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Understanding the Situation of ELDERLY CITIZENS in Bhutan

Lham Dorji, Cheda Jamtsho, Tashi Norbu, Garul Dhoj Bhujel

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DISCLAIMER

NSB hopes the monograph would be useful for policy-makers, politicians, development partners, researchers, private sector, communities, and any other interested individuals.

The views expressed in the present publication are those of the authors and do not imply the expression of any opinion on the part of the National Statistics Bureau (NSB) representing the Royal Government of Bhutan. NSB takes no responsibility for any inaccuracy or omission of facts, statements, opinions, recommendations, or any other errors in this monograph.

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ABOUT THE MONOGRAPH

We strived to produce ten issues of monographs, two issues of research digests (summary of the monograph), and other occasional thematic publications since the Socio-Economic Analysis & Research Division (SEARD) came into function in 2011. All our monographs, research digests and occasional publications contained topical issues on Bhutan, prepared by triangulating and analysing data from various sources (census, surveys and administrative data). We made great efforts to use whatever data were available [to us] to convert data into evidence and information and contribute towards creating a knowledge-based society. We wanted to improve the quality or standards of our publications when data becomes available, but it is not likely to happen.

The result of recent Organisational Development Exercise (ODE) was that SEARD will cease to exist though Research and Statistics always go hand in hand. With the dissolution of the Division, we will not continue to produce monographs, research digests and occasional publications. We regret to inform our readers/users that this issue will be the last one. We apologise [to everyone] for not being able to continue with our publications. We hope our previous publications were useful to our readers/users.

About this particular thematic study, our initial idea was to conduct policy specific and concise research and publish a short report. We decided to conduct the more detailed study after we realised that not many studies on old age have been conducted in the country. We are hopeful that this study will serve as the groundwork for many policy specific research to follow.

SEARD Research Team

2017

PREFACE

As part of our Socio-Economic Analysis and Research Division's (SEARD) annual thematic studies, our research staff has made a tremendous effort to investigate the situation of elderly citizens in the country. I am very pleased to introduce this research, which I suppose is one of its first kinds if not the very first one.

With our country's population set to the process of ageing, it is crucial that we understand the changes happening in the lives of elderly citizens so that we can better respond to and address the problems of elderly people or get prepared to face the social and economic consequences of the ageing population in future. A study of this nature is expected to provide an understanding of the predicaments that some of our elderly people face and advocate for policy responses. At the least, this study is expected to provide baseline information or groundwork for more specific and rigorous future research or provoke positive debate among public on various social issues emerging among the older populace.

The Royal Government is well aware of the emerging social and economic issues and consequences that population ageing is likely to produce. It has the commitment to promote positive ageing and improve the lives of those elderly citizens who are affected by the process of ageing and modern development. I am hopeful that the report such as this may contribute to the formulation of policies and design of programmes and projects targeted at the older population in the country. This research has provided an opportunity for our research staff to interact and listen to elderly citizens to identify the old age problems, their possible causes, and solutions. Their meaningful interactions with senior citizens might have not only provided them with a true understanding of ground reality that some of our senior people are in, but also given them the opportunity to contemplate on solutions.

I am sure this exploratory study in the field of gerontology would make a useful contribution to future policy advice and more research in this area. I am happy that NSB's research staff, despite all odds against them, particularly the disruption caused by having to partake in the National Population & Housing Census of Bhutan (PHCB), 2017, have made all their efforts to complete the study on time and publish this report. I am told that our research staff will try to update the report as and when data

become available. I am sure data from PHCB, 2017 and BLSS 2017 will enrich the report. I would like to thank our research staff and all others who were involved in the study, directly or otherwise.

Chhime Tshering

DIRECTOR

ACKNOWLEDGEMENTS

Multiple-study such as the present one incorporates contributions from individual researchers and other experts who supported them. We were fortunate to get the support from various individuals and groups. Some of them have directly contributed the primary information (as research participants) while others provided us the support needed to conduct the study, especially during field research and data analysis. Still, a few others guided us towards the fulfilment of the study goals and production of this monograph.

First and foremost, we wish to express our gratitude to Phub Sangay (then heading NSB) and Chimme Tshering (present Director) for their support during our field works: questionnaire survey, in-depth interviews and Focus Group Discussions; data analysis; and report writing. Their endorsement of our proposals to conduct field research and data analysis in the manner we wished [to] was crucial. A three-week research retreat at a reclusive place outside Thimphu provided us the work environment conducive to carry out the literature review, data analysis, and report writing more efficiently and effectively. We always found research retreat beneficial for reinforcing teamwork, motivation, concentration, and work efficiency.

We thank all our elderly research participants, elected local leaders, and GAOs from Darla, Lokchina, Phuentsholing, Samtse, Deothang, Martshala, Gomdar, Trong, Fangkhar, Nangkor, Bji, Naja, Shaba, Katsho, Guma, Linmukha, Chubur, Tangsibji, Langthel, Korphu, Singye, Chuzurgang, and Gelephu Gewogs. We owe our gratitude to Dasho Dzongdags of Haa, Samtse, Paro, Chukha, Thimphu, Trongsa, Punakha, Sarpang, Samdrupjongkhar, and Zhemgang Dzongkhags for allowing us to conduct our field research in their respective Dzongkhags. We thank Dasho Dzongrab of Samdrupjongkhar Dzongkhag and Dasho Dungpa of Samdrupcholing Dungkhag.

DSOs of Punakha Dzongkhag (Pema Jampel), Samtse (Phuntsho Chogyal), Trongsa (Sonam Wangdi), Haa (Sonam Wangchuk), Sarpang (Kishore Chetteri) and Zhemgang (Tshewang Rinzin) deserve our grateful recognition of their contributions to our field research. Our special thanks to Tsheten Wangchuk (NSB, AFD) and Ugyen Zangmo (NSB, Accounts) for making transactions of research fund smooth, especially

during our travel to different Dzongkhags. Without their prompt and timely release and arrangement of the fund, field research could have been hampered.

We were fortunate to be working with some international experts who reviewed our works, shared with us old age research materials, and gave us generous advice towards putting the report in the present form. Among many, we thank Professor John Enrique Matta, Western University of Health Sciences, USA and Murayama Mayumi, Senior Researcher, Institute of Developing Economies (IDE), JETRO, Japan. Working with Professor John has been a rewarding experience.

In addition, a few research interns (enlisted with MoHLR) lent their support to transcribe our interviews, which we always found arduous. Thanks to Tempa Zangmo, Sangay Lhamo, and Priya Sharma (all research interns). We found all of them sincere and diligent, and we foresee the bright future for them. Yeshi Wangchuk (Martshala Middle Secondary School) and Ngawang Tenzin (Tendu Higher Secondary School) deserve our special appreciation for transcribing a large chunk of our interviews. Karma Chophel supported our field research in Darla Gewog. Thanks to him.

We thank His Eminence Yangbi Lopen Dreb Chimi Dorji and elderly members of Bhutan Elderly Sangha Project under Zhung Dratshang (Tshochagsa, Punakha) for participating in our qualitative study. *Kidu* Officer of Punakha Ugyen Pema merits special mention for sharing us her experience of working with older people. GAO of Naja Gewog Tshering Phuntsho contributed a note on his observations of the plights of some elderly people. We thank him for that contribution. We owe our gratefulness to the Member Secretary of Gelephu Gensho Tshogpa. We thank Rinchen Tshering (NSB) and Tandin Dorji (NSB) for designing CSPro data entry template and helping us sort out the hitches associated with data entry and processing.

Finally, we wish to thank the Record Section of JDWNRH, Psychiatric Department (PD) and HMIS (Ministry of Health) for sharing with us the medical records of both inpatients and outpatients. These records were used to perform simple-descriptive analysis of mental health disorders.

CHAPTER I

INTRODUCTION

POPULATION AGEING AND SOCIAL PROTECTION IN BHUTAN

Lham Dorji[1]

> Children that have been the charge of their parents to bring them up to be capable of doing something, should not presently, in hope of doing better for themselves, desert their helpless parents, as thinking it now time to look for themselves and left them shift as they can (*Samuel Willard, eighteenth-century Colonial preacher).*

Introduction

In Bhutan, social protection for elderly citizens is largely the responsibility of family and community. The traditional old-age care and support system (based on filial piety) still exists. This informal care and support system rests on the principles of hierarchy, obligation, obedience, and commitment (*tha dhamtshi*). The traditional joint family system ensures the continuity of the family and contributes towards the maintenance of family solidarity. At the same time, elderly citizens being abandoned, neglected, and even abused by their children are becoming conspicuous. The country's progressive socio-economic transformation may increasingly set a limit to the traditional family care system. This may come with long-term implications. The country's greying demographic profile, rising old age dependency ratio, and the decline in informal old age care and support system is emerging as the national policy concerns.

The growing ageing population in the country has begun to bear significant consequences for providing social protection. The formal social pension and provident fund schemes made available by the National Pension and Provident Fund (NPPF), Royal Insurance Corporation Limited (RICBL) and Bhutan Insurance Company Limited (BICL) caters to only a small segment of the population. Concurrently,

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[1] He is Chief Research Officer at NSB. He worked as multi-disciplinary researcher at the Centre for Bhutan Studies and GNH Research from 2001 to 2010. He joined NSB in 2010. His main research interested until 2010 was society, history and culture.

the family care and support system for the aged population is undergoing the change. Are we then not running late to put in place the right policy framework and social protection schemes for responding to new challenges of demographic change? These call for our attention; and in fact, diversion of more resources from the government to the ageing people—be it in terms of upholding informal care and support system or putting in place more formal public welfare schemes?

We must celebrate our rapid socio-economic progress and advancement in human development, but we should also be cognisance of their adverse impacts, especially on the lives of elderly people. We must, in essence, ensure that the development benefits are equitably distributed among different sections of the society. This would entail making elderly people part of the human development process. We should allow them realise their full potentials to contribute towards achieving higher levels of human development.

Today's ageing people have gone through the generational experience of hardships and change. Most of them recount the ordeal they had to endure in having to partake in development processes and contribute labour for building new roads, irrigation networks, schools, hospitals, Dzongs, and other development infrastructures. What Bhutan has accomplished today is the fruit of hard works and sacrifices our older generation has made some decades ago. Is it then justifiable for the present generation to let some elderly citizens struggle through pain, suffering, and poverty on their own? In a society like Bhutan that rests on GNH conscience, is it not wrong to remain oblivious to the great contributions our present generation of elderly citizens have made for the country's development and neglect them when they are at a vulnerable stage of their lives?

Identifying elderly people's vulnerabilities and understanding their causes and consequences are not only the human development concerns, but also essential for pursuing GNH-based social policy and programmes. We must understand their dotage situation in order to design effective old age social protection policy that is in consonance with cultural norms and tradition. Every elderly person must be able to live to the best of his or her life with dignity and freedom of choice. In the face of growing evidence of some elderly people suffering from the vagaries of old age, it has become critical to appraise various options for minimising the

ramifications of such social problem. For this, there is the need for problem appraisal: a comprehensive investigation of the nature of the emerging problem, its origin and symptoms, and its consequences. This can come about only through proper research and studies. We know that policy decisions and actions related to old age care are based on the discretionary judgment of policy and development actors (which most often goes wrong or proves ineffective) rather than on research and practice. In view of the current data gap on old-age care *vis-à-vis* social protection and absence of any credible research, carrying out research related to the ageing population has become very crucial.

As emphasised earlier, it is critical to understand the old-age situation and the social protection system (through gerontological research) for effective policy formulation, a design of institutions and delivery of various social services to elderly citizens. Against these backdrops, this thematic study broadly tried to: (1) assess the socio-economic situation of elderly citizens; (2) determine the contexts influencing the vulnerability of elderly citizens (mainly the factors); (3) examine their coping mechanisms; and (4) draw implications to inform old age social protection policy and practice.

Background: Context and Significance

The rise in population longevity, decline in fertility, and the upward shift in the population median age suggest that Bhutan has begun experiencing the burden of population ageing. At present, the majority of elderly citizens primarily rely on informal family insurance and community support system. But worryingly these systems are under some strain of social and economic changes despite the State's constitutional mandate to foster and strengthen the integrity of the extended family and community vitality.

In the face of declining traditional family care and support system for aged people in Asia Pacific, the World Bank and the OECD (2009) had issued a report 'Pensions at a Glance Special Edition: Asia/Pacific,' urging the nations to develop a comprehensive pension system. The report states: "Many of Asia's retirement income systems are ill-prepared for the rapid population ageing that will occur over the next two decades." In Bhutan, the formal old age social security provisions like the pension, provident fund, and gratuity schemes are limited to the public servants,

corporate employees, and the members of the armed forces. Private schemes attract a significantly small proportion of the private sector workers. In total, the formal social security schemes cover less than 10 per cent of the total population (NPPF, 2012) or less than 20 per cent of the total labour force. The presence of covariate risks, adverse selection problems, high unit cost of transactions, and the risk of its sustainability makes it difficult to extend the pension and provident fund schemes to the rural populace and informal sector, making the skewed coverage favouring only the country's organised workforce.

Providing old age social protection has become a matter of human rights and the integral component of human development. The Human Development Report (UNDP 2013: 1) recommends that the progress in social and human development in the Global South should now be supported by a more-representative framework of development embodying the principles of equity and justice, voice and accountability, sustainability and changing demography. The right to social security is articulated in Article 22 of the Universal Declaration of Human Rights (1948) and in Article 9 of the International Covenant on Economic, Social and Cultural Rights.

Bhutan is one among 160 UN Member States that has endorsed the 'MadridPlan of Action on Ageing, 2002'. This Plan of Action aims to address development, health, well-being, and supportive environment for elderly citizens. It obligates governments to integrate elderly citizens' rights and needs into the national economic and social development policies and programmes, though it is not legally binding. The Constitution of the Kingdom of Bhutan's Article 7 (Fundamental Rights) and Article 9 (Principles of State Policy) guarantee social security for every Bhutanese individual, irrespective of age and economic status.

As a member of the Madrid Plan of Action on Ageing (2002), Bhutan needs to account on how it has adopted and executed this plan of action. In the early 2000s, the Bhutanese government did not see much problems of ageing in the country. It then chose to rely on the family care and support amid some concerns that the country might soon begin to experience the problems of ageing (Kuensel, April 9, 2002).

Those concerns are now becoming reality. In the recent years, we have seen several media reportages on abandonment, negligence, and abuse of

elderly citizens. Social media now features stories of how some elderly persons eke out living through a difficult situation. These are symptoms of population ageing, and manifestly the unintended consequences of modern progress. The government has begun to recognise these new trends as emerging social problems. It is envisaging some policy responses.

The post-2015 SDG goals and target frameworks are people-centric, people-powered, and universal (leave no one behind). The SDG goals recognise the powerful impacts of demographic trends both on the present generation of elderly people as well as on the future generation. Nations need to be prepared to confront the adverse impacts of demographic changes. It is an opportune time for Bhutan to lay the groundwork for greater demographic shift near future.

The country's commitment to fulfilling the UN's global goals of eliminating all poverty and hunger, combating inequalities, delivering safe and secure future for people of all ages, and meeting the SDG's 'leave no one behind' agenda must now take into serious consideration ever proliferating predicaments faced by elderly citizens.

Having working policies and programmes for active ageing could make a lot of difference. The Global AgeWatch Index (2015) has ranked Switzerland at the top and Afghanistan at the bottom (among 96 countries) for addressing the age-related problems. Switzerland's better ranking can be ascribed to the presence of a range of policies and programmes on active ageing, promoting capability, health and the enabling environment for elderly people while Afghanistan has fewer local and national policies. Going by Switzerland's experience, the presence of a comprehensive social protection policy for elderly people could have positive impacts on their quality of life—Happiness and Well-being.

In the domestic context, both GNH and Human Development approaches call for a people-centric and multi-dimensional approach to development (GNH Commission, 2011: 1). The GNH development approach underscores creating enabling conditions for every individual to seek and pursue happiness at individual and societal levels. One of the GNH pillars is the 'promotion of balanced and equitable socio-economic development' through the promotion of universal values of human

rights, equity, social justice, compassion, and people-centric governance. The Human Development (HD) approach emphasises on enhancing human capabilities through recognition of every individual's capability and rights. It recognises elderly people as repositories of knowledge, wisdom, and experience—those who should be granted support to realise their potentials, rather than treat them as merely social and economic burden groups or dependents.

Despite impressive growth and achievement in human development front, much remains to be done to improve the delivery of basic services to elderly citizens, especially underprivileged ones. Bhutan Living Standard Survey (BLSS, 2012) shows that a significant proportion of elderly people lived in poor households. Approximately 5560 households out of 127942 households (4.3%) with at least one elderly person (by age 60 and above) were below the national poverty line (NSB estimation. 2012). Poverty among the households with at least one elderly member (age above 70) was roughly 2.3 per cent. This accounted for a total of 2943 households (NSB estimates, 2013). This figure is at the household level. Poverty among elderly people at the individual level could be even higher though no statistics are available to confirm that. A growing number of indigent elderly people in towns and cities manifests proliferation of old age poverty.

When the first ever shelter home for elderly people was formed in the country in 2011, there surfaced a moral dilemma over whether this 'sits comfortably on the GNH country's conscience' (Bhutan Observer, April 08, 2011). It was considered to be politically and culturally inappropriate to take over the responsibility of elderly people from family and community. At the 11th 'Meet the Press', the former Prime Minister Lyonchhen Jigme Y. Thinley acknowledged: 'the government should not be actually encouraging a formalised old age care homes' in order to recognise the validity and vitality of the informal care and support system. Nonetheless, he reclined to a view that it is needed as a short-term measure against the emerging trend of abandonment, neglect and abuse of elderly people (*ibid*, 2011). The Prime Minister was rather disposed to set up the old age homes. This, according to the former National Assembly Speaker was the necessity from the GNH viewpoint (*ibid*). The important question that arose then was: 'what could be the most appropriate short-term and long-term measures against the old age problems'?

In most countries, growing poverty among elderly people is linked to the decline in the customary family care and support. In absence of formal social welfare system, the family has been tasked with providing economic security for the elderly (HelpAge International, 2002; Isabella Aboderin, 2004: S 128). If adult children and other family members fail to provide family care to aged parents; the government must step in. But in Bhutan, institutionalising care and support for aged parents may contradict the Constitution's (Article 2) provision: "The State should preserve and promote the integrity of the extended family system and community life." The provision of institutional care and support should be considered a last resort unless critically necessary. It should not contravene the effort of promoting the family as primary caregivers. In spite of that, consideration should be made to look after the welfare of elderly people, especially those who do have families and lack basic means of subsistence.

Social protection policy and programmes for elderly citizens are long overdue from the time of the previous government. The political promise to look into the matter seems to reach the peak only during the elections. The government's pledges to effectuate old age programmes are yet to be fulfilled. Reasons for these 'non-decision, inaction, and rhetoric' may be multiple, but the government seems to be in what could be termed as 'policy dilemma'. The dilemma ensues over whether the government's taking over the responsibility of old age care and support from the family might not lead to breaching of the legislative mandate. The government's constitutional mandate is to uphold the integrity of the extended family system and community life. It includes the customary practice of using family as primary caregiver. There is a public concern that institutionalisation of elderly care and support may manipulate cultural norms and traditions, particularly the filial piety and integrity of the extended family system.

Even in such situation of policy dilemma, the Monastic Body has set up an old age care home in Punakha. This home is for retiring monks who have no children on account of having spent their lives in the monastic communities and now needing institutional care and support and to facilitate the continuation of the spiritual practice. Numerous voluntary initiatives for poor, frail and childless elderlies are undertaken across the country. These point to the fact that the need to initiate formal policy responses and programmes has already emerged even if doing so

contravenes the constitutional mandate for the State to underscore the family care and support system.

The previous democratic government attributed the emerging old age issues mainly to the rural-urban migration, urbanisation, and the structural changes in the family. The former Prime Minister stated: 'old people in the country are abandoned not in a very big way, but the trend is beginning to emerge; the number is enough to worry' (Tandin Pem, Bhutan Observer, April 08, 2011). The ideal solution as he posited is to make sure that elderly citizens continue to get reverence, care and support from the families and communities. The challenge is how to ensure the continuity of customary practice of caring elderly parents when the country is fast modernising and family structure is changing and imbibing a value system that conflicts with the traditional values and practices.

The gravity of the old age issue was further unfolded by the present government when its party made a political commitment to 'promote the elderly citizens' access to basic amenities and maximise their welfare through the provision of shelter, care and income support' (PDP Manifesto, 2013). At the first 'Meet the Press' on 29 August 2013, the government announced its plan to provide public shelter and income support (social pension) to elderly citizens using an approach that accord well with local tradition and culture. The government made it known that time they haven't gone into details of the proposed policy initiative (30 August, 2013, the Bhutanese). Whether it will remain rhetoric or become practical in the immediate future is yet to be seen, but it is clear that initiating the most appropriate and acceptable social protection measures for the ageing population was high on the government agenda.

Ensuring social security for every Bhutanese citizen could be one genuine marker of a GNH society. There are two main options to do so: either reinforce the traditional mechanism of providing social care and support to elderly people through family and community or introduce the formal or institutionalised care and support system for the needy ones.

The critical question arises: how does one justify the introduction of institutionalised care and support for elderly citizens who are in need of them? First, it is definitely the need to respond to an inevitable change within families and communities. The traditional old age care and support

system are in gradual decline. They have to be either reinforced or replaced by formal old age care and support system.

Second, the present cohort of elderly citizens (above seventies) has made tremendous contributions towards the nation-building in their prime age. Their young and productive stages of life had coincided with the beginning of modern development in the country, mainly the construction of the new roads and bridges. Most of them had directly or otherwise contributed to the nation-building and the country's modernisation.[2] Their involvement development works and sacrifices they have made during their young age must be acknowledged and reciprocated by the state and society. This acknowledgement of their contribution could be made by not letting them suffer in poverty and destitution.

Third, since almost all of them had worked in the informal sector, they have failed to generate coverage of contributory pensions. They represent a vulnerable group and they must have access to some kind of social security system the benefit of which is similar to formal pension or annuity.

Recognising the plights of some elderly citizens may require the effort to first identify who among elderly people are in a difficult situation, and second, to determine what their plights are. These can be done through research and media advocacy. It is important to candidly assess our progress in targeting age-related goals, and our preparedness to confront the emerging old age issues. For this, the situation of elderly citizens must be assessed through regular surveys and studies.

Change in Demographics and Socio-Economic Profile

According to the National Statistics Bureau's (NSB) projection, the number of elderly people of age 60 years and above in 2005 was 44319 (6.98% of the total population). The projected elderly population in 2017 is 58,804 (7.54% of the total population). Elderly people of age 80 and above make up 0.86 per cent of the total population. Table 1.1 present the observed and projected elderly population in 2005 and 2017 respectively.

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[2]*Chunidhom*-12 labourers combined and *drugdhom*-6 labourers combined.

Table-1.1: The actual and projected population of elderly citizens in 2005 and 2017 by gender

Age group	2005 (Observed)				2017 (Projected)			
	Male	Female	Total	Total %	Male	Female	Total	Total %
60-64	7,564	7,010	14,574	2.30	10,940	9,854	20,794	2.67
65-69	5,999	5,362	11,361	1.79	7,351	6,767	14,118	1.81
70-74	4,493	4,249	8,742	1.38	5,171	5,055	10,226	1.31
75-79	2,677	2,568	5,245	0.83	3,504	3,462	6,966	0.89
80+	2,162	2,235	4,397	0.69	3,356	3,344	6,700	0.86
Total old age	22,895	21,424	44,319	6.98	30,322	28,482	58,804	7.54
Grand total	333,595	301,387	634,982	100	404,347	375,319	779,666	100.00

Source: Population Housing and Census of Bhutan, 2005.

A notable aspect of the ageing process in Bhutan is the stark increase in the number of people in the age group 25-59. As shown in table 1.2, the increase was by about 79.48 per cent between 2005 and 2017 while there was a decline in the age group 5-24. The increase in the age group 60-69 was 8.42 per cent and 1.59 per cent in the age group 80+. From the trend, it can be concluded that youth population is declining and shifting towards the adult group and adult to the older group. The populations in the age group 60-69 (old age) and 80+ have increased indicating that the population is ageing.

Table 1.2: Change in the population in different age groups between 2005 and 2017

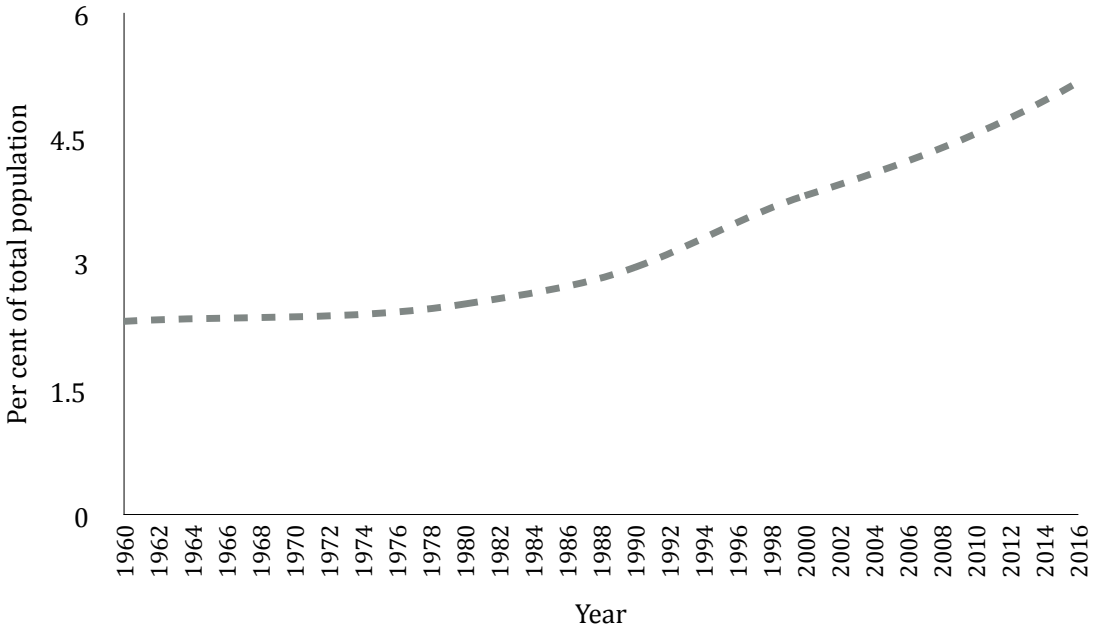
Age group	2005 (Observed)			2017 (projected)			Change	% Change
	Male	FMale	Total	Male	FMale	Total		
0-4	31,489	31,064	62,553	40,804	40,140	80,944	18,391	12.71
5-24	152,033	141,183	293,216	146,346	143,686	290,032	3,184	-2.20
25-59	127,178	107,716	234,894	186,875	163,011	349,886	114,992	79.48
60-69	20,733	19,189	39,922	26,966	25,138	52,104	12,182	8.42
80+	2,162	2,235	4,397	3,356	3,344	6,700	2,303	1.59
Total	333,595	301,387	634,982	404,347	375,319	779,666	144,684	100.00

Source: Population Housing and Census of Bhutan, 2005.

The World Bank's estimates of Bhutan's elderly population (aged 60 and above) were available from 1960 to 2016. It is not possible to tell how these estimates were derived, but according to these statistics the population of elderly population was rising steadily. The rise was somewhat steeper in the recent years.

Figure 1.1 shows the trend in the growth of elderly population from 1960 to 2016.

Figure 1.1: World Bank's estimates, percentage of elderly population in the total population (1961-2016)



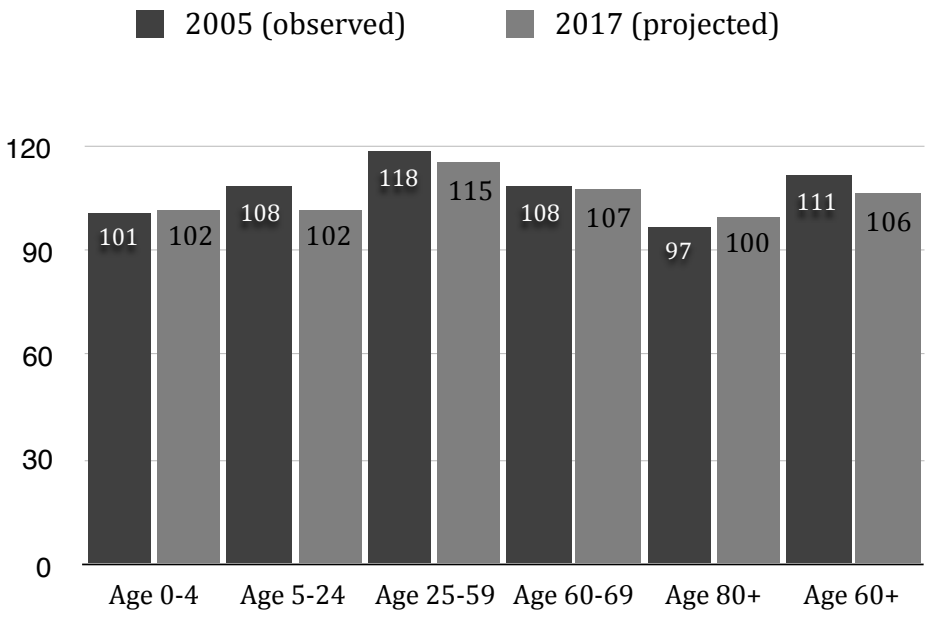
Source: http://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS?locations=BT

Bhutan's life expectancy at birth in 2015 was 69.83—male's life expectancy was 69.57 and female's was 70.11. Although female's life expectancy was slightly higher than that of male (2015), elderly males accounted for a significant majority of the elderly population.

The sex ratio among the elderly population in 2005 was 111 males per hundred females. It has decreased to 106 males per hundred females in 2017 (projected).

The sex ratio among the elderly population of age 80 and above in 2015 was 97 males per 100 females. Relatively more females than males were surviving to older age. The gender gap has closed (for 80+ population) in 2017, that is, there are 100 males to 100 females (figure 1.2).

Figure-1.2: Number of males per hundred females (sex ratio) among different age groups for 2005-2017



Distribution of Elderly People by Residents and Dzongkhags

The proportion of persons over 60 was significantly higher in rural areas in 2015. Over 6 per cent of the total population who were over 60 resided in rural areas. Elderly people in urban areas constituted 1.37 per cent of the total population.

In total, 7.80 per cent of the total population in the country in 2015 was elderly people. There were an equal proportion of elderly males and elderly females in urban areas. In rural areas, slightly higher proportion of elderly males was present. As a whole, the population of elderly males was higher than the population of elderly females. The details are given in table 1.3.

Table-1.3: Distribution of elderly people (60+) across residents by gender (projected, 2015)

Age group	Urban			Rural			Bhutan		
	Male	FMale	Both	Male	FMale	Both	Male	FMale	Both
60-64	0.31	0.25	0.56	1.07	0.99	2.05	1.37	1.24	2.61
65-69	0.20	0.19	0.39	0.83	0.77	1.61	1.03	0.96	1.99
70-74	0.12	0.14	0.26	0.61	0.57	1.18	0.73	0.71	1.44
70-79	0.07	0.10	0.17	0.4	0.37	0.77	0.47	0.47	0.94
80 +	0.07	0.10	0	0.33	0.32	0.65	0.4	0.42	0.82
Total	0.78	0.77	1.37	3.24	3.02	6.26	4.01	3.79	7.80

Source: Population Housing and Census of Bhutan, 2005.

In 2005, elderly people constituted 6.85 per cent (44319) of the total population in the country. About 12 per cent of them lived in urban areas; 87.34 per cent lived in rural areas. This could be due to the reasons that those who migrated to urban places were by majority the younger people. A higher proportion of elderly people living in rural areas may not be interpreted favourably from old age welfare perspective. This is because elderly people living in rural places could be mostly the ones who were left behind by their adult children; and compelled to run the ancestral homes and participate in developmental activities (*woola or lemi*).

Among Dzongkhags, Thimphu Dzongkhag had the highest population of elderly people in 2005. The sex ratio was lower. There were 98 elderly males per 100 elderly females. The next high proportion of elderly people was observed in Trashigang Dzongkhag (9.70% of the total elderly people in the country). There were 107 elderly males per 100 elderly females. Samtse had the third highest population of elderly people (9.59%). The sex ratio was 135 elderly males per 100 elderly females. The sex ratio was imbalanced and this reflected the presence of some social issues. Gasa Dzongkhag had the lowest population of elderly people (0.62%). The sex ratio was 72, which was lowest among twenty Dzongkhags.

As shown in table 1.4, the highest sex ratios were observed southern Dzongkhags. It is not possible to explain the presence of higher sex ratios in the southern region. Mongar Dzongkhag had perfect sex ration (100 males per 100 females).

Table-1.4: Distribution of elderly people across residents and sex ratio in 2005 (observed)

Dzongkhags	Urban			Rural			Both areas		
	n	% total	Sex ratio	n	% total	Sex ratio	n	% total	Sex ratio
Bumthang	217	3.37	89	1,210	3.19	86	1,427	3.22	87
Chukha	815	12.66	103	2,170	5.73	125	2,985	6.74	119
Dagana	46	0.71	100	1,235	3.26	122	1,281	2.89	121
Gasa	13	0.20	117	260	0.69	70	273	0.62	72
Haa	100	1.55	96	718	1.90	90	818	1.85	91
Lhuentse	59	0.92	136	1,460	3.85	93	1,519	3.43	94
Mongar	179	2.78	113	2,908	7.68	100	3,087	6.97	100
Paro	105	1.63	91	2,626	6.93	106	2,731	6.16	106
Pemagatshel	51	0.79	155	1,595	4.21	92	1,646	3.71	93
Punakha	73	1.13	115	1,439	3.80	114	1,512	3.41	114
Samdrupjongkhar	297	4.61	95	2,634	6.95	103	2,931	6.61	102
Sarpang	455	7.07	110	1,902	5.02	122	2,357	5.32	119
Thimphu	2,893	44.95	88	1,491	3.94	120	4,384	9.89	98
Trashigang	239	3.71	113	4,061	10.72	107	4,300	9.70	107
Trashiyangtse	127	1.97	105	1,423	3.76	105	1,550	3.50	105
Trongsa	103	1.60	140	1,225	3.23	97	1,328	3.00	99
Tsirang	44	0.68	100	1,505	3.97	124	1,549	3.50	123
Wangdue	214	3.33	84	2,443	6.45	101	2,657	6.00	99
Zhemgang	100	1.55	100	1,636	4.32	104	1,736	3.92	104
Bhutan	6,436	100	96	37,883	100.00	109	44,319	6.85	107

Source: Population Housing and Census of Bhutan, 2005

In 2015, a drastic change in the number of elderly people was observed in Thimphu Dzongkhag. It continued to be the Dzongkhag with the highest proportion of elderly people (15.40% of the total elderly people). The sex ratio was 114 males for 100 females. Chukha came out as the Dzongkhag with the second highest population of the older population. It was Trashigang Dzongkhag in 2005. This suggests that there was a growing rural-urban migration of elderly people as well between these two time periods. The population of elderly people in Gasa Dzongkhag, in fact, decreased in 2015. However, the sex ratio had increased. There were 87 elderly males per 100 elderly females in 2005. This had increased to 107 elderly males per 100 elderly females in 2015. Bhutan's share of the elderly population in 2015 was 7.51 per cent of the total population. It was 6.85 per cent in 2005. The difference between these two reference points was 0.66 per cent. The detail is presented in table 1.5.

Table-1.5: Distribution of elderly persons across residents by gender (projected, 2015)

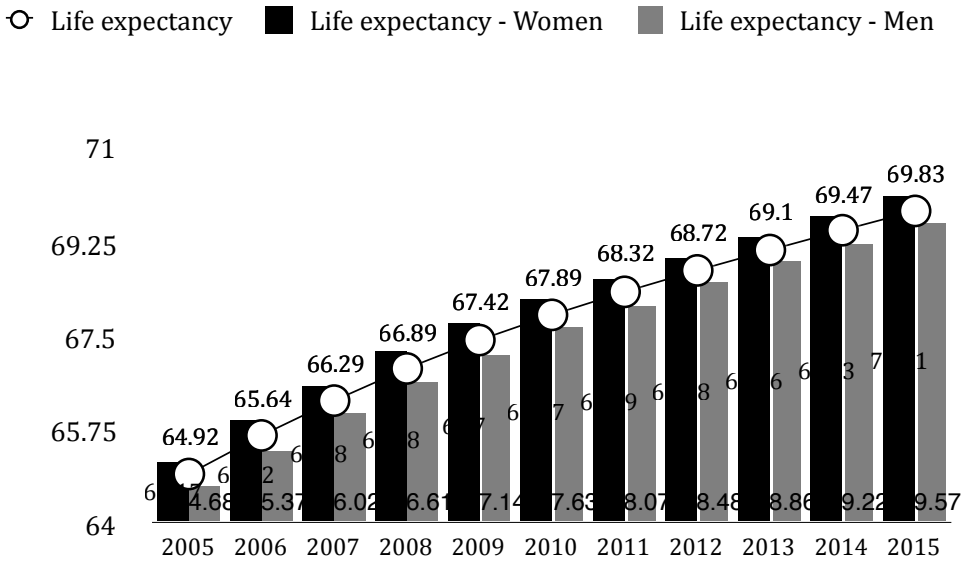
Age	Male	Female	Both Sex	% of total population	Sex ratio
Bumthang	728	647	1375	2.38	113
Chukha	3798	2972	6770	11.72	128
Dagana	1049	1063	2112	3.66	99
Gasa	146	137	283	0.49	107
Haa	549	486	1035	1.79	113
Lhuentse	547	560	1107	1.92	98
Mongar	1670	1727	3397	5.88	97
Paro	1717	1594	3311	5.73	108
Pemagatshel	940	993	1933	3.35	95
Punakha	1066	1070	2136	3.70	100
Samdrupjongkhar	1579	1549	3128	5.42	102
Samtse	2760	2657	5417	9.38	104
Sarpang	1787	1714	3501	6.06	104
Thimphu	4736	4159	8895	15.40	114
Trashigang	2144	2167	4311	7.47	99
Trashiyangtse	781	821	1602	2.77	95
Trongsa	614	615	1229	2.13	100
Tsirang	835	839	1674	2.90	100
Wangdue	1453	1429	2882	4.99	102
Zhemgang	821	830	1651	2.86	99
BHUTAN	29720	28029	57749	7.51	106

Source: Population Housing and Census of Bhutan, 2005

Trend in life expectancy

In 1960, Bhutan had one of the lowest life expectancies in the region. Men's life expectancy then was 32.01 while that of women was 32.72. Within the period 2005 to 2015, the number of elderly people in the total population had increased from 44,319 in 2005 to 57,749 in 2015. The increase was about 23 per cent. This increase indicated more people were living into old age. The increase in life expectancy observed would also mean the population ageing had set in before 2015. The increase in life expectancy could be due to rapid economic, demographic and epidemiological changes. The increase in life expectancy was observed in both the sexes, but was little higher for women. Figure 1.2 shows the changes in life expectancy between 2005 and 2015 by gender.

Figure-1.2: Progression of life expectancy at birth in Bhutan by gender between 2005 and 2015



Source: http://countryeconomy.com/demography/life-expectancy/bhutan

The ageing index[3] rose from 14 in 2005 to 16.3 in 2013 (PHCB, 2005; NSB, 2013). The population median age increased from 22.1 in 2005 to 24.6 in 2013.

Old age dependency

The old age dependency ratio (proportion of the population aged 60 years or above versus the proportion aged 15-59 years) had been increasing in a small way between 2005 and 2015. To the contrary, the child dependency ratio (proportion of the population aged less than 15 years versus the proportion aged 15-59 years) was decreasing in the recent years.

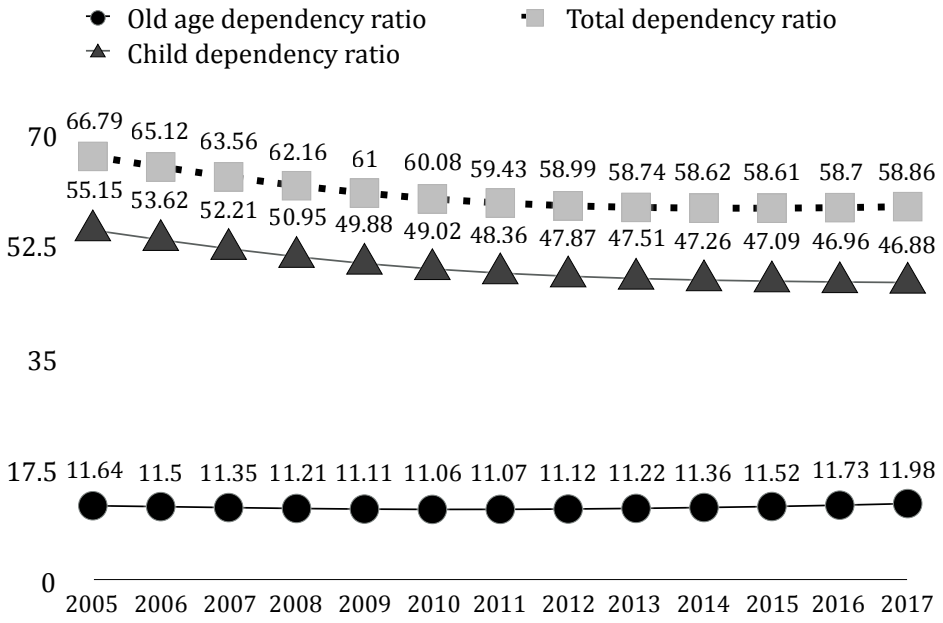
Figure 1.3 demonstrates these trends. When these two trends would balance out is not known. However, as the ratio of elderly people to working age persons grows, the need to provide old age care and support, pension coverage, and a growing pension liability would bear heavily on

[3] The ageing index is calculated as the number of persons over 60 years old over per hundred persons under 15.

the country. A higher dependency ratio is a problem for any country, as a large share of the public resources would have to be used for supporting the dependents.

Bhutan's old age dependency ratio had been increasing gradually, and if this trend continues, it may entail higher expenditure on providing care and support to elderly people in the longer-run. However, it should be noted that not every person above 60 could be dependent (they may be working) while not everyone in the working age group (15-59) would be productive.

Figure-1.3: Dependency ratios between 2005 and 2015



Estimated using PHCB, 2005 and projections data

Regardless of the expected rise in old age dependency ratio, the UN (2009) has estimated that the ratio of working age to non-working age in the country would rise from what was 1.88 in 2010 to 1.98 in 2050. The increase in this ratio normally corresponds to increases in the rate of per-capita economic growth (benefit of demographic dividend).

Poverty among elderly people

In 2012, the poverty rate among the households headed by persons age 65 and beyond (older elderly) was 14 per cent and 13.3 per cent among those households headed by persons aged 55-64 (younger elderly) (NSB, PAR, 2013, pp: 14). Table 1.6 presents poverty rate, poverty gap, and poverty-squared gap among households headed by individuals belonging to different age groups. The correlation between age of the households' heads and poverty rate was observed (i.e., higher the age of the households' heads, higher was the poverty rate).

Table-1.6: Poverty rate, gap and squared gap among households headed by individuals in different age groups (2012)

Area/Age of HH Head	Poverty Rate	Poverty Gap	Poverty Squared Gap
Urban	1.4	0.3	<0.2
< 25	0.6	<0.2	<0.2
25-54	1.3	0.2	<0.2
55-64	1.9	0.3	<0.2
65 +	3.3	1.6	0.8
Rural	12.4	2.6	0.8
< 25	5.2	1.3	0.5
25-54	12.3	2.7	0.9
55-64	15.2	3.1	1.0
65 +	15.3	3.2	1.1
Bhutan	8.6	1.8	0.6
< 25	2.8	0.7	0.2
25-54	7.1	1.4	0.5
55-64	13.3	2.7	0.8
65 +	14.0	3.0	1.1

Source: Poverty Analysis Report, 2012, NSB, pp; 32.

The poverty rate among the households with at least an elderly person of age 70 and above was 2.3 per cent. It was 4.3 per cent among the households with at least one member of age 60 and above member (NSB estimates, 2013). Overall, poverty rates among elderly population were low, but there is no room for complacency. The poverty assessment conducted jointly by the World Bank and NSB (2012) shows that despite an impressive reduction in overall poverty, the rural families remain vulnerable to shocks. For every two families that escaped poverty between 2007 and 2012, one previously non-poor family became poor. This could

be, among many factors, due to a gradual rise in the number of elderly people in rural areas (with children having migrated to urban areas).

Living arrangements of elderly people

In 2007, 39 per cent of elderly people lived in the households with at least one child (third-generation co-residency households). The multi-generational co-residency is the common form of family solidarity. This sort of co-residency had declined to 31 per cent in 2012 (BLSS, 2007 & 2012). Contrarily, the households without an elderly member, but with at least one child increased from 50.51 per cent in 2007 to 54 per cent in 2012 indicating the shrinkage of family size, decline in co-residency, and increase in non-third generation households. The change in family structure and composition may bear negatively on elderly people whose children are dispersed and as a result of which they are forced to live on their own.

The country is also witnessing rising divorce rates. Divorce has become synonymous with development, as its rate was higher in more developed districts, while the divorce was becoming common in rural areas. For example, Thimphu had the highest divorce rate at 13.3 per cent in 2012; and divorce was highest among the heads of the households (39.6%) (LFS,2012). Divorce usually affects social and economic circumstances of both children and dependent elderly people, and of course, it causes the decline in traditional social protection mechanisms.

Labour Force Participation

The Labour Force Participation Rate (LFPR) is defined as the proportion of people aged 15 years and above that is economically active. The labour force is understood as the people who supply labour to produce goods and services within a specified period. Elderly people normally are considered 'dependents' and they are assumed to be out of the labour force. The labour force participation rate among elderly population of age 60 and above in 2015 was 63.1 per cent. That means elderly people were participating in the labour force. Slightly higher number of elderly people living in rural areas was participating in the labour force (64.8%) compared to elderly people living urban areas (59.2%). The LFPR for male elderly persons was higher than that of the female elderly persons see Table 1.7.

The unemployment rate among elderly people was 1 per cent. It was higher for female elderly people. The unemployment rate among urban elderly people was about six times more than the unemployment rate among their rural counterparts. Female elderly people experienced higher rate of unemployment (3.1%) than their male equivalents (1.8%). The employment rate among rural elderly people was almost close to 100 per cent.

Table-1.7: Distribution of older people by employment status, gender & residence

Work Status	**Sex**	**Bhutan**	**Rural**	**Urban**
Employed	Male	22374	20410	1965
	Female	11105	10274	830
	Both	33478	30684	2795
Unemployed	Male	0	0	0
	Female	13	0	13
	Both	13	0	13
Labour Force	Male	22374	20410	1965
	Female	11117	10274	843
	Total	33491	30684	1808
Not in Labour Force	Male	18327	15810	2515
	Female	29665	25844	3821
	Both	47992	41654	6337
Labour Force Participation Rate	Male	71.2	69.7	74.6
	Female	55.9	60.4	45.5
	Both	63.1	64.8	59.2
Unemployment Rate	Male	1.8	0.7	4.3
	Female	3.1	1.2	9.3
	Both	2.5	1	6.3
Employment Rate	Male	98.2	99.3	95.7
	Female	96.9	98.8	90.7
	Both	97.5	99	93.7

Source: Labour Force Survey, 2015, MoLHR

Grouping the individuals into different categories as shown in table 1.8, labour force participation rates in 2015 were the lowest among individuals in the age groups of 15-24 and 65 and above. The individuals belonging in these two age groups are usually considered dependents. A huge difference was observed in the labour force participation rates among individuals in age group 60-64 (younger elderly) and age group 65+ (older elderly). The labour force participation rates among elderly people (60

and above) declined with the increase in age. On the whole, the labour force participation rates among elderly people were higher in rural areas compared to their equivalents in urban areas. More elderly males participated in the labour force than elderly females.

Table-1.8: Labour force participation and unemployment rates among individuals in different age groups

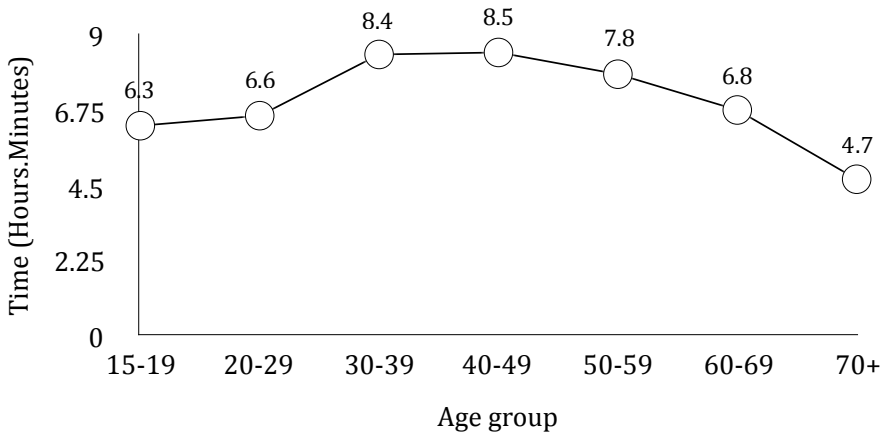
Urban						
Age	**Labour Force Participation Rate**			**Unemployment Rate**		
group	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
15-24	25.8	26.0	25.9	25.2	32.0	29.6
25-49	96.2	56.2	76.2	2.7	4.2	3.3
50-59	85.2	43.5	66.3	0.8	1.6	1.0
60-64	63.1	27.2	45.2	0.0	2.7	0.8
65+	30.9	12.5	21.3	0.0	0.0	0.0
Total	**74.6**	**45.5**	**59.2**	**4.3**	**9.3**	**6.3**
Rural						
15-24	33.6	39.4	36.5	3.0	4.4	3.8
25-49	95.3	84.4	89.2	0.6	0.6	0.6
50-59	87.2	70.3	78.6	0.0	0.0	0.0
60-64	76.6	34.6	53.9	0.0	0.0	0.0
65+	46.0	24.4	35.7	0.0	0.0	0.0
Total	**69.7**	**60.4**	**64.8**	**0.7**	**1.2**	**1.0**
Bhutan						
15-24	31.4	34.5	33.1	6.9	10.6	9.0
25-49	95.8	75.0	84.6	1.5	1.8	1.6
50-59	86.9	66.2	76.5	0.1	0.2	0.2
60-64	74.8	33.7	52.9	0.0	0.2	0.1
65+	44.5	23.1	34.2	0.0	0.0	0.0
Total	**71.2**	**55.9**	**63.1**	**1.8**	**3.1**	**2.5**

Source: Labour Force Survey, 2015, Ministry of Labour & Human Resources

Participation rate in work and related activities

As presented in figure 1.4, the average time people spent on work and related activities in 2015 decreased with age (GNH Survey, 2015). It was about 6 hours and 8 minutes for individuals in the age group 60-69. Elderly people in the age group 70 and above spent 4 hours 7 minutes on work and related activities. It was observed that even in old age, unless restricted by some form of severe disability, elderly people were doing some works. The qualitative study also revealed the same.

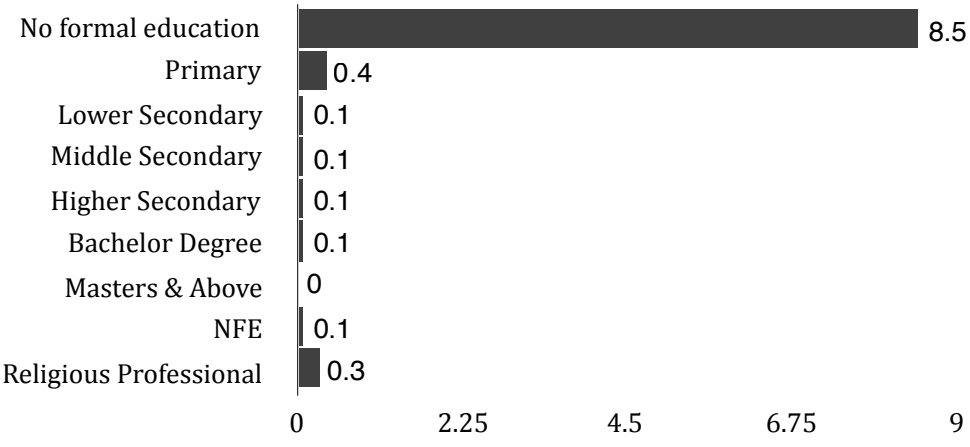
Figure-1.4: Participation in works and related activities



Source: A Compass Towards a Just and Harmonious Society (CBS-GNH Research, pp. 145)

Among elderly people who were employed in 2015, 8.5 per cent of them did not have any formal education. The others (who were employed) had some level of education as shown in figure 1.5.

Figure-1.5: Percentage employed elderly persons by education level



Source: Labour Force Survey, 2015, MoLHR

According to the study conducted by the Royal Society for Senior Citizens (RSSC, 2012: 31-32), out of 101,563 senior citizens, 11.7 per cent were continuing to work, 14.1 per cent earned income as interests from

savings, 0.4 per cent earned interests from shares, and 68.1 per cent had fixed assets to meet their livelihood. The issue was that 28,822 (27.8%) of senior citizens were incapable of meeting their own expenses. About 54 per cent did not have reliable income sources and were dependent on their children and 22.5 per cent relied on their relatives.

The labour markets tend to become inflexible for people who have crossed age 60 and are looking for employment. In fact, about 1.3 per cent (5639) of elderly citizens were looking for additional works in 2012 (LFS, 2012). The RSSC's study shows that 49 per cent of retired senior citizens aspired to continue in the services; 33.3 per cent felt retirement has made their lives insecure.

Traditional Social Protection System

The Constitution necessitates the State to secure the integrity of extended family system and community life. The ideal situation could be to keep elderly people within the protection of family and community life. In many developing countries, because the responsibility for elderly people traditionally rest on the families and communities, the governments, development players and humanitarian agencies give somewhat a low priority to the welfare of elderly. In fact women and child issues in many countries receive more precedence over old age issues.

Bhutanese families have started to shrink and have a fewer children unlike in the past when a single mother would deliver more than ten children. Today, adult children in most cases do not co-reside with their parents. They are dispersed everywhere. These changes pose important challenges to family-based old age care and support system. The qualitative data revealed widespread awareness that family size has substantially decreased. The increased migration related to education and employment opportunities were resulting in fewer adult children living with or near their ageing parents. In general, there was a strong normative support for having children live with their ageing parents and widespread preference among ageing parents for children to be the main care providers.

Given that personal care requires geographical proximity, a disjuncture appears to exist between norms and the changing empirical reality. Although adult children generally proclaim their willingness to care for their parents (when the need arises), it remains an open question if these

intentions would materialise. The present generation's adult children are caught in between (double burden): having to deal with two categories of dependents—aged parents and children. More emphasis is normally given to their children (especially due to the need to educate).

Bhutan has had strong informal social security systems built on family and community solidarity. Traditionally, family has held the exclusive responsibility for providing material and emotional support to elderly people. The filial obligation and duty of children to their ageing old parents are premised on the customary moral code *pham dha bugi tha dhamtshi*, literally translated as 'boundary of sacred path and relationship between parents and children (Kinga, 2001, pp.153). Parents are revered as *drinchen phama* plainly meaning 'parents who owe immeasurable gratitude from their children'.

The Constitution provides a legal framework for the government to promote extended family system and community life as traditional social safety net. Article 9 (Principles of State, section 19) states 'The State shall endeavour to promote those conditions that are conducive to co-operation in community life and the integrity of the extended family structure'.

The family care and support to elderly people in the past seems to have been satisfactory because (1) living style was simple, as the family sustained on traditional farms that suited the extended family structure; (2) customary code of filial duties was not affected by western ideas of individualism, but rather, community life was vital; and (3) the relationship between elderly and younger people was driven by an element of exchange—elderly members providing domestic help and childcare in return for the care and support they received. In contrast, a growing number of urban families have started to find it difficult to render full care and support to their ageing parents for many reasons :(1) livelihood depends on the earning of the working adult members; (2) families have to now cater to the needs of both children and aged parents; (3) change in family lifestyle; (4) elderly people have a little role in domestic help, as the household works are not so diverse as in the farms; and (5) children attends schools, cutting short the interactions between grandparents and children.

Modernisation and urbanisation may have some effects on the traditional social security system, though family will continue to serve as a primary source of elderly social protection. The adverse impacts of modernisation on family and community care and support were evident from the recent trends. In 2012, only 45 per cent of aged parents lived with their children while 9 per cent of them lived with their cousins and relatives (RSSC, 2012: 25). The rest relied on other means of support. A gradual rise in number of elderly destitute in urban centres may be one of the symptoms of deteriorating family care and support system.

The question arises: what then causes decline in family provisions to elderly people? The Focus Group Discussions in eight Gewogs (sub-districts) of four poorest districts, conducted jointly by the World Bank and National Statistics Bureau in 2014 concluded that younger people tend to leave their rural communities seeking better economic and other opportunities, leaving behind their aged parents to toil on their ancestral farms and to struggle and fend for themselves. Both physical distance and time separate them, which often results in the gradual deterioration of the traditional social fabric of multi-generation homes. This was one major policy issue that emerged clearly in all the eight FGDs.

There is no denying the fact that the socio-economic reforms could contribute towards the overall improvement in the people's welfare. But, we know of their unintended consequences, mainly on disintegration of traditional forms of social capital. The traditional social capital includes close networks and relationships between families, neighbours, and community members, which are based on trust, shared norms and reciprocity. These collective goods facilitate risk-pooling, cooperative actions, and in overcoming individual and common crises. The contemporary forms of social capital that are mostly the replicas of modern civil societies, charities and formal member-based organisations are gradually replacing the traditional ones. For example, some of them like Tarayana Foundation, Royal Society for Senior Citizens (RSSC), and Jangtrul Community Service Association look after the social and economic welfare of elderly citizens.

In 2002, the United Nations had highlighted the unfavourableness of urban contexts for the maintenance of traditional family bonds. In spite of the great efforts, no countries have been very successful in sustaining and reinvigorating family bonds in the face of rapid urbanisation. The

same trend is likely to repeat in Bhutan. One of the major concerns is that rural-urban migration in the country is taking place at an unprecedented rate. The UN Human Development Report (2009) considered Bhutan's rural-urban migration as one of the highest phenomena in the region. More than half of the Bhutanese population is expected to live in urban areas by 2020 (Bhutan National Urbanisation Strategy, 2008). In 2012, about 69 per cent of the population lived in rural areas (Labour Force Survey, 2012), but the rural population may shrink dramatically if the current trend of rural-urban migration prevails. In the light of this, the family nuclearisation or shrinking in the size of family will take place in both rural and urban areas with implications on welfare of elderly citizens. Such development will necessitate institutionalisation of elderly social care and support system.

Formal Pension and Provident Fund Schemes

Two formal income security schemes that existed in Bhutan before 2002 were Gratuity Scheme (GS) and the Government Employees Provident Fund Scheme (GEPF). The GS was an occupational scheme. These schemes were restructured into multi-tiered retirement scheme in 2002 now known as the National Pension and Provident Fund Plan (NPPF). It provides the combination of lump sum payment and pension as an annuity for life. The 2002 reform was aimed at providing old age income security, enhancing income redistribution (across different income groups and different generations), and encouraging lifetime savings.

The NPPF's tier one is the National Pension Plan (NPP). This is a partially funded pay-as-you-go and defined benefit scheme. The members are entitled to monthly pension benefits upon retirement. Tier two is the Provident Fund Plan (PFP). It is a defined contributory provident fund scheme. The members contribute 11 per cent of their monthly basic salaries (civil servants and public corporations) and 12 per cent (armed force members) matched with equal contributions from the employers. Out of the total contributions of 16 to 20 per cent, 10 per cent is credited to a member's pension account and the rest to the provident fund account.

The defined pension benefit is paid in a lump sum when a member retires either upon reaching a retirement age (56, 58 and 60 years for different categories of public servants) or when a member retires after completing

a minimum of ten years contributory period. By design, the pension benefits are calculated using a formula that provides higher replacement rates for low-salaried persons than to one who is paid higher.

The NPPF Scheme (as of June 30, 2013) had 48,966 members and 3833 pension beneficiaries. The NPPF's record shared to us on January 16, 2017, shows 4241 beneficiaries. This could be the record for the period until December 2016. The beneficiaries include pensioners, surviving spouses and dependent parents. Out of the total, 2117 (49.93%) were in the civil group and 2124 (50.07%) in the armed force group. Thimphu Dzongkhag had the highest number of both civil and armed force pensioners and their beneficiaries. This accounts for 32.18 per cent of the total pensioners and their beneficiaries (total was 4242). See table 1.9.

Table-1.9: Distribution of civil and armed force pensioners and their beneficiaries across 20 Dzongkhags

Dzongkhags	Civil	Armed Force	Total	Civil	Armed Force	Total
Thimphu	816	549	1,365	19.24	12.94	32.18
Sarpang	186	270	456	4.38	6.36	10.75
Chukha	185	156	341	4.36	3.68	8.04
Samtse	206	109	315	4.86	2.57	7.43
Paro	107	105	212	2.52	2.48	5.00
Wangduephodrang	65	127	192	1.53	2.99	4.53
Trashigang	66	125	191	1.56	2.95	4.50
Tsirang	82	90	172	1.93	2.12	4.05
Mongar	83	83	166	1.96	1.96	3.91
Samdrupjongkhar	68	96	164	1.60	2.26	3.87
Pemagatshel	44	78	122	1.04	1.84	2.88
Punakha	46	71	117	1.08	1.67	2.76
Zhemgang	23	59	82	0.54	1.39	1.93
Trongsa	30	43	73	0.71	1.01	1.72
Bumthang	48	20	68	1.13	0.47	1.60
Dagana	19	49	68	0.45	1.16	1.60
Trashiyantse	13	42	55	0.31	0.99	1.30
Lhuentse	18	31	49	0.42	0.73	1.16
Haa	12	19	31	0.28	0.45	0.73
Gasa	1	2	3	0.02	0.05	0.07
Total	2,118	2,124	4,242	49.93	50.07	100.00

Source: NPPF, 2017

Elderly pensioners and beneficiaries (above age 60) constituted 35.52 per cent (1507) of the total (4242) while 64.48 per cent (2735) belonged to

younger age group (10-59). Table 1.10 provides the pensioners and beneficiaries belonging to different age groups (until 2016).

Table-1.10: Distribution of pensioners and other beneficiaries across different age groups

Age category	Freq.	Per cent	Cum.
10-19	1	0.02	0.02
20-29	16	0.38	0.4
30-49	541	12.75	13.15
50-59	2,177	51.32	64.47
60-69	1,450	34.18	98.66
70-79	55	1.3	99.95
90-99	1	0.02	99.98
100-105	1	0.02	100
Older pensioners & Beneficiaries	1,507	35.52	
Total	4,242	100	

Source: NPPF, 2017

The total population of the country in 2015 was projected at 7,57042 and elderly population (60+) was 57749. The recorded number of the NPPF's pensioners and their beneficiaries (age 10-105) in 2016 was 4242 among which 1507 were elderly people of age 60 and above. About 0.56% of the total population were the NPPF pensioners and their beneficiaries (age 10-105). This was a very insignificant number.

The proportion of elderly people who were the NPPF pensioners and other beneficiaries was just 0.20 per cent. Out of the total elderly population, just 2.61 per cent of them were the NPPF pensioners and other beneficiaries (table 1.11). These facts and figures show that the NPPF's coverage still tends to remain very low and insignificant.

Table-1.11: The NPPF's pensioners and their beneficiaries

Population	Number & Percentage
Total population (projected, 2015)	757,042
Total elderly population (projected, 2015)	57749
Population with pensions (NPPF-- as of 2016)	4242
Elderly population with pension (NPPF-- as of 2016))	1507
% people (age 10-105) Who are NPPF pensioners and their beneficiaries out of the total population	0.56%
% elderly(age 60+) people with pension among total population	0.20%
% of elderly people (age 60+) among total elderly population	2.61%

Source: NPPF, 2017

In both civil and armed force categories of pensioners and other beneficiaries, the majority of them were males. When these two groups were combined, 84.46 per cent were males compared to females (15.54%). These results demonstrate gender disparity in terms of the distribution of the NPPF's pension benefits. This gender disparity existed not only in absolute term but also in terms of gender representation in the total population. Males constitute 51.86 per cent (projected, 2017) of the total population while females accounted for 48.14 per cent of the total population (table 1.12). There was not much difference in the composition of males and females in the population, but there was a huge difference in gender representation of the NPPF's pensioners and beneficiaries. It is highly likely that a majority of females were the beneficiaries of male members who have succumbed to untimely illnesses and deaths.

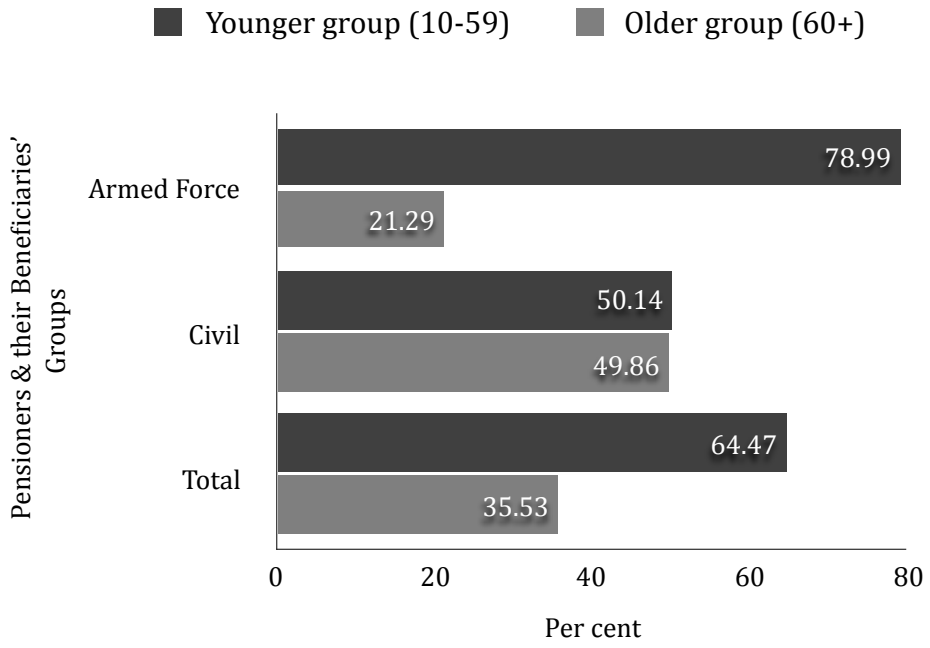
Table-1.12: The NPPF's pensioners and their beneficiaries by gender

Sex	Civil	Armed Force	Total
Male	1824 (86.12%)	1759 (82.82%)	3583 (84.46%)
Female	294 (13.88%)	365 (17.18%)	659 (15.54%)
Total	2118 (100%)	2124 (100%)	4242 (100%)

Source: NPPF, 2017

Younger age group (age 10-59) was represented more in the armed force group (78.99%) compared to older age group (60+). Nevertheless, there was almost equal representation of younger group (50.14%) and older group (49.86%) in civilian pensioners and other beneficiaries group. This shows that more members retired earlier in the armed force than in the civil service. Figure 1.6 presents the distribution of younger and older pensioners and their beneficiaries in two groups viz., civil service and armed force.

Figure-1.6: Distribution of younger and older pensioners & their beneficiaries in two groups



Source: NPPF, 2017

The NPPF delivers service to 401 government agencies and corporate bodies. The fund size of the NPPF as of 2013 was 15.14 per cent of GDP at the current price. The average payout rate between 2008 and 2012 (within Tenth FYP) was 16.40 per cent. The funds were invested in hydropower projects, real estate business, and hotel development. The equity investment is the most preferred area of investment.

The Royal Insurance Corporation of Bhutan Limited (RICBL) manages Private Provident Fund (PPF) and Life Annuity Scheme (LAS). These

schemes covers the employees of private companies and non-governmental organisations. The PPF is a defined contribution scheme—an employee makes a monthly contribution equivalent to 5 per cent of his or her basic salary with matching contribution from an employer. The PPF money is invested for the socio-economic development. The PPF members are paid minimum of 7 per cent interest on the returns from the investment funds. By 2013, there were 82 companies and NGOs as its policyholders. The LAS helps its member to plan for a steady income source when he or she is not able to earn income as a result of old age, and illness or disability. The monthly annuity can be drawn when a member reaches age of 50 years. The annuity payment is either a fixed amount or an amount at the rate of 5 per cent per annum.

The coverage of the formal social security schemes remained all-time low. It covered 6.7 per cent of the total population in 2013. This was in terms of retirement benefits. The other forms of social protection in the country are charity and grants and social welfare schemes and services targeting at poverty reduction such as provision of free electricity to rural populace, water supply schemes, subsidised insurance schemes, agricultural subsidies, and other income generating programmes. These schemes and services had immense and lasting benefit to the population as a whole. But the level of benefits of these social services to elderly people needs to be determined, as many of the services are not targeted at reducing old age poverty.

The government and some NGOs, through various social welfare and assistance schemes, and others have been at the forefront in providing social protection for the Bhutanese people if declining poverty rates over the years were any indication. The poverty rate had drastically come down to 12 per cent in 2012 from about 24 per cent in 2007 and 31.7 per cent in 2003. RICB had been providing financial, insurance, and pension schemes to enhance and reinforce traditional social safety net in the country. A perfect example is that of the life annuity scheme that provides a monthly pension when a member is no longer in a position to earn income either due to old age, chronic illness or disability, and other insurance schemes that enable individuals to counter life's crises. The public servants receive lump sum gratuity upon retirement. The gratuity schemes are the privileges of workers in an organised sector.

The government runs a universal 'funeral insurance scheme,' which pays a flat rate of Ngultrums 10,000 to a bereaved family to support funeral rite expenses. A funeral rite in Bhutan is an expensive religious event. This scheme is considered as the most important one, as most of the Bhutanese people yearn for a decent funeral. Our qualitative study revealed that many elderly people worried about who would conduct funerals for them than their present living situations.

Bhutan Insurance Limited (BIL) that was established in 2010 provides a mandatory, tax-qualified, and defined contribution Private Provident Fund (PPF) and Gratuity Fund schemes for private sector workers. A private employee contributes a minimum of 5 per cent of his or her basic monthly wage with equivalent contribution from an employer (has no upper contribution limit). The benefits of its provident fund scheme are (1) risk-free return of 7 per cent per annum; (2) tax-exemption on lump sum withdrawal; and (3) PPF loan. It encourages higher employee retention in the private companies. BIL had over 1030 provident fund members from 56 private enterprises (as of August 2013). BIL started Gratuity Fund Management in August 2014. The scheme can be availed by both private and public agencies. Gratuity Fund Scheme is a defined benefit scheme (lump sum payment an employer make to an employee) without contributions from an employee.

Royal Kidu

Kidu (Welfare Grant) is traditionally a Royal Prerogative and is granted by His Majesty the King to the most vulnerable section of the society. It is enshrined in the Constitution that granting *kidu* is a fundamental responsibility of the King. Besides, the other members of the Royal Family grant *kidu* to poor and needy people. *Kidu* system continues under the aegis of the Office for People's Welfare and Well-being (Office of Gyalpoi Zimpon). The Kidu Foundation complements the government's efforts in areas such as education, democracy and media, the rule of law, sustainable economic development, environment, and culture, land redistribution among poor people, disaster relief, and protection of vulnerable people (kidufoundation.org).

His Majesty currently provides monthly allowances to 850 elderly and other disadvantaged citizens. His Majesty has instituted a special scheme to look after the welfare of elderly people who do not have any family

members (June 16, 2015, State of the Tsawa Tsum-Fifth Session of the Second Parliament of Bhutan, pp. 5).

His Majesty's *kidu* supports several elderly destitute through a minimum monthly grant of about Nu. 1200 (exact information not available), but because it has diverse areas to support, not all destitute and elderly people in the difficult situation are covered. Gyalpoi Toezey programme supports 3500 children and adolescents studying in various schools and colleges (Wangchuk, Rinzin, 2014). Although *kidu* serves the purpose of social protection mechanism, it is not a substitute for formal old age social protection.

Kidu Foundation helped the establishment of Royal Society for Senior Citizens (RSSC) through technical and financial assistance. The Rural Livelihoods Fund was established in 2013 under the Kidu Foundation of His Majesty the King. A Singaporean couple, Mr. Choon Huat TAN and Mrs. Beng Hwa KHOO proposed the Fund. The Fund supports sustainable rural livelihood programmes to improve the lives of rural people, for rural poverty reduction and to mitigate rural-urban migration. The fund has positive impacts on the lives of elderly people living in rural areas.

Existing Old Age Legislations, Policies and Programmes

The Constitution of the Kingdom of Bhutan guarantees social protection to every section of the society and for every age group. The Article 9 of the Constitution of the Kingdom of Bhutan, Section 7 states:

> 'The State shall endeavour to develop and execute policies to minimise inequalities of income, concentration of wealth, and promote equitable distribution of public facilities among individuals and people living in different parts of the Kingdom'.

Section 22 under the same Article states:

> 'The State shall endeavour to provide security in the event of sickness and disability or lack of adequate means of livelihood for reasons beyond one's control'.

Introduction

The Constitution provides a legal framework for the promotion of extended family system and community life as traditional social safety net.

Article 9 (Principles of State, section 19) states:

> 'The State shall endeavour to promote those conditions that are conducive to co-operation in community life and the integrity of the extended family structure'.

The Constitution postulates:

> 'The State shall strive to create conditions that will enable the true and sustainable development of a good and compassionate society rooted in Buddhist ethos and universal human values'.

The universal human values of rights and freedom overlap with the spirituality of compassion, though the concepts of rights and freedom connote self-centrism while spirituality compassion pertains to concerns and responsibility for others' well-being and happiness. Good and compassionate society cannot afford to have its ageing members go through pain and suffering.

The Draft Social Protection Policy prepared by the Ministry of Labour and Employment (MoLR) states:

> 'The Community-based social support forms the foundation of social protection in Bhutanese society and contributed to social security and cohesion long before any formal institution existed. Even today, it plays an important role in promoting individual and family welfare and should serve as an overall guide for policymakers in that it is a representation of the social and cultural values of the Bhutanese people' (2013, pp.1).

Under the leadership of the Druk Gyalpo, the *kidu* system serves as a crucial safety net for the most vulnerable members of our society. We know that the "*kidu* has served as an enduring source of comfort and welfare for the most vulnerable sections of the Bhutanese population" (Draft social protection policy Bhutan, 2013, pp.1).

The Labour and Employment Act of 2007 encompasses provisions for mandatory workers' compensation, pensions, wages, hours, overtime; universal rules on leave including maternity and nursing leave; comprehensive provisions on employment contracts and related rights and remedies. The law explicitly places the financial burden of ensuring occupational health and safety on the employers and requires accident and safety reporting.

Royal Society for Senior Citizens (RSSC)

His Majesty the King envisioned the emergence of the Society, the one that can work towards promoting human security (freedom from fear and wants) among elderly citizens in Bhutan. In 2011, His Majesty commanded the establishment of the Royal Society for Senior Citizens (RSSC) in 2011. It is a civil society organisation that seeks to harness and promote the experiences, expertise, skills and knowledge of retired senior civil servants and corporate employees.

RSSC helps senior citizens to lead a meaningful life through various programmes. These programmes include promotion of peer counselling; provision of information and advice on healthcare, legal issues, and financial matters; and to support religious pursuits and pilgrimage among the senior citizens. It is responsible to advocate policies and programmes that serve to promote the needs and rights of senior citizens. It has the responsibility to support underprivileged elderly people through provisions of livelihood opportunities, the formation of self-help groups, and entrepreneurship programmes.

Current situation of social protection for elderly people

The proportion of elderly people needing social care and support is expected to rise, which will only call for new social protection policy and programmes or restructuring and reinforcement of the existing ones. We know that the traditional forms of old age care and support are getting weakened while formal social protection policy specific to elderly people is yet to come into existence. The draft social protection policy prepared by the Ministry of Labour and Human Resources is restricted to cover the welfare of elderly people who belong to the national workforce and other wage workers. Many of us are concerned about what policies and programmes would best work. The ideal social protection policy for

elderly citizens we prefer would be the one with wide coverage, egalitarian in nature, and firmly embedded in the traditional social protection system.

Policy and Programme Alternatives

Understanding old age problems and initiating need-based and contextual social protection mechanisms for elderly citizens have become urgent issues. The emerging old age problems may worsen with the country's fast economic growth and accompanying social and economic changes if they are left without any policy responses and mitigating actions. There is no perfect social protection system that a nation can replicate; it would depend on a country's contexts—demographic, economic, social, historical and political circumstances. Reinforcing the role of the family as the principal source of care and support for elderly citizens is the ideal one, but given that the tradition of family care and support is also at risk of losing its vitality, we may have to look for various policy alternatives.

There are many policy alternatives, which could be relevant to the Bhutanese contexts. These policy and programme options are:

1. Designing policies and programmes to preserve and promote the institutions of extended family system and community life so that elderly citizens continue to enjoy social protection [within them] including the legal obligations for children and family to look after their aged parents;

2. Clearly redefining and promoting the complementary functions of the existing tripartite social protection system: *kidu* system, family care and support system, and formal social security schemes;

3. Introducing either universal, supplementary or means-tested social pension system;

4. Initiating flagship public residential care provision (old age care homes) specifically for elderly people lacking financial means and family support or for those who are childless;

5. Strengthening social hospitalisation schemes through which the elderly people without anyone often with little need of medical care [to turn to] are resident in hospitals. For ex: JDWNRH's patients' guest house have such residents;

6. Introducing compulsory old age insurance scheme. The World Bank has, since the mid-1980s, initiated several old age social insurances and contractual saving systems in developing countries. These initiatives were driven by three key factors: (1) population ageing, (2) decline of filial piety and traditional family insurance, and (3) operational weakness in pension systems (World Bank, 2008).

7. Promoting voluntary and mutual help care schemes (whereby young volunteers help elderly people in return for social credit they would accumulate to be used for their own old age needs).

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CHAPTER II

THEORIES, CONCEPTUAL FRAMEWORK AND RESEARCH METHODS

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Theoretical Background

Old age care and support

Bengston *et al.* (1997) had deduced that one of the major setbacks in social gerontology is lack of clear social theory and conceptual framework for the studies related to ageing unlike other social and human disciplines. Jason L. Powell (2001) objected the idea of theoretical paucity in gerontological research. He asserted that several theoretical ideas and conceptual models for studies on ageing have emerged in recent years. One of the theories that influenced the understanding of the old age problems was the postmodern theory. This theory has been used for explaining various dimensions of ageing and social protection. The postmodernist's theoretical idea was relevant for the present study. The modernism is the humanist rejection of age old tradition and customs in favour of something new; and post modernism is all about favouring modernisation while maintaining certain elements of the past (James Morley, 2000).

Burgess (1960) and Cowgill's (1972) modernisation theory attributed the declining trend in old age care and support to the weakening of the customary filial values, norms and practices, which in turn are weakened by the rising influence of modern values of individualism and secularism. Furthermore, the combined tendencies of globalisation, economic integration, mobility, and occupational flexibility engender disintegration of the extended family system and community vitality. Studies on the influence of cultural values and beliefs on old age have been prevailed by

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differentiating ageing in Western and non-Western cultures (Giles et al. 2003; Eboiyehi, 2015, pp:345). These studies were motivated by the idea practice of filial piety and positive views towards ageing were dominant in Asians and sub-Saharan Africa societies (Davis, 1983; Sung 2001; Eboiyehi, 2015). Conversely, western societies were considered to be youth-oriented and holding negative views towards ageing and elderly people (Palmore, 1975; Eboiyehi, 2015).

The postmodernism theory has emerged to rectify the ills of modernism. It advocates modernisation without losing certain elements of the past (Morley, 2000). Some developed countries are trying to revive certain elements of traditionalism, for example, by adopting the ideas of family and community care. Family social protection system differs across regions and societies. For example, in the US and UK, children have no legal obligation to support their parents, while in France, Singapore and China, children are morally liable for the welfare of their parents (Twigg and Grand, 1998; Galasso and Profeta, 2011: 3).

Cain (1981) lexicographic safety-first model has propounded that parents expect to reproduce a minimum number children to safeguard against future illness and disability risks. In developing countries where capital markets are not so flourished, children are viewed as durable goods desirable to maintain family lineage and serve as insurance against old-age insecurity (Dasgupta, 1993). The underlying transfer mechanism between parents and children is based on mutuality and reciprocity where parents provide for children first and then the latter reciprocate without much intergenerational conflict (Nerlove *et al.1987).*

The elderly care and support largely hinge on younger generation's conception of old age problems rather than the influence of traditional and customary values, norms and practices. Traditionally, it is believed that children who mistreat their parents would be subjected to the law of cause and effect (karma, *ley-judrey*). Elderly parents often make reference to a Bhutanese saying: 'You have your share [laid] on the shelf'. The saying connotes that adult children who mistreat their elderly parents would, in turn, be abused by their own children in future. As young people's respects and sentiments toward elderly parents change, the latter are left with little powers to enforce children's conformity with filial duties (Aboderin, 2004). The presence of the relationship between population ageing and economic structure leads to stereotyping elderly people as

'burden group' or 'economic dependents'. The idealist views associated with Durkheim's Division of Labour theory (1893-1964) reckon changing human minds as driving force for changing family norms and behaviour. In the similar vein, Buddhism views that bad era has come—an era that is not associated with changing time, but with changing human values and behaviour, and this change might affect the way elderly people are cared and supported.

The political economy perspective attributes old age problems to the economic reality rather weakening of family system and customary obligations to elderly parents (Goldstein, Schuler & Rose, 1983; Logue, 1986; and Aboderin, 2004). Poor families are caught in a dilemma of how to allocate scarce resources for children and elderly parents (double-burden situation). In most cases, they tend to invest more in children than for the welfare of elderly parents. Most adult children and their families are not disposed to deliberately dishonouring customary filial piety. Their economic circumstances often render them least capable of meeting the needs and expectations of elderly parents. This perspective treats the neglect of older people by their adult children as 'unintentional decision' and as a matter of economic choice. It corresponds to the Marxist theory that social change is determined by economic factors. Changing material circumstances to a certain extent influences how children treat their elderly parents.

There is contention over whether informal family care and support system and the state welfare system are complementary or they could co-exist. According to Titmuss' (1963, 1997) residual model of welfare, the States assume social welfare responsibilities only when families or markets fail. From the viewpoint of the classical family sociology (Parsons, 1943), development of a strong welfare state conduces diminishing role of families, and hence, crowds out the family care and support to elderly people (Schoeni 1994; Cox and Jakubson, 1995).

Some Bhutanese people view that the state dominated old age social protection schemes would encourage 'dependency culture' and worsen the fiscal deficit in the public sector. Townsend (1981) observes that the State's provision of social welfare as a part of poverty reduction or retirement schemes actually creates 'structured dependency'. Townsend's view may be valid in some countries, but the State's provision of social welfare to needy people in Bhutan is indispensable. Most people tend to

conceptualise social welfare schemes in terms of costs and expenditures but overlooks their potential positive effects on socio-economic development. Therefore, rather than subscribing to a view that social pension or any kind of cash transfer is a separate programme; it is important to treat them as one of the effective poverty reduction measures.

Though the 'crowding out' theory has wider support among the economists, family sociologists have recently challenged the theory. They argue that modern welfare support services reinforce the traditional family care and support system (Motel-Klingebiel ***et al***., 2005: 864). Ku ¨nemund and Rein (1999) provides (using international comparative data) evidence of 'crowding in' effects of state welfare services. They show that formal state welfare services reinforce family support, especially when the needs of elderly people increase and families' economic conditions cannot meet all those needs. Cox (1987b) and Lingsom (1997) shows that through 'mixed responsibilities approach,' the formal state and informal family social security systems could complement each other.

Social security schemes

Many theories discussed so far are relevant to understanding declining trend in family care and support to elderly people in the face of modernisation. We further discuss theories and models of old age social security vis-à-vis social protection, why the need for formal old age social protection arises, and what constitutes the most popular approach to effectively deliver social protection to the ageing population.

Social security concept has originated in the western society and has become a major component of welfare policies in all industrialised countries. Social security is generally linked with the loss of income earnings (Leiiveld, 1991: 5; Atkinson 1989:100-12). In other words, social security schemes were more correlated to consumption than development and treated as an arrangement better suited to the contexts of advanced industrial nations. However, in recent years, introduction of universal social assistance in Nepal, creation of pension and provident fund schemes in Bhutan, conditional cash transfer schemes in Latin America, expansion of social assistance in South Africa, and launching of rural employment guarantee scheme in India have shown that social security plays an important role in poverty alleviation and development. These

examples prove that there is scope for applying the concept in the non-western and developing countries' contexts (Midgley, 11995).

The International Labour Organisation (ILO, 2000:29) defines social security as 'the protection which society provides for its members through a series of public measures to offset the absence or substantial reduction of income from work that results from various contingencies (notably sickness, maternity, employment injury, invalidity, old age and death of a breadwinner)'. The ILO's definition (1984) points out two important issues: first, the state has to organise social security schemes; and second, it assumes that a large proportion of the population is employed in the formal sector.

Fuchs (1985), Mesa-Lago (1978) and Mouton (1975) suggest that state-provisioned social security schemes are rarely good and cover less than 10 per cent of the population (Fuchs's estimate, 1985:35-7). The definition, by limiting itself to the state's provision of protection against social risks, downplays the role of other social protection mechanisms present in developing countries such as family and community care and support.

The Bismarckian model (Olivier, 1999 13-14) defines social security as 'social insurance'—an employment-based public scheme with benefits derived from the contributions from the employees, employers and the state. The Beveridge model places importance on ensuring minimum income protection for the entire population through universal or means-tested 'social allowance' scheme (Berghman, 1997: 16). There has been a gradual convergence of 'social insurance' and 'social assistance' schemes to deliver a comprehensive social security scheme. A variety of 'mixed system' has been developed across different countries (Jutting, 1999: 5).

The World Bank has, since the mid-1980s, initiated several old-age social insurances and contractual saving systems in developing countries. These initiatives were driven by three key factors: (1) population ageing, (2) decline of filial piety and traditional family insurance, and (3) operational weakness in pension systems (World Bank, 2008). The World Bank's multi-pillar system (1984-2004) consists of the five pillars: (1) a non-contributory 'zero pillar'; (2) a mandatory 'first pillar'; (3) a mandatory 'second pillar'; (4) a voluntary 'third pillar'; and (5) a non-financial 'fourth pillar'. This multi-pillar system uses new Social Risk Management Framework (SRMF) that can 'provide the conceptual underpinnings for

dealing with diverse risks to which individuals or households are exposed in a world characterised by asymmetric information and malfunctioning or non-existent markets'(Holzmann & Hinz, 2005: 37).

The diverse old-age related risks are dealt by making three main arrangements: informal (family and community-based); public (state funded or unfunded, contributory (insurance) or non-contributory (redistribution); and market-based. These, in the industrialised countries, are known as three-tiered or four-tiered based on whether categorisation is grounded on the type of providers or objectives of the pension systems. Social security system with a higher number of tiers is considered as desirable because it allows for diversification of old age income sources and different platforms to mitigate diverse risks. Different theoretical perspectives discussed above shows that at a certain point, the State has to take the responsibility of old age social security or transfer it to market.

Conceptual Framework

The literature reviews point out that any research on old age care and support vis-à-vis quality life and well-being of the later life hinges on an individual's vulnerability and resilience. Policy interventions are needed not just to reduce vulnerability, but also to enhance a person's coping capacity or resilience. We drew the conceptual framework [for the present study] from the concepts of vulnerability, resilience, life course, human development, capability approach, and GNH. The conceptual framework was used to underscore the following when conducting the analyses of administrative data, questionnaire survey, Focus Group Discussions and In-Depth interviews:

(1) The current situation of elderly persons (study participants) and threats/opportunities leading to the current situation;

(2) How vulnerabilities of elderly people acquired interacted with the temporal and contextual factors at present at individual, household and community levels to affect their quality of life;

(3) How vulnerability of early life (life course) interacted with the temporal and contextual factors at present (In-depth interviews was based on life course approach);

(4) Policy instruments effective in reducing multi-dimensional vulnerability among current and future generations of elderly citizens.

Bengston *et al.* (2005) found that individuals are the key agents in the construction of their own lives at present and the state of being in the receding years. The choices they make within the opportunities and constraints of their families and structural and temporal contexts affects their life courses. Our in-depth interviews were aimed at obtaining extensive narratives of elderly participants related to their earlier stages of life, current circumstance, and future expectations.

In the GNH approach, the quality of life of elderly citizens could be measured in terms of what improves and impedes their material, spiritual and emotional well-being at individual and societal levels. The GNH approach believes in promoting an individual's psychological well-being, high living standards, ecological vitality and people-centric governance based on the universal values of human rights, equity, social justice, and compassion. In a similar manner, the promotion of human development is all about deepening human progress in which personal capabilities are enhanced in various dimensions.

GNH and Human Development models both allow people overcome various threats or vulnerabilities by (1) enhancing individual capability, and (2) creating economic, social and physical environments that are capable of enhancing individual's coping mechanisms or resilience to various vulnerabilities. A person's income security, health status, education, employment, and social support, as well as external social and physical environments, determine his or her individual capacity. When low individual capability and restrictive social and physical environments act together, an elderly person cannot benefit from the opportunities available to him or her. Therefore, it is important to understand both the individual capabilities of elderly people and external environments to understand the nature, extent, and causes of the old age problems and for formulating effective policy and programme responses.

Coping capacities of elderly people can be broadly categorised into three groups, namely: individual capacities (personal wealth & human capital), social networks and family (social capital), and formal social protection. Individual coping capacities cannot by itself sufficiently deal with the

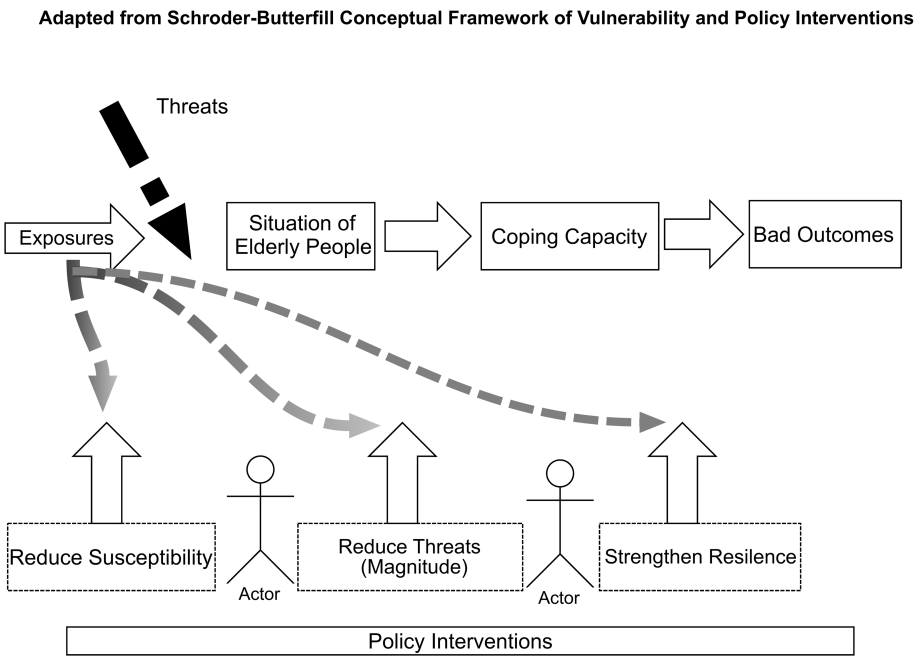
challenges of old age. The relational and family networks and formal sources of support are indispensable. Whether institutionalisation of old age care and support are necessary is being debated in the country. It is imperative that we draw lessons from other countries to make a logical conclusion of this debate. In Europe, for example, the decline in family support has led to the institutionalisation of old age care (Scott and Wenger 1995: 164).

In Asia, institutionalisation of old age care and support usually leads to destitution and reliance on charity (Indrizal 2004; Vera-Sanso 2004) though they often are associated with social stigmatisation. Biddlecom, Chavovan and Ofstedal, 2003; Grundy 2003 & Wenger, 1995 underscored the importance of family networks for old age care and support. This entailed us conduct a deeper examination of family networks and support to understand old age vulnerability. We emphasised on understanding our study participants' family networks and care and support base.

Chambers (1989) defined vulnerability as 'exposure to contingencies and stress and difficulty in coping with them'. The vulnerability could be external or internal. An external vulnerability could constitute risk, shock and stress to which a person or household is exposed while an internal vulnerability is a state of defencelessness or lack of resilience to cope with damaging loss. Loss can assume many forms: physical weakness, economic impoverishment, social dependence or humiliation and psychological damage (Chambers, 1989, pp.33 & Zaidi, A, 2014, pp.5). Alwang *et al.* (2001) identified three components of vulnerability: Risks, Response, and Results (welfare loss) termed as three R's.

Building on Chambers (1989) and Alwang *et al.* (2001), Schröder-Butterfill and Marianti (2006) developed a conceptual framework for an empirical examination of old age vulnerability and mitigating responses. Schröder-Butterfill (2012) improved the conceptual framework by framing it on three analytical domains: exposure to threat (Risks), coping (Resilience), and outcomes (Results) as shown in figure 2.1.

Figure 2.1: Schröder-Butterfill's conceptual framework of vulnerability and policy interventions



The framework illustrates how policy interventions at three domain levels can counteract vulnerability. Policy interventions could be made: (1) before threat or risk occurs or a person becomes susceptible to threat; (2) reduce the magnitude of a threat so that it doesn't become a hazard, and (3) build a person's capability to escape or overcome bad outcomes.

We used Schröder-Butterfill's conceptual framework of vulnerability and policy interventions to guide our questionnaire survey, Focus group Discussions (FGDs) and In-depth interviews. Basically, we used broad questions related to this conceptual framework: (1) Who are the vulnerable elderly persons? (2) What are their main problems (Risks)? (3) Why are they vulnerable to risks? (4) What different policy interventions can mitigate old age vulnerability? The desired outcome in the conceptual framework is 'happiness and well-being' in older age. As happiness and well-being differ from one context to another, we used multidimensional happiness and well-being measures used in GNH measurements (Nine domains and 33 Indicators).

The Global AgeWatch Index's most crucial domains for elderly people are (1) Income Security, (2) Health Status, (3) Individual Capability and the (4) Enabling Environment. These domains are crucial aspects of reducing elderly people's vulnerability, for enhancing their resilience to threats, and to avoid or overcome bad outcomes. Each domain includes several indicators.

Income Security:

(1) Pension coverage, (2) poverty rate in old age, (3) the relative welfare of older people, and (4) living standards.

Health Status:

This is measured in terms of (1) life expectancy at 60, (2) healthy life expectancy at 60, and (3) physical and psychological well-being.

We know life expectancy at 60 had increased due to improvement in health care system. Nevertheless, there are barriers to health care for elderly citizens such as difficulty in getting physical access to health care, skepticism in the efficacy of modern medical treatment, lack of awareness in elderly people's health conditions, and inadequate health care and social services (geriatric care) devoted to elderly people.

Capability:

This is measured in terms of (1) employment levels and (2) education status of the elderly people (proxy indicators).

Enabling environment:

It is measured in terms of (1) social connections, (2) mobility, (3) civic freedom, (4) civic participation, (5) autonomy and (6) choice of living arrangements.

While we used some indicators from the Global AgeWatch Index, we also adapted part of GNH survey 2015 for our questionnaire survey. Our survey included questions related to 28 indicators from GNH's eight out

of nine domains (environment domain is not taken into account) and Global AgeWatch Index's 4 domains. In order to delve deeper into the actual vulnerabilities (problems or bad outcomes for elderly people), we asked elderly respondents/study participants about their problems, needs, and expectations (that is, what they strive for and try to avoid in their lives). Two new domains namely elderly needs and elderly protection were added to the questions adopted from GNH Survey's eight domains. The total indicators considered for the small sample questionnaire survey was 32.

The key assumptions we made were that in the past, old age care and support were adequate because: (a) living style then was simple, as the families sustained on the traditional farms; (b) families were joint/ extended; (c) modern ideas of liberalism and individualism had not much influence on customary code of filial duties; instead, family and community life based on trust, reciprocity and mutual coexistence were vibrant; and (d) the relationship between elderly and younger people was warm, affectionate and strong.

In the urban setting today, providing care and support to elderly people are becoming difficult on the following accounts:(a) livelihood depends on earning of the working adult members of a family; (b) urban families are more exposed to modern values of individualism, secularism and competition; (c) elderly people have a little role in domestic help because household works are not as diverse as in traditional households; there is little that elderly members could contribute to urban families; (d) unlike in the past, children do not stay at home throughout, as they have to attend works and schools, thus cutting short healthy interactions between elderly people, adult children and grandchildren; and (e) families are burdened to cater to the needs of both children and elderly parents. This double burden circumstance is becoming increasingly applicable to rural families as well.

Definition of Old Age

The United Nations defines older people as those who are above 60 years of age. However, the definition should be adapted to local contexts. For example, in many developing countries, people aged 50 years are considered to be old while in the developed countries they consider those persons over age 65 as an old persons.

Bhutan Civil Service Rules (BCSR) 2012, under article 20, prescribes different retirement age for civil servants in different levels. The BCSR has fixed the retirement age for those in grade three and above to 60 years. For those in grades four and eight, the retirement age is fixed at 58 years and those in grades nine and below at 56 years.

There is no simple age at which a person can be described as 'older' but for the present purpose, we used age 60 and above, though in the case of health data analysis, we used age 65+ (as permitted by data).

RESEARCH METHODS

Overall Research Design

We applied the explorative, descriptive, and mixed method design for the study as a whole. The quantitative study constituted the analysis of administrative and survey data. The administrative data were collected from relevant agencies like Ministry of Health, JDWNRH, NPPF, RICB, BIL and many others. The survey approach included (1) the simple analysis of PHCB 2005 and past national surveys' data and (2) the analysis of small sample questionnaires survey data. Data from the past national surveys were sourced from the GNH Survey 2015, Labour Force Surveys (LFS, 2013, 2015 & 2015), BLSS, 2012 and Senior Citizens' Survey, 2012. A small sample survey was administered together along with in-depth interviews in eight Dzongkhags viz. Chukha, Punakha, Thimphu, Samtse, Sarpang, Zhemgang, Tsirang and Samdrupjongkhar. It would have been ideal if we had sufficient resource to conduct the cross-sectional survey of a representative sample of elderly people. We could not conduct the nationally representative elderly people survey owing to the budget and time deficits. The Focus Group Discussions (FGDs) were conducted in seven Gewogs of four Dzongkhags: Trongsa, Paro, Haa and Chukha.

The main feature of the Mixed Method was the triangulation of the results from different analyses. The study may be updated once the PHCB, 2017 and BLSS 201y data becomes available.

Research problem

In Bhutan, the informal system of care and support for elderly citizens is gradually losing its supremacy and functionality in the face of rapid social and economic transformations. The accompanying rural-urban migration of young productive people has begun to erode the norms and practices of the extended/joint family thus exposing many elderly parents to social and economic risks like poverty, social exclusion, and chronic morbidity. The current trend in the emergence of new problems associated with the ageing population may call for the reinforcement, restructuring, and reformulation of certain policies and programmes.

Research Questions

During our pre-study consultations with the local leaders, members of parliaments, civil servants, and a few other people, one recurrent issue that emerged was the issue of declining traditional old age care and support system and rising number of elderly people living in difficult situation. Based on these consultations, we have identified the main policy decision problem as: 'there is the need to understand, recognise and improve social, economic and emotional conditions of many elderly people in the country'. This decision problem led to the formulation of the following research questions:

1. What are the problems and needs of the Bhutanese elderly citizens?
2. What are the policy and programme gaps in elderly care and support system?
3. What are the social and economic factors affecting the overall well-being of elderly citizens?
4. What needs to be done to reduce elderly citizens' risks and vulnerabilities?

Overall Study Objectives

Based on the pre-research consultations with various individuals and groups, we have formulated the following broad objectives of the study:

1. To investigate and provide deeper insights into the social, economic and other risks and vulnerabilities of elderly people;
2. To examine how the responsibilities of family and community for providing care and support to elderly people are changing.
3. To examine various assistance schemes available to elderly people such as from the state and society including their own coping strategies;
4. Determine which/what type of the national and local policies and programmes could contribute to and sustain a pro-poor policy environment for elderly people;
5. To bring the voices of marginalised elderly people to the fore of development policies and programmes;
6. To inform the design of a context-specific comprehensive social protection policy instruments that are most effective in ameliorating vulnerabilities of a multidimensional nature among current and future generations of elderly people;
7. To motivate action by the authorities and other relevant groups in society who are, or feel, responsible for elderly people, among others; and
8. To provide the groundwork for any future gerontological research and policy analyses.

Combination of the Results

The mixed method basically involves combining the qualitative and quantitative research paradigms. Different approaches to data collection and analyses were used and results were presented separately. However, we made an attempt to converge the results or findings of different approaches through the process called triangulation of results. This was done to give more accurate and robust findings (complementing the results) and adding scope and breadth to the study.

Ethical considerations

We had the professional obligations to respect the rights, values, and desires of the study participants (mainly elderly people), and more so, this

because our study participants were elderly people. Though our ethnographic approach was little obtrusive, we had our participants informed about the study and its benefits through local leaders prior to our interactions with them.

We gave the ethical issues the utmost importance, as the approach and nature of the study and its objectives were such that we had to collect personal and sensitive information (participant's situation, family relationships, etc.) from the vulnerable group. The following ethical processes were exercised to respect and assure the study participants' rights and protection: (1) the participants were explained about research objectives until we were convinced that they understood them (even when we had time constraint); (2) participation in our study was voluntary; (3) we sought the approvals from the Dzongkhags and Gewogs leaders for collecting data from their jurisdiction; (3) we assured the study participants the confidentiality of data and anonymity of a person (in the report); and (4) the we sought and executed written informed consent with elderly participants.

Study's Limitations

Conducting interviews with elderly people was difficult due to several functional limitations—many of them had hearing and speaking problems. This study was designed to encourage elderly participants to speak more and without much hesitation. This was done firstly, by convincing them of the importance of the information they shared with us in understanding not only their own problems, but that of other elderly people in the country, and secondly by guaranteeing them 'no harm' for participating in the interviews. However, as is the case in most research that involves the views of the human subjects; it is possible that not all could express as much as they wished to. This was one main setback. The other limitation was that since the sample size was small, it remains a concern whether we could generalise the study at the national level.

Conclusion

The theoretical and conceptual frameworks that are commonly used in geriatric research guided our study designs. We used the combinations of different approaches to examine the situation of elderly people, their

vulnerabilities, coping mechanisms and policy interventions. Five main approaches were (1) interview-based qualitative study, (2) Focus Group Discussions, (3) small sample questionnaires survey, (4) analysis of national level surveys (GNH survey, 2015, Labour Force Survey and other surveys), and (5) analysis of administrative data.

In this report, each of these approaches is presented in separate chapters. The important feature of this study is that the findings of different approaches were triangulated. The key issues (of policy relevance) are presented and discussed in Chapter VIII. The administrative data collected from various sources were analysed to supplement the qualitative studies. The health data (records) were analysed and presented as separate chapters, as health constitute one integral component of ageing.

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CHAPTER III

THE ANALYSIS OF IN-DEPTH INTERVIEWS

Lham Dorji[1]

Introduction

The qualitative paradigm as a constructive approach provides 'context-bound' information related to 'what happens on the ground' (Creswell 1994). It has an ability to provide complex textual descriptions of how people experience a particular problem and about the 'human' dimension of that issue, for example, beliefs, opinions, experiences, and often, contradictory behaviours (Mack *et al.*, 2005).

The in-depth interview approach constituted an important component of the qualitative study. The in-depth interviews with 42 elderly people of age 60 and above were conducted in eight Dzongkhags in the Western, Eastern and South Central regions, namely Chukha, Punakha, Thimphu, Samtse, Sarpang, Zhemgang, Tsirang and Samdrupjongkhar. Elderly people who were known to be facing multiple problems were selected for the in-depth interviews. The aim of this interview-based study was to ascertain the views and experiences of elderly people and to incorporate this knowledge into a more comprehensive understanding of the situation of elderly people.

In this chapter, I have tried to analyse the narratives of elderly persons (told to us in their own words), largely focusing on the different situation they were in, and their own experience of what it meant to be becoming old. It was intended to explain and describe old age situation: their problems, needs and wishes from their own perspectives rather than the experts' points of views. I have occasionally used the GNH Survey 2015 data to supplement the findings of the in-depth interviews. This part constitute the main component of the qualitative study. We met many elderly people who were really in pathetic conditions. Not all the interviews were included in the analysis because some of the narratives were short, as they due to functional limitations could not talk more.

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Data Collection

Sampling

I have used the multi-stage and convenience sampling methods to select the elderly participants. There is no appropriate sample size for the qualitative study, but most researchers and experts believe that a qualitative study should have 12 to 26 participants. Luborsky and Rubinstein (1995) proposed that 'sampling for meaning' is the most appropriate sampling approach for a qualitative study. For the present study, at least 42 elderly people with multiple problems were purposely selected from six Dzongkhags. The Gewog Administrative Officers (GAOs) and Tshogpas (elected representatives of chiwogs/group of villages) carried out the identification and selection of the study participants based on the set criteria.

A seminal work on sampling techniques titled 'sampling in qualitative research on ageing' provided some guidelines for qualitative research. The selection processes were guided by two principles: (1) optimal representation of elderly persons in terms of age, gender and region of origin; and (2) consideration of income poverty, health, and social deprivation.

Elderly people selected for the in-depth interviews were the ones who the local people perceived them to be poor and were living in the most difficult situation. The inclusion criteria were: (1) elderly persons of age 60 and above; (2) poor elderly persons were to be defined as those people coming from income-poor families who were living in difficult circumstances, including those who had no one to look after them; (3) those elderly persons who were experiencing deprivation of basic needs such as food and nutrition, clothing, proper houses, and so forth; and (4) elderly persons who did not have spouses and children. During the selection phase, the selection teams were instructed to inform and convince the elderly participants that they would be recruited only for the study purpose but not for any kind of support.

Conducting in-depth interviews with elderly people

To improve the face validity (whether the questions asked were what the study purported to unearth) and refine the questions (content, flow and

format), pilot testing was done in Thimphu (mainly with the selected elderly citizens present at Chubachu, Begana, Chang Jiji and National Memorial Chorten).

The team leader conducted most of the in-depth interviews occasionally supported by three other members who were focusing on the questionnaire survey. Before each interview, the interviewers were given a written set of questions (logically sequenced). We used life history approach—the elderly participants were allowed to freely narrate their life histories. The interviews were divided into five stages: narration of a participant's early stage of life (as a child and young adolescent); entry into the next phase of life (as young person) and young adulthood (taking responsibility and starting family); stage of old age; and their future dreams and expectations.

The interviews took place at places wherever the study participant were present. Unlike in the past, we did not ask the study participants to gather at a particular place (with a few exceptions). This was done considering their physical and functional limitations and to avoid causing them inconveniences. Each interview was conducted in isolation from the others to prevent distractions. The narratives were recorded upon participants' consents. The languages that participants felt comfortable with, mainly Dzongkha, Sharchopkha, Lhotshamkha and Khengkha were used.

The interviews were premised on the belief that the quality of elderly persons' participation would depend on their feelings of ease and self-confidence. To the extent possible, the interviews were conducted in informal manner. We made every effort to ensure that the interviews were guided by a sensitive approach; that is, not probing if an interviewer felt the questions were causing some emotional disturbances to the interviewees. The interviewers explained to each participant the purpose of the study and its benefits.

During the course of the interviews, the interviewers took note of the physical observations and emotions. These observations allowed contextualising the interviews. The physical observations, which could not be conveyed through the transcripts, were made on the following attributes:

1. The participants' physical appearance, presence of functional disability, and observation of other characteristics that illustrated their state of being;

2. Expression of emotions such as crying and facial expression when narrating the difficult life situation [they had faced] such as being poor or mistreated by their children.

These observations were not analysed, but they were taken into account when making sense out of the narratives. They provided the contextualised perspectives. The interviews were conducted over the period of less than four weeks in February-March 2017.

Data Analysis

Data analysis was based on the combination of three strategies: ethnographic (established dimensions/perspectives based on universal statements, cross-cultural description, general statements about old age care and support, specific context, specific statements and actual behaviours); grounded theory (presenting information from open-coding —a list of categories/taxonomy, using coding that explained propositions/assumptions and synthesis of knowledge about the elderly participants through clustering of themes) and ; phenomenology (outcome presented in the form of narratives or a person's own words).

I have adopted a deductive approach to analyse data. It involved analysing data with no predetermined theory or framework (to avoid biases). However, some theories or conceptual frameworks were used to guide the choice of questions and method of data collection. I used a thematic content analysis—a method that originated from the grounded theory. It involved the process of analysing transcripts, identifying themes, and associating those themes together. Data were objectively coded into themes. The transcripts or texts represented the views of the elderly participants.

MAXQDA software was used to do the thematic data analyses. This is a program designed for computer-assisted qualitative, quantitative and mixed methods data, text and multimedia analyses in academic, scientific, and business institutions.

Further, I used both interpretive and phenomenological approaches to analyse data. In the interpretive approach, the texts were organised or reduced to reveal the patterns of the views and meanings. The characteristics of the narratives were identified and coded thematically. The interpretive content analysis often results in the loss of meaning when the texts are reduced to numeric forms. To make up for this loss, I used the phenomenological approach. In this approach, data were presented without being condensed (through sorting or coding operations). The results of the phenomenological analysis were presented as quotes (anonymised). The quotations were selected based on their relevance to the issues being studied.

As part of the interpretive approach, I carried out frequency evaluation (conversion of texts into numeric forms). This was done by adding up number of times a particular word, phrase or concept appeared in the text. The frequencies were then transformed into percentages. Both *manifest content* and *latent content* coding were used. The *manifest content* coding involved identifying those elements, for example, say the word 'I live all by myself' that were countable in the entire text and then adding them up, while in the *latent content* coding, the phrases with similar meaning were counted (for example, 'My children have left me and they never came back to see me' was considered akin to saying: 'I live all by myself'. I have restricted to doing simple descriptive analysis.

Quality and Reliability of In-depth Interview Findings

The quality and reliability of findings could depend so much on the internal, external and operational validity. Internal validity means 'avoiding any external factors that may influence data reliability'; external validity is related to generalisability of data, and operational validity is about measuring what is needed to be measured (Yayasan, Mendaki, 2015).

Limited generalisability (external validity)

The intent of any qualitative research is usually to go into depth of any issue being studied rather than to generalise the findings. It is about a unique interpretation of events, issues and experiences. In the present case, the elderly participants were selected from the representation of all three regions. The main setback was the smallness of sample. The extent

to which the findings could be generalised is left to the readers' judgement. However, since elderly persons interviewed were generally poor and faced myriad of problems, the level of generalisability could be extended to elderly persons with similar characteristics.

Reliability (limitations in replicating the study)

The in-depth interviews were conducted in multiple sites. We constantly examined the emerging patterns and tried to pay attention to whether the thematic constructs were being replicated in different study sites. It was almost similar to cross-case comparisons.

I have attempted to seek the believability of information based on coherence, insight and instrument utility, and trustworthiness through a process of verification rather than through traditional validity and reliability measures. The local leaders and other informants were interviewed to get supplementary information and validate the information provided by the primary informants.

Internal validity

To ensure internal validity, all interviews were conducted in separate rooms or isolated places. This was done to ensure that no other persons were around—those who could otherwise have influenced the way elderly persons narrated their stories.

Operational validity

The effort was made to ensure the operational validity by ensuring similar interpretations of the semi-structured questions between the interviewers. The interviews were taped and then transcribed meticulously by the translators who had gained sufficient experience in this area.

Research Ethics

The in-depth interviews with elderly people had to be handled with utmost delicacy. Many of the elderly participants were not only in the physically vulnerable situation, but also susceptible to emotional outbursts, especially when recounting the stories of their hard lives. To

provide the elderly participants with their rights to protection, we abided by the following ethical procedures:

- Informed them about the purpose of the study. We explained to each of the participants that though the benefits of study might not trickle down to individuals, it might help raise the voices and bring the concerns of elderly people to the notice of policy makers, development actors, and others;
- Told them their rights to withdraw if they felt they would not be able to participate;
- Sought the permissions of their children (in case they were living with their children) or other caregivers in order to interview them;
- Executed written consents with each of the participants. The consents were available in both English and Dzongkha.
- After the interviews and during data analysis, a strict code of ethics was applied to ensure anonymity of the elderly participants and confidentiality of their information. I have assigned the unique codes to each of them and their narratives were presented without their names (but with codes).

Profile of Elderly Study Participants

Forty-two elderly people had participated in the in-depth interviews. The interviews were conducted in February-March 2017. The study participants' origin of Dzongkhags is given in table 3.1. A majority of them belonged to age group 70-79. There were slightly more males than females. About 45 per cent of the elderly participants were widowed (loss of spouses), 40 per cent had their spouses surviving while 7 per cent each was divorced or never married.

Table-3.1: Profile of the study participants

Characteristics	Frequency	Percentage
Age Group		
80-90	11	26.19
70-79	16	38.10
60-69	15	35.71
	42	100
Gender		
Male	23	54.76
Female	19	45.24
	42	100
Dzongkhags		
Punakha	10	23.81
Samdrupjongkhar	9	21.43
Sarpang	7	16.67
Chukha	6	14.29
Zhemgang	5	11.90
Trongsa	1	2.38
Trashigang	1	2.38
Pemagatshel	1	2.38
Wangduephodrang	1	2.38
Bumthang	1	2.38
	42	100
Marital Status		
Widowed	19	45.24
Married	17	40.48
Divorced	3	7.14
Never married	3	7.14
	42	100

Situations of Elderly Persons

The in-depth interviews were conducted with the aim to understand the situation of elderly people through the lens of those who had experienced various problems of old age. We adopted the life history approach to conduct the in-depth interviews. The usefulness of life history method for research on old age rests on the premise that a person's behaviour, attitude and actions in the twilight years often depends on the earlier phases of life. The situation an elderly person is facing today may be the consequences of his or her earlier life. Ageing is a process that spans over one's lifetime, and can be understood only

through the narration by that person who went through different phases of life. We considered it important to examine an elderly person through his or her life experiences to understand broader meaning of ageing.

In different stages of life (childhood, adolescence, youth, adulthood and old age), human being faces different problems. Children faces various deprivations critical for their physical growth and cognitive development like health, nutrition, sanitation, shelter, education, sanitation and water (Bristol Deprivation Studies). Adolescents are challenged with creating their social identity as a person and transition from home life to broad social life. Young people are concerned with education and transition to independent living through a search of proper employment. Adults focus on achieving social and financial security and building careers and families. Elderly people face challenges of seeking secured and happy retired life and healthy ageing. The specific problems a person may experience in each stage of life may depend on a combination of social, cultural, economic and biological factors and may vary from one socio-economic-cultural group to another.

In an old age, people face various issues such as financial insecurity, health problems, retirement, negligence and abandonment, social exclusion, poverty, abuse, discrimination, mental health, etc. To develop appropriate policy and programme responses, the situation of elderly people must be assessed, and this chapter is devoted to assessing the situation of elderly people.

Perceptions of old age

During the in-depth interviews, we requested our interviewees to respond to the general question on their perceptions of old age and ageing with the purpose to understand how the perceptions of old age impede or reinforce the old age care and support.

An overwhelming number of the participants described ageing as gradual journey to a period of declining health (poor vision, impaired hearing, stooping while walking, onset of functional limitations, multiple illness, loss of mobility, etc.) and loss of energy and capability (productivity loss, not being capable to do what they want to do, being looked down by others, etc.). Most of them perceived old age as a period of gradual retirement from normal labour to pursue spiritual practice, mainly

spending their lives in performing prayers, pilgrimages; and if conditions favour, to retire to secluded and sacred places for the serious pursuit of spiritual activities.

Most of them looked at old age as a period when they are supposed to depend on children for care and support (food, clothes, income, care during illness, etc.). That's why almost everyone desires to reproduce and strives to ensure the success of their children. The whole essence of bearing and upbringing children, some with great difficulty, is to have someone to look after one's welfare when old and ill and ensure proper funeral when one dies.

In general, those elderly persons living alone, either due to not having their biological children or being abandoned by their children, described old age as a period characterised by misery and hardship, social isolation, inadequate care, pain and being burdensome to others. What it is like becoming old was described by two elderly interviewees:

> I am getting older day by day. I am getting weaker and losing my energy and ability (both physical and mental). I feel pain in my arms, legs, and back. I get frequent stomach pain and constipation. I can't see and hear properly. I can't walk a long distance. I can't think well also. When I get ill, I can only wish if my children are there to take care of me, but they are all gone to live elsewhere. Getting older doesn't mean we don't have to eat, drink, and have good shelter. I get frustrated when I am not able to work to obtain my own sustenance like I could when I was young. My children do not come to see me. May be, they have their own share of problems in having to rear their children. I don't have much expectation from them. Sometimes, I wish if they could help me repay the loan that I availed to build a house (Nu. 200,000). I have to pay monthly instalment of Nu. 3000. I worry if I can repay my loan before I die. I want to devote my time to spiritual practice, but I can't do so because I have to do something to sustain myself. My biggest worry is whether my children would give me good funeral [when I die] (*ND, Male, aged 66, Samdrupjongkhar*).

> I am 84 years old. All my three sons died when they were very young. My only daughter is abnormal. I lost my husband a few days ago. Today is the tenth day after he died. I don't know what to do; I am totally lost now. I have no resources to perform death rituals for my late husband. I am too

> old. This is the reality of old age. I had an accident three months ago during which I got my back burnt. I was in the hospital when my husband passed away and came back to the village after he died. I am a poor old woman with no land of my own. My son-in-law has some land. I have one granddaughter and four grandsons. Eldest grandson is in Thimphu. I don't know what he is doing. He did not attend the funeral rite of his grandfather. It is only with the help of relatives that we could perform the funeral rite for my late husband. I am suffering my old age. I wish to die now. My husband is gone. Each day he is going far away from me (She cries…). Being old and nearing death, I worry who will look after me. If I die, I don't think my daughter can perform my funeral and death rituals. May be my body will be left to rot or be thrown into a river (*XX, Female, aged 84, Samdrupjongkhar Dzongkhag*).

Elderly people and living arrangements

A Strong family is as important for elderly persons as it is for children. In general, an elderly person who has a strong family relationship (with spouse, children, siblings and other relatives) can always turn to the family members for care and support than the one who lives in the family that is not biologically his or her own. In the Bhutanese society, spouse, children and grandchildren are often seen as primary caregivers for elderly parents. Data collected from 42 elderly persons shows that while the greater majority of them lived with their spouses, children and grandchildren, roughly 20 per cent of them had reported that they managed their old age alone (without family) as shown in table 3.2.

Table 3.2: Family status of elderly persons selected for the study

Name	Frequency	Per centage
Spouse	14	34.15
Alone	8	19.51
Daughter(s)	5	12.20
Son(s)	4	9.76
Grandchildren	3	7.32
Relatives	2	4.88
Others	2	2.44
Not accounted	9	21.95
Total	42	100.00

It was evident from the in-depth interviews that a person's choice about where and with whom to live was shaped by individual resources and constraints as well as broader social and economic environments in which he or she lived. The presence or absence of many choices implied varying levels of independence. However, there were elderly persons who were forced to be alone and dependent on people other than their own relatives, and this implied they did not have many choices. The selection of specific types of living arrangement outcomes nevertheless was based on a reasoned consideration of personal health, presence or absence of social support, and availability of economic resources, and the presence or absence of spouses, children and other kith and kin.

The situation of life may change as one's living arrangement changes. The ageing can involve isolation from family and friends, mostly through the loss of spouses and peers. For successful ageing in the Bhutanese context, it is not all about living in the luxurious homes in the opulence of material wealth. Most of the study participants agreed that having enough to eat, drink and wear, being free from physical illnesses, hardships and mental disturbances, and living with one's own close ones suffice to be called a successful ageing.

In later life, the worst nightmare for the aged parents comes from being deprived of the companionship of spouses and care from spouses and children, especially when they are ill and dying. There were a good number of the elderly participants who were forced to lead lonely life on account of not having children or being neglected by children and relatives and having lost their partners through divorce or death. One of the elderly participants has shared his experiences of living alone:

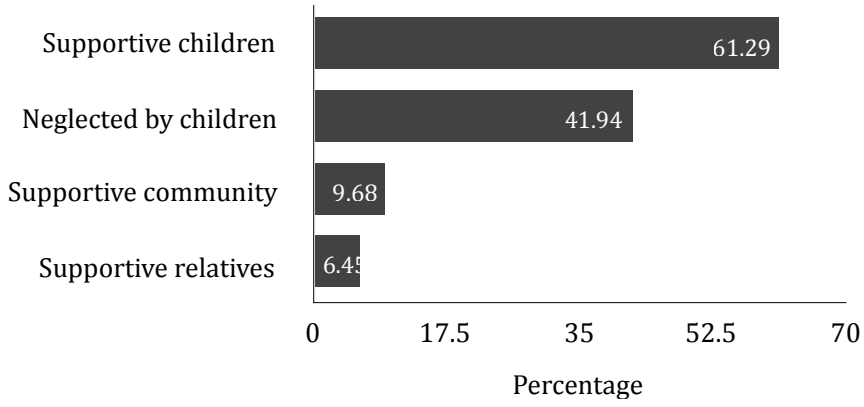
> I live alone and all by myself. This house (I live on the ground floor) belongs to my distant relative. She is not at home. She seems to have gone to herd her cattle. She gets sick often and she may die soon. She is good to me, but her daughter is not. I have no child and no family. My wife died long ago. I feel sad and lonely. Sometimes I feel I would leave the village and go elsewhere. But where can I go? I survive on whatever villagers give me. I don't mind begging, but I am against stealing. By begging, I feel I am earning an honest life. I eat as long as food stock last, and I think I can manage to survive this way. What worries me the most is who will care for me if I become terminally ill or who will conduct my funeral and death rituals (*NP, Male, aged 86, Trongsa Dzongkhag*).

Social care and support

The ageing could involve either being cared for by family, relatives and community or being neglected and isolated by them. The composition of the family and neighbourhood, which in turn is affected by the phenomenon of rural-urban migration of younger people, may determine the extent of care and support elderly parents get. Both the amount and quality of care and support they get may influence the process of ageing and the quality of their end year life.

The abandonment and neglect by children and relatives were common issues. These were some major changes that occurred in their lives. The changing social and economic environments seemed to have led to change in elderly people's positions and social roles. For most of the elderly participants, children were the primary providers of care and support (shown in figure 3.1). Still then, there was a high percentage of elderly people (among the study participants) reporting their children were neglecting them. However, there were some elderly participant who reported they receive adequate care and support from the relatives and community members.

Figure-3.1: The primary sources of care and support for elderly persons



Some study participants narrated the plight of elderly persons whose children have refused to care and support them:

> I have seen many elderly people suffering the last phase of their lives. They do not get any pension or any other forms of social assistance.

Some sons ignore their parents after being influenced by their wives and so is the case with daughters. Some children fail to conduct any funeral rituals or keep them [funerals] minimal. Some children make their parents sleep in the kitchens while they sleep in more comfortable rooms. Many children do not bother to send money to their parents to perform annual rituals at homes. I have seen seven elderly persons experiencing similar problems. Some children move to towns, and never look back at homes. In general, poorer children do not neglect their parents; it is just that they simply can't afford to provide care and support (*DD, Male, aged 67, Wangduphodrang Dzongkhag, 2017*).

I am 84 years old now. My son lives here in the village. He has built a house of his own. I lived with his family, but later he chased me out of the home. I stayed in the forest under rain for months. The rain damaged my blankets and clothes. I felt I would die without proper food and shelter. Later, I made some money by selling oranges. I used this income to build a small hut. I collected *pipla* and earned money enough [for me] to buy rice and other basic commodities. I survived through [in] this way for last three years after my son and his wife threw me out of their family.

In fact, if he knows how to be grateful to me, he owes me a lot. I gave him three acres of wetland and three acres of cardamom land. Through my hard work [when young], I bought land, developed orange orchards, and cultivated cardamom. I gave my assets to this son and two other daughters equally. He wanted every asset of mine; he wanted to deprive his sisters of their inheritance rights. My daughters have left the village with their spouses. They treat me well. But, I don't understand why my son hates me so much. I think the daughter-in-law is influencing him.

Now even as I live on my own, he tries to torment me. When I get money through the sale of oranges (I have half an acre of orchard), I have to be careful. He and grandsons would come to my house to steal my savings. They did it twice. They would find the money even if I bury it underground. Now I keep money with me even when I take bathe or go to toilet. They stole my oil, sugar and kerosene. The worst is that he threatened me to lash with a rope, and grandsons tried to beat me. Now it seems they have realised that I am making enough money. They ask me to rejoin their family. But, I will not…never in my life. I am dead for

> them. I always pray that my son meets the same fate as me! (*RR, Male, 84, Sarpang Dzongkhag, 2017*).

Not all children neglect or abandon their parents. For many elderly parents, children are not only the source of material needs, but also the source of joy, satisfaction, love and care. One of the elderly persons described his fulfilling relationship with his children:

> Our children are a source of our pride. I have a daughter and son. They care and support their mother and me. My daughter has four small children, and her husband passed away a few years ago. As a single mother, she has to work hard. We can't help her; rather she tries to support us though we do not expect much from her. She runs a pan shop. She sends us vegetables and in return, we send her betel nuts that we have cultivated. It is for the sake of our daughter and son that we are here taking care of the house and land; otherwise, we would have gone elsewhere to pursue spiritualism (*PP, Male, 76, Sarpang Dzongkhag, 2017*).

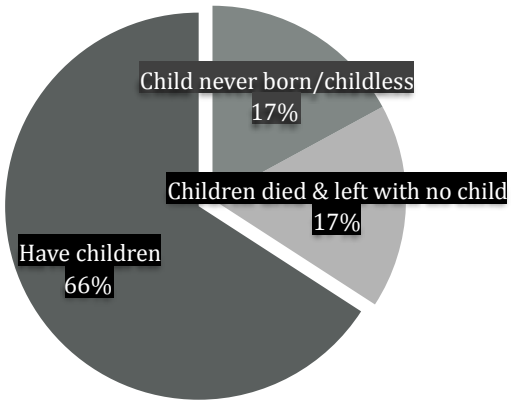
Whatever it is, the fact is that within the joint family living arrangements, children are responsible for providing care and support to their ageing parents, mainly in return for inheriting the parents' assets. Even as parents have nothing to inherit to children, the cultural norm is that children are responsible for the welfare of their frail parents, though this is not legally reinforced.

In some cases, parents relinquish the family estates and move into smaller houses with their small plots of land (*toezhing,* literally subsistence land), and many retire to nearby monasteries. Some co-resides with their son or daughter's family with a separate kitchen. Some of the study participants have done this. The reason they gave us was that as aged persons they couldn't adjust to the foods that other family members consume owing to their own health conditions.

Traditionally, family is looked at as the primary source of old age care and support. In the medieval period (under theocratic system), there evolved a matrilineal system of inheritance in the country. This cannot be generalised to the entire country. The patriarchal system is present in some regions. Under both these systems, the eldest daughter or son is responsible for his or her elderly parents, though other family members could also assume this responsibility.

Among 42 study participants, the greater majority of them had reported they have child/children, but then there was substantial number of them with no child (either never born to them or died) as shown in figure 3.2.

Figure-3.2: Percentage of elderly people getting old 'with children' and 'no children'



Growing older without kids may not mean a doom just as ageing with kids doesn't guarantee old age care and support. A person may be ageing with a spouse or getting support from other kith and kin. Nevertheless, the fact that there were elderly people deprived of children either through a death of a child or due to fertility challenge was sufficient indication that many would enter into old age childless. This may become an issue of concern especially in our context where children are considered the primary caregivers in old age.

Having no children of their own poses them a higher risk of finding themselves without an informal old age care and support system, and this may become worse in absence of formal social assistance schemes. Some people opt for an adopted child, who often prove beneficial in their old age:

> Though I don't have any biological child, I have an adopted son. I feel as if I have a bloodline child. Some people have many children, but they face problem sharing and apportioning land to them. Some of them even try to denigrate me by saying I have no child of my own. I usually react

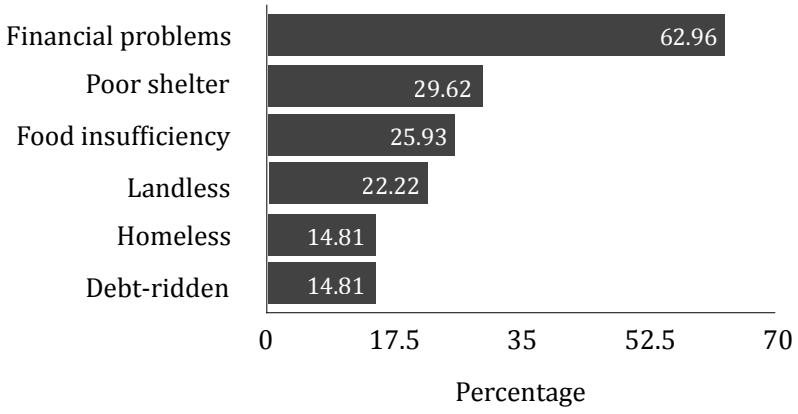
> saying: 'you have many children, but none of them is good to you'. I feel happy when my adopted son calls me father. He is good to me and so is the daughter-in-law (*PP, Male, 74, Zhemgang, 2017*).

Living standards

The economic security is key to better living standard for elderly people. Without proper saving and planning for retirement, elderly people are more likely to experience poor living standard, especially these days when the livelihood for many people is changing from that of subsistence farming to a monetised one. Decent homes are fundamental to the well-being of elderly people, as they spend most of their time at homes due to decreased mobility and illnesses related to old age. Ideally they would require the homes with some specialised support adaptations, which is not feasible for the greater majority by our standards. Nevertheless, at least decent homes that can protect them from heat and cold are desirable. Proper nutrition is another important requirement for health and protection of their weak and susceptible bodies from diseases.

Through their narratives, the study participants had highlighted four key components that could determine their living standards. The majority of them faced financial problems (62.96%), lived in poor shelter conditions (29.62%), and had to cope with food insecurity (25.93%). Some of them were found to be landless, homeless, and debt-ridden as shown in figure 3.3.

Figure-3.3: Living standards of the elderly study participants



By homelessness, it means they lived in the homes that were not of their own, but owned by relatives, friends and neighbours. The predicament of typical poor and desolate elderly persons are represented by these narratives:

> After I retired from the Armed Force, I did not go back to the village, as I have no one out there. My wife left me for another man. I was a vagabond moving from one village to another, earning little by doing needlework (*lag-tshem*). I arrived at this village ten years ago. I am now homeless. I live in a shack close to this temple. The villagers give me foods and clothes, and small amount of money (about Nu. 30-50 in a month). Sometimes, I have to go on without even a chetrum and without ration. I am worried that I might fall sick or die anytime. I can't see or hear properly now. I plan to go to Thimphu and stay with people like me. I rely my hope on the government, whatsoever (*KW, age 74, Paro Dzongkhag, 2017*).

> I am afraid I will have insufficient food this year. It seems I will not have a good betel nut harvest. This crop is the only source of my income. When the yield is good, I get some money sufficient to buy the essentials. If the elephants and monkeys damage my crops this year, I may have to buy a stock of rice, which I did not do. I do not have money to buy food stock.

> I cannot depend on my son because his family is poor too. He has many children to feed. Without money, it is difficult to survive now unlike in the past. I am frequently getting sick (cries…) I feel I should work hard, but my body is too weak for work. If I sit, I can't stand up instantly without using the support of my arms. I am really not sure what I should do (*HM, Female, aged 71, Sarpang Dzongkhag, 2017*).

> I don't get to eat properly when I do not have money. I bought one goat on credit, and I am not able to repay the debt. Sometimes, I am forced to work on daily wage. Some people even remarks: 'why is this old lady coming for work'? I usually reply 'I need to earn my living' (*SM, Female, aged 77, Sarpang Dzongkhag, 2017).*

> I had suffered enough now, and there is no end to it. I lost my son long ago. I was all-alone in this world for more than 20 years. I live in such a dilapidated house—its roof is leaking and the wooden floor has started to

> disintegrate. I have to sharecrop, as I cannot work. I sell oranges and get little money (*ZM, Female, aged 68, Punakha Dzongkhag*).

> My children have been long away from me. I hope they might come to at least see my dead body. I have availed a loan of Nu. 200,000 to build a house. The money was not enough. So I managed to build just a small a house. It is still not completed. I have agreed to pay Nu. 3000 as a quarterly loan instalment. I am not able to do it, as it all depends on whether I could fetch good price for ginger. This year, ginger price has gone down. That's why the loan interest gets accumulating. I wonder if I could repay the loan before I die. I am really getting mad about it (*TS, male, aged 66, Samdrupjongkhar Dzongkhag, 2017*).

During our in-depth interviews, we came across only a few elderly persons who were receiving the benefits of a formal pension. Those who we met turned out to be the ones who were not happy with their pension benefits. They expressed their grievances over the difference in the amount of pension benefits between those who retired little earlier before the recent changes in the civil pay allotment, and those who resigned after the change. One of them related why he was unhappy about his pension benefit:

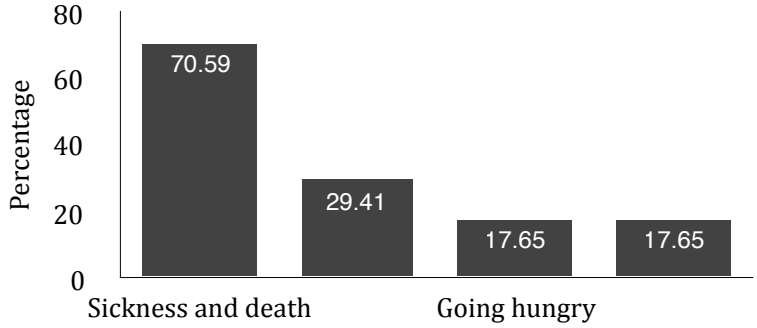
> I resigned one year earlier than my junior. He resigned after the recent change in civil pay allotment. He was junior to me in the civil service, and now he is enjoying much higher benefit than me. This is not fair. I and others affected are not happy about it (*Retired civil servant, Gelephu, Thromde, Sarpang Dzongkhag*).

Fears and worries

Getting old is a natural process, but for most people, it is accompanied by fears and worries. This is an unpleasant reality. The greatest fears and worries among the elderly participants were getting seriously ill and dying. The thought of falling terminally ill without anyone to look after becomes terrifying to anyone. Many elderly participants expressed their desires for an instant death rather than being laid down on the bed with terminal illnesses. For them, the fear of death was about whether appropriate funeral rites would be conducted and what would the life after death be like.

Many of them worried about whether their children would live before they (parents) die. The fear of being abandoned by children was what most of them dreaded the most. Some of them expressed their worries of whether or not they might have to go hungry, indicating the unpredictability of the situation even in terms of meeting their survival need. Figure 3.4 provides the detail.

Figure-3.4: Percentage of elderly participants with different fears and worries



The following cases illustrate the fears and worries of the elderly participants:

> My two sons and husband died a few years ago. I have long left behind my village to be resettled here (*zhisar*). My daughter-in-law is very ill-hearted. All she wants is my land. She wants to bully me rather than being sympathetic and caring for me. My grandson never bothers to call me forget about coming to see me though I am concerned about his studies and life. I am alone now—and this is my life. I can't sleep well, and the most dreading thing is what happens if I fall sick or die. Will someone be there to give my dead body a decent cremation? Sometimes I feel like selling off my land and betel nut trees and pursuing spiritual practice. But then, this grandson: I have to take care of the property for him. He is still studying (*Aum S.C, Female, aged 72, Sarpang Dzongkhag, 2017*).

> At this age, I cannot think of anything because my mind is full of fear and anxiety. I worry about getting ill or dying. When I cough or face difficulty in breathing, I think about death. Even my neighbours may not know if I die. My corpse might decay. I fear I might die when I am asleep (*SZ, female, aged 84, Samdrupjongkhar Dzongkhag, 2017*).

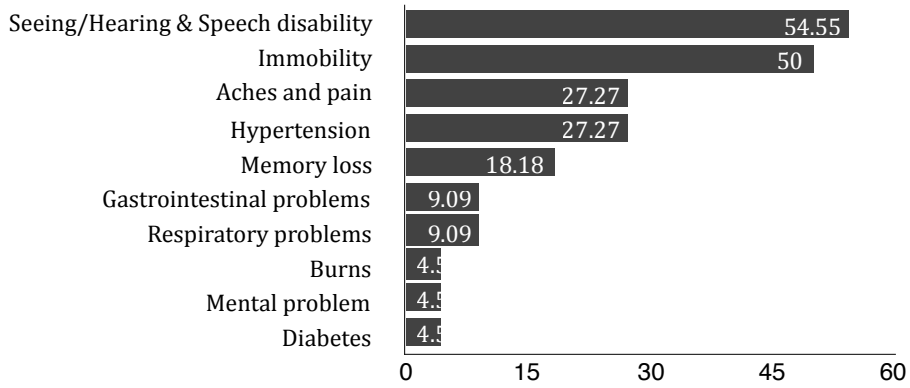
> My greatest worry is my children's future. I am not sure how they will lead their lives. I raised them with love and care. Now that I am too old, soon I will be gone forever. I always pray for their good health and successes. As you know, a funeral rite is an expensive affair. I rely my hope on my children that they will not abandon me [if I get sick] and conduct proper funeral rite for me [if I die]. They have been good to me; particularly my daughter. She calls me at least five times a day. I always pray that I die first before my children (*LZ, Male, Aged 80, Samdrupjongkhar Dzongkhag, 2017*).

> I don't know what I need just because my needs are many. If I have more money it will help me a lot. That's because I am in such a situation that if I eat breakfast, I worry about dinner. Now that I can't work, I may end up dying of hunger. Then the thought about who will perform my funeral rite makes me too anxious. I don't know what to do. I stay on like this doing nothing. I worry about my daughter. She is suffering too much. Many things come into my mind (She cries…). I am grateful that my fellow-villagers support me, otherwise, I might not be able to sustain myself (she cries again…). If I die there will be no one to help and support my daughter (*SY, Female, aged 84, Samdrupjongkhar Dzongkhag, 2017*).

Health problems

If an old person is to maximise the quality of life, it must be done through maintenance of healthy life. The emerging reassuring trend in ageing today is the heightened emphasis on elderly persons' physical and mental health and living in decent housing with adequate income (Defever M, 1991; 19:1-18). Besides infectious disease, the incidence of Non-Communicable Diseases (NCDs) or chronic diseases are on the rise in the country. Disability in old age is becoming common. The most common disability among the elderly participants was the visual impairment (figure 3.5). The speech and hearing disability were prevalent among them. The mobility problem was common. Both eyesight and mobility problems could hamper their full participation in the family and society, affecting their overall well-being. Most of them considered adequate healthcare services and functional ability to access them as necessary for maintaining their independence and to raise their capability to meet their daily needs.

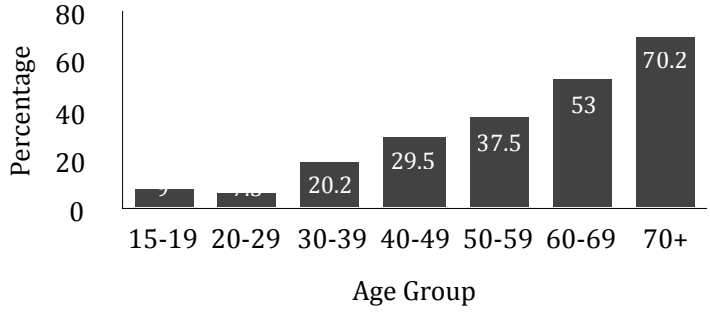
Figure-3.5: Health problems prevalent among elderly participants



Disability

As expected, the percentage of GNH survey (2015) participants reporting 'disability restrict their usual activities all the time' increased with the age (figure 3.6). The disabilities included were visual, hearing and speech impairments; disabled arms or legs; missing body parts; cardiovascular, respiratory, psycho-social and other disabilities (CBS-GNH Research, pp. 128). The in-depth interviews' results almost matched with the findings of GNH Survey 2015.

Figure-3.6: Percentage of population reporting 'their activities are restricted by disability always' by different age groups

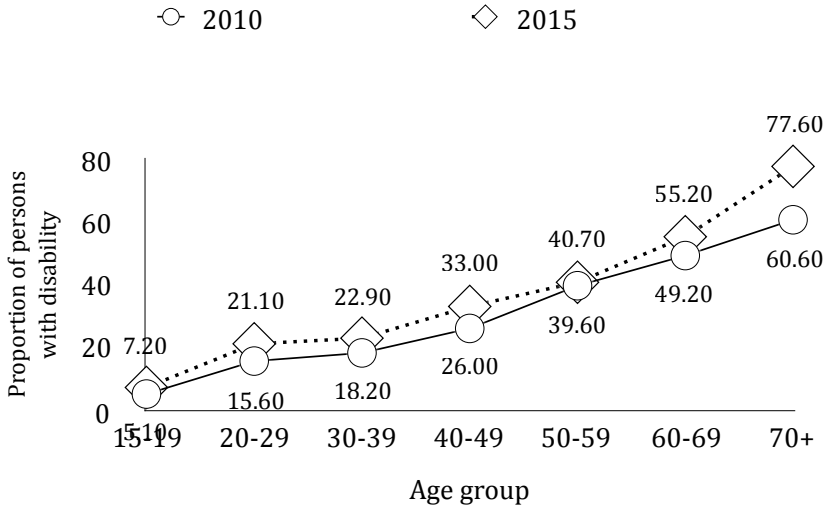


Source: A Compass Towards a Just and Harmonious Society (CBS-GNH Research, pp. 130)

The prevalence of severe disability, mainly among elderly persons has increased in 2015 compared to that of 2010. As shown in figure 3.7,

55.20 per cent of elderly persons in the age group 60-69 reported that they faced severe disability compared to 49.20 per cent of them (in the same age group) reporting the same in 2010.

Figure-3.7: Comparison of prevalence of long-terms disability among elderly people between 2010 and 2015



Source: A Compass Towards a Just and Harmonious Society (CBS-GNH Research, pp. 83)

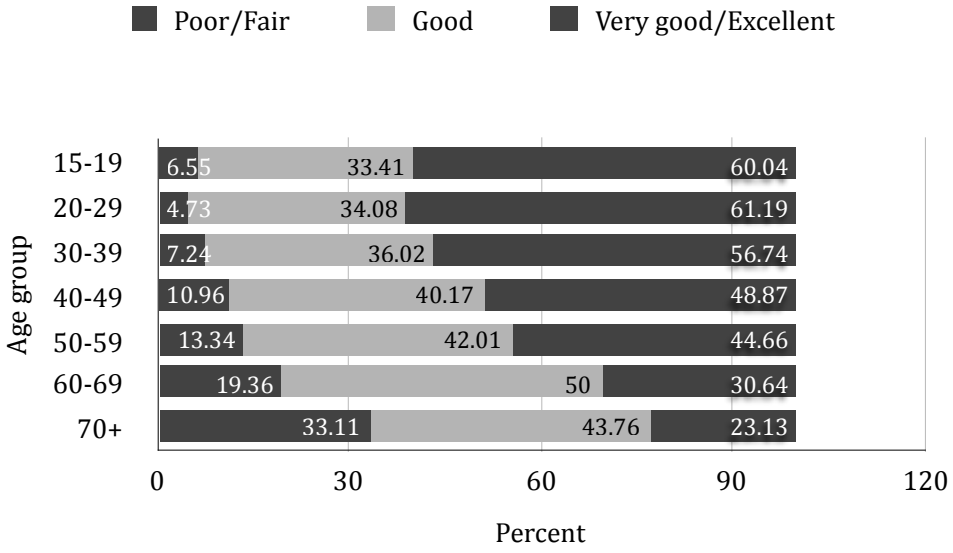
Body aches and joints pain were common among the elderly participants. The analysis of their interviews revealed that most of them tend to dismiss these problems as normal part of ageing, being unaware that these could be caused by more serious underlying conditions like arthritis, cancer, and others. They choose to self-medicate or endure the pain. As was communicated by the Focus Group Discussions (FGDs) participants (conducted as part of this study), even the health personnel seem to take the old age medical conditions rather less seriously. Many of them said: "When we visit hospitals with body aches or joints pain, we are usually told that we would suffer from these conditions because we are old. This frustrates us" (FGD participants). One of the elderly participants who talked about his health problems represented the views of many who considered co-morbidity at old age as the normal part of ageing:

> I have many health problems. They are not serious problems. They are just old age problems. I can't walk as I could when I was young. I can't do what my mind feels I should do. Those sorts of problems…I think are natural…age-related problems (*DD, Male, 85, Zhemgang Dzongkhag, 2017*)

Self-rated health

In general, age and health are inversely correlated. Data from GNH Survey 2015 revealed that the percentage of people reporting their health as 'very excellent' decreased with the increase in the age (GNH Survey, 2015, pp. 126). As shown in figure 3.8, the percentage of elderly people (age 60-69 and 70+) reporting poor health increased significantly compared to the other younger age groups. The highest percentage (33.11%) of people reporting their health was 'poor' belonged to those elderly persons in the age group 70 and above.

Figure-3.8: Self-rated happiness among persons in different age group



Source: A Compass Towards a Just and Harmonious Society (CBS-GNH Research, pp. 127).

The multi-morbidity problem was common among the elderly participants, and most of them had at least one functional limitation. While it was obvious that some of them were suffering from some kind of mental problems, none of them talked about it. This may be due to the reason that in Bhutan, mental diseases are not considered as serious health issues. However, in the latter part of this chapter, some notes on the sense of loneliness and sadness among elderly participants are presented. These are, to a certain extent, the mental problems by themselves or may have been caused by certain other medical conditions.

Hypertension in old age is not a normal part of ageing. It may affect the quality of life. Many elderly participants had reported suffering from what's commonly known as 'blood pressure'. Multiple health problems seem to afflict elderly people as revealed by a few participants:

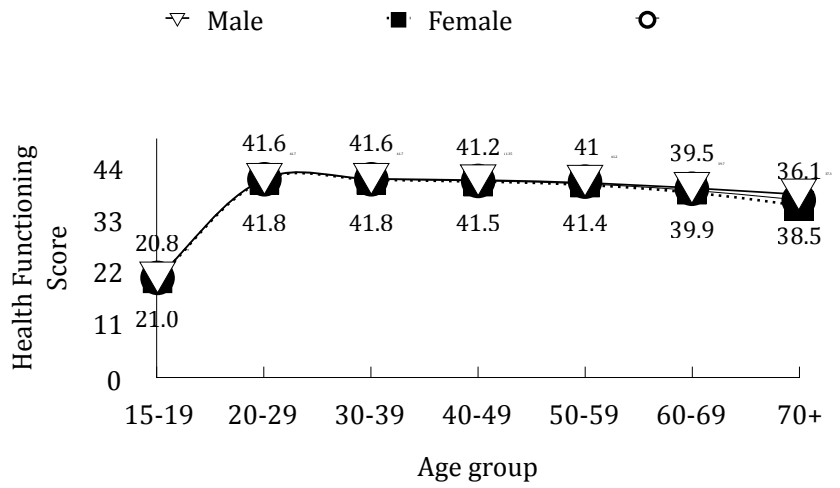
> Things are not same for me. I am getting weaker day by day. Even my capacity to remember has gone down. I can't see properly and can't speak well. I feel the pain in my arms and legs. I often get stomach ache and constipation. I wish to go to Samdrupjongkhar Hospital, but I don't have money for transportation. I can't walk like in the past. Sometimes, I can't sleep, and at other times I tend to oversleep. I wish to do many things, but I can't do. I am now dependent on others, and yet, my heart remains ever young (*TT, Male, aged 66, Samdrupjongkhar Dzongkhag, 2017*).

> My body aches. I have epilepsy. I went to Thimphu hospital recently. A doctor told me I have a high sugar (*chini*) level and high blood pressure. I have a fractured arm as well. I really don't know why I have to suffer in this way (*SS, Male, age 70, Chukha Dzongkhag, 2017*).

Health functioning score by age and gender

CBS & GNH Research has constructed the Health Function Score (HFS) using data from 2015 GNH Survey. Seven important daily activities of a person and difficulty in carrying out these activities were considered. These activities and associated difficulties were: (1) dressing, (2) walking, (3) bathing, (4) eating, (5) using fingers, (6) getting into or out of it, and (7) using toilets (GNH Survey, 2015, pp. 130). The most difficult activity elderly participants of the GNH Survey 2015 had reported was walking followed by getting in/out of bed and using toilets (pp.130). These difficulties were highly associated with elderly people, as the score dropped after the age 60+. Higher the HFS, lesser was the difficulty a person faced and vice-versa. As shown in figure 3.9, slightly more elderly women were facing difficulty than elderly men.

Figure-3.9: Health Functioning Score (HFS) by gender

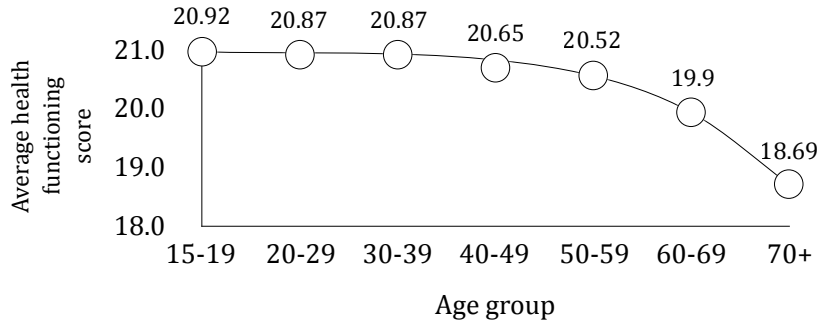


Source: A Compass Towards a Just and Harmonious Society (CBS-GNH Research, pp. 130)

Average health functioning score

The average HFS (as shown in figure 3.10) declined with the increase in age. It was the lowest for the oldest group of people and the highest for the youngest group of people. As expected, this showed that elderly people need more care and support to carry out their daily basic activities; and having caring children and relatives close to them at their prime age is indubitably compelling.

Figure-3.10: Average Health Functioning Score by age

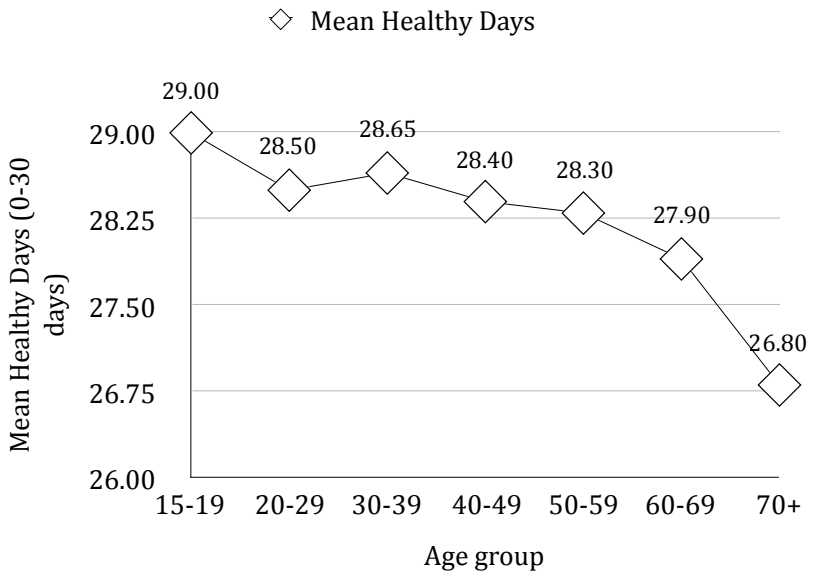


Source: A Compass Towards a Just and Harmonious Society (CBS-GNH Research, pp. 132).

Mean healthy days (0-30 days)

The calculation of mean healthy days was based on how many days a person experienced healthy days in a month. GNH Survey 2015 data shows that the mean healthy days decreased with the rise in age (figure 3.11). On an average, a person falling in between age 60-69 experienced 27.90 days of mean healthy days whereas those people in the age group 15-19 experienced 29 days of mean healthy days. There was a sharp decrease in the mean healthy days for people falling in between the age of 60 and 70. It cannot be explained why there was a sudden drop in the mean healthy days among younger people in the age group 20-29.

Figure-3.11: Mean Healthy Days by age



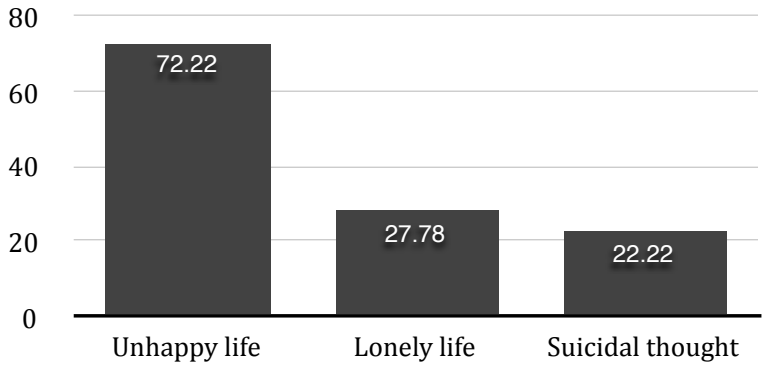
Source: A Compass Towards a Just and Harmonious Society (CBS-GNH Research, pp. 82)

Mental conditions

Many elderly participants of the in-depth interviews had reported being unhappy and lonely. They were the ones who were living alone, had no spouses and children, those who lacked close family ties and meaningful connections with others, and those who had physical health problems. Then there were some elderly participants, who reported that they often

get frustrated with life that they go to the extent of thinking about committing suicide (as shown in figure 3.12).

Figure-3.12: The participants state of mental well-being



Elderly persons with limited social support and experiencing social isolation, deteriorating health with chronic pain, and major life changes (economic hardship and loss of loved ones) are at increased risk of suicide (McCoy, K, 2013). A person quoted below had multiple problems: chronic illness, economic hardship, and separation from loved ones. She reported that she often thought of committing suicide:

> I have high blood pressure. I get dizzy and most of the time I feel like I am going to fall down. I am medically dependent. My body is full of wounds. Often, I feel like committing suicide. A thought of dying comes even when I am not able to work. I feel like dying when I think about how my close family members have left me alone. I always feel sad and lonely. My granddaughter-in-law reprimands me for always blaming my own health conditions (*HM, Female, Aged 71, Sarpang Dzongkhag, 2017*).

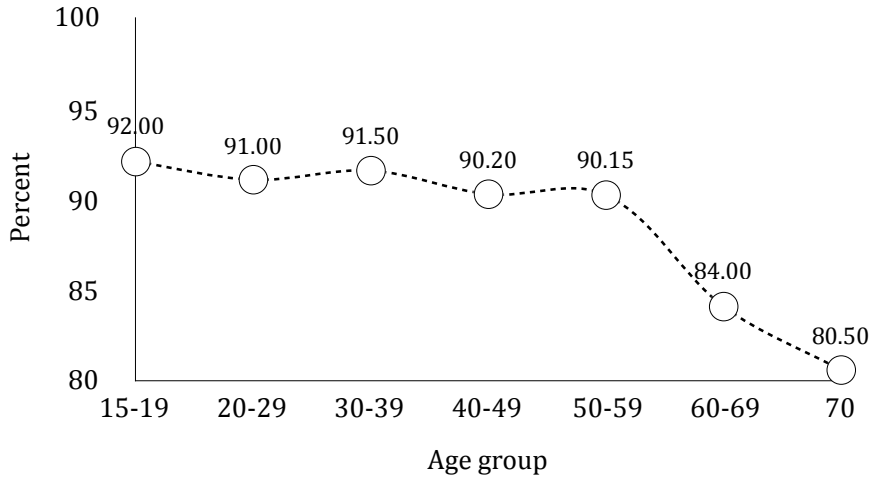
The Royal Bhutan Police's record for the period 2009-2013 shows that while suicidal tendency was high among younger age groups, it was not altogether absent in old age groups. There were 37 suicide cases among the older group (age 60+) between 2009 and 2013. Table 3.2 gives the detail.

Table-3.3: RBP's suicide record for the period 2009 to 2013

Age group	Attempt to suicide		Age group	Suicide	
	Cases	**Per cent**		**Cases**	**Per cent**
<15	0	0.0	<15	17	4.9
15-20	19	24.4	15-20	51	14.7
20-25	15	19.2	20-25	48	13.8
25-30	15	19.2	25-30	44	12.7
30-35	6	7.7	30-35	40	11.5
35-40	6	7.7	35-40	34	9.8
40-45	1	1.3	40-45	22	6.3
45-50	2	2.6	45-50	17	4.9
50-55	4	5.1	50-55	17	4.9
55-60	0	0.0	55-60	12	3.5
60-65	0	0.0	60-65	16	4.6
65+	2	2.6	65+	21	6.1
	78	100	**Total**	**347**	**100.0**

As presented in figure 3.13, among different age groups, percentage of people experiencing normal mental health decreased by age. The figure was derived using data from GNH Survey 2015.

Figure-3.13: Percentage of people enjoying normal mental health by age groups (2015)

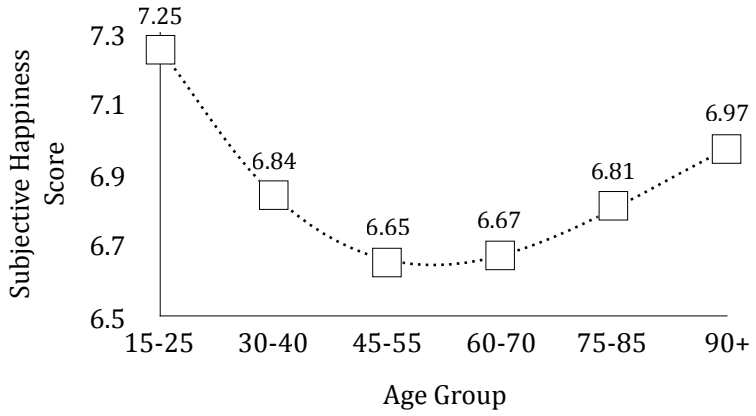


Source: Extrapolated from A Compass Towards a Just and Harmonious Society'(CBS-GNH Research, pp. 85).

Subjective happiness score

To assess the level of current subjective happiness level, the respondents of GNH Survey were asked to give their responses (11-point scale) to the question: 'Taking all things together, how happy would you say you are happy' (CBS-GNH Research, pp. 253)? The Subjective Happiness Score was higher among the youngest age group, dipped to a low for the age group 45-55, and then gradually rose with the increase in the age. Elderly people above age 60 had the Subjective Happiness Score higher than those people in the age group 45-55 (figure 3.14). This was in contrast to the majority of elderly people participating in our in-depth interviews reporting to be 'unhappy in life'. This may have to be investigated further in future. Normally, we expect elderly people to be unhappy than younger ones due to old age predicament. Buddhism also holds the view that old age is one of the four stages of suffering according to the Buddhism.

Figure-3.14: Subjective Happiness Score by age groups



Source: Extrapolated from A Compass Towards a Just and Harmonious Society (CBS-GNH Research, pp. 256).

Household situation: land, income and labour

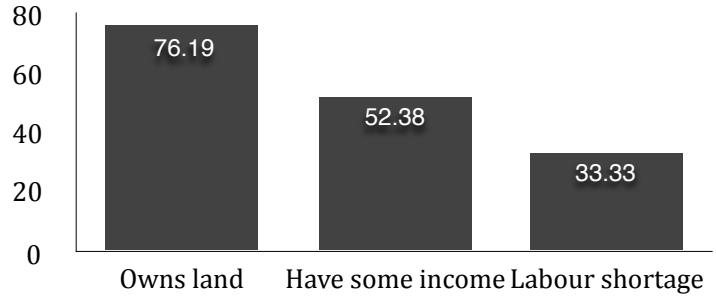
The land holding remains one of the most important family or individual assets in the Bhutanese society. Besides being the main source of livelihood for many people, it controls the affinity and ties between the family members, more so, through the intergenerational transfer of land

from the older to the younger generation. The land holdings influence younger generation's perception of elderly people through the normative prescription that children inherit land and they reciprocate by providing care for the aged parents.

Usually, when ageing commences, parents began to share out their land, house, livestock, and other family assets to their children. Such transference of land and other assets through inheritance provides a mechanism for old age care and support. However, there are the cases of legal discords between aged parents and their children over the issue of land inheritance. This is only an indication that land serves as one of the social security assets for the aged parents. Land holdings are becoming smaller through land apportioning and urbanisation, which may, in the long run, affect the traditional mechanism of old age care and support.

Among the elderly participants of the in-depth interviews, 76 per cent reported that they own land and 33 per cent of them talked about a labour shortage. About 53 per cent reported they have some source of income, which was basically farm produce (oranges, betel nuts, etc.) as shown in figure 3.15.

Figure-3.15: Household situation of the elderly participants



Carefully analysing the interviews revealed that most land they owned were not cultivated [by them], but sharecropped with others due to a shortage of labour and age-based loss of their productivity. Labour shortage was found to be the result of out-migration of young people who also left behind the burden of farming to elderly people. To almost every elderly participant, the land was an important source of livelihood. Some elderly participants from Sarpang Dzongkhag talked about sharecropping their lands with Indian people across the borders:

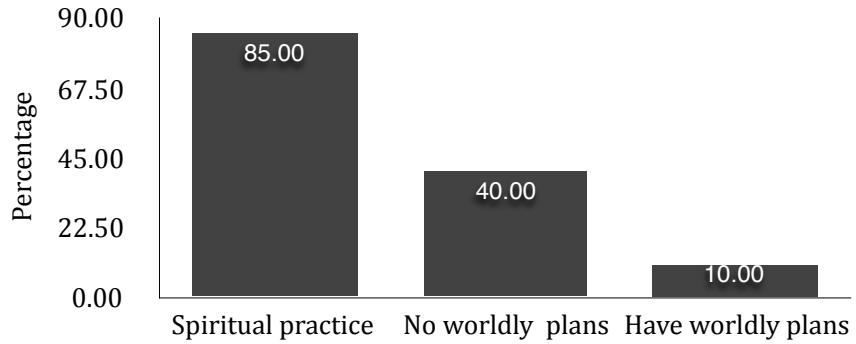
> After my husband died, I had to manage the paddy fields alone. My late husband's children from his previous wife want the land, but they don't want to support me. I am now too old to work in the field, and still, I need to cultivate the field to make my living. What I do is, sharecrop the land with Indian people. In the past, when our lands were sharecropped, we used to get 12 *muarey* (20 dreys per *maurey)*, but now it has gone down to 7 *muareys*. Over the years, it has become difficult to get the Indian sharecroppers. My step-children never turn up to cultivate the land. They know only to claim their share of land. I can't get full paddy yield due to a labour shortage and my age and related loss of productivity. This is, in fact, a great loss. Many of my neighbours face the same situation (S*S, Female, 72, Sarpang Dzongkhag, 2017*).

> My wife and I are just the ones staying at home. Our children have migrated to towns—one is doing business and another is studying. We have become old, and can't work in the fields. We sharecrop our land with Indian people. In the past, crop sharing used to be fifty-fifty of the yield. In a few years, Indian sharecroppers started demanding for something called *ngori* (extra share of 10 to 12 quintal of paddy) on top of fifty-fifty apportionment (*kuut*). Now they want one part for us and two parts of the paddy yield for them (1:2). Even with this, we find it hard to get the sharecroppers. Whether we get the sharecroppers or not, we can survive by selling betel nuts. We are taking care of land only for the sake of children. Whether our children will come and cultivate the field, it is all up to them (*PP, Male, 76, Sarpang Dzongkhag, 2017*).

Future Plans

Most Bhutanese people consider old age as a stage of life that should be devoted to prayers and spiritual practices to accumulate merits for better future rebirths. However, things are not always as desired; cultural ideals and spiritual aspirations clash with economic realities. The normative expectations of most elderly people are to live out their final years in small retirement homes near temples. This is considered the ideal option. Moving to retirement home depends on whether elderly parents would get family support or support from others. As shown in figure 3.16, most of the elderly participants preferred spiritual practice (85%) rather than making any future worldly plans.

Figure-3.16: Future plans of elderly participants



Lack of energy and inspiration to work more and earn more at old age was common among the elderly participants. Some of their narratives reflect these aspirations and expectations:

> I have no plans. What plans should I have now? I am on the verge of dying. Children supply me food and clothes. It is fine as long I get enough food. There's no need for any plan. It is rather good to recite prayers than those unnecessary worldly plans, which in any case we won't be able to achieve (*DD, Male, 85, Zhemgang Dzongkhag).*

> I am here at the monastery reciting prayers. I always dreamt of this. My dream is now fulfilled, and I have no other wishes. I am glad about where and who I am now. I don't think it is necessary to make any new worldly plans. Both my mental and physical capacity won't allow me to do any significant world affair. Of course, in India, people become leaders at my age. It is their way of life. Ours is that old age is a crucial time for us to prepare for death. We have played our parts and what more now? (*NT, Male, 70, Trashigang Dzongkhag, 2017*).

> I think it is useless to make worldly plans now. I can't do anything due to my age. I don't know whether I will live long or die soon. My only wish is, I remain independent (not under anyone). If my children could come and build a house, then I can relinquish my land and go elsewhere to practice dharma. I have a plan to go back to the village. There is a generation old temple. I can stay near that temple and recite prayers. I hope my own sister will provide me with food supplies. I am simply waiting for my daughter's children to grow up and complete their education (*PP, Male, 76, Sarpang Dzongkhag, 2017*).

Elderly people's perception of children and siblings

A primary motivation of any parents to have children is to get care and support when they become old. Parents always try to ensure the success of their children in whichever fields they get into. Some elderly participants expressed their regrets of not getting care and support from their children or the care and support given to them being inadequate. Most elderly participants had their adult children living in places far from them, and due to distance, they were not able to get adequate care and support. Some of them who were living either with their children or were located close to their children were found to be working hard to sustain their lives or contribute to their families' welfare.

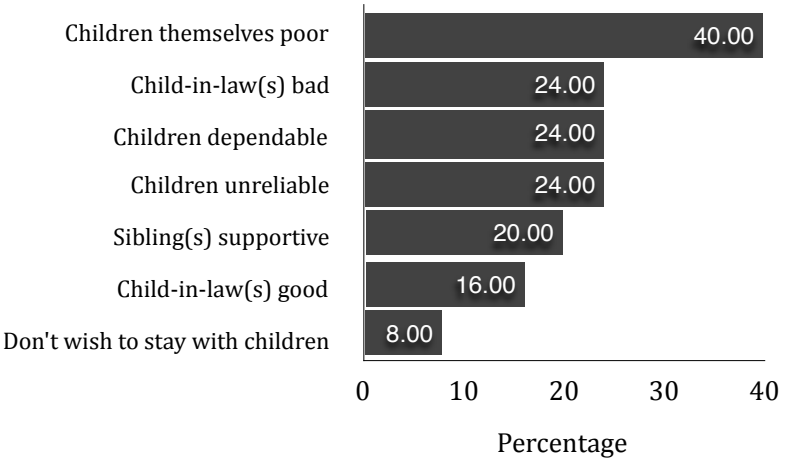
For adult children, things have become challenging, especially due to changing social and economic realities. Today's working adult children have to invest in the education of their own children while they have the responsibility of providing care and support to their ageing parents. These must be the reasons why most of the elderly participants said: 'Children themselves are poor and we do not expect them to care and support us' (figure 3.17).

Living with the families of adult children, especially with that of their sons was something many of them did not prefer. Firstly, living with sons or daughters in urban areas did not fit into their cultural preference and traditionalistic orientation. Typically, for most ageing parents, living with their children in urban areas is difficult, as they tend to find it hard to adapt into the urban families, where members rarely associate; and secondly, there are not much social interactions within the neighbourhood. Some of them dread being mistreated by their in-laws. From the perspectives of most elderly participants, daughters are most suited to provide them old age care and support; they regarded daughter-in-laws with some unease.

As shown in figure 3.17, 24 per cent of them reported that child-in-laws were not good, while 16 per cent had positive impression of their child in-laws. All these must be the reasons why 8 per cent of them didn't choose to stay with their children. Studies have shown that receiving remittances from adult children and stronger emotional bond with children improve the well-being of elderly people. Most elderly participants preferred traditional family arrangements *per se* rural life than

living in the modern families. They asserted that rural life gives them the fulfilment of cultural ideal, whereas urban life though may offer them material comforts causes them 'cultural shocks' and mental disturbances. The growing trend of abandoning elderly people in rural homes was becoming noticeable in urban areas too. There was increased incidence of social hospitalisation, which means elderly patients refuse to leave hospitals even after their discharges because there is no body at their homes to look after them.

Figure-3.17: Elderly participants' perceptions of children and in-laws



In the past, old age security concerns coupled with the need for more labour on the farms had induced high fertility among younger adults. The childbearing responsibilities were shared within the multigenerational family. This is changing today—families prefer to be smaller because having more children entails more investments in education with no guarantee that children would provide old age care and support. This change in the fertility preference, and hence, the family structure have begun to affect the traditional provision of old age care and support.

Dependency on children has to do with 'whether children are reliable providers of care and support when aged parents are sick, and to perform decent funerals when they die'. Half of the elderly participants told that their children are not dependable while another half reckoned their children are reliable. Some of them did not have children, but they reported about the alternative source of old age care and support. These alternative providers of care and support mostly turned out to be their

siblings. About 20 per cent of them said that in times of need they could seek help from their siblings:

> My sons do not give me money. Betel nut is my only source of income. My children are themselves too poor. They do not have enough money. They have many school-going children. There's no use expecting monetary support from them. I try to manage myself (*SS, Female, 70, Sarpang Dzonkhag, 2017*).

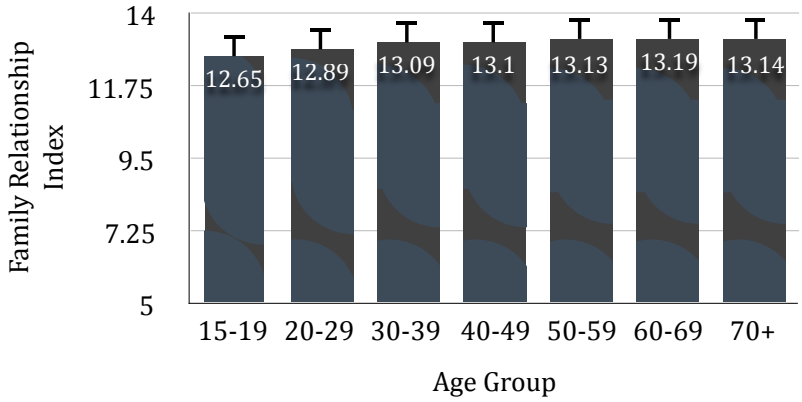
> Performing funeral rites and rituals require huge expenses. Many elderly people worry about that. In my case, I do not worry, as I know well that my children will not neglect me. I am sure they will take the responsibility of my funeral (*LZ, Male, 80, Samdrupjongkhar Dzongkhag, 2017*)

Family Relationship Index

The GNH Survey 2015 had collected information useful to measure the strength of family relationships. The survey respondents were asked to agree or disagree with seven statements (CBS-GNH Research, pp. 205). These seven items were: (1) the member of your family really care for each other; (2) you wish you were not part of your family; (3) members of your family argue too much; (4) you feel like a stranger in your family; (5) you have enough time to spend with your family; (6) there is lot of understanding in your family; and (7) your family is a real source of comfort to you. CBS-GNH Research has developed Family Relationship Index (FRI) using the responses to these seven statements. The mean FRI was 13.04 with Standard Deviation of 1.54.

As presented in figure 3.18, the FRI was lower in younger age groups and increased with the increase in age. The FRI for the age group 60-69 was 13.19, and 13.14 for those people who were age 70 and above. The result was good because a relatively larger proportion of elderly people reported feeling strongly about the family relationships. However, the result ought to be interpreted with caution. It do not indicate there were no elderly people who did not feel strongly about the family relationships.

Figure-3.18: Family Relationship Index by age groups



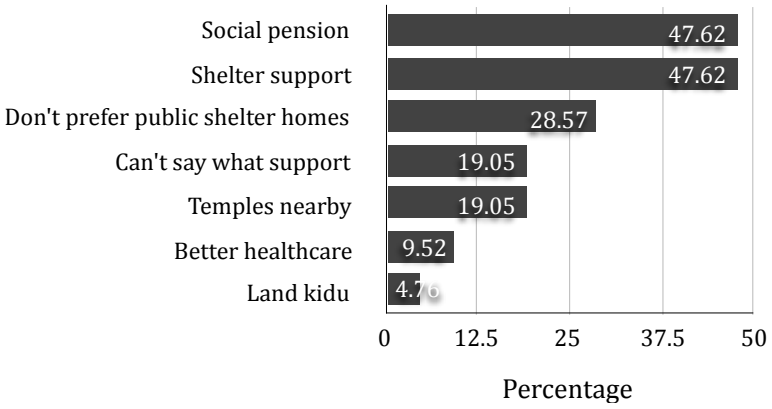
Source: A Compass Towards a Just and Harmonious Society (CBS-GNH Research, pp. 207).

Expectations from the Government

The family is seen as the primary provider of old age care and support, but the social and economic situation is constantly changing, that too, in disfavour of elderly people. Many of the Bhutanese people thinks it is high time for the government to initiate various old age welfare programmes for the growing number of elderly destitute. Among the elderly participants, 83.33 per cent did not expect the government to provide them with any help. The main reason they stated was that the government has many obligations and is burdened with having to cater to various needs of its people. Nevertheless, about 17 per cent of them expected some kind of the government's support.

There was an equal proportion of elderly participants who desired for social pension and public shelter homes respectively. Some of them were not able to say what they expected from the government (19%). About 10 per cent wanted the government to provide them the improved health care services that could cater to their specific needs. A few of them desired for land *kidu* (figure 3.19).

Figure-3.19: Elderly participants' expectations from the government



Most of the elderly participants stated about the need for social pension and shelter support from the government or any other stakeholders. This could be due to the reason that they were aware of the promises the two political parties had made. One party promised old age spiritual homes and another party promised universal social pension for elderly people of age 70 and above. These promises remain unfulfilled, but many elderly participants were hopeful that such support schemes were under way. Most of the elderly participants suggested that such schemes could be targeted at elderly people deprived of family care and support. Some of their views are summed up as follows:

> The government's provision of public old age homes will be a better option. It will be more sustainable than monthly sustenance payment. The money will be spent very easily, whereas public old age homes will remain for a longer time. Furthermore, those people who live in these homes can interact and help each other during the times of need (like when we get sick) (*TT, Male, 84, Zhemgang Dzongkhag*).

> Well, I think public old age homes would be a better choice for aged people like me. Money can help, but not last long. Giving elderly people monthly allowance will not be sustainable. If the government initiate old age homes, I think many elderly people, particularly destitute would benefit (*NN, Male, 81, Zhemgang Dzongkhag, 2017*).

> If the government plans to initiate old age support system, it is well and good. We need every kind of support at this age. But, is this realistic, considering the sheer number of elderly people in the country? It's not that the government has not done anything for the welfare of elderly people; the government has been supporting all of us. Nonetheless, if the government wants to initiate specific plan and programme for elderly people, that's well and good. I would think of monetary support in the form of monthly allowance, not exceeding Nu. 1500 to every elderly citizen and Nu. 3000 on the death of an old person (*NN, male, 81, Zhemgang Dzongkhag, 2017*).

> The government must set up small homes (even a small hut) for elderly people without children and proper homes. Providing them with the monthly allowance can bring a big change in their well-being, as they can use this allowance to buy basic necessities (*DD, Male, 67, Wangduephodrang Dzongkhag, 2017*).

> There are many things we require. The list is long. However, it would be a good idea if the government could provide financial support to elderly people like us. We get sick quite often. When we get sick, all we need is money. Money can provide us everything (*NT, Male, 70, Trashigang Dzongkhag, 2017*).

A temple or any religious structure is seen as essential infrastructure for elderly people to pursue their spiritual ambitions while these religious structures also fulfil other social functions. One good example is, the Memorial Chorten in Thimphu, which facilitates not only the spiritual practice among old and young, but provide avenue for social interactions. The pre-study interviews (with a few elderly people) revealed the spiritual and social functions of the Memorial Chorten.

Most elderly people who usually visit the Memorial Chorten are elderly parents who are bored and restless at their children's homes. Having the opportunity to meet and interact at this sacred place seems to relieve them from the weariness of being secluded at homes. It seems to provide them with the excitement of meeting new friends (social interaction help improve well-being) and gives them a sense of fulfilment. In fact, 19 per cent of elderly participants have said: 'If the government wants to support elderly people, it could do so by building or renovating temples nearby' (as given in figure 3.19).

Dorji *et al.* (2013, pp. 121) asserted that temple is an epicentre of the community where social events take place and where people from all walks of life and of all ages meet and interact. Paradoxically, the urban development sometimes dismisses the idea of putting in place religious structure, which otherwise could provide the avenues for social interactions and exchanges. In fact, Changji Community leader recounted that after a Mani Dungkor (prayer wheel) was set up within the community, many elderly people were seen circumambulating it; and in the process, spending their time together talking about their lives. He did not know until that time that there were so many elderly people in the community.

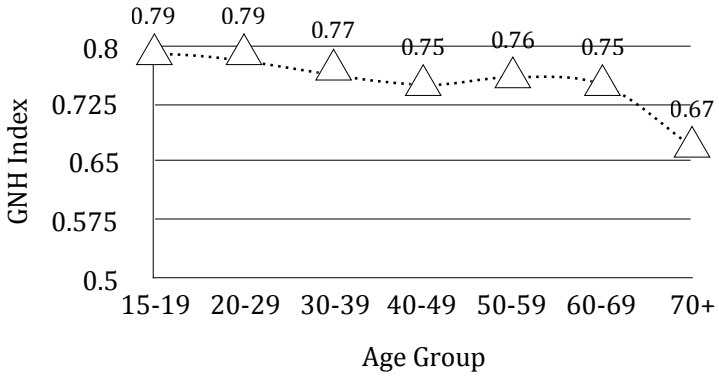
In the above figure (3.19) 29 per cent of elderly said they 'don't prefer public shelter homes or any kind of residential care'. It might have been because they did not wish to isolate themselves from their families and community members. Some elderly people did not want to leave behind their homes and ancestral land. Their views on old age public homes are summed up by the case below:

> I don't bother whether the government set up old age homes or not. I live here and I must die here. I have my own land here. Why should I leave this place for elsewhere? Of course, my son does not treat me well, but I think I will end well [here]. I have many friends with whom I spend my time talking about youthful days. If I stay in a shelter home, would I get good friends even? (*RR, Male, 84, Sarpang Dzongkhag, 2017*).

GNH Index by age

GNH Index was highest for people under age of 30 after which it decreased. Happiness (GNH) decreased after the age group (60-69) and was lowest among people in the age group 70 and above. This shows that the older people were relatively unhappier than the younger groups (figure 3.20).

Figure-3.20: GNH Index by age groups



Source: Extrapolated from 'A Compass Towards a Just and Harmonious Society' (CBS-GNH Research, pp. 72).

Views of the Local Government Officials

Even as our focus was on elderly citizens, we took the opportunity to seek the views of the local leaders and gewog officials on old age issues. Some insightful perspectives and examples of old age problems were provided [to us] by a Gewog Administrative Officer (GAO):

> Once aged, the existence isn't so easy and cherishing. When some elderly persons enjoy good care and support from their families, some just have to lead lonely and painful lives. The development progress does not bring equal benefits to everyone. Some people enjoy the results of development while others do not benefit much. Instead, they have to struggle just to survive. We build roads and improve our access to drinking water, healthcare, education, and so on, and yet, we find many poorest of poor and elderly persons facing multiple deprivations.
>
> I have seen many elderly people struggling through their old age. Angay Ugyen who cannot speak and walk properly is one case. She has an injured right leg. She is now running in the sixties. She was never married in her life. She lives alone in her improvised hut. Her disabled younger brother lives nearby. He is a loner too. He owns a few acres of dry land, which he usually share crops with others. He has recently managed to buy tarpaulin (for roofing his hut) using

money that he had earned by selling some portion of the sharecropped harvest.

Angay Ugyen is a *kidu* beneficiary, but she has to share this benefit with her brother. The local road passes by their houses, but this road does not benefit them. The NFE centre is located nearby, but they could only watch and listen to others attending the NFE classes. The national highway passes above their houses, but it serves them no purpose. Soon 9 km new irrigation channel will be constructed. This irrigation channel will not benefit them. Angay Ugyen once mentioned to me that despite many development activities and changes taking place, they made no difference to her and people like her, whatsoever.

Angay Ugyen told me that her life was getting more challenging, as she grew older. Her house is as transparent as glass and as filthy as a dirty swamp. This is because her house lacks proper wall and roof. By no means, she can use her living allowance to improve her shelter.

Just a few kilometres away from her house lives a paralysed man in his late seventies. He has no children. His two siblings are of no help to him. He drags his body and moves from one house to another begging for food. This is not just one case. If one goes to the communities, one could come across many such persons.

An old woman in her seventies (with three adult children) is now seen babysitting her grandchildren. Instead of devouting her time on prayers and spiritual practices, she is seen doing most of the household chores. This is a good example of children abusing their aged parents. Of course, there may not be many such cases, but then there is enough reason for us to be concerned about such old age plight. It is often disappointing to see some loner elderly persons being deceived by their children, relatives, and grandchildren. I have seen many cases whereby children or relatives coax elderly parents to transfer their land and assets to them only to be neglected once the transfers are done.

Once I saw an old woman standing by a roadside expecting someone to give her a lift. She was to go to Thimphu (JDWNRH) to see a doctor. I was following a taxi and private i20. Both cars did not have

other passengers. This old woman sought a lift, but both cars did not stop for her. I stopped and gave her a lift. She thanked me with her folded hands and told me that elderly persons like her find it hard to get transportation. It made me think many times. Yes, they were the ones who in the 1960s struggled to build roads that we are using today. How ungrateful are we [to them] not to give them much-needed rides?

In 2016, I had to visit many hospitals and health centres. I used to see many elderly people, some able to walk properly and some not, and of course many of them without any attendant. They would be seen waiting for many hours when the queues were long. Very recently, a man in his sixties was in one of the banks. His token number was 126 and mine 125. He was standing in front of me though token number called was 125 (mine). He handed over his documents to a cashier. The cashier asked him to wait, as it was not his turn. I explained the cashier it's just a difference of one number and that I would not mind giving this old man my turn. What struck me hard was that this elderly man frustratingly saying it was the third time the cashier was being rude to him just to do a simple transaction. At that moment, I thought the same must be happening to many elderly citizens. I even wished if banks could open separate counter for the senior citizens.

Similarly, in many offices, I have seen young people with good outlooks could get better and faster services. Elderly people with disability and those who look frail and poorly dressed are the ones who have to wait for hours to avail different services. It is important that we consider giving faster and better services to the underprivileged and elderly people. This will surely maximise GNH among elderly citizens. (*Tshering Phuntsho, GAO, 25th April 2017*).

Discussions and Conclusion

The qualitative study involving interviews of 42 elderly people has revealed myriads of issues associated with the population ageing. The analysis of in-depth interviews began by considering the living arrangements of elderly people. These results indicate that family responsibility characterises Bhutan's integral approach towards old age social care and support. However, the narratives of the elderly participants suggest that development *per se* modernisation has brought

about the change in families' propensity and capacity to provide old age social care and support. Some of the important reasons (that were identified through in-depth interviews) for the decline in family based social care and support system were: (1) rural-urban migration of young and productive people; (2) change in the family structure; (3) decline in co-residency and physical distance between ageing parents and children, (4) poverty among adult children and double burden of having to invest in children and look after the welfare of ageing parents, (5) change in family norms and values, and (6) generation gap between older and younger generation.

The in-depth interviews revealed the presence of elderly people who were forced to struggle through their lives alone on account of having lost their spouses through divorce or death, not having children due to premature death or fertility challenge, and being neglected by their children and relatives owing to the latter's irresponsibility or their own poverty and incapability.

The changing social and economic environments have changed elderly people's positions and social roles relative to that of younger ones. Undervaluation of elderly people's contributions and growing young people's perceptions of them as weak, unproductive and dependent group were apparent when most of the elderly participants asserted that they do not enjoy the kind of respects and regard from younger people that they had given to their parents when they were young. Unless something is done to check younger generation's growing low perception of old age and aged persons, increasing number of people are likely to enter old age with a lesser guarantee of social care and support from their children.

The abandonment and neglect of elderly persons are the emerging issues and are related to both healthcare and social contexts. Though there is no exact factual evidence to show how many elderly people are impacted by abandonment and neglect, growing number of elderly people roaming the streets and communities and elderly persons being abandoned in hospitals indicate the presence of old age problems, which were rare a few decades ago. Such abandonment and neglect could be due to diminishing social roles of elderly persons in the family and society and growing societal attitude that elderly persons are added liability that one could avoid.

The low perception of elderly people by younger groups could be attributed mainly to modern influence, but it cannot be an exclusive factor; other explanatory factors might be in action. The other factors that became evident through the in-depth interviews were poverty among adult children and distance that kept aged parents and adult children apart (attributed mainly to urbanisation and rural-urban migration). Many elderly people are left behind (by their children) in rural homes not only to take charge of the ancestral farms and homes, but to eke out living on their own despite their increasing susceptibility to numerous physical ailments, loss of productivity, and functional limitations. Many of them living in the southern region talked about labour shortage due to which they have to either do a lot of physical works or sharecrop with the Indians across the border who take the major share of crop yields.

It was evident from the in-depth interviews that old age is characterised by multi-dimensional poverty prevailed over by income deprivation and debt. In absence of any support from family members or relatives, some of them were found to be living alone on charity (Royal *Kidu*) and support from a few NGOs, volunteer groups and individuals. The three key determinants of poor livelihood situation as reported by the elderly participants were economic insecurity (financial problems), poor shelter conditions, and food insecurity. It was noted that the overall development changes had relatively lesser positive impacts on the lives of elderly people.

It is common to understand that the rise in poverty and vulnerability in the later life is connected with a declining capacity of elderly people to earn their own livelihood. Elderly people's access to paid work could improve the quality of life. In fact, many of the study participants desired to participate in the paid work. The Labour Force Survey 2015 data revealed high labour force participation rate among the older group, but this participation was predominantly in the informal or agriculture sector.

The greatest fears and worries among the elderly participants were getting terminally ill, dying, and whether they would get decent funerals. Many of them reported that they worry about how to complete the life in the face of growing income and food insecurity. Some of them reported worrying about their children, mainly whether or not their children would live long to look after their old age welfare (care during illnesses and funerals).

Seeing, hearing and speaking disability and mobility problems were the common physical ailments. Body aches and pain and hypertension were also prevalent among them. There was a high prevalence of long-term disability among elderly people according to GNH Survey 2015 data (that was used to supplement the in-depth interviews).

Not much was mentioned about mental health disorders during the in-depth interviews, but a substantial number of the elderly participants reported feeling unhappy and lonely to the extent that some of them even occasionally experienced suicidal ideation. The reasons for these were lack of close family ties and meaningful interactions with other, financial problems, worries about how to earn a livelihood and physical health problems. GNH Survey 2015 data (used in this analysis) evinced that more older people rated their health as poor than the younger groups. The same data revealed a high prevalence of mental health issues among the aged people. GNH Index computed by CBS-GNH research showed elderly people were relatively unhappy than the younger groups. GNH Index decreased after the age group (60-69).

Comorbidity was common among the elderly participants. Many of them had reconciled to endure these multiple ailments considering they are integral to the process of growing old. Due to some functional limitations (mainly the limited mobility), many of them bewailed their inability to travel far to avail health care services, and even if they could, the healthcare services are normally found to be short of their need and expectations, as the health care system is yet to introduce geriatric care component in its many hospitals and health centres. Going by words of some respondents some hospital staff seem to adopt 'you are not sick, you are just old approach' to many of elderly people who visit hospitals to avail healthcare services. This could be due to the fact that there are no specialist geriatric facilities and those working in hospitals find elderly people simply difficult to deal with, especially when the staff has to stretch beyond their capacity

Lack of energy and inspiration to work more and earn more was common among elderly people who have crossed the age of 70. Except for a few of them, the majority others did not have any future worldly plans. They rather wanted to devote their later life to prayers and spiritual practices. Their normative expectations were to seek secluded life in spiritual retirement homes located near monasteries. The achievement of

this goal would much depend on their savings or existence of a continued source of income or presence of family's support to sustain them the rest of their lives in spiritual retirements. For elderly people who felt they cannot afford to manage spiritual retirements at the monasteries or certain sacred places, having temples or any other religious edifices within their reach was what would fulfil their aspirations.

Good shelter, sufficient food, economic security and access to better healthcare services were what most elderly participants considered as important to improving their well being. If the government wants to intervene, the areas they identified were the provision of public shelter homes for those who were left destitute, social pension, and improved access to better healthcare services.

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CHAPTER IV

THE ANALYSIS OF FOCUS GROUP DISCUSSIONS (FGDS)

Lham Dorji

Introduction

Seven Focus Group Discussions (FGDs) were organised to identify: (1) specific problems of elderly people, (2) their causes and effects, and (3) possible solutions. The FGDs were conducted in seven gewogs of four Dzongkhags: Trongsa, Paro, Haa and Chukha. Each FGD was conducted with 12 to 15 participants. The groups constituted both young and elderly people and had equal gender representation. The emphasis of the FGDs was on identifying the possible solutions to various old age issues.

The FGDs are useful for obtaining data on social norms, social experiences, and cultural expectations on various issues, appropriate for collecting relevant data on the meaning, identities and contexts associated with the ageing experience and the issues of providing old age social care and support. The FGDs are effective in obtaining general background information about a topic of interest, generating research hypotheses for further research, and quantitative testing, and stimulating new ideas and creative concepts (Stewart and Shamdasani, 1990).

The FGDs are normally used in the qualitative studies, as they are useful to provide group dimension of an individual's belief and conduct through dominant discourse, consensus, and wider acceptability or unacceptability of a particular viewpoint (Ingham and Stone, 2001). We chose to include the FGDs in our study to complement the in-depth interviews because the latter involved collecting the individual viewpoints through individual experiences of self and surrounding social environments. The FGDs on the other hand involved subjecting individual viewpoints to group discourses. They allowed identifying the old age issues in which there was agreement or disagreement [among discussants] and drawing out the appropriate policy suggestions from the groups.

Research Method

Participant selection

The strict sampling of the study participants (discussants) was not a major concern since generalisation was not critical in a qualitative research. Luborsky and Rubinstein (1995) contended that in a qualitative study, one should stress on 'sampling for meaning' than sampling for research subjects. They suggested 12 to 26 subjects for a qualitative study. A sampling strategy and sample size in a qualitative study usually depend on a researcher's time and budget consideration.

For each FGD, we recruited a minimum of 12 and maximum of 15 participants with almost equal gender representation. The participants were selected from different chiwogs (sub-gewogs or usually group of villages). The participants were rather heterogeneous in terms of age though they were homogeneous in terms of culture and socioeconomic background. We sought the help of the local leaders to identify and recruit the participants. This was more of purposive or convenience sampling. The criteria to select the participants were (1) to select elderly people of age 55 and above, and (2) to select a few young people who knew about the local situation.

FGD questions

The discussion frameworks were adapted from the works of Schröder-Butterfill's conceptual framework consisting of three analytical domains: exposure to threat (Risks), coping mechanisms (Resilience) and outcomes (Results). The framework elucidates how policy interventions at three domain levels can counteract vulnerability. Policy interventions could be made: before a threat or risk occur or a person becomes susceptible to threat; reduce the magnitude of a threat so that it doesn't become a hazard, and build a person's capability to escape or overcome bad outcomes. The discussions broadly focused on elderly people's life: risks and vulnerabilities, causes of old age problems, and possible solutions. In general, the following questions were asked to guide the discussions:

1. What do you think are the main problems elderly people are facing in your community?
2. What do you think are the causes of the old age problems in your community?
3. What do you think should be done to reduce the old age problems?

Conduct of FGDs

The FGDs were conducted in the Gewog Centres. The two-member team conducted the groups. The moderator spent about 20 to 30 minutes explaining the purpose of the overall study as well as that of the FGDs. The team proceeded with the discussions only when it was convinced that the participants understood the study's purpose and its benefits. The moderator usually presented each question/issue to provoke discussions while his assistant took notes and audiotaped the proceedings of discussion. The FGDs started with the deductive approach, that is, the more exploratory approach in which case the discussants were made to discuss old age issues, causes and effects and solutions on their own. Then when the moderator felt the discussion was done exhaustively, he threw a list of points/issues that did not come out in discussions for the discussants to validate or invalidate (deductive).

Each FGD lasted for more than one hour. Dzongkha was the main medium of the discourses. However, the discussants were allowed to express themselves in any language they felt comfortable [with]. The participants were served with tea, snacks, and other refreshments.

Data Analysis

The content analysis of the FGDs was done using MAXQDA software. This is a program designed for computer-assisted qualitative, quantitative and mixed methods data, text and multimedia analysis in academic, scientific, and business institutions. It is developed and distributed by VERBI Software based in Berlin, Germany.

Data were objectively coded into three main themes: (1) common old age problems in the community, (2) causes of the old age problems in the community, and (3) perceived solutions to the old age problems.

The analysis draws from the orientation that allows researchers to treat social action and human activity as texts. The views of the participants were collected and converted into texts for the analysis. I have used both interpretive and phenomenological approaches data analysis. It can be called an interpretive approach, as in the first part; the texts (or data) were reduced to uncover the patterns of the views and meanings allowing for the objective identification of the characteristics of the messages. These characteristics were then coded thematically. The thematic coding is given in Annexure 1. It is phenomenological, as in the second part, the data was presented as it had been recorded (that is, without condensing data or framing data by various sorting or coding operations) to uncover the essence of discussions that actually took place.

Study Limitations

The main limitation of the FGD-based qualitative study was that the FGDs were conducted only in a gewogs in the central and western Bhutan. A random sampling of the study sites nationwide was not conducted. Therefore the findings from this research might not be generalised with certainty to the national level.

Results of FGD Analysis

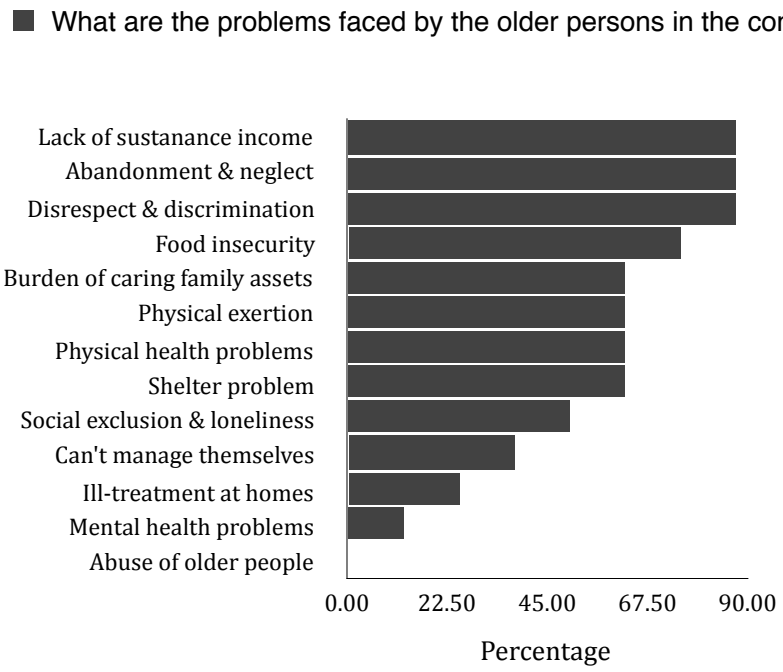
The multi-site focus groups were conducted in a free manner to allow the participants to discuss on the old age issue based on their perspectives and personal experiences. All participants, mostly elderly people, expressed their gratefulness for the opportunity to discuss the old age issues, which they considered was highly relevant to them.

What are the common old age problems in your community?

During the FGDs, participants were requested to respond to the general question on various problems of ageing and aged people in their communities. As can be discerned from figure 4.1, FGD participants identified several inter-related issues of old age and ageing. The significant problems mentioned by most discussants in all groups were broadly: difficulty associated with the sustenance of livelihood in old age (income, food security, shelter, etc.); decline in family care and support (loss of respect, undervaluation of elderly persons, etc.); health problems (physical and mental) and access to health care services; and old age

burden and physical hardship (managing farm and natal households and *woola*). The problems that focus groups identified are shown in figure 4.1.

Figure-4.1: Problems of elderly people as identified by FGD participants



Lack of sustenance income

The ability of elderly persons to cope with old age problems, to a very large extent, depends on their income. Thus, lack of income becomes not only the problem by itself, but also the cause of other problems in old age. The fact that it came out as the most significant issue was indicative of low formal pension coverage or the lack of social pension schemes, which otherwise could have addressed basic material deprivations and helped elderly people to maintain many other aspects of quality of life. The findings showed that in general the situation of elderly people is affected due to low or total lack of income. The words of a few discussants sum up the income insecurity faced by some elderly people:

> Most of the parents who have now entered old age have invested on their children. So they don't have savings. Lack of saving has to also do with our spending habits. For example, Indian people save money for their old age, but the Bhutanese people spend a lot believing that life is uncertain and that it'd be better to spend when alive. In the end, they become old without adequate income to support themselves (*FGD participant, Korphu Gewog, Trongsa Dzongkhag*).

> The main problems our elderly people are facing are either lack income or have very little income. There is just a handful of them who get formal pension benefits; otherwise, the majority do not have pension benefit coverage. As a result, we see many of the aged parents going through hardships. In our gewog alone, there could be between 30 and 40 of them who are in dire need of income support. Everyone knows that our gewog is considered one of the richest gewogs in the country, and yet we could see a good number of elderly people with an extreme financial problem. Having a reliable source of income might help some elderly people meet their material needs. Moreover, many children nowadays regard and respect their parents only if they have sufficient money. Poorer the aged parents are, lesser care and support some children tend to provide them. So providing some income support to aged people (without income) could improve their relationship with their children and relatives; and of course their well-being. Money is power these days; money attracts people (*An FGD participant, Shaba Gewog, Paro Dzongkhag*).

Neglect and abandonment

The findings showed that in general the situation of elderly people depends on the extent and quality of care and support they get from their children and family members. The groups revealed that abandonment and neglect were emerging as an old age problem. These are the major changes that occur in the life of some elderly people, particularly due to changing social and economic environments, coupled with the changes in their positions and social roles. It was found that the aged people, especially those 80 years or over, who are unable to support themselves, are seen as "family burden". The discussants ascertained that such aged persons are more likely to be abandoned or neglected until they die. Such situation was captured through the comments of some FGD discussants:

I live alone, as both my spouse and daughter died. I have a son, but I do not know where he lives. I am sick now—I can't walk and speak well. I find it difficult to even cook. I have enough land, but there is no way I can cultivate the land myself other than sharecropping it with other people. I regret that my son is neglecting me at this age. I was not like that in the past. I served in several important posts in the community. People used to respect me. Now even my own son has deserted me (*FGD participant, male, aged 80*).

In our community, a person called (not named) lives a vagrant life. He used to serve in the armed force. When he was getting pension benefits, his children took care of him. Now that he no longer gets pension benefit, his children have deserted him. He lives alone and survives on whatever he gets by begging. This is the reality for some elderly persons (*FGD participant, Shaba Gewog, Paro Dzongkhag, 2017*).

I met an old lady beggar. On inquiring about her relatives, she told me that her children and relatives have deserted her. She seemed to have not been eating enough for a long time. She told me she wished to eat some rice, which I offered from a restaurant. This lady was not seen for some time. I assumed either her children/relatives or NGO would have rescued her. But, after a few months, I learnt that the lady fell seriously ill and was struggling to survive at one corner of a pavement. When I went to see her, she was lying on the pavement covered with faeces, urine and sores. This was her extreme plight. I wish if the government could initiate social welfare schemes for people like this lady (*FGD young participant, Naja Gewog, Paro Dzongkhag, 2017*).

Ap 'X' lived in our village. He was leading a vagabond life. I heard that his children had long abandoned him. I helped him get admitted to Bjimina Hospital. That time I was a gup. He was suffering from a kind of disease —the symptom of which was a hair loss. He was successfully treated in the hospital. The hospital management later called me to fetch him back to our village. As I was not related to him, I could not take him back to thevillage. Instead, I requested the hospital to provide him with any menial job they could. He was given a job in the kitchen. After that, he started to do well in his life. I heard that his children and relatives are now showing up to him (*FGD participant, Shaba Gewog, Paro Dzongkhag, 2017*).

Disrespect and discrimination

In all seven FGDs, participants emphasised on how young people disrespect elderly people. There was a common viewpoint among discussants that for the younger generation, elderly people are simply weak, traditionalist, old-fashioned, irritating, incapable, inflexible and burdensome. Some elderly discussants shared how young people scorned them. The following examples unveil how some aged persons were ridiculed and even abused:

> Young people often called us 'Agay Rogyep' meaning 'old man, old corpse'. This is something too much to bear. In the past, when we were young, we would seek advice from our seniors. Now even when we speak out in a good faith, young people would tell us to 'keep shut' 'you won't know anything' and 'I will kick you down'. It is better we keep silent and mend our own way. We feel we have no place in the society (*FGD participant, Korphu Gewog, Trsongasa Dzongkhag, male, age 67, 2017*).

> These days, young people think and act differently. They do not respect their seniors. Some young people grumble at us even when we wanted to join them in the archery matches. This happened to me. I wanted to play an archery game, but a few young people denied to accommodate me. I told them that we had been playing the archery since our early age, and that I could play it well, but they cast me aside. The worst was that they spoke to me in the most discourteous manner. When we were young we would give preference to senior persons—be it while serving foods, be it playing archery or taking part in any community events. These days, young people lack moral values; they lack respects for their seniors (*FGD participant, Bji Gewog, Haa Dzongkhag, 2017*).

> There are elderly persons who can take important responsibilities in the community. The problem is that young people undervalue our contributions. This may be the reason why most elderly persons recline to spiritual practice than taking up societal roles. Many of them are accomplished and capable, but they do not come forward to contribute, and this could be simply because they know that the educated young people do not hold senior citizens in high esteem any longer (*FGD participant, Bji Gewog, Haa Dzongkhag, 2017*).

> The younger generation does not know how to respect their seniors. They do not even know how to speak to/with them. They want to avoid us in any discussion that concerns them. In fact, they look down on us (*FGD participant, Katsho Gewog, Haa Dzongkhag, 2017).*

Participants in all FGDs lamented that some elderly persons have to face discrimination within their community, particularly destitute. They felt that this happens because elderly destitute lack voices. It was evident from the groups that there are many destitute in the communities who are eligible for charity, but aren't receiving any due to the failure of those responsible to acknowledge their plights and their growing social alienation. Most discussants felt elderly people are being increasingly marginalised within the communities by denying them the opportunities that others could get such as accessing credit from the banks or other social and economic services (either being refused or delayed). Some discussants reflected how ageist our society is becoming:

> I have been enlisted several times for some kind of external charities. The officials come and take our names, but I have not received any charity until now. There are a couple of us here like that. It may be that we are too poor, helpless, and voiceless that the officials do not take our predicament seriously; and we do not have the capacity to follow up with them (*FGD participant, Korphu Gewog, Trongsa Dzongkhag, 2017*).

> Elderly persons gathered here are saying that they are being discriminated even by public transport services. This could be true. I have seen such thing happening. In one such incidence, an elderly man (with grey hairs) was trying to get on a bus. He was refused a seat. I knew that the bus could accommodate extra passengers. It appeared to me that a bus operator preferred younger passengers because older ones were 'difficult' and at higher risk of accident while boarding on or off the bus. It pained me to see other passengers taking the seats in place of this old man. These days the private vehicles would offer free lift/journey if travellers are beautiful women and refuse if older persons solicit lift. Elderly persons are discriminated in this way. This is just one example. Such discrimination must be taking places in many other service areas (*FGD participant, Naja Gewog, Paro Dzongkhag, 2017*).

> These days, whenever the community development activities are implemented, we find many elderly persons taking part in them. It can't

be that they wanted to participate; they are forced to, as they have no other persons to represent their families. AP XX was recently made to contribute labour (*woola*) for renovating the community temple. I know he was all-alone at home. His son was in Samtse. Pathetic it was that he had to use a walking stick to reach the temple renovation site. He was assigned to the group that was responsible for moving stone slabs. The younger members of the group wanted him to carry stone slabs equally. They failed to understand that such physical labour could be arduous to someone of his age. He later told me that he had to endure being scorned by the group members for being incompetent. This reflected the presence of extreme ageist attitude in our society. Young people usually refuse old persons to their group, especially during *woola* saying: 'older persons are just liability for the group' (*FGD participant, Naja Gewog, Paro Dzongkhag, 2017*).

When I was a teacher (I am no more now), I went to Thimphu with a group of students. We visited the Memorial Chorten. There, we saw an old man soliciting money from the visitors. Some people were kind enough to give him some money, but there were others who denigrated him saying: 'you beg to get boozed'? I asked this man about his life. He told me that the moments come in his life when he can't imagine that the Bhutanese people could be so harsh and mean to him. He said he would often cry when reflecting on how people treated him. That made me think that it is high time we start social welfare schemes to help elderly people like this man (*FGD participant, young, Naja Gewog, Paro Dzongkhag, 2017*).

Some discussants in Paro and Haa FGDs observed that elderly people are not given prompt services by some bank staff, especially when they are availing loans:

When we (elderly persons) go to banks to avail credit, the staff there would ask us so many questions: "you are old, how are you going to repay the loan? Do you have land and children? Who will repay loans on your behalf if you die? They do not ask us 'when you are young, how did you serve the country"? (*FGD participant, Naja Gewog, Paro Dzongkhag, 2017*).

Since we are discussing about availing loans from the banks, I would like to talk about my own experience. The matter is that in order to avail loans, we have to transfer *thram* (land ownership certificate) to our

> children's names, otherwise we are denied the loans. Bank staff says this is the rule. I don't understand why we, elderly persons, are required to that. Are they not trying to devalue us as human beings? Are they worried that we can't repay the loans? Where is the room for us to access our rights to avail loans, invest, and create better economic opportunities for our families and ourselves? (*FGD participant, Bji Gewog, Haa Dzongkhag, 2017*).

Household burden and physical hardship

We found out that most aged parents, whose children have out-migrated, continue to work on the farms. The old age in the Bhutanese context is a stage in life when one is supposed to devote time and energy to spiritual practice. But, many elderly people are mired in the worldly affairs, and that too, mostly for the sake of their children, who are settled elsewhere. In most cases, the aged parents are left back as homesteaders to continue their responsibilities of managing the farms, ancestral homes and livestock. The direct consequences of rural-urban migration are borne by the ageing parents, as they are forced to carry out arduous tasks despite their receding age, frailty, and loss of strength. The comments of some FGD discussants throw more light on these issues:

> Some parents want to live with their adult children working elsewhere, but they are held back at homes to take care of family property and livestock. On the other hand, once children leave the village and settle in towns, they get preoccupied with their works and managing their own families. Distance is created between the aged parents and children. This physical distance becomes emotional distance. Children gradually forget about their parents' welfare [back at homes]. Forget about providing entire care and support to their aged parents, some children do not pay their own taxes (land tax, life insurance, etc.) and compensate *woola*. The worst things happen when the aged parents fall sick and children are not there to care. Some elderly people are really suffering in this manner. More such cases will emerge as the country develops and rural-urban migration of young people escalates (*FGD participant, Tangsibji Gewog, Trongsa Dzongkhag, 2017*).

> Over the years, we have seen the rise in the number of development activities in the community. We have to complete those development activities on time, otherwise the government's funds get lapsed. For some activities like maintaining farm roads and irrigation channel, we are asked

> to contribute *zhabtog woola* (labour) on a household basis. Our kids study up to class eight or ten and then drop out of schools. They can neither contribute to the farm works nor choose to stay back at farms for a longer period. They migrate to town looking for better economic opportunities and better lives. In absence of our children, we have to do all the works at farms, including taking part in *zhabtog woola*. This way, we tend to get overburdened with daily works and get very less time for prayers and other religious practice (*FGD participant, Langthel Geowg, Trongsa Gewog, 2017*).

> Young people have migrated to towns leaving us (aged parents) behind to shoulder the farm responsibility. Young people migrate to urban areas for education and employment, and this phenomenon has led to acute shortage of farm labour. Even when we are old and frail, we have to work on the farms and contribute to development activities with so much of physical hardships (*FGD participant, Korphu Gewog, Trongsa Dzongkhag, 2017*).

> Our children today are not good. First, we take loans or borrow money from others to spend on their education. When they get jobs, they ignore us. They have no time to come to the village. The aged parents are left to manage on their own and clear the debts they have accumulated (for children's education) (*FGD participant, Langthel Gewog, Trongsa Dzongkhag, 2017*).

Some adult children who are working in urban places prefer their aged parents to stay with them. In many cases, aged parents do not wish to accompany their children to urban centres. The reasons for this are that they are wonted to rich rural social life and they do not want to part with their natal homes and ancestral property. On the contrary, most elderly people who have gone to live with their children return to rural homes after they find it difficult to get accustomed to urban life. They do not find much social interaction with relatives, friends and neighbours. A young educated woman who was taking part in the FGD commented:

> It is not that we do not want our parents to stay with us. It is parents themselves who refuse to stay with us. Many adult working children who live Thimphu or other towns want their parents to stay with them knowing that they are suffering back in the village. But then parents, despite good treatment and comfortable life, refuse to stay with their

> children. They usually find it hard adjusting to urban life or feel isolated, as we know there are not many social interactions among the neighbours in urban areas (*FGD participant, Korphu Gewog, Trongsa Dzongkhag, 2017*).

Social exclusion

Social exclusion could mean individuals, who have limited resource and capability, being isolated from groups and networks. Some discussants talked about elderly persons in their communities who they observed were leading isolated and lonely lives. One discussant talked about his situation:

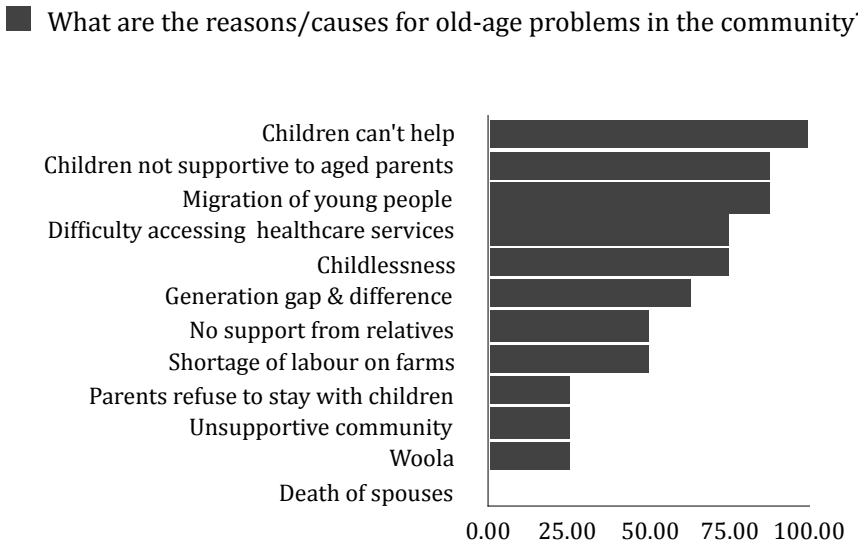
> I am alone at home. I feel lonely and isolated. My only daughter died (of alcoholism) and my wife too died. I have adequate land and a good house. The problem is I can't walk and gets sick frequently. I cannot participate in the community events. It was not like this in the past. I used to be very active in the community. Now things have changed. When one is in such situation, even the neighbours ignore us. Elderly older persons like us are bound to suffer in the state of isolation and loneliness (*FGD participant, Korphu Gewog, Trongsa Dzongkhag, 2017*).

No one talked about how the death of spouses leads to the emotional problem among elderly people. Perhaps, they might not have thought about it. Studies elsewhere have found that the loss of spouses or close ones is one typical process of ageing that could enkindle sense of loneliness among elderly people. According to Anti-Poverty and Social Inclusion (CASPIS), elderly people most at risk of social exclusion are those who face financial problems. So social exclusion is the result of both social and economic deprivations.

What are the probable causes of the old age problems in the community?

We asked the FGD participants to determine the possible causes of old age problems in their communities. Among many causes, the most common causes they had identified were related to children. Singling out this cause was indicative of the widespread recognition of children as the primary caregivers. The determinants of old age problems as identified by discussants are given in figure 4.2.

Figure-4.2: Possible causes of old age problems (as identified by the FGD participants)



In the course of discussions, participants segregated children's neglect of their aged parents into wilful and unintentional. In the traditional Bhutanese society (past), old age was perceived as some sort of 'good fortune' and those who could cater for their aged parents as 'fortunate.' Since people lived in a close-knit society with less mobility, elderly people had their caregivers/children on their duty. It was easier to know who was doing good or bad to their aged parents, and children could dare to deny their parents their care and support without running the risk of social sanction. Moreover, the belief that the karmic consequence for neglecting their aged parents would be 'their own children will do the same' kept children obligated to their ageing parents.

Discussants agreed that the values associated with old age are changing in the modern Bhutanese society. The effectiveness of the traditional caring system is somewhat compromised due to the change in young people's perceptions towards aged people. The family caregivers' attitudes and perceptions towards the aged people may also affect the way the ageing parents are treated in the family. Some young discussants subscribed to the view that young people are not entirely to be blamed because it is often the aged parents who misconstrue their children thus leading to indifference between them. Discussants concurred to the view that while some children/family caregivers neglect their aged parents, the majority

of them felt that children can't help their aged parents because of their own socioeconomic circumstances.

Children's inability to provide care and support to their aged parents are further affected by other factors: (1) unlike in the olden days when aged parents co-reside with their children and grandchildren in a joint family setting, adult children now have to migrate to other areas seeking for social and economic opportunities. This decline in co-residency due to rural-urban migration impacts negatively on the traditional caring system; (2) modernisation has changed the way family emphasises on childcare. The families are obliged to emphasise on children both in terms of care and investment in their education from their limited resources. In doing so, the aged parents tend to receive secondary care or in many cases lead to unintentional neglect of them; (3) physical distance contributes to declining interactions between children and the aged parents. With the passage of time, it results in neglect of each other; and (4) generation gap between children, grandchildren and aged parents. Discussants raised different views on children's care and support to their aged parents as presented below:

> There is an issue with the external support given to the aged destitute. Some elderly people have children and some do not. Some of them live such a difficult life even when they have their children close to them. Children themselves are struggling and there is no chance that such children can afford to care and support their aged parents. One issue is that just because they have children (though incapable of helping them) many elderly persons are not eligible for external charities. I wish this matter is investigated, as this often leads to deserving ones not getting charity and underserving ones getting it. Some of them are doing well even without children while some are not doing well despite having many children (*FGD participant, Tangsibji Gewog, Trongsa Dzongkhag, 2017*).

> I am a young parent. I have two burden— responsibility for parents as well as responsibility for my children. I have many children to look after. The educational expenses of my children are increasing year by year. I have no proper source of income. At the same time, I know my aged parents need my help, but I can't help them though my intention is to help them (*FGD participant, young parent, Tangsibji Gewog, Trongsa Dzongkhag, 2017*).

While many children cannot help their parents because they are incapable, some children tend to ignore their aged parents no matter whether they are capable or not. This is an indication of the decline in the practice of filial piety. Discussants considered this as an issue of great concern. Some discussants shared examples of how adult children neglected their aged parents:

> I know of a man. He got married to a woman from Trongsa. They opened a shop and they became rich. He ignored his aged parents who were going through difficult times. He was not able to help his parents because his wife did not favour it. It is sad that such thing is happening (*FGD participant, Tangsibji Gewog, Trongsa, 2017*).

> There are many reasons why we are not willing to support our aged parents. First, some of us feel that we do not owe much to our parents because they were not supportive of us. Of course, this is true in most cases of divorce that put children into problems, and later children grudge against their parents. Second, though the parents have done all they could to bring us up, later we tend to forget them (*FGD participant, Tangsibji Gewog, Trongsa Dzongkhag, 2017*).

> The difference between parents and children emerge when dividing ancestral land and property among children. Some parents tend to give more land and property to their favourite child. This often forces other children to complain and in the worst scenario, they fight a legal battle. In such case, the aged parents lose the care and support from their children (*FGD participant, Shaba Gewog, Paro Dzongkhag, 2017*).

> We hear about children not caring their aged parents. I have found out that in many cases, there is lack of communication among children. One sibling thinks that the other sibling is supporting the aged parents and vice-versa, and in the end, elderly parents end up not getting support from any of these children (*FGD Participant, Bji Gewog, Haa dzongkhag, 2017*).

These days, mobile phones have helped close the physical distance. However, discussants agreed that the situation becomes difficult when the aged parents lives alone and fall sick. Having the net connection helps, but for ailing parents, presence of their children and their care are more important. One of the discussants summed up this viewpoint:

> I agree with others that neighbours would help elderly persons in case they get ill even when their children are far away. Our neighbours may help, but how long could they help? Once, twice? Children could transfer money, but what use is the money if children are not their to provide care to a bedridden parent? That's why I say the government must work out the strategies to keep children and aged parents in the neighbourhood (if possible), or at least within one Dzongkhag (*FGD participant, Tangsibji Gewog, Trongsa Dzongkhag, 2017*).

Rural-urban migration and social change

The rural-urban migration of young people (children) has telling effects on the aged people. Discussants felt that unlike in the past when children would continue to live in the community (except in case of some external marriages), aged parents have always found homes with their children. Today, the social and economic conditions have changed so much so that most educated children (and even uneducated ones) tend to leave rural homes for urban areas in search of better social and economic opportunities. The rural-urban migration phenomenon thus creates distance between aged parents and children, generates more burden on the aged parents to look after the ancestral land and other property, and makes elderly parents manage on their own (either by working or sharecropping), which involves so much of physical hardships.

On the other hand, aged parents are not willing to go with their children, either because they fear their children won't be able to support them due to economic circumstance or they dread their in-laws might not treat them well or they worry they may not adapt well to the hustle-bustle life of towns and urban isolation. Parson's Theory of Pattern Variables attributes the decline in care and support for elderly people to the society's change from collectivism to individualism. Things happening in Bhutan seems to support this theory.

Health and health care service

Group discussants stressed strongly on the difficulty associated with accessing the health care services. By this, they did not mean the health care services were not provided. They opined that ideally, it would be good if every village has a minimum of a health clinic, though this they felt may not be possible. They reasoned that most BHUs and hospitals

are located at some distance. For those who can walk or have certain means of transportation, access to healthcare services is not a big issue. The access becomes a problem when some elderly people fall sick and they are alone or when they can't go to BHU or hospital owing to certain kind of functional disability and immobility.

Some discussants raised the issue of difficulty getting healthcare services in urban health centres. Having to stand in a long queue for a long time seem to cause a lot of trouble to elderly people. Some aged discussants recounted how hospital staff was less sensitive in dealing with them. They critiqued that whenever they visited the health centres with some ailments, the staff always pointed out their illnesses as 'gyen-ney' literally diseases of old age. We found that elderly people are discouraged to attend the health centres this way. In fact, this calls for the need to change the way the health professionals deal with elderly people. This could be due to the fact that the country does not have gerontologists or doctors who can effectively handle geriatric care. One elderly discussant related his experience:

> When I get ill, I make it a point that I go to a hospital. I am grateful to the government that we are given health care services free of cost. Nevertheless, it becomes annoying to many of us who due to old age cannot stand for long hours in a queue. Some health staff tells us that we are suffering from age-related diseases and that there is no cure. I don't think our physical ailments are incurable though old age is associated with certain kind of chronic disease (*FGD participant, Korphu Gewog, Trongsa Dzongkhag, 2017*).

In Paro, a male discussant observed that he has often been turned away by the hospital staff with the reproach: 'you are not sick, you are just old'. Some other discussants elaborated on this issue:

> The hospital staff has sent me away many times. The health staff said that my backache is just an indication that I have become old (*FGD discussant, male, Shaba Gewog, Paro Dzongkhag, 2017*).

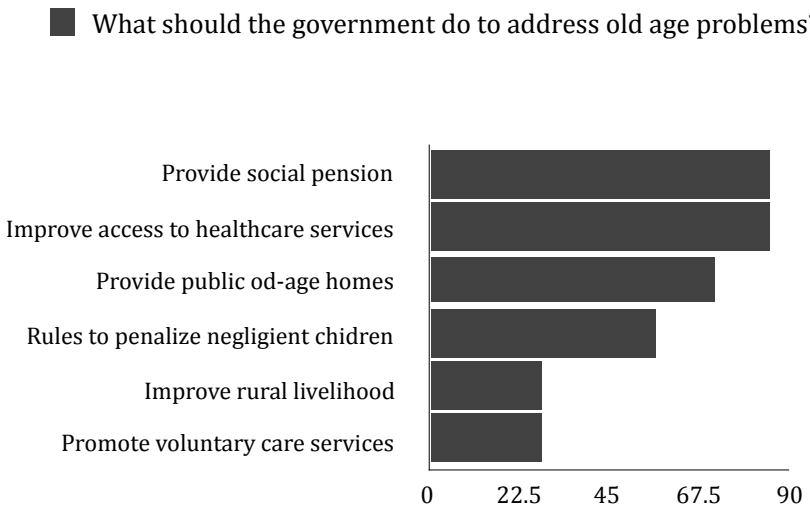
> When we visit a hospital, first, we have to stand in a long queue, which becomes intolerable for us (elderly persons). When we finally get to meet a doctor, he or she ask us our age. And when we tell him or her, I am 70 and suffering from joints pain, a typical response is 'it is time for joints

pain'. They send us back with some medicines, which normally do not help us. I wish if the health staff could stop handling elderly patients in this way so that we do not feel let down (*FGD participant, Shaba Gewog, Paro Dzongkhag, 2017*).

What should the government do to address the old age problems?

The last phase of the discussions were centred on possible policy and programme responses the government could consider for a range of old age problems. An overwhelming majority of the groups suggested the need to introduce social pension/income allowance for elderly people who have lost informal family care and support. The need to improve and strengthen the healthcare system that takes into account the different healthcare service needs of elderly people was another important suggestion. The other suggestions were: providing destitute old-age shelter service, penalising the negligent children for abandoning their aged parents, improving rural livelihood through balanced development, and promoting voluntary care services (for the senior citizens) among the young population. See figure 4.3.

Figure-4.3: The FGD participants' suggestions to address old-age problems



The need for social pension arises from the fact the number of elderly people who are exposed to the risks of multiple problems emanating from to poverty is likely to grow. The key to addressing old age problems is to first prevent more elderly people falling into poverty trap and next is

to take them out of poverty through targeted poverty interventions. Discussants were of the view that conventional approach to alleviating poverty may have little positive impacts on elderly people, especially the ones who are in the state of extreme poverty due to lack of family support, income deprivation, and those who do not have basic means of livelihood. They felt that initiating means-tested social allowance for elderly destitute might resolve many of their other problems.

The majority of them insisted that provision of allowance should not be made universal, which they felt would undermine parent-children bonding and adversely affect traditional family care and support system. Their justification for this assertion was that the government's scheme of providing universal pension might lead to taking over the responsibility of aged parents from their children and other family members. If the social pension is targeted at those elderly citizens who do not have anyone to rely on, there is no risk of impairing parent-child relationships and care based on filial piety. One of the discussants expressed this:

> If the government provides the financial support to every elderly person, it will do more harm than good. This may encourage many children to neglect their aged parents. They may resort to thinking that social pension would suffice the needs of their aged parents. I would suggest the government to target elderly people who have no children and relatives to support them. In this way, the government could save money. We know that money may not reach the neediest ones because of flaws in selection and targeting, but we can always think about instituting a system of identifying and selecting the deserving beneficiaries and transparent mechanism to deliver allowances to them. If this is done, the government's financial support will go a long way to improve the livelihood of truly poor elderly people (*FGD participant, Korphu Gewog, Trongsa Dzongkhag, 2017*).

> It would be a noble initiative for the government to provide the financial support to elderly people. It will be feasible only if destitute are targeted. If this scheme includes every elderly person, it might lead to a biased distribution of allowance. For example, let us take the case of a household with three elderly members and another with just one elderly person. The first household would get more allowance than the second one. Social allowance should be given only to those who are in the serious

> state of destitution (*FGD participant, Langthel Gewog, Trongsa Dzongkhag, 2017*).

> There are many elderly persons who want to pursue the spiritual practice but they cannot, owing to lack of resource, mainly money. It would do no harm even if the government does not provide a social allowance to elderly people who have supportive children. I have seen many elderly people facing hardship due to lack of income, and they are also the ones without any children or relatives to rely on. If elderly people who are neglected and abandoned by their children or do not have children due to fertility reasons are given some money for their daily subsistence, the government would not be doing any greater and nobler initiative than this for the welfare of its people (*FGD participant, Shaba Gewog, Paro Dzongkhag, 2017*).

The discussions then continued on the difficulty in accessing healthcare services by elderly citizens. Discussants were talking about long queue observed in some regional and district hospitals. The National Referral hospital has introduced a separate check-up unit for elderly persons. They suggested if the Ministry of Health could explore the possibility of introducing separate check-up units in the district and regional hospitals. They said that it is not going to cost much to the government while it is going to benefit elderly people. Ideally, it will be better if a separate department or geriatric units are established, but how realistic it is, remains a question in view of other impending priorities.

Discussants then brought up the real issue affecting elderly people in rural areas. Elderly people were found to encounter a huge problem when they get ill, have some functional constraints or lack money to visit BHUs or hospitals. They proposed that local health staff could provide monthly health checkup services by going around the villages. In the words of an FGD participant:

> First, elderly people need good health facility. They are usually handicapped by various physical health problems (visual impairment), inability to move their limbs, backache, etc., which makes it difficult for them to visit BHUs or hospitals. It would be good for them if the government could explore the viability of introducing mobile healthcare service which could be provided on regular basis by local health staff. This will help to take the health care service at their doorsteps of our

> indigent and ailing elderly people. This will certainly be a noble initiative. It is doable; the government just needs the will to initiate it (*FGD participant, Korphu Gewog, Trongsa Dzongkhag, 2017*).

The groups stressed on the need for government to set up the public old age homes. They were against the idea of setting up old age homes for the general elderly population, but only for elderly destitute. Some discussant voiced concerns against letting a few elderly people [manage themselves] in the state of despair: absence of social support, deprived of basic survival necessities, and living in ramshackle huts. They called for the local governments' attention to such old age predicaments. In fact, they opined that the local governments should identify such elderly people and do something about their miseries such as spending the local development fund to renovate or build shelters for destitute. According to a male elderly discussant:

> This old woman—who is sitting in the middle—has a daughter, who is of no benefit to her. Fire accident destroyed their house and now they are homeless. They simply put up with whichever neighbours accommodate them. Can their neighbours accommodate them for so long? It is possible that there are many such persons across the country. For such people in despair, the government could set up old age homes or help them build small houses in their villages (*FGD participant, Korphu Gewog, Trongsa Dzongkhag, 2017*).

However, there were strong reservations among discussants about instituting public old age homes for the general elderly population. They again insisted on targeting the scheme at vagabond elderly people. In the words of a group discussant:

> I don't think most of the elderly people will opt to stay in the public old age homes. We have been living in our village for a long time, and we cannot think of leaving our village. We were born here, we grew up here, and we will die here. But then, many elderly citizens who are homeless or living in dilapidated houses deserve public residential facility. We observe them sleeping wherever they find a place to sleep both in rural and urban areas. Nothing would be worth than to set up old age homes (with food) for such people (*FGD participant, Korphu Gewog, Trongsa Dzongkhag, 2017*).

Most old age problems, according to group discussants, are the unintended consequences of young people migrating to urban areas. In this way, children and aged parents are separated, which in the long run lead to emotional distance between them. They opined that encouraging adult working children to stay close to their native homes through job posting or improving livelihood opportunities in rural areas would make nice strategies for upholding family care and support system [for the aged people]. The rural development projects could target at retaining young people back at homes, closer to their aged parents. One discussant summed up the views of the entire groups:

> To make life easier for everyone—children, parents, and community, the efforts should be made to retain children within their communities of origin. For this, rural development that can provide economic opportunities for younger people will be crucial. We should as the medium term strategies try to build Dzongkhag and satellite towns as the economic hubs for young people to explore various social and economic opportunities. This will encourage young people to settle close to their parents who could then be in the better position to be at the service of their aged parents (*FGD participant, Langthel Gewog, Trongsa Dzongkhag, 2017*).

Another discussant described how the present situation is affecting the family support to aged people:

> It is like this. At present, looking for jobs means young people have to migrate far to Thimphu, Paro or Pheuntsholing. Since they are gone far, and if anything wrong happen to their ageing parents, it becomes difficult for them to travel back to their rural homes. It is high time that the government work on various strategies and programmes to generate employment opportunities within the Dzongkhags, otherwise it will not take much time for urbanisation to destroy the traditional families affecting the lives of elderly people (*FGD participant, Pheuntsholing Gewog, Chukha Dzongkhag, 2017*).

The groups discussed how elderly people (whose children have left them) have to take charge of ancestral homes and farms, who are then forced to undergo extreme physical exertion despite their age and frailty. One thing that most groups felt should be considered was the mandatory *woola* (labour contribution for community development activities). Elderly

parents (above age 70 and with some functional disability) who are in charge of rural households are obligated to contribute *woola* even when their physical conditions are not favourable for taking part in the community development works. Many discussants opinionated that the local governments could identify the aged people who cannot genuinely contribute *zhabto woola* and make exceptional exemptions.

The groups discussed at length about the significance of community-based and voluntary service programmes as perfect complements to family care and other social protection systems. Not many of discussants were aware of the significance of voluntary programmes proving to be effective alternatives in other countries. The moderator usually initiated the discussions on the idea of social voluntarism and elderly care citing Japanese case (deductive process).

The idea discussed was that in the face declining family care and support system and inadequacy of the formal social protection system, the innovative approaches must be built as supplementary measures. One such idea was to develop mutual help networks of young people based upon a time-banking system, under which the voluntary groups are formed to provide care and support to elderly people within their own community. The benefit of such approach is that volunteers earn time credits for the services they render to elderly people, and they could use these credits to buy similar services when they become old. This is similar to CareBank, which is popular in Windsor and Maidenhead, UK. Almost all discussants saw some merit in trying this approach, which they felt was less expensive, humane and sustainable. They said this approach might help promote positive attitudes and perceptions among young people towards older people. In the words of a discussant:

> Forming the communities of youth volunteers to help elderly people is a good idea and it is likely to work well. The crucial thing is that there should be a government agency to record the care and support services these network groups render to elderly citizens so that they could claim the credits for their own use when they grow older. Such approach is cheap and might help promote young people's understanding and appreciation of elderly citizens' plights while inculcating in them a sense of volunteerism. This will promote linkages between young and elderly people, which all of us know is deteriorating at the moment (*FGD participant, Pheuntsholing Gewog, Chukha Dzongkhag, 2017*).

Conclusion

The major problems elderly people were facing (as identified by the groups) were the inadequacy of formal contributory pensions and extreme reliance on the care and support provided by their family and social networks. The issue is that the existing family and informal care and support mechanism are changing in the face of urbanisation and modernisation with serious implications on elderly people. The younger cohorts today have received some level of education and they normally choose to migrate to urban areas in search of better livelihood opportunities. This leaves aged parents (back at rural homes) often without regular care and support. These often tantamount to abandonment and neglect of aged parents, which could be either intentional or unintentional.

It was difficult to segregate problems and causes, as some causes are problems in themselves. However, the participants of the FGDs had pointed out the presence of a good number of elderly people who are living alone without much support from their children. The most common problem reported was the lack of income or inadequate income among elderly people to support their livelihood needs. The rural-urban migration of young people results in creating a physical and emotional separation of aged parents from their children. It also causes a deprivation of care and support from their children. As a consequence, elderly people are forced to work hard to earn livelihood even when their body can't endure physical hardships.

The conclusions drawn from seven FGDs were that many elderly people are exposed to multiple problems: deprivation of income and basic sustenance need, abandonment and neglect (by family), physical hardship (field works and *zhabto woola* obligations), emotional ill-being (loneliness, hopeless and helplessness), disrespect and derision (by younger people), social discrimination, homelessness, and difficulty accessing health care services (crowding in health facilities and immobility issues).

The probable causes of the old age problems identified were: rural-urban migration of younger cohorts, change in family and society's structure, degeneration of family values and norms, growing negative attitudes and perceptions of young people towards aged people, social discrimination

(in accessing certain services), and less positive impacts of development on the lives of many destitute.

The groups suggested several measures to address the problems faced by elderly people in their communities. These measures include: provision of income support through targeted social transfer (means tested social pension), providing residential care and shelter support to those who have no family support (destitute), introduction of mobile health check-up clinics in the communities for the aged persons who are bedridden and immobile, setting up separate medical consultation units, especially in the district and regional hospitals, exemption of elderly persons (too old and physically dysfunctional) from *woola* obligations, and encouraging volunteer groups and networks to support welfare of elderly people.

The access to healthcare was stressed in view of the fact that our national health system largely constitutes primary health care. General practitioners play key roles in the provision of healthcare, though elderly people may require more specialised health care services. Geriatric care service in the country is underdeveloped.

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CHAPTER V

THE ANALYSIS OF QUESTIONNAIRE SURVEY DATA

Cheda Jamtsho[1] and Tashi Norbu[2]

Introduction

Bhutan as a Buddhist and GNH country stands committed to preserve the integrity of the extended family system, community life, and compassionate living. Traditionally, children are obligated to take care and support their ageing parents, though this filial tradition is gradually losing its significance as a result of a change in the family structure. Importantly, with economic growth and development, we observe the demographic change. We could expect to see more elderly people in the years to come. The number of elderly people (defined as those aged 60 and older) in 2005 (as per PHCB, 2005) was about 44,000. Elderly people then made up about 7 per cent of the total population compared to about 59,000 (projected) in 2016. This was an increase of about one in every hundred persons. The proportion of elderly people is projected to increase to 8 per cent by 2020 and to 10.1 per cent by 2030.

The growth of elderly population can be more or less associated with the improved healthcare services and enhanced longevity. In less than 35 years, the average life span of the Bhutanese people had increased by 84 per cent—-36.9 years in 1970 to nearly 68 years in 2012. The prospect of longer life expectancy could be improved by ensuring older adults the conditions for better life and well-being. The reality is that increase in life expectancy has not paralleled with the overall socio-economic development for some elderly people. There were also a growing number of elderly people facing several challenges related to health, poverty, abuse, financial insecurity, social exclusion, abandonment, neglect, etc. These challenges have resulted in dissatisfied life, unhappiness, frustration, worry, depression, and so on for some elderly Bhutanese citizens.

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Ultimately, the quality of life in later life would more or less depend on how we can provide right conditions for elderly people to improve their self-confidence and harness their potentials. They have to be fit emotionally, socially and financially. By the very delicate nature of ageing, elderly people must draw considerable policy attention. Elderly people need to be given specialised healthcare services, family care and support, adequate finance and emotional buttresses. Sadly, this ever growing subpopulation is not given reasonable policy attention assuming that they are taken care of by family and community. The situation of elderly people warrants careful examination. In this context, we made an attempt to examine the situation of elderly people not only to unravel ground reality, but to spark future research interests. In fact, more scientific and gerontological studies and policy analysis are expected to come as we began to recognise emerging issues brought about by population ageing.

Research Question

In order to understand elderly people's situation and expectations—socially, financially, and emotionally, we attempted to answer the following questions:

1. What are the main problems and needs of elderly people? (threats/risks)
2. How does family care and support mechanism work? (coping mechanisms)
3. What does elderly people expect from the government and society?
4. How well are elderly people physically and psychologically? (resilience)

Objectives of the Study

1. To determine the problems, needs and expectations of old people;
2. To examine social, economic, and psychological dimensions of ageing including spirituality, and health conditions.

Research Design

To get the holistic understanding of the situation of elderly people, we saw merit in integrating some questions from GNH Survey 2015 with those of HelpAge International. The Centre for Bhutan Studies & GNH Research (CBS-GNH Research) had conducted GNH Survey in 2015. For our small sample questionnaire survey, we adapted questions from GNH 2015 survey available on www.bhutanstudies.org.bt. GNH Survey questionnaire contained questions on nine domains: h*ealth, living standard, education, cultural diversity, ecological diversity, time use, good governance, community vitality*, and *psychological well-being*. Most of the questions were relevant for our old age situational analysis questionnaire survey except those pertaining to the environmental domain. We appreciate CBS-GNH Research's generous act of making available online its GNH Survey questionnaire for use by other researchers. We have adapted some questions from HelpAge International's studies, especially those related to abuse of elderly people.

Methods

Sample and survey coverage

The questionnaire survey was administered using non-probability sampling methods: both convenience and purposive sampling techniques. The survey respondents were selected based on our convenience (proximity, availability and accessibility of respondents, availability of time and cost effectiveness). We purposively selected the respondents according to the study's purpose. We chose to conduct such survey to supplement the In-depth Interviews and Focus Group Discussions (FGDs) that were carried out concomitantly. The inclusion criteria were to select elderly people of age 60 and above and unlike in the case of In-depth Interviews (emphasis was on poor and vulnerable elderly people), we included every elderly person present and willing to participate in our questionnaire survey irrespective of their health, living standard and vulnerability.

Data collection, processing and analysis

The questionnaire survey was conducted to supplement the in-depth interviews and FGDs. The questionnaire was designed to obtain basic

data for wide range of social and economic issues affecting elderly people, including happiness, worries, and their dreams and expectations. We administered the questionnaire survey in eight Dzongkhags grouped into three main regions–East, Central, and West. These Dzongkhags were: Thimphu, Punakha, Chukhha, Samtse, Sarpang, Tsirang, Zhemgang, and Samdrupjongkhar. The choice of the Dzongkhags was largely determined by time constraint and fund limitation. From each Dzongkhag, two gewogs and one thromde were selected depending on the population size of the gewog and thromde, except for samtse and Tsirang where the data was collected from town areas.

Data were entered into CSPro software. The format included inbuilt logical checks to caution the data entry personnel on any kind of data entry errors. We carried out simple descriptive and explorative analysis. The results were presented in tables and graphs.

Research ethics

The old age study involves a certain level of sensitivity, as elderly people are usually considered 'dependents' and vulnerable. One of the challenges was obtaining properly informed consents from many respondents, especially those who were unable to decide themselves to participate in the research.

We used both English and Dzongkha written consent forms. Before taking consent to participate, we explained him or her the purpose and significance of the study. We refrained from assuring any direct benefit to an individual participant but talked about possible generalised benefits in the form of information generation that could inform old age policy and practice. Participation was voluntary. In the event an elderly person was not able to decide on his or her participation in the survey, we solicited approval from his or her children or other family members.

Considering the vulnerability of sick and frail, we excluded those elderly persons who were sick or infirm. Interviewing sick and infirm would require the specific expertise of professionals or health service providers (Worthington, 2017). We assured the anonymity of the participants and confidentiality of data.

Limitations

Some major weaknesses were a small sample size and the use of non-probability sampling technique. Both convenience and purposive sampling usually results in under-representation or over-representation of the respondents. Generalising the results to the entire country must be done with extreme caution, though the results may be suggestive of old age issues and provide a framework for future research.

Characteristics of the Aged Respondents

We have collected respondents' basic information like age, sex, marital status, religion, education, and occupation, along with their source of income/financial support, savings, accommodation, and care when sick. Demographic and social characteristics of elderly people were useful for understanding their situation.

Demographic characteristics

The survey interviewed about 150 elderly people aged 60 and above (Min. age: 60 & Max. age: 97). However, we could use only 129 survey forms for the analysis due to many missing values or cases of non-responses. The average age was estimated at 72 years implying that half of the respondents were below 72 years. The demographic characteristics of elderly participants are presented in table 5.1 below. Overall, the survey captured more elderly males than females: 73 were males (56.6%) and 56 were females (43.4%).

The majority of them (72.1%) were from rural areas compared to urban areas (27.9%). About 60 per cent of them were from the western region; 28.7% from the central region and the least were (11.6%) were from the eastern region. By age, about 77 per cent were in the age group 60-79 years, little more than 19 per cent between 80-89 years, and just about four per cent were in the age group 90 to 99 years.

Table 5.1 shows that over nine in ten (92.3%) elderly persons surveyed had 'no formal education'. Only 7 per cent had 'primary education' and less than one per cent 'lower secondary education'. The reason could be because modern education was not so easily accessible when these elderly persons were at their school-going age.

Table-5.1: Demographic characteristics of elderly persons interviewed, 2017

Characteristics		Elderly people	
		Number	**Per cent**
Sex	Male	73	56.6
	Female	56	43.4
Area	Urban	36	27.9
	Rural	93	72.1
Region	Western	77	59.7
	Eastern	15	11.6
	Central	37	28.7
Age group	60-69	48	37.2
	70-79	51	39.5
	80-89	25	19.4
	90-99	5	3.9
Marital status	Never Married	7	5.4
	Married	83	64.3
	Divorced	6	4.7
	Separated	1	0.8
	Widow/Widower	32	24.8
Education	No formal education	119	92.3
	Primary education (I-VI)	9	7.0
	LS education (VII-VIII)	1	0.8
Religion	Buddhism	112	86.8
	Hindu	16	12.4
	Others	1	0.8
Last occupation	Farmer	100	77.5
	Armed force	16	12.4
	Civil servant	4	3.1
	Monk	5	3.9
	Homemaker	2	1.6
	Others	2	1.6

Table 5.2 shows the percentage distribution of marital status of male and female elderly persons in rural and urban areas. A majority (62.8%) of elderly people interviewed was married: about 73 per cent of female elderly had co-residing spouses, in contrast to about 55 per cent among their male counterparts. The percentage of married female elderly was significantly higher than that of males in both urban and rural areas. About one-fourth (24.8%) was widow and widower. A similar trend was observed between male and female elderly people in both urban and rural areas.

Table-5.2: Percentage distribution by marital status of elderly males and females (60-97) by area

Marital Status	Area & Sex								
	Urban			Rural			Total		
	M	F	B	M	F	B	M	F	B
Never Married	5.3	0.0	2.8	11.1	0.0	6.5	9.6	0.0	5.4
Living together	0.0	0.0	0.0	1.9	0.0	1.1	1.4	0.0	0.8
Married	42.1	76.5	58.3	59.3	71.8	64.5	54.8	73.2	62.8
Divorced	5.3	0.0	2.8	5.6	7.7	6.5	5.5	5.4	5.4
Separated	5.3	0.0	2.8	0.0	0.0	0.0	1.4	0.0	0.8
Widow/Widower	42.1	23.5	33.3	22.2	20.5	21.5	27.4	21.4	24.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Abbreviation: M-Male, F-Female & B-Both sexes

The proportions of elderly divorced males and females were just little over five per cent. No divorced elderly females were captured in the urban area. Those who were never married were only elderly males in both urban and rural areas, with about five per cent and 11 per cent respectively.

Economic Characteristics

Main source of financial support

The major sources of income for elderly respondents were remittance from children, wages and salaries, cash crop, rental, benefits from charitable institutions, and income transfer from other family members (Table 5.3 & Figure 5.1). Remittances from children (41.1%) were the leading source of income. Other major sources of income were wages and salaries (9.3%), rent from a fixed property (5.4%), a sale of cash crops (4.7%), and through a sale of farming/livestock products (3.1%). About 3.1 per cent of them reported their other family members like grandsons and granddaughters as a source of their incomes. Most of the respondents–about 23 per cent–had no income. A very low percentage of them (1.6%) had 'social security benefits/pension'.

By area and sex, among urban elderly males, 42 per cent relied on remittance from children as the main source of income compared to just about 18 per cent of urban elderly females. Similarly, among rural elderly

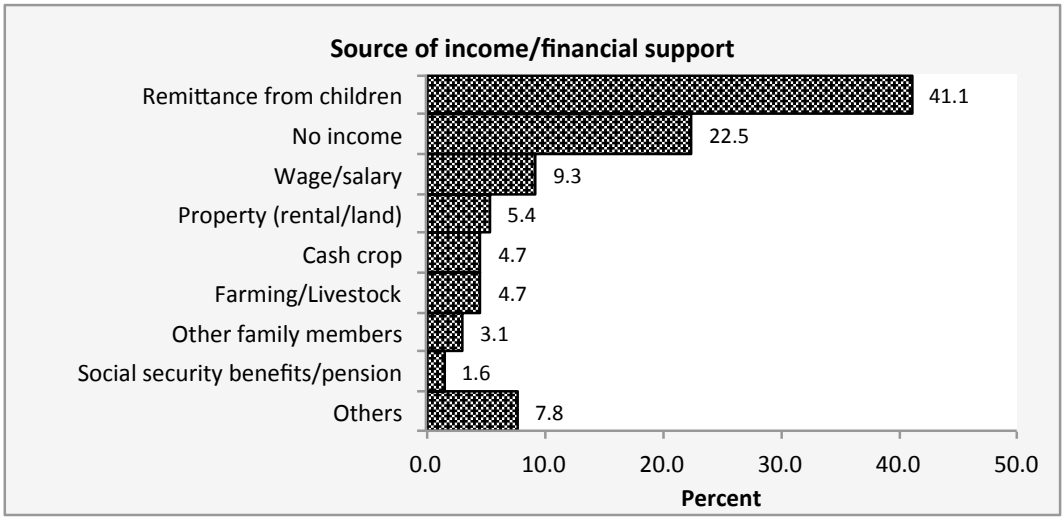
males and females, an almost equal proportion of them relied on remittances from their children. However, as compared to urban elderly females, a higher proportion of rural elderly females were dependent on remittances from children. Among those who relied on social security benefits or pension, there was a higher percentage of urban elderly males (5.3%) compared to rural elderly males (1.9%). There was no elderly female receiving pension benefit.

Table-5.3: Percentage of elderly persons disaggregated by main sources of income, by sex and residence

Source of Income/ Support	Urban			Rural			Total		
	M	F	B	M	F	B	M	F	B
Wage/salary	15.8	5.9	11.1	13.0	2.6	8.6	13.7	3.6	9.3
Property (rental/land)	5.3	5.9	5.6	5.6	5.1	5.4	5.5	5.4	5.4
Remittance from children	42.1	17.6	30.6	44.4	46.2	45.2	43.8	37.5	41.1
Social security benefits/ pension	5.3	0.0	2.8	1.9	0.0	1.1	2.7	0.0	1.6
Other family members	0.0	0.0	0.0	5.6	2.6	4.3	4.1	1.8	3.1
No income	31.6	58.8	44.4	9.3	20.5	14.0	15.1	32.1	22.5
Farming/Livestock	0.0	5.9	2.8	7.4	2.6	5.4	5.5	3.6	4.7
Cash crop	0.0	0.0	0.0	5.6	7.7	6.5	4.1	5.4	4.7
Others	0.0	5.9	2.8	7.4	12.8	9.7	5.5	10.7	7.8
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Abbreviations: M=Male, F=Female & B= Both sexes

Figure-5.1: Percentage distribution of elderly persons by their main source of income



Slightly more urban elderly males and elderly females had 'wages/salaries' compared to their rural equivalents as their main source of income (Table 5.3). Nearly half (44.4%) of elderly persons had no income in urban areas; 20.5 per cent their rural counterparts had no income. Apparently, a higher proportion of females (32.1%) were without any source income compared to males (51.1%), both in urban and rural areas. Other sources of income accounted for about 8 per cent. These include business, benefits from charitable institutions, donation, and *kidu* grant.

Savings of elderly people

Elderly respondents were asked whether or not they had savings either in banks or hoarded at homes, and a further question was asked on the amount of their savings. A majority of elderly respondents (79.8%) reported lack of savings. About one-fourth (20.2%) reported having savings (Table 5.4). Among those who had savings, 38.5 per cent of them had between Nu. 5000–20,000; 15.4 per cent had between Nu. 20,00–35,000; and another 15.4 per cent of them between Nu.35, 001–50,000. Little over 11 per cent reported having savings less than Nu. 5000, and about 19 per cent had more than Nu.50, 000. The minimum and maximum range of savings recorded were Nu.500 and Nu.200, 000 respectively. More urban residents reported having savings.

Table-5.4: Percentage of elderly respondents with savings by residents

Saving/Amount	Total		Residence	
	Number	Per cent	Urban	Rural
Saving				
Yes	26	20.2	13.9	22.6
No	103	79.8	86.1	77.4
Total	**129**	**100.0**	**100.0**	**100.0**
Saving amount				
Less than 5000	3	11.5	20.0	9.5
5000-20,000	10	38.5	60.0	33.3
20,001-35,000	4	15.4	0.0	19.0
35,001-50,000	4	15.4	20.0	14.3
Above 50,000	5	19.2	0.0	23.8
Total	**26**	**100.0**	**100.0**	**100.0**

Note: Urban (n=5), Rural (n=21)

Social Characteristics

Current living arrangements

A vast majority of elderly persons (86%, n=111), almost 22 in 25, reported having children. Table 5.5 gives the percentages of elderly respondents "with child," and those "childless" and elderly persons who lived with spouses, relatives or live alone. The majority (54.3%) of elderly respondents reported living with their children. This was the case prominent among elderly females than elderly males. About 13 per cent of them reported they live alone, and yet they have children. More elderly persons of both sexes in urban areas reported being staying with their children than those in rural areas.

The proportion of living alone and childless was higher among elderly females (8.8%) than among elderly males (4.2%). In the case of those who had reported they live alone though they have children, there was a higher percentage of elderly males (16.7%) compared to the female counterpart (8.8%). Only about three per cent reported they live with spouses and have no children. An insignificant proportion of elderly respondents without children reported they live with relatives. Just over one per cent reported they live in the homes provided by the temple/ *lhakhang* authorities with a sole intention of reciting prayers and mantras. They were mostly childless. See table 5.5.

Table-5.5:Percentage distribution of elderly respondents' current accommodation by area and sex

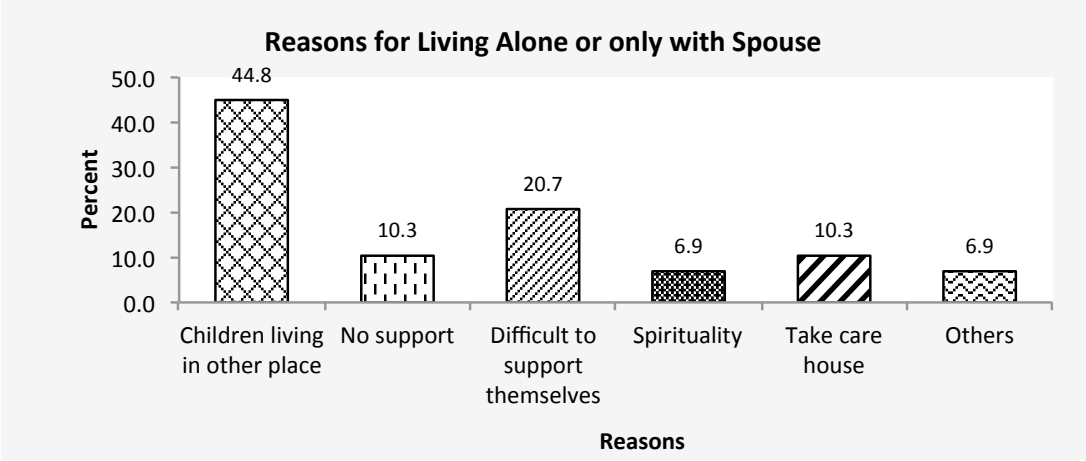
Current Accomodation	Urban			Rural			Total		
	M	F	B	M	F	B	M	F	B
With children	63.2	58.8	61.1	45.3	60.0	51.6	50.0	59.6	54.3
With spouse, have chid	10.5	5.9	8.3	13.2	7.5	10.8	12.5	7.0	10.1
Lhakhang homes, have child	0.0	0.0	0.0	1.9	0.0	1.1	1.4	0.0	0.8
With relatives, have child	0.0	23.5	11.1	9.4	2.5	6.5	6.9	8.8	7.8
Alone, have child	21.1	5.9	13.9	15.1	10.0	12.9	16.7	8.8	13.2
With relatives, childless	5.3	5.9	5.6	3.8	0.0	2.2	4.2	1.8	3.1
Alone, childless	0.0	0.0	0.0	5.7	12.5	8.6	4.2	8.8	6.2
With spouse, childless	0.0	0.0	0.0	1.9	7.5	4.3	1.4	5.3	3.1
lhakhangs homes, childless	0.0	0.0	0.0	3.8	0.0	2.2	2.8	0.0	1.6
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Abbreviations: M=Male, F=Female & B= Both sexes

Among married elderly respondents, close to 10 per cent did not have children. About the same percentage of them were widows and widowers. Figure 5.2 gives details. As seen in the case of widows living alone, 10 per cent have children compared to about 32 per cent of widowers living alone on account of not having children. The majority of widows (8 in 20) and little over 6 in 10 widowers reported they live with their children. In the case of married elderly respondents, about 63 per cent of them reported they temporarily live with their children while on medical checkup or just to help babysit their grandchildren.

As shown in Figure 5.3, elderly respondents who lived alone (n=17), about 43 per cent had to live alone on account of their children being far away in other places rather than because they prefer to stay independent of their children. Correspondingly, 18 per cent reported they live alone because their children have difficulty supporting themselves. About 10 per cent of them were forced to live alone, as they have to look after the natal households in the village. Nearly 7 per cent reported they live alone to practice spirituality. About one in ten reported lack of support from their children.

Figure-5.3: Percentage distribution of elderly persons by reason for living alone



Main caregivers

Table 5.6 shows the main caregivers for elderly respondents when they are sick. About 79 per cent of elderly males reported that their main caregivers during illnesses are the family members (son, daughter, and

spouse). The corresponding figures for elderly females ranged from about 4 to 52 per cent summing up to 84 per cent. The family is not only the main source of care and support, but also the main caregiver in the Bhutanese society. Overall, the proportion of elderly females whose main caregivers are children was much higher than among elderly males. This was so even in rural areas. In urban areas, more elderly males had children as caregivers than among elderly females. More elderly females in rural areas had other family members (3.1%) as caregivers. Most of the other family members were grandchildren. This indicates the continuity of grandparents-grandchildren affiliation.

Table–5.6:Percentage distribution of elderly respondents by caregivers (when they are sick)

Caregivers	Urban			Rural			Total		
	M	F	B	M	F	B	M	F	B
Total Numbers	**19**	**17**	**36**	**54**	**39**	**93**	**73**	**56**	**129**
Son	26.3	52.9	38.9	51.9	51.3	51.6	45.2	51.8	48.1
Daughter	63.2	29.4	47.2	20.4	28.2	23.7	31.5	28.6	30.2
Self	5.3	0.0	2.8	3.7	0.0	2.2	4.1	0.0	2.3
Spouse	0.0	0.0	0.0	3.7	5.1	4.3	2.7	3.6	3.1
Other family members	0.0	0.0	0.0	1.9	7.7	4.3	1.4	5.4	3.1
Others	5.3	17.6	11.1	18.5	7.7	14.0	15.1	10.7	13.2
Total	100	100	100	100	100	100	100	100	100

Abbreviations: M=Male, F=Female & B= Both sexes

Health Status

The question on health status asked: "Could you tell us about your health status for the past one month?" No proxy answers were allowed. Table 5.7 shows the percentage distribution of elderly respondents based on their self-reported health status. Among those elderly respondents, 44 per cent reported 'poor health' and 33 per cent reported 'average health'. Poor health refers to chronic diseases like diabetes, hypertension, depression, etc. Average health includes seasonal problems like a cough and cold, fever, etc.

Around 16 per cent of elderly respondents reported that their health condition during the past one month was 'good', with the proportion of males higher than females in both urban and rural areas. The proportion of elderly females (50%) who reported poor health was much higher than male counterparts (39.7%). An almost same pattern in health condition was observed among elderly males and elderly females in both urban and rural areas. The proportion of elderly respondents with 'very poor' health, was higher among elderly females (8.9%) than among elderly males (5.5%). Very poor health status was associated with elderly persons suffering from more than one chronic disease such as diabetes, hypertension, depression, etc.

Among elderly males, about 21 per cent of those aged 60-69, 18 per cent of those aged 70-79, and 19 per cent of those aged 80 and above (rural and urban combined) reported "good health." The corresponding percentages were 21, 13, and zero for elderly females. Almost 17 per cent of elderly respondents (in the age group '80 and above') reported they have 'very poor' health compared to those in the age group 70-79 (7.8%). No persons reported 'very poor health' from among elderly people in the age group 60-69.

When elderly persons (60-69) with 'good' and 'average' health status were combined, it summed up to little over 56 per cent. This was the highest among the other age groups. All elderly males were more likely to report good health status except those in the age group 60-69. More elderly females rated poor health status compared to elderly males.

Table-5.7: Percentage distribution of elderly persons with their self-reported health status by sex and residence

Age/Health status	Urban			Rural			Total		
	M	F	B	M	F	B	M	F	B
Total Numbers	**19**	**17**	**36**	**54**	**39**	**93**	**73**	**56**	**129**
Good	15.8	11.8	13.9	20.4	12.8	17.2	19.2	12.5	16.3
Average	42.1	17.6	30.6	33.3	33.3	33.3	35.6	28.6	32.6
Poor	42.1	64.7	52.8	38.9	43.6	40.9	39.7	50.0	44.2
Very poor	0.0	5.9	2.8	7.4	10.3	8.6	5.5	8.9	7.0
Total	100	100	100	100	100	100	100	100	100
60-69									
Good	14.3	12.5	13.3	22.7	27.3	24.2	20.7	21.1	20.8

Age/Health status	Urban			Rural			Total		
Average	28.6	12.5	20.0	45.5	36.4	42.4	41.4	26.3	35.4
Poor	57.1	75.0	66.7	31.8	36.4	33.3	37.9	52.6	43.8
Very poor	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100	100	100	100	100	100	100	100	100
70-79									
Good	16.7	11.1	13.3	18.2	14.3	16.7	17.9	13.0	15.7
Average	66.7	22.2	40.0	27.3	42.9	33.3	35.7	34.8	35.3
Poor	16.7	55.6	40.0	45.5	35.7	41.7	39.3	43.5	41.2
Very poor	0.0	11.1	6.7	9.1	7.1	8.3	7.1	8.7	7.8
Total	100	100	100	100	100	100	100	100	100
80 and above									
Good	16.7	0.0	16.7	20.0	0.0	8.3	18.8	0.0	10.0
Average	33.3	0.0	33.3	20.0	21.4	20.8	25.0	21.4	23.3
Poor	50.0	0.0	50.0	40.0	57.1	50.0	43.8	57.1	50.0
Very poor	0.0	0.0	0.0	20.0	21.4	20.8	12.5	21.4	16.7
Total	100	0	100	100	100	100	100	100	100

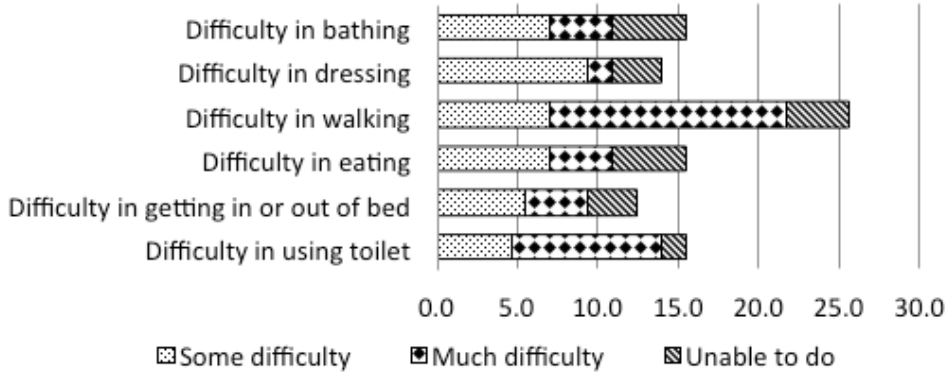
Abbreviations: M=Male, F=Female & B= Both sexes

Daily activities

The question "Do you have any difficulty in performing the following activities?" was asked to elderly respondents. This question appertained to their day-to-day activities such as dressing, eating, bathing, walking, and using a toilet. The percentage distribution of elderly persons facing difficulties in performing activities of daily living is shown in figure 5.4. Only elderly respondents reporting different levels of difficulty is reflected in the graph. Those elderly persons who reported no such difficulty are not shown in the figure.

The main difficulty was walking (25.6%, n=129, n=33) followed by difficulty in using toilet (15.5%, n=129, n=20) and difficulty in eating (15.5%, n=129, n=20). Detail is given in figure 5.4. On the whole, 74.4 per cent of elderly respondents reported 'no difficulty' in performing activities of daily living.

Figure–5.4:Percentage distribution of elderly respondents and their reported difficulty in performing activities of daily living

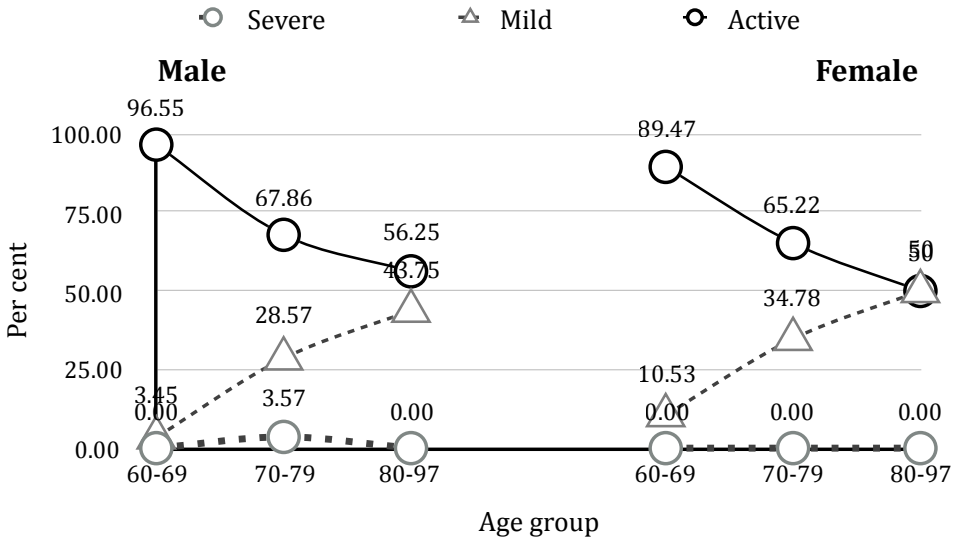


While comparing among the six activities on the difficulty level, 15 percent reported "more difficult". This was the highest and was in terms of difficulty in walking. About 9 percent (second highest) reported difficulty in using the toilet. Around 4 percent accounted not being able to walk at all. This was next to not being able to eat or drink (4.7%) and bath or shower (4.7%) on their own.

According to Kartz *et al.* (1970), as cited in Zeng Yi *et al.* (2002), the Activities of Daily Living (ADL) functional status measures elderly people's degree of independence. The ADL functional status includes six activities: dressing, walking, bathing or showering, eating, transferring, and using a toilet. The intensity of functional status is categorised into mildly disabled, severely disabled, and active. In the present case, if a respondent faced difficulty in performing one or two activities, he or she was classified as "mildly disable"; "severely disabled" applied to elderly persons with difficulty in carrying out three or more activities; and elderly respondents with no difficulty in discharging six activities were considered "active".

Two significant patterns of ADL status were manifested albeit this study had involved a smaller sample. These patterns are shown in figure 5.5. First, the functional capacity in daily living declined rapidly from age 60-69. Second, the ADL status of elderly females was worse than that of their male counterparts (at all age groups). In short, the ADL status of elderly male respondents was better than their female counterparts.

Figure–5.5: Percentage of elderly persons classified by functional status according to ADL, by age, and sex



On the whole, slightly more than one-fourth (25.6%) of elderly respondents were mildly disabled. More elderly females (30.4%) were mildly disabled than their male counterparts (21.9%). In the same way, the dominance of elderly females in mild disability was present in both rural and urban areas. Less than one per cent (0.8%) of elderly respondents were 'severely disabled'. Approximately 29 per cent of elderly males aged 70-79 and 35 per cent of their female counterparts were 'mildly disabled'.

Suicidal Ideation and Attempt

Until now, suicide among elderly people has not been considered a cardinal issue in Bhutan. Nevertheless, the recent Action Plan Report of 2015 on Suicide Prevention in Bhutan highlights suicide being among the top six leading causes of death. Getting accurate data to gauge its extent and severity has been a challenge, considering its complex and sensitive nature, including the practical problem of determining a person's intention. Suicide has never remained as a 'standalone' factor. According to the report, multiple factors ranging from social circumstances (e.g., family issues, failing to fulfil one's life expectations) and economic (e.g., financial circumstances) to physical and mental health conditions have interacted to provoke suicide in a person.

We tried to ascertain factors causing suicidal ideation and suicidal attempts among elderly persons. Our data may not be robust enough to determine the factors leading to suicidal ideation and attempt. This is because elderly people we interviewed were reluctant to talk about their emotional problems. In fact, studies have shown that elderly people are less predisposed to report depression and suicidal ideation to others (Worthington, 2017).

The response to the question "Have you ever seriously thought of committing suicide?" is presented in table 5.8 below. Though 93.8 per cent (n=121) of respondents reported they had never thought of committing suicide, 6.2 per cent (n=8) had suicidal ideation or seriously thought of committing suicide. More elderly females reported having had suicidal ideation than their male counterparts. About 8 per cent of elderly people from urban areas reported suicidal ideation compared to 5 per cent of elderly people from rural areas. More elderly females (11.8%) from urban areas reported having had suicidal thought or ideation compared to elderly males (5.3%). Out of eight old persons who reported suicidal ideation, half of them (50%) were aged 80-89, about 37 per cent in the age group 70-79, and just over 12 per cent in the age group 60-69 (table not shown).

Table–5.8: Percentage distribution of elderly respondents as per their suicidal ideation by sex and residence

Suicidal thoughts	Urban			Rural			Both Areas		
	M	F	B	M	F	B	M	F	B
Yes	5.3	11.8	8.3	5.6	5.1	5.4	5.5	7.1	6.2
No	94.7	88.2	91.7	94.4	94.9	94.6	94.5	92.9	93.8
Total	100	100	100	100	100	100	100	100	100

Abbreviations: M=Male, F=Female & B=Both sexes

Among elderly respondents who reported suicidal ideation, 37 per cent (n=3) revealed they had it in the past 12 months prior to the interview (table not shown). One-fourth of elderly males and two-fourth of elderly females had suicidal ideation within past 12 months before the interviews. Asked about the frequency of suicidal ideation they had experienced, two elderly respondents reported they had this as many as three times. One of them reported he experienced it for five times within the past 12 months. These respondents were in the age group 60-79 years. The reason they

gave for suicidal ideation was 'severe stress'. This showed that poor mental health conditions, possibly driven by a loss of control over physical health or financial circumstances or lack of family/children's support could result in feelings of hopelessness and frustration, and consequently, suicidal ideation.

Table 5.9 shows the percentage distribution of elderly respondents, their suicidal ideation and emotional states like losing self-confidence, feeling depressed, and feeling worried. Among elderly persons who had suicidal ideation over time in their lives, four-tenth (37.5%) reported that their self-confidence has been weakening more than usual. Five-tenth (50%) of them reported having had lost much sleep over worry more than usual. Four-tenth (37.5%) reported feeling depressed more than usual. A higher proportion of elderly persons who reported experiencing thoughts of committing suicide also reported losing self-confidence compared to elderly persons who never thought of committing suicide. Elderly respondents who reported suicidal ideation also reported experiencing depression, sleeplessness and worries.

Table–5.9: Percentage distribution of elderly respondents, suicidal ideation, and their emotional states, by sex, and residence

Categories	Have you seriously thought of committing suicide?			
	Options	Yes	No	Total
Total Numbers		**8**	**121**	**129**
Been losing self-confidence	Less than usual	12.5	7.4	7.8
	More than usual	37.5	34.7	34.9
	Not at all	12.5	36.4	34.9
	Don't know	37.5	21.5	22.5
	Total	100.0	100.0	100.0
Been feeling depressed	Less than usual	12.5	7.4	7.8
	More than usual	37.5	30.6	31.0
	Not at all	25.0	50.4	48.8
	Don't know	25.0	11.6	12.4
	Total	100.0	100.0	100.0
Lost much sleep over worry	Less than usual	12.5	8.3	8.5
	More than usual	50.0	40.5	41.1
	Not at all	12.5	44.6	42.6
	Don't know	25.0	6.6	7.8
	Total	100	100	100

Awareness and Knowledge of GNH

The principle of Gross National Happiness (GNH), inherently and inclusively, sits at the forefront of all policy, development, rule of law, and democracy in Bhutan. Its importance has been translated into an increased focus on people's participation in development process. GNH encompasses the social inclusion of ensuring everyone a set of conditions for pursuing happiness, especially through equitable distribution of resources and services among people of different livelihood situations.

We examined how aware were elderly respondents about GNH and democracy. They were asked two separate questions: 'How aware are you about Gross National Happiness (Gyelyong Gakid Pelzom)'? 'Do you know the names of the four political parties who contested in the primary round in 2013'? The results are shown in table 5.10.

There were equal proportions of elderly persons reporting having 'heard about GNH' and 'never heard about GNH'. Slightly over 44 per cent (summation of all three 'Yes') reported having heard of GHN; 46 per cent reported that they do not have any idea or knowledge or understanding about GNH. More elderly males were aware or knowledgeable about GNH than elderly females.

Table–5.10: Percentage distribution of elderly respondents based on their awareness and knowledge of GNH, by sex and residence

Happiness (Gyelyong Gakid Palzom)	Urban			Rural			Total		
	M	F	B	M	F	B	M	F	B
Total Numbers	**19**	**17**	**36**	**54**	**39**	**93**	**73**	**56**	**129**
Yes, I have heard of it and have a good understanding of it	5.3	5.9	5.6	3.7	0.0	2.2	4.1	1.8	3.1
Yes, I have heard of it and have some understanding	31.6	17.6	25.0	25.9	5.1	17.2	27.4	8.9	19.4
Yes, I have heard of it but I am unsure about it	26.3	35.3	30.6	35.2	28.2	32.3	32.9	30.4	31.8
Not at all	36.8	41.2	38.9	35.2	66.7	48.4	35.6	58.9	45.7
Total	100	100	100	100	100	100	100	100	100

Abbreviations: M=Male, F=Female & B=Both sexes

Just 3.1 per cent of elderly respondents mentioned they heard about GNH and had a good understanding of this concept. A few elderly females (1.8%) admitted they heard about GNH and understand it well than elderly males (4.1%). About 19 per cent had some understanding of GNH while 31.8 per cent has heard about it, but they did not know what it was all about.

More elderly respondents living in urban areas had heard about GNH and understood it well (5.6%) against 2.2% of elderly respondents living in rural areas reporting the same. More elderly urban males (5.3%) understood GNH well against 3.7 per cent of elderly rural males who understood well the concept of GNH. More elderly rural females were less aware or knowledgeable about GNH. About 48 per cent of rural elderly respondents and 40 per cent of elderly urban respondents knew nothing about GNH.

More elderly respondents from in eastern (53.3%) and central (62.2%) regions knew nothing about GNH. About 36 per cent of elderly respondents from western region knew nothing about GNH. In fact, more elderly respondents in the western region have heard about GNH and knew about it than those elderly respondents in the other two regions. With an exception of elderly respondents in the western region (5.2%), none of the elderly respondents in the eastern and central region reported being aware of and having understood the concept of GNH.

Problems of Old Age

When asked 'how would you rate yourself or your household in terms of poverty'? more than half (57.2%) of elderly respondents reported 'neither poor nor rich'. About 19 per cent of them reported they were 'poor' and 16.3 per cent 'very poor'. Just over four per cent reported that they were rich. On combining elderly respondents reporting being "very poor" and "poor," there were a higher proportion of elderly people in rural areas than in urban areas under the new indicator. The details are summarised in table 5.11a.

Table–5.11a: Percentage distribution of elderly respondents as per their poverty perception, by sex and area

Poverty	Sex		Area		Total
	Male	Female	Urban	Rural	
Very poor	13.7	19.6	11.1	18.3	16.3
Poor	20.5	16.1	19.4	18.3	18.6
Poor nor rich	53.4	62.5	63.9	54.8	57.4
Rich	6.8	0.0	2.8	4.3	3.9
Don't know	5.5	1.8	2.8	4.3	3.9
Total	100	100	100	100	100

Using six dimensions: food, clothing, shelter, water, toilet, and money, a question was asked to elderly respondents: 'Which of these is a problem to you'?" Their responses by sex and residence are presented in table 5.11b. A majority of them reported not having any problem in six basic dimensions of livelihood, except for money. About 41 per cent reported they faced moderate monetary problem while 26 per cent reported having 'serious" monetary problem. In most dimensions, slightly more elderly females than elderly males reported having a serious problem. Combining 'serious' and 'moderate' problems, food insecurity accounted for about 40 per cent; 35 per cent clothing; 25 per cent shelter; 22 per cent deprivation of water; 15 per cent toilet deprivation; and 68 per cent monetary problem.

Table – 5.11b: Percentage distribution of old persons as per their problem and its severity, by sex, and rural-urban residence

Current problems	Urban			Rural			Total		
	M	F	B	M	F	B	M	F	B
Food									
Serious	15.8	5.9	11.1	11.1	20.5	15.1	12.3	16.1	14.0
Moderate	21.1	29.4	25.0	29.6	23.1	26.9	27.4	25.0	26.4
Not a problem	63.2	64.7	63.9	57.4	56.4	57.0	58.9	58.9	58.9
Not applicable	0.0	0.0	0.0	1.9	0.0	1.1	1.4	0.0	0.8
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Clothing									
Serious	5.3	11.8	8.3	11.1	15.4	12.9	9.6	14.3	11.6
Moderate	26.3	17.6	22.2	22.2	28.2	24.7	23.3	25.0	24.0
Not a problem	68.4	70.6	69.4	64.8	56.4	61.3	65.8	60.7	63.6

Current problems	Urban			Rural			Total		
Not applicable	0.0	0.0	0.0	1.9	0.0	1.1	1.4	0.0	0.8
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Shelter									
Serious	5.3	5.9	5.6	7.4	10.3	8.6	6.8	8.9	7.8
Moderate	21.1	17.6	19.4	13.0	20.5	16.1	15.1	19.6	17.1
Not a problem	73.7	76.5	75.0	77.8	69.2	74.2	76.7	71.4	74.4
Not applicable	0.0	0.0	0.0	1.9	0.0	1.1	1.4	0.0	0.8
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Water									
Serious	0.0	5.9	2.8	5.6	10.3	7.5	4.1	8.9	6.2
Moderate	31.6	0.0	16.7	11.1	23.1	16.1	16.4	16.1	16.3
Not a problem	68.4	94.1	80.6	81.5	66.7	75.3	78.1	75.0	76.7
Not applicable	0.0	0.0	0.0	1.9	0.0	1.1	1.4	0.0	0.8
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Toilet									
Serious	0.0	0.0	0.0	7.4	7.7	7.5	5.5	5.4	5.4
Moderate	15.8	17.6	16.7	1.9	15.4	7.5	5.5	16.1	10.1
Not a problem	78.9	76.5	77.8	88.9	76.9	83.9	86.3	76.8	82.2
Not applicable	5.3	5.9	5.6	1.9	0.0	1.1	2.7	1.8	2.3
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Money									
Serious	21.1	11.8	16.7	24.1	38.5	30.1	23.3	30.4	26.4
Moderate	52.6	47.1	50.0	38.9	35.9	37.6	42.5	39.3	41.1
Not a problem	26.3	41.2	33.3	37.0	23.1	31.2	34.2	28.6	31.8
Not applicable	0.0	0.0	0.0	0.0	2.6	1.1	0.0	1.8	0.8
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Abbreviations: M=Male, F=Female & B=Both sexes

Psychological Well-being

Subjective happiness and wellness perception

To assess the level of happiness, elderly respondents were asked: 'Taking all thing together, how happy would you say you are'? As shown in table 5.12, a majority of them (69%) reported they are 'happy', followed by 'very happy' (21.7%). Just over 9 per cent reported they are 'not happy'. About 91 per cent (very happy and happy combined) of elderly respondents reported they are 'happy'. Less than 5 per cent elderly males were 'not happy' while the corresponding percentage of elderly females constituted 16 per cent. This indicated elderly males were happier than elderly females. The proportion of rural elderly respondents (69.9%) who

reported to be 'happy' was slightly higher than urban elderly respondents (66.7%). A similar pattern was seen in the case of being 'very happy'.

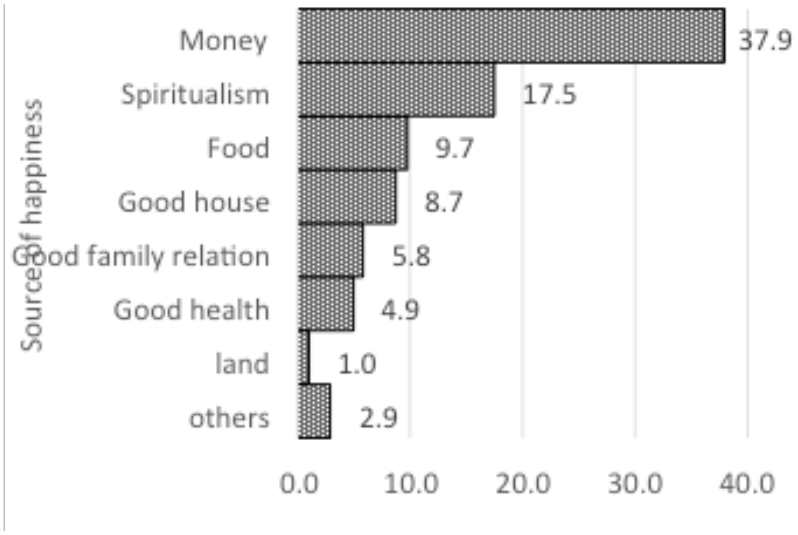
Table–5.12: Percentage distribution of elderly respondents according to their happiness level, by sex and area

Happiness status	Urban			Rural			Total		
	M	F	B	M	F	B	M	F	B
Very happy	26.3	11.8	19.4	27.8	15.4	22.6	27.4	14.3	21.7
Happy	68.4	64.7	66.7	68.5	71.8	69.9	68.5	69.6	69.0
Not happy	5.3	23.5	13.9	3.7	12.8	7.5	4.1	16.1	9.3
Total	100	100	100	100	100	100	100	100	100

Abbreviation: M=Male, F=Female & B=Both sexes

Furthermore, elderly respondents were asked: 'what are the most important things (sources) that will make you lead a truly happy life'? Figure 5.6 shows the percentage distribution of elderly respondents based on their source of happiness by sex and area. As high as 38 per cent of them reported the money as leading source of happiness. Spirituality (17.5%), food (9.7%), good house (8.7%), and good family relation (5.8%) were other sources of happiness. Good health (4.9%) was the second least important source of happiness next to land (1%).

Figure–5.6: Percentage distribution of elderly respondents according to their source of happiness, by sex and area



The wellness perceptions of elderly respondents were based on ten items. The reported results are summarised in table 5.13. More than half of them agreed with most of the life aspect's statements (strongly agree and agree combined). However, there were relatively more elderly respondents disagreeing to the statements: 'In general I feel confident about my abilities (38%),' 'I sometimes think that I am a worthless person,' and 'I am always down hearted and depressed'. The corresponding percentages accounted for 38 per cent, 39 per cent, and 40 per cent respectively. These result could be interpreted in two ways: most elderly people were less confident in their capabilities on what they could do, and most of them exhibited strong mental health by less agreeing with being worthless and depressed statement. Even by males and females, a similar pattern was seen, but the proportion of females (strongly agree–1.8% and agree–21.4%) who feel confident about their abilities was slightly less than their male counterparts (strongly agree–11% and agree–38.4%). Likewise, the proportion of elderly females who think they are a worthless person and feels down hearted and depressed was higher compared to their male equals.

Table-5.13: Percentage distribution of old people according to their wellness perception on different aspects of life by sex and area

Current problems	Urban			Rural			Total		
	M	F	B	M	F	B	M	F	B
	Food								
Serious	15.8	5.9	11.1	11.1	20.5	15.1	12.3	16.1	14.0
Moderate	21.1	29.4	25.0	29.6	23.1	26.9	27.4	25.0	26.4
Not a problem	63.2	64.7	63.9	57.4	56.4	57.0	58.9	58.9	58.9
Not applicable	0.0	0.0	0.0	1.9	0.0	1.1	1.4	0.0	0.8
	Clothing								
Serious	5.3	11.8	8.3	11.1	15.4	12.9	9.6	14.3	11.6
Moderate	26.3	17.6	22.2	22.2	28.2	24.7	23.3	25.0	24.0
Not a problem	68.4	70.6	69.4	64.8	56.4	61.3	65.8	60.7	63.6
Not applicable	0.0	0.0	0.0	1.9	0.0	1.1	1.4	0.0	0.8
	Shelter								
Serious	5.3	5.9	5.6	7.4	10.3	8.6	6.8	8.9	7.8
Moderate	21.1	17.6	19.4	13.0	20.5	16.1	15.1	19.6	17.1
Not a problem	73.7	76.5	75.0	77.8	69.2	74.2	76.7	71.4	74.4
Not applicable	0.0	0.0	0.0	1.9	0.0	1.1	1.4	0.0	0.8

Current problems	Urban			Rural			Total		
	Water								
Serious	0.0	5.9	2.8	5.6	10.3	7.5	4.1	8.9	6.2
Moderate	31.6	0.0	16.7	11.1	23.1	16.1	16.4	16.1	16.3
Not a problem	68.4	94.1	80.6	81.5	66.7	75.3	78.1	75.0	76.7
Not applicable	0.0	0.0	0.0	1.9	0.0	1.1	1.4	0.0	0.8
	Toilet								
Serious	0.0	0.0	0.0	7.4	7.7	7.5	5.5	5.4	5.4
Moderate	15.8	17.6	16.7	1.9	15.4	7.5	5.5	16.1	10.1
Not a problem	78.9	76.5	77.8	88.9	76.9	83.9	86.3	76.8	82.2
Not applicable	5.3	5.9	5.6	1.9	0.0	1.1	2.7	1.8	2.3
	Money								
Serious	21.1	11.8	16.7	24.1	38.5	30.1	23.3	30.4	26.4
Moderate	52.6	47.1	50.0	38.9	35.9	37.6	42.5	39.3	41.1
Not a problem	26.3	41.2	33.3	37.0	23.1	31.2	34.2	28.6	31.8
Not applicable	0.0	0.0	0.0	0.0	2.6	1.1	0.0	1.8	0.8

Abbreviation: M=Male, F=Female & B=Both sexes

Spirituality

In general, people resorting to spiritualistic practice as they grow elderly is a common practice in Bhutan. It is believed that old age is time to prepare for death and life after death through spiritual practice. To examine the spirituality, elderly respondents were asked a question: 'How spiritual do you consider yourself to be'? They were further asked whether they carry out Buddhist practices such as reciting prayers/ mantras, practising meditation, visiting temples, and believing in karma or *ley judrey*.

Overall, as shown in table 5.14, more than half (55%) of elderly respondents said they were 'very spiritual'; 30 per cent of them said they were 'moderately spiritual', and 11 per cent said they were 'somewhat spiritual'. Most of the elderly respondents (both males and females) considered themselves 'very spiritual'. A higher proportion of elderly urban males (68.4%) regarded themselves 'very spiritual' compared to elderly urban females (23.5%). It is not the case for a rural area. The proportion of elderly rural males who reported being "very spiritual" was lower than their elderly rural female co-equals. Combining very spiritual,

moderately spiritual, and somewhat spiritual accounted for 96 per cent of elderly respondents considering themselves 'spiritual'.

Table-5.14: Percentage distribution of elderly respondents according to spirituality level, by sex and area

Spirituality level	Urban			Rural			Total		
	M	F	B	M	F	B	M	F	B
Very	68.4	23.5	47.2	50.0	69.2	58.1	54.8	55.4	55.0
Moderately	26.3	52.9	38.9	33.3	17.9	26.9	31.5	28.6	30.2
Somewhat	0.0	17.6	8.3	16.7	5.1	11.8	12.3	8.9	10.9
Not at all	0.0	0.0	0.0	0.0	5.1	2.2	0.0	3.6	1.6
Don't know	5.3	5.9	5.6	0.0	2.6	1.1	1.4	3.6	2.3
Total	100	100	100	100	100	100	100	100	100

Abbreviations: M=Male, F= Female & B=Both

Nonetheless, when it comes to actual practice such as reciting prayers/ mantras, practicing meditation, visiting places of spiritual significance, consideration of karma, or receiving and attending religious teachings, the figures varied largely. Table 5.15 shows the percentage distribution of elderly respondents across spiritual practice like prayer recitation, meditation and visit to places of spiritual significance.

Table–5.15: Percentage distribution of elderly respondents across various spiritual activities

Spirituality level	Urban			Rural			Total		
	M	F	B	M	F	B	M	F	B
Recite prayers/mantras									
Several times a day	78.9	52.9	66.7	55.6	56.4	55.9	61.6	55.4	58.9
Once a day	10.5	11.8	11.1	20.4	10.3	16.1	17.8	10.7	14.7
A few times in a week	5.3	23.5	13.9	13.0	23.1	17.2	11.0	23.2	16.3
Only on certain occasion	5.3	11.8	8.3	11.1	7.7	9.7	9.6	8.9	9.3
Never	0.0	0.0	0.0	0.0	2.6	1.1	0.0	1.8	0.8
Total	100	100	100	100	100	100	100	100	100
Doing meditation									
Several times a day	0.0	11.8	5.6	1.9	2.6	2.2	1.4	5.4	3.1

Spirituality level	Urban			Rural			Total		
Once a day	10.5	5.9	8.3	3.7	5.1	4.3	5.5	5.4	5.4
A few times in a week	0.0	0.0	0.0	3.7	0.0	2.2	2.7	0.0	1.6
Only on certain occasion	5.3	5.9	5.6	5.6	5.1	5.4	5.5	5.4	5.4
never	84.2	76.5	80.6	85.2	87.2	86.0	84.9	83.9	84.5
Total	100	100	100	100	100	100	100	100	100
Visit place of religious significance									
Several times a day	10.5	0.0	5.6	20.4	2.6	12.9	17.8	1.8	10.9
Once a day	21.1	17.6	19.4	3.7	10.3	6.5	8.2	12.5	10.1
A few times in a week	36.8	17.6	27.8	9.3	10.3	9.7	16.4	12.5	14.7
Only on certain occasion	26.3	64.7	44.4	57.4	56.4	57.0	49.3	58.9	53.5
never	5.3	0.0	2.8	9.3	20.5	14.0	8.2	14.3	10.9
Total	100	100	100	100	100	100	100	100	100

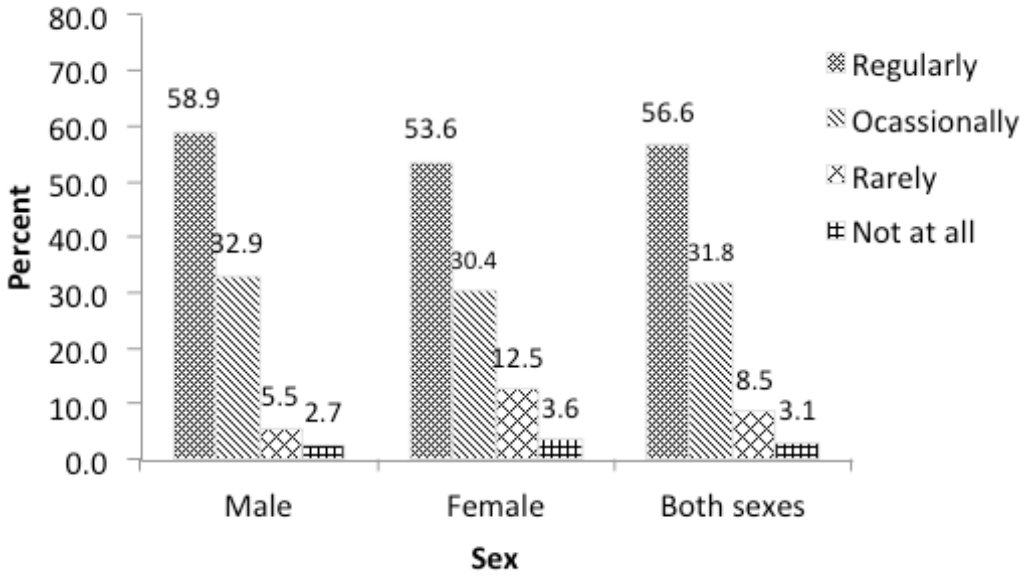
Abbreviations: M=Male, F=Female & B=Both

The majority of elderly respondents (6 out of 10) had accounted reciting prayers/mantras several times a day. However, only 15 per cent of them accounted they practice meditation (combined percentages of 'several times a day,' 'once a day,' 'few times in a week,' and 'only on certain occasion'). The meditation was the least practised spiritual activity. More than half (35.5%) of elderly respondents visited temples and places of religious significance on certain occasions.

Consideration of ley-ju-drey (the cause and effect)

As a part of spirituality aspect, the question: "Do you consider *karma* (*ley-ju-drey*) in the course of your life?" was asked to elderly respondents. In general, the majority of them expressed being mindful of their actions and consequences. As shown in figure 5.7, more than half (56.6%, n=73) of elderly respondents stated they would consider *karma* or *ley-je-drey* 'regularly' and 32 per cent (n=41) of them said they would consider it 'occasionally'. Only three per cent (n=4) did not at all consider *karma or ley-ju-drey* in their daily course of life. Slightly higher proportion of elderly males (regularly and occasionally combined) reported they adhere to l*ey-ju-drey* than their female correlatives.

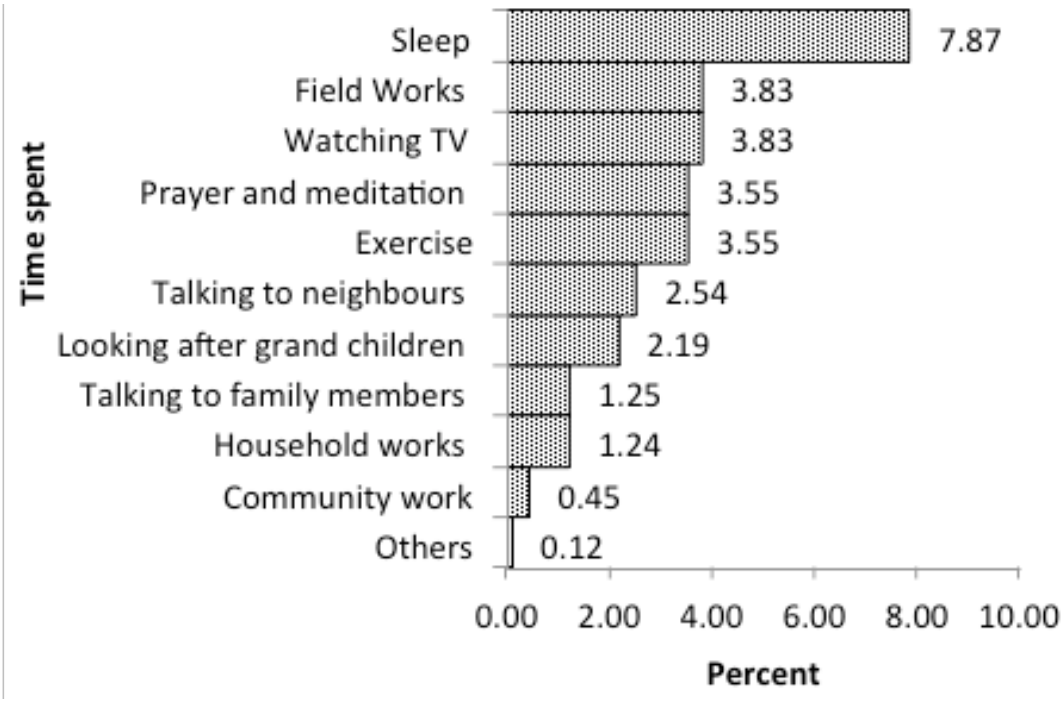
Figure–5.7: Percentage distribution of elderly respondents according to their perception on *ley-ju-drey*



Time Use

One parameter that proved very useful to understand the situation of elderly respondents was the time use. Elderly respondents were asked how they spend their time on a range of daily activities: household works; field works; looking after grandchildren; prayer and meditation; watching television; talking to family members; talking to neighbours; doing exercise; sleeping, and community works. The mean aggregated time-use reported by them from the given activities is illustrated in figure 5.8. Besides sleeping (7 hours 52 minutes on average), which made up one-third of the total time, the three other most common activities among elderly respondents were field works, watching TV, and prayer and meditation. Spending their time on watching television and on prayers and meditation were indicative of favourable situation they were in. However, many of them reporting they spend most of their time on carrying out hard labour on the farms do not bode well our GNH policy. Elderly persons at their prime ages are expected to spend their time on prayers and leisure rather than on physical labour.

Figure–5.8: Distribution of elderly respondents' aggregate time use on different activities



According to GNH survey 2015, an elderly person in the age group 60-69 typically spends 8 hours 5 minutes on sleep. Our result on time use almost conformed to that of 2015 GNH Survey. Further analyses were done to find out whether a number of hours spent on sleep, field works, watching TV and engagement in prayer and meditation [four most common activities] had any relationship with ageing. To determine this, elderly respondents were categorised under four groups: 60-69 years (37.2%, n=48), 70-79 years (39.5%, n=51), 80-89 years (19.4%, n=25) and 90-99 years (3.8% n=5).

Figure 5.9 shows that time they spent on different activities varied with age groups. Elderly people falling within age 60-69 years spent an average 7 hours 4 minutes, while those in the age group 70-79 years spent almost 9 hours on different activities. With the 80-89 years age cohort, average time spent on various activities dropped to 6 hours 9 minutes while the average time spent on sleep increased to 8 hours 2 minutes hours. This was the case among those respondents above 90 years.

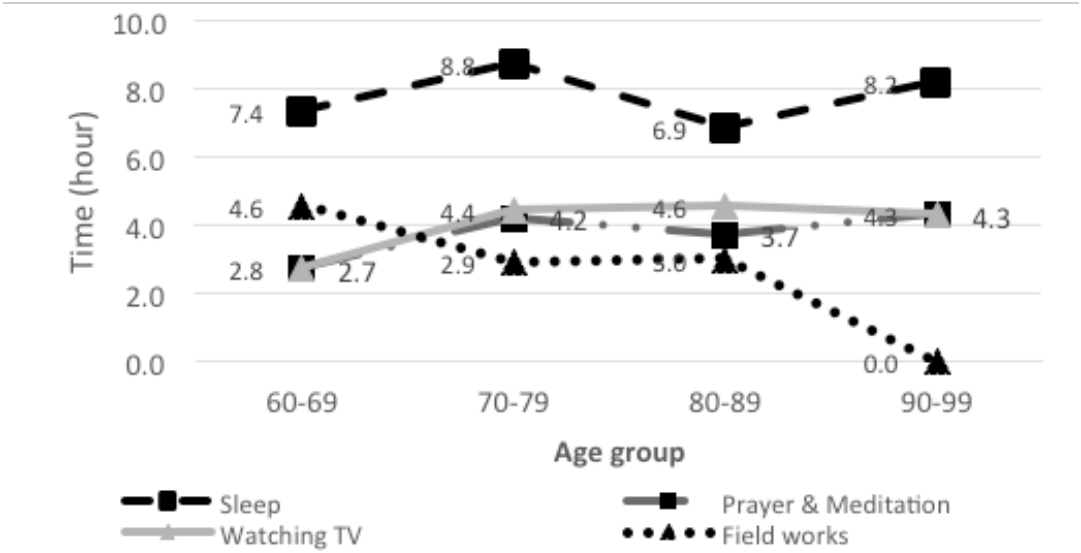
More elderly females spent longer time on sleep than their male equivalents. On average, elderly females spent 8 hours 56 minutes on sleep against 7 hours 6 minutes spent on the same by elderly males. According to the GNH Survey, 2015 as well, more elderly females spent longer time on sleep than elderly males albeit the difference was small. The GNH survey found the presence of correlation between sleeping time and age (CBS-GNH Research, 2016).

It is hard to think about elderly people spending their time on carrying out field works (labour), but upon deeper analysis, it was found that the proportion of elderly respondents who devoted maximum time (4 hours 6 minutes) on field works belonged to the age group of 60-69 years. Many of them (in the age group 60-69) could have been comparatively physically strong enough and thus active. Time spent on field works generally decreased with the rise in age. The youngest age cohort of elderly respondents spent maximum time on field works while the oldest age cohort (90+years) spent minimum time in carrying out field works. The average time spent on the field works was 3 hours 55 minutes among the oldest age cohort. Comparatively more elderly males spent longer time (4 hours 15 minutes) in doing field works than their female equals. The latter spent 3 hours and 38 minutes in carrying out field labour.

Elderly people seem to be spending their daily time watching television quite often. Elderly females spent longer time watching television (3 hours: 55 minutes) compared to elderly male respondents (3 hours 38 minutes). There was no major difference among the age groups in terms of the amount of time spent on watching television except that the youngest age cohort (60-69) spent slightly shorter time watching television.

With regard to time spent on prayers and meditation, not much gender difference was. This indicates that there was no gender influence on the spiritual practice. The elderly males spent 3 hours 32 minutes while their female counterpart spent 3 hours 34 minutes on the spiritual practices. No major time difference was observed among elderly respondents in different age groups when it comes to prayers and meditation.

Figure–5.9: Average time spent by elderly respondent on different activities, by age group



Community Vitality

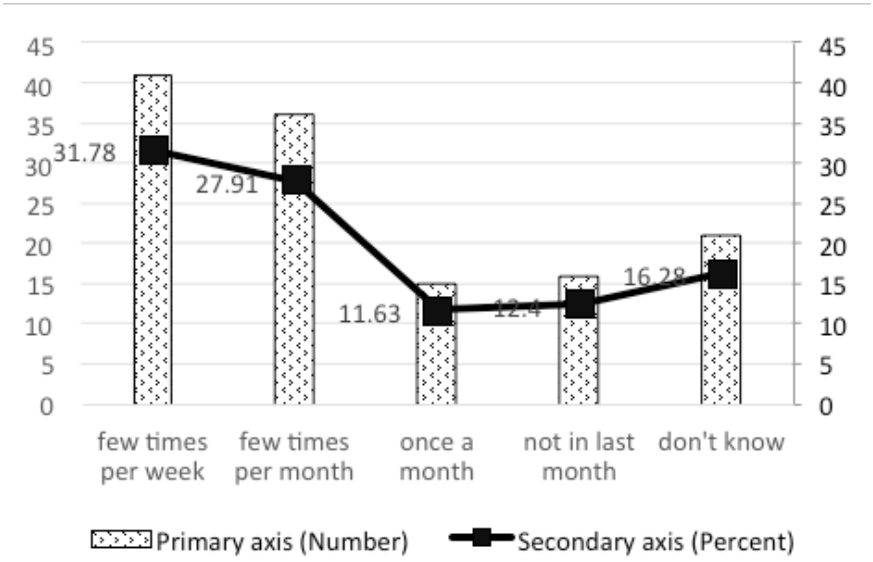
The proportion of elderly respondents who volunteered for community works was fairly low. Less than 10 per cent (9.3%, n=12) reported affirmatively about their participation in community works while 90 per cent (90.7%, n=117) of them reported negatively. Within the 9.3 per cent of those elderly respondents who had volunteered for community work, the average number of days volunteered to conduct range of social activities (such as construction and renovation of religious establishments, and ritual performances, including death rites, fund raising, etc.) was 7.6 days (SD =11.54, Median= 7.25) during the past twelve months preceding the survey.

To a question on whether elderly respondents felt a sense of belonging to their local community, the majority (45%, n=58) of them responded either 'somewhat strong' or 'very strong' (data not shown). Nevertheless, 30.23% (n=39) of them had weak sense of community belongingness. About 25 per cent (n=32) of them had reported they 'don't know'.

One indicator of community vitality was the frequency of social interaction among individuals or families. Elderly respondents were asked how often they socialised with their neighbours in the past one month.

About 32 per cent reported that they socialised with the neighbours few times a week. The percentage of social interaction on different time scales is illustrated in the figure 5.10.

Figure–5.10: Percentage distribution of social interaction at different time scales among respondents

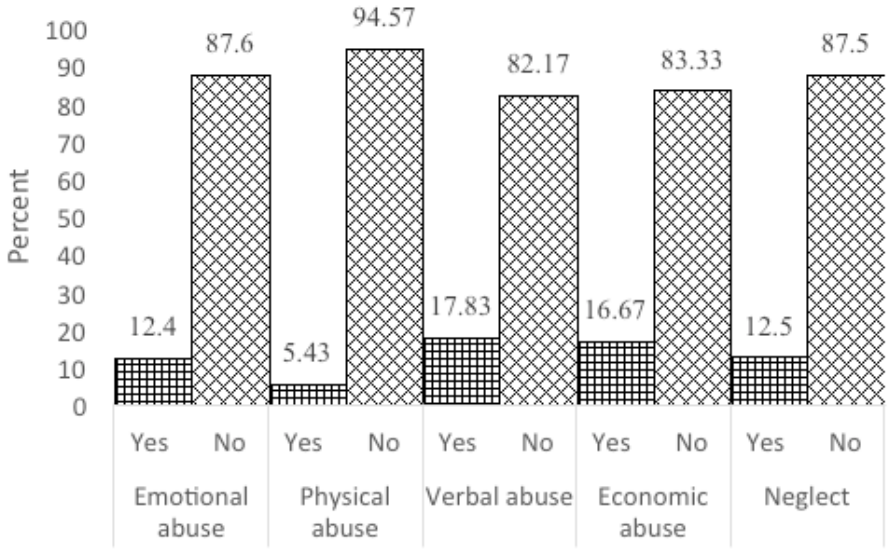


Elderly Abuse

Elderly respondents were asked if they had experienced any kind of abuse: verbal, emotional, economic, physical, and neglect during the past twelve months preceding the survey. The majority of them reported they did not experience any kind of abuse. Figure 5.11 shows the percentage of elderly respondents who reported they experienced some form of abuse.

Although the majority of elderly respondents felt that abuse was not an issue with them, 18 per cent (n=23) of them had experienced 'verbal abuse'; 17 per cent had experienced 'economic abuse,' and slightly over 12 per cent (n=15) had faced 'neglect'. These figures show the presence of some kind of elderly abuse.

Figure–5.11: Percentage distribution of elderly respondents and reported abuses



Family Relationships

A number of indicators could be drawn from the responses elderly respondents have made to various statements pertaining to their relationships with the family (table 5.17). The majority (71%) of them agreed with the statement: 'My family is a source of comfort to me'. About 67 per cent of them agreed with the statement: 'Members of the family care for each other'.

On the contrary, the majority of elderly respondents disagreed on some statements. Close to 65 per cent of them disagreed with the statement: 'I wish I was not part of my family'; 69 per cent of them disagreed with the statement: 'I feel like a stranger in my family," and 63 per cent disagreed with the statement: 'Members of my family argue too much'. These results indicate the bond (*tha dhamtsi*) between parent and children or family members still holds strong.

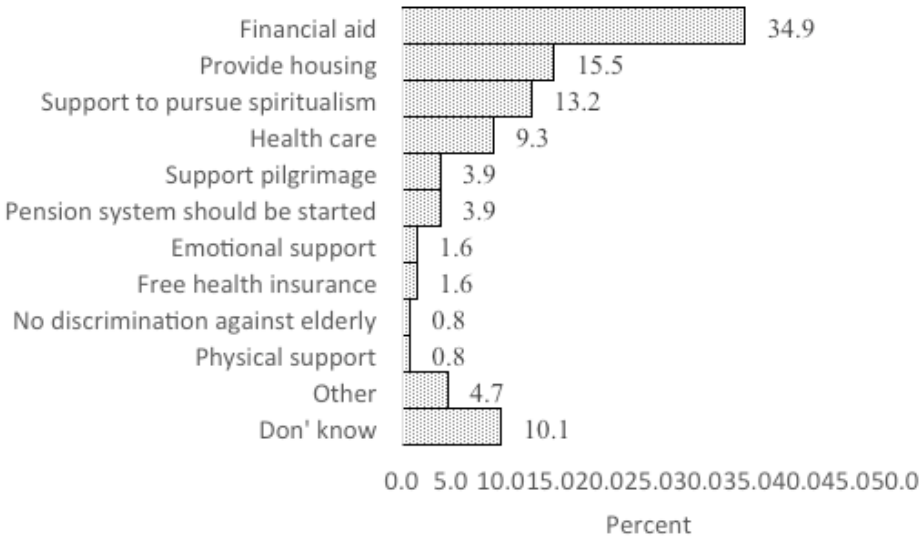
Table–5.17: Elderly respondents' perceptions on family relationships (%)

Statements	Disagree	Neutral	Agree	Not applicable	Don't know
Members of family care for each other	9.1	8.3	66.9	10.7	5.0
I wish I was not part of my family	64.8	8.2	10.7	10.7	5.7
Members of my family argue too much	63.1	8.2	12.3	11.5	4.9
I feel like stranger in my family	68.9	5.7	10.7	9.0	5.7
There is lot of understanding in my family	13.9	4.1	67.2	9.8	4.9
My family is source of comfort to me	11.4	3.3	71.5	8.1	5.7

Elderly People's Needs and Support

In order to assess elderly respondents' needs, they were asked the question: 'What are your basic needs at this age'. The list of basic needs is presented in figure 5.12. Among the basic needs, 35 per cent of elderly respondents needed 'financial aid' followed by housing (15.5%), support to pursue spiritualism (13.2%), and health care (9.3%).

Figure–5.12: Elderly respondents' needs and expectation of support (%)



Discussions and Conclusion

Overall, the data showed rather an incomplete picture of elderly people's situation. This was due to small sample size and data representativeness. In view of this, a more representative and comprehensive study using probability-sampling technique needs to be considered in the future. This study provides the basic data on demographic, socioeconomic, health, and well-being of the selected elderly people in Bhutan, a subpopulation which is expected to grow over the years and is likely to need more policy attention. A majority of elderly people were far less educated and more likely to rely on children for support.

The primary source of income for elderly respondents was remittance from their children. This accounted for about 41 per cent. A very low percentage of elderly respondents (1.6%) had access to formal social security schemes. Moreover, 77 per cent of them did not have any savings. About 35 per cent of elderly respondents expressed the need for financial help or support. This suggested the importance of improving elderly citizens' access to formal social security schemes or pensions or other forms of financial support schemes like universal or means-tested social pensions. Initiating or improving such social security schemes could at least help the neediest elderly citizens meet their basic material needs.

Many elderly citizens are increasingly forced to live alone for several reasons. Although 86 per cent of elderly respondents reported having children, just 54 per cent of them actually lived with their children. Many of them were living alone or own their own. The reasons given them were: (1) their children have migrated and lived far from them; (2) most of their children face difficulty managing themselves and their families; and (3) Many adult children do not care and support them. This emerging issue is likely to have far-reaching implication on the lives of elderly people. This issue merits an urgent policy attention.

Poor health of elderly people is another important dimension bearing on their lives in the receding period. Just 16 per cent of elderly respondents reported their health being good compared to 44 per cent of them reporting to be poor in health. In general, more elderly males were more likely to be in good health. The female disadvantage in health was observed from the self-rated health status. There is not only the need to promote good health among elderly people but also to improve elderly

people's access to health care services. This is on account of elderly people's vulnerability to various physical and mental ailments. The gender inclusiveness in terms of access to healthcare services must be considered. As one gets older, performing daily activities is expected to become a challenge. It was found that one of the leading difficulties elderly people face is not being able to move or walk. This will have implications on elderly people's access to healthcare and other services.

The present data may not give the complete picture of elderly citizens' propensity towards suicidal thought, attempt, and action. However, data revealed that 6 per cent of elderly respondents had experienced suicidal ideation. Suicide issue among younger people is getting policy attention; the same issue among elderly people warrants policy attention as well. Among elderly respondents who had experienced suicidal thoughts and attempts, 36 per cent reported some kind of mental or emotional ailments. Mental health disorders among elderly people may have long-term implications on the delivery of healthcare services.

A Higher percentage of elderly respondents reported being happy (91%). However, 9 per cent of them were not happy. Improving conditions for those elderly people who are not happy to pursue happiness is one area that may need to be prioritised. Just over 9 per cent of elderly respondents reported they participated in community works and events. A little over 31 per cent reported they socialised with neighbours few times a week. Policy and programmes aiming to preserve and promote social capital stock in the country must be put in place on very urgent basis.

Apparently, the sense of responsibility towards elderly people was observed to be present among children in general. Children and grandchildren should continue to play a crucial role in providing the financial and material support to the aged parents. However, wherever families cannot shoulder the responsibility for the aged parents or for those elderly people who do not have families, it is crucial to initiate formal old age care and support welfare schemes.

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CHAPTER VI

COMMON MORBIDITIES AMONG ELDERLY BHUTANESE PEOPLE[1]

Garul Dhoj Bhujel[2]

Abstract

The objective of this study was to find the common morbidity among the elderly population in Bhutan. The data sourced from HMIS and mined from Annual Health Bulletins revealed top five morbidities prevalent among the elderly population in Bhutan. Other than showing the pattern and trend, data did not allow inferential and causal analyses. The common cold, other musculoskeletal disorders, skin diseases, peptic ulcer syndrome, hypertension and hypertension were five most common diseases of old age with common old in the first rank and hypertension in the fifth. Masculo-skeletal disorders and hypertension were increasing steadily between 2011 and 2016 while other three diseases were increasing with the same period but fluctuating in some years. Diabetes and other digestive diseases were other health problems becoming common among elderly people.

Introduction

Ageing is a natural phenomenon which changes the dynamic of demography. In the 21st century, it has implications for all aspects of society such as economic, social, and healthcare (World Population Ageing 2013). One estimate found that in next few decades many developed nations will have the proportion of population above age 65 doubled (Glass, de Leon and Marottoli, 1999).

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[1] This chapter came to the present form with lots of input from Professor John Enrique Mata, Associate Professor at the College of Osteopathic Medicine of the Pacific-Northwest, Western University of Health Sciences, USA. Lham Dorji, Chief Research Officer at NSB guided the research. HMIS of Ministry of Health provided data of all 20 Dzongkhags. I would like to thank all of them for their contributions.

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There is, in fact, no universal definition of old age. It differs from one context to another. The dictionary defines old age as 'the latter part of normal life'. The United Nation regards a person as old if he or she has attained the age of 60. Many developing countries define old age not by years, but by new roles, loss of previous roles, or inability to make an active contribution to society. Old age is perceived and understood in different ways, often with cultural variations (Sherlock, 2000). Definition of old age varies with physical appearance, key life events (for example retirement or some other form of disengagement), or social roles (grand-parenthood, or ceremonial duties) (Midwinter, 1991). In Africa, the World Health Organisation (WHO) has set 50 years as the beginning of old age. Usually developed nations have a higher age limit (to be considered as an old age) and in poorer countries, people at lower age are treated as elderly people.

A population is said to be ageing if there is a higher percentage of elderly people compared to younger ones. According to the United Nation Fund for Population (UNFPA, 2012), the life expectancy at birth has risen substantially across the world. In 2010-2015, the life expectancy was 78 years in developed regions and 68 years in the developing regions. It has been reported that by 2045-2050, newborns can expect to live up to 83 years in developed regions and 74 years in developing regions. UNFPA reports that life expectancy at birth is now 80 years for 33 countries as compared to 19 countries just half a decade ago. It has been estimated that many of the population in these countries can expect to live beyond the age of 80 years.

The world population is in fact ageing. Population ageing is faster in the developing countries, including those that have a large population of young people (UNFPA, 2012). The report shows that 15 countries have more than 10 million elderly and that seven of these countries are developing. It was projected that one in five will be 60 years old or more by 2050 as compared to one in nine persons today. This would mean there will be high consumption of medical services. B.G. Celler *et al.* had reported that the per-capita expenditure on health services in the UK in 1995 had increased by 278% in the age group 65-74, 563% in the age group 75-84 and 1034% for the age group over 85.

The countries like Japan, UK, France and Germany, have the more elderly population (coolgeography.co.uk, 2017). Japan's elderly population

constitutes about 30 per cent of its total population. It is expected that by 2050, 64 countries will join Japan with an elderly population of more than 30 per cent.

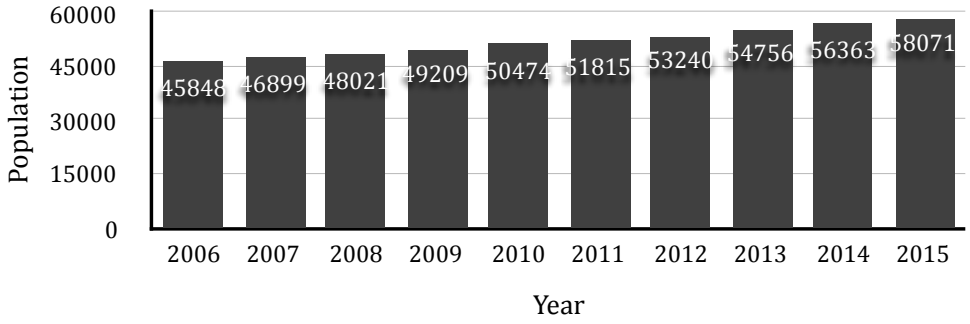
The overall increase in the population age has been associated with the decline in fertility rate and increase in survival rate among elderly people (Khan *et al*., 2011). Development in the field of medical science is often seen as a victory in the history of mankind, as it has helped in prolonging human's life (WHO, 2004). Additionally, the population ageing had been correlated with improved access to better economic possibilities with which elderly people could access better nutrition, sanitation facilities, advanced medical health care, and education. On the down side, population ageing has presented the countries in the world many social, economic, and cultural challenges. The old age morbidity and co-morbidity have increased the healthcare expenditure (UNFPA and HelpAge International, 2012).

Ageing in the Bhutanese Context

In general, elderly people in the Bhutanese society enjoy the important social status and regarded with high esteem. They are considered to possess abundant knowledge, wisdom and experience and consulted when important family and community decisions are made. Nevertheless, with modernisation, social roles and status of some elderly people have started to change. Some children who migrate to urban areas looking for better social and economic opportunities have failed to take up the responsibility of their aged parents' welfare.

Bhutan's elderly population (age 60+) had been projected to have been increasing between 2005 (45,848) and 2015 (projected 58,071). This is shown in figure 6.1. The increase in elderly population could be attributed to the improvement in the health sector and living standard (improved socioeconomic conditions). The country has made a tremendous improvement in the healthcare system, which has led to an increase in life expectancy at birth from only 32.4 years in 1961 to 69.5 years in 2014 (AHB, 2017). However, the country's unprecedented progress in human development is not free obstacles. One challenge now is ever increasing trend of morbidity and comorbidity among elderly people.

Figure-6.1: Increasing Trend of Old Age Population



Note: People age 60 years and above considered for this chart

Some political parties had announced about addressing the issues faced by the elderly population. In 2008, the previous government had promised to initiate old age homes for elderly people. It was not clear of what kind of residential care and support it was to be. But, many people felt such scheme would led to the government taking over the family's responsibility for the welfare of elderly people. It could have contradicted Article 9 (Principle of State, section 19) of the Constitution, which states that;

> "The State shall endeavour to promote those conditions that are conducive to co-operation in community life and the integrity of the extended family structure".

This could have led to a catch-22 policy situation, wherein the government that came into a power was willing to initiate schemes to address the emerging issue faced by elderly population, but there was a possibility of such initiatives contradicting the law. Similarly, in 2013, the present government in its manifesto had pledged the following to address the issue of elderly population;

- Senior citizens' homes will be built along monasteries;
- For citizens above the age of 65, we will sponsor the annual pilgrimage to Bodhgaya, India;
- Low cost spectacles to elderly will be provided;

- An allowance for senior citizens above 70 years of age will be instituted;
- Special training will be given to health workers to take care of the elderly; and
- Designated seats in public transport will be provided for senior citizens, pregnant women, mothers with toddlers and people with special needs.

The present government has introduced priority seats in city buses and hospitals. JDWNRH has introduced designated chambers for senior citizens, pregnant women, mothers with toddlers, and people with special needs. It is good that the government had started to pay attention to special needs of elderly people, but more needs to be done. One area the government may have to give the priority is the health issues among elderly people. For the government to prioritise policies and programmes, it important know what are the actual problems and their levels. Keeping these in view, this chapter focussed on determining the main morbidities affecting elderly population and their trends. It is hoped this might at least provide shed some light to the policy makers and implementors the areas of elderly people's health that are in need of attention.

Literature Review

With ageing, our body tends to become weak and delicate. The key to optimum health in later years is a balanced approach that includes access to medication, nutrition and water, exercise, education and community support. Early recognition of risk factors and timely intervention can prevent many of the common diseases among elderly people. This is well supported by Sharon Brangman, MD, AGSF, spokeswoman for the American Geriatrics Society, who said: "The more you do in middle age to prepare yourself for successful ageing, the better." Most current works of literature on active ageing suggests the need for early intervention with appropriate medical, psychological and social therapies to reduce the gradual transition from healthy, energetic group to sick and frail group (B.G.Celler, *et al.* 1995). It is widely accepted that making healthy lifestyle choices greatly improves the likelihood of healthy ageing and prevents the onset of disease among the aged (Madeline and Vann, 2017).

The prevention and control of health problems earlier in life necessitate a multifaceted approach incorporating active collaboration of health, social welfare, rural/urban development, and legal sectors (Shrivastava *et al.*, 2009). Establishment of a comprehensive policy that includes these factors is essential to building a robust community based geriatric health-care programmes.

To reduce the incidence of morbidity among the elderly population, it is important that a track record of elderly population's health status is maintained. Kernisan (2016) in her finding states that properly maintaining and using a personal health record (PHR), will go a long way to ensuring that one's loved ones get better and safer medical care. It could help to avoid potentially life-threatening medical mishaps. She suggests that the key is to learn what medical information is to updated in this PHR, and how to use it effectively for care coordination. Madeline and Vann, *et al.*, 2017) suggests that awareness and documentation of common chronic conditions can be beneficial to monitor these common chronic conditions. The use of PHR is a simple technology that can be easily adopted compared to more advanced technologies being introduced to the health care industry that will require a greater effort and infrastructure before it is widely accepted (Kernisan, 2016).

One of the most crucial needs of elderly people, apart from access to medical care, is family care. To balance behavioural changes, medications, and symptom relief strategies, elderly people need knowledge about what to do, the belief that they can achieve success, and family to help (Bennett and Flaherty-Robb, 2003). This gap between chronic health conditions and lack of preventive strategies is a major policy deficit that has been difficult to manage. Effective implementation of health policies and programmes for elderly people with the help of gerontologists could provide culturally sensitive options. Jeanne Wei of the Reynolds Institute on Ageing at the University of Arkansas for Medical Sciences said that a geriatrician—a doctor who specialises in the health concerns of ageing, can help elderly people to learn how to live better with any chronic diseases.

To understand the pattern of the disease among the elderly population, there is a need for evidence-based health policy. This would examine the widest array of available research and information to identify actionable recommendations that improve the cost and quality of care (Health

Policy Institute, 2015). The policy choices are often made without adequate knowledge from the full range of available effectiveness research, and often, policy research treats health problems narrowly, ignoring evidence that reveals effective interventions (*ibid*, 2015). Though ageing has impacts on many sectors like family income, economics, and community dynamics, our analysis is limited to determining common morbidities among the elderly population in Bhutan and the yearly trends.

Approach and Limitation

I used explorative approach to data analysis rather than hypothesis-testing or inferential analysis. I have considered an elderly person as some who have attained the age of 55 years and above. The reason for doing this was because there is no agreed definition of old age in Bhutan. The Ministry of Health (prior to 2017) has considered a person of age 65 years and above as an elderly person while from 2017 onwards MoH has started to treat some attaining the age of 60 years and above as an elderly person. Although one can observe the records of many diseases affecting elderly people, I have focussed on top five morbidities. A simple analysis was done by gender, and the yearly trend was determined for the year 2011 to 2016. Data for 2017 was not examined considering that data was only for mid-2017.

The Recent development of recording system in primary health care under Health Management and Information System (HMIS) has generated a huge amount of data that could be used for epidemiological studies. This data could have been used to estimate the prevalence of many chronic diseases recorded in all three levels of health care system including differences between genders, between young and elderly as well as district wise. Not much analysis could be carried out due to time constraint, as the study was required to be completed within a short span of time to fulfil Annual Performance Agreement (APA). I learnt that the study was delayed by seven months, as the core research staff were engaged in the preparation of Population and Housing Census of Bhutan (PHCB), 2017. The study coincided with the actual conduct of PHCB, 2017. Thus the research staff were under severe pressure and had little time for this study. I was instructed to just carry out simple analysis though data provided the scope for much deeper analysis.

Moreover, data received did not have a singular age, which could otherwise have helped me segregate morbidity patterns within the group that the study as a whole considers as elderly people (60 years and above). Therefore, the analysis of top-five morbidities was done using age 65 and above as the onset of old age. Since the definition of old age has changed from 2016 onwards, I have not included 2016 part in trend analysis of top five old age morbidities. However, I have included a separate analysis using data of 2016. 50 years and above as an ageing population in Bhutan for this paper. The data received from HMIS does not segregate between male and female, which was addressed by the data mined from AHB.

Findings

The data received from HMIS and mined from AHB for the period 2011 to 2017 shows that the five most common disease among the elderly in Bhutan are hypertension, common cold, peptic ulcer syndrome, skin diseases (two diseases) and musculoskeletal disorders (Figure 6.2). The other diseases that are common among the elderly population are diabetes, other nervous including peripheral disorders, other eye disorders, acute pharyngitis/tonsillitis, and other respiratory and nose diseases.

Figure-6.2:Trend of top five morbidities among elderly Bhutanese population who sought healthcare services

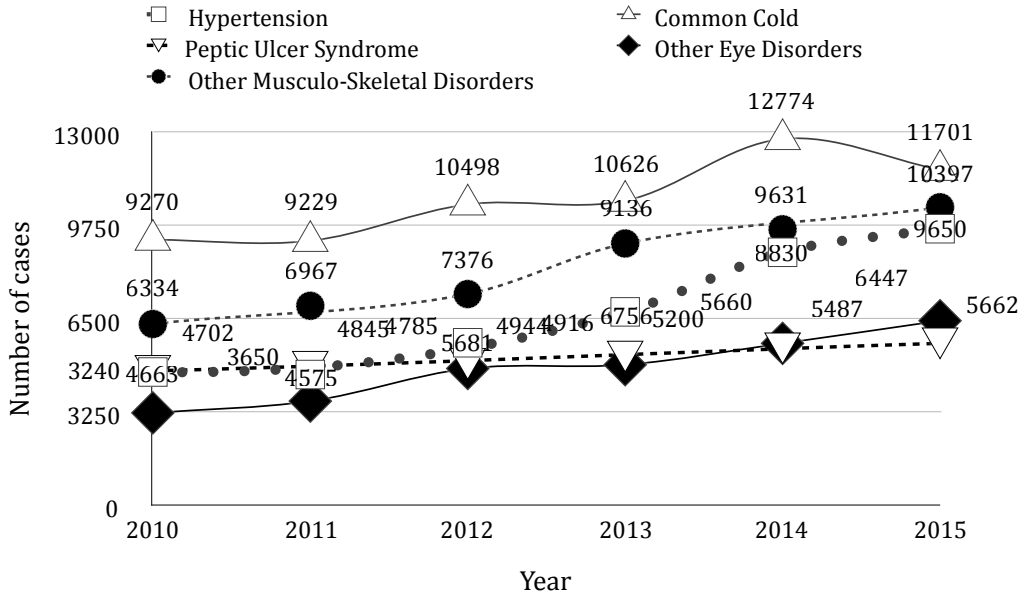
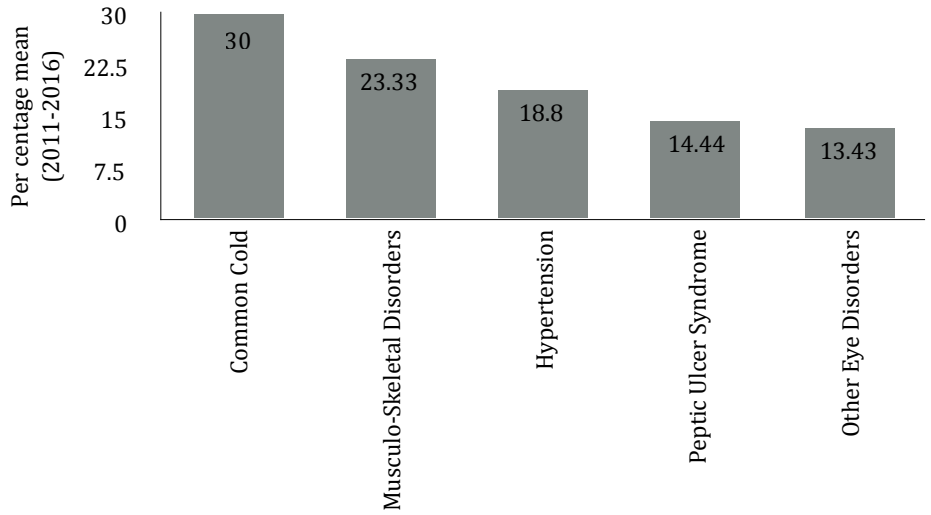


Figure 6.3 shows percentage means of elderly persons who visited health facilities across the country between 2011 and 2016 and were diagnosed with a medical condition. The common cold has the highest percentage mean (mean of six years) indicating it was the most common disease among elderly people. The musculoskeletal disorders ranked the next and hypertension the lowest among top-five morbidities.

Figure-6.3: Percentage mean of top five diagnoses among elderly persons who sought healthcare services between 2011 and 2016



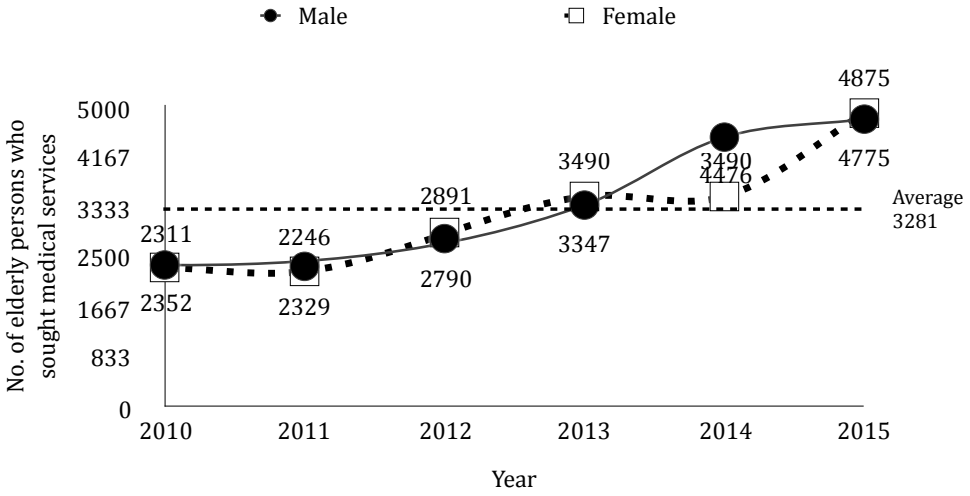
Hypertension among Elderly Women Seeking Healthcare Services

Hypertension is more common amongst the Bhutanese elderly women as compared to elderly men. Figure 6.4 shows the comparison the number of cases registered by the hospitals and BHUs in Bhutan.

A study done by August and Oparil (1999) concludes that after 59 years of age, hypertension is more prevalent among women than among men. Further, Staessen, *et al.* concludes there is a fourfold higher prevalence of hypertension in postmenopausal women than in premenopausal women (Staessen et al., 1989). Risk factors for the development of hypertension are well established and include overweight or obesity, lack of physical activity and poor diet (Forman, *et al.*, 2009).

Data collected by the HMIS provides insight into the possible reason for increases in diseases related to diet. There has been a steady increase in the percentage of the population suffering from other digestive diseases, increases in percentages of the population suffering from diabetes (even with increased surveillance), and increases in musculoskeletal diseases.

Figure-6.4: Comparison of hypertension between males and females

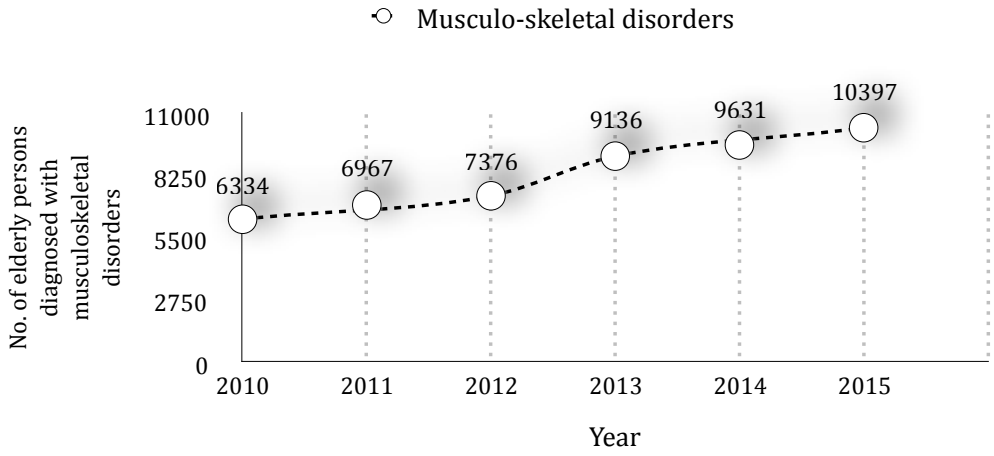


Trend of Musculoskeletal Disorders

The number of elderly people diagnosed with a musculoskeletal disorder is increasing on a yearly basis. With increasing number of the elderly, there is also increase in a total number of morbidity resulting from Musculoskeletal Disorder.

Figure 6.5 shows the increasing trend of elderly people who were diagnosed with the musculoskeletal disorder from 2011 onwards. As mentioned above, the steady increase in musculoskeletal disorders is trending with other increases in health related problems associated with diet and exercise in western culture. The musculoskeletal disease among elderly people was rising fast as indicated by 2017 figure. For 2017, data was for mid-year only and yet the number as exceeded that of the previous years'.

Figure-6.5: Increasing trend of Musculoskeletal Disorders



This finding is supported by Wolff, Starfield, and Anderson, 2002, which says that musculoskeletal disorders are common problems affecting the elderly. Musculoskeletal disorders are often related to age; with osteoarthritis a common manifestation within ageing populations. In addition, with increasing age, our body shows increased bone fragility, loss of cartilage resilience, reduced ligament elasticity, loss of muscular strength, and fat redistribution decreasing the ability of the tissues to carry out their normal functions (AJ, JA and Pathol, 2007).

Peptic Ulcer Syndrome among Elderly People in Bhutan

There has been no study done to understand what causes peptic ulcer syndrome among elderly people in Bhutan. It can be assumed that the greater use of aspirin and non-steroidal anti-inflammatory drugs could be one of the many reasons for it. Gregory and Lucy (2011) in their journal states that excessive alcohol intake and age are the other two factors that could be led to peptic ulcer syndrome. Since alcohol is used for every occasion in Bhutan, this could be one of the reasons for increasing diagnoses of peptic ulcer syndrome. Figure 6.6 shows increasing trend between 2011 and 2016 peaking in 2014.There has been no study done to understand what causes peptic ulcer syndrome among elderly people in Bhutan. It can be assumed that the greater use of aspirin and non-steroidal anti-inflammatory drugs could be one of the many reasons for it. Gregory and Lucy (2011) in their journal states that excessive alcohol intake and age are the other two factors that could be led to peptic ulcer syndrome. Since alcohol is used for every occasion in Bhutan, this could

be one of the reasons for increasing diagnoses of peptic ulcer syndrome. Figure 6.6 shows increasing trend between 2011 and 2016 peaking in 2014.

The other reason why the number of elderly with peptic ulcer syndrome continues to grow in Bhutan has also to do with the standard of living. Until 2008, the poverty rate in Bhutan was 23.2%. This section of the population could have been devoid of a clean source of clean water. It could have resulted in transmission of Helicobacter Pylori (H. Pylori), a type of bacteria that causes an infection in the stomach. It may have been spread by unclean goods and water, but no research or study has been done to ascertain this claim. But it is very evident that H. pylori causes peptic ulcers and can also cause stomach cancer.

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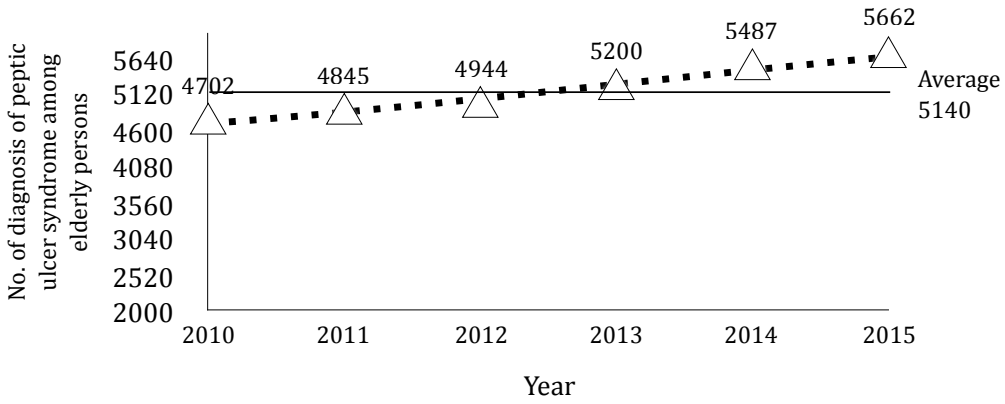
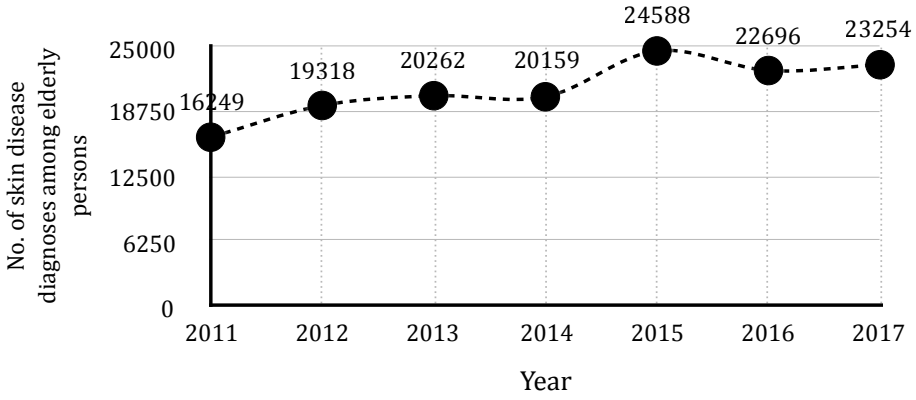
Figure 6.6: Peptic Ulcer Syndrome among elderly persons who visited health facilities



Skin Diseases are Common among Elderly Persons

Skin disease is a common and inevitable consequence of ageing. With the elderly population on the rise, skin disease is common among the Bhutanese elderly and consequently growing into the population. The figure 6.7, shows that in 2011 the number of elderly with skin diseases was 16249 as compared to 23, 254 in 2017.

Figure-6.7: Skin Disorders among elderly persons who sought healthcare services



A clinical study done by (Smith and Leggat, 2005) found that elderly people are vulnerable to a wide variety of dermatological conditions due to degenerative and metabolic changes occurring throughout the skin layers. Jindal, (Jindal et al., 2016) in their journals, say there is a high prevalence of infections and infestations among the elderly population. This reflects the decrease in immunological functions of skin in elderly persons associated with a decrease in personal care. The journal also reports that fungal infections were the most common infections seen in elderly patients.

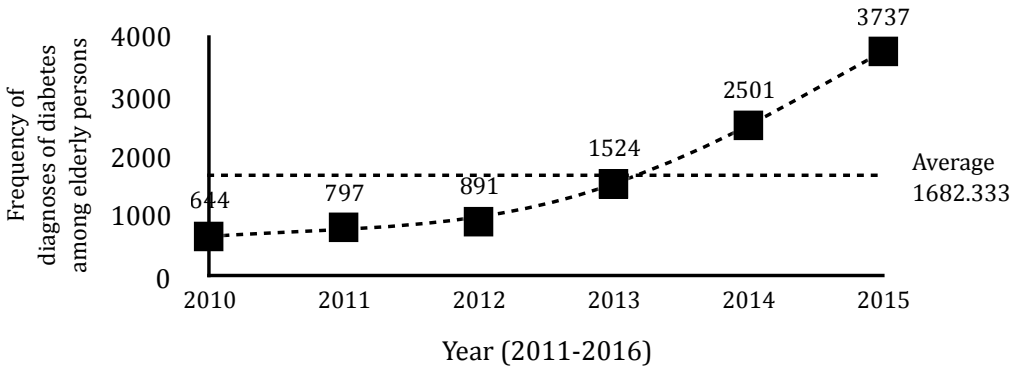
Detecting Diabetes is now Hassle-Free

In 2011, the number of elderly people with diabetes was 2,095, but from 2014 onwards we can see the number of elderly people with diabetes jump to 6,709. This is almost 300% increase in the total number of elderly with diabetes. The increase in a number of diabetic patient in 2014 and 2015 can be attributed to the implementation of the 10-protocol package of essential non-communicable diseases, where all the patients

above 18 years are being screened. The other reason for the increase in diabetic patients is due to awareness and advocacy programme carried out by the Ministry of Health. However, with increasing numbers of cases and increasing cases of related diseases mentioned above suggest that diligence in the monitoring of diabetes cases is warranted.

The figure 6.8, below shows how the implementation of the 10-protocol package of essential non-communicable diseases and awareness and advocacy programme helped in detecting diabetic among elderly people.

Figure 6.8: Elderly Population detected with diabetes in Bhutan (2011-2016)



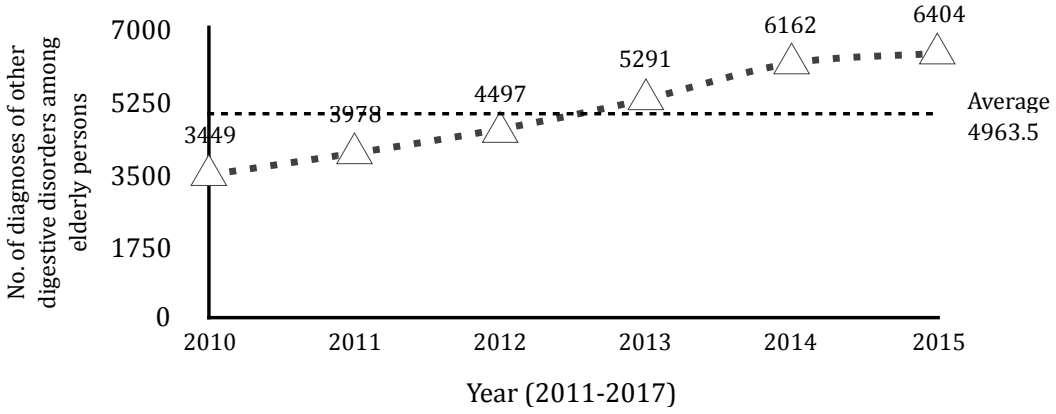
Other Diseases of the Digestive System diagnosed among elderly persons

A study done by Brenda Conaway says that nearly 40% of elderly adults have one or more age-related digestive symptom each year (Conaway, 2017). The data mined from AHB reveals that there is growing number of elderly with other diseases of the digestive system. We can see from the figure 6.9, that there is a gradual increase in the number of elderly people with other diseases of the digestive system. Coinciding with this increase are increases in diarrhoea and dysentery both diseases often related to access to potable water.

The increases in digestive systems are likely multifactorial and may include higher risk due to reduced activity, lack of exercise NSAID and medication use, etc. Stein et al. says that elderly tend to fall ill frequently and are advised bed rest by the doctors which can have a negative effect on their digestive system. The other reason as mentioned by him is that the continuous intake of medicine can make the elderly people

constipate, which can be severe as they age. The other digestive problem that many elderly people have are ulcers because they are often prescribed anti-inflammatory drugs to control pain from arthritis and other types of chronic pain. Regular use of NSAIDs increases the risk of stomach bleeding and ulcers.

Figure 6.9: Increasing number of other diseases of the digestive system diagnosed among elderly people



Morbidity Pattern in 2016

I looked further into 2016 data of the Health Management and Information System under the Ministry of Health. This data was used to examine 16 broad categories of morbidity prevalent among elderly people. This separate analysis had to be done because beginning 2016, HMIS has used a different method of age grouping (in the record). Until 2015, they have considered the following age groups: under 1 years, 1-4 years, 5-14 years, 15-49 years, 50-64 years and 65+ years. In 2016, a grouping of old age has been revised to consider the onset of ageing at 60, not 65. HMIS has a disease coding system which is different from the ICD-10 (International Classification of Diseases).

Table 6.1 presents the distribution of two groups of people who had availed medical/healthcare services from various health facilities across the country. In this dataset, records of the outpatients who had availed medical/healthcare services from the National Referral Hospital have been omitted. Two age groups considered for the analysis were: (1) adults in the age group 50-59 and (2) elderly adults in the age group 60 and

above. Diseases related to respiratory system were the most common morbidities among people in both 50-59 and 60+ age groups. Respiratory diseases represented 19.71 per cent of the total 16 major disorders affecting elderly people of age 60 and above. An almost similar percentage was observed in case of those adults in the age group 50-59, who will also soon enter the old age.

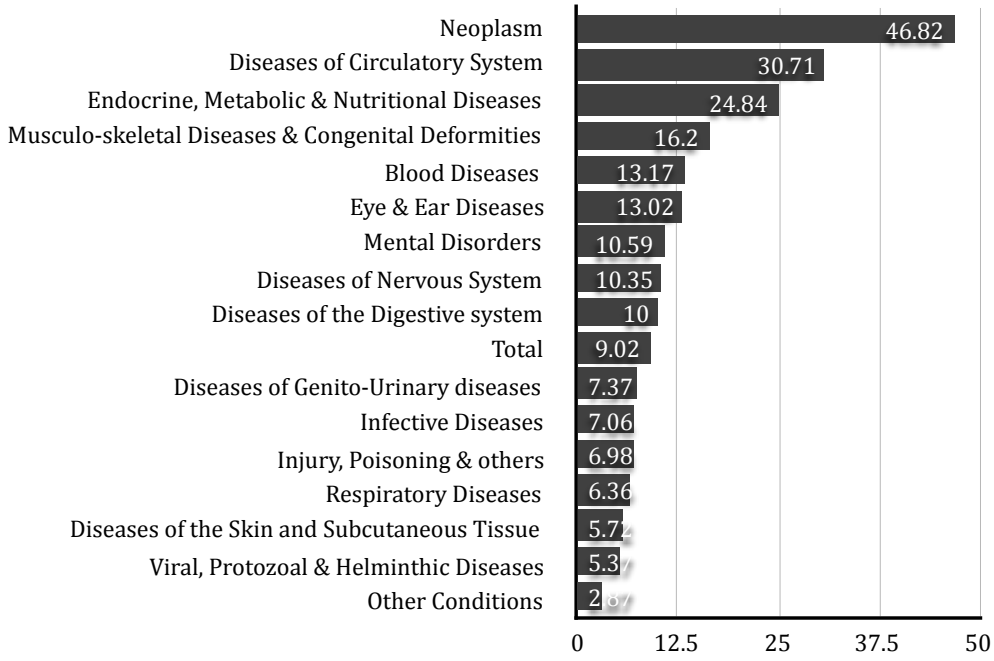
The other diseases with high prevalence were diseases of digestive system, diseases of the musculoskeletal system & congenital deformities, diseases of the circulatory system and eye & ear diseases (in order of prevalence). The difference in the prevalence of 16 broad categories of morbidity between people under two age groups (50-59 and 60+) was observed to be not so significant. The least common was diseases related to neoplasm and was almost three times more prevalent among elderly people in the age group 60 and above compared to those adults in the age group 50-59.

Table-6.1: Broad category of morbidity at national level by g two age groups, 2016

Diseases /HMIS Code	Age group	
	60+	50-59
Respiratory Diseases (J00-JZZ)	19.71	19.26
Diseases of the Digestive system(K00-KZZ)	17.34	17.99
Diseases of Musculo-skeletal system & Cogenital Deformities (M00-MZZ)	12.52	12.48
Eye & Ear Diseases (H10-H90)	10.04	7.59
Diseases of Circulatory System (I00-IZZ)	8.69	6.94
Diseases of the Skin and Subcutaneous Tissue (L00-LZZ)	8.10	8.80
Diseases of Nervous System (G00-GZZ)	5.11	5.37
Injury, Poisoning and certain other consequences of External Causes (T65,VO1, W00-W86, X00-XZZ & Y96-ZZZ)	4.28	5.66
Infective Diseases(A02-A77)	3.40	3.11
Endocrine, Metabolic & Nutritional Diseases (E10-EZZ)	2.95	3.03
Diseases of Genito-Urinary diseases (N30-NZZ)	2.73	3.72
Blood Diseases (D00-D55)	1.55	1.59
Other Conditions (YZZ-ZZZ)	1.52	1.98
Viral, Protozoal & Helminthic Diseases (B01-BAZ)	1.28	1.63
Mental Disorders (F03-FZZ)	0.47	0.73
Neoplasm (C15-CZZ)	0.31	0.12

When morbidities of elderly people were treated in relation to the overall morbidities for all ages, 46.82 per cent of neoplasm cases were among elderly people (age 60 and among) while 53.18 per cent of neoplasm cases were present among all other ages (under 1 to 64 years). Diseases of neoplasm were ranked lowest among all 16 groups of morbidity among elderly people when taking in absolute terms. However, when taken in the percentage of that particular morbidity among elderly people relative to g all age groups, neoplasm came up as the top-most. The other four topmost morbidities among elderly people (60 and above), when taken in relation to all other ages group, were a circulatory system, endocrine, metabolic and nutritional, musculo-skeletal-congenital, and blood diseases. Details are presented in figure 6.10.

Figure-6.10: Top-five morbidities among elderly people when taken in relation to total cases of each morbidity among all ages.



Slightly higher percentage of elderly females were recorded than males in most categories of disease. Overall, elderly women represented 50.7 per cent of the total. There was not a significant difference in terms of the prevalence of all 16 broad categories for two age groups as shown in table 6.2.

Table-6.2: Broad category of morbidity at national level by gender and two age groups, 2016 (percentage represent in brackets)

Diseases /HMIS Code	50-59 Years			60 + Yrs			Total (all ages)
	M	F	B	M	F	B	
Respiratory Diseases (J00-JZZ)	12996	12746	25742 (19.3)	13813 (9.7)	14135 (9.97)	27948 (19.7)	439579
Diseases of the Digestive system(K00-KZZ)	11899	12136	24035 (17.99)	11825 (8.24)	12763 (9.0)	24588 (17.3)	245915
Diseases of Musculo-skeletal system & Cogenital Deformities (M00-MZZ)	8316	8359	16675 (12.48)	8946 (6.31)	8799 (6.21)	17745 (12.5)	109533
Eye & Ear Diseases (H10-H90)	4698	5444	10142 (7.59)	6580 (4.64)	7656 (5.40)	14236 (10.0)	109312
Diseases of Circulatory System (I00-IZZ)	4447	4829	9276 (6.94)	6060 (4.27)	6264 (4.42)	12324 (8.69)	40127
Diseases of the Skin and Subcutaneous Tissue (L00-LZZ)	6232	5531	11763 (8.80)	6202 (4.37)	5289 (3.73)	11491 (8.10)	200910
Diseases of Nervous System (G00-GZZ)	3006	4176	7182 (5.37)	3177 (2.24)	4069 (2.87)	7246 (5.11)	69980
Injury, Poisoning and other consequences of External Causes (T65, W00-W86, X00-XZZ, Y96-ZZZ)	4616	2945	7561 (5.66)	3667 (2.59)	2402 (1.69)	6069 (4.28)	86915
Infective Diseases(A02-A77)	2026	2132	4158 (3.11)	2309 (1.63)	2514 (1.77)	4823 (3.40)	68338
Endocrine, Metabolic & Nutritional Diseases (E10-EZZ)	2007	2041	4048 (3.03)	1950 (1.38)	2235 (1.58)	4185 (2.95)	16849
Diseases of Genito-Urinary diseases (N30-NZZ)	1760	3208	4968 (3.72)	1720 (1.21)	2156 (1.52)	3876 (2.73)	52576
Blood Diseases (D00-D55)	904	1217	2121 (1.59)	1009 (0.71)	1182 (0.83)	2191 (1.55)	16638
Other Conditions (YZZ-ZZZ)	1223	1425	2648 (1.98)	1097 (0.77)	1053 (0.74)	2150 (1.52)	74901
Viral, Protozoal & Helminthic Diseases (B01-BAZ)	1167	1016	2183 (1.63)	971 (0.68)	842 (0.59)	1813 (1.28)	33744
Mental Disorders (F03-FZZ)	458	514	972 (0.73)	304 (0.21)	358 (0.25)	662 (0.47)	6251
Neoplasm (C15-CZZ)	49	107	156 (0.12)	218 (0.15)	217 (0.15)	435 (0.31)	929
Total	65804	67826	133630	69848 (49.3)	71934 (50.74)	141782	157249

Discussions and Conclusion

This chapter has explored morbidity pattern and trend among elderly people. Between 2010 and 2015, the top-five morbidities were increasing —some steady and others fluctuating. As the population ageing has already set in the country, it is likely that the morbidity among elderly people will rise in the years to come. In view of this conclusion, it is high time that our health system began to prepare for providing better healthcare services to a growing number of elderly people.

In absolute terms, that is, when only elderly people who were diagnosed with different illnesses was considered, diseases related to respiratory system (mainly common cold) were the most prevalent morbidities. The other diseases with high prevalence were diseases of digestive system, diseases of the musculoskeletal system & congenital deformities, diseases of the circulatory system and eye & ear diseases (in order of prevalence). The difference in the prevalence of 16 broad categories of morbidity between people under two age groups (50-59 and 60+) was observed to be not so significant. The least common was diseases related to neoplasm and was almost three times more prevalent among elderly people in the age group 60 and above compared to those adults in the age group 50-59.

However, when elderly people's morbidities were taken in relative terms, that is, when compared with all other ages, the most common diseases were those that fall under neoplasm (cancerous). This implies that neoplasm was more common among elderly people. The other morbidities more common among elderly people, when compared to people of all ages who were recorded in the health records, were circulatory, endocrine, metabolic and nutritional, musculo-skeletal-congenital and blood diseases.

Among top morbidities, hypertension was found to be increasing steadily followed by other musculoskeletal diseases. These diseases are not infectious and this is the prevalence of such morbidities among senior people bear policy implications. Is it not important to give the policy priority to improving the lifestyle (diet, exercise, etc) of our people to reduce NCDs and promote healthy ageing?

Increasing number of elderly people seeking health care services is likely to put pressure on health resources and delivery in services. The

important findings of the qualitative studies were that elderly people have low access to healthcare services due to their immobility, face problem accessing services in hospitals due to overcrowding, and that some health staff do not handle elderly people with patience and sensitivity. The MoH has allotted a chamber at Jigme Dorji Wangchuck National Referral Hospital to make the process easier for elderly people to meet general physicians (GP), but the outcome has not been satisfying. GPs may not have adequate expertise to understand the morbidities of elderly people. If healthy ageing is what we want to promote, it is crucial for the country to now either bring in or train our own geriatrician, who can better understand and treat old age morbidities. We must promote the habit of maintaining a health diary for every citizen after a certain age. This would make it easier for the medical personnel to understand the pattern of diseases among elderly people and prescribe them medications and treatments accordingly. Leslie Kernisan has succinctly put 'the key to treating older people is to learn what medical information they have put into this health diary and how to use it effectively for care coordination'.

As it was clear that increasing number of elderly people are seeking medical services, the health ministry may set up separate counters and chambers for them, if it is not possible to set up geriatric care units in regional and district hospitals.

We should promote independent research and studies like the ones being carried out by NSB's Research Division on regular basis. Unfortunately, many recent reforms in the civil service or other sectors have led to dissolving many research divisions (in different agencies and ministries) instead of strengthening them. The unintended consequences of such policy change and reforms (as I was given to understand by researchers themselves) was that such reforms might bear severely on the development of research in the country amidst concerns that Bhutan is still performing poorly among the countries in the region when it comes to promoting research.

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CHAPTER VII

MENTAL HEALTH DISORDERS AMONG ELDERLY CITIZENS

THE CASE OF OUTPATIENTS AND INPATIENTS AT JDWNRH

Lham Dorji

Introduction

This chapter attempts to look into various mental health disorders affecting elderly people by doing the retrospective analysis of hospital records. Such inquiry is important to understand type and pattern of the old age mental health problems. The old age mental health remains much-neglected area; no such inquiry has been ever made so far. It is of even more serious concern that not many studies have been done on mental health in general in our country (Jamtsho, 2015; Pelzang, 2012; Nirola, 2010; Dorji, 2004) forget about the age-group specific study. Mental health issues draw little attention in Bhutan than physical illnesses, and this must be impacting on the quality and coverage of mental health services. The study sets out to answer an important and timely question: What are different mental health problems that elderly citizens of Bhutan face?

Though the hospital records may give the very limited information needed to generalise the findings to the whole nation (because they do not capture the unreported ones), we could use such data to map the type of diagnosis, and to the extent possible, the yearly trend of reported mental health problems among elderly citizens. Hospital administrative data often covers a large proportion of the population and are systematically collected for over years. In absence of survey data, administrative data become an attractive resource for epidiomelogical studies.

Elderly citizens' mental health is an important area of public policy, though not much attention is given to it at the moment. Failing to understand and pay attention to older people's mental health represent the failure to pay attention to their mental or emotional well-being. Administrative data are data collected for monitoring, reimbursement, or

regulatory purposes, most often by government agencies or insurers, and not primarily collected for research purposes.

The rationale behind this inquiry is that as much as the mental or psychological health problems affect younger people, they also affect the older people in terms of leading meaningful and productive lives. Mental illness and disability have no age barriers except that the incidence and degree of illness may vary among different age groups. For example, personality disorders may be less prevalent among elderly people while mental conditions related to organic brain disease could be more common among them (Whitehead, 1990:207).

Data to carry out main simple descriptive analysis was drawn from the outpatient records of the Psychiatric Department (PD) of Jigme Dorji Wangchuck National Referral Hospital (JDWNRH), Thimphu. Out of 6441 OPD mental cases recorded between 1998 and 2014 (17 years), 292 cases were older people of age 60-95. Older people constituted about 4.53 per cent of the total OPD mental cases. This shows that the recorded outpatient cases of mental disorders were significantly lower than that of the younger age groups, but this may not necessarily indicate that mental health problems are less common among older people. It may be the case that a fewer number of older people were seeking medical services than the younger age cohorts. Further, I looked into the inpatient data for JDWNRH and found there were 90 cases of older mental disorder inpatients for the period between 2005 and 2014.

The most common mental health problems as per the outpatient (OPD) records were depression, anxiety disorders, alcohol withdrawal delirium, schizophrenia, dementia, somatoform disorders, bipolar affective disorders, and stress. Dorji, C. (2004), who specialises mental health treatment at the JDWNRH maintained that the common mental health disorders among the population like epilepsy, dementia, schizophrenia, anxiety disorders, depression and alcohol dependence syndrome are of great policy concerns (Jamtsho, C. 2015: 116). Nevertheless, among the inpatients, the most common mental disorders were somatoform disorders, behavioural syndrome of physiological disturbances & factors and disorder of psychological development.

Material and Method

As supplementary to the restrictive information on mental health provided by the elderly participants for our qualitative study (not many talked about their mental health conditions), I looked into the hospital record of mental health. It would have been ideal if I had an access to the mental health records from all the health facilities across the country. I had an access to the mental health record of Psychiatric Department of JDWNRH, Thimphu. It was in 2015 that we proposed the Psychiatric Department (JDWNRH) to allow us to enter the OPD mental health patients' records into the computer from the bulky registers. They were gracious enough to accept our initiative. That time, we needed data for the analysis of mental health among young people.

The OPD records for diagnoses were maintained according to the International Classification of Diseases (ICD-10). The ICD-10 is the WHO's system of classifying and coding diagnoses and symptoms. Having the records maintained as per the ICD-10 made the analysis easier.

There were (in the records) many specific mental health diagnoses, which were later group into ten broad categories. For example, Depression alone had many types: (1) Mild depressive episode (F32.0) with somatic syndrome (F.32.01) and without somatic syndrome (F32.00); (2) Moderate depressive episode (F32.1) with somatic syndrome (F32.11) and without somatic syndrome (F32.10); (3) Severe depressive episode with psychotic symptoms (F32.3) and without psychotic symptoms (F32.2); (4) Other depressive episodes (32.8); and (5) Depressive episodes, unspecified (32.9). All these specific diagnoses and symptoms were group under a broad category 'Depression (F32)'. The same was applied to other diagnoses and symptoms.

The inpatient data was maintained by the record section of JDWNRH. The management of JDWNRH was gracious enough to share with us the database for all hospital records (maintained in ICD-10) written in Microsoft Access. Data contained additional information such as a patient's age, sex, education, occupation, birthplace, and present residence. The information on education, occupation and present residence was not complete, and thus, I had to delete them. Such data incompleteness is expected in the administrative data, particularly when

record entries were done erratically and casually unforeseen [of] that these records might find their ways into such analysis. The year of registration was treated as the year in which a patient availed the mental health service. Simple descriptive analysis of JDWNR Hospital's data was done separately for outpatients and inpatients. This chapter is therefore organised in two parts: part I-outpatients record analysis and part II-inpatient record analysis.

Limitations

The analysis used the mental health record of just one hospital, albeit it being the National Referral Hospital. There is no denying that the medical records are the most direct measure of the official responses or treatments, but still, they remain an inadequate measure of mental health in the country, though they may be relevant (to a certain extent) in absence of other rigorous research.

Using only the hospital record may present both conceptual and methodological problems because these records consider only those who avail the mental health services. Many of the people with actual symptoms of mental health disorder and those who do not report to health centres remain hidden. This raises the question of representativeness. The ideal thing would be to do a large representative sample survey to unravel the people in whole society with and without mental health conditions.

Part I-Mental Disorders among Elderly Outpatients

The records contained information on a patient's age, sex and place of origin, I tried to construct the socioeconomic profile from this limited information (table 7.1).

Table-7.1: Profile of elderly mental disorder outpatients (JDWNRH)

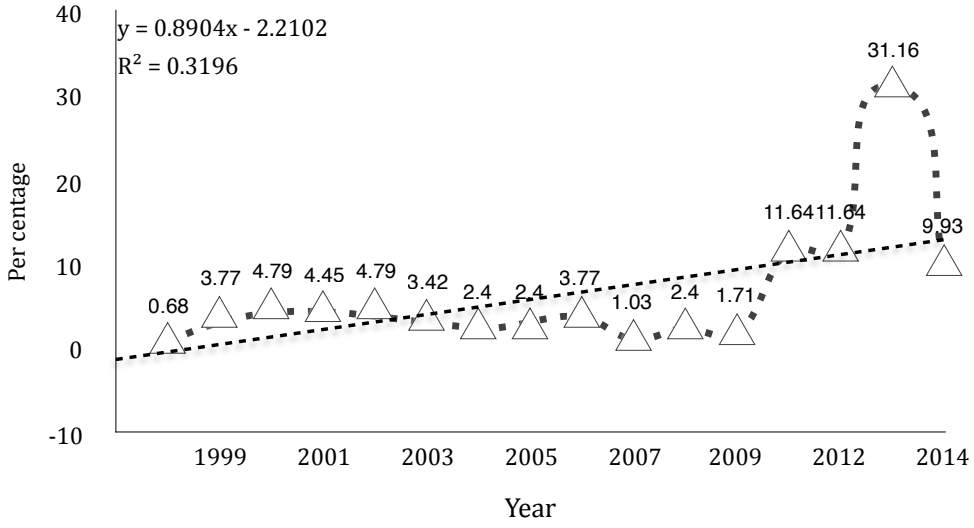
	Frequency	Per cent	Cumulative Frequency
Gender			
Male	134	45.89	45.89
Female	158	54.11	100
Age group			
60-69	193	66.10	66.10
70-79	76	26.03	92.12
80-89	21	7.19	99.32
90-99	2	0.68	100.00
Dzongkhags			
Paro	36	12.33	31.85
Thimphu	34	11.64	72.26
Samtse	25	8.56	56.16
Wangduephodrang	23	7.88	96.58
Samdrupjongkhar	20	6.85	47.6
Trashigang	20	6.85	79.11
Punakha	14	4.79	40.75
Sarpang	13	4.45	60.62
Dagana	12	4.11	10.62
Lhuentse	12	4.11	16.44
Pemagatshel	12	4.11	35.96
Tsirang	11	3.77	88.7
Bumthang	10	3.42	3.42
Chukha	9	3.08	6.51
Mongar	9	3.08	19.52
Trashiyangtse	9	3.08	82.19
Trongsa	8	2.74	84.93
Zhemgang	7	2.4	98.97
Haa	5	1.71	12.33
Foreigners	3	1.03	100
Total	**292**	**100.00**	

The mean age of elderly outpatients was 67.57 with the standard deviation of 0.40 and confidence interval between 66.78 and 68.36. There was a higher percentage of females (54.11%) compared to males (45.89%) mental disorder outpatients. The highest percentages of elderly outpatients were from Paro and Thimphu followed by from Samtse Dzongkhag. This may not have to do anything with the prevalence;

possibly more elderly mental disorder outpatients were from these Dzongkhags due to their proximity and access to the JDWNRH.

There were 292 mental health cases (among elderly outpatients of age 60-99) recorded for the year 1998 to 2014. The recorded number of cases of mental health disorders were low and steady until 2010. The number of cases increased from 2011 onwards (as shown in figure 7.1) with the highest number of cases recorded in 2013. This relatively and unusually high number of cases in 2013 cannot be explained. The increase in the number of reported cases in the recent years could be: (1) either the incidence of mental health disorders among elderly population increased over the years; or (2) more and more people became aware of the mental health services; or (3) social stigma associated with identifying oneself as someone with mental disorders was abating. No specific reason could be singled out from the present data other than just making assumptions.

Figure-7.1: Trend of a recorded elderly mental disorder outpatients at JDWNRH



Mental Health Conditions (Diagnoses) among Elderly Outpatients

Several specific mental health diagnoses were categorised into ten diagnoses. As presented in table 7.2, the leading mental health disorder was depression (F32, 32.88%). Among young people of age 10-24, the most common mental health condition (2000-2004) was epilepsy followed by depression and anxiety disorders (Jamtsho, 2015: 118). The

other mental disorders prevalent among elderly mental disorder outpatients were: (1) Alcohol Dependence Syndrome (F10, 14.38%), Anxiety Disorders (F41, 14.38%) and Epilepsy (G40, 10.96%).

Table-7.2: Diagnoses of mental health conditions among elderly outpatients at JDWNRH (1998-2014)

Mental Health Illness	Male	Female	Male+Female
Depression	48.96	51.04	32.88
Alcohol Dependence Syndrome	29.17	14.58	14.38
Anxiety Disorders	18.75	25.00	14.38
Epilespsy	20.83	12.50	10.96
schizophrenai & Delusional Disorders	7.29	21.88	9.59
Dementia	5.21	12.50	5.82
Somatoform Disorders	3.13	13.54	5.48
Bipolar Affective Disorders	2.08	10.42	4.11
Severe Stress & Adjustments Disorders	3.13	2.08	1.71
Chronic Headache	1.04	1.04	0.68
Total	**45.89**	**54.11**	**100.00**

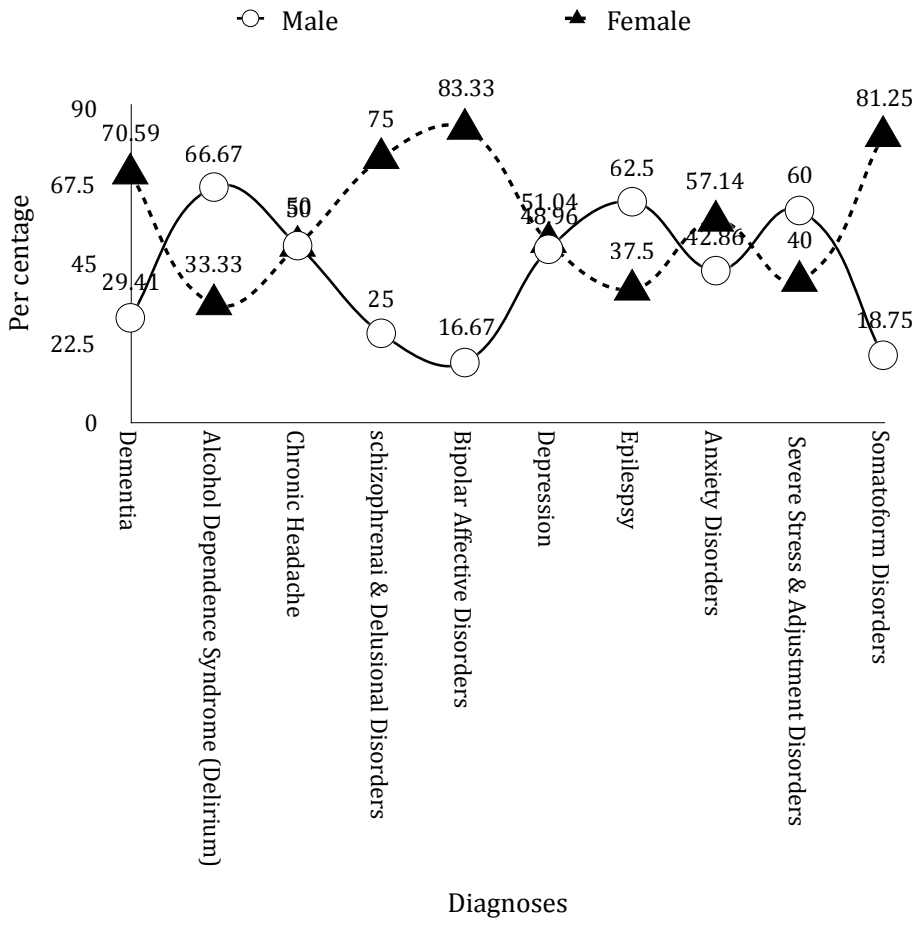
Gender Differentiation of Mental Health Disorders

In 2002, World Health Organisation (WHO) passed its first Gender Policy to acknowledge that gender matters in terms of the physical and mental health of a person. Today, gender is increasingly and inappropriately interpreted as the differences in 'biological traits' or 'sex'. Gender is beyond the biological distinction of sex. It includes culturally and socially determined difference between men and women (Afifi, 2007). More women tend to suffer from depression and anxiety disorders due to the dominance and violence executed by their male spouses, while men are more likely to develop substance abuse mental health disorders and antisocial or personality disorders

There were some gender differences in terms of the type of diagnoses of mental health conditions among elderly outpatients. Gender could be correlated with the prevalence of certain mental disorders (Eaton *et al.* 2012). Women are more likely to internalise emotions often leading to withdrawal, loneliness and depression, while men are more likely to externalise emotions leading to belligerent, forceful and non-complaint behaviour (*ibid.* p.256).

As presented in figure 7.2, dementia, schizophrenia & delusional disorders, bipolar affective disorders, depression, anxiety disorders and somatoform disorders were more common among elderly women mental disorder outpatients. Alcohol Dependence Syndrome (ADS), epilepsy and reaction to severe stress and adjustment disorders were more common among elderly men mental disorder outpatients. The findings conform to many of the international studies' findings.

Figure-7.2: Gender differences in type of mental health diagnoses among elderly outpatients at JDWNRH (1998-2014)

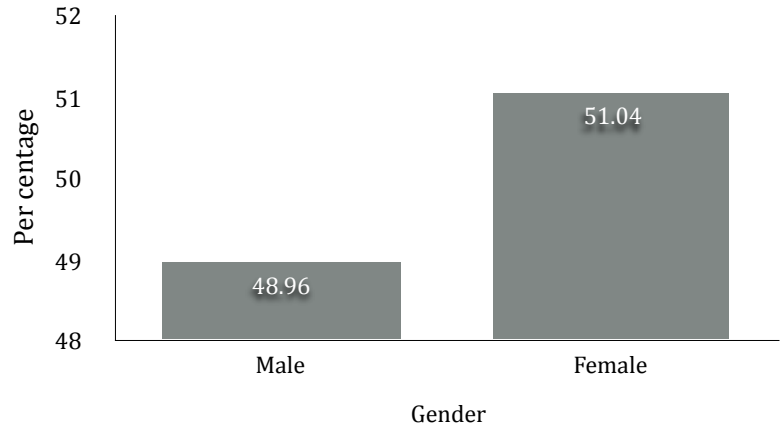


Various Types of Mental Health Diagnoses

5.1 Depression (F32; F30-F39)

It is a common belief that old age psychiatry is more associated with the problems of dementia or Alzheimer's Disease and the associated disorders. Depression is prevalent in every society, but an unusually high prevalence of depression among elderly outpatients is of some concern. While it is too tedious and unnecessary to detail the various types and classifications of depression, all that needs to be understood is that the older people are afflicted by depression more prevalently than other age groups (Whitehand, 1990: 208). Depression is one typical mental health condition that can cause a person continued feeling of sadness, loss of interest and enjoyment, apprehension, loss of sleep, constant fear of death, unexplained bodily pain, chronic aches and pain, poor concentration, and reduced energy and vivacity, often causing fatigue and diminished engagement in daily activities. Many of the qualitative study's participants talked about some of these symptoms though they did not mention about having any mental health disorder. As shown in figure 7.3, a case of depression was higher among elderly female outpatients (51.04%) compared to elderly male outpatients (48.96%).

Figure-7.3: Prevalence of depression among elderly male and female



A study conducted by Eaton *et al.* (2012) suggested that women suffer more than men from depression, because "women ruminate more

frequently than men, focusing repetitively on their negative emotions and problems rather than engaging in more active problem solving." Depressive symptoms are common in old age (Snowdown, 1990; Cole, Bellavance & Mansour, 1999). Depression among the Bhutanese people normally goes under-reported due lack of understanding of the disorder or the associated shame talking about it. The type of depression that the elderly outpatients were found to experience ranged from mild to severe forms with or without psychotic and somatic symptoms.

Depression was common among younger population (Jamtsho, 2015), but depressive symptoms in the elderly impair functioning, reduce the quality of life, and induce somatic (unknown physical illnesses) complaints than in a younger group (Mulsant and Ganguli, 1999). Poor physical health and immobility at old age are likely to contribute to depression in older age. A study in Amsterdam has proven that depression in old age usually ensues from chronic physical health problems in most cases (Beekman, Bremmer, Deeg Balkom et al. 1998). In general, older persons get depression when they are widowed, become unemployed without much income savings, due to physical disability, and when they are lonely or isolated beside neurobiological changes associated with ageing and genetic susceptibility caused by ageing (NHS Foundation Trust).

5.2 Alcohol dependence syndrome (F10; F10-F19)

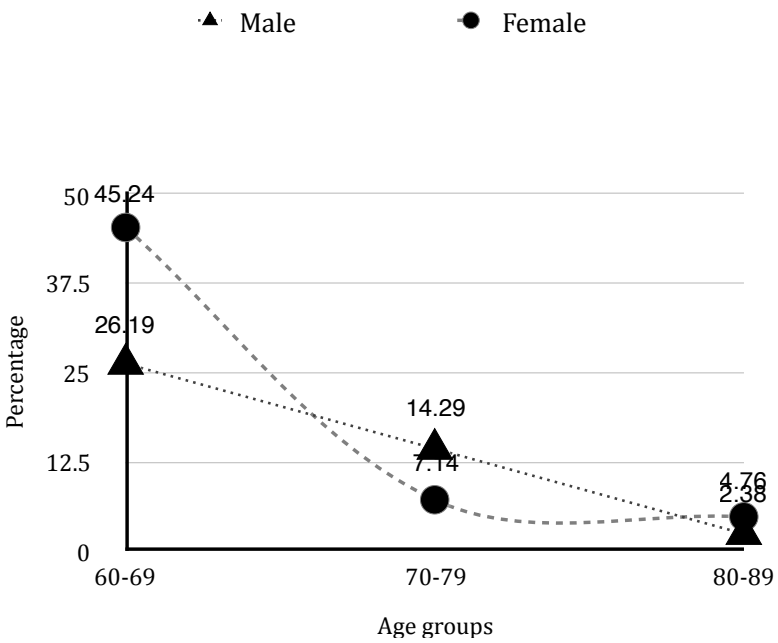
Mental and behavioural disorders due to use of alcohol (ICD-10, F10) was the second most common diagnosis elderly outpatients. I have categorically identified it as 'Alcohol Dependence Syndrome (ADS)', though F10 disease is not specifically that, and the psychiatrists at the JDWNRH had also chosen to identify it specifically as ADS. In broad, this disease could be placed under 'Delirium' the state of acute confusional states (unlike the chronic organic brain syndrome); and the symptoms normally include abnormalities of memory, orientation, and attention with incapacity to concentrate and maintain alertness (WHO, 1991).

Alcohol abuse problem is not only the problem of younger people; this problem is more likely to go unrecognised or overlooked among older people (he/she is old enough, why not let him/her drink misconception). Stressful later life events such as retirement, financial problems, marital bereavement, social isolation, chronic physical illnesses, and mental

disorders are some of the main contributing factors to alcohol abuse among older people (Yasamy, Dua, Harper and Saxena, 2012).

Among elderly outpatients with ADS problem, older men (66.67%) constituted about double the number of older women (33.33%). ADS was typically and dominantly the problem of males. This problem was common among older people of age group 60-69 (figure 7.4).

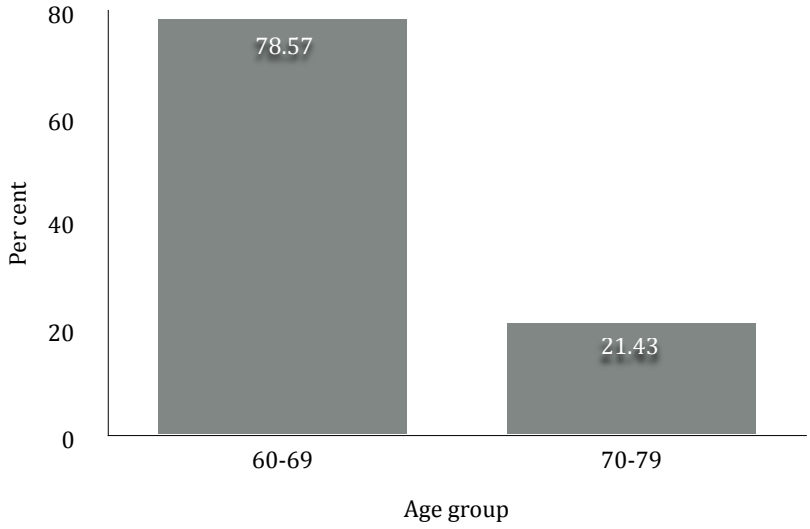
Figure-7.4: Alcohol Dependence Syndrome (ADS) by age groups among elderly outpatients at JDWNRH



5.3 Anxiety disorders (F40-F48)

The third common diagnosis was anxiety disorder (F41). Anxiety disorder in older people could be present along with other physical illnesses (Schraub and Linden, 2000). As per the record, panic disorder (episodic paroxysmal anxiety) and phobic disorders were common (either moderate or severe). There were cases of mixed anxiety and depressive disorders. There was a gender difference in terms of this mental health condition. More elderly women outpatients (57.14%) were diagnosed with anxiety disorder than elderly men outpatients (42.86%). This gender difference converged at the higher ages (figure 7.5), and this conformed to the study by Krasucki, Howard and Mann (1998).

Figure-7.5: Anxiety disorders among elderly outpatients at JDWNRH (1998-2014) by gender

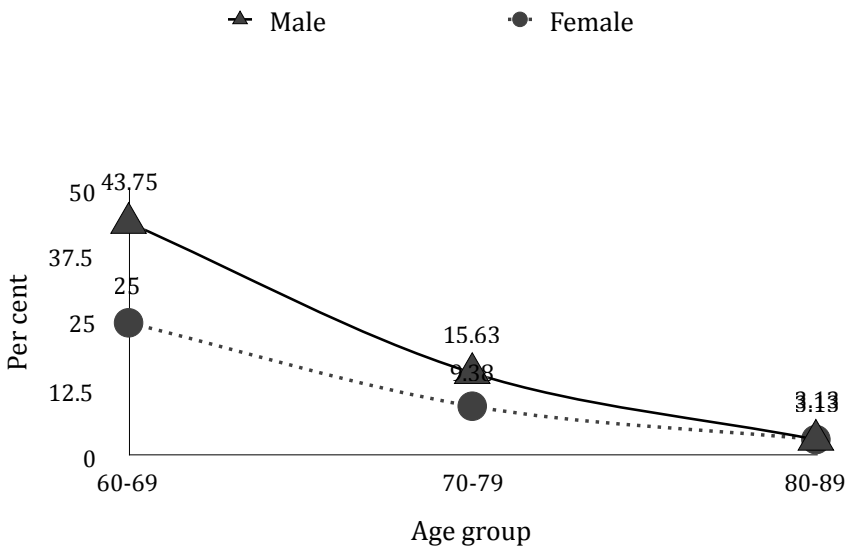


5.4 Epilepsy (G40)

Epilepsy is the most common neurological disorder among elderly people after stroke and dementia (Johnston and Smith, 2010). This disease can be life threatening especially when it is accompanied with co-morbidities. Dorji, C. (2004) maintains that epilepsy was historically treated as a mental disorder, because those people with epilepsy suffer social stigma and severe disability, and moreover, it is a brain disorder that causes seizures.

Epilepsy was more common in elderly male outpatients (62.5%) compared to elderly female outpatients (37.5%). It was more prevalent among the age group 60-69, which closed in on at the higher ages as shown in figure 7.6.

Figure-7.6: Epilepsy among elderly outpatients at JDWNRH (1998-2014) by gender



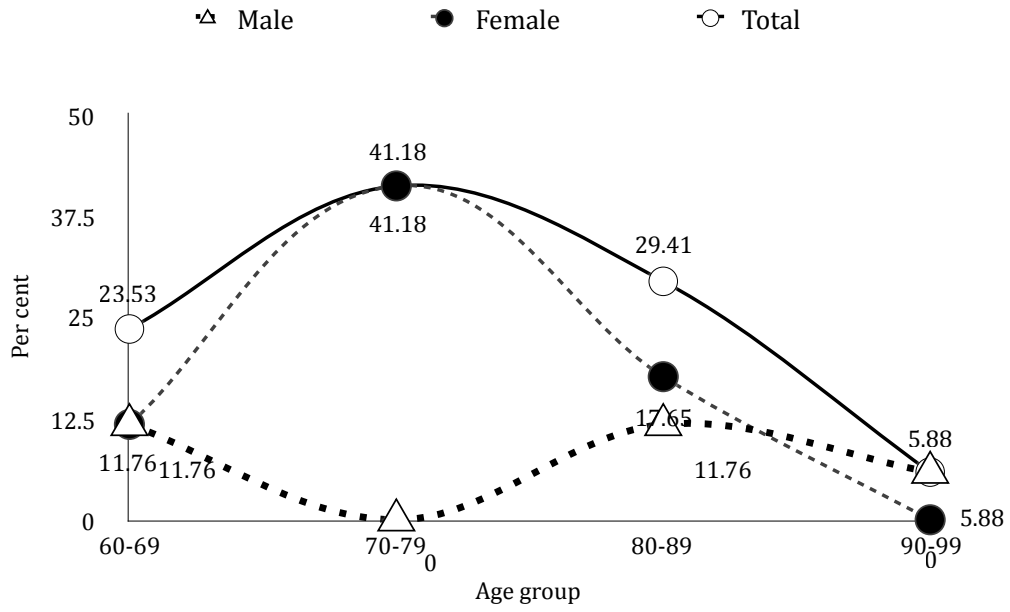
5.5 Schizophrenia and delusional disorders (F20; F20-F29)

Schizophrenic disorders are usually characterised by fundamental and characteristics perversion of thought and perception leading to cognitive deficits in the long run (ICD-10). A disorder with a single delusion of a set of related delusions constitutes delusional disorder. The cases of paranoia and psychosis were recorded that were grouped under this same broad heading. Sir Aubrey Lewis in 1950 wrote: "It is not extravagant to say that nowadays insanity is mainly diseases of old age."It is difficult to identify and treat schizophrenia and delusional disorders, as the sufferers usually try to conceal their symptoms. This is so in the Bhutanese society because persons showing such symptoms are often ridiculed by others and marked as 'mad person-*chelo*'.

Paranoid delusions and hallucinations are prominent in the fourth and fifth decades of life, though the emotional, volitional, and intellectual characteristics remain fairly well preserved (BMJ, 1962). Kay and Roth (1961) has attributed schizophrenia to environmental factors, mainly 'social isolation' that arises due to single and widowed women living alone with fewer surviving children and fewer siblings.

Schizophrenic and delusional disorders were more prevalent among female PD outpatients (75%) than among male PD outpatients (25%) and were common in the age group 60-69. There was none at the higher age group of 80+ (figure 7.7).

Figure-7.7: Schizophrenia and delusional disorders among elderly outpatients at JDWNRH (1998-2014) by gender

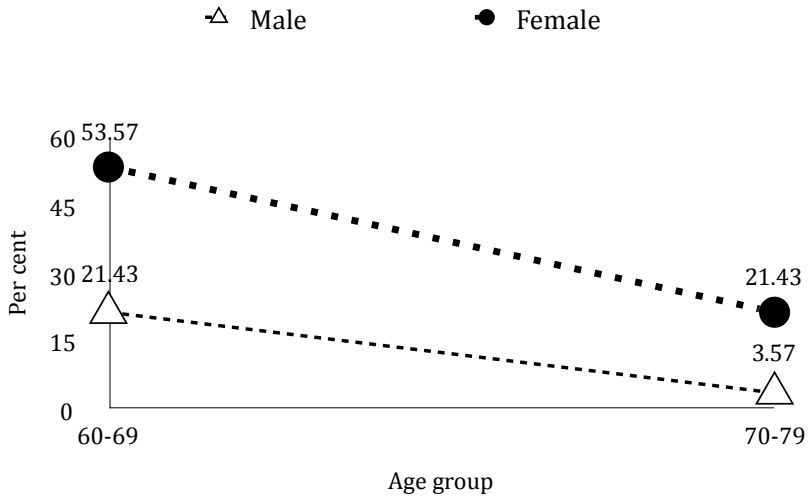


5.6 Dementia (F00; F00-F09)

In developed countries, a high prevalence of chronic organic mental disorders (also called dementia) is what necessitates geriatric care units. Defined as a syndrome of acquired memory impairment and other cognitive functions, dementia is more prevalent among older adults (Higler and Fischer, *n.d*).

The present data shows 17 cases of dementia with higher prevalence among older female PD outpatients (70.59%) compared to 29.41% older male PD outpatients (figure 7.8). Dementia deteriorates a person's ability (mentally and physically) to carry out daily activities such as dressing, eating, personal hygiene and toilet activities.

Figure-7.8: Dementia among elderly outpatients at JDWNRH (1998-2014) by gender

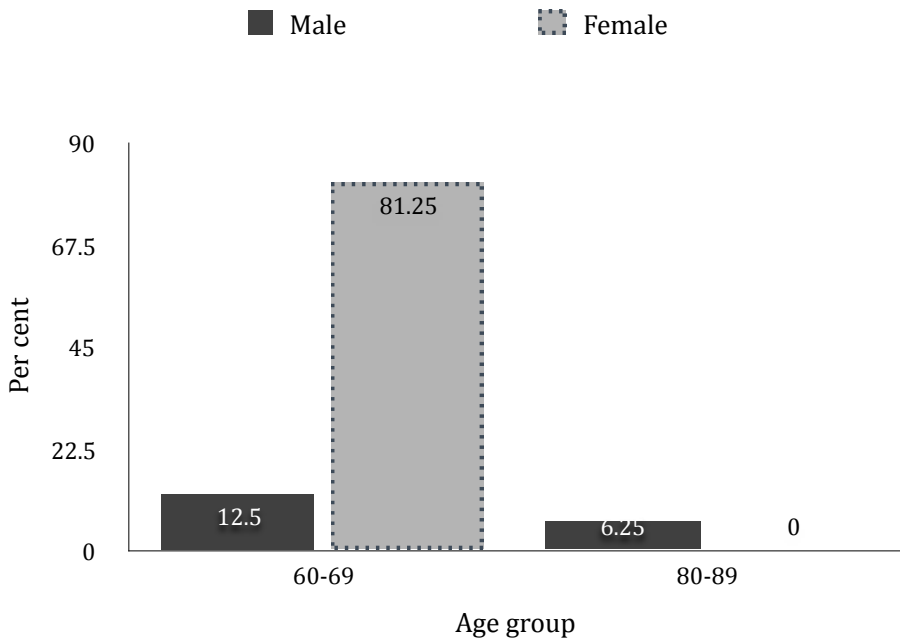


5.7 Somatoform disorders (F45; F40-F48)

Somatoform disorders (Briquet's syndrome) are a group of psychological disorders in which a patient experiences a physical symptom that cannot be fully explained by any underlying medical or neurologic condition. These disorders are characterised by complaints without any medically identifiable physical disease. In general, the somatoform disorders are characterised by disturbances in the patient's physical sensations or ability to move the limbs or walk. Somatic disorders are prevalent in younger and older age groups, usually beginning before that age of 30. Lipowski (1998) defined somatisation disorders as "the tendency to experience and communicate somatic distress and somatic symptoms unaccounted for by relevant pathological findings, to attribute them to physical illness, and to seek medical help for them."

There were 16 cases of somatoform disorders recorded between 1998 and 2014. These disorders were more prevalent among elderly female outpatients (81.25%). Out of the total, only 18.75 per cent of elderly male outpatients were diagnosed with somatoform disorders. As shown in figure 7.9, the prevalence of somatoform disorders was higher among female and in the age group 60-69 (93.75%).

Figure-7.9: Somatoform disorders among elderly outpatients at JDWNRH (1998-2014) by gender



5.8 Bipolar affective disorders (F31, F30-F39)

Bipolar disorders are the mood disorders with alternating mood states of depression or mania. Mood disorders represent a major disease of the burden for older age cohorts, as they contribute to suffering, medical disability, functional impairment, and even mortality (Ellison, Kyomen and Verma, 2009). Data shows some case of bipolar disorders diagnosis, though geriatric bipolar disorder is a grossly understudied area. There is a large gap on this type of mental disorder in the literature as well. There were 12 cases of recorded bipolar disorders between 1998 and 2014. It was more prevalent among elderly female outpatients (83.33%) against 16.67 per cent among elderly male outpatients, and common in the age group 60-69 (66.67%).

5.9 Reaction to severe stress and adjustment disorders (F43; F40-F48)

The cases of phobic anxiety disorders had been recorded. These disorders relate to set of anxiety evoked at a certain well-defined situation, and are usually associated with fears of dying, losing control or often feeling of going mad. Panic disorders were reported. The

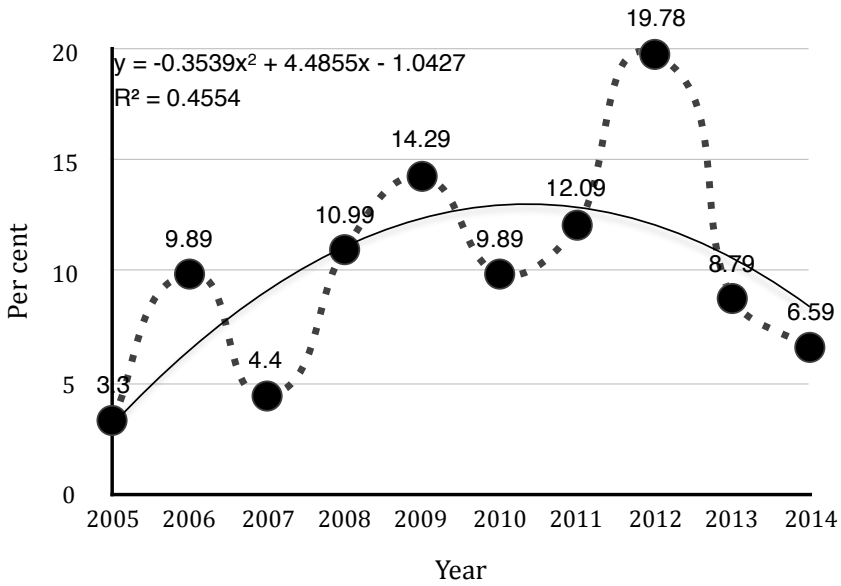
adjustment disorders (situational depression) occur when individuals are not able to cope up or adjust to a particular stress of a major life event. The common characteristics are mild depressive symptoms, anxiety symptoms and traumatic symptoms. External stressor causes such symptoms. There were 5 cases of such mental disorders recorded with the Psychiatric Department (only outpatients at JDWNRH during the period 1998 and 2014).

Part II-Mental Disorders among Elderly Inpatients at JDWNRH

Yearly trend

I looked at the psychiatric inpatient data of JDWNRH for the year spanning over 10 years (2005-2014). Thirteen major mental health disorders were observed. There were 90 cases of elderly inpatients at JDWNRH during the period 2005-2014. There was rather an erratic trend in the hospitalisation of elderly mental health cases starting with as low as 3.3% (3) cases in 2005, peaking at 30% (18) cases in 2012, and falling down to 5.56% (5) in 2014. A polynomial trend was used, as it is best when data fluctuates. The R-squared value was 0.455, which though not so close to 1 was still reasonable to show the goodness of line fit to data. See figure 7.10.

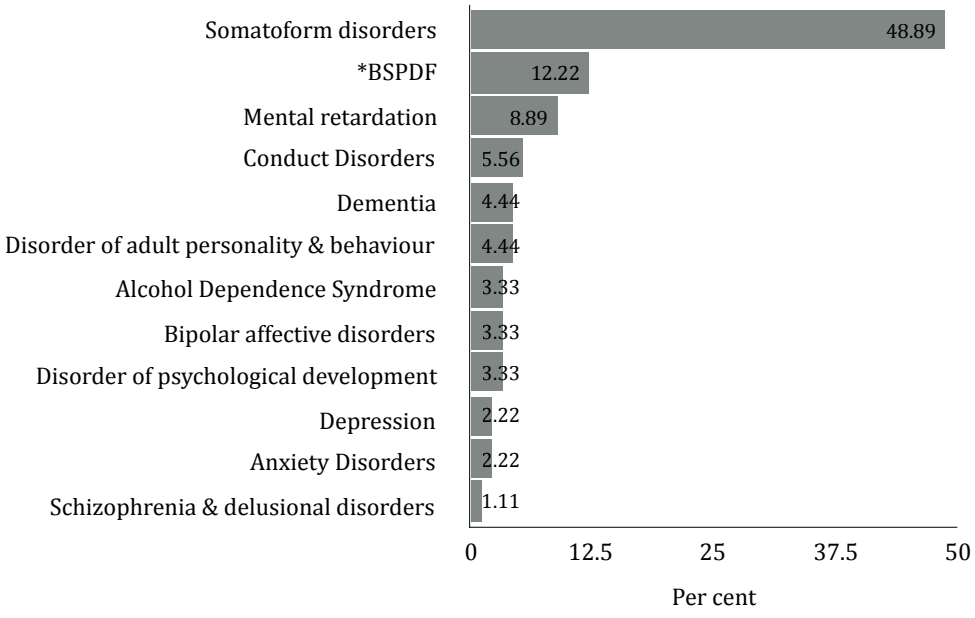
Figure-7.10: Yearly trend of elderly inpatients (2005-2014) at JDWNRH



Diagnoses of Mental Health Disorders among Elderly Inpatients

Mental health disorder diagnoses differed greatly between those of elderly outpatients and elderly inpatients. The most prevalent mental disorder among elderly mental disorder inpatients was somatoform disorders (F45, 48.89%). This is a kind of mental disorder with complaints of physical pains and aches without any identifiable medical aetiology. The second most common mental illness was Behavioural Syndrome of Physiological Disturbances and Factors (BSPDF, F53, 12.22%). The third frequent mental condition was mental retardation (F70, 8.89%). The other mental disorders like Dementia (F00), Alcohol Dependence Syndrome (F10), Bipolar Affective Disorders (F31), Depression (F32), Anxiety Disorders (F40) and Schizophrenia and Delusional Disorders (F40) were less common among elderly inpatients compared to elderly outpatients. New mental disorders among elderly inpatients were Mental Retardation (F70-F79), Personality Disorders (F69), Psychological Disorders (F54) and Conduct Disorders (F91). Figure 7.11 presents different mental disorders among elderly outpatients at hospitalised at JDWNRH from 2005 to 2014.

Figure-7.11: Diagnoses among elderly inpatients at JDWNRH, 2005-2014

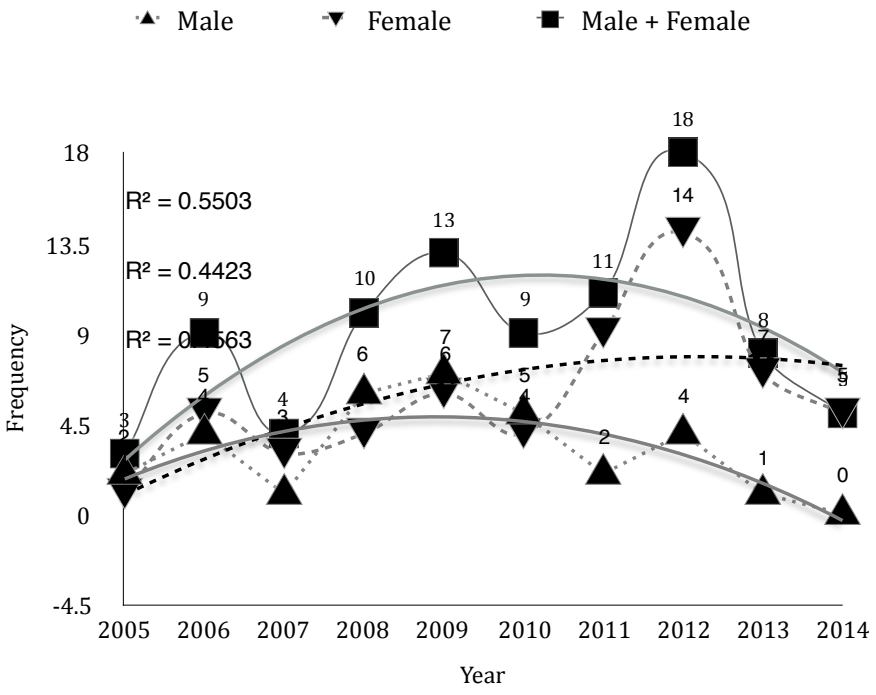


**BSPDF= Behavioural Syndrome of Physiological Disturbances & Factors*

Gender Differentiation of Mental Disorders among Inpatients

There were notable differences between males and females in terms of different diagnoses of mental conditions among elderly inpatients at JDWNRH. In fact, the number of elderly female inpatients was growing sharply from 2010 onwards compared to males. Figure 7.12 present number of elderly males and females inpatients. The only instance when males outnumbered females in hospital admission were in 2008, 2009 and 2010. The polynomial trend lines show the reasonable fit of lines into data (though not very close to zero).

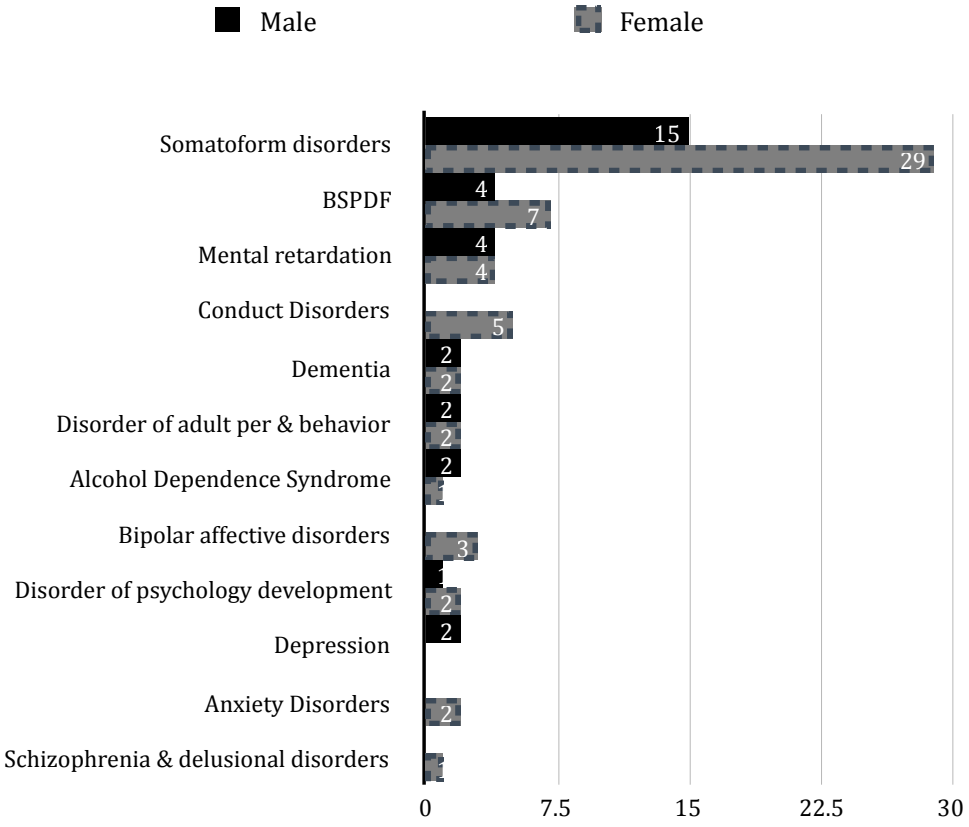
Figure-7.12: Yearly trend of mental disorders among elderly male and female Inpatients



There was a distinction between diagnoses among elderly male inpatients and elderly female inpatients. In all, there were more elderly female inpatients (64.44%) than males (35.56%). More elderly female inpatients were diagnosed with Somatoform Disorders (n=29), Behavioural Syndromes of Physiological Disturbances and Factors (BSPDF, n=7), Conduct Disorder (n=5), Bipolar Affective Disorders (n=3), Anxiety Disorders (n=2), and Schizophrenia & Delusional Disorders (n-1)

compared to elderly male inpatients. The rest were equally present between two sexes (figure 7.13).

Figure-7.13: Gender differentiation in mental disorders diagnoses among elderly inpatients at JDWNRH (2005-2014)



Mental Health Disorders among Different Age Groups

Comparing diagnoses among different age groups in the old age category (60+), most mental disorders were prevalent among elderly inpatients in the age group 60-69. Somatoform disorders were not only prevalent overall, but concentrated in the age group 60-69. Mental retardation was prevalent among those inpatients in the age group 70-79, and the conduct disorders among the inpatients in age group 80-89 (shown in table 7.3).

Table-7.3: Different diagnosis of mental disorders among elderly inpatients at JDWNRH

Diagnoses	60-69	70-79	80-89	Total
Dementia	1	3	0	4
Alcohol Dependence Syndrome	3	0	0	3
Schizophrenia & delusional disorders	0	1	0	1
Bipolar affective disorders	1	2	0	3
Depression	0	1	1	2
Anxiety Disorders	2	0	0	2
Somatoform disorders	44	0	0	44
Behavioural Syndrome of physiological distrubances & factors	4	7	0	11
Disorder of adult personality & behaviour	0	4	0	4
Mental retardation	0	8	0	8
Disorder of psychological development	0	3	0	3
Conduct Disorders	0	1	4	5
Total	**55**	**30**	**5**	**90**

Although a diagnosis of somatoform disorder in elderly patients is difficult due to the presence of a combination of symptoms associated with organic pathological changes, mental processes, and medication side effects (Wutzler, 2007), somatoform disorders came out as the most prevalent among the inpatients. Consideration for admission of a mental disorder patient into hospital involves cost. Among many different mental disorders, it could be that somatoform disorders cost much resources and hospital staff's time. When compared with other chronically ill patients, somatoform disorder patients are known to lead lower quality of life, impairment of physical function, poor perceived general health, and worse mental health (Smith, Monson and Ray, 1986).

Discussions and Conclusion

Among ten broad categories of mental health conditions among elderly people (outpatients) recorded with Psychiatric Department of JDWNRH, the top three diagnoses were: (1) Depression (32.88%, F32), Alcohol Dependence Syndrome (14.38%, F10) and Anxiety Disorders (14.38%, F41). These three mental disorders among older people merit the highest

attention, but we cannot underplay the significance of other mental disorders like epilepsy, schizophrenia, delusional, adjustment, bipolar (mood), somatoform, stress, and anxiety disorders, all of which must be contributing to the deterioration of quality of life for elderly people. Starting from 1998, the incidence of recorded mental health outpatients at JDWNRH had been increasing sharply (peaking in 2013) until 2014 (available records). This rise could be either that the cases of mental health disorders are increasing or more people are now seeking medical attention.

Geriatric Psychiatry in Bhutan remains an ignored area. Mental health has been the lowest priority among all health priorities, and geriatric mental health remains unheard and underdeveloped. The present generation of the ageing population is unique in the fact that the presence of mental health problems among them is revealed through the hospital records, though in general, this is a misconception that mental disorders are caused by underlying clinical, medical and psychiatric problems. The demographic changes that have already set in will not only breed an increasing number of older adults, but produce a good number of them suffering from one or other psychiatric or mental illnesses.

Unfortunately, there is a dearth of mental health professionals in the country, and worse, there is hardly any geriatric mental health professional. Geriatric psychiatric disorders were rising as shown by the rising incidence of hospital attendance by older people with mental health problems (peaking in 2013), and this trend is likely to create an unmet need for diagnosis, therapy, and provision of mental health services for elderly persons. The need to strategise the health system with geriatric-psychiatric services has become imperative.

There was a higher percentage of elderly females (54.1%) compared to elderly males (45.89%) among elderly mental health outpatients. One plausible explanation could be that females have a higher longevity of life (70.11) in 2015 compared to males (69.57). Even a difference of a year could have added to females living little longer as a widow. The state of widowhood at old age is usually characterised by the feeling of loneliness and sadness over having lost the loved ones. This gender differentiation in terms of the type of mental health conditions suggests the need for gender-focused policy responses and strategies for prevention and treatment of mental disorders among the older population. Women, as

other studies suggest (Eaton *et al.* 2012) tend to internalise emotions while men tend to externalise emotions in the form of personality disorders and impulsive behaviours. For example, for women treatment might focus on developing coping and cognitive skills, while for men treatment might cover more on shaping aggressive tendencies into docile and non-harmful behaviours. Whatever, the findings suggest that there should be the difference in the way the strategies for mental disorders prevention and its risk factors' reduction for men and women, as the risks themselves are gender specific.

Ageist attitudes (stereotyping old age) among younger generation were found to be common in the country as reported by elderly participants of the qualitative study. They reported that younger people treat them as frail, the out-of-fashion lot, century, unable to work, weak, disabled, and mentally ill persons. In fact, as 'by way' of reducing this negative stereotyping of elderly citizens or to promote active and healthy ageing, especially mental and emotional health, meaningful interactions, and strong partnerships between old and young should be promoted. The family members should understand and recognise old age mental issues, and this can happen only if there is a high level of advocacy programmes for the mass and dispel stereotyping of those individuals with mental health disorder symptoms and seeking psychiatric and medical help. Civil societies and NGOs could facilitate the implementation of health promotion strategies for elderly people.

Depression, the topmost mental health disorder among elderly outpatients can be disabling and debilitating, though most of us consider it a normal feature of ageing. Depression among older population in Bhutan mostly remains under-recognised and untreated. Not much can be blamed on the service providers; people who are ill with depression themselves and their family members often fail to recognise depression as a serious disease. They are usually swayed by the common misconception that elderly people showing symptoms are a normal part of ageing, or in some cases as the influence of evil or karmic forces. There's greater need to create awareness among the mass that depression in older age could affect the quality of life of patients and their family members (caregivers), and that such symptoms should be recognised as some kind of 'illness' just as they recognise physical illness.

Among mental disorder older inpatients, the most common disorder was somatoform disorder. Diagnosis of this mental disorder associated with unexplained physical illnesses is very difficult, and treatment is not easy and costly. In terms of resource used to provide mental health services to elderly patients visiting JDWNRH (both outpatients & inpatients), it is possible that the highest per capita expenditure is on treating somatoform disorder, as it is the most prevalent among elderly mental disorder inpatients, and secondly, medically unexplained symptoms (MUS, Somatoform) remains one of the most complicated, frustrating, and costly illnesses in primary care. In addition, Somatoform disorder patients generate higher health-care costs as a result of increased use of diagnostic tests. They have longer visits to doctors when compared with other patients (Smith, Monson and Ray, 1986).

Given that the NCDs such as high blood pressure, diabetes and high cholesterol can lead to old age mental illnesses (WHO, 2012) and are common among elderly people, preventing and treating old-age mental health problems could be largely determined by the effectiveness of managing the other NCDs. Fighting NCDs may be done within the purview of addressing mental health conditions rather than treating them as an isolated problem.

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CHAPTER VIII

TRIANGULATION OF RESULTS AND DISCUSSIONS

Lham Dorji

Introduction

In this chapter, I have revisited the various results of each separate analysis presented in the previous chapters and attempted to triangulate those key results. The mixed method that we have adopted was the triangulation at methodological and results level. Triangulation can be understood as the use of multiple methods or data sources, mainly in qualitative research to develop a comprehensive understanding of an issue or phenomenon (Patton, 1999). It is a strategy to test the validity through the convergence of information from multiple sources leading to more valid findings.

Every research method has advantages and disadvantages. The problem arises when we rely on one particular research method. In the mixed research method, several research methods and data sources overlap—complimentary sometimes and contrary at other times with the balancing effect on each method, giving more valid findings. Thus, Cohen and Manion (1986: pp.254) has defined triangulation as an attempt to map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint.

Building on our assumption that few works were done in Bhutan to determine the situation of elderly people, we have emphasised on examining the situation of elderly people using multiple data sources. These data sources were the past national surveys, a small sample survey, administrative data, in-depth interviews, and Focus Group Discussions (FGDs).

By this time, we have enough shreds of evidence to show that the combination of increasing longevity, the accompanying change in family structure—relationship between parents and children, and young caregivers' perception of old age are adversely affecting old age social care and support system.

The problems related to the ageing population, which are deepened by the dramatic change in socioeconomic conditions at macro and family levels, are important public policy issues. In fact, the old age problems are the very results of our broad progress in human development. The HDI report (2013: 3) has acknowledged that our progress in income, health, and education cannot assure long-term development. This study acknowledged the view that human development must be set in the right context by incorporating into the process of human development all aspects of human life and for people of all ages. The SDGs now corroborate this view by acknowledging the importance of people of all ages in the development process.

The country's GNH development paradigm recognises the need to ensure equity of development outcomes and that the benefits of development perpetuate all segments of society. Development and modernisation often may pose a serious risk of rendering elderly citizens into a more vulnerable situation. To prevent this, proactive planning and designing of an appropriate policy framework and putting institutional arrangements in place should receive the highest priority. Honouring elderly people's dignity and their rights have now become a matter of social justice, human rights, and extension of human rights to social protection.

The analysis of administrative, qualitative, and questionnaire survey data revealed several inter-related issues affecting the lives of elderly people. In this chapter, I have enlisted and then discussed the most notable old age issues and concerns. To reiterate, the main objectives of this study were to examine the situation of elderly people, sources of old age social care and support, and to highlight policy implications of population ageing and change in traditional social care and support system.

We faced many definitional, conceptual and methodological problems in examining the old age issues. This difficulty stemmed out from the fact that there was no agreement on the definition of old age in the country. For examples: NSB and Ministry of Health defined an old person as someone who has attained the age of 65+ while Royal Society for Senior Citizens (RSSC) considered someone having attained age 55+ as an elderly person. The retirement ages varied in different public and private sectors. However, in this study, we have considered an old person as someone who has attained the age of 60. The UN system uses this definition for most of the developing countries. At times, when data did

not permit, we used age 65, especially for the analysis of morbidity trend using the MOH's medical records.

Triangulation of Results

Different analyses have yielded results that were converging and complementary albeit there were some contradictions as well. It was not possible to single out the issues that elderly people were facing; the issues confronting some elderly people were multidimensional in nature.

The qualitative data (in-depth interviews and Focus Group Discussions) in fact revealed that the key problems affecting elderly citizens are: (1) physical hardships in old age such as having to work on the farms, or earn their own living (material deprivation), (2) emotional ill-being that arise from the feelings of loneliness, unhappiness, and frustration over their poor and desolate situation, (3) physical illnesses like chronic body aches, joints pain, hypertension, seeing and hearing disability, and mobility limitation, (4) poor quality of life that arises from being poor (to the extent that they face food insecurity and shelter deprivation), (5) lack of children and relatives to turn to during the times of illnesses and emergencies, and constant worry over who would take care of their funeral rites, and (6) difficulty accessing the health care services owing to their immobility and difficulty to reach the health facilities.

Several causes of the old-age problems identified through the analysis of the in-depth interviews and Focus Group Discussions were: (1) decline in traditional family care system; (2) steady decline in co-residence of elderly parents and adult children (brought about by increased rural-urban migration of adult children); (3) physical distance between ageing parents and adult children; (4) poverty among adult children (that they are not able to care and support their aged parents); (5) gradual degradation of social values (*ley judey tha damtshig*) among newer generation with effect on the filial piety; and (6) transformation in social and economic structure of family and community. I have presented the key results in table 9.1.

These results suggest the emergence of many different problems of the ageing population in our country. In order to conform the full validity of these results, certain advanced empirical analysis and statistical testing may have to be considered for which we may have to carry out the nationally representative surveys specific to the older population.

Nevertheless, the results of the present study are suggestive and may inform policies and programmes as well as serve as theories for advanced empirical studies.

Table-9.1: Triangulation of results of analysis of multi-source data

Key Results
CHAPTER I: POPULATION AGEING AND SOCIAL PROTECTION IN BHUTAN
Population ageing has set in the country. There was a stark increase in the population of elderly people by 79.48% between 2005 and 2017, while the population in the age group 5-24 decreased. The youth population was shrinking and shifting towards adult group and adult to the older group.
The majority of elderly people were living in rural areas. In 2005, about 87.34 per cent of them lived in rural areas; 12 per cent lived in urban areas. Many elderly people living in rural places were the ones who were left behind by their adult children who have migrated to urban areas for employment, education and others. Most of these elderly people were compelled to manage the ancestral homes and participate in developmental activities (*zhabto woola*) despite their old age.
The Dzongkhags with the major social and commercial hubs continue to have a higher proportion of elderly people. In 2015, Thimphu and Chukha Dzongkhags had the highest proportion of elderly people, indicating some elderly people were also migrating to urban areas.
The old-age dependency ratio had been increasing between 2005 and 2015. It was 11.64 in 2005, which had increased to 11.98 in 2015. The old-age dependency ratio is expected to rise.
In 2012, poverty rate among the households headed by persons age 65 and beyond was 14 per cent, and 13.3 per cent among those households headed by persons aged 55-64 (younger elderly).
The multi-generational co-residency has declined to 31 per cent in 2012 from 39 per cent in 2007. The households without an elderly member, but with at least one child increased from 50.51 per cent in 2007 to 54 per cent in 2012, indicating the shrinkage of family size, decline in co-residency, and increase in non-third generation households. The change in family structure and composition may bear negatively on elderly people.
The labour force participation rate among the elderly population in 2015 was 63.1 per cent. Whether the participation of elderly people in hard labour is causing them torment or physical hardship has to be studied.

Key Results
The Constitution mandates the government to promote the extended family system and community life as the traditional social safety net. This in turn may serve as a setback to the government's effort to take the responsibility of elderly people from their families unless some intelligent and innovative approaches are adopted.
The coverage of formal social security like pension, provident fund, and insurance remained an all-time low. It covered only 6.7 per cent of the total population in 2013.
The proportion of elderly people needing social care and support is expected to rise, which will only call for new social protection policy and programmes or restructuring and reinforcement of the existing ones
CHAPTER III: THE ANALYSIS OF IN-DEPTH INTERVIEWS
Family responsibility characterises Bhutan's integral approach towards old age social care and support, but modernisation may continue to affect family structure and traditional old age social care and support system.
Some possible reasons for the change in traditional old age social care and support system are: rural-urban migration of young people; change in the family structure; decline in co-residency, poverty among adult children, double burden on adult children (welfare obligation for old parents and their own children), and change in the family values and norms.
There was some indication that elderly people's contributions were being undervalued and there was growing negative perceptions of elderly people among young people. The increase in the number of people entering old age with lesser guarantee of social care and support from their children was observed.
Growing number of elderly people was roaming in the streets, communities, and was abandoned in hospitals. Many of them were left behind in rural homes to bear the burden of running households, taking care of family property, and *zhabto woola* contribution.
Some elderly people were obliged to struggle through their lives due to loss of their spouses (death or divorce), lack of children, and neglect by children (intentional or unintentional).
The old age was characterised by multi-dimensional poverty prevailed over by income deprivation and debt. The key determinants of poor livelihood situation of some elderly people were economic insecurity (financial problems), poor shelter conditions, declining capacity, and food insecurity.

Key Results
Seeing and hearing disability, mobility problems, body aches and pain, and hypertensions were common health issues among elderly people. Co-morbidity situation was found to be widespread.
Functional limitations (especially mobility) deprived some elderly people of the access to healthcare services. Hospital overcrowding and lack of specialised care were said to affect elderly people.
The greatest fears and worries of elderly people were: getting terminally ill (and lack of care providers), death, funerals, income deprivation, and food insecurity. There was a growing sense of loneliness and hopelessness among many elderly people participating in this study.
The overall development changes were said to have relatively lesser positive impacts on the lives of some elderly people, especially destitute (as highlighted by many elderly people participating in this study).
Lack of energy and inspiration to work and earn more was common among elderly people. Most elderly people expressed their desire of devoting their later life to prayers and spiritual practices.
Most elderly people (interviewed) considered good shelter, sufficient food, economic security, and access to better healthcare services important for enhancing their well being.
Provision of public shelter homes (for destitute) and needy ones, social pension, and easy access to better healthcare services were what most elderly people (who participated in the study) felt the government may have to look into.
CHAPTER IV: THE ANALYSIS OF FOCUS GROUP DISCUSSIONS (FGDS)
There was an inadequacy of formal contributory pensions due to which elderly people were forced to depend on the care and support provided by their family and social networks. The issue was that the existing family and informal care and support mechanism were changing in the face of urbanisation and modernisation with serious implications on elderly people.
The presence of elderly people who were living alone (without much support from their children) were reported to be becoming more visible in the local communities.
The most common old age problem that the study participants identified was the lack of income/inadequate income among elderly people to support their livelihood needs.

Key Results
Most elderly people in rural areas, who were left behind at natal/rural homes by their children reported they were being forced to work hard to earn livelihood and contribute *zhabto woola* even when their body can't endure physical hardships.
Many elderly people were reported to be exposed to multiple problems like deprivation of income and basic sustenance need, abandonment and neglect (by family), physical hardship (field works and *wool*a obligations), emotional ill-being (loneliness, hopeless, and helplessness), disrespect and derision (by younger people), social discrimination, homelessness, and difficulty accessing healthcare services (crowding in health facilities and the immobility issues).
The probable causes of the old age problems were: rural-urban migration of younger cohorts, change in family and society's structure, degeneration of family values and norms, growing negative attitudes and perceptions of aged people, social discrimination (in accessing certain services), and less positive impacts of development on the lives of many destitute.
There is the need to provide income support through targeted social transfer (means tested social pension), public residential care, and shelter support to those who have no family support (destitute) as supplementary to the existing government's social protection and other charity programmes.
The need to set up mobile health check-up clinics in the communities for the aged persons who are bedridden and immobile was identified as important along with the need to introduce specialised healthcare for elderly people.
Setting up separate medical consultation and checkup units, especially in the district and regional hospitals was suggested.
The participants suggested the government should exempt elderly persons (too old and physically frail) from *zhabto woola* obligations, and encourage the volunteer groups and networks to support the welfare of elderly people.
CHAPTER V: THE ANALYSIS OF QUESTIONNAIRE SURVEY DATA
The majority of elderly people were far less educated and more likely to depend on children for support.
The primary source of income for elderly respondents was remittance from their children. Most of them have low savings, and very low proportion of elderly people had access to formal social security schemes.

Key Results
Many elderly citizens were increasingly forced to live alone for the reasons like rural-urban migration of children, poverty among adult children, and negligence by adult children.
Poor heath of elderly people was reported to be another important factor bearing on their lives in the receding period. The female disadvantage in health was observed.
There is not only the need to promote good health among elderly people, but also to improve elderly people's access to healthcare services, including gender inclusiveness.
Relatively a high level of emotional ailments among elderly people was reported. Mental health disorders among elderly people may have long-term implications on the delivery of healthcare services.
About 9 per cent of elderly people were considered to be not happy. Improving conditions for those elderly people who are not happy to pursue happiness is one area that may need to be prioritised.
Socialised or community vitality was observed to be on a decline, which may have severe implications on the lives of elderly people. Policy and programmes aiming to preserve and promote social capital stock in the country must be put in place on a very urgent basis.
In general, the sense of obligation towards elderly people was observed to be present among children. Children and grandchildren would continue to play a crucial role in providing the financial and material support to the ageing parents. However, wherever families cannot shoulder these responsibilities, it is crucial to initiate the formal old age care and support welfare schemes.
CHAPTER VI: COMMON MORBIDITIES AMONG ELDERLY BHUTANESE PEOPLE
In absolute terms, diseases related to respiratory system (mainly the common cold) were the most prevalent morbidities among elderly people who sought medical care. Other diseases were related to digestive system, musculoskeletal system & congenital deformities, circulatory system, and eye & ear diseases (in order of prevalence).
In relative terms, the most common diseases among elderly people (who sought health care services) were related to neoplasm (cancers). Other morbidities common among elderly people when compared to people of all ages were related to circulatory, endocrine, metabolic and nutritional, musculo-skeletal-congenital and blood diseases.

Key Results
Between 2010 and 2015, the top-five morbidities (among elderly people who sought medical care) were increasing—some steady and others fluctuating. It is likely that the morbidity among elderly people will rise in the years to come.
Among top morbidities, hypertension was found to be increasing steadily among elderly people followed by other musculo-skeletal diseases. These are NCDs and may bear huge health policy implications.
Setting up separate counters and chambers for elderly people are important, if it is not possible to set up geriatric care units in regional and district hospitals in the immediate future.
CHAPTER VII: MENTAL HEALTH DISORDERS: THE CASE OF OUTPATIENTS AND INPATIENTS AT JDWNRH
Among ten broad categories of mental health conditions (elderly outpatients) recorded with Psychiatric Department of JDWNRH, the top three diagnoses were Depression, Alcohol Dependence Syndrome, and Anxiety Disorders.
The other common mental disorders were epilepsy, schizophrenia, delusional, adjustment, bipolar (mood), somatoform, stress, and anxiety disorders, all of which could contribute to the deterioration of quality of life for elderly people.
Starting from 1998, the incidence of recorded mental health outpatients at JDWNRH had been increasing sharply (peaking in 2013) until 2014 (existing records).
Geriatric Psychiatry in Bhutan was found to be underdeveloped area needing more priority.
The recorded geriatric psychiatric disorders were rising, and this trend is likely to create an unmet need for diagnosis, therapy and provision of mental health services for elderly persons. The need to strategise the health system with geriatric-psychiatric services has become imperative.
More female elderly people were affected by mental health disorders among the national referral hospital's outpatients.

Key Results
Depression among the older population in Bhutan mostly remains under-recognised and untreated. Not much can be blamed on the service providers; people who are ill with depression and their family members often fail to recognise depression as a serious disease. They are usually swayed by the common misconception that elderly people showing such symptoms are normal part of ageing, or in some cases attributed to the influence of evil or karmic forces.
Among the hospital's elderly mental health inpatients, the most common disorder was the somatoform disorder. Diagnosis of this mental disorder associated with the unexplained physical illnesses is very difficult, and treatment is not easy, but costly.

There was a good agreement between the results of the in-depth interviews, focus groups, and the information gathered by other methods. Among many other issues presented above, I discuss some of them below.

Declining co-residency and old age vulnerability

The international literature has consistently shown that throughout the developing world, the family has been the fundamental institution for elderly people, their living arrangements, and their health and well-being. In the traditional Bhutanese society, the younger and elderly generations lived together or close to each other for mutual benefits through sustained co-residency (joint family), cooperation, and coördination. Co-residency could mean they either live in the same households or elderly people retire to a small house near the main house. We have come across several elderly people living separately from their children on account of not being able to adjust to the general family diet (*khasung*, literally, dietary restriction associated with certain old age chronic illnesses). This was typical of traditional peasant society, and so it continues till date. In the past, ageing parents usually kept small landholdings to meet their consumption (*toezhing-sustenance land*). Their children helped them cultivate this landholding. This system seems to be in terminal decline due to some change in land ownership legislations.

Traditionally, the younger generation ensured care and support to elderly people. In return, elderly people served as family guides, guardians of

cultural traditions, mediators in case of family conflicts, and contributed to minor household activities, especially child-rearing of grandchildren. For all these roles, the family and community held elderly people in high esteem, and they always found a good home with the family of children.

The traditional custom of children providing care and support (material and psychological) for elderly parents as a sort of repaying the debts they owe to their parents for producing and caring for them in infancy and early childhood is still vibrant. Most children dare not ignore the ageing parents without running the risk of social sanctions. In developed countries, old age care and support comes from a combination of public and private sources. In our case, the family remains the cornerstone of social care and support, complemented by support from Kidu Foundation and several other NGOs.

Unfortunately, if the current trend of rural-urban migration among adult children (for education and employment) continues, ageing parents in rural areas will have more dispersed children. In the past, due to co-residency (within a large extended family), family support and care were pervasive in our society. Shortage of farm labour was said to affect the lives of elderly people, who in place of their children have to work on the farms. They have to make household labour contributions for the community development activities, which involves a lot of physical strain. In the past, a tradition of mutual labour exchange had ensured the availability of farm labour in addition to sufficient labour available within a large joint family.

The continual decline in the co-residency of elderly parents and children is now visible. Such co-residency has declined to 31 per cent in 2012 from 39 per cent in 2007. There was enough indication of the rise in the number of non-third generation households (families getting smaller). Change in the family structure, composition, and co-residency may force more and more elderly people to live on their own and into the state of isolation.

The qualitative studies have ascertained that the onus of family responsibility (natal house, land, and other family assets), including participation in local development activities (*woola* or *zhabto lemi*) rest on ageing parents, particularly in rural areas. In fact, the statistics show that the majority of elderly people were living in rural areas. Most adult

children (of our study participants) have migrated to towns seeking better social and economic opportunities, while their assets were left under the charge of ageing parents.

The results of our qualitative studies revealed that co-residency and the close physical proximity of children are lynchpins of family support and care for elderly people. There was a widespread preference for children as main care providers among the study participants. Further, we observed an increasing disjuncture between ageing parents and their adult children. The ground reality and observed norms were that adult children albeit their disposition to care and support ageing parents were not able to materialise it for three important reasons: (1) poverty among adult children; (2) double burden on adult children—constrained to provide filial support to ageing parents and look after the welfare of their own growing children (priority usually given to children); and (3) geographical distance between them caused by relocation of adult children for work, education, and other reasons.

In fact, some of the study participants have highlighted receiving some remittances from children, but only a few of them had received enough money and on time to cover their basic needs. In absence of consistent material or monetary support, elderly parents have to carry out manual works—on the farms and for local development (*woola*). They were forced to work on the manual labour so long as their health allows, which yields diminishing returns. Even as they may be willing and capable of participating in the formal labour sector, other than agriculture sector that involves farming of their own land holdings, they do not have much scope to work in other sectors that directly yields them cash. The perception that older people are weak and infirm usually serves as a barrier to their participation in the economic activities that can otherwise help them earn wages. Reliance on household support tends to increase if they have children or other close relatives, otherwise, due to lack of alternative strategies, they end up as destitute. Consequently, most of them migrate to urban centres seeking for the alternative source of livelihood, which often tends to be to seek charities or alms. In this way, they become vulnerable to several risks, including exposure to disease and abuse.

Inheritance rights seem to have a large effects on the intergenerational exchange. Elderly people who own houses, land, and other valuable assets

have a higher resilience to vulnerabilities. Transfers of house, land and other assets from parents to children usually occur with the understanding that the latter would take care of the former's old age needs. However, many of our respondents have accentuated that transfer of land and other inheritances has not assured children's support to some aged parents. This was because migration of adult children from rural areas has disrupted the traditional notions of inheritance and children's duty to aged parents as repayment for inheritance.

The tradition has it that some aged parents keep separate land holdings in their ownerships (locally known as *phamai toeshin*g—parents' subsistence land) as insurance in the events their children fail to provide them old age care and support. But, the recent changes in land regulations (as told by our respondents) have led to the decline in this tradition, thus increasing the vulnerability of aged parents. They reasoned that the transfer of the ownership of parents' subsistence land [when they die] have become complex or impossible in the recent years.

The neglect and abandonment of elderly people are becoming more prominent. Obviously, there is a growing number of elderly people who are experiencing an increased sense of insecurity and isolation. The media often reports that it is not only young people who leave their villages in droves, but that even elderly people have started to migrate to towns and cities, as 'with age fast catching up on them, and no one to look after them in the villages, they come to towns to spend their last days [with their children]''(Kinga Dema, Kuensel, 2009). Some of them do not adjust well with their adult children and in-laws. The family relationship breaks down. Some elderly parents act stubborn and walk out of homes (*ibid.*, 2009). This usually happens among the low-income urban families. The effects of abandonment then become obvious when formal social protection programmes directed at elderly people are insufficient.

Many aged parents who co-reside with their adult children in urban areas find themselves difficult to adapt to urban livelihood. Urban social isolation, adjustment problem, and cultural shocks usually make aged parents to hanker to return to villages. Elderly citizens in urban areas other than those destitute on the streets are known to be in better positions resource-wise and tend to rely more on children. What they usually find lacking in urban areas is the avenue for 'social interactions' within the neighbourhood. Temples and stupas are some places that

attract elderly people and facilitate social interactions and networking among the peers. This suggests that building vibrant urban centres should not ignore those facilities that serve the needs of senior citizens such as temples, stupas, health and fitness centres, and so on.

Curbing rural-urban migration of young people remains a major development challenge. Urban unemployment, overcrowding issues, and other social problems continue to dominate policy discourses. However, the issues such as the strain of work and burden that elderly citizens in rural areas have to bear are hardly talked about at the policy level. Since the majority of elderly citizens live in rural areas, the problems affecting them deserve both media and policy attention.

An important issue for policy implications concerns the changing structure and role of the family in taking care of aged people. The conventional argument to explain these change and their effects rely on the assumptions that changing socioeconomic conditions, capital market formations, and structural change in labour markets are causing distortion in the way people manage their lives with unintended consequences on the families and their caring roles for aged people.

Making serious efforts through formal policy and programmes to strengthen the role of the family as a primary caregiver for elderly people is very crucial. Our constitution makes an explicit commitment for the state to promote the integrity of the extended family and community, implying the family should be able to provide for elderly members. While it is important to sensitise the younger generation about their filial responsibility towards ageing parents, providing certain incentives to adult children taking responsibility of parental care and support must get some consideration. These incentives, for example, could be in the form of better employment opportunity, better access to credit, and certain tax discounts.

Dependency stereotyping and old age poverty

The RSSC's 2012 study concluded that the majority of retired senior citizens (73.8%) aspired to practice spiritualism, 18.4 per cent wanted to be with families, and 7.7 per cent wished to operate businesses. NPPF's data revealed that the majority of pension beneficiaries were residing in Thimphu (32.18%) and Sarpang (10.75%). This was suggestive of the

higher concentration of the retirees in urban locations. Most study participants were of the view that the younger generation has less respects for them unlike in the past when elderly persons were respected as source of knowledge, experiences, and for their role as conflict mediators. Today, though not in a huge way, the contributions of senior citizens are undervalued, consequently reinforcing the notion that elderly people are dependents on the families, communities, and state. Elderly citizens themselves too, consider their later life as a period of spiritual practice. They try to minimise (if not compelled by material deprivation) their involvement in the activities related to their material well-being.

In many other countries, as people get older they are drawn to businesses and politics and play major social and economic roles. The customary norms of our elderly people aspiring for spiritual life can be viewed positively. Nonetheless, engaging able-bodied elderly citizens in the activities that benefit society at large is equally worthwhile. Denying elderly citizens the right to participate in society and economy can have some repercussions. The RSSC's study (2012) found that out of 8610 senior citizens (aged 55+), about half of them wished to serve some more years in their previous jobs. The retired elderly citizens we talked to suggested the retirement age in the civil and corporate sectors needs to be reworked.

Through our qualitative studies, we found a growing penchant among some young people for stereotyping elderly people as incapable of doing anything worthwhile (even when playing archery)! The Royal Society for Senior Citizens' (RSSC, 2012) report shows that about 24 per cent of elderly respondents had reported ill-treatment by young people and the general public, and 30 per cent had reported they felt disrespected in the society, though social respectability of elderly people is fundamental to caring for them. This trend might result in increasingly undervaluation of elderly people's contributions to the society and economy. Undervaluing their contributions and their own aspirational insistence to devote rest of life on spiritual practice may lead to unintended marginalisation of elderly citizens from development thinking, policy and practice. Access to employment, market, micro finance, education and preventive healthcare, to name a few sectors, are almost never associated with elderly people.

To recall an elderly destitute (woman): "many development changes are taking place, but they make no difference to me and people like me. What

use are such developments for people like us when we are fighting for the mere survival?" Her candid view hint at incapability of many elderly persons and destitute to take advantage of the overall development progress that we make in social and economic fronts. This calls for the need to relook at the old age problems more specifically rather than assuming that a broad development progress might impact everyone equally. Importantly, something ought to be done to enhance social interactions between the old and young such as through youth-elderly forums or experience sharing projects. Our policy priorities must be geared towards eradication of misery and enrichment of opportunities for elderly people.

People become less productive at the latter stage of life. This is an inescapable biological reality. Poverty tends to be higher among them. Studies providing the estimates of poverty rates by age groups generally conclude that poverty rates are higher among the oldest and youngest than among the working population. The relationship between age and poverty usually assume 'U' shape (Barrientos, Gorman and Heslop, 2003). The evidence that emerged from our analyses suggests that old age poverty is linked to an inadequate family and social support, absence of income security, age dependency, poor health, and inadequate access to healthcare. Indeed, a reduced capacity for livelihood earning and a growing risk of serious illness was found to increase the vulnerability of elderly people to fall into the poverty trap. By logic, those people who were born into poverty are less likely to reach old age, still, we found a growing minority of them entering into old age as destitute. This minority group is the one that require specific poverty alleviation interventions.

With our population gradually ageing, old age poverty is likely to emerge as a policy issue. At present, the old age poverty in the country is taken within the purview of overall poverty; it is not dealt as a separate policy issue. Low priority accorded to old age poverty is best evinced by the absence of old age poverty comprehensive indicators and studies. Our understanding of old age poverty, its factors, and appropriate framework for old age care and support have in many respects remained deficient. Population ageing and the associated problems may have important implications on poverty and poverty reduction strategies. The results of our various analyses showed that elderly people who were more affected

by multidimensional poverty were the ones who were marginalised from policy thinking and practice.

To the extent that family size and composition continue to change and rural-urban migration persists, the incidence of old age poverty is expected to rise. It is high time that policy and programme initiatives for tackling old age poverty are given some priority. This would come about only if the roles and contributions of elderly people in sustaining family traditions and communities, and of course to broader development processes are acknowledged. Effective plans and programmes for the aged people must take into account both individual characteristics and the varying situations in which elderly people live, rather than hinging them on the formulaic approaches.

The change in perception of old age and the aged can be linked to the modern influence, which is gradually eroding the traditional/cultural belief that sees old age in a positive light. The family solidarity—the agreement on values and attitudes, and beliefs among family members is changing. This change can be possibly because the level and depth of interactions between aged parents and young children have changed. For example, in the past, most children grew up listening to the stories that grandpas and grandmas had to narrate. Today, children grow up watching television, playing video games, and excessively using mobile phones. There is the need for cultural reawakening and fostering an ethos of positive intergenerational exchange.

In addition to the existing charities, we could consider social policy initiatives to support the diverse range of livelihood strategies that many elderly people pursue. In fact, we could do much to improve the well-being of poor elderly people without having to increase the social expenditure. It is more or less about targeting the underprivileged groups and focussing on their heterogeneity and varying needs. The need to consider heterogeneity stems from the fact that ageing is a gradual process rather than a sharp change from adulthood to old age. People may differ in their level of economic activity, development, productivity, and vulnerability. As the old age poverty is multi-dimensional in nature, it would require multi-sectoral approach. Any social protection policy that will be formulated should be done within the broader livelihood strategies of elderly people. For example, we have, during the course of our field works come across many elderly people living alone, but weaving baskets,

cane rope or working for others for meagre wage as their livelihood strategy. Efforts should be made to increase the capacity of every elderly citizen to engage in successful livelihood strategies. Particular attention should be paid to the problems of destitute, who neither have access to family care or support from the other charities.

What we must prioritise on?

The family will continue to remain the primary provider of old age help and care. Nevertheless, we have to be cognisance of the limits of family care and support system. Public social welfare schemes could compensate for such limitations. If elderly care and support are not available from family or friends, public provision must take care. There is no such thing as purely private or public, as there is no fixed amount of care and support to be provided by each of these two providers. In fact, public old age care and support must supplement the informal ones, but not substitute them.

In view of our findings, the government's schemes to provide financial support to the underprivileged group may prove effective in reducing old age poverty. We found that elderly people pursue various forms of economic livelihood, but the core purpose of these pursuits remain income. Three key suggestions that our study subjects made, based on their perceived needs were (1) provision of social pension for the underprivileged, (2) shelter support (old age homes) and spiritual homes for the homeless, and (3) improving the general access to geriatric health care. Underprivileged elderly people constitute the heterogeneous group of elderly people with high vulnerability, varying needs, and living in a different situation, especially destitute and homeless elderly people. Systematic targeting will be very crucial.

The decision to initiate social welfare schemes should not be based on the political effects of concerns for the underprivileged, but on compassionate orientation and humanitarian ground. Many of the study's participants felt such concerns come to play during the heightened political campaigns and then more or less remain a rhetoric afterwards. It is high time that social welfare policy and initiatives are undertaken at the national level even if it means duplicating the activities of the other charities. Some mechanism to accommodate complementary functions of different players or actors may be required

Provision of non-contributory social pension

In general, research and policy debates on the economic well-being of elderly people have largely centred on the contributory pensions. The talk about the state-run noncontributory social pension came into policy and public discourse only in the recent years. Obviously, there is the relevance of social pension to the problems of elderly people when contributory pension funds cover the minority and only the formal sector. The merit of social pension is that it would improve both the material and social situation, including independence of elderly people in difficult situation.

Though much had been talked about elderly social welfare programmes in the recent past, not much has been done in terms of the institutional design and delivery to inform policy and practice. In broad, the current social protection like contributory schemes and formal insurances are strongly biased towards urban areas and the formal sector, leaving out those who are in the informal and agriculture sectors. Insufficiency of the existing social protection system in the country undoubtedly increases the vulnerability of elderly people, especially women who generally tend to have slightly higher life span than men and work in the informal sector—unpaid domestic chores and family responsibility. They are less eligible for formal pensions, resulting in inadequate resources in their old age.

Most of the low and middle-income countries favour universal social pension, but in our case, the study's subjects proposed the means-tested social pension as the better choice (they did not mention means-tested, but said 'the support focussed on the needy ones'). The means-tested social pension could be more cost-effective in the case the government could come up with a practical mechanism for targeting the poor and vulnerable elderly citizens. The success of the means tested social pension is largely dependent on the ability to collect comprehensive information on the household or individual income/wealth and other indicators verified by a competent and independent means.

The means tested social pension can entail lower state budget spending and higher allowance payout to the genuine beneficiaries. In Australia, this kind of pension or allowance has been found to be very effective in reducing poverty, as the fund goes to all low-income elderly people (John McCallum, 1994:22). The disadvantages are that it may serve as disincentives for voluntary saving for retirement; the cost of the

administration will be high, and the issue of proper targeting may emerge. Nevertheless, since the focus will be on the needy ones, who mostly will be the elderly people who were born into poverty, the issue of saving disincentives may not be so grave. One strong reason for the choice of a means-tested social pension over the universal one is that the former will not lessen family functions. If every elderly person gets social allowance as their entitlement, the risk is that families might gain incentives to reduce their obligations towards their aged parents.

The purpose of the non-contributory universal social pension is to guarantee the poor and vulnerable people the minimum income, and exclude those who have adequate means of livelihood. In Thailand, academic researchers until now did not prefer a universal social pension for three reasons: it risk making all elderly people dependent on the government instead of becoming self-reliant; resources are shared among the privileged and underprivileged; and it is dependent on the financial capacity of the government which already has many other priorities (Sakunphanit and Suwanrada, 2011: 403). The universal pension system is preferred because pieces of evidence from other countries show that the means-tested scheme often does not fully cover the most neglected and isolated ones.

The identification of the most deserving beneficiaries for the social welfare scheme remains a challenging task. The merit or deservingness approach, even though desirable, presents selection complexity. In many societies, individuals possessing some means (like land ownership, family, etc.), but who failed to succeed are not eligible for social welfare benefits irrespective of their wretched situation. Instead, they are blamed for their own destitution.

In the case the government decides to introduce a social pension scheme for the needy people, the issue will be: who is eligible for a state-run social pension? Should it be decided through medical diagnosis, social and economic condition assessment, or by the local leaders? Viewed from the social model, an older person with a disability may not need support if he or she is rich enough and has a supportive family and community or possess land and other assets. In contrast, a physically healthy older person may need support if he or she lives in poor material conditions despite having a supportive family or assets. So, targeting and selection of right beneficiaries may involve the assessment of the complex

combination of social, economic, medical and personal circumstances. The eligibility of an elderly person for social pension will be determined by various other factors such as access to information and referral. On the whole, the selection of beneficiaries should ideally be based on the need-based approach. In such approach, it does not matter how and what caused destitution, but rests on the qualification that he or she needs social assistance. In fact, the need-based approach is more in line with the principles of justice.

Of course, people who have attained age 70 and above are logically more eligible for welfare support than those who are age 60 and above. This is because one gets more vulnerable as one ages, and is more likely to become less capable to earn an economic livelihood. It would be logical to consider 'elderly people with high support need' as those 'above age 60 who are trapped in multiple poverty, on account of not having their own children, family and relatives to support; or those who are abandoned by their adult children and relatives due to their [children] own social and economic circumstances. The other criteria for consideration may include physical frailty, the presence of chronic diseases or multiple impairments in addition to being in absolute poor conditions'.

In the countries that have adopted the means-tested schemes, the recipients usually have to make claim and provide evidence of their income and capital. At least for the present generation, and particularly the illiterate destitute, it is unlikely that they would be able to apply for the scheme themselves. Local leaders, public welfare officers (kidu officers), NGOs and researchers will be appropriate agents to identify poor elderly people for the welfare schemes. The local committees under the local governments could manage the social pension scheme.

Providing shelter support to elderly people

The other welfare scheme on the priority list of the study's participants was the need to institute public shelter or old-age homes for elderly destitute. The National Housing Policy, 2002 underlines 'the provision of safe and affordable shelter to all'. One of the strategies is to provide the low-income group with the access to affordable housing through housing finance, including 100 per cent loans and progressive repayments; the house being mortgaged against the loan to prevent banks from seeking additional collateral (NHP, RGoB, 2002). The National Housing and

Development Corporation (NHDCL) is responsible to supply housing units for the low-income groups, primarily for those who do not own homes and whose incomes are not sufficient to afford decent shelters. The National Pension and Provident Fund (NPPF) as the largest real-estate developer in the country also contribute to building decent and affordable housing units in the major urban centres.

The RSCC 2012 survey data has shown that about 44.6 per cent of elderly people were living with their children. Unfortunately, no survey has captured the homelessness though it is believed that the number of homeless elderly people was increasing. In the project proposal for the establishment of an old age home in Thimphu by a social entrepreneur, it was mentioned that close to 12 percent of elderly people do not have children to depend in twilight years-and thus-they are forced to come out on the streets (Tenzin 2013).

The importance of the public home or shelter support to homeless elderly people is increasing. Several reasons seem to render elderly people homeless. These reasons are disruption of once intricately linked hierarchal family, conflict with children-in-laws, a dispute over inheritance, mental illness, and others. Homelessness, especially when someone is old and weak is a serious social issue. King (2001) has noted that elderly people with the highest support need often have complex needs among which proper shelter constitute the crucial one.

An incident (26th August 2013) when a son and daughter-in-law forced their 76 years old father out of their house demonstrated how some elderly people become homeless. The father was asked to leave the family without any reason, and to beg on the street. His time spent with his son's family was typically characterised with verbal abuse, and for this reason, he decided he would not go back to his son even if it meant death for him (Gyelmo 2013). It has been a common observation in the capital's bus terminal where elderly people come for bus tickets to travel back to their villages. In most cases, they are the victims of ill-treatment and abuse by their children (*ibid,* 2013).

Following this sensational media story, there was a strong public expression on social media calling for the need to set up public old age homes for the abandoned and abused parents. The debate took in the context of difficulty some elderly people face in absence of the state-

sponsored home arrangements, and when their children desert them. The policy makers and leaders stood divided on this issue. The views against the initiative centred on the risk of undermining the institution of family as a source of care and support to them, and further risk of encouraging negligence by adult children deliberately to qualify their ageing parents for the welfare scheme. In general, there was a strong view that the government need to set up old age homes on a case-by-case basis. State provision of either universal or means-tested social pension can solve most of the problems of elderly destitute, but complementary interventions are important to realise the value in income security.

Many elderly people migrate to urban areas without choice; they are forced to migrate trailing their children and some to avail medical services that are not available in rural villages. While on the whole elderly people in urban sector enjoy better lives i.e. they have better access to basic amenities and health care than their rural peers, many of them are not as fortunate as they appear to be (Tshultrim 2013). The ones who take recourse to the street are mostly the rural migrants. Given the increasing trend of rural-urban migration, it will not be long when setting up old age homes will become a pressing urban issue. It would not be justifiable to deprive the disadvantaged elderly people of their basic needs—food, clothing, and decent shelter just in the name of protecting the traditional institution of family care and support. Society has to respond to changing time and situation. If the society has accepted the day-care centres for children and rehabilitation centres for vulnerable women, it is illogical not to accept the idea of old age homes for the needy ones.

However, a certain degree of prudence may have to be adopted in operating old age homes (in urban areas). These homes may attract more elderly people from rural areas. Creating imbalance in the provision of old age shelter between rural and urban sectors can only exacerbate the problem. People often tend to migrate for resources, overlooking what is there in their backyards. The best alternative is to set up short-stay urban homes (say not exceeding 100 days) to provide them emergency services, rehabilitation, and facilitate their reintegration into their families and native communities. It might bode well if such shelter scheme has provision for encouraging elderly people in need of long term care and support to return to their own communities with assured basic life sustenance support from the government, charities or NGOs.

There are homeless people in rural areas too. But, shelter deprivation in rural areas is not a serious as in urban areas. Rural places have at least social support mechanism by which relatives and neighbours provide shelter on a short-term basis. There are cases of old sterile and couple living in dilapidated houses—their physical, social and economic conditions rendering them incapable of doing basic house maintenance. So far, many local volunteer groups have rendered them some support.

NHDCL cannot fulfil its vision of providing 'shelter for all' by simply focusing on the housing schemes with reasonable returns. Spearheaded by NHDCL, the corporate bodies in the country might consider social schemes of providing basic shelters to elderly people on a case-by-case basis as a component of their social corporate responsibility. Such corporate and private support schemes could be implemented in coordination with the local governments, volunteer groups, youth groups (mainly schools and institutes), women's association, spiritual groups, etc.

In Malaysia, the Ministry of Rural Development provided rudimentary homes for rural elderly people that could accommodate 5 to 20 people in the 1980s. The local leaders were responsible to submit proposals [to set up such homes] to the government, and the government provided the construction costs. Individual volunteers and voluntary groups helped to construct the houses. By 1990s, there were more than 30 such homes and the programme was regarded as a huge success. Like in Malaysia, there are a few cases in the central Bhutan where local governments divested their local development fund to build small old age homes. Such initiative has resulted in sharing the development fund to the deprived elderly individuals.

We know a few old age homes are in operation at present. The study participants were of the view that setting up at least one old age home in a Dzongkhag through the cooperation of local governments, corporations, the charities, voluntary sector, and the communities is necessary. These special housing schemes could offer flexible packages of care, including health care need and as a part of advocating for the rights and entitlements of elderly people. Such mixed-financed shelter programme is considered a viable option in the Netherlands and has been successful in replacing the institutional form of shelter. Having such old age homes in every Dzongkhag may help retain elderly people closer to their root communities and reduce the number of elderly destitute and

infirm from migrating to the capital or other major towns. This programme may be a precursor to the country's national aspiration of providing a decent home for every citizen.

Again, like in the case of the social pension scheme, the study's participants suggested the means-tested shelter scheme as desirable alternative. The public shelter programmes can be directed at two categories of recipients: one for those elderly people who need short-term care and the other for those who need long-term care. The short-term recipients can be the ones whose physical activity could be restored through appropriate medical interventions, who have skills for productive engagement, those people who require budgetary inputs to support themselves, and those who have children with the possibility of re-integration with them. Those elderly people who fall under long-term category can constitute the ones with no children and family members combined with permanent physical or mental disabilities, lack of ability to work, those people who are marginalised, at high risk of being exploited or abused and further impoverishment, and the widows or widowers with no capacity for self-help.

One of the key objectives of such programme could be to attain the sustainability in the long-run. That is, it should be able to provide an opportunity to the residents to work and engage in productive activities such as organic green house farming, dairy and handicraft production, and solid waste management. Tamaraikulam Elders Village in India provides such opportunities to elderly residents including linking them with local community and end of life ritual services. In essence, old age homes should have good medical, spiritual, and healthy environment.

The public at large appreciated the recent pledge by the government to build shelters for elderly people near or in the monasteries. The idea was welcomed because traditionally many people take to spiritual pursuits at old age. Monasteries and sacred places are one of the most preferred destinations of elderly people where they could retire to prepare for life after death. The RSCC's survey data revealed that the majority of elderly people (73.0%) aspired to devote their prime time in spiritual practice. Fulfilling this dream through the provision of free shelters can be an important source of self-satisfaction and contentment for them.

Some people fear establishing old age homes at the monasteries may separate aged parents from their families and communities. Social segregation through such initiatives may not affect the well-being and happiness of elderly people, though in some other countries the old age homes are known to lead to parental isolation from their children, friends, and kin. Hundreds of elderly people already live in the monasteries for daily spiritual practice and prayers. Being able to enter retreat is a life time fulfilment for many of them. The government's support to provide spiritual homes for elderly people is justifiable, as it is well known that many of them in the monasteries live in poorly built houses and on a meagre supply of daily necessity. We have found that some of them even brew alcohol for sale just to maintain their livelihood, despite being resident in *Gonpas* (monasteries). They may not have to resort to such illegal practice if they get some support from the government. The RSSC (2012) survey data revealed that 28 per cent of the elderly respondents expressed the need to set up old age homes.

Shelter provision in the monasteries can be in no way comparable to the old age homes in developed countries in its context, content, objective, and outcome. The context is to uphold the tradition of supporting people in their spiritual pursuits and build a fertile ground for the older like-minded people to seek companionships to help through spiritual life under the proper guidance of Sanga community. The content may not be as complex as providing sophisticated care needs like in modern old age homes; objective may be to allow elderly people meet their spiritual aspirations of spending their final years to prepare for death, and the outcome could be lesser care burden for the families while aged parents achieve satisfaction over life and contentment. However, such policy initiatives will not be as simple as building homes—that is not the end point. It may require substantial public commitment, social and political impetus, and responsible agencies. The issues such as eligibility, location, provision of integrated services, the involvement of family and community, and sustainability will emerge.

Availing shelter services near the monasteries cannot be strictly restrictive just as the case with the public shelters for destitute and homeless elderly people. Spiritual homes cannot be equalled to charitable homes for the indigents though more preference could be given to those people who lack means to enter spiritual retreat. A growing number of financially independent senior citizens may opt to stay in the spiritual homes.

Spiritual homes that provide the combination of physical, social and spiritual services could be the ideal ones. The first condition can be that formal care and support does not replace informal care, but rather supplement it. However, the government needs to put in place the policies and programmes that are useful to reinvigorate the 'reciprocal social contract' between generations, and encourage families to take care of their elderly members. When the shelter provisions are being set up in the monasteries, consideration should be made that the family networks are not broken up by isolating the aged parents from their children.

Some concerns were there among elderly people (who we met) that availing public shelter support would be stigmatising for them. This may be valid because an old age home that we visited had a few members, far lesser than its fuller capacity. It appeared to us that this was due to certain stigma associated with being a part of old age home and disapproval by the close or distant kin. This may be the case with those elderly people who have the support and help from informal caring network, family and friends, otherwise for destitute, social stigmatisation may not be an issue. Whatsoever, it is worthy to explore the possibility of such spiritual homes on case basis, as the retirement homes have proven to work in many other countries.

Promote access to quality healthcare services for isolated elderly people

Similarly, the easy access to healthcare services has been raised as an important policy issue. Health policy, which primarily focusses on primary care approach accords a high priority to the provision of equitable and quality universal access to free healthcare services, including referral of patients abroad. Section 21 and 22 of Article 9 of the Constitution of the Kingdom of Bhutan states that: 'the state shall provide free access to basic public health services in both modern and traditional medicines' and 'the state shall endeavour to provide security in the event of sickness and disability or lack of adequate means of livelihood for reasons beyond one's control'. These provisions reflect the explicit commitments of the state to provide access to free healthcare support for every Bhutanese citizen.

The study's participants lauded the government's commitment to providing free and quality universal health care. It is, however, often proven to be difficult for some elderly people in rural areas to access the

health care services. These people are the ones with chronic, terminal and degenerative illnesses, lacking alternative forms of support, and those who are confined to their locality due to mobility dysfunctions. The healthcare needs of this group remain inadvertently overlooked or unattended mainly due to their own access incompetence. Our study's participants suggested the government to explore the possibility of initiating the mobile health clinics in rural areas. These clinics could be operated by district hospitals to reach elderly people who are not able to travel to the BHUs and hospitals on account of their mobility constraint. Services could include routine checkup, chronic disease screening, preventive health care, dental services, and other benefits. Many elderly people in remote areas have potentially debilitating medical conditions, but they are not seeking treatment due to mobility constraint. Efforts must made to reach out to them.

Some little changes in the way the healthcare services are delivered could make a huge difference to elderly citizens. The Health Ministry could perhaps consider setting up separate health care units or separate queues for registration and clinical examinations in the hospitals so that elderly people would not have to wait long to get the services. These arrangements are necessary until the government could set up the specialised geriatric care units. This seems something doable without having to incur huge cost implications. It is all about putting in place a workable mechanism. There were some concerns among elderly participants that hospital staff do not take their illnesses with reasonable seriousness and sensitivity. Either the health workers do not get sufficient training to prepare them enough to provide the kind of services expected by elderly people or they are too demanding and stubborn that they are never satisfied with healthcare services. This merits a separate study, and accordingly something must be done to address this issue.

Encourage community-based social welfare mutual support networks

There are hundreds of local community welfare and spiritual groups (traditional or contemporary). These groups have multiple and overlapping social and religious functions. Some of these groups have a high potential to become a source of care and support for elderly people.

One major barrier to community initiatives is the growing sense of dependency among our people. This dependency attitude among the

citizens that the government would take the responsibility for every aspect of human security continue to remain, though in the long run the citizens will have to take charge of their own lives. One risk of the government introducing numerous welfare programmes is that this might discourage the individuals and communities to bring about the civic-driven change. From the long-term perspective, it is better for the government not to provide every material assistance, but to initiate policy and programme support to increase the community's propensity towards self-help as a way of encouraging self-reliance and avoiding the dependency syndrome. Ideally, the individuals and groups should not simply remain as mobilised resources for policy delivery, but as actors in their own capacity and right with potential to make a change. The main justification for the government's need to initiate social welfare schemes is that there are individuals and communities who by virtue of being disadvantaged on multiple fronts cannot face up to their own challenges and garner civic driven actions.

While space, actors and beneficiaries are at the local level, they have to be linked to the national and international programmes through certain intermediate government or non-state actors. In this respect, Dorji (2010: 30) in his paper 'improving local service delivery in Bhutan' suggested the need to explore the new avenues of cooperation between the local governments, national NGOs/non-state actors, and smaller community self-help groups. Some national NGOs and charities are already running programmes and projects for the disadvantaged citizens. They could better foster and garner the support of local self-help and spiritual groups for providing welfare supports to elderly people. For example, Tarayana Foundation, Women's Association, Youth Groups, etc have huge potential to drive civic-driven actions and change that benefit elderly people. They could work with the local groups by providing various non-institutional services to assist and strengthen the capacity of the local self-help groups to deal with the problems of old age in their respective communities. One of the reasons Dorji's study found why many local self-help groups fail is poor institutional design, operational framework, and lack of funding.

The Royal Society for Protection of Senior Citizens' (RSCC) is one non-profit organisation mandated to inspire and facilitate senior citizens to lead meaningful and fulfilling lives and bring changes to the community at large (RSCC 2013). This Society is further responsible to advocate for old age related policies and programmes, and encourage active participation

of elderly in areas that matter to them. While its efficacy was not assessed, we found the immense necessity to set up district-level senior citizens' society, especially in those areas with a higher concentration of elderly people. Several senior citizens' groups that emerged in the recent years were found to be mostly based in urban areas. Their functions are restricted to organising a few socialising events, facilitation of intra-members bereavement consolation, and certain health check-ups. Broadening the areas of their activities and outreach is seen as crucial, and above all, their role in fostering the relationship with the youth groups, is important.

An innovative idea of building mutual support networks of people to provide old age care and support similar to that of Japan's Fureai Kippu (Ticket for a Caring Relationship) was discussed in the focus groups. There was a popular acceptance of this idea among the group discussants. They saw so much merit in this approach and considered worthy of trying it. If it works well, it is likely to be less expensive, humane, and sustainable, while promoting positive attitudes and perceptions among young people towards elderly people. In one of the villages we visited for interviews, there is an informal self-help group of younger people. Every month, they come together to fetch firewood and repair houses of elderly people living in the monastery above their village. This is one good example of civic-driven community support for elderly people.

Fereai Kippu in Japan is a system of old age care and support, built upon mutual support networks of members of all ages. The members of the group provide help and support to elderly people in return for time credits. They can use these time credits (that they earn every time they help elderly people) in exchange for various benefits when they retire to old age. Phillip Colligan of the quango National Endowment for Science, Technology and the Arts (NESTA) in London described Japan's Fureain Kippu: "The Fureain Kippu schemes in Japan enable people to earn credits for caring for elderly people in their community. These credits can then be used to 'buy' similar person to person services by their relatives in another part of the country, or even save them for their own retirement. Developed over the past 15 years, the use of this currency is now nationwide, creating an alternative gift economy of shared time, skills, and resources" (Colligan, 2011; Hayashi, 2012:32).

Fereai Kippu (Ticket for a Caring Relationship)

In Japan, the 1980s saw the birth of grassroots mutual help groups in urban and metropolitan cities to provide help to frail and needy elderly people, who were living alone or abandoned by their family members. Initially, these groups provided free care and support to the registered care-dependents (Tanaka, 1996). But, as the reciprocity characterised Japanese culture, older people who received the services felt embarrassed when they did not have anything to reciprocate. Social stigma, shame, and psychological stress of obligations and owing associated with 'free service' gradually made this kind of help less popular among elderly people.

In addition, these mutual help groups were small and lacked operational fund. To sustain the operation, they began to charge small fees for the services (Tanaka, 1996). This kind of volunteerism paradoxically became 'paid volunteering,' which attracted criticisms, The main criticism was that paid volunteering cannot be considered voluntary. In response, the mutual help groups began to adopt a new reimbursement arrangement to pay the volunteers in the form of time credits. Thus emerged the Fureai Kippu model that addressed most problems of grassroots mutual help groups. The volunteers were offered the choice of time credits in lieu of cash payment to acknowledge their altruistic motives and action while harmonising volunteer-beneficiary relationships.

One good example is Kobe Life Care Association (1982). Its registered members provided services to dependent elderly members in return for a mix of time credits and cash payment (Tanaka, 1996; Miller, 2008; Hayashi, 2012). The government and other non-governmental agencies supported such associations. The credits were paid back in the form of time.

New initiatives are constantly made to improve Fureai Kippu schemes. The non-profit Sawayaka Welfare Foundation, the founder and key promoter of Fureai Kippu, has identified two types of Fureai Kippu (Hotta, 2006). One is based on time banking and is called vertical type, in which the volunteers earn credits for their services. They can use these credits over the life course, especially when they become old or during emergencies. The other form is time-based

currency or horizontal type, in which the earned credits are used within a short period of time, including limited credit transfers from volunteer members to their own aged parents living elsewhere (Hotta, 2006; Hayashi, 2012).

The coordination and expansion of Fureai Kippu in Japan rested partly on the government's and quasi-governments' subventions and encouragement. In the 1990s the government's funding and acknowledgement of voluntary works, particularly in the area of elderly care influenced the rapid expansion of Fureai Kippu schemes (Hayashi, 2012).

Although Fureai Kippu model is one alternative form of driving civic actions to benefit elderly people, they are not without problems. The complexity arises in rewarding credits, its coordination, and credit transactions.

We are witnessing the emergence of many voluntary groups formed by younger as well as senior people. Some of these groups exclusively focus on providing voluntary care services to elderly destitute. This reflects the compassionate approach, and there is a huge potential to build on such altruistic groups to effectively deliver local services. In our case, it might be worthwhile for some self-help groups to try operating in line with Japan's Fureai Kippu schemes. Of course, we cannot entirely embrace their models, but there is a huge scope in experimenting it and building on this concept. Both the government and stakeholders could help promote such mutual exchange groups by providing seed fund and supporting research, experimentation, and of course innovations.

Concluding notes

This is one of the first studies that have sought to understand the situation of elderly people in Bhutan. Our initial idea was to carry out small and action-oriented research, but then we felt the need to look into the old age issue in greater detail, which might serve as the foundational study for other more specific researches to follow.

The results presented provide a generally negative outlook of old age issue because the focus was on elderly citizens in difficult circumstances. We did not intend to project the negative picture of elderly people, and

our results did not mean all elderly people were in pathetic circumstances. It is only that research basically involved identifying problems and in the process, we ended up projecting the old age issue or elderly people in a negative undertone. Overall, the Bhutanese people are known to be happy and the efforts are made to maximise the conditions conducive to happiness and prosperity of every citizen.

Our results suggested that in the future, there is a possibility that the traditional norms such as aged parents looking towards children for support in old age may change with the change in demographic profile of the elderly population. We should see these changes in the context of changing expectations of the elderly population. Our policies and programmes should be designed in such a way that they maximally suit these changing contexts and expectations. Looking ahead, the role of family care may change, and more and more elderly people are expected to live on their own. Not every elderly individual will do well, in the case of which, ensuring the availability of social care and support within the communities is expected to be of great benefit to our elderly population.

In general, 'genshos' or seniors are given social and physical space and status as people with wisdom, knowledge, experience, as guardians of families and communities, and as managers and arbitrators of local conflicts. The modernisation perspectives advocate that a growing number of elderly people falls into poverty and destitution due to the weakening of traditional values. The spin-off effects of modernisation and urbanisation *per se* development have both positive and negative effects on the lives of elderly people. A few decades ago, most young people lived in the agrarian society, but now rural-urban migration of young people has become a trend. Elderly parents are left behind to toil on farms and fend for themselves.

Being old and frail (with no younger people around to support them), elderly people are exposed to the risk of physical, social, and economic hardships. In fact, in the majority of cases, it is not that adult children do not want to care and support their ageing parents or that value of filial piety—*phadang bugi thadamtshig* (parent-child bond) has degenerated to irrevocable level. Their own socioeconomic constraints and physical distance that separates them from their parents seem to incapacitate them in providing old age care and support. For most young adults, investing in their young children has greater social payoffs than making an investment

on their aged parents because of higher productivity potential of young children than that of their aged parents. This could be, both at the household and societal-level, influencing the formulation of public policy and public programmes in favour of more investment in the younger groups compared to the older groups.

No public policy or programme could be considered holistic if it does not value the intrinsic value of every human life and leads to one-sided concentration of public investments. Undervaluation of elderly people's contributions and over-emphasising on the young productive groups are becoming the trend in most developing countries. If development policies and programmes are to be truly humanistic, public policies and poverty reduction strategies must not undervalue some groups over other groups. Adequate consideration must be made to balance the focus of public policy and anti-poverty strategies on both young and ageing populations. In short, poverty among elderly people deserves equal policy priority.

Social policy that promotes inclusion through non-discriminatory approach is crucial to address the needs and rights of elderly people. The national social protection policy that may address the specific needs of the disadvantaged elderly people is just in the draft form. While it is important to build the old age care and support policies and programmes on traditional ethos and ideas; we must consider the change in the social and material contexts. Lives in the rural areas are changing. No doubt the government is making a tremendous effort to uplift rural conditions, still, rural-urban migration of young people is on the rise. One thing is clear. This never-ending exodus of young people to urban areas is prompted mainly by insufficient opportunities to make money in the rural economy. More needs to be done to enhance the income-generating capacity of the rural economy. This will surely help to retain the productive groups of people back in the rural places and bring positive implications on the lives of elderly people.

The RSSC survey (2012) data shows that 40 per cent of elderly citizens (aged 55 and above) desired for loans at lower interest rate. Micro-financing schemes targeting elderly people may allow them to work, earn and compensate for lack of filial material support. We know that elderly people are unlikely to stand by passively as the world about them changes. As the needs emerge, it is more likely that they will exercise whatever

skills and energy they have to adapt to the new circumstances to minimise negative impacts and maximise potential benefits. In the situation the economy is changing, one effective way of developing elderly people's resilience is to create conditions [for them] to pursue productive activities such as through the provision a low-interest credit and other supports.

Though the customary value of filial piety has not changed to a damaging level, it may be important to note that unless the values of filial piety and sense of respects for older generations are instilled in children right from childhood, generation gap may impact on old age care and support. One way of upholding traditional filial values and practice is to incorporate the values of filial affections—one of the core Bhutanese values into the main school curriculum. This has to be interpreted in the context of the constitutional mandate to uphold the integrity of the extended family system. Encouraging the members of the family to see elderly people and ageing itself in a positive light through public awareness programmes and media could have positive implications on the sustenance of traditional old age care and support system.

There is the need to formulate and strengthen policies and programmes meant for enhancing positive interactions between older and younger generations. Unlike in the past, when grandparents found joy in mutual interactions with their children and grandchildren, today the trend is the interactions between them are not so frequent, affectionate, and meaningful. In fact, an increasing number of children are found to spend their time watching televisions, playing computer games and using phones. Something has to be done to maintain affectionate and meaningful interactions between elderly and young people.

Ultimately, among a plethora of priorities, the most pressing one is to achieve social care and support system that combines social pension for the neediest ones, provision of shelter support, and improvement of access to healthcare services. The most significant aspect of the care for elderly people is economic. Since one of the issues among elderly people is securing livelihood subsistence, able-bodied seniors should strive to work till they become incapable, while public sector and other employers should reorganise jobs and human resource policies to retain productive seniors.

The social welfare programme cannot be entirely private or public funded; some level of blending should be there. The effort to attain welfare pluralism or welfare mix, where there is a mix of the roles of the government, family; voluntary sectors, and the market may be needed. The most desirable approach to old age care and support could be the family responsibility with some supplementary and means-tested involvement of the state, charities, NGOs, voluntary groups, and private individuals. We can try to build the mutual care networks and groups comprising of volunteers, paid staff and able-bodied seniors who can focus on the provision of social or health care support to elderly people.

The financial institutions could come up with several innovative schemes in favour of elderly people. One good example is a saving scheme or fixed deposit for all elderly people over the age of 60 with slightly higher interest rates. The commercial banks could have special accounts for senior citizens that offer special services like priority services, special bank cards, etc. They could provide elderly people the low-interest loans. The telecom companies may explore the possibility of providing telephone or mobile connection concession to elderly people. Lowering taxes for elderly people to ease their financial burden is one of the best practices in other countries. As is being done by the national airlines and city buses, elderly citizens may be given some discount fare for travel on buses or other means of transport. Transportation was pointed out as problematic by some elderly people. Certain bus seats must be reserved for elderly people. There are many possibilities that each private, corporate entities and government sector could initiate to make the lives easier and better for our elderly people.

The public education focussing on the fundamentals of retirement planning and building individual's capacity for self-reliance in old age through diversified assets, including health insurance, annuities, and social capital may be useful. Given the knowledge and experience of elderly people, the question arises how could the rising number of them be encouraged and helped to contribute to the society. What role can the government take to re-conceptualise the meaning of retirement and active citizenships? Regular in-depth and more specific studies should be encouraged to understand the emerging old age issues and as a part of the preparation for the population ageing.

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CHAPTER IX

UNDERSTANDING AGEING THROUGH LIFE HISTORIES

Lham Dorji, Cheda Jamtsho, Tashi Norbu & Garul Dhoj Bhujel

Introduction

With enhancing life expectancy and increasing growth of older population, it is crucial to take interest in understanding how people age and what constitutes successful ageing. Understanding the life history of the aged people through their own narratives is not only important for ameliorating conditions for elderly people, but also for ourselves in our own waning period. The situation of current older generation is not much known to us because today they live in a space in the life course that is in all respects distinct from what they had experienced some decades ago. Modernisation has created different socio-economic environments, and the current cohort of elderly people are the pioneers in experiencing these changing social, cultural, economic and political circumstances. They have gone through several episodes and learned to adapt to new historical circumstances (new dominion of human experiences).

In addition to the analyses already presented, we have resolved to incorporate the life history recording of each of our research participants. Our interviews were divided into four parts that included a person's narratives of: (1) his or her early life (as a child and young adult); (2) adult life that constitute responsibility-taking and family life; (3) present life as an elderly person; and (4) his or her future dreams, expectations, and plans.

The logical basis for presenting each interview in the form of narratives (though some were already quoted in the previous chapter) is that: (1) attitude and behaviour of the people in the later life depends on their earlier phases of life; and (2) understanding of ageing entails understanding how they passed through different stages of life. It was considered important to present individual narratives in their own words rather than simply presenting our interpretations of these narratives. This is because the essence of a person's life cannot be grasped from our

vantage point, as we have not experienced his or her life (Merton, 1972; Fisher, 1991).

One significant benefit of presenting the life histories of our study subjects is that it may offer our younger generation the understanding of what it means to be growing old. Today, many of the young people consider elderly people as 'weak, uninteresting, traditionalist, old-fashioned, and burdensome' to the family and society (Butler, 1975; Fisher, 1991). Some of the interviews revealed that elderly people are not a particular group of people with a negative stereotype, but with diverse personalities, characteristics, and expectations like younger people.

Life histories

(01) Participant ZG-01, Male, 74

When I was a young person, I was severely deprived of food and clothes. It was hard for me to get three meals a day. We normally would survive on porridge and wild tubers. Those years, life was harsh and unthinkable, really unimaginable!

I lived in Trongsa (above the Trongsa Junior School that time) for many years. I have faced many kinds of problem, and worst one was, have had to hungry most of the time. When I got money, I would buy rice. I would cook not more than a small cup full of rice for breakfast and lunch. I would borrow other's clothes and wear hand-stitched clothes all the time. Once I got Nu. 7 after working for seven days in Tencholing. I spent the money to buy an old-fashioned pant.

I don't have any problem at present, though before I had to face many problems and suffer so much. For example, while travelling towards Trongsa from Samtengang, I had to walk barefooted on the snow. Imagine the cold!

I arrived at the present village when I was 30 years old and got married to my present wife. She is now 62 years old, the age almost a dozen of years younger to me. We adopted her nephew as our son. We don't have a biological child. During the Fourth Druk Gyalpo's Coronation, I went to Thimphu. I underwent a surgery that time at Thimphu Hospital. I was just 20 years then. After the surgery, the doctor told me I might not be able to reproduce. My wife left me after she knew I was sterile. I got married and

remarried nine times before I met the present wife. Most of them left me after two or three years after knowing that I was infertile.

At present, we live in a small hut. We have our property in the village. The land on which we built our hut belongs to my wife's cousin brother. He lives in Samtse and works for the government. We don't have to pay any rental charges.

My wife's family had five acres of land holdings, which was apportioned among the siblings. Her family was a huge family. The share of land she got is very small. My brother and I did not get any land from my natal family. My aunt inherited our family land and a house from my mother, as they were living together. She might have sold some land. I did not demand my share of land. I don't regret the fact that the aunt did not give us our mother's land. After all, we cannot take land with us when we die. If I have enough to eat, that's it.

Until last year, we were looking after our grandchildren who were then attending a nearby school. Only two of us live here, and now we don't have to wake up early to prepare and pack meals for our grandchildren. It used to be a big challenge for us. Our adopted son and daughter-in-law live in another village looking after their parental property. There is no school. Our daughter-in-law has registered her land and house in son's name. They have many children: three daughters and two sons. One is a monk.

Though I don't have any child, I have an adopted son. I feel as if I have a bloodline child. Some people have, but they face problem sharing and apportioning land to children. Some of them even tell me that I have no child of my own. I usually react saying though they have children, I see their children not doing good to them. I feel happy when my adopted son calls me father. He is good to me and so is the daughter-in-law.

We don't have much problem. We have sufficient food. We plant maize and brew alcohol for sale out of the harvests. With the income we get, we buy oil, chilies, and sugar. Our son and daughter-in-law send us rice. I hesitate to go to work. People refuse to engage me saying that I am too old to work. This is sort of discrimination that elderly persons face. I can't do anything rather than to respond: "wait, you'll also one day become like me!"

We used to get around one thousand Ngultrums last year out of which we would spend Ngultrum five hundred for our grandchildren. They used to love to buy eatables. Still then, the money was sufficient to meet our basic needs. This year we had a bumper maize harvest. Wild boars-our true menace did not destroy the crops this year.

Today, life is far easier than four decades ago. Rice and clothes are readily available in the shops. It was not like that in the past. There were just a few shops and rice was a rare commodity. We would then have to depend on farmland. We had to pay a different kind of taxes and levies. Even butter, we had to offer to the government. At present, whether we want to have things or not, it's all in our hands. There were no motor roads those days.

I was 18 years when the first road was built to connect the present day Gelephu and Trongsa. I took part in the road construction in Trongsa. It was during Dzongda Ngawang Jamtsho's tenure. We had to use our bare hands and physical energy. There was nothing such as sophisticated machines. Life has changed so much now. The difference is like sky and earth. I must thank the Third and Fourth Druk Gyalpos for bringing such developmental change within a short period and making life easier for their subjects.

Those days, we had to carry loads on our backs. These loads, I suppose, were taxes in kind collected from different regions. We would get wounds on our back. Sometimes, we would be away for more than a month carrying tax loads.

When I was in Trongsa, I heard the government was going to grant special support scheme to poor people. But, I had to leave Trongsa and come here. Many people say we could apply for kidu, as we do not have children to support in our old age. Others say, my wife and I have separate census registration and would not be eligible for kidu. Actually, I do not expect much from the government. The government has so many priorities and we can't go on burdening it.

I will die here. Now that I am old, I don't have any worldly plan. I don't dream to become rich. I would rather spend time reciting and chanting prayers. That's true wealth, which will help us when we die.

(02) Participant ZG-02, Male, 81

After spending my entire childhood in the village [Goshing], I joined the Army and then the Police. Life was hard then. As a child, I used to help my mother and sisters to prepare a weaving material. Weaving used to be one of the main household activities in my family. Those days, we had to bear a huge tax burden. My family had to pay handwoven cloth to the government. Besides helping with weaving tax clothes, I used to be passionate about cooking, which I started learning from my mother when I was eight years old.

In 1959 when I was 20, I left my village to become a soldier. It was during the time of *Chabda*. After undergoing tough nine months of rigorous training at Tencholing, I was posted in the South where I served a number of years. After many years in the South, the government allowed me to switch my from the army to the police. Many of us who served in the South were then instructed to join the police.

Having joined police fraternity, I was posted at Zhemgang. It was an order from *Tamzhing Jagar*, then the Minister for Home Affairs. I was serving as *Nyerpa* during the construction of Thimphu Memorial Chorten, so he [Tamzhing Jagar] instructed me to go to Zhemgang. The Gongzo Chorten was actually constructed when he was a Minister. He would come to the construction site as early as 5 in the morning to monitor the construction works. On the first month of the fifth month Bhutan corresponding to 1975, I came to Zhemgang. Since then, I continued working here until I resigned in 1988. Today I live here though I find my own situation very different may be because of my age now.

I had a very challenging family life. I got married in 1954. It was an arranged marriage. We [kheng community] have the culture of arranging a bride and groom by our parents at a very young age. I got married this way and already fathered a child [son] before I joined the armed force. The story does not end here. As my professional life continued with the regular transfers and change of work places, I met my second wife with whom I had many children. In fact, she gave birth to 15 children out of which eight had survived. Some died prematurely during pregnancies, some died three days after delivery, and others after a week of delivery…]. Life became hard for me as children grew up.

None of my children excelled in studies. They kept dropping out from schools. Some dropped out at the tenth standard, some after completing class eighth, while others dropped after completing class six. I tried to discipline them, took care of them, but nothing worked.

The most painful part of my life when I lost all my assets [including two buildings and five acres orange orchard]. My eldest daughter was responsible for this mis-happening. She was a crazy gambler! Her gambling partners were some big shots. She had taken loan mortgaging my assets forging my signature. When we could not pay the instalment, the bank auctioned my properties. That's how I lost my property. It's very painful to lose a property in such short time having invested my entire savings and energy. It's simply unimaginable!

Having lost all the hard-earned assets, I got divorced with my wife. Today, at this age I live in a rented house with another woman. I need to pay a house rent of Nu. 8000 per month, which my small shop is fairly not able to earn. Because my children are struggling to support themselves, I do not expect anything from them though sometimes I feel like going to their houses. At this age, when my health often fails, I I need someone to look after me—someone who would offer me as simple as hot water when I get sick. Therefore, I decided to remarry the present wife [third wife]. She is a dozen of years younger to me.

If the government plans to support elderly people, we need every kind of support. The government cannot fulfil all our needs. This is not realistic. We have to think of every elderly people in our country. It isn't that our government is doing nothing for the welfare of elderly people, the government is providing continued support to improve the lives of its people. Yet, if the government plans to come up with any welfare scheme, I would suggest the government to provide elderly people with the monetary support. May be, the government could give every old person Ngultrum 3000 as funeral provision and a monthly allowance of Nu. 1500. Further, it will be better if the government establish the old age homes for those who do not have children or who do not get any support from children.

Now that I am old, I think I have no more plans in life. At this age, I find it difficult to take regular meals, forget about planning what I will do. My memory has deteriorated. I find it difficult to remember a recent past. With such disability, it's not worth thinking of any plans.

(03) Participant SP-01, Female, 72

I am too old that I don't have any more energy to work now. I simply depend on other people for foods and other basic needs. Before coming here, I lived in Pemagatshel with my husband. He died after we resettled here. My two sons also died, leaving me alone. The elder son was a government driver. The younger son died due to illness. The older son married a Nepalese girl. He would have beaten her when he found out that she was into an extramarital affair. For that, I doubt she and her relatives might have performed a black magic [against my son] due to which he succumbed to a serious illness and died.

I have a stepson—and I guess he is living in Surey. He is a teacher. He may be just surviving on a mere salary. Whatever, he doesn't bother me. He has three children. His wife is from the East. I know that she was studying here, and later she studied in Gyelpozhing School. I guess she has finished studying.

I settled here in Chuzurgang after I got the land *kidu*. My husband and I worked hard. We planted some betel nut trees. In the middle, when things were getting good, my husband died. It has been 7-8 years since he died. He was washed away by the River Maukhola. During the recent land survey, I helped the survey team to the best of my ability, hoping they would help me sort out the land issue [that I have]. Actually, my stepdaughter is claiming the land. But, she is not nice to me.

I survive on my own. I share crop with the Indian farmers across the border who take much of the share. In the past, we used to apportion more crop share, but now the Indian share croppers have become unpredictable and demand more. We used to get 12 *muareys* of paddy; now we get only 7 *muareys*. The crop yield is continually decreasing. I have four and a half acre of wetland. But, as I can't cultivate the land, I get less crop share. I cannot work due to my old age. I have a few betel nut trees. I do not earn much by selling the betel nuts. This year, I earned a little. I harvested about 12 bags of betel nuts. I earned around one thousand Ngultrums.

I have relatives back in the village—sisters, nieces, and nephews. They can't reach here even though they might know that I am suffering alone after a series of misfortune in my family. They do not seem to bother me. It has been almost 20 years since I left my village. I used to own a medium size

traditional house in the village. My relatives took over the ownership of this house when I left the village for the resettlement. My son built a small house. It is small compared to the houses of other people in the neighbourhood. My son was a driver at Gedu. He used to look after me. Now he is gone, and this must be my own fate that I have to live alone with no one to support me.

My step-son's family is not nice to me. They simply want to take over the land from me. Of course, I gave them some part of the land. They want the land that has betel nut trees. I gave them as they wanted thinking they would be good to me.

My grandson is studying at Gedu. I want to inherit some land to him, as his father died. I know he will face a lot of problem without his father. But, I don't know. He never bothers to call me, forget about coming to see me. His mother was working at Gedu. I don't know whether she is still working in the project. She is a very cunning woman. She might have now got remarried. She has a daughter as well. This year she had somehow managed to transfer their census with me without my knowledge. I am sure this is her strategy to take the whole land that I own. No matter what, I am not giving her my land and house as long as I am alive.

They do not call me. My stepson and grandson have their census registered with me. My late husband had one son and a daughter from the previous wife. The stepdaughter (my stepson's wife) is not good to me either. She is the evil-hearted woman I should say. It seems she is influencing my stepson to take over my assets. In the past, I helped them. My late husband, I think might have known he would not live long. That might have had been the reason why he had transferred his son's census here. She had completed all the formalities and had come here to register her census [with me]. The census official told she should have consulted me before registering her census here. But, these officials they do not do her anything. On the document, she has put a big finger print; the smaller faded one they say was mine. I did not give any finger print to anyone. I am sure they have forged my fingerprint on the document to get themselves registered with my census. It has been two years since I had been paying their life insurances and individual taxes though I don't receive any help from this stepson and his family.

I went to Mang-apa (assistant gup) to seek clarification on the land issue. My daughter-in-law has laid her land claim with the gewog office. So, I have two parties claiming my land: my late husband's son's family and then my late son's wife. Mang-apa told me I cannot decide whether I want to inherit the land or not and that the gewog office doesn't help with such issue.

I know I had to suffer alone so much to take care of the land: I contributed labour to maintain irrigation canals and build roads. Now the Gewog office is saying that they can't help me retain my land. This is not fair. I have planted betel nut trees, and now the daughter-in-law (late son's wife) and the stepson wants those trees [as well] while they don't want to support me in my old age. If I die soon, then they could take my assets. But, as long as I live, I will never give them the betel nut trees that are registered in my name no matter how hard they try to influence the Gewog officials. I have already given them some trees. They should be satisfied with what I gave them.

Here, life is not so easy. We have to make never-ending contributions. Only recently, I had to contribute Nu. 500 and some rice for mask dancers. I have to manage all these contributions, which often become difficult for me. The most difficult part is when I am asked to contribute labour (woola). I am too old to work. When I feel lonely and sad, I usually visit my friend and sleep there. I have a friend nearby. Some neighbours help me when I get sick, but there are other neighbours who do not bother to help people like me.

When I got ill last year, my friend might have asked the daughter-in-law to perform some religious rites. She refused to do so. She had rudely told her: "let her perform rimed herself." My daughter-in-law is not a good person. How could she tell like that after I had been kind enough to her? I have no one to care and look after me. I have an old cow. I sell butter, cheese, and milk. I make some money by selling home-brewed alcohol. I have to do many things to earn my livelihood despite my old age.

Forget about being happy, I don't even sleep properly. I get sad over my own life. I worry that no one will be there to look after me if I fall sick. If I die, my body might decay with no one to conduct a funeral. I have no future plans. I chant prayers at home. Last time, I went to a temple to chant prayers.

My neighbour's daughter wants me to stay with her. She was here in the village. She got a job and emigrated. She left the village after the last losar. I thought to go with her, but then I could not leave the house and land. If I am not here, the thieves might break into my house and take away whatever I have at home.

I always think there is no one to care for me. This thought comes even in my dreams. I can't expect the government to help me. The government has done enough. I am taking care of the land and property for my grandson only. I don't know why he does not understand that I care for him. He never bothers to keep in touch with me. Sometimes, I feel I would sell the property and go elsewhere. But then I think for his future. If I do not keep land and house for him, he might say his grandmother has not done that and blame me.

(04) Participant WD-01, Male, 67

I live with my son in Martshala. I have two sons and a daughter. The daughter lives at home (village) and son is working here. My daughter studied, but she had to drop her study, as she was needed at home. The other son is a school basketball coach. My wife is with me. She joined us only recently. We came here to drop our son and his family. My wife will soon leave for home while I will stay back with my son's family. I won't feel sad when my wife leaves for the village. My wife and I are in very good terms. We don't tell anything bad to each other. I married only once in life. Back in the village, we have a traditional house. We had to build the house after our relative (my wife's sister) claimed the ancestral house. We built it in 2008. It is roofed with CGI sheet. I used my retirement benefit to build this house.

I worked in Bhutan Telecom for 43 years. I was working as a network inspector in Bhutan Telecom. Today I get the pension worth Nu. 6500 per month. I claimed around 7 lakhs of gratuity. Earlier I had some procedural problem getting my pension. Now they deposit it into my bank account every month. So there is no problem getting my pension. Once I had a problem. The pension officials have deposited my pension into other's account. I did not get my pension for three months. I raised the issue with them. They sorted it out.

My pension benefit is more than enough to sustain myself. I don't have any other sources of income. Earlier I used to get some income from the sale of oranges, but now the orange trees have got damaged by disease. Sometimes, I suspect our orange trees died due to dust emitted from the Gypsum Mines.

We were 11 siblings altogether. Now only two of us are alive. My relation with the younger sister is good. The land ownership was given to me before my mother died, as I was the eldest son. But then, since I decided not to go back to the village, I transferred the property to my sister. I have transferred my census to my wife's village.

I had suffered so much in my early days. In 1961 I was enrolled in Gaselo primary school. In 1966 when I was studying in class 3, the late Dasho Lam Penjor selected me as a post and telegraph assistant. He sent me to Calcutta in 1966 for one-year training. I joined back and continued to work with the Project Dantak for 12 years in Gelephu. In 1978, the telephone infrastructures were established in many Dzongkhags. The Dantak handed over the telecommunication service to the government in 1980. I worked hard to establish new telephone connections in different places. It was not as easy as it is today. The lines had to be set up through wires. In 1991, I went to Sherubtse College and worked there as a telephone operator for seven years. I was involved in setting up telephone lines in Pemagatshel, Mongar, Khaling, Yangtse, Tagmachu, and Yongphula. I retired in 2007 when I attended the age of 58. Since then, I went to live in my wife's village.

My daughter has completed class 10 and the youngest son completed class 12. My eldest son studied till class 12 in Khaling School. He did not qualify for the government's college. I told him to work in place of me, but he refused. He was willing to continue his studies in Darjeeling. For that, I had to borrow money from others. He graduated from Darjeeling and sat for the RCSC common exams. He got through and was posted in Trashigang Dzongkhag. He had worked with the Gewog for six years now.

My son and daughter-in-law treat me well. My wife is into practicing *threma* and other spiritual activities. Our son helps her with all expenses related to her spiritual practice. I use my own pension money to meet the expenses related to the spiritual practice of making donations, going on pilgrimage, buying butter for butter lamps, etc.

All my three children are good to me. They listen to whatever we (parents) tell them. We don't quarrel. I see many old people suffering their receding years. They do not get any pension. Some sons ignore their parents under the influence of their wives. Even after the death of their parents, some of them do not perform decent funerals. Some children make their aged parents sleep in the kitchen while they sleep in good rooms. They do not bother to send home money for annual rituals. I have personally seen five such elderly people suffering their old age.

Some children do not support their parents, they leave parents and move to town. Some parents do not have children. Some children do not care and don't perform proper funerals for their parents. Poor children, in general, do not neglect their parents; it is the children of the richer parents [who neglect their parents]. I have seen the negative roles played by daughter-in-laws. If a husband is dominant, he beats his wife and then gets divorced. This is common. It's the children who suffer in the end.

If children are well-educated, then it would be better. For most parents, children are an important source of care and support. But sadly, some young people get into drugs, gambling, and in the circle of gang forget about helping their old parents. This happens mainly when their parents get divorced. One thing is, after studies they remain unemployed, which force them into drugs habit.

I feel the government should help those elderly people who do not have children or those old people who are not taken care by their children. The government could give them monthly subsistence allowance and provide shelter. The most important thing in our life is money. It is even more important for those people who do not have children. The other thing is, I feel we should encourage young people to be responsible. In this way, they could serve both the country and their parents.

(05) Participant SP-03, Female, 71

I was born in Tsirang. I came to live here through marriage. I was just 12 years old when I got married. I have never gone to school [in my life time]. I am a believer and practitioner of Hindu faith. My husband died 15 years back.

I have five children: three sons and two daughters. None of them are here [with me]. They are struggling to make their own living. My eldest son is settled in India through marriage. It's been a very long time that we met. I have even forgotten how he looks now. In the past, it was legitimate for cross border marriages. One son lives in Thimphu while the other has left for overseas during the 1990s problem. While one daughter was married to Indian and got settled in India, the youngest daughter is here in the village.

Today I am staying with my grandson. His family will soon shift to their new house. After they move to their new house, I will be alone. I am worried about how I could sustain [living alone]. With age, it's difficult to work on the farm. My only source of income is a few Areca trees. These trees have also seemed to be affected by the disease. During a good season, I fetch around 40 to 50 thousand a year. Otherwise, most of the time betel nut trees yield poorly.

I don't expect my children to look after me because I find them facing difficulties in supporting themselves. I normally borrow money from others to buy rice during times of special needs such as when losing crops to wild animals. The human-wildlife conflict is which is very rampant in our community. This year, I didn't have to buy rice, but I feel I will face food shortage next year.

My children won't care for me even when they know that I have a broken leg. My late husband built this house. We just spent about eight or nine thousand Ngultrum. I have three small rooms. I use the temporary toilet. If I get some good amount of money, I think of renovating it. I face the food shortage, forget about repaying this house. We have many Buddhists priests who conduct rituals. I visit them and receiving their blessings. Now my body is feeble. It would be better if our community has one Hindu temple.

My grandson treats me good, but his wife is sometimes rude to me. They quarrel sometimes because of children. I am old and I just keep shut even when they fight. I feel sad that my own children are not here. Then grandson's wife scolds me. The reason is that I am always blaming my own body. Especially when I am sick and not able to work, I feel there is nobody to look after me and that everyone is deserting me. I would better die. What to do sir? I can't work. I don't know whether I will have enough to eat once my grandson's family move to their new house.

I have a high blood pressure. I get dizzy and feel like I am going to fall down. That's why I have to take a lot of medicines. I am not supposed to eat butter because of pressure. I have wound all over my body. Sometimes, I think I will commit suicide. When I think much about my life, my blood pressure tends to become high. I have not attempted suicide, though I think about it. When I am not able to work, I feel it would have been better if I were already dead.

The problem in our country is people have fewer children now. In the past, people used to have many children. Children now have little time for their parents. Even if the government provides old age homes, I won't be happy with it. I'd better stay with my own sibling. It would be better if the government could help us with some money.

I deposit 1000 or 2000 (earned through the sale of betel nuts) in the bank. I use this money when I get sick. I don't get money all the time because I don't have cows or goats like other neighbours. I think this way. My youngest son tells me that I am being too selfish and greedy. But, I do not listen to him. I have submitted a letter to the Gup stating that as long as I am alive the betel nut trees would belong to me. I am old now, not intelligent. I can't speak well. I don't have anything more to say. I feel our king is great. That's it la.

(06) Participant SP-04, Male, 60

I am 60 years old. I have been here for last 15 years by now. I got married when I was 25 years old. I have a small hut with one room. At present, we are five members [in the house]: 3 children and my wife. I could not build a good house [like others]. I have got to support schooling of my eight children. The eldest son is in the Army. Two daughters completed class 12, but they did not qualify for the higher studies. The youngest daughter is studying in class one and the youngest son in class six. One daughter is working in a hotel in Paro. The eldest daughter is also in Paro. She supports me more than the other children.

That time I was staying at Punakha Kabesa. Within few years, I had 3 children. I did not have land. This made me worry. I applied for land *kidu* in the 1990s. However, due to the ngolop problem, my land *kidu* was put on halt. After a few years, I re-applied for the land *kidu*. By that time, the government announced that people without land would be given land *kidu*

of 5 acres each. I was so happy. After a few months, I was called to Punakha Dzong for the land *kidu*. There were many of us. Some of us were sent to Dagana and some to Samtse. I was part of Dagana group. After seeing the land, I did not like it. I again submitted my application to Punakha Dzongkhag. However, I had to wait for 3 years. I was then relocated at Tarithang under Sarpang Dzongkhag. But, then the conflict was still going on in Tarithang. So, we were not allowed to stay there. We were relocated to other gewogs through lucky picks. I got land in Chuzergang Gewog, where I am today. By that time, I had eight children. My family size was growing.

This village was then all covered by forest. The place being plain and thickly covered by bushes, we would often get lost. We would find it difficult to come back to the same place. There were no roads like today. That was the situation then. I started to cultivate ginger. We had no access to the market. To reach Gelephu town, we had use boat and it was risky too. We had to risk our life, as we did not have other option. Nowadays, our community is connected by the road. I had suffered a lot for about 3-5 years, not knowing what to do in this new place.

My children do not talk anything about building a new house. I think they are not comfortable with our financial capacity. They themselves find it difficult to meet their daily needs. I wish to build a new house, but I have no money. I do not know how I will be able to build the house. I don't think I can build a house because I have agriculture loan that I took for ginger plantation. Since I did not get a good price for ginger I find it very difficult to repay the quarterly loan instalment.

Very often I face food shortage. Last time, I faced food shortage for about 1 month. I borrowed money from neighbours. I would often buy basic necessities such as rice and oil on credit. When I get money, I repay them. I have no other problems except the problem of not having enough to eat, not being able to build a decent house and difficulty of paying loan instalment. I am happy here now. I don't want to go back to Punakha. I have no relatives there.

I am 60 years old. I have many children look after. At the age of 60, we consider ourselves old enough. Despite by age, I have to work hard. After all hard works, I still find it difficult to sustain my family. I do not what to do. Even if children are growing up, I wonder whether they will support me and my wife. At this age, instead of worrying about becoming old, I spend most

of my time worrying about food and house. Anyway, the situation here is much better, as I have enough land. If stayed back in my native place, I would be struggling landless. I should be able to endure all these physical hardships.

(07) Participant SP-05, Male, 76

When I was a child, my life was not very easy as enjoyed by today's children. I find it very difficult to put it into words, but my life was really hard-going. Those days everything was done manually, unlike today when most of the things could be done by machines.

As a child, I used to go for farming. Because there were very limited infrastructures [those days], we were not spared from taking part in woola: constructions of roads, bridges, and renovation of Dzongs. Life has become much easier now. Those days, we used to wake up when the cock crowed. Nowadays, we are more relaxed. We would consider it satisfactory if by working hard our food could last for six months. There was big problem food shortage. Most of the time we had to survive on porridge, wild tubers, roots, shoots and wild fruits often. Nowadays, even the dog refuses to accept such food!

Having spent my childhood days in my village, I joined the armed force (sometime in 1969). I served the armed force for many years until I resigned in 1994. After my retirement, I started running a small tea shop in Tingtibi. I thought it would be difficult to go back to the village and do farming. I survived this for around 20 years. I resettled in Chuzugang. It has been now more than 20 years since I moved to this place.

My parents died when I was in the Army. Being a simple soldier, I could not do anything good to my parents. However, I did perform their funeral and other rites. I am satisfied with what I could do to my parents, at least. I regret that I could not reach them when they were alive. My father passed away when I was at Tencholing camp while my mother died when I reached Cherithang.

I have one son and a daughter. Having studied up to class six, my daughter got married. She has four children now: one son and three daughters. At present they are at Gelephu. She is running a small pan shop. My son

studied till class ten and he's still looking for a job. Only two of us [wife and I] are left at home now.

We live in a small hut. I could not build a bigger house. The gratuity that I got when I retired from the armed force was not good enough to afford a bigger house. My daughter is unable to help us, as she has many children to support. Moreover, she is a single mother. Although I retired from the post of Drimpon, the salary that I drew was very minimum. It was just Nu. 3000 a month. In addition, there was no pension system in our time. The nominal gratuity that we drew could not sustain us long. I feel we are very unfortunate compared to those batches who resigned later. They got a very handsome pension benefits. Sometimes it gives me the pain to think of such things (unfair pension benefits), but I stay content with what I got. It's not good to compare myself with others.

Though we are all by ourselves now, we are pretty happy that our children are doing us good to the best of their capacity. At this age, it's very difficult to work. In the past, people used to come forward to do sharecropping. It is different now. My wife can do a bit of household chore though she's older than me. But she often complains about joint pain. I have hypertension, and often I get back pain. My daughter wants to help us, but she has her own problems. She has a huge responsibility of bringing up her children. We feel very uncomfortable to ask for her help. People say life is full of sufferings. I think it is true, and it is worse at this old age, but we will have to move on.

I think it is useless to make worldly plans now. I can't do anything given my age. I don't know whether I live long or die soon. My only wish is, I remain independent. If my children could come and build a house, then I can relinquish land and go elsewhere to practice dharma. I have planned to go back to the village. There is a generation old temple. I can stay near that temple and recite prayers. If in case I decide to go to the village to practice spiritualism, I am hoping my sister's children would support me with rations.

If the government provides shelter and food, I will be very happy to go and chant prayers. I am ready to go to old age homes if the government build such homes. The only issue is who will take care of this land?

(08) Participant PK-01, Female, 65

I come from a broken family. My parents got divorced when I was nine. My younger brother was just seven years old. Since then, life has been very difficult for two of us.

While I did not get an opportunity to study, my brother had a chance to study in Logodama Primary School (when our parents got divorced). The headmaster used to visit our home. He would tell my grandmother to send me to school. Her only response: "If I send her to school, there is no one at home. She has to look after me and attend to daily household chores."

Even though we had enough land, we did not have the parents to guide us how to make the available land productive. We had to survive with the little income we could make by working on the neighbouring farms. Because our stepmother had a large family, we had to contribute even those little income [we generated] to the family.

Further, it was a nightmare to see my father punishing his son on the words of the stepmother. I felt it was just not acceptable. Firstly, when we were deprived of the love and care of a mother, witnessing such behaviour from our father was very painful and unbearable. By age 13, I was already taking an additional responsibility. I realised that it was not correct for me to stay idle when neighbouring households were working hard. I started working hard. I had four pigs and few cattle to managed. I started to work on the farms: for paddy cultivation and kitchen gardening.

Our mother was always supportive and vigilant of me and my brother. As she saw us growing and suffering at home, she had other ideas. She wanted me to get married soon. She proposed a husband for me, which I could not refuse. Obeying the words of my mother, I got married and gradually started shaping our life. In the due course of our married life, we managed to build a decent house. The darkness that we went through saw the light. However, the light of happiness was only short lived. At the age 46, my father passed away. It was yet another difficult moment in my life. Having faced the difficulty of building a house earlier followed by the tragic and untimely demise of my father, life was never easy for me. The burden of debt kept rolling.

Like adding fuel to the fire, the misfortunes of my life did not seem to end. Last year, I lost my husband in an accident. We had very difficult time looking for his dead body. The series of misfortunes I had suffered so far only added to the burden of debt I already had. Today, I owe more than eight lakhs of debt to the bank. It's a nightmare to live in such a debt trap at this age.

In general, over here, I mean in our community, I have not seen any elderly people suffering. Of course, there may be a few, but I feel every elderly people are taken care by their children. When it comes to the old age support, I think it's not wise for me to say the government should support us this way or that way. Our government, with the wise leadership of our kings, is supporting us in every aspect of our lives. Anyway, if the government is planning to support old people, I would prefer some financial support be given to older people who are in a difficult situation.

I don't think I would stay in an old age home that many people talk about after the previous government discussed setting up old age homes. Anyway, I am sure there will be some poor old people who will be interested to stay if the government plans to institute old age homes. I have a lot of debt (as I shared you before). My only plan is to try and work hard to repay the loan.

(09) Participant PK-02, Male, 76

I did not want to live in the village because I thought I would suffer having to work in the fields. So, my parents admitted me to a monastery to become the monk. I have been in the Dzong until I was 61 years. I resigned. The monastic authority gave me the options of either to continue living in the Dzong or go to this place (Dratshang's Old Age Home for retired monks). I decided to come here. The monastic body now provides me a ration.

I did not do any naughty things when young. The rules in Dzong were very strict. Our teachers would beat us if we were not found in our room. When eating meals, we were not even supposed to look at each other. I was a monk in Punakha Dzong.

I am all alone. All my parents and siblings are dead. Since I was the youngest, they never used to call me when they have a family problem. My father died when I was 25 years old. I was in retreat that time. I did not see my mother. Since I was the youngest, my father sent me to the Dzong.

Whenever there was a ritual in the village, my father would come to take me and again drop me back to the Dzong. When my father came to drop me back to the Dzong, I used to feel sad. Once, I ran away from the Dzong, but as I did not know the way to Thimphu, I got lost on the way, and later Kudrung found me. He whipped me mercilessly.

I have beaten monks when I was Kudrung. No one could stand against me. The rules were very strict that time. I received three scarfs in my life. I served as Nyn-gay, Kudung and Kalu Lopen. I served as Kalu Lopen for 24 years. Je Khenpo a free quarter in the Dzong.

After coming to this monastery, I went to the village once or twice only to perform the annual rituals. I do not want to leave this place. If I go back to the village, I may not be able to work. People may tell me to work and herd cows, which I won't know. They might not like me keeping idle and tell me something bad. I feel better here. I had eight siblings. I was the youngest and 5 of them already died. Another sibling elder to me died last year. Now I have only grandchildren. I helped to perform funeral and death rituals for most of my siblings.

Je Khenpo instructed me to stay here. If I go to the village my grandchildren may tell me to do work and scold me if I don't do. If I argue they won't feel happy and they may not give me food. Dratshang is providing me with every thing that I need to survive. I just chant prayers. Even if I die, Dratshang will perform the funeral. I thank His Holiness Je Khenpo for give me such life (after retiring from the monastic community). I think of His Holiness before I sleep that even parents would not be so kind as His Holiness. I don't have to wash cloths, plates, and mugs. We have a toilet attached to our bedroom. I get three meals in a day. The only thing I have to do is to prepare morning tea for myself.

When I was 37 years I took an oath that I would not marry. If I do I will go to 'hell of hell'. I did not engage in any sexual activity so far. When I go to the village I wear this dress. I did not wear Gho. I don't know how to play archery though I played dego when I was in the Dratshang. My friend, late Kinley Gyeltshen of Tango helped me come to this Old Age Home.

I eat meat sometimes, but very little. His Holiness Je Khenpo and teachers instructed to serve us only dried meat.

Sometimes we hear from saints that there are many oaths like not lying and not marrying. When we join monk, first we need to take advice then oath. We can take oath on the 15th day of the Bhutanese calendar. We can talk with ladies, but cannot sleep together inside one room. That was what His Holiness Je Khenpo taught us. If I break the oath then I will go directly to hell.

No no… I will not go anywhere. I will live here and recite prayers. I don't have any sibling, so I better stay in this Old Age Home. I have no other purpose of going anywhere when I am happy here.

(10) Participant SJ-01, Female, 84

My marriage brought me to this place. I am already 84 years old. My husband brought me here. I had 3 sons. They all died very young age. I have one daughter; she is somewhat abnormal. I experienced so far very sorrowful life. First, my three sons died; second, my daughter is abnormal; and third, my husband died a few days back. Today is the 10th day since he passed away. I had difficult times. I lost everything now (close ones). Since daughter is abnormal, I don't know how she will perform the ritual and rites in case she gets sick. She has no brothers and sisters (She cries). Everything is gone. May be I will die soon. My back is all burnt. This accident happened three months ago. I went to the hospital and still, the burns are not properly healed. I had to come back from the hospital after I heard my husband died. The wounds are still itching. It is very painful. I am going through sleepless nights these days. I am a hopeless old woman now.

I don't want to think like that, but what to do I cannot bear the sadness and helplessness. It was unfortunate for me that such accident happened to me. I was sleeping near the oven. That time, I was wearing nylon shirt. I think the fire caught through the nylon shirt. I was in the hospital undergoing treatment when the husband died. It is time to cure, but it is taking time. I wish to die. I can't bear the physical pain and my mind is full of sorrow. I don't feel like eating. Would there be any other old woman like me in this world?

I am a poor woman. The death of my husband made me poorer. I have no money. I don't have land. My son-in-law has the land. I have one granddaughter and four grandsons. The eldest grandson is in Thimphu. I don't know what he is doing. He did not turn up even when his grandfather

died. The second grandson is a machine driver. Other grandsons are studying. I have no money to perform the death rituals for the late husband. I don't know what to do. My daughter is suffering too. I feel pity for her, as she is abnormal. My relatives have come; they gave us their helping hands during the demise of my husband.

After my body was burnt, I have become a disabled person. I am not able to walk properly. I do not have any other disease except that I am suffering from the burns. I have suffered. I wish I die too. My husband is gone now. Each day, he is going far away from me (She cries again). I wish I am dead too. But I don't think of taking my own life. It is better to stay alive rather than committing suicide. Once dead, we cannot come back to this world.

May be my time to part from this world is approaching. At the same time, I also think why I am suffering so much. May be I had committed a lot of misdeeds in my past life so that I have to suffer this life. I used to chant mantras or prayers before, but after the demise of my husband and the fire accident, I don't chant prayers. I forget to chant. I have lost my mind. I am helpless. I did not suffer like this before (in my life). This one year has been very bad for me and my family. It is suffering upon suffering. At least I am fortunate that my neighbours, relative and village folks are helping us in carrying out the final death rites. My grandchildren did not come. They can help us if they can. If they are helpless, there is nothing we can do. The eldest grandson could not come. May be he has his own problem. I should understand, but I am unhappy that he did not come.

Being old and nearing death, I worry who will look after me; husband is gone. I feel terribly sad. If I die, I don't think my daughter can perform my funeral and death rituals. May be I will be left like that or thrown into the river. Who knows I may die tonight or maybe I will die tomorrow.

I am suffering a lot. I feel I need many things, but I don't know exactly what I need. If I have more money, it might help me a lot. I don't have enough money to perform death rituals. I don't know what to do. I stay doing nothing. I worry about my daughter. She is suffering (She cries). I am happy at least that the village people are helping me. Without them, I am helpless (She cries). If I die there will be no one to help my daughter.

(11) Participant SJ-02, Male, 85

I am 85 years old. I don't exactly remember my childhood days. It was many years back that I worked as a night guard. I used to get Nu.180. I had to work on the road construction from Samdrupjongkhar to Tshelingor (Pemagatshel). It has been 24 years since I came to this place. My eldest son has a job, other children I have to look after. I served for 17 years in Dzong. That time, the Dzong was being renovated. Dasho Dzongda Passang Tobgay appointed me as a night supervisor, as the works were being carried out even at nights.

I married twice. My first wife died. I have five children from the first wife. Four years after her death, I had to get married to the present wife. I had to remarry because I had to go for woola (community service) almost on daily basis, and I had no one at home in my absence. From the present wife, I have three children. I have one daughter from the present wife and three from the previous one. I have four sons. One is in Samdrupjongkhar, one in Haa, one in Samtse, one in Gedu and one is at home. The eldest son is here at home. Before, he was working in animal husbandry as an officer. The elder son is in Samtse. One who is staying in Haa is peon (I guess). I did not go to his place. I just stayed here at home. One son is working as a Health Assistant. The eldest son working in animal husbandry has a better job. I have one daughter here and she is the one who cares for me the most. She runs a shop. She stays near me and looks after me. Other children are very far [from me]-east, west, north and south. They usually don't come home to meet us.

I think it's been around three years since I have seen them. One son went recently. My children don't give me much money. I think it is not even enough for themselves, so I don't expect much also. I manage everything by myself substantiated my daughter here. May be I am not good or they are not good, I don't know about it. If they are able to live happily, it is fine for me. I don't ask and they don't send. I manage myself everything. So far I have lived on the profits earned from a cattle business. I had many cows once; I sold around 35 cows so far. Now I have only one cow. I saved the money in the bank. I have used all the money now. I spent some money for my son when he was undergoing HA training. He just joined the profession. I hope he will repay me when he earns enough in future and when I become too old.

What to do, so as their father, I did all I could to bring them up in the best possible manner. Our children, when they earn, then they will get married and have children. In this way, they might not be able to help us, old parents. This is the way of life. First, as soon as they get a job, they may have to get settled, then they would get married and after that many expenses would follow. We, parents, will have to survive this way only.

I have purchased this land at Nu. 4000. Other two plots at Nu.7000 each, and another there at Nu.10,000. I have given shares of my land to all the children. I did not keep a single plot for my own subsistence. We call it *gancha* (land kept for parents' old age subsistence). I did not keep any land for myself because anytime I may die, and there will be disputes because of this *gancha*.

(12) Participant SJ-03, Male, 77

I was born in Nepal, but I lived in Mongar for the most part of my life. I became Bhutanese in 1966. My census is in Mongar. I received a gratuity of Nu.75420 and 50 chettrum from when I resigned. I am fortunate to have met the King and Queen. The King granted me land. I have land and house in Mongar. I have around three acres of land. I worked in Mongar School as a cook for many years.

Now, I live alone in Deothang taking care of other's house. I am a caretaker for a retired MP. I don't remember his name, but I know his brother works in Loan Section in Samdrupjongkhar. I take care of his cattle. I have no relatives [here], but I have many relatives in Mongar.

It was after I lost my CID card that I came here. I submitted an application stating my CID is lost to the Dzongkhag. Without it, I cannot go anywhere, not even to Samdrupjongkhar. The MP brings rice, but he does not give me money. I do not see any money. Those people who know me give me alcohol. I may die soon of old age and alcohol. I almost died a few years back

I have one daughter. I did not see her for last 21 years. I heard that she completed her studies. She might have completed class 12 from Gyelpozhing School. She started her pre-primary in SamdrupJongkhar and after that, she went to Mongar. I heard that she did her degree from

Shillong. I do not know where she is working. I hear many students are unemployed. I do not know whether she is employed or unemployed.

I do not keep contact with my daughter. If daughter cares about me or not, it depends on her 'heart'. My wife died long ago. My daughter was three years when she died. I have a daughter-in-law. I do not meet her as well. I do not know where my daughter lives. I do not really understand. At present, I am in good health. I do not have any illness. In the past, I was sick and was admitted in Deothang Hospital. I stayed there for two and half months. Doctors were good to me. No one abuses me. They are friendly. I want to go to Mongar, but I do not have CID. May be I will die in this place only.

(13) Participant SJ-04, Male, 66

I do not remember my past years accurately. Let me recall and narrate whatever I can remember. My parents died a long time back. It is 36 years since they died. I suppose my mother died at an early age of 36 and father was around 48 years (may be). I still remember their death. Although there was a school, my parents felt that I was needed at home to work on the farm. I was 12 years old when the officials came to pick students. I just work in the field like my forefathers and make my living.

I have three children. All of them are sons. My eldest son is a lay-monk. He received religious teaching from our Rimpoche. One son is a night guard. The youngest son is studying in Karmaling in grade 11. Four of us stay together—my wife, my elder brother, and sister-in-law. We have our censuses together. My brother and sister-in-law do not have any children. Their three children died. My brother is old and is not even able to walk. His wife cannot see properly.

Here, I have around one acre of land. I have around the two-acre land in Kawpani. I plant maize. We face a labour shortage. If we have enough labour, we would have enough to eat. I have to hire some young people by paying in exchange of the same amount of labour. Sometimes we get enough to harvest and sometimes not. I also work for wages. I use this earning to buy rice. There is no one to work. Two of are helpless. We live by eating less. My wife and I manage everything for the family. When we have no money, I worry how we could survive.

I get some money by selling potato and radish. Sometimes, I cultivate ginger. I heard that cardamom can fetch us a lot of money, but no one cultivates cardamom here. We have oranges, but a disease damaged most of the trees. Usually, people here survive on maize. I have around 5-acre land. The problem is I am not able to cultivate all the land.

I have availed a loan of Nu. 200,000 to build this house. The money was not sufficient and thus I kept the house half done. We just have one room. The roofing is CGI sheet, but veranda and windows are not completed. I doubt I can fully build this house. We have no electricity. It is because we can't afford electrical wire, plugs and all. On the other hand, I have to repay the loan. I have to pay Nu. 3000 every four months. I am not able to pay on time and that must be the reason why my loan keeps on increasing. When I get money, I pay it little by little. Usually, I pay by selling ginger. This year ginger price has gone down. If the price is favourable I get around Nu. 30,000. My children are all away. They do not help me repay the loan. No matter what, I have to pay it. I think it is not that they don't want to help us. Maybe, they do not have enough themselves.

I am getting old day by day. I don't have energy and getting physically weak. I feel frustrated when I am not able to work as even if we get old we have to eat and drink. I don't know what is important. I feel pain on my arms and legs. I get a frequent stomachache. I get constipation. Sometimes I am able to pass stool and sometimes I can't. So I am not able to work. I am not able to see well. I can't see properly from a young age. I visit BHU whenever I get sick. Sometimes I feel my children are with me when I get sick.

I have no future plans. I worry I will not be able to repay the loan. For me money is happiness. If we have money we can live a better life. Without money, life is full of suffering.

(14) Participant SJ-04, Female, 60

I stay alone [here]. It's been 4 years after my husband's death. I did not go anywhere. I have three children. Actually, I have given birth to seven children. Four of them had died. Now I have three sons. They live in town. One son is working in a factory. The second son got married and left the village with his wife. The youngest son has one daughter. She was born last year. He told he would come to take me. Still, he did not come.

Since I am alone, I get sufficient to eat. May be it is due to old age that sometimes I don't feel like eating. I work in the kitchen garden. This time I did not cultivate maize. I am old, and yet, I have to work hard for a living.

Children don't give me money most of the time. I earn little by myself by working for other people. I think it's not that they don't want to give me. They may not have a good source of income. When they get enough money, I think they will give me some money. The eldest son has two children. The other son has four children: three daughters and one son. They come to see me often. My middle son's wife was sick so he sold land, he invited shaman from Trashiyangtse to perform rituals. Now she is all right.

When parents get old, most of them usually think their own children are not caring for them without trying to understand the children's situation. In a place like Thimphu, the couples are working and still, they don't get time and enough money to be given to their ageing parents and children. Some parents may think their children are not looking after them. I don't know what could be a situation in the village. In my case, I am satisfied with what children give me and care for me. As I get too old, they may have to look after me. Otherwise, who will care for me? I am their mother and if they fail to look after me, then they will be considered as useless children. At present, I think I can manage myself. I had only one daughter who died when young.

My youngest son called me to tell me that he will come to take me with him after one month. He might be needing me to look after his daughter. My daughter in-law is from the western part of the country. I did not meet her once. So I want to go and visit them. If I die she may not know me. She is his second wife. He got divorced with the first wife. I sometimes worry how she would treat me. Some daughter-in-laws are kind and would care for parents better than sons. If she does not do well to me, then I will come back. If she does well then I will stay longer. If she does well, I will look after the grand-daughter and let her grow up well. I will stay with them because I am old and death is nearing. My middle son's eldest daughter is studying in class six and her two siblings are studying here in school. Three siblings of the middle son are in school. The eldest son has only two children.

I don't have any other problems, except paying the debt. During the one year death anniversary rituals of my late husband, I borrowed some money from the shop. Out of Nu.12,000, I borrowed, I still need to pay Nu.5000. My sons wanted to perform rituals for all three years after his death. But they did not pay. I paid myself. I had some money saved. I earned this money by selling oranges. My sons promised they would pay for their father's death rituals when they get salaries. They did not bring any money. I managed such a huge amount of money though it was very difficult for me.

If the Government could build a shelter home near the temple for older people, that would be of so much benefit to an old woman like me. It is going to be a great idea. But in my case, even if the government build a shelter home, I may not get a chance to stay because our temple is very far from my village. It is at Tidung. We do not have a temple within the village. It would be better if we have a temple here. I can then visit the temple daily.

My late husband and I built this house. It has become old without any proper fencing. Whatever, I am happy to stay alone. I get peace when I am alone. My life with the husband was not that happy. I had to live somewhat disturbed life. He used to drag and beat me. I even decided to divorce him, but somehow we reconciled and stayed together. When I was young he used to beat me very often. I think my back pain is due to his constant beatings. He would not listen to anyone. Once, he ran away after our fight and beating. I stayed at my home, but he came back after three months. I feel happy by staying alone. When he died it was me who suffered. I had to look after him when in a hospital and even after death. We went twice to Thimphu hospital, and after coming back from Mongar hospital, he died (after seven days). When he died, other relatives came to help. I did not feel pity also. I thought he'd better die.

Although I was suffering with him, I never thought of committing suicide. May be some people try to do that. I would prefer to a natural death rather than killing myself. We get one chance as a human being and why to waste our life like that. One old lady in my village committed suicide. The reason was that her husband divorced her and went with another woman. I will not die by hanging. She hanged herself with a rope tied to the tree. I will not die by hanging like that. We won't get a human life again. Life is too precious.

I don't have any dreams. I am old now. I just want to chant 'Baza Guru' mantra. I have to prepare for death before I die. My only prayer is that my children lead a happy life.

(15) Participant SJ-05, Female, 84

I have five children—two sons and three daughters. One daughter is in Nganglam and rests all are here in the village. I stay with a daughter, who is divorced. I feel comfortable staying with a daughter. I don't feel comfortable staying with one daughter in-law. She scolds me so I stay where I feel happy. It's been two years since I haven't gone to the son's house. I often get leg pain. So I always put up with this daughter. My son actually does not tell me not to come; I just don't want to go to his house. They come to see me often.

It has been 24 years since my husband died. We used to stay in that big house, which is below this house. When the land was being divided among the brothers, my husband was given the land there, where my sons live now.

At this age, I don't think of doing anything. I can't remember things well. I simply think about death. Death is uncertain. I feel I will die soon. When I cough and face difficulty in breathing I think that the death is coming to me. Sometimes I think I might die in sleep.

I did not have any disease when young. Now I feel I have many diseases. My leg swells frequently. I feel pain when I walk and often falls down. Sometimes my daughter used to support me while going to the toilet. I take bath myself [little by little].

My daughter gives me enough to eat. She goes for work and when she brings rations I prepare myself and eat. I don't have a problem with food. My daughter (divorcee) brings enough ration for both of us. When she doesn't have money she gets essentials on credit and pays later (after harvesting and selling oranges). We have around 30 orange trees, but most trees have died. The yield is not good now. This year she earned around Nu. 20,000.

My daughter has two children: son and a daughter. My granddaughter is a student and grandson is working in Thimphu. He brought me 'beads' as a gift. But I don't chant mantras. I did not go on any pilgrimage. I am old and

I can't travel or walk. I used to go on pilgrimage when young. Even though I am getting old, I don't worry about anything other than that of dying. I cannot see properly. I can hear well. Despite my old age problems, I am happy because my children take care of me. What more should I want apart from their care at this age? I have no more expectations from them.

(16) Participant SJ-06, Female, 83

I was born in Thrizor. I studied up to class four. I served in the police for 23 years. I came back to the village in 1992. I do not get a pension. I have 6 children: four sons and 2 daughters. Some are working; others are married and staying with their husbands. At present, my wife and I are only the ones here looking after the house. Last year, I got seriously ill. My son and daughters took me to Gelephu hospital. I was happy, as they took care of me. They do not neglect me.

Currently, I am a member of Jersey cooperative. Four villages namely Gorthongma, Dungmanma, Martshala and Thrizor initiated this cooperative. I bought few jerseys. I sell milk. I earn around Nu. 4000 thousand per month. The earning depends on the amount of milk we sell. Sometimes I earn about Nu. 8000 per month. However, we have to buy fodder to feed the jerseys. The fodder is expensive and its price is going up every time.

I suffer from Gout. Due to this health problem, my knees swell once or twice in a month. I am not able to walk when knee swells. It is painful. My children take care of us. My relatives are all kind to us. They help us whenever we face a problem. I have enough to eat. My children help and support us. My only worry is getting sick and dying. The government gave our cooperative the machinery.

I do not worry whether my children will look after me in future or not. They will care me. Even at present, they care for me [when I am sick]. They took me to Gelephu Hospital and Thimphu Hospital as well. If they don't care their parents who will care then? It is their responsibility. As a parent, I cared them and gave education. Now they have to take care of us when we need their support. As of now, my children have been very good to us. I am happy with them. I will be happy if I can buy more jersey cows. I can earn more income through the sale of more milk. I can be independent and help my children too.

(17) Participant SJ-06, Male, 63

I am 63 years old. I stay with my son and daughter-in-law. Sometimes I stay with my daughter and son-in-law. I came here 12 years ago from Gomdar through government resettlement's programme. I have two acres of land. I have two daughters and four sons. Most of them are in other places. One son and two daughters live here. I am a farmer. I am not able to work, as I am getting old day by day. I just chant mantra or prayers.

I could not afford to send my children to school. My father had not sent me to school, and thus, I did not realise the value of education. May be my father too had not known its importance. Now, I know the importance of education. However, my granddaughters and grandsons are going to school.

I have enough to eat and drink. I do not face much problem. In the past, I suffered a lot of not having enough to eat and wear. The whole village suffered that time. My family uses to eat just potatoes. Most of the time, we survived on simple porridge.

I cannot see properly even with the glasses. Whenever I get sick, I go to BHU. I have neither hypertension nor other diseases. I only have body pain. May be this is due to my old age.

I have no other worries except getting sick and dying. I worry that I am getting old day by day and nearing death. I know astrology. So, as per the astrology, most people die at my age. This death thing worries me all the time. That is why I recite prayers and chant mantras all the time. I am preparing for the death. Fortunately, I have good and caring children; they do not neglect me. They care for me all the time. They have to look after me. It is their responsibility to care their old parents. If they neglect us, their children will also neglect them when they are old. This is karma-the cause and effect. Nonetheless, I worry whether they will care me if I get seriously sick. I also worry whether they will perform my funeral rites. Anyway, they are good children. They give me money whenever I need it. The care for me when I get sick. Until now, they did not neglect me. I am happy with my children. At the same time, I have good relationships with my neighbours. Most of the time, they come to my house. I offer them a cup of tea, at least.

Now I have no expectations in life. All my children are grown up. I worry about their future. I don't care if they neglect me or not. They have to look after us; it is their responsibility. I am old now, and they have to take care of me. I am worried about dying. Whatever, we all will have to die one day.

(18) Participant SJ-07, Male, 80

I am 80 years old. I stay with my grandson. I will stay here for few weeks. I just came to visit him. I stay in Kerung, Nanglam. My wife is in Kerung. I was born in Zhemshem, Pemagatshel. Due to the insurgent (Ulfa-Bodo) problem, I had to move to Kerung through the resettlement programme. I have two sons and a daughter. My daughter is married and living in Kerung. My elder son is in Samtse. Another son is working in Thimphu. I could not send all my children to school except the youngest son. They look after me. They give me money whenever I ask for it. I served in the army for three years.

I have enough to eat. My children support me. Of course, we face a problem, but those are not the major ones. It is part of life to have problems. Nonetheless, children do not come to visit us as often as we expect. It is not that they want to abandon us. They must be busy. They call me sometimes.

I have some land. I bought 83 decimals land for Nu. 320 in Nanglam. It was a long time ago. At that time, Ngultrum 320 was a huge amount. I had to pay it in three instalments. I gave the land to my sons and daughter. It is better to give them before I die. I feel satisfied that I gave them what I was supposed to give.

I worry about sickness and particularly death. I worry about my children's future. I wonder how they will lead their life. As a parent, I raised them with care. In absence of parents, I worry about their health and future. I always pray for their good health. As you know, funeral and rituals require a lot of money. However, I do not worry that my children will abandon or neglect me. They are good to me, particularly my daughter. I have good relationships with my children. My daughter calls me at least 5 times a day.

If the government provides me with a free house to stay and chant mantras in the temple, I would be grateful. I will be happy to stay with my wife, as we will be spending our old age together chanting mantras.

(19) Participant PK-05, Female, 72

I was born in Nowakha, Chubu Gewog, Punakha. When that big house was being constructed, I was a baby drinking milk from my mother. Before, we were eight siblings; I was the youngest. Now all of them have died, I am only the one surviving. When I was 25 years old, my family said the food was not enough, particularly due to large household size. There were many members. My brothers and three sisters got married. There was constant conflict in our house between brother in–law and brothers. Then our parents decided that some of us would have to live separately, so I had to leave home. While leaving the natal home, they promised me an inheritance. Later, my relatives refused to give me my own inheritance. I stayed in neighbour's house for some months.

In the past, I suffered carrying woola in Punakha Dzong. During the Dzong roofing, I had to carry CGI sheet from Thinleygang to Punakha. Those days, the road reached only up to Thinleygang. I regret my young life and now my old years are not happy too.

I heard the government was providing land *kidu* for those people who were landless. It was during the Third King's reign that I submitted my pledge to the King. I had to do so because I did not have even a small plot on which I could plant chilies. Ashi Sonam choden granted me the land *kidu*. However, I did not get thram (land ownership certificate). My husband and daughter died by then. I requested the Dzongkhag many times to grant me the land ownership certificate. They turned down my request. I was living all alone at home. I spent most of my time looking for food. I suffered a lot. Later my relatives gave me a plot of land with orange trees. The government built the school on my *kidu* land stating that I did not have *thram*. I did not get any land substitute or compensation.

I stayed with neighbours. As we had water problem then, I had spent so much time and energy fetching water for my host family. Slowly, I manage to build a small house. And later my parents gave me 22 decimal of land. That land, I could hardly manage. I was so poor to even cultivate the small field. During the recent land survey, the officials warned me that my land would be taken over by the government as I was not able to toil it and it is very small. I decided to let anyone do anything. I am surrendering myself to this life. After all, I am a poor old woman and I may die soon.

My relationship with the parents was good. They were good to me as the youngest daughter. It was my elder siblings who always bullied me. The fact that my daughter died makes me feel sad even now. It is, I think, the effects of sins I had committed in my past life. I wish if the government could help us with foods and clothes. People like me do not need more than that. Soon, I may not be able to look for food. I prefer sudden death. I do not know what I should do. This is my life. I do not get *kidu* as I own a small plot. Sometimes I think I will present my land to Dratshang.

(20) Participant PK-06, Female, 68

I served my parents well. After both my parents died, I felt like my life was in prison. I was 50 years at that time. When I was 13 years, I took part in Thimphu Dzong renovation. My sister was pregnant, so I had to go in her place. I could not work like others. I could hardly carry a stone, so the supervisors used to scold me. I had a tough time working for the Dzong reconstruction.

Not being able to tolerate the hardship, I ran away from the Dzong reconstruction and joined nun. My sister did not keep me in the monastery for long. I was a nun for two years. I was brought back to home to work. I was not given even a small plot of land. My father was in Nobgang. He told my sister to give some land, as it was her who did not allow me to pursue religion (as a nun). I was not happy in the village.

I looked after my mother in her old age for about thirteen years. My sister's family was living in a different house. Beside the Dzong renovation, I had to take part in bridge renovation. Since the work required crossing the river by holding on the rope, I would not dare to do so. There too, the supervisors would scold me and even ask me to jump into the river. I had to suffer so much and there is no reward for it.

My only son died leaving me alone. My house leaks when it rains. The wooden floor has decayed. My ex-husband left me for another woman. It is now more than 20 years since I had been living alone. I gave my land on lease. I get some share. I have some orange trees. I sell oranges and earn some money. I think I have around 20 trees. At least, I don't have to beg from others. It is due to the grace of my late mother and father who inherited me orange trees.

I took care of my mother while my other siblings neglected her. I had to clean her stool and wash her clothes. Those days, the hospital was near Lekithang School. I would have to leave her at the hospital alone when I had to return home. I would worry how she would be doing in the hospital. She was bed-ridden for so long. The hospital staff told me that my mother needed a good diet. I used to give her meat and eggs. I don't know counting, I requested my close friends to help me while shopping. My mother used to drink, but I don't drink. I drink tea only. I had to buy her drinks.

All the siblings have died. Before last year, I bought CGI sheet with Nu. 4000. I got this money by selling oranges. The CGI sheet was not enough. What I bought could cover only half the roof. When it rains, water seeps through into the floor and damages the planks. I did not get any support or *kidu* from anyone. I don't know who to approach. I am supposed to share water with my own niece. I worked and even hired two men to lay the pipeline. When the work was done, she refused to share me the water. I had submitted a petition to the court on this issue.

(21) Participant PK-07, Female, 69

We are four siblings; one died last year who is younger to me. One is here and another one is [up there] where there are two houses. Can you see that house? Now only two of us are surviving. I am 69 years old. I have grandchildren and great grandchildren. I have 6 children, three sons, and three daughters. Two sons are in RBG; the other son went as the groom. The eldest daughter is living in that big house. She built that house on her own expenses. Her husband is an astrologer and teacher. Earlier, he worked in the Dzong. My two daughters live with me. One is always is sick. It has been a year and a half now since she was sick. I have performed rituals, but her health is not at all improving. She was admitted in Thimphu Hospital. Her health improved a bit. But she is not getting fully well. I don't know what happened to her. This two-storied house is mine. It is roofed with CGI sheet. My sick daughter's father-in-law helped to roof the house.

When I conduct annual rituals my sons come home. They have their own children. Yesterday also one of my sons told me if he should come home, as his sister is not recovering well. I said he need not come and that we could perform rituals. If he comes then there would be no one to look after his children and wife. He wants me to stay with him at Dechencholing. I am not able to go. I have gone before. I went to the youngest daughter in-law's

house. She was kind to me. She used to wash my clothes and even my legs and hands. Sons usually don't stay at home. Even if I stay there for a week they would just come once. They are always busy[duties]. My younger daughter-in-law is kind. Compared to another daughter in-law, she is far better. It so happens that when I go to Thimphu, the elder daughter-in-law would complain I am always putting up with the younger one. I used to tell her that I feel better to be with the younger son, as the toilet is closer.

My father died during my infancy. My mother and grandmother looked after three of us. I had to go to work in the field and they would prepare food and even pack lunch for me. When I was young, grandmother took care of me. My mother had many children to rear.

(22) Participant PK-08, Female, 71

I am the eldest among nine siblings. When I was a child, I lived with my parents and I served them by taking part in Thimphu Dzong construction by providing labour. I was only sixteen when I started to contribute labour (woola). While working as a labourer, I met my husband and stayed with him as well as contributed labour on behalf of my parents. I used to support my family by sending few foods, drinks and all. My parents divided the land that they had among three relatives when they became old. All my relatives died due to illnesses. They were three girls and a boy. In Thimphu, I stayed with six children. After the death of my parents, I accumulated huge debt. To clear the debt, I had to sell my assets. I was very poor, but I stayed with my spouse. After 25 years of the marriage, we got divorced. My husband did not give me anything. He simply expelled me from the house.

I don't know as well as don't understand how we reached the decision to divorce. I remember that he slapped me once. That angered me and in midst of anger, I left him. After that incident, he didn't give me anything—even my clothes. My children stayed with me after the divorce. I looked after three younger kids and my ex-husband looked after three elder ones. After they grew up, they all went away. They were not so helpful to me. It was not that I did not look after them. Some of my children went to the East and some to the North, but none of them has a secured job, except the eldest son. He was a working as a school teacher. However, he died at the age of twenty-three…no..he was forty-three. He died of alcoholism.

After the death of my eldest son, I went to Paro and stayed with my sister for one year. I had nothing to do. While in Paro, I met my ex-husband [Paro Tshechu]. We rejoined. Even after this, our children did not look after us. Perhaps, they did not even know I was alive or dead. I looked after my grandson and niece. They lived with me from the very early age. My niece was just high months old. I had to look after them, as their parents got divorced when they were still babies.

I had to undergo many challenges in upbringing those children. I sent my grandson to Sikkim to become a monk. My niece received *kidu* grant to study in Sonam Kuenphen School. My husband and I rented a house. The rent was Nu. 1000 per month. Though we did not have the burden to look after any children, I still felt unhappy to be living in a rental house. I always felt we need our own house. I had to sell my land to settle my debt. I accumulated some debt while upbringing those children. I just had three Langdho of land, which I inherited from my mother. For a single Langdho, I got Nu. 20,000.

Some children who I brought up are in Thimphu. I have no idea of other children's whereabouts. I have not been in contact with any of them for so long. I don't think they care whether I am dead or alive. When my elder son was alive, he did not bother to give me a single Ngultrum or even a piece of betel nut (doma).

It would be good if the government could provide shelter to the homeless older people who do not get any support from their children. I don't know if I will be eligible for free housing because I have niece and grandson. Otherwise, I would be comfortable to live in an old age home (if ever the government establish such homes). I can then recite prayers without having to worry about food and shelter. I always worry about my niece and grandson. They may suffer like me. I regret that I have no land and house to bequeath to them.

(23) Participant PK-09, Female, 67

I am 67 years old. I have two children: a son and a daughter. My husband lives in Pangrizampa. He is in spiritual retreat. Someone is providing him free housing and foods. My son is in Thimphu. I live with my daughter. She is single. She got divorced 20 years ago and never married again. She has

three children. My grandson serves in the army. The other grandson is a monk and granddaughter is studying.

We have enough to eat. We cultivate rice, but we always face some problem with money. I hurt my leg and I am having difficulty walking. I have to use a walking stick. Despite all these odds, I still have to look after the cattle. I have two old cows and one ox. If I get *kidu* money, I will invest in buying an ox to make up the pair. We cannot afford to buy a tractor or pay the hiring charges for power tiller. We need money to hire people to work in the field. These days, it is difficult to do agricultural works without money. I feel that money is all-important to lead a comfortable life.

I worry about getting sick and dying. I am too old and I fear that the death is nearing. I wonder who will conduct my funeral. My daughter is poor. I doubt if my children will take care of me if I get terminally ill.

(24) Participant PK-10, Female, 68

I am 68 years old paralysed woman. I cannot speak properly. My husband died a long time ago. I am staying with my youngest daughter. I have three other children. I don't know where my children are. They do not care for me. My youngest daughter is the only child who cares for me.

I suffered from paralysis long time back. It is hard to remember exactly when and how it happened. I was healthy. It was one morning when I woke up and realised that I was not able to move my body. I did neither have any medical condition before that nor any accident. It happened so suddenly. At that time, my husband was sick. He died not long after I got paralysed. I suffered a lot when my husband died. It has almost been 2 years that I have seen some improvement in my health. I have been able to walk a little. I can walk around Punakha Dzong five times a day. I attribute this to the blessing of Kenchosum (triple gem).

I do not have any land. So I am Gyalpoi Kidu recipient. I get a financial assistance of Nu. 1200 every month. It really is a blessing to me. I survive on this allowance. Though the amount is not enough it is much better than not having it. I feel I can be more comfortable if I have some more money. Money is important in life. I have no problem hearing and seeing. My only problem is that I am not able to walk. I have seen some improvement in my

ability to walk compared to the past years. My youngest daughter has suffered having to take care of me. She is good to me.

Note: Her daughter told us that she has problem recollecting the past.

(25) Participant CK-01, Male, 70

I was born and raised here in Lokchina. I used to help my parents when I was young. My father was a blacksmith, and I learned all the necessary skills from him. I used to help my parents by doing all sorts of work. I have one brother who is married. I am married and have sons and daughters. Since we had lots of family problems, I was not able to send my sons and daughters to school. My parents distributed the land equally among the siblings. I received half an acre of land from them. I have a good relationship with my brother. All the past and present gups here know about me. I have been honest throughout my life.

I have a very large family. My daughter, niece, and in-laws live with me. One of my nieces got married recently and now stays at Bangapani. One daughter lives with us along with her husband. They have four children. My other daughter is married and lives in Samtse.

My nephews are in Thimphu. One of them is teaching in a private school. My children sometimes send us rations. They know that I cannot work. They treat me very well and I am happy with them. My daughter has been supportive to me. She provides basic things though she has her own share of difficulty.

I have many reasons for me to be happy and sad. I am happy because my children help me by providing rations and they stay with me. I am sad because my house is very small. I have not been able to construct a new one. I need a bigger house to accommodate my family. The present house is not big enough and it is roofed with plastic. I do not have a bigger house to accommodate my family. This is my biggest problem. If I can construct a bigger house I will demolish the small one. Sometimes we do not have enough money to buy vegetables and other essentials. Unlike others, I do not cultivate cardamom.

I am not eligible for *kidu*, as I have my family. I have given up on my life. I cannot say whether I am satisfied or not satisfied with my life. I lack the

physical strength to work and have some difficulty in walking. Since I am not working I do not have any income. At present, I am not doing so well. I have to sacrifice one thing for another. I had to borrow this gho from my son-in-law so that I can come and meet you.

Recently, I was seriously ill and fell unconscious. My children had to carry me all the way to BHU. I was referred to Phuentsholing hospital and later to Thimphu for further check-ups. I came to know that I had high blood pressure and diabetes. I also suffer from epilepsy. I am a blacksmith. My profession requires physical strength. Due to my medical condition, I am not able to work. I can't do even menial works. Recently my hand was fractured and got treated in Thimphu Hospital. I still feel pain on my hand.

I do not expect much from the government. But, I would be happy if it could provide us some financial assistance. With the money received, I would first repair my house. It becomes unbearable to stay here during winter. The roof does not provide us protection from rain and the sun. My children are willing to help me but I cannot ask them for any assistance. They live from hand-to-mouth.

I would be happy if there is any kind of assistance to help poor people like us. The government has provided us with roads, electricity, water, free health, and education. It has been kind enough to look after us. I would be grateful if the government could identify the people like me and provides the assistance. Life has been faring better for many of us unlike in the past when there was nothing. Now the government has provided us with the road, we can reach to market and back without any problem. In the past, I had to carry loads on my back and walk all the way to market under, that too under severe heat and rain. Life has really changed from the past.

(26) Participant CK-02, Male, 60

I had an elder brother who died at Darla School. My mother died when I was 10 years of old. I was raised by my father but he did not consider sending me to school. He did not send me to school because I had a hearing problem. He died in 2005 at the age of 78. He had cows and after his death, I inherited a traditional mud house. I renovated this house. I do not have much problem except that I do not hear properly.

People of Rinchentse do not do much agricultural works due to the steep landscape. If we were to hire a power tiller for a day, we must pay Nu. 1400 to the gewog, which is quite high considering the people's income. Some of the people in the gewog can afford to hire power tiller, but some of us cannot. This is the reason why many people are dependent on the income generated from the sale of cardamom. The income from cardamom is not sufficient to last one year.

A few months ago I went to Paro to treat my ear. My son works there. I was informed that my ear is infected with dust. The doctor asked me to report to the same hospital after a week. I requested him if I can do my ear check-up at Gedu, but they refused. Later, I went to Gedu Hospital. They referred me to Phuentsoling Hospital. I did not go to BHU here in Rinchentse, but travelling to Phuentsholing for treatment incurred extra expenditure. My wife accompanied me to Phuentsholing.

I do not have anybody to rely on for money. The taxi fare is too high for people like me. Having to travel many times to Phuentsholing means very expensive affair for people like us. I did not even go to Jaigoan for further check-ups. This would have meant extra expenditure. I cannot afford to pay. I am satisfied with the health services provided within Bhutan. My wife has been really supportive towards me. She helped me whenever I had a problem.

I am a simple farmer who rears his cows and has sufficient meals on my plate. I am a regular radio listener but due to my ear problem, I often don't hear. Often I am told that I ask my wife to put it on when it is already on. When I was young everything was fine. As I became older my ear started to give malfunctioning. Well, this has been my story so far. Even If the government gives us a monthly allowance I would still prefer to stay with my children till I die.

(27) Participant CK-03, Male, 67

My daughter died a couple of years ago due to illness. My son is now staying with his mother. We were divorced. I am currently staying alone in Phuntsholing. I work as a security guard in private furniture shop and I am paid Nu. 6000 per month. I have served Royal Bhutan Army for 20 years and I worked I Pepsi factory for 13 years.

I do not have much problem at present. However, I am worried who will look after me if I fall ill. I do not have any relatives to rely on. I am happy that the company provides me with free accommodation. I can at least help my son to continue his education. Once he completes his education, I may be able to save money for my own old age.

My son often visits me during his vacation. It gives me lot of joy to meet him. We share a very good father-son bonding. This year he did not visit me. I doubt my ex-wife and her husband must be discouraging him to meet me. I talk with him frequently over the phone.

For me, life is all about helping others. I am not frustrated with my life. Sometimes I feel sad leading a lonely life. I feel that elderly people are suffering. Some of them do not have family or relatives to depend on. Some do not have enough money to have a decent meal and clothes to protect themselves from harsh weather. Some do not have a decent job to have a reliable source of income. I am worried whether my son will look after me in the future. My plans for future is to lead a happy and prosperous life by reciting prayers. This can be possible for many of us only if the government provides us with old age home care facilities.

(28) Participant CK-04, Female, 65

People call me Abe Sonam. I am 65 years old and my husband died eight years ago. I come from Trongsa. At present, I am staying in Phuentsholing with my youngest son and daughter-in-law. I have been staying with them for the past three years. I have four children: two sons and two daughters. All of them are not so rich. I could not afford to send them to school. I could afford education for my youngest son, who completed class fifteen. He is teaching in a private school. He is married and has a three-year-old son.

I came to Phuentsholing when my daughter-in-law was pregnant (the first child). My son was yet to complete his teacher's training from Paro, so he requested me to look after the daughter-in-law and the new born baby. Since then I have been here taking care of them. I have some difficult times looking after the baby. My daughter-in-law is stingy when it comes to money. She does not give me even one Ngultrum. She always tells me that the baby is my own grandson and I have to tend to him. Whenever I ask her for money for some purpose, she tells me to ask money from my son.

She is not cruel like other people. I can say that because she does not mistreat me. I do all the household chores including cooking. Since she is a working woman I take care of my grandson. But whenever I ask her for some money she all the time says that she does not have money. So far she has not mistreated me. When her sister came to stay here, she might have told her to remove me from the home. I fear that my daughter-in-law might be influenced by her.

Fearing that some problem might arise between my daughter-in-law and me, I thought it better to go back to the village. I went back. It was the son who insisted me to come back to babysit his baby. I requested him if he could get me an alarm clock and slipper for me. He was kind enough to buy those things without having a second thought. This has led to a quarrel between them. I hear them quarrelling quite often. I believe I may be the source of their contention.

I feel like going back to the village. I do not get time to recite prayers and visit temple here. I alway spend time babysitting. But even if I go to the village, I still have to babysit my granddaughter. It is the same thing for me. Since my grandson is not enrolled in daycare centre I get enough time to recite prayers as I wake up early morning. I have changed my sleep timing, I go to bed at 8 pm in the evening so that I can wakeup early and recite prayers.

I feel sad that I have not been able to visit holy places like Dorjidhen in India and Nepal. Whenever I see an advertisement on television about the pilgrimage to these places I feel like visiting them. I have visited Dorjidhen, but this time it was not possible due to financial constraints. Recently I had an eye problem and had difficulty in seeing properly as my eyes become teary.

I have a friend who is an old lady. She is not treated well by her children. She often says that she wants to stay with me. I told her that I am staying with my son and daughter in law. I told her that even I am not sure whether my daughter-in-law will treat me well in future. I think money is everything these days. One should have enough money to be happy. Whatever we do we need money; without money nothing is possible.

(29) Participant BT-01, Male, 74

I am 74 years old. At present, I am staying here in Naja, but my birth place is in Lame Goenpa. I reached Naja while I was vagabonding from one village to another. It has been more than ten years now. I do not have any relatives. I have been married thrice. My wife was from Jabana, Haa. She left me when she realised that I was not going to reproduce. She is now married to another man.

My father died when I was l a child and my mother married another man. My stepfather used to beat me a lot. He had three children from his previous marriage. My step-father was not good to me and he disowned me. I went to meet them once but they did not treat me well so I stopped visiting them.

I was a soldier, I got recruited in 1966 and served in the army for 19 years before my retirement. I served in Wangduephodrang, Yonphula, and Haa. Those days the government used to pay us very well. But before joining the army I served Dasho Tsheten. I did all sort of works assigned to me. After my retirement, I roamed like beggars without any meaning in life. I did hand-tailoring to support myself because the pension that I received was all spent. Whenever I did tailoring works people provided me with foods and shelters. Some people did not bother to give me anything.

I have one niece. I hardly meet her because she does not consider me as her uncle. She never cared for me. Her husband is a driver. Once I went to meet her. I stayed with them for three days. I had one sister, but after she married a Tibetan man, she started to disown me. She took all my assets. Despite all these problems, there are few good people in this village like Aum Dema and Chimi Lham. They often give me the essentials and sometimes some money.

I often go to Bitekha to buy oil and salts. Some people are very kind and they give me money. Sometimes I am penniless. I am totally dependent on others now. I can't work and my meal depends on the rations and clothes. Sometimes I run short of rice and have to sleep empty stomach. The villagers give me their used clothes.

I wish to spend the rest of my life close to a temple reciting prayers. If I live a bit longer I plan to go to Thimphu and look for people like me. I expect

the government would help people like me. The *kidu* officer does not come here and do not see our sufferings. I am worried about having to die pathetically. I am worried who would look after me if I happen to fall terminally ill and who will conduct my final rites. So far, the God has been kind enough to me.

I had an eye surgery in Thimphu where I was required to stay for three months. One of the Ashis (princesses) was kind enough to give me monthly expenditure of Nu. 1800 per month for two months and Nu. 500 as a travel expenditure. Her Majesty asked me to call her if I have some problems, but the Tshogpa here did not allow me to call her. I had a minor accident while being drunk. I fell off the truck. I took a lift. I thought the truck had halted and jumped. The accident took place near Khasadrapchu. Lam Yeshi Wangchuk treated me and I was cured. I do not want to go back to Bumthang. Definitely, I want to go to Thimphu and stay near the crematorium. If I die the people might just bury me. I hope the government would help me.

(30) Participant PK-11, Female, 77

I live in Pemakha. I don't have my own children. My younger brother's daughter has six children. One is a policeman; three are in the school; one will go to school this year, and two children are in the monasteries. I met with my husband from a very young age. I was 25 when I met with him. Before he was a monk and after we met he joined the police. He serves in the police for a long time. I was at home, as nobody was there to look after our house.

My mother died when I was 25; father died 26 years ago. My mother was blind. I had to help her in all daily activities like taking her to toilet, washing, cooking, going here and there and looked after the household chores. My father was at home. She never got well. As time passed by, she started to pass faeces on the bed and vomited blood.

We took her to the BHU. There was only one BHU located above the cremation ground. One man there told us that someone vomiting is not a problem, but she succumbed to this serious illness. As a daughter, I am satisfied that I tool care of her.

I had been staying here since birth. I was born here, grown up here, eating and working here only. I could not study, as my family was too poor. My husband received land as *kidu*. He is a responsible husband; he brings all household needs but now he drinks. He comes home drunk. As he becomes older he takes more and more. He drinks and sleeps without eating food. I never scolded him for drinking. Before, he was a policeman. We had enough to eat. We do not have to depend on other much.

Unfortunately, we do not have children. My husband is sad over this. Anyway, my younger brother's children might care for us. We took care of them when young. It was not that their parents could not take care of them. We took care of them because we had no children. These children like us. I think nothing about my life. My worry is whether my brother's children will look after me as I get older. I worry if they will give me food. I hope they will look after us.

(31) Participant SP-11, Male, 84

My father died when I was 10 years old. And mother died when I was 40 years old. I have four brothers and three sisters. Three younger sisters and two younger one elder brother is in America. My mother and sister suffered after our father died prematurely. We worked in the field. We had about three acres of land. We used to cultivate maize. There was no road. I saw one bus in Sarpang otherwise just bullock cart. There was nothing in Gelephu. The market was not there. Now there is a big market. It was called Hatisar that time.

I worked in Phuentsholing to Thimphu highway construction project. I worked for 17 days. I used to get Nu.3, which was just sufficient. Most people who have died by now or are surviving participated in the national road construction. The Northern Bhutanese (drupka) women used to participate. They would bring their children to workplaces.

There was a discussion stating the Southern Bhutanese women should come for the work. The works were very difficult. We faced risks of dying in accidents. I had worked few days in Suntalakha and then moved to Gonglakha. There were supervisors. They did not beat us.

I had to face many problems. Since I did not have a father to support, we were taken cared by a single parent. Even my brothers were very young. He

was only seven or eight years old. I had to look after the cattle, fetch water and firewood. It was tough. We had sufficient food. We used to plant maize. Today, the elephants and other animals are destroying crops. Those days, the elephants did not destroy crops. It was the monkeys. My family had around 30 cows. Our village was small then, and so it was difficult to sell milk. We used to sell butter in Sarpang market. The villagers produced cheese and milk to sell in Sarpang market. The price of the butter price was very less, only Nu. 2 or 3 per kg.

I was able to do good to my mother. We stayed together until her end. She died of sickness (Fever). My wife was from the same village. We used to stay in Doban [before]. Now at this age, I have to stay alone. I live alone because I have a conflict with my son. My one daughter is in India, and I never heard about her. Another daughter lives elsewhere in the North. My son is here in the village. He has built a house of his own.

I lived with his family, but later he chased me out of the home. I stayed in the forest under the rain. The rain damaged my blankets. I felt I would die in the forest. Slowly, I built a small hut with the money I earned by selling oranges. I have a couple of oranges tree, which I did not inherit to my children, thinking I might need to support myself in my age. I do not understand why I was chased away by my son's family. I think the only reason was simple. In our custom, once a baby is born in the family, older parents can't eat from the same pot. We have to cook separately. My son has brought three villagers to remove me out of the house. One day, I spilled some salt. It was an accident. My son raised an issue out of it and expelled me out of his family. That was the reason.

As I continued to live in the forest, I started to collect *pipla* and sold it. With the money, I bought rice and whatever I needed. When living in the forest, the rain damaged my clothes. I had to use an umbrella to sleep under the rain. I suffered a lot. I do not wish to go back to that family. They know I get orange income. Now they ask me to rejoin the family. I have some cardamom crop. My son and his sons wanted to lash me with the rope.

I gave lands and even cardamom land to my children. But in my old age, my children neglect me. I am still strong. I could walk 20 km to and fro Sarpang. I go there to buy kerosene and other household needs. I earn enough money to support myself. But one bad thing is that I lose money if I keep it at home. My son and grandsons come and steal my money. I tried burying

money and yet they could find it. I now keep my money with myself. Grandsons even threatened me they would physically abuse me.

I think it is my daughter-in-law who was responsible for creating this father-son conflict. I will not go back to their house. I have enough cardamom and oranges—the fruits of my hard work at young age. I can survive like that. I don't prefer going elsewhere. Even if the government set up old age homes, I will not go there. I do not want to go leaving this place. I have land here and why should I go? My son works on my land on a sharecropping basis. I get paddy from here and I can survive on this.

For three years, I stayed like that suffering. But what do I do? I collected *pipla*, sold it and with that money, I survived. They tell me I come back, but now I will not go whatsoever. I will not give my oranges, but after my death, they may take my land and oranges. I have two daughters, but I will not go. I will stay here no matter even if I am alone.

This son, I gave him three acres of wetland and three acres cardamom land. I divided my land among children. I had to give to this land to this son. I did not want to inherit this land to him, but local Tsogpas came and forced me to give. This son was even saying I should not give land to the daughters. He wanted everything I own.

My daughters are good to me thought they do not live in the village. They come and keep firewood for me. This son is about 50 years. He is a simply farmer. He has six children. I do not keep money in the bank. Who will deposit and withdraw? I can't read and write. I lost my money three or four times. This son did even steal my sugar, oil and kerosene. Actually, he should not do such things to me. He should be helping me at this age. He is bullying me.

I do not know what support the government could give us. I feel we should learn to support ourselves. If I feel sick, others may come to look after me, otherwise, I will die like that. My daughter is saying to inform her in case of my severe sickness. She lives with her husband. She is in Lobesa and her husband works as a forester.

From now what I do? I have no strength and ambition. I am not sure. If something goes wrong with me, I am not sure who will take are of me. The

government or children? My wife left me with the son for Nepal. She was angry with me. I did not feel sad when she left.

These days, young people cannot take care of themselves. We do not expect from these days young people. I buy kerosene from Petrol Pump. Sometimes they say they do not have kerosene. Then I ask them to give me the diesel. I need kerosene to light a lamp. At present, what do I do even if I suffer, but my child will get it? I will pray for that he be punished. I eat once a day. I sleep more and then go to my friends' houses and talk with them.

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Annexure

Annex 1: Coding for Focusing Group Discussions data

Code System	Characteristics	Memo	No.
I	**What needs to be done to solve the old-age problems?**		1
A0	Promote voluntary care services		5
B0	Rules to penalize negligient chidren		11
C0	Improve access to healthcare services		16
D0	Provide social pension		28
E0	Provide public od-age homes		19
F0	Improve rural livelihood		6
II	**What are the reasons for old-age problems in the community?**		0
G0	Woola		15
H0	Generation gap & difference		6
I0	No support from relatives		5
J0	Children can't help		28
K0	Parents refuse to stay with children		4
L0	Poor access to healthcare services		19
M0	Unsupportive community		3
O0	Death of spouses		0
N0	Shortage of labour on farms		19
P0	Migration of young people		30
Q0	Children not supportive to aged parents		38
R0	Childlessness		13
III	**What are the old-age problems in the community?**		0
A00	Ill-treatment at homes		2
B00	Can't manage themselves		6
C00	Disrespect & discrimination		38
D00	Abandonement & negligence		17
E00	Abuse of older people		0
F00	Physical exertion		17
G00	Burden of caring family assets		14
H00	Social exclusion & loneliness		12
I00	Lack of sustanance income		12
K00	Food insecurity		7
L00	Shelter problem		7
M00	Mental health problems		1
N00	Physical health problems		19

Annexure 2: Morbidity at national Level among elderly citizens (65+) in 2010

HMIS Code	Diseases	65+		
		Male	Female	Both
J00	Common Cold	4775	4495	9270
MZZ*	Other Musculo-skeletal disorders	3417	2917	6334
K20*	Peptic Ulcer Syndrome	2223	2479	4702
I10*	Hypertension	2352	2311	4663
JZZ*	Other Respiratory & Nose	1837	1769	3606
H10	Conjunctivitis	1639	1823	3462
KZZ*	Other Diseases of the Digestive	1773	1676	3449
H2Z*	Other Eye Disorders	1473	1767	3240
L00*	Skin Infections	1634	1084	2718
LZZ*	Other Disorders of Skin & Subcutaneous-tissues	1558	1102	2660
GZZ*	Other Nervous inlcuding Peripheral Disorders	1123	1189	2312
A02*	Diarrhoea	1075	1101	2176
J02*	Acute Pharyngitis/ Tonsilitis	931	797	1728
K02	Dental Caries	955	690	1645
M00*	Arthritis & Arthrosis	898	681	1579
NZZ*	Other Kidney, UT/ Genital Disorders	626	664	1290
A03*	Dysentery	594	583	1177
Y96	Work Related Injuries	562	293	855
IZZ*	Other Circulatory Diseases	427	420	847
K00*	Diseases of Teeth & Gums	423	310	733
D50*	Nutritional Anaemia	305	393	698
YYY*	Others (injuries other than above & unknown cause of injury)	426	260	686
E10*	Diabetes	367	277	644
HZ2*	Other Ear Disorders	315	279	594
ZZZ*	ANC, Immunisation & Other counseling	269	211	480
W00*	Accidental Falls	236	169	405
J12*	Pneumonia	182	170	352
B65*	Intestinal Worms	176	164	340
B86	Scabies	207	132	339
BAZ*	Other Infections (excluding ear, brain, STI)	173	138	311
H65*	Otitis Media	156	148	304
H25*	Cataract	154	141	295
K70	Alcohol Liver Diseases	154	91	245
W54	Dog Bite	177	60	237
CZZ*	Other Cancers	119	73	192
I60*	Cerebro-vascular Diseases	89	49	138
EZZ*	Other Nutritional & Metabolic Disorders	85	52	137
I00*	Rheumatic Heart Disease	61	60	121
D55*	Blood & Immune Disorders	63	46	109
W50*	Other Bites & Stings	65	37	102
A15*	Tuberculosis	64	31	95
N30	Cystitis	33	59	92
K80*	Gall Bladder Diseases	32	53	85

HMIS Code	Diseases	65+		
		Male	**Female**	**Both**
X00*	Contact with Heat & Hot substances &	37	37	74
I20*	Ischaemic Heart Diseases	32	38	70
D00*	Neoplasm (benign + CIS)	55	3	58
YZZ*	Complications of Health Care	33	22	55
K35	Acute Appendicitis	47	5	52
FZZ*	Other Mental Disorders	24	26	50
V01*	Transport Accidents	24	20	44
F31*	Depression	30	9	39
N91*	Menstrual Disturbances	0	22	22
G40*	Epilepsy	14	7	21
N70*	Pelvic Inflammatory Disease	0	21	21
E40*	Malnutrition (exclude child clinic attendance)	10	9	19
F40*	Anxiety	5	14	19
X60*	Intentional Self Harm	11	7	18
A54*	Urethal/Vaginal Discharges	13	3	16
F10	Mental and behavioral disorder due to alcohol	9	3	12
B15*	Viral Hepatitis	7	4	11
N62*	Other Disease of the Breast	1	10	11
B51*	Other Malaria	6	4	10
G00*	Meningitis/Encephalitis	3	6	9
T65	Mushroom Poisoning (Toxic effect of other unspecified	4	5	9
X20	Snake Bite	6	3	9
N61*	Infection of Breasts, including Puerperium	0	8	8
A51*	Genital Ulcer/Bubo	5	1	6
A63*	Disease, excluding HIV/AIDS	4	2	6
B50	Plasmodium falciparum malaria	5	1	6
F20*	Psychosis	1	4	5
X21*	Contact with Venomous animals (excluding Snake bite)	3	2	5
A77*	Rickettsial Disease	3	1	4
W65*	Drowning & Submersion	2	2	4
B01	Chicken Pox	1	1	2
QZZ*	Malformations	0	2	2
B95	Streptococcus Group A	0	1	1
W86*	Exposure to Electric Current	0	1	1

Annexure 3: Morbidity at national Level among elderly citizens (65+) in 2013

Sl	Diseases	65 + Yrs		
		Male	Female	Both
J00	Common Cold	5575	5051	10626
MZZ*	Other Musculo-skeletal disorders	4848	4288	9136
I10*	Hypertension	3347	3409	6756
KZZ*	Other Diseases of the Digestive System	2818	2473	5291
K20*	Peptic Ulcer Syndrome	2484	2716	5200
H2Z*	Other Eye Disorders	2424	2492	4916
JZZ*	Other Respiratory & Nose Diseases	2578	2286	4864
GZZ*	Other Nervous including Peripheral Disorders	1722	1807	3529
LZZ*	Other Disorders of Skin & Subcutaneous-tissues	1955	1465	3420
L00*	Skin Infections	1857	1323	3180
H10	Conjunctivitis	1318	1422	2740
A02*	Diarrhoea	1045	1039	2084
J02*	Acute Pharyngitis/Tonsilitis	1144	893	2037
K02	Dental Caries	1075	773	1848
NZZ*	Other Kidney, UT/ Genital Disorders	800	785	1585
E10*	Diabetes	769	755	1524
M00*	Arthritis & Arthrosis	727	630	1357
D50*	Nutritional Anaemia	563	656	1219
IZZ*	Other Circulatory Diseases	529	650	1179
Y96	Work Related Injuries	775	376	1151
K00*	Diseases of Teeth & Gums	553	370	923
A03*	Dysentery	434	406	840
HZ2*	Other Ear Disorders	418	414	832
BAZ*	Other Infections (excluding ear, brain, STI)	344	306	650
H25*	Cataract	302	285	587
J12*	Pneumonia	221	170	391
ZZZ*	ANC, Immunization & Other counseling	203	179	382
B86	Scabies	221	150	371
H65*	Otitis Media	195	173	368
B65*	Intestinal Worms	173	130	303
K70	Alcohol Liver Diseases	172	99	271
N30	Cystitis	122	143	265
W54	Dog Bite	155	98	253
CZZ*	Other Cancers	140	83	223
I60*	Cerebro-vascular Diseases	110	74	184
W50*	Other Bites & Stings (excluding dog bite)	61	61	122
D55*	Blood & Immune Disorders	49	59	108
K80*	Gall Bladder Diseases	34	68	102
I20*	Ischaemic Heart Diseases	52	46	98
X00*	Contact with Heat & Hot substances & exposure to smoke, fire, flames	45	29	74
A15*	Tuberculosis	35	35	70

Sl	Diseases	65 + Yrs		
		Male	**Female**	**Both**
V01*	Transport Accidents	34	22	56
YZZ*	Complications of Health Care	30	20	50
K35	Acute Appendicitis	25	24	49
FZZ*	Other Mental Disorders	18	27	45
D00*	Neoplasm (benign + CIS)	39	3	42
F10	Mental and behavioral disorder due to alcohol	22	15	37
E40*	Malnutrition (exclude child clinic attendance)	16	16	32
N91*	Menstrual Disturbances	0	23	23
F31*	Depression	11	11	22
F40*	Anxiety	9	10	19
A54*	Urethal/Vaginal Discharges	11	7	18
X60*	Intentional Self Harm	14	3	17
B15*	Viral Hepatitis	10	6	16
A63*	Other Sexually Transmitted Disease, excluding HIV/AIDS	9	3	12
X20	Snake Bite	10	2	12
T65	Mushroom Poisoning (Toxic effect of other unspecified substances)	6	4	10
F20*	Psychosis	5	4	9
G00*	Meningitis/Encephalitis	3	5	8
A77*	Rickettsial Disease	1	6	7
N61*	Infection of the Breasts, including Puerperium	0	7	7
B01	Chicken Pox	4	2	6
N62*	Other Disease of the Breast	1	5	6
X21*	Contact with Venomous animals (excluding Snake bite)	2	4	6
QZZ*	Malformations	4	1	5
B50	Plasmodium falciparum malaria	2	2	4
B55	Visceral Leishmaniasis (Kala-azar)	3	1	4
N70*	Pelvic Inflammatory Disease	0	3	3
W65*	Drowning & Submersion	2	1	3
F19*	Mental and behavioral disorder due to multiple drug use & other use of psychoactive substances	2	0	2