

DAY 2: 27 AUGUST 2013, MULTIPURPOSE HALL

India International Centre 40, Max Mueller Marg, New Delhi-110001

TIME: 9:30-11:15 AM

The Session for Plenary Theme: 3 Pillars- Participation, Health, Security was taken by

1. *Chair: Dr. Siva Raju, Professor and Dean of School of Development Studies, Tata Institute of Social Sciences, Mumbai*
2. *Dr. Manjari Tripathi, Department of Neurology, AIIMS; ARDSI Chairman, Delhi*
3. *Dr. Nirupama Prakash, Director, Amity Institute of Social Sciences, Amity University, Noida*
4. *Ankur Gupta, Joint Managing Director, Aashiana Group*
5. *Dr. Penny Vera- Sanso, Programme Director, Assistant Programme Director, Development Studies, Birbeck, University of London*

Topics covered:

- a) *Dementia in Ageing Women by Dr. Manjari Tripathi, Department of Neurology, AIIMS; ARDSI Chairman, Delhi*
- b) *Socio Economic and transport related issues amongst elderly population by Dr. Nirupama Prakash, Director, Amity Institute of Social Sciences, Amity University, Noida*
- c) *Ageing in place and senior living by Ankur Gupta, Joint Managing Director, Aashiana Group*
- d) *Ageism and Age discrimination: Stereotypes and Counter imagination, Dr. Penny Vera-Sanso, Programme Director, Assistant Programme Director, Development Studies, Birbeck, University of London*

Abstracts from this sessions are:

1. *Author: Dr. Siva Raju, Professor and Dean of School of Development Studies, Tata Institute of Social Sciences, Mumbai*

Population ageing is a phenomenon that is progressing at a rapid rate both in the developed and developing countries. It is however, progressing fastest in developing countries, especially where there are significant proportions of youth populations. It has been observed that men and women experience old age differently. In other words, female elderly, due to a variety of factors, are faced with higher and multiple vulnerability. Recent data on female elderly show that an overwhelming proportion of them are illiterate. Owing to a multiplicity of factors, the female

elderly occupy a distinct position among the elderly population and the issues related to them. It is a well known fact that globally, women tend to live longer than men. Some recent studies show that more than half the population of female elderly are widows. As a result of this, there are more older women than older men, thus, resulting in the feminization of ageing.

In many situations, older women tend to become more vulnerable to discrimination, including poor access to jobs and healthcare, subjection to serious forms of abuse, denial of the right to own and inherit property, and a lack of basic minimum income and social security. Some aspects of population ageing like, sharp increase in the population of the oldest-old and emergence of living alone as a living arrangement add to the vulnerabilities elderly women are faced with.

Moreover, in terms of programmes and policies directed especially at the elderly, the female elderly are mostly seen to be lagging behind with respect to awareness of such schemes. Female elderly also have very poor utilization of such schemes. More emphasis should thus be laid on improving the awareness and utilization of schemes targeted at the elderly in general and the female elderly in particular.

2. Title: MENTAL HEALTH AND WELL-BEING OF OLD AGE WOMEN

Author: Mansi Verma (*Neuropsychologist, AIIMS*), Manjari Tripathi (*Prof Neurology, AIIMS*)

“A woman has to live her life to the fullest, or live to repent not having lived it.”

— D.H. Lawrence,

India is a country which is recognised across the globe for its age-long prevailing tradition of interpersonal bonding and a woman is such an integral part of it, who keeps this bond deep, intense and strong. Greying of population across the globe is an important issue of concern in the twenty-first century and UN criterion categorises India as an ageing country i.e. any country is classified as ageing country if it has seven percent or above older adult population. The population of senior citizens has crossed 100 million mark in India. According to 2001 census, 7.4 per cent of total population in India was 60 years and above. Projections based on Census 2001 data suggest that a proportion of elderly would increase to 9.9 per cent (133 million) by 2021 and would further increase to 20 per cent by 2050 (Rajan, 2006). When the data on elderly was disaggregated by gender, only 7.1 per cent elderly males as compared to 7.8 per cent female elderly were found. The decadal growth rate of female elderly is 42.2 as compared to only 28.6 for elderly males which highlights towards the rapidly increasing proportion of elderly women in India. As women tend to live longer than men, there are 1,600 women per 1,000 men in the age group of 70, as per the 2011 census, while the overall gender ratio favours the male population (940 females per 1,000 males) however, for the elderly population, at 60 plus, it favours elderly women (1022:1000). At the ages of 65, 70, 75 & 80 there are 1,310, 1,590, 1,758 & 1,980 elderly women respectively per 1,000 elderly men (Sagar, 2012). The data mentioned above

highlights the fact that a demographic transition is occurring at a very fast pace in India and hence it becomes very important to address the issues related to successful ageing to ensure the mental health and well-being of woman, as the implications of aging are greater for females during their later years of life.

Past few millennia have witnessed many changes in the status of women in India, right from the equal status with men in ancient times, to low points of the medieval period, to promotion of equal rights by many reformers in the modern India, the history of Indian Women has been quite eventful.

Due to the difference in the biological compositions, social role, emotional regulation, position in society at large, women and men especially in old age have to face different experiences and problems. The socio-economic implications for women are greater than males in old age, the decadal growth rate of 42.2 mentioned above highlights that women tend to have a longer life span in comparison to males hence they are more likely to be widowed, which means, post her husband's death, she is expected to be supported by her husband's pension (if such facility is provided by his employment) or else her sons and daughters will have to take her responsibilities on their shoulder. However, it is a bitter reality but a fact that in a few families, luckily not all, members are not quite receptive of such responsibilities, and they often consider such duties as a burden, as a tax on their independence and free style of living. They either accept such responsibilities with a lot of expressed strain or the just shrug it off to any old age home (Duvvuru & Jamuna, 2008). In both the conditions, such intergenerational distance leaves her feeling overwhelmed & alone, at this stage in her life where she is a lot more weaker physically emotional and financially, without her husband and without her children from whom she once expected a lot. In a study to establish both the direct and indirect effects of widowhood on self-reported health status among aged Indians using National Sample Survey Organization 2004 data, Pandey and Jha (2011), found that poor economic conditions have a mediating effect on the relationship between widowhood and health. Results showed that widowhood has an adverse effect on health – both directly and through reduction in their employment opportunities and economic freedom. Census 2001 clearly reflects that proportion of non-worker amongst 60 years and above is high to the extent of 60 per cent and for elderly women it is 79.1 per cent. Connected to this issue, Illiteracy or being less educated is another major concern of life at this age, as the opportunities for education for present era's older generation were present approximately 40-50 years back. During that period of time education for women was not quite encouraged and usually males were given more preference over women for pursuing higher education. Census 2001 clearly reflects the consequences of the deprivations faced by women over their life course. Literacy rate of 60 years and over in India is 36.3 per cent which is only 20.3 percent amongst elderly women. Women were expected to master the art of cooking and managing a household, as that is something which they will benefit from in their course of life. Hence neither could they develop their knowledge and judgments as superior to males so that the can take part in any important decisions related to their life, nor could they take up any

employment, through which they could have supported themselves monetarily as well as in terms of self-confidence, by not making them dependent members then by being a contributing member of the family. In one study it was found that in India, older women are seldom part of the development agenda. Their contributions are slighted and discussions of their situations are usually afterthoughts. Their work is not considered as economically productive and their contribution throughout their lifespan is not quantified or valued. (Alam, 2006).

Not just economic independence, Indian families have mostly followed the patriarchy system of decision making, in which a male member is the head of the family and also is the primary decision maker, it is at his discretion whether or not to involve female members' suggestion into his decision. This trend is however changing with newer generations, where both the spouses collectively take the decision, but with the older couple still, the importance of husband's decision is way above wife's suggestion, and hence at times she has to suffocate her wishes, desire or thinking and at times self-respect & importance owing to this pressure, which leaves her inner feelings and mental health affected. A woman in comparison to a male, be it in any life stage, is the only one who is expected to adjust and accommodate others, she does not have the luxury of getting the same benefits from opposite gender, no matter how loyally or wholeheartedly she serves them.

Yet another very important facet influencing mental health and well-being of women is intergenerational relationships, which is the underlying factor influencing the processing of all the above mentioned issues. The aged in these societies enjoyed unparalleled sense of humour, legitimate authority with the family or community, had decision making responsibilities in the economic, political, social and religious activities of the family. They were treated as repositories of experience and wisdom. The elderly women acted as a link between traditions and customs and were responsible for engaging them in day to day life. All these reflections gave all generations a sense of happiness, satisfaction, respect, love, belongingness, achievement and most importantly, from an eclectic sense a feeling of subjective well-being. Not just in India, but across the world, research shows that inter-generational relationships generally found to contribute to subjective well-being of individuals throughout their life course (Rossi and Rossi 1990; Marry Levitt (1992); Litwak et al., 2003; Beate Schwarz (2006); Eva merz 2008) and maintaining high levels of subjective well-being is considered to be an important aspect of successful ageing (Freund and Baltes 1998). However, as the current younger generation is searching for new identities and redefined social roles within and outside the family. Families are changing enormously in their composition, roles of their members, and quality of the intra-familial relationships. It has become difficult to talk about a typical family. Today we have nuclear families, single-parent families, remarried and step families, non-marital cohabitation families, foster and adoptive families, and multi-adult households. Increasingly, unlike in the family of the past, inter-generational relationships in these groupings are more affection-based than necessity-based or norm-based and hence are more complex and variable (Koyano, 2003). Even in less changed situations, the family's ability to care for its elderly appears to be

diminishing. Like western countries, the traditional sense of duty and obligation of the younger generation towards their older generation is being eroded (Koyano, 2003). The older generation is caught between the decline in traditional values and the absence of an adequate social security system (Bhat & Dhruvarajan, 2001).

The dominant perspective on gender, health, and ageing asserts that older women are more likely than older men to experience poor health (both physical and mental), more illness episodes, greater difficulty in physical activities, and more disabilities (WHO, 2007). It is well recognized fact that women in India, is challenged by various deprivations and concerns during their entire life course, it can be due to the socio-cultural context or gender roles or yet any other reason. These deprivations over their life course in addition to low literacy, low participation in paid employment, poor access to assets and poor nutrition among elderly women make them more vulnerable to both acute and chronic health conditions as well as increase the vulnerability to mental illnesses. The onset of chronic illnesses at old age adversely affects the quality of life of those elderly who enter old age with overlapping and chronic socio-economic deprivations (Balagopal, 2009).

Older adults and their families usually deny the existence of mental health problems. As a result, elderly patients may seek medical care for nonspecific somatic complaints such as headache, insomnia, dizziness or memory issues or yet other vague physical symptoms, instead of requesting seeking psychiatric care. In addition to physical disability, dementia and major depression are the two leading contributors (Cullum et al., 2006; Ruiz, Merri & Silverstein (2007)). In an analysis of NFHS-2, Agrawal (2012) found that elderly who are living alone are likely to suffer more from both chronic illnesses, such as asthma and tuberculosis, and acute illnesses, such as malaria and jaundice, than those elderly who are living with their family, even after controlling for the effects of a number of socio-economic, demographic, environmental and behavioural confounders. Female elderly compared to their male counterparts suffered from functional impairments like malnutrition, depression, impaired physical performance and urinary incontinence more significantly (Shan, Sahu, Sahani & Swain, 2003).

In an epidemiological study on dementia in Maharashtra (Saldanha et al., 2010), in which 2145 respondents were randomly selected, it was found that the prevalence of dementia in the community was seen to be 4.1% and the risk of dementia increases more than five-fold in the old oldest old. 'The percentage of those with dementia showed an increase from 2.8% in the age group of 65 - 70years, to 18.4% in the oldest old living in the community.' Sharma, (2009) in his study on mental health issues of elderly reveals that elderly women are affected more by dementia, depression and psychosomatic disorders than their male counterparts

Marital status and economic dependence play a significant role in determining morbidity amongst elderly women (Dilip, 2003). It was found that with increasing age, diseases are more likely to increase with widowhood, divorce and economic dependence. A medico-social study of the urban elderly, by Siva Raju (2002), in Mumbai has revealed that there is a significant

influence of the socio-economic, cultural and behavioural factors on both the perceived and actual health status of the elderly and these vary considerably across different classes and sexes of the elderly. The factors that were found significant in determining the health status of urban elderly were educational status, economic status, age, marital status, perception on living status, addictions, degree of feeling idle, anxieties and worries, type of health centre visited and whether or not taking medicines.

The absence of gender-specific health services, poor health due to child bearing, less nutrition and their priority role as the providers of care for the young and the elderly combined with economic deprivation throughout their lives, often make the female elderly face a greater risk of ill health in later life.

All the above mentioned facts highlight to various important issues that elder women are challenged with. Because of the loop hole is a lot of governmental policies they might have limited access to social and materialistic resources, for instance due to public policy failure, or lack of medical insurance scheme by the government specifically for elderlies, or may be due to lack of specific provision or preference given to take care of elderlies in health care systems, as a lot of health care system at various levels in our country is designed for the general population. Due to poor health conditions and lack of available nutrition during pregnancy and later life, due to demands of their social role and economic deprivation throughout their lives a women is often faced with greater risk of ill health, as a result attaining high standards of quality of life as well as security of life become a very difficult task for them to achieve.

However, with the help of reformers and growing awareness for such issues provision of better life conditions for women, so as to enhance their health has become a critically important issue and will continue to increase in its importance owing to their increased longevity and morbidity and decreased access to healthcare as compared to men. The need of the hour at present is to provide our elderly women with sounder socio economic and health conditions as their needs are enormous but, unfortunately, the financial resources, policies and programmatic capacity available to meet them are inadequate. It is essentially very important to develop clear strategy or schemes for the development of overall well-being and healthcare for elderly women as well as enhancing effective social security schemes. Public healthcare utilisation should be enhanced, particularly in remote, rural areas; focus should be laid upon improving institutional infrastructure with high standards of quality and care in these institutions. Poverty, illiteracy, general backwardness and adherence to superstitious beliefs for curing illnesses and diseases may be the cause (Siva Raju, 2006) therefore should be eradicated by spreading awareness to promote successful ageing, only then can we expect a healthier and happier old age.

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3. Title: Challenges and Concerns Amongst Elderly-Socio-Economic & Transport Issues- Case Study of Rajasthan

Author: Professor Nirupama Prakash, *Ph.D, Director, Amity Institute of Social Sciences, Amity University, Noida*

An empirical study was conducted in Pilani, Rajasthan to explore socio-economic, health and transport related problems among aged population during 2007-08. 491 elders were surveyed from urban area, namely Pilani and 183 elders from two villages, namely Morwa and Dheendwa Athuna. Data was collected through questionnaire and interview schedule. Rural elders were more prone to health risks as compared to urban elders. In urban area elders faced difficulty in undertaking physical activities such as arising, eating and walking and the least was gripping of objects. In rural area the problem in arising was more prevalent as compared to other problems like walking, hygiene, eating and least was gripping of objects. Female elders in urban and rural area reported higher level of physical disabilities as compared to male elders. Most female elders complained about the difficulty in boarding and alighting from a bus or a train. Majority of respondents were not aware of the concessions offered by the government to elderly population with respect to travel. Following suggestions were given by respondents:

- Most elders had difficulties in day-to-day living pertaining to walking, arising, and hygiene. They said the helping aids available in the market to overcome such difficulties were not affordable.
- The buses should have separate boot space for luggage.
- Elders especially, females found it difficult to board or alight from a bus or a train as the pavements of buses and trains were too high. Respondents suggested that suitable changes may be made for elders' convenience.
- Facilities like reservation of seats for elders, ladies and physically handicapped people have been formulated but at times the elderly do not get benefit of such facilities. Although government has provided facilities yet they are not implemented properly.
- The sarpanch (elected head of local government body) and many elders suggested that there should be frequent stoppages of government buses in villages. They said government buses hardly stop at village bus stops. With the result, villagers had to travel by private buses. The owners of private buses charged more as compared to the government buses. The drivers of such buses used to stop at their own whims and fancies. In this situation, elders in particular really had a tough time. This led to scarce use of transport.
- There should be reservation for elders in first and last compartments of the train so that the elders may easily go to the toilet during the day or night. This would enable them to reach the toilet conveniently without crossing the long distance and moreover it will be easy for them to get in and out of the train easily.

- There should be provision of escalators at railway stations although they are available in metro cities but they should also be provided at other railway stations too so that elders may use the facility of train without the fear to cross over from one platform to another.
- With regard to air travel, elders said they had to wait for too long in queue (custom clearance). Many elders proposed that they may be allowed to form separate queues so that they don't have to wait for long duration.

(Due acknowledgement is made to Prof. Ajay Kapoor, Swinburne University of Technology (SUT), Hawthorn, Australia for sponsoring the Study and to Ms. Rashmi Kapoor(SUT) for inputs.

4. Title: Ageism, age discrimination: stereotypes and counter imaginings

Author: Dr. Penny Vera- Sanso, *Birkbeck, University of London*

No one wants to be labelled as old, and with good reason. Ageism is rife in interpersonal relations, the labour market, legislation and in policy. It stereotypes people (from age 60) as incapable and dependent, as no longer adults capable of contributing to family, society or the economy. Instead it equates older people with children – positioning them as incapable of thinking and acting for themselves, as needing protection. Ageism legitimates age discrimination in all arenas of life. It underlies the lack of recognition older people receive for their work in the home (cooking, childcare, caring for the sick, fetching water) and in family businesses (classed as ‘time-passing’ irrespective of the hours worked or significance of their role). It underlies the age discrimination in the labour market (pushed into menial, low-paid work). It also underlies the expectation that older people constrain their food and other needs and that the needs of older people, who are often described as ‘having had their life’ are placed in the back of the queue, behind those of everyone else in the family and society.

Despite the convenience of laying the blame for old age suffering on ‘negligent’ families, the real issue is the failure of government to address ageism. In fact ageism is unaddressed in the Constitution, where age discrimination is not prohibited, and it is embedded in legislation that positions older parents as the dependents of their children, not as adults with rights. By using an economic concept, ‘the working population’ as aged 15-60 years, data gathering and policy making not just utilises a fictitious category that ignores older people’s contributions to the economy which can be seen throughout India, it promotes the erroneous image of the older population as a looming economic burden. This image is picked up and spread by newspapers and provides the context in which an employer’s age discrimination can be passed off as charity. The main mechanism for assessing the nation’s health, The National Family Health Survey specifically excludes women aged over 49 and men aged over 54 – demonstrating that older people’s health is of negligible interest to the state. Similarly the social pension of Rs200 per

month to a fraction of older people demonstrates the government's lack of real commitment to the survival of its older citizens.

Instead of trapping everyone aged 60 and over in discourses centred on family relations and assumed frailties we need to abandon ageist thinking, focusing instead on older people's rights as humans, as adults, as workers and as citizens.