ISSN: no. 2519-1594 | ONLINE

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. 2, 2016

https://www.inia.org.mt/journal/issue
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International Journal on Ageing in Developing Countries

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Editorial

Marvin Formosa[1]

Welcome to the second issue of the International Journal on Ageing in Developing Countries. A lot of water has gone under the bridge since the publication of the first issue. The NGO Committee on Ageing in New York - in partnership with the Permanent Mission of the Argentine Republic and the United Nations Department of Economic and Social Affairs Focal Point on Ageing - organised an event to commemorate the United Nations International Day of Older Persons at the United Nations Headquarters in New York on 6 October 2016 on the theme 'Take a stand against ageism'. The event drew attention to and challenged negative stereotypes and misconceptions about older persons and ageing. More recently, the seventh working session of the Open-ended Working Group on Ageing (OEWG) was held at the United Nations Headquarters in New York from 12 to 15 December 2016. Finally, it is noteworthy that in a comprehensive report (A/HRC/33/44) the Independent Expert on the enjoyment of all human rights by older persons, Ms. Rosa Kornfeld-Matte, assessed the implementation of existing international instruments with regard to older persons while identifying best and good practices and gaps in the implementation of existing laws related to the promotion and protection of the rights of older persons. The report was transmitted to the Human Rights Council at its thirty-third session in September 2016, and was issued in all six official languages of the United Nations.

The International Institute on Ageing has also been keeping a busy, thanks to funds from the United Nations Population Fund. In the second half of the past year, in-situ missions were organised in Nigeria, Malaysia, Philippines, Belarus, Kenya, and China (Nanjing and Wenling). In the same interim, INIA organised for the seventh year running an international training programme in Policy Formulation, Planning, Implementation and Monitoring of the Madrid International Plan of Action on Ageing, as well as planning another manuscript publication on ageing issues in Turkey, and receiving, reviewing and producing articles for this second issue of its landmark journal.

Issue 2 of the *International Journal on Ageing in Developing Countries* contains six original entries and two book reviews - namely, *A study of pastoral care of the elderly in Africa*: *An interdisciplinary approach with focus on Ghana* (Ayete-Nyampong, 2014) reviewed by Emem Omokaro, and *The new age of ageing: How society needs to change* (Lodge, Carnell, & Coleman, 2016) reviewed by Mario Garrett.

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The first contribution, by Friday Asiazobor Eboiyehi and Akanni Ibukun Akinyemi, is titled 'We are strangers in our homes: Older widows and property inheritance among the Esan of South-South Nigeria'. This article examines the plight of older widows as it relates to property inheritance among the Esan of South-South Nigeria. The paper identifies the challenges associated with bereavement among widows particularly on property and assets bequeathed from their late spouse and the strategies they employed to cope with the identified challenges. This was conducted with the aim of raising discourses towards addressing the social-cultural issues affecting the survival of the widows. Data for the study were purposively collected from respondents in two local government areas - namely, Esan Central and Esan West - with the aid of questionnaires and in-depth interviews. It concludes that socio-cultural practices attributed to inheritance among widows escalates their predicaments among the Esan people. The policy implication is for actions geared towards correcting these oppressive actions towards the widows through the instruments of social institutions and legal framework.

The second contribution, by Le Duc Dung and Gian Thanh long, is titled 'Gender differences in prevalence and associated factors of multi-morbidity among older persons in Vietnam'. This paper examines the prevalence and the determining factors of multi-morbidity among older men and women in Vietnam. Data for this study was utilised from a nationally representative survey - that is, the Vietnam Ageing Survey in 2011. The study sample was restricted to older people (those aged 60 and over). Multi-morbidity was defined as having at least two presences of chronic diseases. Bivariate, t-test, and multivariable logistic regression analyses were applied to identify potential factors correlated with multi-morbidity among older men and women. The results showed that around 44 per cent of older persons reported having multi-morbidity, in which a higher prevalence was found in women (49.4 per cent than men (36.7 per cent). The results of multivariate analysis indicated that factors associated with multi-morbidity were found to vary by gender, in which advanced age and living alone were the strongest predictive variables in both genders.

The third contribution, by Charles Scerri, is titled 'Malta's strategic vision for a National Dementia Policy'. This article highlights how Malta is experiencing a demographic transition characterised by an increase in the old age population, especially in the 75-cohort. WAs Scerri underlines, this will pose significant societal demands as most dementia care is provided informally by family members living in the community. Furthermore, local research studies have shown that there is considerable lack of awareness and professional training that is seriously undermining timely diagnosis and management. As a result, Malta opted to take a holistic approach towards dementia care by embarking on a long-term strategy focusing on increasing awareness, providing the best services leading to high quality dementia care, and fostering dementia training to healthcare professionals in order to be better equipped to support individuals with dementia.

The fourth contribution, by Pia Jolliffe, is titled 'Intergenerational relations and rural development among the Karen in northern Thailand. This scholarly article provides a qualitative analysis of how rural development - in particular changing modes of production

and learning - shapes inter-generational relationships among the Karen people in northern Thailand. Based on long-term ethnographic research with the Karen, the author argues that inter-generational relations and household inter-dependency give meaning to ethnic Karen peoples' aspirations for work and family life. The author explains how traditionally, during childhood transitions, Karen adults guide children and young people towards mastery of culturally relevant skills and technologies and discuss how social transformations and rural development in the last decades have led to major changes in Karen household economies and inter-generational relationships.

The fifth contribution, by Nidhi Gupta, is titled Development, elder abuse and quality of life: Older women in urban India'. The authors argues that often the concept 'development' is simplistically equated to economic growth. However, philosophically it has a deeper meaning that points towards improvement of humankind. The implicit meaning entailed in 'improvement of mankind' is 'increasing the lifespan' as well as 'quality of life' of people. This paper highlights the types of abuse experienced by older women in an urban context in India, and its influence on various dimensions and overall quality of life of older women. The data from a cross-sectional survey conducted in Mumbai, India, has been used to meet the objectives of this study in addition to review from other empirical studies in Indian context. The findings show a high incidence of elder abuse and family members being the main perpetrators. Elder abuse had a significantly negative impact on all dimensions of quality of life of older women reflecting an urgent need for change in social attitude.

The final contribution, by Maryam Tajvar, Astrid Fletcher and Emily Grundy, is titled 'Exploring associations between social support and mental health in older people: A systematic narrative review'. The purpose of this review is to summarize the current state of research on the topic. The authors undertook a systematic review to identify all review studies irrespective of date, and new primary research studies published since 2007 that examined the associations between social support and mental health among older people. Overall, 24 citations (6 review and 18 original articles) met the inclusion criteria. The results for the 'main effect' model and the 'stress-buffering effect' model of the action of social support on health were summarised. Overall, the review studies provided moderate evidence that social support has a protective effect on mental health. Results from primary research studies lend some support to the hypothesis of a protective main effect of support, but are far from conclusive.

As in the first issue, all six 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.

Marvin Formosa
Editor-in-Chief
International Journal on Ageing in Developing Countries

We Are Strangers in Our Homes: Older Widows and Property Inheritance among the Esan of South-South Nigeria

Friday Asiazobor Eboiyehi [1] **and Akanni Ibukun Akinyemi** [2]

Abstract. The study examined the plight of older widows as it relates to property inheritance among the Esan of South-South Nigeria. The aim of the paper was to identify the challenges associated with bereavement among widows particularly on property and assets bequeathed from their late spouse and the strategies they employed to cope with the identified challenges. This study was conducted with the aim of raising discourses towards addressing the social-cultural issues affecting the survival of the widows. Data for the study were purposively collected from respondents in two local government areas - namely, Esan Central and Esan West - with the aid of questionnaires and in-depth interviews. In all, 200 questionnaires were administered, out of which 180 (90.0 per cent) were retrieved and analysed. Moreover, 36 in-depth interviews were conducted with purposively selected older widows with certain peculiarities. About 33 per cent of the widows suffered eviction from late husband's house, others suffered partial denial from inheritances. Arising from these, the consequences of negative cultural practices were illustrated through loneliness (16.7 per cent), poor access to basic healthcare (15.5 per cent), constant illness (11.5 per cent) and poverty (6.6 per cent). Other challenges identified include psychological trauma (5.6 per cent), poor nutrition (5.6 per cent), abandonment (3.9 per cent) and loneliness (1.7 per cent). It concluded that socio-cultural practices attributed to inheritance among widows escalates their predicaments among the Esan people. The policy implication is for actions geared towards correcting these oppressive actions towards the widows through the instruments of social institutions and legal framework.

Keywords: older widows, property inheritance, Esan, Nigeria.

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Introduction

> The widow is a veritable specimen of suffering. She depicts clearly the male-dominated society in which we all live and man's inhumanity to woman. She is buffeted on all sides, first by her grief which she is not allowed to suffer silently, then by the society who decrees that she is a leaf in the wind, all on her own (Egbemode, 2006 : 1).

In Sub-Saharan Africa countries, inheritance is a critical mode of property transfer usually bequeathed through either formal or informal channels (Cooper, 2011). Crucial to this concept, are three basic assumptions: first, that men by their nature need to acquire property for their sustenance and to be able to live a good life; second, that when they die, they leave their property to those left behind; and third, that mechanically, they continue to controls their property even upon their death (Nyong'o & Ongalo 2005).

In many traditional African communities, older widows are generally the poorest of the poor and least protected by the law because their lives are determined by local, patriarchal interpretations of tradition, custom and religion. In many of these communities, social and economic indicators portray that the older widows suffer the double jeopardy of ageism and sexism (Bernard, Phillips, Machine & Davis, 2000). In traditional African society, death does not end a marriage, as a widow is expected to move into a 'levirate' arrangement with her brother-in-law or other male relative or heir. The children conceived are born within the union belonged to the dead man. In some ethnic groups widows are 'inherited' by the heir and integrated into the extended family. While these traditional practices effectively guaranteed the widow and her children's protection, in contemporary time, these cultural arrangements are changing. This is partly due to modernization and gradual erosion of the extended family system. It is not surprising that nowadays, the older widows find themselves deserted and thrown out of the family homestead for good. The grief that many of the older widows experience is not just the sadness of bereavement but the realization of the loss of their position in the family that in many cases, results in their utter abandonment, destitution, dishonour property disinheritance. Thus, for an older woman, the loss of a partner through death involves a series of losses, which include loss of companionship, material resources, a life partner and someone to negotiate on her behalf in a male dominated society.

In traditional Nigeria society, a woman was not entitled to own land (Akande, 1999), nor had the right to inherit family property as she was always bypassed, when there was a male child to inherit the father's property in her instead. Property is regarded as a source of personal protection from intruders and from the climate. It is also said to be the base, the 'legitimacy' for further territorial or commercial acquisition, without which the right to ownerships, there is no source of security, identity, shelter, leisure and so on. Therefore, acquisition of property becomes issues of welfare or 'needs' rather than claims (Ashworth, 1993). Similarly, the concept of inheritance in the traditional Nigerian society does not consider women as entitled to inherit any property. In fact, women were regarded as part of the property to be shared at the demise of their husbands. This was more prominent and

peculiar in the Igbo society. Hence, the pre-colonial Nigeria society recognized widow's inheritance, and therefore, elevated men above women (Omoruyi, 1994; Emiola, 1997). Lack of inherited assets in the form of land, savings and other forms of capital was found to have left many older widows vulnerable to both chronic and intergenerational transmitted poverty (Cooper, 2011). Following the death of their husbands, many of them subsist on no or low wages earned in physical arduous jobs in the informal sector. Consequently, the financial burden on the household for food security can be very dire. It is therefore not surprising that many widows continue to work well into old age in a bid to support their household financial needs. According to the United Nations (2001) and Orubuloye (1987), the situation of older widows is compounded by the dwindling economic fortune, diminishing extended family system, the shift from agro-based to industrial society, migration of young people to cities which have often left older persons unsupported, as well as eroding their economic independence. In many African countries, attempts to revise discriminatory laws and encourage women's participation in all spheres of social life have been frustrated by deep-rooted cultural barriers that frequently run correspondingly with poverty. These cultural practices indicate that older widows occupy a precarious position in societal affairs and more often than not, they suffer from discriminatory laws and traditions which keep them in perpetual jeopardy.

Although concerns are being raised on the plights of younger widows are made to undergo after the demise of their spouses so as to address perceived or real gender imbalance in many African societies, older widows' deprivation of property left behind by their husbands, the conditions in which they are forced to live, the violations of their human rights has attracted very little attention among social researchers and policy makers. One explanation for the neglect of this vast category of abused women is the assumption that widows are mainly older women who are cared for and respected by their extended or joint families. It is this neglect and gap in understanding the compounding challenges of widow who suffer extreme dispossession of bequeathed property which are further compounded by the dwindling social support network that this paper aimed at raising discourse about. The particular reference to the contemporary Esan society is motivated by the social of this practice with very high prevalence.

Older widows and property inheritance among the Esan

As in many African societies, the concept of inheritance exists among the Esan. In many of the Esan communities, when a man dies, the properties he acquired over his life time are transmitted to those he left behind as their inheritance. It is one of the most common means by which a man transfers his physical property and assets to his successor/s. It could be in form of estate or property that he acquired through inheritance or handed down to his heir upon his death. Traditionally, it was a kind of social insurance bequeathed to the inheritor/s as a means of survival. Crucial to the concept of inheritance among the Esan, is that Native Laws and Customs are governed by the principles of primogeniture whereby the first surviving son in a family inherits the entire estate (the title, if any) of his late father, with none of the inheritance going to the wives and other children provided he performed the proper burial ceremony.

Although, the principles of equality and non-discrimination form the cornerstone upon which all human rights are based, under the Esan native laws and customs, discriminatory practices against the female child and women is widespread. Thus, under the Esan Native laws and customs, the concept of equality of both male and female was not only an illusion but an allegory. By Esan tradition, women are not entitled to property inheritance whether from their family of orientation or procreation. Like many African societies, Esan women suffer all forms of discrimination rights from birth to old age, some of it are inflicted by other women (Ajie, 2009). As Isibor (n.d.) and Akande (1999) stated,

> The female child at birth is regarded as inferior to the male child and boxed into stereotypes. She does all the chores as useful as she is, her mother risks being thrown out of her matrimonial home if she is unable to produce a male child even though it has been biologically and scientifically proven that the choice of the sex of the child is hinged on the male spermatozoa. At old age, she is branded a witch and stoned to death if married and childless. If her husband dies even at the ripe old age of 90, she is the first suspect. To prove her innocence she is compelled to go through certain obnoxious widowhood practices such as, must shave her hair, must sleep on the floor with the corpse for days, must drink the water used in bathing deceased. She is disposes of the property she helped to acquired with her husband. (Isibor, n.d. : 4-5).

> Women were non-persons. When they were not making babies or performing domestic chores and tilling the soil, they faded into anonymity. They could not own land. They could not hold titles in a society where titles were the ultimate testimony of self-actualization. They were merely pieces of property owned by the men and thus subject to whatever use they were put to. (Akande, 1999 : 114).

Under Esan native laws and customs, women are generally relegated to the status of second class citizens. For instance, they also postulate that a widow cannot inherit in the intestate estate of her deceased husband because she is regarded as part of the estate to be inherited by the son or relative. Most Esan men believe that '*okhuo ilagbada bhu uku*', meaning that 'a woman does not inherit a sword'. Literally, the 'sword' symbolises property or assets left behind by their late father. Among the Esan, it is only the first son that has an exclusive right to inherit the sword. According to Obi (1966), even where a husband in his lifetime allots a farm, a house or some other form of landed property to his wife for her use and enjoyment, the latter does not thereby acquire inheritance rights in it.

However, a widow of a deceased Esan man is not entirely without some rights in her husband's estate. She has a life interest in the use of a house which is not an '*igiogbe*'(daughter whose parents are of that same village) as long as she remains within the deceased's house. Since Esan society is patriarchal and patrilineal, the sons (especially the first son) enjoy a pre-eminent position in succession matters. The principle of primogeniture

applies in its pure form among the Esans. The eldest son inherits all the properties of his deceased father after performing the funeral rites. The property inherited includes land, house, economic trees, domestic animals, his married and unmarried sisters, brothers and even debts incurred by his late father (Okojie, 1994). He also inherits all his late father's wives except his mother who is usually inherited by the uncle (*omin-ijogbe*). If neither the son nor the uncle wanted the woman, any other man in the extended family *(uenlen*) would be asked to inherit her since it is against the tradition for any woman who is not a daughter of the family to live as such after she had become a widow. Thus, in traditional Esan society, an older widow who inherits had a place in the family after the death of the original husband. Even the childless ones are inherited and integrated into the family. However, they are highly disadvantaged in matters of inheritance and succession.

Among the Esan, the allotment of property rights to only the first son has historically left older widows particularly disadvantaged. Thus, in Esanland, property inheritance is one area where older women customarily face significant discrimination and abuse of their rights. She cannot inherit in the intestate estate of her deceased husband because according to the native laws and customs, she is part of the estate to be inherited by the first son or relative (Obi, 1966; Okojie, 1994; Eboiyehi, 2008). By tradition, upon the demise of her spouse, an older widow is inherited as it is believed that upon her marriage she became the property of the husband and considered to be property inherited (Eboiyehi, 2008, 2014). This cultural practice is justified by the common saying that '*a property cannot inherit property*'. The only exception is when she could only enjoy her husbands' estate through her first son (if she is the mother of the first and oldest son in the family) who is the primogenitor without any opposition from the extended family members. Thus, the polygynous system of marriage among the Esan, which involves a man marrying more than one wife, further complicates older widows' inheritance and property rights particularly, those who are not opportune to give birth to the first son in the family. This implies that other older widows within the household who did not have the opportunity of having the first son in the family are usually cut of any sort of inheritance from the deceased husband. In most cast cases, they are often stripped and cheated out of the property and assets they helped to acquire with their late husbands (Peterman, 2010). Rather than supporting them, relatives also confiscate the property and assets that legally belonged to them, including land, housing, bank savings, pensions, furniture, cattle, farming equipment, cooking utensils, clothing and in most cases, they are expelled from their family home (Izumi 2007). This leaves them without access to means of livelihoods, which would eventually make them vulnerable to further hardship and exploitation.

It is noteworthy here that accusation of witchcraft activities is often used by family members to disinherit them of their property. During the process, some of them are humiliated and robbed of self-esteem while others literally die defending their property. Without shelter, food security or means of livelihoods, older widows often become subject to physical, sexual and mental abuse. While they suffer the grief of the bereavement of their spouses, they also realize that the demise of their husbands implies losing their position in the family which, in many cases, leads to their abandonment, destitution, and dishonour. Certainly, lack of shelter to lay their heads and money to support themselves, mean an undignified and

unpleasant last period of life or premature death. Since they have no resources to rely on, they are easily susceptible to preventable diseases which often lead to untimely death. It is in this respect that Izumi (2007) defines property disinheritance of older widows as a form of gender-based violence while Blair (2010) described their plight as 'a hidden humanitarian crisis'. Moreover, the intergenerational relationship that existed to integrate older widows into the extended family system in the traditional Esan society is diminishing due to urban migration, western influence and other exogenous forces. A number of studies (Higuchi, 1996; United Nations, 1998a, 2001; Sokolovsky, 2000; Akeredolu-Ale & Aribiah 2001) have shown that ill health is most prevalent among older widows in most developing countries and that majority of them are living in devastating poverty. Unlike in the developed countries where social security for older persons is a priority, there are no policy or government welfare systems for older persons in Nigeria (Ebigbola, 2000; Akeredolu-Ale & Aribiah, 2001; Eboiyehi, 2008). In an attempt to forestall the increasing plights of this segment of the older population, the federal government and some voluntary bodies have taken on the responsibility of establishing institutions for them. These institutions are however, located in major cities and are only meant for destitute and those older persons without children. In addition, these homes are not only too few to accommodate the increasing number of the older widows, but also in most cases, they are seen as alien to most African societies (Kayongo-Male & Onyango, 1984). Furthermore, these homes are located in the urban centres to the detriment of the rural areas, as it has been presumed that the problems of older persons are worse-off in the urban areas compared to the rural areas.

The great diversity in the socio-economic fate of these older widows excluded from property inheritance then poses a persistent question as to how they survive in the face of harsh economic climate especially the rural ones whose hardships are aggravated by migration of the young family members to cities in search of job opportunities that are sometimes not in existence. This unfortunate situation has led some of them to resort to begging or become destitute, an act, which was in the past considered as demeaning and shameful to the entire family members (Togonu-Bickersteth, 1997, 2014). In recognition of the challenges facing older women, the United Nations (1983) held its first *World Assembly on Ageing in Vienna* in 1982. This was followed by the *Commission of the Status of Women - The Beijing Platform for Action* (ibid., 1996) adopted at the Fourth World Conference on Women in 1995, *International Year of Older Persons in 1999* (ibid., 1998b), and the *Second World Assembly on Ageing in Madrid* (ibid., 2002) in 2002. The latter included a number of recommendations which encompassed a plan of action to provide older persons with protection, housing and environment, health and nutrition, income security and provision of care and support. It was also suggested that special studies be carried out on the situation of the poor, vulnerable and handicapped older women in various societies. Nevertheless, despite these efforts and recommendations emanating from them, there was not mention of the plight of older widows who are being disinherited of their property. Although there is no official data on the disinheritance of older widows of the property they acquired with their late husbands, various research reports exist on how this cultural practice continues to underline both younger and older widows (Barrera, & Corbacho, 2012). Furthermore, the ways in which older widows sustain themselves after their properties have been taken away, and themselves thrown out of the family house, have not been yet been officially documented in Nigeria. It is noteworthy that

the belief that it is the duty and responsibility of the children to cater for their aged mothers is no longer held due to Nigeria's economic crunch since mid-1980s. It is against this background that this paper addresses the following research questions: What are the experiences and challenges associated with property inheritance among widows in the study area? And, what are the social explanations for property disinheritance and how can these be addressed?

Methodology

Study Location

The Esan people, formerly known as Ishan people, inhabit an area that lies between Longitude 60° 5′ and Latitude 60° 5′ in the geographical centre of Edo State, about 80 kilometres north-east of Benin City, and hence, in south-south Nigeria. By this factor of proximity and the fact that they share a basic cultural substratum, they are regarded as neighbours of Bini (Bradbury, 1973).

Geologically, Esan land is on a highland, surrounded by slopes down to the lower River Niger. The Esan people are bordered to the south-east by Agbor, to the south by Benin City, to the east and north by Etsako and to the west by River Niger. The Esan live in compact village settlements ranging in size from small hamlets to towns of several thousand people. They subsist primarily on yams, supplemented by corn (maize), plantains, cassava, and other vegetables. Livestock includes goats, sheep, dogs, and fowl, used mainly for sacrificial offerings. Blacksmithing and weaving ceremonial cloth (*igbolu ododo or igbulu esan)* are traditional crafts. Presently, Esan people are predominantly found in five Local Government Areas (LGAs) namely; Esan West, Esan Central, Esan South-East, Esan North-East and Igueben. These local government areas consist of over thirty major towns and several villages that share common cultures and social systems. Esan people dwell in rural, semi-urban and urban areas. The Federal Republic of Nigeria Official Gazette (2007) put the population of Esan at 587,898 comprising 300,729 (51.2 per cent) males and 287,129 (48.8 per cent) females, and is estimated to grow to 605, 535 by the year 2020, at three per cent growth rate.

Sources of Data

Data collection for this study was first carried out between February and June, 2009 when we were collecting data for a study titled, *Surviving without children: Life histories of childless aged women in Esan, Nigeria* (Eboiyehi 2009*)*. The second round of the data collection for this paper was conducted from October 2015 to January 2016. Hence, this study is a portion of a large qualitative and quantitative data collected in 2009. The data were collected from respondents in two selected Local Government areas in Esan with the aid of questionnaires and in-depth interviews. The questionnaires consisted of four sections. Section one focused on socio-demographic characteristics of the respondents. This involved their age, religion, highest level of formal education attained, occupation, level of income, number of children and living arrangement. Section two dwelled on the challenges facing older widows

disposed of their property after the demise of their husbands. Section three centred on various strategies employed by the respondents to cope with the identified problems while section four provided policy implication of the study. In all, 200 questionnaires were purposively administered to older widows using semi-structured interviews schedule. Out of the 200 questionnaires administered, 180 (90.0 per cent) were retrieved and analysed. Since the majority of the respondents were not literate, the questions were read out to them and filled by the researchers and their assistants who understand and speak Esan dialects fluently. Older widows in this study were defined as women aged 60 years or older whose husbands have died and who have not remarried. Simple descriptive model were used to analyse each of the objectives.

Face-to-face interviews were also conducted using an interview schedule. In all, thirty-six in-depth interviews were conducted to further understand the impacts property disinheritance on the interviewees, assess the various strategies employed to cope with the identified problems and suggested what could be done to improve their living conditions. Due to the low literacy level of the participants, interviews were conducted in local dialect since one of the researchers hailed from study area. The study employed the snowball sampling approach, whereby an older widow volunteered information leading to the identification of other older widows facing similar circumstances. There was no strict sampling procedure utilized. Interviews were held based on the willingness of the interviewees to participate in the study. However, the interviewees who met the criteria used for the definition of older widows were selected for the study. Where an interviewee's permission was obtained, a tape recorder was used. Interviewees were encouraged to express their views freely and as elaborately as time would allow. The use of in-depth interview method also enabled the researchers to record non-verbal displays for a meaningful interpretation. The data provided were transcribed and translated for analyses. Verbatim quotations of relevant statements were done.

Interpretation of Results

Social and demographic characteristics of the respondents

Tables 1 and 2 show the percentage distribution of respondents by their socio-demographic characteristics. Table 1 indicates that more than half of the respondents (51.1 per cent) fall within a wide range of young old age from 60 and 70 years. Out of this, 27.8 per cent falls within the age range of 60 and 65 years while 23.3 per cent are within the age range of 66 to 70 years. This age category could more critical and demanding for older widows in terms of self-support, especially farming, petty trading, feeding, clothing, etc that would have been provided if spouse were to be alive. This was followed by 18.3 per cent who were within the age bracket of 71 to 75 years and 13.9 per cent of them fall with the age range of 76 to 80 years. Precisely 9.4 per cent, 4.5 per cent and 2.8 per cent of the respondents were within the age bracket of 81 and 85 years and 91 years and above respectively.

Table 1: Social and demographic characteristics of the respondents (N= 180)

Socio-Demographic Characteristics	Frequency	Percent
Age in years		
60-65	50	27.8
66-70	42	23.3
71-75	33	18.3
76-80	25	13.9
81- 85	17	09.4
86-90	08	04.5
91 +	05	02.8
Total	**180**	**100.0**
Age at Marriage		
15-20	64	35.6
21-25	49	27.2
26-30	34	18.9
31-35	19	10.5
36 +	14	07.8
Total	**180**	**100.0**
Type of Marriage		
Monogamous marriage	15	8.3
Polygynous marriage	165	91.7
Others		
Total	**180**	**100.0**
Number of Children Currently Have		
1-2	17	09.5
3-4	42	23.3
5-6	51	28.3
7-8	42	23.3
9-10	20	11.1
11+	08	04.5
Total	**180**	**100.0**
Status in Family		
First wife	35	19.4
Second wife	40	22.2
Third wife	55	30.6
Fourth wife	50	27.8
Total	**180**	**100.0**
Sex of first child		
Male	30	16.7
Female	150	83.3
Total	**180**	**100.0**

Socio-Demographic Characteristics	Frequency	Percent
Religious Affiliation		
Christianity	140	77.8
Islam	15	8.3
African Traditional Religion	25	13.9
Total	**180**	**100.0**
Level of education		
No formal education	130	72.2
Primary school	40	22.2
Secondary school drop-out	05	02.8
Secondary school	05	02.8
Tertiary Institution	-	-
Total	**180**	**100.0**
Occupation		
Civil Servant	-	-
Professionals (e.g. Traditional Birth Attendants)	05	02.8
Farming	40	22.2
Petty Trading	80	44.4
Full-time housewife	55	30.5
Begging	20	11.1
Total	**180**	**100.0**
Level of Income per month		
No income	90	50.0
Less than ₦ 5000.00	26	14.5
₦ 5,001- ₦ 10,000.00	24	13.3
₦ 10,001- ₦ 15, 000.00	20	11.1
₦ 15,001 – ₦ 20,000.00	11	6.1
Above ₦ 20,000.00	09	5.0
Total	**180**	**100.0**

Age at marriage shows that majority of the respondents (35.6 per cent) got married at the age of between 15 and 20 years, 27.2 per cent of them got married between the ages of 21 and 25 years while 18.9 per cent got married between the ages of 26 and 30 years. Only 10.5 per cent and 7.8 per cent of the respondents got married at the ages of between 31 and 35 years and 36 years and above. Most of the respondents (91.7 per cent) were polygynists (i.e. married to men with another wife or other wives while only 8.3 per cent were monogamists. Majority of the respondents (28.3 per cent) had between five and six children, 23.3 per cent had between three and four children and seven and eight children respectively. Surprisingly, 11.1 per cent and 4.5 per cent of the respondents reported having between nine and ten children and over 11 children respectively. Only 9.5 per cent of the respondents reported having between one child and two children. The majority of the respondents (30.6 per cent) were their late husbands' third wives, 27.8 per cent were fifth wives, 22.2 per cent were second wives and only 19.4 per cent were first wives.

Table 2: Family Characteristics (N= 180)

Respondent's Family Related Data	Frequency	Percent
Educational level of Respondent's Children		
No formal education	70	38.9
Primary school	50	27.8
Secondary school	45	25.0
Tertiary education	15	8.3
Total	**180**	**100.0**
Employment Status of Children		
Unemployed	90	50.0
Formal employment	10	5.6
Informal employment	80	44.4
Total	**180**	**100.0**
Children's Family Size		
1-2	37	20.5
3-4	66	36.7
5+	77	42.8
Total	**180**	**100.0**
Living Arrangement		
Alone	60	33.3
With children	30	16.7
On rent	40	22.2
Parent's family house	45	25.0
With Others	5	2.8
Total	**180**	**100.0**
Adult Composition of the Household		
None	105	58.3
Presence of Adult Male	55	30.6
Presence of Adult Female	20	11.1
Total	**180**	**100.0**

Most of the respondents (83.3 per cent) said their first children are females while only 16.7 per cent had first children as sons. The majority of the respondents were Christian Muslims. Only a few of them were traditional worshippers. Christianity contributes more than half (77.8 per cent of the sample) indicating a preponderance of Roman Catholics in the study area. This is traceable to the history of Christianity and the first of the latter to come to this area was the catholic mission. This dominant religious influence is likely have a remarkable positive impact on respondents' coping strategy. Islam is not a strong factor in the area and those who subscribed to it are mostly migrants from Agbede and Ujagben near Auchi and Irrua who have reasonable number of Muslims.

Illiteracy level among the respondents was very high perhaps due to rural nature of the of the study area such that 72.2 per cent had no formal education. Primary education was remarkably high compared to other educational level attained with 22.2 per cent who had completed their primary school education, 2.8 per cent dropped out of secondary school and only 2.8 per cent completed their secondary school education. This result would have a lot of implications for the level of income, occupation and the number of children they currently have. It is therefore not surprising that 44.4 per cent of the respondents responded they were petty traders, 30.5 per cent were full-time housewives. 22.2 per cent were farmers, 11.1 per cent begged for alms while 2.8 per cent were professional Traditional Birth Attendants (TBAs). Arising from the respondents' low level of education and occupational status, their level of income was also extremely low. Their income distribution shows that half of the respondents (50 per cent) had no monthly income. As many as 14.5 per cent received less than ₦ 5,000 per month, 13.3 per cent received between ₦ 5,001,000 - ₦ 10,000. Only 5 per cent of the respondents earned more than ₦ 20, 000.00 per month. The implies that the income is so low that it does not cover their basis needs. Further inquiry into how they spent their income revealed that the majority of the respondents spent most of their income on illnesses, food and house rent. This was found to have negative impact on household food security, which further pushes most of them below the poverty line.

Table 2 also shows the data related to respondent's family. The table indicates that majority of the respondents' children (38.9 per cent) had no formal education, 27.8 per cent attended primary school, and 25.0 per cent only attended secondary school while only 8.3 per cent attended tertiary institutions. This finding is traced to low educational background of the respondents themselves, their occupations and level of income. For instance, the employment status of respondents' children has revealed that 50 per cent of them were unemployed, 44.4 per cent were employed in the informal sectors while 5.6 per cent were in the formal sectors. The table indicates that 42.8 per cent of the respondents' children have family size of five and above, 36.7 per cent have family size of between three and four while the family size of 20.5 per cent of them was between one and two. Respondents' living arrangement shows that 33.3 per cent of them were living alone, 25 per cent were living in parents' family house, 22.2 per cent were on rent, 16.7 per cent were co-residing with children while 2.8 per cent were living in other places such as church houses and houses built mosques. Data on adult composition of the household reveals that more than half (58.3 per cent) were living alone, 30.6 per cent were residing with adult males while only 11.1 per cent had the presence of adult females.

As table 3 demonstrates, different kinds of challenges ranging from 'cultural practices such as primogeniture and widow inheritance' (33.3 per cent), 'isolation' (16.7 per cent), 'poor access to basic healthcare' (15.5 per cent), 'constant illness' (11.1 per cent), 'poverty' (6.6 per cent), 'psychological trauma' (5.6 per cent), 'poor nutrition' (5.6 per cent), 'abandonment' (3.9 per cent) to 'loneliness' (1.7 per cent) were identified. Psychological trauma was found to be more prevalent among those rural older widows most who were ejected from their spouses' houses.

Table 3: Challenges

Cultural practices (e.g. primogeniture, widow inheritance etc)	60	33.3
Psychological trauma	10	5.6
Poor access to basic healthcare	28	15.5
Loneliness	3	1.7
Isolation	30	16.7
Constant illness	20	11.1
Abandonment	7	3.9
Poor nutrition	10	5.6
Poverty	12	6.6
Total	**180**	**100.0**

It is noteworthy that the poor shelter in which some of the respondents lived after being ejected from family house. During the in-depth interviews, it was found that 20 of the older widows were ejected from their spouses' houses. Poor diets without nutritional values were also observed to be common among the rural older widows (five cases), while payment of house rent and electricity bill was a major challenge for three older widows in the urban area. Mostly affected by this shift are the childless older widows particularly, those who have nobody to cater for them. A woman aged 78 years, and living in the rural community, stated that

> All the properties I acquired with my husband including my personal effects have been wickedly taken away from me because I do not have a child from him. They said all the assets belonged to my late husband, which only the oldest son is entitled to. By this act I have been wickedly thrown into abject poverty. Government should please come to my aid. Government should stop thinking that the family members are still there to take care of us. That era has gone. Our situation is compounded because the culture says everything a man owns belongs to the oldest son alone. In most cases the oldest son abandons the older widow especially if such widow is not his mother to fend for herself with failing strength. Help us tell government that older widows are suffering. We are dying. In most cases, I go to bed with empty stomach. How can a woman suffer all the days of her life with her a man and in the end she is thrown away without any inheritance? This is where the culture has placed us. That is why we are calling on government to come to our aid.

A respondent aged 75 years, also living in a rural setting, affirmed the above and stated with deep sorrow that

> This is the eleventh year since my husband died. This is the eleventh year since I have been denied access to his house and property. This is the eleventh year since I have been ejected from the house I helped to build with him. This is the eleventh year since I have living in penury, lack and want. I was thrown away from my husband's house by his family members simply because I did not have children from him. They call me a witch because I do not have a child to fight for me. If not for some kind-hearted people who give me food, money and clothe me, I would have since died. My church members also assist me and assure me of expected good end. I have no child of my own to take care of me and support me.

Similarly, an 84-year old interviewee living in a rural community noted that when she

> …married my husband, I never knew that life would turn out this way. I suffered with him under the rain and under the sun to ensure we have a roof over our heads. We plant all the cash crops (economic trees) together. I have three daughters from him. When I could not give birth to a son, I advised him to marry another wife who eventually had three sons from him. I assisted in bringing them up but when my husband died, I suddenly became a stranger in my house. My husband's first son who used to call me his 'mother 'was advised to send me away from the house based on advice he received from extended family members. That is how I became a "stranger in my house". I have challenges paying for a room apartment. I am hypertensive. I have no good food to eat and no money to buy the prescribed drugs. Unfortunately, my daughters are in the cities. They have their families to cater for. I never thought life would turn out this way.

Congruently, another childless widow aged 80 years, and also living in a rural community, remarked

> When my husband died, his children summoned me and asked me what I was still doing in the house. I was told that the man who I was married to had died and that I no longer belong to the family. They said if I did not know, I am a stranger in the family. I was given only one week to pack my few belongings without having access to his property. This was how I became a beggar; a poor woman begging for money, food and clothes to put on. Old age is a serious problem at

> least to those of us who do not have children to lean on. How to feed is a problem. At my age, I am supposed to depend on my children for food and other support especially now that I have been ejected from my late husband's house.

In Esan culture, a woman who is not lucky to be the mother of the first or oldest son also suffers the same disinheritance as the childless older widows. According to an older widow living in a rural community and aged 65 years,

> In our culture, women do not have any right of inheritance not only in their husbands' house but also in their fathers' house. The problem with those of us who are not so lucky to give birth to the first son is the same with the childless women. Having only daughters is the same as having no child. That is not to say the mother of the first son is entitled to inheritance. No, she can only enjoy the assets left behind by her late husband through her son. No son or child will like to see his mother suffers. The rest wives are left to fend for themselves in the midst of nothing and so, many of them remain poor for the remaining part of their lives. So, if I must answer your question I will say poverty is a major problem we are facing.

In addition, another widow aged 69 years old, also living in a rural community, stated:

> In this place, a woman who is not the mother of the first son is like a woman without a child. She will not be given any inheritance rights. A mother with first son in the family can only inherit through the husband first son. The first son alone can inherit all the property including his father's younger wives and his own younger sisters. Nobody cares about me any longer because I am an old woman. Sometimes, I go to bed without food and nobody cares. My children are in the city. Unfortunately, none of them has a good job in the city.

Loneliness was another major challenge facing some of the older widows after the death of their spouses. This is compounded with the diminishing supports from the extended family members and rural-urban migration of young family members who are supposed to cater for them. Although some of these older widows visit their friends, they complained that loneliness was a prominent problem at least at the homestead. An older widow aged 75 years, and living in a rural community, remarked as follows:

> I lost my husband about six years ago. Since then life has not been the same for me. As you can see, I am living alone here on rent when my husband's children ejected me from his house. I was his third wife and had three children, all boys, from him. My first son is the sixth son in the family and has no inheritance rights. The three of them are in the city. Although they are trying their best, I am not as happy as I

> should be because money is not everything. You need to see how I feel; it is as if I am living alone in the midst of a crowd. I need somebody around me to talk to, run errands for me, cook for me and discuss with me. I am seriously missing my husband. He was a great man.

Another interviewee aged 78 years, but living in an urban setting, stated:

> The major problem facing us is that those who are supposed to take care of us or support us are longer there, unlike in the olden days when an older person is surrounded with his or her offspring. They are in the cities with or without jobs leaving us to fend for ourselves with little or no strength. What can an old woman without husband do? The extended family who used to cater for them are the ones who are throwing them away from the house they helped to build now. In the olden days, extended family members used to send the best part of their harvest to the older person or send their children home to stay with them and help them. What we have today is older widows living in loneliness and poverty. This is a major problem confronting me most especially. Without any means of livelihood, I am helpless.

Hence, no wonder that an interviewee in her late 70s, and living in a rural community, affirmed that she is

> …struggling to procure food and to feed is my major challenge. Most times, I develop high blood pressure, when on daily basis I think of where and how to get money to buy food, drugs, pay my rent and live a healthier life. But as you can see, I am walking on a tight rope between survival and starvation.

Indeed, it is not surprising that insufficiency of food and malnutrition remains a key challenge for many of these older widows since, unlike what happened in the past, their offspring provided them with much food and comfort. Practically, all the in-depth interviewees consistently mentioned ill-health and lack of basic income as their major challenges. According to an 82 years old interviewee living in an urban setting, her

> …major problem is ill health. I need money to buy drugs, food to take care of myself. But the money is not there. Initially, I felt bad when I was denied my inheritance. But my daughter rose up to the occasion. I would have since died if not because of my daughter… She is the one supporting me.

Another interviewee aged 78 years, and also living in an urban setting, was not as lucky as the above interviewee, and remarked that:

> Thinking about not inheriting a pin from my husband is traumatizing. It is seriously affecting my health. I see myself as someone who has come to the world to labour in vain. How can one suffer all her life to help build a house and at the end she is thrown out from the same house? It is very painful. I have been ill but I do not have money to go for medical check-up or feed myself. I do not have anybody to look after me. I have no access to my husband's property. My husband's children have since abandoned me. They said I was the one who was responsible for his death. They called me a witch. Because of this I was driven away from his house. My question is, how could I have killed a man who had made me a woman? How can I kill my pride?

Table 4 shows the different coping strategies as employed by the respondents to alleviate their sufferings. Material supports from co-resident and non-co-resident children and relatives were found to be the most important coping strategies for the older widows.

Table 4: Coping Strategies Employed by the Respondents

Coping Strategies	Frequency	Percent
Alms begging	9	5.0
Support from co-resident and non co-resident children	70	38.9
Support from other family members	10	5.6
Support from religious bodies	6	3.3
Petty trading	35	19.4
Subsistence farming	30	16.7
Support from Local Government	17	9.4
Pension	3	1.7
Total	**180**	**100.0**

Two types of material support were identified during this study which included provision of food and/or clothes, while financial support consists of payment of house rent, medical and electricity bills. Half of them received support in the form of food and/or clothes from non-co-resident children while a similar number received financial and material support from non-co-resident offspring. When only older widows with at least one non-co resident children are considered, less than half receive both material and financial supports from children outside their households. Altogether, 38.9 per cent of the respondents received

support from children and other family members (5.6 per cent). According to an interviewee aged 76 years and residing in a rural community,

> My family is of immense assistance to me. My children support me according to their ability and capability, although some of them are trying to survive in a situation of high unemployment and scarce resources. They are really trying their best for me. Nobody can blame anybody nowadays because the country is hard.

Another interviewee aged 70 years and also living in a rural community stated that her "brothers and sisters in the cities have been assisting me. They send money, drugs, foodstuff and clothes". Similarly, another female interviewee aged 62, and again living in a rural setting, commented as follows:

> I am living in my son's house. My son and other children employ a medical doctor who is always coming here to take care of me whenever I am ill. He comes regularly for my medical check-up. My children also employ a woman for me who is always coming here to clean the house, wash my clothes and cook for me. Apart from these, they send money and food items regularly. Also, they sent three of my grandchildren who are living with me to assist and run errands for me.

A quarter (nine) of the interviewees relied on church-related assistance and good Samaritans for means of livelihood. As affirmed by an interviewee aged 72 years living in a rural setting, "I would have since died if not for members of my church. They assisted by giving me food, clothes and money. At times, they send their children to assist me". Only a few of the interviewees' livelihoods - (1.7 per cent) - depended on pension. One of the pensioners aged 69 years, and living in an urban setting, affirmed that

> I worked and retired as a clerk from the State Ministry of Education. Since I am not used to farming, I cannot suddenly go into farming after my retirement about ten years ago, I depend on pension and sporadic remittances from my children.

An emerging trend in the study was that the traditional responsibilities of the extended family of catering for the older widows were gradually being taken over by service care providers. Out of the 36 interviewees, five reported that they benefited from financial support, provision of eyeglasses and repair of their roof from the local government. Three recorded formal services for the widows by the local government included relief scheme for

the older widows, the childless and destitute, roof repairs and provision of eyeglasses. One of the interviewees stated as follows:

> [the Local Government Chairman, Esan Central] introduced a scheme which he called 'Relief Scheme for the older widows, the childless and destitute'. He has been assisting us by placing all the older widows on ₦ 500.00 monthly. He also assisted some of us whose roofs were blown off by winds during the last raining season. The local government also bought glasses for some of us who cannot see clearly.

In the urban community, the few older widows without support noted how they solicited for public alms as a coping strategy. This finding was affirmed in the words of one of the childless older widows aged 78 years: "After the death of my husband, I have been begging for food and money because there is nobody to cater for me". Similarly, another interviewee aged 70 years stated that

> Suffering leads to frustration. When one does not have food to eat, no husband and children to lean on and no money to spend, one will become restless. An average human being will like to survive. In trying to survive in the midst of this economic hardship and there is neither child nor husband to lean on for support and when no family member is willing to assist, one would have no option than to beg. I do not want to die in hunger, so I beg to survive.

Discussion of findings

As exposed in this paper, the myriads of challenges associated with loss of spouse that widows are confronted with in the study area cut across cultural practices, isolation, and poor access to basic healthcare, constant illness, poverty, psychological trauma, poor nutrition, and abandonment to loneliness. These challenges were linked to cultural practices, diminishing of functions of the extended family system, migration of young people to towns and cities in search of education and employment opportunities and the down-turn of the economy. The findings are similar to those identified in other research reports (e.g. United Nations, 1998c; Orubuloye, 1987; Akeredolu-Ale & Aribiah, 2001; Eboiyehi, 2008). Eboiyehi (2008) for instance, observed that the challenges facing the older persons in general and older widows in particular, stem from the current economic crisis, the shift from agro-based to industrial society, migration of young people to cities which have often left older persons unsupported or eroded their economic independence. Children's absence was also found to have left many of the older widows (whose properties and assets were grabbed) without emotional, financial and physical support. Material supports from co-resident and non-co-resident children and relatives were found to most important coping strategies for the older widows indicating that even though there is a decline in care and support for older widows in the study area, family members particularly children still provides some supports for their older mothers excluded from property inheritance. In other words, although there are

still evidences of support networks for vulnerable widows, the effect is far below that obtained in a typical traditional Esan society. The traditional Esan system provides every older widow an easy way to be integrated to the extended family system.

Surprisingly, an emerging phenomenon in the study area is that some of older persons who had nobody to cater for them had resorted to alms begging unlike what was obtained in the traditional Esan society where it was the collective responsibilities of the children and entire extended family members to cater for the older widows. These responsibilities were found to be gradually being taken over by service care providers. Others who have nobody to cater for them resorted to alms begging. This finding is in tandem with earlier study by Togonu-Bickersteth (1997, 2014) of Yoruba older persons of South-western Nigeria. In the study she found that this unfortunate situation has led some older persons to resort to alms begging which in the past were considered demeaning and shameful to the entire family members (ibid., 1997).

In contemporary Esan, survival among older widows is a difficult process in which coping strategy is very demanding. Even though they still depend on their kin for survival, meeting their needs in the absence of spouses poses a lot of strain on them. In the face of present economic crisis, high inflation, unemployment and out-migration of offspring, it seems that the future care and support for this segment of the population may be more difficult. The difficulty arises from government's failure to provide social security for the aged, particularly of older widows. Sadly, the economic reforms embarked upon by the Federal Government have also imposed constraints on older widows and their supposed caregivers. However, the same structure, which has imposed these constraints, has also enabled the older widows to do things they would not otherwise be able to do by employing various mechanisms such as petty trading, farming among others. That is what Giddens (1991) referred to when highlighting the 'constraining' and 'enabling' functions of the structure.

A little difference was observed between rural and urban older widows with respect to support from non-co-resident children. The older widows who live in rural areas were more likely to receive remittances from their non-co-residing offspring in form of money, drugs as well as clothes, than their urban counterparts. Furthermore, it was found that compared with their counterparts in the urban areas, the older rural widows with children were also more likely to live adjacent to or near non co-resident children. A cluster of related dwelling units in which the aged parents and married children reside functioned in ways similar to a single household with a substantial amount of sharing of food and resources, especially with aged parents are common. This situation made it possible for family members in the rural areas to cater for their older mothers though minimally compared to the traditional period. Unlike in the urban area, it was found that some, though very few, of the older widows living in the rural areas lived with at least a younger relative who they depended upon for care and support. Thus, in rural areas, the familial system of taking care of older widows, either with or without children, remains in existence, though minimally.

Conclusion

The issue of disinheriting older widows of property after the demise of their husbands in Nigeria is clearly a growing human rights concern requiring increased attention and action from government, Civil Society Organizations, Community Based Organizations and academia. This issue is similar to a number of other practices which have negative effects on older women's rights of enjoyment, including elder abuse, witchcraft accusations, abandonment and lack of care and support. In particular, the failure of government over the right of older widows to inherit property left behind by their late husbands which result in older women's rights abuse highlight the need for increased collaborative work on the most appropriate and effective ways to address such issues and for joint evaluations from all relevant actors on the development of policies and interventions. The paper concluded that since older widows are among the most vulnerable groups in the study area, denying them their bequeathing rights will further exacerbate their already poor conditions which may also negatively affect them and members of their households. The paper therefore suggests that there is a need for government and all other concern agencies and organization to look at the direction of this segment of the population so as to alleviate the infringement of their fundamental human rights.

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Gender differences in prevalence and associated factors of multi-morbidity among older persons in Vietnam

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Abstract. The aim of this study was to examine the prevalence and the determining factors of multi-morbidity among older men and women in Vietnam. Data for this study was utilized from a nationally representative survey - that is, Vietnam Ageing Survey (VNAS) in 2011. The study sample was restricted to older people (those aged 60 and over). Multi-morbidity was defined as having at least two presences of chronic diseases. Bivariate, t-test, and multivariable logistic regression analyses were applied to identify potential factors correlated with multi-morbidity among older men and women. The results showed that around 44 per cent of older persons reported having multi-morbidity, in which a higher prevalence was found in women (49.4 per cent than men (36.7 per cent). The results of multivariate analysis indicated that factors associated with multi-morbidity were found to vary by gender, in which advanced age and living alone were the strongest predictive variables in both genders. Therefore, health interventions with regards to gender are increasingly essential to reduce burdens of chronic diseases.

Keywords: Ageing, chronic disease, gender, inequality in health, multi-morbidity, older persons.

Background

Vietnam has witnessed significant improvements in healthcare achievements, resulting in both declining in fertility and mortality as well as increasing life expectancy of people during the past three decades (United Nations Population Fund, 2011). The country now is at the end of demographic transition, shifting in age structure has produced a huge young population in working age and a growing number in older persons (United Nations, 2006).

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The process of individual ageing has been proved to be significantly associated with deterioration of health status and higher rates of morbidity (Haseen, Adhikari, & Soonthorndhada, 2010; Hoang, Dao, & Kim, 2008). In particular, a previous study on ageing in Vietnam found that the more advanced age, the higher proportion of older persons with illness (Evan et al., 2007). As one of the fastest ageing societies in the Association of South East Asian Nations (ASEAN), Vietnam is facing the challenges of epidemiological transition in term of shifting in disease patterns and it poses greater demands and higher expenditures on healthcare (Dam et al., 2010; Evans et al., 2007; Nguyen, 2010). Moreover, older persons in Vietnam are now facing with 'double disease burden' (United Nations Population Fund, 2011), and most of older persons in Vietnam are suffering at least one disease and have to deal with chronic diseases (Dam et al., 2010).

According to the World Health Organization (2011), non-communicable diseases are the main burdens for older persons, and older persons of middle-income nations are suffering more from the burden of non-communicable diseases as compared to wealthier nations. Recent evidence also shows that around 80 per cent of death caused by non-communicable diseases happens in low-and middle-income countries and most deaths occur after the age of 60 in the world (ibid., 2011). In addition, it has been implied that non-communicable diseases have become primary causes of illness for older persons in developing countries (Yach, Kellogg, & Voute, 2005). Indeed, non-communicable diseases are the main diseases of Vietnamese older persons in recent years, in which cancer and cardiovascular diseases are the main causes of years of life loss while lung and liver cancers are the major cause of deadly burden in both men and women (Nguyen et al., 2011). Therefore, understanding the association between health status and non-communicable diseases at a later age is crucial to build appropriate healthcare strategies in the future.

In terms of health, gender discrimination appears when people are aged (Moller, Fincher, & Thornhill, 2009). Vulnerability of older women has raised critical issues for government's social programmes to improve their living standards (United Nations, 2007). Furthermore, the World Health Organization (2008) reported that solving gender inequity is an only possible way to narrow the health gaps between countries and within countries, and this implies that empowerment of women is considered a key to achieve health equality. In addition, there has been growing concerns on the association between gender and ageing issues among policy makers in Vietnam. There are concerns that older women might suffer more than their male counterparts, since older women might be more vulnerable to health problems than male peers due to unfavorable socio-economic status when they were young and in addition, they also tend to be widowed when they are aged (Giang & Pfau, 2007). Studies on chronic diseases have been of longstanding interests to researchers in Vietnam, but these studies mostly focus in place of residence inequity (i.e., rural versus urban area) in terms of daily care and quality of life views. In addition, their sample settings are limited as their data are collected in a rural district in Vietnam, namely FilaBavi (Hoang et al., 2008; Le, Nguyen, & Lindholm, 2010; Le, Pham, & Lindholm, 2011).

At the best of our knowledge, there has been only one study examining the association between multi-morbidity and its social determinants among older persons (Ninh, Ninh,

Khanal, & Moorin, 2015). However, this study provided only a general picture about the prevalence and the association between multi-morbidity and selected factors rather than focusing on gender issues. Its sample, similar to previous studies, was derived from only two provinces in southern Vietnam, and thus it might not reflect the real situations of the older population as a whole. Our study, taking advantage of the first-ever nationally representative survey on older persons in Vietnam, namely the Vietnam Ageing Survey (VNAS) in 2011 (Vietnam Women Union [VWU], 2012), aims to provide information on the prevalence of multi-morbidity and potential factors associated with multi-morbidity among older persons in terms of gender.

Data and Methodology

Data

Data of this paper was utilized from the VNAS (Vietnam Women Union, 2012), a nationally representative survey on persons aged 50 and over in Vietnam, which was conducted in late 2011. This survey was designed and sampled by using the results from the Population and Housing Census in 2009 (General Statistics Office, 2010). Eligible interviewees were chosen by multi-stage sampling method. In the first stage, samples were drawn from 12 provinces of six ecological zones in Vietnam. In the second stage, 200 communes were chosen using the probability proportional to size method from the 12 selected provinces. In the third stage, within each selected commune, two villages were randomly selected. In the final stage, a list of all households with people aged 50 and over was collected from each selected village, and a sample of 15 people aged 50 and over was selected systematically using a random start. Out of 15 selected people, 10 people were officially interviewed and five people were reserved as alternatives. Data collection was conducted by face-to-face interview using a structured questionnaire. Once completed, all questionnaires were double-checked on-site by interviewers and then by supervisors to ensure that all questions in the questionnaire were filled out completely. All valid questionnaires were gathered for further review and data entry. The total survey sample consisted of 4,000 people aged 50 and over. However, this study was confined to those aged 60 and over. Thus, the sample size of this study comprised 2,789 people aged 60 and over (or older persons as defined in this paper). Among older persons, 1,683 were females and 1,106 were males; and 2,050 were living in rural areas, while 739 were living in urban areas. The response rate was about 93 per cent. All the information, such as those about individual and household socio-demographic characteristics, living conditions, health conditions, and roles and contributions of older persons to their families, is provided in VNAS (VWU, 2012).

Variables and measurements

Dependent variable

Questions related to health conditions of older persons in the questionnaire were based on references to a number of questionnaires used in aging surveys by the World Health Organization's *Study on Global Aging and Adult Health* (SAGE) (World Health Organization,

2016). Chronic diseases were constructed in such a way that they would represent major public health problems and cover a wide range of conditions among older persons. Particularly, in order to examine the presence of chronic diseases, participants were asked the question 'Have you ever been diagnosed with/told you have any chronic diseases as follow?' and there were 12 response options for them, namely: arthritis, angina, diabetes, chronic lung diseases, depression, blood pressure problem, cancer, cataract, heart diseases, and liver diseases. A person is defined as having multi-morbidity if he/she has at least two presences of diagnosed disease (Jerliu, Toci, Burazeri, Ramadani, & Brand, 2013).

Independent variables

A wide range of independent variables were included in this study – namely, demographic characteristics, socio-economic factors and lifestyle risk behaviors. These included (all variables are summarized in Table 1)

- Age was categorized into three sub-groups: 60-69 years, 70-79 years, and 80 and over.
- Gender was divided into two categories: male and female
- Marital status was grouped into two groups: married and others (single/divorced/ separated/widowed).
- Living arrangements were categorized into four sub-groups: living with at least one child, living alone, living with a spouse only and living with others without children.
- Place of residence was coded as rural and urban areas.
- Educational levels were transformed into four sub-groups: no schooling/did not complete primary school, primary school, secondary, high school and over.
- Household wealth was constructed by using principle component analysis techniques (Vyas & Kumaranayake, 2006). Five wealth quintiles were constructed by documenting a number of variables including: household income, lands' possession, type of house, materials of roof and floor, toilet facilities, electricity, water supplies, and household assets. These five quintiles then were continued to be grouped into three sub-categories as poor, average, and rich.
- Perceived sufficiency of income, respondents were asked about their self-perceived income to meet their daily needs, then this variable was coded as: no (rarely or never enough/sometimes not enough) and yes (enough/more than enough).
- Employment status was categorized as: still working and not working.
- Alcohol consumption measurement was based on frequent consumption of alcohol and this variable was collapsed into four categories: one or less than once a month, 2-3 times a month, several times a week, and one or more than twice a day.
- Smoking status was defined by individuals' confirmation of being a current smoker at the time of the interview and then was coded as yes and no.

Table 1: Variable measurements

Variable	Classification and measurement of variables
Dependent variable	
Multi-morbidity	No disease/having one chronic disease = 0; have multi-morbidity = 1.
Independent variables	
Age groups	Aged 60-69 = 0; 70-79 = 1; 80+ = 2.
Gender	Female = 0; male = 1.
Marital status	Others (single/divorced/separated/widowed = 0); married = 1.
Living arrangements	Living with at least one child = 0; living alone = 1; living with a spouse only = 2; living with others without children = 3.
Place of residence	Rural = 0; urban = 1
Educational levels	No schooling/did not complete primary school = 0; primary school = 1; secondary = 2; high school and over = 3.
Household wealth	Poor = 0; average = 1; rich = 2
Perceived sufficiency of income	No (rarely or never enough/sometimes not enough) = 0; yes (enough/more than enough) = 1.
Employment status	Not working = 0; working = 1
Alcohol consumption	One or less than once a month = 0; 2-3 times a month = 1; several times a week = 2; one or more than twice a day = 3.
Smoking	No = 0; yes = 1

Note: variables with a value of zero were treated as reference groups.

Methodology

Several analytical methods were applied in this study. Firstly, descriptive analyses were used to provide background information about socio-demographic characteristics and prevalence of having multi-morbidity among respondents by gender. Secondly, bivariate analyses were applied to differentiate the probability of having multi-morbidity among older males and females by socio-demographic and lifestyle risk factors, then t-test analyses were performed to examine whether the differences in reporting multi-morbidity were significant or not. Thirdly, a Chow test was conducted to examine whether parameters (slopes and intercept) have an equal effect on multi-morbidity between older men and women (Chow, 1960).. Finally, separate multivariable logistic regression models were performed to examine the association between potential factors and the presence of having multi-morbidity among older males and females. The odds ratios were used to measure the

significant effect of the independent variables on the dependent one. A p-value of <0.05 was regarded as statistically significant. Before performing the multivariable logistic regression models, multi-collinearity analysis was applied to make sure the independent association among the selected variables.

Results and discussion

Distribution of chronic disease in the older population

Distribution of chronic disease in the older population was presented in Table 2. Nearly two-third of the total population reported having chronic diseases, accounted for 72.12 per cent. Among them, more than half of disease-reported respondents had multi-morbidity with 43.91 per cent. Table 2 shows the distribution of chronic disease of the older population.

Table 2: Simple distribution of dependent variable

Variable	Weighted percent
% Chronic disease	
Having no disease	27.88
Having one chronic disease	28.21
Having multi-morbidities	43.91

Source: Authors' calculations, using VNAS 2011 (VWU, 2012)

Socio-demographic characteristics of respondents by gender

Table 3 presented the distribution of selected characteristics of sampled respondents by gender. The mean age for men was 71.5 years old, while corresponding figure for women was slightly higher, 72.2 years. Those aged 60-69 took the largest share of the selected sample (45.6 per cent), followed by those aged 70-79 (31.3 per cent) and 80 and older (23.1 per cent), respectively. Of those, the proportion of women was higher across age groups, except the youngest age group. A significantly higher prevalence of having morbidity was found in women than men (49.4 per cent versus 36.7 per cent), while having no or one chronic disease was seen significantly higher in men as compared to women (63.3 per cent versus 50.6 per cent). Our study added to the existing knowledge that a higher prevalence of multi-morbidity was found in women than men (Khanam et al., 2011; Marengoni, Winblad, Karp, & Fratiglioni, 2008; Ninh et al., 2015; Phaswana-Mafuya et al., 2013). The estimated association between men and multi-morbidity could have lacked of accuracy as the sampled women outnumbered their men counterparts in this study. However, it could reflect that the deficit number of men in a later age was because of a selected group of healthier individuals. In addition to that view, the notion that older women tended to perceive poorer health status than men but have better longevity has been well-established in the literature (Molarius et al., 2007; Singh, Arokiasamy, Singh, & Rai, 2013).

Table 3: Background information of socio-demographic characteristics and lifestyle risk behaviours of respondents by gender

Variables	Total	Female	Male	Female-Male Difference
% Chronic disease				
Having no or one chronic disease	56.1	50.6	63.3	***
Having multi-morbidity	43.9	49.4	36.7	***
% Age groups				
60-69	45.6	41.6	50.8	***
70-79	31.3	32.2	30.1	ns
80+	23.1	26.2	19.1	*
Mean age (±SD)		72.2 (±9.1)	71.5 (±8.6)	
% Marital status				
Married	68.5	52.7	89.4	***
Others (single/ separated/ divorced/ widowed)	31.5	47.3	10.6	***
% Living arrangements				
Living with at least one child	67.2	67.4	66.8	ns
Living alone	5.3	8.0	1.6	***
Living with a spouse only	17.1	12.6	23.1	***
Living with others without children	10.4	12.0	8.5	ns
% Place of residence				
Rural	67.1	67.0	67.3	ns
Urban	32.9	33.0	32.7	ns
% Educational levels				
No schooling/ did not complete primary school	50.1	64.7	30.2	***
Primary school	17.9	16.1	19.9	ns
Secondary school	16.3	10.9	23.0	***
High school and over	15.7	7.8	26.0	***
%Household wealth				
Poor	40.9	40.2	41.9	ns
Average	33.0	30.8	36.0	ns
Rich	26.1	29.1	22.1	**
% Perceived sufficiency of income				

Variables	Total	Female	Male	Female-Male Difference
Not enough (rarely or never enough/sometimes not enough)	61.1	60.6	61.9	ns
Enough (enough/ more than enough)	38.9	39.4	38.1	ns
% Working status in the past 12 months				
Not working	61.2	66.8	53.8	***
Still working	38.8	33.2	46.2	***
% Alcohol consumption				
One or less than once a month	35.2	57.7	30.4	***
2-3 times a month	19.5	13.0	21.0	***
Several times a week	13.1	11.9	13.4	***
One or more than twice a day	32.2	17.4	35.2	***
% Smoking				
Yes	21.0	5.9	40.9	***
No	79.0	94.1	59.1	***

*Note: *, **, *** denote P<0.05, P<0.01, and P<0.001, respectively. (ns) indicates insignificant.*
Source: Authors' calculations, using VNAS 2011 (VWU, 2012)

A majority of the sampled respondents were married (68.5 per cent), in which the proportion of married men (89.4 per cent) was significantly predominant that of women (52.7 per cent). Living with at least a child was the most common living arrangements of the sample (67.2 per cent) and the pattern was similar for both men (66.8 per cent) and women (67.4 per cent). A higher proportion of older men (23.1 per cent) than older women (12.6 per cent) resided with a spouse only, while the proportion of living alone was higher among older women (8.0 per cent) than older men (1.6 per cent). Those living in rural areas (67.1 per cent) outnumbered those from urban areas (32.9 per cent) in both genders, in which the proportion of both men and women was similar.

Regarding socio-economic circumstances, although half of the sample of older persons was uneducated, there were more educated men than women among those who did complete education. A majority of older persons were not working (61.2 per cent). Among those who still participated in the workforce, a significantly higher proportion of working men (46.2 per cent) than women (33.2 per cent) was found in this study. In terms of household wealth, more than one-third of the selected sample reported living within a poor household (40.9 per cent), and there were near equal proportions of men (41.9 per cent) and women (40.2 per cent) within this category. In contrast, a higher proportion of women indicated living in rich households as compared to their male counterparts (29.1 per cent versus 22.1 per cent). A

majority of older persons perceived their income as insufficient to meet their means (61.1 per cent), and women were more likely than men to indicate such economic insecurity.

With regards to lifestyle risk behaviors, drinking alcohol one or less than once a month was the most common drinking behaviors among men and women, in which, the proportion of women (57.7 per cent) was significantly higher than men (30.4 per cent). However, daily drinking alcohol was found to be higher in men (35.2 per cent) than women (17.4 per cent). Most respondents did not smoke, only 21 per cent of respondents reported smoking and smoking was seen significantly more prevalent in men than women.

Differences in reporting multi-morbidity by selected variables and gender

The results of bivariate and t-test analyses in Table 4 showed that most of the selected variables were found to be statistically significant difference in reporting multi-morbidity among older men and women, except age groups, perceived sufficiency of income, and place of residence.

Table 4: Differences in reporting multi-morbidity by selected variables and gender

Variables	Female	Male	Female-Male Difference
% Age groups			
60-69	46.08	27.55	18.53
70-79	55.71	46.31	9.4
80+	46.8	45.74	1.06
% Marital status			
Married	53.08	37.64	15.44***
Others (single/ separated/ divorced/ widowed)	45.23	28.42	16.81***
% Living arrangements			
Living with at least one child	50.45	35.01	15.44
Living alone	51.62	54.56	2.94***
Living with a spouse only	43.83	45.41	1.58***
Living with others without children	47.6	22.39	25.21*
% Place of residence			
Rural	49.89	37.99	11.9
Urban	48.31	33.95	14.36
% Educational levels			
No schooling/ did not complete primary school	48.53	28.54	19.99***

Variables	Female	Male	Female-Male Difference
Primary school	52.43	39.68	12.75***
Secondary school	49.64	37.12	12.52***
High school and over	49.14	41.05	8.09***
%Household wealth			
Poor	58.72	38.2	20.52
Average	40.42	40.13	0.29
Rich	44.93	28.74	16.19**
% Perceived sufficiency of income			
Not enough (rarely or never enough/sometimes not enough)	51.56	36.28	15.28
Enough (enough/ more than enough)	46.01	37.1	8.91
% Working status in the past 12 months			
Not working	54.52	43.64	10.88***
Still working	40.05	28.54	11.51***
% Alcohol consumption			
One or less than once a month	41.21	35.8	5.41***
2-3 times a month	39.52	24.71	14.81***
Several times a week	31.29	43.87	12.58***
One or more than twice a day	25.8	31.44	5.64***
% Smoking			
Yes	50.01	43.87	6.14***
No	39.19	26.25	12.94***

*Note: *, **, *** denote P<0.05, P<0.01, and P<0.001, respectively.*
Source: Authors' calculations, using VNAS 2011 (VWU, 2012)

Of those significances, marital status, educational levels, employment status, smoking, and alcohol consumption were found to be statistically significant differences in reporting multi-morbidity in all categories by gender. In which, no schooling/did not complete primary school category was shown as the highest difference between men and women, accounted for around 20 per cent, followed by those who were single/separated/divorced/widowed with 16.81 per cent of the difference. On the other hand, those who drank alcohol one or less than once a month ranked the smallest difference with only 5.53 per cent.

Overall, the proportion of having multi-morbidity was higher among women than men in most categories of the selected variables, including variables that were not shown their significances. The proportion of having multi-morbidity consistently increased with age and was shown clearest in the age of 70-79 for both genders (55.71 per cent for women and 46.31 per cent for men). Married group was seen to have a negative association with multi-morbidity in both sexes as compared to other group, and a significantly higher proportion of having multi-morbidity was found in women (53.08 per cent) than men (37.64 per cent). Living alone was the highest proportion of having multi-morbidity in both genders and the figures were higher in men (54.56 per cent) than women (51.62 per cent). Living with spouse only and living with others without children were the smallest proportion of having multi-morbidity in women (43.83 per cent) and men (22.39 per cent), respectively.

Educational levels showed a negative relationship with having multi-morbidity among both men and women, such as the proportion of having multi-morbidity was found to be higher in those with higher educational levels than those with lower education. However, the proportion of having multi-morbidity was shown significantly and consistently higher in women than their male counterparts. Women with poor household wealth (58.72 per cent) and men with average household wealth (40.13 per cent) were found to be the highest proportion of having multi-morbidity. However, statistical significance between men and women was found in rich group only, and in general, the proportion of multi-morbidity was consistently higher in women than men. The highest proportion of having multi-morbidity was found in those who were not working in both sexes and the figures were seen to be higher in women as compared to men (54.52 per cent versus 43.64 per cent).

Those who drank alcohol one or less than once a month in women and several times a week in men were the highest proportion of having multi-morbidity. It was interesting to see that those who drank alcohol daily were less likely to have multi-morbidity in women. Those who smoked had a higher prevalence of multi-morbidity than those who did not smoke in both genders and the pattern was higher in women than men.

Determining factors associated with multi-morbidity among older men and women

Results of Chow test showed that effect of variables of interest on multi-morbidity among older men and women was significantly different, thus logistic regression models were executed for men and women separately. Table 5 presents results of multivariate logistic regression analysis estimated to determine the association between the selected factors and probability of having multi-morbidity among older men and women in Vietnam. The results reiterated that age was strongly correlated with multi-morbidity, however, statistical significance was found only in men, but not in women.

Table 5: Multivariate logistic regression results: likelihood estimated of having multi-morbidity among older men and women

	Having multi-morbidity			
	Female		Male	
Variables	O.R (s.e)	p-value	O.R (s.e)	p-value
Age groups				
60-69 (ref)	-	-	-	-
70-79	1.5 (0.3)	ns	2.3 (0.6)	<.01
80+	1.0 (0.2)	ns	2.6 (0.8)	<.01
Marital status				
Married (ref)	-	-	-	-
Others (single/separated/divorced/widowed)	0.5 (0.1)	<.05	0.4 (0.2)	<.05
Living arrangements				
Living with at least one child (ref)	-	-	-	-
Living alone	1.9 (0.6)	<.05	4.9 (2.6)	<.01
Living with a spouse only	0.8 (0.2)	ns	1.4 (0.3)	ns
Living with others without children	1.2 (0.3)	ns	0.5 (0.2)	ns
Place of residence				
Rural (ref)	-	-	-	-
Urban	0.6 (0.1)	<.05	0.6 (0.1)	<.05
Educational levels				
No schooling/did not complete primary school (ref)	-	-	-	-
Primary school	1.1 (0.3)	ns	1.5 (0.4)	ns
Secondary school	1.0 (0.3)	ns	1.5 (0.5)	ns
High school and over	0.8 (0.3)	ns	1.9 (0.5)	ns
Household wealth				
Poor (ref)	-	-	-	-
Average	0.3 (0.8)	<.001	1.1 (0.3)	ns
Rich	0.3 (0.9)	<.001	0.5 (0.1)	<.01
Perceived sufficiency of income				
Not enough (rarely or never enough/sometimes not enough) (ref)	-	-	-	-
Enough (enough/more than enough)	0.6 (0.1)	<.01	0.9 (0.2)	ns
Working status in the past 12 months				

Not working (ref)	-	-	-	-
Still working	0.6 (0.1)	<.05	0.7 (0.2)	ns
Alcohol consumption				
One or less than once a month (ref)	-	-	-	-
2-3 times a month	0.6 (0.3)	ns	0.5 (0.2)	<.05
Several times a week	0.4 (0.3)	ns	1.4 (0.5)	ns
One or more than twice a day	0.4 (0.2)	ns	0.8 (0.2)	ns
Smoking				
Yes (ref)	-	-	-	-
No	0.7 (0.3)	ns	0.5 (0.1)	<.05

*Note: *, **, *** denote P<0.05, P<0.01, and P<0.001, respectively. (ns) indicates insignificant. OR means odds ratio. (s.e.) denotes standard error. "Ref" means reference group.*
Source: Authors' calculations, using VNAS 2011 (VWU, 2012)

For men, older groups (i.e., aged 70-79 and aged 80 and over) were more likely to report multi-morbidity than those who are younger (i.e., aged 60-69). In detail, the likelihood of reporting multi-morbidity among those aged 70-79 and 80 and over was 2.3 and 2.6 times higher than that of those aged 60-69, respectively. Our study's findings remain consistent with previous studies (Hoang et al., 2008; Jerliu, Toci, Burazeri, Ramadani, & Brand, 2012; Phaswana-Mafuya et al., 2013) that more advanced age was strongly associated with multi-morbidity, but in this study, statistical significance was seen in men only. The reason why older age groups suffer more from multi-morbidity than those who are younger is possibly because as described by World Health Organization (2005), chronic diseases are diseases of long duration and slow progress. Moreover, in Vietnam, healthcare system for older persons is not well-established, community-based care is underdeveloped and regular health examination is not a traditional custom among individuals. Thus, chronic diseases normally are detected at an older age and a late stage of progression.

Regarding marital status, those who were in other group (that was, single/separated/ divorced/widowed) had a lower probability of having multi-morbidity than those who were married in both genders. The odds ratios of other group were 0.5 and 0.4 for women and men, respectively. This implied that those who were in other group were 0.5 and 0.6 times less likely to have multi-morbidity than those in reference category in men and women, respectively. The association between marital status and multi-morbidity is not clearly understood and this needs a further investigation. However, this finding is in line with previous studies (Khanam et al., 2011; Phaswana-Mafuya et al., 2013).

Living alone was found to be positively and significantly associated with having multi-morbidity in both genders. Those living alone were 1.9 and 4.9 times more likely to have multi-morbidity than those living with at least one child. Impacts of other categories (i.e., living with a spouse only and living with others without children) on having multi-morbidity were found to vary by gender, however, none of them showed statistical

significance. This could be explained by the fact that living alone in developing countries may reflect an individual's vulnerable status in terms of financial insecurity, which in turn may influence the health conditions of older persons (United Nations Population Fund & HelpAge International, 2012). As traditional, extended family structure is still prevalent and most important healthcare for older persons in Vietnam (Le et al., 2011). Thus, lack of such support may increase the risk of having chronic diseases among those living alone. Possible explanation for a much higher probability of having multi-morbidity among men living lone than women in the same category is that, although women are seen to have disadvantages in economic activities, they tend to have stronger social networks than men at an old age. In particular, older women are more likely to receive material and spiritual support from their adult children than older men and that may result in better health conditions and disease managements among women when they co-reside with adult children.

The odds ratios of those living in urban areas were 0.6 for both women and men. This implied that those living in urban areas were 0.4 times less likely to have multi-morbidity than those living in rural areas in both genders. This finding could be explained by healthcare accessibility and healthcare development system between rural and urban areas in Vietnam. Indeed, previous studies in Vietnam showed that those living in rural areas had struggles to access healthcare services (Nguyen, Nguyen, & Phan, 2007), or older persons in urban areas were seen to access healthcare service more often than those living in rural areas (Ministry of Health, 2003; Giang and Bui, 2013). In terms of the quality of healthcare, a higher prevalence of using low-quality services was found in older persons living in rural areas than those living in rural areas (Giang, 2008). Another possible explanation is that rural-to-urban migration among younger generations is significantly associated with health conditions of older persons in both spiritual and material senses as such phenomenon may cause social isolation and lack of social network between older persons and their younger family members in urban areas (Agewell Foundation, 2010). This finding is consistent with the existing knowledge of the association between place of residence and multi-morbidity (Hoang et al., 2008; Ninh et al., 2015).

Educational levels were shown statistically insignificant in both genders. However, the results revealed that the higher the education, the higher the probability of having multi-morbidity in men. Possible explanation is that individuals with higher levels of education are more aware of their health conditions and they are more likely to see doctor, resulting in having chronic diseases diagnosed. Another explanation is that those with low education levels just die and are not in the sample of this study. Household wealth was significantly associated with having multi-morbidity in both sexes, except average category in men. For women, those who were in average or rich category were 0.7 times less likely to have multi-morbidity than those with poor household wealth. For men, those who were rich were 0.5 times less likely to have multi-morbidity than those who were in reference category. These findings were in line with other studies on ageing (Hoang et al., 2008; Jerliu et al., 2012; Khanam et al., 2011). This could be reflected by the fact that wealthier individuals can spend their financial resources to afford healthcare services and a better and healthier diet, resulting in reduction in sickness and poor and unhealthy nutrition that lead to be less associated with multi-morbidity.

Perceived sufficiency of income was seen positively and significantly correlated with multi-morbidity in both genders, but statistical significance was shown in women only, not in men. Those who perceived sufficiency of income were 0.4 and 0.1 times less likely to have multi-morbidity than those who perceived insufficiency of income for women and men, respectively. Possible explanations could be lying in the fact that financial resources such as income may play a more important role for women as compared to men in terms of health conditions. For example, a previous study indicated that inequality in health between men and women would have disappeared if women had financial security (Molarius et al., 2012). In fact, women are seen to have poorer finance as compared to men as they tend to be less active in economic activities (World Health Organization, 2008). In addition to that view, simultaneous with the feminization phenomenon of old age, there have been growing concerns about the consequences of gender imbalance among older persons in Vietnam that older women are more susceptible to health problems than men. This may be owing to the fact that women are more likely to have unfavorable socioeconomic status when they are young and tend to be widowed when they are aged (Giang & Pfau, 2007). It has been argued that self-perceived income is a more applicable assessment than the amounts of money. A person really has in reporting health problems since it reflects the perception of individuals as to whether they have sufficient resources to afford daily living expenditures or medical care or to maintain their health (Andrade, Lebrão, Santos, Teixeira, & Duarte, 2012; Beverly, Pozehl, Hertzog, Zimmerman, & Riegel, 2013).

The likelihood of reporting multi-morbidity was lower among those who were working than those who were not working in the past year in both sexes. However, the results did not find statistical significance in men. Working women in the past year were 0.4 times less likely to have multi-morbidity than non-working women. Non-working may reflect sedentary status of an individual and a systematic review on the association between sedentary behavior and health outcomes indicated that sedentary was associated with risk factors for health, such as increasing the probability of having metabolic syndrome, or reducing in HDL cholesterol (a good cholesterol for health), or increasing blood pressure, or having obesity, and increasing mortality (Rezende, Rey-López, Matsudo, & Luiz, 2014). Another possible explanation is that healthier individuals are more likely to continue working, while those in poorer health or in illness are more likely to withdraw from the workforce.

In contrast to previous studies that found alcohol consumption a risk factor of chronic diseases (Hoang et al., 2008; Islam et al., 2014). This study found that drinking alcohol seemed positively associated with not having multi-morbidity in women. However, it was not statistically significant. Among men, consumed alcohol 2-3 times a month or one or more than twice a day was negatively associated with having multi-morbidity, while consumed alcohol several times a week was found to increase probability of having multi-morbidity. However, the results found statistically significant in those who consumed alcohol 2-3 times a month only. Previous studies revealed a positive effect of drinking alcohol on health status, such as those who consumed small to moderate amounts of alcohol were found to report their health status as being better as compared to heavy drinkers (Demirchyan, Petrosyan, & Thompson, 2012), or regular alcohol consumption was seen to

contribute to better health status (Perlman & Bobak, 2008). In this study, those who consumed alcohol regularly (that was, more than one or less than once a month) in both genders, except those who consumed several times a week in men, may consume adequate amounts of alcohol each time, which in turn result in good health conditions. However, this hypothesis needs a further investigation.

As expected, smoking was shown to be positively associated with having multi-morbidity in both genders, but statistical significance was found in men only, not in women. For men, those who did not smoke were 0.5 times less likely to have multi-morbidity than smokers. Smoking is well-known to be a risk factor of chronic diseases and a main cause of a wide range of fatal diseases, such as lung diseases and various types of diseases. Tobacco use has a substantial negative effect on health conditions and is responsible for millions of deaths each year in the world. It has been estimated that tobacco use is responsible for around 5 million deaths annually and is projected to kill 8 million deaths by 2030. Tobacco use ranks as a leading cause of death in Vietnam as it was estimated that smoking caused approximately 40,000 deaths in 2008 and is expected to cause 50,000 deaths by 2023 (Ministry of Health., 2010). As one of the leading causes of chronic diseases, tobacco use poses a great burden on society and the healthcare system due to the cost of treatment. Previous studies indicated that smoking was seen to have a strong association with chronic diseases (Hoang et al., 2008; Islam et al., 2014). Future studies may benefit from the findings of this study and further research should focus on the healthcare needs and healthcare expenditures of the older population. Several limitations in this study should be taken into account. Firstly, since this study was a cross-sectional study, thus it could not tell the cause-effect relationships between multi-morbidity and the selected factors. Secondly, because the data for this study came from community-dwelling participants, individuals with severe disease status, e.g. hospitalised patients, may not have been included in this survey dataset.

Policy recommendations and conclusion

Population ageing in developing countries poses a huge impact on many public services, especially for health care. Healthcare systems in many developing countries are still focusing on infectious diseases and reproductive health. However, healthcare for older persons is increasingly needed to meet the high prevalence of chronic diseases and rapid ageing process in these setting contexts. By identifying the determinant factors of multi-morbidity among older men and women, some policy recommendations are being proposed. Firstly, the results showed that having multi-morbidity was prevalent in the older population. In order to achieve healthy and active ageing, more efforts from policy makers and government should be given to:

- Focusing and investing more on chronic disease management and treatment as well as health conditions of older persons by improving healthcare facilities and the quality of healthcare services. Courses on geriatric issues, especially chronic diseases, should be provided for healthcare providers.
- For long term care, community-based care is increasingly essential to cope with a high healthcare demand and lack of geriatric care centers among older population in Vietnam.

Secondly, in order to decelerate the process of chronic diseases and promote the health conditions of older persons, health promotion should be encouraged as follows:

- Providing appropriate nutrition programmes for older persons by promoting well-balanced and healthy diets, such as encourage older persons to have sufficient fruit and vegetable, low-fat, low-cholesterol foods in their daily meals and to try and avoid food substances that may be associated with chronic diseases, such as fatty, salty and sugary foods.
- Encouraging older persons to do physical exercise at least 30 minutes per day by walking or riding a bicycle to stay physically active.
- Encouraging older persons to have health examination regularly and, by doing so, latent health problems like chronic diseases can be detected in early stages.

Thirdly, living alone was shown to be the most vulnerable group to multi-morbidity in this study. There should be:

- Establishing and expanding elderly clubs so that older persons can communicate, share information, open their social network, and help each other.
- Encouraging older persons to participate in cultural and social activities that are appropriate for both genders.

Finally, smoking is one of the main factors associated with multi-morbidity in this study and Vietnam is seen to have a high prevalence of tobacco use, especially in rural areas. Therefore, governments should:

- Provide and enhance healthcare information, healthcare education and damages of smoking to older persons through mass media, local loudspeakers.
- Develop and replicate tobacco-abstained models based on community. By doing so, smokers can be encouraged and referred to such models to quit smoking.

Advanced age is associated with health deterioration. Health status of older persons in Vietnam is relative poor as reports of VNAS in 2011 (VWU, 2012) showed that 65.4 per cent of older persons reported poor or very poor health status, while nearly 5 per cent of older persons perceived their health status as being good or very good. Older persons in Vietnam are susceptible to chronic diseases due to rapid demographic transition and social changes. This study found that factors associated with multi-morbidity varied by gender, in which increasing age and living alone were the strongest determinants of having multi-morbidity in both genders.

Acknowledgements.

We would like to thank Vietnam Women Union for allowing us to use the data from the Vietnam Aging Survey (VNAS) in 2011. We are also grateful to a number of researchers and research assistants at the Institute of Social and Medical Studies (ISMS) and Institute of

Public Policy and Management (IPPM) at the National Economics University (NEU) for their helpful suggestions and discussions to this study.

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Malta's strategic vision for a National Dementia Policy

Charles Scerri[1]

Abstract. Malta is experiencing a demographic transition characterised by an increase in the old age population. While this may indicate social success, it creates important challenges such as the inevitable rise in age-related neurodegenerative disorders, including the most common forms of dementia. This will pose significant societal demands as most dementia care is provided informally by family members living in the community. Furthermore, local research studies have shown that there is considerable lack of awareness and professional training that is seriously undermining timely diagnosis and management. As a result, Malta opted to take a holistic approach towards dementia care by embarking on a long-term strategy focusing on increasing awareness, providing the best services leading to high quality dementia care, and fostering dementia training to healthcare professionals in order to be better equipped to support individuals with dementia. It is a vision that promotes excellence, and effectively reflects the current and future needs of these individuals, their relatives and caregivers.

Keywords: Alzheimer's disease, dementia care, dementia national strategy, Malta.

Introduction

Dementia is a group of brain disorders characterized by progressive deterioration of cognitive function. It is the most common neurological disorder in old age and a major predictor of morbidity and mortality in the elderly. The most common form of dementia is Alzheimer's disease (AD) with other types including vascular dementia, dementia with Lewy bodies, fronto-temporal dementia and dementia secondary to disease (Jellinger, 2006). Symptoms include impairment of short-term memory, difficulty in verbal communication and decision making, difficulty in carrying out complex activities of daily living (ADL) and changes in mood and behaviour. With disease progression, individuals become more forgetful, have increased difficulty in communication, are unable to perform basic ADL and live independently and may display inappropriate behaviour such as wandering, hallucinations and disinhibition (Reisberg, 2006). The amount of informal caring for an

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individual with dementia is also related to progression with half of the caregivers spending more than ten hours a day in caring for an individual with late-stage dementia compared to 20 per cent for early-stage dementia (Georges et al., 2008). For the most common form of dementias, no cure exists that stops or reverses the observed brain cell death.

According to Alzheimer's Disease International, the total number of people with dementia worldwide is projected to almost double every twenty years reaching 75.6 million in 2030 and 135.5 million in 2050 (Alzheimer's Disease International, 2013). Much of this increase is attributed to low- and middle-income countries, and driven by population growth and demographic ageing (World Health Organization, 2012). The global societal costs of dementia are enormous as the total estimated worldwide expenditure for the year 2015 was calculated to reach US$818 billion (Alzheimer's Disease International, 2015).

In the recent years, there has been a significant shift in advancing the dementia agenda on the global stage. In the European Union (EU), research on neurodegenerative disorders has been strengthened as part of the Health Theme within FP7 (2007-2013) with special reference to brain research and particular emphasis placed on translational research and the development of new drugs. In 2011, the European Parliament adopted a resolution calling for dementia to be made an EU health priority and urging member states to develop dedicated national plans and strategies with the aim of addressing the social and health consequences, as well as services and support for affected individuals and their family members. Taking action against dementia through various intervention streams such as strengthening capacity, leadership, governance, risk reduction, public awareness and facilitating technological and social innovations was one of the main recommendations put forward by the World Health Organization (WHO) in its first Ministerial Conference on Global Action Against Dementia organized at the beginning of 2015. The Organization for Economic Co-operation and Development (OECD) also identified dementia as an increasing threat to global health and recommended member countries to strengthen health and social care systems in order to improve care and services for people with dementia.

As a consequence of the need to address the challenge of dementia, and following the example of other European countries including the United Kingdom and France, Malta embarked on a nationwide consultation process, starting in 2009, with the aim of developing a holistic approach towards dementia management and care through policy development that focuses on issues including awareness, the provision of high quality dementia care, development of an able work force and increase in funding. Following numerous discussions with stakeholders, a policy document was published and officially launched in April 2015 making Malta the 21st country to have a national dementia plan worldwide.

Dementia in Malta

The first study to determine the prevalence rates of dementia in the Maltese Islands was published in 2007 (Abela et al., 2007). Using the European Community Concerted Action on the Epidemiology and Prevention of Dementia (EURODEM) data methodology, it reported that in 2050, the number of individuals with dementia would reach 6,369, accounting to 2

per cent of the Maltese population. This data was revised in another study published in 2012 (Scerri & Scerri, 2012) using the latest prevalence rates as reviewed by the EuroCoDe project (Table 1). The results showed that the estimated number of individuals with dementia in Malta in 2010 was 5,198; a significant increase from the previous predicted data. Likewise, the number of dementia individuals over the age 60 in 2030 is projected to be close to 10,000 or 2.3 per cent of the total population. Thus the 2 per cent estimate will be reached in 2025, twenty-five years prior to what was previously reported. This discrepancy between the two prevalence set of data originates mostly from the oldest-old age groups, the latter being underreported in previous estimation studies. The significant increase reaching 3.6 per cent of the Maltese population over the next 50 years will invariably put greater demands on the already stretched national health care services resulting in considerable socioeconomic consequences.

Although state-run services for individuals with dementia and their caregivers have received a boost recently, they remain limited and currently not meeting the demands of the ever increasing number of diagnosed dementia cases. Two dementia activity centres are currently available, one located within the premises of the largest long-term residential care facility in Malta with the other located in the sister island of Gozo. This service provides an opportunity of social interaction for residents and non-residents with dementia. Rehabilitation services, a Memory Clinic, respite care and a round-the-clock Dementia Helpline are also offered and managed by staff comprising interdisciplinary healthcare professionals. With few exceptions, none of the privately owned residential homes are dedicated to solely cater for the needs of individuals with dementia. In 2015, the Dementia Intervention Team was launched with the objective of having a number of multidisciplinary professionals providing support to community-dwelling individuals with dementia and their caregivers. In late 2012, in conjunction with the introduction of donepezil in the government formulary list, there was the setting up of dementia clinics in the community intended to offer support to the already existing Memory Clinic and the Cognitive Behavioural Disorders Clinic within the Neurology Department at Mater Dei Hospital, the latter being the main and largest acute hospital in the Maltese Islands. Although free drug entitlement is only authorized by consultant geriatricians, neurologists and psychiatrists in patients with a Mini Mental State Examination score ranging from 13-26, all treatment options are available as an out-of-pocket expense from community pharmacies following prescription by any medical practitioner. To date, no protocol exists on the use of medication to control the behavioural and psychological symptoms of dementia (BPSD) experienced by the majority of individuals with dementia. Interestingly, these drugs are rarely used in Malta among in-patients with dementia (Scerri, Abela & Innes, 2010).

Table 1. Estimated number of gender-specific cases of individuals with dementia (IWD) in the Maltese Islands according to age groups using EuroCoDe data for the years ranging from 2010 to 2060. Data shown as M/F (M: males; F: females) (adapted from Scerri & Scerri, 2012).

Year							
Age groups	2010	2015	2020	2030	2040	2050	2060
60-64	30/139	27/124	27/127	21/100	27/123	29/127	25/105
65-69	179/154	240/201	223/186	217/177	198/164	234/193	246/185
70-74	242/346	246/344	381/513	376/493	292/391	382/488	419/507
75-79	367/577	419/601	446/616	671/871	677/847	639/800	777/959
80-84	448/834	493/945	620/1038	1100/1672	1154/1681	946/1380	1306/1784
>85	483/1399	619/1812	750/2248	1164/3021	2012/4806	2337/5400	2356/5368
Total IWD	5198	6071	7175	9881	12372	12957	14037
% of the population	1.24	1.47	1.73	2.37	3.04	3.26	3.62

Dementia awareness and support in the community mostly comes from the Malta Dementia Society. This non-governmental, non-profit organization was launched in 2004 with the aim of increasing awareness on dementia care and management in the Maltese Islands through the organization of talks and seminars for individuals with dementia, their caregivers and healthcare professionals. Another important aim of the society is that of collaborating with the central health and social care authorities to improve and design new services that enhance the quality of life of individuals with dementia. As previously highlighted, most of the dementia care is provided by family members in the community. A study on the organization of dementia care in the Maltese Islands found significant difficulties in providing care for a relative with dementia (Innes, Abela & Scerri, 2011). Furthermore, caregivers views of formal services were dismissive as to their lack of suitability for their or relatives' needs.

Dementia in Malta: policy development

Given the huge burden of dementia, the challenges facing governments worldwide in terms of social, medical and economic aspects are considerable. In these last few years, there has been an increase in recognizing the extent of this problem and the need to take action. Apart from Malta, only a few countries have dementia plans and policies in action that address the key aspects that dementia pose on the society in general (World Health Organization, 2012). In the beginning of 2009, the Malta Department of Health, through its then Parliamentary

Secretariat for the Elderly and Community Care, launched the National Dementia Strategy Group with the aim of identifying a number of recommendations that would provide a strategic framework in order to deliver quality improvements in local dementia services and address any local shortfalls in dementia care (Scerri, 2012). The work undertaken at the time included a detailed analysis of services that were available to individuals with dementia and their caregivers, a consultation process with stakeholders working in the field of dementia management and care including professional bodies, and a questionnaire designed for the public in order to obtain feedback regarding the various aspects of informal dementia care.
The general findings, as highlighted in a report presented to the health authorities in January of 2010, included:

a. Considerable lack of support at all levels of dementia care together with a dearth of healthcare staff professionally trained in dementia patient-centred care.
b. Services available were not tailored for the needs of these individuals, their family members and caregivers.
c. Professional training at undergraduate and postgraduate level mostly focused on the medical model with very limited emphasis on social models of care.
d. Basic awareness among the general population was found to be lacking with most individuals adopting a wait-and-see approach towards seeking professional advice.

A number of recommendations were also included, aimed at:

a. Improving awareness of dementia in the community
b. Facilitating early diagnosis and intervention
c. Providing information at the point of diagnosis and beyond
d. Increasing knowledge of services that are already available
e. Enhancing the quality of care in acute and long-term settings
f. Strengthen community support services
g. Providing end-of-life support services
h. Adopting an ethical approach to dementia management and care

Following the publication of this report, a number of government-led initiatives were launched. These included the addition of one anti-dementia medication (donepezil) on the national drug formulary, the collection of data on the number of dementia cases, the publication of a number of information booklets to increase awareness among the general public and the delivery of training sessions on dementia care to healthcare professionals and support staff working in long-term residential/nursing homes. With a change in government in 2013, a National Focal Point on Dementia was appointed with the aim of advising the local authorities on measurements that need to be adopted in order to improve the quality of lives of individuals with dementia, their caregivers and family members. This included the revision of the 2010 recommendations and the drafting of a dementia strategy for the Maltese Islands.

Concurrently, research interest in the field of dementia increased significantly at the University of Malta, the latter being the only tertiary-level academic institution in the Maltese Islands. As a result, a number of research initiatives related to dementia policy development were conducted in recent years. These included investigating the organisation of dementia care by families in Malta (Innes, Abela & Scerri, 2011), knowledge and attitudes of nursing students towards dementia (Scerri & Scerri, 2013), the role of general practitioners in diagnosing, disclosing and pharmacotherapeutic management of dementia (Caruana-Pulpan & Scerri, 2014), hospital staff perceptions of dementia care (Innes *et al*, 2016), implementation of person-centred dementia care programmes in hospital wards (Scerri, Innes & Scerri, 2016), knowledge and pharmacological management of Alzheimer's disease by managing community pharmacists (Zerafa & Scerri, 2016), training of older adults about Alzheimer's disease (Scerri & Scerri, 2016) and knowledge of Alzheimer's disease and training needs in final year medical and pharmacy students (Scerri, 2016). Complimentary to this, the University of Malta launched, in February of 2016, a Master in Arts degree programme in ageing and dementia studies with the objective of empowering professionals working in the gerontological and geriatric setting to be leaders in future dementia care.

The road towards empowering change

In April of 2015, Malta officially launched its national dementia strategy titled 'Empowering change: a national strategy for dementia in the Maltese Islands (2015-2023)'. It highlights various measures that need to be implemented in order to enhance the quality of life of individuals with dementia, their caregivers and family members. The vision of this strategy is for people in various sectors of society to come together and create a system whereby individuals with dementia have access to the support and care they require. Dementia also has a profound effect on relatives and caregivers and thus the policy document is also aimed to address their needs as part of the holistic approach to dementia care.

The strategy outlines a number of recommendations spread out over 6 interventions streams that include; an increase in awareness and understanding of dementia, the provision of timely diagnosis, the availability of a trained workforce, improving dementia management and care, promoting an ethical approach to dementia care and strengthening research in this field (Table 2). Its implementation will run till the year 2023. Due to the challenging nature of dementia, this exercise will entail substantial investment in human, financial, technical and infrastructural resources. However, the gradual delivery of the objectives is projected to have a considerable positive impact on the quality of life of individuals with dementia, their family members and caregivers. The latter are carrying an enormous burden and thus require more solidarity from the government and society in general.

Since its launch, a number of recommendations have already been implemented. In the intervention stream of workforce development, all nursing staff working in the area of long-term care has attended an extensive training course in dementia care and skills development. This 14-hour programme was jointly financed by the Maltese government and the European Social Fund. Initiatives in other intervention streams included the extension in operation of the Dementia Helpline, the opening of a new dementia activity centre in Gozo,

the opening of new hospital wards for individuals with dementia, the launch of new information booklets intended for the general public and community caregivers, the organisation of dementia training programmes in all day centres for the elderly and the launch of the Dementia Intervention Team, the latter composed of multidisciplinary professionals that offer support to community-dwelling individuals with dementia. A pilot project on dementia-friendly communities has also started in the village of San Lawrenz in Gozo.

Table 2. Streams of interventions, objectives and main recommendations of the National Strategy for Dementia in the Maltese Islands (2015-2023)

Interventions	Objectives	Main recommendations
Increase awareness and understanding of dementia	Changing the perception of dementia Encourage help seeking Provide guidance	Continuing information campaigns Appointing Dementia Activists Online guide on dementia caregiving Promote the work of civil society organizations Strengthening of the Dementia Helpline
Timely diagnosis and intervention	Improve diagnosis at an early stage Provide information on available services upon diagnosis Timely access to care	Promote the value of early diagnosis in primary care Enhance training in dementia diagnosis, disclosure and management to primary care physicians Setting up of Dementia Intervention Teams Development and distribution of information at the point of diagnosis and beyond
Workforce development	Ensure health and social care professionals working with individuals with dementia receive specialized training	Provision of dementia patient-centred care training to the workforce Supporting information technology platforms that facilitate online training Continuous professional development programmes
Improving dementia management and care	Availability of all dementia medications on the drug formulary Improve care delivery Provide community support Implementation of dementia-friendly measures	Full access to medication and regular review Establishing training opportunities in non-pharmacological methods Ensure individuals with dementia have a care plan Involvement of all stakeholders in decision taking Increase respite facilities Implementation of dementia-friendly design Availability of palliative care support Ensuring the necessary quality standards in residential/nursing settings

Interventions	Objectives	Main recommendations
Ethical approach to care	Promote an ethical approach to dementia management and care	Provision of training in ethical decision taking, respect for personhood and wellbeing Promoting the use of advanced directives Provision of psychological support services Adoption of the 'partners in care' approach Monitoring of abuse
Research	Promote and foster research in the field of dementia	Ensure that dementia becomes a national research priority Facilitate access to clinical trials Enhanced participation in European and pan-European research projects on dementia

During the implementation process, a number of gaps may become apparent. Interim evaluations will be carried out to gather new information and assess the usefulness of different projects being proposed in the various areas of dementia care. This will aid in further detailed planning of long-term objectives. Moreover, the implementation exercise is expected to reveal other important needs that will require assessment and further plans to adequately address them. Individuals with dementia, their family members, caregivers and policy makers all expect to see progress in a cost-effective way. It is therefore important that the results achieved are regularly communicated to the general public in an efficient and comprehensible manner.

Conclusion

There is little doubt that dementia will pose one of the greatest societal and health challenges that must be addressed nationally as well as at personal and family level. The huge costs involved in its care and management will challenge health systems worldwide with the predicted increase in the prevalence rates in line with an ageing population. Dementia is also overwhelming for family carers who often feel that they are left to fend on their own due to the lack of adequate support that promotes independence and wellbeing. Community support is needed to enable informal carers to continue in their caring role for as long as possible and should involve respite services and financial support. Moreover, training for healthcare professionals should be expanded and include multidisciplinary educational programmes focusing on patient-centred dementia management and care. The organization of effective campaigns that enhance public understanding of dementia will not only reduce misconceptions, stigma and discrimination but will invariably aid in timely diagnosis and support seeking. The full implementation of the national dementia strategy, aimed at holistically addressing the dementia challenge, will undoubtedly have a positive impact on the quality of life of individuals with dementia in the Maltese Islands.

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International Journal on Ageing in Developing Countries, 2016, 1 (2): 143-157

Intergenerational relations and rural development among the Karen in Northern Thailand

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Abstract. This scholarly article provides a qualitative analysis of how rural development - in particular changing modes of production and learning - shapes inter-generational relationships among the Karen people in northern Thailand. Based on long-term ethnographic research with the Karen, the author argues that inter-generational relations and household inter-dependency give meaning to ethnic Karen peoples' aspirations for work and family life. The author explains how traditionally, during childhood transitions, Karen adults guide children and young people towards mastery of culturally relevant skills and technologies and discuss how social transformations and rural development in the last decades have led to major changes in Karen household economies and inter-generational relationships.

Keywords: Intergenerational relations, rural development, Karen, Thailand, ethnography

Introduction

The global economy impacts on social relationships, economic and cultural life at different places. The global and the local are always related, so there is a "simultaneous coexistence of social interrelations at all geographical scales, from the intimacy of the household to the wide space of transglobal connections" (Massey, 1994: 168). This also holds good for relations between the generations (Harper, 2016). This research article explores intergenerational solidarity and economic life of families in ethnic Karen communities in northern Thailand. Focusing on the micro-level of the family, I analyse how patterns of intergenerational solidarity express themselves through working activities inside and outside the household.

The article starts out with some reflections on the theoretical framework, methods and ethics that inform this research. This is followed by some background information about the Karen people who participated in this study. The main part of the article discusses my empirical findings. I argue that among the Karen people in northern Thailand, childhood transitions

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are about girls′ and boys′ increasing participation in family work. I explain how in a traditional Karen economy based on subsistence farming, learning of practical skills and knowledge was largely organised within families and communities. Through communal work, adults guided children and young people towards mastery of culturally relevant skills and technologies. Young peoples' activities were largely organised according to their age and gender. Next, the article discusses how social transformations and rural development in the last decades have led to major changes in Karen household economies and family life. Boys and girls access increasingly modern education and spend less time learning practical skills at home. The fourth part highlights how intergenerational relations and interdependency give meaning to ethnic Karen peoples' aspirations for work and family life. In participatory research exercises, boy and girls expressed their concern for the flourishing of their individual, family and community lives. For their transition to adulthood, Karen children and youth in my study are aiming for professional careers. They say they hope to marry, have children and contribute with their skills and knowledge to economic processes within their families, village and regional communities. In this way they realise intergenerational solidarity at the micro, intermediate and macro levels of society.

Research concepts, methods and ethics

Around the world, intergenerational solidarity is a characteristic of family life. Yet, most theories of justice have difficulties including children: while individuals have rights and obligations in national and international legislation, to preserve society and let it flourish, there is no special emphasis on the parent-child relationship. Religious debate tends to be sensitive to the obligations of children to their parents. Even there, reciprocal obligations between different generations in families find less attention (Arrow, 2006).

In this article, I understand the word 'generations' as representing objective positions within a continuum of human development. 'Generations' can mean the parents or grandparents of research participants, their children or grandchildren. Intergenerational relations either show solidarity between the generations, or neglect it. Solidarity between generations can be conceptualised in various ways at the micro, intermediate and macro levels of society. At the micro-level, we can focus on inter-personal relations and on the different ways in which one generation may or may not be supportive of their seniors and juniors. At the intermediate level, inter-generational solidarity could relate to a particular social institution, like a work place or public school. We could then ask how far participation in work or school activities encourage solidarity between boys and girls, men and women of different socioeconomic groups. At the macro-level, 'solidarity' could relate to the consideration that a given generation manifests consciously or unconsciously towards the future of the mankind. Food, security and fertility would be examples. Importantly, macro, intermediate and micro levels of society are interrelated: an individual can be actively involved in all three levels at the same time. Therefore, a complete analysis of intergenerational solidarity would need to pay attention to all levels of society and see how these operate simultaneously in the lives of different individuals (Donati, 2002; Archer, 2004).

In Thailand, intergenerational relations are structured according to seniority. It is important to know the age and profession of a person, to understand whether an encounter requires senior or junior treatment. The Thai terms *pii* (senior) and *noong* (junior) derive from kinship language. Although they originally signify genealogical relations, the terms extend to the structure of wider society formed of Thai and other ethnic groups (Ewers Andersen, 1979/80; Kemp, 1984; Siriphon, 2008; Terwiel, 1984). A senior is perceived as older, stronger and more experienced, which in turn implies a superior social status. A junior is seen to be younger, weaker, less experienced and of lower status. Typical examples of senior-junior relations are parents and children, teachers and students, richer and poorer households. Importantly, these relations are reciprocal and entail social obligations and benefits for both parties. The junior pays respect and obedience to the senior, while the senior, in turn, returns these respectful signs through benevolent acts, thus supporting the welfare of juniors. In everyday life, verbal and non-verbal behaviour express seniority. The principle of seniority further applies to patronage relations. This means unequal social, economic and political exchanges between two parties of different status, such as richer and poorer households. They are not legally codified and last as long as both sides benefit from the agreement. Political patronage indicates reciprocal obligations and this often encompasses mutual assurance and aid, as well as validation of social status.

Thus, senior-junior relations permeate all levels of society, ranging from the intimacy of the household to national and international politics (Jolliffe, 2016). This becomes apparent when analysing individual life course aspirations and how they fit into a wider network of social relations:

> Aspirations form parts of wider ethical and metaphysical ideas which derive from a larger cultural norm. Aspirations are never simply individual…They are always formed in interaction and in the thick of social life' (Appadurai, 2004 : 67).

This means, as individuals identify ways to reach their own good, they become aware of the need to cooperate with others in a way that is mindful of their personal attempts to achieve their individual goods. Therefore, the making and sustaining of such networks of giving and receiving at different institutional settings - e.g. households, schools, work place - is crucial since the good of each can only be pursued through intergenerational solidarity - that is, in communion with the good of others (MacIntyre, 1999). Focussing on the Karen people in Thailand, this research article provides empirical evidence for cooperation between the generations as a way towards individual and communal flourishing.

Throughout this study, I opted for an ethnographic multi-method approach to understand how changing modes of production and learning shape intergenerational relations and life course aspirations (Wyness, 2012). My qualitative research methodology is particularly apt in capturing the Karen peoples´ diverse experiences of social mobility, intergenerational relations and life course within a changing society. Data presented in this article stems from my long-term ethnographic fieldwork with Karen ethnic minorities in the highlands and lowlands of northern Thailand. The empirical findings presented in this research article are

based on 14 months of fieldwork in Chiang Mai province, northern Thailand. My first fieldwork trip covered a period of nine months between November 2007 and July 2008. During this time, I spent two months largely in Chiang Mai improving my Thai language skills and exploring potential research sites. In late December 2007, I moved to Huay Tong village, Mae Wang district, Chiang Mai Province for seven months of village-based fieldwork. Other fieldwork sites included Mae Ta La village (Mae Chaem district), Ban Kad (Mae Wang district), Chiang Mai city, as well as a range of other highland villages mostly in Mae Wang district but also in the surrounding areas. A second and third field trip comprised a period of three months between July and September 2009 (second field trip) and a period of two months between November 2013 and January 2014 (third field trip). In March 2015, I spent another week visiting Chiang Mai and meeting research participants. These subsequent visits allowed me to follow up key issues that emerged from my initial round of data analysis. Also, I learned about important changes in their lives. This added a temporal dynamic to my study on intergenerational relations, migration and economic life among the Karen.

My engagement with Karen children and adults is guided by the underlying premise that people of all ages are valid research participants, capable of accounting for their lives in relation to others such as peers, family members, teachers, and colleagues at work. Inspired by ethnographers working on intergenerational relationships, I opted for a combination of qualitative research methods to enable maximum participation and enhance the dynamic of the research process. Through interviews and the contributing remarks of the participants, I examined inter-generational relationships, in particular through focusing on children's working and learning activities. In addition, I engaged children and young people in participatory research exercises (both as individuals and in groups) to gather more in-depth information about their life course aspirations. My sample at Huay Tong (my major fieldwork site) included, in 2008, 24 boys and 21 girls of between 11 to 17 years of age, as well as 46 household members, teachers and fellow villagers. While it was possible to catch up with some of them when revisiting Huay Tong in 2013, several research participants had migrated out of the village for study and work.

At all stages of fieldwork, research assistants helped with translations. The highlands of northern Thailand are multi-lingual, multi-ethnic and multi-religious. The Karen in Mae Wang province, and in my study village Huay Tong, speak Skaw Karen as their mother tongue and Thai as a second language. Throughout my fieldwork, I continued to improve my spoken Thai and Skaw Karen in everyday life and developed broad conversational skills in Thai. In addition, I found that non-verbal communication can sometimes be equally important and revealing than verbal discourse. Ethical issues have been treated thoughtfully throughout the whole research process of fieldwork preparation, data gathering, analysis and representation of research findings. Having said that, there are limits to how much any individual can grasp of other cultures. I accept the limits my culture places on me in understanding Karen culture, and ask only for acknowledgement that I have made every effort to be fair-minded in my research.

Research context

The ethnographic study on intergenerational solidarity and economic life among the Karen is situated in the geographical context of Chiang Mai province, northern Thailand. The term 'Karen' includes around 20 subgroups of Karennic speaking peoples who live at different places in the world. Therefore, there exists much cultural, socio-political and religious diversity between the Karen of different generations and at different locations. There are five to seven million Karen in Burma and an estimated number of 400,000 Karen who are born in Thailand. In addition, by September 2016, 79.6 per cent of the 103, 366 displaced persons in camps at the Thai-Burma border are ethnic Karen (The Border Consortium, 2016). The Karen people settled in the highlands of northern Thailand around 1804. They mostly live in the northern and western parts of the country, particularly in the provinces of Chiang Mai, Mae Hong Son and Tak. My major fieldwork site, Huay Tong village, is located 1,010 metres above sea level in Mae Win sub-district, upper Mae Wang district, Chiang Mai province. In January 2014 Huay Tong village had 120 households and 586 registered residents. Karen households are generally composed of a nuclear family, and are matrilocal (that is, married couples reside with or near the wife's parents). Women hold a relatively strong position within the family and men are conventionally associated with ritual and public life (Mischung, 1984). Social relationships are structured according to the principal of seniority:

> Karen frequently talk of their relations with others in terms of kinship, which may be a reference to the real facts of marriage or descent, may refer to a myth, or may refer to closeness of social relationships regardless of genealogical connections (Kunstadter, 1979 : 137).

Religion is an important element for Karen peoples' identity. The majority of Karen in Thailand are Buddhists, 20-30 per cent are Christians and many Karen practice animist ancestor worship (Worland & Vaddhanaphuti, 2013). In general, Karen people of different faith live peacefully together.

Agricultural transition and expansion of the cash economy in the highlands of northern Thailand are intimately linked to state development projects. Traditionally, ethnic Karen villagers have been engaging in seasonal subsistence wet rice farming. Wet rice farming tells of the interdependence of households and communities. A system of intergenerational co-operation ensures that the whole community manages their rice production in due time. The cash economy entered the lives of the ethnic Karen people in Mae Wang through the British teak companies. By the 1930s Karen men and youth were working largely for British logging companies, and from the early twentieth century until the late 1950s they worked for other national logging companies (Elliot, 1978). Against the backdrop of the Vietnam war and rising international concern for poppy production in the Mekong area, the Thai King established in 1969 the first *Royal Projects* in the highlands of northern Thailand (Leblond, 2010). Facilitated by infrastructure improvements, the cash economy thus expanded in the highlands while subsistence agriculture gradually diminished.

It can be argued that state and royalty sponsored development has improved lifestyles in many highland locations. Many villages welcome the expansion of infrastructure and state schools and inclusion in national development processes:

> Rather than being swamped by commercialism, Karen communities appear to be exploring paths of market oriented diversification that support regularly under-producing paddy and upland rice systems (Walker, 2001 : 154-155).

Nevertheless, the developmental pace remains uneven. As a consequence, some villages, like Huay Tong, are well connected to national markets and education systems, while other places lack access to modern institutions. Such inequality because of location, in turn, explain diversity of life course experiences among Karen minority people residing at different places.

Childhood transitions and work in the family

In Thailand, relations between adults and children are reciprocal. Work during childhood is considered neither morally dubious, nor harmful. Instead, the work of girls and boys forms part of their cultural learning at home and at school. Children learn through watching, listening, and practice. Shared working activities are important for liaising and thus confirm intergenerational relationships.

Also among the Karen people, intergenerational learning takes place from early childhood on as children assist adults with simple chores in the household economy. Children come to be familiar with the gendered social roles of adults from an early age. Among the Karen people, children mostly play until around the age of five. The play of young children often consists in imitating adult behaviour through observation and practice: 'they watch the mother, then they are doing'. Toddlers accompany others in the rice field, and play alongside their working families. Boys also 'play' catching birds, imitating the hunting activities of their older peers. Mothers ask toddlers to go with them to take care of the buffalo or just stay around while they prepare food with an older sibling, thus children learn through watchful participation in the cultural routine of cooking.

Until the age of five, children help with washing dishes and fetching water. Then, around the age of seven, children's contribution to household chores increases gradually. Girls spend much more time in the household than boys. Earlier in life they start to help their elders with household tasks such as fetching water, cooking rice, washing dishes, clothes and cleaning. They also know how to wash themselves and their own clothes. Some girls care for younger siblings, for example, by taking them along when playing with their peers. Boys work less inside the household than girls. They contribute to providing for the household, for example, through fishing with spears, as well as hunting snakes or birds with slingshots. Boys are aware of the privilege of being able to move around, and often value it highly. At the age of 10 or so, children are considered to have achieved their first responsibilities, whereby instead of just cooking the rice, girls are by that age entrusted with

the preparation of side dishes. This way, adults convey to children the idea of contributing little bits to the successful completion of larger working processes. With the onset of their teenage years, working responsibilities increase. By the age of 12, girls and boys are fairly familiar with the gendered mastery of culturally valued tools and technologies. Weaving is a traditionally female activity, whilst boys learn to work with the plough and hunting tools such as slingshots and guns. Most girls learn weaving from their grandmothers, mothers, other female relatives or foster mothers.

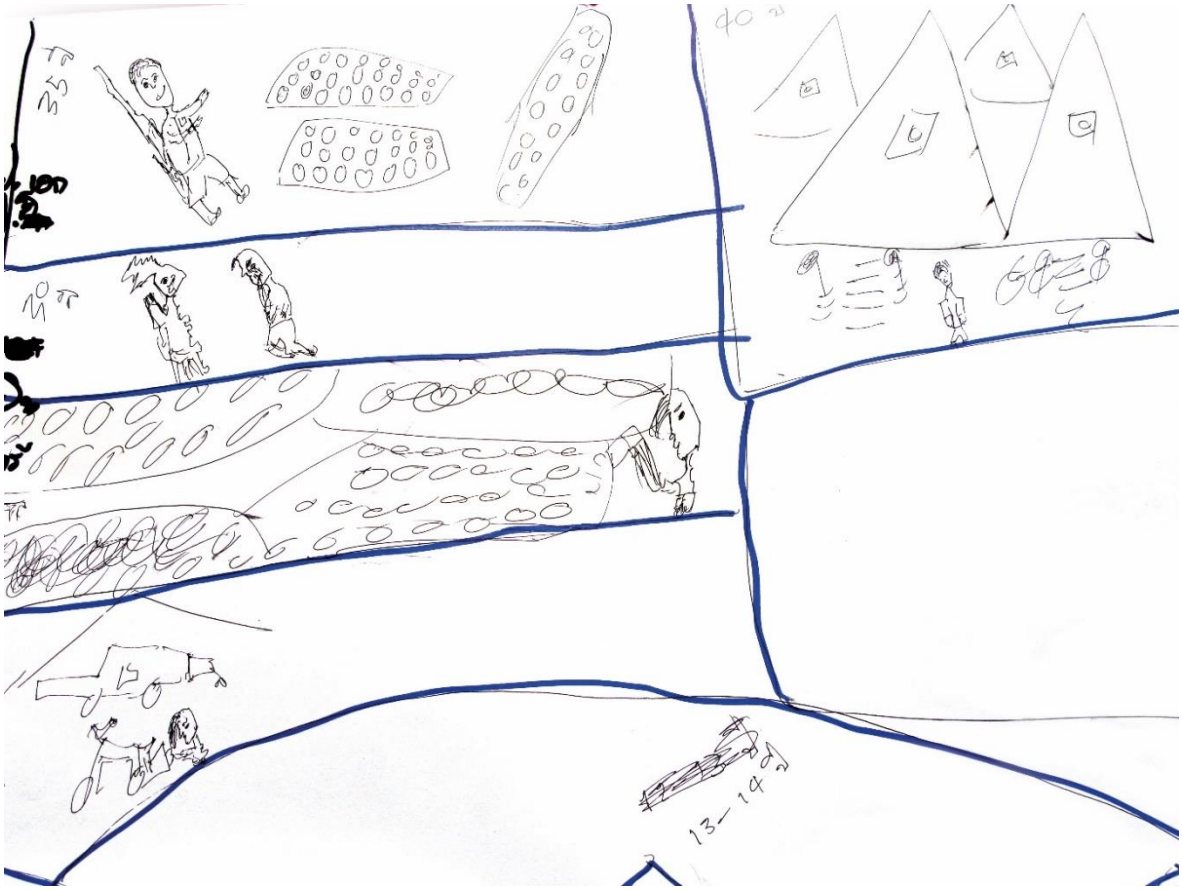
Sometimes, girls produce a garment together with a more experienced weaver. In general, girls are considered more mature than boys. At the age of 12, boys and girls also participate in unpaid seasonal agricultural work on villager's fields. The hot and rainy seasons are the most labour-intensive periods for rice production and children's working assistance is highly demanded. School holidays cover cultivation and harvesting periods, thus allowing children to fully support their household's subsistence economies. Rural development processes impact on young peoples´ transition to adulthood. Among the Karen, a youth becomes an adult when he is economically independent. As outlined above, in a subsistence economy, children reached the status of economic independence of adults by the age of 12. This age usually coincided with mastery of culturally relevant working skills, such as weaving and ploughing. In an expanding market economy, rising educational aspirations and growing household need for cash, young peoples' adult status is linked with their ability to earn an income. Today, in Huay Tong, children's financial contributions to the household income are increasingly important. My study found children around the age of 15 assuming responsibility for income generation at different occupations. Therefore, processes of uneven development in rural mountainous areas of northern Thailand impact on patterns of intergenerational working activities among the Karen.

Intergenerational relations and rural development

In my study village Huay Tong, commercialized agriculture was introduced in 1978 through the *Royal Agricultural Project* (Maniratanavongsiri, 1999: 152). Since then, intergenerational working activities in the family have changed. For instance, because of the scheduled working hours at the *Royal Agricultural Project*, women in Huay Tong find it difficult to prepare food in the evening. Very often, this task is handed over and becomes the responsibility of teenage daughters. Moreover, with most adults working at the Royal Project, hunting and gathering tasks have been delegated to boys and girls, thus creating new intergenerational responsibilities children have towards their parents. Most households in Huay Tong rely on the help of teenagers to earn cash income. Karen teenagers in my study are aware of the economic value of their work as contributions to household economies. They usually combine their studies with income generation for their households. Assisting their parents adds value and meaning to their work and makes them feel well. In their own words, "I like it, because I can help mother, and she does not have to feel tired. I feel well when I can help mother, it makes me be someone who is not lazy".

Thus, during the time of fieldwork most high school girls in the village found paid employment with the Royal Project during weekends and school holidays. Especially during labour-intensive periods, such as the rainy season, intergenerational solidarity is important and mothers may ask daughters to cover their working hours at the *Royal Agricultural Project*. That way, the mothers are free to transplant rice in their own fields. Moreover, commercialized agriculture at the *Royal Agricultural Project* is also perceived as a 'safe haven' for unemployed youth. Dei's life course drawing illustrates this.

Figure 1: Dei's life course, June 2008



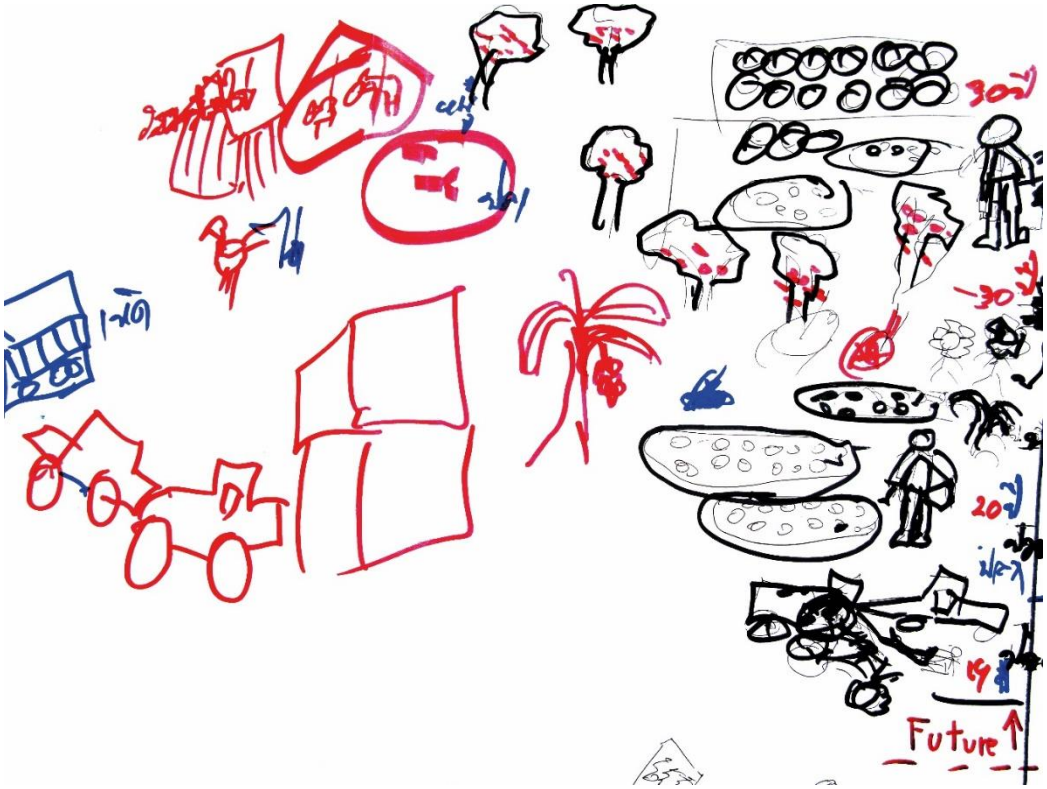
In 2008 Dei was 16 years old and had just graduated from lower secondary school. At that time, he said he would like to move to the lowlands and learn to be a mechanic. In addition, he said he would be interested in studying agriculture academically in order to become a researcher in this domain. He said that during his studies he would stay a while outside the village. Yet, he expected to be unemployed when he was 30. After losing his job, Dei explained he would return to Huay Tong for unpaid work. For example, in his drawing he portrayed himself at 35 roaming the forest as a hunter equipped with a gun. This indicates

he knows how to earn a livelihood in the forest. At the age of 40, he anticipated being employed at the Royal Agricultural Project. When I revisited the village in December 2013, Dei's twin sister said he was working in a hotel in Chiang Mai. He occasionally sends money to support their mother. So, intergenerational solidarity and interdependence between girls' and boys' work and their family and village economies are very important in young peoples' life ambitions.

Intergenerational solidarity and life course aspirations

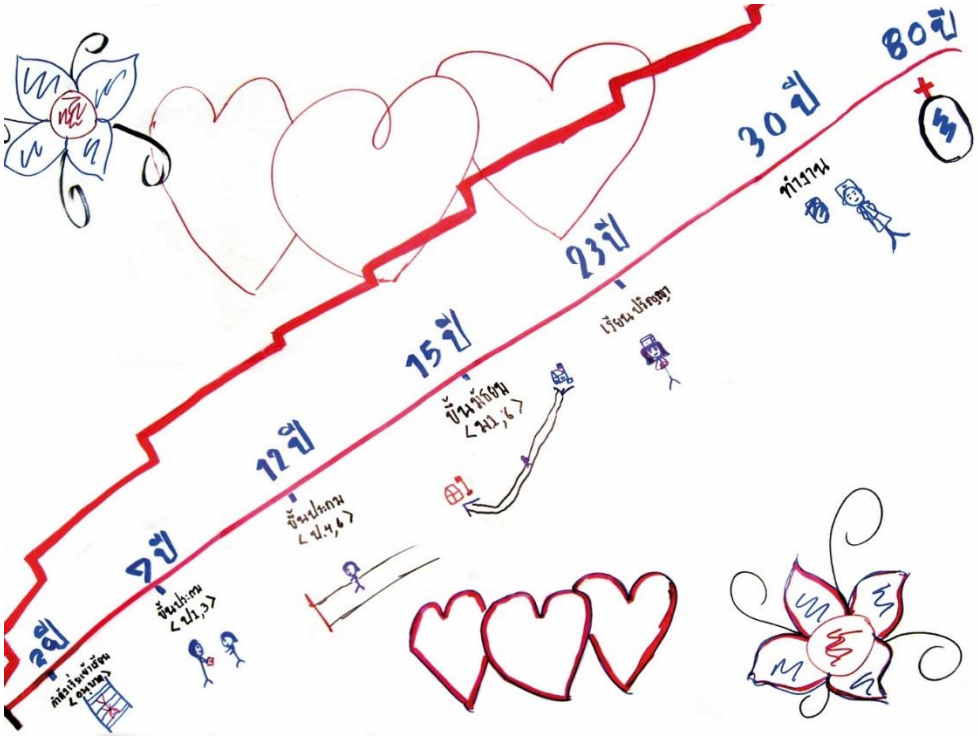
As outlined above, Karen girls' and boys' economic activities always fit into a wider socio-political context of family and community life. Accordingly, their life ambitions are interdependent with the economic needs of their families and communities. Individual case studies highlight how the context (whether political, or economic or social, or cultural), shapes young peoples' intergenerational relationships and aspirations in different households and places. For instance, Bee's life course drawing clearly illustrates inter-generational relationships during working activities in his past childhood and his future adult life.

Figure 2: Bee's life course drawing, June 2008



According to his life course drawing, in 2008 Bee expected to finish his studies and learn the skills of a mechanic in the lowlands. Afterwards, he planned to return to Huay Tong and to work for the *Royal Agricultural Project*. At the same time, he wanted to continue working with his parents, thus contributing to the household income. Furthermore, he said he would like to earn an academic doctorate and afterwards cultivate his own vegetables and keep cows as well as chickens. He emphasised he wanted to have two cars and a house. The idea of two cars indicate an aspiration towards upward social mobility because his family owned one already, thus considered as one of the economically better-off villagers. Revisiting Huay Tong four years later in 2013, his mother told me Bee was indeed continuing his studies outside the village and visited the family regularly. Nok also planned to migrate for education and work out of her village.

Figure 3: Nok's life course drawing, May 2008.



According to her drawing, in 2008 Nok planned leaving the village temporarily for studies and work in town. She envisaged a school transition to secondary school in Chang Dao district. After graduation from high school she considered continuing her studies at a nursery school in the city. At the age of 30 she thought she would work as a nurse. Nok also signalized a return to Huay Tong, where she said she would like to live her adult life. Finally, Nok also reveals in her drawing that she hopes to make her final transition – from life on earth to life eternal – in Huay Tong and be buried in her home village. When revisiting Huay Tong in December 2013 I met Nok who just returned to her village for

Christmas with her family. We saw each other during Christmas celebrations in the village and this is when she told me she was attending 11th grade of higher secondary school in Ban Kad – a different school than she thought she would attend back in 2008.

The case studies of Nau Eu and her friend Nau Mugi also illustrate how life courses may develop in different ways. I met Eu during fieldwork in 2008. She is the second of three siblings in a Buddhist-Christian household in Huay Tong. Her parents cultivate their own garden and rice field. Eu´s family earns additional income thanks to Eu´s mother´s employment with the Royal Agricultural Project and some production of alcohol for sale in the village. Since I met Eu in 2008 her working and learning activities are connected to the needs of her family. Intergenerational solidarity is particularly pronounced between Eu and her mother, a Catholic Christian married to a Buddhist husband. Like her mother, Eu is a Catholic and participates in Buddhist ceremonies when visiting members of her father´s side of the family. Her father, by contrast, is a burden to the family. He used to consume drugs and drinks a lot of alcohol. Since childhood Eu´s working activities have been interdependent with her home and related to the wider national economy. For example as a teenager, in order to help her mother, Eu took on a lot of economic responsibilities. At home, she was responsible for preparing food. She downplayed her own cooking talents, saying that she only made rice. However, once we became friends, she invited me for evening meals and I learned that she was also in charge of preparing side dishes, a skill usually reserved to mature women in a Karen household. When Eu cooked, she sent her father on errands. This highlighted to me her ability to take decisions.

Eu's economic activities were also linked to the wider regional and national economy. During weekends, she helped with income generation at the Royal Agricultural Project. She replaced her mother, for example, in working with saplings in a greenhouse. This allowed her mother to cultivate their family garden. During school holidays, Eu accompanied her mother for half- day work in their garden. Eu's mother valued her daughter's working activities. As recognition for her solidarity, but also as a sign of confidence, Eu was granted by her mother certain freedoms other girls her age did not enjoy. For example, Eu was allowed to use the family's mobile phone. Access to the telephone enhanced her social status among her peers. Eu used the mobile phone to build up social relations with her peers, e.g. lending the phone to her girlfriends, who otherwise had no way to make or receive calls. At Huay Tong school, Nau Eu was a good student and very responsible. After graduating from Huay Tong lower secondary school, Eu made the transition to a high school in Mae Sot (Tak Province) in May 2009. In this way, she left her home village Huay Tong and moved as a foster child into the household of her older maternal uncle in Mae Sot. This uncle was a widower with two adopted Karen children from Myanmar. One of the children was a handicapped girl on crutches. Since she and Eu were the same age, Eu was called to help in the household and befriend the girl. As a foster child, Eu cleaned the laundry, cooked rice and side dishes and drove her peers on the motorbike to school. Because of the geographic distance between Mae Wang and Tak province, it was impossible for Eu to return to her home village, except for major seasonal school holidays.

In 2008, Eu and her friend Mugi took part in research exercises where those interviewed actively participate by suggestions. Together they prepared a drawing of a life course line that tells about their ambitions for adult life.

Figure 4: Eu and Mugi's life course line, June 2008.

When I met Eu again between November 2013 and January 2014 she was enrolled in a teacher training programme at the Buddhist Wat Chedi Luang in Chiang Mai. Her ongoing formation has been made possible through a church-based scholarship programme run by the Jesuit Order in Chiang Mai. Eu was specializing to teach the Thai national language as a school subject in primary and lower secondary schools and she told me that with this formation she would hope to find employment in the highlands and help Karen children to learn Thai. As in the past, Eu still had a very good relationship with her mother and tried to visit her home village every weekend. During these visits, she assisted her parents with household tasks and income generation at the Royal Agricultural Project. When we met again in late 2013, Eu was 21. She told me she is not yet thinking about marriage and childbearing because she wants to finish her studies first. By contrast, her friend Nau Mugi married a man from Mae Hong Son in December 2013. She was already five months pregnant. Mugi and her husband usually work in Chiang Mai where they help caring for the elderly and providing income. They also support relatives in the Karen villages in the highlands. Their wedding was in the mountains because according to Karen custom a

wedding takes place in the bride's home village, followed by a ritual visit to the groom´s native village. So compared to their aspirations in 2008, both Eu's and Mugi's lives turned out differently than planned. While both emigrated to receive secondary education to different places, none of them became an air hostess. Instead, Mugi married and prepares for motherhood, while Eu continues to be enrolled in tertiary education in order to become a teacher of the national Thai language and assist younger generations with Thai.

My research evidences how Karen families aspire for their children's secondary and if possible even tertiary education and children emigrate to different locations and institutions of learning. Despite this general trend of emigration, my research suggests that young people maintain a sense of intergenerational solidarity. While employment situations in cities and towns are unstable, intergenerational relations are safety nets which allow young people to aspire to return for marriage and childbearing to their native villages to support their household and village economies through paid and unpaid economic activities.

Conclusion

In this article the author explored intergenerational solidarity and the economic life of families among the Karen people in northern Thailand. It was argued that through participation in practical working activities, Karen people enact intergenerational solidarity at the micro, intermediate and macro levels of society. Empirical data evidences showed that from early childhood, Karen adults guide children towards increasing participation in culturally valued working activities. Throughout their childhood transitions, girls and boys learn to assume increasing responsibility at home and at school. As the economy changes, likewise young people's economic contributions to their families and local communities change. Indeed, following the lives of research participants allowed the researcher to understand young men and women's awareness of their growing intergenerational responsibility. In order to fulfil intergenerational responsibilities in their interdependent households, young Karens hope to find paid employment in an insecure Thai labour market. Yet, lifetime ambitions can be difficult to realize, because of the Karen people's marginal status (socially, economically and politically) in Thai society.

Therefore, in this research young people have no illusions about their transition to adulthood. They showed acute awareness of family, household and community needs, as well as of structural constraints within an insecure labour market. Having completed secondary education, students increasingly enter tertiary education. Sometimes young people stay in the city and work. After completing their formation, many say they plan for marriage and childbearing in their rural highland communities and transmit their newly acquired knowledge and skills to older and younger people in their village. Through this transmission of knowledge and experience, young Karen adults participate in local, regional and national processes of economic development. In this way, inter-generational solidarity is reinforced: at the micro level of the family; the intermediate level of the village economy; the macro-level of the nation state. More research is needed to explore the impact of fertility decline and population ageing on intergenerational relationships in rural communities in northern Thailand.

Acknowledgements

The author wishes to thank Sarah Harper and the Oxford Institute of Population Ageing for generously founding parts of this research through a research fellowship. The author is also grateful for her husband William Jolliffe´s and an anonymous reviewer´s comments on previous parts of this manuscript and also for her father Franz Vogler´s help with the illustrations. Last but not least the author wishes to thank also Fr. Vinai Boonlue SJ, and all the Karen people for their generous time in participating to this research.

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Development, Elder Abuse and Quality of Life: Older women in Urban India

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Abstract. Often, 'development' is simplistically equated to economic growth, however, philosophically it has a deeper meaning that points towards improvement of humankind. The implicit meaning entailed in 'improvement of mankind' is 'increasing the lifespan' as well as 'quality of life' of people. With economic development and technological advancements, life expectancy at birth in India has almost doubled in the last five decades and continues to increase. However, with the changing socio-cultural context and weakening inter-generational bonds, the value system of filial piety is rapidly fading. These changes have led to increased incidence of elder abuse and neglect, especially within the family, that adversely affects the quality of lives of older persons, more so, for older women. Older women are more vulnerable due to inadequate access to resources, and dependence on their spouse and family to meet their basic needs during their life course. This paper highlights the types of abuse experienced by older women in an urban context in India, and its influence on various dimensions and overall quality of their life. The data from a cross-sectional survey conducted in suburbs of Mumbai, India, has been used to meet the objectives of this study in addition to review from other empirical studies in Indian context. The findings show a high incidence of elder abuse and family members being the main perpetrators. Elder abuse had a significantly negative impact on all dimensions of quality of life of older women reflecting an urgent need for change in social attitude coupled with policy and programmatic interventions.

Keywords: elder abuse, quality of life, older women in India, physical and psychological health of older women, development and ageing.

Introduction

Development is a highly contested concept and there are various perspectives of conceptualising 'development' which depend on the context in which it is being studied. Officially, 'development' is understood as economic growth, whereas philosophically it is

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understood as the improvement of humankind (McMichael, 2012). So, we can say that the pursuit of economic development is 'improvement of humankind' - that is, to improve the life of humans, more specifically their longevity, and the quality of their life.

In India, the life expectancy at birth has almost doubled in the last six decades - that is, the post-independence period - suggesting that there has been a substantial increase in the life span of population in the country (Ministry of Statistics and Programme Implementation, 2016). This improvement in life expectancy at birth can be attributed to the developments in science and technology which led to significant improvements in the field of medicine, health and nutrition of the population. These developments have consequently led to a rapid increase in the proportion of older population in India, in the last two decades. The Indian society, like various other Asian societies, is undergoing transition. The joint family system is withering due to rapid urbanisation, changing socio-cultural contexts and weakening of intergenerational bonds (Siva Raju, 2011a). Due to these changes in the socio-cultural contexts and the changing institution of 'family', the situation of older persons that was imagined to be safer and secure considering the value system of filial piety, is also changing rapidly.

The size of the older population, i.e. persons above the age of 60 years, in India is over 100 million (Census of India, 2011), which is projected to triple between 2011 and 2050 to over 323 million older persons (United Nations, 2015). This demographic transition and the increasing life expectancy coupled with changing socio-cultural contexts especially the institution of family, has economic and social implications. The majority of older persons are being marginalized from mainstream life (nuclear family, migration of the young to towns and cities, acceptance of small family norm), becoming dependent (as their living and health costs are to be met for an extended time) are increasingly seen as burdensome by the younger population (Rajan, 2006; Siva Raju, 2011, Bhat & Dhruvarajan, 2001). The differing values and attitudes among the young due to socio-cultural change, embracing of liberal values (individualism, increased entry of women into paid employment), lowered filial obligation (seeking independence among the young and older persons) and expectations of care of older persons from their children is contributing to the likelihood of neglect and abuse toward the older persons. Women are more commonly victims of almost every type of abuse than men, and people aged 80 years and above are at greatest risk for neglect. Neglect is more commonly perpetrated by women, being caregivers, but men are more often responsible for all other types of abuse (Siva Raju, 2013; Hoban & Kearney, 2000).

Elder Abuse

Elder Abuse is a problem that exists in both developing and developed countries, and yet, it goes seriously underreported. One of the way to define elder abuse is "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. Elder abuse can take various forms such as physical, psychological or emotional, verbal, sexual and financial abuse. It can also be the result of intentional or unintentional neglect" (World Health Organization, 2016). Although the extent of elder abuse is unknown, its social and moral

significance is obvious. Estimates of its prevalence rates exist only in selected developed countries - ranging from 1 per cent to 10 per cent (WHO, 2008) and in India, the prevalence of elder abuse is 11.4 per cent with wide differentials across states which ranges between 1.8 per cent in Tamil Nadu and as high as 35 per cent in Maharashtra (United Nations Population Fund, 2012). With demographic transition coupled with changing cultural and social values in India, the abuse and neglect of the older people in the family context is emerging as a significant social as well as public health concern which is affecting the overall quality of the older people.

The issue of abuse and neglect of older people especially older women in India, is still under recognized and insufficiently acknowledged, though recent empirical evidence clearly suggests that a very high proportion of older people especially older women experience abuse and neglect. In India, about one-third (31 per cent) of urban older persons have experienced abuse and one-fourth of older persons face abuse daily. Frequency and duration of experiencing abuse is higher amongst older women as compared to older men (Helpage India, 2012). Another study revealed that more than one-third of older people from Maharashtra, India reported to experience abuse (United Nations Population Fund, 2012) and 30.2 per cent older women living in urban regions of Maharashtra reported experience of abuse after age of 60 years.

Elder Abuse holds serious consequences for the elder longevity, shorter life spans, higher risk of death as compare to those who have not been mistreated (Schroeder, 2013). In addition, older persons who experience, physical abuse suffer more psychological and other health problems - such as depression, history of depression/suicide attempts - and other overall health problems (Gupta, 2015). Victimized persons are also put at a higher risk for additional disability and recurrent abuse (Anisko, 2009). It has been identified that domestic violence is the most common form of abuse against older women, and many women who suffer at the hands of their partners when they are young continue to be abused in their old age (Kaur & Garg, 2008).

Due to rapid feminisation of ageing, and given the vulnerability of older women, it is important to understand the extent, forms of abuse experienced by older women and its impact on their quality of life.

Objectives and Methodology

The main objective of this paper is to explore the incidence and forms of abuse experienced by older women and elicit its influence on the quality of life and wellbeing of older women in India. The paper also attempts to throw light on research, policy and programmatic implications of abuse experienced by older women in India.

This study drew data from a cross-sectional survey conducted in suburbs of Mumbai (Gupta, 2014) to understand quality of life of older women across different socio-economic class groups in addition to critical analysis of empirical evidences from India. In this survey, a sample of 450 older women (60 years and above) was drawn randomly using

disproportionate stratified sampling from three socio-economic classes - that is, poor, middle-income-group (MIG), and well-to-do (WTD) - based on housing criteria. Information about the socio-demographic and economic characteristics was obtained using a questionnaire designed for this study. The WHOQOL-BREF (World Health Organization, 1996) and WHOQOL-OLD (ibid., 2006) were used to assess their quality of life (QOL).

Bi-variate analysis was performed to present the distribution of older women experiencing abuse by various background characteristics. In addition, independent-sample t-tests, was performed to explain the significance of differentials in quality of life and its dimension among older women who reported to have experience abuse and older women who have never experienced abuse. A few quotes from the interviews have also been presented to illustrate life situations of older women as described by them.

In this study, all the research participants were asked if they have experienced any abuse (or neglect), since they grew old (since they turned 60 years). Further information about the forms of abuse and if they experienced abuse since one month from survey was collected from respondents who reported to have ever-faced abuse. Older women, who have faced abuse, were probed to get details on their relationship with perpetrator and if they experienced any health problems due to abuse. As it was a sensitive question, proper care was taken to be polite and sensitive to responses from the respondents. Abuse was operationalized as any neglect, disrespect or violence faced by older persons in any form or intensity. As in most of the quantitative studies on abuse faced by older persons, a similar phenomenon of underreporting of experience of abuse and neglect was observed in this study as well.

Findings and discussion

Socio-demographic characteristics

The average age of older women was 67 years and there was no significant difference in age of respondents by class. Over half of total older women (50.9 per cent) were widows. Older women from poor strata (61.3 per cent) were more likely to be widowed. Almost half of the total older women (46.4 per cent) had no formal education. Almost all (94 per cent) of the older women from poor group had no formal education. A little over a quarter (28.7 per cent) from MIG & about a fifth (16.7 per cent) of older women from well-to-do class, had no formal education. Although, almost half (50.9 per cent) of the respondents migrated from Mumbai, it was observed that majority (54.0 per cent) of respondents from poor strata migrated from rural areas of Maharashtra due to drought in their respective villages during 1970s, while respondents from upper strata migrated from Mumbai as this place offered them better living conditions.

On exploring the living space of older women it was observed that a majority of older women (78.0 per cent) from poor strata did not have a separate living space for themselves while in upper strata a majority (88 per cent in WTD and 61 per cent in MIG) of respondents had a separate room for themselves. About half of the respondents had participated in work

force. However, on disaggregating the data by class, it was observed that a majority of respondents from poor class (80.7 per cent) a little over one-third respondents (38.0 per cent) from MIG and over a quarter of respondents (28.7 per cent) from WTD had ever worked. About half of the respondents (49.6 per cent) had no income - hence were dependent of their family members for economic needs. The mean monthly income of older women (and spouse) from poor, MIG and well-to-do class, who reported to have some source of income, was about Rs. 4,302, Rs. 8,568 and Rs. 15,287 respectively.

Experience of abuse

Table 1 shows that more than one in five older women (22.0 per cent) reported to have faced some form of abuse, which varied in intensity and forms. Over one-third of respondents from poorer strata (36.0 per cent) reported that they have faced abuse. A majority of the respondents who have faced abuse since they turned 60 years also reported to have faced it in last one month - that is 19.3 per cent of the total respondents from the survey, reported to have faced abuse in last one month. This suggests a high frequency of elder abuse and its consistent infliction. On disaggregating this data by economic class, it was observed that more than one-third of older women from poor class followed by one-fifth (20.7 percent) of older women from MIG and less than one-tenth (9.3 percent) of older women from WTD class. There is a significant relationship between the experience of abuse and the social class of older women ($p<0.001$). Older women from poor class reported significantly higher incidence of experience of abuse and this reduces as the socio economic status of older women improves. The reporting of abuse experienced by older women is quiet similar to the findings from Helpage India survey in Mumbai (Helpage India, 2012). Though abuse is mostly underreported, the reported fraction is clearly indicative of the ongoing violations faced by older women in urban settings across all economic classes.

Table 1: Percentage distribution of older women experiencing abuse by economic class and background characteristics

Background Characteristic	POOR	MIG	WTD	TOTAL
Age ^{ns}				
60-69 yrs	34.7	21.0	7.8	21.0
70 to 74 yrs	38.7	20.8	8.7	24.4
75 yrs and above	38.1	19.2	16.0	23.6
χ^2 (2, 450) =0.537, p < 0.765				
Caste***				
SC	40.3	20.8	0.0	35.3
ST	42.1	0.0	0.0	40.0

Background Characteristic	POOR	MIG	WTD	TOTAL
OBC	20.0	14.3	11.1	14.3
No Caste	28.6	22.1	9.3	17.1
χ^2 (4, 450) =20.115, p < 0.001				
Marital Status n.s				
Currently Married	35.7	20.3	7.1	19.0
Others (widowed, deserted, never married)	36.2	21.0	12.3	24.6
χ^2 (1, 450) =0.172, p =0.097				
Educational Status***				
No education	37.6	16.3	4.0	29.2
Up to primary	14.3	25.0	28.0	25.0
Secondary /HSC	_	21.2	9.0	14.8
Graduation/PG	_	20.0	0.0	2.6
χ^2 (3, 450) =19.016, p < 0.001				
Living Arrangement ns				
Living Alone	37.5	33.3	22.2	30.4
With Spouse	62.5	9.1	3.8	15.6
children or others	35.2	17.6	9.4	22.1
With Spouse and children	32.6	27.1	9.8	22.5
χ^2 (3, 450) =2.067, p < 0.559				
TOTAL	**36.0**	**20.7**	**9.3**	**22.0**
χ^2 (2, 450) =31.31, p < 0.001				
Experienced abuse in last ONE mth	56.3	31.0	12.6	19.3
Health problems due to abuse	57.1	44.4	63.6	54.0

*Note: n.s. indicates not significant, *** indicates p<0.001*

Caste is a vital component of socio-cultural context in India that determines the quality of life of people. The 'scheduled castes' (SCs) and 'scheduled tribes' (STs) and 'other backward

classes' (OBCs) are various officially designated groups of historically disadvantaged indigenous people in India. These terms are recognised in the Constitution of India and the various groups are designated in one or other of the categories. The rest were classified under open/no caste category (Karade, 2008). Two-fifth of the older women belonging to schedule tribes (ST) and more than one-third belonging to schedule caste (SC) reported experience of abuse, while less than one in six older women reported abuse in other backward classes (OBC) and those belonging to general caste. Lesser proportion (19 per cent) of currently married older women, tend to experience abuse as compared to those who were widowed/deserted or others (25 per cent), however this difference is not statistically significant. Older women who were illiterate were more likely to experience abuse and the likelihood of experiencing abuse reduced with improvement in educational status of older women, as less than 3 per cent of those who had completed graduation or higher studies, reported abuse as while one-third of those who had no formal education experienced abuse. These differentials in the experience of abuse and level of education were statistically significant ($p<0.001$). Living arrangement had no significant impact on the experience of abuse by older women, however, some differentials were observed. One-third of those who were living alone reported experience of abuse as compared to about 15 per cent reporting abuse if they were living with their spouse. However, there were significant class differentials with highest proportion (62.5 per cent) of older women from poor class living with spouse only reporting the abuse.

Forms of abuse

Table 2 depicts that most of the respondents, (66.7 per cent) who reported experiencing abuse in last one month, experienced emotional abuse and about a quarter of total respondents (26.4 per cent) faced both physical as well as emotional abuse.

Table 2: Per cent distribution of respondents according to class and type of abuse experienced in last one month

Type of abuse experienced	Poor	MIG	Well-to-do	Total
Emotional abuse	65.3	74.1	54.5	66.7
Physical abuse	2.0	18.5	0.0	6.9
Both physical and emotional abuse	32.7	7.4	45.5	26.4

Very few respondents (6.9 per cent) who reported to have faced abuse in last one month reported experience of only physical abuse. About one-third (32.7 per cent) of older women from poor class reported to face both physical and emotional abuse. It is worth mentioning, that though the total proportion of older women from well-to-do class reporting abuse is lowest, the proportion of those facing both physical and emotional abuse is high (45.5 per

cent). Most of the respondents (74.1 per cent), who experienced any abuse in one month prior to survey, from MIG reported to experience emotional abuse.

The data clearly suggests that emotional abuse of older women is rampant across all class, in addition, a high proportion of older women from poor class as well as well-to-do reported experience of both emotional and physical abuse. On further exploration about the various forms of abuse faced by older persons, table 3 shows that a majority (80.5 per cent) of respondents experiencing abuse reported to face verbal abuse, over two-fifth (41.4 per cent) reported physical abuse, more than half (56.3 per cent, 55.2 per cent, 54.0 per cent) reported economic abuse, facing disrespect and neglect respectively. The majority of the respondents reporting experience of abuse reported to have faced multiple forms of abuse.

Table 3: Per cent distribution of respondents who experience abuse, according to form of abuse reported in last one month of survey

Form of abuse	Poor	MIG	Well-to-do	Total
Physical abuse	46.7	27.6	53.8	41.4
Verbal abuse	84.4	72.4	84.6	80.5
Economic abuse	66.7	48.3	38.5	56.3
Showing disrespect	60.0	44.8	61.5	55.2
Neglect	48.9	55.2	69.2	54.0
Others	22.2	3.4	0.0	12.6

A majority of older women from poor, MIG and WTD class reported verbal abuse (84.4 per cent, 72.4 per cent, and 84.6 per cent respectively). Proportion of economic abuse reported by older women from poor class was highest among poor class (Poor: 66.7 per cent; MIG: 48.3 per cent; WTD: 38.5 per cent) clearly indicating loss of control over older women's own income and assets as they grow old. It is also worth mentioning that about 81 per cent of older women from poor strata work to earn a living, hence, it is all the more regressive for their emotional as well as psychological health to not have control over their income earned. This further pushes them to not have sufficient resources to meet their basic needs.

The data clearly suggests that though the frequency of respondents reporting each form of abuse was higher amongst older women from poor class, the proportion of respondents reporting physical abuse, verbal abuse, neglect and disrespect was higher among respondents from well-to-do class. It clearly suggests that abuse of older women is a phenomenon experienced across all classes, though the extent of underreporting may vary by class.

Perpetrators of Abuse

In order to elicit the role of family in abuse and type of abuse experienced, the respondents reporting experience of abuse were asked if they experienced abuse from within family or outside family or both. Table 4 indicates that a majority of respondents (78.3 per cent) reported that they experienced abuse from within their family.

As reflected by the findings from this study, over three-fourth of the respondents (78.3 per cent) reported that they faced physical abuse from within family, an overwhelming proportion of respondents (83.0 per cent) reported verbal abuse from within family and almost all respondents reporting economic abuse reported to have experiences economic abuse from within family (87.5 per cent). Most of the respondents also reported to have experienced disrespect and neglect from their own family members (78.1 per cent and 82.8 per cent respectively).

Table 4: Per cent distribution of respondents according to form of abuse and role of family in abuse, reported in last one month of survey

Type of Abuse & inflected from Within/outside family	Per cent
Physical abuse	
Within family	78.3
Outside family	10.9
Both within and outside	10.9
Verbal abuse	
Within family	83
Outside family	6.8
Both within and outside	10.2
Economic abuse	
Within family	87.5
Outside family	7.1
Both within and outside	5.4
Showing disrespect	
Within family	78.1

Type of Abuse & inflected from Within/outside family	Per cent
Outside family	14.1
Both within and outside	7.8
Neglect	
Within family	82.8
Outside family	8.6
Both within and outside	8.6

The data clearly suggest that majority of older women reported abuse from within the family, irrespective of the type of abuse. It clearly reflects the eroding intergenerational binds and respect for older women in the family. This makes older women vulnerable and abuse has a direct impact on the overall quality of life of older women.

Prime perpetrators

As reported from various studies on elder abuse in India (Helpage India, 2012), the prime perpetrators are from within the family. Most often, older women are abused by their sons as they are particularly dependant on their sons for support during old age due to the Indian cultural context. Figure 1 clearly illustrates a similar phenomenon, where a little less than two-fifth of respondents (36.4 per cent) experiencing abuse reported their sons to be prime perpetrators. This was followed by over nearly one-fifth reporting abuse from their daughter-in-law (17.2 per cent), followed by their husband (15.2 per cent). It is important to highlight that most of the older women experience abuse from more than one perpetrator who is most often from within the family, relatives or neighbours. Table 5 shows that in poorer strata, where reporting of experiencing abuse was highest in this study, the prime perpetrator was the son (38.9 per cent) followed by daughter-in-law (11.1 per cent) and husband (11.1 per cent).

Figure 1: Per cent distribution of total respondents according to their reporting about prime perpetrators of abuse

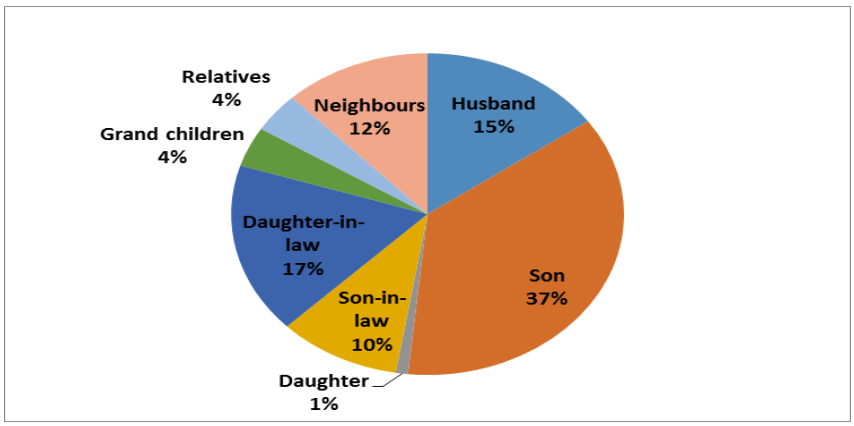

Table 5: Per cent distribution of respondents who experienced abuse according to prime perpetrator of abuse and class

Prime Perpetrator	Poor	MIG	Well-to-do	Total
Husband	11.1	25.8	7.1	15.2
Son	38.9	25.8	50.0	36.4
Daughter	0.0	3.2	0.0	1.0
Son-in-law	13.0	9.7	0.0	10.1
Daughter-in-law	11.1	19.4	35.7	17.2
Grand children	7.4	0.0	0.0	4.0
Relatives	5.6	0.0	7.1	4.0
Neighbours	13.0	16.1	0.0	12.1

These findings were also found in well-to-do class whereby most respondents (50.0 per cent) reported sons to be the prime perpetrator followed by their daughter-in-law (35.7 per cent). In MIG class, husband as well as son were reported as the prime perpetrators (25.8 per cent). The data suggests that sons are the prime perpetrators, followed by daughter-in-law and respondent's husband. As these family members are the primary care givers and older women face abuse from these people in the family, they have no other support system to seek help in instance of abuse. Due to these reasons, older women have to face abuse and cannot raise their voice against it, as they are dependent on these family members for fulfilling their basic economic and social needs.

Multiple perpetrators

About two-fifth of the respondents (59.6 per cent) reporting experience of abuse, reported that they experience abuse from more than one perpetrator. About one-third of the respondents (34.3 per cent) experiencing abuse reported that they experience abuse from at least two perpetrators. The extent, type and forms of abuse faced by older women across all class groups clearly suggests that they are very vulnerable and most respondents reporting abuse reported to face abuse from more than one perpetrator which is mostly a family member.

Health Implications of abuse

It is obvious that older women experiencing any form and intensity of abuse, will have health problems which may vary from physical, emotional and psychological and may also vary in intensity. All the respondents reporting experiencing abuse in last one month were

asked if they faced any health problems due to abuse. Table 1 shows that almost half of the respondents (54.0 per cent) who experienced abuse reported that they faced health problems as a consequence of abuse experienced. Class-wise disaggregation revealed that almost two-third (63.6 per cent) of the older women from WTD class and over half of respondents (57.1 per cent) from poor class experiencing abuse in last one month, reported health problems due to experience of abuse. This clearly reflects the impact of abuse on health of older women, which has a negative effect on their quality of life.

Impact of Abuse on Quality of life of older women

The data was further analysed to understand the impact of abuse on older women's quality of life and its dimensions. Five dimensions of their QOL namely Physical Health, Psychological Health, Social Relations, Environmental Domain and specific facets of old age were studied to understand the impact on QOL. In addition, the impact of abuse on overall of QOL of older women was also studied.

It was observed that all the dimensions of quality of life of older women were significantly affected by experience of abuse. Older women experiencing abuse had significantly low mean scores all the dimensions of QOL. Physical health of older women experiencing abuse (mean 12.3) was significantly lower than older women not experiencing abuse (mean 13.2). Highest differentials were observed in the mean scores of psychological health of the older women experiencing abuse (mean 11.4) and those not experiencing abuse (mean 13.1). Social relations of women experiencing abuse were considerably affected (mean 12.7).

Table 6: Impact of experience of abuse on dimensions of quality of life of

Dimensions of QOL (Mean scores)	Ever experienced abuse	Never experienced abuse	Total
Physical Health**	12.3	13.2	13.0
Psychological Health**	11.4	13.1	12.8
Social Relations*	12.7	13.5	13.3
Environmental domain**	12.8	14.4	14.1
Specific facets of old age**	13.5	14.6	14.4
Overall Quality of Life Index**	12.5	13.8	13.5

*Note: * indicates significant at p-value <0.01 and ** indicates significant at p-value < 0.001*

The mean scores for overall QOL of older women experiencing abuse was very low (mean 12.5) as compared to those who did not experience of any abuse (mean 13.8). The results clearly shows that older women experiencing any form of abuse have significantly lower

physical health, very low psychological health, hampered social relations, low mean scores for environmental domain, as well as poor overall quality of life as compared to those not experiencing any form of abuse. Some of the quotes from interviews of older women reflecting their feelings about quality of life in due to experience of abuse are as follows:

> Jeene se behtar hai marna. Mere bahu saas ban gaye hai aur mein bahu.
> *It's better to die than to live. My daughter-in-law has become my mother-in-law and I have become her daughter-in-law'.*

> Me banjuti aahe, mehnun sab log torcher kartat.
> *Because I am infertile, cannot bear children, everyone torchers me.*

> Bete bahut sharab pite hain aur gali dete hain; mule roz daru pitat ani roz bhande kartat.
> *Sons drink daily and verbally abuse me; as they drink daily, there is a quarrel in the house almost every day.*

> Mera pati mujhe kisi se zyada baat nahi karne deta, shak karta hai. Pati kamata nahi, sharab pita hai, marta hai, ek beta tha who bhi guzar hgaya, mere jeene ka koi matlab nahi hai.
> *My husband does not allow me to talk to anyone, he does not trust me. He does not earn money, drinks alcohol, physically and verbally abuses me, I had one son who has passed away. There is no reason for me to live.*

The above quotes give an idea about the extent of abuse faced by older women, the prime perpetrators as well as the impact abuse has on their overall quality of life. Abuse negatively affects the health as well as quality of life older women irrespective of economic class. These quotes also reveal that older women experience abuse irrespective of their class. The findings on abuse experienced by older women clearly reflects that a substantial proportion of older women reported abuse that significantly varies with class. Majority of those who experience abuse reported multiple forms of abuse and the prime perpetrators were sons and husband in majority of cases. This clearly reflects on the need to promote awareness about abuse and neglect in society and encourage a positive social attitude.

Conclusions and recommendations

The study clearly brought out that elder abuse negatively influences QOL of older women. It was observed that older women who experience any form of abuse had lower QOL across all economic class groups, however, there were significant class differentials with older women from the poor class being the most vulnerable. In addition, older women who had no formal education were more vulnerable to elder abuse. Family members who were the caregivers were the prime perpetrators of elder abuse, this clearly questions the filial piety in the changing socio-cultural context in India. All the dimensions of the quality of life i.e. physical health, psychological health, social relations, environmental domain and specific

facets of old age were compromised for older women experiencing abuse across all economic class groups (Gupta, 2015). This had a consequential impact on the overall quality of life of older women. These evidences clearly point towards questioning the sustainability of path of 'development' in India that is bringing demographic transition in a changing socio-cultural context that is unfavorable for people to enjoy the added years to their life. In order to alter this context and make it favorable for older people to cherish each and every moment added to their lives, there is an urgent need for bringing out change at various levels.

The first and foremost being at the family level by strengthening the inter-generational bonds because that is where majority of the older people want to live in their old age (UNFPA, 2012). Also, in a country like India where there are resource constraints and the quantum of ageing population due to high absolute numbers, we cannot look at the models of institutional care as adopted by developed countries. Hence, promoting ageing in place by *improving the social attitude and strengthening intergenerational bonds* provide a sustainable solution towards improving quality of lives of older persons. *Improving security* of older people by providing enabling environment and ensuring social environment to maintain older women's autonomy and integrity also emerged as an important predictor of overall QOL (Gupta, 2014). Abuse emerged as a significant predictor of overall QOL index of older women across all class groups, with its contribution to variance in QOL index ranging from 4.5 per cent to 2.4 per cent (Gupta, 2014). Therefore, policies to prevent abuse and neglect of older women - improving their decision-making in the household emerged as important factors that will help to improve older women's overall QOL index across all class groups. There is a need to promote social attitude and that we can take positive steps such as educating people about elder abuse, increasing the availability of respite care, promoting increased social contact and support for families with dependent older adults, and encouraging counselling and treatment to cope with personal and family problems that contribute to abuse. There is an urgent need to take this up at programmatic level and design strategies to check abuse experienced by older women. Various strategies that can be adopted to improve awareness about elder abuse and reduce its incidence are proposed:

- *Zero tolerance towards abuse at any age*. Education about abuse is the cornerstone to prevent it. The first and most important step toward preventing elder abuse is to recognize that no one, of whatever age, should be subjected to violent, abusive, humiliating or neglectful behaviour.
- *Social contact and support*. Programmes need to work on social relations by designing strategies to improve social mobility and participation of older women. This will help older women to be more vocal about the issues faced by them, improve their awareness on ways to curtail abuse and access counselling services to maintain their psychological wellbeing.
- *Improving social activities*. Isolation of elders increases the probability of abuse and it may even be a sign that abuse is occurring. Hence programmes should focus on improving social activities and mobility of older women as a strategy is one way to improve physical and psychological health in addition to reducing their vulnerability.

- *Counselling*. For behavioral or personal problems in the family or for the problems of older women can play a significant role in helping people change lifelong patterns of behaviour or find solutions to problems emerging from current stresses. Provision of accessible counselling services to help older women overcome stress in life as stress was found to hinder their overall QOL index.
- *Financial security*: This was observed to have positive and significant influence on physical and psychological health domains of quality of life, hence provision of universal financial schemes will greatly enhance the overall QOL of older women from all class groups.
- *Respite care*. Another important fact that is highlighted by various studies is that the caregivers are the prime perpetrators of abuse. This clearly suggests the need to create opportunities for respite care so that the care givers can be relieved and get respite from their care-giving roles periodically. Respite care is especially important for caregivers of people suffering from Alzheimer's disease or other forms of dementia or of older people who are severely disabled.

These strategies if implemented through adequate policy and programmes, will immensely help in preventing elder abuse and contribute towards improving the quality of lives of older persons in India. The study also has implications for future research work. There is a need to undertake studies that explore the dynamics of changing family relations, and reasons for silence of older women on experience of elder abuse. In the light that the majority of older persons want to live with their families and in the community rather than institutions (United Nations Population Fund, 2012), it will be useful to study the coping mechanisms of older persons and identify as well as study the communities that have been able to retain the value system of filial piety in the modernising socio-cultural context.

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International Journal on Ageing in Developing Countries, 2016, 1 (2): 174-193

Exploring Associations between Social Support and Mental Health in Older People: A systematic Narrative Review

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Abstract. The association between social support and mental health is still not fully understood, especially among older people. The purpose of this review is to summarize the current state of research on the topic. The authors undertook a systematic review to identify all review studies irrespective of date, and new primary research studies published since 2007 that examined the associations between social support and mental health among older people. Overall, 24 citations (6 review and 18 original articles) met the inclusion criteria. The results for the 'main effect' model and the 'stress-buffering effect' model of the action of social support on health were summarised. Overall, the review studies provided moderate evidence that social support has a protective effect on mental health. Results from primary research studies lend some support to the hypothesis of a protective main effect of support, but are far from conclusive. There was weak evidence for a stress buffering effect on the mental health. Stronger evidence was found for the association of emotional support than instrumental support with depression. Although diversity in the characteristics of the studies included, in addition to methodological limitations, makes the estimation of the effects of social support on health complicated, overall at least a moderate importance of social support for mental health of older people was demonstrated. This review indicates areas which need further investigation, such as studies focusing on older people, across non-western countries, studies with prospective research design, and investigation on the role of gender and support providers, using more comprehensive instruments.

Keywords: social support, mental health, older people, systematic review

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Introduction

Social support has been conceptualised in a range of different ways. In a basic definition it is defined as resources provided by other persons (Cohen & Syme, 1985) to be intended to enhance the wellbeing of the recipient (Shumaker & Brownell, 1984). Social support includes two dimensions, perceived and received. 'Perceived social support' is a subjective feeling of being supported, whereas 'received social support' refers to indicators of what people receive from others (Tardy, 1985). In addition to its different dimensions, social support has also been conceptualised to have 'structural' and 'functional' aspects. The functional aspect refers to the type or content of support, while the structural aspect is the actual physicality of the support and includes quantitative elements such as size of social network (Cobb, 1976).

Research interest in social support began in the 1970s (Bowling, 1994), grew until 1990s and gradually decreased since then (Callaghan & Morrissey, 1993). The interest in social support and health research was triggered by a number of influential review papers published in the mid-1970s (Kaplan, Cassel & Gore, 1977; Cassel, 1976 and 1974; Cobb, 1976). These review papers generated a great deal of scientific interest in the possibility that interpersonal relationships might protect health. Two main models of the action of social support on health have been hypothesised, the 'main effect' model and the 'stress-buffering effect' model. The main (or direct) effect model implies that social support has a positive effect on health and operates at all the times, irrespective of the individual's exposure to a stress (House, Umberson, & Landis, 1988; Berkman & Syme, 1979). Alternatively, the stress-buffering model proposes that the buffering effect of social support occurs only when the person is exposed to a stressful situation, and in the absence of stress, social support is not linked to health (Taylor, 1995). Evidence exists to support both models, but is also contradictory.

The concept of social support was first used in the mental, rather than physical, health literature and in social support research there has always been a strong emphasis and focus on mental health (House et al., 1988). This is because social support is believed to play an important role in moderating the effects of stress, particularly on mental health (Cooper et al., 1999). Mental health has also been conceptualised variously with positive or negative perspectives. In the positive perspective, mental health is conceptualized as a matter of wellbeing, while in the negative perspective, it implies mental disorders, symptoms, and problems (World Health Organization, 2005). Research has focused more on negative rather than positive measures of mental health, mainly because it is easier to measure mental disorders or symptoms, rather than characteristics of a good mental health (ibid., 2001).

A brief review revealed that most of the available evidence reported a significant association between lack of social support and poorer mental health. However, most studies were cross-sectional and concerns were expressed about the direction of the association between social support and mental health (House et al., 1988). For example, people who are depressed may perceive and report inadequate support despite receiving a high level of support (Berkman, 1984). Even in the existing longitudinal studies (e.g. Bums & Farina, 1984; Henderson, 1981) and experimental studies (Broadhead et al., 1983; Levy, 1983; Mumford, Schlesinger & Glass,

1982; DiMatteo & Hays, 1981) causal interpretation is to some degree uncertain mostly because of methodological limitations of these studies. Therefore, the association between social support and mental health is still not fully understood.

The association is even less understood among older people and no review study so far specifically focused on older people. This is while, social support is of particular importance for older people due to increasing various age associated stressors such as increased risk of chronic diseases (McLeod & Kessler, 1990; Oxman, Berkman, Kasl, Freeman and Barrett, 1992). On the other hand, sources of social support may diminish in later life as a result of widowhood, mobility of kin and loss of sources of income (Gottlieb, 1983; Broadhead et al., 1983). Therefore, understanding the effects of poor social support on mental health of older people is especially important.

Additionally, in the social support and mental health literature a number of issues remain unclear. There is inconsistency between different reviews in the magnitude of the main and stress buffering associations and differences on the importance of various dimensions and aspects of social support on mental health, in particular the moderating role of gender and providers of support in the associations has received less attention. To address these issues, we conducted a systematic literature review on quantitative research studies which have explored associations between social support and mental health in older people.

Design of the systematic review

Criteria for considering studies for this review

Two types of studies on the associations between social support and mental health were included, review studies irrespective of date and primary research studies published since 2007. Although ideally it might have been desirable to include all primary studies, regardless of date of publication, a preliminary online search using the key search terms 'social support' and 'mental health' in older people identified over 400,000 references so this was clearly not practicable. Moreover, knowledge gained from these earlier studies is included indirectly in this review both through the inclusion of key review articles and because more recent studies have been informed in design and conceptualisation by the earlier literature.

Review articles were not restricted to systematic reviews. Reviews that focused exclusively on children or young people (Chu, Saucier & Hafner, 2010) were excluded. In the review of primary research studies, all quantitative studies investigating the associations between any type of social support and mental health in older people aged 60 or over conducted in the five years (2007-2012) were included. However, studies that investigated outcome measures such as stress (Viswesvaran, Sanchez & Fisher, 1999), or loneliness (Golden et al., 2009b) were excluded, although they were related to mental health in some ways. In both types of publications, studies which measured both social support and mental health but did not examine the associations between them were excluded. Studies focussed on 'Social Networks' (Macêdo Corrêa, Moreira-Almeida, Menezes, Vallada, & Scazufca, 2011; Golden,

Conroyb & Lawlor, 2009a), rather than social support were also excluded. However, as previous research has sometimes used these concepts interchangeably, to avoid missing the social support studies, we initially included both terms and then read the abstracts (or full-text) of all papers before excluding those that dealt only with social networks. The search was limited to English language papers. No geographic limitation was given. Studies were not excluded on grounds of methodological quality.

Search strategy

Twenty-one electronic databases, as listed below, were searched to identify studies that met the inclusion criteria of this review. The selection of databases and websites was made based on their relevance to our research area.

Table 1: Electronic databases researched

1. Age Info
2. CAB Abstracts (Ovid SP) (1973 to present)
3. Centre for Review and Dissemination (CRD)
4. Cochrane Collection databases (1993 to present)
5. Dissertations & Theses (N. American PhD theses) (1637 to present)
6. Eldis
7. EMBASE (Ovid SP) (1947 to present)
8. EThoS (UK theses)
9. FRANCIS (1984 to present)
10. Global Health (Ovid SP) (1910 to present)
11. IMEMR
12. Index to Theses of the British Isles (1716 to present)
13. International bibliography of the social sciences (IBSS) (1951 to present)
14. ISI Web of Science (Journal Citation Reports) (1970 to present)
15. JSTOR
16. Medline (Ovid SP) (1946 to present)
17. PsycARTICLES (EBSCOhost) (1894 to present)
18. PsycEXTRA (EBSCOhost) (1908 to present)
19. PsycINFO (1806 to present)
20. PubMed (EBSCOhost) (1950 to present)
21. Social Policy & Practice (social policy) (Ovid SP) (1890 to present)

Table 2: Terms or phrases mainly used in most of the databases

"Social Support"[Mesh] OR social [Title/Abstract] AND support[Title/Abstract] OR social [Title/Abstract] AND network*[Title/Abstract]*
AND
"Mental Health"[Mesh] OR "Mental Disorders"[Mesh] OR psych[Title/Abstract] OR depression*[Title/Abstract] OR anxiety*[Title/Abstract]*

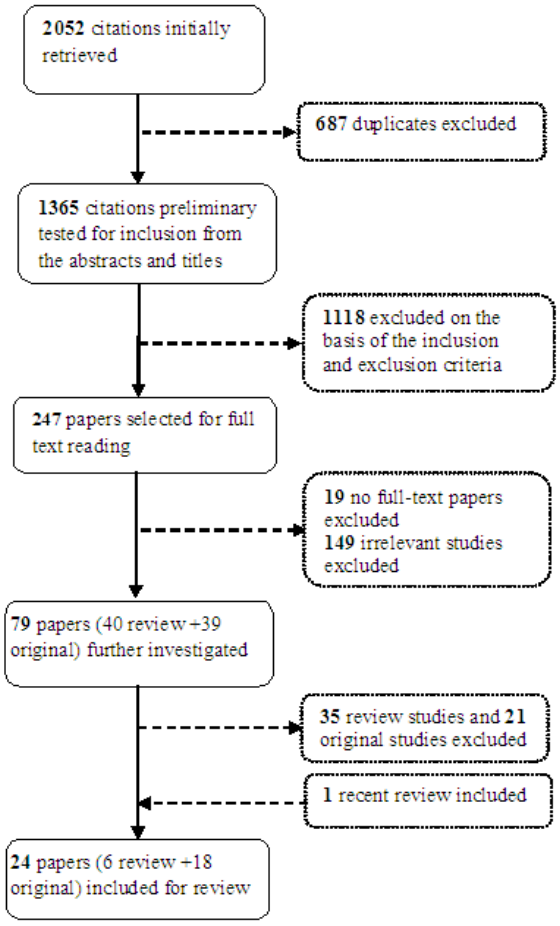
Articles were identified by searching keywords, abstracts and titles in the electronic databases and selected websites. When the titles and abstracts were not sufficient to determine if the inclusion criteria were met, the full-text of the papers was obtained and read. In most of the databases limiting the search by publication type was possible. These were then searched twice, once to find review articles for all years and then to find individual original articles published since 2007.

In addition to electronic searching, a number of highly relevant journals were hand searched to insure as many relevant studies were included as possible. Additionally, the bibliographies of the included studies, electronically or by hand, were also searched. We scanned the reference lists of all included papers to identify the main contributing authors to this topic. A further search was then made using the name of these authors in order to ensure that the most relevant studies were included in the review.

Article identification and selection process

The process of article identification and selection of papers is shown in Figure 1. Using different search methods and after applying the study criteria eventually, 24 citations (six review and 18 original articles) were included.

Figure 1: Article identification and selection process



We extracted the required data from the included review and original articles using a purposefully designed data extraction form. The studies included were developed for a diversity of objectives, used a variety of measures and methods and included study participants with different characteristics. This diversity made formal meta-analysis impossible. Therefore, the results of similar dimensions or aspects of social support were identified and grouped together and then the findings were reported, compared and examined descriptively.

Results of the systematic review

Findings from review articles

Although only six review studies were included in our review (Letvak, 2002; Wang, Wu & Liu, 2003; Wang, 1998; Salter, Foley & Teasell, 2010; Prati & Pietrantoni, 2010; Tajvar, Fletcher, Grundy & Arab, 2013), as each review summarised the results of many studies thus their results are very valuable. Among the review articles, all apart from one (Letvak, 2002), were conducted systematically, of which three were meta-analytic review studies. Of these articles only the study of Salter et al. (2010) comprised a review of studies exclusively relating to older people, but included only those who had a stroke. Most of the review studies were fairly recent, conducted in the last 10 years. The number of primary studies included in these reviews ranged from only four in the study of Latvak (2002) to 75 in the study of Wang et al. (2003). Overall, 156 studies were included in six review papers, of which 100 studies examined only the main effect model, 11 studies examined the stress-buffering effect model and the remaining 45 studies did not specifically provide information on this.

Of 100 studies examining the main effect of social support, four studies found a significant association between social support and mental health (Letvak, 2002), but the individual results of 96 other studies were not reported. Instead, it was reported that the pooled effect size (ES) of social support in those studies were significantly correlated with all the mental health outcomes. However, it was also reported that the ES of social support on depression was medium in 75 of 96 studies (Wang et al., 2003) and small in 21 studies (Wang, 1998). The ES of social support on coping behaviour and positive mood state was reported to be medium and the ES of social support on psychological symptoms and responses, psychosocial adjustment, negative mood state and stress was reported as small.

Of the other 45 studies in which it was not clear whether stress buffering or main effects were considered, eight studies reported a significant association between social support and mental health measures and the ES in 37 studies (Prati & Pietrantoni, 2010) was reported as to be medium. Moreover, both studies (Tajvar et al., 2013; Prati & Pietrantoni, 2010) that reported on the associations between dimensions of social support and mental health indicated a stronger association with perceived social support than received social support and depression. Of 11 studies examining the stress-buffering effect model, only two (Claiborne, 2006; Koopman et al., 2001) found a significant buffering effect of social support on the association between a stressor and depression. In summary, although most of the

studies reported that social support has a significant main association with mental health, ESs in most of them were of medium or small magnitude (as reported by the reviewers). There is less evidence to support the stress-buffering effect of social support. It should also be noted that most of the studies included were cross-sectional. Nevertheless, most of the review papers concluded that interventions aimed at increasing social support among individuals might promote their mental health. However, Salter et al.'s (2010) review of intervention studies found that only 1 of the10 randomized controlled trials included found a significant, positive effect of the social support intervention on depression. Overall, this overview of review studies provides moderate evidence to support the notion that social support has a protective effect on mental health.

Findings from primary research articles

All of the 18 studies examined the main effect model, and eight studies also examined the stress-buffering effect model of social support. The characteristics of these studies are summarised in Table 1.

Table 1: Summary of primary research studies included in the present systematic review

Ref., Setting, Main Objective	N	Sample, Sampling	Design and Methods	Measures of SS and MH	Key Findings
Alexandrino-Silva et al. (2011) Brazil M *To examine the association of life events and SS in depression in late life.*	367	Household community sample of older people 60+, 65% female Over sampling people over 60 in a sampling frame of people 18+	XS Regression analysis	MH measure: 'Old age symptomatic depression' measured by CIDI 1.1 (RVT) SS measure: PSS measured by Assessment and Referral Evaluation (SHORT-CARE) inventory	Depression was associated with a perceived lack of SS in men (OR=3.5, 95%CI= 1.1-12.1, P=0.04) but not in women (OR=0.7, 95%CI= 0.4-1.4, P=0.29). Thus, gender differences should be considered.
Nemeroff et al. (2010) USA M/B *To investigate the relative influence of SS and perceived control on the psychological distress under stressful life circumstances*	134	Community-dwelling older people aged 65+, 64% female Convenient sampling	XS Regression analysis	MH measure: BSI to detect psychological distress (RVT) SS measure: PSS measured by SSQSR (RVT)	In testing the main effects model, only SS but not stress (measured by Elders Life Stress Inventory) was found to be a significant predictor of psychological distress; Greater satisfaction with SS was associated with lower levels of psychological distress ($p< 0.001$). The interaction of stress × SS had a non-significant relationship with psychological distress ($p>0.05$)
Bierman & Statland (2010) USA M/B *To examine how SS resources and the timing of limitations intersect to shape the relationship between ADL limitations and changes in psychological distress*	1167	Community residents older people aged 65+ in wave 1 of the ASH study and 925 people (79% retention rate) after 2 years Random sampling RR=65%	Longitudinal study over a 2-year period Regression Analysis	MH measure: Depression measured by Hopkins Symptoms Checklist (Derogatis, et al., 1974) (RVT) SS measure: PSS measured by a 4-item scale adapted from Schieman (2005) (RVT)	Neither the main effect model, nor the buffering model of SS was significant; While, greater limitations in ADLs were positively related to changes in depressive symptoms over the course of the study, PSS was not significant (OR=0.003, $p>0.05$). Also, PSS did not interact in the relationship between ADL limitations and depressive symptoms (OR=0.047, $p>0.05$).

Ref., Setting, Main Objective	N	Sample, Sampling	Design and Methods	Measures of SS and MH	Key Findings
Lee & Dunkle (2010) South Korea M/B *To investigate how worries and psychosocial distress are related to depressive symptoms*	193	Community-dwelling oldest old 85+ years old, 71% female	XS Hierarchical regression analysis	MH measure: Depression measured by 15-item version of GDS-SF (RVT) SS measure: Self developed 8-item questionnaire (4 items for received emotional SS and 4 items for received instrumental SS (RVT)	There was a strong correlation between worries and depressive symptoms. Both emotional support and instrumental support received from adult children had main effects on depressive symptoms. However, only emotional support from adult children had a powerful buffering effect on the relationship between worries and depressive symptoms.
Olutoyin Oni (2010) Canada M *To determine how specific types of informal social relationships affect the health of the elderly*	54	Older people aged 65+ in nursing homes, 70% women convenience sampling RR=87%	XS Regression analysis	MH measure: Depression measured by 15-item GDS (RVT) SS measure: Duke SS Scale (including 2 subscales; PSS from family and PSS from friends) (RVT)	Both support from family (OR= 0.16, p=0.02) and support from friends (OR= 0.09, p=0.01) were significantly associated with depression; however, friend support was a more reliable factor for predicting the levels of depression after controlling for all other covariates.
Jawad et al. (2009) Lebanon M/B To investigate the moderating role of various SS factors in the stress–depression relationship	490	Community-residing older adults in post-civil war Lebanon aged 60+, 58% women	XS Regression analysis	MH measure: Depression measured by GDS-15 (RVT) SS measure: Availability of SS (having spouse and number of co-resident children) and quality of SS	Availability of SS: There was no significant association between presence of a spouse and lower depression (OR= 0.39, p>0.05) but having more children was associated with lower depression (OR= 0.10, p<0.001). Quality of SS: Reported good relationships with others were associated with fewer depression symptoms. The buffering effect of SS depended on the nature of the stressor and the source of SS. But for 'total number of life stresses' SS did not show a buffering role.
Safezadeh (2009) Iran M To identify the associations between characteristics of older people with their mental health	312	Community-resident older people 65+ years old, 55% men Stratified sampling method RR=94%	XS Bivariate analysis	MH measure: GHQ-12 to detect Psychiatric disorders SS measure: A single question asking whether SS is low, median or high	The mean GHQ scores of those with low, median and high SS were 30.8, 31.2 and 33.2 and differences were significant using bivariate analysis. Women, widowed, older, less educated, less income, and those with low class occupation had significantly poorer MH.
Bozo et al. (2009) Turkey M/B To examine the effects of ADL and perceived SS on the level of depression and the moderating role of SS in relations between ADL and depression	102	Older people aged 60+ selected from three cities of Turkey, 67% women Convenient sampling	XS Hierarchical regression analysis	MH measures: Depression measured by BDI-21 (RVT) SS measure: PSS measured by MSPSS from different sources (RVT)	While both higher ADL functioning and higher PSS had significant associations with lower depression (main effect model) (p<0.001), there was no interaction of PSS in the association between ADL impairment and depression (p>0.05), rejecting the stress-buffering theory of SS.

Ref., Setting, Main Objective	N	Sample, Sampling	Design and Methods	Measures of SS and MH	Key Findings
Mechakra-Tahiri et al. (2009) Canada M To assess differences in the associations between social relationships and depression across urban and rural settings.	2670	Community dwelling older persons aged 65+, 60% women Random sampling RR= 66%	XS Regression analysis	MH measure: ESA– Q measuring 9 associated symptoms of depression (RVT) SS measure: Three questions on SS (availability of SS resources, emotional SS and instrumental SS) and overall SS score	There was a significant association between overall SS score of total population and their depression in multivariate logistic regression model (OR=0.64, 95% CI= 0.47-0.88).
Lien et al. (2009) Taiwan M To detect the relationships of uncertainty, SS and psychological adjustment during the period of the surgery	43	Older cancer patients aged 65+ who were undergoing surgery, 93% men Purposive sampling RR=73%	pre-/post descriptive design (longitudinal correlative study 10-14 days) Bivariate analysis (before-after analysis using Pearson correlation)	MH measure: Anxiety and depression measured by Chinese version of HADS (RVT) SS measure: PSS measured by Interpersonal Support Evaluation List (RVT)	There was a positive correlation between anxiety and SS after surgery, so that with increasing SS, anxiety was also increased ($r = 0.30$, $p < 0.05$). There was no significant correlation between SS and depression neither before nor after surgery. Healthcare professionals were the main providers of information; while spouses, family members and friends provided mostly emotional support. Spouse is the main provider of SS in the social network.
Rueda &Artazcoz (2009) Spain M To analyze the social determinants of health in Catalonia, using a combined framework of socio-economic position, family roles and SS.	2597	Older people 65-85 years old of a representative sample of the non-institutionalised population of Catalonia- Spain 57% women Random sampling	XS Hierarchical regression analysis	MH measure: GHQ-12 to detect psychiatric disorders (RVT) SS measure: Reduced version of Duke SS Scale (measuring confidant and affective SS) (RVT)	Confidant SS was negatively associated with poor MH in both sexes (Men: OR=0.92, 95% CI=0.86-0.98, $p<0.01$, Women: OR=0.95, 95% CI=0.91-0.99, $p<0.05$), whereas affective SS was only negatively associated with poor MH status of women (Women: OR=0.89, 95% CI=0.83-0.96, $p<0.01$).
Cruza-Guet et al. (2008) USA M/B To test five theoretical models (including the main and buffering effects of SS) for explanations regarding the efficacy of naturally exchanged SS	273	Community-dwelling Hispanic elders aged 70+ living in a Miami, Florida Neighbourhood, 59% female Random clustering	XS Hierarchical regression analysis	MH measure: A composite score of anxiety and depressive measured by STAI and CES-D respectively (both RVT) SS measure: Frequency of RSS and satisfaction with RSS in the forms of informational tangible and emotional SS (RVT)	In the main-effects model, satisfaction with RSS was associated with lower psychological disorders, whereas frequency of RSS was unexpectedly associated with heightened psychological disorders. Hispanic elders who receive SS in the form of informational SS, despite tangible and emotional support, exhibited higher levels of psychological disorders. Neither frequency of RSS nor did satisfaction with RSS buffer the noxious effects of financial strain on psychological disorders.

Ref., Setting, Main Objective	N	Sample, Sampling	Design and Methods	Measures of SS and MH	Key Findings
Thygesen et al. (2008) Norway M To investigate the influence of risk factors and personal resources on perceived psychological distress	214	Elderly aged 75+ receiving home nursing care in 7 municipalities in southern Norway, 70% female Selected randomly RR=65%	XS Regression analysis	MH measures: GHQ-30 cut off 4+ to detect psychiatric disorders (RVT) SS measure: PSS measured by revised SPS (RVT)	No significant association between SPS and psychological distress was found (OR= 0.006, p>0.05). Of other covariates in the multivariate analysis sense of coherence, education and subjective health complaints were factors that were significantly related to psychological distress
Pasha et al. (2007) Iran M To compare general health and SS of community-resident older people with those of institutionalised older people	100	50 institutionalised (random selection) and 50 community resident older people (convenient sampling) Aged 65+ years, Same proportion of men and women	XS Bivariate analysis	MH measure : GHQ-28 to detect psychiatric disorders (RVT) SS measure: SS Philips Questionnaire (RVT)	SS was correlated with better MH in both community residents and institutionalised people. Community residents reported significantly better MH and higher SS compared to institutionalised people.
Koosheshi (2007) Iran M To investigate the relationship between living arrangements, SS and health of older people	526	Community resident older people 60+ years old	XS Regression Analysis	MH measure: GHQ-12 to detect psychiatric disorders (RVT) SS measure: Received emotional and instrumental SS in the last 1 year, developed by the author	Neither emotional nor instrumental support had direct associations with MH. While older men received SS from their wife more than other sources, the main source of SS for older women was their children
Wong et al. (2007) USA M To examine whether SS is positively related to psychological well-being.	200	Self-identified older Chinese and Koreans aged 65+, 56% women convenience sample RR= 75%	XS Regression analysis	MH measure: Overall psychological well-being measured by MHI-17 (domains: depression, anxiety and positive affect) SS measure: RSS (financial, information/advice, emotional/companionship and language) measured by a self developed 30-item questionnaire (RVT)	Having more emotional/companionship support significantly contributed to better overall psychological well-being less depression and higher positive affect. Those who had less financial support were more likely to be anxious. Language support and information/advice support were not associated with any domain of psychological well-being.
Leung et al. (2007) Taiwan M/B To investigate how SS and family functioning affect MH, and to examine the buffering effects of support in the presence of health stressors.	507	Elderly 65+ years old in industrial city or a rural community in northern Taiwan, 63% male Cluster random	XS Hierarchical regression analysis	MH measure: Depression and anxiety measured by Chinese version of SCL-90-R (RVT) SS measure: PSS (instrumental and emotional) measured by SSRS (RVT)	Instrumental support had neither main effect nor buffering effect on depression and anxiety. Emotional support had significant main effects on both depression and anxiety. However, emotional support modified the stress of cognitive impairment on depression only but not on anxiety.

Ref., Setting, Main Objective	N	Sample, Sampling	Design and Methods	Measures of SS and MH	Key Findings
Han et al. (2007) USA M/B To examine the relationships among acculturative stress, SS, and depression also examining main and buffering effect of SS	205	Elderly Korean aged 60+ immigrants in the Baltimore area, 63% Female Selected randomly from a sampling frame RR=61%	Secondary research of XS Hierarchical regression analysis	MH measure: Depression measured by KDSKA (RVT) SS measure: Structural SS (network size and satisfaction with the support network resources available) and PSS measured by Korean-translated PRQ (part 1 and part 2) (RVT)	Lower PSS were associated with higher depression, whereas network size and satisfaction with support were not. Neither structural SS nor PSS buffer the noxious effects of acculturative stress on depression in the sample of Korean elderly immigrants. Adult children were found to be the main source of support utilized by elders regardless of the type of need, even when the elder had a living spouse. Spouses were the next common source of support.

Abbreviations: Social Support (SS); Mental Health (MH); Main or Buffering Effect (M, M/B); Sample Size (N); Perceived social support(PSS); Received social support(RSS); Reliability and validity tested (RVT); Cross-sectional (XS); General Health Questionnaire (GHQ); Social Provisions Scale (SPS); Personal Resource Questionnaire (PRQ); Composite International Diagnostic Interview 1.1 (CIDI 1.1); Hospital Anxiety and Depression Scale (HADS); Centre for Epidemiological Studies–Depression Scale (CES-D); Spielberger State Trait Anxiety Inventory (STAI); Brief Symptom Inventory (BSI); SS Questionnaire–Short Form (SSQSR); Symptom Checklist 90-R (SCL-90-R); SS Rating Scale (SSRS); Mental Health Inventory (MHI); Geriatric Depression Scale (GDS); Multidimensional Scale of Perceived Social Support (MSPSS); Kim Depression Scale for Korean Americans (KDSKA); Activities of Daily Living (ADL); Beck Depression Inventory (BDI); Ageing, Stress, and Health (ASH) study; Etude de Sante´ des Aine´s study questionnaire (ESA-Q)

Studies included reported on research undertaken in 10 countries. In 12 studies, as expected, women predominated. The participants in 14 studies were household community dwelling older people with no particular diagnosed diseases. Others were older people who were receiving home nursing (n=3) or were living in nursing homes (n=1).

Most studies (n=16) used a cross-sectional methodology and only two studies were conducted longitudinally (Lien, Lin, Kuo & Chen, 2009; Bierman & Statland, 2010). Conceptualisation and measurement of social support and mental health differed in most of the studies. Assessment instruments in many of the studies had poor or unknown validity and reliability, particularly for social support. Another limitation was the small sample size in most studies. This may have had limited statistical power to detect associations, particularly when studies aim to identify interaction effects (Smith & Day, 1984), as did eight studies in this review. In addition, many of the studies had limited external validity, because of using convenience sampling rather than population based random sampling method or exclusion of some groups of the older population such as those with psychiatric disorders. These methodological problems, may limit the validity of the results of the studies reported below.

Main (direct) associations between social support and mental health

Of the 18 studies, 14 examined the association between perceived social support and mental health and six studies examined the association between received social support and mental health. Thus, two studies (Rueda &Artazcoz, 2009; Cruza-Guet, Spokane, Caskie, Brown & Szapocznik, 2008) measured both dimensions. Moreover, two studies (Jawad, Sibai & Chaaya, 2009; Han, Kim, Lee, Pistulka and Kim, 2007) also investigated structural aspects of social support. Because some studies examined the relationship between more than one dimension/aspect of social support and/or more than one measure of mental health there

were in total 40 relevant analyses. Of the 40 analyses, 23, 14 and 3 respectively, examined the associations between perceived, received and structural social support and mental health. Of the types (functions) of social support, emotional support was the most researched type (n=8) and instrumental support was the second popular type measured (n=6); other types were rarely investigated.

The results of the associations between social support and mental health provided below are based on only statistical significance, although it was preferable to report also some quantitative results such as Odds Ratios (OR) and Confidence Intervals (CIs). This is because only a few studies provided these data, or provided these only for significant associations. Nevertheless, where available these data were extracted and added to Table 1.

Of 23 analyses examining perceived social support, 11 showed a significant association (Nemeroff, Midlarsky, Meyer & Source, 2010; Olutoyin Oni, 2010; Jawad et al., 2009; Bozo, Toksabay & Kürüm, 2009; Cruza-Guet et al., 2008; Han et al., 2007; Mechakra-Tahiri, Zunzunegui, Préville & Dubé, 2009), and nine a non-significant association (Bierman & Statland, 2010; Thygesen, Saevareida, Lindstromb & Engedal, 2008). Additionally, one analysis was significant for women only (Rueda &Artazcoz, 2009) and one for men only (Alexandrino-Silva, Ferraz Alves, Fernando, Wang & Andrade, 2011). All these analyses were in the expected direction (negative associations) but the study of Lien et al. (2009) found a significant- but positive- association between social support and anxiety (i.e. those with more support were more anxious). Leung, Chen, Lue & Hsu's (2007) study found various results depending on the type of social support, there were significant associations between emotional support and depression and anxiety, but associations with instrumental support were not significant.

Of 14 analyses examining the associations between received support and mental health, eight found significant negative associations (Lee & Dunkle, 2010; Safezadeh, 2009; Rueda & Artazcoz, 2009), four no significant associations and two found significant positive associations (Cruza-Guet et al., 2008). Wong, Yoo and Stewart (2007) and Cruza-Guet et al. (2008) found varying results depending on the outcome measure used and the type of social support.

Considering results by studies rather than analyses, we found that of 14 studies examining perceived support, nine studies found only significant associations with mental health, two studies no significant associations and three studies reported mixed results. Of the six studies examining received support, three found significant associations with mental health, one study found no significant association and two studies reported mixed results. In short, results of analyses using measures of received social support appear more diverse than those using perceived social support.

With regard to the associations between types (functions) of social support and mental health, the results showed a relatively strong association between emotional support and mental health. Six of eight analyses (Lee & Dunkle, 2010; Rueda & Artazcoz, 2009; Cruza-Guet et al., 2008; Wong et al., 2007, Leung et al., 2007) found a significant association.

However, the evidence for an association between instrumental support (particularly perceived instrumental support) and depression is comparatively weak - only two out of six analyses (Lee & Dunkle, 2010; Cruza-Guet et al., 2008) showed a significant association. Other types of social support (n=4) including informational, financial and language support showed varying associations with mental health. Some differences by outcome are also reported in some studies. For example, Wong et al. (2007) found that emotional social support was significantly associated with depression and overall mental health score but not with anxiety, while financial social support was associated with anxiety only. In summary, evidence for an association between emotional social support and mental health appears stronger than evidence for associations between instrumental or other types of social support.

Regarding associations between structural aspects of social support and mental health, Han et al. (2007) found no significant relationship between the size of support networks and depression. Jawad et al. (2009) found that having more children was associated with a lower risk of depression but no significant association was found between presence of a spouse and depression.

In summary, the results reported here from studies considering the main effects of social support on mental health are mixed. Overall, of the 40 analyses performed in the 18 studies, 22 showed a significant protective association (including one only in men and one only in women), 15 analyses found no significant associations and three analyses found a significant but positive association between social support and worse mental health. Consequently, these results lend some support to the hypothesis of a protective main effect of support, but are far from conclusive.

Stress-buffering associations between social support and mental health

Overall, eight studies examined the relationships between life stress, social support, and mental distress. Some of these studies examined the buffering effect of various types of social support on different stressors and mental health measures so overall 18 analyses were reported. Most of these studies (n=6) used hierarchical multiple regression analysis. The studies considered various types of stressors; either a specific type of life stress such as financial stress (Cruza-Guet et al., 2008), or general stresses of life (Nemeroff et al., 2010) measured by scales. Health related stressors including limitations in ADL functioning, cognitive impairment and chronic diseases received the most attention (Bierman & Statland, 2010; Bozo et al., 2009; Leung et al., 2007). The results indicated that all stressors measured in these studies were significantly (and positively) associated with mental health, except the general stressors of life measured in Nemeroff et al. (2010)'s study.

The studies that examined the stress-buffering effect model, hypothesized that social support would moderate the deleterious effects of life stresses on mental health. However, of 18 analyses only two found a significant moderating role for social support. Leung et al. (2007) examined the buffering effects of perceived instrumental and emotional support in the presence of health stressors (cognitive impairment and chronic diseases) on depression

and anxiety. Results suggested a possible buffering effect of emotional support on depression in the presence of cognitive impairment but other interactions examined were not statistically significant. Lee and Dunkle (2010) found that received emotional support from adult children, but not instrumental support, had a powerful buffering effect on the relationship between general stresses of life and depressive symptoms.

Role of gender and sources of support in associations between social support and mental health

The studies considered in this review shed little light on possible gender differences in the association between social support and mental health status. Only two studies in this review examined gender differences. Alexandrino-Silva et al. (2011) found that perceived lack of social support was associated with depression among men, but not women. The authors attributed this finding to a differential effect of widowhood, as widowers may be more vulnerable than widows to a lack of spousal support. Rueda and Artazcoz (2009), by contrast, consistent with the wider literature found that perceived emotional support was associated with mental health status among women but not men. In short, evidence on gender differences in the associations between social support and mental health is limited and not consistent.

Additionally, only a few studies considered whether sources of perceived or received support were associated with mental health. In a study from Lebanon (Jawad et al., 2009) no significant association was found between presence of a spouse and depression, while having more children was found to be associated with lower risks of depression. The studies of Alexandrino-Silva et al. (2011) in Brazil and Koosheshi (2007) found that while women tend to have a close confiding relationship with children, men usually depend more on their wives for this kind of support. In Western countries, support from friends may also have a considerable influence on mental health. Olutoyin Oni (2010) found that in Canada friend support was a better predictor of depression among older people than family support. However, this may not be the case for all Western societies. Consequently, the inconsistent evidence may suggest that the importance of support of a specific source may vary by gender, setting and culture.

Discussion of the systematic review

Overall, the studies included in this review provide evidence, albeit not wholly consistent, that social support has a moderate main, and a weak stress buffering effect on the mental health of older people. This conclusion differs from that reached in most of the old and new review studies, several of which have argued for a stronger association between social support and health. Three major reviews of the literature published in the1970s (Kaplan et al., 1977; Cassel, 1976; Cobb, 1976), for example, suggested that there was a significant direct or modifying effect of social support on health and emphasized that much or most of the beneficial health effects of social relationships are due to their buffering properties in the presence of stress (Bowling, 1994). Additionally, Schwarzer and Leppin (1989) in their meta-analysis of 93 studies investigating the buffering hypothesis concluded that social support was the most important factor in modifying the health effects of hardship. A number of

more recent review studies have also reported that available evidence consistently supports a link between social support and health outcomes (Lakey & Orehek, 2011; Brewin, Andrews & Valentine, 2000; Finch, Okun, Pool & Ruehlman, 1999). However, there are also other reviews that have failed to find consistent significant main effects (George, 1989; Antonucci, 1985) or support for the buffering potential (Alloway & Bebbington, 1987) of social support on mental health. The result of our review of the six review articles, as presented above, showed generally moderate evidence to support the notion that social support has a protective effect on mental health.

The main difference between this review and the mentioned reviews is on the focus here on the older population. The imbalance between social support needs of older people and what they receive may explain the approximately weaker evidence for an association of social support and mental health in our review compared to other more general reviews. According to Contingent Theory, the effects of social support are contingent upon people's pre-existing needs (Cruza-Guet et al., 2008). Cruza-Guet et al. (2008) suggested that the benefits of receiving social support may only be evident when congruency between needs and amount of social support received is achieved. Another relevant factor is the small numbers of older people included in some studies (11 of 18 studies had sample sizes of less than 300), which may result in less statistical power to detect associations.

As noted earlier, evidence from the review to support the stress buffering role of social support was weak. Possibly this partly reflects the indicators of stressors used. Jawad et al. (2009) and Cruza-Guet et al. (2008), for example, used measures such as familial conflict or financial problems, while it has been suggested that health decline, for instance, is a more important stressor predicting depression in old age (Brilman & Ormel, 2001; Chong et al., 2001). With regard to the types of social support, stronger evidence was found for the association of emotional than instrumental or other types of social support with depression in this review. It has been suggested that in cross-sectional studies, the relationship between instrumental support and psychological symptoms may be confounded by the health status of participants. Ill people may receive more instrumental support than healthy subjects (Leung et al., 2007). Regarding the lack of a significant association between network size and depression, it has been discussed that network size alone is not a useful indicator of support and at least other quantitative aspects, such as frequency of contact with network members should also be considered (Han et al., 2007). In contrast to the expected negative association between social support and poor mental health, a number of studies in this review found a positive association. It has been suggested that ill-timed, unwanted, ineffective or excessive support may actually be stressful (Krause & Rook, 2003). This hypothesis is similar to the 'reverse buffering' effect that suggested the presence of social support does not protect from stress but actually exacerbates the trauma experience (Prati & Pietrantoni, 2010). However, most of evidence seems to point to helpful rather than harmful effects of social support (Prati & Pietrantoni, 2010).

Our review study is subject to a number of limitations that should be taken into account in interpretation of the results of this review study. Only one review author screened abstracts for relevancy and determined eligibility and extracted data which may be biased by the

reviewer. Only a few review and original studies were included with a high level of diversity, making the final estimation of the influence of social support on mental health of older people inadequate and meta-analyses was not performed. This review only included original studies published since 2007 and only used databases in English.

Conclusion

Diversity in the characteristics of the studies included in this systematic review, in addition to limitations in their size and methodology, as discussed above, makes comparisons and the estimation of the effects of social support on health complicated and the interpretation of their findings difficult. Nevertheless, overall at least a moderate importance of social support for mental health of older people was demonstrated in this study. Our review highlights the following significant gaps in the social support and mental health literature for future research:

- Studies of associations among older people are sparse.
- Most research to date has been conducted in Western countries. Studies need to be conducted across other cultures and geographic boundaries.
- Few studies measured the complex concept of social support comprehensively by its all dimensions and aspects and at the same time also examined its main and buffering effects on mental health. The complexity of social support theories should be matched by the instruments developed and piloted appropriately for each context.
- The role of structural aspects of social support in mental health wellbeing is less researched.
- The evidence on gender differences in the association between social support and mental health is limited and inconclusive.
- The role of different sources of social support in relationships between social support and mental health needs further investigation.
- Studies with prospective research design are sparse. Also, intervention studies are needed to investigate the effectiveness of social support on mental health.

Funding: This work is a part of a PhD thesis which was funded by Iran's Ministry of Health and partly supported by Tehran University of Medical Sciences (TUMS)

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Ayete-Nyampong, S., (2014). *A Study of pastoral care of the elderly in Africa: An interdisciplinary approach with focus on Ghana*. Bloomington, IN: Author House, 279pp. ISBN: 978-1-4969-8909-3

Reviewed by Emem Omokaro[1]

The focus of *A Study of Pastoral care of the elderly in Africa: An interdisciplinary approach with focus on Ghana* is on the development of pastoral care models as alternative support systems to enhance the status and wellbeing of the elderly in Africa and Ghana in particular. Written by Samuel Ayete-Nyampong, the book examines the implications of demographic trends, the converging issues of industrialization, urbanization, massive rural urban migration in Africa and their demands and burdens which make traditional family care for the elderly not adequate and sustainable. Reverend Dr. Samuel Ayete- Nyampong (PhD) is a Minister of the Presbyterian Church of Ghana where he served as the Chairman of Presbyterian National Committee on Ageing in Ghana and Pastoral Counselling. He also served as Adjunct lecturer of Pastoral Care and Counselling at the Central University College in Ghana. He is the President of African Association of Pastoral Studies and Counselling (AAPSC).

The book promotes the integration of the academic discipline of practical theology with pastoral care as a vocation for the community of Christians within the context of cross-cultural inter-church exchanges of resources, for the mutual benefits of the elderly. With increasing age and longevity, the risk of chronic diseases rises along with age related disabilities and dependency, clearly making the need for long-term care an increasingly vital psycho-social, economic, and health concern as the African population ages. The hope is to create awareness at both statutory and non-statutory levels of the need to develop alternative support systems to enhance the status and wellbeing of the elderly on the African continent.

The author's comprehensive interrogation of the cross-cultural applicability of theoretical perspectives on ageing and care models, accounts for the realistic evaluation of peculiar local and cultural challenges of ageing in Africa in contrast to situations in developed countries with Britain as case study. The elaborate review of literature widens the scope of

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discussion for cross-cultural benefits enabling the development of care models which emphasise community as the context within which pastoral care can be effectively practiced in Africa. With interdisciplinary and multi-sectoral approach, each chapter builds a precept for the development of pastoral care models within the context of community as an alternate support system.

The book's procedural construction of appropriate models for pastoral care and the context within which to apply appropriate pastoral methodology is guided by the synthesis of theoretical insights from John Pattons' communal contextual paradigm and John Fowler's faith development theory. 'Older persons' are defined by the chronological age of 65 years and pastoral care as a holistic helping relationship between Christians and their recipients. The target benefactors of pastoral care are the so called Mainline Churches excluding Pentecostal and Independent African Churches.

The book presents 11 chapters. Every chapter title is preceded by a definition of objectives and review of theoretical perspective with in-depth examination of cross-cultural contextual relevance. The introductory chapter sketches the subject of ageing, its process and socio-economic health, cultural and spiritual implications. It sets out the statement of problem, limitation of study, definition of terms, methodology and objectives, relating the content as the culmination of an original research on a comparative study of the general situation of the elderly in Britain and Ghana.

The first four chapters namely, 'Pastoral care of the ageing population in Africa'; 'A sociological profile of the elderly in Africa'; 'Social change and its effects on the elderly in Africa', and 'Health and medical problems of elderly people in Ghana', discuss the situation of the African elderly; the socio-cultural changes which have rendered family caring tradition vulnerable**.** They convey the inability of the traditional system of extended families to sustain a continuous provision of care to the elderly, thereby serving the contextual framework for the design of 'pastoral care modules'. The implication of increasing absolute number of the elderly in Africa, the challenges faced by the elderly and the inadequacies of the family system raise the crucial questions about what can be done to support the elderly people in Africa society and to engage them in continuing production? ; what insight can be gleaned from other countries to enrich the African traditional model? and can churches initiate solutions to the problem of ageing?. Answers to these questions preoccupy the author as he searches for a conceptual and theoretical framework. The analysis of a conceptual framework of 'Pastoral Care' is contained within the presentation of a brief history of 'Pastoral Care' variations and their suggestions of care model in Chapter one. Jesus Christ is posited as a model of care with Christology tradition and the evolution of tradition of pastoral care is traced from reformation penitential discipline and public penance to genuine pastoral care of the individual need and his community. It incorporates the general view of 'Pastoral Care' with the 'Shepherd Model'; a form of proclamation of the gospel aimed at conversion and spiritual discipline and the ethical model of the good person. The chapters relate a multi-disciplinary, multi-sectoral perspective of pastoral care which integrates psychological, spiritual, sociological and political dimension to seeking solution to human problems. They relate the contribution of social change in the formation

of the new image of the elderly. The pastoral care model recognises the whole dimension of human living - social, environment, economic, biological and psychological utilising the holistic approach of World Health Organization (WHO). The role of the church is highlighted in collaboration with other statutory or non-statutory institution in providing pastoral care.

Chapters five to eight on 'Contemporary care of the elderly in Ghana', 'A general survey of older persons in British Society: A study of western institution', 'A comparative structure of pastoral care paradigm: Western and African', and 'A theoretical framework for contextualization of pastoral care of the elderly in Ghana', examine the provision of pastoral care in some Protestant and Catholic churches and the tension between Christian theology, African traditional healing and biomedical practice. While medical practice is accepted and trusted, African traditional healing is deemed unchristian. Also related are limitations of pastoral care programmes and services both from the Presbyterian and the Catholic Churches. A comparative analysis of the socio-cultural milieu in Britain and Ghana which unearth similarities and differences provide the insights from the caring models of Britain. New approaches draw from these insights for the construction of a pastoral care model for Ghana within the framework of Patton's and Fowler's theories of Communal Contextualization and development of Faith. The former expressed analogically to reflect care as reciprocity of God's kindness within community and the latter as a people's way of finding coherence in and giving meaning to the multiple forces and relations that make up our lives.

The final chapters on 'Pastoral ministry and the elderly in Ghana: A new paradigm of care for Africa', 'Gerontological education as preparation for Ministry with the elderly in Africa', and 'The way forward for African pastoral care of the elderly', aim to look at the way forward for appropriate and contextual African pastoral care which will provide sustainable and comprehensive community care for the elderly with particular emphasis on Ghana. The chapters discuss the benefits of integrating multi-sectoral engagements, including faith based and formal long-term care provisions, and the implications of these for the church. Specific types of community care services and systems are examined as well as the challenges of leadership and skilled personnel for long term-care assessment and care provisions. Capacity building focusing on gerontological education is endorsed as a major agenda towards creating directions, principles, and holistic and sustainable systems and care services.

A study of pastoral care of the elderly in Africa: An interdisciplinary approach with focus on Ghana is multidisciplinary and therefore intended for readers from multiple backgrounds including clergies, parishioners, policy makers, practitioners in the field of ageing and students of sociology, development, gerontology and theology. It is also hopefully for use for social workers, care givers and general interest readers.

Lodge, C., Carnell, E. & Coleman, M. (2016). *The new age of ageing: How society need to change*. Bristol: Policy Press, 224 pp. ISBN: 978-1447-326830

Reviewed by Mario Garrett[1]

The New Age of Ageing: How society needs to change by Caroline Lodge, Eileen Carnell and Marianne Coleman has already received many reviews. These reviews address the central idea of this book that society (mis)treats older adults and diminishes them. The book is nicely peppered with anecdotal examples throughout. Each narrative highlights the personal feelings across a comprehensive array of issues. From physical issues, to work, housing, work, medical needs and consumerism, the book explores how older adults are undervalued, ignored and discarded. In the chapter titled "How society makes people old" the authors drive the idea that there is a collusion in the process of ageing. A self-fulfilling prophecy.

None of these arguments are necessarily wrong, nor are these ideas necessarily new. Despite their assertion that "We do not find this view [age-inclusive] comprehensively explored elsewhere" (p.7) such an approach has a long history. By exploring this history, we can identify answers that the authors of this book overlook.

After Simone de Beauvoir's 1949 most famous work *The Second Sex*, came her 1970 book on ageing *The Coming of Age* which discusses how society rejects older adults. Using examples of famous artists to illustrate the productivity of older adults. It is important to see the parallels between the ideas nurtured in the second wave of feminism—where Beauvoir outlines the ways in which women are perceived as "other" in a patriarchal society, second to men—and how older adults become the "other" second to younger adults. This connection, from feminism to ageism, was also favoured by Betty Friedan, a renowned feminist who in later life turned her attention to ageing. The theoretical parallels between ageism and feminism remain with sociology of ageing to this day. So, it is only fitting that three other women follow the same feminist parallels. And they explicitly make this connect in the section on "Feminism and Ageism: what can we learn?" But they falter in their pursuit of an answer, it is still "…middle-class, rich people who want to have a say." (p. 247).

Each chapter in *The New Age of Ageing* is used to highlight the dissonance between what is expected of older adults and older adults' own experiences. The authors have practical

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advice at the end of each chapter on "How do we get there?" and "What needs to be changed?" The question that eludes these analyses is how come some individuals thrive despite such harsh societal restrictions? What they miss in their analyses is that older adults are varied. For the past 50 years, gerontology has tried to answer this question: Does society discard older people and do older adults acquiesce? *The New Age of Ageing*_does venture superficially into the theory of disengagement and role continuity, but falls short in reflecting the latest theoretical interpretations.

As early as 1959, when Eric Erikson developed the first personality theory that extends to old age—remember that Freud considered older adults unable to learn and therefore not likely to benefit from psychotherapy—there was an appreciation of how society deals with older adults. Starting with the theory of disengagement which was developed by Elaine Cumming and Warren Earl Henry in their 1961 book *Growing Old*. Which argued that there is a mutual separation with older adults distancing themselves from society as they age while society in turn pushes them away. This view was challenged that same year 1961 by Robert Havighurst - and later by Bernice Neugarten - arguing for Activity Theory that old age is no different from middle age and that staying engaged contributes to successful aging. Very much the argument in *The New Age of Ageing*. Then in 1968 Robert Atchley elaborated on this idea that there is continuity in life, describing this theory in the 1989 book *A Continuity Theory of Normal Aging.* Given this historical context, it is not surprising to see the resurfacing of the same "new" arguments being proposed.

The discipline of gerontology has been around since 1903 - named by the Russian immunologist Ilya Ilyich Metchnikoff. We have over a century of research. *The New Age of Ageing* overlooks the still evolving psychological theories from: Learning (e.g., Watson, Skinner, Bandura); Cognitive Theories (e.g., Piaget, Kohlberg); Ecological & Systems (e.g., Bronfenbrenner, Lawton & Nahemow); and the latest Lifespan (e.g., Baltes). But then this is not an academic book, it is a discussion piece. This is both the strength and the weakness of *The New Age of Ageing.* What this book does very well is to highlight the disparities between our perceptions, societal expectations and real life experiences.

This is a well written comprehensive book that covers topics of general interest in a way that argues for change. How much this is preaching to the converted remains to be seen. How to bring about change is opaque. Education, policy changes and "must", "should", and "ought". The straightforward answers to redress these inequities is engulfed by whether we have the political will to enforce any change.

In the chapter on "The Best Bits" the authors came close to doing what they recommend. They show us how individuals change and what is so great about ageing using real life examples. This chapter and subsequent chapters on "Wiser Together", "We're Still Here", and "Our Vision for the Future" came close to talking about what is new in ageing. It needs more: Sexual, physical, economic, humour, reminiscing. Once the academic shackles dissolve what we are left with is an unencumbered sense of humanity that *The New Age of Ageing* so beautifully attempts to impart. It is patchy but they succeed in parts.

The problem is that you cannot understand all of ageing from an experiential perspective, you need to study it as a discipline. You cannot learn about cancer from experiencing cancer or talking to cancer victims. You have to appreciate that there is great variance among older adults. In fact, that is one of the distinguishing features of getting old. It is only by recognizing this fact can you then understand both the frailty and the strengths of older adults. As older adults are the richest they can also be the poorest, the healthiest and most privileged and vulnerable and weak. Creative geniuses and dullards. This diversity is what makes ageing so special. As we can find exceptional vigorous older adults, we can also find exceptional frail older adults. To understand this, you need to approach it through the discipline of gerontology. Collective analyses just brings the discussion into disarray. This book should have focused on the later chapters. This is where we can see what is "new" in ageing.

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