

# Seniors' Recreation Centers in Rural India: Need of the Hour

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## ABSTRACT

**Aim:** To empower and bring the underprivileged senior citizens in the rural areas to the mainstream of life through setting up of model “senior citizens’ recreation centers” that can be replicated in the other parts of the country. **Materials and Methods:** Six senior citizens’ recreation centers are run in six villages under a community health program of a leading Medical College in South India, which were started by looking into their perceived needs and in a location where organized self-help women groups (SHGs) showed willingness to take the role of caretakers. Together there are 140 members in 6 centers and the most deserving members were identified using a participatory rural appraisal (PRA) method. These centers are open for 5 days a week and the main attraction of the center has been provision of one good, wholesome, noon-meal a day, apart from several recreational activities. The members were also assessed for chronic energy deficiency (CED) and quality of life at the beginning of enrolment using body mass index (BMI) and WHO-BREF scale. **Results:** The attendance to these centers was nearly 90% of the enrolled beneficiaries. A statistically significant improvement was noticed in quality of life in the physical, psychological, social, and environmental domain ( $P < 0.05$ ). There was also a significant increase in the average BMI after 1 year of the intervention ( $P < 0.05$ ). **Conclusion:** Care of underprivileged senior citizens is a growing need in the rural areas and the “Recreation centers” proved to be a beneficial model that can be easily replicated.

**Keywords:** Aged, nutrition, quality of life, senior citizens’ recreation centers

## Introduction

Twenty-first century ushers in greater focus on ageing population as they have become a significant group both in developed and developing countries.<sup>(1)</sup> In India, nearly 75% of the senior citizens are residing in the rural areas. The geriatric population, who currently constitute 8% of the India’s population, is expected to become 20% by 2050.<sup>(2)</sup> This inevitably warrants our attention toward their medical, social, and economic well-being.<sup>(3)</sup>

In the Indian tradition, especially in the rural areas, immediate family members were the providers of social security for the elderly. However, in the recent years, it has been observed that failure of agriculture as a profitable occupation to make a living had led the young in the rural areas to migrate to the nearby towns seeking jobs and as a consequence senior citizens were left behind

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in the villages and they had to fend for themselves. Further the economic stress and poverty in the rural families have caused an attrition of the traditional care mechanism, especially for women, raising concerns regarding their universal security.<sup>(4,5)</sup> Various studies have shown that the geriatric population in India was financially insecure and many elderly people were facing physical abuse and neglect, which was directly linked to gender and social support.<sup>(6)</sup> Some were even abandoned by their family and were surviving only on meager pension received from the government.<sup>(7)</sup> The abysmal state of nutrition among the senior citizens also warrants special attention as statistics show that nearly half were underweight,<sup>(8,9)</sup> with factors such as low socioeconomic status, lack of decision-making power, poor financial security, and death of the partner adding to it.<sup>(10)</sup>

It was in addressing these issues of the vulnerable senior citizens in the rural communities, Rural Unit for Health and Social Affairs (RUHSA) Department, an outreach Community Health Programme of Christian Medical College, Vellore, started recreational facilities for them in the service area. The ultimate aim of this endeavor was to assess a feasible model of "seniors' recreation centers" in the rural areas to identify and improve the health and social welfare of the poor senior citizens in the community that could be replicable in the other parts of the country.

## Materials and Methods

### Project development with partnerships with international and national agencies and local community participation

#### *Participatory rural appraisal to identify the beneficiaries*

In order to identify the most deserving senior citizen who could be helped through the recreation facility, a qualitative study was done that enabled us to identify the beneficiaries and also to assess the specific needs of the geriatric population. Qualitative design has the advantage of being flexible and it is driven by responders rather than the data collectors. The methods used included social mapping and wealth ranking collectively called as participatory rural appraisal (PRA) through which the households were classified as poorest of poor, middle class, and rich. Households with poor senior citizens and older people with special issues were identified. Information regarding aged men/women who have been neglected, widowed, or abandoned was also collected.

The overriding theme identified time and again in all the discussions with the community was that the senior citizens were the most vulnerable group with majority of them being poor and abandoned by their family members. There were many interlinking themes

identified as a result of PRA of which the greatest priority was that of providing a good meal a day at the center. The other issues that were raised during the discussions are given in Table 1. Several priority areas of interventions were identified which were listed in Table 2.

#### *Activities of the center and other support for welfare*

Six centers were started in six villages. The sites for the centers were selected in discussion with the community leaders and self-help women groups (SHGs), by looking into the perceived need in the village and willingness of one SHG from the community to take up the responsibility as caretakers. Each center had an average of 25 members enrolled. There were a total of 140 senior citizens in all the six centers combined, out of which 39 (28%) were men and 101 (72%) were women. The centers function from 10 am to 2 pm. One of the main activities at these centers was the provision of a wholesome and nutritious midday meal. For many of them it is the main, and sometimes the only meal of the day. The other recreational activities include morning prayer, singing folk songs, folk dance, and playing some board games and traditional games; for literates reading out the contents of the Tamil newspapers provided to them; watching television in two of the centers. They are also made to practice daily exercise, led by the caretakers including joint-mobility exercises and other simple exercises, taught to them by the occupational therapist from RUHSA, who visits these centers once in a week.

Other services include regular health checkups through RUHSA's outreach and base hospital clinics, special attention was given to dental health, vision, and hearing; and they were provided with hearing aids and spectacles free of cost and were also facilitated to undergo surgery for cataract.

In addition, they were motivated to engage in small income-generation activities including goat rearing and paper bag making to be able to make a small pocket

#### **Table 1: General issues of the senior citizens in the village**

In many families, the senior citizens are not given adequate food  
Some of them are chased out of their homes thus struggling for food, livelihood, and proper shelter  
They are not involved in family activities and so are very depressed  
Some are abandoned by their children

#### **Table 2: Priority interventions requested by the beneficiaries**

Intervention	Theme
Provide one good meal a day in the center	Neglect, hunger
Contribute to clothing	Dignity, self-care, poverty
Provide medical facility	Neglected health care needs
Provide training for care givers	Mobility, physical function

money. Assistance was provided to them to avail social security government schemes such as old age pension. On their request, one-day picnic or an outing has been arranged once a year for them to the nearby natural and town parks.

### Sustainability of the centers

With regard to sustainability of the centers, community participation was sought since the inception of the idea of starting "seniors' recreation centers." The members of women SHGs in the same village volunteered to be the caretakers of these centers for a very nominal cost support; received contributions from the community and village leaders that included provision of lunch on special days, such as festivals and family occasions, construction of toilet in one center, and provision of water facility in all the centers. Of the six centers, three are in the unused "Panchayat Building," "Balwadi" center, and SHG building during the day, donated by the community and three are in our own outreach clinic centers. Thus, of the total annual estimated cost of about ₹4,00,000 for running one center with 25 beneficiaries, 40% of the cost that included cost of renting a building and wages for manpower were borne by the community. Remaining required funds were raised from donors both international and national, who are committed to make contributions on a regular basis to social projects. RUHSA, the community health division of Christian Medical College, Vellore, provides the logistics and operational guidance for the successful management of these centers.

### Outcome

In all the centers, the attendance was good with the average attendance being 88%. When quality of life was assessed for the members in one of the centers using WHO-BREF Quality of life (QOL) questionnaire, at the beginning of the project and after the completion of 1 year, it was found that at the time of enrollment, 38% had rated their QOL as "poor" and 58% had rated it as "neither poor nor good," and only 4% had rated it as "good," and it was very gratifying to see that after 1 year, 33% of the subjects had rated their QOL as "good" and none rated it as "poor". The mean scores of

the physical, psychological, social, and environmental domains of QOL at the time entry and after 1 year are shown in Table 3.

As a marker of nutritional status, body mass index (BMI) was calculated for the members at the beginning of the project and it was reevaluated again in 2015. A statistically significant difference in BMI was noticed with mean increase in BMI being 2.5 (+/-1.8) kg/m<sup>2</sup>, ( $t = 2.79, P = 0.007$ ). A gradual trend away from chronic energy deficiency (CED) was noticed among the participants that are shown in Table 4. The percentage of senior citizens affected with CED reduced from 42.3% to 33.8%.

### Qualitative assessment of the centers

The senior citizens in these centers and the SHG caretakers were asked to give their feedback about the centers. Their responses are displayed in Table 5.

### Relevance of the project

India is the second most populous country in the world.<sup>(11)</sup> The geriatric population in India increased

**Table 3: Comparison of quality of life at registration and after 1 year (N = 25)**

Domain	At registration		After 1 year		Paired "t" test	
	Mean	Std. dev.	Mean	Std. dev.	t value	P
Physical	37.4	10.5	51.5	6.5	12.9	0.0001
Psychological	35.7	10.1	48.9	10.8	10.75	0.0001
Social	36.2	11.2	50.8	17.3	6.38	0.0001
Environmental	37.5	9.4	56.9	10.1	19.89	0.0001

**Table 4: Comparison of chronic energy deficiency before and after the inception of the project n = 71**

Chronic energy deficiency classification (CED) using BMI	At registration No. (%)	Status in 2015 No. (%)
CED 3 (BMI less than 16)	3 (4.2)	5 (7.0)
CED 2 (BMI 16.0-16.9)	13 (18.3)	7 (9.9)
CED 1 (BMI 17.0-18.4)	14 (19.7)	12 (16.9)
Normal (BMI 18.5-24.9)	36 (50.7)	34 (47.9)
Over weight (BMI 25.0-29.9)	5 (7.1)	5 (7.0)
Obese (BMI 30 and above)		8 (11.3)

**Table 5: Response from the senior citizens and the SHG caretakers at the center**

Response from the senior citizens	Response from the SHG caretakers
Provision of food is a great help	Consider serving senior citizens as an obligation
Coming to this center helps to overcome loneliness	Serving them provides us satisfaction
Opportunity to learn about social issues through reading newspaper and watching	Feel proud to serve senior citizens and be part of RUHSA
Feeling entertained with games, TV, and visitors	Feel the senior recreation center project is the source of income to support our family
Interacting with people and the respect shown by them helps us to ventilate our feelings	Feel involved in social services activity by caring for the senior citizens
Happy to experience love and affection from people who visit us.	
Appreciate the special food and eatables provided by community members on special occasions.	

by 42% in the last 15 years,<sup>(12)</sup> and the population of the elderly people in rural area consistently outnumbered the elderly population in the urban area.<sup>(13)</sup> But presently all the health facilities, recreation centers, and old-age centers primarily target the urban population. A rapid demographic transition and urbanization in recent areas has led to the breakdown of the joint family structure and emergence of the nuclear families. With no social security structure in place and with poor access to health care, rehabilitation, and recreation facilities, the senior citizens in India is staring at a bleak present and future.<sup>(12)</sup> This project was started in response to a felt need of the community, gauged by rapid appraisals. The primary concerns revealed through the rapid appraisals was that lack of access to at least one good meal a day, neglect and abandonment by the family members. It has been shown in various studies done on deprivation and vulnerability among the geriatric population, in other parts of India, that they lived in extreme poverty and thus compelled to go for work irrespective of their poor physical status.<sup>(14)</sup> The senior recreation centers tried to address these concerns and managed to alleviate these issues to a certain extent. The quality of life of the participants showed improvement in physical, psychological, social, and environmental domains and it was statistically significant. There was also a statistically significant improvement in BMI of the participants after the inception of the project. The senior recreation centers provided an avenue for the geriatric population to share their miseries or their happiness with others, which they were unable to do earlier. The centers foisted a feeling of belonging and togetherness among the members, which helped to reduce their overwhelming low feeling of being abandoned and being lonely. This has undoubtedly contributed to the growing popularity of this model.

Care of the aged is a growing need, not just in urban areas but also in rural areas, and our senior recreation centers proved to be a novel model that can be replicated in any rural settings with community participation.

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### Conflicts of interest

No potential conflicts of interest were disclosed.

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