Call for Editorial Board Members

As you are well aware that we are a medical and health sciences publishers; publishing peer-reviewed journals and books since 2004.

We are always looking for dedicated editorial board members for our journals. If you completed your master's degree and must have at least five years experience in teaching and having good publication records in journals and books.

If you are interested to be an editorial board member of the journal; please provide your complete resume and affiliation through e-mail (i.e. info@rfppl.co.in) or visit our website (i.e.www.rfppl.co.in) to register yourself online.

Call for Publication of Conference Papers/Abstracts

We publish pre-conference or post-conference papers and abstracts in our journals, and deliver hard copy and giving online access in a timely fashion to the authors.

For more information, please contact:

For more information, please contact:
A Lal
Publication–in-charge
Red Flower Publication Pvt. Ltd.
48/41-42, DSIDC, Pocket-II
Mayur Vihar Phase-I
Delhi – 110 091 (India)
Phone: 91-11-22754205, 79695648
E-mail: info@rfppl.co.in

Free Announcements of your Conferences/Workshops/CMEs

This privilege to all Indian and other countries conferences organizing committee members to publish free announcements of your conferences/ workshops. If you are interested, please send your matter in word formats and images or pictures in JPG/JPEG/Tiff formats through e-mail attachments to sales@rfppl.co.in.

Terms & Conditions to publish free announcements:

1. Only conference organizers are eligible up to one full black and white page, but not applicable for the front, inside front, inside back and back cover, however, these pages are paid.
2. Only five pages in every issue are available for free announcements for different conferences.
3. This announcement will come in the next coming issue and no priority will be given.
4. All legal disputes subject to Delhi jurisdiction only.
5. The executive committee of the Red Flower Publication reserve the right to cancel, revise or modify terms and conditions any time without prior notice.

For more information, please contact:
A Lal
Publication-in-charge
Red Flower Publication Pvt. Ltd.
48/41-42, DSIDC, Pocket-II
Mayur Vihar Phase-I
Delhi – 110 091 (India)
Phone: 91-11-22754205, 79695648
E-mail: info@rfppl.co.in

Win Free Institutional Subscription!

Simply fill out this form and return scanned copy through e-mail or by post to us.

Name of the Institution_____
Name of the Principal/Chairman_____
Management (Trust/Society/Govt./Company)_____
Address 1_____
Address 2_____
Address 3_____
City_____
Country_____
PIN Code_____
Mobile_____
Email_____

We are regular subscriber of Red Flower Publication journals.

Year of first subscription_____

List of ordered journals (if you subscribed more than 5 titles, please attach separate sheet)

Ordered through

Name of the Vendor	Subscription Year	Direct/subs Yr

Name of the journal for which you wish to be free winner

Terms & Conditions to win free institutional subscription

1. Only institutions can participate in this scheme
2. In group institutions only one institution would be winner
3. Only five institutions will be winner for each journal
4. An institution will be winner only for one journal
5. The free subscription will be valid for one year only (i.e. 1 Jan – 31 Dec)
6. This free subscription is not renewable, however, can be renewed with payment
7. Any institution can again participate after five years
8. All legal disputes subject to Delhi jurisdiction only
9. This scheme will be available to participate throughout year, but draw will be held in last week of August every year
10. The executive committee of the Red Flower Publication reserve the right to cancel, revise or modify terms and conditions any time without prior notice.

I confirm and certify that the above information is true and correct to the best of my knowledge and belief.

Place: Signature with Seal
Date:

Revised Rates for 2020 (Institutional) Title of the Journal	Frequency	India(INR) Print Only	India(INR) Online Only	Outside India(USD) Print Only	Outside India(USD) Online Only
Community and Public Health Nursing	3	6000	5500	469	430
Indian Journal of Agriculture Business	2	6000	5500	469	430
Indian Journal of Anatomy	4	9000	8500	703	664
Indian Journal of Ancient Medicine and Yoga	4	8500	8000	664	625
Indian Journal of Anesthesia and Analgesia	6	8000	7500	625	586
Indian Journal of Biology	2	6000	5500	469	430
Indian Journal of Cancer Education and Research	2	9500	9000	742	703
Indian Journal of Communicable Diseases	2	9000	8500	703	664
Indian Journal of Dental Education	4	6000	5500	469	430
Indian Journal of Diabetes and Endocrinology	2	8500	8000	664	625
Indian Journal of Emergency Medicine	4	13000	12500	1016	977
Indian Journal of Forensic Medicine and Pathology	4	16500	16000	1289	1250
Indian Journal of Forensic Odontology	2	6000	5500	469	430
Indian Journal of Genetics and Molecular Research	2	7500	7000	586	547
Indian Journal of Law and Human Behavior	3	6500	6000	508	469
Indian Journal of Legal Medicine	2	9000	8500	703	664
Indian Journal of Library and Information Science	3	10000	9500	781	742
Indian Journal of Maternal-Fetal & Neonatal Medicine	2	10000	9500	781	742
Indian Journal of Medical and Health Sciences	2	7500	7000	586	547
Indian Journal of Obstetrics and Gynecology	4	10000	9500	781	742
Indian Journal of Pathology: Research and Practice	6	12500	12000	977	938
Indian Journal of Plant and Soil	2	7000	6500	547	508
Indian Journal of Preventive Medicine	2	7500	7000	586	547
Indian Journal of Research in Anthropology	2	13000	12500	1016	977
Indian Journal of Surgical Nursing	3	6000	5500	469	430
Indian Journal of Trauma and Emergency Pediatrics	4	10000	9500	781	742
Indian Journal of Waste Management	2	10000	9500	781	742
International Journal of Food, Nutrition & Dietetics	3	6000	5500	469	430
International Journal of Forensic Science	2	10500	10000	820	781
International Journal of Neurology and Neurosurgery	4	11000	10500	859	820
International Journal of Pediatric Nursing	3	6000	5500	469	430
International Journal of Political Science	2	6500	6000	508	469
International Journal of Practical Nursing	3	6000	5500	469	430
International Physiology	3	8000	7500	625	586
Journal of Animal Feed Science and Technology	2	8300	7800	648	609
Journal of Cardiovascular Medicine and Surgery	4	10500	10000	820	781
Journal of Emergency and Trauma Nursing	2	6000	5500	469	430
Journal of Forensic Chemistry and Toxicology	2	10000	9500	781	742
Journal of Global Medical Education and Research	2	6400	5900	500	461
Journal of Global Public Health	2	12500	12000	977	938
Journal of Microbiology and Related Research	2	9000	8500	703	664
Journal of Nurse Midwifery and Maternal Health	3	6000	5500	469	430
Journal of Orthopedic Education	3	6000	5500	469	430
Journal of Pharmaceutical and Medicinal Chemistry	2	17000	16500	1328	1289
Journal of Plastic Surgery and Transplantation	2	26900	26400	1954	575
Journal of Psychiatric Nursing	3	6000	5500	469	430
Journal of Social Welfare and Management	4	8000	7500	625	586
New Indian Journal of Surgery	6	8500	7500	664	625
Ophthalmology and Allied Sciences	3	6500	6000	508	469
Pediatric Education and Research	4	8000	7500	625	586
Physiotherapy and Occupational Therapy Journal	4	9500	9000	742	703
RFP Indian Journal of Medical Psychiatry	2	8500	8000	664	625
RFP Journal of Biochemistry and Biophysics	2	7500	7000	586	547
RFP Journal of Dermatology (Formerly Dermatology International)	2	6000	5500	469	430
RFP Journal of ENT and Allied Sciences (Formerly Otolaryngology International)	2	6000	5500	469	430
RFP Journal of Hospital Administration	2	7500	7000	586	547
Urology, Nephrology and Andrology International	2	8000	7500	625	586
Coming Soon					
RFP Gastroenterology International	2	–	–	–	–
Journal of Food Additives and Contaminants	2	–	–	–	–
Journal of Food Technology and Engineering	2	–	–	–	–
Journal of Radiology	2	–	–	–	–
Medical Drugs and Devices	3	–	–	–	–
RFP Indian Journal of Hospital Infection	2	–	–	–	–
RFP Journal of Gerontology and Geriatric Nursing	2	–	–	–	–

Terms of Supply:

1. Agency discount 12.5%. Issues will be sent directly to the end user, otherwise foreign rates will be charged.
2. All back volumes of all journals are available at current rates.
3. All journals are available free online with print order within the subscription period.
4. All legal disputes subject to Delhi jurisdiction.
5. Cancellations are not accepted orders once processed.
6. Demand draft/cheque should be issued in favour of "**Red Flower Publication Pvt. Ltd.**" payable at **Delhi.**
7. Full pre-payment is required. It can be done through online (http://rfppl.co.in/subscribe.php?mid=7).
8. No claims will be entertained if not reported within 6 months of the publishing date.
9. Orders and payments are to be sent to our office address as given below.
10. Postage & Handling is included in the subscription rates.
11. Subscription period is accepted on calendar year basis (i.e. Jan to Dec). However orders may be placed any time throughout the year.

Order from

Red Flower Publication Pvt. Ltd., 48/41-42, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi - 110 091 (India)
Mobile: 8130750089, Phone: 91-11-**79695648**, 22754205, 22756995, E-mail: sales@rfppl.co.in, Website: www.rfppl.co.in

RFP Journal of
Gerontology and Geriatric Nursing

Corresponding address
Red Flower Publication Pvt. Ltd. 48/41-42 DSIDC, Pocket-II, Mayur Vihar Phase-I Delhi - 110 091(India)
Phone: 91-11-22754205/79695648, Fax: 91-11-22754205, Mob: 8130750089

E-mail: info@rfppl.co.in, Web: www.rfppl.co.in

RFP Journal of Gerontology and Geriatric Nursing (JGGN) (p-ISSN 2582-1407, e-ISSN 2582-3426) is a half yearly peer-reviewed journal publishing latest developments in the management of acute and chronic disorders and provide practical advice on care of older adults across the long term continuum. The **Journal of Gerontology and Geriatric Nursing** is publishing clinically relevant articles on the practice of gerontological nursing across the continuum of care in a variety of health care settings.

Subscription Information

India

Institutional (1 year): Rs.6000

Rest of the World

Insitutional (1 year) USD 469

Payment methods

Bank draft / cashier & order / check / cheque / demand draft / money order should be in the name of **Red Flower Publication Pvt. Ltd.** payable at **Delhi**.

International Bank transfer / bank wire / electronic funds transfer / money remittance / money wire / telegraphic transfer / telex

1. **Complete Bank Account No.** 604320110000467
2. **Beneficiary Name (As per Bank Pass Book):** Red Flower Publication Pvt. Ltd.
3. **Address:** 41/48, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi – 110 091(India)
4. **Bank & Branch Name:** Bank of India; Mayur Vihar
5. **Bank Address & Phone Number:** 13/14, Sri Balaji Shop,Pocket II, Mayur Vihar Phase- I, New Delhi - 110091 (India); Tel: 22750372, 22753401. **Email:** mayurvihar.newdelhi@bankofindia.co.in
6. **MICR Code:** 110013045
7. **Branch Code:** 6043
8. **IFSC Code:** BKID0006043 (used for RTGS and NEFT transactions)
9. **Swift Code:** BKIDINBBDOS
10. **Beneficiary Contact No. & E-mail ID:** 91-11-22754205, 79695648, E-mail: redflowerppl@gmail.com

Online You can now renew online using our RFPPL renewal website. Visit www.rfppl.co.in and enter the required information and than you will be able to pay online.

Send all Orders to: **Red Flower Publication Pvt. Ltd.,** 48/41-42, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi – 110 091(India). Phone: 91-11-22754205, 79695648, Fax: 91-11-22754205, Mob: 8130750089
E-mail: sales@rfppl.co.in, Website: www.rfppl.co.in

RFP Journal of

Gerontology and Geriatric Nursing

January - June 2020
Volume 3, Number 1

Contents

Original Articles

Review Article

p-ISSN 2582-1407, e-ISSN 2582-3426
Original Article

RFP Journal of Gerontology and Geriatric Nursing
Volume 3 Number 1, January - June 2020

Disability among Senior Citizens in India

Krishnakumar C S

Author Affiliation

Director, Institute of Development Research, Prasanth Nagar, Ulloor, Thiruvananthapuram, Kerala, 695011, India

Corresponding Author

Krishnakumar C.S, Director, Institute of Development Research, Prasanth Nagar, Ulloor, Thiruvananthapuram, Kerala, 695011, India,

E-mail: krishnaidr@gmail.com

Abstract

In this paper, an attempt is made to understand the disability condition of senior citizens in India using the Census of India 2011. The levels and patterns of disability rate, and the distribution of disabled population by the type of disability were examined across states as well as gender. Results indicate that irrespective of the age, a considerable proportion of senior citizens have multiple disability, and the levels significantly varies across states. Even though females live longer, males reported relatively higher levels of disability rate.

Keywords: Disability Rate; Senior Citizens; India.

How to cite this article:

Krishnakumar C.S Disability among Senior Citizens in India. RFP Journal of Gerontology and Geriatric Nursing. 2020; 3 (1) : 09–14.

Introduction

In India, disability among senior citizen is a significant problem both in terms of its larger magnitude and complexity. As per the Census of India 2011, the disabled population aged 60+ years in India is around 53 million. Of this disabled, 27 million are males and the remaining 26 million are females (Census of India 2011).

Even though several studies are available on disability, none of them exclusively devoted to the conditions of senior citizens using the data of latest Census of India(Nidhiya Menon, Parish, and Rose 2011; Agrawal, Keshri, and Gaur 2009; Addlakha and Mandal 2009; Gupta 2018; Singh 2008; Mishra and Mohanty 2018; Reddy and PavaniSree 2015; Mitra and Sambamoorthi 2008; Pandey 2012; Sengupta and Emily 2002). Again, the spatial and gender dimension of disability conditions among senior citizens were scientifically unexplored in the previous studies.

Senior citizens in the country are vulnerable to multiple risks (Chermak 1990; Addlakha and Mandal 2009; Mehrotra 2011; Hiranandani and Sonpal 2010; Barnes and Sheldon 2010; Patel, Rodrigues, and DeSouza 2002; Pandey 2012; Patel et. al. 1998; N Menon, Parish, and Rose 2014). Their well-beings are an outcome of the absence of disability, and proper health care. Since the country has insufficient social security measures, due care must be given to reduce their risk of disabilities as much as possible. Proper planning of social and health interventions for them requires a vivid understanding of the levels and patterns of disability both at macro and micro level.

The main objectives of this paper is to examine the levels and patterns of disability rates among senior citizens in India, and its variation across states and gender. Also, to understand the distribution of disabled population by type of disability, gender and place of residence.

Materials and Methods

The data used for the analysis is taken from Census of India 2011 (Census of India 2011). Census is the most reliable data source on disability. The members of the household were asked whether they suffered from physical or mental disability. If suffered, the type of disability was enquired. These two information was used to analyze conditions of disability of senior citizens.

In this paper, the term 'disability' means a person with restrictions or lack of abilities to perform an activity in the manner or with a range considered normal for a human being. Disability rate is defined as the number of disabled population per every 100 old aged persons.

Results

Before understanding the levels of disability rates, it is necessary to understand the absolute magnitude of disabled senior citizens across states and its fractions in relation to the total disabled population in India. Table 1 shows number of senior citizens with disability and its share to disabled population in India and major states by sex. Around 20 percent of the disabled persons are senior citizen. In other words, one in every five disabled persons is a senior citizen.

Table 1.: Number of senior persons with disability and its share to disabled population in the major states of India by Sex, 2011.

Major states	Senior Persons with Disability*			Share to disabled population		
	Total	Males	Females	Total	Males	Females
Andhra Pradesh	491816	247027	244789	21.7	20.2	23.5
Assam	107682	51868	55814	22.4	20.2	25.1
Bihar	327172	187924	139248	14.0	14.0	14.1
Chhattisgarh	174926	79991	94935	28.0	23.9	32.6
Gujarat	191513	91616	99897	17.5	15.0	20.8
Haryana	124185	62735	61450	22.7	19.9	26.6
Himachal Pradesh	48776	24148	24628	31.4	28.0	35.7
Jharkhand	147684	75865	71819	19.2	17.8	20.9
Karnataka	219668	111087	108581	16.6	15.3	18.2
Kerala	224855	101198	123657	29.5	25.6	33.7
Madhya Pradesh	333712	165753	167959	21.5	18.7	25.3
Maharashtra	513756	271468	242288	17.3	16.0	19.1
Punjab	121552	66229	55323	18.6	17.4	20.2
Rajasthan	558192	244632	313560	35.7	28.8	43.8
Sikkim	4527	2475	2052	24.9	25.3	24.4
Tamil Nadu	190254	103840	86414	16.1	15.8	16.5
Uttar Pradesh	660245	351486	308759	15.9	14.9	17.2
Uttarakhand	44373	21409	22964	24.0	20.8	27.8
West Bengal	365892	187136	178756	18.1	16.6	20.1
India	5376205	2713757	2662448	20.1	18.1	22.5

Note: *senior persons aged 60+ years

Source of Data: Census of India 2011

The share of disabled senior citizens in disability population varies across states. The lowest share was found in Bihar with 14 percent, and the highest share in Rajasthan with 35.7 percent. Compared to the national level, around 10 states have a higher share. After the Rajasthan, the highest disability shares are found in Himachal Pradesh, Kerala and Chhattisgarh.

In comparison to men, the proportion of aged disabled women is relatively high in Gujarat, Punjab, Madhya Pradesh, Haryana, Kerala, Himachal Pradesh, Chhattisgarh, and Rajasthan.

The male-female differentials are relatively less in Bihar, Karnataka, Tamil Nadu, West Bengal, Maharashtra and Sikkim.

Table 2 gives the disability rates among senior citizens in terms of place of residence, gender and state. Here, the disability rate is the number of disabled elderly persons per 100 elderly persons. The disability rate of the elderly in India is 5.18. it means, for every 100 old persons, five are disabled.

Table 2.: Disability rate among aged (60+ years) in India, 2011 (%).

	Total			Rural			Urban		
Union Territory	**Total**	**Males**	**Females**	**Total**	**Males**	**Females**	**Total**	**Males**	**Females**
Andaman & Nicobar Islands	5.82	6.23	5.30	7.11	7.57	6.52	2.74	3.01	2.39
Andhra Pradesh	5.94	6.32	5.60	6.38	6.75	6.05	4.72	5.15	4.32
Arunachal Pradesh	7.61	7.26	8.01	8.10	7.74	8.48	3.89	3.71	4.10
Assam	5.18	4.92	5.45	5.47	5.20	5.74	3.67	3.43	3.93
Bihar	4.25	4.58	3.87	4.27	4.60	3.89	4.03	4.35	3.66
Chandigarh	3.58	3.63	3.54	3.46	3.93	2.87	3.58	3.62	3.55
Chhattisgarh	8.73	8.62	8.83	9.35	9.21	9.47	6.29	6.37	6.21
Dadra & Nagar Haveli	3.10	3.24	2.97	3.64	3.68	3.60	2.21	2.61	1.81
Daman & Diu	3.52	3.51	3.53	3.91	4.51	3.49	3.34	3.08	3.55
Goa	5.65	5.56	5.72	6.68	6.72	6.65	4.95	4.81	5.07
Gujarat	4.00	4.08	3.93	3.94	4.01	3.89	4.09	4.19	4.00
Haryana	5.66	5.76	5.56	5.87	6.02	5.73	5.20	5.21	5.18
Himachal Pradesh	6.94	7.08	6.80	7.14	7.31	6.99	4.47	4.52	4.41
Jammu & Kashmir	9.09	9.13	9.05	10.07	10.20	9.93	6.73	6.52	6.96
Jharkhand	6.27	6.42	6.11	6.75	6.94	6.57	4.57	4.74	4.38
Karnataka	3.79	4.04	3.57	3.97	4.23	3.74	3.42	3.66	3.19
Kerala	5.36	5.37	5.35	5.67	5.72	5.62	5.03	4.98	5.06
Lakshadweep	6.03	5.72	6.36	9.46	9.06	9.92	5.13	4.79	5.48
Madhya Pradesh	5.84	5.98	5.71	6.30	6.37	6.22	4.58	4.92	4.27
Maharashtra	4.63	5.17	4.14	4.95	5.56	4.41	4.09	4.53	3.66
Manipur	4.30	4.54	4.06	4.35	4.57	4.12	4.21	4.47	3.96
Meghalaya	3.93	3.99	3.87	4.28	4.25	4.31	2.62	2.92	2.38
Mizoram	4.19	4.31	4.07	5.45	5.36	5.54	3.06	3.31	2.83
Nagaland	6.96	6.79	7.14	7.55	7.41	7.72	4.69	4.52	4.89
NCT of Delhi	4.36	4.34	4.39	5.32	5.38	5.26	4.34	4.31	4.37
Odisha	8.24	8.31	8.18	8.59	8.68	8.50	6.03	6.01	6.05
Puducherry	5.47	5.99	5.05	6.21	7.21	5.40	5.15	5.46	4.90
Punjab	4.24	4.59	3.89	4.52	4.87	4.16	3.65	3.97	3.31
Rajasthan	10.92	10.06	11.70	12.25	11.26	13.14	6.53	6.23	6.81
Sikkim	11.11	11.01	11.23	12.42	12.21	12.67	5.36	5.48	5.23
Tamil Nadu	2.53	2.84	2.25	2.71	3.01	2.42	2.33	2.63	2.05
Tripura	4.60	4.47	4.73	4.48	4.32	4.63	4.90	4.83	4.96
Uttar Pradesh	4.28	4.37	4.17	4.29	4.38	4.19	4.22	4.33	4.10
Uttarakhand	4.93	4.84	5.00	5.42	5.32	5.52	3.43	3.52	3.32
West Bengal	4.73	4.86	4.59	5.18	5.39	4.98	3.94	3.99	3.89
India	5.18	5.31	5.04	5.59	5.71	5.48	4.18	4.36	4.01

Source of Data: Census of India 2011

Around 14 states in India show a disability rate that is higher than that of the country. The highest disability rates were reported in Sikkim (11.1%), followed by Rajasthan (10.9%), Jammu and Kashmir (9.1%), Chhattisgarh (8.7%), Odisha (8.24%), and Arunachal Pradesh (7.6%). Among the states, the lowest disability rate was reported in Tamil Nadu (2.5%), followed by Karnataka (3.8%), Meghalaya (3.9%), Gujarat (4%), Mizoram (4.2%), Punjab (4.24%), Bihar (4.25%) and Uttar Pradesh (4.3%).

The disability rates of aged males and females in the country are 5.31 and 5.04, respectively. Irrespective of rural or urban areas, the disability rates have been higher among men than women.

Table 3 gives the distribution of disabled population by type of disability, gender and place of residence in India. It is clear from the table that issues related to sight, hearing, and movement were found to be relatively predominant among old people. The levels of these problems increases as the age progress in individuals. A considerable proportion of old aged persons have multiple disability. This is found true irrespective of the gender, age and place of residence.

Table 3: Distribution of disabled population by type of disability, gender and place of residence, India 2011.

	Type of disability							
Age Group	**SE**	**HE**	**SP**	**MOV**	**MR**	**MI**	**AO**	**MD**
India								
60-69	25.2	18.5	4.7	25.6	2.2	2.1	13.6	8.1
70-79	26.3	19.4	3.2	25.6	1.3	1.4	9.9	13.0
80-89	24.5	20.0	2.3	24.5	1.0	1.1	7.9	18.8
90+	21.1	19.2	2.6	21.5	1.3	1.0	8.7	24.6
Males								
60-69	22.9	17.6	5.0	28.6	2.2	2.0	14.1	7.6
70-79	24.7	19.4	3.5	27.5	1.3	1.3	10.6	11.8
80-89	23.6	20.8	2.5	25.3	1.0	1.0	8.5	17.2
90+	20.8	20.4	3.1	21.7	1.5	1.0	9.7	21.7
Females								
60-69	27.7	19.5	4.4	22.4	2.1	2.2	13.0	8.6
70-79	28.0	19.4	2.8	23.7	1.3	1.5	9.3	14.2
80-89	25.2	19.2	2.0	23.7	1.0	1.2	7.4	20.3
90+	21.3	18.2	2.2	21.4	1.1	1.0	8.0	26.8
Rural India								
60-69	26.1	18.4	4.1	26.0	2.0	2.0	12.8	8.6
70-79	27.3	18.9	2.7	25.6	1.2	1.3	9.2	13.8
80-89	25.4	19.1	1.9	24.5	0.8	0.9	7.3	20.0
90+	21.6	18.2	2.1	21.9	1.1	0.9	7.8	26.3
Urban India								
60-69	22.4	18.9	6.5	24.6	2.5	2.6	15.8	6.6
70-79	22.8	20.9	4.8	25.4	1.7	2.0	12.4	10.1
80-89	21.2	22.8	3.5	24.2	1.4	1.6	10.1	15.0
90+	19.4	22.4	4.3	20.1	1.9	1.3	11.9	18.7

Note: SE = in seeing, HE = Hearing, SP = in Speech, MOV = movement, MR = Mental Retardation, MI = Mental Illness, AO = Any Other, MD = Multiple Disability

Source of Data: Census of India 2011

Discussion

In this paper, we examined the proportion of senior citizens in the disabled population in India and states. It has been found that the share of disabled senior citizens is considerable and the levels significantly varies across states. It implies considerable disability cases are taking place in old ages. It is a well establish fact that disability is associated with economic dependency and most of the old aged persons are highly dependent on their family members(Jain et al. 2015; Agrawal, Keshri, and Gaur 2009; Chermak 1990; Prakash 2003; Singh 2008; Mitra and Sambamoorthi 2008; Barnes and Sheldon 2010; Patel, Rodrigues, and DeSouza 2002; Das et al. 2007; Pandey 2012; Mishra and Mohanty 2018). The social security in the country is poor and the most of the poor find difficult to both ends meet. Consequently, poor people are less likely to seek health care on time(Narayanan, Ramachandran, and Krishnakumar 2019). This increases the vulnerability of disability among them.

It is worth to mention here that the states like Rajasthan, Orissa, Sikkim and Jammu & Kashmir, that showed higher levels of disability rates, also have higher levels of economic dependency. This does not mean that disability rate and economic dependency are positively related in all states of India. For instance, the southern states, particularly in Kerala, have a low level of disability rate and high level of economic dependency among the senior citizens. Perhaps, nutritional food and proper exercise be a good predictor of disability than the economic dependency.

Another notable aspect would be that the share of the disabled being greater than their population share indicates the extent of vulnerability to disability in old age. This phenomenon is consistently higher for elderly males when compared with their female counterparts. The substantial share of the disability among the elderly population raises multiple concerns regarding its burden and implications.

However, the disability conditions of the elderly discussed in this paper are completely based on the information available in the Census of India 2011. Census data does not account for the temporary disability conditions of senior persons. Therefore, the disability estimates may be interpreted with due consideration for this aspect.

Conclusion

The social welfare programs must consider the state-level conditions of the disabled since the disability rates,and the distribution of disabled senior citizens by the type of disability significantly varies across states, and gender. Again, all such programs must be both disabled-friendly and old-age friendly. It is advisable to form state level policy for the disabled persons. Chhattisgarh already formulated a well disability policy. The disability policy must consider the aspects of social and technological interventions, disabled friendly sanitations and transport, subsidized medical drugs, use of Corporate Social Responsibility (CSR) funds, and proper evaluations.

References

1. Addlakha, Renu, and Saptarshi Mandal. 2009. "Disability Law in India: Paradigm Shift or Evolving Discourse?" Economic and Political Weekly 44 (41/42): 62–68.
2. Agrawal, Gopal, Kunal Keshri, and Kirti Gaur. 2009. "Aging, Disability and Health Care Services among Older Persons in India." ME-JAA 6 (5).
3. Barnes, Colin, and Alison Sheldon. 2010. "Disability, Politics and Poverty in a Majority World Context." Disability & Society 25 (7): 771–82. https://doi.org/10.1080/09687599.2010.520889.
4. Census of India. 2011. "Census Data, Population Enumeration Data 2011." Registrar General of India, Ministry of Home Affairs, Government of India. Retrieved from http://www.censusindia.gov.in/2011census/population_enumeration.aspx.
5. Chermak, Gail D. 1990. "A Global Perspective on Disability: A Review of Efforts to Increase Access and Advance Social Integration for Disabled Persons." International Disability Studies 12 (3): 123–27. https://doi.org/10.3109/03790799009166266.
6. Das, Jishnu, Quy-Toan Do, Jed Friedman, David McKenzie, and Kinnon Scott. 2007. "Mental Health and Poverty in Developing Countries: Revisiting the Relationship." Social Science & Medicine 65 (3): 467–80. https://doi.org/10.1016/j.socscimed.2007.02.037.
7. Gupta, Sadhna. 2018. "Rights of Physically Disabled Persons: An Inclusive Approach." In Marginalities in India: Themes and Perspectives, edited by Asmita Bhattacharyya and SudeepBasu, 247–60. Singapore: Springer Singapore. https://doi.org/10.1007/978-981-10-5215-6_17.
8. Hiranandani, Vanmala, and DeepaSonpal. 2010. "Disability, Economic Globalization and

Privatization: A Case Study of India." Disability Studies Quarterly 30 (3/4): 1041–5718. https://doi.org/10.18061/dsq.v30i3/4.1272.

9. Jain, Nishant, Alok Kumar, Sunil Nandraj, and KheyaMelo Furtado. 2015. "NSSO 71st Round: Same Data, Multple Interpretations." Economic and Political Weekly 1 (46 & 47): 84–87.
10. Mehrotra, Nilika. 2011. "Disability Rights Movements in India: Politics and Practice." Economic and Political Weekly, 65–72.
11. Menon, N, S.L Parish, and RA Rose. 2014. "The 'State' of Persons with Disabilities in India." Journal of Human Development and Capabilities 15 (4): 391–412.
12. Menon, Nidhiya, Susan L Parish, and Roderick A Rose. 2011. "The Economic and Demographic Well-Being of the Disabled: Evidences of State-Level Variability from India." IZA Discussion Paper, no. 6218.
13. Mishra, RadheShyam, and Sanjay K Mohanty. 2018. "Socio-Economic and Health Correlates Dsability in India." International Journal of Community Medicine and Public Health 5 (2): 600–610.
14. Mitra, Sophie, and UshaSambamoorthi. 2008. "Disability and the Rural Labor Market in India: Evidence for Males in Tamil Nadu." World Development 36 (5): 934–52. https://doi.org/10.1016/j.worlddev.2007.04.022.
15. Nair, KN, and Mahesh Ramachandran. 2016. "Persons with Disabilities in India: An Analysis of Using 2011 Census Data." In .Shornur, Palakad.
16. Narayanan, N Krishnan, Mahesh Ramachandran, and CSreedharanan Nair Krishnakumar. 2019. "Disability and Its Link with Human Development in India." International Journal of Disability and Human Development 18 (3): 2191–1231.
17. Pandey, Manoj K. 2012. "Poverty and Disability Among Indian Elderly: Evidence From Household Survey." Journal of Disability Policy Studies 23 (1): 39–49. https://doi.org/10.1177/1044207311411299.
18. Patel, Vikram, Jerson Pereira, Livia Countinho, RomaldinaFernandes, John Fernandes, and Antony Mann. 1998. "Poverty, Psychological Disorder and Disability in Primary Care Attenders in Goa, India." The British Journal of Psychiatry 172 (6): 533–36. https://doi.org/10.1192/bjp.172.6.533.
19. Patel, Vikram, Merlyn Rodrigues, and NanditaDeSouza. 2002. "Gender, Poverty, and Postnatal Depression: A Study of Mothers in Goa, India." American Journal of Psychiatry 159 (1): 43–47. https://doi.org/10.1176/appi.ajp.159.1.43.
20. Prakash, Indira Jai. 2003. "Aging, Disability, and Disabled Older People in India." Journal of Aging & Social Policy 15 (2–3): 85–108. https://doi.org/10.1300/J031v15n02_06.
21. Reddy, C Raghava, and K PavaniSree. 2015. "Situating Census Data in Disability Discourse: An Analysis of Census 2011 and 2001." Indian Anthropologist 45 (2): 59–74.
22. Sengupta, M, and A Emily. 2002. "Gender and Disability among Older Adults in North and Sourth India: Differences Associated with Coresidence and Marriage" 17: 313–36.
23. Singh, Amarjeet. 2008. "Burden of Disability in a Chandigarh Village." Indian Journal of Community Medicine : Official Publication of Indian Association of Preventive & Social Medicine 33 (2): 113–15. https://doi.org/10.4103/0970-0218.40880.

Indian Journal of Library and Information Science

Library Recommendation Form

If you would like to recommend this journal to your library, simply complete the form given below and return it to us. Please type or print the information clearly. We will forward a sample copy to your library, along with this recommendation card.

Please send a sample copy to:

Name of Librarian

Name of Library

Address of Library

Recommended by:

Your Name/ Title

Department

Address

Dear Librarian,

I would like to recommend that your library subscribe to the Indian Journal of Library and Information Science. I believe the major future uses of the journal for your library would provide:

1. Useful information for members of my specialty.
2. An excellent research aid.
3. An invaluable student resource.

I have a personal subscription and understand and appreciate the value an institutional subscription would mean to our staff.

Should the journal you're reading right now be a part of your University or institution's library? To have a free sample sent to your librarian, simply fill out and mail this today!

Stock Manager
Red Flower Publication Pvt. Ltd.
48/41-42, DSIDC, Pocket-II
Mayur Vihar Phase-I
Delhi - 110 091(India)
Phone: 91-11-79695648, 22754205, 22756995, Cell: +91-9821671871
E-mail: sales@rfppl.co.in

Red Flower Publication (P) Ltd.

Presents its Book Publications for sale

1. **Drugs in Anesthesia (2020)**
   By Dr. R. Varaprasad — **INR 449/USD35**
2. **MCQ in Minimal Access & Bariatric Surgery Second Edition (2020)**
   By Anshuman Kaushal, Dhruv Kundra — **INR 545/USD42**
3. **Beyond Medicine A to E for the medical professionals (2020)**
   by Kalidas Dattatraya Chavan, Sandeep Vishwas Mane, Sunil Namdeo Thitame — **INR 390/USD31**
4. **Statistics in Genetic Data Analysis (2020)**
   By Dr. S. Venkatasubramanian, J. Kezia Angeline — **INR 299/USD23**
5. **Chhotanagpur A Hinterland of Tribes (2020)**
   by Ambrish Gautam, Ph.D — **INR 250/USD20**
6. **Patient Care Management (2019)**
   By A.K. Mohiuddin — **INR 999/USD78**
7. **Drugs in Anesthesia and Critical Care (2019)**
   By Bhavna Gupta, Lalit Gupta — **INR 595/USD46**
8. **Critical Care Nursing in Emergency Toxicology (2019)**
   By Vivekanshu Verma, Sandhya Shankar Pandey, Atul Bansal — **INR 460/USD34**
9. **Practical Record Book of Forensic Medicine and Toxicology (2019)**
   By Akhilesh K. Pathak — **INR 299/USD23**
10. **Skeletal and Structural Organizations of Human Body (2019)**
    By D. R. Singh — **INR 659/USD51**
11. **Comprehensive Medical Pharmacology (2019)**
    By Ahmad Najmi — **INR 599/USD47**
12. **Practical Emergency Trauma Toxicology Cases Workbook in Simulation Training (2019)**
    by Vivekanshu Verma, Shiv Rattan Kochar & Devendra Richhariya — **INR395/USD31**
13. **MCQs in Minimal Access & Bariatric Surgery (2019)**
    by Anshuman Kaushal & Dhruv Kundra — **INR450/USD35**
14. **Biostatistics Methods for Medical Research (2019)**
    by Sanjeev Sarmukaddam — **INR549/USD44**
15. **MCQs in Medical Physiology (2019)** *by Bharati Mehta & Bharti Bhandari Rathore* — **INR300/USD29**
16. **Synopsis of Anesthesia (2019)** *by Lalit Gupta & Bhavna Gupta* — **INR1195/USD95**
17. **Shipping Economics (2018)** *by D. Amutha, Ph.D.* — **INR345/USD27**

Order from

Red Flower Publication Pvt. Ltd.
48/41-42, DSIDC, Pocket-II
Mayur Vihar Phase-I
Delhi - 110 091(India)
Mobile: 8130750089, Phone: 91-11-79695648, 22754205, 22756995
E-mail: sales@rfppl.co.in

p-ISSN 2582-1407, e-ISSN 2582-3426
Review Article

RFP Journal of Gerontology and Geriatric Nursing
Volume 3 Number 1, January - June 2020

Living Arrangements and Family Support of Elderly in the Contemporary Society – A Review

J Balamurugan

Author Affiliation

Assistant Professor, Department of Social Sciences, Vellore Institute of Technology Vellore, Tamil Nadu 632014, India.

Corresponding Author

J. Balamurugan, Assistant Professor, Department of Social Sciences, Vellore Institute of Technology Vellore, Tamil Nadu 632014, India.

E-mail: balasocio@gmail.com

Abstract

India has been experiencing changes in its family system. A system that had provided not only support and care to the elderly for their wellbeing but also had acknowledged their status of authority and decision making is virtually unable to extend the same support and respect to them today because of various reasons. Thus, for voluntary or involuntary reasons, many a time elderly may either left alone or maybe alienated from their children and family despite living with them. This may have a direct bearing on their decision making role, adjustment, and/or life satisfaction. With the declining capacities, increasing age-related debility, anxiety about economic and physical support, fear of death, and bereavement they may pose a challenge to the society which is practically growing apathetic to the elderly. The present paper has attempted to review the available research studies on this aspect of the living arrangements and family support of the elderly. The author has tried to highlight the reasons for their living with or without their children/relatives or the near and dear ones and the consequences there off. Further, it is also attempted to examine the gaps in this area of research and suggest the likely issues which need to be focused on in future research.

Keywords: Living Arrangement, Housing, Nuclear, Modernisation, Industrialisation, Mobility, Family Support, Elderly.

How to cite this article:

J. Balamurugan. Living Arrangements and Family Support of Elderly in the Contemporary Society – A review. RFP Journal of Gerontology and Geriatric Nursing. 2020; 3 (1):17–21.

Introduction

The problem of ageing among the senior citizens has a special significance in contemporary societies. In the traditional society of the past in India, old age was no problem at all. The place of honour traditionally assigned to the elderly in India has been spelt out by religion, social values, norms and socio-economic organizations of the society. However, the Indian family system has been considered as a chief source of support and sustenance for the elderly. But it is seen to be changing in structure and functions because of industrialisation, urbanisation and occupational mobility. In the new scenario have risen many forms of institutional support but too inadequate to meet the demand. So the basic hurdles and problems of the elderly are various. Although the elderly have traditionally respected, however, in the Indian social structure and value system undergoing changes, social institutions like joint family, caste and village community shedding some roles, economic pressure and high

cost of living confronting the traditional care-givers and weak physical condition of the aged are adversely affecting the aged, ageing possess serious challenges.

Moreover, it is predicted that in the future era the elderly population will subsequently increase. But the bad news is that they are likely to be more vulnerable due to socio-cultural reasons. Therefore, without the safety, security and dignity of status in the family, the elderly are finding themselves vulnerable. Welfare of the elderly has been a low priority with the state. Most hospitals do not have a special geriatric facility. At present most elderly patients are still being treated in general medical wards.

It is of concern that the weakening of traditional informal support systems, both communities and families and the marginalization and elimination of the elderly' social roles is dangerous (Eldermine, 1997). Some researchers have proposed 'Filial Piety' and 'Cultural Script' as appropriate cultural phenomena influencing the support extended to the old parents (Gene-Woong, 2001). Cumming and Henry (1961) in the 'disengagement theory' have held decline in commitment to norms and values as one of the three components accounting for decline in support. Such kind of holistic study about elderly will definitely encourage policy makers to make special support policies to tackle the elderly problems.

The Meaning of Home

Home has been characterized as an essentially private place, which is the centre of domesticity, a place of intimacy and sometimes a place of solitude. Sixsmith and Sixsmith (1991) identifies three themes, which underlie the meanings that older people generally associate with home and which are central to an understanding of home and residential experience in later life.

The first theme is one of homes providing the major focus in life. As people age they become more oriented towards home; it is seen as a refuge and becomes increasingly important as other social roles in later life are relinquished. The second theme highlights the need of elderly people to remain independent of other; they appear more concerned with the instrumental aspects of home. The third theme reflects the attachment that older people have for their homes. The importance of 'memories' is significant, with past associations affective the present experience of home.

Of course, how older individuals perceive home will be influenced by their life careers and how others in society have allowed men and women, and people from different social minorities to relate it to 'home'. There will exist a diversity of such experiences and, therefore, a diversity of perceptions of home.

Change in living arrangements are likely to be associated with changes in the level of care and assistance received by the elderly. Living together with other family members' eases situations of illness while alone makes coping with illness harder. In addition, feeling isolated or left alone may induce illnesses (Borsch-Supan, 1995).

The multifarious dimensions of ageing in India can sociologically be thought to be series of transition from one set of social roles to another and such roles are structured by the social system. Changes in life during old age, which is considered to be sanyas ashram of the Hindu ashram theory, are influenced by the biological as well as the social and cultural systems. However, in recent times, the status and role of the elderly population have been diminished due to the technological development that have colonized the outlook of the youth.

Indian Family System

The Indian family system is thus supportive of age, provides a formal location, a role and a status for the aged in which they are respected, are expected to guide and counsel the young. While no elder individual can escape the physical consequences of ageing in terms of failing health and decreasing physical capacities, he/she is well supported in his/her social, familial status, his/her sense of worth and the sense of being wanted. The status of the elderly within the family seems to be affected by gender differences, rural-urban location and by the degree of economic self-sufficiency of the elder.

Nayar (1996) says that the old are besotted with an important set of problems-fight of young able bodied to distant places for jobs and establishment of household there. Sometimes they take the elderly along with them, but in most cases, the aged are left behind and sometimes they are even forced to destitution. In some states like Kerala, the migration of young is very high, resulting in a crisis of caring for older people. According to Rao (2012), in rural India people are losing their control and authority and are forced to depend on their kin due to migration of sons. There is evidence to suggest that migration of the young is leading to

nucleation of the family and thereby, adversely affecting intergenerational support. The greatest complication for the parents arises when an only child chooses to migrate; even if there are other children, the loss of support can be substantial because it is generally the most dynamic and the most educated of adults who want to migrate.

Caring by the emigrated family is from a distance. Distance, time and expense separate children and parents. This is especially the case, if they have no other children. The parents do not have close interaction with the grandchildren. Visits may be short, infrequent and only when they are able to travel. The elderly may feel insecure that the children may not be able to return in time of emergency. The emotional vacuum the parents face reduces the quality of their life considerably.

Living Arrangement

It is seen that family plays a much lesser role in the country today on account of the structural changes taking place in Indian society and the concomitant disintegration of joint family leading to rejection of the aged (Planning Commission, 1963). Younger couples due to industrialization are displaced and live in nuclear household affecting the daily living of the elderly (Sudha, et.al., 2004). Hence, living arrangement of the elderly originates from the assumption of declining joint family in the Indian society (Rajan, et.al., 1995). There arises the elderly support differentials based on the family constitutional members and their living arrangements. The different living situation causes elderly to be valued most comprehensively (Burch and Mathews, 1987). What consists of the differential treatment of the elderly in variety of living arrangement depends upon the "component" of household goods including physical shelter, personal care, companionship, independency, power and authority (Martin and Perston, 1994). Living arrangements are influenced by variety of factors including marital status, family size, and cultural tradition. The changing household structure translates into a decline in support for the elderly (Muthukrishnaveni, 2010).

With regard to declining support of elderly in transition in living arrangements, studies show that in the living arrangement of houses in relation to elderly problem majority of elderly in rural areas expect to rely on children when they become old (Arnold, 1975), specially mothers are likely to depend on their sons for old age support (Sharma, 2002). Elderly living with family and living with spouse are the most popular destinations of transition. It also suggests that attitudes toward living arrangements may also be an important factor for other developing countries in analysis of transition in living arrangements. It could be especially true for those countries which traditionally have a favourable attitude toward living with children and recently have experienced a rapid increase in the proportion of living either alone or with spouse only due to structural change (Balamurugan, 2013).

Chakravarty (1998) feels that the family still plays a major role in elderly care, but the sign of change are now becoming more visible. Mohanty (1997) from a study observed that care of the elderly, considered as a sacred duty in the past is breaking down in nuclear families. Due to socio-economic, political, psychological and physical changes coupled with changes in the family system and life style, the aged need specify Medicare besides other support. Case studies from rural areas reflect that, though the joint family system does look after the elderly there are, however, some emerging stresses and strains which in varying degrees, tend to increase the vulnerability of the aged (Upadhyay, 1992). Lakshminarayanan (1993) found that rural aged male are better adjusted and better education is associated with a greater ability to adjust. Female elderly who live in rural areas perhaps lack of social interaction and hence would have poor adjustment in their life widowhood could also be a factor in which social isolation plays a vital role. In addition, there is a negative stereotyped attitude towards older persons.

Kulkarni et. al., (2009) studies the adjustment problems of elderly using the technique of well adjustment inventory. It was found that older people have significantly more adjustment problems in the emotional, social, wealth and home areas than young people. It was also found that among old individuals, the non-working persons had more adjustment problems in the home area than the working persons. On the whole, the findings indicate that engagement in some purposeful and productive takes contributed significantly to old age adjustment.

Family support

The strength of family support cannot always be measured by the frequency of co-residence or of contact within the family. Rather, the strength lies in the ties of obligation and affection, bound in custom and social processes. For instance,

frequent contact between the generations in the same household can co-exist with a lower level of satisfaction for the elderly, most likely as a result of the lower socio-economic status associated with the multigenerational household. Emotional support, requiring longstanding trust and involvement between intimate persons, may be most universal kind of support rendered among family members regardless of living arrangement.

The kind of support that is affected most by residential separation in most countries is instrumental support. Modest assistance with the tasks of daily living potentially can be provided through private purchase, non-resident family support, or community services. However, when needs are intense and continuous care is required, there is little alternative to co-resident support, either in the home or in an institutional setting.

The underlying importance of family support for the elderly remains true across the countries though manifested and extended differently. Wherever the family persists, family support persists even if it is not always fully adequate and available for all older people. Families play important roles in providing financial, practical and emotional support.

Changes in the family support are more often predicted in the third world. Rapid changes in the structure of the economy, occupation, and education are inducing change in family size, location and geographical proximity. While changes in the family structure also mould changes in family support, the much-lamented "disintegration of the family" is neither a necessity nor a re-determined outcome, if adaptations to change are made appropriately and successfully.

In the recent past there have been marked changes in the living arrangements of elderly people, which have been associated with economic and behavioural changes. It is important to remember that there are also age-related changes in the circumstances of individual elderly people over time; longitudinal studies have shown that later life is often marked by changes in both household circumstances and location. Greater residential independence, especially in the context of an ageing elderly population, implies a greater demand for formal health and welfare services; greater pressure on the housing market and a greater incentive for the providers of public and private goods and services to take account of the needs of single persons and other small households. However, the age-specific prevalence of widowhood and childlessness is currently failing slightly and there are some suggestions that the pace of change in living arrangements may also be showing in the longer term, changing patterns of family formation, fission and reconstitution.

A changing household structure is a most prominent socio-economic change with important implications for the elderly. The extended or joint family system has been the traditional basis of support for the elderly in most societies. Under the impact of modernization and increasing independence from the traditional family occupation, more and more siblings are moving away from the base family to distant places of work. Consequently, the nuclear family has become the norm in the present day context. Decline in family size has also contributed to this phenomenon.

These changes have also affected the living arrangements of the elderly. It is obvious that under the impact of increasing "nuclearization" of the families brought about by a reducing family size and the migration of siblings to distant places of work, the immediate family support for the elderly may further weaken.

Dependency among the Elderly

To maintain self-respect and status, one should not be economically dependent on others, and should have some personal income. Income flows from assets, past savings, pensions and gainful work. Some activities such as household work though may be supportive and hence very necessary, do not yield independent income. In India, assets, past savings and pensions account for income only in respect of a few. It is the gainful work, which is a source of income for a vast majority.

Discussion

The force of modernisation, technological change, mobility and the explosion in the later transmission of knowledge are making changes in the life style and values to adjust to the changing circumstances. Individuals and modernity, which sometimes lead to ambivalence in attitude towards the use of the knowledge and experience of the past in solving problems of the present, tend to make old people feel less valued.

The shortage of housing accommodation in the cities and high rentals act as a severe constraint in common residence of the aged with their sons, particularly for migrant families. The migration of younger people increases the vulnerability of the old who stay behind, particularly for families,

which do not have independent production assets such as land, livestock or household industry and are dependent primarily on their labour. Increasing employment of women outside the home in offices and in factories implies that they can spend less time for taking care of the older members, especially those who required constant care. Further, the relatively independent status acquired by a white-collar women worker, who has her own career and aspirations, sometimes leads to demand on the husband for setting up a separate nuclear family.

There is now a great investment by the family on education and upbringing of children, which affects the intra-family distribution of income in favour of the younger generation. The joint family system, an important sustaining factor of which is the common ownership of the means of production, is gradually breaking down. This has increased the vulnerability of the old, particularly those with no children or immediate kin, as there is lesser readiness in discharging long-term social obligations towards such members.

References

1. Arnold F. The value of children: A cross-national study. University Press; 1975.
2. Balamurugan J. A Study On Living Condition And Familial Support Of Rural Elderly In Puducherry (Doctoral dissertation). 2013.
3. Börsch-Supan A. Age and cohort effects in saving and the German retirement system. Ricerche Economiche. 1995 Sep 1; 49 (3) : 207-33.
4. Burch TK, Matthews BJ. Household formation in developed societies. Population and development review. 1987 Sep 1 : 495-511.
5. Chakrabarti P. Health management and care for the elderly. The Eastern Anthropologist. 1998;51(3):249-68.
6. Cumming E, Henry WE. Growing old, the process of disengagement. Basic books; 1961.
7. Eldemire AM. Health of the Elderly. In Health conditions in the Caribbean 1997 (pp. 251-64). Pan American Health Organisation.
8. Gene-Woong C. Elders in the family and the strain of the discourse of filial piety. Korea Journal. 2001 Dec;41(4):144-58.
9. Kulkarni J, Bharati V, Rekhade N. Adjustmental Problems of Old Persons. Shodh, Samiksha aur Mulyankan. 2009 Oct;2(9-10).
10. Lakshminarayanan TR. A comparison of male and female rural aged in adjustment. Aging and Society. 1993;3(3):5-12.
11. Martin LG, Kinsella K. Research on the demography of aging in developing countries. Demography of aging. 1994 Jan 15:356-403.
12. Mohanty, M. Socio-economic Problems of Aged Santals of Mayurbhanj, Orissa. Indrani Chkrabvarty (Ed.) Life in Twilight Years. Kwality Book Company. 1997:115-127.
13. Muthukrishnaveni S. Living arrangements and health conditions of Elderly in Rural India. Serials Publications; 2010.
14. Nayar PK. The Elderly in India: Their Problems and Needs. BOLD-VALLETTA-. 1996;6:2-8.
15. Planning Commission. Plans and Prospects of Social Welfare in India: 1951-61. Government of India. 1963:62.
16. Rajan SI, Mishra US, Sarma PS. Living arrangements among the Indian elderly. Hong Kong Journal of Gerontology. 1995;9(2):20-8.
17. Rao N. Breadwinners and homemakers: Migration and changing conjugal expectations in rural Bangladesh. Journal of Development Studies. 2012 Jan 1;48(1):26-40.
18. Sharma KL. Images of Ageing. Indian Journal of Gerontology. 2002;16(3):286-97.
19. Sixsmith AJ, Sixsmith JA. Transitions in home experience in later life. Journal of Architectural and Planning Research. 1991 Oct 1:181-91.
20. Sudha S, Rajan SI, Sharma PS. Intergenerational family support for older men and women in South India. Indian Journal of Gerontology. 2004;18(3):4.
21. Upadhyaya, RK. A Study of the Problems of the Aged and Need for Social Intervention in the States of Haryana and Himachal Pradesh.: Ministry of Welfare, Govt. of India. 1992.

SUBSCRIPTION FORM

I want to renew/subscribe international class journal "**RFP Journal of Gerontology and Geriatric Nursing**

" of Red Flower Publication Pvt. Ltd.

Subscription Rates:
• Institutional: **INR6000/USD469**

Name and complete address (in capitals):_____

_____

Payment detail:
Online payment link: http://rfppl.co.in/payment.php?mid=15

Cheque/DD: Please send the US dollar check from outside India and INR check from India made payable to 'Red Flower Publication Private Limited'. Drawn on Delhi branch.

Wire transfer/NEFT/RTGS:
Complete Bank Account No. 604320110000467
Beneficiary Name: Red Flower Publication Pvt. Ltd.
Bank & Branch Name: Bank of India; Mayur Vihar
MICR Code: 110013045
Branch Code: 6043
IFSC Code: BKID0006043 (used for RTGS and NEFT transactions)
Swift Code: BKIDINBBDOS

Term and condition for supply of journals
1. Advance payment required by Demand Draft payable to **Red Flower Publication Pvt. Ltd**. payable at **Delhi.**
2. Cancellation not allowed except for duplicate payment.
3. Agents allowed 12.5% discount.
4. Claim must be made within six months from issue date.

Mail all orders to
Subscription and Marketing Manager
Red Flower Publication Pvt. Ltd.
48/41-42, DSIDC, Pocket-II
Mayur Vihar Phase-I
Delhi - 110 091(India)
Phone: 91-11-79695648, 22754205, 22756995, Cell: +91-9821671871
E-mail: sales@rfppl.co.in

STATEMENT ABOUT OWNERSHIP AND OTHER PARTICULARS

"RFP Journal of Gerontology and Geriatric Nursing" (See Rule 8)

1.	Place of Publication	:	Delhi
2.	Periodicity of Publication	:	Quarterly
3.	Printer's Name	:	**Dinesh Kumar Kashyap**
	Nationality	:	Indian
	Address	:	3/259, Trilokpuri, Delhi-91
4.	Publisher's Name	:	**Dinesh Kumar Kashyap**
	Nationality	:	Indian
	Address	:	3/259, Trilokpuri, Delhi-91
5	Editor's Name	:	**Dinesh Kumar Kashyap**
	Nationality	:	Indian
	Address	:	3/259, Trilokpuri, Delhi-91
6.	Name & Address of Individuals who own the newspaper and particulars of shareholders holding more than one per cent of the total capital	:	**Red Flower Publication Pvt. Ltd.** 41/48, DSIDC, Pocket-II Mayur Vihar, Phase-1, Delhi-91

I, **Dinesh Kumar Kashyap**, hereby declare that the particulars given above are true to the best of my knowledge and belief.

Sd/-

(Dinesh Kumar Kashyap)

p-ISSN 2582-1407, e-ISSN 2582-3426
Review Article

RFP Journal of Gerontology and Geriatric Nursing
Volume 3 Number 1, January - June 2020

Geriatric Abuse – Reason Behind Cruel Act

Prabhuswami Hiremath, Lekshmi S Nair

Author Affiliation

[1,2]Lecturer, Department of Nursing,Krishna Institute of Medical Sciences universities, Karad, Maharashtra 415539, India.

Corresponding Author

Prabhuswami Hiremath: Lecturer, Department of Nursing, Krishna Institute of Medical Sciences universities, Karad, Maharashtra 415539, India.

E-mail: prabhuh252003@gmail.com

Abstract

Elder abuse is usually by a relative or other caregiver. At greatest risk are the frail and/or isolated. What is the right response depends on the circumstances. But usually they will want to talk to the older person to find out what is going on, if the person would like assistance, and what kind of support or assistance they would like. In some provinces, certain people will have a legal duty to respond to abuse and neglect that occurs in specific circumstances by reporting abuse to a government or other agency. In comparison, in some provinces and territories there is no duty to report abuse and no agency designated to receive reports and respond to abuse. But education about the law, an awareness of ethical considerations, and knowledge of key resources and services can make it easier to decide what to do, to identify who they can seek guidance from in their agency or to whom they should refer an issue, as well as make they feel more confident that they did the best they could under the circumstances.

Keywords: Geriatric Abuse, Cruel Act.

How to cite this article:

Prabhuswami Hiremath, Mrs. Lekshmi S Nair. Geriatric Abuse – Reason behind Cruel Act. RFP Journal of Gerontology and Geriatric Nursing. 2020; 3 (1):25–29.

Introduction

Elder abuse is usually by a relative or other caregiver. At greatest risk are the frail and/or isolated. Elder abuse may include physical violence, threats of assault, verbal abuse, financial exploitation, physical or emotional neglect, or sexual abuse according to WHO elerly abuse is a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. Many people believe that elder abuse happens in nursing homes or skilled nursing facilities. While some abuse does exist in these facilities, the majority of elder abuse, neglect and exploitation, occurs in the home. Elder abuse comes in all shapes and sizes. Although older adults are mistreated by strangers and con artists, older adults are often abused by people they care about or rely on for assistance, services or companionship.

- Family
- Friend
- Spouse, boyfriend, girlfriend
- Neighbour
- Volunteer caregiver
- Legal guardian

- Care facility staff
- Professionals - doctor, lawyer, nurse

Abuse is on the rise in this society. Nearly 5.3 million intimate partner victimization occur each year among older. Certain symptoms can appear, such as changes in depth perception, confusion over when an event occurred, loss of control over bodily functions, and hearing loss. Although there is no crime called "elder abuse", sometimes acts of elder abuse can be crimes listed in the Criminal Code, which is the federal law that lists most crimes in Canada and applies across the country.

Some examples:

- Assault
- Sexual Assault
- Uttering Threats
- Unlawful Confinement
- Theft
- Fraud
- Failing to provide the necessaries of life (criminal neglect)
- Theft by a person holding a power of attorney

Psychological abuse: Threatening to put an older person in a retirement home or to not let the older person see the grandchildren or other family unless he or she does what they want can be psychological abuse. Some kinds of mistreatment can fall into more than one category: for example, a caregiver who is unnecessarily rough when lifting a patient in and out of bed and belittles the patient by talking down to him like he is a child is being physically and psychologically abusive.

Financial abuse: Older adults who are socially isolated and have acquired assets or property through lifelong saving for retirement are often targeted for theft or scams. Abusers also sometimes see older people as easy targets because of a perception that older people are more trusting. An attorney is someone legally appointed (through a document called a power of attorney) to make financial transactions or decisions for another person. But the attorney must still make financial decisions consistent with the older person's wishes. Identity theft is when a crook uses personal or confidential information to access someone else's accounts and credits cards without permission. Another common form of financial abuse is when an older adult opens a joint account with a person they trust on the understanding that this person will only access those funds to help the older adult pay bills and run errands. Then this trusted person spends some or all of the money on herself. That is financial abuse. Financial abuse is a very complex topic that we can't cover in detail today. Financial abuse is one of the most common forms of mistreatment of older people.

Chemical abuse is medication abuse. Too much or not enough medication can cause harm. When medication decisions are motivated by things other than the older person's well being or when medication decisions are made without the agreement of the person who needs the medicine or the legal substitute-decision-maker, that's abuse. Medications abuse is most common when older adults have health problems that make it impossible or difficult for them to take care of themselves, fill prescriptions, or understand medical information. For example, denying their mum expensive medication to save money for their inheritance could be mistreatment. On the flip side, giving their mum a higher dose of her medicine so she is more docile and makes fewer demands on they is also abuse.

Spiritual abuse is mentioned in very few laws, but it can go hand-in-hand with psychological abuse, and can have a devastating effect on an older person. Our faith is an important part of who we are as people. Preventing a person from practicing her or his faith or Forcing a person to participate in a spiritual ritual or to practice a religion is spiritual abuse. When someone prevents an older person from practicing his or her faith and seeing people in a chosen faith community, this is mistreatment. Consider actions that stop a person from going to church, mosque, or any other place of worship, or from being involved in spiritual or religious practices of choice. Forcing a person to practice a different religion or forcing a non-believer to attend a faith institution can also be abusive. Forcing a person to participate in any religious or spiritual ceremony, event or ritual could be elder abuse. Requiring a person to receive any form of spiritual-based healing would be abuse.

An increase in the incidence of child abuse and related fatalities has also been documented.

Predisposing factors:

A. Biological theories

1. Neuro-physiological influences

Various components of the neurological system in both humans and animals have

been implicated in both the facilitation and inhibition of aggressive impulses.

Areas of the brain mainly involved

- Temporal lobe
- Limbic system
- Amygdaloid nucleus

2. Biochemical influences

Nor-epinephrine, dopamine and serotonin – may play a role in the facilitation and inhibition of aggressive impulses.

3. Genetic influences

Various genetic components related to aggressive behavior have been investigated. Some studies have linked increased aggressiveness with selective inbreeding in mice, suggesting the possibility of a direct genetic link. Another genetic characteristic that was once thought to have some implication for aggressive behavior was the genetic karyotype XYY. The XYY syndrome has been found to contribute to aggressive behavior in a small percentage of cases.

4. Disorders of the brain

(a) Brain tumors (particularly in the area of temporal lobe and limbic system)

(b) Trauma to the brain (resulting in cerebral changes)

(c) Diseases (encephalitis)

(d) Epilepsy (temporal lobe epilepsy)

5. Psychological theories

(a) Psychodynamic theory

The psychodynamic theorist implies that unmet needs for satisfaction and security result in an underdeveloped ego and a week superego. It is thought that when frustration occurs, aggression and violence supply this individual with a dose of power and prestige that boosts the self image and validates a significance to his or her life that is lacking.

(b) Learning theory

Children learn to behave by imitating their role models, which are usually their parents. Models are more likely to be imitated when they are perceived as prestigious or influential, or when the behavior is followed by positive reinforcement. Children may have an idealistic perception of their parents during the very early developmental stages but, as they mature, may begin to imitate the behavior pattern of their teachers, friends, and others.

6. Socio-cultural theories

Social scientist believes that aggressive behavior is primarily a product of one's culture and social structure. Studies have shown that poverty and income are powerful predictors of homicide and violent crime.

Battering

A pattern of coercive control founded on and supported by physical and/or sexual violence or threat of violence of an intimate partner.

Profile of the victim

- Represent in all age, racial, religious, cultural, educational and socio-economic groups.
- May be married or single, housewives or business executives
- Low self esteem
- Often accepts the blame
- Feelings of guilt, anger, fear and shame

Profile of the victimizer

- Low self esteem
- Pathologically jealous
- Dual personality (one to partner and one to rest of the world)
- Often under a great deal of stress
- Limited ability to cope with the stress
- Becomes threatened when she shows any sign of independence or attempts to share herself or her time with others
- Always insults and humiliates her
- He demands to know where she at every moment
- Always challenges her honesty.

Responding to Abuse

What is the right response depends on the circumstances. But usually they will want to talk

to the older person to find out what is going on, if the person would like assistance, and what kind of support or assistance they would like. In some provinces, certain people will have a legal duty to respond to abuse and neglect that occurs in specific circumstances by reporting abuse to a government or other agency. In comparison, in some provinces and territories there is no duty to report abuse and no agency designated to receive reports and respond to abuse. Reporting abuse and neglect is only one possible way to respond to abuse concerns, and it is often not the most helpful response. However, it is important to be aware of theyr legal obligations. This section highlights any legal duty to respond to abuse or neglect in theyr province or territory. In every instance it is ideal to talk to the older person about his or her own experience and then help connect the person with resources and services. The Resources Handout contains a lengthy list of agencies in each province and territory.

It is not always appropriate to call the police, especially if the older person is not able to access other support and assistance. In some instances a report to the police can increase the likelihood of further abuse.

Care of elderly with abuse:

The overarching goal is always to find the right balance between

1. Protection, and
2. Independence.

How can they support an older person to get the support or assistance they need and live free from abuse (protection), while at the same respecting a person's inherent right to freedom, independence, and privacy (independence)?

In other words, how do they assist a vulnerable or mistreated person without undermining their autonomy or increasing their risk of harm?

Respect Personal Values

Respect the personal values, priorities, goals and lifestyle choices of an older adult. Identify support networks and solutions that suit the older adult's individuality

Recognize the Right to make Decisions

Mentally capable older adults have the right to make decisions, including choices others might consider risky or unwise Mental capability refers to an adult's ability to make a reasoned decision. In general, a mentally capable adult is able to understand information and appreciate the consequences of a decision. Some adults will be capable of making some decisions and not others. The issue is not whether the decision the adult makes is reasonable to THEY, but rather whether the adult went through his or her own reasoning process, weighed the options, and came to his or her own reasoned conclusion. Mental capacity is a legal concept that is generally decision-specific and a different standard or test applies depending on the nature of the decision at issue.

Respect Confidentiality and Privacy Rights

Get consent before sharing another person's private information, including confidential personal or health information In general it is against the law to disclose a person's personal or health information without first getting consent from the person. Violating privacy rights may also be against their professional code of conduct or theyr organization's internal policies. Sharing confidential information can also harm an older adult's sense of dignity, stop an older adult from trusting they to help them, and do damage to other efforts to get assistance and support to a person who is vulnerable to abuse and neglect. In some exceptional situations it is legal and appropriate to disclose information without prior consent. Organization's policies may also permit volunteers to share private information in order to consult with staff and supervisors. Some organizations require volunteers and staff to explain confidentiality policies to all clients. Privacy law is complex. If they a volunteer, they should always consult a supervisor before disclosing someone's personal information to an outside agency. Organizations should have policies in place to help staff and volunteers to know when and to whom to disclose personal information without consent.

Even with education and awareness, responding to elder abuse is complex and challenging. But education about the law, an awareness of ethical considerations, and knowledge of key resources and services can make it easier to decide what to do, to identify who they can seek guidance from in their agency or to whom they should refer an issue, as well as make they feel more confident that they did the best they could under the circumstances.

Conclusion:

The care of elderly people has emerged an important issue around the globe. Elder people who experience abuse is subjected to an increased risk of health complications while financial exploitation is by close family members; who are the only care takers. Elders who are helpless may not readily reveal the actual situation. It's important to identify such elders an giving appropriate care is necessary of every health care team members.

Conflict of interest: None declared.

Funding: None.

References

1. Soneja S. Elder abuse in India. Country Report for WHO. Helpage India: New Delhi; 2011
2. World health organization. Elder maltreatment. WHO fact sheet. 2011 [cited 2012 Sep 27].
3. International Institute for Population Sciences and Macro International. National family health survey-3. 2005-06
4. MacKay-BM, Csiernick R. An exploration of Elder Abuse in a Rural Canadian Community. The University of Western Ontario; 2012
5. Sigma research and consulting private limited. A report on elder abuse and crime in India. 2010
6. Daliya S, Sekar T.V. Extent and nature of elder abuse in Indian Families- A study in Kerala. Helpage india research and development journal 2011 Oct; 17 (3) : 20-8.
7. World health organization. A global response to elder abuse and neglect
8. Naughton C, Drennan J, Lyons L, Lafffert A, Treasy M, Phelan A. Elder abuse and neglect in Ireland-results from national prevalence study. Age and aging 201 Jan 1; 41(1) : 89 103.

p-ISSN 2582-1407, e-ISSN 2582-3426
Review Article

RFP Journal of Gerontology and Geriatric Nursing
Volume 3 Number 1, January - June 2020

Hypertension in the Elderly

[1]Sankendla Bhagya Seela, [2]VamshiKrishna T V

Author Affiliation

[1]Incharge, Department of Critical Care Units [2]Assistant Professor, Department of General Medicine, Chalmeda Anand Rao Institute of Medical Sciences Karimnagar-505001, Telangana, India.

Corresponding Author

Sankendla Bhagya Seela, Incharge, Critical Care Units, Department of Critical Care Units, Chalmeda Anand Rao Institute of Medical Sciences Karimnagar-505001, Telangana, India.

E-mail: sheel.1981@rediffmail.com

Abstract

Hypertension is a global public health problem, and it is estimated that by 2025 more than 1.5 billion individuals worldwide will have hypertension, accounting for up to 50% of heart disease risk and 75% of stroke risk. Hypertension is an important risk factor for cardiovascular morbidity and mortality, particularly in the elderly. It is a significant and often asymptomatic chronic disease, which requires optimal control and persistent adherence to prescribed medication to reduce the risks of cardiovascular, cerebrovascular and renal disease. The aim of this review article was to highlight the importance of aged related factors, complications, assessment, nursing management and prevention.

Keywords: Hypertension; Elderly; Complications; Nursing Care.

How to cite this article:

Sankendla Bhagya Seela, VamshiKrishna T V. Hypertension in the Elderly. RFP Journal of Gerontology and Geriatric Nursing. 2020; 3 (1) : 31–33.

Introduction

Hypertension is a global public health problem, and it is estimated that by 2025 more than 1.5 billion individuals worldwide will have hypertension, accounting for up to 50% of heart disease risk and 75% of stroke risk.[1] Three out of 4 adults older than the age of 65 have 3 or more chronic conditions such as diabetes, obesity, cardiovascular disease, congestive heart failure, atrial fibrillation, stroke, cognitive impairment, renal insufficiency, and not the last of which, hypertension.[2]

Hypertension in the geriatric population is typically characterized by a high systolic BP (SBP) in the setting of a normal or even decreased diastolic BP. Both elevated SBP and elevated pulse pressure (the difference between SBP and diastolic BP) are related to an age related increase in arterial stiffness. The incidence of hypertension overall rises with age, reaching a prevalence of 60-80% beyond 65.[3]

Hypertension is an independent risk factor stroke, IHD, peripheral vascular disease, congestive heart failure, renal failure, and dementia in all age groups, but in older patients it is SBP and widened pulse pressure that are the strongest predictors of adverse cardiovascular outcome.[4]

Factors in the Age Related Increase in Blood Pressure[5]

- Arterial stiffness: Hypertrophy and loss of contractility of vascular smooth muscle cells, fibrosis, collagen deposition, fragmentation of elastic lamina, calcification.
- Decreased baroreceptor sensitivity
- Increased sympathetic nervous system activity
- Increased α- adrenergic receptor responsiveness
- Endothelial dysfunction: decreased nitric oxide production
- Sodium sensitivity: decreased ability to excrete a sodium load
- Low plasma renin activity
- Insulin resistance
- Central adiposity

Clinical Manifestations

- Fatigue
- Dizziness
- Palpitations
- Angina
- Dyspnea
- Headache and nosebleeds.

Complications

- Hypertensive heart disease
- Cerebrovascular disease
- Peripheral vascular disease
- Nephrosclerosis
- Retinal damage

Assessment

- Complete history- to assess the signs and symptoms that indicate target organ damage.
- Measure with a well maintained, calibrated device, with an appropriate sized cuff:
  - Check supine and standing BP (orthostatic hypotension can cause symptoms when treatment initiated.
  - Take at least two measurements in a single consultation
  - Never initiate treatment based on single reading
  - Consider ambulatory measurements if drug resistance, variable BP, white coat hypertension, or postural symptoms.
- Examine for evidence of target organ damage (stroke, dementia, carotid bruits, cardiac enlargement, IHD, peripheral vascular disease, renal disease, retinal changes).
- Consider secondary hypertension rare in older patients, but consider if drug resistant, severe hypertension or with suggestive examination of laboratory findings.

Diagnostic Considerations

- All new patients should have measurements of complete blood counts, serum sodium, potassium, bicarbonate, chloride, fasting glucose, blood urea, nitrogen, creatinine, uric acid, and calcium cholesterol screening should be performed should be performed.
- ECG
- Urinalysis
- lipid profile
- Echocardiography

Nursing Management

The overall goals for the patient with hypertension are that the patient will

1. Achieve and maintain the goal BP
2. Understand and follow the therapeutic plan
3. Experience minimal or no unpleasant side effects of therapy
4. Be confident of the ability to manage and cope with this condition.

Prevention Care

- Life style modifications as a important and effective in reducing BP in older patients as in the Young.
- Salt restriction
- Weight reduction
- Regular exercise are particularly effective
- Avoid alcohol intake
- Smoking cessation and decreasing saturated fat

intake helps with overall risk reduction.

- Proper diet care

References

1. Kearney PM, Whelton M, Reynolds K, Muntner P, Whelton PK, He J. Global burden of hypertension: analysis of worldwide data. Lancet. 2005; 365217-23.
2. Philip AK, Mark AS. Hypertension in the Geriatric population. A patient centered approach. Medical clinics of North America. 2015; 379-389.
3. James MA, Polter JF. Orthostatic blood pressure changes and arterial baroreflex sensitivity in elderly subjects. Age Ageing. 1999; 28:522-30.
4. Halter J, Ouslandr J, Tinetti M et. al. Hazzard's Geriatric Medicine and Gerontology. 6th edition. New York: McGraw- Hill; 2009.
5. Cheryl RDH, Yvonne CM. Expanding the role of nurses to improve hypertension care and control globally. Annals Global Health. 2016; 82(2):243-253.
6. Miller NH, Hill MN. Nursing clinics in the management of hypertension. In: Oparl S, Weber M eds. Hypertension. 2nd ed. Philadelphia, PA: Saunders; 2005.
7. Mary Ann F, Risa LM, Edna PS. Geriatric secrets. 2nd ed, Jaypee Brothers Medical publishers LTd, New Delhi, 2000.

Subscription Information

India
Institutional (1 year) (Print+Online): INR6000

Rest of the World
Institutional (1 year) (Print+Online): $607

Payment instructions Online payment
link:
http://rfppl.co.in/payment.php?mid=15

Cheque/DD:
Please send the US dollar check from outside India and INR check from India made payable to 'Red Flower Publication Private Limited'. Drawn on Delhi branch

Wire transfer/NEFT/RTGS:
Complete Bank Account No. 604320110000467
Beneficiary Name: Red Flower Publication Pvt. Ltd.
Bank & Branch Name: Bank of India, Mayur Vihar
MICR Code: 110013045
Branch Code: 6043
IFSC Code: BKID0006043 (used for RTGS and NEFT transactions)
Swift Code: BKIDINBBDOS

Send all Orders to: Subscription and Marketing Manager, Red Flower Publication Pvt. Ltd., 48/41-42, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi - 110 091(India)
Mobile: 8130750089, Phone: 91-11-45796900, 22754205, 22756995
E-mail: sales@rfppl.co.in, Website: www.rfppl.co.in

Guidelines for Authors

Manuscripts must be prepared in accordance with "Uniform requirements for Manuscripts submitted to Biomedical Journal" developed by international committee of medical Journal Editors

Types of Manuscripts and Limits

Original articles: Up to 3000 words excluding references and abstract and up to 10 references.

Review articles: Up to 2500 words excluding references and abstract and up to 10 references.

Case reports: Up to 1000 words excluding references and abstract and up to 10 references.

Online Submission of the Manuscripts

Articles can also be submitted online from http://rfppl.co.in/customer_index.php.

I) First Page File: Prepare the title page, covering letter, acknowledgement, etc. using a word processor program. All information which can reveal your identity should be here. use text/rtf/doc/PDF files. Do not zip the files.

2) Article file: The main text of the article, beginning from Abstract till References (including tables) should be in this file. Do not include any information (such as acknowledgement, your name in page headers, etc.) in this file. Use text/rtf/doc/PDF files. Do not zip the files. Limit the file size to 400 Kb. Do not incorporate images in the file. If file size is large, graphs can be submitted as images separately without incorporating them in the article file to reduce the size of the file.

3) Images: Submit good quality color images. Each image should be less than 100 Kb in size. Size of the image can be reduced by decreasing the actual height and width of the images (keep up to 400 pixels or 3 inches). All image formats (jpeg, tiff, gif, bmp, png, eps etc.) are acceptable; jpeg is most suitable.

Legends: Legends for the figures/images should be included at the end of the article file.

If the manuscript is submitted online, the contributors' form and copyright transfer form has to be submitted in original with the signatures of all the contributors within two weeks from submission. Hard copies of the images (3 sets), for articles submitted online, should be sent to the journal office at the time of submission of a revised manuscript. Editorial office: Red Flower Publication Pvt. Ltd., 48/41-42, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi – 110 091, India, Phone: 91-11-22754205, 45796900, 22756995. E-mail: author@rfppl.co.in. Submission page: http://rfppl.co.in/article_submission_system.php?mid=5.

Preparation of the Manuscript

The text of observational and experimental articles should be divided into sections with the headings: Introduction, Methods, Results, Discussion, References, Tables, Figures, Figure legends, and Acknowledgment. Do not make subheadings in these sections.

Title Page

The title page should carry

1) Type of manuscript (e.g. Original article, Review article, Case Report)

2) The title of the article should be concise and informative;

3) Running title or short title not more than 50 characters;

4) The name by which each contributor is known (Last name, First name and initials of middle name), with his or her highest academic degree(s) and institutional affiliation;

5) The name of the department(s) and institution(s) to which the work should be attributed;

6) The name, address, phone numbers, facsimile numbers and e-mail address of the contributor responsible for correspondence about the manuscript; should be mentoined.

7) The total number of pages, total number of photographs and word counts separately for abstract and for the text (excluding the references and abstract);

8) Source(s) of support in the form of grants, equipment, drugs, or all of these;

9) Acknowledgement, if any; and

l0) If the manuscript was presented as part at a meeting, the organization, place, and exact date on which it was read.

Abstract Page

The second page should carry the full title of the manuscript and an abstract (of no more than 150 words for case reports, brief reports and 250 words for original articles). The abstract should be structured and state the Context (Background), Aims, Settings and Design, Methods and Materials, Statistical Analyzis used, Results and Conclusions. Below the abstract should provide 3 to 10 keywords.

Introduction

State the background of the study and purpose of the study and summarize the rationale for the study or observation.

Methods

The methods section should include only information that was available at the time the plan or protocol for the study was written such as study approach, design, type of sample, sample size, sampling technique, setting of the study, description of data collection tools and methods; all information obtained during the conduct of the study belongs in the Results section.

Reports of randomized clinical trials should be based on the CONSORT Statement (http:// www. consort-statement. org). When reporting experiments on human subjects, indicate whether the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional or regional) and with the Helsinki Declaration of 1975, as revised in 2000 (available at http://www.wma. net/e/policy/l 7-c_e.html).

Results

Present your results in logical sequence in the text, tables, and illustrations, giving the main or most important findings first. Do not repeat in the text all the data in the tables or illustrations; emphasize or summarize only important observations. Extra or supplementary materials and technical details can be placed in an appendix where it will be accessible but will not interrupt the flow of the text; alternatively, it can be published only in the electronic version of the journal.

Discussion

Include summary of key findings (primary outcome measures, secondary outcome measures, results as they relate to a prior hypothesis); Strengths and limitations of the study (study question, study design, data collection, Analyzis and interpretation); Interpretation and implications in the context of the totality of evidence (is there a systematic review to refer to, if not, could one be reasonably done here and now?, What this study adds to the available evidence, effects on patient care and health policy, possible mechanisms)? Controversies raised by this study; and Future research directions (for this particular research collaboration, underlying mechanisms, clinical research). Do not repeat in detail data or other material given in the Introduction or the Results section.

References

List references in alphabetical order. Each listed reference should be cited in text (not in alphabetic order), and each text citation should be listed in the References section. Identify references in text, tables, and legends by Arabic numerals in square bracket (e.g. [10]). Please refer to ICMJE Guidelines (http://www.nlm.nih.gov/bsd/uniform_ requirements.html) for more examples.

Standard journal article

[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006; 35: 540–7.

[2] Twetman S, Axelsson S, Dahlgren H, Holm AK, Källestål C, Lagerlöf F, et al. Caries-preventive effect of fluoride toothpaste: A systematic review. Acta Odontol Scand 2003; 61: 347–55.

Article in supplement or special issue

[3] Fleischer W, Reimer K. Povidone-iodine antisepsis. State of the art. Dermatology 1997; 195 Suppl 2: 3–9.

Corporate (collective) author

[4] American Academy of Periodontology. Sonic and ultrasonic scalers in periodontics. J Periodontol 2000; 71: 1792–801.

Unpublished article

[5] Garoushi S, Lassila LV, Tezvergil A, Vallittu PK. Static and fatigue compression test for particulate filler composite resin with fiber-reinforced composite substructure. Dent Mater 2006.

Personal author(s)

[6] Hosmer D, Lemeshow S. Applied logistic regression, 2nd edn. New York: Wiley-Interscience; 2000.

Chapter in book

[7] Nauntofte B, Tenovuo J, Lagerlöf F. Secretion and composition of saliva. In: Fejerskov O,

Kidd EAM, editors. Dental caries: The disease and its clinical management. Oxford: Blackwell Munksgaard; 2003. pp 7–27.

No author given

[8] World Health Organization. Oral health surveys - basic methods, 4th edn. Geneva: World Health Organization; 1997.

Reference from electronic media

[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979–2001. www.statistics.gov.uk/downloads/theme_health/HSQ 20.pdf (accessed Jan 24, 2005): 7–18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

More information about other reference types is available at www.nlm.nih.gov/bsd/uniform_ requirements.html, but observes some minor deviations (no full stop after journal title, no issue or date after volume, etc.).

Tables

Tables should be self-explanatory and should not duplicate textual material.

Tables with more than 10 columns and 25 rows are not acceptable.

Table numbers should be in Arabic numerals, consecutively in the order of their first citation in the text and supply a brief title for each.

Explain in footnotes all non-standard abbreviations that are used in each table.

For footnotes use the following symbols, in this sequence: *, ¶, †, ‡‡,

Illustrations (Figures)

Graphics files are welcome if supplied as Tiff, EPS, or PowerPoint files of minimum 1200x1600 pixel size. The minimum line weight for line art is 0.5 point for optimal printing.

When possible, please place symbol legends below the figure instead of the side.

Original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay.

Type or print out legends (maximum 40 words, excluding the credit line) for illustrations using double spacing, with Arabic numerals corresponding to the illustrations.

Sending a revised manuscript

While submitting a revised manuscript, contributors are requested to include, along with single copy of the final revised manuscript, a photocopy of the revised manuscript with the changes underlined in red and copy of the comments with the point-to-point clarification to each comment. The manuscript number should be written on each of these documents. If the manuscript is submitted online, the contributors' form and copyright transfer form has to be submitted in original with the signatures of all the contributors within two weeks of submission. Hard copies of images should be sent to the office of the journal. There is no need to send printed manuscript for articles submitted online.

Reprints

Journal provides no free printed, reprints, however an author copy is sent to the main author and additional copies are available on payment (ask to the journal office).

Copyrights

The whole of the literary matter in the journal is copyright and cannot be reproduced without the written permission.

Declaration

A declaration should be submitted stating that the manuscript represents valid work and that neither this manuscript nor one with substantially similar content under the present authorship has been published or is being considered for publication elsewhere and the authorship of this article will not be contested by any one whose name(s) is/are not listed here, and that the order of authorship as placed in the manuscript is final and accepted by the co-authors. Declarations should be signed by all the authors in the order in which they are mentioned in the original manuscript. Matters appearing in the Journal are covered by copyright but no objection will be made to their reproduction provided permission is obtained from the Editor prior to publication and due acknowledgment of the source is made.

Approval of Ethics Committee

We need the Ethics committee approval letter from an Institutional ethical committee (IEC) or an institutional review board (IRB) to publish your Research article or author should submit a statement that the study does not require ethics approval along with evidence. The evidence could either be consent from patients is available and there are no ethics issues in the paper or a letter from an IRB stating that the study in question does not require ethics approval.

Abbreviations

Standard abbreviations should be used and be spelt out when first used in the text. Abbreviations should not be used in the title or abstract.

Checklist

- Manuscript Title
- Covering letter: Signed by all contributors
- Previous publication/ presentations mentioned, Source of funding mentioned
- Conflicts of interest disclosed

Authors

- Middle name initials provided.
- Author for correspondence, with e-mail address provided.
- Number of contributors restricted as per the instructions.
- Identity not revealed in paper except title page (e.g. name of the institute in Methods, citing previous study as 'our study')

Presentation and Format

- Double spacing
- Margins 2.5 cm from all four sides
- Title page contains all the desired information. Running title provided (not more than 50 characters)
- Abstract page contains the full title of the manuscript
- Abstract provided: Structured abstract provided for an original article.
- Keywords provided (three or more)
- Introduction of 75–100 words
- Headings in title case (not ALL CAPITALS). References cited in square brackets
- References according to the journal's instructions

Language and grammar

- Uniformly American English
- Abbreviations spelt out in full for the first time. Numerals from 1 to l0 spelt out
- Numerals at the beginning of the sentence spelt out

Tables and figures

- No repetition of data in tables and graphs and in text.
- Actual numbers from which graphs drawn, provided.
- Figures necessary and of good quality (color)
- Table and figure numbers in Arabic letters (not Roman).
- Labels pasted on back of the photographs (no names written)
- Figure legends provided (not more than 40 words)
- Patients' privacy maintained, (if not permission taken)
- Credit note for borrowed figures/tables provided
- Manuscript provided on a CDROM (with double spacing)

Submitting the Manuscript

- Is the journal editor's contact information current?
- Is the cover letter included with the manuscript? Does the letter:

1. Include the author's postal address, e-mail address, telephone number, and fax number for future correspondence?
2. State that the manuscript is original, not previously published, and not under concurrent consideration elsewhere?
3. Inform the journal editor of the existence of any similar published manuscripts written by the author?
4. Mention any supplemental material you are submitting for the online version of your article. Contributors' Form (to be modified as applicable and one signed copy attached with the manuscript)