

International Journal on Ageing in Developing Countries



**International Institute on Ageing
United Nations - Malta (INIA)**

International Journal on Ageing in Developing Countries

Volume 1, No. 1, 2016

**<https://www.inia.org.mt/journal/issue>
<https://www.inia.org.mt/>**

Copyright

The *International Journal on Ageing in Developing Countries* is published under the auspices of the International Institute on Ageing, United Nations – Malta (INIA) Electronic Press.

All Authors retain the copyright of their articles. The publishers will keep this document online on the Internet - or its possible replacement - for a considerable time from the date of publication barring exceptional circumstances. The online availability of the document implies a permanent permission for anyone to read, to download, to print out single copies for your own use and to use it unchanged for any non-commercial research and educational purpose. Subsequent transfers of copyright cannot revoke this permission. All other uses of the document are conditional on the consent of the copyright owner. The publisher has taken technical and administrative measures to assure authenticity, security and accessibility. According to intellectual property law, the author has the right to be mentioned when his/her work is accessed as described above and to be protected against infringement.

The views and opinions expressed in this journal are not those of the Editor-in-Chief or members of the International Editorial Board, but are those of individual contributors.

International Journal on Ageing in Developing Countries

Editor-in-chief

Marvin Formosa, *International Institute on Ageing, United Nations - Malta & Department of Gerontology, Faculty for Social Wellbeing, University of Malta*

Deputy Editors

Peter Ferry, *International Institute on Ageing, United Nations - Malta*

Rosette Farrugia-Bonello, *International Institute on Ageing, United Nations - Malta*

International Editorial Panel

Harrison Bloom, *Mount Sinai School of Medicine, New York, USA.*

Nikolai Botev, *UNFPA, Ashgabat, Turkmenistan.*

Christopher Cabalza, *School of Medicine, St. Paul University, The Philippines.*

Elly M. de Heus, *Age Concern International, Luxor, Egypt.*

Raja Gopal Dhar Chakraborti, *Calcutta University, Kolkata, India.*

Muhammed Fouad Ibrahim, *Ain Shams University, Cairo, Egypt.*

Tengku Aizan Hamid, *Universiti Putra, Malaysia.*

Boris Gilca, *UNFPA, Chisinau, Moldova.*

Yesim Gokce Kutsal, *Geriatric Society, Ankara, Turkey.*

Radhouane Gouiaa, *Policlinique CNSS, Sfax, Tunisia.*

Gerald Koh, *National University of Singapore.*

Tomas Kucera, *Charles University, Prague, Czech Republic.*

Benson Kwemol Kamary, *Tongmyong University, Busan, South Korea.*

Gulnara A. Minnigaleeva, *Senior Resource Centre, Bashkortostan, Russia.*

Freire Nato, *Brazilian Geriatrics & Gerontology Society, Belem, Brasil.*

Emem Omokaro, *The Dave Omokaro Foundation, Abuja, Nigeria.*

Jacqueline Parkes, *University of Northampton, UK.*

Pedro Paulo Marin, *Pontificia Universidad Catolica de Chile, Santiago, Chile.*

Clara Maria Pereira Perez, *Social Security Institute, Uruguay.*

Brigit Pianosi, *Huntington University, Ontario, Canada.*

Oscar Sandino, *UNFPA, New York, USA.*

Alexandre Sidorenko, *International Policy on Ageing, Vienna, Austria.*

Poot Ix-Chel Xunan, *National Council on Ageing, Belize.*

Asghar Zaidi, *University of Southampton, UK.*

Book Review Editor

Sailesh Mishra, *Silver Innings Group, India*

Contents

Editorial	1
<i>Marvin Formosa</i>	
Articles	
Ageing and development: Putting gender back on the agenda	5
<i>Rachel Bennett and Asghar Zaidi</i>	
Challenges and opportunities of population ageing in the CIS+ countries	20
<i>Alexandre Sidorenko</i>	
Population ageing and the development of social care service systems for older persons in China	40
<i>Peng Du and Yongmei Wang</i>	
State of widowhood in Iran: Challenges of ageing spouses	54
<i>Mohammed Taghi Sheykhi</i>	
Elder abuse, depression, relationships, and attachment: Determinants of mental health in later life	68
<i>Ritu Sharma and Rupinder Kaur</i>	
Book reviews	
Formosa, M. (2015). <i>Ageing policy in Malta: Issues, policies and future trends</i> . Malta: Book Distributors Limited. (286 pages) ISBN: 9781447300571	
<i>Reviewed by Suhana Bhatia</i>	80
Emmatty, L.M. (2009). <i>An insight into dementia care in India</i> . New Delhi: Sage. (118 pages). ISBN: 9788178298887.	
<i>Reviewed by Jacqueline Parkes</i>	84

Editorial

Marvin Formosa¹

In November 1990, the first Issue of BOLD, the in-house periodical of the International Institute on Ageing, United Nations - Malta, was published. It was a modest publication, with four to five short articles from practitioners and academics working in the field of ageing in developing countries. BOLD was published uninterruptedly until November 2014, during which years it also published short reports on training programmes held in Malta and in developing countries, brief book reviews, and The International Institute on Ageing, United Nations - Malta, international calendar. Under the editorial guidance of Gillian Tipping (1990-1991), Joanne Valentino (1992), Victor Griffiths (1992 – 2012), and subsequently, Laurence Grech (2012 – 2014), BOLD accomplished the aim and objectives that one expected of a news quarterly prior to the coming of the Web 2.0 revolution. In recent months, a decision was taken to cease this publication as its goal and purposes were taken on in a more efficient and cost-effective manner by online strategies - namely, the Institute's overhauled and interactive website, across-the-board electronic postings, and online social network services. A broad consensus exists in both academic and advocacy fora that newsletter agendas are nowadays better served through the Internet Protocol Suite to which most computers and smart phones are now connected to.

Since its establishment in 1987, the International Institute on Ageing, United Nations - Malta, has gone a long way in fulfilling its mandate - namely, to train personnel from developing countries who are working or who intend to work in the field of ageing or with older persons; provide advocacy to developing countries in matters concerning capacity building; and act as a practical bridge between developed and developing countries in the area of information exchange in the field of ageing. Indeed, the past quarter of a century has seen the Institute acquiring unique experience and expertise in organising training programmes in various areas of policy development, services and practices all over the world. Up to 30 June 2016, the Institute has trained 2,189 participants from some 150 countries in its regular international short and long-term training programmes held in Malta. Since 1995, the Institute has also carried out 102 *in-situ* training programmes in 28 different countries - thus training more than 3,200 various professionals in the field of ageing. In China alone, the International Institute on Ageing has collaborated with various government and non-government organisations to train more than 600 candidates.

¹ International Institute on Ageing (United Nations - Malta) (INIA) (marvin.formosa@inia.org.mt)
Department of Gerontology, Faculty for Social Wellbeing, University of Malta (marvin.formosa@um.edu.mt)

Now, in 2016, the International Institute on Ageing (United Nations - Malta) is launching a peer-reviewed journal under the title of *International Journal on Ageing in Developing Countries* which, partly evolving from BOLD, will - nevertheless - be governed by new ethos. Ethos, which will strengthen the Institute's information exchange directive. Why launch a new journal in this field? There are other journals concerned with ageing, older persons, and later life, which sometimes publish articles focusing on gerontological and geriatric concerns in developing countries. However, INIA does not believe that the presence of these journals have filled the gap when it comes to our knowledge on human capacity building in low-income countries and other nations with economies-in-transition. It is evident that a journal that combines the unique critical blend of research, scholarship, policy, and practice concerning developing countries - something to which the *International Journal on Ageing in Developing Countries* clearly aspires to - is in rare supply. Nor do available journals focus on the emergent inter- and multi-disciplinary issues, as well as evidence-based practices, in the field of ageing in far-afield developing countries that, generally, remain flying under the radar.

Of course, it would be highly presumptuous of INIA to consider that the *International Journal on Ageing in Developing Countries* is taking the study of ageing in completely uncontested territories, or that it is somewhat akin as to re-inventing some academic wheel. The scope of this international journal is, in a nutshell, to take the current state of affairs a step forward, to bring closer to the surface that interface between ageing and development, and in doing so, document the work of professionals toiling in subaltern geographical avenues who rarely find cost-effective opportunities to learn from each other's studies through an unrestricted dissemination of information. It is hoped that the journal will be essential reading for those engaged in research and scholarship related to ageing in developing countries, for trainers of those who work with older people in difficult socio-economic circumstances in 'peripheral' geographical zones, for managers or users of services in community- and long-term care facilities that operate in absence of those norms and taken-for-granted assumptions so prevalent in high-income countries, and for those working in older people's movements which deal with advocacy issues and human rights of older persons.

Any publication will ultimately be judged by the quality, clarity and relevance of what it contains, and the *International Journal on Ageing in Developing Countries* must also stand this test in the coming years. The editors hope and intend that the journal will foster new approaches to research, theory, and practice, and their application to ageing, later life, and older persons in developing countries. Whilst acknowledging the fact that research in gerontology and geriatrics does not have any fixed and well-defined borders, researchers are urged to pay great attention to theory, since this is such a crucial component to the process of creating cumulative knowledge - that is, the construction of explicit explanations in accounting for empirical findings. Contrary to what many journals on ageing studies may seem to assume, theory is not a marginal, meaningless 'tacked-on' exercises, which accompany empirical results. Rather, cumulative theory-building represents the core of the foundation of scientific inquiry and knowledge.

In terms of methodological strategies, the *International Journal on Ageing in Developing Countries* encourages mixed methods research. Mixed methods can refer to using unlike epistemological beliefs, different methods of data collection, and different forms of data analysis. It is necessary to integrate qualitative and quantitative approaches because gerontological and geriatric research deals with multi- and inter-disciplinary structures. Phenomena under focus are always best described in terms of highly complex, multifaceted, and diverse processes of social constitution or construction, in which no simple causality is present, and which build on the principle of continuous change. Therefore, middle-range theories, as opposed to 'grand' theorising, will be especially appropriate. Space will also be given to practice-based research, especially the study of models of best practice. Alongside person-based approaches, and those based on the history of ideas, hermeneutic approaches drawing from the tradition of the humanities are also eagerly anticipated.

Issue 1 of the *International Journal on Ageing in Developing Countries* contains five original entries and two book reviews - namely, the most recent International Institute on Ageing's (United Nations - Malta) publication *Ageing and Later Life in Malta: Issues, Policies and Future Trends* (Formosa, 2015) reviewed by Suhana Bhatia and *An Insight into Dementia Care in India* (Emmatty, 2009) reviewed by Jacqueline Parkes.

The first contribution, by Rachel Bennett and Asghar Zaidi, is titled 'Ageing and development: Putting gender back on the agenda'. This article highlights the potential of global population ageing as a vehicle for socio-economic development and demonstrates the value of taking a gendered approach to ageing and development. With the use of country level data on gender equality, education, health and life expectancy in later life, Bennett and Zaidi's analysis shows that older women in low-income countries face disproportionate disadvantages relative to both their male counterparts in low-income countries and female counterparts in high-income countries. Bennett and Zaidi conclude that the new, broader, post-2015 Sustainable Development Goals provide unparalleled opportunities to place gender back on the emerging ageing and development agenda, support both older men and women to realise their potential and in the process maximize opportunities for prosperity and wellbeing for all.

The second contribution, by Alexandre Sidorenko, is titled 'Challenges and opportunities of population ageing in the CIS+ countries'. This article reviews the main characteristics of population ageing, its societal implications and possible policy responses in the twelve countries of the former Soviet Union. In spite of demographic, cultural, and economic diversity the countries under consideration share several common characteristics, such as joint political history, as well as the context and content of social policy. These characteristics are essential for understanding the specifics of the ongoing process of multifaceted transition, including demographic transition, in these countries. Sidorenko concludes that, as elsewhere in the world, population ageing in the ex-soviet states presents both challenges and opportunities, which should be carefully examined and taken into consideration while designing and implementing the measures of adjustment to population changes.

The third contribution, by Peng Du and Yongmei Wang, is titled 'Population ageing and the development of social care service systems for older persons in China'. The authors highlight how China's population ageing has the characteristics of having an enormous number of older persons with an accelerating ageing pace, a weakened traditional elder familial care capabilities and vast regional and rural-urban differences. The elder social care service system of 'families serving as the foundation, communities as the base and institutions as the supplementation', has initially formed in China but there remains various problems. Du and Wangmei conclude that the Chinese government is now making efforts on the reconstruction and consolidation of elder family care capabilities to support elder care capacities of the families through social services, the development of long-term care insurance system and relevant service systems, and narrowing the gap amongst various areas of service provision.

The fourth contribution, by Mohammed Taghi Sheykhi, is titled 'State of widowhood in Iran: Challenges of ageing spouses'. The article represents how ageing, widowhood, and loneliness are surging in Iran. Due to rise in longevity in Iran in recent years - 76 years for women and 72 years for men - Iranian women are very likely to lose their spouse than ever before, and become widows albeit under the lack of adequate infrastructures. For Taghi Sheykhi, shortages of social security and pensions in the third age make the remaining spouse very vulnerable which is sociologically worth studying. Similarly, their social links and relations are impaired under such circumstances. Taghi Sheykhi concludes how the loss of interactions within the ageing people become problematic and demoralizing. Many remaining spouses experience poverty in this stage of life and need planned supports and services.

The fifth contribution, by Ritu Sharma and Rupinder Kaur, is titled 'Elder abuse, depression, relationships, and attachment: Determinants of mental health in later life'. The purpose of this article is to explore the issue of elder abuse and depression among older persons in India. In addition, relationship and attachment with relevant others, and its effect on positive mental health of older persons were also examined. Data was collected from 200 older persons living either with their families or in care homes for older persons. Schedules of social support, socialization, depression and elder abuse were used. Immediate support system, relationship with relevant others, mental health and abuse were assessed, using both quantitative and qualitative methods. The study revealed that depression was prevalent among both groups, with incidents of elder abuse least admitted by people living with their families.

All five articles, which come from a range of disciplinary backgrounds and use a variety of models and concepts, are prime examples of research and/or scholarship. I trust that you will find them intellectually stimulated and welcome additions to your library. On a final note, I can never overestimate how much I welcome critical comment on the policy and content of the journal, and how much I look forward to enlarging my own horizons through receiving manuscripts (which are peer-reviewed) from many new people, places and perspectives.

Marvin Formosa

Editor-in-Chief

International Journal on Ageing in Developing Countries

Ageing and development: Putting gender back on the agenda

Rachel Bennett¹ and Asghar Zaidi²

Abstract. We live in a world where women over fifty account for almost one quarter of the total population. This article highlights the potential of global population ageing as a vehicle for socio-economic development and demonstrates the value of taking a gendered approach to ageing and development. With the use of country level data on gender equality, education, health and life expectancy in later life, the analysis shows that older women in low-income countries face disproportionate disadvantages relative to both their male counterparts in low-income countries and female counterparts in high-income countries. For instance, an older woman in a low-income country is over 24 times less likely to have completed secondary education than an older woman in a high-income country. Despite the widely documented female survival advantage, an older woman in a low-income country spend a smaller percentage of her remaining life expectancy at age sixty in good health than her male counterparts. Our analysis show there are strong correlations between gender inequality and diminished life expectancy and healthy life expectancy at age 60 amongst both genders, indicating that both older women and older men fare better when they live in societies which realise the contributions of women to the development process. The correlation is particularly strong in low-income countries, suggesting countries with the lowest levels of economic development have the most to gain from promoting gender equality. The United Nations Millennium Development Goals (2000-2015) had given an exclusive place to women in the standalone goal on maternal mortality and a goal on gender equality and female empowerment with explicit indicators on school enrollment amongst girls and literacy amongst young women. These goals are linked to the achievements such as the near doubling of the number of women in parliament and a near halving of the maternal mortality ratio over the last twenty years. However the development discourse has given minimal attention to women beyond reproductive age. The new, broader post-2015 Sustainable Development Goals provide unparalleled opportunities to place gender back on the emerging ageing and development agenda, support both older men and women to realise their potential and in the process maximize opportunities for prosperity and wellbeing for all.

Keywords: ageing, gender, equality, development, Sustainable Development Goals.

¹ University of Gloucestershire, United Kingdom. (rbennett3@glos.ac.uk)

² University of Southampton and London School of Economics, United Kingdom. (Asghar.Zaidi@soton.ac.uk)

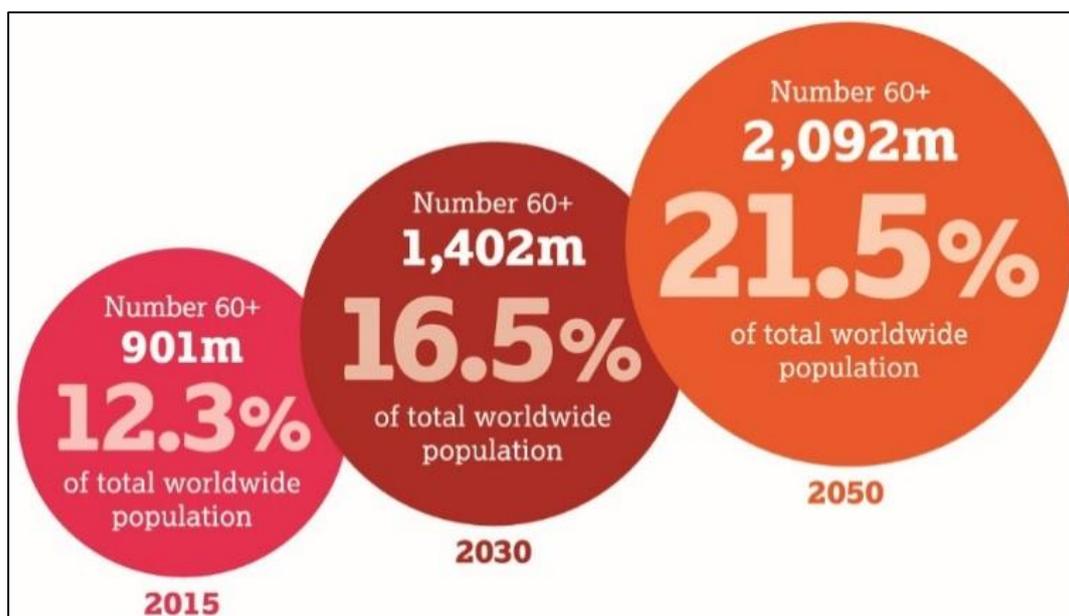
Introduction

This article makes the case that population ageing is not a prohibiting phenomenon for social and economic development but can strengthen the case for supporting the wellbeing and prosperity of populations across the life course. It also explores the interrelationships between gender equality and health in later life globally in order to highlight the importance of placing gender on the agenda for all processes linked with ageing and development.

Population ageing is unprecedented and profound

We live in an incredible world, almost unimaginable to that lived in by our grandparents. Increasing numbers of us are living longer than ever before, we are also healthier and many more of us can look forward to the prospect of an active and healthy life in old age. The world's population is ageing across all regions of the world. As fertility declines and life expectancy increases, the proportion of population aged 60 and over are growing in countries rich and poor. There are currently around 900 million people aged 60 or over worldwide, representing approximately 12.5 per cent of the global population. By 2050, this will have increased to 2.1 billion or 21.5 per cent of the global population.

Figure 1: Number and proportion of older people globally in 2015, 2030, 2050



Source: UNDESA Population Division, World population prospects: the 2015 revision, as cited in HelpAge International (2015).

People over 60 now outnumber children under five, and by 2050, they will outnumber those under 15. These demographic changes are most rapid in the developing world which, by 2050, will be home to eight out of 10 of the world's over 60s. The speed of population ageing,

especially in low- and middle-income countries, has led many commentators to say that the developing world is 'growing old before it grows rich'.

Population ageing will have profound impact, especially since many of the governments around the world have yet to put in place the policy frameworks to respond to the challenges posed by the ageing of their populations. There is a mismatch between advances in longevity and in the evolution of policies that protect and empower older people. In particular, many of the sub-Saharan, Middle Eastern and Asian countries fall short in their awareness of potential of older people in being net contributors in the development process. Policies to support a dignified and secure old age should be of serious concern not just to older people but also to today's young people, not least because they are the ones who stand to benefit from them in the longer term. The 2014 Human Development Report makes an important point in this respect: early interventions result in more resilient, secure and healthier adults (United Nations Development Programme, 2014a). The longer term benefits of this justify the expenditures to be made for better education, health and employment opportunities for both young and old. Larger older population also implies greater voting power. Many countries now have political parties formed by the pressure group of older people. There is no evidence though, as yet, that this grey voting power is causing conflict between young and old. That said, there is a gap between the generations, especially in terms of knowledge and wisdom. With supportive environments and good planning, older people can contribute more effectively in the mentoring of younger people.

Population ageing a motive for development

In contrast to the preceding Millennium Development Goals (United Nations, 2000), the new post-2015 Sustainable Development Goals (SDGs) (ibid., 2015a) make a specific mention of older people and ageing as a cornerstone of sustainable development. In monitoring the SDGs, there is a broader commitment that "all indicators should be disaggregated by sex, age, residence (urban/rural) and other characteristics, as relevant and possible". Goal 3, Ensure healthy lives and promote wellbeing for all at all ages, is particularly relevant for older people as it has older people as one of the main beneficiaries for all future international development processes. Indeed, every person should be able to live the best life that they can at every stage, with dignity and freedom of choice. The SDGs pledge "no one will be left behind" and "to reach the furthest behind first", implying that every individual must benefit from the development process and that the most vulnerable should get the highest priority in the development agenda. People's experiences of older ages vary enormously depending on where they live. Countries that support human development throughout life are more likely to attain higher levels of quality of life of older people and also have higher rates of their participation in volunteering, working and engaging in their communities. The evidence available in the Global AgeWatch Index, since its launch in October 2013, has helped us identify contexts in which older people fare better, and point to policy interventions that are effective in reducing their vulnerabilities (for purpose and methodology of Global AgeWatch Index, see Zaidi , 2013).

The countries doing best in the Global AgeWatch Index have social and economic policies supporting older people’s capabilities for employment, wellbeing in terms of income and health and autonomy with the help of enabling environments. They have long-standing social welfare policies delivering universal pensions and better access to healthcare, as well as action plans on ageing. This approach is apparent not just in some Western, Nordic and North American countries but also in some medium income countries like Chile, Argentina and Mauritius (HelpAge International 2015).

Figure 2: Global AgeWatch Index ranking of 96 countries with respect to older people’s wellbeing, 2015

1. Switzerland	21. Chile	41. Vietnam	61. Croatia	81. Ghana
2. Norway	22. Czech Republic	42. Mauritius	62. Dominican Republic	82. Honduras
3. Sweden	23. Estonia	43. Armenia	63. Lithuania	83. Lao PDR
4. Germany	24. Belgium	44. Ecuador	64. Belarus	84. Morocco
5. Canada	25. Spain	45. Romania	65. Russia	85. Jordan
6. Netherlands	26. Slovenia	46. Sri Lanka	66. Serbia	86. Nigeria
7. Iceland	27. Uruguay	47. Malta	67. Bangladesh	87. Iraq
8. Japan	28. Costa Rica	48. Peru	68. Montenegro	88. Uganda
9. USA	29. Georgia	49. Bulgaria	69. Paraguay	89. Rwanda
10. United Kingdom	30. Cyprus	50. Philippines	70. Nepal	90. Zambia
11. Denmark	31. Argentina	51. Kyrgyzstan	71. India	91. Tanzania
12. New Zealand	32. Poland	52. China	72. Mongolia	92. Pakistan
13. Austria	33. Mexico	53. Albania	73. Ukraine	93. West Bank & Gaza
14. Finland	34. Thailand	54. El Salvador	74. Indonesia	94. Mozambique
15. Ireland	35. Latvia	55. Bolivia	75. Turkey	95. Malawi
16. France	36. Colombia	56. Brazil	76. Venezuela	96. Afghanistan
17. Australia	37. Italy	57. Nicaragua	77. Moldova	
18. Israel	38. Portugal	58. Tajikistan	78. South Africa	
19. Luxembourg	39. Hungary	59. Guatemala	79. Greece	
20. Panama	40. Slovakia	60. South Korea	80. Cambodia	

Source: HelpAge International (2015)

Norway and Sweden for instance progressively invested in education, healthcare, employment and training, and social security throughout the life course long before they became “high income countries”. Likewise, countries such as Mauritius and Sri Lanka are lighting the way for other emerging economies. In Sri Lanka, long-term investments in education and health have generated a cumulative lifetime advantage for many older people, offering lessons to other South Asian countries such as India and Pakistan. While in Mauritius nearly all the over 60s receive a non-contributory pension, which offers lessons for Africa in providing income security for older people (HelpAge International 2015).

Population ageing a spur for development

Older people remain vulnerable in many ways as in previous generations, but they also have the potential to be active and productive long after the traditional age of retirement. Modern technological, economic and social environmental breakthroughs make all of this possible. Yet until relatively recently our understanding of the capacities and vulnerabilities of people in older ages has been tied to pre-industrial precepts about ageing and its challenges.

As countries age, they need to invest in supporting the contributions, experience and expertise of their growing number of older citizens. An example is Japan, a hyper-ageing country, with a third of the population over 60. As early as the 1960s, it adopted a comprehensive welfare policy, introduced universal healthcare, a universal social pension, and a plan for income redistribution, low unemployment rates and progressive taxation. This investment has paid off not just with a healthier labour force and increased longevity. As a result, Japan is currently not just the oldest, but also one of the healthiest and wealthiest countries in the world. Western European and Nordic countries also illustrate the range of approaches to policies on ageing and the associated positive results. A clear message is that greater social policy priorities, including social protection and universal social services are required to empower older people, without losing sight of making welfare systems more sustainable.

The post-2015 Sustainable Development Goals give us an unparalleled opportunity to shape the international and national development agenda that will have people and their prosperity at their core. The hard work of ensuring that the SDGs are implemented and deliver on their commitments will test our commitment to ending the most serious problems we face today. Identifying conceptually-clear, commonly-, and frequently-measured indicators that will enable global comparisons will be a major challenge. The work of the Global AgeWatch Index, and also the Active Ageing Index (Zaidi & Stanton 2015), provide strong insights into the larger task ahead for UN Member countries to improve both the credibility of indicators and their measurement. If we get this right we will be sure to capture progress and outcomes for all people all ages.

Cumulative gendered disadvantages

The experience of ageing varies dramatically between men and women, as documented by a wealth of research on ageing and gender, predominately from the perspective of high income countries. Cumulative gendered disadvantages in terms of socio-economic position, access to resources and roles and relationships have been shown to manifest in poorer outcomes for women in later life (Pratt, 1997, United Nations Economic Commission for Europe, 2009; Zaidi, Gasior, & Zólyomi, 2013). However, Knodel and Ofstedal (2003) amongst others have highlighted that a blanket assumption of a female disadvantage at older ages may be detrimental to supporting older people most in need and advocate the value of contextualised understandings of the role of gender in the ageing experience. We are only starting to understand gendered experiences of ageing in developing countries settings, and also discuss roles of both older men and women within families.

In terms of the dynamics of gender and health, a commonly observed phenomenon is the 'female survival advantage'. Indeed female life expectancy at birth started to exceed male life expectancy at birth in every country globally for the first time a decade ago (Barford, Dorling, & Smith, 2006). The female advantage is linked both to biological explanations and to different exposures and responses to environmental and social risk factors (Liang, Bennett, Sugisawa, Kobayashi, & Fukaya, 2003). The female survival advantage contributes to the fact that the majority of older people are women: 54% of the world's population aged 60 years or over are women and 61 per cent of the world's population aged 80 years or over are women (United Nations Population Division, 2015). The gender difference in old age survival is projected to eventually narrow in western countries as women are increasingly exposed to lifestyle-linked risk factors (Centers for Disease Control, 2004; Des Meules, Manuel, & Cho, 2003). However the dynamics of gender differences in old age survival in other world regions with varying socio-cultural and economic conditions has received minimal attention in the scientific literature. A recent study in Kenya's Nairobi slums showed unadjusted mortality rates did not differ significantly between older men and women and that the female advantage only becomes apparent after accounting for the cumulative influence of individual characteristics, social networks, health status and socio-economic status (Bennett, Chepngeno-Langat, Evandrou & Falkingham, 2016). Women and girls in this setting experience significantly more limited economic opportunities across the life course than their male counterparts and over two thirds of older women are currently unmarried, which is likely to be a measure of social and economic vulnerability given the patriarchal nature of Kenyan society (Ezeh, Chepngeno, Kasiira, & Woubalem, 2006). Thus, the findings on gender and old age survival suggests the female advantage in old-age survival may not apply to contexts where women experience very significant disadvantages across multiple life domains.

The female survival advantage has frequently been observed alongside a paradoxical finding that women have poorer self-rated health than men (Oksuzyan, Peterson, Stovring, Bingley, Vaupel, & Kristensen, 2011). This manifests into a greater length of time spent in poor health amongst women, indeed the female survival advantage itself extends the length of time women spend in poor health (Luy & Minagwa, 2014) and can mean females need extra care, especially during the late stages of their lives. As women outlast their male partners in most instances, they are also less likely to have access to informal care from their partners and may be at higher risk of social isolation. Older women and older men in many low- and middle-income countries have limited access to formal social security, but opportunities for paid employment and pension coverage can be particularly scarce for women (Lloyd-Sherlock, 2010). Whilst men and boys are engaged in care work (and this is likely to be underreported and underrepresented), women and girls shoulder a disproportionate responsibility for caring globally (Chopra, Kelbert, & Iyer, 2013). This can limit their economic opportunities and earning potential. However involvement in care work can also lead to greater role continuity and opportunities to contribute to their families and communities in later life. For example, the role of older women in particular in providing care for children and grandchildren affected by the HIV epidemic in sub-Saharan Africa has been highlighted and championed in academic literature and policy documents (Schatz, 2007; World Health Organization, 2007). Studies focusing on earlier stages of the life course show clear advantages of investing in the education and empowerment of women and girls for the health and wellbeing of women,

their families and their communities (Kar, Pascual, & Chickering, 1999; Schultz, 2002; Varkey, Kureshi, & Lesnick, 2009; Zaidi 2014).

Research methods

Data

The analyses draw on country level data across a number of income levels, gender equality and health indicators. The World Bank (2015) country classifications based on Gross National Income (GNI) per capita were used to categorise countries as high-income, middle-income and low-income. The United Nations (2014b) Gender Inequality Index (GII) was used to provide a measure of gender equality. The GII is a composite measure scored between 0 and 1 based on indicators which includes three broad categories of indicators relating to:

- health (the maternal mortality ratio and the adolescent (15-19 years) birth rate),
- empowerment (share of seats in parliament held by women, percentage of women aged 25 or older with secondary education or higher and percentage of men aged 25 or over with secondary education or higher) and
- the labour market (percentage of women aged 15 or over in the labour market and percentage of men aged 15 or over in the labour market).

Values closer to 0 indicate that the human development lost due to gender inequality is lower (for more information, see United Nations Development Fund, 2014b).

In addition, the percentage of older men and older women with secondary or higher education was used as measures of gender equality specific to the current cohort of older people. This data was compiled by the Global AgeWatch (2015) and sourced from Barro-Lee (2010). Moreover, life expectancy at 60 and healthy life expectancy at 60 were used as measures of health. Life expectancy at 60 is the average number of years a person aged 60 can expect to live, whilst healthy life expectancy at 60 is the average number of years a person aged 60 can expect to live in good health, both assuming age-specific mortality rates remain constant. These are key indicators of the health of older people and constitute two of the three health measures used for the Global AgeWatch Index (for details, see Zaidi 2013). Both measures are also available disaggregated by gender for the majority of countries. The data were compiled by the Global AgeWatch (HelpAge International, 2015), drawn from the World Health Organisation (2013) and the Institute for Health Metric and Evaluation (2010).

The analytic sample included 139 countries with complete data across the variables described above. Countries with missing data across the health and gender equality measures were disproportionately low-income countries: 39 per cent of United Nations member states classified as low-income could not be included due to incomplete data compared to 19 per cent of high income United Nations member states. This reflects a broader challenge of data availability for ageing research globally, and particularly in developing countries. However in total 72 per cent of United Nations member states were represented in the analysis, thus it covers a large majority of countries.

Methods

To investigate income level and gender differentials across the health and gender equality variables their average values for high-income, middle-income and low-income countries were calculated. The median was used as an alternative average to the mean due to the non-normal distribution of some of the variables. The interquartile range was presented as a measure of variability. The associations between the GII and healthy life expectancy at 60 and life expectancy at 60 stratified by gender and country income level were assessed using Spearman's Correlation Coefficient.

Key findings

Gender inequality and older people's educational attainment by country income level

Table 1 includes average Gender Inequality Index score by country income level. There is a clear relationship: low-income countries will be losing the most the human development potential due to gender inequality, with an average GII score over 4 times higher than that in high-income countries. The table also presents data on the average percentage of older men and women with secondary or higher education by country income level. The results show that globally older women have lower educational attainment than older men and that educational attainment of older people is worse in low-income countries than in high or middle-income countries. The trend by income level is particularly pronounced for older women: an older woman in a low-income country is over 24 times less likely to have completed secondary education than an older woman in a high-income country.

Moreover, there is also a greater inequality within country income levels. An older woman in a low-income country has approximately one quarter of the chance of having at least finished secondary education than an older man, whilst in a middle-income country the equivalent chance is approximately two thirds and in a high-income country the equivalent chance is approximately three quarters.

Table 1: Average Gender Inequality Index and educational attainment of older population by country income level and gender

	High-income		Middle-income		Low-income	
	Median	(IQR)	Median	(IQR)	Median	(IQR)
GII index score	0.13	(0.16)	0.43	(0.18)	0.60	(0.15)
Percentage of older population with secondary or higher education						
Men	68.6	(37)	27.5	(34)	9.2	(2)
Women	53.5	(50)	17.5	(29)	2.2	(4)

Notes: Authors' analyses of educational attainment data compiled by HelpAge International (2015), the United Nations Gender Inequality Index (2014b) and country income data from the World Bank (2015). Median refers to the value of the second quartile (or midpoint) of the frequency distribution of the variable. IQR (interquartile range) is the difference between the third and first quartile and is used as a measure of variation.

Limited educational attainment of older women in low-income countries is indicative of a systematic disadvantage of women in the society from early childhood. These experiences and further disadvantages during the subsequent stages of the life course place them at a higher risk of living in poverty in later life (Zaidi 2014).

Life expectancy and healthy life expectancy at 60 by country income level and gender

Table 2 presents average life and healthy life expectancy at 60 by country income level and gender. There is strong evidence of acute inequality between country income levels for older women. For example, older women living in a high-income country can expect to live almost six and a half years longer in good health from her 60th birthday than an older woman in a low-income country, whilst differences amongst men are less stark. There is a clear female survival advantage in later life in high-income countries: on average, older women in these countries can expect to live three years longer than their male counterparts. However, in low and middle-income countries women can only expect to live only one additional year of life over their male counterparts. The findings on healthy life expectancy show that this difference by country income level are even more pronounced: whilst older women in high-income countries enjoy on average an additional 2.8 healthy years as compared to older men, in low-income countries there is hardly any female advantage in healthy life expectancy.

Table 2: Average life and healthy life expectancy by country income level and gender

	High-income		Middle-income		Low-income	
	Median	(IQR)	Median	(IQR)	Median	(IQR)
Life expectancy at 60 years						
Men	22.0	4.0	18.0	3.0	16.0	1.0
Women	25.0	2.0	19.0	4.0	17.0	2.0
Female survival advantage (years)	3.0	-	1.0	-	1.0	-
Healthy life expectancy at 60 years						
Men	16.0	2.0	13.7	3.0	12.3	18.8
Women	18.8	2.0	15.4	3.0	12.4	3.0
Female healthy survival advantage (years)	2.8	-	1.7	-	0.1	-
Average percentage of life expectancy at age 60 spent in good health						
Men	72%		76%		77%	
Women	75%		81%		73%	

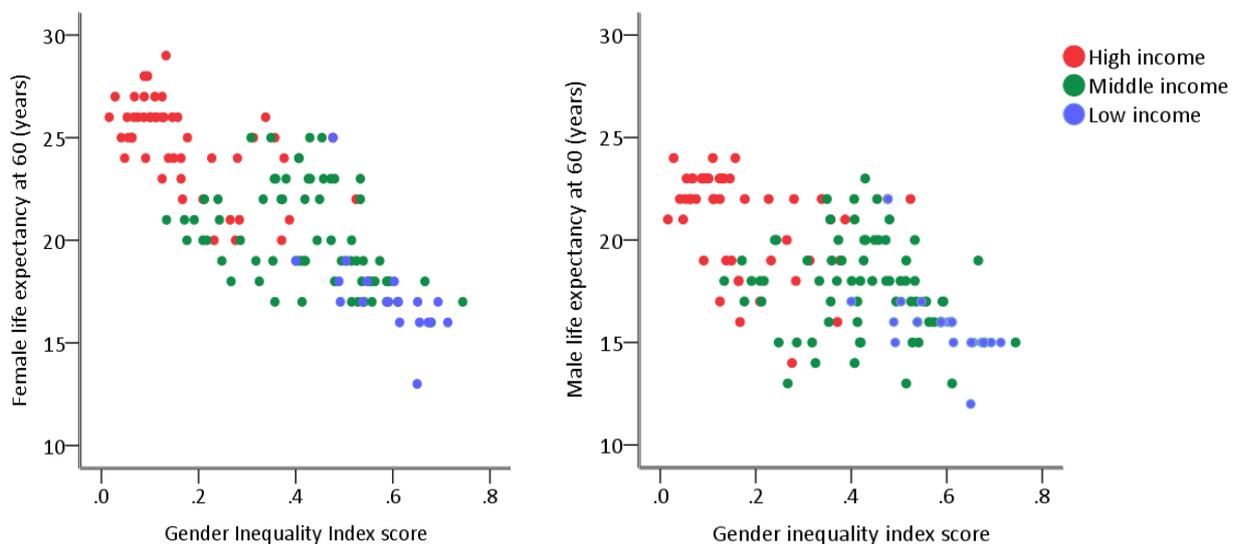
Notes: Authors' analyses of life expectancy at 60 years and healthy life expectancy at 60 years compiled by HelpAge International (2015), the United Nations (2014b) Gender Inequality Index and country income data from the World Bank (2015). Median refers to the value of the second quartile (or midpoint) of the frequency distribution of the variable. IQR (interquartile range) is the difference between the third and first quartile and is used as a measure of variation. The bottom rows are calculated by dividing median healthy life expectancy at 60 years by median life expectancy at 60 years.

Furthermore, older women in low-income countries can actually expect to spend a lower percentage of their life expectancy at age 60 in good health, whilst an older man in a developing country can expect to spend 77 per cent of his remaining life expectancy at 60 in good health, an older women can only expect to spend 73 per cent of her remaining life expectancy at 60 in good health.

Life expectancy at 60, healthy life expectancy at 60 and gender inequality

Figure 1 illustrates the relationship between male and female life expectancy at age 60 and Gender Inequality Index (GII) score. The first graph shows clearly that older women enjoy longer life expectancy at age 60 in countries with lower levels of gender inequality.

Figure 3: Female/male life expectancy at 60 by GII score and country income level



Notes: Authors' analyses of life expectancy at 60 years data compiled by HelpAge International (2015), the United Nations (2014b) Gender Inequality Index and country income data from the World Bank (2015).

The relationship is weaker for men's life expectancy (shown on the second graph), but still apparent. This trend suggests that living in a country with high levels of gender equality is beneficial for both older women and older men. The data points are colour coded by country income level and reveal that even amongst countries of the same income level, those with lower levels of gender inequality achieve higher life expectancy at 60.

These trends are confirmed in table 3 which presents the correlation coefficients for the relationship between life expectancy and healthy life expectancy at 60 for women and men and gender inequality index, collectively and by country income level. It is evident that there is a strong statistically significant correlation between both life expectancy and health life

expectancy at 60 and the Gender Inequality Index for older men and older women. The correlation is particularly strong for life expectancy at 60 in low-income countries, for both men and women. These results identify a specific policy priority for low-income countries: reducing gender inequality will have the most benefit in terms of improving health outcomes.

Table 3: Spearman's correlation coefficient for the relationship between health indicators and the GII index, by country income level and gender

	High-income	Upper middle income	Low-income	All
Men				
Life expectancy at 60	-0.477***	-0.234**	-0.758***	-0.642***
Healthy life expectancy at 60	-0.439***	-0.289**	-0.099	-0.612***
Women				
Life expectancy at 60	-0.569***	-0.497***	-0.779***	-0.800***
Healthy life expectancy at 60	-0.589***	-0.573***	-0.444*	-0.799***

***p<0.001, **p<0.01, *p<0.05

Notes: Authors' analyses of life expectancy at 60 years and healthy life expectancy at 60 years data compiled by HelpAge International (2015), the United Nations (2014b) Gender Inequality Index and country income data from the World Bank (2015). A correlation coefficient close to -1 is indicative of a strong negative correlation. A correlation coefficient close to 1 is indicative of a strong positive correlation.

Discussion

Experiences of ageing vary enormously by where an individual lives, but also by their gender. The empirical results in this article highlight that older women in low-income countries are disproportionately disadvantaged relative to both their male counterparts and to their female counterparts in higher income countries. The average percentage of older women with at least secondary education in a low-income country stands at just 2.2 per cent - indicative of lifetime of disadvantage and curtailed opportunity and empowerment. The emergence of a universal female survival advantage in life expectancy at birth has been attributed to reductions in maternal mortality and the emancipation of women earlier in the life course (Barford, Dorling, & Smith, 2006). Indeed the United Nations Millennium Development Goals (2000-2015) included a standalone goal on maternal mortality and a goal on gender equality and female empowerment with explicit indicators on school enrollment amongst girls and literacy amongst young women. The goals can be linked to achievements including the near doubling of the number of women in parliament and a near halving of the maternal mortality ratio over the last twenty years (United Nations, 2015b). Yet, the development discourse has given minimal attention to women beyond reproductive age, despite the fact that women aged over 50 years account for almost one quarter of the world's population (Global AgeWatch Index, 2015).

The results in this article show the female survival advantage in life expectancy at age 60 is much more modest in low and middle-income countries than in high-income countries. Moreover, we find that older women in low income countries not only spend a greater absolute length of time in poor health relative to older men, but that they also spend a greater percentage of their remaining life expectancy at age 60 in poor health than older men. This speaks to an urgent need to provide for the health and economic wellbeing of older women in low-income countries.

The findings presented herein also examined the interplay between country income, health outcomes in later life and level of potential human development lost to gender inequality, as measured by the United Nation's Gender Inequality Index (GII). The GII draws on health indicators which focus on younger women (maternal mortality ratio and the adolescent birth rate) but also empowerment and labour force participation indicators without an upper age limit (share of seats in parliament held by women, labour force participation disaggregated by gender and educational attainment disaggregated by gender). The results show a very clear correlation between lower levels of gender inequality and better life expectancy and healthy life expectancy at 60 for older people. Older women *and* older men fare comparatively better when they live in societies that realise the contributions of women to the development process, regardless of whether they live in a country classified as low-income, middle-income or high-income. This provides strong evidence for reducing gender inequalities and empowering women globally, and builds on existing literature which shows improving the status of women is beneficial for their families and communities (Kar, Pascual, & Chickering, 1999; Schultz, 2002; Varkey, Kureshi, & Lesnick, 2009; Zaidi, 2014). Given the inequalities faced by older women, investment in the status and opportunities of this age group should be given greater prominence alongside investment in younger women and girls.

The post-2015 SDGs have given us an unparalleled opportunity to shape the international and national development agenda, with people and their wellbeing at their core. In this way, the SDGs represent a key milestone for placing older people and ageing on the development agenda. The SDGs also go further than their predecessors in tackling gender inequality and championing the position of women and girls. The goal dedicated to gender equality, goal 5: achieve gender equality and empower all women and girls, has a much broader (and age inclusive) remit than its counterpart in the Millennium Development Goals. Comparable data on older people globally is scarce. Yet, comparable data on older people globally by gender is even scarcer. The commitment to disaggregating indicators by relevant characteristics in the SDGs will not only make it possible to highlight the position of older people separately from other adults and to monitor progress in supporting older people, but also to monitor the inequalities among the older people and monitor progress in supporting older men and older women. Promoting access to education, employment and training, healthcare and social security throughout the life course contribute to wellbeing for all and help insure positive outcomes in later life. The development discourse focused on the early life stages has long recognized the centrality of gender equality and female empowerment to achieving its goals. The emerging ageing and development discourse must also place gender firmly on the agenda in order to fulfill our global commitments to 'leave no one behind' and 'to reach the furthest behind first'.

References

- Barford, A., Dorling, D., & Smith G.D. (2006). Life expectancy: Women now on top everywhere. *British Medical Journal*, 332 (7545), 808.
- Barro-Lee. (2010). *Educational attainment database*. Accessed 17 May 2016 from: <http://barrolee.com>.
- Bennett, R., Chepngeno-Langat, G., Evandrou, M., & Falkingham, J. (2016). Gender differentials and old age survival in the Nairobi slums, Kenya. *Forthcoming*.
- Centers for Disease Control. (2004). *Deaths: Final data for 2002*. Washington, DC: United States National Vital Statistics Reports, Volume 53, Number 5.
- Chopra, D., Kelbert A., & Iyer, P. (2013). *A feminist political economy analysis of public policies related to care: A thematic review*. Empowerment of Women and Girls Evidence Report Number 9. Institute of Development Studies, Brighton, United Kingdom.
- Des Meules, M., Manuel, D., & Cho, R. (2003). Mortality, life and health expectancy of Canadian women. *Women's Health Surveillance Report*. Ottawa: Canadian Institute for Health Information and Health Canada.
- Ezeh, A., Chepngeno, G., Kasiira, A., & Woubalem, Z. (2006). The situation of older people in poor urban settings: The case of Nairobi, Kenya. In B. Cohen, & J. Menken (Eds.), *Aging in sub-Saharan Africa: Recommendations for furthering research* (pp. 189–213). Washington, DC: National Academies Press.
- Global AgeWatch Index. (2015). *Older women count*. Accessed 17 May 2016 from: <http://www.helpage.org/global-agewatch/population-ageing-data/infographic-older-women/>.
- HelpAge International. (2015). *Global AgeWatch Index 2015: Insight report*. London: HelpAge International.
- Institute for Health Metrics and Evaluation. (2010). *Global burden of disease study*. Accessed 17 May 2016 from: http://ghdx.healthmetricsandevaluation.org/sites/default/files/record-attached-files/IHME_GBD_2010_HALE_BY_COUNTRY_1990_2010_Y2010M02D23.CSV.
- Kar, S., Pascual, C.A., & Chickering, K. (1999). Empowerment of women for health promotion: A meta-analysis. *Social Science & Medicine*, 49 (11), 1431-1460.
- Knodel, J., & Ofstedal, M. (2003). Gender and aging in the developing world: Where are the men? *Population and Development Review*, 29 (4), 677-698.
- Liang, J., Bennett, J.M., Sugisawa, H. Kobayashi, E., & Fukaya, T. (2003). Gender differences in old age mortality: Roles of health behavior and baseline health status. *Journal of Clinical Epidemiology*, 56 (6), 572-582.
- Lloyd-Sherlock, P. (2010). *Population ageing and international development: From generalisation to evidence*. Bristol: Policy Press.
- Luy, M., & Minagwa, Y. (2014). Gender gaps-life expectancy and proportion of life in poor health. *Health Reports*, 25 (12), 12-19.
- Oksuzyan, A., Peterson, I., Stovring, A., Bingley, P., Vaupel, J.W., & Kristensen, K. (2009). The male-female health-survival paradox: A survey and register study of the impact of sex-specific selection and information bias. *Annals of Epidemiology*, 19 (7), 504-511.
- Pratt, C. (1997). Ageing: A multigenerational, gendered perspective. *Bulletin on Ageing*, 2 (3), 1-9.

- Schatz, E (2007). 'Taking care of my own blood': Older women's relationships to their households in rural South Africa. *Scandinavian Journal of Public Health*, 35 (69 suppl.), 147-154.
- Schultz, T. (2002). Why governments should invest more to educate girls. *World Development*, 30 (2), 207-225.
- United Nations. (2000). *United Nations Millennium Declaration*. Accessed 31 May 2016 from: <http://www.unmillenniumproject.org/documents/ares552e.pdf>.
- United Nations Development Programme. (2014a). *Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience. Human Development Report 2014*. Accessed 21 April 2015 from: <http://hdr.undp.org/sites/default/files/hdr14-report-en-1.pdf>.
- United Nations Development Programme. (2014b). *Gender Inequality Index*. Accessed 17 May 2016 from: <http://hdr.undp.org/en/composite/GII>.
- United Nations. (2015a). *The Sustainable Development Goals*. Accessed 31 May 2016 from: <http://www.un.org/sustainabledevelopment/sustainable-development-goals/> (Accessed 31st May 2016).
- United Nations. (2015b). *The Millennium Development Goals Report 2015*. Accessed 30 May 2016 from: [http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20\(July%201\).pdf](http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf).
- United Nations Economic Commission for Europe. (2009). *Gender equality, work and old age. Policy Brief on Ageing No. 2*. Geneva: United Nations Economic Commission for Europe.
- United Nations Population Division. (2015). *World Population Ageing Report 2015*. Accessed 31 May 2016 from: http://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf.
- Varkey, P. Kureshi, S., & Lesnick, T. (2010). Empowerment of women and its association with the health of the community. *Journal of Women's Health*, 19(1), 71-76.
- World Bank. (2015). *Country income classifications*. Accessed 31 May 2016 from: <http://data.worldbank.org/country>.
- World Health Organization. (2013). *Global Health Observatory Data Repository: Life expectancy data by country*. Accessed 17 May 2016 from: <http://apps.who.int/gho/data/view.main.680>.
- World Health Organization. (2007). *Impact of AIDS on older people in Africa: Zimbabwe Case Study*. Accessed 31 May 2016 from: http://apps.who.int/iris/bitstream/10665/67545/1/WHO_NMH_NPH_ALC_02.12.pdf.
- Zaidi, A. (2013). *Global AgeWatch Index 2013: Purpose, Methodology and Results*. Report prepared for HelpAge International, Centre for Research on Ageing, University of Southampton. Accessed 31 May from: <http://www.helpage.org/download/52949b561453d/>
- Zaidi, A. (2014). *Life cycle transitions and vulnerabilities in old age: A review*. Occasional Paper, UNDP Human Development Report Office, New York. Accessed 31 May from: http://hdr.undp.org/sites/default/files/hdr_2014_zaidi_final.pdf

Zaidi, A., & D. Stanton (2015). *Active Ageing Index 2014: Analytical Report*. Geneva: United Nations Economic Commission for Europe & Brussels: European Commission, Directorate General for Employment, Social Affairs and Inclusion.

Zaidi, A., Gasior, K. & Zólyomi, E. (2013). Poverty among the older women and pensions policy in the European Union countries. In B. Marin (Ed.), *Welfare in an idle society? Reinventing retirement, work, wealth, health and welfare* (pp. 97-108). London: Routledge.

Challenges and opportunities of population ageing in the CIS+ countries

Alexandre Sidorenko¹

Abstract. This article reviews the main characteristics of population ageing, its societal implications and possible policy responses in the twelve countries of the former Soviet Union. In spite of demographic, cultural, and economic diversity the countries under consideration share several common characteristics, such as joint political history, as well as the context and content of social policy. These common characteristics are essential for understanding the specifics of the ongoing process of multifaceted transition, including demographic transition, in these countries. As elsewhere in the world, population ageing in the ex-soviet states presents both challenges and opportunities, which should be carefully examined and taken into consideration while designing and implementing the measures of adjustment to population changes in this unique group of countries.

Keywords: ageing, Commonwealth of Independent States, demography, Eastern Europe.

Introduction

This review article is dealing with a unique group of countries - the Commonwealth of Independent States (CIS+), the former constituencies of the Soviet Union. The CIS+ group includes twelve countries: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan. The 'plus' symbol is added to the acronym to reflect the fact that Georgia is actually a former member of the group as it withdrew in 2006. Three other ex-soviet republics - Estonia, Latvia and Lithuania - have become member states of the European Union since 2004, and therefore are not included in the article's deliberations. CIS+ countries are united by the two common characteristics: geography and political history. The former characteristic is rather ambiguous as the countries included in this group are spread over vast continental space from the eastern border of the European Union to the Pacific coast. The latter characteristic, political history, is a more uniform attribute of the CIS+ grouping as all twelve countries used to belong for seventy years to the same political, administrative and economic entity - the Union of Soviet Socialist Republics [USSR] - and all of the today's independent states were dependent territories of the Russian Empire, some of them for centuries. The common political history is of particular relevance to the subject of this article as it implies that uniformity of institutions as well as

¹ European Centre for Social Welfare Policy and Research, Vienna, Austria. (sidorenko.alexandre@gmail.com)

uniform social policy context and content may persist, and indeed they do. At the same time, in spite of long-term political, administrative and other forms of consistency and subordination, each CIS+ state has preserved its national identity and cultural essentials, including religious attachments. Various national particulars are among the primary causes of diversity of this group, including demographic diversity.

The typical geopolitical designation attributable to the CIS+ countries is 'economies in transition'. This designation however is not unique for the CIS+ countries and has been used for a much broader scope of European and Asian countries. International Monetary Fund, for instance, includes in the category of 'transition economies', along with the CIS+ countries, also Baltics, some Central European States, Southeast Europe EU members, Non-EU Southeast Europe, or Western Balkans, and several Asian countries, such as Mongolia and Vietnam (Roaf, Atoyamn, Joshi, & Krogulski, 2014). Most often, however, the term 'economies-in-transition' refers to the two groups of countries belonging to the region of the United Nations Economic Commission for Europe²:

- countries of Eastern Europe, Caucasus, and Central Asia (EECCA): the above mentioned twelve countries of the former Soviet Union;
- countries of South-Eastern Europe (SEE): Albania, Montenegro, Bosnia and Herzegovina, Serbia, Croatia, Turkey, and The former Yugoslav Republic of Macedonia.

This article is dealing with the EECCA group as its membership is identical to that of the CIS+ grouping. A key word 'transition' applied to the group denotes primarily an economic transition of countries from centrally planned to market economies. Accordingly, the ultimate content of the process of transition has been a reintegration of the former communist countries into the global economy, and for many ex-communist countries the process of accession to the European Union has been the most important catalyst for transitional reforms (Roaf et al., 2014). The perspective of European integration, however distant, serves as a main stimulus of societal reforms even in some non-EU countries of the former Soviet Union, such as Georgia, Moldova and Ukraine.

In addition to economic content, the term 'transition' entails profound changes in the political and social fabrics of the CIS+ societies. The gist of political transition was supposed to be a passage from communism to democracy; however, in too many places it has become a chimeric mixture of incoherent processes, such as efforts aimed at (re)discovering 'national roots', and ongoing, often futile, battles of pro-democracy forces with kleptocratic regimes controlled by oligarchy and manifested in proliferation of endemic corruption. The process of transition began after the collapse of the Soviet Union in 1991 and is still far from completion (Chawla, Betcherman, & Banerji, 2007; European Bank, 2013; Roaf et al., 2014) owing to, among other reasons, tenacious resistance to reforms by political and economic power

² The region of the United Nations Economic Commission for Europe includes 56 countries: all countries of Europe, two countries in North America (Canada and United States), five countries of Central Asia (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) and one country of Western Asia (Israel) (United Economic Commission for Europe, 2016).

holders. As noted by one IMF official, “the Commonwealth of Independent States (CIS), are still far from completing transition, and have gone through repeated cycles of hope followed by crisis” (Lipton, 2014 - online document). It is against this backdrop of incomplete and unfulfilled societal transition that another type of transition, demographic transition, has been unfolding in many CIS+ countries.

Distinctiveness and diversity of population ageing in the CIS+ countries

This section is confined to highlighting the distinctive parameters of population ageing in the CIS+ countries, some of which, as has been earlier noted, have so far no parallels in world population history (Botev, 2012). One of the distinctive characteristics of the CIS+ countries is their demographic diversity. This group of countries occupies a wide range on the scales of rating of the world countries by the proportion of older persons in their populations or by the median age of their populations (Sidorenko, 2010; Botev, 2012). On those scales Ukraine appears demographically ‘oldest’ and Tajikistan demographically ‘youngest’ country in the grouping, with more than 100 world countries scattered between these two CIS+ countries. On the basis of these two demographic parameters the twelve CIS+ countries can be divided in two sub-groups: ‘younger’ and ‘older’ countries (Table), with Kazakhstan occupying an interjacent position.

Table 1: Demographic sub-groups of the CIS+ countries (2015)

Sub-groups of the CIS+ countries	Percentage of 60+ years old	Percentage of 65+ years old	Median age
‘Younger’ countries			
Azerbaijan	10	5.6	30.9
Kyrgyzstan	7.1	4.2	25.1
Tajikistan	5	3	22.5
Turkmenistan	6.9	4.2	26.4
Uzbekistan	7.4	5	26.3
Kazakhstan	10.7	6.7	29.3
‘Older’ countries			
Armenia	16.3	10.8	34.6
Belarus	20.3	14	39.6
Georgia	19.3	14	37.5
Moldova	16.6	10	35.6
Russia	20	13.4	38.7
Ukraine	22.6	15.3	40.3

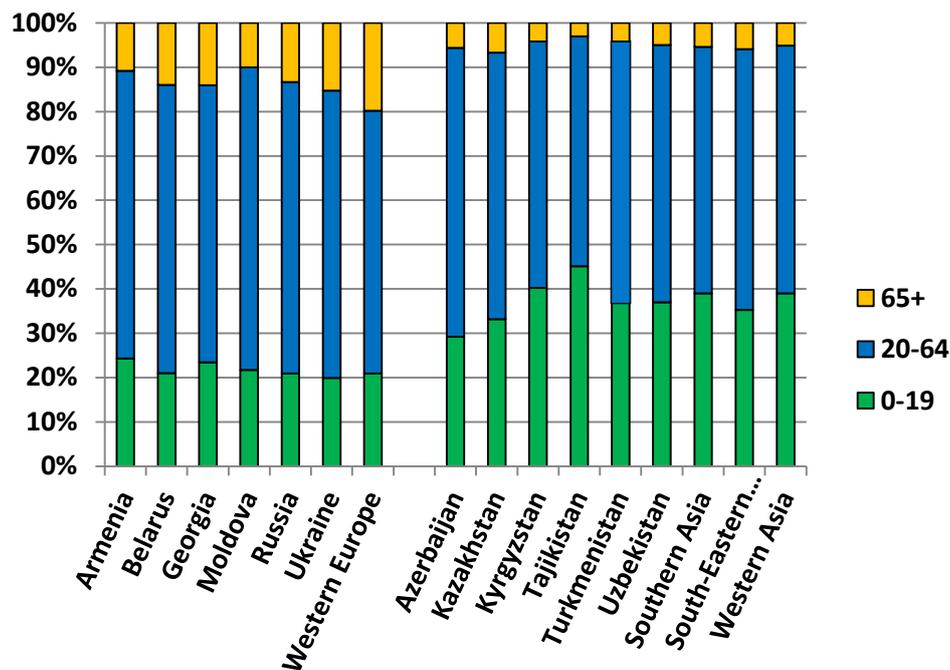
Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

Age structure of population

Demographic diversity of the CIS+ countries is revealed in the age structure of their populations. While the age structure of population in the ‘older’ sub-group resembles the

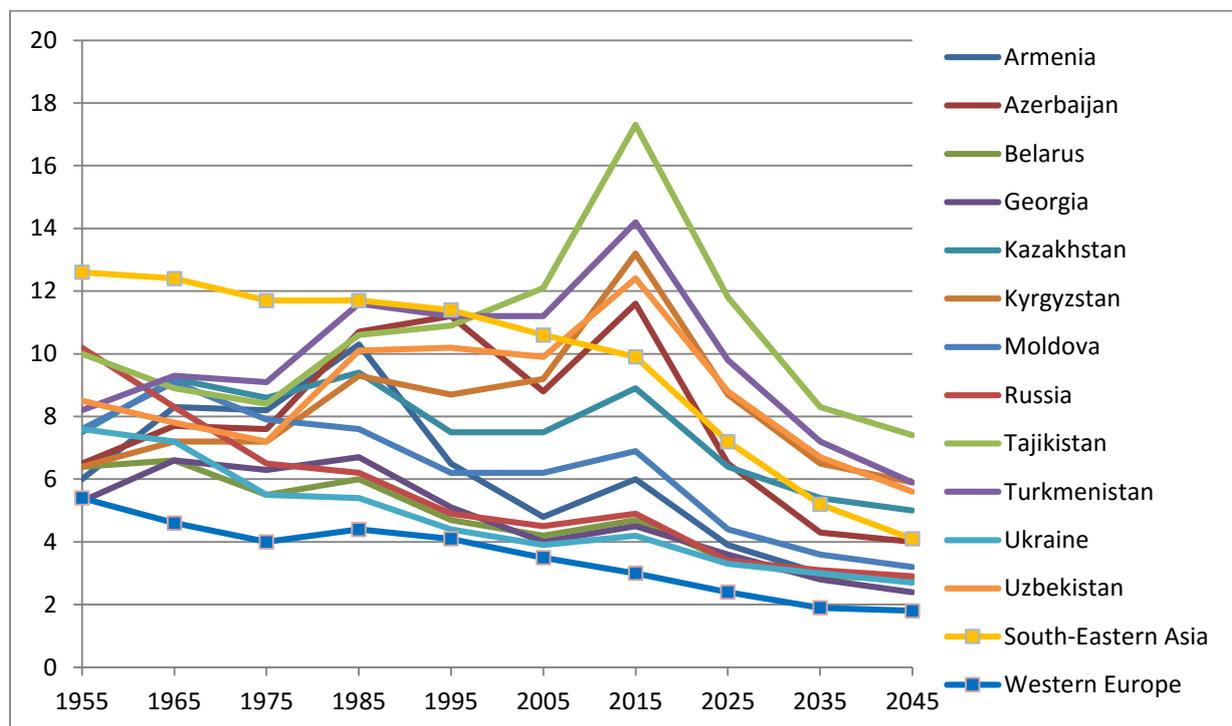
Western European patterns, the countries of the 'younger' sub-group are much closer by this characteristic to the countries of Asian sub-regions comprising predominantly developing countries (Figure 1).

Figure 1: Population Structure in the CIS+ Countries; Asia and Western Europe, 2015



Source: United Nations (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website. <http://esa.un.org/unpd/wpp/DataQuery/>

Demographic structure of society can also be mirrored in such demographic indicator as potential support ratio: the ratio between the number of presumably working age (supporting) population and presumably post-working age (supported) population. This indicator is of particular significance as besides illuminating demographic processes it points to socio-economic implications of demographic transition. The dynamics of potential support ratio in the CIS+ countries also has specific sub-group patterns: in the countries of 'younger' sub-group this indicator has been steadily growing until 2015 and is projected to rapidly decrease in the following years (Figure 2). In the 'older' sub-group of the CIS+ countries the same indicator has been declining with several periods of rebound and is projected to continue its descent after 2015. The decline of potential support ratio is a global phenomenon which is caused by shrinking the 'working age' population and increasing the 'post-working age' population (United Nations, 2015b). Yet, in countries at different stages of demographic transition the decline varies in time and speed – just as it is noticeable in the two sub-groups of the CIS+ countries.

Figure 2: Potential support ratio by age: Ratio of population 20-64 years old per population 65+ plus

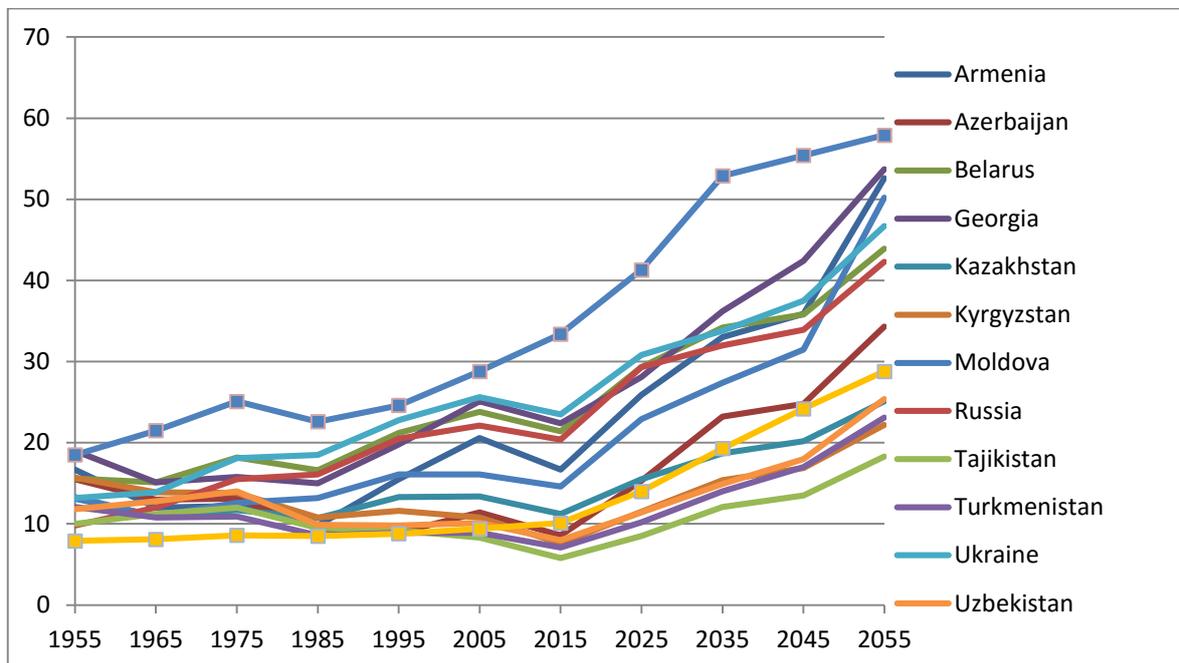
Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

The 'inverse' indicator of the potential support ratio, the old age dependency ratio, demonstrates an opposite dynamics (Figure 3), again with sub-group specific patterns: while this indicator since the middle of current decade has been ascending in *all* CIS+ countries, the countries of 'older' CIS+ sub-group have led the ascent followed by the countries of the younger sub-group. The total dependency ratio, a sum of ratios of 'pre-working age' (children) and 'post-working age' (old age) populations to 'working age' population, demonstrates its own dynamics which is also sub-group-specific (Figure 4). The total dependency ratio was growing until the last quarter of previous century in Central Asian countries (excluding Kazakhstan where it stopped growing earlier) and Azerbaijan and then has begun a decline. This decline is projected to continue well into the middle of the current century with a rebound expected later. In Azerbaijan the rebound of this indicator has started earlier, around the middle of second decade of this century, at almost the same time as it has occurred in the 'older' sub-group of the CIS+ countries.

The relative values of two components (child and old age) of the total dependency ratio vary between the sub-groups of the CIS+ countries. For instance, in Tajikistan the child component was making up to 90 per cent of the total dependency ratio in 1990s³.

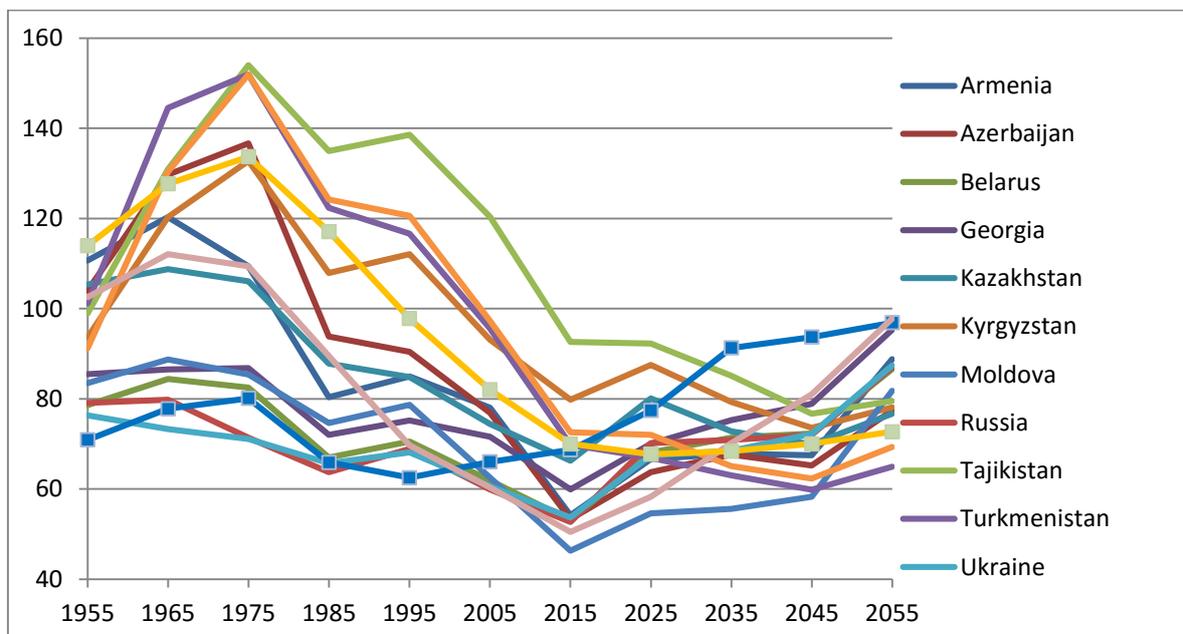
³ Tajikistan was selected as a demographically 'youngest' country within the CIS+ group to illustrate the pattern of dependency ratio dynamics in Central Asian countries.

Figure 3: Old age dependency ratio: ratio of population aged 65+ per 100 pop. 20-64 years old



Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

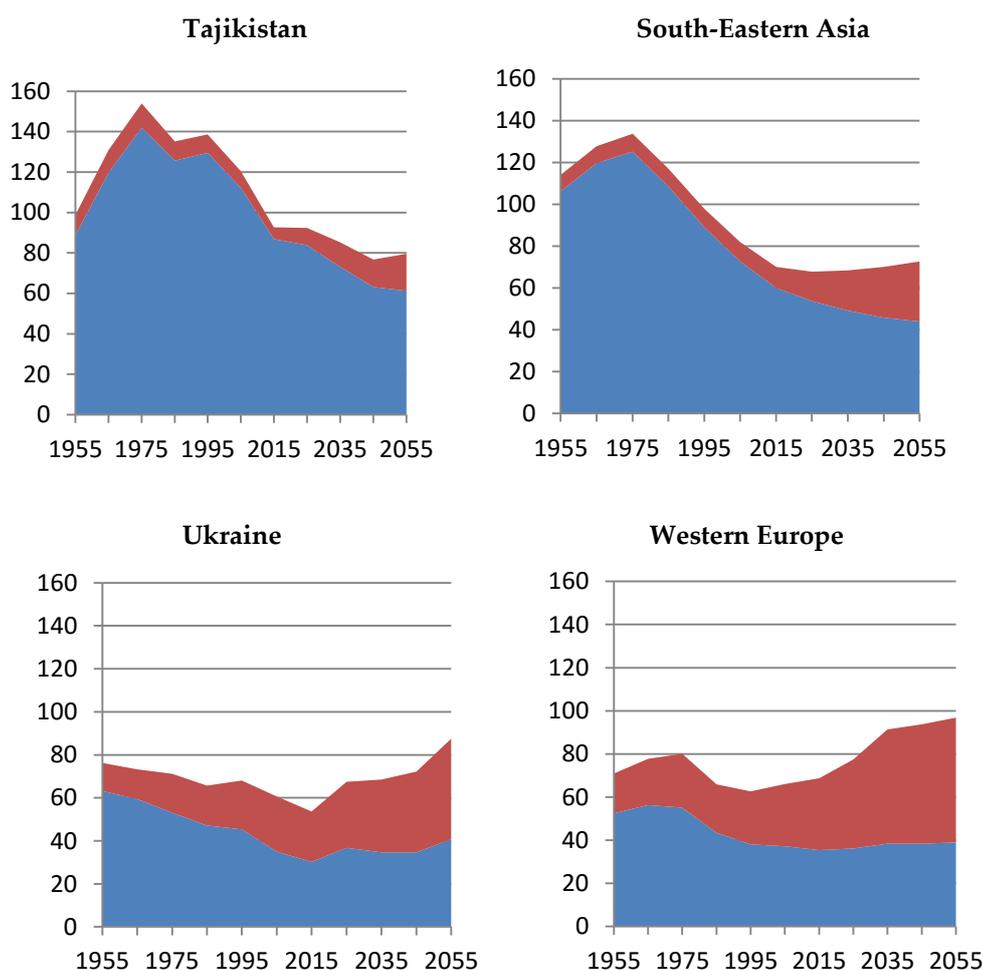
Figure 4: Total dependency ratio (ratio of population aged 0-19 and 65+ per 100 population 20-64)



Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

The decline in the child dependency indicator was and is projected to be the contributor to a decline of the total dependency ratio up to the second half of the twenty-first century, and only at later stages the old age component would start furthering a rebound of the total dependency ratio. This period of declining total dependency, which in case of Tajikistan is projected to last for several decades.

**Figure 5: Child dependency ratio & old-age dependency ratio
(blue shades 0-19 years; red shades 65+)**



Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

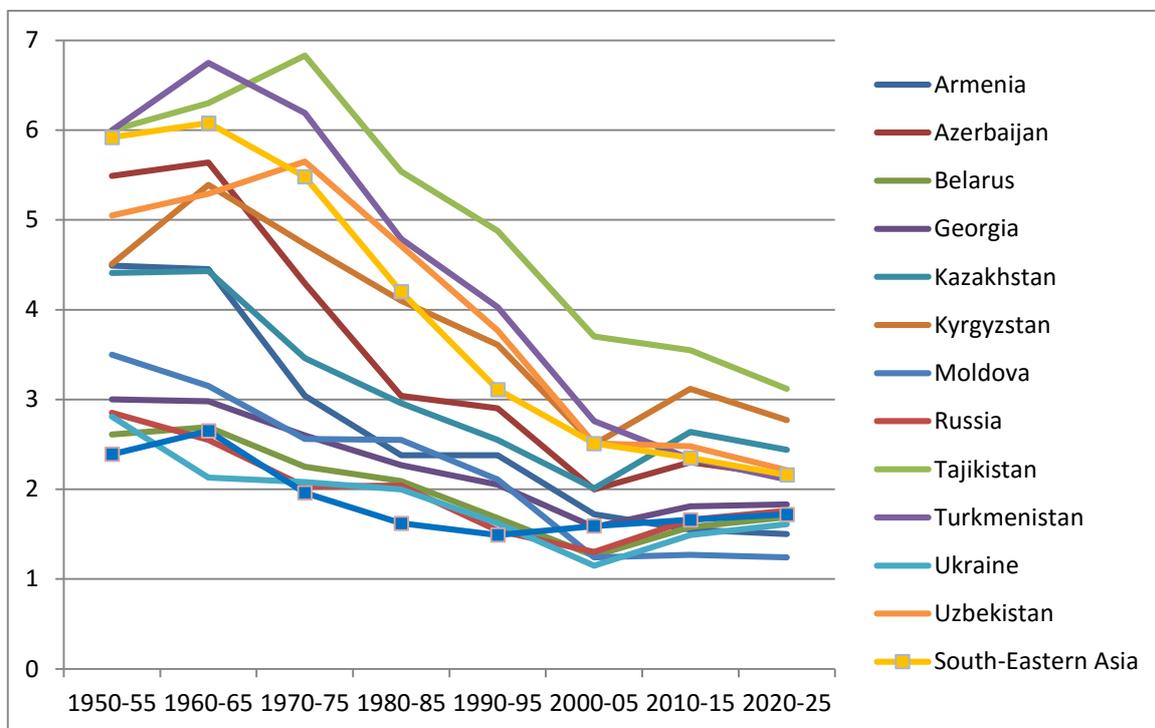
It corresponds to the period of availability of the ‘first demographic dividend’ when a ‘window of opportunity’ for adjusting to demographic transition stays open (United Nations, 2015b). In Ukraine, the demographically oldest CIS+ country, the relative value of the old age component in the total dependency ratio in 2015 was 43 per cent, and the relative value of the child component - 57 per cent. As shown in Figure 5, after 2015 the total dependency ratio in Ukraine, as well as in other demographically older CIS+ countries, is projected to grow due to increase of its old age component, following the pattern of Western European countries, thus

leaving behind the period of availability of the first demographic dividend. Yet, for this sub-group of the CIS+ countries a 'second demographic dividend' might become available, provided these countries would be able to introduce measures for investing in human capital and promoting retirement savings and, as a result, increase industrial investment and enhance economic growth (United Nations, 2015b).

Changes in fertility and mortality - major mechanisms of population ageing

Of the two primary causes of population ageing, low fertility and low mortality, the former one is obviously at play in all ex-soviet states, even though significant differences exist between the two sub-groups (Figure 6).

Figure 6: Total fertility (children per woman)

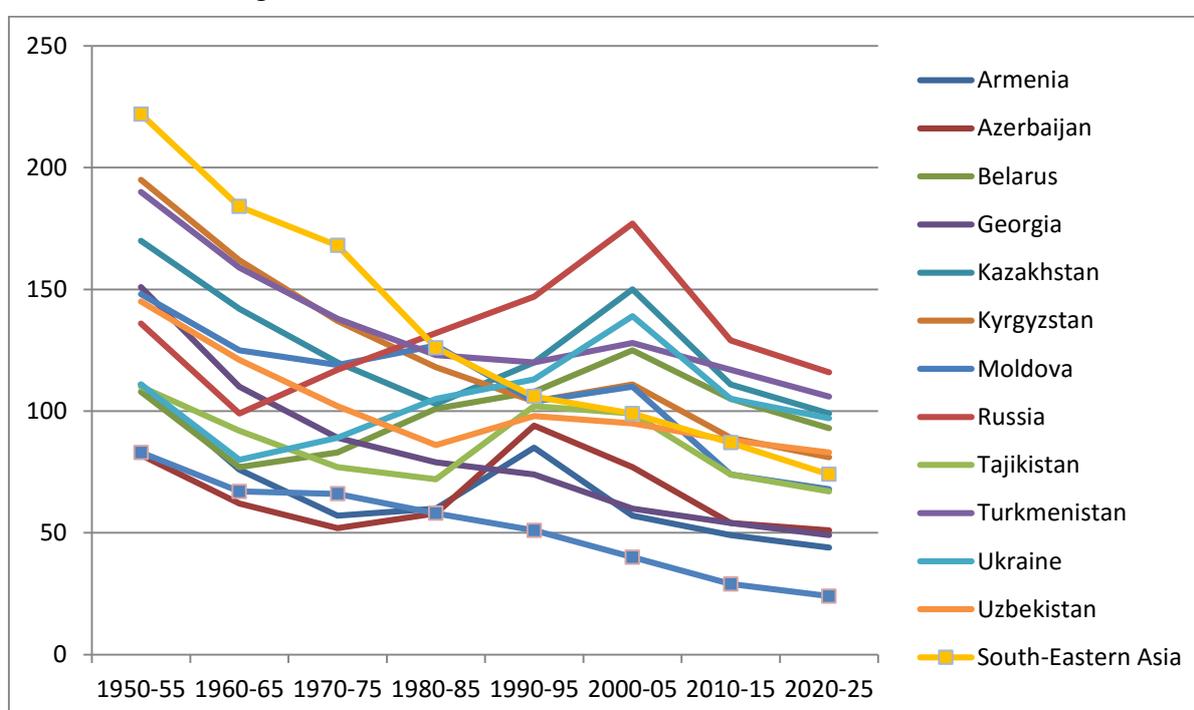


Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

During the current decade the highest level of total fertility was registered in Kyrgyzstan (3.55 children per woman) and the lowest – in Moldova (1.27 children per woman). For comparison, the corresponding figures in South-Eastern Asia and Western Europe during the same period were 2.35 and 1.66, respectively. It should be noted that in Georgia during the current decade the total fertility rate has rebounded above the replacement level – not a small achievement for a country experiencing a significant population decline (United Nations Population Fund, 2015).

Mortality, however, is much higher in the CIS+ countries than in more developed countries. The excess mortality is registered in practically all age groups of the CIS+ countries, but its levels are particularly striking among younger populations, including the working age population. As shown in Figure 7, during the period 2010-2015, the highest number of deaths in the population group 15 to 50 years old among the CIS+ countries was in Russia: it was more than four times higher than in the same age group of the Western European countries and almost 1.5 times higher than in the countries of South-Eastern Asia. The mortality in the same age group of Russian men during 2000-2015 was more than five times higher than the mortality of the Western European men and 1.8 times higher than the mortality of South-Eastern Asian men of the same age (Figure 7).

Figure 7: Adult mortality between age 15 and 50 years old, 35q15 (deaths under age 50 per 1,000 alive at age 15), both sexes combined



Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

The following CIS+ countries (in descending order) had the mortality levels higher than those of Western European and South-Eastern Asian countries but lower than the corresponding figures in Russia: Belarus, Kazakhstan, Kyrgyzstan, Moldova, Turkmenistan and Ukraine. In Azerbaijan, Armenia, Georgia and Tajikistan the mortality levels among men at the age 15 to 50 years were below the corresponding levels in the countries of South-Eastern Asia, but higher than in Western European countries. While during the second half of the twentieth century and the first decade of the twenty-first century the mortality levels in the 15 to 50 age group had been descending in most parts of the world including Western Europe and South-Eastern Asia, in the CIS+ countries, with the notable exception of Georgia, it had been growing

until the beginning of this century before starting to decline (Figure 7). Given the history of reversibility of mortality indicators in many CIS+ countries, it remains to be seen whether the current decline is sustainable.

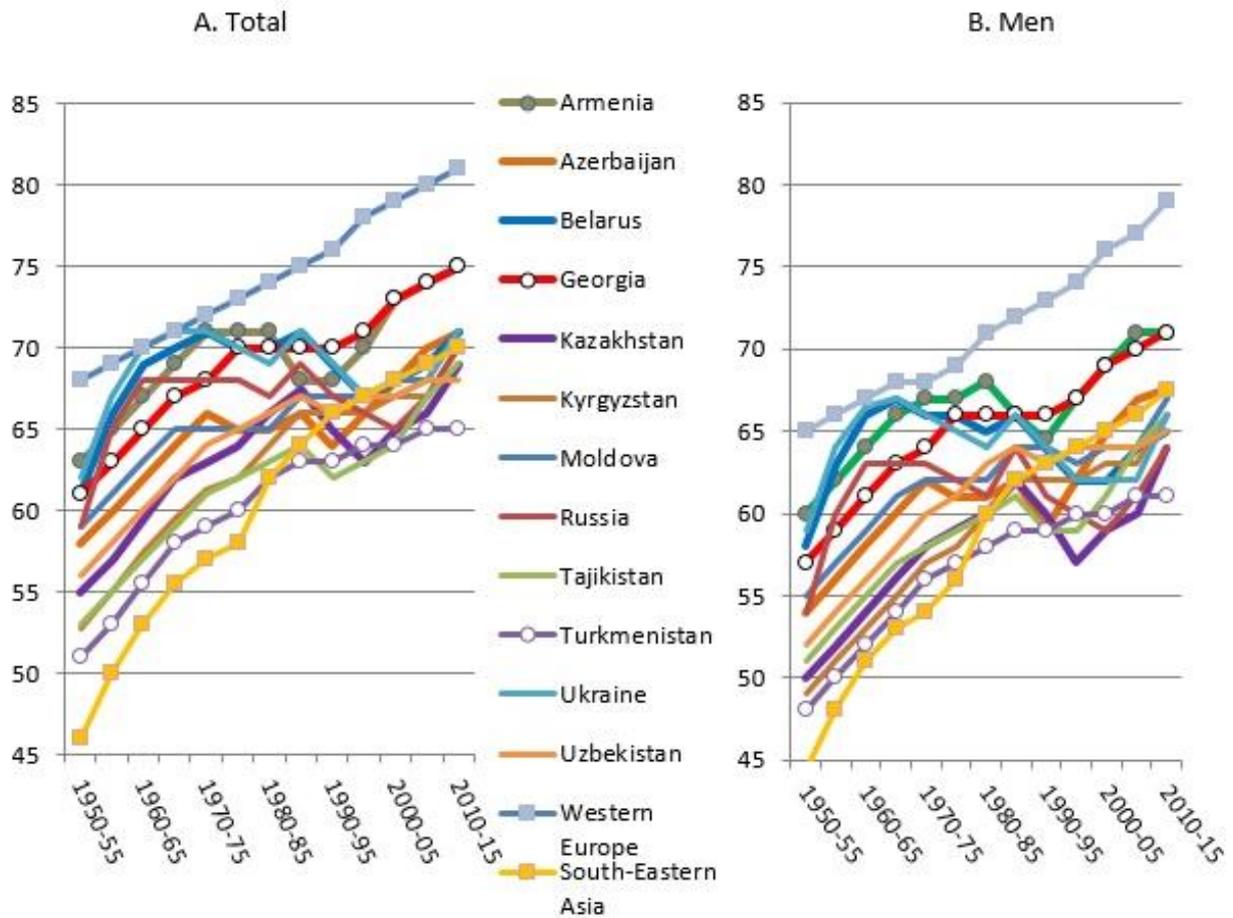
The CIS+ countries with the highest levels of mortality of younger population are also the countries with the highest proportion of older persons, Turkmenistan being an exception as it possesses only the former pattern. High mortality of younger population in some of the CIS+ countries is considered to be one of the causes of shifting population structure towards an older type. This points to a special characteristic of population ageing in this group of countries, 'ageing from the bottom', that is ageing owing to shrinking the younger population (Botev, 2012). High mortality in the CIS+ countries is registered in practically all age groups, which prompted some authors to speak about 'mortality crisis' in several ex-Soviet countries (Eberstadt, 2010; United Nations in Russia, 2008; World Bank, 2010), and also refer to a specific phenomenon of 'ageing without living longer' (Botev, 2012), or in other words, ageing without longevity. Indeed, during the period from 2010 till 2015, life expectancy at birth in all CIS+ countries, notwithstanding recent increase, had lagged behind Western European countries with the differences in total life expectancy varying from six years in Armenia and Georgia to 16 years in Turkmenistan (Figure 8). During the same period of time, the life expectancy at birth in the Central Asian countries, with the exception of Kyrgyzstan, was below the corresponding value for South-Eastern Asia.

From 1950 through 2015, the South-Eastern Asian countries have added 24 years to their total life expectancy at birth, though starting with rather low level of 46 years and rising it to 70 years. The biggest gain in the value of this indicator among the CIS+ countries was in Kyrgyzstan - 17 years (53-70 years). Noticeably, the increase in life expectancy during the recent 65 years has been steady in both the Western European and the South-Eastern Asian countries, though occurring in these regions at different levels and rates. The CIS+ countries, with the exception of Georgia, Kyrgyzstan, Moldova, and Turkmenistan, have experienced periodic declines in the value of this indicator, thus widening the gap with the Western European countries. For example, during the ten year period of 1960-1970 the life expectancy at birth in Ukraine (70 to 71 years), which had the highest level of this indicator among the Soviet Union republics, was equal to that in the Western European countries. However, in the following years the Western European countries had outstripped Ukraine, with the gap reaching its maximum of 12 years during the decade of 2000-2010. These features are particularly visible in the male life expectancy (Figure 8).

Aggravated imbalances in sex structure of older populations

Excess male mortality is behind the aggravated imbalances in the sex structure of older populations of the CIS+ countries (Figure 9). Globally, the number of older women exceeds the number of older men, and the gap increases with age. In Western Europe, in 2015, there were about 82 men per 100 women in the age group 60+, and in the age group 80-plus, there were about 56 men per 100 women.

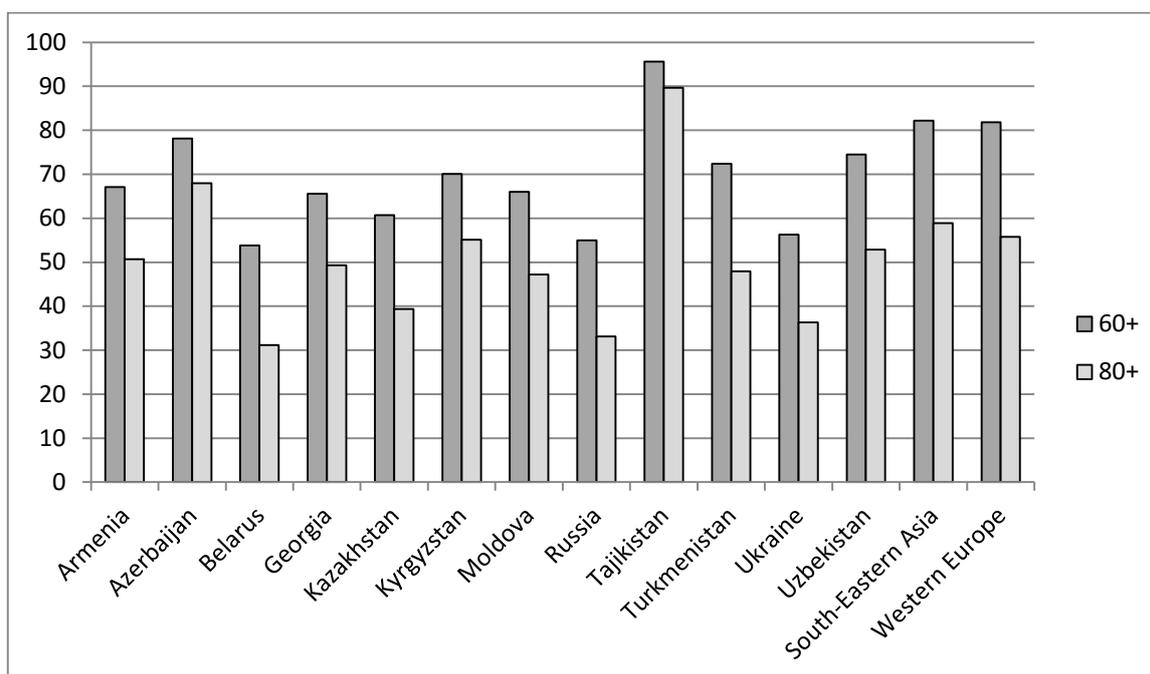
Figure 8. Life Expectancy at Birth



Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

Very close figures were registered in the region of South-Eastern Asia. In several CIS+ countries the sex differences in life expectancy are 'beyond anything ever recorded in peacetime population history' (Botev, 2012).

The CIS+ countries again demonstrate their demographic diversity. Belarus, Russia, and Ukraine exhibit the widest gaps in the sex ratios in the two older population groups with the lowest ratio figures in Russia being 55:100 at age 60+, and 33:100 at age 80+. Armenia, Georgia, Moldova and Kazakhstan have interim values of this ratio. The highest values are registered in Azerbaijan and in four Central Asian countries, namely Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. The figures for Tajikistan are astonishingly high being 96:100 at age 60+ and 90:100 at age 80+. The author is unable to submit any plausible explanation for such high ratio of men to women in the older population of Tajikistan.

Figure 9: Sex ratio (males per 100 females) at ages 60+ and 80+, 2015

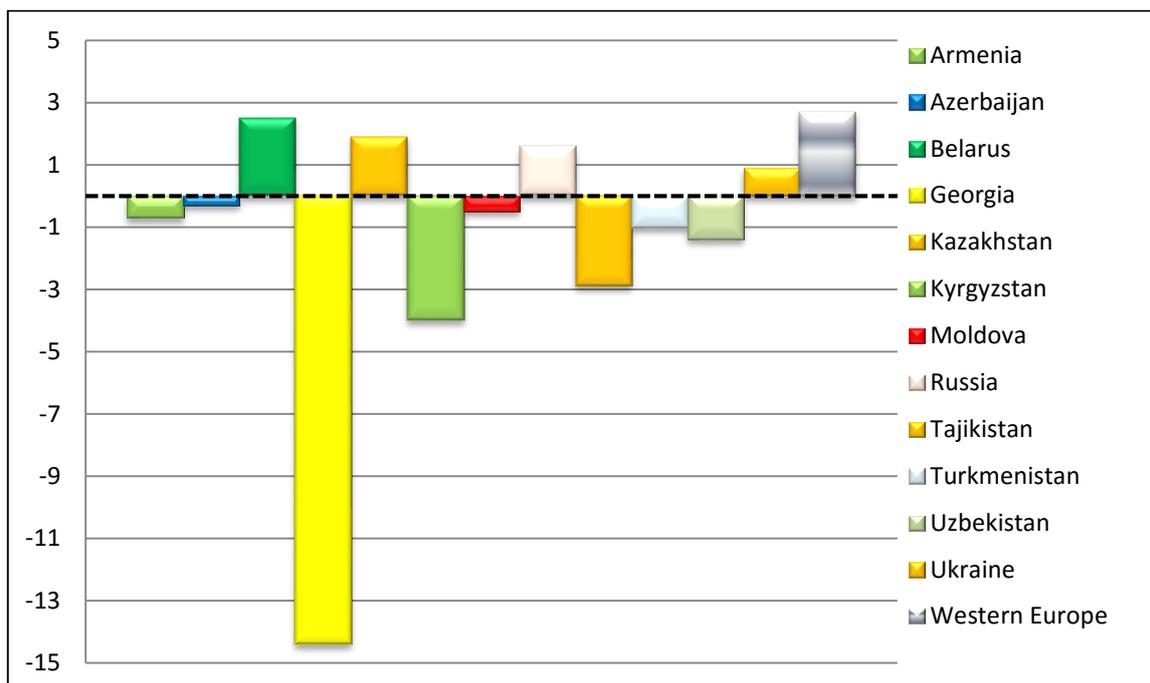
Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

The low sex ratios are reflected in high prevalence of widowhood amongst older women, particularly in Belarus, Russia and Ukraine, and this trend is projected to continue for several decades (Botev, 2012). The direct social implications of this demographic trend are solitary living of older women, their isolation and limited access to home care. On the other end of the demographic spectrum are younger people in the CIS+ countries who will have relatively low availability of grandparents of both sexes for intra-family exchanges and mutual support.

Role of migration

Another contributor to 'ageing from the bottom' in the CIS+ countries is *emigration*. It might appear that migration plays relatively small role in shaping the demographic structure of the ex-soviet countries. By the rate of net migration, in 2010-2015 four CIS+ countries, namely Belarus, Kazakhstan, Russia and Ukraine, had a migration surplus (Figure 10).

In 2015 Russia hosted 12 million migrants – the third largest numbers worldwide. At the same time Russia had the third largest diaspora in the world (11 million), Ukraine had the sixth largest diaspora of 6 million (United Nations, 2016a). During 2010-2015 several CIS+ countries had negative net migration rates, particularly Georgia, followed, in descending order, by Kyrgyzstan, Tajikistan, Uzbekistan, Turkmenistan, Armenia, Moldova and Azerbaijan.

Figure 10: Net migration rate (per 1,000 population), 2010-2015

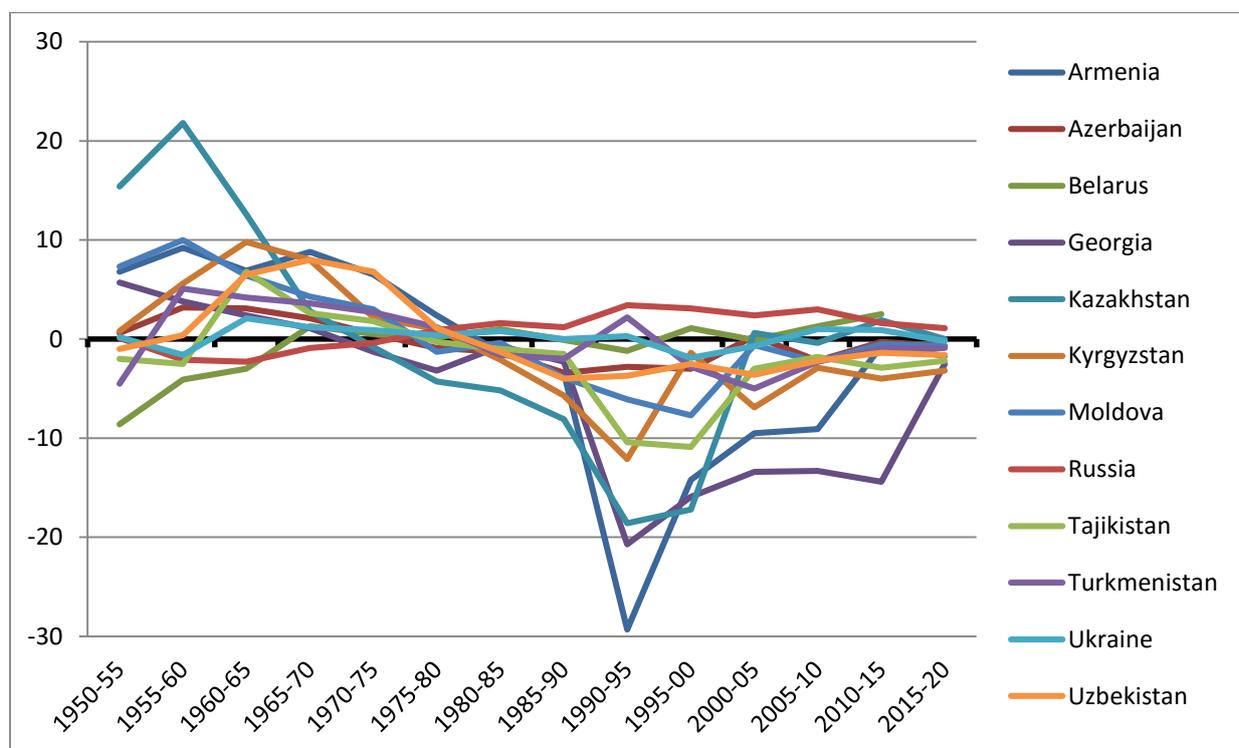
Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

The negative figures of net migration in the above eight countries appear modest in comparison to significant decline in corresponding figures during the first decade of transition (Figure 10). In fact, it has been only Russia that escaped the negative balance of emigration and immigration during the last forty years (Figure 11).

Globally, the majority of international migrants are of working age: in 2015, 72 per cent of them were between age 20 to 64, compared to 58 per cent of the total population of receiving countries (United Nations, 2016a). In 2015, the percentage of persons at age 20-64 among the migrant stock in Western European countries was 69.7⁴. It appears that positive net migration has prevented Europe from experiencing the depopulation between 2000 and 2015 and has accelerated the population ageing process in some (sending) Eastern European countries (United Nations, 2016a). Given the predominance of younger persons among migrants, the process of migration, subject to its magnitude, may influence the age composition of population in both sending and receiving countries. For instance, in Ukraine, during the first decade of independence (1991-2001), emigration had contributed to ageing of population, diminishing working age population, and declining fertility, owing to losing younger population (Malinovska, 2012; Ptoukha Institute for Demography and Social Studies, 2014).

⁴ Author's calculations based on data from: Trends in International Migrant Stock: The 2015 Revision (Table 24. Percentage distribution of the international migrant stock by age and sex and by major area, region, country or area, 2015) (United Nations, 2016b).

Figure 11: Net migration rate (per 1,000 population), 1950-2020

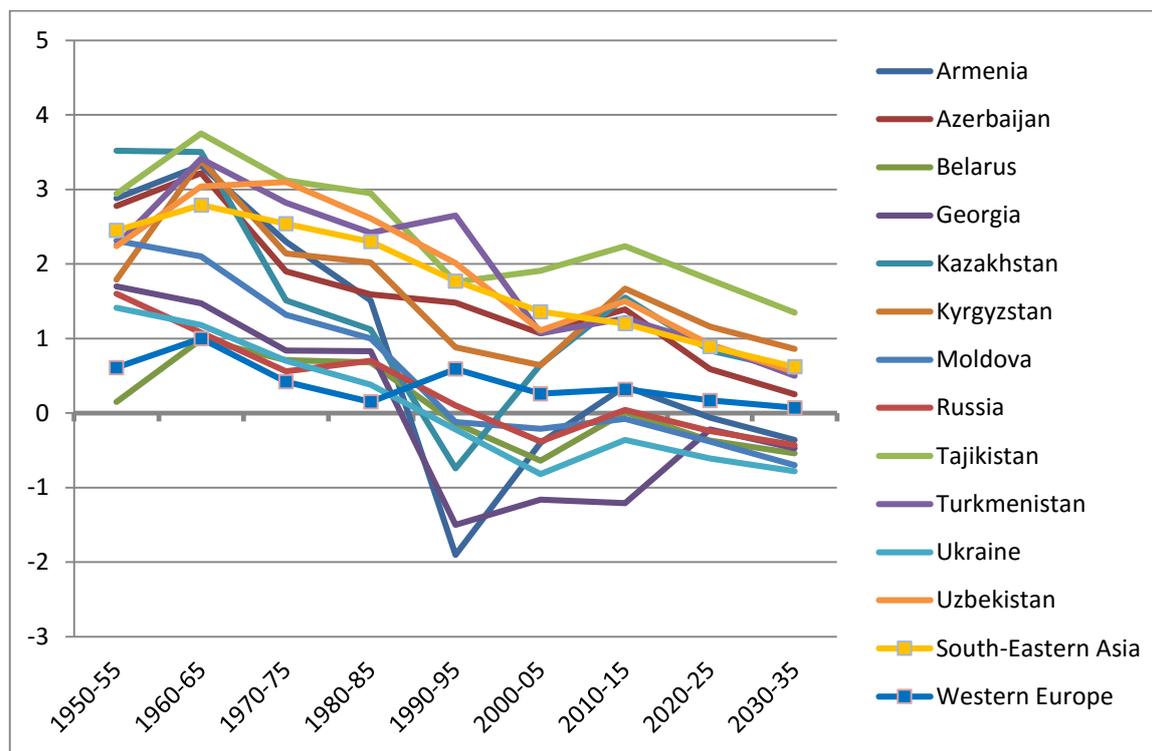


Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

Population ageing and population decline

In addition to and in parallel with the accelerated population ageing several CIS+ countries are experiencing periodic or continuous decline of their populations: Armenia, Belarus, Georgia, Kazakhstan, Moldova, Russia and Ukraine (Figure 12). The highest rates of decline were registered during the decade followed the collapse of the Soviet Union, partial or full recovery of population growth had occurred in several countries at the beginning of the second decade of the twenty-first century. Yet, in several CIS+ countries, Belarus, Moldova and Georgia, population decline has prompted their governments recognize it as a matter of national security (Government of Belarus, 2011; Republic of Moldova, 2012; Ministry for Foreign Affairs of Georgia, 2016).

As in the case of population ageing, two demographic processes are the major causes of population decline in some CIS+ countries: low fertility and high mortality. Emigration is also an important factor of population decline in countries with the negative net migration rates such as Armenia, Moldova and particularly Georgia. Possible population decline in many European countries owing to low fertility has been compensated by inflow migration (United Nations, 2016a). The above demographic features are not unique on the global scale, but their combination in the CIS+ countries is distinctive.

Figure 12. Average annual rate of population change (percentage)

Source: United Nations. (2015a). *World Population Prospects: The 2015 Revision*, custom data acquired via website: <http://esa.un.org/unpd/wpp/DataQuery/>

Moreover, the specific features of demographic change are combined in this group of countries with simultaneously ongoing political and economic transitions thus making these countries particularly prone to the challenges of ageing societies.

Challenges *versus* opportunities

The consequences of population ageing include both challenges and opportunities, and the principal policy task is to overcome challenges and utilize opportunities in order to adjust to population and individual ageing (United Nations, 2002). The societal impact of population ageing can be most significant in such areas as labour market and productivity; social security; health care services; and social services, particularly long-term care. This impact has already been felt in the 'older' CIS+ subgroup, but it would inevitably be experienced by the demographically 'younger' countries of Central Asian and Azerbaijan.

Many policy measures dedicated to adjusting to demographic transition and population ageing are based on utilizing the first and second demographic dividends (Lee and Mason, 2010; United Nations, 2015b). As was noted in the demography section of this article, the first demographic dividend can be employed in the Central Asia countries and Azerbaijan and should envisage measures for increasing human capital through promoting employment and

providing opportunities for dissent work. The principal target population group for utilizing the first demographic dividend is people of working age.

The potential advantages of the second demographic dividend are rooted in increasing longevity and would be particularly valuable in the demographically 'older' countries of the CIS+ grouping. The corresponding policy measures should, like in the countries of the 'younger' sub-group, aim at supporting the human capital, and also at increasing the financial capital available for investing in economic growth and social development of countries where the healthy and active longevity is promoted and utilized.

The first and second demographic dividends provide potentially most valuable opportunities for overcoming the challenges of demographic transition and, in more general terms, for adjusting to demographic changes, including population ageing. Yet other opportunities do also exist in the CIS+ countries. In the first instance, it is high level of education of population: the CIS+ countries have a higher level of educational attainment than the EU-28 Member States (Eurostat, 2016) and practically 100 per cent literacy rates (World Bank, 2016). Further investment in professional training and lifelong education is the major prerequisite for utilizing both demographic dividends in the CIS+ countries, as anywhere else.

As noted above, several most advanced in terms of population ageing countries of the CIS+ 'older' sub-group, are also those facing another demographic challenge – population decline. These two simultaneous and interdependent demographic processes lead to shrinking labour forces thus creating a condition of 'demographic deficit' (Farrel, Ghai, & Shavers, 2005). Demographic deficit with its three 'symptoms' – population ageing, population decline and contracting labour force – can be detected in several CIS+ countries, namely Armenia, Belarus, Georgia, Moldova, Russia and Ukraine. This phenomenon is not unique to the CIS+ countries, it takes place in many other countries of the world belonging to both more and less advanced economies (Farrel et al. 2005; Harper, 2014). While low fertility is the universal cause of demographic deficit, several additional factors are at play in the CIS+ countries: high mortality among working age population and emigration of younger workers coupled with an outflow of skilled professionals.

Demographic deficit if unattended may lead to declining productivity, which would be caused by simultaneous ageing and shrinking of labour force. It is also claimed that older labour force would trigger decreasing the potential of economy for innovations and adaptability (for discussion, see Harper, 2014). The social cost of demographic deficit can be felt in diminished budgetary resources needed for covering the increasing costs of social security, health care and social care of the growing ageing population.

The numerous challenges of demographic deficit are real yet manageable. Most often, governments see the key task for adjusting to population ageing and overcoming the demographic deficit, in finding additional financial resources to cover the rising cost of support for the growing ageing population when the working age population is shrinking. An alternative approach would strive to overcome demographic deficit through measures for improving labour productivity and augmenting the labour forces (Harper, 2014; Bussolo,

Koettl, & Sinnott, 2015). The experts of the World Bank suggest that ‘measures taken to improve labor productivity would swamp any quantity effects of smaller labor forces’, in the CIS+ countries (Chawla et. al, 2007).

In a broader sense, both public and individual measures would be required for offsetting the demographic deficit (Harper, 2014). Public measures could be designed to, first, change the age composition of the population through increasing childbearing and encouraging immigration; second, decrease dependency by promoting longer working life and gradual retirement; and, third, increase productivity by among other measures, stimulating technological innovations. Individual measures could include life-long personal adjustment to challenges and opportunities of ageing society, namely life-long education; mental adjustment (accepting positive self-images of ageing); and physical adjustment (healthy life styles). In addition to macro (public) and micro (individual) levels, measures would also be needed at meso-level, including adjustment in social networks within the family and community.

Many CIS+ countries which experience demographic deficit have focused their population policies on increasing the fertility. However, the effect of transfer-based pronatalist policies is often negligible (Chawla et al., 2007). This does not mean that fertility in the CIS+ countries cannot be restored up to the replacement level. The recent experience of Georgia, if sustained, would be a proof of such possibility (United Nations Population Fund, 2015). More sustainable approach could be based on measures aimed at supporting family in its childbearing expectations and childrearing capacity.

Another policy approach under discussion is managed intraregional migration (Chawla et al., 2007). The views on short- and long-term effects of migration on the age structure of receiving countries are controversial (Vishnevsky, 2004; Vignon, 2005; King & Lulle, 2016). As noted in the demographic section of this article, some CIS+ countries are and will be gaining working age population, while others will be losing it, such demographic ‘asymmetry’ may create predispositions for intraregional migration. However, potentially receiving countries will be required to provide the necessary incentives and conditions through reformed policy and transformed institutions in order to be able to attract the needed labour force, including by promoting the return migration. This is not going to be an easy task as many of such potentially receiving countries, such as Armenia, Georgia and Moldova, today belong to the ‘net sending’ countries suffering also from brain-drain. The experience of Russia, with its almost equal numbers of immigrants and diaspora, points to the need of careful assessment of existing migration policy.

As noted in the Madrid International Plan of Action on Ageing, countries with economies in transition face special difficulties in responding to the opportunities and challenges of population ageing in the twenty-first century (United Nations, 2002). Some of the difficulties faced by the CIS+ countries can be related to the specific aspects of demographic transition outlined above. Yet, many other difficulties stem from undesirable effects of the incomplete process of multifaceted transition from the centrally planned economies toward a society with loosely defined goals and values. These undesirable effects are primarily related to lingering

in reforming the policies and institutions. The continuing stagnation of reforms has compelled the market structures and institutions of many CIS+ countries to lag far behind those in advanced economies (European Bank, 2013) with the incurring economic and social cost of rising unemployment, stagnating or even falling life expectancy and growing inequality (Roaf, et al., 2014).

Policy responses aimed at reacting to and preventing the negative implications of population ageing are well defined and have been attempted in several countries (United Nations Population Fund & HelpAge International, 2012; Sidorenko & Zaidi, 2013). The barriers for advancing such policies in the CIS+ countries are also well known: complacency and lack of continuity. Many CIS+ countries have chosen a gradualist approach delaying and avoiding reforms and thus preserving many features of old socio-economic system (Roaf et al., 2014). However trivial it may sound, the universal task is to accelerate the process of multifaceted societal transition, which should comprise policies for adjusting to population changes such as population ageing.

References

- Botev, N. (2012). Population ageing in Central and Eastern Europe and its demographic and social context. *European Journal of Ageing*, 9 (1), 69-79.
- Bussolo, M., Koettl, J., & Sinnott, E. (2015). *Golden aging: Prospects for healthy, active, and prosperous aging in Europe and Central Asia*. Washington, DC: World Bank.
- Chawla, M., Betcherman, G., & Banerji, A. (2007). *From red to gray: The third transition of aging populations in Eastern Europe and the former Soviet Union*. Washington, DC: World Bank. Accessed 9 May 2016 from: http://siteresources.worldbank.org/ECAEXT/Resources/publications/454763-1181939083693/full_report.pdf
- Eberstadt, N. (2010). *Russia's peacetime demographic crisis: Dimensions, causes, implications*. NBR Project Report, May 2010. Seattle, WA: The National Bureau of Asian Research
- European Bank. (2013). *Transition report 2013. Stuck in transition?* London, UK: European Bank for Reconstruction and Development. Accessed 9 May 2016 from: http://2013.trebrd.com/images/downloads/357_TR2013v3.pdf
- Eurostat. (2016). *Educational level and tertiary education*. EU-Commonwealth of Independent States (CIS) - Statistics on population, employment and living conditions. Accessed 9 May 2016 from: [http://ec.europa.eu/eurostat/statistics-explained/index.php/EU-Commonwealth_of_Independent_States_\(CIS\)_-_statistics_on_population,_employment_and_living_conditions](http://ec.europa.eu/eurostat/statistics-explained/index.php/EU-Commonwealth_of_Independent_States_(CIS)_-_statistics_on_population,_employment_and_living_conditions)
- Farrel, D., Ghai, S., & Shavers T. (2005). *The Demographic deficit: How aging will reduce global wealth*. The McKinsey Quarterly, March. Accessed on 10 May 2016 from: <http://www.mickeybutts.com/globalagingQuarterly.pdf>
- Government of Belarus. (2011). *National Report of the Republic of Belarus on the Implementation of the Regional Strategy for the Madrid International Plan of Action on Ageing* (in Russian). Country Reports, UNECE : Second Review and Appraisal of MIPAA/RIS, 2012. Accessed 9 May 2016 from: http://www.unece.org/fileadmin/DAM/pau/age/country_rpts/BLR_report.pdf

- Harper, S. (2014). Economic and social implications of aging societies. *Science*, 346 (6209), 587-591.
- King, R., & Lulle, A. (2016). *Research on migration: Facing realities and maximising opportunities*. Luxembourg: Publications Office of the European Union. Accessed 9 May 2016 from: https://ec.europa.eu/research/social-sciences/pdf/policy_reviews/ki-04-15-841_en_n.pdf#view=fit&pagemode=none
- Lee, R., & Mason, A. (2010). Fertility, Human capital, and economic growth over the demographic transition. *European Journal of Population*, 26 (2), 159-182
- Lipton, D. (2014). *Building market economies in Europe: Lessons and challenges after 25 years of transition*. Accessed 10 May 2016 from: <http://www.imf.org/external/np/speeches/2014/102414.htm>
- Malinovska, O.A. (2012). *Diversification of population in Ukraine as a result of international migration: challenges and responses* (In Ukrainian). Kyiv: National Institute for Strategic Studies. Accessed 9 May 2016 from: http://www.niss.gov.ua/content/articles/files/malin_dop-e2d16.pdf
- Ministry of Foreign Affairs of Georgia. (2016). *National security concept of Georgia*. Georgia: Ministry of Foreign Affairs of Georgia. Accessed 9 May 2016 from: <http://www.mfa.gov.ge/MainNav/ForeignPolicy/National%20SecurityConcept.aspx?lang=en-US>
- Ptoukha Institute for Demography and Social Studies. (2014). *Imperatives of demographic ageing (2014) Kyiv: "ADEF-Ukraine"* (in Ukrainian). Accessed 9 May 2016 from: http://www.idss.org.ua/monografii/2014_Naselennya.pdf
- Republic of Moldova. (2012). *National Report on the Follow-Up to the Regional Implementation Strategy (RIS) of the Madrid International Plan of Action on Ageing (MIPAA) in the Republic of Moldova (2007-2011)*. Country Reports, UNECE : Second Review and Appraisal of MIPAA/RIS, 2012. Accessed 9 May 2016 from: http://www.unece.org/fileadmin/DAM/pau/age/country_rpts /MDA_report.pdf
- Roaf, J., Atoyamn, R., Joshi, B., & Krogulski, K. (2014). *25 years of transition: post-communist Europe and the IMF*. Washington, D.C.: International Monetary Fund. Accessed 9 May 2016 from: https://www.imf.org/external/pubs/ft/reo/2014/eur/eng/pdf/erei_sr_102414.pdf
- Sidorenko, A. (2010) *Population ageing in the countries of the Former Soviet Union: Concerns and Responses*. The WDA-HSG Discussion Paper Series on Demographic Issues No. 2010/7. Accessed 9 May 2016 from: <http://www.wdaforum.org/fileadmin/ablage/wdaforum/publications/dp2010-07.pdf>
- Sidorenko, A., & Zaidi, A. (2013). Active ageing in CIS countries: Semantics, challenges, and responses. *Current Gerontology and Geriatrics Research*. Accessed 10 May 2016 from: <http://downloads.hindawi.com/journals/cggr/2013/261819.pdf>
- United Economic Commission for Europe. (2016). *Geographical scope*. Accessed 10 May 2016 from: <http://www.unece.org/oes/nutshell/region.html>
- United Nations Population Fund. (2015). *Population situation analysis (PSA) Georgia 2014*. Tbilisi, Georgia: United Nations Population Fund. Accessed 9 May 2016 from: http://eeca.unfpa.org/sites/default/files/pub-pdf/PSA%20_Final%20Print%20version.pdf

- United Nations Population Fund & HelpAge International. (2012). *Ageing in the twenty-first century: A celebration and a challenge*. New York: United Nations Population Fund and London: HelpAge International.
- United Nations. (2002). *Madrid International Plan of Action on Ageing*. New York: United Nations. Accessed 10 May 2016 from:
http://www.un.org/en/events/pastevents/pdfs/Madrid_plan.pdf
- United Nations. (2015a). *World Population Prospects: The 2015 Revision*. Accessed 10 May from: <http://esa.un.org/unpd/wpp/DataQuery/>
- United Nations. (2015b). *World Population Ageing*. New York: United Nations. Accessed 9 May 2016 from:
http://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf
- United Nations. (2016a). *International Migration Report 2015*. Highlights. New York: United Nations. Accessed 9 May 2016 from:
http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2015_Highlights.pdf
- United Nations. (2016b). *Population Division. Internal Migration*. Accessed 10 May 2016 from:
<http://www.un.org/en/development/desa/population/migration/data/estimates2/estimates15.shtml>
- United Nations in Russia. (2008). *Demographic policy in Russia: From debate to action*. Moscow, Russia: United Nations in Russia.
- Vignon, J. (2005). Responses to the new demographics: Present and future strategies for the European Union. In M., Macura, A.L., MacDonald & W., Haug (Eds.), *The new demographic regime: Population challenges and population responses* (pp. 45-56). New York & Geneva: United Nations.
- Vishnevsky, A. (2004). Replacement migration: Is it a solution for the Russian Federation? *Population Bulletin of the United Nations*, 'Policy responses to population decline and ageing' Special Issue Nos. 44/45 2002 (pp. 273-287). New York: United Nations
- World Bank. (2010). What underlies Ukraine's mortality crisis? Europe and Central Asia: The World Bank. Accessed 10 May 2016 from:
<http://siteresources.worldbank.org/UKRAINEINUKRAINIANEXTN/Resources/PrichinysmertnostivukrainiENG.E.pdf>
- World Bank. (2016). *Adult Literacy Rate*. Data. Accessed 9 May 2016 from:
<http://data.worldbank.org/indicator/SE.ADT.LITR.ZS>

Population ageing and the development of social care service systems for older persons in China

Peng Du¹ and Yongmei Wang²

Abstract. China has the largest ageing population in the world and the absolute number of the older persons accounts for over one-fifth of the world's population. China's population ageing has the characteristics of having an enormous number of older persons with an accelerating ageing pace, a weakened traditional elder familial care capabilities, and vast regional and rural-urban differences. The elder social care service system of 'families serving as the foundation, communities as the base, and institutions as the supplementation' has initially formed in China, but there remains various problems. The Chinese government is now making efforts on the reconstruction and consolidation of elder family care capabilities, to support elder care capacities of the families through social services, the development of long-term care insurance system and relevant service systems, and narrowing the gap amongst various areas of service provision.

Keywords: social care, service systems, older persons, China.

Introduction

China has entered the ageing society since 2000, and the size of its older population is the most populous in the world. The number of people aged 60 and above was 222 million at the end of 2015, accounting for 16.1 per cent of the total population (National Bureau of Statistics, 2016). There is no doubt that whether China, with nearly one quarter of the world's ageing population (United Nations, 2015), could actively address the issue of population ageing or not is directly related to the overall quality of life of the world's older population. Therefore, it is necessary to have an understanding of the characteristics of China's population ageing and its policy response.

Over the past 40 years, China experienced such profound social transformations as rapid economic growth, continuous decline of birth rate, shrinking size of families, endless development in urbanization, frequent population flow, improving social security systems

¹ Director, Institute of Gerontology, Renmin University of China, Beijing, China. (dupeng@ruc.edu.cn)

² Ph.D candidate, Institute of Gerontology, Renmin University of China, Beijing, China. (wang_ym@ruc.edu.cn)

and so on. All these have made profound impacts on the pattern of China's care services for older persons, and issues of who is responsible for such care, of where should older persons be cared for, and of how to care them are all to be changed greatly (Du, 2016). Since the new century, the Chinese government has attached great importance to the course of ageing and has defined the development of social care service for older persons as the major livelihood issue that the government cares for, the society concerns and the people urge to solve. Currently, the social care service system for older persons of the family serving as the foundation, the community caring as the base, and institutions as the supplementation is being followed.

As a developing country with its special governance systems, cultural traditions, and intergenerational relations (e.g the realistic basis of 'getting old before being rich'), China has to develop a social care system based on the Chinese realities. In particular against the background of China's New Normal in population and economy (namely low fertility rate and lower economic growth rate) (Li, 2015), measures of actively responding to the population ageing should be continuously improved in practical exploration. In order to improve the understanding of foreign scholars about China's population ageing and its countermeasures, this paper will discuss about the ageing issues and related ways of resolution on the basis of talking about its features and development direction.

The features and the trend of China's population ageing

Similar to the world's population ageing process, China's population ageing also benefits from the decline of birth rates and extension of life expectancy. Meanwhile, the percentage of the older persons is also increasing. Statistics show that the number of older persons aged 80 and above in 2010 has reached 21 million, which accounts for 11.82 per cent of the total ageing population and is 2.59 per cent higher than that in 2000 (Research Center of the State Council, 2015).

The size of China's older population is quite large and it is ageing rapidly

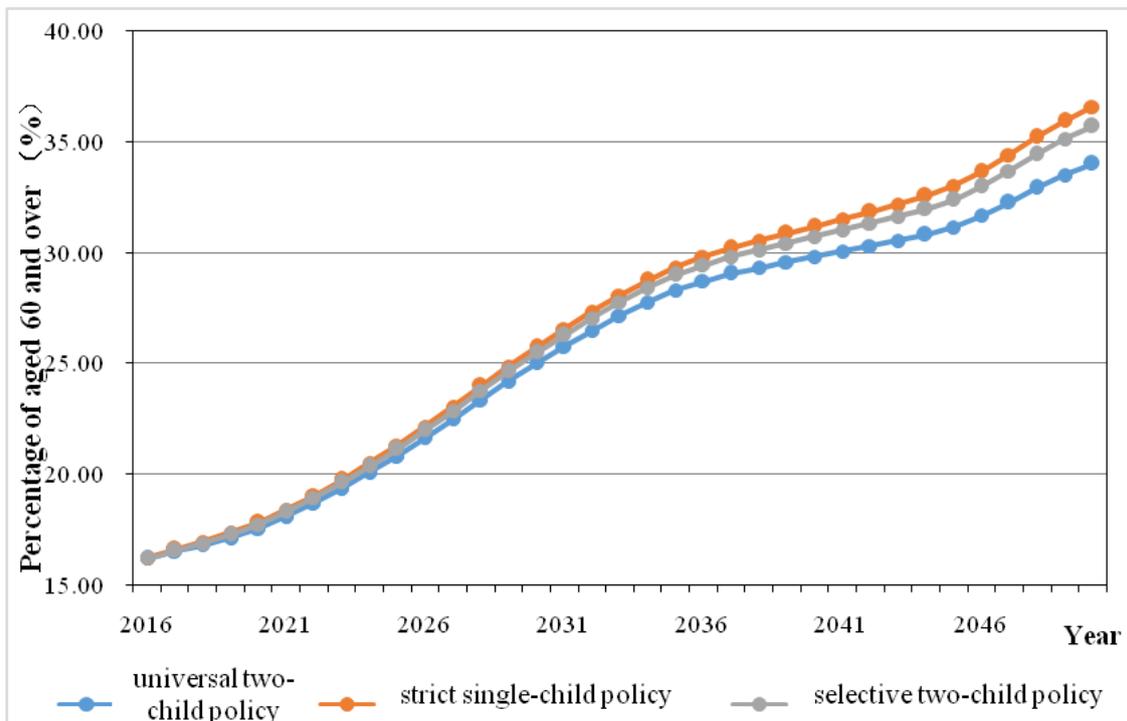
As mentioned earlier, the number of people aged 60 and above was 222 million at the end of 2015 which accounted for 24.64% of those in the whole world³ (United Nations, 2015). In order to promote the balanced development of population and to improve the family planning policy, Chinese government adjusted its population policy in October, 2015. The new policy is that "a couple can have two children (abbreviated as 'the universal two-child policy')", so that action ended the "selective two-child"⁴ policy and "single-child" policy (Community Party China - Central Government, 2015). Undoubtedly, this action will definitely influence China's population ageing. However, statistics show that after implementing the 'the

³ According to statistics given by the United Nations (2015), the total number of old persons in the world was 901 million at the end of 2015. It could be calculated that China's persons aged 60 and above accounts for 24.64 per cent of the total older population in the world.

⁴ The 'selective two-child policy' refers to the possibility that a couple could have two children if either parent is an only child. This policy was raised and implemented in 2013.

universal two-child' policy, the ageing proportion is only 2 per cent lower than that after implementing the 'the selective two-child' policy, although it will be reaching 34 per cent by 2050. There will be more than 470 million older persons in China by 2050 and this number will not be changed by the current new population policy. Figure 1 shows the development trends of China's population ageing under different fertility policies. Figure 2 shows the development trends of the number of China's ageing population in the years from 2016 to 2050 (Institute of Gerontology of Renmin University of China, 2016). The huge ageing population and rapidity of ageing pose great challenges for China in addressing the population ageing.

Figure 1: Development trend of population proportion (%) of persons aged 60 and over under different fertility policies

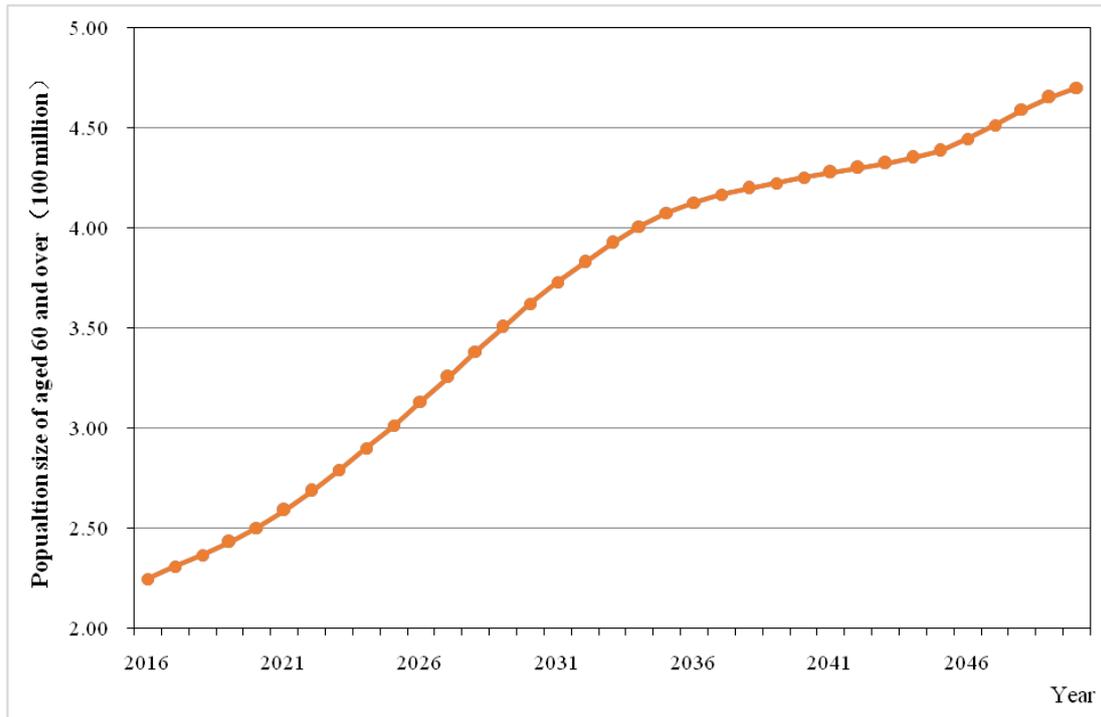


Source: Institute of Gerontology of Renmin University of China, (2016).

The traditional family capabilities in caring for older persons have been weakened significantly

Traditionally, China depended on the family-based care model for older persons for a long period of time. Family members (especially female ones) were deemed as the major caregivers for older persons and the government was only responsible for those vulnerable older persons without family members and the poor. However, with the implementation of the family planning policy, the number of children for the families have been decreasing gradually. Also with the improvement of living conditions, the family size began to shrink since the late 1970s, more and more older persons choose to live separately with their children actively or passively (Li, 2010; Zhang, 2012).

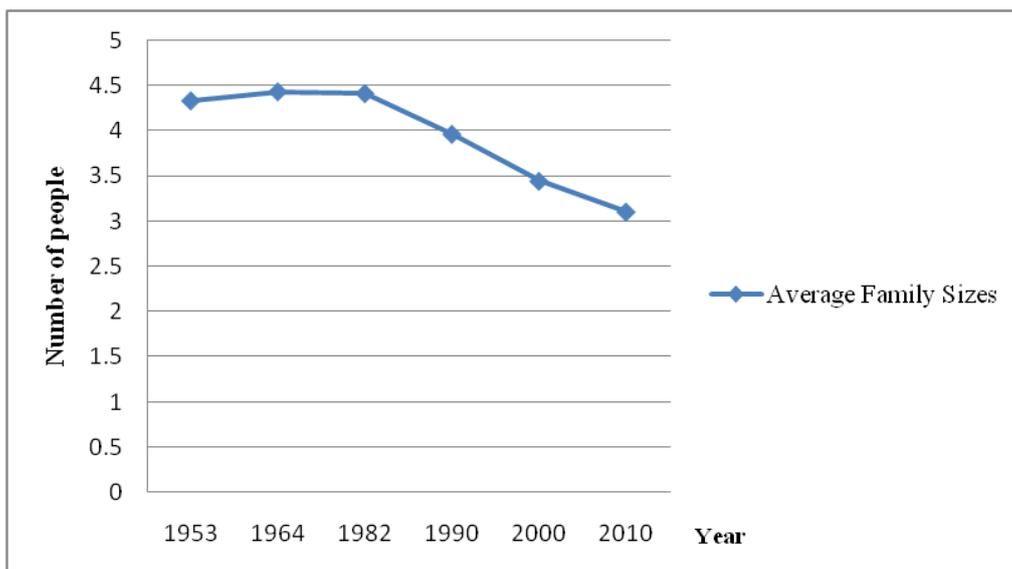
Figure 2: The population size of older persons aged 60 and over in 2016-2050



Source: Institute of Gerontology of Renmin University of China, (2016).

Figure 3 shows the changes of average family sizes from 1953 to 2010. The shrinking family size will unavoidably influence the supply of traditional elder care resources.

Figure 3: Changing trends of Average Family Sizes in 1953~2010



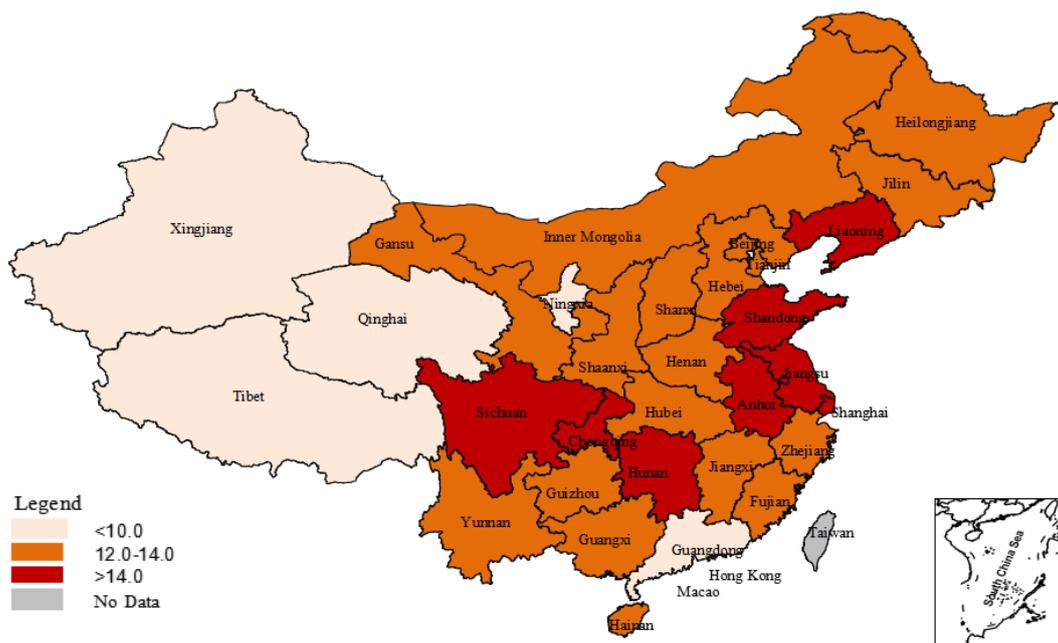
Source: Data calculated based on the 1953, 1964, 1982, 1990, 2000 and 2010 Censuses as cited in Census Office of the State Council, National Bureau of Statistics, (2014).

Meanwhile, because of the concept of gender equality and women empowerment movement, the proportion of women participating in a job is now gradually increasing (Ma, 2013). Both reasons have resulted in the weakening of China's traditional elder care resources. Statistics show that higher numbers of older persons are afraid that no one would look after them when they need care. The Sampling Survey of the Ageing Population in Urban/Rural China (SSAPURC) indicate that 39.88 per cent of older persons are worried about this, among whom 23.64 per cent are 'somewhat worried' and 16.24 per cent are 'very worried' (Wu, Guo & Miao, 2014). This concern serves as the fundamental driving force for the country and the society to improve the elder care service policies.

The regional and rural-urban differences of China's population ageing has been on expansion

The regional differences of China's population ageing are quite large. When western China (e.g. Xinjiang, Qinghai, Tibet) has not entered the ageing society (the proportion of older persons aged 60-plus is lower than 10 per cent), central and eastern China (e.g. Shanghai, Jiangsu, Hunan) has already entered the advanced stage of ageing (proportion over 14 per cent). The differences are shown in Figure 4. Studies show that China's ageing population process gradually rises from the eastern coastal area to the western area (Wang, Sun & Li, 2013). Since the 21st Century, as China entered the rapid urbanization stage, the population flow has become one prominent feature, with the flow 'from rural to urban areas' becoming the major force in the floating population. The Population Census carried out in 2010 indicates that China's floating population has reached 221 million, rising to 253 million at in 2014 (National Health and Family Planning Commission Mobile Population Division, 2015).

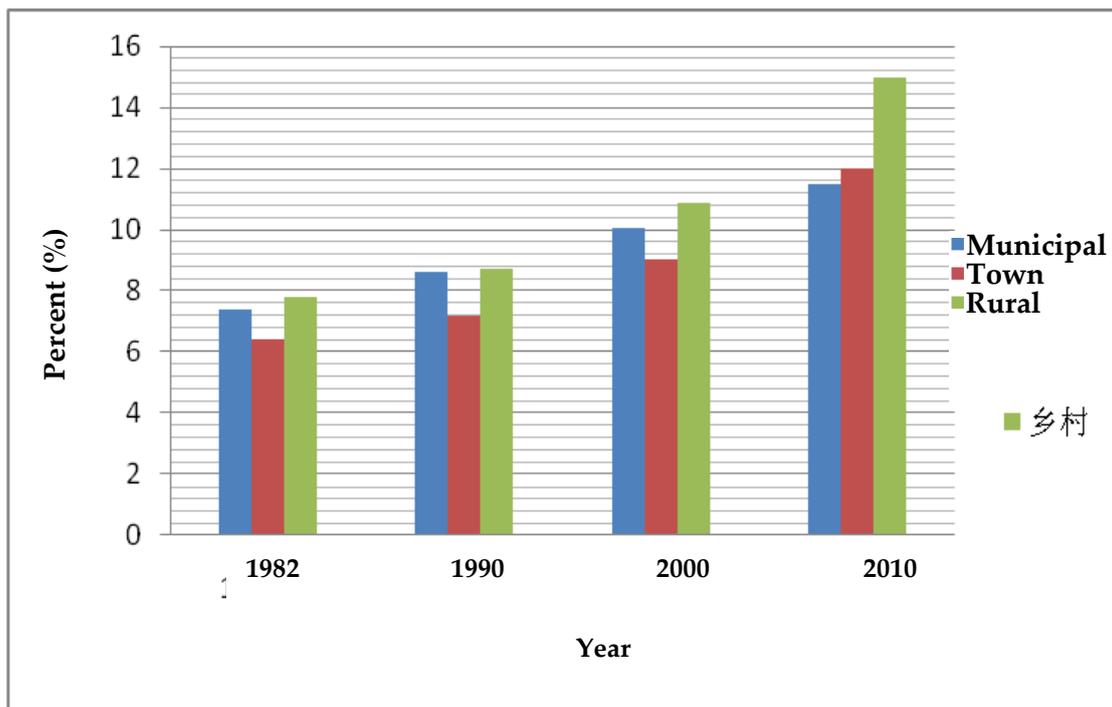
Figure 4: The regional differences of China's population ageing



Source: Drawn in accordance with the Sixth Census on 2010 (Census Office of the State Council, National Bureau of Statistics, 2014)

As higher numbers of younger people move from rural areas to cities, enhancing the ageing degree in rural areas. Statistics show that the number of older persons who are left-behind in rural areas has reached 50 million (National Bureau of Statistics, 2015), which means that nearly one-fourth of China’s older persons have been left behind, and that many of them have lost their place in the traditional elder care system. We can get a glimpse of this idea in Figure 5 which shows the trend of ageing degrees in urban and rural areas over the past 30 years. How to make them being looked after properly is really a big challenge. Above all, China’s population ageing is the result of the economic and social development. The development of medical services and health technologies has prolonged the average life expectancy, resulting in the ageing ‘on-top’; and the implementation of the family planning policy has lowered the birth rate, resulting in the development of the ageing ‘at the bottom’ (Wu, Wang & Miao, 2003). The shrinking family sizes, the increasingly frequent population flow and the modernization of living patterns cause the weakening of traditional family care capabilities.

Figure 5: Proportions of Chinese municipal, town and rural older persons aged 60 and above during 1982-2010



Source: Data for 1982, 1990 and 2000 as cited in Wu and Du (2006). Data for 2010 as cited in Census Office of the State Council, National Bureau of Statistics (2014).

Considering the realistic condition of ‘getting old before being rich’ in China, we hold the idea that the change of China’s elder care pattern manifests itself as an effort in exploring a dynamic equilibrium in the process of establishing the elder care pattern under the new social supporting system after the weakening of family elder care capabilities (Du, 2016), so it has

become a prominent strategic decision in actively addressing the population ageing to develop and improve the elder social care service.

Challenges and strategies of China's social service system for older persons

History of elder care service policies and the challenges

Since the founding of People's Republic of China (in 1949) to the Reform and Opening-up period in late 1970s, the elder care policy in China stipulated that in urban areas, the working units should be responsible to support its retired workers; in rural areas, families and their children should look after older relatives. The government was only responsible to ensure that the rural 'Five-Guarantee' older persons and urban 'Three Noes' older persons have the basic needs for food, clothing and care⁵. As the reform of economic and social systems was deepening, the social welfare ideology changed accordingly and the State started to explore the reform whereby 'society should be responsible for social welfare'. Therefore, during the years from 1978 to 2000, Chinese government, represented by the Ministry of Civil Affairs, introduced a series of policies, laying the ideological foundation for social forces to take part in ageing care.

Since 2000, the Chinese government began focusing on the best suited design for elder social care service and the Communist Party of China's Central Committee and the State Council issued important documents such as *Decision on Strengthening the Undertaking on Ageing*, *Notification on Opinions About Speeding up the Development of Elderly Care Service*, the 10th and 11th *Five-Year Plans for China's Development of the Ageing Undertaking*, and so on. In this period, the improvement of elder care infrastructures and the avocation of its ideas have laid the important foundation for the development of the service. During the years from 2010 to today, China's social care service system experienced substantial development, and more important documents have been introduced, including the 12th *Five-year Plan for Construction of System of Social Services for the Elderly (2011-2015)* issued in 2011, *Some Suggestions of the State Council on Speeding up the Development of Elderly Care Service* issued in 2013, and *Guidance on Promoting the Combination of Health Care and Elderly Care* issued in 2015. However, although China has achieved a lot in developing elder social care, there still exist many problems, such as the supply-demand imbalance of the elder care service, the difficulties in implementing the top-level policies, the serious fragmentation of elder social care services, the imbalanced supply of the service (such as the serious shortage in rural areas), the ambiguities of responsibilities of all elder care providers (such as families, governments and the society) and so on. How to solve these challenges remains to be a huge challenge for Chinese government.

⁵ Urban "Three Noes" older persons refer to those who don't have labor capacity, source of income and supporters, or their relatives having no supporting capacity. Rural "Five-Guarantee" older persons refer to those whose eating, clothing, housing, medical treatment and funeral services are provided by the Government.

Key points of Chinese government's work in the ageing undertaking

To address the above challenges more effectively, Chinese government, observing the principles of population ageing, has made great efforts, not only to solve the current problems but also to make preparations for the future advanced and even serious ageing society. Currently, the key points of Chinese government's work can be summarized as follows.

...focus on the reconstruction and consolidation of elder family care capabilities.

In China, families are still the important subjects of responsibilities of elder care, which could be seen from the stipulation of 'the fundamental position of family elder care' in the *Elderly Rights Law* in 2012. And policies stipulate that over 90 per cent of older persons should be looked after by their families.

On one hand, the government pays much attention to the birth number of families. It is mentioned in the beginning of the article that Chinese government adjusted the population policies in 2013 and 2015 respectively and implemented 'the universal two-child' policy in 2015 to promote the sustainable development of the population. Though the implementation of the new policy can hardly change the rapid development of ageing, it can obviously delay its process (Zhai, Zhang & Jin, 2014). The birth of more young people will definitely improve family elderly care capabilities in several years.

On the other hand, the government cares about the construction of elder family care capabilities. In recent years, Beijing, Shanghai, Nanjing and Hangzhou have made useful attempts in respite services, economic subsidies, and social system supports and these efforts have achieved good results. In the newly issued *13th Five-year Plan on National Economic and Social Development*, it is clearly pointed out that 'we should perfect the reward, assistance and special assistance system for family planning families in rural areas and enhance the care and help for families which lose their single child'. And the government started to explore flexible work system, elder care vacation system and other methods to improve family capabilities.

However, the implementation of the new population policy would increase the burden of raising children, which will influence the families' capabilities in caring for older relatives to some extent. How to construct the families' elder care capabilities in the new situation is still the work direction for both the government and the scholars.

...focus on the responsibilities of governments and social subject.

Since the beginning of the 13th Five-year Plan, namely 2016, the Chinese government began to focus more on the quality and efficiency of social elder care service system by

- Adjusting the role of care homes for older persons. During the 12th Five-year Plan, Chinese government proposed to establish the system of families serving as the foundation,

communities as the base, and institutions as the support and raised the pattern of '9073'⁶. After many explorations and practices, the government changed it into the system of families serving as the foundation, communities as the base, and institutions as the supplementation, weakening the role of institutions.

- Defining the government's responsibilities in elder care. The government and scholars begin to realize that if they want to motivate social forces to participate in the elder care, they should first know what the government should do. Due to the ambiguity of the separation of duties, especially that in what the government should do, the efficiency of this system is low. Currently, the scholars have reached a common consensus that the government should ensure that elder care should not only cover the 'Three Noes' and 'Five Guarantees', but also include the 'old-old' and older persons with disability and dementia.
- Enhancing the construction of assessment standards to standardize the development of elder care service. Though the national standards have not been established, Shanghai took the lead to establish the assessment system for their demands and compiled local standards such as *Assessment Requirements on the Grade of Elderly Care*. And Beijing has also finished the preliminary investigation on the comprehensive assessment. In 2013, Ministry of Civil Affairs issued *Licensing Procedures for Establishing Elderly Care Institutions and Management Methods for Elderly Care Institutions* and began to standardize and enhance the regulation for these institutions; in 2016, the Ministry introduced the industrial standard of *Service Guide for Social Work on Older Persons* and began to specify the working standard. Meanwhile, the construction of infrastructures for the service is changing from being driven by investment to demands and actual demands of older persons to attract more attention (Wang, 2016).

...focus on the development of long-term care insurance system and related services.

Chinese government and scholars pay high attention to the establishment of the long-term care insurance system and regard it as the necessary way to respond to the elder care in the advanced society of ageing. Due to the condition of 'getting old before getting rich', whether the economic development level could support the system has always been the focus of academic argument. Currently, scholars think that China does not have the conditions to establish the welfare, inclusive, and mandatory system and China will not establish the national Long Term Care insurance system in the next five years.

However, Beijing, Qingdao and other cities have started to explore pilots of this system, making preparations for establishing the national system. What lies in contrast is the development of the elder care service. Chinese government has always been proposing the pattern of government being the leading force for and multi-entities participating in the service. Researches also show that Public-Private-Partnership (PPP) pattern could help improve the supply efficiency of elder family care service (Gao, 2015). Therefore, the 13th Five-

⁶ '9073' means that 90 per cent of all older persons shall be cared in their home, seven per cent be cared in communities using social service, and three per cent be cared in the institutions.

year Plan for National Economic and Social Development (2016-2020) clearly points out that under the conditions of ‘overall planning the construction of public elderly care service market’ and ‘improving the welfare and charity systems adapting to ageing’, and that China should ‘completely open up the elder care service market and support market entities to increase the supply of the service and goods through buying services by government, equity corporations and other methods’.

...focus on the equalization of elder social care services

The development of China’s elder social care service is in disproportion and there are huge regional and rural-urban differences. From the perspective of rural-urban differences, though the ageing degree in rural areas is higher than that in urban areas (the ageing degree in urban areas in 2014 was 13.9 per cent and that in rural areas was 17.6 per cent) (National Bureau of Statistics, 2015), its service resources fall far behind those in urban areas in both quantities and qualities (Ding & Wang, 2011). Statistics in 2015 showed that the number of community service centers including the elder care in rural areas, accounting for 34.8 per cent of the total number, was only half of that in urban areas (Ministry of Civil Affairs, 2015). In recent years, the government’s work for older persons begins to tilt toward rural areas. For example, Li Ligu, Minister of the Ministry of Civil Affairs, pointed out that the elder social care industry in rural areas will be our key work point and the tilting direction. We should develop the service in rural areas by enhancing the construction of day care infrastructures in communities, giving full play of the role of market resource allocation, and depending on the mode of ‘Internet plus’ (see <http://shfl.mca.gov.cn/article/ldjh/201603/20160300881739.shtml>). From the perspective of regional differences, the elder social care service in eastern China develops fast while the elder care infrastructures and services in central-western China develop slowly. For example, statistics show that the average index of public elder care service in eastern regions such as Shanghai, Beijing and Jiangsu has reached about 2.0, while that in central-western regions such as Shaanxi, Yunnan and Guizhou is only about 0.46 (Chen & Man, 2013). In recent years, governments and scholars begin to realize that elder care resources should be inclined to central-western regions and late-starting advantage should be made use of to develop social elder care service in accordance with local ageing features (Shi & Tang, 2015).

...focus on the integrated development of the elder care service.

Due to lacking of theoretical knowledge of the elder care service, the development of China’s elder care service is in ‘fragmentation’. The most typical situation is the separation of medical care and daily nursing care – that is, one cannot enjoy elder care in places where they can see a doctor and one cannot see a doctor in places where they can enjoy the service. After many years of exploration and practice, the government and scholars begin to think about what on earth is the connotation of ‘elder care’? In recent years, the concept of ‘integrated care’ began to be recognized by China’s scholars (Du, Li & Li, 2014). In 2015, the concept of ‘new healthy ageing’ was raised in *World Report on Ageing and Health*, issued by World Health Organization (2015) - namely, that countries should work hard to help improve the physical and mental capacities of older individuals and enable them to perform their functions in the interaction

with favorable external environment (including such micro environment as families, homes and interpersonal relationships and such macro ones as social ideas and public policies). Both concepts of 'integrated care' and 'new healthy ageing' serve for an integrated development of elder care resources. In 2015, the State Council introduced the *Instructions for Promoting the Combination of Health Care and Elderly Care Service* and clearly put forward the idea that 'we should promote the combination of health care and elder care service' in the newly issued 13th *Five-year Plan for National Economic and Social Development*. The integration of service resources is also manifested in interdisciplinary cooperation. For example, the Smart Ageing, trying to apply technological achievement in the service, develops rapidly in recent years. The National Committee on Ageing (CNCA) also set up the 'National Committee of Experts of Smart Ageing' in 2013, guiding the Smart Ageing of China. In 2014, the 'Informational People-Benefit Project for Elderly Care Service' was included in 11 projects started by the Ministry of Industry and Information Technology. It means that the government will spend great efforts to promote the integrated development of elder care, health care and medical service. The multi-disciplinary, multi-sector, and multi-resource coordination will definitely improve the quality and efficiency of China's elder care service.

...and at last, the government will begin to focus on constructing an age-friendly livable environment (e.g. livable communities)

Just as what is mentioned in the concept of 'new healthy ageing', a favourable external environment could help improve the self-care ability of older persons. It is precisely the recognition of the importance of the environment that the government discussed 'livable environment' in a single chapter in the revised edition of the *Law on Protecting the Rights and Benefits of Older Persons* in 2013. Indeed, China is the first country in the world that includes the livable environment for older persons into its laws. Many places, such as Shanghai, Hangzhou, Qingdao, and Qiqihar, have started to implement the construction of the livable environment. Besides, the national *Instruction on Promoting the Construction of Livable Environment for the Elderly* is going to be issued soon.

Coda

With the largest population in the world, China has entered the rapid ageing stage. Compared with the population structure with more young people before the end of last century, the population ageing has influenced China in many ways and poses as a serious challenge to the elder care capability to this big developing country. The biased word of 'Chinese style elderly care', which makes people feel helpless, has caused heated discussion in Chinese and foreign academic world. And many people believe that according to the current development situation in China, it would be very hard (at least be stretched) to address the issue of elder care for so many older persons. Many problems would be unavoidable to happen, including 'children could not support their parents after they grow old', 'imbalance of resource allocation', 'a lack of service staff', and 'rapid landslide of economy' and so on.

However, due to China's distinct features and advantages in its development stages, cultural traditions, family relations between generations, and governance systems, China must embark on 'an elderly care road with Chinese features' (Du, 2016). First, because of the fundamental realities that China is still a developing economy, China is doomed to integrate the elder care into the economic development, and China's economy is now changing from being led by industry into service. Chinese government grasps the opportunity to propose the suggestion to strive to develop elder care service and to integrate the challenge of addressing population ageing into economic transformation. Second, Chinese people used to emphasize the reciprocal support among family members. This cultural tradition of elder family care provides cultural foundation for the 'elderly care road with Chinese features'. The fundamental status of elder family care is also made clear in laws and the elder social care plays the role of 'helping families achieve elderly care'. In this way, the content and pattern of elder social care service would definitely have Chinese features. And finally, 'promoting the all-round development of people' is the core value of the governance of Chinese government. What's more, to re-understand the social value of older persons, to encourage them to participate in social activities, and to realize their all-round development have also naturally become the connotation of the 'elderly care road with Chinese features'. And greater longevity bonus would be generated as a result.

With the adjustment of population policies, the population ageing in China will develop further whilst the number of elder families with no children will increase. With the urbanization, the population begins to move in a larger scale. These conditions which have weakened the function of elder family care are challenging the wisdom of Chinese government and the society. And much more efforts are needed for the development of China's elder social care in the future.

References

- Census Office of the State Council, National Bureau of Statistics. (2014). *China's Population towards a well off society (National)*. Beijing: China Statistic Press.
- Chen, Y., & Man, Y. (2013). A study on supply level of pension public service. *Population Journal*, 1, 22-26.
- Community Party China - Central Government. (2015). *Communiqué of the Fifth Plenary Session of the 18th CPC Central Committee*. Accessed on 29 October 2015 from: <http://news.163.com/15/1029/19/B749ETF600014JB5.html>.
- Ding, Z., & Wang, L. (2011). Study on the equalization of home-based care service for the elderly in China. *Population Journal*, 5, 83-88.
- Du, P. (2016). *Retrospect and prospect: Research on China's elderly care manner*. Beijing: Unity Press.
- Du P., Li B., & Li, H. (2014). 'Integrated care' and perfection of China's policy on ageing. *Journal of China National School of Administration*, 3, 86-91.
- Ga, K. (2015). Study on the PPP model applied in the Chinese home-based elderly care service. *Modern Management Science*, 9, 82-84.
- Institute of Gerontology of Renmin University of China. (2016). *Report on China Longitudinal Ageing Social Survey*. Beijing: Institute of Gerontology of Renmin University of China

- Li, J. (2015). China's new normal in population and economy. *Population Research*, 39(1), 3-13.
- Li, B. (2010). Diversification and characteristics: The living arrangements and housing of the elderly in China. *Chinese Journal of Population Science*, 2, 101-110.
- Ma, Y. (2013). *The impact of the care-giving for elderly parents on the employment of young and middle-aged urban women*. Unpublished dissertation, Doctoral Degree, Renmin University of China, Beijing, China.
- Ministry of Civil Affairs. (2015). *National social service statistics for the first quarter of 2015*. Accessed on 30 April 2015 from: http://www.gov.cn/xinwen/2015-04/30/content_2855545.htm.
- National Bureau of Statistics. (2015). *Authority issued: The latest number of old persons is 222 million which is up to 16.1% of population*. Accessed on 20 January 2016 from: http://news.xinhuanet.com/politics/2016-04/21/c_128916010.htm.
- National Health and Family Planning Commission Mobile Population Division. (2015). *A report on the development of China's floating population (2015)*. Beijing: China Population Publishing House.
- Shi, W., & Tang, D. (2015). Path Choice and Innovation of Elderly-Care Issue in Underdevelopment Areas. *Chinese Public Administration*, 4, 94-98.
- Research Center of the State Council. (2015). *Compilation of research results on enhancing the construction of China's social pension service system 2*. Beijing: Research Center of the State Council.
- United Nations. (2015). *World Population Ageing 2015*. New York: Department of Economic and Social Affairs, Population Division, United Nations.
- Wang, Q. (2016). Demands and determinants of community home-based care service for urban elderly: Based on the 2010 National Elderly Survey in China. *Population Research*, 40 (1), 98-112.
- Wang, Z., Sun, T., & Li G. (2013). Regional Difference and Evolution of Population in China. *Population Research*, 37 (1), 66-77.
- World Health Organization. (2015). *World Report on Ageing and Health*. Geneva: World Health Organization.
- Wu, C., & Du, P. (2006). *The changes and challenges of China's population aging*. Beijing: China Population Publishing House.
- Wu, C., Wang, L. & Miao, R. (2003). Process, prospect and countermeasures of population ageing with China characteristics. *Population Research*, 28 (1), 8-15.
- Wu, Y., Guo, P., & Miao, W. (2014). *Analysis on data acquired during 2010 China longitudinal urban / rural old population survey*. Beijing: China Society Press.
- Zhang, L. (2012). Living arrangements and living willingness of the aged population. *Population Journal*, 6, 25-33.
- Zhai, Z., Zhang, X., & Jin, Y. (2014). Demographic consequences of an immediate transition to a universal Two-Child policy. *Population Research*, 38 (2), 3-17.

State of widowhood in Iran: Challenges of ageing spouses

Mohammad Taghi Sheykhi¹

Abstract. The article represents how ageing, widowhood, and loneliness are surging in Iran. To conduct the research, Tehran City was chosen as the empirical universe of study. Due to rise in longevity in Iran in recent years - 76 years for women and 72 years for men - women are very likely to lose their spouse than ever before, and become widows albeit under the lack of adequate infrastructures. This emerging state of affairs leads to demographic challenges within in later life. Shortages of social security and pensions in the third age make the remaining spouse very vulnerable which is sociologically worth studying. Similarly, their social links and relations are impaired under such circumstances. The article indicates how the loss of interactions within the ageing people become problematic and demoralizing. Many remaining spouses experience poverty in this stage of life. Such ageing citizens need planned supports and services, and also effective projections for the years to come.

Keywords: ageing, longevity, widowhood, Iran, familial relations

Introduction

The present demographic window reflects various aspects of the quality of life of women and men after the death of a partner². Loneliness as a social reality happens to women and men mostly in later ages. Such events are recognized as disasters by those who are concerned. The research will also uncover some of the commonalities and similarities of such loneliness in Tehran City as a metropolitan composed of various social classes, races, and social backgrounds. It provides an overview of the theoretical perspectives concerning such women and men after a death. It will also reflect on relevant key themes and issues. Though the body of literature and research in sociology has touched various subject-matters, the pathological situations of such loneliness has been ignored. The paper also tries to cite the identifiable stages/phases of human development and the quality of life of such people. It aims to reflect

¹ Department of Social Science, Alzahra University, Tehran. (mtshykhi@yahoo.com)

² The term 'quality of life' describes a social atmosphere in which standard of living lies in economic progress of a given society. Quality of life also denotes to the manner in which an individual or group lives. It is currently used in a variety of contexts such as sociology, family, economics etc. The notion of quality of life among its other applications, is used to describe and distinguish between rural and urban, married and widowed life. Quality of life also arises as a social manifestation has constitutive socio-economic elements.

loneliness and death event in life cycle by portraying the period as a time of loss, and as a life condition which stands in isolation from the rest of couples' lives³. The study explores the loneliness transition in terms of new roles and the lost roles. However, loneliness as a potential beginning and a new experience will be explored and elicited. This research also tries to reflect a perspective of how to make later years of life worthwhile and successful for current and future cohorts of isolated women and men.

The background context

Traditional Iran was profoundly influenced by the ideas of respect for elder that endured for thousands of years. Since the past few decades with the increasing of urban life, the nuclear families and fewer children in the families, care and respect for the elders have diminished. Similarly, the introduction of one child or two children for the majority of families, means far fewer adult children available in the future to care for older people. For example in early 1980s the total fertility rate (TFR) was above 6 children for a woman, whereas it has been estimated to be 1.9 in 2014. Likewise, while the percentage of age groups under 15 was over 40 per cent in early 1980s, it was declared 25 per cent in 2014 (World Population Data Sheet, 2014). In urban areas it is less and less possible for multi-generational households to exist. In rural areas, pressing poverty means that few people are able to save for retirement. Women in particular face increased risk of poverty in old age. Not only Iran, but many other developing countries are facing such demographic disasters in modern time. In addition, both women and men usually face memory loss in old age which is problematic.

Iran's population is rapidly changing. Change is reflected in every aspect of our lives, from norms and values to technology. Change has become such a prevalent element that we frequently it for granted. Predicting future socio-demographic changes on the basic of existing trends is called *extrapolation* which is sociologically of great importance to avoid risks in the future. Nevertheless, some attempts at social forecasting are necessary in order to plan more effectively for the future, and to develop appropriate solutions for problems that may arise with change. Technological change is a major source of social change. Changes in technology usually precede changes in other areas of the culture and, in turn, this situation results in *cultural lag* - a concept introduced by William Ogburn (1922). Cultural lag is the time, between the introduction of a change and society's adaptation to it. For example, recent advances in medical technology have made it possible to prolong life by extending end-of-life care through the use of assistive technologies. But, there is a lag in the cultural ideas that regulated how we use this new technology (Kornablum, 1988). Another source of social change is a change in the demographic structure of the population. The rapid growth of our older population

³ The life cycle is the process of personal change from infancy through to old age and death, brought about as a result of the interaction between 'biological events' and 'societal events'. The sociological concept of life cycle does not refer to the purely biological process of maturation, but to the transitions of an individual through socially constructed categories of age, and to the variations in social experiences of ageing. For example, while men and women have very different social experiences of biological ageing, the length and importance of 'childhood' varies among cultures. In alternative sense, the life cycle of a family is a process which includes courtship, marriage, child-rearing, children leaving home, widow(er)hood, and finally, the dissolution of the family unit.

provides an example. The social institutions in the society have not yet adjusted to the change in the size of older population, thus resulting in cultural lag. Iran is currently in the process of changing from a young nation to an ageing nation. This transformation is the result of a declining younger population and a growing older population (Pifer & Bronte, 1986). Living longer also means of deterioration in health, especially among the oldest-old, their losing spouse and their loneliness in old age. Consequently, a large number of people in this age group now require of will require long-term care, and the absence of which will be problematic.

Loneliness appears as an effect of marital dissolution or death of a partner worldwide; in some cases it happens due to divorce, and in most cases, and as a natural event, it appears because of the death of spouse. Research shows that in both cases, women tend to suffer long-term negative social and economic consequences while men do not (Neubeck & Glasberg, 1996). While marital dissolution tends to improve men's standard of living, the income of women drops considerably in later life. Moreover, the widows' social relations drop since they are mostly left in an isolated atmosphere. So far as Iran and many other developing societies are concerned, the extent of lonely women's decline in economic status is quite considerable. The greatest decline following the death of a partner occurs for women whose pre-widowhood family incomes were high. Under such conditions, women suffered a 71 per cent drop in income in the United States (Weitzman, 1985, 251). Research has also demonstrated that in many countries including Iran, the economic effects of widowhood are just as disadvantageous for women as divorce - that is, their poverty rate tends to increase as compared to their pre-widowhood status, and before the death of their husbands (Hurd & Wise, 1989). While many husband-lost women in developing countries such as Iran do not have any social security/pensions at all, in the developed world like the United States, widows under the age of 60 are more likely to fall into poverty. That is because in many insurance policies, greater benefits accrue to an older widow (Holden, 1991).

Upon losing their husband, women may experience a whole range of emotions including chaos, anger, resentment, denial and disbelief. This may be followed by intense grief, and a search for the lost person, and that usually happens in every society. Eventual acceptance of the death of one's partner can lead to depression and apathy. To successfully survive, the lonely woman or man has to recognize her/his life in an entirely new and unexpected way (Bernardes, 1997). Under the hard social and economic conditions, many especially women fall into deep poverty and disasters from which the only escape is one's own death. Such a status may be more severe even in the industrial societies where the network of family relations does not function in a strong manner. As a social phenomenon, loneliness must have been in existence as long as socially- regulated marriage. The consequences of loneliness are many and grave. Between birth and death of a person, the most important event in life being marriage, it changes the personalities, the attitudes and lifestyle of women and men. Marriage is entered into with great hopes and expectations. On the contrary, family dissolution due to the death of a partner, and the failure of marital life, has serious repercussions on the individual, family and the community. Many researches and observations have shown the negative results of loneliness after the death a partner. In a way, dissolution of marriage in the

form of loneliness brings about personal, familial and social disorganization, and the effects of which are more severe for women (Pothen, 1996).

On the basis of existent research, as a result of the emotional crises to which lonely women have been subjected, many of whom develop symptoms of personality disorganization⁴. These psycho-social manifestations include suppressions, repressions, regressions, ambivalent motivations, loss of self confidence, doubts, indecisions, and nightmares, amongst others. As a whole, loneliness for both women and men is nearly always a tragedy. In the present article, the author tries to find out the socio-economic background of the partner-lost women and men, and know as to how far the age, education, income etc. affect their new life course. Likewise, through the research, the author hopes to trace the adjustment process of the widows in starting a new life. Loneliness as an institutionalized way of compulsory ending of a marriage, is demonstrated differently in various cultures and societies (Devir, 1998).

However, losing one's husband is the largest social and emotional loss which the women face and suffer it in the course of their ordinary life. It is initially an experience which we must live with that, and secondly, it is a social condition which we should get used to, and put up with that (Sadrusadat, Minaei & Sadrusadat, 1999). Assuming that widowhood is such a major feature of later life, it is surprising to discover that research on the lives of older widows is so scarce (Bernard, 2000). Under such conditions, the author was motivated to demonstrate a sociological perspective of the lonely women and men in Tehran. However, loss and bereavement felt by such lonely women and men, though problematic, are worth probing. The vast quantity of problems as faced by the widows in the society, convincingly portrays widowhood as an experience fraught with poverty, ill-health, loneliness, grief and readjustment. However, poverty has many causes and manifestations, making it difficult to describe with a single indicator with reference to partner-lost women and men (Jaiyebo, 2003). To better understand and identify the problem, the whole scenario needs scientific sociological research.

Literature review

The theoretical context

It is often thought that loneliness is a common problem everywhere regardless of race, religion, poverty or affluence, and geographical position, amongst other differences. One of the main constraints of the lonely women and men especially in countries like Iran, is their

⁴ The term 'emotional crises' is used for emotional behaviour in disconformity with, that expected from an individual's age level within a given society. Emotional crises may be any disruptive life events, possibly entailing the loss of important relationships and social status, which may threaten the integrity of the self and its social relationships. An indicative list is bereavement, divorce, marriage, widowhood, job loss or change, disability, retirement, migration etc. which may involve stress and anxiety, are implicated in the causation of some diseases and emotional crises. They form an important area of study for sociology of health and medicine. It is also counted as a central factor for consideration in the fields of counselling and psychotherapy.

social isolation which highly stems from cultural norms and values prevalent in the society⁵. Loneliness is also reflected as a psycho-social transition in which the phenomenon is seen as a disruption to an accustomed way of life. Individuals will cope differently, depending on their personality, culture, education and social status (Kimmel, 1995). Research on older lonely women and men is increasingly beginning to consider issues of reciprocity and/or exchange. In this model, older women are not seen as powerless victims. Social exchange theory (Antonucci, 1985) identifies loss of reciprocity as a condition under which social support may have negative consequences. For example, the support given to older partner- lost women, particularly by family, often leaves them in the role of passive recipients, or patients receiving treatment, and can leave them feeling powerless and dependent. Other social scientists - such as Watanabe, Green and Field (1989) who looked at the wellbeing of older partner - also found that too much support and lack of reciprocity had a negative effect on the women, perhaps because they felt they had less control. Such a focus on reciprocity allows us to see older widows as active participants in their social world, and thus builds in them the possibility of growth.

From a demographic perspective, the process of ageing is often confounded with other associated factors, such as, deteriorating physical health, poor nutrition, bereavement, social isolation and depression (Kuper & Kuper, 1996) - all likely plus memory loss at the stage of losing a partner. That is to say, all the above situations are mostly experienced by the older lonely women and men in any society. To better elaborate the subject-matter, sociologists discuss the social changes brought about as successive generations of people pass through life's stages – that is, one of them being widowhood. Widowhood and the solitude caused by that is also a period of change and new challenges. It is a crisis for many women and men. It is a time for reevaluating what has been accomplished so far, and for deciding what can realistically be achieved in the years remaining.

To further discuss the theoretical perspectives of late life widowhood, (Blau, 1973) identified widowhood as a 'role-less status', lacking any culturally prescribed rights and duties towards others in the social system. On the other hand, Ferraro (1984) identified some changes within family roles in the early stages of widowhood, particularly between mothers and daughters, when the daughter might take on the "mothering" role for a period of time. However, the effects of 'role loss' in widowhood as Ferraro found, were not consistent, but were more likely to be the result of other factors surrounding widowhood, such as poverty, ill health, and/or very old age, rather than widowhood per se. Nevertheless, older women, though losing the role of 'wife', but they compensate for this loss by adopting to other roles. By using these theoretical ideas, we can explore the cause-and-effect reflections of change in later life widowhood. Finally, life-cycle theory rests on the belief that normal families go through

⁵ Cultural norms and values are essential for the survival of any society. Cultural norms are the prescriptions which are serving as guidelines for social action. Human behaviour is the product of adherence to common expectations or norms. While deviation from norms is punished by sanctions, norms are acquired by internalization and socialization. The concept is central theories of social order. On the other hand, social order and cultural survival depend on the existence of general and shared values which are regarded as legitimate and binding, and act as a standard by the means of which the ends of action are selected. The linkage between norms and values is achieved through the process of socialization.

normal stages of birth, growth, and decline. Marriage initiates the family, the arrival of children develops and expands it, their departure contracts it, and it ends with the death of one of the spouses (Bilton et al., 2002).

The empirical context

Historical literature on widowhood denoted that in earlier centuries in the Western world, widows dominated the category of women without husbands, and death was a major source of instability in marriage. Estimates assert that, from medieval times to the mid-19th century, about half of those who married in their mid-twenties had lost their partner before they reached 60, and another view suggests that marriages in the last century were as fragile as those today: in the 1960s, a third of all marriages dissolved with the death of a partner within twenty years of being formed (Chandler, 1991). However, widows are seen as a historically vulnerable group, with varied position due to their socio-economic structure. Widowhood in its radical context could be found and followed in ancient India in the form of Sati wherein widows were obliged to burn themselves on the cremation ceremony/funeral of their husbands⁶. Though not practiced in modern era, yet, it could be sought among the very religious Hindus.

Most of the research on late-life loneliness was conducted in developed world in 1970s and 1980s. The focus of the research has mainly been on the problems of loneliness and the support systems available for the lonely elders, and in many cases, studies were conducted within three years of the death of a spouse (Chambers, 1994). However, much of the literature on lonely women and men in the 1980s would be better construed as literature on 'widows in bereavement'. The overall review of the literature indicates that lonely elders are a homogeneous group; and widowhood is synonymous with the acute state of bereavement. Older widows are not presented as self-determining, but as lonely and isolated. Generally speaking, late-life loneliness has been typified as a period of decline. Consequent research (e.g. Pickard, 1994) focused on the fact that loneliness in later life is a major stressful life event. On the other hand, Martin-Matthews (1991) reports that a major characteristic of the Canadian widowhood research is its stress-related nature, with a focus on the event of becoming a widow. However, widowhood is referred to, as the loss of a spouse, namely, a life event which requires most adjustment. Jones-Porter (1994) suggested that when it is assumed that the death of a spouse is a stressful event, researchers are more likely to frame data collection in terms of grieving and coping. When one listens to older lonely women and men talking about their present lives, they first express the difference that older women face in later life, and second, how their experience is shaped both by their own life expectation and the expectations of others. However, the challenges faced by the partner-lost women and men may include:

⁶ 'Sati' or 'Suttee' is a Hindu custom known as a solution to widowhood was found in ancient India. In that, Hindu women who had lost their husbands were obliged to commit suicide on the funeral pyres of their dead husbands. There are a number of explanations for this practice. Sati has an economic basis. It was customary in India for a husband's property to be distributed between his mother and his sons. The widow, not having any means to live on, and no support, her only option was suicide. Another explanation express Sati as a part of Hindu culture, and the caste system. It is an act of self-sacrifice to assist the spiritual progress of the husband after death, and was practised more by higher caste women (Chandler, 1991).

family ties, friendship, residence, social interests, financial issues, loneliness, poor health, solo/alone living, and sometimes lack of confidence.

Although the lonely women and men used to comprise the largest group of the elderly people in the industrial world in the last three decades, many Asian countries including Iran are appearing the same in recent years. However, while the industrial societies have developed their social security systems to protect and handle the elderly widows and widowers, the developing societies including Iran, yet, have a long way to go, to be able to handle these people favourably. Indeed, it is remarkable that although the number of the widows is increasing more due to the socio-demographic changes occurred, yet, very little information of these vulnerable people is within reach (Kinsella, 1996, 26). Therefore, to obtain a picture of the myths and realities of the widows, one must search a number of different sources of medical profession, researches done by sociologists, psychologists, social workers, and many other different viewpoints. However, in modern time, due to increasing socio-economic developments, governments have compulsorily intervened in the private affairs of families such as birth control etc. Though they compassionately try to promote social welfare, health and food standards, and quality of life of the families (Ezazi, 2002), yet, the problems of the widows are not well recognized and touched, especially in Iran.

Gender and marital status

One of the most paining and key social problems that has long preoccupied sociologists of gender and mental health is that women have higher rates of depressive disorders than men due to the death of a partner. Recent studies indicate that women are twice as likely as men to experience such mental health (Kessler, 2003). Similarly, in most studies conducted, from the 1970s to the present, women report significantly more symptoms of depression than men (Rosenfield & Mouzon, 2013). The present study revolves around the vulnerability hypothesis, with respect to the etiology of women's greater emotional distress after the death of one's husband. They usually express more emotional upset relative to men. By vulnerability hypothesis is meant that women are more vulnerable than men to the impact of the death of one's spouse. However, while women tend to be more reactive to family-related stress, men tend to be more reactive to employment-related stress (Simon & Lively, 2010). Several longitudinal studies find that becoming married (and remarried) results in a significant decrease in symptoms of depression, whereas becoming divorced, widowed and losing spouse result in a significant increase in these symptoms of distress (Barrett, 2000). However, socio-structural, socio-psychological and socio-cultural factors contribute to persistent gender, marital status and quality-of-life differences in emotional well-being of women and men after the death of one of the partners. Loneliness after the death of one of the two spouses has also been described as a social pain - it is meant to alert an individual of isolation, and motivate her/him to seek social connections (Cacioppo, 2008).

Gender differences in loneliness

Women in the developed countries generally live to seven to eight years longer on average than men. This is becoming even apparent in developing societies, and such a gap is widening

further and further for the Iranian elderly lonely women too. This simple fact has many implications for the society's social structure. For example, there are five times as many widowed women in the U.S. as there are widowed men. Likewise, since women tend to marry older men in Iran as in many other societies, they are much more likely to be widowed during a large portion of their old age. As investigated in countries like the United States, by their 65th birthday, about 25 per cent of married women will be widowed; and half of the remaining ones will be widowed by age 75. Only one man in five will lose his wife during the same time span (Clausen, 1986). Putting it another way, for people aged 65 or older, 75 per cent of men, but only 40 per cent of the women were living with their spouse (United States Bureau of the Census, 1990).

The experience of loneliness itself is different for women and men. Either of the partners after separation, i.e. loss of one spouse, will begin a difficult life, especially at the initial stages, and either woman or man will experience different phases/aspects, depending on one's social, familial and cultural conditions (Asgari, 2001). In some ways, it is more difficult for men to adjust to, for they, not only lose their wives, but a system of domestic support is impaired as well; one that they have always taken for granted. As many men currently in their sixties and seventies tend to be unfamiliar with cooking and household chores, so partner-lost lonely men may experience physical decline due to skipped meals and poor nutrition. Loneliness also clashes with men's self-definitions as independent and resourceful. They are not accustomed to asking for help, so they may get less assistance than they need from relatives and friends, because they are not seen as 'needy'. Among those over the age of 65, rates of suicide are much higher for widowed men than for those whose wives are still alive (Keller, Light & Calhoun, 1994). Though in this regard, there is not a clear statistical evidence in Iran, but the case is very close to that of an industrial society with special reference to Tehran. At the same time, however, remarriage is a predominantly male prerogative, for both demographic and cultural reasons, in 1981, there were only twenty-three unmarried men aged 65 and older for every one-hundred unmarried women in an industrial society like the United States which could be generalized to other developing societies like Iran. In addition, older men still have further option of marrying younger women. As a result, men aged 65 and older are eight times more likely to remarry than women at this age (Horn, 1987). Interestingly, social status affects remarriage rates among the widows and widowers in opposite ways. The more education a woman has, and the higher her income, the less likely she is to remarry, while the reverse is true for men.

Research design

The research techniques used in the present survey for specific fact-finding, and operations to yield the required social data, have been of a mixed-method strategy of investigation. While the main technique of study in this research is administering questionnaires, the author used interview method where necessary as well. Documents and books as major sources of evidence were used too, as primary source materials. While so far lesser attention has been paid to the loneliness studies and the disasters followed, in Iran, in the theoretical section, the author has referred to various theories and approaches, literature review and so forth. The survey based on questionnaire- design, attitude measurement and question wording, were as

well accompanied by face to face interviews where necessary. In completing the research, lonely women and men were randomly selected, and for whom the questionnaires were filled in. Eventually, 584 questionnaires were elicited and extracted. However, in completing the present research, and to produce a reliable and valid work, the procedure of research was followed through the fundamental methods mentioned.

Findings

The respondents included 395 females and 189 males, 67.6 and 32.4 per cent respectively. The distribution of their age is found in Table 1.

Amongst respondents, 52 widows (8 per cent) declared that they had lost their husbands for less than one year, and 15 (2 per cent) widows asserted that they had lost their spouses for more than 30 years. As regards men, 40 widows (6 per cent) declared that they had lost their wives for less than one year, and 3 (0.3 per cent) asserted that they had lost their spouses for more than 30 years.

Table 1: Respondents by gender and age in Tehran City

Age	Females		Males	
	No.	Per cent	No.	Per cent
<30	8	1.37	0	0
30-39	16	2.74	4	0.68
40-49	38	6.51	7	1.2
50-59	77	13.18	23	3.94
60-69	115	19.69	48	8.22
70-79	96	16.44	61	10.45
80-89	43	7.36	33	5.65
90+	2	0.34	13	2.23
Total	395	67.64	189	32.37

The remaining range of distributions are found in Table 2. The high rate of maternal death and other health-related issues are responsible for the relatively high frequency of loss of wives among the widows.

Table 2: Classification of widowhood by gender and time of event

Age (years)	< 1		1-5		6-10		11-15		16-20		21-25		26-30		30>	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Total	92	15	178	30	130	22	67	11	51	3	32	5	16	2	18	3
Females	52	8	107	18	87	14	47	8	42	7	30	5	15	2	15	2
Males	40	6	71	12	43	7	20	3	9	1	2	0.3	1	0	3	0

Tables 3 to 5 attempt to classify widowhood with (i) the state of monthly pensions, (ii) safety/illness, and (iii), medical insurance. Results revealed that 80 widows (13.7 per cent) and 145 widowers (24.83 per cent) held 'self-pensions', 218 widows (37.33 per cent) and 4 widowers (0.68 per cent) held a 'pension from ex-spouse', and 97 widows (16.61 per cent) and 40 widowers (6.85 per cent) held no pension.

Table 3: Widowhood by gender and the state of monthly pensions in Tehran City

Age	Total		Self-pension		Pension from ex-spouse		Without pension	
	No.	per cent	No.	per cent	No.	per cent	No.	per cent
Total	584	100	225	38.53	222	38.01	137	23.46
Females	395	67.64	80	13.7	218	37.33	97	16.61
Males	189	32.36	145	24.83	4	0.68	40	6.85

As far as safety/illness were concerned, 131 widows and 85 widowers considered themselves to be 'safe', 144 widows and 58 widowers held '1 illness', 66 widows and 26 widowers held '2 illnesses', and 54 widows and 19 widowers held '3 illness or more' (Table 4).

Table 4: Widowhood by gender and safety/illness in Tehran City

Age	Total		Safe		Having 1 illness		Having 2 illnesses		Having 3 illnesses and more	
	No.	%	No.	%	No.	%	No.	%	No.	%
Total	584	100	216	36.99	202	34.59	93	15.92	73	12.5
Females	395	67.64	131	22.43	144	24.66	66	11.3	54	9.25
Males	189	32.36	85	14.55	58	9.93	27	4.62	19	3.25

With respect to medical insurance, 309 widows (68 per cent) and 136 widowers (32 per cent) were in possession of 'medical insurance', 86 widows (15 per cent) and 53 widowers (9 per cent) held no 'medical insurance' (Table 5).

Table 5: Widowhood by gender and medical insurance in Tehran City

Age	Total		With medical insurance		Without medical insurance	
	No.	%	No.	%	No.	%
Total	584	100	445	76.2	139	23.3
Females	395	67.64	309	52.91	86	14.73
Males	189	32.36	136	23.29	53	9.08

The study also focused on the extent of the problems experienced by respondents. As much as 177 (30.31 per cent) of widows stated they experienced serious problem as the result of their marital status, with 76 (13.01 per cent) declaring their key problem as lack of income, 79 (13.53 per cent) highlighting their illness as their key concern, and finally, 63 (10.79 per cent) widows underling their problems as ‘others’. With respect to widowers, 111 (19.01 per cent) declared that they experienced serious difficulties following the loss of their wives, with 32 (5.48 per cent) pointing to inadequate income, 25 (4.28 per cent) highlighting illness, and 21 (3.6 per cent) declaring their problems as ‘others’. With respect to quality of life, findings reveal 141 (24.14 per cent) widows suffered from ‘social isolation’, 148 (25.34 per cent) widows experienced material poverty, 35 (5.99 per cent) widows had limited relationships with friends, and finally, 71 (12.16 per cent) widows expressed to have limited relationships with the relatives. On the other hand, 92 (15.75 per cent) widowers suffered from social isolation, 17 (2.91 per cent) widowers suffered from material poverty, 27 (4.62 per cent) widowers had limited relationships with friends, and 53 (9.08 per cent) widowers stated to have limited relationships with relatives.

The study also questioned living arrangements (Table 7). On one hand, only 10 (1.71 per cent) widows were positive to residing in nursing homes, whereas 367 (62.84 per cent) widows did not appreciate living in nursing homes, and finally, 18 (3.08 per cent) widows stated that they like to stay in care homes ‘only to an extent’. Only 19 (3.25 per cent) widowers were positive to living in care homes, 149 (25.51 per cent) widowers did not appreciate living in care homes, and finally, 21 (3.6 per cent) widowers professed that they like to stay in care homes ‘only to an extent’.

Table 7: Widowhood by age, gender and their state of accommodation in Tehran City

Age	Total		Owning private residence		Tenant	
	No.	per cent	No.	per cent	No.	per cent
Total	584	100	479	82.02	108	17.98
Females	395	67.64	315	53.94	80	13.7
Males	189	32.36	164	28.08	25	4.28

Leisure time patterns was another focus of the study, with 133 (22.77 per cent) widows stating that most of their leisure involved participating in religious meetings. Similarly, the same number of widows enjoying spending their leisure time visiting their children, whilst 26 (4.45 per cent) widows took care of their grandchildren, and 39 (6.68 per cent) widows spent their leisure time by visiting their family relatives. As far as widowers were concerned, 30 (5.14 per cent) widowers spent their leisure time in religious meetings, 67 (11.47 per cent) widowers stated that they spent their leisure time by visiting their children, 12 (2.05 per cent) widowers took care of their grandchildren, and 14 (2.4 per cent) widowers enjoyed visiting family relatives. Finally, the study found that 183 (31.34 per cent) widows asserted to feel ‘isolated and lonely’, 32 (5.48 per cent) widows felt ‘poor’, 107 (18.32 per cent) widows felt ‘dependent’, and finally, 73 (12.5 per cent) widows stated to feel ‘fortunate and happy’. With respect to the

men, 120 (20.55 per cent) widowers stated they experienced 'isolation and loneliness', 15 (2.57 per cent) widowers felt 'poor', 35 (5.99 per cent) widowers experienced 'dependence', and finally, 19 (3.25 per cent) widowers, perceived themselves to be 'fortunate and happy'.

Conclusion

Not only China and India have their population-related problems, and their disasters caused by large populations in the form of air pollution, environmental issues, other countries such as Iran is also facing new disasters stemming from ageing, widowhood, shortage of social security in old age, increasing marriage age for the youth, decline in fertility ratios and other such issues. However, Iran needs further infrastructures to be able to respond to the increasing demands of its surging ageing population, and if not, Iranian society will not be able to meet the challenges of population ageing. As a result of the death of one of the spouses, the remaining other spouse, particularly if female, faces various social, economic, psychological and emotional constraints/disasters. Therefore, widowhood is strongly associated with poor mental health (Das, Friedman & McKenzie, 2008). The state of having lost one's spouse to death could leave the wife with increasing problems regardless of where it happens. If we go back in history, widows in many cultures used to wear black for the rest of their lives to signify their mourning. Though it has been loosened in many societies and cultures, yet many widows comply with that. In the meantime, and as far as the remaining female spouses are concerned, their social networks are severely and negatively affected. Such invisible group of women are usually excluded - they are painfully absent from the statistics of many developing countries. In such countries the exact number of such women (widows), their ages and other social and economic aspects of their lives are unknown.

Widows comprise a significant proportion of all women; ranging from 7 to 16 per cent of all adult women (United Nations, 2001). However, older women are far more likely than older men to be widowed. The proportion of which in Western Asia where Iran also is situated, is 48 per cent for women aged 60-plus as compared to 8 per cent for their male peers in the period 1985 to 1997 (ibid.). As far as women are concerned, the maximum proportion is 59 per cent for women in Northern Africa and 39 per cent in developed regions of the world - similarly, as far as men are concerned, the lowest proportion is 7 per cent in Africa and 14 per cent in Eastern Europe (ibid.). Yet, in order to achieve real advancements, women who have lost their husbands need support to get organised. A low-fertility combined with increased life expectancy has led to a population structure that is increasingly weighted towards older members of society in Iran in the past few years. Similarly, the current middle-aged generation of Iran has failed to replace itself. Various studies of demographic change in Iran have linked declining fertility to other changing social factors as increased education, delayed marriage age, aspirations to get economic opportunities for women, and the expense of raising children in modern urban societies. All these have played role in reducing fertility over the past few decades, i.e. leading to surging ageing population, more widows and widowers over the age of 65 and the like facing increasing socio-economic disasters with special reference to women. Not only in Iran, but across the globe, the women who have lost their husbands share two common experiences: a loss of social status and reduced economic circumstances. Even in developed countries the older generation of widows, those now over 60, may suffer a

dramatic, but subtle change in their social position. Similarly, the monetary value of widows' pensions is a continuing source of grievance, since the value often does not keep up with fluctuations in the ever-changing cost-of-living indices. A global overview indicates that countries like India has the largest recorded number of widows in the world - 33 million (10 per cent of the female population, compared to only 3 per cent of men), creating increasing problems for such women (ibid.). Iran too, is in the same position relative to its population.

The data collected in this study reflects different dimensions of the quality of life of those who lost their partners in Tehran, could help plan their lives in a better way; particularly under the circumstances that life expectancy is ever increasing, and women in their later life get the chance to remain alone for a longer course of time. As a result, many of the lonely women expressed satisfaction with their quality of life, and challenged the view that widowhood is a period of decline. They acknowledged that many changes had occurred in their lives. Many of them also acknowledged that they often were alone and isolated. Most of the widows studied, recognized that there had been changes from their married lives, adjusting to the new phase of life, network of friends, relatives, and neighbours. The study found that they had undergone a transition to another phase in their lives with new values and standards - some, however, reflected positive aspects of their lives, although some dimensions caused them distress. Further research about such silent groups of elder women needs to be carried out, to listen to their voices and their needs in order to improve their quality of life and so forth.

References

- Antonucci, T.C. (1985). Personal characteristics, social support, and social behavior. In R.H., Binstock & E., Shanas (Eds.), *Handbook of aging and the social sciences* (pp. 94-128). New York: Van Nostrand Reinhold.
- Asgari, H. (2001). *Role of mental health in marriage, marital life, and divorce*. Tehran: Gofteman Publishers.
- Barrett, A.E. (2000). Marital trajectories and mental health. *Journal of Health and Social Behavior*, 41 (4), 451-464.
- Bernard, M., Phillips, J., Machin, L., & Davies, V.H. (2000) (Eds.) *Women ageing: Changing identities, challenging myths*. London: Routledge.
- Bernardes, J. (1997). *Family studies*. New York: Routledge.
- Bilton, T., Bonnett, K., Jones, P., Lawson, T., Skinner, D., Stanworth, M., & Webster, A. (2002). *Introductory sociology*. New York: Macmillan.
- Blau, Z. (1973). *Old age in a changing society*. New York: Franklin Watts.
- Cacioppo, J., & William, P. (2003). *Loneliness: Human nature and the need for social connection*. New York: W.W. Norton and Co.
- Chandler, J. (1991). *Women without husbands*. London: Macmillan Education Ltd.
- Chambers, P. (1994). A biographical approach to widowhood. *Generation Review*, 3 (4), 8-12.
- Clausen, J.A. (1986). *The life course: A sociological perspective*. Englewood Cliffs, NJ: Prentice-Hall.
- Das, J., Friedman, J., & Mackenzie, D. (2008). Mental health patterns and consequence: Results from survey data in five developing countries. *World Bank Economic Review*, 23 (1), 31-55.

- Devir, U. (1998). *Divorced women*. New Delhi: APH Publishing Corporation.
- Ezazi, S. (2002). *Family violence (battered women)*. Tehran: Sali Publishers.
- Ferraro, K. (1984). Widowhood and social participation in later life. *Research on Ageing*, 6 (4): 451-68.
- Green, W., & Field, S. (1989). Social support coverage and wellbeing of the elderly widows and married women. *Journal of Family Issues*, 1 (10), 33-51.
- Holden, K. (1991). The economic costs of marital dissolution. *Annual Review of Sociology*, 17, 51-78.
- Horn, J.C., & J. Meer. (1987). The vintage years. *Psychology Today*, 21 (5), 76-90.
- Hurd, M., & Wise, D.A. (1989). *The wealth and poverty of widows: Assets before and after the husband's death*. Chicago, IL: University of Chicago Press.
- Jaiyebo, O. (2003). Women and household sustenance: Changing livelihoods and survival strategies in peri-urban areas of Ibadan. *Environment and Urbanization*, 15 (1), 111-120.
- Jones-Porter, E. (1994). The life world of older widows: The context of lived experience. *Journal of Women and Ageing*, 7 (4), 31-46.
- Keller, S., Light, D., & Calhoun, C. (1994). *Sociology*. Columbus, OH: McGraw Hill.
- Kessler, R.C. (2003). Epidemiology of women and depression. *Journal Affective Disorders*, 74 (1), 3-15.
- Kimmel, D. (1995). *Adulthood and ageing*. London: John Wiley.
- Kinsella, K. (1996). Demographic aspects. In S., Ebrahim & A., Kalache (Eds.). *Epidemiology in old age* (pp. 32-40). London: BMJ Publishing Group.
- Kornblum, W. (1988). *Sociology in a changing world*. New York: Holy, Rinehart and Winston.
- Kuper, A. & J. Kuper (1996). *Social science encyclopaedia*. London: Routledge.
- Martin-Mathews, A. (1991). Widowhood in Later Life, P.30, Toronto, Butterworths.
- Neubeck, K. J., & Glasberg, D.S. (1996). *Sociology*. New York: McGraw-Hill Inc.
- Ogburn, W.F. (1922). *Social change*. New York: Viking.
- Pickard, S. (1994). Life after a death: The experience of bereavement in South Wales. *Ageing and Society*, 14 (2), 191-214.
- Pifer, A., & Bronte, L. (1986). Introduction: Squaring the pyramid. In A., Pifer & L., Bronte (Eds.), *Our ageing society* (pp.3-13). New York: W.W. Norton.
- Pothen, S. (1996). *Divorce*. Bombay: Vikas Publishing House.
- Rosenfield, S. & Mouzin, D. (2013). Gender and mental health. In C.S. Aneshnsel, J.C. Phelan, & A. Bierman (Eds.), *Handbook of sociology of mental health* (2nd ed.) (pp. 277-298). New York: Kluwer.
- Sadrusadat, S.J., Minaei, A., & Sadrusadat, L. (1999). *Familial life, retirement, and the years of later old age*. Paper presented at the First International Conference on Ageing, Tehran, October 1999.
- Simon, R. W., & Lively, K. (2010). Sex, anger, and depression. *Social Forces*, 88 (4), 1543-1568.
- United Nations. (2001). *World population ageing: 1950-2050*. New York: United Nations
- United States Bureau of Census. (1990). *Current Population Reports: Series*. Washington, DC: United States Government Printing Office.
- Weitzman, L. (1985). *The divorce revolution: The unexpected social and economic consequences for women and children in America*. New York: Free Press.

Elder abuse, depression, relationships and attachments: Determinants of mental health in later life.

Ritu Sharma¹ and Rupinder Kaur²

Abstract. The purpose of this research was to explore the issue of elder abuse and depression among older persons. In addition, relationship and attachment with relevant others, and its effect on positive mental health of older persons were also examined. Data was collected from 200 older persons living either with their families or in care homes for older persons. Schedules of social support, socialization, depression and elder abuse were used. Immediate support system, relationship with relevant others, mental health and abuse were assessed, using both quantitative and qualitative methods. The study revealed that depression was prevalent among both groups, with incidents of elder abuse least admitted by people living with their families. People living in care homes for older persons affirmed experiencing abuses of several types. Lack of social support and socialization were found to be the key factors behind abuse and depression.

Keywords: elder abuse, depression, India, mental health, attachments.

Introduction

Population ageing is a world phenomenon that is progressing fastest in the developing countries (United Nations Population Fund & HelpAge International, 2012). Although ageing is a clear indicator of advancements in health care, improved nutrition, better socio-economic and educational opportunities, it also has its unique challenges depending on the age, socio-economic status, health, and living arrangements to mention some (Siva Raju, 2002; Alam, 2006). Older people, through their socio-economic contribution, caregiving and passage of traditions and cultural values, are an asset for the society. Nevertheless, old age in itself can often be a very vulnerable phase. As the physical and emotional health in later life declines, the increasing dependency on the caregivers, results in older persons being exposed to the risk of being mistreated, neglected and abused. According to the World Health Organization (2002 : 126), "elder abuse is as an act of commission or of omission (neglect) that may be intentional or unintentional, and that may be of a physical nature, psychological (involving

¹ Aditi Mahavidyalya, Department of Psychology, University of Delhi, India. (ritusharen@rediffmail.com)

² Systemic Practitioner, Independent Researcher, United Kingdom. (k.rupinder@gmail.com)

emotional or verbal aggression), financial or material, inflicting unnecessary suffering, injury or pain". Older persons who face abuse often live in silent desperation, denial and avoid seeking assistance. They do not want to speak about such experiences because it threatens to shatter the honour of the family and self or they are ashamed at being subjected to violence and exploitation by their own children, relatives and people from the community. Older persons might also fear further retaliation from their abusers. Many remain silent to protect abusive family members from the legal consequences of their crimes. It is a sensitive and a taboo subject. Thus, it may take the courage of a caring family member, friend or caregiver to take action when the victim may be reluctant. Several theories exist to understand various causes of elder abuse, ranging from situational theory, exchange theory, psychopathology (mental and emotional of caregiver), social learning theory, feminist theory, to political economic theory. The tapestry of theoretical viewpoints presents the complexity of the issue of elder abuse. It is difficult to identify the dominance of one factor over the other. The causes of elder abuse change with the socio-economic, cultural and political scenario. Therefore, elder abuse is contextual and cannot be generalized. In India, the older population (aged 60 years or above) accounted for 7.4 per cent of total population in 2001. For males it was marginally lower at 7.1 per cent, while for females it was 7.8 per cent. The old-age dependency ratio climbed from 10.9 per cent in 1961 to 13.1 per cent in 2001 for India as a whole. For females and males the value of the ratio was 13.8 per cent and 12.5 per cent in 2001 respectively.

Different types of elder abuse

Elder abuse can take place at the victims own home and is termed *domestic elder abuse*. It refers to a maltreatment of an older person by someone who has a special relationship with the elder (e.g. spouse, sibling, child, friend, daughter-in-law and caregiver). It can also take place at professional care settings and is termed as *institutional elder abuse*, that is, abuse that occurs in care homes for older persons (e.g. nursing homes, foster homes, group homes, board and care facilities), wherein abusers are persons who have legal or contractual obligation to provide elder victims with care and protection (e.g. staff, professionals, paid caregivers). Elder abuse can take place in various different forms. Familiar types of elder abuse include (Callaghan, 1998; Nerenberg, 2000):

- Physical - e.g. hitting, pushing, slapping, punching, restraining, pinching, force-feeding;
- Psychological - e.g. verbal aggression, intimidation, threats, humiliation;
- Sexual - e.g. any kind of non-consensual sexual contact;
- Material - e.g. theft of cash or personal property, forced contracts, misuse of income;
- Violation of rights - e.g. deprivation of rights such as voting, assembly, speech, privacy;
- Medical - e.g. withholding medication or overmedicating;
- Abandonment - e.g. desertion of an older person for whom one has agreed to care for
- Neglect - e.g. failure to provide necessary physical or mental care of an older person;
- Self-neglect - behavior that threatens one's own health or safety.

According to the HelpAge India (2014), the most common form of abuse nationally experienced by older persons was disrespect (79 per cent) followed by verbal abuse (76 per cent) and neglect (69 per cent), and a disturbing (39 per cent) older persons faced beating or

slapping. Among the cities, Madurai in Tamil Nadu recorded the highest incidence of elder abuse (63 per cent) followed by Kanpur in Uttar Pradesh where (60 per cent) of older persons reported experiencing abuse. About 20 per cent of older persons faced abuse in the national capital (Delhi). Almost all cases of elder abuse go unreported in Jammu, Kashmir and Rajasthan. Among the cases of elder abuse, a shocking 16.19 per cent in Rajasthan, and 13.67 per cent in Andhra Pradesh faced beating or slapping. This report, more than focusing on the number of elders who chose to come out and speak about their trauma, revealed how an astonishing number of such cases goes unreported every year (ibid.). On the other hand, Bhatia who chose to come out in the open with 70 per cent of the respondents admitting that they were abused but did not report the matter.

Methodology

The purpose of this research study was to understand the prevalence and the probable causes of elder abuse in Delhi. An attempt was also made to find out the possible ways to overcome the vastly increasing problem of elder abuse in our society. Therefore, the objectives included (i) to explore the relationship between ages, marital status, education and living arrangement on elder abuse and (ii) to explore the causes of elder abuse among older people living in Delhi.

Sample. A total sample of 100 older persons from the community and 100 older persons residing in care homes participated in the study. People aged 60 years and above were included from all socioeconomic classes. People below the age of 60 years, older persons who came to Delhi to spend holidays with their children at the time of data collection and non-permanent residents of Delhi, were excluded from the study.

Variables. Variables were selected on the basis of the review of available literature. Independent variables included age, gender, education, marital status, living arrangement, depression and social support. The dependent variable was elder abuse.

Design. The study consisted in a cross-sectional study assessing elder abuse among residents of Delhi. Out of the total sample of 200, 100 participants were randomly selected from the community in the central and north-west regions of Delhi. Ten care homes were selected at random from a list of care homes for older persons provided by HelpAge India. Hundred participants were randomly selected from the 10 care homes previously selected. Permission for data collection and informed consent was taken from the care homes and from all the participants. In-depth interviews were conducted with 20 older people depending upon the severity of elder abuse and willingness to respond. Prevalence rates of elder abuse was calculated using descriptive statistics using the 11.0 version of the Statistical Package for the Social Sciences. Factors were compared between groups using independent samples t-test, and one way ANOVA wherever applicable. A simple linear regression analysis was used to determine association between elder abuse scores and the variable being studied. The in-depth interviews were analyzed using thematic analysis.

Tools used. Personal information schedule was used to collect the demographic information from the participants of the research. It included information such as name, gender, age,

address, phone number, name and address of the old age home, duration of stay in old age home, marital status, living arrangement, financial status, occupation and education. A tailor-made social support schedule, geriatric depression scale (Yesavage et al. 1982), elder abuse screening test (Hwalek & Sengstock, 1986) and an inventory for general assessment of elder abuse were used to assess state of mental health, elder abuse and socialization.

Analysis and discussion

Gender. Respondents comprised 35 and 65 per cent male and females, respectively. 24.4 per cent of respondents were in the 60-65 age-bracket, 24.4 per cent were in the 66-71 age bracket, 13.4 per cent were in the 72-77 age bracket and 23.4 per cent were aged 78-plus. Whilst 21.5 and 13.5 per cent of males were living in the community and in care homes respectively, 28.5 and 36.5 per cent of females were living in the community and residential homes respectively.

Marital Status. The study revealed that the percentage of respondents who were married and widowed was 43.5 and 56.5 per cent respectively. The percentage of respondents who were married and widowed and living in care homes was found to be 11.5 and 38.5 per cent respectively. Moreover, it was also found that care homes included a higher number of widowed females than widowed males and older family couples. Amongst those living in the community, 43.5 per cent were married, 46 per cent were widowed, 5 per cent were single and 2.5 per cent were divorced. In the case of care homes, 11.5 per cent were married, 29 per cent were widowed, 10 per cent were single, and 6 per cent 'never married'.

Living arrangement. Amongst those living in the community, 8 per cent were living with spouse, 23 per cent were in joint family households and 15.5 per cent lived alone. As far as married couples were concerned, 11.5 lived in residential homes and 38.5 per cent of widowed older persons were living in care homes.

Dependency ratio. The study revealed that 58.5 per cent were economically dependent on others for their livelihood, 24 per cent were partially dependent, and 17.5 per cent were independent. It was also found that 2.5 per cent of dependents lived with spouse, 5.5 per cent lived in joint family households, while 5.5 per cent lived alone. Most respondents were financially reliant.

Education. As much as 18.5 per cent of respondents were illiterate, whilst 7 per cent had five years of schooling, 44 per cent had 10 years of schooling, 10.5 per cent had 12.5 years of schooling, and 7.5 per cent had 17 years of schooling. Results indicated that the education levels of respondents living in care homes for older persons were as follows: 14 per cent illiterates, 12 per cent had 5 years of schooling, 19.5 per cent had 10 years of schooling, two per cent had 12 years of schooling, six per cent had 15 years of schooling, and three per cent had 17 years of schooling. It therefore resulted that people with lower levels of education are at higher risk of taking residence in care homes for older people.

Table 1 reveals that females and widowed participants are at more risk of experiencing elder abuse than their male peers. The same is for persons living in care homes who reported higher levels of abuse.

Table 1: T-test comparison on the basis of gender, marital status and living arrangement

Variables	Male (N=70) Mean (SD)	Females (N=130) Mean (SD)	Married (N=87) Mean (SD)	Widowed (N=113) Mean (SD)	Community (N=100) Mean (SD)	Care homes (N=100) Mean (SD)
Social Support	44.62 (±7.65)	42.81 (± 8.82)	45.74 (±7.62)	41.68 (±8.67)**	42.98 (±8.57)	43.92 (±8.36)
Geriatric Depression Scale	19.35 (±3.25)	22.25 (±3.70)**	20.78 (±3.66)	21.59 (±3.89)	20.90 (±4.21)	21.58 (±3.33)
Elder Abuse	18.62 (±3.47)	20.18 (±3.71)**	18.83 (±3.06)	20.25 (±4.03)**	18.57 (±3.66)	20.71 (±3.43)**
General assessment of elder abuse	24.85 (±15.09)	25.02 (±15.59)	20.79 (±10.89)	28.17 (±17.47)**	19.37 (±8.51)	30.56 (±18.43)**

Notes: The variable marked (*) indicate that the result is statistically significant through one way ANOVA, Bonferroni Post Hoc test, with $p < 0.5$, and (**) when $p < 0.1$.

Marital status and gender is significant in the context of care in old age as those who are married seems to fare better in all economic and social aspects than those who are single. Table 1 shows that older females tend to be depressed and at higher risk of elder abuse when compared with their male peers. Similarly, widowed respondents tend to profess lesser levels of social support and at higher risk to experience elder abuse, especially in terms of frequent fractures, burn marks, and cuts. The feminization of widowhood tends to make older females highly vulnerable to elder abuse in Indian society and by 2050 the population of older women will exceed 18.4 million compared to the male older population (Chakrabarti & Sarkar, 2011; Prakash, 1997). Indeed, a major concern relates to the increasing proportion of older women, especially widows in the population. Two reasons are given for the marked gender disparity in widowhood in India, namely (i) longer life span of women compared to men, (ii) the general tendency for women to marry men older than themselves (Gulati & Irudaya, 1999). Besides, widowers are more likely to remarry and thus restore their earlier status but same is not true for female older persons. Remarriage of female widows is not encouraged in Indian society. Though the relationship between the well-being of older persons and their marital status cannot be spelt out precisely, any change in the marital status of older persons deserves careful examination (Chadha et al, 2006). Loss of spouse is a major calamity in old age and widows deserve suitable and adequate social safety nets irrespective of gender (Sharma, 2013). Designing policies to protect older females, particularly widows, should form a major welfare programme in the country. Table 2 shows further comparisons indicating that that social support was significantly high among the age group of 72-77 years, so that elder abuse was significantly higher among the age group of 66-71 years. Young-old people found it difficult to cope up with the circumstantial changes occurs after retirement from work. It is the challenging phase of the life-cycle during which they have to deal with loss of job, loss of partner, loss of health and status. These losses can be traumatic, leading to emotional and relationship conflicts (Carter & McGoldrick, 1980; United Nations, 1987), and thus, further vulnerability to abuse.

Table 2: T- test comparison on the basis of Age

Variables	60-65 (N=72) Mean (SD)	66-71 (N=51) Mean (SD)	72-77 (N=28) Mean (SD)	78 and above (N=49) Mean (SD)
Social Support	43.98 (±8.76)	41.20 (±8.84)	48.00 (±6.39)*	41.98 (±7.63)
Geriatric Depression Scale	21.93 (±3.74)	21.39 (±4.23)	20.17 (±2.86)	20.67 (±3.78)
Elder Abuse	19.33 (±3.54)	20.56 (±4.72)*	17.62 (±1.80)	20.24 (±3.04)
Hygiene	27.94 (±18.55)	29.66 (±18.05)	20.35 (±6.24)	18.32 (±4.03)*

Notes: The variable marked (*) indicate that the result is statistically significant through one way ANOVA, Bonferroni Post Hoc test, with $p < 0.5$, and (**) when $p < 0.1$.

Table 3 shows that the number of years of education was found to have an impact on the well-being of older persons. The results indicated that the longer the length of education, the higher is the social support. Depression and elder abuse was found to be high among the illiterate group. This could be attributed to the fact that higher education can equip a person with more knowledge and awareness of the life-cycle changes, the challenges and entitlements. Thus, education plays an important role in providing a vision to an individual to plan his/her life and decide on the way in which s/he wants to spend it. Some five or 10 years of education can only make him/her capable of understanding the basics to read and write. However, longer years of education opens the gateway to creativity and innovation to handle the challenges of life (Sharma, 2014).

Table 3: T-test comparison on the basis of level of education

Variables	Illiterate (N=37) Mean (SD)	5 years of schooling (N=14) Mean (SD)	10 years of schooling (N=88) Mean (SD)	12 years of schooling (N=21) Mean (SD)	15 years of schooling (N=25) Mean (SD)	17 years of schooling (N=15) Mean (SD)
Social Support	38.00 (±5.78)	46.28 (±6.15)	45.37 (±8.70)	39.57 (±12.14)	44.48 (±5.30)	46.66 (±4.67)*
Geriatric Depression Scale	23.83 (±4.03)*	21.50 (±2.27)	20.75 (±3.58)	21.80 (±4.21)	20.56 (±3.29)	17.80 (±1.37)
Elder Abuse	21.35 (±4.44)*	21.14 (±2.65)	18.97 (±2.90)	20.38 (±4.96)	20.08 (±3.61)	16.13 (±0.35)
Hygiene	20.93 (±7.50)	24.78 (±6.87)	22.27 (±15.05)	21.85 (±8.87)	36.60 (±20.00)*	35.73 (±22.33)

Notes: The variable marked (*) indicate that the result is statistically significant through one way ANOVA, Bonferroni Post Hoc test, with $p < 0.5$, and (**) when $p < 0.1$.

Further analysis, as shown in Table 4, indicates that older people living alone had high depression and elder abuse. In addition, older persons who lived in care homes for older persons reported being abused as well. The term 'living arrangement' is used to refer to one's

household structure (Palloni, 2001). Irudaya, Mishra, & Sharma (1995) explained living arrangements in terms of the type of family in which older persons live, the headship they enjoy, the place they stay in and the people they stay with. The kind of relationship they maintain in living arrangements, family structure and mode of retirement affect older persons (D'Souza, 1989), influencing psychological wellbeing, depression, leisure time activity and life style. People who live in families, as compared to care homes for older people, were found to be more active when compared with those living alone (Sharma, 2014).

Table 4: T-test comparison on the basis of living arrangement

Variables	Spouse (N=16) Mean (SD)	Joint family (N=46) Mean (SD)	Alone (N=31) Mean (SD)	Care homes (N=107) Mean (SD)
Social Support	43.00 (±7.41)	44.87 (±8.29)	39.96 (±9.54)	43.91 (±8.18)
Geriatric Depression Scale	21.25 (±4.07)	20.86 (±4.06)	21.70 (±4.54)	21.26 (±3.44)
Elder Abuse	17.18 (±1.42)	18.15 (±2.82)	20.22 (±5.14)	20.47 (±3.44)*
Hygiene	15.50 (±0.89)	18.71 (±9.99)	21.87 (±8.52)	29.96 (±17.96)*

Notes: The variable marked (*) indicate that the result is statistically significant through one way ANOVA, Bonferroni Post Hoc test, with $p < 0.5$, and (**) when $p < 0.1$.

There exist several living patterns for older persons such as living with the spouse, living with children and living in care homes for older persons. Living alone or with the spouse is the most stable living arrangement for people who are not too old yet, whereas for the oldest-old, living with a child or grandchild is the most stable arrangement (Wilmoth, 1998). Researchers have put a lot of effort to investigate the determinants leading to a specific living arrangement. Living arrangements are influenced by a variety of factors including the number and availability of children and other relatives, kinship patterns of society, location of household, marital status, financial status, availability of services and physical and mental well-being of older persons (Kan, et al, 2001; Schafer, 1999). Attitude towards and perception about the living place is another important component that decides where they should live (Chen, 1998).

In Indian society, parents are majorly the responsibility of their son and not the daughter. Therefore, the sole responsibility of taking care of parents comes onto the shoulders of son and daughter-in-law (Jamuna, 1995). If they have loving bonds, then life becomes easier for the dependent parent. There is social stigma in Indian society against disclosing the internal family matters in public. That is why most of the time children take their parents for granted because they know that they will not say anything wrong about them in front of others. The changes in the traditional Indian norms related to the living arrangements and family constitution, wherein, older persons live with their children, specifically the son, has had an impact on the well-being of older persons. There is a general trend towards living in nuclear

families, whereby children live far away due to studies, work and personal preferences (Palloni, 2001). Besides living arrangements, housing conditions of older persons are a prominent research area, as everyday environment has a direct impact on the well-being of individuals (Knodel & Auh, 2002; Gaymu, 2003).

As can be seen in Table 5, older persons who were more dependent on others for their financial needs had low social support system and high prevalence of elder abuse. Siva Raju (2011) reported that since a major percentage of workforce in India is employed in an unorganised sector, most often than not, older people do not get the benefits of retirement in terms of a reasonable pension. As a result, in later life persons become increasingly dependent and poor, relying mostly on the support from their children. The situation can be harder for women due to higher life expectancy and cultural dependency on men (Chadha et al, 2006). Similar results were found in a Ministry of Statistics Report published by the National Sample Survey Organization in its 52nd round (July 1995-June 1996) (Government of India, 1998). According to this survey, the most vulnerable group consists of older females in urban areas; 64 per cent of them are dependent on others for food, clothing and health care.

Table 5: T-test comparison on the basis of financial dependency

Variables	Dependent (N=117) Mean (SD)	Partially dependent (N=48) Mean (SD)	Independent (N=35) Mean (SD)
So Support	42.64(±8.69)	41.52(±7.22)	48.80(±7.22)*
Depression	21.69(±3.75)	21.60(±3.90)	19.22(±3.25)
Elder Abuse	20.58(±3.74)*	19.35(±3.66)	16.85(±1.61)
Hygiene	27.10(±15.85)*	20.16(±11.18)	24.40(±17.47)

Notes: The variable marked (*) indicate that the result is statistically significant through one way ANOVA, Bonferroni Post Hoc test, with $p < 0.5$, and (**) when $p < 0.1$.

Linear regression analysis showed that social support is highly correlated with living arrangement (0.41), then financial condition (0.30) and then marital status (0.23) (Table 6). Depression is correlated with marital status ($r=0.51$), living arrangement ($r=0.46$), age ($r=0.44$), education ($r=0.41$) and gender ($r=0.36$). Results as shown in table 6 indicate that elder abuse is correlated with Financial dependence ($r=0.36$), Living arrangement ($r=0.31$), education ($r=0.25$). General assessment of elder abuse is correlated with living arrangement ($r=0.35$), Social profile ($r=0.35$), education ($r=0.29$).

Table 6: Regression: Dependent variable - Elder abuse

	R	R Square	Sig.
GDS	0.62	0.39	.00
Living arrangement	0.69	0.47	.00
Hygiene	0.71	0.51	.00
Age	0.73	0.54	.00
Financial Dependence	0.75	0.56	.00

Care homes

Out of the total list of 12 care homes obtained from the HelpAge India, most had adequate open spaces and staff quarters. Nearly half had a common room or dining hall and a medical room. Only two out of the entire list had a library and three had appropriate facilities for older persons with special needs. None of the care homes for older persons employed professionals like a yoga instructor, a counsellor, social worker, psychiatrist or a dietician. It is also important to note that there was a lack of recreational activities and essential professional support that could have a positive impact on the physical and mental well-being of older persons living in the care homes.

In order to develop a deeper understanding of the situation and experiences of older persons and to add richness to the data elicited, the themes obtained during the in-depth interviews are discussed in the following paragraphs. The purpose of the interviews was to explore the dynamics in later life and what leads to the decision of moving into an old age home. The study revealed that there are various socio-economic, cultural and situational factors which can influence older persons' decision to choose to live in an old age home. It was found that some of older persons chose to live in a care home because they had no children to rely on as they grew older and hence needed more support. In some cases, parents had only a daughter. Traditionally it is not appropriate to seek help and/or to live with a daughter. It was found that even if the daughter is caring, she is sometimes unable to stand for her parents as she succumbs to pressures and expectations of her in-laws and society at large in a patriarchal society. Other prominent reasons include property rows amongst family members and as a result older persons were left homeless. An ever increasing problem in the metropolitans today is the lack of space and tiny accommodations (Scommengna, 2012). Older persons are almost forced and sometimes choose to live in an old age home in order to get some personal space because of inadequate living space in their home or in their children's home. Some other reasons that emerged from the study were constant arguments between couples or between older persons and their family due to differences in expectations, attitudes and inability to adjust. However, some chose to maintain confidentiality and not discuss family matters. When asked about abuse, it was revealed that in most cases the perpetrators of abuse were mainly their son and/or daughter-in law (HelpAge India, 2014). The abuse could be intentional or unintentional.

It was also found that many older persons considered themselves responsible for having been abused by others. They felt that they had no capacity or skill to deal with or protect themselves from any form of abuse. A majority of them were unaware of any socio-legal help that was available and laws that could protect them. Only 14 per cent were aware of Maintenance and welfare of parents and senior citizens act 2007, a recent law introduced by the Union Cabinet in India aimed at serving older persons to maintain self-respect and live in peace. It includes provisions to guard India's senior citizens and it also would specifically include the State's role in taking care of them. The Bill also places a legal responsibility on children and relatives to maintain the senior citizen or parent in order to facilitate a good quality of life for older persons. This obligation applies to all Indian citizens, including those who live abroad. The offspring and relatives of seniors will be required to provide sufficient support for senior

citizens. This bill is a ray of hope for many senior citizens because in a country like India which has approximately 100 million populations of older people at present, institutionalization is not the answer to provide care and support to senior citizens. The mindset of senior citizens is such that they want to spend their old age in their home with their family and feel happy with them in all situations. In this context, the best solution for the wellbeing of senior citizens is that family should understand its role and responsibility towards older relatives by providing them love and care. Care homes become the option for senior citizens when no other option is left to them. They miss their grandchildren more than their children, becoming emotional in the memories of time they spent with their grandchildren.

The study revealed also, that depression is high among females. This is not related to increase in age and can affect a person in his/her 60s, 70s, 80s and 90s. Depression was found to be directly correlated with education levels, the higher the education level, the lower depression frequency. The data also indicated that depression was high among dependent people and among those living alone. Elder abuse was found to be high among females and the widowed. The study also elicited that abuse is experienced more by people living alone and by those residing in care homes, other than by older persons still living in the community with family (Sharma & Chadha, 2006). Incidences of abuse increases with age and decreases with education and independence. Increasingly, as a result of abuse, more number of people taking up residence in care homes (Government of India, 2007).

Conclusion

It was found that a combination of individual, relational, community and culture based factors are responsible for occurrence and prevention of elder abuse. Old age is considered as an age for practicing nirvana. In Indian culture, it is supposed that an older person has lived his/her life, fulfilled all his/her duties and responsibilities and learnt a lot through life experiences. During this period, one was mostly busy with family responsibilities, friends and society at large. Old age is the time when one should move towards self-exploration, that which Maslow (1943, 1954) and many humanists called self-actualization. According to Indian mythology (Kriyananda, 1998; Rama, 1985), at this age, a person enters in *Vanaprastha Ashram* where one devotes most of one's energy and time in actualizing one's own potential, whilst trying to strengthen the pre-existing bond between the self and the Almighty. Therefore, in Indian society, older persons' needs and concerns are mostly ignored due to placing too much faith in wisdom of older persons themselves and in the beliefs of their sacrificing nature. That is, they do not need anything and are satisfied with whatever they have. It is believed that in old age people should limit their needs, wishes and desires as these limitations will bring about more life satisfaction and furthermore facilitates the connection with God (Kriyananda, 1998). Another reason for neglecting older people in the society is the excessive belief in the traditional family system, a belief which has been followed thousands of years in Indian society. Family is considered to be the largest institution or the sole main provider of older parents (Chadha & Sharma, 2006). As per traditional Indian value system, those who get the opportunity to take care of older parents are considered to be fortunate because they will be fulfilling *seva* (serve). It is believed that this will make up for their sins and holy deed and good karmas are added in their fortune, which will further help when faced with critical

situations throughout their life. Therefore, it is presumed by the society, that the care of older parents and grandparents is the sole responsibility of the family (Sharma & Chadha, 2006). It is considered shameful if the family fails to support its ageing members and the state has to intervene.

Lack of knowledge and information about one's rights, poor coping skills, emotional and psychological problems, financial dependence (of the older person on the caregiver and vice versa), inability to adapt, lack of social and formal support for older persons and sometimes for the caregivers as well, along with the cultural and traditional expectations, negative beliefs attached to ageing and a culture whereby people choose to silently endure suffering can all contribute to the prevalence of elder abuse (Irudya, Mishra, & Sarma, 1999). In addition, informal and formal caregivers, might benefit from specialized training regarding the needs of older persons. Untrained and unprepared caregivers, whether informal or formal, might feel overwhelmed. They may experience burnouts which in turn, would have negative impact on the vulnerable older persons being cared for. Therefore, having strong and secure relationships and attachments can help older persons to have good quality of life during later life. This is particularly true in the Indian context where the family system is considered as the primary source of support and care. A change in the attitude towards ageing in the wider population could be the key towards a smooth transition between the different phases of the life cycle. Ageing should be viewed as growing mature and wiser rather than a liability. This could be attained through regular sessions of moral education in schools, intergenerational programmes to sensitize young children and help them appreciate older people as a resource in their lives and in the society at large. Furthermore, stringent laws against elder abuse and prompt police intervention would facilitate protection of older persons from abuse in old age.

Policy recommendations and limitations

Contingent upon the results and analysis of data emerging from this research study, it arises that the following ten policy recommendations are highly warranted: (i) there should be special wards for treating older persons in general hospitals throughout the country; (ii) the health status of older persons is very poor in India therefore some definite health intervention measures are necessary to cater for specific diseases associated with old age - there is a need for the establishment of special geriatric wards within public sector health facilities and concessions in private hospitals through identity cards for poor older persons; (iii) most of India's older persons are economically dependent thus the cost of treatment is often a burden on the household - this results in many older persons ignoring their ailments until it becomes chronic and acute; hence, there is a great need for an appropriate insurance for older persons to meet their medical expenses; (iv) a greater coordination among agencies that work for older persons is needed to attain high efficacy; (v) trained professionals to support the needs of older persons should be available at the care homes, not only for the benefit of the social-psychological needs of older persons, but also to give support to the caregivers; (vi) training centres should offer courses to adult illiterate women so as to help them to join the skilled workforce if they wish; (vii) Awareness and education to all on the cultural mentality on remarriage of widowed women - a national campaign regarding this awareness should be promoted also by the media; (viii) a policy should be drafted and implemented by the

government to allow people into the work environment after retirement, if they wish to do so; (ix) educational programmes for all ages and awareness through the media on a national level should be embarked upon in order to change the traditional reserved and egoist images of males in an Indian society; and (x), awareness among the young generation to pursue higher education since this is positively correlated with independence and good psychological health.

Limitations of the research study included the fact that quantitative measurement does not help much in tapping elder abuse. Moreover, qualitative analysis is required on a larger sample size, and that separate investigations should be done on families recently migrated (10 years or less) from rural areas to Delhi and family settled in Delhi for the past 50-60 years.

References

- Alam, M. (2006). *Aging in India: Socio-economic and health dimensions*. New Delhi: Academic Foundation.
- Callaghan, J. (1998). Elder abuse and one community's response. *International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services*, 11 (2), 6-10.
- Carter, B. & McGoldrick, M. (1980). *The changing family life cycle: A framework for family therapy*. New York: Gardner.
- Chen, M.A. (1998). *Widows in India*. New Delhi: Sage Publications.
- Chadha, N.K. & Sharma, R. (2006). The elderly in Asia: Impact of urbanization and migration. *Shelter*, 9 (4), 21-27
- Chadha, N.K., Majumdar, P., Chao, D., & Sharma, R (2006). Psychological health of the elderly: Age and Gender issues. *Aging and society: Critical issues in gerontology*. 16 (1), 35-50.
- Chakrabarti, S., & Sarkar, A. (2011). Patterns and trends of population aging in India. *The Indian Journal of Spatial Science*, 2 (2), 2000-2011.
- D'Souza, V.S. (1989). Changing social scene and its implications for the aged. In K., Desai (Ed.), *Aging India* (pp. 61-76). New Delhi: Ashish Publishing House.
- Government of India. (1998). *Morbidity and treatment of ailments*. A report by the National Sample Survey Organization, 52nd Round (July 1995-June 1996), *Sarvekshana*. New Delhi: Government of India.
- Government of India. (2007). *Maintenance and welfare of parents and senior citizens act 2007*. Ministry of Social justice and empowerment. Accessed 17 May 2016 from: www.socialjustice.nic.in
- Gaymu, J. (2003). The housing conditions of elderly people. *Genus*, LIX (1), 201-226.
- Gulati, L., & Irudaya, R.S. (1999). The added years: Elderly in India and Kerala. *Economic and Political Weekly*, 34 (44), 46-51.
- HelpAge India. (2014). *Main findings: Report on elder abuse in India*. Accessed on 18 May 2016 from: <https://www.helpageindia.org/pdf/highlight-archives.pdf>
- Hwalek, M., & Sengstock, M. (1986). Assessing the probability of abuse of the elderly: Toward development of a clinical screening instrument. *Journal of Applied Gerontology*, 5 (2), 153-173.

- Irudaya, R.S., Mishra, U.S., & Sharma, P.S. (1995). Living arrangements among the Indian elderly, *Hong Kong Journal of Gerontology*, 9 (2), 20-28.
- Irudya, R.S., Mishra, U.S., & Sarma, P.S. (1999). *India's elderly: Burden or challenge?* New Delhi: Sage.
- Jamuna, D. (1995). Issues of elder care and elder abuse in Indian context. In P.S. Liebeg & R.S. Irudaya (Eds.), *An aging India: Perspectives, prospects, and policies* (pp. 125-142). Philadelphia, PA: The Haworth Press.
- Kan, K., Park, A., & Chang, M-C. (2001). *A dynamic model of elderly living arrangement in Taiwan*. Paper presented at the Annual Meeting of the Population Association of America, Los Angeles, CA. Accessed 17 May 2016 from: <http://ihome.ust.hk/~albertpark/papers/livarr.pdf>
- Knodel, J., & Auh, T.S. (2002). Vietnam's older population: The View from the Census. *Asia Pacific Population Journal*, 17 (3), 5-22.
- Kriyananda, S. (1998). *The Hindu way of awakening*. Nevada City, CA: Crystal Clarity Publishers.
- Maslow, A.H. (1943). A theory of human motivation. *Psychological Review*, 50 (4), 370-96.
- Maslow, A. (1954). *Motivation and personality*. New York: Harper.
- Nerenberg, L. (2000). Developing a response to elder abuse. *Generations*, 24 (2), 86-92.
- Palloni, A. (2001). Living arrangements of older persons. *United Nations Population Bulletin*, 42/43, 201-226.
- Prakash, I.J. (1997). Women and ageing. *Indian Journal of Medical Research*. 106, 396-408.
- Rama, S. (1985). *Perennial psychology of the Bhagavad Gita*. Honesdate, PA: Himalayan Institute Press.
- Schafer, R. (1999). *Determinants of living arrangements of the elderly, W99-6*. Joint Centre for Housing Studies, Harvard University. Accessed 17 May 2016 from: http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/schafer_w99-6.pdf
- Scommegna, P. (2012). *Today's research on aging: Program and policy implications*. Washington DC: Population Reference Bureau.
- Sharma, R. (2013). Social support as a mental health indicator and its influence on IADL of the community dwelling senior citizens in Delhi. *International Journal of Stress Management and Allied Sciences*. 2 (1), 34-37.
- Sharma, R. (2014). Effectiveness of Life style interventions as self-help technique to enhance psychological well-being of institutionalized and non-institutionalized senior citizens. *Journal of Gerontology & Geriatrics Research*, 3 (5), 189.
- Sharma, R & Chadha, N.K. (2006). Self-rated mental health of the elderly on their life satisfaction. *Indian Journal of Gerontology*. 20 (4), 389-404.
- Siva Raju, S. (2011). *Studies on aging in India: A review*. BKPAI working paper no.2. New Delhi: United Nations Population Fund.
- Siva Raju, S. (2002). *Health status of the urban elderly: A medico-social study*. New Delhi: B.R. Publishing Company.
- United Nations Population Fund and HelpAge International. (2012). *Aging in the twenty-first century: a celebration and a challenge*. New York and London: United Nations Population Fund and HelpAge International.

United Nations. (1987). Population Ageing: Review of Emerging Issues, Asian population studies, series no 80, Economic and social commission for Asia and the Pacific, Bangkok, Thailand.

Wilmoth, J.M. (1998). Living arrangement transitions among America's older adults. *The Gerontologist*, 38 (4), 434-444.

World Health Organization. (2002). *World report on violence and health*. Accessed 16 May 2016 from: http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf?ua=1

Yesavage, J.A., Brink T.L., Rose, T.L. Lum, O., Huang, V., Adey, M.. & Leirer, V.O. (1982). Development and validation of a geriatric depression screening scale: a preliminary report. *Journal Psychiatric Research*, 17 (1), 37-49.

Formosa, M. (2015). *Ageing and later life in Malta: Issues, policies and future trends*. Malta: Book Distributors Limited, 286 pp. ISBN: 978-1-44730-057-1

Reviewed by Suhana Bhatia¹

Everything in the international arena is geared towards young people, ranging from products to services to advertisements to television content, to mention some prime examples. One can safely say that the entire market is youth-centric! Yet, many nations are waking up to a new reality, that of increasingly ageing nations. Barring a few countries like India, which will have more than 60 per cent of its population below the age of 35 in 2020, the world is heading into a scenario, whereby a majority of the population will be older adults - persons, who are, as per international standards, older than 60 or 65 years, depending on individual countries. Formosa has made a painstakingly detailed study on the subject, with a specific focus on the Maltese Islands, which are situated in the Mediterranean and form part of the European Union. *Ageing and later life in Malta* is a timely and necessary book that reviews the evidence base of the Maltese Islands. This research publication is without doubt a valuable mirror to all European countries, since they are also facing similar patterns of ageing population. Considering that Malta only achieved its independence, the book is in a unique position of demonstrating the way ahead to other newly-independent nations irrespective of their geographical position and political system.

Ageing and later life in Malta includes 13 chapters that address various aspects of the Maltese population ageing scenario by using a vast range of data sources. The book also comes with a strong foreword and a preface which gives an excellent context and background to the issues discussed in the subsequent chapters. This is a beneficial starting point especially to readers who are not so acquainted with Malta, its socio-political history and its geography. The book features a very helpful section for the reader on 'Structure of the book', which is found at the end of chapter one though, perhaps, this section could have been better placed in the preface.

Chapter one, 'Introduction', starts by questioning whether older persons are a burden to the society at large or whether older people are seen as valuable members of the community, who can still contribute actively to society even in their later years and hence seen as a resource. As the author shares, the aim of this book is to uncover the relationship between ageing on one hand and demographic trends, the family, the labour force, income security, social services and mortality, morbidity and health care on the other. Formosa gives a clear and detailed description of the phenomenon of an ageing population and what will be the consequences once it becomes a reality. Better health care, lower fertility rate and a higher life

¹ Write In Light, India. (iwriteinlight@gmail.com)

expectancy have led to an increased percentage of older persons in the last twenty years. In the second chapter, 'The international context', Formosa discusses the global context as a critical discussion to the ageing situation in Malta, while highlighting both the demographic patterns and policy implementations. Chapters three and four, titled 'Demographic trends' and 'The economics of ageing' respectively, addresses the demographic and the economics of ageing in contemporary times. Here the author presents the reader with a demographic profile of the ageing population in Malta, and further on, discusses the effect that this has on the economic growth. He does this by exploring the overall consequences of population ageing on state expenditure and financial costings, as well as the effects of labour supply and income security.

In the fifth chapter, 'Healthy ageing', Formosa examines the trends and differentials in the health conditions of the Maltese ageing population, whereas chapter six, 'Active ageing', deals with the importance of social contact and relations in an older person's life. In chapter seven, 'Older adult learning', the author explains the importance of lifelong learning from a sociological point of view, and then discusses related policies and data on older adult learning in Malta. He concludes that a critical scrutiny of present ideologies and trends finds that present policies on older adult learning as being no more than seductive rhetoric. Chapter eight, 'Poverty and social exclusion', discusses those issues and situations which may deprive older persons from not experiencing material affluence and social inclusion. This leads us to chapter nine, 'Ageism, age discrimination and elder abuse', whereby Formosa highlights the difficulties that older people are faced with when they end up as the victims both in their own homes and in care homes, and hence, the need for stronger legislations and policy implementations. The three subsequent chapters focus on care. The care given at home by the family to an older person/s is discussed in chapter ten, 'Informal care'. The care provided by the formal (paid) carer in the community is discussed in chapter eleven under the heading of 'Community care', whilst 'Long-term care' is described in detail in chapter twelve. In these three chapters, the author speaks about the difficulties that formal caregivers face when caring for a loved one at home and the government's initiatives towards dependent older persons residing both in the community and in residential settings. The book concludes with the final chapter on 'The future of ageing policy'. Here, Formosa puts forward suggestions of what policies are still needed to be implemented as part of the ageing policy in Malta, so that social justice, social equity and empowerment prevails, even among older persons and their caregivers.

Formosa's efforts towards producing *Ageing and later life in Malta* should be applauded for presenting a timely, needed and important text book on the various aspects of ageing in Malta. A key strength of the book is the use of huge breadth of published and constantly evolving evidence available on the topic, which are covered in each of the chapters. Formosa draws on a range of policy, seminal texts, websites and research evidence in putting forward his thesis. Some chapters reproduce extensive quotes from academic sources. Moreover, the writing style Formosa adopts is accessible throughout and the background information about Malta's socio-political history is a bonus for readers who are not so familiar with the Maltese Islands. Excellent referencing and index. Overall, this book is an authoritative source of information to rely on. I sincerely believe that this makes the book as an important resource / academic

text for those who are studying social gerontology, are involved in geriatric/gerontology research or are in a position to influence policies revolving around older persons. As Thomas Scharf, Professor of Gerontology, Ireland, pointed out in his blurb for the book - "Formosa makes a compelling case for a reorientation of ageing policy and practice to better meet the needs of an increasingly diverse older population, not only in Malta but in other western nations".

Emmatty, L.M. (2009). An insight into dementia care in India. New Delhi: Sage Publications, 119 pp. ISBN: 978-81-7829-8887

Reviewed by Jacqueline Parkes¹

Leena Mary Emmatty's 'An Insight into Dementia care in India' has emerged largely from two main sources of evidence, the conclusions drawn from her theoretical knowledge, and her personal encounters with caregivers during her pre-doctoral and doctoral studies while in India. Currently, a licensed Social Worker in America, Leena felt compelled to write the book after receiving positive feedback from the academic community about her research in this field. Her first study (Study I), undertaken while in Bangalore, Karnataka in 2000 looked at the burden of caring for a person living with dementia (PwD); and her second study (Study II) completed in 2003 which explored the personal and social support mechanisms adopted by primary carers in order to help maintain their own physical and mental wellbeing, whilst also providing daily care for their loved ones. Caring for someone diagnosed with a dementia can be very physically demanding and emotionally distressing; but in this book, the author endeavors to provide a plethora of helpful suggestions for interventions and approaches which may help to at least alleviate the effects of carer burden. These range from psychosocial interventions for the PwD and the carer, through to sources of informal community support and more formal support from NGOs.

Divided into five parts, the 'Introduction' sets the scene in relation to global ageing populations, the association with growing numbers of people being diagnosed with a dementia, and presents the focus of the text, which is caregiving practices in India. Part I offers a rather thin overview of the types (only three are mentioned), signs and symptoms, and possible causative factors for some dementias, neglecting to mention types which are more commonly associated with younger onset (aged under 65 years old), for example, fronto-temporal dementia. Later in this section, interesting research currently being undertaken in India into the prevalence of dementias does however address both younger and later onset. Part II explores a range of caregiving practices, and these are much more strongly and clearly located within the context of caregiving in India. Part III highlights the psychological distress and emotional burden associated with carer burden. Part IV explores the positive benefits of both psychosocial interventions and social support mechanisms for both the PwD and primary caregivers, which can help to reduce the level of expressed emotion and therefore carer distress. The final section highlights aspects of caregiving practices which may be worthy of further research, focusing on the need for additional

¹ Centre for Applied Mental Health Research, Institute of Health & Wellbeing, University of Northampton. (jacqueline.parkes@northampton.ac.uk)

training for health and social care professionals in delivering person-centred dementia care, and closes with a resume of the resources available to PwD and carers in India.

Having been invited to review this book, given my current work in the development and implementation of social support groups for PwD and their carers in the United Kingdom, I was keen to ascertain its relevance for alternative international contexts outside of India. Initially, I thought it might provide rich insights and descriptions in care giving practices within a very different cultural setting from my own western experience, which may prove valuable in my own relationships with individuals from an Indian background I encounter in my own daily practices in this field; after all, this is the text's unique selling point. And "yes", illustrations of dementia care experiences within Indian family and community networks do emerge sporadically throughout the book's pages, but these are not as prevalent as I would have indeed expected, given the early claim in the text to focus on this issue. We are first introduced to current Indian prevalence studies in Chapter 1. In Chapter 3, we finally learn more about Indian care giving practices, and how this information has been acquired via the author's own research; and in Chapter 10, the reader is presented with descriptions of the formal care pathways and services in parts of India. This significant contextual information I felt was too little too late, and perhaps could have been introduced much earlier in the text to help the reader to understand the cultural context of both informal and formal dementia care practices in India.

The book's strength for me lay in understanding that much of the evidence-base for the book's focus lay in the findings from the participants in the author's own studies. This particularly related to the intensity of carer distress, and the individual and support mechanisms available to assist with the provision of daily care. Part III provided some academic theoretical support (if a little dated on occasions) in the inclusion of Lazarus et al.'s theoretical coping model as the basis for problem focused and emotional focused coping strategies, but it may have been helpful to novice readers to have explained the 'Transactional Model of Coping' before suggesting how it might be applied in the context of care giving. The 'Social Support for Caregivers' section Chapter 7) was particularly beneficial in offering the reader with an evidence-base for the development and sustainability of social networks for both PwD and carers. The highlight for me, however, was the checklist for "things to look for when conducting a holistic assessment" in chapter 8, which is designed to provide professionals with a tool to 'equip [them] with further dimensions in therapy to enable needy families to deal with hardships effectively' (p.68).

On balance, the text only provides some useful, but brief, insights in dementia care in India, despite being its primary claim. It does, however, also present the novice learner with easily accessible descriptions of the nature of care giving in dementia care, irrespective of the culture in which the practice is taking place. It describes an extensive range of interventions which might be applied to alleviate, to varying degrees, the extent of carer burden. For the novice learner being introduced to the field of dementia care, this text will provide a starting point; however; for those who are reading expecting to discover more about care experiences in India, the ground was less fertile. It might have been more exciting to see and understand how these are being developed more specifically for PwD and their carers living

in India, than have yet more generic information about dementia care that is already extensively available from more eminent sources. The book claims to offer an “Insight into Dementia Care in India”, and it provides just that, an insight.



**International Institute on Ageing
United Nations - Malta (INIA)**

117, St. Paul Street, Valletta, VLT1216, Malta | +356 2124 3044

www.inia.org.mt

Twitter: @UNAGEING | facebook: fb.com/INIAMALTA