Older Women as Community Resources: Choosing to Care[1]

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ABSTRACT

Ang Pamilyang Pilipino ay likas na mapag-alaga sa kanilang mga nakakatanda. Ang pagkupkop na ginagawa ng pamilya ay sumasaklaw hanggang sa mga huling araw ng buhay ng nakakatanda maging sa panahon ng kalusugan at pagkakasakit. Ang pagsubok na kakaharapin ngayon ng ating lipunan ay kung paano mapupunan ang pangangailangan ng mga nakakatanda—na sa taong 2030 ay tinatayang bubuo sa 13.5% bahagi ng pangkalahatang populasyon ng bansa.

Ang papel na ito'y tumatalakay sa isyu ng mga kababaihan at kung paanong bilang kasarian na bubuo at bumubuo sa mas malaking bilang ng nakakatandang populasyon, ang suliraning kaakibat ng katandaan ay suliranin nila. Kaalinsabay ng katotohanang ito, dapat na mabuksan ang mga mata ng mga organisasyong pampubliko at pampribado upang mailagay sa pinakamataas na antas ng kapakinabangan ang papel na ito na ginagampanan ng nakakatandang kababaihan.

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INTRODUCTION

When global ageing became an agenda for international communities in Vienna in 1982, our government took up the cause. When Helpage International sponsored a consultation in Manila inviting government, non-government agencies and people's organizations about the looming crisis of care for older persons, the Coalition of Services of the Elderly was established. When the United Nations declared 1999 as the International Year of Older Persons, the Philippines once again contributes to this celebration.

Yet while all this talk and planning and sharing and policy-making has been going on, we know that we are still a young nation with an elderly population (defined in our country as 60 years old and above) of 5.8 % (Table 1)[2]. The Philippines will become a "mature population" in the year 2030, when the proportion of older people is projected to comprise 13.5%.[3]

TABLE 1
TOTAL AND PERCENTAGE OF ELDELRY POPULATION
FROM 1980 - 1995

YEAR	TOTAL POPULATION	ELDERLY POPULATION	% ELDERLY POPULATION
1980	48,098,460	2,541,831	5.2%
1990	60,703,206	3,187,967	5.2%
1995	68,616,536	3,736,622	5.2%
1998	73,130,885	4,280,364	5.8%

*Source: 1980, 1990, 1995 Census of the Philippines
National Statistics Office, Information and Dissemination Section

Traditionally, the Filipino family has been known to keep their elderly, in sickness and in health, within their midst until the latter's last days. Until today, it is customary for a member of the family, usually the female, to give up his/her occupational status to perform this family duty. Other built-in systems for old age support are having a large family to begin with that respects its elders, and an extended family system that is closely knit. Ageism—the discrimination against older persons—is therefore out of context because of the way the elderly is cared for in the Philippines.

With the challenges of global ageing and Filipino population ageing, in particular, an important concern now for government and other non-governmental agencies is to maintain the integrity of the Filipino family during the looming crisis of care for older persons. In its own modest way the government is doing its part. Republic Act 7432 is an act recognizing the Senior Citizens as valuable contributors in nation-building and granting benefits and other privileges to them. Republic Act 7876 establishes a senior citizen's center in every city and municipality of the Philippines. Organized elderly can use this facility for meetings, training and income generating opportunities, or as a venue for their social activities. There are also pending bills which address other economic, health and social concerns including the proposed National Council for the Welfare of Older Persons.

The gender issue as it relates to older Filipinos remains unexplored. Because of longer life expectancies, an ageing nation's problems may ultimately be older women's problems.[4] Policymakers, current women's groups, legislators, non-government organizations as well as people's organizations must therefore be aware of this tendency. The current generation of older women today play essential roles in the family, the community, and the labor force. These roles must be understood better in aid of maximizing their contributions to society.

THE FILIPINO OLDER WOMEN

Although life expectancy for both men and women has increased worldwide over the last twenty years, in general women are living longer than men[5]. The ageing world therefore is becoming a world of females[6].

Table 2[7] shows that in the Philippines, there is only a small difference between the number of elderly males and females from 1980 to 1998, with the females, however always outnumbering the males. This is partially explained by the differentials in life expectancy. The World Health

Organization states that as of 1998, life expectancy of females was 71 and males was 68 years.[8]

The Philippine Health Statistics of 1992 identified the leading causes of death among the elderly as follows: diseases of the cardiovascular system, pneumonia, tuberculosis and malignant neoplasms. Table 3[9] shows the distribution of disabled elderly by age group and sex according to the 1990 census. It is apparent that the number of persons with disabilities decreased as age increased except at age 80 years and above, when the number of those with disabilities increased. Decreasing number of disabled from the 65 years to 74 years age group may be explained by decreasing number of survivors. Among the survivors, i.e., those aged 75 and above, there were more females with disabilities, this age group being predominantly female.

Traditionally, women's role was secondary to men. It was the male sibling who was given higher priority for education[10]. Women stay at home and help their mother in doing household chores instead of getting a formal employment, and are less likely to receive pension at older ages. It is expected, therefore, that an average 80 year old Filipina today, although with some family support, is a widow, chronically ill, disabled and without financial support.

WHO ARE THE FAMILY CAREGIVERS?

During the pre-colonial period, the older woman can be the Babaylan or healer or adviser to the Datu. She is also considered as the "bearer of culture" and " spiritual leader."[11] The grandmother, the wife, the daughter and/or daughter-in-law are the caregivers. The grandmother or Lola can provide the needs of the children that their parents cannot give[12]. In a multi-generation household with Lola still married, Lola can still be wife and caregiver, and her daughter can also be the same. However, with the economic crisis of today, Lola's daughter, who is also her potential caregiver, may have to work to improve their economic situation. Hence, the middle generation woman today is different from her predecessor: she is in the labor force; and most probably she is also abroad. Although she maybe contributing to the country as a financial resource, she leaves behind a gap in the availability of carers therefore putting her family at risk in the face of such a crisis. Who will then take care of Lola and Lolo and the children?

GROUPS FOR OLDER PERSONS

The classic study of Lowenthal and Haven[13] demonstrated that as one ages, maintaining relationships becomes increasingly difficult.

However, a caring one may act as a buffer against these age-linked social losses. The study also said that there are two kinds of relationships experienced in old age -- primary (the family) and secondary, (the formal or group affiliations, etc.). Both are threatened in the light of the increasing frailty of older person. The primary relationship is threatened due to the burden of caring; the secondary relationship may be lost due to the increasing limitation of the frail older person in participating. As with the loss of potential carers for our elderly today, who then fills the gap?

It has been proposed by policymakers in international conferences on poverty and social development that community-based services for those in the later years of life shall be supported to break the cycle of poverty and enable women, especially older women, to share fully in the benefits of development[14]. Community-based programs and services, therefore, may serve as the secondary network or the group of relationships that can provide more meaning and be more nurturing to the older person. An example at the micro-level is the Coalition of Services of the Elderly, a non-government organization exclusive for older persons residing in urban poor areas in Metro Manila. It works on this definition of community: to work on problems directly affecting the lives of the urban poor older people while at the same time mobilizing their own resources. It has a total number of 1700 member-older persons and 75% of them are women.

COSE's mission is the empowerment of older persons despite their poverty. The key to the empowerment process is the community organizer who works on two basic principles: 1) he/she will never do anything for the people which they are not willing to do for themselves, and 2) setting goals is always with-and not for-the older people[15]. For example, in a consultation in 1995, the elderly declared that they need medical services.... COSE in turn asked them if they are willing to be health workers. Thus was born a model of a community-based health program (described in Table 4), an approach described as "bringing health into the hands of the people."[16]

OLDER WOMEN AS HEALTHCARE RESOURCES

We looked at the personal data sheets of the 17 elderly health workers who received their training in community gerontology in 1988 (see Table 5). About 88 % were females, and most of them had at least high school education. 87% were self-employed, while 4 (24%) had no income. Coming third was the category of dependent on allowance from children.

These figures can be said to parallel the general situation of older women today.

The community gerontologists are elderly health workers. They attended a 5 days workshop on diseases common to elderly people, and on remedies including herbal medicine, massage and local practices. They were also taught to monitor vital signs and keep records. Inputs on strategies for healthy ageing such as balanced nutrition, the role of exercise, stress management and spiritual enhancement, etc. were also given. During graduation, they received a bag with a stethoscope, thermometer, blood pressure apparatus and some over the counter medications for emergency purposes[17]. Since the majority of health problems are at the primary care level, the regular services of the physician are not needed. The community gerontologist is expected to be able to address this need of healing common ailments through the skills he/she learned in the workshop. The CG is a person who promotes better life with his/her community through the provision of elderly health services[18].

Initially, two community gerontologists were trained for every organized community. However, this ratio can increase if more are needed per area. CGs are chosen by their group to deliver health services. After their training, they are advised to visit their neighbors and monitor their health problems and treat them within their communities. Otherwise, they may be referred to external resources. If they had training from other community based health programs before, then the knowledge, skills and attitudes they have gained would be in addition to what they already know as health workers. By targeting the old health workers trained by community-based health programs that started 15, 20, or 25 years ago, training on common ailments of the elderly would complete their knowledge on diseases of all age groups.

PARTICIPATION AND HEALTHY AGEING

The core principle of the community gerontology program is participation. In planning, managing and decision-making, the elderly are consulted, and they are also co-implementors of the program. Through actual experiences, they will begin to be aware of their individual and collective ability to take care of their most basic health needs. As they do so, they may apply this awareness to work on other community problems.

Ebersole and Hess call this collective actualisation[19] ; in some societies these are called self-help groups, pressure groups, and advocacy. As carriers of empowerment activities, the members use processes and skills that can help them transcend their present miserable situations. In fact, there are already a number of self-actualized older persons attaining power and gaining recognition; so powerful that they could cause social transformation. Within these community based-health programs are indeed some older persons with such potentials. But is it a tool to gain political prowess? Economically, culturally and humanly speaking, it is clearly the best solution to keep the majority of the older people active and healthy in their own community for as long as possible.

NOTES

[1] Paper read for "Older Women's Health, the Nation's Gain" sponsored by Tsao Foundation and KK Women's and Children's Hospital. July, 1999.

[2] National Statistics Office.

[3] Based on the Moderate Series Projection of the Inter-Agency Committee on Population and Vital Statistics, National Census and Statistics Office, 1983.

[4] Sadik N. What is Feminization of Poverty and Who Does It Affect? Symposium on Inspite of Poverty…the Older Population Builds Towards the Future. March 1996. New York City.

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[6] Carlos CR. Concerns of Elderly Women In the Philippines. 4th WSAP General Assembly and National Conference. April 1999. Quezon City.

[7] National Statistics Office.

[8] World Health Organization. Ageing in the Western-Pacific Region, Country Profile. WHO. 1998.

[9] National Statistics Office.

[10] Carlos CR. Ibid.

[11] Architectural Resource Center on Barrier-Free Environment Fact Sheets.

[12] Natividad JN and Cruz GT. Patterns in Living Arrnagements and Familial Support for the Elderly in the Philippines. Asia-Pacific Population Journal. December 1997. United Nations.

[13] Lowenthal MF. Haven C: Interaction and Adaptation: Intimacy as a Critical Variable. Am Sociol Rev. 33:20, 1968.

[14] Sadik N. Ibid.

[15] Gerlock EM: "Community Organizing as a Method for Empowering Older Peole." New Age Asia. Jan 99.

[16] Tan JG: Primary Health Care: Health In the Hands of the People. Book of Readings. Primary Health Care. University of the Philippines and Department of Health. 1998.

[17] Camagay DMD. Care for the Elderly—by the Elderly. World Health. July-August, 1997.

[18] COSE. Healthcare Manual for Community Gerontologists. 1998.

[19] Ebersole P and Hess P. Toward Healthy Ageing 1994. Mosby USA.

TABLE 2
MALE AND FEMALE DISTRIBUTION OF ELDERLY IN THE PHILIPPINES

YEAR	MALE	%	FEMALE	%
1980	1,236,000	49%	1,306,000	51%
1990	1,497,000	47%	1,691,000	53%
1995	1,741,000	46%	1,996,000	54%
1998	2,006,000	46%	2,274,000	54%

*Source: National Statistics Office

TABLE 3
DISABLED ELDERLY MALE/FEMALE*
AGE-SEX DISTRIBUTION IN THE PHILIPPINES

AGE GROUP	MALE	FEMALE
65-69	14,389	13,754
70-74	14,092	13,489
75-79	12,157	14,975
80+	15,800	20,020

* Number of disabled per 100 normal population
*Source:World Health Organization, Country Profiles, 1998

TABLE 5
FOUR MODELS/LEVELS OF PEOPLE'S PARTICIPATION IN PRIMARY HEALTH CARE*

CATEGORIES	HOSPITAL/CLINIC BASED	COMMUNITY ORIENTED	COMMUNITY-BASED	COMMUNITY-MANAGED
GUIDING PRINCIPLE	Health to the People	Health for the People	Health with the people	Health by the People
WHO IS RESPONSIBLE FOR HEALTH?	Helath is the sole responsibility of the doctor	Health is the responsibility of health professionals	Health is the responsibility of the community health worker and leaders	Health is the responsibility of everyone in the community
LEVELS OF COMMUNITY PARTICIPATION	Community is just informed of health activities	Community is just consulted on what can be done	Community actively discusses and decides on plans and activities together with health professionals	Community identifies needs, defines objectives, implements, monitors and evaluates the health program
MAIN DECISION-MAKERS		Doctors and other health profesionals decide	Decision-making is shared by community and health staff	The community is the main decision-maker
VIEW ON AWARENESS BUILDING	The community should be kept ignorant of health	Community is made aware to change their behavior or to pacify them if their hardship revolts	As a means for community organizing and for understanding the interrelationship of economic, political and cultural problems	As a means to generate people's power and ensure continuing community participation
VALUE GIVEN TO COMMUNITY ORGANIZING	The community is not capable of being organized	As a means to change people's attitudes to cooperate with health authorities	As an end in itself and as an opportunity for people to develop leadership and management	As the main tool for empowerment and as a long-lasting safeguard to protect the community's interest
EFFECT ON THE PEOPLE AND COMMUNITY	Central authority allows little or no participation by the community	Pretends to be supportive, allowing some participation but resists some genuine change	Help people find ways to gain more control over their lives	Self-reliance and self-determination
GENERAL IMPACT	No change	Behavior change	Social change	Structural change

Source: Lifted from Table ___ of Tan, J.G., Primary Health Care: Health in the Hands of the People. Book of Readings on Primary Health Care. College of Public Administration, University of the Philippines and Department of Health. 1998.

TABLE 5
SOCIO-ECONOMIC PROFILE OF THE COMMUNITY GERONTOLOGISTS*

AGE VS. SEX DISTRIBUTION (n=17)

AGE	MALE		FEMALE	
	f	%	f	%
55-65 yrs	1	5.88%	13	76.48%
66-75 yrs	1	5.88%	2	11.76%
TOTAL	2	11.76%	15	88.24%

EDUCATIONAL ATTAINMENT VS. SEX (n=17)

Educational Attainment	MALE		FEMALE	
	f	%	f	%
College Level			2	11.76%
HS Graduate			3	17.65%
HS Level	1	5.88%	8	47.07%
Elem Grad			1	5.88%
Elem Level	1	5.88%	1	5.88%
Total	2	11.76%	15	88.24%

PRIMARY INCOME VS. SEX (n=17)

PRIMARY INCOME	MALE		FEMALE	
	f	%	f	%
No Income			4	23.53%%
Allowance from Child/ren			3	17.66%
Retirement Pension			2	11.76%
Self-Employed	1	5.88%	4	23.53%
Irregularly Employed			1	5.88%
Pension % Allowance	1	5.88%	1	5.88%
TOTAL	2	11.76	15	88.24%

* Source: COSE Document. Personal Data of Community Gerontologists. 1998