Geriatric club attached to a primary care hospital as an effort to physically, socially, and mentally engage elderly: A case study from Kerala, India

Lakshmi Premnazir¹, Arun S. Nair¹, Sujith Suji¹, Amrita M. Das², S. Divyamol³, P. S. Rakesh¹

¹Amrita Urban Health Centre, ²Departments of Community Medicine and ³Geriatrics, Amrita Institute of Medical Sciences, Amrita ViswaVidyapeetham, Kochi, Kerala, India

ABSTRACT

Introduction: Ageing leads to physiological, social and mental changes. The case study shares experiences about the development and evolution of a ‘geriatric club’ attached to a primary health centre in Kerala, India and the early outcomes noticed among the members of the geriatric club. Process: This club, established three years before, has become an ongoing self-sustainable organisation helping senior citizens to socialise with their peers. Meeting on a regular day every week at the health centre, with programs varying from discussions on health issues to entertainments like music, dance, festival celebration and film shows, the club has become part of all elderly patients in and around the health centre. Outcome: Outcome of the club was looked qualitatively and quantitatively through Focus Group Discussions and before and after comparison of Mini Mental Status Examination Scores and Geriatric Depression Scale scores of elderly club members. FGDs concluded that members were benefitted through participation in the club and the club activities helped them to get engaged physically, mentally and socially. Mean GDS scores of the participants decreased from baseline [5.43, SE 0.76] to after six months [5.20, SE 0.74] (P=0.006). Mean MMSE scores showed improvement from baseline [22.26, SE 0.69] to after six months [24.80, SE 0.81] (P=0.001). Conclusion: Geriatric social clubs attached to primary health care hospitals with suitable contextual adaptations can engage elderly patients physically, mentally and socially. It is hypothesised that such activities can have positive impact on depression and cognitive improvement.

Keywords: Cognitive impairment, elderly club, geriatric club, geriatric depression, social engagement

Introduction

Epidemiologic and demographic transition coupled with improvements in health has resulted in a steady increase in the proportion of elderly (above 60 years) in India from 5.3% in 1951 to 8% in 2011. Kerala, a state in southern India, which has good indicators of health and social development – such as the human development index (0.84), life expectancy at birth (75 years), infant mortality rate (06/1000 live births), sex ratio (1084 females to 1000 males), and female literacy rates (92.07%), seems to be aging fast with proportion of elderly forming 12.6% of the total population. The age structure has resulted in a new set of problems in the society with direct and indirect effects.

Aging leads to physiological, social, and mental changes. Community-based mental health studies have revealed that the point prevalence of depressive disorders among the geriatric population in India varies between 13% and 35%. Depression is also known to be a risk factor for cognitive impairment among geriatric populations.

Address for correspondence: Dr. P. S. Rakesh Department of Community Medicine, Amrita Institute of Medical Sciences, Amrita ViswaVidyapeetham, Kochi, Kerala, India. E-mail: rakeshrenjini@gmail.com

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elderly. Cognitive status disturbance is a prevalent problem of the elderly and even mild cognitive impairment is associated with increased risk of mortality. With aging of Indian society, maintaining cognitive health in late life is a public health priority. A study in Kerala found the prevalence of cognitive impairment to be 11.5% in those more than 65 years of age. A recent study on quality of life (QOL) among elderly women from Kerala reported that QOL was poor in more than half of the participants and it was least in the psychological domain.

Singh et al. studied the psychosocial profile of the elderly in an urban area of north India and found that illness (73.1%) and loneliness (66.7%) were the common reasons for having unfavorable attitude toward life. To address depression among elderly, problems of loneliness and lack of emotional and social support need to be tackled. Social engagement is also of particular relevance in elderly as old age is associated with major life events such as retirement, the empty nest phenomenon, or the death of the spouse or close friends. Moreover, absence of social engagement in elderly is associated with adverse health outcomes such as cognitive decline or mortality. Numerous studies have shown that social activities are beneficial to various health outcomes of elderly people including self-rated health, physical functioning, depressive symptoms, and QOL. Previous research has also shown that greater participation in social activities can reduce cognitive decline in the elderly by providing intellectual and emotional stimulation. Participation in social activities can also provide meaningful social roles, self-esteem, and social competence, which might protect against neuropathology including reduction in stress response.

**Geriatric Club: Formation and Evolution**

Amrita Urban Health Centre is a primary healthcare center attached to the Community Medicine Department of Amrita School of Medicine, Kochi, India. The center provides free primary healthcare to people accessing this center predominantly from divisions 64 and 65 of Kochi Municipal Corporation, which constitutes its field practice area. Clinical services include patient consultations, essential medicines including those for primary care management of non-communicable diseases, and basic laboratory services including blood routine, urine routine, and blood sugars using glucometer. Average attendance in outpatient department (OPD) is around 60. New patients constitute around 17%, whereas the remaining used to be revisits. About 30% of the OPD attendance used to be constituted by people above 60 years. Staff strength includes two medical officers including a lady medical officer, a staff nurse, a pharmacist, a laboratory technician, two social workers, two field workers, a clerk, a cleaning staff, and medical interns.

As experienced by doctors in any primary health setting in Kerala, our doctors also observed that along with medical conditions, most of the elderly had some somatic complaints. They have also observed that many elderly patients especially women used to experience loneliness and many had low mood with worries, forgetfulness, irritability, anger, and lack of interest in day-to-day activities. The overall picture of the elderly in OPD is that of lonely old women and men, with higher morbidity, many of whom were either living alone or with other relatives with a feeling that they were not being adequately cared for in the family. The idea of starting a geriatric clinic on a fixed day of a week with better coordination of clinical services for the elderly along with social workers originated then. Elderly people were happy talking to their peers on the day and were interested in listening to the health education activities conducted in OPD by our medical interns. These observations led to organizing the elderly members to sit together at a particular time (10.30 am–11.00 am) on the day of geriatric clinic) every Thursday) in the class room in the health center for specifically discussing the health issues of the elderly. Average attendance during that time (August 2014) was around 10 members. Tea and biscuits were offered for them by the staff of the center.

Later we realized that something more than a cup of tea was needed to keep the foster and interest of members and prevent the less socially interacting from drifting away. Based on discussions with the elderly patients, a “club” was established to give them one more interest in life other their loneliness, idleness, and increasing sense of insecurity. Our aim in doing so was to help the patients socialize and overcome their psychological difficulties. We had few preconceived ideas of club management and we were prepared to act upon our observations and let the club grow naturally with minimum interference from our side. This led to the birth of “Geriatric Club” attached to our health center.

Geriatric club started meeting on every Thursday at our health center. Members started coming early in the day (8.30 am–10.30 am) to attend the geriatric clinic and get their consultations done. The discussions on health issues of elderly led by interns continued as such (10.30 am–11.00 am). Social workers were given the charge of organizing the initial meetings. No formal committee was formed, but three to four members among the members evolved naturally as leaders. Initial entertainments were group songs with little organization. This has rekindled the sense of nature and art in many. Later, the members took over the entertainment session which usually lasted for 60 min per club meeting. Musical programs have been the one most widely appreciated where seeds of group consensus were sown. The members started coming prepared with the songs for the meeting. They used to select songs which everybody can sing as a group where one leads and other follows. Songs included old film songs, traditional folk songs, and devotional songs of all religions. Later, five to six members had books with lyrics of songs written and two members started bringing traditional musical instruments (Ganjira, ilathalam).

The entertainment program varied from games, film show, short picnics, and festival celebrations decided and organized by the members themselves with the help of social workers. During the meetings, they started celebrating their birthdays, wedding days,
events happening in their families like birthdays, exam success, and marriages of their grandchildren. Later, they decided to form a “Kaikottikali” team – a traditional folk-dance form. One of the members took lead and started training others. The rehearsals and trainings lasted for 6 months for an hour after usual time of the meetings (12 noon–1 pm). They started bringing potluck lunch also during those days even for staff of the health center. There were active and passive members for this dance program. Passive members had an active role in motivating and criticizing the active members while doing their performances. The “Kaikottikali team” under the banner of our “Geriatric club” now had performed 25 stage programs as invited by other cultural/charitable/government organizations nearby. Yoga training is a new initiative this year where one among them teaches yoga to other members.

Staff at health center used to invite geriatric patients attending the OPD on other days to attend the geriatric club. The members started bringing many of their peers and relatives for the club meetings. The attendance started growing slowly. In all, 78 members were registered on the club roll. Average attendance per meeting was 28 for the year 2017 with attendance up to 67 during special occasions like festival celebrations and annual meetings. The club met regularly on every Thursdays without a break and has celebrated its 150th meeting with a grand feast prepared by the club members itself on June 2017.

Later, some of the members themselves tried to organize similar clubs in their locality. The meeting places of those clubs were either public buildings or the house of one of their members. Based on their requests, our social workers and interns are extending initial support for formation and stabilization of those clubs. As of May 2018, there were seven such clubs initiated in various parts of the city with varying frequency of meetings and structure.

Resources

Only direct financial implication from the side of health center to date was tea and biscuits served during the meeting. The health center has provided space for them to meet regularly and initiated the process. One social worker was kept in charge for helping the club members in organizing meeting and activities. Social workers also started maintaining the records of each participant including their personal and medical data as individual files. No membership fee was collected from members till date. Rest of the resources (potluck lunch, picnic, feast, etc.) were planned and pooled by the club members themselves.

Outcome

We tried to look at the impact of the club on the life of its members qualitatively and quantitatively. Two focus group discussions were conducted by a research team, who were not part of the day-to-day functioning of the health center. One group had seven male members and second group had eight female members. A focus group discussion (FGD) guide was developed and the key themes of the FGDs were impact of the club on their lives, things which they like in the club, suggestions for improvement, reasons for dropouts, and opinions about its sustainability. The aims of the investigations and implication for participation were explained at the start of the FGDs. Confidentiality was ensured and participants were given a chance to opt out freely at that stage without giving any reason. The moderator ensured that the themes were fully discussed and that all participants were given a chance to express their views fully. Each FGD lasted for 40–60 min with additional 10–15 min for informal conversations. The proceedings were audiotaped with the consent of participants. Two researchers recorded the proceedings, noting key themes and monitoring verbal and non-verbal interactions. The audiotapes were transcribed verbatim. These were in Malayalam and were translated into English before coding. The team read the transcripts and notes and reached a consensus. Any disagreements were discussed regularly within the team to reach a consensus regarding theme coding. Sections with similar coding were grouped according to the predetermined themes. Repeated themes were marked as important in red. All the flagged statements were put together and synthesized. Important quotations were quoted which evoked spontaneous discussion, around which a lot of time was spent and had some emotional cues attached with.

Generally, the team felt that members were benefitted and the club activities help them get engaged physically, mentally, and socially. Members expressed their happiness and positive changes in their life after started participating in club activities. A few verbatim accounts of club members during the FGDs are given in Box 1. While discussing about 10% dropouts in the club, poor physical and material conditions of their peers were cited as the reasons. When asked about its sustainability, “we ourselves are the proof that it is sustainable” was the response.
cited and agreed by all. They all wanted to popularize similar efforts in all regions so that the services could be extended to all elderly. Isolated personal conflicts among members were noticed in other newly started clubs, but presence of an external support from the health centre has been cited as the reason for not seeing such incidences here.

We have increasingly observed the effect of group cohesion and the therapeutic impact of the club. The most striking example of this group solidarity was the sympathy which members will extend toward one of their members during distress. The most unexpected result of founding and developing this club was the enrichment experiences which we ourselves have experienced – the intensified relationship we have established with the group as a whole and with individual members in particular. We have employed an informal non-professional approach to members and have been rewarded by their respect and affection. This we feel is unique to the club setting and could not be found in the hospital setting. Within a short span of time, the club members become integral part of our health center itself with a sense of ownership.

From 2017 March onward, as part of clinical services, Mini-Mental Status Examination (MMSE) and depression screening using Geriatric Depression Scales (GDS) were initiated for all members bi-annually. Medical Social Workers, who were trained in applying the tools, did routine screening. None of them was prescribed any psychiatric medications nor underwent professional counseling even though five of them were referred to a psychologist.

MMSE questionnaire is one of the most common measurement instruments which tests cognitive status in the fields of navigation, recording, attention, calculating, reminding, and designing and finally yields a total score. If the test shows no problem in any of the above fields, the score will be 30, which is the maximum possible score. Frooghi et al. reported Cronbach’s alpha of this scale as 0.78, and using a cutoff point of 21 reported its sensitivity as 90% and its specify as 84%. GDS is the most widely used depression screening scale that is specifically used in the elderly population. Each item can only be rated as 0 or 1, and the sum of the scores of all the items is the total score of GDS. The range of the total score is 0–15.

The details of 30 members who have completed both the screening at baseline around the time of joining and after 6 months of attending the clubs were available and were compared. The mean age of the people who were included in the analysis was 72.57 (standard deviation 8.18) years and it ranged from 60 to 96 years. Of them, 20 (66.7%) were females. Among them, six were widows (20%), one was a widower (3%), and one male was unmarried (3%). Sixteen (53.3%) were only doing household chores, while others were employed previously which included a variety of jobs including a teacher, naval base officer, petty shop owners, mechanic, manual laborers, carpenter, and those with government jobs. Of them, 5 (16.6%) had successfully completed their 10th-grade education, while 3 (10%) had completed up to second standard.

MMSE scores at baseline ranged between 15 and 30. Nine (37.5%) had a score more than 24, while 7 (23.3%) had a score less than 21. GDS scores at baseline were more than 10 for 5 (16.6%), less than 5 for 13 (43.3%), and between 5 and 10 for 12 (40%) participants. After 6 months, GDS scores decreased for seven people, whereas it remains same for the rest. MMSE scores improved for 16, decreased for 3, and remained static for the rest. Comparing the scores using paired t-test analysis has shown that the differences noticed in the improvements in scores were statistically significant. The details of the scores are shown in Table 1.

While we agree that it is difficult to comment upon the outcome measures in this study without a control group and not taking into account about the confounding factors, we hypothesize that similar interventions can reduce depression and improve cognition among the elderly. Attendance in day care elderly centers has reported to positively influence health-related QoL, cognition, and depression in a neighboring state.

### Challenges

Throughout the formation and evolution of geriatric club at our health center, we have not encountered any major challenges other than isolated conflicts among the members on certain decision, for example, to have yoga next week or film show. But to a great extent, involvement of our doctors whom they respect and our social workers whom they love has solved those issues easily. We have seen such conflicts in a newly started geriatric club in the community, which has reached almost to a dead stage, before our active involvement in revamping it. Keeping the external stimulation at optimal minimal level and making the club self-reliant need to be planned and implemented carefully. Another challenge foreseen is limiting the attendance of the club for want of space and logistics. Even though two of the members who were on mobility support instruments used to attend this club,

### Table 1: GDS and MMSE scores of club members at baseline and after 6 months

| Parameter           | Time period | Number | Mean scores | SE  | 95% CI of the mean difference | t   | P   |
|---------------------|-------------|--------|-------------|-----|-------------------------------|-----|-----|
| Geriatric depression| Baseline    | 30     | 5.43        | 0.76| 0.27-0.39                     | 2.97| 0.006|
| Scale               | After 6 months | 30     | 5.20        | 0.74|                               |     |     |
| Mini-mental status  | Baseline    | 30     | 22.26       | 0.69| -3.93 to -1.13                | -3.70| 0.001|
| Examination score   | After 6 months | 30     | 24.80       | 0.81|                               |     |     |

SE: Standard error; CI: Confidence interval
many elderly members in the community may find it difficult to participate in such ventures regularly.

**Lessons Learnt**

This club was initially perceived as an ongoing self-sustainable organization which will help senior citizens to socialize with their peers. Despite rapid growth, we are still at a formative stage and will refrain from making far-reaching suggestions or predictions. We would recommend that geriatric social clubs to be attached to primary healthcare hospitals. The value of this club lies not only in helping those old people to overcome psychological difficulties but also restoring them to their self-confidence and self-respect and ability to make fundamental social contacts. It may give them an interest, a meaning, and a purpose – a sense of still belonging to the community for remaining years of their life.

Elderly people are facing many physical, mental, emotional, and social issues. It remains so mainly in the absence of social cohesion. The bends and curves of elderly care entangle into chaos in the absence of hands to untwine them. Physically, mentally and socially engaging elderly patients attending primary healthcare setting through development of a geriatric club is a reality feasible under routine primary healthcare conditions. This model is easily replicable with suitable local adaptations to all primary healthcare facilities which has committed staff who love grey hairs.

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**Conflicts of interest**

There are no conflicts of interest.

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