I believe in the power of deeds (P10-71-year-old female)

Similarly, few participants acknowledged the long-term impact of karma. Several participants believed that if they had done good or offered help when we could do so, it would be reciprocated sooner or later.That could return in the form of people who helped them when they lived apart from their children and couldn't do things for themselves. A 74-year-old distant care receiver who lives alone believe s in the impact of actions and the importance of being harmless. She stated:

"I cannot do much at this age. Still, I feel if someone is taking care of me when I am not well it is because me or my ancestors might have done the same when someone else needed a helping hand. Karma will play its role sooner or later. So, all I try to do is to be harmless even though we cannot help much" (P3-74-year-old female)

Meditation

For a few participants, self-care routines including yoga and meditation were found to have an influential impact in managing their lives through stress and storms. Participants stated that meditation, yoga, and similar practices were beneficial in dealing with the anxiety of living apart from their children. When asked about the other sources of emotional support during long-distance care a74-year-old female stated:

"I used to meditate and practice mindfulness earlier. It helped me to stay composed even when struggled to manage things all alone. I was able to control my anxiety to an extent while I did meditation" (P3-74-year-old female)

Several participants acknowledged the importance of self-regulation to reduce anxiety associated with growing old alone. During the pandemic, such practices were found particularly helpful in dealing with loneliness and anxiety in later years.

"We had online yoga and meditation classes. I used to follow the same during the covid. It was indeed helpful in regulating thoughts. I want to resume the practice soon" (P8)

In brief, irrespective of religion and religiosity older adults believed in the impact of deeds and the importance of self-care practices including yoga and meditation in dealing with the struggles of later life. Altruism and charity were regarded to have a profound impact in deriving spiritual fulfillment in later years.

Discussion

The study aimed to unearth the role of spirituality among left-behind older women in dealing with later life while they grew old outside the

Participants stated that meditation, yoga, and similar practices were beneficial in dealing with the anxiety of living apart from their children.

intergenerational residence. The analysis revealed the Influence of religiosity spirituality and nonreligious forms of spirituality in mediating long-distance care among older women.

One of the major themes derived from the analysis was the influence of religious practices in old age. For several participants, a life rooted in the foundations of religious practices and rituals such as daily prayer, attending retreats, enchanting mantras, and visiting temples or churches was decisive in bringing stability amidst day-to-day chaos and demands. The findings are in line with the insights of Rainville & Mehegan (2018) indicating an implicit relationship between the practice of religious rituals and the regulation of emotions in old age (Jothikaran, 2023; Mcmanus, 2024) The implications of the global review on religiosity and spirituality argue a consistent positive association between spiritual practices and overall well-being during later life(Koenig, 2012; Zimmer et al., 2016). Aging is positively correlated with increased spirituality and belief in God, which is further evident among older women who are living alone or with spouses outside intergenerational residence.

The belief in God's goodwill profoundly impacts managing family dynamics and intergenerational relationships

Another important theme was the impact of God's goodwill in leading optimistic lived even when their children live miles apart. The belief in God's goodwill profoundly impacted managing family dynamics and intergenerational relationships as stated by Jaihind Jothikaran et al., (2023).Robust feelings about living God's Goodwill were pivotal in accepting and adjusting to the current living arrangement, irrespective of their socio-demographic determinants. The present findings seem to be consistent with the arguments on the impact of religious support, faith, and God-mediated control in later life in reducing the level of depression in old age (Shaw, Gullifer, and Wood 2016; Upenieks, 2023).However, Thauvoye et al., (2018) suggests contradictory findings indicating depressive feelings predict attachment to God, instead of the other way around.

Another notable theme derived through the analysis was the firm belief in the companionship of God irrespective of the living arrangement. Older women were often perceived to be more spiritual when compared to their male counterparts and they tend to rely on the divine connection with God in dealing with the challenges posed by loneliness. Similar findings were observed by Scholarworks & Hardenberg, (2017) arguing the significance of faith in God among older women while navigating through the challenges in later years of life.The belief in the holy companionship with God often extends to their perceptions towards death.

Several participants perceived the sense of spiritual connection with God makes them less anxious about their current living arrangement leading to more fulfilling lives. This belief was further strengthened by their comfort of ageing in a place where everything was familiar even when they grow grey all alone.

The existing studies reported that older adults living alone were more depressed and less healthy. Furthermore, older adults living alone are reported to experience a significantly higher

spirituality than older adults living with family members which is positively related to mental health among older adults in solitary living (You, et at., 2009).The analysis revealed that the belief in God and the optimistic acceptance of later life are instrumental in managing the emotional turbulence of growing grey. Nonreligious forms of spirituality including helping others in need, practicing self-regulation through yoga and meditation, and belief in the effect of deeds were held significant by several participants while they grew old.

Being spiritual was not necessarily associated with belief in religion and God. However, several broad dimensions of spirituality are significant while dealing with the stress and storm of later adulthood (Stelcer et al. 2023). The existing evidence argues a significant relationship between belief in the impact of karma and subjective well-being among older adults (Anjali & Mithra, 2023). The belief in Karama increases with age, leading to a profound impact in regulating existential anxieties and purpose in later years. Similar findings were observed by Kahana et al., (2013) suggesting the contributions of Informal helping behaviors, voluntarism, and altruism in mediating satisfaction with life in later years. However, women lag behind their counterparts in terms of opportunities for active socialization leading to reduced participation in voluntary engagements. Physical impairments and declining functional capabilities hinder voluntary contributions outside the home. However, self-care practices such as yoga, mindfulness, and meditation are found to have a crucial impact on cognitive and emotional well-being in later life.

Laird et al., (2018) argue that the practice of mindful movements outperforms conventional physical exercise in terms of improving the effects of positive emotions and quality of life. The subjective choices in later years were are nonreligious yet spiritual were found to have a profound impact in meditating challenges and emotions, especially during the empty nest phases of old age.

The present study explored the experiences and perceptions of spirituality and distance care among older women in migrant and emigrant households across three districts of Kerala employing a qualitative approach. The analysis revealed that the role of spirituality is pivotal in bridging the care gap caused by the distance between the caregiver and older women in long-distance care.The connection with God, meaningful religious practices, and non-religious forms of spirituality were found to have a vital impact in mediating the hassles of virtual care. Future efforts to foster spirituality and practices such as yoga meditation and mindfulness could be effective in complementing distance care.

However, the study could not consider the impact of spirituality on solitary living particularly in the context of intra-district migration and childlessness. Further studies can explore the intersection of spirituality living arrangements and gender while growing grey.

Conclusion

As people age, increasing physical and emotional needs require more support, while long-distance caregiving can add psychosocial challenges that diminish the quality of life in later years. Women

Being spiritual is not necessarily associated with belief in religion and God. However, several broad dimensions of spirituality are significant while dealing with the stress and storm of later adulthood

Non-religious forms of spirituality such as the practice of yoga, mindfulness, and the practice of altruism are found to have a positive impact on the aging process.

experience gendered vulnerabilities such as; higher rates of depression, anxiety, and dependency as well as limited opportunities for socialization outside their homes. Religious as well as nonreligious forms of spirituality were found to have far-reaching implications among older women to deal with the various vulnerabilities. Spirituality fulfills later years by mediating the absence of physical care from their children due to distance. The companionship of God, the positive influence of religious practices, and firm faith in God's will and non-religious forms of spirituality are crucial in dealing with daily life demands as a distance care receiver. Non-religious forms of spirituality such as the practice of yoga, mindfulness, and the practice of altruism are found to have a positive impact on the aging process. More programs and provisions to foster spirituality in old age, life cycle education, and programs specific to address the diverse concerns of isolated women are vital in promoting positive aging among older women during later life.

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Quality of Life (QOL) of the Institutionalised Elderly: A Comparative Study

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Abstract

This paper investigates the Quality of Life (QOL) of institutionalised elderly by employing a comparative study conducted in three districts of Kerala, namely Kottayam, Alappuzha, and Pathanamthitta. Using the Purposive Sampling technique, the researcher selected 60 respondents, with 30 from both paid and unpaid homes. The WHOQOLQuestionnaire was used to measure the elderly's QOL. Quantitative data were coded, tabulated, and analysed using SPSS, with Correlation, T-test, and ANOVA employed for the analysis.

The study emphasises the role of the living environment in shaping the QOL of the institutionalised elderly. The findings revealed that institutionalised elderly residing in paid homes experience a higher quality of life compared to those residing in unpaid homes. This difference could be attributed to the superior facilities provided by paid homes, including separate accommodation, home nursing services, improved dietary options, and enhanced recreational amenities. The majority of respondents reported a "Good" QOL.

The study suggests that institutions catering to the elderly should consider appointing professional social workers to enhance their Quality of life. Such professionals could play a crucial role in addressing the psycho-social and emotional needs of the elderly residents. The study not only highlights the disparities between paid and unpaid homes; but also advocates for integrating professional social work services to further improve the well-being of the elderly in institutional settings. The findings are crucial in the context of the massive migration of young people to foreign countries, suggesting potential implications for policy formulation related to elderly care in regions experiencing demographic shifts.

Keywords: Quality of Life, Institutionalized Care, Elderly, Professional Social Workers, and Migration.

The study emphasises the role of the living environment in shaping the QOL of the institutionalised elderly. The findings reveal that institutionalised elderly residing in paid homes experience a higher quality of life compared to those residing in unpaid homes.

Introduction

Population ageing is a permanent demographic reality, driven by longevity and fertility decline. The global elderly population is expanding faster than the general population due to decreased fertility, reduced mortality, and

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increased survival at older ages (International Institute for Population Sciences (IIPS) & United Nations Population Fund (UNPF) 2023). The EAC-PM's Quality of Life for Elderly Index predicts a rise in the proportion of seniors in the nation's population from 7.5% in 2001 to almost 12.5% by 2026 and surpassing 19.5% by 2050(EAC-PM, 2021). According to the UNFPA Report, 2023

- Decadal growth rate of 41% for the elderly population in India
- Increasing life expectancy and declining fertility rates contribute to a global ageing population trend.
- About 40% of India's elderly population is in the poorest wealth quintile, and around 18.7% live without income.
- The high poverty level among the elderly can significantly affect their QOL and accessibility to healthcare services.

The majority of southern Indian states, including Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu (Alam & Karan, 2011), as well as a few northern states, including Himachal Pradesh and Punjab, reported a higher percentage of the elderly population in 2021 than the national average; by 2036, this difference is predicted to increase. In Kerala, the share of the elderly population is projected to increase from 16.5 per cent in 2021 to 22.8 per cent in 2036. (IIPS & UNPFA, 2023). Elderly individuals often prefer to live in their own homes for care, especially when their children are away or if they seek personal space. However, for unmarried, widowed, or widowed elderly without children, old age homes are becoming more familiar and accepted as care homes (Gangopadhyay et al., 2022).

Several progressive policies and initiatives have been put in place by the Indian government, including the National Programme for Health Care of the Elderly (NPHCE), the Maintenance and Welfare of Senior Citizens Act, 2007 (Amendment) Bill, the National Social Assistance Programme (NSAP), the Atal VayoAbhyuday Yojana (AVYAY), and the national helpline Elderline. It also addressed the needs of the elderly with the National Policy on Older Persons in 1999(Wojnar, 2023).

The United Nations Decade of Healthy Ageing: 2021-2030 (2020) aims to improve lives, families, and communities of the elderly. The 2030 Agenda for Sustainable Development seeks to ensure everyone can fulfil their potential with dignity and equality. The 73rd World Health Assembly endorsed the proposal, and the United Nations General Assembly proclaimed 2021-2030 the Decade of Healthy Ageing. WHO is leading this work in collaboration with other international and regional organisations.

The high poverty level among the elderly can significantly affect their QOL and accessibility to healthcare services.

Problems of the Elderly

The ageing population is a global phenomenon, and with it comes the growing concern for the well-being of older people, particularly those residing in institutional settings. India is undergoing a significant demographic shift with a rapidly growing elderly population, expected to make up a substantial portion of the total population by 2050. This demographic change poses economic and social challenges, particularly for older women and those living in poverty. Abuse of older people is a growing international

problem and leads to several health and emotional problems. Digitisation and increasing e-governance have posed problems for the elderly.

According to Ageing in India: Exploring Preparedness & Response to Care Challenges-A HelpAge India 2024 Report (2024), which was released on "World Elder Abuse Awareness Day" (June 15, 2024); nearly 65% of elderly people cannot make ends meet with their current income, savings, and investments. The research brings out the 'unpreparedness and inadequacy' amongst the elderly in India in terms of access and knowledge to utilise essential services across numerous sectors to lead a dignified life. The survey found financial inadequacy amongst elders, with one out of three elders not having any source of income in the last year, higher amongst women (38%) than men (27%). Only 29% of the elderly are having access to social security schemes, such as provident funds, old-age pensions, or contributory pensions, whereas 32% of the elderly or their partners earn less than Rs. 50,000 annually (HelpAge India, 2024).Due to financial issues, the poor elderly must keep working for their livelihood, even in old age.

The research brings out the 'unpreparedness and inadequacy' amongst the elderly in India in terms of access and knowledge to utilise essential services across numerous sectors to lead a dignified life.

Feminisation of Ageing

Women are more likely than males to spend a more significant portion of their lives ill or disabled, especially as they age. Chronic illnesses (including depression, osteoporosis, and arthritis) have a negative impact on quality of life and are more common in older women than in older men. Financial instability in old age can be exacerbated by the fact that elderly women are more likely than elderly men to be widowed, to live alone, and less likely to remarry (Ginette, A et at., 2023)

India has the highest number of widows globally, with around five crore widowed women, according to the World Widows Report from The Loomba Foundation (2016). The prevalence of widowhood is expected to increase due to the increasing elderly population and longer life expectancy of women. India and China accounted for 35.2% of the total widows worldwide in 2015. India is more concerned about widows' well-being than China due to lower education levels, more profound and more widespread extreme poverty, widespread severe malnutrition, poor sanitation, lack of clean drinking waterand low employment rate.The rise in widows can be attributed to age differences, life expectancy differences, and the proportion of men and women remarrying (Gulati, 1993).

In 2023, women aged 55-59 were more likely to live in extreme poverty than men, with 8% living in poverty. Many women reach old age with inadequate resources and lack pension or social safety benefits, leading to job interruptions, part-time employment, lower salaries, and more time spent on unpaid care. Universal pension access is available in 56 out of 116 countries, but women's pension coverage lags behind men's in 47. Older women often face emotional, financial, and physical abuse and social isolation, but complete information is lacking (Ginette Azcona et al., 2023).

In India, societal norms suggest that females are more caring than males, leading to a perception that females are more satisfied with care. This is especially true in old age when marginalisation and diminishing power due to physical or cognitive incapacities

necessitate care. Male elder people are less satisfied with care than their earlier attentive care, while females are more satisfied, leading to better quality of life (QOL) and better social adjustment and intra-generational-interpersonal relationships among female elderly individuals(Gangopadhyay et al., 2022).

Quality of Life of the Elderly

Quality of life (QOL) is multifaceted and encompasses various dimensions that contribute to an individual's well-being. QOL includes those aspects of life and human function deemed essential for living fully. This implies a holistic approach, considering basic needs and factors contributing to a fulfilling and meaningful existence.

WHO defines Quality of life as "(an) individual's perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards and concerns. It is a broad-ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships and their relationship to salient features of their environment."(WHO, 2004).

Bowling et al. (2013)identified that older people's perspectives on QOL may change between community and aged care settings. The community-dwelling elderly value an optimistic perspective, good health, psychological well-being, social contacts, recreational activities, neighbourhood resources, required funds, and independence. Age care home residents emphasise physical comfort, functional competence, privacy, autonomy, dignity, meaningful activities, significant relationships, and safety. The views of the elderly on the QOL can also differ according to their gender, ethnicity, health, and socio-demographic background.

QOL is influenced by various factors such as physical health, psychological well-being, social relationships, financial stability, and environmental factors. Understanding and evaluating QOL becomes crucial, especially in vulnerable populations like institutionalised elderly individuals, as it informs interventions and policies to enhance their well-being.

This study aims to investigate the QOL of institutionalised elderly by examining their socio-demographic profile, including age, gender, religion, marital status, number of children, educational qualifications, family type, previous employment, residence, income, source of income, mode of residence, and duration of stay in the institution. The study also seeks to understand the relationship between these socio-demographic variables and their Quality of Life.

Material and Method

This Quantitative cross-sectional study was conducted in Kerala's three districts: Kottayam, Alappuzha, and Pathanamthitta. Kerala was selected due to its demographic shift, defined by its rapidly ageing population and well-established network of elderly homes. The districts - Kottayam, Alappuzha, and Pathanamthitta - represent different socio-economic settings within Kerala. These places have an enormous elderly population and paid and unpaid geriatric care facilities. Using the purposive sampling technique, the researcher selected 60 respondents, with 30 from both paid and unpaid homes, for a comparative study.

The views of the elderly on the QOL can also differ according to their gender, ethnicity, health, and socio-demographic background.

The QOL Questionnaire developed by the World Health Organisation was used to measure the elderly's QOL. Cronbach's Alpha of 0.886 indicates high statistical reliability of the scale. It is a widely used, internationally standardised instrument for assessing quality of life (QOL). It comprises 26 items across four domains: physical health, psychological, social relationships, and environment. Translated into over 30 languages, it suits clinical and community-based research. It is used in many countries to evaluate QOL in various populations, including patients with chronic diseases, older adults, and those with mental health conditions.

Institutions are more likely to house elderly individuals with declining physical or cognitive capacities, which require long-term care.

IBM SPSS (Statistical Package for Social Sciences) Statistics 22 was used to code, tabulate, and analyse the data obtained. The Independent Samples t-test, Welch Test, ANOVA and Chi-Square Test were done to examine any significant difference between the respondents' socio-demographic profile and QOL. Both primary (questionnaire data) and secondary sources (journal articles, book chapters and reports) were used for this study.

The researcher informed the participants about the purpose of the study, their right to participate in / withdraw from the study, confidentiality of data, and willingness of the researcher to share the results and findings of the study with the respondents, and sought permission to use it for academic purposes.

Results and Discussion

Table 1 depicts the socio-demographic distribution of the respondents. It reveals that most respondents were 70-79 years old, with a higher proportion of older seniors. Institutions were more likely to house elderly individuals with declining physical or cognitive capacities, which require long-term care. The gender distribution was nearly balanced, with 51.7% male and 48.3% female. This contrasts with the trend of feminisation of ageing in India, where women typically outlive men(Chauhan & Rathore, 2022).

The religious composition of the sample is predominantly Christian (63.3%), followed by Hindus (31.7%) and Muslims (5%). This could reflect Kerala's religious demographics and its historical association with institutional eldercare services run by Christian organisations. Religious affiliation may also influence attitudes towards institutionalisation and familial caregiving.

The marital status of the respondents is a significant predictor, with 63.3% being married, 28.3% unmarried, 5% divorced, and 3.3% widowed. This indicated that institutionalisation may not always result from being without family support but might stem from other factors like health needs or preferences for specialised care. The low representation of widowed individuals contrasts with the feminisation of ageing, which often correlates with widowhood, highlighting potential cultural or financial reasons preventing widow institutionalisation (Ginette, A et al., 2023)

Elderly individuals without children are more likely to seek institutional care due to a lack of familial caregivers. In contrast, those with more children may enter institutions due to strained family dynamics, migration, or an inability of children to provide adequate care.

Table 1 : Socio-Demographics of the Respondents

Variables	Categories and Percentages
Age	60-69 yrs. (25.0), 70-79 yrs. (43.3), 80 yrs.& above (31.7)
Gender	Male (51.7), Female (48.3)
Religion	Christian (63.3), Hindu (31.7), Muslim (5)
Marital Status	Married (63.3), Unmarried (28.3), Divorced (5),Widow (3.3)
Number of Children	Nil (38.3), One (8.3),Two (23.3),Three & above (30)
Educational Qualification	Illiterate (18.3), Primary (38.3), Matriculation (16.7), Higher Secondary (5), Graduation (13.3), Professional (8.3)
Family Type	Nuclear (58.3), Joint (41.7)
Previous Employment	Govt. Employed (13.3), Business (1.7), Unemployed (36.7), Others (48.3)
Place of Residence	Rural (61.7), Urban (5), Semi-Urban (33.3)
Income Per Month	Nil (50), Rs 2000-5000 (16.7), Rs. 5000 & above (33.3)
Source of Income	NA (50), Pension (16.7), Fixed Deposit (26.7), Children (5), Relatives (1.7)
Mode of Residence	Paid (50), Unpaid (50)
Duration of stay	Below 1 yrs. (21.7), 1-3 yrs (33.3), 3-6 yrs (20), Above 6yrs (25)
Quality of Life	Average (35), Good (65)

The inferential statistical analysis highlights the relationships between socio-demographic variables and the Quality of Life (QOL) of institutionalised elderly.

•The institutionalised elderly enjoy a more or less similar quality of life irrespective of their age, gender, religion, marital status, no. of children, family type, place of residence and duration of stay in the institution.

•The respondents with higher secondary education (95) enjoyed better QOL than those who were

illiterate (79.3) and had primary education (78.3).

•The respondents with professional education (92.2) enjoyed better QOL than those who were illiterate (79.3) and had primary education (78.3).

•Government employees (92.8) experienced better QOL than those unemployed (82.9) or in unskilled jobs (79.9).

•Income level showed a significant difference in their QOL. Respondents with no income (76.7) enjoy less QOL than those with any income source (92.7 & 87.4).

Elderly individuals without children are more likely to seek institutional care due to a lack of familial caregivers.

•The institutionalised elderly at 'paid homes' (89.2) enjoyed a better quality of life than those at 'unpaid homes' (76.7). The paid homes provided better facilities like separate rooms for accommodation, home nurses for taking care of, better food and amenities for recreation, etc., contributing to higher Quality of life.

•A majority (65%) of the respondents enjoyed a Good QOL.

The findings illustrated the multidimensional interplay of socio-economic and institutional elements in shaping the well-being of the elderly, identifying opportunities for focused interventions to improve their living situations. Similar to observations by Bowling et al. (2013), the study indicated that paid homes offer a more conducive atmosphere for QOL due to better facilities and services. This highlighted the importance of bridging the care quality gap between paid and unpaid institutions.

Consistent with the India Ageing Report 2023 (UNFPA, 2023), income and employment history greatly influenced the QOL of the elderly. Financial autonomy, typically missing in unpaid homes, was crucial for psychological well-being and access to appropriate healthcare .

As underlined by Ginette Azcona et al. (2023), the feminisation of ageing challenges QOL considerations. Older women, often widowed and financially dependent, may confront compounded issues in unpaid homes, requiring targeted interventions.

The findings support the significance of incorporating professional social workers into eldercare, as urged by the *WHO Decade of Healthy Ageing 2021-2030. Social workers can address the psychological, social and emotional needs of the elderly.

The future studies should investigate regional variations in eldercare practices across India to understand cultural and socio-economic factors influencing QOL. The longitudinal studies could track changes, focusing on policy reforms and societal shifts. Gender-focused research is crucial for addressing challenges faced by older women, especially widows in unpaid homes. Technology-based interventions can improve psychological and social well-being among the elderly. These insights can help develop inclusive and sustainable models for institutional eldercare.

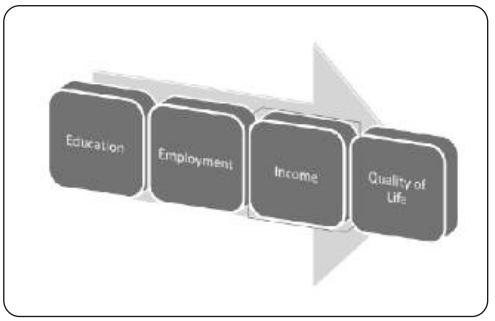

Fig. 1 Conceptual Framework

Conceptual Framework

The framework, as given in Figure 1, focuses on essential variables that influence the QOL of older people living in institutions. The following aspects are interrelated and flow from one to the other, impacting the general health and well-being of the aged.

1. Education and Awareness (among elderly and caregivers): The Quality of care given is directly impacted by the education of older people's rights, health, and well-being, as well as the knowledge of caregivers about geriatric care. Understanding available services and health literacy among the elderly or their caregivers can empower them to seek better support.

2.Employment/Engagement (Meaningful Engagement of Elderly): Older people can participate in social activities or worthwhile jobs even in institutional environments.The three components of engagement—social interaction, recreational activities, and mental stimulation—all impact psychological health and help people avoid feeling isolated.

3. Income/Resources (Financial Security): The care that the elderly in institutions receive can vary depending on the availability of financial resources. Resources impact the standard of living in several areas, including access to leisure activities, medical treatment, housing,and nutrition.

4. Quality of Life (QOL) results from combined education, employment and financial resources. For older people living in institutions, factors influencing their Quality of life include autonomy, social interactions, mental and physical health, and contentment with the care they get there.

The arrow that connects these variables shows how the availability of financial stability, employment opportunities, and education leads to the ultimate objective of improving life quality. It is possible to compare the QOL in various senior care facilities and assess the effectiveness of institutional settings using this paradigm.

Institutions are more likely to house elderly individuals with declining physical or cognitive capacities, which require long-term care.

Recommendations

•Develop programs encouraging community engagement and interaction between the institutionalised elderly and the broader community.

•Assess and address the facilities and services in free homes to improve the Quality of life for residents. This might involve collaborations with government agencies, NGOs, or private organisations to enhance the living conditions and amenities in these institutions.

•Create and promote occupational engagement programs within the institutions, catering to the diverse backgrounds and skills of the elderly residents. This could include vocational training, skill development, or even recreational activities to keep them mentally and physically active.

•Develop programs to enhance the

educational opportunities for the institutionalised elderly, especially those with lower educational levels.

•Efforts should be made to ensure the availability and accessibility of medical care and social security measures and enhance the geriatric care health infrastructure, especially in rural areas.

•Institutions catering to the elderly should consider appointing professional social workers to enhance their quality of life. Such professionals can play a crucial role in addressing the psychological and emotional needs of elderly residents.

•Social work curricula should pay more attention to the problems and needs of the geriatric population. It may help them to provide more effective professional care to older people.

•Family empowerment programs can be facilitated to reduce the institutionalisation of the elderly and promote awareness of the problems and needs of the aged population.

The study highlighted the disparities between paid and unpaid homes and advocates for integrating professional social work services to further improve the well-being of the elderly in institutional settings.

Conclusion

The study emphasised the role of the living environment in shaping the QOL of the institutionalised elderly. The findings revealed that institutionalised elderly residing in paid homes experienced a higher QOL compared to those residing in unpaid homes. This discrepancy can be attributed to the superior facilities provided by paid homes, including separate accommodation, home nursing services, improved dietary options, and enhanced recreational amenities. The majority of respondents reported a "Good" QOL.

The study highlighted the disparities between paid and unpaid homes and advocates for integrating professional social work services to further improve the well-being of the elderly in institutional settings. The findings are crucial in the context of the massive migration of young people to foreign countries, suggesting potential implications for policy formulation related to elderly care in regions experiencing demographic shifts. There should be a shift from demographic challenge to resilience, inclusivity and growth. Elderly care may be regarded as a 'responsibility' rather than a burden. As India faces demographic shifts with an ageing population, the study calls for stakeholders to view ageing as an opportunity for resilience and inclusivity. Future research should explore the longitudinal impacts of institutional care, regional variations, and the evolving role of technology in enhancing QOL for institutionalised elderly across diverse socio-economic contexts.

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Assessment of Quality of Life Among Elderly Population Residing At Old Age Homes In Hyderabad, Telangana

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Abstract

With global ageing and changing family dynamics, the decision to place ageing parents or relatives in Old Age Home (OAH) is becoming more common. Quality of Life (QOL) in these settings is influenced by social interaction, access to health care and emotional well-being. Understanding their QOL helps to address any deficits in their living conditions, thus promoting their dignity. This research paper quantitatively assesses the QOL among elderly residents of OAH and to study their socio demographic profile.

A descriptive cross-sectional study was conducted among 150 elderly residents 60 years and above in seven OAH in selected areas of Hyderabad, Telangana using a socio-demographic and WHOQOL-BREF questionnaire. Most female participants (67%) were widowed (73.33%). The Primary reason cited for living in an OAH was lack of family support. Majority of the participants were having good QOL in environmental domain. There was a association between demographic characteristics and QOL for variables such as marital status, previous employment sector, source of income, use of personal mobile, frequency of visits from family members or relatives and participation in social activities across physical, psychological, social and environmental domains. Few OAH had facilities that met the minimum standards set by the Ministry of Social Justice and Empowerment (MoSJE). Conclusion: Overall, the QOL of majority of older people living in OAH is good in environmental domain i.e. 61% when compared to other domains. It can be improved by providing individualised care plans, fostering social connections, access to health services and promoting a sense of autonomy. Addressing these tailored needs, OAH can provide holistic and person-centred care that enhances the well-being and QOL.

Key words: Ageing, Elderly, QOL, old age home.

The Primary reasoncited for living in an OAH was lack of family support. Majority of the participants were having good QOL in environmental domain.

Introduction

The ageing population is a world-wide trend and one of the most critical concerns of demographic transition in this century.The term ''elderly'' refers to the population aged 60 and above (Vignesh et al., 2022). The proportion of adults over 60 has increased rapidly

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worldwide. India's population represent 17.76% of the total world population and is ranked first on the list of countries with the highest population and is also referred to as an "Ageing Nation"(Shri & Mendez, 2019). The number and proportion of elderly people in India is increasing exponentially, while with the fertility rate is decreasing life expectancy is increasing (Kengnal et al., 2019). According to 2011 Census, India was home to 71 million older women and 67 million older men. However, by 2050, it is projected that the number of older women will exceed older men by 18.4 million. The older adult population will likely double to 20%(Ageing and Health India-WHO, n.d.).

Ageing is an inevitable developmental phenomenon that brings many changes, influenced by physiological, social, psychological, economic, environmental and cultural factors, all of which impact QOL. The World Health Organisation (WHO) defines QOL as the individual's perception of their position in life in the context of culture and value systems in which they live and in relation to their goals, expectations, standards and concerns(WHOQOL: Measuring QOL, n.d.).

Due to urbanisation, modernisation, the dissolution of joint family structures, and the shifting roles of women, India's traditional family structure which was intended to support the elderly is transforming. As a result, OAH have emerged as a solution for elderly care. There are already many OAH in India and their number is increasing(Areeckal et al., 2021). 4.4% of India's elderly population lives in OAH (Vignesh et al., 2022). Although OAH cater to all basic needs, they don't receive the necessary support and care, leading to a deterioration in the overall well-being and QOL of the elderly.

Assessing the health status of older people is crucial to consider the general circumstances and QOL (kumar et al., 2016). Various studies have utilised different instruments to assess QOL of elderly. In this study, the WHO BREF QOL questionnaire was used which focuses on physical, psychological, social and environmental health (WHOQOL: Measuring QOL, n.d.).

This study aimed to evaluate the QOL of elderly living in OAH in Hyderabad, Telangana and to study their socio demographic profile.

Material and Methods

A descriptive cross-sectional study was conducted among elderly residents aged 60 years and older from OAH in Hyderabad, Telangana from October 2023 to March 2024. The approval to conduct the study was granted by management board of the respective old age homes and written informed consent was acquired from each participant following an explanation of the study's purpose.

The sample size calculated was 150 based on the Prevalence of QOL among elderly living in OAH reported in a previous study using a formula, n= 4pq/l2. The study included elderly people who have been living in OAH for more than 6 months in Hyderabad, Telangana. The elderly who were bedridden, severely ill, hearing or visually handicapped and cognitively impaired were excluded from the study. Ethical clearance was granted by the Institutional Ethics Committee of

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University of Hyderabad, India. Study was approved under IEC number (UH/IEC/2023/567).

Quantitative method was used for data collection. A convenience sampling technique was applied and data was gathered accordingly from 150 elderly people across 7 different OAH.

The data collection tool consisted of a socio demographic information sheet and WHOQOL-BREF Questionnaire (WHOQOL: Measuring QOL, n.d.).

The Ministry of Social Justice and Empowerment (MoSJE) has established minimum standards for OAH to ensure the well-being and QOL for elderly residents.

A semi structured questionnaire for gathering socio-demographic profile was developed. The WHOQOL-BREF standard Questionnaire was used to assess the QOL. It comprises of 26 questions on the individual's views on health and well-being which includes physical, psychological, social and environmental domains. The recall period for participants was past 4 weeks. The responses were pre-assigned scores ranging from 1 to 5 points. The four domain scores were each converted into a scale from 0 to 100. Finally, QOL was categorized on a scale of 0 to 100 as follows(Gupta et al., 2014).A score of 0-20 indicated a very poor QOL, 21-40 indicated a poor QOL, 41-60 indicated neither poor nor good QOL, 61-80 indicated a good QOL and 81-100 indicates very good QOL. The Ministry of Social Justice and Empowerment (MoSJE) has established minimum standards for OAH to ensure the well-being and QOL for elderly residents. To evaluate the facilities provided by these homes, a checklist was prepared in accordance with these standards.

Data Analysis

Microsoft Excel was used for the analysis. WHO BREF QOL domain was categorized based on scores as per Likert scale and analyzed in Microsoft excel version 2408. Fisher's exact test was employed to determine the association between socio demographic variables and QOL domains. A p value of $P \leq 0.05$was consideredstatistically significant at 95% confidence interval.

Results

Data were collected from 150 elderly residents in OAH during the study period. The sociodemographic attributes of the study population have been described in Table.

Table 1: Frequency and Percentage Distribution of Socio Demographic Characteristics (n=150)

Socio Demographic Characteristics		
Variables		N (%)
Age(year)	60-65 years	26 (17 .33 %)
	66-70 years	26 (17 .33 %)
	71-75 years	21 (14 %)
	Above 75 years	77 (51 .33 %)
		73 .90 ± 6.91

Socio Demographic Characteristics		
Gender	Male	50 (33 .33 %)
	Female	100 (66 .67%)
Graduate and above	35(23.33%)	
	Married	8(5 .3 3 %)
	Separated	12 (8 %)
	Never Married	18 (1 2 %)
	Widowed	110 (73 .33 %)
Children	0	6 (4 %)
	1	38 (25 .33 %)
	2	45 (3 0 %)
	>2	43 (28 .67 %)
	Not applicable	18 (1 2 %)

Level of Education	Illiterate	2 5 (1 6 .6 7 %)
	Primary -(51)	5 0 (3 3 .3 3 %)
	Secondary-1(06)	2 0 (1 3 .3 3 %)
	Intermediate	2 0 (1 3 .3 3 %)
	Intermediate	20(13.33%)
	Graduate and above	35(23.33%)
Previous Employment Sector	Government	21(14%)
	Private	23(15.33%)
	Self employed	13(8.67%)
	Unemployed	93(62%)
Source of Income	Dependent on old age home	30(20%)
	Family	67(44.67%)
	Pension	29(19.33%)
	Others	24(16%)
Paying for OAH accommodation & Service	Yes	115(76.67%)
	No	35(23.33%)
Usage of personal Mobile phone	Yes	96(64%)
	No	54(36%)
Physical Activities	Yes	80(53.33%)
	No	70(46.67%)
Health Issues	Yes	110(73.33%)
	No	40(26.67%)

If yes type of health issue	Hypertension	90(81.81%)
	Diabetes Mellitus	41(37.27%)
	CVD	3(2.91%)
	Arthritis	117(97.5%)
	Others	18(16.36%)
Visit by family members or relatives	Yes	79(52.67%)
	No	71(47.33%)
If yes frequency of visit	Monthly	13(16.46%)
	Rarely	66(83.54%)
Close friends in OAH	Yes	118(78.67%)
	No	32(32.33%)
Participation in social activities	Active participant	2(1.33%)
	Occasional Participant	73(48.67%)
		75(50%)
Reasonsa for not participating	Due to health issues	46(61.33%)
	No provision in old age home	20(26.66%)
	Don't want to socialise	9(12%)
Duration of residence	6 months -1 year	35(23.33%)
	➢ 1 years – 2 years	33(22%)
	➢ 2 years	82(54.67%)

More than half of the participants (51.33%) were aged over 75 years with a mean age of 73.90±6.91 years. There was also significant association between age and QOL in physical domain (P=0.01), social domain (P=0.002) and environmental domain (P=0.02). Most participants were female(67%) with significant association between gender and QOL in psychological domain (P=0.004). Majority of participants were widowed (73.33%). Significant association was found between marital status and QOL in physical domain (P=0.007), psychological domain (P=0.007), social domain (P=0.01) and environmental domain (P=0.01). About 30% elderly had two children.

Significant association was found between close friends in OAH and QOL in physical domain (P=0.005) and environmental domain (P=0.004).

Majority of the elderly (33.33%) completed primary education (1-5). Most participants were unemployed (62%) and previous employment sector was significantly associated with QOL in physical domain (P=0.01), psychological domain (P<0.001), social domain (P<0.001), environmental domain (P=0.001). Nearly 45% of the elderly were dependent on their family's income with source of income having significant association across all domains (P<0.001). Most participants (76.6%) paid for accommodation and services in the OAH.

Only 64% of the participants had a personal mobile phone which was associated with QOL in physical domain (P=0.03), psychological domain (P=0.02), social domain (P<0.001), environmental domain (P<0.001). Elderly male participants were physically active (22%). Significant association was found between physical activity and QOL in physical domain (P=0), social domain (P=0.01), environmental domain (P=0.04).

Majority 73.33% of the participants reported having health issues, with the many suffering from Arthritis, Hypertension and Diabetes Mellitus. Only 16.46% reported receiving monthly visits from family or relatives and 83.54% reported being rarely visited. Significant association was found between family visits and QOL in psychological domain (P=0.03), social domain (P=0), environmental domain (P=0.002). There was also significant association between frequency of visits and QOL in physical domain (P=0.01), psychological domain (P=0.003), social domain (P<0.001), environmental domain (P<0.001).

About 21.33% didn't have close friends in the OAH. Significant association was found between close friends in OAH and QOL in physical domain (P=0.005) and environmental domain (P=0.004). Half of elderly (50%) didn't participate in social activities, mainly due to health issues. Significant association was found between participation in social activities and QOL in physical domain (P<0.001), psychological domain (P=0.003), social domain (P=0.002), environmental domain (0.01). Over half, 54.67% had been residing in the OAH for more than 2 years. Significant association was identified between the duration of residence in OAH and QOL in physical domain (P= 0.04).

Table 2 : Reasons for Residing in OAH (n=150)

S .No	REASONS FOR RESIDING IN OAH	n (%)
1	Lack of family support	110 (73%)
2	Death of spouse	11 (7%)
3	To have personal space	8 (5%)
4	Children staying in abroad	7 (5%)
5	No care taker at home	5 (4%)
6	Loneliness	5 (4%)
7	Due to health issues	2 (1%)
8	Financial reasons	2 (1%)

Table 3 : Overall QOL Scores across various WHO BREF Domains

Overall QOL (N=150)	Physical domain	Psychological domain	Social domain	Environmental domain
Poor	19%	21%	33%	-
Neither poor nor good	66%	59%	51%	15%
Good	11%	15%	9%	61%
Very good	4%	5%	7%	23%

In the physical domain, only 4% of elderly residing at OAH had a very good QOL. In the psychological domain5% of the participants reported a very good QOL, while in the social domain 7% of participants did. In the environmental domain 23% of the participants were having very good QOL, 61% had a good QOL.

Minimum Standards of OAHs

The Ministry of Social Justice and Minimum Standards in OAHs and Empowerment (MoSJE) had laid down the minimum standards to be met by OAH (Ministry of Social Justice, n.d.). In this study, a total of seven OAH were assessed using a checklist prepared

Significant association was identified between the duration of residence in OAH and QOL in physical domain (P= 0.04).

Table 4: Comparison of OAH Facilities in Hyderabad

OAH facilities (as per MoSJE)	OAH1	OAH2	OAH3	OAH4	OAH5	OAH6	OAH7
Adequate staff to resident ratio	+	-	-	+	-	+	-
Ramp	+	-	+	-	-	-	+
Hand rails	+	-	+	-	+	+	+
Elevator facilities	+	-	-	+	+	+	-
Wheel chair access	+	-	+	+	+	+	+
Lighting & ventilation	+	+	+	+	+	+	+
Flooring	+	+	+	+	+	+	+
Night lights ,safe Drinking water & hand washing facilities, clean kitchen	+	+	+	+	+	+	+
Provision od space for wheelchair access for bathing facility	+	-	-	+	_	+	-
Grab bars in Bathrooms	+	-	-	+	-	-	-
Fire extinguisher & smoke alarms	-	-	-	-	-	-	-
Worship facilities	-	+	+	+	-	+	+

Recreational facilities	+	+	+	+	-	+	-
Care giver facilities	+	-	-	+	+	+	-
Closed bind for garbage collection	+	-	-	+	-	+	-
Mosquito control measures	+	-	-	+	-	+	-
Space between Beds	+	-	+	+	+	+	+
Hygiene& Sanitation	+	+	+	+	+	+	-
Medical facilities	+	-	+	+	+	+	-
Communal areas	+	-	+	+	-	-	-

The results of the study showed that only 3 OAHs had an appropriate staff to resident ratio and ramps, 5 OAHs have hand rails for a better grip and 4 OAH had elevators, indicating a deficit in barrier free infrastructure.

Only 3 OAHs had wheel chair access in the bathroom and 6 OAHs had facilities for wheel chair access at the entrance and in the living area. Additionally, 2 OAHs had grab bars in the bathrooms.

The results of the study showed that all facilities had adequate lighting and ventilation and the floors were non-slip. The facilities should also have closed garbage cans and mosquito control measures. Only 3 OAHs had the above indicators.

The results of the study showed that no facility had fire extinguishers and smoke alarms, leaving elderly vulnerable in the event of a fire. 1 OAH was not maintaining hygiene& sanitation and there was insufficient space between beds, according to the study. 3 OAHs had communal areas and 5 OAHs had worship spaces.

Discussion

The study findings revealed that majority of the participants were female i.e. 66.67%. This result is consistent with the studies conducted by Praveen Kumar BA et al and Sahaya Sona Thresa et al both of which reported a higher proportion of female residents in old age homes (kumar et al., 2016; Sahaya

The results of the study show that all facilities had adequate lighting and ventilation and the floors were non-slip.

Sona Thresa et al, 2020). The predominance of women in such facilities can be attributed to their longer life expectancy compared to men, as well as social and cultural factors that influence their relocation to old age homes. The feminisation of old age is a well-documented phenomenon – that can be attributed to behavioural reasons than biological (Feminisation of Old Age, 2016). A report on senior care reforms in India states 54% of women are widows and are more likely to face social isolation (NITI Ayog Senior Care Reforms in India, n.d.). India has observed a higher level of financial dependency among the elderly population, along with significant gender disparities (Nair, 2023). In line with this, the current study found a greater number of elderly women who were widowed and lacked both social and financial stability. There were few 16.67% of the study participants who were illiterate. Since education also effects the QOL of older people, higher education leads to good job opportunities, higher income and access to health facilities. Most 44.67% of the study participants cited family as a source of income and 20% of the participants stated that they were dependent on OAH.

The present study shows that older people aged above 75 years had a poor QOL in the social domain compared to the other domains. Women had a poorer QOL in the physical, psychological, social domains compared to men.

A study conducted by chou and chi reported that elderly people living in OAH need more financial support as they often feel they don't have enough money to meet their daily needs(Chou & Chi, 2000). The majority of study participants (73.33%) cited lack of family support as one of the main reasons for staying in an OAH. This observation is consistent with findings from previous study conducted which also reported that insufficient familial care and support were significant factors influencing elderly individuals to seek residence in such facilities(Bansod et al, 2006).

With regard to the assessment of QOL in the environmental domain, most of the participants had a very good QOL i.e. 23%. The Senior Citizen Act and related regulations provide for old age allowances, free health check-ups, treatment and transportation concessions which may have contributed to the higher score in the environmental domain(Vaishnav et al., 2022). The elderly in OAHs scored poorly on social domain (33%) similar to findings among urban elderly in West Bengal (Datta et al., 2015). The findings of the present study in the social domain are similar to those of many national and international studies which also show low scores, as the social domain includes components related to social support, personal relationships and sexual activity where lower scores are evident due to lack of family support, lack of sexual activity due to ageing or death of spouse (Kumar et al., 2014).

A study conducted in rural Maharashtra reported the highest scores in the physical domain and the lowest in the psychological domain (Mudey et al., 2011). Another study conducted in OAH of Amravati city, in Maharashtra found that the scores in the environmental domain were lower than the scores in the other domains (Lokare et al., 2015)

The present study showed that older people aged above 75 years had a poor QOL in the social domain compared to the other domains. Women had a poorer QOL in the physical,

psychological, social domains compared to men. The reason for this was that older women felt unattractive, which could lead to low self-esteem and also contribute to a negative perception of ageing in older women (Pereira et al., 2006; Vitorino et al., 2012). Most of the participants, who had a very good QOL in all domains, had a graduate degree or higher according to study results. Physically inactive female participants had a poor QOL in all domains. Long term residents (over 2 years) reported poorer QOL in physical, psychological and social domains. Age was significantly associated with the physical domain. This is due to the fact that older individuals experienced more functional limitations than their younger counterparts.

Another result of this study shows that only 57% of the OAHs had care giver facilities. Access to care services enhances elderly well- being and also relieves the stress on family caregivers (Ma & Shen, 2023).

The study's focus on only seven OAHs in Hyderabad, which could affect the generalis ability of the results.

Recommendations

Develop programs and activities to foster social interaction among residents and also implement initiatives to improve physical health, including access to exercise classes, health education sessions. Develop a comprehensive healthy ageing program tailored to specific needs and preferences of the elderly population living in OAHs. Government run OAH with better infrastructure and facilities should be established to provide a comfortable and supportive environment for elderly residents, to improve their QOL. Integration of older women in their own community settings may enhance QOL in social and psychological domain. The old age pensions to women above 75 years to keep up with increasing costs of living could be considered.

Conclusion

The overall results show that the QOL of majority of elderly living in OAH is higher in environmental domain and lower in other domains. The study also highlights the significant impact of demographic characteristics on QOL of elderly for variables such as marital status, previous employment sector, source of income, use of personal mobile, frequency of visits from family members or relatives and participation in social activities. Periodic assessments and tailored interventions are required to improve the overall QOL. As per Maintenance and welfare of Parents and Seniors Act, 2007 the state government should establish at least one OAH in each district to accommodate 150 senior citizens. Thereby it is imperative the OAHs provide adequate facilities including elderly care to improve the well-being and QOL.

The overall results show that the QOL of majority of elderly living in OAH is higher in environmental domain and lower in other domains.

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Gender Disparities In Disability And Quality of Life Among Elderly Diabetic Patients In Telangana, India: A Community-based Cross-sectional Study

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Abstract

Diabetes mellitus poses a growing public health challenge globally, particularly affecting elderly populations. In India, the prevalence of diabetes among the elderly is alarmingly high, increasing the risk of disability. Understanding the epidemiology of disability within this demographic is crucial for developing targeted interventions. This study investigates the prevalence and predictors of disability among diabetic elderly in Telangana, India, focusing on the intersectionality of gender and ageing.

This study aimed to estimate the prevalence and predictors of disability among diabetic elderly in Telangana, India. It explores the association between disability, socio-demographic factors, and assesses their quality of life. The objective was to provide insights into the health equity issues faced by this vulnerable population.

A cross-sectional study was conducted in Medak district, Telangana, India among diabetic individuals aged 60 years and above with a minimum of 10 years of diabetes history. Multistage random sampling was used to select participants. Data on socio-demographic characteristics, disability status (assessed using the WHO MDS-Brief), and quality of life (WHO-QOL BREF) were collected.

The mean age of 68.3 ± 5.67 years, comprising 56.6% males and 43.3% females. Among them 20.0% were widowed, and 3.3% were separated. A significant portion (63.3%) had no formal education. The prevalence of disability was 76.6%, with 23.3% having no disability, 20.0% mild, 50.0% moderate, and 6.6% severe disability. Quality of life scores indicated that those with no or mild disabilities had a better overall quality of life compared to those with moderate or severe disabilities. Gender differences were notable, with females experiencing higher levels of disability and lower quality of life scores compared to males.

The high prevalence of disability among diabetic elderly in Telangana underscores significant health disparities influenced by socio-demographic factors such as gender and

This study aims to estimate the prevalence and predictors of disability among diabetic elderly in Telangana, India. It explores the association between disability, socio-demographic factors, and assesses their quality of life.

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lack of formal education. Elderly women, in particular, face a higher burden of disability and poorer quality of life. This study highlights the urgent need for targeted public health interventions and policies to address these inequities, ensuring equitable access to healthcare and improving the quality of life for elderly women. By focusing on the intersectionality of gender and ageing, the findings provide a comprehensive understanding of the unique challenges faced by diabetic elderly individuals, advocating for more inclusive and effective healthcare strategies

Keywords:

Elderly diabetic patients, Gender disparities, Disability, Quality of life

Introduction

Aging is a natural and universal process that affects all humans, involving changes in physical, psychological, and health-related abilities over time, which impact economic and societal roles. While ageing is not a disease, older individuals are more susceptible to developing chronic conditions (Kaur G et al., 2019). Worldwide, the number of elderly people is increasing by 2.6% per year, much faster than the overall population growth rate of 1.1% annually (Prabhakar et al., 2022). In India, 8.2% of the population is over 60 years old, making it an ageing nation. The elderly population in India is growing faster than in other regions of the world, with projections estimating that the number of elderly people will double from 83.6 million in 2006 to 173 million by 2026(Goswami, 2019). Older adults, as one of the most vulnerable groups in society, are at higher risk for non-communicable diseases (NCDs), infections, and disabilities (WHO). Globally, NCDs cause over 41.5 million deaths and account for more than 73% of all mortality. In India, more than half of the elderly population has at least one chronic condition (Marmamula et al. 2021).

Hypertension and diabetes affect approximately 1 billion and 422 million people globally, respectively the impact of diabetes on disability is particularly significant in the aging population, where disability rates are higher than in younger people

Diabetes Mellitus is prevalent among the elderly across various regions and socio-demographic groups in India. Hypertension and diabetes affect approximately one billion and 422 million people globally, respectively the impact of diabetes on disability is particularly significant in the aging population, where disability rates are higher than in younger people (Singh J et al., 2011). Gender disparities in NCDs are evident, with women reporting higher morbidity rates than men. This difference is influenced by both biological factors and societal roles, often leading to greater health neglect among women (Sharma S. K et al., 2020). Addressing these disparities is crucial for improving overall public health outcomes. Promoting healthy aging practices is essential to enhance the quality of life for the elderly.

This study aims to estimate the prevalence and predictors of disability among elderly diabetics in Telangana, India. Specifically, it explored the association between disability, socio-demographic factors, and assesses their quality of life. The objectives were as follows: 1. To determine the prevalence and predictors of disability among diabetic elderly individuals living in Telangana, and 2. To assess the quality of life among diabetic elderly individuals living in Telangana. By providing insights into the health equity issues faced by

elderly diabetics, this research seeks to contribute to targeted interventions and policy formulations aimed at improving their health outcomes.

Material and Methods

The study was conducted in Medak district, Telangana. A cross-sectional study design was employed using quantitative methods to collect data. The study focussed on elderly individuals aged 60 and above with confirmed type 2 diabetes for at least 10 years, aiming to explore how gender impacts their health outcomes in terms of disability and overall well-being.

To select participants, a multistage random sampling method was used. Initially, a comprehensive list of confirmed diabetic patients was procured from the NCD registers and healthcare providers operating within the Primary Health Centers (PHCs) and the office of the District Medical & Health Officer (DM&HO), Medak. From this list, only elderly patients with a diagnosis of type 2 diabetes for over a decade were included in the study. The pilot phase of the research involved 30 participants, representing 5% of the total target sample size of 600.

The participants met the inclusion criteria of being 60 years or older with confirmed type 2 diabetes for at least over a period of 10 years, while individuals below 60, those without diabetes, severely ill or hospitalized patients, and those unwilling to participate were excluded. The ethical approval for the study was obtained from the Institutional Ethics Committee (IEC) of the University of Hyderabad (UH/IEC/2022/275), and the study received permission from the DM&HO Medak for data collection.

Data collection was structured around two key tools. First, the WHO Disability Assessment Schedule (WHO-DAS) Brief MDS Questionnaire was employed to evaluate disability levels. This standardized tool assesses six domains: cognition, mobility, self-care, interpersonal relationships, life activities, and participation, offering a comprehensive view of the functional limitations faced by elderly diabetic patients. Second, the WHO Quality of Life-BREF (WHO-QOL BREF) questionnaire was used to measure the quality of life across four domains: physical health, psychological health, social relationships, and environmental factors. These tools, validated for use in diverse populations, were administered in local languages to ensure clarity and accurate responses.

Three primary tools were employed for data collection. First, a Socio demographic Questionnaire was designed to gather relevant background information, including age, gender, education, marital status, living arrangements and income. Second, the WHO Brief Model Disability Survey (MDS) Questionnaire was used to assess disability. This standardised tool measures the extent of functional limitations across various domains of life, including environmental factors, functioning, and capacity & health conditions. Third, the WHO Quality of Life-BREF (WHO-QOL BREF) Questionnaire was administered to evaluate participants' quality of life across four domains: physical health, psychological well-being, social relationships, and environmental factors. These validated questionnaires

The study focussed on elderly individuals aged 60 and above with confirmed type 2 diabetes for at least 10 years, aiming to explore how gender impacts their health outcomes in terms of disability and overall well-being.

were administered in local language (Telugu) to ensure participants' understanding and accuracy of responses. The systematic use of these tools allowed for a comprehensive evaluation of both disability and quality of life among elderly diabetic patients in Telangana.

Data analysis was conducted using Microsoft Excel and SPSS software. After data collection, responses from the Sociodemographic data, WHO Brief MDS, and WHO-QOL BREF Questionnaire were systematically entered into Excel for data cleaning and organization. Descriptive statistics, such as frequencies and percentages, were calculated to summarise the demographic details and key variables. The cleaned data was then imported into SPSS for further analysis, where patterns and trends related to gender disparities in disability and quality of life were explored.

The systematic use of these tools allowed for a comprehensive evaluation of both disability and quality of life among elderly diabetic patients in Telangana.

Results

Data were collected from 30 elderly individuals aged 60 and above with confirmed type 2 diabetes for at least 10 years during the study period. The socio-demographic attributes of the study population have been described in Table1. The socio demographic characteristics of elderly diabetic patients in Medak district offer critical insights into the intersecting factors of age, gender, social category, and economic status that affect the quality of life and disability rates among this vulnerable group. The analysis below underscores these factors, highlighting the distinct experiences and challenges faced by elderly diabetics in Telangana.

The mean age of participants was 68.3 ± 5.67 years, with a significant concentration of individuals aged between 65-69 years (36.6%). Smaller groups included those aged 60-64 and 70-74 years, each representing 23.3% of the sample. The elderly aged 75 and above comprised a smaller but particularly vulnerable subset, accounting for 10% in the 75-79 age group and 6.6% in the 80+ age group. The gender distribution was relatively balanced, with 56.6% male and 43.3% female participants.

While the study sample showed this balance, gender-specific factors influencing disability, healthcare access, and social support need further exploration. Research consistently shows that elderly women, especially in rural and under served areas, may face greater barriers to healthcare and social support, which could impact their diabetes management and overall well-being.

Half of the elderly participants (50%) belonged to Other Backward Classes (OBC), while 33.3% were from Scheduled Tribes. A smaller proportion represented the General category (10%) and Scheduled Castes (3.3%). Educational attainment was low, with 63.3% of participants being illiterate, which likely impacts health literacy and the ability to self-manage diabetes. Only 10% had completed higher education. In terms of housing, 53.3% resided in semi-pukka houses, followed by 36.6% in pukka houses. Marital status revealed that 76.6% of participants were married, while 20% were widowed, and 3.3% were separated. In terms of family structure, the majority (60%) lived in extended families, with 76.6% residing with both their spouse and children,

indicating substantial caregiving support. Meanwhile, 20% lived without a spouse but with children, reflecting a different family caregiving dynamic.

A large percentage of participants (43.3%) were not working due to health reasons, emphasising the disabling effects of diabetes and aging. Economic independence also varied, with 50% partially dependent and 33.3% fully dependent on others for financial support. This economic reliance could limit access to private healthcare, medications, and proper nutrition, further exacerbating their disability and health outcomes. Access to comprehensive and continuous diabetes care is crucial for managing complications and preventing further disability.

In terms of family structure, the majority (60%) lived in extended families, with 76.6% residing with both their spouse and children, indicating substantial caregiving support.

Table 1: Frequency and Percentage Distribution of Socio Demographic Characteristics

Variables		N	%
Age	1. 60- 64	7	23.3
	2. 65- 69	11	36.6
	3. 70- 74	7	23.3
	4. 75- 79	3	10.0
	5. 80 +	2	6.6
Gender	1. Male	17	56.6
	2. Female	13	43.3

Category	1. General	3	10.0
	2. General EWS	1	3.3
	3. OBC	15	50.0
	4. SC	1	3.3
	5. ST	10	33.3
Marital status	1. Married	23	76.6
	2. Widowed	6	20.0
	3. Separated	1	3.3
Education	1. Not literate	19	63.3
	2. Literate without any schooling	3	10.0
	3. Primary	4	13.3
	4. Secondary	1	3.3
	5. Graduation	3	10.0
Type of House	1. Pukka	11	36.6
	2. Semi pukka	16	53.3
	3. Kaccha	3	10.0

Type of family	1. Nuclear Family	8	26.6
	2. Extended Family	18	60.0
	3. Joint family	3	10.0
	4. Single	1	3.3
Living arrangements	1. Living alone	1	3.3
	2. Living with spouse and children	23	76.6
	3. Living without spouse but with children	6	20.0
Current Occupation	1. Not working: Health reason	13	43.3
	2. Not working: Other reasons	2	6.6
	3. Business	5	16.6
	4. Home maker	2	6.6
	5. Retired	3	10.0
	6. others	5	16.6
Past work experience	1. Self-employed in agriculture	7	23.3
	2. Small business employment	6	20.0
	3. Casual labour/ Daily wager	9	30.0
	4. Govt. Services Employment	3	10.0
	5. Homemaker	5	16.6

Annual family income	1. below 50 thousand rupees	1	3.3
	2. 50 thousand to below 1 lakh rupees	3	10.0
	3. 1 Lakh to below 5 lakh rupees	22	73.3
	4. 5 Lakhs to below 10 Lakh rupees	3	10.0
	5. Above 10 Lakh rupees	1	3.3
Economic dependence	1. Not dependent on others	5	16.6
	2. Partially dependent on others	15	50.0
	3. Fully dependent on others	10	33.3
Family history of diabetes	1. No	23	76.6
	2. Yes	7	23.3
Type of Hospital visit	1. Government hospital	30	100
	2. Private hospital/ clinic	9	30.0
	3. AYUSH	1	3.3
BMI	1. Under weight	0	0
	2. Normal	22	73.3
	3. Over weight	8	26.6
	4. Obesity	0	0

Prevalence of Disability among diabetic elderly

Among the diabetic elderly participants, a notable 76.7% showed some level of disability. Specifically, 50% had moderate disability, 20% had mild disability, and 6.6% experienced severe disability. Only 23.3% of participants reported no disability, highlighting a significant burden of disability among the elderly diabetic population.

These findings emphasize the greater vulnerability of elderly diabetic women in terms of physical limitations and functional impairments compared to their male counterparts.

Table 2: Prevalence of Disability among Diabetic Elderly

Disability status	No disability	Mild	Moderate	Severe
N (%)	7 (23.3)	6 (20.0)	15 (50.0)	2 (6.6)

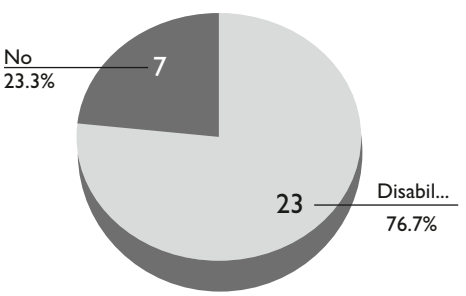


Fig:1

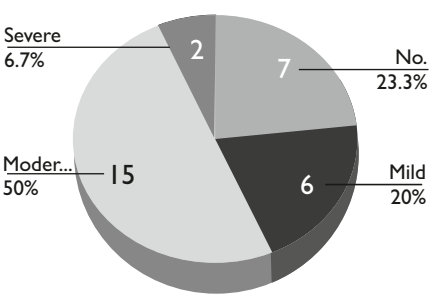


Fig:2

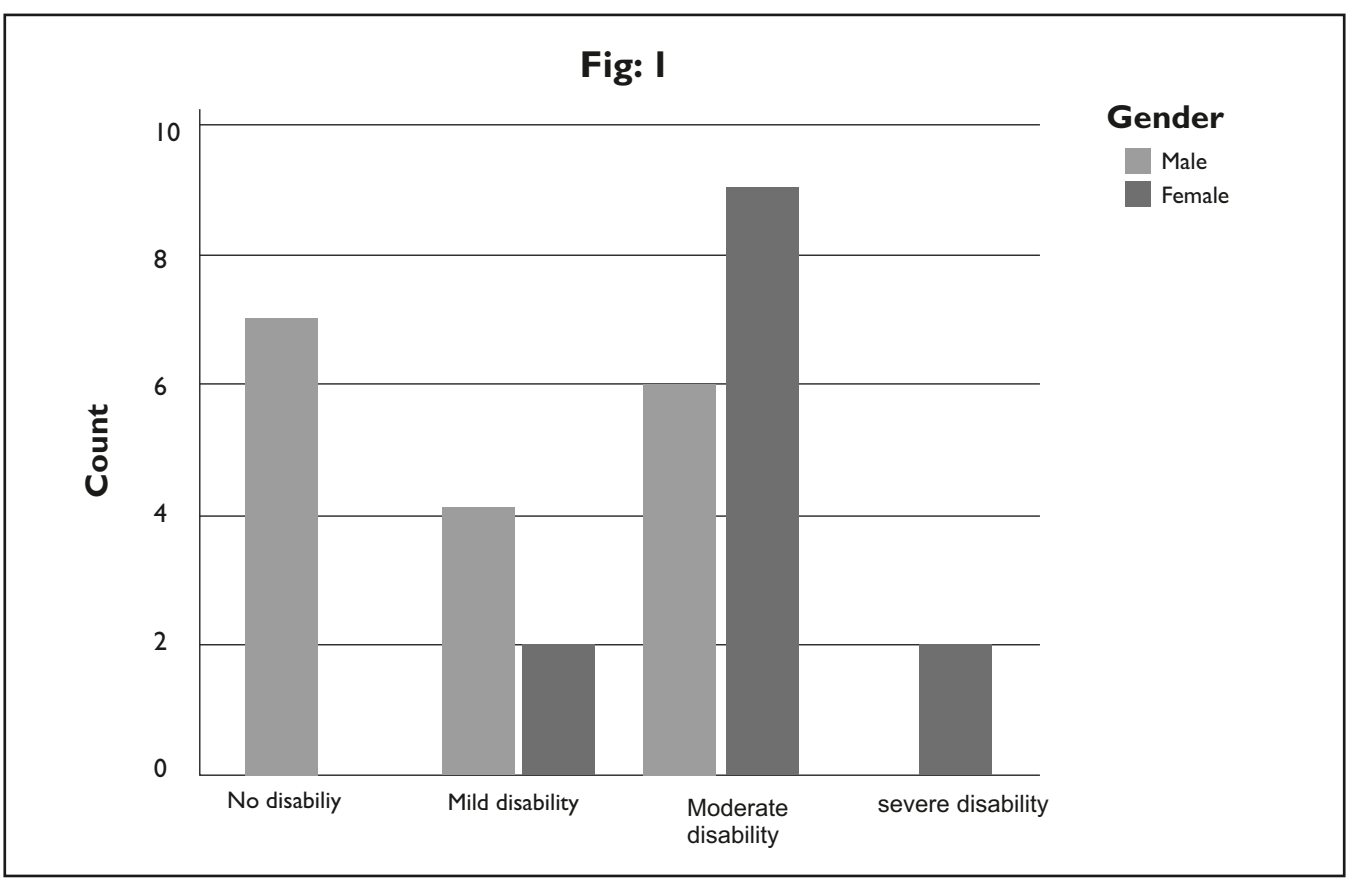
Gender-wise Distribution of Disability Status among Diabetic elderly

Disability among elderly diabetic patients revealed significant disparities, with women being notably more affected than men. Of the male participants, 41.1% reported no disability, whereas none of the female participants were free from disability, highlighting a stark contrast in health outcomes. A more detailed look at the levels of disability showed that 69.2% of women experienced moderate disability, nearly double the proportion of men, of whom 35.2% fell into this category. Additionally, 15.4% of women suffered from severe disability, while no male participants were classified as severely disabled

These findings emphasize the greater vulnerability of elderly diabetic women in terms of physical limitations and functional impairments compared to their male counterparts. The absence of women in the 'no disability' category and the higher proportion of women in the moderate to severe disability categories reflected a broader gender-based disparity in health outcomes, particularly within this elderly diabetic population.

Table 3: Gender-wise Distribution of Disability Status among Diabetic Elderly

Disability Status	Gender	
	Male(N)	Female (N)
No disability	7	0
Mild disability	4	2
Moderate disability	6	9
Severe disability	0	2



Quality of Life among Diabetic elderly

Quality of Life (QoL) scores among elderly diabetic participants further demonstrated the impact of disability on overall well-being. Participants with no disability showed the highest QoL scores, with 4 out of 7 having scores above 88.95, indicating optimal levels of well-being. In contrast, individuals with mild disabilities had more varied QoL scores, with the majority falling between 79.54 and 88.94, reflecting moderate quality of life

Among those with moderate disability, a large proportion had mid-range QoL scores, with 7 participants scoring between 70.14 and 79.53, and 6 participants scoring between 79.54 and 88.94, suggesting some degree of functional impairment. However, participants with severe disabilities uniformly scored at the lowest level, with QoL scores $\leqslant$ 70.13, indicating a profound reduction in overall quality of life. The relationship between increasing levels of disability and declining QoL is evident, with those facing more significant physical limitations experiencing greater declines in their day-to-day well-being.

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Table 4 : Quality of Life Scores across Different Disability Levels among Diabetic Elderly

	Quality of Life Score			
	<= 70.13 (N)	**70.14 - 79.53 (N)**	**79.54 - 88.94 (N)**	**88.95+ (N)**
No disability	1	1	1	4
Mild disability	0	1	3	2
Moderate disability	2	7	6	0
Severe disability	2	0	0	0

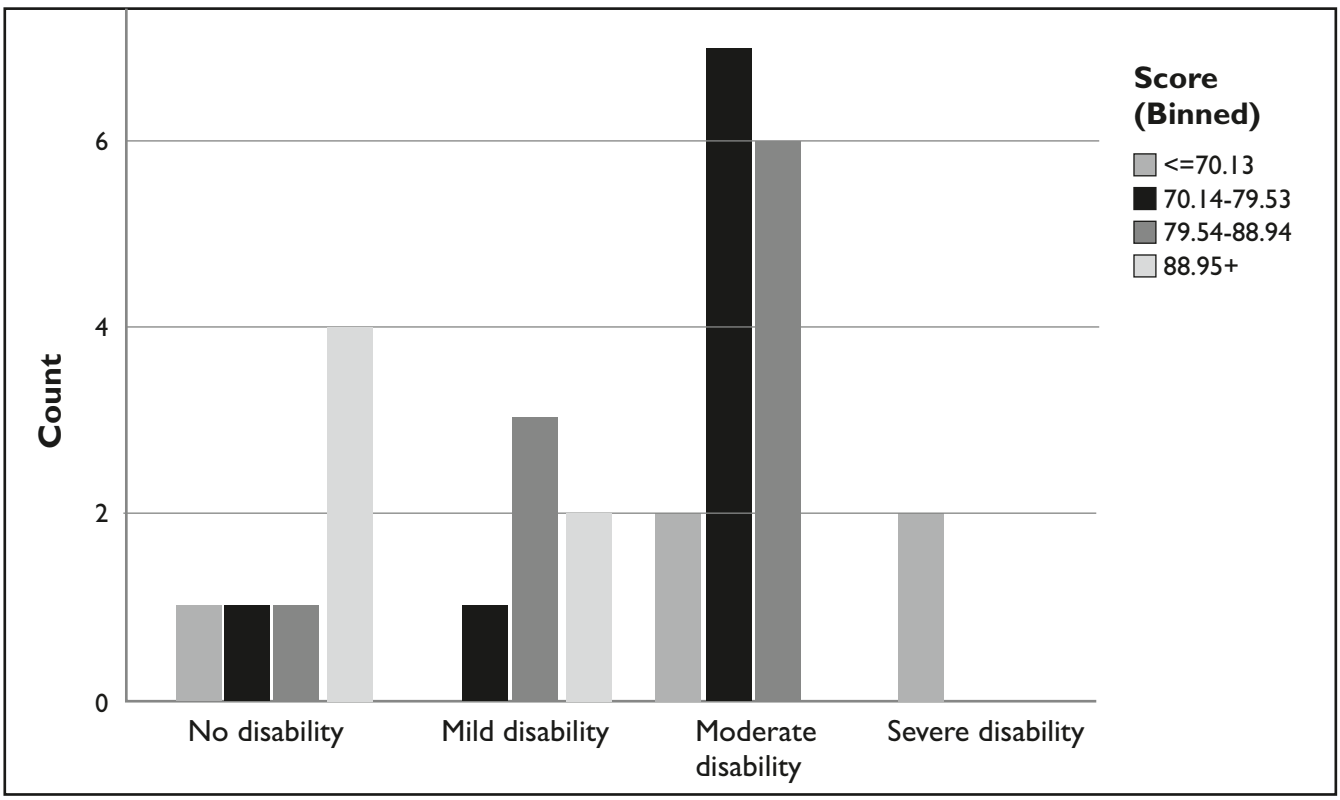

Fig:4

Additionally, traditional gender roles may limit women's ability to seek timely medical care, exacerbating their vulnerability to disability and lowering their quality of life.

Gender disparities in disability and quality of life among elderly diabetic patients were evident, with women disproportionately affected. None of the female participants were free from disability, and a larger number of women experienced moderate to severe disabilities compared to men. This increased burden of disability in women likely leads to poorer quality of life, as reflected in their higher representation in the lower QoL score categories. These findings underscore the need for targeted interventions to address the unique challenges faced by elderly diabetic women.

Several factors may contribute to these gender-based disparities. Elderly women in India often face socio-economic disadvantages, including limited access to healthcare, lower literacy rates, and heightened caregiving responsibilities. These challenges may reduce their ability to manage chronic conditions such as diabetes effectively, leading to more severe health complications and greater disability. Additionally, traditional gender roles may limit women's ability to seek timely medical care, exacerbating their vulnerability to disability and lowering their quality of life.

The health-seeking behaviour of elderly diabetics in Medak district was significantly influenced by socioeconomic factors, cultural beliefs, and physical limitations. A substantial proportion of participants (83.3%)

relied on ASHAs and ANMs for diabetes management guidance. These community health workers served as crucial intermediaries between elderly patients and healthcare services, facilitating access to essential care and providing education on lifestyle modifications and medication adherence.

Access to healthcare facilities was strongly supported by these community health workers, with 100% of participants utilizing government healthcare services. This reliance on public health systems emphasized the critical role of government initiatives in providing necessary care for elderly diabetics. However, economic constraints limited access to private clinics for additional care, which was sought by only 30% of participants. The assistance of community health workers significantly improved access to healthcare services, ensuring timely medical attention and enhancing the quality of life for elderly individuals with diabetes.

Despite the availability of healthcare services, several barriers impede optimal health-seeking behaviour among participants. A significant proportion (43.3%) were unable to work due to health-related reasons, and 76.7% reported functional disabilities, hindering their mobility and access to healthcare facilities. These impediments not only hindered effective diabetes management but also contributed to poorer health outcomes. Addressing the presence of functional disabilities is essential for developing targeted interventions that ensure equitable access to healthcare, ultimately improving the quality of life for elderly diabetics in Telangana, India.

Discussion

The findings from this research study emphasize the significant burden of disability and its impact on the quality of life (QoL) among elderly diabetic patients in Telangana. Gender disparities were evident, with women showing a higher prevalence of disability compared to men. Notably, none of the female participants reported an absence of disability, while 41.1% of men did not experience any disability. A large proportion of women had moderate disabilities, and 15.4% faced severe disabilities, in contrast to no severe disabilities reported among male participants. This disparity extended to QoL, with women, particularly those with moderate to severe disabilities, experiencing lower QoL scores. These results highlight the gender-specific health challenges faced by elderly diabetic women in managing their condition and overall well-being.

Similar findings are reported in other studies across India. For instance, Sharma et al. (2020) also observed that women in India bear a greater burden of non-communicable diseases, including diabetes, due to social and economic disadvantages. Women often face barriers to accessing healthcare, which exacerbates their health conditions, leading to worse outcomes, as reflected in the current research. This aligns with Katta et al. (2017), who found that elderly women, particularly in rural Telangana, experience more significant levels of disability due to multiple socio-economic factors, including lower literacy and financial dependence.

The relationship between disability and

community health workers serve as crucial intermediaries between elderly patients and healthcare services, facilitating access to essential care and providing education on lifestyle modifications and medication adherence.

quality of life highlighted in the research is consistent with other findings. Hazra et al. (2023) observed that functional disabilities among elderly populations in urban slums were closely linked to poor quality of life, reinforcing the idea that disability negatively impacts well-being, as also seen in the current research. Furthermore, Goswami et al. (2019) pointed out similar associations between disability and socio demographic factors in elderly populations, indicating that socio-economic background plays a crucial role in shaping health outcomes, particularly for women.

The economic dependence of elderly women, as noted in this research, is another important factor influencing health outcomes. Kondeth et al. (2024) pointed out that elderly individuals, particularly women, who rely financially on others are more likely to experience poor health outcomes and reduced access to healthcare.

Studies from rural settings, such as Medhi et al. (2021) and Rath et al. (2021), have similarly reported that functional disability is prevalent among elderly populations, especially women, which aligns with the results of this research. These studies emphasized the importance of addressing gender-specific health challenges to improve health outcomes in the elderly. The findings also resonate with Marmamula et al. (2021), who highlighted the high prevalence of non-communicable diseases and disabilities in elderly populations in Telangana, with women being disproportionately affected.

The economic dependence of elderly women, as noted in this research, is another important factor influencing health outcomes. Kondeth et al. (2024) pointed out that elderly individuals, particularly women, who rely financially on others are more likely to experience poor health outcomes and reduced access to healthcare. The current research supports these conclusions, showing that financial dependence may further compound the challenges faced by elderly diabetic women in managing their condition and maintaining quality of life. Same study identified a link between illiteracy, inadequate housing conditions, and poorer health outcomes which reflects the findings of this study, where 63.3% of participants were illiterate and many resided in semi-pukka houses. These socio-economic disadvantages likely contribute to the high rates of disability, particularly among women.

The LASI (Longitudinal Aging Study in India) report further supports these findings, highlighting that rural elderly women face an increased risk of chronic diseases and disability due to lower access to healthcare and social support, as seen in the study's participants. Finally, the WHO report on the global burden of non-communicable diseases underscores that elderly women in low- and middle-income countries often face compounded disadvantages, including limited healthcare access and high caregiving burdens, which were evident in the experiences of women in this research.

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Gender disparities in disability and quality of life observed among elderly diabetic patients in Telangana reflect the intersection of socio-economic challenges and unequal access to healthcare services. The higher prevalence of disability and lower quality of life among women, as seen in this study, highlights a significant public health concern. Consistent with findings from other studies, these results emphasize the urgent need for targeted interventions that address the specific needs of elderly women. Prioritizing access to healthcare, improving social support, and addressing the underlying socio-economic barriers can help mitigate the vulnerability of elderly women to disability and poor health outcomes.

Conclusion

The findings of this study highlight the high prevalence of disability among elderly diabetic patients in Telangana, India. The results indicated that approximately 76.6% of participants experienced some level of disability, with a significant proportion facing moderate to severe limitations. This impacts not only their ability to manage diabetes effectively but also their overall quality of life. the intersectionality of gender and disability revealed alarming disparities among diabetic elderly. Female participants reported higher levels of disability and lower quality of life scores compared to males. This disparity highlights the need for focused interventions to address the unique challenges faced by elderly women who often encounter additional barriers to healthcare access due to socio-cultural factors.

People with disabilities frequently face significant healthcare access barriers, which can adversely impact chronic disease management, such as diabetes, leading to poorer health outcomes. A comprehensive public health approach is crucial for promoting healthy aging and addressing the specific needs of older adults with disabilities and NCDs. By developing targeted strategies to improve access to care, promote healthy behaviours, and enhance the quality of life we can significantly improve the health and well-being of this vulnerable population.

The urgent need for public health policies that prioritize equitable healthcare access and targeted interventions for elderly diabetics particularly women. Addressing these issues is essential for improving health outcomes and ensuring a better quality of life for elderly individuals.

Recommendations

Implement health interventions that address gender disparities, ensuring elderly women receive the necessary support and resources to effectively manage their health conditions.

Provide educational initiatives to enhance health literacy and self-management skills among elderly diabetic patients, empowering them to take an active role in their health management and make informed decisions.

Increase awareness among elderly individuals about existing government welfare schemes, health policies, and support measures to bridge the knowledge gap associated with high illiteracy levels observed in the study.

The higher prevalence of disability and lower quality of life among women, as seen in this study, highlights a significant public health concern.

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CALENDAR **2024**

16th -17th May
7th International Conference on Aging & Gerontology
Rome, Italy
Organized by: Aging Conference
Website:https://cellularmechanisms.healthconferences.org/

8th -10th July
6th World Aging and Rejuvenation Conference (ARC-2024)
Paris, France
Website: https://www.aging-geriatrics.com
Email : aging_conference@eventinex.org

9th -10th October
International Conference on Ageing, Gerontology & Geriatric Nursing (ICAGGN - 24)
Vitoria, Brazil
Organized By: Research Plus
Contact Person: Sukumar Sen
Website: https://researchplus.co
Email: info@researchplus.com

30th - 31st October
(ICAGGN - 24) International Conference on Ageing
Chengdu, China
Organized By : Science Cite
Contact Person: Akash Shinde
Website:https://www.sciencecite.com
Email: info@conferencealerts.co.in

5th - 6th December
International Conference on Ageing Gerontology & Geriatric Nursing (ICAGGN - 24)
Brasilia, Brazil
Organized By: IIERD
Contact Person : David Jacob
Website :- http://iierd.org/
Email : info@iierd.org

11th - 12th December
International Conference on Ageing Gerontology & Geriatric Nursing
Vitoria, Brazil
Organized By: Research Plus
Contact Person: Sukumar Sen
Website: https://researchplus.co
Email : info@researchplus.com

27th - 28th December
ICAGGN - 2024 :International Conference on Ageing Gerontology & Geriatric Nursing
Kingston, Jamaica
Organized By: Science Cite
Contact Person: Akash Shinde
Website: https://www.sciencecite.com

30th - 31st December
International Conference on Ageing Gerontology & Geriatric Nursing
Kranj, Slovenia
Organized BY: World Academics
Contact Person: John Richardson
Website: https://www.worldacademics.net
Email : Info@worldacademics.net

CALENDAR **2025**

7th - 8th January
International Conference on Aging, Gerontology & Geriatric Nursing (ICGTGY-2025)
Edinburgh, UK
Organized By: WRF
Contact Person: Daniel Brown
Website:conferencealerts.co.in/event/2651778

24th -25th February
International Conference on Ageing, Psychology and Neuroscience (ICAPN)
New Delhi, India
Organized by : World Academy of Science, Engineering and Technology
Website: https://waset.org/ageing-psychology-and-neuroscience-conference-in-february-2025-in-new-delhi

4th - 5th March
International Conference on Aging, Gerontology & Geriatric Nursing (ICAGGN-2025)
Novosibirsk, Russia
Organized By: IIRST
Contact Person: Alex Stewart
Website:https://allconferencealert.net/eventdetails.php?id=2734635

21st- 22nd April
3rd Edition of Unite Scientific Aging Conference (USAC-2025)
Vienna, Austria
Organized by: Unite Scientific Explores
Contact person: Aaron Scott
Website: https://aging.uniteexplores.com/

6th – 7thMay
International Conference on Aging, Gerontology & Geriatric Nursing (ICAGGN-25)
Dallas,USA
Organized By:Science Cite
Contact Person: Akash Shinde
Website:https://www.sciencecite.com/event/index.php?id=288999l

Awards & Accolades

Through the years, HelpAge India's work has been recognised by several organisations and institutions. We are thankful for their faith and belief in our services by giving us such an honour. It encourages us and instils a sense of belief that we are on the right path whilst reminding us of the great responsibility we carry toward the elderly of our society.

More awards on our website:
https://www.helpageindia.org/aboutus/awards-recognition/

Our work is recognised by
THE GOVERNMENT - MEDIA - SOCIETY

CRISIL VO1A Grading for excellence in operations & Financial Transparency
Awarded by CRISIL, 2022

UN Population Award
Awarded by UNFPA, 2020

Platinum Award for Transparency & Public Accountability Awarded by Guide Star India, 2017

Times Social Impact Award
Awarded by Times Group,2015

NGO Leadership & Excellence Award
Awarded by ABP News, 2015

Vayoshreshtha Samman (National Award for Senior Citizens) Awarded by Ministry of Social Justice & Empowerment, Govt. of India, 2014

HelpAge India | Fighting isolation, poverty, neglect

C-14, Qutab Institutional Area
New Delhi – 110016

Elderline: 14567

CRISIL VO 1A Grading

UN POPULATION AWARD 2020
Institutional Category

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HelpAge India's **Support a Gran** programme links such needy grans to kind-hearted and generous people like you. Your donation can provide them food and ration, clothes, medicines, some pocket money, etc.

Make a difference by donating just `9,000/- a year (`750/- per month) and be a Lifeline for those who need your help the most!

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Yes, I wish to join hands with HelpAge India for Support a Gran programme. Please accept my contribution of:

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Cheque/DD No..... Date..... in favour of **HelpAge India**

Name.....Address.....

.....Nationality—**Indian/Others** Tel.....

PAN No..... **(Please note that tax exemption as per law is only available if PAN is quoted)**

Date of Birth .....E-mail.....

HelpAge India will forward to you a receipt-cum-tax exemption certificate within 21 days

PAN: AAATH0021N

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C-14, Qutab Institutional Area, New Delhi 110 016, Tel. 011-41688955-56, 42030400 E-mail: rm@helpageindia.org

Information for the Contributors

HelpAge India Research and Development Journal is the official journal of HelpAge India and is published thrice a year in January, May and October. It is devoted to publication of contributions that focus on the information pertaining to different issues concerned with older persons.

Manuscripts

The paper should be only on issues concerning ageing and aged in India. The manuscript should be typed in double space with a wide margin and should not exceed 4000 words. The title page should carry the title of the paper, name and affiliation of the author/s. The official designation and official address should be typed at the bottom of the first page of the script. The paper should be divided into Abstract, Introduction, Material and method, Results and discussion, conclusion, acknowledgements (if any) and references. Tables should be given in Arabic, serial number and each table on a separate page. References should be listed at the end of the paper in alphabetical order and they should include only works referred to in the text. The format for the reference is:

1. Periodicals: Surname and initials of the author(s). Year of Publication. Title. Edition. Name of the Journal. Volume. Number: Page No(s)

2. Books: Surname and initials of the author(s). Year of Publication. Title. Edition. Place of Publication. Name of Publisher.

Note: Please follow above mentioned system to help maintain a particular pattern in the Journal. Submit your contribution both on printed format (hard copy) and soft copy in CD. It should be sent on the following address and soft copy could also be sent by email.

HelpAge India C-14, Qutab Institutional area New Delhi-110016 Email: info@helpageindia.org

Helpful Tips: You can contribute to this column by sending a small article (1000 words) on any subject that concerns the older persons. You can also send us such useful news items published in other magazines or journals. Please give proper reference for the same. Please follow instructions given in column (1) & (2).

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Successful research on elder benefits plays a pivotal role in enhancing the quality of life for senior citizens. By identifying their needs and challenges, it facilitates the development of tailored programs such as improved healthcare, social security, and housing support. This research fosters awareness and ensures policy-makers allocate resources effectively, reducing inequalities. Ultimately, it empowers elders to lead healthier, more dignified, and independent lives, benefiting society as a whole.

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