

She too counts: Critical Need for Gender Responsive Healthcare for the Elderly

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Demographic Transition & Emerging Issues

“As we begin the twenty first century, population ageing is poised to emerge as a pre-eminent worldwide phenomenon. The confluence of lowered fertility and improved health and longevity has generated growing numbers and proportions of older population throughout most of the world.’ (An Ageing World: 2001). While on one hand, population ageing represents a human success story, on the other, the steady, sustained growth of older people poses myriad challenges to policy makers and societies all over the world.

In a first for United Kingdom, Wales has appointed a “commissioner for older persons” to champion the interests of older people. He will be independent from government and will have the mandate to challenge government bodies

The United Nations estimates put the number of those aged 60 plus at 600 million, i.e. 10% of the world population and this number is expected to go up by 2 billion by 2050. The Indian scenario of ageing population, brings to light that India’s population of just over one billion in the year 2000 continues to grow at about 1.5% per annum and is expected to exceed one and a half billion by mid century. According to the Census 2001, the number of older persons in India was 70.6 million, or 6.9% of the total population. It is projected that the number of older persons will be 94.8 million in 2011 (or 8.3%), and 143.7 million by 2021 (or 10.7%). Further, 63% of the total elderly population is in age group of 60-69 years, 26% in age group of 70-79 years and 11% in age group of 80 years and above.

Trends in gender studies of the elderly reveal that the life expectancy of women is expected to remain higher. For the period 2006-2010, the life expectancy of female is 68.1 in comparison to 65.8 of males which is expected to rise to 72.3 for females as compared to 69.02 for males during the period 2011-2016. This indicates that the population of elderly women will account for a larger population as compared to their male counterparts in 60+ age bracket. Similarly, a closer look at the location demographics highlights that around 75% of older persons live in rural areas and 25% in urban areas.

With changing lifestyles the younger generation are migrating from not only rural to urban areas but from country to another as well; leading to increase in old age dependency ratio. The old age dependency ratio (number of old persons 60+ years) to the working age group (15-59 years) has increased from 9.8 per cent in 1981 to about 12.6 per cent in 2001. (Census of India, 2001)

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^o Centre for Health Education, Training, and Nutrition Awareness (CHETNA) is a non- government support organisation based in Ahmedabad in Gujarat State, India. CHETNA’s mission is to assist in the empowerment of disadvantaged women, adolescents and children to gain control over their own, their families’ and communities’ health.

While the existing support system of joint families, preponderance of physical activity, vegetarianism, and social and spiritual enrichment, all known to promote healthy ageing, are widely prevalent in India, with the increasing pace of population ageing, the health of older persons has been the focus of recent attention. Existing data indicate a significant morbidity among the aged, and considerable variations in morbidity exist with respect to gender, place of residence (rural vs. urban), and socioeconomic status. Further, the dual load of infections and degenerative diseases in older persons is the final cause of death.

The increase in life expectancy with better health care, nutritious food and socio-economic status, has led to the demographic transition which impacts the prosperity and health of the people. This necessitates an exclusive health management system for the elderly to address their specific age-linked health problems like cataract related blindness, osteoporosis and fractures, osteoarthritis, hypertension, diabetes, coronary heart disease, stroke, heart failure, Alzheimer's disease and other dementias, Parkinson's disease, cancer, enlarged prostate and depression, etc. Further, the needs of older persons living in rural areas require special attention. This involves planning for post retirement socio-economic security through continued skill up-gradation, employment and participation in other creative and gainful activities.

Need for Addressing the Concerns of Older Women

Gender governs the structure of relationships through the life cycle, from birth to old age. Gender differences in the aging process reflect biological, economic, and social differences. It influences our access to resources and opportunities, and shapes our choices at every stage of life. While gendered experiences impact the health and well being of both women and men in their later years, women who enter their older years with a past or continuing experience of discrimination, violence and abuse often suffer unrelenting poverty and persistent health problems including chronic pain, depression, and disability.

Current status of women

Women comprise by far the greater number and proportion of older population in almost all societies; this disparity is increasing with advancing age. In India, while the sex ratio favours men at all ages, the trend reverses in favour of females above the age of 70 years with the number of women exceeding the number of men in this age group. Sex ratio in elderly population, which was 928 in the year 1996, is projected to become 1031 by the year 2016. More often than not, women are over burdened with cumulative inequalities throughout the life cycle from womb to tomb as a result of socio-cultural and economic discriminatory practices leading to a secondary status. Thus, a longer life span is directly correlated to greater morbidity and higher incidence of health related problems among the older women.

The marital status among the elderly clearly indicates that there is a much larger proportion of married men as compared to married women and also the proportion of widows is much higher than that of widowers. Among those who were widowed, 64% were women as compared to 19% of men. Among those 70 years and above, 80% were widows

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compared to 27% widowers. Besides demographic trends, the preference for nuclear families, male dominated patriarchal society and gender discrimination make women more vulnerable throughout their lives. Further, older women are often too weak to fight injustice due to their poor health and lower status in the society.

In comparison to men, women are also denied access to opportunities for personal growth and social development, in education, employment, professional and political life. Furthermore the patriarchal system and preoccupation with sexual and reproductive functions during adult age, perpetuates the subservient role of women in the family and in the society. Women also spend majority of their working hours in domestic labour, which is usually unpaid and unrecognized.

The cumulative effect of the above mentioned conditions during the formative years of their life leads to women becoming marginalized in their old age as compared to their male counterparts. As stated earlier the nature and complexity of old age morbidities are also significantly different for women as compared to men. Therefore it becomes necessary to specially focus on the issues of older women.

Women in general, and older women in particular have lower status in the family and society thereby having restricted access to family or social support system. They continue to remain care providers until such time that they are physically active. *Widows are the worst affected by social customs.* Lack of education during early years deprive the older women from having access to latest information and knowledge intensifying their social isolation and widening the generation gap. In sum, older women are marginalized by the family, society and the Government and are not integrated in the development process. To raise awareness on the issues of ageing October 1, has been declared as International Day of Older Persons by the United Nations.

Economic status and resulting dilemma

More elderly men participate in the economic activities compared to women. The participation is high in rural areas compared to urban areas. Older women, especially in developing countries, are likely to be poorer than older men as a result of the accumulated impact of unpaid work at home and in farms, lower life time earnings, lower wages, lack of adequate pension or social security scheme for those who work in unorganized sector and laws and social customs which are insensitive to women. Economic dependence on the male members throughout their life restricts their freedom to choose to avail necessities of life such as food, clothes, health care and enjoy pleasurable activities. Older women also suffer from health problems which are different from those of older men due to basic biological differences. However, health care facilities are common for both.

The older women from rural areas prefer **Annapurna Scheme*** in which 10 kg of grains are given to poor older persons instead of pension. According to them they can directly use

* A scheme called " ANNAPURNA" has been initiated by the Govt of India under which free food grains up to 10 kg per month will be provided to such destitute older persons who are otherwise eligible for old age pension under the National Old Age Pension Scheme but are not receiving it and whose sons are not residing with him.

the grains for their food whereas the pension amount may be taken away or used by the male members in the family. Is the invisibility of older women related to their diminished role in society? It is believed that older women get the maximum benefit of the economic and health schemes but they hardly contribute to the nation's economy. This conviction pays scant regard to the fact that taking care of the household responsibilities in a joint or extended family, taking care of children, cattle, are invisible tasks but unmatched both in terms of emotional bonding in the family and also in economic terms.

Health and Health Care of Older Women

Though women generally live longer, they experience greater morbidity (as indicated in CHETNA study) and have less access to health care than men. The health needs of older women will thus become increasingly important over the next decades. The definition of "older" varies among countries and societies. A common thread is that the word 'old' almost inevitably has negative connotations, conjuring up other words like disability or dementia. It is a commonly held belief that older people need to be "looked after", and their views are rarely taken into account in the formulation of health policy. This is especially true of older women, where the conjunction of gender and age can have detrimental effects on their quality of life. It is essential to remember that each woman's health situation is different, and age alone should not be used as a basis for universal categorization, diagnosis or treatment. More importantly, care must be exercised to ensure that age is not used to justify discrimination or inequitable treatment.

The emotional turmoil which a woman goes through, the sense of anxiety, fear, anger and desperation that she faces in her early years, take its toll during the later years of life if she manages to survive the reproductive years. On reaching menopause, she looks forward to the years of freedom from the responsibility of bearing and rearing children and freedom of movement but often she finds herself with the responsibility of taking care of grand children, older husband or in semi urban and rural areas, she has to struggle for her daily livelihood. The relation between poverty and ill health has been universally established. Poverty affects the older women in rural areas the most.

Studies have revealed that the most common chronic problems of older women are fever, cold and cough, asthma, respiratory infections, dysentery, visual impairment, cataract, hearing impairment, swollen feet and diabetes whereas the major diseases and disorders of older women are rheumatoid arthritis, osteoarthritis, osteoporosis, backache and muscular problems, hypertension, cardiovascular and pulmonary disease, nervous disorders, demential Alzheimer's disease and depression. Common reproductive health problem are pruritis vulvae, vaginal discharge, dispareumia, incontinence, uterus prolapse, cervical and breast cancer. Anaemia, ulcer in mouth and intestines, constipation, diarrhoea are the other manifestations of prolonged under-nutrition. In addition there may be diseases directly related to their occupations or habits like chewing tobacco (as a pain killer or hunger suppressant)

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"Gynecological problems of older women, who have passed the reproductive period, have yet to receive attention of researchers and programme planners. Problems related to menopause and those that occur in the post-menopausal period and later years have rarely received adequate attention in the Indian context. Research needs to be undertaken to study these problems and to identify those that need urgent attention. The magnitude of specific problems as well as the cost effectiveness and feasibility of organizing services need to be addressed. Some criteria should be developed to determine which service interventions should receive priority and how services can be incrementally expanded to address the particular priority problems." (Pachauri Saroj, 1995)

The quality of health care available in India significantly differs in rural and urban areas. In the rural areas women usually first try home remedies, failing which they visit a government or a private hospital depending on access to services or the family's paying capacity. Failing that treatment, they consult a village witch doctor. If there is nobody, to take them to a doctor, they just suffer in silence (CHETNA, 2001). This is also true for women from urban slums. The middle classes in urban areas visit the government or the private hospital depending on the distance and their paying capacity. However the quality of medical care available in most of the general hospitals is not satisfactory. National Family Health Survey - 3 conducted in 2006 states that in both urban and rural areas in India only about 1/3 prefer to use the public health facilities, majority use private facilities.

While quality of health care available may be less than satisfactory in India there are additional issues with regard to the care 'provided' to the elderly. This is often based on the socio economic class of the person. There are rampant cases of discrimination in making health care available to the poor - both urban and rural - as well as those belonging to the 'lower castes'. Due to living conditions and poverty the incidence of disease is often higher among these segments and they are also denied access to the public health care made available by the government.

Geriatrics is still relatively less known and geriatric wards exist merely in two hospitals in the whole of India. This shows the gross apathy towards this age group. In densely populated urban areas and poverty stricken rural areas where basic amenities are inadequate, health care of general population and specifically of the older population poses a great challenge. To meet the preventive, curative, restorative and rehabilitative needs of older population in general and older women in particular, in a country with a population of over one billion is a Herculean task.

Family and Social Support Network

In a developing country like India, multigenerational living arrangements have been an integral part of the rural and urban scenario. However, due to migration, industrialization and modernization, several young adults prefer to live in nuclear families even in rural India. This shift in the trend leaves older women to fend for themselves particularly after their husband's death. It may be because they are no longer considered productive, useful and are considered to be interfering, a burden or old fashioned.

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At the Sixth South Asia Regional Ministerial Conference, Commemorating Beijing in January 2008, New Delhi, India the Ministers, Secretaries and Senior Officers of the Governments in South Asia, women's Groups /networks, civil society, and researchers from - Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka, with representation from the SAARC Secretariat, acknowledged the achievements made by the countries of South Asia and also recognized the continuing **gaps and challenges** in several areas, of which I wish to draw your attention to the following:

1. Inadequate implementation of plans, policies and programmes relating to women due to inadequate allocation of resources
2. Inadequate commitment, awareness, measures and resources to combat violence against women.
3. Inadequate attention to eliminating harmful traditional practices that continue to infringe the human rights of women
4. The increasing prevalence of HIV/AIDS among women, including exposure to infection from husbands
5. Lack of gender sensitive policies and interventions to combat communicable diseases, anaemia, TB, malaria etc.
6. Inadequate, and lack of gender sensitive reproductive and sexual health information and services and care to women

While the above gaps refer to women in general, they aptly bring into focus the pathetic condition of older women who are most vulnerable and marginalized among women.

Policies and Programmes of the Indian Government

Across the globe, steps have been taken by various countries to provide social systems for the elderly and other disadvantaged groups. Such systems ensure that senior citizens are not deprived of their most basic needs when they lack the resources to fulfill them. A brief overview of the policies and programmes of the Indian government for the elderly is presented for a deeper understanding.

National Policy on Older Persons (NPOP)

Government of India (GoI) announced the National Policy on Older Persons in 1999 to reaffirm its commitment to ensure the well-being of the older persons in a holistic manner. The NPOP while promising to safeguard their interest in terms of financial security, health, legal, social and psychological security, also envisages a productive partnership with them in the process of development by creating opportunities for their gainful engagement and employment. The Policy also appreciates special needs of older persons and therefore lays emphasis on empowerment of community as well as individuals to adequately meet the challenges of the process of ageing. To fulfill these objectives the NPOP broadly provides for the following:

1. **Financial security** through coverage under Old Age Pension Scheme for poor and destitute older persons, better returns on earnings/savings of Government/Quasi-Government employees' savings in Provident Fund, etc.

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2. **Health Security:** The NPOP recognizes special health needs of the older persons to be met through strengthening and reorienting the public health services at Primary Health Care level, creation of health facilities and implementing health insurance.
3. **Recognizing Shelter as a basic human need,** the NPOP provides for earmarking 10% of the houses/housing sites in urban as well as rural areas for older persons belonging to the lower income groups.
4. **Education/information needs of older persons** the NPOP provides for proactive role in ensuring the same by disseminating knowledge about preparation of Old Age. It is also emphasizes the need for schools to have programme on inter-generational bonding.
5. **Welfare and Institutional Care:** *Institutional Care has been provided for in the NPOP as the last resort.* The State should also create infrastructure in partnership with voluntary organizations to provide for poor, destitute and neglected older persons whose care cannot be ensured within the family.
6. **Protection of Life and Property of Older Persons:** Maintenance of elderly within family, resorting to the provisions of law whenever needed is required to be ensured.
7. **Training of Human Resource to care for Older Persons:** The Policy lays emphasis on need for trained personnel/care givers.

This policy highlights the plight of older persons and offers an array of state interventions. However, let us examine some of its shortcomings to keep these in view as learnings for future efforts of this nature:

1. The pension rates paid to older persons afford hardly any additional income or livelihood security but is merely a token payment to ward off extreme destitution
2. The policy statement relied on the figure of 33% of general population for an estimate of the proportion below poverty line among those above 60 years as well - this may be an understatement
3. As there is no mention of the financial implications of carrying out the commitments questions of financial capacity, capability and viability arise
4. The provision for maintenance of parents by children is not to provide income or old age security but to prevent destitution and cannot substitute state action for providing risk cover to older persons. Further, there is reluctance on part of the parents to go to court against children
5. A 39 member National Council for Older Persons was created to advise, provide feedback, lobby and address complaints but ministries specifically dealing with important aspects of ageing have not been represented in it

The challenge of implementing such a multi level and multi dimensional promise is therefore, enormous and requires coordination, leadership, strategizing, networking, advocacy and above all effective monitoring, feedback and continuous system improvement.

National Social Assistance Programme (NSAP)

The National Social Assistance Programme came into effect from 15th August, 1995 and is a social assistance programme for the poor households. The NSAP includes three benefits as its components: *National Old Age Pension Scheme (NOAPS)*, National Family Benefit Scheme (NFBS) and National Maternity Benefit Scheme (NMBS).

The Indira Gandhi National Old Age Pension Scheme (IGNOAPS)

The Scheme covers older persons/destitutes having little or no regular means of subsistence from his/her own source of income or through financial support from family members or other sources. It covers older persons under Below Poverty Line and the government contributes Rs.200 (approximately \$5) per month per beneficiary. In November 2007 it was rechristened Indira Gandhi National Policy on Older Persons (IGNPOP) and enlarged to include all persons above 65 years of age under BPL. The scheme currently covers 87 million old persons and the 2008-09 Union Budget has proposed an outlay of Rs.34 billion with the target of reaching 157 million beneficiaries.

Insurance Coverage

Some of the public sector insurance companies provide life insurance coverage up to 75 years of age and many private insurance companies now have 55 years as the last entry age providing old age security to millions of elderly.

Old Age Social and Income Security (OASIS)

This 'project' put forth by the Ministry of Social Justice and Empowerment, GoI, has constituted an expert committee. The report of the committee recommends a pension system which can be used by individuals and enables them to attain old age security by making modest contribution during their working career.

Jan Arogya (People's Health) of SEWA

This scheme by Self Employed Women's Association, Ahmedabad caters to older women who work in the unorganised sector. The scheme allows payment of premium in lump sum after harvest time when they are in a position to make payments. Health insurance schemes such as this may be up scaled at the state and national level as well.

Annapurna[∞] Scheme

Annapurna Scheme covers all the other elderly below poverty line who are not covered under the NOAPS. Destitute senior citizens or 65 years of age or above who, though eligible for old age pension under the National Old Age Pension Scheme (NOAPS), are not getting the pension are covered under the Scheme. 10 kg of food grains per person per month is supplied free of cost under the scheme. In 2005-06 a total of 167,000 tonnes of grains were allocated under the scheme.

(An interesting observation here is that women beneficiaries of this scheme find it particularly useful as very often the 'pecuniary dole' to them is taken away by the male members of the family while this scheme ensures they are fed)

Reverse Mortgage System

The government has launched a Reverse Mortgage System for senior citizens to extract value out of their property and lead a hassle free life by securing a regular income as loan against their existing property - the loan may be taken in installments or a lump sum.

[∞] Annapurna in Indian language refers to the Goddess who 'fulfills the requirement for grains'

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- *This scheme did not take off after launch in 2007 due to tax related issues - subsequent to clarifications on these in the 2008-09 Union Budget (no income tax or capital gains tax to be levied on loans taken) it is expected to get underway now*
- *However, in India women would usually mortgage their jewelry - this aspect has not been taken into account. The Self Employed Women's Association (SEWA) Ahmedabad is doing commendable work in this area through its microfinance body.*

Integrated Programmes for Older Persons

Ministry of Social Justice & Empowerment, GoI is implementing an Integrated Programme for Older Persons where financial assistance is provided to Non-Governmental Organizations, Autonomous Bodies, Educational Institutions, Cooperative Societies, etc. for up to 90% of the project cost for setting up and maintenance of Day Care Centres, Mobile Medi-care Units, Old Age Homes and Non-Institutional Service Centres. The scheme has been made flexible so as to meet the diverse needs of older persons including reinforcement and strengthening of the family, awareness generation on issues pertaining to older persons, popularisation of the concept of life long preparation for old age, facilitating productive ageing etc. Over 1000 old age homes/day care centers /mobile Medicare units are operational under the scheme.

The Senior Citizens (Maintenance, Care and Protection) Act is to enable senior citizens to obtain maintenance from their children to meet their basic requirements and lead a life with dignity. The most important provision of the Act is to make the maintenance of parents by their family a legal right. The object/purpose of the Act is,

- ☞ To provide an effective mechanism for senior citizens to claim need based maintenance from their children including foster children, adopted children, step children, grandchildren and also from such relatives to whom they have provided financial support
- ☞ To make provisions for maintenance to be provided or steps to be taken by the government for the benefit of such senior citizens, who do not have children grandchildren or relatives from whom they can claim maintenance.
- ☞ Set up appropriate mechanism to provide need-based maintenance to the parents and senior citizens
- ☞ Providing better medical facilities to senior citizens
- ☞ Institutionalization of a mechanism for protection of life and property of older persons
- ☞ Setting up of old age homes in every district

After dedicating her whole life to social work (founder of Stree Shakti Samaj - for women's empowerment) Indumati Patel, 85, had to knock on the door of Bombay High Court alleging that she had been thrown out of her apartment by her daughter in law to let out the same to paying guests. An interim order of the HC directs the paying guests to vacate

Indubai Kamble, 65, worked as domestic help for 4 years and has now approached the Bombay High Court seeking police protection and against her son who allegedly threw her out of the house and illegally rented it out. She further alleged that her son assaulted her and threatened to kill her if she did not sell the house allotted her by the govt. slum rehab scheme. HC issued notice to the son to make representation before the court.

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The government acknowledged the need for steps to be taken to address the needs of women in this Act, stressing that sensitive initiatives for women within the elderly population needed to be taken to prevent them from becoming 'victims of triple neglect and discrimination on account of gender, widowhood and age'. Yet, no special strategies have been formulated. According to officials of the Ministry of Social Justice and Empowerment, the nodal department, the ministry does not want to discriminate between men and women although it accepts that the older women will outnumber older men. So its initiatives are aimed at the elderly in general.

National Rural Health Mission (NRHM)

While India produces over 30,000 doctors every year the entire rural population of over 750 million is served by a handful of 26,000 doctors. Government of India (GoI) launched the 7 year NRHM (2005-12) as a new approach to provide quality healthcare in rural areas. It therefore seeks to improve access to the basic primary health care and provide affordable and effective health care to the rural poor, especially in the states which have weak health indicators and / or infrastructure. The NRHM has clearly spelt out goals as well as strategies to achieve the goals.

Further, the government has clearly defined the mechanism for community participation and roles of NGOs in monitoring, evaluation and social audit of the health care system. With 462,000 Associated Social Health Activists (ASHA) trained and 178,000 village health and sanitation committees functional since its inception, the 2008-09 Union Budget has provided a sum of Rs.120 billion for this programme. The budget also proposes decentralized health centers and upgrading of district hospitals.

The 2008-09 Union Budget has two new provisions for the elderly -

- Allocation of Rs.2 billion as the central government's share of the premium for **national health insurance** scheme for the poor.
In response to the persistent demand from the senior citizens associations for formulating appropriate Health Insurance Schemes, which offer protection to the senior citizens from the exorbitant medical expenditure and are available to the senior citizens, the National Insurance Company came up with Varistha (Old age) Mediclaim policy for the senior citizens in 2006. The other three public sector insurance companies also now offer similar products to the senior citizens.
- A National Programme for the elderly with a planned outlay of Rs.4 billion to establish two **national institutes of ageing**, eight regional centers and department for geriatric medical care in one medical college or hospital in each state.

While the government had devised these policies and programmes in good faith and with the intent to benefit the elderly, it is vital the potential beneficiaries are widely informed about these. A study conducted by CHETNA in select districts of Gujarat and Rajasthan, showed that in Gujarat virtually none of the older women were aware of the Old age or widow pension schemes and in Rajasthan a mere 4% were availing of these. Secondly, all these programmes address the concerns of the elderly but do not address specific health issues of ageing women. It is noteworthy that due to their different gender identities both men and women age differently and therefore, have different health care needs.

A gender sensitive perspective on women's health care

Finally, life is continuum and health status of an older woman depends on the nutrition and health care that she has received throughout her early years. We at CHETNA therefore, propagate the holistic 'life cycle' approach instead of laying greater emphasis on geriatrics. The life cycle approach or perspective recognizes that older women's health will be largely dependent on their earlier lifestyle and behaviour. Linking the health of older and younger women is crucial in any health program that seeks to emphasize prevention over treatment. To address older women's health, the following factors must be taken into account.

Lifestyle - How a woman has lived since birth, her diet and nutrition, body weight, level of physical activity, of physical and emotional stress, of tobacco, alcohol or drug use, her sexual history

Work - While women's paid labour may end at the age of 60 -65, the vast majority of women in India work until they die. Yet this fact is unrecognized in the health community and in labour statistics. Women bear most of the domestic responsibility in a household. Older women are increasingly heading households and taking over care of the family

Social Protection - Women's labour in developing countries is concentrated in the informal, agricultural and service sectors. They have less access to social protection such as health insurance, which has a cumulative negative effect over a woman's lifespan and can seriously affect her health in old age.

Care-giving Responsibilities - This deserves special mention, because it is a significant yet invisible part of women's domestic labour. Caring for sick partners, children and grandchildren is a task that often falls to older women, one that can have severe consequences on physical and psychological health

Socio-economic Status - The value that communities place on gender and race can have a distinct impact on women's health and their quality of life. Obviously income level is one of the key determinants of health, particularly among older women who, no longer working, often find themselves dependent on savings or other family members (who may also be impoverished or in a position to abuse them).

Marital Status - As a large proportion of older women may be widowed this may result in lack of resources for health services, depression, lack of mobility and poverty

Access to health services - In terms of prevention, whether or not a woman has had access to health services throughout her life will impact her health as she ages. This includes not only the ability to afford and access health services, but the way in which an older woman is treated by health professionals.

Family/Medical History - Family history can be an important determinant of women's risk for certain illnesses, such as breast cancer. Knowledge of a woman's family history is essential both for her and her health professional. Similarly, a woman's own medical history (childhood illnesses and injuries, exposure to different medications, reproductive health, exposure to violence, surgeries etc.) will have an effect on her health as she ages and must be taken into account in assessing her health profile.

Physiological Health - Women must be aware of the status of their own health: bone structure and density; joint health; heart/lung/endocrine health; blood pressure; cholesterol level etc. to determine what risks lie ahead and how best to minimize them.

Distinct profiles/needs of developing countries - older women in developing countries suffer from malnutrition resulting in health problems such as anemia and osteoporosis.

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The view of ageing as nothing more than mental and physical deterioration is all too common among both health professionals and the general public. In reality ageing is a complex process that requires in-depth study and response. Generally, a person is considered "older" once they reach the age of 60-65, regardless of their individual health history and situation. Age, therefore, should not be used to 'justify' discrimination in making quality health care, focusing on specific needs of the elderly, accessible to them.

Studies of older women's health must employ a gender perspective to highlight their predominance among the elderly population, their increased morbidity and disability despite their longer life-expectancy and the different ways they are affected by disease and lack of access to care. The participation of older women in the formulation of policies and programmes regarding their own health is essential, both to counteract the view that old people are incapable and to ensure that policies truly reflect and respond to the needs of the older population. Inquiry and interventions into older women's health must emphasize improving the quality of their lives, rather than merely extending them.

As I researched the material for this paper and compiled information from the various sources I was rather surprised and disheartened to note the tremendous paucity of information available on the status of health care for the elderly in India. While I have listed the numerous schemes and programmes proudly launched by the government, I cannot vouch for the efficacy, outreach or success of these programmes. The National Family and Health Survey (NFHS) conducted every few years does not cover problems and diseases of the elderly nor does the NRHM mentioned above have specific provision for the elderly. Is this reflective of the status of this segment of the population in the society and points to the urgent need for a more sensitive and inclusive health care system? Let me share the experience of CHETNA in a study conducted only few years ago.

CHETNA Study on Health of Older Women (OW)

A study on older women was conducted by CHETNA in 2001 in select districts of Gujarat and Rajasthan states of India. The objectives of the study were to assess the status of OW in selected rural areas of Gujarat and Rajasthan, to devise and pilot test strategies to improve status of OW and finally, initiate advocacy on issues in favour of OW. The sample for this study included older women (age 45 years and above) and young adults, their children. The findings of the study indicate:

Head of household: that 21% of households in Gujarat and 29% in Rajasthan were headed by the OW and the remaining by their husbands or sons.

Health Problems and Health Care: This study revealed that health problems were not priority issues for the rural population; more so for the elderly and among the elderly, the women. Their life time struggle was focused on meeting their basic needs i.e. food, water, clothing, housing and attending to social customs.

Health Problems of OW in Gujarat and Rajasthan (%)

No	Type of health problems	OW facing Health Problem in Gujarat	OW who took the treatment	OW facing Health Problem in Rajasthan	OW who took the treatment
1	Respiratory problems	46.7	27.0	41.2	13.7
2	Digestive problems	42.8	26.3	45.8	21.6
3	Orthopedic problems	51.3	17.1	50.3	17.6
4	Vision problems	66.4	23.7	63.4	14.4
5	Hearing problems	25.0	5.3	15.7	3.3
6	Dental problems	57.2	11.8	55.6	6.5
7	Cardiac problems	23.0	9.9	7.2	2.6
8	Urinary problems	11.8	4.6	12.4	1.3
Total OW interviewed			152		153

As indicated by the study the major problems faced by OW were related to vision, orthopedic, dental, respiratory, digestion and urinary tract. Problems such as osteoporosis and osteoarthritis are included in the orthopaedic problems.

Barely half the OW suffering from any particular health problem, actually received medical treatment - in case of orthopedic or dental problems the propensity to seek health care was negligible. This is primarily due to two main reasons cited by them - the distance they had to travel in order to reach the nearest PHC, clinic or hospital and their inability to pay for the treatment and medicines.

The health care pattern for any ailment was thus: first they try home remedies; if there was no improvement they went to a government hospital, a PHC or a private hospital /clinic depending on their spending capacity; if this treatment also did not work, then as a last resort, they went to the witch doctor in the village.

The details about the surgery undergone by the OW are given in the following table:

Surgeries and OW (%)

No	Type of Surgery	Gujarat 61 Plus years	Rajasthan 61 Plus years
1	Eye operation, mainly cataract	22.2	46.2
2	Sterilization(tubectomy)	44.4	38.5
3	Hysterectomy	33.3	7.7
4	Fracture of bone	-	7.7
Total number of OW interviewed		152	153

It is also worth noting that the women we met had never visited a dentist for extracting their teeth. A few OW who had dentures made, did not use them as they did not fit their jaws and were not comfortable. Inability to chew food properly could be one of the reasons for under nourished, anaemic OW. CHETNA

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strongly feels that providing dental care to the elderly is critical and more urgent as it directly contributes to poor health and morbidity.

Also interestingly OW who had undergone eye surgery were more (13% in Gujarat and 23% in Rajasthan) than those who used spectacles (2% in Gujarat and 7.0% in Rajasthan respectively).

When OW were asked as to who had paid for the medical treatment, hospitalization and medicines when they were sick, their response revealed a pattern as follows - their husband, son, themselves, in-laws' and natal family paid for the medical expenses in this order. Most of them could not give an accurate response about the amount spent per month on health care. The study does not indicate any gender discrimination in the young adults' spending money for mother or father in Rajasthan whereas in Gujarat more young adults (45%) borrowed money for their mother as compared to their father (16%).

Source of Health Care for OW and OM (%)

	Gujarat		Rajasthan	
	Aged Women	Aged Men	Aged Women	Aged Men
Government clinic	82.8	78.1	83.4	82.3
Private clinic	73.5	72.8	49.7	49.7
Bhuva [*]	72.5	70.9	25.5	24.2
Home remedies	49.7	47.0	24.2	24.2
Vaidya ^o	13.9	14.6	5.1	5.1
Number of young adults interviewed		151		157

The study also found that most of the villages were not connected to the public transport system and the villagers had to walk 2-3 kilometers in order to reach the main road in order to get a bus or jeep. The young men in case of emergency took the elderly to the hospital in a hammock made from a cloth, carrying her/him to the hospital. In another village where there was a telephone in a shop, the young women said that they phoned and got a jeep to take the elderly to the hospital.

Number of Pregnancies and Planning the Family: The study indicated that 24% of women in Gujarat as well as Rajasthan became pregnant four to five times whereas 60% became pregnant six to thirteen times. This included still birth, miscarriages, abortion and dead children too. Majority of the OW in both the States mentioned that repeated pregnancies had adverse effect on their health such as general weakness, early ageing and gynecological problems.

Financial status: The main source of income for 96% of OW in Gujarat and Rajasthan was from cultivation of their family land. Those who did not possess agricultural land worked as agricultural labourers on someone else's land or as non agricultural labourers in Relief Sites started by Government for construction of roads and dams.

^{*} Bhuva - Traditional healer found in villages

^o Vaidya - Medical Practitioner who follows an Indian system of medicine viz., Ayurveda.

In Gujarat except for one family, nobody was aware of the Old Age Pension Scheme and Widows Pension Scheme of the Government. In Rajasthan, people were aware of these two pension schemes and 4% of OW were receiving either Old Age Pension or Widow's Pension. In Gujarat no OW had a Bank Account whereas in Rajasthan 3% had a Bank Account. When the OW needed money, they asked their son or husband. In Rajasthan the OW told us that they usually retained with them an amount of Rs.50 to Rs.100 earned by them as wages, and spent it either on sickness in the family or to serve tea or snacks to the guests when male members were not around.

Perceptions of the Younger Generation on Economic Status of Ageing Women

Almost half of the young adults in both the states said that their mother as well as father should work as long as their health permits in order to earn their living. 88% of young adults in Gujarat and 54% in Rajasthan expected their mothers to contribute towards household expenditure. The reason given for this was that since their mothers stayed with them, their contribution to the family expenses would increase the family income and would make their lives more comfortable.

Almost all the young members of the family interviewed for this study said that the elderly should have a property and/or land in their name as security in their old age. Another reason which they gave was a more practical one - that children would be motivated to take care of their elderly with a hope that they would inherit the property/land in the future.

The young adults expressed their disappointment at the inadequate social security measures provided by the government and their own ignorance about the pension schemes for the elderly and the widows.

Responding to the Challenge

The aim of health care for elderly should be to provide quality services closest to their home, keep them functional and enable the elderly to return to the community soon after treatment. Further the system should have full knowledge of its users - their financial status as well as socio cultural resources. It is important to note that in case of the elderly the goal of health care should be to ensure 'functionality' as soon as possible; given that 'cure' is not an option.

It therefore, requires several levels of intervention - primary care at community level, specialized care by internists or geriatricians, and specific intervention by physicians, surgeons, etc. The function of the primary care is to provide curative and rehabilitative services. In addition to the acute health problems the primary health care professionals should be required to manage chronic non communicable diseases after their diagnosis on a long term basis. The objectives of the hospital services are to minimize morbidity and complications of disease and thereby avoid preventable death, apart from rendering specialized care. Finally, at the tertiary level services should be available as both out patient and in patient services. Training of general practitioners and reorientation of the internists in care of the elderly is critical - as also need to produce trained geriatricians.

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As described above the GoI has devised several policies and programmes, some integrated, for care of the elderly. However, the policy makers have never deemed it fit to involve the elderly or even consult them in the process of formulation of the same. In the absence of information on the level of awareness among the potential beneficiaries and effective implementation of these programmes, it is difficult to say whether the programmes do address the true concerns of the elderly, particularly older women.

Taking into consideration the health rights of older women there is need to reaffirm the importance of integrated approach, combining elements of curative and rehabilitative health care. Such measures should be based on periodical check ups and rehab measures aimed at maintaining the dignity and functionality of ill person. Towards this end we propose the following enabling measures:

- Establishment of geriatric wards within public health facilities and concession in private hospitals - special identity cards may be used for the elderly
- Provision for eye, ear and dental care at concessional rates or as free services
- Separate counters for the older women so that they do not have to wait in long lines
- Provision for aids or equipments needed by the older women on lease / hire as well as wheels chairs and elevators in public places
- Provision for counseling, patient listening, emotional support and nutritional supplements

The issues of economic dependency, health care, family and social support, education and training of older women pose a great challenge to policy makers and social organizations. It is an obligation for socially conscious people to address long term health and care needs of the older women by using available resources more equitably and effectively. In order to improve quality of life of older women we need to ensure following strategies:

General Strategies

- ☞ It is imperative to enhance the capacity of public, private, voluntary and non governmental organizations to work together for the welfare of older women.
- ☞ Older women should be encouraged to participate in the social, cultural and political activities at local, national and international levels.
- ☞ The human rights of the elderly are not recognized in many parts of the world. What is needed is the full and strict application of the Declaration of Human Rights, recalling that it must be enforced for all citizens, regardless of age.
- ☞ Elderly women must be given special protection in order to defend their rights. They suffer from shortfalls in multiple respect: lower income levels, greater disability more solitude, less access to education, culture and leisure. Their participation in decision - taking process is still today very limited.
- ☞ The creation of Ombudsman for the Elderly should be fostered, as should councilors for the Elderly at all municipalities or local authorities.
- ☞ Promote universal design standards to ensure the safety of the elderly in all types of buildings, as well as in all forms of public and private transport.

Strategies for Action by the Government and Government Organisations (GOs)

- ☞ Devising pension schemes which cater to different sections of older women (from unorganized and organized sector) to meet their survival needs.
- ☞ Revising the existing Old Age Pension Scheme and Widow's Pension Scheme to make them sensitive to older women's needs and concerns.
- ☞ Designing schemes and programmes to provide nutrition and food security to older women.
- ☞ Designing health insurance schemes to provide long-term security to the older women particularly from disadvantaged and marginalized population.
- ☞ Promoting policies and programmes that ensure their wellbeing and support healthy life styles across the complete life span.
- ☞ Orienting the trainers of medical and para-medical professionals and induction of health care of elderly in the training curriculum of Primary Health Centre (PHC) staff at different levels.
- ☞ Providing a separate time-slot for older women to increase access to offices and public places such as banks, post offices, railway/airlines reservation offices etc.
- ☞ Financially supporting the development and expansion of alternate living arrangements in families that substitute or supplement institutional care.

Strategies for Action by the NGOs

- ☞ Designing health insurance schemes to provide long-term security to the older women particularly from disadvantaged and marginalized population.
- ☞ Protecting older women from exploitation, mental and physical abuse particularly those staying alone.
- ☞ Promoting policies and programmes that ensure their wellbeing and support healthy life styles across the complete life span.
- ☞ Developing and promoting cost-effective approaches to providing long term care to older women.
- ☞ Expanding the Mobile Medicare facility and introduction of Meals on Wheels or community kitchens to provide nutritive diet to older women.
- ☞ Financially supporting the development and expansion of alternate living arrangements in families that substitute or supplement institutional care.
- ☞ Setting up Day Care Centres for the elderly to facilitate interaction with other members of the same and younger age groups and participating in recreational activities.
- ☞ Recognising older women as valuable resources and involving productive older women in a number of community services ranging from crèches, community kitchens, canteens, welfare, religious, cultural, artistic, recreational, leisure and environment related activities to caring for the young and old and providing informal education.
- ☞ Involving older women in developing moral, religious and cultural values and traditions among the younger members.
- ☞ Encouraging older women to expand the horizons of care assuming role in community service.
- ☞ Documentation of knowledge and experiences of older women in form of case studies.
- ☞ Facilitating older women's access to relevant information.

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- ☞ Strengthening intergenerational dialogue by encouraging scheme as “Adopt a Grandmother/Grandfather.”
- ☞ Recognizing and rewarding youth who take up voluntary care of older women.
- ☞ Generating awareness on women’s issues particularly among older women but not excluding older men and community.
- ☞ Using folk media to change the mindset of people in general and older women in particular on issues such as gender equality, violence against women, traditional health practices, dietary problems etc.

Homes for Aged (Vrudhashram) are required and are occupied in urban areas whereas the same concept is not acceptable by majority of the older women or by the young adults living in rural areas. While the present trend is to make the family responsible for taking care of the elderly, for single destitute older women, some of who may be infirm, Homes for the Aged or infirmaries are necessary. What is also required - both in rural and urban areas- is a Day Care Centre where older women or older persons can meet once a week or fortnight to exchange views, share experiences and participate in recreational and useful activities such as sports for the elderly, cooking, craft and gardening related competitions, exposure tours to places of interest, listening to a religious discourse etc. These Day Care Centers may also be equipped with facilities for physiotherapy acupressure and such primary health care facilities to those who require it. Healthy old women themselves could be encouraged to manage such activities so that they feel useful to others and their self esteem may be enhanced.

The concept of Mobile Medicare Services[□] as initiated by Help Age India or the Traveling Day Hospital as pioneered by Dr. Hetteriachy in U.K could be adapted and such services expanded to reach all the remote villages in rural and interior tribal areas. Older women’s leadership potential should be utilized by the social and political organizations and skills by the socio-cultural organization.

The scheme of training and supplying contractual home nurses, as it is being followed in Kerala, India (by National Institute of Health and Family) should be reviewed. Adolescents and young adults should be given orientation for providing nursing care to the older persons keeping in view the local conditions and available resources. Young adults need to be educated on avoiding gender discrimination in health care by spending the same amount on the health care of their old mother as they would on their old father.

The state of Rajasthan in India has launched ‘Abhilasha Yojna’ (Wishes scheme) for nursing homes under which unemployed women will be trained in medical colleges and made available to care for the elderly in their own homes. These ‘nurses’ will work eight hours a day, providing full support to the elderly.

□ Mobile Medicare Services includes a van equipped with medicines and basic medical equipment accompanied by a doctor, a nurse and a ward boy or an ayah which visits a village once or twice a week, gives medicines to the older persons and refers them to hospital, if necessary

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For groups of young and old women life-useful adult education classes may be organised where they can learn more about topics such as gender discrimination, protecting women from violence, women and law, nutritive recipes for children, HIV-AIDS, Sexually Transmitted Diseases, hygiene, sanitation and so on. Skill oriented crafts, oral traditions of mythological stories, folk songs, folk dances could also be introduced which would widen their perspective and improve their skills.

Government and non-government organisations could facilitate the access to continuing education and training programmes for older women to bridge the gap between ignorance and knowledge, illiteracy and functional literacy. Learning in the distance education mode may be effectively used for the purpose.

The physical and emotional/psychological problems faced by the elderly due to aging demand that these problems and issues are addressed in a holistic manner. We need to ensure that the elderly receive adequate state and social support to live an active and socially productive life till the end. At the minimum we require comprehensive health care directed at the elderly, in particular the older women, equipping our health care system in geriatric care. Both geriatric support and social engineering aimed at improving the competence of elderly and ensuring their active participation in the society should be considered when evolving any policy on care for the elderly. It is equally important to learn from the experience of other countries, particularly those where elderly face problems due to weak social support mechanisms.

I hope that our attempt to 'learn' from each other on this platform is meaningful and fruitful and at the same time opens further avenues of continued dialogue on improving the lives of the elderly in each of our societies.

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