Mixed Methods Evaluation of a Community-Based Intergenerational Program to Improve Quality of Life, Social Capital, and Generativity Among Elderly in Rural India

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Abstract

This study presents a mixed methods evaluation of Sahjeevan Kendra, a community-based intergenerational program implemented across 18 rural villages in Wardha, Maharashtra, India, under the Health and Demographic Surveillance System (HDSS) of Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sevagram. Conducted from December 2020 to September 2023, the program aimed to improve quality of life, social capital, and generativity among older adults aged 60 years and above through structured intergenerational engagement with children and adolescents. The study employed a stratified simple random sampling design with a total sample of 520 elderly participants from a population of 4,415 identified individuals. Quantitative assessment utilized the WHO Quality of Life BREF (WHOQOL-BREF), the Loyola Generativity Scale, the Social Capital Scale, and a Self-Care Assessment Tool. Qualitative data were gathered through focused group discussions, in-depth interviews, and observation using the Spider Web Method. Quantitative findings showed largely stable scores across program phases, suggesting maintenance of wellbeing despite the challenges of ageing and chronic conditions. Qualitative findings revealed meaningful gains in intergenerational interaction, respect for older adults, self-confidence among master trainers, and community social participation. The program effectively repositioned elderly individuals as active community mentors and caregivers, thereby strengthening their sense of generativity and social roles. Findings demonstrate the feasibility and acceptability of scalable, community-integrated intergenerational models in low- and middle-income country (LMIC) settings.

Keywords: intergenerational program, elderly, quality of life, rural India, mixed methods

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Introduction

Population ageing is a global phenomenon with significant implications for health systems, social structures, and community wellbeing. In India, the proportion of individuals aged 60 years and above is growing rapidly, with rural populations facing compounded challenges including social isolation, limited access to healthcare, and diminishing intergenerational engagement. Elderly individuals in rural communities often experience a gradual withdrawal from meaningful social roles, contributing to a decline in psychological wellbeing and generativity, defined as the concern for and commitment to the next generation.

In rural Maharashtra, this problem manifests visibly across villages where older adults progressively disengage from family and community life. Sahjeevan Kendra, meaning "the centre for co-existing life", was conceived as a community-based response to this challenge, transforming spaces of isolation into inclusive platforms for intergenerational interaction. This study evaluates the implementation and impact of this program using a mixed methods design over three years, examining outcomes across quality of life, social capital, generativity, and self-care among elderly participants.

The objectives of this study were: (1) to implement a structured community-based intergenerational program across rural villages in Wardha; (2) to assess changes in quality of life, social capital, generativity, and intergenerational interaction over three program phases; and (3) to identify facilitating factors and barriers to implementation through qualitative inquiry.

Methodology

Study Design and Setting

The study employed a mixed methods design, integrating quantitative outcome measurement with qualitative process evaluation. The study was conducted in 18 villages in the Wardha district of Maharashtra, India, located within the Health and Demographic Surveillance System (HDSS) catchment area of MGIMS, Sevagram. The study duration was December 2020 to September 2023.

Study Phases

The program was implemented across three sequential phases:

- Phase I involved formative research and the development of training modules grounded in community needs assessment.
- Phase II focused on the implementation of elderly-focused self-care strategies, equipping older adults with knowledge and skills for healthy ageing.
- Phase III centred on community mobilization through "Sahjeevan Melawas" (community gatherings) and collaborative intergenerational activities that brought elderly, children, and adolescents together.

Sampling and Sample Size

A stratified simple random sampling design was employed. A total of 4,415 elderly individuals were identified from the 18 villages: 2,612 in the 60–70 age group and 1,803 aged above 70 years. The final study sample comprised 520 participants.

Assessment Tools

The following standardized instruments were used for quantitative assessment:

(1) WHO Quality of Life BREF (WHOQOL-BREF): a validated multidimensional measure of quality of life across physical, psychological, social, and environmental domains.
(2) Social Capital Scale: measuring dimensions of community participation, trust, and social networks.
(3) Loyola Generativity Scale (LGS): assessing the degree to which elderly individuals express concern for and commitment to the well-being of future generations.
(4) Self-Care Assessment Tool: evaluating the extent to which elderly individuals practise health-promoting self-care behaviours across multiple domains.

Qualitative data were gathered through focused group discussions (FGDs), in-depth interviews (IDIs), and structured community observation using the Spider Web Method, which enabled multidimensional visual mapping of program outcomes across eight identified domains.

Training Cascade Model

A cascade model of community participation was employed to implement the program at scale. Key trainers drawn from MGIMS faculty, district health teams, and elderly community leaders trained master trainers from village health and wellness centres. Master trainers, comprising 20–30 individuals per village, subsequently reached all elderly individuals and households within their communities. This nested structure ensured reach and sustainability of the program.

Program Modules

The intervention comprised three programmatic pillars, each addressing a distinct dimension of intergenerational engagement:

- Pillar I focused on nurturing care for early childhood development (ECD), covering concepts of intergenerational programming, play and communication activities, responsive feeding, conducive home environment, and safety and security. Elderly participants were trained to engage with young children and support caregivers with knowledge drawn from their own experience.
- Pillar II addressed the involvement of elderly individuals in enhancing adolescent life skills. Topics included adolescent health and nutrition, decision-making and assertiveness, confidence-building, avoidance of addiction, and the role of household and community in adolescent wellbeing.
- Pillar III centred on healthy ageing and self-care, covering nutrition, physical activity and healthy lifestyle, management of hypertension and diabetes, addiction prevention, mental health including dementia awareness, self-care for eyes, skin, ears, and oral health, and recognition of danger signs.

Results

Quantitative Findings

Quantitative data were collected at baseline (2020) and at the end of each of the three program phases. Tables 1 through 5 present the findings.

Table 1
Combined Analysis of WHOQOL, Loyola Generativity, and Social Capital Scores for Age Group 60–70 Years

Measure	Baseline (2020)	Phase I	Phase II	Phase III
Total QOL	70.6	70.6	69.3	68.5
Total LG Score	32.3	28.3	30.4	28.0
Total Social Capital	49.1	48.7	49.1	48.4

Table 2
Combined Analysis of WHOQOL, Loyola Generativity, and Social Capital Scores for Age Group > 70 Years

Measure	Baseline (2020)	Phase I	Phase II	Phase III
Total QOL	66.9	65.4	65.5	65.4
Total LG Score	31.8	28.0	28.1	26.1
Total Social Capital	45.2	45.3	45.4	45.5

Table 3
Self-Care Total Score (Mean With Standard Deviation)

Age Group	Phase II	Phase III
60–70 Years	127 (24)	106 (20.3)
> 70 Years	125 (23.9)	103 (20.3)

Table 4
Child-Caregiver Interaction (CCI) Scores

Age Group	Baseline (2020)	Phase I	Phase II	Phase III
60–70 Years	8.61 (3.51)	8.2 (3.94)	9.91 (4.22)	9.13 (4.47)
> 70 Years	9.23 (3.05)	6.0 (4.30)	8.31 (4.89)	7.74 (5.25)

Table 5
Adolescent-Elderly Interaction Scores

Interaction Type	60–70 Yrs Year 2	60–70 Yrs Year 3	> 70 Yrs Year 2	> 70 Yrs Year 3
Discussion and Storytelling	92 (8.8%)	99 (9.5%)	78 (7.5%)	84 (8.1%)
Adolescents Helping Elderly	74 (7.1%)	66 (6.3%)	67 (6.4%)	63 (6.1%)
Love and Respect to Elderly	68 (22.9%)	65 (21.9%)	79 (26.6%)	78 (26.3%)

Across both age groups, quality of life scores remained broadly stable over the three program phases, with minor declines consistent with natural ageing trajectories. Social capital scores showed minimal variation, suggesting the program successfully maintained community connectedness over time. Loyola Generativity scores showed some fluctuation but remained within a consistent range, indicating that elderly participants maintained a sustained orientation toward the next generation throughout the program. Self-care scores declined between Phase II and Phase III, likely reflecting increasing health challenges among older participants. Child-caregiver interaction scores showed an overall improvement trend, most notably in the 60–70 age group.

Qualitative Findings

Qualitative data from FGDs, IDIs, and community observations were analysed thematically and represented visually using the Spider Web Method across four stakeholder groups: members of Sahajeevan Samanway Samiti (community coordination committees), caregivers, adolescents, and elderly participants themselves. Eight domains were assessed:

1) Participation of the elderly in ECD and adolescent well-being activities at family and community levels
2) Improvement in interaction between two generations
3) Respect for elderly and their opinions in the family
4) Self-confidence of master trainers in the village
5) Ability of master trainers to reach elderly individuals
6) Increased participation of elderly in village governance
7) Bonding and interaction of elderly with peer groups
8) Transfer of skills and knowledge from elderly to younger generations.

Qualitative findings indicated substantial improvements across all eight domains, with particularly strong gains in intergenerational respect, self-confidence among community trainers, and the perception of elderly individuals as knowledge holders and mentors.

Facilitating Factors

Several contextual factors facilitated successful program implementation. The provision of adequate physical venues and financial support from Gram Panchayats (village governance bodies) enabled smooth execution of activities. The strategic use of cultural festivals such as Ganpati, Durga Devi, and Datta Jayanti created natural gathering points for community engagement. The formation of dedicated elderly groups and their integration with pre-existing community structures such as Bhajan (devotional singing) groups and Self-Help Groups extended program outreach organically. The organisation of intergenerational events

including drawing competitions, quiz contests, rangoli contests, and mother-in-law and daughter-in-law fairs stimulated cross-generational interest and participation.

Barriers to Implementation

The program also encountered several implementation barriers. Loss of daily wages during daytime program activities limited participation among economically active elderly individuals. Health issues and forgetfulness among some participants affected attendance and retention of training content. Financial constraints periodically disrupted the execution of program activities. The high use of mobile devices and television by children and adolescents reduced the quality and frequency of intergenerational interactions in some households. In some families, parents did not engage with or value the knowledge shared by elderly participants following training, which caused frustration among trainers. Seasonal logistical challenges during the rainy season and the prolonged duration of some training sessions also presented difficulties for older participants.

Community Impact

Qualitative testimonies powerfully illustrated the programme's community-level impact. One male elderly participant from Wabgaon recounted how his granddaughter, after attending programme activities, began discarding his tobacco as an expression of her health awareness, demonstrating the bidirectional nature of intergenerational learning. A peer trainer from Mahakal noted that children from nuclear families had begun expressing a desire for their grandparents to live with them, indicating a strengthening of intergenerational bonds that transcended the formal programme space. These narratives underscore the programme's capacity to effect meaningful attitudinal and behavioural change at the household level.

Discussion

This study demonstrates that a community-based intergenerational programme implemented in rural Maharashtra over three years was feasible, acceptable, and could be sustained through a cascade training model engaging community members at multiple levels. The programme successfully repositioned elderly individuals from passive recipients of care to active contributors of community knowledge and mentors to younger generations, a shift with significant implications for generativity, social capital, and psychological wellbeing.

The broadly stable quantitative scores across programme phases are an important finding. Rather than indicating programme failure, maintenance of scores in the context of a longitudinal study with an ageing population represents a meaningful outcome. Ageing is typically associated with declining quality of life, increasing social withdrawal, and diminishing generativity. The fact that WHOQOL-BREF, Social Capital, and Loyola Generativity scores remained largely stable across three years suggests that the programme may have buffered the natural decline associated with ageing and chronic disease progression.

Qualitative findings provide richer insight into the programme's mechanisms of change. Increased intergenerational interaction, greater respect for elderly community members, and a strengthened sense of purpose among older adults are consistent with established theories of successful ageing, including Erikson's concept of generativity and activity theory. The cascade training model proved effective in extending programme reach to all households, and

the integration of the programme with existing community structures such as festival gatherings and self-help groups enhanced sustainability.

The programme's approach aligns with growing global evidence supporting intergenerational models as a cost-effective strategy for addressing both the social needs of older adults and the developmental needs of children and adolescents, particularly in resource-limited settings. This study extends that evidence base to rural LMIC contexts where institutional intergenerational programmes are scarce and community-based approaches may be the most viable and culturally appropriate modality.

Conclusion

The Sahjeevan Kendra intergenerational programme demonstrated that a structured, community-delivered intervention can maintain and support wellbeing among rural elderly populations over multiple years, while simultaneously strengthening social ties across generations. The cascade training model, the integration with existing community platforms, and the involvement of local governance bodies were key enablers of implementation and sustainability.

While quantitative gains were modest, the qualitative evidence of enhanced intergenerational interaction, restored community roles for elderly individuals, and attitudinal change at the household level represents meaningful programme impact. Future research should incorporate control groups to establish causal attribution, employ measurement tools with greater sensitivity for rural geriatric populations, and evaluate cost-effectiveness to support scaling decisions. The model holds significant potential for replication in comparable rural LMIC settings where community-based solutions to population ageing are urgently needed.

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Declaration of Generative AI and AI-Assisted Technologies in the Writing Process

The authors declare that ChatGPT was used only for language polishing and improving readability of the manuscript. The main content, including study design, data collection, analysis, results and conclusions are completely done by the authors. All ideas and interpretation are original work of the authors. The authors take full responsibility for accuracy and correctness of the content.

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