Building Knowledge Base on Ageing in India:Increased Awareness, Access and Quality of Elderly Services

Thematic Paper 2

Older Women in India: Economic, Social and Health Concerns

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Economic, Social and Health Concerns

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ACRONYMS

ADL	Activities of Daily Living
BKPAI	Building Knowledge base on Population Ageing in India
BPL	Below Poverty Line
CEDAW	Convention on the Elimination of All forms of Discrimination against Women
ESHG	Elderly Self-help Groups
GHQ	General Health Questionnaire
IADL	Instrumental Activities of Daily Living
IFA	International Federation on Ageing
IPOP	Integrated Programme for Older Persons
MDG	Millennium Development Goal
MIPAA	Madrid International Plan of Action
MoSJE	Ministry of Social Justice and Empowerment
MPCE	Monthly Per Capita Consumption Expenditure
NCD	Non Communicable Diseases
NISD	National Institute of Social Defence
NPHCE	National Programme for Health Care of Elderly
NPOP	National Policy on Older Persons
NGO	Non Governmental Organisation
PRI	Panchayati Raj Institutions
RSBY	Rashtriya Swasthya Bima Yojana
SC	Scheduled Caste
SUBI	Subjective Well-Being Inventory
ST	Scheduled Tribe
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organisation

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OLDER WOMEN IN INDIA: ECONOMIC, SOCIAL AND HEALTH CONCERNS

by

G. Giridhar, Lekha Subaiya and Supriya Verma

I. Introduction

Population ageing is often called a silent revolution, a compelling demographic phenomenon with several implications to socio-economic and cultural aspects, all of which influence the quality of life of older persons in general and more particularly of older women. Globally, the older population 60 years and above is expected to increase from about 810 million in 2012 to over 2 billion by 2050, representing an increase from 11.9 percent to 22 percent of the total population during that period. The number of people who turn 60 each year is nearly 58 million. By 2050 for the first time, the population of older persons will be larger than the number of children below 15 years. Japan is currently the only country with more than 30 percent population in the age group 60 years and above but by 2050 there will be 64 countries with over 30 percent older person (UNFPA and HelpAge International 2012). Bottom heavy family structures with many grandchildren and at best one set of grandparents is giving way to top heavy family structures with two or even more sets of grandparents from 2-3 generations but relatively smaller number of grandchildren.

The old age dependency ratio could more than double in 50 years in some developing countries whereas in much of the developed world this doubling happened over a period of 150-200 years. This rapid pace of ageing in developing countries is not accompanied by an increase in personal incomes as happened in the developed world. Further the governments of newly ageing countries are much less prepared to address this significant and rapid shift in age structure and are also somewhat slower in recognising and responding to the significant demographic shift and implications to socio-economic and health issues. Added to this is a general apathy to address this issue, including seeing older persons as burdensome. Ageism (the stereotyping of older people and prejudice against them) and age discrimination (treating someone differently because of their age) continue to exist. When ageism is combined with sexism, older women face a double layer of discrimination (Soropimist 2011). Only in recent years is there is a gradual recognition that older persons are involved in (a) the substantial transfer of resources within the family and community; (b) providing instrumental support (shopping, cleaning, home maintenance, child care etc.) and (c) providing emotional support for children (advice and validation). In more recent times, older persons have also been recognised as an important group of consumers and a profitable market for health products (Knipscheer et.al. 1995). The United Nations has made significant contributions in changing this mindset.

There are three key demographic changes that contribute to population ageing: declining fertility, lower infant mortality, increasing survival at older ages– all of which are indicators of success and development. Many challenges faced by an ageing population are generally related to two common features across almost all countries: (i) ageing of the aged, resulting in a large increase of population 80 years and above and (ii) feminisation of ageing as women live longer than men. It is estimated that women constitute 55% of all older persons and a majority of them (58%) live in developing countries. By 2025, nearly three-quarters of the world's older women are expected to reside in what is today known as the developing world (Gist and Velkoff, 1997). Together the two phenomena (ageing of the aged and feminisation of ageing) will result in large numbers of very old women out-living their spouse. Such late life transition in marital status affects older women's living arrangements as well as economic and emotional wellbeing, especially when they carry higher burden of ill health and disability. Women dominate the older person population in terms of numbers, but it is hardly a woman's world for older women as strong gender barriers are likely to have influenced the younger years of their life course and continue even in late age becoming in fact more explicit. The level of vulnerability among older persons often increases when younger people decide to out-migrate for employment. When caught between modernity and tradition, individuals and families develop ambivalence towards the wisdom and experience of older persons in addressing present day concerns and problems, and the perceived value of older persons in general and older women in particular gets diminished (United Nations 1999).

As women live longer (than men), they experience a longer period of ill health, poverty, financial insecurity, high levels of dependency and gender-based discriminatory practices. Often gender stereotypes lock women into care giving to other older family members. Further, widowhood is associated with harmful traditional and cultural practices.

While much of late life experiences of women seem to be adverse, there is some evidence that aspects of the ageing process are positive for women. Studies have shown that older women feel a greater sense of fulfilment and self-actualization than during their younger years. (Susan Nolen-Hoeksema, 2010). As women usually feel powerless towards many things in a typically male dominated society, they feel less depressed in old age than men who are unused to the powerlessness and loss of control that often accompany old age. The inherent resilience (ability to adapt well to different life situations) among women is known to help them cope with old age problems better than their male counterparts. Although women generally carry a higher morbidity burden, they are also known to have larger and better family support networks in old age. Older persons often become active co-constructors of their reality and adapt coping measures to minimise the effects of ageing (Lagase et al. 2012).

This thematic report on Socio-economic and Health Status of Older Women in India is divided into five sections:

Section-1 briefly describes relevant national and international efforts by the United Nations in drawing attention to issues of population ageing in general and concerns of older women in particular. The UNFPA contribution in India through a project called Building Knowledge base on Population Ageing in India (BKPAI) is also briefly described in this section.

Section-II is on economic status of older women with respect to work, income status and financial dependency;

Section-III is on social status covering living arrangements, life changes due to marital transition and loss of spouse, participation in decisions on family matters, time use patterns and participation in social networks outside home;

Section-IVis on the health status of older women, their levels of morbidity and their health seeking practices;

Section-V describes gender disparity on the above socio-economic and health dimensions as well as in levels of awareness and use of social security schemes by government;

Section-VI contains some specific suggestions emanating from the findings and some general suggestions relevant to policy and programmes for older women.

Section-1 International and National Efforts

1.1 International Initiatives and Plans of Action

Over the past three decades the topic of women and aging has received considerable attention across the world. The fact that women live longer than men and with distinct needs has been recognised in several international plans of action and in many research documents. The United Nations has played a lead role in bringing together governments from most countries of the world with the aim of increasing awareness and advocacy towards creating effective national policy responses to population ageing. Technical support was made available for countries to respond to population aging in general and to the special needs of older women in particular. These efforts have helped enhance clarity on aging issues, by including future projections and scenarios as well as the voices of older men and women.

The UN Decade for Women was launched at the First International Conference on Women in Mexico in 1975 at which only a brief mention was made of the vulnerabilities faced by older women. The 1982 Vienna International Plan of Action on Ageing identified areas of concern for ageing women for the first time and called for social security and social programmes for older women in member countries. The Forward Looking Strategy adopted at the end of UN Decade for Women 1985 mentioned that ageing in general and experiences of older women in particular need to be considered from a life course perspective. In 1990, the UN designated October 1 as the International Day of Older Persons, followed in 1991 with a set of five principles for older persons: Independence, Participation, Care, Self-fulfilment and Dignity. (Please see Annex-1 for more details). In October 1992 the UN passed a resolution called the Proclamation on Ageing, urging governments to support practical strategies for enhancing quality of life of older person. The resolution called for policies and programmes to be developed to meet special needs of older women and to give adequate support for their largely unrecognised contributions to the economy and to the well-being of society. To give special emphasis to ageing, the UN designated 1999 as the International Year of Older persons. (Please see Annex-2 for more details).

The International Conference on Population and Development held in 1994 in Cairo and the World Conference on Women held in 1995 in Beijing further urged UN member states to formulate effective policy responses to population ageing in general and improving lives of older women in particular. This was followed by the second World Assembly on Ageing in 2002 in Madrid by which time rapid ageing had been recognised as a more developing country phenomenon. The Madrid International Plan of Action (MIPAA) got over 170 countries including India to agree to the need to link ageing with other frameworks of social and economic development and human rights, recognising that ageing will be the most dominant aspect of the demographic landscape of this century. The MIPAA calls for a comprehensive and inclusive development objective that recognises the special needs of older women and for recognising and supporting their contributions to family, community and society. Empowering older women to develop as community agents of change is also an area of focus. To support the national implementation of MIPAA, the UN published a guide for use at the national level (United Nations, 2008). In 2009, the UN Population Fund brought out a publication on Population Ageing and the MDGs, stressing among others the serious lack of attention to the demographic revolution of ageing in the MDGs (UNFPA, 2009).

The World Health Organisation (WHO, 2007) has proposed six major determinants of Active Ageing (economic determinants, health and social services, behavioural determinants, personal determinants, physical environment and social determinants), with gender and culture as cross cutting factors that affect all the others. For example, the gendered nature of care giving and employment means that women are disadvantaged in the economic determinants of active ageing. Similarly, health seeking behaviours are also affected by culture and gender related societal practices. Using UN's five principles for older persons referred above, WHO suggested three pillars of active ageing: Participation, Health and Security and emphasised the need to use a gender lens while reviewing them. In a high level consultative meeting by UNFPA India in 2014, three pillars - Dignity, Health and Security - were proposed for support to India's older persons. The International Federation on Ageing (IFA) held its global meeting for the first time in India (Hyderabad) in 2014 and helped move this agenda for improving the quality of life of older persons in general and older women in particular.

In 2012, several UN agencies and leading international NGOs coordinated by UNFPA and HelpAge International brought out a very useful joint publication marking MIPAA+10 titled

Ageing in the 21st Century: A Celebration and a Challenge. Very recently, the UN released the zero draft of the outcome document titled Transforming the World by 2030: A New Agenda for Global Action which will be discussed and approved in September 2015 as a successor to the MDGs as the post-2015 development agenda.

CEDAW: While the above UN efforts have been very important in their own right, the Convention on the Elimination of All forms of Discrimination against Women (CEDAW) is special with its three universally agreed principles: (1) principle of equality, (2) principle of non-discrimination and (3) principle of state obligation. In a significant move, CEDAW in

January 2010 through General Recommendation #27 focussed on older women's enjoyment

of their human rights and fundamental freedoms which State Parties are under the obligation to respect protect and promote. CEDAW mandates countries to pay attention to issues of ageing and women at the country level against global normative standards of gender equality in later life. Countries are also obligated to permit an international review of actual performance by countries against these standards.

The Convention recognises that women tend to suffer disproportionately from various forms of discrimination. Ageing makes this situation more complex. The Committee which drafted recommendations on protection of rights of older women expressed concern on the lack of statistical data, disaggregated by age and sex, regarding abuse, neglect and violence against older women, and also their insecurity in respect of their financial, medical and housing needs. Older women experience many forms of exclusion which cumulatively expose them to

multiple forms of discrimination based on deep-rooted cultural and social bias (CEDAW 2010).

CEDAW's focus on the vulnerabilities of older women through GR 27 is therefore seen as a landmark development on gender issues in population ageing.

1.2 Ageing in India and National Policy Response

In India the pace of population ageing is not as rapid as in some other countries in the region like Sri Lanka, Thailand, China, Singapore, South Korea, Malaysia etc. By 2050, these countries are likely to have 30% or above older persons in their population while in India this is expected to be around 20%. However, relatively young India is also gradually moving towards an ageing India as the demographic bonus is likely to last for only a decade or so. By 2050, life expectancy for males are projected to be 71.8 years and for females 75.7 years if the current demographic conditions persist. By that year, the number of older women will exceed the number of older men by 18.4 million. Further, while there were 23 older persons for every 100 children in 2001 this ratio will rapidly increase to 53 older persons for every 100 children by 2026. During this period, there will also be a reduction in the number of persons in the working ages available to provide economic support to an increasing proportion of older persons (Subaiya and Bansod, 2014).

During 2000-2050, the overall population of India will grow by 56% while the population 60+ will grow by 326%. During the same period, the population 80+ will grow 700% with a predominance of widowed and highly dependent very old women. The number of older women compared to the number of older men will progressively increase with advancing ages from 60 through 80 years.

India is signatory to all the global conferences on ageing as well as the Regional Plans of Action showing a clear commitment to addressing ageing issues. The Government of India brought out the National Policy on Older Persons (NPOP) in 1999, almost three years ahead of MIPAA. The National Social Assistance Programme for the poor is also an outcome of the Directive Principles of our Constitution (articles 41-42) recognizing concurrent responsibility of the

central and state governments in this regard. The government also implements welfare schemes such as Old Age Pension and Widow Pension schemes through the Ministry of Rural Development albeit with limited reach. Increasing the meagre pension amount and implementing easy and transparent disbursement processes are also areas needing much attention. The BKPAI project is in the process of documenting and disseminating information about such good practices.

The Ministry of Social Justice and Empowerment (MoSJE) coordinates age friendly programmes implemented by several other ministries. In 2007 the Ministry piloted the landmark legislation called the Maintenance and Welfare of Parents and Senior Citizen's Act. Following the NPOP, the Ministry of Health started a dedicated health initiative for older persons called the National Programme for Health Care of Elderly (NPHCE) to enhance access and utilisation of health care services by older men and women.The Ministry of Panchayati Raj focuses on age-friendly PRIs to better involve older persons in local development initiatives. Many other Ministries are also implementing several schemes specially meant for older men and women (including travel concessions, subsidies and higher interest rates in banks etc.) (Rajan, 2014). Recently, the government has also initiated a contributory insurance scheme and old age pension scheme that would help the poor and those working in unorganised sectors in their later years.

Three significant areas in which NPOP makes specific reference to older women are: (1) expanding social and community services and enhance accessibility by removing barriers and making services client-oriented and user-friendly; (2) making family members appreciate and respect the contribution of older women with special programmes and partnership with media; and (3) working with the legal system to protect widow's rights of inheritance. The government recognises that policy and programme initiatives from many government departments would be needed as ageing responses cut across mandates of many Ministries. Further it is also recognised that active involvement of NGOs/CSOs and the private sector would be essential in efforts to enhance the quality of life of senior citizens. The Integrated Programme for Older Persons (IPOP) has specific allocations for this purpose.

Review of NPOP: At the end of 10 years of NPOP implementation, MoSJE set up an expert group to review and suggest revisions. The revised draft called the National Policy for Senior Citizens (NPSC) was prepared in 2011 based on several consultative meetings across the country. In addition four expert sub-committee reports were also used as basis for revisions. These are: (1) sub-committee on oldest old (80 plus); (2) sub-committee on safety and security; (3) subcommittee on gender perspective; and (4) sub-committee on health and disability. Each sub-committee prepared a background paper for use in the review process.

The gender background paper (Shankardas, 2013) builds on the observation that higher proportion of older women than men experience several vulnerabilities that are largely gender based. Both older women and men have their sets of concerns but these are more severe on women due to a life time of gender based discrimination arising out of deep rooted cultural and social bias. Drawing from the 2001 Census data, the paper points to the high rate of widowhood among older women compared to men. The reach of old age pension schemes was also very limited; the amount grossly inadequate; and the process of claiming and disbursement has many shortcomings.

The draft NPSC proposed universalising the current pension scheme to all senior citizens, especially widows, single women and oldest old and a monthly pension of Rs 1000 per person was recommended with additional pension in case of disability, loss of adult children and for indigent women. Regular health checkups particularly for older women who tend to neglect their health and bonding between generations through value education through school curricula are some of the many recommendations of the draft NPSC which is still awaiting cabinet approval.

1.3 UNFPA India: Initiatives on Population Ageing

In line with UNFPA's global strategic plan, the country office in India launched, in 2009, the Building Knowledge Base on Population Ageing in India (BKPAI) project in collaboration with the Institute for Social and Economic Change in Bangalore, the Institute of Economic Growth in Delhi and the Tata Institute of Social Sciences in Mumbai. Phase-1 of this project supported the review of existing literature and the analyses of secondary data including the Census,

National Sample Surveys, National Family Health Surveys, etc., covering various aspects of older persons lives including demographics, workforce participation, living arrangements, health status and policies and programmes (Giridhar et al., 2014).

While Phase-I focussed on the analysis of secondary data Phase-II, launched in 2011, supported primary data collection through a sample survey in 7 states (Himachal Pradesh, Kerala, Maharashtra, Odisha, Punjab, Tamil Nadu and West Bengal) with a sample size of 1280 households with at least one older person from 80 primary sampling units in each state, equally divided amongst rural and urban areas (Alam et.al., 2012). The national and state reports based on the survey data have been disseminated and have generated considerable interest on ageing issues. In order to encourage research on ageing, the BKPAI project has made the primary data set available to other Indian researchers in academic and research institutions on request, together with modest funding support if needed. The BKPAI project houses a working paper and thematic paper series based on the survey data.

Further, several advocacy efforts are being undertaken, including working with media, documenting selected good practices across the country and active involvement of senior government officials in the some core Ministries relevant to population ageing. A management study of the National Institute of Social Defence (NISD) which supports capacity building on ageing issues will make recommendations for upgrading it as a centre of excellence. Further the UNFPA also provided support to a leading NGO working on women's empowerment, Stree Shakti, in bringing out a very useful publication that includes nine selected innovative practices for care of elderly women in India (Stree Shakti, 2014).

Overall, the survey covered 9852 older persons from 8329 households in which at least one older person lived (households with no older person were not selected in the survey), of which 53% are women and 47% are men. Among the surveyed older persons there is a higher proportion of young-olds as 62% of them were 60-69 years old. However, it is in the 70-79 age group where the number of older women were significantly higher than older men (1122 women per 1000 men). Among rural older women, 73% have no formal education and a further 10% have completed less than five years in school. The urban situation is slightly better although even there, 46% older women have no formal education. This is further reflected in lower potential for earnings, higher dependency and lower status of older women in general as described in subsequent sections of this report.

Section-II: Economic Status of Older Women

Income insecurity is a significant source of vulnerability among older women. More than four out of five women have either no personal income at all or very little income. Economic dependency among older women is therefore high. One-third of older women do not own any assets, although more widowed women own assets compared to married women. Only a third of widowed women receive social pension. Poverty drives over ten percent of older women to work, largely in informal sectors with low wages, no retirement or post-work benefits. The accentuated economic vulnerability and poverty of older widowed women is found across all survey states.

The survey covered several economic aspects of the households in which at least one elderly lived as well all the older individuals themselves. These included: the household's monthly per capita consumption expenditure (MPCE), several elements of a comprehensive wealth index of the household, sources of financial support for the older person, personal income and asset ownership, individual work status, the older person's economic dependency and contribution to family expenditure.

About 36% of households in the sample fall below the poverty line with an MPCE of Rs. 1000 or below. Over 80% of households reported not receiving any support (financial or in kind) from India or abroad. The small proportion of households (14%) receiving financial support report government as the primary source of such support.

2.1 Older women have low levels of personal income and asset ownership and high levels of dependency:

Income insecurity is a significant aspect of vulnerability among older women. Overall 59% of older women do not have any personal income from salary, interest, pension, etc.,. Another 26% of them have less than 12 thousand rupees annually (Table 2.1). Income insecurity increases with advancing age. Among the older persons reporting no personal income, about 42% are poor, 4% are living alone and 49% are widowed. About 66% of all older women are fully dependent financially on others and another 21% are partially dependent.

One-third of older women and about 11% of older men do not own any assets at all. Older women have much less asset ownership than older men whether it is inherited or self acquired. About 19% of older women own inherited land, while 23% own an inherited house and 23% own houses that are self acquired. Much higher proportions of older men own these assets. The son is the main source of financial support for older women, particularly after the loss of spouse. The high level of economic dependency among older women, combined with lower levels of asset ownership (land and housing either inherited or self acquired) and no income place older women in positions of accentuated vulnerability.

The proportion of older women reporting no personal income and no social pension is high across all survey states. This suggests that social pensions have not reached those in need. As seen in Fig. 2.2 only a meagre proportion of older women reporting no income receive social pension. Punjab has the lowest proportion (45%) of older women with no income. Further, with highest proportion covered under social pension (42%), Punjab is clearly better off than other survey states. It is notable that Odisha which is a less developed state in the overall sense does not fare as poorly where older women with no personal income and level of coverage under social pension schemes is concerned. In the remaining states,

Figure-2.1 High level of financial dependence among older women by states, 2011

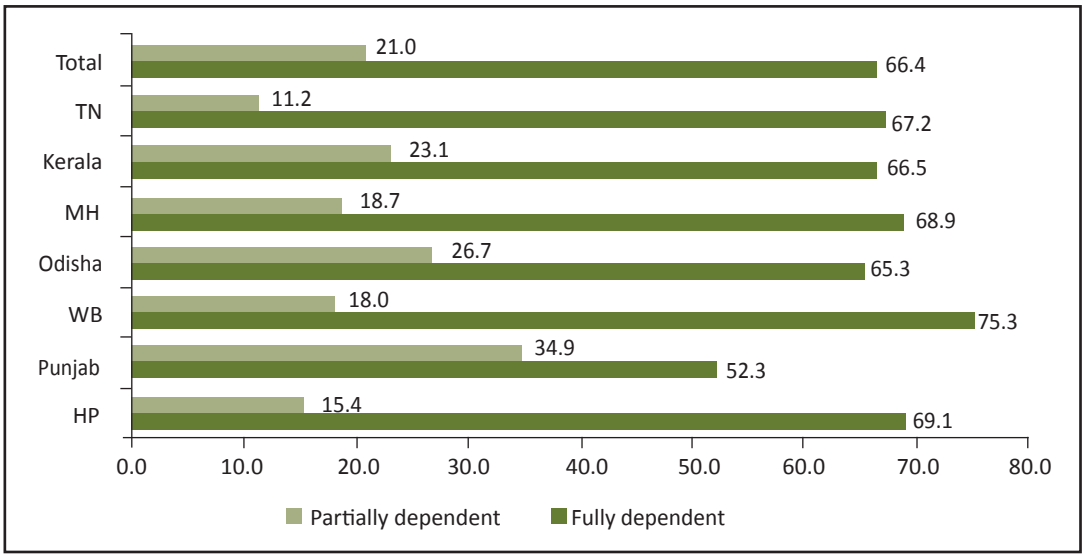
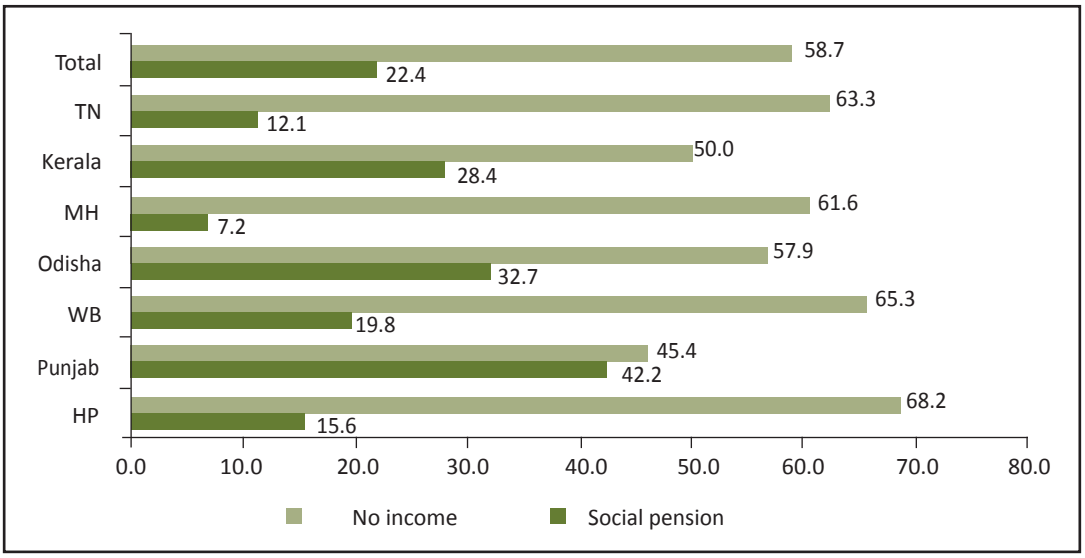


Figure-2.2 Older women who have source of income as social pension and who have no personal income by states, 2011

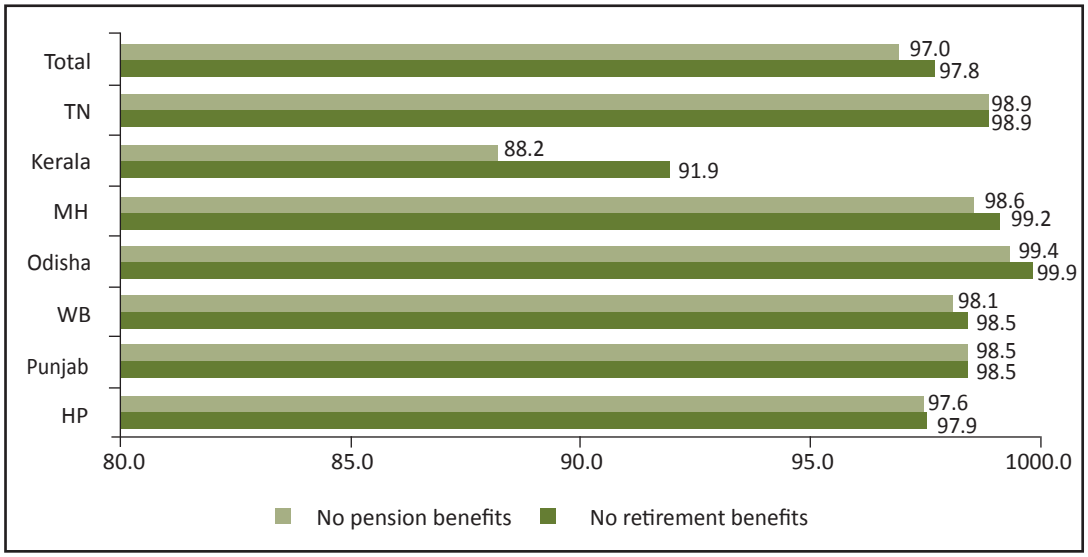


Although the proportion of women reporting no personal income do not perceive making any contribution to household expenses is quite high (64%), there is a small proportion of others who perceive that they are making some such contribution Of the older women who have some personal income, 36% perceived that they are contributing to households expenditure, whether in rural or urban areas. About 13% of these older women perceived that their contribution covered about half of the household spending, largely on daily expenses, medical expenses and towards education of grandchildren. Better access to social pensions will increase the proportion of such older women who make financial contributions, however little. This is one of the important aspects of ageing with dignity.

2.2 Low work participation; Low earnings; High economic need:

About 11% of older women were working at the time of survey and their work intensity is quite high as 73% of them are classified as main workers (more than six months a year) and 89% working for more than four hours a day. Such intense participation in the workforce at older ages indicates economic necessity to earn. Work participation is higher among the poor, less educated and those belonging to SC/ST communities. A large proportion of older women who are working (68%) are engaged in the informal sector where there is no retirement pension or benefits. About half of all working older women are engaged as agricultural labourers (Table 2.2). More than 4 out of 5 currently working older women are poor and face economic and other compulsions to work.

Figure 2.3 Older women who do not receive retirement or pension benefit by states, 2011



Over 95% of older women were in employment where neither pension nor retirement benefits are awarded. This large group of older women are vulnerable and driven largely by poverty and economic compulsions to work. A similar situation exists in all surveyed states. These proportions are relatively lower in Kerala but even in that state this aspect of economic vulnerability is quite high. The work participation rate drops significantly between married men (41%) and widowers (24%) but there is no such decline for older women, suggesting higher economic need for widows to work particularly after death of their spouse.

2.3 Income security and late life widowhood

The relationship between economic wellbeing and marital status of the older population is of interest because women are primarily dependent on their husbands for financial support. Losing a partner means that women are deprived of this source of support, and will have to turn to their children or provide for themselves. A new care providing relationship with other relatives such as children, daughters in law or siblings will have to be negotiated.

Although 85% of widowed women report that they are partially or fully dependent on others for their economic needs, this level is actually less than among elderly women who are currently married (Table 2.3). Widowed women are also 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.

About 35% of widowed women receive social pension and consider it as only source of income. Thus the Widowhood Pension Scheme is an important welfare support for older women but the flip side is that this support is not reaching 65% widowed women. Among men, a slightly larger proportion of older men receive social pension than currently married men, most likely due to the fact that the former group belong to an older age segment and are more likely to be eligible for Old Age Pension.

In general, a majority of women who belong to BPL households do not avail any form of social pension. In Tamil Nadu and Maharashtra, more than 85 per cent of widows from BPL households do not avail this benefit. On the other hand, financial deprivation among widows measured as having no income and no assets in the form of land or housing is highest in West Bengal.

Comparing across states, it appears that widows in West Bengal fare the worst in terms of income, assets, poverty and availing social benefits combined together.

Sulochana is 69 years old and as widow is living alone in a village in Nasik because she has no sons, only three daughters all of whom are married and living with their families in different districts of Maharashtra. She has been working as unskilled labourer in a large cycle making factory for many years and is now thinking of retiring from work as her health has not been good for the last one year and she is unable to put in the normal 8-10 hours of work every day. She asked for a part time work schedule but the company did not accept her request. There are many younger workers who are waiting in line to take her job when she can no longer work. Finally Sulochana had to quit the job but the factory had no obligation to give her any pension. They gave her Rs. 5000 as a one-time payment. With no other source of income and with her "retirement benefit" dwindling fast, Sulochana does not know what else to do and where else to go. She asked a few friends but no one can help. She has now taken up two jobs as a maid in a nearby apartment complex but her health condition is not allowing her. She has already received warnings that she will lose her jobs if she does not put in the proper hours of work.

Source: TISS: Voices of elderly women

Section-III Social Status of older women

Many older women live without spouse and experience a shift in living arrangements in old age. One in ten women over the age of 60 years live alone and this is even more among widowed women with many of them never having contact with their non-co-residing children. In general, living with family, particularly the son, is the most common living arrangement among older women. What is positive is that about 70% of older women have some role in family decision making. Further, many are active in various activities such as prayer, yoga, household chores, taking care of grandchildren etc. Their social networking outside home is also reasonable, albeit limited to religious activities, visiting family or chatting with neighbours.

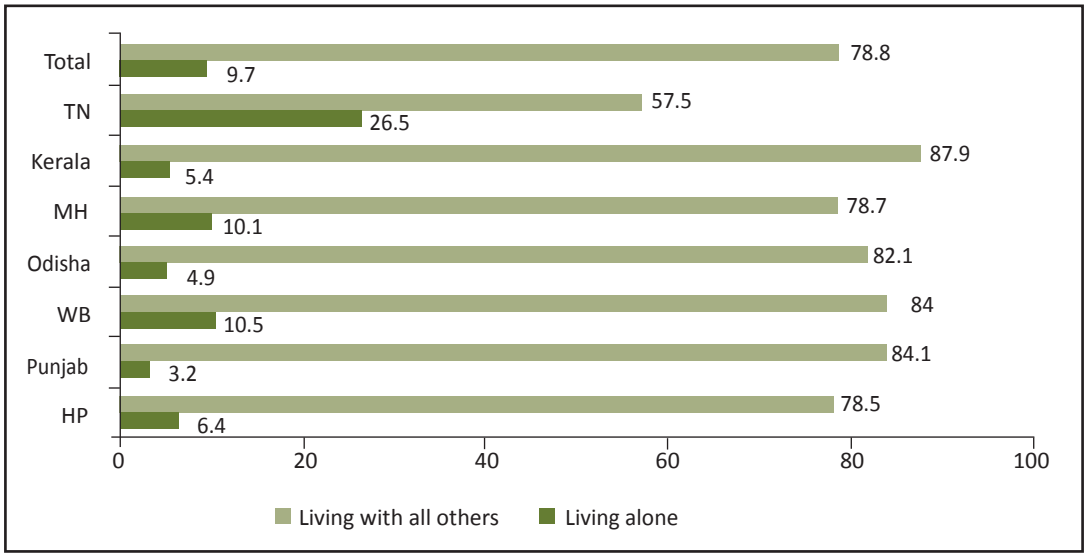
The survey covered various social aspects of elderly lives including living arrangements and family relations, participation in decision making in the family, daily activities, social networking and activities outside the home.

3.1 Living Arrangements of Older Women are Worrisome: Family, more particularly, the male child, has been a strong institution of support in India over the years. However, increasing job related migration is likely to weaken the co-residential structure of the family with clear implications for the future living arrangements of older persons. Due to the high cost of housing associated with rapid urbanisation, children are often forced to leave ageing parents behind when they move to urban areas. This is not by itself necessarily bad for parents as they do not get uprooted from where they have lived for many years and can age in place and financial assistance and money transfers from non-co-residing children could supplement older persons household incomes. In general, however, weakening social security systems are likely to have a negative effect on the quality of life of such older persons. Yet some studies show that technology, transportation and communication systems can to some extent counter balance the perceived negative effects of solitary living in old age (Knodel, 1999).

As women live longer than men, they live longer without a spouse and consequently 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 2% of older men. A significant reason for older women living alone is that their children are away. About 20% older women have begun living alone after 60 years of age (Table 3.1). About a third of all older women living alone are dissatisfied with living alone but perhaps have no better choice, a fact which creates a further worrisome situation. In general, there is a much greater tendency for older women to co-reside with children/grandchildren (46%) compared to only 12% among older men.

Living with family is the most common form of living arrangement for more than three out of four older women in the seven states. An exception is Tamil Nadu where only 58% are living with family while 27% of older women are living alone. The socio-cultural factors in Tamil Nadu underlying this phenomenon require further exploration.

Figure-3.1 Living arrangements of older women by states, 2011



Overall, the survey estimates that about a third of all children co-reside with their parents while the rest live elsewhere. On an average there are 2.7 non-co-residing children per older person.

> Born in 1951 Mrs. S has worked in a rice mill for many years and is currently retired. She is childless and after the death of her husband she has no close relatives except her younger sister who is living in another city. She stays in touch with her sister through telephone and occasional meetings. Mrs. S faces emotional loneliness and has very little social interaction. Childlessness further intensifies both social and emotional loneliness leading to depression. Mrs. S has virtually no post-retirement benefits and has neither any source of income nor any assets. Totally unaware of old age social pension entitlement, Mrs. S is currently looking for a job that can give her some income for her day-to-day living.
>
> Source: TISS: Voices of elderly women

3.2 Coping with changes in old age

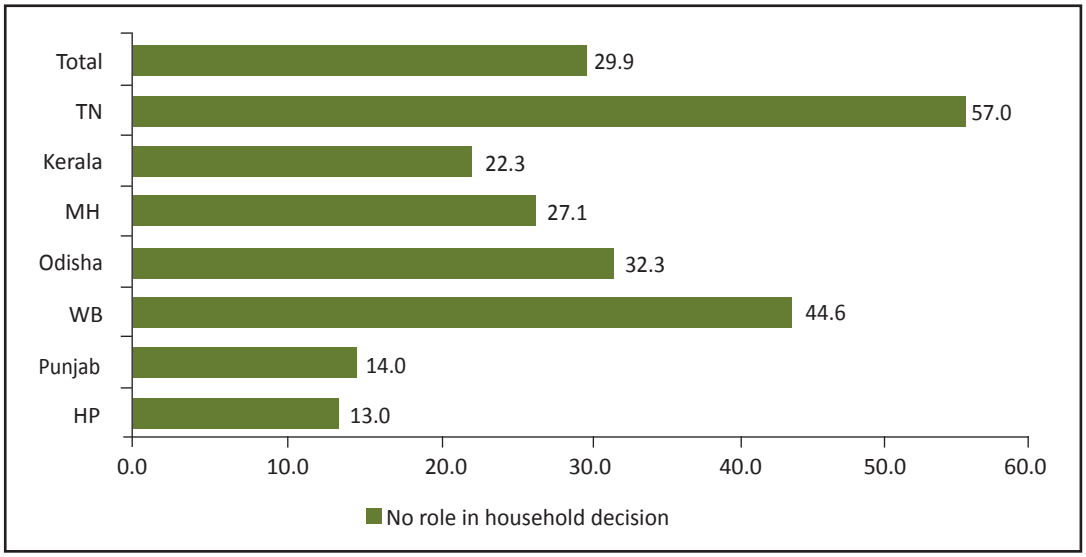
In both rural and urban areas, a significant majority of older women (and also older men) prefer that children (particularly sons) should support parents in old age. Over 56% of older women perceive that children should support them in old age. About 21% of them (mostly those living alone) felt that 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. Living with male child is the most common preference across the states with Kerala topping this list with 81%. Older persons in Odisha (35%) and Maharashtra (28%) prefer the government to support them.

In terms of actual and preferred living arrangement, older women show a higher level of resilience and coping ability. For example, 69% of older women who are living alone also prefer to live alone (that is they are able cope) while only 35% of older men living alone prefer their current living arrangement (Table 3.2).

About 80% of older persons living alone are in contact with their children while about 20% living alone are never contacted by non-co-residing children. Meetings with non-co-residing children is much less in number. Older women in particular face such an emotionally disturbing situation more than older men because they are much less capable than older men of initiating communication with their non-co-residing children due to inability to handle communication equipment by themselves without assistance from others. Only 45% of older women living independently report receiving some financial assistance from their non-co-residing children. This is yet another cause of increased vulnerability amongst older women.

Older women in general perceive that their role in family decision making is much lower compared to older men. Among the states, Punjab has the highest level of participation of older women in family or household decision making, followed by Himachal Pradesh and Kerala. The proportion of older women having no role in household decision making is highest in Tamil Nadu (where the proportion living alone is also the highest) followed by West Bengal. Does this imply a lower level of "respect and status" for them in the family? Or is it because of their living alone? Is having no role in the family decision making by their own choice because they realised that less involvement leads to healthy detachment and resultant peace? While the BKPAI data are not able to answer these questions, it is clear that lack of involvement in decision making will be perceived as a problem only when they desire to get involved but cannot. This is where some amount of adjustment and coping with changes in social situations would be needed on the part of older persons.

Figure-3.2 Older women having no role in household decisions by states, 2011



3.3 Time Use and Social Networking

The most common activity among older women is spiritual in nature, with 3 out of 4 women saying that they engaged in prayer, yoga or singing bhajans at some time during the day. Cooking, washing and other household chores are the second most popular activity, followed by taking care of grandchildren, visiting relatives and shopping. To a large extent, widowhood does not modify the activity mix significantly among older women, except for reduction in time spent on more physical activity in older ages after loss of spouse. (Table 3.3). Social networking activities (such as public meetings on community or political affairs, working with neighbourhood to fix or improve something, participation in religious activities, visit friends or relatives or routinely spending leisure time with friends) outside home do not seem to be important in the lives of older women. A very high proportion of even 60-69 women have never participated in most of the activities and even older women have even less participation. However there are two exceptions to this trend - participation in religious activity and secondly visiting friends and relatives in which nearly 60% of elderly women 60-69 years in rural areas and even more older women in urban areas participate. Data also shows that main reasons for limited participation in social activities outside home are health and financial problems.

3.4 Marital Transition and Related Life Changes

Transition in marital status from being married to becoming a widow or widower is a significant new vulnerability during the ageing process. About 86% of older men are still married while 60% of older women have lost their spouse. Loss of companionship, care giving and primary source of support increases vulnerability for all elderly. However, the vulnerability is more likely to be psycho-social for men and additionally also financial for older women. Since women traditionally do not own land, housing or other assets such as savings, they become and also feel more dependent.

Although men and women who have lost their spouses are older compared to those who are still married, about half of older persons who have lost their spouses are not very old. About 52 per cent of widowed women and 43 per cent of widowed men are in the age group of 60 to 69 years (Table 3.4). A majority of the elderly in each group (married and widowed) live in the rural areas, but lot more widowed women live in urban areas compared to any other group probably due to migration of children to urban areas, and women moving to the houses of their children after the loss of spouse. About 70% of widowed women are illiterate, a level higher than that among all other groups. This higher level of illiteracy is likely to be a barrier when accessing health care and social welfare programmes.

Thus transition to widowhood raises some issues of vulnerability for men and women. The combination of age and loss of spouse is associated with poor health, as well as with new economic situations for women wherein they now have to provide for themselves or negotiate financial and care-related support from other relatives.

The seven states covered by the study show that levels of vulnerability vary across regions in the country. To begin with, Tamil Nadu has the highest proportion of widows living alone. About one in 3 women who have lost their spouse live in a household that has no other relative. A significant proportion of widows in West Bengal and Kerala, followed by Punjab report that they have poor health, while on the other hand, the proportion of older women with poor health is lowest in Tamil Nadu (Table 3.5).

3.5 Abuse After Sixty

About 13% of rural older women and 9% of urban older women have reported experiencing some form of abuse after 60 years of age. Verbal abuse is the main form of abuse for women and the least form is physical abuse. Source of abuse appears to be largely neighbours and son. Notably, a higher proportion of older women report abuse by daughters-in-law. About a quarter of older women report health problem resulting from abuse. In any case, it is good to know that nearly 90% of older women have not experienced any abuse.

Section-IV Health Status of Older Women

Many older women rate their health as poor and experience relatively low mental health status. One in five older women rated their health to be poor. More than half of all older women indicate signs of mental distress according to measures of subjective wellbeing. They also carry higher burden of both acute and chronic morbidity than their male counterparts. Yet, among those who report having an ailment, the vast majority seek treatment from both private and public sources. In general the reasons for not seeking treatment include financial problems and inadequacy or lack of access to public health facilities. As for the health insurance programme offered by the government (RSBY) both awareness and use among older women is negligible.

4.1 Subjective Health of Older Women

Health is a complete state of physical, mental and social wellbeing and not just absence of disease (WHO, 1946). In this sense, health and wellbeing requires a life course approach that starts from early years when men and women are in their 40s. This concept is also intended in the health pillar of MIPAA when it is positioned as "health and wellbeing i*nto* old age".

Health is a very important determinant of quality of life of older person and health problems is a key inhibitor for older women's ability to participate in community activities together with their peers. The survey looked at five aspects of subjective health and functionality:

a. *Self-rated health*: rating of (i) current health; (ii) current health compared to one year ago; and (iii) current health compared to people of same age;
b. *Mental health status:* measured using GHQ and SUBI inventories;
c. *Functional health status*: measured using ADL, IADL, disability in vision, speech, hearing etc and use of aids among older persons;
d. Cognitive *abilities*: measured using ability to recall words; and
e. *Risky health behaviours*: smoking, alcohol and tobacco chewing.

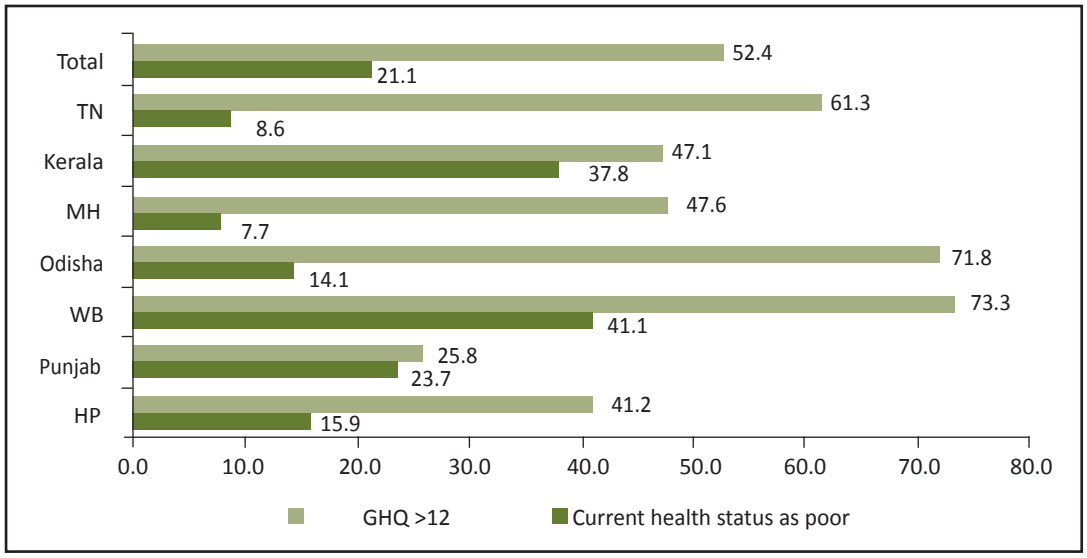
4.1.1 Many older women have low self- rating of their own health

About 60% of older women in rural areas rate their health as fair or poor. About 37% say that their health compared to the previous year is worse; while 54% say it is the same as last year (Table 4.1). About a third of older women living in rural areas feel that their health is worse than that of their peers. These patterns of subjective health rating are similar in rural and urban areas but on all three measures, older men do better than older women perhaps due to very different life course experiences that women go through. On all three dimensions, self-rated health worsens with increasing age and poverty, as can be expected. There is a significant socio-economic gradient in self-rated health with the poor, the illiterate and widowed older women rating their health much worse in all three dimensions. Over 70% of older women in Odisha and WB and over 60% in TN felt that their current health status is "poor". In other states this is about 40-50%. Older women in Punjab are a healthy exception where only 24% felt that their health status is poor.

4.1.2 Mental wellbeing is also lower among older women

The BKPAI survey explored two instruments used for screening psychological distress: the 12-item General Health Questionnaire (GHQ) and the 9-item Subjective Wellbeing Inventory (SUBI). The GHQ scores show that (i) about half of all older persons have sound mental wellbeing and (ii) older men fare better than older women with 54% of older men and 45% of older women scoring a GHQ of less than or equal to 12. Older women in rural areas have marginally lower mental wellbeing than their urban counterparts. Among the states, West Bengal, Odisha and Tamil Nadu have much higher proportions of older women with psychological distress (GHQ>12). In general, psychological distress is related with poor self-rated health among older women in many states with the exception of Punjab and Kerala to some extent. Poor perception of own health may contribute to mental distress and lack of psychological wellbeing among older women.

Figure-4.1 Current health status and mental health status of older women by states, 2011



On the second instrument of mental health - the 9-item SUBI that aims to measure "feelings of wellbeing or ill-being experienced by an individual in various day-to-day life concerns" (Sell and Nagpal 1992), the survey shows that over 55% of older women of 60-69 years experienced some sense of ill-health and this steadily increases with advancing age. At every age, older women fare worse than older men on SUBI. And just like in the case of self-rating, older women who are poor, illiterate and belong to disadvantaged sections have lower mental wellbeing. Currently married older women also fare better than widowed older women on GHQ and SUBI, an indication of psychological distress that widowhood can cause in older women. Age and sex appear to be strongly connected with mental wellbeing with women and aged being more vulnerable. The poor mental health among older women is not un-related to the life cycle experiences and accentuated vulnerabilities faced by women during younger years which make them feel dependent at every stage in life.

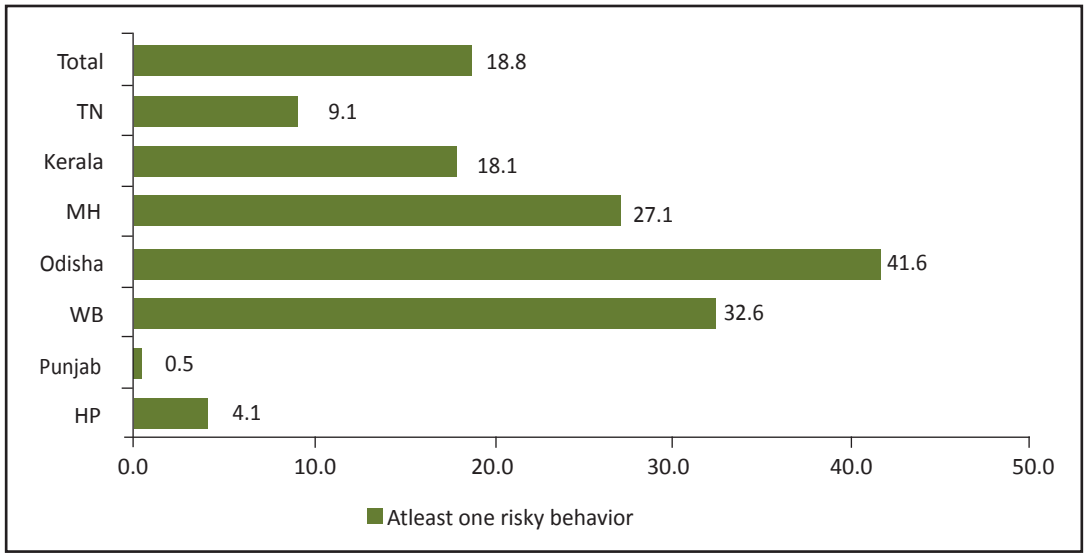
4.1.3 Functional health concerns of older women

Functional health is measured through (a) Activities of Daily Living (ADL with six activities) and (b) Instrumental Activities of Daily Living (IADL with eight activities). Analysis shows that 9% older women need help in at least one of the six ADLs (6% for older men). About 14% of older women can perform all eight IADLs (10% for older men) (Table 4.2). As in most cases, the level of assistance needed increases with advancing age. Both ADL and IADL limitations have strong socio-economic gradient. But unlike in the case of ADLs, more older men seem to need help in IADLs than older women, most probably due to the engendered nature of some of these activities (eg. cooking and laundry which in the typical Indian context are largely carried out by women).

4.1.4 Risky Health Behaviours among older person are not insignificant

Risky health behaviours (smoking, alcohol consumption and tobacco chewing) are common among 21% of older women in rural areas and 14% in urban areas as they currently use any of the three risky behaviours. In each case, more older men have a risky health behaviour than women. Nearly 29% of older persons reported consuming all three substances and most of the ever-users are also continuing to use currently (Table 4.3). There is an inverse relationship between age and smoking and alcohol consumption. Both older men and women spent about 11-15 rupees a day for their smoking requirements. Due to engendered roles, older women are generally further exposed to both passive smoking and smoke from kitchen while cooking.

Figure-4.2 Older women having at least one risky behaviour by states, 2011

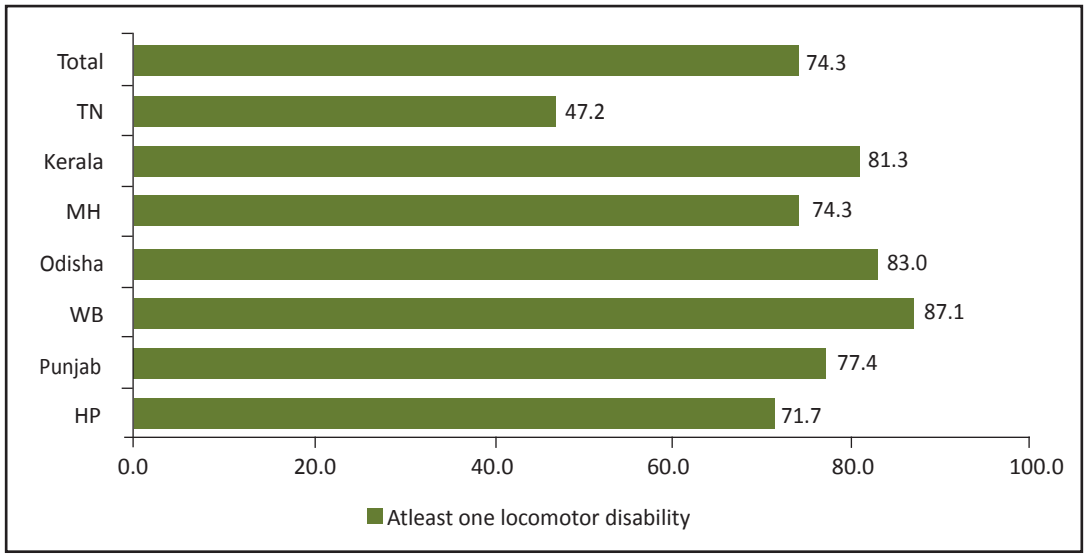


4.2 Inevitable consequences of ageing

4.2.1 Disabilities

The six selected age-related disabilities (partial or full) such as vision, hearing, speaking, walking, chewing and memory have a strong relationship with age but not with gender, place of residence or socio-economic status, as many are perhaps inevitable consequences of ageing (Table 4.4).

Figure-4.3 Older women having at least one disability by states, 2011



As evident from the above figure, large proportions of older women (70-80%) have at least one age-related disability, with the exception of Tamil Nadu where this is less than 50%. The use of aids to overcome the difficulties (such as use of spectacles, walking sticks, hearing aids etc) is quite limited, except for use of spectacles, irrespective of men or women living in rural or urban areas. More financial assistance to older person for use of aids is needed, particularly for older women since income insecurity and dependence on others are higher among them.

4.2.2 Cognitive Potential

In terms of cognitive ability measured by immediate recall of ten commonly used words. The mean number of words recalled lies between 3-4 among older women or men living in rural or urban areas. About 66% of older women and 63% of older men could recall 3-5 words with rural older person doing better than urban older person in this particular recall range (Table 4.5). As can be expected, level of cognitive ability decreases with increasing age both among older men and women. However, cognitive ability is better among more literate, currently married older person as well as those living with spouse.

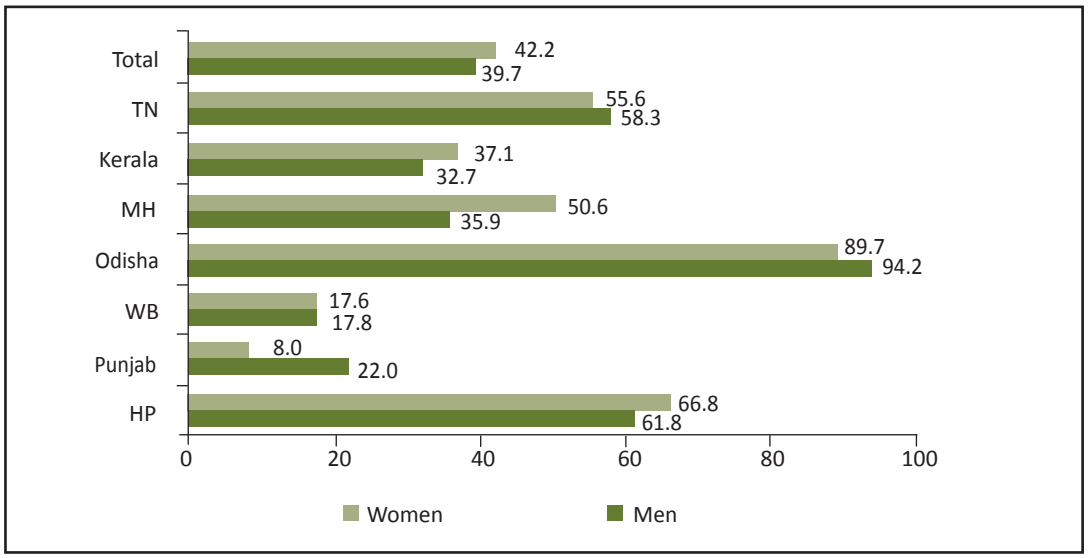
4.3 Acute and Chronic Morbidity: Levels and Treatment Seeking Behaviour.

4.3.1 Women carry larger burden of acute morbidity

Acute morbidity is defined here as reporting an event of sickness or ill-health during the 15 days prior to the survey. Overall, the prevalence rate is about 13% of all older persons (Table 4.6). The prevalence rate is higher among older women both in rural and urban areas. A higher morbidity burden is carried by widowed women than currently married older women, the root cause being their age as well as life course experiences mentioned earlier. Older persons with lower levels of education and those belonging to SC/ST groups and lower wealth quintiles report higher rates of acute morbidity (Table 4.7). Morbidity load among older person consists of a mix of both communicable and non-communicable diseases, as revealed in the survey.

Treatment seeking patterns indicate that over 90% of the older persons (both men and women) take treatment somewhat equally between public and private health facilities. As can be expected those from rural areas go more to government health facilities for all spells of acute morbidity. More older persons with lower levels of education or from lower wealth quintiles receive treatment from government health facilities. Private hospitals are preferred more by urban older persons. Among those not seek treatment, the major reasons are financial inadequacy in rural areas while in urban areas about 43% older person felt that the ailment is not serious enough to warrant medical attention and treatment.

Figure-4.4 Older women and men who went to government hospital for the treatment of acute morbidities by states, 2011



4.3.2 Chronic Morbidity is also higher among older women

Arthritis, hypertension and cataract are the three most common ailments among allolder persons. Among older women- whether in rural or urban areas prevalence rates are much higher (Table 4.8). The increased level of disease burden among urban older women is largely contributed by diabetes, a life style disease. Data indicate that increasing urbanisation and (consequent) changes in life styles are likely to make the older women more susceptible to life style diseases. This requires not just medication but awareness and practice of to prevention and control.

Majority of older persons (both men and women) receive treatment for chronic ailments, except Cataract for which only less than half of older women (as also men) received treatment. As there are no significant rural-urban or sex differences in treatment seeking behaviour, one can say that women or those living in rural areas are not particularly lagging behind in terms of access to services, although overall there is still some scope for improvement in this respect. And for all chronic morbidities, private sector is the predominant source of treatment (65-70%). As in the case of acute morbidity, reasons for not seeking treatment for chronic ailments include financial problems particularly among poorer women as these ailments require long term treatment and repeat visits to the doctor. Inadequacy of public health services is also an added reason.

Health insurance can be a good source of support in such situations but the survey showed very small proportions of older have this coverage; 11% of BPL older women are aware of RSBY and only 7% have registered under the scheme (Table 4.9). This gap deepens vulnerability of older women (and also men).

4.3.3 Poor Health unrelated to Widowhood:

Since disabilities increase with age, some of this effect may be due to the fact that the widowed population is older than the currently married population. A multivariate analysis of the factors related to health status does indeed reveal that after controlling for the effects of age, there is no significant relationship between widowhood and poor health among older women (Table 4.10).

Section V Gender Disparities in Old Age

Gender disparities exist at all ages but when women become old, the consequences of engendered roles become more explicit. Poverty is inherently gendered in old age when older women are more likely to be widowed, living alone, with no income and with fewer assets of their own and fully dependent on family for support. The survey shows that older women headed households are poorer than older male headed households. Much fewer older women accrue personal income or assets compared to older men and financial dependency among older women is at a much higher level. Living alone is higher among older women than among older men. It is also more common for older women to live with their children/grandchildren and they seem to better accept such realities of ageing. As for late age disparity in health, more women rate their physical and mental health to be poor compared to men. Older women are also worse off in comparison to older men with regard to acute and chronic morbidity. Among the poor, awareness of social pension schemes is higher among elderly men than elderly women in both urban and rural areas. The same is true of the many special facilities made available by the government for older persons.

Gender based discrimination is a well documented socio-cultural phenomenon in India. Starting from conception (gender biased sex selection) to education, health care, nutrition, early marriage and child bearing, household work responsibilities generally lock many young girls and women particularly in rural areas into vulnerability that continues through later years. Responsibility for informal care giving within the family further restricts women's access to employment and social security. Perhaps the only new gender gap in later years is a result of longer life span for older women, loss of spouse and consequent socio-psychological and financial insecurity experienced by older women. Rest of the late life gender gaps largely arise from experiences of early years in life course.

Men and women age differently due to biological reasons (physical, hormonal and psychological/emotional response) as well as societal practices, belief systems, discriminatory laws and stereotypes that adversely affect women through their life course, all of which are largely rooted in patriarchal culture in which women live. Older women's socio-economic status is also rooted in gender division of labour which assumes women's primary role in reproduction, unpaid household work, care giving and unequal power relations at home. These in turn restrict women's employment opportunities, mobility, education and skill building, independence and dignity. Even when they participate in labour market, most of them typically end up in low paid demanding jobs or relegated to part-time employment in unorganised sectors. (UN Commission on Women). While both men and women experience age discrimination, women experience gender discrimination as well.

It is when women become old that the consequences of gender roles (men as bread-winners and women as housekeepers even if they have been economically active in their working years) get explicitly revealed (UNFPA,2008). Widowed women become particularly more vulnerable not only in economic terms but also in social status within the family and community. Older women also experience proportionately higher levels of chronic illnesses and disability than older men, as shown in the section. Due to longer life span than men, many older poor and widowed women end up living alone, even though they prefer to live with others. For these reasons ageing is characterised both as a distinction (maturity, wisdom and respect) and a disappointment as it tends to devalue social perceptions of older people, particularly older women whose contributions largely remain invisible (UN 1999). Others have questioned if ageing is more a cause for celebration or a serious challenge. Gender stereotyping, namely the social and economic roles that families and societies "assign" to women and men, often driven by culture, passed on from one generation to another is an example of one such challenge. In this sense, it is also said that one is not born but rather becomes a woman.

This section is limited to gender disparities in four aspects: (1) Income and Assets; (2) living arrangements and social relations; (3) health and wellbeing; and (4) awareness and utilisation levels of social security schemes.

5.1 Income and Assets: Late Life Gender Disparity

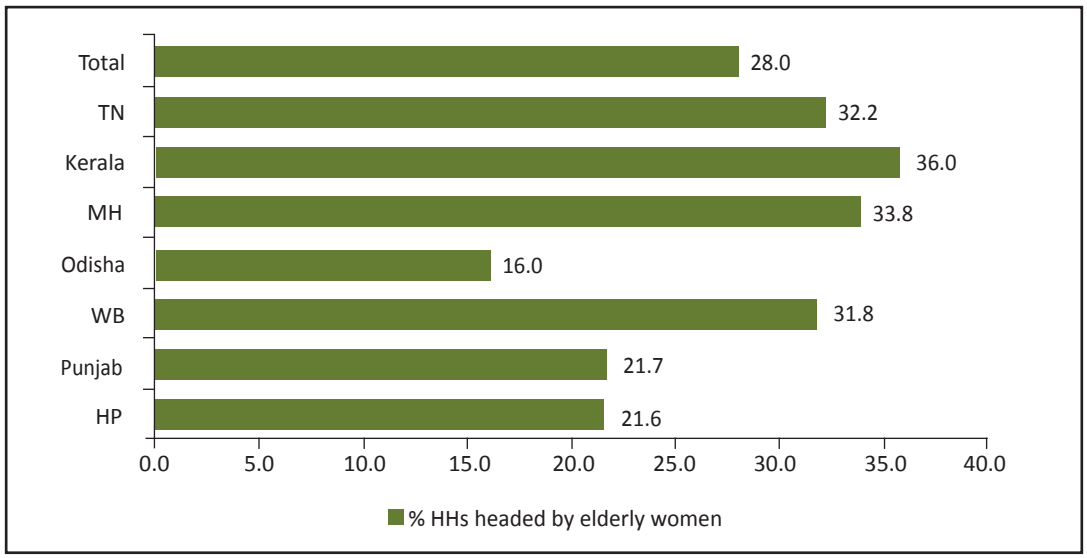
5.1.1 Women headed households are generally worse off:

Overall about 60% of households are headed by an older person of which about 28% are headed by older women and a very high percentage of these women heads are widows which shows only after husband dies, the wife is considered as household head. There is higher level of illiteracy among female heads than male heads (64% as against 41%); more older

male heads (31%) are currently working than female heads (17%). Nearly one-third of women headed households are in the lowest wealth quintile whereas only 22% of male headed households are in this category. Social pension is the only source of income for 29% of female heads while this is more than double in the case of older male heads. As high as 47% of women headed households are below the poverty line.

Among the households headed by an older person, Odisha has the lowest proportion of older women heads 16%). Kerala, Maharashtra and Tamil Nadu have approximately one-third of such households headed by older women - perhaps an indication of socio-cultural practices that tend to value of older women.

Figure 5.1 Percent older female headed households among all older person headed households by state, 2011



5.1.2 Older Women meagre incomes and assets than older men

About 59% of older women have no income and an additional 26% earn less than Rs. 12000 a year. Among older men these proportions are much less at 26% and 17% respectively. Over 50% of all older women who have no income are poor and in the lowest wealth quintile. This is only 31% among older men (Figure 5.2). Asset ownership (as a resource to fall back on in times of need) shows that fewer older women own land, housing and savings compared to older men. Overall 34% of older women do not own any asset at all while only 11% of older men are in this category. Among those who own some asset, inherited land is the most common asset in rural areas while inherited housing is the most common asset in urban areas. About 46% of older men and 23% of older women in rural areas own inherited land.

Yet the workforce participation among older women is quite low compared to older men at every age group (Figure5.3). A very high proportion of working elderly women (82%) as against 68% among working older men are working due to economic or other compulsions and not by choice. This shows vulnerability of all older persons but the fact that it runs much deeper among older women. This is true in all states (a minor exception in Himachal Pradesh). In West Bengal (100%) and Punjab (92%) almost all elderly women experience desperate need to work and earn for the family (Figure-5.4). In general more working elderly women are engaged in informal sector (67%) compared to elderly men (47%) characterised by low incomes, no retirement age and no post-work pensions. This is same in many states (except in HP) with differing degree of gender disparity as seen in Figure 5.5.

Figure-5.2 Older person with no income in lowest wealth quintile by states, 2011

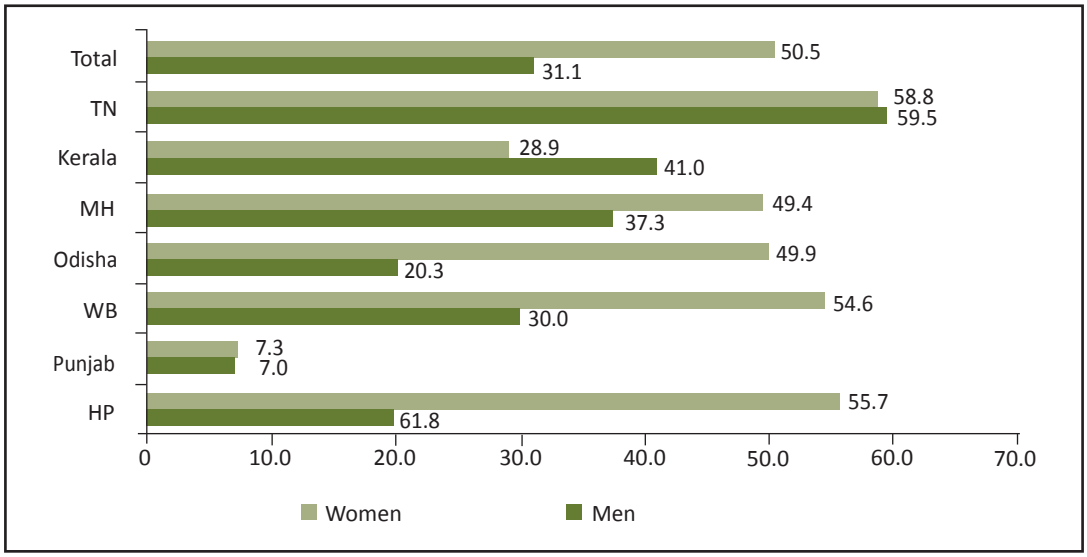


Figure-5.3 Currently working older women and men by age group, 2011

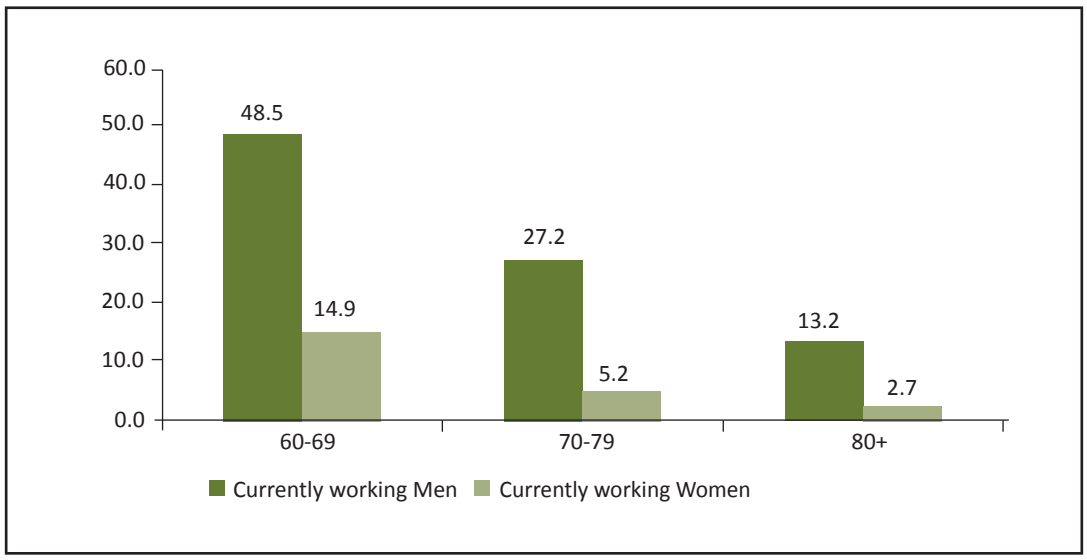


Figure-5.4 Older women and men who are currently working out of economic or other compulsions by states, 2011

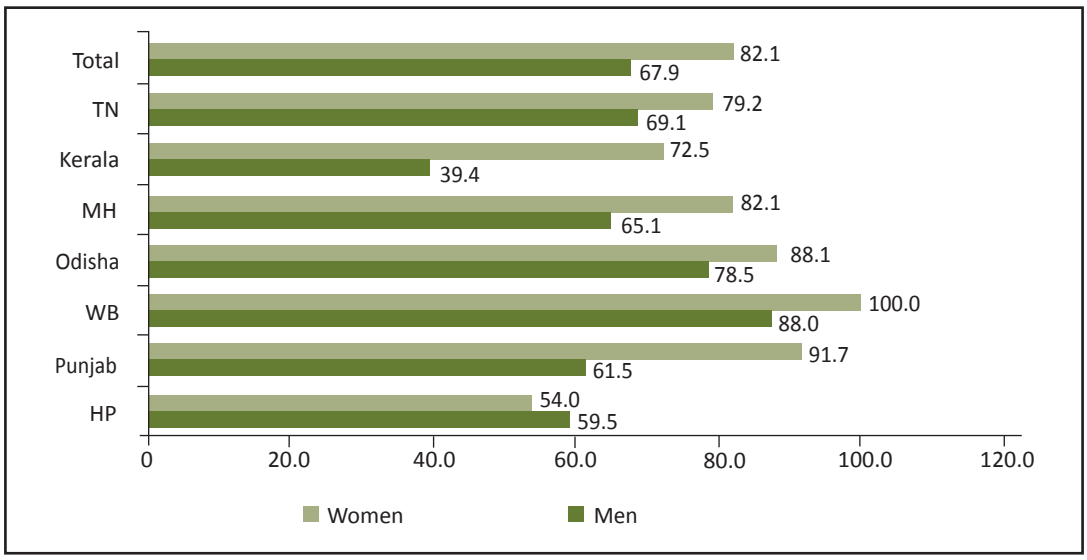
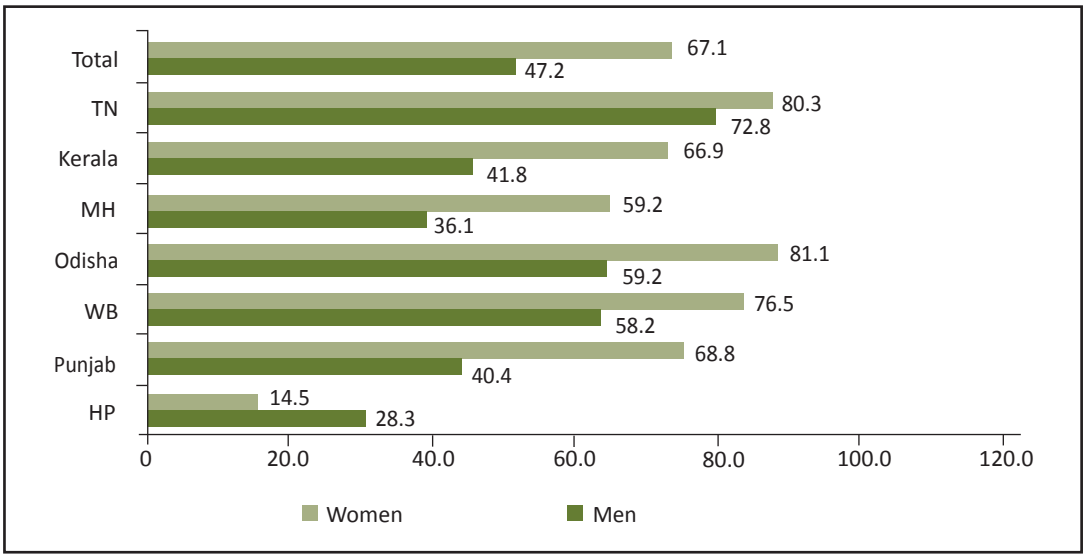


Figure-5.5 Older women and men who are working currently in informal sectors by states, 2011



5.1.3 Financial Dependency among Older women is much higher

About 66% of older women are fully dependent financially on others while only about 33% of older men are financially dependent on others. Spouse is the source of support for older women and upon loss of spouse, son is most frequently the source of financial support. Dependency increases with age both among men and women. Poverty is inherently gendered in old age when older women are more likely to be widowed, living alone, with no income and with fewer assets of their own and fully dependent on family for support. Older men also face issues and their engendered experiences of old age must not be ignored (HelpAge International).

5.2 Living Arrangements and Social Networks: Late Life Gender Disparity

5.2.1 Older women cope better with their living arrangement

As pointed out in Section-III, a serious life-transforming old age disparity results from loss of spouse. Among older women, 59% are widowed while only 14% of older men have lost their spouse. Percentage of widows increases from 44.5% among 60-64 to 86.8 among women 80 plus. Absence of personal income and asset ownership makes older women more dependent on family than their male counterparts. The proportion living as complete dependents on their children increases with age for all older persons but more for older women. In urban areas, a much higher proportion of older women (65%) are widowed, perhaps moving to urban areas after loss of spouse, a very different living environment that could further accentuate their vulnerability. Nearly half of all older women live with their children/grandchildren as against 11 % among older men. In fact, nearly half of all older women who are currently living with children and grand children have adopted this living arrangement *after* the age of 60. Living alone is also higher among older women (10%) than among older men (2%). There is no gender disparity in reason for living alone, since over 60% indicate children being away as the major reason.

Older women also show a higher level of acceptance of their current living arrangement, even if they are living alone. Of the older women living alone, 69% actually preferred their current living arrangement as against only 35% amongst older men living alone. This higher level of acceptance among older women points to their resilience and coping strength compared to their male counterparts. Older women in general perceive that their role in family decision making is lower compared to older men. This disparity is not very high since even among older women, about 80% perceived having some decision making role in the family. Similarly, there is no gender difference in old age abuse.

5.2.2 Social activity of older women is very limited

Older women who have never participated in any social activities outside home (such as community meetings, neighbourhood improvement initiative) outnumber older men in both rural and urban areas. In terms of time use, older women more time on taking care of grandchildren, for cooking and also in prayer and related activities than older men. On activities outside home such as shopping, working for remuneration, walking/exercise and in visiting friends etc., older men typically spend more time (Table 3.3). Time use analysis clearly shows a similar pattern in all survey states.

5.3 Health and Wellbeing: Late Life Gender Disparity

5.3.1 Older women experience lower level of wellbeing than older men

On all aspects of health covered under the survey (self rated health, mental health, functionality, loco-motor disability, cognitive disability and use of disability aids), older women generally are worse off than their male counterparts. For example, 67% older men feel that their current health compared to last year is better or same. This is 61% for older women. About 56% men and 48% women showed better mental status (GHQ below 12). About 6% men and 9% women needed assistance in at least one ADL activity. Older women have higher rates of prevalence and incidence of acute morbidity, although the difference is not very high (please see section-IV).

There are also some areas in which gender gaps are not very significant. These include: (a) seeking treatment for acute morbidity episodes (both older men and women equally high at over 90%); (2) place of treatment (government or private facility), although somewhat more women go to government facility compared to private clinic than older men; and (3) older women or men under the care of a medical doctor (81% for elderly men and 85% for elderly women). Absence of risky behaviours such as smoking, alcohol consumption and tobacco chewing are the only health aspects on which older women do better than older men.

Better family support to older women is reflected in who accompanies them when they go for treatment of acute morbidity.

Nearly 67% of older women are accompanied by children or grandchildren (as against 41% among older men). But this also reflects higher level of dependency among older women than older men.

> At 77 we feel fortunate to be living with our two sons and grand children who support both of us and are sensitive to our needs. They take care of our medical expenses including my husband's heart surgery last year. I strongly believe that sons are necessary for old age protection. We believe that our positive attitude towards late life experiences is the real reason for physical independence and mental peace. We have no income, no social pension and we are economically dependent on our children. Yet our other contributions to the family are appreciated by our children and grand children. Ability to adjust and being generally satisfied and non-complaining are some of the essential ingredients of successful and peaceful ageing. The choice is mine to a large extent.
>
> Source: TISS: Voices of elderly women

5.3.2 Do older women get less frequent and delayed care?

In terms of source of payment of medical bills older men are more independent as 44% of them pay themselves while less than 20% of older women are able to pay bills by themselves. More than half of older women depend on their children to pay their medical bills. The average expenditure for treatment of acute morbidity is higher for older men (Rs. 1175) compared to older women (Rs. 911). Similar trend is seen for hospitalization expenditures also. Older women also lag a bit behind in use of some disability aids such as spectacles/lenses (M-57%, W-50%), hearing aids (M-5%, W-4%); walking sticks (M-32%, W-23%). This disparity is partly due to higher propensity of older women going to less expensive government facility as also due to perhaps less frequent and somewhat delayed treatment visits - although data on these aspects are not available.

5.4 Social welfare Schemes: Late Life Gender Disparity

5.4.1 Lower awareness and use of social security schemes

Only about 28% of widowed women who are poor and also living alone (the real target group for widow pensions) are accessing/using/benefiting from the widow pension scheme that is most relevant to them. Awareness level is better compared to use but still low. Rural penetration of this scheme appears much better than in urban areas. Awareness and utilisation of old age pension scheme and health insurance are also low among BPL elderly. The survey reveals that in most cases of social security, elderly women fare worse than elderly men.

Among the BPL households awareness of Old Age Pension Scheme is higher among elderly men than elderly women in both urban and rural areas. However more women knew about Widow Pension Scheme than men. Awareness was higher among more literate and economically better off older women. Awareness among non-BPL families is higher than among BPL families. Further, widows and those living alone have lower level of awareness of social pension benefits of the government. One out of four widowed BPL older women from disadvantaged sections is not aware of Widow Pension Scheme, the scheme most particularly addressing them. Further, awareness of widow pension scheme decreases with age, which is not in the right direction. Only one out of four BPL older widowed women are benefitting from this scheme. This means as high as 75% of such older women have not been reached by the scheme.

5.4.2 Special government facilities also not reaching older women

The government has certain special facilities available only for older persons. These include: train ticket concession, bus seat reservation, faster telephone connection, higher interest rates for deposits, tax benefits etc. The survey asked the respondents about their awareness and use of these special facilities. Consistently in all of these facilities, both awareness and use (both in rural and urban areas) among older men exceeds that of older women. Gender disparity in urban areas is greater than in rural areas, indicating very limited reach of these government efforts everywhere.

> I am Sita Devi, 85 years old living in Araria district of Bihar with one of my daughters. I have seven daughters and two sons but none of them are willing to take care of me except the daughter with whom I am currently living, knowing well that my son-in-law is not happy with my staying with them. My two sons are well settled: one in Delhi as a daily wager and the other in Araria. My advancing age and failing health does not permit me to go out anywhere or do any work at home. With no savings of my own, I am fully dependent on my daughter's family. As I do not have a BPL card, I went to our village chief who does not help in anyway but wants Rs. 200 to fill up application forms. Without a BPL card I am not eligible for my social pension and hence feel and experience many instances of indignity. But I am helpless and you should do something to help me rather than just asking me questions or writing my story.
>
> Source: TISS: Voices of elderly women

Section-VI: Suggestions and Way Forward

Drawing from the analysis of economic, social and health status of older women, and more generally from experience of development planning and implementation, this section makes three specific and three broader suggestions, the latter representing enabling actions necessary for achieving the specific suggestions for older women.

6.1 Specific Suggestions

6.1.1 Ensure Benefits are better availed

Income insecurity and economic dependency among older women is wide spread in both rural and urban areas Asset ownership is also skewed against older women. Further, the reach of old age pension schemes and widow pension schemes is very limited even among BPL families and widowed women who have no other source of income. On the social pension schemes, increased amount and coverage, including easy and transparent disbursement system is essential.

A more sharply targeted approach is needed to benefit BPL older women and more particularly those living alone. It is necessary to carry out a survey of BPL families and women headed households in which older persons live in accentuated vulnerability more fully understand the size and distribution of older women needing more social security to increase coverage. Simultaneously, many administrative and procedural bottlenecks in accessing social welfare schemes should be reviewed and removed. The active role of PRIs will be particularly essential for better availing of social welfare schemes by both older men and older women.

6.1.2 Help strengthen social networks

Experience indicates that older persons often become co-constructors of their reality and collectively adopt different coping measures to mitigate effects of ageing (Lagace et al. 2012). Participation in social networks outside home, meeting friends and sharing experiences are usually common practices of older persons. However, as shown in the report, the social interaction of older women in community activities is very limited, except in some religious activities and visiting family. Following positive results in some Asian countries (China, Thailand), it would be good to set up local level older women clubs with facility for some entertainment and learning some new skills etc that would help older women in the community spend their time usefully. The Elderly Self-help Groups (ESHGs) under the Ministry of Rural Development could be used as a platform for setting up such older women clubs for a more organised way of spending their free time.

6.1.3 Older women need more and better health care

Older women carry higher burden of ill-health/morbidity on almost all health dimensions covered in section-IV. There is also an indication of their delayed access to health care probably due to their higher level of poverty and dependency. The National Programme of Health Care for Elderly (NPHCE) with its greater focus on NCDs should consider offering more dedicated services for older women. Further, reach of health insurance is very negligible and older women in BPL families face particular disadvantage. The primary health care system needs to be upgrade itself to meet their specific needs for medical care. In a holistic sense, it is necessary to recognise that both economic and social status will also have an effect on health status, since health is not just absence of disease but is a complete state of physical, mental, social and spiritual wellbeing (WHO: Health For All).

6.2 Broader suggestions

6.2.1 Are the initiatives achieving intended results?

(1) A critical review of selected social schemes for elderly to be carried out to see if the expected results or positive changes are being achieved, moving beyond just activities and budgets.

(2) Actual field based measurement of results achieved and implementation bottlenecks faced is needed in order to improve plans and implementation mechanisms.

(3) As there is significant gender disparity in outcomes, gender impact assessment of selected schemes would be needed to understand problems faced by older women and how to address them.

6.2.2 Modifying mindsets towards older persons:

(i) A strong research based activity to support the media in running campaigns on the rights of older persons and women in particular and in creating positive attitudes and images of ageing would be needed. More attention to elderly contributions would be needed and to avoid projecting them as weak, dependent and burdensome.

(ii) Working with parliamentarians who have shown enthusiasm and interest in population ageing concerns would be needed to enable them to be effective advocates both in their respective constituencies as well as in the parliament. Establishment of a formal Working Group on Population Ageing and working closely with a group of champion parliamentarians for this cause would be important.

(iii) Advocacy with local leaders, opinion makers, others with influence, faith-based organisations etc would also be necessary to complement media and political leaders mentioned above.

6.2.3 Convergence and capacity development

(A) Set up a model district for coordinated multi-sectoral interventions and with strong PRI and SHG involvement, particularly for older women. The aim should be to develop a good convergence of social welfare schemes so that the total overall effect on older persons will be more than a mere sum of individual schemes delivered without synergy.

(B) Capacity development and empowerment of older women with information on existing schemes, how to access them and where to go for support when needed, all aimed at enhancing their participation in local level planning. Also capacity development of PRIs for local needs assessment and designing initiatives most relevant to local conditions;

(C) Institutional Strengthening of National Institute of Social Defence (NISD) starting with a management assessment and developing capacity for review and results-based monitoring of national schemes, including taking necessary corrective actions would be essential. At the request of MoSJE, UNFPA has recently initiated a management study of NISD for upgrading it as a Centre of Excellence for work in social defence in India. NISD is one of its kind in the country and this initiative will go a long way in enhancing social defence environment in general and quality of life of older persons in India.

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Annexure

1: Principles for older persons

To add life to the years that have been added to life. The UN Principles aim to ensure that priority attention will be given to the situation of older persons. The UN Principles address the independence, participation, care, self-fulfilment and dignity of older persons.

Independence:

1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.
3. Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.
4. Older persons should have access to appropriate educational and training programmes.
5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

Participation:

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
8. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
9. Older persons should be able to form movements or associations of older persons.

Care:

10. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well- being and to prevent or delay the onset of illness.
12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13. Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

Self-fulfilment

15. Older persons should be able to pursue opportunities for the full development of their potential.
16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

Dignity

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.

18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

2: Proclamation on Ageing

Having considered the challenges inherent in implementing the International Plan of Action on Ageing and having recognized the need for a practical strategy on ageing for the decade 1992-2001, the UN General Assembly urges the international community:

(a) To promote the implementation of the Plan of Action;
(b) To disseminate widely the United Nations Principles for Older Persons;
(c) To support the practical strategies for reaching the global targets on ageing for the year 2001;
(d) To support the continuing efforts of the Secretariat to clarify policy options by improving data collection, research, training, technical cooperation and information exchange on ageing;
(e) To ensure that the ageing of populations is adequately addressed in the regular programmes of competent United Nations organizations and bodies, and that adequate resources are assigned through redeployment;
(f) To support broad and practical partnerships within the United Nations programme on ageing, including partnerships between Governments, specialized agencies and United Nations bodies, non-governmental organizations and the private sector;
(g) To strengthen the Trust Fund for Ageing as a means of supporting developing countries in adjusting to the ageing of their populations;
(h) To encourage donor and recipient countries to include older persons in their development programmes;
(i) To highlight ageing at major forthcoming events, including, in the near future, events in the areas of human rights, the family, population, the advancement of women, crime prevention, youth and the proposed world summit for social development;
(j) To encourage the press and the media to play a central role in the creation of awareness of population ageing and related issues, including the celebration of the International Day for the Elderly on 1 October and the dissemination of the United Nations Principles for Older Persons;
(k) To promote intraregional and interregional cooperation and exchange of resources for programmes and projects on ageing, including those for life-long healthy ageing, income generation and new forms of productive ageing;
(l) To provide the immense human and material resources now urgently needed for adjustments to humanity's coming of age, which can be understood as a demographic phenomenon, but also as a social, economic and cultural one of great promise;

The General Assembly also urges the support of national initiatives on ageing in the context of national cultures and conditions, so that:

(a) Appropriate national policies and programmes for the elderly are considered as part of overall development strategies;
(b) Policies which enhance the role of Government, the voluntary sector and private groups are expanded and supported;
(c) Governmental and non-governmental organizations collaborate in the development of primary health care, health promotion and self-help programmes for the elderly;
(d) Older persons are viewed as contributors to their societies and not as a burden;
(e) The entire population is engaged in preparing for the later stages of life;
(f) Old and young generations cooperate in creating a balance between tradition and innovation in economic, social and cultural development;
(g) Policies and programmes are developed which respond to the special characteristics, needs and abilities of older women;
(h) Older women are given adequate support for their largely unrecognized contributions to the economy and the well-being of society;

(i) Older men are encouraged to develop social, cultural and emotional capabilities which they may have been prevented from developing during breadwinning years;
(j) Community awareness and participation is encouraged in the formulation and implementation of programmes and projects with the involvement of older persons;
(k) Families are supported in providing care and all family members are encouraged to cooperate in caregiving;
(l) Local authorities cooperate with older persons, businesses, civic associations and others in exploring new ways of maintaining age integration in family and community;
(m) Decision makers and researchers cooperate in undertaking action-oriented studies;
(n) Policy makers focus attention and resources on tangible opportunities rather than on desirable but unobtainable goals;
(o) International cooperation is expanded to the extent feasible in the context of the strategies for reaching the global targets on ageing for the year 2001;

The General Assembly decides to observe the year 1999 as the International Year of Older Persons, supported by the regular programme budget for the biennium 1998-1999 and by voluntary contributions, in recognition of humanity's demographic coming of age and the promise it holds for maturing attitudes and capabilities in social, economic, cultural and spiritual undertakings, not least for global peace and development in the next century.

3: Tables

Table 2.1. Elderly women and men by income status, contribution to HH expenditure, financial dependence and sources of support, and assets, 2011

Income (in Rupees)	Men	Women
No income	26.0	58.7
<=12,000	16.7	25.9
12,001–24,000	12.3	5.4
24,001–50,000	19.9	5.2
50,000 +	24.2	4.3
Don't know/No answer	0.8	0.4
Contribution to HH expenditure		
Yes	71.2	35.5
No	28.8	64.5
Financial dependency		
Fully dependent	32.6	66.4
Partially dependent	31.8	21.0
Not dependent	35.5	12.5
Don't know/No answer	0.1	0.1
Source of support		
Son	46.8	52.2
Spouse	7.3	22.1
Daughters	2.4	4.8
Others	8.0	8.5
Not dependent	35.5	12.5
Assets		
Inherited land	37.8	18.5
Self acquired land	18.5	6.2
Inherited house(s)	37.3	23.2
Self acquired house(s)	46.6	23.4
Housing plot(s)	2.7	1.6
Inherited gold or jewellery	6.0	10.7
Self acquired gold or jewellery	18.3	21.4

Savings in bank, post office, cash	30.8	14.7
Savings in bonds, shares, mutual funds	0.2	0.1
Life insurance	2.5	0.7
Don't own any asset	11.0	34.1

Table 2.2. Elderly women and men by work participation, motivation of work and type of sector, 2011

Work status	Men	Women
Never worked	1.4	67.6
Previously worked	59.7	21.5
Currently working	38.9	10.9
Working compulsion for currently working		
By choice	32.1	17.7
Economic/other compulsion	67.8	82.2
Type of sector		
Public sector	5.0	2.4
Private organised	3.9	2.2
Self-employed	41.2	19.9
Informal employment	45.2	66.3
Others	4.7	9.2

Table 2.3: Economic indicators of older men and women according to marital status, 2011

	Men			Women		
	Currently Married	Widowed	Divorced/ separated	Currently Married	Widowed	Divorced/ separated
Partially or fully dependent on others	63.0	74.7	55.4	92.2	84.7	77.4
Possess BPL card	43.2	43.8	33.0	39.5	49.7	51.9
Received social pension	12.7	18.5	21.2	10.9	29.9	25.6
Have no personal income	24.1	39.4	21.3	74.8	48.7	44.7
Own assets						
Inherited land	38.2	36.5	28.7	13.0	21.6	32.3
Self acquired land	18.9	17.0	15.3	4.5	7.4	7.2
Inherited house	37.2	39.0	32.3	14.6	28.7	27.5
Self acquired house	48.5	36.9	32.2	14.7	29.2	23.0
No personal income & no assets	2.4	6.0	8.3	28.9	13.2	14.1
No personal income and poorest quintile	6.2	13.0	5.5	14.5	11.9	9.7
Number	3,901	661	110	1,946	3,107	127

Table 3.1. Elderly women and men by their present living arrangement, reasons for staying alone, and satisfaction with the present stay, 2011

Living Arrangement	Men	Women
Living alone	2.0	9.6
Living with spouse	21.1	11.3
Living with spouse, children and grand children	58.0	24.9

Living with children and grand children	12.1	45.5
Living with all others	6.7	8.7
Reasons for living alone		
No children/children away	60.4	59.1
Family conflict	17.3	18.5
Prefer to be independent	17.6	17.5
Others	4.7	4.9
Feeling about Present Living Arrangement		
Comfortable/Satisfied	88.7	85.9
Uncomfortable	11.3	14.1

Table 3.2.Older women and men by preferred living arrangement according to actual living arrangement, 2011

		Preferred Living Arrangement			
		Alone	Spouse only	Children and Others	Total
			Men		
Present Living Arrangement	Alone	35.5	1.9	0.7	2.0
	Spouse only	17.6	41.2	9.9	21.0
	Children and Others	46.8	56.9	89.5	77.0
	Total	118	1,624	2,930	4,672
			Women		
	Alone	69.4	6.4	5.2	9.6
	Spouse only	4.8	34.6	4.1	11.3
	Children and Others	25.8	59.0	90.7	79.1
	Total	301	1,186	3,693	5,180
			Total		
	Alone	60.3	3.8	3.2	6.0
	Spouse only	8.3	38.4	6.7	15.9
	Children and Others	31.5	57.8	90.1	78.1
	Total	419	2,810	6,623	9,852

Table 3.3. Percent of older women who engaged themselves in the activities anytime a day by marital status, 2011

	Men			Women			Men	Women
	Currently married	Widowed	Others	Currently married	Widowed	Others	Total	Total
Taking care of grand children	34.9	38.8	32.4	45.0	42.6	31.5	35.4	43.3
Shopping	61.3	48.2	56.6	36.6	36.0	44.9	59.4	36.5
Visiting family, friends and relatives	54.0	46.0	46.9	46.0	40.8	35.0	52.8	42.7
Prayer/Yoga/Bhajan	71.5	69.3	69.3	77.4	75.4	70.1	71.2	76.1
Medical	36.4	32.3	28.8	36.8	37.7	38.3	35.7	37.4
Cooking, washing	10.9	18.1	11.6	72.0	55.0	63.3	11.9	61.8
Collecting fuel	17.0	15.3	6.8	17.9	17.6	21.0	16.5	17.8
Paying bills and other financial activities	38.1	23.8	31.9	8.2	9.6	16.0	36.1	9.2
Assisting in agricultural activities	27.3	18.9	21.0	14.3	8.5	11.7	26.0	10.8
Looking after domestic animals	20.6	16.2	25.9	20.0	10.8	11.6	20.1	14.4
Assisting in business activities	10.7	6.9	12.6	4.2	3.1	7.4	10.2	3.6

Walking and other exercises	39.4	33.5	40.5	30.5	25.3	24.6	38.6	27.3
Work for remuneration	72.9	83.2	70.5	9.3	10.0	19.4	74.2	10.0

Table 3.4. Demographic characteristics of older persons by marital status, 2011

Age	Men			Women		
	Currently Married	Widowed	Divorced/ separated	Currently Married	Widowed	Divorced/ separated
60-69	65.2	43.0	55.1	76.9	51.6	65.9
70-79	26.7	30.0	29.9	20.0	32.4	25.8
80+	8.2	27.0	15.0	3.0	16.1	8.3
Residence						
Rural	74.3	76.2	75.5	77.3	69.4	78.9
Urban	25.7	23.8	24.5	22.7	30.6	21.1
Education						
Illiterate	32.7	46.9	47.6	60.7	69.2	58.6
Less than 5 years	14.0	19.5	14.5	12.0	11.4	12.8
5 to 7 years	14.7	15.6	11.7	11.3	9.9	16.5
8 years or over	38.6	18.0	26.2	15.7	9.1	11.3
Work history						
Never worked	1.2	1.9	7.1	72.5	65.1	47.8
Ever worked	57.6	73.9	51.1	17.2	24.0	29.9
Currently working	41.2	24.2	42.1	10.2	10.9	22.4
State						
Himachal Pradesh	15.9	13.7	16.2	17.7	12.6	10.4
Punjab	13.0	18.5	30.2	18.6	10.8	6.0
West Bengal	12.7	11.2	25.6	8.8	16.0	10.4
Odisha	15.6	21.0	4.5	17.1	12.3	8.2
Maharashtra	15.0	14.6	6.3	14.6	14.3	15.7
Kerala	13.0	8.7	8.1	12.9	15.8	38.1
Tamil Nadu	14.8	12.4	9.3	10.2	18.2	11.2
Number of older persons	**3,901**	**661**	**110**	**1,946**	**3,107**	**127**

Table 3.5. Indicators of vulnerability across states.

States	% living alone	% reporting poor health	% belonging to BPL households but not receiving pension	% with no income and no assets
Himachal Pradesh	11.5	17.2	66.0	12.1
Punjab	6.1	27.7	33.5	17.8
West Bengal	13.6	44.7	58.4	34.7
Odisha	8.5	17.9	36.7	6.2
Maharashtra	16.6	11.0	89.2	10.5

Kerala	7.5	39.0	40.0	16.5
Tamil Nadu	35.1	9.9	86.4	21.2
Total	**15.3**	**24.1**	**64.9**	**17.7**

Table 4.1. Self reported health of elderly by sex, residence, education and wealth quintiles, 2011

	Self reported health		
Sex	**Excellent/very good/ good**	**Fair**	**Poor**
Male	47.7	37.0	15.1
Female	41.5	37.2	21.1
Residence			
Rural	42.9	37.9	19.0
Urban	48.6	35.0	16.3
Education			
No formal education	38.6	40.8	20.4
<5 years completed	40.9	35.9	23.0
5-7 years completed	48.6	34.5	16.8
8 years and above	57.3	30.8	11.7
Wealth Index			
Lowest	37.7	40.6	21.7
Second	43.8	40.0	16.0
Middle	46.9	34.1	18.9
Fourth	51.6	32.1	16.1
Highest	44.2	37.6	17.9

Table 4.2. Elderly women and men by functionality(ADL) and IADL, 2011

Functionality	Men	Women
Need assistance in atleast one activity	6.0	9.1
Do not need any assistance	94.0	90.9
IADL		
None	3.3	6.6
1-3	18.9	22.7
4-5	34.2	28.0
6-7	33.7	28.8
All	9.8	13.8

Table 4.3. Elderly with their current use of risky health behaviour by residence and sex, 2011

Current Use	Rural	Urban	Men	Women
Smoking	12.3	7.0	21.8	1.1
Alcohol consumption	4.3	3.0	8.1	0.2
Chewing Tobacco	20.5	13.2	19.4	17.8
All the three risk behaviours	32.4	20.3	40.7	18.8
Total	**5,138**	**4,714**	**4,672**	**5,180**

Table 4.4. Elderly by Full/Partial Locomotor Disability according to age, sex, residence and wealth quintile, 2011

Background Characteristics	Vision	Hearing	Walking	Chewing	Speaking	Memory	Number of Elderly
Age							
60-69	52.7	12.6	15.9	20.1	4.5	22.5	6,239
70-79	66.9	28.7	30.1	37.0	9.1	30.4	2,601
80+	75.5	46.1	47.8	52.2	15.5	38.2	1,012
Sex							
Men	57.3	19.0	20.9	27.0	6.8	25.5	4,672
Women	60.6	22.2	25.4	29.3	7.1	27.2	5,180
Residence							
Rural	59.3	22.1	24.1	30.9	7.4	29.7	5,138
Urban	58.3	16.5	20.9	20.6	5.5	17.0	4,714
Wealth Index							
Lowest	61.5	25.9	26.0	31.2	9.8	38.6	1,954
Second	54.8	21.3	23.6	28.0	7.5	26.4	1,974
Middle	55.7	20.7	25.1	27.9	6.8	22.9	1,938
Fourth	57.2	16.7	19.0	25.5	4.8	21.0	1,962
Highest	68.3	16.0	20.9	27.2	4.3	17.7	2,018

Table 4.5. Cognitive ability of elderly by their sex, residence, marital status, education, and living arrangement, 2011

Background characteristics	0-2	3-5	6-8	8+	No of elderly
Sex					
Men	11.9	62.8	24.7	0.7	4,670
Women	19.8	65.6	14.5	0.2	5,168
Residence					
Rural	16.7	66.4	16.6	0.3	5,133
Urban	14.3	58.2	27.0	0.6	4,705
Marital Status					
Married	11.3	65.2	22.9	0.5	5,844
Widowed	23.6	62.6	13.6	0.2	3,757
Others	17.3	63.9	18.8	0.0	237
Education					
No Schooling	20.8	68.6	10.5	0.1	4,529
1 - 4 years	18.2	67.7	14.0	0.1	1,255
5 - 7 years	13.1	63.5	23.2	0.3	1,322
8 + years	5.9	52.6	40.1	1.4	2,679
Living Arrangement					
Alone	19.7	62.5	17.6	0.2	612
Spouse only	9.0	64.2	26.3	0.5	1,468
Children and others	17.2	64.4	18.0	0.4	7,770

Table 4.6. Prevalence of acute morbidity among olderpersons by residence and sex, 2011

	Rural		Urban	
	Men	Women	Men	Women
Prevalence rate of acute morbidity	13.6	14.4	8.9	12.8
Incidence rate of acute morbidity	4.1	4.2	2.7	3.5

Table 4.7. Prevalence of acute morbidity among olderwomen and men by residence, education, marital status, caste and wealth quintile, 2011

Residence	Men	Women
Rural	13.6	14.4
Urban	8.9	12.8
Education		
No Schooling	14.0	14.4
1 - 4 years	15.1	16.6
5 - 7 years	13.3	12.7
8 + years	9.6	10.4
Marital Status		
Married	12.0	11.6
Widowed	13.9	15.4
Others	17.5	18.0
Caste		
SC/ST	15.3	14.3
OBC	11.0	13.9
Others	11.8	13.9
Wealth Index		
Lowest	17.0	15.1
Second	15.3	15.5
Middle	11.7	14.7
Fourth	7.9	12.6
Highest	8.3	10.0

Table 4.8. Chronic morbidities according to place of residence and sex, 2011 (prevalence rate per 1,000)

Chronic ailments	Rural			Urban			Total		
	Men	Women	Total	Men	Women	Total	Men	Women	Total (sorted)
Arthritis	261	357	311	194	285	243	243	338	293
Hypertension	169	228	200	204	269	240	178	239	210
Cataract	125	136	131	110	134	123	122	135	129
Diabetes	89	87	88	142	135	138	103	100	101
Asthma	94	68	80	73	66	69	89	67	77
Heart diseases	60	50	55	82	56	68	65	52	58
Number of elderly	2,453	2,685	5,138	2,219	2,495	4,714	4,672	5,180	9,852

Table 4.9. Awareness and Utilization of Rashtriya Swastha Bima Yojana among BPL households older women and men, 2011

	Men	Women
Awareness of RSBY	10.1	12.0
Registered under RSBY	5.6	8.0
Number of elderly	1,836	2,210

Table 4.10. Logistic regression analysis of elderly who report their health as poor and who has no income and no assets

	Self reported health as poor		
	β	Sig.	P value
Constant	-1.716	.000	.180
Age group(70-79 as ref)			
60 -69	-.499	.000	.607
80+	.480	.000	1.616
Sex (Female as ref)			
Male	.241	.008	1.272
Residence (Urban as ref)			
Rural	-.031	.622	.969
Marital Status (currently married as ref)			
Widowed	-.023	.757	.977
Others	-.233	.204	.792
Education (1-4 yrs as ref)			
Illiterate	.034	.698	1.035
5-7 yrs	-.156	.148	.855
8+ yrs	-.545	.000	.580
Employment (never worked as ref)			
Ever Worked	.048	.575	1.049
Living arrangement (Living with all others as ref)			
Living alone	-.019	.879	.981
Living with spouse	-.135	.156	.873
Wealth Index (middle as ref)			
Lowest	.456	.000	1.578
Second	-.010	.916	.990
Fourth	-.186	.046	.830
Highest	-.238	.016	.788
States (HP as ref)			
Punjab	.630	.000	1.877
West Bengal	1.158	.000	3.182
Odisha	-.417	.001	.659
Maharashtra	-.589	.000	.555
Kerala	1.399	.000	4.050
Tamil Nadu	-.697	.000	.498
Log Likelihood square			7920.201

About the Project

The United Nations Population Fund - UNFPA supported project BUILDING KNOWLEDGE BASE ON POPULATION AGEING IN INDIA aims at contributing and further expanding the existing knowledge base on the emerging population dynamics in India which are resulting in significant shifts in the age structure towards higher proportions of older persons aged 60 years and above. In first stage, the project supported the preparation of a series of thematic studies using existing secondary data sources. In the second stage the project initiated a primary survey in seven states in India. Dissemination of the findings to various stakeholders is a key objective of the project to help enhance the overall understanding of the situation of elderly in the country for further research and policy analysis on the growing numbers of India's senior citizens. The project is a partnership between the Institute for Social and Economic Change (ISEC), Bangalore, the Institute of Economic Growth (IEG), New Delhi and Tata Institute of Social Sciences, Mumbai

More information on the project can be obtained from www.indiaunfpa.org or http://www.isec.ac.in/prc.html

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