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

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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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M. K. Shankardass (ed.), *Older Women and Well-Being*,
https://doi.org/10.1007/978-981-16-4605-8_9

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

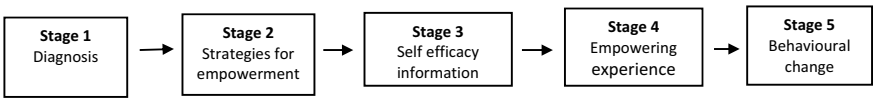

Fig. 9.1 Linear empowerment model

(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.

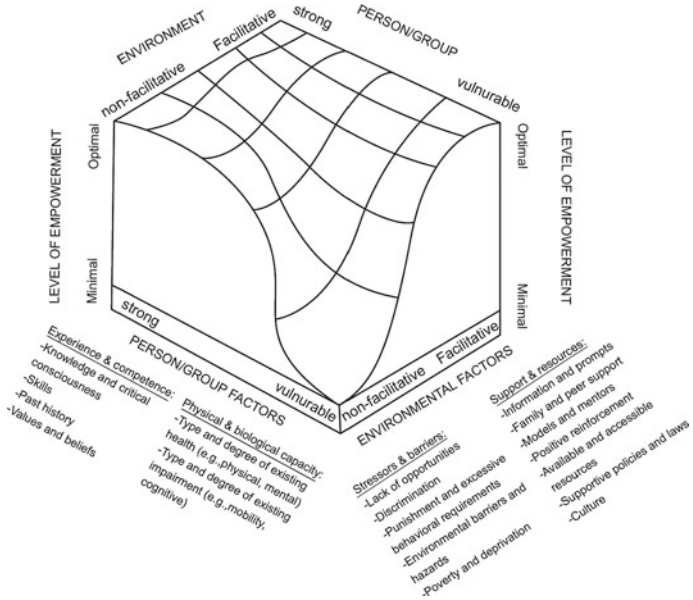

Fig. 9.2 Contextual behavioral empowerment model

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

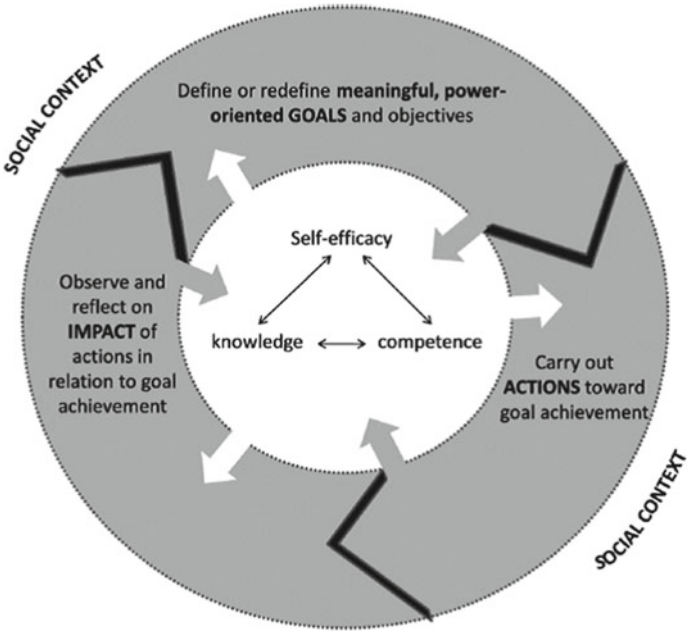

Fig. 9.3 Iterative empowerment process model

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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