Introduction

Pakistan is not yet facing the problem of broadly ageing populations as in the global North, although it is on the verge of ageing rapidly. The over 60s have not been increasing as a proportion of the population in Pakistan since the 1960s. This is due to poor gains in survival in late middle age, which identifies the welfare of the elderly as a priority area for public policy. This paper offers a gender analysis of the health of the elderly in Pakistan. It explores how gender relations in Pakistan shape the ageing of men and women’s bodies and encroachment of ill-health and disability.

Methods and study setting

This study combines qualitative and quantitative methods. Quantitative data is used to establish the extent and distribution of health problems amongst the elderly, and the qualitative data describe the processes through which ill-health amongst the elderly is managed. The qualitative data provide a sense of scale, generalisability, and allows for comparisons with other countries, whereas the qualitative data allow us to look at life experience and social life in the round (Wallman and Baker 1996).

Various types of quantitative data were used in this study. Initially, the paper brings together nationally representative demographic data on the progress of ageing in Pakistan, taken from the 1998 Census of Pakistan and the yearly Pakistan Demographic Surveys (PDS), which collect data on mortality and causes of death.

Secondly, new analysis was carried out on surveys specifically on the elderly, to test hypotheses about the factors underlying variation in the welfare of the elderly. In particular, with the support of Dr Jahangir Khan of the Pakistan Medical Council, we consulted the Survey on the Health and Living Conditions of Elderly Population.

Lawrence Cohen’s work on ageing in North India argues that ideologies about strong family values and the family care of elders are a resistive narrative against modernization and the West, where elders are said to be abandoned by their families and put into ‘old homes’ (Cohen 1998).

In face of this, descriptions of the realities of intergenerational relations, in the context of impoverished families in countries like Pakistan, can be read as an indictment of culture and identity. However, this paper intends not to malign family care in Pakistan, but rather to unpack the normative discourses surrounding old age support by looking at variation in welfare in old age and the social and gender relations that underpin this variation.

Understanding about the body and physical capacity were gendered, and conditioned by socioeconomic class and kinship relations in the household.

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(SHLCEP) carried out by the Pakistan Medical Research Council in 1999-01. With the support of Dr Syed Mubashir Ali of the Pakistan Institute of Development Economics, we analysed the Pakistan Socio-Economic Survey Round 2 (PSES2) carried out by PIDE in 2001. The SHLCEP is a national survey of the over 60s with a sample of 2,899 elderly. Although the survey was not conducted using random sampling, it is representative of the country, comprising data from 12 Primary Sampling Units representing rural and urban elderly of different ethnic groups from all the provinces of Pakistan. The PSES2 is a nationally representative survey conducted using simple random sampling of villages and enumeration blocks, stratified by rural and urban area. It included a specific module on the circumstances of the elderly, including 1,174 individuals over 60 years. The methods of analysis comprised simple cross tabulations, z-tests, X2 analysis and Analysis of Variance.

The qualitative data in this study represent a sub-set of the quantitative data, giving the perspectives of rural elderly. The data were generated through fieldwork in a village in Punjab employing the ‘micro-demography’ approach influenced by Caldwell, (Caldwell and Reddy 1988). I have given the village the pseudonym ‘Pind’. I collected data in Pind during February-March 2005. Pind is in Lahore district in the North-East of Punjab. It lies along one of the main roads leading out of Lahore, 26km from the centre of the city, and 6km from the Indian border. It is relatively small, comprising 10,000 inhabitants, 90% of whom were Awan Muslims and 10% of whom were Christians, and some 500 acres of land, cultivated for wheat, rice, and cow-feed. The village was unusual in having its own health centre, which was run by an NGO in Lahore. With the help of lady health visitors and dais (traditional maternal health providers) at the health centre, I interviewed villagers from over 40 elderly households. Research participants were purposefully selected from amongst the contacts of the dais at the centre, all of whom had worked in Pind for more than 2 years, and some for all their lives. Initially they took me to visit the elderly households they knew closely. To explore variation in circumstances, I then asked the centre women to introduce me to elderly people they considered not to be doing so well. The case histories collected cannot be considered representative in any statistical sense. However, I would claim that they document the range of living arrangements of elderly people in Pind.

Defining old age
For the purposes of collective survey data, old age in Pakistan is arbitrarily set at the age of 60, as in other developing countries where life expectancy at birth has only recently approached this age. In the quantitative data in this paper, therefore, the elderly are usually defined as the over 60s. However, being elderly is not, of course, just a matter of chronological age. Christine Fry (2002) suggests that the way to minimize a ‘chronocentric’ view of age is to look at how differences in maturity are used socially. In carrying out the qualitative research, the category of ‘old’ was understood to signify ‘somebody whose body, demeanour, behaviour, social position, or history is suggestive of the later decades of the life-course in a given place or time’ (Cohen 1998: 33). The qualitative parts of this paper reflect how ageing is understood and socially constructed in the village, Pind. In this context, the elderly were those who are regarded as elders (barhe), and behave as elders.

Old age was substantially a matter of generation and household developmental cycles. People become elders when they had lived long enough for their children to become jawaan...

There are manifold ways in which old age is constructed in Pind. Clearly, physical maturity is an important element of ageing. People in Pind referred to old age (bohrappa) in ways synonymous with frailty (kamzoori). Physical deterioration was thus naturalized. Unlike certain schools of gerontology, which view ageing as distinct from pathology, ageing in Pind was understood as an inevitable process of encroaching physical incapacity. However, physical ageing was an uneven process. Understandings about the body and physical capacity were gendered, and conditioned by socio-economic class and kinship relations in the household.

Aging: Gender, Social Class and Generational Differences
In her work on the Gambia, Caroline Bledsoe (2002) presents a gendered view of ageing in which she suggests that, for women, ageing is not equated with the passage of linear time but with ‘contingency’: the salutatory, cu-
cumulative hardships of personal history, particularly obstetric trauma. Gambian men, who do not bear children, have a much more linear pattern of ageing than women. These understandings about the ageing process were echoed in Pind, where women were said to become old quicker than men. Childbearing was said to wear women out and make them age prematurely. Ageing was thus embodied in gendered ways.

Ageing was faster and more debilitating for landless labourers, who endured arduous working conditions, malnutrition and inadequate levels of medical care, than it was for landowners...  

Ageing was furthermore patterned by social class. It was faster and more debilitating for landless labourers, who endured arduous working conditions, malnutrition and inadequate levels of medical care, than it was for landowners (see Vera-Sanso 2004b). In Pind, work was said to prevent physical decline, and hard work was celebrated for keeping elders healthy (tandrust). In Pind, the hard work and strength of the working elderly was contrasted with the opulent lifestyle of landowners, city dwellers and ‘modern people’, whose laziness was said to be the root cause of chronic illness and early mortality. Moreover, whether the physical changes of ageing were socially recognized varied according to necessity (majboori). In poor households, elders continued to work despite grinding physical frailty, as did elders who were without available children. Thus, socio-economic location and kinship relations condition the degree of frailty (kamzoori) that is endured before a person can step into the full social role of being an elder (Erb and Harris-White 2002). Generational difference is an extremely prominent element in the construction of ageing in Pind. Old age was based on a subjectivity of where a person stood in relation to other people and thus was inherently contextual. Old age was substantially a matter of generation and household developmental cycles. People become elders when they had lived long enough for their children to become jawaan (young adults). Most decisively, people start to be classified and behave like elders when their sons get married and have children of their own. The relationships between parents and children hinge around changes of sexuality and reproduction in the life-course. When sons became sexually active, it was considered appropriate for parents to withdraw from sexual activity, and this was particularly the case for women. For instance, Shahida, in her early 40s, was ashamed of her pregnancy, as she had five grown-up children and a daughter-in-law who was also pregnant with her first child. She was seeking a termination as she felt that it ‘didn’t look good’ for a mother-in-law to be pregnant at the same time as her daughter-in-law. There is usually a close overlap between the ages of the mother-in-law’s last child, and the oldest daughter-in-law’s first child. The observations from Pind thus suggest that the physical changes associated with maturity can be less important than generational differences.

The demography of the elderly
Currently, 6% of the population of Pakistan is over the age of 60 (7.3 million people), whilst 40% of households contain an elderly person. The elderly have stayed at approximately 6% of the population since 1961. Throughout the last half century, the greatest population growth has been in the section of the population which is at ‘working-age’, partly due to population momentum and partly due to poor gains in survival in late middle age (Government of Pakistan 2002).

Pakistan is on the verge of ageing rapidly. Mortality has been in decline since the 1950s, and an incipient fertility decline has been identified since the late 1990s (Sathar 1991; Sathar and Casterline 1998). Population ageing is built into the momentum of current growth, and it will take place in a matter of decades, rather than centuries. By 2050 Pakistan is predicted to have 42.8 million elderly, making up 12.4% of the population, and the elderly population will be growing much faster than the rest (United Nations 2002). Already there is geographic variation in the progression of population ageing. District-level census data show that the proportion of elderly varies between 3.2% and 8.9% (Government of Pakistan 1998).

The gender balance is a very important characteristic of the elderly population in Pakistan. Women live longer
than men in most countries in the world, giving rise to a preponderance of women in the elderly population (Austad 2006). In Pakistan, however, there has been a stark preponderance of older men until very recently. In 1950 there were 134 elderly men to every 100 elderly women. Current estimates of the extent of sex bias in Pakistan vary slightly, from 119 in the 1998 census (Hashmi 2003) to rough parity in the UN 2000 population estimates (United Nations 2002). Life expectancy at birth is still longer for men in Pakistan (61.2 years) than women (60.9 years) (United Nations 2002). This phenomenon is only observed in a few countries such as India, Bangladesh, Egypt, Qatar and the United Arab Emirates, and is likely to reflect a heavy burden of maternal mortality and relative female neglect throughout the life-course (Mubashir Ali and Kiani 2003). The ‘missing’ elderly women (Sen 1992) are an embodiment of the manifold ways in which gender relations prevent women’s potential for longevity from being realized.

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Mortality
Life expectancy at birth has increased in Pakistan from 41 years in 1950 to 61 years in 2000. Most of this improvement in life expectancy at birth is driven by reduced infant-child mortality, but also by a general decline in adult mortality (Sathar 1991).

We examined trends in age-specific mortality rates between the 1980s and 1990s using the Pakistan Demographic Survey (PDS), which is the only regular source of data on adult mortality in Pakistan. The sample of deaths is relatively small and there may be considerable error around the estimates. However, the data from successive rounds of the PDS can be pooled to give a more consistent picture (see Figure 1).

Figure 1: Changes in age-specific mortality rates 1984-90 to 1991-01

Amongst the over 65s, there has been no clear change in mortality between the 1980s and 1990s. Female mortality amongst the elderly appears to have declined more than male mortality (a 6% decline compared to 0.95% for elderly men). However, for those aged 50-64, mortality appears to have actually increased between the 1980s and 1990s. Thus, survival in late middle age and older life seems to have deteriorated since the 1980s, particularly for women. This highlights the welfare of the elderly as a priority area for public policy.

Healthy life expectancy
Healthy life expectancy measures the number of years people can be expected to live, free of disability. Currently, men in Pakistan can expect to live 54.2 years without disability and women 52.3 years. At age 60, disability-free life expectancy is only 11.4 years. The loss of healthy years of life is greater for women than for men. Women can be expected to lose 9.3 healthy years of life (15% of their total life expectancy) whereas men only lose 6.9 years (11.3%) (World Health Organisation 2003).

Ill-health
Non-communicable chronic illness is the most important cause of mortality and morbidity amongst the elderly in Pakistan (see Table 1). Cardio-vascular and musculoskeletal disease are the most common sources of morbidity. As would be expected, elderly women tend to report higher rates of morbidity than elderly men.
Furthermore, as the table suggests, the prevalence of chronic illness is strongly socially patterned. Higher levels of chronic illness are generally found amongst elderly living in urban areas, and amongst those who are of a higher socio-economic class (when this is measured) (Pakistan Medical Research Council 1998).

Table 1: Chronic health conditions among the elderly in Pakistan

<table>
<thead>
<tr>
<th></th>
<th>National Health Survey of Pakistan (65 yrs and above)</th>
<th>SHLCEP (60 yrs and above)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Hypertension</td>
<td>29%</td>
<td>38%</td>
</tr>
<tr>
<td></td>
<td>rural</td>
<td>urban</td>
</tr>
<tr>
<td>Diabetes</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>rural</td>
<td>urban</td>
</tr>
<tr>
<td>Heart disease</td>
<td>10%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>rural</td>
</tr>
<tr>
<td></td>
<td></td>
<td>urban</td>
</tr>
<tr>
<td>Cardio-vascular disease</td>
<td>17%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>rural</td>
<td>urban</td>
</tr>
<tr>
<td>Musculoskeletal disease</td>
<td>7%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>rural</td>
<td>urban</td>
</tr>
<tr>
<td>Renal impairment</td>
<td>17%</td>
<td>9%</td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td>7%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>rural</td>
<td>urban</td>
</tr>
</tbody>
</table>

Sources: National Health Survey of Pakistan (1990-94) and SHLCEP (1999-01)

The elderly in Pakistan are increasingly being afflicted by ‘diseases of affluence’, which are precipitated by the sedentary urban lifestyles associated with ‘modernization’. However, alongside the growing epidemic of non-communicable chronic illness is a persistent force of ill-health from communicable disease. Tuberculosis and viral hepatitis are still major causes of death amongst the elderly (Government of Pakistan 2002). Pakistan is thus suffering a double burden of mortality in which non-communicable chronic disease amongst the urban rich coexist alongside malnutrition and infectious disease amongst the poor.

The importance of family care

Financially, elderly people benefit economically from living in joint families. Using econometric data on Pakistan from the 1991-92 World Bank Living Standards Measurement Survey Anjini Kochar found that fathers worked fewer days as their sons’ wage earnings increased, indicating that fathers benefit from their sons’ incomes. She identified that these benefits arise mainly due to the joint consumption of household public goods. Sons’ incomes finance expenditures on consumer durables and ceremonial events, particularly weddings (Kochar 2000).

Similar findings are also reported using more holistic measures of quality of life. Using an index that combined measures of socio-economic status, health status, autonomy and happiness, Syed Mubashir Ali and Mohammad Kiani found that the elderly living in extended families had a better quality of life than those living in joint or nuclear families. This association persisted after taking account of the variation in quality of life associated with other cross-cutting factors such as age, gender, urban-rural residence, and poverty. Notably, elderly women had a poorer quality of life than elderly men, even in the multi-variate model (Mubashir Ali and Kiani 2003).

Here, we chose heart disease as a case study to examine the factors associated with ill-health in the SHLCEP. Heart disease is particularly informative as it is associated with high levels of morbidity amongst the elderly, and is also one of the leading causes of mortality. Heart disease was reported by 10.8% of the elderly men in the survey and
15.4% of the elderly women. The factors associated with variation in health status among the elderly in a bivariate X2 analysis are shown in Table 2.

### Table 2: Percentage of elderly with heart disease according to various risk factors

<table>
<thead>
<tr>
<th>Risk factors</th>
<th>All</th>
<th>Male</th>
<th>Female</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban-rural residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>16.0%</td>
<td></td>
<td></td>
<td>1551</td>
</tr>
<tr>
<td>Rural</td>
<td>9.6%</td>
<td></td>
<td></td>
<td>1370</td>
</tr>
<tr>
<td>Monthly family income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 6000 Rs</td>
<td>10.8%</td>
<td>7.1%</td>
<td>14.8%</td>
<td>1567</td>
</tr>
<tr>
<td>6-10,000 Rs</td>
<td>17.0%</td>
<td>15.6%</td>
<td>19%</td>
<td>587</td>
</tr>
<tr>
<td>&gt; 10,000 Rs</td>
<td>18.4%</td>
<td>16.8%</td>
<td>20.8%</td>
<td>304</td>
</tr>
<tr>
<td>Don’t know</td>
<td>12.5%</td>
<td>12.3%</td>
<td>11.6%</td>
<td>398</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Now married</td>
<td>11.3%</td>
<td>10.6%</td>
<td>12.3%</td>
<td>798</td>
</tr>
<tr>
<td>Widowed</td>
<td>17.3%</td>
<td>12.4%</td>
<td>19.3%</td>
<td>622</td>
</tr>
<tr>
<td>Economic dependence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent</td>
<td>14.4%</td>
<td>12.3%</td>
<td>15.8%</td>
<td>2181</td>
</tr>
<tr>
<td>Not dependent</td>
<td>8.9%</td>
<td>8.4%</td>
<td>10.8%</td>
<td>743</td>
</tr>
<tr>
<td>Dependent on whom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>9.9%</td>
<td>9%</td>
<td>10.1%</td>
<td>465</td>
</tr>
<tr>
<td>Sons</td>
<td>15.1%</td>
<td>13.1%</td>
<td>16.9%</td>
<td>1525</td>
</tr>
<tr>
<td>Other</td>
<td>11%</td>
<td>8.6%</td>
<td>17.6%</td>
<td>934</td>
</tr>
<tr>
<td>Family type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear</td>
<td>16.5%</td>
<td></td>
<td></td>
<td>656</td>
</tr>
<tr>
<td>Joint</td>
<td>12%</td>
<td></td>
<td></td>
<td>2292</td>
</tr>
<tr>
<td>Literacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>11.9%</td>
<td>7.8%</td>
<td>14.5%</td>
<td>1903</td>
</tr>
<tr>
<td>&lt; Matric</td>
<td>14.3%</td>
<td>12.1%</td>
<td>18.7%</td>
<td>663</td>
</tr>
<tr>
<td>&gt; Matric</td>
<td>16.2%</td>
<td>15.7%</td>
<td>18.9%</td>
<td>352</td>
</tr>
<tr>
<td>Currently working</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>13.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: SHLCEP (1999-01)

As the table shows, the risk of heart disease is associated with factors concerning family support as well as socio-economic status. In relation to family support, the prevalence of heart disease is considerably higher amongst those who are widowed, compared to those who are currently married, never married, divorced or separated. This relationship is statistically significant at the p<0.001 level. The strength of the association is, however, driven by the strong association between widowhood and heart disease amongst women (19.3% of widows compared to 12.3% of currently married women); amongst men there is little difference in the prevalence of heart disease by marital status. Elderly people who are living in nuclear families and rural areas. Elderly who are dependent on their sons have higher rates of heart disease than those who are dependent on their spouse or ‘other’ relatives (p=0.00012). However, these is likely to be confounded by the age of the elderly person, as widows, who also tend to be dependent on their sons rather than on their spouses, are likely to be older than elderly who are still married.

Looking at the associations with socio-economic factors, heart disease appears to be associated with factors usually thought to indicate high socio-economic status, such as living in an urban area (p<0.001), having a high family income (p<0.001) and being well educated (p=0.046),
thus bearing the characteristics of a disease of affluence. The quantitative data thus lead us to examine the family care for the elderly as an important input to their welfare, especially for elderly women.

**Doing Khidmat (Obligatory Service)**

In Pind, family care for the elderly was referred to as doing khidmat, which literally means 'to serve'. Doing khidmat is a complex socio-cultural formulation of the care relationship, legitimated with reference to culture and religious tenets. People in Pind understood khidmat in terms of religious obligations (farz) to care. Children also did khidmat for their parents in repayment for the sacrifices that the parents made in bringing the children up (Murutta 2005). As Sylvia Vatuk (1995) argued for North India, socialisation into these expectations about khidmat begins from the early stages of childhood. Using the language of doting and teasing, mothers in Pind explained to their sons from a young age how they hope they will give them khidmat in old age and be their bohrappe da sahara (support for old age). To make such explicit claims to intergenerational reciprocity are not associated with emotions like shame or guilt, as have been reported for western elderly people unable to conform to their cultural ideals of self-reliance in later life. People in Pind are taught to think of the parent-child relationship not in terms of a selfless one-way flow of attention and resources, but as a form of mutuality or reciprocity enacted over the life-course.

"The elderly in Pakistan are increasingly being afflicted by 'diseases of affluence', which are precipitated by the sedentary urban lifestyles associated with 'modernization'."

*Khidmat* was done for elders in accordance within a strong and gendered normative framework. In general, forms of economic support were provided by male kin, particularly sons. There was strong stigma and taboo surrounding the receipt of economic support from married daughters, particularly transfers of financial resources and accommodation. Elderly parents who found themselves majboor (in need) and requiring support from their married daughters might largely spend parts of the day in their daughter's household, but whilst they still had the choice, they refused to sleep under her roof. By contrast, practical support and personal care was typically provided by female kin, particularly daughter-in-laws and unmarried daughters. For emotional support concerning personal problems, elderly women turned to their daughters and daughters-in-law, whilst elderly men turned to their wives.

Cultural norms in Pind affirmed an ideal of supporting elderly via the 'joint family', where aged fathers and mothers live with their married sons, daughters-in-law and grandchildren, and unmarried sons and daughters. In principle the joint family is a system of mutual interdependence, in which all members are cared for according to expectations about duty (farz) which are based on gender, generation and position in the household structure. David Collard (2000) and Naila Kabeer (2000) describe this as an 'inter-generational bargain'. Parents consider it their duty to care for their children until they are established and married, which includes giving them a job or livelihood, and arranging their children's marriages. In return, grown-up sons were supposed to manage the property and act as breadwinner, and their wives should carry out the work of caring for children, the sick and the elderly. In Pind, these ideas were legitimated with reference to Islam, as expressed in sayings such as if a parent died without arranging a child's marriage, that they would be in eternal torment.

It was common for the work of khidmat to be shared between sons. Sons that moved out and established their own households usually did so within the compound or nearby, producing clusters of agnatically-related families. Cousin-marriage and endogamy within the biraderi ensured that daughters also often married within the village, which meant that they lived nearby and were able to make frequent visits to their natal home for companionship and emotional sustenance. People remained committed to the united family, if not to the single household. This local kinship facilitates flows of work and resources between sons and elderly parents. In Pind the roles of economic support and practical care for elderly parents were sometimes split so that the co-resident son cooks and budgets with the parents on an everyday basis, whilst...
another son paid for additional expenses such as health care. It was also common for elders, particularly widows, to move between their sons’ houses for extended periods of time. Elders said that this was their will, and that they ‘go when they please and where they please’. However, such moves are usually prompted by changes going on in their sons’ lives, and it also has the result of spreading the khidmat between the various sons and daughter-in-laws.

Variation in entitlements to family care
The vast majority of elderly people live in joint families (60%), and only 23% live in nuclear families. The elderly are more likely to be living in extended families than younger people (Hashmi 2003). Interestingly, the SHLCEP shows no statistically significant differences in the proportion of elderly people living in nuclear families between urban or rural areas, or between elderly men and women (Pakistan Medical Research Council 2005). According to the 1998 census, only 3% of elderly people in Pakistan live alone (Hashmi 2003), although some surveys, such as that of Grace Clark (2002) and colleagues, have given estimates as high as 10%.

In the SHLCEP, 6% of elderly were living alone. The most commonly cited reason given for living alone was the death of a spouse (32%), followed by never having married (13%), not having any relatives (13%), the separation of children (13%) and children being away due to employment (8%). Gender differences in reasons for living alone were apparent. Women were more likely to report living alone because their spouses had died or because their children were away due to unemployment. Men were more likely to state that they were alone because they had never married or because their children had separated (Pakistan Medical Research Council 2005).

Variation in the receipt of family care thus seems to be connected with: (1) the availability of kin and (2) the socio-economic circumstances of the family.

The availability of kin
The structural foundations of family care may break down in circumstances of widowhood, separation or divorce, polygamy or family conflict, or childlessness, where there are no de facto family members available. The consequences of a lack of available kin are gendered, as are the strategies for managing them.

According to the SHLCEP, 43% of elderly women are widows compared with 17% of men, whilst 80% of elderly men are married compared with only 55% of women (Pakistan Medical Research Council 2005). The relative commonness of widowhood in women relates to female longevity, but also reflects a social bias against widow remarriage in Pakistan. Marital status is a critical dimension of welfare for the elderly, and widowhood is closely associated with poverty and mortality in South Asia, especially for women (Dreze and Srinivasan 1997; Bhat and Dhruvarajan 2001).

The ‘missing’ elderly women are an embodiment of the manifold ways in which gender relations prevent women’s potential for longevity from being realized.

The anticipation of old age incapacity without any social welfare institutions other than the khidmat provided by children appears to be, amongst other factors, an important prop to marriage and high fertility in South Asia (Cain 1986; Vlassoff 1990; Cain 1991c; Sathar and Kazi 1997; Sathar and Casterline 1998). The elderly people interviewed in Pind had an average completed family size of 5.1 living children, of whom 2.9 were sons and 2.2 were daughters. None of the elderly couples in Pind had only daughters, although four had only sons. Couples are not generally satisfied with only daughters, and keep having children until the arrival of a son. Two sons remains the childbearing preference in Pakistan (Sathar and Casterline 1998). Intriguingly, in rural Bangladesh, Omar Rahman (1999) showed that having one son does not significantly improve parental survival, but having two does. Despite almost universal rates of marriage, childlessness is relatively common, and becomes a major cause of marital instability. In cases of childlessness, widowhood or marital break-down, there is an expectation that the extended family should take on responsibilities for vulnerable relatives. The logic of who steps in to provide support broadly follows the principles of patrilineal-
ity (Shaw 2004). In Pind, other male kin usually took on this responsibility, so childless or single women may be expected to be looked after by their fathers, brothers or brother's children. To receive support from daughters and sisters was considered somewhat shameful.

The normative framework guiding the receipt of *khidmat* is thus also highly gendered, and reflects ideologies about the relative claims of different family members. Elders are due respect, but in practice, not all elders are entitled to equal *khidmat*. For example, Saira Bibi, an elderly woman in Pind who never married at all, lived in a mud house that she built for herself in her brother's compound. She cooked for herself and was not supposed to have any access to the milk from their cow. As Lawrence Cohen's (1998) North Indian ethnography suggests, spinster or widowed aunts are considered quite different from venerated and cared-for mothers, and are weaker and more likely to be neglected. The entitlement to *khidmat* from the next generation is predicated on having achieved parenthood.

**Social class and claims to *Khidmat***

Whilst it is considered a blessing to be able to provide *khidmat* for elders, in conditions of poverty, the additional presence of elderly people in the household can be an economic stress. PSES2 data reveal that elderly nuclear families tend to be poorer than elderly extended families (Mubashir Ali and Kiani 2003). Applying the methods used by Sarmistha Pal and Robert Palacios to the PSES2 (Pal and Palacios 2006), it is possible to assess the economic status of households containing elderly. The poverty indicator used was average per capita consumption expenditure (APCE), which was calculated from the PSES2 based on household expenditure on a range of basic goods. The poverty line was calculated to be 725 Rs per month.

The data are shown in Table 3. As in the Indian data, Pakistani households containing elderly people appear to be slightly better off than households without. Amongst the households with elderly people, those containing more than one elderly person are slightly more affluent. However, after adjusting for household composition, the benefit of having elderly people in the household may be removed and sometimes reversed. As the data show, the presence of dependent children (aged 0-15 years) is more strongly associated with poverty than the presence of elderly, but the added presence of elderly is additionally associated with poverty. The poorest households are those with old people and children. For households without children, the additional presence of an elderly person is associated with poverty.

**Table 3: Average per capital consumption expenditure by household composition**

<table>
<thead>
<tr>
<th>Type of household</th>
<th>Percentage of households</th>
<th>Average per capital consumption expenditure (Rs/m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>With old person</td>
<td>40%</td>
<td>1236</td>
</tr>
<tr>
<td>Without old person</td>
<td>60%</td>
<td>1146</td>
</tr>
<tr>
<td>With old person and child(ren)</td>
<td>33%</td>
<td>1032</td>
</tr>
<tr>
<td>With old person but no child(ren)</td>
<td>7%</td>
<td>1878</td>
</tr>
<tr>
<td>Without old person but with child(ren)</td>
<td>52%</td>
<td>1049</td>
</tr>
<tr>
<td>With more than one old person</td>
<td>12%</td>
<td>1286</td>
</tr>
</tbody>
</table>

Source: PSES2, 2001 N=4080 households

Thus, although elderly people benefit in welfare from living with their children, the economic benefit of having elderly people may disappear at the household level when there are dependent children present. This is reflected in the qualitative data, which revealed a tendency for the *khidmat* from sons in poorer elderly households to decline, and for tensions in the joint family to emerge in response to poverty.

Makbool’s situation exemplifies the tensions that can
emerge in the joint family in response to poverty, and elderly people's commonly expressed anxieties about dependency on children. Makbool is a widower whose wife died of fever 13 years ago. He himself was very thin and frail. He had no land and despite his infirmities and advanced old age he continued to work as a watchman at the health centre. He had four sons, but he and his wife had always lived with his divorcee daughter, and her two children, instead. His sons were married and living elsewhere in Pind and none of them provided for him materially. He said that his sons were only just managing to get by themselves, and all their earnings went to their wives and children:

'My sons aren't looking after me, they aren't giving me respect. My daughters-in-law are the ones making the decision. They say their money is already short, so they can't afford to give anything to me. But it doesn't look good for sons not to look after their parents (log ache naysamajde). People don't give you respect'

Whether poor families break up depends on how sons negotiate their loyalties towards their natal and conjugal families. The break-up of joint families tends to be blamed on the behaviour of daughters-in-law (Parry 1979). In Pind, daughters-in-laws were often described as greedy (lalchi) or argumentative (larhakoo) by the elder generation. This is another important way in which the honour of a family is critically bound up in the conduct of its women (Shaw 2000). Thus, as Penny Vera-Sanso argues in her work on South India, inter-generational relations are mediated by socio-economic location and by the conjugal relationship (Vera-Sanso 2001).

Inter-generational flows of resources

In circumstances of poverty, there may be little in the way of inter-generational support within the household. A survey of the elderly in Punjab reported that 38% of elderly men and women received no financial support from their adult sons, and that 23% of elderly rarely or never received help from their children when they were sick (Clark, Zaman et al. 2002). Tensions in inter-generational relationships within households may be expressed through the medium of resource consumption. In Pakistan, as in Amartya Sen's formulation of the entitlement approach, intra-household entitlements to food and other inputs to health appear to be related to an individual's labour power. For example, econometric analysis of the 1987-88 Household Income and Expenditure Survey of Pakistan showed that men have a larger impact on the household food share than women, and that male workers command more of the household food budget than male dependents. However, patterns of resource allocation towards the elderly are complex, and depend on which resource is under consideration. Biases in food allocation towards the elderly have not been identified in Pakistan. The same survey revealed no consumption biases against the elderly, regardless of whether the elderly were working or not. Rather, the authors found that young adults who are not working consume less than the elderly (Bhalotra and Attfield 1998). Rather, significant anti-elderly biases have been identified in relation to medical expenditures. Using panel data from the International Food Policy Research Institute (1986-89) and the World Bank's Pakistan Living Standards Measurement Survey (1991-92), Anjini Kochar (1999) confirmed that old people have different health entitlements in Pakistani households. Although more money is spent on medical expenditures for the elderly than for other household members, this is still less than, as would be required to meet the needs of their poorer health status. According to the LSMS data, medical expenditures peak for males in their early 30s and decline with age. Furthermore, the extent of this bias depends on the elderly person's economic contributions to the household.

"For emotional support concerning personal problems, elderly women turned to their daughters and daughters-in-law, whilst elderly men turned to their wives."

In poor households in Pind, the entitlements to resources amongst the elderly are partially shaped by perceptions about their economic productivity, particularly for elderly women. Muktaree, an elderly Christian lady who used to work as a dai, had a tumour in her stomach the size of a football. Her son, a road cleaner, took her to an allopathic doctor in Lahore, who said that she needed an operation to remove it. However, the family has no money to pay for the procedure, and Muktaree is taking no medicine at all.
In poor families, scarce resources are directed towards children, who are seen to have their lives ahead of them and need their health so they can work for the good of the whole family. Muktaree herself says that she's old and reaching the end of her life, so she's tacitly being allowed to die. Thus, elderly people justify these painful biases in the allocation of scarce resources by saying that their lives are nearly finished (khataam), that the young have their lives ahead of them, and that the young are more necessary to the household than they themselves. Nasreen also acquiesced with her family against claiming what she needs for her health. Nasreen suffered from debilitating joint pains which made her stop working, as a domestic worker, four years ago. At the time of the interview she was unable to haul herself off the bed without calling for the help of her granddaughter. Nasreen didn't tell her son that she was ill, so that he didn't have to face the question of what to do about it:

"Mashallah, my sons bring me medicines. But it is difficult to ask them when they are so short of money themselves."

Conclusions
Gender and social class are extremely important factors differentiating the health of the elderly in Pakistan, and the management and care for ill-health amongst the elderly. Patriarchal gender relations impinge on women's health throughout the life-course. Pakistani women have no advantage in survival over men, unlike in most other countries in the world. They have higher rates of disability, communicable and non-communicable disease, and report a lower quality of life. Elderly people's entitlements to care are gendered and depend on kinship position. Women's entitlements to care can be particularly negotiable, depending on the availability of kin and the socio-economic circumstances of the family, and whether produced a large family, nurtured a net of close relationships with her children, and succeeded in securing the respect of her daughters-in-law.

Socio-economic class is central to the provision of care, and nuclear family living may be a privilege of the affluent. Thus, gender relations are worked out in relation to other dimensions of social structure, such as socio-economic class. In conditions of poverty, inputs to health may be directed away from the elderly towards the young, who are perceived to be more economically productive, and in greater need.

References


The quality of life variable they derived was a composite variable consisting of health status, measured by the proxy ‘was (name) sick during the last two weeks’; educational status; per capita income; the availability of a suitable place for rest; role in decision-making; satisfaction with present living conditions; disability status; self-perceived nutritional level; status of present life as compared to life when in middle-age; a feeling of satisfaction with life; confidence of well-being in the future; presence of drinking water, electricity, gas and telephone in the house; household crowding; being gainfully employed and owning the house (Mubashir Ali and Kiani 2003).