Research Article

A Comparative Study to Assess the Needs of Elderly Residing in Gated and Non-Gated Communities in Selected Areas of Delhi

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A B S T R A C T

Introduction: In the twenty-first century, ageing has become one of the most discussed global issues. Keeping this in mind the present study was conducted to evaluate and compare the needs of older people residing in gated and non-gated communities with a view to give recommendations to residents' welfare associations based on the elderly needs.

Methodology: A quantitative research methodology with descriptive comparative research design was used for the current study. The sample was taken among elderly residing in gated and non-gated communities of Delhi. The collection of data was done using purposive sampling technique for 100 elderly from gated and 100 elderly from non-gated communities. A standardised tool (CANE) was used to evaluate the elderly needs.

Results: The results showed that the elderly had various needs which varied according to their residential status. There was a statistical difference of 1.154 between the needs of the elderly residing in gated and non-gated communities. The highest need was related to eyesight/ hearing and communication (1.01 in gated) and (0.98 in non-gated) in both and the least was associated with safety from self-harm (0) in both communities.

Conclusion: It was concluded that the elderly in gated and non-gated communities had various needs which differed according to their residential status. The priority needs included eyesight-related needs, household skills and physical health. To fulfil the various needs, certain recommendations based on their basic, security, belongingness, self-esteem, and actualisation needs were provided which included counselling sessions, yoga sessions, sewer cleaning, government scheme information, dedicated helplines, senior citizen clubs etc.

Keywords: Elderly, Needs, Gated Community, Non-Gated Community

Introduction

In the twenty-first century, ageing has become one of the most discussed global issues. In India, there are now three times as many people over 60 as there were fifty years ago.[1]

The average lifespan has grown and the proportion of citizens over the age of 65 has risen as a result of the progressive improvement in healthcare delivery services. By the year 2025, roughly 75% of this senior population will reside in countries that are still developing, and have a strained infrastructure for the provision of healthcare services. These shifts in demographics demand that worldwide attention be strongly redirected to address the medical and preventive demands of older people.[2]

The demands and issues of this ageing population frequently go unmet. Chronic illnesses, physical impairments, mental illnesses, and other co-morbidities are more common.[3] Acute illnesses are less common than chronic illnesses, notably aches and pains; therefore, older individuals must spend more time and money on medical issues than younger ones. Growing concern over the cost of medical care among older individuals and society as a whole has led to ongoing reviews and reforms of institutions and initiatives intended to help the elderly with these costs.[4]

A study was done to determine what necessities must be met for the elderly to age healthily, especially in low- and middle-income nations. The study revealed that financial stability is the first fundamental demand. Personal safety and security constitute the second necessity. Mental health is the third need. Healthcare that is easily available is the fourth necessity. The elderly's ability to pay for healthcare represents the biggest challenge for low- and middle-income nations. Self-actualisation is the last requirement. Despite the fact that these requirements must be satisfied for healthy ageing and elderly welfare, they have not yet been accomplished and continue to pose difficulties for countries with low and moderate incomes.[5]

Considering the older population, the UN Decade of Healthy Ageing (2021–2030) seeks to minimise disparities in health while bettering the senior citizens quality of living, their loved ones, and their surroundings through coordinated efforts in the following four domains: altering our mindsets regarding getting older and ageism; establishing neighbourhoods that promote older people's capacities; promoting person-focused holistic healthcare and basic medical services receptive to older people.[6]

Background

A few existing studies showed that there are various types of needs among the elderly, such as physical, social, emotional, security, etc. These aspects often vary based on the residential status of the elderly. Gated communities are often referred to as the safer ones, with the walls and the perimeter covered compared to the non-gated communities.

In Pune, researchers Dani and Bhore compared the life quality for old people living among family and those in nursing homes.[7] Seniors living with their families have a higher quality of life than those living in an old-age home, according to the results, which depicted a substantial difference in overall quality scores between the two groups. It was seen, that the residential status of the old people was also an important aspect that affected their quality of life.

Kengnal et al.[8] carried out another study in Karnataka to determine and compare the quality of living of senior citizens (> 60 years) living in old age homes in urban and rural areas. It was found that individuals with urban residences had higher mean scores in the physical, psychological, and social domains than those with rural residences or senior living facilities. In contrast to metropolitan areas and nursing homes, rural areas had higher environmental domain mean scores.

In a systematic review in Iran, Cheraghi et al.[9] attempted to evaluate the care needs of older people while focusing on the physical components, psychological aspects, and social problems associated with ageing. The results showed that the physical (45%) had the highest and social (21%) categories had the lowest levels of satisfied needs, respectively. In addition, the physical components and social areas had the highest rates of unfulfilled requirements (0.07%), while the psychological and environmental aspects had the lowest rates of unmet needs (0.04%).

The population's ageing process is not uniform due to differences in genetics, way of living and general health status.[10] Elderly face various issues related to health, such as societal, abuse towards themselves, lack of knowledge, nutritional needs, financial needs and other physical issues which impact their living in a big way.[11] The creation of pension plans for the elderly, construction of old age homes and inculcating the habit of taking care of the elderly by the children are a few measures to support them during their old age.[12]

Methodology

A quantitative research methodology with descriptive comparative design was used for the current study. The study was conducted over the period of five months from October 2022 to March 2023. The sample was selected from the elderly residing in gated and non-gated communities of Delhi. Purposive sampling technique was used to select 100 elderly people from gated and 100 from non-gated communities. Gated and non-gated communities were selected by non-probability sampling with convenience sampling technique for the study. Sample subjects from two

gated communities were selected using total enumeration sampling technique. For non-gated communities, three streets were selected and thereafter total enumeration sampling technique was employed from these streets. The elderly who participated in the study needed to be 60 years or older, willing to participate in the study, present during the time of data collection and able to understand Hindi or English. The elderly, who were mentally and physically not in a condition to answer the questions, were excluded from the study. A house-to-house survey and face-to-face interview technique were used to collect the data. A standardised tool Camberwell Assessment of Need for the Elderly (CANE) was used to assess the needs of the elderly along with the demographic profile of the subjects. CANE was developed by Reynolds et al. in the year 2000. It is a comprehensive instrument for evaluating the needs of elderly individuals. There are 24 social, medical, psychological, environmental, etc. needs that are covered by CANE. There is a need-specific question for each area. Responses are rated on a three-point scale, 0 indicates need not required, 1 indicates a need had met, i.e. proper intervention for the problem, and 2 indicates a need which is unmet, i.e. problem that has not been solved well. The sum of the total met and unmet needs and the total needs were calculated for each individual.

Formal administrative approval was obtained from the Resident Welfare Association (RWA) in gated communities and from the Member of Legislative Assembly in non-gated communities. Institutional Ethics Committee Jamia Hamdard, New Delhi, granted the ethical permission to conduct the research study. Informed consent was taken from subjects before their participation in the research study. Confidentiality of responses was assured. For need analysis, descriptive and inferential statistics were employed using SPSS.

Results

Section I: Findings related to Demographic Characteristics of the Elderly Residing in Gated and Non-Gated Communities

Tables 1a, 1b, and 1c show the frequency and percentage distribution of study subjects according to their demographic characteristics.

Table 1a.Frequency and Percentage Distribution of Study Subjects as per Their Demographic Characteristics (Age, Gender, Educational Level, and Religion)

N = 200

Sample Characteristics	Gated (n = 100)		Non-Gated (n = 100)		Test of Homogeneity
	Frequency	Percentage	Frequency	Percentage	
Age (Years)					
60–69	34	34.0	50	50.0	Fisher exact test's p value is 0.112.
70–79	47	47.0	39	39.0	
80–89	15	15.0	9	9.0	
90+	4	4.0	2	2.0	
Gender					
Male	35	35.0	57	57.0	The chi-square statistic is 9.7424*.
Female	65	65.0	43	43.0	
Educational level					
Illiterate	0	0.0	30	30.0	Fisher exact test's p value is less than 0.01*.
1st–5th	4	4.0	13	13.0	
6th–12th	14	14.0	47	47.0	
Graduation	42	42.0	8	8.0	
Postgraduation	40	40.0	2	2.0	
Religion					
Hinduism	88	88.0	100	100.0	Fisher exact test's p value is less than 0.01*.
Islam	1	1.0	0	0.0	
Christianity	6	6.0	0	0.0	
Others	5	5.0	0	0.0	

*Significant at 0.05 level of significance

The data in Table 1a depicts that according to the age groups, in gated communities, 47% were around 70–79 years old, whereas in non-gated communities, 50% were in the age group of 60–69 years. Regarding gender, the majority, i.e., 65% of the elderly, were female in gated communities. However, in non-gated communities, the majority, i.e., 57%, were male. Regarding education level, in gated communities, 42% were graduates, whereas in non-gated, 47% had education ranging from 6th to 12th standards.

Regarding religion, in the gated communities, 88% were Hindu. The non-gated communities consisted entirely of Hindus.

While testing for homogeneity, it was found that the two groups i.e. gated and non-gated communities were homogeneous in terms of education, gender and religion, and non-homogeneous in terms of age.

The data in Table 1b states that in terms of marital status, in gated communities, 73% of respondents were married, while in non-gated communities, 69% were married. In gated communities, number of children was 1–2 in 76% of participants, whereas in non-gated communities, 65% had 3 children or more.

Regarding occupational status, in gated communities, 63% were retired from their jobs. In non-gated communities, 40% were retired from their jobs.

Related to living arrangements, in gated communities, 51% lived with their spouse. In non-gated communities, 69% of residents lived with their children and spouses.

While testing for homogeneity, it was found that the two groups were homogeneous in terms of number of children, occupational status and living arrangement, whereas they were non-homogeneous in terms of marital status.

Table 1b.Frequency and Percentage Distribution of Study Subjects as per Their Demographic Characteristics (Marital Status, Number of Children, Occupational Status, and Living Arrangement)

N = 200

Sample Characteristics	Gated (n = 100)		Non-Gated (n = 100)		Test of Homogeneity
	Frequency	Percentage	Frequency	Percentage	
Marital status					
Married	73	73.0	69	69.0	Fisher exact test's p value is 0.531.
Unmarried	0	0.0	0	0.0	
Separated/ divorced	1	1.0	0	0.0	
Widowed	26	26.0	31	31.0	
Number of children					
1–2	76	76.0	35	35.0	The chi-square statistic is 34.0318*.
≥ 3	24	24.0	65	65.0	
Occupational status					
Never worked	18	18.0	38	38.0	Fisher exact test's p value is less than 0.01*.
Working	10	10.0	18	18.0	
Retired from job	63	63.0	40	40.0	
Working after retirement	9	9.0	4	4.0	
Living arrangement					
Alone	6	6.0	0	0.0	Fisher exact test's p value is less than 0.01*.
With children	19	19.0	31	31.0	
With spouse	51	51.0	0	0.0	
With children and spouse	22	22.0	69	69.0	
With others	2	2.0	0	0.0	

*Significant at 0.05 level of significance

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Table 1c.Frequency and Percentage Distribution of Study Subjects as per Their Demographic Characteristics (Financial Dependency Status, Monthly Income (Self), and Family Monthly Income)

N = 200

Sample Characteristics	Gated (n = 100)		Non-Gated (n = 100)		Test of Homogeneity
	Frequency	Percentage	Frequency	Percentage	
Financial dependency status					
Fully dependent	24	24.0	40	40.0	The chi-square statistic is 36.9386.*
Partially independent	8	8.0	33	33.0	
Independent	68	68.0	27	27.0	
Monthly income (self) (INR)					
No income	27	27.0	35	35.0	The chi-square statistic is 85.618.*
10,000-50,000	6	6.0	56	56.0	
50,001-100,000	67	67.0	9	9.0	
Family monthly income (INR)					
10,000–30,000	0	0.0	1	1.0	Fisher exact test's p value is less than 0.01*.
30,001–50,000	0	0.0	13	13.0	
50,001–70,000	0	0.0	34	34.0	
70,001–100,000	13	13.0	38	38.0	
> 100,000	87	87.0	14	14.0	

*Significant at 0.05 level of significance

The data presented in Table 1c depicts that regarding financial dependency status, in gated communities, 68% of participants were independent; in non-gated communities, 40% were fully dependent.

In gated communities, 67% of respondents had an individual monthly income of around INR 50,001-INR 100,000, whereas in non-gated communities, the individual monthly income of 56% of participants was INR 10,000-50,000.

In gated communities, family monthly income for 87% of participants was more than INR 100,000, while in non-gated communities, 38% of subjects had monthly family income between INR 7,0001 and 100,000.

Table 2a.Frequency and Percentage Distribution of Needs (Accommodation, Food, Household Skills, Self-Care, Daytime Activities, Physical Health, Psychotic Symptoms, Information, and Psychological Distress) of Elderly in Gated and Non-Gated Communities

N = 200

Needs	Gated (n = 100)		Non-Gated (n = 100)	
	Frequency	Percentage	Frequency	Percentage
Accommodation				
No need	60	60.0	45	45.0
Met need	40	40.0	50	50.0
Unmet need	0	0.0	5	5.0
Food				
No need	19	19.0	4	4.0
Met need	80	80.0	96	96.0

Unmet need	1	1.0	0	0.0
Household skills				
No need	0	0.0	2	2.0
Met need	100	100.0	98	98.0
Self-care				
No need	98	98.0	97	97.0
Met need	2	2.0	2	2.0
Unmet need	0	0.0	1	1.0
Daytime activities				
No need	49	49.0	27	27.0
Met need	35	35.0	70	70.0
Unmet need	16	16.0	3	3.0
Physical health				
No need	14	14.0	9	9.0
Met need	85	85.0	90	90.0
Unmet need	1	1.0	1	1.0
Psychotic symptoms				
No need	94	94.0	98	98.0
Unmet need	6	6.0	2	2.0
Information				
No need	83	83.0	80	80.0
Met need	14	14.0	6	6.0
Unmet need	3	3.0	14	14.0
Psychological distress				
No need	64	64.0	35	35.0
Met need	33	33.0	60	60.0
Unmet need	3	3.0	5	5.0

While testing for homogeneity, it was found that the two groups were homogeneous in terms of financial dependency status, monthly income (self) and family monthly income.

Section II: Findings related to Needs of the Elderly Residing in Gated and Non-Gated Communities

The data in Table 2a portrays the frequency and percentage distribution of the needs of the elderly. It was found that in the gated communities, accommodation was not needed by 60% of respondents, whereas in non-gated communities, this need was reported as met by 50% of participants. Food was a met need for 80% of participants in gated communities and in 96% of non-gated communities.

Household skills were met in 100% of gated communities and 98% of non-gated communities. Self-care was not needed for 98% of gated communities, whereas in non-gated communities, it was not needed for 97% of participants. Daytime activity was mentioned as not needed in 49% of gated communities, whereas in 70% of non-gated communities, it was a met need.

In gated communities, 85% of health needs related to physical health were met, whereas in non-gated communities, they were met for 90% of people. In gated communities, 94% had no need for psychotic symptoms, whereas in non-gated communities, 98% had no need for them.

In gated communities, 83% had no need for information, whereas in non-gated communities, 80% mentioned the same. In gated communities, 64% mentioned psychological distress had no need, whereas in non-gated communities, 60% mentioned it as a met need.

The data in Table 2b portrays that in gated communities, there was no need for safety from intentional self-harm, as in non-gated communities. In gated communities, 68% had no need, whereas in non-gated communities, 83% had no need for safety from accidental harm. In gated communities, 99% had no need, whereas in non-gated communities, 95% had no need for safety from abuse and neglect.

In gated communities, 90% had no need regarding behaviour, whereas in non-gated communities, 69% had no need. Regarding alcohol, in gated communities, 91% had no need, whereas in non-gated communities, 81% had no need. In gated communities, regarding drugs, 82%

had no need, whereas in non-gated communities, 98% mentioned it as no need.

Company was mentioned as a met need by 73% of participants from gated communities and 64% from non-gated communities. In gated communities, intimate relationship was regarded as a met need by 57% of participants, and in non-gated communities, 60% considered it to be a met need. In gated communities, care for someone else has 'no need' for 75% of respondents, whereas in non-gated communities, 69% mentioned it as a met need.

Table 2b.Frequency and Percentage of Needs (Safety (Self-Harm), Safety (Accidental Harm), Safety (Abuse/ Neglect), Behaviour, Alcohol, Drugs, Company, Intimate Relations, and Care for Someone Else) of Elderly in Gated and Non-Gated Communities

N = 200

Needs	Gated (n = 100)		Non-Gated (n = 100)	
	Frequency	Percentage	Frequency	Percentage
Safety (self-harm)				
No need	100	100.0	100	100.0
Met need	0	0.0	0	0.0
Unmet need	0	0.0	0	0.0
Safety (accidental self-harm)				
No need	68	68.0	83	83.0
Met need	31	31.0	17	17.0
Unmet need	1	1.0	0	0.0
Safety (abuse/ neglect)				
No need	99	99.0	95	95.0
Met need	1	1.0	0	0.0
Unmet need	0	0.0	5	5.0
Behaviour				
No need	90	90.0	69	69.0
Met need	0	0.0	0	0.0
Unmet need	10	10.0	31	31.0
Alcohol				
No need	91	91.0	81	81.0
Met need	0	0.0	0	0.0
Unmet need	9	9.0	19	19.0
Drugs				
No need	82	82.0	98	98.0
Met need	18	18.0	2	2.0
Unmet need	0	0.0	0	0.0

Company				
No need	20	20.0	35	35.0
Met need	73	73.0	64	64.0
Unmet need	7	7.0	1	1.0
Intimate relationship				
No need	30	30.0	30	30.0
Met need	57	57.0	60	60.0
Unmet need	13	13.0	10	10.0
Care for someone else				
No need	75	75.0	30	30.0
Met need	24	24.0	69	69.0
Unmet need	1	1.0	1	1.0

Table 2c.Frequency and Percentage of Needs of Elderly in Gated and Non-Gated Communities (Mobility/ Transport, Money, Benefits, Memory, Eyesight/ Hearing, and Continence)

N = 200

Needs	Gated (n = 100)		Non-Gated (n = 100)	
	Frequency	Percentage	Frequency	Percentage
Mobility/ Transport				
No need	40	40.0	60	60.0
Met need	54	54.0	30	30.0
Unmet need	6	6.0	10	10.0
Money				
No need	97	97.0	99	99.0
Met need	3	3.0	1	1.0
Benefits				
No need	98	98.0	68	68.0
Met need	2	2.0	16	16.0
Unmet need	0	0.0	16	16.0
Memory				
No need	57	57.0	44	44.0
Met need	42	42.0	56	56.0
Unmet need	1	1.0	0	0.0
Eyesight/ Hearing				
No need	1	1.0	7	7.0
Met need	97	97.0	88	88.0
Unmet need	2	2.0	5	5.0
Continence				
No need	67	67.0	75	75.0
Met need	29	29.0	18	18.0
Unmet need	4	4.0	7	7.0

The given data in Table 2c illustrates that in the area of mobility and transportation, 54% of respondents from gated communities had met need, whereas 60% from non-gated communities had no need. In gated communities, regarding money, 97% had no need, and in non-gated communities, 99% had no need. In the gated communities, regarding benefits, 98% had no need, whereas in the non-gated communities, 68% had no need.

Regarding memory, 57% of respondents from gated communities had no need, whereas in non-gated communities, 56% had met need. In gated communities, in the field of eyesight/ hearing, 97% had met need, whereas in non-gated communities, 88% had met need. In gated communities, regarding continence, 67% had no need, whereas in non-gated communities, 75% had no need.

The provided data in Table 3 illustrates that the mean score of needs faced by the elderly in gated communities was 9.8 and in non-gated communities, it was 11.68, which indicates that the needs of the elderly residing in non-gated communities are more compared to those residing in gated communities. The standard deviation was 4.003 for gated communities, while it was 2.849 for non-gated communities.

Table 3.Mean, Median, Standard Deviation, Mean Difference, Standard Error of Mean Difference and 't' Value for Significance of Mean Difference between Needs of Elderly Residing in Gated and Non-Gated Communities

N = 200

Group	Range of Maximum Scores	Range of Obtained Scores	Mean	Median	Standard Deviation	Mean Difference	Standard Error of Mean Difference	t Value
Gated (n = 100)	0–48	3–24	9.8	9	4.003	1.154	0.491	3.826
Non-gated (n = 100)		4–18	11.68	12	2.849			

't' (198) = 1.98 (< 0.05 significance level)

Table 4.Mean and Rank Order of Different Needs of Elderly Residing in Gated and Non-Gated Communities

N = 200

Gated (n = 100)			Non-Gated (n = 100)		
Areas	Mean	Rank	Areas	Mean	Rank
Eyesight	1.01	I	Eyesight	0.98	I
Household skills	1.00	II	Household skills	0.98	I
Physical health	0.87	III	Food	0.96	II
Company	0.87	III	Physical health	0.92	III
Intimate relations	0.83	IV	Intimate relations	0.80	IV
Food	0.82	V	Daytime activities	0.76	V
Daytime activities	0.67	VI	Caring for someone	0.71	VI
Mobility	0.66	VII	Psychological distress	0.70	VII
Memory	0.44	VIII	Company	0.66	VIII
Accommodation	0.40	IX	Behaviour	0.62	IX
Psychological distress	0.39	X	Accommodation	0.62	IX
Continence	0.37	XI	Memory	0.56	X
Safety (accidental self-harm)	0.33	XII	Mobility	0.50	XI
Caring for someone	0.26	XIII	Benefits	0.48	XII
Behaviour	0.20	XIV	Alcohol	0.38	XIII
Information	0.20	XIV	Information	0.34	XIV
Alcohol	0.18	XV	Continence	0.32	XV

Drugs	0.18	XV	Safety (accidental self-harm)	0.17	XVI
Psychotic symptoms	0.12	XVI	Safety (abuse/ neglect)	0.10	XVII
Money	0.03	XVII	Self-care	0.04	XVIII
Self-care	0.02	XVIII	Psychotic symptoms	0.04	XVIII
Benefits	0.02	XVIII	Drugs	0.02	XIX
Safety (abuse/ neglect)	0.01	XIX	Money	0.02	XIX
Safety (self-harm)	0.00	XX	Safety (self-harm)	0.00	XX

The mean difference between the two groups was statistically significant as the calculated t value of 3.826 was higher than the table value of 1.98 at the 0.05 level of significance. This indicates that the needs of the two groups were statistically significantly different.

The data in Table 4 depicts that the highest need in gated communities was for eyesight/ hearing and communication (1.01), followed by household skills (1.0), physical health (0.87), company (0.87), and intimate relations (0.83). The lowest need was for safety from self-harm (0.00).

In non-gated communities, the highest need was for eyesight/ hearing and communication (0.98) and household skills (0.98), followed by food (0.96), physical health (0.92), intimate relations (0.80), and daytime activities (0.76). The lowest need was for safety from self-harm (0.00).

Discussion

The findings of the current study represent that the unmet needs in gated communities were most seen in daytime activities (16%) and intimate relations (13%), and in non-gated communities, it was seen in behaviour (31%) and alcohol (19%). This is in partial agreement with the study of Tobis et al.[13] in Poland. According to their findings, the following categories had the highest rates of unmet needs: company (15.9%), psychological distress (14.0%), close relationships (11.4%), eyesight/ hearing/ communication (11.4%), and daytime activities (11.0%).

The findings of the present study showed that the highest met need was for household skills (100% in gated and 98% in non-gated communities), whereas the lowest met need was for self-harm (0%) in both gated and non-gated communities, which are in contrast with the study of Cheraghi et al.[9] who conducted a study by systematic review on older adults. Their findings indicated that physical (45%) and social (21%) domains had the highest and lowest levels of met needs.

In the present study, needs which were not met in the gated communities were mostly in daytime activities (16%) and intimate relations (13%), while in the non-gated communities, they were in behaviour (31%) and alcohol (19%). This is in contrast with the study of Hancock et al.[14] Their findings demonstrated that eyesight/ hearing, psychological distress, and incontinence were the three most often mentioned unmet requirements among the patients.

In the present study, unmet needs pertaining to daytime activities in gated communities were 16% and in non-gated, they were 3%, which is in contrast with the study conducted by Singh et al.[15] Their study showed that 32.5% of participants had unmet needs for one or more Activities of Daily Living (ADL) categories.

The findings of the present study showed that unmet needs in psychological distress were 3% in gated and 5% in non-gated communities, which is similar to the study conducted by Raju and Bansal,[16] which also showed that only 4% of subjects had low levels of psychological satisfaction.

The present study revealed that there was no need for daytime activities in gated (49%) and non-gated (27%) communities indicating that the elderly were able to perform their daily activities, which was in contrast with a study conducted by Das Gupta et al.[17] as per which, most of the males (68.70%) and females (71.26%) were able to do their daily physical activities without any problem.

Conclusion

It was concluded that the elderly in gated and non-gated communities have various needs and there is a statistical difference between the needs of the elderly residing in gated and non-gated communities where the elderly in non-gated communities had more needs as compared those in to gated communities. Recommendations were given to RWAs on the basis of the same which included addressing the specific needs of the elderly based on their physiological, security, belongingness, self-esteem, and self-actualisation requirements. These recommendations encompass counselling sessions, yoga sessions, sewer cleaning, government scheme information, dedicated helplines, senior citizen clubs, monthly meetings, technology classes, public park creation, small-scale industrial work, and training modules for various skills.

References

1. Dash B. A comprehensive textbook of community health nursing. 1st ed. New Delhi: Jaypee Brothers Medical Publishers; 2017. 613 p.

2. World Health Organization [Internet]. Ageing; [cited 2022 Oct 12]. Available from: https://www.who.int/health-topics/ageing#tab=tab_1

3. Boutayeb A, Boutayeb S. The burden of non communicable diseases in developing countries. Int J Equity Health [Internet]. 2005 [cited 2022 Oct 12];4(1):2. Available from: https://pubmed.ncbi.nlm.nih.gov/15651987/#:~:text=CONCLUSION%3A%20Non%20communicable%20diseases%20are,support%20the%20burden%20of%20disease [PubMed] [Google Scholar]

4. Britannica [Internet]. Old age: human life span; 2023 [cited 2023 Sep 19]. Available from: https://www.britannica.com/science/old-age

5. Putri AA, Lestari CN. The ability to meet the elderly's basic needs for healthy ageing in low- and middle-income countries. KnE Life Sciences [Internet]. 2018 Jan 11 [cited 2023 Feb 6];4(1):39-46. Available from: https://knepublishing.com/index.php/KnE-Life/article/view/1364 [Google Scholar]

6. World Health Organization [Internet]. Ageing and health; [cited 2022 Oct 12]. Available from: https://www.who.int/news-room/fact-sheets/detail/ageing-and-health#:~:text=Common%20health%20conditions%20associated%20with,%2C%20diabetes%2C%20depression%20and%20dementia

7. Dani P, Bhore N. A comparative study to assess the quality of life among senior citizens residing at homes and old age homes of Pune city. Innov J Nurs Healthcare [Internet]. 2015 [cited 2022 Oct 10];1(3):218-26. Available from: https://www.researchgate.net/publication/309179577_A_comparative_study_to_assess_the_quality_of_life_among_senior_citizens_residing_at_homes_and_old_age_homes_of_Pune_city [Google Scholar]

8. Kengnal PR, Bullappa A, Kumar A. A comparative study of quality of life among elderly people living in old age homes and in the community. Int J Community Med Public Health [Internet]. 2019 [cited 2022 Oct 10];6(8):3588-93. Available from: https://www.researchgate.net/publication/334722419_A_comparative_study_of_quality_of_life_among_elderly_people_living_in_old_age_homes_and_in_the_community [Google Scholar]

9. Cheraghi P, Delbari A, Cheraghi Z, Karimi-Shahanjarini A, Zanjari N. Assessment of met and unmet care needs in older adults without mental disorders using the Camberwell Assessment of Need for the Elderly: a systematic review and meta-analysis. J Res Health Sci [Internet]. 2021 Oct 12 [cited 2022 Oct 10];21(4):e00530. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC8957665/ [PubMed] [Google Scholar]

10. Levine ME. Modeling the rate of senescence: can estimated biological age predict mortality more accurately than chronological age? J Gerontol A Biol Sci Med Sci [Internet]. 2013 [cited 2022 Oct 5];68(6):667-74. Available from: https://pubmed.ncbi.nlm.nih.gov/23213031/ [PubMed] [Google Scholar]

11. Song Y, Ma W, Yi X, Wang S, Sun X, Tian J, Wang S, Zheng C, Zhang B, Xu Z, Marley G. Chronic diseases knowledge and related factors among the elderly in Jinan, China. PLoS One [Internet]. 2013 [cited 2022 Oct 12];8(6):e68599. Available from: https://pubmed.ncbi.nlm.nih.gov/23826394/ [PubMed] [Google Scholar]

12. WHO Collaborating Center for Research on Health of the Elderly. Key policy issues in long-term care [Internet]. Geneva: World Health Organization; 2003 [cited 2022 Oct 5]. Available from: https://books.google.co.in/books?hl=en&lr=&id=J8DXL147v_MC&oi=fnd&pg=PR3&dq=12.%09Key+Policy+Issues+in+Long-term+Care+%5BInternet%5D.+World+Health+Organization&ots=KVbX3G92rj&sig=bZODMHHay64hojuYg5vhf40P3PQ&redir_esc=y#v=onepage&q&f=false[Google Scholar]

13. Tobis S, Wieczorowska-Tobis K, Talarska D, Pawlaczyk M, Suwalska A. Needs of older adults living in long-term care institutions: an observational study using Camberwell Assessment of Need for the Elderly. Clin Interv Aging. 2018 Nov 21;13:2389-95. [PubMed] [Google Scholar]

14. Hancock GA, Reynolds T, Woods B, Thornicroft G, Orrell M. The needs of older people with mental health problems according to the user, the carer, and the staff. Int J Geriatr Psychiatry. 2003 Sep;18(9):803-11. [PubMed] [Google Scholar]

15. Singh A, Bairwa M, Goel S, Bypareddy R, Mithra P. Prevalence and predictors of unmet needs among the elderly residents of the rural field practice area of a tertiary care centre from Northern India. Malays J Med Sci. 2016;23(5):44-50. [PubMed] [Google Scholar]

16. Raju KR, Bansal NK. Psychological satisfaction of elderly people for meeting the basic psychological needs. J Bio Innov. 2021;10(2):650-3.

17. Das Gupta R, Loha A, Roy S. Morbidity pattern and health-seeking behaviour among the senior citizens in a selected urban area of Bangladesh: a cross-sectional study. South East Asia J Public Health. 2015;5(2):43-9. [Google Scholar]