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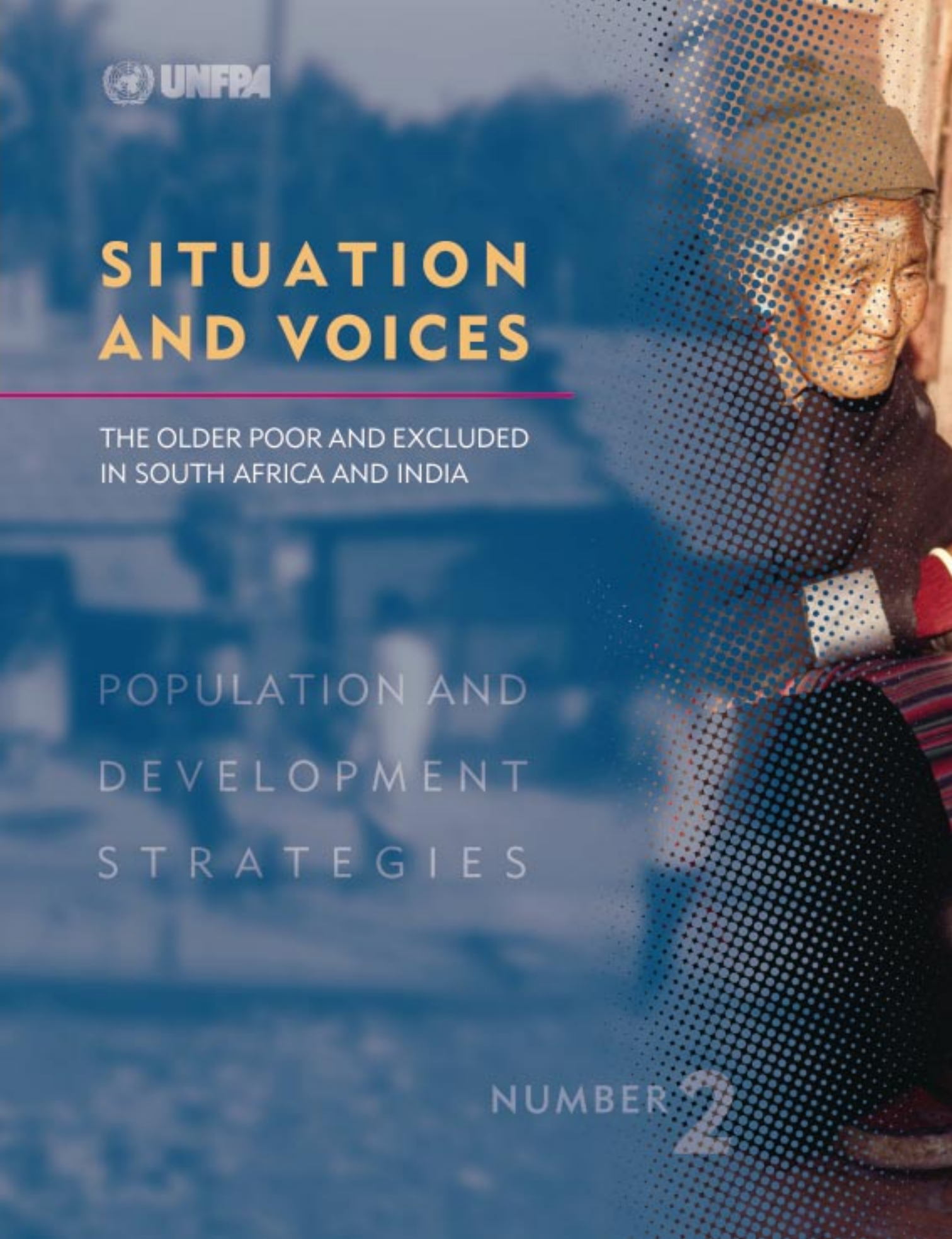
SITUATION AND VOICES

THE OLDER POOR AND EXCLUDED IN SOUTH AFRICA AND INDIA

POPULATION AND DEVELOPMENT STRATEGIES

NUMBER 2



United Nations Population Fund (UNFPA)
in collaboration with
The Population and Family Study Center (CBGS)

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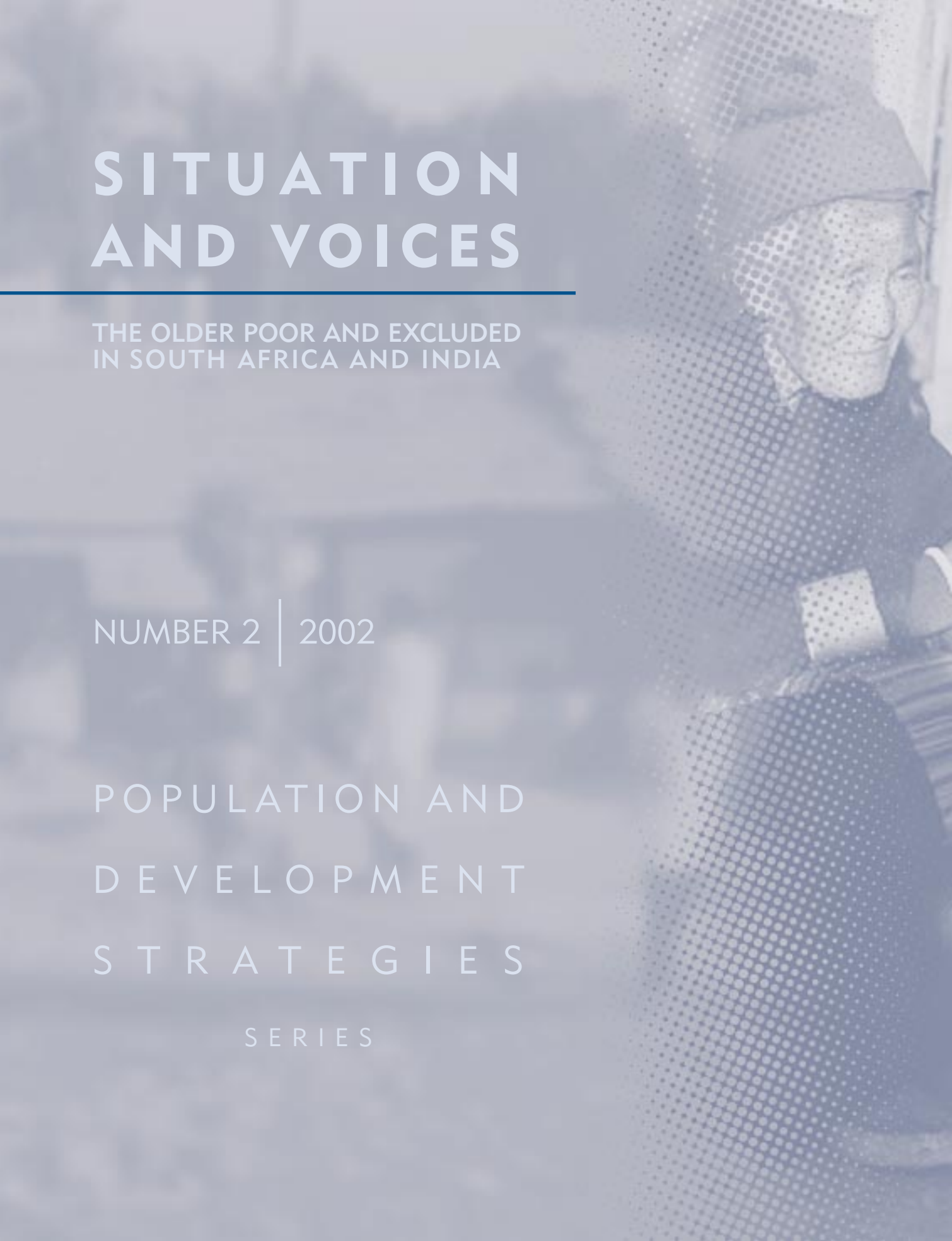

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POPULATION AND DEVELOPMENT STRATEGIES

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FOREWORD

Population ageing is increasingly becoming an issue for concern throughout the world, and particularly in less developed countries where the growth of the older population is ever more rapid. Population ageing is now seen as a major development challenge, particularly in settings where social safety nets do not exist, where there is limited institutional and human resource capacity, and where there are only scarce resources to respond to the health and basic needs of older persons.

Most older people live in less developed countries. In numerical terms, in year 2000 there were approximately 374 million persons aged 60 years and over in less developed countries, compared with around 231 million in more developed countries. By 2020 these totals are projected to rise to 706 and 317 million respectively. Therefore it is imperative that the priority issues affecting older people, a majority of whom are women, be addressed today.

The elderly are a diverse group and experience varying degrees of dependency on external support. The situation of many older persons living in less developed countries is one of extreme poverty and exclusion. They often lack access to adequate and affordable health care and other basic requirements, especially in rural areas, and some are also confronted with psychological and physical abuse. Traditional family support mechanisms are being eroded due to declining family size, rural to urban migration, urbanization and declining co-residence, and in some countries, younger family members dying of HIV/AIDS. As a result many older people, and particularly older women, are faced with isolation, abandonment and loneliness.

UNFPA has been actively participating in the preparatory processes leading up to the 2002 World Assembly on Ageing, and will continue to play an active role in the implementation of the International Plan of Action on Ageing – an expected outcome from the World Assembly. UNFPA views the Second World Assembly on Ageing as an event of major significance, coming 20 years after the International Plan of Action on Ageing was endorsed by the United Nations General Assembly in 1982 - having been adopted earlier the same year at the first World Assembly on Ageing in Vienna. UNFPA continues to advocate for mainstreaming ageing issues into the development agenda, with a particular focus on the needs of the older poor, especially women. Meeting the basic needs of older persons is crucial for progressing towards the Millennium Development Goal of halving the proportion of people living in extreme poverty by 2015.

In order to sharpen international focus on some of the key operational challenges faced by older people today, in early 2001 UNFPA commissioned a pilot study in South Africa and India. The study methodology entailed a literature review, including an analysis of the socio-cultural factors affecting older people, and a participatory assessment of how older persons perceive their lives. This publication contains the main findings of the study.

In South Africa, the study findings showed that the main concerns of older people relate to conditions associated with extreme poverty: inadequate living conditions, problems with access to the national social protection scheme and inter-generational violence and abuse. Older people, and particularly older women, increasingly act as caregivers for their adult children infected with HIV/AIDS as well as for their orphaned grandchildren, despite the fact that their own situations are characterised by extreme poverty and they themselves often need support.

Older people in India constitute the fastest growing age group in the population. India contains the second largest number of older persons in any country worldwide. Most older Indians live in extreme poverty, particularly those located in rural areas. Poor economic and health conditions, changes in traditional family support structures and elder abuse all increase their vulnerability. In extreme circumstances, older women are disowned by their family and ill-treated by children after their husband's death. Widowhood in Indian society is generally associ-

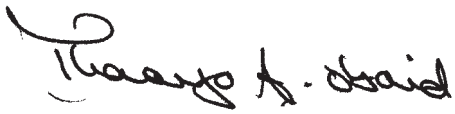
ated with considerable deprivation and discrimination and has many implications for the health and well being of older women.

In carrying out this study, UNFPA worked in partnership with the Population and Family Study Center (CBGS), a scientific research institute of the Flemish Community in Belgium, and national teams in India and South Africa. It is a pleasure for me to acknowledge and thank the Governments of Belgium and Flanders for their generous support for the study. I would also like to extend my sincere thanks and appreciation to all members of the study team (**listed on page vi**) who ensured the timely completion of the case studies, as well as the staff of UNFPA Country Offices in India and South Africa.

UNFPA, working in multiple partnerships, continues to support gender and culturally-sensitive activities that address population ageing at the global, regional and country levels. The emphasis is on training and research at national and local levels with particular focus on the most vulnerable groups of older persons, including the very poor and frail, especially women. UNFPA seeks to facilitate policy dialogue and policy development to address the consequences of population ageing and to meet the needs of older persons, as well as promoting inter-generational solidarity.

I sincerely hope that the findings contained in this report will be taken into account in new policies and programmes for meeting the urgent needs of older persons, in the participating countries and elsewhere. Programmes must be developed and strategies designed and monitored at all levels with the help of older people themselves. They should aim to make positive changes to the lives of older persons so as to enable them to continue to actively contribute to their communities.

Thoraya Ahmed Obaid



Executive Director, UNFPA
February 2002

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CHAPTER 1

THE OLDER POOR AND EXCLUDED IN THE DEVELOPING WORLD

By Richard Leete and Therese Jacobs

Background

Population ageing refers to shifts in the age distribution of the population in which the relative share of persons at older ages increases, and the share at younger ages decreases. This is distinct from absolute increases in the number of older persons that can occur even if their share does not increase.

The fertility levels of earlier decades are the primary determinants of a population's age structure: high fertility rates resulting in relatively young populations, and low rates in relative old populations. By contrast, the impact of mortality is more diffuse across all ages of a population, and that of migration, while often concentrated at young adult ages, is more erratic, often relatively localised, and of limited impact in all but major population movements.

At the commencement of the twenty-first century, the older population (here defined as those 60 years of age and over) in Less Developed Countries (LDCs) comprises cohorts born before 1940, at a time of high fertility and high infant and overall mortality. This means that their life course experiences have exposed them to the vicissitudes of both global and local political, economic and social circumstances and events extending back to the first half of the twentieth century.

Mid-twentieth century population trends in most developing countries resulted in the moderate levels of population growth that preceded the transfer of medical technologies and therapies and characterized the

phase before public health programmes had impacted significantly on life expectancy. As a consequence, the proportions of most of these populations aged 60 and over, generally in the vicinity of seven or eight percent, is still quite modest compared with that of societies in More Developed Countries (MDCs) which average in excess of 19 percent. (UNFPA and CBGS, 1999).

Since birth rates are still quite high in many countries in the developing world, especially in sub-Saharan Africa, and because of the considerable lead time required following fertility decline for the shift in age distribution to become apparent at older adult ages, the greater part of the ageing process in LDCs is still to come. This will occur as a product of the high fertility and reduced mortality in the second half of the twentieth century that has given way in recent years and in many developing countries, especially in Asia, to the transition to low fertility, relatively low mortality and a consequent rise in life expectancy.

Although the large scale of the impact of the ageing process will not be apparent for some time yet, several important features are already apparent. Compared with the MDCs, there will be a more rapid *pace* of ageing reflecting the generally faster rate of fertility decline. There is already considerable variation in the *timing* of the onset of the ageing process among the countries comprising the LDCs and this, combined with the pace of ageing, is likely to determine the observable *levels* of population ageing attained in each society at any particular date.

So far there is less evidence of substantial improvements in life expectancy among the older population itself than in MDCs, but this can be expected to change. Certainly the recurrent imbalance in the sex ratio among the older population is clearly evident in most societies, though usually not to the extremes experienced in MDCs. Since this phenomenon becomes progressively more marked with advancing age, the issues in older age groups must increasingly take account of gender and the particular circumstances of women.

The numerical scale of older populations

The proportional distribution of populations according to age suggests that the scale of any issues with which society must deal to enhance the living conditions and life style of older people is much greater in the developed countries than it is in less developed countries. This is a mis-

apprehension. While it is true that older populations comprise an unusually large proportion of the population in more developed societies, sheer numbers are far larger in less developed countries. And growing old affects all social groups, not just the middle classes.

As long ago as 1950, the majority of the world's population aged 60 and over lived in the less developed regions of the world: 110/205 million, or 54 percent. By 2000, the majority had expanded to an estimated 374/606 million or about 62 percent. Further into the future, the share of older people located in the developing world is expected to escalate rapidly: in 2020, the numbers are anticipated to be around 707/1,024 million, or about 69 percent; and by 2050, 1,569/1,964 million or over 80 percent of the world's population aged 60 and over (**Table 1.1**). Not only does the majority of the world's older population live in less developed countries, but the scale of that majority is rapidly increasing.

TABLE 1.1: Numbers and distribution of the population aged 60 and over, 1950-2050

Region	World	More Developed Countries		Less Developed Countries	
Year	*millions*	*millions*	*percent*	*millions*	*percent*
1950	205	95	46	110	54
1970	312	147	47	165	53
2000	606	232	38	374	62
2020	1,024	317	31	707	69
2050	1,964	395	20	1,569	80

SOURCE: : Based on United Nations (2001).

At the turn of the century, few developing countries were really coming to grips with the issues accompanying these major structural changes in the population in terms of awareness, policy development, capacity building or in any other way, although the need is widely apparent. This is a salutary situation, because for these societies, the main challenge is yet to present itself in the increase from 374 million to about 1,569 million older people in the fifty-year period 2000 to 2050. Raising the definitional age of 'older people' to 65, as commonly adopted in many developed countries, makes relatively little difference to the enormity of the situation.

Some countries in less developed regions are still attempting to cope with the high levels of population growth that result from relatively high birth rates, but these circumstances do not necessarily exempt them from having to deal with this issue. While population ageing is certainly more conspicuous in societies that have experienced sustained replacement level fertility, nevertheless, some large populations in which fertility still remains relatively high or has shown only moderate signs of decline, as in Nigeria, can still have substantial numbers in the older population. In such instances, the issues relating to the older population also need to be addressed.

Even where the current numbers or proportions of older people do not seem particularly significant, this is only the beginning, the numerical base on which the bulk of the ageing process, mostly still to take place in the future, is commencing to build. Fortunately, because of the lengthy lead time, and the readily and accurately predictable numbers (the 60 and over population of 2050 had all been born by 1990), the type and scale of the issues arising can be anticipated well ahead of time.

Actual numerical size must be taken into account because most planning, if there is to be any, must deal with people, with individuals as distinct from proportions: mouths to feed, patients to be cared for, elders to be accommodated, and consumers to be supplied with the basic necessities of life. 'It is this numerical growth that is of prime relevance to social and economic programmes in the short and intermediate terms' (Knodel, 1999, 45; Hugo, 1996).

The issues and challenges

Economic and social support

An adequate income equates with independence of choice and the exercise of preferences for people of older ages. Absence of a sufficient and reliable income reduces them to varying degrees of dependence. The most vulnerable have no productive assets, little or no savings or investments, no pensions or retirement funds, and no family to care for them or, are part of families with low or uncertain incomes (Nizamuddin, 1999). Indeed poverty is the most recurrent and constraining issue of all in most developing societies.

The majority of workers living in developing countries are involved in the less structured, small-scale informal sector in urban areas, or in agri-

culture and allied sectors in rural areas. For them, the prospects for their well-being at older ages can be daunting. The absence of pension schemes, provident funds or other savings, the lack of information and foresight with regard to the impending issues of old age, the irregular flow of income during their working lives, and the constant pressures to meet current needs, ensure a high degree of dependence, commonly on their adult children. Those without children frequently run a severe risk of joining the indigent and homeless.

In a large number of developing societies, family has traditionally been the primary source of care, often in the form of coresidence with adult children. However, although care is more easily and willingly provided to older people within households than outside them, elements of social modernisation suggest that in developing countries the retention and support of older persons within the home is becoming increasingly unsustainable. Yet for many groups in a country like India, putting elderly parents into a nursing home – even where that is feasible – may be culturally unacceptable.

Weakening of the traditional system of family care of older people to some degree, is a pattern common to most countries which have experienced or are undergoing a process of modernisation and transition, especially substantial rural to urban migration (KIHASA and UNFPA, 2000). Even where coresidence persists, the extended family structure does not necessarily imply a family supportive of the elderly since the flow of wealth may be in either or both directions and even where they are beneficiaries, older people may not be the recipients of actual cash transactions from their children for discretionary personal spending (Neville, 2000). Indeed, in the South African case, older family members' pensions frequently provide the only income for the support of an extended family.

While favouring a policy of family support does not preclude a modest public programme to provide a safety net for the most needy, it is commonly a limited response adopted by governments in order to avoid diverting resources from other priorities. As Caldwell (2001) points out, even though families in more developed countries are prepared to make huge investments in their children using a drip-feed approach, there is a cool reception to the suggestion that a similar scale of resources be collected as part of regular taxation payments to support the older pop-

ulation *en bloc*. It is hardly surprising, therefore, that in countries with fewer resources, making fiscal contributions to such an anonymous sector of society is unpalatable to government and taxpayer alike.

In practice, an increasing number of governments in developing countries maintain social welfare measures as an 'ultimate-need' safety net, targeting older persons who have been abandoned or who are indigent or disabled, a provision which may not always be readily accessible or even generally known. Sustaining a family-based, no-government-participation approach is becoming progressively more impossible in any society with pretensions to assuring the well-being of their needy older people.

Health and health care

Public health services in many developing countries are limited in their coverage and are largely confined to urban areas. These facilities are often overcrowded, unevenly distributed and overstretched due to paucity of funding and qualified personnel, shortage of space, poor maintenance and indifferent services (Bose, 1996). More fundamentally, however, the nature of health issues has shifted, especially in their significance for older people.

Early improvements in health and mortality rates were largely achieved through the reduction in infectious and contagious diseases achieved by relatively inexpensive technology transfer of medical and public health provisions. Now, degenerative diseases account for most mortality, especially among older cohorts. For most urban populations and virtually all rural populations, little intervention takes place in the case of circulatory disease, cancers, or any condition requiring surgery (Caldwell, 2001).

The vast majority of older people accept that poor health, often accompanied by increasing poverty, is an integral part of old age. Degenerative conditions are seldom explicitly diagnosed and the individuals and their families alike tend to accept this process as a normal stage in the life course. However, this acceptance, and attitudes to health and health care, will change. Rising expectations are being perpetrated by increased educational levels, by media penetration and a raised awareness of the medical options accessible to those with the resources to purchase them.

Poor health and uncertain finances also result in high levels of stress in older populations living in poverty and difficult circumstances. Stress takes the form of loneliness, violence or abuse of older people and these are further compounded by a lack of awareness of where and how to find help - or by its total unavailability.

Gradual improvements are occurring in many countries, but access for the majority of older people, especially if they are rural dwellers, is problematic. However, in countries like South Africa, there is still a serious lack of adequately trained geriatric specialists, and a paucity of standardised training for paramedical and other care givers in support of the elderly – a reflection of the lack of demand for training as well as a lack of capacity.

Poverty and older people in need

Poverty commonly evidences itself in developing countries in two major ways. The most conspicuous is the deprivation of a large proportion of the population of the basic necessities of life, a phenomenon in which the older age groups generally represent the extreme case. This situation is frequently characterized by the second recurrent feature: the inability of the governments of the countries in which the chronically poor live to mobilize the necessary resources to eradicate the causes or even alleviate the symptoms of deprivation to any significant degree.

While both urban and rural populations suffer widely from poverty, the problem is generally most acute in the large rural populations that predominate in the majority of developing countries. Since large sectors of most rural populations comprise peasant farmers and manual labourers functioning outside the formal sector, the concept of retirement has little currency, and there are virtually no provisions for pensions.

In South Asia, technological change in the agricultural sector raised the rate of growth of food production above that of the population, but because of the failure of employment growth in other sectors, the incidence of poverty increased among the majority of the landless and among smallholders. In sub-Saharan Africa, the deterioration of the agricultural production base and general economic decline has resulted in a dramatic increase in the incidence of poverty among subsistence farmers (United Nations, 1999b).

Where poverty is most severe, competition for resources among generations creates problems that even subvert kinship allegiances. Furthermore, young adults are leaving rural areas for the city, undermining the structure of the traditional family, and leaving older persons, especially widows, living in poverty in rural areas. Conditions faced by older people in urban contexts of squatter housing and shanty towns impact on the poorest and most vulnerable, such as blacks in South Africa. Here, even though the government introduced a social pension scheme shortly after the collapse of Apartheid, there are extensive problems and abuses in implementation of the programme, including access, delays, lack of security and cheating. So immense is the depth of poverty that even household members may inflict physical violence and emotional abuse on the poor and frail elderly, taking their pension money and marginalising them within the household.

For the vast majority, whether urban or rural, old age is conceived of less in terms of chronological age than as an inability to work and therefore of a relentless and progressive poverty. Because the incidence of poverty is high, and likely to remain so well into the future, poverty will continue to be a significant barrier to policy development and programme implementation in aged care (Hugo, 1996).

The most positive steps, even in the poorest societies, include involvement of older people in community-based activities. Inclusion provides the basis for a network that ensures that their voices and views are heard in the development of policies and programmes that affect them. These measures apply particularly to determining appropriate responses to the demand for home-based care, in linking up the network of multiple NGOs that are attempting to deliver effective support and services, and in providing these services at accessible distribution points.

Gender and ageing

Most of the issues challenging older persons are disproportionately concentrated among females. This is especially significant in developing countries for two main reasons. First is the predominance of women (often elderly themselves) in care-giving roles in support of older members of the family. Secondly, large numbers of older women live alone, either because they are unmarried or widowed. This situation is accentuated among the older age groups in societies such as those of South Asia because, forty or fifty years ago, most marriages were arranged,

resulting in an age disparity as large as 10 years or more between women and their much older spouses.

Most men spend their final years with a wife to care for them, but women commonly spend their later years without a partner. In such circumstances, women are perceived to be economically and socially vulnerable. Their productive activities at most stages of their lives are commonly home-based and therefore lie outside the formal economic sector. This vulnerability is reinforced by the inherent gender inequalities that tend to recur in the family and community life of many societies.

Where employees have been fortunate enough to benefit from a public service pension or the like, women who have not worked in formal employment for most of their adult lives become even more heavily reliant on their husbands' status and incomes – one or both of which may be forfeited upon his death. The large numbers of women who are single, widowed or divorced are therefore especially vulnerable, receiving few or none of the entitlements of men, and in some instances even lacking acceptance in the community or family.

The circumstances of younger women, potentially and traditionally the main care givers, are in the process of altering radically. Decreasing family size, expanding career opportunities and increased mobility are introducing new levels of financial and social independence for women, and personal advancement is likely to appeal much more than being confined to the home and caring for ageing parents in deteriorating health and advancing frailty. Younger women are increasingly seeking employment and therefore their mothers are caring for their grandchildren. Nevertheless, positive outcomes of these trends may result in benefits to older people in the form of remittances or consumer goods (Gubhaju *et al.*, 2001).

There is potential for conflict in many situations where gender-based attitudes and behaviour are undergoing change. The obligations of children (especially sons) to parents are being diminished and even superseded by obligations to wife and children. The subordination of the daughter-in-law by her parents-in-law and the failure of young husbands to give priority to their wives and children is inimical to messages coming increasingly forcefully from the wider world (Caldwell, 2001).

HIV/AIDS and older people

The incidence of HIV/AIDS worldwide is extremely uneven, and the implications for the older sectors of populations and their economic and social circumstances is not well understood. Currently the main impact of HIV/AIDS on older people is not so much suffering from the disease themselves but more as parents of young adult victims, and the widespread dependence on intergenerational arrangements for care giving and support.

The disproportionate mortality among younger parents, especially in the severely affected countries of Africa, necessitates the fostering of children – a culturally acceptable option that ensures there are few deserted orphans. However, much of the childcare is provided by grandparents, so that instead of those older people being cared for, they are doing the caring. Many older people therefore become involved in stressful and exhausting situations that are not of their own making and that constitute a frustrating conclusion to the hard lives they have led. HIV/AIDS campaigns tend to target younger people therefore older people's knowledge and awareness of the illness is depressingly low.

The impact of HIV/AIDS compared with other illnesses can be particularly severe given the lengthy periods of illness and disability, the untimely nature of the death, and stigma of community reactions to persons with HIV/AIDS and their families, including older parents. The plight of older people enmeshed in these circumstances becomes most traumatic in conditions of poverty and truncated kinship structures and makes the need for support in the form of income, physical help and counselling services all the more acute. HIV/AIDS can also function as an instrument of violence and power in many communities.

The case-study countries

South Africa

South Africa is home to over 43 million people and the growth rate is expected to exceed 47 million by mid-century (**Table 1.2**). With a total fertility rate of just under three, the level of fertility is still quite high, but the impact of births is somewhat offset by a life expectancy of less than 50 years for the population overall. Not surprisingly, in these circumstances, the proportion of older people in the population is still less than six percent, but this share is expected to more than double by 2050. While the sex ratio for the population as a whole shows a small preva-

lence of females (which will become negligible by mid-century), women predominate strongly at ages 60 and over with just thirteen men to every twenty women. South Africa therefore confirms the widely recurrent pattern that the issues of older people are principally those of women.

TABLE 1.2: Population parameters for South Africa and India, 2000 and 2050

	2000	2050
Country	*South Africa*	
total population (numbers)	43,309,000	47,301,000
annual growth rate (percent)	0.77[1]	0.54[2]
sex ratio (per 1,000 females)	970	1,039
aged 60 and over		
share of total (percent)	5.7	13.7
sex ratio (per 1,000 females)	668	824
total fertility rate (per woman)	2.85[1]	2.10[2]
life expectancy at birth (years)		
males	46.5	65.3[2]
females	48.3[1]	67.5[2]
Country	*India*	
total population (numbers)	1,008,937,000	1,572,055,000
annual growth rate (percent)	1.52[1]	0.41[2]
sex ratio (per 1,000 females)	1,065	1,018
aged 60 and over (percent)		
share of total (percent)	7.6	20.6
sex ratio (per 1,000 females)	918	909
total fertility rate (per woman)	2.97[1]	2.10[2]
life expectancy at birth (years)		
males	63.6[1]	73.5[2]
females	64.9[1]	77.4[2]

1: 2000-2005 2: 2045-2050

SOURCE: United Nations (2001).

South Africa is confronted by a multiplicity of complex problems deriving from its cultural diversity and variegated history. The people of the Republic are contending with economic and social structures, rooted in the apartheid system, that are now undergoing rapid but uneven change. Problems proliferate as communities attempt to rectify the injustices and inequities of the past with an extremely limited number of formally educated and experienced people, an inadequate pool of contemporary work skills and severely constrained financial resources.

Overall indicators of the socio-economic conditions in South Africa tend to conceal marked differences between the Whites and Blacks.

The key issues with which South Africa must deal in the context of the well-being of the older population relate mainly to extreme poverty and inadequate and undignified living conditions, especially of the Black community. With the vast majority of the Black population living in townships and makeshift settlements, implementation of the government's social pension scheme is problematic and abuses are rife. Practical problems in claiming and utilizing their pensions loom large for older people who must contend with difficulties of access, interminable queues, cheating by hawkers and lack of security. Poor and frail older persons are not immune from harassment by family members, frequently being subject to physical violence and emotional abuse, and even confiscation of pension payments when there is competition for resources among generations.

As elsewhere in Africa, the problems associated with HIV/AIDS obtrude in the lives of many South Africans, and there is widespread ignorance of the nature and implications of the disease. As previously noted, this issue does not exempt older people but commonly involves them in the role of carers to adult children and especially to orphaned or abandoned grandchildren. Such responsibilities, commonly in the context of entrenched poverty, add greatly to the stress and trauma of coping with the ageing process for many people, particularly women. In these circumstances, mutual support from within the community, and a sense of belonging and participating in the making of policy decisions that affect the community, is of primary significance to those hard pressed by their circumstances.

India

As the second largest national population in the world (and on track to becoming the largest within the foreseeable future), India occupies an influential role among countries in developing regions. Its population of just over one billion in 2000, continuing to grow at the turn of the century at about 1.5 percent per annum, is expected to exceed one and a half billion by mid-century, at which stage the anticipated growth rate will be down to 0.4 percent (**Table 1.2**). By then, the total fertility rate, as in South Africa, is expected to be near replacement level (2.1 children per woman).

Life expectancy in India is about 64 years for both sexes, and therefore relatively high for countries in less developed regions. This contributes significantly to the substantial proportion of older people (7.6 percent in 2000) in the population, and this proportion is expected to escalate to the very substantial share of more than 20 percent by 2050. The sex ratio among the older population is unusually balanced with more than nine men for every ten women. This is partly a consequence of the situation in the total population for which the sex ratio is also exceptionally high (as in many Indian communities around the world): 1,065 males per thousand females.

The majority of older people in India, located particularly in rural areas, live in poverty. Since large proportions of the population are active in the informal or unorganized sector, neither the concept nor the implementation of retirement have much currency, there is no system of provident or contributory retirement funds, nor, in any case, the resources to be spared from current needs and dedicated to a significant degree of future self-sufficiency.

As in many countries of Asia, the primary source of care and support is the family. However, economic development, enhanced employment and career opportunities through education and skills training, and widespread migration of young adults (women as well as men), are becoming highly disruptive of the traditional structures and practices that provided older people with a sense of security and certainty. Older women in particular, especially if they are unmarried or widowed, are highly vulnerable, experiencing shrinking roles and declining status in their families and communities.

Although the government recognizes that there are serious issues that require addressing in the context of a large older population, the needs of older persons do not rate very highly on official priority lists in the face of many competing development priorities. Resources dedicated to homes for the aged (culturally not acceptable but in practice essential) and day-care centres are quite inadequate, the scale of pension payments by government and individual states is tiny, and the prospect for capacity building in most areas of care and support is not reassuring.

Operational Challenges

The multiple problems faced by the older poor present significant challenges for introducing policies and multi-sectoral programmes capable of effectively responding to their needs, expectations and rights. (Leete and Pawliczko, 2001). These include:

- **Mainstreaming ageing issues into the development process, with a focus on the older poor, especially women**
- **Examining the economic, social and cultural implications of the population and demographic changes, and how they relate to development concerns and the needs of older persons**
- **Promoting good health throughout the life cycle, starting from young ages and especially through the reproductive ages, to the older age, including through the provision of affordable, accessible and appropriate health-care information and services**
- **Recognising and supporting the care-giving services provided by older persons, especially women, to grandchildren orphaned by the effects of HIV/AIDS**
- **Promoting appropriate social services and welfare coverage for the elderly, particularly of the poor elderly, most commonly women**
- **Eliminating discrimination, violence and other crimes against the elderly, especially women, including inter-generational violence *and***
- **Promoting inter-generational solidarity with the goal of maintaining and improving social cohesion and the full participation of older persons in community life**

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South Africa

CHAPTER **2**

THE PLIGHT OF OLDER PERSONS IN SOUTH AFRICA

By Priscilla Reddy

Background

'Apartheid', a socially constructed concept promoted to perpetrate White[1] supremacy, has riddled South African society with a multiplicity of imbalances. Its founders entrenched it in every aspect of South African life from limiting Black South Africans' access to education, determining where they could live, and proscribing their access to resources such as health care. But a major legacy of apartheid that will outlive indefinitely the system's official abolition, is the overwhelming poverty that it brought in its wake. The majority of the elderly bear testimony to this phenomenon to this very day. Despite several triumphs in promoting equality in some aspects of South African life, the distribution of wealth remains one of the most unequal to be found anywhere.

Due to the inhumane manner in which Black South Africans were treated in the past, one of the fundamental principles of South Africa's constitution[2] is that 'everyone has inherent dignity and the right to have their dignity respected and protected'. Yet where is the dignity in living without land, being unemployed, and lacking the bare essentials of life: food, water, sanitation and shelter? The Minister of Social Development has described South Africa as 'sitting on a time bomb of poverty and social disintegration' (Department of Social Development, 2001a).

Poverty

Poverty in South Africa has three distinct dimensions, namely, race, gender and location (that is, a spatial dimension). South Africa has a popu-

lation of over 43 million of which 53.9 percent are urban dwellers and the remaining 46.1 percent non-urban dwellers.

The population comprises 'Black-Africans' (77.8 percent) followed by 'Whites' (10.5 percent), 'Coloureds' (8.9 percent) and 'Indians' (2.8 percent) (Statistics South Africa, 2000). The 1998 Poverty and Inequality Report (Wilkens, 1998) classified 19 million, or about 45 percent of the country's population as 'poor'. Poverty is heavily concentrated among Black South Africans (71 percent).

Box 2.1

Uneven distribution of poverty by gender and location

The gender difference characterizing poverty adds to the burden with 60 percent of female-headed households compared to 31 percent of male-headed households classified as poor. About 72 percent of the total population who are poor come from rural areas. What is more, poverty is unevenly distributed between South Africa's nine provinces, with the highest levels occurring in the Eastern Cape. The poorest 40 percent of households, representing 50 percent of the population, receive only 11 percent of the total income. On the other hand, the wealthiest 10 percent of households, representing seven percent of the population, receive more than 40 percent of the total income.

While income inequality exists between racial groups this trend to inequality has recently become evident within racial groups. The inequality between the richest and the poorest Black Africans is increasing, as is the case among Coloureds and Whites (Hirschowitz, 2000). Unemployment rates in South Africa are high (National Report on Social Development, 2000). The number of entrants into the job market has increased as seen in the 1999 October Household Survey (OHS) (Statistics South Africa, 2000). However, job creation has not followed suit. The inability of the formal job sector to cater for new entrants has affected women and youth the most, with unemployment rates twice as high in this group (National Report on Social Development, 2000). Unemployment rates also show racial differences with 36.9 percent of Black South Africans unemployed compared to 5.5 percent of White South Africans (Central Statistics, 1997).

The OHS has shown an improvement in access to basic services among Black households since 1996 – the group for which the greatest deficiencies have been found. In 1996, only 48 percent of Black households, both urban and non-urban, had access to running water in the house or on site. This increased to 56 percent in 1999. Improvement has been less marked in non-urban households with 21 percent receiving safe water in 1996, increasing to only 27 percent in 1999.

People at older ages

Almost five percent of South Africa's population is 65 years of age or older (Statistics South Africa, 2000) with nearly half of the population (45.1 percent) below the age of 19. South Africa, with its structural and economic imbalances, has invested in the well-being and nurturing of its young as the future pillars of society. Life expectancy in South Africa, taking into account the triple burden of disease (namely, infectious diseases including HIV/AIDS, chronic diseases of lifestyle, and death from trauma), stands at 57 (Timaeus *et al.,* 2001). Like the rest of the world, and especially as part of the developing world, South Africa is participating in the demographic transition, and as a consequence, is facing expanding numbers in the older generation. Thus it is economically responsible for the country to plan for improving the lives of older persons and creating an environment that is conducive to tapping into their fountain of knowledge and life experience.

Females comprise 60.8 percent of the 65 and over age group. The racial distribution in this older persons age group is 68.5 percent Black-African, 23.1 percent White, 6.3 percent Coloured and 1.9 percent Indian. Almost equal percentages of older persons live in urban (50.8 percent) and non-urban areas (49.1 percent). But the distribution between racial groups differs with over two-thirds of Black elderly living in non-urban areas compared to only 6.3 percent of White elderly (Statistics South Africa, 2000).

Females in South Africa (60.4 years) have an advantage of almost 10 years in life expectancy at birth compared to males (50.8 years) (Timaeus *et al.,* 2001). Gender inequality within the system of racial inequality means that older Black-African women in particular, suffer immensely. Households headed by women, particularly in rural areas, are amongst the poorest in the country (Hirschowitz, 2000). According to a Time Use Survey (Lehohla Pali, 2001) women spend a larger propor-

tion of their time on productive activities than men, yet women were likely to be paid for less of the time they spent on productive activities per day than men. In South Africa, because of the lack of basic resources, females again spend significant amounts of time compared to men, collecting water and fuel, all unpaid work. Besides imposing a physical and therefore health risk, these types of activities prevent women from engaging in work that provides an income and therefore independence.

Health

It is generally acknowledged that the normal ageing process that increasingly exposes one to increased risk of disability and chronic disease is speeded up by continual exposure to health problems (Gorman, 1999). In developing countries like South Africa, lack of access to health care facilities intermingled with a life of poverty expedites the onset of chronic diseases and 'old age' at a much younger age. The nature of the life of women in South Africa, particularly Black-African women, is submissive, entailing multiple pregnancies, hard physical labour (toiling on the farms, collecting water and fuel) and rearing children; and marked by inaccessibility to health facilities and therefore untreated health conditions, poor nutrition and the necessity of generating some form of income.

The South African Demographic and Health Survey (Department of Health, 1998) reported that almost 1 in 5 males and 1 in 5 females in the 45-54 age group were clinically confirmed as hypertensives. Of those confirmed as hypertensives, only 36.9 percent of males and 61 percent of females were aware of their hypertension. What is more, only 8.8 percent of males and 26.8 percent of females had controlled blood pressures. All of this has resulted in the manifestation of disability and therefore characteristics of old age early in life. By age 65 and older, confirmed hypertension rose to 34.3 percent in females compared to 28.5 percent in males. According to the South African Health Review 2000 (Bradshaw *et al.,* 2000), stroke, ischaemic heart disease, diabetes and cancers, all chronic diseases, are important causes of death in the 45-59 age group.

The impact of chronic diseases from a relatively young age on the ability to remain economically productive is a cause for concern for both the economy and the health care sector, which must bear the cost of treatment. What is more, the appearance of chronic diseases earlier on in life brings into question the chronologically based definition for old age, a question which is being addressed by South Africa's Ageing Policy which

acknowledges that ageing should not be defined by age but by mental and physical capabilities of the individual (South African Policy on Ageing, 2000). However, the practical application of this definition in developing guidelines for the issuing of social grants needs to be further elaborated.

Identifying the issues

South African older persons, defined as those women over 60 years of age and those men over 65 years of age, have lived through the indignity of apartheid. The majority of them, in addition to the emotional trauma, are still caught in the grip of poverty that is unlikely to end in their lifetime. In fact, a study initiated by HelpAge International in South Africa recorded the impact that historical policies have on the lives of older persons, creating emotional and material poverty, the effects of which they battle with on a day-to-day basis (Heslop *et al.,* 2000). A country that was at war with itself, rarely had the time to cater for 'non-productive' members of its society.

Despite the non-provision of services, a significant amount of research has been conducted on older persons in South Africa. However, this research remains fragmented and hidden in the shadows of grey literature. Few national studies exist, with many studies limited to particular racial groups, geographic settings and concentrated on certain topics (for example, Moller and Sotshongaye, 1996; Moller, 1998; van Vuuren and Groenewald, 2000; Jourbet *et al.,* 1998; Keikelame *et al.,* 2000). Even though pockets of research on older persons are continuing throughout the country, what is missing is a linking element that ensures prioritisation of research, minimises overlap and encourages collaboration. WHO, in partnership with various African countries, has undertaken the task of developing a 'Minimum Data Set for sub-Saharan Africa'. The project aims to develop a database of complete and reliable data on the health, social, economic and mental status of older persons in the population. Currently Ghana, Zimbabwe, Tanzania and South Africa are involved in this project (Kowal *et al.,* 2000).

Kalache and Sen (1999), together with others, call for the rejection of ageing as a crisis. South Africa, like other developing countries with a large percentage of its population still below the age of 19, has time in hand to make policy changes and develop programmes to improve the lives of its elderly. Furthermore, it is argued, rather than approaching

Box 2.2

Issues of older people... on the political agenda

With the change in political dispensation in South Africa in 1994 and the re-entry of the country into the international arena, concerted efforts are being made to bring the plight of older persons on to the political agenda. This has been aided by the mass media and lobbyists for older persons providing glimpses of their lives. The screening of incidents of abuse of older people, and the public outcry that resulted, provided the impetus for the setting up of a Ministerial Committee to investigate such abuse. This has opened up a Pandora's box, for the problem it seems is multifaceted and deep-rooted.

ageing from the perspective of disease and disability, older persons should be revered for their wealth of knowledge and skills accumulated through life long experience. In the South African setting, older persons throughout the political struggle have been the backbone that held communities together, while the middle aged and young people fought on the many battlefronts. They nurtured the young while their parents sought work in the mines and in urban areas.

The reason for highlighting the problems associated with ageing in South Africa is not to assert that old age is wholly beset with problems, but rather an attempt to identify the gaps in policy and service delivery, so that solutions can be found to harness the potential of older persons in reshaping South African society. The Minister of Social Development has recognized the contributions, both social (in the form of caring) and economic (in the form of providing financially for entire families on their pensions), that older people have made and continue to make in sustaining South African society. He asserts that government, via an integrated plan of action that involves the Departments of Social Development, Housing, Safety and Security, Justice, Health and Home Affairs and in partnership with the private sector including NGOs, would share the responsibility for caring and protecting older persons in South Africa (Skweyiya, 2001).

The Social Security system

South Africa's constitution affords access to social security to all of its citizens.[1] Access to social security both before and after the introduction of democracy in 1994 has been precarious, especially for Black South Africans. Repeatedly it has been hypothesised that the pension grants of

older persons, in a country caught in the depths of poverty, sustain entire households. In fact, it is suggested that, in some provinces 'small rural towns exist on pension money' (Moller, 1998). Several studies in South Africa have shown that pension income is chiefly spent on purchasing food and other necessities for the household, as well as paying for grandchildren's school fees (Heslop *et al.,* 2000; Moller and Sotshongaye, 1996; van Vuuren and Groenewald, 2000), a practice especially prevalent in three generation households, where the majority of the Black older persons live.

During the transitional period in South Africa's political history, in trying to streamline a bloated social security system to ensure social support is delivered to those most in need, it was, ironically, those in greatest need, namely older and disabled persons, who experienced the worst impact of the transition. The only way to establish the actual needs of the social security system is to quantify the number of who are eligible and then to budget accordingly. While this principle no doubt is sound, the lack of interim measures to cater for the needs of older and disabled persons has had severe consequences on their lives.

South Africa's policy on older persons in the form of a social pension scheme dates back to 1928 with the introduction of the Social Pension Act for the White and Coloured populations. Black South Africans were excluded on the alleged grounds that 'Native custom makes provision for maintaining dependent persons' (Sagner, 1998). Although the 1944 Pension Law Amendment Bill provided for the welfare of older Black South Africans, the value of the pension, a mere one-tenth of that accorded White people (Van der Berg, 1998), was dismal and differential in terms of urban and rural residence. As far back as 1949 it was recorded that, in the case of Black persons, old age pensions did not merely provide for individuals, but clothed, fed and sheltered entire families. Such was the significance of the pension.

In 1965, under the National Welfare Act, a uniform and incremental pension scheme was made available to all Black South Africans. In 1975, the value of the Black pension was R15 per month (US$1.90).[3] By 1979, the value of the pension had increased to R27.50 per month (US$3.40) lagging by almost 72 percent behind the value of a White pension. Parity was eventually reached in 1993; the value of the pension being R370 per month (US$46.25) (Department of Social Development, 2001b).

The Social Pension Act of 1973 was replaced by the Social Assistance Act of 1992, which was proclaimed only in 1996. The Committee for the Restructuring of Social Security, formed as a result of the crisis in the delivery of social grants, recommended among others items: a national system for the delivery of social grants; national guidelines on the outsourcing of pension payments; negotiations with banks for payment of pensions; as well as a communication strategy to inform beneficiaries of their rights and of changes in the social security system (Department of Social Development, 2001b).

The challenge of achieving change

Because of the historical backlog and the challenges associated with the transformation to an equitable society, change has occurred very slowly, if at all. The Welfare Law Amendment Act of 1997, centralised control of the social pension scheme and delegated powers to provinces. Another investigation into the social security system in 1998 recommended the standardisation of application forms, together with information for applicants, a charter of rights for pensioners, upgrading of the data base used for pension payouts, training of staff, inspection and improvement of conditions at pay points and stricter control of private contractors (Department of Social Development, 2001b).

Despite the multiple commissions of inquiry and a multiplicity of recommendations, little has changed. As far back as 1979, non-governmental organisations (NGOs), like the Soweto Care for the Aged, complained of pensioners having to stay overnight at pay points. In 1992, the South African Council for the Aged (South AfricaCA) conducted a survey that highlighted several problems with the system and with the methods of delivery of pensions. In 2000, despite the public hearings of elder abuse commissioned by the Minister of Social Development, these problems still persist. Even beyond the Ministerial Commission Report, as recently as July 2001, payments have been delayed to almost 400 000 beneficiaries (Department of Social Development, 2001c) and a pensioner has been killed during a robbery at a pension pay point (Department of Social Development, 2001d).

The problems associated with the social security system as highlighted by older persons at the public hearings, concur with the findings of studies on intergenerational relationships (Joubert *et al.,* 2001b); the International Year of Older Persons Study (IYOP Study: Joubert *et al.,*

1998; Joubert *et al.,* 2001b); the study on elder abuse on the Cape Flats (Keikalame *and Ferreira,* 2000); and as reported by victims of abuse via the Halt Elder Abuse Line (Bryan, 2001).

A quantitative study on pension expenditure refutes the qualitative claims above, that large amounts of pension income are spent on children and grandchildren; that large amounts of money are spent on repayment of cash loans; and that much of the pension money is lost by robbery (van Vuuren and Groenewald, 2000). While these are positive findings for older persons, they have to be interpreted with caution, for

Box 2.3

Issues encountered by older people in dealing with the Social Security system

- pensioners have to queue at specified pay points with little or no access to food, water, shelter or sanitation facilities; furthermore transportation to pay points is unaffordable or non-existent; in some cases, the frail elderly are carried on someone else's back or in a wheelbarrow to a pension pay point;
- security risks are significant because of persistent cash payments;
- pensioners continue to sleep overnight at pension pay points to shorten their wait in the queue;
- pensioners are greeted with the humiliating attitudes and insulting treatment by pension staff;
- several grants including Child Support Grants and Disability Grants are issued on the same day as the pension payout, leading to chaos at the pay point;
- moneylenders, hawkers, liquor vendors and burial societies abound at payout points to lure pensioners into spending their money;
- pension payments are sometimes stopped without warning or explanation and, upon restoration, arrears are not paid;
- pensioners lacked information on how to re-register themselves during the national re-registration process;
- many pensioners were not in possession of an identity document required to draw a pension; the process of acquiring an identity book is a long, drawn out one, with further systemic abuse commonly encountered at the Home Affairs offices;
- help desks, which are supposed to be present at all pay points, are non-existent;
- many pensioners are unable to read or write, and barely understand English, yet all communication at pay points is in English;
- hospitalised pensioners are forced to be physically present at pay points to receive payment of pensions, otherwise payment is not made.

poverty, one of the reasons for pension sharing in South Africa, has a strong spatial dimension. While this might be the case for the study area, national data is required to investigate and verify the phenomenon of pension sharing.

Language, literacy and lack of education

Literacy levels in South Africa vary with age, with 95 percent of those in the age group 25-29 able to read (Statistics South Africa, 2000). This figure decreased to 58 percent in the 65 years and over age category. In urban areas, 78 percent of those 65 years and over could read compared to only 38 percent in non-urban areas. Men and women overall have similar literacy levels up to the age of 35, but in the 65 and over age group, 62 percent of men and 55 percent of women respectively, are literate (Statistics South Africa, 2000). Under the Bantu Education Policy of the apartheid government, many Black children, currently the older persons of South Africa, lacked access to education because Black children were forced to leave school at a young age in order to work, because they had to care for younger siblings, lacked schooling facilities or access to schools.

During the needs assessment for the IYOP, older persons recognised education for the elderly as a need to assist them in securing part-time jobs in order to supplement their pensions (Jourbet *et al.,* 1998). Heslop and colleagues (Heslop *et al.,* 2000) also reported older persons' frustration with a lack of education as a major hindrance in gathering the documentation they required for a pension application. The South African constitution states that all citizens have the right to basic education including adult basic education. Under the Adult Basic Education Training Policy, the Education Department makes provision for adults, including older persons, to educate themselves. In addition, South AfricaCA, through its wide provincial network, provides opportunities for adult education at many of its centres.

South Africa has 11 official languages, English being one of them. Only nine percent of the population regards English as their home language (Central Statistics, 1997), yet English predominates as the official language medium, even where it is not spoken. This situation can be redressed by using the language most commonly spoken in the area, as currently practised by the education system. However, this will only become a reality when policy guidelines are set out for outsourced contractors, and the policy is actively enforced by government.

Language problems are also experienced at residential homes for older persons. While homes are supposed to be accessible to all South Africans, residents are still predominantly White. However, change has started to surface in the racial identity of nursing personnel, with over 50 percent being Black. Due to language differences between care givers and residents, several problems can be anticipated. Under these circumstances, holistic care that includes the needs of the patient as expressed by them cannot currently be taken into account when rendering care. Care is then limited to the apparent physical needs of the patient (Perold and Muller, 2000).

Improving the administrative and delivery systems

In order to eliminate fraud and corruption (e.g., 'dead' pensioners drawing a pension; cheques made out to 'ghost' pensioners; multiple grants to a single individual; and to validate beneficiary records), the Ministry of Social Development undertook the massive task of re-registering all beneficiaries. The amalgamation of 16 different systems proved to be an administrative nightmare with several thousands of beneficiaries lacking identity documents. The re-registration process unearthed several problems. Among these were the fact that pensioners considered they were not adequately informed of the process to be followed, and felt destitute without a source of income during the transitional period (Department of Social Development, 2001e). The successful completion of the re-registration process varies between provinces, with a 100 percent completion in the Free State, to 25 percent completion in the Northern Province (Department of Social Development, 2001f).

The Minister, in his ten-point plan for social development, recognised that the system of social grants is not working and does not provide a safety net to those in greatest need. He recognised the lack of uniform policies, the poor attitude of officials, the delay in processing applications, the failure to reimburse new applicants for the entire time period that their applications were being processed, and that the pension means test is unjust and difficult to administer. He highlighted the need for the creation of a comprehensive social security system that is monitored and evaluated to alleviate the high levels of fraud and corruption currently plaguing the system. The plan aims to make social services accessible and available to those living in rural, peri-urban and informal settlements and to ensure equity in the delivery of services (Department of Social Development, 2001a).

In his budget speech for the financial year 2001/2002 (Zkweyiya, 2001), the Minister paid particular attention to the plight of older persons. He stated that some of the injustices of the past would be corrected by old age pension grants accruing from the date of application and the assets means test no longer being applied. Following the findings of the Ministerial Commission on Elder Abuse, the Minister also highlighted plans to improve conditions at pay points by providing security, first aid, water and toilets.

The Minister added that pay points would also be fitted with help desks managed by staff fluent in the local language and with information on the local beneficiaries. He has also held discussions with private pension contractors to discuss standards of service delivery and penalties that would follow for inefficient service delivery. He also announced that the Department of Social Development was in the process of developing a uniform national norms and standards manual for the delivery of social grants. A committee of inquiry into a Comprehensive Social Security System was due to present its findings to the government by July 2001.

Social Welfare policies

The Aged Persons Act of 1968 provided for the establishment and maintenance of residential homes for the aged; the registration of residential homes; payment of subsidies to homes, clubs and service centres; inspection of homes; and with investigation of cases of abuse to be conducted by social workers. Residential homes were developed exclusively

Box 2.4

Problems arising from the Social Assistance Act and its enforcement

Some of the problems experienced by older persons, as expressed in various studies, can be traced back to deficiencies in the present Social Assistance Act or the lack of enforcement of the Act. These include:

- **the Act does not permit deductions from pensions, yet these continue to occur in some provinces, e.g. by outsourced contractors charging administration fees, and burial societies deducting payments directly from pensions. The study by van Vuuren and Groenewald (2000) showed a statistically significant difference between rural and urban dwellers in the amounts of pension income spent on burial services and cash loans. The authors assert that this pattern of expenditure is a result of agents exploiting**

uninformed Black and Coloured pensioners in rural areas, many of whom, because of their 'high-risk status', lack access to reputable financial institutions. With limited choices, these people then become vulnerable to exploitation and abuse. On the other hand, in another study, because of the receipt of state pensions, older women were viewed by local shop owners as creditworthy and were allowed to purchase household goods on account. In this way, they were able to meet the household requirements of their families. However, women in these studies earned their credit-worthiness by placing high priority on repayment of debts (Moller and Sotshongaye, 1996);

- the value of the pension is not inflation linked, resulting in devaluing of the pension. Older women have asserted that the purchasing power of the pension at R410 (US$51.25) in 1995, was equivalent to what it was some years earlier when the value of the pension was about R30 (US$3.75) (Moller and Sotshongaye, 1996). Many pensioners in this, as well as in other studies (Jourbet *et al*., 1998), considered that the pension was inadequate as it had to be used to meet their own needs, that of the family, both in the context of rising costs. Despite their request for an increase in the value of the pension, many older women were grateful to the government for affording them a source of income (Moller and Sotshongaye, 1996);

- the 'means test' used as a qualifier for the pension implies that a pension will be paid if income is less than R142 (US$17.75). With the current pension valued at R570 (US$71.25), this brings severe hardship to pensioners who cannot supplement their income beyond R142 (US$17.25). It also serves as a disincentive for older persons to engage in productive work and to declare their true income, as well as discouraging younger persons from saving towards their retirement;

- for those in possession of property exceeding R18,000 (US$2,250), the pension is out of reach. Yet again, the poverty trap emerges, for many older persons who own property have no other source of income. This results in many older persons gifting their shelter to relatives in order to have purchasing power for food in the form of a pension;

- the policy for payment of pensions to those in institutional care is fraught with problems; those in state-aided homes do not qualify for pensions while those in privately run residential homes do qualify;

- the outsourcing of contracts for payment of social security grants is without national guidelines to regulate the process;

- non-South Africa citizens lost their access to the pension despite the Act specifying that those registered for the pension prior to 1996 could still receive payment.

for older White people, with 600 homes and 400 housing complexes being built for 58,000 older White persons over a twenty-five year period (1968-1993). In contrast, only 11 homes were created for older Black persons, accommodating approximately 1,200 older people. While 15 billion Rand (US$1.9 billion) was spent on White elderly in this time period, a mere eight million (US$1 billion) was spent on Black elderly (Department of Social Development, 2001b). The result was an enriched sector financially dependent on government subsidies.

Welfare services for older persons had become weighted to the extent of being about 80 percent in support of residential care. A new policy on ageing was clearly long overdue. Even before 1994, the Departments of Health and Welfare tried to set up policies on ageing with a shift in focus from residential care to community care. However, each department failed to support the other's endeavour. A seminal document called the Management of Age, produced in 1995, aimed to shift the focus from residential to community care; to highlight the value of older persons; to develop policy in order to combat abuse of the elderly; and to bridge the persistent racial inequities in the care of the elderly.

Again, a policy with good intentions achieved mixed results in that it was not adopted as the *official* policy. It did achieve its objective of decreasing residential care by 40 percent. However, savings in residential care were not re-directed to community care as suggested in the original policy. The initial objective of community care has not materialised because of a lack of funding. Clubs and service centres that were in existence have progressively closed due to a cut in subsidies. Home care, one of the principles of the Welfare White Paper of 1997, failed to get off the ground due to a lack of funding.

Management and funding of residential homes

Racial disparities increased rather than decreased, contradicting the fourth objective of the policy in a number of ways. Subsidies are paid to homes on a monthly unit cost per resident. Subsequently homes in poorer areas could not access their full subsidy because they could not increase their unit cost. Housing schemes are still exclusively available to White elderly. This means that destitute and frail Black elderly are forced to seek residence in private homes or are left without accommodation. Due to the lower monthly unit cost of Black homes; a compromise has to be made in the number of staff who can be employed by

these homes. Black homes experience management and staffing problems because of lack of funding. Hence the quality of care that can be rendered to older persons is also compromised (Department of Social Development, 2001b).

The Aged Persons Amendment Act of 1998[4] aimed to improve upon the Act of 1968 by: stipulating conditions regarding the use of subsidies, monitoring compliance regarding conditions for registration of homes, enabling the establishment of management committees for homes, discussing accessibility to homes, requiring reporting of cases of abuse and the setting up of a national register on abuse of the elderly, facilitating investigation at residential homes to be conducted by designated bodies rather than social workers, as well as allowing for the issuing of warrants for the removal of older persons to places of safety in cases of abuse. The regulations to this Act were promulgated only in July 2000. The Department of Social Development is aware of the limitations of this Act, and that it is directed at residential care, whereas government is advocating community care. The Department is therefore engaging with various stakeholders to fast track the development of an Older Persons Act for South Africa (Mahlangu, 2001).

The decision was made that residential homes would now cater to just two percent of older persons, that is, Group III, the frail elderly, who require 24-hour care. Groups I and II would be catered to by community-based care in the form of service centres, clubs and home-care services. However, a study among a poor Coloured community in Namaqualand

Box 2.5

Ubuntu – *'people are people through people'*

The new Social Welfare Policy for older persons is located within the spirit of Ubuntu, which is an African philosophy meaning that 'people are people through people. It acknowledges the rights and responsibilities of every citizen in promoting individual and social well being' (Oakley, 1998). It calls for a reversion from a racially divided system of institutional care to family and community care. Ubuntu is in line with the United Nations' and WHO recommendation for the move away from state dependency to individual and family care. In order to scale down residential care, older persons living in residential homes were classified into three groups, namely: Group I, fit elderly; Group II, semi-fit elderly; and Group III, frail or dependent elderly.

highlighted the hardship endured by some residents classified in Groups I and II as a result of the change. Many older persons felt angry and frustrated because they had no family or friends to turn to, and faced homelessness once they had to leave the residential homes. In addition, the communities from which they came, although willing to assist, lacked the financial means to support them (Oakley, 1998). Again, a good plan of action in principle, lacked the interim measures to cater to the needs of those older persons most severely affected by the change. Older persons have been critical of government in failing to provide the resources and infrastructural development required to make the shift from institutional to community care (Heslop *et al.,* 2000).

Future provision for social and financial independence at older ages

Oakley (1998) has undertaken a critical appraisal of the fundamental principle of Ubuntu in social welfare policy. She asserts that in a society where Black, Coloured and Indian people, many unskilled and semi-skilled labourers, survived on a minimum wage for much of their lives, the expectation that they will be able to develop a nest egg for retirement is unrealistic. This reality is incongruent with the principle 'all persons have the responsibility to provide for social and financial independence in ageing'. Furthermore, the belief that the traditional value of care for the ill, elderly and disabled is a shared responsibility of the family, has possibly changed and perhaps needs re-visiting.

The impact of migration on the lives of Black people by way of their ability to reintegrate into communities and to maintain and rekindle familial relationships also needs consideration. The Minister of Social Development, in outlining the welfare priorities for the next five years, recognised the social crisis that South Africa is facing as a result of historical imbalances. He came face to face with this in his visit to the various provinces in South Africa, including those experiencing the greatest level of poverty.

The Minister acknowledged that even though the country's social policy views the family and community as the fundamental unit, in fact, families and communities are in a state of disintegration. He also acknowledged the need for welfare to 'open its eyes' and see the nature and extent of problems in families and communities that are fuelled by increasing levels of poverty and social inequality. The chief priority in

the ten-point plan is to rebuild family, community and social relations as a means of restoring the ethic of care and human development (Department of Social Development, 2001a). This is followed by the need to develop an integrated poverty eradication strategy to address poverty in both rural and urban areas.

The Department of Social Development reports that there are currently 474 homes for the aged, which receive 75 percent of the total budget allocation for care of the aged. In addition, there are seven state run homes. The Department maintains that private residential homes have a capacity of 42,952, but unofficial provincial data show that this capacity is limited to 27,000. It is proposed that the shortfall of 16,000 beds should be made up by affluent older persons living in private residential homes (Department of Social Development, 2001b).

Racial disparities in homes still exist. Most Black residents are social pensioners. This denies them access to White homes because they or their families cannot afford the additional fees. A study to assess the composition of old age homes in South Africa has shown that 83 percent of residents are still White older persons (Perold and Muller, 2000). In order to eliminate racial discrimination in access to residential homes, the Implementation of the Finance Policy for the Ministry of Social Development aims to ensure that support is provided only to those private welfare institutions where services are accessible and available to all (Skweyiya, 2001).

Prevailing poverty inhibits family support

The majority of older persons in South Africa live in private homes with their families. Caught in the grip of poverty, they endure the hardships of lack of basic services like water and sanitation. It is estimated that 13 percent of older persons live in homes with no toilet, and 25 percent lack access to any water (Department of Health, 1998). The IYOP study highlighted older persons' desire for adequate housing with electricity, water supply and sanitation. They felt that access to such amenities would facilitate their independence and break the cycle of forced labour that takes the form of unpaid household work and shouldering the responsibility for care of children (Jourbet *et al.,* 1998). In this study Black older people expressed the need for old age homes in the areas where they reside to care for the very sick and the frail.

The mushrooming of unregistered homes that provide care for the poor, abused and homeless elderly is a cause for concern. Conditions in these homes are often poor and cannot be regulated. The Department of Housing, despite its acknowledgement of the needs of older persons in the Housing White Paper of 1995, is yet to set aside funding for sheltering this group, believing it to be the task of welfare (Department of Social Development, 2001b). South AfricaCA, in partnership with local and international donors, has engaged in the development of Frail Care Centres for both abused and displaced older persons. However, this development is largely provincially based and needs a national plan of action to provide for older persons throughout the country.

The Department of Social Development is making a concerted effort, at both the policy and service delivery level, to provide for the needs of older persons. The Department of Social Development will be undertaking a comprehensive review of all social welfare legislation to assess its relevance and ability to meet the need of this sector of government (Skweyiya, 2001). In facing the challenge of providing for and protecting older persons, the Department currently has two documents available on its website for public comment. These are, the South African Policy on Ageing, and the South African Older Persons Act. Both are based on international plans for older persons including the United Nations Resolution 46/91, and the Vienna International Plan of Action for older persons.

The South African Policy on Ageing, 2000

The South African Policy on Ageing (2000) emphasizes the importance of family life in the African context and reverts to the 1995 Management of Ageing Paper. It speaks of an inclusive policy that sees residential care as part of community care with the support of the family. Service delivery should be achieved by multidisciplinary one-stop centres, where people with similar needs can be cared for. Sensitive services that respect the dignity and human rights of all persons are recommended. Government's financial responsibility should be shifted from curative to preventative care, with the key being intersectoral collaboration.

The report of the South African Policy on Ageing has also undertaken a much needed situation analysis that includes the demography of ageing; services that are required e.g., housing needs, health care needs; profile

of service providers and an assessment of staffing needs; cost and value of old age grants; private sector involvement; capacity-building needs; the impact of HIV/AIDS on older persons; and the prevalence of elder abuse. Such a comprehensive report will allow for the development of research-based interventions and will meet the real needs of the elderly.

A South African Declaration on the status of older persons is also provided in the Policy report. It rejects the chronologically based definition of ageing. Instead it focuses on the mental and physical capabilities of the individual. It acknowledges government's responsibility to develop policies on ageing with an integrated approach. A three-tiered model for integrated community based care and support services is also elaborated. Minimum standards of service delivery are outlined for the various levels of care provided to the elderly including residential care, community care and health and social services.

A standardized admission policy for residential care is also proposed. A comprehensive chapter on abuse of the elderly provides definitions on the types of abuse and a protocol to be followed in cases of abuse. The protocol also provides guidelines for the development of a much needed ombudsman system. A charter on the right of older persons living in residential care has been developed. The document concludes with a chapter on funding to provide for an integrated social welfare plan.

Elder abuse in South Africa

Abuse of the elderly, like child abuse or abuse of a spouse, has traditionally been a hidden subculture falling within the 'sanctity of the home' where few outsiders dare to venture. In South Africa, where violence and injury is one of the leading causes of death (Bradshaw 2000), domestic violence, including elder abuse, has come to the forefront. But elder abuse, although commonly perpetrated by family members, extends beyond the home. The Aged Persons Amendment Act of 1998[4] defines abuse as 'maltreatment of an aged person or any other infliction of physical, mental or financial power on an aged person, which adversely affects that person'.

Research on elder abuse in South Africa is an emerging discipline, and as such has several definitions of the concept and its components. The South Africa Policy on Ageing defines types of abuse in accordance with the definition of abuse in the Aged Persons Amendment Act of 1998.

These include: physical abuse; sexual abuse; psychological, emotional and verbal abuse; financial/economic abuse or exploitation; active/passive neglect or intentional neglect; violation of human rights, as well as witchcraft.

Attempting to trace the history of elder abuse in South Africa is not very informative or practicable, because of its hidden nature. The development of legislative interventions and their lack of implementation partly illustrates how the problem developed to the level experienced today. The Aged Persons Act of 1968 was developed, in principle, to regulate residential homes for 'White' older persons in order to protect them from exploitation. However, the fundamental principle became obscured in other detail and was rarely enforced. As in other areas concerning older persons, many efforts by NGOs and the mass media were made in the 1980s and 1990s to showcase elder abuse and the need for intervention. However, little change has taken place at grassroots level to improve the situation for older people.

In 1998, as part of the planning for the International Year of the Older Person (IYOP), South AfricaCA commissioned the Medical Research Council (MRC) to determine the knowledge, perception and needs of older persons in South Africa with reference to IYOP (Jourbet *et al*., 1998). Although not intending to investigate elder abuse, participants requested legal provision for education and protection against abuse of their pension by family members; for methods to counter abuse of women; to educate on human rights; to recognize the need for love, respect, support and care, especially by younger people; to provide safety against crime, security against abuse and protection against verbal abuse by the family. In defining what they hoped IYOP would achieve for them, the MRC again referred to the hope that older persons could be protected by law, that they could be made aware of their rights, and that the media could highlight abuse of the elderly.

The Department of Health, as part of its effort for IYOP, sent out a survey on elder abuse to service providers. All of the abuse types were mentioned except for sexual abuse. Financial abuse was the most prevalent type of abuse with over 90 percent of the cases of abuse perpetrated by family members (Africa Strategic Research Corporation, 1999). As a result of this study the Department of Health produced a National Strategy on Elder Abuse (Department of Health, 1999).

Box 2.6

Basis of the National Strategy on Elder Abuse

The strategy is based on the principles of equality for all; social justice and equity that make services accessible, affordable and acceptable to older persons; solidarity with and between people with disabilities; integration and participation of older persons in all aspects of community life, the right to dignity and security that is devoid of exploitation, abuse and discrimination. The strategy calls for an integrated approach, highlighting the roles that can be played by the Departments of Health, Justice, Safety and Security, and Welfare, and by NGOs, the religious sector and business, in preventing and managing abuse.

The varied forms of elder abuse

In 1997/1998, a study to explore Black older persons' perspectives on intergenerational relationships was conducted (Jourbet *et al.*, 2001a). Even though the focus of the study was not on elder abuse, the main findings highlighted that issue. Physical and financial abuse commonly go hand in hand. In this study, and that by Keikelame and colleague (Keikelame and Ferreira 2000), participants spoke of family members beating and even killing older persons for their pension money. In some cases older persons had to hide their precarious situation from outsiders because of the fear of beatings from their children. Besides entire households being dependent on the pensions of these older people, which constitutes financial abuse on its own, these older people were sometimes abused by their families because of their pension. Older persons reported losing control of their money when family members demanded that they hand it over. This was a source of great emotional stress for them.

Financial abuse also takes the form of children expecting older persons to care for grandchildren and perform housework without being paid (Jourbet *et al.*, 2001). Sometimes older persons were expected to pay for grandchildren's' food, shelter, clothing and school fees. Children also, in some cases, sequestrate their parent's property leaving older persons to live in squalid conditions (Keikelame and Ferreira 2000). Sometimes, because of the social pension mean test precluding pension payments to persons with a property valued at greater than R18,000 (US$2,250),

older persons are forced to turn over their properties to their children (Department of Social Development, 2001b).

Older people, because of their physical limitations, are also easy targets for assault and robbery, especially after receiving their pension money. These are often combined with rape of older women. In 1998, reported crimes against older persons (>50 years) for January to December 1998 numbered over 10,000 murders, 1,095 cases of rape, 11,255 cases of assault with grievous bodily harm, and 9,878 cases of common assault (Department of Social Development, 2001b). Older persons have called for increased protection in their communities because of the high crime rate. They even ask for protection from their own children who abuse them! (Jourbet *et al*., 2001a).

While the intergenerational study described various combinations of psychological, physical and financial abuse, what stood out was the level of verbal abuse and disrespect. The authors suggest that these two types of abuse should be classified outside the categories of neglect and psychological abuse (Jourbet *et al*., 2001a), a finding supported by other research (Keikelame and Ferreira, 2000). Where older persons are not beaten, they are often forgotten and disregarded as superfluous. They feel that the traditional values of respect for older persons are lost when younger generations disrespect their advice and words of wisdom (Jourbet *et al*., 2001a), and engage in activities like kissing or living away from home, which culturally is regarded as disrespectful. Closely linked to disrespect is verbal abuse. Younger generations insult and swear at older people and speak in a manner that is not culturally acceptable. Disrespect was also endured at pension pay points and at health care facilities where staff insulted and humiliated older people (Bryan *et al*., 2001).

In the study of elder abuse on the Cape Flats, sexual abuse of older persons was spontaneously mentioned and outnumbered all other types of abuse (Keikelame and Ferreira 2000). Incestuous cases of sexual abuse predominated, where sons raped their mothers. Surprisingly, however, older people did not classify forced incestuous sexual relationships as rape. This challenges the Western definitions of abuse, and calls for a better understanding of the influence of cultural beliefs on defining abuse within the social context.

Domestic violence between spouses is traditionally associated with younger generations. However abuse by spouses knows no age limits for it often continues into old age. It has been reported that both men and women are abused by their spouses. Cases of verbal abuse, sexual abuse and physical abuse by spouses were reported (Keikelame and Ferreira, 2000).

Several studies (Heslop *et al*., 2000; Jourbet *et al*., 1998, 2001a; Keikelame and Ferreira 2000) have elaborated cases of systemic abuse relating to the pension system and to the health care system. The attitude of staff and the dehumanising conditions at the respective locations were highlighted. Long waits, often without food, water or shelter tired older persons who were waiting. The public health system was criticised for being overloaded and understaffed leading to inadequate health care. Older persons expressed a complete lack of confidence in the public health care system because of the lack of respect displayed towards them (Heslop *et al*., 2000).

In fact, inadequate health care was viewed as one of the main reasons for older persons' sense of vulnerability. Infrastructural abuse is closely linked to the levels of poverty in the country and has a strong racial undertone. Besides inadequate water, sanitation, food and shelter at

Box 2.7

Elders' perception of reasons for abuse

The reasons proposed by older people for the level and extent of abuse perpetrated against them is strongly aligned to the transitional nature of South Africa society. Poverty, unemployment and the subsequent use of alcohol and drugs are viewed as root causes of abuse. The increasing westernisation of society, the loss of traditional values, and the breakdown of family structures that brings with it disrespect and disregard for older persons are also blamed for the increasing levels of abuse. In addition, both the lack of education and too much education are held responsible for the poor treatment of older persons. Government is also held accountable for being too liberal with young people, as in banning corporal punishment and failing to provide adequately for older persons (Jourbet *et al*., 2001a; Keikelame and Ferreira 2000). Older women in particular (Moller and Sotshongaye, 1996), felt that the burden for the care by them of large numbers of dependents could be alleviated if government increased job opportunities for the younger generations.

health care facilities and pension pay points, older persons complain of problems in their living conditions. They lack proper homes, sanitation, running water and electricity. Transport is also either unavailable or unaffordable.

The abuse resulting from the accusation of witchcraft is a unique case of abuse. This type of abuse often befalls older women who, because of their physical appearance (appearance of extensive wrinkles) physical limitations (walking slowly, dragging their legs) and sometimes mental incoherence (talks to herself, talks in a confused manner), are labelled as witches. Once suspected, these women are strongly stigmatised and ostracised by the community. They suffer psychological abuse in being socially isolated and verbally assaulted. Sometimes they suffer physical abuse and in several cases are set alight and killed for being witches (Keikelame *and Ferreira*, 2000; Department of Social Development, 2001b).

Developing contextually and culturally sensitive interventions

Elder abuse in South Africa requires contextual and culturally sensitive interventions at both policy and grassroots levels. It requires an integrated approach that can be implemented and that is sustainable. South Africa has some policies in place that can provide protection for older people, but it is not specific to them and is implemented within vertical programmes that, in most cases are unknown to older people. Until the intended Older Persons Act (which includes an integrated strategy for elder abuse) is enacted, and all of the stakeholders involved can come together and develop an implementable plan, older persons will remain vulnerable to all forms of abuse.

Following the Ministerial Committee's findings on the extent of abuse perpetrated against older persons, the Department of Social Development has engaged in developing provincially based training programmes. The Amendment Act, despite it limitations, does provide protection to older persons in cases of abuse. However, awareness of the strengths of the Act is lacking. Hence the Department of Social Development is developing a training programme for care givers to make them aware of the provisions of the Amendment Act so that they can take appropriate steps where necessary. In addition, from 1999, the Department of Social Development engaged in 'Operation Dignity' to restore the dignity of older persons, to promote intergenerational communication and to make older persons aware of their rights (Mahlangu, 2001).

Currently, the Domestic Violence Act of 1998 is applicable in cases of abuse of older persons. Protection orders can be issued for victims of abuse with or without their consent. The Act also provides protection from family members besides spouses, such as children, grandchildren or other family members. The definition of abuse in the Act is wide, taking into account physical, emotional, psychological, financial and other types of abuse that are encountered by older persons. Although this Act is a comprehensive one, few older persons are aware of the protection it affords them.

Even though the Domestic Violence Act of 1998 facilitates the removal of older persons from a situation of abuse, safe houses or interim housing for older persons who have been abused are few and far between. Some residential homes do allocate beds for these purposes and South AfricaCA in the Eastern Cape has made significant strides in this regard Department of Social Development, 2001b). However a more concerted effort is required by government, particularly from the Department of Housing and Social Development, to ensure the safety of victims of elder abuse.

The failure of the law previously to recognise customary marriages meant that husbands could subject older women to economic abuse by denying them access to matters concerning the estate. However the Recognition of the Customary Marriages Act, 1998,[5] gives them equal power to manage their joint estate. Women who live longer than men in South Africa were particularly hard hit in old age upon the loss of their husbands. Due to the failure of the South African succession law on estates to include Black South Africans, Black women were often left destitute when their husbands died because the estate was handed over to the first-born male, leaving the mother at the mercy of her son. However the amendment has brought the law into line with the principle of gender equality as stated in the constitution, and now provides protection to elderly Black women. Older women in South Africa, a large percentage of whom are illiterate and have lived a subservient life, are unlikely to be able to enforce their rights within a patriarchal society like that of South Africa. Older women need to be made aware of their rights and the necessary support mechanisms developed, to assist them in asserting their rights.

A network of professionals and volunteers, as part of the South AfricaCA infrastructure, has been established to manage referrals in the commu-

Box 2.8

Practical support... national access to a help line

As a result of research conducted by the Medical Research Council (MRC), the South African Council for the Aged established a telephonic help-line intervention, entitled the Halt Elder Abuse Line or HEAL Line (Bryan *et al*., 2001) to provide support to victims of abuse, to direct persons to available resources and ensure follow-up, to provide advice to the public and professionals in the field of ageing, and to collect and disseminate reliable data on elder abuse. South AfricaCA decided to make the line nationally available via a toll free number so that the line would be easily accessible to older persons and other citizens.

nity. During the period, March 1999 to March 2001, the line received 3402 calls of which 65 percent were to report cases of abuse. The remainder of the calls were from persons seeking information about elder abuse, how the line works and how to access services for older persons. In almost 50 percent of cases where abuse was reported, the victim was female. One-third of the reported victims of abuse was in the age groups 60-89 years of age. Over 60 percent of cases of abuse took place in private homes.

Physical, financial and systemic abuse with regards to the pension system, as well as emotional abuse, predominated. Financial abuse coupled with neglect; physical and emotional abuse or verbal abuse were common, reflective of the reliance of families on the pension of older persons in the context of severe poverty in South Africa. Institutional abuse was reported both by victims of abuse and by staff who felt helpless to change conditions. As a result of the high number of calls providing information, South AfricaCA, in cooperation with the provincial welfare departments, has set up training courses for professionals including police, social workers, doctors, nurses, lawyers, prosecutors, magistrates and local authority officials, to make them aware of the needs of older people and the challenges that they face. The uniqueness of the HEAL line is the ability it has to listen, counsel and follow up cases of abuse at grassroots level where change can be seen and felt in the lives of older persons. Attempts are being made to secure governmental funding for the project.

The Department of Social Development has recently added to its website 'Focus on Elder Abuse'. Focus on Elder Abuse, formally known as 'Concerned Friends of the Frail and Aged', was formed in 1992. It has engaged in various activities, including submissions to the Human Rights Commission regarding the needs of the elderly, a training seminar for professionals in the field of geriatric care, and actively involved the elderly in drafting of legislation (Department of Social Development, 2001g).

Family care and care giving

When the concept of care giving is broached, the vision of providing care for children, the disabled and frail older persons comes to mind; such has been the focus of research. Few have given attention to the care giving rendered by older persons for many generations. In South Africa, in fact, few attempts have been made to research care giving by older persons. A time use survey in South Africa (Lehola Pali, 2001) showed that while South Africans on average spend 103 minutes on care for persons in the household, older persons (60 years and older) spend 98 minutes on caring. They also spent 192 minutes per day on household chores compared to the national average of 162 minutes per day, and 144 minutes per day on community service compared to a national average of 121 minutes per day.

The older person as care giver

Studies in South Africa, not necessarily pertaining directly to care giving, have highlighted the role that older persons play in providing both financial and day-to-day care for grandchildren, children and sometimes entire families (Jourbet *et al*., 2001b; Keikelame and Ferreira 2000) both by choice and in some cases, forced. Older persons' caring roles are as diverse as: caring for grandchildren while parents seek work in urban areas; caring for the home and grandchildren while children work, thereby making their contribution to the household; and caring financially for the entire household via their pension, because of high rates of unemployment and almost endemic poverty.

The tasks performed included household assistance, personal care and hygiene, shopping and health care tasks. About 29 percent of older care givers performed this work without a break, affecting their health, social life and financial status. Almost two-thirds of older care givers had no choice in performing care giving tasks. Over half of the sample of care

Box 2.9

Who cares?... and in what circumstances?...

In a study on informal care giving in South Africa (Jourbet *et al*., 2001a), 28 percent of the sample of informal care givers were 55 years and older. In this older age group, females were primarily care givers (86 percent) with 41 percent of care givers having only primary school education or less. Care giving was often providing in trying circumstances with no running water (18 percent), no sanitation inside the home (28 percent), 30 percent without access to a telephone in the home and 19 percent without electricity. Furthermore, 26 percent of these older care givers had spent over 15 years providing care. In 64 percent of the cases, the average number of hours spent on care giving exceeded 20 hours of the day, up to 24-hour care.

givers did not receive any professional information or advice on care giving. Care giving was provided to a range of people including 35 percent to children or grandchildren, and 30 percent to partners or spouses. Despite the hardships experienced by these older care givers, 89 percent felt happy or very happy about the idea of caring, while 88 percent intended to provide care for the lifespan of the recipient of their care or themselves.

South Africa, it seems, has a tremendous resource in the form of older persons providing care for both young and old. Yet their own needs are barely catered for despite the White Paper for Social Welfare (1997) that points this out. In light of the HIV/AIDS epidemic in South Africa, with 4.7 million South Africans estimated to be HIV/AIDS positive (Department of Health, 2000a), care giving by older persons, particularly older women (for sick children and grandchildren, as well as HIV/AIDS orphans) needs serious consideration. The move towards community and home based care does not only have implications for the care of older persons but also for the care provided by older persons.

Creating awareness and enabling access to child support grants when older persons care for grandchildren, would be a step forward in relieving the financial burden placed on older persons. The Minister for Social Development has emphasized that 'child support grants must go to the care giver of the child, not necessarily the mother of the child. If the

grandmother is the person who looks after the child, then the child support grant should be given to the grandmother. This is what is provided for in our laws'.

Box 2.10

Grandmothers caring, in the context of poverty and disease...

Grandmothers, as the primary care givers, face multiple problems in the form of grieving for the loss of loved ones; coping with the rejection of family, friends and the community due to the stigma associated with the disease; providing care and support to grandchildren; and performing duties as the head of the household and trying to generate income (Ferreira, 2000). What is more, these combinations of events and responsibilities often occur within the malaise of poverty. In order to provide the medical and moral support that a stigmatized disease like HIV/AIDS demands, older persons need support from both welfare and health agencies to continue rendering this unpaid service. Again, the White Paper for Social Welfare (1997) pledges this support.

Caring and counselling in the context of HIV/AIDS

The HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 (Department of Health, 2000b) has a focus on youth because of the high HIV prevalence in this age group. It also regards treatment, care and support services in the form of community and home based care as a priority to care for the patients themselves. Even though the plan is to educate the sexually active population or the potentially sexually active population, care givers like grandparents, who are also sexually active, need education on how to prevent HIV infection and destigmatize the disease.

Besides providing protection to themselves, as a primary source of support to these younger people, grandparents are also a potential source of counsel for them and other older persons, especially in destimatizing HIV/AIDS in the community. South AfricaCA is currently fulfilling this role by providing training to older informal, unpaid care givers in dealing with HIV/AIDS-ill children and grandchildren, as well as caring for orphaned grandchildren. This is an accredited care-giving programme that runs over two weeks. In order to ensure successful follow up, South AfricaCA has appointed trainers in each province who can circulate and assist those who have gone through the training courses, in overcoming obstacles and applying their knowledge in care giving.

In addition, as a result of the MRC/South AfricaCA national study on the needs, experiences and circumstances of informal care givers, South AfricaCA is launching a National Carers Association with one of its goals being to prevent and detect the abuse of older persons while in these care-giving roles (Bryan, 2001). The Department of Health provides training on home based care, but these programmes are not specifically for older persons as care givers or as recipients of care although the programmes do encompass older persons in both categories (Mahlangu, 2001).

NGOs and community-based organisations also cater to homebound people with a meals on wheels service. This service is limited to urban areas and only reaches a limited number of older persons. South AfricaCA spearheaded the concept of lending depots to provide equipment for the care of the frail elderly. Currently there are 31 lending depots countrywide. The intention is to develop 30 more lending depots in the near future (Bryan, 2001).

Capacity development and training

In 1993/1994, the Centre for Gerontology, following a request from South AfricaCA, undertook a study to investigate the nature and extent of training on gerontology provided by both tertiary institutions and service providers. While some training was taking place, no institution offered a comprehensive programme on gerontology as a specialty. Gerontological issues were integrated into parts of programmes particularly in medicine, psychology and sociology. Nursing colleges included gerontological nursing as part of their curriculum. Several departments engaged in postgraduate research in ageing, but only to a limited extent. However, there was a dearth of staff qualified in the field of gerontology and the field was not considered a priority for the curriculum.

The training provided at the organisational level was diverse in the variety of programmes, the target groups, the settings, and duration of programmes. While the focus was chiefly on nursing care or basic care for older persons, a holistic approach encompassing their psychosocial needs was lacking. Training was mainly in the form of in-service programmes and the level of accreditation varied widely, without a set of norms and standards for accreditation across the institutions. Several organisations sent their staff for training in various aspects of geriatric care, although the number was still low.

While many organisations acknowledged the need for continuing education for their staff members, in some organisations this was impossible due to staff shortages. Several organisations did not see the need for staff to undergo training over and above their professional qualifications. Some organisations also offered courses for older persons themselves, including areas such as adult basic literacy, first aid, child care, physical exercise, correct use of medication and various health related issues, for example, foot care, ear care etc. Skills were also imparted to older persons in the form of needlework, knitting and painting among others. Many organisations requested information regarding the training of volunteers (Ferreira, 1995).

Paucity of professional practitioners in this specialised field

Care for the elderly is a specialised field. Currently eight social work schools in South Africa teach their students about the management of ageing and care for older people (Department of Social Development, 2001b). Even though, by law, social workers previously had to visit old age homes, severe understaffing made this a virtually impossible task. Social workers were assigned up to 100 homes and visits by health inspectors to homes took place once in 2-3 years. The Ministerial Report (Department of Social Development, 2001b) showed that social workers, because of their heavy caseload and the lack of statutory or legislative requirements, did not regard older persons as a priority. Social workers admitted not having the skills or expertise to manage the special needs of the elderly.

Among the medical practitioners in South Africa, there are currently nine registered Geriatrics Specialists. Training for Geriatricians is provided at three accredited medical schools, namely University of Bloemfontein, University of Cape Town, and Stellenbosch University. Several of the Medical Schools in South Africa house Geriatric Units, namely, University of Cape Town, University of Stellenbosch, University of the Free State, University of Witwatersrand and the Nelson Mandela Medical School situated in Durban. A diploma in geriatric care is currently being developed for medical doctors. All undergraduate medical students do receive training regarding geriatric care but this is very limited (Burns, 2001).

Understaffing of homes and lack of qualified personnel has severely compromised the standard of care given to older persons. A study to

assess the composition of old age homes in South Africa has shown that registered nurses comprise a very small proportion of the nursing personnel; this being the case despite the fact that the majority of residents were above the age of 85 and highly dependent (Perold and Muller, 2000). Following a needs assessment, the National Department of Health (NDOH), in collaboration with the University of Witwatersrand, has developed a course on gerontology for nurses. The course was initiated as a one-year certificate course in 1999, and has now been upgraded to a two-year distance learning diploma. The NDOH has subsidized several nurses to attend this course. NDOH is investigating the training of auxiliary nurses in the field of ageing (Munsamy, 2001). The University of South Africa offers a three-year diploma in Advanced Nursing Science that includes 20 modules on Gerontology. These modules can also be studied as part of a Bachelor of Arts Degree (Curationis) under the Community Health Module (Lourens, 2001).

In light of the low ratio of health professionals to patients and the burden of HIV/AIDS patients, the only way that older persons can remain in the community for as long as possible is if the capacity of volunteers is strengthened through formal training programmes. Even in residential care, designed for the frail elderly, evidence exists to show that lay workers with no formal nursing training make up a large proportion of the nursing workforce (Perold and Muller, 2000). A home care service, which is critical in the case of the frail elderly, is currently a skeleton service in South Africa. Again NGOs like South AfricaCA, are making attempts to train volunteers to deliver a quality home based care service.

South African Council for the Aged

Since 1956, the South AfricaCA has championed the cause of older persons through advocacy at governmental level, and meeting the needs of older persons at the grassroots level. In the absence of services for older persons in marginalised communities, through its People Empowerment Programmes it created over 400 organizations that are involved in service delivery. The uniqueness of this programme is that it actively engages older persons in serving their peers and their communities (Burns, 2001).

In order to meet the needs of older persons in South Africa, under its strategic plan South AfricaCA has redirected its efforts to: promote advocacy and lobby for recognition of the human rights of older people;

Box 2.11

Community-based care and the role of NGOs

With the move towards community-based care, community health workers (often volunteers) and NGOs will have a critical role to play in caring for older persons. South Africa's history is rich in the support of NGOs but many have struggled since 1994 to reorient their services from freedom fighters to service deliverers. The Department of Social Development is in the process of assisting NGOs in achieving this objective (Mahlangu, 2001). Much of the NGO sector, particularly in rendering care for the aged, relies on the help of volunteers. Equipping them with necessary knowledge and skills is essential to the delivery of an effective and efficient service.

conduct social research as a basis for service delivery; develop accredited learning and development programmes; and create economic empowerment opportunities for older persons (South African Council for the Aged, 2001). South AfricaCA is the major service delivery organisation for older people in South Africa, and has about 837 member organisations across South Africa. South AfricaCA is partly funded by the National Development Agency of the South African Government. It also receives subsidies for social-work posts from government (Bryan, 2001). South AfricaCA operates under financial constraints but through the good will of its members, both young and old, it has cared for and nurtured older persons through a variety of programmes already noted in this chapter. Several church-based organizations also run homes and provide a variety of services for older persons.

South AfricaCA has adopted a multifaceted programme for tackling the issue of elder abuse in South Africa, ranging from prevention and early detection to active intervention. It has created shelters for those older persons who have been abused, or who are destitute. It has also recognized the lack of experience of health professionals and allied professionals to deal with elder abuse. In response to this need, South AfricaCA (with the assistance of the University of South Africa) has enabled health professionals to attend an accredited training programme on Victim Empowerment that trains professionals in the understanding of elder abuse and how to respond in such cases.

South AfricaCA has also engaged in capacity-building activities for the young elderly to be trained by health professionals in order to raise awareness of the phenomenon of elder abuse within the community and to identify and report such cases, thereby acting as informal ombudsmen and women. In addition, these volunteers, working in partnership with the social workers, are part of the response network making HEAL referrals in the community. For 2001, South AfricaCA set as its goal the training of a thousand people on issues relating to Elder Abuse - a number already exceeded two-thirds of the way through the year (Bryan, 2001).

The Ministerial Report (Department of Social Development, 2000b) highlighted several cases of managerial problems at residential homes resulting in the abuse of older persons. South AfricaCA is helping to resolve this issue by providing training for management skills and creating awareness among managers of the requirements of the country's labour laws.

The Department of Education, in partnership with NDOH, is providing modules on basic care as part of the Adult Basic Education and Training initiative. Training is currently being facilitated by the St John Ambulance service (Munsamy, 2001).

As South African society is progressively sensitised regarding the needs of older people, business is starting to respond to these needs. Several companies have financially assisted the affiliates of South AfricaCA in the development of service centres and in sponsoring various events for older persons (South African Council for the Aged, 2001). In addition, a few chain stores designated particular days of the week as 'Senior Citizen Days' and provided discounts for older persons on those days. Such transport services as buses, trains and air travel have also provided special rates for older passengers. While these efforts must be lauded, these subsidies are not uniformly available across the country as they are not supported by any statutory requirements. Furthermore, the 50 percent of older persons living in rural areas (Statistics South Africa, 2000), often the poorest of the poor, do not have these services available to them.

The contribution of Non-Governmental Organizations (NGOs)

South Africa has adopted the United Nations Resolution 46/91, which has as one of its principles, access to community centres and recreational opportunities for older persons. But in practice, access by older

people to these facilities is uncertain and unevenly distributed across the country. The sheer neglect and disregard shown towards older persons in South Africa, has created a mass of people who are lonely, unloved and craving social interaction. In the IYOP study (Joubert *et al*., 1998), participants expressed a need for love, care and attention from their families. Older persons in fact place a high value on family relations, for where it does exist; it often provides them with a sense of security (Heslop *et al*., 2000).

The HelpAge study found that older persons valued the interdependence within their families. They could access social support, shelter, food and medical care via relationships with their family members. In return, they shared their pension with the family, some also engaging in productive work like farming, trading or craftwork, as well as investing significant amount of time caring for the home and children. Moller and Sotshongaye (1996) found that older women felt a sense of pride and purpose in life in being able to provide financial support for the household by way of their pension, even if it meant curtailing the meeting of their own needs and running up accounts. In fact they commonly endured personal hardship in order to meet the needs of the family, particularly that of grandchildren.

A need was also identified for community centres where older people could engage in recreational activities with their peers (Joubert *et al*., 1998). They felt that access to these centres would help them overcome loneliness and boredom; they could work together with other older persons on different projects; and they could engage in handwork or gardening, as well as sell their products as an additional source of income. In practice, community based organizations providing social and educational opportunities for older persons are well received by them (Heslop *et al*., 2000). Residential homes also lacked social or recreational activities. Many residents have minimal contact with family because of strict visiting policies.

Much of this type of care for older persons has been provided by NGOs. Clubs for the aged have increased from 320 in 1993 to 840 in 2000 (Department of Social Development, 2000b). South AfricaCA has numerous clubs, also known as luncheon clubs, throughout the country, providing meals, companionship, home care, income generation, socialisation and religious activities. Clubs are run by volunteers and pre-

dominate in poor communities. Currently 25 percent of clubs receive government funding (Department of Social Development, 2000b). In the spirit of active ageing, South AfricaCA's affiliates are teaching and encouraging physical activity amongst older persons through its 'Sangala' programmes (South African Council for the Aged, 2001). In addition, health promoters employed by the NDOH provide training to members of luncheon clubs on various issues including active ageing and healthy diets (Munsamy, 2001).

The Department of Social Development, in creating linkages with international organizations, is currently affiliated to the International Federation of Ageing (Mahlangu, 2001). From an international perspective, HelpAge International is currently working with 19 partners in Gauteng, 15 in the Northern Province and one in KwaZulu-Natal. They provide support to homes and day care centres for older persons. These homes cater to the frail elderly, as well as to those who are destitute and homeless. The day care centres provide older persons the opportunity to interact with their peers during the day, while returning to their families at night. HelpAge International also supports older persons in income generation projects by such measures as assisting them to establish fruit and vegetable gardens. The produce is shared with peers and some of it sold to generate an income. HelpAge International is also engaged in advocacy for the rights of older persons and providing assistance in the development of national strategies and legislation on ageing (HelpAge International, 2001).

Box 2.12

Prioritising an integrated research strategy for South Africa

Research on older persons is continuing. However it remains fragmented, lacks representative studies at the national scale and is concentrated in certain fields of ageing. Further, collaborative strategies are required in order to prioritise research efforts and to make results more accessible, preferably through some centralised agency, so that findings can be used effectively to inform policy and programme development. National studies are also required to investigate such issues as: accessibility and affordability of travel and housing; housing arrangements; the provision of basic utility services such as reticulation of water and electricity; the extent and nature of elder abuse; and to establish the view of older people on community care in the context of changing family structures.

Notes

1 During the Apartheid years, all South Africans were classified in accordance with the Population Registration Act of 1950 into 'racial groups', namely 'Black/African', 'Coloured', 'White' or 'Indian', and the provision of services was determined along these racially segregated lines. The disproportionate allocation of services to different racial groups led to inequities. Information is still collected according to these racial divisions. In no way do the authors subscribe to this classification.

2 The Constitution of the Republic of South Africa, 1996. Act 108 of 1996.

3 An exchange rate has been adopted of eight South African rand to one United States dollar (R8 = US$1).

4 Older Persons Amendment Act of 1998. No. 19514.

5 Recognition of Customary Marriages Act of 1998. No 19539.

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CHAPTER 3

VOICES OF THE OLDER POOR AND EXCLUDED IN SOUTH AFRICA

By Gladys Makondo, Tersia Moagi, Sheila Graupner and Elizabeth Smith

Background

While the majority of the needs of older people are similar to those of younger adults, their special needs and their vulnerability are rarely appreciated by the government or the bureaucracy at the grassroots level. For the purposes of this research, a small team of professionals embarked on a project which would enable them to listen to the concerns, the needs and the voices of older persons in South Africa, with the aim of understanding their concerns and explaining them to those who need to know.

The research had two main aims. The first aim was to identify the main problems and real issues being experienced by the older communities in South African society. The second aim was to identify official agencies and non-governmental organisations (NGOs) where the elderly can obtain needed assistance; for example, accessing free, or at least affordable, medical assistance in the form of eye-glasses, low-cost hearing aids, low-cost housing and the like.

The team, comprising two social workers and two nurses based in Gauteng Province, visited six of South Africa's nine provinces (namely, Northern Province, Kwa-Zulu Natal, Gauteng, Eastern Cape, North West and Mpumalanga) and interviewed people from a number of ethnic groups including Northern Sotho, Zulu, Xhosa, Asians, Coloured, White-Afrikaans, Tswana, Southern Sotho and Ndebele in their homes. The individual interviews were structured to create an opportunity for older people (who ranged from 63 to 88 years of age) to express their concerns, fears, needs and successes.

For the country overall, Blacks comprise over three-quarters of the total population with Whites numbering less than 11 percent, and Coloureds less than nine percent (**Table 3.1**). The proportions at ages 65 and over, however, are significantly different with Blacks (67.0 percent) and Coloureds (6.7 percent) comprising significantly smaller proportions of the older population, and Whites representing over 23 percent of all older persons.

According to the 1996 Census, some 430,000 older people suffer from some form of disability and require care and support. Home-based care is available in the main cities and in some adjacent parts of rural areas. By 1998/99, a total of 474 subsidised old age homes and 900 state owned old age homes existed in South Africa, providing a total of 42,953 beds. Maintenance of health standards in the homes is the responsibility of the Department of Health and Social Development. Strict procedures are followed when non-profit organisations apply for registration that makes them eligible for subsidies.

In practice, most older people of all races live in their own homes, but old age homes are a significant option for Whites, and some 39,000 have made that choice (**Table 3.1**). Although some Blacks and Indians also live in old age homes, this is not an option for the majority and, in any case, for most it is their cultural preference to stay in their own homes.

Compared with the other races, the living circumstances of older Blacks are very poor, as evidenced by types of rural and run down urban envi-

TABLE 3.1: Population Numbers and Proportions, and Old Age Home Residents, 1996

Race	Total Population		Population Aged 65 and Over		Older Persons Resident in Old Age Homes
	Numbers (thsds)	*Proportions %*	*Numbers (thsds)*	*Proportions %*	*Numbers*
Blacks	31,100	**76.7**	**1,300**	**67.0**	**1,500**
Whites	4,400	**10.9**	**455**	**23.5**	**39,000**
Coloureds	3,600	**8.9**	**129**	**6.7**	**3,600**
Indian	1,000	**2.6**	**39**	**2.0**	**500**
Total	40,600	**100.0**	**1,940**	**100.0**	**44,600**

SOURCE: : Census of Older Persons, 1996

ronment in which most of these older persons live. Generally, Whites live in areas which have all or most of the resources they require, whereas in the Black townships and in rural areas most people still have no access to basic needs like water, electricity, health services or welfare facilities.

The Collective Voices of Older People

People from all of the different cultures included in the study experienced similar problems and had the same fundamental needs and preoccupations. These ranged from the very specific needs of daily living to fearfulness that, for them, old age might equate with destitution and homelessness, and from the fear that their adult children might contract HIV/AIDS to becoming solely responsible for the well-being of their grandchildren. Their major attitudes and priorities are encapsulated in the observations and concerns that follow.

Priority needs

Widespread deficiencies in their lives, identified by many older people, included the need for such basic requirements as:

- **food/groceries**
- **money and/or a pension**
- **identity documents**
- **adequate health-care facilities**
- **access to a telephone**
- **water and/or electricity**
- **birth certificates**
- **adequate accommodation**
- **support in caring for a spouse**

Understanding HIV/AIDS

Many older people are uncertain of the symptoms of HIV/AIDS and although they do not understand how the disease is contracted, they know that it kills and (partly because they believe it affects only the young), they are fearful that their children will catch it. Some have heard others talking about HIV/AIDS, recognise it as a major problem with no apparent cure, and have concluded that it is a curse from their ancestors.

Box 3.1

The fears of people at older ages

Many older people are:

- worried that their children may resort to violence and delinquency because they cannot care for them
- scared of being killed and nobody knowing who they are because they have no identity documents
- worried about getting ill because there is nobody to care for them
- afraid of isolation and rejection
- fearful that their grandchildren will resort to burglary and theft, because they have no money to give to their children and their grandchildren
- afraid of contracting all kinds of diseases because of their unfavourable social and economic levels and living environment
- afraid of being thrown out and left to fend for themselves on the streets
- fearful of dying before their spouses so that there will be nobody else to care for them
- scared of a dark and bleak future
- afraid of death and dying
- worried about their retarded children, their unemployed children and their grandchildren
- afraid of walking for fear of falling because of their weak muscles
- fearful of criminals and rapists

Experience of violence and why it occurs

Many older people :

- have heard about violence, but consider themselves fortunate that it has not happened to them directly;
- consider that violence occurs because people are hungry and unemployed;
- blame the police who do not exert sufficient control;
- resent violence and crime as unfair, with people taking what does not belong to them and often going unpunished;
- consider that the government is not strict enough and that the death penalty should be reinstated;
- believe that during the Apartheid regime violence was under control and that their safety was assured.

Queuing for monthly pensions

Some older people:

- do not like the way pensions are paid out because it makes them vulnerable to crimes such as armed robbery and heists;
- walk long distances to the pension payout points;
- complain that there is no shelter when it rains or when it is too hot;
- sometimes even die at the payout centres due to chronic hunger or ill health;
- entitled to the pension but could not get it because they lack the requisite identity document;
- find standing in the queue for the whole day on an empty stomach is a major problem;
- have difficulty determining the day of the pension payout and go on the wrong day;
- have had threats to take their money at the paypoints, especially if their children have not accompanied them;
- are cheated by hawkers selling food or other goods at the paypoints;
- receive their pensions at the bank but, because they have previously borrowed cash loans, they end up with little or nothing after paying off their debts;
- contribute half of their money to the old age home where they live, so they receive the money there.

Feelings about family/household members

Anxiety among parents, especially women, because of:

- desertion by a spouse resulting in solo parenthood and rearing of children, causing bitterness and continuing uncertainty into older ages;
- unemployment of their children and the obstacle to equal opportunities resulting from nepotism;
- their responsibility for, and the stress of, caring for their mentally retarded children who are sometimes violent and physically endanger their elderly parents.

By contrast, some are happy because their children still visit them and the church also cares for them.

Box 3.2

Caring for grandchildren

Commonly, older people :

- care for six to eight children (ages ranged from six to eight years); nobody works, and they are responsible for the whole family
- buy and sell vegetables which are then sold by their grandchildren in order to augment their social pensions
- have children who went to school up to grade 7/9 , all are unemployed and they depend on the older people
- have grandchildren to care for because the parents whereabouts are unknown; they dump the children and disappear
- have to deal with, and care for, difficult family responsibilities, like retarded grandchildren
- live alone, but just a few fortunate older persons live with their children who care for them

Attitudes towards neighbours and community

Some older people had the perception that:

- they are disadvantaged compared with more well-to-do neighbours who help each other, in contrast to their own family problems of poor health and unemployment of children;
- because they are poor, nobody is concerned for them or gives them any attention; other people mostly just ignore them;
- people in their own neighbourhoods do not communicate with them, whereas, sometimes, complete strangers will do things to help;
- they never get out of the house and do not have much contact with other people; their main contact is with providers of health services, and the nurses in the clinics are caring people;
- some neighbours hate them because they perceive older people, especially women, as witches.

Nevertheless, some older persons are very positive about their neighbours because they do give them and their grandchildren food, or help them in some way, and their neighbours are very kind.

How older people feel about advancing old age

Among the older population:

- some feel very old and depressed because of the unrelenting poverty, the continuing battle just to survive, and sheer exhaustion in coping with their situation;
- others become depressed at the ailments, often increasingly serious, which accompany advancing age:
- cataracts, a lump in the breast, arthritis, diabetes, high blood pressure and many other degenerative conditions;
- these problems have a flow-on effect on general health, so that people are always feeling tired and sickly.

Box 3.3

Some good experiences

- women especially find that regular meetings at church are supportive and provide a major opportunity for socialising, and it is with their friends at the church that they find happiness
- some older people are successfully growing vegetables and selling them at the nearest market, and this augments their social pensions
- family celebrations, such as their children's and grandchildren's birthdays, provide social occasions and opportunities to invite friends
- for the more fortunate, being well cared for makes them feel good
- some older women still work in the community as midwives which gives them a sense of worth and recognition
- some older people who were orphaned as young children and had hard lives growing up in a neglectful environment are still finding great satisfaction in being married and having their own families even at older ages
- others, now widowed, live on the memories of the good times they and their families had when their spouses were still alive, and those memories are sustaining them still

Box 3.4

General concerns, issues....

- ***survival*** is a constant struggle for many, and inadequate supplies of food and other resources are a continuous source of concern
- ***utility costs***, especially for expensive electricity and rent bills, are a problem; some feel obliged to use candles which increase the risk of fire
- ***cooking and heating*** with coal stoves is often preferred by older people because it is cheaper than electricity in winter
- ***roles in leadership*** undertaken in the rural areas, where older people participate in conflict resolution and negotiations, have been eroded in the urban areas and this has left most older persons feeling confused and useless
- ***economic activity*** in rural areas is still possible for older people who engage in farming and other small-scale enterprises, as well as in family duties like baby sitting
- ***exclusion*** of many older people from active spheres of life - economical, social and political, can be most frustrating
- ***caring*** for others in the household, by contrast, enables people at their age to feel good and useful
- ***escalation of HIV/AIDS*** in communities is scary, because if they are not to be left destitute, older people must take on the task of caring for them
- ***diseases*** suffered at older ages are predominantly degenerative and chronic in nature (e.g., arthritis, impaired vision, mental disorders etc), and sufferers can seldom afford the multiple aids that would make life easier for them (walking sticks, eye-glasses, hearing aids and the like)
- ***incontinence and hypertension*** are also problems and their children are often impatient with sufferers, especially those who are bedridden
- ***accidents*** are a constant threat with advancing ages: older people often lose their balance and easily fall, slipping on rugs or carpets or wet surfaces
- ***a sense of helplessness*** can become pervasive among older people who, although they recognise that ageing is a biological process which cannot be stopped or reversed, would still prefer to be physically active and manually dexterous but are unable to undertake any physical labour
- ***social activities*** are immensely important and for most older people, according to their frame of reference, remaining socially active is the best antidote for avoiding brooding and mental depression
- ***isolation*** consequent on the loss of a spouse is commonly offset by involvement in luncheon clubs and service centres where older people meet friends in a social context
- ***old age homes*** are not favoured by most older people and many of those resident in these homes said that they had no choice but were forced to move into these homes

Box 3.4 *continued*

...and a success story

When conducting interviews at Mamelodi Old Age Home in Gauteng Province, the researchers discovered that a group of students from the Mamelodi Campus of Vista University volunteer every Saturday to assist with gardening, cooking, cleaning and reading books for the elderly residents... a success story in which young people in the community constructively acknowledge the existence and presence of older people.

Types of opportunities sought by older people

Older people often have clear and positive ideas of how they wish to be involved and how this will help them to cope with the particular circumstance of their lives. Such opportunities include:

- involvement of older persons in decision making processes that affect them socially, economically and politically
- engagement of older people in poverty alleviation projects allow them to make a positive contribution and feel recognised and accepted
- residing in rural areas which is still the preference of many older people because they favour self-sufficiency from subsistence farming, and this enables them to maintain and even enhance their skills
- access for older persons to bank loans for small and medium enterprises that, together with lower repayment requirements, could benefit many people still working on their farms
- engaging older persons in policy formulation relating to issues on health, pensions, agriculture and other basic matters of concern to them
- providing advice to the many older persons who still believe in the efficacy of traditional medicines, while others resort to these treatments because of lack of money, and because it is a part of their culture
- the multidisciplinary efforts of various professionals in building alliances between older people and the state, welfare organisations, NGOs, CBOs, youth organisations, the church and similar organisations
- provision for the training needs of older persons, since, if they are capable of looking after children, they are almost certainly trainable in other areas as well
- the empowerment of older persons in order to preserve family structures (which have often been eroded by urbanization and migration), through community groups, luncheon clubs, religious groups, and the like

In the course of collecting the research data for this study, detailed individual information was recorded for a large number of individuals interviewed by the research team. While general findings have already been discussed under a series of thematic headings, much of the value of this information is to be found in the integrated detail of the lives of individuals. The particular circumstances of their experience through the life course is unique and is most effectively viewed holistically if the real significance of their experiences is to be understood and appreciated by others.

Consequently, the remainder of this chapter is devoted to case studies that are reflective of the many stories related to the researchers in the course of their interviews with their respondents. For reasons of privacy, full names and detailed addresses have been omitted.

The individual voices of older people

Name: Baba
Age: 84
Sex: Male
Location: Phagameng Township
Northern Province

Baba was originally from Thabazimbi in the North West Province. He is a divorcee and is presently staying with relatives.

Daily routine

He is helping people as a gardener to generate more income. He also repairs shoes part-time. He does not belong to a luncheon club or service centre.

What the respondent sees as his priority needs

Owning his own property and getting someone to do his washing.

What are his fears?

Baba cited crime against pensioners, and fear of being thrown out by his relatives.

His understanding of HIV/AIDS

He does not know about HIV/AIDS. He has only heard people talk about it and that some believe that *sangomas* can cure HIV/AIDS. According to him, HIV/AIDS resulted from people not respecting their ancestors.

His experience of violence and why it occurs

He has not been directly affected by violence but knows of elderly people who have been robbed of their pensions in town. He says that the police in Nylstroom are always on the alert and he trusts their expertise.

Name: Mabel
Age: 77
Sex: Female
Location: Phagameng Township
Nylstroom, Northern Province

Mabel is divorced and presently staying with her unemployed son. Her other children are married and staying in Gauteng Province.

Daily routine

She is an active member of the pension payout committee. She also belongs to the Dutch Reform Church and participates in their weekly activities such as prayer meetings.

What the respondent sees as her priority needs

Paying rent, buying food and paying for medical bills. She is not receiving any financial assistance from her children.

What are her fears?

Mabel cited three main fears: being raped by her own son who is taking drugs (dagga); crime against pensioners (extortion of their money); and losing her home because she cannot afford the rent.

Her understanding of HIV/AIDS

She knows about HIV/AIDS, and she watches an awareness programme on television. She knows about children of friends who are infected and some who have died. She is scared of AIDS although she has not come into direct contact with it.

Her experience of violence and why it occurs

Her place of abode (Nylstroom) is peaceful, except that many young people are engaged in the abuse of alcohol. Her own son has been arrested more than once for being involved in a street fight.

Name: Mmasetshaba
Age: 75
Sex: Female
Location: Old Age Home
Mamelodi, EastGauteng

Mmasetshaba is presently staying at an Old Age Home, in Pretoria, Gauteng Province. She has five children. Her husband passed away 10 years ago. She was evicted from her house because she could not afford to pay the rent. Her children are staying in informal settlement houses. Only one of them is employed.

Daily routine

She is a paying member of the old age home. She is contributing half of her pension towards food, medication, accommodation and a funeral plan. At the home there are volunteers who involve the old people in activities such as singing and physical exercises. They have a full time nurse and a (volunteer) doctor in the home.

What the respondent sees as her priority needs

Getting her house back; a relative saved it from being completely irrecoverable by renting it from the City Council. Having her sons learn to be responsible and assist her. Nobody is visiting her and she feels rejected.

What are her fears?

Crime against pensioners and fear of being raped.

Her understanding of HIV/AIDS

She does not know about HIV/AIDS, nor its mode of transmission. She sometimes hears people talk about it, but she believes that because younger generations no longer observe cultural rituals, the ancestors are punishing them. She blames disrespect of ancestors as a cause of all their curses.

Her experience of violence and why it occurs

People are selfish. They want to own everything themselves. She is aware of car theft and of house breaking in Mamelodi. It did not affect her directly but she knows of people who were affected. She also blames the police for their involvement in and tolerance of crime. Criminals are not arrested, but are given bail or discharged and still continue to put people's lives in danger.

Name: Mantombi
Age: 89
Sex: Female
Location: Madadeni Township
Kwazulu-Natal

Mantombi is presently staying with her two grand children. One, the boy, has just finished his matriculation examinations. The other one, the girl, is in Standard 5. Their parents are in Johannesburg. Her husband passed away some years ago. She has seven children of her own. Two are married and others are staying in Johannesburg.

Daily routine

Mantombi is a member of the local Day Care Centre managed by Chiliza from the nearby community. She said that belonging to the Day Care Centre makes her feel accepted. She contributes R5 per month to the Centre. Activities carried out at the Centre include craftwork and gardening projects, but organisation of these activities is still in its infancy. There are more women than men at the Centre. Gender still influences roles at older age. For example, Mantombi mentioned that older women are the pillars and breadwinners in their households providing assistance for their children and grandchildren, and sometimes even financial assistance to older men.

What the respondent sees as her priority needs

Addressing the poverty people experience in their own households. Poverty and lack of jobs emerged as the most serious threats in the area. More jobs for their adult children would then enable them to take care of their own children. She uses her money for household survival such as buying food, paying for water and electricity, and when possible, giving her grandchildren pocket money when they go to school.

What are her fears?

AIDS and more deaths among the youth; abuse of alcohol by young people leading to violence; crime against pensioners, in particular, extortion of their money; sexual assault of older people.

Her understanding of HIV/AIDS

She has a fair understanding of the disease and its mode of transmission. She said that she has seen people dying of HIV/AIDS in the local, Madadeni, hospital. She admitted that she lacks knowledge about caring for HIV/AIDS infected individuals. She noted that HIV/AIDS is still a taboo subject, and if people have relatives who died of HIV/AIDS, they prefer not to talk about it. She further said that if one admits that a relative has died of HIV/AIDS, people may conclude that you are also HIV positive.

Her experience of violence and why it occurs

She cited lack of tolerance among various population groups and political parties. Mantombi said that she had worked in Johannesburg in the 1970s, but had to leave that job to move to a more peaceful area where she could raise her seven children. She said she stills owns a house in Nancefield, a suburb of Johannesburg, but does not plan to return there.

Queuing for the monthly pension payout

Mantombi said she experienced problems with slow processing because of inadequate computers which, at times, were not working at all; standing queuing for long hours for the pension; and walking long distances to the pension payout.

Her experience of caring for grandchildren

Seeing them without food, and without an opportunity to get a good education can be depressing, especially when one does not have enough money to pay for a tertiary education. Because she has a steady pension income, she is the breadwinner. She relies completely on her pension income to meet the expenses of caring for herself and the grandchildren in her charge. It is discouraging seeing your grandchildren leaving for school every morning without pocket money and the prescribed textbooks.

Feelings about family and household members

When asked how she could be helped, she cited creation of jobs for her unemployed children and grandchildren. If my children can get decent

jobs with regular income they will be able to care for their own children, and I can spend my pension money on myself and on fixing my house.

Feelings about neighbours

They are no help. People do not have money to give to others.

Feelings about being old

She says she feels old and does not have any energy anymore. My grandchildren have drained me, I scream at them all the time. Talking too much will make me sick, and I will eventually die.

Some good experiences

Sometimes my children get casual jobs. Then they are able to buy us clothes and they send money home so that I can buy more adequate food.

Name: Johanna
Age: 64
Sex: Female
Location: Pietersburg
Northern Province

What the respondent sees as her priority needs

Johanna has no food in the house. Her telephone has been cut off because she could not pay the bill. She also has no water or electricity as she cannot afford them.

What are her fears?

She is worried about her children and that they will resort to violence and delinquency because she cannot care for them adequately.

Her understanding of HIV/AIDS

Johanna has heard about HIV/AIDS, but she does not know what the symptoms are and she does not understand how it affects people. She is scared that her daughters will contract the disease.

Her experience of violence and why it occurs

She sees violence, but fortunately nothing of this kind has happened to

her or her family. She is very scared that something will happen to them because it is a topic of conversation everyday. She believes crime and violence happen because people are hungry and unemployed.

Queuing for the monthly pension payout

Johanna does not like the way pensions are distributed. People waiting for their money are always scared of being robbed. She walks for more than one hour to the payout station. Then she waits there until afternoon when the payment is made. There is no shelter and sometimes it rains or is extremely hot. People even die there sometimes - she has seen that happen twice.

Her experience of caring for grandchildren

Johanna cares for six children as well as herself: four are her children and two are grandchildren aged between nine and 26. The 26 year-old boy is in Grade 12. Nobody works. She sells vegetables to supplement her income and makes approximately R25 per day.

Feelings about family and household members

Her husband left her long ago - she cannot even remember when. She raised the children all by herself. She feels a lot of pain with regard to her children because she loves them and cannot bear to see them suffering.

Feelings about neighbours

She feels very sorry for her neighbours as they are all poor. They help each other whenever they can. However, there is also a lot of violence and crime.

Feelings about being old

Johanna says she feels very old. She is healthy except for colds and flu. However, she is constantly depressed because of the poverty.

Some good experiences

In the past they were farming and the crops were good. They lived well and she often thinks of the good times they had. Then the government took them away from the farm and resettled them in the homeland. There they could not farm anymore.

Name: Mogade
Age: 65
Sex: Female
Location: Bok Street
Northern Province

What the respondent sees as her priority needs

Mogade's priority need is an identity document. She cannot obtain an ID because she does not have a birth certificate. Her parents died when she was young and she grew up with family. She does not know how old she is, but according to her peer group she thinks she must be approximately 65 years old. Because she does not have an ID, she cannot get a state pension; all doors are closed to her. She has been to the Home Affairs Department numerous times, but she is also illiterate and they just say they cannot help her. She does not have a house - she lives in a shack.

What are her fears?

She is scared she will be killed and nobody will know who she is because she has no ID. She is discouraged, because she does not know how she will solve this problem.

Her understanding of HIV/AIDS

Mogade hears people talking about HIV/AIDS, but she does not know what kind of disease it is.

Her experience of violence and why it occurs

Fortunately nothing bad has happened to her or her family. She believes crime and violence take place because of hunger and poverty.

Queuing for the monthly pension payout

She cannot get a pension because of the ID. She sells vegetables. Sometimes she sells nothing, but on other days she makes R10.

Feelings about family and household members

Mogade has no husband. She has five children all of whom went to school but only up to Grade 3. The older children sometimes bring food, although all of them are unemployed, and therefore they commonly steal food. Three of them are living in the shack. She feels very depressed and her heart aches for her children.

Feelings about neighbours and the community
Because she is so poor, nobody pays her any attention - they just ignore her.

Feelings about being old
Mogade says she feels old and tired. She is healthy, but has to battle constantly to survive.

Some good experiences
Because she was an orphan and the family did not care for her very well, she cannot remember any good experiences. She had a good husband but he died young. When he was alive, life was much better.

Name: Cleopatra
Age: 88
Sex: Female
Location: Overport
Durban, Kwa-Zulu Natal

What the respondent sees as her priority needs
Foodstuffs.

What are her fears?
She is worried that she will get ill and there will be nobody to care for her.

Her understanding of HIV/AIDS
Cleopatra understood a good deal about HIV/AIDS. She had read a lot when she was still able to do so, but her eyesight is too bad now.

Her experience of violence and why it occurs
As an individual, thankfully, she has not had any experience of crime or violence. She believes that so much crime and violence is a reflection of a lack of control in society.

Queuing for the monthly pension payout
Cleopatra is in the fortunate position that her daughter collects her pension from the Post Office.

Her experience of caring for grandchildren

She does not care for any of her grandchildren as they live with their parents.

Feelings about family and household members

There are four adults living together in the house, all of them females. They are very happy and share everything.

Feelings about neighbours and the community

The neighbours and the community are just out to look after themselves and their own interests. There is no communication.

Feelings about being old

I feel old; I am sickly. Cleopatra had a lump in her breast recently, and must also go for cataract operations in both of her eyes.

Some good experiences

Every third Saturday there is a Women's Meeting at the Methodist Church, and on Sundays people from the Church pick her up for church services. She says she is very blessed.

Name: Nophumzile
Age: 68
Sex: Female
Location: Scenery Park, Wilsonia
East London, Eastern Cape

What the respondent sees as her priority needs

Nophumzile considers money as her greatest need – especially for accommodation. She is alone, and she feels she has no hope, no future. She receives only the state pension of R570 and has great difficulty surviving on it.

What are her fears?

She has no particular fears, and is just so happy that we are visiting her.

Her understanding of HIV/AIDS

HIV/AIDS is familiar to her – she has heard that it kills. Beyond that she does not really understand anything about it.

Her experience of violence and why it occurs

Fortunately nothing has happened to her yet, but her neighbours have had problems. She believes there is so much crime because people are living in poverty.

Queuing for the monthly pension payout

Standing for long periods in the queues is a major problem, and there is a lot of pushing and shoving. Sometimes when it is her turn, they tell her she must come back tomorrow. They commonly stand in the queue for the whole day. People sometimes threaten to take the pensioners' money.

Her experience of caring for grandchildren

Nophumzile has four children and eight grandchildren. She is caring for all of the grandchildren. She does not know where their parents are. They just dumped the children on her.

Feelings about family and household members

Nine people are living in the shack. She does not like being so crowded and feels very bad about the situation, but she cannot push the children out.

Feelings about neighbours

There are some people who will help when she has problems, but her actual neighbours do not take any notice of her.

Feelings about being old

She is old and feels there is no hope for her. Nophumzile is also suffering from arthritis.

Some good experiences

The church is where she finds happiness. The people at church help and support her.

Name: Lina
Age: 63
Sex: Female
Location: Scenery Park, Wilsonia
East London, Eastern Cape

What the respondent sees as her priority needs

Having work in order to ensure a steady income.

What are her fears?

Lina worries day and night about how she will cope, because she does not have enough money. The children resort to burglary and theft because she does not have any money to give them. She is also afraid of all the diseases she might contract because of the family's low socio-economic level.

Her understanding of HIV/AIDS

She is aware that it affects the young people and is a sexually transmitted disease. Young adults must use condoms. She is well aware that HIV/AIDS kills, and that everybody who contracts HIV/AIDS dies.

Her experience of violence and why it occurs

Lina has seen a great deal of crime and violence in East London. She was the victim of pick-pocketing, but fortunately the police helped her.

Queuing for the monthly pension payout

Having to stand in a queue is not a good experience and she gets very scared. The pensioners waiting for their money wait there the whole day. They get very hungry.

Her experience of caring for grandchildren

Lina has six children and three grandchildren. Two sons are living with her and two grandchildren, but they are all unemployed. There are five of them altogether living in the shack. She took a third grandchild to her cousin because she could not cope.

Feelings about family and household members

Lina feels very sorry about the way they are living.

Feelings about neighbours

The family has no problems with the neighbours. They all help each other when necessary.

Feelings about being old

She does feel old and her health is not good. She has a problem with her leg which was broken and did not heal properly.

Some good experiences

Lina has a garden where she grows vegetables for their own use, and that gives her considerable satisfaction. She is a Christian and she enjoys her involvement in the church.

Name: Sheila
Age: 68
Sex: Female
Location: Irene Caravan Park
Centurion, Gauteng

What the respondent sees as her priority needs

A roof over her head. She feels she has no dignity because she must always look to other people for help. Sheila also feels guilty about her situation which makes it very difficult for her to accept things from other people. She cannot even afford soap and other cleaning materials.

What are her fears?

Her greatest fear is that she might be thrown out on the street and finish up having to try and live there.

Her understanding of HIV/AIDS

Sheila understands what HIV/AIDS is about; it is the result of promiscuity.

Her experience of violence and why it occurs

The crime and violence is terrible. She was the victim of pick-pockets twice when they cut her handbag with a knife. She feels all this violence and crime is very unfair because people take what does not belong to them and in many cases they are not even punished. However, she feels safe here in the Park where she lives; she cannot lock anything, but she is not afraid.

Queuing for the monthly pension payout

Sheila receives R320 from the pension fund and this is paid directly into her bank account. She pays R600 per month for the stand.

Her experience of caring for grandchildren

Sheila has four children and eight grandchildren, but she lives alone. Only one of her daughters used to help her until she lost her job. Now she has contact with none of them; she thinks they feel guilty when they see how she suffers and therefore they ignore her. She is separated from her husband and feels rejected and discarded.

Feelings about family and household members

Sheila lives alone with her dog Peanut. He is her only friend and companion.

Feelings about neighbours and community

People in the caravan park help each other when there is a need, because most of them are in a similar situation.

Feelings about being old

Although she is not always well and her body is often tired, she is too busy surviving - there is no time to worry about being or feeling old.

Some good experiences

Sheila preserves vegetables and sells them at the market every second week. There are many people who reach out and care for her. She has been used to giving and it is now very difficult for her to accept help from other people.

Name: Marijke
Age: 75
Sex: Female
Location: Lyons Haven
Centurion, Gauteng

What the respondent sees as her priority needs

Marijke needs strength to care for her husband who is 83, disabled and very sickly. He has prostate cancer and has just been discharged from

hospital. He also has a lot of trouble with his lungs and is still on oxygen therapy. She is caretaker of the house and prays that she will always have a good relationship with everybody and be healthy enough to fulfil her duties. Money is always a problem because of all the medical expenses.

What are her fears?

She is afraid that she will die before her husband and that there will be nobody to care for him. She also does not know whether she will be able to cope financially. The future is dark, but she hopes for the best.

Her understanding of HIV/AIDS

She understands that it is a big problem and it is terrible that there is still no cure for it. Unfortunately there are thousands of ignorant young people who suffer the most..

Her experience of violence and why it occurs

Fortunately Marijke and her husband have not experienced any crime or violence themselves, but she believes that the government is not strict enough and cannot control the situation. In her view the death penalty should be re-instated. Her daughter was high-jacked a while ago and her briefcase stolen.

Queuing for the monthly pension payout

Marijke and her husband receive a state pension of R570 each which is deposited directly into their bank account.

Her experience of caring for grandchildren

The couple have seven children and 13 grandchildren who all live on their own.

Feelings about family and household members

They are 15 people living in the house. They are like one big family and help and support each other where they can. They really care for each other.

Feelings about neighbours and community

All the neighbours and people in the community are very kind and friendly.

Feelings about being old

Sometimes she feels old, but most of the time she does not.

Some good experiences

The children are very good to them and help where they can. She is involved in a lot of activities in the community and enjoys her involvement.

Name: Annelies
Age: 78
Sex: Female
Location: 360 Smuts Avenue, Kloofsig
Centurion, Gauteng

What the respondent sees as her priority needs

Annelies is very unwell and is mainly concerned about her health and medical support.

What are her fears?

She is afraid she will have another fall and become really ill or completely immobilised. If that happens she does not know what will happen to her three sons who live with her.

Her understanding of HIV/AIDS

Annelies has heard about HIV/AIDS but really does not know what it is.

Her experience of violence and why it occurs

She hears a lot about it and sees evidence of it, but has not had any personal experience yet. Once intruders nearly came into the house, but the neighbours phoned the police.

Queuing for the monthly pension payout

Annelies receives R700 from her late husband's pension which is deposited directly into her bank account. Two of her sons receive disability grants.

Her experience of caring for grandchildren

She has nine children, 21 grandchildren and three great grandchildren. Three sons who live with her are all disabled. The sons are middle aged.

Feelings about family and household members

There are four people living in the house and they have no relationship problems. The sons always try to help where they can.

Feelings about neighbours and community

Annelies never goes out and therefore she does not have much contact with other people. However the neighbours are very kind.

Feelings about being old

She says she sometimes feels old and tired. Her legs give her a lot of problems.

Some good experiences

Her children are good to her and help where they can, and when she is ill, they all come to see her.

Name: Betty
Age: 78
Sex: Female
Location: Agra Street, Laudium
Centurion, Gauteng

What the respondent sees as her priority needs

Betty's major need is for food and groceries. She receives a state pension of R570 but it is not enough for her basic needs.

What are her fears?

I cannot go anywhere because of my arthritis. I feel quite safe - there is nothing I fear.

Her understanding of HIV/AIDS

Betty knows that it is a dangerous disease, but she does not understand anything about it.

Her experience of violence and why it occurs

She sees violence on television. Her son, who lives next door to her has had two burglaries and they stole a lot of things.

Queuing for the monthly pension payout
The pension officer brings the pension to the house.

Her experience of caring for grandchildren
She has 10 children, 32 grandchildren and 45 great grandchildren. The grandchildren do not live with her but come and visit her.

Feelings about family and household members
Two sons live with her. They are very happy and do not have any problems with regard to relationships. One son is mentally retarded and the other son suffers from asthma.

Feelings about neighbours and community
Betty feels all right about them, but does not bother with them nor they with her.

Feelings about being old
Yes, she says she feels old, but it is nice because everyone respects you. However, she is not healthy because she has high blood pressure and arthritis. The nurse brings her tablets regularly.

Some good experiences
When her husband was alive they had good times. Her children are also good to her and help when they can. She is a Hindu and prays a lot and that gives her strength.

Name: Zainub
Age: 77
Sex: Female
Location: Agra Street West, Laudium
Centurion, Gauteng

What the respondent sees as her priority needs
Zainub's pension is not enough to survive. She is ill and therefore concerned about her health. She had a fall a long time ago, but despite having an operation on her knee she cannot walk. She is confined to a wheelchair.

What are her fears?
She is afraid of attempting to walk in case she falls again. She is also scared of burglars because, she says, 'today nobody is safe'.

Her understanding of HIV/AIDS
Zainub does not know anything about HIV/AIDS, nor does she understand how people contract it.

Her experience of violence and why it occurs
The neighbours had a burglary. She feels that when there was apartheid people were better off because nowadays you never know whether or not you are safe.

Queuing for the monthly pension payout
Zainub's son fetches it and brings it home to her.

Her experience of caring for grandchildren
She has three children, five grandchildren, and three great grandchildren. Some of them are good and visit her; others never come to see her.

Feelings about family and household members
Zainub lives with her daughter. They are very happy, and her daughter looks after her.

Feelings about neighbours and community
They are not bad; some will help, others will not.

Feelings about being old
Zaibun says she does not feel old; for her, it is just the problem of walking.

Some good experiences
She says she had a good husband; and appreciates the children who care for her.

Name: Margaret
Age: 79
Sex: Female
Location: Section TT, Soshanguve
35km north of Pretoria, Gauteng

Margaret is staying on her own in a very bad domain shack that burned down in the winter of 2000 while they were making fire in a tin can for some heat. Her only brother, 10 years older than her, died in the flames and now she is left alone without any other relatives. Her mobility is very limited indeed because of her history of suffering from polio, and she walks around on her knees.

Daily routine

Due to her disability she is completely tied to her home. In mid-2001, she joined the project for the aged that operates in her block. She has no pension or any other source of income because she lost it all in the fire. Before joining the projects she often went without food up to three days. Her neighbour that stays 500m from her, a lady aged 92, sends her food when she is well enough to cook, or when she has money. Margaret now receives a meal and water three times a week delivered to her house by the project's community nurse. Her hygiene is poor due to the lack of running water. A neighbour who lives a kilometre away from her wheels water to her once a week in a wheelbarrow, in which case the friend has had to walk three kilometres to obtain the water.

What are her fears?

Margaret is afraid that she may die of starvation. She also fears the risk of sexual assault.

Her understanding of HIV/AIDS

She has heard about HIV/AIDS and knows that it is also referred to as 'a slow-puncture disease'. Old people do not suffer from it because HIV/AIDS only began to occur when the new government came into office.

Her experience of violence and why it occurs

Margaret's brother that lived with her until the fire, was injured due to taxi violence, and was left a mentally disabled person that she had to look after. She had to leave the Western Cape where she was born and which was a very peaceful area. She moved to Soshanguve to look after

her brother. She considers violence and crime occur in the area because the young people do not have any jobs and they want to live like rich people.

Feelings about being old

Margaret says she does not feel old and would show the world what she could do if she just had an ID and a pension.

Some good experiences

Good experiences include belonging to the aged project, getting time to talk to other older people that have similar problems. 'While we are singing during the time when we are doing some needlework, it feels like my spirit is being lifted right out of my old body, and then I feel young!'

Name: Anna
Age: 88
Sex: Female
Location: Block P
Soshanguve, Gauteng

What the respondent sees as her priority needs

Counselling in order to achieve reconciliation between her granddaughters and herself.

What are her fears?

Anna is afraid of being abused by her grandchildren because her son stays in Steelpoort and her daughter in Soweto.

Her understanding of HIV/AIDS

She has heard about HIV/AIDS but does not know exactly what it means. The grandchildren (two girls) always talk about it and they say that condoms will cure it when you have sex.

Her experience of violence and why it occurs

There are so many people at home without jobs, and where do you think they get money from to buy food? They must steal to stay alive.

Queuing for the monthly pension payout

This is a bad experience for Anna. There are long queues that she must stand in even in the cold winter, without any hot tea or coffee. There are some people that you can pay R10 to be helped and moved up to the front.

Her experience of caring for grandchildren

The only care that she is given is to be robbed of her pension and assaulted by her grandchildren. There are times where they have parties and the only food available is beer.

Feelings about neighbours and community

The neighbours assist her when she runs and hides from her grandchildren.

Feelings about being old

She does not like being old because that is why she is being abused - because she cannot defend herself anymore.

Some good experiences

The A Re Tshwaraneng project gave counselling for her grandchildren and herself to try and establish a better relationship. They also contacted her son and he is coming to see her once a month now.

India

CHAPTER 4

MEETING THE NEEDS OF THE OLDER POOR AND EXCLUDED IN INDIA

By S. Siva Raju

Population ageing in India

Examination of the social and economic implications of population ageing and the related problems faced by older people in India has begun only since the 1960s. Participation in the World Assembly on Ageing in Vienna in 1982 led to serious thinking about population ageing and its effects on family, community and state. Since then there has been an increasing awareness of the need for the development and promotion of policies and programmes dealing with an ageing society.

An attempt is made in this chapter to critically examine the existing policies and programmes for meeting the particular needs of the older poor in India. This review focuses on the demographic, social, economic, psychological and health aspects of older people, and on the initiatives taken by both government agencies and non-governmental organizations (NGOs) in meeting their needs. The discussion also addresses the consequential issues that must be confronted and resolved if there is to be substantial improvement in the quality of life of older persons in India.

The population of India aged 60 and over, which numbered about 57 million in 1991 and about 77 million in 2000, is expected to reach about 141 million by 2020. As a proportion of the total population, this represents an increase from 5.1 percent in 1901, to an estimated 7.7 percent by 2001 (**Table 5.1**). In the 1990s, approximately 78 percent of the population aged 60 and over lived in rural areas. The decennial percentage growth in the older population for the intercensal period 1991-2001 is estimated to be 37.2 percent, or more than double the rate of increase in the total population as a whole.

TABLE 4.1: Population of India aged 60 and over, 1901-2016

	Numbers aged 60 and over (millions)			Proportions aged 60 and over (percent of total population)		
Year	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
1901	5.50	6.56	12.06	4.6	5.6	5.1
1911	6.18	6.99	13.17	4.8	5.7	5.2
1921	6.48	7.00	13.48	5.0	5.7	5.4
1931	6.94	7.27	14.21	4.9	5.4	5.1
1941	8.89	9.15	18.04	5.4	5.9	5.7
1951	9.67	9.94	19.61	5.2	5.7	5.4
1961	12.36	12.35	24.71	5.5	5.8	5.6
1971	16.87	15.83	32.70	5.9	6.0	6.0
1981	22.49	21.49	43.98	6.4	6.5	6.4
1991	29.36	27.32	56.68	6.8	6.8	6.8
2001[1]	38.22	37.71	75.93	7.6	7.9	7.7
2016[2]	55.60	57.36	112.96	8.6	9.3	8.9

1: Sharma and Xenos (1992). 2: Office of the Registrar General of India (1996).

SOURCE: : Office of the Registrar General of India, 1996

Wide variations in life expectancy at birth occur between states. Demographically disadvantaged states such as, Bihar, Madhya Pradesh and Orissa have the lowest life expectancy at birth, whereas states like Kerala, Maharashtra, Punjab, Tamil Nadu and Gujarat have higher life expectancy.

Changes in the traditional support base

The traditional norms and values of Indian society stress respect and provision of care for the elderly. Consequently, the older members of the family have normally been taken care of within the family itself. The family and social networks provided an appropriate environment in which the elderly spent their lives, engaging in religious activities, participating in the rearing of grandchildren, and following other pursuits. In this way, the institution of the family fulfilled the needs of the elderly in providing social, psychological and economic security.

In addition, the family took care of the physical welfare as well as the psychological well-being of the older family members, and in turn, the elderly contributed by dispensing their acquired wisdom and prudence, distributing their wealth and belongings, and maintaining family harmony. In this way the relationship has been one of symbiosis and reciprocity. Unfortunately, however, such a system of mutual support is becoming increasingly difficult to achieve in a modern, industrial society.

Because of demographic changes in society and changing family circumstances, it can no longer be assumed that the elderly in India live comfortably at home receiving care from family members. Government efforts, and policies generally, are directed at strengthening the family and developing support systems which help sustain family structure and enable continuation of traditional security for the aged. However, government and society are aware of the socio-economic pressures on this long-established but deteriorating, traditional institution and realize that positive steps are required to cater for the newly emerging needs of the growing numbers of the aged, especially the poor who lack adequate support from both family and community.

Needs of older people

The needs of older people in India are many and complex. Older persons become increasingly vulnerable, not only because of physical disabilities, but also due to social, economic, psychological and health related issues. The particular and special problems of old age are being aggravated by the unprecedented speed of socio-economic transformation

Box 4.1

Differing perspectives on allocation of resources...

In analyzing the resource allocations among different age groups, Gore (1993) took the view that in *developed* countries, population ageing is resulting in a substantial shift in emphasis that is producing a significant increase in the share of social programme resources being allocated to older groups. But in *developing* societies these transfers take place informally and may well be accompanied by high social and psychological costs in the form of intra-familial misunderstanding and strife. For a developing country like India, the rapid growth in the number of older population present issues, barely perceived as yet, that must be addressed if social and economic development is to proceed effectively.

that is leading to a number of changes in living conditions to which older people are adjusting in varying degrees. These problems range from absence of assured and adequate income to support themselves and their dependents, to ill health, absence of social security, loss of a social role and recognition, and the paucity of opportunities for creative use of free time (Siva Raju, 2000).

A comparative study of rural and urban elderly (Hussain, 1997) showed that persons from urban communities have more problems than people living in rural communities. Urban and rural aged mainly differ in education, occupation, household income and personal earnings. The majority of the urban aged are migrants from rural areas in their youth. This migration increases the proportion of the aged in urban areas. These migrants have a mix of rural and urban values which is likely to give rise to a conflict of values.

Economic conditions

Among the numerous problems of older people in Indian society, economic problems occupy the predominant position. The Indian reality is one of mass poverty, and the vast majority of families have incomes far below a level that would ensure a reasonable standard of living. The World Bank (2000) has estimated that 35 percent of the population in India is below the poverty line. The proportion of the population below the poverty line is larger in rural areas (36.7 percent) than in urban areas (30.5 percent). The Ministry of Social Justice and Empowerment (1999), in its statement on the National Policy for Older Persons, has adopted the figure of 33 percent of the total population living in poverty, and has concluded that one-third of the population in the 60 and over age group is also in that category.

As people survive longer to advanced ages of 75 years and over, they need more intensive and long-term care, which, in turn, is likely to increase financial stress within the family. This situation is exacerbated by the fact that nearly 90 percent of the total work force is employed in the unorganised sector (Irudaya Rajan, 2000). With advancing age, these people retire from gainful employment without any financial security like pensions or other post-retirement benefits.

About 40 percent of the elderly in both rural and urban areas are still economically active. Those who are not independent, rely economically on their children, especially on their son(s). Because of generally poor economic conditions, their children also experience difficulty in providing even the basic necessities of life to the elderly, as their limited income has to provide for their offspring as well. In the absence of any regular financial support, most people continue to work from sheer necessity, even at an advanced age. Many retirees opt for some employment, either full-time or part-time, in order to optimize their financial position. Many elderly in low-income groups spend their retirement benefits on the unfinished tasks involving their children such as education and marriage.

Social aspects

Looking after their elderly was particularly the traditional concern of adult children in the old agricultural societies. Unlike most Western countries, where the negative effects of modernisation and urbanisation on family structures tend to predominate, the preference in India is still in favour of promoting the family unit as the vehicle for performing many activities. But often the younger generation is largely undertaking the functions that the elderly used to perform, due largely to significant changes in education, economic mobility and contacts in urban areas.

A comparison of the positions of the retirees in the family before and after retirement shows that loss of status is brought about not by retirement per se, but in conjunction with other intra-familial and personality factors (Menachery, 1987). Similarly the degree of socio-economic

Box 4.2

Changes in the status and role of older people

Loss of the role of decision-maker is experienced especially by those who have surrendered their properties in favour of younger family members and who consequently no longer have control over the sources of income. This loss of status and decision-making opportunities has been suffered more by ageing women than by men (Nandal *et al.*, 1987). Although a majority of the younger generation view the elderly as a socio-economic burden, the mutual benefits, like care in times of sickness, advice on family matters, education, and all round development of the family are also recognised by some younger family members.

dependence has no direct implications for the perception of older persons of their status in the family and the respect enjoyed by them. In order to overcome the burden of mental worry and physical fatigue, all individuals, but especially older people, need some leisure time.

During their active working careers, people often do not think seriously of ways of using their leisure hours. But after retirement, due to shifting residence, changing professional status, a shrinking circle of friends, and the decline of physical and mental health, older people often experience problems of purposeful utilisation of leisure time. The various leisure time activities of the elderly are: reading newspapers, household activities, morning and evening walks, listening to the radio, sitting and gossiping with children or grandchildren, chatting with friends, talking with their spouse, kirtan and bhajans, inviting and entertaining friends at home, and even sleeping during the day. An increase in the duration of unutilised time during the post-retirement period is conspicuous in contrast to pre-retirement activity. Religiosity also seems to have a positive relationship with age.

Psychological aspects

As older people become aware of their reduced competencies, they begin to revise their ideas about themselves. They have to start coping with reduced income, change of status, loss of friends and spouse and eventually, their own waning physical health. Psychological changes accompany the passing of years, marked by slowness of thinking, impairment of memory, decrease in enthusiasm, an increasingly cautious approach to life, and alteration in sleep patterns. Social pressure and inadequate resources can create many dysfunctional elements in old age.

The incidence of mental illness among older people also tends to be much higher. The psychological problems encountered by people retiring from the formal sector tend to be much wider, and their impact on individuals is substantially different from that on those in the unorganised sectors. Declining health, reduced income and a sudden break with a particular kind of professional life results in a range of socio-psychological problems for the retired. The attitude of family members changes with a person's retirement and this attitudinal change is often reciprocated. Attitudes towards old age, declining status in the community, problems of isolation, loneliness and changing perspectives on life are among the most prominent elements, and these often result in socio-psychological frustration among the elderly (Mohanty, 1989).

Studies have found that non-institutionalised older people tend to be better adjusted than institutionalised and geriatric patients. Younger generations, as well as elderly themselves, view institutionalisation of the elderly unfavourably, partly due to the deep rooted tradition that it is the duty of the children and family to care for the elderly. Some of the factors found to influence the adjustment of the elderly (Mishra, 1987) include rigidity, opportunities for involvement, the nature and quality of husband-wife communication, marital satisfaction, attitudes to the future and to death, and the state of physical and mental health (Ramamurti and Jamuna, 1993).

Health conditions

Health problems and medical care are major concerns among a large majority of the elderly as they become more and more susceptible to chronic diseases, physical disabilities and mental incapacities. The majority refrain from seeking medical aid from public hospitals because of the many impediments to ready access including the lack of money. Some of the health problems of the elderly can be attributed to social values also. The idea that old age is an age of ailments and physical infirmities is deeply rooted in the Indian mind and much of the suffering and stress within curable limits are accepted as natural and inevitable by the elderly. Sick old people often feel that their end is so close that they need not bother themselves or others with their ailments. Also, it is not uncommon to hear of older persons who refuse to take proper treatment merely because they have never taken such treatment before.

The distribution of ageing phenomena through the population, both physical and mental, appear to depend on environmental and social factors such as diet, level of education, adjustment to family and professional life, and consumption of tobacco and alcohol. Males are commonly reported to have more ailments than females. Influences on both the perceived and actual health status of the elderly include factors such as educational status, economic status, age, marital status, perception of living status, addictions, perception of opportunities, anxieties and worries, type of health centre visited and whether or not a person is taking medication; all are found to be significant and to vary considerably by class and gender (Siva Raju, 1997).

The relationship between poverty and ill health is universally true. Many communicable diseases, especially debilitating diseases like fever and

Box 4.3

Access to medical facilities versus traditional preferences

Existing medical facilities in India are inadequate and their utilisation by the public is very limited. The problem is more acute in remote areas where the meagre facilities that are available, are not optimally utilized by the community (Siva Raju, 1991). Instead, people prefer to go to private practitioners of indigenous medicine who may not be qualified, but do live among them locally. Accessing proper medical treatment is often not practicable for the elderly for a variety of reasons including poverty, illiteracy, general backwardness, and adherence to superstitious beliefs for curing illnesses and diseases.

diarrhoea, take a heavy toll on the poor. In the case of both acute and chronic diseases the lower socio-economic groups fare very badly compared to those who are better off. The same trend is seen in the case of disabilities and handicaps too. In both instances, morbidity shows a recurrent pattern: whatever the illness, its prevalence increases with decline in socio-economic status (NSSO, 1998). Also poor people spend a larger proportion of their incomes on medical expenses than the rich. Since medicines and consultations are very expensive, sufferers take medication only until the symptoms disappear, and as a result most of the leading ailments become chronic in nature.

Elder abuse

Studies of elder abuse in India (Vijaya Kumar, 1991; Rao, 1995) indicate that more women than men complain of maltreatment in terms of both physical and verbal abuse. The most likely victim of elder abuse is a female of very advanced age, with no clear role, functionally impaired, lonely and living at home with someone, most commonly her adult child, spouse or other relatives. The prevalent patterns of elder abuse include psychological abuse in terms of verbal assaults, threats and fear of isolation; physical violence and financial exploitation. The health profile of the aged victims indicate that a person suffering from physical or mental impairment, and dependent on the care takers for most of his or her daily needs, is most likely to be the victim of elder abuse.

Older individuals suffering from depression, poor health or physical impairments were reported to be more at risk of being abused than those of similar age and normal health status. This suggests that a

dependent, elderly person with physical or mental impairment may be perceived as a burden by care givers, and the resulting stressful situation is likely to lead to the abuse and neglect of the aged person. Though a large sector of victims of elder abuse are less educated and have no income of their own, old people with high educational background and sufficient income are also found to be subject to abuse.

With regard to the identity of likely abusers, it was reported (Rao, 1995) that son and daughter-in-law together, daughter-in-law alone, and spouse were most commonly mentioned by the elderly respondents. Besides the dependent position of the older person as a risk factor, other issues such as perceived powerlessness, social isolation, drug or alcohol addiction, and anti-social behaviour of the abusers were also found to be related to elder abuse. Certain major and recurrent explanations of elder abuse in India include: a cycle of abuse or inter-generational transmission of violence; dependence because of impairments; intra-individual dynamics; stress; negative attitudes towards the elderly; and social isolation. Abuse is likely to occur as a result of the interplay of several of these factors.

The vulnerable older person

Older widows are one of the most vulnerable groups needing special attention. The 1991 Indian census data on marital status reveal that, among the older population, 64 percent of women are widowed compared with just 19 percent of men. Among the old-old (70 years of age and over), 80 percent of women are widows compared to the 27 percent of men who are widowers.

Women in general are increasingly neglected in their old age due to factors such as urbanisation, migration and changing family structure. The cumulative effects of a lifetime of nutritional deprivation, hazardous occupations, heavy work, continuous childbearing and low levels of self-esteem leaves them physically and mentally frail; while widowhood often leaves them destitute. Most of the problems affecting women after the age of 45 or 50 are chronic injuries and infections (particularly tuberculosis) that contribute to disabilities in later years, as do malnutrition, anaemia and loss of visual acuity. In addition, menopause leads to deterioration in the skeletal, cardiovascular, nervous, skin, urinary and gastrointestinal systems and can affect women's capacity to perform every day activities. Widowhood snatches away from a woman both eco-

nomic and social support. Changing sex ratios with advancing age and weakening family roles mean that the number of older women living alone increases markedly. Legal and customary practices also frequently prevent them from owning property.

Similarly, other vulnerable groups also deserve special care and attention. These groups include men and women who are disabled, frail older persons, those who are still obliged to try and work in the unorganised sector of employment like landless agricultural workers, small and marginal farmers, artisans in the informal sector, unskilled labourers on daily, casual or contract basis, migrant labourers, informal self-employed or wage workers in the urban sector, and domestic workers.

Government provisions for the care of older people

From time to time, social welfare policies and interventions by the government identify older people as a priority group. The major focus of governmental attention is in the areas of financial security, recognition of voluntary organisations, and the provision and promotion of measures to improve the quality of life of the older person.

Box 4.4

Welfare of the aged through voluntary assistance and grants-in-aid

The main thrust of the programmes for the elderly is through the non-institutional services, which are family and community based. Financial assistance is given to voluntary agencies not only to provide care but also to help raise the incomes of the elderly, involve them more closely in the activities of the community. During the eighth five-year plan, welfare measures for the elderly were made more specific and comprehensive. Consequently, in 1992, the Ministry of Welfare initiated a scheme called 'Welfare of the Aged', to encourage voluntary organisations through grant-in-aid assistance, to provide old age homes, day care centres, mobile medicare facilities and other non-institutional services for older persons aged 60 and above.

National policy for older persons

The Government of India announced a National Policy for Older Persons (NPOP) in January 1999. This policy aims to strengthen the legitimate place of older people in society and to help them to live the last phase of their lives with purpose, dignity and serenity, with the help of family, the

community, the state and the private sector (Government of India, 1999). The year 2000 was observed as the National Year of Older Persons by the Government of India. The Plan of Action 2000-2005, to operationalize the NPOP, was prepared by the Nodal Ministry, Ministry of Social Justice and Empowerment, and circulated to all of the Ministries, Departments and organisations concerned for implementation (Asha Das, 2001).

The NPOP states that all older persons below the poverty line will be beneficiaries under the Old Age Pension Scheme. In pursuance of the NPOP, AADHAR has been established under the Ministry of Social Justice and Empowerment to provide legal, medical and social assistance to old people across the country (NISD, 2001). Since its inception in December 1999, AADHAR has received 4,157 suggestions, complaints and grievances from individuals and organisations. AADHAR also identifies committed individuals and organisations across the country up to district level, as agents of the grassroots action programme. On this basis, over 8,000 NGOs and 516 district collectors and organisations have been selected to set up voluntary action groups at the local level to provide help for older people (Government of India, 2000).

Under the terms of the Integrated Programme for Older Persons, financial assistance of up to 90 percent of the project cost is paid to NGOs to

Box 4.5

Looking to the future: the OASIS programme initiative

The Ministry recognizes that poverty alleviation programmes directed at the aged alone cannot provide a solution to the income and social security problems of the elderly and has therefore initiated the National Project entitled OASIS (Old Age Social and Income Security). This strategy has been adopted as a result of the growing concern for social and income security at older ages. In particular, it aims to provide for the 330 million young workers in the unorganized sector (including farmers, shopkeepers, professionals, taxi-drivers, casual/contract labourers and the like) out of the total of 370 million workers in India. Under the provisions of this project, every young worker can build up enough savings during his/her working life to serve as a buffer against poverty in old age. It is hoped that regular savings at the rate of between Rs.3 to Rs.5 per day through the entire working life will suffice to sustain beneficiaries above the poverty line in their old age, provided the assets of the pension fund are invested wisely.

establish and maintain old age homes, day care centres, mobile medicare units. In addition they are expected to provide non-institutional services for the reinforcement and strengthening of the family, awareness generation on issues pertaining to older persons, promotion of the concept of lifelong preparation for old age, and the facilitation of productive ageing. The basic thrust of this programme in support of older people is particularly towards those who are infirm, destitute or widowed.

As a part of strengthening the partnership between the young and the old, a collaborative project with Nehru Yuvak Kendra Sangathan was launched, under which 100 new Day Care Centres for older persons have been established in different parts of the country. Under the scheme of Assistance to Panchayat Raj Institutions and Voluntary Organisations such as registered societies, a number of public trusts and charitable companies or registered self-help groups of older persons have been set up. Already 59 old age homes have been constructed in different parts of the country.

Voluntary organisations are being encouraged and assisted to organise such services as day care, multiservice citizens centres and outreach services. They also supply disability related aids and appliances, provide assistance to older persons in order to learn how to use them, short-stay services, and friendly home visits by social workers. Assistance is also given to voluntary organisations to enable them to support older couples or persons living on their own with a helpline and telephone assurance services, in maintaining contacts with friends, relatives and neighbours, and in escorting older persons to hospitals, shopping complexes and other places.

Older persons are being encouraged to form informal groups of their own in their neighbourhoods, in order to satisfy their needs for social interaction, recreation and other activities. The formation of senior citizens' forums is being encouraged among groups of neighbours and within villages.

The Department of Telecommunications gives priority for telephone connections to senior citizens aged 65 years and above. On the request of the Nodal Ministry, the Ministry of Health has issued instructions to all the state governments to make provision for separate queues for older persons in hospitals at every stage of processing. The chief justice

of India, on the request of this Nodal Ministry, has advised the chief justice of all high courts in the country to accord priority to cases involving older persons and ensure their expeditious clearance. Special income tax rebates and higher interest rates on their bank savings accounts are being provided to older persons as incentives providing economic security.

Retired central and state government employees and their dependents have now been permitted to avail themselves of health facilities through the Central Government Health Service Scheme (CGHS), Medical Reimbursement Scheme (MRS) and Railway Medical Scheme (RMS) following registration. Geriatric services and facilities are available in government hospitals located in the major cities. Furthermore, mobile medical wards under the control of medical colleges and regional government hospitals, are in operation and support geriatric wards.

The Ministry of Railways provides concessional travel rates for those aged 65 and over. One of the State Road Transport Corporation (Karnataka) gives a 50 percent travel concession to citizens aged 60 and over on city and suburban services during restricted hours. Health Insurance Schemes such as Bhavishya Arogya and Mediclaim are available for the elderly through the General Insurance Corporation of India. Retirement benefit schemes such as Jeevandhara, Jeevan Mitra, Jeevan Sandhya and Jeevan Akshay are accessible to employees through the Life Insurance Corporation of India, a provision that serves as supplementary income for older people.

A few states have extended welfare services in kind, such as providing a dhoti or sari to a destitute older person on every Independence Day (Tamil Nadu), aid of Rs.1,000 towards expenditure on the funeral ceremony of an old age pension beneficiary (Gujarat). A new scheme called 'Annapoorna' makes provision for all destitute older persons who are eligible for the NOAP scheme but who cannot get it due to numerical restrictions placed on each state. Under this scheme these destitute people are provided with 10kg of free food grains every month, but such is the demand that the programme is yet to catch up.

Evaluation studies carried out on the functioning of the programmes on the care of older persons (Soodan, 1982; Mahajan, 1987) have brought out some important findings. Several distortions have been observed in the implementation of the old age pension scheme right from the ini-

Box 4.6

Beneficiaries tend to be women... widows... without sons

The profile of the NOAP beneficiaries reveals (Nair, 1980; Mahajan, 1987) that most of the pensioners are women, commonly widows without sons but with very low economic status. Some of them are engaged in a variety of jobs, and a few of them are even begging and living on the pavement as the amount of the pension is quite inadequate. As the monthly pension is not adequate for basic daily living, the majority of the pensioners are reported to be receiving some kind of assistance in cash or in kind, regularly or intermittently, from their kin or their neighbours. Many of the beneficiaries opined that since they started receiving the pension their lives have been more comfortable and it has helped them in achieving a better adjustment with the family and the community, because they were no longer a burden on the limited resources of their families.

tial submission of an application to the receipt of the amount. Some of the major, identified distortions are: cumbersome procedures in submitting the application, inappropriate eligibility criteria; unusual delays in processing the application; and irregular payments. Administrative hurdles and procedural problems are also observed in implementation of the National Old Age Pension Scheme.

Voluntary organizations caring for older people

There is no denying the fact that, in the eyes of the majority, there is no substitute for family care as far as older people are concerned, but there are numerous situational constraints which compel some aged in India to seek alternative, institutional services. Problems like the absence of close relatives, migration of children from village to towns and even overseas in search of career opportunities, lack of proper living space for senior people in the household, and even bitter interpersonal relationships, may force the elderly to seek institutional care. These homes provide basic facilities including food, shelter, clothing, bed linen and medicare. Some of them also offer their residents such facilities as a reading room, indoor games, training in arts and crafts, and even remunerative work.

Day care centres assume relevance by attempting to cater to the psychosocial problems of the elderly. Such services can provide substantial cathartic value without disturbing the basic family structure. Often called an 'activity centre', 'hobby club' or 'golden-age centre', these cen-

tres are managed by voluntary organisations. Enrolling those who are 60 and over, these centres offer such services as reading rooms, indoor games, medical check ups, group outings, lectures and vocational activities.

Box 4.7

The HelpAge network

There are a number of smaller organisations working in various regions with assistance from the government and different larger organisations or donor agencies. HelpAge India, which was established in 1978, operates throughout the country with a network of centres in major cities. The organization encourages other regional and voluntary organizations to undertake projects and programmes for the elderly by providing financial backing. The organization's 95 mobile medical units are servicing lakhs of older persons residing in slums, resettlement colonies and adjoining rural areas, providing medicines, counselling and health care services free. Their 'Adopt a Granny' scheme is intended to provide rehabilitation at the doorstep for the aged women living under the poverty line. HelpAge India is accredited by the United Nations and is a founder member of HelpAge International.

In 1992, the Ministry of Welfare started a scheme called Welfare of the Aged. Under this scheme, financial assistance was provided to the voluntary organizations for running programmes like old age homes, day care centres and provision of mobile medicare services for older persons. Some voluntary organizations have set up multiservice centres. These include Action for Social Help Assistance (ASHA), Centre for the Welfare of the Aged, Cheru Resmi Centre, Geriatric Society of India, Family Welfare Agency and Dignity Foundation in Mumbai, and so on in different parts of India.

Age Care in India provides residential and institutional services for the aged 50 years of age and over, in the area of educational, recreational, social, cultural and spiritual services, arranging for medical check-ups, part time employment to supplement incomes, organizing tours, trips and pilgrimages, making available professional consultancy services for taxes, duties, property, pensions and other economic and financial requirements, and conducting research, seminars and conferences. In addition to Delhi, its activities are dispersed through some of the major states.

Bharat Pensioner's Samaj headquartered at New Delhi is an All India federation of pensioners' associations. It functions as a nodal point for pensioners supported by central and state governments and quasi-governmental organizations. It highlights the difficulties faced by pensioners and other senior citizens at various forums and strives to resolve the grievances of its members by negotiating with appropriate authorities. It holds periodic seminars and conferences to focus on the problems of pensioners and other elderly citizens. The Samaj helps the needy pensioners through a benevolent fund created with contributions from its well-to-do pensioner members. All pensioners are eligible to become members of these organisations.

CARITAS India, a member of CARITAS International, undertakes activities in the different states and union territories of India. It is the official national level organisation of the Catholic Bishops Conference of India, established for the education and enhancement of society at all levels. It aims to promote care for the sick, crippled, handicapped, destitute and the aged.

The Indian Association of Retired Persons headquartered in Mumbai is funded through membership fees, donations and grants-in-aid from the government, and undertakes a variety of programmes for the welfare of retired persons. The association organises regular talks and discussions with the authorities to convey the problems faced by retired persons in Indian society. Its membership is open to all retired persons and to those 60 years of age and over.

Age Care, a voluntary body, helps older people to lead a healthy and dignified post-retirement life. It has also been recognized by the United Nations and is listed in the UN Handbook of Organizations active in the field of Ageing. Agewell Foundation, an NGO based in Delhi, started a Helpline for older persons in 1999. Other noteworthy organizations working in varying fields related to ageing issues and carrying out their activities in different parts of the country include Anugraha (Delhi), Centre for Gerontological Studies (Trivendrum), CASP (Pune), Heritage (Hyderabad), CEWA (Chennai), and the Calcutta Metropolitan Gerontological Institute (Calcutta). These voluntary agencies, together with the NGOs, play a significant role in implementing government policies and in initiating their own programmes as envisaged by the NPOP.

Box 4.8

Issues and Challenges in Supporting the Older Poor in India

- the institution and functioning of the family as a support structure for older people is under severe pressure because of poverty, unemployment and changing attitudes; external support is needed to strengthen the family and provide supplementary income;
- older people are disadvantaged by stereotypes which largely discredit the poor older worker in the unorganized sector; measures are required to create opportunities, increase the competence of older workers and offset this negative image;
- occurrence of widowhood among women even before reaching older ages results in a seriously disadvantaged experience of old age;
- among the poor, lack of food is a major cause of poor health; priority for the elderly in these circumstances receiving nutritional supplements is highly desirable;
- the older poor are almost entirely deprived of health aids, medical check-ups and medication; these could be priorities for NGOs which can either provide or promote appropriate measures;
- the configuration, design and general physical environment in which older people live (housing, transport, work place, recreation) could be made more user friendly to achieve greater independent personal mobility, safety and convenience;
- systematic analytical studies on the needs of the elderly in India, both urban and rural, are required to add substance to the many preliminary and exploratory studies already made;
- the social neglect of the poor seriously exacerbates the particular needs of this group as they move into and through old age;
- given the shortage of trained personnel in many specialist fields, the training of professionals and para-professionals to organise and promote services and programmes for the elderly needs to be given high priority, especially in such areas such as family support, financial provisions, health care and community involvement;
- the specialised health needs of older people require greater attention through the expansion and integration of geriatric and gerontological training in the medical curricula; mainstreaming of geriatric services in the Primary Health Centres and geriatric rehabilitation in the Integrated Community Development programmes as an integral component of community-based services would ensure that the full range of support services is accessible to older people in the health system;
- mass and folk media in villages and rural areas provide a popular medium for relaying information on government programmes and policies for the well-being of older people; advocacy, orientation and training programmes add substance and complement capacity building in the public and private sectors;
- traditional values that recognize older people and the wisdom of the contribution they can make need greater support in order to prevent the alienation of poor older people from the family and the community;
- abuse of the elderly can be prevented by reducing social isolation and, where abuse occurs, by ensuring health and social workers are trained to provide the needed assistance;
- the poor elderly not only need cash support but also culturally sensitive services in the areas of housing, health and nutrition, transportation, employment and community participation;
- NGOs cannot function effectively without government agencies creating the requisite environment; partnerships can be optimal in providing explicitly for the needs of poor older people and involving them in a supportive capacity in the implementation of welfare policies.

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CHAPTER 5

VOICES OF THE OLDER POOR IN INDIA

By Mala Kapur Shankardass

'The least noticed of the destitute in India are the elderly. Millions of elderly in India are trapped in misery through a combination of low income and poor health... While there is a need to initiate poverty alleviation programmes designed to support the elderly, the gigantic dimensions of the problem defy an easy solution. A poverty alleviation programme, which aims to pay even a modest subsidy would require a staggering expenditure much beyond the capacity of the government.'

Maneka Gandhi, Minister of State for the Ministry of Social Justice and Empowerment, Government of India, February 1999.

Background

One of the many challenges facing India in the new millennium is meeting the needs of its rapidly expanding older population (those 60 years of age and over), estimated to be about 77 million in 2000 and about 141 million by 2020. Of these increasing numbers of older people more than half are considered to be on the verge of poverty, in poor health and living in unhygienic conditions.

Although social indicators of development have improved since the mid-1960s, reflecting morbidity and mortality declines and rising life expectancy at birth and older ages, the poverty situation of the country remains a serious concern. The National Sample Survey indicates only a marginal decline in the prevalence of poverty in the 1990s, despite the Indian government's emphasis on poverty reduction in national planning ever since the achievement of independence. High inflation rates, rapid increases in food prices, poor governance and infrastructure, lack

Box 5.1

National Policy for Older Persons

In 1999 the government of India announced a National Policy for Older Persons. The strategic areas of intervention and action identified in the policy include provisions for :

- financial security for older persons working in both the formal and informal sectors;
- preventive health care and improved nutrition to enable older persons to cope with their health and associated problems;
- housing and shelter suited to the life styles of older persons;
- the educational, training and information needs of older persons;
- priority of services to vulnerable groups such as the destitute, widows and disabled older persons;
- the establishment of a welfare fund for older persons;
- measures to protect the lives and property of older persons;
- appropriate concessions, rebates and discounts for older people;
- active participation of NGOs in the provision of services for older people;
- encouraging the formation of self-help groups among older persons;
- implementation of the concept of 'productive ageing';
- strengthening the family and reinforcing intergenerational relationships between older people and their children;
- the promotion of research and advocacy in the field of care for older people;
- the development of trained manpower for the care of older people in medical colleges and schools of social work;
- creative use of the media to promote concepts such as life-long preparation for old age, life-long learning and building a society for all ages;
- the establishment of a separate bureau for older persons in the Ministry;
- preparation of sectoral annual and five-year plans identifying issues concerning older people;
- a detailed review of the National Policy for Older Persons every three years;
- establishment of a National Council for Older Persons;
- establishment of a National Association of Older Persons;
- use of Social Justice Committees of the Village Panchayats for implementing the policy;
- use of experts in public administration to coordinate and monitor the implementation of the policy.

of human development and paucity of social services are some of the factors retarding poverty reduction and the provision for minimum needs (World Bank, 2000).

Older people in India constitute the fastest growing age group in the population and the second largest numbers of older persons in any country worldwide. The group is very heterogeneous in character but overall comprises one of the more vulnerable sectors of society. Yet, to date, there is no comprehensive estimate available in India assessing the prevalence of poverty among older persons. However, with the announcement of the National Policy for Older Persons in January 1999, the government drew attention to the concerns of this group of people (**Box 5.1**). The challenge is to raise the priority of poverty among older people in the social, economic and ethical debates of the country with a view to alleviating the dependent status of older persons (**Box 5.2**).

This dependency derives from the invisibility of older people's lives and the failure to include them explicitly in public and social policy. Lack of economic and other resources, including food, housing and medical care, leads to dependency, limiting the decision-making power of older persons and their ability to protect and enhance their own well being.

This chapter is based on interviews conducted over the last decade with older people across India. In particular, it features the narratives of 20 older poor respondents residing in both rural and urban areas, who were interviewed in September 2001. Excerpts from the interviews are cited to draw attention to the issues and experiences of growing old and the need for developmental action to empower the older poor with a life course perspective. Condensed summaries of selected interviews are presented in the second part of the chapter. The narratives are personalised accounts of individual experiences, but they serve to demonstrate the varied circumstances and vulnerability of the older poor throughout the country and in doing so, express the concerns of millions of older persons. Names of individuals have been changed, and the narratives are translated from Hindi.

Box 5.2

The vulnerability of older women

Older women are particularly disadvantaged because they face structural, social and economic inequalities throughout the course of their lives.

Social practices, often located within the family, and the social structures

Although the gender-related development index (GDI), which focuses on the inequalities between men and women has improved since 1970, the pace of progress has been slow and much remains to be done to ensure gender equality[1]. The concerns for older women are pertinent especially because of the feminisation of later years when, in most parts of the country, females outnumber males at advanced ages. Although this contrast is less marked in India than in many other countries, in 2000, women comprised about 52 percent of the population aged 60 years and over, and about 55 percent of those aged 80 and over.

The significance of these statistics is chiefly in the high levels of economic dependence[2] they imply. The National Sample Survey in the 52nd round of data collection during 1995-96 noted nearly 71 percent of women aged 60 and over in rural areas are economically dependent on others, and about 76 percent of those in urban areas. By comparison, over 31 percent of older men in rural areas are dependent and nearly 30 percent in urban areas. The vast majority of older persons, about 90 percent, are supported by their own kin, (spouse, children and grandchildren), although most of these (75 percentage points) are supported by children and grandchildren only. Understanding the nature and dependability of available support mechanisms is therefore very important. Ensuring their effectiveness across and between generations is essential if the quality of life (QOL) for older people is to be enhanced. This is particularly challenging since, if the WHO definition of QOL[3] is adopted, the outcomes must satisfy multifactorial, variable and relative criteria.

The issue of widowhood

The experience of widowhood in Indian society is generally associated with considerable deprivation and has many implications for the health and well being of older women. Widowhood is one of the leading factors associated with poverty, loneliness and isolation as a widow suffers much indignity, often losing her self-reliance and respect. The prevalence of widowhood in India is asserted to be the highest in the world for all age groups (Chen, 2000, 2).

There is considerable risk of widowhood for older women in India as there is a tradition of women marrying men five years older on average

and male mortality rates are generally higher than those of females after the younger reproductive ages. In addition, as the data from the Sample Registration System (SRS) indicates, female mortality at older ages has declined faster than male mortality at older ages in all states (Ramachandran et.al., 1997). Remarriage of widows, particularly at older ages, is uncommon.

The National Family Health Survey conducted in 1992-1993 indicates that widows comprise over 49 percent of the age group 60-69 years, and 73 percent for the age group 70-79. For those 80 years and over the proportion of widows is as high as 86 percent. An emerging concern is how to meet the needs of women widowed in later years, as well as those who were widowed younger in life. Rural-urban differences also need to be taken into account as national data reveal high proportions of aged widows, divorced and separated females throughout all states.[4]

The miserable life of widows at the hands of in-laws and society in general has been revealed by many studies. The urgency of their plight is apparent when families, despite traditionally close and revered relationships with the elderly, condemn older widows, 'the mothers', to beg for their food. The four narratives, 'voices of older widows', which follow, command serious thought and action in order to improve the condition of older widows and curtail familial ostracism. Attention of the government is required to plan strategies from a life course perspective in order to improve the status of older women in society. Only when the discrimination faced earlier in life in areas like property rights, education, employment, wages, career opportunities, health and social status is addressed and eliminated, will older women be able to enjoy a life of dignity and respect.

Voices of older widows

I was left by deceit by my three sons and their wives in this place two years ago when they brought me to offer prayers for my dead husband. I had no money to go back and no possessions to sell and support myself. My jewellery - two rings, a pair of ear-tops, a chain, all in gold, which I wore regularly, was taken away by my family with the request to appear as 'a widow' in performing the ritual rites. ...I wanted to die, but I started to beg. Sitting outside this temple, living on food doled out, I have managed to accumulate small savings from the alms thrown on this cloth in front

of me. I sleep in the shack close by... How can I go back? Where can I go? I am a burden to my family, a mouth to feed a body to maintain. My sons will realise their folly only when their children will ill-treat them...

There are many like me in this town. You see that row of beggars; they are all widows, with nobody to take care of them. Parents, brothers, sisters, children, no one from the family or society supports a widow... Look at, this old woman, Sujata, sitting next to me. Her family also disowned her. She refused to part with the jewellery she had in her possession. Her children ill-treated her after her husband's death. She came to this holy town from Gujarat thinking she would settle down in an ashram. She sold her jewellery, bringing all the money with her, breaking her ties with her family. Her money was stolen and she had nowhere to go. She tried to work as a domestic servant, but nobody gave her employment on the basis of which she could settle herself. She found this corner to spend her last days. She has been here for the last 10 years or so. She cannot see, she is blind. She has no money to treat herself for her eye ailments. She taught me how to beg. She is the only companion I have....

After seeing her visual disability, I am saving my meagre earnings to take care of any such calamity. The other day I went to get my eyes tested. So far they are okay. In the last few years I have had dental problems. Losing teeth is part of getting old. Nothing can be done. One has to accept it and live with it. It does not bother me. Anyway what opportunity do I have to select what I want to eat. I do no cooking. I eat what is given to me by the people visiting this temple. It is enough some days, not always. At times it is also more than I need. With my leftovers I feed the stray dogs.

Sarla, about 66 years of age, living in Haridwar, a pilgrim town in Uttar Pradesh.

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A bond has developed between Sarla and me. Since she arrived I have not felt so isolated and neglected. She helps me in coping with my handicap. I have accepted my way of life as part of my destiny and God's will. I wonder how long I will live, but hope that my days in the future are not worse than they are now. I do not fear death. I no longer think of my family. I do not regret not handing over my jewellery to them. They would have ill-treated me despite taking my possessions. Living here at least I am at peace with myself.

Sujata, about 65 years of age, came to Haridwar from Vadodra, a town in Gujarat.

I spend all my time in this garage since coming to live with my son after my husband's death about a year ago. I have this cot to sit and sleep on. I eat here. There is a toilet attached to the room. My son and daughter-in-law work in an office. They lock the house when they go to work. They leave my morning meal and a bottle of water and also the vegetables for cutting; my daughter-in-law returns and cooks the evening meal. Then she serves me dinner here... My grandchildren from school go to their maternal grandparents' house in the neighbourhood and return home in the evening with their parents. They greet me, but beyond that there is no conversation... I do not have much to do during the day. I sit and watch the road, people going by. Occasionally, there is a visitor; it brings a change. I would like to spend time watching programmes on television but that is in my son's room and I cannot go there. I do not step out of this gate as I am not familiar with the roads and have difficulty in walking. Also I can not speak the local language fluently... I had no option but to move in with my son. How could I have lived alone back home? I cannot live with my married daughters.

Swapna, is a woman from Orissa, about 72 years of age, now living in Delhi.

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I have lived alone in this house since my husband's death seven years ago. My children, three sons, have migrated abroad. They have never bothered to inquire about me. My sister stays in this village. She looks after me. I have no income and hardly any contact with anyone. This small house is in my husband's name. I need my sons' signatures to sell it... I will die like this. I have no life, and am lonely and frail.

Raji, about 75 years of age, lives in Aligoan, a village on the outskirts of Delhi.

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The experience of ageing and poverty

There is ample evidence from all over the world that poverty and exclusion remain the greatest threats to the wellbeing of older people. In developing countries particularly, the right to participation in development by older people is routinely denied, with ageing issues seen as a minority interest or a case for special pleading (HelpAge International, 1999).

In India, being old is the reality of many, including those who have become 'old' long before the benchmark of 60 years, the age adopted internationally as the chronological reference age for national and transnational comparisons of older populations. On an individual level, 'being old' is based on subjective criteria influenced by changing social roles. For instance, age is related to becoming a grandparent or retiring from work, in terms of physical condition such as the greying of hair, visual problems, deteriorating health, and the onset of adult disability. Many other socio-economic characteristics that contribute to poor living conditions can also contribute to the ageing of individuals and be reflected in an individual's progressive ageing. The daily harshness and inequalities of their earlier lives, beginning right from childhood, (poor nutrition, ill health, dangerous working conditions, lifestyle related diseases) all exacerbate chronic health and ageing conditions associated with older people.

The difference in individual ageing experiences is often related to socio-economic issues and income security. Many people 70 years old and above who belong to the more affluent classes in Delhi or other metropolitan cities, and who have substantial incomes that support their life style, fully enjoy participation in their chosen activities, and continue to function satisfactorily within their families and the community. They may have personal problems and strained relationships, but they are able to cope with their difficulties within their resources, enjoying a reasonable quality of life in their later years.

Being old and on social security

India, with its predominantly agrarian based economy, has inadequate social security provisions for its older people. Despite India's goal of being a welfare state, social security still covers only a small proportion of the population. At one extreme are those in absolute destitution, and at the other, those working in the formal or organised sector and retiring on pensions (Shankardass, 1995). Nonetheless, those retiring from low and middle-level jobs in the organised sector do not necessarily avoid the threat of poverty, as pensions and benefits[5] do not necessarily remove financial insecurity.

I have pension benefits - I get a sum of Rs.6,700 per month, but how can I manage on it? I have a wife to support and a daughter to marry off.

Box 5.3

Surya, migrant, miner, slum dweller, 'old' at fifty...

In contrast to affluent city dwellers, a 50 year old male migrant from Bihar, named Surya, works at a mining site, and like many other respondents working under hazardous conditions in the informal sector all over the country, has developed ailments that make him, at 50, an old person in every respect. With no savings, lack of job security in later life, poor health, and no economic support from his children (who earn just enough to meet their own needs), old age is a phase of life he does not look forward to. Living with his wife who cooks for him and shares the hardships of day to day existence, there is no prospect of help from the neighbours in the slum cluster at Pehladpur in Delhi, where he dwells, beyond the hope of their presence at his funeral. He copes with his frail health alone and only in an emergency visits the government hospital. Here he does receive free medical consultation, but he cannot afford to take days off from work nor purchase the medicines prescribed for his ailments. He views beggary as an alternative means of living if he is jobless, which he thinks he will probably have to resort to in a couple of years.

> *In my old age, with frail health, who will give me a job?... For the present job I had to coerce the employer, he agreed after I offered to work at half the salary he pays to other employees... At least now I have some income to meet my needs.*

This 'old' mine worker does not understand the word 'retirement', and equates it with the end of life, since without work there is no question of survival. The reality of his ageing life is similar to that of those living in slum dwellings in urban areas or on the outskirts, the majority of whom are not covered by any social security scheme. Due to informal organisation, at times the illegal nature of their employers' business, lack of government control, and corruption, many older people are denied the minimum wages and other benefits stipulated by the government. At present nearly 90 percent of the total workforce is employed in the informal sector. Among these, only 40 percent are wage earners. Low wages, job insecurity and lack of legal and governmental provisions to protect their rights, make this group vulnerable to economic hardships and makes their old age a period of struggle.

I should have built a house, then I would not have had to pay rent. Life is expensive, cost of essential things has gone up, vegetables, fruit, electricity, telephone, transport, everything one needs. I am lucky that I have a medical benefit, otherwise I would not have been able to afford the medicines for my wife and myself. We are both asthmatic and everyday there is some problem or other, dental, eye, blood pressure, viral fever, pains, etc. I do part-time work and my daughter has started working to contribute towards meeting our day-to-day expenses and to save for her marriage...

I have not saved much. I spent most of my earnings bringing up my four children - three sons and a daughter, educating and settling them. They are all in government jobs, and they are my security. My sons stay separately as they have official accommodation and also it does not put a strain on our relationship; all of us living together would not be easy. Where is the space to reside together? Everyone needs their privacy, and also children these days are demanding. They need various facilities... We have seven grandchildren. It would be difficult for my wife and me with our ill health to cope with our grandchildren... But my sons contribute Rs.400 each per month for our expenses. Just two years back they were giving us Rs.300 per month. My sons take care of us. They visit us often.

Bipin Choudhary, 68 years of age, lives in low-income housing in Delhi.

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I made the mistake of using my provident fund for building a house, thinking that it would give me security in my old age, and that I could rent a portion of it to supplement my income from the pension... My tenant has played dirty and for the last 12 years has not paid me the rent. I have a court case going on, but really do not have the money and energy to fight... I am still working, as I have to support my wife and myself. Our medical expenses are increasing. Both of us are suffering from high blood pressure, and she also has arthritis. It is a strain for me to work. I want a relaxed pace of life. I am an old man now. We do not have sons on whom we can depend. We have four daughters who care a lot and are always there to help. I am thinking of selling the house to have some income and live in a smaller, affordable place.

Gopal Gupta, 77 years of age, residing in Kalkaji, Delhi..

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Retirement benefits such as provident fund, gratuities, paid-leave, insurance cover and a pension paid to those who are eligible are generally used by beneficiaries, either by compulsion or by choice, on things other than for their old-age. Many use the money to build a house, educate and marry off their children, and also on the health problems of their elderly parents. In any case, retirement benefits, which are not linked to the cost of living index, prove inadequate at the time of retirement because of escalation in the cost of living. Furthermore, even though over the years the schemes have been liberalised in terms of coverage, procedures for benefit disbursement need to be streamlined and simplified.

None of the older people interviewed on their perception of old age agreed with the view that age 60 or 65 should be the threshold for defining the old. They want 'being old' to be judged by the health status and physical capacity of a person. Many in employment in the formal sector question fixing the retirement age at 58, 60 or 62, when, at that age, many are still active physically as well as mentally and seek to remain economically productive. There is not much scope for re-employment at that age anywhere in the country. Some consider the prevalent welfare measures nurture the notion of dependency on society.

As one respondent stated,

It is ironic that those who are fit, qualified and wanting to work have to retire, and those who want relief from their drudgery are forced to carry on as long as their bodies permit or until death brings an end.

Many want a social security system that defines beneficiaries on the basis of need and circumstances. There is also a concern among the small percentage of women retiring from the formal sector, both government and corporate, that many of them do not receive the full benefits due to them because of factors such as an incomplete record of their continuous paid employment. Gender issues need to be addressed through affordable, accessible social security or social insurance provisions.

Voices of older women on work and assets

An observation by an older poor woman respondent in an urban area sums up the situation of many older women.

Earlier, women, as they advanced in age, gave the responsibility of household work to younger women in the family. Now there is no respite for the ageing women. With the younger ones preferring work outside the house, the older woman in the family has to carry on with the household chores. There is no retirement and relaxation for her.

The burden of caring for the family is tremendous on the older woman in society. Whether she can cope or not, she has to carry on. She will ignore her health and problems in finishing the household tasks. It is a job nobody appreciates, but it drains her of all her energy. When she requires care, no one comes forward.

Other women present alternative views and observations.

At times I think that I should also do something to earn money. It would definitely improve our standard of living... My daughter works as a schoolteacher, but does not earn much, and we need to save for her marriage. My two sons also have low paid jobs. They can do better, but it is difficult to get good employment. My husband used to work as an accountant in a firm. He has no pension benefits. I wish he was still working. He just whiles away his time. He is 68 years old... He has a lot of problems with his knee joints. He cannot do much with such pain, except take medicines... I am good at making pickles and a few times I have tried to sell them also. But I have been hesitant to make profits, I do not have the confidence to handle the business. At present I have reasonably good health, but it may not be so for long... My mother died around my age... I encouraged my daughter-in-law to take up jobs. Most women are working today. Extra earning is required to have a better life. They have two children each. They have to be educated in good schools, otherwise their lives will also be a struggle. It is expensive bringing up children... Household work is actually management of time, and if a person wants, then she can be involved with other useful activities. I do all the shopping for the house. My husband does not move out... I am very familiar with the roads. We have been living here for more than 40 years. We live in a rented flat. There was never enough money to buy a plot and build a house to meet our needs. This house does not suit us now, but we cannot afford new rents. We are paying old rent.

Sudesh, 62, a housewife educated to 5th grade, resides at Gole Market, New Delhi

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I am getting old, it worries me. I am developing lots of pains and aches. I do not know what to do. A doctor in the neighbourhood asked me to take some vitamins. I cannot afford that. He said to eat well, buy fruits. I would like to follow his advice, but where is the extra money. When I complain to my family about my ailments they think I am making excuses to shirk household work. Whenever I go to the temple, I go every Monday and Friday, my daughter-in-law says - 'don't your pains and aches trouble you now'. I do go with great difficulty, but if I would not do this, I will not have any peace of mind. Going to the temple gives me solace. I seldom go out of the house otherwise. My daughter-in-law speaks very rudely every time I express my discomfort in cutting vegetables. I cannot hold the knife

properly. I can no longer bend to sweep the house. Nobody understands my problems, or rather they do not want to. If I do not do the household work, who will do it? No one has the time. My daughter-in-law works as a typist in a private office. Very often she has to work late in office. My son, is a salesman, he travels a lot. My husband works as an assistant in a shop. He has long working hours. Anyway he will never do any household work. My family tells me - 'either you work outside or inside the house, we cannot keep an idle woman.

Rupwati, 64, a housewife, educated till 4th grade, residing in a low-income group residential colony, Sangam Vihar, New Delhi.

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Box 5.4

Women and work

A popular perception in society is that older women are not part of the country's labour force. They are stereotyped as frail and inactive. An analysis of the work participation of older person by the various surveys carried out at the national level indicates that this is not true. Qualitative studies also suggest that besides older women being 'family workers', in rural areas they are also engaged in agriculture. According to the 1991 Census, more than 40 percent of women aged 60 years and over are cultivators, and 44 percent are agricultural labourers. However a very small proportion of women farmers are landowners. The 52nd round (1995-1996) of The National Sample Survey Organisation indicates that less than 18 percent of older women had financial assets in rural India as compared to 57 percent of older men. Nearly 38 percent of older women in urban areas have financial assets – more than double the proportion of rural women.

Interviews with older women reveal active participation in work in rural and urban areas, including that associated with home - cooking, water collection, cleaning, child care, repairs and so on. In spite of various ailments and locomotive disabilities, they remain involved with their families and communities, contributing in many meaningful ways. This observation raises the crucial issue of recognition of older women's contributions as 'income generation'. Their role in the economy should not be underestimated or ignored. Nevertheless, few resources are accessible to women, even though they comprise a large share of both paid and unpaid labour. The failure to pass and enforce laws ensuring women equal access to productive resources such as land and credit, predestines them to an economic future that is abysmal at best.

My day starts at 4 in the morning and ends at 9 at night. I have no rest in between. I do not know how time flies so fast. Before I realize it the day has ended... I do all the household's work in the morning. Then I go to my client's house to give them a massage. I return home for lunch. My grandchildren come back from school. I have two. Their mother works in a beauty parlour. It is not easy for her to come home in the afternoon. After finishing lunch I go to a nearby nursery school to do the cleaning - sweeping and mopping. In the evening I go to where my husband works, a storehouse. I help him a little and we return. He is asthmatic, so he needs somebody to help him. If he tells his employer that he cannot do the job, he will be out of work. We cannot afford that... I do not think of my health problems. As long as I am working, it is okay. I have lost four teeth, and there is a bit of problem with my vision, but life carries on... I am religious and I feel that when the end has to come, we cannot do anything to stop it. I do not worry about my health but am concerned about my husband's. He may require special medical care, which we will not be able to afford. It is difficult to care for an ailing person. When 'caring' there is very little else that a carer can do. So there must be somebody available full time. If I have to take care of my husband at home, then how will I work? I need to earn for the family.

Champa, 62, illiterate, a massage woman and casual labourer staying in Lakharpur village, Faridabad District.

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Family support and living arrangements

For millions, particularly those for whom pension provision and retirement remain unattainable, family support remains the most viable option as a means of security in old age. A number of studies and surveys conducted on older persons indicate their dependency on others. This generally implies reliance on members of the stem and extended families for various types of support both in cash and in kind. Significantly, older people themselves want to believe in the unity and unitedness of the family, in close affinal and kin ties, in the essential features of the caring family, and fear being dependent on anyone. Feelings in this regard were often expressed by those interviewed.

The fear of losing their independence with advancing age, whether physical or economic, is extremely strong and this observation is confirmed by many other qualitative studies conducted in different parts of

the country. In addition to the concern to maintain their independence in meeting their daily living requirements, there is the constant worry of meeting medical expenses in the event of sickness or disability. While there is almost universal preference in Indian society for living with children, the awareness of the strains and stresses of living together are also understood by families. The creation of enabling environments for older people to be self-sufficient is one of the growing needs of the country.

Care, health, disability and quality of life

Coresidency with children does not always assure care and love for the older persons. On the other hand, independent living also has its problems, particularly in cases of ill health and disability, given the fact that professional care, limited as it is in India, is expensive. The question of space and accommodation has consequences for the quality of life of older persons.

Most of the older people carry on with their life in spite of health problems, but require proper management and understanding of their ailments. A common tendency is to ignore health related problems in old age as part of the ageing process. Many of these problems are preventable, and timely precautions can reduce the adverse consequences to a considerable extent, improving the quality of life. Educating older people on aspects of health and diseases of older people has emerged as an urgent

Box 5.5

The frequently expressed fear of becoming dependent...

My prayer to God is never to make me dependent on anyone. As far as I can earn and support myself, I will do so. I can minimise my needs but I do not want to ask for support.

My sons on their own offered to send us money for our daily expenses. We accept that, but I would have never asked them for assistance.

I stay with my son, he looks after me, takes care of my basic needs, but I have never asked him for anything. I live within whatever he provides and I do whatever household work they want me to do.

In so far as I am physically mobile and can contribute towards housekeeping, I do not mind staying with my children. But the day I become totally dependent on them I would like to end my life.

need. However, very little is being done in this respect for the illiterate members of society, which is a large sector of the society. Media response to educate the masses on healthy ageing has been minimal.

I had vision problems for a number of years. Lately I had stopped going out of the house. I felt constrained but it was better than meeting with an accident on the road. Recently I was invited by an organisation to get my eyes checked and they also treated me by performing an operation. I am okay and thankful to them for having had my vision restored. Last week I attended my grandson's wedding. I was very happy. Earlier I was depressed that I would not be able to participate fully in such occasions.

Shyam Lal, 74 years of age, is a resident of Seelampur village, Delhi.

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The role of spouses and other family members as care givers needs attention in terms of quality of care, the burden it imposes, its availability, the nature of living arrangements, and the gender implications. Interviews with respondents suggest that a large proportion of care givers cannot perform their caring tasks well because of their own age, illness, job commitments or other reasons. The role of the wife as the main provider of care was taken for granted by everyone interviewed. There were reservations about the men being care givers in the family. Most also commented that, while it was possible for family members to provide general care, special care required for particular diseases and ailments was beyond the capacity of families. In the absence of any alternative or additional support, the needy person suffers.

There is also a general lack of interest by families, communities, and government in meeting the housing, sanitation, water and environmental needs of older persons. In fact, as pointed out by many older persons who have resigned themselves to being excluded from participation in many activities, older people are not a force to be reckoned with. The general attitude is that once you move into the 'old-age bracket', the end is not far away, so why bother to strive for change? The concerned older person is unlikely to be the beneficiary. Quite clearly there is the need to identify the 'unmet needs' of the current cohorts of older persons in order to improve the life of future cohorts (Shankardass, 1998).

In addition to these concerns must be the recognition of harmful situations faced by older people. These may occur through deliberate infliction of physical harm, through financial and other forms of exploitation, or simply through failure to provide sufficient care to prevent physical and mental deterioration, or even emotional abuse from persistent criticism or ridicule.

Over the years, changes in social and family circumstances have occurred together with many other changes in political, technological and environmental circumstances, all of them shaping the lives of older persons in ways different from those in the past. These changes are equally profound for those living in rural and urban areas, but impacts vary with marital status, education, class, health, attitudes and age. The worst affected are the poor and illiterate older people who do not own property or other assets and whose access to information on the existing legal, health and welfare provisions essential to their physical, mental and social well-being is limited.

I was postponing getting my cataract operation because, being on a daily wage, I would lose salary for being absent from work. It is only now that my other eye also has a cataract and I have lot of problems with my vision so that it affects my work and I might lose my job, that I have now decided to go for the operation.

Ramnath, 68 years of age and working in an export house in Delhi.

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Many older persons carry on living in the same dwelling, their home of many years. However, the house may be unsuitable for their present requirements but they cannot afford to change, or to pay for the necessary repairs or modifications to meet their needs which have changed over the years due to the ageing process and related circumstances.

I have seldom gone out since I began suffering from pain in my knee joints. I find using the staircase a really painful experience. We have lived as tenants in this house for the last 40 years and pay a nominal rent. Moving to a ground floor house would mean paying higher rents. We cannot afford it.

Ramnath, 68 years of age and working in an export house in Delhi.

In such circumstances, older people remain malnourished and anaemic due to their inability to pay for cereals, fruit and vegetables, or for food of their choice. Above all, they accept their circumstances without trying to change them as they approach the end of their lives. It is also significant that, for these older poor people, poverty is much more than income alone. Perceptions of powerlessness over one's life and of voicelessness in the community are common. So is their anxiety and fear of the future.

The national response to the poverty of older persons

The provision of the National Old-Age Pension Scheme (NOAP) (**Box 5.6**) from August 1995, was envisaged by the government as a means of providing social assistance to the destitute aged 65 years and over. It is implemented in the State and Union Territories through Panchayats and Municipalities. Both Panchayats and Municipalities are encouraged to involve voluntary agencies in taking responsibility for the destitute elderly for whom this scheme is intended. The central National Social Assistance Scheme is fixed at the rate of Rs.75 per older person, to which many states have added another Rs.25 - Rs.75 (**Table 5.1**).

Several problems in the implementation of the scheme have been observed, and these have diminished the positive impact on the conditions of the older poor in India. The problems relate primarily to the achievement of accurate identification of the beneficiaries, foolproof distribution methods, and the assessment of the appropriate financial allocation for each of the states. Many critics suggest that there is a need for an urgent revamp of the scheme, even though, over the years, the percentage share of the beneficiaries among the scheduled castes, scheduled tribes, women and the disabled has increased. In some states a lower age limit is prescribed for females and widows, and for the physically and mentally disadvantaged.

The Ministry of Rural Development, with the assistance of the Ministry of Food and Civil Supplies, sanctions certain privileges and benefits for widows. These include:

- **the Old Age and Widows' Pension in Maharashtra, which awards a pension of Rs.250 to a widow with one or more children below 18 years of age;**
- **the Widows' Pension in Karnataka, the amount of the pension is Rs.75 per month, and there is no minimum age;**

Box 5.6

Changing times... changing needs... changing support systems

Caring, emotional and financial support are becoming more scarce to the present cohorts of older people than they were for the earlier ones, and this is occurring despite the need for more resources to meet continuous increases in the cost of living index and their longer life expectancy. It is with great anguish that a large majority of older persons voice their inability to pay for medical and nursing care and continue to live with their ailments, diseases and disabilities, many of which could be treated and even overcome.

- **the Widows' Pension in West Bengal for those below the poverty line; the amount is Rs.150 per month and there is no minimum age; and**
- **the Widows' Pension in Kerala, where the amount is Rs.110 per month to those who are destitute, and again, there is no minimum age.**

The adequacy of the old-age pension is often questioned in terms of its adequacy for older persons who must buy their daily requirements of food, pay rent for accommodation, and meet such other expenses as electricity, water and transport. On average, the old age pension works out at Rs.150 (less than US$3) per month. It does not meet the real needs of a large proportion of the beneficiaries.

A notable attempt at addressing the problem has been made by the government by enabling people to prepare for their old age by accumulating savings during their decades in the labour force[6], through the launching of Project OASIS (an acronym for Old Age Social and Income Security) in August, 1998. The project is the government's first comprehensive examination of policy issues connected with old age income security. The basic mandate of the project is to make concrete recommendations for action that the public and private sectors can implement immediately so that every young person can build up a stock of wealth through his or her working life to serve as a protection against poverty in old age.

The Expert Committee constituted under the project submitted its first report to the Ministry of Social Justice and Empowerment in 1999, addressing needed reforms to the existing provisions. The second report was submitted in 2000, and suggested improvements in the existing provisions of the three most important retirement schemes in India. These schemes are: the Employee Provident Fund (EPF), the Employee Pension Scheme (EPS), and the Public Provident Fund (PPF).

The major recommendations included restrictions on premature withdrawals, improvements in the rates of return, and increase in coverage of the schemes. The objective of the report is to recommend a pension system that can be used by individuals, which enables them to attain old age security at the price of modest contribution rates through their working careers. It has the capacity to convert modest contributions into reasonably large sums in an almost risk-free manner for old age security. The project is awaiting approval for implementation.

In 1999, the government of India announced another social assistance scheme, Annapurna, for the older destitute who have no one to take care of them. Under this scheme, an older person will be provided with 10 kilograms of rice or wheat per month, free of cost, through the existing public distribution system. This scheme, implemented by the Ministry of Rural Development through the provision of food and civil supplies, aims at covering those destitute who are otherwise ineligible for the old age pension under the NOAP scheme. The progress of this scheme has been very slow in the first and second year of its implementation. The allocated amount was released to only few states and many states and union territories have not introduced the scheme.

The societal response to the poverty of older persons

A few NGOs at the national, regional and local level have come forward with various services to cater to the needs of the older poor persons in the country. These are a significant and important supplement to the limited provisions that the union and state governments are able to provide. These agencies are able to draw on a variety of funding sources, which also extend beyond the country into internationally sponsored agencies and schemes.

With the participation of the voluntary sector in delivering services the outreach is to the older poor located in urban and rural areas including those living on the urban fringes. However, in spite of these efforts (Shankardass, 2000), further steps need to be taken to create mechanisms for the efficient and adequate delivery of services. Given the increasing costs of service provision, there is need to encourage resource sharing to respond to the diversity and multiplicity of needs of the growing numbers of older poor persons. Encouragingly, many older people are now beginning to think differently and need opportunities at differing levels of activity to enable them to live a life of dignity and respect.

Box 5.7

The National Old-Age Pension Scheme

One component of The National Social Assistance Scheme introduced in 1995 was the National Old-Age Pension Scheme (NOAPS). The NOAPS is a centrally-sponsored programme targeted at the poor elderly. There is 100 percent central funding to the states and union territories based on criteria determined by the central government. The Ministry of Rural Development manages the scheme.

The criteria for eligibility are strictly adhered to, and the distribution of funds follows specified procedures:

- age of eligibility, irrespective of gender if 65 years or over;
- to be eligible, an applicant must virtually be destitute, that is, have little or no regular income from work, family members, any other source;
- destitution may be as defined by the state or union territory concerned if any such criteria are already in place; the central government reserves the right to review these criteria and propose appropriate revisions;
- the national old-age pension is Rs.75 per month, from central government;
- the maximum number of old-age pensions for which central assistance can be claimed, is specified by the government from time to time;
- the benefit delivered under the NOAPS regulations is to be disbursed in not less than two instalments as determined by the state government.

The village panchayats and relevant municipalities must report each pensioner death at the time of its occurrence to the appropriate sanctioning authority which immediately stops payments. The sanctioning authority has the right to stop and recover payments which, for any reason, have been inappropriately made.

The allocation of these funds to the states and union territories is calculated as:

numerical ceiling: total population x poverty ration x proportion of the population 65 years and over x 0.5;

financial entitlement: Rs.75 x 12 (months) x the numerical ceiling.

For the 1995-96 year, the numerical ceiling was 5.4 million elderly (i.e., 50 percent of the population below the poverty line in the age group of 65 years and over), and the financial entitlement was Rs.48,020 lakh for the whole of India. In the 1998-99 year, both the numerical ceiling and the financial entitlement were increased to 6.9 million and Rs.61,929 lakh respectively.

Over the past five years, the scheme has become better known and the amount claimed has reached above 90 percent of the entitlement. However, the amount actually dispensed under the NOAPS provisions is still lower than the financial entitlement of the states. Some of the smaller states and union territories have recently registered more than a 100 percent change in their numerical ceiling and financial entitlements. This phenomenon requires further investigation to determine whether the cause for this shift has been an increase in the proportion of persons below the poverty line in these states, or an increase in the percentage of elderly persons 65 years of age and over.

TABLE 5.1: Payments to Each Pensioner by the Union and State Governments under the Provisions of the National Old-Age Pension Scheme

State or Union Territory	Funding (Rupees)		Total
	Central Government	State Government	
Andhra Pradesh	75	Nil	75
Arunachal Pradesh	75	75	150
Assam	75	25	100
Bihar	75	25	100
Goa	75	25	100
Gujarat	75	not available	75
Haryana	75	200	275
Himachal Pradesh	75	25	100
Jammu and Kashmir	75	150	225
Karnataka	75	Nil	75
Kerala	75	25	100
Madhya Pradesh	75	75	150
Maharashtra	71	25	100
Manipur	75	not available	75
Meghalaya	75	125	200
Mizoram	75	25	100
Nagaland	75	25	100
Orissa	75	25	100
Punjab	75	125	200
Rajasthan	75	25	100
Sikkim	75	25	100
Tamil Nadu	75	25	100
Tripura	75	25	100
Uttar Pradesh (urban)	75	25	100
(rural)	75	50	125
West Bengal	75	25	100

SOURCE: : Ministry of Rural Development, Government of India, unpublished data, 2000.

The institutional response to the poverty of older persons

There are 728 Old Age homes in India (HelpAge India, 1998) and out of these 325 are free, and a further 116 have free as well as pay-and-stay facilities. A total of 278 old age homes all over the country care for the sick, and 101 homes are exclusively for women.

Public medical institutions are now providing health care facilities to older persons on a priority basis, particularly in the out-patient departments (OPD) of hospitals. A number of hospitals have made OPD services and facilities accessible on Sundays to enable working older people and those requiring working companions to accompany them, to avail themselves of medical services without having to take time off from their workplaces. These hospitals have separate counters for older people for registration, out-patients and prescriptions. The All India Institute of Medical Sciences in Delhi, catering to patients from all over the country, has a Geriatric Clinic functioning on Friday afternoons.

Portraits of the older poor

...in urban areas

Pyari, comes from a family of gardeners in a village in Uttar Pradesh which she has not visited in the last 50 years or so. There has never been enough money to travel and visit the family and community back home. She had five sons and one daughter. All the sons died before they were a year old; her daughter was mentally disturbed and died recently. She and her late husband worked hard all their lives, for many years living in a slum cluster and later in a small room in her employer's house. She and her husband did not earn much, he as a gardener and she as a domestic helper. They rarely had enough to eat. When the husband died six years ago, she tried to continue working but could not do so due to frailty. Her employer for many years brought her to this old age home by paying a nominal charge, and where for the first time in her life she could eat her fill and be comfortable without the worry of making ends meet. She is content with her life, as she has nothing more to hope for now. She only wishes for good health so that she remains mobile. She cannot think of leaving the home, and the fear that if she steps out she might not be able to return has made her stay within the walls of the home for the last five years. She spends time talking to other residents and sleeping whenever she feels like doing so. She feels her body needs the rest as it is slowly degenerating.

Champa, 62, illiterate, a massage woman and casual labourer staying in Lakharpur village, Faridabad District.

Box 5.8

National, regional and local agencies provide a range of support services

Age Care India organizes free geriatric health check-up camps in a few states for the urban and rural destitute over the age of 50, and for those from low-income groups around the metropolis. They also have a pension scheme providing Rs.100 per month to the economically deprived and indigent older people above the age of 65, particularly those from rural areas.

HelpAge India, the largest voluntary organization in the country with 23 regional offices, in one of its most important initiatives, has started the Mobile Medicare Unit (MMU) programme, which enables older people to assume an active role in looking after their own health. MMUs are at present serving hundreds of thousands of older persons residing in slums, resettlement colonies and adjoining rural areas, providing medicines, counselling and health care free of cost. Another widely acclaimed concept is the Adopt-a-Gran (AAG) programme. It links older people in need with sponsoring families, individuals and corporations, and help is provided in the form of food, clothing, medical care, bedding, articles for personal use and pocket money.

Smaller organizations, such as the Development, Welfare and Research Foundation (DWARF), Action for Social Help Assistance (ASHA), the Family Welfare Agency, Meals on Wheels, and many more operating in different parts of the country, provide counselling on second careers, income generating activities, companionship, nutrition and other health related items.

Bawa is a carpenter, suffering from leprosy. He still works hard and earns enough to feed himself and his 68 year old wife. They live in a two-room house. They have four children, two sons and two daughters, who live separately and do not help their parents financially. Bawa and his wife share a lot with each other and depend on their neighbours for any small help needed in their day-to-day routine. His nephew stays close to their house and visits them often. When faced with a major problem they call for their sons who, not very willingly, do provide assistance. Bawa is not sure how long he can continue to work. When asked how they will manage in future, he replies that they will depend on their neighbours who will not let them starve. Being a religious man, he thinks of the possibility of staying in a gurudwara (a religious institution which provides shelter to needy followers of the faith). His wife is healthy and remains active with household work, doing most of the tasks herself without any outside help.

Bawa is 75 years old, living in Ludhiana, Punjab, and was interviewed at his workplace.

Box 5.9

A need to assess the efficacy of the programmes and mechanisms of implementation

While many facilities and services are available throughout India, a comprehensive assessment of their efficiency and accessibility is yet to be made. Is there wastage and overlapping? Are the beneficiaries being correctly and comprehensively identified? Are the provisions and assistance sufficient? More attention is required in ensuring the efficacy of the mechanisms being adopted, to ensure that they really are improving the poverty situation. Quality of care and more complete identification of the full range of the needs of older persons must still be a priority. The challenge is to provide for the present and simultaneously prepare for the future and the increasing numbers of older people, within a political economy framework. Without such a focus, measures to alleviate poverty among older persons will not lead to a sustainable solution for containing the problem of old age destitution.

Mamta is married, and works as a casual labourer with her husband of about the same age. Their work generally is related to house construction. She is happy that both of them have employment at their age and would like to continue working as long as they can. They have three sons, also casual labourers. They are all married and staying in the same colony. The question of the sons supporting them does not arise as in their circumstances everyone has to work to survive. She and her husband do not have any major health problems, but have frequent episodes of fever and cough. They have a small television in their shack and every evening, as a ritual, watch the entertainment programmes. They never watch health programmes as these do not relate to their life. They have two meals a day which she cooks, implementing her notions of 'good' and 'bad' food as, for example, avoiding cooking any sour food when their coughs are bad. A 'doctor' staying in the colony has imparted these little tips on food to her. She is not aware of any pension programmes.

Mamta is about 60 years of age, and lives in a slum colony in Ohkla, New Delhi.

...in rural areas:

Ramesh retired from the police force and earns a pension of Rs.1,600 per month. He went back to his village, as his pension is not enough for him and his wife to live on in the city. He is not keen on re-employment as he is fed up with regular routines. In the village he is happy as he has a home and expenses are low. He has grown some vegetables in a small garden in

front of his house. His wife does the housekeeping and is also happy to have come back to spend their last years in familiar surroundings. They have two sons and two daughters, all married and working to make ends meet. The eldest son sends Rs.100 to his parents as a contribution towards their expenses. Ramesh and his wife at present do not have any worries, although fear disability in old age and worry about who will care for them. They feel it will be difficult for them to live with their sons for various reasons: economic considerations and inadequate dwelling space are the prime limitations. Besides, nobody will have the time to look after them. At present both care for each other and are contented with their life.

Ramesh is 66 years old and lives in Seelampur Village, Delhi.

Chandra is a cobbler, who commutes every day on his cycle to nearby Delhi. He lives with his wife, two sons and their families, in a rented house, which is cramped for all of them. He sleeps in the outside courtyard with his wife, and his two sons occupy a room each of the house. The household work is shared by his wife and daughters-in-law. He has six school age grandchildren who are good company for each other. There is nothing particular he has to say about his relationship with his sons and grandchildren. His wife takes an interest in the children's clothes and food. He finds the daily commuting tiring and would like to stop working, if only he had some other source of income. His income contributes to the monthly household budget, and because of his earning he has the feeling of being the head of the family. His family members give him respect, and if they did not, they would be reprimanded by their community. He feels that in the villages there is still regard for older persons. His wife has many health problems: she is diabetic and asthmatic. There is a doctor in the village, who treats her. They have never thought of consulting a specialist. He feels that as he and his wife advance in age they will face many health problems and his daughters-in-law will care for him and his wife.

Chandra, 62 years old, lives at Pala Faridabad Village, Haryana.

Sushma was interviewed while she was resident in the Geriatric Clinic at AIIMS, in Delhi, for few months where she is being treated for heart problems. Her husband is an invalid and they live with their youngest son and his wife. Her other five children, two sons and three daughters, are married. Her two older sons do not bother about the parents, and have their own lives, one in Ajmer and the other in Jaipur. Her daughters visit them

occasionally. Her youngest son and his wife provide all the support and care to Sushma and her husband. Her husband owns a shop and the house where they stay. The youngest son now manages the shop. Sushma helps around the house, not because she has to, but in order to provide relief for her daughter-in-law, who has three small children to look after. Sushma also looks after her husband and watches television to entertain herself. She is religious, and says her prayers every morning and evening.

Sushma is 72 years old and lives in a village on the outskirts of Jaipur, Rajasthan.

Lajwanti works and is a care giver to her husband. He is 78 years old and does nothing except lie on the cot. She earns money by selling dung cakes. She spends the day collecting cow dung and doing the household chores. She also looks after the three grandchildren of her two sons who are married and stay with them. Their wives work as sweepers in offices in Delhi. The daughters-in-law leave the house early in the morning and return in the evening. The two sons work as assistants in shops in Delhi. Although they live together, verbal interactions between the members are limited. The house is cramped for so many of them, so the sons and their wives spend a lot of time after their return from work in the open space outside the house. The daughters-in-law do not really help with the housework.

Lajwanti is about 70 years old and lives in Mauzpur Village, Delhi.

Shyam Lal leads a simple life. He lives in a house owned by his eldest son. He used to do trading, but stopped because of certain handicaps. His income reduced considerably after that. He cut down on his expenses and his wife has been very unhappy about it. She keeps herself involved with domestic chores and provides a lot of help to her two granddaughters-in-law who work in an office, bringing up their children. She cooks for them, knits for them and washes their clothes. Her one daughter-in-law met with an accident sometime back and after that has a problem using her right arm and hand. Their sons provide financial support, but he would have preferred to do without it. His youngest son lives in a rented house adjoining. His sons are in petty businesses and his grandson helps in the business. Their three daughters are married and he finds it difficult to keep up the traditional practice of giving them gifts on festivals etc. He believes in traditions and is very religious. His wife and he seldom go out but participate in family functions, though in the last few years have had to cut down on that. His wife is six years younger than him, but looks older.

She is always worried about something or other and the family does not like it, even though it is always in their interest. Very often in their family there is unpleasantness because of it. She feels that if she and her husband were living on their own, they would be better tolerated.

Shyam Lal is 74 years old, retired, and lives in Seelampur village, Delhi.

Ramnath works in an export house in Delhi as a daily wager. He commutes by bus everyday and since over the last five or six years has found the travel every day rather strenuous, but has no option. He often ignores his ailments and later suffers the consequences. He is thin and frail. His earnings are small compared to his expenses. His wife has been almost bedridden with arthritis for the last two years and he has employed a maid to help her in domestic chores. He has four married daughters who are too involved with their own families to have time to look after their parents. They visit them occasionally, but it is always an expense when they come as their in-laws expect that they will return with gifts. His brother and his family stay in the same village and are willing to help his wife in household matters, but she prefers not to be under any obligation.

Ramnath is 68 years old and lives in Seelampur village, Delhi.

Nathu is a widower living in an outdoor room of a farmhouse. He helps the owner of the farmhouse in doing odd jobs. He does not get any salary but has a place to stay and gets food from their kitchen. On festivals and other occasions he is given money as a gift. Nathu has had ties with the family for many years as his brother and he used to cultivate the land owned by the present owner's father. The land was later divided and some portions sold off. Nathu at present has no major health problems, but a few years ago met with an accident and was incapacitated for many months. He now has a constant back problem and finds it difficult to carry on with certain tasks. He is grateful to the family for giving him shelter and looking after him. Nathu's two sons work for the owner, but in his factory at Meerut. Every month his sons send Nathu money; the amount varies from Rs.100 to 200. Nathu's world revolves around the village, which he finds has changed considerably, upsetting the lives of the poor cultivators who have not had much work for the last decade or so.

Nathu is 62 years old and lives in Bijwasan village, Delhi.

Lajja lives alone in a one-room house with a small lawn where she grows vegetables to meet her needs. She used to be hired for cultivation of land until a few years ago. Her husband left her for another woman about twenty years ago. Her two sons died in quick succession about four years ago. Her only daughter died in childhood. She has one son living who works in a bank and was posted to Nagpur. She does not want to leave her home to settle with him. He visits her occasionally but his wife and children do not come. They do not like staying in the village. She is fond of her grandchildren and always sends a small gift for them whenever her son visits her. She saves from the money her son gives her for her monthly expenditure. Lajja has no serious health problems, but is frail and gets tired easily. She keeps to herself as some of her age group contacts have passed away. She thinks that her end is not far away but as long as she is living, she has to carry on. She has kept her routine of getting up early and getting the various chores done.

Lajja is 70 years old and lives in Bijwasan village, Delhi

Om Prakash was a tailor until about 12 years ago. He had a shop in his house. His three sons got together and forced him to sell the house in order to make good money as property prices had gone up. He sold his land and soon came to realise that the money had been distributed between his sons with a small share for him. He now lives in a rented place with his wife who is seven years his junior. She has difficulty in walking as her knee joints have given way. He is a cancer patient and feels he will not live long though it does not really trouble him. His sons invested their share of the money into businesses and are quite comfortable. His funds have not multiplied and he feels the hardship in making ends meet. He and his wife worry for each other. They have two daughters who are married and visit them often. The sons visit frequently but do not provide much support. The daughters come and cook for them and do other jobs in the house, which is a help to his wife. His daughters-in-law come occasionally but they use the excuse that they are babysitting the grandchildren. He has a sister who lives in the village with her family. She comes to their house often but only for a short duration. His wife's brother also stays in the same village but they do not get along. They have a small temple in the house where everyday he and his wife pray for things not to become worse.

Om Prakash is 80 years old and lives in Lakharpur village, Haryana.

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Box 5.10

Listening, hearing, responding...

Listening to the voices of older people is central to the work of effectively improving their situation (Bose and Shankardass in press). Both institutional and individual care givers must evaluate what they are doing by responding to the needs expressed by these voices. There is a constant need to assess and evaluate existing programmes aimed at benefitting the older poor. Beyond this, there is also the need to explore and support new processes that will help give them a stronger voice on development policies and actions. It is essential that older poor people's views and priorities become key inputs into emerging development policies and actions. Only when strategies are designed and monitored with the help of the older poor themselves, and have a focus on effective action that will assist poor older people, will a real impact be made.

Notes

1 A gender related development index (GDI) value of 1.0 reflects perfect gender equality. No society has achieved such a value. India had a value of 0.250 in 1970, and 0.424 in 1995, according to the UNDP's Human Development Report.

2 A person is considered to be economically dependent if he or she is obliged to accept financial help from others in order to live a normal life.

3 WHO defines quality of life (QOL) as an individual's perception of his or her position in life in the context of the culture and value system in which he or she lives, and in relation to his or her goals, expectations, standards and concerns. It is broad ranging, incorporating in a complex way, a person's physical health, psychological status, level of independence, social relationships, personal beliefs and relationship to salient features of the environment.

4 The National Sample Survey Organization in its All India data in the 42nd round (June 1986 - July 1987) recorded the proportion of aged widows, divorced and separated females as about 65 percent in rural areas and 20 percent in urban areas. A similar pattern was also noted in the 38th round of data collection. This pattern was also observed in almost all the states of India.

5 The benefits available to an employee are contributory in nature and

have existed in India for a very long time. They are enforced by the state through statutory and administrative measures on business enterprises and industrial establishments in the corporate sector under various social security acts. These include the Pension Act 1871; the Workers' Compensation Act, 1923; the Employees' Provident Funds and Miscellaneous Provisions Act, 1952; the Employees' State Insurance Act, 1948; and the Payment of Gratuity Act, 1972. These welfare measures are applicable only to those employed in the organized sector, and on a national scale this covers less than ten percent of the work force.

6 The 'labour force' includes those persons who are currently engaged in any economic activity, or who are actively looking for work.

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