ACHSM Asia-Pacific Journal of Health Management shape

RESEARCH ARTICLE

WOMEN, AGING, HEALTH AND QUALITY OF LIFE: A FRAMEWORK FOR ACTION AND POLICY FORMULATIONS

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ABSTRACT

The population of the elderly in the world will double from 2015 to 2050, reaching nearly 2.1 billion. The ageing population suffers from physical, mental health, and psychological well-being. There is no such customized policy that caters to helping the ageing population. The current examination studies ageing women, their health, and their quality of life (QoL) in India. The study tried to capture the two major and vast diversified areas.

Respondents were randomly selected from four south and north Indian states. The present investigation covered 64 cities in these four states and collected 1,100 samples. The data analysis revealed that QoL has a significant difference with different demographic factors as well as health status, Literacy level, marital status, socioeconomic status, and health status of elderly women. Most of them suffer from diabetes, hypertension, and digestive system issues, so they need regular medical care and attention. Further data analysis unearthed that most ageing women belong to middle and lower socio-economic backgrounds. The government should focus more on their financial assistance and food security and arrange proper counselling therapy for their mental health to improve their QoL.

The study contributes to the constructive and reflective handling of the health and well-being of the ageing female population. Policymakers must look into the health issues of the elderly population and make customised policies and actions that can assist the elderly population.

KEYWORDS

women, ageing, health, quality of life, random sampling, policy, India

INTRODUCTION

The elderly population could double in developing countries in the next 50 years. The situation of older women is made worse by a legacy of discrimination based on gender. Our socioeconomic system discriminates against them twice because it is ageist and sexist. The population of older women will increase much more than men. For every 1,000 elderly males, there are, correspondingly, 1,310, 1,590, 1,758, and 1,980 older women in the 65, 70, 75, and 80 age categories in India.[1] They are more susceptible to health concerns, poverty, financial instability, and dependency. However, ageing is an integral part of every woman's life cycle. Moreover, the effects of ageing vary across populations, genders and geographical regions,

revealing various diversities and influences. Ageing issues have gained prominence in national and international media forums concerned with the reported distribution of demography and population communities. Ageing is a highly individualised (relevantly and vitally personalised and essentially humane) and complex process and varies with gender and culture. [2] As we move from a primitive society to a modern society, human life expectancy has also increased; women outlive men by about five to ten years. In such a scenario, the constructive and reflective handling of issues related to their physiological health and mental well-being needs to be a priority for the government. Women 0f 60 years plus age have reached the 50% mark and now account for 54% of the older population who face significant health and financial challenges that affect the quality of their lives. [3] The explosive ageing population and quickly evolving social-economic changes (i.e., urbanisation, ladies' labour force, monetary autonomy, expanding independence, and family units, disintegrating between generational bonds, occurring, maturing issues) represents a more noteworthy test to non-industrial nations inferable from asset imperatives and continuous political responsibility towards improving quality of life. [4,5] The World Health Organization (WHO) defined Quality of Life as an "individual's perception of life in the context of culture and value system in which she or he lives and with her or his goals, standards, expectations and concerns" [6].

Over a year, the QoL decreases primarily due to access to resources that impact the material condition that cannot be reversed but is always on the decline. In India, most families live with joint families, although this culture is changing in favour of the nuclear family due to urbanisation.[7] For those that have yet to receive any financial and medical assistance from the government, then in that case, their situation will be even more difficult to survive because of their illiteracy, low economic status, and lack of social support. Not only will they experience financial instability, but it will also negatively impact their physical and emotional health and quality of life. The Madrid International Action Plan on Aging (MIAPA) developed a plan for the ageing population's well-being and prosperity. [8] With this growing number, health issues are also increasing. Physical health, psychological well-being and mental health issues need priority. Through comprehensive policies, the government caters to the needs of the younger population, and fewer policies focus on the needs of the elderly.

This paper investigates the relationship between QoL and illiteracy, socio-economic status and health of elderly women to cater to and help the ageing population; our study comes with the following research objectives and research.

RESEARCH OBJECTIVES & RESEARCH QUESTIONS

RO1: - To study the women, ageing, health and quality of life of elderly women populations in North India, namely Uttarakhand and Uttar Pradesh and South India, namely Telangana and Andhra Pradesh.

RO2: - To study the relationship between the literacy level of older women and how it affects their QoL.

RO3: - To investigate their social and economic status and quality of life.

RO4: - To understand their marital status and their quality of life.

RO5: - To understand the importance of medical and financial assistance for older women concerning their health issues and QoL.

RO6: - To suggest a broader and inclusive plan of action and better policy measures that can assist older women rather than being marginalised and stereotyped as a helpless burden or funny bones, inspiring humour for soap serials or stand-up comedies.

RESEARCH QUESTIONS

RQ1: - Is there any relation between their literacy level and QoL?

RQ2: - How does a Social and Economic Status (SES) related to the QoL?

RQ3: - Does the quality of life relate to marital status?

RQ4: - Is there any relation between women's ageing and their physical health issues?

RQ5: - Is there any association between their health issues and QoL?

REVIEW OF LITERATURE

WOMEN, AGING AND HEALTH

The old-age-invested air of reverence in the eastern cultures has been erased, and a negative representation of old has emerged in their place. [9] Popular culture, primary stream culture, and media have perpetuated these images, valorising youth. Many wrinkle-free creams and dyes to turn the grey hair into black are seen regularly. In the modern-day, everyone else becomes second-class citizens due to the youth-obsessed culture, to be shunned, and this view is propagated by the media regularly. [10] Inside the sociological speculations of maturing, factors of nationality, sexual orientation, way of life, and financial status were insignificantly considered beforehand. The rise of the social speculations old enough and maturing can be followed back to the period soon after the universal conflicts with the rising worry of the legislatures regarding the results of segment irregularity and the lack of youthful specialists in the USA and UK.[11] Due to their institutional setbacks in India, older women are strictly banned or even polarised from earning or educating themselves. In some families, the husband strictly bans their wife and daughters from working, earning money, or even getting higher education, reducing, polarising, and labelling them as cooks and caretakers.[12] Even husbands stigmatised with anger or domestic violence that the house will be run only by men's earnings. Older women being ill-educated, cannot identify and seek relevant awareness and avail the policies governed and administered. We find that the dependence on social welfare leads to a more relevant trap in widows entangled in receiving money. More than anything, in the case of unmarried women, the greatest dread comes from the way that there are numerous primary restrictions on the off chance that they experience the ill effects of any illnesses. [13] Apart from the welfare framework, single ladies and widows need to track down their way to get their fates, and they are approaching an adjustment of the family-focused social arrangements. " The tax system, welfare policies, and even the medical insurance system are also designed for families, and they alienate widows, sisters and unmarried single-person households". [14]

Ageing people experiences differ in various societies and cultures. A people's culture teaches them to value individual independence and uniqueness from birth through collaborations with their folks.[15] Women in India face the challenges of ageing, such as inadequate diet, crime, hazardous working environments, and lifestyle-related diseases. [16] Late-life problems included family relationships, economic stability, health issues, role loss, working role differences. [17] Higher levels of psychological distress resulted from unstable financial conditions, personal health issues and inability to do daily activities. The relationship between stressed life, financial fear and experience of stress due to such factors in an ageing population. [18] The Aging population suffered a lot from diseases (communicable and non-communicable). There is a decline in immunity at one age, which leads to higher numbers of communicable diseases. [19]

The number of elderly individuals is growing worldwide. Economic status may affect the access that elderly individuals have to healthcare management and quality of care. [20] Traditionally, women live longer than men and thus comprise a majority of older adults. While increased longevity is a bonus for some adults, it may be accompanied by chronic health conditions, frailty, vulnerability, social isolation, and resource scarcity. Older women face a greater risk of outliving their savings. Moreover, older adults, particularly those who are widowed, experience worse health than those whose spouses are still alive". [21] Elderly women face tremendous challenges and unexpected hurdles in the form of insecurities and loss of past social roles, thus impacting their wellbeing and quality of life. [22] Old age-related chronic conditions can be prevented by practicing effective lifestyle changes and through conscious preventive measures, i.e., by adopting healthy lifestyle changes such as paying attention to and adopting healthy promoting behaviours and not to health demoting behaviours which would protect the elderly from major life events, lifestyle health problems and significant financial burdens. [23] The old wellbeing improvement was identified with offering significance to their connectedness to their grown-up kids and grandkids alongside changes made (or not made) in communicating closeness in their advanced age, and how trust and question are reintegrated for some through just taking an interest in rigorous exercises and certifying their absolute confidence. [24] Behavioural factors such as stress reduction, exercise, and getting good sleep and nutrition also have the potential positive effect and help deal with ageing. [25] The effects of rapid urbanization and societal modernization lead to a greater breakdown in family values. There is a deterioration of the closely-knit fabric of family support and the problems faced in the form of financial frailty, social disconnection, and old maltreatment prompting a large group of mental diseases.

Likewise, widows are inclined to confront social disgrace and shun. [26] Older women who are more experienced are more likely than more established men to be victims of abuse. [27] The old are likewise inclined to maltreatment in their families or institutional settings. [28] Women who suffer from loneliness lead to significant physical impairment, increased psychological issues, reduced mobility with age, lower life satisfaction, smaller social networks, and lack of confidence. [29] Living alone and financial needs were directly proportional because alone elderly people faced issues with the feeling of loneliness, adjustment problems, inability to experience and tolerate differences, feeling of rejection by close and extended social connections in family and community and loneliness indirectly affected their affiliations such reduction in visits with family members and paved path to increasing worries. [30] The financial issues of the older are disturbed by elements, for example, the absence of government-managed retirement and insufficient offices for medical services, recovery, and amusement. [31] Many studies have shown that retired old individuals are faced with the issues of monetary instability and depression. Many older women are more likely to be socio-culturally influenced by health conditions because they are less financially independent and have less control and status than older men. [32] Since most people do not work in the formal sector to make a living but still act as spouses and mothers, the feminization of ageing and the lack of inter-familial care leave most women financially insecure in old age. [33, 34, 35]

In the dominant characterization of the society, the senior citizens are understood to be unproductive and therefore made to feel useless or unwanted. The World Health Organization (WHO) defines QoL as an "individual's perception of their position in life in the context of the culture and value systems in which they live and with their goals, expectations, standards, and concerns". [6] However, QoL can be conceptualized differently depending on the "discipline, paradigm, and research time frame. [36] QoL is intrinsically related to health. Under the umbrella of QoL is the concept of health-related quality of life (HRQoL). [37] Quality of life is an all-inclusive concept incorporating all factors that impact an individual's life, while HRQoL includes the subset of the important or most common ways health or healthcare impacts well-being. [38] The intersection between the physical and the social leads to problems that affect both the physical and mental bodies. The complexity of the issues in an aged woman's life in general and the women's health is not made a part of the concerns about ageing, may further contribute to the issue of older women's health and wellness not being looked at as priority public health issues From the perspective of the aged, after keeping the house or working for years, when the 'empty nest syndrome' sets in, and when nuclear families find no elbow room to spare for an aged parent, the setback in the form of neglect feels like a slap in the face. For older women in India, the additional burdens of culturally imposed stigma and the notion of 'inadequacy' for not being good enough complicate things further. [39] Such an idea is part of the cultural baggage of a rural environment where muscular production predominates. Besides this, the onset of old age is also associated with many health issues. Mental health in itself needs to be taken seriously and given due attention with appropriate empathy, care and sensitization. Mental health takes on a grimmer picture in its intersection with age and gender, particularly from the supply side of aid and assistance. [40; 41] This resulted in a large proportion of the senior population living and related problems of living. However, the question that some of the elderly ask is whether this increase in longevity is blessing or curse. The government of India adopted the 'National Policy on Older Persons' in January 1999, where it defined 'senior citizen' or 'elderly' as a person who is of age 60 years or above. [42] We need to take back that space appropriately for the well-being of our older women. India has a vast population, and 1/10 of this population are hospitalized for specific disabilities, which are primarily due to at least some conditions of old age, and this population of the old is amounting to people about the age of 60 years only have used. [43; 44] We see that older adults suffer from specific problems related to high blood pressure and associated disorders classified as cardiovascular diseases. Further, we also have some ideas about the other diseases that arise from lack of proper nutrition and lead to changes in metabolism and the functioning of kidneys and other circulatory problems related to the endocrine systems. It was also seen that there was a significant relationship between age and self-reporting of diseases. [45] To date, research hardly seems to have attempted to study exclusively women's health to protect and safeguard their rights and to fulfil their age-related needs through supportive interventions and feasible policies. There is evidence in the literature that health and biology are two variables linked to improvements in physical health among older people. The most critical factors on the changes in older adults are physical, socioeconomic, political, and social contexts in his research on the social determinants that affect health inequalities. [46] Across the centuries, there was mutual empathy, affection, and reverence.

However, in today's shifting family situations, mainly where the daughter-in-law works and contributes to the family budget and the elderly are financially reliant, the desired harmonious coexistence does not always occur. Three adverse effects were observed on older adults' physical, social, and psychological status, as evident in the above scenario. [47] Barriers to social engagement among lonely older adults and the impact of social fears and identification. [48]

Indian society as a whole is dealing with lonely older lady. Against this background, there is a strong need to develop a multipronged approach to deal with the issues related to elderly women from all the perspectives mentioned above. Ethnomethodology centres on the investigation of people's techniques in "doing" public activity to create common conspicuous connections inside an arranged setting, delivering organization. It investigates how individuals' natural, routine exercises create and oversee settings of coordinated regular circumstances. [49] Studies demonstrate a need to sanction a preventive health care package to facilitate all aspects above. There is a need to fully understand ageing and health from a gender perspective. The research focused on the socioeconomic and health status of elderly women in rural areas t that relates to the approval.

Do not say that ethics clearance was not required better understand their situation. It was found that elderly women often suffered from psychiatric issues such as depression, alienation, solitude, and anger. These issues will become a source of tension and stress if they are not appropriately addressed.

RESEARCH DESIGN & METHODOLOGY

The current investigation was carried out with quantitative methods and random sampling. Firstly, we collected information on old age from secondary and web sources and got information on the different statistics, policies and health needs of the elderly population. The study chose the two different geographical areas to highlight policy differentiation according to demographics. The researchers collected the data with a self-administrated questionnaire from the women staying in Institutions and the homes in these four states. We have a total sample size of 1,000 in the two states of South India, Andhra Pradesh and Telangana and two in North India, Uttar Pradesh and Uttarakhand. Besides this, we had collected data of 100 more in Telangana and Uttarakhand as part of our pilot study. Hence our total sample size was 1,100. The study tried to fix an equal number of women staying in care institutions and old age homes and those staying at home with families in urban and rural dwellings. The inclusion criteria were aged women above 60 years of age, and the exclusion criteria were individuals with a terminal illness.

PROFILE OF WOMEN

The data representation of respondents shows 162 respondents belong to the 56-60 age group, 418 respondents are from the 61-65 age group and 232 respondents belong to the 66-70 years age group and the remaining are in higher age groups. A large number of women were illiterate and had not studied beyond primary. The majority of the women in our sample knew only one language but in Uttarakhand, most of the women knew two languages: the Kumaoni or Garhwali language and Hindi. In the other states in Andhra and Telangana, the majority of the women knew Telugu, and in Uttar Pradesh, they knew Hindi. When we asked the women the language they had studied, it was mainly in the native tongue and in Uttarakhand, they had studied in Hindi. As far as the socio-economic status of these women was considered most of them came from the middle and lower classes. While the majority of the women in Andhra Pradesh and Telangana were from the Middle class, in Uttar Pradesh and Uttarakhand they were from lower classes. Most of the women in our sample did get a pension because either they were working or had a pension. The other women had received the pension from their husbands but a large number of these women were receiving the pensions paid by the Government.

In accordance with ethical guidelines and principles, this research project obtained ethics clearance from the Institutional Ethical Committee of the University of Hyderabad. The approval was granted after a thorough review of the study's methodology, objectives, and potential impact on participants. The ethical clearance reference number for this project is UH/IEC/2019/171. This approval ensures that the study was conducted in compliance with established ethical standards and that the rights and welfare of the participants were safeguarded throughout the research process.

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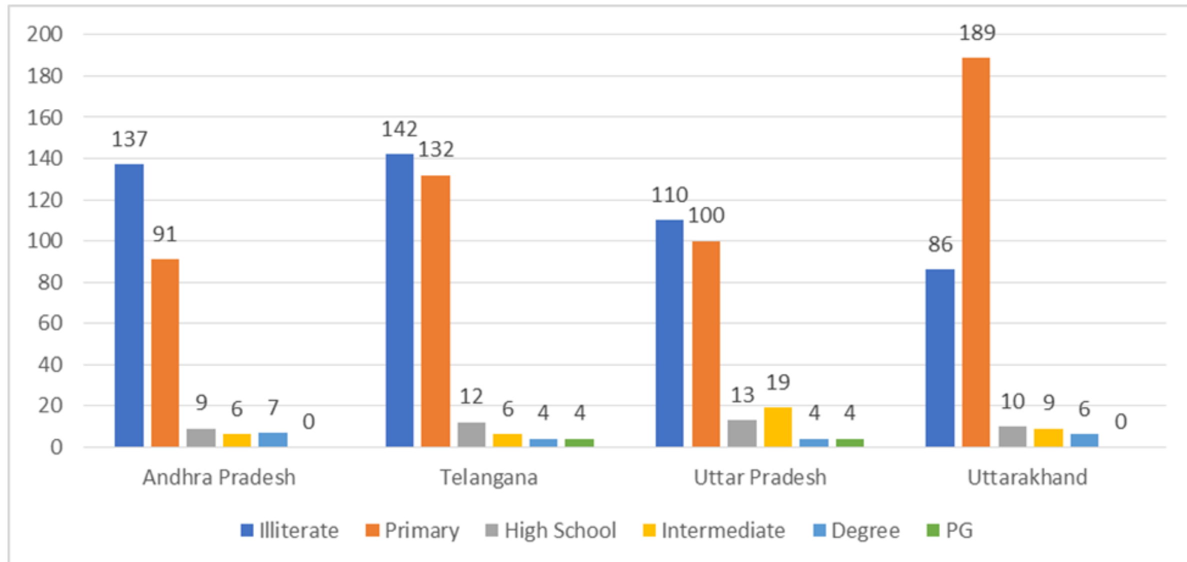
RESULTS AND ANALYSIS

DESCRIPTIVE ANALYSIS

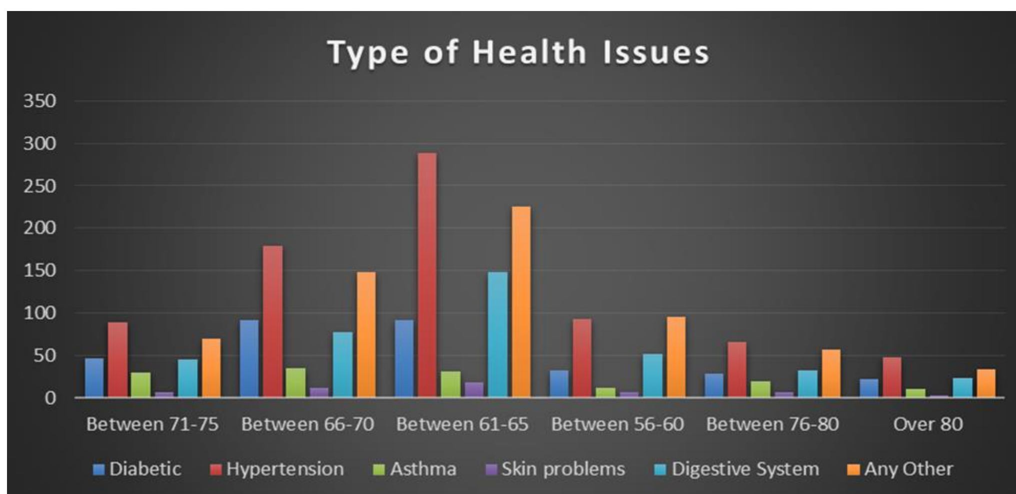
The present investigation was focused on the health and demographic details of elderly women, especially in the northern and southern parts of India (i.e., Uttarakhand & Uttar Pradesh and Telangana & Andhra Pradesh) concerning demographic details and their difference. Sample respondents' features are measured in various socio-demographic details (see Figure 1)

FIGURE 1: RESPONDENT'S EDUCATION IN RESPECTIVE STATES



We investigated that many women were illiterate and had yet to study beyond primary in selected states. Uttarakhand was a state where the women had studied until primary, and this number was more than that of the total women that were illiterate in Uttarakhand. Older women who are ill-educated need help to identify and seek relevant awareness and avail of the policies governed and administered. We find that the dependence on social welfare leads to a more relevant trap in the case of widows who are enmeshed in receiving money. More than anything, in the case of unmarried women, the greatest dread comes from the way that there are numerous primary restrictions on the off chance that they experience the ill effects of any illnesses. [11] 600 respondents came from urban areas and 418 respondents from rural areas and 82 respondents belong to semi- urban areas. Most of the respondents stay in their home, with 713 respondents staying in home, 381 respondents are staying in an institution and 6 members are staying in other places like old age homes. Majority of the women in our sample were married and a large number of women were widows. Hence for the old women there was a double issue of being old as well as being a widow and often they felt lonely and could not depend on anyone. It was interesting to see that among the women we interviewed, 14 for Andhra Pradesh and 18 from Telangana, were divorced. As far as the socio-economic status of these women was considered most of them came from the middle and lower classes. While the majority of the women in Andhra Pradesh and Telangana were from the Middle class, in Uttar Pradesh and Uttarakhand they were from lower classes. Most of the women in our sample did get a pension. This was either they were working and had a pension. The other women had received the pension from their husbands but a large number of these women were getting the pensions paid by the Government.

FIGURE 2: HEALTH ISSUES OF RESPONDENTS



In the 61-65 years of age group, 92 have Diabetes, 289 have Hypertension, 31 have Asthma, 18 have skin problems, and 148 people are suffering from Digestive system issues (Figure 2). This makes one recall the report of the World Health Organization that also claimed that life expectancy had increased worldwide by five years [46], but concerning the previous report, it is also essential to consider health status while life expectancy has increased as the present study indicates.[47] Considering the not too senior age group of 61-65 years having greater reported health issues, it is pertinent to pay attention to their future life course where the health issues may worsen their living if not taken care of early. This also calls for attention to the very senior age groups, probably owing to their relatively better living style reporting lesser history of health issues, whereas the same is not the case with relatively lower age groups. However, the sample size being a limitation, further exploration on a larger scale is required for coming up with clear findings regarding incidence and prevalence of health issues and the role of age variation in senior women.

Our literature review reveals that many elderly women are suffering from more than one disease. [43,44] Our study does not point out that women are suffering from any psychological issues, which contradict certain other recent studies. [40,41] Our data analysis suggests (Table 3) that only 3.2% of women said they are suffering from psychological issues.

The following analysis is made to check the differences in quality of life with variations in several demographic factors discussed so far. The following ANOVA tables describe the attempt in detail. Using the tables and graphs, the present section discusses and depicts the analysis describing the quality of life in its association with the demographic details. Results revealed that the quality of life of older women has significant differences with different age groups. Previous reports also suggest that the right policy can make a big difference in women's health, especially ageing. [48,49] The study further explained that quality of life has significant differences with age, literacy, socioeconomic status and place of residence of the respondents.

RESULTS & DISCUSSION

The results demonstrated that there is a difference in QoL with different demographic factors as well as health status. There was a significant difference in QoL with literacy level, marital status, retirement, social economic status, area of residence and place of staying and health status of elderly women. This calls for paying attention to the age requirements regarding the factors mentioned. Further exploration is recommended in future studies for a deeper understanding of the causes of the areas where the differences have been significantly observed concerning QoL variation. With a deeper understanding of factors affecting QoL and contributing to the differences among the aged, appropriate interventions must be planned to enhance the QoL in the identified areas.

If factors have to be considered from a psycho-social perspective, we can see that increasing age influences their QoL. Literacy level contributes to financial independence, awareness about the ongoing contexts and happenings around and functional independence in many aspects. Thus, variation in literacy level may also indicate a difference in QoL. Marital status and support from a spouse may also contribute to social support that a

woman may deem available as her own. Thus, the difference in marital status may contribute to the difference in QoL. Retirement may bring into the life of an individual some relaxation and relief. However, it may also lead to certain uncertainties and insecurities from financial, psychological and social perspectives. Thus, retirement may contribute to the difference in QoL. They similarly reside in rural areas, handicapping some persons, especially the aged, thus impacting their QoL owing to the non-availability of medical and social support facilities. The same is the case with the financial security that pension may offer them, and non-availing of pension may also affect their QoL.

As the health problems of aged women reported are more in the lower age range in the sample, it may be noted that 60-65 is the age of several transitions happening in a woman's life. Having devoted most of her time to the family, upbringing of children and livelihood and responsibilities, it is a common fact that a woman ignores her health. It is not improper to say that lower literacy levels, lack of awareness, lower SES, inability to avail proper resources, etc., may be reasons for the varied health issues women report. The women between the ages of 60-70 years feel that they are not functionally dependent on others and hence have to carry on with responsibilities and become a support system to others in the family rather than taking help and being dependent on others for chores or family responsibilities. On the other hand, when women move towards the advanced age of senior citizenship, some care and support may be expressed by significant others. In contrast, on the lower end of senior citizenship, such support may not be felt strongly by others. Women who remain a pillar of the family may not perceive their weakening of health, nor may the others perceive owing to their seemingly untiring routine performance.

TABLE: 3 ANOVA TESTING OF QOL AND DEMOGRAPHIC (AGE, LITERACY, MARITAL, RETIREMENT, SOCIAL ECONOMIC STATUS, HEALTH STATUS)

With Age group	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	7.944	5	1.589	16.65	0
Within Groups	104.491	1095	0.095		
Total	112.435	1100			
With Literacy Level					
Between Groups	7.944	5	1.589	16.65	0
Within Groups	104.491	1095	0.095		
Total	112.435	1100			
With Marital Status					
Between Groups	5.813	3	1.938	19.936	0
Within Groups	106.622	1097	0.097		
Total	112.435	1100			
With Retirement					
Between Groups	0.558	1	0.558	5.482	0.019
Within Groups	111.792	1098	0.102		
Total	112.35	1099			
With Social Economic Status					
Between Groups	5.09	2	2.545	26.03	0
Within Groups	107.345	1098	0.098		
Total	112.435	1100			
With Health Status					
Between Groups	16.717	4	4.179	47.854	0
Within Groups	95.718	1096	0.087		
Total	112.435	1100			

Source: data analysis by authors

IMPLICATIONS

There is a need for policy-level attention towards elderly women who, under the several adverse circumstances and contexts that they live in, face psycho-social problems which are largely neglected. Healthcare facilities need to improve and be more available in terms of home care and availability at a closer distance for the benefit of older women. Improving the networking between health care and service-related organizations to optimize the resources available for elderly care and to share expertise is felt important. For the institutionalized elderly more human interactions with voluntary health care and psycho-social support services will partially compensate for the aloofness felt due to a lack of family support. Social services such as visiting the elderly in the community or in institutions who may feel lonely may be integrated into the outreach activities of schools and colleges. This may offer the dual benefit of developing human compassion, service orientation and empathy for the younger and growing generations, and on the other hand, the feeling of being cared for and attended to by the elderly. Financial constraints must be focused on as not all elderly, especially women, are financially independent. Elderly pensions to suffice the essential requirements and health care access and services free of cost and, if not possible, at subsidized and affordable costs may be considered irrespective of public/private health services. Direct interactions with specialists from bio-psycho-social perspectives and for those who find solace in spirituality, some spiritually-based programmes may contribute towards enhanced wellbeing. Technology-assisted interventions such as crisis support and health information provided with simple mobile apps on ordinary phones or using television programmes may be planned with the involvement of relevant experts. Virtual services, such as free access to video mode technology for doctor's appointments and consultations, primarily help them. There is a need to build apps where women can easily access hospitals, doctors and nurses through a mobile app. A multi-level system of social support involving family level, community/society level, and governmental support through relevant professionals (a holistic approach as mentioned in the previous points) as an integrative model is recommended. Mental health services also need to be paid attention to. Policies and practices that benefit older women and men should support and improve the care provided by their families (e.g. respite cares and training). Incorporate mental health assessment and management of depression and other mental health problems into primary health care and pay special attention to women who have experienced elder abuse or other forms of violence. Help remove the stigma associated with mental illness and include legislation to protect the human rights of institutionalized people with severe mental disorders. There is a requirement for centres around Positive Aging and Aging in Place with the goal that more seasoned individuals need to stay coordinated in the public eye. Further, there is a need for a Positive self-view of maturing sound, cheerful and confident – is helpful for life span, advances more prominent certainty among the older and results in better acknowledgement and comprehension by family and society.

CONCLUSIONS

Socioeconomic status is a factor as a SES difference may be in several facets of living conditions and social relations. With increasing age, reduced independent functionality, and being less 'useful' to others, there is a possibility of neglect towards women of senior age groups. The cognitive, cognitive and affective functioning slowing down and the resultant behavioural aspects probably contribute to this neglect from family or society. The woman herself may not be able to articulate her health and psycho-social needs and well-being owing to the differences in the bio-psycho-social mechanisms in mutual respects. There is a need to consider customized policies to help persons of a higher age by understanding their needs and required facilities. Rural areas handicap some persons, significantly the aged, thus impacting their QoL owing to the non-availability of medical and social support facilities. The same is the case with the financial security that pension may offer them, and non-availing of pension may also affect their QoL. There is a substantial disparity in understanding and use of old age remunerations among senior citizens even though the federal government has created various programmes and schemes for older people as state-specific initiatives. Unfortunately, only some ministries are responsible for addressing all aspects of the ageing issue; hence, inadequate attention is paid to ageing issues.

ACKNOWLEDGEMENT

We thank the IMPRESS Project from ICSSR/MCHRD for providing financial support, which made this study possible. We would also like to acknowledge the exceptional support and contributions of the following Research Associates during the data collection phase: Mr Ejaz in

Andhra Pradesh, Ms Sana Fatima and B. Mounika from Telangana, Ms Suman Kumari from Uttar Pradesh, and Dr Girish Bhatt from Uttarakhand. Their expertise and efforts in gathering the required data have been truly commendable.

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