INTERNATIONAL COLLOQUIUM
ON THE OLDEST OLD (80+)
With Focus on Health and Care Giving

Thiruvananthapuram, India
February 9 – 11, 2009

CONCLUSIONS , SUGGESTIONS, RECOMMENDATIONS AND POLICY IMPLICATIONS

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Introduction

This is the first ever conference on the oldest old at the global level. It was held in Thiruvananthapuram, capital of Kerala State in India on February 9-11, 2009 and was organized by the Centre for Gerontological Studies (CGS), Thiruvananthapuram and co-sponsored by the Government of Kerala and the United Nations Population Fund (UNFPA).

The oldest old (80 years and over) is the fastest growing segment of the older (60 +) population throughout the world. In 2006 they constituted 89.3 million, i.e., 13.% of the 60+ population. By 2050, 394 million, i.e., 20% of the old, will be 80 years and over. In countries like Japan and Switzerland, the oldest old will be 40% at that time. The problems and needs of this segment are much different from those of the younger old (60-79 years). But the general tendency for policy makers around the world has been to treat all old as a homogeneous group. Unless the uniqueness of the oldest old is appreciated and recognized and early measures are taken to address to their critical problems and needs, the world's oldest old may end up in great agony and misery. Hence, by all counts, it is necessary that the world's attention should be turned to this matter on a priority basis. The present colloquium was organized by CGS to draw the attention of the world to this scenario and to stress the need for urgent action in the matter. The delegates from India and abroad presented situation analysis and case studies on the 80+ in their countries and presented their views concerning the policies and programmes that could address these issues in the future.

The Colloquium was attended by 110 specially invited delegates, a good number of whom were from outside India, mainly sponsored by UNFPA. There were 4 Symposia, 2 Round Tables and 5 Technical Sessions besides the inaugural and valedictory sessions. There was a Theme Paper titled "Who Cares for the Oldest Old? Plight of the 80+ in Global Perspective" prepared by Dr. P.K.B. Nayar, Chairman of CGS, to provide background information and data on the issue to the delegates.

The themes of the **Symposia** were the following:

I. Health Profile and Health Management of the Oldest Old.
II - Social Dynamics of Aging
III - Human Side in the Care of 80 Plus
IV - State-Civil Society Interface in the Care of the Oldest Old

The Round Tables discussed the scenario of the 80+ around the world.
The themes for the **technical sessions** were

1. Pattern of Health-seeking Behaviour of the Oldest Old
2 Care-giving of the 80 Plus
3 Support System for the Oldest Old
4 Concerns and Needs of the Oldest Old
5 Brain Storming Session

The conclusions, suggestions, recommendations and policy implications that emerged out of the colloquium are given below. They are in two parts, viz. (1) Conclusions and suggestion and (2) Recommendations and Policy implications**.** They reiterated the confirmed view of the colloquium delegates that the oldest old differ from the younger old age group in their orientations, mindsets, concerns, needs and problems and that this fact should be recognized and appreciated while framing policies and programmes for the elderly. The conclusions and suggestions of the Colloquium are given in Section I. The recommendations and policy implications are given in Section II.

I. CONCLUSIONS AND SUGGESTIONS

1. Demography

While the 21st century may be considered as the Century of Older Persons *par excellence*, this century will also experience the phenomenon of "aging of the aged", i.e., if we take the elderly as a distinct demographic group, we will notice an aging process within this category, with two broadly identifiable sub-groups, the 60-79 and the 80+. While the two sub groups share many common characteristics, they also differ in many others. By 2050, the oldest old will be one-fifth of the global elderly population and their proportion will increase progressively for some decades though it will stabilize thereafter. During the peak period, in some countries the proportion of the oldest old would be more than 40% of the elderly population.

It is therefore suggested that in formulating policies and programmes for the elderly, the present approach of treating all the old as a homogeneous group should be discontinued and the oldest old should be treated as a distinct group within the old, requiring welfare polices and programmes geared to their special needs and concerns. In short, there is need for a paradigm shift in policy making for the elderly.

2. Family

The colloquium unanimously held the view that the family should be the best and most appropriate place for a person of 80+ years to spend the last segment of his/her life and as such every support should be provided to the family to keep them in it. Provision should also be made to ensure that the oldest old are integrated with the family. Many of the oldest old will be frail, some may have limited activity, some may be bed-ridden or with limited mobility and some with debilitating diseases. Even those who are active will find their circle of friends and sphere of activity dwindling rather drastically and many of them will be moving towards a stage of dependence both physically and otherwise.

Even under the best of circumstances a family may not be always considerate in dispensing care to its old unproductive kin, and this is more so when he/she is a liability in physical and medical terms. Policy on this category of the old therefore should aim at making them acceptable to the entire family in spite of the physical strain and financial burden and other inconveniences this may impose upon the family members. This needs expert counseling of all members of the family including the oldest old. (See below for details)

Studies have found that globally around 3 to 5% of the old live in institutions, 17% live with spouse and another 13% live in single person households, leaving the overwhelming majority of the old to live with children. However, these studies relate to *all* old and not just 80+ only. Even so, one could project these figures to the 80 plus with a caveat that at this age the number living in institutions, alone and with spouse will be smaller than the general average. **Hence, the family becomes central to any welfare measures intended for the 80+.** But families differ in their attitude and disposition towards care giving of their old kin and this may be mainly due to the economic condition of the family, housing facilities for accommodating the kin, health condition of the elderly kin, paucity of care givers in the family and, not unimportant, problems of adjustment between the old kin and other family members.

To induce the family to accept the care of the elderly kin without grudge, and to relieve care-giving of much of its unpleasantness, the Colloquium suggested the following:

A reasonable amount of money every month as pension to the oldest old if the family is unable to take care of the old without augmenting its income/financial position. This should be irrespective of the fact that the family is above or below poverty line and based entirely on the family's overall financial responsibilities. It could also be in the nature of a subvention.

Free or subsidized medical care for all the oldest old, including hospitalization, clinical tests and medical supplies and equipment as necessary or alternatively free or subsidized health insurance for all the oldest old.

Rebates on taxes and utilities to the family maintaining an 80+ old member. Priority to the family when distributing concessions by the government.

Community assistance to the family taking care of the 80+. Since there would be several families in a community having 80+ members, it is advisable to "communalize" some of the services that families require in the maintenance of their oldest old members but would find difficulty in securing them individually. Also there will be more efficiency and economies of scale if these services are provided at the community level.

Three agencies are suggested for this purpose.

(1) One is a <u>Multi-Service Elder Care Centre</u> (Elder Care Centre for short or Age Care Centre) preferably run by the local elders (of younger ages).

The services of this community centre with a professional social worker and professional health worker as core staff and with a part time doctor and basic medical supplies and services could be availed by a family in the care of its 80+. There will be other consultants who could advise and assist the old on almost all their problems. The social and health workers could visit the households periodically, monitor the welfare of the old and advise and assist the family and the old member. The Elder Care Centre can function as an agency catering to all or most of the needs of the family vis-à-vis the old. It can organize families of the 80+ and orient them to their tasks in elder care. It can organize meetings of youth and children and impart information on better interpersonal relationship between them and the old. It can, through several other skillful ways and programmes, enlighten families in better care of the oldest old member and help build

stronger intergenerational bonds. The Centre should have a round-the-clock Helpline for attending to the calls of the 80+ or their families. A fully developed Age Care Centre will ideally have the following functions - family care, economic assistance, health care and extension and outreach services.

Elder abuse has become more common especially with increasing poverty of the family, sickness of the kin and spiraling health care cost, to mention the major ones. Some countries (India is one) have enacted laws against elder abuse but such laws have been found to be less effective in preventing elder abuse as there are several subtle ways of circumventing the law. Instances have been pointed out when the abused does not like to reveal the event for fear of displeasure and retaliation by the abuser and also due to social pressure, leading to the perpetuation of abuse.

(2) To overcome this situation, the Colloquium recommended the formation of small ***Senior Citizens' Clubs*** *(mainly informal or semi-formal neighborhood get-togethers of senior citizens) whose members can visit the victim's family and use persuasion and moral pressure on the abuser*. The club members being local elderly will be more acceptable to the abuser than a government official or even a trained counselor. Even when no abuse is reported, members can still visit a home-bound elderly in his/her house, provide possible domiciliary service, remove his/her feeling of loneliness, boost his/her morale and add to his/her feeling of self-worth and self-confidence. More than 40% of the oldest old are reported to suffer from depression and the club members can provide at least partial relief for this malady.

The Senior Citizens' Club and the Elder Care Centre can work hand in hand and strengthen their activities to the best advantage of their clients.

(Please note that the Elder Care Centre and Senior Citizens' Club are different from the *senior citizens' associations* functioning in most urban areas around the world in that the first (Elder Care Centre) is a specifically service-providing agency and the second (Senior Citizens' Club) is mostly an informal close-knit group with small membership).

(3) The third agency proposed is a ***Geriatric Mobile Medicare Unit (GMMU)*** *with medical and para medical staff and social worker and with basic medical equipment and supplies*. (In India, this arrangement exists in some major cities and is supported by the Government of India). The GMMU will go to different locations on notified days. Those old who can manage to visit the GMMU during its rounds will be given basic medical advice and assistance; those who cannot will be visited in their families by

the medical team including the social worker. Cases which cannot be handled by the GMMU will be referred to a referral hospital or to a specialist for personalized attention and for treatment at affordable cost which will be facilitated and monitored by the social worker.

Thus, with the services available at the Elder Care Centre, the Senior Citizens' Citizens' Club and the GMMU, care giving can be made less burdensome and more welcome to the family. The oldest old also would find themselves more acceptable and welcome in the family.

The Elder Care Centre, the Senior Citizens' Club and the GMMU are not intended for the 80+ only but they will be catering more to the needs and problems of this segment of the elderly. In fact, it is the 80+ and their families that require the services of these agencies much more than the other segments of the elderly and the families keeping them.

3. Economic Aspects

Most countries have instituted old age pensions and usually this is a flat amount that never changes during the life time of the pensioner.

Since one's expenses increase as one becomes older due to the need for special care and medicines etc, it is suggested that the amount of pension be calibrated to their requirements. One way is to increase the pension amount progressively after every ten years starting with 60. An alternative to this is to divide pension into two slabs – one for those below 80 years and a higher amount for those 80 years and above.

The Colloquium suggests that countries that do not currently have any old age pension scheme should introduce it on the above lines.

A major problem of the oldest old is inability and helplessness in managing one's own finances. Most of the 80 plus may not have any property or savings but even those who do have assets are not in a position to manage them for reasons relating to their advanced age. They are often obliged to depend on their kin many of whom, as studies have revealed, use the income for their own betterment, spending precious little on the old kin. Owning property or assets in this case does not benefit the elderly owner. The total dependence of the victim on the family for all his/her requirements in the last years of life makes him/her to stoically bear all the privations even when financially viable.

Here again, the senior Citizens' Club can come to the rescue of the victim and pressurize the offender to make better sense to prevail.

4. Health Care Aspects

Health statistics regarding the 80 plus though scanty reveal that at least 80% of them will be having single or multiple illnesses, many of which are chronic and some of them imposing some restriction on the individual – on diet, movement, daily routine, etc. About 20% will have physical disability - problems with performing the activities of daily living (ADL) including problem of extended mobility and taking care of daily chores. Around 30% will be home-bound and another 20% will be bed-ridden and 15 to 20% will be having some form of dementia. The number in each category will rise as age increases. All-told, around 35% of the 80+ will be debilitated in one form or other and they will need medical management. One worry of the 80+ and their care givers is reaching out to the right doctor.

Old age treatment at times is a gamble, by the wrong doctor giving the wrong treatment, with the result that not only the cost of health care increases but it causes avoidable agony and pain and offers little relief to the patient. The Health Care Unit of the Centre and GMMU can direct the patient to the right doctor who will give better treatment at affordable cost. This also takes out much of the burden of care-giving from the family. The Elder Care Centre and Senior Citizens' Club can assist/supplement in follow-up matters.

Deficiencies in geriatric care have been observed in most countries not only because there is an acute shortage of trained medical personnel but also because most diseases of old age often have no cure. They are called "terminal diseases" implying that there is no cure except palliative care. Also, medical ethics is getting increasingly eroded and the profession is in the grip of commercialization. The resultant victims are mostly among the oldest old.

The Colloquium was very much concerned with the issue but did not have any specific solution focusing on the 80+ except to reiterate the earlier suggestion that health care of all the 80+ should be made free or at least free for all the destitute 80+ and heavily subsidised for the rest and further that the state should take the responsibility for training more doctors in the treatment of old age illnesses. The medical profession should evolve appropriate ethics and codes of conduct for the doctors handling terminally ill patients, with the government acting vigil on the whole practice – medical practitioners, hospitals, and pharmaceutical and medical equipment manufacturing companies. These are in addition to the opening up of free geriatric hospitals, geriatric homes and geriatric clinics for the entire 80 plus.

5. Eighty-Plus Women

It was noted that women constituted the overwhelming majority among the oldest old and their problems differed from those of men due to biological and cultural factors. The colloquium identified three areas where the problem is conspicuous – support system, health care and living arrangement. Since women live longer than men and since the extended period of life is spent more or less in morbidity and neglect and is crowned with widowhood, they (these women) should be treated as a preferred category in healthcare and social support.

It is suggested that the amount of old age pension should be higher for women than for men and the difference should be maintained when the amount is increased at every slab of ten years or after attaining 80 years.

Counselors at the Elder Care Centre and social workers at the GMMUs should be entrusted with special responsibility for ensuring justice to elderly women and for enhancing their self esteem and self confidence. The seniors Citizens' Club also should take up the cause of the 80+ women as special cases needing special attention. All services for the 80+ should have special units for catering to the needs of the oldest old women. The helpline at the Elder Care Centre should attend to calls relating to the oldest old women on an urgent and priority basis.

6. Old Age Homes

Old age homes are not a phenomenon of the developed countries any more; they are mushrooming in developing countries to cater to the needs of the growing elderly population. Most old age homes do not provide for the extra needs of those who are in advanced ages and with chronic diseases.

To cater to the needs of the 80+, geriatric institutions rather than general old age homes may be established. They should have counseling and medical facilities which most existing old age homes currently lack. Instead of being custodial in structure and nature, they should imbibe the spirit of a "home away from home". To keep up with the trend, old age homes may be re-designated as "Senior Citizens' Homes" or merely "Seniors' Homes". There is also need for better supervision and regulation of old age homes to ensure that they indeed deliver the services expected of them. To ensure the proper handling of the special needs and concerns of the oldest old in these institutions, local Senior Citizens' Clubs should act as watchdogs of these institutions. Elder Care Centres should establish Visiting Committees on old age/geriatric homes in their locality and ensure standards in supplies and services.

7. Empowering the Oldest Old

"The Principles of Older Persons" (independence, participation, care, self-fulfillment and dignity) enacted by United Nations Assembly in 1991 will be of little use in empowering the oldest old. Administrative and operational difficulties have constrained national governments from adopting them or implementing them *even for the young old*. Because of the special handicaps, the oldest old are not in a position to get any of the five principles enforced to their advantage.

The Colloquium suggests that the Senior Citizens' Clubs could empower the oldest old by espousing the concerns of the oldest old. They can act as watchdogs of the disadvantaged old in ensuring a life with honour and dignity in their last years. Perhaps for the frail elderly these clubs could do more than any other single agency ranging from the family to the state in the matter of empowerment. The Elder Care Centres could supplement the services of the Senior Citizens' Clubs in these matters.

8. Training of Care Givers

As the number of oldest old requiring domiciliary care is steadily increasing, and as families lack the skills as care givers, it is necessary to develop institutions for producing trained care givers and qualified trainers for this work.

The colloquium suggests that training programmes by competent agencies be organized on a large scale to meet at least a significant part of the demand for this new service. State of the art institutions for training the trainers in this area also should be established to ensure high standard of training in this new area. Currently there is only one such programme in India run by the National Institute of Social Defence (NISD). This programme needs to be strengthened and expanded. Civil society organizations should come forward in a big way to supplement the programmes of the government. Similar or better agencies could be established in the developing countries in both the government and NGO sectors to solve the problem of shortage of trained care giver and their trainers.

9. Crimes Against Elderly

Globally, crimes against the elderly are on the increase as the old are soft targets for anti social elements. The oldest old are more vulnerable victims. Police should set up helplines for this and take prompt follow-up action. Senior Citizens' Clubs, mentioned earlier, may monitor such cases and help the families and the police in preventing such crimes and booking the culprits. Ensuring the safety and security of the elderly should be seen as a responsibility also of the civil society and not of the family alone. The

Elder Care Centres also should take this up as one of their special missions.

10. Research

The delegates felt that there is a real dearth of data on many areas relating to the oldest old. Almost all available studies on aging are confined to general aging and not the 80+. This keeps the planners and programmers for the oldest old in the lurch with little basic data to start with. *The delegates even felt that it is due to absence of the required data that the magnitude of the problems of this segment is not adequately appreciated by those concerned,* with the result that their problems are assumed to be an extension and continuation of those of younger age groups. There is need for data on many vital areas of life of the 80+, more so in the fields of health and morbidity, economic activity, living arrangements, domestic abuse and the pattern of care giving of this segment.

The colloquium therefore suggests that adequate priority be given to research on the 80+. Studies on 80+ at micro, macro, national and cross national levels should be encouraged and supported.

Census data in many developing countries do not provide basic information on population beyond 60 and this also vitiates much of the plans and estimations regarding the 80+. In fact, the methodology and tools for census data collection were designed when life expectancy in these countries was much less than 60 years.

Now that life expectancy has increased phenomenally, the census should fully reflect the dynamics of the additional number of years lived by the population. There is need for detailed information and useable data on the socio-economic and morbidity pattern of the oldest old as well. Governments and UN agencies are requested to take note of this.

II. RECOMMENDATIONS & POLICY IMPLICATIONS

It may be pointed out that only recommendations that specially benefit the Oldest Old are given here. They may be applicable to all old but the oldest old will be the prime beneficiaries and without these programmes and services they will be poorer and more miserable. It should be borne in mind that these items are supplementary to and not substitutive of a general plan for the elderly including the 80+. ***They should be read along with the conclusions and suggestions given in the earlier section***

1. Treat the 80+ as a Special Category

The oldest old differ from the younger old age group in their orientations, mindsets, concerns, needs, problems and requirements and this fact should be recognized and appreciated while framing policies and programmes for the elderly. Their needs and requirements can be adequately and appropriately accommodated by either a sub- plan within the main plan on aging or by a supplementary plan which can be dove-tailed into the main plan. In any case, such a plan should address the concerns, problems and needs of the oldest old on a distinct and prime basis.

2. Ensure Family Support

The concern was expressed that the oldest old are not getting the desired/ expected support of their families primarily due to economic reasons which also impinge on health care. Therefore the government should ensure minimum economic support for every family maintaining an 80+. This could take several forms. – outright subventions to needy families, free or subsidized health care support or free or subsidized medical insurance for the oldest old and rebates on taxes and charges for utilities to families taking care of the 80+. If public distribution system in food and other essential provisions is available, this should be free to the 80+ and their families. Financial support in the form of old age pension is dealt with below.

3. Provide Community Level Support

Families taking care of the oldest old can be further assisted by providing three sets of community level services:

(i) Multi service community elder care centres which could provide various services required by the 80+ and the families taking care of them. These centres could be established by government or by NGOs/Civil Society Organizations but should be run by senior citizens. The social worker in the centre should visit the families of the oldest old and provide counseling and emotional support and supplement the care that is required by the oldest old and is normally provided or expected to be provided by the family. Similarly the health worker who should be of the level of a public health manager can attend to many problems of an 80+ person that do not necessarily or immediately need the services of a doctor. These centres could function as watch dogs for the cause and care of the oldest old.

(ii) There is also a need to organize Senior Citizens' Clubs in each community. The club will consist of seniors only and could be self-sponsored or sponsored by Government or NGO. The multi service elder care centre also can sponsor such a club and help and monitor its activities.

Club members will visit the oldest old who are frail/bed-ridden or with movement problems or feel lonely/isolated/abused/neglected. Clubs will function in an informal or semi formal manner.

(iii) Geriatric Mobile Medicare Unit (GMMU). Details are given in Item 4 below

Many of the frail 80+ are a singularly helpless and hapless lot whose misery is little known to the world outside of the four walls of their families. They are the ones who are in many cases abandoned and abused. For them government should ensure not only that there are enough programmes for their care and protection but also that they indeed enjoy these facilities and are able to maintain dignity and honor. (In this context, the delegates noted with satisfaction the recently passed Government of India Act for the Maintenance and Welfare of Parents and Senior Citizens). The major way to achieve this will be through the Senior Citizens' Club whose members by their periodical visits to them can monitor their condition and ensure their welfare. This will go a long way in reducing domestic abuse and violence on the 80+.

4. Improve Medical Care

It was obvious that the oldest old suffer from multiple ailments and disabilities and the medical care available for them is by and large unaffordable, inadequate, and inaccessible. One way to obviate this situation is to make health care free to all the 80+ or at least free to the destitute and highly subsidised to the rest. Geriatric facilities should be established in all government hospitals. A Geriatric Mobile Medicare Unit (GMMU) in every community or group of communities, with a core team consisting of a doctor, nurse and social worker should go to each community on assigned days and team members should visit those 80+ who cannot come to the unit. Those needing referral care should be directed to the right doctor whose services and prescriptions should be affordable to the patient and their families. The social workers attached to the GMMU and Elder Care Centre should oversee and monitor such cases.

5. Empower the Oldest Old.

Old age pension should be instituted for all needy old in a staggered manner and the amount should be increased with every ten years. Alternatively, there should be one rate of pension for those below 80 and a *higher rate* for those 80 and above. Free ration to all destitute- or near destitute 80+ and subsidized ration to destitute or near destitute families

taking care of the oldest old should be provided. Old age pension, Elder Care Centre, Senior Citizens' Club and GMMU can do a lot more for empowerment of the oldest old than any law or government fiat on the subject.

6. Open up Geriatric Homes

Currently most old age homes do not admit the oldest old and the frail elderly. Hence, separate homes for these persons are needed especially since the main service they require is geriatric care rather than custodial care. The geriatric homes should also be treated as terminal homes since many of the oldest old are terminally ill. There should be a mechanism for monitoring the working of old age homes to ensure that the 80+ in them are appropriately taken care of.

7. Training for Care givers

In view of the growing need for care givers for the 80+ on the one hand and acute shortage of trained care givers on the other, it is recommended that adequate arrangements be made for professional training of care givers and an apex institution for training the trainers of these care givers. While this could be the primary responsibility of the government, civil society orgnisations may be encouraged to take up this responsibility in a big way. However, the supervision and control of these institutions by government is necessary to ensure quality.

8. Ensure Special Care for Oldest Old Women

Women constitute the vast majority among the oldest old, most are widows and poor and carry ailments mainly related to their earlier reproductive process. They are also the majority among the abused and abandoned. The Elder Care Centres, Senior Citizens' Clubs and the GMMUs should be especially equipped and geared to take care of the needs of the 80+ women ands should have special wings/units to attend to these women's problems, concerns and needs. Higher rate of old age pension is also recommended for women.

9. Compile Data on the Oldest Old

At present data are lacking on the oldest old. Most classifications by age in the population censuses and national sample surveys end with 60+, which is a legacy from the past when there were relatively few old persons. With the growing proportions of oldest old in the population it is imperative that the 60+ age group should be further divided into 60-64, 65-

69 ……. up to 100 and above sub groups, ensuring availability of adequate data on all sub-groups among the old including the oldest old. Country censuses should take cognizance of this.

10. Undertake Research and Evaluation Studies

Since precious little studies have been done on the 80+, future research should have focus on this area. Governments and universities have special responsibility in promoting this research. Academic agencies and research institutes should be pressed into service for carrying out such studies. Evaluation studies are needed to evaluate the policies and programmes meant for the aged in general and the oldest old in particular.

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This Centre was launched in 1983 as an international centre for inter-disciplinary studies and research on aging by futuristic senior social science professors from universities in 5 South Indian States. The collaborating Universities are Karnatak University, Kerala University, Madras University, Marathwada University, and Sri Venkateswara University. The major objectives have been study, research, training, extension and publication. Over the years it also undertook consultancy on aging and advocacy for the aging. The Centre has conducted several research studies on aging for international, national and state agencies. These include various UN organizations – WHO, ILO, FAO and World Bank, the different Ministries of the Government of India and statutory bodies like ICSSR and ICMR. The Centre prepared the State Plans for Older Persons for Goa (2001) and Kerala (2006). The Centre has taken a holistic view and a life course perspective on aging and so extends its studies to population of all ages though the focus has always been on aging. It has organized several conferences and seminars including 3 international conferences on aging. In fact the first international conference on aging in India was organized by the Centre at Thiruvananthapuram in 1986. The first all India seminar on elder abuse, and the first national conference on widowhood in India with focus on elderly widows were also organized by the Centre. The Center's focus on and concern for the marginalized groups among the elderly persuaded it to organize the International Colloquium on the Oldest Old (February 2009) which, in fact, is the first conference on the 80+ at the global level. *At a time when gerontology was a little known subject in the academy and in policy making circles in India, the Centre popularized it and made it respectable.* The Centre has an Executive Committee, a Governing Body and an International Advisory Council. It is on several networks – national and international.

Further details are available from:

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