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Chapter One

Diversity of Aging Experience in Latin America and the Caribbean

Luis Alberto Vargas, MD, PhD

Editor's Introduction

Vargas begins this volume by shattering the fallacious image of the generic (and hence, stereotypical) Hispanic. Diversity describes the different Hispanic culture(s) on this continent. Variables such as population growth and migration, as well as differences in history, political systems, and economic development, account for the diversity.

LATIN AMERICA AND THE CARIBBEAN

The American continent is varied from both a natural and a sociocultural perspective. The people that lived in it before the Old World and the New World met, ranged from tribes of hunters and gatherers with a Paleo-

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lithic technology to nations that had achieved knowledge and technology that in some aspects was more advanced than the ones of their conquerors. After 1492, South of the United States, the ways of the Old and New Worlds amalgamated and gave birth to a new and different way of life.

From a social and cultural perspective, the countries of the Americas can be classified the following way:

1. *North America*, encompassing Canada and the United States of America.
2. *The Caribbean*, which can be subdivided in:
   a. The English speaking countries.
   b. The Spanish speaking countries and territories (Cuba, the Dominican Republic and Puerto Rico).
   c. Haiti.
   d. The European territories and colonies.
3. *Latin America* geographically is part of North, Central and South America, and includes all the countries South of the United States of America in which Spanish or Portuguese is spoken. Although Cuba and the Dominican Republic are in the Caribbean, culturally they are akin to the Latin American countries. From a cultural perspective, these countries can be divided in those with:
   a. A large Indian population and a cosmopolitan minority (for example: Perú, Bolivia, Guatemala).
   b. A small or nonexistent Indian population and a cosmopolitan majority (for example: Costa Rica, Argentina).
   c. The *mestizo* countries, where Indians, Negroes, Europeans and others have intermarried, although some ethnic minorities may remain (for example: México, Brazil, Nicaragua).

Mestizo is the Spanish word for hybrid, that is the offspring of living beings of different biological stock. But *mestizo* is also used in a larger sense, to include culture. Many of the Latin American societies are truly a mixture of the Iberian culture (including its Jewish and Arabic components) with that of the Indians that lived before the arrival of the Europeans, the slaves brought from Africa, and all the later immigrants. This is reflected in their way of life: despite the powerful influence of the United States, France, England, Japan and other countries, Latin America maintains its identity, based on the use of the Spanish and the Portuguese languages, and reinforced through a common heritage of music, literature and other arts. Latin Americans do have a sense of being *Latinos*.

MAJOR DEMOGRAPHIC AND SOCIOECONOMIC CHANGES IN THE AREA

This century, Latin America has suffered a series of changes that affect the situation of the elderly. Among the most important of them are:

Population Increase

Latin America and the Caribbean are two of the areas in the world with the greatest demographic expansion. This has many causes, but its net effect is a population that constantly augments through a sustained birth rate and a decrease in child deaths. About half of the population in this area is under 15 years of age. The United Nations has estimated the following figures for the years to come (cited in Anzola, 1985). Life expectancy at birth is anticipated to increase from 64.1 years in 1980-1985 in both Latin America and the Caribbean, to 71.8 in Latin America and 70.7 in the Caribbean in 2000-2025. In the same years the number of people (in thousands) is expected to enlarge from 363,704 to 865,198 in Latin America and from 30,648 to 61,887 in the Caribbean. The number of people above 60 years of age is predicted to gain from 23,328 to 93,317 in the whole Region. This is truly an "elderly boom," since the general population increase will be of 237% and that of the elderly 400%! This age group will become 10.8% of the population.

This situation has a series of consequences. The health of the elderly is worse than that of their younger cohorts since they tend to have more chronic and degenerative diseases as a result of their age. This creates demand for more medical services and for growing numbers of members of the health team, specialized in geriatrics. Some old people are bedridden and need hospital care. At the same time, the enlargement in the number of the elderly with the decrease of men and women who are economically active will be a burden to the social security systems of the Region, that will have proportionally less resources for a larger population. Money will also be increasingly spent in paying for pensions and disabilities.

Migration

Several countries of Latin America and the Caribbean suffer the "megalopolis syndrome." This means that they have few large cities and a host of scattered small towns, villages, and hamlets. One of these large cities is usually the capital, where one can find most of the administrative structure of the country, large industries, centers for higher education, medical

care, and the best places for leisure, among many sources of income and public need or attraction. On the contrary, rural areas tend to have less public services, education, sources of income, social stimulation, and are poor and isolated. Better transportation has favored the possibility of migrating from rural areas to the larger cities.

The consequence of this situation is that urban areas grow larger, and the rural areas become depopulated. People go to the big cities thinking that they offer better opportunities. They settle in the marginal areas, creating the squatter settlements that are known in Latin America under names such as *barrios nuevos*, *asentamientos precarios*, *villas miseria*, *ciudades perdidas*, *favelas*, etc. This internal migration has complex results. There is a large pressure to create sources of income in the cities, rural food production diminishes, many people work in the area of services and not in the primary production of goods, the national budget becomes burdened by governmental investments in providing services to this increasing population, etc. But probably one of the most important results is that the population abandons its traditional culture, to adopt the urban pattern, which is usually a form of the so called Western cosmopolitan way of life. In many cases this gives rise to hybrid cultures in which tradition and modernity overlap, but there is a definite change in the values and in the lifestyle of people.

In some countries the situation is made more complex due to the possibility of migrating legally or illegally to a more affluent country. This is the case of the extensive exodus from Central America, Mexico, and the Caribbean to the United States, the migration of Central Americans to Mexico, of Bolivians to Peru, Colombians to Venezuela, and many others. The explosive political situation of several countries in the area has favored this international movement. Its effects are again very intricate, but among them, one can find: (a) the flow of foreign and usually harder currency to the family that has been left behind; (b) the breaking of family ties, due to the migration of young adults that leave behind their children and their elders; (c) the importation of different lifestyles and values, such as electronic and electric gadgetry, food, vehicles; (d) the desire to live as they do in other countries; and many others.

Social and Political Upheaval

This Region has been socially and politically unstable for a long time. Its revolutions and war take a toll on the whole population but mostly among the young. Sometimes the elderly are left without support, many women become widows or do not have the possibility of finding a stable companion. Social and political upheaval contributes to migration. This

situation affects the whole social structure, increasing the numbers of the elderly, particularly of women.

CULTURE AND THE CARE OF THE ELDERLY

Despite the cultural complexity of Latin America and the Caribbean, it can be said that the traditional ways of life are being substituted by modernization and cosmopolitism. This has changed the attitudes towards the elderly and their care.

In general, traditional societies have reverence for old people. They are considered as ancestors, sources of wisdom, teachers, moral examples, the link of the living with the deceased, and in some cases they are attributed supernatural powers. For instance, the Nahuatl-speaking people that lived in Central Mexico before the arrival of the Europeans supposed that the *tonalli*, one of the three souls of man, became stronger as time passed and people acquired social positions and experience. They were also conscious that old people could have mental deterioration and become an *oppa piltontli*, or child for a second time (López Austin, 1980). In many societies there is a sense of responsibility for the care of the aged. Usually this is done within the family. Sometimes this is the natural result of life. Men, and particularly women who do not marry will tend to continue living with their parents. This is frequent when access to land for cultivation is gained by forming part of a household, and where housing is scarce. On the other hand, in societies where married couples leave their parent's home to establish their own, it is usual for the eldest daughter to invite one of their parents to live in her house, when the other partner dies. It is also true that grandchildren are "loaned" to the household of the elderly who are alone or handicapped. These situations are common in villages where families live together and where the living conditions are not too challenging. In stressful conditions it has been reported that the elderly who are not self sufficient die of neglect.

According to information that has come from research done in Latin America, it can be stated that the aged have a high status where society: (a) is socioeconomically homogeneous, (b) has sequential roles that entail progressively higher responsibility and authority (such as the *cargo* system of civil and religious authorities, not linked to the official government, found in the Region, (c) has a life-cycle sequence of roles characterized by continuity, (d) allows the elderly to control important family or community resources, (e) permits old people to engage in valued, useful, and important activities, and (f) where the extended family is a viable residential or economic unit (Finley, 1981 and Press et al., 1972).

The socioeconomic changes that go with urban lifestyles have modified the care of the elderly. Cities have among others the following characteristics that affect this situation: (a) higher population density, (b) costly living, (c) a more difficult access to food, (d) a rigid time schedule due to the type of employment found in them, (e) less physical security, (f) the need to use some kind of transportation, due to difficulties to move to and fro, (g) isolation due to the size of cities and the cost and problems associated with transportation, (h) crowding, and many others. The pressures of life in the cities cause nuclear families to become isolated and to give less and less support to the elderly. Young people are more likely to migrate into cities and leave their parents in the rural areas where they come from. Once in the cities young people try to find places to live by themselves and consider their parents and grandparents a burden. This has created the need of special institutions to keep old people. Some of them need hospitalization because of their senility, chronic diseases, or lack of capacity for self-maintenance. Unfortunately, in poor countries this is not always possible and old people suffer and are abandoned. This is particularly tragic in cases of persons who have no family. Of course this situation is not the same among all socioeconomic levels. The affluent have access to nursing homes and can pay servants or nurses to take care of their parents. Persons who are covered under the social security systems that exist in the Region receive social and economic benefits. Among them, is an economic pension, usually at or below the minimum wage, access to medical care, possibility of hospitalization in case of acute or chronic diseases, etc.

In Latin America and the Caribbean churches may play a very important role in the care of the elderly. These are places where they feel comfortable and find the social atmosphere that allows them to interact and provide activities that help people cope with the daily problems of life. For instance, many churches sponsor nursing homes or home visits for people who need them. The Catholic Church plays an important role in these matters through several of its orders of nuns and friars. What one does not frequently find in these countries are services such as the delivery of hot meals at home, or day care centers, but these are starting in some areas.

It is important to stress that Latin America and the Caribbean are very heterogeneous in the way that they treat the elderly. One can find groups with very simple technology and a social organization that some consider primitive, such as the Indian tribes of the Amazonian of Central American

forests. In contrast, the Region also has some of the most populated and cosmopolitan cities such as Rio de Janeiro, Buenos Aires or Mexico City.

SOME DATA ABOUT FAMILY CARE OF THE ELDERLY

The literature about family care of the elderly is scanty. Very few articles or books deal exclusively with this matter. Information can be found in texts dealing with other aspects related to this age group. In addition, research done in Latin America and the Caribbean is scattered in hard to find journals and books. In the following paragraphs appear some examples of the family care of the elderly, found in the literature.

Santo Tomás Mazaltepec is a *Zapotec* community in the valley of Oaxaca, Mexico. Its inhabitants speak their language in daily life and some use Spanish in transactions with people who do not speak Zapotec. It is a small and isolated village of about 1,245 persons. People are poor, they grow corn, and are subsistence farmers with no other important sources of income. Mazaltepec can be considered typical of the many Indian communities in Southern Mexico and Central America. In regard to the care of the elderly, one striking fact is that they are not isolated. They tend to live in three generation households; for instance, about half of the men and 90% of the women of 50 or more years of age have their grown children living with them. A very small minority of the elderly live alone. If they do not share their household with their children, they do it with their siblings, parents-in-law, or even with people who are hired to help them in their tasks as farmers. About half of the children from 13 through 17 years of age in the village live with their grandparents, although it would seem that they would be the least likely to do so. Some grandchildren either choose to or are sent to live with their grandparents to keep them company. The elderly are well informed of the gossip of their village; they are a very active part of their society. Death is seen as inevitable and it is customary for the whole family to be at the death-bed of the elderly. Nevertheless, the whole situation is changing with the contact of the Zapotecos with the values of urban life. For example, the knowledge of the elderly in the traditional ways has become less important; they do not know about the new technology or the "modern" ways of life, which are considered important by younger people. Even so, the elderly still have ways to keep their authority. Among them are their ownership of land and other possessions, which they can inherit or give away at their will. The expectations of younger people about this are controlled by the elderly in

subtle ways, such as preferring those that have given them support in their old days, the ones who live with them, those who are more industrious and honest in their dealings, etc. Of course this form of social control works both ways. Sons and daughters who feel that their parents did not provide for them, will not feel responsible for the welfare of the elderly. This situation further being transformed now that the younger generations are finding other sources of income, as in the case of those who migrate to the cities (McAleavy Adams, 1972).

A similar situation is found in *Bojacá, Colombia*, a peasant village in the Andes. They are also poor subsistence farmers who are interested in reaching the level of the urban life of Bogotá, the capital. The elderly are much respected. They also tend to live in two generation houses and they also can have grandchildren on "loan" from their own sons or daughters. Old people are sought to help in specific tasks, such as cooking, going to the market, curing with medicinal plants, doing justice, counseling others about personal problems, religion, etc. But they are avoided when problems arise in the areas of economic activities that involve the exchange of cash or dealing with nonvillagers, the use of mechanical devices, formal education and school activities, village planning, romantic or sexual matters, etc. The advantage of being old in this town is that they know their place in society, and fulfill important roles and find positive reinforcement in their activities. As in the case of the Zapotec, this situation is changing (Kagan, 1980).

Costa Rica is one of the most developed countries in Latin America. It has shown considerable interest in the welfare of its aged population. Their life expectancy at birth is of 73 years. The situation of the elderly is similar to the one found in developed countries. Among 2,114 persons from 60 to 64 years of age, a third did not have a spouse; this figure increased to 62% among those over 75, and was higher among women. Out of 882 elderly that did not have a partner, 14.62% lived alone. The country has responded by creating several programs to improve the quality of life of the elderly. They have 32 institutions to house 1,944 old persons and 6 homes that offer aid to the disabled. The University of Costa Rica has created a program to allow the elderly to pursue studies (Brenes, 1987 and Trejos, 1985).

Uruguay also has an exceptional situation: it has a greater elder population than most countries in Latin America. Its life expectancy is high with a low birth rate. Young people tend to emigrate to other countries. The elderly are concentrated in urban centers. It has problems that are similar

to those of developed countries: an increasing number of elder women who are left alone, a trend towards two generation households, loss of roles and few sources of income for the aged, etc. The government has tried to give social protection for this group, but their pensions are low and there are few facilities for their care (Alberieux, 1980). The social implications of this situation have been well explored (Ganón, 1970).

Seen as a whole, from the few data found in the literature, the situations in Latin America and the Caribbean seem to have a great deal of variability. It is important to state that health care delivery in the Region is provided basically by three types of institutions: governmental, private, and the social security systems. In regards to the care of the elderly, the three of them are well prepared to deal with acute illnesses, and the medical or surgical care of chronic problems. The government and social security systems provide pensions for those who have worked for a number of years or are disabled. But other types of care, such as nursing homes, day care centers, the provision of meals, etc. are left to the private sector and in most cases to the church. The majority of the community based services for the elderly consist of nursing homes, which range from the traditional poor ones, to the newer and modern, destined to the affluent sectors of society. There is also a growing number of clubs and organizations that gather the elderly together and in some countries sponsor specific organizations to handle their global problems (Tapia Videla, 1982). The situation has not improved as it would be desirable, due among other things to the political and economic instability of the Region.

PRELIMINARY RESULTS OF A SURVEY

Precise knowledge about the situation of the elderly is needed in order to develop a regional strategy for the care of their problems. As seen in the last section of this chapter, the information is meager and irregular. This is the reason why the Pan American Health Organization has started a survey on the needs of the elderly in selected Latin American and Caribbean countries. This survey is still in process and the data that will be presented here are to be considered preliminary and tentative, since they are based only on partial results. The importance of this survey is that it is being applied with the same content and methodology in different places of the Region, and will provide a first "snapshot" of the situation of people over 60 years of age.

Trinidad and Tobago (PAHO, 1987a)

Trinidad and Tobago is one of the Caribbean countries included in the study. A sample of 875 persons of both rural and urban areas was interviewed.

As in most of the world, women live longer than men and widows were frequent, but at age 80, the number of men and women who have lost their spouse is about the same. The majority of the elderly lived within two to three generation households, but 13.6% lived alone. Most of the men lived with their wife, and both sexes shared their home with the family of one of their children and their grandchildren. More men than women owned their house; it was more frequent for women to live in a house that was not their own. About a quarter of men under 70 and women over that age, felt that the facilities found in their houses were inadequate. Most houses (70%) had electricity, a shower, and a stove. Drinkable water, a refrigerator, an indoor toilet, television, and radio were less frequent in this order; telephones were scarce (20 to 30%). There were differences of about 10% in these items between men and women. Very few people reported not having either an indoor toilet or an outhouse (2.3%). The average number of people who lived with the elderly went from 2.4 to 3.9, with more persons living with those of more advanced ages.

Most of the men under 80 and women under 75 called themselves healthy. Those who had health problems agreed that they had difficulties to carry out needed or desired activities. From 40 to 45% of those above 80 reported visual problems as creating problems in their life; less than 20% had disabilities due to hearing problems, and 15 to 35% had difficulties chewing their food.

Almost all of the elderly interviewed could complete the basic personal self care activities, such as dressing and undressing, combing their hair, taking a bath, using a toilet, walking on a flat surface, and taking their own medicine. Most of those under 80 could carry out more complicated activities as cutting their toenails, doing housework, cooking meals, or climbing stairs. These activities could be done by few of those over 80. A good number of the elderly needed help to venture away from their home. Men came out as more dependent than women for the care of their illnesses. In the case of married couples, the wife usually took care of her husband, but not vice versa. Sons and daughters were the most frequent source of help.

The greatest problem that the elderly perceived was economical, followed by health. These surpassed the need for health and social services, housing, transportation, family, isolation, and social rejection. One quar-

ter of those men over 70 and women under that age reported that their housing needs were not adequately satisfied.

This survey concludes stating that more elderly over 80 years of age can be defined as needy, both in their health, physical functioning, and financial situation. Eighty years of age seems to be the threshold of a decline in the satisfaction of the basic needs of those interviewed. Those living alone after this age are in a particularly difficult situation.

Costa Rica (PAHO, 1986)

As mentioned before, Costa Rica is one of the most socially developed countries in the Region. Its population has a high coverage by the social security system, its rate of literacy is high, and its political and economical situation has been quite stable.

A sample of 1,156 persons was obtained. Of these, 59.7% was in the urban areas and the remainder was in the rural part of the country. As expected, many more women (32.4%) than men (10.8%) were widowed. Women became widows at earlier ages than men. Very few were divorced (2.1%). The average household size was 4.6 people. There were more persons living with those above 80 years of age in the urban samples. Most of the houses were of two or three generations, but some reached four generations, since they included great-grandchildren. Only 7.5% lived alone, and 13.3% were couples living alone. Most of the elderly owned their house or lived in one belonging to their family. In the urban areas from 6% to 16% rented their dwellings. Less women than men owned their houses, due to being widows and having moved to live with their family. As age increases, this becomes more important for both sexes. Seventy to 80% of the houses had drinkable water, electricity, toilet, bath or shower, stove, and radio. Many of them also had television and refrigerator, but in the urban areas only half of the houses had a telephone. A little less than a fifth of the rural and a third of the urban men between 60 and 64 received a pension. This figure increased to between 50 and 60% at latter ages, but it was always less among rural men and women in both areas.

About 80% of the sample considered their health as adequate, but about half of them felt that their health impaired them to accomplish what they needed or wanted to do. One quarter of the sample felt that their vision created problems; the figure is less than 2% for hearing problems. Both vision and hearing were more frequently reported as a problem after age 80. Dental ailments caused difficulties in feeding for 18.3%. About 86% of the sample said that they had right to receive medical care in a public

institution. Only 10% more claimed this in the urban areas contrasted to their rural counterparts.

Nine out of ten elderly could bathe, dress, groom, feed themselves, get in and out of bed, and remain continent without help. Twenty percent of those over 80 could take their medicines by themselves, 40% could not do their house work, and 33% needed help preparing their food. Women were more likely than men to be able to prepare their own food. The most difficult activities for these elderly were climbing stairs, cutting their toe-nails, taking a bus and leaving the house. As in the case of Trinidad and Tobago, those aged 80 and over were more dependent than the younger ones. Most of the help comes from family members and more frequently from spouses and daughters. Health and economy were cited as the main problems in this sample. Rural elderly over 75 and urban women over 80 can be considered needy, particularly in their health and economic needs.

Chile (PAHO, 1987)

Chile is a country that has a varied population, ranging from isolated Indian tribes to cosmopolitan cities. The sample for this survey was taken only from urban communities of more than 100,000 inhabitants, where 80.1% of the Chileans live. The survey was answered by 1,562 persons.

One interesting aspect of the Chilean study is that the communities could be classified as old, transitional, and young. Old communities were those where more than 10% of their people were aged 60 or more. The percentage for transitionals was from 6% to 9.9%, and 5.9% or less for the young communities. The sample was analyzed separately for each type of community, but the number in the young ones was too small to be considered separately.

As in Trinidad and Tobago and Costa Rica, women tended to lose their spouse before the men did, and eighty years of age also was the beginning of a period of greater vulnerability for both sexes. Women were widows in a proportion of three to one, in relation to widowers. Less than 10% of the sample were divorced. Most of the elderly lied in two to four generation households; the average home of the transitional communities was larger than the one of the old ones. It was more frequent than men lived with their wife, than for women to live with their husbands, because of the high rate of widows. This also accounts for the larger number of men (20 to 30%) who lived isolated with their couple, in contrast with the women who did so (less than 25%). More people lived alone in the old communities (10.9%) than in the transitional ones (5.4%). Nevertheless, 12% of those between 75 to 79 years of age lived alone.

About two thirds of the sample lived in their own house; the rest lived in one owned by their family, but an important number lived in a rented

dwelling. Nine out of ten homes had drinkable water, electricity, toilet, kitchen, radio, and television. In the old communities, bathrooms or showers and telephones were more frequent than in the transitional ones; but telephones ranged from 30 to 70% depending on the community.

Most of the sample under age 80 could take care of themselves, but more needed help to leave their homes and to climb stairs. Self care needed more help after 80 years of age. Help was usually provided by another family member, being this was more frequent in the old communities. One important finding in Chile is that one tenth to one fifth of the elderly of the old communities stated that they did not have any potential help if they would become ill. Daughters were frequently cited as a source of help by both men and women who did not have a living partner.

Most of the sample was satisfied with their economic situation. Most of the men had pensions; women depended on more varied sources of income. As in the two other countries, the most frequently expressed concerns were related to economy and health. As in the two other countries, the most frequently expressed concerns were related to economy and health. As stated in the two other countries, visual, hearing, and dental problems became more serious after age 80.

CONCLUSIONS

The analysis of the data from the literature and the preliminary results of the survey lead to the following conclusions:

1. The family care of the elderly in Latin America is highly variable. It goes from the total involvement of society in the welfare of the elderly in gerontocratic Indian groups, to the nearly complete isolation of some old persons in the large cities.
2. The death pattern of the sexes causes that men tend to be cared for by their wives, but once women become widows, their family, and particularly their daughters become responsible for their welfare.
3. There is a difference in the quality of life after age eighty, when people become more dependent on the help of others, due to the deterioration of their vision, hearing, chewing, and capacity for self care.
4. The group with a higher risk are women over 80 years of age that live in urban communities.
5. The different social organization of the family found in the countries of the sample affects the care of the elderly.
6. The generalized notion that children are a good investment for old

age holds true, according to the results of the survey. Daughters in particular take a more active role in the care of their parents.

7. The way a person acts through his lifetime, especially in relation to accumulation of material wealth, friendship, and love, determines in good part his situation as an old person.
8. The smaller the community in which the elder lives, the greater his chances are of finding help.
9. The larger the family of the elderly, the greater the possibilities of having someone to live with them. This included the cases of grandchildren "on loan."
10. In general the elderly of Latin America and the Caribbean fare relatively well, probably because they are the survivors of cohorts with high mortality in childhood and adulthood.
11. Most of the elderly can take care of themselves at home; they need more help to climb stairs, leave their homes and prepare their meals. This has consequences for the design of housing for them and the type of help that has to be planned.
12. Latin America and the Caribbean are in the stage when concern for the elderly has arisen. According to some studies (Teski, 1982), concern not necessarily means action and excessive concern may take the place of action. Thus, now that we have some of the basic information, it is time to proceed to carry out concrete programs to help the elderly. The number of elderly in the Region is not as overwhelming as it is in Europe or the United States. Governments need not wait for their number to increase to take definite steps. The time to do it is now.

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