ISSN No. 0976-8602 VOL.-II, ISSUE-IV, OCTOBER-2013

Asian Resonance

A Peep into the Health Scenario and Utilisation of Health Services of Elderly Women

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Abstract

Background: Feminisation of ageing is a worldwide phenomenon with India being no exception. This paper aims to look into the health needs and health status of elderly women of various states of India. A peep into the availability, accessibility and affordability of both common and specialised health services available to elderly women has been made in the following paper. In old age, many ailments crop up in the body, while expenditure on health increases manifolds and service available become hardly sufficient-quantitatively and qualitatively. In the case of elderly women, the situation is all the more dismal. Chronic malnutrition since early childhood; dependence on others, socially, economically and culturally; repeated and multiple pregnancies in prime time; apathy towards seeking health service; ignorance and cultural taboos related to sexual health- have been some of the salient reasons for the deteriorating health status of women in old age.

Method: The paper is based on secondary data which is chiefly based on the findings of an empirical work done by Haryali, National Sample Survey (NSS) and National Family Health Survey(NFHS III) to find out the vulnerability issues with regard to the health status of elderly. Elderly women from various socio-economic strata across rural and urban residence, major religions and other, social groups, have been taken as the sample, to capture a broader view of the health condition of elderly women in northern India. The poster looks into the common ailments and disabilities elderly women suffer from, their activities of daily living, their health-seeking behaviour in the context of the healthcare system, policy measures and health security system available to them. In the light of the findings, the poster offers suggestions relevant for policy makers and social planners.

Keywords: Feminisation, ageing, malnutrition, health services.

Introduction

Health concerns in old age have no longer remained a private matter confined to the elderly themselves and their care-givers in the family. Increasing role of the state in the health security of the elderly has been reflected in the policy guidelines and action plans of the health department. With advancement in public health and medical sciences, death rate has reduced substantially and life expectancy has increased. This trend is observed throughout the world, though with varying rates. Increasing proportion of elderly in the population of the world is indeed an indicator of success of public health and medical sciences. However, this has posed serious problems, especially to the developing countries having scarce resources. According to one estimate, in developed nations, three persons earn for the security of one elderly and in future this ratio would go down further, putting burden on the earning population as well as the state (***Panda*: 2005**). Further, in the developing countries, providing social security and welfare to the elderly is also putting pressure on the economy. Within the population of the elderly, aged women attract more attention for reasons more than one _ firstly, feminisation of ageing is a world –wide phenomenon as demographic projections confirm that elderly women would far outnumber their male counterparts in the next couple of decades; secondly, the patriarchal social structure puts additional and excessive burdens on women in almost all walks of life; and thirdly, higher incidences of widowhood, illiteracy, malnutrition and high economic dependence depict the vulnerability of elderly women.

In the case of elderly women, health vulnerability is accentuated for many biological as well as social and cultural reasons. Biologically, after menopause, chances of osteoporosis increase significantly, reducing bone

strength and vigour. Chronic malnutrition since childhood gives rise to many deficiency disorders. For majority of elderly women, multiple and repeated pregnancies in their prime time not only takes away their stamina but also leads to many gynaecological complications, which get aggravated due to apathy towards their own health and cultural taboo to discuss sexual and reproductive health issues. Along with these ailments, women also suffer from general degenerative diseases in old age like deterioration in sensory capacities (like cataract, hearing impairment), trembling, locomotion problems, blood pressure, diabetes, ulcers, cancers, asthma and the like, as their male counterparts. Researchers and scientists often maintain that women are more prone to illness while men enjoy less longevity of life.

This apart, availability, accessibility and affordability of health services, both common and specialised, play a crucial role in determining the health security of the elderly. In developing countries poor health infrastructure accentuates the health vulnerability of the elderly. Though traditionally informal support systems like family have played a pivotal role in the care of the elderly, their role is increasingly becoming minimal as migration of labour precipitated by globalisation, modernization, and the diversified healthcare services. According to one estimate, two-thirds of the elderly people live in or on the margins of poverty (***Glendenning:*** **1992**). Despite availability of the finest healthcare system, majority of the elderly find it beyond their reach. Family bonds are quiet strong and senior citizens and their married prefer 'distance-care'. Social service departments are mainly concerned with crisis intervention, short-term support such as respite care, crisis intervention and it is only in severe breakdown that long-term care is offered.

In the Indian setting, the socio-cultural environment is dominated by a patriarchal social structure. Subordination of women and male domination characterise Indian society. Gender discrimination is clearly reflected from birth to death, including old age. Education, health, nutrition and other opportunities of growth and development are distinctly for males while girls are socialised to be dependent on and subordinate to male members of the family. Their childhood is typified by illiteracy and under-nutrition, marriage at an early age, repeated multiple pregnancies in adulthood-all accentuating vulnerability in old age. Evidently, lack of social and economic skills emaciated body with chronic malnutrition coupled with learned helplessness speed up the process of deterioration in old age among women.

Research Design:

The present paper attempts to look into the situation of elderly women in India with respect to the factors that influence their health vulnerability. It would examine the availability, accessibility and efficacy of healthcare system available for elderly women.

Findings:

There are certain intrinsic factors that make a person vulnerable in old age. Age-related changes are reflected in deteriorating strength and vigour of the body. Anatomically, catabolic or breaking down reactions increase in the body that initiate the decaying process. However, a lot of variables like health status, genetic endowment, nutrition, lifestyle, economic status and the like play an important role in accelerating or inhibiting the ageing process in the body. Ageing makes the body vulnerable to deterioration and eventually death***. Kirkwood*** (1998) observes that bodies have an 'in-built programme' to decay and die in order to make way for younger members of the species-preventing overcrowding-which is termed as 'programmed senescence'. It is often held that poverty is a significant factor that makes the elderly vulnerable to destitution. *Table* **1** gives an overview of elderly population from 1901 to 2001 as well as decadal growth rates. It indicates that decadal growth rate among the elderly in 2001 has been more than four times its value in 1911. It may be noted that the proportion of female population among the elderly is decreasing consistently over the decades which is in contrast with the world-wide phenomenon of feminisation of ageing. This indicates the vulnerability of elderly women in the country.

Table 1 : Population and Decadal Growth of Older Persons in India

Year	Old Age Population					*Decadal Growth Rate (%)*					
	Male		Female		Total	Male		*Female*		Total	
	No.	%	No.	%		60+	All Ages	60+	All Ages	60+	All Ages
1901	5501791	46%	6558055	54%	12059846	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
1911	6181329	47%	6987458	53%	13168787	12	6	7	5	9	6
1921	6482389	48%	7002375	52%	13484764	5	0	0	1	2	0
1931	6944128	49%	7264263	51%	14208391	7	11	4	11	5	11
1941	8890700	49%	9149300	51%	18040000	28	15	26	14	27	14
1951	9671048	49%	9941222	51%	19612270	9	13	9	13	9	13
1961	12356687	50%	12355422	50%	24712109	28	22	24	21	26	22
1971	16874325	52%	15825406	48%	32699731	37	26	28	24	32	25
1981	22022869	51%	21144519	49%	43167388	31	24	34	25	32	25
1991	29363725	52%	27317915	48%	56681640	33	24	29	23	31	24
2001	39268889	49%	40091904	51%	79360793	34		47		40	

Source: Ministry of Social Justice & Empowerment, Govt. of India, New Delhi

Let us take a look at the socio-demographic scenario of India in order to understand the socio-cultural context in which most of the elderly women struggle to live. According to the census of 2011, the population of India is 1,210,193,422; sex ratio is 940 females per 1000 males and average population density is 382 persons/ sq.km. The country is divided into 28 states and 7 Union Territories. There are 640 districts and 31.16 percentage of the population is urban. It signifies that India still has predominately a rural contour. The total literacy rate is 74.04 percent, with 75.3 percent males and 53.7 percent females constituting the literate population. Census 2011 further brings out that there are 308 lakhs elderly persons who are working, out of which 227 lakhs are males and 81 lakhs females.

Further, a brief analysis of the budgetary allocations of the government shows that out of the total budget, 20,822 crores is spent on health services. (**Union Budget, 2012-13**). The National Health Policy (NHP) envisaged that 2-3 percent of the total Gross Domestic Product (GDP) had been spent on health by 2010. This amount has been static at 0.9 percent for almost two decades and whatever actual increase in money allocation has occurred is because of increase in GDP percent. Data on all India

performance of the 20 point Programme during the tenth plan period also bring out that during the year 2003-04, against the target of establishing new 575 Community Health Centres (CHCs), only 148 (that is 25.7 percent success)have been materialized. Likewise, for the same year, against the target of 406 Primary Health Centres (PHCs), only 41 (10 percent success rate) could be established. Trend analysis brings out the serious gap between the planned and available health infrastructure for the general public including the elderly continuously for years together. (**Ministry of Statistics and Programme Implementation, GOI, 2007).**

Table 2 presents relevant information about the elderly. In terms of number of elderly population, Uttar Pradesh tops the list, followed by Bihar and Madhya Pradesh. Sikkim has the lowest number of elderly persons. Looking at the gender distribution among elderly population, Orissa and Jharkhand have equal proportion of elderly males and females. Chhattisgarh remains the only exception where feminisation of elderly population is clearly visible.

Table 2 State-wise Population of Old Age Persons-2011

S. No	Name of State	Total Population	Population of Aged Persons	
		(All Ages)	Total	
			No.	%
1.	Assam	31169272	1560366	2.04%
2.	Bihar	103804637	5501274	7.18%
3.	Chhattisgarh	25540196	1504383	1.96%
4.	Jharkhand	32966238	1578662	2.06%
5.	Madhya Pradesh	72597565	4280924	5.59%
6.	Orissa	41947358	3039100	3.97%
7.	Sikkim	607688	29040	0.04%
8.	Uttar Pradesh	199581477	11649468	15.2%
	India	1210193422	2262413	

Source : Ministry of Social Justice and empowerment, Govt. of India, New Delhi

A brief overview of the important demographic and development indicators of the states under study is presented below:

Assam: it has a population of about 3,11,69,272 according to the Census of 2011. This north-eastern state is predominantly rural, with just 14.08 per cent of urban population. It has a literacy rate of 73.18 per cent, with 78.81 per cent literate males and 67.27 per cent literate females. Work participation rate in the state is merely 35.88 percent, which includes 49.93 percent males and percent females. Assam is one of the states with the highest number of indigent persons. 19.7 percent of the population in the state lives below the poverty line. The state has the fourteenth place on HDI or Human Development Index (dimensions: education, economy and health).

Bihar: It has a total population of 10,38,04,637. Bihar is mainly rural and barely 11.3 per cent of its population lives in urban areas. It has a literacy rate much below the national average: 63.82 per cent, with 73.39 per cent male and 53.33 per cent female. Again, work participation rate is among the lowest in the country, that is, 33.88 percent. Gender disparity is quiet pronounced, work participation rate among males is 47.73 percent, as against 18.84 percent among females. Another socio-demographic indicator showing the dismal state of affairs in Bihar is the proportion of population living below the poverty line - 42.6 percent, only next only to Orissa. Bihar occupies the fifteenth place on HDI.

Chhattisgarh: it is a newly constituted state with a total population of 2,55,40,196, as per the census 2011. The state 23.24 per cent of urban population, but it also has a substantial component of tribal population.71.04 per cent of the population is literate, which includes 81.45 per cent of men and 60.59 per cent of women. Work participation rate in Chhattisgarh is 46.54 percent. In the case of females, it is 40.04 percent while among males it is 52.97 percent. Handbook on Social Statistics, 2004, Ministry of Social Justice and Empowerment, shows that 37.87 percent of people in Chhattisgarh live below the poverty line.

Jharkhand: it is also a newly created state. It has a population of 3,29,66,238. 24.05 per cent of the population lives in urban areas. Literacy rate is 67.63 per cent (male: 78.45 per cent; female: 56.21 per cent). Turning to work participation rate, the state has quite a low proportion of people working as main or marginal workers. The rate of work participation is merely 37.64 percent, with 48.21 percent for males and 26.4 percent for females. As per recent official statistics available with the Ministry of Social Justice and Empowerment. 42.6 percent population in the state lives below the poverty line.

Madhya Pradesh: It stands as the seventh largest state according to population size. In the state, 45.23 per cent population lives in urban areas. Literacy rate, in consonance with the national average, is 70.63 per cent, with 80.53 per cent male and 60.02 per cent female. Further, work participation rate is 42.75 percent that comprises 51.62 percent males and 33.1 percent females. The proportion of person living below the poverty line in the state is 37.87 percent. The state is twelfth on Human Development Index.

Orissa: According to census of 2011, Orissa has population of 4,19,47,358. Among its 30 districts, Ganjam, is not only the most popular one, but also a source of maximum out-migration. The state has a total urban population of 16.68 per cent, almost half the national average. Literacy rate in Orissa is a shade better than other states. It is 73.45 per cent(males 82.40 per cent, females 64.36 per cent). Work participation rate is low, the rich natural resources of the state is not withstanding. Among males, work participation is 52.75 percent, while among females it is 24.62 percent, with the state average of 38.88 percent. Economic conditions are rather discouraging; 47.15 percent of population lives below the poverty

line. Further, the state ranks eleventh on Human Development Index.

Sikkim: One of the north-eastern states, Sikkim has a population of about 6,07,688 only. Only 24.97 per cent of the population in the state is urban. It has a literacy rate of about 82.20 per cent – 87.29 per cent males and 76.43 per cent females are literate. However, work participation in the state is only 48.72 per cent (male: 58.75 per cent : female:38.59 per cent). In Sikkim, 20.1 per cent population lives below the poverty line.

Uttar Pradesh: According to the census of 2011, the population of the state is 19,95,81,477. Literacy rate is 69.72 per cent, 79.24 per cent for males and 59.26 per cent for females. Work participation rate in Uttar Pradesh is 32.6 percent (47.26 percent for males and 16.28 percent for females). The urban population component in the state is 22.28 per cent.32.8 per cent population in the state is estimated to be below the poverty line. On Human Development Index, Uttar Pradesh figures at the thirteenth position.

Let us look at the situation of elderly women in our country. It gives a dismal picture of the situation of elderly women in India. Typically, elderly women are in 'old' age group (65-74) with an average of 68 years. Services need to be initiated and established keeping in mind that with increasing age, dependence on formal and informal support system increases manifold. In the study, two thirds of elderly ladies are widows. They are found to be more vulnerable economically and socially. In most cases, after widowhood, abuse and exploitation has increased considerably. Legislative measures need to be put in place effectively with strong punitive action to curb abuse and exploitation on elderly ladies. In the study, nearly one elderly woman in every ten is staying all alone. They are the most vulnerable and need to be protected and supported. Involvement of police force to protect them, expanding options of old age homes or shared living would be beneficial. In the study, most of the elderly women are illiterate and majority of them have remained housewives or non-workers. There are 43 percent rural elderly women and 54 percent urban aged females who are living below the poverty lines. A very discouraging picture emerges when the coverage of social security measures (17 percent are getting OAP and nearly 12 percent are getting Annapurna) is seen in the light of the needy (roughly 48 percent of the respondents living below the poverty line).

Against this backdrop, let us understand the issues that influence health vulnerability of elderly women in India. Old age is characterised by decreased vigour and strength in the body. The elderly invariably become susceptible to many ailments as body organs reduce their functional capacity. This health vulnerability, in turn, affects social functioning. Locomotion problem restricts movement and interaction with friends and neighbours. Autonomy in activities of daily living like getting up and sitting, taking medicines, etc., reduces with increasing age. Dependence on others makes the elderly more vulnerable. Looking at the sensory capacity, data bring out that most of the respondents (78.1 percent) complained of their vision going down and 46 percent stated that their hearing capacity has reduced. Further, 70.1 percent respondents have locomotion problems. In old age many ailments crop up in the body. In the study, 20.4 percent respondents have high or low blood pressure, 10.4 percent have heart problems, 4.3 percent have gynaecological complaints. 4.1 are diabetic, 29.3 percent have digestive upsets and 29 percent have prolonged coughing. Similarly, 2.2 percent have kidney stones while 2.3 percent complained of liver/ jaundice problem. Coming to mental ailments, 39.5 percent have anxiety, 45 percent have sleeplessness and 23 percent have mental pressure/depression. This shows that elderly respondents have high health vulnerability.

Affordability of health services is also very crucial especially when seen in the context of the fact that an estimated 3.3 percent of the population in the country is assumed to be getting pushed below the poverty line on account of high costs of medical treatment. Added to this, in old age, a person requires eight times more health services than a young adult (Gatzen: 1992). A look into the availability and accessibility of the healthcare system would be beneficial to comprehend the vulnerability of elderly women.

Although most of the states in India have a fairly large public sector health infrastructure comprising of super speciality institutions, government and private medical colleges and hospitals, district hospitals, combined hospitals and a well-knit web of Community Health Centres, block Primary Health centres, Sub Centres, apart from private dispensaries and a large number of registered and non-registered medical practitioners who play a vital role in providing medical service to the population, their efficacy is often under scanner. Let us take a close look at the health system available in the country. It may be noted that though the National Policy on Older Persons, 1999 claims to ensure quality healthcare services to the senior citizens, which includes establishing geriatric wards, clinics and dispensaries and creating a cadre of healthcare professionals specifically trained in geriatric medicine, the proportion of such specialised service is meagre. Therefore, we are focussing on the general healthcare system available in the country which the elderly approach when in need.

Records on hospitals and beds, in the year 2002, bring out that there are 12,760 government hospitals in the country out of which 3,748 are in urban areas and 6,795 are in rural areas. Similar is the case of hospital beds (3,99,195 beds in urban areas and 1,49,690 in rural areas), and 24,448 dispensaries.

Lack of adequate personnel has remained a serious constraint, which even the National Health Policy, 2002, intended to address. It may be noted that just ensuring availability of health service would tantamount to work half done, as several other deterrents such as bad roads, the unreliability of the

health provider, costs for transport and wages foregone, etc., make it cheaper for a villager to get some treatment from the local quack. It is estimated that nearly 10 per cent of the people in India are not able to access medical care due to locational reasons. Further, even when accessed, there is no guarantee of sustained care.

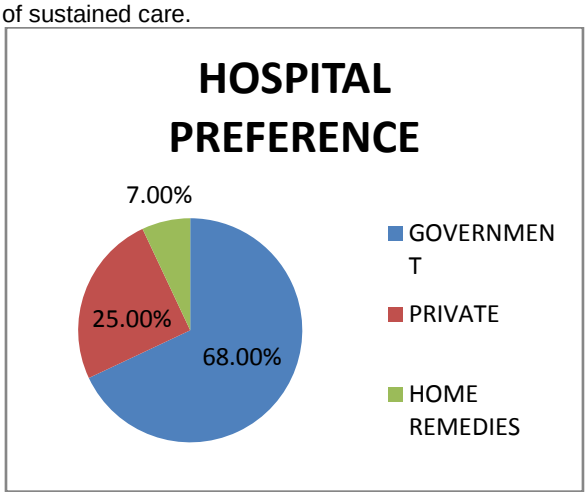


Fig. 1

In the study, 68 per cent respondents preferred going to government hospitals and 25 per cent preferred private healthcare settings. Seven per cent elderly preferred home remedies or traditional healers or quack. (fig. 1)

Information about the distance of the nearest government hospitals from the place of residence of respondents bring out that 41.8 per cent elderly women have to travel a small distance to reach to the nearest hospital. Another 30 per cent stay at about 2.5-5 kms away. For the rest of the respondents, the nearest government health care centre is located very far (6 to 50 kms). This shows that for a huge size of population, health care service by the government is no way near and easily approachable.(fig. 2)

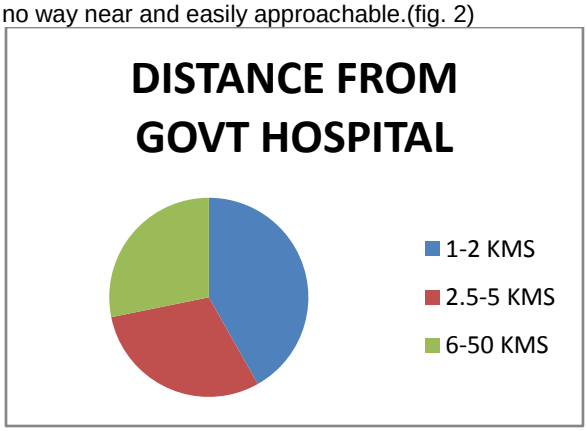


Fig.2

Likewise the private health care facilities are also not within easy reach: for 35.2 percent respondents, it is within 1 to 2 kms, for another 20.8 percent respondents, it is within 2.5 to 5 kms and for the rest 44 percent of the population, locational hurdles are enhanced as they have to travel upto 6 to 50 kms to access the nearest private health care services. (fig. 3)

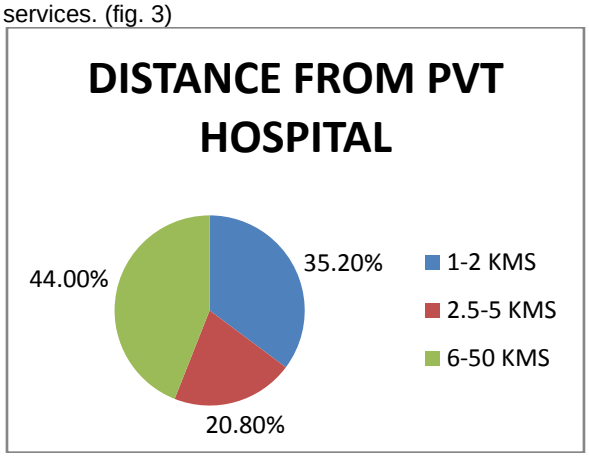


Fig 3

There are 20.4 percent elderly women who, for some or the other ailment, were admitted to hospitals in the last one year. When asked about quality of treatment received in the hospital, 12.5 percent considered it bad and 8 percent mentioned that people care was not upto the mark. Further only 2 percent elderly answered that Mobile Medical Unit has visited their neighbourhood in the last one year. Similarly, 16 percent confirmed that a medical camp was organised in their area in the last one year. Outreach services or door step health care services like Mobile Medicare Unit and Medical Camps for screening of many age related ailments are very much needed for the elderly as with declining body strength and, more often than not, lack of care givers/attendants who can take them to health care institutions, accessibility and affordability become difficult propositions with increasing age.

Further, in the study, when asked about the efforts made to maintain good health, 84 percent of the respondents do not do any exercise or yoga etc. This indicates the need for creating awareness about the importance of healthy lifestyle for active and productive ageing.

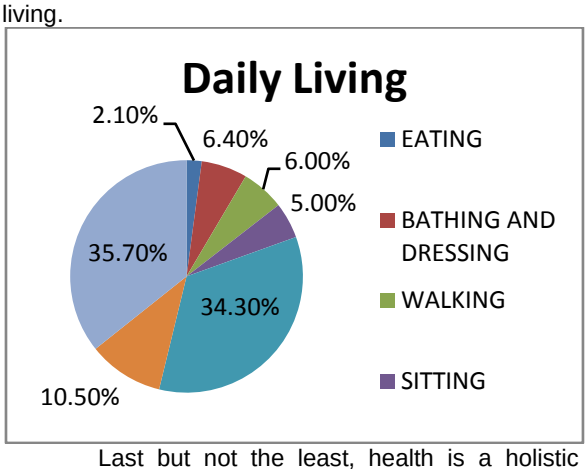
Another crucial finding is that only 21 percent family members felt that they can easily meet the expense of medical treatment of the elderly lady. This means that more than three fourth of the elderly women are quite vulnerable economically if their health deteriorates. Lack of adequate measures vis-a-vis health security of the elderly, and especially of elderly women, is a major drawback in our country when compared to other nations like Canada and Germany, etc.

Added to this, only 1 percent elderly women have got their health insurance done and therefore medical expenses could be met with some ease. For the rest of the aged women, shelling out a lot of money for the medical treatment may be quite sapping. This speaks volumes on the affordability of health services especially by elderly women, who are considered as spent force, useless by the society. When seen in the context of illiteracy, poor economic condition,, dependence on others for survival needs, learnt dependence, lack of skills for self-reliance, such

situations make the procession of elderly women all the more precarious.

The study reveals that almost one fourth (24.3 percent) of the elderly women have been neglecting their treatment for some ailment or other. This apathetic attitude of elderly women towards their health is, among other factors also attributed to their socialisation practice in a patriarchal society.

When asked about independence in activities of daily living, 21.1 percent of the respondents reported to be requiring health in eating, 6.4 percent in bathing and dressing, 6 percent in walking and five percent in getting up and sitting. 34.3 percent elderly respondents need help in kitchen work, 10.5 percent in taking medicine and 35.7 percent in washing clothes/laundering. Data further show that as age advances, autonomy in activities of daily living reduces considerably which in turn increases their vulnerability. Thus, middle-old and old-old women become much more vulnerable and dependent on others for their activities of day-to-day living.



Last but not the least, health is a holistic concept. Many of the seemingly unrelated factors like role in the family (poor health, least involvement and vice-versa), involvement in decision-making (no participation in decision making may result in passive, dependent subdued status making the elderly lady more prone to ailments), relationship with significant others like son, daughter-in-law, grandchildren (direct impact on care issues and meeting health needs), marital status (widows tend to fall sick more frequently than their married counterparts), abuse (elderly abuse may mean denial of provision of needed medical attention, medicines, adequate nutrition and so on, severely influencing the health status of victim elderly women), actually have profound influence on the health status of elderly ladies.

Conclusions:

Data in the study reflect health vulnerability with increasing age. High/low blood pressure , diabetes, heart problem, gynaecological ailments, respiratory problems, digestive upsets are quiet common. Awareness about maintaining a healthy lifestyle is low and aged women are apathetic towards their own healthcare. Even mental disorders are frequently reported and day care centres are hardly present that could provide a place for solace and catharsis, friendship and companionship to the elderly. Added to this, their presence in Self Help Groups, Mahila Mandals and even Panchayats needs to be made more prominent. The elderly themselves should act as a pressure group or advocate ensuring their rightful place in the family, community and society. Mobile Medicare Units and regular their frequent health camps would help in reducing their health vulnerability. Providing health insurance to all the elderly may not be feasible for our country but free or highly subsidised health services through geriatric out-reach programmes may be expanded. Social security network needs to be expanded to cover all the needy elderly women. Administration requires being more gender sensitive. Raising the amount of old age pension and getting rid of the crippling conditions of producing age proof and domicile would increase the effectiveness of service delivery system including the healthcare system. Last but not the least, it is the duty of the society and the state in particular to ensure that all the elderly live their lives to the fullest and that WHO's mission of the health longevity may be realised.

Suggestions:

- Distance care: - As strong family bonds are still in the genes of Indians, we can develop some models where by the elderly are looked and taken care of by close community members.

- Social security offered by government is no solution to tackle this continuous stream of elderly people. Rather, long term goal should be achieved such as education of the females, their empowerment, right to property, stringent laws against their abuse and above all a change in patriarchal society where women may not be treated above men but at equal and important place.

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