



THE IMPERATIVE FOR A SENIOR CITIZEN COMMUNITY HOME IN RURAL GUNTUR DISTRICT, ANDHRA PRADESH

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Abstract: The demographic shift towards an aging population in India, coupled with the erosion of traditional joint family structures due to urbanization and migration, presents significant challenges for elderly care, particularly in rural areas. This paper examines the compelling need for establishing a dedicated Senior Citizen Community Home in the rural expanse of Guntur District, Andhra Pradesh. Current research indicates that there are two segments of elderly population that need to be addressed. One from the affluent families where their children have migrated to big cities or abroad and are not able to readily attend to their parents. Another class of elderly that face issues of **low emotional well-being**, a high burden of **chronic lifestyle diseases**, financial vulnerability, and in some cases, elder abuse and neglect. While existing old-age homes are concentrated in urban pockets, a community-centric models in a rural setting are essential to address the unique socio-economic, health, and psychological needs of the local geriatric population. The proposed Community Homes are envisioned as facilities offering comprehensive health and psychosocial support, and an environment that fosters dignity, social engagement, and an improved quality of life for the rural elderly.

IndexTerms – Old age home, Rural, Guntur, Andhra Pradesh

I. INTRODUCTION

The senior living sector in India is experiencing rapid growth, fueled by profound demographic shifts, including the projected doubling of the senior population by 2050 and an expected increase in the age dependency ratio to approximately 34%. The Southern states, encompassing Andhra Pradesh, currently lead the market, accounting for an estimated 60% to 68% of the organized senior living supply due to a confluence of factors, including greater cultural acceptance of organized communities, established medical infrastructure in regional hubs, and strong investment from the NRI diaspora.

Table 1: Increase in proportion of 60+ population over decades in India and world

Year	India	World
1970	6.5%	9.0%
1980	7.0%	9.6%
1990	7.5%	10.5%
2000	8.0%	11.6%
2010	8.5%	12.9%
2020	10.5%	13.5% (approx.)
2030	12.5%	16.7%
2040	16.5%	19.5%
2050	20.8%	22%

At the global level the share of the 60+ has risen from 8% in 1950 (200 million) to around 13.5% in 2020 (1.0 billion) and is expected to be 22% (2.1 billion) in 2050. The share of the 80+ has edged from 0.6% of the world population in 1950 (15 million) to around 1.6% (110 million) of the world's population in 2011 and is expected to reach 4% (400 million) by 2050. Between 2010 and 2050 the total population will increase by 2 billion while the older population will increase by 1.3 billion. Women account for about 55% of the 60+ rising to 64% of the 80+ group and 82% of the 100 plus group. On an average, women outlive men by 4.5 years.

During this period, life expectancy (Table 2) also increased, thanks to better health management and the control of killer diseases. Thus, global life expectancy which was 46.5 in 1950 rose to 72.8 in 2020 and it will reach 77.2 by 2050.

Table 2: Trends in Life Expectancy at birth in the world including India

Region / Country	World	Asia	China	India
1950 (1950-1955 Est.)	46.5	43.1	43.7	37.2
2000 (2000-2005 Est.)	67.2	68.1	71.7	62.7
2020 (2020-2025 Est./Proj.)	72.8	74.0	78.1	70.0
2050 (2045-2050 Proj.)	77.2	79.8	82.8	77.0

As mentioned above, both increase in the proportion of the elderly in the population and longevity of life have contributed to the problem of aging in the world. While the developed countries have been able to provide for the aging situation the developing countries have not been able to do so except by some countries and that too in a marginal manner. More or less the same trend is visible in the movement of population in India and Andhra Pradesh also as given in Table 3.

Table 3: Distribution of Elderly Population (60+) India and Andhra Pradesh (As percent of total population)

Year	India	Andhra Pradesh
1971	5.97%	≈7.0%
1981	6.20%	≈7.4%
1991	6.58%	≈7.9%
2001	7.40%	7.70%
2011	8.60%	9.88%
2020	≈10.5%	≈12.0%
2030	≈13.1%	≈15.8%–16.5%
2040	≈17.5%	≈19.5%–20.8%
2050	≈20.8%	≈22.0%–24.5%

During this period, expectation of life at birth in India and Andhra Pradesh between genders is given in Table 4.

Table 4: Expectation of life at birth in India and Andhra Pradesh

Year	India		Andhra Pradesh	
	(Male)	(Female)	(Male)	(Female)
2001	62.3	64.6	62.2	67.7
2011	65.8	69.3	64.2	69.2
2021	68.2	71.6	69.0	72.0
2025 (estimate/proj.)	~71.0	~74.1	~71.4	~72.96

Andhra Pradesh is already home to a substantial proportion of the country's elderly. Elderly population in Rural Guntur is significant due to:

- Out-migration of youth to Hyderabad, Bengaluru, Gulf countries, Australia, and USA.
- Improved life expectancy in coastal Andhra.
- Limited economic opportunities for middle-aged rural families leading to nuclear families.

In Guntur District, this demographic group, particularly in rural communities, is increasingly vulnerable. The traditional support system of the **joint family is dissolving**, leading to isolation and financial distress for many elders who often lack a regular source of income or are dependent on family members who may have migrated for work.

Another significant sector is the parents of NRIs. NRIs prioritize **trust, transparency, medical reliability, and cultural familiarity** when selecting eldercare for parents. Long-distance caregiving creates persistent anxiety; NRIs prefer paid services

that offer remote monitoring, documented care plans, and legal clarity over informal home arrangements. This creates a market niche for premium, subscription-style community homes that combine hospitality with clinical oversight.

Crucially, the demand for this specific integrated model in Andhra Pradesh is not purely lifestyle-driven but is mandated by high morbidity rates. Andhra Pradesh exhibits a chronic disease prevalence rate of 43% among the elderly population (aged 60 and above), significantly higher than the national average. This high incidence rate for conditions such as hypertension and diabetes (which account for 68% of chronic diseases in the state) necessitates a community that fundamentally integrates continuous health monitoring and professional clinical support. The focus shifts from merely offering independent retirement living units to providing a comprehensive, medical-first ecosystem, a service that justifies premium pricing and assures sustainable occupancy. The target demographic is defined as the financially independent segment and NRI families, for whom quality of care and professional management are priorities over traditional family care models, particularly as nuclear families rise and career mobility increases.

Existing studies highlight that the rural elderly in Guntur District experience a **lower mean satisfaction with life** compared to their urban counterparts. Furthermore, a significant number suffer from chronic illnesses like hypertension and diabetes, often compounded by factors like illiteracy and widowhood [1]. Access to specialized geriatric care and psychosocial support is notably inadequate in rural settings. This paper argues that a locally situated Senior Citizen Community Home is a critical intervention required to bridge the gap in care and support.

II. CURRENT SOCIO-DEMOGRAPHIC AND HEALTH PROFILE IN GUNTUR DISTRICT

2.1. Demographic Vulnerability

The elderly population (60+ years) in rural Guntur District represents a significant demographic segment. Analysis of a rural community in Guntur revealed that over **11%** of the total population was aged 60 and above [1, 2]. A substantial percentage of these elders are economically vulnerable:

- Approximately **one-third** are reported to be living below the poverty line.
- About **90%** belong to the unorganized sector, indicating no regular, secure source of income.
- **Elderly women** face a heightened risk, with a high prevalence of widowhood (55% of older women in one study) and illiteracy, increasing their dependence and vulnerability.

2.2. Health and Well-being Challenges

The health status of the rural elderly is a major concern:

- A significant number (around **45.5% of men and 52.3% of women**) have chronic lifestyle illnesses.
- Hypertension, diabetes, and arthritis are prevalent.
- The overall **physical well-being is low** for the majority of rural elders ($\approx 93.3\%$).
- A high prevalence of **depression** (around 38.63% in a rural field practice area) is reported, which is significantly associated with being financially dependent and not working [4].
- A majority of rural elderly respondents showed **low levels of emotional well-being** ($\approx 83.3\%$), indicating a pressing need for psychological support [3].

2.3. Neglect and Abuse

The shift to nuclear families and migration has led to increased instances of elder abuse and neglect. While reported abuse is statistically lower in rural compared to urban areas, instances of neglect, especially related to adequate healthcare, are a persistent problem. The feeling of being a "burden and useless" can lead to ignorance and marginalization of the elderly within the family setting.

III. THE GAP IN CURRENT CARE INFRASTRUCTURE

A review of existing retirement and old-age homes in Guntur District shows a significant concentration of facilities in the **urban areas**. While some institutions are charitable and cater to the poorer sections of the society, their location in or near Guntur city (e.g., Pedapalalaluru, a few kilometers from the city center) poses a geographic and cultural barrier for the deep rural population.

Crucially, **geriatric care** and specialized nursing/recreation facilities are overwhelmingly concentrated in urban centers, leading to "medical indifference" toward rural elders. Government health programs in rural areas often prioritize maternal and child health, leaving the elderly population's complex needs unmet.

IV. RATIONALE FOR A RURAL SENIOR CITIZEN COMMUNITY HOME

The establishment of a community home in a rural setting addresses the identified gaps and challenges by offering a holistic model of care:

4.1. Accessible and Affordable Healthcare

A rural facility would ensure **proactive, accessible, and affordable healthcare**, focusing on the high burden of chronic lifestyle diseases. It should include regular medical check-ups, medication management, and collaboration with local Primary Health Centers (PHCs) to overcome the current urban-centric bias in geriatric care [4].

4.2. Psychosocial and Emotional Support

Given the low levels of emotional well-being and high prevalence of depression, the Home must function as a **community center** to combat loneliness and isolation. Services should include:

- Structured **inter-generational activities** to foster a sense of purpose and connection.
- Group therapy and individual **counseling** to address psychological distress.
- Opportunities for social engagement and recreation, leveraging the often-reported average levels of social and spiritual well-being in the rural community.

4.3. Financial and Social Security

For the financially vulnerable and dependent elders, the Home provides basic necessities—shelter, food, and clothing—guaranteeing a baseline level of security and protection from neglect. Its structure as a community home, rather than a traditional nursing home, can mitigate the stigma associated with institutionalization, particularly when located within or near the local community fabric.

4.4. Fostering Dignity and Community

A Community Home encourages a sense of **belonging and dignity**. By providing a shared living space for peers, it facilitates mutual support and reduces dependency on over-burdened or absent family members, thereby improving overall satisfaction with life.

V. RECOMMENDATIONS FOR IMPLEMENTATION

Strategically locate the facility in a central, accessible rural hub to serve a cluster of villages, ideally near existing community infrastructure like a PHC. Ensure well trained staffing that includes a resident care manager, nursing staff, cooks, and cleaning staff, with provisions for regular visits by a general physician, physiotherapist, and a counselor/social worker. The elder population can be divided into two categories.

- a) One group of affluent section consisting of the children who are in far off places and cannot attend to their parents because of their employment obligations. They would prefer for their parents
 - **Clinical Care:** Onsite nurse, telemedicine links to specialists, routine health monitoring, and emergency response.
 - **Residential Design:** Accessible comfortable single or double-occupancy units, communal dining, activity spaces, and culturally appropriate cuisine.
 - **Remote Management:** Secure digital portal for NRIs with live updates, billing transparency, and video visits.
 - **Social Programming:** Daily activities, local cultural events, and mobility support to reduce isolation.
 - **Legal and Financial Safeguards:** Clear contracts, insurance facilitation, and estate coordination.
- b) A low cost and free model for elderly rural population who have meagre affordability or with no children or abandoned by their families.
 - **Model of Care:** Adopt a **low-cost, community-integrated model** focusing on basic shelter, nutrition, and comprehensive healthcare access (including mental health support).
 - **Funding and Sustainability:** Seek initial funding through government schemes for the elderly and philanthropic organizations, with a long-term goal of a subsidized model accessible to the poorest, possibly integrating skill-building/light work activities for physically able residents to foster self-reliance and community contribution.
 - **Focus on Women:** Given the heightened vulnerability of older women (widowhood, illiteracy, chronic illness), the Home must specifically address their needs in its design and program offerings.

This initiative represents not just a welfare measure, but a crucial investment in the social capital and dignity of the aging population in rural Guntur.

VI. CONCLUSIONS

The evidence unequivocally supports the need for a **Senior Citizen Community Home** in rural Guntur District. The convergence of an aging demographic, the fragmentation of traditional family support, high rates of chronic disease, and poor emotional well-being underscores the urgency of this intervention.

The recommendation is to setup two types of senior citizen homes:

- a) Catering to higher income people who can afford to make the necessary payment while expecting additional comforts.
- b) Catering to lower income people that will be either free or minimal payment basis with the help of Government and community support.

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