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GENDER INEQUALITY AND HEALTH: A STUDY OF ELDERLY IN ALIGARH CITY

Ms. Arshi Khanam[1], Dr. Sadaf Nasir[2]
[1]*Research Scholar, D/o. Sociology, Aligarh Muslim University, Aligarh, Uttar Pradesh, India*
[2]*Assistant Professor, D/o. Sociology, Aligarh Muslim University, Aligarh, Uttar Pradesh, India*

***Corresponding Author**- Ms. Arshi Khanam*

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ABSTRACT

Women are more susceptible to unjust treatment, discrimination, and denial of fundamental human rights such as survival, education, health, inheritance, etc. due to social factors such as male domination and their subordinate status. Women experience two distinct disadvantages in the aging population due to gender-based roles and stereotypes. As a result, they are treated poorly in society. While aging is unavoidable, its gendered inequalities are not. Gender greatly impacts both men's and women's health in India. This in turn affects a person's susceptibility to illness and likelihood of experiencing health problems. The present study is both primary and secondary in nature. This paper tried to analyse the social and health issues faced by the elderly and examine gender-based inequalities in healthcare among the elderly in a selected area of Aligarh City in India and suggest ways to promote gender equality among the elderly by challenging the established pattern of inequality in health.

KEYWORDS: *Elderly, Gender, Health, Aging*

INTRODUCTION

This paper is based on gender inequality in healthcare among elderly in Aligarh City. There are several domains in which men and women have encountered unequal opportunities. These domains include mortality, natality, basic facilities, special opportunities, professional, ownership, and household (Sen, 2001, pp. 466-468).In the 2011 census, the senior population in India accounted for 103 million individuals, which represents 8.6% of the total population (LASI Wave I, 2017-2018, p.2). India is positioned at 135th rank among 146 nations with respect to the Global Gender Gap 2022. It can be inferred that gender refers to the socially constructed characteristics that are associated with males, females. It exhibits variation across cultures and is susceptible to transformation over time according to World Health Organisation. Gender inequality is unequal and biased treatment between male and female (Tiwari, 2013, p.24). Gender norms, socialisation, power relations, and access to resources are among the factors that influence differences in vulnerability and susceptibility to illness, the experience of illness, health behaviours, access to and use of health services, treatment responses, and health outcomes (WHO, 2023).

Elderly (Old) age is a stage of life marked by substantial shifts for both genders, including changes in societal responsibilities and gender-related expectations and status within the family (Caramel, 2019, p.2). The perpetuation of gender discriminatory practices across generations results in the violation of the rights of girls and impedes their growth. This gap is attributed to their increased longevity, the loss of a partner, and the resulting socio-psychological and financial instability (Giridhar et.al, p. 21). It is not uncommon for elderly women to experience financial hardship and social isolation subsequent to extended periods of providing uncompensated care to their loved ones. Some of the factors that contribute to vulnerability among the elderly population include poverty or the likelihood of experiencing poverty, exposure to violence, and instances of elder abuse. The elderly women may face financial difficulties in their later years due to a history of discrimination, resulting in a reduced amount of financial resources and assets, thereby posing a challenge to their ability to sustain a satisfactory standard of living. Women in the majority of countries exhibit a lower probability of receiving pensions in comparison to their male counterparts, and even when they do, their benefits are typically considerably reduced. As a consequence of this, elderly women exhibit a higher vulnerability towards exploitation and mistreatment (Nair et. al. 2019, pp.1-5). The present study is supported with the intersectionality theory proposed by Kimberley Crenshaw. Intersectionality is a conceptualization framework for how various forms of prejudice and discrimination affect one individual, a group of individuals, or a society issue. It considers how people's multiple identities and life experiences intersect in order to comprehend the complexity of prejudices they encounter. (www.ywboston.org/2017/03/what-is-intersectionality-and-what-does-it-have-to-do-with-me/). As per the 2011 Census, 104 million Indians are above 60 years of age, making up 8.6% of the country's overall population. Ages 60 and older make up 12% of the population. The states of Tamil Nadu (16%), Puducherry (16%), Kerala (20%), Himachal Pradesh (17%), and Goa (15%) have larger percentages of senior people (60 and above) (WHO). So the

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concern of this paper is to investigate gender biases in healthcare among elderly in selected wards of Aligarh City. Aligarh district is a district in Uttar Pradesh, and Aligarh City serves as the district's administrative center (BIPDA, 2021, p.3).

OBJECTIVES OF THE STUDY

This paper tried to analyses the social and health issues faced by the elderly and examine their gender-based inequalities in healthcare expenditure in family.

RESEARCH QUESTIONS

Q1. What are the socio-economic circumstances of the elderly?
Q2. What health issues do elderly have?
Q3. Are there any gender biases in healthcare expenditure encountered by the elderly in the family?

REVIEW OF LITERATURE

Nagaraju Kilari (2020) posits in his scholarly article titled "Gender Inequality in India" that in India, gender inequality is a complex problem with many facets, including labor engagement, traditional lineal systems, tendency for sons to provide for their elders, employment inequality, loan access, occupational inequities, and social and cultural factors. The problem is exacerbated by son preference, forced financing practices, restricted access to higher-paying jobs, and traditional male lineage inheritance. The problem is further compounded by cultural and social factors, such as the dowry system and health inequities.

Giridhar et.al. reported that gender inequality exists at all ages, but as women get older, the effects of socially constructed roles become more obvious. Widowhood is more prevalent among elder women, who live alone, have no income, have fewer assets, and be completely dependent on family for support, which makes poverty in old age inherently gendered. The study found that homes with older women as the head are poorer than those with older men as the head.

According to Ghosh's (2009) article, 'Women face significant challenges in the ageing process due to deeply ingrained institutionalized gender hierarchies within their society'. It has been observed that globally, older women constitute the demographic that is most vulnerable to poverty, thereby rendering the ageing process for women even more arduous. It is imperative for women to initiate the planning process early on in their lives, particularly with regards to the ageing process. The apprehensions regarding ageing women in India are intricately linked to anxieties surrounding feticide, dowry deaths, and the custom of dowry, domestic violence, and sati, among other institutionalized and oppressive cultural practices that are indicative of the position of women in the nation.

E. Harnois' article titled Age and Gender Discrimination: Intersecting Inequalities across the life course" (2015), it is evident that women across all age groups, including the young, middle-aged, and elderly, " are subjected to various forms of sexism throughout their lifetime, as observed in previous research on gender discrimination and sexual harassment. The authors explicitly acknowledge that the elderly population encounters various forms of prejudice, such as those rooted in gender, race, ethnicity, and physical impairment.

Nair et.al. (2021) conducted a narrative review entitled "Gender Problems in the Care of Elderly" and discovered that age-related physiological, anatomical, emotional, and cognitive changes were influenced by gender. The research indicates that advanced age in women is associated with a higher likelihood of experiencing mental health issues, elder abuse, and less gratifying sexual encounters. Notwithstanding this, they are provided with inadequate long-term care and are afforded limited opportunities to avail medical interventions. The investigation of gender-related concerns in geriatric healthcare, particularly in the domains of frailty, mental health, and sexual health, among others, holds significant significance.

According to Kaur & Kaur (2019) reported that women over 65 years of age had considerably greater rates of chronic morbidity, poor vision, cataracts, blood pressure, back pain/slipped discs, malnutrition, depression, reduced physical performance, and elder abuse than older males did. Age-related prejudice and neglect are pervasive, often exacerbated by widowhood, total reliance on others are experienced by older women.

Tama et.al. (2020) in their study analysed that the healthcare expenditures for elderly females were comparatively lower than those for elderly males. The expense of healthcare is impacted by multiple variables, such as the prevalence of chronic ailments, the gravity of said ailments, and the nature of medical establishments and provisions. Despite the higher frequency of medical facility visits among older women compared to older men, there is a possibility that they may exhibit a preference for public healthcare institutions over private hospitals. For patients to use their insurance, those medical facilities collaborate with the Healthcare and Social Security Agency (BPJS Kesehatan). The medical costs will be covered by the Healthcare and Social Security Agency, clinics, or health centers. The study did note that the prevalence of non-communicable diseases is rising with age and that they are a common health issue for the elderly. Furthermore, it was shown that women are more likely to be exposed to risk factors that compromise

their functional health and have a higher incidence of diseases as they age. These risk factors, which could all contribute to the health issues faced by older women, could include poverty, being divorced or widowed, unemployed, having a lower level of education, and having less decision-making authority.

Roy & Chaudhri (2016) have posited that disparities in health and healthcare utilisation among older individuals based on gender are impacted by factors such as socioeconomic status, financial resources, and empowerment. The results of the study indicated that elderly females exhibited comparatively lower levels of self-reported health in contrast to elderly males, along with higher incidences of disability, fewer occurrences of chronic illnesses, and reduced healthcare utilisation. The study comprised a representative sample of 34,086 elderly individuals who participated in the survey.

Tomar (2021) looks at the connections between the lockdown and risks to the health of senior Indian women. For older women in India, there are still health inequities. The physical and psychological well-being of the population has been impacted by the legal lockdown in India. Due to the limits on mobility during the lockdown, older individuals confront challenges such as limited access to healthcare services, a lack of attendants, and prolonged social isolation. These issues may cause gender and age-based disparities to become much more obvious. Because they are more prone to illnesses than males, older women may be particularly vulnerable to health problems. However, this is related to long-term chronic health problems, economic reliance, gender-based discrimination, and elder abuse. Women typically live longer than men.

Carol Estes (2009) posits that a key aim of feminist political economics of ageing is to examine the ways in which existing social institutions contribute to the perpetuation of dependence and vulnerability among elderly women across their life spans. The proposed strategy is founded upon four fundamental assumptions: The circumstances and encounters of women are socially constructed over the course of their lifetimes. The second premise posits that the experiences and challenges faced by older women cannot be solely or predominantly attributed to their individual actions and decisions. Women and other socially disadvantaged groups often face significant limitations in their preferences and options, which may be perceived as illusory. As per the third principle, concept of cumulative advantage posits that individuals are allocated and selected on the basis of their status and achievements, thereby suggesting that the elderly population will exhibit greater levels of social stratification compared to earlier life stages, the fourth assumption posits that the marginalization of elderly women is impacted by the interrelated and complex oppressions of ethnicity and race, socioeconomic status, sexual orientation, and financial hardship.

AREA AND METHODS OF STUDY

This study was carried out in Aligarh city of Uttar Pradesh. Aligarh district is a district in Uttar Pradesh, and Aligarh City serves as the district's administrative center. Since there are numerous lock factories in the area, it is known as *Tala Nagri,* which means "City of Locks". Prior to the 18th century, Aligarh was commonly referred to by its previous name, Kol or Koil. The district is divided into 5 tehsils. Moreover, it comprises 24 towns and 1199 villages. Hinduism and Islam account for 79.05% and 19.85% of the district's population, respectively, as well as 19, 51,996 males and 17, 21,893 females. In the district, there are 882 females for every 1000 males. The city is divided into 70 wards (BIPDA, 2021, p.3). This area is selected because no prior research has been done in this area on the given topic secondly comparative study is possible between retired working and non working elderly in terms of health disparities. The study is carried out in selected four wards of Aligarh City including NaiBasti, Nai Abadi, Doharra, and Usmanpara. This article investigates the impact of gender inequality on the health of elderly women through the utilisation of primary and secondary data sources. The research has been conducted on a population of elderly male and female who were 60 years and above, residing in a specific region of Aligarh city. This area is selected because no prior research has been done in this area on this topic. Owing to limited time and resources, a sizable cohort could not be chosen. A purposive sampling technique was employed to select a total of (50) fifty participants, consisting of (20) twenty males and (30) thirty females through personal contacts. Purposive sampling is thought to not accurately reflect the population however for the purposes of this study there was no other method for finding participants. This approach seemed to be the most suitable one to employ since there was no official data bank on the elderly population in Aligarh. This study is descriptive in nature. Interview schedule and observation have been employed as tools of gathering data. The case study approach has been utilized to gain a comprehensive understanding of the participant's individual experiences. This paper comprises of four case studies, (1) one male and (3) three females including pseudonyms (name changed of participants) out of these above fifty participants.

PRIMARY DATA

CASE STUDIES

Case study 1: Noor Jahan (name changed) is a 70-year-old illiterate Muslim widow from Malda. She is a beggar who lives on the roadside near Lal Diggi. Her husband passed away 30 years ago who used to work as an agricultural laborer in the fields there. She has two children. At the time of the death of her husband, her daughter was 15 years old and her son was 13 years old. Her son was also involved in working in the agricultural field for daily wages there. After her husband's death, her family suffered from financial crises and she started to beg for money and food from people. As she said, "*When my husband was alive, at least I used to get food*

two times, but later there was a lot of problems". She came to Aligarh after four years when her daughter got married to a son of her village neighbors. With her daughter, she also started living in Aligarh. Earlier they live on rent in a small room but due to pending charges of rent, the owner asked to leave the room. Therefore, she started to live in a slum area separately and her daughter lived with her husband at some other place. But after one year, her daughter's husband died due to a severe heart attack while sleeping. She has two children who also knock on doors begging for money. Noor Jahan lives alone. When the researcher asked why she does not live with her son in Malda, she explained that her son also works as a laborer, earns a little money and since she didn't receive two meals a day there and daughter in law treats her badly, abuses her and sometimes asked to leave the house as they didn't have much to feed her also. Therefore, she came to Aligarh, she begs for money from strangers in places near the AMU (Aligarh Muslim University) campus, Amir Nisha and sometimes Dodhpur because she got tired to walk far places due to lack of energy in body due to continuous standing for the whole day and sometimes takes medicine from the medical store to get relief from the pain in legs. In the morning she comes from her area to these places after eight o'clock and returned back after sunset. Noor Jahan is unable to lift heavy objects like flour etc. due to weakness in her bones, therefore she asked for simple money and meals at a place. She barely receives about 100-200 rupees a day wandering here and she stated, *"If I beg while sitting at one place, I will not get it properly".* About her food habits she stated that within that amount she purchases food from shops or asks people to give food

"*What can I do, no one gives me food, if I get 10-20 rupees from someone, I eat from that*" she said. She takes meal whatever is available at that place in shops at that time therefore she doesn't maintain a balanced diet however in the morning she takes tea with rusks or biscuits. She neither takes milk nor fruits. And occasionally she went to sleep without taking a meal at night while she was starving because neither food nor money was left to buy anything as she stated when she has a fever or any other problem she didn't go outside. When the researcher asked about her health status, she don't know her weight and never measured whenever she suffers from any kind of acute disease she just goes to the medical store for medicines as she doesn't have much money to pay doctors' fees. When she lives in Malda she went to a government hospital there for any kind of suffering. When she was asked here in Aligarh why she doesn't visit government hospitals if needed, she stated that "*I've been there once, but often I don't go; instead, I get my medications at the pharmacy because no one is available to take me there*". She occasionally fell in places due to weakness and pain in her joints. She stated that she has the problem of *Gathiya* (Arthritis). Her eyesight is also weak but never went for checkups as she said, "*If I get food two times that is enough for me, as there is no one to look after in the life ahead*". She said that life is very difficult for her neither she has any financial support from her family members, nor she gets love from them. Even she doesn't want to go back to his son because of the unforgettable and unfair treatment done by her daughter-in-law. She has nobody to share her problems and feelings which lead to loneliness.

Case study 2: Fatima (name changed) is a 65 years old woman. She is a widow and has studied till the fifth standard. She lives in *NaiBasti*. Due to a lack of a source of money, she worked on the press to produce locks keys before she became sixty. Her spouse, who also worked as a mechanic in a car repair shop, passed away six months ago from cancer. There are seven family members in her family, two married sons with their wives and two grandchildren. Both her sons are illiterate. They both work as auto part repairers in various locations. She lives in a small room in her home. She relies on her elder son because her younger son doesn't give her a monthly payment. She assists to her daughter-in-law with housework. After asking the general questions on socio-economic background, then turned to the questions about her food habits and daily diet she stated that she takes a meal twice a day and said *"It is enough to obtain roti (bread) from children"* mostly vegetables and pulses are taken and do not get milk and fruits. She has no idea of her present weight. Whenever she fell ill she visits 'Malkhan Singh Hospital', a government hospital for her treatment and sometimes avoid to go because of long-distance walking due to a lack of energy in her body. At the time of interview, she was suffering from a fever and took one dose after consulting a doctor who takes charge of Rs. 50 and didn't visit the doctor the second day as she said, "from where a lot of money will be brought in each day". She said her younger son and his wife do not take her to the hospital but he takes care of his wife and takes her to the hospital while her elder daughter-in-law takes her to the doctor. Coming to his present health status, she has problems with cataracts, osteoporosis, arthritis, gas, and fever all the time. In her opinion old age is a curse without her husband as she doesn't have a partner now with whom she can share her feelings and problems said crying…*"don't know how life will go ahead".*

Case study 3: Azmat Ali (name changed) is a married 64-year-old man. He has done post-graduation and lives in a nuclear family. He has four children two daughters and two sons. He earned 50,000 rupees a month as a university employee before he turned 60 and he is receiving half of it after retirement. His wife is a homemaker. Regarding his health, he is dealing with high blood pressure, diabetes, physical weakness, and memory loss. Every day, he takes medicines. He visits the doctor every month and goes to medical for his treatment. In terms of eating habits, he takes three meals each day. He consumes milk on a regular basis but does not consume fruit. He serves as the family's head and makes all decisions. He said "*Due to the half pay, the fact that all three of my children are in school, and the lack of any extra income, my financial situation has changed after retirement*". He made the decision to conduct some business after retiring, but he took no action because of covid. As he said he spends the same amount on food and health for girls and sons. In terms of the treatment of their children, he says all children love him and her wife also takes care of her, she gives

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them food on time and they take lunch together. He sometimes feels lonely after retirement due to a lack of social contacts and does not have any work to do. He is quite introverted so do not share much with his children, he used to go market to buy home-related things and used to watch television and according to him he wants to make his children successful in their careers both daughters and sons.

Case study 4: Bhoori (name changed), a 61-year-old woman, resides with her sister's husband. She has been divorced for 40 years. She exclusively resides in Aligarh with her older sister's husband because when her mother passed away, her sister raised her there as she was childless. There are only two people in the family. Her sister died 10 years ago due to some illness. She has one daughter who was married to a man who works in a factory eight years ago. When it was enquired as to the cause of her divorce, she said that *"My husband didn't talk to me properly, my in-laws mistreated me due to dowry demands, and my husband also hit me, so my sister brought me home, and I soon got divorced".* Along with it, she said*, "My sister used to look after me like a mother, yet she never let anything go wrong because of her love".* Nonetheless, she claimed that initially, everything went smoothly but that over time issues developed and people began to wonder why she made this choice. Her relatives taunt her that because of some of her own faults, her spouse had to divorce her. Along with her husband, her sister made incense sticks boxes. Nevertheless, her sister passed away 8 years ago. Also, his brother-in-law does not treat him properly. Provide no financial assistance. She, therefore, does her own work on a piece of fabric like embroidery work. She received 100 rupees for one outfit in exchange for it, but the amount of time and observation required to do so weaken her eyesight. She visited her neighbours since she was feeling lonely. She is unaware of her weight. "*Physically, maybe I look healthy, but mentally, I'm not,"* she said, because her son-in-law does not allow her daughter to meet her mother. And they continually make demands for money or other materials, saying "*your mother has a lot of money*". She claimed that because no one is around in her life to share sentiments or sufferings, her health is deteriorating day by day. She eats anything she could prepare and fit into her diet three times a day, depending on how much she has. Despite having a little income, she has never had a food crisis. Also, her brother-in-law resides on the ground floor and consumes prepared food from the market and sometimes takes from her.

TABLES

Table 1

Social Status of Elderly (Total number of respondents: 50)

Attributes	Frequency	Percentage
Age in years		
(60 -70)	35	70
70 & above	15	30
Gender		
Male	20	40
Female	30	60
Educational Status		
Literate	14	28
Illiterate	36	72
Marital Status		
Married	18	36
Unmarried	0	0
Widowed	31	62
Divorced	01	2
Religion		
Hindus	10	20
Muslims	40	80

Source: Field Study

Data from Table 1 shows that 70% of respondents are in the 60–70 age group, and 30% are in the 70 above age group. The findings show that out of 50 respondents, 36 % were married, none of them was single, 62% were widowed, and just 2% were divorced. The results showed that 20% of the respondents were Hindus, whereas 80% of the respondents were Muslims. Therefore, Muslim respondents made up the bulk of the study's elderly participants in this study.

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Table 2
Economic Status of Elderly

Attribute	Frequency	Percentage
Occupational status before turned out 60 years		
Employed	22	44
Unemployed	28	56
Total	50	100
Occupation		
Government worker	4	8
Business	6	12
Unorganised sector	12	24
Homemaker	28	56
Total	50	100
Present occupational status after 60 years		
Working	6	12
Not working	44	88
Total	50	100
Total salary per month before retirement or 60 years of age		
0 - 5000	28	56
5000-20000	18	36
20000- 50000	4	8
50000 & above	0	0
Total	50	100

Source: Field study

According to the data shown in Table 2, 56% of the respondents were unemployed before they turned out 60 and 44% were employed. It is also shown that majority of the respondents worked in the unorganized sector i.e. 24% followed by business i.e.12% and government workers i.e. 8%. As per their current occupational status after 60 years of age, only 12% are working whereas 88% are not working. Data also reveals their total salary per month before retirement or 60 years of age 18% got 5000-20000, 4% got 20000-50000, and 0% in 50000 & above.

Table 3
Head of Household

Attribute	Frequency	Percentage
Elderly Male	16	32
Elderly Female	10	20
Son	24	48
Daughter in law	0	0
Total	50	100

Source: Field study

According to Table 3, the data shows that 32% of the respondents who are heads of the household are elderly males, followed by elderly females i.e. 20%, 48% by the son of their families and 0% by daughters-in-law.

Table 4
Meal taking in a day

Attribute	Frequency	Percentage
Meal twice a day		
Males	10	20
Females	10	20
Meal thrice a day		
Males	12	24
Females	18	36

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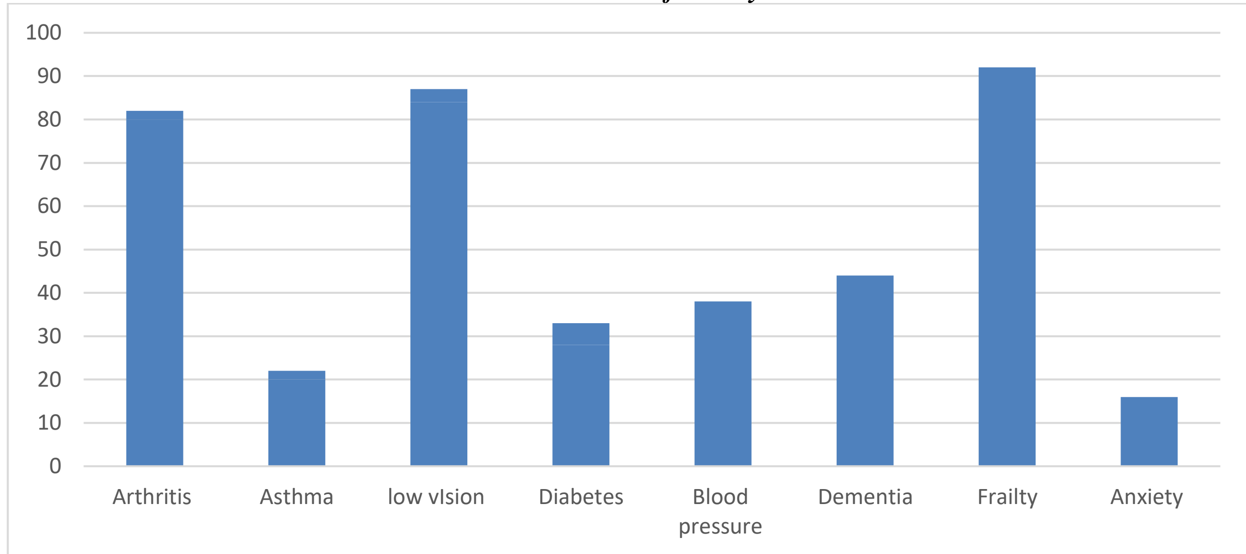
Total	50	100

Source: Field Study

The data in Table 4 shows that meal taking twice a day is equal in both men and women i.e. 20% both elderly males and females and 36% of males and 24% of females took a meal thrice a day.

Graph 1
Health Issues of Elderly



Source: Field study

According to the data presented in the graph, out of 50 respondents, 92% have the problem of frailty in their bodies. After that, 80 % of the respondents have the problem of arthritis disease, 22%of the respondents suffered from Asthma, 84% of the respondents suffered from loss of vision, 32% of the respondents suffered from diabetes, 38% of the respondents suffered from blood pressure issues, 44% of respondents from dementia and a small number of respondents suffered from the problem of anxiety i.e.18%.

FINDINGS AND DISCUSSION

Above study reveals that, number of obstacles such as gender inequality, socio-economic status, financial dependence hinders the elderly population's ability to avail healthcare services. The experience of diminished self-esteem can arise as a consequence of reduced financial resources and a decline in social status. The shift from a salaried income to a pension or unemployment benefit can result in an economic deficit, necessitating reliance on family members or offspring for financial support as stated by Dey et.al.(2012). In this context the following analysis has been categorized on the basis of research questions of the study.

1. Socio-Economic Circumstances of the Elderly
2. Health Issues faced by Elderly
3. Gender biases in healthcare expenditure encountered by the elderly

1. Socio-Economic Circumstances of the Elderly

Income insecurity is a significant factor contributing to vulnerability among elderly women. Approximately 10% of elderly women who are employed as a result of financial hardship predominantly work within the unorganised sector, where remuneration is meager and retirement and other benefits are not provided. It has been observed that elderly women who have lost their spouses are at a higher risk of economic vulnerability and poverty.

Findings have shown that elderly women tend to exhibit a high degree of dependency and have relatively low levels of personal income. Furthermore, income insecurity has been found to significantly impact the precariousness of elderly women.

The majority of the elderly participants who were interviewed exhibited a lack of literacy skills and was dependent on their offspring for financial support. Among the total respondents, it was found that 72%were illiterate. It was suggested by the respondent that the individual's dependency issues could potentially be mitigated through the acquisition of skills or education. The participant reported that their spouse did not leave any financial assets or other resources, leaving them to manage their livelihood with the resources available to them. They expressed a sense of reliance on a higher power to sustain them through this period. Elderly women are frequently denied dominance in their families, even in instances that are entirely normal, even after the death of her husband.

Findings show that elderly women have reported enduring abuse of some kind. The most common type of violence experienced by women is verbal, whereas physical abuse is the least common. The son seems to be the main perpetrator of the abuse. Notably, elderly women report being abused by their daughters-in-law also.

2. Health Issues faced by Elderly

Findings of the study show that around 80% of elderly women have self-reported their health status as poor. The incidence of acute morbidity is observed to be significantly higher in women when compared to men. Prevalent ailments observed among the elderly population include asthma, auditory impairment, cataract formation, cervical and back pain, arthralgia, hypertension, frailty and arthritis, cardiovascular disorders, anxiousness, diabetes, dementia affective disorders and cognitive decline. The prevalence of osteoporosis, arthritis, high blood pressure, and eye problems is higher among women. Additionally, hypertension is more prevalent among the female population. Patients commonly opt for medical care at state-run healthcare facilities and resort to self-administered remedies.

3. Gender Biases in Healthcare Expenditure Encountered by the Elderly

The denial of the supremacy of elderly women can be attributed to gender bias. Elderly women may encounter instances of disrespect in emotional matters. The financial dependence of elderly women is significantly elevated. It is reported that the elderly women following their marriage, they have consistently adhered to their spouse's directives and allowed them to make all decisions. This behaviour has persisted even in their current stage of life, where they seek their spouse's approval prior to engaging in certain activities or meeting with others.

Women experience higher levels of loneliness and isolation within the home environment when compared to men. Women who experience the loss of a spouse due to death undergo a challenging period of bereavement, often characterised by intense feelings of loneliness, preoccupation with the deceased, sleep disturbances, physical complaints. This can lead to a decline in mental well-being. The results of the study indicate that loneliness is a significant concern among elderly widows, who exhibit higher rates of mortality, illness, and misery compared to their married counterparts.

Notwithstanding the longevity advantage that elderly women typically enjoy over elderly men, their healthcare needs and requirements are often disregarded by their family members. It reveals that elderly women receive comparatively lesser attention from their children with respect to their healthcare needs. The inadequate allocation of financial resources results in a lack of appropriate nutrition for individuals of varying ages and genders. However, in matters of familial preference, priority is typically granted to male members. In one of the case, the elderly woman expressed their preference to offer their spouse priority access to any desirable meals available. Any remaining portions would then be consumed by her. Furthermore, gender disparities exist in the expenditures made by elderly towards diverse health-related commodities, including pharmaceuticals, medical practitioner and surgical fees, hospital and long-term care facility charges, and other healthcare outlays.

CONCLUSION

The findings suggest that various factors such as illnesses, family conflicts, and dependency significantly impact the ageing population, regardless of gender. Women are at a risk of experiencing adverse health outcomes, financial instability, poverty, and gender-based discrimination due to their longer lifespan compared to men especially the elderly widows appear to experience the most pronounced systemic disadvantage.

Conversely, it appears that women who are financially secure do not experience significant disparities in healthcare provision. The study suggests that elderly males with higher levels of education and those who reside with their spouses and children demonstrate more appropriate health-seeking behaviour. Our study revealed that individuals, who were elderly, lived alone, had low levels of literacy, and came from lower socio-economic backgrounds exhibited inadequate health-seeking behaviour. The study suggests that a higher proportion of elderly males tend to seek medical attention, while a larger proportion of elderly females tend to rely on home remedies.A shift from a salary-based income to a pension-based income or a state of unemployment leading to financial dependence on family members can result in significant financial loss. The decline in economic potential and social standing may lead to a sense of poor self-worth.

The subject under consideration pertains to the examination of interrelated systems of oppression, domination, or discrimination, as well as the convergence or intersection of social identities. The present study is underpinned by the theoretical framework of intersectionality. The adoption of an intersectional perspective reveals the manner in which individuals' social identities can intersect, leading to the experience of compounded forms of discrimination. As a result, in later life, the elderly confront elder abuse and discrimination, while elderly women face both elder abuse and gender inequality. The concept of age can be considered as a self-contained structure of inequity, as it represents a form of disparity that is not contingent upon bodily transformations or the compounded impacts of other forms of injustice experienced throughout an individual's lifespan. The autonomy and authority of

elderly individuals may be restricted due to the societal tendency to associate ageing with decline and physical weakness. Therefore, it is imperative to incorporate mental health and psychological healing into the treatment plan for the elderly. The incorporation of gender-responsive care is imperative for achieving universal health coverage and enhancing the overall health status of the elderly population.

LIMITATION

It is plausible that the outcomes of these qualitative interviews may not be generalizable to all elderly populations. As a result of the low representation of elderly males in the designated regions, the researcher was unable to obtain a balanced distribution of male and female participants within the households due to feminization of ageing. The number of respondents is fifty therefore only the above issues have come out and with large sample more concerns will come out. More research on this topic with a bigger sample size is advised in light of the elderly population to comprehend better and offer more information about additional problems that India's elderly citizens face.

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Competing interests

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Conflicts of Interest

The author declares no conflicts of interest

REFERENCES

1. *BIDPA (Botswana Institute for Development Policy Analysis). (2020). District Survey Report, 1-25. Retrieved from https://aligarh.nic.in/notice/district-survey-report/*
2. *Caramel, S. (2019). Health and Well-Being in Late Life: Gender Differences Worldwide. Frontiers in Medicine, 1-11.*
3. *Dey, S. Nambia, Devaki. Lakshmi, J, K. Sheikh, Kabir & Reddy, K. S. (2012). Health of the Elderly in India: Challenges of Access and Affordability. National Research Council (US), 1-486 Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK109208/*
4. *E, Harnois. (2015). Ageing and Gender Discrimination: Intersecting Inequalities Across the Life course. Advances in Gender Research. 20, 1-23. /doi:10.1108/S1529-212620150000020005*
5. *Estes, C. (2009). Feminist perspective on ageing. In Sociology of Ageing. Kumar et.al. (Ed.),1-444. New Delhi: Rawat Publications.*
6. *Ghosh, Huma, Ahmad. (2009). Ageing and Gender in India: Paradoxes of a Feminist Perspective. Asian Women, 25, 1-27.*
7. *Giridhar et.al. Older Women in India: Economic, Social and Health Concerns, 1-52. Retrieved from https://india.unfpa.org/sites/default/files/pub-pdf/ThematicPaper2-Womenandageing.pdf*
8. *Global Gender Gap Report. (2022), 1-374. Retrieved from https://www.weforum.org/reports/global-gender-gap-report-2022/*
9. *Kaur, M. & Kaur, J. (2019). Health Issues of Women in Old Age: A Literature Review. AMEI'S Current Trends in Diagnosis & Treatment.3(1), 27-32. https://doi.org/10.5005/jp-journals-10055-0065*
10. *Kilari, Nagaraju. (2020). Gender Inequality in India. Indian Journal of Archaeology of Egypt/Egyptology.17(9), 1-5.*
11. *LASI (Longitudinal Ageing Study in India Wave I). (2017-18). Executive Summary, IIPS. Mumbai. An Investigation of Health & Social Well-being of India's Growing Elderly Population. 1-632.*
12. *Nair, S. Sawanat, Neena. Thippeswamy. Harish & Desai, Geetha. (2021). Gender Issues in the Care of Elderly: A Narrative Review. Indian J Psycho Med, 43(5), 1-5.doi 10.1177/02537176211021530*
13. *Retrieved from https://www.futurelearn.com/info/blog/what-is-feminism*
14. *Roy, K. & Chaudhuri, A. (2008). Influence of socioeconomic status, wealth and financial empowerment on gender differences in health and healthcare utilization in later life: evidence from India. SocSci Medicine,66(9), 51-62.doi: 10.1016*
15. *Sen, A. (2001). The Many Faces of Gender Inequality. The New Republic. 466-477.*
16. *Tika, Dwi, Tama. Ulfa, N, H. & Hapsari, A. 2020. Who Spend more on Health Expenditures among Elderly? Men or women. KnE Social Sciences, 1-7. DOI 10.18502/kss.v4i10.7402*
17. *Tiwari, A. 2013. Gender Inequality in Terms of Health & Nutrition: Evidence from National Family Health Survey-3. Pacific Business Review International, 5(12). 24-34.*

18. *Tomar, Aditi & Hossain, M. Mahbub. (2021). Health disparities among older women in India during the COVID-19 pandemic.Journal of Health Research, 36(4), 1-3. 10.1108*
19. *What Is Intersectionality, And What Does It Have To Do With Me? (2017). Retrieved from https://www.ywboston.org/2017/03/what-is-intersectionality-and-what-does-it-have-to-do-with-me/*
20. *WHO (World Health Organisation). (2023). Gender and Health. Retrieved from https://www.who.int/health-topics/gender*