Mala Kapur Shankardass *Editor*

Older Women and Well-Being

A Global Perspective

Springer

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The making of this book begins with watching many older women around who show many different characteristics reflecting sorrows, happiness, resilience, courage, strength as well as weakness in dealing with life in their own ways. The responses seen to concerns related to their well-being from different socio-cultural contexts in my opinion called for certain scholarship to discuss these aspects stemming from individual, societal, or administrative levels. This book brought together experts working on this topic from different parts of the world, and I am grateful to each one of them for their significant and meaningful contribution. The work of different scholars has made this volume rich in substance and content, and I am extremely appreciative of each one of them for making this possible.

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This section would not be complete without acknowledging the support extended by Satvinder Kaur and the publishing team of Springer Nature to fruitfully take forward the delivery of this academic project on older women which will interest a broad cross section of the population wanting to give visibility to issues related to older women. In this attempt of reaching out to a wider audience by bringing focus on older women, I also need to thank all my family members, including my husband, my son, daughter-in-law, little grandson, and extended clan of siblings for their support and necessary distractions to improve my concentration for this worthy project and focus. I enjoyed working on this and am grateful to all who contributed toward its successful completion.

Contents

About the Editor

Mala Kapur Shankardass is a sociologist, gerontologist, health and development social scientist. She is a teacher, writer, researcher, consultant and an activist. She recently retired as Associate Professor from the University of Delhi, India. She has been involved with ageing studies since 1992 when she started postdoctoral work on ageing issues. She has done prestigious assignments with United Nations agencies and international as well as national institutions. She has participated in panel discussions, delivered keynote addresses and chaired sessions on ageing concerns with reputed organizations both in India and in abroad. She has been recognized for her work and contributions in gerontology across the world. She is editor of many books on ageing.

Chapter 1
Older Women: Global Concerns and Responses Toward Their Well-Being, Is a Serious Issue—An Introductory Note

Mala Kapur Shankardass

Abstract Older women are generally regarded with negativity, but this needs to be overcome. There is increasing need for their concerns to be heard, responses generated toward improving their well-being and they be given respect and status in society. There are many strengths and resilience which older women bring in their lives, and these aspects need to be acknowledged by generating policy and societal response toward their well-being. This chapter with focus on older women's lives, on their images in society, on identifying their problems and concerns discusses the need for proactive practices, policies, and programs which enhance their status in society and contribute to toward giving them respect and dignity. The chapter points to difficulties older women face in their private lives, working situations, in relationships with different sections of society. The chapter puts forth an agenda which overcomes gender discrimination, fights ageism, removes barriers in health and social fields, and provides a positive approach toward recognizing their potential and their contributions in society. The analysis presented here adopts a development and human rights-oriented approach.

Keywords Negativity · Resilience · Policy and societal response · Proactive practices · Contributions and human rights approach

Older women defined here as sixty years and above are the fastest growing segment of the population, and their numbers are swelling in all countries, in some at a slower phase but in many rapidly resulting in feminization of aging, with important policy implications. This phenomenon not only brings attention to the question of well-being among older women but also makes us reflect on what it means to be an old woman in general and more specifically in different societies with various cultural contexts and in various circumstances. Given the heterogeneity among older people, while both men and women in their later years do go through a variety of experiences and react in many different ways but given certain gender commonalities as seen across the world, older women face specific vulnerabilities which relate to their well-being. The concerns for older women become more acute and serious because

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of their vulnerabilities affecting their access to affordable health care, utilization of health services, seeking provisions for social care, shelter, food, freedom from abuse and living with dignity with adequate economic resources, and enjoyment of human rights. This then calls for a systematic universal response to address issues that affect their well-being by essentially taking into account the social, cultural, economic differences which exist impacting lives of both older men and women, but older women merit special attention, thus a focus on them specifically in this book. There are many issues related to older women that can be discussed from multiple perspectives; however, this volume is not exhaustive of these but touches on some of them. The various chapters bring forth selected concerns related to different aspects be it the vulnerabilities of older women or their strengths, be it discussing certain programs, actions applicable to them or just referring to certain dimensions which require our attention for improving their well-being across later years.

This book in no way suggests that many concerns voiced here are exclusive to older women and do not cover those for older men, but nonetheless the chapters only focuses on one gender keeping the discussion on the other gender for a future publication. Also the chapters here are illustrative of few countries, but the topics and emphasis on the issues cut across nations and regions of the world as many concerns related to older women are universal in nature, penetrating through social, cultural, and economic boundaries. There is unintentional absence of mention of certain countries/regions, but this is not to undermine that these societies do not reflect the concerns and similar responses voiced here. The discussion on older women presented here through specific chapters by experts who have a reputation of international scholarship has some amount of universality and applicability which speaks of certain commonalities that cannot be overlooked; thus, wider coverage of different countries/regions is seen not as a necessity. The idea reflected in this book is to bring to the reader concerns and responses which speak about different discourses going on in the world and more specifically discuss those concerns which are dominating in the field of gender and aging studies. This volume does not aim to provide a complete theoretical orientation to issues which concern older women though takes support of certain conceptual analysis. It must be remembered that while there is literature available on older women in many countries and as a field requiring affirmative action from both government and non-government sectors as well from the civil society members it is only recently since last two decades or more that interest on the well-being is being looked at from a rights-based perspective and more diligently in some parts of the world. The chapters of the book point toward new directions which discourse on older women is generating in this century. It in no way overlooks or rejects thinking which shaped it from the past. Mixing some of the old and new ideas on the lives of older women, the different chapters take us to various dimensions, some upcoming that not only show the urgency to deal with it but also indicate the need to be pragmatic in our approach. Thus, many of the chapters practically and realistically discuss the contributory dimensions and responses to the well-being of older women while not getting lost in the theoretical frameworks.

In general, viewing it from gender and age lens older women's well-being is affected by many factors, but seldom are the impacts of all of these recognized nor

older women's contributions acknowledged and very little research is available to highlight the different aspects and more importantly to suggest remedies to improve the well-being of older women across the world. This book tries to overcome this drawback to some extent by taking into account their contributions in terms of caring, their caregiving role, coping mechanisms, despite experiencing various forms of mistreatment, undergoing forms of depression, facing gender-based violence, taking into account lives of oldest old women in their 90s who like their younger counterparts continue facing different kinds of vulnerabilities. The book brings attention to the view that differential vulnerabilities require specific interventions which can create empowering environments. The challenges cut across countries and regions as shown in certain chapters of the book pointing to the need to adopt strategies that facilitate better health care, access to specific public services, overcoming agist attitudes and prevailing discriminatory practices. As highlighted in some of the chapters in this volume in order to improve quality of life of older women and contribute toward their well-being in a holistic way, a universal recommendation is to put policies in place for their betterment, raise awareness on their rights, and promote a realistic image of them in society. This all means having a gender- and age-focused strategy at national and international levels to aging issues and life in later years. Older women's lives in general are undergoing a change in many ways and more so in certain parts of the world. While concerns related to their poverty, social security measures, labor force participation remain significant and should be included in our planning for their well-being, there is need to recognize how emerging circumstances be it to take the role of being the sole caregiver and bread earner as in the case of impacts of HIV/AIDS seen in many countries of Africa, or in conflict situations as witnessed in some parts of Asia, Europe, Middle East or facing any other contingencies is shaping the lives of older women and compelling societal responses for their well-being by recognizing their elements of independency, ability to make adjustments, strive for their rights as part of heterosexual or homosexual unions or even remaining single. Some of these concerns have been dealt in this volume, but others have been left out with the promise that future publication will take note of changing emerging scenario related to lives of older women.

There is growing concern about health issues among older people, and one emerging area requiring immediate attention is increasing cases of dementia as highlighted in the book. Dementia like few other diseases is seen to occur more among women compared to men, and the burden of it on the social and healthcare systems is tremendous. There is lack of well-organized responses both from the public and the private sectors to deal with the impact of dementia like it is for many other age-related ailments. At the most what is available in most countries especially in developing societies to deal with acute or chronic illnesses is availability of informal care provisions mainly by the family members where gender considerations dominate. Not only is caregiving structured around gender and age lines with providers being mainly women and receivers of care often being not women and especially those in later years beyond their reproductive phase. Many diseases especially being in the category of non-communicable ones have a gender dimension, and bringing

focus on health needs of older women is the need of the hour especially with feminization of aging taking place. This also brings focus to pay attention to the requirement for specific gender-based caregiving and care-receiving practices existent in different parts of the world and the need to improve facilities and services for older women. As data from all cultural and development context reveal older women's vulnerability to health care, access to services, impact on their quality of life is a matter of grave seriousness. There are issues related to treatment and management of diseases which are specific to older women including barriers in accessing them and facing abusive environments. Disability issues within a broad framework of enabling environments have over the years emerged as an important aspect of life in old age. Connected with dependency, negativity, frailty, losing of autonomy, and self-esteem, it intersects with gender, caste, class, and many other factors. A growing issue requiring attention is how to overcome these constraints and can older women come out as strong individuals when handling limitations being set in by their physical, mental, social, and cultural conditions. How do they handle a change from independent health status to dependency or facing certain types of impairments in later stages of life and managing their lives without being isolated or marginalized in the society? Not much has been discussed on these dimensions in the available literature, and thus, the contribution in this book adds on to bringing focus on it.

Many aspects of older women's well-being as much as it is for older men too are affected by living arrangements, though studies indicate that the gender dimension adds on to the vulnerability of women getting more affected. The impact on their experience of old age, feeling of loneliness, and their quality of life depends a lot on with whom women stay in old age and what kind of relationships emerge out of their associations and family ties. Interestingly, a contribution in this book indicates that safety net provided by family members is not always conducive to better quality of life. Many factors contribute toward the well-being of older women as much as they do for older men too. The quality of relationships, involvement with activities, be it leisure or work related, social interactions at the family, community levels or in the society all add on to the experiences of well-being. Such research findings assure us that older women's well-being is dependent on many factors, and these must be understood within the socio-cultural milieu. While families do play an important role, it is significant to realize that many more aspects are pertinent for the well-being of older people and more so for women as their levels of occupation, dependency, interests, resilience, and coping mechanisms speak a lot about their position in society. Policies, programs, and provisions in society must comprehend the unique needs of older people and more specifically of women as they not only have the tendency to live longer but also have poor health status as they move on in years. Findings from various studies show mortality patterns having a gender dimension as much as they are affected by economic and social factors. Overall health status of older women is pivotal for any aging society and must be taken care of by proactive approaches toward their well-being. What alternatives exist to better the position we need to think of and as a community we must work toward enhancing the status of women in general and more specifically as they move on in years. It is imperative for aging societies to make later years holistically comfortable and meaningful for

its citizens. Bringing in work-related issues, opportunities for productive economic activities, providing financial security, eradicating poverty, all become important and serious concerns when we discuss well-being of older women. Deep thought in this regard must be given to what interventions will be useful culturally and universally for the well-being of older women. The different chapters in the book dwell on some aspects of these concerns and discuss existent responses and what should be course of action in the future. As researchers, as policymakers, as civil society members, and as those involved with old age issues in various capacities our focus must be to take into account health aspects, psychological and social challenges, economic and work-related concerns which positively and meaningfully make lives of older women better and enhance their well-being. This century when most societies will have a notable aging population an integral part of our strategy toward improving the well-being of older women requires focus on active aging and leading a dignified lifestyle throughout the life.

Adopting a life course perspective is necessary, essential for well-being of older women. Many health ailments, socio-economic conditions, psychological and emotional needs in later years are a result of continuum of vulnerabilities, experience of discriminatory practices, and disadvantages from a younger age. The gender-based attitudes, beliefs, and representations which exist in societies all influence how women are treated throughout their life and have major consequences for later years and end of life care. We are on the threshold of highlighting concerns related to older women by taking into account lifelong consequences of their ill health, low socioeconomic health status, being victims of mistreatment by family members, domestic violence or intimate personal relationships, weak psychological and emotional support, and caregiving burden especially while coping with their aging issues. While all these impacts get manifested on the well-being of older women, it also becomes crucial for us not to ignore their personal strength, their capabilities, their adherence to managing affairs, and their resilience to deal with their lives finding their own path toward their well-being. As much as older women's public image is a cause for concern, knowing about their private lives, about their personal experiences and reactions to deal with their problems or strengths is a significant aspect of molding interventions from a human rights perspective. Voices of women need to be heard and more so of older women as they because of age go through many life and lived experiences and move from one circumstance to another be it in terms of their marital status or residence or dependency due to health or economic reasons. Voices of older women often go unheard, suppressed, ignored, and even denied when it comes to giving them their rightful place in society. Certain movements emerging in present and very recent times in different countries have brought attention to the need for giving visibility to women and older women in particular and protect them from being dismissed, silenced, or denied their rights.

Concerns of older women as few chapters in this book highlight be it to remove them from abusive environments, or improve their health and social status or provide them with work opportunities to continue with their occupations in the informal and formal sector can no longer be ignored. They need positive responses at the policy planning level, in organizing specific programs at the societal level, in bringing out

legal measures to safeguard and protect their interests, rights in empowering them with a life of dignity and respect. As this book upholds research and planning for the well-being of older women is not only an urgent need in present and future times, it is also an important task for humanity where women dominate in numbers and more so in later years. Thus, a framework for action as suggested through the chapters of this volume in different ways is to keep the focus on older women prominent, to include not only their interests in policy and programmatic directions but also let their voices be heard, make them participatory group in advocating for their rights at the local, regional, national, and international levels. Both age and gender lens need to be applied in making women central to well-being issues. It is hoped that the various chapters in this edition touching on certain selected dimensions will generate further and enough interest to take forward concerns of older women with regard to multiple issues and suggest responses that are age and gender friendly and enabling. Lives of older women need to be celebrated, and the attempt through this volume is to provide aging women an environment conducive to their well-being through a life course approach and human rights perspective. It is hoped that the deliberations stated and focused on in this book will interest a wide range of readers and result in proactive outcome at different levels to take forward concerns and responses for the well-being of older women on a global scale notwithstanding the need for retaining a socio-cultural focus which absorbs their interests from their viewpoint. We must not only think about and for older women but empower them to bring about a change by personally and at individual level taking steps toward their holistic well-being.

Chapter 2
Beyond the Barriers of Aging—Coping, Caring, and Contributions of Older Women

Bhavika Thakkar

Abstract The article titled "Beyond the Barriers of Aging—Coping, Caring and Contributions of Older Women" will begin with discussion on need for addressing issues of aging population, their well-being, negative stereotypes and images of older people, specifically older women. It will move on to talk about how contrary to these beliefs many older women not only lead active lives but also make important contributions that remain unrecognized. It will further discuss the variants linked with positive and successful aging using research-based evidence and theoretical perspectives drawing from important theories of aging. The article will throw light on contributions made by older women at family, community, and societal levels. It will include qualitative analysis based on individual interviews of nine actively aging women using verbatim and narrative responses. The article will conclude with a discussion of learning based on life experiences of older women who exemplify active and satisfactory aging.

Keywords Older women · Aging · Successful aging · Positive aging

Introduction

Longevity and health have been the most widely conveyed wishes and benediction showered people across cultures and times. With the passage of time due to medical advancements, better healthcare facilities, and improving quality of life, these blessings are becoming reality. There is an increase in life expectancy worldwide, and India is no exception. The aged population of India is fast increasing, and in the next few decades, India will be placed in the zenith of both having the largest population and also the highest number of the older population in the world. The life expectancy at birth, in India, has improved from 49.7 years in 1970–75 to 67.9 years in 2010–14, registering a significant surge in the last four decades by 18.2 years. Census data of 2011 suggests that the percentage of the elderly population (60+) has gone up

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from 6% in 2001 to 8% in 2011. This is due to better education, health facilities, and an increase in life expectancy. The decline in the Total Fertility Rate (TFR) from 3.2 in 2000 to 2.4 in 2011 is also an important factor in this demographic change. "India Ageing" report (by UNFPA, 2017) warns that India's window of opportunity for demographic dividend will be closing soon. The report projects that by 2030 around 12.5% of India's population will be 60 years and above and by 2050 one-fifth of India's population will be aged. This in fact makes it crucial for academicians, researchers, human service professionals and policymakers to analyze and understand the situation and needs of older people. As the years are getting added to the lives, adding more life in these years will be an important issue for all to contemplate in the years to come to ensure quality life in later years.

Women and Aging

Aging women's issues need special attention as the experiences of men and women across the lifespan differ considerably. Across countries and cultures, social scientists and activists have raised concerns regarding the secondary status and the differential treatment of women throughout their life course. During the cross-cultural study on the effects of gender and residence on disability and aging in India and China, it was claimed that gender inequality in India is attributed to the distribution of employment, education and household wealth (Williams et al., 2017). According to Srivastava (2010), the problems faced by aging women are the product of widespread perception of inferior status of women throughout their lives rather than "aging." In the words of Davis (2005),

> The challenges of aging often are more pronounced in women because of the cycle of discrimination. This cycle begins with educational disparities, early marriage and childcare; and continues with occupational segregation, lower income, movement in and out of the job market to provide care for the family members, physical and mental health problems and limited retirement income.

Additionally, when researchers study the issues of aged, they too often fail to analyze the data from the lens of gender, thus glossing over the differences and losing valuable information (Payne & Whittington, 1976). Impact of previous experiences of discrimination and its continuation makes women further vulnerable when faced with age-related changes, generally decline in physical and health condition and other socio-cultural barriers. Negative stereotyping of aged, particularly aging women is another important issue that needs to be addressed. Payne and Whittington (1976) pointed to concerns, particularly in western culture, about older women being socially devalued and subject to harmful negative stereotypes that picture her as sick, sexless, alone, and uninvolved except for church work.

Traditionally in Indian culture, older people are assigned higher status and their wisdom used to be highly valued; modernization in the last five to six decades, though, has had a serious impact on structure and functions of families and status

of older people (Jamuna, 2000). In the process of this transition, individuals and families seem to be caught up between modernity and traditions creating ambivalence in society about the value of older people. Abilities, maturity, and contributions of the older women are easily overlooked due to the stereotypical image of frail, weak, and powerless individuals who are dependent and burdensome on families and communities. Often, gender stereotypes confine older women into either being dependent or in certain specific caregiving roles. Challenging the stereotype about older women being dependent and burdensome, Rajan and Mishra (1995) argued how elderly women could be labeled as dependents if they were participating in economic activities, quoting the statistics from government report on the agricultural sector which indicated that, 70% of elderly females worked as cultivators compared to 62% elderly males. Giridhar et al. (2015) point out harmful cultural and traditional practices that lower the status assigned to widows which creates additional road blocks for the aged women.

Bai (2014) suggested an important link between the image and status of older persons. He warned about negative stereotypes toward "aging" resulting in discrimination and mistreatment of older people. At the same time, he also talked about possible links between positive images of aging with effective utilization of human resources and a better intergenerational relationship. Furthermore, recognition of capacities and contributions by older women in families and societies will help in shifting the outlook from considering them as a burden to appreciating them as valuable assets. Although there are no defined and standard measures on which the effectiveness of aging can be evaluated, researchers have increasingly started discussing the promotion of healthy and successful aging.

Successful Aging

Successful aging as a term is comparatively recent; however, different ideas about what makes transition to old age more effective, meaningful and satisfactory have been explored and discussed for centuries. In Hinduism, since ancient and medieval era, human life is believed to comprise four stages. The two later stages—the life of Vanaprastha and that of Sannyasa—are the stages of withdrawal from the world and adoption of the path of renunciation and being totally devoted to God. Over the years, several theories have been developed worldwide to explain what makes life in old age fulfilling and meaningful. Cottrell (1942) explained the role theory of aging as Individual's adjustment to changing roles as per one's age; learning to perform new roles while relinquishing the old ones. According to Srivastava (2010), the role theory provides directives for the aged about role learning, role changing, and role transition.

Havighurst (1961) proposed that a theory of successful aging is about a statement of conditions whereby an individual gets maximum satisfaction and happiness at the same time society maintains an appropriate balance among satisfactions for the

various groups including different age groups as well as gender. It was proposed that individuals should be able to choose how one could derive maximum satisfaction.

Disengagement theory also talks both about accepting the changing roles as suggested by role theory; however, it further suggests the change toward more sedentary roles and even withdrawal akin to ashrama dharma theory. It assumes that all societies must find ways for encouraging older people to disengage from their previous roles to ensure they can be undertaken by the younger generation that is presumably more able to carry out these roles; while accepting roles more appropriate to their physical and mental decline (Cumming & Henry, 1961). Furthermore, it propels withdrawal of aging individuals and society from each other as an important basis for successful aging as well as orderly continuation of the society (Dhillon, 1992).

Contrary to above, the activity theory developed by Havighurst (1963) assumes that normal and successful aging involves preserving as long as possible, the attitudes and activities of middle age. The belief is that both the older people and society benefit if elderly remain active and try to continue to perform the roles they had earlier. A number of research studies have established the relation between activity level and its impact on physical and mental health as well as life satisfaction in old age (Cramm & Lee, 2014; Dhillon, 1992; Havighurst and Vries, 1969). Rowe and Kahn (1997) define successful aging as including three main components: low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life.

What makes life most meaningful and gratifying during old age actually can be quite subjective and is often influenced by different factors such as one's priorities, values, or beliefs. However, there are certainly some common determinants that help the journey toward successful aging. Chatterjee (2019) has summarized the determinants of successful aging in the following diagram. According to him, as the below given chart illustrates, successful aging is a composite and dynamic concept, influenced by few non-modifiable factors like gene and environment, but mostly modifiable factors like diet, regular physical activity, personality, aspiration index (preparation), happiness quotient (life satisfaction), morbidity profile, and subjective well-being (Fig. 2.1).

Case Studies

To understand and appreciate how different theoretical explanations and assumptions link to life experiences of older people, particularly women, in the present context; nine case studies were conducted. In-depth one-to-one interviews, and discussions were carried out with nine women aged 65 years and above. These women were considered to be "aging successfully", or "aging positively" or "aging well" by themselves as well as their families, friends, and as other associates. People in their social network also considered them to be well-adjusted and inspirational. The sample was chosen using purposive snowball technique, and the objective was to explore the factors linked with successful aging through life stories of the older women who

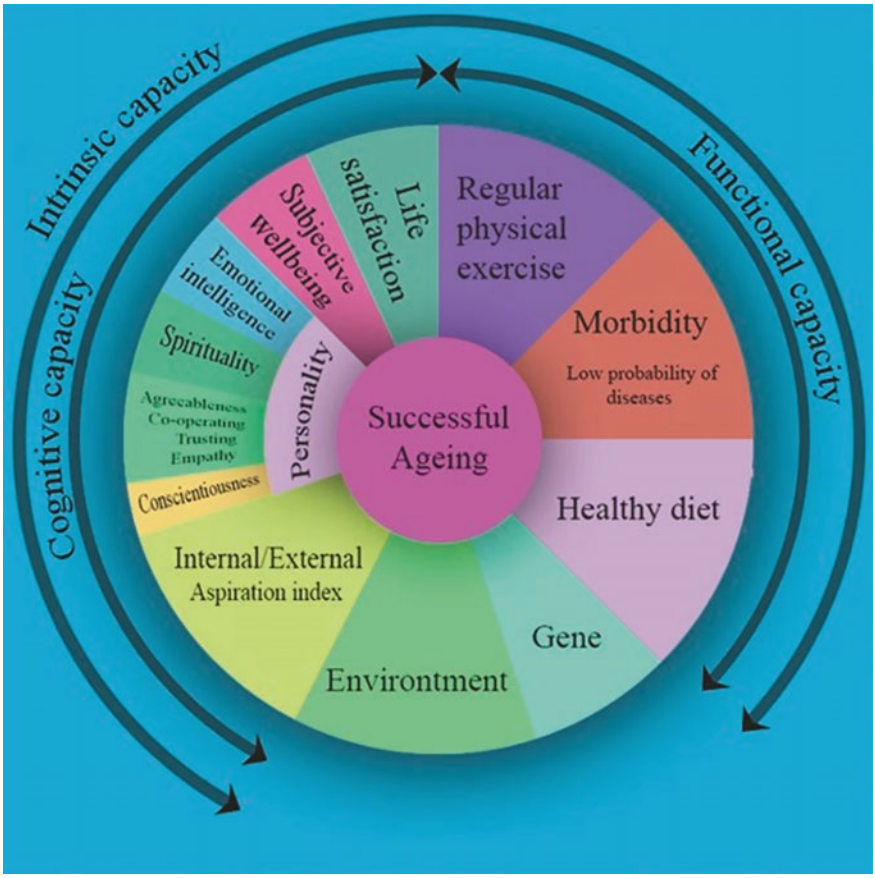

Fig. 2.1 Determinants of successful aging. *Source* (Chatterjee (2019). https://link.springer.com/content/pdf/10.1007%2F978-981-13-8938-2.pdf)

personified successful or optimum aging. These case studies were aimed at understanding overall life experiences of the older women including their childhood and adulthood experiences, their health status, support system, their contributions to families and societies, their views, and attitudes toward aging as well as their aspirations. Narratives of the respondents were analyzed to understand the determinants of satisfaction and sense of well being in their lives. All the respondents were from urban and middle or upper-middle socio-economic background. The names of the respondents have been changed to maintain anonymity and protect their identity.

Case Study 1—Namrata Patil (83 Years)

Namrata is a gentle, soft spoken, and confident woman with a special glow on her face which she attributes to her long years of practice of meditation. Eighty-three-year-old Namrata proudly shares her story of teaching transcendental meditation to more than two thousand people on a voluntary basis in her lifetime. She possesses an extreme level of self-motivation and enthusiasm through which she could teach and train many for meditation. The long list of those who she taught includes successful professionals such as doctors, engineers across the Indian cities including some of the eminent members of the royal families across Gujarat.

Namrata, an Arts graduate in Hindi literature from the M. S. University of Baroda, firmly believes that age cannot curb her passion. She presently resides in a nursing care home in Vadodara, Gujarat. She spends several hours meditating, reading books about meditation and spiritual gurus and listening to soft music. She wishes to teach meditation to the residents of the care home as she believes this will help all the residents for their physical health and mental peace.

Due to her husband's transferable job with Indian Railways, she traveled and lived in different cities of India. She owns a house in the city; however, prefered to stay in the care home after her husband passed away a few months ago. She feels that the current arrangement is convenient as all her practical needs are taken care of by the management of the care home.

Namrata's sons settled in the United States after obtaining their higher education from there. She is a proud mother and has visited them on a few occasions but chooses to live in India. She has her siblings and other extended family members, who live in the city, yet she has chosen to live independently in the care home. According to Namrata, she is living "comfortably" in the care home. She is able to support her living cost with her husband's pension and financial support from her sons.

Namrata was brought up in a highly educated and well-respected family. Her father was a chartered accountant, and mother was a homemaker. She was born in Kolkata (India) and completed her elementary education there. However, the family moved to Vadodara due to communal riots which took place in Kolkata in 1946–47. She continued her education and went on to become an arts graduate. She had an arranged marriage at the age of 20 with an officer who worked with the Indian Railways. "*Moving and living in different places due to my husband's transfer to different cities made me a very sociable and friendly person and I built very warm and cordial relations with many people*" she says.

Namrata found her passion when she learned meditation from Maharishi Mahesh Yogi, an Indian guru, known for developing the transcendental meditation technique. She claims, "*My husband was very supportive and only because of his support I could move forward in my spiritual journey through meditation.*" Off late she needs a walker to support her mobility; however, she maintains a very good health for which she credits the meditation practice. She remembers she had a tachycardia attack, a cardiac condition, about 10 years ago; however, she managed the emergency situation very well with her meditation until she reached the hospital. "*Even the doctors were*

surprised to see my recovery. I explained to them about meditation and taught them as well!" she shares.

Besides being an extremely satisfied mother for raising her children who are well-established today, Namrata is very proud and happy for the life she led and the contributions she made to other people's lives. She expresses her inner joy stating, "*I have lived my life very well. All I want to do now is to attain higher levels in spirituality through meditation.*"

Case Study 2—Savita Dwivedi (67 Years)

"*Old age is only a state of mind. One can be lively and cheerful at the age of 75 if one is positive and strong, or helpless and hopeless at the age of 37 if one gives in to the challenges of life.*" These are the words of 67-year-old Savita who has lost her eyesight due to glaucoma; however, her never-say-die attitude keeps her going; taking life in her stride; using her strong will and humor to live her life meaningfully. Savita is a very jovial, confident, and outspoken person who can easily strike a conversation with anyone and make them laugh with her contagious laughter. She is a resident of a care home in Vadodara. Savita is a trained dancer and has a special liking for classical vocal music. She loves listening to music and enjoys singing. She knows several Indian languages as she traveled extensively due to her husband's transferable job.

Although Savita's blindness has brought restrictions to her movement and confined her within the four walls of an old-age-home room for the last five years, she is very much in touch with the world through her constant companion—radio (*Vividh Bharti*). "*My radio is on from 6 am to 11 pm. I listen to news, talks and music which not only keeps me occupied but also informes me about what is happening in the outside world*."

Savita is very particular about her daily routine. She is an early riser and starts her day as early as 4 a.m. Her strict daily routine includes doing body and head massage, physical exercise and prayers. "*I am a dancer and I have to look after my fitness, I have an NCC background since my school days so exercise has always been part of my life.*" Savita regularly orders audio books to quench her thirst for knowledge which according to her is her mental exercise. She is a very active and confident resident who regularly gives feedback to the management about improvement of the care home and betterment of their services as well as welfare of other residents. "*My eyes have gone; my movements have got restricted but my brain is my biggest asset and my strength. I am able to think, remember and make decisions!*" Savita exclaims.

Savita was born in an aristocratic family in Madhya Pradesh, India. Both her parents were well educated. They provided ample opportunities and encouragement to her for her education and training. Her parents ensured that she regularly took part in extracurricular activities for holistic development. She obtained a master's degree in Science and stood forth in her university. She also completed *Visharad (Master's degree)* in Performing Arts (Dance).

Savita's husband, an engineer by profession, loved traveling. Due to his work in different cities of India, Savita got ample opportunities to travel around the country which gave her exposure to different cultures and languages. "*He encouraged me to learn and do whatever I wished to do. In childhood I was overprotected by my parents and siblings as I had four older siblings, but my husband gave me a lot of confidence and made me an independent person*," she shares. Unfortunately, Savita lost her husband due to a heart attack, when she was only 37 years old. She raised her daughter who was just 15 years of age then. "*Although we were financially secured, there were a lot of other challenges…lots of decisions about the education and future of my daughter but these experiences only made me and my daughter stronger*." Savita's daughter is married and settled in the USA. She shares a very close bond with her daughter.

Savita expresses her gratitude to God for giving her a fulfilling life. She believes in having a positive attitude as one of the most effective qualities in life. She extends her advice to others that they must surround themselves with people having positive attitudes. Savita says, "*I pray to god to keep me strong and positive till the last day of my life!*"

Case Study 3—Vidya Talati (66 Years)

Vidya Talati, 66-year-old yoga instructor, starts her day with an early morning yoga session, followed by a visit to the temple. She returns home to complete her household chores before heading to her office. She started this office about 2 years ago to expand her start-up on matrimonial services which she used to operate from home earlier. "*I just don't feel tired*," says very energetic Vidya. "The belief that *you can't do certain things after a certain age is completely a mental block; old age is in the mind*."

Vidya is a simple and family-oriented person. She grew up in an upper-middle-class business family which faced lots of hardships due to uncertainties around her father's business. Vidya was an apple of her mother's eye, whereas her father was a strict disciplinarian. She went to school; however, education came to halt when her family arranged her marriage just before she could give her final examination of Class XI (based on the old SSC model in the State of Gujarat, India). As her fate decided she had to move to a remote village of Gujarat to join her husband who lived in a joint family. While living with her in-laws, Vidya experienced immense restrictions and discrimination from her extended family members. However, she took this experience as a "challenge" and ensured her children were well educated. She also encouraged her children to participate in extracurricular activities on a regular basis which in fact boosted their confidence.

According to Vidya, she experienced enormous hardships in her life. In order to survive and to meet the family's financial needs, she took up odd jobs including making and selling potato chips, stitching clothes, and giving tuitions to little children. A strong will power, and conviction always led Vidya's future action. In order to make economic progress, the family moved to Vadodara about 15 years ago. Her

self-conviction and positive attitude toward her life culminated in starting her own business. Today, she runs a successful matrimonial service. In the midst of all the roles, she also made significant contributions in raising her granddaughter. Due to her ongoing support, her daughter-in-law could continue her work. As her daughter-in-law who is a school-teacher, expressed that she would be struggling to manage household work, child care, and her career without the much needed support from her mother-in-law (Vidya).

Vidya is a successful business woman today and takes immense pride for finally realizing her dreams. Exploring new things has never been a challenge for Vidya, as a result, she is now learning to use the computer and smartphone for her office work. Her son runs an independent business now, and the family has bought their "own" house and a car. She gets very emotional and tearful thinking that her husband is no longer alive to witness the success and achievements she made as he passed away 8 years ago.

With Vidya's successful business initiative and satisfying family life, she feels that the current phase is the best time of her life. "*I just don't like to sit idle, I always feel like doing something whether it is the household work, office work, community services like yoga sessions. People ask me how I get so much strength, I think it is God's gift*," says Vidya.

Case Study 4—Pallavi Desai (71 Years)

Pallavi is a retired university professor who believes in active aging and enjoying each moment of her life as it comes. She lives independently in her own apartment in Vadodara. Not a single day is dull and boring for her as she has learnt to enjoy her "me time". Nevertheless, she has a strong social network of friends and relatives. Pallavi believes in being a lifelong learner thus she continues to take up opportunities to learn new skills, be it drawing, swimming, playing musical instruments or meditation. She is very particular about following her daily routine which includes physical exercise, meditation, and attending prayer meets. She enjoys solving crossword puzzles and playing carom. Pallavi considers independent living as bliss. She says "*Fortunately, I am living alone and don't need to make adjustments unlike some of my friends who live with their sons and daughters-in-law*." *According to Pallavi, there is a difference between being alone and being lonely*.

Pallavi recalls, she was a very well-looked-after child. She remembers how relentlessly her parents pursued her treatment when one of her legs got affected due to polio at a very young age. In those days, the polio vaccine was not easily available. She was one of the very few children who not just survived but could also walk and lead a normal life. This was possible due to the strong determination and care given by her parents that included long hours of exercise, massage, and physiotherapy. Pallavi's mother was very an efficient homemaker and a disciplinarian at the same time. Her father was a businessman; had a great sense of humor and love for literature. Pallavi gives credit to her mother for her academic achievements.

Pallavi had a love marriage and a relatively short; nevertheless, very fulfilling married life as the couple had complementing personalities and similar interests. Pallavi shares how they enjoyed and appreciated the game of bridge, music, or bird watching together. The couple did not have children. Unfortunately, Pallavi lost her husband in her early 40s which left her emotionally devastated. In spite of this emotional blow, she gathered courage to focus on her career.

Pallavi had a very successful career as an academician, researcher, and administrator. She traveled around the world for her academic work and held several important positions. Her work received recognition from national and international academic institutions. Pallavi retired at the age of 62; however, continued to work on voluntary basis to share her expertise with different academic bodies. While she was making interesting retirement plans to enjoy the freedom and peace of retired life, all of a sudden, she was diagnosed with cervical cancer at the age of 65. Unfortunately, soon after this diagnosis she also developed retinal macular degeneration that affected her eyesight. For a strong and independent person like Pallavi, this was the first instance when she felt that age was taking a toll on her. Nonetheless, she gave a brave fight to two major health related crises in a short span of time and came out victorious on both the fronts. She continues to lead a healthy life and maintains discipline about her diet, exercise, and medical follow-ups.

According to Pallavi, she has learnt some important lessons that help her to live happily. "*I have learnt to accept the changes which are inevitable; accept the people as they are. I have learnt to detach from situations and people. Meditation has helped me to control my anger. Some people tend to be very negative and complain a lot; I have learnt to respectfully say 'no' to be in the company of such people.*" She goes on to recommend that acceptance is the key to happiness.

Case Study 5: Geeta Nanavati (71 Years)

Geeta (71 years) is an expert at making designer women's garments. She states "*I feel life in old age is wonderful! I can relax on the sofa and read for hours. In fact, these days I read on kindle which my son has gifted me.*" She goes on to share how she appreciates this new technology which allows her to find meanings of any unfamiliar word at one click. Geeta is a voracious reader and also spends time to reflect and understand her own self.

Although Geeta has now closed her boutique, thousands of her clients wish that she would start her work again. "*I still design and stitch but that is to keep my own sanity; I do not want to do anything where I have to commit myself now*," says Geeta who has penned a very informative and educational book on dressmaking and tailoring which was published and accepted by several prestigious fashion institutes. While explaining her inspiration to write this book she said, "*I wanted my knowledge, skill and talent to benefit others rather than die with me.*" She is also a certified yoga instructor and has been practicing yoga for several years. She is very regular with

regard to her physical exercise and morning walks and does not miss them, no matter whatever the circumstances.

Geeta is grief-stricken due to the demise of her husband about three months ago; however, she still demonstrates immense courage to move on alone. She was the primary and sole caregiver to her ailing husband who had a decade long battle with several health issues. Geeta has a son and a daughter who currently live away from her due to their jobs in different cities. Her husband was on dialysis for more than 8 years; during which she managed all his health care needs by herself. In addition, she managed the household work and all her professional commitments without compromising on her personal routine of yoga and physical exercise. At the age of 64, Geeta started driving again after a decade-long break from driving to facilitate her husband's hospital visits. She could manage these multiple responsibilities as she is highly organized. She does not have any major health issues at present; however, due to her tall and thin structure Geeta suffers from chronic backache which she has been managing with the help of yoga.

As a child, Geeta received lots of stimulation from her parents. Her mother was a simple yet highly organized and efficient homemaker. Her father, an artist trained at prestigious J.J. School of Arts in Mumbai, is a healthy and completely independent man at the age of 95. Geeta did not study further after completing class 11 as she did not consider further education important at that time. Due to her interest in music, her parents sent her to Mumbai where she learned Sitar from the great sitar maestro Pandit Ravishankar. Geeta continued learning Sitar till she had her first child. She decided to dedicate herself only to her son as she did not want to compromise her children's care. Geeta subsequently had her second child, a daughter. When both her children started school, she decided to do something of her own. She started reading books about designing and began stitching clothes for family members and neighbors as she enjoyed doing it. Soon she received very positive feedback from people who gave her the confidence to initiate this work professionally.

In the early 1980s, Geeta's family moved to Vadodara. After a few months of the shift to Gujarat (Vadodara), Geeta started her own boutique. In a short span of time, her popularity grew and she had a huge clientele. However, she had to close her very successfully running boutique to support her daughter who was suffering from leukemia. She frequently travelled to the USA as her daughter lived there. At that time, she took personal initiative and trained all her 15 workers, who would be left jobless if and when she closed her business, in special techniques of designing to ensure that they could start their independent businesses and support their families. Such was the generosity and magnanimity of Geeta.

According to Geeta her children are her greatest support and they have been extremely supportive and responsible children. However, she would like to live on her own till the time she can. She explains, "You can enjoy old age when you are not dependent. If you are dependent, and the other person stops responding according to your dependency, you will start feeling bad." Geeta shares that she is extremely satisfied that she could be there for her family members and care for them when they needed her the most.

Geeta has seen lots of ups and downs in her life, but her mantra is "positive outlook and positive thinking". She states, "*Age should not take over one's state of mind. Whatever I can do, I will do.*" She adds, "*One needs to find one's passion in old age and this might be same or different from one's occupation; not necessarily to earn living but for one's inner self*." Geeta believes in aging gracefully which she explains by saying "*With age body gets old and less powerful but mind gets mature, I would never like to color my hair, it has taken so many years for them to turn gray.*"

Case Study 6: Purna Shah (65 Years)

Purna's life has gotten busier with advancing age. After her children got married, her responsibilities had reduced to a great extent. Her children and other relatives advised her to join *Mahila-Mandal* (women's group) in her housing complex to utilize her free time. Instead, Purna thought of working toward realizing her unfulfilled dream to start something of her own. Purna had been a homemaker all her life as in her family women were not allowed to work outside homes.

Over the years, Purna had a burning desire to start her own business. She shares, "*I used to always think, how nice it would be to earn money with my own efforts!*" Her dream finally came true three years ago when she started her own home-based business. All her life she was praised for her culinary skills which she thought could be used for her new start-up. Her friends from her morning walk group became her first clients. In no time Purna's popularity grew and now she receives lots of appreciation along with big orders.

Purna also is a grandparent who is the main caregiver to her three grandchildren. She encouraged, both her daughter as well as daughter-in-law, not to give up their careers due to responsibilities of child care. With multiple responsibilities of household, grandchildren and business, life for Purna, at the age of 65, is busier than ever!

Purna was brought up in a conventional middle-class family in a small town of Gujarat (India). She was married after she completed her board exam at the age of 18 and moved to Mumbai. This also was a conventional joint business family consisting of 13 family members. Her life revolved around the household chores and her three children. Soon after the birth of her third child, her husband suffered a huge financial loss in his cosmetic business which left him severely depressed. Like the saying goes "you don't know how strong you are until being strong is the only choice you have", Purna had to find inner strength to support her family. Although her in-laws did not believe in medical treatment of depression, she put her foot down and availed psychiatric help for her husband's treatment. She stood by him through thick and thin.

Soon after this challenging phase, the family moved to Vadodara, Gujarat. Gradually her husband's business prospered, her children completed their studies and got married. Purna remained strong through all the ups and downs of her life. She says,

"whatever God does, he does for our good, even though we might not understand at that time."

Purna has some chronic health problems including high blood pressure and diabetes. She manages her health by being very particular about her medication, exercise, morning walks, and diet control. She believes in taking full responsibility for her own health for which she says, "first of all, I need to be healthy to live well and fulfill my duties." She wishes to be completely independent till her last breath. Purna Shared, "I feel very inspired when I look at people who are much older yet very active and productive." She wishes to expand her business and live with her children and grandchildren in harmony. Her motto is "be active, live healthy".

Case Study 7—Usha Joshi (72 Years)

Usha is an ever-smiling, jovial and easy-going person. Unlike many older women who lose interest in grooming themselves, Usha is very particular and conscious about her appearance. She is always keen on dressing up well and does not shy away from wearing her choice of bright colored sarees, wear nail paints, *Mehendi* (Heena) and diamond studded jewellery. She says, "*Some people make fun when women of my age groom themselves, some of my friends feel very hesitant because of this but I believe in doing things that make me feel good and give me pleasure.*"

Usha lives in a joint family with her husband, three sons and daughters-in-law and four grandchildren. Her sons and daughters-in-law are caring and extend support; however, their obligations toward their own work and children keep them busy. Usha, as a result, is the main carer for her husband who is 77 years old and has restricted mobility due to severe back pain. She also is a great support for her youngest daughter-in-law who has two young children. Usha looks after her granddaughters when her daughter-in-law is busy with her work as fashion designer. Beside family, Usha is actively involved with a women's group of the temple she visits regularly. They gather together in temples and sing *bhajans* (religious hymns and songs). She enjoys singing *bhajans* which is her hobby as well as means to worship god.

Usha was brought up in a traditional middle-class business family. Her parents were very gentle, kind, and religious. She studied till Class 9 and was married off at the age of 18 years. She had repeated miscarriages before she gave birth to her first son. This had taken a toll on her health at that time; nevertheless, she recouped. Lately, she has developed some health issues due to high blood pressure and dental problems; however, Usha ignores her own health needs over her husband's physical well-being.

Usha says, she doesn't like to let her age interfere in the way she wants to live her life. According to her, no matter what the age, young or old, one might come across various physical and emotional challenges due to health or relationships issues in joint families; however, they are best handled by not getting bogged-down by them. She says, "*Complaining about your problems to the world is not going to solve anything. It is best to put up a brave front, smiling face and high spirits.*"

Case Study 8—Jayna Soni (73 Years)

Jayna has been actively engaged in charitable work for the past 30 years. She is the secretary of the women's wing of the NGO run by members of her own community. The women's group raises funds to provide monthly groceries to the poor families and support financially disadvantaged students for education. Jayna shares that despite her wish to retire and repeated requests to her organization to appoint a new secretary, members of the group are insistent on her continuation due to her active and committed role. She spends substantial amount of time of her day in the activities of the organization.

Jayna was raised in a conventional family in rural Gujarat by a very strict father and a very simple mother who did not really have much of a say in decision making in the family. After completion of her secondary education, she got married through an arranged marriage; thereafter, she moved to Vadodara. Her husband had just returned from the USA after completing his studies there. According to Jayna, he was a broad minded and sophisticated person. He always encouraged her to follow her heart and pursue her interest. Jayna shared that she travelled a great deal with her husband, both within and outside India.

During the initial days after marriage, Jayna's primary role was that of a homemaker with the responsibility of raising her three children. However, with her social skills and curious mind, she was not the person to be confined to the four walls of her house. In the midst of household responsibilities, she developed her interest in studying the stock markets and following the national and international news to remain updated with time. Now she spends substantial time in these activities besides charitable work as the household responsibilities are taken over by her daughter-in-law. For the past three years, her role in managing the family business and properties has increased following her husband's death due to kidney failure. Jayna shared that she missed the companionship of her husband a lot. She talked about the importance of being connected with the outside world and remaining socially active, especially in old age as she expressed, "*It is painful to lose your companion, but you have to be strong. You need to go out of the house, meet people, engage in different activities and live meaningfully rather than locking yourself up in your house.*"

Jayna accepts that age adversely affects the body and as a result health. She reported experiencing some health related difficulties in the past few years including difficulties in hearing. She has been diagnosed with diabetes recently. She has also undergone knee replacement surgery two years ago. Jayna says, "*Although due to these health issues I can feel the impact of age lately, it has not deterred me from performing my roles and responsibilities whether household or social.*" Jayna has recently become a great grandmother, and she jokingly boasts in front of her siblings about having the highest status of them all as she was the first one among her 3 siblings to have a great granddaughter.

According to Jayna, life is all about keeping an open mind. In her own words, "*One should respect the traditions but challenge the exploitative and unjustifiable practices and welcome change*". She gave her own example whereby she learnt

trading financial market and became a seasoned trader in the stock market which was unheard in her community. She also gave an example of inter-community marriage of both her daughters at the time when such marriages were not easily accepted in her community. Jayna puts it as, "*ability to embrace change makes life, specifically old age, easier*."

Case Study 9: Ganga Patel (84 Years)

Ganga feeds around 250–300 people every day. Feeding the poor patients and their relatives at the government hospital in Vadodara has been Ganga's special mission for the last 29 years. Such is the commitment and zeal of Ganga that at the age of 84, her day starts with cleaning and cutting the vegetables and cooking full Indian meals for the poor and the sick. The mission of helping the disadvantaged section of society who cannot afford their basic needs was the initiative of Ganga's husband. He had expressed his desire to do this noble cause as a means to serve God. Ganga had not only supported this noble idea but also fully dedicated herself to this mission. The couple used to cook food themselves and carry it to the hospital. Almost 18 years have passed after the death of her husband; however, Ganga relentlessly carries out this work. She has now hired a van to carry the food as the number of beneficiaries has increased with time.

Ganga has put up pictures of Gods and Goddesses in her kitchen and has a firm belief that God watches over her and provides the strength to continue the good work. She says "*Not even once have I cut my finger, or ever got burned. That's because they are watching over me.*" She does not make any efforts to publicize or raise funds for her work "*Thanks to grace of God, there are always well-wishers and donors who are willing to support this mission*" *Says Ganga.*

Ganga was born and brought up in a joint family in a village of Gujarat. She studied till class six. Growing up in a large-conventional family, she got trained to do household work, especially cooking. At the age of 16, her marriage was arranged by her parents; after which she moved to Vadodara. Ganga lived all her life as a home-maker and a loving mother of two sons and a daughter. She was always very religious and had a strong faith in God. Her life completely changed once she dedicated her life in service of humankind. Presently, Ganga lives in a joint family who are very supportive of her cause.

At the age of 84, Ganga is completely independent and enjoys good health and has lots of stamina to carry out such physically demanding work. "*I have no health issues and my needs are very limited. I have a very loving and supportive family*" she says. "*I have never thought about till what age I will continue this work. I will serve as long as God gives me the strength to carry on.*"

Analysis and Discussion

As discussed earlier here, the above case studies indicate that there is no set formula for successful aging. Sense of satisfaction and feeling of well-being are subjective phenomena. There are, however, some evident commonalities and repeated themes in the life stories and routines of the respondents which could be clearly linked with positive aging experiences. Following important factors were identified after analyzing the life stories of these older women.

Health

There is a very popular saying in Gujarati "pehlu sukh te jaate narya" which can be translated as "the first and foremost element of well-being is good health". This proverb is applicable across all the stages of life; however, it is the utmost important aspect in the context of old age. Health has been officially defined by the World Health Organization (WHO) as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity.

All the older women interviewed reported enjoying good levels of health and mobility as a result of which they were independent. Only one respondent had dependency on others for mobility due to loss of eyesight as a result of Glaucoma; however, she was completely independent in managing her personal care needs. Some of the respondents talked about experiencing less energy and physical tiredness which is an established phenomenon that with advancing age decreased metabolic activity results in changes such as decrease in vigor and physical capability (McLain, 1978). Despite these physiological declines, all the respondents were found to be active and zealous.

This is not to suggest that the respondents did not suffer from any health-related problems. In fact, most of them had some chronic health-related issues varying in severity such as diabetes, back or knee pains, partial or full sensory impairment such as vision impairment or difficulties in hearing. Some of them had suffered episodes of most severe health problems such as cancer or cardiac problems. However, they had managed and coped with these effectively with the help of proper medical treatment and in some cases alternative healing methods like yoga and meditation combined with strong will power, firm discipline about their life-styles, eating habits, exercise, family and social support and of course, the positive attitude. This is in line with the findings of the study by Jamuna (2001) where all persons with longevity were found to be slender, had good eating habits, and deep faith in God and religion.

It is a well-established fact that physical health is closely associated with emotional well-being, particularly for older people who suffer much higher levels of chronic ill health than the rest of the population. Health is overwhelmingly felt to be the most important determinant of happiness among the over 55s. It has been estimated that up to 70% of depression arising in older people may be caused by disability

associated with health (Surr et al., 2005). Being healthy is one of the most important determinants of positive aging. Respondents expressed their wish to be independent till the last day of one's life, which is directly linked with good health.

Exercise, Meditation, and Yoga

Seven out of the nine respondents followed a strict routine involving physical activities. For some it was conscious efforts through morning walks, physical exercise, and yoga, whereas for others it was part of their routine of physical household work. Although in different forms, all the respondents reported engaging in physical activities. According to Chatterjee (2019), physical exercise increases oxygen supply in the body, prevents depression by releasing endorphins in the bloodstream, reduces stress and anxiety; and most importantly adds years to life. Importance of physical activities in later life was also highlighted in a longitudinal study conducted in Finland which concluded that mental well-being is associated with higher physical activity, better health, and better mobility status (Lampinen et al., 2007). A study conducted by Age UK in 2017 also found physical activity to be the 2nd biggest individual direct factor linked with well-being. In addition to physical exercise, practices like yoga and meditation were also found to be helpful in coping with ailments and emotional stressors as well as feel energetic and positive.

Religion and Spirituality

The present study also reveals that meditation, chanting of *mantras*, and other forms of prayers helped in developing positivity and mental peace in these older women.

Regular visits to temples, chanting of *mantras*, singing *"Bhajans" (religious hymns and songs)*, and listening to spiritual talks were some of the important activities of the daily routine of most of the respondents. Most of the participants mentioned the importance of engaging in religious or spiritual activities to achieve inner strength or peace and develop coping mechanisms to deal with the challenges in life. Dull and Skokan (1995) have developed a cognitive model to explain the relation between spirituality and the immune system. In their model, they posit that spirituality is a complex system of beliefs that can have an impact on all aspects of an individual's daily life. Spiritual practices may affect a person's cognitions and subsequently impact health practices and outcomes. Although the respondents did not categorically identify religious and spiritual practices as means to successful aging, it was mentioned as their way of life. This was a common practice in the lives of most of the older women and likely to be strongly linked with their feelings of positivity, enthusiasm meaningfulness.

Economic Security

As it is evident from the case studies that all the respondents had a sound economic situation. Personal savings, pension from one's own or spouse's job, financial support from children, and valuable assets owned by them were some of the different sources of financial support for the respondents. None of the respondents were entirely dependent on their children for their financial needs. All of them reported that their children were always willing to extend financial and material support however they were self sufficient owing to their own income or security as finances were planned well by of their husbands.

Although most of the respondents stated that their needs were very basic, having assurance about financial needs was an important factor that made them feel secure. This further substantiates the importance of financial stability for positive aging experience as they could avoid the fear and anxiety faced by older people living in economic deprivation. According to Paslithil (2009), socio-economic status is one of the important factors that decides if the person is likely to be happy or unhappy.

While financial stability and security alone cannot assure successful aging, it is one of the essential elements especially in a country like India. According to a report published by the Government of India 2011–12, 82% of total workforce worked in the unorganized sector in India (Government of India Report, 2013–14), most of them in agriculture, where there are minimal or no social security provisions like pension schemes or financial assistance for the older people. Thus, there are only a limited numbers of older people who enjoy security of pension and other savings after retirement. Financial security thus is a crucial factor for order people to ensure quality of life and access to healthcare which increase feeling of security in later years.

Meaningful Engagement

The power of meaningful engagement was found to be helpful to all the older women interviewed for this study. It was observed that all the respondents had active involvement in different activities that they enjoyed or valued the most. These activities include meditation, reading, cooking, grandparenting, caregiving to other family members besides getting involved into social activities or voluntary work, or even learning a new skill such as drawing, painting, or playing a musical instrument. Whether these activities were a continuation of what they did in their younger days or a newly taken up hobby; the older women did not perceive age as a constraint. Passion and commitment toward activities that had a meaning for them was found to be present among the respondents which was certainly having linkages with their positive experience in old age. Age UK report (2017) also reported participation in enjoyable, meaningful activities as the biggest direct factor for well-being. This could be in creative, cultural, civic, and/or social activities. Chatterjee (2019) in his

work on successful aging highlighted the importance of meaningful engagement. He went on to state that when someone becomes utterly absorbed in what one is doing, one pays undivided attention and dedicated action toward the task which contributes to successful aging.

Contributions

In the current study, four of the older women were involved with charity/voluntary work contributing for the welfare of their communities and society at large. They were involved in raising funds to help the poor families, feeding the hungry or training people to meditate. One of the respondents was a retired professor who actively contributed to other educational institutions and students with her expertise on a voluntary basis. Two respondents had been the main caregivers either to their old and unwell spouses who had high levels of health and personal care needs. Three respondents were very active grandparents and primary caregivers to their grandchildren as their parents were in full-time employment. Thus, contrary to the beliefs about older women being dependent on families, these women were making active contributions to their families and communities.

These and many such contributions made by women in families and societies irrespective of their age tend to go unnoticed. Contributions and care given by older women further tend to be invisible due to negative stereotypes about old people being dependent and weak. Due to social conditioning, women themselves look at these tasks more as their duty and responsibility and do not recognize these as important contributions toward smooth functioning of their families and betterment of their communities. Confirming this trend, most of the respondents did not recognize or consider their work as contribution; nonetheless, they reported deriving great satisfaction from the same.

As Lee (2006) put it, the older people often refer to being an active grandparent to their grandchildren as both a source of pleasure, and as giving them a purpose. In his study in the UK, Lee found that grandparents provided 26% of child care, more than any other source, either formal or informal, which in turn saved families in the UK £3.9 billion in child care costs annually and made a highly significant contribution to the national economy and to the lives of children. In the Indian context, joint families have been a source of immense support in child rearing. Older people are also playing a very significant role as grandparents when an increasing number of women with children are taking up full-time employment. Although, exact numbers are not available, observations and trends suggest that there is an increasing number of grandparents in India who travel to different countries to care for their grandchildren. This trend is increasingly becoming visible in some of the states and cities of India where a sizable number of youth have immigrated to different countries for better educational, career and economic opportunities.

The study revealed that satisfaction derived from these positive contributions is an important determinant of feeling of fulfillment in old age. Recognizing these

contributions would be an important step toward creating a positive image of older people rather than having a stereotypical view of older women who are believed to be always at the receiving end of the care and support.

Social Support

The study found that four of the nine older women lived in joint families with their children and grandchildren. Despite the increasing trend of nuclear families due to several socio-economic factors, family remains to be an important and a strong source of support. It is important to point out that physical and social support received within the families was mutual. The respondents received care and practical support from their family members in terms of arranging and escorting them for their medical appointments, ensuring supply of medication and other essentials besides providing emotional support. The older women on the other hand provided support in terms of managing household chores and active grandparenting. It is important to note that physical ability as well as willingness of the older women was an important factor that allowed them to be extending their support.

Not all the respondents lived with their children though. One of the respondent did not have children and lived alone in her house with considerable support from the paid help. Three respondents' children lived away from them either in other cities or countries and out of these three respondents, two lived in the care homes. One of them lived alone in her house and visited or stayed with her children occasionally. According to conventional expectations, this would be a source of disappointment and unhappiness for older people, especially women. These participants, however, did not perceive living alone or in the care home as a negative experience. In fact, they celebrated the achievements of their children and felt grateful about the availability of quality care services which provided practical solutions for their day-to-day living. Those who lived alone valued their independence and used modern communication technologies to maintain close contact with their loved ones.

The traditional intergenerational agreement is that parents raise their children and when the children attain adulthood, they in turn provide care and support to parents in old age; however, this traditional agreement is undergoing some changes (Chakrabarty & Bansod, 2014). These changes are mainly due to increasing nuclear families led by urbanization as well as migration within and outside countries for better educational and employment opportunities.

It is important to note that besides children, siblings, friends, relatives, and, other people such as colleagues and neighbors were providing social support to the older women irrespective of their living arrangement. Emphasizing the importance of friendships in later life, Jerrome (1981) suggested that old friends contribute something unique to the acceptance of aging and adjustment to changing circumstances. Positive social support system can thus be linked to well-being in old age leading to positive aging. These findings are confirming the findings of Amin (2017) who

studied perceptions of successful aging concluded that successful aging is multi-dimensional, including adaptation to an aging body, financial security, family and intergenerational care, and social participation.

The study also suggests that most of the older women had received a lot of support and encouragement from their husbands. Two of the respondents mentioned about their husbands being their active partners like teaching meditation or doing charitable work. Two other respondents shared about their experiences of companionship in pursuing hobbies or leisure activities together with their husbands.

All the other respondents also suggested that they received a lot of understanding and cooperation from their spouses to fulfill their wishes and follow their dreams, whether it was about completing their education after marriage, learning new skills and arts, or starting their own business. These positive experiences of support and encouragement from their spouse, especially in the backdrop of conventional society where women are compelled to sacrifice their identity and wishes to live under patriarchal control; had a positive impact in their lives. These experiences also helped the respondents to be independent and build on their strengths. As per Erikson (1982), when one looks back at one's life during old age and feels satisfied and happy, it leads to coherence and wholeness. Positive life experiences during the life course are important to experience "integrity" during old age as per Erick Erikson's psychosocial theory.

Childhood and Other Life Experiences

Education and Training

The educational levels of the respondents varied, from some women who barely could finish their school education to others who had gone to universities and even had completed doctorate level education. Three respondents had studied up to graduation or above. They came from families, with progressive thinking, where parents encouraged their daughters for educational attainment. It is important to note that although there were vast differences in the respondents' level of education, all of them, by and large, had positive experiences in childhood and received a lot of encouragement and stimulation from their parents. Majority of the respondents were supported by their parents to acquire additional skills like typing, sewing, playing musical instruments, and dancing. Opportunities for self-development through skills was a common theme among the respondents.

Travel and Exposure

More than half of the respondents shared about their experiences of traveling extensively or having lived in different cities, states, or countries due to the job of a

spouse or children who are settled away from home. It is quite likely that exposure of different cultures, ways of life languages and interactions with people is linked to confidence and resilient personalities of the respondents. Considering that positive aging is not just about old age but includes all the experiences during the course of life, it is highly likely that these experiences contributed to positive outlook towards life in later years.

Positive Outlook and Acceptance of Change

One of the common aspects found among the respondents was their positivity and their optimism. All the respondents during the interviews mainly talked about their blessings and things they were grateful about. All the respondents had seen different kinds of difficulties and crises relating to health issues of their own self or family members or financial issues. However, they focused on positive aspects which gave them strength to overcome these challenges.

Most of the respondents not only just talked about the importance of accepting the change but also showed how they had put it in practice. For example, three of the respondents had adopted electronic gadgets like Kindle (a product of Amazon) and audio books to pursue their interest in reading. They were using smart phones to communicate with their children through video calls. Some of the respondents also talked about importance of accepting the physical impact of aging on their bodies such as reduced strength to do work, graying of hair, and physical ailments. Retirement was seen as an opportunity to enjoy life on one's own terms, and solitude was seen as an opportunity to get in touch with self and attain higher spiritual levels by them. This acceptance prepared them to take things into their stride and deal with changes positively rather than denying or complaining about them.

All the respondents talked about old age being a mind-set rather than biological or physical constraint. It is because of this belief and conviction that they could do different things like initiating new start-ups, learning a new skill, providing intensive care to ailing family members and serving the society in different ways by dedicating themselves for ta social and humanitarian cause.

Conclusion

Good health, economic security, and strong support system emerge as the pillars of successful aging. Additionally, a positive attitude, wisdom, and maturity to accept the changes which include changes in one's body, health, strength, relationships, family, and society at large are the key to build further on the foundation of positive aging. Since aging is not a one-time event that happens overnight, experiences of childhood and adult life influence adaptation to old-age. A lot of good and healthy habits,

discipline, values, attitudes, and qualities like resilience and courage are developed early in life and are constantly imbibed through the course of life.

As per the continuity theory, people retain a high degree of consistency in their personality over the various stages of the life cycle. Thus, it is important to understand some of the behavior patterns and skills that help in achieving healthy and successful aging and start shaping them from earlier on. Although detachment from commitments and compulsions was seen as a way forward by a few, active physical and social life along with meaningful engagement and making positive contributions led to positive and successful aging for others. There is no carved-out formula or universally accepted theory of positive aging; however, comprehensive understanding of events during the life course and determinants linked with vital aging, can help in designing interventions and adopting pro-active approach to prepare for greater well-being in later years.

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Chapter 3
Women as Elder Caregivers in a Global Context

Lauren M. Bouchard, Lydia Manning, and Michael J. Pessman

Abstract Population aging is a phenomenon happening on a global level. It is estimated that the global population of people ages 60 and over will increase 56% between now and 2030. This global trend impacts people who are caring for older adults, particularly those who are working. Given that over half of all informal caregivers are women, it is important to better understand the impact caregiving has for people at all ages and at different stages of the life course, especially as for women in the workforce. Women in the workforce face significant disadvantages in career advancement and retention due to caregiving responsibilities, especially related to unexpected health needs of an aging parent or family member. These caregiving responsibilities can include instrumental yet unpaid activities both inside and outside the home (i.e., assistance with activities of daily living as well as general coordination of community services or medical care). Lack of supportive employment can lead to burnout, loss of professional identity, and even early retirement. Women may also experience physical and mental health concerns, general exhaustion, and difficulty in functioning due to balancing caregiving and market work roles. This chapter will explore global research trends and future considerations regarding vocational, workplace, and economic policy for aging women as elder caregivers.

Keywords Eldercare · Institutional care work · Gender inequality · Global context

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Introduction

In some countries, women are participating in the workforce in increasing numbers due to a new expanse of opportunity in the wave of gender equality (Martire & Stephens, 2003). Despite new opportunities in the professional or market workforce, women may face more expectations regarding housekeeping, informal labor, and caregiving of children and/or aging family members (Richardson, 2011). Often, the common question uttered is: Can women have it all? This question is increasingly important as women build careers and face challenges throughout middle and late life, especially when juggling caregiving roles. Cultural expectations, economic landscape, and gender parity often play a role in this dynamic across the world. When considering existing research and policies regarding caregiving in a global context, two key common themes emerge: the focus on family and the gendered nature of providing care (Phillips & O'Loughlin, 2017).

Gray and O'Brien (2007) indicated balancing work and family obligations may cost women important professional opportunities such as leadership aspirations or career choices which require advanced training or limited flexibility. A global aging population coupled with increased rates of chronic and comorbid conditions correlates with an increasing need in the long-term care support of older adults. With more and more people, particularly women, providing care researchers as well as policymakers need to pay careful attention to the unique challenges this demographic reality will present. Eldercare presents additional challenges in this realm when women often need to balance their time as caregivers and employees in a new and unsupported realm. Adult daughters who are caregivers especially face decisions and choices in attempting to juggle informal care responsibilities along with career advancement and development (Martire & Stephens, 2003). Caregiving can also have a negative impact on older women in the workforce who are in the midst of planning and saving for their own retirement (Orel et al., 2007). Perkins (1992) indicated that women who provide care over their lifetimes are at a greater risk for poverty themselves during their later years.

This question of work–life balance does not end when women become empty nesters as many women are increasingly caring for aging family members just at the point more vocational freedom seems available. As Richardson (2011) described, the common vernacular of "work" often means market labor, or the careers or jobs people have for pay and tangible health, retirement, or other benefits. This definition is increasingly limited as women often take roles in their personal lives that also consist of unpaid work, such as caregiving for children or aging parents, attending to household chores, and other emotional labor (Richardson, 2011). Not only is this type of work often unpaid, but even formal "personal care" market work is highly undervalued across cultures, contexts, and systems for those who choose caregiving as a career (Richardson, 2011).

Women are often more likely to perform personal care tasks, (e.g., grooming, bathing, or physical hygiene) when compared to men (Cranswick & Dosman, 2008). These tasks also include meal preparation, care management, financial planning,

medication administration, and bathing/grooming (Cranswick & Dosman, 2008). Due to their unpredictable nature, these tasks may impact daily work schedules, and employers often have few policies in place for those who are absent, must leave work early, or come to work late (Katz et al., 2011).

Despite a lack of written workplace policies, eldercare is becoming a reality for many employees, especially those in the "sandwich generation," aptly named for those in midlife caring for both children and aging parents (Miller, 1981). Many working parents have cultivated a work–life balance when their children need much of their attention, and yet, caring for aging parents can become an unexpected financial, emotional, and social burden due illnesses or increased physical limitations as older adults age (Do et al., 2014; Doress-Worters, 1994; Wellman, 2005; Williams et al., 2003). Difficulties in caregiving can be dependent on the context of the caregiver, and potential obstacles are compounded by socioeconomic status and other disadvantages (Do et al., 2014). Do and colleagues (2014) suggest there is an association between caregiver rated health and children in the household, which may be related to the increased stress in the sandwich generation. Additionally, these researchers report income and race and ethnicity also play a role in caregiver reported health (Do et al., 2014). Income appears to be associated due to the nature of formal eldercare as well. Williams and colleagues (2003) reported that as the general population ages, fewer adult children are left with the financial burden of caring for parents or other family members who increasingly do not have the means to pay for supportive eldercare resources. These authors reported higher caregiver distress for caregivers who could not access additional help or respite from their caregiving responsibilities.

Researchers noted working women who care for both children and aging parents experience the most stress when compared to others in their cohort (Aazami et al., 2017). Others have also noted the number of "double duty" or "triple duty" caregivers, often women who work in healthcare, who are increasingly serving in both formal and informal roles (DePasquale et al., 2016). The emotional labor of women is often expected, unpaid, and an extreme toll on their professional vocational lives. Women often face higher rates of poverty and financial insecurity in old age, which is rooted in a web of contextual factors such as lower salaries and fewer retirement funds as well as more informal work responsibilities and lack of career development (often tied to one another; Calasanti, 2010; Orel et al., 2007; Williams et al., 2003).

Research corroborates the experience of women who find themselves overwhelmed with a lack of helpful resources to assist when a caregiver is employed in market work (Wellman, 2005). Women also have a propensity to feel guilt and obligation at higher rates when compared with other family members or adult children, and this exacerbates their desire to help despite potential negative health consequences for themselves (Friedemann & Buckwalter, 2014). Due to the complex nature of women's work lives and family caregiving obligations, professionals must consider how to bolster workplace policy, offer sufficient resources in caregiving while also considering the context of each individual herself.

Cultural Landscape of Eldercare

To date, many researchers have focused on younger, working caregivers in the developed work while scant research exits on the realities of informal and working caregivers in the developing world and older working caregivers in general (Phillips & O'Loughlin, 2017). In much of the developing world, eldercare responsibilities are primarily the responsibility of the family. Several countries have sought to strengthen the role of family support for eldercare by implementing policies related to eldercare and working caregivers (Chen et al., 2018). It is difficult to paint formal and informal work as monolithic across countries, governments, and cultural diversity, to name a few. For example, eldercare policies of the USA are drastically different than those in Denmark or Switzerland where support may be more readily available for older citizens and family caregivers (Kotsadam, 2011). Differences in family leave law can also drastically impact the experience of caregiving (Yang & Gimm, 2013). Yang and Gimm (2013) reported a shift in life expectancy, change in workforce demographics, and cost of eldercare impacted the need for family leave laws as well as affordable eldercare (via formal caregivers or residential spaces). However, the USA falls behind compared to the leave policies of Denmark, France, and Canada.

Cultural values related to caregiving also play an instrumental role in eldercare across countries and cultures. For example, some countries offer more formal eldercare opportunities, which is associated with more autonomy in caregiving decisions and less subsequent stress (Kotsadam, 2011). Other countries offer little to no choice in formal caregiving (due to financial constraints or lack of eldercare infrastructure) causing more stress and financial strain on the family unit (Ahmad, 2012) and sometimes causing "anticipatory anxiety" regarding the balance of work and caregiving (Laditka & Pappas-Rogich, 2001). Globally, it is important to understand contextual differences in eldercare and formal work environments as policy, support, and social roles will impact women differently across cultures.

Consequences of Care

Women face specific challenges and consequences of care due to the emotional nature of family caregiving, expectations regarding caregiving, and lack of work–life balance. Ahmad (2017) found that younger women in Pakistan, particularly daughters-in-law, shouldered much of the caregiving responsibilities resulting in working caregivers experiencing stress and financial strain more than non-working caregivers. These findings suggest that family caregivers had a need for formal support and special health services for their care receivers—another common theme when considering the realities of working caregivers in a global context. Similarly, Chen et al. (2018) found that in China there were similar gendered patterns of care with deleterious consequences. They explained that data analysis of data using China Health and Retirement Longitudinal Study (CHARLS) indicated a significant gender

division in patterns of family care. While men are more likely to receive care from their wives, women are primarily cared for by their children and chronically ill women who had healthy husbands were less likely to receive care than chronically ill men with healthy wives. Not only is caregiving expected of women, but women also espouse high levels of obligation to care for family members themselves, often without help (Friedemann & Buckwalter, 2014). Eldercare presents unique challenges as it is a role reversal which can affect an entire family system of functioning and cause stressful changes in the way adult children relate and care for their parents and each other (Friedemann & Buckwalter, 2014). Women are often thrust into the caregiving role due to societal patterns and expectation, and it is important to note this feeling of responsibility can also impact emotionality and psychological toll of the caregiving role itself (Friedemann & Buckwalter, 2014).

For example, researchers have shown many women who care for older family members and have a much higher rate of depression, exhaustion, and breakdown (Friedemann & Buckwalter, 2014). These researchers also note the emotional side effects of eldercare for women are often coupled with working to the point of crisis, which may put both caregiver and aging family member at risk. Due to feelings of obligation and cultural expectation, women are also more likely to forgo market work entirely while caring for relatives or spouses. This not only affects their level of general stress, but also their career prospects and ability to pursue career advancement or their own retirement security (Lee et al., 2015). It is plausible that these experiences are more common than different across cultures.

Although work can offer many positive benefits to women who are caregivers, family caregiving resources and supports are often not available to help maintain a balance (Lee et al., 2015). As responsibilities mount for increased care of their parents or family members, chances of full-time employment become less likely for women despite satisfying work being a protective factor against the stress of caregiving (Martire & Stephens, 2003). Not only does this impact women during caregiving, it also may impact prospects when they later attempt to enter into the workforce. The stress of navigating dueling roles in informal care for family members while also attempting to pursue career stability can cause immense stress physically, mentally, and emotionally despite employment acting as a potential escape and buffer from the daily stress of caregiving (Lee et al., 2015; Lyonette & Yardley, 2005; Martire & Stephens, 2003; Mitchell, 2014).

Health and Caregiving

The research indicates the stress of these roles impacts women in tangible mental and physical health outcomes. Some caregiver advocates such as Wellman (2005) report giving up everything to care for elder parents, and losing career opportunity, health, and stability in the process. Some researchers indicate "anticipatory anxiety" regarding caring for a spouse or parent can even impact mental health prior to becoming an informal caregiver (Laditka & Pappas-Rogich, 2001, p. 3). Lyonette and

Yardley (2006) reported women who held high-stress occupational positions while caring for an older adult had the most psychological distress. Embimgbo et al. (2019) found that in Nigeria that providing care to older adults had negative implications for the social, financial, material, emotional, and physical health of family caregivers, particularly for women.

It should be noted younger women with more satisfaction in their work roles reported higher positive affect, yet older women consistently indicated the combination of roles caused the most stress (Lyonette & Yardley, 2006). Women who act as professional caregivers or health providers may experience a heightened level of stress and psychological distress when caring for an older family member, especially as compared to unrelated formal caregivers (DePasquale et al., 2016). Income also impacts caregiver stress with lower income women reporting higher stress potentially due to lack of access to available services including respite, transportation, and social support (Williams et al., 2003).

In addition to feeling emotional burden as caregivers, women also reported less optimal physical health when caring for the health of a loved one (Friedemann & Buckwalter, 2014). Due to cultural expectation, many spouses may be exhausted but reluctant to reach out to services such as respite or formal caregivers (Friedemann & Buckwalter, 2014). General stress, exhaustion, and burnout are reported across the literature, often hitting working women most (Depasquale et al., 2014; Lee et al., 2015; Lyonette & Yardley, 2005; Martire & Stephens, 2003; Mitchell, 2014).

Ethnic and Racial Differences in Caregiving

Much of the current research explores gendered caregiving in White Americans in the USA, while often discounting differences in racial and ethnic minority Americans and immigrant populations (Mitchell, 2014). Scant research exists on the ethnic and racial differences in different global regions. The USA has its own distinct ethnic and racial issues associated with caregiving. There are clear disparities, not only in the research, but also in access to healthcare, social services, and other assistance for racial and ethnic minorities and immigrants in the USA (Takamura, 2014). Elder caregivers may have difficulty accessing these services as well, especially in rural areas or where there is limited healthcare access (Friedemann & Buckwalter, 2014; Takamura, 2014). Cultural understanding and language barriers can also play a role in senior services which may have been helpful otherwise (Dilworth-Anderson et al., 2012).

Discrimination based on race or ethnicity as well as language barriers are also consistent obstacles to caregivers themselves (Friedemann & Buckwalter, 2014). From an intersectional perspective, socio-economic status, family structure, and race and ethnicity all account for health changes in informal caregivers (Do et al., 2014). While Blacks, Hispanics, and Asians may not report health status changes in caregiving, there is still little information regarding how caregiving may affect some groups in a more significant way (Do et al., 2014). Discrimination, lack of access to

resources, and general health disparities remain salient considerations, especially for working women who may be economically disadvantaged or facing discrimination in the workplace itself (Do et al., 2014; Friedemann & Buckwalter, 2014; Takamura, 2014). Existing research on ethnic and racial differences in caregiving is concentrated with the USA and has not been fully explored nor understood in a global context.

Public Policy and Caregiving

During a time of global aging and the increasing demand for caregiving, most developing countries are exploring ways to reduce the dependence on institutional care and considering how to expand home-based, informal care efforts (Kodate & Timonen, 2017). Recommendations provided by researchers and policymakers vary widely across the globe as the notion of family is determined by cultural expectations and norms. The philosophical underpinnings related to care, family, and work hinge on the extent to which countries use policy as a means to support family caregiving and the need for time away from work. For example, Kodate and Timonen (2017) argued that in Asian countries, there is a general acceptance that informal care is a family issue rather than a policy matter as compared to Europe where caregiving is seen not only as a family issue that of policy concern. This is evidenced with many of the European welfare states providing paid leave for workers who need to care for aging loved ones. While there are resources available to informal caregivers in the USA, given that the USA in one of few developed countries without paid care leave, one could argue that caregiving remains an individual and family issue.

Few options exist in the USA regarding family leave, and eldercare is only becoming a topic of discussion in the USA general population due to almost every person experiencing aging family members (McCallips, 2006; Wellman, 2005). Established programs in the USA include the Family and Medical Leave Act (FMLA), which provides authorized unpaid leave up to 12 weeks for employees who need to care for a sick child, spouse, or aging parent; however, the policy is only available to some workers with these benefits and includes strict guidelines on return to work (Bailey, 2017; Lee et al., 2018). Although FMLA was originally designated for the express purpose of aiding in caregiving during times of illness, it is vague in its scope and interpretation and many may not be able to take a leave of absence due to lack of benefits or financial concerns (Bailey, 2017).

Additionally, while some employees have access to these FMLA benefits, many others including those working in positions without benefits or limited hours, may not even be able to submit claims for FMLA. FMLA is unpaid leave, and spouses, adult children, or other caregivers may still need income during these times, especially with mounting expenses from illness or injury. FMLA also does not allow for bereavement leave after the death of the family member, which is short-sighted given the nature of caregiving and the grief associated after this period (Lee et al., 2018).

Katz and colleagues (2011) reported many employers may be sympathetic to those who are caring for an aging parent, and yet another extreme indicated a written policy

was unnecessary due to the personal nature of caregiving, which the individual should cope with by some other means. Often the opinions on policy within the workplace are dictated by those in leadership positions themselves who may have privilege to assess caregiving differently than those who face financial, economic, or gendered disadvantages in caregiving. The employers who were reluctant to implement a policy often cited financial or economic concerns in terms of the company (e.g., lack of desire to give flexible time).

On the other hand, many employers believed a policy would be positive to raise awareness and support in their company's culture (Katz et al., 2011). Public policy should attempt to aide long-term caregivers, especially beyond FMLA's 12 weeks, when considering the impacts of chronic disease such as Alzheimer's or related dementias, or other health impairments which could last years. However, this is a difficult task when many employers see caregiving as a personal problem and are reticent to create clear-cut policies to support their employees.

Caregiving Options and Work

Many caregivers feel an obligation to their aging parents or family members to allow aging in place with their assistance (Barnes et al., 1995; Katz et al., 2011; Martire & Stephens, 2003). This cultural expectation often leads many women to attempt to juggle the demands of their work schedules with the scheduled and non-scheduled caregiving tasks associated with their family members' care. Because personal care typically falls in the realm of female caregiving, these women are coordinating and conducting medical, emotional, and physical needs of their family members (Cranswick & Dosman, 2008). Additionally, many caregivers hire formal home care aides in order to maintain safety and continued care in the home while the caregiver is away. Some researchers indicate home care aides are instrumental in ensuring the satisfaction of the general caregiving dynamic (Ayalon & Roziner, 2015).

Often in home care can be an ideal situation; however, women in the workforce often still have the responsibility to coordinate care, supervise the living situation, and take care of any emergencies that arise. In home care can also be expensive for caregivers, especially due to the competing demands of juggling work responsibilities with caregiving. Lack of employer support and official policy often impacts these competing demands even further, causing many women to make the tough choice between long-term care facilities or quitting their jobs entirely to focus on the older adult who may need additional help and support.

Other caregivers are part of the rising trend of long-distance caregiving; that is, coordinating care across distances where they are not able to see aging parents or family members consistently. These caregivers are also more likely to be middle-aged women, but they typically report more education and income than local caregivers. These women typically spend significant amounts of time coordinating home care, transportation, and other services for their family members (Bledsoe et al., 2010).

They also reported their mental and physical health is negatively impacted by their caregiving stress (Bledsoe et al., 2010). These women also report their employment was negatively impacted, and they were also likely to take unpaid leave and lose upward mobility and/or benefits (Bledsoe et al., 2010).

Long-term care for family members is also an additional emotional and time-consuming decision, which also presents financial considerations and transition difficulties (Kokonya & Fitzsimons, 2018). Many adult daughters are the primary caregiver of their aging parents and attempt to help their parents age in place, but the health limitations, safety concerns, and caregiver stress can be an overwhelming task (Martire & Stephens, 2003; Wellman, 2005).

Consistently, caregivers may face unexpected doctor appointments, concerns with transportation of aging parents, or increased incidences of falls or other emergencies. These "competing demands" can very much affect work–life balance and may even lead to discontinuation of work despite the positive benefits (Martire & Stephens, 2003, p. 169). Health limitations, disability, and cognitive impairment may begin to impact the safety of the aging adult, and it may be time to consider long-term care options to ensure the wellbeing of both the resident and the caregiver (Barnes et al., 1995; Jolanki, 2015; Koyonka et al., 2018; Martire & Stephens, 2003).

Career-Related Coping

Due to the challenges of elder caregiving and lack of cohesive policy in workplaces, it can seem overwhelming to maintain a career while caring for an aging family member. The literature indicates many women find themselves emotionally obligated to care for family members, especially those who have raised them (Katz et al., 2011). With this in mind, it is also important to consider the potential career-related coping for these women juggling competing demands. Coping with these demands may include respite, self-care, and emotion-based strategies such as counseling or support groups in order to temper the mental and physical health burden of caregiving itself (Killian et al., 2005). However, some women may see additional tasks and appointments as unattainable due to an already hectic schedule (Barbosa et al., 2011; Killian et al., 2005). Some caregivers may appreciate a more solution-focused approach, especially related to tangible caregiving resources and ways to maintain the demands of a busy schedule (Barbosa et al., 2011).

In terms of solution-focused coping, caregivers may need assistance in determining care and navigating policy, work demands, and community-based resources. Caregivers may benefit from support from others who have coped with family caregiving as well as those who have knowledge and expertise in navigating eldercare specific systems such as Area Agencies on Aging, home care agencies, senior centers, respite care, and long-term care facilities. Often, caregiving decisions are laced with emotions, and women who are working are facing the challenge of navigating perception of obligation and lack of general support (Katz et al., 2011).

Employers may be able to ease the burden of caregiving even if official policies may not be in place. Including age as a diversity variable and welcoming discussion (such the discussion mentioned in Katz et al., 2011) may be a good starting place even if official policy cannot be put in place. Those who work with women in the workforce may be helpful in destigmatizing elder caregiving and supporting in small and concrete ways. Yeandle and Buckner (2017) found that in England that people ages 55–64 were caring at higher levels of intensity for older people and were doing so alongside paid work. It is plausible that there is a growing number of older workers while providing care for older loved ones. This shapes the realities of career trajectories.

Finally, women who are caring for older adults in their families may benefit from preplanning, even when there is anticipatory caregiving anxiety (Laditka & Pappas-Rogich, 2001). Paid and unpaid work affect the general physical and mental well-being, but preplanning can affect the general work–life balance of women caregivers. For example, self-employment, irregular shifts, and/or multiple jobs could decrease work stress depending on the context of the unpaid labor (Macdonald et al., 2005). Another avenue in stress reduction could be the retention of work, which allows for the buffer of meaning outside of caregiving without the feeling of time stress (Macdonald et al., 2005). Preplanning in terms of delegation, care coordination, and work schedule could provide relief for women who would like to continue advancing their careers while maintaining their commitment to their families. Perkins (1992) suggests counseling and education for women employees regarding retirement, available financial resources, and other supports to help maintain their careers during this time. Regardless of career-related coping employed, it is important for caregivers to access help and resources even if reluctant to do so early in the process of caregiving.

Conclusion

Aging women in the workforce face considerable options, and yet also have tremendous strength in persistence, advancement, and commitment to their work and families. Eldercare is becoming an increasingly important topic of investigation due to parents and other family members who are aging with lack of preplanning and proper infrastructure in aging care. Innovative approaches to aging, including those which use technology, are being developing to help seniors age in an engaged and meaningful way, whether in their homes or long-term care facilities (Majumder et al., 2017).

But with all the talk of technology, telehealth, smart homes, and increased efficiency in caregiving, many women are caring for elder parents with little to no support from the community or other family members—this is a global phenomenon. Juggling these tasks, without the luxury of workplace policy, can be a daunting task, which affects depression, stress, exhaustion, and a host of mental and physical health outcomes (Macdonald et al., 2005). Personal well-being is tantamount to engagement

with work and the buffer effect which can come from career itself even while caregiving is taking place. New solutions to eldercare problems can be best understood in terms of the needs of both the older adult, caregiver, and the match between them (Hollis-Sawyer, 2011). In terms of solutions, it is always important to remember the context of the caregiving situation, potential resources available, as well as the dynamic in the family unit itself. Direct service providers should additionally keep in mind the impact of bereavement and anticipatory grief on the caregiver as well (Lee et al., 2018).

At a global level, there is considerable work that needs to be done to provide better and innovative approaches to long-term care facilities, eldercare workplace policy, and general awareness of caregiving. Consequences of unsupportive work and personal care labor responsibilities can even affect retirement for aging women in the workforce, a consideration which could economically impact further generations as well (Perkins, 1992). Women are the backbone of the workforce as well as often the constant and primary support of their families. Workplace policy, educated helping professionals, and available resources can help maintain the mental and physical health of caregivers throughout the lifespan. Given the existing research of working and non-working, informal caregiving in a global context, it is clear that elder caregiving is a gendered issue which necessitates the need for designing gender-sensitive policies in eldercare (Chan et al., 2017; Dorin et al., 2016). Specially, these policies must take into account the unique needs of both younger and older working caregivers.

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Chapter 4
Understanding and Responding to the Needs of Older Women Who Have Experienced Mistreatment

Caroline Pelletier, Marie Beaulieu, and Françoise le Borgne-Uguen

Abstract Few scientific studies present gender-based analyses on the subject of mistreatment experienced by older women. Nevertheless, women who have lived through such a situation can suffer serious consequences in their daily lives. How do they react when they have been mistreated? How do they express a request for help—or do they ask at all? This chapter presents the findings from research carried out in Québec (Canada), as part of a doctoral dissertation that uses a phenomenological research design, and that seeks to better understand older women's experience of mistreatment, the decision-making process that leads them to ask—or not ask—for help in this context, and the significance they attribute to this request for help. The chapter begins with a description of the state of knowledge on mistreatment of older adults and the objectives to, and incentives for, asking for help following an episode of mistreatment. Next, it presents the methodological approach, from data collection through to their analysis using NVivo software, and a sample composed of five women aged between 71 and 77. Semi-directed, qualitative interviews were held with these women. This section is followed by a diagrammatic conceptual framework for the main findings drawn from a review of the literature and an analysis of the data. Finally, avenues are suggested so that more mistreated older women will be encouraged to break the silence about their experiences and share their stories with someone they trust.

Keywords Older women · Life course · Mistreatment · Needs · Seeking help

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Introduction

The Universal Declaration of Human Rights, which stipulates that "all humans are born free and equal in dignity and rights," was adopted more than 70 years ago (Nations Unies, 1948). Nevertheless, in numerous countries around the world, women of all ages have experienced or are still experiencing gender inequities. Over the course of their lives, older women are likely to suffer the effects of numerous types of discrimination, such as sexism and ageism, which result in financial insecurity, social isolation, and loneliness (UN Women, 2012). But what about the mistreatment of older women? Few studies have been carried out on the subject, so it is difficult to establish the prevalence rate (Yon et al., 2019) even when older women have been identified as those most at risk for experiencing mistreatment in the form of violence (United Nations, 2003). The few studies available about mistreatment of older women are difficult to compare due to major differences in the research design, the sampling, and the measurements (Yon et al., 2019).

If we look beyond the figures, how do older women react when faced with the mistreatment they suffer, how do they ask for help? To gain a better understanding of the older women's mistreatment experience, we have carried out one phenomenological research at the doctoral level with three specific objectives to find out about: (1) the experience of living with mistreatment as older women; (2) the decision-making process that leads older women to ask or not ask for help in a context of mistreatment (obstacles and incentives), and (3) the significance they ascribe to asking or not asking for help. The purpose of this chapter is to elicit from this research a comprehensive vision of the experience that leads them to seek or not seek help.

To understand this phenomenon better, women must be given their say, because it is they who are the experts about their own experiences. Their accounts of what they have experienced, their personal histories, allow them first to take ownership of their own stories, and second, to attribute significance to their experience (Demazière, 2007). The chapter begins with the current state of knowledge about mistreatment of older adults (all genders combined), focusing on what is known specifically about older women, and on the main obstacles and incentives for requesting help following an incidence of mistreatment. A methodology section describes the approach used—semi-directed qualitative interviews with five women aged between 71 and 77, analyzed using the scientific phenomenological methodology espoused by Giorgi (1997). A diagrammatic conceptual framework of the main outcomes is presented and discussed. This chapter concludes with the pathways to be proposed so that more mistreated older women feel able to break the silence that surrounds their situation.

State of Knowledge

Let us begin by defining mistreatment, and estimating its prevalence, to then ask what is known about asking for help in the context of mistreatment. As stated, any information specific to women is emphasized.

Defining Mistreatment

The definition of mistreatment of older adults most widely recognized around the world is that proposed by the World Health Organization (2002), in the Toronto Declaration, in which Québec (a province of Canada) has been slightly amended by adding the notion of intention to the *Governmental Action Plan to Counter Elder Abuse* (PAM 2017–2022).

> Mistreatment is a single or repeated act, or lack of appropriate action, occurring within a relationship where there is an expectation of trust, which causes harm or distress to an older adult, whether the person deliberately wants to cause harm or not. (Government of Québec, 2017, 15)

There are seven types of mistreatment, whether it involves violence or neglect: psychological, physical, sexual, material and financial, violation of rights, institutional and ageism (Government of Québec, 2017).

Estimating the Scope of the Problem

A meta-analysis of 52 studies, carried out by Yon et al. (2017), estimates that the annual prevalence rate for the mistreatment of older adults living at home is 15.7%. This means that each year, one out of every six people aged 60 or over, living at home, will experience mistreatment. Mistreatment of older women is often considered as representing a pattern in the context of intimate partner violence (Lundy & Grossman, 2009), which raises questions, because this does not become mistreatment just because a woman crosses the threshold for old age, set at 50, 60, or 65 years of age depending on the country. Yon et al. (2019), through a systematic review and a meta-analysis of 50 studies on prevalence, published between 2002 and 2015, on the mistreatment of older women (60 years of age and older) living in the community, estimate its prevalence at 14.1%, which represents just over one out of seven older women. The similarity of the rate of mistreatment for all genders combined and that for women specifically may seem surprising. It might suggest that there is no specificity based on gender. We will touch on that later. These two prevalence rates are merely the tip of the iceberg, because in addition to the methodological challenges posed by the fact that there is no gold standard for measuring the prevalence of mistreatment, there are obstacles in terms of screening, reticence in denouncing

professionals, and the attitudes of older adults themselves (Cooper et al., 2009; McCool et al., 2009; O'Brien, 2010; Yaffe et al., 2008).

Ascertaining the Obstacles and Incentives for Older Women in Requesting Help

There are few research papers that give women a voice in specifying what prevents or encourages them to ask for help when they find themselves in a situation involving mistreatment. In order to gain a better understanding of the obstacles to, and incentives for, asking for help, a review of the international literature, of the type that assesses the scope, was carried out. It covers the period from 2006 to 2018, in ten English-language data banks[1] and four French-language data banks,[2] all computerized, using the words "denunciation," "mistreatment," and "older adults" together, as well as their synonyms. No exclusion criterion was specified regarding the type of reference (periodic, volume, dissertation, thesis, etc.).

True to our epistemological stance aimed at acknowledging the expertise of older adults, and more specifically older women, only publications that would indicate giving older adults a voice regarding the obstacles to, and incentives for, asking for help in the context of mistreatment (future or past) were examined. Thus, any that dealt with the points of view of professionals were rejected.

In total, 33 publications that gave older adults a voice on the subject of obstacles to, and incentives for, asking for help in the context of mistreatment were listed. In 20 of these publications,[3] the older adults did not have to have experienced mistreatment in order to participate in the research. It was their perception, their perspective, their conceptualization or their point of view on the subject that was sought, rather than their personal experience of mistreatment. Thirteen publications focused on giving a voice to older adults who had been mistreated.[4] For the needs of this chapter, we are only considering those that referred specifically to requests for help by older women, along with a few comparative nuances with the data on older men.

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[1] Abstracts in Social Gerontology, Ageline, CINHAL, Eric, Francis, Medline, Pascal, Social Work Abstracts, SocINDEX, PsychInfo.

[2] Eric, Francis, CAIRN and Érudit.

[3] Aday et al., 2017; Anand et al., 2013; Brank et al., 2012; Buri et al., 2006; Chang, 2018; Charpentier & Soulières, 2013; Dakin & Pearlmutter, 2009; Dong et al., 2011; Gibson, 2013; Knight et al., 2016; Lai, 2011; Lee et al.,2014a Lee et al., 2014a; Lee et al., 2011; Lichtenberg et al., 2016; Lichtenstein & Johnson, 2009; Mysyuk et al., 2016; Roger et al., 2015; Shilling & Myers, 2016; Ziminski & Rempusheski, 2014.

[4] Band-Winterstein, 2012; Hightower et al., 2006; Jackson & Hafemeister, 2012, 2015; Lafferty et al., 2013; Lichtenstein & Johnson ,2009; Madhurima, 2008; McGarry & Bowden, 2017; Smith, 2015; Stonehouse & Scahill, 2012; Walsh et al., 2011; Yan, 2015; Zink & Fisher, 2006), of which 5 concerned older women specifically (Hightower et al., 2006; McGarry & Bowden, 2017; Smith, 2015; Stonehouse & Scahill, 2012; Zink & Fisher, 2006).

Table 1 Characteristics of selected research on obstacles to, and incentives for, asking for help in older adults who have experienced mistreatment

Studies	Country	Age	Total Sample Size	Data Collection Method	Sampling procedure
Band-Winterstein (2012)	Israel	62 + (women) 67 + (men)	15 couples (30 participants)	Face to face interview	Theoretical sample
Hightower et al. (2006)	Canada	50 +	64 women	Interview	
Jackson and Hafemeister (2012)	USA	22–70 60–94	71 APS caseworkers 55 victims	Interview	Convenience sample
Jackson and Hafemeister (2015)	USA	22–70 60–94	71 APS caseworkers 55 victims	Interview	Convenience sample
Lafferty et al. (2013)	Ireland	65 +	32	Semi-structured interview	Purposive sampling
McGarry and Bowden (2017)	UK	50 +	5 women	Workshop	Purposive sampling
Madhurima, 2008	India	65	5		
Naugthon et al. (2013)	Ireland	65 +	2021 (survey) in 2010; of this number, 120 older adults experienced mistreatment	Face to face interview	Cluster random sample
Smith (2015)	USA	62 +	15 women	Interview	Theoretical sample
Stonehouse and Scahill (2012)	USA	71	1 woman		
Walsh et al. (2010)	Canada		40	15 focus groups 1 individual interview	Purposive sampling
Yan (2015)	Hong Kong	60 +	40 Chinese (26 women/14 men)	Interview	
Zink & Fisher (2006)	USA	55 +	995 women	Questionnaires	

Sources: *Requesting help in the context of an experience of abuse: a voice to older women.* Doctoral thesis (in progress): Sherbrooke University

Table 2, in the appendix, presents the characteristics of the research in which the participants were given a voice as people who had experienced mistreatment.

Determining the Obstacles to, and Incentives for, Asking for Help in the Specific Context of Mistreatment of Older Women (N = 8 Articles)

The eight articles dealing specifically with older women were given an in-depth analysis. The findings from these articles were compared to those based on sampling that included both genders. Certain authors, who raised the issue of the lack of gendered analysis in research on aging (Bawin-Legros & Casman, 2001; Yon et al., 2019) or the lack of attention paid in the research to violence toward older women (Harris, 1996; Philips, 2000), mentioned important elements that need to be taken into account in the case of older women. The latter were socialized and educated according to the social gendered standards of their era, thus different from those of today. These days, the fact that an older woman refuses to talk about an incidence of mistreatment or to ask for help may, among other things, be explained by the importance given to the notion of "private life" (McGarry & Bowden, 2017; Zink et al., 2003), which is also characterized by a form of culture of silence (Zink & Fisher, 2006) and loyalty to a life partner or family members (Roger et al., 2015). In brief, many of these women keep their secrets to themselves, because what happens in the family must stay in the family.

Generally, research works specific to women identify the same obstacles and incentives as those that deal with men or both genders. Nevertheless, one research study examines the experience of low-income mothers living with a problem child (e.g., behavioral issues, mental health issues) and provides a better understanding of the point at which their request for help can become distressing, even impossible (Smith, 2015). In certain cases, the removal of the child from the home may lead to the mother's own relocation to a care home or to their child becoming homeless (Smith, 2015).

In 2006, in a research study on women who live in or have experienced situations of mistreatment, Zink and Fischer noted that they usually open up to "another person" whom they trust, someone other than an official intervener such as a physician, a member of the clergy or the police. This then goes back to the importance of informal support networks, perhaps mutual aid, where women can be heard and accompanied when reporting the mistreatment or asking for help. To our knowledge, this avenue has not been studied, so this poses the question of the number of women who talk about situations of mistreatment with no expectations of the person with whom they share this confidence. However, even though this act may not be documented because it does not represent the start of an official intervention, whether psychosocial, police-based, or other, it can represent the start of a request for help. A better understanding of what encourages or precludes an older person from talking about a situation of mistreatment they have experienced would promote the use of incentives in terms of prevention. Scientifically, this poses the question of what approach to take to help older adults reveal the extent of the obstacles and incentives that may result in the simple act of opening up, or not, to others.

In the study by Lafferty et al. (2013), one participant explains that it was only when she was hospitalized, following incidents of mistreatment by her life partner that she understood that she could access the appropriate services. The fact that women do not understand or recognize that what they have experienced is mistreatment represents a major barrier to asking for help (Lafferty et al., 2013). Add to this the fact that women are unaware of the services available and have difficulty accessing them (Aday et al., 2017; Lafferty et al., 2013; Shilling & Myers, 2016; Yan, 2015).

Conclusion on the Status of Knowledge for All Genders Combined

In order for older people to recognize themselves as mistreated, they must have some knowledge about mistreatment. This knowledge is key in the decision-making process in making them aware of the situation and asking for help (Yan, 2015). Moral and emotional support from family, friends, volunteers, and professional services represents a major incentive for older adults to talk about their situation (Lafferty et al., 2013). This social network can become the factor that allows an older adult to acknowledge that they have been mistreated and for that network to be in a position to support them and refer them to an appropriate resource (Yan, 2015). Thus, it is important that everyone be able to recognize a mistreatment situation and then be capable of referring the mistreated person to the right people, to the appropriate authorities.

The connection between the abuser and the mistreated older adult influences whether the older adult asks for help or not. For example, certain older mothers consider the aggressive behavior of their adult child as a violation of their rights. In this type of situation, the older mistreated woman will act and ask for help, including from the police (Smith, 2015). Other older women will refrain from acting, giving their maternal role as the rationale for the decision and the fact that they do not wish to act in a "heartless" way, as they themselves describe it (Smith, 2015). Finally, the length of time between recognizing a mistreatment situation and denouncing a third party is longer when the older adult has known the protagonist of the mistreatment for a long time (Jackson & Hafemeister, 2015). In contrast, the delay between awareness of the mistreatment situation and denunciation will be shorter if the older adult has only known the protagonist for a short while, if there is a lack of closeness or if the relationship can be characterized as superficial (Jackson & Hafemeister, 2015). This may explain, in part, why it may be difficult to denounce a family member. The choice of vocabulary during data collection could influence the answers given by the participants. For example, denouncing or reporting such a situation generally means the act of telling official authorities such as the police or the courts. A request for help, on the other hand, is more the act of telling another person, whether or not that is an official authority, for the purpose of getting help, support, advice, etc., in order to put an end to an undesirable situation.

Methodology

Research Design

The research method selected uses a phenomenological qualitative approach that promotes giving a voice to the participants, who are considered the experts about their own experience. The purpose of choosing scientific phenomenology is to look for the scientific essence (significance) in detailed descriptions of specific experiences by people who have lived through them—contextualized meanings dependent on the perspective of the researcher's discipline. The search for scientific essences or meanings involves five steps (Giorgi, 1997): (1) collecting verbal data; (2) reading the data; (3) dividing the data into units; (4) organizing and interpreting the raw data in the language of the discipline; and (5) summarizing the findings for the purpose of communicating them to the scientific community.

Recruiting Participants

Selection criteria were not established for the form or type of mistreatment experienced. This choice simplified the recruitment of older adults who agreed to talk about their situation with the researcher. It allowed for a richness of information in the stories told.

At the start, the thesis project was looking to recruit anyone interested in talking about mistreatment—those who had personal experience as well as those who had witnessed it. In specifying the theoretical framework, the objective of the thesis was narrowed down to focus specifically on a better understanding of the request for help by people who have experienced mistreatment as older adults. The initial contact with each potential participant took place over the phone following a precise protocol, previously submitted to and accepted by one ethical board of the Sherbooke University. A second objective of this protocol was to explain the objectives of the thesis to each of the potential participants. The first five women contacted, and who had experienced mistreatment, agreed to participate in the data collection. Thus, the choice was to start interviewing these five women and then to reflect on the need to recruit men or other women to complete the data collection. This decision was also based on the fact that the sample size in a phenomenological device can vary between 5 and 25 participants (Creswell, 2013; Polit & Beck, 2011; Polkinghorne, 1989), until theoretical saturation has been reached.

Table 2 Socio-demographic data on the participants in individual interviews

First name*	Age	Civil status	No. of children	Education	Living environment
Suzy	77	Widow	3	12th grade	Co-owner
Mary	75	Spinster	0	University	Seniors' home
Debbie	73	Divorced	2	12th grade	Apartment
Michelle	73	Widow	2	12th grade	COOP seniors' housing
Evelyn	71	Divorced	1	University	Apartment

*First names are fictitious
Source: *Requesting help in the context of an experience of abuse: a voice to older women.* Doctoral thesis (in progress): Sherbrooke University

Sample Characteristics

The sample consists of women in their seventies aged between 71 and 77. Two are widowed, two are divorced, and one is a spinster. Each lives alone and is not in a couple relationship. They are educated; three completed high school and two have university degrees. Two of them live in group home environments and the other three in apartments or condos. The following table presents the participants (Table 1).

Data Collection

Data were collected from semi-directed individual interviews and a short socio-demographic questionnaire. Following an initial phase of in-depth analysis of the data, the findings—the significance that women attributed to asking for help in a context of mistreatment as older adults—were shared with the same participants in second, non-directed interviews. An interview protocol for this second interview was not established. Each participant was given the opportunity to discuss the subjects they wanted to learn more about.

Findings

The data analysis used the methodology put forward by Giorgi and revealed the significance that older women attribute to asking for help in the context of mistreatment. For them, it is the result of a life journey in which they made various requests for help for which the responses had been both positive and negative and which had left their mark and consequences on their lives. These marks and consequences resurface whenever they acknowledge living in a situation of mistreatment and they begin a process of reflection. However, a process prior to the data collection provided

a better understanding of what had already been learned from the scientific literature in order to elicit this significance attributed to asking for help.

Rather than a preestablished plan, the conceptual framework was constructed from a summary of knowledge resulting from the review of the literature. It presented the main elements to be studied, and expanded as the research continued. Figure 4.1 presents the conceptual framework based on the scientific literature.

The phenomenological timeline represents a period of time relative to the situation of mistreatment described by the participants. *Before* represents the participant's daily life. This represents an older adult characterized by their intrinsic factors (personal strengths, weaknesses, etc.) and extrinsic factors (family/social network, etc.). This is where the trigger kicks in: actions, gestures, words, or even the lack of appropriate action. Once the older adults become aware of their situation, they consider themselves as being in a situation of mistreatment. This is why their status changes inside the circle. The intrinsic and extrinsic factors change with each phenomenological time period. Once they become aware of the situation, it is assumed that older adults will begin to question themselves about the possibility of asking for help in order to put an end to the situation.

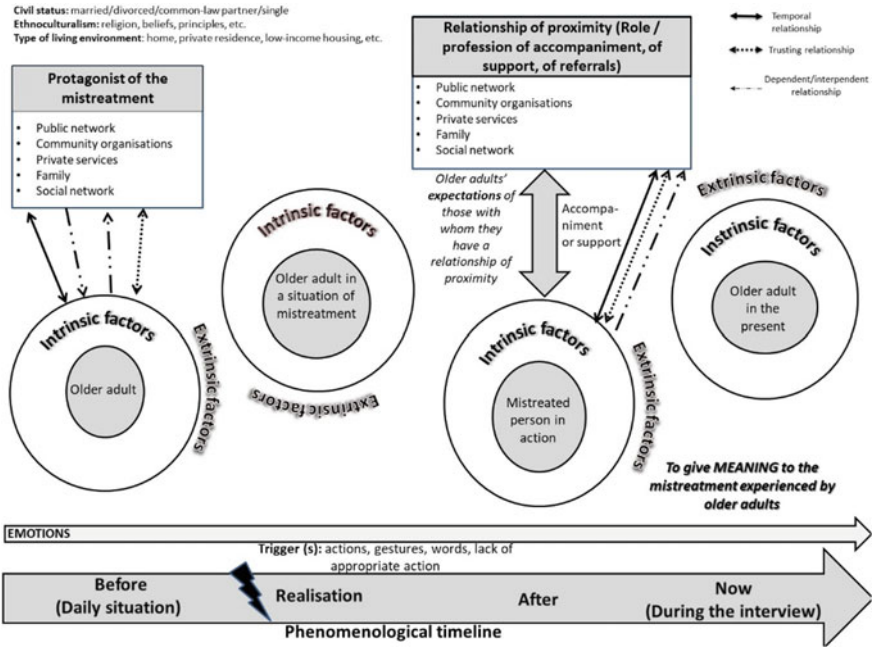

Fig. 4.1 Conceptual framework based on the scientific literature: the significance attributed to the mistreatment experienced by older adults. Sources: *Requesting help in the context of an experience of abuse: a voice to older women.* Doctoral thesis (in progress): Sherbrooke University

In terms of the relationship of proximity with a mistreated person, three specific relationships are identified: temporal relationship (new relationship or long-term relationship), trusting relationship, and dependent/interdependent relationship. Finally, the emotions experienced also change in accordance with the different phenomenological timelines.

Data Collection Findings

Risk and Protection Factors in Older Women

When the participants themselves identify risk factors to explain a situation of mistreatment, this supports the premise put forward by Yan (2015) who states that certain older adults mistreated by a family member say that they are not mistreated but instead speak of family conflicts or personality disorders.

Other findings support the scientific literature in terms of risk factors: the characteristics of the mistreated person (Beaulieu et al., 2018b) were mentioned several times in the stories told by the women. Debbie described her daughter as having character and with whom she had to learn to set limits in order to be respected. While she was having her functional autonomy evaluated in an institutional setting, it was her daughter who made all the decisions for her without any professionals checking with Debbie as to whether she agreed with these decisions. She said, *"My daughter had a lot of power and they put her very much on a pedestal. So I said to myself, what am I going to do?"* It was difficult for her to assert herself, as she believed this would anger her daughter. In Mary's case, the mistreatment was perpetrated by her three daughters, who all had different personalities. She described one of them as manipulative:

> I was a bit lost, I'd never been alone before in my whole life... And then, it occurred to me that she was being manipulative. Especially since I arrived here, I see her true nature. I understand her true nature. So I'm never going to trust her again. Never, never, never.

Evelyn stated that it was her son who mistreated her. She excused his actions by saying that he had mental health issues. The research published by National Initiative for the Care of the Elderly (NICE, 2015) also identified mental health issues in the abuser as a major risk factor. Here is what Evelyn said:

> It has to do with my son. I just have one boy. In 2015, at that moment, it was Christmastime. He came to see me, but it would have been like that for a while, the relationship with him, it was very difficult because he's a boy who is hypersensitive about everything. And I would say that he isn't aware of it, but he suffers from mental illness. I would say he's bipolar.

Michelle gave some significance to asking for help by referring to certain factors for protection. For example, she talked about her late husband during the interview to describe her wonderful life with him and their children and that she had never experienced mistreatment. Twice during the interview she stated that she had not

deserved to be mistreated: "*This makes me very sad. I don't think I deserved that.*" (19 min and 34 s) and "*Because it seems to me I didn't deserve that."* (50 min). In fact, Michelle does not understand how a woman who was her friend could have become intimidating, abusing her verbally and psychologically in front of witnesses. Among other factors for protection, Michelle refers to her ability to ask for help; she asked someone responsible from the neighborhood, and at a regional organization devoted to countering mistreatment. Finally, she acknowledged the sadness that she felt, the physical consequences (fatigue, increased pain from arthritis, etc.), and her desire to remove herself from this situation.

Obstacles to, and Incentives for, Asking for Help

When telling her story, Debbie mentioned having experienced different types of mistreatment, such as the violation of her rights, and psychological, organizational, and physical mistreatment. These different types of mistreatment were committed by numerous perpetrators—her daughter, and healthcare and social services professionals. She described her relationship with her daughter as "complicated." She did not dare talk about her daughter's behavior to the professionals in the institutional setting, because she believed she would be moved to a long-term care home. She said: "*When I was 60 years old, she wanted to place me. So I need to be careful, if ever I don't feel well, I don't want that to be used against me."* Debbie constantly believes that her daughter will punish her if she denounces her or if she tells someone. She believes that her daughter is making plans to have her moved against her will. Here too, the scientific literature supports these findings. In fact, the belief that she will be institutionalized (Aday et al., 2017; Shilling & Myers, 2016; Ziminski & Rempusheski, 2014) is the greatest obstacle for her. Due to her lack of trust (Jackson & Hafemeister, 2012) in herself and in her abilities, it took her some time to realize that she had the necessary skills to complete the assessments with the objective of returning home to live. Debbie also felt that the professionals were not listening to what she wanted to share with them, which led to difficulties accessing help and support from a service (Jackson & Hafemeister, 2012), until she spoke to a trusted geriatrician. The latter took a stand with the care team to have Debbie's choices respected, which rekindled her hope that the problem could be resolved (Dakin & Pearlmutter, 2009; Jackson & Hafemeister, 2012).

Just like Debbie, Mary experienced several types of mistreatment: violation of rights, psychological (verbal and financial) mistreatment, and abandonment. Mary, in addition to experiencing numerous episodes of mistreatment and violence during her life, was also mistreated by her three daughters, and the situation persisted over time with two of them. Whenever she tried to attribute significance to asking for help, Mary referred to previous requests for help to which she had received negative responses to explain why she had not asked for help as an older woman. She described a serious sexual assault by an employer while she was a young adult. When she confided in her mother, the latter advised her to put up with the situation, at least until she had found another job. She also described another situation where the priest with whom

she had shared her difficulties in married life told her that she should tolerate this situation because she had "married for better and for worse." When the findings were presented, Mary allowed herself to describe other anecdotes from her life in which she questioned her future. We will return to that later. These elements illustrate that women of this era were expected to obey their husbands. When she became aware that she was experiencing mistreatment by her three daughters, Mary also understood that she did not have the knowledge to recognize what she had experienced, which represents an obstacle to asking for help that is identified by several authors (Jackson & Hafemeister, 2012; Lai, 2011). In fact, she stated: *"I don't see it as mistreatment. They weren't nice to me."* In the first semi-directed interview, Mary was clear that she did not wish to ask for help with the situation she was experiencing and at risk of reliving, because her daughters did not change when she told them. A volunteer gave her the contact information for an organization working to combat mistreatment and explained that she could find support and accompaniment there, if necessary. By the time the validation interview took place several months after the initial interview, Mary had made some progress. In fact, in September 2017, she had stated that she no longer wished to ask for help because of the bad experiences she had had when she asked previously. In February 2018, she mentioned receiving unofficial support from her grandson on whom she could count in case of aggression by another person. As numerous authors note, trust toward a specific person becomes an incentive for asking for help in a situation of mistreatment (Gibson, 2013; Jackson & Hafemeister, 2012; Lafferty et al., 2013).

For her part, Suzy spoke of her worry about retrieving money loaned to a "supposed" friend. She told this to her financial advisor who proved to be a vigilant individual. Suzy did not consider the situation as being mistreatment because she trusted the man who had asked her for the money. This trust connection is also a key factor in the WHO's definition of mistreatment (2002). Before deciding to ask for help from a community organization in her region, Suzy experienced a range of emotions such as shame (Lee et al., 2011, 2014a, 2014b; Smith, 2015) in not having understood the situation before, and of having allowed herself to be deceived, which are obstacles to asking for help identified in the scientific literature. In her life story, Suzy had previous positive experiences with asking for help, so her interactions when asking for help were therefore on a strong footing. The findings in terms of incentives for asking for help are also supported in the scientific literature. In fact, Suzy identified several of them: hope of finding a solution (Dong et al. 2013); having a good knowledge of the real signs of mistreatment (Naugthon et al., 2013; Yan, 2015); hope of finding money that's been lost (Jackson & Hafemeister, 2012, 2015; Knight et al., 2016); feeling of trust (Gibson, 2013; Jackson & Hafemeister, 2012; Lafferty et al., 2013) toward the financial advisor and the coordinator of the regional organization working to combat cases of mistreatment; feeling of relief (Gibson, 2013; Zink & Fisher, 2006) and of injustice (Gibson, 2013) because the money involved was what she had put aside for living comfortably in retirement.

Michelle experienced a complex situation while making an appointment over the phone that she qualified as psychological and verbal mistreatment. When telling her story in the interview, she herself admitted that she had experienced intimidation

instead. Thus, Michelle had knowledge about mistreatment and was aware of the situation from the first time it happened with her former friend, in whom she had placed her trust. Michelle quickly identified the situation and asked for help. However, the requests for help that she made to stop the abuse had consequences for her daily life.

> I spoke to the [manager of seniors housing COOP] about it and he went to talk to her. Mr. X does not mince his words, he spoke to her and she said, "So, you went and complained to Mr X! You went and cried on Mr. X's shoulder!" He told her to be careful and respect others, but nothing much happened, I think that was worse.

While these retaliatory measures in the literature (Aday et al., 2017; Brank et al., 2012; Charpentier & Soulières, 2013) represent major obstacles, Michelle did not give up, because she felt that the situation would never stop (Yan, 2015); she had strong hopes for a solution (Dong et al., 2013) and she recognized that what had happened to her was unjust (Gibson, 2013). Suzy feels that the incentives were stronger than the obstacles, despite the various unfruitful requests for help made previously for this same situation.

While telling us about her life, Evelyn said she had experienced various situations of mistreatment and conjugal violence. The psychological mistreatment by her son happened over a period of time. She revealed quite clearly that the biggest obstacle to asking for help had to do with her relationship with the abuser: her son, her child, her family.

> It's because of love. I would say I still love my son and I respect him. Basically, I respect what happens to him because I figure I won't be able to help him if I call the police, and calling the police won't do anything. In my opinion, it's an authority that he just would not accept, not at all, it would merely make things worse. I really feel it would make things worse. Now it's true that he could be to blame, but I don't want to blame him.

In attempting to find significance in asking for help as she could have done, Evelyn identified several obstacles that are also mentioned in the scientific literature: her son is a child with limited resources (Jackson & Hafemeister, 2015; Smith, 2015; Ziminski & Rempusheski, 2014); she wants to avoid putting him in the hot seat (Brank et al., 2012; Charpentier & Soulières, 2013; McGarry & Bowden, 2017), she wants to find a solution other than the police (Brank et al., 2012; Lichtenstein & Johnson, 2009) and alerting the authorities would worsen the situation. On several occasions, she stated that she gave her son a chance to seek counseling, because she still hopes he can change with help (Gibson, 2013), which also represents an incentive for asking for help in the literature. During the interview to validate the findings, Evelyn had a different view of the situation. She clearly stated that her son had had his chance and that at her age she had the right to say "no" to his mistreatment of her.

Creating the Narrative

The women chose to be interviewed on their own at home. They gave themselves some downtime, time in the "here and now," to tell their stories. In their attempts to give significance to asking for help in a context of mistreatment as older women, they made the journey through their lives and made stops at specific moments in time. The theoretical framework used in this research allowed the participants to explore the different time periods as phenomenological time periods, time periods that were part of their own experiences across various modes such as now, before, after, one after the other, etc. (Husserl, 1985).

While the initial question for the interview protocol targeted the mistreatment experience directly, four of the women traveled through phenomenological time to speak about other experiences that they associated with their instances of mistreatment as older women. One of the women returned to the past instead, to describe her experience with her husband and children without any history of violence or mistreatment. Although it is impossible to generalize, given the sample size, the result of this research suggests an exploration of the possibility that women who live with mistreatment, conjugal violence, or difficult relationships in their life journeys are at greater risk of experiencing mistreatment when they are older. This comprehensive hypothesis is corroborated by research that incorporates the life journey into the study of mistreatment in older adults, which concludes that the fact of having experienced mistreatment at some point during their life (childhood, adolescence, adulthood) constitutes a risk factor for mistreatment as an older adult (NICE, 2015).

While telling their stories, two women said they had experienced mistreatment by their parents and/or their siblings during childhood; two others spoke of conjugal violence as adults, and one participant also as an older women; one of them said she had experienced major difficulties in her relationships with her father and brother, which she said was due to the fact that she was born a girl. Suzy stated that her father had disinherited her, because she did not conform to the image of a conventional woman of that era because she studied at university, had a professional career that gave her sufficient income to live independently, had never married and had no children. In terms of conjugal violence, Debbie said she had dated men who were alcoholics and violent; Mary stated she had married a gambler, an alcoholic and a *skirt-chaser*. The women recalled their fathers and other men when they made connections between the current episodes of mistreatment and other previous episodes in an attempt to give significance to a request for help as older women who had experienced mistreatment. As adults, these women had conformed to the expectations of western society: submissive, gentle, and able to adapt (Léonard, 1982, cited in Morneau & Spain, 1989). Today, these women have a life history with partners, children, friends, neighbors, etc. They have evolved and adapted over time, even though as young people their education had probably not prepared them for these changes in their roles (Morgan 1983, cited in Morneau & Spain 1989).

The recollections of these older women led to reflecting (Descheneaux, 2012) on the past, which became a perceived element (Barbaras, 2015). At the time that they told their stories, they were able to put into words their experiences and the factors

related to risk, vulnerability, and protection with which they identified. In their reflections, the women were able to recognize elements that characterized them prior to experiencing the mistreatment, when they realized what they had experienced and thus determined their own evolution over the phenomenological time span defined by the various experiences of mistreatment. Their experiences allowed them to imagine themselves in various situations and thus give themselves an idea of what they would do if such a situation occurred again (Descheneaux, 2012). After having told their stories of mistreatment through their recollections in order to attribute significance to asking for help as an older adult, these women thought more deeply about them and promised to ask for help should such a situation occur again. They were able to identify the people to whom they would turn to talk about what they were experiencing. The notion of trusting a person or an authority that could listen to them, accompany them, refer them, etc., was the most important incentive for each of the women.

Final Conceptual Framework

As a result of the meetings with each of the women and the presentation of the findings in this chapter, it is possible to establish the importance of the phenomenological timeline in their stories. Based on their life history, they are able to give meaning to what they have experienced as older women. The decisions made today are connected to the events that occurred in the past, at different times in their lives, and the consequences of those events. Thus, the following figure presents the final conceptual framework, as it was provided to each of the participants. It helps answer the research question: What significance do older adults attribute to asking for help in a context of mistreatment? *The significance older women attribute to asking for help is the result of a life journey that includes experiences endured and a unique combination for each woman of obstacles to, and incentives for, asking for help, presented to them once they recognize the situation of mistreatment.* The curved arrows express the process of change that each of the women experiences, which they revisit when sharing their life stories over the course of the phenomenological timeline (Fig. 4.2).

The significance attributed to the experience of mistreatment is influenced by the accompaniment or support received in the relationship of proximity and also as a result of a request for help made at a specific moment in the life journey. This attributed significance takes into account the intrinsic and extrinsic evolutionary characteristics of the women at different times in their life journeys.

An in-depth reading of the individual interviews elicited "traces of a past influenced by value judgments, descriptions of a present influenced by evaluations, anticipations of a future influenced by conditions of possibility or desirability" (Demazière, 2007, 7). Over the course of the data analysis, temporal markers were incorporated—markers that allowed older adults to attribute significance to the situation that they had experienced (Demazière, 2007).

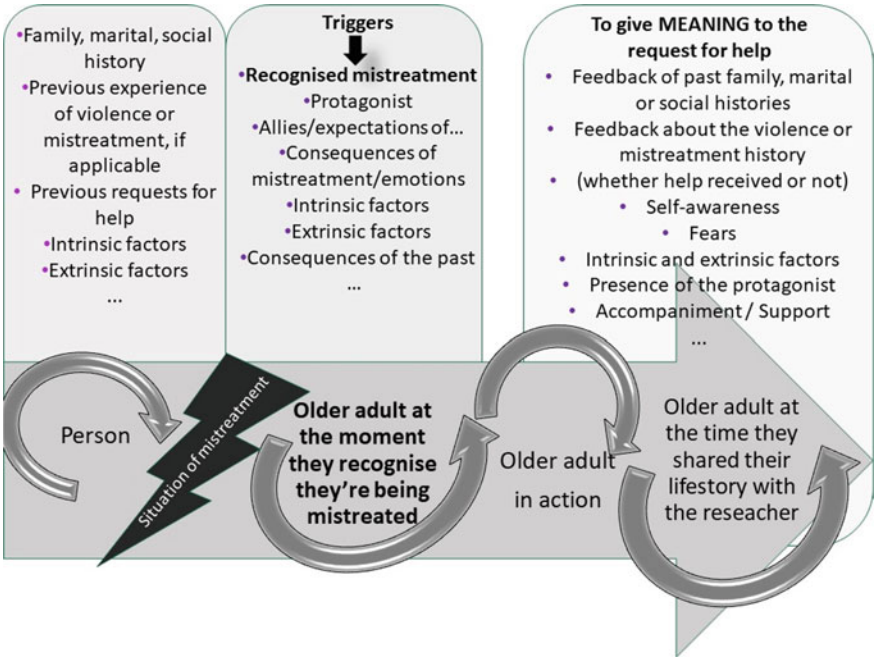

Fig. 4.2 Significance attributed to asking for help in a context of mistreatment of older women. Sources: *Requesting help in the context of an experience of abuse: a voice to older women*. Doctoral thesis (in progress): Sherbrooke University

This notion of timelines allowed for a better understanding of the data collected in the sense that it brought to light the significant elements in the older participants' discourse when compared to their experience. The framework gives us a better understanding of a person's life story, helps in exploring past events that may have left marks, in understanding the woman that she was and that she has become, in getting to know her allies, her factors for protection, etc. From the narratives told by each of the women, it is now possible to identify the elements that may represent workable pathways for them so that they open up about their suffering. In this way, more can be learned or relearned in terms of asking for help from the appropriate resource in order to obtain a satisfactory response.

Validating the Findings

Validating the findings with the participants elicited a variety of reactions. For example, Debbie asked for a copy of the figure, as she had seen her contribution to the work there, her involvement in the research project. When the figure was presented, the elements chosen in each of the participants' stories had been placed

in its context. The women were aware of the importance given to their stories, to the facts they chose to express in trying to gain a better understanding of the choices they were making today. While listening to the presentation of the findings, Mary expressed surprise at having provided so many anecdotes from her life. A review of the statements she made during the initial interview led her to conclude that she no longer wished to dwell on the past, that she wanted to turn the page permanently. She also recognized that being so open about her past, from her childhood through to today, had evoked memories that she had thought were long buried. She confided that in the initial interview, she recalled events described every evening when she went to bed. At the end of the meeting, Mary was thanked for divulging as much as she had. The consequences of her participation had been impossible to anticipate, but the price paid was heavy for a woman who merely wished to help a student complete her doctorate. The audio-digital recording was terminated at the end of the validation interview. For Mary, this was the moment when she was exposed for a second time, at the moment when the figure in paper format was being offered as a thank you for her participation. She refused the copy, giving as a reason that it represented the life that her mother had stolen from her and that now she wished to be at peace with her past. Even though during the initial interview she insisted that she had never asked for help, she added a nuance at the end of the second interview, when the recording was halted. She explained that on several occasions she had visited a psychic, who repeatedly told her that everything was going to get better. This comforted her and gave her the strength to endure the situation, the marriage, the unfaithful husband, the difficult children, etc. She had also consulted her priest but the response received, which was referred higher up, left scars, and questioned the legitimacy of older women today asking for help, especially for problems experienced within a couple relationship.

Again during the presentation of the figure, Evelyn explained that the findings were related to her personal experience and her life story: *"This couldn't have been done any other way, because we operate as a whole."* In order to properly understand the decision-making process and behaviors of an older person in the context of a given situation, it is important to know their life story, because the significance that they attribute to that situation will depend on their perception and their viewpoint when they experience it on a daily basis (O'Reilly, 2013).

For all the participants, a return to remembered awareness was a necessary step. By stimulating memories of experiences or promoting the recollection of events, participants thought more about them and were pushed to foresee (future already present) or anticipate that something might happen (Descheneaux, 2012). In summary, the participants were directed by their thoughts, allowing them to express how they were before and whether they would take the same or a different course of action if they experienced a similar situation today.

Discussion

Essentially, the woman spoke of psychological mistreatment in their experiences, by presenting it as linked to other types of mistreatment. This finding also matches the conclusions of a systematic review of the literature concerning older adults living at home (Yon et al., 2019). No matter the type or types of mistreatment discussed in the interviews, the relationship of trust, as described in the definition of mistreatment by the WHO (2002), was central to the thinking. This relationship of trust that exists between the abuser and the person being mistreated was the main barrier to recognizing some of the situations experienced by the older women.

Situations of mistreatment, as well as the types and forms of the experiences, differ from one woman to another. Abandonment was felt to be a type of mistreatment through the neglect experienced by Mary and Evelyn, who gave it a high level of importance when describing their experiences of mistreatment. They spoke of the scars left by this feeling of having been abandoned, and which they still feel today. Even though abandonment is not part of the terminology in Quebec for mistreatment toward older adults, the United Nations consider and characterize it as neglect (2002). The findings point to the importance of considering mistreatment in its entirety, by also seeking to understand the various fragments of the lives of women who have experienced it.

The "significance" sought, and attributed to asking for help by older women in situations of mistreatment, has a philosophical meaning, the essence of phenomenology. To elicit this meaning, the women reread all of their life journeys. This was an unusual task, a task of reflecting on themselves. The conversations that were collected provided a diagrammatic conceptual framework of the findings, such that the significance attributed to asking for help in the context of mistreatment of older women will depend on their life journeys, strewn as they were with specific moments that had either a positive or negative impact on the person, either in childhood, in adolescence, as an adult or as an older person. Within these journeys are earlier requests for help for all types of situations experienced; some met expectations, and others did not. The response, or non-response, to these requests marked the person's experiences and influenced what happened to them in later life. The significance attributed to asking for help belongs to a world of subjectivity, emotions, and feelings.

Recognizing that the five interviews shed light on the significance attributed to asking for help in a context of mistreatment, an approach from the perspective of gender was chosen to provide a second look at the research findings. The sample comprised only older women of the same generation, allowing them to be compared. The scientific literature suggests that men and women ask for help in different ways. Asking for help is socially acceptable for women, but represents a failure for men (Roy, 2012). The literature identifies several examples of reluctance to ask for help in a situation of mistreatment in men and in women, but some authors state that in women, this reluctance might be explained by a history of violence or by the fact that women, once they reach adulthood, have been socialized into roles considered as more traditional (Beaulieu et al., 2018a, 2018b). As already stated, Mary said she

had met with a priest (validation interview) to ask him for help and support. The priest's advice was that she should put up with the situation and respect her husband. This was a very normal response for the era in which a woman's request for advice was made, in which people married for life, no matter the vagaries of that union, and in which a divorced woman had no acceptable social status. Essentially, this was not what society expected of a woman. This was a response given by a man, who has never married, to a woman who is being abused, neglected and worried about what will happen to her young children. In these days, it is easier to focus instead on the asymmetry of this relationship.

As seen in this research, the focus is on the woman in the present moment, on what she is experiencing right now. The phenomenology used as a theoretical and methodological framework allowed a more in-depth look. By recounting their experiences as older women, they had the opportunity to go back into the past, into their histories, to create links between who they were then and who they are now and even who they will become in the future. They have a right to speak out without being judged and with no restrictions on time and place.

The five interviews with the women shed light on a whole facet of life that they had not even considered at the start. They allowed themselves to examine certain elements identified during the presentation of the findings to validate the need to incorporate this period of their lives into those findings. These elements were of great significance to them, and they were given the time to talk about and explain them.

Conclusion

While the scientific literature is full of material about the obstacles to, and incentives for, asking for help in a context of mistreatment toward older adults, little of the research has given a voice to those who have actually experienced this mistreatment. Obstacles and incentives are generally discussed without considering the gender of the person consulted, while the authors state that the request for help is experienced and made differently depending on whether a man or a women is involved (Beaulieu et al., 2018a). This research, based on a sample of five older women, explores the obstacles to, and incentives for, asking for help for a woman who experiences mistreatment after the age of 65, which is the usual retirement age in Québec. The findings highlight the importance of knowing just a little about people who may decide to ask for help to put an end to a situation of mistreatment.

The distinctiveness of this thesis comes, among other things, from the fact that it answers the question that should have been raised: What does asking for help by an older woman signify? Understanding the significance of this point of view of a woman who has experienced such a situation is to comprehend every aspect of this woman, her history, and her culture.

The analysis of the data collected showed that four of the women recruited recognized that they were experiencing mistreatment only when a third person expressed

to them what they themselves were experiencing. This finding led to some reflection about the influence of witnesses to situations of mistreatments and also about the people who are told of these situations in confidence by a friend, neighbor, another resident, a user of their services, etc. These witnesses need tools so that they know how to get the person to understand what they are experiencing, without pressuring them. An older woman may be outraged or embarrassed when she realizes that her own son is stealing her money or she is being psychologically abused. Once she does acknowledge it, she needs to know that she will be able to receive help or support at her own pace and of her own choice (to either ask or not ask for help), as long as her safety is not compromised.

This research refines what is understood by the concept of "asking for help." Must the request always be clearly formulated, or is the simple fact of telling someone else about it the best way to express the request? In our research, the women opened up to a third party, they trusted that this person would listen to them, understand their story, and eventually, offer solutions. Thus in our opinion, asking for help begins with the act of talking about it without it needing to be clearly formulated as a request.

Among other avenues to explore in encouraging women to liberate themselves from the silence or the secret surrounding what they have experienced, they need to be told about the different options for asking for help. There are many possibilities, from telling a friend about it to making a formal report to the police. Anticipating the legal consequences deters many women from denouncing their abuser. In order to open up about the situation, older adults need to be reassured about the benefits of doing so for themselves, and also for the abuser, who oftentimes is a major source, perhaps the only source, of support. An older women experiencing a situation of mistreatment needs to feel protected and reassured that everything will be done to limit the negative impact on her quality of life and possible reprisals on the part of the abuser or their network.

In conclusion, the participants navigated their way as women in a society influenced by patriarchal values, each following their own course. Today, they are living with the consequences of past events and their choices in life. Yet the current literature still puts too much emphasis on the differences between older men and older women. In Québec, at 65 years of age, people become part of the seniors' group (Bawin-Legros & Casman, 2001), often ignoring any reflection about similarities or differences in growing older as men or women. This research shows that it is impossible to make standardizations based on gender for people 65 and older. History has left its mark, as seen in the after-effects in the life journeys of older women because of discriminatory behavior in society and disrespect for some of their fundamental rights. In 2002, the United Nations acknowledged that the condition of older women right across the globe should become a priority and made a "commitment to gender equality among older persons through, inter alia, elimination of gender-based discrimination" (8). Nevertheless, it must be said that many societies are still influenced or guided by patriarchal values, violating the rights of women. This commitment remains a priority in attempting to reach as many women as possible around the world, to identify situations of mistreatment or those at risk of becoming so, much

earlier, and to help these women to open up about what they are experiencing, in order to improve the process of accompaniment.

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Chapter 5
Health and Well-Being in Older Women: A Universal Issue

Meena Yadav

Abstract Aging is a universal phenomenon, and it affects everyone. The chronological age is different from the biological age in many people, and thus people experience different health issues during aging which are influenced primarily by social and economic factors. Other than health-related issues, women face emotional, mental, and social issues. All over the world, the society is primarily patriarchal, and hence, women do not enjoy the social status as their male counterparts. The psychological, social, and emotional well-being of women plays a very important role in their overall health and well-being during later years of their life. In the UK, for most of the elderly women, menopause, depression, and mood changes are of more concern than other health issues like osteoporosis, incontinence, prolapse of the womb, problems in sexual life, and gynecological cancers. In the USA, women outlive and outnumber men, most elderly men are married while elderly women are unmarried and elderly women are poorer than men of the same age group within each race/ethnic group. In Africa, age and gender discriminations are the two most important concerns for elderly women which may lead to consequences such as poor health, disempowerment, victimization, or even death. Women in Asia are far behind in the social well-being when compared to their American or European counterparts. The reason for this could be intrahousehold gender disparities in Asia, especially South Asia, where women are considered to have second status. In India, the status of elderly women is still largely tragic, and there is a need to address the medical and socioeconomic problems faced by them. This chapter will focus on various social, emotional, psychological, sexual, and other health-related issues faced by elderly women globally and the measures taken/to be taken to address these issues.

Keywords Elderly women · Multimorbidity · Well-being · Gender disparities · Menopause · Geriatric syndromes

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Introduction

In the Western world, a chronological age of 65 years and above is considered as the old age, but the United Nations set the age of 60+ years as the older population (WHO, 2002a, 2002b). Within the old age also, UN has made categories like oldest–old (80+ years), centenarian (100+ years), and even super-centenarian (110+ years) (WHO, 2010). However, in most of the developed countries, the age at which people retire is considered as the beginning of old age while in developing countries when a person becomes incapable of contributing actively in social life, he/she is considered old. The number of elderly people is increasing at a higher rate in the South-East Asia Region (SEAR). In SEAR, the population of elderly people was 142 million in 2010 and is likely to reach 242 million by 2025, while the world population of elderly people will reach 1.2 billion by 2025 (WHO, 2010). In Japan, more than 30% of population consisted of people above 60 years by 2012, and it is expected that by 2050, 64 countries will have more than 30% people who will be above 60 years in age (Giridhar et al., 2012). According to the data from World Population Prospects: the 2019 revision, there is one person above 65 years of age per 11 persons in 2019, and this number will go up to one in six persons by 2050. In Europe and America, one in every four persons will be 65 years in age or above by 2050. Another, startling fact is that the number of old people (60+ years) will outnumber children below 5 years in age, and 80% of these people will be living in low- or middle-income countries by 2050. Also, the number of people of 80 years or above in age will become three times by 2050, i.e., from 143 million in 2019 to 426 million in 2050 (United Nations, 2019). Thus, there is a sharp increase in the number of elderly people than in the past. All the countries thus face major challenges in addressing the social and health issues due to the sharp shift in the demography (WHO, 2018).

Aging is a natural and normal phenomenon for any person who is born. WHO (2002) has defined active aging as follows:

> "the process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age including those who are frail, disabled, and in need of care."

WHO (2015) has further defined healthy aging as follows:

> "the process of developing and maintaining the **functional ability** that enables **wellbeing** in older age."

Healthy aging is the focus of the WHO from 2015 to 2030. Healthy aging has replaced WHO's previous concept of active aging. WHO (2015) has declared the time period of 2020–30 as the *Decade of Healthy Aging* and hopes that the governments, civil society, academics, media, and private sectors will come together to take actions to improve the living conditions of older people, their families, and the communities.

With time, body undergoes several changes that are constantly occurring at the cellular and molecular levels and may be manifested morphologically. These biological changes are significantly influenced by the environmental, social, and lifestyle factors. Some people age faster than others, although their chronological age might

be the same. People usually have different biological and chronological age, and this difference is reflected in the quality of life. Although both men and women face health issues in their old age, but women experience more difficulties than men which can be attributed to several factors like social, cultural, and religious practices. There are three key demographic changes that contribute to aging in a population, viz. decline in fertility, decline in infant mortality, and increase in the life expectancy. These factors cause demographic shifts which result in "**feminization of aging**." This shift is due to the decline in fertility in the developed countries as compared to developing countries. In countries like China, Cuba, and Uruguay, there is a decline in fertility, but in other developing countries like Bangladesh, Kenya, and Zaire, the fertility is high (Amarya et al., 2018). By 2012, women constituted 55% of the older population and a majority (58%) of them lived in developing countries (Giridhar et al., 2012). In India, according to 2011 census, at the age of 65, 70, 75, and 80 years' women outnumbered men by 1310, 1590, 1758, and 1980, respectively, per 1000 men, and by 2050, women above the age of 60 years will outnumber men by 18.4 million (Govt. of India, 2011).

The real problem for the governments would be to address the health and well-being of the ever increasing older population, especially older women. The concept of well-being is very broad and involves parameters such as self-contentment, happiness, and satisfaction from the social relationships and independence. Well-being not only concerns the idea of happiness for oneself but the views of others too. Thus, well-being is actually the interplay of an individual's feelings and their social environments (McNulty & Fincham, 2012). As the age advances, the well-being of older women is affected by declining physical health and less functioning (Halaweh et al., 2017).

Aging brings with it several complications for women. For example, they suffer from health issues, financial insecurity, high dependency on others, discrimination based on gender, providing care to other older members of the family, after the death of husband they have to bear harmful traditional and cultural practices and live alone. The needs of the older women are not fully attended to. Thus, gender hugely influences the quality of life of older women, and in most parts of the world, their issues are largely overlooked. Older women experience severe health problems and thus lead a poor quality of life (Tuohy & Cooney, 2019). Although most of the experiences of older women are adverse, there are some positive changes as well. For example, adults remain more stressed as compared to older people, but older women feel more satisfied and fulfilled as compared to their younger self (Giridhar et al., 2012). Due to rapid rate of increase of the aging population, it is a matter of grave concern for the countries to look after the older people and take necessary steps to ensure their healthy and successful aging.

Physical Health Issues in Older Women Across Continents

Some of the common health issues in older age are diabetes, cataract, depression, back and neck pain, arthritis, chronic obstructive pulmonary disease, dementia, and urinary incontinence to name a few. Such diseases that are characteristic of old age are referred to as **geriatric syndromes** (Rosso et al., 2013). Few countries have developed dedicated health care for geriatric syndromes known as geriatric medicine, but largely these syndromes are not included in the traditional healthcare services. Chinese men and women have the best health, and Caucasians also fare well in terms of health. However, men and women from Pakistan and Bangladesh have worse health than other ethnic groups.

Health Issues of Aging Women in America

By 2018, women represented more than half of the total population in USA, and generally they outnumber men. Women, who were 80 years or more, outnumbered their male counterparts by 2 to 1 (Daniel et al., 2018). It has been observed in USA that elderly persons suffering from chronic and disabling medical issues form a higher percentage of medical care users. Also, elderly people are frequent visitors to hospitals and clinics than younger generation and are hospitalized for longer durations than the younger people as they suffer from more health issues than younger generation.

Breast cancer is the most common form of health problem in the USA which affects the women of 65 years and above. Presbycusis or loss in hearing is another common problem in elderly people in USA, and around half of adults above 85 years have hearing impairment problem. By the age of 85 years, around 20% of people suffer from loss of muscle mass and strength, the two factors that affect mortality. Approximately, 50% of older women often suffer from asymptomatic bacteriuria, and the condition is more common in women who are hospitalized and are long-term habitants in hospitals. Older women also suffer from many somatic diseases in their fourth quarter of life like cardiovascular diseases, hypertension, cancer, osteoarthritis, diabetes mellitus, osteoporosis, and multiple chronic conditions (Jaul & Barron, 2017).

Thus, various geriatric syndromes in older women lead to many types of disabilities in them (Rosso et al., 2013). Older women suffer from other physical dysfunctions like their walking speed goes down, and if they have some disease it goes down further, inability to perform daily activities, falls leading to disability and mortality, etc. Urinary incontinence is another problem that the older women often face which could be due to overactive bladder, stress incontinence, and functional incontinence (Jaul & Barron, 2017).

Health Issues of Aging Women in Africa

The common health conditions faced by older women include osteoporosis, breast cancer, diabetes, arthritis, cardiac problems, dementia, and depression. The older women in South Africa generally suffer from whole body pain like pain in legs, back, hands or necks, and high blood pressure. Due to lack of money, majority of women do not go for treatments. However, they look for other methods of alleviating their pain like prayers in churches, taking random tablets from chemists, or some traditional medicines which are cheaper. In spite of the common problems of body pain and high blood pressure, the older women do not visit hospitals due to large distance of hospitals, distrust for doctors, and higher cost of the medical care. Majority of the families depend on the pension of the older members of the family for their survival. The family size is usually larger, say 7–8 members, so it becomes difficult for the family to spend more on the medical needs, especially of the older women (Schatz & Gilbert, 2012).

Sub-Saharan Africa faces threat from three major epidemic diseases: HIV, TB, and chronic diseases. There is a burden of communicable as well as non-communicable diseases. Depression is generally associated with other health conditions like diabetes, angina, asthma, and arthritis. The depressed people are more likely to use the healthcare services than those who are not depressed (Nyirenda et al., 2013).

Health Issues of Aging Women in Asia

The Asia Pacific region is also posed with the problem of "feminization of aging," and the region is not prepared to handle this. As per WHO report (2018), the life expectancy of women is 72.6 years as against men which is 66.2 years. Cancer has emerged as the most common health issue in elderly people in the region. If the woman is a housewife, was dependent on her husband and her husband dies, she is left alone in her old age. Due to lack of money, she has to compromise on her health issues, and this becomes a major disadvantage for her in her old age (Icamina, 2019).

In China, the rapidly growing older population faces many problems. Older Chinese women face lot of gender disparities that are a disadvantage to them. Elderly Chinese women experience higher levels of depression as compared to men, and the condition worsens in women above 75 years of age. A more number of older women suffer from hypersensitivity, especially after 75 years of age. However, most of the women remain undiagnosed and untreated. Diabetes is another disease that is affecting Chinese people; however, the reported cases are less due to poor rates of diagnosis. Hence, largely women and men remain unaware of the condition. In China, women older than 75 years of age, on an average, have more children as compared to younger women. However, due to change in the living environments, more and more younger people are leaving their parents and migrating to urban

areas, thereby making the parents especially women vulnerable in their old age. The problem is more severe in rural areas (Smith et al., 2014). In China and India, a more number of older women suffer from disabilities due to various reasons like falls, lower household income, and multimorbidity. Disability is higher in India than in China, and rural women report more disability than urban women. In India, there is more inequality in the disabilities between older women and men. In China, gender equality in disability is promoted through national agenda (Williams et al., 2017).

In Pune, India, the proportion of elderly women is higher in rural and urban areas as compared to men. Since women outlive men, the proportion of widows is more than widowers. Most of the elderly live with spouses or children while only few live alone. Majority of the elderly women suffer from depression, anemia, hypertension, dental problems, cataract, diabetes, hearing impairment, falls, visual impairment, diabetes, heart diseases, asthma, cancer, paralytic attacks, and Parkinson's disease (Thakur et al., 2013).

In Malaysia, older women in rural areas are in much need of the health services, but they also face economic hardships to have access to healthcare facilities than urban women. As per a survey in 2004, older women outnumbered men and a higher percentage of them were widowed. A higher percentage of older women live with their families in urban as well as rural areas. More than half of the older women in Malaysia are not educated, but they receive pensions. Older women suffer from chronic health problems like joint pains, hypertension, respiratory problems, and diabetes (Sidik et al., 2004).

Health Issues of Aging Women in Europe

In Europe, older women in lower social strata have poorer health than women in more favorable places (Tuohy & Cooney, 2019). In the UK, older women are more concerned and affected by falls. They suffer from hip fractures more often as compared to men. The reason for this may be that women are more prone to osteoporosis and fragile bones which makes their bones weaker and thus are the cause of frequent falls. Serious injuries from falls, like hip fractures, require hospitalization and are a costly affair (Age UK, 2019).

Poverty is an important factor that affects the lives of older women in Europe. Older women who live alone are at risk of poverty as their lifetime earnings are less than men and so are their pensions. In Europe, older women experience health issues more often than men like pain, arthritis and arthrosis, visual impairment, and osteoporosis. Older women suffer longer and are highly dependent. Further, a more number of disabled older women live alone than disabled men. It has been observed that older women pay more attention to their health than men with respect to the consumption of alcohol and tobacco and also adopt healthy eating habits (Healthy Aging Project European Commission, 2006). The life expectancy of men and women has been increasing in all the 28 countries of the European Union (EU). However, the increase in life expectancy does not necessarily mean "healthy life."

Older people suffer from many chronic diseases simultaneously, a condition known as multimorbidity. Multimorbidity is becoming increasingly common among older women, reduces the quality of life of older women, and puts an additional burden of huge health budget on them. Cancer has emerged as the prime disease that is affecting a greater number of people. By 2017, there were around 16–17 million European citizens who were either being treated or were in post-treatment phase, and their number is going to increase further (Brennan et al., 2017).

In Sweden, there was a decline in the geriatric syndromes (GS) in older adults from 1992 to 2002, but GS remained stable from 2002 to 2011. The older natives of Sweden show less GS than elderly people born outside Nordic countries. The older women in Sweden experience problems such as physical ailments, mobility issues, and cognitive disorders (Liang et al., 2018). Thus, it appears that Sweden has comparatively less burden of treating geriatric syndromes in its citizens as compared to other European countries.

Switzerland and Italy are the two European countries with the lowest cases of self-reported long-term illnesses, while Germany and Spain have the highest such reported cases. Older women of Spain and Czech Republic suffer from the highest chronic illnesses. Some of the factors that have strong negative influence on the lives of older women are childlessness, high parity, and early age at the first birth (Sironi, 2019). There is thus a relationship between fertility and health of older women. The negative effects of these factors have been seen to be mitigated by socioeconomic factors in the USA, but the same has not been observed in the UK (Henretta et al., 2008).

Psychological Well-Being of Older Women

Women need more attention than men during their reproductive as well as post-reproductive phase of life. There is much awareness currently about the reproductive phase in women in rich countries, and the awareness is increasing even in the low- and middle-income countries. However, not much attention is paid to the health and well-being of the older women. It has been observed that perimenopausal women are at high risk of developing depression and clinical and subclinical depressive disorders. The vulnerability of developing such symptoms can be due to several factors like discomfort from somatic symptoms of menopause, insufficient social support, psychosocial stressors, socio-demographic factors, and lifestyle to name a few. Thus, there is greater risk for women of going into depression in the later years of aging and simultaneously developing other health issues (Bromberger and Kravitz, 2011). After menopause, sexual well-being often declines in women and can result in personal and relationship distress which is known as **female sexual dysfunction (FSD)**. Although sexual problems increase with age, but distress decreases as the aging advances. Now, again the problem is that women are more aware and open about discussing such matters with the professionals in the Western world to alleviate the symptoms, but in the developing world, where majority of the older women live, they

hesitate in discussing such matters with anyone other than close relatives probably, and hence the symptoms keep piling up, thereby increasing their complications and reducing their well-being during aging (Simon et al., 2018).

It is a common observation that older adults are often concerned about their cognitive abilities. Older people suffer from many neurological disorders like Parkinson's disease, dementia, Alzheimer's disease, etc. Alzheimer's disease may cause memory loss, changes in personality, depression, mood swings, social apathy, irritability, not trusting others, and even aggression (Amarya et al., 2018). Maintaining a good cognitive health is one of the parameters of successful aging. The cognitive health depends on the factors such as social connectedness, independence, and ability to lead an independent life. It can be nurtured and maintained by keeping a physically active life and getting involved in the intellectual works (Halaweh et al., 2018). Older women are more affected by psychological disorders like depression than older men and suffer from greater symptoms of depression than men. Globally, depression is two to three times more common in women than in men. Men and women react differentially to mental stress. Depression, anxiety, and suicidal tendency are more in women, while men tend to go for substance abuse, violent antisocial behaviors, and suicide (Vafaei et al., 2016). There is a close association between psychological well-being and health, and the relationship increases more during old age. The psychological well-being may also act as a protection against chronic diseases and thus improve health of older women. It also increases their lifespan (Steptoe et al., 2015).

America

The health of a person is closely related to psychological well-being, and the relation between these two parameters becomes stronger in the old age, especially for women. As the age advances, health issues become prevalent, but with the advancement in the medical care, these issues are being addressed efficiently. However, the psychological well-being of the people is affected by several factors including social and family relations and participation in other social activities. There are three defined aspects of psychological well-being, viz. **evaluative well-being** (a sense of satisfaction from life), **hedonic well-being** (a sense of happiness, sadness, or other emotions), and **eudemonic well-being** (a sense of purpose of life). Some findings report that people in the older age group are more satisfied by their life, are less stressed, worry less, and show less anger as compared to middle-aged people, although they are less healthy and less productive. In rich and English-speaking countries, people in old age are happier as compared to older people in the Middle East regions (Steptoe et al., 2015).

Loneliness is an acute problem faced by elderly women in America. Loneliness may be due to living alone, absence of close family ties, less connection with the culture, or inability to participate in the local cultural or community events. As a result, depression is the most common condition experienced by such women. In USA, women have different perceptions about aging. Some become depressed, demoralized, and ashamed of their bodies while others embrace the changes. Older

women also report loss of sexual desire and sexual capacity. Women are aware that their metabolism slows down during old age as compared to when they were younger. They are aware that during aging, they can contact their doctors who can guide them about the changes happening in their bodies. Another important observation is that women feel younger than their chronological age and they feel that their brain does not age as the body ages. Women also feel that they are more concerned about their appearance during younger age, and in old age they are more appreciative and grateful for life and are self-accepting. On the other hand, some women also feel that there is societal pressure on them to look thin and attractive, and hence, they undergo various surgical procedures. The society expects them to look unwrinkled, youthful, non-gray haired, and also to behave in a certain manner. In American culture, looking youthful and attractive is most important for women of all ages. Some women also feel that men get more respect when they grow older but women lose respect. The society treats an older woman as aged and ugly person. Further women feel that health care during old age is a difficult process. They feel that taking care of their bodies is their own responsibility during young as well as old age (Hofmeier et al., 2017). In Canada, around half of the elderly women are living alone (Fave et al., 2018).

Older women in USA suffer from psychological conditions such as cognitive aging, dementia, and depression. Depression is not a normal symptom of aging. Depression is common in adult Americans which drops after 60 years of age, but it again rises after 80 years. Depression is more common in older women who live in institutional care homes than those who are disabled but live with the family members (Jaul & Barron, 2017). Around 5% of older women are homebound and leave home only for medical purposes. Alzheimer's hits hard on women as around two-thirds of the patients with Alzheimer's disease are women in America. As in 2019, of the 5.6 million people above 65 years suffering from Alzheimer's, 3.5 million were women while 2.1 million were men. The reason for this could be that women have longer life span than men, and there is a higher risk of developing Alzheimer's as the age advances. Another reason for depression among older women is that the major responsibility of caring for the other older and disabled people in family lies with the women (Report on Alzheimer's disease, 2019).

Africa

It is widely accepted that health and disease are the products of the social structure around a person at a particular time and place. People in different cultures have different perceptions and beliefs regarding health and aging. The social context of the well-being thus varies in cultures, places, and time. In sub-Saharan Africa, the presence of HIV/AIDS in the population significantly affects the lives of these people (Ogunmefune et al., 2011). The healthcare needs of South Africa need strategic implementation due to two reasons: First, the region is at the receiving end of epidemic of non-communicable diseases, especially prevalence of HIV/AIDS;

secondly, the government gives non-contributory pensions to people above 60 years of age. The older people receiving pensions are sometimes the sole sponsors for the entire household. The younger generation which should be taking care of the older generation becomes affected due to AIDS, and thus, older people have to care for the younger generation (Mudege & Ezeh, 2009). Thus, Africa presents a unique social structure which is highly influenced by the AIDS epidemic.

The prevalence of HIV/AIDS is low among the older people in South Africa, but their social, physical, and mental well-being are affected due to the increased incidences of HIV/AIDS among the younger generation. In such scenario, older women experience worse physical, psychological, and social issues as compared to their male counterparts. The older women are responsible for taking care of the children and other domestic duties, hence they feel more exhausted physically as well as mentally and are actually overworked as compared to older males. The role of a caregiver for the family members inflicted with HIV/AIDS puts an additional psychological burden on older women (Myer et al., 2008; Munthree & Maharaj, 2010).

The family structure of Africa is different from the American households. The older people live with their families in Africa, while in America, older people generally live alone. In Africa, the younger generation takes care of their elders. Older people of middle-class households, who are little well off financially, prefer to live in institutional care centers, while the lower-class people prefer to live with their family due to financial constraints (Dovie, 2019). Sub-Saharan Africa faces the burden of epidemics as well as psychological distress. The relationship between depression and HIV is not simple. Diagnosis of an HIV infection in a family member can lead to depression among other members, especially older women as they have to take care of the ill. Older women have poorer physical and mental health as compared to men. They carry the burden of caregiving, especially to adults, in most low- and middle-income families, and the effects of depression spread to whole family influencing the quality of life of not only older women but also other family members (Nyirenda et al., 2013).

Asia

In India, two-thirds of the older people live in rural areas, and around half of them have poor socioeconomic status. Around 70% of elderly people are women, and more elderly women live alone as compared to men. Presently, older women outnumber men in urban as well as rural areas. An interesting observation is that more women report health problems, but a far greater proportion of men are hospitalized as compared to women. This is an eye opener and suggests that the health of older women is not given priority in rural areas. Also, in India, after the death of husband, the property is passed on to children, older women are not left with any property, and this makes their life miserable (Dey et al., 2012). In India, a higher number of older women face abuse from their adult children, daughters-in-law, sons-in-law, and their

spouses as compared to older men (Ingle and Nath, 2008). A mild decline in cognitive abilities occurs in women as they become 60 years of age, and it progresses further. There could be many factors that contribute to the cognitive decline and result in a threat to the quality of life of those who are affected and also to their caregivers. Neurological disorders are more common in rural areas in India as compared to urban areas. Impaired cognitive abilities can also result in increased risk of injuries to self and others and also decline in functional abilities (Amarya et al., 2018). Dementia and Alzheimer's disease are more common in India with nearly 6% of older women affected by it (WHO, 2014).

The status of girls and women in India is worse than their counterparts in China, a developed country, in view of social and economic parameters. In India, there has been a transition in and for the attitude of younger women, as they are getting more educated, but the older women are still stuck in the traditional roles that they have been playing as homemakers, leaving very little chance for them to explore themselves. Majority of them are dependent on their husbands for all kinds of needs. In rural India, older women form a large part of the agriculture workers and are facing poverty. In China and India, in rural areas, older women are part of the family and have a tradition of being looked after by the younger generation. However, in many cases due to poverty, older women do not get access to proper healthcare facilities. They also face social and economic hindrances in their lives, and along with these factors geographical barrier is also a disadvantage for them to get proper health care (WHO, 2013). In India and China, disability is a major problem for older men as well as women, but older women are more affected. Older women also experience more of non-life threatening but chronic conditions such as depression and arthritis. In India, poor education level is a major factor that contributes to poorer health in older women as compared to men. Also, in India men are usually favored as compared to women in respect of cultural, social, ethnic, and religious beliefs, and this factor plays a more important role in the decline in quality of life of older women (Jayachandran, 2015).

In Bangladesh, the problems faced by older women are very serious. It is one of the world's poorest countries, and elderly women form a major part of the population that are deprived of access to health care. These women are subjected to socioeconomic discrimination, and several factors limit their access to health care (Hamiduzzaman et al., 2018). Older women in India and Pakistan suffer from depression more as compared to white population. However, depression rates are lower in women from Bangladesh and Black Caribbean women (Allen, 2008). Older women in Malaysia also suffer from depression and cognitive impairment (Sidik et al., 2004).

In a study in Palestine, it was found that happiness, social connectedness, self-contentment, and independence are the key factors that are considered vital for healthy aging. Older women in these countries feel that finding joys in activities is a good way of successful aging. They find joys in small activities like small gatherings, spending time with grandchildren, or doing some other activities. The feeling of being secured and satisfied along with the financial security is an important indicator of good aging. Older women feel that living alone can be hard for them, and being in the company of their children and grandchildren gives them satisfaction.

They also feel that if they are able to take care of themselves in old age and are independent, it gives them more satisfaction. Active involvement in physical activities, absence of diseases, healthy eating habits, preventing falls, and a good physical appearance are considered good for successful aging by older women in Palestine (Halaweh et al., 2018).

Europe

In Germany, older women are at higher risk of experiencing low subjective well-being than men. They are at a disadvantage with respect to health care, employment, education, financial, and other material needs. Older women who are living alone experience a dampening effect which affects their overall well-being. Living with a partner gives more satisfaction. Women give more importance to social connections than men, and hence, when they live alone, it affects their well-being. Older women face more depression and have lower subjective well-being (Lukaschek et al., 2017). Many women are dissatisfied with the changes happening in their bodies especially during and after menopause. They experience several symptoms during and after menopause like insomnia, skin dryness, loss of sexual appetite, depression, and anxiety disorders. Postmenopausal women experience multimorbidity which affects their sexual desires, and thus their dissatisfaction levels rise. Older women with mental, neurological, or eye diseases are most dissatisfied in Finland (Lukkala et al., 2016).

It has been observed in the UK that dissatisfaction levels peak at 44 years of age, and after that the satisfaction levels improve to the highest in the lifetime. It has also been observed that depression is more common in men and women during old age. In the UK, older women are more prone to depression, self-harm, and eating disorders resulting in obesity and other medical conditions. Older women feel more lonely and isolated due to factors like poor physical health, moving into a new house, moving into a care home, or becoming a carer themselves. Divorce and getting separated from the spouse cause significant mental problems for older women. In many European countries, it has been observed that married men experience less mental problems unlike married women who have to undergo psychological problems if the marriage fails. Thus, the status in marriage and divorce or separation are important factors that cause mental health problems and influence emotional well-being of older women. Further, it was observed that from 1986 to 2006 in the UK, the proportion of older women living alone was high suggesting the problem of loneliness for women in their later lives (Allen, 2008).

Events happening in one's life are major factors that affect the onset of depression in older people. Retirement is one such factor. The employment rate of women in the UK is lower than men, and they retire earlier than men. In older age, women face difficulties in finding work and thus do part-time jobs. They do majority of the caring for grandchildren and old, sick or disabled family members (Age UK, 2019).

Retirement is accompanied by reduction in income, more dependence for the day-to-day expenditure, etc. Older women are more affected by bereavement and grief as they live longer than men. In a study in Australia, it has been observed that people who live in care homes are affected as they cannot take part in the activities, do not have cordial relations with the staff, or are not visited often by family members (Allen, 2008).

In Greece, women who are above 70 years of age, are childless and also from poor socioeconomic status, they are likely to suffer from depression as compared to men from a similar background. Activities such as meetings with friends in free time, taking care of the grandchildren, and going out for picnics prevent the older women from possible serious effects of depression. In 2012, around 30.3% older people were affected by depression in urban Greece, and a majority of them were women. Depression is more prevalent in older women who are single, viz. never married, widowed, divorced, or separated, and it is severe in older women who lose their partners. Also, chronic illness in older women increases their risks of depression (Carayanni et al., 2012).

Emotional Health and Social Wellbeing

Well-being is a complex perception that includes physical, psychological, and social factors. Emotional well-being depends on subjective experience of positive and negative emotions. The most common factor that contributes to stress and thus emotional disturbances is interpersonal tension. In most of the cross-sectional studies, emotional well-being is reflected in the balance between positive and negative experiences. Globally, the proportion of aging people is increasing at a rapid rate; hence, there is an urgent need of policies for promoting overall well-being in old age including emotional and social well-being.

America

In America, it is reported that physical activity is the only important aspect that is considered for assessing the well-being of older women, whereas the aspects like satisfaction from life, cognitive ability, participation in the social functions, and absence of disease are not even considered for assessing successful aging. The most important physical aspects include absence of disability, arthritis, and diabetes (Depp & Jeste, 2006). Women who have low levels of emotional support are likely to die early as compared to women who have high levels of emotional support. Traumatic childhood experiences have an association with cardiovascular diseases and higher reactivity of immune system in older women. Older women who have had poor emotional and parental support during childhood suffer from more depression and other chronic health conditions as compared with their counterparts who have

had normal childhood (Charles & Carstensen, 2010). Women are more likely to be diagnosed with chronic diseases. The risk factors such as diabetes, cardiovascular diseases, and high cholesterol levels are becoming more prevalent in women of reproductive age. With this background, older women often are more prone to physical and mental health problems (Daniel et al., 2018).

Africa

Most of the women in South Africa suffer from psychological distress. The loss of family members especially younger members, due to HIV/AIDS or other epidemic aggravates the psychological burden on older women. Most of the women worry for their family members (Myer et al., 2008). In a study in Uganda, it was found that there are several factors that cause depression in older women like their gender, wealth, education levels, chronic back pain, diabetes, visual impairment, and other psychosocial factors. For older parents, children are like an investment as there is no social security system, and when their children are consumed by HIV or other epidemic, they feel devastated and depressed (Wright et al., 2012). Older women who are infected with HIV are given psychosocial counseling before, during, and after HIV testing which helps them in their physical, mental, and social well-being. However, older women who are uninfected but provide care to HIV-infected adults also require psychosocioenvironmental support to face the higher levels of depression. Further, older women who receive government grants are less likely to undergo depression than those who have no source of income (Nyirenda et al., 2013).

Asia

The life for older women is tougher than their male counterparts, especially in South Asia. In the changing scenario when everything is available for younger generation, there is lack of concern for the older generation, especially women. In India, the situation is execrable for older women. They do not even raise a voice for their needs, especially emotional needs. They are more prone to developing psychological issues. The society is milder to widowers than widows and that makes life harder for older widows. The most important reason for their misery is unemployment and lack of steady income. The older women in the present time come from a social background, where education and employment for women were not considered good for girls. Many of the psychological problems for the older women arise from the household neglect and abuses, which are prevalent in India. In most of the communities, violence is uncommon, but older women have to bear abuses in the form of disrespect, neglect, and lack of financial support (Soneja, 2019). In India, elder abuse shows a negative association with mental health of older women from lower economic background, and this association is stronger in wealthy households. In India, life expectancy is

increasing, and with it older women experience more chronic illnesses and functional limitations. The younger generation often migrates to cities in search of jobs leaving behind the older parents who are forced to live alone without any caretaker. Like many other low-income countries, in India too mental health is not given importance and most of the older women feel "unwanted" and "useless" (Evandrou et al., 2017).

Older women in Palestine feel that having a good mental health is a good indicator of aging well. They feel good about being alert. Managing their own affairs gives them a feeling of independence. Further, having a positive attitude helps them feel stronger. Older women have strong faith in God, they pray regularly, and thus they maintain a positive attitude in their lives. Activities like reading newspapers, books, watching television and listening to radio, playing mental games, and eating certain foods like nuts help them in remaining mentally active. Prevention of falls is an important issue for these women. The fall rate is higher in older women as compared to men, so women associate falling with aging. Falling leads to physical and social constraints for women, thereby affecting their emotional and social well-being (Halaweh et al., 2018).

In the countries of the Arab region, older people tend to live with their adult children. However, many older women live alone, and their number is increasing. The reason for this lies in the migration of younger men to other countries or cities leaving behind their wives and children to care for themselves and the older parents. Several factors such as urbanization, modernization, and migration of the youth are a threat to the traditional ways of eldercare in these countries. A majority of the older widowed women in the region live alone. There are many factors for this: higher life expectancy of women, large age gap between husband and wife, polygyny, and lower rates of remarriage for women after widowhood or divorce. Living alone means the older women have to fend for themselves, and their life becomes difficult due to lack of finances, health care, and lack of other emotional and psychological support (Hussein & Ismail, 2017).

Europe

The well-being in old age revolves around the concept of successful aging. Earlier, successful aging meant simply the absence of physical abnormalities, cognitive disabilities, or social limitations, but more recently the concept has changed and now it also includes wisdom, emotional stability, rational decision making, compassion, empathy, etc. (Ardelt, 2016). The subjective attitude toward these factors influences the well-being in old age. In Canada and Sweden, successful aging is associated with high levels of emotional well-being and independence. Older people feel that the occurrence of serious chronic diseases can be handled in a positive way if they are satisfied with their lives (Fave et al., 2018). The Irish older women prefer to work to retain their autonomy and want to take important decisions about household, their lifestyle, or health issues by themselves (Tuohy & Cooney, 2019). It is imperative to remember that knowing one's health condition makes it easier for them to make

decisions about the kind of treatment that women wish for which gives them more satisfaction (Sixsmith et al., 2014).

Need for Recognition and Attention: Policy Making

Many countries in the Arab region are not paying attention to the rapidly growing older population. The increase in the life span has resulted in the older people suffering from chronic diseases and disabilities, and they depend on their family for all the support and care. However, the Arab countries are not facing the problem of rapid aging as in the developed countries. By 2050, in nine countries in the Arab region, older people will outnumber children below 15 years of age. Arab countries have two systems of eldercare: (1) care from the family members and (2) formal care providers such as nursing aids and paid eldercare workers. The family care system is a traditional and deep-rooted system of eldercare practiced by people in Arab countries. Recently, elders are also using the services of formal care providers. However, a social stigma is attached with the system where elders are kept in private care homes (Hussein & Ismail, 2017). Generally, the elder people are marginalized in health and policy-making programs by the governments in the region. Although older people are given equal rights in the constitutions, there exists a huge gap in its implementation. However, governments of some countries in Arab region have recognized the necessity to address the healthcare needs of older people. In countries like Egypt, Tunisia, Kuwait, Morocco, Jordan, Lebanon, and Palestine, there exist services for older people which are initiated either by governments, non-government organizations, or religious groups (Sibai et al., 2014).

Women in USA feel that their needs and requirements are not taken seriously by the society, and they desire to be considered wanted in the society (Hofmeier et al., 2017). The society, government, and non-government organizations must come forward and take note of the issues of older women to make them feel "wanted." There are some factors that must be taken into consideration while making policies for older women like women outlive men in most of the countries, there should be special healthcare programs for women of all sections, and they should be made economical so that such programs have more outreach and benefit a larger number of older women. Geriatric syndromes should be made a part of the regular medical practice, and dedicated programs for older women should be put into action.

In addition to this, better functioning in older age can be ensured by regular physical activity. It makes older women feel fulfilled as they can be involved in social activities. A good physical functioning also decreases the incidences of falls which might restrict their activities in the old age (Halaweh et al., 2017). In addition to this, older women may be involved more in social activities so that they get a feeling of "wanted" and of some "value." The family and society should also come forward and embrace older women as significant part of the society and involve them in regular activities.

Challenges for Older Women

America

In USA, there is a rise in the obesity cases in people of 60 years and above. A majority of older people are divorced, and the percentage of divorced women, above the age of 65 years, increased from 3% in 1980 to 14% in 2018. About 26% of women in the age group 65–74 years, 39% of women in the age group 75–84 years, and 55% of women above 85 years of age lived alone as per a report in 2018. Further, around 5.8 million Americans are living with Alzheimer's disease and their number is expected to increase to 13.8 million by 2050 and older women form a higher percentage of the affected people as compared to men (Mather et al., 2017). Certain steps need to be taken care for older women: caregiver support healthcare services at home, promoting exercises at home, and transportation of ill women to nearest healthcare clinics (Jaul & Barron, 2017). Thus, America faces the challenge of older women who are left alone in their last phase of life with nobody to take care of them. This gap should be filled by sensitizing young generation to the issues of older women.

Africa

In Ghana, there is lack of geriatric infrastructure. Private players have grasped the opportunity to provide care for elders which comes at a cost. A growing number of older people are opting for care homes (Dovie, 2019). In sub-Saharan Africa, around 4% of the medical colleges teach about geriatrics. The lack of geriatric education is largely due to the lack of expertise, infrastructure, and funds (Frost et al., 2015). As population of the region is expanding, there is need for institutional homes for older people, especially those who require continuous nursing. Dependence on the traditional ways of eldercare puts lot of burden on women and girls; hence, there is need of formal care homes where elder people can be cared for chronic illnesses. However, the geriatric care requires some prerogative arrangements for older adults as well as physicians. Older adults must regain their lost function as a result of treatment and feel independent while physicians must diagnose and treat reported medical conditions as well as manage chronic diseases in the population (Dovie, 2019).

In Africa, the middle generation is prone to deaths by HIV/AIDS creating a "care deficit" for younger and older generation. In such a scenario, children are left to be looked after by grandmothers. In Zimbabwe, South Africa, and Namibia, 60% of the AIDS orphans live with their grandparents (Dovie, 2019). South Africa has a history of high-level violence, trauma, and more diversity in sociocultural and economic parameters as compared to other middle-income countries. Due to this social diversity, it becomes difficult to ascertain the factors determining mental health (Myer et al., 2008). If depression is considered a normal symptom of aging, it

will go unrecognized and untreated, and such people will report more to the health clinics putting an additional burden on the already constrained health facilities in these countries (Nyirenda et al., 2013). Similar is the case in Cameroon where older women bear the burden of taking care of the children infected with HIV. They have no time to participate in social and religious activities which could have given them an opportunity to interact with others from the community and get support and encouragement from them. Lack of money, time, and fear of stigmatization are the key factors that cause social isolation of older women in Africa. Thus, government must take notice of the aging women especially in HIV-infected areas (Tanyi et al., 2018) and programs need to be initiated for older women to take care of their psychological and emotional needs as well.

Asia

Older people and especially older women are not able to avail benefits of the social welfare schemes of government in India like pension or health insurance. Further, older women have more limitations—from society, family or due to disabilities and are not able to afford benefits of healthcare schemes. The condition is worse in rural areas, which constitute a major part of India (Williams et al., 2017). In China, there has been a good progress with respect to the control of infectious diseases, but there is a rising threat from the non-communicable diseases (NCDs) which form the largest share of the disease burden (Abegunde et al., 2007). On the other hand, India is under double burden from communicable as well as NCDs (Dey et al., 2012). The population in India is poorer and less educated than in China; hence, they are less aware to avail the benefits of such schemes from the government. The governments need to spread the word about public schemes that benefit older women at large so that the target population is well informed and can receive the benefits. Mere making the policies does not guarantee their reach to the target population, there should be strict implementation of such schemes, especially in rural areas. China is expanding its public-funded healthcare schemes to reach maximum people, but in India, health care is mostly in private hands and thus out of reach for most of the older people, especially older women (Williams et al., 2017). In India, although there are government hospitals and clinics, they are not sufficient to cater to rural population and the private healthcare facilities are still not available sufficiently to provide services to older women in rural areas. Thus, in India providing healthcare facilities is the priority. Once this is achieved, attention can be given to other psychological and emotional requirements of older women.

Europe

In Europe, five ways have been suggested which might help older people to live a healthy life in older age: having a home and keeping active; managing lifestyles, health, and illnesses; balancing social life; and balancing material and financial needs (Sixsmith et al., 2014). Gender is an important factor for policy making and planning. Women have longer life span than men in all European countries. Gender-based differences in the opportunities and quality of life always exist in society. Older women experience more psychological problems and consult health professionals more often than men. Thus, older women require separate healthcare programs as their needs are different from older men. Also, women receive less salary during their working years and less pension in older age. The lack or scarcity of money makes older women susceptible to more psychological and health problems (Healthy Aging project, 2006).

The constantly aging European population has put a burden of chronic diseases on national health budgets in Europe. The Global Action Plan for prevention and control of non-communicable diseases has made a target of 25% reduction in premature deaths by 2025. Thus, there is an urgent need to develop cost-effective and feasible public health policies that will reduce the burden of health care for older women (Brennan et al., 2017).

Positive Developments for Older Women

In USA, the gender gap has narrowed from 7 years in 1990 to 5 years in 2017. By 2017, average life expectancy of women was 81.1 years as compared to men at 76.1 years. The poverty rate among older people, above 65 years of age, has dropped significantly from 30% in 1966 to 5% in 2017 (Murphy et al., 2018). Other positive developments in USA that would be helpful towards healthy aging include increase in the education levels, rise in the average life expectancy, narrowing of the gender gap in life expectancy, and decline in the poverty rate (Mather et al., 2019).

Successful aging can be represented by factors such as good physical health, social support from family and friends, self-engagement, and physical activity. Leisure activities like sports, art and craft, attending cultural activities, and becoming part of social activities are important predictors of hedonic as well as eudaimonic well-being (Kuykendall et al., 2015). These engagements make older women feel connected with society and family and also give them positive emotions. Wherever elderly women are engaged in physical activities, they not only remain physically fit but the activity also promotes psychosocial well-being during aging (Fave et al., 2018). In China, the most positive event is the education of women which will go a long way in reducing the gender gap in the population and thus a better health care and well-being for the aging women (Smith et al., 2014).

In Europe, pension systems contribute 60% of the total income for older people including older women. This ensures older people to live a healthy life after their retirement. However, despite the success of pension system, all the older women are not able to avail its benefits due to lacunae in its distribution. Women constitute two-thirds of the pensioners for people above 75 years of age, and these benefits do not reach many of such women (Healthy Aging Project, 2007).

Conclusion

Because of their gender, older women have to bear several physical, social, and psychological complications. The problems begin for women when they start undergoing menopause. The decline in the levels of hormones leads to many physical changes in their bodies, and thus, older women are more prone to developing diseases, especially osteoporosis, diabetes, etc. In addition to these, they have to undergo several psychological as well as social changes in the nature of their duties toward family and society. Menopause also follows events like retirement from jobs which creates an additional vacuum in their lives. Loss of partner is an important event in their lives which makes them lonely and puts a lot of psychological stress on them. In most of the low- and middle-income countries, older women have no or very little source of finances to avail healthcare facilities for themselves. Although, Arab countries and South Asian countries have a traditional way of taking care of elderly in the family by adult children but due to modernization and globalization, the practices are changing. The scenario is not any better in rich and developed countries. There also older women are not cared for by their adult children during their old age, and they have to take care of themselves with whatever little resources they have and fight conditions such as disabilities by themselves. Loneliness adds to their problems during old age.

In most of the countries all over the world, geriatric problems are not even identified as a subject for policy making by the governments. Only rare countries pay special attention to geriatric problems and teach them as a medical subject, but there too, due to lack of expertise and funds, the services are not available to everyone. The population of older people is increasing all over the world, and women constitute a major proportion. Thus, there is an urgent need for identifying, assessing, and making policies to take care of the older population, especially women so that they can live a life full of satisfaction during their old age.

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Chapter 6
Depression in Elderly Women: Clinical Challenges

Avinash De Sousa

Abstract Geriatric depression is one of the commonest problems seen in the elderly populations. Men and women are equally inflicted with the disorder. This disorder aims to look at the unique clinical challenges posited by women that suffer from depression. There are unique socio-demographic variables and environmental factors that contribute to depression in women. Multiple factors like hormonal factors and menopause play a role in the genesis of depression in elderly women. This is coupled with factors like death of a spouse, loneliness, and the empty nest syndrome. There are also challenges in the accurate detection and management of depression as well as the long-term management of the disorder. It is also important to look at the overlap and differences between depression and dementia in women. The chapter highlights specific clinical aspects of depression in elderly women and highlights future research needs for the same.

Keywords Depression · Elderly women · Dementia · Loneliness · Geriatric depression

Introduction

Depression is among the leading cause of mental health problems and disability with work loss in the world and is a serious public health problem among geriatric populations (Lépine & Briley, 2011). Geriatric depression is equally common in men and women, and many seek help from primary care physicians as they have a large number of medical problems that complicate their physical condition (Watson & Pignone, 2003). When treating patients with geriatric depression, it is prudent to address not only their mental health problems but also to treat their acute and chronic medical conditions that are common and that coexist with depression (Fountoulakis et al., 2003). Depression in the elderly is often chronic and persistent, and recurrent research studies have demonstrated that geriatric depression can be treated

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effectively when mental health professionals and treating physicians provide effective consultation and collaborative care together (Cole, 2005). In this chapter, we will provide a contextualized overview of geriatric depression in women and discuss trends in geriatric depression noted specifically in relation to women and recommend future directives for the effective management of geriatric depression in women in the community.

Epidemiology of Geriatric Depression in Women

In community settings, studies have noted that above the age of 65 years, about 5–10% of adults meet the clinical diagnostic criteria for major depression (Ganguli et al., 2006) and 8–25% have probable subsyndromal depression (Jain & Aras, 2007). Recent epidemiological data show overall rates of depression to be similar between developed countries and developing countries, but the rates in the elderly tends to increase with age in many developing countries (Papadopoulos et al., 2005). The rates of geriatric depression increase to 12–30% in psychiatric wards and 50–60% for nursing homes and old age homes with long-term care (Seitz et al., 2010). Depression has been seen to be equally distributed in both genders, and more men come for help than women. It has also been noted that geriatric depression in women is often considered to be normal, and they are not brought to a mental healthcare facility for treatment (Alexopoulos & Kelly, 2009). Specific epidemiological data that highlight differences between geriatric depression trends in men and women are sparse, and hence, firm conclusions cannot be made.

Geriatric Depression in Women in Underdiagnosed

Depression is very common in elderly women and is often under-detected, underdiagnosed, untreated, and undertreated in most cases. Studies have shown that primary care physicians successfully detected only 40–50% of depression among older adults (men and women), and this was less than the rate at which they were successful in detecting depression among younger adults (Djernes, 2006). Many women with geriatric depression did not receive effective treatments for depression, and this leads to poorer outcomes and further serious public health problems. Studies on suicidality in geriatric cohorts have found that during the year prior to a suicide attempt, just 4–8% of the elderly had been diagnosed with depression before the attempt and only 57–65% received treatment even after the attempt (Meeks et al., 2011). The barriers to effective late-life depression treatment in women are at a patient, physician, hospital, and healthcare system level. Many women with geriatric depression present with somatic rather than emotional complaints, deny the presence of depressed mood, and thus decrease the likelihood of being diagnosed with depression (Wuthrich & Frei, 2015). Many elderly women with depression resist a diagnosis of

depression and often attribute symptoms to many physical causes or as a part of aging rather than depression or psychological factors (Park & Unützer, 2011). The stigma associated with seeking psychiatric help, lack of awareness among the patient and doctors, and poor compliance to any treatment has been also identified as barriers to elderly women receiving care. Lack of specialized geriatric care services, time pressure, inadequate knowledge about diagnosing geriatric depression, and lack of psychosocial orientations and poor insights into different clinical presentations of geriatric depression may also hamper diagnosis (Wetherell & Unützer, 2003). The lack of mental health coverage in many healthcare policies, limited availability of geriatric mental health specialists, and inadequate continuity of care also affects the outcome of geriatric depression in women (Sarkisian et al., 2003).

Factors Implicated in Geriatric Depression in Women

Risk Factors

The risk factors for developing depression in women after the age of 65 is akin to those in young adults. Female gender is a risk factor to develop depression. Apart from that being single, widowed, belonging to the poorer strata, the presence of chronic physical or medical illnesses, social isolation and loneliness, presence of a family history of depression, and past history of depression when younger are all important risk factors. The other important factors for women include early death of a spouse, the following loss, and grief with caretaking responsibilities. The presence of any cognitive impairment, age greater than 70 years, a lack of or poor social support, presence of substance or alcohol abuse, and lower educational level are also a risk factors for depression in elderly women (Maurer, 2012; Rajkumar et al., 2009; Weyerer et al., 2008).

Protective Factors

Protective factors for geriatric depression in women include good social and family support, being busy and active with social activities such as volunteering for a good cause and regular physical activity. Religiosity and spirituality may play protective roles in many older women with depression and may serve as a protective factor from worsening of depression and from suicidality. This may help them negotiate personal losses and life's challenges, reducing the risk and severity of depression. Religion is interlinked mental health via social connectedness, good social support derived from taking part in religious and associated social activities, and belonging to prayer and religious groups. Religion may also serve to reduce guilt associated

with depression in elderly women (Marty et al., 2010; Roh et al., 2015; Yaka et al., 2014).

Spousal Loss and Grief

All over the world, millions of women lose their spouse each year, leaving many million widows that may constitute 5–12% of the population (Galatzer-Levy & Bonanno, 2012). The death of a spouse is associated with reduced mental and physical health, increased suicidality, and medical problems leading to non-suicide mortality and reduced finances (Williams, 2005). Major depressive disorder, substance abuse, anxiety and panic disorders, and post-traumatic stress disorder are common within the first year of a spouse's death in elderly women. A total of 29–58% of widowed women meet criteria for major depressive disorder at one month, while 25–40% meet these criteria at three months after the death of a spouse (Sikorski et al., 2014). Spousal loss is an extremely stressful experience for women, and widowhood leads to higher rates of depressive symptoms in older women than in the general population (Alpass & Neville, 2003). Many older women may experience far more devastating losses like the death of their children and sometimes the death of grandchildren either due to accidental or medical causes that can be far more traumatic and cause depression of a greater severity in those affected (Catalano, 2005).

Depression in Women Who Are Caregivers

The risk of depression is higher in older women who are taking care of someone with serious medical or cognitive impairments (Covinsky et al., 2003). The caregiving process is a burdensome and complex one, and the burden from caregiving can compromise the physical health of the individual and increase the risk for medical morbidity and mortality both physical and psychological (Sanders & Adams, 2005). Depression is common in older women that are caregivers for spouses or relatives or parents with dementia or any other major mental illness (Epstein-Lubow et al., 2008).

Depression in Women with Medical Illnesses

A total of 65–90% of older women have one or more chronic medical illnesses and around 15–20% women may have more than four medical conditions coexisting together. These medical conditions often interact with each other and impair the quality of life of the patient. Rheumatoid arthritis, osteoarthritis, hypertension, diabetes, heart disease, hearing impairment, urinary incontinence, thyroid problems,

cancer, visual problems, and stroke complicate the picture in elderly women (Birrer & Vemuri, 2004). Medical illness is an established risk factor for depression in the elderly (Niti et al., 2007). Conversely, comorbid depression in elderly women has shown to be associated with increased morbidity and mortality, prolonged recovery, and negative prognosis among those with medical problems (Lyness et al., 2006).

Several biological mechanisms have been proposed to explain the relationship between depression and comorbid medical illness which is bidirectional and far more complex than what any single theory can encompass (Himelhoch et al., 2004). Depression in elderly women also leads to poor adherence and compliance to treatments, poor physical activity, dietary deficiencies, and poor quality of life in general. Depression in elderly women thus affects the outcome and prognosis of coexisting medical conditions as well (Drayer et al., 2005).

Clinical Features of Geriatric Depression in Women

The diagnosis of geriatric depression faces substantial challenges. This is due to the ensuing biological changes in the aging brain, comorbid physical and medical illnesses, developmental trajectories due to aging itself, and heterogenous symptoms at first presentation (Sözeri-Varma, 2012). Thus, these patients present substantial diagnostic and clinical challenges. The phenomenon of geriatric depression in women are often attributed to normal aging itself, spousal loss and grief reactions, onset of dementia, and poor quality of life due to medical illnesses, and thus, many women may thus not undergo treatment for an eminently treatable health problem (Lapid & Rummans, 2003).

Older women with depression may always not fit the typical picture of depression and many may never report symptoms such as sadness or low mood. The presence of loneliness, anhedonia, avolition (lack of will), multiple unexplained physical or somatic symptoms, chronic fatigue, and vague symptoms may all be seen. These symptoms are always attributed to medical conditions that are underlying and stressful life events (Yates et al., 2004). These patients may not be receptive to psychological interventions and may not be positive about occupational therapy or psychotherapy when offered as a treatment. They may refuse antidepressant medication, and this may be due to their low self-esteem and feeling that nothing is going to work for them (Heok & Ho, 2008).

In older women with medical illness, depressive symptoms may be undiagnosed because they are thought to be due to or as a result of the concurrent medical illnesses. The symptoms of depression such as fatigue, loss of appetite, sleep disturbances, lack of attention and concentration, and lack of appetite are all seen in chronic medical illnesses (Alexopoulos et al., 2005). Many studies have found a strong relationship between depressive symptoms in elderly women and chronic physical pain (Forlani et al., 2014). Although pain may be an indicator for depression, we must mention that not all pain signifies geriatric depression as many medical conditions in old age are painful by nature. Untreated physical pain is a bad prognostic indicator of treatment

response in geriatric depression, and an effective pain management is a must for successful alleviation of depression (Hegeman et al., 2012).

Subsyndromal Depression in Elderly Women

Many older women with clinically significant depressive symptoms do not meet the clinical diagnostic criteria for major depressive disorder or dysthymia. The presence of clinically significant non-major forms of depression like minor depressions and subsyndromal depression is common in elderly women. The reason that these women do not meet diagnostic criteria for depression is either lesser symptoms or lower duration of symptoms (VanItallie, 2005). It is important to detect this subsyndromal depression in elderly women as they are at a high risk for the subsequent development of major depressive disorder with suicidal thoughts and also sustain a fair degree of functional impairment and poor quality of life (Chopra et al., 2005). There is a scarcity of literature on the diagnosis and management of subsyndromal depressive conditions, and clinicians are confounded on how to diagnose the same.

Treatment of Geriatric Depression in Women

Many older women are less likely to access adequate mental healthcare services than their younger counterparts and may receive poor care as well. Poor treatment adherence and compliance are other factors that affect the management of the condition. Geriatric depression in women is a very treatable condition if effective treatments are provided, with remission rates of 50–75% shown in studies (Crystal et al., 2003). Antidepressants and/or psychotherapy is recommended as the first-line treatment, and a combination always works better than both treatments individually (Alexopoulos, 2005).

Early Detection and Diagnosis

Geriatric depression in women as mentioned earlier is often undetected, undiagnosed, and undertreated. There are many simple rating scales and tools available for the screening of patients with depression in the elderly. Using a single question, like, "*Do you often feel sad or depressed?"* to which the patient is required to answer either "yes" or "no" was tested and found to help in early detection of cases (Lenze, 2003). Such brief screening methods can be easily administered by general physicians or nurses during a routine health checkup. There are many established rating scales for geriatric depression that may be used, and these include the geriatric depression scale (GDS) (Wancata et al., 2006), the nine-item patient health

questionnaire (PHQ-9) (Löwe et al., 2004), and the Beck Depression Inventory scale (Wang & Gorenstein, 2013). These can also be used to clinically monitor the patient weekly and assess improvement with various treatment modalities. On detection, it is prudent that appropriate referrals be made and the patient receives treatment immediately.

Managing Patient Adherence and Compliance

The use of health services by elderly women is a variable that depends on location, socio-demographic, clinical, financial, and many social factors. The presenting complaint, symptoms, mobility, medical problems, and lack of social support are other factors that affect patient compliance. The great amount of negativity and myths that surround psychiatric intervention also plays a role in the regularity with treatment (Ayalon et al., 2005). The nature and approach of the mental health professional handling the psychiatrist plays a vital role in the same as well. Many older women may in general find it difficult to engage in therapy and also complete a proper course of medication as prescribed. Researchers have suggested several methods to increase treatment adherence among older patients with depression which are—(Alexopoulos et al., 2008).

(a) Personalizing treatment of depression to improve adherence
(b) Identify the risk factors that may contribute to poorer treatment outcomes
(c) Develop comprehensive care algorithms that shall target these populations.

Supportive family members play a vital role in treatment adherence and compliance to treatment. Many elderly women stop medication prematurely, and poor social support is a critical predictor of adherence (Zivin & Kales, 2008).

Approach to the Treatment of Geriatric Depression in Women

There is a need for algorithmic approach in the management of geriatric depression in women. Simple approaches are started first followed by more complex approaches as simple approaches may fail. Behavioral activation approaches like pleasant event scheduling, physical or social activities. A variety of psychotherapeutic interventions play a role in the management of geriatric depression. Self-help interventions with brief psychotherapy and cognitive behavior therapy also must be applied (Wilkins et al., 2010). Sound psychoeducation about pharmacological interventions along with the correct choice of antidepressants is prudent in the management of geriatric depression. Most patients can be treated on an outpatient basis, while some patients may need inpatient admission to assess them in detail. Stigma reduction must also be applied where necessary (Mackin & Arean, 2005).

Collaborative Care in Women with Geriatric Depression

There is a need for a team approach for the management of geriatric depression in women. This has been applied in the US, UK, many European countries, and Australia. The core tenet of collaborative care and the team approach is that general physicians work closely with a mental health professional to treat depression in elderly women (Chang-Quan et al., 2009). A case manager like typically a nurse, social worker, or a psychologist is responsible for assessing a patient's needs, coordinating appropriate levels of treatment, monitoring treatment adherence and compliance, family psychoeducation, and assessing treatment outcomes. This will ensure regular follow-up and shall also handle the multifaceted needs of depressed older women. The case manager works with the mental health professional by educating patients about depression, coaching patients in behavioral activation like pleasant event scheduling and supportive counseling techniques (Adli et al., 2006).

Health Care Issues that Must Be Addressed

Certain groups of elder women are at a high risk for not receiving treatment. These groups include older women with low socioeconomic status, poorer education, women living alone, and those who are residents in old age homes. The level of satisfaction with the neighborhood environment, availability of transportation, and economics are important determinants of depression among older women (Wuthrich & Frei, 2015). Many older women may have difficulty in coordinating clinic visits and reaching the clinic due to lack of transportation and reduced mobility in general. Cultural beliefs and practices of mental health and attitudes toward depression care also serve as a barrier in many women. Many patients may have less faith in the neurobiological causes of depression, are more doubtful about the efficacy of antidepressant medications, and show stronger pull toward counseling rather than drug treatments (Lawrence et al., 2006).

Evidence suggests that treatment for depression that offers both pharmacological and non-pharmacological treatment options can increase the use of treatments and improve health outcomes in older women. There is no one form of treatment and one must individualize the treatment to meet the specific needs of patient, combining multiple treatments and meeting the preferences of individual patients and families (Bartels et al., 2004).

The Role of the Family

A large number of young adults provide mental health care to their elder family members and those with depression need more care than other elderly. Family

members of depressed older women may experience certain levels of caregiver stress, extra burden, and burnout during the caregiving process. There is a need to support family caregivers of depressed older patients as this may serve to help both the patients and family caregivers. Families have a huge role in improving healthcare utilization by the elderly, monitoring treatment adherence, and positive treatment outcomes while they also shall manage the coexisting medical disorders that may be present (Taqui et al., 2007). Older women with good social support are less likely to be in hospital or in old age homes. Good family support is protective and beneficial to the patient and are predictors of outcome and mortality in depression (Aylaz et al., 2012). By providing support to patients and family members with managing depression and navigating the healthcare system, we may be able to prevent negative health outcomes in both the patients and their family members (Routasalo et al., 2004). Studies have demonstrated the effectiveness of education for elder adults and their family members, including a psychoeducational workshop for elderly with recurrent major depression and providing psychotherapy and counseling for both families and the patient (Horowitz et al., 2003).

Specific Areas that Need to Be Addressed

Need to Create Awareness About Geriatric Depression

There is a need for the community and patients as well as caregivers to be made aware of the problem of geriatric depression. Very little attention is anyways given to the mental health of the elderly and recognizing depression is a major challenge. Patients who are started on treatment for geriatric depression often get no information about the nature and long-term goals of treatment (Schulz et al., 2005). Many patients thus drop out of treatment and do not follow up for the entire duration of the treatment. Depression management and screening must be a part of regular medical care of elderly women and must be addressed when they come for the management of chronic medical conditions such as diabetes, hypertension, and other medical disorders. The need to integrate psychiatric treatments into mainstream medical geriatric care rather than segregate them shall go a long way to ensure that many elderly women with depression receive effective treatments (Prakash & Kukreti, 2013).

Training of Family Physicians and Mental Health Professionals

Psychiatric training in the assessment and management of late-life depression must be made an educational priority for family physicians and mental health professionals alike. They must be made equal members of collaborative and interdisciplinary teams that look after geriatric patients. The roles of psychiatrists in these teams vary from routine outpatient consultations and need training in new skills like individualized geriatric consultations, psychotherapy in the elderly, and dealing with patients in diverse medical settings (Lodha & Sousa, 2018). Mental health professionals, psychiatric nurses, social workers, and psychologists or counselors need to acquire new skills such as supporting medication management in geriatric depression, family psychoeducation, using rating scales for depression, and providing evidence-based brief psychosocial treatments in the elderly. A multidisciplinary team may include members from a broad range of disciplines with varying degrees of training, and they must all empower each other (Bartels & Naslund, 2013).

Overlap of Depression and Dementia

There is an evidence base to suggest that depression may be a future risk factor for the development of dementia (Leyhe et al., 2017). A past history of depression is known to exponentially increase the risk of developing dementia in both men and women. Studies have shown that a past history of depression nearly doubles the risk of developing dementia in the elderly. Neurobiologically, prolonged damage to the hippocampus due to hypercortisolemia states linked to stress and depression has been proposed to start a cascade that may later cause dementia like processes (Mast, 2005).

Many scientists feel that the geriatric depression may sometimes represent a predementia syndrome or that it serves as a start of cognitive decline in the elderly. Elderly men and women with depression go on to develop dementia within a few years after the onset of depression (Tagariello et al., 2009). Multiple genetic, vascular, familial, or environmental determinants also play a role. Depression can also unmask clinical cognitive impairment and serves to compromise existing cognitive reserves and allow the symptoms of dementia to be manifested behaviorally and cognitively earlier than they would have been seen (Pattanayak & Sagar, 2011).

Conclusions

Geriatric depression in elderly women in a complex and vexing problem. There are many specific factors that need to be considered when addressing the problem of

depression in elderly women. The chapter has tried to provide an overview of these factors and has outlined the risk and protective factors for geriatric depression in women, diagnosis and treatment needs, the need for awareness, and the overlap of depression and dementia that may happen. There is a need for future research into the gender differences in the genesis, coping, and symptoms of geriatric depression as well as treatment differences when it comes to elderly women. The lives of elderly women in modern society are multipronged, and when depression strikes, it needs to be addressed in a scientific and clinically sound manner.

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Chapter 7
Older Women Killed by Their Partners: A Socio-Demographic Analysis and Risk Factors

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Abstract Gender-based violence is a relevant issue that is receiving major attention in the last decades. Unfortunately, the violence that several elderly women are suffering from their partners does not receive the same attention. This chapter analyzes the main variables of this phenomenon in the cases of 30 older women killed in Spain by their partners. These murders meant the 57.69% of all the older women killed in the family. It is also reviewed in the chapter the results founded in other countries about this problem. Some of the victim risk factors reviewed are age, disability, dementia, and mental disorders; about offenders there have been analyzed factors as age, disability, disorders, or criminal records. Risk factors of elderly women killed by their partners are compared with risk factors in the homicides of elderly peopled killed by other family members.

Keywords Gender-based violence · Partner violence · Femicides · Elderly women · Risk factors

Relevant Definitions

Violence

Violence is any intentional action or omission that harms or may harm a person (Sanmartín, 2006). Based on this definition, various kinds of violence can be distinguished. When violence is directed toward properties is usually called "vandalism," whereas when violence is against people; it can adopt different forms depending on a series of criteria as the type of action (actions or omissions), the type of harm caused (psychological, physical, financial, or sexual), the type of aggressor, the type of the victim or the context where it occurs (Sanmartín & Iborra, 2011) (Fig. 7.1).

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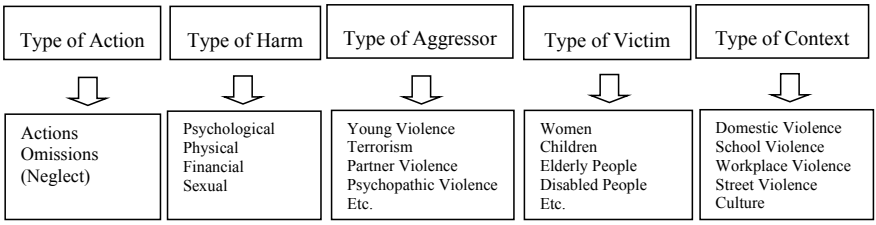

Fig. 7.1 Taxonomy of violence (Sanmartín & Iborra, 2011)

For the purposes of this chapter, we are especially interested in the classification by the type of victim. Although in theory anybody can suffer violence, certain risk groups exist. Thus, in the context of domestic violence, the most vulnerable victims are women, minors, and elderly people. It is relevant to highlight that the higher risk of suffering violence of women is applicable not only to family violence but also to the other contexts in which violence can occur. In this sense, women are the main victims of bullying (schools), mobbing and sexual harassment (workplace), sexual violence (streets, armed conflicts, etc.), and several harmful traditional practices. All those various kinds of violence that women experience simply because they are women are called "violence against women" or "gender-based violence" (Sanmartín et al., 2010).

Gender-Based Violence: Partner Violence

As mentioned above, women can experience violence in different settings. When it occurs in the home, it is called "domestic violence" or "family violence." In this context, women are vulnerable to suffer violence from different aggressors: they are the main victims of child abuse and of filio-parental violence. Nevertheless, the major risk of victimization for women comes from their partners or ex-partners. These cases receive the name of "partner violence against women" (Sanmartín et al., 2010).

Partner violence is one of the most widespread forms of gender-based violence in the world. It affects practically all populations, social classes, and educational levels.

Many people still consider partner violence to be a scourge but end up tolerating it because they believe that it pertains to the private sphere and should be solved by the partners without any outside intervention. This is unacceptable. Any kind of violence cannot be considered as a private issue, since they involve not only those who experience it, but the whole society. Violence is a violation of human rights and, consequently, a public matter. Furthermore, it has a high cost for the state in economic and social terms.

According to the classification of partner violence by type of harm, the main types are psychological, physical, and sexual abuse. Regarding psychological abuse, as Echeburúa and de Corral (2010) propose, it is more difficult to detect than the

physical, but it is important to do it because it can have very negative consequences for women's health and emotional well-being. Another important characteristic of this type of abuse is that, when the first episode has emerged, the probability of new episodes occurring is much higher. Moreover, the chronicity of maltreatment leads to an escalation in violence, and so it becomes worse over time. Psychological abuse usually turns into physical abuse.

Theoretical Models of Partner Violence Against Women

There are different theoretical models of this kind of violence. Among these models, we can find the ecological model by Bronfenbrenner and the cycle of violence by Leonor Walker. The former tries to explain the origins of this phenomenon, whereas the latter tries to explain its maintenance.

Ecological Model by Bronfenbrenner (1979, 1987)

The ecological model by Bronfenbrenner does not specifically explain violence against women, but it provides a general explanation for different kinds of violence. In fact, this model emerged in the late 1970s (Bronfenbrenner, 1979), and it was initially applied to child abuse (Garbarino & Crouter, 1978), and subsequently to youth violence (Garbarino, 1985), partner violence (Heise, 1998), and elder abuse (Carp, 2000; Schiamberg & Gans, 1999).

The basic proposal of the ecological model is that:

> No single factor explains why some individuals behave violently toward others or why violence is more prevalent in some communities than in others. Violence is the result of the complex interplay of individual, relationship, social, cultural and environmental factors. Understanding how these factors are related to violence is one of the important steps in the public health approach to preventing violence. (Dahlberg & Krug, 2002, p. 12)

Therefore, the term "risk factor" is probabilistic (not deterministic). The fact that a person has some risk factors does not mean that she/he is necessarily going to develop violent behavior; it only means that she/he has a higher probability of developing these behaviors, in comparison with a person without risk factors. Therefore, violence risk factors are characteristics that increase a person's vulnerability to violent behavior.

The ecological model by Bronfenbrenner (1987) explores the relationship between different levels of factors and considers violence to be the product of multiple levels of influence on behavior. These levels are the following: microsystem, mesosystem, exosystem, and macrosystem (individual, relational, community, and sociocultural) (Dahlberg & Krug, 2002, p. 12–13):

- Microsystem (individual risk factors): seeks to identify the biological and personal history factors an individual brings to his or her behavior. Biological and demographic factors are considered, as well as other factors such as impulsivity, low educational achievement, substance abuse, and a prior history of aggression and abuse.

- Mesosystem (relational risk factors): explores how proximal social relationships—for example, relations with peers, intimate partners, and family members—increase the risk of violent victimization and perpetration of violence.
- Exosystem (community risk factors): examines the community contexts where social relationships are embedded—such as schools, workplaces, and neighborhoods—and seeks to identify the characteristics of these settings that are associated with being victims or perpetrators of violence. Some examples are communities characterized by problems such as drug trafficking, high levels of unemployment, or widespread social isolation. Research on violence shows that opportunities for violence are greater in some community contexts than in others—for instance, in areas of poverty or physical deterioration, or where there are few institutional supports.
- Macrosystem (sociocultural risk factors): examines the larger societal factors that influence rates of violence. It includes factors that create an acceptable climate for violence, factors that reduce inhibitions against violence, and factors that create and sustain gaps between different segments of society. Larger societal factors include: cultural norms that support violence as an acceptable way to resolve conflicts, norms that give priority to parental rights over child welfare, and norms that entrench male dominance over women and children, etc.

Cycle of Violence by Leonor Walker (1979)

Leonor Walker's theory (1979) of the cycle of violence offers an explanation about how partner violence against women appears and is maintained. It is a stress reduction theory that affirms that there is a cycle of violence (Walker, 2012):

> Walker found that battering did not take place all the time in abusive relationships, but neither was it as random as those involved perceived it to be. Rather, there was a definite pattern which included three phases of the cycle of violence: Phase I was the period of tension-building, phase II was the acute battering incident, and phase III was the period of loving-contrition or absence of tension. In some cases where the violence has reached dangerous proportions all or most of the time, phase III is not readily visible, and although there is some lessening of the tension, the woman never feels out of danger. (Walker, 1992, p. 330).

The three phases of the cycle of violence are the following (Walker, 2012):

Phase 1. Tension-building: a gradual increase in the aggressor's anxiety and hostility. During this phase, the aggressor shows his hostility through insults or unpleasant behaviors but not through extreme or explosive behaviors. Women try to reduce their partners' anger.

Phase 2. Acute battering incident: explosion of physical violence in which the aggressor discharges the accumulated tension. "The second phase is characterized by an uncontrollable discharge of the stress accumulated during the first phase" (Walker, 1979, p.59). The violence can be verbal and/or physical and is usually uncontrolled. This is the most dangerous phase, the one in which more injuries occur. It ends when the man stops the aggression.

Phase 3. Loving contrition (also sometimes called the "honeymoon"): a period of relative calm, usually preceded by the aggressor's "regret." In the third phase,

the aggressor's behavior changes: he apologizes, is kind, promises not to repeat the behavior in the future, and even gives the woman presents. The victim, at least early in the relationship, wants to believe that her partner will change. This phase is characterized by a lack of tension and violence, which reinforces this idea of possible change in the victim. As the relationship progresses, the tension-building phase becomes more common, and the loving contrition phase decreases (sometimes until it disappears). For Arcas (2014), in this phase, the woman feels an ambivalence that leaves her in a state of confusion and distorted reality that leads her to take responsibility for the aggression, which perpetuates the cycle of violence.

The woman's lack of control over the aggressor's behavior may lead to the development of "learned helplessness." Learned helplessness is a state that occurs after people have repeatedly experienced a stressful situation. They come to believe that they are unable to control or change the situation, and so they do not try—even when opportunities for change become available. The result is that the victim remains passive in a harmful situation, which facilitates the continuity of the abuse.

Risk Factors for Partner Violence Against Women

Individual Risk Factors of Perpetrators

Any woman is prone to being abused by her partner or ex-partner merely for being a woman. There are no specific individual risk factors for women, although economic dependence and an excessively romantic view of love relationships may help to maintain, if not cause, a violent relationship (Sanmartín et al., 2010).

Among perpetrators, some of the main individual risk factors are:

- Internalization of a rigid and stereotyped model of masculinity. These men interpret certain behaviors by women as a threat to their authority, and they apply what they consider legitimate use of force to maintain control over the situation and their partner. This, by the way, may explain why so many aggressors kill their partners when they decide to break off the relationship.
- The presence of psychological traits related to having received a sexist socialization. Misogyny: a belief in the superiority of men over women and in the existence of proper roles for each sex; insecurity and low self-esteem: usually accompanied by a strong dependence on the partner, fear of abandonment, and pathological jealousy; impulsivity or lack of self-control: a belief in the legitimacy of the use of force and discipline with one's partner; possessiveness: a belief that marriage means that one's wife becomes a possession, an item of ownership; overcontrol: a tendency to compulsively control all aspects of a partner's life, including her clothes, contacts with family, friends and colleagues, the places she goes when she leaves home and when she returns, etc.
- A strong diet of real or screen violence: Watching violence on a screen can have different effects. The behavioral effects include learning by observation or "modeling," i.e., learning behavior by observing models, either real or symbolic (Iborra,

2007). In addition to publicity, a growing number of television programs attack women's dignity, which amounts to an attack on human rights. When women are presented as objects, this can reinforce the cognitive distortion of men who view their partners as possessions.

- Toxic-substance abuse: Alcohol and drug use are often said to correlate positively with violence in its various forms. Only in the case of a handful of countries, however, can this statement be backed up by completely reliable figures. The latest international research seems to indicate that, on average, alcohol or drugs were present in 3 out of every 10 cases (Sanmartín et al., 2010). In the case of drugs, special mention goes to ecstasy and cocaine due to the damage they cause not only to neural physiology but also to the brain's anatomy, especially in regions associated with the display and inhibition of aggressive responses.

Familial Risk Factors

- Authoritarianism: Interactions in the family are characterized by a vertical structure where the man wields power over his partner and the other members of the family. He exerts excessive control over all areas of his partner's life (clothing, activities, friends, etc.), to the point where he decides what she can or cannot do and who she can or cannot see. In this model, family members have a very low level of autonomy and a strong adherence to gender stereotypes and the corresponding distribution of responsibilities in the family.
- Authoritarian and permissive parenting styles: On the one hand, perpetrators raised with an authoritarian family model may internalize a rigid and hierarchical family structure. In their view, the male figure must occupy the top position and establish strict control over the members of the family. They also place a higher value on sanctions than on discipline. On the other hand, some perpetrators have been socialized in permissive families, which are characterized by a lack of limits and norms. These children learn that they have the power and that they can do whatever they want to at any time. This behavior is common among young batterers who blame their female victims for their own abuse, arguing that they (the aggressors) are only defending themselves from them (their victims, in reality).

Sociocultural Risk Factors

Among the victims, we can highlight the following sociocultural risk factors:

- Lack of social support: This is a risk factor and, therefore, something that occurs prior to the abuse that favors its appearance. The victim is isolated, largely because the aggressor has devoted himself to severing her ties with the outside world, starting with her family and friends. This factor, however, also maintains the abuse because a victim who is isolated becomes an easy target for the perpetrator. In fact, social isolation is a characteristic risk factor in families with domestic violence, partly because behaviors that are considered unlawful are usually kept hidden. If the abuse becomes known, it can bring informal sanctions from friends,

family, or neighbors, and formal sanctions from the police or the courts. It is, therefore, assumed that continued abuse is less frequent in families with strong social support networks (Pillemer, 2005).

- Poor institutional support: The response by law enforcement and the justice system is usually insufficient or inadequate. The same is true for the social support resources available to these women. This clearly plays a role when victims do not dare to break off the abusive relationship or file charges against the aggressor. This factor, therefore, perpetuates the abuse.

The main sociocultural risk factors for perpetrators are:

- A patriarchal culture that promotes sex inequality: Women are considered subordinate to men, inferior, or even items of property. In these cultures, power and authority are attributed to men, both in society and in the family.
- The existence of institutions (educational, labor, legal, etc.) that reproduce a relationship model of vertical, authoritarian, and sexist power.
- The existence of institutions and a social environment that minimize or justify violent behavior in general, and partner violence in particular, with the latter considered a family matter in which other people should not interfere.

Elder Abuse/Maltreatment

Elder abuse is not a modern-day phenomenon (Eastman, 1984; Stearns, 1986). Historical studies have shown that some ancient literary works contain depictions of behaviors that would be described as abuse today (Rheinharz, 1986). However, it was only in the twentieth century when researchers began to pay attention, first, to child abuse (60s), then to domestic violence (70s), and finally to the abuse and neglect of older people (80s). This latter problem was first identified by a group of doctors in the UK in the 1970s. They coined the term granny battering (Baker, 1975), and by the end of the decade, the term elder abuse had appeared (Bennett et al. 1997).

Concept, Kinds, and Scope of Elder Abuse

Elder abuse is a complex problem and difficult to define. There is no universally accepted definition that takes into account all the different aspects of maltreatment that should be included (Penhale et al., 2000). Some definitions mainly focus on family violence, others on the maltreatment occurring in care homes, and others on social abuse, which refers to the types of administrative abuse that keep an older person from receiving the necessary basic services for his/her welfare.

Some of the most recognized definitions of elder abuse are the following (Iborra et al., 2013):

The first is the concept coined by Action on Elder Abuse in 1995 and ratified by the International Network for the Prevention of Elder Abuse (WHO/INPEA, 2002) and

by the WHO in the Toronto Declaration (2002). It defines elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person."

The second definition came out of the First National Conference on Elder Abuse, which then led to the Almeria Declaration (1996). It states that "elder abuse means any act or omission suffered by a person of 65 or over which harms their physical, psychological, sexual and financial integrity, their autonomy or their individual basic rights; either subjectively or objectively evident, irrespective of intentionality or the setting in which it occurs (family, community or institution)." Finally, the original definition of the Queen Sofía Center is also available, which defines elder abuse as "any voluntary, i.e., non-accidental act, which harms or may harm an elderly person; or any omission that deprives an elderly person of the care she/he needs for his/her well-being; as well as any violation of his/her rights. To be classified as elder abuse, such acts or omissions must take place within the framework of an interpersonal relationship in which one expects a certain trust, care, *convivencia* (positive coexistence), or dependency. The perpetrator may be a family member, a staff member from an institution (health sector or social services), a hired caregiver, a neighbor, or a friend" (Iborra, 2006). The age at which someone is considered to be elderly is 65 years.

In connection with the different kinds of abuse, five categories of elder abuse are now commonly accepted (Iborra, 2010a, 2010b; Bazo, 2001; Pérez et al., 2011; IMSERSO, 2005, 2007; WHO, 2011). This is the same typology traditionally used for child abuse (Sanmartín, 2005), but with the obvious addition of financial abuse (Iborra et al., 2013):

- Physical abuse: intentional actions that are potentially physically harmful. Some examples of this type of abuse are hitting, slapping, burning, pushing, shaking, etc., but it also includes physical and chemical restraints.[1] The most frequent consequences of physical abuse are scratches, wounds, contusions, marks, bruises, fractures, dislocations, abrasions, burns, loss of hair, and even death.
- Psychological abuse: acts (normally verbal) or attitudes that cause or may cause psychological harm. Examples of this are rejecting, insulting, terrorizing, isolating, shouting, blaming, humiliating, threatening, enforcing isolation, ignoring, and depriving the person of love, affection, and security. Especially relevant in the psychological abuse of older people are the threats made, the most common being those of abandonment and institutionalization. The main consequences of this type of abuse are depressive and anxious sintomatology, despair, sleep problems, fear, food aversion, and confusion. Psychological violence is usually confined to language—both verbal acts and those accompanied by a physical gesture—with the consequences usually affecting the victim's cognitive, emotional, and behavioral functioning. Psychological abuse is the most prevalent

[1] Physical restraints include any physical or manual method, or any mechanical instrument, material, or equipment attached to patients that they cannot easily remove and that restricts their freedom of movement as well as access to any part of their body (Burgueño et al., 2008).

type of abuse in the majority of the existing studies, and it often occurs alongside other types of abuse.

- Neglect: failure to meet one's obligations in caring for a person. It basically involves withholding basic needs, such as adequate nutrition, hygiene, weather-appropriate clothing, and health care, among others. Abandonment is one of the most extreme forms of neglect. The typical consequences of this type of abuse are malnutrition, dehydration, bad hygiene, hypothermia, hyperthermia, and pressure ulcers.
- Financial abuse: the illegal or non-authorized use of a person's financial resources or property. The main consequences are the inability to pay bills, lack of service provision, eviction, and a deterioration in the standard of living. The elderly have traditionally been considered and still are at risk of experiencing this kind of abuse. Women who suffer abuse at the hands of their partners are the other particularly vulnerable group to financial abuse.
- Sexual abuse: any non-desired physical contact where a person is used as a means to obtain sexual stimulation or gratification. Some examples include fondling or kissing; oral, anal, or vaginal penetration with objects, fingers, or the penis; sexual harassment; and forcing the person to perform sexual acts on the aggressor or look at pornographic material. Among the consequences for victims, it is very common to find trauma in the genital, breast, mouth, and anal areas; sexually transmitted diseases; bite marks, etc.

In addition to these categories, some professionals include things such as abandonment (where the person who takes on the responsibility for an elderly person's welfare or has custody of an older person physically abandons him/her) or the violation of basic rights (understood as depriving the older person of his/her basic legal rights in terms of privacy, decision making, religious opinions, etc.) (Pérez et al., 2011).

Finally, in relation to the scope of elder abuse, according to the Report of the World Health Organization (WHO, 2015), the prevalence of this phenomenon in countries with high or medium incomes is between 2.2% and 14%. By types of maltreatment:

- Physical abuse: 0.2–4.9%.
- Sexual abuse: 0.04–0.82%.
- Psychological abuse: 0.7–6.3%.
- Financial abuse: 1.0–9.2%.
- Neglect: 0.2–5.5%.

Risk Factors for Elder Abuse

Applying the ecological model developed in the 1970s by Bronfenbrenner (1979) to the analysis of violence, we need to understand that it is the result of the complex interplay among individual, relationship, and sociocultural factors (Krug et al., 2002). According to the WHO report (Iborra & Penhale, 2011) and Penhale and Iborra (2015), the main risk factors for elder abuse are the following.

Individual Risk Factors

- Gender: There appears to be a strong consensus in the literature that women suffer from the more severe cases of physical and emotional abuse and are the main victims of sexual abuse (Pillemer & Finkelhor, 1988), but the levels of neglect are similar for both sexes.
- When considering the gender of the perpetrators, several studies have found a higher prevalence of male abusers than female abusers. However, there is an increasing tendency to differentiate these data by the type of abuse perpetrated. Authors following this line of research confirm that women are more responsible in cases of neglect, whereas men are more likely to be responsible for the more extreme forms of abuse, as well as physical and sexual abuse.
- Age of victim: The risk of abuse increases with age. Many studies have found higher levels of abuse in people over the age of 75, especially in cases of neglect and financial abuse.
- Victim's dependence or disability: Maltreatment rates increase with dependency, disability, or declining health status. Certain questions related to disability—such as changes in expectations, decreased functional capacity, and ignorance about the effects of the illness on cognition—may increase the risk of certain types of abuse (Bazo, 2002).
- Dementia: Different studies have found higher levels of abuse in older people with cognitive problems. People with Alzheimer's disease or dementia in particular are three times more likely to suffer abuse, compared to the general population. One factor to take into account is that research carried out on people with dementia has shown that aggressive behavior on the part of the older person may trigger a violent response from the caregiver (Pillemer & Suitor, 1992).
- Psychopathology: Various studies have found that depression, suicidal thoughts, and feelings of unhappiness, shame, or guilt are common among victims (Bonnie & Wallace, 2003; Muñoz, 2004).

  As far as the perpetrators of maltreatment against older people are concerned, studies (of which there are few) show that they are more likely to have psychological problems (especially depression) and substance abuse problems than caregivers with no (known) history of abusive behavior (Cooney & Mortimer, 1995; González et al., 2005; Lachs & Pillemer, 1995; Pillemer, 2005; Wolf & Pillemer, 1989). The abuse of psychoactive substances and, especially, alcohol dependence among perpetrators has been closely associated with situations of continued and severe maltreatment, specifically in cases of physical abuse.

- Aggressor's financial problems: A review of studies carried out by the WHO showed that the perpetrator's financial difficulties are a major risk factor for elder maltreatment (Krug et al., 2002).

Relationship Risk Factors

- Stress: Several studies have highlighted the importance of the perception of stress and burnout syndrome as predictors of the presence of elder maltreatment (Coyne & Reichman, 1993). However, there is no direct causal relationship between caregiving, stress, and maltreatment. The latest research seems to point to the type of relationship prior to the abuse as possibly being an important predictive factor in maltreatment (Wolf et al., 2002).
- Financial dependence of the aggressor: In many cases, perpetrators are financially dependent on the victim for their accommodations, maintenance, transport, and other costs.
- Living conditions: According to different studies, living alone reduces the risk of maltreatment, whereas living with a family member is a risk factor for becoming a victim of violence (Pillemer, ; Pillemer & Suitor, 1992).

Sociocultural Risk Factors

- Social isolation: Social isolation is a characteristic risk factor for domestic violence in families. Elderly victims of maltreatment have fewer social contacts. It is also common for victims to live alone with the perpetrator, who on many occasions may be their sole caregiver (Pillemer, 2005). In addition, some research studies have suggested that perpetrators also have problems with social relationships and are more isolated (Cooney & Mortimer, 1995; González et al., 2005).
- Lack of social support: Many studies show that abusive caregivers lack social support to assist them with their caregiving tasks. The available data indicate that the importance of the lack of social support as a risk factor may be related to the presence of burnout in caregivers, extremely high levels of need in victims, and social isolation, among other issues.
- Ageism: Robert Butler coined the term "ageism" in 1969 to refer to "a process by which people are systematically stereotyped for the mere fact of being old, in the same way as racism and sexism act in reaction to the color of a person's skin or gender" (Johnson & Bytheway, 1993). In this regard, ageism may act as a major category, serving as a societal or cultural backdrop where elder maltreatment is accepted and allowed (Penhale et al., 2000).
- Violent culture: Culture is believed to play a very important role in spreading violent behavior. Tolerance of violence in a society may be reflected in the media, in the behavior toward disabled people, or in the way nations resolve conflicts. This acceptance or normalization of violence permeates daily activities and may contribute to the manifestation of violence.

Gender-Based Violence Against Elderly Women

Women across the lifespan can be victims of violence, but little attention has been paid to neglect, abuse, and violence toward older women (Brownell, 2014). In addition, although partner violence is a relevant issue that has received considerable attention in recent decades, unfortunately, violence against elderly women by their partners has not received the same attention. The objective of this chapter is to analyze this phenomenon.

Although some studies have found no significant differences in elder abuse between men and women (Archer, 2000, 2002; Yon et al., 2017), most studies have highlighted gender as a key factor in this phenomenon (Amstadter et al., 2010; Bazo, 2001; Hemblade, Gerz, Kirilova, Appelboom, Kafka, Adu-Atwere, & Platzer, 2017; O'Keeffe et al., 2007), as recognized in the initial statement of the WHOSEFVA Project (Working with Healthcare Organizations to Support Elderly Female Victims of Abuse):

> Elder abuse is a worldwide concern that touches on human rights, gender equality, domestic violence and population ageing. The feminisation of ageing and its consequences is troubling, particularly given that older women as a group experience unique and compounding disadvantages. Older women face triple jeopardy in that they are part of three different marginalized groups: they are elderly, abused, and female. Gender discrimination across the lifespan therefore has a cumulative effective, and neglect, abuse and violence across the lifespan results in a high lifetime rate of suffering from abuse for older women. (Hemblade et al., 2017, p. 7)

Penhale (1999, 2003) highlights some interesting ideas about the relevance of gender in elder abuse. First, men are more likely to be physically violent and commit more serious violence than women. The kinds of abuse committed mainly by women (such as neglect or psychological abuse) are less likely to be reported, and so less visible. Second, much of the elder abuse is between partners in later life, and the main form of abuse for male abusers is physical violence toward women, and so it may appear that more women are abused than men. Finally, as is the case for younger women, sexual abuse in later life appears to be highly gendered: victims are female, and abusers are male.

In fact, the profile of a victim of elder abuse in early research was that of a woman, 75 years old or more, with dysfunction or dependency, who lived with an adult son/daughter, and this has been confirmed in Spanish studies (Iborra, 2008). Nevertheless, there are few data about elderly women suffering from partner violence (Nägele et al., 2010). Next, some of this information is analyzed.

A research study using a survey of 355 elderly people (over 60 years old) in China found a prevalence of elder abuse of 21%, and 26.9% of the aggressors were the partners (Tang & Yan, 2001).

Pillemer and Finkelhor (1988) also found that partners were the perpetrators in a high percentage of cases of elder abuse in the USA. The prevalence of elder abuse in a sample of 2,000 people was 3.2%, and the aggressor was the partner in 58.7% of these cases.

In 2010, an interesting study was carried out on elder abuse and maltreatment against elderly women in the European Union. The sample consisted of 2,880 elderly women (over 60 years old) from Austria, Belgium, Finland, Lithuania, and Portugal. The results showed that 30.1% had been abused in the past 12 months, with the most reported abuse being psychological. In 41.4% of the cases, the perpetrator was the current partner (Hemblade et al., 2017).

In Canada, a study was carried out on femicides between 1974 and 2012, and the situation of elderly and young victims was compared. The sample consisted of 2,025 women who were killed in that period, and 17% (335) were 60 years old or more. They found that 34% of the elderly women were killed by their partners, a higher percentage than in the young victims (Hemblade et al., 2017).

Eisikovits, Winterstein &Lowenstein (2004) carried out research with a sample of 1,045 retired people in Israel. The prevalence of elder abuse was 18.5% (18% neglect, 8% verbal abuse, 2% physical or sexual abuse, and 6.6% financial abuse. Physical, psychological, and sexual abuse were perpetrated mainly by partners. In a specific study on the number of elderly women killed between 2006 and 2015, the results showed that, in that period, 15 elderly women (over 60 years old) were killed, that is, 10.34% of the total number of women killed.

Between 2009 and 2016, 1,048 women were killed by their partners in the UK, and 15.36% (161) of the victims were elderly women (over 66 years old) (Hemblade et al., 2017).

In Spain, the Ministry of Equality (*Delegación del Gobierno contra la Violencia de Género*) publishes the statistics on femicides due to intimate partner violence. Between 2003 and 2019, the prevalence of elderly women femicides ranged from 5.5% to 21.2% of the total number of femicides. From 2003 to 2019, 129 elderly women were killed by their partners in Spain. In the figure below, the information about these victims is broken down by age group (Fig. 7.2).

Intimate partner violence (IPV) against elderly women presents two characteristics (Gracia-Ibáñez, 2012):

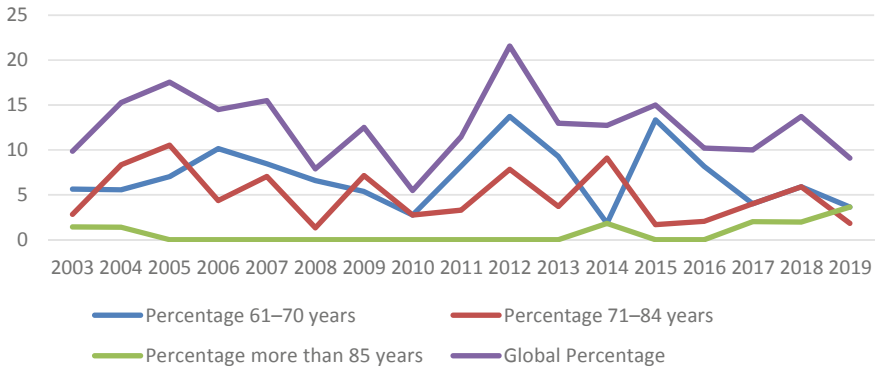

Fig. 7.2 Percentage of elderly women killed by their partners in Spain (2003–2019). *Source of data* Ministry of Equality (Delegación del Gobierno contra la Violencia de Género)

- First, related to the persistence of this kind of violence, the literature indicates that IPV has usually existed from the beginning of the relationship, and so it is very resistant to change. Moreover, victims are likely to require specific caregiving (dependency, physical problems, etc. related to aging).
- Second, these women are especially vulnerable because of their age, cognitive and physical impairments, and the consequences of the violent behavior.

It is important to highlight that consequences of abuse in elderly women can be serious and involve psychopathological consequences such as anxiety and somatizations, with depression being the most common consequence in elderly people. Moreover, in the elderly, experiencing abuse increases the risk of death. A 13-year longitudinal study carried out in the USA found that elderly people who suffered abuse were twice as likely to die as those who did not (World Health Organization, 2016).

Several studies have shown that elderly female victims of intimate partner violence present worse health (objective and subjective) in different areas of their life (Mouton et al., 2010; World Health Organization, 2015, 2016):

- Physically: physical injury, bone and digestive problems, chronic pain, increased blood pressure, or heart problems.
- Psychologically: high levels of stress, depression, and anxiety, low self-esteem, etc.
- Socially: less social support and emotional and financial dependency.

Analysis of 30 Cases of Intimate Partner Femicides of Elderly Women in Spain

The killing of a woman or girl, particularly by a man and due to her gender, is called femicide.

The definition of femicide differs from culture to culture, country to country, and state to state, and so does the definition of an "elderly person." In some cultures, a woman is old after menopause; in other countries, a woman is considered elderly at the age of 60, 65, or later. As life expectancy increases and gender egalitarianism takes root, Western countries are attempting to redefine what an elderly person is and readjust the ages for pensions and retirement. It is ironic that although female longevity is greater than male longevity, women are often forced to retire at an earlier age than men. As an indication of the variation in attitudes toward elderly women, along with data on longevity, it is useful to point out that in 2017, the retirement age of women in China was 50, and in the USA, it was 66 (Hemblade et al., 2017, p. 32).

Below, the main variables in this phenomenon are analyzed in the cases of 30 older women (over 65 years old) killed by their partners in Spain.

On the one hand, it is relevant to point out that almost 60% of the cases of women killed by a family member in Spain; the aggressor was the partner. Therefore, more

than half of the extreme violence (resulting in the death of the victim) against elderly women is committed by partners; hence, it is a very relevant issue.

On the other hand, gender is an important factor in extreme violence in old age because, during the period studied, no man was killed by their partner in Spain. Being a woman is, therefore, a risk factor for this kind of violence.

Socio-demographic risk factors

Date of the killing: 20.69% of these homicides were carried out on holidays (Fig. 7.3).

Area: The majority of the female older victims of partner homicide between 2005 and 2007 were killed in urban areas (71.78%) (Fig. 7.4).

Victim's risk factors

Victim's age: The percentage of older women killed by their partners was 50% for the 65-to-74 age group and 50% for those over 74 years old. The prevalence is somewhat higher in the 65-to-74-year age group (2.40 per million) than in the over 74 age group (2.23 per million) (Fig. 7.5).

Victim's nationality: Ninety percent of the older women killed by their partners were Spanish, and 10% were foreign (6.67% from the European Union and 3.33% Asian) (Fig. 7.6).

Victim's disability: We have data on whether victims had a disability for 56.67% of the cases. Graphic 35 shows this information. At the time of their deaths, 52.94% of the older women killed by their partners did not have any disability, whereas 47.06% did. In particular, 29.41% had a physical disability, 29.41% had an intellectual

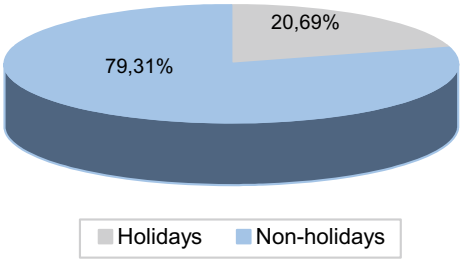

Fig. 7.3 Percentage of older women killed by their partners on holidays

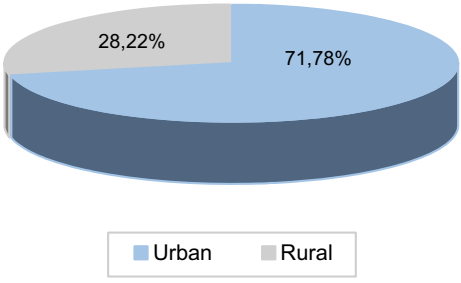

Fig. 7.4 Percentages of older women killed by their partners by area

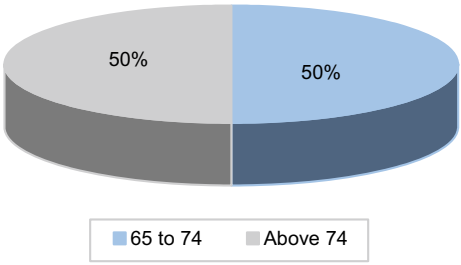

Fig. 7.5 Percentage of older women killed by their partners according to the victim's age

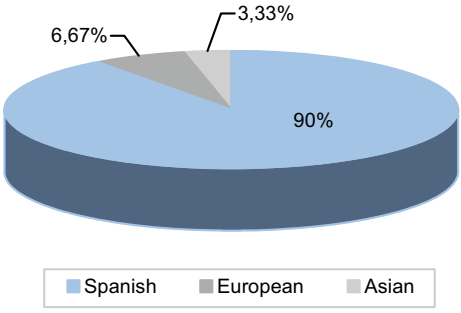

Fig. 7.6 Older women killed by their partners, by nationality

disability, and 5.88% had a sensory disability. Of the older women for whom we had disability information, 17.65% had more than one type at the same time (Fig. 7.7).

Senile dementia in victims: 29.41% of the older women killed by their partners suffered from Alzheimer's disease.

Mental disorders in victims: We have data on whether victims had a mental disorder for 60% of the cases. In these cases, 88.89% of the older women killed by their partners did not have any mental disorder at the time of their death. The rest did have mental disorders: depression in 11.11% and a personality disorder in 5.56%. All the older women with a personality disorder also suffered from depression.

Victim's dependency: We have this information for 63.33% of the victims. The percentage of dependent older women was 47.37%, whereas 52.63% of the older women were not dependent.

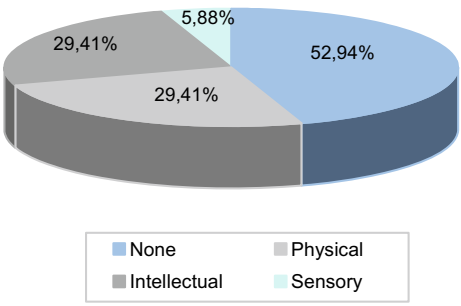

Fig. 7.7 Older women killed by their partners, by type of disability

Perpetrator's risk factors

Offender's age: The majority of the offenders were over 64 years old (28 cases). Only two aggressors were between 55 and 64 years old. As with the incidence, the average prevalence of offenders over 64 years old (2.94 per million) is higher than the average prevalence of offenders between 55 and 64 years old (0.28 per million).

Offender-victim relationship: Most of the men who killed their older partners (90%) were married to them. Of the remaining 10%, 3.33% were ex-husbands, 3.33% were former living-together partners, and 3.33% were boyfriends (Fig. 7.8).

Offender's nationality: 93.10% of the offenders were Spanish, and 6.90% were foreigners. Of these foreigners, 3.45% were from the European Union, and the remaining 3.45% were from Asian countries (Fig. 7.9).

Offender's disability: We have data on offenders and their disabilities in 70% of the cases. Of these offenders, 85.71% did not have any disability, whereas 14.29% did. In all the cases where the offender had a disability, it was physical (Fig. 7.10).

Mental disorders in offenders: We have information on whether offenders had some type of disorder in 66.67% of the cases. Thirty percent of the offenders had a mental disorder. In 10% of these cases, the type of disorder was not specified. In 10%, the disorder was affective (depression), and in the other 10%, the disorder was psychotic in nature (mainly schizophrenia) (Fig. 7.11).

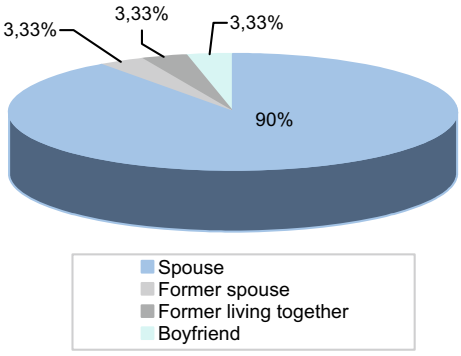

Fig. 7.8 Percentage of men who killed their older partners, by the offender's relationship with the victim

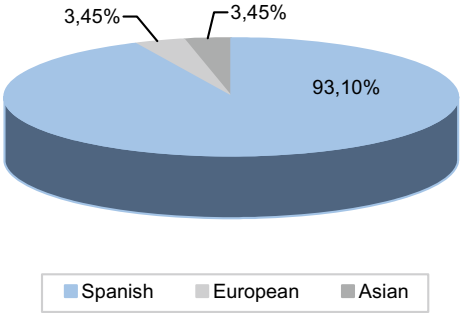

Fig. 7.9 Men who killed their older female partners, by nationality

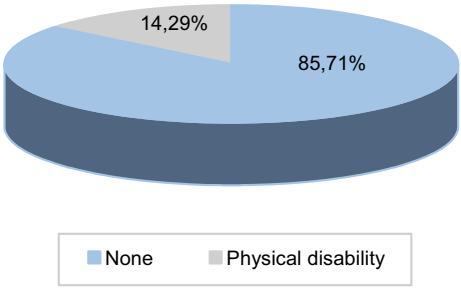

Fig. 7.10 Men who killed their older partners, according to whether or not they had a disability

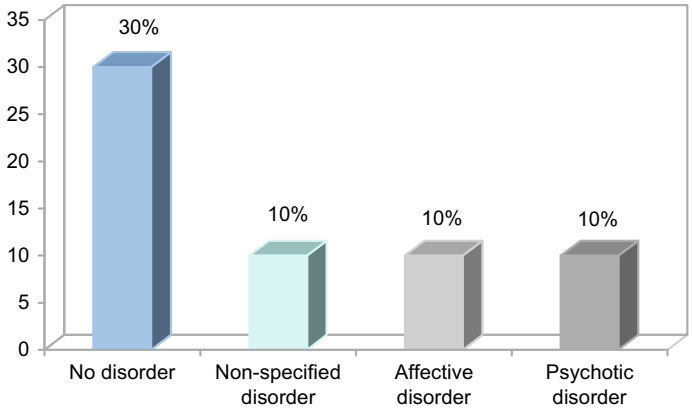

Fig. 7.11 Men who killed their older partners, by type of mental disorder

Offender's criminal record: 13.33% of the offenders had at some time come into contact with the police for breaking the law before killing their partners, although only 3.33% had criminal records prior to killing their partners. With regard to a prior history of partner abuse, at least 20% had one, and 10% had had charges filed against them for abusing their victims. In addition, at least 3.33% were under court orders to stay away from their victims when they killed them.

Criminological variables

Location of crime: 93.33% of the homicides took place in the victim's home, whereas 6.67% occurred in residences for older people (Fig. 7.12).

Method of killing: As the graphic shows, knives (63.33%) were the weapon used the most. In the rest of the cases, 16.67% of the offenders used blunt objects, 10% strangling, 6.67% choking, and 3.33% hanging (Fig. 7.13).

Finally, regarding consequences for offenders, 56.67% of the offenders were arrested by law enforcement (40% were detained, and 16.67% turned themselves in), 30% attempted to commit suicide, and 13.33% committed suicide (Fig. 7.14).

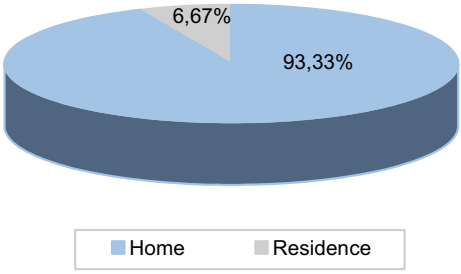

Fig. 7.12 Percentage of partner homicides of older women, by location of crime

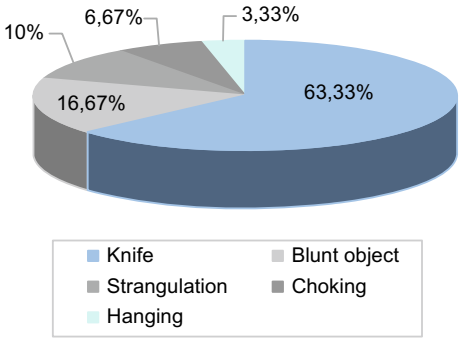

Fig. 7.13 Methods used to kill older partners

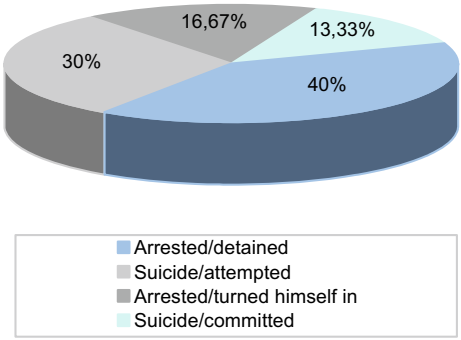

Fig. 7.14 Consequences for offenders after killing their older partners

Conclusion

More research on intimate partner violence against elderly women is necessary. There are few studies on this topic, but the data show that this is a real problem that has to become more visible. Specific studies are needed about risk factors of the victim and perpetrator, consequences of this violence in victims, and existing policies to deal with IPV against elderly women.

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Chapter 8
Life World of the Oldest–Old Women from Phenomenological Persepective

S. Jayashree and K. Rajendra

Abstract Men and women experience aging differently due to structural, social, economic, and cultural factors. Among aged women, 90+ are more vulnerable and helpless segment. Feminization of aging is evident in this segment due to extended longevity. The present study explores the lived experiences of 90+ elderly women living in family. It also seeks to comprehend the conditions, life situations, and day-to-day activities of elderly. It further attempts to know the social support mechanisms available to elderly and adaptive mechanisms adopted by the elderly. Whether enhancement of life span for women is really a boon or a bane? The needs and demands of the oldest–old women have not been given any priority in welfare policies. Lack of gender-specific old age policies and gender-specific health policies is the real constrains to meet the needs of the elderly women. Thus, an elaborate and accurate knowledge of the position of elderly women is a primary requirement to frame a social policy relevant to the well-being of the elderly women. Realistic appraisal of current situation of elderly women is need of the hour. In the present study, interpretive phenomenological perspective is used to understand the everyday life and inner feelings of elderly. Sociological phenomenology is also administered to understand day-to-day life of oldest–old women.

Keywords Interpretive phenomenology · Oldest–old women · Feminization of aging

Recently there is an accelerated growth of elderly population all over the world and it will grow rapidly due to declining fertility, declining mortality and inventions in the field of medical science in controlling diseases and morbidity. By 2050; aged 65+ is expected to rise to 1419 million or 15.9 percent of the world population. (UNDP, 2003; McCracken & Phillips, 2005).Besides this, very old especially 80+ and 90+ segments are increasing very fast. When society has limited number of elderly people, issues pertaining to them were more or less same. Now, researchers

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found that elderly are not homogenous segment. Life of elderly differ on the basis of various socioeconomic and cultural parameters such as age, sex, marital status, geographical location, income, and in case of India it is caste and class. On the basis of various challenges faced by elderly in general and different segments of elderly in particular gerontologists have classified aged as young–old, old–old, and oldest–old.

Men and women experience aging differently due to structural, social, economic, and cultural factors. Issues of elderly women in general have been studied by various scholars. However, tribulations of 90+ elderly women have not been given importance in research studies, because societies do not bother to have concern on the dying and unproductive segment of the population. From various studies on elderly, we have now come to know the fact that, elderly women are also not homogenous group; each segment of elderly has different issues, challenges, and problems. Among aged women, 90+ are more vulnerable and helpless segment; they have already been relegated and marginalized by society, and they are further sidelined, when they reach advanced age. Feminization of aging is evident in this segment due to extended longevity as compared to men in later part of life.

Women at any age and stage have already been neglected, because of structural constrains and marginalization. Being a woman, aged, dependent, and being widow, their condition is pathetic and dismal. Besides these, issues, social security, meager financial means, psychological trauma, grinding poverty, discrimination, social stigma of various types and other structural constraints are haunting elderly women. With all these hassles of life how they lead their life is a whooping question. Hence, the valid question arises, whether enhancement of life span for women is really a boon or a bane? Under these circumstances, how best they can meet the genuine needs. The needs and demands of the oldest–old women have not been given any priority in welfare policies. Lack of gender-specific old age policies and gender-specific health policies is the real constrains to meet the needs of the elderly women in general and oldest–old women in particular. Thus, an elaborate and accurate knowledge of the position of elderly women is a primary requirement to frame a social policy relevant to the well-being of the elderly women. For that we have to prepare a realistic appraisal of current situation of elderly women. (Jayashree, 2017).

Theoretical Background

During the late 1970s and 1980s, a widespread transformation occurred in the sociological study of aging in which the "facts" of aging—as stated in the big theories by the big theorists—were increasingly ignored or questioned. Indeed, they began to oppose or avoid metanarratives and catch all explanations of aging. Humanistic gerontology developed at this time and drawing on social phenomenology to provide entry points to the social construction of aging focused on the meaning and experience of aging (Hepworth, 2000). Most recently, the 1990s and the beginning of the new millennium have seen the emergence of a critical cultural gerontology (Gullette,

2000). Overall there has been a greater adoption of postmodern theories, a celebration of specificity and difference in research, a focus on body, self, social identity, self-identity, autonomy, and everyday life (Sahoo et al, 2009).

In the present study, interpretive phenomenology was used to understand the everyday life and inner feelings of elderly women. Interpretive phenomenology is both a philosophy and a methodology that is used to analyze meaning in everyday life. (Koch, 1995) Hermeneutic phenomenology stresses that, every event or encounter involves some type of interpretations from an individual's background, and that we cannot separate this from an individual's development through life. (Susann, 2003) How older people peep into their past and recall and construct their lives through autobiographical narratives. They had distinct ways of life. It also provides link and bridge between past and present, continuity and change. As individuals grow old, they expose to new and diverse experiences which will be reflected in everyday life of older people.

Sociological phenomenology also administered to understand day-to-day life of oldest–old people. According to Alfred Schutz "all humans, carry in their minds rules, social recipes, conceptions of appropriate conduct, and other information that allows them to act in their social world. Schutz views the sum of these rules, recipes, conceptions and information as the individuals 'stock knowledge at hand.' This stock knowledge gives people a frame of reference or orientation with which they can interpret events as they pragmatically act on the world around them." (Turner, 2013: 685).

In any population, oldest–old are limited in number and they are mostly dependent and susptible to all sorts of problems and challenges. Their mobility is restricted due to higher morbidity rate. They have come to this stage of life due to many interwoven factors, from genetics to lifestyle, finance to interpersonal relationships. Though most of the elderly women in India, live in family atmosphere issues of living arrangments and caring are the twin challenges they encounter the most. Who looks after them? What they anticipate from caregivers, from government and from larger society? How they lead their day-to-day life? What are their inner feelings? The present study explores the lived experiences of 90+ elderly women living in family. It also seeks to comprehend the conditions, life situations, and day-to-day activities of elderly. It further attempts to know the social support mechanisms available to elderly and adaptive mechanisms adopted by elderly. As Schutz pointed out "Peoples' reality is their stocks of knowledge." Researcher used these stocks of knowledge of the respondents through long hours of face-to-face interaction. It allows the researcher to see the world from the social actors' point of view. Hockschild (1973) pointed out that, previous studies are "age-centric" and ignore the elderly's view of themselves and their viable roles in society. Hence, present study focused on lived experiences of elderly women which will be helpful for the policymakers on elderly women. Therefore, an attempt has been made to get the valid experiences though a different methodology. It is carried out by using extended rounds of semi-structured and sometimes unstructured interviews.

In India, generally women are considered as core caregivers for the whole family. She has never been seen as care receiver. Caregiving has been ingrained to her by

birth. Caregiving does not fetch any monitory benefit which has pushed women to periphery. A long tradition of devaluing women and concomitantly their work of caring…. Women are socialized to serve and care for others…. This expectation probably emerges far more from women's lower status in society than from a natural predisposition in these directions. Kerner Furman (1997).

Review of existing literature indicated that, a number of studies have been carried out on pathological, socioeconomic and psychological aspects of aged in general. Studies on elderly women concentrated more on widowhood and care issues, and these studies treated all women elderly are homogenous group. Despite their multiple marginalization (being women, widow, being old and dependent) studies are deficient, in case of old–old elderly widows and their caring scenario and woes.(Jayashree, 2017: 194) No study, so far conducted on 90+ elderly women by using hermeneutic phenomenological perspective.

Limitations of the Study

Those who are living in old age homes were excluded. Male elderly were also excluded in the study.

Objectives of the Study

1. To record overall life experiences as narrated by respondents.
2. To identify everyday activities of the respondents.
3. To know their attitude toward modern society and youth.
4. To ascertain social support mechanisms available to them.
5. To suggest policymakers

Sample

The study conducted in Dharwad city of Karnataka State. Elderly women who have crossed 90 years were taken for the study. Dharwad city consists of 22 wards. Out of that, 25 percent of the wards (05 wards) have been chosen for the study. There were 61 elderly women who have crossed 90+ age in these five wards. Respondent's age was ascertained through latest voter's list. Semi-structured interview schedule with more open end questions was used to elicit information from the respondents. Researcher conducted **three rounds of interviews** and each round of interview enhanced the researcher's insight and we could gather lot of information in successive interviews. Confidentiality and anonymity were ensured for the respondents.

Interviewing 90+ elderly is not an easy task, because most of the time, they were not interested to interact, "withdrawal symptoms" already set in among most of the elderly; hence, dropout rates were very high and they were not interested to share certain things with others. Hence, building a rapport was a herculean task for the researcher.

Aging Scenario in India, Karnataka and in the Study Area

With continued decline in fertility and mortality, population aging is accelerating in India. According to 2011 census, elderly comprised of 8.6%, and it is projected to increase to 12.4% by 2026. The composition of elderly in different segments is also changing, for example, the share of young–old has decreased from 65.2% in 1961 to 61.7% in 2011, whereas the share of the old–old has increased from 34.8% in 1961 to 38.3% in 2011. (Irudaya rajan & Balagopal, 2017: 03) Feminization of widowhood is also evident in India which impinges the life of elderly women in all respects of social life. According to National Sample Survey (NSS) 42nd round there were 654 widows and 238 widowers per 1000 old persons in rural areas. The respective figures were 687 and 200 for urban areas. Table 8.2 substantiates the fact.

Presently, Karnataka State has 9.5% of aged population (Census 2011). Elderly population in Karnataka increased from 7.3% in 2001 to 9.5% in 2011. Out of the total elderly, 4.5% were elderly males and 5.0% were elderly females. There are 30 districts in Karnataka in which Udupi District has highest number of aged (13.15%) and the lowest number of elderly found in Raichur District. Highest number of female elderly also found in Udupi District. Feminization of widowhood and feminization illiteracy is evident in all the districts of Karnataka. In Karnataka, 0.5% were widowers whereas 2.70% were widows (Census 2011). Following tables present the glimpses of aging scenario in India as well as in the State of Karnataka and Dharwad dist (Tables 8.1, 8.2, 8.3 and 8.4).

Table 8.1 Elderly population aged 60 years and above in India, 1961—2011 (in millions)

Census year	Total			Rural	Urban
	Persons	Female	Male		
1961	24.7	12.4	12.4	21.0	3.7
1971	32.7	15.8	16.9	27.3	5.4
1981	43.2	21.1	22.0	34.7	8.5
1991	56.7	27.3	29.4	44.3	12.4
2001	76.6	38.9	37.8	57.4	19.2
2011	103.8	52.8	51.1	73.3	30.6

Source Elderly in India (2016), pp.15

Table 8.2 Elderly persons and widowed in Karnataka State

All ages	% of elderly			% of widowed		
	Persons	Males	Females	Persons	Males	Females
60–64	3.4	1.6	1.7	0.8	0.1	0.7
65–69	2.5	1.2	1.3	0.7	0.1	0.6
70–74	1.7	0.8	0.9	0.7	0.1	0.6
75–79	0.9	0.4	0.4	0.4	0.1	0.3
80 +	1.0	0.4	0.6	0.5	0.1	0.4
Total	9.5	4.5	5.0	3.2	0.5	2.7

Census of India, 2011 (DDW-2900C-02fer3-MDDS.xls)

Table 8.3 Elderly population in Dharwad district

Elderly population		
Dharwad district	2001	2011
Total population	16,04,253	18,47,023
Elderly male	55,572	82,759
Elderly females	61,910	91,008
Total elderly	1,17,482	1,73,767
% of elderly	7.3	9.4

Census of India 2011

Table 8.4 Elderly persons and widowed in Dharwad

All ages	% of elderly			% of widowed		
	Persons	Males	Females	Persons	Males	Females
60–64	3.4	1.6	1.8	0.8	0.1	0.7
65–69	2.6	1.2	1.4	0.8	0.1	0.7
70–74	1.6	0.8	0.8	0.7	0.1	0.6
75–79	0.9	0.4	0.5	0.4	0.1	0.3
80 +	0.9	0.4	0.5	0.5	0.1	0.4
Total	9.4	4.5	4.9	3.2	0.5	2.7

Census of India, 2011(DDW-2900C-02fer3-MDDS.xls)

First Round of Interview

In the first round of interview, we have collected all the relevant socioeconomic cultural profile of the respondents. Respondents who were shown interest and were able to converse well were selected for the second level of interview. At the third round of interview, there were only nine respondents. These nine respondents' responses were "real-life experiences." Third round of interview was conducted at home as well

as in parks and in playgrounds where elderly are freely available. Third round was combination of both informal talk and interview. In the third round, body language, atmosphere in the home/park/playgrounds, conversation of other members, interruption of members, and other trivial aspects have also been taken into consideration in order to arrive at a comprehensive understanding of the life situations of elderly.

In the first round of interview, out of 61 oldest–old women, we could collect information from 53 respondents; eight respondents were not able to answer and not ready to give interview. Overwhelming majority of the respondents were between the ages of 90–95 years and only two respondents crossed 100 years. 91.66% of the respondents were illiterate, and 5.17% were retired from government service. Majority of the respondents have elderly children as their caretaker. Respondents who were living alone left their children's home long back. Feminization of widowhood was clearly evident in the study. Respondents were having intimate relationship with their grandchildren than their own children, and they spend time in watching TV and chanting God's name. Majority of them were taken one or the other benefits from the government (Sandhya Suraksha, or Indira Gandhi National Old age pension (IGNOAP)/ widow pension). 89.16% of the elderly were living with son, and 10% were living in daughter's house. Staying in daughter's house is not a usual phenomenon in Indian social fabric because of staunch patriarchal principles. Respondents revealed some of the interesting facts about living with daughters. Respondents do not have sons was an obvious reason for their stay in daughter's house. In some cases, sons were not looking after, some of them had left son's house due to harassment; sons were staying in different places and caretaking by rotational base were some of the other reasons. In three cases, respondents are staying permanently with daughter. They had come during daughter's delivery and stayed in daughter's house by looking after grandchildren. Those elderly who were staying with daughters are feeling better as compared to those who were staying with sons.

None of the respondents were ready to go to old age homes, and they never thought of the same. Respondents pointed out that, family atmosphere is very important and it is first priority during old age. Relatives and well-wishers come home enquire about health and well-being of the elderly that gives lot of solace to the aged. The study conducted in Japan revealed that, older people who reported a lack of social contact were 1.5 times more likely to die in the next three years than were those with higher social support (Sugiswa et al., 1994).

Only 15% of the respondents pointed out that, their health is very good. These respondents did not have any ailments. 80% of respondents visit doctor along with son/daughter and 12% of the respondents visit doctor along with grandchildren. Except two respondents, all the other respondents visit private hospitals. Some of them were suffering from multiple ailments which inhibit them from doing day-to-day chores. Majority of them were suffering from diabetes (35.84%) BP (28.24%), and joint pains (78%). 71.66% were suffering from eye and ear problems. Respondents reported that, they get required social support from the family. Families in which son and daughter-in-law were employed, social support mechanism was not so cherished, and it is more of a routine in nature, because it is provided by the servants and the people who are not the family members. Most of the elderly do

not have vibrant activities of daily living. Some of them expressed that, they are not able to cope up with the modern gadgets like mobile, TV, and other household gadgets. Modern values and life patterns are not palatable to them. Hence, they grumble, irritate and some of the respondents said that, they talk themselves. Thus, **self-murmuring mechanism** they resort when they are not happy about family members.

Second Round of Interview

In the first round, researcher has made close rapport with the respondents and by seeing their interest, willingness, ability to participate, they had been asked to partake in second round of interview. 14 respondents gave their consent to participate in second round of interview. However, researcher could take interview for 11 respondents due to their non-availability and ill health during interview period. In some cases, sons/family members were not allowed them to give interview. Second round of interview focused on everyday activities of elderly, adaptive mechanisms as well as attitude toward younger generation and perceptions about modern society were collected. In the second round of interview, some of the earlier questions were repeated to ascertain whether answers given were correct. Time of the interview, presence of family members, body language of the members in the family, activities, situations/contents (both material and non-material) conditions of the home are potential contextual data which helped the researcher to arrive the finding of the study.

In the second round of interview, respondents were very happy because someone is listening to them carefully. During the interview, some interruptions by the family members was usual phenomenon. Second round of interview was time consuming; researcher took half a day with each respondent. Majority of the respondents narrated their past life, their job, turmoil, children, friends, values, and old social fabric during the course of the interview. They have mixed feeling about today's modern society. They commented that, today children are not having patience to listen; peace and happiness both are missing among them.

As one woman said *"I married at the age of 16 now I am 93 years. I spent entire life in this home; my old memories are attached to the soil and stone of this home."* She said, *women are born for adjustment; for women natal home and marital home are two different islands. After marriage, only woman has to adjust to new atmosphere, new ideas, attitudes, values, desires, and ambitions. Adjustment is ingrained in women, whereas men are always living and staying in their own house with their kith and kin.* She indirectly hinted on patriarchy. She further said, *"Elderly of tomorrow will have lot of complexities and difficulties unless they make their own financial and social arrangement. Government is doing little things for elderly women, whatever they are doing is not sufficient for their survival and maintenance of health.*" She lamented that, women are heavily penalized in the coming years. Because women in general are regarded as traditional caregivers and society always

see elderly women as care provider and seldom see as care receiver. According to her, *filial piety and intimate relationships will evade in future.*

Questions on younger generation, modern society, elderly care, and old age homes, health issues, everyday activities, leisure and recreation, interpersonal relationships, family bondage, adjustment mechanisms and financial matters were discussed. Some of the elderly were not so vocal in their expressions with regard to finance and interpersonal relationships. Overall response was very good and researcher could able to arrive at some generalizations which are given below. With regard to caring, one of the respondents expressed that *"My children are at least looking after me. If not, at this advanced age where I can go? Compared to other women in my neighborhood, I am lucky"* Overwhelming majority of the respondents were not dependent on others for their routine daily activities like going to toilet, dressing, and bathing, (ADL). They were dependent on others while going out for bank, post office, and hospital. One of the respondents said "*Age related health issues are common. I am not engaged and involved in many activities as earlier, whatever essential I do. I am not washing my cloths. Not attending any function. If I want to attend some function I am not insisting family members to take me. I know that, they don't like to take me. They give some lame reasons like "dinner will be late there" "you are diabetic patient," "there will be lot of crowd,"*etc..

One old lady whose husband is suffering from Alzheimer disease was very vocal. She expressed that *"because of me my husband is alive; he lost his memory when he was young-old and I have to monitor everything. At this age I am taking all possible care. Children are also supporting me, she wept and said "he should die before me otherwise his life will be miserable. I am taking good care of his health I don't have the feeling that he is dependent on me."*

Health is a big challenge and it influences all other aspects of life in old age. All the respondents attributed their health to food, lifestyle and heredity. Majority of them had a proud feeling that, they lived up to 90 years without major health issues. Mental health and depression were totally absent among respondents. Majority of the women do not visit doctor for small ailments and resort to home remedies. However, some hurdles in administering medicines and appointment with doctors have been expressed. Because of rampant illiteracy among respondents, they are not able to recognize the tablets. On the basis of color of the tablet, they take medicine. With regard to intake of medicine respondents pointed out that, if there is multiple medicines they are confused and they totally dependent on others. Almost all the respondents revealed the same opinion about their everyday life. They follow the routine and engage in only essential activities, majority of them confined to a particular room/place/bed/chair. They talk very less and spend more time in relaxing.

Third Round of Interview

By the time of third round of interview, researcher has established very good rapport and intimacy with the respondents. Respondents were confident that, researcher has

lot of empathy on them. In this round, elderly women narrated their inner feelings. In the first and second rounds of interviews, most of the elderly were reluctant to reveal the negative aspects which they were encountering in their daily life. They have some kind of phobia that, they lose family member's confidence. When researcher asked first time they never revealed because it is embarrassing and painful to disclose with others that, one's son is not looking after and rejected them. They used gentle terminology like, "N*ot comfortable; Children have their own problems, It is new way of life. We are not useful, Our era has gone,* etc." Some of the respondents revealed family secrets and took promise from the researcher that, matter discussed should not be revealed to anybody.

One elderly woman was not happy about her family members. She said *"we have lot of reputation as a big and prestigious family and our family is known to everyone in this place. If I reveal the difficulties I face, my family prestige will vanish. To keep my family stature I just kept it to myself and swallowing the pain which I am undergoing."* Family members are not giving proper food to her and they say, "Older people do not need more food." Since she is a diabetic patient she wants to eat frequently, but family members are not providing adequate food. She has five sons and on rotation-wise she has been looked after by her sons. She said, *I should have at least one daughter she would have understood me and I would have shared my feelings I do not have any friends, all my age mates have passed away. God has given me long life and I am waiting for the final call from the God.*"

Majority of them talked about God at one time or another and involved in spiritual activities. They opined that, "*God determines everything, Trust in God, He will direct us, Life is God driven. You have to follow His will. Future is in the hands of God*.

A woman aged 93 pointed out that, past life was a glory "*we had many pressing problems. there was no money not even things which we needed, there were not much cloths to wear, not even electricity in the house, toilets and bathrooms were outside the house, no tap water, we have to draw water from well. I was nurtured in a joint family and married to joint family. With all these hassles of life we did not fight for anything, women in the family used to be together, work together, enjoy together. Preparation for festival was a joyous occasion and all of us sit together for lunch and dinner. Of course, we did not have much freedom to take decisions. Today everything is there for the younger generation but they are not happy and contented. She again lamented that, without contentment what is the use of freedom? She reminisced 'Earlier life was so good.'"*

One of the respondents aged 96 narrated her story. She has been interviewed thrice and she was at ease during all three interviews. She was living with her son and grandchildren. She did not have any ailments during the second round of interview. When we have gone for the third round of interview, she had fracture in the leg. She used to do all her daily activities without depending on others. Because of fracture she was not able to move, her daughter from nearby village came to look after during her immobility. She said *"when I am unable to move, I am more comfortable with my daughter than sons. She said God has graced me by bestowing long life and now waiting for the final call of God*." She attributes her long life to her prayers, peaceful life, and intake of limited food, lifestyle, contentment in life and heredity.

The lady about 92 years has two daughters and four sons. Presently, she is living with fourth son and his family. She was ready for the third round of interview. In the first two rounds, she provided lot of information regarding her family (husband, children, and daughters-in-law). She said food, shelter, and clothing have been provided by son who is also crossed 60 + . *"These are not the only needs of elderly; I would like to give something to people who have helped me during crisis. I have taken lot of pain to bring my children to this level. She lamented that now-a-days people are forgetting past life. Being a widow, I took the help of my parental house and educated all my children. Now family members in my home treat me like a thing not as a human being. My existence is not at all considered in any of the family matters. They think, I don't know anything if I did not know anything, how I would raise my family in crisis."* She feels that, she should have been given little money for her own expenditure.

A subtle issue of gender identity was expressed by a woman. In her words *"I have accepted masculine role and performed my role as a male due to circumstances. People used to comment on me remarked that, she has done work like male because I used to take up all work which is traditionally designated as male work*." By gender identity is meant "how one defines oneself as a woman (or man), and in what ways one feels feminine or masculine" (Huyck, 1994:203). Social isolation, toleration, remain invisible, constant insults, not raising the voice, are some of the ingrained features of womanhood, and these will be precipitated due to financial insecurity and dependency during old age.

A woman who has just completed 90 years was very vocal and also independent. She was well informed and daily reading newspaper and does her work without taking assistance from anybody. She said: *"People advise me that, due to my age I should disengage from all the affairs of the family, but I am not interested to disengage when I am not dependent on others why I should disengage?* In this case, Robert Butler's (1987) idea is apt to mention, he concludes that, in some cases, old age is equated by society with powerless and useless as a result of disease, disability, and uselessness. Butler (1987: 243) defines agism as "reflecting a deep seated uneasiness on the part of the young and the middle aged, a personal revulsion and to aversion for growing old, disease, disability and a fear of powerlessness, uselessness and death."

The above narration reflects that, for Indian women, widowhood and old age always go hand in hand. Feminization of widowhood and poverty culminates at fag end of life. "Lifetime" work done by women is not recognized nor counted in monetary terms. Manu's dictum is still hold and practiced by society. Laws of inheritance are constrained by social structure of society, which is not favorable to women. Elders are not seen as human beings but as objects, who therefore can more easily be denied opportunities and rights. In many cases, she has to fight for her husband's property. Her "invisible contribution" in young ages compound in poverty and insecurity at old ages. A vast majority of women are homemakers and their "invisible work" is neither quantified or remunerated nor recognized. Thus, their invisible work does not fetch them solid income and financial security. It is assumed that "women are passive and invisible receivers" mere dependants and not

contributing to economy of the family because of these they hardly have a voice in the decision-making forums.

Cultural practice and tradition in India preferred to give more importance to elderly in the family. Advanced age always respected and revered by society and family. Oldest–old are treated with honor and respect. However, of late these feelings are slowly evading and fading out. Social isolation and loneliness are precipitating the well-being of the elderly. Stereotypes are accepted, perpetuated, and reinforced in language, in medical practice, in policy and programs not just in individual relationships. (Jai Prakash, 2011: 120).

91-year-old widow lives alone in a big house, and she is well educated having a son and daughter. Son stays in USA. Daughter is married moved to her husband's place in the same city. She had lots of issues with her daughter who has married to a different caste person. Whenever daughter visits her, she reacts in a typical manner either she keeps mum or she talks too much by quoting what all she did for her children and sacrificed a lot for bringing up children. This lady is suffering from attention seeking syndrome. Because of her good health as well as sound economic background, she expects her daughter to be with her. There was no dearth of finance, as she was working in a bank. Daughter and son-in-law are good caretakers; however, she is not happy and feels that daughter should take care of her as she cared her daughter during childhood. Lack of understanding and too much expectations are the main reasons for her behavior.

Most of the experiences and contexts related to elderly women are always constructed by society. Woman aged 93 staying in her brother's house, she lost her husband at the age of 33, and she has one daughter. After the death of her husband, along with daughter she came to her elder brother's house. She is doing her day-to-day activities without depending on others. She narrated her 60 years story where she suffered a lot along with her daughter. She gets old age pension from Government of India. She experienced lot of humiliation, distress, agony in her life because of her poor financial conditions. She said *"Emotionally I was totally deprived and depressed. Feeling of emptiness, routine life pattern and aimlessness bothered me. There were lot of restriction on my talk, dress, movement, and participation in social life.. Now I am looking after myself and not depended on others for my daily needs. I should die without burdening on others". She said "Women's social responsibilities and roles are decided by men in the family."* In this connection, it is worth to mention French Sociologist, Pierre Bourdieu in "Masculine Domination" (2001) speaks to the social practices of the society that are so dominant that they are hardly perceived. Masculine domination is "a form of symbolic violence, a kind of gentle invisible pervasive violence that is experienced through the everyday practices of social life." Robert Connell advances the concept of hegemonic masculinity, referring to the gender practices of everyday life that "embod (y) the currently accepted answer to the problem of the legitimacy of patriarchy which guarantees (or in taken to guarantee) the dominant position of men and the subordination of women" (Connell, 1995: 77).

Elderly women aged 96 is staying alone in her own house. She was a teacher in a school and living in a portion of the house and the other portion she has rented

it out. Her son lives in the same locality in a different house. She was not adjusted with her son's family and she moved out after the death of her husband. She is able to perform her work without any difficulties. She has a cook and a servant to look after the daily chores. She said *"I never feel lonely and deserted, If I am not looking after my health, who will help me in future? With my pension I do whatever I want. I want to have independent life. I keep myself active and it is the secret of my life."*

Majority of the respondents commented on younger generation and modern society. They opined that, social disability and oppression were tagged to women in our generation, today's women are lucky they have been given lot of opportunities to participate in social and economic activities and discriminatory attitudes toward women have been reduced. In today's society everything is available without any difficulty. Younger generation is very intelligent, progressive, competent, and potential. In addition to this, individualism, success in career, selfish nature, impulse buying, market-driven culture, comparison, intense desire to have everything at a time, and materialistic attitude are widely seen among them.

Some of the respondents expressed that, *we have very formal talks with our own children. It is like question and answer type like, how are you? Take medicine in time, Take care, Look after, and Sleep well.* Though elderly wanted to talk more with them, children are busy and cut short their communication. However, compared to other elderly, we are blessed; at least our children are asking and enquiring us.

Majority of the respondents pointed out that, modern society offers many new things for youngsters to enjoy their life. They opined that, in a past changing world; values of the society are also changing drastically. With regard to youth, respondents did not express positive opinion. According to them, they are restless, money oriented, engrossed in modern gadgets especially in mobile. They are quarrelsome, not respecting old values and old people. However, they are more competent, smart, have big dreams, more fashionable, more intelligent than earlier generation. They are spendthrift and invest money on temporary things derive immediate happiness than think about permanent and enduring things.

However, they lack patience and do not know how to maintain their health and emotions. According to them, *great strength of their generation was contentment, acceptance, adaptive nature, emotional control and maintenance of tranquility; hence life satisfaction is higher for our generation than today's generation. Without anything we were happy and with everything youngsters are not happy. We live in old memories and we always cherish these memories even today. We had great ability to withstand everything in life. Today's modern society is full of inconsistencies, contradictions, uncertainties, imperfection emotional detachment, appalling interpersonal relationships.*

Results

The aforementioned results of the study show that, 90+ elderly women's day-to-day life is very simple. They brood over the past things and compare the earlier

spent hard days with the present situation. Mental health and depression were totally absent among respondents. Majority of the women do not visit doctor for small ailments. Initially, they try out home remedies, self-medication, food restriction, asking informal advice from close circles, modifying the sleeping pattern, dieting, asking religious healers, and seeking alternative healing to maintain their health.

They have also adopted some mechanisms to overcome the family tussle, in most of the cases they have engaged in spiritual activities which solace them. Some of the respondents kept quiet for all the unwanted happenings in the family.

Counseling interventions for both caretakers as well as elderly women need to be planned for their quality of life. Almost all the respondents opined that, their health was good. They opined that, as we have lived up to 90 years, without good health how it is possible to live more than 90 years. Though they look pale and have at least one ailment they never bothered much. Study found that, families provide support for elderly respondents. However, as caretaker's family grows, they have other obligations and responsibilities; quality care and respectful care are not available to elderly as anticipated. Elderly women who are illiterate and poor were more vulnerable and dependent because they do not possess any assets, no savings, and unable to demand anything from their own children.

A common idea from these narratives is that one must have some financial security during old age. Before the onset of aging people should make own financial provisions for the unforeseen conditions during old age. Some of the following suggestions can be incorporated. Minimum pension scheme exclusively for elderly women may be thought of. Special pension for very old women may be introduced. Health insurance cards for elderly women. IT benefits may be extended to children who are looking after elderly can be thought of. Daycare centers and recreational clubs can be opened for elderly women. U3A (University for Third Age) may be introduced, so that hidden talents of old people can be explored for future generation.

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Chapter 9
Older Women in India: Differential Vulnerabilities and Empowerment Interventions

Archana Kaushik

Abstract Population aging is considered as a mark of success of human civilization achieved through medical advancement and public health initiatives containing mortality rates and increasing longevity. And aging is more peculiarly a female experience. World over, societies and nations are aging fast, and "feminization of aging" is becoming a reality. However, for most females, old age is not a cherished stage of life. For more than three-fourths of elderly women in the world, old age is illustrated by increased morbidity, disability, dependence, despair, depression, and marginalization. India is a home to nearly 90 million elderly women. Aged ladies who have lived 50–60 years of their life in poverty, illiteracy, chronic malnutrition, learnt helplessness, devoid of skills, their old age are invariably portrayed by loneliness, alienation, powerlessness, without assets and resources, marginalization, and social exclusion. This paper chalks out the causal factors of the vulnerabilities faced by elderly women in India at the biological, social, and psychological levels. It also captures the efforts and interventions geared toward ameliorating their sufferings and empowering them. These interventions are undertaken by civil society organizations and government agencies. The paper also identifies the gaps in services and provides suggestive measures so that the elderly ladies can live the last years of their lives with health, dignity, independence, fulfillment, productivity, and happiness.

Keywords Elderly woman · Economic vulnerability · Health vulnerability · Social vulnerability · Empowerment

Introduction

Continuing since the second half of the last century, an unprecedented phenomenon called population aging has surrounded the world as a silent revolution. While this demographic transition is celebrated as triumph over death, leading to increased life expectancy, aging of populations has several implications at the socioeconomic and cultural levels. Increase in number and proportion of elderly is also seen as a burden

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on scarce resources for meeting the health and social security needs of a large segment of population in a given nation. It is anticipated that every family in the near future has to care for one or two or more generations of elderly relatives, due to escalation in life expectancy. Ageism stereotypes, increased dependency ratio, and other related factors have been and are impacting the quality of life of the elderly in general and aged women in particular.

It is estimated that each year nearly 58 million people turning 60 are added in the world population. Worldwide, the elderly population is expected to rise from nearly 810 million in 2012 to over two billion by the year 2050, showing almost double the increase (from 11.9 to 22%) of the total population during that period. Interestingly, projections say that by 2050 there would be more grandparents than grandchildren, meaning that population of people 60 years and above would surpass the number of children below 15 years. According to UNFPA and Helpage International (2012), at present, Japan is the only country with more than 30% of elderly people in their population, but by 2050, there would be 64 countries having proportion of the elderly more than 30% in the country's population (UNFPA & HelpAge International, 2012).

One of the prominent features of population aging, across the globe, is "feminization of aging", which is due to women outliving men because of their higher expectancy of life. Estimations show that elderly women constitute 55% of the aged population and about 58% of them live in the developing countries. Gist and Velkoff (1997) bring out that by the year 2025 about 75% of the world's older women would be in developing countries.

Social scientists and planners have noted that feminization of aging is coupled with a trend of "aging of the aged" that implies increased section of older people 80 years and above in the general population. These two aspects of demographic transition have given rise to unique set of vulnerabilities and challenges among older women. Enhanced years in the life of most women are not a welcome feature as they encounter longer periods of ill health, high morbidity rates, financial insecurities, poverty, diminished earning capacities, and increased dependency levels in the context of gender-based discriminatory sociocultural milieu. Old age, for most women, particularly those residing in developing nations, accentuate their vulnerabilities, powerlessness, and destitution. With rate of widowhood much higher among elderly women, they become increasingly susceptible to abuse and exploitation within their families and neighborhood.

In this backdrop, the present paper looks into the gender-specific vulnerabilities and challenges faced by older women in India at the physical, economic, social, and psychological levels. Further, it documents and analyzes the role of the state and civil society organizations to curb disempowering factors among aged females, identifies gaps in services, and provides suggestive interventions.

Aging in India

Looking at the demographic scenario in India, Census 2011 provides that there are nearly 104 million older persons aged 60 years or above that comprise 53 million elderly women and 51 million aged men. The share of elderly population in the total population for males is 8.2%, while females is 9.0%.

Demographers have projected that by the year 2050, India would be having nearly 20% of its population as elderly people. At that time, if the present socio-demographic conditions persist, life expectancy among males is estimated to be 71.8 years and among females 75.7 years. It is projected that by that year (2050) the number of elderly females would exceed the older males by 18.4 million. It may be noted that according to Census 2011, currently, sex ratio among the elderly is 1033 females per 1000 males.

Ministry of Statistics and Programme Implementation (2016) notes that during the period 2009–13, the life expectancy at birth is 65.8 years for males and 69.3 years for females. The average remaining length of life for that period is 18 years; almost 17 years for males and 19 years for females. It vividly confirms the trend of feminization of aging. Further, life expectancy at the age of 70 years is about 12–11 years for males and 12.3 years for females. Giridhar et al. (2016) calculate that during 2000–2050, while the overall population of India would grow by 56%, population of elderly (60+ years) would increase by 326%. Additionally, by 2050, there would be an exorbitant increase in the category of the "old-old elderly" by 700%. Subariya and Bansod (2014) bring out that with increase in number and proportion of the elderly in India, there will be reduction in the number and proportion of people in the working ages who could contribute to provision of health and social security for the increasing demands of older persons. Old age dependency ratio has increased from 10.9% in 1961 to 14.2% in 2011. Elderly women, for various reasons, have higher share of dependency ratio (14.9%) than aged men (13.6%) as per the census 2011.

Inference from these statistical estimations provides a grim picture for older women who, though would be outnumbering their male counterparts, may not be able to enjoy the last years of their life with health and happiness.

Vulnerabilities of elderly women on health aspects may first be looked into for the deeper analysis.

In the present paper, among other studies, findings of two large-scale research studies exploring vulnerabilities of elderly women in India are highlighted. One UNDP-sponsored study is conducted by Khan et al. (2013) on 11,520 households having elderly women and their caregivers and 1661 other stakeholders (government functionaries, doctors, other healthcare professionals, and NGO representatives) in the eight low-income states of north and north-east India (Uttar Pradesh, Madhya Pradesh, Bihar, Jharkhand, Assam, Chhattisgarh, Odisha, and Sikkim). Another UNFPA-commissioned study is by Giridhar et al. (2016) covering 1280 households having elderly in the seven states—Punjab, Himachal Pradesh, Odisha, Kerala, Maharashtra, West Bengal, and Tamil Nadu. Both the studies have looked

into the health, economic, and social vulnerabilities of older women in the study states, and the findings are thematically delineated below.

Health Vulnerability

> Savita (name changed) is 81-year-old widow living in a village of India with her younger son, daughter-in-law, and grandchildren. Her wrinkled, ailing body has become a hub of diseases. Arthritis, diabetes, coronary heart disease, urinary incontinence, and several other discomforts have made her daily living a struggle. She has almost turned blind due to cataract as she cannot be operated upon having high diabetes. She is dependent on others for her daily activities. Bedridden the whole day in her room, she keeps on staring at the door for want of some interaction with family members or at the roof asking the God to end her life.

Old age is generally considered as the set of deteriorative and degenerative changes occurring among individuals with increasing age. One of the most prominent and visible signs of old age is on the health and strength of individuals. Old age that is universal and natural phenomenon brings with it decline in sensory capacities, body's muscle mass and strength and vigor, thereby increasing chances of infirmities. Changes in various bodily systems such as digestive, circulatory, respiratory, and neuromuscular make aging individuals encounter several challenges in day-to-day functioning, increasing their susceptibility to a number of illnesses.

Though women have biological advantage of increased life expectancy than men, old age is far from a pleasant experience for most females. It is generally said that "elderly women are sicker and men die sooner." Older women, apart from suffering from common aging-related problems and ailments, also face two additional categories of health disorders—gynecological and postmenopausal morbidities.

Patriarchal social structure has gross implications on the health and well-being of females in India. All through their life, females experience gender-based discrimination, abuse, and oppression. A vast majority of women, who survive threats to life in terms of female foeticide and infanticide, encounter denial of equal access to developmental opportunities like health and education along with early marriage, repeated and multiple pregnancies, accumulated effects of which result in high rates of morbidity when they reach old age (see: Bagchi, 1997). Moreover, for most Indian women, malnutrition has been the way of life. Having food in the last when all family members have had and many times, just the "left over" has been the cultural practice followed by girls and women. Menopause accelerates osteoporosis that leads to degeneration of bones. Panda (2005) notes that with advancing age, dependence in activities of daily living increases, and hence chances of elder abuse also rise.

Khan et al. (2013) in their study have noted the following points with regard to their health vulnerability:

Looking at nutritional status, three percent of aged women in the study could not have even staple diet. More than 70% women have inadequate dietary intake leading to deficiency disorders. Depletion of purchasing power affects nutritional intake, and elderly women because of lack of economic autonomy are all the more vulnerable.

Poverty, poor nutritional awareness, and cultural notion of "females do not require nutritious food" have resulted in poor health conditions among aged women. In the states like Assam and Odisha, aged ladies are worst affected during natural calamities like floods and cyclones, owing to their nutritional and health vulnerabilities.

Almost 80% women reported their vision going down, 70% informed reduced functioning of bones/joints, and 46% encountering hearing loss. Though with varying rates, elderly women reported a wide range of medical complaints like general weakness, high/low blood pressure, heart problem, gynecological complications, digestive problems, prolonged coughing, etc. These ailments severely hamper their daily activities, interactions with significant others and also pinch the family budget.

Only one percent of elderly women had medical insurance. Most aged ladies postpone treatment. For destitute elderly women (four percent) and those below poverty line (51%), availing health facilities is a luxury which invariably they cannot afford.

Giridhar et al. (2016) have provided the following findings:

Over 60% of aged females in Tamil Nadu and more than 70% of them in Odisha and West Bengal rate their health as "poor". More than 55% of aged ladies in the age group of 60–69 years have ranked their well-being as poor, and it gets worse with increasing age. Most (70–80%) of aged women have at least one age-related disability. Usage of aids such as walking sticks, spectacles, and hearing aids is very limited especially among rural elderly women.

Findings further show that elderly females, particularly the widowed ones, bear higher burden of both chronic and acute ailments than aged males. Financial constraints and limited accessibility to public health services are the main reasons cited for not seeking treatment. Government-initiated health insurance programmes like Rashtriya Swasthya Beema Yojana have largely remained ineffective because of limited awareness and negligible usage among older women.

Economic Vulnerability

Gokhi Bibi (name changed), a 65 years old, illiterate Muslim widow, lives in the city of Tezpur. She is in perpetual state of destitution with no close relatives to take care. In a dilapidated thatched hut, she is living all alone for several years. Her sons, after getting married, left her and almost forgot about their aging mother. Isolation and loneliness bother her a lot.

Economically impoverished, even her basic needs remain unfulfilled for want of money. She works as a maid servant in the neighborhood and is somehow able to keep her body and soul together.

Though Gokhi Bibi is aware of old age pension scheme, she neither has money nor courage to keep on visiting the social welfare department again and again to avail the pension. Somehow, she is managing her food but finds it difficult to afford medical treatment or repairing of her hut.

Financial dependence or economic insecurity accelerates vulnerability among the elderly, and this is particularly true with regard to aged females. In a patriarchal social structure like India, while males are taken as the economic being or provider of the family, females who play a vital and productive role in domestic sphere are seldom considered economically worthy. Economic value of women remains invariably unaccounted, unnoticed, un-remunerated, and invisible, despite their substantial contribution in the household work as well as family's economic engagement, say, agriculture. Economic dependency among aged women is higher.

Women who today are sixty plus years old, and more often their childhood is characterized by skewed gendered relations—their brothers were preferred over them in provision of education, skill enhancement, and other developmental needs. A large majority of these elderly women have failed to develop adequate skills to remain economically independent. Consequently, their old age is featured by economic insecurity, dependence, and vulnerability to abuse and exploitation. Women are socialized to be dependent on their father in childhood, husband in youth, and son in old age. Prakash (1996) has aptly questioned, "if men who were once active in the labour force, are considered as 'burden', then what about women, who always had been invisible contributors, be treated when they are no longer useful (p. 29)"?

Giridhar et al. (2016) have observed that nearly two-thirds of the elderly women economically fully dependent on others and about 20% are partially dependent. With advancing age, income insecurity increases among aged females. They further noted that one-third of aged women do not possess any assets and only one-thirds of elderly widows receive social pension. Their findings show that 50% widowed, 42% poor, and four percent of elderly women living alone have had no personal income. Being poor, ten percent of older women are forced to work, mainly in unorganized sector with much lower wages, with no retirement or social security benefits. A high proportion of elderly women are found amidst poverty with heightened economic vulnerability in all the seven surveyed states. It was further observed that in Tamil Nadu and Maharashtra more than 85% elderly widows from BPL households remain out of the pail of social pension despite being the genuine claimants. High level of income insecurity and widowhood adds to the vulnerability of elderly women manifolds.

In their study, Khan et al. (2013) have observed that in rural areas, Bihar (67%), Jharkhand (57%), and Odisha (51%) have more than a half of the older women from BPL households. Likewise, in urban areas, Bihar (77%), Odisha (69%), Chhattisgarh (66%), and Uttar Pradesh (54%) have more than a half of the aged female respondents from BPL families. Further, nearly 83% aged women do not have any movable and/or immovable property in their name. A quarter of the elderly ladies are paying some amount for their upkeep to their family. In addition, 57% of aged women have reported that their expenditure is held up for want of money; some of the manifestations are medical treatment of self or husband, marriage of daughter, house needing repair, etc.

Looking at social security measures, only 23% of aged women respondents are availing old age pension, with Uttar Pradesh having the lowest proportion (ten percent) and Sikkim (31%) and Odisha (30%) highest.

Next, in Annapurna scheme initiated by the Government of India, ten kilograms of food grains (rice or wheat or both) were provided free of cost to the needy elderly who remain uncovered under the old age pension scheme. Findings show highly poor awareness as well as coverage of Annapurna scheme in the study states—12% in Jharkhand, six percent each in Odisha and Bihar, five percent in Sikkim, two percent each in Assam, Chhattisgarh, and Uttar Pradesh, and merely one percent aged women in Madhya Pradesh have availed benefits under Annapurna scheme.

Psycho-Social Vulnerability

> Bimla Devi (name camouflaged), a 63 years old widow, lives with her son, daughter-in-law, and two grandchildren in the outskirts of Aligarh city. Her son is a vegetable and fruit vendor, and her daughter-in-law works as a maid/helper in a nearby play school.
>
> Life was going on smoothly for Bimla until two years back when her husband died and soon she was shifted from exclusive room to *barsati*. Her medical treatment for arthritis and cataract is postponed. Her interaction with neighbors and relatives has become almost negligible. She is ignored, neglected, ridiculed, and even thrashed on trivial issues.
>
> Once in a month her son accompanies her to the Bank to withdraw her pension amount, snatches the money and drops her back home. Situation is getting worse as a couple of times in a week she is not given food; Bilma has to sleep empty stomach tying *dupatta* to her waist to subside hunger pangs...

Though chronological age of a person has administrative significance, it is more of a misnomer for elderly women in India. The notion of social aging indicates certain dimensions of social vulnerability of aged females. Socially, while a man is considered old when he retires from his workplace or economic pursuit, a woman is taken as old when her eldest son brings home the "*bahu*" or daughter-in-law. So, a society makes a woman older much earlier than her male counterpart.

Psycho-social vulnerabilities faced by elderly women in the present can best be understood in the backdrop of the past. In ancient times, agrarian societies with joint family system were predominant, which acted as boon for elderly people. Invariably eldest male would head the family, control family property, and reserve decision-making rights. Younger family members unquestionably obey the elderly.

It is assumed that the elderly women would have not enjoyed the same status and privileges as did the aged men. Nonetheless, they exercised full control over the younger females of the household. They played significant roles in the family such as mediators, educators, doctors, teaching and making young daughters and daughters-in-law proficient in cooking, child care, and home management. They were consulted in matters related to pregnancy, child birth, and home remedies for minor health issues not only by the younger females of the household but also by neighbors. They were also the useful link for transmission of traditional cultural practices and values (see: Panda, 2005).

However, in the contemporary world, forces of social change like industrialization, urbanization have impacted the traditional ascribed status of the elderly.

Family structures are changing, and joint family system is giving way to nuclear and now alternate family patterns where there is hardly any space for the elderly. Values of privacy, personal growth, and independence have taken over interdependence, self-sacrifice, and cooperation that characterized joint family patterns. Role and status of the aged ladies too have shrunk significantly. Doctors have replaced the grandmothers' home remedies, and television and computers have eroded the storytelling function of grannies. These and such other related factors have taken away important roles of elderly women, making them role-less, "unproductive" and "worthless". Ageism or stereotypes against old age and elderly people, loneliness, alienation, abuse, exploitation, marginalization, and social exclusion are some of the manifestations of psycho-social vulnerabilities of the elderly women in the present times.

Khan et al. (2013) have noted that poverty accelerates aging as 43% aged women, almost all economically impoverished, appeared older than their age and 18% were living in barsati/outskirts of the house. About five percent women told that they are forced to do household work, which amounts to elder maltreatment. Nearly one-thirds of the elderly ladies are not involved in household decision-making. They further observe that widowhood increases vulnerability and marginalization manifolds; widows in the study reported that after widowhood their respect has gone down (42%), neglect and being ignored have increased (58%), food, clothing needs are unmet (40%), medical care has gone down (45%), and instances of elder abuse such as shouting, pushing, slapping, and beating have increased (24%). Five percent of the women were thrown out of the household.

In India, traditionally, children, especially sons, are expected to provide support and security in old age. Giridhar et al. (2016) find that due to increasing rate of migration of youngsters to urban areas in search of job and high cost of living there, more and more elderly in rural India are staying alone. About ten percent of elderly women are living alone in contrast to two percent aged men. In Tamil Nadu, 27 percent of aged ladies are living alone, while the national average is ten percent. And more than 20% of the elderly living alone are never contacted by their children. Further merely 45% of aged women living independently report receiving some financial help from their non-coresiding children, which further increases vulnerability among older women. The researchers also observe that almost 30% of women are not involved in household decision-making.

With population aging, there is a need to invest more resources in social security and social care of the elderly. Among other factors, this has given rise to stereotypes against the elderly as they are considered "consumers" of social welfare and social security services rather than contributors. They are labeled as spent-force, burdensome, unproductive, and useless. This is all the more true with regard to aged women as their contributions in the household remain unnoticed and unrecognized. This negative viewpoint against older women is one of the biggest challenges in elder empowerment.

Patriarchal social structure has created several barriers for women and illiteracy, higher incidence of widowhood, chronic malnutrition and high economic dependency

define accentuated vulnerability of elderly women. Aged widows are more prone to destitution than their male counterparts.

Theorizing Vulnerability and Empowerment

The discussion above has vividly depicted that vulnerability is amplified manifolds due to certain peculiar health conditions along with social factors that exist in the patriarchal context. Vulnerability in simplest way means the capacity to be harmed. It denotes potential for negative consequences or outcomes. In view of the present study, vulnerability may be defined as the contingent conditions that hamper the social functioning and well-being of the elderly women, and there is a need for the social systems and services other than the existing ones to mitigate the factors that threaten their health and well-being. Vulnerability among the elderly, and more so among elderly women, is a complex phenomenon, which is depicted in three broad domains—health, social, and economic—in the present study, though these domains are highly interrelated.

In juxtaposition, empowerment, as a process, focuses on the transfer of power in significant relationships with the outcome of "liberation, emancipation, energy and sharing power" (Leyshon, 2002, p. 467) and may be viewed from different perspectives like social and developmental (Shearer, 2004; Shearer & Reed, 2004). Empowerment, as a social process, is linked to external social forces that influence an (older) individual's sense of control and power (see: Shearer, 2004). Social support paves way to empowerment of elderly as it entails providing needed assistance, resources, reinforcement, and motivation (Shearer & Fleury, 2006). There are various models on empowerment of the elderly, and a few prominent ones are explained below:

Linear empowerment process model developed by Conger and Kanungo in 1988 provides five stages of empowerment having antecedent conditions, psychological domains, and strategies for empowerment. The first stage of diagnosis focuses on identification of conditions that lead to a psychological state of powerlessness. The second stage is featured by appropriate usage of empowerment strategies. As a part of the stage 2 and stage 3, these strategies not only address the external or structural disempowering factors but also aim at providing self-efficacy information. Some of these strategies and techniques can be participatory approach, goal setting, capacity building, persuasion, motivation, cognitive restructuring, etc. As a result, in stage 4, elderly start to feel empowered. Stage 5 is characterized by behavioral changes that lead to sustainable empowerment (Fig. 9.1).

The contextual behavioral empowerment model was developed by Fawcett and his colleagues in 1994. It has three components as follows:

(a) The person or group in which factors making him/her/it strong or vulnerable are assessed

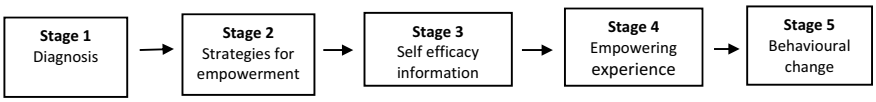

Fig. 9.1 Linear empowerment model

(b) The environment which can be facilitative or non-facilitative and include factors like opportunity, access to information, discrimination, etc.
(c) The level of empowerment that may range from minimal to optimal.

The model encompasses strategies like removing social and environmental barriers, enhancing experience, competence and capability, etc. Details are presented in Fig. 9.2.

The social work model for empowerment-oriented practice was conceptualized by Coxs and Parsons (1994). It has four dimensions as mentioned below:

Dimension 1 covers personal individual aspects like needs, values, attitudes, and difficulties.

Dimension 2 entails personal common aspects that influence social support.

Dimension 3 deals with micro-environment and interpersonal aspects like health, social, and economic services, challenges in accessibility and interventions to address such challenges.

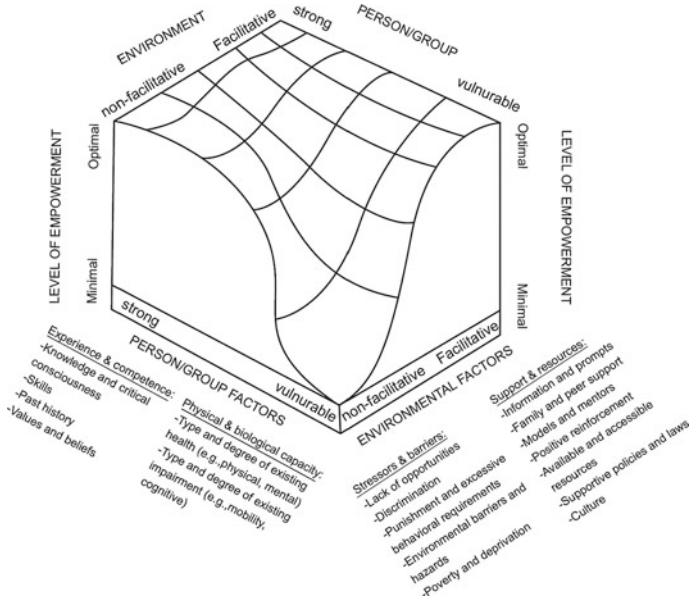

Fig. 9.2 Contextual behavioral empowerment model

Dimension 4 covers macro-environment aspects such as social, economic, and political factors.

This practice-based model assesses the situation of at-risk elderly people coving personal to political aspects and recognizing strengths and resources of the elderly it aims to develop interventions for social support networks and empowerment.

The iterative empowerment process model was propounded by Cattaneo and Chapman (2010). It is based on the assumption that with increase in power, an individual's influence on interpersonal relations and interaction with components of the system enhances. It entails that with social context as a cross-cutting variable, empowerment is an iterative process where an individual sets meaningful goals, takes action, observes, and reflects on the impact of the action taken, drawing on his/her self-efficacy, knowledge, and competence (see Fig. 9.3).

Drawing from the empowerment models discussed above, "empowerment" may be taken as a dynamic notion—a continuum, a process rather than a stage or state. In the context of the elderly women in a sociocultural setting like that of India, empowerment is an increased degree of control over their lives. The psychological domain, which includes an innate sense of self-worth, critical thinking, reflexivity, motivation, confidence, is the inherent characteristics of empowerment that play a critical role in the actual manifestation of behaviors or actions meant to ensure greater access and utilization of resources. As vulnerability is multilayered, so is empowerment, and both these domains vary from one aged lady to another. Getting

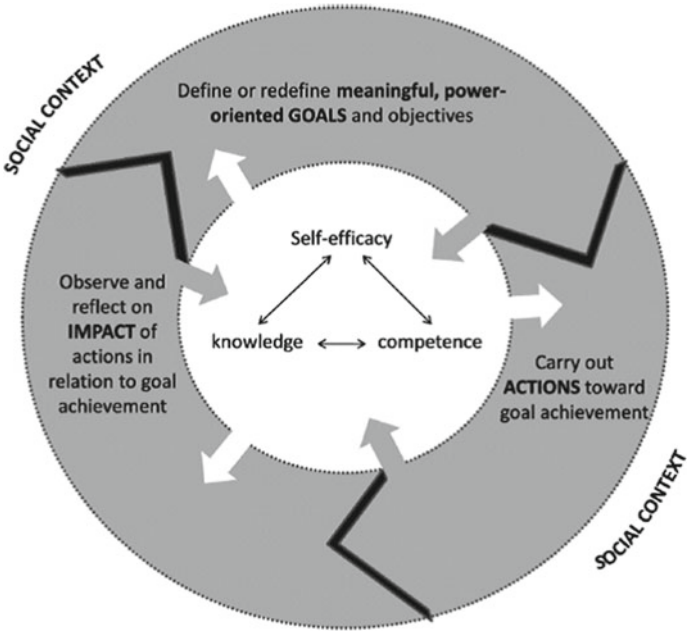

Fig. 9.3 Iterative empowerment process model

information, say, about old age home or old age pension, may instill hope in a destitute aged woman and, thus, is empowering. For elderly ladies in family setup, involvement in decision-making can be empowering. Other elderly women getting pension after struggle and advocacy may bring sense of empowerment.

Another aspect of empowerment is related to addressing structural issues such as poverty and gender that act as barriers in empowerment of older ladies. Amicable social relations and social support act as antidote against age-related vulnerabilities (Kaushik, 2014). Awareness generation, advocacy, social action, legislative measures, income generation activities with gender-sensitive approaches are some of the strategies that get manifested in several initiatives by the government and non-government agencies for empowerment of aged women as discussed in the subsequent section.

Initiatives on Empowerment of Elderly Women in India

Though in Indian social fabric, family has been the prime institution to provide care and support to the elderly, the Government of India has taken various measures for the welfare and well-being of the older persons. Some of the salient interventions may be delineated below with special reference to elderly ladies.

The Constitution of India lays down important provisions for the elderly such as Article 41 of the Directive Principles of State Policy talks about old age social security. Article 47 makes improvement of public health system, raising nutritional and living standards as the primary duties of the state. Among several other provisions, items 20, 23, and 24 of the concurrent list are on old age pension, social security, social insurance, and social and economic planning.

Likewise, section 125(1) (d) of the Code of Criminal Procedure 1973 and section 20 (1 and 3) of the Hindu Adoption and Maintenance Act, 1956, provide rights to aged parents, without any means, to get financial supported from their children having sufficient means, thereby guarding against destitution. Maintenance and Welfare of Parents and Senior Citizens Act, 2007, is a comprehensive law where aged parents can legally claim financial assistance from their grown-up offspring for their upkeep, failing which they may face imprisonment. It accords primary responsibility for upkeep of parents on their children, grandchildren, or relatives who may inherit the property of the elderly. It also entrusts the state to protect and maintain the elderly, in case the family fails to do so. Though the constitutional and legislative provisions are gender neutral, as senior ladies in India, for various reasons, more vulnerable, these measures are more beneficial for them. The National Policy on older Persons (NPOP) was enforced by the Indian Government in 1999 to reaffirm its commitment to ensure welfare and well-being of older persons and to promote their health, safety, and social security. It envisages the state support for the elderly in the areas of financial security, nutrition, health care, food security, shelter, welfare, education, protection against abuse and exploitation, protection of life and property, etc. It mentions about multistakeholder interventions including government and voluntary

organizations to supplement family care. Following this, National Council for Older Persons (NCOP) was established in 1999 to operationalize the NPOP with the aim to advise the government on policies, programmes, and schemes for older persons and represent the collective opinion of older persons to the government.

Coming to the administrative setup, though various ministries have schemes and programmes for the elderly, Ministry of Social Justice and Empowerment is the prime ministry to look after the matters related to old age and the elderly. Other important initiatives are as follows:

Integrated Programme for Older Persons (IPOP) provides financial assistance of up to 90% of the project cost to NGOs for constructing and running old age homes, daycare centers, mobile medi-care units, or any programme for improving the quality of life of the elderly. The scheme provides flexibility so as to meet varied needs of the elderly, and many innovative projects have also been added under it such as running respite care homes, continuous care homes, awareness and sensitization programmes for children, families, and establishing regional resource and training center for caregivers of older persons, forming senior citizen associations and volunteer bureaus, elder helplines and counseling centers, daycare centers for older patients of Alzheimer's disease and dementia, and physiotherapy centers, distributing hearing aids, and such others. In 2008, the scheme was revised, and along with increased amount of financial allocation, local bodies of governance such as Panchayati Raj institutions are also eligible for getting financial assistance.

National Old Age Pension (NOAP) Scheme now known as Indira Gandhi National Old Age Pension Scheme is one of the most crucial centrally sponsored social assistance schemes for the needy elderly in India. Implemented through panchayats and municipalities, the amount of pension varies from state to state. Certain states like Gujarat have lowered the age criteria for women, and they are eligible for getting pension from the age of 55 years, while for elderly males, the age criterion is 60 years.

National Programme for Health Care of Elderly (NPHCE) aims to ensure health security for the elderly by providing comprehensive accessible, affordable, and quality healthcare services. The effectiveness of this programme lies in its convergence with National Rural Health Mission, AYUSH, Ministry of Social Justice and Empowerment, etc. In view to the heightened health vulnerability in old age, it intends to provide an easy access to preventive, curative, rehabilitative, and promotional services to older persons through community-based primary healthcare system along with strong referral backup support. It offers geriatric wards and other dedicated facilities at district hospitals. It has also introduced PG courses in Geriatric Medicine and training to healthcare functionaries at various levels.

A quick look into the schemes and services of other ministries would be relevant. **The Ministry of Railways** provides separate ticket counters for the elderly at their reservation centers, lower berth quota, 30% discount in tickets, wheel chairs at stations for disabled elderly passengers, etc. **The Ministry of Health and Family Welfare** through its Central Government Health Scheme gives pensioners of central government highly subsidized medical treatment and medicines. It has provided geriatric clinics in several government hospitals. **Ministry of Finance** offers a range of exemptions from Income Tax for senior citizens of 60 years and above. **Ministry**

of Civil Aviation provides concession in air fare up to 50% for male passengers aged 65 years and above and female passengers aged 63 years and above. Likewise, **Ministry of Road Transport** offers reservation of seats in buses and other public transport. Some state governments like Punjab give fare concession to senior citizens and elderly women enjoy free travel. In addition, bus models are introduced with elderly friendly facilities like low floor buses. This apart, police departments and many NGOs run helplines for senior citizens. Postal saving schemes and several banks offer higher rate of interest to the elderly on their savings. Large number of senior citizen associations have come up acting as support groups to the elderly.

While the government continues its efforts toward the welfare and well-being of the elderly, the non-governmental organizations (NGOs) have been playing a key role in bringing the issues of older persons to the center stage, and their work is largely concentrated to the disadvantaged and weaker groups such as elderly women amidst poverty. NGOs working with and for the elderly are offering a wide range of services such as day care, residential care, counseling, medical and psychiatric care, and financial assistance. However, mentioned below are the innovative and good practices of these civil society organizations with special reference to the aged women.

Widowhood is considered a curse especially in the case of women, and widows have been facing varied degrees of prejudices and discrimination. Instances of elder abuse increase among aged women, as shown in research studies mentioned above. Traditionally, numerous widows, deserted by their families, could get shelter in the ashrams of Vrindavan, run by religious and philanthropic organizations. However, widows, most among them are elderly, invariably live in abject poverty and poor living conditions. They are largely illiterate and hardly have any skills for economic pursuits and irk their livelihood by singing bhajans in temples, while many other beg for alms. Unaware of their basic human rights, they have no choice but to accept their life full of plight.

Sulabh International, on the request of the Supreme Court, in 2012, began an intervention by providing financial assistance of 2000 rupees per month to the widows. This resulted in economic independence and raise in self-worth among the aged widows. Subsequently, medical facilities, ambulances, reimbursement of medical treatment and purchase of medicine claims, vocational courses, language classes, organizing of outings and celebration of major festivals, and a helpline for widows in distress were also initiated. The project covered eight ashrams or homes and nearly 800 widows. The initiative has brought significant changes in the self-esteem and lifestyle of aged widows and portrays a success story on active aging of earlier highly distressed elderly widows.

Rajasthan is one of the states of India where women have been given very low social and economic status due to patriarchal values are ingrained in the social fabric. Several anecdotes and cases on record indicate that widows face multiple violence by their in-laws/children/families by denying them food and other basic needs, snatching them their properties, and even worse, branding them as witches. Rajasthan is known for the cases of witch hunting where these women are either stoned to death or abandoned and made to experience all forms of social exclusion.

To address the social and economic isolation and trauma faced by widows, *Ekal Nari Shakti Sangathan* (ENSS), incorporated in 1999, has more than 43,000 members from rural and urban Rajasthan. With its conviction in collective power, ENSS helps single/widowed women by advocating for their entitlements and rights. Associations and committees of single women were formed at various levels (blocks, districts, and the state) with the aims of lobbying with the government and other stakeholders on issues and concerns of single women and contesting gender stereotypes that lead to customs like witch hunting discriminating against single women. The block committees deal with problems faced by single women like witch hunting, land grabbing, abuse by family members, thereby significantly improving the quality of life of single women and ensuring their respect and dignity in their families and community. In 2005, Himachal Pradesh and Jharkhand also established ENSS platforms, followed by Gujarat, Bihar, and Punjab. As of October 2013, the national body of ENSS had 87,462 members from across the country.

The International Longevity Centre-India (ILC-I) is a not-for-profit organization that, since 2003, is working for promoting healthy, productive, and participatory aging with head office in Pune, India. Among its several activities, three projects are worth mentioning here:

(a) **Aajibai Sathi Batwa (sachet of medicines for grandmothers)**: This project uniquely provides medical assistance to the needy and poor aged females in the slums through sponsorship. Traditionally, in Indian families, the grannies called *"aajis"* would invariably have a small bag or *"Batwa"* of herbal and homemade medicines that they give to their family members when they fall sick. However, in the present times, not only the "doctor" role of elderly women has waned but numerous of them are unable to seek medical treatment for want of money. In this project, most vulnerable and needy poor elderly women are identified like the widowed, destitute, abandoned, physically challenged, etc. Sponsorship of 6000 rupees per annum is provided to them to meet their medical expenses. These aged women have access to a network of doctors and chemists known as "*Jyeshthamitras*" (meaning friends of the old) in the community under the project.

(b) **Elders' Volunteers Bureau**: Over 300 senior citizens including 160 women are part of this project who offer their services like volunteering in hospitals, at helplines for elderly at Police Commissioner's office, interacting with patients, residents of orphanages, and old age homes, etc. The objective of the project is to use the knowledge, skills, expertise, and experiences of older persons and thereby address their mental health challenges like loneliness and isolation, providing them opportunity to remain productive and useful members in their communities.

(c) **Athashri Housing Project: It is a pioneering elderly home project that covers** residential complexes built exclusively for the aged with elderly friendly infrastructure and facilities that include anti-skid flooring, emergency bells in corridors and bathrooms, doctor on call, ambulatory facilities, to name some.

It has offered better alternative to old age homes giving hundreds of elderly females an opportunity to live in the comfort and warmth of home.

The Calcutta Metropolitan Institute of Gerontology (CMIG), located in Kolkata, was established in 1988 with the aim of rendering help to the needy elderly, promoting research in gerontology and working toward instilling confidence and worthiness among the senior citizens and ensuring scope for active aging. The CMIG has been consistently striving to create a social environment where inherent human values, expertise, and experiences of the elderly are respected and utilized. In its research, CMIG has found that there are nearly 25 lakh elderly living below poverty line in Kolkata, and about 75,000 are in urban slums. Based on it, the Institute has started daycare centers for the aged, especially women, living below poverty line and having provisions of livelihood options. Further, CMIG has conducted an exhaustive process of identification of vulnerable elderly women through door-to-door survey who were later provided holistic health care. Dietary counseling and addressing mental health needs have remained integral part of healthcare management of among elderly ladies. It initiated mobile medi-care service and daycare centers in two different areas. Income generation programmes have proved crucial in livelihood security for aged women. This apart, CMIG has skill development, geriatric care training and supports needy grannies programmes along with community-based participatory research on varied topics based on which further interventions are planned and carried out.

Elderly and elderly women in India are particularly prone to Alzheimer's disease and dementia due to their higher longevity. It is estimated that over 3.6 million people in India have dementia and out of which 2.1 million are women and 1.5 million men (Dementia India Report, 2010). Nightingales Medical Trust (NMT) in Bangalore is one among the pioneers in providing quality services to people from all socioeconomic groups, suffering from Alzheimer's disorder and dementia. Moreover, NMT strives to maintain and enhance family bonding through innovative family-based support services like information dissemination and counseling for the older dementia patients. The high relevance of the work of NMT is seen in view of lack of awareness among the people about dementia and the stigma attached to mental health ailments in general. Dementia accelerates vulnerability of aged women amidst poverty manifolds, often leading to their destitution. In response to it, NMT initiated an innovative telemedicine-enabled center to provide high-quality and yet cost-effective care to the elderly suffering from dementia. Its three noteworthy projects are as follows:

(a) **Nightingales Centre for Ageing and Alzheimer's**: Initiated in 2010, it provides comprehensive long-term and short-term residential care facility for elderly people with disabilities. It includes holistic dementia care model. Training to caregivers is also provided. Since 2010–13, almost nine percent of the total outpatients with dementia have accessed long-term care, and 15% have received short-term care at NCAA. Most family caregivers have utilized day care and support group services.

(b) **Nightingales Dementia Day Care Centre**: This initiative, started in 2006, supported by government grant is extremely useful and popular as it provides

some relief and respite to the family caregivers and postpone institutionalization of the elderly.

(c) **Nightingales Telemedicine-Enabled Dementia Care Centre**: Institutional care of elderly, especially those inflicted with physical and mental disabilities, is highly expensive proposition, especially for middle-class and lower middle-class families. To address this, in the year 2014, NMT has designed the first dementia care facility through telemedicine in the country. It offers several services like memory screening by an interdisciplinary team of professionals on long- and short-term basis, using specially designed tele-dementia management software.

Financial insecurity or dependence is one of the critical factors fuelling vulnerability among elderly women in India, particularly those from low-income families and/or in unorganized sector. In response to this, Self-Employed Women's Association (SEWA) Bank, in collaboration with the Government of India, has provided financial support in terms of National Pension Scheme (NPS) to poor elderly women. SEWA bank as a microfinance organization also offers facilities for savings and fixed deposits and also provides credit for income generating activities. It serves more than 350,000 women, majorly aged females' access to loans, savings, insurance, and pension products with life cycle approach for financial inclusion for their financial inclusion. At SEWA Bank, in lieu of the traditional collateral, regular savings record of one year period is taken as a form of security.

In addition, as a pioneer project, in partnership with UTI, SEWA offers the Micro-Pension scheme to help women below 55 years save about 50 rupees a month in their pension account. When account holders turn 58 years, they receive their savings plus interest so as to live with financial independence and dignity in old age. More than 26,500 members of SEWA have UTI retirement benefit pension accounts in SEWA Banks.

Another initiative by HelpAge India of their Elder Self-Help Groups (ESHGs) is noteworthy. Initiated as Vidarbha Project, it aimed to reduce financial burden on elderly female victims from the families of farmers who committed suicides in Maharashtra. In view of more than 70% of farmer suicides in Maharashtra in 2005, HelpAge India provided short-term credit loans to widowed women and covered nine villages of Vidarbha. Soon ESHG programme catered to about 75,600 older persons across nineteen states in the country through 5400 groups. Along with ESHGs for microfinance, many other interventions were laid down like vocational training and income generating activities and provision of health care and screening of several diseases through mobile medical camps. These ESHGs helped in reducing the burden of debt on widowed elderly women, thereby ensuring their financial autonomy and sustainable livelihood options. The initiative also acted as an antidote to abuse and exploitation of the elderly women (in particular) due to their economic dependence on their children. It instilled confidence, courage, and resilience among them as they enjoy financial security.

Further, several old age homes have adopted innovative strategies like intergenerational bonding programmes, involving communities in providing care, income generating activities, vocational training, and enabling environment and infrastructure along with efficient policies of health care, comprehensive support system offered to the institutionalized elderly.

Conclusions and Suggestive Interventions

The paper has delineated vulnerabilities encountered by aged women, mainly in Indian context. Along with usual age-related ailments, gynecological and post-menopausal morbidities add to health vulnerabilities among elderly females. Cultural practices too lead to accentuated malnutrition and deficiency disorders. Illiteracy, negligible skills, and opportunities of economic independence have been the typical aspects of majority of women in India leading to heightened economic vulnerabilities in their old age. Changing sociocultural situations have deteriorated the traditionally high position, status, and power of the elderly, and women bear the additional burden of gendered vulnerabilities and discriminations.

Empowerment is a multidimensional, multifaceted notion that in its action reduces vulnerabilities. Various initiatives by the government as well as civil society agencies are presented in the paper as efforts toward empowerment of the elderly women.

This in view, the following suggestions are offered to ensure well-being and empowerment of aged women, where policymakers, social planners, gerontologists and geriatric professionals, informal and formal caregivers, and the elderly women themselves are the critical stakeholders:

Awareness generation on nutrition, balanced diet, preventive and promotive healthcare practices, management of age-related ailments is required for the elderly, their family, and among geriatric professionals. Free or highly subsidized and yet quality healthcare system with easy accessibility for the aged women is needed. Linking aged women, particularly those amidst poverty, with community-based supplementary nutrition programs (such as Integrated Child Development Services) would be an important step to ensure their food security.

Since financial security is the backbone of empowerment of aged women, advocacy for implementation of Universal Pension scheme, income generation programs and avenues, strengthening national old-age pension scheme for timely and hassle-free disbursement are the needed action-points. The amount given to the elderly in old age pension should be linked to the cost of living index and reviewed and updated from time to time. Preference should be given to aged women in all welfare schemes with fixing up of minimum quota for them.

With breaking down of joint family system, there is an emerging need for setting up of substitutive institutions for the care and support of elderly women. Community-based care over institutionalized services for the elderly is in sync with the cultural values of Indian society. Strict implementation of laws against elder abuse is a

must. Family enrichment programs for strengthening of amicable intergenerational bonding may be taken up by NGOs.

A number of good practices for welfare, well-being, and empowerment of elderly women by civil society organizations are discussed in the paper, which should be scaled up and replicated in other parts of the country too.

National and state commissions for older persons may be set up to review policies and programs for older persons. Finance Commission, legislators, and policymakers should earmark funds for the welfare and development of the elderly, giving special attention to elderly women.

Hopefully, with coordinated and concerted efforts, various actors like the government, civil society organizations, community, families, and the elderly ladies themselves, a conducive sociocultural milieu can be created and alongside service delivery system be improved, further streamlined, and implemented in the spirit and letter. This would go a long way in bringing in a ray of hope and sunshine in the lives of senior ladies and in acquitting the society of an important social obligation.

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Chapter 10
WHO CARES? Challenges of Women Aging in Contemporary Indonesia

Mayling Oey-Gardiner

Abstract Even though not yet declared an aging society, Indonesia's demographic transition is rapidly approaching that status. The numbers of the elderly continue to rise and at an ever-higher rate. As is the case elsewhere in the world, life expectancy for women is higher than for men, and the sex ratio which starts to favor males at birth reverses to favor women, currently only starting around retirement age and rising rapidly thereafter. While aging is a general concern of governments, the gender bias is not necessarily being attended to. It is the purpose of this paper to shed light on the gender bias and the consequences thereof on the ability of the elderly to access necessary services in their living arrangements, to close with a finding of the family being the main source of care.

Keywords Aging · Gender · Women · Access to public services · Indonesia

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On Aging in Indonesia

With rising expectation of life, Indonesia's population is on the way to join the world's aging populations.[1] Following a reversal in population policies from pro- to anti-natalist approaches which emphasized fertility control that was introduced as part of overall socioeconomic development orientation program has resulted in improvements in health and consequent rising life expectancy and thus causing expansion of the proportion of seniors. The 1960 Population Census, the first after Independence in 1945, recorded the share of the population aged 65 and over at only 2.5% (BPS, 1963). It took half a century later when the 2010 Population Census recorded a doubling of this proportion to 5.0% of the population belonging to this age group (Bappenas, BPS and UNFPA, 2013). Yet toward the future, the latest official population projections suggest that the next doubling of this share to reach 10% shall occur only two decades later in the early 2030s, and when Indonesia celebrates a century of Independence in 2045, it is expected that 14% of the population shall be 65 years and over (Bappenas, BPS, and UNFPA, 2018).

In fact, the Indonesian government's position on population changed over time. Indonesia's first President, Soekarno (August 18, 1945, to March 17, 1967) promoted a large population to gain international recognition. And thus, he favored large families with many children. Over the period of 1950–1970, the Indonesian population is said to have grown from 81.5 million to 122.5 million people or an overall increase of 41.0 million. Of that total, children aged 0–14 years increased by 19.95 million, constituting 48.65% of the increase in the total population. The adult population aged 15–64 years grew slightly more at 20.49 million and thus constituting 49.95% of the total population growth, while the elderly of 65 years and older increased by 575 thousand or composed only 1.4% (Fig. 10.1).

However, an emphasis on politics at the cost of ignoring concerns for improving people's welfare when extreme inflation levels weakened the ever-growing population in poverty ended in a takeover of the government. The next President, Suharto, turned to a different agenda that of development with an essentially anti-natalist agenda. And thus, like in many other developing countries during the 1970s, an emphasis on improving lives through investing in the social services of health and education with an economic orientation of development have led to declining mortality and fertility and slowly but surely rising expectations of life. For Indonesia

[1] Contrary to initial expectations, there is apparently no general agreement on a fixed definition of aging. The United Nations' definition of aging has changed over time. As recent as 2017 the United Nations defined aging in terms of age 60. But then, only two years later, the 2019 United Nations report defines aging in terms of age 65 and over. They also note arbitrariness in the definition. Until today, while some countries refer to aging as the share of the population aged 60 and over, developed countries consider people elderly when they reach 65 years, in line with official retirement age. On another indicator, a country is defined as 'aging' when the share of the population aged 65 and older exceeds 7%, a population is said 'aged' when the proportion exceeds 14%, and it is labeled 'super aged' when the share reaches more than 20%. In 2019, Duffin recorded already 20 countries to have the share of their population 20% or more. As the share of the elderly continues to rise, we can expect further adjustments in the definition.

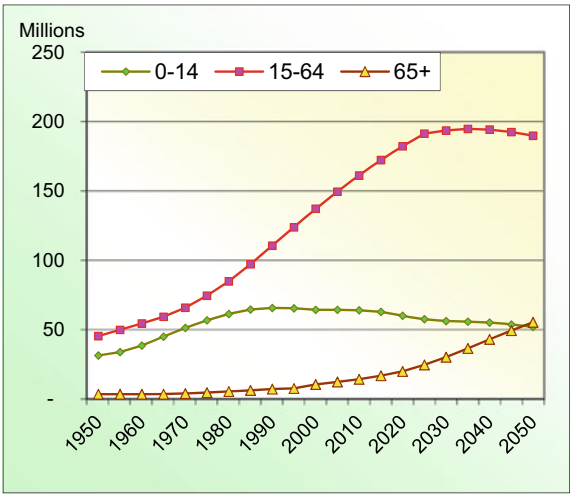

Fig. 10.1 Indonesian population projection 1950–2050. *Source* United Nations (2007) *World Population Prospects, the 2006 Revision*

that has meant rising from 48.65 years in 1960 to 66.28 years at the turn of the century and in 2019, we have reached 71.2 years (World Bank Database). Consequently, the number of elderlies has eventually risen with ever stronger speed, a worrying phenomenon of the nation "getting old before we get rich" and the fear of being stuck in the middle-income trap.

Feminization of the Elderly is Irrespective of Gender Compositions of the Youth

It is not only that the numbers of the elderly are growing rapidly the world over but they also become increasingly more feminine with age. The gender differential starts at birth when more baby boys are born than baby girls. Even during infancy, due to genetic and biological makeup, male mortality exceeds that of females (Pongou, 2012; Alkema et al., 2014). Apparently, this tendency continues throughout life resulting in girls and women more likely to outlive boys and men, and eventually, they dominate the elderly.

Besides, while it used to be accepted that there was a natural standard of sex ratio at birth of 106 males for 100 females,[2] later research on populations other than Western developed societies shows significant variation among populations across the world. The latest available data show that at the global level the sex ratio of under-five stands at 106 boys for 100 girls (Table 10.1). That number represents, in fact, great variation in sex ratios of under-fives around the world, with the highest ratios recorded for Asian populations and the lowest for black populations (1985a;

[2] This was based on more than two centuries worth of reliable data from developed countries (Johansson & Nygren, 1991; Yi et al., 1993).

Table 10.1 Age-specific sex ratios for the world, Asia, Eastern Asia, and Southeast Asia, 2020

Age	World	Asia	Eastern Asia	Southast Asia
0–4	106	109	116	104
5–9	107	109	118	104
10–14	107	110	120	104
15–19	107	110	120	104
20–24	107	110	117	104
25–29	106	109	114	103
30–34	105	107	109	102
35–39	103	105	105	100
40–44	102	104	104	99
45–49	101	103	103	97
50–54	100	102	103	96
55–59	97	100	102	95
60–64	95	98	100	92
65–69	91	94	96	88
70–74	85	89	92	81
75–79	79	82	85	74
80–84	69	74	75	67
85–89	59	64	62	61
90–94	47	53	47	52
95–99	33	38	32	42
100 +	25	27	21	25
Sum	102	104	106	99
Tot pop (m)	7.675	4.596	1.640	654

Note Sex Ratio—Number of Males over 100 Females
Source Calculated based on United Nations (2009) *World Population Prospects, the 2008 Revision, Volume II: Sex and Age Distribution of the World Population* (Medium Variant)

Jacobsen et al., 1999; James, 1984; Ruder, 1985). The highest sex ratios of under-fives are recorded for the largest populations in the world, China and India. This characteristic is attributable to son preference combined with the one-child policy in China and dowry system in India.

Because of the size of these two populations, their gender compositions affect the wider populations of their regions. A substantially higher sex ratio is recorded for Eastern Asia of 116 males for 100 females. This region covers Mongolia, China, North Korea, South Korea, Japan, Hong Kong, Taiwan, and Macau. At the time, China recorded a sex ratio for under-fives of 117, while other countries like Japan and South Korea have been shifting away from son preferences (Fuse, 2013; Chun & Das Gupta, 2021). Compare this to Asia which recorded a sex ratio of 109 as

the region includes both China and India, as the latter recorded a sex ratio for its under-five population of 108.

Another interesting issue concerns the pattern of the gender composition as a population grows older. In general, the sex ratio initially stays fairly stable from the youngest children of under-fives to when they are young adults in their 20s, to then slowly but steadfastly decline with age and eventually the older age groups are dominated by women. The balance of equal numbers of males and females, or a sex ratio of 100, is achieved at different ages—the earliest among Southeast Asian populations when they are at their prime ages of between 35 and 39 years and of course the latest is experienced by the Eastern Asian populations at retirement age from 60 to 64 years; slightly earlier for the total Asian populations when they reach 55–59 years and again a step earlier is noted for the overall world population when they reach 50–54 years. But then, when people reach centenarian ages, the world over is extremely female with four women for every man.

Of interest to Indonesia are the patterns for Eastern and Southeast Asia, which lie beyond the patterns for the World and Asia. Eastern Asia shows a different pattern from the World and Asia. The sex ratio for Eastern Asia initially rises from 116 for the youngest children of zero to 4 years old, to 118 for those aged 5–9 years old, and for teenagers from 10 to 19 years to 120 to then decline thereafter following the pattern of other populations albeit at a slower pace. At first glance, we attribute this pattern to the widely known practice of son preference in China, a strong patrilineal society which, for 2020 is projected to number 1.4 billion people, constituting 87% of the East Asian population thereby dominating the East Asian population and population patterns. While not ignoring the many population conditions that have been attributed to a son preference perspective,[3] it is interesting to note the difficulty finding studies of the impact or the relation of the universal and strengthening feminist movement on son preference in China.

Yet, this social phenomenon of strong son preference is weakening, even in China where this tradition has lasted for generations, even centuries. The tendency for weakening son preference started early this century, even though at the turn of the century the tendency was for son preference to initially strengthen as indicated by a rise in the sex ratio of under-fives from 119 in 2000 to 122 in 2005. It was only thereafter that the sex ratio started to decline, apparently with rising speed—initially by only one point over a 5-year period between 2005 and 2010, but then rising to two points in each 5-year period between 2010 and 2020, when it had already reached 117 males for 100 females.

At the turn of the century, son preference in China was still strong and even gaining strength during the first five years of this century as indicated by a rise in sex ratio of under-fives. This incorporates the sex ratio at birth, a strong indicator of ante-peri-to postnatal practices of son preference and the consequent reverberating call by Sen as early as 1990 and again promoted in 2003 of the "More than 100 million missing

[3] In fact, studies on son preference are overwhelming, a few are identified as follows: Gupta et al., 2003; Jin et al., 2007, 2009; Lei & Pals, 2011; Murphy et al., 2011; Poston & Conde, 2011; Loh & Remick, 2015).

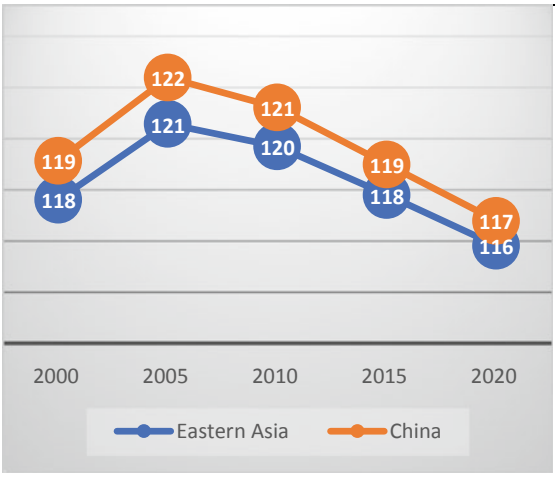

Fig. 10.2 Under-fives sex ratios for China and Eastern Asia, 2000–2020. *Source* United Nations, *World Population Prospects*, the 2008 Revision, Volume II: *Sex and Age Distribution of the World Population*

women" in China.[4] Even at the turn of the century, son preference in China continued to gain strength, thereby resulting in an increase in the sex ratio of under-fives from 119 to 122 (Fig. 10.2). It was only thereafter that initially slowly, declining by only one point to 121 by 2010, but gaining speed subsequently with declines of 2 points in each of the following 5-years periods to 119 in 2015 and 117 in 2020.

With her contribution of 87% to the Eastern Asian population, it is not surprising that the Chinese population trends and patterns strongly dominate those for Eastern Asia. The sex ratios of under-fives for the Eastern Asian population differed very slightly by only one point lower from that of China. It is suggested that this difference is mainly contributed to Japan and Korea, the strongest contributors to the Eastern Asian population beyond China, with 8 and 3%, respectively, while the remaining five countries like Mongolia, North Korea, Hong Kong, Taiwan, and Macau combined constitute only two percent of the total Eastern Asian population. Both Japan and South Korea have started to shift to value daughters more, thereby reducing their strong attachment to their sons for their future and the family (Fuse, 2006, 2013; Choe, 2007; Chun & Das Gupta, 2021, 2007).

A multitude of transformations have been and continue to occur in the largest population in the world. The traditional ideal elite Chinese family, living in three generation households, where sons remain "at home" after marriage to continue the family name and daughters move out into their husbands' households to live under the tutelage of mother-in-law,[5] is hardly found today or may also no longer exist.

[4] This idea of the millions of missing women as a consequence of son preference, combined with the one-child policy, is a topic of research interest in various parts of China as well as other strongly patrilineal and patriarchal societies in other countries of Asia in Anderson & Ray, 2010; Ebenstein, 2013; Ebenstein & Leung, 2010; Quanbao et al., 2013; Shi & Kennedy, 2016; Attané, 2006; Zhu et al., 2009, Hesketh, 2009; Gupta, 2018; Junhong, 2011).

[5] Most likely as portrayed by Pearl S. Buck in her various novels on the Chinese family, one of them, *The Good Earth* (1931). Albeit no longer common, this tradition can still be found in Indonesia.

Modern China is very different today from those memories of bygone days since Deng Xiaoping instituted market reforms in the late 1970s. If in 1981, 88% of the population was classified as living in extreme poverty, less than one percent, or more exactly, only 0.7% were so classified in 2015.[6] At the same time, families have become much smaller, especially since the implementation of the one-child policy and the tendency to live in two generations nuclear families of parents with their child(ren).

Like elsewhere in the world, development has activated the demographic transition resulting in declining mortality[7] and fertility and rising life expectation and thus the consequent aging of the population. All these changing trends are associated with rising shares of aged single and couple households (Yi & Wang, 2003). But then, housing developments, availability, and accessibility compounded with migration are also claimed as factors affecting residential patterns among the elderly, some of whom chose to move in with their children (Hu & Peng, 2015; Silverstein et al., 2006).

Of late, however, the value of son preference is eroding (Guilmoto, 2005, 2009), even in light of the one-child public policy having to be practiced by parents in China. We attribute this to the feminist movement gaining increasing strength even in strongly patrilineal societies of East Asia. And thus, parents become increasingly aware of the value of having daughters. As discussed earlier, this is reflected in Fig. 10.2 showing declining sex ratios of under-fives starting in 2010 for China.

The same can be said to be happening in South Korea, which used to be referred to as "one of Asia's most rigidly patriarchal societies, a centuries-old preference for baby boys over baby girls is rapidly receding" (Choe, 2007; Chung & Das Gupta, 2007; Das Gupta et al., 2003; Den Boer, 2017; Shin, 2016). This is well depicted by the experiences of a newspaper executive of 61 years old in 2007. She remembers when she was a young mother of three sons and no daughters. She used to be approached by other women asking her for her secret. Years later early this century when she tells people about her children, they pity her for her misfortune. She notes that within a generation she has turned from the luckiest women to a pitiful mother (Choe, 2007). This phenomenon attracts the study of the value of daughters, girls, and women in Korean Society (Shin, 2016). This is in line with feminist appearance in society that is gaining strength and importance. Popular are not just "boys" band(s) but "girls" bands and also joint gender bands are all gaining popularity, not just in Korea but also as far as in Indonesia where the millennials eagerly watch K-pop artists.

When we get to Southeast Asia (which consists of Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand, East Timor, and Vietnam), even among under-fives, the sex ratio stands only at 104, approximately the natural level. This level remains up to the cohort of early twenties between 20 and 24 years. What is interesting is that the rates continue to be the lowest for each of the cohorts presented here until they become centenarians. If in the case of East

[6] Based on the World Bank database, retrieved in 2017 and 2019 https://en.wikipedia.org/wiki/Poverty_in_China.

[7] Especially among infants and under-fives.

Asia, we attributed the high masculinity from birth to retirement age in terms of son preference among the Chinese, and it is a different system which dominates the Southeast Asian populations and explains gender relations. If the Chinese population in East Asia follow strong patrilineal rules of descent and hence practice son preference, most Southeast Asian populations are said to follow bi-lineal rules of descent (Yeung et al., 2017).

In a bi-lineal system, individuals or both males and females are members of both their mother's matrilineage and also their father's patrilineage, or also known as "double descent" (O'Neil, 2009). And thus, marriage does not require the couple to move in with either parental family, or at a later date to accept either paternal or maternal parents when they become elderly. This pattern is irrespective of their sex and child order. All children can stay in their parental home if they so wish and the parents agree, and later any of the children, usually the best off, and/or the child that best gets along with parents is where the parents stay when they have to.

The dominance of the bi-lineal kinship system is attributed to the large share of populations that do so. Three of 11 countries count for two-thirds (67%) of the overall region's population, and most ethnic groups share norms of living arrangements. The first is Indonesia with a projected population for 2020 of 254 million constituting 39% of the total Southeast Asian population of 654 million. The second is the Philippines (Gallego, 2015; Turner, 2013) with a population of 110 million constituting 17% of the region's population. Thailand is the third country fulfilling the criteria of constituting more than 10% of the regional population and the majority following a bi-lineal kinship system (Friedman, 1998; Kuwinpant, 2002) with 71 million people making up 11% of the region's population. And thus, all together these three countries make up 67% of the overall Southeast Asia population.

The largest country with the largest population, the Indonesian archipelagic state, consists of 17,491 islands,[8] some of which are not inhabited. Indonesia is not just blessed with a large number of islands but also with the consequent variation in norms and values among ethnic groups and also kinship systems. All basic kinship systems are represented in the archipelago. While the Batak of North Sumatra adhere to a patrilineal system, identifiable by the family or clan names, the Minangkabau of the neighboring province are known to follow a less common but well-known matrilineal rule of inheritance. This culture demands that wealth remains with the clan and is passed down through daughters and cannot be disposed of. The family continues with female offspring and is said to be extinct (*punah*) without daughters.[9]

Even though there are several hundreds of ethnic groups in the country,[10] it is generally accepted that it is the Javanese, who make up 40% dominate the Indonesian

[8] According to the latest count by the Coordinating Ministry for Maritime Affairs and Investments dated December 2019.

[9] The author knows a Minangkabau family with six children, of which four are female. Yet, the daughters were either not married or did not produce offspring and thus also no daughters. And consequently, the family is said to be *punah*, and it has become extinct.

[10] Available references recording numbers of ethnic groups that vary greatly, from more than 300 to 1,340 according to the 2010 Population Census, or some 633 (Wikipedia https://www.google.com/search?client=firefox-bd&q=Number+of+ethnic+groups+in+Indonesia).

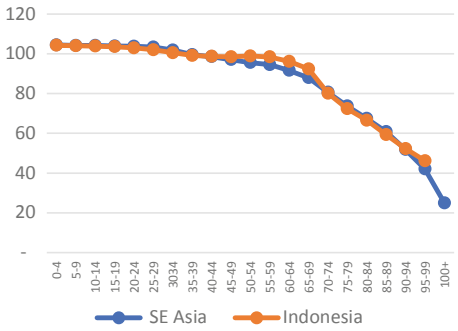

Fig. 10.3 Age-specific sex ratios for Southeast Asia and Indonesia, 2020. *Source* Calculated based on United Nations (2009) *World Population Prospects, the 2008 Revision, Volume II: Sex and Age Distribution of the World Population*

population. And it is the Javanese who adhere to a bi-lineal kinship system of having only the Western equivalent of first names, in the past that could mean only 1 (one) word.[11] Young modern Indonesians, however, are increasingly more likely to expand their individual names. The longest I have found consist of up to five words with no family name.[12] This phenomenon suggests that the modern country of Indonesia is not necessarily adopting but more likely and maybe even increasingly accepting some cultural norms of Javanese culture, including its kinship rules, which shares greater similar practices around the world. Modernity is also often characterized with greater practicality, and it is practicality which applies to decisions on residential patterns of people going through their life cycle—who stays with whom.

Indonesian Elderly Women and Men in the Household

This is a story of elderly Indonesian women, who, like their sisters the world over, are more likely to survive men of the same cohort. But, as part of Southeast Asia, Indonesian women share similarities with the populations of the region. And yes, the expectation was also to find similarity in the demographic parameters. As such, it was a surprise to find an almost perfect fit between the Indonesian and the Southeast Asian age-specific sex ratios from birth to the oldest ages of 100 years and older (Fig. 10.3). The sex ratios in 2020 started at 104 males for 100 females for the youngest age group for under-fives. This level remained until the teen ages of 15–19 years for Indonesia and slightly older for Southeast Asia to age 20–24 years.

[11] I remember the story of a colleague who went to the USA for further education, who, when arriving at the LaGuardia airport in the early 1960s, was asked her "first name" responded "Kadariah" and next when asked her "last name" responded "none". As a result, in USA archives, she became known as Kadariah None. (None in Indonesian means miss).

[12] Modernization is occurring in all walks of life, including naming of children. In the past, one could associate names with ethnicity, which is far less likely today. In fact, few of the names of students in one of my classes sound typical and easily associated with a particular ethnic group. I now find my students' names consisting of 3–4 words, with no family name, common among both male and female students.

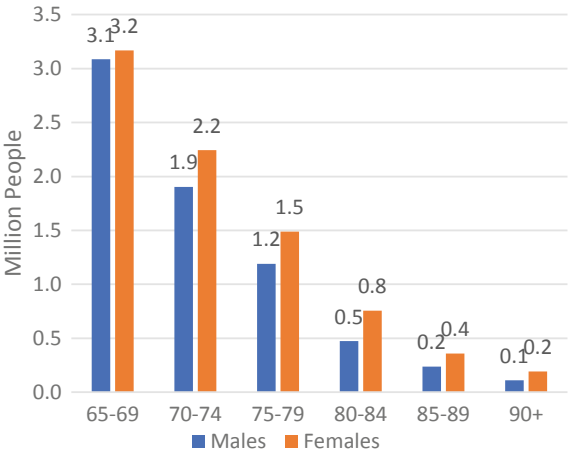

Fig. 10.4 Age distribution of the elderly by gender (in millions). *Source* Processed from Statistics Indonesia, 2018 National Social Economic Survey

Thereafter, sex ratios start to decline, slowly by 1 or at the most two points for the next five-year age group until the age group of around retirement age for the age group between 60 and 64 years recording sex ratios of 92 for Southeast Asia and 96 for Indonesia. It is only after around retirement age of 65 years that the gender gap in favor of female survivorship becomes more accentuated. If by ages between 65 and 69 years Indonesia recorded a sex ratio of 92 males for every 100 females, for the age group aged 80 to 84 years, there were already only 67 males for 100 females, and then, for the oldest age category available between 95 and 99 years, there are only 46 males left for every 100 females.

At this juncture allow me to focus on the center of attention of this study, the elderly in Indonesia. In this study, the elderly is defined as those aged 65 years and older in 2018 (the time of the survey). The higher female survival when elderly is reflected by the larger numbers of women compared to men for each five-year age group (Fig. 10.4). There was a total of 8.2 elderly women and 7.0 million elderly men in 2018. Among those aged 65 to 69 years, the difference was limited with 3.1 million men compared to 3.2 women or only about 3% more women than men. This number rises very fast thereafter to reach 76% for the very old of 90+ years (Fig. 10.5). We show these differences as a reminder for later analyses regarding the social discrepancies experienced by women compared to men in Indonesia.

The earlier mentioned excess of women over men among the elderly is further also characterized by women of that generation being disadvantaged in terms of the benefit of human capital investments. In that generation of elderly, the youngest were born in the 1950s, not long after Indonesia declared Independence on August 17, 1945, and thus still a very young nation coming out of colonization and thus still very poor. We assert that in poverty at both the family/household level as well as the overall economy, parents tend to prioritize their sons to gain an education. The reason for this is that during that time, there were very few employment opportunities available, and thus, the labor market was then dominated by men. Moreover, another reason is that

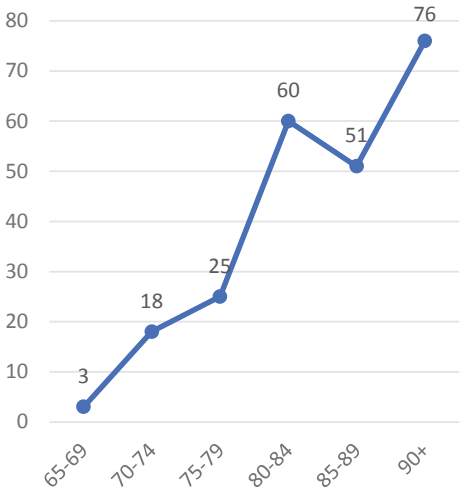

Fig. 10.5 Percent excess females over males. *Source* Processed from Statistics Indonesia, 2018 National Social Economic Survey

tradition demands men to be household heads and therefore responsible for being the breadwinner, while women are housewives in marriage and therefore responsible for running the household with the earnings given to her by her husband. It is up to her ability to use her wits to make ends meet which she does in the shadows, and consequently, she is generally not (supposed to be) visible. However, as Indonesia has grown and continues to develop in an environment of universal and national gender equity demands, women and girls have and continue to make inroads into a world earlier the world of men, the public sector.

Women can no longer be held back to be part of the public sector, for which they require increasing investments by attending school and later on to higher education. We suggest that in Indonesia's case the market created an ecosystem which makes it favorable for both parents and governments to open the gates to the world of knowledge and skill development to their daughters as well (Oey-Gardiner 1989; 1997a, b). The labor market continues to develop in a more gender-friendly environment, with jobs for men and women, especially in the service sector requiring at least post-secondary education (Oey-Gardiner, 1985, 1986, 1991, 1993, 1996, 1997a, b, 2001, 2002; Sugiyarto et al. 2006). And thus, today we notice that with the worldwide corona pandemic the frontline "soldiers" of health workers are at least shared between women and men and in some cases even dominated by women.

In patience, over time women can no longer be withheld to gain equal, if not greater access, to human resource investments (Fig. 10.6). We were pleasantly surprised to note that the millennials of 20–39 years old (the birth cohort of the last two decades of the last century) have different educational aspirations. If among the elderly women were much disadvantaged in terms of education (29 versus 13% of women and men respectively have no education or never went to school), among the millennials, women are already "better educated" with 19% as compared to 16% of women and men who completed tertiary education. We suggest that this is partly attributable to

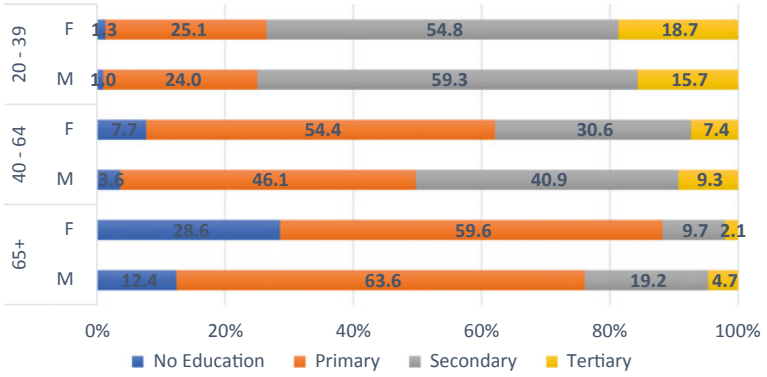

Fig. 10.6 Percentage distribution of millennials, adults and elderly, by completed education, Indonesia 2018. *Source* Processed from Statistics Indonesia, 2020 National Social Economic Survey

males being more likely to discontinue schooling in favor of entering the labor market after completing their education. This assertion is supported by the relatively higher proportion of males having completed secondary schooling compared to females (59 compared to 55% for males and females).

If we attribute the similarity in the age and sex structure of the Indonesian to the Southeast Asian populations due to the general bi-lineal kinship system, there are also other social determinants affecting the gender differential demographic characteristics. Indonesia is also known for holding the largest Moslem population of the world, with 229 million followers of the Islamic faith, constituting 13% of the total world Moslem population, and 87% of the country's population.[13] It can be expected that in the not-too-distant future, Indonesia will be overtaken by Pakistan as the world's largest Moslem population due to the significantly higher fertility regime of the Pakistani population.[14]

As a predominantly Moslem nation, marriage patterns condoned by the predominantly religion affect the overall population sex structure, with different consequences for men and women. Men are allowed to be polygamous with up to four wives at any one time.[15] But it is also common knowledge that the religion tells them that they can only do so if they can be just to all wives, the practical meaning of which is not clear. As there is no formal data available on the incidence of this phenomenon,

[13] According to the World Population Review latest adjustment of February 17, 2020, Moslems are found in 210 countries around the world. In 72 countries, there are more than 1 million followers, in 31 countries, there are more than 10 million, in four countries, there are more than 100 million and even more than 200 million, like Indonesia. In 29 countries, more than 90% of their population are followers of the Islamic faith, and in another addition 16 countries, they constitute more than half the population.

[14] As measured in terms of the total fertility rate, which stands at 2.32 children per woman of reproductive ages for Indonesia and 3.38 for Pakistan (World Bank Database, downloaded 19 April 2020 at https://worldpopulationreview.com/countries/total-fertility-rate/).

[15] Which means that they can have had more than four wives over their lifetime.

Table 10.2 Marital status distribution of the elderly 65+ in Indonesia 20,203

Marital status	Males	Females	Total
Never married	0.8	1.2	1.0
Married	78.8	31.1	53.0
Divorced	1.3	2.7	2.1
Widowed	19.1	65.1	43.9
Total (in 000)	6998	8207	15,205

Source Processed from Statistics Indonesia, 2020 National Social Economic Survey

except for a current legislator bragging on TV about his life with his three wives all living in the same abode, no analysis can be conducted on this issue.

Then, there is another social factor affecting the demographics in the population. Like elsewhere in the world, there is definitely a gender difference in socialization patterns and practices. Boys and later men are often excluded from household chores and management relegating such activities to girls and women. In addition, in Javanese society, women hold the household purse strings.[16] That means that men are supposed to hand over their earnings to their wives,[17] and it is up to the wife how she manages the household taking care of feeding, clothing, schooling, and housing all being women's responsibilities. This is what a colleague mentioned.

> Very true, family wellbeing is the responsibility of mothers. Husbands bring home money, whether enough or not he never asks. Its mothers who have to juggle things, if necessary, she will pawn anything she owns.
>
> Tina, Javanese.

This means that men, throughout their life cycle, are generally not used to take care of themselves. The consequences of the preceding discussion are reflected in the composition of the elderly by their marital status (Table 10.2). The excess of women among the elderly is reflected in the numbers of 8.2 million women compared to 7.0

[16] This is not a universal rule in Indonesia, which is rich in variation, including the variation of gender relations in the family and household. This is exemplified by the Acehnese where Shari'ah law prevails (Kusujiarti et al., 2015). Culturally, the Acehnese are also followers of a bi-lineal system but with very different gender relations, where the public sphere is allocated to men and the private space to women, who should remain "invisible" and have no right to be in the street (Mernissi, 2003). This cultural norm affects the husband–wife relation as experienced by the author: During a meeting in Banda Aceh after the 2004 Christmas Tsunami, the author spoke to a male Acehnese, who claimed that was not possible in Aceh. Men keep their earnings, and they make most household decisions, including household expenditures, which are consistent with the norm that women are limited to the private sphere remain invisible. Consequently, contrary to the situation in traditional Javanese markets which are dominated by women as both sellers and buyers, in Aceh, it is all men.

[17] Some years ago, there were limited employment opportunities available. The civil service became the dominant source of formal sector jobs mainly occupied by men with low levels of wages and salaries. These were compensated with activities supplements, like for instance to attend meetings or travel somewhere, usually handed over in envelopes, and combined could well exceed their salaries. At the time, jokes were expressed as salaries going to their wives, and the envelope money was cigarette money to be kept by men.

Table 10.3 Relation to household heads by gender among Indonesian Elderly 2020

Relation to household head	Males	Females	Total
Household head	87.8	37.3	60.5
Spouse	0.6	27.3	15.0
Parents/in-laws	10.2	31.3	21.6
Others	1.4	4.1	2.8
Total	100.0	100.0	100.0

Source Processed from Statistics Indonesia, 2020 National Social Economic Survey

million men in 2020. Note also the gender contrasts in the marital status composition. Whereas most elderly men are married (79%), most elderly women are and tend to remain widowed[18] (65%). It is commonly understood and socially accepted that upon loss of their spouse, men will remarry not long thereafter, especially when the couple used to live by themselves. In contrast, elderly women are less likely to remarry after the loss of their spouse and are widowed. They continue life but without a husband.

Even though most Indonesians trace descent through both parents and individuals can choose who stay with, if there is a man in the household, he will be the household head. This custom is not just socially sanctioned but legally reinforced in the 1974 Indonesian Marriage law, which states: "Husbands are the heads of the household and wives are housewives" (Article 31).[19] By implication, Indonesians basically follow a patriarchal system of male power relations and preferential treatment with gender discriminatory consequences, much discussed in the feminist domestic and international literature.

And thus, elderly males, irrespective of household size in which they reside, are very likely to claim and be named household head (88%, Table 10.3). That there are also women who are household heads (37%) is a function of age, and among this group of elderly women, a good proportion is widowed (65% in Table 10.2) and has thus become the household head (Table 10.3). It can also be noted, however, that there are 10% of elderly males who are in fact either parents or parents-in-law of the household heads, reflecting the condition in which they live as dependents of their children. I also like to call attention to the fact that the probability for elderly women to be dependents (31%) living in possibly their children's households.

In fact, most elderly live in households with other members as well (Table 10.4). That is true of 94.5% of elderly males and 84% of elderly females live in households with multiple members. There is a substantial difference in the gender-specific proportion of the elderly living alone or as couples, while the proportions living in larger households are rather similar between elderly men and women.

[18] Maybe anecdotal but corroborated by these data is the author's personal experience at the death of her husband was visited by quite a number of elderly women who came alone to the wake, not because their husbands could not make it but rather that they were already widowed.

[19] One consequence of this regulation is that within a household, which is socially acknowledged as a nuclear family consisting of one male father, one female mother, and their children, but is legally split into two families, as experienced by the author.

Table 10.4 Composition of elderly males and females (65+) by household size, Indonesia 2020

No. HH members	Males	Females	Total
1	5.5	16.1	11.2
2	30.8	22.8	26.5
3	18.5	14.4	16.3
4	13.6	14.2	13.9
5	13.9	14.8	14.4
6+	17.7	17.6	17.7
Total	100.0	100.0	100.0

Source Processed from Statistics Indonesia, 2020 National Social Economic Survey

We argue that the data reflect gender cultural patterns of male dependence in households, and thus the small proportion of elderly males living alone (5%), while almost a third (31%) live in two-person households, and the remainder live in larger households (64%). Note the contrast with elderly women, who are much more capable to live on their own (16%), and thus, a slightly smaller proportion live in two-person households (23%), while not too different from males, the majority live in larger households of three persons and more (61%).

Who to Live with in Old Age?

The choice of which adult children the elderly live with is another statement of the Indonesian bi-lineal kinship system which is not supposed to favor either sons or daughters but there used to be a general preference to live with daughters, at least among the X-generation born after World War II in the 1950s–1960s. Below are opinions and experiences of a number of elderly women (Box 1):

Box 1—Living Arrangements Experiences

I am lucky because my father died in 1994 when visiting with us from the village. His last wish was that my mother should stay with us, which she did until I had to take care of my husband in 2012.

Today she is staying with my younger sister.

One day I had to take my husband to the hospital which was full of women. Why? I guess, when husbands are sick it is their wives who take them to the doctor. If the wife is sick, it is the daughter who accompanies her. If a child is sick, it is the mother who takes care. – Zum is Javanese

It is true of myself. It is my daughter who currently takes care of me.

My daughter in law is like a little angel to me, always busy with her husband who is very active.

We are lucky with our customs. – Yudha, a Javanese

I think that daughters take care of their parents is our tradition because parents are also closer to their daughters than daughters in law. This is true of ethnic groups in Sumatra as well as Java.

My mother stayed with my sister until she died. – Tini, a Minangkabau from West Sumatra

My in-laws prefer to stay with their daughter in Surabaya, but every year they will stay with us for a few months as my husband is their eldest son. – Henny is Javanese and her husband is Karo from North Sumatra

My parents and in-laws all stayed in their own homes until they died. It is my younger sister who moved in together with her children to keep our parents' company and take care of them. – Mia, is Javanese

As the data show, there is no gender preference in who can stay with parents into adulthood and even in marriage. This is true of all children as well as married children living with their in-laws (Table 10.5). We show here the number of elderly heads of households who live with their adult children, most of whom are ever married. There are more male household heads (6.1 million) compared to female household head (3.1 million). Male household heads are more likely to live with their own children (54%) compared to female household heads (43%), a phenomenon attributed to dependence of men in managing their households or the independence of women under similar circumstances and therefore the greater likelihood of elderly male household heads having children living with them.

Table 10.5 Living arrangements of elderly household heads with adult children by gender, Indonesia 2020

Children in the household of elderly HHH	All Children				Married Children			
	Males		Females		Males		Females	
	No	%	No	%	No	%	No	%
No own children	2819	45.9	1731	56.6	2795	45.5	1715	56.1
Male children	1502	24.4	608	19.9	991	16.1	413	13.5
Female children	1148	18.7	524	17.1	649	10.6	347	11.4
Male and female children	677	11.0	194	6.3	1712	27.9	582	19.0
Total (000)	6147	100.0	3057	100.0	6147	100.0	3057	100.0

Source Processed from Statistics Indonesia, 2020 National Social Economic Survey

Table 10.6 Living arrangements of dependent elderly parents in their children's households, by gender, Indonesia 2020

Children	Males		Females	
	No	%	No	%
Sons	48.9	6.8	241.0	9.4
Daughters	69.0	9.6	327.6	12.8
Sons and daughters	597.9	83.5	2000.0	77.9
Total	715.8	100.0	2568.6	100.0

Source Processed from Statistics Indonesia, 2020 National Social Economic Survey

Notice also that irrespective of gender of the household head, there appears a greater tendency for adult male children to stay with their parents. It is suggested that this phenomenon is not a function of following a particular kinship rule, which in bilineal societies generally favor uxorilocal or matrilocal residence, but is rather driven by practicality of the situation and/or condition of the household members, including the children. Among male heads of households, 24% have their male children stay with them as opposed to 19% female children, and a similar pattern is also observable for female household heads—20% have their sons live with them as opposed to 17% daughters. The pattern for married children is similar even though at lower levels—16 and 11% for male household heads living with married sons and daughters, and for female household heads, it is 13 and 11%. These are new phenomena in the context of a society dominated by Javanese culture, where marriage used to mean setting up a new household meaning separate from parents, even though in the neighborhood of the wife's mother following patterns of uxorilocality or matrilocality (Geertz, 1961). This tendency is attributed to high divorce rates resulting in women returning to their maternal home[20] and men tending to move further away on subsequent marriages. It is suggested that these changes are a function of changing residential patterns with population and economic growth resulting in higher land taxes the closer to the city center of elite residences, a hypothesis worth testing.

Another interesting finding is the choice elderly make of who to live with as parents or as parents-in-law. These data are contrary to an idea held by the author of parents preferring to live and stay with adult daughters and their husbands rather than with sons and their wives.[21] In a way the pattern appears similar to the above, of elderly parental choices which children to stay with when they become dependent (Table 10.6). Notice that there are far fewer dependent fathers (716 thousand), compared to the number of dependent mothers (at 2.6 million there are more than three times the number of fathers), living with one or more of their children, one of them being the

[20] Transportation was relatively underdeveloped until the end of the last century.

[21] This idea held by the author is based on personal experiences in the family, friends, and acquaintances (expressed in Box 1). This is a valuable lesson not to just rely on anecdotal and personal experiences, but it is always better to check with available data.

head of the household.[22] Part of this difference in numbers is of course a function of women living longer than men. Besides, for this generation of elderly women, the youngest were born in 1955 and the oldest during the worldwide depression of the 1930s, the majority were and are poor throughout most of their lives, and thus, in old age, they have no savings and are thus most likely financially dependent and therefore live with their children when possible.[23]

Even though, yes, the proportion of elderly parents choosing to live with their daughters is slightly higher than those living with sons, still the overriding majority live with both sons and daughters. Seven and ten percent of elderly fathers choose to live with their sons and daughters, while among mothers, it is 9 and 13%. In both cases, the majority of dependent parents live with their sons (84%) and/or daughters (78%), at times moving between their children. These data reflect that Indonesian society does not practice a fixed normative gender-specific preference in living arrangements of adult children, some married already, in their elderly parents' homes or the other way round when elderly parents have to live with one of their children. Instead, we suggest that the pattern reflects pragmatic decision making of who lives with who in the life cycle of family members.

These findings on adult children living with parents as well as the other way round of dependent parents with children do not exactly follow "ideal" bi-lineal kinship rules of residence that favor matrilocality. Similar findings were observed toward the end of the last century by Ihromi (2000), who suggested that flexibility, which I rather call practicality, characterizes residential decisions. And we agree that the practices may well be here to stay and with even further modifications should be expected as life continues to change, especially in light of what we are currently experiencing, living with the new coronavirus COVID-19, which dictates a new normal, the outcome of which remains unknown today.

Access to Housing

What a cultural shock! After enjoying a holiday in well-organized neat and clean countries of Western Europe, we landed in New York, one of the most cosmopolitan and rich cities of the richest country in the world. I was bewildered and shocked to find the kind of poverty when walking around the city meeting a number of scavengers and then being informed that they were also homeless. I thought that if in such a rich country there are so many homeless, it must be much worse in a poor country like Indonesia. Besides, listening to the news in May of 2020 when many cities are in lockdown mode, the impact of which weighs heavily on many Americans' inability

[22] Notice that there are no elderly living in institutions like old people's homes, because the survey that does not cover institutions. The data collection unit of the survey is the household.

[23] While there are state-run and private old people's homes in the country, when possible, children are more likely to take care of the elderly parents.

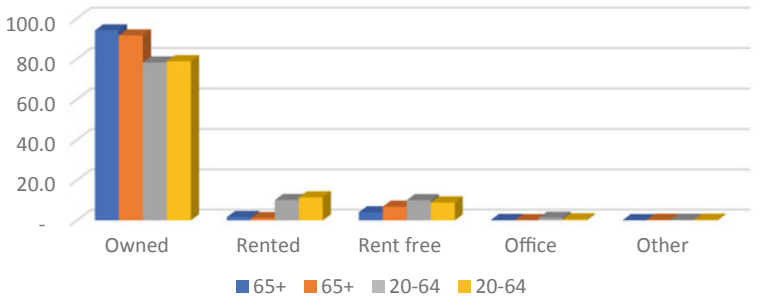

Fig. 10.7 Home ownership by age and gender of household head. *Source* Processed from Statistics Indonesia, 2020 National Social Economic Survey

to pay rent. However, home ownership data are only available for 46[24] and 52[25] of 197 countries[26] in the world, and Indonesia is in neither list. The highest recorded rates of 96–97% are for Romania in both lists. Except for Singapore, other countries having high home ownership rates of around 90% are Eastern European countries. At the other end of the spectrum, the lowest recorded rate is 43% for Swiss. These data suggest the absence of a relation between home ownership and wealth.

In the absence of an international comparison to gain an understanding of home ownership status among Indonesian elderly, we turned to the younger generation. It turns out that there is an intergenerational difference, even though only slightly, in the level of homeownership. Interestingly, homeownership is not a gender issue in Indonesia, but there is a substantial generation difference. The elderly strongly value owning their homes, as an overwhelming majority of more than 90% of both male and female household heads own their homes (Fig. 10.7). On the other hand, the younger generation, adults aged 20–64 years[27] are not as much concerned with having to own their homes at almost 80%. These adults include the millennials, often defined as those born during the last two decades of the last century and would thus be aged between 20 and 38 years in 2018. The true reference to the millennials is that

[24] https://tradingeconomics.com/country-list/home-ownership-rate.

[25] https://en.wikipedia.org/wiki/List_of_countries_by_home_ownership_rate.

[26] As a matter of fact, home ownership rates are only published for about one of four countries. According to the World Population Review (https://worldpopulationreview.com/countries/how-many-countries-are-there/), there are a total of 197 countries, consisting of 193 UN member countries, two UN observers (Holy See (Vatican) and Palestine), and two self-governed territories (Taiwan and Kosovo).

[27] Noticeably, we have placed the lower age limit of adults to 20 years. The reason for this cut-off is the current working definition of childhood, which ends at age 18 years, adopted by the United Nations in the Convention of the Child since November 30, 1989, and ratified by the Indonesian Government on September 24, 2012. It is since then that issues on children, like age at marriage if before age 18 are currently referred to as child marriage, draw the attention of the feminist movement.

they are also reasonably educated, with at least some post-secondary education,[28] and therefore can afford to want to feel free, including not to be bothered and tied down by home ownership. Millennials are not like their predecessors who strive for ownership of fixed assets, including their homes. Instead, as this generation prefers experience over ownership of goods, it is not surprising to note the survey recorded a slightly lower proportion of adults owning their homes (78 and 79% for males and females).

Next, notice the age difference among the home renters—around 1 of 10 adults but only 1 (one) percent among the elderly. While not as extreme, adults are slightly more likely to live-in rent-free accommodation than the elderly: For adult males, it is 10% and females at 9%; among the elderly, relatively slightly more females live in rent-free housing at 7% and males only 4%. The slight gender difference in access to rent-free housing is here attributed to the earlier discussed greater dependency status among women, a societal norm and also legalized in the 1974 Marriage Law.

Given the overwhelming level of home ownership in Indonesia in general and especially among Indonesian elderly, obviously it is not an indicator of differentiation. The survey is a rich source of housing information, which allows measurement of a variety of indicators often searched as indicators of development. With that goes the increase in home improvement projects across the world,[29] the development of the real estate industry, and the commensurate studies and reports on the value of housing on improving welfare and quality of life (Kemeny, 2001).

While an overwhelming majority of the population and also the elderly Indonesians live in their own homes, like elsewhere in the world, most would appreciate living in better quality housing. Indonesia's development achievements have taken 52 million people out of poverty into the middle class (World Bank, January 2020, right before COVID-19 became a pandemic) with rising expectations, wishing and wanting better living conditions, including better housing quality.

Quality housing is here defined in terms of longer lasting construction materials for roofing, walls, and flooring. We distinguish here between permanent and temporary housing. When and where possible most households would like to improve the quality of their homes toward permanent housing. In 2018, households living in permanent housing were still less than 40%. Or on the contrary, more than six of every ten households still live in temporary homes with roofs made of either asbestos, tin, bamboo, or straw, or thatched roofs; walls made of meshed bamboo or wires, wood; flooring made of wood, bamboo, or dirt. Notice that the share of households headed by elderly women (29%) is significantly less likely than those headed by elderly males (35%) to live in permanent housing (Fig. 10.8). We suggest that as stated earlier, this phenomenon is a function of elderly women being older and poorer than the men, the latter being a consequence of earlier dependence on men, their husbands, during their married lives. This is a condition which should be attended to.

[28] Millennials are here defined as aged 20–39 with post-secondary education. They constitute 16% of the age group.

[29] Some of course with loans from well-known international banks.

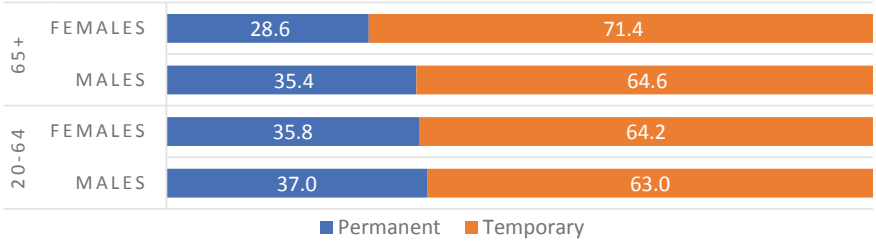

Fig. 10.8 Building materials of homes of household heads by age and gender. *Source* Processed from Statistics Indonesia, 2020 National Social Economic Survey. *Note* Permanent building materials is here defined in terms of (a) Roofing is either concrete or tiles; (b) Walls is made of bricks; and (c) Floors are covered with marble or granite, ceramic, or parquet tiles. Temporary materials are any other

The above assertion is supported by the pattern for the younger generation of adults of 20–64 years old. Among adults, there is great similarity between genders in the shares living in permanent housing. The proportions of households headed by men or women living in permanent housing are fairly similar (37 and 36% for males and females). As we have noted earlier, women dominate among the elderly and are more likely to have to take care of themselves and their dependents, often as widows with little experience of earning a living as main breadwinner.

Hygiene and Sanitation

Besides construction materials, quality of life improvements in living arrangements also include other components of the house. In the country's development efforts, improving the lives of the people, an important health concern is the absence of proper sanitation accessible to the poor. When living in rural areas of many areas of the country, where population densities were low and settlements were sparsely populated, personal disposals or defecation was often conducted over ponds or in open fields. Prepared for a few years before, in 2008, the Government started a program called PAMSIMAS (*Penyediaan Air Minum dan Sanitasi Berbasis Masyarakat*/Community-Based Drinking Water and Sanitation Provision). The general purpose of the program was directed at improving the access to drinking water and sanitation for the poor in rural and peri-urban areas through raising the value and healthy behavior by building and providing sustainable and adaptable community-based facilities and infrastructure. This program becomes a model for replication, scaling up, and mainstreaming models for other areas in an attempt to achieve the MDG target. More specifically, the objectives are as follows: (a) Promoting hygienic behavior in the community; (b) Improving community access to sustainable drinking water and sanitation facilities; (c) Improving local capacity (both in local government as well as the community) to focus and expand program

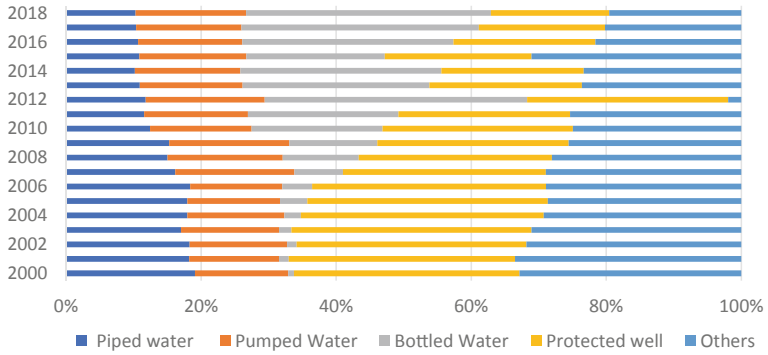

Fig. 10.9 Sources of drinking water, Indonesia 2000–2018. *Source* Statistics Indonesia, Annual *Statistical Yearbook of Indonesia 2000–2019*

implementation; and (d) Increase effectivity and sustainable long-term development of the community-based drinking water and sanitation infrastructure (Badan Perencanaan Pembangunan Nasional et al., 2006). This document served as it is called, an Implementation Guide, for at least the first Phase of 2008–2012 and followed by Phase 2 of 2013–2015. The success of the program, having reached 10.4 million people in 12 thousand villages, spread out in 233 district/cities in 32 provinces of Indonesia, has strengthened the commitment to continue to the next Phase 3 for the period 2016–2000, with a much greater target to create access to the overall Indonesian population, at the time estimated at 51 million people (Lestari, 2015), living on large and small islands, at various stages of development. Continuation of the Program as Phase 3 for the period 2016–2020 is legalized by the Minister of Health of the Republic of Indonesia Regulation Number 3 of 2014 on Community Based Total Sanitation (World Bank, 2014).

Regrettably, the excitement with the program is not fully reflected at the macroscene, which appears to increasingly rely on drinking water obtained in the market. This is reflected in the data collected by *Statistics Indonesia* (national statistics office). Data for the period 2000–2018 (Fig. 10.9) show the following patterns: First, access to piped water does not seem a popular alternative with the consequent declining share of overall household choice of source of drinking water. In fact, in 2000 one of five households relied on piped water as their main source of drinking water, but in two decades or more exactly by 2018, only half or one of ten households subscribes to that service. This is an interesting tendency considering that toward the end of last century provision of running water, supposedly delivering clean water for health purposes in particular, was handled by improving access to piped water. As a public sector service, it is the government or more specifically local governments, which are responsible for provision of clean water and services.[30] Quite likely, this

[30] The Western part of the Indonesian capital city of Jakarta is serviced by a joint company between the local government and an international company, here called PT Pam Lyonnaise Jaya, better known as Palyja. The company is under a current contract starting on February 1, 1998 for a

trend may well be a reflection of declining appreciation for the service in favor of other alternatives.

One alternative is pumped water, which, based on the photos in the various reports, including those promoted by the World Bank (2014), seems the choice for community-based alternative source of drinking water under PAMSIMAS. Pumped water can be built and then maintained by the community. Besides the underlying idea for the pump is that it also serves as a gathering focal point, especially for women, an idea which may well have been a misguided observation of very incidental occurrence. At the overall macrolevel, this source is also not an overwhelming popular choice, rising by only 2 percentage points from 14% in 2000 to 16% over a period of almost two decades ending in 2018.

Unexpectedly from the beginning of the century when branded bottled water was slowly introduced in the country, today it is bottled water that dominates drinking water choice of Indonesian households, which rose from less than one percent (0.8%) in 2000 to 36% in 2018. In Indonesia, we currently know two types of bottled water: branded (of all sizes and brands) and refills (non-branded gallon size bottles), and it is the latter which has gained significant popularity among the rapidly growing lower middle class. The refill drinking water businesses can be found in residential neighborhoods, not just in major cities or urban areas but also in less populated rural areas. This type of drinking water is a popular choice for drinking water, for it has become increasingly affordable and it is also a practical source of drinking water which does not require boiling, as is the practice with other sources of ground or surface water. Its popularity is reflected by Indonesia recording the highest growth rate in the world at 10.1% between 2013 and 2018 (Bedford 2020).

The last categories have also been pushed out of the market by the continuously expanding businesses of refill bottled water. These are the protected wells, which declined in reliance of households from 33 to 17%. A similar fate is experienced by all other sources of not very good quality water consisting of unprotected wells, protected spring, unprotected spring, surface water, rainwater, and others, which combined declined from 33 to 20%, still substantial. We suggest that these changes are a function of the development process itself as the market economy expands toward rural areas. With development and rising education[31] increasingly people are willing and recognize the importance of attending to one's health, in spite of blaming morbidity and mortality to fate, including the choice of drinking water consumption. Second, it is further suggested that the underlying assumption of the

25 years cooperation agreement with PAM Jaya, to end in the not-too-distant future, which, given the trend is questionable to continue.

[31] Unlike in the past when the poor felt helpless against disease and death, today there is greater awareness of how it can be prevented. We suggest that this is a function of rising education. School enrolment among elementary aged youngsters (7–12 years) is practically universal at more than 99, 95% among lower secondary school-aged youngsters (13–15 years), and 72% among upper secondary aged youth (16–18 years). This means that even upper secondary aged youngsters in rural areas are increasingly also attending school. We suggest that it is this rising education which introduces the populace to an awareness about health, what it takes to be healthy and that morbidity and mortality can be prevented.

Fig. 10.10 Percent of households having private toilets, Indonesia 2000–2018. *Sources* Statistics Indonesia, Annual *Statistical Yearbook of Indonesia*

community-based organization, the pump being a meeting place, ignores technological developments, where face-to-face relations are no longer a requirement for interpersonal exchanges to occur. Third, efficiency and practicality become increasingly appreciated in a world when and where time becomes an increasingly scarce commodity.

We are also able to verify the impact of the complement component of the PAMSIMAS program. Besides improving access to clean drinking water, the program also promotes households to invest in private toilets. Even at the beginning of this century, in some rural areas, there was an unwillingness to have toilets in the house, if necessary then they would agree with outhouses. That was of course also still the time when population densities were low and space for outhouses was still available. Today, it is suggested that socialization of sanitation appears to have been effective. Households are increasingly willing to invest in private toilets (Fig. 10.10). In fact, there was already a movement for households to build private toilets at the beginning of the century (from 55 to around 60%) then a lull between 2004 and the beginning of the program in 2008 at around the 60%, and thereafter, it seems to have taken off, hopefully attributable to the program, and with the program strengthened. By 2018, close to 80% of households already had an indoor private toilet.

The above general finding of 8 out of every 10 households claiming ownership of indoor private toilets generally also means an absence of striking gender gaps. The rich dataset also allows us to measure at more refined levels, by combining additional information. Specifically, we differentiate between toilets (modern) and latrines (traditional) options. Modern toilets are defined as privately owned, of the gooseneck type (water based), and disposed of in a septic tank. Traditional latrines are of the following types: shared with the public and no specific disposal. The results show slight differences between generations as well as gender in favor of the younger generation and males (Fig. 10.11). Among adults, the difference is minimal as 63, and 62% of households headed by males and females have modern toilets, but

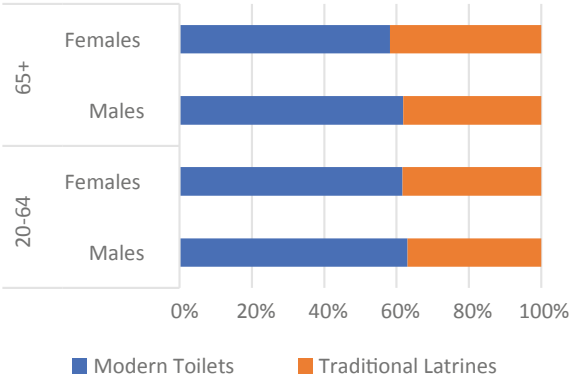

Fig. 10.11 Access to sanitation facilities by type, age, and gender, Indonesia 2018. *Source* Processed from Statistics Indonesia, 2020 National Social Economic Survey. *Note* Modern = Private toilet, Goose neck closet, and Septic tank disposal

among the elderly, there is a greater gender gap of 4 percentage points composed of 62 and 58% of elderly households headed by males and females. Since the criteria used to classify households relying on toilets or latrines imply differences in access to financial resources, these apparent gender differences may well be a reflection thereof. These findings suggest gender differences between generations—greater among the elderly than the younger generation. Given the difference in age and education composition by gender of the elderly (see Figs. 10.4 and 10.6), there is a difference in welfare status. And thus, when the concern is about the ability to access from the market, differential welfare status may well explain some of the gender difference, which we argue is being dampened by a feminist argument[32] that women run households and therefore they make such decisions, including acquisition of hygiene and sanitation facilities for the household. And thus, the consequence is also on younger households which show hardly any difference.

Unlike the case of having a private toilet in one's residence, which is true of eight out of every ten households, access to drinking and cooking water is far more varied (Fig. 10.12). As noted earlier when focusing on drinking water at the national level, the most popular source is bottled water, consisting of branded and refill bottles. And, it is significantly higher for younger adults than elderly, but only slightly higher for males than females—38 and 36% of adult males and females and 23 and 22% among elderly males and females. The significant difference of about 15 percentage points between generations in the ability to consume bottled water as drinking water is attributed to differences in general welfare and second also differences in education. The younger generation is better off and can therefore better afford bottled water which can be reasonably expensive. This preference is also related to the younger generation being better educated (Fig. 10.6) and therefore also better recognizes the important relation between relying on clean drinking water consumption and health, where morbidity and mortality are not just a function of fate. Today, it is widely believed that the cleanest and reasonably accessible water is still bottled water. But

[32] Currently, still based on personal and friend's experiences as no wider survey data are as yet available.

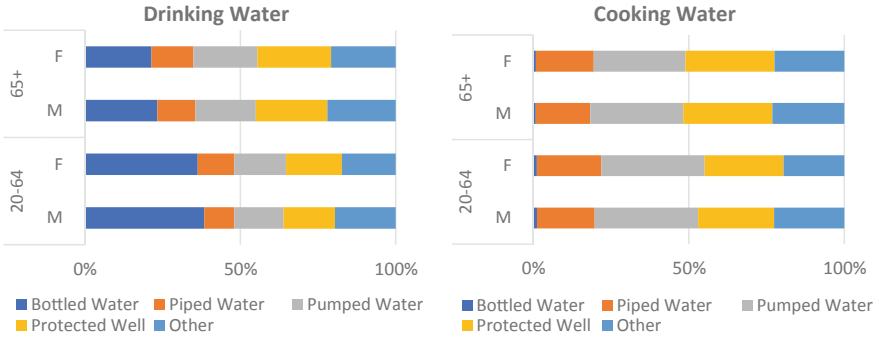

Fig. 10.12 Access to different sources of drinking and cooking water by adults and elderly, Indonesia 2018. *Sources* Processed from Statistics Indonesia, Annual *Statistical Yearbook of Indonesia. Note* M = Males; F = Females

then, bottled water is rather expensive, and thus, very few households use bottled water for cooking. Only around one percent of all households can afford to use bottled water for cooking.

Earlier we noted that over time piped water for drinking water has lost its popularity as main source of drinking water. This is not surprising given the sharp decline in water and service quality. Complains include inconsistent water flow as well as the quality of the water. Specific complains include inconsistency in water flow and the often-poor water quality, such as smelly, dirty with mud.[33] However, given that about one of every ten households still rely on piped water as their main source of drinking water and double or two of every ten households use it for cooking, and it suggests that the complains are not nation-wide or that in some areas the connections are of reasonable quality and are willing to put up with a few inconveniences. But, for all the complaints about the service and quality, an important message to leave is that gender of household head is not an important differentiator in access to piped water.

The gender message is similar for other sources of drinking and cooking water—the difference is not that striking. The greater difference is in the use of the water. The earlier noted striking difference is in the reliance on bottled water mainly for drinking. And thus, other sources of water are more likely to be used for cooking. Take the example of pumped water,[34] an important source for cooking, three of every ten households rely on this source, but only two or less in regards to drinking water. Similar differential patterns can be noted for protected well water, is more likely used for cooking water, and the same is true of other sources of water. Although not very

[33] There is a dearth of studies on this declining trend in piped water connections and thus no information on reasons for this trend.

[34] In fact, pump water users can be differentiated between the majority of those who rely on surface wells, and a few others have dug far deeper artesian wells. This is a difference in investment and resulting quality of water. Deep wells produce clean and clear water, believed to be the best quality water besides bottled water.

striking, if there is a gender difference, it is slightly more pronounced in terms of drinking rather than cooking water. The fairly equitable access to the various sources of drinking and cooking water suggests that these are likely caused by other factors, such as household welfare, which also takes into account residence and therefore often also availability. This brings us to close this section with the assertion that reliance on different sources of drinking and cooking water can mostly be attributed to welfare conditions of household. It appears that piped water is no longer in vogue and the less advantaged are to rely on shallow pump or well water or even worse alternatives, most likely not producing good clean and clear water.

So, Who Cares?

If women have fairly equal access to drinking and cooking water as men, we notice a rather pronounced gender difference in the common sources of livelihood. Interestingly, the survey identified sources of livelihood that are common to all and more applicable to the better off. The survey provides four categories: (1) a working household member; (2) care package (money and/or goods); (3) investment; and (4) pension, where the first two are the common sources ,and the latter two can only be done by the better off (Fig. 10.13).

An important difference between Indonesia and many rich countries of the world is that even in old age, so far, the government cannot yet be present to take care of its

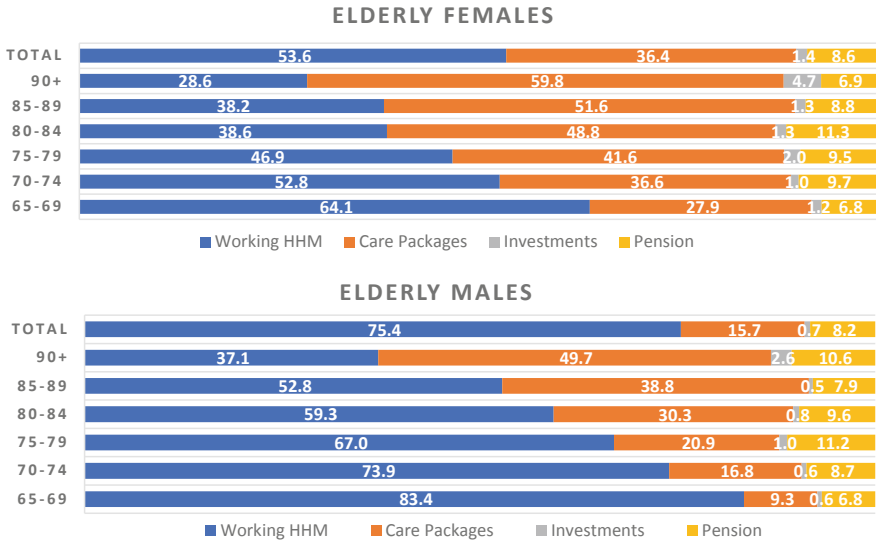

Fig. 10.13 Age-Specific Sources of Livelihood to Elderly Household Heads in Indonesia 2020. *Source* Processed from Statistics Indonesia, 2020 National Social Economic Survey

citizens. Indonesia does not have a social security system. And thus, when in need Indonesians turn to the family as they have always done. In the past, large numbers of children were a social security for old age, guaranteeing at least some children to survive to take care of their parents in old age. And reliance on children continues until today for the current elderly, in some cases for company and care, but also for financial support. As shown earlier (Tables 10.5 and 10.6), many elderlies live with children, male and/or female, single or married, own children and/or in-laws. That is how even in old age, some may have to continue to earn their own living even when they have reached a very advanced and tender age of the 80s and even 90s and irrespective of gender, or, if they are sufficiently lucky, they may be living with a younger family member still in the workforce (Fig. 10.13). However, as the elderly advance in age, this availability of a working household member declines (for females from 64 to 29% and for males from 83 to 37%), and reliance on care packages rises (for women from 28 to 60% and for men from 9 to 50%).

It is suggested that the underlying explanations for the complementary sources of livelihood in households with an elderly are rather different. The greater dependence of households with a male elderly on a working member as source of livelihood can partly be attributed to the much lower proportion of single households headed by men (Table 10.4 single households among men were only 5% while 16% among women).

Another important arrangement for survival in old age is reliance on care packages, more prevalent among women than men, but for men increasing in importance with age. This is again attributed to the higher proportion of women living alone compared to men (Table 10.4). This means that old-age survival is not ideal. The recipient is dependent on the condition and/or situation of the sender and therefore potentially not regular. The recipient is subject to having to do with what is available. On this count, for Indonesians, particularly for Javanese women, that is not too problematic as they have had to experience it throughout their lives. We remind that earlier we mentioned that women control the household purse. Men are supposed to give their earnings to their wives, the housewife, in charge of running the household in abundance or scarcity. Women are used to having to rely on their wits to manage the household, often by borrowing from family and neighbors and or local shops, owned by a member of the community.

Other sources of old-age survival (3) investment and (4) pension come from activities most likely achieved before retirement. Overall, there is hardly any difference in the percentages of elderly women and men relying on these sources of livelihood. These two types of sources of livelihood show that they are only accessible to the more fortunate. Only around one percent of both female and male elderlies benefit from investments they made during their younger years which in old age produce sufficient earnings as a major source of livelihood. More than eight percent live of their pensions (8.6 and 8.2% respectively). This latter relative similarity in the shares of pensioners between elderly women and men is surprising considering that women are far less likely to be in the labor force, and if they have to work, they have fewer

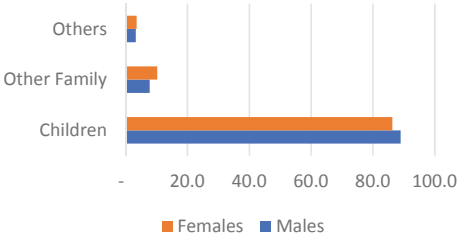

Fig. 10.14 Sender of care packages by gender of recipients, Indonesia 2020. *Source* Processed from Statistics Indonesia, 2020 National Socio-Economic Survey

opportunities to be absorbed in the formal sector.[35] And thus, to the question as to how elderly women have almost similar opportunity to men to be pensioners is because some of them are widowers of men who used to be civil servants eligible to pensions upon retirement.[36] In Indonesia to date, it is still only civil servants who enjoy the benefits of pensions.

This brings us to close this study on a promising note. The family remains important in Indonesia, even in these modern times when families are much smaller with fewer children. In old age, parents continue to rely on their children to provide them with care packages. This is true not just of the majority but almost all, at close to 9 of 10 elderly females and males rely or even survive on care packages sent by their children (Fig. 10.14). And then, if not children then there are still other family members, could be nephews or nieces being reminded of their aunts and uncles who they feel they should take care of—indicating the strength of the family.

We found the answer to the question Who Cares? Which has become clear only at the end of this study—it is the family that cares.

The Strength of the Family Throughout Life

Like elsewhere the world over, Indonesia's population is aging, and onto the future the share of the elderly is expected to continue to rise at an increasingly rapid rate. As an Asian nation, Indonesia is part of Southeast Asia and therefore shares cultural values and norms favoring a bi-lineal kinship system where individuals, both males and females, can claim membership in their maternal as well as paternal lineages. And thus, even though the natural sex ratio at birth favors the male offspring, and therefore in youth, the patterns of masculinity are indistinguishable from strongly male preferred societies as exemplified by the Chinese population, in Southeast Asia, the population starts feminizing at an earlier age. That is the pattern that also characterizes the Indonesian population, the largest in Southeast Asia residing in an

[35] According to the 2018 National Labor Force Survey, participation among 15 + males stood at 83% while for females only 52%. Of these, males are also more likely absorbed in the formal sector with 46% while only 38% among females (BPS, 2018).

[36] The latest update is Government Regulation No. 18 of 2019 Establishing the Basic Pension for Civil Servants and their Spouses.

archipelagic state where all basic kinship systems are represented, but yet various social and family practices follow those commonly performed by the Javanese, the dominant ethnic culture in the country.

As female life expectancy exceeds that of men, the elderlies are dominated by women. Considering that this generation, in 2018 age 65 and older, the youngest were born in the 1950s, only a few years after Indonesia declared Independence, the country was still very poor and was thus not yet able to provide education for all, as is the case today. In poverty, sons are given priority to access education as they become household heads in marriage. This is reflected in the gender bias in human capital of the elderly as women were much more likely not to have had any schooling. In a bilineal society in which daughters and sons can be considered equally responsible for their parents in old age, a labor market that is gender friendly can help that cause. For that to happen, we argue, it is necessary for girls having equal access to education as their brothers. And this appears to have occurred in Indonesia. Whereas grandma is so much less educated than grandpa, among the millennials, girls are better educated than boys with a higher proportion of girls having enjoyed higher education.

The notable gender difference is found in the position and structure of their households. For one, in a predominantly Moslem society acknowledging polygamy and high divorce and remarriage, men, including elderly men, are most likely married, while women are more likely widowed as they are less likely to remarry upon the death of their husbands. And in marriage, men can continue life without ever having to be responsible for household finances, the domain of women as housewives, a cultural and reinforced as also legal status in the family. And thus, by sociocultural and legal definition, men are much more likely than women to be heads of households, and women can only claim that position when there is no adult male in the household. It is therefore no surprise to find women to be much more likely to live in single households than men, even though the majority live in households with multiple members.

Between norms and practicality is the best way to sum up who the elderlies live with. On the one hand, in Javanese society, the norm is for parents to live with their daughters, when married with their families as well. That is how it used to be. However, that is not what the data say. It is a mix and match reality between the sexes of parents with children in relations of both directions of who is living with who. In today's language, this is the new normal, and it is more a matter of who can best afford to support the relationship between parents and children rather than rules and regulations of culture.

On the physical side, the conditions are mixed between surprises and expectations. The surprise came in contrast to the developed world, and Indonesian elderly recorded almost universal home ownership with little gender difference. On the other hand, given that elderly women are less advantaged, it is no surprise that their housing conditions are less favorable with relatively more living in temporary housing. The reliance on bottled drinking water in Indonesia is phenomenal, the fastest growing in the world. This is a revolution negating the age old publicly supplied piped water as the source of supposed clean and running water but has become less accessible over time. Access is fairly similar by gender but lower among the elderly. A good

news concerns sanitation with rapidly rising ownership of modern toilets defined as privately owned, of the gooseneck type and connected to a septic tank final disposal. As the acquisition requires financial access, women are regrettably somewhat behind men in accessing this valuable sanitary facility.

What matters is the family. In one way or another, in old age, the bonds continue. Children are not only a source of love but also of care on to old age. In a society with no social security system in place, old age is a family affair. The majority survive on earnings of a working household member or they rely on care packages, where men are more likely to live of the first alternative and women of the second, but in both cases as they age both women and men increasingly rely on care packages. On both counts, reliance on the family is paramount, children are either the source of livelihood, and they are the primary source of care packages, true of both elderly mothers and fathers.

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Emeritus Professor Mayling Oey-Gardiner received her Ph.D. from the Australian National University is affiliated with the Faculty of Economics and Business of the University of Indonesia. Most of her working life revolved around teaching and fairly broad-based social science research with much of the latter carried out for over 20 years running a private social science research and consulting firm in Jakarta where the work ranged from sectors such as education and labor to women's issues and social aspects of infrastructure development. Driven by her background in demography, a key focus of her work has been on the application of real population data (primary and secondary) to answer practical scientific research questions, something that continues until today.

Chapter 11
Plight of Older Americans: Insights into the Lives of African American Women

Sandhya Gupta and Navneet Kaur Baidwan

Abstract The proportion of Americans aged 65 years and above is increasing steadily, and one in seven Americans is now in that age group. There are 126 females per 100 males in this age group. Around 9% of those in age group are non-Hispanic African Americans. The latter experience worse health and racial inequalities in health as compared to white Americans owing to their disproportionate access to resources like education, income opportunities etc. They also have a lower median income as compared to their White peers. Low-income African Americans are also disproportionately more likely to be exposed to violence and crime which in turn affects both their physical and mental health. In fact, four in five African American women are overweight or obese and are almost twice as likely to have diabetes as compared to their White peers. This community is also at a higher risk of experiencing mood and anxiety disorders which are linked to their greater mortality and morbidity rates. Despite this, this group is less likely to use healthcare services as opposed to Whites as help-seeking behaviors are driven by culturally specific attitudes and experiences. The healthcare system is now becoming more aware of this phenomenon, and several policy and healthcare culture changes have been introduced.

Keywords Older African Americans · Women · Resources · Health care

The proportion of Americans aged 65 years and above has tripled since the 1900s. Currently, one in every seven Americans is aged 65 years and above contributing to 49.2 million adults in the population in the former group. Out of this, around 56% are females, thus attributing to 126 females per 100 males. Further, among the oldest–old, there are 187 females per 100 males. A much lower proportion of older females compared to males in the population are married and around a third are widows. A substantial proportion (45%) of these aged 75 years and above live alone as per the most recent estimates. There were, respectively, 24% males and 16% females who were working or actively seeking work in the year 2017. Next, while the median income for older males has been reported to be around $31,000, the same for

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females is around $18,000, as per estimates from the year 2016. Poverty rates were relatively higher among females as compared to males (Administration on Aging, 2017a).

Almost one-fourth of the Americans aged 65 years and above are members of racial or ethnic minority populations with majority (9%) being non-Hispanic African Americans, followed by non-Hispanic Asian and Pacific Islander. Additionally, Hispanics, irrespective of race, represent 8% of this population group. Around respective 80 and 65% each of non-Hispanic White and African American males and females report their health status to be good to excellent. However, this proportion is relatively lower among oldest–old African American females (Administration on Aging, 2017b). In general, African Americans continue experience worse health and racial inequalities in health as compared to white Americans and have higher mortality rates for the majority of fifteen leading causes of death (Pullen et al., 2014). The leading causes of mortality among African Americans aged 65 years and above include heart disease, cancer, stroke, diabetes, and pneumonia/influenza. The leading causes of morbidity on the other hand include hypertension, coronary artery disease, stroke, end stage renal disease, diabetes, and certain cancers. There is known to be an inverse relation between socioeconomic status and hypertension meaning that those with a lower socioeconomic status are more prone to developing hypertension. Among cancers, while African American women appear to have a similar incidence rate as compared to women from other ethnicities, the survival rate is lower.

In 2016, among households headed by adults aged 65 years and above, while the reported median income for non-Hispanic Whites was around $61,000, and the same for African American older adults was around $44,000. Further, around 19% African Americans as opposed to 7% Whites were living in poverty in the same year (Administration on Aging, 2017b). As far as these indices are concerned, African Americans belong to lower socioeconomic status groups, and very large and growing segments also belong to middle- and upper-income groups. While a large proportion live in rural South, more live in North and West. Among older African Americans that live in community settings, older women are more like to live by themselves (Hargrave, 2010).

Low-income African Americans are also disproportionately more likely to be exposed to violence and crime which can in turn affect both physical and mental health (Pullen et al., 2014). Life expectancy at age 65 years and above among African Americans is reported to be around 17% as compared to around 19% for Whites in this category. Next, the incidence of multiple myeloma is twice as high among African Americans as compared to Whites. Older African Americans have also rated their physical health and functional status lower than their White peers in various surveys. For example, while 25% of older African Americans report experiencing limitations in walking, the corresponding proportion among Whites is around 19% (Hargrave, 2010).

Louis Israel Dublin, in the year 1920 (Noonan et al., 2016), had remarked that "An improvement in Negro health, to the point where it would compare favorably with that of the white race, would at one stroke wipe out many disabilities from which the race suffers, improve its economic status and stimulate its native abilities

as would no other single improvement. These are the social implications of the facts of Negro Health." Dublin's assertion still remains valid to date. In fact, the first comprehensive review of health disparities in the African American community as compared to the Whites was only published relatively recently in mid 1980s. To date, African Americans continue to endure significant health disparities and lack of power and actions that could help alleviate such disparities (Noonan et al., 2016).

A large body of research has demonstrated that disproportionate access to resources like education, income opportunities, etc., has resulted in health disparities between American racial minorities and the White population. Discrimination, which is defined as a socially structured and sanctioned phenomenon that is intended to maintain privileges for members of dominant groups, has also been recognized as an important determinant that contributes toward such disparities. In fact, research provides evidence for the association between perceived discrimination and poor health. Among African Americans, researchers have established an association between this social determinant of health and health disparities. Specifically, perceived discrimination among this population has been linked to diseases or conditions like hypertension, depressive symptoms, elevated C-reactive protein, and diabetes. More recently, it has also been linked to mental health issues like psychological distress, depressive symptoms, and post-traumatic stress disorder. Such associations have been documented among various age groups, including those older and genders in this population (Nadimpalli et al., 2015).

Race-related stress, resulting from social and historical experiences of discrimination, impacts older African Americans health as stated above. Further, age also impacts mental and physical response to such experiences of racism. The latter have deprived the community of equal access to education, employment, health care, housing, and political participation, thus leading to increased rates of mental health disorders. Productive aging is also hindered by limited access to community resources like grocery stores, pharmacies, culturally competent health and aging service providers, transportation, housing, etc. (American Psychological Association).

Older African American women are viewed within the community as resourceful, energetic, courageous, hard-working are key figures in the stability and continuity of the black family and the community. Their sense of self-worth, belonging and history, and their ability to preserve their family is highly reputed within the community (Dena et al., 1998). Even today older African American women pass on cultural understandings to the younger generation (Peterson, 1990). However, given the years of discrimination, the African American women have had impaired aging progress owing to poorer health and well-being-related outcomes (Baker et al., 2015).

There is still limited literature that has specifically focused on older African American women in terms of identifying and analyzing factors that may impair their successful aging. The latter is more than a pathological and non-pathological state and includes avoiding disease and disability, high cognitive and physical functioning, and remaining productive and actively engaged (Baker et al., 2015). Methods through which research data are gathered, defined, and validated have been long challenged by feminists owing to the male bias in research. Alternative theories have therefore been provided, and the notion that gender influences behavior and lifestyle has been

legitimized. Specifically, research among African American women has not always focused on the complex interactions between race, ethnicity, age, and sexual orientation, and researchers may have long ignored their potential impact on behaviors (Wyche, 1993).

Physical and Mental Health Outcomes and Health-Seeking Behaviors

Physical health: While African American women are perceived to retain youthful features until older age ("Black Don't Crack"), they perform poorly on almost all other health indicators than women in any other racial or ethnic group (Belgrave & Abrams, 2016). Physical and mental well-being and successful aging are impaired among African American women and other minorities due to challenges posed by social change, exclusion, violence, discrimination, and cultural alienation (Baker et al., 2015). Not only do that experience excess morbidity associated with obesity, diabetes, and adverse birth outcomes, they also experience greater mortality rates associated with breast and cervical cancer, cardiovascular disease, and HIV/AIDS. In fact, four in five African American women are overweight or obese and are almost twice as likely to have diabetes as compared to their White peers (Belgrave & Abrams, 2016).

Physical activity: Physical activity, a primary source to prevent several health-related issues, is found to be lower among the African American population. Further, there is evidence that African American women are among the least active members of the society. While physical activity has been actively promoted as an affordable and effective means to prevent and treat chronic disease and to improve quality of life and well-being, racial/ethnic disparities persist. Research efforts have suggested that such disparities may be overcome by employing more culturally sensitive physical activity interventions and strategies. It is also important to understand that what women believe is involved in physical activity in terms of range of activities (Sebastião et al., 2015). The social cognitive theory suggests that it is important to understand how complex interactions between individual or personal factors and the social and poor physical environment (crime, access to facilities) shape physical activity among older adults. The theory also emphasizes on the need to identify the determinants of behavior including barriers and motivations. Primary motivation for doing physical activity among older African American women is to maintain good physical and mental health. Social support from family, friends, or community is also considered important factors. Barriers that may prevent women of this community to engage in physical activity include weather, time, and physical limitations. Family responsibilities have also been documented to prevent women from participating in physical activity (Gothe & Kendall, 2016).

Mental Health: Older adults, including women, the proportion of which is rapidly growing the American population are now at the forefront of changing healthcare

policy as healthcare providers have grown culturally sensitive and are providing community-based care. Most initiatives have, however, only focused on community settings and have aimed at improving health and quality of life along with mitigating illness, and fewer have focused on mental health disparities and healthcare services utilization. Specifically, even fewer efforts have focused on the former among African American older adults (Wharton et al., 2018).

Not only do African American older adults bear a disproportionate burden of chronic health diseases and have a shorter life expectancy than their White peers, but mental health disparities are especially a concern in this population. This is because mortality and morbidity are both associated with mood and anxiety disorders. While accurate statistics are not known, it is estimated that a quarter of this population in the community settings experiences depressive symptoms. Further, African American older adults, as compared to Whites, are 44% more likely to experience the onset of depression over a 10-year period, but they still are less likely to seek formal care for the same. This is because due to cultural and experiential reasons and stigma associated with mental illnesses, older African Americans mistrust aspects of the healthcare system (Wharton et al., 2018).

More recently, spirituality and religion have been incorporated into treatment considerations as recognition has grown regarding the role of the former in shaping an individual's life. Serving as facilitators in healthy development, African American churches are the cornerstones of many communities. The churches offer both spiritual healing and community-based mental health services. The theory of social ecology suggests that successful community-based interventions require working the multilevel community systems to engage individuals within their social networks. Such interventions are thus required to address the disparities in mental health care among older African Americana adults (Wharton et al., 2018).

Body image: At an individual level, a human body is experienced with regard to physically determined experiences, such as health, illness, body size, and ability, and at a social level, they are constructed and appraised through various lenses including gender and age. Such social experiences of being objectified by or assessed physically by others tend to be psychologically internalized. This internalization then produces a range of physical and mental health responses. Such experiences are particularly important for aging women. While the American population in general is aging, it is disproportionately women, and body image has been established as an important component of both physical and mental health among them. Such body perceptions and their associations with health vary by ethnic groups (Sabik, 2012).

Western culture specifically promotes women's evaluation on the basis of their physical appearance. This idea is particularly harmful for older women as they move farther from the youthful ideal but are still subject to evaluation (Sabik, 2012). An increased awareness among older women regarding the association between beauty and youth may lead them to perceive themselves negatively, thus affecting body image and self-esteem. In turn, both ageism and lower body image are independently associated with poor psychological well-being. Older adults, especially women who perceive the aging process negatively, are more susceptible to experience deleterious

health and well-being consequences. As per the social expectancy theory, an individual's self-perceptions are influenced by their cultural values. Specifically, one's cultural understandings provide explanations for who would be considered attractive or not based on which individuals tend to develop their self-concept, including body and health-related perceptions. Therefore, older women who experience more age-based discrimination are more likely to perceive that they are treated differently and negatively so. Negative age-related stereotypes that women may be exposed to may lead them to direct it inwards. The latter is associated with lower life expectancy, impaired memory, high blood pressure and heart rate, and impaired motor skills (Sabik, 2015).

Research shows that body dissatisfaction is frequently linked to depression among older women. It is particularly important to note that the rates of depression among women are much higher than men. This relationship between age, gender, and body image is multifaceted, and it is important to understand that there is heterogeneity within older women. Research suggests that there are ethnic group-based differences that suggest that experiences of the body are not uniform across all older women. Several research efforts have suggested that African American culture is more accepting of the different body shapes and sizes which act as a buffer against this body dissatisfaction among older women of the community. There is a general preference for large body sizes which is associated with health and prosperity. Next, among this community, physical attractiveness is defined in terms of stylishness than the physical body. It has been argued that as compared to older American counterparts, African American women may be more satisfied with some aspects of the body. However, still little is known about the association that these perceptions of body image have with mental health issues among older African American women (Sabik, 2012).

Health services utilization: While regardless of race, those with insurance are more likely to use health-related services, specifically over 20% African American women have no health insurance and are also less likely to have one based on employment as compared to their white counterparts. Further, among the former, help-seeking behaviors are driven by culturally specific attitudes and experiences. Research suggests that experiences with racism and sexism have had a significant effect on the women of color in terms of morbidity and mortality mediated through stress or other pathways (Pullen et al., 2014).

Racism, classism, and sexism of the ethnic minorities done to main the status quo have been blamed for the existing health disparities. It has been argued that past and current repression and oppression of this community is linked to cultural barriers to healthcare utilization. One of these cultural barriers includes religious and cultural codependence, and the other is interracial dissonance. While education and economic status are often stated to be unequivocally related, this may not be the case for all ethnic groups. Until recently, there has been reports of wage gap between African Americans and the Whites. Currently, while there are 4 million fewer poor Whites than 30 years ago, White to African American poverty ratio is 1:3. Also note that median household income among White household is 8 times greater than African

American households. This socioeconomic racial disparity persists through disproportionate access to education, employment, housing, and justice system. Although this community was awarded citizenship in 1865, still they are disenfranchised and continue to be punished severely and are unprotected under the law (Chandler, 2010).

Further, the medical institutions' western biomedical beliefs coupled with limited recognition of alternative beliefs and practices may further deter African Americans, including African American women from using the available health services. African American women are likely to have social networks that may influence their patterns of healthcare utilization. African American women also have high religious involvement, and there is evidence suggesting that more religious women of the community are less likely to use preventive and healthcare screening facilities, thus relying more on spiritual beliefs (Pullen et al., 2014). As research on these disparities grows, both researchers and healthcare providers are now becoming more aware of the oppression and suppression faced by this community and its role in health-seeking behavior. Hence, they are becoming more and more mindful of the phenomenon of cultural mistrust (Chandler, 2010).

Following health care-related strategies have been suggested to facilitate successful and productive aging among older women of this community (American Psychological Association):

1. Understanding the impact that everyday racism has through their lived experiences
2. Acknowledging their past and present experiences and being empathetic toward it
3. Providing equal access to resources and other shared spaces
4. Provide resources that enhance positive racial group identity
5. Encourage and celebrate their cultural belongingness
6. Limit exposure to and be mindful of culturally insensitive events or incidents
7. Seek training for culturally competent geriatric care
8. Facilitate culturally sensitive mental health services.

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Chapter 12
Older Women and Agism

Rosette Farrugia-Bonello

Abstract In this chapter, the author will be discussing the double jeopardy that women face in their old age arising between that interface between agism and gender. The general well-being of older persons can be impacted by agism and stereotyping. Society applies unique set of principles toward older women, especially in terms of stereotypes, prejudices, and expectations. Moreover, internalized negative stereotypes can produce self-fulfilling prophecies which often results on attitudes based on "just old age" which further contributes to weakness and dependency. One hears so much about "active aging" and "adding years to life," however, unless agism inflicted on older women is not halted, such concepts will remain so. The author argues that in order to improve the quality of life for women in a holistic way, there should be more awareness and policies in place in order to decrease agism and increase positive and realistic images of of older women.

Keywords Agism · Older women · Active aging · Quality of life

Introduction

Population aging is the result of longer average lifespans and lower birth rates. More people are growing older and healthier all over the world. The population 65-plus is projected to triple by 2050, which the World Health Organization (WHO) considers as one of the largest global societal challenges (WHO, 2015). This is the result of the inevitable consequence of attaining desired smaller family sizes, lower mortality rates and longer lives, with many living beyond 100 years. This increase in the older population is a triumph of civilization, a phenomenon to be celebrated.

Unfortunately, on the other side of the coin, the increase in population aging may also force society to consider aging as a social problem with a global impact. Often in the literature, especially that involving socioeconomic factors, one reads about this "gray tsunami"—a negative connotation, referring to the increase in number of

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the older population. According to Donizzetti, 2019, this is the result of the rising prejudices that have spread concerning older people, who are seen as hindering productivity and social dynamism—hence seen as the "dependents" on society. The notion of older people being portrayed in a negative way and stereotyped is called "agism," a word which had been coined by Butler in 1969a, b. It is a form of age discrimination against older adults which is shown in the practices of humiliation; lack of dignity; violation of basic human rights and also in the exhibit of negative stereotypes and installations concerning older persons (Butler, 1969a, b).

Unfortunately, we are surrounded by agism. It is found in the media, culture of the masses, day-to-day discourse, public policy debates, and also in professional discourse. It has seeped in our fabric of society. Aging population is making us more aware of the prevalence of agism; however, it is also an opportunity to address it so as to recognize the value of older adults as contributing members of societies.

Moreover, there is also the reality that the aging of the males and females is viewed from different lenses. Images portrayed in the media depict the aging women in a different light than older men. Aging in women is unaccepted. This is communicated through the array of beauty products presented on the market which are mainly for older women, with the aim of concealing the aging markers being white, hair, wrinkles, etc.… The situation of older women being different from that of older men is also seen in other sectors like health and employment.

This article will in fact be discussing "Older women and agism." This will be done by highlighting various factors whereby "the aging" of women is viewed and hence treated differently from "the aging" of older men. The effects of these differences will also be discussed. The article will close by proposing ways to be incorporated to policies and implemented in action as soon as possible, with the aim of decreasing agism in older women worldwide.

The Rise of "Agism"

As referred to earlier on, the word "agism" was first coined and introduced by Butler in 1969a, b. Butler was a gerontologist and was also the founding director of the National Institute on Aging in the United States of America (USA). Butler singled out three different but related characteristics of agism. Namelythese are attitudes and beliefs behavioral discrimination and formalized policies and practices. Basically, he adopted an intersectional approach whereby class, race and age all interact such that there is discrimination against older people (Malta & Doyle, 2016).

The main focus of the concept of agism was to give visibility to the different forms of marginalization and discrimination that older people are subject to:

> …a process of systematic stereotyping and discrimination against people because they are old, just as racism and sexism accomplish this for skin color and gender. Older people are characterised as senile, rigid in thought and manner, and old-fashioned in mortality and skills. (Butler, 1975: 35)

Policy development is the result of perceptions and attitudes. This will without doubt be reflected in the implementation and practice of the said policy. Studies from the human sciences such as gerontology, psychology, communication, and sociology have all been influenced by Butler's views. As a result, agism has emerged as a research field in itself (Gullette, 2011, 2017; Katz, 2001; Nelson, 2002; Schonfield, 1982). Research has continuously shown, that agism is more than just exhibited behavior and attitudes. According to Snellman, agism as a concept has now become deeply embedded not only in the social structures, but it also leads to the negative construction of old age taking place on an individual level. Agism is everywhere. Agism is visible in our everyday life—in the terminology and conversations we use when addressing and/or talking about older people; the way older adults are portrayed in all social media; through engagement in employment; in healthcare policies; and in the attitudes and behavior of health professionals.

Moreover, Barnett (2005) and Rippon et al. (2014) found out that agism not only reinforces social inequalities, but it is also more explicit toward older women, especially those who are living in poverty and/or living with dementia. For women, agism and sexism work in combination to provide "a double standard of aging" (Sontag, 1979), a double layer of discrimination known as "double jeopardy," which had been introduced in Social Gerontology by Dowd and Bengtson in 1978. Barrett and Naiman-Sessions (2016), Handy and Davy (2007), Walker (1998) describe "double jeopardy" as two interacting power structures having a negative heavy impact on the vulnerability of older women. This view of double jeopardy emphasizes the male-controlled norms. Moreover, present as well is the preoccupation with lost youth. All these combined result in a faster deterioration of older women's status when compared to that of men (Barrett & Naiman-Sessions, 2016).

Gendered Agism

Women outlive men and make up the majority portion of older people with their percentage of the population group increasing with age. Between the ages of 65–74, one finds 82 men for every 100 women. In the age group between 65 and 74, 65 men are found for every 100 women, while in the age group between 75 and 84, the ration is 41 men for every 100 women. Currently women outlive men by 4.8 years (United Nations, 2019). Globally women aged 65 are expected to live another 18 years, while men at the same age add on the average of 16 years (United Nations, 2019). Projections indicate that in 2050 women will comprise 54% of the global population aged 65 or over. However, though women make up the greatest majority of older people, one finds limited research in the fields of women's studies and gerontology (Bookwala, 2015; Calasanti & Slevin, 2001, 2006). Similarly, less attention on women's issues has been paid by social and health professionals (Freixas et al., 2012; Sugar et al., 2002).

The fact that women tend to live longer than men leads them to have more interaction with society. According to (Blieszner & Denmark, 2010), this very fact of living

longer makes women particularly vulnerable to age discrimination due to "gendered agism." The term "gendered agism" refers to differences in agism faced by women and men. It covers the intersectionality of age and gender bias. In later life, the women experience of aging is much more stressful than the experience of men mostly due to discrimination they have to endure in all aspects of life.

The Double Jeopardy of Aging

One example of the main pressures that women have in their later life more than their male counterparts is to keep up a youthful gaze. As women age, they are continuously judged upon the appearance of their bodies (Chrisler & Ghiz, 1993; Garner, 1999; Peat et al., 2008). We are living in a society whereby wrinkles and gray hair are associated with "old age" rather than associated with "experience" and "wisdom." The markets are invaded with "anti-aging" products that have been developed so that females may "erase" any reference to their age and hence are seen as younger than they are (Ostenson, 2008). Women are damned if they appear to age. Here, we have a scenario whereby women are culturally devalued—in both wisdom and experience, since older women's bodies are judged harshly for showing any signs of aging (Garner, 1999).

On the contrary, attitude posed on women is not the same for men. The same signs of aging as described above, i.e., wrinkles and gray hair, are usually seen as making men look prominent, wise, and experienced. This is what Deutsch et al., (1986), Sontag (1979) refers to as the "double standard of aging," where older men are put into an advantageous position. Sontag (1978) claims that there are double standards for women's and men's aging. She explains that while older men are valued for their accomplishments, older women are valued for their appearance. This gives them different experiences of aging. While older men can receive advantages such as prestige, power, and professional positions, older women are more likely to feel aversion to and shame with the onset of old age. Sontag's thesis is that women's aging is more painful since they are valued for their appearance and are supposedly unable to live up to norms of youth's beauty as they age (Sontag, 1972).

Images of Women, the Mass Media, and Aging

The famous artist Leonardo Da Vinci, in 1910, painted a picture of St. Anne with her daughter Mary and baby Jesus. Psychologist Sigmund Freud who happened to own such a painting had commented that Leonardo had painted the image of the grandmother (St. Anne) as a member of the same generation of her daughter (Mary). Most of Leonardo's biographers commented that the painter "*could not bring himself to paint old age, lines and wrinkles*." Here, we have a testimony that through the centuries, women were never "allowed" to grow old (Woodward, 1995).

In the classical literature, other examples are found in poetry. The "Mirror," a poem by Sylvia Plath written in 1961, speaks about the struggles that the women in the poem faces with the loss of her beauty, with the idea of ever getting old. In the short two-stanza poem, the poet is admitting that she is getting older, *"In me she has drowned a young girl, and in me an old woman rises toward her day after day, like a terrible fish"* (Plath, 1961).

In our society, one can see similar scenarios happening in the entertainment business like in the film industry. Hollywood actresses are perceived as "old" years earlier than actors do (Lemish & Muhlbauer, 2012). Male actors are allowed to age into their fifties and sixties, while female actresses remain firmly on the positive side of 40. Unless older women continue to look like "girls" with their youthful looks, their life experiences and wisdom are ignored and devalued. This doubled standard of aging may result in older women being under pressure than men to hide signs of aging "agelessness" and would not reveal their age for the fear of being discriminated at and hence ending up being ashamed of their age (Holstein, 2006). This is in part what turns aging into a trauma for many women. Sontag (1972), in fact did stress that *"…ageing is much more a social judgement than a biological eventuality*."

As described above, media does not only contribute to agism, but is also distinctly gendered due to its structures on older person's visibility (Baumann & De Laat, 2012; Harrington et al., 2014; Signorielli, 2004; Vasil & Wass, 1993). Apart from the entertainment business in Hollywood, other most mainstream media signal that older women are not newsworthy by the complete absence of older women. Aging in men does not threaten "masculinity" which is often identified with competence, autonomy, and self-control qualities. On the other hand, "femininity" in old age is identified with helplessness, passivity, and non-competitiveness. Older women are seen as not interesting or desirable subjects. When represented, women over 65 years are projected as "ordinary people" whereas older men are introduced as experts or spoke persons. In the words of Andrew Achenbaum and Peggy Ann Kusnerz[1], *"…an officer in his prime at 50 still appeared vigorous twenty year later. In contrast, by the sixth decade, the burdens of caregiving appear to have drained the woman of her vitality*."

The struggle continues to this present day, especially now that even the simplest technology found in one's home can be used to enhance and alter one's images—with the aim of making the image looks younger and/or deleting any signs of the aging process. Humanity must strive for a society where women should be comfortable to allow their faces to show the lives that they had lived. People need to be aware that growing older is not a sickness, on the contrary it is a privilege, which is unfortunately denied to many.

[1] Afterword in "Images of Old Age in America," 1982.

Gendered Agism and the Labor Market

Employment in the labor market is another vital social area that reflects the intricacy of agism (Dennis & Thomas, 2007). It is not easy for an older adult to find a job since they are perceived as costly and less productive—at a time when "active aging"[2] is promoted as the way forward.

Various dimensions like the labor market, employment, and society's organizational structures expose agism. This is visible through advertisements for jobs processes of selection, job tasks evaluations, career development, salaries, and other employee benefits. Agism is also visible in the selection of individuals for trainings and transfers to other jobs, promotions, termination of employment, and pension provisions. They are also the ones being pushed to leave into early retirement in times of economic recession. Moreover, Gafarova (2013) noted that in workplaces, agism is manifested in the use of discriminatory language and attitudes toward older workers simply based on their age. These behaviors are learned and accepted in society which unfortunately is led by various types of stereotypes. The researcher has also identified a number of prejudices affecting older adults like being slow due to physical and difficulties and hence the need to have rest periods; those related to cognitive difficulties—do not react quickly and do not learn new things; difficulties in relations with young people, resistant to changes, and lastly older people are associated with mistakes and accidents. Besides, since older adults themselves hold age stereotypes that affect their interpretation of other people's behavior toward them and of their own behavior, various age-related barriers have been reported by older workers re-entering the labor market. These include feelings of being overqualified, lack of empathy, or perceived age difference between the applicant and the interviewer.

Itzin and Phillipson (1993, 1995) had introduced the term "gendered agism" in their study of age barriers at work, which mostly focused on gender in both the public and private sectors. It has been found that even at the screening stage, older women experience age discrimination more frequently than older men. Since women is affected by agism at a lower age than men, women are seen to be impacted by agism at work earlier and hence face this additional barrier in the workplace. Research shows that agism hinders women's careers at every phase starting with hiring. Older women endure more employment rejections than older men. The misperception that age affects ability leads many companies to create workplaces that are quick to dismiss older employees. The truth is that older employees, especially older women, can contribute to companies. By hiring and retaining older women in the workforce, companies may retain and improve work output and culture. Businesses who do not acknowledge that an aging workforce has potential will be loosing out from the experience and other trademarks that older people can contribute toward the labor market.

[2] Active aging refers to the situation where people continue to participate in the formal labor market, as well as engage in other unpaid productive activities (such as care provision to family members and volunteering), and live healthy, independent, and secure lives as they age.

Older women around the world are trapped in poverty because they spend much of their time on "uncompensated" work. They spend amounts of time and energy on taking care of children and/or older relatives or managing the home, vital work which unfortunately, falls under "unpaid work." According to the Organisation for Economic Co-operation and Development (OECD) 2014, on average, women globally spend 4.5 h of their day on unpaid work while men spend about half that time. In a gender-equal country like Norway, women find to spend about an hour more on unpaid work than men. In India, women spend almost six hours doing unpaid work while men were found to spend less than an hour. Even when women work outside the home, they often do not take on higher-paid jobs that might require commitment, due to their responsibilities at home which takes much of their time. Women end up earning less than men. This creates a vicious cycle which places women at the bottom of the economic pyramid, perpetuating the gender pay gap.

It is not surprising that life-long differences in pay and working time result in different pension band (if any) and poverty rates differences increase after the age of 65 and even more after the age of 75. This is at a time when older women live longer and often alone, due to marrying partners older than themselves. Older women acquire the position of financial vulnerability through earlier life course (Arber et al., 2003). Earlier positions as housewives or working with low wages—characteristics of a gendered labor market where traditional female work is poorly paid—result in a financially vulnerable position when women get older.

One of the main objectives of policymakers is to extend the working life and increase the employment rates among older age cohorts. At the same time though, legislation is important so as to not only defend the rights of older workers, but also to avoid gendered agism at work which they may face through recruitment, training opportunities, working conditions, and flexibility. Legislation would also be safeguarding and promoting equal rights and opportunities for all. Policies should also offer incentives to households to reduce and rebalance the burden of unpaid labor and offer family-friendly policies like paid parental leave so that woman will not be in a disadvantage in her older years.

Gendered Agism and Health

Agism results into negativity (Burnes & Pillermer, 2019). When people are perceived according to their birth age, they are placed in the "old and unattractive box." This will lead to other negative expectations like exhibiting poor health, depression, weakness, fragility, passivity, inability to learn new things, inability to understand technology, dependency etc.… Most of these are associated with older women and hence make people perceive them as more incompetent than older men.

In the literature, one finds that depression is underdiagnosed in old age (Chrisler et al., 2016) since this is expected to be an integral part of aging and hence older persons are less likely than young ones to be referred to therapy. Many are those who associate aging with sickness and hence lack of memory, confusion, frailty, and

other symptoms may be dismissed as part and parcel of the aging process without a good medical investigation (Calasanti & Slevin, 2006; Stewart et al., 2012). For example, in the case of older women, they are not likely to be screened for sexually transmitted diseases since many assume that older women are not sexually active. A similar scenario can be found in, old age abuse. Abuse, often go undetected by healthcare professionals since domestic abuse is quite often not associated with old age, since older women are perceived weak and unsteady, healthcare professionals readily may accept explanations that injuries have resulted from falls.

According to Cameron et al. (2010), Correa-de-Araujo (2006), Donovan and Syngal (1998), when compared to older men, older women rarely get flu vaccines or are screened for cholesterol or undergo other health check-up treatments for stroke prevention. Moreover, although women are found to have a higher prevalence of knee and hip arthritis and other forms of joint disease and disability, it is only the minority that manage to undergoing joint replacement surgery. On top of all this, it is found that the greatest gender difference is found to be in the treatment of cardiac situations where older women are less likely than men to receive heart bypass (Travis et al., 2012), therapy (Wenger, 2012), and other treatment such as daily aspirin, beta blockers, and rehabilitation programs after a heart attack. Older women are also disadvantaged in the diagnosis of heart attacks. Wenger (2012) also found out that since commonly, women are older than men when diagnosed, their age together with gender stereotyping result in being perceived as too frail and vulnerable to undergo the necessary procedures.

Other differential treatment and practices found in medical resources are based on age which results in restrictions for procedures like transplant surgeries and treatments of fertility. Older women are also found not to have and gain from opportunities of rehabilitative, innovative, or expensive treatments (Austin et al., 2013; Kagan, 2008). An increase of lifespan in older people is coupled with an increase in costs on the healthcare system (Ayalon & Tesch-Romer, 2018). This results in a major challenge, that is the pressure between providing good quality of life as opposed to maintaining longevity (Ben-Harush et al., 2016).

North and Fiske (2015) wrote also about "hostile agism." These are the beliefs that older people are useless, dependant, and a total burden on society. This type of agism is dangerous since older persons might end up being denied health care, especially if this care is expensive. Research also found that doctors especially do not like to attend to older people as they think that older people are not able to follow the "*doctor's orders*." As a result, they might be disrespectful or impatient with them. As Higashi et al. (2012) word it, it is "*frustrating and difficult because of incompetence*." Given that women make up the majority of older people it is this group who are mostly being discriminated at, since they are not only the largest segment of recipients which make up the older population seeking medical treatment, but also this is the greatest segment which will be needing medical treatment and care for a longer time span. This group comprises also older women living with dementia, which unfortunately, once again we note that this is the largest group diagnosed with such a condition.

The literature speaks also about benevolent agism. This is the belief that older people are warm, vulnerable, and need to be cared for tenderly. This is often accompanied by infantilization and baby talk experienced by older women. Older women have complained that they have been treated by medical professionals as though they were children and were addressed as "sweetie," "dearie," "young lady," and even "good girl" (Chrisler & Palatino, 2016). Such infantilization is even seen in care homes where caregivers address female residents especially with expressions such as "grandma" and "my love" which are often spoken in a higher pitch and brighter tone than usual. Also, personally I have also witnessed objects used in care homes and/or day centers to carry out activities. Time and again, I have seen activity coordinators using children's jigsaw puzzles depicting cartoon characters as pictures. While jigsaw puzzles are great to be used during activities in care homes and in day centers since they tap multiple cognitive abilities in older people (Fissler et al., 2018) and also encouraging social participation, jigsaw puzzles ideal for grownups with pictures of views, countries, famous landmarks, etc.… should be used. Older people are senior citizens who should be addressed and treated like any other adult.

Benevolent agism may also lead to treatment discrepancies between older men and women. Older women, since they are perceived as fragile, are treated in a more paternalistic manner by male doctors. It has been suggested by Travis et al. (2012) that this could be one of the reasons why medical professionals do not risk giving older women aggressive medical treatment compared to older men with similar conditions. Similarly, this could result in refusal to honor "*do not resuscitate"* (DNR) requests or, on the other hand, are persuaded to have another round of chemotherapy—as a result of the general belief that they (older women) do not know what is best for them or do not know how to take a decision. All these disparities among older persons and differences in treatment between older men and older women are unfair and hazardous to older women's health.

Older adults may hold negative views toward old age as well and hence tend to view negatively individuals who are older or more disabled than themselves. I have witnessed older adults in care homes refusing to engage in activities, for the simple reason that the "other" residents are either older than they are or using aids for daily living like walking frames and wheelchairs or are living with dementia. These negative views of aging are particularly noticeable among women (Ayalon, 2013). These agist attitudes of prejudice and discrimination may lead to different forms of stress. Literature specifies that stress reduces the immune system functioning which might affect the onset or worsening of chronic illnesses (Taylor, 2012) and are thus may experience poorer health.

Moreover, a growing literature indicates that lower-body image is highly prevalent among older women (Bedford & Johnson, 2006; Lewis & Cachelin, 2001; Mangweth-Matzek et al., 2006; Szymanski & Henning, 2007). It is likely that low body esteem may be associated with poor psychological well-being for women in late middle age. Social expectancy theory posits that culturally shared standards of attractiveness influence how we view (or stereotype) and interact with others, and these views are internalized and shape individuals' behavior and self-perceptions. This approach is particularly relevant when considering the effects of

agism on women's body esteem and psychological well-being. Specifically, women may internalize agism (Levy, 2002) and begin to view their own bodies through a discriminatory lens, potentially leading to negative body image. Holding negative views on aging may lead to one to perceive other peoples' attitudes as discriminating against older people. It could also act as self-fulfilling prophecies to provoke ageist behaviors by others (Voss et al., 2016). Attitudes toward aging may result in heavy negative tolls on older peoples' holistic well-being. It has been reported that self-directed agism holds a high risk for increased morbidity and mortality (Levy et al., 2002, 2009).

Also, internalized agist applied to self can serve as a barrier to health promotion (Yeom, 2013). One may believe that he/she are not capable of adhering to exercise, and to healthy living in general and that they are too forgetful. All this contributes to dependency, weakness, and perceived ill health. Agism has been shown to negatively affect health and well-being and can reduce life expectancy by up to 7.5 years.

Conclusion

The term "agism" was coined by Robert Butler almost half a century ago in order to describe the symptoms and roots of the unequal and degrading treatment given to older persons (Butler, 1969a, b; 1975). Today, at a time when demographic changes favors old age, societies are still not recognizing the wisdom that comes with later life. Though we are living in the twenty-first century, agism, unfortunately, continues to be an extensive and widespread phenomenon. It is highly dominant but at the same time it is often unnoticed due to its being so ingrained in our lives (Ayalon & Tesch-Römer, 2018). The aging process is still being devalued and simply not accepted as a reality, a natural part of the life course that is bound to happen to those who are privileged to live beyond the age of sixty and above. Age and aging are related to biological phenomena, but their meanings are socially and culturally determined.

The *United Nations Universal Declaration of Human Rights* (UNDHR) which was adopted by the United Nations (UN) General Assembly in 1948 celebrates its 72th anniversary this year. While Article 1 of the Declaration recognizes that all humans are born free and equal in dignity and rights, it is interesting to note that "age" is not included in the article. Unfortunately, to date there is no general legal instrument to dispel prejudices against older people in the international human rights system.

That is not to say that work has not been done. Work has been carried out by human rights law actors to study how human rights can combat agism. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) is an international treaty adopted in 1979 by the United Nations General Assembly. It is an international bill of rights for women, instituted on September 3, 1981 and has been ratified by 189 states. Agism has been recognized as a human rights issue by the committee supervising the Convention on the Elimination of all forms of Discrimination against Women (CEDAW). This is seen in their general recommendation no. 27,

when it reminded that States "*have an obligation to eliminate negative stereotyping and modify social and cultural patterns of conduct that are prejudicial and harmful to older women*" (CEDAW, 2010, para 36).

Both General Assemblies on Ageing, namely the *Vienna International Plan of Action on Ageing* (1982) and particularly the *Madrid International Plan of Action on Ageing* (MIPPA) (2002) addressed the need for older persons to be empowered and for their voice to be heard. Most notably, MIPPA in Priority direction 3, issue 4 which talks about the importance of "*Promoting positive images of older persons in society."*

In December 2010, the United Nations General Assembly established an open-ended working group, open to all States Members of the United Nations for the purpose of strengthening the protection of the human rights of older persons. This was resolution no 65/182, a follow-up to the Second World Assembly on Ageing. The main goal of the working group is to consider the existing human rights framework in relation to older persons and to identify possible gaps and how best to address them. The working group will also consider, as appropriate, the feasibility of further instruments and measures to protect the rights of older persons.

One of the most good moves was the appointment of the United Nations Independent Expert on the Enjoyment of All Human Rights by Older Persons in 2014. In a United Nations Human Rights Council 2015 report, it was pointed out by the first Independent Expert, Rosa Kornfeld-Matte that "Ageist attitudes still persist throughout the world, leading to discriminatory practices towards older persons, including in care settings. *Age-based discrimination generates a lack of self-esteem and disempowerment, and undermines an older person's perception of autonomy.*"

Promoting gender equality, eradicating poverty, and ensuring healthy lives and well-being at all ages are indeed part of the United Nations Sustainable Development Goals (SDGs) goals with the aim to be achieved by 2030 (UN, 2015a, b). Following the 146th World Health Organisation (WHO) Executive Board's recommendation made in February 2020, during the 73rd World Health Assembly have *WHO have endorsed the proposal for a Decade of Healthy Ageing (2020–2030).The Decade of Healthy Ageing 2020–2030*, which will consist of 10 years of concerted, catalytic, sustained collaboration, is another positive approach forward. Older people themselves will be at the center of this plan, which will bring together governments, civil society, international agencies, professionals, academia, the media, and the private sector to improve the lives of older people, their families, and their communities.

The rights of older persons and their protection from agism are increasingly becoming a subject of international interest. However, to date existing mechanisms to combat agism, particularly agism faced by older women is still non-existent. The "active aging" paradigm has potential as an alternative to the idea of older people as dependent, disabled, or vulnerable. Strategies on active aging are without doubt useful tools in managing effective approaches to non-discrimination and equal opportunities, but unless interventions to change attitudes and beliefs on older persons, particularly on older women are going to be addressed and necessary actions are taken on an international level, such policies will be deficient since agism will continue to persist. Older women should be given a voice, older women should be empowered

but for that to happen, attitudes of all need to change—interventions to improve the perception of older persons in general and older women in particular need to be adopted as part of an international strategy to reduce and eventually eliminate agism once and for all.

Currently, during the COVID-19 pandemic, agism has never been so visible. It is being openly discussed which certainly is increasing to the pressure of older people in living through the pandemic. COVID-19 pandemic has a deep effect on the exclusion of and prejudice against older adults. Discourses which are agist carried out by different stakeholders like the media, healthcare workers, policymakers, etc., result to the devaluing of older people and contribute to their feelings of worthlessness, sense of being burdensome, and increased dependency. The present scenario of this current pandemic has created a clear age divide between the young and the old, calling the latter as "the vulnerable," thus treating all older people as heterogenic. Such discourses disregard older persons contributions to society while opening Pandora's box, with the re-emerging of intergenerational conflict and reinforcing negative age stereotypes. Unfortunately, we are currently witnessing agism at its best. United Nations Secretary-General Antonio Guterras in a powerful statement that was largely supported by United Nations 146 member states including European countries and the European Union itself and welcomed by more than 100 civil society organizations worldwide, stated that "*Our response to COVID-19 must respect the rights and dignity of older people."* Moreover, it was also recognized that *"The majority of older people are women, who are more likely to enter this period of their lives in poverty and without access to healthcare. Policies must be targeted at meeting their needs"* (United Nations, 2020). The need for increased awareness on gendered agism is important in order to be able to change the narrative about older women.

Conventions and policies create awareness, and they allow advocates to track progress and hold governments accountable for transgressions and inaction; they establish laws, rules, and regulations; safe guard the rights of older people and call for data collection and regular reporting. Besides, to a certain extend, they also encourage older persons to voice their needs and be empowered. But, to combat agism more needs to be done.

Strategies on active aging are without doubt useful tools in managing effective approaches to non-discrimination and equal opportunities, individual and social attitudes, stereotypes and behavior directed to people on the basis of their gender and chronological age need to be addressed in order to combat agism. Similarly laws, policies, and other institutions and authority support agism or do not anything to halt it. Research is definitely needed on age and gender particularly in healthcare sector, employment, and in the media. The lack of interest in such researches acts toward the further existence of agism. Older women should be given a voice. More education is needed for all stakeholders, including older persons most especially older women themselves. Older women should know their rights, have the power to defend them, distinguish between chronic illness and old age, and above all be assertive to insist with healthcare professionals in getting the right information about their health and hence to get their well-deserved treatment. Positive self-perceptions lead to holistic positive physical health and well-being and will reduce negative

stereotyping. Services should be improved so as to decrease the barriers that exist between older women and the rest of the population and hence increasing social integration and participation. The last but not the least, advocacy is necessary. Policymakers should ensure that in all policies, the needs of older women are addressed so as to avoid discrimination and hence gendered agism.

To bring about change, there is a need of cooperation among the various stakeholders, as well as the engagement of older persons themselves. Policies need to empower older persons, particularly older women so as to embrace the notion that biases and perceptions of aging based on chronological age are to be perceived as negative. Only when society shows zero tolerance to agism, we would be then seriously be advocating for a "society for all ages," and a society where women and men are perceived, respected, and treated equally and have the same opportunities throughout their life. Declarations without implementation will not make any difference. Action to stop agism—especially agism faced by older women need to be taken now. As people get older, agism affects their life chances and opportunities, and hence their well-being and quality of life. Aging is a privilege, aging is here and now. Growing old is one of the universal human experiences and everyone has a right to experience this phenomenon without being discriminated at. This is one of the basic human rights. Age segregation impoverishes us because it cuts us off from most of humanity. Exchanging skills and stories across generations enriches us and makes us stronger. Aging is a natural phenomenon and someday we are all going to stand on the "other side" of the bridge. We should remember that agism is that prejudice against our own future selves—so let us commit to work together so as to strive to make agism on older women a reality of the past.

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Chapter 13
Dementia and Women—Global Concerns

Avinash De Sousa and Bhumika Shah

Abstract Dementia is a common disorder involving memory loss, behavioral changes, and changes in personality that occurs after the age of 60 years. More women have dementia than men and often outlive men as well. This chapter looks at the interface of women and the dementia conundrum. We shall first look at women and some of the risk and protective factors that they have in developing dementia. The symptom differences and sociocultural factors that play a role in dementia in women are explored from a global perspective. The interface between hormonal replacement therapy and dementia is also looked at along with epidemiology of medical disorders in women and the propensity for dementia in the same population. Treatment and management differences with regards to dementia in women are highlighted, and finally, the chapter looks at the specific factors in women caregivers of patients with dementia.

Keywords Dementia · Women · Elderly · Geriatric · Caregivers

Introduction

Dementia is one of the greatest challenges to the geriatric healthcare scenario. It is a disorder with no known cure and limited treatments, and its onset redefines the collective experience of aging (Williams et al., 2009). Women all over the world have differing rates of dementia when compared to men in respect to the epidemiology, diagnosis, and management of dementia which is now required at a global level (Crooks et al., 2008). The subject of women and dementia remains under-researched and under-explored. While men and women may age in the same way and have similar needs, older women are particularly vulnerable and treated differently since childhood in many societies (Rosenthal, 2014). Several studies show

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the prevalence of dementia syndromes, and specifically Alzheimer's is showing an increasing trend in women as a global phenomenon (Vina & Lloret, 2010). The increase in life expectancy is in favor of women and also indicates that more women shall be prone to dementia (Wu et al., 2016). This chapter aims to explore the various facets of dementia and women from a global perspective.

Life Course Perspective

Assuming a life course approach, dementia in women is caused by various different pathological processes. It is a product of many trajectories, i.e., biological, psychological, social, political, cultural, and economic, and women need to be studied separately. As people age, women and men share same fundamental human rights. Older women are more susceptible to prolonged inequalities and discrimination in developing countries. Thus, from a life span perspective just like all physical and psychological disorders, dementia demands a separate perspective from a female point of view.

Terminology Used in the Chapter

In the following chapter, the term "***sex"*** will be used to refer to "*differences which are biological, genetic, or phenotypic (genetic or physiological characteristics of being a man and woman)"* while the use of the term "***gender"*** will be with regard to psychosocial factors such as social influences. "***Dementia"*** will be used as the generic term in the chapter, to describe "*the symptoms that occur when the brain is affected by certain processes and aging"* rather than denoting a specific type of dementia.

Few Considerations

While we focus on dementia and women in this chapter, it does not imply that dementia in men is less important. The chapter is not a radically feminist viewpoint on dementia but rather based on scientifically supported facts on how dementia presents in women. Many factors mentioned in this chapter with regard to dementia and women apply equally for men. The role of gender and being a woman cannot be seen as the sole factor in health and well-being with the onset of dementia in later life. The gender lens cannot portray succinctly the complex, intersecting, and multilayered factors that go into the genesis of a neuropsychiatric disorders like dementia. Dementia is influenced by the interplay of a wide range of factors. Women are a diverse group, just as old age is dynamic and lies on a continuum of dependence

and interdependence (Tilly et al., 2016). Thus, just being a woman does not ascertain and determine risk or protection from disorders like dementia, and it would be morally and mortally incorrect to treat women as the same by stereotyping them.

Epidemiological Concerns

The growing aging population is a concern in all nations worldwide. In 2010, more than 83% of a global rise in the number older people was seen in developing countries (Pilkington, 2009). This trend will continue, and the number of women above the age of 60 years and more shall surpass 1 billion by the year 2050 (). In the population above the age of 80, there will be more women than men as well. Worldwide, by the age of 80, there are 189 women for every 100 men, and for age around 100, there are 385 women for every 100 men (). Paradoxically, women live longer but are not healthier in their old age. Research says larger number of women are compromised with age-related medical comorbidities as compared to men (Gelber et al., 2012).

Many epidemiological studies have reported arise in the prevalence of dementia, and it is reported to double for every 5 years increments in age post 65 years (Chêne et al., 2015). It is known in medicine that dementia is not age dependent and rather age related and can be prevented by the reduction of various risk factors that lead to dementia (Rocca et al., 2014). The relationship between gender and dementia is confounding with lack of regularity and discrepancies across studies based on methodology that was used and other statistics of the region in which the study was conducted (Beydoun et al., 2014). There are many factors that make dementia a significant concern for women. The average life expectancy is more in women than men. Thus, dementia would be more common in women than men in the coming years (Rizzi & Rosset, 2014).

A recent meta-analysis on dementia suggests a strong epidemiological relationship age, gender, and dementia. The incidence and prevalence of dementia increased exponentially with age and gender had an effect in most regions of the world. Men had a lower predicted prevalence than women and was in the range 19–29% (Mitchell et al., 2014). In some studies done in Europe and Asia, dementia incidence rates are higher in women than in men. There are significant gender differences in European nations after the age of 85 where older women have a greater risk than men. Studies have demonstrated a great incidence of dementia in women in very old age for Alzheimer's, while the reverse is true for vascular dementia (Fiest et al., 2016; Pendlebury & Rothwell, 2009).

Dementia and Its Global Burden

Dementia makes up 0.8% of all disability adjusted life years in worldwide studies. As dementia is seen more in older populations, the contribution is higher in the age

group 60 years and above with a burden being twice as higher in women than men (Nichols et al., 2019). The disease burden is greater in developed nations, and no uniform patter has been reported. Varied results have been reported from studies in Asia, and women with dementia above the age of 60 years are also at a greater risk for the development of depression (Alladi & Hachinski, 2018; Wimo et al., 2010). Thus, the burden of dementia is greater in women, because they live longer and because they outlive men in older cohorts. Greater medical issues like poor vision, cataract, hypertension, arthritis, and depression also impinge on the burden in dementia (Launer, 2019).

Many women with dementia fail to receive adequate care and may not even be diagnosed properly by their treating doctors due to lack of training. Many may not receive adequate treatment and may not get the care needed and the rehabilitation needed for the disorder (Venketasubramanian et al., 2010).

Lack of Access to Dementia Care

Women suffer more than men with regard to dementia care and its access. Discrimination against women is well-documented in many societies, and they are rarely brought for treatment and diagnosis early. Dementia as a diagnosis is powerfully stigmatizing both in the public health and residential care settings, as many patients have disturbed behavior, poor self-care, memory loss, and incontinence. There are prejudices that exist toward women getting the right care and medical help (Giebel et al., 2015).

Caregivers can also be a cause of discrimination and prejudice to patients. The majority of caregivers are women, and women often have to bear the brunt for the demented state of their spouses and elder men in their families with dementia. In many countries, dementia and psychiatric disorders is considered akin to "*madness*" which renders the individual not getting access to care or getting it with stigma and ridicule (Garand et al., 2009). Women may be taken to traditional healers which further promotes stigma and isolation. Stigma in mental health and fear of admission may serve to act as barriers to women seeking care and getting diagnosed with dementia, and the awareness of dementia is also low in some countries (Herrmann et al., 2018).

Lack of Diagnosis in Women

Diagnosis rates in women also depend on their ability to access dementia care and successfully use the healthcare system. The multiple medical problems faced by women with old age such as lack of mobility, hearing impairment, memory loss, and depression may serve as barriers to going to a healthcare professional (Religa et al., 2012). Older women in various countries live alone and are lonely, and the death of

the spouse is a stressor that makes it further difficult. Some studies on diagnosis rates of dementia have shown slightly lower rates in people living alone than those with a family and caregivers (Bunn et al., 2012).

Risk Factors for Dementia in Women

There are many risk factors for dementia that have been identified. While there are differences in the risk factors for men and women with regard to the development of dementia, sex and gender differences are seen in this domain regard. There is no single risk factor but rather multiple complex modifiable and non-modifiable and modifiable risk factors that play a role in the development of dementia (Chen et al., 2009).

Age: We all know that advancing age is a major risk factor for all forms of dementia. Women live longer than men and form a large part of adults in the oldest old age groups, and hence, where the risk of dementia is greater, more women than men have dementia (Song et al., 2011).

Sex: Several studies have suggested that women are at greater risk of Alzheimer's disease. However, as Alzheimer's is the most common form of dementia and due to women outliving men, we may have more women than men having dementia in the years to come. The risk of developing dementia in women compared to men is 5–7 times greater (Bamford & Walker, 2012; Podcasy & Epperson, 2016).

Genetic Factors: There are numerous genetic studies conducted to determine the genetic risks for dementia. Several genetic causal theories have been put forth for dementia and many with genes seen more in women. Research has proposed that there is an Apolipoprotein E genotype interaction with women who are thus at a greater risk for Alzheimer's than men in older age groups (Rosvall et al., 2009). Results of these studies taken together suggest that women are more susceptible than men to dementia irrespective of apolipoprotein genotype (Bäckman et al., 2015).

Hormonal factors: A biological hormonal factor for women and dementia is linked to some blood reproductive hormone levels (Whitmer et al., 2011). It has been proposed that low estrogen levels with other factors account for an increased risk of Alzheimer's disease in women (Georgakis et al., 2016). Estrogen replacement therapy has been considered to reduce the risk of Alzheimer's disease. Many studies suggest estrogen to serve as a protective agent for postmenopausal women and reduces the risk developing Alzheimer's disease (Rasgon et al., 2014).

Cardiovascular factors: Cardiovascular factors have been implicated in the causative pathway of dementia in women and include stroke-related factor that may contribute to the onset of vascular dementia. There are risk factors associated with coronary heart disease and stroke like chewing tobacco, smoking, hypertension, raised cholesterol, obesity, lack of exercise, and a poor diet. Women also have higher rates of silent ischemic episodes and cerebral white matter degeneration. Diabetes is a risk factor in women associated with the development of dementia (Alonso et al., 2009; Fillit et al., 2008).

Physical Activity: A number of risk factors and lifestyle associated factors influence the risk of developing dementia. The associations between walking regularly and protection from Alzheimer's and related dementia syndromes have been noted in women (Aarsland et al., 2010). There have been reported reductions of the risk of dementia by 50–60% in women with greater levels of physical activity as compared to those with less or no physical activity (Blondell et al., 2014).

Diet and lifestyle: Dietary factors considered in the same study yielded the protective effect of regular red wine consumption. Moderate amounts of wine consumption were associated with a reduced dementia risk in women (Stockley, 2015). Women who are obese seemed to be at a greater risk for dementia than men (Hassing et al., 2009).

Depression: For women, a higher risk of dementia has been associated with subclinical depression and even presence of depression increases the risk of dementia development in women. Untreated depression is at a greater risk to cause dementia in women due to brain based and neurochemical theories beyond the scope of this chapter (Byers & Yaffe, 2011).

Language and education: The Nun study which was a longitudinal study based on 678 American Roman Catholic sisters demonstrated how early life experiences and educational status along with linguistic abilities showed that cognition like poor idea density and lower grammar complexity was found to be liked to dementia (Mortimer, 2012).

Most studies on risk factors in dementia are marred by their small sample sizes, geographical circumscribed locations, and small population bases that make national and international comparisons difficult (Barnes et al., 2009).

Treatment Response in Women

Women have not been a part of early studies and most clinical trials due to safety issues. There are limited studies on gender specific effects of drugs used in the management of dementia. Many older women have medical problems and may be on multiple drugs with diverse medication combinations causing the chance of drug reactions. With regard to dementia, the problem is further compounded by cognitive decline where response to therapy can never be measured by the subject's response but rather one has to rely on the caregiver. The male subject bias in dementia research may have gender-based implications in studies on the medical management of dementia (Johnell et al., 2013; Patterson et al., 2008).

Dementia Care for Women

In developing countries, proper care for dementia is not available, and even if it is, it is expensive and beyond the reach of all. Thus, most patients are managed by the

family or neighbors and in some cases by charitable non-governmental organizations. The developing nations neither have the capacity nor the healthcare infrastructure to rise up to the increasing graying population that shall soon suffer from dementia. Elderly women are in a more vulnerable position than elderly males when it comes to dementia and quality of life (Witt et al., 2010). Lower educational status in women and lack of attention given to their care are other factors. Education of women is not a priority in many countries (Bott et al., 2017). Many situations arise where women may either work within the family environment or maybe involved in low-skilled and poorly paying work. A United Nations Human Development Report mentions that "*poverty accentuates gender gaps, and when adversity strikes, it is women who are often the most vulnerable"* (Frazer et al., 2012).

Elder Abuse and Dementia in Women

In respect to elderly women, topics like elder abuse are important as this applies to any form of care that they receive. Women with dementia are more susceptible to elder abuse due to deteriorating cognitive function, poor memory causing a vulnerable state where they may be taken advantage of Dong (2015). Elder abuse manifests as elder bullying, physical violence, intimidation, emotional and physical neglect, and even financial abuse. In most nations, elder abuse is under-reported and has always received poor attention and priority in both developing and developed countries. Women are more susceptible to elder abuse given many live longer and older and are also more likely to be lonely and at the mercy of the caregiver. Elder abuse studies across the globe report higher rates in women as well as under reporting of the same (Dong et al., 2014; Yon et al., 2017).

Women as Caregivers in the Dementia Process

Caregivers of patients with dementia are an invisible workforce and are neglected in terms of healthcare support. Family members as caregivers remain the mainstay for elder care in dementia. Women may derive happiness and satisfaction from their role, and caution must be sued when we refer to caregiver burden for them (Zauszniewski et al., 2015). Population studies report chances that particularly in developing countries indicate a shortfall in informal care provision. The proper education of women and their increasing participation in the healthcare force, their migration causing mobile populations, and a breakdown of traditional families as well as more couples reducing the number of children, they have shall affect caregiving for the future. In the future, there may be less women available, who are keen to assume caregiver responsibilities, and this will have huge repercussions for the future of informal dementia care at home (Stewart et al., 2016).

Future Research Needs

The following, we feel, are the future research needs in the area of women and dementia and their interface:

1. Dementia health policies should inculcate a female- or women-based dimension in their design, delivery, and execution.
2. Gender-specific risk factors should be included as a key health indicator in the primary prevention of dementia.
3. Gender- and age-based dementia research at a regional and national level.
4. More research across disciplines shall combine biological and social aspects of dementia care in women.
5. Women and men should be recruited in drug trials and treatment studies in dementia care.
6. Women must be considered at healthcare policy level and resource allocation in dementia.
7. Drug response studies to treatments in dementia.
8. Genetic studies for dementia in women.
9. Specific studies of women caregivers in dementia.
10. Specific studies on elder abuse and women with dementia.
11. Phenomenological and qualitative studies of women with dementia.

Conclusions

Though there is a greater risk for dementia among women, several factors are also protective in nature and can play a role in the well-being of aging women. Interestingly, the biologically determined sex as well as the gendered aspect of being a woman can pose risk factors as well as protective factors in the development of dementia. There are unique challenges that women (and men as well) face as a result of developing dementia that demands for an adequate health infrastructure in order to address those. While there is a need for the health sector to provide for holistic dementia care, the psychosocial care received from the family can aid in preventing dementia to a fair extent. Genetically underpinned dementia can also be managed well at the family level to a decent extent. Psychoeducation and awareness are key to understanding and addressing dementia at the family level. While a more comprehensive nature of research will help address the nuanced challenges of dementia among women, there is a lot one can do in order to delay dementia. However, there is a need for understanding the phenomenon of dementia better in women by including greater number of women subjects in research.

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Chapter 14
Negotiating with an Acquired Disability: Experiences of Elderly Women in Kashmir

Tania Farooq, Shazia Manzoor, and Saima Farhad

Abstract Aging is associated with prejudices that are described as negative; a phase of life marked by dependency, frailty, and un-productivity. Elderly people are often perceived to be unfit and incapable to perform the activities of daily living. This assumption is aggravated by the condition of disability as the common perception about the disabled population is also the same. The reality for many older people with any form of impairment is a life full of struggle. Disability is highly stigmatized, and people with disability are perceived to be dependent, incapable, passive, and in need of care. The disabled population is never a homogeneous category; it consists of people from different class, gender, and age. Nevertheless, disability impacts everyone in a different way. As a person ages, there is a possibility of acquiring a disability, thus making the person more vulnerable to dependency. The reality for many older people with any form of impairment is a life full of struggle. Being aged and being disabled is a double jeopardy and to acquire any form of disability in old age is a painful phenomenon. Acquiring a disability in old age can directly affect the quality of life around and requires adapting and readapting with the new conditions of life. In addition to this, the condition may be aggravated by the intersection of various other factors like gender, caste, and class. In line of the above discussion, this paper will use a qualitative methodology to examine the experiences of women who are aging and have acquired a disability in Kashmir. The focus will be on the experiences of life changes from being independent to dependent.

Keywords Aging · Disability · Dependency · Gender · Vulnerability · Kashmir

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Introduction

"India is witnessing a demographic revolution, leading to a considerable increase in the proportion of older people in the population" (Prakash, 2003, p. 85). The elderly population might be higher in the developed world, but the population is aging faster in the developing countries (Balagopal, 2009). Aiken (1995) argues that old age traditionally has been perceived to be as that stage of life "where decrements outweigh increments, when capacities and opportunities decline rather than expand." Furthermore, the stereotype of aging is one of inevitable ill health, mental, and physical incapacity which leads to disability and dependency (Bond et al, 2007). It is generally said that aging may increase the risk of acquiring a disability (Torgé, 2014).As a person ages, there is a possibility of acquiring a disability, thus making the person more vulnerable to dependency. While this may not be completely true, a large number of people while moving from adulthood to older age may face certain disabilities. Several factors that may lead to disability in old age may include "inappropriately treated diseases, depression, cognitive, sensory and physiological impairment, smoking, sedentary lifestyle, unhealthy dietary habits, deviance from optimal body weight, high or no alcohol use compared to moderate use, and insufficient social support" (Burden of Disease Network Project, 2004, p. 2). It may also be due to the poor eating habits and exercise patterns in younger and middle-aged populations (Murphy et al., 2007). Some age-related disorders may also include life-threatening diseases such as "heart disease, stroke, cancer, diabetes, and infections, as well as certain disabling conditions affecting vision, mobility, hearing, and cognition" (Kumar, 2003).

The relationship between aging and disability has been intensified by the population aging (Murphy et al., 2007). The terms age and disability have both "chronological and social dimensions" (Torgé, 2014). They have been categorized as similar social constructions as they have been constructed as negative categories (Priestly, 2003). Aging is also associated with prejudices that are described as negative; a phase of life marked by dependency, frailty, and un-productivity. Aged people are perceived to be unfit and incapable to perform the activities of daily living. They may face discrimination that stems from the ageist attitude of the society that makes the position of an older person with disability more vulnerable (Murphy et al., 2007).

An important point to discuss here remains the vulnerability of women as they age. A gender divided society operates at many levels and has definitely not left elderly women untouched. Mallick (2011) says that "ageism, sexism, and structural division" together create "power imbalances" that "predicate on the notion of women as being of inferior status." In India, aging has become a gender issue because of the fact that the number of women surviving into old age is increasing and because they are disadvantaged and vulnerable in numerous ways (Prakash, 2003). Although women have higher life expectancies, but they are more likely to experience poor health and functional disabilities in old age than their male counterparts (Penning & Strain, 1994; Sengupta & Agree, 2002; Vebrugge & Wingard, 1987; Verbrugge, 1985, 1989; Verbrugge & Jette, 1994). Women who are aging and have a disability

may be jeopardized in multiple ways. It is commonly said that age and disability may lead to "double burden." But for women, who recognize themselves as aging with a disability in a developing nation, the burden may be manifold. The report by UNFPA (2017) in India makes some interesting conclusions toward this end. It acknowledges that although "gender disparities exist at all the ages but when women become old, the consequences of engendered roles become more explicit." It further notes poverty is "inherently gendered" in older age when women are more likely to be living alone, have fewer assets, are dependent on family for support, or become widowed.

Elderly in Kashmir

According to the Census, 2011 the elderly population (60+) in Jammu and Kashmir is 8.4% of the total population. Elderly population in Kashmir may face same problems as we have discussed above. But the condition is aggravated by the longstanding conflict. The conflict in Kashmir has added to various psychological problems like depression, post-traumatic stress disorder (PTSD), and anxiety. It has also increased the risk of conflict induced disability. A number of studies have been conducted in Kashmir like (Showkat, 2016) which has focused on the issues of elderly in Kashmir that has concluded how elderly persons in Srinagar (summer capital of J&K) face various health issues in addition to the social and psychological problems like depression, isolation, and lack of social interaction. The study also points that old age can bring "impairment in hearing, speech, vision memory, and loco motor ability; these impairments compound discomfort, loss of pleasure, and add aggravate social and psychological problems." Also, the findings of study that the participants complained of fear psychosis because of a conflict situation must be pointed out.

Similarly another study by (Munshi et al., 2008) has been conducted to analyze the depression level in relation to family support. The study has concluded that the depression in the sample studied was directly proportional to the family support. A decrease in depression was observed in the participants having family support as compared to those who were not having any family support. Also, the study showed that the prevalence of depression was twice more in female participants as compared to their male counterparts.

Although some studies have been done (see Rafiq et al., 2016; War et al., 2018), but they have focused particularly on health, psychological problems of elderly in Kashmir. These studies have predominantly used a quantitative lens and have focused on problems of health and psychological issues. In this context, our paper focused on a dimension that has been neglected by the researchers in this area. The study focuses on elderly women who have acquired a disability (after 60 years of age) and will qualitatively explore their experiences. The qualitative exploration will help us to document the experiences of their life changes. As (Murphy et al., 2007) argue that "older people with a disability should not be treated as a homogeneous group or 'batch-processed'; rather, they need to be centrally involved in giving meaning and

interpretation to their own disability and how that disability impacts on quality of life" (p. 37).

Methodology

Qualitative data were gathered through in-depth interviews by the first author. Qualitative data are a source of well-grounded rich description of social processes. With qualitative data, we can "preserve chronological flow to derive plausible explanations for outcomes" (Miles et al., 2019). "Through qualitative research, we can explore a wide array of dimensions of the social world, including the texture and weave of everyday life, the understandings, experiences and imaginings of our research participants, the way that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate"(Mason, 2002, p. 1).

A semi-structured interview guide was used, which was developed around the general research questions. But this served as a basic tool for questioning and the participants were free to discuss range of experiences.

The interviews were done with eight women who were above 60 years of age and had acquired a disability. Locating the women for this study was difficult because they are confined to their homes only. The researchers then identified two rehabilitation organizations who work for persons with disabilities. Persons with disabilities register themselves at these organizations for physiotherapy sessions, or for availing the hearing aids, or other medical supplies. Among the list of institution, women who fitted the inclusion criteria of this study were approached for interviews. At the onset, the purpose of the interviews was explained and the meetings were set according to the convenience of the participants. The interviews were semi-structured and spanned for an average of 45–65 min. At least a minimum of three interviews were done with each family. At first, an informal introduction with the participants was done. As the author belonged to the same place (Srinagar, place of study) and was known to the language, getting acceptance became a bit easy. As qualitative methods give the participants the flexibility to open up about their personal experiences and account to a considerable extent, as such the information, we gathered spanned over a number of issues. It was generally in the second meeting that questions related to experiences of acquiring a disability were asked. The interviews began with certain open-ended questions and then certain prompts were used to fulfill the purpose of interviews.

Informed consent was taken from all the participants and the purpose of in-depth interviews was made clear. The interviews were tape recorded with prior permission of the participants; pseudonyms are used for the purpose of this paper. The interviews were translated from Kashmiri to English and the transcribed material was subject to content analysis in terms of broad categories such as the experiences of transition from one stage of life to another, negotiating with acquired disability and the support from families.

The Participants: The criteria that was established for the inclusion and exclusion in the sample was:

Table 14.1 Demographic details of the participants

Name (Pseudonym)	Age	Previous occupation	Occupation of spouse	Number of children	Present medical diagnosis
Hajira	67	House wife	Govt. employee	3 (one son and two daughters)	Post stroke paralysis
Faiza	68	House wife	Govt employee	3 (one son and two daughters)	Low vision
Sofiya	65	School teacher	Doctor	1 (one son)	Low vision
Gulshan	70	House wife	Self employed	4 (three sons and one daughter)	Mild Hearing Loss (Uses Hearing Aid)
Zeenat	71	School teacher	Govt. employee	3 (three sons)	Dementia stage 1
Saira	75	House wife	Self employed	5 (three sons and two daughters)	Parkinson's disease
Gazala	66	House wife	Bank employee	4 (one son and three daughters)	Mild Hearing Loss
Sabreena	67	House wife	Self employed	2 (two sons)	Parkinson's disease

a. Female adults above 60 years of age.
b. Who had an acquired disability (After 60 years of age).
c. Who were willing to give an informed consent.

Eight women participated in the study who had a range of impairments. The age ranged from 65 to 75 years. The participant's demographics along with the type of disabilities are given in Table 14.1.

Results and Discussion: After carefully analyzing the data, we developed three major themes. These are

1. Experiences of life changes: The Old Self v/s the new "OLD" self.
2. Negotiating with an acquired disability.
3. From being an asset to liability: Support from family.

The narratives and themes that emerged after transcribing the data show that negotiating with an acquired disability has been a difficult task for these participants. Participants describe their experiences in terms of journey from adulthood to old age and from being independent to dependent. We begin with the narratives of experiences of life changes to the support that they had been provided from their families.

1. Experiences of life changes: The Old Self versus the new "OLD" self

A major theme that emerged from the data was the experiences of the life changes that these women had witnessed. Participants did a constant comparison between

their past and present. The narratives discussed below show that the transition from adulthood to older age along with the presence of an acquired disability was certainly a painful phenomenon for them. As Saira, one of the participants says:

> The transition of life while moving from one stage of life to another is definitely challenging. Earlier I was an independent person; I would walk for long distances. I would visit our relatives on my own but now I am dependent for everything. She further says that: When I was young, I used to walk miles to get water for the entire family and do all the household chores. But now I am not even able to get a glass of water for myself.

We found that such narratives came up during all the interviews. The participants did a constant comparison between their past and present lives. Every participant we interviewed took us back in time to their "old self." There is an importance attached to the meanings that the participants associated with their "old self" and their present "OLD" self.

Another participant, Sofiya notes that:

> I vividly remember how active and enthusiastic I used to be. As I worked as a teacher for almost 35 years, I had a very punctual routine. I used to get up early and do all my household chores and leave for work. But now I feel that my disability has left a profound effect on my life. I miss my 'old self'. These things are difficult to explain, they can only be experienced.

Prakash (2003) notes that old age is often accompanied by loss of "physical, mental, and social functions." Also, when "young old" move into the "old-old" category, they may face increased health complaints and diagnosed illness. The participants felt that their new "OLD" self is synonymous with dependence, frailty, and passiveness. Faiza, while narrating the experiences of her transition, shares that:

> I would be considered indispensable for our family celebrations, as I would do all the work tirelessly. 'be aesis mazuer seind paeth kaem karan' (I used to work like tirelessly like a labor would do[1]). But nowadays, I feel I have turned incapable and dependent.

Although the narratives revealed how this transition was a painful phenomenon for most of the participants, yet some of them were able to accept this transition as a "phase of life" which was inevitable. Also, one important point to note here relates to the gendered notions of work where in women are expected to do all the household work. The participants of our study predominantly did a comparison to their "old self" in terms of the household activities that they would do. It is because women in patriarchal settings are the "sole" caregivers of family. Various studies have documented that women do more household work, are involved in child care and care of kin as compared to men (Bianchi et al., 2006; Gerstel, 2000; Hochschild, 1989). Now, if these patterns continue, then older women will be more engaged than older men "in helping other relatives such as aging parents and grandchildren" (Kahn et al., 2011). Srivastava (2010) argues that the heterogeneity among the aged gets accentuated when gender-based comparisons are done. These gender-based comparisons became important for our study because the participants shared their experiences around the gendered nature of work. Although the binaries of able/disabled

[1] In Kashmir, it is used as a proverb to denote the capacities of an individual to work hard. It determines how hardworking and capable a person is.

body were thoroughly discussed by the participants, yet "gender and gendered work' came up as an important intersection.

2. Negotiating with an Acquired Disability

The acquiring of disability in old age is regarded as a "dynamic social phenomenon" that relates not only to "individual, physiological, and medical conditions but also to socioeconomic position, cultural norms and environment" (Burden of Disease Network Project, 2004). People who have acquired disabilities early in life are said to "age with disability," while those who acquire them later in life are said to have a "disability with aging" (Verbhugge & Yang, 2002). The experiences of both groups would be different depending upon the length and time spent living with the disability. Their expectations, adaptations, and coping strategies for dealing with disability will be different (Murphy et al., 2007).

Participants agreed that acquiring a disability in old age is a painful phenomenon as one has to adjust to a new phase of life. Hajira says that:

> I suddenly became dependent for my basic necessities. I had suffered a stroke that left my body paralyzed on one side. This phase was frustrating and I was not able to accept my own body. My husband supports me with my basic needs but how long can he support me, as he is growing old too. The experience of having an acquired disability is really painful. You are born and raised with a particular situation, and then suddenly it is entirely different. During my adulthood, I could never imagine that my old age would be marked by dependence and disability. I regret the loss of my earlier vigor and optimism.

The adjustment to this phase of life can be a disturbing experience as Prakash (2003) points that they have been "able-bodied" throughout and then acquire disabilities later on in their lives. The combination of aging along with a disability can be a double disadvantage. Also as cited in (Prakash, 2003), Genskow (1988) notes that the adjustment patterns and the nature of problems may not be same for them as compared to those who have lived with a disability and are now aging. Sabreena discusses that:

> ..It is a very painful phenomenon as one has to adjust with the new phase of life with additional liabilities. When I look at someone who is not having any disability, I feel sad about myself. Maybe we never appreciate what we have until it is no more. I wish I could be the same again.

Negotiating with an acquired disability becomes much more difficult than negotiating with a congenital disability as during old age it is considered to be an additional liability. As the age of an individual increases, age and disability can jointly combine to make disabled more disadvantaged and vulnerable (Prakash, 2003).

Another participant (Gulshan) who was having hearing impairment shared how she felt that her own family members sometimes become irritated by her "constant" questioning (when she is not able to hear the conversation clearly). She adds that

> It feels useless to be a part of our family discussions.

In response to this question, one of the participants (Gazala) had a different opinion. She shares that:

> The only thing that makes me content is the fact that I was able to live a good part of my life as a healthy person….. This is an Azmaish, (test from God) and I have to accept it.

For Muslims, *azmaish* connotes that God tests those whom he loves the most. These tests are in the form of hardships and difficulties to which Muslims must respond with patience to get rewards in the hereafter. This often becomes a defense mechanism by which people (Muslims) accept certain conditions in life. These narratives describe that it becomes very difficult for people having an acquired disability to come to terms with the reality and adjust to the new phase of life.

3. From being an asset to liability: Support from family

Disability increases the risk of getting home help (Avlund et al., 2001; Linden et al., 1997). But the emotional and practical support provided by families may prove essential in helping the individual to cope up with their disability (Murphy et al., 2007). This theme emerged when participants constantly felt that they were an asset to their families or even to their spouses because they were able to cater to their needs. As one of the participant, Faiza claimed that people who are able to help their families earn more respect than others. The other participants also echoed this statement. According to the sociocultural constructions in Kashmir, people who are aging are often left out from household work. But off lately, it has been seen as a trend in Kashmir that grandmothers cater to the needs of their grandchildren (especially to the children of son). The participants felt a sense of guilt for not being able to do so. As Sabreena, adds that "my granddaughter cuts my nails, combs my hair. I feel good that I have such a family." She felt how the roles are reversed when "you are not able to perform your activities of daily living by yourself."

Saira shares how she feels left out and unattended by her family. She says:

> My children make sure that I am treated by the best doctors and take care of my material needs. As all of them are busy in their lives, caring for an aged and disabled person like me can be a difficult task...They come, meet me, give me the medicines and then they are off to their work. I spend most of the time with our domestic helper.

"Families also require a range of support services to be able to successfully care for a disabled member" Chakravarti (2008). In Kashmir, there is no institutionalized system of geriatric care; as such the family becomes only source of providing care. Moreover, without a proper support system and "respite services," the burden of caregiving can become extensive. (Prakash, 2003). Also as discussed by Daly and Rake (2003), even if a state provides institutionalized care in any society, the family often provides the informal care. The participants shared how they felt their transition from "being an asset to a liability" within their families. The narratives discussed below describe the same. As Hajira says:

> My children used to seek advice from me at every stage of their life, but no one considers me as a capable person now, I was an asset to them but now I am a liability. I was never left out of the family discussions and decisions, but the case is different now. I am still happy that they consider their father's opinion, because he is aging well, unlike me.

In the similar line, Zeenat shared that how it was a right decision on part of her son to arrange a helper for his children. She says:

> My elder sister has three grandchildren like me. But she is able to take care of them unlike me. When I look at her, I usually feel how even in her old age she is a support for her family and everyone tends to respect her a lot. I usually have to keep on asking that what day is it today, which month it is, so it is natural for my children to behave like that ..not entrusting me with their children.

Schieman and Turner (1998) as cited in (Prakash, 2003) describe that aging encompasses losses which may result in the loss of social support. It may also imply rolelessness. Although participants agreed that their families and spouses cater to their needs, but still they felt that this transition had changed the perception of their families toward them. At the very onset, the participants noted how this change had a profound effect on their daily lives. The acquiring of a disability in old age also means that activities of daily living are affected. Older people who have difficulties in carrying out daily activities are also in a danger of losing independence (Laukkanen et al., 2000). The report of UNFPA (2017) discusses that with the declining functional abilities, the vulnerabilities of older person may increase. Furthermore, when older people are not able to do the activities of daily living (like feeding, bathing, dressing, mobility, use of the toilet and continence) by themselves, it may be indicative of the burden of care in any society. Such "burden" can have a direct impact and effect on the lives of elderly.

Conclusion

Following the line of discussion in this paper, it can be argued that "as persons without disabilities, age into middle or later life, they are at greater risk of acquiring impairments within the natural aging process such as vision loss, hearing loss, cardiovascular diseases, cognitive impairments, and muscular skeletal conditions" (Myhill & Blanck, 2009, p. 56).

However, disability along with old age marks a double jeopardy on them. A third dimension of gender, if added, can make this vulnerability turn into a triple jeopardy. When we try to explore the intersection of old age and disability, then gender can be seen as an important axis of oppression. Gender is a significant variable which influences the quality of life at all ages, particularly in old age (Prakash, 1997).

Gender, here, can be conceptualized on certain levels. One important level becomes the gendered nature of work that has been established in patriarchal societies. On this level, the participants of this study found themselves as incapable, dependent, and felt guilty for not being able to fulfill the responsibilities that were "expected" from them.

On another level, gender as an axis of oppression indicates fewer privileges in terms of finance, pension, and other benefits. Various studies have documented that the literacy level among women (who are above 60 years of age) tends to be low.

It is because majority of the elderly women are less likely to be educated, literate or having held a job, and are thus most likely to be dependent on others for their economic needs (Prakash, 1995; Verma, 2018). On this level, the participants were again vulnerable as they were dependent upon their children or spouses for financial needs. However, the case for the participants who were working and had retired was different.

One point we want to underline is that no physical abuse was reported in any case. But due to the qualitative nature of this study and a small sample size, this may not be the reality for all the women belonging to this category in Kashmir.

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Chapter 15
Some Insights on the Living Arrangements and Quality of Life of Older Women

Smita Bammidi

Abstract In India, out of the total population of general category of 1210 million, those in the 60+ and 80+ years age categories comprise of 104 and 11 million, respectively. The distribution of rural (70%) and urban (30%) elderly is 73 and 31 million, respectively. Of the estimated 104 million elderly (60 years and over), 53 million are women (51%) and 51 million are men (49%). Older women, once they reach the age 60 years have a life expectancy of 18.6 years, whereas for men it is 16.5 years; so women tend to outlive their male counterparts by at least 2 years. The proportion of elderly who are 80 years and above is 11 million, and on the rise; 6 million women fall in that specific category. Older women in 60+ and 80+ age categories have been observed to face social issues such as indifference, alienation, abandonment, abuse, neglect, mental health disorders, and compulsion to work or care for family (Census of India 2011). Within the 60+ age category, given the demographics and the patriarchal setup existing in India, women are at a far greater disadvantage than older men, and the government has to look out for them. It is therefore clear why the National Policy for the Senior Citizens 2011 that was announced in the year 2016 called for tending to the needs of the older persons that impact the quality of life, especially of the oldest–old (80+ years), the rural poor, and elderly women. Living arrangements (LAs) of older women are—they live with their spouse, adult children, relatives, and with a personal attendant or alone. It is important and possible to measure their Quality of Life and related domains within the respective living arrangements to ascertain whether they are having a good life. The current study has made this attempt with a sample of 243 elderly from both the genders in Vadodara, Gujarat. In this chapter, findings from studying the quality of life, adaptation to old age and loneliness of the sample older women ($n = 123$) across five identified living arrangements are exclusively presented and discussed. Surprisingly, the older women seemed to report experiencing a much lower quality of life, poor adaptation to old age, and higher levels of loneliness compared to older men in the sample. Women who were living with their children and relatives fared poorly on the quality of life, adaptation to old age, and level of loneliness experienced, showing that contrary to common belief, close family members failed to provide them with a safety net. Also,

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findings on relevant factors that may be studied within the context of living arrangements such as family relations, interaction with family members, social interaction, leisure time and daily leisure activities, nutrition and access to food, preferential living arrangements and life preparatory measures are presented and discussed. The need for further studies to understand why older Indian women fared so low on Quality of Life and related domains has been highlighted. The kind of social security programs that may be designed and implemented by the government to improve womens' situation in their old age are reflected upon. Recommendations are given for interventions that may be initiated by the civil society such as creating awareness about the poor quality of life experienced by older women, improving the family and intergenerational relationships by using the thrust of value education, ensuring informal supports required by the family to care for older women, and carrying out advocacy efforts to enhance their well-being.

Keywords Older people · Elderly · Population aging · Vulnerability of women · Living arrangements · Quality of life and related domains

Introduction

Graying of population is spreading rapidly with time, and across regions of the world. The population of older persons in the world was 205 million in the year 1950 that grew to 606 million in 2000 and is now projected to rise to 2 billion by 2050. In 1950, only three countries reported that their nations had more than one million elderly—they were China, India, and the USA. In 2000, two more countries, i.e., Japan and Russian federation joined the list. By 2050, 33 countries are supposedly going to join this list. The growth rate of the older population in the world at 1.9% in the year 2000 is much higher than that of its total population, which is at 1.2%. It is projected that the growth rate of older population would be 2.8% compared to 0.8% growth rate of the total population of general category in 2025–30. The distribution of older population across the regions of the world show some significant trends. In 2025, the number of older people is growing at a faster rate that that of the total population of general category in the more developed regions of the world (19.4% in 2000, 28.2% in 2025, and 33.5% by 2050), but the pace is observed to be faster in the developing regions of the world (7.7 in 2000, 12.6 in 2025, and 19.3% by 2050). In the least developed regions of the world, it is interesting to find that graying of its population is not projected to begin untill 2050 and even by then, older persons will still constitute a 10% of the total general population (United Nations, 2002). Hence, the global pace of aging is marked by characteristics such as tripling in number of older persons over the last 50 years in developed and developing regions, growth rate of the older population being far greater than that of the total population of general category in countries almost all over the world, and their concentration being found in developing regions of the world (Chakraborti, 2004, 33–41).

The rise in the number of elderly as a proportion of the total population as discussed in the preceding paragraph and certain other unique demographic trends observed among the older population constitute the phenomenon of "population aging" that needs mention to bring focus on the magnitude of aging issues. Due to technological and medical innovations, more people are living up to and beyond 60 and 80 years, and the numbers of 60 and 80+ years old persons as a proportion of the total population are higher (Alam, 2006, 30). Similarly, at birth, at age 60 and at age 80, the number of years the infant/elderly may live (life expectancy at birth and at the respective ages of 60+ and 80+) has also increased. As men are exposed to more hazardous life style, stress, and occupations than women, they are more prone to die before reaching the age 60 or 80 years. Hence, in the 60 and 80+ age categories, women whose life expectancy at birth and at the ages of 60 and 80 is higher constitute a higher percent than their male counterparts. In the Asian countries, men marry women who are much younger than them. This coupled with the higher life expectancy among women leads to a greater number of women who are widows, both in the 60+ and 80+ age category, among the married older persons. In developing countries, the family structure has been transformed from joint and extended to the nuclear type (Chakraborti, 2004, 52–63).

Elderly Women as a Vulnerable Group

In India, in terms of literacy rates, work participation, health care, property rights, political participation, other rights, etc., women still lag behind men. The demographic trends specific to older women are that they are more in number than men both in the 60+ and 80+ age groups, they have a higher life expectancy than their male counterparts at birth and in late adulthood, they may most likely be widowed, separated, or deserted, have higher disability rates, and coming to their living arrangements, and they may be living alone or with the kin in the family. Given the patriarchal system that leads to inequity in gender socialization and gives girls and women a secondary status, it has varied implications and a bleak predicament for older women's quality of life, adaptation to old age and loneliness, in a developing country like India. This research area needs an urgent focus, a discussion with relevant findings, and there are indications for further research.

Although social security for the elderly covers a gamut of needs, it is clearly enmeshed in notions of the family where women are dependent on male family members who are the breadwinners. Women may involve in unpaid work at home throughout their life and well into old age, but this is not recognized. Many of the elderly women who have been in productive labor in the unorganized sectors or those who are self-employed hardly have any protections or privileges. As unorganized labor, elderly women do receive social security benefits but as destitute, and this is outside the ambit of the family (Neetha, 2006, 3497–3499). Hence, due to this discrimination, the elderly women fare poorly than their male counterparts even in the family, in terms of receiving supports. As a result, elderly women become

dependent on other family members, and they are vulnerable to abuse and neglect. Further, the review of state and national initiatives for providing social security to the elderly women points to this serious lack of will to address the concerns of a silent yet vulnerable section (Arber & Ginn, 1995, 2–3).

Due to the above specific demographic and social scenario, elderly women are more vulnerable to face marginalization, experience loneliness, neglect and abuse, and face financial constraints, and this adversely affects their well-being (Wolf, 1994, 165–168). It forms the background for long-term efforts being urged in to change attitudes and behaviors of the family members, to step up government initiatives for provision of assistance and safety net to women in their later life, apart from advocating against unequal gender socialization and patriarchal systems.

Research Design

The data being analyzed in the current chapter were reported as part of a research study that was conducted during 2010–12 in Vadodara (Urban) Municipal Corporation (VMC) limits. As part of the quantitative approach, a household survey of 243 sample elderly respondents comprising of 123 women was conducted using an interview schedule, and for qualitative approach, the case study and observation methods were used. The schedule comprised questions covering socio-demographic and family details, work and economic background, financial security, living arrangements, family relations, interaction with family members, social interaction, nutrition and access to food, leisure time and daily routine activities, preferential living arrangements, and life preparatory measures.

Operational Definitions

Older person. One who has attained the age of 60 years or above at least 6 months prior to the date of the study.

Living arrangements. Living arrangements in relation to older population refer to two aspects, i.e., the type of residence, whether institutional or private dwelling, and the household composition, which comprises the presence or absence of others and the kin relationship among the coresiding individuals. Keeping this in view, the definition given by Rajan and Kumar (2003, 75–80) was considered for the study. According to them, living arrangement is the type of household/family setting in which the elderly live, the headship they enjoy, the place they stay in and the people they stay with, the kind of relationship they maintain with their kith and kin, and on the whole, the extent to which they adjust to the changing environment (Fig. 15.1).

After careful reading of the literature, the following scheme of classification of the types of living arrangements of the elderly was identified to be adapted for the

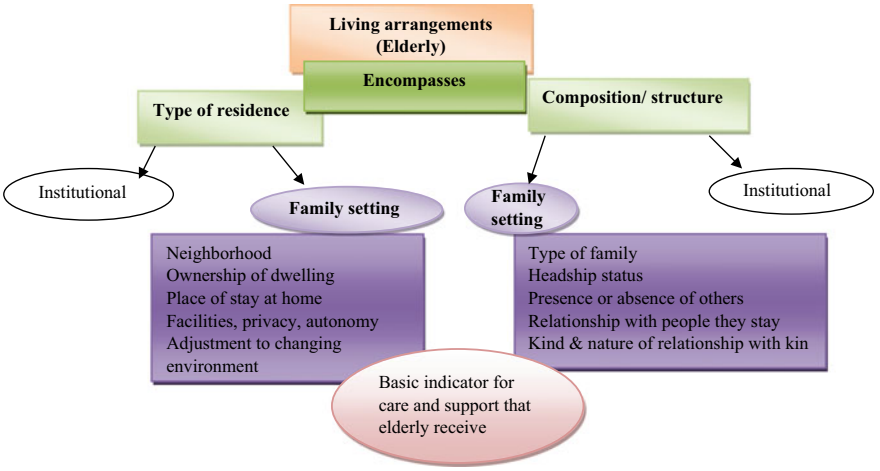

Fig. 15.1 Meaning and scope of the living arrangements of the elderly

study. This classification was suggested by Shanas et al. (1968, 227) and modified by Palmore (1975, 148).

1. *Coresidence with children*: The household comprised the elderly person or couple who are living along with son(s) or daughter(s) (married or unmarried).
2. *Living with spouse only*: The household comprised the elderly married couple.
3. *Living alone*: The household comprised the elderly person who is staying alone.
4. *Living with relatives*: The household comprised the elderly person living along with siblings/grandchild(ren) or other relatives of the family (paternal/maternal).
5. *Living with assistance*: The household comprises the elderly person living with the assistance of a full-time hired person who takes care of household maintenance, physical support, nutrition, health needs, and personal care of the elderly person.

Current living arrangement. The living arrangement in which the elderly person has been living for **2** or more years.

Interaction with family members. Refers to the information about the respondents' relationship with the hardest person to get along with in the family.

Social interaction. Refers to the purpose/place and the frequency of visits of the elderly to the neighborhood and farther, and their engagement with friends, visitors, and community voluntary work.

Nutrition and access to food. The food habits and routine for food intake of the elderly based on the presence or the absence of arrangements in the family for ensuring nutrition are made available to them.

Leisure time and daily routine activities. Leisure is discretionary time, or time when a person is free to do as he chooses. Leisure is unobligated time—free from prior commitments to physiological or social needs (Williams, 1961, 926–927). However, daily routine includes all the activities that are carried out by the elderly person on any typical day from morning to evening till they go to bed, to maintain the household and their life.

Life preparatory measures. The changes in habits, routine, decisions, and resolutions taken and followed by the older persons after they attained the age of 60+ years in order to maintain a healthy life in the old age.

Measures Used in the Study

Measures like WHOQOL-BREF questionnaire, Index of Independence in Activities of Daily Living, University of California and Los Angeles Loneliness scale (Version 3), and Adaptation to Old age Questionnaire were incorporated into the interview schedule to collect information about the key variables of the study. Both fixed-end and open-ended questions were used.

a. **Quality of life**. It is the subjective rating of personal well-being and life satisfaction of the elderly in relation to specific domains such as physical health, social relationships, psychological well-being, and environment. A WHOQOL-BREF questionnaire has been used to measure this dimension (WHOQOL Group, 1998, 551–558).
b. **Loneliness**. It is a feeling expressed by a person defining his or her form or level of relationships with others as inadequate (Russell, 1996, 20–40). Such feeling is an expression about the presence of relative deprivation, looking at one's own lifestyle, situation, or relationships as socially and emotionally inadequate in comparison with the past or in anticipated future, or in comparison with other people who are assumed to be satisfactorily engaged. The Version 3 of University of California and Los Angeles (UCLA) Loneliness Scale is used to ascertain this state of feeling.
c. **Adaptation to old age**. Adaptation to old age refers to the evaluation of the older person's adjustment to life along the subdomains of health comparison, self-control, self-efficacy, and generativity. The adaptation to old age questionnaire is used to measure this (Efklides et al., 2003, 178–191).
d. **Activities of daily living**. Refer to a set of common, everyday tasks, which are required for personal self-management, maintenance, and independent living such as bathing, eating, dressing, toileting, and transferring (Chadha et al., 2006, 135–158). Katz Independence in activities of daily livingi is used to measure the level of functioning of the respondent elderly (Katz et al., 1970, 20–30).

Sampling Procedure

Data were collected from a sample of 243 respondents who are 60 years and over, selected from the 13 wards, which was arrived at using a multistage probability sampling in Vadodara City. The map of the Vadodara City with the 13 wards already outlined was divided into 26 equal-sized grids and then serially numbered. Out of the 26 grids, only 22 grids covered residential areas. Further, in the 26 areas which have been identified falling in the 22 grids covering the 13 wards, older persons living in the family context were enumerated using the preliminary data sheet. In this manner, a list with a total of 640 elderly was enumerated from all the 26 areas. Next, keeping the constraints of time and human power in view, it was decided to select randomly around 40% of the older persons from the list thus generated. Thus, the researcher arrived at a sample of 250 respondents. While finalizing the filled interview schedules, seven schedules were found to be incomplete and were discarded thus making 243 persons as the final sample for study. The sample turned out to be purposive in view of the mobility and non-availability of some of the respondents when approached during data collection.

Framework of Analysis

Living arrangements have been established as the single most important entry point (variable) through which to assess the various indicators to understand an older person's well-being in a community setting. Data of the older women are analyzed to reveal their basic profile, how they had scored on their quality of life, and adaptation to old age and loneliness in correlation with the type of the living arrangement in which they experienced these. An attempt is then made to understand the factors in their current living arrangement such as nature of family relations, interaction with family members, social interaction that they experienced, their nutrition and access to food, leisure time and daily routine activities, preferential living arrangements, and life preparatory measures that may have in some way influenced their quality of life and related domains.

Results

The data analysis of information that was collected during the study pertaining to the profile of older women, their living arrangements and its correlation with their QoL and related domains, and factors that may influence their QoL and related domains revealed various findings that are showcased in this section of the chapter.

Profile of the Respondents

Age: The mean ages of the elderly men and women were 70.32 (SD = 7.08) and 68.11 (SD = 6.8), and median ages were 69.5 and 66 years, respectively, indicating that women were younger compared to the elderly men in the sample. More than half of the sample (52%) was in the age range of 65–74 years, with a slightly higher percent of elderly men (55%) as compared to elderly women (50%) in that age category. In the 60–64 years age category, women were represented in higher number (32%) as compared to men.

Education: More elderly women (32%) compared to that of elderly men (7%) were found to be illiterate. Similarly, the representation of elderly women with primary and college level education (23 and 28%, respectively) was more, compared to those with similar education levels among elderly men (22 and 25%, respectively). At technical and professional levels, elderly men were more as compared to women respondents (Table 15.1).

Marital status: As can be seen, of the total married respondents who were in the majority (70%), a higher percent were men (83%) compared to that of women (57%), whereas, among the widowed elderly, women (35%) were more in number compared to that of men (11%). With the exception of the remarried, a slightly higher percent of the elderly women were seen in both unmarried and separated categories (3.3% each) compared to that of men.

Head of the household: Among the 66% of the elderly who said that they were heads of the households, men were more (94%) as compared to women (40%). Added to this, another 50% ($n = 61$) of the elderly women said that their husbands were the heads of the households. According to data, while elderly men reported as being heads of households irrespective of their work status, in the case of women, they heading the household were found to be less frequent if they were a homemaker or have retired.

Current income p.m.: It refers to income earned by the respondent. It was found that of the 55 respondents who reported current income, elderly women were less in number, and they fell within the lower-income ranges of Rs. 5000 and below and Rs. 5001 to Rs. 10,000. While most of these women reported their spouse or son, and a few reported self as head of the household, it was mostly the elderly men from across the current income p.m. groups who were found to be heading the household.

Family Background

With regard to the *type of family* that the sample elderly belonged to, it can be seen that around 70% of the sample elderly reported belonging to nuclear (36%) and joint families (34%), and more elderly men were in these two types of family settings

Table 15.1 Socio-demographic profile of the sample elderly

Characteristic	Sex of respondent		Total (N = 243)
	Male (n = 120)	Female (n = 123)	
Age			
60–64 years	24 (20)	39 (31.7)	63 (25.9)
65–74 years	66 (55)	61 (49.6)	127 (52.3)
75–84 years	25 (20.8)	19 (15.4)	44 (18.1)
85 years+	5 (4.2)	4 (3.3)	9 (3.7)
Education			
Illiterate	9 (7.5)	39 (31.7)	48 (19.8)
Primary	26 (21.7)	28 (22.8)	54 (22.2)
High school	17 (14.2)	14 (11.4)	31 (12.8)
College	30 (25)	34 (27.6)	64 (26.3)
Technical	19 (15.8)	–	19 (7.8)
Professional	19 (15.8)	8 (6.5)	27(11.1)
Marital status			
Married	99 (82.5)	70 (56.9)	169 (69.5)
Widowed	13 (10.8)	43 (35)	56 (23)
Separated	1 (0.8)	4 (3.3)	5 (2.1)
Unmarried	2 (1.7)	4 (3.3)	6 (2.5)
Remarried	5 (4.2)	2 (1.6)	7 (2.9)
Head of the household			
Self	113 (94.2)	48 (39)	161 (66.3)
Spouse	4 (3.3)	61 (49.6)	65 (26.7)
Son	2 (1. 7)	9 (7.3)	11 (4.5)
Other (sibling, son-in-law)	1 (0.8)	5 (4.1)	6 (2.5)
Total	120	123	243

as compared to women. However, a higher percent of elderly women were living in extended family settings (37%) as compared to men (13%). Around 5% of the respondents reported as staying alone (see Table 15.2).

The *family income (p.m.)* comprised the combined income of all the earning members in the family including that of the respondent. More than 75% of the elderly fell in the income ranges from Rs. 5000 and below to Rs. 20,100–Rs. 40,000, with around 40% of the sample falling in the income range of Rs. 5000 to Rs. 10,000. It appeared from the data that among the sample elderly, more women belonged to families with comparatively lower incomes. However, a few elderly women were from families with higher family incomes. Compared to women (20%), more men (29%) reported a family income in the range of Rs. 40,100 to Rs. 100,001 and above per month.

Table 15.2 Summary of family background characteristics of the sample elderly

Characteristic	Sex of the respondent		Total ($N = 243$)
	Male ($n = 120$)	Female ($n = 123$)	
Type of family			
Nuclear	50 (41.7)	37 (30.1)	87 (35.8)
Joint	49 (40.8)	34 (27.6)	83 (34.2)
Extended	16 (13.3)	45 (36.6)	61 (25.1)
Staying alone	5 (4.2)	7 (5.7)	12 (4.9)
Family income (p.m.)			
Rs.5000 and below	20 (16.7)	28 (22.8)	48 (19.8)
Rs.5100–10,000	27 (22.5)	22 (17.9)	49 (20.2)
Rs.10100–20,000	19 (15.8)	28 (22.8)	47 (19.3)
Rs.20100–40,000	19 (15.8)	20 (16.3)	39 (16.1)
Rs.40100–60,000	10 (8.3)	10 (8.1)	20 (8.2)
Rs.60100–80,000	8 (6.7)	5 (4.1)	13 (5.3)
Rs.80100–100,000	7 (5.8)	4 (3.3)	11 (4.5)
Rs.100,001 and above	10 (8.4)	6 (4.9)	16 (6.6)
Total	120	123	243

Work and Economic Background

Almost 66% of the total respondents (120 men and 40 women) reported that they were in paid employment before they attained 60 years of age. Out of a majority of the men who reported *previous work status* as salaried job (60%), 47% reported to have retired. However, it seems that the homemakers and those who worked as domestic help in their previous work status, who were exclusively women, continued to function in the same capacity and retirement did not appear to apply to them as in the case of men. Of them, only 34% (37 men and 18 women) reported as in paid employment at the time of the interview as seen in Table 15.3.

Of the 160 sample elderly who reported *previous income p.m.* (being in paid work before attaining 60 years of age), only 25% were women. A majority (76%) of these women reported lower earnings per month of Rs. 5000 and below. Compared to them, 7.6% elderly men reported an income in that range. Also, more men were represented across the income categories.

Pension details: Of the total sample elderly, only 27% ($n = 65$) said they were receiving a monthly pension of some kind, with men outnumbering women (34% men as against 23% women). Out of the 72 elderly men who have previously worked in a salaried job, 57 men retired (see Table 15.3) of whom 41 reported receiving a job pension (see Table 15.4). Of the 14 elderly women who worked previously in a salaried job, ten retired (see Table 15.3), of whom nine reported receiving a job pension (see Table 15.4). Fifteen elderly women reported receiving their deceased

Table 15.3 Sexwise distribution of the sample elderly by their current work status

Current work status	Sex of the respondent		Total (N = 243)
	Male (n = 120)	Female (n = 123)	
Not working	26 (21.7)	12 (9.8)	38 (15.6)
Homemaker	–	83 (67.5)	83 (34.2)
Daily wage labor	4 (3.3)	1 (0.8)	5 (2.1)
Salaried	4 (3.3)	–	4 (1.6)
Professional	2 (1.7)	2 (1.6)	4 (1.6)
Business	20 (16.7)	4 (3.3)	24 (9.9)
Retired	57 (46.7)	10 (8.1)	67 (27.6)
Domestic Help	–	8 (6.5)	8 (3.3)
Other[a]	7 (5.8)	3 (2.4)	10 (4.1)

[a]Includes cattle tending, tuitions, paper agent, free-lance, honorary member, volunteer work, and part-time work

Table 15.4 Sex-wise distribution of the sample elderly by the job pension (p.m.) received by them

Job pension (p.m.)	Sex of respondent		Total (n = 65)
	Male (n = 41)	Female (n = 24)	
Rs. 2000 and below	13 (31.7)	2 (8.3)	15 (23.1)
Rs. 2100–5000	6 (14.6)	9 (37.5)	15 (23.1)
Rs. 5100–8000	6 (14.6)	4 (16.7)	10 (15.4)
Rs. 8100–11,000	7 (17.1)	4 (16.7)	11 (16.9)
Rs. 11,100–14,000	4 (9.8)	2 (8.3)	6 (9.2)
Rs. 14,100 and above	5 (12.2)	3 (12.5)	8 (12.3)

Note In the case of women, 15 of them received their deceased husbands' job pension

husbands' pension and another four received a government old age pension (see Table 15.4). As can be seen from Table 15.4, of the 65 respondents, all the 41 men and only nine women reported receiving their job pension.

Possession of assets: Almost 75% of the sample, comprising 43% men and 32% women reported possessing some type of asset on their name. Though 181 respondents reported possessing assets, only 87 of them reported earning an income, and the remaining (n = 94) did not earn any income on the asset(s). With regard to the type of assets being reported, a majority of men (73%) and women (47%) were having savings, and 70% men and 38% women had house(s).

Respondents' income (p.m.): It refers to their exclusive earnings constituting income from work, pension, and assets. Out of the total sample, 61% respondents (n = 149) reported monthly income under this head (more men compared to women). The

Table 15.5 Sex-wise distribution of the sample elderly by the respondents' income (p.m.)

Respondents' income (p.m.)	Sex of the respondent		Total ($n = 149$)
	Male ($n = 82$)	Female ($n = 67$)	
Rs. 2000 and below	–	25 (37.4)	25 (16.8)
Rs. 2100–10,000	33 (40.2)	26 (38.8)	59 (39.7)
Rs. 10,100–20,000	26 (31.7)	14 (20.8)	40 (26.8)
Rs. 20,100–40,000	12 (14.6)	1 (1.5)	13 (8.8)
Rs. 40,100–60,000	2 (2.5)	–	2 (1.3)
Rs. 60,100–80,000	5 (6.0)	1 (1.5)	6 (4)
Rs. 80,100–100,000	2 (2.5)	–	2 (1.3)
Rs. 100,100 and above	2 (2.5)	–	2 (1.3)

remaining elderly were completely dependent on their children, relatives, or others. Except for the income category of Rs. 2000 and below, men were represented in all other income ranges. A majority of the women reported an income that fell in the ranges of Rs. 2000 and below to Rs. 10,100–20,000 (see Table 15.5).

Present income sources: An equal percent (58%) of elderly men and women responded that the children they stayed with were the source of their income. Around 62% elderly men and 41% women told that their past savings and their spouse's past savings, respectively, were the sources of their income. A substantial number of elderly men (36 and 31%) reported job pension and income from their employment as sources of livelihood compared to women (9 and 15%). Interestingly, more women (34%) compared to men (3.3%) reported their source of income as the job pension of their spouses. It was clear from the data that more men (62%) than women (27%) had past savings to rely upon during old age. This is because women's employment was less during the earlier times.

Ownership of the dwelling: Out of the 243 elderly, only 19 lived in rented dwellings. The remaining though not living in rented dwellings, the nature of ownership differed. Of the nearly 34% of the sample who reported staying in their own house, only 17% were women as against 50% men. Of the nearly 22 and 8% of the elderly who lived in a house owned by spouse and their child(ren), respectively, there were more women than men.

Living Arrangements of the Sample Elderly Women and Their Quality of Life

It is seen that a majority of the elderly men and women live in parent–child coresidence, followed by living with spouse. Compared to men, more elderly women reported as living alone and with relatives (see Table 15.6; Fig. 15.2).

Table 15.6 Sex-wise distribution of the sample elderly by the type of living arrangements

Characteristic	*N*	Type of living arrangement				
		Parent–child coresidence ($n = 156$)	Living alone ($n = 9$)	Living with spouse only ($n = 57$)	Living with relatives ($n = 18$)	Living with assistance ($n = 3$)
Sex						
Male	120	78 (65)	3 (2.5)	31 (25.8)	6 (5)	2 (1.7)
Female	123	78 (63.4)	6 (4.9)	26 (21.1)	12 (9.8)	1 (0.8)

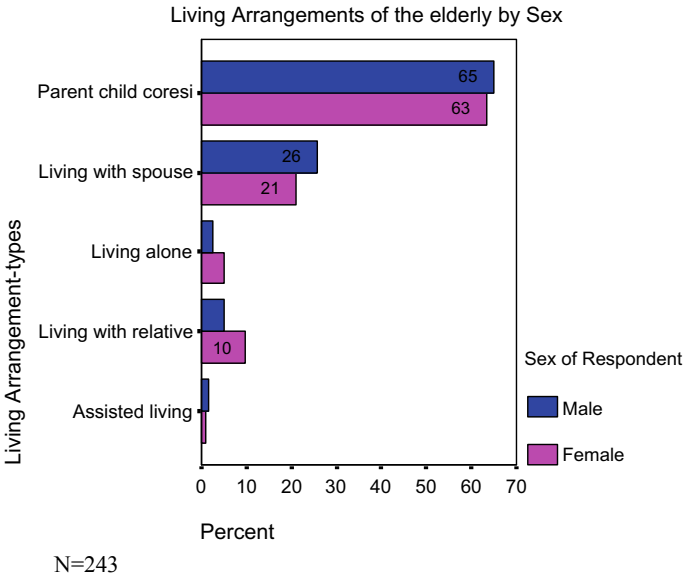

Fig. 15.2 Sex-wise distribution of the sample elderly by type of living arrangements

The next question was whether the means of age and mean scores and SDs of quality of life and its related measures differed because of the sex of the respondents.

In Table 15.7, an attempt was made to test whether the differences in the means of age and in the means of scores of quality of life and its related variables for the elderly men and women were statistically significant. Elderly women were younger (68.1 years) than men (70.3 years), and women exhibited consistently lower scores on the quality of life domains with the exception of psychological well-being. Further, they reported experiencing higher levels of loneliness and a lower adaptation to old age as compared to men. These differences of mean scores for these variables by sex were found to be statistically significant on a *t*-test, except for psychological well-being.

Table 15.7 Significance of the difference between the means of age, means, and SDs of scores of quality of life domains and its related variables of the sample elderly by sex

Characteristic	Sex	Mean	SD	*t*-value (d*f* = 241)	Sig. Two-tailed
Age	Male	70.32	7.08	2.46	0.01
	Female	68.11	6.8		
Quality of life					
Physical health	Male	14.84	3.04	3.04	0.00
	Female	13.66	3.02		
Psychological well-being	Male	15.80	2.59	1.35	0.17
	Female	15.33	2.74		
Social relationships	Male	13.90	3.30	2.05	0.05
	Female	13.02	3.36		
Environment	Male	16.51	2.49	2.00	0.05
	Female	15.81	2.91		
Loneliness	Male	43.88	8.94	−2.26	0.02
	Female	46.59	9.66		
Adaptation to old age	Male	63.47	9.58	3.15	0.00
	Female	59.45	10.28		

$N = 243$ (Female(n)= 123; Male(n) = 120)

It was found above that the well-being of the sample elderly varied greatly by sex (see Table 15.7), where women consistently fared poor than men on the three measures used. Hence, a further analysis was done by taking a sex-wise distribution of the sample elderly in each type of the living arrangement, to see whether there were any variations observed in the three measures used by sex and type of living arrangements. The information is given in the following pages (Tables 15.8, 15.9, and 15.10).

First, the means of scores on the four domains of quality of life distributed by sex and living arrangements of the sample elderly were examined in Table 15.8. On the whole, in all types of living arrangements for the four qualities of life domains, men fared better than women, with a few exceptions. That is, women living with spouse reported better psychological well-being, better social relationships, and environment than men in the same type of living arrangement.

The means of scores of loneliness of the sample elderly who were distributed according to their sex and type of living arrangement were looked at in Table 15.9, to see whether levels of loneliness reported by men or women varied with the type of living arrangements they were in. While women in the sample were lonelier (mean = 46.59, SD = 9.6) than men (mean = 43.88, SD = 8.9), even in the different types of living arrangements they continued to report being lonelier. Moreover, the experience of loneliness was greater among women when they were living alone, followed by living with relatives and in parent–child coresidence, in that order.

Table 15.8 Means and SDs of scores of the quality of life domains by sex and type of living arrangements of the sample elderly

Living arrangement	Sex	*n*	Quality of life							
			Physical health		Psychological well-being		Social relationships		Environment	
			Mean	SD	Mean	SD	Mean	SD	Mean	SD
Parent–child coresidence	Male	78	14.51	3.06	15.68	2.79	13.66	3.30	16.31	2.52
	Female	78	13.32	2.96	15.15	2.85	12.68	3.12	15.47	2.85
	Total	156	13.91	3.06	15.41	2.82	13.17	3.24	15.89	2.72
Living with spouse	Male	31	15.41	3.26	16.06	2.44	14.45	3.48	16.74	2.63
	Female	26	15.12	2.70	16.33	2.14	15.23	2.90	17.33	2.55
	Total	57	15.28	2.99	16.19	2.29	14.81	3.22	17.01	2.59
Living alone	Male	3	16.57	0.57	17.33	1.15	15.11	2.04	17.83	0.76
	Female	6	11.43	1.62	13.67	1.62	11.11	3.12	16.08	3.73
	Total	9	13.14	2.89	14.89	2.31	12.44	3.33	16.67	3.10
Living with relatives	Male	6	15.71	2.36	15.78	1.17	13.56	3.52	16.50	2.19
	Female	12	14.14	3.56	15.11	3.29	11.67	4.07	14.54	2.86
	Total	18	14.67	3.23	15.33	2.74	12.30	3.90	15.19	2.76
Living with assistance	Male	2	14.29	0.81	14.00	0.00	14.00	2.83	18.50	0.00
	Female	1	10.29	0.00	16.67	0.00	9.33	0.00	16.50	0.00
	Total	3	12.95	2.38	14.89	1.54	12.44	3.36	17.83	1.15
Total (N=243)	Male	120	14.85	3.05	15.80	2.60	13.90	3.31	16.51	2.50
	Female	123	13.66	3.03	15.33	2.75	13.02	3.37	15.81	2.92
	Total	243	14.25	3.09	15.56	2.68	13.45	3.36	16.15	2.73

Table 15.9 Means and SDs of scores of loneliness by sex and types of living arrangements of the sample elderly

Living arrangement	Sex of respondent								
	Male			Female			Total		
	n	Mean	SD	*n*	Mean	SD	*n*	Mean	SD
Parent–child coresidence	78	42.8	8.6	78	46.1	9.2	156	44.5	9.0
Living with spouse	31	45.0	10.1	26	45.1	9.4	57	45.0	9.7
Living alone	3	50.3	7.0	6	53.3	8.7	9	52.3	7.9
Living with relatives	6	46.6	5.7	12	49.5	12.6	18	48.5	10.7
Living with assistance	2	48.0	8.4	1	41.0	0.0	3	45.6	7.2
Total (N=243)	120	43.8	8.9	123	46.5	9.6	243	45.2	9.4

Table 15.10 Means and SDs of scores of adaptation to old age of the respondents by sex and type of living arrangement of the sample elderly

Type of living arrangement	Mean	Sex of respondent		Total
		Male	Female	
Parent–child coresidence	Mean	63.29	59.45	61.37
	SD	9.44	9.21	9.49
	n	78	78	156
Living with spouse	Mean	63.19	64.58	63.82
	SD	10.00	9.67	9.79
	n	31	26	57
Living alone	Mean	61.67	47.67	52.33
	SD	15.50	9.81	13.01
	n	3	6	9
Living with relatives	Mean	64.5	54.5	57.83
	SD	8.04	12.58	12.04
	n	6	12	18
Living with assistance	Mean	74.5	57	68.67
	SD	0.71	0.00	10.12
	n	2	1	3
Total	Mean	63.48	59.46	61.44
	SD	9.59	10.28	10.13
	N	120	123	243

Similarly, as mentioned earlier, in terms of adaptation to old age, overall, the elderly men expressed better levels of adaptation to old age than women. Now, the data were analyzed further to find out how the living arrangements by sex of the respondents made a difference. The results are shown in Table 15.10.

As can be seen, elderly women living with spouse showed better adaptation to old age (mean = 64.58, SD = 9.6) followed by those who were staying in parent–child coresidence (mean = 59.45, SD = 9.2) than those living in other living arrangements.

Factors that May Influence the QoL and Related Domains of Older Women in LAs

Living Environment

Majority of the sample (31%) lived in a two bed rooms, living hall, and kitchen type of house followed by 16% in 1BHK houses. Among the elderly living in one roomed houses, there were more elderly women (15%) than men (10%). Coming to the space

they slept in during the night, differences between men and women could be seen. Less number of women mentioned sleeping in a room of their own and more women slept in their living room, compared to men. Sleeping in the verandah, which is a space outside the house, was also reported by more women as compared to men.

Relations with Family Members

Of the 243 sample elderly, about half of them (comprising 58 men and 63 women) reported a family member as the hardest person to get along within their life, who might or might not be living with them at the time of the study. Son emerged as the hardest person in the case of both men (41%) and women (32%). Daughter-in-law (20%) was the person hardest to live with for women (25%) than men (14%). In the case of a few elderly women, the daughter or son-in-law did emerge as the hardest persons to live with. Out of the 121 elderly who mentioned having a person hardest to get along with in their life, 86 reported that the hardest person caused arguments and tensions. According to the data, a majority ($n = 60$) comprising 73% men and 67% women reported that arguments and tensions with the hardest person occurred as frequently as about 10 times in a year. In the case of 23% of the elderly (mostly women), such situations had occurred almost daily. Out of the total sample elderly, about 6.5% (12 women and four men) reported abuse and neglect by family members in their current living arrangement.

Intake and the Access to Food

An analysis of the 143 elderly who reported skipping meals in a day showed that in all types of living arrangements, a higher percent of women compared to men skipped meals in a day. A considerable percentage of the elderly women who lived with relatives and in parent–child coresidence reported that they skipped meals in a day. Of those who reported ($n = 143$) skipping meals in a day, more than half (57%) of the elderly cited *Upavas* (fasting) for religious purpose as the reason. Around 23% of the elderly stated health consciousness as the reason. A smaller percentage of the elderly gave the reasons such as not having the practice of eating breakfast, cannot afford, and none at home to prepare food. As can be seen from data, throughout the reasons given, women were slightly more in number compared to men.

Social Interaction

The sample elderly went out to a variety of places with different purposes in mind. A majority (73%) of them reported that they went out for attending social functions, grocery purchases (68%), to visit relatives (67%), and to the places of worship (62%). Some went out to interact with people, pass the time, for walks, on errands, to shop, or to attend events in the city. For almost all the places/purposes that the elderly

went out to, especially for going for a stroll, to run errands, hanging out in a place in the neighborhood, and going to the park, the elderly men were relatively higher in number. Those who were unable to go out because of their inability to move were also included here for comparison. About a half and another quarter of the elderly sample reported going out daily and a few times in a week, respectively. The percentage of the elderly who went out less frequently was small. In all the frequencies of going out mentioned (except for going out daily), a higher percent were women compared to men. A small (4%) number of the elderly (comprising more women than men) were unable to move and hence did not go out. It is seen that more than half of the sample elderly ($n = 128$) consisting of 59% men and 46% women reported having friends. Among those who did not have friends, women outnumbered men. Overall, the number of friends the sample elderly had ranged between 1 and a maximum of 20. A higher percent of the elderly (more women than men) had one or two friends. Further, it was assessed whether having or not having friends had any influence on the quality of life domains and its related variables for the sample elderly (see Table 15.11).

It is seen clearly from Table 15.11 that the elderly who reported having friends had higher mean scores on the four domains of quality of life, lower mean scores for loneliness, and higher mean scores for adaptation to old age and its four subdomains—than those who reported less number of friends or visitors. This difference of mean scores on the abovementioned variables for those who had comparatively more and less friends and visitors was found to be significant on a *t*-test.

Engagement with Leisure Activities

Out of the 243 samples elderly, 228 reported that they were engaged in indoor activities during leisure time. Of these 228 elderly, more men (51%) compared to women (49%) pursued these activities. They gave multiple responses for their engagement in the kind of leisure activities. These are given in Table 27 in the descending order of their percentage. The top three activities mentioned were praying/performing religious rites (85%), followed by watching television/video (57%) (more women than men in both cases), and reading books/newspapers/magazines. However, more men (53%) reported reading as an indoor leisure activity. Out of the 243 samples elderly, 48% ($n = 116$) stated that they were engaged in outdoor leisure time activities. It may be noted that the sample elderly who were engaged in outdoor activities were lesser compared to the number of elderly who were engaged in indoor activities ($n = 228$) during their leisure time. Of the 116 elderly who engaged themselves in outdoor activities during their leisure, 60% were men and 40% were women. A majority (60%) of the elderly (more men compared to women) followed by more than half of the elderly (55%) (more women compared to men) mentioned that they went for walk/exercise, and to a place of worship, respectively. Sex differentials in the nature of outdoor activities taken up during leisure time were observed. More elderly men compared to women were represented as being engaged in outdoor leisure time activities like going for walk/exercise (69%), going to the park (29%), going to a club

Table 15.11 Means and SDs of scores on the measures used for the sample elderly by their having or not having friends

Measures	Have any friends?	*N*	Mean	SD	*t*-value (d*f* = 241)	Sig. 2-tailed
Quality of life						
Physical health	Yes	128	15.22	2.80	5.47	0.000
	No	115	13.17	3.05		
Psychological well-being	Yes	128	16.29	2.31	4.61	0.000
	No	115	14.76	2.84		
Social relationships	Yes	128	15.08	2.77	9.27	0.000
	No	115	11.64	3.02		
Environment	Yes	128	16.98	2.29	5.26	0.000
	No	115	15.23	2.90		
Loneliness	Yes	128	42.19	8.34	– 5.7	0.000
	No	115	48.67	9.37		
Adaptation to old age	Yes	128	65.55	8.74	7.3	0.000
	No	115	56.86	9.61		
Health comparison	Yes	128	17.01	2.33	7.04	0.000
	No	115	14.73	2.71		
General adaptation	Yes	128	17.47	2.62	3.39	0.001
	No	115	16.19	3.23		
Self-control	Yes	128	14.65	3.70	7.1	0.000
	No	115	11.46	3.25		
Generativity	Yes	128	16.43	2.74	4.7	0.000
	No	115	14.48	3.70		

$N = 243$

(10%), and involving in social service/politics (10%), while more women compared to men were represented as being engaged in outdoor leisure time activities which were more expressive such as going to a place of worship (65%), visiting friends and relatives (15%), going to picnic/tours (9%), and going to the movies (2%).

Levels of Functioning and Independence

The mean score of the elderly on the Independence in activities of daily living index (IADL) indicated their functional status in performing activities like bathing, dressing, toileting, transferring, continence, and feeding. On the whole, for the total sample, elderly women (mean = 5.95, SD = 0.402) reported better level of functioning when compared to men (mean = 5.88, SD = 0.568). The mean scores on independent activities of daily living for the elderly in 60–64 years (mean = 5.98,

Table 15.12 Distribution of the sample elderly by association between some variables and measures taken by them after 60 years of age to keep healthy

Characteristics	*n*	Took measures to keep healthy after 60 years	X^2	$p <$ (two sided)
		%[a]		
Sex				
Male	120	69.2		
Female	123	47.2	(1, 12.08)	0.001

SD = 0.12) and 65–74 years (mean = 5.95, SD = 0.39) age range indicated their better levels of functioning and independence, and this seemed to decrease with the increasing age of the sample.

The next aspect examined was the activities of daily routine of the sample elderly. By asking the elderly respondent to describe what they did during the day, their actual routine comprising the three time periods of the day, i.e., before noon, before dark, and before going to bed was captured. The results are presented in the respective tables, in the descending order of the percent responses for the activities reported. The kind of daily routine activities they did seemed to vary by sex. Similarly, certain activities through the three time periods were common for the elderly respondents. Except in performing activities such as morning ablutions, prayer, attending to household chores, preparation of lunch and watching TV, etc., in the rest of the daily routine activities from waking up till noon, the men were represented more than the women. Also, the elderly women were represented more than men in the two daily routine activities which were more confined to the home and specific to gender such as attending to household chores (89% women as against 29% men) and preparation of lunch (80% women as against 7% men).

Life Preparatory Measures

Out of the 243 respondents, about 59% ($n = 143$) reported that they started taking certain measures after attaining 60 years of age, to keep themselves healthy. There were more men (69%) than women (47%), and the differentials were statistically significant ($\chi^2 = 1, 12.08$; $p < 0.001$) (see Table 15.12).

Discussion

Who Were These Older Women?

The 123 samples older women mostly fell in the age ranges of 65–74 followed by 60–64 years, and their mean age at 68.11 (SD = 6.8) was lower than that of the older men which was 70.32 (SD = 7.08). These elderly women would have been

born in the 1940s or 50s, and their lower literacy rates are reflective of this. Many of the women were illiterate, some had finished college, and others attained only primary schooling. This did seem to have a bearing, along with their sociocultural milieu on what occupation they went on to take up in their productive phases of life and hence the level of financial in/dependence they attained. There were more number of widowed women (as the age gap in marriage is higher in India), followed by those who were still married. Many women reported their spouse followed by self as head of the household. An exploration into their current work or income, taken as factors in assigning the head of household status, showed that women who worked seemed to more often take on that role, while men even after they retired continued to hold that status. Women's current income p.m. was also found to be in the lower ranges. Most women were homemakers, and they reported their spouse, followed by themselves or their sons in that order, as HoH. Therefore, an individual's gender, current earning power, and who took the decision-making responsibility seemed to decide this position for them in the household. More number of older women reported living with extended family (relatives), followed by nuclear (spouse only) and joint family (adult married children). The sample older women lived in middle-class families, while men were reflected slightly more in high-income households.

As per the data, widowed women are the ones who by default or "may be compelled to" go on to live in parent child coresidence or alone or with relatives. Majority of the married older women stay with spouse only, followed by coresidence, indicating a shift into nuclear family structure or of the preferences of child/older parent for new forms of LAs. Older women who reported themselves as HoH, who work or have income, seemed to be with spouse only or live alone. Older women from middle-class background seemed to live in coresidence or with relatives or spouse only. Therefore, it may be understood that variables of the older women such as education, marital status, HoH status, current work/ income, and type of family did seem to in part decide for them, their current living arrangements.

Living Arrangements of Elderly Women and Their Quality of Life

A majority of the elderly women live in parent–child coresidence, followed by living with spouse. Compared to men, more elderly women reported as living alone and with relatives. An analysis of the distribution of older women (and men) as per their living arrangements and the mean scores of QoL and related domains reported provide a concrete ground to discuss, and the following linkages may be made.

Older women's mean scores on psychological well-being and environment in parent child coresidence were almost as high as that of men in that LA. This may be due to the positive aspects of parent child coresidence such as regular interactions with family members, financial comfort, bigger home, emotional support, and connectedness. However, in this LA, the loneliness experienced by women is higher,

and there is lower adaptation to old age reported, compared to men. Though women are living with the family members, the relationships may be strained or not positive or their husband passed away or there may be several limitations/restrictions they face while staying with a large family, for instance, there may be space and time constraints, daily arguments, resources crunch, poor mobility, health issues with advancing age, and most older women reported daughter-in-law, son, daughter, and son-in-law as the hardest person to get along with that may explain this.

Living with the spouse seemed to provide women with a better environment and on physical health, social relationships, psychological well-being domains, they were almost at par with men. Further, their adaptation to old age was better than that of men, and loneliness experienced was similar to that of men. For women, this LA seems to reduce possible instances of friction with family members, they are generally financially well off, younger, independent, able to care for their nutrition and health, and if there is a good partnership with the husband, this LA seems to be beneficial for women. On the other hand, for the women, the space overlap with husband may be too much or they may be missing their children or lack social connectedness, and they may be caring for the sick husband, leading to various stressors. This living arrangement anyway is of short duration and generally paves path to them entering any one of the other LAs, when the spouses pass away.

The women living with relatives reported poor social relationships, environment, and their physical health, while their psychological well-being was almost at par with men in that LA. They faced higher loneliness and experienced much lower adaptation to old age compared to men in those LAs. Older women who are unmarried, divorced, or have lost their spouse or are unable to live with the married son may have to opt for this LA. The mean age of women living with relatives is 66 years, for those living alone it was 72 years, and it is anticipated that this may lead to them facing health problems, mental health issues, widowhood, isolation, a lack of emotional support and financial hardships, and therefore a report of poor QoL and related domains. Living with relatives may afford them a safety net or lowering of expectations or make available a person(s) that they get along with easily and therefore could explain their psychological well-being that is at par with men in that LA.

Older women living alone fared the worst in comparison with men in that LA and women in other living arrangements. Except for reporting a better environment (almost at par with men), on their physical health, psychological well-being, and social relationships, they seemed to fare poorly compared to men. The loneliness levels expressed are higher than that of men in that LA, and their adaptation to old age is especially low compared to the men who are living alone. While living alone, women may have access to whatever space, privacy, and resources that are available. Women living alone, on the other hand, may face financial constraints, suffer more illnesses, have fewer interactions with the outside world, may miss their child(ren), may not eat properly, and cannot care for themselves—that throw light on the poor mean scores on QoL and related domains.

Factors Influencing the QoL and Related Domains of Elderly Women

Older women consistently reported poor mean scores on QoL, adaptation to old age, and loneliness compared to men, irrespective of their current LAs. It may broadly be due to these LAs operating in a sociocultural milieu that we currently live in, their socio-demographic and family profile or the patriarchal systems that women live amidst, including the family. The relevant indicators studied in the living arrangements taken specific to women throw a light on aspects that may be leading to poor QoL and related domains among the older women.

During the later years, the living environment, i.e., living space for the older person in the house, and how the house was kept makes a lot of difference to their quality of life. More women were found to live in one roomed houses, and for those living in larger houses, they did not have a room of their own and their sleeping area such as living room, on the verandah or terrace were also not offering them space for keeping belongings, privacy, or safety.

The presence of hardest persons to get along with might influence their quality of life and the related variables. In the case of women the son, daughter-in-law, daughter, or son-in-law did emerge as the hardest persons to live with. Out of the 121 elderly who mentioned having a person hardest to get along with in their life, 86 reported that the hardest person caused arguments and tensions. A majority of women reported that arguments and tensions with the hardest person occurred as frequently as about 10 times in a year or had occurred almost daily. Older women did report abuse and neglect by family members in their current living arrangement. Some older women also did not perceive that their family members were concerned about their well-being.

Usually, as people age, their diet needs to change, and either the elderly or their family members have to make changes accordingly in the current living arrangements. For the elderly who reported skipping meals in a day and in all types of living arrangements, it was a higher percent of women compared to men. The reasons given such as for fitness or for upvaas are where they require guidance as it may lead them to not getting enough nourishment and having no one to cook as a finding that is of concern.

Having interaction with people in the outside world is important for the elderly persons' quality of life. To understand these patterns, information about the places and purposes that elderly go out to, frequency of their going out, and whether they had friends is helpful. The sample elderly went out to a variety of places with different purposes in mind that overlap with their age such as social functions, social visits, picking up grocery, interaction with people, hanging out, and worship. For almost all the places/purposes that the elderly went out to, especially for going for a stroll, to run errands, hanging out in a place in the neighborhood and going to the park, the elderly women were relatively lower in number. The elderly women seemed to go out in general, but their frequency was on the lower side. More women were unable to go out often as they were unable to move easily, physically. Lesser percent of

women reported having friends and in category of older persons with no friends, women outnumbered men. More women than men had one or two friends. Results clearly show that older persons with friends reported better on the QoL and related domains.

Less number of women compared to men pursued indoor leisure activities such as praying/performing religious rites, followed by watching television/video, and a few women were reading books/newspapers/magazines. There was no deliberate use of leisure time for a range of activities that may enhance their well-being. Compared to those who engaged in indoor leisure activities, those who took up outdoor leisure were fewer in number and were more in the case of women compared to men. Less number of women went for walk/exercise, going to the park, going to a club and involving in social service/politics, while more of them engaged in expressive activities such as place of worship, visiting friends and relatives, going to picnic/tours or going to the movies.

The functional status of the elderly determines their ability to engage in certain tasks of daily routine like bathing, dressing, toileting, transferring, continence, and feeding on their own. The finding that the elderly women reported better level of functioning when compared to men needs to be interpreted with caution, and this maybe because they are trained to be less dependent due to social expectations in an Indian society. The activities of daily routine taken up by older women revealed they were more confined to the home/kitchen and specific to gender such as attending to household chores and preparation of food.

The elderly may hold beliefs about the extent of role of adult children in caring for old parents and may give importance to taking up measures for healthy old age. Slightly more women felt that adult children definitely had role in caring for older parents and comparatively lesser women took measures in taking care of health during old age.

Therefore, from the above discussion one is made aware of the factors that may be making the LAs non-conducive for older women's well-being, while living in them. It is a strong call for reform in current LAs or for bringing in new forms of LAs that ensure better QoL and related domains for the older women.

Suggestions and Implications for Social Work Practice

Suggestions for Specific Programs to Update Policy and Legislation for the Older Women

- Family life education/lifelong learning programs in taking care of older women may be introduced. They can include issues covering older persons' mental health and well-being, long-term care, cultural traditions and values congenial for the promotion of respect and dignity, intergenerational bonding, etc., which will strengthen the family's ability to take care of them.

- Mass media has an important role to play in highlighting the changing situation of the elderly women and to mold people's opinion toward their issues. NGOs and social workers working with the elderly can make use of media in this direction.
- Intergenerational bonding may be developed and promoted so that the younger generation can value/appreciate the need to take care of elderly women. Value-based education to strengthen intergenerational bonding can be incorporated in school textbooks and in other educational contexts.
- Creating and encouraging of women senior citizens support groups in the community.
- Establishment of support services such as tax benefits, subsidies for medical needs and health care of the elderly, especially of the urban poor, the oldest–old and widowed women so that families are better partners in their care.
- Support to the community/neighborhood by the local self-governing bodies such as municipalities in starting daycare centers for the elderly women, and in establishing help lines will create safe and elderly friendly neighborhoods.
- Faith-based organizations, churches, mosques, and temples can be involved in rebuilding the culture of taking care of the elderly women.
- As a last resort, old age homes with assisted living facilities for neglected and abandoned women senior citizens are required to be established.

Implications for Social Work Practice

- Professional social work interventions with the elderly women can take place at different levels—policy, individual, family, and community.
- Several suggestions were made in the earlier discussion with regard to policy. In light of those discussion points, professional social workers can advocate and lobby for bringing out the changes and in the formulation of services and programs for the older women.
- Social workers can organize workshops for building life skills of the older women so that they are equipped to cope with situations in the different types of living arrangements.
- Social workers can extend support to the families or primary caregivers of the elderly women by organizing training programs for them to better care for them.
- Social workers can play an important role in the provision of community-based care in the resource centers, daycare centers, and other similar informal institutions providing services to the elderly women. The task for the social workers is to use methods like community organization and social action and garnering support of the local community to sustain these institutions.
- Social workers can first assess the social networks and supports available to the older women at family and neighborhood level and those who have poor social support may be linked with other elderly, community centers, or volunteers.

- The social workers working in any setting can provide referrals to hospitals, counseling centers, financial or legal aid and mental health facilities available in the community for the elderly women who are in need of assistance.
- Another important social work intervention is to give support to those older women who are identified as abused and neglected by provision of crisis intervention, legal help, counseling family members, provision of shelter if needed and advising for an alternate living arrangement or placement in an eldercare facility, as a last resort.
- In order to create a cadre of professionals to work in this field, there is a need to initiate and offer programs in gerontological social work, specific to women and aging. There is an urgent need to revive and strengthen this component in social work and interdisciplinary educational programs. Such steps will simultaneously promote adequate research and documentation in the field of gerontology and gerontological social work.

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Chapter 16
Psychosocial Challenges of Older Women and Services to Facilitate Their Well-Being

Murli Desai

Abstract The article on "Psychosocial Challenges of Older Women and Services to Facilitate their Well-Being" starts with discussing the sources of psychosocial challenges of gender in old age such as androcentry, agism and sexism, and feminization of aging, leading to women's vulnerability in old age. In this context, the article examines the challenges of changing status, roles, and relationships in family life as a wife, mother, mother-in-law, grandmother, and caregiver; and in marital life, and sexuality in old age. The article further discusses women's challenges of coping with grief and bereavement, widowhood, and acceptance and planning for death. In this context of these changes, the challenge is to adapt one's roles and relationships, find new life goals and sources of personal meaning, and a new pattern to daily life in this stage for achieving psychosocial well-being. For facilitating older women's psychosocial well-being, the article recommends the psychosocial services of life skills development, facilitation of reminiscences and life reviews, and death education.

Keywords Psychosocial challenges · Older women · Gender · Sexism · Family life · Sexuality · Bereavement · Widowhood · Coping · Well-being · Life skills development · Life reviews · Death education

Introduction

Psychosocial Challenges in Old Age

According to the psychosocial theory, human development is a product of the ongoing interaction between individual biological and psychological needs and abilities, on the one hand, and societal expectations and demands, on the other. Major changes in old age comprise changes in identity, roles, and relationships, due to reduction in active work roles and active parenting roles, declining abilities and health, probably loss of spouse, and anxiety of death. For psychosocial well-being, the challenge is to

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find new life goals, sources of personal meaning, adaptation of roles and relationships, and a new pattern to daily life in this stage (Newman & Newman, 2009). This article focuses on psychosocial challenges and well-being for older women, and therefore, gender is used as a major construct to understand this phenomenon.

Androcentry in Gerontology

When the Dharmashastra discusses Vanaprasthashram and Sannyasashram, they refer to men. It states that in Vanaprasthashram, the man should leave the village and go to the forest. He may go either with his wife or leaving her in the care of his sons. Thus, in the scriptures, women's role in old age is not identified independently. She has to facilitate the performance of men's social duties (Kapadia, 1966). Like religion and most of the disciplines, gerontology has also not been free from androcentry. Early research in gerontology focused explicitly or implicitly only on issues relating to older males (Abu-Laban, l992). While gerontology has not given importance to women's issues, in the 1970s, the women's movement, composed primarily of younger professional women, also did not define aging as a feminist issue. However, it is but natural that the patriarchal controls throughout their lives shape many of the problems faced by women in old age (Hooyman, l987).

Sexism and Gender in Old Age

While older men face the prejudicing ideology of agism, women face agism as well as sexism, making it double difficult. Sexism consists of attitudes, policies, institutional structures, and actions that discriminate against one sex (often but not always, against women), limiting freedom and opportunities (Griffin, 2008). For ages, it was believed that the subordinate status accorded to women in society is determined by biology (that is, sex), that it is natural and, therefore, not changeable. The distinction between "sex" and "gender" was introduced to deal with this tendency to attribute women's subordination to their anatomy. Gender is a matter of culture; it refers to the social classification of men and women into "masculine" and "feminine." Gender has no biological origin; the connections between sex and gender are not natural (Bhasin, 2000). Gender has determined access to resources such as access to education and health services, lower earning capacity and limited access to rights to land ownership, contributing to their vulnerability in older age (Helpage International, 2012). This vulnerability is faced by increasingly more women due to feminization of aging.

Feminization of Aging

With a few exceptions, women have longer life expectancies than men in both developed and developing countries. Globally, during 2010–2015, women outlived men by an average of 4.5 years (United Nations, 2015). In India, life expectancy at birth in 2009–13 was 65.8 for males and 69.3 for females (India: Ministry of Statistics & Program Implementation, 2016). The reasons relate to both female biology such as hormonal protective factors and fatal risk factors associated with male working conditions, lifestyles, and higher risk of injury (World Health Organization (WHO), 2007).

As a result of higher longevity among women, the sex ratio in the 60+ age group is better than that in the population as a whole (United Nations, 2015). It is interesting to note that in India, up to the Census of 1991, the number of elderly males exceeded the number of females, probably due to poorer health status of women at that time. In the last two decades, however, the trend has been reversed and the elderly females outnumber the elderly males (India: Ministry of Statistics & Program Implementation, 2016). According to the Census of India in 2011, there are nearly 104 million elderly persons in India; 53 million females and 51 million males (Helpage India, 2015).

Thus, because of higher longevity of women and higher proportion of women in the old population, the problems of aging are increasingly becoming women's problems. This is called "feminization of aging" (Helpage International, 2012).

Conclusion

In conclusion, the problems of older women are found to be not so much a product of the aging process per se as they are a product of the subordinate status of women throughout their life cycle. Women dominate the older person population in terms of numbers, but older women suffer more than men due to strong gender barriers that continue even in late age in a more explicit manner (Giridhar et al., 2015). In the context of agism and sexism, this article examines the challenges of changing status, roles, and relationships in family life as a wife, mother, mother-in-law, grandmother, and caregiver; and in marital life, and sexuality in old age. The article further discusses women's challenges of coping with grief and bereavement, widowhood, and acceptance and planning for death. In this context of these changes, the challenge is to adapt one's roles and relationships, find new life goals and sources of personal meaning, and a new pattern to daily life in this stage for achieving psychosocial well-being. For facilitating older women's psychosocial well-being, the article recommends the psychosocial services of life skills development, facilitation of reminiscences and life reviews, and death education.

Challenges of Changing Family Life for Older Women

Living Arrangements

According to the 2011 Census of India, more than 56% of elderly persons live with their spouse and 32% live with their children. About five percent of elderly persons live alone, while another four percent live with other relations and non-relations (India: Ministry of Statistics & Program Implementation, 2016). Giridhar et al. (2015) note that a higher percentage of older women live with their children or grandchildren (46%) compared to only 12% of older men. This is not surprising as in India children are supposed to provide care in their old age. Preparation for old age includes the attempt to have at least one son to take care of one's needs in old age. Childless couples and those who have only female children begin at some point to consider alternatives such as remarriage, adoption, or the taking of a *Ghar Jamai* (son-in-law) with their old age in mind (Vatuk, 1975).

Changing Family Roles and Relationships

Stets and Burke (2000) note that femininity is associated with being expressive, emotional, tender, and sympathetic. This learned behavior is what makes up gender identity and determines gender roles (Williams et al., 1994). This identity makes even career women more family-oriented, and changes in this identity and roles are challenging for older women.

Traditionally, old age gave a high status to elderly women and power over her grown up children and the younger women in the family. The arrival of the daughter-in-law was supposed to reduce the workload of the aging woman. Conventionally, in India, both the women are supposed to be competitors for the attention of the son/husband and, therefore, rivals. The divide between mother-in-law and daughter-in-law, created to secure women's cooperation to patriarchy, gets aggravated with growing individualism in the liberalized scenario. The modern urban family is individualistic and consumeristic where relationships are considered secondary to the creation and satisfaction of wants (Pereira, 1997). Individualism has led to increased self-centeredness and the commodification of relationships. The elderly cannot claim authority or role in family decision making if they are not productive. On the contrary, they are often neglected in this scenario. The elderly women who generally do not have the ownership right to family housing or property tend to continue the household duties in order to prove useful to their family (Shah et al., 1995).

Becoming a grandparent brings a psychological transformation as well as a change in the family system. With the birth of the first grandchild, the elderly may begin to reflect on the life phases of their own childhood and parenthood. Depending on one's level of engagement in the grandparent role, grandparenthood may require a renewal of parenting skills that have been stored away. A person's parenting skills,

patience, and knowledge come into play in a new configuration. However, this role is negotiated by their adult children (Newman & Newman, 2009). Women provide care to their grandchildren in a much less stressful state of mind, than when they were caregivers to their children. They are also known to be less authoritative and more indulgent with their grandchildren (Shah et al., 1995).

Challenges of Caregiving

Increased longevity has led to impairments and health problems and the need for caregiving for older persons. In the absence of appropriate services in developing countries, the responsibility for providing long-term care for very old/disabled/immobile older persons usually falls on the family. This can be a heavy burden for families with already stretched resources, especially when it prevents adults from working and children from attending school. Within the family, women provide most of the day-to-day care for older persons who need assistance in both developing and developed countries (United Nations, 2011).

The sexist ideology of patriarchy argues that because women give birth to children and are weaker, they, and not men, are biologically better at care of children, spouse, and the elderly in the family. However, caregiving work that women do all their life is not considered work in the patriarchal society. It is considered private as against men's work, which is market-oriented and public. Moreover, the provision of family care is often achieved at the detriment of female caregivers' economic security and good health in later life (WHO, 2002).

In the future, India's system of family-based support will not be able to withstand the increased numbers of older Indians, especially given increased female labor force participation, smaller numbers of more mobile children, widening generation gaps, and increasing burdens of costly-to-treat diseases such as diabetes, cancer, and stroke (Bloom, 2011, cited by Population Reference Bureau, 2012). In this context, an old woman is often the caregiver to her elderly husband, who is generally older than she is. Older women are also more likely than older men to be caregivers of children or sick relatives, particularly in families affected by migration or illness (Helpage International, 2012). However, the domestic and caring contributions of older women, which often enable family members to take paid work outside the house, are rarely acknowledged and are often belittled by older women and men themselves. As the number of very old women continues to increase and the pool of available caregivers continues to decrease, families and policymakers increasingly look for other options.

There is a need to recognize and address gender differences in the burden of caregiving and make a special effort to support caregivers, most of whom are older women who care for partners, children, grandchildren, and others who are sick or disabled. Moreover, it is important to recognize that older caregivers may become socially isolated, financially disadvantaged and sick themselves, and attend to their needs (WHO, 2002). Caregivers must be supported and nurtured to enable them to maximize the care they deliver, to manage the considerable stress that can accompany

caregiving, and to be able to sustain a caregiving role over a long period of time—often many years. Part of the answer may lie in increased home and community support services (WHO, 2007).

Challenges of Neglect and Abuse

Domestic violence against the vulnerable family members has increased in the context of the nuclearization of family, separation of private and public spheres, increased individualism and commodification of relationships, and weak community supports. Everything that happens within the four walls of the modern family is considered a private matter, and no outside intervention is encouraged. Family violence, therefore, often remains invisible, undiscussed, and unchallenged (Bhasin, 2000). The elderly who are not considered productive are also vulnerable to violence.

Elder abuse is generally defined as physical, emotional, or sexual abuse of older persons by someone in a position of trust, which occurs worldwide. It can take place within the family, in hospitals, in old age homes or elsewhere. There are also specific threats related to traditional beliefs, including violence as a result of accusations of sorcery and violence against particularly vulnerable older persons such as migrants, older persons with disabilities, older persons in conflict situations, and older persons living in poverty, particularly the homeless (United Nations, 2011). High level of illiteracy and lack of remunerative occupation, among elderly women, in comparison with their male counterparts, make elderly women more vulnerable than elderly men, to get abused by their sons and daughters-in-law (Shah et al., 1995).

According to Giridhar et al. (2015), about 13% of rural older women and nine percent of urban older women have reported experiencing some form of abuse. For women, verbal abuse is the main form of abuse, and physical abuse is the least prevalent form. The abuser of the older women is generally the daughters-in-law.

The United Nations (2011) identified the following as risk factors of elder abuse:

- Social isolation can increase family stress and decrease problem visibility or intervention.
- Dementia can foster abuse or retaliation against abuse by the caregiver.
- Shared living arrangements between the victim and the perpetrator with the frequency of contact serve to inflame conflict and abuse.
- Pathology on the part of the perpetrator can provoke anger or frustration and reduce inhibitions for abuse occurrence.
- Older women are at special risk of being abandoned and having their property seized when they are widowed in many societies.
- For older persons in residential/institutional long-term care facilities, abuse is documented as having been perpetrated by staff, visiting family members and friends, and residents.

Conclusion

While grandparenting is a new source of psychosocial well-being, increasing number of elderly women experience loss of status and roles in the family. Since women have traditionally always linked their identity with their roles and relationships, the changes and vacuums in this area can lead to despair. Increased longevity, nuclearization of families, and increased female labor force participation also imply that the very old women continue to carry out household chores and provide caregiving roles. In the consumeristic and individualistic modern families, older women are also vulnerable to loneliness due to neglect and indifference from their children. Further, elderly women are more vulnerable than elderly men, to get abused by their sons and daughters-in-law.

Challenges of Changing Marital Life for Older Women

Married older persons are less likely than those who are unmarried to show signs of depression and to feel lonely and are more likely to report that they are satisfied with life. Being married has also been linked to lower mortality (United Nations, 2011).

Changing Marital Roles and Relationships

Gutmann (1987, cited in Turner, 1994) noted that the end of active parenting and earning in old age are thought to remove the context of gender role enactment in old age. He further suggested that, if gender typing were a power attribute, social behavior that is viewed as less important or less relevant to societal maintenance, would be seen as feminine. Social behavior in old age is being seen as less important and thus as less masculine. These changes are likely to bring about more closeness in husband–wife relationship in old age (United Nations, 1993). While increased closeness in the marital relationship in old age is a new source of pleasure, changing sexuality is a challenge and brings further changes in the marital relationship.

Challenges of Sexuality in Old Age

Menopause in Women and Implications

Menopause as cessation of menstrual periods and reproductive role of women. It generally takes place between 45 and 55 years of age, bringing a variety of physiological changes, some of which are the result of cessation of ovarian functions and

others are an effect of the aging process (WHO, 1996). It is directly associated with physical symptoms including increases in vasomotor symptoms, vaginal dryness, pain during sexual intercourse, and central abdominal fat, as well as decreases in breast tenderness, bone mineral density, and sexual functioning (WHO, 2007). This can make sex uncomfortable. However, not all women lose interest in sex after the menopause. Some women find they can relax and enjoy sex even more now that they no longer have to worry about getting pregnant. Women may be less interested in sex than before as the result of other stress in their own or their partner's life, and their interest in sex may return when this stress has gone (The Women's Health Council, 2008). Although generally sexual interest and need continue throughout old age, for both men and women, at the level at which it was in the earlier decades (Starr, 1987), the many fallacious myths, surrounding menopause, have perpetuated a negative attitude about the decreased utility of women in the postmenopausal phase.

Menopause marks the beginning of a new stage for women, aging. The years before may have been taken up with rearing the family, building relationships, and career. Around the time of the menopause women's relationships with your partner, parents, children, or close friends change as they too become older. Their attitude to work may change; they may look for new challenges or feel they want to slow things down (The Women's Health Council, 2008). Regardless of differences in how it is experienced, the menopausal transition can provide an important focus, a time that can be used to reassess one's health, lifestyle, and goals (WHO, 2007).

Many women go through this stage of their lives without any psychosocial problems. For those who do have problems, each woman's experience may be different. Besides the physiological changes, women experience psychosocial changes, dramatically affected by sociocultural factors. For example, losing the bodily youth may lead to depression in women for whom it is an important part of their life. While there are many causes of depression and anxiety, the symptoms of the menopause may contribute to these feelings. For example, night sweats can disturb your sleep, and tiredness makes it harder to cope with stress. The changing hormone levels may also affect their mood. This is often a time of change and stress for women, and this can contribute to feelings of depression (The Women's Health Council, 2008).

Sexual Behaviors in Old Age

Sexual interest and need continue throughout the life cycle for both men and women. The type and frequency of sexual behaviors in old age is contingent upon physical and psychosocial factors. Sexual behaviors not only comprise intercourse but range from petting to masturbation to intercourse. Whether sexually active or not, older persons have a continuing need for an intimate relationship to at least one other person. Sexual activity in old age can take the form of masturbation for those who do not or choose not to have a partner (McInnis-Dittrich, 2005). Long-lasting marriages tend to be more companionate in nature, emphasizing intimacy, and commitment over passion (Newman & Newman, 2009). However, old couples who do not have their own

bedrooms in their homes shared with their children, or living in nursing homes, or old age homes, may not have adequate privacy for sexual behaviors (McInnis-Dittrich, 2005).

Agism in Sexuality

While the circumstances in old age may bring husband and wife closer to each other, agism discourages sexuality in this stage of life. Older adults face agist that is negative social attitudes about sexual activity that may inhibit their sexual behavior. These social attitudes include assumptions that very old adults do not have sexual desires, they cannot have intercourse because of sexual dysfunction, sex may be dangerous to their health, they are physically and sexually unattractive, and it is morally wrong or perverted for older adults to be sexually active (Crooks & Bayer, 2005, cited by Newman & Newman, 2009).

Gender Differences in Sexuality

Throughout life, women's sexuality is suppressed through dressing codes, restrictions on mobility, emphasis on early marriage, virginity and monogamy, imposition of purdah, limits on interaction between the sexes and exclusive emphasis on heterosexual relationship, in order to control women's reproduction. However, with the cessation of women's reproductive role with the onset of menopause, these restrictions are generally relaxed. However, asexuality is assumed to replace passive sexuality among women after menopause (Golub, 1992). Even when older women do not have children, they are generally called a mother, in harmony with her asexual image (Kua & Ko, 1998).

Arber and Ginn (1991, cited by Powell, 2001) claim patriarchal society exercises power through the sexualized promotion of a "youthful" appearance in women. Media also portray mature men as sexually attractive, but women in the postmenopausal age are depicted as neither sexually active nor sexually attractive, since society equates attractiveness in women with youth. Feelings of shame and revulsion toward their aging body may be sexually inhibiting for the older women (Kua & Ko, 1998).

Another gender difference in old age with reference to sexuality is that society is generally accepting of older men seeking out younger female partners, but negatively views older women seeking out partners (Kua & Ko, 1998). Moreover, with the uneven ratio of older men to older women, men may have more opportunities for sexual partners compared to women (McInnis-Dittrich, 2005).

Conclusion

Marital life in old age is likely to bring husband and wife together due to the end of active parenting and earning roles. Women also experience increased sexual freedom after menopause However, older women need to cope with the psychosocial challenges of implications of menopause and gender stereotype of sexuality changing from women being sexually passive to being asexual in old age. In this context, companionship, emphasizing intimacy, and commitment often overtake passion in marital relationship.

Challenges of Grief and Bereavement for Older Women

Challenges of Grief and Bereavement

Newman and Newman (2009) note that death is at once a certainty, in that all living things die, but the timing of death is not known. So, death is inevitable but unknowable. Yet we do not like to talk about it at any stage in our lives. However, in old age, anxieties related to one's own and one's spouse's death start bothering the elderly. At this time, the realities about death are important to accept. In middle adulthood, most people experience the death of their parents. During young old age, one's peers including siblings and spouses may die. These deaths are sources of psychological stress and require the emotional process of grief and mourning and the cognitive strain of trying to accept or understand death (Newman & Newman, 2009).

Challenges of Widowhood

Demography of Widowhood in Old Age

A major transition into old age occurs due to the loss of spouse that contributes to a feeling of increased insecurity among both men and women (United Nations Population Fund (UNFPA), 2011). Not having a spouse in the older ages is a cause for concern for both men and women. However, most of the older men in the world are married, while most of the older women are not, as they are likely to be widowed. The reasons is that women usually outlive their husbands—a circumstance linked both to women's higher life expectancy and to the fact that they tend to marry men older than themselves. Moreover, men are more likely than women to remarry after being divorced or widowed. Because the surviving spouse is usually the wife, older women are very likely to become widows and spend their older years alone (United Nations, 2011). The 2001 Census of India shows that about half of all elderly women were widowed at that time, while only 15% of elderly men were widowers. In more

advanced age of 80 years and above, 71% of women and only 29% of men having lost their spouses (UNFPA, 2011).

According to Giridhar et al. (2015):

- In India, widows experience a shift in their living arrangements in old age from living with spouse to either living alone or living with adult children, a shift that fewer older men face.
- About 10% of older women live alone as against two percent of older men. A significant reason for older women living alone is that their children are away.
- A majority (69%) of older women who are living alone also prefer to live alone (that is they are able to cope) while only 35% of older men living alone prefer to live alone.

According to Giridhar et al. (2015), about 80% of older persons living alone are in contact with their children. They note that older women are less capable of initiating communication with their non-coresiding children due to inability to handle communication equipment by themselves without assistance from others than older men.

Sociocultural Challenges for Old Widows

Traditionally, to be a Suhagan is the best status a woman can attain among Hindus. The wife is supposed to be bound to her husband even after his death. Traditionally, on the death of the husband, the woman lives a life devoid of any status in the society. Besides facing the problems of bereavement, a widowed woman is particularly pushed to the periphery of the society, as a woman has any status in the society only if she is married. Sexuality outside of marriage is out of question for widows. They also have to renounce all the other joys of life. Moreover, they are considered unlucky, so generally not allowed to attend auspicious functions. While this situation is changing, the societal ideal in industrialized countries also emphasize the normalcy of not just marriage but also couple activities. As the status of women in many societies is linked to the status of their husbands, widows and unmarried older women can become particularly vulnerable to poverty and social exclusion (Helpage International, 2012).

Financial Challenges for Old Widows

With death of the spouse, the effect is more likely to be also financial for older women. Many widowed women depend on the husband's pension, and those benefits may be too meagre to prevent poverty. Since women traditionally do not own land, housing, or other assets such as savings, they become and also feel more dependent. However, widowed women are more likely to have assets in their name compared to married women, since the asset is transferred to them on the death of their spouse (Giridhar et al., 2015). However, in some developing countries, women lack legal and enforceable property inheritance rights when the husband dies and have little or

no recourse if the husband's relatives move to take over the dwelling, landholding, or other property (United Nations, 2011).

Only 45% of older women living independently report receiving some financial assistance from their non-coresiding children. This is yet another cause of increased vulnerability among older women. About 21% of them (mostly those living alone) felt that the government should support them. There is also a good proportion of older women (23%, particularly in 60–64 age group) who felt that adults should be independent.

In 1997, I had carried out case studies of institutionalized elderly women, which showed that the elderly women's social status changed when they lost their husband/men. Until their husband/men were alive, they had a place to live. Even for women who earned more than their husband, they did not have ownership of their matrimonial home. Thus, widowhood leads to social, emotional, and financial insecurity.

Conclusion

Older women are more likely to face death of the spouse than older men are and be less in contact with the non-residing children. They are, therefore, more likely to feel lonely. Older women also face the sociocultural challenges of widowhood and financial deprivation more than older men.

Summary of Psychosocial Challenges faced by Older Women and Services to Facilitate Psychosocial Well-Being

Summary of Psychosocial Challenges Faced by Older Women

While older men also face psychosocial challenges, the psychosocial challenges faced by older women are based in gender biases aggravated by age. Since women have traditionally always linked their identity with their roles and relationships, the changes and vacuums in this area can lead to despair. Older women need to cope with the psychosocial challenges of implications of menopause and gender stereotype of sexuality changing from women being sexually passive to being asexual in old age. Older women are more likely than older men to lose their spouse, face grief and bereavement, and life of widowhood. In the consumeristic and individualistic modern families, older widows are also vulnerable to loneliness and neglect and indifference from their children. Further, as discussed in this article, older women are more vulnerable than elderly men, to get abused by their sons and daughters-in-law. Older women are more likely to face death of the spouse than older men are and be less in contact with the non-residing children. They are, therefore, more likely to

feel lonely. Older women also face the sociocultural challenges of widowhood and financial deprivation more than older men. Older women also need help in coping with death of the loved ones and accepting the certainty of their own death and planning what they think is a "good" personal death.

Many old women in India are active in various activities such as prayer, yoga, household chores, and social networking (Giridhar et al., 2015). These activities provide social support to older women. Such support is useful as:

- It reduces isolation.
- It reduces the impact of stressors.
- It increases longevity (Newman & Newman, 2009).

Support centers for older persons need to be set up in every community, appropriate to local needs, decentralized, and democratically locally self-governed. These centers for older persons can provide the following services to promote psychosocial well-being of older women: workshops for life skills development, facilitation of reminiscences and life reviews, and death education.

Psychosocial Well-Being

Well-being is one domain of quality of life and is concerned with one's subjective perception of and feelings about life, commonly operationalized in terms of "happiness" or "life satisfaction." The term subjective well-being (SWB) is defined as an individual's experience of affective reactions and cognitive judgments. The affective component is associated with emotions, feelings, and moods, while the cognitive component refers to what the individual thinks about his or her life satisfaction. Happiness is sometimes used interchangeably with SWB, but the terms mean different things. Assessing life satisfaction involves past experience and future expectations. Having a high SWB involves having "pleasant emotions, low level of negative mood, and high life satisfaction" (Diener et al., 2002, cited by Rojas, 2016).

Psychosocial well-being is essential not only for mental health but also for physical health, at preventive as well as remedial levels. The self-perception of healthy people, characterized by having positive feelings about themselves, a feeling of self-control, and an optimistic vision of the future, provides reserves of and a driving force for resources not only to cope with everyday difficulties but also with those which are especially stressful and even threatening for one's existence (Taylor et al., 2000, cited by Vázquez et al., 2009).

Workshops for Life Skills Development

Importance

The psychosocial challenges that older women and men face can be very effectively dealt with by workshops for life skills development. These workshops are useful for psychosocial well-being of the caregivers of the elderly also. Older women and female caregivers may benefit from gender awareness integrated into these workshops.

Concepts and Modules

- According to Newman and Newman (2009), life skills are psychosocial in nature. The psychological skills comprise self-awareness, proactive thinking skills, and emotional intelligence. The sociological skills include collaborative interpersonal relationship skills, family life education, and sexuality education.

Objectives

These modules can be conducted with the following objectives (For more details, see Desai, 2018).

Objectives of self-empowerment:

- Identify one's unique identity and balance it with group identities.
- Learn to accept, value, and love oneself.
- Learn to be assertive and avoid being passive or aggressive.
- Take responsibility for one's thinking, feelings, decisions, and behavior.
- Develop integrity that leads to genuineness, honesty, and trustworthiness.

Objectives of proactive thinking skills:

- Turn reactive thinking into proactive thinking skills.
- Turn irrational thinking into rational and critical thinking skills.
- Turn rigid thinking into flexible and creative thinking skills.
- Turn negative thinking into positive thinking skills.
- Develop decision-making skills.

Objectives of emotional intelligence:

- Develop awareness of emotions in self and skills to express them.
- Develop awareness of others' emotions through sensitivity and empathy.
- Learn to regulate healthy negative emotions and prevent unhealthy negative emotions.
- Develop problem-solving skills.
- Learn to enhance positive emotions of love and happiness.

Objectives of sensitive interpersonal relationship skills:

- Develop positive perception of and positive feelings for others.
- Learn to value adaptability and interdependence in relationships.
- Learn the sensitive verbal, non-verbal, and listening skills.
- Develop skills for giving and receiving positive feedback.
- Learn the skills to identify win–win goals, giving and receiving negative feedback, and conflict management.
- Learn the teamwork skills of commitment to group goals, group accountability, and consensual decision making.

Objectives of family life education:

- Learn to democratize family's internal dynamics.
- Learn to democratize family's interaction with its environment.

Objectives of sexuality education:

- Obtain knowledge about sexual and reproductive anatomy.
- Obtain knowledge about biological changes in menopause.
- Learn to deal with psychosocial implications of menopause.
- Develop positive values, attitudes, and social norms of sexuality.
- Learn to enjoy changing sexual relationships.

Facilitation of Reminiscences and Life Reviews

Importance

In old age, accepting one's past life, as it has been, is often a difficult personal challenge. The elderly may face a continuous haunting desire to be able to do things differently, or of bitterness over how one's life has turned out. Most people have some regrets. The gradual deterioration or loss of certain physical capacities contributes to their frustration and discouragement. Facilitating reminiscences and life reviews for older women are also effective in helping them bring integrity to their life instead of despair. Reminiscence can be used to foster skills of self-understanding, conflict resolution, acceptance of life as lived, and the understanding that life is finite. Reminiscence is an important strategy in old age that promotes a sense of identity across the life cycle and allows a person to cope with change and loss (Serrano, 2016). As a prevention strategy, it has great potential for promotion of well-being in old age.

Concepts

Reminiscence is the intentional process of retrieving episodes personally lived in the past. This retrieval of past memories may or may not have a logic or sequence in terms of the topics recalled. Reminiscence tends to be highly spontaneous and mostly

unstructured, without understanding and evaluation of the memories. On one hand, reminiscence provide people with the opportunity to relate episodes and/or tell their life history. On the other hand, especially in older adults, reminiscence can be used as a way to promote mental health and a prevention strategy for mental disorders as it helps a person feel more confident and self-assured when dealing with the changes related to old age (Serrano, 2016).

Approach

In contrast to simple reminiscence, discussed above, life review reminiscence is much more structured, focusing on the integration of positive and negative life events (Serrano, 2016). One's life review may be a playful recalling of a life adventure and/or a painful review of some personal or family crisis. Individuals must be able to take pride in areas of achievement as well as be able to accept areas of conflicts, failure, crisis, or disappointment without being overburdened by a sense of inadequacy. Through this review, they can revise the meaning of past choices, decisions, and events by using current wisdom to understand or accept what took place in the past. The attainment of integrity is ultimately a result of the balance of all psychological crises that have come earlier, accomplished by all the ego strengths that have accumulated along the way. Integrity is an ability to integrate one's past history with one's present circumstances and to feel content with the outcome. In this process, a person seeks to find an integrative thread that makes sense of the life one has led without belaboring past mistakes. It helps them to appreciate the significance of the events in the formation of their unique adult personality (Newman & Newman, 2009).

Death Education

Objectives

Objectives of death education are:

- Learn to cope with grief and bereavement after loss of a loved one.
- Understand death from religions and other sources and accept death as a certainty.
- Planning for a good personal death.

Coping with Grief and Bereavement

Grief refers to the cognitive and emotional reactions that follow the death of a loved one and comprises:

- Preoccupation with thoughts of the deceased person.

- Longing for the person.
- Painful emotion.
- Feeling of dissociation—disconnected from reality.
- Sensory illusions that lead to the impression that the deceased person is still present (Newman & Newman, 2009).

Grief is an active process that involves choices in coping in which a person must do several things:

- Acknowledge the reality of the loss.
- Work through the emotional turmoil.
- Adjust to the environment where the deceased is absent.
- Loosen ties to the diseased (Worden, 1991, cited by Kail & Cavanaugh, 2007).

Bereavement is a long-term process of adjustment to the death of a loved one and is more all-encompassing than grief. It commonly includes:

- Physical symptoms.
- Role loss.
- Seeking meaning in the loss.
- Trying to solve problems that arise as a result of loss of the loved one.
- A variety of intense emotions, including anger, sorrow, anxiety, and depression (Newman & Newman, 2009).

Bereavement may be expressed in very individual ways and may also be guided by cultural practices that shape the behaviors and activities of those in mourning. The bereavement process can include both confronting the loss and seeking ways to move away from or beyond the loss (Newman & Newman, 2009).

Based on his research with widows and widowers, Carr (2003, cited by Newman & Newman, 2009) suggested the following dimensions of what people perceive to be a good death of their spouse:

- Spouse was at peace with the idea of dying.
- Spouse was aware of the impending death.
- Respondent and spouse discussed the death.
- Respondent was with spouse at the moment of death.
- Spouse led a full life.
- Spouse was not in pain.
- Spouse did not receive negligent care.

Understanding and Acceptance of Death

Different religions have different beliefs about death and life after death that influence the old persons thinking about death. Newman and Newman (2009) note that the very old are faced with the challenge of conflict between acceptance of death and the intensifying hope for immortality. Having lived longer than their cohort of friends and family members, they struggle to find meaning in their survival. One can get

bound by the limits of one's own life history, experiencing a great fear of extinction. A psychosocial sense of immortality may be achieved and expressed in the following possible ways:

- One may live on through one's children, sensing a connection and attachment to the future through one's life and the lives of one's children.
- One may believe in an afterlife and or a spiritual plane of existence that extend beyond one's biological life, based in one's religion.
- One may achieve a sense of immortality through creative achievements and their impact on others.
- One may develop the notion of participation in the chain of nature. In death, one's body returns to the earth, and one's energy is brought forth in a new form.
- One may achieve a sense of immortality through experiential transcendence, independent of religion.

Planning for a Good Personal Death

What is a Good Death: A "good death" means different things to different people. Some people might want to know when death is near, so they can have a few last words with the people they love and take care of personal matters. Some people might want to die quickly and not linger. Some people would like to be at home when they die, while some people want to be in a hospital where they can receive treatment for their illness until the very end. Some people want to be surrounded by family and friends; others want to be alone. Of course, often one does not get to choose, but having the end-of-life wishes followed, whatever they are, and being treated with respect while dying, are common hopes (National Institute on Aging, 2016).

Gawande (2010) noted that surveys of patients with terminal illness find that their top priorities include, in addition to avoiding suffering, being with family, having the touch of others, being mentally aware, and not becoming a burden to others. Reaffirming one's faith, repenting one's sins, and letting go of one's worldly possessions and desires are crucial. Families need to offer prayers and put the elderly in the right frame of mind during their final hours. Last words come to hold a particular place of reverence.

Planning a Good Personal Death: Planning a good personal death includes the following:

- Planning for religious and spiritual needs.
- Planning physical comfort.
- Resolving conflictual relationships.
- Having a viewpoint on euthanasia.
- Planning death-related rituals.

Planning for Religious and Spiritual Needs: People nearing the end of life may have spiritual needs as compelling as their physical concerns. Spiritual needs involve finding meaning in one's life and ending disagreements with others, if possible. Many people find solace in their faith. Praying, talking with a priest from one's religious community, reading religious text, or listening to religious music may bring comfort (National Institute on Aging, 2016). This may help them deal with concerns about the consequences of dying including fears of the unknown, loss of identity, etc. (Newman & Newman, 2009).

Planning Physical Comfort: The fear of personal death, with reference to the actual process of dying and the consequences of it, is natural and normal. Concerns about the process of dying include fears of being alone, being in pain, etc. (Newman & Newman, 2009). Physical discomfort can come from a variety of problems, which can be dealt with depending on the cause. For example, a dying person can be uncomfortable because of pain, breathing problems, skin irritation, digestive problems, temperature sensitivity, and fatigue (National Institute on Aging, 2016).

Resolving Conflictual Relationships: It is important to help the dying person manage any mental and emotional distress. Encouraging conversations about these feelings might be beneficial. Resolving conflicts in key personal relationships includes reframing negative emotions of hatred, anger, guilt, pain, depression, resentment, and so on into positive emotions of acceptance, forgiveness, love, and meaning in death, so that death can be faced with peace (National Institute on Aging, 2016).

Having a Viewpoint on Euthanasia: Euthanasia is the practice of ending life for reasons of mercy. Euthanasia can be passive or active. Passive euthanasia involves allowing a person to die by withholding available treatment, especially when the treatment would do nothing but prolong and make even more agonizing an already certain death. On the other hand, active euthanasia involves the deliberate ending of someone's life, which may be based on clear statement of the person's wishes or decision made by someone else who has the legal authority to do so. Usually this involves situations when a person is in a persistent vegetative state or suffer from the end stages of a terminal illness (Kail & Cavanaugh, 2007). Active euthanasia is also called mercy killing as it is done in order to end a person's suffering (Newman & Newman, 2009). Older people may decide on a personal viewpoint on euthanasia.

Planning Death-Related Rituals: The death-related rituals have the advantage of offering a prescribed set of religions or cultural practices at a time when people may be too distressed to make complex decisions. These rituals address three critical aspects of death:

- How to treat the physical body: cremation or burial.
- How to address the fate of the spiritual aspect of the person—the soul.
- How to meet the emotional needs of the survivors: mourning.

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Chapter 17
Project Nana: Seasoning Our Seasoned Women

Vanessa L. Hill and Vinu Ilakkuvan

Abstract There are many public health campaigns targeting women's health. For women over 55, more prominent health campaigns tend to address issues to improve cardiovascular care, to prevent hip injuries, and to reduce the prevalence of dementias. However, it appears that health campaigns geared toward improving and maintaining gynecological health are mostly targeted to a younger audience concerned with reproductive health and fertility. This excludes a key demographic, given that postmenopausal women are at an increased risk for gynecological cancers. And while the rates of occurrence may be relatively the same among Caucasian and other women of color, black women tend to have a higher mortality rate. Black women are also disproportionately affected by sexually transmitted infections (STIs) and the human immunodeficiency virus (HIV). The impact of the lack of interventions to postmenopausal women and, specifically, to this high-risk group is not only late stage diagnosis of some preventable and treatable gynecological diseases, but also a reduction in longevity and quality of life. Addressing this concern, the non-profit organization, Project Nana, Inc. was established out of an ongoing research study titled *Project Nana: An Intervention to Increase the Utilization of Gynecological Services in Senior Women of Color.* The study assesses attitudes, beliefs, and knowledge of postmenopausal women as it relates to seeking and maintaining gynecological care. The subsequent intervention and service provided by the non-profit seeks to increase awareness, improve attitudes and beliefs, and ultimately increase gynecological care. Using a combination of educational workshops, visual and performing arts, collaborative community engagement, provider training, and peer-to-peer outreach, the goal of the intervention is to overcome educational, economic, and cultural barriers in order to reduce the late stage diagnoses of gynecological cancers and sexually transmitted infections. Since the population of senior women is expected to substantially increase in the next 30 years, prevention and early detection of disease will improve

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health outcomes, improve quality of life, decrease economic burdens, and decrease potential loss of valuable resources to the community—our seasoned women.

Keywords Primary care · Postmenopausal women · Geriatric gynecology · Women's cancers · Gynecology' health campaigns · Health Interventions · Project Nana · Social cognitive theory · Theory of planned behavior · Community workshops · Ovarian cancer · Cervical cancer · Endometrial cancer · Cancer of the uterus · Vaginal cancer · Vulvar cancer · Pelvic exam · Pap smears · Sexually transmitted infections · HIV · AIDS · STD · Sexually transmitted diseases · STI' · Menopause · Seniors · Post menopause · Vagina

There are many public health campaigns targeting women's health. For women over 55, more prominent campaigns tend to address issues to improve cardiovascular care, to prevent hip injuries and to reduce the prevalence of dementias. But why does it appear to be the case that campaigns geared toward improving and maintaining gynecological health mostly targeted to a younger demographic concerned with reproductive health and fertility? Postmenopausal women are at an increased risk for gynecological cancers. And while the rates of occurrence may be relatively the same among Caucasian and women of color, black women tend to have a higher mortality rate. Black women are also disproportionately affected by sexually transmitted infections (STIs) and the human immunodeficiency virus (HIV). The impact of the lack of interventions to postmenopausal women and, specifically, to this high-risk group is not only late stage diagnosis of some preventable and treatable gynecological diseases, but also a reduction in longevity and diminished quality of life. Addressing this concern, Project Nana, Inc. was established out of an ongoing research study titled *Project Nana: An Intervention to Increase the Utilization of Gynecological Services in Senior Women of Color*. The study assesses attitudes, beliefs, and knowledge of postmenopausal women as it relates to seeking and maintaining gynecological care. The subsequent intervention and service provided by the non-profit seeks to increase awareness, improve attitudes and beliefs, and ultimately increase self-efficacy in the ongoing care of gynecological issues. With the aid of the creative arts, Project Nana seeks to reimagine and fortify the humanity of our seasoned women, pulling them from the shadow of societal invisibility and supporting them to regain their own sense of agency and utility. Using a combination of educational workshops, visual and performing arts, collaborative community engagement, peer-to-peer outreach, and provider communication training, the goal of the intervention is to overcome educational, economic, and cultural barriers in order to reduce the late stage diagnosis of gynecological cancers and sexually transmitted infections. Specifically, the overall all health goal is to decrease the incidence rate of late stage diagnosis of cancers and sexually transmitted diseases in postmenopausal, black women, age 55 years and older in Hampton Roads, Virginia by 5% over 10 years. There are several objectives to meet in order to ultimately hit the program goal. The behavioral objective is to increase the utilization of gynecologists for annual screenings. Communication objectives include to increase knowledge of the benefits of gynecological care;

reduce perceive barriers to seeking gynecological care; increase positive attitudes toward seeking and continuing gynecological care; increase the belief that speaking with the gynecologist about issues relating to gynecological health, sexual issues, and overall health concerns can enhance quality of life; increase the confidence in talking about sex and their bodies with their physicians; and increase the comfort level in obtaining current information on gynecological issues from their gynecological care team. And finally, the self-efficacy objectives are to increase self-efficacy to seek gynecological care and increase support efforts to provide information on current gynecological issues such as risk of STIs, cancers, and need for routine pelvic exams by a gynecologist to their peer groups.

Since the population of senior women is expected to substantially increase in the next 30 years, prevention and early detection of disease will improve health outcomes, improve quality of life, decrease economic burdens for the patient and taxpayers, and decrease potential loss of valuable resources to the community—our senior—seasoned women.

Background

Seeking out and navigating the communal margins of society, on the surface, appear to be a statement wrought with hyperbole. However, globally, elder women are one of the most disenfranchised group. Before we can even address the idea of self-efficacy and their gynecological health, we must understand some contributing factors for mental and emotional barriers that may make it difficult for a seasoned woman to advocate for herself. A quick tour through headlines highlights this point: In a Korean Study titled Living Profiles of Older People Survey, the results suggested that emotional elder abuse was the most frequent type of abuse experienced by the elderly populations. Specifically, of the 10,184 respondents, 10.6% of the women stated they experienced abuse, compared with 8.8% of men. Of note, there was a significant correlation with poor self-rated health with elder abuse in women, than that of men (Jeon et al., 2019).

In other parts of the world, older women's voices are threatened, keeping the women locked in perpetual silence about daily experiences. A total of 75%, 83%, and 39% of women over 50 years of age in Mozambique, Peru, and Kyrgyzstan, respectively, stated that they have experienced violence. As a result, they may internalize the abuse and come to believe that their mental, emotional, and physical health is of little consequence and thus not seek help. According to HelpAge International, "Violence against older women is a severe human rights abuse. It is driven by both agism and sexism, and grounded in deep-rooted prejudices, dehumanizing stereotypes and social norms that tolerate and even condone awful acts of violence. An older woman may be the victim of verbal and physical abuse, be accused of 'witchcraft,' denied the right to land from her husband when he dies, and deprived autonomy in a [health]care setting, with other people making decisions for her that may not be her wish. Women may face many forms of sexual, physical, financial, and emotional

abuse, committed by various perpetrators and attacked or even murdered by members of her own community" (Rossman, 2017). With this understanding of the dehumanizing activities that are occurring at the intersection of sexism, agism and holistic health, it is incumbent on the public health advocate collective to amplify voices surrounding nuanced ideas and discussions on seasoned women's health.

There are moments within our life, nanoseconds, when you must respond to a significant emotional event. These moments tend to define or even redefine our character and may stretch our coping capacity beyond our preconceived limits. We either succumb to the gravity of the challenge at hand, or it becomes fuel that may launch other moments that have the potential to be more impactful than one can ever imagine. I experienced one of these life defining moments.

It was September 29, 2010, in hospital room 329 in Hampton Roads, Virginia, where my Nana, Merlice Yvonne McIntosh Henderson, was awaiting medical transport to take her home to hospice. Two weeks earlier, she had presented to the emergency department experiencing abdominal discomfort. After emergency surgery, she was diagnosed with stage IV cancer of the uterus. Now, she waited in pain which even morphine could not tame for the rainstorm to subside, so she could make it to the comfort of her own home. At the same time, my family also anticipated my granddaddy's arrival from the Veteran Affairs Hospital. Three weeks earlier and three days before my Nana was admitted to the hospital, Granddaddy had a stroke. My family did not tell him about Nana's health for fear that it would negatively impact his recovery. The plan was to bring them home together, so they could see each other for, however, long their last moments. The emergency medical technicians (EMTs) retrieved Nana, but the other transport company, citing safety concerns due to the stormy weather, would not bring Granddaddy home. Nana arrived safely, late on Wednesday. She died the next morning on September 30. My Granddaddy died 13 days later. During this period, I was in Miami teaching film serving as Director of a university graduate fine arts department. When I received the news of my Nana's diagnosis, she got on the phone with and made it clear that she wanted me to complete my preparation for my new incoming class and to not travel until after orientation. "We finish our work with excellence," I recall her saying. I booked my airline ticket to Virginia to see my Nana on Friday, October 1st. I was a day too late.

In the year that followed, I descended into a deep grief. I decided to move to Virginia, the epicenter of my life shattering moment in order to grieve…to fall apart. I could not make sense of how Nana could go so quickly. She was a breast cancer survivor and was seeing her primary care and oncologist on a regular basis. As I began my Google research, I discovered that uterine cancer exhibits visible symptoms. Why did not anyone notice? Why did not Nana say anything? The "but why" led me to uncover the growing power of advocacy within me. Through speaking with community and faith-based organizations, retelling Nana's story and educating citizens regarding issues, particularly healthcare issues, my call to action became clear. Soon I began developing the framework for an advocacy organization to be named Project Nana. I had no desire or will to return to my former life or work. I took every opportunity to talk about Project Nana and issues related to seasoned

women's health. I wanted to know more, to become an expert in order to earn the right to lead Project Nana.

I contacted The George Washington University (GWU) to express my interest in their medical program and was informed that one of the prerequisites needed to apply was direct patient care experience. It was suggested and I heeded the advice to become an EMT. I heeded that advice and completed my EMT training program and certification. Since I was still in Virginia at the time, I decided to apply to and was hired by the same hospital that diagnosed Nana. I knew it was going to be a major lifestyle transformation as it relates to finances and experience, especially since I was starting out at the entry level. But I was compelled by the opportunity to investigate my Nana's full experience by diving fully into what was her world. My first day on the job was horrendous. The work was physically challenging, and the emotional toll from navigating peer personalities to working with vulnerable patients made me question if I could continue. And at what was most definitely the proverbial fork in the road, when I had to decide on what type of human I wanted to become, I received a call offering me a job that would put my life in a much more comfortable position that paid more money and was more prestigious. Instinctively, I wanted to accept the offer, but instead I chose to remain at the hospital and learn from the grassroots experience. I knew that I needed to enrich my own limited understanding with the experience that can only come from true immersion.

During my time at the hospital, I was humbled with the privilege of caring for other Nanas. I also had an opportunity to finally set foot in room 329. Whether empty or occupied, that room became my fueling station. It made me view each patient engagement as though I was taking care of my Nana. I observed everything and asked many questions from a variety of perspectives—the patients, families, and medical providers. Most importantly I developed my ear for the patients with whom I was honored to engage. Each personal contact was a master class in how to present information while supporting their dignity as I participated in routine and critical care transport, in and out of hospitals, dialysis centers, nursing homes, etc.

My time at the hospital affirmed that I could use all my skill sets as an advocate, an educator, and a creative to amplify the voices of those who find themselves in the shadows and muted. With this realization, I decided to focus on public health and to attend a global virtual program. I graduated in 2018 with my masters from Milken Institute School of Public Health at GWU. My thesis further developed Project Nana, now a 501c3 non-profit, into an evidence-based intervention organization with the goals of overcoming communication, cultural, economic, and educational barriers to improve health outcomes, the healthcare experiences, and quality of lives of seasoned women, in honor of my Nana.

Rationale

During a woman's life span, critical biological set points are a major focus of concern that necessitate attention and further research. According to the Mayo Clinic, due to

the specific biological composition of a woman, the stages of her life are based on the reproductive season and are marked by hormonal changes. These stages include the menarche, the line of demarcation indicating the onset of puberty and the ability to procreate. Women are able and choose to may experience pregnancy. And the menopause occurs once the menses have ceased and continue beyond. Through further exploration, we will decipher the transformations that occur in a woman's body, and the medical needs required to support optimum health during the pivotal points of her life cycle to assist her in living life to the fullest (Mayo, 2019).

Heralded by the onset of her menstrual cycle, puberty is the first set point. Aside from one's mother, the gynecologist is the guide and teacher of the newly initiated. It is at that point that we pay close attention to the woman's body making sure that she strives for optimum health in preparation for the time and season of childbirth. Pregnancy is the second set point. The woman ensures that her body, mind, and spirit is in optimum condition by eating proper foods, engaging in exercise and healthy activities, and, if necessary, taking interventions in the form of fertility medicines. The gynecologist becomes a mainstay, during this period, and at times, becomes the primary care physician for the woman. The period when the menses cease or the initial menopausal years is the third set point. It is during this time when the woman's body goes through additional hormonal transformations. The gynecologist provides welcome relief to the hot flashes and mental and emotional misery that typically come when females go through "the change." But what happens to the body, mind, and spirit in postmenopausal period?—and—What role does the gynecologist have in the life of an older, seasoned woman?

Research has shown that women typically outlive men. According to the Population Reference Bureau, "the population of seniors who are 65 years or older will increase to almost 100 million by 2060 and will comprise 24% of the total population" (Mather, 2016). Although the gender gap is narrowing, women, since they statistically outlive men, will make up the majority of the older population (Mather, 2016). Project Nana is proactive in its vision toward the future of women's healthcare; the protocol for disease prevention for women should include gynecological care to complement optimum health screenings and improve health outcomes and quality of life. According to the Global Library of Women's Health, primary care physicians, with the focus on volume-based care, may not be addressing vital concerns relating to gynecological care. For example, 14% of women between the ages of 65 and 74 years and 39% of those older than 75 have never had a Papanicolaou (Pap) smear (Utian & Sultana, 2008). The Pap smear is critical in the early detection of cervical cancer. Primary care physicians (PCPs), in particular those not focused on women's health, tend not to perform critical pelvic exams, palpations of the vaginal cavity, abdomen, and in some cases, breasts, which are necessary to detect physiological irregularities that may be early indications of disease potential. PCPs may not ask the pertinent "basement issue" questions and/or investigate issues such as the level of or quality of sexual activity, the existence of mild incontinence, postmenopausal vaginal discharge, and pelvic pain or fullness, the latter which may be an indicator of a serious issue such as ovarian cancer (ACOG, 2017). In addition to not seeing the gynecologist, the other concern is the "official" recommended frequency of the

gynecological visit. According to the United States Preventative Services Task Force (USPST), it is no longer recommended for women over 65 years of age to have a Pap smear (USPST, 2018). This recommendation, or lack thereof, compelled the American College of Obstetricians and Gynecologists (ACOG) to release a statement reiterating the need for women to have an annual well-woman exam to include pelvic examinations, routine screenings for cancers or sexually transmitted diseases, and counseling by a gynecologist (ACOG, 2017).

Additionally, blatant health disparities persist between women of color and non-women of color from childbearing age to beyond postmenopause. According to a January 2017 Johns Hopkins report, black women and women over 65 years of age continue to exhibit health disparities. For example, when corrected for hysterectomies, the rates of mortality for cervical cancer for black women were 10.1 per 100,000 per year compared to 3.2 per 100,000 per year for white women. Older women are dying at higher rates than women younger than 65 years of age due to lack of screening (Johns Hopkins Bloomberg School of Public Health, 2017). There are also regional differences with the South having the highest incidence (8.5 per 100,000 persons) and mortality rates (2.7 per 100,000 persons) of any region of the US (Yoo et al., 2017). Black women are also at an increased risk for sexually transmitted diseases. According to the CDC, in 2018, the overall rate of reported chlamydia cases among blacks in the US was 1192.5 cases per 100,000 population and 392.6 cases per 100,000 population for Hispanic women or five times the rate and 1.9 times the rate of white women, respectively. "During 2014–2018, rates of reported cases of primary and secondary syphilis increased for all race/Hispanic ethnicity groups," (CDC, 2019). Thus, an older woman of color is at an increased disadvantage when it comes to health and well-being (Tang et al., 2011), especially as it relates to gynecological, women's health outcomes.

Community Analysis

Since the intervention was the response to a personal call to action, Project Nana started its first chapter and activities focused on Hampton Roads, Virginia, which is located in the southeast region of the state. It is comprised of seven cities: Portsmouth, Virginia Beach, Hampton, Norfolk, Newport News, Suffolk, and Chesapeake. According to the 2010 Census, the region is diverse with total population of 1.67 million people consisting of 59.6% white, 31.3% black, and 5.4% Hispanic. It has more females than males at a rate of 51–49%. A total of 22.7% of the population are 55 years of age and older (City of Norfolk, 2014).

In a first-time analysis spearheaded by the Virginia Healthcare Foundation, the Virginia Hospital and Healthcare Association published its community health assessment from all its hospital membership. Of particular interest, three of the hospitals serving the Hampton Roads region, Sentara Careplex Hospital (SCH), Sentara Norfolk General (SNG), and Sentara Virginia Beach General Hospital (SVBH) noted service gaps in aging/geriatric services, maternal health, and an exponential increase

in the senior population from 2012 through 2017, respectively (VHHA, 2016). Six years later, the gaps still exist. According to the 2019 Sentara Health Community Assessment, women's health, access, and prevention were three areas identified in the Hampton Roads regional survey that respondents noted needed strengthening and further surveillance (Sentara, 2019). The limited focus and resources devoted to healthcare disparities for women and aging services and the healthcare gaps related to access and preventative health care continues to fortify barriers against engagement about and improved health outcomes for postmenopausal health for services.

Historically, there has been a modicum of personal biased, at best, who has permeated health care as it relates to the intersection of women's health and aging. In his 1969 best-selling book, *Everything You Always Wanted to Know About Sex, But Were Afraid to Ask*, psychiatrist Dr. David Reuben declared that,

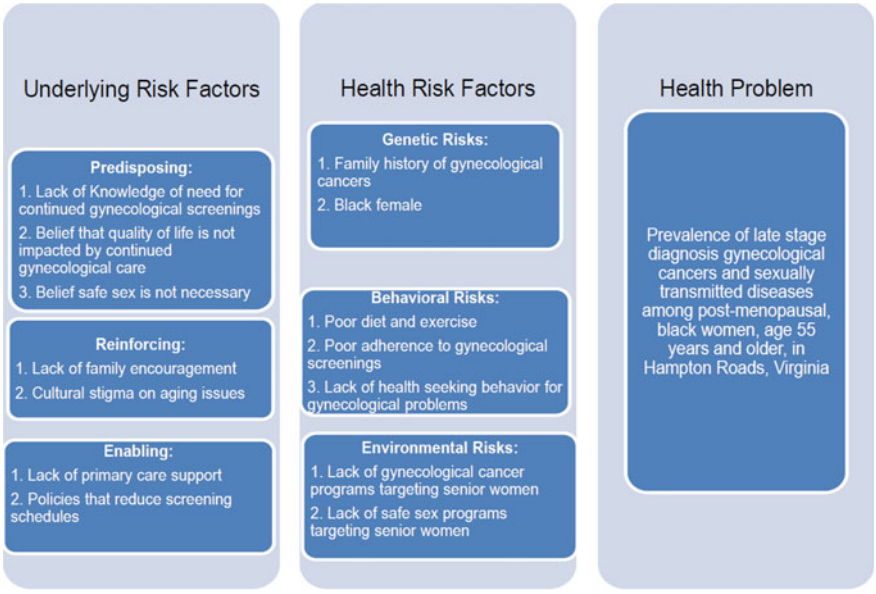
> as estrogen is shut off, a woman comes as close as she can to being a man. Increased facial hair, deepened voice, obesity, and the decline of breasts and female genitalia all contribute to a masculine appearance. Coarsened features, enlargement of the clitoris, and gradual baldness complete the picture. Not really a man, but no longer a functional woman, these individuals live in a world of intersex…sex no longer interests them. To many women the menopause marks the end of old age, the beginning of the end. They may be right. Having outlived their ovaries, they may have outlived their usefulness as human beings. The remaining years may be just marking time until they follow their glands into oblivion. (Reuben, 1969)

This book was adapted to film, by Woody Allen and released in 2000. We are not stating that these views are pervasive in healthcare. However, with the added use of mass media, these views have the potential to inform and impact implicit bias.

Several other barriers have been identified by our stakeholders (see Table 17.1). One barrier is patient experience and communication with primary care providers. Primary care providers are the gatekeepers, the central figures in ongoing healthcare. Their role in women's health should be to encourage continued gynecological screenings and address initial gynecological concerns for their patients who are in the target audience. However, due to perceived potential time constraints designated by health insurance mandates and a volume-based care modality, important discussions on postmenopausal women's health are not being addressed. Of the many discussions not tackled in the primary care setting, none have been mentioned more in the initial community interviews, than a need for clarifications of terms.

When faced with a deluge of mass media commercials regarding the latest recommendations for HPV and cervical screenings, there has been confusion between Pap smears and pelvic exams. While recommendations have changed in recent years regarding the screening intervals for Pap Smears, the need for annual pelvic exams have not changed. However, anecdotally noted, there is common confusion on the differences between the two. It is correct that if a woman no longer has a cervix through hysterectomy, or is over the age of 65, she no longer needs to have Pap smears, the standard screening for cervical cancer (USPST, 2018). However, pelvic exams, which are not just about Pap smears, but also include external visual observations, internal palpation of the pelvic cavity, and a general physical exam should occur annually and especially if there are any unexplained symptoms, such as postmenopausal bleeding, pain, and/or abdominal bloating (Mayo, 2019). Providers and

Table 17.1 Identifies the environmental and behavioral risk factors that may contribute to the late-stage gynecological cancer and STI diagnosis among postmenopausal, black women, age 55 years and older, in Hampton Roads, Virginia



patients alike need to be educated and made aware of the distinction between and importance of the two.

Additionally, some primary care physicians may opt to perform screenings rather than send patients to the gynecologist. As noted by gynecological oncologist Stacey Rogers, M.D., at times this lack or late referral could prove detrimental as some early warning signs may be missed and diagnosis may not be provided until late stage of the disease (S. Rogers, personal communication, February 15, 2018). Another barrier is the perception by some among the target audience that it is cost prohibitive to go the gynecologist since it is a specialist. According to gynecologist Keisha Burfoot, M.D., a common misperception is that insurance does not pay for gynecological care. However, every two years Medicare pays for a well-woman visit, and if there are any noted issues, it will also pay for gynecological visits. Even if a person has a physical exam at a primary care facility, as long as they decline the well-woman portion and have the primary care physician note that the patient intends to go the gynecologist, Medicare will also cover that visit (K. Burfoot, personal communication, January, 19, 2018).

Solutions to Meet the Needs

The chart below (Table 17.2) identifies environmental and behavioral risk factors which impact postmenopausal seasoned women when it comes to continued gynecological care. The societal, individual, more changeable, and less changeable categorization describes those factors that are easier to change via an intervention. The absence of the other previously identified factors does not negate their importance.

In order to increase knowledge of the benefits associated with continuing gynecological care and screenings, Project Nana presents education workshops targeting program participants. Initially, the educational workshops were only targeted to the research group of black women. However, after research and discussions with providers, advocates, and women within the community, it was decided that the workshops would be presented to all postmenopausal women, 55 years and older in Hampton Roads, Virginia. The gathered data would still look at the ethnic disparities in access, awareness, and care.

The various workshop topics are presented by a diverse group of healthcare providers and community advocates. Specifically, collaborative partnerships include Sentara Healthcare through their physicians and community cancer navigator program; local gynecological practices, pelvic floor physical therapists, Old Dominion University's School of Nursing, and the Lesbian, Gay, Trans, and Bisexual (LGTB) Life Center. Having presenters that represent various ethnicities, genders, ages, and sexual orientations ensures that the participants will be more engaged if they see someone with whom they can relate and perceive represents them. Workshops are presented in a creative way using a mix of interactive drama vignettes and monologs (what Project Nana refers to as Nanalogs) in order to reinforce information presented. Psychodramas are successfully used in depression interventions for their ability to allow participants to address issues in a creative way (Ahmet & Zeynep, 2016). Vignettes depicting a variety of situations that necessitate a gynecological screening are performed by actors, participants, and workshop leaders. This process of providing information in a way that will be easily understood and recognizable is known as knowledge, translation, and exchange (KTE) which has been shown to improve the comprehension and retention of health information (Ellen et al., 2017). The following sample Nanalog is presented to introduce the lecture topic clearly:

> Seasoned. What is seasoned? If it means my mind, my body and my heart marinating and maturating in a variety of experiences-some great, some not so bad, some challenging, then I guess I'm seasoned. Less sugar, more spice, but everything is nice.

Table 17.2 Identifies the changeability importance matrix for proposed solutions

	Individual	Societal
More changeable	Lack of knowledge of need for continued gynecological screenings	Lack of family/social encouragement
Less changeable	Lack of primary care support	Cultural stigma on aging issues

> Heck I'm getting all the mail and advertisements of a seasoned women. I got the AARP magazine. I got mail from the Alzheimer's Association, Social Security. Heck I even got something from Medicare. That made me feel over seasoned cause it is confusing. You got to know about Part A, Part B, Part C, Part D. One is for the hospital. One is for prescription drugs. One is for going to the regular doctor. One gives you an advantage, for what I do not know. I hope there's no E, F or G, cause I'm clueless.
>
> I see the commercials to make sure I get the pneumococcal and the flu shot. I got a checklist going. I see more commercials than enough about erectile disfunction and its saviors Cialis and Viagra. And let's be honest you know a man created that and made those over the top commercials that aren't true. You got a woman half my age, immediately turned on by a man twice my age and he acts all goofy and sweating. Viagra? The men I know see a woman like that they going to pass out before they even swallow that damn pill. They better hope she can do CPR. That's the only woman that's going to feel on that old man…a nurse.
>
> But what about women? The seasoned women like me? I'm over 55. I eat healthy. I go to my yoga class. I go to Zumba class. I even lift weights. I hike. I'm down for adventures. All adventures. You know a mission trip. I go to doctors and see all professionals like I'm supposed to. My internist, my dentist, my dermatologist. It's been a while, but I finally decided to go back to the gynecologist. You know to check things out, to make sure things are still working and haven't dried up too bad. You know in case I take some "mission" trips and don't accidentally bring back souvenirs. Thank God I can't get pregnant anymore. I tried calling a couple of doctors, but they said I need to go back to my primary because either I needed a referral, or they just flat out refused to see me because I had Medicare. That's the other alphabet, N for no. What am I supposed to do? I need to go to the type of doctor who can talk to me about my body, a woman's body. There's a difference you know. The primary care sees everyone but rushes me and never takes time to talk with me about my needs and specific experiences with an aging body. I need a specialist who really understands. After all I am special. Hey maybe I'll be heard if I make a commercial like the men do. Imagine with me you are driving a Bentley, a Mercedes, AN expensive car? And you have some maintenance issues to take care of. You have a choice to drive up to the specialist, or since we are using car references, the "dealer." OR you can get a 15 minute, in and out, checkup and oil change from the Jiffy Lube? Where would you take your most valuable possession? – © 2019 Vanessa LaTanya Hill

Another part of the intervention calls for increasing general and familial awareness of the need for gynecological care in postmenopausal women. The main way this occurs is through outreach and a social marketing campaign. Using a combination of printed material and audio/visual media, information is distributed through physicians' practices, faith-based and community organizations, as well as through commercials and public service announcements and in local print media (see Fig. 17.1). In addition to online media, specifically Facebook and Instagram, mass media, known as an effective compendium to program interventions, is used an advocacy approach, creating awareness for some and reinforcing information for others (Tabassum et al., 2018). Involving a more aware family and social network supports the participant in overcoming barriers.

Postmenopausal women are not always encouraged to utilize gynecologists for screenings as illustrated in the previous Nanalog. At times, primary care physicians include gynecological exams in routine physicals and well-woman exams. According to gynecological oncologist Stacey Rogers, M.D., although there are primary care physicians who are comprehensive when conducting exams on postmenopausal women, with increasing time constraints placed on primary care appointments, some

Fig. 17.1 Project Nana brochure, 2018

may not address gynecological concerns in routine exams; concentrating on seemingly more important issues such as hypertension, elevated cholesterol, and other cardiovascular issues. However, the primary care physician can be the entry point for some gynecological issues and need to know when to refer their patients to the gynecologist (S. Rogers, personal communication, 2/15/2018). Project Nana has engaged the Women's Health Nurse practitioner program at Old Dominion University to encourage nurse practitioners and other nurses to participate in the peer support advocate training in order to support and women who may not initially go to the gynecologists. The KTE method is also frequently used to increase the support of primary care providers and reinforcing the collaborative partnership necessary to provide the optimal treatment for their postmenopausal patients. KTE has been successfully utilized by providers in order to reinforce information and promote awareness and understanding on issues specific to marginalized populations (Tarasoff et al., 2014). Thus, this method is also used during the lunch and learns when presenting the program and communication techniques to physicians. Peer Support Advocates along with provider volunteers conduct training sessions with providers on how to better engage with patients. The addition of the communications training to physicians provides another opportunity to disseminate health information to reach a larger audience beyond the workshops.

The other less changeable, societal factors of the program has to do with changing cultural stigma on aging issues pertaining to postmenopausal women. Most have difficulty seeing seniors as sexual beings or engaging in sexual activity. In a study where students were asked to draw images of seniors, students overwhelming depicted the elders as genderless from a perception that seniors do not think about or engage in sexual activity (Barrett & Cantwell, 2007). This cultural stigma, though improving slightly over time, has historically been pervasive. The resulting exclusion of seniors in the safe sex discussions may lead to limited sexual healthcare (Syme & Cohn, 2016). According to the CDC, people 50 years and older are more likely than younger people to have a late-stage diagnosis of HIV. Specifically, in 2014, 40% of those people 55 years and older already had AIDS when the HIV infection was diagnosed (Center for Disease Control and Prevention, 2018). The following Nanalogs address this topic head-on as a lead in to the presentation by the LGTB Life Center:

> I did everything I was supposed to do. Ladies I'm sure you understand. At a certain time in our lives we reassess who we are, what we really want, and what we are willing to take.
>
> I've been married before and quite honestly, I didn't think I would marry again. But one day when I was at a church conference, I met a man. Of course, I didn't go with the intent of meeting a man. I'm there for a whole different reason. But this man…he was fine as wine. He came up to me and started a conversation. We talked about our jobs, our missions, travel…I mean he was interesting. He was really cool and funny. He didn't live far from me, so after the conference we kept in touch. He did everything right. Everything that I had been praying for he was. And honestly, I had already done the work on myself and was ready to be the woman, the friend, the wife. I did everything right.
>
> We got married after a year of courtship. And we consummated our relationship after the vows. And can I tell you, he didn't change. Everything he did to get me, he was doing to keep me. I didn't want for anything. He was caring not only to me but to my children, my parents, my family. He treated them as if they were his own. He didn't grow up with his

family. As a matter of fact, he had a rough childhood. So what he had always longed for he found in me and my family. We were very happy.

After about 3 years of marriage, a happy marriage, my husband got sick. It started as a flu that he could not get rid of. It wouldn't go away. I finally convinced him to go to the doctor – I don't know the last time he went. What is it with men and doctors? I would not take no for an answer so I took him myself, to my doctor.

After the exam and some tests, my doctor came in with a very stone face. There was a shift in the atmosphere. I knew something wasn't right. My husband took one look at the doctor and put his head down. The doctor just stared at him for a minute and then asked if I could give him some time alone to speak with my husband. My husband took my hand, never looking at me in my face and told the doctor that I was staying in the room.

The doctor revealed that my husband had AIDS. My husband did not look shocked. It was then that I found out my husband had been an IV drug user when he was younger. He was strong enough to get clean, turn his life around and give so much in the community. He wanted to forget all his mistakes of the past, so he decided to forget to remember that he should have told me this. He never had an HIV test.

I went through all the emotions. Anger, sadness, more anger. I prayed for what I should do. This man who devoted his time to the family, to the community, to his church. I realized that this man who was so good to me needed me. I did everything I right. Now I am a widow. A successful businesswoman. I serve my church and community. And I am HIV positive. – © 2019 Vanessa LaTanya Hill

Planning Procedures

Developing the Project Nana intervention has been a nine-year endeavor. Contacts were made to the National Institutes of Health's National Institute on Aging, American Association of Retired Persons (AARP), and Cleveland Clinic. Though formal letters of request for meetings and/or information was sent numerous times, concrete discussions did not happen right away. It was necessary to modify the communications strategy by focusing on local stakeholders. Productive meetings were held with local gynecology practices, the Virginia Oncology Association, local departments of health, aging advocates, and Sentara Women's Health Center at Sentara Virginia Beach General Hospital. These meetings resulted in vital background information and the development of key partnerships among community stakeholders. The main consensus was that research and data on postmenopausal women were limited, at best. There was general support to assist in the program intervention and to participate in the recruitment and research component.

Background research for evidence-based community education programs was conducted through reviews of Web searches using the key words women's health, gynecological oncology and sexually transmitted infections, links and other resources found at the Foundation for Women's Cancer Foundation Web site, and interviews with local gynecologists, gynecological oncologists, women's cancer advocates, and women's health advocates. The goal was to assess programs that were easily replicated in other locations, easy for the target demographic to understand, did not require too many resources to implement, and, most importantly, were deemed successful

in their respective goals to educate the constituency with information that could lead to behavior change. Three best-practice programs were chosen as models for the intervention.

The first program that was examined was the Alzheimer's Association's Peer-to-Peer Outreach program. This program pairs those living with early stage Alzheimer's and those who are newly diagnosed. Peer counselors share their experiences and encourage compliance with medications and other medical interventions. Assessment of the program shows that it has improved attitudes and created a support network for the patient and family (Alzheimer's Association, 2017). Another program is the Mammography Promotion and Facilitated Appointments Through Community-based Influenza Clinics. This program used a compressed time period to encourage the target audience to get a flu shot. While at the flu clinic, health educators took the opportunity to discuss breast cancer screenings and to make appointments for participants. The intervention has increased breast screenings among the target audience, even in the compressed, seasonal period of the intervention (Shenson et al., 2001). The other evidence-based program is the Peer Navigator Breast Cancer Screening Program for Korean-American Women. This is an education-based intervention designed to increase the amount of mammography and cervical cancer screenings. The program used faith-based organizations as the locations to hold the education workshops. The result was an 18% increase in the number of breast cancer screenings and over 13% increase in having both tests (Hae-Ra et al., 2017).

Theoretical Approach

The Project Nana intervention was influenced by two theories, the Theory of Planned Behavior and the Social Cognitive Theory, that have a collaborative effect on the intervention, including the social marketing campaign and social interactions, in order to change the target audience's behavior.

Theory of Planned Behavior

In 1985, Icek Ajzen developed the Theory of Planned Behavior based on his previous work, the Theory of Reasoned Action, which he developed along with his colleague Martin Fishbein. Theory of Planned Behavior takes the basic premise of TRA which is to explain the relationship between attitude and behavior, and further estimates the influence of perceived control in order to determine behavioral intention (Ajzen, 1991).

As the original conceptual framework, Theory of Reasoned Action posits that the best predictor of behavior is a person's intention to perform the behavior. The intention is not only influenced by a person's attitude toward the behavior, but also by a person's subjective norm, which is the perceived acceptable behavior (Ajzen, 1991).

In this framework, there is a strong correlation between attitude and belief. Thus, if there is a strong belief in a positive behavioral outcome, then there is positive attitude with regards to that behavior. Likewise, subjective norms are heavily influenced by the belief of acceptability of the behavior by those whom a person may seek to appease. Thus, if others approve of the behavior, then a person may hold a positive subjective norm toward the behavior (Glanz et al., 2008).

The inclusion of perceived control to the original framework is the differentiator that is the cornerstone for Theory of Planned Behavior. A person's perception of control can either facilitate or inhibit the ability to perform a behavior. Thus, a lack of agency can impede the intention to perform the behavior (Glanz et al., 2008).

The Theory of Planned Behavior has been used in various public health campaigns designed to predict and explain behaviors and intentions toward such interventions as smoking campaigns, promotion of breastfeeding, and the utilization of health services (Glanz et al., 2008). In 2017, the American Journal of Health Behavior published a study on the utilization of Theory of Planned Behavior in HIV testing intention. Previous studies on HIV prevention in sub-Saharan Africa focused on using this theory to address the intention to modify sexual behaviors. Evaluating prevention interventions from the standpoint of motivations to get tested for HIV, Ayodele used Theory of Planned Behavior in order to determine the intentions of a group of Nigerian college students with respect to HIV testing. Ayodele concluded that Theory of Planned Behavior was indeed effective in predicting HIV testing and prevention intentions (Ayodele, 2017).

Social Cognitive Theory

Originally known as the Social Learning Theory, Social Cognitive Theory posits that individuals learn and adapt behavior by observing the consequences of the behavior of others. Developed by Albert Bandura in 1986, Social Cognitive Theory integrates constructs from sociology, political science, and psychology to provide a comprehensive conceptual framework for how people learn from social experiences (Glanz et al., 2008). Social Cognitive Theory explores how people form and maintain behaviors through the lens of past experiences and the social environment. It introduces the concept of reciprocal confluence and interaction between behavior, the environment, and the individual (Glanz et al., 2008). Some key constructs of the Social Cognitive Theory include: reciprocal determinism (a change in either environmental factors or individual cognition or behavior affects the others); self-regulation (controlling oneself through self-monitoring and social support); observational learning (learning by viewing the rewards and consequences received by others as they perform a behavior); and self-efficacy (a person's ability to perform a specific behavior) (Glanz et al., 2008).

Social Cognitive Theory has been used to employ culturally specific interventions. In 2017, the American Journal of Health Behavior published a study titled the Utility of Social Cognitive Theory in Intervention Design for Promoting Physical Activity

among African American Women: A Qualitative Study. In the study, the authors used focus groups to examine how Social Cognitive Theory could be employed to develop an intervention. Focusing on the specific concepts of behavioral capability, outcome expectations, self-efficacy, self-regulation, and social support, the study found that Social Cognitive Theory was indeed effective in elucidating findings to develop a comprehensive intervention design (Joseph et al., 2017).

Intervention Design

Project Nana is a 10-year program, targeting 1000 senior women of color for a total of ten, 12-week intervention cohorts. For each year of the intervention, a cohort of 100 women will participate in the five-phase intervention (see Table 17.3) to be delivered over an implementation time of 12-weeks. The initial year of the intervention began with a pilot study July 1, 2018, and September 30, 2018, in Hampton Roads, Virginia.

The first education workshop for the pilot occurred at Sentara Virginia Beach General Hospital (see Fig. 17.2). The presenters included gynecologists, primary care providers, and community advocates who volunteered their time. Volunteer outreach coordinators recruited participants who were chosen as a result of indicating that it had been over two years since a gynecological exam occurred on the eligibility survey. This survey was conducted at local churches, senior living facilities, medical offices, and at community events.

Project Nana is divided into five phases:

Phase One: Education Intervention

In the first four weeks of the program, participants participated in an interactive education workshop. Using a combination of lecture style and interactive vignettes, participants were exposed to information about gynecological care and the need to continue well-women screenings. They also learned about the role of the primary care physician in their gynecological care and how gynecologists and primary care physicians work together. Participants were educated about risk factors, symptoms, and prevalence rates for gynecological cancers with an emphasis on ovarian, cervical, and uterine cancers. Participants also learned about issues related to sex including successful interventions to maintaining sexual activity and risk factors, symptoms, treatments, and prevalence rates for sexually transmitted infections with an emphasis on HIV and syphilis.

The plan was to have program clinicians to conduct lunch and learns with community women's health and primary care providers. Studies have linked the coaching of the use of checklists in patient examinations to the increase in quality of communication and information gathered. The result was improved patient satisfaction, knowledge, and health outcomes (Ferguson, 2012). The lunch and learn sessions are designed to teach better communication with patients and to examine the goals of the intervention, and to provide education on gynecological health considerations of postmenopausal women. In a study found in the American Cancer Society Journal,

Table 17.3 Project Nana intervention design

Intervention phase	Corresponding objective	Corresponding theory
Phase one: Education Intervention—Training for program participants, lunch and learns for physicians	Increase knowledge of the benefits of gynecological care for postmenopausal, black women, age 55 years and older, in Hampton Roads, Virginia, by 60% within 3 months from the start of the intervention	Theory of Planned Behavior
Phase two: Social Marketing Campaign—via Facebook, print, radio, television, Web site, dissemination of information of the health issue and the event	Reduce perceive barriers to seeking gynecological care for postmenopausal, black women, age 55 years and older, in Hampton Roads, Virginia, by 40% within 3 months from the start of the intervention	Theory of Planned Behavior
Phase three: Training Senior Community Workers—Senior women from the target audience who are active patients of a gynecologist	Increase self-efficacy to seek gynecological care among postmenopausal, black women, age 55 years and older in Hampton Roads, Virginia, by 20% over 2 years	Social Cognitive Theory
Phase four: Peer-to-Peer Engagement—Senior community workers follow up with participants to schedule GYN visits	Increase self-efficacy to seek gynecological care among postmenopausal, black women, age 55 years and older in Hampton Roads, Virginia, by 20% over 2 years. (Participants will support efforts to provide information on current gynecological issues such as risk of STIs, cancers, and need for routine pelvic exams by a gynecological care team to their peer groups.)	Social Cognitive Theory
Phase five: Take Your Nana to the Doctor Day—Program participants receive well-woman exams from participating gynecologists and their designees (PA's, NP's)	Increase the utilization of gynecologists for annual screenings among postmenopausal, black women, age 55 years and older in Hampton Roads, Virginia, by 20% over 2 years	Social Cognitive Theory

researchers found that communication training improves therapeutic humility, assists providers in compassionately engaging a patient, and the perception of authentic, active listening impacts the patient experience, reduces patient distress, and ultimately improves the quality of medical care (Chochinov, 2013). Therefore, the goal of provider engagement is to create a safe space for discussion on sexual activity and gynecological issues the patient may be having but historically not disclosed and

Fig. 17.2 Project Nana workshop

to have providers consider and promote routine annual gynecological exams with gynecologists with the target audience among their patient population.

Phase Two: Social Marketing Campaign

Upon completion of phase one, a six-week social marketing campaign consisting of print materials and social media was launched. The social marketing campaign served two purposes—to educate the community about the need for senior women to continue gynecological screenings and to direct people to participate in Take Your Nana to the Doctor activities. Print materials were distributed in the form of brochures and fliers to faith-based organizations, senior centers, aging advocacy agencies, and physician practices (see Fig. 17.3). Brochures and fliers provided information on Take Your Nana to the Doctor and directed readers to the Web site and social media sites for contact information on participating medical practices and additional resources.

Phase Three: Training Peer Support Advocates

Outreach coordinators recruited women from the target audience to participate in training to become Peer Support Advocates (PSA), or essentially, community outreach workers. In a study analyzing the effectiveness of peer coaching on physical activity of breast cancer patients, the authors found that peer-led interventions have the potential to positively impact health behaviors (Pinto et al., 2015). In the Project Nana intervention, women from the target audience who are active patients of a gynecologist and consistently receive well-women visits were invited to be trained. Thus, they had more of an impact in persuading their peers to schedule gynecological exams and to provide ongoing resource support for information such as insurance, available providers, transportation, etc. Over the course of a weekend, participants

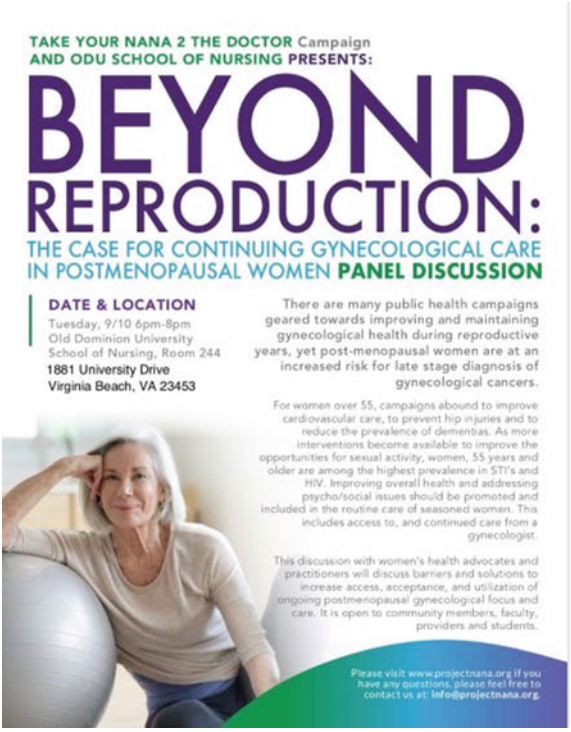


Fig. 17.3 Take Your Nana to the Doctor campaign flier

were educated on specific gynecological issues, how to engage others, and how to overcome objections.

Phase Four: Peer-to-Peer Engagement

The Peer Support Advocates are key in following up with the participants from the phase one education workshops in order to reinforce the education received and to get them to commit to schedule appointments with designated gynecologists during the Take Your Nana to the Doctor week. They conduct home visits and make phone calls to participants. The aim is to give the participants a sense of accountability to following through on scheduling medical appointments. A similar approach was applied to an outreach program to target and treat psychiatric illness in seniors. The study published in the Journal of the American Medical Association found that when using a model of care including trained community peers who conduct home visits and encounter patients on a daily basis as part of a treatment team to locate and speak with the target audience, there was a decrease in the levels of symptoms among psychiatric patients who lived in high risk neighborhood settings (Rabins, 2000). PSAs also provide initial engagement to any organization or group who may want additional information regarding senior women's health and Take Your Nana to the Doctor week.

Phase Five: Take Your Nana to the Doctor Week

This is a weeklong event where participants go to medical appointments for screening by participating gynecologists. Gynecologists use the step-by-step questionnaire and guide in order to acquire necessary medical and social history and to engage participants in conversations in more sensitive topics such as sexual activity/history. Gynecologists perform a well-woman visit, including pelvic examinations and any other physical exams that are deemed necessary.

Although the original intervention included a five-phase education and engagement intervention to be offered within a 12-week timeframe, due to scheduling issues and time constraints, the initial pilot consisted mainly of conducting surveys and presenting the education workshops. The Take Your Nana to the Doctor campaign was impacted due to hurricane and subsequent evacuations in the region. However, partnering physicians did note that some participants from the workshops did follow up and become patients.

Additionally, it was determined that there should be programming to support the medical visits in order to continue to make the community aware of the issues associated with senior women. Thus, in 2019, panel discussions and small groups were added to the offerings (see Fig. 17.4). In association with the partnership with Sentara Healthcare and Old Dominion University School of Nursing, the following activities are scheduled for 2020: a co-educational prostate/gynecological cancer awareness program and football tailgating event; panel discussion; community dinner; and a health expo to include women's health screenings.

Fig. 17.4 Project Nana panel discussion

Evaluation Design

Evaluations occurred after the pilot phase and will continue throughout the intervention. Using survey instruments that measure pre-intervention attitudes, perceived norms, perception of agency, and knowledge, the intervention program applied a variety of engagement opportunities to influence more positive attitudes with regards to going to the gynecologist. Project Nana employed the Theory of Planned Behavior to predict whether or not postmenopausal women of color, who do not consistently go to a gynecologist for well-woman visits, will schedule a gynecological exam as a result of the intervention. Participating in a cohort of women of similar demographics and psychographics, the program created new subjective norms that encouraged gynecological visits. The education workshop provided the opportunity to overcome perceived educational, cultural, and economic barriers to gynecological services.

Prior to the initial educational workshop, surveys were distributed to senior women participants to evaluate their attitudes about seeking gynecological care, a self-assessment of their knowledge of gynecological health, and their beliefs of the importance of gynecological health to their overall quality of life before they were introduced to the information. After the education workshop, participants were provided with a post-workshop survey with the same questions and included additional questions on their intent to participate in *Take Your Nana to the Doctor* week by scheduling a well-woman visit with participating gynecologists. The Social Cognitive Theory was applied to Project Nana throughout the intervention. Project Nana encouraged visits to the gynecologists by providing education on consequences and rewards and through testimonial accounts by postmenopausal women who either benefited from consistent gynecological visits and those who did not have gynecological screenings. Creating a cohort also allowed for social support among peers to have a sense of accountability to follow through on scheduling a gynecological visit by the end of the intervention.

In 2020, upon completion of the Take Your Nana to the Doctor Day week, a final survey is scheduled to determine how many of the participants scheduled and completed well-woman visits at the participating gynecologists. Focus groups divided between those participants who completed gynecological visits and those who did not are scheduled to further investigate the reasoning behind their respective decisions.

Method of Evaluation

The intervention is designed to increase the utilization of gynecological services in postmenopausal women, 55 years, and older. The program seeks to increase knowledge about the need for continued gynecological care and reduce barriers associated with attitudes and beliefs among the target audience. The evaluation should answer the following questions:

- *To what extent was there an increase in knowledge of the benefits of gynecological care for the target audience?*
- *To what extent was there a reduction in perceive barriers to seeking gynecological care for the target audience?*
- *To what extent was there an increase in positive attitudes toward seeking and continuing gynecological care for the target audience?*
- *To what extent was there an increase self-efficacy to seek gynecological care among target audience?*
- *To what extent was there an increase the utilization of gynecologists for annual screenings among target audience?*

The program intervention consists of a target audience who volunteer to participate in the program. There may be individuals who do not complete the entire intervention program. A new cohort will begin each year with cohort continuing to be monitored to evaluate program recommendations and adherence.

Results from Pilot Workshop

During the first education workshop in 2018, there was a total of 46 participants who answered preworkshop and post-workshop surveys. These participants attended as a result of the outreach to the faith community specifically. The 46 participants' knowledge about cancer items were summated at the pre- and post-workshop levels, and a paired samples *t*-test performed to determine whether knowledge of cancer levels increased after exposure to the workshop. A pair-wise deletion approach was used to remove missing values, such that comparisons were made based on participants that completed the survey pre- and post-intervention. The paired samples t-test was statistically significant, $t(31) = 6.57$, $p < 0.001$, indicating that there was a statistically significant difference in participants' knowledge at post-test compared to pretest. Specifically, participants' knowledge levels were higher after the workshop ($M = 206.72$, SD = 23.24) compared to before the workshop ($M = 178.31$, SD = 26.09). Specific sets of items were examined further to determine the areas in which knowledge increased from pre- to post-intervention. Questions related to cervical cancer were summated at the pre- and post-workshop levels to determine whether participants' knowledge of approaches to preventing cancer increased (see Table 17.4). A sample question asked the participant to indicate level of agreement for the following statement: For cervical cancer prevention, one has to be protected against sexually transmitted diseases. The paired samples t-test was not statistically significant, $t(31) = -0.41$, $p = 0.342$, indicating there was no statistically significant difference in participants' knowledge of how cancer can be prevented post-test compared to pretest. Therefore, participants' knowledge levels of prevention were similar before the workshop ($M = 12.69$, SD = 3.49) compared to after the workshop ($M = 12.34$, SD = 3.47).

Table 17.4 Results from initial pre- and post-workshop survey

Comments about the workshop							
	Strongly disagree	Disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Agree	Strongly agree
Prepared me to make informed decisions	0	1	0	0	0	8	21
	(0.00%)	(3.33%)	(0.00%)	(0.00%)	(0.00%)	(26.67%)	(70.00%)
Learned new information	0	0	0	1	0	8	21
	(0.00%)	(0.00%)	(0.00%)	(3.33%)	(0.00%)	(26.67%)	(70.00%)
Corrected about some information	0	2	0	2	1	10	15
	(0.00%)	(6.67%)	(0.00%)	(6.67%)	(3.33%)	(33.33%)	(50.00%)
Workshop was a valuable tool	0	0	0	0	0	6	24
	(0.00%)	(0.00%)	(0.00%)	(0.00%)	(0.00%)	(20.00%)	(80.00%)
Workshop changed my mind	0	2	0	5	1	7	14
	(0.00%)	(6.90%)	(0.00%)	(17.24%)	(3.49%)	(24.14%)	(48.29%)
Broader understanding of GYN impacts health	0	0	0	2	1	5	21
	(0.00%)	(0.00%)	(0.00%)	(6.90%)	(3.49%)	(17.24%)	(72.41%)
Broader understanding of GYN impacts quality of life	0	0	0	1	2	5	21
	(0.00%)	(0.00%)	(0.00%)	(3.49%)	(6.90%)	(17.24%)	(72.41%)
Adequate time for the information to be presented	0	0	4	0	1	8	16
	(0.00%)	(0.00%)	(13.79%)	(0.00%)	(3.49%)	(27.59%)	(55.17%)

However, questions related to risk factors of gynecological cancers were also summated at the pre- and post-workshop levels to determine whether participants' knowledge of cancer risks increased as a result of the workshop. Sample questions asked to the participant to indicate level of agreement for the following three statements:

1. *Being pregnant at an older age is risk factors for cancer of the uterus.*
2. *Getting pregnant three or more times starting at an early age is a risk factor for cervical cancer.*
3. *There are noticeable symptoms for ovarian cancer.*

The paired samples *t*-test was statistically significant, $t(31) = 4.82$, $p < 0.001$, indicating there was a statistically significant difference in participants' knowledge of cancer risks at the post-test level compared to the pretest level. Specifically, participants' knowledge of cancer risks increased after the workshop ($M = 85.34$, SD = 10.55) compared to before the workshop ($M = 75.44$, SD = 9.92).

Discussion

Project Nana is an innovative approach to increasing the lives of some of our most valuable resources in our community—our senior women. The pilot program compressed the schedule for the actual intervention. This provided mixed results. For those women who consistently get medical care, there were not too many barriers to convincing them to get a gynecological exam providing they attend the education workshops and have reinforcing support via their primary physicians, social networks, and the senior community interventionists. Conducting preworkshop surveys also allowed the participants to query the presenters regarding further discussion to items addressed in the survey.

Once the workshops were conducted and the participants encouraged to schedule medical visits, access became a major unanticipated barrier. Via frustrated phone calls and emails from program participants, it was revealed that in the Hampton Roads region of Virginia, there were few gynecologists who would accept Medicare or Medicaid as a form of insurance. This was an unexpected issue that arose for our patients for whom Medicare was the primary insurance and for our participants in the lower economic bracket who only had Sate sponsored insurance. Through off the record conversations with practice managers of the major gynecological practices in the area, it was revealed that the difference in reimbursement was the reason for this disparity. Thus, the participants who had private insurance had a wider selection of gynecological practices than those who did not have private insurance. Those who did not either asked for a suggestion for provider who accepted Medicare/Medicaid, opted to go to their primary care provider, or continued to not seek gynecological care.

The pilot phase also had a limited budget request. In order to increase donations and successful bids for funding, Project Nana must demonstrate success in increasing awareness and new patients to schedule visits. With an increase in budget, the opportunity to train more Peer Support Advocates and provide more workshops also increases. More community outreach workers enable the ability to train for a variety of community interventions that are under-resourced with regards to human capital. Additional training of PSAs will allow Project Nana to not only staff more workshops and conduct more outreach for gynecological awareness, it will also allow Project Nana to expand its scope and serve as a clearinghouse and pipeline to train advocates to engage in grassroots community organizing and outreach. Awareness and maintaining gynecological health may have a secondary outcome in decreasing comorbidities, which may in fact allow participants, who are now healthier to become

more productive by learning new tools as PSAs and becoming engaged in community activities. Organizations that need volunteers will have a trained group of people to assist.

Women who experience success in the program through early detection of a disease have been effective in proving that the intervention works. This means that there must be available gynecologists who provide good experiences for the senior women. First, the program must be able to recruit a substantial number of gynecologists who will open their schedules for this one-week campaign blitz. Excitement will increase by seeing groups of participants in medical practices simultaneously. An increase in patient acquisition will be a good outcome especially for those physicians who need to increase their patient panels. However, as mentioned earlier, the access to gynecology services for those with Medicare and Medicaid needs to be addressed. One solution that is integrated into the 2020 program is to provide more information to and about women's health nurse practitioners. This is an initiative in collaboration with Old Dominion University's School of Nursing.

Some religious organizations may be more conservative and may not be open to discuss gynecological health, let alone issues of sexuality pertaining to senior members of their congregations. However, given the opportunity to discuss these issues during the recruitment process, program representatives have been able to highlight the opportunity to improve overall health which may result in increased productivity within their houses of worship.

With proper buy-in by key stakeholders in the community, Project Nana does have potential for success. With suggestions and modifications that will come from the activities and study evaluations, the program can be improved to help ensure its ongoing sustainability.

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Chapter 18
The Status and Well-Being of Elderly Women Suffering from Dementia: Case Studies from Bengaluru

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Abstract Dementia, generally predominant among the elderly, is associated with the progressive degeneration in memory, thinking, and reduced ability to perform everyday activities. The impairment in cognitive function is commonly accompanied and occasionally preceded by deterioration in emotional control, social behavior, and motivation. As per the 2018 data, there are about 50 million people worldwide are living with dementia. The World Alzheimer's Report (2009) focuses on the global prevalence of dementia, its impact, and how it can be brought from recognition to action. Dementia patients were 35.6 million in 2010. The number will be doubling every 20 years, to 65.7 million in 2030 and 115.4 million in 2050. Of the people who have dementia worldwide, 58% live in low- and middle-income countries, which will rise to 71% by 2050. According to the Dementia India Report 2010, the prevalence of dementia is seen more among older women than older men. In India, the lack of a state-sponsored well-defined social support system has made family the central focus of care networks where women play the primary caregiver's role. However, changing family structure with increasing nuclearization, women's education, and subsequent professional career, the available expensive private institutional care has thrown many challenges before the critical care system and pushes women with dementia more vulnerable in terms of their need for care and their dependent status in a patriarchal societal setup. Thus, it is necessary for us to address the preventive measures and affordable home-based care for the well-being of women who have dementia. Following the Geronto-Feminist theoretical perspectives and ethnographic method, the present paper focuses on the burden of care and affordable home-based care for older women with dementia. The research includes participant observation, case study, and in-depth interview (IDI) of experts from various fields (e.g., yoga, psychiatrist, nutrition, and ayurveda) as tools to propose an affordable care model.

Keywords Elderly women · Dementia · Yoga · Nutrition · Ayurveda · Psychiatrist

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Introduction

The world population is gradually turning gray. The population aged 65 and above is growing faster than all other age groups. According to the World Population Prospects, the 2019 Revisions data shows that by 2050, one in six people in the world will be over age 65 (16%), up from one in eleven in 2019 (9%). By 2050, one in four persons living in Europe and Northern America could be aged 65 or over. In 2018, for the first time in history, persons aged 65 or above outnumbered children under five years of age globally (https://www.un.org). Since 1950, life expectancy has substantially increased in all regions due to breakthroughs in medical science and technology.

According to the State of World Population 2019 report by the United Nations Population Fund (UNFPA), India's population in 2019 stood at 1.36 billion, growing from 942.2 million in 1994. Six percent of India's population was of the age 65 and above.

India also recorded an improvement in life expectancy at birth, which was 47 years in 1969, growing to 60 years in 1994 and 69 years in 2019 (https://economictimes.indiatimes.com). As per the 2011 census, about 104 million elderly persons in India, 53 million are females, and 51 million are males (Government of India, 2016). For the last two decades, Indian females have outnumbered elderly males. This longer life span is leading to many other chronic illnesses, and one such is dementia.

Dementia is usually chronic, characterized by a progressive deterioration in intellect, including memory, learning, orientation, language, comprehension, and judgment due to disease of the brain. It mainly affects older people; in only about 2% of cases, the disease starts before the age of 65 years. It is also a degenerative disease and worsens with time (Shaji et al., 2010). The global prevalence of dementia as per the World Alzheimer's Report 2009 indicates that there were 35.6 million people with dementia by 2010. These numbers will double every 20 years, to 65.7 million in 2030 and 115.4 million in 2050. Almost 58% of dementia-affected people will be living in low- and middle-income countries, which will rise 71% by 2050. In the next 20 years, it forecasts 40% increase in the number in Europe, 63% in North America, 77% in Southern Latin America, and 89% in developed Asia Pacific Countries. There will be 117% growth in East Asia, 107% in South Asia, 134–146% in the rest of Latin America, and 125% in North Africa and the Middle East (World Alzheimer's Report 2009). Dementia is a formidable public health challenge for many reasons, including high global prevalence and the economic impact of dementia on families, caregivers, and communities: the social stigma and subsequent social exclusion associated with the disease increase the burden. Therefore, the global health community must recognize the need for action and place dementia on the public health charter for action (WHO, 2012; Mukherjee, 2018).

Undoubtedly, the vulnerabilities of dementia patients are high. Still, it magnifies with poor, older women dementia patients who are trebly vulnerable by their class position, age, and gender along with the disease. Financial dependency and the status of primary caregivers inside the home often make women more vulnerable, especially when they require intensive care. Developed countries have put affordable geriatric care under their social securities extended by the state. Nevertheless, India's evident absence of required social security measures for the elderly turns the field of senior care extremely challenging (Mukherjee, 2015, 2018).

Methodological and Theoretical Background of the Study

In this backdrop, the following study, by adopting the ethnographic method with the use of participant observation, case studies (20 dementia patients in home care and ten dementia patients in institutional care) and in-depth interviews (IDI) with experts try to assess the care burden of the disease and propose a non-clinical affordable care model for Indian dementia patients. The limitation of the study is its non-inclusive character in terms of the sample. In the absence of geriatric units in public hospitals, we had to depend on the private system to access patients diagnosed with dementia. Thus definitely, there is a class and urban bias in the sample. However, since we were aware of our limitations, we tried to overcome them in research.

In this study, we have tried to understand the core challenges posed by dementia through the "capability approach." When poor, marginalized women have dementia during old age, their dependence and subordination reach their nadir. They have been deprived of their full participation in society as they continue to be marginalized socially, economically, physically, and politically across the world. Martha Nussbaum, a capability theorist, has indicated that "unequal social and political circumstances give women unequal human capabilities" (Nussbaum, 2002: 1). Dementia is increasing the vulnerability of the lives of already vulnerable, like poor women (Mukherjee, 2018). A person's capability is the alternative opportunities available to her, the extent of her positive freedom. The valuation of her positive freedom is determined by her access to objective well-being based on the range of available options (Sen, 1993, p. 31). A person who has a disability may have a larger basket of primary goods and yet have fewer chances to lead an everyday life (or pursue her objectives) than a non-disabled person with a smaller basket of primary goods. Similarly, an older person or a person with dementia can be more disadvantaged in a generally accepted sense even with a larger bundle of primary goods (Sen, 1999: p. 74). Even if a person with a disability earns significantly, they might require an even more significant amount to accomplish the same functioning as other non-disabled people.

Gary L. Albrecht, Patrick J. Devliegerin's article "The disability paradox: high quality of life against all odds" (1999) defined the concept "**disability paradox"**. The disability paradox highlights the importance of personal experience with disability in defining the self, view of the world, social context, and social relationships. Our interpretation of quality of life in terms of balance shares many of the assumptions and findings of Antonovsky's salutogenic orientation and the closely related theory of the sense of coherence Antonovsky (1987). Based on Antonovsky's work, we can understand how some people with disabilities establish and maintain a deep understanding of well-being and manage stress well. In contrast, for others, disability presents an enormous problem. Usually, women who have dementia do not experience a high quality of life because:

- They do not have ordered and predictable worlds.
- They do not possess the knowledge, resources, and social contacts that provide the social adhesiveness necessary to reconstruct a balance and well-being in their lives.
- Their low quality of life is often related to impairments that produce fatigue, constant or unpredictable pain, and physical and social environments that discourage them from becoming empowered and acting as agents in their own lives.
- The sociological evidence suggests, then, that low quality of life for persons with dementia is based on the difficulty to manage impairments, lack of knowledge and resources, and disabling environments (Mukherjee, 2018).

Therefore, theoretical initiatives to understand the quality of life among women with dementia demand those intervention efforts designed to enable and empower individuals and propose to build on both the organic base of impairments and the social model of disability. This paper is an effort to propose non-clinical affordable social care perspectives of the disease.

Understanding Dementia

Dementia is described as a collection of symptoms, including the decline in memory, reasoning, communication skills, and a gradual loss of skills needed to carry out daily activities. The person with dementia also experiences changes in their mood or behavior and losses control of essential bodily functions. These symptoms are caused by structural and chemical changes in the brain due to physical diseases such as Alzheimer's disease. Like age, genetic background, medical history, and lifestyle, the factors can lead to dementia. Dementia is a progressive condition (http://ardsi.org). The changes are often small to start with, but the symptoms become more severe over time (https://www.alzheimers.org). Dementia is one of the significant causes of disability and dependency among older people worldwide, and it also

causes lots of stress and strain for their caregivers and families. It is the cumulative outcome of a lack of awareness, scant understanding of dementia as a disease, and barriers to access care and diagnosis. There are four major subtypes of dementia, and each subtype has its specific characteristics. The following are the subtypes of dementia (Shaji et al., 2010).

Alzheimer's Disease: Alzheimer's disease is the most common form of dementia. The symptoms occur when the brain is damaged. During the disease, proteins build up in the brain to form structures called plaques and tangles, leading to the loss of connections between nerve cells and eventually to the death of nerve cells and loss of brain tissue. It is due to the shortage of some brain chemicals in the brain (Shaji et al., 2010).

Vascular Dementia: It is the second most common type of dementia; it occurs when the blood flow reduces in the brain. Blood carries essential oxygen and nourishment to the brain. Without it, the brain cells can die. The network of blood vessels which carries blood around the body is called the vascular system. Stroke-related dementia takes place when there is the occurrence of a series of small strokes. It also includes dementia that occurs after the stroke is called post-stroke dementia (https://www.alzheimers.org.uk).

Dementia with Lewy Bodies (DLB): The proportion of Lewy bodies dementia is less than five percent. The early characteristic of Lewy bodies' dementia is marked by fluctuations in cognitive ability, visual hallucinations, and Parkinsonism (tremor and rigidity) (Shaji et al., 2010).

Frontotemporal Dementia (FTD): Frontotemporal dementia (FTD) refers to a group of diseases; the damages are seen in the brain's frontal or temporal lobes, which results in significant changes in personality, behavior, and language ability. The two frontal lobes of the right and left at the front of the brain are mood, social behavior, attention, judgment, planning, and self-control. Damage can lead to reduced intellectual abilities and changes in personality, emotion, and behavior (https://www.fightdementia.org).

Common symptoms experienced by people with dementia syndrome

Early stage	Middle stage	Later stage
Friends and family generally overlook dementia early stage as a problem related to old age—just a normal part of the aging process • Patients become forgetful, especially regarding short memory • They have some difficulty with communication, like finding the right words • They feel lost in otherwise familiar places • They lose time tracking, including time of day, month, year, and season • They have difficulty making decisions: be it a complex household task or matter related to finance Patients may become less active and lose interest in activities and hobbies. Mood swings, including depression or anxiety, are expected. They may react unusually angrily or aggressively on occasion	With the gradual progression of the disease, limitations become more apparent and more restricting • Patients tend to become more forgetful, especially with short-term memory • They encounter increasing difficulty in comprehending time, date, place, and events and communication (speech and comprehension) • They become dependent on personal care (toileting, washing, dressing) and managing day-to-day life • Life becomes challenging as they can not live alone safely without considerable support • Behavioral changes may include wandering, repeated questioning, calling out, clinging, disturbed sleeping, hallucinations (seeing or hearing things that do not exist). They often display inappropriate behavior in the home or the community (e.g., disinhibition, aggression)	The last stage is characterized by total dependence and inactivity. Memory disturbances become a grave concern, and the physical side of the disease becomes evident • Usually unaware of time and place, patients have difficulty in understanding what is happening around them • In this stage, patients become unable to recognize relatives, friends, and familiar objects and ultimately become dependent on others for self-care • Patients may have difficulty in swallowing and have bladder and bowel incontinence. They face change in mobility, may be unable to walk, or be confined to a wheelchair or bed • Behavior changes may escalate and include aggression toward the caregiver; nonverbal agitations (kicking, hitting, screaming, or moaning) are also part of the changed behavior

Source WHO (2012, p. 7), World Alzheimer's Report (2009), World Health Organization (2006), Mukherjee (2018)

Understanding Dementia as Caregiver's Challenge

As per the global burden disease report, dementia is the second most burdensome chronic non-communicable disease. There is a need for enormous care for older people who are suffering from dementia. Generally, the care is provided by the informal caregivers (family caregivers), which is unpaid. Almost 10 million Americans provide unpaid care for a person with one or the other forms of dementia. Among

the caregivers, the person who takes care of the dementia patient feels stressed with higher levels of psychological illness because of intensive and extensive care. The economic cost of dementia worldwide estimated in 2009 Alzheimer's report is US $315 billion. The annual cost is estimated at US $1521 in a low-income country. It is rising to US $4588 in middle-income countries and US $17,964 in high-income countries (Prince & Jackson, 2009). Dementia India Report 2010 estimated that the cost of taking care of a person with dementia is about 43,000 annually, much of which is met by the families as the state is virtually nonexistent in this sector. At present, the institutional cost in private clinics ranges from Rs. 30 000–40,000/pm, which is prohibitively high for ordinary citizens (The dementia India report, 2010, Mukherjee, 2018).

Treating dementia as a stigma, treating the individual as undesirable, emphasizing its symptoms is unhelpful. Professor Peter Piot says that overcoming stigma is the first step to beating Alzheimer's disease and dementia (Batsc et al., 2012). In the world's population, every 1 in 20 persons is dependent. Thirteen percent of older people who are aged 60 years and above are dependent. The global dependency will be changing drastically between 2010 and 2050; people worldwide will be nearly doubled from 349 to 613 million. The number of older people in need of care will be 101 to 277 million, increasing drastically in low- and middle-income countries. The need for long-term care for dementia-prone persons is very high in high-income countries. Due to this, there is a transition from home care to institutional care and nursing homes. The report says that half of the dementia patients need personal care support. About four-fifths of dementia patients need nursing home care (Prince et al., 2013).

Social protection for older people with dementia in low- and middle-income countries

Population-based catchment area	Number	Receiving a government or occupational pension (%)	Receiving a disability pension (%)	Receiving income from family transfers (%)	Experiencing food insecurity (%)	No children within 50 miles (%)
Cuba (urban)	323	81.4	0.9	7.4	5.6	19.5
Dominican Republic (urban)	242	27.3	0.8	23.6	13.7	25.1
Venezuela (urban)	146	41.1	4.1	2.7	2.7	13.4
Mexico (urban)	93	78.5	1.1	7.5	3.2	4.3
Mexico (rural)	87	34.5	2.3	17.2	12.6	5.8
China (urban)	84	84.5	0.0	11.9	0.0	0.0
China (rural)	56	10.7	0.0	23.2	3.6	7.8
India (urban)	75	13.3	2.7	28.0	28.0	5.3
India (rural)	108	26.9	0.0	44.4	17.6	10.9

(continued)

(continued)

Population-based catchment area	Number	Receiving a government or occupational pension (%)	Receiving a disability pension (%)	Receiving income from family transfers (%)	Experiencing food insecurity (%)	No children within 50 miles (%)

Source World Health Organization (2012), dementia: a public health priority, p. 43

In India, it is estimated that 3.7 million people are being affected by dementia in 2010. It is expected to be doubled by 2030. From the above table, it is clear that much of the care is met by the family members in India in the absence of a state-supported social security system. The future challenges stay as a financial burden. In India, this is the only report we can refer to for the information and details to know the impact of dementia in India. As per the report, there are 3.7 million Indians aged over 60 years who have dementia. Of these, 3.7 million, 2.1 million are women, and 1.5 million are men. It shows that the prevalence of dementia is seen more among women than in men. The report specifies that gender is not a risk factor for dementia (Shaji et al., 2010). In India, dementia remains a hidden problem due to a lack of awareness among the people, and they believe that it is a normal part of aging.

In India, persons with dementia continue to live with their families. Dementia care is usually a joint effort by the adult members of the family who stay in the same household. It is also expected that one person would be more involved with the care at any given point in time, and that person can be considered the primary caregiver. Most people with dementia lived with adult children and children-in-law. Living alone or with a spouse only was very uncommon. Carers were most often women and spouses, children, or children-in-law (Shaji et al., 2010).

The Impact of Dementia Care

The caregivers' burden is multidimensional. It arises from physical, psychological, emotional, social, and financial stress associated with the caregiving experience. The caregiver's perception of the burden, rather than the perception of other family members, societal or healthcare providers, determines the impact on his or her life. The primary caregiver may be the spouse or partner of the person with dementia, or caregivers are often the son or daughter. Those who are financially capable hire professional caregivers. Different arrangements have different care challenges. A spouse often at the same age or older than the patient has health problems of his or her own, increasing the care challenges. Adult children are likely to be economically active and not prefer living with dementia patients or under professional/marital requirements live in faraway places. The families of younger people with dementia are likely to have additional sets of issues; they may have dependent children and financial commitments associated with younger age (Kitwood, 1997).

The very requirement of caregiving brings myriad restrictions in the caregiver's life. They often give up full-time employment, switch to part-time jobs, give up employment, restrict time with friends and family, and sacrifice their pursuits and hobbies. Caring for a person with dementia is complex and demanding. Most of the time, the caregiver forced him/herself without any formal training. Caregivers generally report physical health problems and worsening of overall health. Carers of people with dementia are often at increased risk of psychological ill health due to all purposive stress associated with it (Brodaty & Donkin, 2009).

The negative consequences of caregiving have been widely studied. It is important to remember that most family and friends involved in providing informal care take pride in their role and perceive many positives. Caregivers' perceptions of strain are often assessed using Zarit Burden Interview (ZBI); it has 22 items that assess the carer's appraisal of the impact of their involvement in care (Prince et al., 2004). Among the 30 case studies conducted with dementia patients and their caregivers in both family and institutional setup selected, three cases are presented here. In contrast, significant findings from other cases are illustrated.

Case studies of women dementia patients living with family members:

Case—1

**Original identity of the patient and caregiver is retained based on caregiver's consent

Name of the patient	Name of the caregivers/relationship	Burden experienced by caregivers
Romila (aged above 90 years)	1. Rajeshwari (daughter) 2. Professional day care, Alzheimer's Care Center	Little or no burden

Background Information of the Patient: Case 1 dealt with the dementia patient Romila (name changed), aged approximately 100 years. She was first diagnosed with symptoms of early dementia in the year 2013. She is a homemaker. Her husband served as a manager in the Bank of India. He passed away at the age of 81 years. Romila has been residing with one of her married daughters since the time her dementia was diagnosed. The help of a professional caregiver is taken from one of the Alzheimer's centers in Bengaluru. Between 10 am and 4.30 pm, daycare center takes care of her from Monday to Saturday. Romila hails from Gujarat and has three sons and four daughters. All three sons stay in the USA. The elder daughter is bedridden and stays along with her husband in an old age home in Mumbai. The second daughter stays in California and the third one in New Jersey. The youngest daughter, Rajeshwari, alone takes care of her mother with occasional financial and emotional support from the siblings.

Case History: Rajeshwari is the primary caregiver in the family. Since Rajeshwari's husband Ashok got transferred to Bengaluru, the family had to shift to Bengaluru from Gujarat. Rajeshwari, along with her husband and mother, stays in Bengaluru now. Rajeshwari has one daughter who lives in the same apartment but in another block along with her husband. Rajeshwari's strength is her family, her husband, daughter, and son-in-law, who support her. They emotionally stood by her when she feels depressed and frustrated in her caregiver's role. Though she loves and cares for her mother very much, she suffers a lot from seeing her condition. Rajeshwari's daughter works in a private bank, and son-in-law, a graduate from IIM, works in Accenture. Sometimes she curses God and asks herself—"*why me*," why everything happens to me, and why the entire burden has to be suffered by me. When Rajeshwari discusses her mother's condition and tantrums with her siblings, no one except her elder sister expresses willingness to share the burden of care. Rest all wanted to send their mother to institutional care. Rajeshwari said that her son-in-law is more supportive and helps her to overcome depression by his positive thoughts. He is more like a son than a son-in-law to her. She also quoted her son-in-law's word that—"*when you being daughter are not willing to look after your mother, how can you rely on old age home to look after your mother‖well*." As such, he is the source of support and strength to Rajeshwari. As they live in the same apartment, they often visit home on weekends. Rajeshwari's son-in-law also spends time with Romila and joins them for bhajans on Sunday morning. Maids have been kept for cooking and other household cleaning purposes.

Another interesting matter is that Rajeshwari is fond of pets and has two dogs, and their presence makes her feel happy, working as a stress reliever. This routine continues every day. However, on Sunday, there is a change in their routine. It is a special day for Romila as she will be taken to Nagarjuna restaurant. It is so familiar that even the hotel management and workers are close to them. They visit the same restaurant every Sunday, and when they reach there, in no time, table arrangement will be made without making them wait for a long time.

The behavior of the patient and engagement in a daily routine: Romila does her work by herself like taking a bath, going to the toilet, wearing a saree, folding her clothes and bedspread, etc., but Rajeshwari makes sure that Romila's belongings will be kept in prescribed proper places and well maintained. Her day starts with taking a bath, doing Tulasi puja, and then having a cup of tea with biscuits. She comes to the dining table to have breakfast when her son-in-law (Ashok) calls her. She will have her breakfast along with him, whether breakfast/lunch/dinner, she takes a longer time (minimum 45 min) to complete it. After that, she will be eagerly looking out for the vehicle to go to the Alzheimer's daycare center. She seems to be happy going out there. The center will charge 16,000/- monthly to provide lunch, tea, biscuits, and a vehicle facility to pick up and drop.

Romila likes to have food (South Indian), especially sweets (Kesaribath in colloquial language) made of broken brown rice. Another unique thing about Romila is that she likes to wear new sarees. This shows her love for life. She likes to go around the city. On the other hand, according to the family members, she turns very aggressive on regular intervention. She does not seem to be in average condition. Seeing her in such a condition, neighbors who are ignorant about the problem make negative comments (spell of black magic, etc.), which increases the stress of caregivers who are family members.

Once when Rajeshwari took her mother to the movie theater, Romila started talking loudly with unusual behavior. She is not taken to cinemas, and even on television, she is not allowed to watch any of the programs except bhajans. This shows how even in an otherwise supportive environment, the caregiver is sufficiently stressed due to compromise of her social and personal life. At home, in order to keep her busy, Rajeshwari makes her mother do various activities like tying flowers for puja daily, cleaning up green leaves and vegetables. Sometimes she will be given a bowl of dal and pulses mixed and makes her separate them. These all activities improve her cognitive abilities. Sometimes, flowers will be put to her husband's photo frame by Romila. However, she does not remember who he is and thinks that it is God's photo. If she feels hungry, she does not tell directly but asks her daughter whether she drank tea. She does not remember anybody and calls Rajeshwari "Baa" (In Gujarati, mother).

Major Findings:

- **Care Model:**
  - (a) In this case, a balance is maintained between the medical and personal care models, which recognizes and maintains personhood, uniqueness, and individuality. It acknowledges this in care plans and care pathways,
  - (b) This professional care model respects autonomy, dignity, privacy, and the patient's rights as individuals and identifies strengths and positive aspects rather than weaknesses and problems (Slater, 2006, pp. 135–44),
  - (c) Person-centered care has been promoted as the best practice in dementia care, but the concept is still poorly defined and lacks an empirical base (Brooker, 2003, pp. 215–222). A positive social environment is an utmost need in which the person living with dementia can experience relative well-being (www.caresearch.com.au/caresearch, Mukherjee, 2018, pp. 67–70).
- **Caregiving**—In this case, there is a balance maintained between institutional care and homecare. The patient visits Alzheimer's center and is taken care of primarily by her daughter and other family members at home.

She has a very supportive grandson-in-law, and that shows caregiving is a gender-neutral activity.

- **Financial status**—The family is economically well off, and the patient has a regular income from fixed deposits. Therefore, they can afford institutional care (Rs. 16,000/pm). The family members did not express any financial burden in looking after the patient.
- **Significant symptoms observed**—The symptoms of the patient are unusual hallucinating behavior, forgetfulness, and memory loss.
- **Experience of burden**—As per the Zarit Burden Interview scale, the interpretation of the score of this family caregiver is **17**, and the interpretation of the score is **little or no burden**. When care is shared, or the caregiver receives physical (daycare center) and emotional support (some of the siblings and daughter and son-in-law), the stress of caring or care burden is significantly less.

Case—2

***Original identity of the patient and caregiver is retained based on caregiver's consent.

Name of the patient	Name of the caregivers/relationship	Burden experienced by caregivers
Eshwari (age 77 years)	1. Malthi Mohan (daughter-in-law)	Mild to moderate burden

Background Information of the Patient: Case 2 deals with a dementia patient named Eshwari, 77 years old, a widow living with her son and daughter-in-law. She has completed high school and lived her life as a housewife. Signs of dementia were witnessed in her 3–4 years back (2014). She receives the pension from her husband as a source of income.

Case History: Malthi Mohan, aged 51 years, has completed her postgraduation in social work (MSW). Currently, she is working as a welfare officer in Mathruchaya Trust in Sevakshetra hospital. Malthi Mohan is a caregiver to her mother-in-law, taking care of her since she was diagnosed with dementia 3–4 years back. As Malthi Mohan is working, her care burden is shared by her family members, i.e., her husband and daughter. They are her source of strength and support. Malthi gives a hint to Eshwari as to recognize and remember people. Malthi's daughter Ankita goes to college, and if she does not arrive by 5.30 or 6.00 pm, Eshwari starts murmuring and asks Malthi why she has not come? This indicates that affection from family members makes her remember,

which will not be there in institutional care. Malthi's says that her mother-in-law and daughter both have bonded with each other, and Ankita loves and takes care of her grandma. Family members take Eshwari when they go for an outing, and Malthi says that she will not help her while getting down from the car as it may become a habit, and she may always depend on her for that. She remembers her family members but cannot remember or recognize others. As Malthi says, it embarrasses her sometimes, but the fact is that all her relatives know the condition of Eshwari. The family knew about dementia earlier itself as it was hereditary in their family. As Malthi was familiar with the dementia problem and its symptoms, she was not frustrated or irritated by her in-law's behavior. She could understand her age-related problems. Relatives and neighbors are very caring and helpful and spend time with Eshwari if she is alone at home. Malthi's presence at home and conversation with Eshwari make much difference. Eshwari is talkative; she wants someone to talk to and stay with her. They both have very close bonding and share household chores.

Malthi says that her professional career is not disturbed or affected while taking care of her mother-in-law. Her office is very near to the house, walkable distance. She leaves home at 9.00 am, and till 12.00, Eshwari is busy doing household work and gardening; meanwhile, the maidservant will come and be with Eshwari. At 1.30 pm, Malthi will come for lunch, and after 2.30, Eshwari will sleep for a while and read books. She feels bored for an hour when Eshwari's granddaughter comes home and spends time with her. Malthi says that it is not a financial burden for her as Eshwari gets a pension. She is given Ayurvedic medication, which is comparatively cheaper than English medicines. Malthi says that it is difficult for people who are financially weak as medical expenses are high nowadays.

The patient's behaviors and engagement in daily routine: Eshwari is physically fit; no institutional or professional caregiver is required. She is physically capable of doing work on her own. She is very talkative, talks continuously to everyone as they enter the home. Eshwari remembers and recognizes her family members, i.e., her son, daughter-in-law, and granddaughter, but not familiar with or recognizing other relatives. In order to keep her active, Malthi engages her in household work. Eshwari enjoys gardening, sowing seeds, cleaning pots, planting new ones, and household chores. Symptoms recognized by them were like forgetfulness, talking the same thing again and again, forgetting things to do like closing the tap after using it, could not recognize relatives and others who are not often met or seen by her, and Eshwari had a problem with hearing if anyone rings the bell.

Major Findings:

- **Care Model** followed, in this case, is the medical care model, personal care model, along with **the risk enablement and safeguarding model** as her daughter-in-law is a social worker herself. This model emphasizes

the development of systems for enabling and managing risk, which allows people with dementia to retain as much control over their lives as possible (Mukherjee 2015, 2018)

(a) This model recognizes the strengths that each person with dementia possesses and builds on the abilities that he or she has retained.
(b) This approach takes a tailored approach for risk management by acknowledging that dementia affects different people in different ways.
(c) Acknowledgements that a shared agreement about risk will not always be possible, but a shared understanding of the viewpoints of all those who are affected by decisions is always possible.
(d) Therefore, this model helps in identifying less cumbersome alternatives for patients as well as caregivers.
(e) Strike a good balance between protecting patients while ensuring the quality of life for the caregivers by mitigating risk.

- **Caregiving**—The patient is cared for by family members; the primary caregiver is the daughter-in-law. The patient is physically active, walks herself, does the task in her daily routine. The caregiver feels mild to moderate burden due to dual role responsibilities.
- **Financial status**—The family members did not express the financial burden of looking after the patient since the patient receives her husband's pension as a source of income.
- **Significant symptoms observed**—The patient's symptoms are forgetfulness, talking the same thing repeatedly, forgetting things to do like closing the tap after using it, and cannot recognize relatives and others who are not often met or seen by her.
- **Experience of burden**—As per the Zarit Burden Interview scale, the interpretation of the score of this family caregiver is **23,** and the interpretation of the score is **mild to moderate burden**.

Case—3

***Original identity of the patient and caregiver is retained based on caregiver's consent.

Name of the patient	Name of the caregivers/relationship	Burden experienced by caregivers
Leelavathi (age 89 years)	Shanthi G. (daughter-in-law)	Moderate to severe burden

Background Information of the Patient:

In this case, dementia borne Leelavathi is 89 years old, a homemaker, diagnosed with dementia in 2000. For the past 17 years, she has been looking after by her daughter-in-law Shanthi. Leelavathi has studied till high school. Leelavathi has three siblings, and she is the eldest among them. Since her childhood, she was most pampered among sisters. Father was key to her happiness and used to fulfill all her demands. When she was made to marry her husband (i.e., Shanthi's father-in-law), she was unwilling to marry him as he was not from an affluent background. Respecting her father's words, she finally agreed to marry. Even after so many years of married life, she was not happy for being married to him. However, opposite to this, her husband was very caring and fulfilled all her wishes. Leelavathi is a dominating personality and yielded lots of power within the family.

Nevertheless, an unfortunate horrifying incident took place. Leelavathi's husband committed suicide. It was a terrifying moment for the family members as there was no reason to die for it. There were no family disputes, quarreling between husband and wife, and any other problems. As such, it had a profound impact on the family members. It might be one of the reasons for Leelavathi's mental health problem. Leelavathi is financially independent as she receives her husband's pension.

Case History: The primary caregiver is a daughter-in-law, Shanthi, aged 57 years. Since Shanthi is a freelance social science researcher, she has given a detailed subjective account of her mother-in-law and experiences that she has undergone from a researcher's perspective. Leelavathi often shouts at Shanthi hysterically for no reason. Leelavathi even tried to blackmail Shanti by trying to falling into well. However, as Shanthi knew about her self-centered mother-in-law, she knew how to control her and told her to jump into well, and she would call her neighbors to lift her. However, from then on, Leelavathi never behaved like that. They closed the well in fear, but her tendency to scold Shanthi continues. Not only Shanthi, but also Bhagyamma (Bhagya) was a victim of her assault. Bhagya is a caregiver (assistant) to Leelavathi and looked after household chores. Leelavathi often uses abusive words that frustrate Shanthi, leading to disquiet between them as Shanthi has never been exposed to such words.

Initially, Shanthi was unaware of dementia and its symptoms. She used to get more frustrated. Shanthi observed many things. When Leelavathi was normal, she used to be finicky about personal hygiene, but with the onset of the disease, she even used to forget to take a bath even after going to the bathroom. This was discovered when Shanthi found lice were in her eyebrow, and with close observed Shanthi found many lice even in the pubic hair. She had gone entirely unhygienic. That was the time Shanthi thought of giving her medical treatment. When Shanthi revealed such behavior of Leelavathi to her sisters-in-law, no one believed her, although they were very close and friendly

with Shanthi. This incidence created more complexity and conflicts at home. Later everyone agreed to look after their mother, but they could not manage her even for a week. They felt sorry for Shanthi and trusted her words about their mother's behavior. One of the Leelavathi's daughters who stays in Mysore could not keep her mother for a long time. Her authoritarian personality has created some amount of unpleasantry at her daughter's place. The other two daughters of Leelavathi, who live in Mumbai and the USA, were unwilling to take care of their mother. Instead, they wanted to send her to a care home. Even Shanthi felt that the institutional care would be helpful for Leelavathi because she might be with the same age group, which may suit her positively.

Leelavathi behaved and pretended to be regular with everyone and liked being at home. She is very attached to the home. Shanthi noticed that the behavior of Leelavathi got worsened during the renovation of their house and that bothered everyone in the family. However, often it is seen that dementia patients relate better to their past. They have a concise memory of the present. The old house was associated with fond memories of Leelavathi's early life, and renovation of the said house was disturbing to her. Leelavathi never liked to go to any relative's home but instead wished her daughters, relatives to visit her home.

Shanthi says that because Leelavathi's authoritarian is cruel (from the beginning) personality, she is never attached to her emotionally. However, being human, it was her moral responsibility to take care of her. Thus, patients' past and present attributes have a lasting impression on the caregivers' minds and accordingly increase or decrease the burden of care.

For the last six months, they have appointed a professional caregiver to take care of her, and Shanthi's husband started involving in his mother's care only after his retirement. Leelavathi loves to cook, do puja, and light *diyas*. But because of her dementia, she often forgets to switch off the gas stove, resulting in a fire accident. Once while doing puja, her clothes caught up with fire. As a result, she was not allowed to work in the kitchen. Shanthi had to replace *diyas* with electric lamps to prevent future problems. This incident might have brought a kind of depression in Leelavathi. She is capable of doing her work and requires only a little assistance. Leelavathi is very independent-minded and prefers doing everything by herself. Initially, she was allowed to wash her plates, but she used to forget, clean them properly, and stop the water tap, resulting in a water drain, so she could not do any work. Her conservative caste taboo also prevents her from seeking the help of Bhagya—domestic help. Often she confuses her bed or living area as a toilet and soil space. Thus to avoid this, to keep her and the clean home diaper is being used for her. Gradually, her dependence on Shanti is increasing as often she forgets how to wear clothes (elaborate traditional Indian dressing makes it more cumbersome). Sometimes she even forgets how to chew or swallow food.

Major Findings:

Care Model: For Leelavathi, along with the medical and personal care model, the social care model was followed. The social care model emphasizes: **maximizing personal control, enabling choice, respecting dignity, preserving continuity (of lived experience and care provision), and promoting equity**.

- **Caregiving**—The primary caregiver is the daughter-in-law, whom her husband and professional caregivers accompany. The caregiving becomes stressful due to the authoritarian personality of the patient. The patient and primary caregiver's strained relationship led to the caregiver's stress and subsequent increase in hypothyroidsm and high blood pressure. The burden of care has immensely impacted her quality of life, career, and health.
- **Financial status**—The family members did not express the financial burden of looking after the patient since they are economically well off, and further the patient is also financially independent.
- **Significant symptoms observed**—The symptoms of the patient noticed were strange behavior, assaulting with abusive words, unhygienic, forgetfulness.
- **Experience of burden**—As per the Zarit Burden Interview scale, the interpretation of the score of this family caregiver is **43,** and the interpretation of the score is **moderate to severe burden**.

Findings on Family Caregivers

30% of the caregivers nearly always feel that they do not have enough time to attend other responsibilities; working and career-oriented women who are also caregivers and those look after two dementia patients feel more deprived of time for their things.

- **35%** of caregivers always have the feeling of anxiety between caring and other priorities. Caregivers who are women are expected to do much multitasking and caregiving responsibilities, leading to a high incidence of stress among caregivers.
- **85%** of the caregivers felt the burden of dependency; the height of dependency will increase with the progress of the disease.
- Only **10%** of the caregivers feel that their health has suffered due to caring responsibilities.
- **30%** of the caregivers quite frequently feel that they have disturbed social life. The personal space of an individual often goes missing.
- 5% of the caregivers strongly felt embarrassed because of irrational behavior.
- 60% of the caregiver feels that their demented relative nearly always expects/demands them to caretake.
- 75% of family caregivers never felt financial pinch since most of the studied patients either are availing the pension or the family members have the steady source of income and are sharing the expenditure.

- 20% of family caregivers experienced little or no care burden because the patients are physically independent; when the family caregivers are supported by daycare center or professional caregivers, their physical and mental stress burden is significantly less.
- In total, out of 20 family caregivers, 12 family caregivers, i.e., **60%**, have experienced mild to moderate burden.
- The reason for all these 12 cases of dementia is the patient's increasing dependency and need for assistance on caregivers to manage their day-to-day activities.
- The 50% of patients in the family care have some income source as a family pension, rent from property, or fixed deposits. The other 50% of the dementia patients are dependent on others financially when the physical burden of care is added with the financial burden, the stress level increases.
- 15% of the family caregivers have 24 × 7 care services at home, and more than one person shares 40% of cases of significant care in the family. Although women are the primary caregivers, even men are also coming forward and joining hands in caregiving which is a welcoming trend.
- Only 5% of the family caregivers have experienced moderate to severe burdens. In such cases, most of the time, the caregiver is a working woman who has to balance her profession, family, and caregiving at the same time.
- 15% of family caregivers expressed the feeling of severe burden. In such cases, there is a double burden of care for the family caregiver as the women caregiver is taking care of two dementia patients at home without any support from other family members. Physically and financially, both ways, patients are dependent on the caregiver.
- Among the caregivers, 55% of them are working women, but only 36.36% are in full-time jobs. 36.36% of them are into the flexible job and change their profession for balancing the caregiving and continuing with their profession. The other 27.7% of the caregivers have quit their jobs to take care the dementia patient at home and 9.09% of the caregiver has opted for the job, to relax them or support the family financially. The challenges faced by working women due to their dual role responsibilities of balancing care and other familial and professional responsibilities.
- When care is shared, or the caregiver receives physical (daycare center) and emotional support (some of the siblings and daughter and son-in-law), the stress of caring or care burden is significantly less.
- Due to lack of support, the general personality of the patient and degree of physical and financial dependence positively contribute to increasing stress.
- When family members and professional caregiver share the care, the care burden is mild to moderate.
- The authoritarian personality of the patient increases caregivers burden from moderate to severe level.
- Complete physical and financial dependence of the patient and non-cooperation and hostility of other family members increases the primary caregiver's burden to a severe level.

- When the primary caregiver handles more than one patient, the care burden increases.
- When care is shared by all family members and love is associated with that, care becomes a burden-free work. Again daughters are proved to be a better care provider.
- When there are supportive neighbors, that significantly reduces the stress burden of the caregivers; therefore, a sensitized community can also act as care support.

Findings from Institutional Case Studies

- Periodic visits (absence of regular monitoring) of family members led to negligence on the institution's part. Although the family was shelling out Rs. 750/- a day, the patient received inadequate care.
- Often family uses institutional care facilities to dump their loved ones. The loneliness and dejection also create a sense of insecurity among patients staying in institutional care.
- Often families cannot afford professional caregivers. In such cases, the absence of women in the house (like wife or sister) or the stormy relationship between mother-in-law and daughter-in-law makes caregiving difficult.
- The vulnerability of dementia patients is generally high due to progressive degeneration of the brain. Those who are having money and property even have to depend on others for their well-being. Thus for the poor and patients not having family members to care for, the community and state can play the role.
- When the patients are in institutional care, there is a visible lax on the family member's side. They equate care with expenditure and do not evaluate whether a patient is receiving quality care or not.
- In the majority of cases, be it at institutions or home, caregivers often are not adequately trained to deal with dementia patients, and as a result, they extend palliative care only, without introducing any stimulating activities to the brain to arrest the progression of dementia.

Limitations in Personal Care

Kitwood (1997) has identified a **culture of care** that arises when there is a narrow view of dementia dominates. He termed this culture of care as malignant social psychology. It is important to emphasize that it can arise even where care staff behaves in ways that they believe to be kind and altruistic. According to Kitwood, the most critical elements of malignant social psychology include

1. **Imposition**: Forcing a person to do something overriding desire or denying the possibility that they may have a choice.

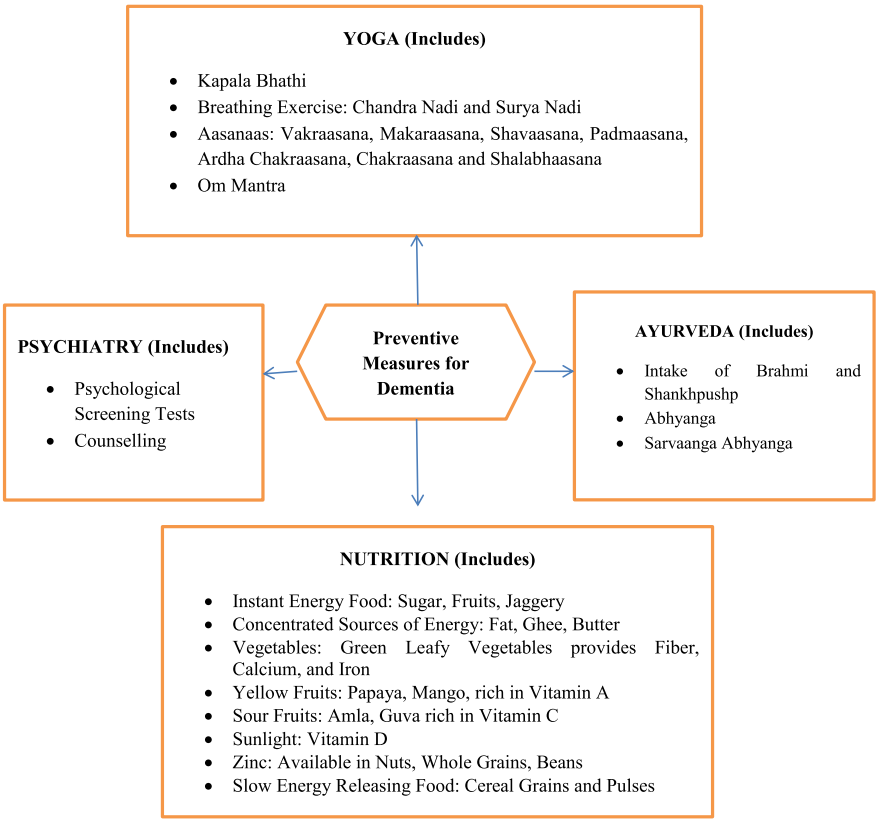
2. **Disempowerment**: Not allowing a person to use whatever abilities they may have.
3. **Infantilization**, i.e., treating an adult like a child; patronizing them.
4. **Intimidation**: Inducing fear through the use of threats, either explicitly or implicitly.
5. **Objectification**: Treating someone as if they were a piece of dead matter, an object to be moved, lifted without proper reference to the fact they are human beings.
6. **Banishment**: Sending a person away or excluding them, either physically or psychologically.
7. **Invalidation**: Fails to acknowledge the subjective reality of a person's experience and how they may feel.
8. **Withholding**: Refusing to meet the evident need or give asked for attention (Kitwood, 1997; Mukherjee, 2018).

Issues in the Use of Antipsychotic Medication for People with Dementia

There has been an ongoing debate and increasing concern about antipsychotic drugs to manage behavioral and psychological symptoms in dementia. Across the globe, these drugs are used too often, and they are not free from potential risk. Studies indicate that prescribing antipsychotic medication for dementia varies from 20 to 33%. Undoubtedly, the first-line treatment for behavioral and psychological symptoms of dementia is non-pharmacological. Despite that, the prescription of psychotropic medication remains high. These drugs appear to have only a limited positive effect in treating these symptoms but can cause significant harm to people with dementia. The risks include cerebrovascular adverse events and mortality (Bannerjee, 2012; WHO, 2012). Evidence suggests that, in many cases, the challenging behavior of patients can be safely managed by the use of psychosocial interventions or a person-centered care approach. Antipsychotics should be considered an option only in imminent risk of harm to self and others. If these drugs must be used, they should be prescribed in low doses over short periods. (WHO, 2012).

Thus in the following section, we will be concentrating on a low-cost home-based social care system for healthy living for dementia patients in the Indian setup.

Diagrammatical representation of preventive measures for dementia



Experiential analysis through expert advice: (Yoga, Ayurveda, Psychiatrist, Nutritionist/Dietician)

Yoga Expert:
Dr. Hemant Bhargav. MBBS, MD (Yoga Rehabilitation) Working as Senior Scientific Officer, National Institute of Mental Health and Neurosciences (NIMHANS) Integrated Center for Yoga (NICY), at NIMHANS Campus, Bengaluru. He is working on yoga and mental health. According to him:

- After 45 years of age, human body starts degenerating speedily. One has to plan yoga activities with least stress postures. Blood circulation needs to be given emphasis in yoga activities, which are simple and easy to remember.
- Fast ones, Surya Namaskaaras, are to be avoided. Standing postures need to be lessened. More of sitting postures need to be adopted. Slower kapala bharathi of 20–30 per minute is preferred in aged participants, than in youths. Simplified pranayama, with inhaling from left and exhaling from right for three minutes and then repeating it vice versa, is easy for elders to remember and practice.

- Breathe in and out with ten rounds of straightened and stretched toes, loosen ankle joints, rotate ankle joints in clockwise and anticlockwise directions; loosen knee joints and hip joints. One shall relax after each exercise.
- After loosening of all joints, certain aasanaas need to be done up to ten counts, e.g, **vajra asana**. This is to be followed by **makaraasana** to be followed by **ahavaasana** (corpse pose for deep restoration). **kapaala bharthi** (skull shining) is to be practiced slowly for 20–40 rounds.

These activities/exercises help to maintain the brain active. The hippo temple volume is increased by yoga module in experiments at NIMHANS yoga that has protective action. A long-term comparative study of meditators and non-meditators revealed that cortex thickness has increased in meditators and yoga practitioners. Neuroplasticity, measured by brain-derived neutrophil factor (BDNF) improved by meditation, which indicates better synoptic connections.

Ayurveda Expert:
According to **Dr. Tejaswini** BAMS, MD. Research Officer, Advanced Center for Ayurveda NIMHANS by adopting shamana (cleansing or evacuatory), shodhana (body purification), and rasaayana (comprehensive package of medicines for healing) chikitsa krama's (treatment therapies) of Ayurveda immature aging can be prevented, along with the prevention of memory loss, hair loss, and skin deformation. Degradation or degeneration of organs as in dementia can be prevented by rasaayana chikitsa krama. Memory enhancement can be had by treatment with brahmi, shankh pushp (Clitoria ternatea), intake of milk will supplement calcium, while that of ghee with hot dishes/hot water helps in digestion. These ayurvedic treatments will lead to prevention of degeneration of nerves and improvement of skin too. Daily abhyanga will stimulate nerves. Application of brahmi oil can reduce sleeplessness. Whole body treatment (sarvaanga abhyanga) will facilitate general health improvement and reduce probabilities of dementia.

Psychiatry Expert:
Dr. C. R. Chandrasekhar, Retired Senior Professor from NIMHANS, worked in NIMHANS for 34 years and retired in 2013. Presently, working in SAMAADHAANA, free counseling, and training center, for the last 11 years. Psychological tests and tools can be used to detect dementia as early as possible. Psychological screening or questionnaire can be used to check vocabulary, language ability, and communication skills to assess the situation. The individual can handle situation (like banking, going out) independently and dementia can be identified. The person, accordingly, can be referred to a psychiatrist or a psychologist. Taking care of demented persons is a challenge, as it affects ones' activities. They can get depressed or problematic. The neighbors or NGOs can help the primary caregivers. Following simple therapies can be suggested:

Music therapy: Playing music or singing a song as per the likings of the dementia patients**; cognitive stimulation therapy**: By using art and crafts for making painting and knitting, by doing daily activities like cleaning around the house by sweeping, wiping the table, or folding clothes and other household tasks to make the person feel a sense of accomplishment. Reading the newspaper, cooking or baking simple recipes together, working on puzzles, watching family videos, looking at books the person used to enjoy, attending the garden work, or visiting a botanical garden can be used as therapies.

The demented persons can be taken to rehabilitation centers, once in a month. The primary caregivers or their families can form social support groups and share their tasks in inevitable situations. With increasing nuclearization of families, women's dual responsibilities along with burden of care make it inevitable for seeking the help of the counselors to ensure better life for the demented families. Active people are less prone to develop dementia. So, staying active will help to avoid dementia. Environmental pollution also may cause dementia. The progress dementia becomes faster if a person experiences stress and anxiety. In vascular dementia, better management of diabetes may slow down the progress of dementia. In the participation in discussion, learning new things will help to postpone dementia. Home care is the best. Efforts should be made to make patient independent and active.

Government can help by opening good daycare/rehabilitation centers, especially for the elders. Organization of entertainment and recreation like activities in daycare center will help to keep the demented active. Any one above 50 years of age need to be screened for dementia at taluka, district level both in public and private hospitals.

Nutritionists Advice:

Dr. Nirmala Yenagi, Retired Professor, Department of Food Science and Nutrition, Rural Home Science College, Dharwad. According to her, food helps in three ways. It provides energy, helps in growth, development and maintenance of body, and it repairs the body. The main components of food are carbohydrates, fats, and proteins. Instant energy foods are sugar, fruits, and jaggery. Concentrated sources of energy are fat, ghee, and butter. Slow energy releasing foods are whole cereal grains and pulses. Among fruits and vegetables, green leafy vegetables provide fiber, calcium, iron and carotene, yellow fruits, and vegetables, namely papaya and mango are rich in vitamin A, and sour fruits, namely amla and guava (also sprouted gains) are rich in vitamin C (which is also essential). These are protective foods and help maintain health generally.

All nutrients are essential for the body. Elderly people, as are less active, require less of carbohydrates. For elderly people, carbohydrates need to be in compound form as they release sugars slowly. This will help to maintain optimum level of blood sugar. Calcium is needed for strengthening of bones and muscle contraction. Quality protein is a must, for this we need to have milk in daily diet, along with cereals and pulses. Fruits rich in mono and polyunsaturated fatty acids are essential to maintain health with diabetic, hypertension, and cardiovascular problems. Sunlight

is a good source of vitamin D. Olive oil and cad lever oils are also source of vitamins. Zinc is also needed for elderly people as it helps in carbohydrate metabolism, sense, smell, and taste, also in secretion of insulin. Zinc is available in nuts, whole grain, and beans. Vitamin B12 helps in the maintenance of microflora in small intestine. It is needed for blood formation and maintenance of nervous system. Fiber helps in maintaining integrity of gastrointestinal tract. Fibrer avoids constipation and reduces body weight and cholesterol. Diet schedule of elderly people should have breakfast, lunch, and dinner, duly balanced with energy, protective, and protein food. Diet should have more fiber and raw salad to maintain blood sugar and cholesterol levels. Early breakfast and early dinner are must for maintaining good health. Cooked food should be served as boiled or steamed.

Comprehensive and Affordable Dementia Care Model

This affordable and economic care model is built with the idea that assisted family care is most suitable for the dementia patients as well as for caregivers. Assistance can come from professionals or from other family members. This care model exhibits how support in terms of care can be extended to the patients who are at different stages of dementia. This model also elaborates the role of the community and state in the process of affordable dementia care. Ultimate goal of this model is to provide dignified assisted living to the women elderlies whose physical dependence is multiplied with financial dependence.

Stage—1:

- In the first stage, the family can support the elderly through regular periodic health checkup to diagnose the disease; the family members should try to understand that dementia as a disease. The family members should use the wrist bands or identity card for the demented patient once the disease is diagnosed as it will help them to be traced once they lost their way back home. They must save family members contact in fast dial option of mobile phones. Phones should not be password protected.
- The community can support the demented patients as well as the caregivers through creating awareness and social support. They must treat the patients with empathy. Community can play vigilant role in reporting abuse of dementive elderlies at the hand of family members.
- The state can contribute by providing mandatory-free dementia screening after 50+ at public hospitals, and government must open geriatric ward in the public hospitals and must organize the awareness campaign and free counseling facilities.

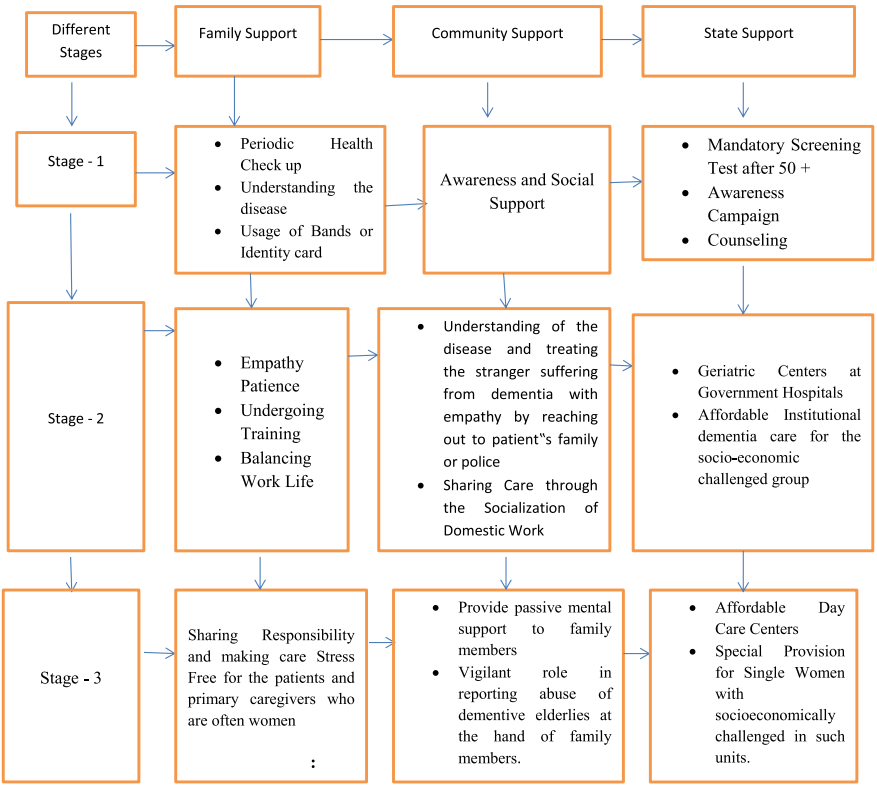
Stage—2:

- In the second stage, the dependence of dementive patients increases so does the care needs. At this level, caring must be shared among family members to give adequate rest to the primary caregiver. The family members (specially the primary caregivers) should undergo training on how to cope up with the situation. The family can support their demented relative with empathy like sharing the feelings and reacting to it positively.
- The community should understand the disease and treat the stranger suffering from dementia with empathy by reaching out to patient's family or police. The community can support through sharing care through the socialization of domestic work. This can help women caregivers to grow as a self-entrepreneur in the care service sector.
- The state should equip itself with good geriatric centers at government hospitals. The state should allocate with affordable institutional care for those who are socially and economically vulnerable.

Stage—3:

- Third stage is high dependence stage,, and therefore, the care demand is also very high. Sometimes family members can take external care help to distress themselves. But of course not everybody can afford that. In such cases, family can support by sharing responsibilities and making care stress free for the primary caregivers who are often women.
- The community can provide passive mental support to family members in this stage. Since patient is almost homebound with high dependence, community has limited role to play. Community can play vigilant role in reporting abuse of dementive elderlies at the hand of family members.
- As the care demand is very high at this stage, many a time family (where patient is a single woman, or caregiver spouse is very old, or nobody willing to share care burden) are not there to care, there we need state should be able to provide affordable institutional care with special provision for single women, socioeconomically challenged women in such units.

Comprehensive and affordable dementia care model:



Toward a Geriatric Inclusive and Dementia Friendly Social Order

Expected Role of Caregivers:

1. Institutional training is needed to equip them for better understanding of the disease, behavior of the patient, and deliver quality caregiving.
2. Opportunities to lessen the burden of stress of caregiving and induce enthusiasm to revitalize quality caregiving.
3. Extending family care facilities for the professional caregivers to improve their involvement in their task.

Expected Role of Patients:

1. Timely and quality diagnosis should be provided to elderly or dementia patients in particular through compulsory dementia test after 50 years.
2. The family caregivers or the professional caregivers should engage the patients through mental stimulating activities in the early stage.

3. Making institutional care an affordable one for all.

Expected Role of Community:

The integration of health and social care provides an opportunity to create a structured, coordinated, and strategic approach to community support for people with dementia and their caregivers to ensure their dignified stay in the community for long. According to Lindsay Kinnaird, the eight pillars of community support for dementia incorporate (Kinnaird, 2012, pp. 13–15; Mukherjee, 2018).

1. **Dementia practice coordinator**: A skilled practitioner who will regularly lead the care, treatment, and support for the patient and their caregivers. The same person should be coordinating access to all the pillars of support and ensuring effective intervention across health and social care.
2. **Therapeutic interventions**: To tackle symptoms of the illness—dementia-specific therapies to delay deterioration, enhance coping, maximize independence, improve quality of life, and need to be introduced in a trained fashion.
3. **Support for caregivers**: A proactive approach in supporting people in the caring role and maintaining the caregivers' health and well-being through community intervention.
4. **Personalized support**: Community must promote flexible and person-centered services to increase participation and independence.
5. **Community connections**: There is a need for support to maintain and develop social networks and benefit from peer support for both the person with dementia and the caregivers.
6. **Environment**: Building accessible public places following universal structures and through adaptations, aids, design changes, and assistive technology, there is a need to sensitize the community to maintain the person's independence and assist the carer.
7. **Mental health care and treatment**: Recognition and access to psychiatric and psychological services to maintain mental health and well-being for both patient and caregivers.
8. **General health care and treatment**: Availability of regular and thorough review to maintain general well-being and physical health is also a requirement.

Expected Role of Government:

1. Policy prioritization to geriatric issues with required budgetary allotment and mandatory dementia screening for all citizen after attaining 60 years as prevention is easier than cure.
2. Provision for state run affordable geriatric daycare and institutional care services with trained caregivers accessible to all. Need of geriatric care centers and the counseling centers at the public/government hospitals equipped to look into the issues-related dementia and psychogeriatric care services.

3. Creation of awareness at the national level, state level, and at the local level about the elderly issues. Government support and funding for policy execution and research in the field of dementia.
4. Initiate measures to prevent degradation of environment and create awareness among the people regarding the problem of dementia through print and visual media.
5. There should be a private and public partnership in providing facilities to reach the larger number of people in facilitating and providing domiciliary care services.

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Chapter 19
Women Workers in Informal Economy and Aging Concerns

Bharti Birla

Abstract As the aging population increases across the world, by the year 2047, we will witness a tipping point where the number of older persons is expected to increase more than the number of children. With the number of children decreasing and life expectancy increasing, we are now witnessing four-generation societies, instead of three generations ones seen earlier. What does it mean for the older women and men and how they are likely to be affected by this demographic shift is a matter of great concern. A decrease in the number of children, lack of public care facilities, the global decline in social security, and public health spending are some of the concerns being raised. A bigger challenge, which is also essential to consider in this environment, is that about two billion workers, representing 61.2% of the world's employed population, are in informal employment. This directly affects their fundamental principles and rights at work, and right to social security and social protection. The employment of older persons is more likely to be informal than that of young people, whatever the socio-economic development of a country and region (ILO in Women and men in the informal economy: a statistical picture (third edition). International Labour Office, 2018a). Worldwide, there are 2 billion workers who are informally employed, of which 740 million are women. These women workers are often found in the most vulnerable employment, for instance, domestic workers, home-based workers, or contributing family workers. The proportion of women working as "contributing family members" is three times higher than in informal employment (representing 28.1% of women in informal employment than 8.7% for men) and are usually considered unpaid workers. The issue of women workers and aging needs to be an integral part of the discussions on eliminating negative aspects of informality and transitioning toward formalization to enable women, especially those in the informal economy, to enjoy active aging and dignified living beyond the working age.

The views expressed are those of the author and do not necessarily reflect those of the International Labour Organization, or of the ILO DWT for South Asia and Country Office for India. In case of suggestions or corrections, please write to bharti_birla@hotmail.com

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Introduction

As the aging population increases across the globe, by the year 2047, we will witness a tipping point where the number of older persons will increase more than the number of children. With the number of children decreasing and life expectancy increasing, we are now witnessing four-generation societies, instead of three generations ones seen earlier. What does it mean for the older women and men and how they are likely to be affected by this demographic shift is a matter of great concern.

This paper looks at several factors and indicators in the employment of women, especially older women. It also looks at the International Labour Organization's (ILO) statistical indicators, especially those related to the labor force participation rates of women and men, the unemployment of women and the nature of jobs available to women. The paper also has a particular focus on informal employment and the challenges it precipitates for women workers, especially as they age. This focus is crucial as about two billion workers representing 61.2% of the employed population in the world are in informal employment (ILO, 2018a). Worldwide, there are 2 billion workers who are informally employed, of which about 740 million are women who work in the most vulnerable and low-paid occupations, for instance, domestic workers, home-based workers, or unpaid contributing family workers. This informal employment directly affects their fundamental principles and rights at work, rights and entitlements at work, and right to social security and social protection. The employment of older persons is more likely to be informal than that of young people, whatever the socio-economic development of a country and region (ILO, 2018a).

The progress toward the Sustainable Global Development Goals (SDGs) on 2030 Agenda for Sustainable Development needs a particular focus on the elderly population, especially women. Different SDGs, including SDG 1 on eliminating poverty, SDG 3 on ensuring healthy lives and well-being, SDG 5 on promoting gender equality, SDG 8 on full and productive employment and decent work for all, SDG 10 on reducing inequalities between and within countries and SDG 11 on making cities and human settlements inclusive, safe, resilient, and sustainable; are all linked to the issue of older workers.

Aging Population—Trends and Challenges

One in six people in the world will be 65+ years (16% of the population, 1.5 billion persons) by 2050. In 2019, it was about one in 11 people (9% of the population, 703 million persons). At the same time, the number of people who will be 80+ years

will triple. They will increase from 143 million in 2019 to 426 million in 2050. For the first time in 2018, the number of children decreased compared to the number of elderly who were 65 years and above (UN, 2019). Life expectancy at birth has increased since the 1950s, and there has been an improvement in longevity. At the same time, fertility has been decreasing. Both these factors drive the population aging phenomena. Another factor contributing to population aging in some regions of the world is the increased rate of migration. Young workers migrate to one part of the world, leaving behind older parents in home countries. Seeking work is not the only reason for migration. People also migrate because of conflicts, violence, insecurity, or climate change challenges in their home countries.

According to ILO Global estimates on international migration, there are 258 million international migrants of which 164 millions are workers, though 234 million international migrants are of working age (15 years and older). The migrant workers also tend to have a higher labor force participation rate (70.0%) compared to non-migrants (61.6%) (ILO, 2018b). In addition, the increasing urbanization that exerts economic and social pressures and breaking up of joint families that takes away the safety net provided to the children and older people also affects the aging outcomes. The feminization of the aging population is a major concern as it is on the rise. Even though, at birth, the sex ratio is 105 boys to 100 girls. This means that more boys are born at birth compared to girls. This initial tilt in the in favor of males changes as the population grows old. At an older age, women tend to outnumber men. In 2019, globally, for every 100 women, there were 81 men in the age-group of 65 years or older. In the age-group of over 80 years, for every 100 women, there were only 63 men (UN, 2020).

The growing concern about aging issues is unavoidable. Most countries in the world will witness a decrease in the number of younger workers and an increase in the elderly population. The old age dependency ratio is projected to increase globally, meaning that older age-group people will increase in number compared to the younger working population, especially in Eastern and South-Eastern Asia and Latin America and the Caribbean (UN, 2020). The potential support ratio, which compares numbers of working-age people aged 25–64 to those over age 65, is declining around the world. In Japan, this ratio is 1.8, the lowest in the world (UN, 2019).

The aging concerns of the elderly population are becoming a critical policy agenda across the globe. The older women are most affected as they experience enhanced vulnerabilities because of a multitude of factors. This includes women's lower labor force participation, gender pay gaps, lack of access to decent income with adequate social protection and old age pension, lack of public care services, and violence and discrimination at the workplace. These critical issues need immediate attention.

Employment of Older Workers

According to the ILO's World Employment and Social Outlook Trends 2020, globally, there are 5.7 billion people worldwide who fall under the working-age population

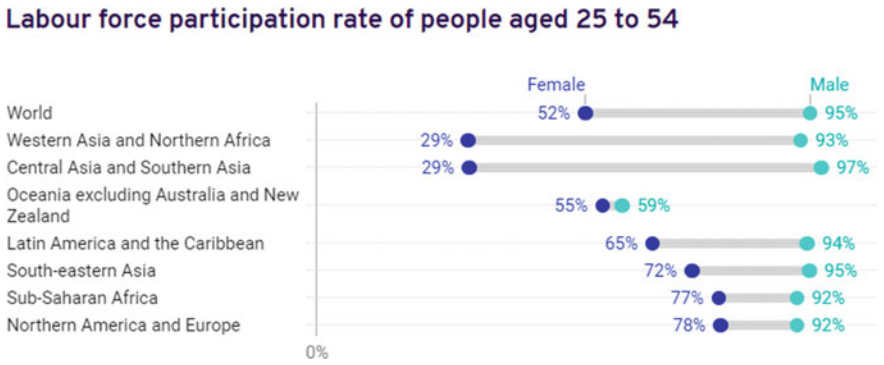

Fig. 19.1 Labor force participation rate of women and men aged 25 to 54 (percentages, 2018). *Source* ILO, Men and women in informality, 2018 (ILO, 2018a)

(15 years and older). However, only 57% (3.3. billion) were in active employment. A significant proportion of 39% (2.3 billion) was not part of the labor force. An estimated 188 million were unemployed (ILO, 2020a).

Globally, the labor force participation for workers aged 25 to 54 years is 95% for male workers and just 52% for female workers. However, this labor force participation varies across countries and regions. For example, in Asia except for South-eastern Asia and North Africa, the labor force participation for women is as low as 29% (Fig. 19.1).

The labor force participation of older workers remains low across the globe. Workers are employed in the formal or informal economy. The formal economy encompasses enterprises or businesses that are regulated. The workers have formal employment relationships and jobs with social protection and labor rights and entitlements by virtue of the formal employment relationship. The informal economy, as defined by the ILO, on the other hand, includes "all economic activities by workers and economic units that are—in law or in practice—not covered or insufficiently covered by formal arrangements". Those in the informal economy lack the protections and entitlements of the formal economy. However, it is also essential to recognize that not all in the formal sector are formally employed. Workers may work as causal, daily wage, and contract workers in the formal sector and may have informal jobs.

In the context of the aging population, worldwide, the older workers are more informal than the formal, and the same is true for younger workers. About 77.9% of the older workers (three out of four) are in informal employment. Similarly, 77.1% of young workers are also working in the informal economy. However, it is seen that the older persons are more likely to be in the informal economy than young persons, irrespective of whether they are in developed, emerging, or developing economies. The socio-economic development of the region or country does not matter (ILO, 2018a).

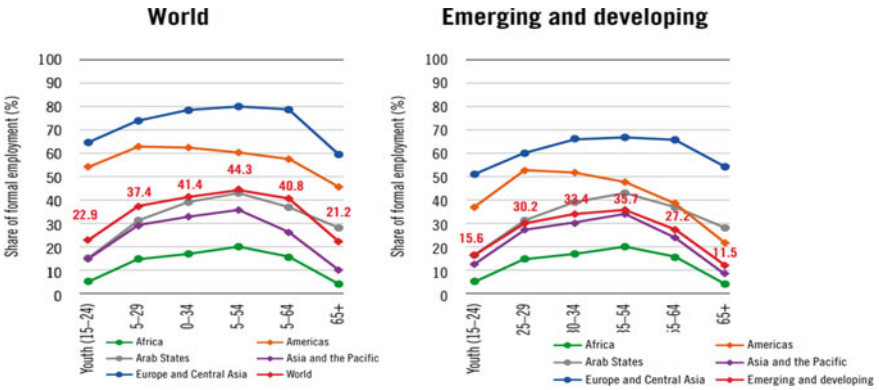

Fig. 19.2 Share of formal employment in total employment by age (percentages, 2016). *Source* ILO STAT 2020, created with Datawrapper, ILO estimates based on micro survey data

According to the ILO, calculations based on household survey micro datasets, the formal employment falls from 44.3% for workers aged 35–54 years to 40.8% for workers 55–64 years and further to a mere 21.2% for workers aged 65+ years and above. In the developing economies, the percentage of the formal employment for the workers in the age-group of 55–64 years falls to as low as 27.2%, and the workers +65 years constitute only 11.5%. A similar pattern is seen worldwide for young workers also in the age-group of 15–24 years. This significant variation, like employment over the lifecycle, shows that about 57% of the young workers and old workers are in informal employment compared to those in the age-group of 25–65 years (OECD-ILO, 2019).

Even though the nature of employment for most workers shows a U-shaped graph as seen in Fig. 19.2, in the case of specific categories of workers, such as own-account workers (including the home-based workers), the graph remains almost flat. It is estimated that 80% of such workers remain informal (OECD-ILO, 2019).

Often demands are made for lowering the retirement age so that younger workers are recruited. In reality, younger workers may or may not be able to replace older workers fully. For many jobs, formal qualifications cannot substitute the experience, competence, and skills needed to do the work. Often, in practice, the younger workers do not replace older workers (Samorodov, 1999). The lack of jobs contributes to youth unemployment or underemployment. At the same time, employers often complain of a lack of skilled workforce, skills and job mismatch, and lack of needed experience. The labor markets are fluid and operate independently of the demand for jobs. They operate when there is business. In addition, the more the demand for jobs, the lesser powers workers have to bargain for wages and working conditions. Workers compete with each other, bringing the wages down and agree to take precarious jobs. So, merely removing an older worker does not result in a job for a younger worker. Instead, it prevents youth from achieving gainful employment. Both older and younger workers need a special focus.

Women in the Labor Force

Before we move to the challenges faced by older women workers, the issue of women's employment and a discussion on the nature of women's work is essential. The global data and statistics on women's labor force participation show that only 48.5% of women are in the labor force compared to 75% men in 2018, a gender gap of 26.5 percentage points (ILO, 2018c). The data on employment shows that women remain underemployed, underutilized, and unpaid workforce. Women remain outside the workforce and paid employment because of several reasons. The most prominent is the presence of children in the household. The unpaid care work, especially childcare, keeps the women more at home, more so when the children are under six years of age. This reverses in the case of single mothers who tend to participate more in the workforce, as they need to support the children and other dependents in the family. Many women do not have the opportunity to access the formal labor markets as they engage in care and household work and a significant proportion of them may work as home workers (producing for the supply chains) or as own-account workers (producing for the market). Own-account workers are those who work on their own or are in a self-employed job, or work with one or more partners and do not employ anyone to work for them. They also work in large numbers as contributing family workers. The contributing family workers are unpaid family workers who work with a market-oriented economic unit or an enterprise operated by the household family member/s.

Women are more likely to leave the paid work soon after marriage or during motherhood. For example, in 2018, worldwide, 606 million working-age women did not join the labor market (either not available or not looking for a paid job) due to unpaid care work. A similar number for men was merely 41 million for the same reasons. Of these, women with young children were over-represented (ILO, 2018d). The "motherhood employment penalty" is universal and consistent across different regions. This is corroborated by the ILO estimates of 2018. The lowest employment rate (47.6%) are for women who are mothers of infants and babies (aged 0–5 years), while non-mothers have 54.5% employment rates. Men who are fathers with children in same age-group (of 0–5 years), the employment rate is as high as 87.9% and those who are non-fathers is 78.2%. While the women pay the motherhood penalty, the report points out contrasting phenomenon of "fatherhood employment premium," as men with small children have the highest employment-to-population ratios across the world compared to non-fathers, non-mothers, and mothers. (ILO, 2018d).

Based on recent estimates (2020), ILO has estimated the participation of women and men in the workforce based on the household type. The estimates show that women's labor force participation rates vary significantly depending on household type. However, men have high labor force participation rates regardless of the type of household they live in (ILO, 2020b) (Fig. 19.3).

Most women want to work and have a paid jobs, as found by the 2017 ILO-Gallup report. This also includes women who are not currently in the labor force. Also, men agree that women should take up paid jobs (ILO, 2017). The report also points toward

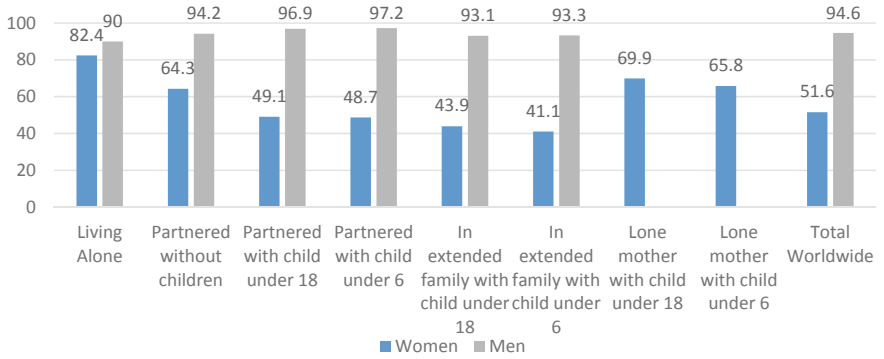

Fig. 19.3 Worldwide labor force participation rate of women and men by household type (2020 estimates). *Source* ILOSTAT 2020, created with Datawrapper

a possible solution to help women and men to engage in productive employment by "enabling universal access to care policies, services, and infrastructure".

The impact of the unpaid care work is that 647 million women and men are out of the labor market as they work as full-time unpaid carers. This includes a significant 41.6% of women who are in full-time unpaid care work among the 1.4 billion women who are inactive in the labor market. In comparison, only 5.8% men are in full-time unpaid care work out of the 706 million men who are not active in labor market (ILO, 2018d). The importance of care work and how it is one of the significant factors for the massive loss of possible productive employment in labor cannot be ignored. Marriage and motherhood for women become key discriminating factors for women's recruitment, affecting not just their full participation, but also decrease opportunities for better jobs and better pay (Fig. 19.4).

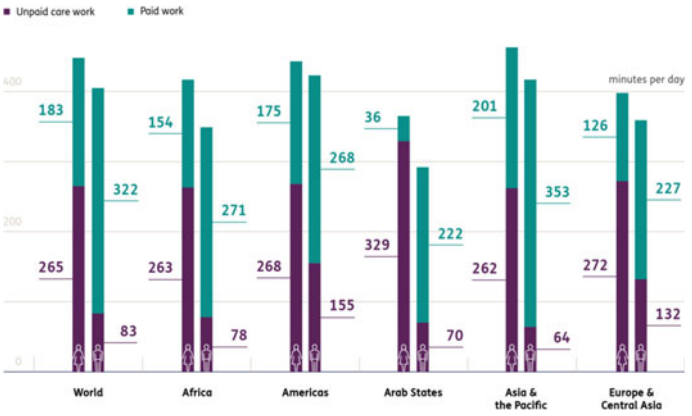

Fig. 19.4 Paid and unpaid care work by women and men (minutes per day). *Source* ILO, Care works and care jobs for the future of decent work (ILO, 2018d)

The unpaid care work remains invisible even though women work a total of 201 days (on eight hours basis) of unpaid care work compared to 63 days by men in a year (ILO, 2018d). This is 3.2 times more than men who work for 1 h 23 min compared to 4 h and 25 min by women per day. When both work for pay or profit and unpaid care work are accounted together, the working day is on average longer for women (7 h and 43 min) than it is for men (6 h and 57 min) (ILO, 2018d). The ILO report categorizes unpaid care work, as comprising of household work (81.8%), direct personal care (13.0%), and volunteer work (5.2%). Because of these multitude of challenges, the women are consistently "*time poorer*" than men. However, it is seen that in countries where men and women share responsibilities of care work, the labor market outcomes for women are also better.

Nature of women's Work

Apart from the unpaid care work that women do, there are additional factors that impact the labor market outcome for women workers. Some of these include lower wages, precarious conditions of work, and a lack of access to workers' entitlements. Women face gender pay gaps, are in precarious jobs, work in highly feminized sectors characterized by low productivity and low wages. Women engage in a significant proportion in informal employment with no social security and a lack of income/job security. These jobs are mostly low paid, and women cannot negotiate collectively for wages, as they remain un-organized and non-unionized. They have no means to resolve disputes or access justice and are generally invisible in policies and programs that affect them.

Gender plays a critical role in employment. The inequalities between men and women in both paid and unpaid work affect the quality of life older women lead. The gender roles, reproductive role, and division of work within households, especially gender stereotyping of care work, dictate the women's ability to participate in the labor market and seek quality jobs. The lack of public care services or robust social protection measures increases the family responsibilities for women workers. Many women are not able to actively participate in the labor force as they struggle to balance paid work and unpaid work for the family.

One of the indicators for the measurement of inequality is the pay differential between men and women. This gender pay gap is so vast that it will take 202 years to close this gap, based on the trend analysis done by the World Economic Forum in 2018. For example, it will take 61 years in Western Europe, 70 years in South Asia, 74 years in Latin America and the Caribbean, 135 years in Sub-Saharan Africa, 124 years in Eastern Europe and Central Asia, 153 years in the Middle East and North Africa, 171 years in East Asia and the Pacific, and 165 years in North America. (World Economic Forum, 2018). Unless there are significant efforts to reduce this gender pay gap or economic gap between men and women by changing existing policies and bringing more gender-equal initiatives, this trend will continue (Fig. 19.5).

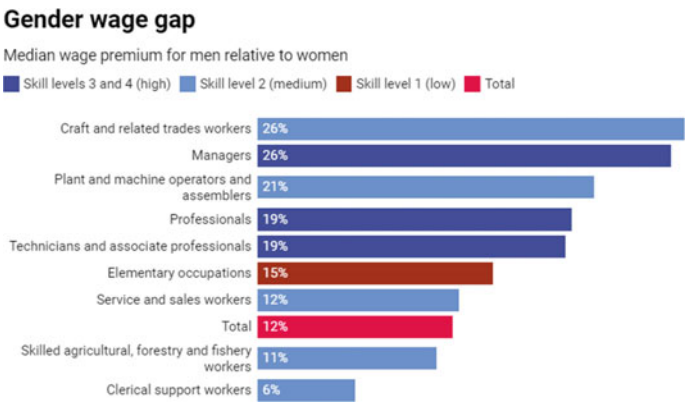

Fig. 19.5 Gender wage gap based on skill levels. *Source* ILO Stat (ILO, 2020b)

According to the estimates by the ILO, there exists a significant gender wage gap even when women and men have the same skills level, with women earning lower than men. The estimates point toward a substantial wage difference between women and men craft workers (26.4%), which is considered a medium-skilled occupation. There is a wage gap of 25.6% between men and women in highly skilled occupations and job roles. The employment of women is much lower in highly skilled occupations compared to men. Both of these indicate the presence of a glass ceiling for women in highly skilled occupations. Whether women are in highly skilled job roles like professionals or medium-skilled jobs like technicians and associate professionals, there exists a wage differential of about 19%. The medium-skilled job role as clerks have the least gender pay gap of 6% (ILO, 2020b).[1] There is also a systemic undervaluation of wages in highly feminized sectors or occupations (ILO, 2018e). Gender pay gaps impact the job quality, and the quantum of contributory social protection as these depend on the quantum of wages directly. Gender pay gaps exist for the uneducated women in informal jobs as well as among well-educated and experienced women in the formal sectors. For example, women face a glass ceiling because of the discriminatory hiring and promotion policies of the businesses (Grimshaw & Rubery, 2015).

A vital issue that needs attention in women workers' context is to understand the nature of women's paid work and where and what kinds of paid employment or jobs are women engaged in. Having paid work does not guarantee that it is decent work. The nature of paid work depends on the status of employment or job in which the worker is engaged, which directly impacts labor rights, including the right to minimum wage, right to social and health security, and other labor welfare measures. These further affect job security, working time, unemployment insurance, and compensation against injuries. As per the ILO, employees (workers holding paid

[1] https://ilostat.ilo.org/decent-work-and-the-sdgs-11-charts-that-tell-the-story/.

employment/regular workers) generally have better working conditions, job security, and social security compared to workers who are own-account (self-employed) workers and unpaid family workers. The latter two are considered to be vulnerable. There may be exceptions to this, as some wage employed persons may have precarious working conditions, and some own-account workers, especially highly skilled, may not be vulnerable.

As women balance their roles within households and society, even when they are in formal jobs, they may need to look for flexible options. They tend to shift from full-time formal jobs with social protection benefits to part-time jobs or move to smaller and informal units, homeworking, and other home-based occupations. These jobs may offer flexibility, but most are unregulated and may not provide social security benefits, paid leaves and other benefits, making women more insecure and vulnerable. Women also tend to concentrate on low-paid, low-productivity, casual or flexible jobs, or work as unpaid family members in family-run economic units making women money poor than men, who tend to be better paid than women. This enhances the vulnerabilities of women, especially those from poor and excluded communities. Women also suffer from societal stigmatization, discrimination, violence and harassment in communities and workplaces. These undermine women's access to decent work.

Informal Economy and Aging Concerns

As mentioned before, informal economy jobs usually represent low-paid, precarious jobs, often with no benefits or social protection, income/job security. A bulk of women are in informal employment or work in the informal sector, depriving them of the social security benefits and other rights generally available to workers. In the informal economy, women tend to be in the most precarious and vulnerable forms of employment, such as domestic workers, home-based workers, or contributing family members. Informal employment is also a challenge not just for women, but also for young people and older workers, as both categories are over-represented in informal employment (ILO, 2018a).

According to the ILO global estimates, of all working people, 39% of the workers are in the formal economy. About two billion people, 61%, of the total number of the employed population in the world, are working in the informal economy. Out of this, 7% of the workers are poor, 12% are moderately poor, and 81% are non-poor.[2] The extent of informality is about 85.2% in Africa, 68.2% in Asia and the Pacific, followed by the Arab States, which are 68.6% informal. In contrast, America's informality is only about 40% and even lower in Europe and Central Asia, which is only 25.1%

[2] The estimates of informality refer to the year 2016. The report elaborates "extreme working poverty (a daily per capita income of below US$1.90 in PPP terms) and moderate working poverty (a daily per capita income between US$1.90 and US$3.20 in PPP terms) are assumed to be zero in North America, the high-income countries in Europe (including European Union countries), Japan, Australia and New Zealand".

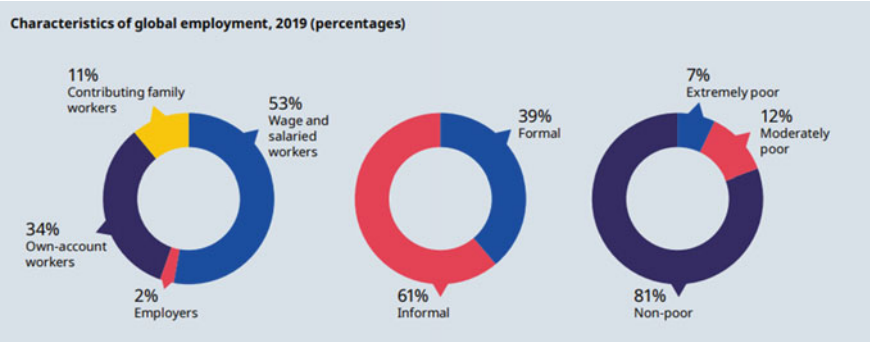

Fig. 19.6 Global employment characteristics (2019). *Source* ILOSTAT, ILO modeled estimates, November 2019 (ILO, 2020b)

informal economy. The informal sector's informal employment is about 51%, 6.7% in the formal sector and 2.5% in households (ILO, 2018a) (Fig. 19.6).

In terms of the nature of employment, 53% of the workers are waged and salaried workers, 34% are own-account workers, 11% are contributing family workers. Only 2% are employers. Women are under-represented as employers; their status as employers is half of that of men (ILO, 2018a).

The informal employees work in work in informal sector units (64.7%), fully formal enterprises (27.3%) and are domestic workers (5.3%). Besides, 86.1% of own-account workers and 50.7% of all employers are operating informal sector units. All contributing family workers, by definition, are in informal employment and 80% of them are informal sector units (ILO, 2018a).

According to the global employment statistics of 2018 by the ILO, almost one-third of the own-account workers are women. However, their share in the low- and middle-income countries reaches up to 50%, while in the upper-middle-income countries, it is about 28%, and in high-income countries, it is 9%. The low- and middle-income countries are also characterized by a lack of social protection for own-account workers, which puts women in a more vulnerable position. What is challenging is that the percentage of workers in these categories is increasing and is up to 76.4% of total employment in developing countries (ILO, 2020a).

The informal economy includes "all economic activities by workers or economic units in law or practice—not covered or sufficiently covered by formal arrangements," based on resolution agreed at the International Labour Conference 2002 (ILO, 2002). The informal economy often exists along with poverty, unemployment or underemployment, precarious jobs, and inequality and exclusion in society. Such conditions of informal and precarious work become more challenging for people in areas that are in an agile political environment, such as internal conflicts. The workers may also face distress because of climate change or development linked displacements, compromised migrant status of the workers and similar fragile situations that force the population to take up precarious jobs in the informal economy to sustain their livelihood.

Work is central to having material well-being, but also for the dignity of life. Decent work is necessary for human development and social justice. Paid work can bring economic security. However, not all paid jobs are quality jobs and not all type of work is decent work. The informal jobs are mostly precarious, low paid, and offer no job or income security. They also tend to offer no social security benefits and no or limited access to rights at work. So, it is worrisome that a considerable proportion of workers are in such employment. Although not all forms of informality are harmful, it is the negative aspects of informality, as described above, which put workers at a higher risk. This informality tends to dominate in the developing economies, which are struggling to fight moderate to extreme poverty and provide social and health protection to the majority of their populations. In the last few years, there has been a movement of trade, capital and labor, and work has reached several countries through the global value chains. There has been shifting of jobs from more advanced and developed economies to developing ones, creating opportunities for women and men to work. However, most of these jobs have also shifted from the more formal to the informal economy, decreasing the wages and the quality of jobs, especially for women.

The informal economies generally have a high incidence of poverty and decent work deficits for workers, including lack of social security, job security and precarious working and living conditions. The youth and older workers tend to be more in the informal economy. Worldwide three out of four young people (77.1%) and older (77.9%) persons working in the informal economy (ILO, 2018a). Mostly younger people are in the informal economy in developing countries. However, the elderly workers tend to be informal, irrespective of the nature of socio-economic development (ILO, 2018a). This shows the older workers' greater vulnerability, as they fail to get access to formal paid jobs. The transition from informal to the formal economy can help eliminate some negative aspects of the informality.

The informal economy generally falls outside labor law coverage, including the health and safety provisions or payment of minimum wages. The informal economy is essential, especially for developing economies. There are advantages of such an economy in enabling people to secure some form of livelihood, in production, generating employment, and contributing to skills development. However, it is also true that people take up informal employment or work in the informal sector not by choice but because of a lack of alternatives or access to formal jobs. Informal employment, in most cases, does not offer labor and social security rights that are available to workers generally in formal employment relationships.

In terms of proportions, if this is seen region-wise, the proportion of women workers in the informal economy are higher than men in, for example, Africa and South Asia. Women tend to be more vulnerable and in informal precarious employment, especially in sub-Saharan African, Southern Asia and Latin American countries.

Even though more men are working globally, there are more countries where women outnumber men working in informal employment. They work in the most vulnerable occupations, such as domestic workers, own-account workers and contributing family members or in low-paid sectors. A vast majority of women work

as unpaid family workers (no wages). Their proportion is almost three times that of men who work as unpaid family workers. Women as unpaid family workers represent 28.1% of the total informal employment of women than just 8.7% of unpaid family work by men in the context of total informal employment (ILO, 2018a). So, women tend to remain largely unpaid or low paid and have higher decent work deficits compared to men.

While some people may prefer to work in informal economy, majority of them are in informal economy not by choice, but because they do not have access to formal paid employment or other reasons, some of which have been discussed before, including unpaid care work. The informal economy tends to absorb people with no or little formal education. People with low education levels may find it difficult to access formal jobs. Most people with no education (93.8%) are in informal employment. As the education level increases, people find opportunities to work in formal sector, but still, 84.6% with primary and 51.7% with secondary and 23.8% people with tertiary education still work in the informal economy (ILO, 2018a). However, having an education is not an accurate indicator that women will be able to get into formal jobs if they have tertiary education. Formal education is also needed to get jobs as employees and regular wage workers. However, it may not work the same way for own-account workers.

Access to Social Protection and Entitlements

The safety nets and public healthcare systems are still not available to the majority of the population worldwide. For example, only 29% of the world's population has adequate social security coverage, and more than half (about 55%) lack any coverage at all. These findings come in the ILO General Survey 2019, compiled by the ILO Committee of Experts on the Application of Conventions and Recommendations (CEACR) (ILO, 2019). Through a set of policies and programs, social protection aims to reduce and prevent poverty and vulnerability by enabling access to child and family benefits, maternity protection, unemployment benefits, employment injury benefits, sickness benefits, health protection, old age pensions, disability pensions, and survivors' pensions.

Social security provides the necessary income and sustenance support for workers as they age. The role extended families played in supporting the elderly is diminishing because of employment challenges faced by the youth and the increasing dependency ratio. Adequate old age pensions and income support for the elderly can provide necessary income support and dignified aging. Globally, about 68% persons, who are above the retirement age, receive some form of old age pension. This includes both contributory and non-contributory pensions (whether or not sufficient for decent living). However, in low-income countries, pension is available to less than 20% of the older persons who are over the statutory retirement age (ILO, 2019).

The major challenge for the provision of social security benefits is the decreased spending and insufficient funds available to cover all workers. Healthcare and other

social security benefits require robust systems that deliver universally. Even where social security is available, often there are segments of populations that can remain out of coverage. This includes for example, the populations in remote villages, or tribal and ethnic minorities, older and disabled populations, pregnant and single women, migrants, etc. The demand for long-term care services is increasing. How such populations will be able to access such services is a matter of concern.

The pension schemes and similar social protection measures, including access to paid health care, which is essential, especially in the old age, are associated with the existing gender inequalities in the policies and the gender-blind design of such schemes and measures. Women already have a lower labor participation rate, and even when they do, the wage gaps between men and women are significant. Most pension schemes are contribution-based, where the volume and the value of the old age benefits, such as pensions, are based on the value of the worker's contributions. Women earn less and have a shorter and broken career and job pathways, which impacts the value of contributory social security. Women have to pay the *motherhood penalty* and have to engage in unpaid care work. They also hit the glass ceilings. Most of them work in low-paid, low-productivity sectors directly impacting the sectoral wages. As mentioned before, many of them work as own-account workers and unpaid family members. The social security and other labor rights and entitlements available to regular/formal workers do not accrue to them, especially in economies dominated by the informal economy. It has been seen that the women-headed households are more prone to poverty, whether women are divorced, widowed, or single compared to men in a similar position. Sometimes, the pension of the deceased husband or son is the only source of income for single women (UN, n.d.). Unless there are non-contributory schemes or welfare and social protection benefits, women workers become highly exposed and vulnerable as they age.

Healthcare challenges for the elderly are well known, well documented, and discussed. As age increases, chronic illnesses increase and resulting disabilities as well. These require long-term care, putting demand on the existing healthcare system, and public care services, if and where they exist. In other cases, these demands for care fall on private caregivers or domestic workers doing care work, or on the family members, mostly women and girls in the household. The domestic workers and other informal caregivers are in equally precarious positions, as they are low-paid, have no income and social security, as domestic work remains unregulated or poorly regulated in many countries around the globe. The gendered notion of care is essential to discuss. Whether it is unpaid care by a female family member or a domestic worker or low-paid care worker, the care burden falls on women. In some countries, such as India, children are mandated by law to take care of their parents without any support from the state. This forced "family care" work is an outcome of gender norms, societal expectations and patriarchal family structures, which invariably throw the burden of care work on women (Birla, 2017). The women in the family are expected to provide care services, while their own needs are ignored, depriving women of opportunities to join paid work and secure their future in terms of income and social protection. These hidden costs of care work contribute to poverty, low participation of women in the workforce or tend to retain women as a low-paid workforce. Women do not

have access to social security protection coverage as they remain outside the formal workforce. So, reconciling the care work burden and participation in the labor force for women becomes challenging. Often, women end up either moving out of the workforce or take up low-paid jobs, such as home-based or casual work, that may offer needed flexibility.

Besides work-related inequalities, women also suffer from violence and harassment at the workplace and in homes and the community. Women also suffer from poor nutrition and lack of access to healthcare and face more exposure to occupational health and safety (OSH) challenges. However, health and safety policies and programs fail to acknowledge these challenges. Most OSH policies and programs are either gender-blind or do not have adequate health and safety profile related to the feminized occupations. The OSH profiles focus on industrial workers who are more vulnerable to physical accidents. However, women's work is generally seen as safe, or they tend to be invisible as workers. This happens in the case of own-account or home-based workers or where women work as unpaid family workers. For women, OSH-related diseases are generally related to repeated muscle movements and awkward bending position or fatigue compared to men who suffer workplace accidents.

Conclusion and Way Forward

Aging is a process and has biological and social contours. Women face gender inequalities during their lifecycles to considerably impact their aging process and their well-being in the old age. This paper has focused on some of the concerns related to women and work, highlighting the challenges women face in employment, type and nature of employment, especially as they age. Gender inequalities at work precipitate the existing vulnerabilities of women, making them both money and time-poor. The ILO's World Employment and Social Outlook Trends 2020 highlights that "access to paid work, by itself, is not a guarantee of decent work" (ILO, 2020a). As seen, women's lack of access to quality jobs and decent work in addition to unequal access to resources, wealth, and social protection exacerbates the existing concerns of aging.

Often the existing laws, socio-economic policies and programs further augment and strengthen these inequalities. These are by no means the only labor market inequalities and challenges women face; there are significant cultural and structural challenges, gender stereotypes that influence the agency of women both within society and the workplace. To enable healthy and productive aging for women workers, gender equality and mainstreaming should be at the center of the ILO's decent work agenda. The decent work agenda of the ILO is built around the four pillars: employment creation, rights at work, social protection, and social dialog. The Sustainable Development Goal 8 also aims to "*promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all*."

To promote social justice and for the societies to be just and fair, the policies and programs need to be gender-responsive. They should not reinforce stereotypes that exist in society. The economic growth combined with social development is possible only when societies can eliminate obstacles to women's participation in the workforce and enable women to have their voice. The concern of older women workers needs special attention. Women tend to remain economically weaker than men. This is more so in the informal economy. Women do not have old age protection, including healthcare insurance, death and disability insurance, no income or old age pension support. Women also suffer discrimination and violence, and this is directly related to the outcomes envisaged under SDG 10, which seeks to reduce discrimination. As per the ILO, social justice's goal can only be obtained if women and men are in productive employment and have access to fundamental principles and rights at work. Enabling productive aging for women and men workers is also crucial for meeting the goals under SDG 16 on building peaceful and inclusive societies and enabling access to justice.

Perhaps, promoting full and productive employment is the key. People should be able to work entirely in their productive work life. Good health and mental well-being enable older workers to contribute beyond the retirement age meaningfully. Nevertheless, they should not be forced to work just because they have no income source and no social protection and working beyond retirement should not be a necessity for survival. Working for the appropriate duration of the work life and in better jobs can enhance the economy of the country. This is also needed for enabling better quality of life not just for the workers, but also for their families. Increasing productive employment of older workers is needed, and many countries have started taking positive steps in that direction.

To enable productive and healthy aging at the workplace and after the older workers cease to remain in the paid work, the following recommendations can be considered:

(a) **Application of international labor standards and other international instruments and aging-related declarations**: In the context of women workers, the implementation of international labor standards, especially The ILO Equal Remuneration Convention, 1951 (No. 100), on a guarantee of equality of treatment between men and women in remuneration is essential to reduce the gender pay gaps. The ILO's Older Workers Recommendation No. 162 lays down the policy measures related to the working time and work organization in the context of older workers. The ILO Convention on Discrimination in Employment and Occupation of 1958 (No. 111) aims at preventing discrimination at the workplace. Age as a form of discrimination is covered specifically by the ILO's Older Workers Recommendation of 1980 (No. 162).

(b) **Mainstreaming aging, especially gender aging in all policies and programs**: Different socio-economic policies, labor-related policies, and labor laws impact the outcomes related to concerns of older workers. An integrated approach is essential to mainstream the issues of aging and older workers in these policies. It is also important to reduce the burden of aging on the younger

population, which is equally vulnerable as the elderly. This would need running a diagnostic on the different policies and programs and amend/strengthen them to make them focused on productive and healthy aging of the population and workers.

(c) **Robust social protection systems**: ILO's Social Protection Floors Recommendation, 2012 (No. 202) calls for basic income security and essential healthcare guarantees from childhood to old age. It lays down that "basic social security guarantees should, at a minimum, comprise essential health care and basic income security for all older persons". This should be treated as a matter of urgency to deal with the implications of global demographic changes. Only strengthened social protection systems can reduce the burden of the rapidly aging population and prevent the workers, especially women, to slip into old age poverty.

(d) **Formalizing the informal economy**: Informal employment affects both younger and older workers. The macroeconomic and labor policies contribute toward formalization and can enable a transition toward formalization of the informal economy. Such formalization policies should include a particular focus on older (as well as younger) workers, especially women workers, who tend to dominate the sector and work in more precarious jobs. The ILO Recommendation, Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204),provides the guidance.

(e) **Employing older workers, especially women**: Employment in formal productive sectors is essential for the healthy aging and retirement of older workers. Employment policies integrating the older workers need to be promoted to change the trend of older workers slipping into informal jobs as they age. As older workers remain gainfully employed, they can get retirement benefits, including access to healthcare and income support in the form of pensions. They can help contribute to the economy. It is well documented that women tend to save more than men and spend on productive assets. This can help reduce the burden on youth and contribute toward addressing poverty, thus making societies more resilient.

(f) **Workplace policies to reduce discrimination and barriers to engage older workers**: Many workplace policies may have agist provisions preventing access to jobs for older workers at the time of recruitment, access to skilling opportunities, or requiring them to mandatorily retire from the job after a certain age, excluding the older workers from the formal labor markets. In a tri-partite consensus, appropriate policies and guidelines can be formulated to remove barriers for older workers, especially women, such as giving clear non-discriminatory guidelines for hiring older workers for jobs where older workers can be employed. Such workplace policies may include provisions for older workers to do tele or remote work, flexible hours of work, or work for reduced hours of work.

(g) **Provision of public care services**: In order to be gainfully employed, women need to stay in the workforce. Access to public care services is one enormous facilitator that can enable women to be employed. Women workers,

especially those in the informal economy, need special attention. They need social security and labor rights protection. A large proportion of women has to fulfill the growing role and demand as income earners. Most find entry into the labor market as unskilled workers and are forced to take up any job to fulfill the family's economic demands. They mostly come from the excluded and marginalized communities. Because of this exclusion and the multiple discriminations they face, including access to nutrition, education, unpaid household work, child and elderly care and prevailing gender norms, they are unable to take up skilled work. They get stuck in low-paid, low-skilled, and low-productivity jobs.

(h) **Skilling and learning**: Companies should make suitable accommodations to retain older workers, especially women. This could include giving opportunities to learn new skills, enabling job rotation/change so that workers can take up fewer physical jobs and instead be able to use their experience to tasks, which require strategizing, planning, and managing execution. Older workers are productive, efficient, and experienced. They can serve as mentors and trainers for younger workers. Older workers can be encouraged and enabled to change and adapt to new technologies, skills, management, and work styles while respecting their experience and skills and using them productively to make gains at the workplace. The older women in informal sector also need special attention and inclusion in skilling programmes. The ILO's Older Workers Recommendation, 1980 (No. 162), calls for equality of opportunity and treatment for older workers, particularly in terms of access to vocational guidance and placement services, employment of their choice, vocational training facilities, and paid educational leave.

(i) **Promoting diverse and inclusive workplaces with suitable accommodation for older workers**: The employers can be incentivized to promote inclusive and diverse workplaces and provide an enabling environment for older workers. This also includes providing suitable adjustments to cater to the needs of older workers. They may also suffer from occupational health issues or coping with the physiological challenges because of the aging process, including morbidities.

The 2030 Agenda for Sustainable Development, especially meeting SDG 8, requires that issue of aging is well addressed and integrated with the decent work agenda. Addressing concerns of older workers and older populations contributes toward the other connected SDG goals as well.

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Chapter 20
The Elderly Women *#metoo* Left Out

Dominique Predali

Abstract The *#metoo* campaign brought the reality of sexual violence against women into the public consciousness, but it needed celebrities to capture people's attention. For the first time, it was being reported in the main media as highly pervasive and endemic rather than sensational and exceptional. Unfortunately, the campaign did not include older women in nursing homes. Defenseless, cognitively impaired, most of them are too vulnerable to speak out. Elderly women who can report assaults are silenced by disbelief, dismissal, or denial. These silent victims are also ignored by nursing homes, staff, health professionals, families, legal actors, governments, society, and scholars alike. Internationally, the paucity of research on the subject is staggering. Institutional sexual abuse is still taboo. The goal of *#metoo* was to highlight the breadth and impact of sexual violence worldwide. The frailest abused women in nursing homes need to be seen and heard and most of all, they need to be protected.

Keywords Metoo · Rape · Sexual abuse · Widespread · Nursing homes · Disbelief · Taboo

> … sexual assault is not like any other crime (R. v. Seaboyer, 1991)

Introduction: A Resounding Silence

> The sexual abuse scandal nobody's talking about (ABC NEWS, 2019c); There is this enormous silence. People don't talk about the sexual assault of older women (The Guardian, 2014); This little-discussed issue is more widespread than anyone would imagine (CNN, 2017b); Hidden plague: the most hidden form of abuse (The Guardian, 2001).

#metoo, the first mass movement against sexual abuse, has taken the world by storm. Sexual abuse, no longer taboo, is being ferreted out wherever it hides, from cinema to sports to politics and to work. Yet sexual abuse of older women is still taboo!

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One of the reasons for this is that sexuality in old age is not usually spoken about. When Iversen and colleagues interviewed staff at nursing homes in Norway, they found it difficult to talk about seniors and sexuality. A serious inhibition that made it hard for them to imagine older residents being sexually abused: "I feel sick, and I feel emotionally bad talking about such a topic" (Iversen et al., 2015). This felling is widespread. Gary FitzGerald, chief executive of the charity Action on Elder Abuse, confirmed that people actually do not want to believe it can happen to older people in the first place (BBC, 2016). No one wants to think about the rape and sexual assault of elderly women. It is an issue not even governments or the nursing homes themselves wanted to address (ABC NEWS, 2019c). When a nursing home resident is raped, the assault is described as extremely rare. "Well, it's an isolated case. These cases of abuse, in fact, are very isolated," said Australian Aged Care Minister, Santo Santoro (ABC NEWS, 2006).

Rape, in most cultures, is seen as being essentially perpetrated against young attractive women. Since old women are longer desirable, it is impossible to imagine that rape is something that could happen to them. There seems to be an idea that old age will make you safe (Bows & Westmarland, 2017). As long as we continue to assume that sexual violence is about misdirected sexual desire, those who are not considered desirable are rendered invisible (Grant & Benedet, 2016). And so is the crime against them. This total denial contributes to maintaining the taboo around the discussion of the sexual assault of older women, but also its credibility and its impunity.

No Common Definition

> You prepare for a phone call your mother has passed. You don't prepare for a phone call that your mother has been RAPED (CNN, 2017b)

When is a rape not a rape, but an "issue" or an "incident," or worst, a "non-event"? Most of the time when the victim is an old woman in a nursing home or a long-term care facility. The term rape is rarely used. Even when describing the rapes of two nursing home residents, Dave Young, District Attorney of Colorado 17th Judicial District, seems reluctant to use the word. "The first victim was raped, there is no other word to say it. The second victim was digitally penetrated by Mr. Nieto" (CNN, 2019). The US Department of Justice's update definition of rape encompasses both: it is "the penetration, no matter how slight, of the vagina or anus with anybody part or object, or oral penetration by a sex organ of another person, without the consent of the victim" (USDOJ, 2012). For the WHO, it is "physically forced or otherwise coerced penetration—even if slight—of the vulva or anus, using a penis, other body parts or an object" (Krug et al., 2002). The treatment of rape by various national and international laws and institutions is inconsistent. The UK, for example, limits rape to penile penetration and uses "sexual abuse" or "sexual assault" for

penetration with other body parts or objects (Metropolitan Police UK, 2020). This constitutes a "less serious crime" (Plummer, 1992). International institutions tend to define rape as one form of sexual violence, sexual assault, or sexual abuse. The World Health Organization states that "sexual violence includes rape/attempted rape, […] can include other forms of assault […]. Sexually violent acts include […] sexual abuse" (Krug et al., 2002). Yet the same WHO explains that, "Sexual assault," "sexual abuse," and "sexual violence" are generally considered to be synonymous (WHO, 2003). Not for Rosa Kornfeld-Matte, the Human Rights Expert on the Enjoyment of all human rights by older persons, who in her 2019 WEAAD statement, deplored the fact that the sexual abuse and rape of older persons is a subject rarely discussed […] Sexual abuse and rape of older persons is still a taboo (Kornfeld-Matte, 2019).

Elder sexual abuse, also known as sexual abuse of the elderly, suffers from the same lack of a common understanding. There is no agreed upon universal definition of sexual abuse (Iversen et al., 2015). Many studies simply include it as a subset of physical abuse against older adults (Dawson & Peirone, 2018) or as a separate type of abuse under the larger elder abuse umbrella—another terminology lacking in common consensus. Elder sexual abuse is defined by the National Centre on Elder Abuse as "non-consensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing" (NCEA, 2006). Some scholars use "sexual assault" when describing an isolated attack by a stranger and "sexual abuse" when referring to multiple sexual aggressions by known perpetrators and over a prolonged period of time. Other researchers choose "sexual abuse" instead of "sexual violence" to account for a broader range of sexual violations perpetrated against older adults (Dawson & Peirone, 2018). The terms "sexual victimization," "sexual maltreatment," "sexual aggression" as well as the old-fashioned "sexual molestation" also appear in the literature on sexual abuse in nursing homes.

Defining rape as a subset of sexual abuse (or sexual assault, or sexual violence), and classifying sexual abuse (or sexual assault, or sexual violence) as a subset of "elder abuse," make difficult to assess the extent and scope of these crimes.

Criminologist Mike Brogden explains that until recently, criminologists and lawmakers have largely ignored crimes against the elderly. He quotes Hugman: "These acts which in other contexts may be regarded as 'criminal' such as assault, rape, or theft, come to be seen as physical abuse in the context of older people with dependency need … Does the understanding of violent acts against the person as 'abuse' rather than within a criminological framework not downgrade acts to which they have been subjected?" (Hugman, 1995). What tacit assumptions underline these linguistic choices? Possibly, says Mike Brogden, the fact that none of that matters too much when "Granny, it's time to go" anyway. A number of scholars suggest, the term "abuse" is often a euphemism for serious criminal acts and may, as a consequence, serve to lessen societal responses since abuse is not viewed as, or responded to as a crime (Moore, 2015).

Confusion in the use of language and choice of terms that should be employed, or the ones avoided, make the reality of rape disappear. They reflect and contribute to a culture of impunity and injustice. This has had a negative impact on identification of sexual abuse of women in general and older women more specifically. It also hides the fact that, in nursing homes, sexual abusers are almost always male, and victims are overwhelmingly female (Dawson & Peirone, 2018). Elderly women are much more likely than elderly men to be abused, but that does not mean that men are not abused (Malmedal et al., 2015). According to studies, between 93 and 95% of victims of sexual assault are women, and over 91% of perpetrators are men. These figures are similar to the demographics of sexual assault in the larger population (Mcdonald et al., 2012).

The Abusers

> A resident of Lou Village nursing home in Embrun suspected of having assaulted other residents. (Le Parisien, 2019a)

Research and media investigations show that in nursing homes and long-term care facilities, perpetrators are likely to be male residents or staff members with criminal histories. The rest are partners, other family members, visitors to the facility, or unknown assailants (CNN, 2017b; Connolly et al., 2012; Ramsey-Klawsnik et al., 2008).

In Ontario, W5 investigators showed that sexual abuse was repeated over long periods of time by known cognitively impaired offenders (CTV News W5, 2016). Studies confirm that when residents abused fellow residents, most suffered from dementia, cognitive impairment, and disinhibition. And that these assaults were quite widespread "that's why the industry is so against extending … reporting to other residents" (Barrett et al., 2014; Rosen et al., 2010).

> Paris: A 92-year old lady raped in her nursing home by a caregiver. (Le Parisien, 2020)

Other studies, including one large North American study of 428 cases of sexual assault in residential aged care, claim that most of the offenders were facility employees (Barrett et al., 2014; Ramsey-Klawsnik et al., 2008). According to records examined by CNN, abuse allegedly perpetrated by aides, nurses, and other caregivers tended to be far more serious forms of sexual assault (CNN, 2017b). *The Observer* found that the sexual abuse of old people by care workers […] could be as common as that suffered by children in the days before the paedophile problem was recognised (The Guardian, 2001). According to the OPAL institute in Australia, sexual abuse is NOT rare, it is rarely reported […]. Sexual abuse may be more prevalent that financial abuse (OPAL Institute, 2019).

Some studies suggest that staff (and visitors) can more effectively conceal their actions than residents with impaired intellectual capacities (Ramsey-Klawsnik et al.,

2008). The abuse can go on unsuspected over long periods of time. For more than a decade, nursing aid Luis Gomez abused Alzheimer's residents convinced they could never testify against him because "they're forgetful and they can't remember and oftentimes they die" (CNN, 2017d). A certified nursing assistant managed to sexually assault 11 women over 2 years in one facility without being suspected. When he voluntarily confessed his crimes to the police, he explained that his victims "all had dementia and were not aware of what was happening" (Burgess et al., 2007). In retrospect, the daughter of one of his victims told the researchers, that her mother looked frightened whenever the aid came into the room. But she did not interpret the warning signs. Neither did the family of a sexually abused nursing home resident in England. They thought Alzheimer's disease was responsible for her rapid deterioration. Only after the facility owner was arrested for sexual attacks on elderly women in his care did they realize what had happened to their mother (The Guardian, 2001).

The Silent Victims

Elder sexual abuse remains a silent and often invisible crime in persons who have limited cognitive abilities (Burgess et al., 2006). There is no official global data on rates of sexual assault of older women (Malmedal et al., 2015). However, the American Nursing Home Center estimates that about 83% of victims reside in an institutional care center, such as a nursing home and a long-term care facility. Most of them are physically and mentally impaired (ANHC, 2020). Cognitively impaired women in nursing homes suffering from various forms of dementia, Alzheimer's, stroke, and brain injury, the frailest physically and the oldest ones (from 79 to 99 years) were particularly vulnerable and six times more likely than men to be sexually abused (Burgess et al., 2006; Gibbs & Mosqueda, 2004; Malmedal et al., 2015; Smith et al., 2019; Teaster & Roberto, 2003). The complete powerlessness in institutional settings leaves elderly women highly vulnerable to sexual and physical abuse (Government of Canada, 2005). Suspects, who were identified as sexually abusing elder women with dementia, had less chance of being arrested, indicted, or having the case plea-bargained. In 2001, Ginny Jenkins, then director of Action on Elder Abuse, said that some paedophile Web sites actually encouraged men to work at care homes. "They say the sex is just as good and there's far less risk of getting caught" (The Guardian, 2001).

Only 30% of the victims capable of reporting their aggressor and identifying him, inform the authorities (Malmedal et al., 2015). Some do not want to because they belong to a generation that did not talk about these things. Ms. Roberts told police investigators that the Certified Nursing Assistant (CNA) had sexually assaulted her nearly 30 times in the two months, including at least four incidents of digital penetration. She had been too embarrassed to tell anyone about the assaults (Lew et al., 2010). Catherine Barrett explains that her mother Norma was hesitant to discuss what had happened to her: "She struggled to find the right words, because of her

dementia, but she also seemed embarrassed or ashamed to be talking about such private things" (Barrett et al., 2014). Rape victims may be unsure of how to define the act, they may find it difficult to name it rape or to verbalize it even when they recognize it. They may not acknowledge themselves as victims of rape (Burgess et al., 2006; Cannell et al., 2014; Smith et al., 2019). They may also feel stigmatized by it—one woman kept saying "I am a bad woman now" (Burgess & Clemens, 2006; Iversen et al., 2015).

The Silenced Victims

> Aged care home carried on 'business as usual' and ignored sexual assault of resident, family says. (ABC NEWS, 2019a)

Women who can report the assault are silenced by fear that they will be doubted, disbelieved, blamed, or ridiculed and that their ordeal will be ignored or minimized. A woman with dementia reported being abused to the facility's staff. The manager questioned her and dismissed her claims (The Age, 2006a). In one case, a resident reported that while in the dining room, a male resident had grabbed and roughly pinched her breast. Although investigating APS workers called the woman "highly credible," facility staff put a note in her medical record: "Makes false allegations of sexual abuse. Monitor carefully" (Connolly et al., 2012). Victims who spoke up were laughed at, accused of consenting to sex or even encouraging it (Burgess et al., 2000). An 89-year-old woman, suffering from dementia, reported being raped by a nursing aid to the nursing home director. He accused her of being a flirt. Officials transferred her to a psychiatric ward (CNN, 2017b). There is a "we don't believe you" attitude because "you're old, you've lost your mind, you're making it up" (Barrett et al., 2014). When Catherine Barrett and her mother Norma told the nursing home manager about Norma's assault, the manager was surprised and disbelieving that the incident had occurred. "She was also distracted, busily preparing (somewhat ironically) for an Aged Care Accreditation audit the following week." (Barrett et al., 2014).

Agism is another barrier. Both police and media campaigns and coverage of cases tend to reinforce the stereotypes of rape based on the desire or men for young attractive females. This can have negative impacts on victims who may be less likely to be believed and/or be reluctant to report cases that are not in keeping with the stereotype (McMillan & Thomas, 2009). After a healthcare worker abused a resident, people just said, "Well, he's a young man, he's married, he's got three children. She's an older woman with dementia. Why would he do that?" (The Guardian, 2014). The nursing homes managers were equally incredulous when Margarita told them that a staff member had assaulted her. "They said that he wouldn't do such a thing, that he was their friend and they had known him for years." They also suggested that "to be making such accusations, Margarita must have a urinary tract infection that was

addling her brain. Margarita called her local GP and asked for a copy of a urine test that her doctor had done not long before. It was clear." (Hocking, 2018).

Victims' reports are disregarded as drug-induced hallucinations, dementia, failing memories, or attempts to attract attention. Officials dismissed the residents' claims as hallucinations or fantasies (CNN, 2017b). Sarah told her daughter that she had been raped many times over a week. The staff filled out a number of incident reports. But nobody believed her. The manager talked about Sarah's "hallucinations of rape." Her GP wrote in her care record that she had "ideas of being raped" but did not recommend any action. When questioned about the bruising on Sarah's arm, staff said it was "self-harm." The geriatrician asked if the rape allegations had any "background." He did not do anything about them. Local hospital staff wrote that she had "delusions of being raped" and was "preoccupied with thoughts of sexual assault." The staff ignored their mandatory reporting requirements to the Department of Health or the police. The Elder Abuse Service was not contacted either. Her daughter asked "Did the staff, including GP, geriatrician, residential manager, nurse practitioner, general manager, registered nurses, and care assistants handle Sarah's allegations appropriately? No, they didn't" (SBS News, 2019). Confusion was also the diagnosis for a nonagenarian who suddenly became very unwell and kept telling the nursing home manager that a man had come into her room in the night and raped her. They put this down to disorientation and sent her to hospital. She had a urinary tract infection, and she was disorientated but the nurse on the ward believed her and told a doctor. He examined her and discovered "occipital fractures of both hips, which was consistent with someone lying on top of her" (Barrett, 2019). The Créteil medico-judiciary unit found out that women without cognitive disorders were more violently assaulted, with gynecological and extra gynecological lesions (Macaigne et al., 2016).

Underreported Crimes

> Rape in Long-Term Care Facilities is Common, Underreported and often Ignored, Allowing it to Continue Says Boca Nursing Home Abuse Attorney Joe Osborne. (CNN, 2017b)

Data from the US Department of Justice and the WHO confirm that sexual abuse in such facilities remains the least reported type of elder abuse (ANHC, 2020). Not reporting abuse is another way to silence victims. Some facilities only alert the authorities days or weeks or even months after they took place (Chicago Tribune, 2010; KHN, 2009; The Age, 2006a) report some attacks but not others, or none at all (CNN, 2017b). In France, a facility operator and the whole team, nursing home GP coordinator of care included, knew about the ongoing abuse. They did not report it, nor did they take measures to protect the victim (Paris Match, 2018). And yet since January 2017, reporting by facility manager to competent authorities "without delay and by any mean" is mandatory. Not reporting abuse is a global phenomenon (ABC News, 2019b; Barrett et al., 2014; CTV News W5, 2016; NPR, 2019; Nursing

Home Abuse Justice Team, 2019). CNN's analysis of state and federal data revealed that more than 500 facilities chose not to ignore sexual assaults (CNN, 2017b). One nursing director told a state inspector that if the facility reported all allegations it would be numerous (sic) and the State Agency would not want that either (CNN, 2017b). Discounting claims of assault can result in another serious form of abuse when victims continue to stay in the same residential care facility as their aggressors. Jessie Jackson's attacker, a fellow resident with no cognitive impairment, stayed in the nursing home for three months after the assault (ABC News, 2019b). For almost a year, Margarita had to carry on living at the facility where the on-site manager had sexually assaulted her. They even refused to change her locks (Burgess et al., 2000). In a review of thousands of nursing home inspection reports, CNN found repeated examples of facilities allowing problematic employees to stay on the job. A facility administrator in Texas allowed a nurse to continue working despite allegations he raped one resident three times and sexually abused two others (CNN, 2017c). The victim should not have to live in an unsafe environment (Fulmer et al., 2005).

> Health Workers Still Aren't Alerting Police About Likely Elder Abuse, Reports Find. (NPR, 2019)

In England, a study on staff failure to report abuse of residents in nursing homes (Moore, 2017) showed that most of them knew about it. They were aware of when they were abusive and when others were. This confirms a previous survey asking nursing home employees if they had behaved at least once in an abusive or neglectful way toward residents. In one study by McDonald and colleagues, carried over a one-year period, over 70% said they had. Psychological abuse and neglect were the most common forms reported by over 50% of the sample. Sexual abuse was not reported (Mcdonald et al., 2012). Moore's study shows abuse is far from being always reported, internally or externally, and that it is sometimes deliberately concealed from outsiders such as relatives and external agencies. Reasons for not reporting abuse were fear of the personal consequences such as victimization; intimidation; ostracism; reprisal from peers, managers, or employers; and loss of employment (Carvel, 2009; Taylor & Dodd, 2003). Solidarity of staff members can hinder the declaration, detection, and prevention of sexual assaults in nursing homes (Smith et al., 2018). "When these staff are working together, a code of loyalty seems to develop, and a blind eye is turned to abuse. I know it happens here. In homes, they [staff] are a law to themselves, a little clique, and they protect each other's backs" [Nurse manager 2] (Moore, 2017). A certified nursing aid, convicted for 14 sexual aggressions in France, did not dispute the facts, but he was extremely shocked that colleagues he respected actually testified against him (Le Courrier de Mantes, 2000). Staff may not want to get involved (Phelan, 2020). Fear of reprisal is a strong deterrent. "In nursing homes, you only see a piece of what is going on and lots goes on behind closed doors that is never reported—you know, in bedrooms, bathrooms and toilets. I've seen it happen and it's not been reported […] I've not reported it, no. I've got to work with these people you know" [Nurse 1]. "Abuse often isn't reported. If you report stuff like that you are in trouble, aren't you? You've still got to work with the same people" [Care staff member 6] (Moore, 2017). Fear of job loss is high on the list. "The nurse in

charge and the owner called me into the office [after I had reported abuse] and the owner asked me if I had a mortgage. I said I did, and he said, 'If you don't shut up about what happened I'll have your house off you.' I was scared he might, so I said nothing" (Moore, 2017). The nurse who reported Luis Gomez to the police was fired days after doing it (CNN, 2017d).

The Star found about 40 cases where homes delayed or did not report to the ministry even though it was mandatory. "Often the administrator tells them [staff] not to report to the ministry nor to the families or doctors. The administrator says the home will take care of it" said Sharleen Stewart, president of the SEIU, whose union represents 50,000 Ontario front-line healthcare workers, including 22,000 in nursing homes. "Also, many of these workers are new immigrants. Going to the ministry would open such a big event in their lives, they are afraid to do it" (The Star, 2011).

Staff may also fear investigators looking into a facility may expose other issues, threaten a nursing home with closure or open the door to costly lawsuits (CNN, 2017b). "It wouldn't be possible to report all instances of abuse, it happens so frequently, and the owner doesn't like it at all. It would mean too many empty beds" (Moore, 2017).

Another reason for remaining silent is that staff in residential care, including doctors and health inspectors, are often unclear on recognizing sexual assault and/or unfamiliar with reporting procedure. They prefer leaving it to the social worker or some other individuals to do the reporting. Only 2% of all elder abuse reports that are generated by physicians, despite state-wide mandates that are present in most states (Wagenaar et al., 2010). Emergency room physicians and primary care physicians also pointed out that reporting elder abuse to local or state authorities may take additional time and resources from already overworked physicians (Kennedy, 2005). Failure to identify sexual assaults on elder women and under-reporting them are likely to be 4 times higher than for younger women (Government of Canada, 2005). With lack of data, paucity of studies, and essentially invisible victims, elder institutional violence is not regarded a significant health concern.

Denial of Proper Care

> What is unimaginable and unacceptable becomes unsayable or invisible. (Barrett et al., 2014)

A study in Norway revealed that sexual abuse of older residents is a taboo topic among health professionals. They find it difficult to imagine, hard to believe, and therefore, they fail to identify the signs and to react accordingly. This attitude makes it even more challenging to report or uncover such acts (Iversen et al., 2015). If you do not believe that it happens, you won't see it either, wrote Wenche Malmedal. She explains that professionals in healthcare and social welfare systems are in key positions to be able to identify and detect sexual abuse. Nevertheless, it is likely that they lack the necessary knowledge about this taboo topic (Malmedal, 2020). Even when obvious signs are

there, such as genital bruising and bleeding, they attribute it to either a "botched catheterization" or "rough perineal care." Bruising to the abdominal area is often attributed to tight restraints for "patient safety" (Burgess & Clemens, 2006). Studies highlighted the lack of training of nursing home staff regarding how to deal with sexual assaults. They also revealed that signs of sexual abuse were not systematically documented, and evidence was sometimes accidentally destroyed (washing of sheets, maintenance of residents' rooms). The collection of biological evidence left by the aggressors is challenging since many nursing homes do not have adequate tools (such as forensic kits) or established intervention protocols (Smith et al., 2018). Healthcare professionals I interviewed in France were unaware that reporting is mandatory for facilities and staff (JORF, 2015) and did not know that they could not be sanctioned for reporting abuse. Physicians are released from their normal professional duty of confidentiality when children and vulnerable adults are at risk (Légifrance, 2018). Many suffer from a gap in knowledge about identification and management of elder abuse. This has been identified as a worldwide phenomenon (Ratnakaran & Sethulakshmi, 2020). Lack of training in these is also common with primary care and emergency physicians and even geriatricians. The majority of primary care physicians (67%) believed that their training about elder abuse was not very adequate or not adequate at all (Wagenaar et al., 2010). A 2005 American study showed that nearly 7% of primary care physicians reported no exposure or a minimal exposure to physical, emotional, or sexual abuse of the elderly (Kennedy, 2005). Many emergency care physicians were unfamiliar with protocols to screen for the presence of cognitive dysfunction and elder abuse in their older patients and were unaware of how to access and utilize resources available to them (Hogan et al., 2010; Schumacher, 2005). In a survey of emergency room physicians in the USA, only 31% knew about a written protocol for elder abuse and most were unfamiliar with the reporting mandates for elder abuse in their state (Jones et al., 1997). The same lack of training was identified with GPs interviewed in France. They all said that elder abuse had not been part of their residency training. None of them attended professional seminars on the subject and most admitted that they were not really interested. Some pointed out that identifying elder abuse was time consuming and that GPs were always in a hurry due to their huge workload (Meyer Coutelle, 2013). Some were not sure what "abuse" meant. Others were in total denial of elder abuse in nursing homes. "I cannot understand or imagine that staff can abuse old people." "Personally, I have never seen any abuse" (Meyer Coutelle, 2013). Both family physicians and general internists were reluctant to accept the problem as universal (Kennedy, 2005).

Most of geriatricians interviewed in France and abroad agreed that institutional sexual abuse existed but they insisted that it was extremely rare. So rare in fact, that there were no studies on the subject. A Deutsch geriatrician explained that this form of abuse was essentially an Anglo-Saxon problem. Just like smoking was. When I asked him to explain why, he said that all the studies were American or British (Prédali & Soubeyrand, 2006).

Sexual abuse is well established as a major social and health problem with significant physical and psychological consequences for the victims (Smith et al., 2018). Rape is the second most typical cause of post-traumatic stress disorder and raped

women are six times more vulnerable to suffer from this condition than those who were not raped (Briere & Scott, 2013). Older victims are less likely to have been referred to specialist sexual violence support services (Bows, 2018a). Lack of knowledge concerning sexual abuse of older persons is undermining their health, security, and welfare (Connolly, 2012). In a pilot study of 20 elderly women in nursing homes, 11 of the 20 victims died within 12 months of the assault. Because more than half of these victims were ages 80–96 at the time of the assault, it is not possible to determine in each case whether the assault accelerated death. But the fact that more than half of the victims died—not from the assault itself but within months of the assault—is clearly noteworthy, if not alarming (Hazelwood & Burgess, 2016). Delays in reporting the assault and absence of medical examination seriously compromise the victims' health. Yet medico-legal examinations are infrequent. Information regarding victim injuries is also limited. Female nursing home victims are less likely to have a rape kit/examination, to be tested for STIs, and to be examined for physical trauma (Burgess et al., 2005). It is recommended that the exam be conducted by a sexual assault nurse examiner or forensic nurse examiner. Laura Mosqueda, a pioneer in elder abuse forensic, makes injuries speak when the victim is silent. Laura and her colleagues found that 90% of accidental bruises occurred on the extremities, and 76% of those were on the dorsal surface of the arm. No accidental bruises occurred on the neck, ears, genitals, buttocks, or soles of the feet. Only 12 of 108 bruises were found on the trunk, all occurring in patients with hypertension, the only medical condition found to correlate with bruising patterns (Mosqueda et al., 2008). Studies show that elderly victims of sexual abuse suffer from significant amount of genital trauma (bruises, abrasions, and lacerations), more common in older women, and injury to non-genital parts of the body. They also suffer from 50 to 70% more central nervous system and stress-related problems (Burgess & Clemens, 2006). Yet they are rarely admitted to a hospital (Burgess et al., 2008; Eckert & Sugar, 2008). In a 2008 study, only 4.25% of women over 55 were admitted to an emergency department during a 9-year period, compared with groups of younger women (Eckert & Sugar, 2008). Conducting a rape exam on an elderly woman can be difficult if she cannot be placed in the pelvic examination position or has contractures, arthritis, or other conditions prohibiting this position (Dyer et al., 2007). It is important that medical examiners adapt their methods when dealing with elderly, cognitively, and physically impaired victims (Macaigne et al., 2016). What happens after the assault can affect the subsequent course of justice. If the victims do not receive forensic examinations or if forensic evidence is destroyed, prior to the examination process, it can impact the course of justice and reduce the likelihood of the offender being charged and found guilty (Burgess et al., 2005). No sexual assault examination, no case (Lew et al., 2010). Another serious case for documentation and testimony being excluded from legal proceedings, according to Dan Sheridan, a forensic nurse examiner and Associate Professor at the Johns Hopkins University School of Nursing, is when non-forensic nurses make documentation errors like using the word *victim*. It should never appear in the medical record. Using the word victim suggests that the nurse has already decided that the patient was abused. Another legal term to avoid is "alleged." If it would be inappropriate to chart *alleged chest pain*, it is just as

inappropriate to chart *alleged elder abuse*, "It should be replaced with *reported* or *suspected*" (Sheridan & Nash, 2007).

Failing Healthcare Services

Nursing homes are not the sole culprits for the massive failure to report and follow up on possible cases of sexual abuse, says research by the Office of Inspector General of the US Department of Health and Human Services. In many cases, the government officials did little or nothing to stop abuses. Ms. Chapman told staff about the assault. The facility administrator notified the ombudsman but not law enforcement. The ombudsman never reported to incident to the BMFEA and no criminal investigation was ever conducted (Lew et al., 2010).

State inspectors of nursing homes who participated in the study appeared to be confused about when they were required to refer cases to law enforcement. One state agency said that it contacted the police only for what it called "the most serious abuse cases" (NPR, 2019). In five states where nursing home inspectors did investigate and substantiate cases of abuse, 97% of those had not been reported to local law enforcement as required (CNN, 2017b). In practice, Adult Protective Services and state regulators' standards for "substantiating" or "confirming" a case vary substantially from state to state, locale to locale, and even employee to employee. Such professionals rarely have training in elder sexual assault, in how to collect forensic evidence, or in how to conduct victim and suspect interviews (Connolly et al., 2012).

After reporting her mother's rape to the French health authorities, Fabienne expected them to get explanations from the nursing home. But they did not. Fabienne told them that she wanted to file a complaint against the nursing home GP coordinator of care, who knew about the abuse and did nothing to stop it. They rejected it and the GP is still working there. During the audition, she was not allowed to speak (Paris Match, 2018). CNN found out that most states could not say how frequently abuse investigations involved sexual allegations. One of the reasons being that sex abuse allegations are not categorized separately from other forms of abuse. Of 386 sexual abuse cases in Illinois since 2013, 59 were substantiated. In Texas, 11 of 251 sexual assault complaints in the 2015 fiscal year were substantiated. Wisconsin informed CNN it didn't substantiate any reported sexual abuse in the last five years (CNN, 2017b). This is also the case in Australia where an investigation by ABC News showed that the federal Department of Health does not analyze any of its sexual abuse data for insights into who the perpetrators are, who the victims are, and how many assaults lead to convictions. "The Department of Health stated that they did not investigate incidents of sexual assault as this was a criminal offence and … was a matter for police." (ABC NEWS, 2019a). In Ontario the reporting requirements do not require that the type of abuse be specified. As such, the generalities used to describe specific incidents make it difficult to draw any conclusions about sexual violence specifically (Grant & Benedet, 2016).

In France, there are no official statistics on elderly sexual abuse. A report on sexual violence published in 2019 focused solely on rapes, sexual assaults, and harassment on minors and adults, but not on old people (Ministère de l'Intérieur, 2019). The second, published in 2020, reported 22,900 rapes and 31,200 sexual assaults on minors and adults. It also mentions domestic sexual violence and non-domestic sexual violence, stating that only 12% of victims of non-domestic violence report to the police but there is no information on institutional sexual abuse of the elderly (Ministère de l'Intérieur, 2020). The observatory for sexual violence in the health sector figures for 2017 (Ministère des Solidarités et de la Santé, 2018) showed sexual abuse reported by public and private healthcare facilities and nursing homes. Sexual abuse is divided into three categories: rapes, indecent exposure, and sexual assaults. But reporting is made on a voluntary basis. Nursing homes reported 3 rapes, 15 indecent exposure, and 19 sexual assaults. But these only account for residents perpetrating them against staff. There is no mention of staff abusing residents (Ministère des Solidarités et de la Santé, 2018). For 2018, 1 rape, 24 indecent exposure, and 40 sexual assaults are reported, with 1 cognitively impaired resident who tried to undress a female resident and another cognitively impaired resident who perpetrated multiple assaults on 2 female residents (Ministère des Solidarités et de la Santé, 2019).

Over 1000 nursing homes were cited by the Federal Government for mishandling or failing to prevent alleged cases of rape, sexual assault, and sexual abuse at their facilities. Out of these facilities, 100 had been cited multiple times. But even those that actively impede investigations or cover up abuse often get little more than a slap on the wrist. The vast majority of nursing homes with horror stories chronicled in the inspection reports are still in business. The investigation also revealed that nursing homes and oversight agencies rarely conduct in-depth investigations. Claims that cannot be investigated are considered unsubstantiated. Then even nursing home employees who are investigated multiple times for sexual abuse can have spotless records and continue to have access to more elderly patients and more victims (CNN, 2017b). When potentially dangerous cognitively impaired residents cannot be isolated from other residents, sexual assaults cannot be prevented. In France, CGT union representative Laurent Margueritat said that abuse, including sexual abuse, was rife in La Creuse nursing homes. "They are closing down special units in nursing homes where potentially dangerous patients could be isolated. And most of all, we are understaffed. We need twice as many nursing aids. We have been alerting the authorities for a year" (France Bleu Creuse, 2020). Facilities are rarely closed. One nursing home director explained that, as far as she was concerned, social services were not the "police" of the facility, but their partners (Hebdo des savoies, 2005). According to CNN's investigation, 226 nursing homes failed to protect residents and investigate substantiated sexual assault claims between 2010 and 2015. Of those facilities, 60% were fined, yet only 16 homes ceased to receive Medicare and Medicaid funding as a result (CNN, 2017b).

Failing Justice

> Just 1.5% of all rape cases lead to charge or summons, data reveals. (The Guardian, 2019a)

Current police practice remains unsatisfactory on handling rape cases in countries including Norway, Sweden, Denmark, Belgium, Australia, the USA, the UK, Canada, and France (Alderden & Ullman, 2012; Amnesty International, 2019; Daly & Bouhours, 2010; Felson & Pare, 2008; GREVIO, 2019). This makes it extremely challenging for victims to report abuse and to access justice. The proportion of reported cases taken to trial and ending with convictions has decreased internationally (Vik et al., 2020). In France, a government report revealed professionals lacked basic training to adequately meet victims' needs; shortcomings in the collection and preservation of evidence resulting in a large number of cases being dropped; statutory prescription not adapted to sexual violence and post-traumatic shock consequences often delaying facts being brought to light; decriminalizing rape by allowing defendants to be judged by the correctional tribunal (the penal jurisdiction of first instance) (HCE RF, 2016). Between 2007 and 2016, convictions dropped by 40%, with only 12% rapes being reported and only 1.2% taken to trial (HCE RF, 2016). In Denmark, most cases were dropped in the initial processing phases, with the police closing 61.7% of the cases and the prosecution closing 53.7% of the cases referred by the police (Hansen et al., 2015). In Japan, 4% of cases are reported to the police and when arrests are made, more than half the time, prosecutors drop the charges.

> Thousands of rape reports are inaccurately recorded by police. (The Guardian, 2019b)

Most cases are dropped in the initial phase of the legal process (Alderden & Ullman, 2012; Daly & Bouhours, 2010; Hansen et al., 2015; McCarthy-Jones, 2018; Nielsen et al., 2018). The research community has begun recognizing and studying police officers' active involvement in the decision-making process (Alderden & Ullman, 2012). Findings show a trend indicating that vulnerable victims may have been less prioritized compared to non-vulnerable victims (Vik et al., 2020). Older women face particular barriers to disclosure and accessing the justice system, resulting in their experiences remaining hidden. Many of these barriers—agism, cognitive and health impairments, and living in a residential care setting—contribute toward older women's experiences being ignored, dismissed, or downplayed by potential bystanders (Fileborn, 2017). An Australian criminological report from 2017 described several types of common misconceptions related to characteristics of the victim: "People with disabilities are rarely victims of rape, and if subjected to rape they are not capable of relaying details about the incident"; "People with mental health problems often fabricate reports of rape" (Vik et al., 2020). Compared to younger victims, incidents involving older victims were significantly less likely to be deemed a crime 69%, and 82% less likely to be referred for charge (Walker et al., 2019). Charges are often dropped when the victim is diagnosed with dementia. The police refused to investigate an elderly lady's sexual assault claim, not because of her cognition; but because of her diagnosis of dementia (SBS News, 2019). In one case,

although the accused admitted to sexually battering three elderly women, prosecutors dropped the charges against him because the patients' memories were so poor that they have no recollection of being sexually abused (Action News Jax, 2015). *Ditto* for a nurse accused of having raped three times and sexually abused two other women, but the charges were dismissed when prosecutors were unable to secure the alleged victim's testimony for trial (CNN, 2017c). Norma was able to tell her story coherently and consistently and identify her attacker, but given the lack of forensic evidence, the case was dropped (Barrett et al., 2014). Lack of evidence, negative community attitudes and denial around older people and sexuality, contributed to these crimes remaining taboo. Frequently, cases are not thoroughly investigated and prosecuted. Conviction rates of the perpetrators were less than 1% (Barrett et al., 2014). But even where the evidence included positive rape kits and statements by victims, and eyewitnesses to the alleged crime, there was no conviction, report Holly Ramsey-Klawsnik and colleagues. Not a single one of the 32 confirmed cases—let alone the 119 alleged cases—resulted in arrest or prosecution of the alleged perpetrator. And these findings echo the results in other case examples, exhibiting a similar disbelief, mishandling, and ignoring of allegations of elder sexual assault (Connolly et al., 2012). Perpetrators of nursing home sexual assaults are rarely prosecuted and convicted of the crime (Burgess et al., 2005). In a study of 82 sexual abuse cases against women residents in nursing homes, in which 95% of the perpetrators were identified, only 5% were prosecuted, and 3 convictions were obtained. In another study, only 6% of APS cases were prosecuted in court, and in only 1 of these cases was the offender convicted (Grant & Benedet, 2016). The older the victim, the less likely an offender will be convicted of sexual abuse, according to a study sponsored by the National Institute of Justice. And victims who lived in facilities were even less likely to see their assailants face charges and guilty verdicts (CNN, 2017b). When the do, the outcome tends toward leniency. The CNA who molested and sexually assaulted Ms. Roberts nearly 30 times in two months, plead to misdemeanor lewd conduct, served six months in jail, and was released on 4 years' probation (Lew et al., 2010). Retired Virginia Police investigator Bill Lightfoot explained that many perpetrators, if caught, only face a single charge of sexual assault. That is if the elder is heard and believed, her story is not attributed to fantasy. When a child is abused, the suspect's history is investigated for previous convictions for similar crimes and to find out if he is a known pedophile. There are no such investigations for sexual abusers of old people, yet rapes of elderly women tended to involve serial rapists. Prosecuting such cases is not glamorous and it is a lengthy process. District attorney offices do not always have elder prosecution units. In Europe, they do not even exist.

A study by Pamila Lew et al. shows that incidents of abuse of nursing home residents by care staff are not handled as criminal matters but as licensing or employment concerns. Their investigation shows that reports to entities in the abuse response and criminal justice systems were delayed; evidence was not gathered; investigations lagged or were never initiated; victims died while awaiting justice; and in at least one case, the assailant moved on to another care facility (Lew et al., 2010). There is an urgent need for additional guidance and training of law enforcement officers,

prosecutors, state officials (including regulators), APS workers, and facility staff about the handling of elder sexual assault matters (Connolly et al., 2012).

Conclusion: Breaking the Silence

> Violence, Against Older Women: Time for a Global Unveiling of the Last Taboo […] often remain shrouded in the global discourse on Elder Abuse. (UN, 2019)

Like child abuse and domestic violence 50 years ago, elderly sexual abuse is a silent and often invisible crime. Shocking, unbelieved, the most hidden as well as the least acknowledged and least reported form of elder abuse (Burgess et al., 2006; Smith et al., 2019; Vierthaler, 2004). UN expert Rosa Kornfeld-Matte warned that with the aging of our societies, "sexual abuse and rape of older persons is expected to grow dramatically" (UN, 2019). Elderly women in nursing homes will be hardest hit, since victims in these facilities are overwhelmingly female (95%) (Dawson & Peirone, 2018; Mcdonald et al., 2012), and cognitively or physically impaired, making them the perfect preys to be abused in almost total impunity. Keeping these crimes taboo, not talking about them encourages them to go on. Criminologist John Braithwaite, believes that until the culture of cover up is demolished, these crimes against vulnerable old people will continue. "There are things that directors of nursing homes do, when allegations of sexual abuse occur, that no school principal would dare do these days" (Braithwaite et al., 2007). Silence needs to be broken and, like with #metoo, sexual abuse of old women has to come under the spotlight. In Australia, the #SheToo campaign (OPAL Institute, 2019) was launched on 8 March 2019 by Margarita, who was brave enough to report sexual abuse and who was lucky to be heard when she did. #SheToo is for the elderly women #metoo forgot, to give a voice to those who cannot speak and those who can but are silenced by their abusers, the system, society, and justice. Unfortunately, no celebrity has endorsed it to attract attention to this major issue expected to get worse rapidly. This cause, just like elder abuse has no champion.

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Chapter 21
Neglect, Abuse, and Violence in Later Life: Intersectionality of Gender and Age

Patricia Brownell and Denise Gosselin

Abstract Research on older women and abuse is important for several reasons: Global trends demonstrate the aging of the world's population; older women outnumber older men in every age cohort 60 years and older; the feminization of aging has important implications for policy and practice as the world ages; and neglect, abuse, and violence against older women remain largely invisible and must become visible to end. Differing theoretical perspectives can highlight different aspects of older women and abuse, but can also result in differing and conflicting prevalence data and profiles of abuse. This can in turn challenge policymakers and practitioners to develop effective policies and interventions to address this troubling social issue. Three differing theoretical perspectives, reflecting intimate partner violence, active aging, and vulnerable older adult frameworks are explored, with recommendations for merging into a holistic synthesis emphasizing a human rights approach.

Keywords Older women · Elder abuse · International aging · Intimate partner violence in old age · Active aging · Vulnerable older adults · Human rights and aging

Introduction

Competing paradigms of elder abuse confound our understanding of neglect, abuse, and violence against older women in later life (United Nations, 2013). A review of these paradigms that have emerged through research and policy advocacy provides a clearer understanding of elder abuse from an international perspective and in particular of abuse in later life affecting women.

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Population Aging and Gender

The global population is getting older. According to the United Nations, Department of Economic and Social Affairs, (DESA), (2020), in 2019, there were 703 million people aged 65 and over, and it is projected to increase to 1.5 billion by the year 2050. The oldest–old, those aged 85 and older, is also expected to increase from 143 million in 2019 to 426 million by 2050 (United Nations, 2020, p. 2).

Feminization of Aging

According to the United Nations (2020), the average life expectancy for women is 74.7 years, while for men, it is 69.9 years. The gender age gap varies by continent; for example, in Latin America and the Caribbean, the average age gap between men and women is 6.5 years. In Central and Southern eastern Asia, the average life expectancy gap is 2.7 years. Globally, there are more older women and older men. For instance, there are 81 men for every 100 women aged 65 and older, but only 63 men for every 100 women aged 80 years and older. The age differences between men and women are shrinking, and it is expected that by 2050, there will be 85 men per 100 women aged 65 and older and 71 men per 100 women aged 80 years and older (United Nations, 2020, p. 2).

In spite of evidence that maltreatment, violence, and abuse of older women are common, yet it remains largely invisible (Crocket et al., 2015). Maltreatment and all forms of abuse against older women must become apparent in order to end.

Theoretical Perspectives

Different research frames based on different theoretical bases use different age cohort data and different variables. Consequently, they result in different and conflicting prevalence data (Brownell, 2014).

Intimate partner violence: For example, in intimate partner violence studies, old age may start at 30, 40, 50, 60, or 65 years of age, and this determines the ages of study samples. Types of abuse may include physical, sexual, and psychological. Perpetrators are typically male if female victims are dating partners, current or former spouse/partners, or strangers in instances of sexual abuse such as rape. The underlying theory is power and control. Prevalence rates for older women can range for 1–3% (within a year's timeframe) and 3–4% (within five years' timeframe) if this is included at all. However, cumulative prevalence rates for lifetime abuse, however, are estimated at 22–27% (Garcia-Moreno et al., 2013).

An example of an international prevalence study on domestic violence (DV) is the by the World Health Organization (WHO). Typical of DV prevalence studies, the

age of the sample population ends at 49 years, effectively eliminating any findings on older women. The underlying theory is that of power and control (Garcia-Moreno et al., 2005).

Active aging: Prevalence studies on elder abuse in the active aging framework utilize study samples of older adults age 60 years and older, who live in the community. Types of abuse included are physical, sexual, psychological, neglect, and financial exploitation. Perpetrated categories include spouse/partners, adult children, grandchildren, other relatives, neighbors and friends, and caregivers. Prevalence rates for a one year period range from 10 to 39%. An example of a research study within this theoretical framework is "Under the Radar", a study of elder abuse in New York State (Lachs & Berman, 2011). The underlying theory is ageism (Butler, 1989).

Vulnerable older adult: Typically, studies on elder abuse in the vulnerable older adult framework do not include prevalence because of the difficulty in random sampling of self-reported abuse by older adults who are presumed to be frail, care-dependent, and often residing in institutional settings. These individuals are also presumed to be cognitively impaired, making informed consent difficult to obtain (Brownell, 2014).

Typically in studies of elder abuse in this framework, subjects' ages are 65 years and older. Types of abuse include—in addition to physical, sexual, psychological, neglect, and financial exploitation—abandonment and self-neglect. Subjects are generally not disaggregated by gender. So, data specifically on older women and abuse are difficult to obtain for frail and care-dependent older adults. The underlying theoretical assumption is that of impairment and vulnerability of the victim, generally assuming cognitive and physical impairment (National Research Council, 2013; United Nations, 2013).

Human rights framework: This framework assumes that all forms of abuse, neglect, and exploitation are violations of rights of older adults. This frame uses a life course, not life stage, perspective and incorporates the concept of trauma, linking abuse experienced early in life with later abuse. This framework includes the broadest array of potential perpetrators including state actors as well. Settings can include institutions like care homes and prisons, as well as community. It prioritizes race/ethnic minority populations that are socially and economically marginalized.

Types of abuse can include social isolation, social exclusion, and poverty, as well as physical, sexual, emotional, financial abuse, and neglect. Studies in this frame incorporate the voices of older victims and assume that older people are rights bearers and the state serve as duty bearer. An example of a study in this frame includes the International Network for the Prevention of Elder Abuse—WHO study: "Missing Voices: Views of Older Persons on Elder Abuse" (2002). The underlying theory is violations of human rights. HelpAge International develops its programmatic interventions for older women within the human rights framework (Sleap, 2010).

Examples of Older Adult Abuse in Three Frames and Implications of Older Women

The multiple theoretical frameworks used for understanding elder abuse or—more contemporarily—older adult abuse can result in fragmentation of conceptualizing and as a result understanding the problem of abuse of older women, as well as developing appropriate responses (United Nations, 2013). For example, when we think about domestic violence, we often think about women of reproductive age. When we think about abuse of older women living in the community, we think of older mothers of adult children who may be homebound and dependent on adult children or aging spouses, leading to caregiver stress. Finally, when we think about elder abuse, we often think about physically and cognitively impaired widows in nursing home. How can we find common ground among these three views of older women?

Imagine three women, each 74 years of age. First, imagine one as a victim of domestic violence. She is in good physical health, well-dressed, and well-groomed. However, she has a black eye and other bruises. Second imagine one as a matronly woman cowering under the gestures of a scolding adult daughter. She looks frightened but alert. Third, imagine a frail elderly woman in bed, thin white hair straggling over her pillow, possibly vision impaired, and with obvious bruises on her face.

What do these three women have in common? They are all the same age. They are all victims of abuse. They are all women. What is different? Their health status differs. They appear to have differing cognitive statuses. Finally, they each represent different stereotypes of older women and abuse.

Definitions of Older Adult Abuse

Intimate partner violence: Intimate partner abuse is defined as violence against women that "incorporates intimate partner violence (IPV)" (Saltzman et al., 2002). This definition was developed by an expert panel convened by the United States of America (USA) Centers for Disease Control and Prevention in 1996. Its purpose was to formulate a uniform definition and recommended data elements for gathering surveillance data on intimate partner violence. It excludes financial abuse, neglect/self-neglect, and abuse by family members other than spouse/partners except for strangers in the event of sexual assault. Victims are assumed to be primarily female. This definition forms the basis of IPV research globally.

Active aging and abuse of older adults: In the Toronto Declaration on the Global Prevention of Elder Abuse, elder abuse is defined as "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust and which causes harm or distress of an older person. It can be in various

forms: physical, psychological, emotional, sexual, and financial or simply reflect intentional or unintentional neglect" (WHO/INPEA, 2002).

This definition was formulated by a group of researchers and policymakers on elder abuse meeting in Toronto, Ontario, Canada, and built on a definition developed by ACE UK. It seeks to have a broad scope to include older adults living independently or with supports in the community and is implicitly gender neutral, assuming that male and female older adults could be victimized in equal measure.

Vulnerable elders: That older adults with impairments are most vulnerable to abuse is a common assumption among members of the general public. A definition using this frame was developed by an expert panel (Panel to Review Risk and Prevalence of Elder Abuse and Neglect) convened by the National Research Council (NRC) of the United States National Academy of Science.

In this definition, abuse of vulnerable older adults refers to "intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or failure by a caregiver to satisfy the elder's basic needs or protect the elder from harm" (National Research Council, 2003). Care dependency on the part of the victim is assumed.

Abuse of Older Women as a Human Rights Violation

International human rights protections for women are codified in the Convention for All Forms of Discrimination Against Women (CEDAW). However, protections for older women are not specified in this Convention. General Recommendation No. 27 on Human Rights for Older Women was approved by the United Nations General Assembly in 2010 (United Nations, 2010); this is just a recommendation that the CEDAW Committee expects countries signed onto the treaty itself to adhere. As a treaty, CEDAW is binding on all parties that ratify it; those countries that sign onto it but do not ratify it are obligated not to act contrary to its provisions. The USA signed onto it in 1980 but never ratified it.

Other non-binding documents that the USA supported include the Madrid 2002 International Plan of Action on Ageing (MIPAA) and the United Nations (UN) Principles of Human Rights for Older Persons (United Nations, 2003). The MIPAA states: "Older women face greater risk of physical and psychological harm due to discriminatory societal attitudes", and the UN Principles for Older Persons states: "Living a life of dignity, free of abuse, is an important human right for all older people, including older women." CEDAW emphasizes that violence against women is rooted in historical and structural inequity in power relations between men and women. The MIPAA and Principles stress ageism as a root cause of violence against older people.

The human rights perspecitve states that physical, sexual, emotional, or psychological, financial, and material exploitation, neglect and abandonment, harmful traditional practices, femicide and proverty as forms of abuse against older women. While abuse prevalence estimates range from 1–2% to 39% of older women age 60 years and older, discrepancies are largely due to differences in theoretical frameworks, measures used, and samples drawn. Internationally, estimates of lifetime experiences of abuse remain fairly stable at 20–27%.

Studies within the IPV framework that include older women in study samples show the lowest prevalence of abuse. A closer analysis of these studies finds that definitional criteria limit perpetrator categories to spouse/partners, dating partners, and strangers in instances of rape or sexual assault. Types of abuse are limited to physical, psychological, and sexual, and locations in which abuse is reported to occur include home and community settings. Ages of sample participants are often limited to women up to 49 years of age, leaving out older women altogether: An example of this is the WHO prevalence study on domestic violence (Garcia-Moreno et al., 2005).

Prevalence studies on older women and abuse in the active aging framework include women age 60 years of age and older and are generally limited to abuse in the community and subjects who can provide informed consent for participation. Abuse can include physical, sexual, psychological, financial, and neglect. Categories of perpetrators can include in addition to spouse/partners, adult children and other relatives, neighbors and friends, and informal caregivers. An example of a study like this includes the DAPHNE study in five European nations (Luoma et al., 2011).

Studies in the vulnerable older adult abuse framework can include abuse in institutional settings like care homes and hospitals as well as in the community. The ages of older adult subjects often start at 65 years and older, and these subjects typically are care-dependent with physical and cognitive impairments. Perpetrators can include spouses/partners, adult children and other relatives, formal and informal caregivers, and other residents of care homes and institutions. Types of abuse can include physical, sexual, psychological, financial, neglect, and abandonment. Examples of studies include those conducted in nursing homes and do not always include gender of victim or prevalence of abuse, with institutional records, other reports, and third party interviews substituting for self-reporting by victims (United Nations, 2013).

Implications of Different Frameworks

Studies are important sources of information for policymakers and practitioners as to the nature and scope of a given social problem and appropriate interventions. However, the differing pictures of older women and abuse create a sense of fragmentation that extends to challenges for effective interventions.

For example, low prevalence found among older women in IPV studies gives a misleading impression that older women do not experience abuse. Rationals include

older women are likely to be widowed, based on the assumption that only intimate partners are abusers, and less likely to be raped by strangers. In fact, other family members can be abusive, and rape is about power and humiliation of the victim, not sexual gratification.

The reasons for finding high prevalence of abuse among older women in active aging studies include that older women are more likely to live with adult children, more likely to be victims of financial and material abuse, and to be caregivers for impaired abusive family members (Luoma et al., 2011).

The largely unknown prevalence of abuse among vulnerable older adults women in care homes and institutional settings is understandable once one realizes that subjects in these settings are more likely to be considered unable to self-report and to be unavailable for studies that require informed consent.

Implications for Policy and Practice

One unfortunate outcome of the fragmented understanding of older women and abuse is the fragmented and largely disconnected service system that has evolved to address different facets of identified problems and needs of victims and perpetrators. For example, many laws and services are based on the prevailing stereotype of elder abuse victims as frail, dependent, and in need of protection. An example is adult protective services, a social service response system that developed in the USA as well as some smaller countries like Singapore. Adult protective service (APS) programs, largely government run or financed, assume cognitive or physical incapacity of victims who need protection. APS programs can provide critical services to older abuse victims or self-neglecters but are often not appropriate for older female victims of intimate partner abuse victims who are not incapacitated.

Many countries have service systems for domestic violence victims that may include shelters, counseling centers, and other crisis intervention programs through the criminal justice and health systems. However, DV services that assume IPV are not appropriate for older women victims of adult child abuse. In addition, older women homeowners may not want to risk losing their housing by entering shelters, leaving their dwellings to their abusers.

Finally, the concept and impact of polyvictimization, including multiple abusers and forms of abuse, is not generally recognized in elder abuse (Teaster et al., 2015). The impact of abuse as trauma, commonly understood as a consequence of DV, is not yet recognized as a factor in abuse of older adults.

What Practitioners and Policymakers Need to Know About Interventions

Intimate partner violence: For older victims of IPV, DV shelters often do not offer age-appropriate programs for older women. State and local shelter regulations can create barriers to shelters' admitting care-dependent victims or victims with a need for supervised medication regimes. Engagement of law enforcement may require older victims to report abuse by family members to police and courts, something older women may resist out of concern for the family member abuser. Criminal and family courts may minimize the impact of abuse of older women victims although orders of protection can be helpful if used appropriately. These may be rendered inactive, however, if the victim violates the order out of concern for the family member abuser.

Active aging in the community: Aging service programs can provide temporary assistance with meals, social programs like senior centers, interim home care, transportation to healthcare providers, and courts and links to law enforcement for seniors. However, aging service programs do not generally prioritize elder abuse detection and intervention. APS programs may be useful in assessing capacity and need for social services. They can serve as a link to District Attorney Offices, law enforcement, and local- and state-funded services in the community. Community-based elder abuse programs with counseling and support groups are available in some communities but are not widely available or accessible. Finally, faith communities can provide opportunities for outreach and abuse prevention. However, they often have limited capacity for assistance, particularly when members refuse this or when both victims and family abusers are part of the same congregation.

Vulnerable older adult abuse: APS programs in the USA, as well as Singapore and some Canadian provinces, can assist older adult victims who lack the ability to protect themselves and are willing to accept services. For institutionalized older women, ombudsman programs in care home settings can help to address institutional abuse by amplifying the voices of victims and their families. For older women victims who lack capacity, District Attorney Offices and forensic centers as well as APS programs can provide access to guardianship programs.

Human rights perspective: Understanding a life course impact of violence and abuse on older adults is incorporated as part of the human rights framework. Some studies have found a correlation between child abuse and elder abuse (McDonald & Thomas, 2013b). This includes older women in the life course trajectory (girls, women of reproductive age, and older women). It demonstrates the cumulative disadvantages at intersections of gender and age for older women and also distinguishes between elites and other women. Feminist gerontology provides a framework for understanding abuse in later life.

The human rights perspective identifies rights bearers and duty bearers/rights enforcers. Government is considered as responsible for enforcing human rights of older adults. This perspective challenges the residual approach to social welfare

policy and stresses an entitlement approach that is rights-based and focused on empowerment. It also incorporates marginalized older women from an international perspective. The work of HelpAge International to make visible human rights abuses of older women accused of witchcraft and deprived of property rights and denied social protection benefits exemplifies this approach.

Barriers to Effective Elder Abuse Practice

Ageism remains a significant barrier to effective practice with older women and abuse; combined with sexism, it is a toxic combination that not only marginalizes but also denigrates older women's abuse experiences. Practitioners and researchers must work together to reach a better understanding of the unique needs of older women victims of neglect, abuse, and violence. Research can inform practice.

In a technical guide on producing statistics on violence against women promulgated by the United Nations Department of Economic and Social Affairs in (2013), readers were advised that "some countries have opted to set an upper limit for respondents [sic—subjects], the reason being that older people are prone to memory recall problems and tend to have a general reluctance to discuss sensitive subjects …. It is also likely that an older age category will be too small for separate analysis." (United Nations, 2013, p. 15).

Misguided and uninformed statements like this can discourage from including older women in studies on violence against women and seemingly encourage nations to exclude data on older women from domestic violence reports that inform national and international policymaking. Funding limitations drive choices as well. Lack of research on older women and abuse limits policymakers' and practitioners' abilities to make informed choices about needed resources and appropriate interventions.

Promoting the Interests of Older Women at the United Nations and Internationally

Several steps need to be taken to promote research and advocacy on older women. First, it is necessary to expand the definition of perpetrators beyond spouse/partners to also include family members and trusted others. Continuing to define domestic violence as a human rights violation is critical, as is challenging the marginalization of older women within society and the international women's movement, as ageist and unacceptable. Finally, it is important to ensure that the voices of older women are included in all forums and discussions on women and domestic violence.

Obtaining data at the country level on abuse of older women age 60 years and older that is disaggregated by age and gender is also critical. It is important to include older women in documents on domestic violence, and some progress has been made

here. The World's Women: Trends and Statistics (DESA, 2010) had no mention of older women and abuse in its DV section. This was remedied in the report for 2015.

There is a need to conduct outcome research on interventions for older women victims of abuse, including evaluations of legislation intended to protect older women from abuse. Finally, within the DV movement, it is essential to expand definitions of family violence beyond physical, emotional, and sexual abuse to include financial exploitation, abandonment, and neglect.

United Nations Organizational Changes to Promote Gender Equality

UN Women was founded in 2010 to include divisions focusing on women and human rights. Divisions for the Advancement of Women (DAW), International Research and Training Institute for the Advancement of Women (INSTRAW), United Nations Development Fund for Women (UNIFEM), and the Office of the Special Advisor on Gender Issues and the Advancement of Women (OSAGI) were consolidated in this reorganization. There have been two Executive Directors: Michelle Bachelet, 2010–2013, and Phumulle Mlambo-Ngcuka, 2013 to the present.

The value perspective of UN Women is feminist. However, since its inception, its response to older women has shifted between a life stage perspective and viewing older women as "other".

The division of economic and social affairs (*DESA*): DESA includes the focal point on aging, which promotes the interests and concerns of older adults from an international perspective. The value perspective is active aging, with aging as gender neutral. Language related to older women includes: "girls and women of all ages" and "all women and girls". It organizes open-ended working groups on human rights of older persons with UN member nations (states) and partners with the NGO Committee on Ageing on events like the International Day of Older Persons (IDOP).

The third major player at the UN for aging issues is the non-governmental organizations (NGO) community. This represents civil society with responsibility for educating and advocating for special interests within the UN. The NGO Committee on Ageing is an umbrella entity for NGOs with consultative status at the UN concerned about human rights of older people and represents an active aging perspective. The NGO Committee on the Status of Women is an umbrella entity for NGOs with consultative status at the UN concerned about human rights of girls and women. Its value perspective is feminist. A subcommittee on older women, representing the intersectionality of women and aging, linked both NGO Committees on Ageing and women together until 2010, when it became a subcommittee of the NGO Committee on Ageing, and 2016, when it was disbanded by the NGO Committee on Ageing.

Within the UN NGO Community, the International Network for the Prevention of Elder Abuse (INPEA) is the only NGO with special consultative status to the UN with a single focus on elder abuse.

Documents promoting human rights of older women—soft law: Two important documents related to older women include the International Plan of Action on Ageing, promulgated in Madrid, Spain, in 2002, and the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW), General Recommendation No. 27 on the Human rights of Older Persons, approved by the UN General Assembly in 2010. Both these documents are non-binding and serve an advisory purpose only. To date, no binding instrument such as a Convention or international treaty has been ratified by the UN to explicitly promote the rights of older people.

Older women are identified as especially vulnerable as especially vulnerable to human rights abuses in a number of UN documents. For example, in the Madrid 2002 International Plan of Action on Ageing and the CEDAW General Recommendation No. 27, the Sustainable Development Goals (SDGs) reference women of all ages, and a discussion paper on neglect, abuse and violence against older women prepared for an Expert Group Meeting on this topic held at the UN DESA in November 2013 is posted on the UN website and on the internet.

In addition, two appointed positions within the UN are charged with responsibility for issuing reports on issues pertaining to older women and human rights. One, the Special Rapporteur on Domestic Violence, focuses primarily on women of reproductive age and violence. The second, the Independent Expert on Human Rights of Older Persons, is responsible for issuing reports on aging and human rights from a gender-neutral perspective. The Independent Expert has recommended movement toward a binding instrument on human rights for older people.

Events promoting awareness of neglect, abuse and violence against older persons: The most significant international event promoting awareness is the World Elder Abuse Awareness Day (WEAAD), designated by the World Health Organization (WHO) as June 15. This became a UN Day in December 2010, when the UN General Assembly voted to add WEAAD to the UN calendar of special days. June 15 is the designated day to organize events locally as well as nationally and internationally promoting education, awareness and reflection on the neglect, abuse and violence experienced by older adults as a human rights violation. Although not explicitly focused on older women and abuse, it provides an opportunity to shine a light on these violations and remedies.

Examples of Researchers Who Challenge Siloed Approaches to Understanding Neglect, Abuse, and Violence Against Older Women

While not an inclusive list of researchers in the field of older women and abuse, some of the leading researchers are listed here. McDonald and Thomas (2013a) incorporate a life course perspective. Penhale (1999) uses a feminist gerontology framework, especially in her role as researcher for the European study on prevalence of abuse experienced by older women, and her work with Garcia-Moreno and

others in developing a methodology for estimating abuse across the lifespan. Band-Winterstein (2015), Mears (2003) and Hightower et al. (2006) include voices of older women in their studies. Yan and Chan (2012) and Lowenstein et al. (2009) disaggregate abuse of older women and men in their prevalence studies. Brandl (2000), Anetzberger (2012), and Smith (2015) expand the paradigm of older women victims of adult abuse and their abusers beyond the vulnerability frame. Crocket et al., 2015 has highlighted the invisibility of older women. Teaster et al. (2015) and Roberto and Teaster (2005) examine sexual abuse of institutionalized older women. Guruge et al. (2010) incorporate the voices of immigrant older women who experience abuse, and Shankardass (2013) explores elder abuse in South Asia.

Gaps in Prevention and Intervention

Internationally, national legislative initiatives, when they exist, are typically bifurcated between domestic violence and aging or protective services approaches (Brownell, 2014). Older women often fail to fit into either approach. When the problem is intimate partner abuse, older women may be referred to aging service programs that lack the capacity to address domestic violence among older spouse/partners. Older women may not meet the eligibility requirements for protective services for the impaired elderly, such as guardianships, if they are not physically or cognitively frail.

Consequently, older women victims of abuse are likely to fall between the cracks of a bifurcated legislative/legal system. In addition, laws related to abuse and neglect of older women by family members or formal caregivers may be legislative but not funded (United Nations, 2013). This typically results in policy implementation gaps, with unfunded mandates resulting in practice and program shortfalls. Refocusing on issues regarding abuse of girls and women of all ages, with multiple intervention points along the life course, can improve the safety and well-being of older women around the world.

Summary and Recommendations

This discussion of prevalence of neglect, abuse, and violence against older women based on different and sometimes competing conceptual frameworks illustrates the difficulties in using these data to understand and promote older women's rights to live free of abuse. In order to address the current fragmentation in services to older women victims of neglect, abuse, and violence, practice, policy, and research communities must come together to promote translational research and address gaps in knowledge and practice, eliminate ageist stereotypes, and evolve a more holistic view of older women in society.

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