



AGEING OF HEALTH CARE IN OLD WIDOWS IN RURAL KARNATAKA: A STUDY OF KOPPAL

DISTRICT

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Abstract

The proportion and numbers of aged are significantly increasing worldwide. They are living with multiple hardships but their health care is becoming a major challenge. It is of a foremost concern as ageing is accompanied by multiple illnesses and physical ailments, thereby making aged people more prone to live with health difficulties. In this context, the present paper focuses upon the main objective of looking at the health conditions of old widows and its access and support in the rural Karnataka. It is based on the data procured from primary field study through interviews and questionnaire. The findings reveal that due to various constraints old widows ignore their health status and consider it as being normal until they suffer from serious medical ailment. At the time of health emergency, it is the family which still determines the health situation of widows in terms of support and care. However, widows try to remain productive to the household (despite health issues) because it entails their social status in the family. The study implicates that health status of old widows or elderly in general has wider implications. It is linked to their economic and social status. A better viable and affordable health care system is a major need in current times considering the diminishing nature of primary family care.

Keywords: *Old age Widows, Health care facilities, Social bear, Economic Benefits*

I. Introduction

Most countries around the world including India are facing or in the midst of demographic ageing. In India, the share of elderly in total population is increasing. As per 2011 census, the percentage of elderly in total population is 09% and by 2050, it is expected to reach 20% of total population of the country. In such situation, India has entered the list of one of the ageing societies of world as per United Nations (UNFPA &

Help Age India, 2012). Besides a demographic concern, ageing population also implies country's struggle in handling various challenges and issues surrounding ageing phenomenon and elderly population.

The elder members of the family are normally taken care of in the family itself, especially in the traditional Indian society. Rapid socio-economic transformation in recent times has however affected the traditional role of family towards its ageing members. Gradual withering of the joint family system exposed the elders to various issues such as absence of assured and sufficient income to support themselves and loss of social role and recognition. In many cases, they are also prone to abuse, emotional neglect, lack of physical support and health difficulties.

Health care issues of aged people needs special attention as it is claimed that multiple illnesses and physical ailments often accompany ageing. In India, chronic diseases are a leading cause of death among elderly, increasingly so over the past twenty-five years. The percentage of elderly with any chronic condition was 64.8 per cent in 2011 (Alam et al., 2012). Chronic condition has multiple affects as poor health and morbidity diminish the quality of life and wellbeing of the elderly while increasing psychological distress and perception of vulnerability. This situation highlights that anxiety towards health of aging population in coming future is going to emerge as a major social challenge.

Gender is an important factor in determining the impact of an ageing population. Therefore, ageing is also a women's issue, as women tend to have greater likelihood of outliving men. For married women this implies they are outliving their husbands and living longer widowed status. As widows, they are more vulnerable and subject to various discriminations, stigma and living without a spouse means they will be living with additional problems and sufferings. Marginalization/isolation or alienation becomes part of their life, which increases as they age. Social and economic insecurity make widows to cope with their life, which emerges to be major worries when they become old.

Longer living years and lack of various security and welfare issues concerning widows or older women, in general, cannot be ignored any longer. Among others, the understanding of their health status is an important aspect that needs to be addressed as it has its implications on their living status in the family. Moreover, limited studies focusing on widow's health status or health care needs further increases special attention towards this group of elderly people.

One of the most important implications of an increasingly female older adult population in India—including variations in the extent of this trend across states—will be the prevalence of widowhood among women. Higher female life expectancies and higher average male age at first marriage are sharply increasing India's population of widowed females. Women whose husbands have died may also spend more years of their lives as widows. In 2012, for example, only 8% of Indian males aged 60 to 64 were widowed, compared with 35% of females in this age group. Among adults 80 and older, a majority of females, more than 60%, had been widowed, compared with just 27% of males (Desai, Dubey et al. 2015). This is highly significant because in many Indian communities, and particularly under traditional Hindu law, widowed women have historically suffered from social stigmatization and discrimination, although evidence exists for improvement in the

treatment of widows in the country as a whole (Kadoya and Yin 2012). Most notably, widowed females may suffer from income insecurity due to inheritance traditions that favor sons over daughters and insecurity in their living arrangements (Dey, Nambiar et al. 2012, Sathyanarayana, Kumar et al. 2014). Evidence also indicates that Indian female widows aged 60 and up suffer from morbidity due to communicable and non-communicable diseases at a significantly higher rate—13% more—than do male widowers in the same age group. Despite this, however, older female widows are also significantly less likely to engage in health care seeking behavior (Agrawal and Keshri 2014).

II. Review of literature

Among various challenges health status of old is significant considering that poor health of elderly generally constitute the second best serious issue after their economic difficulties. Studies carried out on morbidity pattern by age finds that burden of ailment is higher among old people compared to other age group and it is increasing over time (Karim, 1997; Kumari, 2001). In addition, there exist medical indifference between rural and urban as most of the geriatric care such as hospital care, elder nursing homes, recreation facilities, old age centers, etc., are present in urban areas. Such mismatch of health care system between rural and urban also points that rural olds are more vulnerable than the old living in urban areas (Mahajan & Ray, 2013). Breakdown of the joint family structure and emergence of the nuclear family due to urbanization and societal modernization in recent times also raised difficulties for the aged people. With no social security structure in place and with inadequate facilities in health care, rehabilitation and recreation, there exists a bleak present and future for the elderly (MOSPI, 2004; Singh, 2017). Most primary surveys have reported that the old in India in general and the old population in the rural areas in particular have serious health problems of physical and mental morbidities (Rajan, 2007).

Globally, women form the majority of older persons. Today, for every hundred women aged sixty or over worldwide, there are just eighty-four men and for every hundred women aged eighty or over, there are only sixty-one men. In many situations, older women are usually more vulnerable. They suffer discrimination including poor access to jobs and healthcare, subjection to abuse, denial of the right to own and inherit property and so on. But older men, particularly after retirement, may also become vulnerable due to their weaker social support networks and can also be subject to abuse, particularly financial abuse. Nevertheless, an important point for old women is that gender relations structure the entire life course, influencing access to resources and opportunities, with an impact that is both ongoing and cumulative. It implies men and women experiencing old age differently (UNFPA & Help Age India, 2012).

It is argued that economic security, good health, and adequate housing, in general, constitute fundamentals for ageing with dignity. However, the impact of gender differences and inequalities limit women to access ageing with dignity, thus hitting them hardest in old age. Due to their secondary status in society, women remain socially, economically and medically marginalized. As most women outlive their husbands they will be living a widowed status for longer years especially in India because wives are usually younger

than husbands (by 5 to 10 years or more) and the remarriage rates among them is low (Gulati & Rajan, 1999; United Nations, 2007; Gubhaju, 2008).

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In most of the northern part of India, man is the holder and controller of power in all spheres while woman live deprived status with hardly any socio-cultural recognition of entitlement rights and resources. In such socio-cultural context and in given hierarchies of power and authority, women remain at disadvantaged position in areas such as education, employment, access to medical facilities and so on. This holds true for the state of Karnataka as well largely where the current study is located. Statistics on marital status reveals that up to the age of forty-nine, married women are more in its population, but above the age of fifty years the situation is reversed. After fifty years, it is the widows outnumbering married women, with larger presence of them in the age group of sixty-five to seventy-five years. Given the magnitude of widows along with their low socioeconomic condition, it is crucial to understand their social position in family in general and their health status especially among those living in rural areas.

III. Objective of the study

The present paper is an exploratory cum descriptive research attempt on old widows living in rural area with an aim to understand their health status, accessibility to health care and social support during medical emergency besides looking at their socio-economic background.

Considering the fact that the children are seen as security provider to parents in old age, the paper also looks at the extent to which this holds good in the lives of old widows.

IV. Methodology

The study is mainly qualitative and depended upon primary field data. Three villages of Koppal District of Karnataka state was selected randomly. Forty-five widows in the age group of fifty years and above from each village (in total 135 old widows) were interviewed to know about their health situation and living status. The widows were selected from the list of widow pensioners available at the village panchayat office. Some of these interviewed women also included those who were referred by other widows. Questionnaire, interview schedule and focus group discussions were the research tools used to elicit relevant information.

V. Results and Discussion:

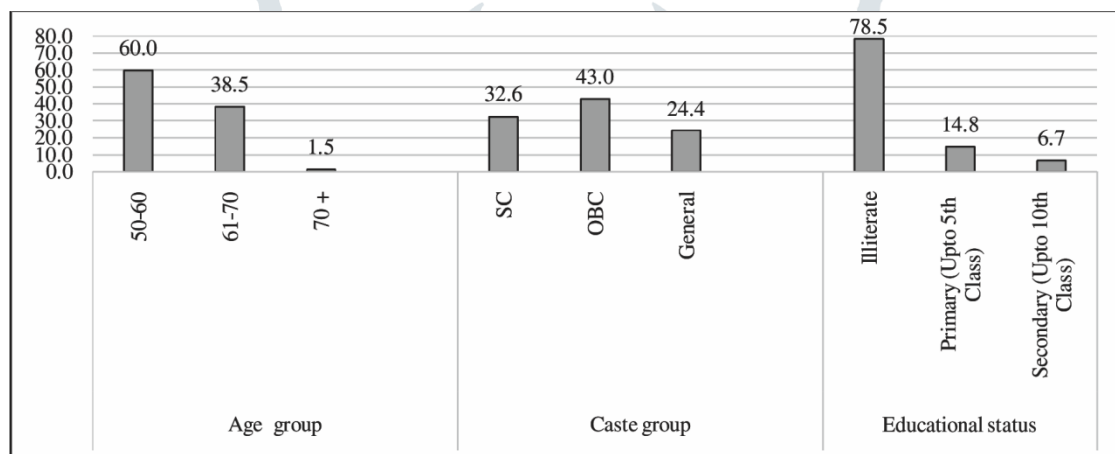
Socio-demographic profile of widows

Out of total sample, a large number of widows (60 %) belonged to fifty to sixty years. Remaining widows were in between sixty and seventy years (38.5 %). One widow was above 70 years of age. Caste composition included majority of them (43 %) being from the Other Backward Classes (OBC) category. This group mostly constituted dominant, agricultural (land-owning) and politically represented castes as well as the village functionaries and service castes.

The next major caste category was Scheduled Castes to which belonged forty four widows (32.6%). About 24 % widows belonged to upper castes of Bramins. Widows from OBC category came mostly from two villages, because in these villages it was numerically and economically dominant.

Similarly, one of the village showed more number of widows from the SC community than of other caste categories as village had more households from the SC community.

Figure 1: Socio-demographic profile of widows



Note: SC-Scheduled Caste; OBC- Other Backward Castes

Education can be an effective facilitator of social mobility besides being an inevitable requirement for survival in today's competitive world, whether rural or urban. However, it is also true that girls in the traditional Indian society continue to be discouraged in respect of schooling for socio-cultural and economic reasons. Although today, the situation of girls education has improved this was also true in the case of studied villages. In the past when today's old women were young sending girls to school was not much in the practice. Moreover, educational facilities were also quite limited or totally lacking, especially in rural areas. Even if schools existed their access were constrained due to caste and poverty considerations (Chakraborty, 2001).

In case some people could access them the opportunity was mainly for boys and not girls, which occurred due to rigid socio-cultural norms and their secondary status in the society. In such circumstances, most interviewed widows could be viewed as the victims of such gender discrimination with respect to their access to education. Hence, illiteracy (78.5%) was high among the widows (see Figure 1). Those who went school had not gone beyond the secondary level (21.5 %). Low level of widows' education show that it has

hampered their access to better resources and opportunities, coupled with lack of awareness and skills fruitful to them both in younger and older days.

In India, a woman's social identity, as well as acceptance in society, continues to be associated with her marital status. The main source of reference for a woman is her father in childhood and husband in her adult life. Remaining single is still held to be a violation of this social norm (at least in the rural society) and is supposed to result in some form of obscurity for a woman (Panda, 2005). It is an established fact that in the traditional society, age at marriage for women was very low as compared to men. Girls were married off much before they attained puberty. As evident in the study as many as sixty-three widows (47 %) got married before their puberty or at the age of fifteen years.

Among them, thirteen widows married when they were ten years old. In seventy cases (51.85%) widows marriage happened when they were in between sixteen and twenty years. Only two widows married at the age of twenty years.

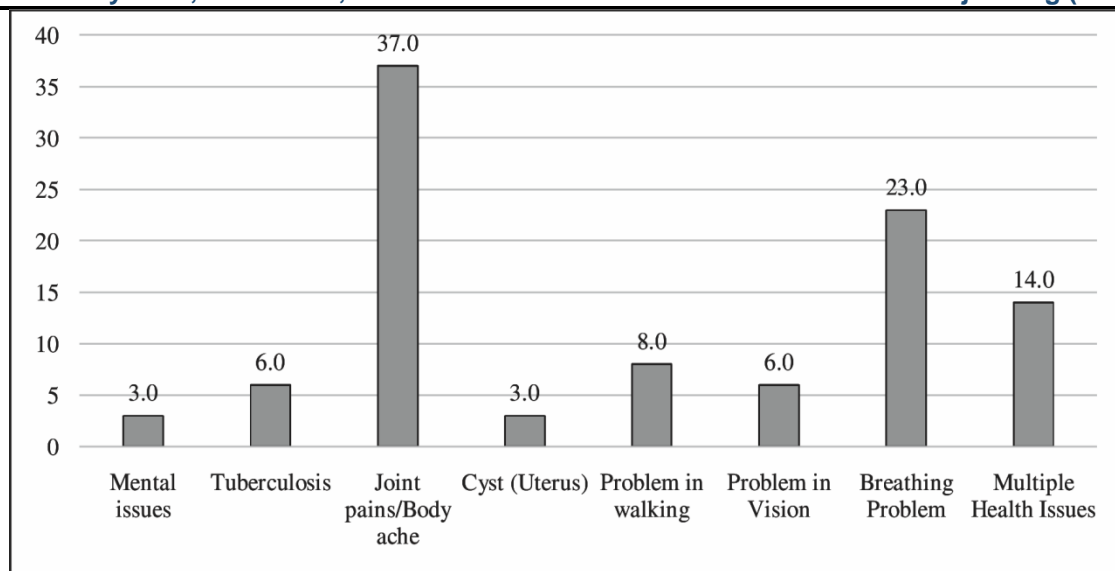
Health status, accessibility, and care:

Ageing as a natural biological process is associated with a decline of specific functional abilities. In old age, body though becomes susceptible to illnesses, yet it does not mean that ageing is synonymous with disease or illness. Criterion of 'being healthy' differs under various contexts and not only to ageing process (Panda, 2005). In the study, most widows (55 %) considered their health as being normal mainly because they do not had any major health ailment. Illnesses like fever, cold, body ache to them were normal as they get cure in short duration with timely medication. Seven widows perceived their health to be very good. This could be because they were not affected with any severe diseases and in case of minor ailments; they attend to them immediately as they hailed from relatively better economic group than other widows. Unless widows suffer from prolonged disease and continuous medicines, they consider themselves in good health.

Health problems among old widows

In order to know more about the kind of health sufferings, widows were asked to mention the ailments causing health difficulties. Only thirty-five widows mentioned about their health issues. Figure-2 shows the pattern of ailments of these widows, which mainly constituted no communicable diseases.

Figure 2: Health problems of widows



Most widows complained about joint pains and body aches (37%), followed by breathing problem stated by 23%. Complaints of poor vision and problem in walking was reported by 6% and 8% widows respectively while 3% suffered from some form of mental illness. Widows living with multiple health issues was reported by 14%. Mehrotra and Batish (2009) also observed similar results on elderly females in Ludhiana city, Punjab. Their study highlighted that many women suffered from health or physical problems. Widows especially had problems of reduced vision, dental decay, body weakness, and pain. Widows and non-widows also reported other serious diseases and ailments such as diabetes, heart problem, gastro-enteritis, indigestion, sleeplessness etc. The authors concluded that the major reasons for their ill health could be a possibility of lack of proper food, stress or lack of proper treatment and care by the family members.

Health care utilization and access to medical care

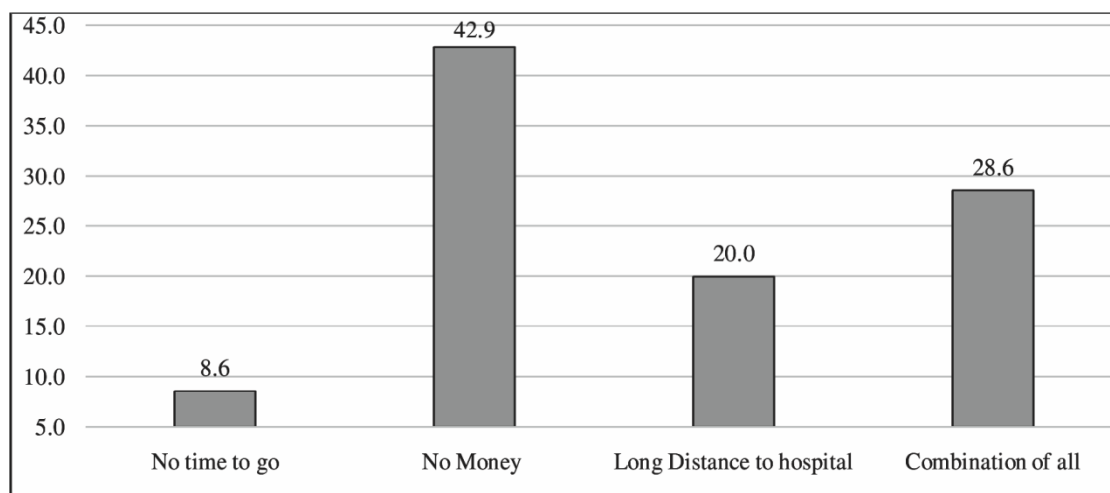
The pattern of health care utilization by the older widows in rural areas indicate not only their financial resources but also reflects the structural constraints in terms of accessing medical care and availability of healthcare providers.

In terms of medical facilities, all villages had primary health centre (PHC), to which widows went for the treatment of normal illness. Only when they were diagnosed with major illness or when referred by PHC doctor, they went to hospitals located in city/town. In two of the villages, most villagers including widows, preferred hospital run by an NGO. This NGO also initiated various other socio-welfare activities in the respective villages.

Accessing medical treatment is also a matter of affordability, and hence, when asked whether widows encounter any problems in accessing medical treatment (those who mentioned of having health problems), then their responses pointed more towards their inability to access it (see Figure 3). The most important reason for not accessing medical care by the widows is the lack of financial resources or no money reported by nearly 42.9% followed by the distance to medical centre (20%). Time constraints to visit hospitals was stated by 8.6% widows as they were depended upon family members (mainly sons) to accompany them to hospital. Sons taking out time and making a visit to hospital for their sick mothers becomes difficult. Since many widows

belonged to the household with daily wages as main household income, sons taking off for a day means loss of one day wage thus affecting monthly budget.

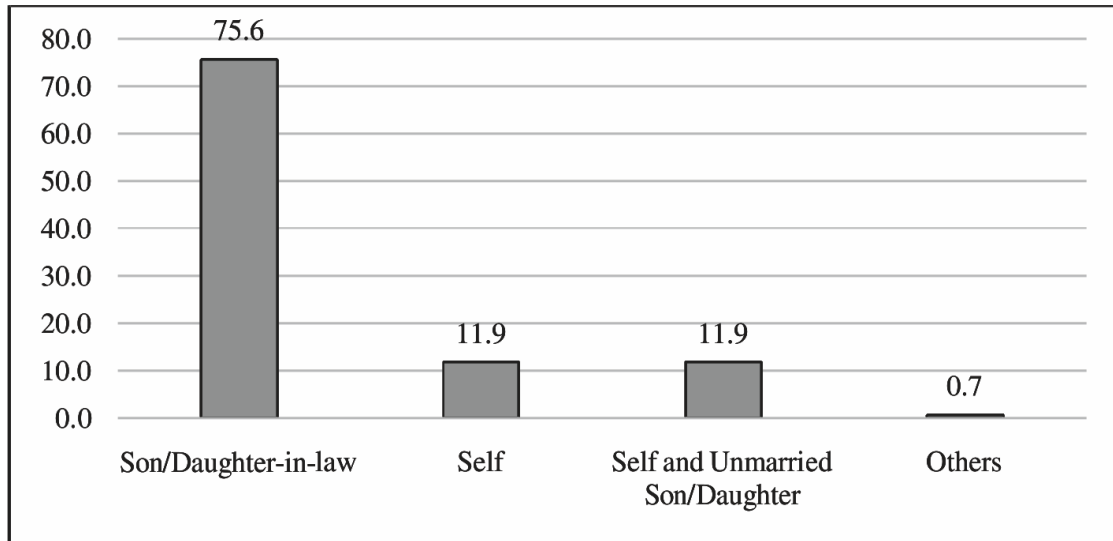
Figure 3: Reasons for not accessing timely medical care



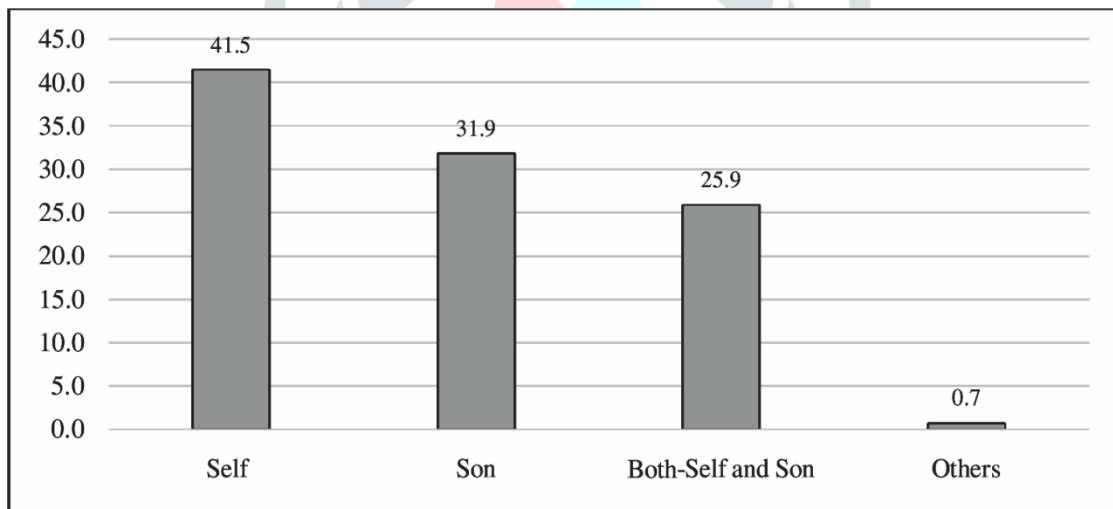
In case of 28.6% combination of reasons i.e. lack of money or/and lack of time or/and long distances to medical centers prevented widows from accessing timely care and treatment. Thus, one can state that for widows access and seeking health treatment is determined by the availability of people to help, implying their dependency on others as crucial for their own health. Additionally, it also infers treatment of widows being extended to extreme or worse situation.

Source of assistance and support during illness

Where people live in later years of life makes a significant difference to, the quality of their living. The availability of care providers during illness, disability, and emergencies, depend on living arrangements (Prakash, 1999). For an old person living far away from hospitals, falling sick can be a major problem. If old persons fall ill, they cannot go to a hospital alone as they need to be accompanied by a family member (Saxena, 2006). Around 75% widows in present study have to seek assistance and help whenever they fall sick from their married sons/daughters-in-law. Like them, some widows(11.9%) were dependent on their unmarried children for health care along with own assistance. A similar percentage of widows were not dependent on children (mainly sons) but were taking care on their own. These widows were either childless or living separately away from married sons.

Figure 4: Person assisting widows during illness

A subject closely related to medical treatment is the source of payment for the same (view Figure 5). Nearly 42% widows reported about bearing the treatment cost from own monetary savings without being dependent for it on their children. Around 26% widows were partially dependent as they took occasional assistance from their son/s. Widows depending entirely on their sons for financial payment of medical bills constituted 31.9%. Among them included women who were neither working nor getting government pension.

Figure 5: Source of financial support for medical care

The cost of the health care during old age appears to be very high and in case one avails private facilities the amount of expenditure further increases. For economically dependent aged, increasing health expenditure also implies additional economic burden on the family (UNFPA, 2017). Ability of widows in paying their own health expenses thus allows them to avoid such financial and social obligation on the family. In some cases, they rather support other family members.

VI. Summary of findings and Suggestions:

Health situation of widows suggest that though they have health issues but they try to ignore them unless it disrupts their day-to-day life. Poor health is of prime importance especially to those widows who were

employed as ill health can lead them to lose their job. Engaged in work/job is vital because it enhances their importance and social status in the family, besides adding to household income.

It is this fact that even those who do not work for wages, try to contribute effectively in any form, showing their worth to the household. Hence, one can argue that since the status and usefulness of aged are determined by their physical contribution, better health is crucial for them.

Lack of time and money also restricts widows in accessing proper treatment. The fact that the villages in which they lived also lacked better health care facilities also enabled poor health condition and delayed treatment. Thus, availability of better health facilities at an affordable cost and easy access to the people living in rural areas especially holds prime importance. This is very well addressed in the collaborative effort of the United Nations and other major international organizations working in the area of population ageing assessment of progress since the Second World Assembly on Ageing in 2002.

The study also suggests a strong association of role of family for the old. It is very much evident that in spite of internal changes occurring in the family system it is the family from whom they can seek support and care. In absence of husbands, for old widows their children remain the main source of help and care during illness-serious or otherwise.

It is also evident that the level of support and care from the family member is limited. During health needs, some of the widows' lives suggest partial dependency over their children. This status is because of their economic standing. As some widows were able to handle medical finances on their own, they limit the support to only physical care thereby evading families' expenses on them.

This is noteworthy as dependency or burden on others imply a sign of low status in the family and society in general and from which widows are trying their best to overcome. It also strengthens the standpoint of women's economic independence and its impact during adverse situations.

VII. Conclusion

All individual either men or women are bound to become old. It is a physiological phenomenon, but the problems that ageing brings in are multi-dimensional in nature. In old age, level of vulnerability to economic or health disadvantages are high compared to other population groups. Life of old widows suggests that they see some health difficulties as part of ageing process. Once, a problem disrupts their daily routine and increases their dependency they get worried and seek medical care.

However, they face hurdles of lack of time, money and assistance which influence the delay in obtaining treatment. Health condition of rural old widows also shows it depending on the inaccessibility of health care facilities at their doorstep. It is also true that widows try to remain engaged in some or the other work (economic or other) until their physical capacity allows, thus overlooking many health problems. Such behavior and negligence of old widows add to more health sufferings in due time thereby complicating the treatment and their life. This suggest that among aged population, problems of aged women especially widows

have to be treated as important as the overlap between the incidence of widowhood and ageing is rather striking among women with serious implications owing to various factors. A gender-sensitive approach towards ageing is therefore required.

In current scenario, there are inherent dimensions for widows (or others) to remain productive and active in the family in their old age, which largely depends on their health condition. Therefore, there is likelihood of many trying to conceal their health difficulties despite being not well health wise due to both economic and social repercussions. Thus, old age policy including the element of productive old-age engagement according to one's capability is significant and a present-day need.

Health care and ageing, therefore, needs a more inclusive approach. To provide care and support to this group of population the foremost step is to develop strong geriatric care facilities in urban as well as rural areas with better accessibility and affordability. 'Modicare' is touted as momentous health care scheme with an aim of making country's citizens healthy. If, it is able to address realities and need of elderly, then in near future it can become a promising health care strategy for country's ageing population.

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