

**THE PROBLEMS OF AGEING IN BANGLADESH:
A SOCIO – DEMOGRAPHIC STUDY**

Dhaka University Library



400489

400489



A. S. M. ATIQUUR RAHMAN

**THE PROBLEMS OF AGEING IN BANGLADESH:
A SOCIO – DEMOGRAPHIC STUDY**

A Thesis Submitted for the Degree of
Doctor of Philosophy
in
Social Welfare

by
A. S. M. ATIQUUR RAHMAN

with 400489
Professor M. Hafizul Islam
Professor, Institute of Social Welfare and Research
University of Dhaka
Dhaka – 1205



May 2002



MD. HAFIZUL ISLAM

MA (HISTORY), MA (SOCIAL WELFARE) [DHAKA]
MSW (MICHIGAN) DPR (EXETER)
PROFESSOR OF SOCIAL WELFARE

UNIVERSITY OF DHAKA

INSTITUTE OF SOCIAL WELFARE AND RESEARCH
DHAKA-1205, BANGLADESH, PHONE : 505864, 868918

May 12, 2002

This is to certify that Mr. A. S. M. Atiqur Rahman has prepared this Ph.D. thesis entitled *The Problems of Ageing in Bangladesh: A Socio-Demographic Study* under my direct supervision. This is his original work. This thesis or any of its part has nowhere been submitted for any degree or publication.

(M. Hafizul Islam)

Professor of Social Welfare

400489



Abstract

Unlike many countries in the world Population Ageing in Bangladesh had not been a mainstream concern until lately. Only in recent times, there has been visible a slow but steadily persisting awareness among the concerned. Estimates say that the country with its 14 million will hold the seventh largest position by 2020 in terms of older population. This necessarily will arrest the well being of older persons unless well-focused strategies are adopted in time. Though this study investigates the overall situation of the older persons in Bangladesh, its ultimate objective is to articulate the problems of the country's older persons easily and readily understandable. The findings of the study support to the supposition that inter alia, lack of access to health services along with poverty is the greatest threat to the interests of older people. By and large the older people in urban areas faces greatly the problems of exclusion and loneliness, lack of employment and income opportunity and mental incongruity and social stress than their rural counterparts. On the contrary, the rural older persons mostly suffer from physical illnesses, poverty and income insecurity. Also they have relatively less access to medicare and health services. Although most of them are still passing their days' amidst tender care and support generally provided by their extended families, the situation is in transition as the family pattern gradually shifting towards the nuclear type due to the change in values, migratory tendency of their offspring and poverty. Excepting Old Age Pension that are introduced only for the retired government employees since 1924 the only recent initiative from the state party is the *Biosko Bhata* (Old Age Allowance) covers only around 24 per cent of the 50 per cent rural older people who are eligible for the scheme. The results thus call for immediate attention together with measures and policies relating to alleviate their destitution with the ways and means as directed by the recommendations made in light of the actual situation and International Plan of Action on Ageing 2002.

Acknowledgements

Several people at different stages of my research work provided their generous help and advice, which I gratefully acknowledge.

I am indebted to all who are related directly or indirectly to the preparation and finalization of my research work. Special thanks are due to those researchers, authors and scholars from whose work I have been benefited immensely in pursuing my Ph. D. research.

I owe a great deal to my reverend guide Professor M. Hafizul Islam, Professor, Institute of Social Welfare and Research (ISWR), University of Dhaka, as he spontaneously guided me all the while for carrying out the research and the completion of this thesis. His bona fide help, efficient advice and kind cooperation encouraged me and I think, ipso facto my endeavor has come to the end.

I am grateful to the Academic Committee and faculty of ISWR as well as the Dhaka University authority for allowing me to pursue this programme and providing necessary assistance.

Prof. Anwarullah Chowdhury, a prominent anthropologist and the Vice Chancellor of the University of Dhaka gave me enthusiastic encouragement. I acknowledge his kind support with gratitude.

I have been benefited by occasional discussion with Professor Profulla C. Sarker of University of Rajshahi; Professor M. Abu Taher, Professor M. Humayun Kabir, Professor Habibur Rahman, Professor Dalem Ch. Barman and Dr. Muhammad Samad of University of Dhaka. They deserve my sincere thanks for their continuous encouragement and valuable advice.

Over and above, my heartiest thanks are due to those friends, colleagues and well wishers, particularly Mr. A. S. M. Rowshanul Haque, Mr. A. K. M. Fazlul Haque and Mr. A. S. M. Zahid who have undergone much trouble in collecting, compiling and analyzing data throughout my research.

I would like to express my thanks to my colleagues and professional friends with the HelpAge International, Asian Training Center on Ageing (ATCOA), International Federation on Ageing, United Nations Population Fund (UNFPA), International Institute on Ageing, Social Science Research Council, Resource Integration center (RIC), Bangladesh Women's Health Coalition (BWHC) and of course, Bangladesh Association for the Aged and Institute of Geriatric Medicine (BAAIGM) for their generous suggestions and providing me with relevant documents.

In fine, I feel obliged to express my indebtedness to my parents and other family members for their continuous inspiration that helped me in many ways in this endeavor.

Institute of Social Welfare and Research
University of Dhaka
Dhaka-1205


(A. S. M. Atiqur Rahman)

May 2002

Contents

	Page
Abstract	iii
Acknowledgement	iv
List of Maps	ix
List of Figures	x
List of Boxes	xi
List of Tables	xii
<u>Chapter One</u> Introduction	1
<u>Chapter Two</u> Ageing and Older Persons: Theoretical Analysis	12
<u>Chapter Three</u> Characteristics of the Older Persons with Reference to the Bangladesh Population	79
<u>Chapter Four</u> Some Studies on Ageing Issues in Bangladesh: A Retrospective	96
<u>Chapter Five</u> United Nations Initiatives on Ageing Issues	103

gide

<u>Chapter Six</u>	Situation and Privileges of the Older Persons	113
<u>Chapter Seven</u>	Situation of the Older Women	167
<u>Chapter Eight</u>	Problems and Prospects of the Older Persons in Bangladesh	192
	Conclusion and Recommendations	245
<u>Appendix A</u>	Status of National Policies on Ageing in Some Selected Countries	256
<u>Appendix B</u>	Services for the Older Persons Currently Available in Some Selected Countries	269
<u>Appendix C</u>	United Nations Principles for the Older Persons	298
<u>Appendix D</u>	Political Declaration of the Second United Nations World Assembly on Ageing, Madrid 2002	302

<u>Appendix E</u>	International Plan of Action on Ageing 2002	309
<u>Appendix F</u>	Interview Schedule	381
<u>Appendix G</u>	Bibliography	394

List of Maps

Number	Title	Page
1.	Tajumuddin Upazila of Bhola District	7
2.	Sarail Upazila of Brahmanbaria District	7
3.	Nagarkanda Upazila of Faridpur District	7
4.	Jaldhaka Upazila of Nilphamari District	7
5.	Beanibazar Upazila of Sylhet District	7
6.	Bangladesh	7

List of Figures

Number	Title	Page
1.	Wild type survival curve	23
2.	Rectangular survival curve	24
3.	Distribution of Major Body Components	27
4.	Aging in organ systems	30
5.	Older population in census years 1911-2001	83
6.	Median Age of The Population, 1911-1991	84
7.	Ageing Index and Old Age Dependency Ratio, 1911-1991	85
8.	Expectation of life at birth, 1911-2000	87
9.	A Sociogram of Kinship Structure	91
10.	The World's 20 Oldest Countries: 1992	116
11.	Average annual percent growth of the older Persons	117
12.	The changing global age structure, 1996	118
13.	The changing global age structure, 2025	118
14.	Expectancy partially offset by disability	177

List of Boxes

Number	Title	Page
1.	Ageing is Lifelong	13
2.	Biological Ageing	18
3.	Ageing and Development	75
4.	Population Ageing in SAARC Countries	123
5.	Older Persons in our Constitution	153

List of Tables

Number	Title	Page
1.	Basic Statistics of the Study Areas	8
2.	Difficulty with hearing among older people	35
3.	Population in census years 1901 to 2001	80
4.	Older population in census years 1911-1991	82
5.	Median Age of the Population, 1911-1991	83
6.	Ageing Index and Old Age Dependency Ratio, 1911-1991	85
7.	Crude Death Rate	86
8.	Expectation of Life at Birth	86
9.	Projected total population, age specific population, older population and percentage of older population, 2011-2051	88
10.	Labor Force Participation by Age, Sex and Place of Residence	93
11.	Work Status of the Older Men and Women by Area	94
12.	Level of Care and Type of Health Facility	95
13.	Percent Older People, by Age: 1990 to 2015	114
14.	Developing countries where the number of older people is projected to surpass the number of persons under age 15 before 2050, by period when this would occur	119

	Page
15. International activities on ageing: United Nations entities, based on replies to the 1996 questionnaires on the fourth review and appraisal of the implementation of the International Plan of Action on Ageing	134
16. Living Arrangement of the Older Persons	148
17. The Nature of the Support of the Older persons Living with their Married Children	149
18. Distribution of the Allowance Recipient by Selected Socio-Demographic Factors	162
19. Percentage Distribution of the Allowance Recipient Older People by Expenditure they incurred in Withdrawing the Last Allowance	163
20. Asian and Pacific Region: Activity Rates of Older Person by Sub Region 1990-2020	179
21. Percentage of older women out of total female population	185
22. Percent distribution of older women according to main person responsible for selected household chores	187
23. Percentage distribution of older persons by age, sex and residence	198
24. Marital Status	199
25. Sex	199

		Page
26.	Religion	200
27.	Percentage distribution of older persons by educational status	200
28.	Percentage distribution of older persons by their present occupation	201
29.	Percentage of widow/widower older persons by the time since they had lost their spouses	201
30.	Percentage distribution of older persons by their age at first marriage	202
31.	Percentage distribution of Muslim older persons by the number of marriages they got	203
32.	Percentage distribution of older persons by duration of their conjugal life	203
33.	Percentage of respondents by their number of children alive	204
34.	Percentage distribution of older persons by whether they used contraceptives in their conjugal life	204
35.	Percentage distribution of older persons by their living arrangement	205
36.	Percentage distribution of older persons by their fathers' age at the time of death	205
37.	Percentage distribution of older persons by their mothers' age at the time of death	206

		Page
38.	Percentage distribution of older persons by their present working status	206
39.	Percentage distribution of older persons who are presently working by their occupation	207
40.	Percentage distribution of older persons who are retired by time in years they have ceased to work	207
41.	Percentage distribution of older persons who are retired by reasons for not working	208
42.	Percentage distribution of older persons who are retired by their opinion on continue working	208
43.	Percentage distribution of older persons by primary occupation at their working age (before 60 years of age)	209
44.	Percentage distribution of older persons by adequacy of income to meet their current basic needs	210
45.	Percentage distribution of older persons by their sources of income	210
46.	Percentage distribution of older persons who do not have adequate income by sources of needed assistance	211
47.	Percentage distribution of older persons by how and when they receive needed assistance	211

		Page
48.	Percentage distribution of pension holder older persons by sufficiency of the amount of pension to meet their basic needs as they opined	212
49.	Percentage distribution of pension holder older persons by their opinion on pension drawing procedure	212
50.	Percentage distribution of older persons by whether they help any body with money	213
51.	Percentage distribution of older persons types of relations who are financially helped by them	213
52.	Percentage distribution of older persons by land ownership	214
53.	Percentage distribution of older persons by their monetary asset and debt	214
54.	Percentage distribution of older persons by their opinion on the Boisko bhata (Old Age Allowance) program	215
55.	Percentage distribution of older persons by their comments on their present health condition	216
56.	Percentage distribution of older persons by whether they are suffering from any disease at present time	217
57.	Percentage distribution of older persons by the types of diseases currently they are suffering from (Reference table 34)	218

		Page
58.	Percentage distribution of older persons by place of getting treatment	219
59.	Percentage distribution of older persons by whom of the family members/relations comes forward as care giver when they become sick	219
60.	Percentage distribution of male older persons by their current habit of smoking	220
61.	Percentage distribution of older persons by whether they need others helps in daily activities	220
62.	Percentage distribution of older persons by the organizations they are associated with as member	221
63.	Percentage distribution of older persons by whether they get invitation in different local social functions	221
64.	Percentage distribution of older persons by their level of participation in different local social functions	222
65.	Percentage distribution of older persons by how they are welcomed by other participants when attending social occasions	222
66.	Percentage distribution of older persons by whether they are familiar with any NGO working with elderly welfare activities	223

	Page
67. Percentage distribution of older persons by their knowledge on different NGOs working with elderly welfare activities	223
68. Percentage distribution of older persons by their level of satisfaction over the service rendered by these organizations (Reference table 46)	223
69. Percentage distribution of older persons by their opinion whether these sources (stated below) are sufficient for their care and benefit	224
70. Percentage distribution of older persons by their leisure time spending	225
71. Percentage distribution of older persons by their participation in religious activities	225
72. Percentage distribution of older persons by how far their decisions are taken in family affairs	226
73. Percentage distribution of opinions of older persons whether they are being neglected / excluded by their family members, relatives and neighbors	227
74. Percentage distribution of older persons by their choice of living place	227
75. Percentage distribution of older persons by how often their sons / daughters who do not live with them pay visit to them	228

		Page
76.	Percentage distribution of older persons by their views on whether family / community support for the elderly is waning gradually	228
77.	Percentage distribution of older persons by the type of family they expect more to live, if possible	229
78.	Percentage distribution of major problems of older persons as they mentioned	229
79.	Percentage distribution of older persons by their recommendations for taking effective steps against the problems faced by them	230
80.	Percentage distribution of opinion of older persons on whether the problems of older people are increasing and becoming complicated day by day	231
81.	Percentage distribution of older persons by their views regarding the causes of gradual increase of their problems	232
82.	Percentage distribution of social visits of older persons	232
83.	Percentage distribution of older persons who do not have adequate income by source of needed assistance	233

		Page
84.	Percentage distribution of older persons on the basis of their opinion on whether preparation should be taken earlier by every one to have a sound and peaceful latter life	233
85.	Percentage distribution of older persons by their suggestions on what older persons themselves should do to have a peaceful and socially dignified later life	234
86.	Dress	235
87.	Hair	235
88.	Beard	235
89.	Nail	236
90.	Leg	236
91.	Teeth	237
92.	Temperament	237

Chapter One

INTRODUCTION

I love to Live

*Today, dear Lord, I'm 80
and
There's much I haven't done
I hope, dear Lord, you'll let me live
Until I'm 81
But then, if I haven't finished
All I want to do
Would you please let me live
Until I'm 82?
So many places I want to go
So very much to see
Do you think that You could manage
To make it 83?
The world is changing very fast; there
Is so much in store
I'd like it very much to live
Until I'm 84
And if by then I'm still alive
I'd like to stay to 85!
More planes will be up in the air,
So I would like to stick
And see what happens to the world*

*When I turn 86
I know, dear Lord, it's much to ask
(and it must be nice in heaven),
But I'd really like to stay right here
Until I'm 87
I know by then I won't be fast,
And sometimes I'd be late,
But it would be so pleasant to
Be here at 88
I will have seen so many things and
Had a wonderful time
So I'm sure that I'd be willing to
leave
When I'm 89 (may be)
Just one more thing I'd like to say:
Dear Lord, I thank you kindly,
But if it's OK with You...
I'd love to live past 90!*

**Association of Former
International Civil Servants,
Geneva**

Chapter One

Introduction

Population ageing – the increase in the proportion of **older people**, i.e. persons aged 60 and over, in the population – has become a prominent topic for studies on the implications of demographic change. Ageing has emerged as a global phenomenon in the wake of the now virtually universal decline in fertility and, to a lesser extent, of increases in life expectancy, and the progressive ageing of older cohorts. Throughout the world, populations are ageing at an unprecedented rate. The United Nations (UN) projects that shortly after the year 2010 there will be more people over 65 years of age in the world than children under the age of 5. By 2050, the UN projects that 18 percent of the world's population will be 65 years of age or older, versus only 5 percent under five years of age. This pronounced demographic trend, of global importance and as yet unknown consequence, gives strong impetus to an international focus on the implications of population ageing for health and long – term care systems as well as family support, living arrangements and caregiving.

Ageing is the sequential or progressive change in an organism that leads to an increased risk of debility, disease, and death; senescence consists of these manifestations of the ageing process. On the other hand, old age, one stage in the development life cycle, is characterized by the following tasks: promotion of intellectual vigor, coping with physical changes, adopting to role changes, accepting one's past life, and facing death. Traditionally anyone with gray hair with grown up children are regarded as older person, and is looked upon with some kind of reverence and respect. But at present,

age is the main factor in deciding whether a person is to be classified as older or not at least in the urban areas. On the contrary, for the self employed, unemployed, and the people working in the rural agricultural sectors, age is far less a factor than health and physical capacity.

Although there is no set age at which ageing begins, it is the opinion of the experts that 60 is a realistic statistical definition for ageing in the region, particularly taking into account average retirement age, legislation, health condition and so on (UN, 1981).

Population ageing has its specific features in developed and developing countries. In developed countries, it is the relative number of older persons that has the most significant implications. In developing countries, it is the absolute growth of older persons along with the speed of that growth that are most important (UN, 1997).

Developing countries have been confronted with such massive problems as raising the levels of living through more employment and income generating activities, promoting higher levels of living for the vast number of the poor, developing social services, raising the status of women and children and such major concerns as elimination of inequalities and poverty and growth with social justice. In addition, ageing has been added of late to the heaps of problems along with its demographic, economic and social aspects. Asian countries have suffered from a kind of ambivalence with regard to measures for the older persons. Social values require that the families take care of them but changing social and economic factors render the fulfillment of that task increasingly difficult in large number of cases. Thus, the welfare of the

older persons has emerged as a problem of large enough dimensions to merit serious academic attention before it becomes too late.

The older population will grow more diverse in terms of health status, resources, and ethnicity. Many older persons will remain independent and active for longer periods. At the same time the needs of older persons with disabilities will create enormous demands. Individuals from racial, linguistic, or cultural minority backgrounds are more likely to live in poverty and to lack adequate nutrition, health care, access to preventive care, and health information. These populations experience a higher rate of chronic disease and disability. In conducting research, we must be cognizant of the diversity of the older population and the special needs of ethnic and religious minority older persons, those living in rural areas, and other vulnerable populations such as those who are illiterate. These populations must be included in on-going research and inform the research process (UN, 1998).

✓ **Objectives of the Study**

The problem of the older persons is a worldwide phenomenon. Even in highly developed and democratic societies, abuses of the senior citizens, who constitute a distinct segment among the suffering section of the population, is present. In Bangladesh, most of the older persons are subject to fear of latter age. Their daily activities are regulated with values, attitudes and behavioral imperatives that old age is a time for reflection about death and withdrawal from the world, that the older people should undertake a passive rather than an active role and that the older persons should devote more attention and time to leisure pursuits and religious activities. They fall into despondency. For them socio-cultural bondage is broken into pieces to

make them fatalists who seek help from other persons and become victim of ineluctable fate. In reality many older persons are found to be socially isolated and lonely and remain devoted to prayer for happiness in the eternal world. This tendency is in fact a form of escapism, stemming from a compromised means to avoid an undesirable reality and to involve oneself deeply in a sublimated existence for transmutation into a form of life imbued with spirituality – the philosophical doctrine that nothing is real but soul of spirit (Sattar, 1995).

With a view to draw^{ing} a complete picture on the lives of the older persons in Bangladesh, the specific objectives of this study are set as follows:

- i. to reveal the socio – economic characteristics of the older persons in Bangladesh;
- ii. to precisely identify the main social and economic problems felt by them;
- iii. to assess the extent of care currently available to them from public and private sources; and
- iv. to study the attitude of the aged population towards the process of ageing.

The ultimate objective of the study is to articulate the findings for making easily and readily understandable the problems of the older persons to the government functionaries, social thinkers and welfare agencies, and to create more awareness of the older persons' problems to the policy makers, planners and different program personnel so that they might take appropriate measures, i.e. policy, plans, programs etc. to solve the problems of the older persons in Bangladesh.

Methods of the Study

The universe of the study includes all citizens of Bangladesh aged 60 years and above and each individual older person was the unit of observation. The general consensus is that older persons residing in every nook and corners of the country should have been covered in order to make the study completely representative. But because of some obvious respects a nationally representative sample of 500 older persons (250 from rural and 250 from urban areas) was drawn at random to examine urban-rural together with male-female variations of the problem by directly interviewing them following the delineated procedures:

- a. The country was divided into 3 strata namely, city area, urban area and rural area;
- b. The 6 major cities namely, Dhaka, Chittagong, Khulna, Rajshahi, Sylhet and Barisal were included in the first stratum as these cities being located in the six administrative divisions in Bangladesh. All the sixty four district towns constituted the second stratum and all the Upazilas other than Sadar Upazilas comprised the third stratum;
- c. One city out of six, four district towns out of sixty four and one upazila each from above districts including the district where the city is located, were selected randomly to represent the city, urban and rural areas respectively;
- d. One ward from the city and each of the selected district towns and one union from each of the upazilas were selected at random basis;

- e. Household lists, which may serve the purpose of the sampling frame, were collected from the respective administrative offices. Suppose N units ($N = nk$, where n is the sample size and k is an integer called the sampling interval) of the population are numbered from 1 to N in some order. For each ward and union, one starting point (household), say i ($\leq k$) was selected again at random from the list of household concern. Finally, the sample comprised the i^{th} unit and every k^{th} unit thereafter to enlist fifty older persons from each of the wards and unions to cover the sample of 500 older persons.

There was provision for the inclusion of the neighboring ward or union for interview with a view to get the required number of samples in case if the required number of fifty older persons were not available in a ward or union.

Thus the notion of stratified random sampling was the basis of sampling of the study where linear systematic sampling procedure was applied to constitute the targeted sample within each stratum finally selected.

Study Area at a Glance

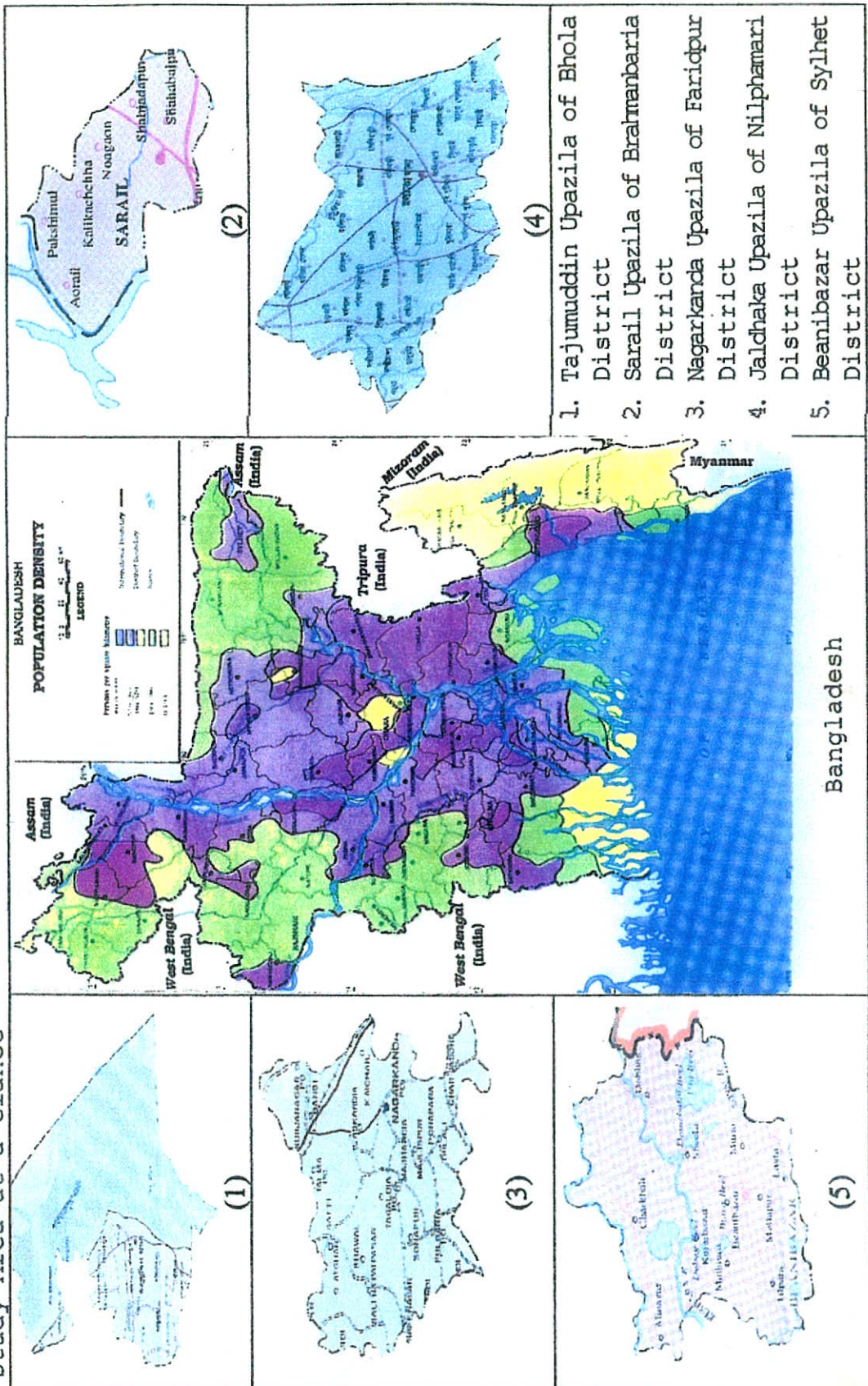


Table 1: Basic Statistics of the Study Areas

Municipality/City Corporation Upazila	District	Area Sq. Km	H/Hold '000'	Population '000'			Literacy 7+ Yrs.	Administrative Unit	
				Total	Male	Female		Ward (Urban)	Union
Bhola ^ξ	Bhola	3403	267	1697	873	824	36.6	9	60
Tajumuddin ^φ		-	6	38	21	17	-	3	-
Brahmanbaria ^ξ	Brahmanbaria	513	20	135	70	65	38.5	-	5
Sarail ^φ		1927	360	2496	1267	1229	43.1	4	97
Faridpur ^ξ	Faridpur	-	20	125	66	59	-	4	-
Nagarkanda ^φ		239	44	297	149	148	36.6	-	10
Nilphamari ^ξ	Nilphamari	2073	278	1706	869	837	43.5	3	79
Jaldhaka ^φ		-	13	74	39	35	-	3	-
Sylhet ^ξ	Sylhet	379	51	303	152	151	35.3	-	-
Beanibazar ^φ		1641	261	1554	797	757	38.4	8	61
		-	6	35	19	16	-	3	-
		304	45	270	140	130	28.0	-	12
		3490	342	2512	1288	1224	48.0	13	97
		-	19	127	71	57	-	13	-
		253	27	213	105	108	56.6	-	11

Note: ^ξ Ultimate Urban Area; ^φ Rural Area

Source: 1. Graphosman (1997). District Map Series, Dhaka.

2. BBB (1998). Statistical Pocket Book of Bangladesh, Dhaka.

Variables under Consideration

In the Study, variables that are taken under consideration are as follows:

- a. Physical Health Status;
- b. Economic Factors;
- c. Social Support;
- d. Marital Status;
- e. Housing Condition and Living Arrangement;
- f. Family Size and Family Relationship;
- g. Income and Occupation;
- h. Extent and Type of Valued Roles Played;
- i. Recreational and Cultural Facilities;
- j. Habits like Exercise, Smoking, etc.

Techniques of Data Collection

- a. A structured interview schedule is used in this study for data collection, which was pre-tested prior to the field investigation in order to improve its reliability and validity.
- b. Requisite data were collected from the selected older persons by direct interview method. In some cases, assistance was sought from the respondent's eldest offspring, as the older persons were unable to speak clearly.
- c. The persons involved in data collection and field investigation were social science graduates who underwent thorough orientation through a series of structured training sessions and field exercises thus familiarized with the study contents and data collection procedures.

- d. In addition to direct interviews, a few case studies on old age feelings, problems and perceptions were also performed.

Data Processing and Analysis

The collected information from the field were coded, recorded and tabulated through the computer. However, it needed some further work in terms of verification and other internal consistency checks. Before been analyzed through the SPSS program, the data were screening adopting the following stages:

Editing

After the completion of fieldwork, the completed data have properly been edited with great care and attention. Literally, editing means to screen out the errors and irregularities, put anything in order. Marking something meaningful is also desirable. Editing must meet three requirements, viz., completeness, accuracy, and uniformity. Editing was done to verify whether the information were collected correctly, interviewing the correct sample, that all the questions in the schedule were asked and so editing work was done on the day on which the interview is conducted.

Coding

Before processing data almost every variable is defined by a unique number called code. The techniques of this process in called coding which makes easier the data processing. After the collection of data, possible answers of the questionnaire were coded into code sheet.

Tabulation

After editing, verification and internal consistency checks, tabulation of data was done with the help of computer. It was made with many combinations of variables likely to draw interest.

Analysis of Data

Analyzed Data, which are presented in this dissertation, are different calculations expressed in percentage, average, rate etc. The estimated frequency table, bipartite cross table, chi-square tests and other necessary tables and graphs that are needed are also introduced.

Organization and Presentation of the Data

The reporting and presentation of field data has been organized and presented under the following broad heads:

- a. Socio-demographic characteristics;
- b. Health status, diseases and treatment;
- c. Psycho-social conditions; and
- d. Status of personal hygiene.

Problems Encountered During Field Survey

Collection of data, one of the main components of the research, is a very difficult task unless the investigators capture the convincing quality and be able to build rapport. However, the overall experience was the spontaneous cooperation of the respondents excepting a very few those were reluctant to give direct interviews. Some of the respondents asked about their benefits to derive from answering of the questions in the interview schedule.

C h a p t e r T w o

AGEING AND OLDER PERSONS: THEORETICAL ANALYSIS

'Younger people must be made aware
that they are living in a biological
process of ageing'

Graciela Gonzalez, Caritas Chile

Chapter Two

Ageing and Older Persons: Theoretical Analysis

Definitions of the Concepts

Ageing

The term *ageing* or *senescence*, which is often used interchangeably, implies decline and deterioration. Ageing is the continuous process (biological, psychological, and social), beginning with conception and ending with death, by which organisms mature and decline (Aiken, 1995: 400).

Ageing begins before we are born and continues throughout our lives; the only cure for it is death (Greer, 1991). Comfort defines ageing as an increased liability to die, or an increasing loss of vigor, with increasing chronological age, or with the passage of the life cycle. The four criteria of ageing as proposed by Strehler (1962) are:

- i. It is universal, (unlike disease);
- ii. It is progressive, a continuous process;
- iii. It is intrinsic to the organism; and
- iv. It is degenerative.

Like death, ageing is fundamental, intrinsic biological properties of living organisms.

The ageing refers to the regular changes that occur in mature organism having under representative environmental conditions as the advancement in chronological age. It can be described, rather than defined, as the aggregate result of the decrement processes, at cellular, sub-cellular, or organ level, that are associated with of the passage of time. It is dependent to some extent (probably 25-30%) on genetic factors (Bono, 1999) and is a process of constant change that is universal in all organisms. The term ageing means to grow older or mature or show signs of advancing age (Sarker, 1998). For

Box 1 : Ageing is Lifelong

Individuals begin their ageing process at the moment of birth, and go through the life course accumulating a range of experiences that may positively or negatively affect their capabilities and well being in later years. Age-adjusted policies and programs that encourage workplace flexibility, lifelong learning and healthy lifestyles, especially during transitional periods, e.g., youth to midlife, midlife to later years, can influence choices with accumulative effects. A clear priority target for old age policies are the younger generations, who may have to reinvent themselves again and again in fast-changing societies; they will need to cultivate healthy lifestyles, flexibility and foresight, continually upgrade work skills and maintain social networks.

Source: World Assembly on Ageing II, Premier site for NGOs interested in WAA2 event. Global Action on Ageing May 2001.

instance, United Nations uses 60 years as the starting point of ageing and defines the very old as being 80 above years old. Although old age varies according to numerous influences on a person, such as life style, health or

family status, However, the old age is considered here as 60 years and above of an individual in connection with the retirement system and state law (Aziz and Maloney, 1985: 16).

Gerontology

Gerontology is a branch of knowledge (science) concerned with the characteristics and problems of the older people (Aiken, 1995, p. 406). It is the study of biological, psychological, medical, sociological and economical factors having a bearing on old age where Biologists contribute their knowledge and research findings concerning the biological process involved in ageing (Hooyman and Kiyak, 1991).

Psychologists study age related changes in mental abilities, personality and behavior while sociologists' contribution to this field is the study of social roles and status of older people, of how social and cultural factors influence the ageing process.

Social Gerontology

The term was first used by Clark Tibbitts. Social Gerontology brings together a broad range of concerns both for the ageing individual and for society, and the interaction between them. It describes the area of gerontology that is concerned with -

- i. the impact of social and socio-cultural conditions on the process of ageing, and
- ii. the social consequences of this process.

Social gerontologists study the impact of changes on both the older persons and our social structures. They also study social attitudes toward ageing, and

the effects of these attitudes on the older population (Hooyman and Kiyak, 1991).

Geriatric

It is a noun meaning a frail old person. The most frequently used synonyms are wrinkly, crumbly, gaga, hag, crone, witch, biddy, and fogey (Featherstone, 1993).

Geriatrics

It comes from the Greek *geras*, meaning old age. Geriatrics is a branch of medicine that deals with health problems of the older persons, including both treatment and prevention of disease and injury (Aiken, 1995: 405).

Geronto

It comes from the Greek word *geron* meaning an older person (Aiken, 1995: 405).

Ageism

The term was first coined by Robert Butler to point toward the social stereotyping of and/or discrimination against older persons (Aiken, 1995: 400). Stereotypes, myths or misconceptions cited by Butler and others, on the one side, may take any or all of the following forms that the older persons:

- a. are ill or in poor health;
- b. are senile or in their second childhood;
- c. are rigid or inflexible;

- d. can not do a good job and should retire;
- e. have no sex life;
- f. want to disengage or gradually withdraw from the active population;
- g. live alone, abandoned by their families and other relatives;
- h. live or should live in institutions (nursing homes, hospitals, etc.)

A society that equates beauty with youth, denies ageing and death, and lacks valued rituals for passages through all the stages of life is a society that practices ageism (Wormer, 1996). Ageism refers to the discrimination and prejudice against people simply because they are old (Zastrow, 1996). Examples of ageism are: devaluing older workers because they are regarded as slow and as having skills that are outmoded; using the word *old* in an intolerant and pejorative way; avoiding dining in restaurants frequented by seniors; using the word *burden* in reference to care for the old but not for care for the young; derogatory mass media portrayals of old persons such as comedy routines making fun of ageing bodies; refusing to let those age sixty-five and over rent cars (common European policy); and politically attacking social welfare programs that make life tolerable for the older population (Wormer, 1996).

Other myths about the old age is that of a magic land where everyone is a happy, playful retiree, free from the worries of the world. However, some advocates of the older people have emphasized the need to do more for the older persons. This form of ageism has been labeled as *the new ageism*.

Old Age/ Later Life/ Third Age

After age 30, additional changes occur that reflect normal declines in all organ systems. This is called *senescence*. Senescence occurs gradually

throughout the body, ultimately reducing the viability of different bodily systems and increasing their vulnerability to disease.

Every society is age graded. Age is a social construct with social meanings and social implications. To call someone a toddler, child, young adult, or old person is to imply a full range of social characteristics (Aiken, 1995).

The definition of old age is very much dependent on its use in a particular context. In the industrialized countries, old age is often determined on the criterion of retirement from the labor market. This way of fixing the old age ignores that a great number of older women has not been in the gainful occupation. In modern times, though old age is considered as the retirement age but it also varies from country to country and within country (Roy, 1985). There is no unique definition of an old age or older person, because definition of old age is highly related with occupational subculture. For example a cricketer or a cinema hero is considered old at 35 while a doctor or a professor may be considered a promising young at that age. Subjective perception of social position of an individual also defines whether he is old or not (Mian, 1996). In SAARC countries an individual with age 60 or more is considered as an older person.

Old age is a stage in the life of an individual while aged constitutes a segment or a stratum of the population of a society. Ageing change over individuals' course of life as their personality develops, experiences accumulate and they adjust themselves to new roles in the Society. Ageing of cohorts are not unique but differ with the conditions of the society in which they belong in particular the physical environment, social values and individual perceptions. Again, the biological, psychological and

physiological concepts of ageing are important in their own rights, but they appear to be not as much suitable for the study of population ageing as they are for the study of individual ageing process.

Ageing: The Field of Gerontology

Gerontology has grown as a field since early philosophers and scientists explored the reasons for changes experienced with advancing age. Roger Bacon in the thirteenth century, Adolph Quetelet in the early nineteenth century, Botkin in the late nineteenth century, and Ivan Pavlov and G. Stanley Hall in the early twentieth century made pioneering contributions to this field. During the early 1900s, in Europe and the United States, the impact of an increasing ageing population on social and health resources began to be felt. Since then, many scholars have contributed to the following four areas of ageing:

Biological Ageing

Box 2 : Biological Ageing

Biological ageing is the physical changes that reduce the efficiency of organ systems (lungs, heart, and circulatory system).

Major causes are

- *decline in the number of cell replications as an organism becomes chronologically older;*
- *loss of certain types of cells that do not replicate.*

(Hooyman and Kiyak, 1991)

Biologically, ageing encompasses all the chronological changes that occur over a lifetime – increase in height throughout childhood, onset and cessation of menstruation, changes in the muscular and sensory systems, and shaping of the young adult and middle-aged body

(Wormer, 1996). The pace of biological ageing differs among individuals,

ageing differs among individuals, but its course is inevitable. The morbid side of growing old – illness, infirmity, and looming death – often is underplayed in the literature. Biologists use the word *senescence* to refer to the process of ageing for all life forms.

Biological Ageing, or senescence, can be defined as the normal process of changes over time the body and its components, a process that eventually affects an individual's functioning vis-à-vis the environment but does not necessarily result in disease or death. This process, which is gradual and common to all living organisms, involves deterioration over time, during which viability decreases and vulnerability increases (Mann, 1995). It is not, in itself, a disease, but ageing and disease are often linked in most people's minds, since declines in organ capacity and internal protective mechanisms do make us more vulnerable to sickness. Because certain diseases such as Alzheimer's, Arthritis, and Heart conditions have a higher incidence with age, we may erroneously equate age with disease. However, a more appropriate conception of the ageing process is a gradual accumulation of irreversible functional losses to which the average person tries to accommodate in some socially acceptable manner.

Psychological Ageing

Psychological ageing is related to biological ageing in the way the mind is very closely linked to the body. It includes the changes that occur in-

- i. sensory and perceptual processes;
- ii. mental functioning (memory, learning, intelligence);
- iii. personality; and
- iv. drives and motives (Hooyman and Kiyak, 1991: 3)

The psychological dimension refers to changes in personality or ways of processing information accompanying the ageing process. Factors of health, idleness, loss of contemporaries, reduced income, and many other social variables shape the psychological reality experienced by older adults (Wormer, 1996). Through the medium of poetry, Wordsworth (1806) captures the essence of psychological survival:

Though nothing can bring back the hour
Of splendour in the grass, of glory in the flower;
We will grieve not, rather find
Strength in what remains behind

-Ode: Intimations of Immortality IX, 1803-1806

Social Ageing

Social ageing refers to an individual's changing roles and relationships in the social structure-

- a. With family and friends;
- b. With the work world; and
- c. Within organizations (v. i. religious and political groups) (Hooyman and Kiyak, 1991: 3).

This side of ageing refers to the cultural expectations for people at various stages of their lives. Socially constructed definitions are important because they ultimately are translated into public policies (Gonyea, 1994). To the extent that the older persons are expected to continue making an active contribution to their families and to society, or conversely, to disengage from responsibility in deference to the younger generation, has profound – and perhaps unsettling – implications for one's social adjustment to growing

old (Wormer, 1996). Race and ethnicity as social class status are significant determinants of an individual's experience with ageing.

Chronological Ageing

Chronological ageing is the definition of ageing on the basis of a person's years from birth. It is not necessarily related to a person's physical health, mental abilities, or social status. After a long debate, the experts come to the conclusion that a person should be taken into account as an older only on the basis of chronological ageing.

The Dynamics of Population Ageing:

The process of population ageing is primarily determined by fertility (birth) rates and secondarily by mortality (death) rates. Populations with high fertility tend to have low proportions of older persons and vice versa. Demographers use the term demographic transition to refer to a gradual process wherein a society moves from a situation of high rates of fertility and mortality to one of low rates of fertility and mortality. This transition is characterized first by declines in infant and childhood mortality as infectious and parasitic disease are eradicated (Kinsella, 1999: 55). The resulting improvement in life expectancy at birth occurs while fertility tends to remain high, thereby producing large birth cohorts and an expanding proportion of children relative to adults.

Global populations begin to age when fertility rates decline and mortality rates at all ages improve. Successive birth cohorts may eventually become smaller and smaller, although countries may

experience a *Baby boom echo* as women from large birth cohorts reach childbearing age. International migration usually does not play a major role in the ageing process, but it can be important in small nations. Certain Caribbean nations, for example, have experienced a combination of working-age-adult emigration, immigration of older retirees from other countries, and return migration of former emigrants who are above the average population age; all three factors contribute to population ageing (Kinsella, 1999: 55).

Although the effect of fertility decline is usually the driving force in changing population age structures, current and future changes in mortality could assume much greater weight in countries with high proportions of elderly citizens. Caselli et al. (1987) have demonstrated the growing impact of mortality change in population projections of France and Italy. Even if Italian fertility is held to a very low level of 1.4 children per woman through the year 2040, they find that more than half the increase in the proportion of population aged 60 and over is due to mortality change, and less than half to fertility change.

Ageing and the Population (Survival Curves and Ageing)

In primitive societies, or non-industrialized societies even now, death rates are high around the time of birth and in childhood, and subsequently the risk of death remains relatively constant through out life (Briggs, 1993). A survival curve for such a population is represented in Figure 3.1.

Such a survival curve is known as a 'wild-type' because it is found in natural animal populations as well as in human populations living under severe

conditions (for example, Europe in the middle ages , Mexico in 1930 , some African countries now). It can be seen that most of the population survive for less than half the maximum life span, so that average age of death might be 30 to 40 years in such conditions, though a few individuals may live to about 100 years of age (Briggs, 1993). Characteristically, these populations would have a pyramidal structure, with large numbers of children and young people but comparatively few old people- perhaps 1 or 2 per cent of the population being over 65. The major concern for public health in such countries is the prevention of infant and child mortality.

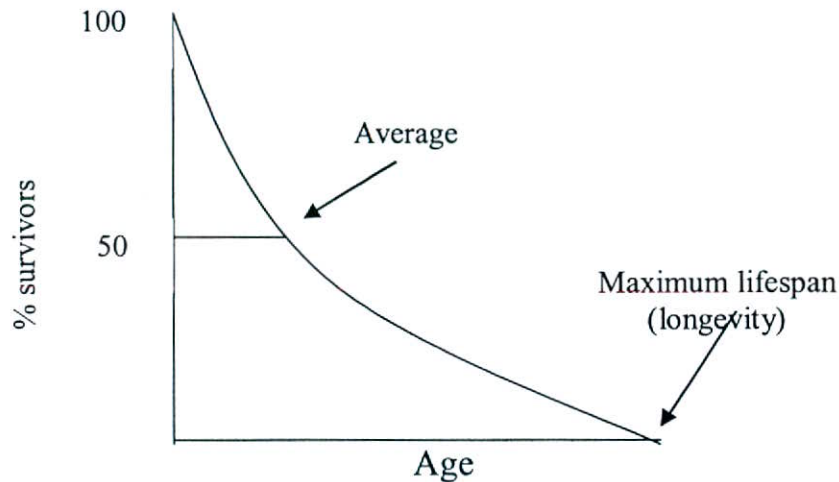


Figure 1: *Wild type survival curve*

Source: Bond, John et al. (ed.) (1993). *Ageing in Society: An Introduction to Social Gerontology*. 2nd Edition. Sage Publications, London.

Modern, industrial societies (or animals protected in an artificial environment such as laboratory) have largely removed the problems of infant and child mortality, causing a rectangular survival curve as shown in Figure 3.2.

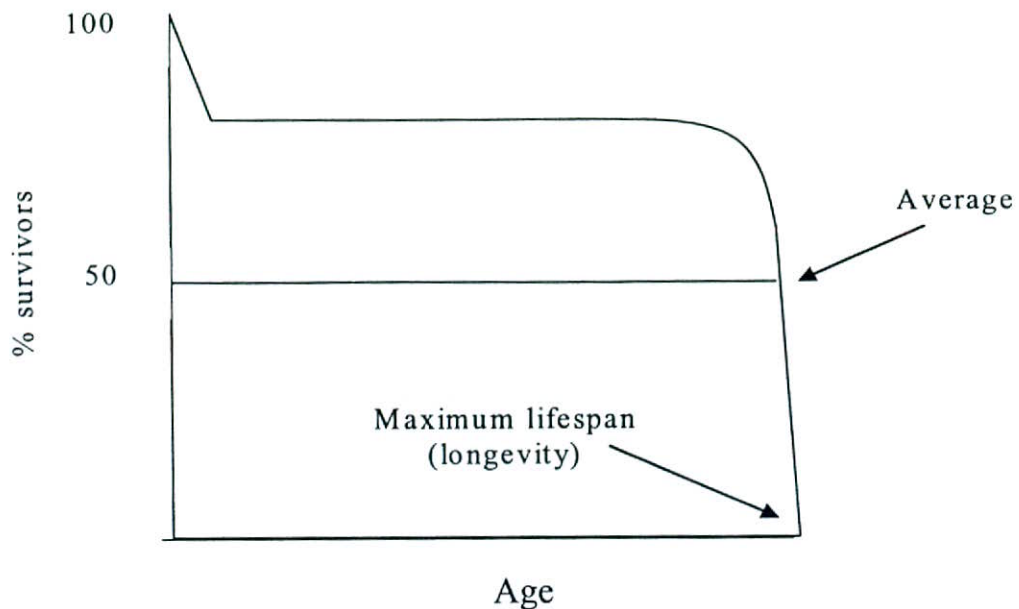


Figure 2. *Rectangular survival curve*

Source: Bond, John et al. (ed.) (1993). *Ageing in Society: An Introduction to Social Gerontology*. 2nd Edition. Sage Publications, London.

As the survival curve of population becomes increasingly rectangular, average life span approaches maximum life span; it should be noted that maximum lifespan is presumed to remain more or less constant. Thus, in 1900, only about a quarter of the population survived their 65th year, whereas now over two-thirds do so. This dramatic change has come about very quickly, and the major challenges to public health in industrialized societies is now to cope with the problem associated with a high proportion (15 to 25 percent) of people over 65 in the population, many of whom will be in their 80s and 90s. It has optimistically been suggested, as medical and social interventions continue to promote a healthy middle age, that the average period of diminished physical vigor will decrease, that chronic disease will occupy a smaller proportion of the typical life span, and that the need for medical care in latter life will decrease (Fries, 1980: 130).

This view is appealing, particularly to health policy makers and fiscal planners, but it must be said that there is very little supporting evidence. In our present state of knowledge, it would be dangerous to ignore the potential for increasing levels of disability in our ageing population (Brody, 1985).

Ageing and Health

As older people live longer, chronic diseases emerge as major causes of death and disability. There are now many more persons suffering from conditions that are managed or controlled rather than cured. These conditions cause afflictions for years together to impair ability to function and to require much more medical care. Because these conditions are often of long duration, they create burdens for the individual and for society (Ali, 1996). Chronic disease prevalence and disability will increase as life expectancy is increased. Consequently it may lead us to a pandemic of mental disorders and chronic diseases (Ali, 1996).

Different types of diseases and symptoms are often associated with chronological ageing. Diseases are defined in different terms such as sickness, illness and morbidity; although they are appropriately defined as human disorders which disturb the normal physical as well as social functioning. It should be mentioned here that in many cases statistics hide the fact that ageing is not a disease and getting old does not necessarily mean getting sick (Weg, 1978). But it is a fact those latter years of life is characterized by a series of biological changes which result in a decreased capacity for functioning and survival (Barrow and Smith, 1977: 129 and Rahman et al., 1997)

Old age has many biological effects. The skin becomes wrinkled, rough, dry and vulnerable to malignancies, bruises and loss of hair. Because ageing also

causes the spinal disks to compress, most elderly people lose one to three inches in height. Another result of ageing is a loss of muscular strength. More important blood vessels harden as we age, creating circulatory problems in the brain and heart, which causes rise in the incidence of stroke and heart diseases among the elderly. Functioning of the kidneys shows the greatest decline with advancing age (Atchley, 1988; Levin and Levin, 1980). Although ageing has all these deteriorative effects, they do not always cause disability in most of the older persons. It should also be noted that the speed of ageing varies greatly from one individual to another. Thus some people at the age of 80 may look like 60 and others who are of 60 years may look like 80. A number of factors may be responsible for these disparities (Rahman et al., 1997).

Changes at Cellular Level

With advancing age there is an increased tendency of cells that normally divide to stop doing so and there is a deterioration of specialized non-dividing cells, such as nerve and muscle cells, which leads to their death (Choudhury and Wahid, 1996).

The functioning capacity of cells in most organs is gradually lost with the advancing age and in those cells remaining there is a gradual change of structural and functional characteristics. In aging cells, the nucleus shrinks, the golgi bodies become fragmented, the nucleoli enlarge, and there is an increased number of intracellular vacuoles. The chemical process of body cells of the elderly is rather different from those of the younger population. In the elderly lactate (ester of lactic acid), histone and lipofuscin (one of a group of partly insoluble lipid pigments occurring in cardiac and smooth muscle cells) levels are raised (Choudhury and Wahid, 1996). Though the

activity of some enzymes increases but the activity of most enzymes slowly decreases. The process of conversion of carbohydrate, in tissues, to pyruvic acid or lactic acid, with release of energy (Glycolysis) increases but the esterification of compounds with phosphoric acid (oxidase) decreases, causing a decline in basal metabolic rate in most cells, particularly those of the brain and heart (Ali, 1996).

Changes in Body Composition

Although individuals vary greatly in body weight and composition, there is a

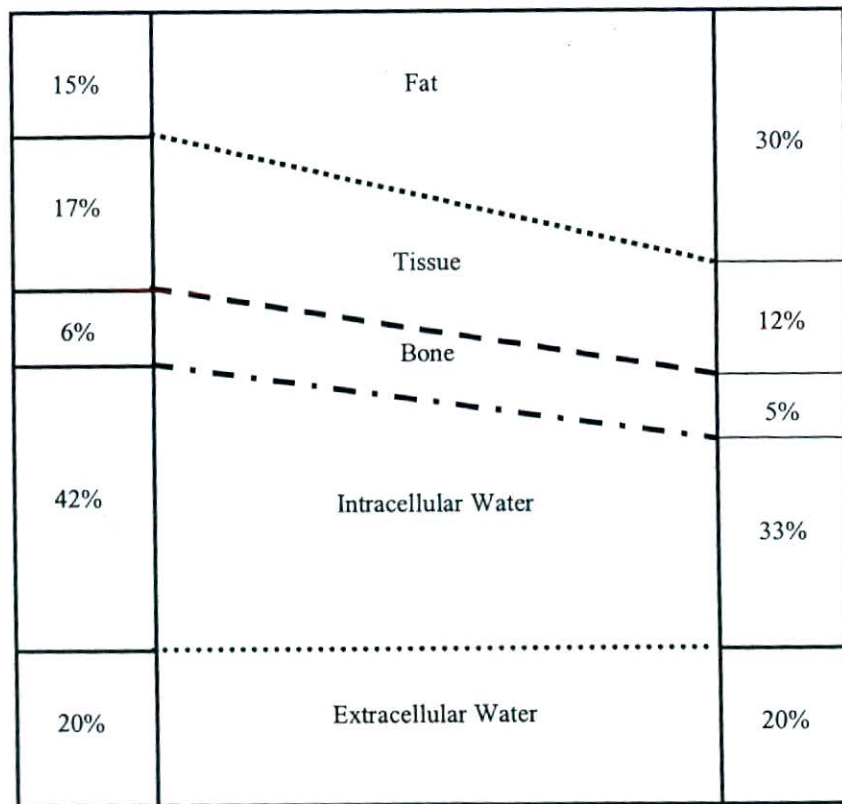


Figure: 3 *Distribution of Major Body Components*

Source: Goldman, R.J. (1970). Speculations on vascular changes with age. *Journal of the American Geriatric Society*, vol. 18, p. 766.

general decline in the proportion of body weight contributed by water for both men and women: on the average, from 60 percent to 54 percent in men, and from 52 percent to 46 percent in women (Kenney, 1982).

The lean body mass, consisting of the skeletal muscles and all other cellular tissues, decreases steadily after physical maturity until, in extreme old age, it may be reduced to two-thirds its value in young adults. Body weight, however, usually increases with age, because stored fat and body water increases in excess of the loss of lean body mass. The relative amount of extra-cellular fluid increases with age during adult life, after decreasing steadily throughout fetal and postnatal development. Despite appearances, therefore, all tissues, even the skin, become more laden with water as a consequence of ageing. The steady loss of voluntary (striated) muscle tissue mass throughout adult life depends somewhat on the pattern of physical activity. Evidence indicates that a large part of the loss of muscle mass with age is the result of disuse and atrophy rather than loss of muscle fibres.

The decrease of lean body mass is accompanied by a decrease in the level of overall metabolic activity. Basal metabolism is greatest during the period of most rapid mass growth; it then declines rapidly until physical maturity is reached and more slowly thereafter. In the rat the slow phase of decrease amounts to about 20 percent over a three-year period. The interior body temperature is maintained, despite lower heat production, by decreased blood flow through the skin with a consequent decrease of heat loss; the cooling of the blood with age, therefore, does not occur in the degree that might be inferred from the decrease in skin temperature. The amount of voluntary physical activity, such as running in an exercise wheel, typically decreases with age but varies considerably between individual animals.

Aging in Organ Systems

Aging can also be defined as a change in the activity of living systems due to passage of time. Different organs and tissues change over a period of time at varying rates. Advanced age is associated with non-uniform changes in the various body tissues. All these changes result in a loss of cells and lower energy levels of the remaining cells. This is associated with a diminished reserve capacity of most organs, slowed reaction times, and a reduced flexibility of collagen and elastin, which comprise over 40 per cent of the body's protein (Natow et al., 1980). The connective tissue proteins, such as collagen, become increasingly rigid, causing blood vessels to be more resistant to flow. Therefore, blood pressure and proper tissue nourishment impairment may occur.

Old age is a continuation of life with decreased reserve capacities for adaptation. Such a progressive decline of physiological functions accounts for 1-1.5 per cent annually of major organ systems (Al-Fallouji, 1998). The organ systems of young adults are able to meet much greater demands than are ordinarily placed on them. The reserve capacity of most of the systems decreases gradually with ageing. The older people are found to be less efficient than the younger group in maintaining the existing body environment when subjected to stress (Shock, 1970). For example after a load of glucose is ingested, the return of the blood sugar level to normal will take substantially longer in the elderly than it will in a young adult (Shock, 1970).

The ageing process is usually associated with physiological changes in the nervous system, cardiovascular system and pulmonary system. There is progressive decline in CNS activity and the loss of neuron particularly in the

cerebral cortex. Cardiac out put declines 1 per cent every year after 30 years of age. Individuals who maintain physical fitness may sustain relatively unchanged cardiac outputs from age 30 to age 60, at which point cardiac output may decline rapidly. Also, there are left ventricular hypertrophy, decreased heart rate, and increased blood pressure. Total lung capacity declines about 10 per cent by 70 years of age (Al-Fallouji, 1998).

Some degree of decline in functional or severe capacity with age is observed in almost every organ system.

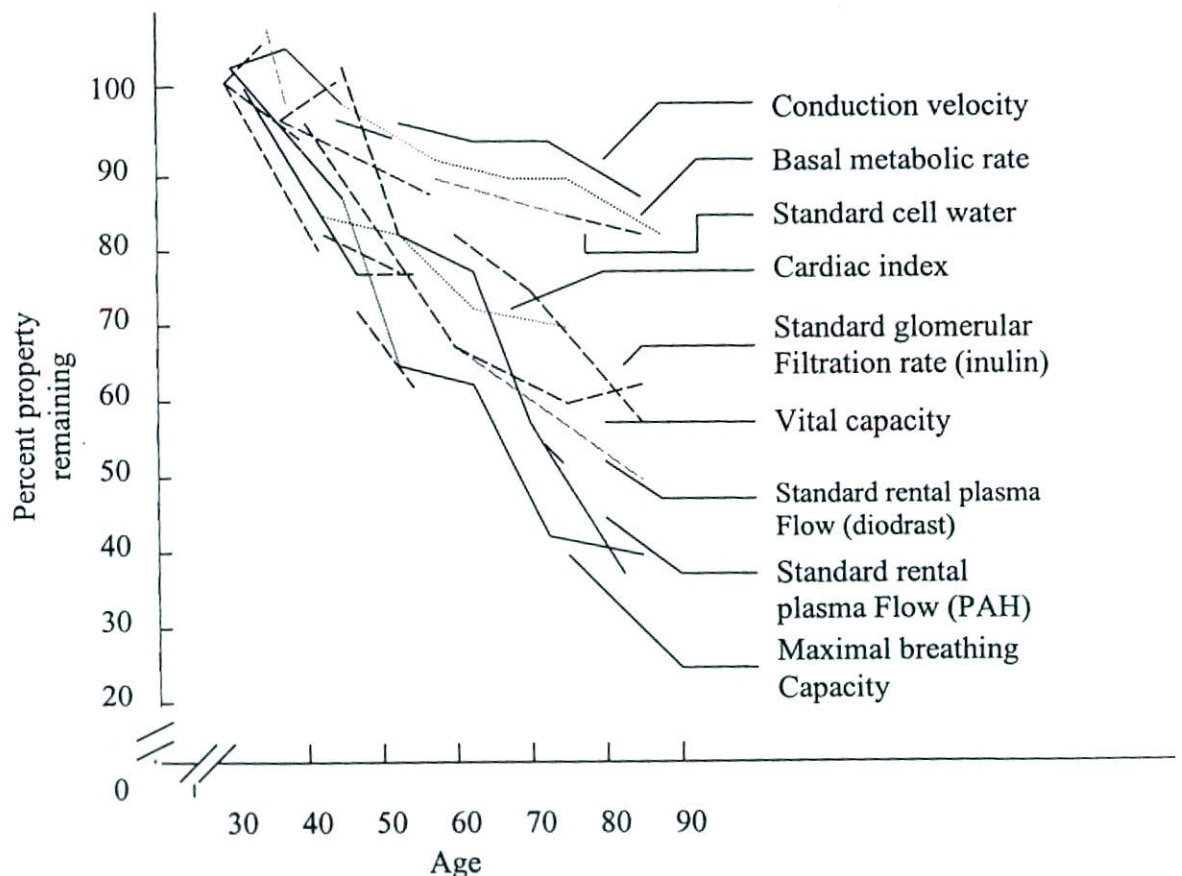


Figure: 4 Aging in organ systems
Source: N.W. Shock, The physiology of ageing. *Scientific American*, vol. 206, p. 110. Copy right 1962.

These changes are illustrated by several physiological indices in the above

figure 3.4. Complex functions that require the combination of multiple systems experience the most rapid decline. For example, maximum breathing capacity –which requires coordination of the respiratory, nervous, and muscular systems-is greatly decreased. Accordingly, normal changes in the respiratory and cardiovascular system become most evident with age.

With ageing, the muscles that operate the lungs lose elasticity so that respiratory efficiency is reduced. Vital capacity or the maximum amount of oxygen that can be brought into the lungs with a deep breathe declines. In fact it has been estimated that the average decline for men is 50 per cent at age 70 from age 25, the peak of healthy man's lung function, or a decline from six quarts of air to three quarts. Longitudinal studies have consistently found the physically active men to have twice the vital capacity of the latter in middle- age (Dehn and Bruce, 1972; Dill, Robinson, and rose, 1967; Bruce, 1984).

Leading Causes of Morbidity and Mortality among Older People

Kumar et al. (1999) identified the following as the leading causes of mortality and morbidity among older people:

Morbidity

- i. Coronary heart diseases
- ii. Falls and Fractures
- iii. Stroke
- iv. Depression and dementia
- v. Cancer
- vi. Defective vision and hearing
- vii. Nutritional disorder

Mortality

- i. Coronary heart diseases
- ii. Cerebrovascular diseases
- iii. Obstructive lung diseases
- iv. Pneumonia
- v. Lung cancer
- vi. Colorectal cancer
- vii. Accidents and falls

Major Diseases, Illnesses and Health Problems Affecting Older People

Ageing can be described, rather than defined, as the aggregate result of the decrement processes, at cellular, sub-cellular, or organ level, that are associated with of the passage of time. It is neither predictable nor inevitable. It is dependent to some extent (probably 25 – 30%) on genetic factors. If the term Ageing is reserved for this process, then longevity or long life might well be used to describe the period of life that is largely free from ageing. Ill health or disease, either acute or chronic, may intervene at any time, and although long life, ageing, and ill-health are inter-connected and inter-active, it is important to view them as distinct.

A. Eye Diseases and Disorders Common in Older People

The common eye problems in old ages are:

i. **Cataracts** are cloudy areas in part or whole of the eye lens. Cataracts keep light from easily passing through the lens causing loss of eyesight. Cataracts often form slowly and cause no pain, redness, or tearing in the eye (Fauci, 1998).

ii. **Glaucoma** results from too much fluid pressure inside the eye (Guyton, 1981). It can lead to vision loss and blindness. The cause of glaucoma is unknown. If treated early, glaucoma often can be controlled and blindness prevented. Most people with glaucoma have no early symptoms or pain from increased pressure (Robbins, 1994).

iii. **Retinal disorders** are a leading cause of blindness of older people in the United States. The retina is a thin lining on the back of the eye. It is made up of cells that get visual images and pass them on to the brain.

Retinal disorders include *age-related macular degeneration, diabetic retinopathy, and retinal detachment* (Robbins, 1994).

- a. **Age-related macular degeneration:** The macula is part of the eye with millions of cells that are sensitive to light. The macula makes vision possible from the center part of the eye (Guyton, 1981). Over time, age-related macular degeneration can ruin sharp vision.
- b. **Diabetic retinopathy:** This disease results from diabetes. It happens when small blood vessels stop feeding the retina properly (Fauci, 1998). It ranges from sight distortion to serious vision loss.
- c. **Retinal detachment:** This happens when the inner and outer layers of the retina become separated.

iv. **Conjunctivitis** happens when the tissue that lines the eyelids and covers the cornea becomes inflamed. It can cause itching, burning, tearing, or a feeling of something in the eye. Conjunctivitis can be caused by infection or allergies (Robbins, 1994).

v. **Corneal diseases and conditions** can cause redness, watery eyes, pain, and reduced vision (Guyton, 1981). Disease, infection, injury, toxic agents, and other things can damage the cornea.

vi. **Eyelid problems** can result from different diseases or conditions. Pain, itching, tearing and sensitivity to light are common eyelid symptoms (Fauci, 1998). Other problems may include drooping eyelids (ptosis), blinking spasms (blepharospasm), or inflamed outer edges of the eyelids near the eyelashes (blepharitis).

vii. **Temporal arteritis** causes arteries in the temporal area of the forehead to become swollen. It can begin with a severe headache, pain when chewing, and tenderness in the temporal area (Robbins, 1994). It may be

followed in a few weeks by sudden vision loss. Other symptoms can include shaking, weight loss, and low-grade fever.

B. Hearing and Older People

In old ages people develop hearing problems. They may mistake words in a conversation, miss musical notes at a concert, or leave a ringing doorbell unanswered. Hearing problems can be small (missing certain sounds) or large (involving total deafness).

Older people who can not hear well may become depressed or withdraw from others to avoid the frustration or embarrassment or not understanding what is being said. They may become suspicious of relatives or friends who they believe mumble or do not speak up on purpose. It is easy to mistakenly call older people confused, unresponsive, or uncooperative just because they do not hear well.

An older person has poor speech discrimination- he or she may know that some one is talking, but cannot discern what is said because some elements such as consonants are missing. This happens due to the higher frequency of consonants than that of vowels. Although deafness is common, it is often neglected and may be associated with significant psychiatric problems such as depressive illness (Herbst and Humphery, 1980).

In old ages hearing loss can be caused by exposure to very loud noises over a long period of time, viral or bacterial infections, heart conditions or stroke, head injuries, tumors, certain medicines, heredity, or changes in the ear that happen with aging.

i. Presbycusis is the most common hearing problem in older people. In fact, people over age 50 are likely to lose some hearing each year. Presbycusis is

an ongoing loss of hearing linked to changes in the inner ear (Fauci, 1998). People with this kind of hearing loss may have a hard time hearing what others are saying or may be unable to stand loud sounds. The decline is slow. Just as hair turns grey at different rates, presbycusis develops at different rates (Robbins, 1994). Perhaps one third of the population over 65 years suffers from a hearing impairment (table 2), which can have unfavorable social consequences.

Table 2 : Difficulty with hearing among older people

Age	65-69	70-74	75-79	80-84	85+	All 65+
	(%)	(%)	(%)	(%)	(%)	(%)
Wears an aid	4	8	10	14	22	8
Does not wear an aid, but has difficulty	20	22	28	31	34	24
Does not wear an aid, has no difficulty	76	70	63	56	44	68

Source: Office of the Population Censuses and Surveys (1982), Table 10.11 (Adopted from: *Ageing in Society*, John Bond, Peter Coleman and Sheila Peace, ed. 2. P. 57).

ii. **Tinnitus** is also common in older people. Tinnitus is a symptom associated with a variety of hearing diseases and disorders (Robbins, 1994). People with tinnitus have a ringing, roaring, or hear other sounds inside the ears. It may be caused by earwax, and ear infection, the use of too much aspirin or certain antibiotics, or a nerve disorder. Often, the reason for the ringing cannot be found. Tinnitus can come and go; or it can stop altogether.

iii. **Conductive hearing loss** happens in some older people when the sounds that are carried from the eardrums (tympanic membrane) to the inner ear are blocked. Earwax in the ear canal, fluid in the middle ear, abnormal bone growth, or a middle ear infection can cause this loss (Guyton, 1981).

iv. **Sensorineural hearing loss** happens when there is damage to parts of the inner ear or auditory nerve. The degree of hearing loss can vary from person to person. Sensorineural hearing loss may be caused by birth defects, head injury, tumors, illness, certain prescription drugs, poor blood circulation, high blood pressure, or stroke (Fauci, 1998).

C. Dementia: Old Age's Companion

The incidence and severity of disorder in dementia and problems in cognitive impairment are directly related to age. They are found to increase with age. The disease in cognitive function may be intrinsic to aging itself. Many older people show no mental decline at all but in those instances when cognitive decline occurs, it develops, in general, insidiously and asymptotically before it reaches a threshold at which it becomes manifest and is referred to as dementia (Choudhury and Wahid, 1996). It has been suggested that research in degenerative disorders is required to find information on the distribution of health status.

D. High Blood Pressure --A Common but Controllable Disorder in old age

When the blood pressure reading goes above a certain point, it is called high blood pressure (Robbins, 1994). Hypertension is another name for HBP. Among people age 65 and older, about 40 percent of Whites and 50 percent

of Blacks have HBP. Often in older adults the first number (the upper or systolic number) is high while the second (the lower or diastolic) number is normal. This condition is called isolated systolic hypertension, and it also should be treated (Guyton, 1981). Studies prove that lowering the systolic number cuts down on strokes and heart attacks in people age 60 and over.

E. Stroke

A stroke is a sudden partial loss of brain function usually caused by a clot or narrowing of a blood vessel that stops or interrupted the flow of blood to an area of the brain. Without oxygen and important nutrients, the affected brain cells are either damaged or die within a few minutes. Other strokes are caused by a hemorrhage (bleeding) from an artery (Fauci, 1998).

F. Infectious Disease

Every year, thousands of older people die needlessly due to infectious disease. Like children they also need to be vaccinated from time to time against serious infectious diseases. In many developed countries the Public Health Service strongly encourages older adults to be immunized against influenza, pneumococcal disease (especially pneumonia), tetanus, and diphtheria. Pneumococcal disease is an infection caused by bacteria. These bacteria can attack different parts of the body. They cause bacterial pneumonia invading the lungs and bacteremia and meningitis entering the blood (Robbins, 1994).

G. Flu - the Short Name for Influenza

It is a viral infection of the nose, throat, and lungs. It is usually a mild disease in healthy children and young adults, but it can be life threatening in

older people and in people of any age who have chronic illnesses such as heart disease, emphysema, asthma, bronchitis, kidney disease, or diabetes. Usually in winter, millions of people suffer from the flu.

H. Urinary Incontinence

Urinary incontinence is the loss of bladder control or the leakage of urine. It can happen to anyone due to urinary tract infection and drugs, but is very common in older people. At least 1 out of 10 people age 65 or older suffer from incontinence. It is a condition that ranges from mild leakage to uncontrollable and embarrassing wetting. Urinary incontinence is a major health problem because it can lead to disability and dependency (Guyton, 1981).

Many people with incontinence pull away from their family and friends. They try to hide the problem from everyone, even their doctors. However, in most cases urinary incontinence can be treated and controlled, if not cured, but the caregivers may not know that treatment is a choice.

I. Enlarged Prostate: Common Male Problems

The prostate is a small organ below the bladder (where urine is stored) and surrounds the urethra (the tube that carries urine from the bladder) (Robbins, 1994). Prostate problems are common in men 50 and older.

J. Osteoporosis-The Silent Bone Thinner Disease: Common in Females

Osteoporosis is a disease that thins and weakens bones. It is called the *silent disease* because symptoms are usually unnoticed. People can lose bone over many years but they are ignorant of osteoporosis until a bone breaks. Bones

break easily—especially bones in the hip, spine and wrist (Fauci, 1998). Osteoporosis occurs due to dropping in estrogen hormone level in postmenopausal period, taking diet too low in calcium and not getting enough exercise.

One out of two women and one in eight men over age 50 will have an osteoporosis-related fracture. White and Asian women are most likely to get osteoporosis. Men have less risk of getting osteoporosis because they do not have the same kinds of hormone losses as women (Robbins, 1994). Osteoporosis can strike at any age but the risk increases as someone get older.

K. Foot Problem

It is a disease of years of wear and tear, ill fitting or poorly designed shoes, poor circulation to the feet, or improperly trimmed toenails cause many common foot problems.

L. Constipation

Constipation is a symptom, not a disease (Guyton, 1981). It is defined as having fewer bowel movements than usual, with a long or hard passing of stools. Older people are more likely than younger people to have constipation.

M. Skin Care and Ageing

Skin does change with age—for example, older people sweat less and skin can take longer to heal. Sunlight is a major cause of skin changes we think of as aging-changes like wrinkling, looseness, leathery-dryness, blotches,

various growths, yellowing, or pebbly texture. But the simplest and cheapest way to keep the skin healthier and younger looking is to stay out of the sun.

i. **Sun Damage:** over time, the sun's ultraviolet (UV) light hurts the elastic fibers in the skin causing it to sag, stretch, and lose its ability to snap back after stretching (Robbins, 1994). The skin also bruises and tears more easily and takes longer to heal. So sun damage may not show until later in life. Nothing can completely undo sun damage, although the skin can sometimes repair itself.

ii. **Smoking:** people who smoke tend to have more wrinkles than nonsmokers of the same age, complexion, and history of sun exposure (Guyton, 1981). The reason for this difference is unclear. It may be because smoking interferes with normal blood flow in the skin.

iii. **Skin cancer:** sun damage also causes skin cancer. The chance of developing skin cancer increases as people age, especially for those who live in sunny areas of the country. There are three types of common skin cancers:

- a. **Basal cell carcinomas** are the most common. They almost never spread to other vital organs, but get bigger and can affect nearby areas.
- b. **Squamous cell carcinomas** are less common but are potentially more harmful because they can grow quickly and spread to other organs (Fauci, 1998).
- c. **Malignant melanomas** are the most dangerous of all the skin cancers because they may spread to other organs and when they do, they are often fatal (Robbins, 1994).

iv. **Dry Skin and Itching:** dry skin is common in later life. About 85 percent of older people develop winter itch, because overheated indoor air is dry. The loss of sweat and oil glands as we age may also worsen dry skin. Anything that further dries the skin (such as overuse of soaps, antiperspirants, perfumes, or hot baths) will make the problem worse.

Dry skin itches because it is irritated easily. If the skin is very dry and itchy, be a symptom of a disease e.g. diabetes and kidney disease that can cause itching (Robbins, 1994). Some medicines make the itchiness worse.

N. Depression-A Serious but Treatable Illness

Everyone gets the blues now and then. It's part of life. But being *down in the dumps* over a period of time is not a normal part of growing old. Not it is a common problem and medical help may be needed. Being depressed for a while, without letup, can change the way a person thinks or feels. Doctors call this *clinical depression*.

O. Sexuality in Later Life

Most of the older people want and are able to enjoy an active, satisfying sex life. Regular sexual activity helps maintain sexual ability. However, over time everyone may notice a slowing of response. This is part of the normal aging process. But men often notice more distinct changes. As men get older, impotence seems to increase, especially in men with heart disease, hypertension, and diabetes. Impotence is the loss of ability to achieve and maintain an erection hard enough for sexual intercourse (Robbins, 1994).

P. Effects of medicine use during old ages

As a group, older people tend to have more long-term illnesses- such as arthritis, diabetes, high blood pressure, and heart disease- than do younger people. So, it is common for older people to take many different drugs.

Drugs can be wonderful tools for the care of people of all ages. Many people over age 65 owe their lives in part to new and improved medicines and vaccines. But for these older adults, drug use may have risks, especially when several medicines are used at one time. It has been seen that people over age 65 make up 12 percent of the American population, but they take 25 percent of all prescription drugs sold in this country.

In general, drugs act differently in older people than in younger people. This may be due to normal changes in the body that happen with age. While getting older people lose water and lean tissue (mainly muscle) and gain more fat tissue. This can make a difference in how long a drug stays in the body and how much of the drug that body absorbs.

Q. Ageing and Alcohol Abuse

Anyone at any age can have a drinking problem. But the problems get worsen with the increasing age.

R. Hyperthermia-A Hot Weather Hazard for Older People

Warm weather and outdoor activity generally go hand in hand. However, it is important for older people to take action to avoid the severe health problems often caused by hot weather. *Hyperthermia* is the general name given to a variety of heat-related illnesses. The two most common forms of hyperthermia are heat exhaustion and heat stroke (Fauci, 1998). Of the two

most common forms of hyperthermia are heat exhaustion and heat stroke. Of the two, heat stroke is especially dangerous and requires immediate medical attention.

Regardless of extreme weather conditions, the healthy human body keeps a steady temperature of 98.6° F (37° C) (Robbins, 1994). In hot weather, or during vigorous activity, the body perspires. As this perspiration evaporates from the skin, the body is cooled. If challenged by long periods of intense heat, the body may lose its ability to respond efficiently. When this occurs, a person can experience hyperthermia.

Lifestyle factors that can increase risk include:

- a. **Unbearably hot living quarters.** People who live in homes without fans or air conditioners should take the following steps to reduce heat discomfort: open windows at night; create cross-ventilation by opening windows on two sides of the building; cover windows when they are exposed to direct sunlight; and keep curtains, shades, or blinds drawn during the hottest part of the day.
- b. **Lack of transportation.** People without fans or air conditioners often are unable to go to shopping malls, movie houses, and libraries because of illness and/or the lack of transportation. Friends or relatives might be asked to supply transportation on particularly hot days. Many communities, area agencies, religious groups, and senior citizen centers provide such services.
- c. **Overdressing.** Because they may not feel the heat, older people may not dress appropriately in hot weather. Perhaps a friend or family member can help to select proper clothing. Natural fabrics such as cotton are best.

- d. **Visiting overcrowded places.** Trips should be scheduled during non-rush hour times and participation in special events should be carefully planned.
- e. **Not understanding weather condition.** Older people, particularly those at special risk (see health factors), should stay indoors on especially hot and humid days, particularly when there is an air pollution alert in effect.

S. Accidental Hypothermia-The Cold can be Trouble for Older People

Cold weather can be risky for anyone, not especially for older people. Winter chill can lead to a temperature drop inside the body that can be deadly if not found quickly and treated properly. Hypothermia is marked by unusually low body temperatures, below 96⁰ F (35.5⁰ C) – well below the body's normal temperature of 98.6⁰ F (37⁰ C). It is a special problem for older people, who often have other illnesses or take medications that can interfere with the body's ability to regulate its temperature (Guyton, 1981). Severe hypothermia can cause an irregular heartbeat leading to heart failure and death. Older people may be vulnerable to hypothermia even when they live in nursing homes or group facilities.

Old Age and Dependency for Care

Most of the young older people are independent. But later in life-especially in the 80s and 90s – they depend for shopping, cooking, walking, or bathing. For many people, regular or *long-term* care may mean a little help from family and friends or regular visits by a home health aids. For others who are frail or suffering from dementia, long-term care may involve moving to a

place where professional care is available 24 hours a day. These services include home health care, adult day care, and transportation services for frail seniors as well as foster care, assisted living and retirement communities, and traditional nursing homes.

Theories on Ageing

The notion of developing and verifying a theory of ageing may seem unnecessary or overly academic. We all grow older. Yet, we all develop theories from our own experience. A scientific theory is based on a logically related set of statements, called propositions or hypotheses, each of which is subjected to testing through empirical research.

The process of ageing is as old as the world. Every thing in the universe including the universe itself is subject to ageing. In case of inanimate objects it is a physical and environmental process while it is a biological and environmental process for living beings. For human beings ageing starts at birth. As people grow in their chronological age some changes gradually take place, which reduce the speed of or stop some bodily functions. The biological theories like *Programd time clock theory*, *Error theory*, *Wear tear theory*, *Auto-immune theory* etc., provide explanations to these changes from different view points with some limitation in each theory (Mian, 1996).

The process of human aging is as old as the history of mankind. But it was not a problem until the recent past. Advancement of medical science reduced the infant and child mortality to a great extent resulting in large life expectancy. Side by side widespread use of family planning devices reduced the fertility rates resulting an increase in the proportion of older people in

comparison to the children. Migration of working age group people intensified the proportion of aged to some extent also. Theories of aging like Disengagement Theory, Activity Theory, Role Theory, Sub-culture Theory, Exchange Theory etc. explain the process of ageing and its impact on individual and society (Mian, 1996).

The recent achievements of modern science have unfolded a consistent progress to lead us to anticipate that the next few years would witness many significant outcomes to open avenues for flourishing our understanding of the chemistry of ageing (Ali, 1996). While such attempts are relatively new, the curious medical scientist who foresees some effective means of slowing the ageing process is pursuing a number of ageing theories and approaches. For example, if the means to prolong longevity proves to be diet dependent on balanced nutrients, there is no reason to believe that most of the people would be willing to change their current habits on taking diets for the increased longevity.

Biological Theories on Ageing

Biological theories on ageing have many facets. Hence there are a number of theories, each of which may explain one or more aspects of ageing; there is, however, no single theory that explains all of the phenomena of ageing.

A. Genetic Theories

i. Program Theory

One theory of ageing assumes that the life span of a cell or organism is genetically determined—that the genes of an animal contain a *program* that determines its life span just as eye color is determined genetically (Aiken,

1995). Although long life is recognized often as a familial characteristic, and selective breeding can produce short-lived strains of fruit flies, rats, and mice, other factors clearly can significantly alter the basic genetic program of ageing.

ii. Error Theories

Another genetic theory of ageing assumes that cell death is the result of *errors* introduced in the formation of key proteins, such as enzymes. Slight differences induced in the transmission of information from the deoxyribonucleic acid (DNA) molecules of the chromosomes through ribonucleic (RNA) molecules (the *messenger* substance) to the proper assembly of the large and complex enzyme molecules could result in a molecule of the enzyme that would not *work* properly. These so-called error theories have not yet been firmly established, but studies are in progress (Hooyman and Kiyak, 1991).

iii. The Somatic Mutation Theory

As cells grow and divide, a small proportion of them undergo mutation; that is, they become *different* with a change in their chromosome structure that is then reproduced when they again divide (Aiken, 1995). The *somatic mutation* theory of ageing assumes that ageing is due to the gradual accumulation of mutated cells that do not perform normally.

B. Non-Genetic Theories

Some theories of ageing focus attention on factors that can influence the expression of a genetically determined *program*.

i. The Wear-and-Tear Theory

This theory assumes that animals and cells, like machines, simply wear out (Hooyman and Kiyak, 1991). Animals, however, unlike machines, have some ability to repair themselves, so that this theory does not fit the facts of a biological system. A corollary to the wear-and-tear theory is the presumption that waste products accumulate within cells and interfere with function (Aiken, 1995). The accumulation of highly insoluble particles, known as *age pigments*, has been observed in muscle cells in the heart and nerve cells of both human beings and other animals.

ii. The Cross-Linking Theory

With increasing age, tendons, skin, and even blood vessels lose elasticity. This is due to the formation of cross-links between or within the molecules of collagen (a fibrous protein) that give elasticity to these tissues (Hooyman and Kiyak, 1991). The *cross-linking* theory of ageing assumes that similar cross-links form in other biologically important molecules, such as enzymes. These cross-links could alter the structure and shape of the enzyme molecules so that they are unable to carry out their functions in the cell (Bjorksten, 1974).

iii. The Autoimmune Theory

Another theory of ageing assumes that immune reactions, normally directed against disease-producing organisms as well as foreign proteins or tissue, begin to attack cells of the individual's own body. In other words, the system that produces antibodies loses its ability to distinguish between *self* and

foreign proteins. This *autoimmune* theory of ageing is based on clinical rather than on experimental evidence (Hooyman and Kiyak, 1991).

These theories all attempt to explain ageing in terms of cellular and molecular changes. Actually, age changes are much more marked in the overall performance of an individual than in cellular processes that can be measured. The age decrement in the ability to perform muscular work is much greater than any changes that can be detected in the enzyme activities of the muscles that perform the work. It is possible that ageing in an individual is actually due to a breakdown in the control mechanisms that are required in a complex performance.

Social Theories on Ageing

Social theories are explanations of the changes in social relationships that occur in late adulthood. These theories attempt to answer questions like:

- a. What makes the successful ageing?
- b. What should the older persons do?
- c. Should we force older persons to retire?
- d. Is it beneficial for the elderly to be active in the community?
- e. What should our society be doing with regard to the older persons?

These theories address the basic issue of determining the optimal way for older persons to relate to their environments. There are many generalization and theories prevalent regarding ageing, of them four are very popular: Disengagement, Activity, Subculture, and Minority theory.

i. Role Theory

People play a variety of social role in their lifetimes, such as student, mother, wife, grandmother, and businessman. Such roles identify and describe a person as a social being and are the basis of self-control.

Each social role is associated with a certain age or stage of life. Chronological age is used to determine eligibility for various positions. Some roles have a reasonable biological basis related to age (the role of a mother). On the other side, many roles could be filled by individuals of a wide age range (the role of a volunteer). However, how well individuals adjust to ageing is assumed to depend on how well they accept the role changes typical of the later years.

The theory identified various role dilemmas that the older adults face, which are:

- a. As age increase people lose roles to acquire new roles, however, with some exceptions, e.g.

<u>People lose roles</u>	<u>Acquire new roles</u>	<u>Exception</u>
1 Loss of the spouses	Widowhood	Some widows remarry
2 The worker	Retirement	Some retirees return to work

But the majority does neither. Some roles are the basis of an individual's self-control; role loss can lead to an erosion of social identity and self-esteem. With age, roles also tend to become more ambiguous. According to Burgess, *the role of the retired person is role less* (Hooyman and Kiyak, 1991).

b. The transition from the worker role to the retiree role is characterized by role discontinuity (Hooyman and Kiyak, 1991). What is learned at one age level may be useless or conflicting at the next age level.

ii. Activity Theory

This theory was developed by Robert Havighurst, who in his study of 300 people - primarily white, middle class, healthy and aged between the ranges of 50 to 90 years - assumes that older persons who are active will be more satisfied and better adjusted than less active older persons.

In order to develop the theory, the presumption that was held is *A person's self-concept is validating through participation in roles characteristic of middle age.*

According to activity theorists, older people do lose certain roles; but most of the older people maintain their social involvement, hence loss does not necessarily produce disengagement in the society. By keeping active, activity theorists say, the older remain socially and psychologically fit, healthy, happy and able to live a long (Havighurst, 1963; Lemon, Benston and Peterson, 1973). This theory holds that:

- a. it is desirable for the older persons to maintain as many middle age activities as possible and to substitute new roles for those that are lost through widowhood or retirement;
- b. in order to minimize society's withdrawal from the older people, which occurs against older people's will or desire, older people must deny the existence of old age by maintaining middle age life styles as long as possible;
- c. behavior inappropriate to middle age is considered to be maladaptive;

- d. *remain active, keep busy and stay young*

iii. Disengagement Theory

The theory of disengagement, formulated by E. Cumming and W. Henry in 1961, challenges the assumption that the older persons have to be active in order to be well adjusted. The process of disengagement may be started either by the older person himself or by society. According to the theory, older persons, experiencing losses of roles and energy, want to be released from societal expectations that they become productive and competitive. Disengagement is thus viewed as adaptive behavior.

Again, disengaged older people, freed from the demands of employment roles, are better able to participate in satisfying family relationships than those who remain occupied with work. While considering for men the process of disengagement tends to be abrupt, and for women their central role as parent is more gradual and smooth, the theory holds that:

- a. Social services, if provided at all, should not seek to revitalize the older person, but rather to encourage their withdrawal; and
- b. All societies need orderly ways to transfer power from older to younger generations.

Disengagement theorists hold that ageing always causes people to disengage from society. Although they do not withdraw totally like hermits, but their social interaction declines with the advancement of age (Rahman et al., 1996). Disengagement theory postulates that society withdraws from the ageing persons to same extent as the person withdraws from society (Cumming, 1963). This theory further holds that this mutual withdrawal is

beneficial both to the society and the older people. This theoretical approach has been rejected and challenged by James Dowd (1980) on various grounds although ageing is universal and inevitable.

iv. Continuity Theory

The emergence of this theory was led by the shortcomings of disengagement and activity theories. This is a social-psychological theory of adaptation in old age. According to continuity theory, the ageing person:

- a. substitutes new roles for lost ones;
- b. continues to maintain typical ways of adapting to the environment in order to maintain inner psychological continuity as well as the outward continuity of social behavior and circumstances (Neugarten, Havighurst, and Tobin, 1993)

The basic tenets of continuity theory are that people, whether young or old, have different personalities and lifestyles, and that personality plays a major role in adjusting to ageing.

According to the theory, the basis of life satisfaction is that an individual ages successfully if he or she maintains a mature, integrated personality while growing old (Aiken, 1995).

v. Age Stratification Theory

Maintaining that an approach similar to that used in sociological analyses of class stratification is useful to understanding the position of age groups and the meaning of age within a particular social context, Riley, M. W. and Foner, A., the proponents of the theory hold that people are defined as

young, middle aged, and old in terms of social roles and responsibilities, not just chronologically – just as societies are stratified in terms of socio-economic class.

The basic assumption of the theory is that age is a universal criterion by which people's roles, rights, and privileges are distributed as they move from one stratum to the next.

Because of the variety of physical, social, or psychological factors that affect the ageing process, age strata differ in age related capacities. Such differences between strata partially result from the process of *allocation* and *socialization* (Hooyman and Kiyak, 1991).

vi. Subculture Theory

According to this theory older persons usually interact with peer groups and develop their own subculture. Some sociologists are of the opinion that in many societies, older people have responded their positions in the society by developing their own subculture (Rahman et al., 1996). The bases for this development are the interest and experiences shared by the older persons as a member of same age group. This theory holds that the older people interact with their peer more than with people of other ages, form a politically oriented consciousness of themselves, as a group and develop a stronger, more positive self-image (Rose, 1965). Atchley (1988) expressed his doubt over a question whether an older subculture actually exists.

vii. Minority Theory

Because of prejudice and discrimination against the aged some sociologists have expressed their opinion that it is more accurate to talk of the older

people as a *minority*. Like race and gender, age is an ascribed status over which the individual has no control (Rahman et al., 1996).

Discrimination against the older people can be seen in mandatory retirement laws, substandard nursing homes, domestic neglect and abuse and overmedication of older patients (Levin and Levin, 1980; Pillemer, 1985).

Cares for the Older People

Formal and Informal Agecare: A Relationship at Risk?

Caregiving of older people is being acknowledged as one of the fundamental challenges facing western societies (Jutras, 1990), and a key issue of the 1990s and beyond (Keating et al, 1997). Health professionals over the past few years have been urged to develop partnerships with family members in the provision of this care. Extermination of the complex boundaries it's between formal and informal caregivers in of particular significance at this time as health care administrators and policy makers' debate and seek to regulate the definitions of home care work and the relationships involved.

Based on a qualitative study of nurses and family members caring for an older person in the home, Ward-Griffin (1999) illustrated that family can giver-nurse relationships are complex and merits closer examination if we are to better understand the private and public care of the older people. The research questions focused on how nurses and family caregivers described their caring work, each other's caring work, and their relationship. Using a critical ethnographic method in a socialist-feminist framework, he found that the relationships between family caregivers and community nurses are complex and multifaceted, and overtime, shift and oscillate between four

interrelated types: nurse-helper, co-workers, manager-worker, and nurse-patient. While both family caregivers and nurses co-operated in and rested existing caring arrangements, ideologies used by nurses are a major force that exploits family members who assume the bulk of this caregiving. His findings support the need to change existing practices and policies in home care if a more equitable sharing of responsibility between public and private sectors of care is to occur.

Role of the Family in Looking after the Older People

Role of the family is utmost important in taking care for the older people who had devoted the major part of their working life to bring the family fortunes to the current status. The strength of the family ties as well as respect, love and affection and a sense of moral obligation of the younger members have been the main source of support for the older persons in the family. The Governments also rely on this source as the major factor in the welfare of the older people particularly in the developing countries where family disintegration is yet to be started and government does not have the capacity to declare the country as welfare state.

In the rural areas of the developing countries people still nurture the sentiment of respecting and caring for the older people. While in the urban areas, compulsions of modern age not only have weakened this support base but also have resulted in considerable suffering by the urban older people due to inadequately developed compensating measures. Government as well as other funding agencies has attempted to provide alternative support within a limited capacity. But

it has been realized soon that the growth rate of the ageing population is such that it would be no longer feasible to do so in long run. Moreover, in the context of developing and least developed countries, there are many burning issues that need to be prioritized. Hence, perceiving the situation United Nations has emphasized on re-inculcating the family culture and in line of that has called to celebrate 1994 as *The International Year of the Family*.

It is to be noted that the emotional well being of the older people is more linked to maintenance of close family ties than just material facilities of shelter, food etc. Such observation has also been drawn from a Sri Lankan Survey on Family ties in that country (Pendse, 1999: 38). It is the equal responsibilities of both the younger and the older members of the family to strengthen the ties. Hence, responsibilities of the younger for enhancing the care of older members within the family are:

- a. To provide training and incentives to the family members in looking after their older members.
- b. To include the topic *care of the older persons* in the curriculum of schools, colleges and university. Such training would be extremely useful in cultivating the right attitudes of the younger generation.

Eventually, the older members in the family also have some roles in maintaining the family bond. These are as follows:

- a. To adapt their life styles to the changes occurring around them.

- b. To attain the ability to meeting the family members on equal terms, looking to the educated sons and daughters for guidance in new areas of knowledge and activities.
- c. To contribute by physical participation in looking after the household and grandchildren. These attributes encourage mutual happiness.

Role of NGOs in Developing Support Systems for Older People: Encouraging Productive and Participatory Ageing

Initiating comprehensive welfare projects for the older people in the developing countries, paucity of funds is a distinct handicap for the Government. Currently, it is the concern in the developed countries too. There is a growing movement to have 'less of Government and more of Community based Services' for the older people (Pendse, 1999: 309). The NGOs (Non Governmental Organizations) thus have a distinct role to play in evolving satisfactory solutions to the problems of the older people. Such initiatives are also desirable on two counts:

Firstly, when individuals and communities sponsor such activities there is less of a feeling of living on dole.

Secondly, by involving a substantial number of elders as volunteers in implementation of the projects a rewarding feeling of worthwhile participation, self help and productive use of one's time is generated.

Thus most of the NGOs in various countries have been established out of sheer necessity to fill the gap between needs and Government /Public resources and they also serve the function of generating self esteem and purposeful living in their membership.

In China major bodies working in this field were mostly government sponsored and financed until now. However, the coverage is quite interesting to note. Apart from National Geriatrics Society and Gerontological Society of China, there are institutes for population research, psychological research of the older people and Elderly Societies for Sports, calligraphy and drawing, retired engineers, teachers etc. These committees and Societies have Chapters in the Provinces so that it becomes a nationwide movement (Aiken, 1995).

Bangladesh Association for the Aged and Institute of Geriatric Medicine (BAAIGM) has played a pivotal role in initiating some policy decisions on part of the Government. It has also started in some prominent cities, health centers, Old Age Homes etc. on their own.

With the initiative taken by the Sri-Lankan Government itself in addressing the problems of the elderly Help Age Sri Lanka and Marg Institute are the only major NGOs in that relatively small country to undertake running of Day Care Centers and monitoring research on population and ageing (Hooyman and Kiyak, 1991).

Major NGOs in Pakistan are the National Council of Senior Citizens Association, Employees Old Age Benefit Institution, Staff Welfare Organizations.

In Thailand the private sector has played a major role in the field of ageing through formation of Senior Citizens Council of Thailand. It has been established to coordinate the activities of these clubs and associations. It is pertinent to note that such old-age peer groups do develop into a form of support system, because of similar social

experience, and an informal network that provides both tangible and intangible assistance. In the rural areas, community support through neighbors, the temple, headmen of the village does play an important role in rendering help to the older people though not in an organized form.

Intergenerational Relationships

History: Change of Topics Demanding Attention:

Less than two decades ago the global population was viewed as young rather than old. That is 35 percent of all persons in the world were 14 years of age or younger, compared to only 8.5 percent who were 60 and over (Link Age 2000, 1998). It is not surprising then, that policy makers focused their attention on issues such as family planning, maternal and child health and education. Little attention, particularly in developing nations, was paid to a growing ageing population and the potential impact it could have on the economy, the social fabric and the political system of a given country.

But today at the dawn of new millennium, we are about to bear witness to a global society that is the oldest in the history of the world. The older population (aged 60 or over) is growing faster than all other age groups and will expand from 200 million older people in 1950 to 1.2 billion in 2025, a six fold increase over the past 75 years according to the United nations statistics. Even more significant, perhaps, is the demographic picture that emerges when ageing populations in developed nations are compared to similar populations in developing countries.

In most western industrialized countries the speed of population growth for

the older people moved fairly slowly, taking from 50-100 years for the percentage of the population over 65 years of age to double from 7 to 14 percent. However in most developing nations a comparable increase among the older population will take place in fewer than 30 years (Link Age 2000, 1998). By 2025, one out of every four people (25 percent) in the developed world is projected to be 60 years of age or older. In contrast, only 12 percent of the developing world will be over 60. However the latter percentage constitutes 860 million people, or 71 percent of the world's older population. And equally impressive, 84 percent of the globe's population will be in the developing regions by 2025 (Chawla, 1993), with Africa's aged population projected to grow the fastest (United Nations, 1985).

Through a combination of declining fertility rates and corresponding increase in life expectancy, both developed and developing nations are witnessing shifts in their respective population structures that, ultimately, will affect their respective dependency/ support ratios. This ratio represents the number of people under age 15 and over age 64 who are dependent on those who are usually participating in the work force (age 15 to 64) and paying taxes to support the too young and the too old. It is precisely at this juncture where questions such as where questions concerning intergenerational equity are spawned. That is, how should resources be allocated across different age groups? And how should pay, how much and why?

Understandably, predictions of major demographic changes combined with challenging policy questions such as those posed above, have produced much anxiety throughout the world. For clearly, evidence is accumulating that the ageing of populations can have a strong influence on the course of

development, both in economic and social terms (United nations, 1985). And not to be overlooked is the fact that the ageing of the world's population is occurring in the midst of an ongoing global economic transition (Schulz, 1930). Therefore, to what extent the impact of population ageing depends or determines the outcome of the economic transition now in progress is large, tantalizing and provocative unknown confronting policymakers throughout the world. Or, put another way, will older people be contributors to, or simply beneficiaries of, improve standards of living?

Concerned about such questions as early as the 1980s, the united nations adopted the Vienna International Plan of Action on ageing in 1982, the first internationally negotiated action document that put forth specific recommendations to address the potential effects of global ageing. The plan of action was anchored to the basic principle that there is a symbiotic relationship between population ageing and economic development. one basic objective of The Plan of Action, then, was to ensure that, as the population of the world ages, the older persons would themselves have opportunities to contribute to, as well as share in, the benefits of development (Chawla, 1993).

Subsequent reports, including three quadrennial reviews of the implementation of The International Plan of Action on ageing and a separate study , The World Ageing Situation (United nations, 1991) have all drawn one common and troubling conclusion: that the older people have come to be viewed as dependent beneficiaries of development, rather than contributors to it (Chawla, 1993). Under such circumstances the older people may be perceived as not only obstacles to economic development, but also as social burdens who divert needed sources away from other age groups. It

is within this context, often referred to as the intergenerational equity issue, that this presentation is structured.

Intergenerational Issue in the Developing Countries

While the interest in global ageing has grown in recent years, most researchers have focused their attention on developed nations rather than on developing countries. But today, of the approximately 580 million older people, that is those 60 years of age or older, in the world, about 355 million are living in the developing countries. And, if predictions hold, by 2020 more than 1 billion people 60 years of age older will be living in the world, with more than 700 million of them residing in the developing countries. More specifically, the rate of increase of older people in developing countries, such as Colombia, Malaysia, Kenya, Thailand and Ghana, is expected to be 7 to 8 times higher than the rate in Sweden and the United Kingdom, for example (World health Organization, 1998). This trend may be problematic for at least three reasons:

- a. As populations age in poor countries, the addition of older dependents to a family may have a negative impact on the subsistence level of others members of the family. So in one sense, at least, there may be intergenerational conflict emerging within poor societies at the most basic level: the family.
- b. The graying of populations in poor countries, in particular when there is significant migration of younger people from rural to urban areas, as tends to occur with industrialization, may force governments to assume greater responsibility for providing services to the older people.

- c. Consequently, not only will migration deplete the older people of many potential personal caregivers, younger workers will have to be taxed in order to meet the needs of the older people. So, on one hand we may witness the social division of families and the isolation of certain age groups as has occurred in developed nations. On the other hand, the potential for conflict between generations because of economic issues, such as tax policies that are perceived to be unfair by the young, may grow.

It should be emphasized here that the place of residence of both young and old, whether it is urban or rural areas, may affect the willingness or resistance of individuals and governments to allocate various resources across generations. For example, in some countries older people currently living in urban areas ranges from 25 to 30 percent, a percentage that is expected to increase to 40 percent by 2000. This fact alone raises yet another challenging question for policy makers to ponder: if this trend towards urbanization continues, will it create conflicts among generations both in rural and urban areas (United Nations Department of International and Economic Affairs, 1995).

Important decisions must be made with respect to the type of pension program that may work best for a given economy. Today, there are three different pension programs from which nations choose to address the financial needs of their retirees. They include:

- i. Public pay-as-you-go programs,
- ii. Employer - sponsored plans, and
- iii. Personal savings and annuity plans.

The most popular plan of the three is the public pay-as-you-go model. It is particularly popular in high-income countries where coverage is universal and only somewhat wide spread in middle-income countries. Under this model, the government mandates, finances, manages and insures public pensions. Its benefit are predetermined, not necessarily linked to the contributions made by retirees, and are financed by a payroll tax on active workers. Such a scheme, which can be a rich breeding ground for intergenerational conflict, is rare in developing countries. Instead Nations such as India, Indonesia, Mexico, South Africa, and Zimbabwe have opted for employer-sponsored plans also known as Employer-sponsored systems. Voluntary personal saving is surfacing in more countries each year and may be managed either by Governments (for example Malaysia, Singapore and several African countries) or by several private companies on competitive basis (currently in Chile). However, whatever model is selected, there is substantial risk involved (World Bank Policy Research Report, 1997; Link Age 2000, 1998).

Even if governments choose to pay a small pension to each older retiree, the number of older people is so large that the total budget becomes huge and individual pensions will be extremely low. As for example, if India decides to pay 100 Indian rupees each month to each older person, by the year 2000 the monthly budget would be 7,600 million rupees, an overwhelming sum for any poor nation. Yet the 100 rupees pension is insufficient to cover even one meal a week. And to make matters even complicated, developing countries tend not have any organized collection system that transfers pension funds from younger generations to old – the so-called pay-as-you-go schemes. Such models have gone bankrupt in almost all developing

countries. Thus policymakers in the developing countries would be better served if they thought of alternate forms of funding pensions, such as fully paid schemes (Link Age 2000, 1998).

Guidelines and Recommendations:

The intergenerational equity question is steadily making its way onto political agendas throughout the world. Because of historical, political and cultural differences, and depending where nations may be on the continuum of economic development, the equity issue, if it emerges at all within a given nation, may take on variety of forms. Therefore, it is difficult to design and apply a set formula to address it. However, in response to generational conflict in the United States, Generations United (1992), an intergenerational organization formed to diffuse the divisiveness of the equity debate, has put forth seven guidelines and recommendations that other nations may find helpful. These are as follows:

- i. Avoid misunderstandings about the implications of population ageing.
- ii. Recognize the diversity of the older population.
- iii. Be prepared to correct any misunderstandings about relations between generations.
- iv. Avoid using narrow and misleading definitions of fairness.
- v. Do not rely on limited measures to draw broad conclusions.
- vi. Avoid any misunderstanding about the common stake in social policies.
- vii. Avoid participating in a Zero sum game.

Future of Intergenerational Issue: Conflict or Solidarity

What then are the prospects for generational relations in the future? Is there likely to be more, or less, generational conflict in industrialized societies? Are future generations likely to support each other: will there be solidarity and will there be reciprocities?

Naturally it is difficult to predict the future. But some insights may be found in the interaction of cohort effects and period effects, as suggested earlier. In particular, what events occur in economic and socio-political areas will determine much of the fate of intergenerational relations in the future. But we can see reasons why intergenerational conflict will be more likely in the next few decades and reasons why it will be less likely.

Let us list some reasons why there might be an increase *intergenerational conflict* between now and 2020:

a. Increase in the dependency ratio

Simply put, there will likely be fewer and fewer workers per dependant (children and aged), along with increased medical-care expenditures for older people. Unless there are marked increases in productivity, or a real cold war peace dividend, which will spread across the industrial world, it will be increasingly difficult to continue as is without setting limits (Callahan, 1987; Bengtson and Dannefer, 1987).

b. Increased perceptions of generational 'inequity'

This is a particularly likely scenario in the United States. If inflation continues to rise (especially in housing costs), the older people are more and more likely to be perceived as greedy geezers in their mortgage-free houses.

It will be increasingly argued that public support for the older people comes from funds that could be allocated to other segments of society, such as youth and affordable housing for young families. This is the generational-equity scenario; Callahan (1987) goes along with this by calling for voluntary restraints by tomorrow's older.

c. Increased ageism

Negative stereotypes of ageing process involve perceptions of the older persons as rigid, terribly old-fashioned, unable to cope, irrelevant and worthless. As more and more of the older population of the future live past 85, as more and more live with mental impairments like Alzheimer's disease and strokes, it could be that ageing itself will be more and more negatively viewed. Moreover, if technological advances become even more part of personal life, those who cannot or will not learn the new techniques involving man-machine interfaces (such as, computerized home banking) may be left behind. And, on the other side of the coin, there may be even greater emphasis on the virtues of youth. With fertility low and children proportionately less common, youth will become valued even more highly and attention will be turned to the young at the expenses of the older.

But there are other reasons to suggest that intergenerational conflict in the twenty-first century may in fact be less than it has been, and that solidarity between generations at both the macro- and micro-social levels may be high.

d. The cultural lag hypothesis

We may be in a situation of temporary normlessness now with regard to the longevity revolution; our social structures and norms may not have caught up to changes in the population age structure. This argument would suggest

that, in another several decades, social structures and cultural values will have evolved to reflect our changing age composition, with the result that we will have created more and more effective mechanisms to deal with large numbers of aged people more adequately.

e. Norms of solidarity and support

Many studies have suggested significant intergenerational solidarity at the family level, with relations between generations' solid and rewarding and much mutual support taking place (Rossi and Rossi, 1990). This reflects-

- i. Norms of filial piety
- ii. Norms of reciprocity
- iii. Expectations for one's own future.

Can similar arguments be advanced at the macro-social level? Are there not society or cultural values of age-caring, reciprocity, self-interest - all of which may dampen or decrease possible generational- inequity conflicts? It can be argued that the welfare state is not likely to go back on the moral principles, which have been in effect for so many decades now. This is seen in Germany, for example, in lack of major changes in welfare provisions despite the recent changes of political structure.

f. Norms of reciprocity

While we have only begun to research them (Rossi, 1989), life course and intergenerational norms of reciprocity are very high. That is, people believe in a cyclical process of being helped and helping through out life; they believe this is normal, and so do not resent it (much of the time). The burdens of care-taking for a child are taken for granted. So, too, are many of the burdens of age- caring. Family contact seems to have high value, especially

in terms of generational relations, even in the case of divorce, when the intergenerational bonds often seem to become more intense.

g. New roles for the older people

As suggested earlier, we may also see the development of collective change in the definition of what older people can and should contribute to society. For example, they may be seen as a resource for non-economic capital- - knowledge about relationships and history. They may be increasingly viewed as repositories of wisdom (Baltes and Smith, 1990).

Conclusion: Intergenerational Relationship and Support

Unlike many western countries, ageing in Bangladesh is becoming a new incident. The longevity of our country has exceeded 60 years, which is due to health awareness, availability of super specialty health centers, and reduced death/birth rates. The result is larger share of older population, which will pose several challenges in this millennium to the policy makers, NGOs and others involved in the care of the ageing.

Migration an inevitable event, to cities and other countries is causing severe stress on the joint family system, which did not affect the older generations till the small family norm was adopted. Hence this left the older people to often fend for them. Hence focused action plan in this direction is required and the Government along with NGOs should start moving in this direction. The launching of intergenerational programs must include the goals to:

- i. Create bridges between generations to prevent alienation of older persons and lack of bondages of the younger ones.
- ii. Create an opportunity for the families to meet and participate in such meets at least every year.

- iii. Help seniors recall their past and this continue to contribute to the society
- iv. Help younger understand better the World of Seniors.

Intergenerational programs foster mutual respect and understanding between younger people and seniors, in innovative and positive ways and raise awareness and promote value for one another (Gangadharan, 1999: 27). Intergenerational relationship and support has to be consciously developed keeping in mind that where healthy older persons are involved, programs and activities that promise sustained amity between generations must be organized.

Ageing: An Ecological Approach

Gerodynamics is not a widely used term. The meaning of the word is the dynamics of ageing. Earlier the explanation of ageing from biological, psychological and sociological point of view was based on static properties. But, in recent time the study of ageing issues are changing.

Understanding the dynamics of ageing is a very complex task. This may explain the trend to study limited aspect of human ageing and generate micro theories. Ageing process is a complex process. Dynamics of ageing can be viewed by different theories. Among them, general system theory dynamic system theory, Biological explanation psychological explanations are the main. But Ecological perspective of understanding the dynamics of ageing i.e.; gerodynamics is the most potential side of understanding ageing.

Since the beginning of the century, about 30 years have been added to the average life expectancy, at least in developed countries. The dynamics of human ageing sets a probabilistic maximum life span potential of 120 to 130

years, which is only remotely genetically influenced. The combination of these data calls for an ecological perspective on the dynamics of ageing (Yates and Benton, 1995). In this context, Birren and Schroots (1996) use the term ecology of ageing to refer to the fact that individual not only express their genome, but also the expression is done in interaction with particular physical and social environment.

The ecological perspective raises some questions with regard to the pattern of transformations over the individual life. In principle, this pattern is determined by internal (biological, psychological) and external (or environmental).

Heikkinen (1995) have developed a model of environmental factors, which affect the ageing process. The factors are well-known, socio-economic status, education, life-style, diet, living condition labor situation and geographical region. But it is extremely difficult to determine due range of environmental influences.

So, in concluding remark we can say that understanding gerodynamics is very complex task. It is to be planned. Cross-cultural, longitudinal studies of ageing can provide better understanding of dynamics of ageing. After all the next century demands of us more integrative thought and more innovative research that can be used to optimize health and competence to maintain independent living and quality of life. Environments for growth, learning and moving toward creative fulfillment should be within the reach of all. What we are learning today about the extraordinary range of abilities and interests of older persons can help us in the task of creating such environments and remove obstacles for new generations (United Nations, 2001).

Ecology of Ageing: Bangladesh Perspectives

Bangladesh is the most densely populated country in the world and one of the world's poorest and least developed countries. Decrease in fertility rate and improvement in life expectancy have led to rapid increase in the number of older people in Bangladesh 6 per cent of the current population or 7.3 million, expected to increase 17.3 per cent by 2024. Gender inequality and discrimination against women is widespread in Bangladesh. The majority of the older people in our country cannot meet their most basic needs and food in the top priority need. The health status of older poor is very much vulnerable and the lack accesses to basic health care and sanitation facilities. Older people are excluded from services and support system.

Our environmental profile is not sound at all. We are one of the most environmentally degraded countries in the world. We are facing severe air and water pollution and losing our forest area rapidly. Our emission level of carbon dioxide is very high.

Northern region of Bangladesh is under threat of desertification. In this crucial situation how will be our rapid growing older population will match with the situation poses a big question. What will be the nature of our climate and how will the older people adopt with the climate, what will be the nutritional and other ecological condition of our older people?

The intensity of ageing problem and environmental problem will very much severe in future. The interaction effect of the problem will be much more threatening for our future generation.

So, in our policy level, high concentration should be given for understanding the problem by proper research and policy should be formulated to tackle the problem.

Ageing and its Classification: Bangladesh Perspective

In Bangladesh, about 78 per cent of the total population lives in rural area. Therefore, majorities of the older population live in rural area. Thus grossly the total older population can be classified into two; rural elderly and urban older population. However, these two can further be classified into two and three types respectively (a) rural poor and (b) rural affluent; (c) urban poor, (d) urban middle class, and (e) urban rich. There is one more group, i.e., special category exists in Bangladesh (Rahman, 2000) for older women, handicapped, widowed, divorced etc. The population belongs to this category is very much vulnerable and should be addressed with special care from the society, community and from the country in a broader spectrum.

The condition of rural and urban older people is very bad. They live in abject and absolute poverty, and do not have their regular sources of income with ill health, illiteracy and malnutrition as the common phenomena.

Rural affluent older people generally live in extended family. They live in society with full dignity as they are engaged in some sorts of social works. Urban middle class older persons, who also live in extended family, enjoy almost the same facilities as of the rural affluent, in spite of the urban political and administrative complexities, anxiety, exclusion, economic hardship that they face. On the other side, most of the urban riches are highly educated, retired high officials, owners of big trading houses, assets, savings etc. Although these people do not have any financial problems or acute health problem, they have very few numbers of descendants to take care off them. Most of their successors are migrated to other countries or another places (Rahman, 2000).

Ageing and Development

The Vienna International Plan of Action on Ageing distinguishes between humanitarian and development aspects of ageing problems. Development (evolution) and ageing (involution) are considered to be the simultaneous and ongoing processes which are essential parts of life from conception to death. These processes depend on various factors, personal, family and community lifestyles, historical, economic and socio-

Box 3 : Ageing and Development

Older people, typically characterized as economically unproductive, dependent and passive, have been considered at best as irrelevant to development and at worst as a threat to the prospects for increased prosperity (HAI, 1999, p.4).

cultural circumstances. These occur not as an optional part of life but work as an integral part, whether we want or not whether we are aware or not, whether we recognize or deny and we develop and age from beginning of our birth until death (Ali, 1996).

For the past fifty years, development policy has been focused on achieving economic growth and increased productivity. Older people, typically characterized as economically unproductive, dependent and passive, have been considered at best as irrelevant to development and at worst as a threat to the prospects for increased prosperity. As a result, Development policy in the post war era has excluded and marginalized people purely on the basis of their age (HAI, 1999: 4).

Older people's great capacity for productivity, independence and active involvement in the development of their communities and countries has been all too frequently overlooked. The benefits of older populations- the wealth of skill and experience that older people bring to the workplace, to public

life and the family- are hardly noticed. All over the developing world, older people make an 'invisible' contribution to their families and society at large, performing domestic tasks and caring for children and sick or disabled adults so that other members of a household may engage in 'visible' economic activity (*HAI, 1999: 36*). In addition, older people engage in a range of income-earning activities in the informal sector, which contribute the household economy but are rarely acknowledged, or are seen only as 'reducing the burden' of their presence.

A growing concern about demographic change in the South has begun to drive a new attitude towards ageing. Now in the midst of an ageing revolution, which will have its primary impact in developing countries the needs and capacities of older people are starting to appear on the global development agenda (*HAI, 1999: 3*).

Ethics and Gerontology

The gerontologists are used to analyze ageism from the ideological framework. Even though, few consider it is time to avert the profound transformations that have taken place and recognize the ethical background that has originated most of the new reality. Our society, on one hand, becomes age-organized i.e. organized according to age, but on the other hand the formerly social roles associated to age, have become relative. Thus the aged are included into the social disposition separated in peer groups. Hence, there are no rigid frameworks that suppose stereotypes about the aged person's behavior. Thus the ethic is discovered and that is the foundation of gerontological speech: to include the older person in the same general demands imposed to any human being, leaving aside the idea of a different subjectivity e.g. The older persons do not have sexual desire, or the

older persons do not think as the other people. The idea of the subjectivity of the older people, radically different from the rest of the human beings, has been the foundation of the generalization all the older people in the concept of the older persons (Jacub, 1999). This misconception generates the greatest prejudices, and this appears the other to idealization or of denigration. So, one's particular desire gets lost in a stereotyped manner.

Pro-modernity broke those patterns, deconstructing the assumptions linked to age, giving birth to new models in which discontinuity and fragmentation are a constant. These changes have determined that an aesthetic in old age is starting to be included in a new manner in the Western society. Even though it does not appear as an age related trait, only in its similarity to the general aesthetic order, that is as always that of youth. Nevertheless we can see now a day the Beauty Contests for the older people, and a complete circuit of sensual desire, until now forbidden and denigrated.

A new body is now being seen in the social scenery that will undoubtedly determine several opportunities for this new corporal disposition that mainstreams to other social groups above their age condition. This is the reason gerontologists should think a new corps of ideas in order to anticipate the formation of an autonomous group, whose members share a common pathos: their ageing (Jacub, 1999). Without altering the inclusion of the older persons within the social demands that allow the inter subjectivity.

A New Vision of Ageing

In Western Australia there is a strong commitment to invest in older generation add value to the whole community. They view their seniors as

one of the most value resources, with a wealth of knowledge and experience at their disposal.

They are a growing resource. Today they comprise 14 per cent of the total population in 2021 will make up almost one quarter of the same. The people aim to develop a Western Australia for all ages, where seniors can lead safe and independent lives, where the relationships between the generations continue to strengthen and our older people find fulfillment their later years (Parker, 1999: 17).

The Western Australian Government is taking a strategic approach to realize vision and thereby developed a five year plan on Ageing underlined by the principle of encouraging respect, independence, responsibility and opportunity for the seniors. The Plan sets the pace for all sectors of government, business and individual themselves to contribute to positive ageing, to create an environment that enables seniors to continue to develop and learn in their later years. Older people, or everyone else, never stop wanting to be all they can be (Parker, 1999: 17).

C h a p t e r T h r e e

CHARACTERISTICS OF THE OLDER PERSONS WITH REFERENCE TO THE BANGLADESH POPULATION

'Young people make rice, old
people make merit'

Older man, Kampot, Cambodia

Chapter Three

Characteristics of the Older Persons with Reference to the Bangladesh Population

Introduction

Bangladesh, an irregularly shaped and low-laying country, has an area of 55,598 square miles of which river area is 3,024 square miles and forest area is 6,387 square miles leaving an effective area of 46,187 sq. miles (United Nations, 1981). The most significant feature of the landscape is the extensive network of large and small rivers. The river system provides drainage, determines the kind of agricultural production, furnishes vast supplies of fish, forms an unparalleled grid of inland waterways for cheap and convenient transportation and continually fertilizes much of the country. At the same time, this great river system is the country's greatest hazard. Seasonal flooding often brings widespread loss of life, crops and property. Cyclones from the Bay of Bengal occasionally intensify seasonal flooding to the point of major national disaster.

Trends in Bangladesh Population

The total population of Bangladesh as estimated from the censuses of 1901 to 2001 with the intercensal increase and the average annual rates of growth is shown in the following table:

Table 3: Population in census years 1901 to 2001

Census Year	Enumerated Population	Intercensal Increase	Percentage Increase	Average Annual Growth Rate
1901	2,89,27,78	19,17,786	7.10	0.69
1911	3,15,25,056	25,97,270	8.98	0.86
1921	3,32,54,096	16,99,040	5.38	0.52
1931	3,56,04,170	23,50,074	7.07	0.69
1941	4,19,97,297	63,93,127	17.96	1.66
1951	4,19,32,329	- 64,968	- 0.15	- 0.02
1961	5,08,40,235	89,07,906	21.24	1.96
1974	7,14,79,071	2,06,38,836	40.59	2.64
1981	8,71,20,000	1,56,40,929	21.88	2.35
1991	11,14,55,000	2,43,35,000	27.93	2.17
2001	12,92,47,233	1,77,92,233	15.96	1.48

Source: 1. Sattar, M. A. (1981). Sex and Age Composition of the Population. Country Monograph Series No. 8, Population of Bangladesh, ESCAP, United Nations, Bangkok, Thailand.

2. BBS (1991), *Census Report*, Dhaka.

The total population of Bangladesh is about 129.25 million. The longevity of the people is rising and consequently, the number of the older people is increasing. In the period between 1911 and 1991, there has almost been a four fold increase in the number of older persons. During this period i.e. 80 years, the older persons i.e., 60 years and above has gone up from 1.4 to 6.1 million and it constituted about 5.4 percent of the total population in 1991

(Kabir, 1991 and Satter and Rahman, 1993). The mass application of immunization against infectious diseases, improvements in nutrition and relatively better quality of life have brought about remarkable changes in the age structure of population in Bangladesh. The existing life expectancy at birth is 56.5 per cent for male and 55.5 per cent for female in Bangladesh (Sarker, 1998).

Trends in Older Population

During the last century, the population 60 and over was increased by about 1.4 percentage points. The trend of older population in Bangladesh reveals a somewhat J-shaped one. As identified by Dr. Mian overestimation of census figures resulting from age misreporting may be the explanation of this J-shape trend.

As reflected from the graph, the trends were observed to be decreasing during 1911-1931 and then increasing onwards. According to Dr. Mian, though the life expectancy at birth showed a decreasing trend in Bangladesh during the period between 1901 and 1921, it had a lagged impact on the proportion of the older people, the lagged period being 60 years. He noted that the influenza epidemic during 1918-19, the economic crisis originating in World War I which resulted in a sizeable migration from Bengal to Assam, and the non-corporation movement of 1920-21 which affected the census enumeration of 1921 have got to be taken into consideration for explaining the decreasing trends in the percentage of aged population during the period between 1921 and 1931.

Table 4: Older population in census years 1911-1991

Census Year	Older (60+) Population as a % of the total population	Total Older Population	Intercensal Increase	Percentage Increase
1911	4.36	13,74,492	---	---
1921	4.04	13,43,465	- 31,027	- 2.26
1931	3.21	11,42,894	- 2,00,571	- 14.93
1941	3.69	15,49,700	4,06,806	35.59
1951	4.43	18,57,602	3,07,902	19.87
1961	5.22	26,53,860	7,96,258	42.86
1974	5.68	40,60,011	14,06,151	52.99
1981	5.63	49,04,856	8,44,845	20.81
1991	5.42	60,40,861	11,36,005	23.16

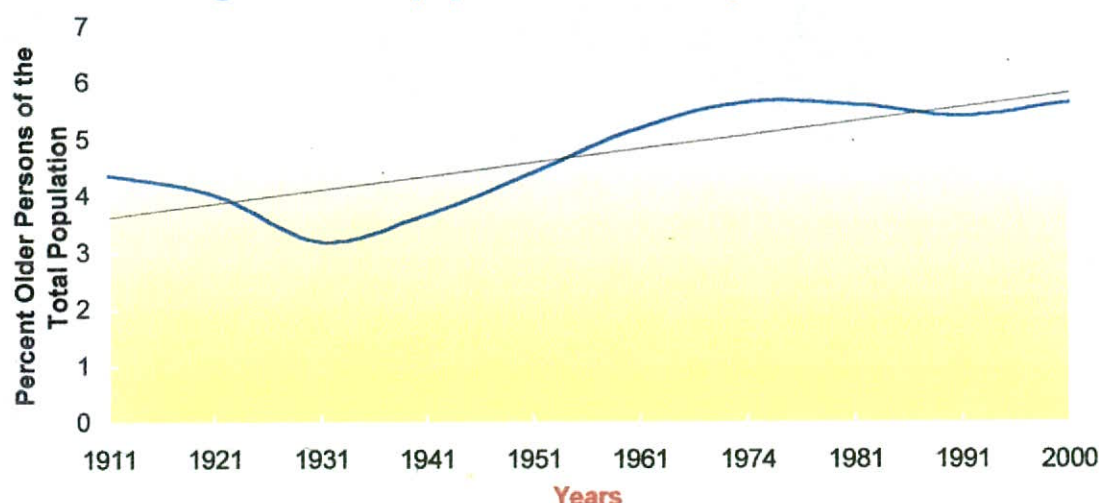
Source: 1. Sattar, M. A. (1981). Sex and Age Composition of the Population. *Country Monograph* Series No. 8, Population of Bangladesh, ESCAP, United Nations, Bangkok, Thailand.

2. BBS (1991), Census Report, Dhaka.

Extended Medicare facilities, import to western medical devices, which had a considerable impact on the death rates at all ages as well as life expectancy at birth, were mainly responsible for the dramatic growth of the aged people in Bangladesh. In spite of Bengal famine in 1943 that caused approximately 2.5 million deaths, partition of India, cyclone and tidal wave in 1970 that snatched about 2-5 hundred thousand lives, war of independence, famine of 1974 and regular natural disasters, older population of Bangladesh had

increased steadily since 1931. In 2000, they constituted 5.67 percent of the total population (United Nations, 1981).

Figure 5: Older population in census years 1911-2001



Demography of Ageing in Bangladesh

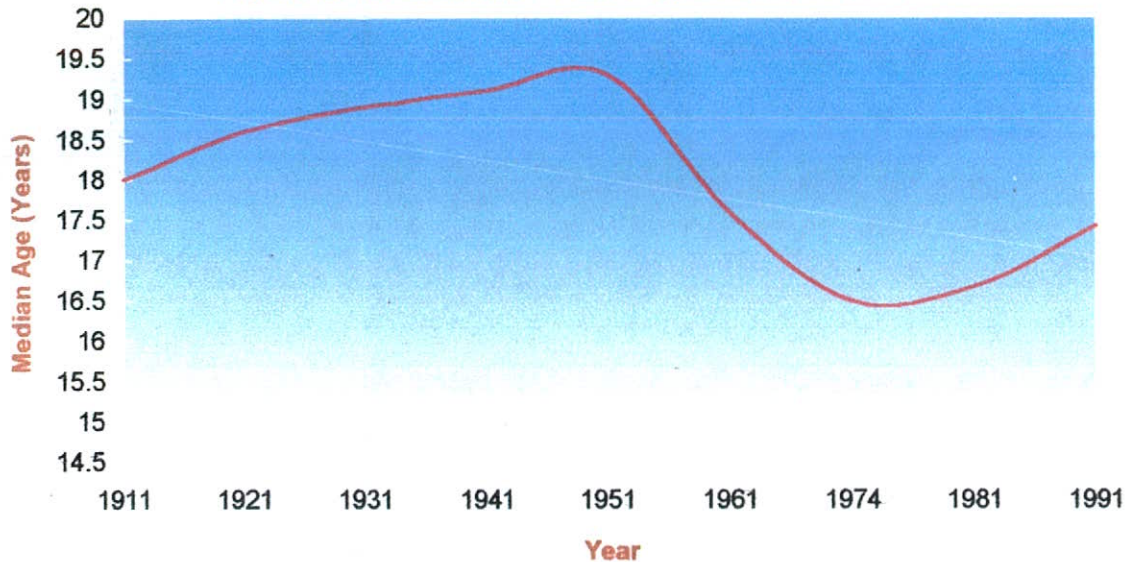
Median Age

Median age is one of the simplest indicators of age structure. This is the age at which the population of a society is divided into two equal parts—one half younger than the median age and the other half older. For the total population of Bangladesh for censuses taken in the 20th century, it is found that Bangladesh had a low median age with a range of 16 to 19 years (Rahim, 1969; Sattar, 1981; Kabir, 1994).

Table 5: Median Age of the Population, 1911-1991

Year	Median Age (Years)
1911	18.0
1921	18.6
1931	18.9
1941	19.1
1951	19.3
1961	17.6
1974	16.5
1981	16.68
1991	17.43

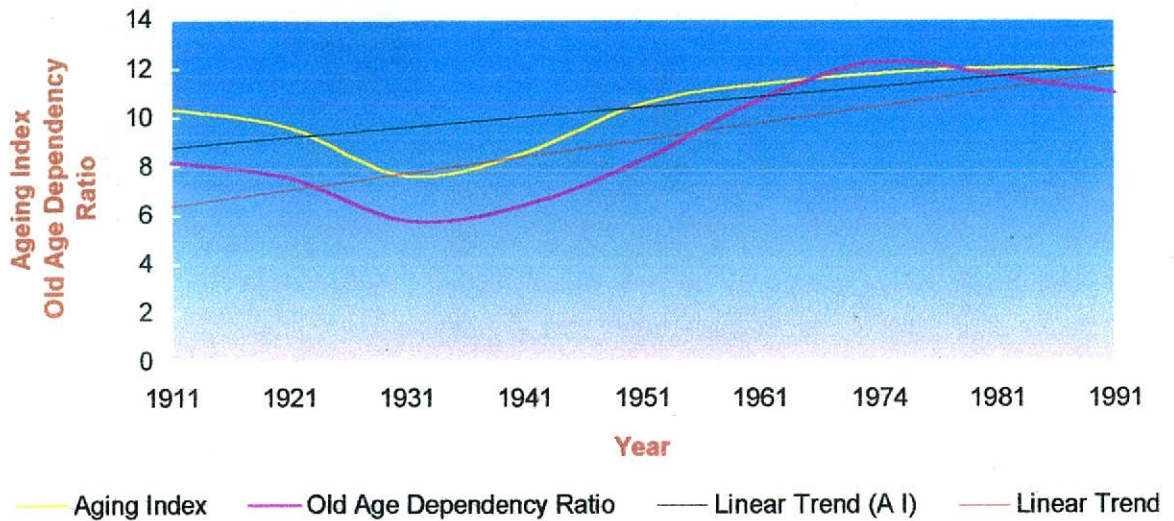
Source: Same as before

Figure 6: Median Age of the Population, 1911-1991

It can be discerned from the table that the population is young in that the median age remained at less than 20 years. Over time, the median age rose from 18.0 to 19.3 years but declined subsequently to 16.5 years, improvement in mortality, particularly in childhood with the control of infectious diseases, accounts for this decline. Since 1974 the median age started to increase substantially.

Ageing Index

Ageing index indicates the number of persons aged 60 years and over per 100 young population 0 to 14 years of age. As shown in the table, it was 10.35 in 1911 and started to decline until 1931 to reach 7.64. Then it began to increase and reached 12.02 in 1981.

Figure 7: Ageing Index and Old Age Dependency Ratio, 1911-1991

Old Age Dependency Ratio

The Dependency Ratio is a simple statistic measure of the impact of the age composition on the economic potential of the population. It includes how many economically active workers there are compared to that of non-economic non-workers. Dependency ratio is usually defined to be the

Table 6: Ageing Index and Old Age Dependency Ratio, 1911-1991

Year	Ageing Index	Old Age Dependency Ratio
1911	10.35	8.18
1921	9.61	7.55
1931	7.64	5.82
1941	8.56	6.42
1951	10.57	8.29
1961	11.35	10.72
1974	11.80	12.28
1981	12.02	11.72
1991	11.96	11.00

Source: Same as before

number of persons of age 60 years and above per 100 persons of working ages 15 to 59. Though this percentage is normally used to denote the

burdening of the productive population due to age consideration but in reality in developing countries like Bangladesh, many persons aged above 60 years work hard to earn their livelihood and many children under 15 years do various types of works to support themselves and their family members (Sattar, 1995).

Old age dependency ratio has increased considering over the census years in 20th century. In 1911, the old age dependency ratio was 8.18 percent, which means that there were about 8 persons over age 60 for 100 persons between the ages of 15 and 59. In 1951, this ratio was 8.29 showing a slight increase during the period and continued to increase in a faster rate to reach the figure 11.00 in 1991. This increasing tendency made the young wage earners responsible for caring for the older persons.

Table 7: Crude Death Rate

Year	Crude Death Rate per 1000 population
1901-1911	45.6
1911-1921	46.3
1921-1931	41.7
1931-1941	37.8
1941-1951	40.7
1951-1961	29.7
1961-1974	19.4
1981	11.5
1990	11.3

Source: Same as before

Table 8: Expectation of Life at Birth

Year	Expectation of life at birth
1901	23.7
1911	22.9
1921	20.1
1931	26.7
1941	31.8
1961	48.1
1974	46.2
1980	56.9
1990	55.4
2000	60.7

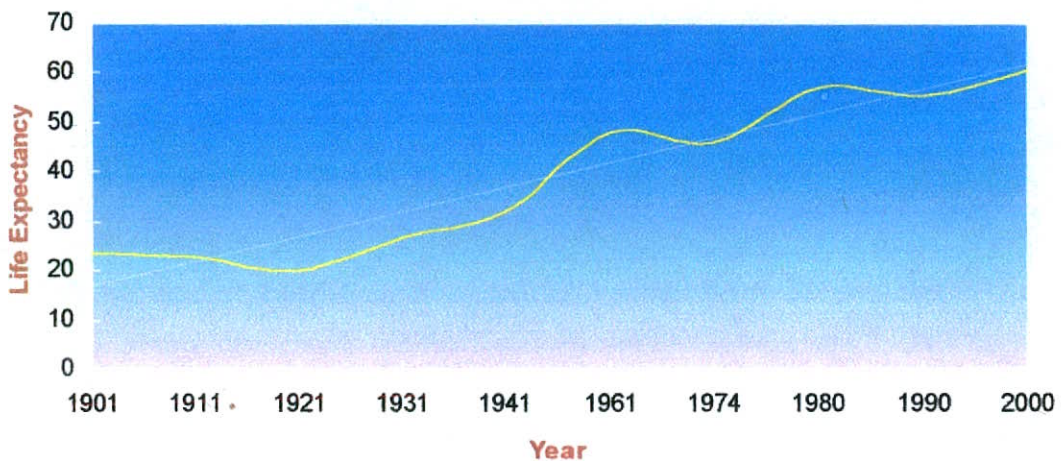
Source: Same as before

Crude Death Rate and Expectation of Life

In the 20th century, there has been a remarkable improvement in crude death rate in Bangladesh. It has been rapidly leveled off at or just above 10 in the 1980s (BBS 1990, p.64), while the birth

rate has not come down so much either before the 1980s or in the 1980s-33.2 in 1988. As a result, expectation of life has increased and more and more peoples are surviving into their advanced ages of life. Over the last 100 years, expectation of life has increased about 37 years. This increase in the expectation of life in Bangladesh has contributed to a greater extent to the gradual rise in the numbers of older people.

Figure 8: Expectation of Life at Birth, 1901-2000



One important reason for life expectancy rising is that those who used to die are not dying yesterday, but are not dying today, are those at childbirth and those in the first four years of life. The imported western medical technology and persistent improvement in public health facilities over the years have been mainly contributing to this (Kabir, 1994).

Further Population Scenario of Bangladesh

Bangladesh Population is both ageing and younging. While the dominant trend throughout the nation's history has been one of younging due to higher fertility, the post 1950 period added an ageing tendency due to persistent

improvement in mortality rates (Kabir, 1994). In 1991, 45.35 per cent of the total population was under 15 years and 5.42 per cent was 60 or over. These numbers became 32.61 per cent and 5.54 per cent in 2001 and will be 24.33 per cent and 6.75 per cent in 2011, 24.8 per cent and 8.9 per cent in 2021, 21.3 per cent and 12.4 per cent in 2031, 16.6 per cent and 16 per cent in 2041 and 18 per cent and 23 per cent in 2051. Thus population pyramids will shift to population column. This increased number of older population increases the dependency ratio, the relationship between the proportion of the population that is involved with work force and the population that is not in the work force.

Table 9: Projected total population, age specific population, older population and percentage of older population, 2011-2051.

(in million)

year	Projected Population	0-14 years population	15-59 population	60+ population			Percentage of older population
				Female	Male	Total	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
2011	148.6	36.15	102.44	4.77	5.26	10.03	6.75
2021	169.1	42.00	111.96	7.27	7.28	15.09	8.90
2031	182.3	38.90	120.93	11.70	11.82	22.52	12.40
2041	188.4	33.12	125.07	15.18	15.07	30.25	16.00
2051	192.3	34.78	112.55	22.29	22.66	44.95	23.00

Source: Islam, 2001. *Demography and Economics of Ageing*.

The above table shows the projected older population that will be 10.03 million in 2011, 15.09 million in 2021, 22.52 million in 2031, 30.25 million in 2041 and 44.95 million in 2051.

The main factors that are contributing to induce the ageing process in Bangladesh are the demographic factors: downward trend of fertility and mortality rates. Besides, economic factors, rapid urbanization and the improvement of health care facilities to some extent are also influencing directly or indirectly to the process of ageing in Bangladesh (Kabir, 1999). Of all the factors, the effects of mortality reduction is the vital one and the following reasons lend support to believe that the age structure changes is contemporary Bangladesh shifting from fertility-dominated to mortality-dominated ageing (Haque, 2001):

First, the fertility decline has been plateau reaching the neighborhood of the replacement level that is total fertility rate (TFR) is about 2.1. In Bangladesh, since 1993 it has been leveled off at 3.3. Mortality, on the other hand, has been declining without a significant slow-down.

Secondly, significant mortality reduction can be achieved only at old ages. In general, mortality decline contributes to the growth of population of all age groups. This feature of mortality decline usually dilutes its effects on the age distribution, because the age composition remains constant if all age groups grow at the same rate. However, as death rates at young ages are becoming small, room for significant mortality improvement is left only for old ages. Moreover, old-age mortality due to degenerative diseases is now on a substantial decline.

Finally, the population ageing itself strengthens mortality effects on the age structure. Although fertility effects on population growth are pronounced at young ages, mortality effects tend to be stronger at older ages. However,

when the proportion of population at old ages is very small, even a large proportional growth of the age group may change the entire age distribution only slightly. An increasing proportion of the older population amplifies the impact of mortality reduction on the ageing of the entire age structure (Yu and Horiuchi, 1991).

Kinship Structure in Bangladesh

Kinship is one of the most important social institutions which interlock the people in affinal and consanguineal relationship in the concept of *atmyo*, *swajan* and *atmyo-swajan* (relatives and well-wisher) (Inden and Nicholas, 1977 and Aziz, 1979). The affinal relationship is related with marital tie and consanguineal relationship is with biological link (Schusky, 1972: 7). It should be pointed out that the term *atmyo* refers to the flexible word *atma* which means one's soul (Aziz, 1979: 25). People who are affinally related are considered *atmyo* in Bangladesh. On the other hand the word *Swajan* mean *nijerlok* (own people). People are consanguineally related is considered *swajan*. But the term *atmyo-swajan* is overlapping with both consanguineal and affinal relations. It indicates a relationship in reference.

A sociogram of a kinship structure is given below to give a clear idea of how the people of Bangladesh are interlocked in the concept of *atmyo*, *swajan* and *atmyo-swajan* (Aziz, 1979).

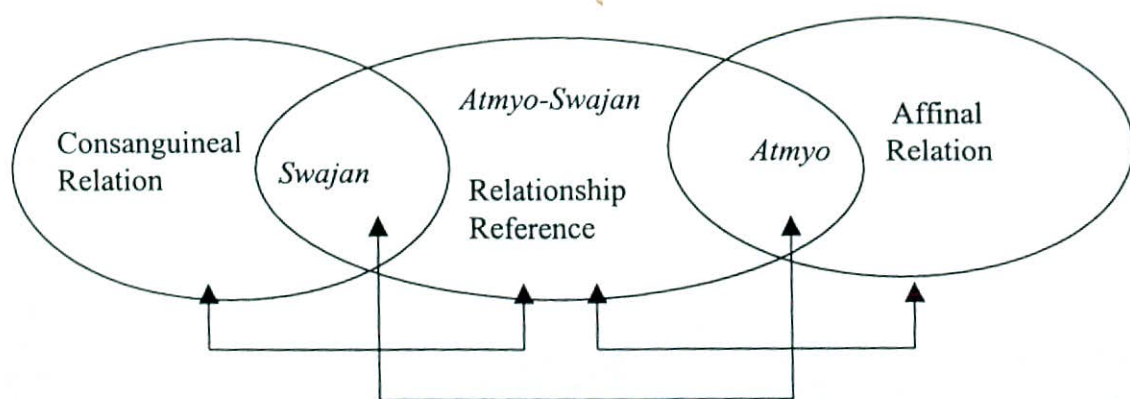


Figure 9: A Sociogram of Kinship Structure

Outside the affinal and consanguineal kinship relation there is a type of kinship system which may be termed as fictive kinship. There is a convention to establish fictive kinship in Bangladesh irrespective of religiosity, caste, sect and ethnic identity by ceremony or without ceremony which is called ritual fictive kinship in the concept of *dharma-atmyo* (Sarker, 1980: 55). Bhowmick (1976) found this term as 'ceremonial fictive kinship' in India. It is established for strengthening social and personal relationship in the community. The ritual fictive kinship is limited to such basic relations as *dharma-bap* (God father), *drama-ma* (God mother), *dharma-chhele* (God son), *dharma-meye* (God daughter), *dharma-bhai* (God brother), *dharma-bon* (God sister) and *bandhu* (friendship between two males), *soi* (friendship between two females) (Sarker, 1998). Mayer (1960: 140) found similar forms of ritual kinship linking among the Mawas in central India. The tie is extended to other members of the families of the involved parties but it does not close likewise the relationship which is developed through the affinal and consanguineal kinship system. Fictive

kinship is also found among the Muslims in Bangladesh through their marriage system. There is a compulsory provision in the Muslim marriage that a married man should be fond to act as an *ukil* (marriage pleader) for the bride. The *ukil* develops a fictive kinship tie with the bride or bridegroom and the members of his family orientation (Khan, 1984: 91). He becomes *ukil-bap* (marriage pleading father) of the bride and *ukil-shashur* (marriage pleading father in law) of her husband (Sarker, 1998).

A type of fictive kinship is also found among the neighbours irrespective of religion, ethnicity and class stratification which may be termed as *prati-beshi-shamparka* (neighborhood relations). It should be noted that in the system of neighborhood relations, the people address to each-other by using the kinship term as it would use in consanguineal and affinal relations. Vatuk (1972: 168) observed this fictive kinship which is established between the people of neo-locally resident in the neighborhood in the city of Meerut in India. This fictive kin relationship is also associated with age, sex, and fictitious relations with the other members of the family of the concerned parties. It is simply a verbal commitment of the parties concerned in connection with the existing customs, values and norms of the society. The fictive kinship is basically a relationship between two persons – a dyadic contact in Foster's (1972) sense of the term. If separation between the two is caused by death or maladjustment, the kinship does not continue as it would in consanguineal and affinal relations (Sarker, 1998).

Economic Activities of the Older Persons

In Bangladesh, census reports count economically engaged people from age 10 (ten). Several studies show that participation of older persons in paid and unpaid labor is reported to be high. More than 70 per cent of the older men are active in paid labor and a high proportion of the older women contribute through unpaid labor, mainly household work. Based on the Labor Force Survey (LFS) of 1995/96, 51 per cent of the country's population aged above 55 years was active in labor force. This is compared to country's overall labor force participation rate of less than 70 per cent. Amongst population aged between 60 and 64 years, labor force participation rate has been estimated at 55 per cent, and 44 per cent for those aged above 65 years. Such a high participation of older population in labor force has been consistent over time (Mahmood and Islam, 1997).

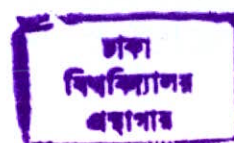
Table 10: Labor Force Participation by Age, Sex and Place of Residence

Year and Age Group	Bangladesh			Urban			Rural		
	Both Sex	M	F	Both Sex	M	F	Both Sex	M	F
55-59	57.85	96.05	14.38	58.33	93.43	16.52	57.74	96.70	13.90
60-64	55.22	88.56	11.44	51.59	77.46	12.17	56.03	91.22	11.18
65 +	43.65	70.18	8.37	32.20	54.26	2.65	46.04	73.51	9.57
Total	51.31	83.06	11.16	45.38	73.30	9.96	52.42	85.29	11.39

Source: Bangladesh Bureau of Statistics (1996). *Report on Labor Force Survey*, Dhaka.

400489

Older persons, male and female, both in urban and rural areas, do work to earn livelihood. Of which majority are employed in agricultural sector thus limit the productivity of older persons due to lack of access to credit and



subsidies. The table delineated below reveals the work status of the older men and women by area:

Table 11: Work Status of the Older Men and Women by Area

(in Percent)

Work Status	Urban			Rural		
	Women	Men	Total	Women	Men	Total
	n = 140	n = 208	n = 348	n = 172	n = 180	n = 352
Paid	21.3	74.4	12.8	72.2	52.9	43.2
Unpaid	64.5	18.4	81.4	24.4	37.1	52.3
None	14.2	7.2	5.8	3.3	10.1	4.5

Source: Kabir, Zarina Nahar. *Social Protection System for Older People in Bangladesh*, Internet.

Health and Family Welfare Service Network

Health and population service facilities are now more or less available at every level of public administration in the country covering large number of population by each type of service.

The health sector is predominantly labor intensive, but it also includes a large variety of skills to support and manage a wide range of health care services. This is evidence by the large number of health professionals engaged in various types of work. As on June 1996 a total of 78,928 staff positions of different categories were sanctioned under revenue head of the Directorate General of Health Services. Of them, 9,209 were class-I positions, 637 were class-II, 48,809 were class-III and 20,273 were class-IV. A total of 72,333 positions were filled. Of them, 55,705 were male and 16,628 were female. The total number of female employees constitutes 21 per cent of those in position (Haider, 2001).

Table 12 : Level of Care and Type of Health Facility

Level of Care	Administrative Unit	Health Facility	Population
Tertiary Referral Level	Division (6) or district	Teaching/Specialized Hospital/Institute (43) 100-1050 beds each	10-15 million
Second Referral Level	District (64)	District Hospital (64) 50-150 beds each	1-2 million
First Referral Level	Thana (460) Rural: 397, Urban thanas for not have THC	Thana Health Complex (THC) with 31 beds each (400)	200,000 to 450,000
First Level Health Facility	Union (4403) UH&FWCs are not established in 397 Unions where UHCs exist	Union Health and Family Welfare Center (UHFWC) Target to be achieved by 2000: 4403	21,000
First Contact with Health Providers	Ward (13,209): One Community Clinic per 6000 population	Community-based each with : • One Family Welfare Assistant (FWA), and • One Health Assistant (HA)	7,000
		Trained Birth Attendants (TBA) and Village Health Volunteers (VHV)	1,000 to 1,500

Source: Haider, 2001. *Assessment of Bangladesh Health System Performance as a Measure to Alleviate Poverty and Improve Quality of Life*, Partnership Agreement on Poverty Reduction between ADB and GOB. READ, Dhaka.

Chapter Four

SOME STUDIES ON AGEING ISSUES IN BANGLADESH: A RETROSPECTIVE

'Who you are, we were;
Who we are, you will be!'

Appeal message in Latvia

Chapter Four

Some Studies on Ageing Issues in Bangladesh: A Retrospective

There had been few research on the socio-economic and physical wellbeing of the older persons as well as factors intervening in the process of ageing in Bangladesh. Also studies on the problem of ageing are very much limited both in number and depth (Mian, 1996). Consequently, there is a scarcity of literature on the older persons in Bangladesh. Older people encounter various problems. Nature and dimension of these problems are associated with the socio-economic, educational and health back ground of the older people. In depth study is, therefore, required to identify the problems and their correlates with a view to chalk out proper plans for the older people in general so that they may be treated as assets of the society rather than liabilities (Mian, 1996).

Population Division of ESCAP has undertaken a series of studies in Asian and Pacific countries during 1992-94 mainly on the economic potentiality of the older people with a very limited coverage. However, some social scientists and non government organizations, especially the Social Science Research Council (SSRC) of the Ministry of Planning, National Institute of Preventive and Social Medicine (NIPSOM), the Bangladesh Association for the Aged and the Institute of Geriatric Medicine (BAAIGM), and Centre for Policy Dialogue (CPD), meanwhile have made a good beginning.

The life span of human being can be divided into four phases i.e. childhood, adolescence, adulthood and old-age. During the first two spans, persons

usually remain under the care and protection of the parents. In the third span, he or she is self-dependent under the existing socio-economic system and state laws and provides shelter for the dependents (Sarker, 1988: 50). The fourth and last span of life, which is indeed crucial, solitary and is characterized by a loss in vitality and a return to the state of dependency upon children, specially sons (Rahman et al., 1996). In western countries, there exist old-age security measures which are fostered by the state and voluntary agencies. But in our society and culture, the responsibility of older person lies with the children, especially on sons.

A recent study on *Social and Health Status of the Older Persons in Bangladesh* indicates that 91 percent of the older people lived either with, or adjacent to, a mature son. The kinship network allowed them to maintain the status within the household. The study showed that the traditional familial structure was prevalent and served as strong livelihood strategy. As revealed by the study, older men played a strong role as household heads whilst older women, including widows, tended to rely more on their sons. There were, however, a growing number of female-headed households which constituted about 6 to 7 percent of total households; some of these households were supported by a non-resident household member (Abedin, 1999). At the same time, another study found the changing attitude of the children as regards the duty towards parents as the major cause responsible for the erosion of social position of the older persons.

Every society until recent times had accorded respect to the older people. Indeed aging and wisdom were directly related and the junior members in the family or the community were ordained to take advice from the senior members almost on all matters. Even in the primitive tribe the older people

were the object of respect as the 'senior' who knew when and where crops grew, how to catch fish, how to hunt game, how to execute a plan for survival, etc. Thus the senior was the primary social link. In the agrarian order the role and the status of the older people remain quite different from that in the contemporary modern setting (Ali, 1996). In the modern urban and industrialized communities knowledge and experiences are transmitted through formal institutions such as schools, colleges, libraries and different mass media. The older people are thus considered to possess outmoded knowledge which is no longer relevant and out-of-date having any use in the current modern age.

To show respect to the older people is the traditional culture of the people of Bangladesh. This is also reflected in the epic and several literatures. It is a learned behavior which is transmitted from one generation to another and more specifically from presents to children and teachers to students. Honor has been shown to the older people because of their rich experience and to solve problem at the individual, family and societal levels (Sarker, 1998). The older persons were most privileged members in the family as well as in the society in the network of kinship relations. They were the heads of the family and central figures enjoying the highest status. Major decisions relating to family affairs were used to be made by the older persons in consultation with other members. Respect to the older persons in the family as well as in the society was not only because of centralized authority in their hands but also for being the well wisher for all. Consequently, the responsibility to take care of the older people was vested upon the children especially on the sons and others who were involved in kinship network relations in wider perspective (Sarker, 1998).

Another important study undertaken in Bangladesh under the project *Local Level Policy Development to Deal with the Consequences of Population Ageing* shows around 15 percent older persons do not own any home and 60 percent have ceased to work of which an overwhelming majority opined health reasons as the cause of not working. A remarkable portion of these older people showed interest to continue work for which they urged for financial assistance (Kabir, 1994). However, older persons who have landed property to support them or who have children to regularly remit money for them, suffer mostly from an acute sense of loneliness and helplessness. Previously rural market place provided an opportunity to the able bodied holder male to recreate and socialize through gossips but the opportunity is being reduced.

One of the correlates of the problem of ageing may be thought of as physical distance between generations. Job market is mainly concentrated in urban centers. Cultivable land is not in a position to support the off-springs. Hence the off-springs are bound to move to urban centers for their livelihood leaving behind their old parents in village home. For this reason off-springs can not look after their old parents except sending some money for them (Mian, 1996). Creation of rural employment opportunity and planning of decentralized economy can minimize the physical distance between the older parents and their off-springs to a great extent and thus minimizing the problem of the rural older at least to some extent.

A social survey conducted on the socio-economic condition and problems of the older persons in Bangladesh notify that the problems of rural older people are mainly physical and economical whilst their urban counterpart faces some psycho-social problems in addition. For them, today, the

situation has become tough due to lack of health services, increase in inflation rate, loneliness, social negligence and so many other negative factors (Rahman, 1990).

Kabir (2001) has recently been pursued her Ph.D. dissertation on the topic "The Emerging Elderly Population in Bangladesh: Aspects of their Health and Social Situation." According to her,

More than 95 percent of the older people reported experiencing health problems and most reported multiple health problems. More health problems were reported by women compared to men and in the rural region compared to the urban. Socio-economic factors were found to have little influence on reporting of health problems.

Several projections were made of the increasing and probable number of older persons in the coming years in Bangladesh. It was assumed that, in the coming decades, many Asian countries including Bangladesh would experience population ageing, and the ageing population would be large in absolute numbers. Under the assumption that replacement fertility would be achieved in Bangladesh by 2005, it was projected that the number of older persons might increase 14.6 million (about 9 percent of the total population) by the year 2025. On the other hand, if replacement fertility is achieved, say 10 years later then the population aged 60 years and above would be 6.7 million in 2002 and 12.5 million (7.4 percent of the total population) by the year 2025 (Kabir, 1999).

One of the major works that have been conducted in Bangladesh, so far, in the field of ageing is one done by HelpAge International (HAI) in 2000. In their study, several key findings have been depicted as follows:

- a. Poverty and exclusion are the greatest threats to the wellbeing of older people, and poverty sets the context for everything else older people experience.
- b. The health status of older people is poor and they lack access to basic health care and sanitation facilities.
- c. Poor older people report that families remain a primary source of support, but family support is undermined by poverty.
- d. Older women are more dependent on their families for survival than older men, which increases their vulnerability.
- e. Older people are excluded from services and support by NGOs and government, their exclusion is due to age limits on participation in programs or limited access.
- f. Most older people engage in some form of income generating activity as long as physically able.
- g. While older men face age barriers to employment opportunities, older women face both age and gender barriers.
- h. Older people continue to play an important (though unrecognized) role in the family, and make significant contributions to ensure the livelihood of the family. They themselves do not recognize their roles and contributions.
- i. Older people feel that decision-making authority within a household is based on the level of economic contribution, rather than the traditional norm of respect for old age.

However, of all the studies conducted till date, a very much far-reaching one is that was undertaken in 1988 by the Bangladesh Association for the Aged and the Institute of Geriatric Medicine (BAAIGM) on the health and other socio-economic problems of the urban vis-à-vis rural older people.

In a bird's eye view, the results show that of the various disease reported, the five most common ones with reference to the first response, which stood for the main ailment were: Pain, Rheumatism, Anemia/Weakness, Asthma and Cough and Cold. The overall prevalence rates of these diseases were 108, 90, 73, 55, and 49 per 1000 respondents respectively. 75 percent of the older persons had to face problems in respect of their treatment. The proportion of the respondents facing problems was the highest in rural areas and the lowest in the city: 81 percent vis-à-vis 63 percent. Furthermore, it was depicted by the study that the overwhelming majority of older persons in Bangladesh does not possess good health and are often sick. About 67 percent males and 79 percent females reported sickness, suffering from one or more disease, in many cases chronically. On an average about 25 percent had been suffering for over ten years, the greater proportion of these being female.

This basic study will, however, be considered as a landmark in the field of ageing in Bangladesh.

Chapter Five

UNITED NATIONS INITIATIVES ON AGEING ISSUES

'I never believed these poor older
people had anything to say. Now, I
have changed my mind and will
always consult them'

Government officer, Ethiopia

Chapter Five

United Nations Initiatives on Ageing Issues

Introduction

Ageing has been on the vital agenda of the United Nations since it adopted the Vienna Plan of Action on Ageing in the First United Nations World Assembly on Ageing in 1982 in Austria. The United Nations specialized agencies, especially the United Nations Population Fund (UNFPA), World Health Organization (WHO), International Labor Organization (ILO) etc. have also given attention to the problems of ageing in their respective fields of competence.

The Vienna International Plan of Action on Ageing, adopted in 1982 by the World Assembly on Ageing, and endorsed by the United Nations General Assembly in its Resolution 37/51, recommended, inter alia, the promotion of training and research, as well as the exchange of information and knowledge in order to provide an international basis for special policies and action. The UN Economic and Social Council, by its Resolution 1987/41 recommended to the UN Secretary-General, the establishment of the International Institute on Ageing. On the 9th October 1987, the United Nations signed an official agreement with the Government of Malta to establish the International Institute on Ageing as an autonomous body under the auspices of the United Nations. The Institute was inaugurated on 15th April 1988 by the then United Nations Secretary-General, H.E. Mr. Javier Pérez de Cuéllar.

International Plan of Action on Ageing

In 1982, the first World Assembly on Ageing at Vienna, Austria adopted the Vienna International Plan of Action on Ageing. This important document was endorsed by the General Assembly and is a very useful guide, for it details the measures that should be taken by Member States to safeguard the rights of older persons within the context of the rights proclaimed by the International Covenants on Human Rights (UNHCHR, 1995).

It aims to strengthen the capacities of governments and civil societies to deal effectively with the ageing of populations and to address the developmental potential and dependency needs of older persons. It promotes regional and international cooperation. It includes 62 recommendations for action addressing research, data collection and analysis, training and education as well as the following sectoral areas (United Nations, 1982):

- i. Health and nutrition;
- ii. Protection of elderly consumers;
- iii. Housing and environment;
- iv. Family;
- v. Social welfare;
- vi. Income security and employment; and
- vii. Education.

The plan is the part of an international framework of standards and strategies developed by the international community in recent decades. It should, therefore, be considered in relation to agreed standards and strategies in the

areas of human rights, advancement of women, families, population, youth, disabled persons, sustainable development, welfare, health, housing, income security and employment, and education (United Nations, 1998).

United Nations Principles for Older Persons

In 1991, nine years after its endorsement of the plan, the General Assembly adopted the United Nations Principles for Older Persons which, because of their programmatic nature, is also an important document in the present context (General Assembly resolution 46/91, 1991). It is divided into five sections, which correlate closely to the rights recognized in the covenant.

“Independence” includes access to adequate food, water, shelter, clothing and health care. To these basic rights are added the opportunity to remunerated work and access to education and training. By *“participation”* is meant that older persons should participate actively in the formulation and implementation of policies that affect their well being and share their knowledge and skills with younger generations, and should be able to form movements and associations. The section headed *“care”* proclaims that older persons should benefit from family care, health care and be able to enjoy human rights and fundamental freedoms when residing in a shelter, care or treatment facility. With regard to *“self-fulfillment”*, the Principle that older persons should pursue opportunities for the full development of their potential through access to the educational, cultural, spiritual, and recreational resources of their societies. Lastly, the section entitled *“dignity”* states that the older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse, should be treated fairly,

regardless of age, gender, racial or ethnic background, disability, financial situation or any other status, and be valued independently of their economic contribution (UNHCHR, 1995). In the same year, 1991, the United Nations decided to observe 1st October as the International Day of Older Persons.

Global Targets on Ageing

In 1992, the General Assembly adopted eight global targets on ageing for the year 2001 and a brief guide for setting national targets. In a number of important respects, these global targets serve to reinforce the obligations of State parties to the Covenant (Global targets on ageing for the year 2001: a practical strategy (A/47/339), chapters III and IV).

Also in 1992, and in commemoration of the tenth anniversary of the adoption of the Vienna International Plan of Action by the Conference on Ageing, the General Assembly adopted the Proclamation on Ageing in which it urged support of national initiatives on ageing so that older women are given adequate support for their largely unrecognized contributions to society and older men are encouraged to develop social, cultural and emotional capacities which they may have been prevented from developing during breadwinning years; families are supported in providing care and all family members encouraged to cooperate in caregiving; and that international cooperation is expanded in the context of the strategies for reaching the global targets on ageing for the year 2001. It also proclaimed the year 1999 as the International Year of Older Persons in recognition of humanity's demographic "*coming of age*" (General Assembly Resolution 47/5, 1992).

Older Persons and the Fourth World Conference on Women

The Platform for Action of the Fourth World Conference on Women clarifies that *“the risk of falling into poverty is greater for women than the men, particularly in old age, where social security systems are based on the principle of continuous remunerated employment...[.]..Moreover, older women also face greater obstacles to labour-market re-entry”* (para. 52).

Paragraph 101 states that, *“with the increase in life expectancy and the growing number of older women, their health concerns require particular attention...”* Paragraph 106 requests Governments to *“Develop information, programs and services to assists women to understand and adapt to changes associated with ageing and to address and treat the health needs of older women, paying particular attention to those who are physically or psychologically dependent”* (United Nations, 1996).

Government – NGO Cooperation for Older Persons

The Regional Seminar on Government-NGO Cooperation for Older Persons was convened by ESCAP in Macau from 16 to 19 June 1997. The main purposes of the seminar were:

- a. To review cooperation between governments and non-governmental organizations (NGOs) for older persons; and
- b. To identify measures for enhancing government –NGO cooperation for older persons and to adopt action-oriented recommendations for improved cooperation. This Seminar served

as an important step for both governments and NGOs to work out measures for the cause of older persons and to make joint efforts towards the achievement of the goals of the International Year of Older Persons (1999).

Macao plan of Action on Ageing for Asia and the Pacific

The Macao Declaration and plan of Action on Ageing for Asia and the Pacific, which was adopted on 1 October 1998, represented a regional benchmark in the field of ageing. By the endorsement of the plan of Action at the 55th session of the Commission in April 1999, the Asian and Pacific region became the first and, thus far, the only region in the world with a regional plan of action on ageing. The Plan contains concise recommendations and guidelines regarding seven areas of concern:

- a. the social position of older persons;
- b. older persons and the family;
- c. health and nutrition;
- d. housing, transportation and the built environment;
- e. older persons and the market;
- f. income security, maintenance and employment; and
- g. social services and the community.

Derivatives of the Plan and Principles: International Year of Older Persons

The General Assembly, on 16 October 1992, in recognition of the rapid ageing of populations in societies across the world, adopted resolution 47/5,

the annex to which contains the Proclamation on Ageing, by which it decided to observe the year 1999 as the International Year of Older persons. The theme of the Year is "*Towards a society for all ages*", with four dimensions:

- a. the situation of older persons;
- b. lifelong individual development;
- c. multigenerational relationships; and
- d. development and the ageing of populations.

The theme and conceptual facets for "1999" underscore the "lifelong" and "society-wide" dimensions of ageing. They point to the importance of policy investments in individual lifelong development in the context of longevity, and of coordinating the effects of population with other societal transformations such as globalization and the technological revolution (United Nations, 1998).

Second World Assembly on Ageing, 2002

The International Plan of Action on ageing 2002, adopted at the first World Assembly on Ageing in Vienna, has guided the course of thinking and action on ageing over the past 20 years, as crucial policies and initiatives evolved. It calls for changes in attitudes, policies and practices at all levels in all sectors so that the enormous potential of ageing in the twenty-first century may be fulfilled. The aim of the Plan of Action is to ensure that persons everywhere are able to age with security and dignity and to continue to participate in their societies as citizens with full rights. The Plan is intended

to be a practical tool to assist policy makers to focus on the key priorities associated with individual and population ageing (United Nations, 2002). The Plan of Action recognizes the many different stages of development and the transitions that are taking place in various regions, as well as the interdependence of all countries in a globalizing world. Hence, specific recommendations are designed to be adapted to the great diversity of circumstances in each country.

The Plan has recommended actions on the following three Priority Directions (PD): PD-I, Older persons and development; PD-II, Advancing health and well-being into old age; and PD-III, Ensuring enabling and supportive environments. Each priority direction has again addressed various specific issues. PD-I has encompassed eight different issues like active participation in society and development; work and the ageing labor force; rural development, migration and urbanization; access to knowledge, education and training; intergenerational solidarity; eradication of poverty; income security, social protection/social security and poverty prevention; and emergency situations. Similarly, PD-II has focused on six issues that are health promotion and well-being throughout life; universal and equal access to health care services; older persons and HIV/AIDS; training of care providers and health professionals; mental health needs of older persons; and finally, older persons and disabilities. In the PD-III, the issues are housing and the living environment; care and support for care givers; neglect, abuse and violence; and images of ageing.

The implementation of the Plan of Action on Ageing 2002 has pointed to the requirements of sustained action at all levels in order to respond to the

demographic changes that will occur and to mobilize the skills and energies of older persons. It has also emphasized on inter alia, a political, economic, ethical and spiritual vision for social development of older persons that is based on human dignity, human rights, equality, respect, peace, democracy, mutual responsibility and cooperation and full respect for the various religious and ethical values and cultural backgrounds of people.

The Assembly has been identified that governments have to play the pivotal roles for implementing the broad recommendations of the International PoA 2002 at national level. The prime step is needed in successful implementation of the Plan is to mainstream ageing and the concerns of older persons into national development frameworks and poverty eradication strategies. NGOs have to play a significant role in supporting Governments in their implementation, assessment and follow up of the International Plan of Action. Furthermore, effective implementation of Plan of Action at national level requires promotion of institutional follow-up to the Plan of Action, formation of national committees, establishment of organizations for older persons, promotion of research activities on ageing, finally impartial monitoring of progress in implementation. In order to complement national development efforts, enhanced international cooperation is essential to support developing countries, least developed countries and countries with economies in transition in implementing this plan, while recognizing the importance of assistance and the provision of financial assistance.

This second World Assembly has recommended systematic review of implementation of the Plan by Member States is essential for its success in improving the quality of life of older persons. The Commission for Social

Development has been assigned for follow-up and appraisal of the implementation of the International Plan of Action on Ageing 2002.

Conclusion

It is not enough only to replicate on the situation of older people in the developed and developing world as we celebrate the International Year of the Older Persons. We need to decide to remedy their hardship by adopting attitudes, policies and programs that protect and support their rights and contributions at all times as an international community committed to humanitarian advancement.

Chapter Six

SITUATION AND PRIVILEGES OF THE OLDER PERSONS

'I worry. I think a lot because I have
no money and am often sick. I have
no children except an adopted
grandchild, but the grandchild is
also poor. I don't know what to think
every day-I think this way, think
that way, like a cat with its head
caught in a coconut shell'

Older woman, Kampong Cham,
Cambodia

Chapter Six

Situation and Privileges of the Older Persons

A. Global Situation and Privileges

Introduction

The world population is ageing at a steady, quite spectacular rate. The 60-and-over population rose from 200 million in 1950 to 600 million in 1999 and is projected to reach 1.2 billion by the year 2025, at which time over 70 percent of them will be living in what are today's developing countries. The number of people aged 80 and above has grown and continues to grow even more dramatically, going from 13 million in 1950 to over 50 million today and projected to increase to 137 million in 2025. This is the fastest growing population group in the world, projected to increase by a factor of 10 between 1950 and 2025, compared with a factor of six for the group aged 60 and above and a factor of little more than three for the total population (UN Report of the Secretary General (A/47/339), para.5.).

World's Older Population Increasing 800,000 Each Month

The global population aged 65 and over is estimated to be 342 million persons in 1992, of 6.2 percent of the world total. This represents an absolute increase of 9.7 million since 1991. The net balance of the world's older population grew by more than 800,000 persons each month (Kinsella, 1999: 49). Projections to the year 2010 suggest the net monthly gain will

then be in excess of 1.1 million older people. In 1990, 26 nations had more than 2 million older persons. Projections indicate that number could increase to 55 nations by 2025.

Table 13 : Percent Older People, by Age: 1990 to 2015

Region	Year	65 years and over	75 years and over	80 years and over
Europe ¹	1990	13.7	6.1	3.2
	2010	17.5	8.4	4.9
	2025	22.4	10.8	6.4
North America	1990	12.6	5.3	2.8
	2010	14.0	6.5	4.0
	2025	20.1	8.5	4.6
Oceania	1990	9.3	3.6	1.8
	2010	11.0	4.8	2.8
	2025	15.0	6.6	3.6
Asia ¹	1990	4.8	1.5	0.6
	2010	6.8	2.5	1.2
	2025	10.0	3.6	1.8
Latin America/Caribbean	1990	4.6	1.6	0.8
	2010	6.4	2.4	1.2
	2025	9.4	3.6	1.8
Near East/North Africa	1990	3.8	1.2	0.5
	2010	4.6	1.6	0.8
	2025	6.4	2.2	1.1
Sub-Saharan Africa	1990	2.7	0.7	0.3
	2010	2.9	0.8	0.3
	2025	3.4	1.0	0.4

¹Data exclude the former Soviet Union.

Source: U.S. Bureau of the Census, Center for International Research, International Data base on Ageing.

Europe is Oldest World Region, Africa Youngest

Among major world regions, Europe has the highest proportion of population aged 65 and over (14 percent in 1990), and it should remain the global leader for at least the next three decades (Table 13). As might be expected, Europe as a whole also has the highest proportion of older population. By the year 2025, more than 1 in 10 Europeans are likely to be 75 years old or older.

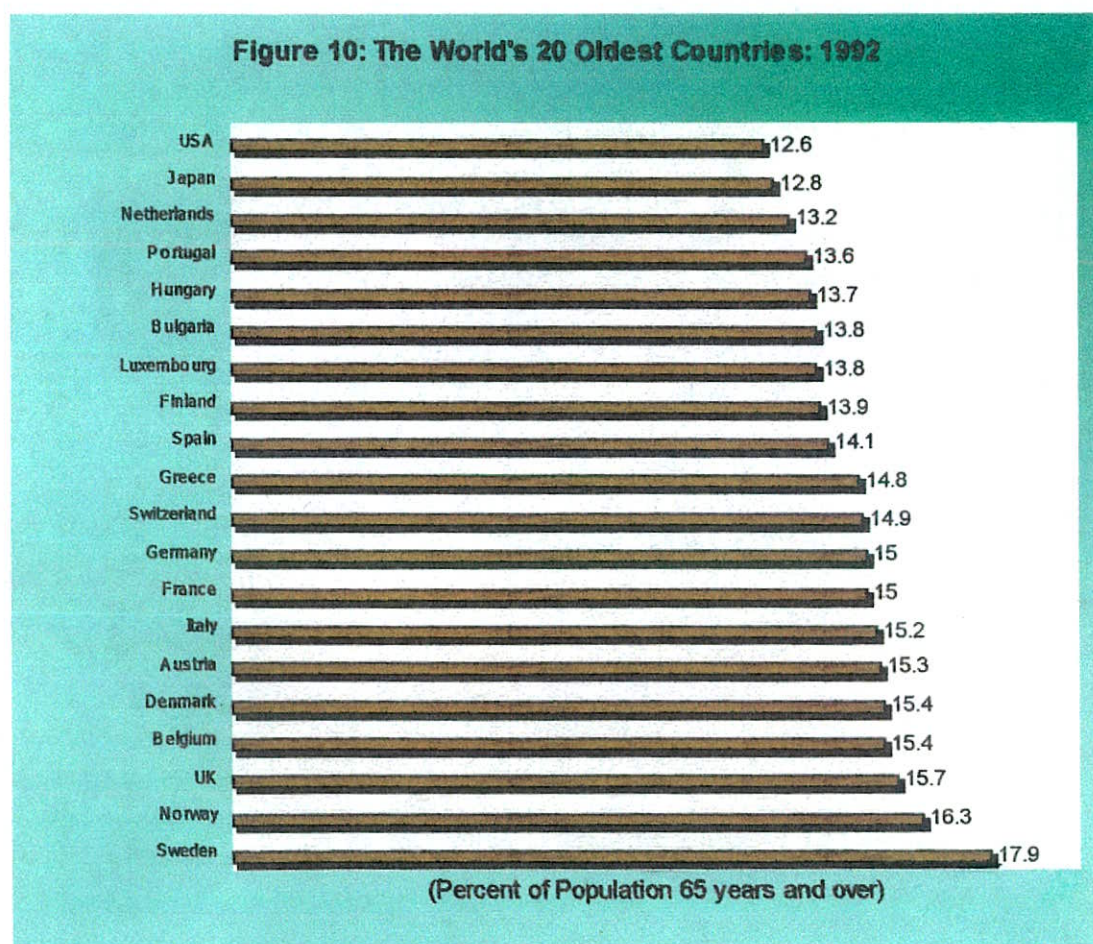
North America and Oceania also have relatively high percentages of older persons, which are projected to increase substantially from 1990 to 2025. The 1990 proportions aged 65 and over in the Asia and Latin America/Caribbean regions are expected to double by 2025. We anticipate growth in Africa and the Near East will be rather modest as a result of continued high fertility in many of the nations in these regions (Kinsella, 1999: 52).

Two important factors bear mention when considering the older peoples' proportion of a region's population. First, regional averages often hide great diversity. For example, Bangladesh and Thailand are geographically close in Asia, but their expected trends of population ageing very significantly as a result of very different levels of past and present fertility. Like-wise, many Caribbean nations have high proportions of older population (the Caribbean is the "Oldest" of all developing world regions) relative to their Central American neighbors (Kinsella, 1999: 53). More importantly, percentages by themselves may not give a sense of population momentum. Although the change in percent older people in Sub-Saharan Africa from 1990 to 2010 is

barely perceptible, the size of the older population is expected to double from 14.6 million to 28.9 million persons.

Sweden is World's "Oldest" Country

In most developed countries, the percent of population aged 65 and over ranged from 11 to 15 percent in 1992. Sweden has the highest such proportion – 18 percent – followed by Norway and the United Kingdom (Figure 10).



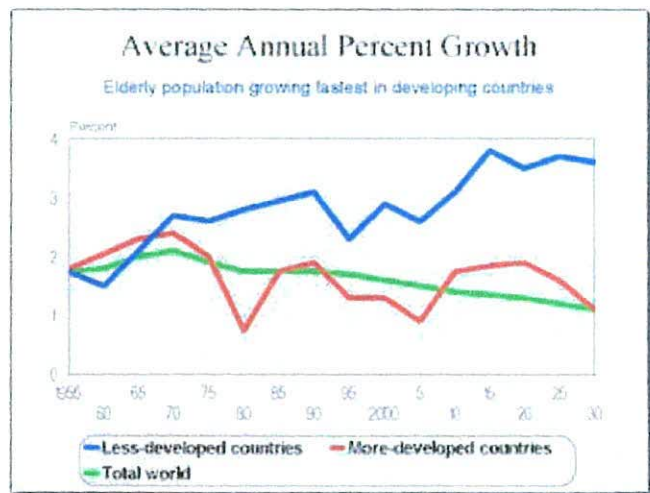
Source: U.S. Bureau of the Census, Center for International Research, International Data base on Ageing.

The Netherlands, Japan and the United States, with about 13 percent aged 65 and over, are relatively young among developed countries. Based on projections of the U.S. Bureau of the Census, the proportion older people in the United States will increase little until after 2010. As the large birth cohorts of the Baby Boom (persons born from 1946 to 1964) reach age 65 after 2010, the percent older people is expected to rise rapidly (Kinsella, 1999: 52). By the year 2025, older people in the United States could constitute nearly 19 percent of the nation's population. It is likely this figure will still be lower than in most countries of Western Europe.

Current Demographic Trends: older Population Growing Fastest in Developing Countries

Although some developing countries are considered to have young populations by most standards, the trend worldwide is toward a “graying population” with an increasing proportion of older persons. The size of the world’s older population has been growing for centuries; what is new is its rapid

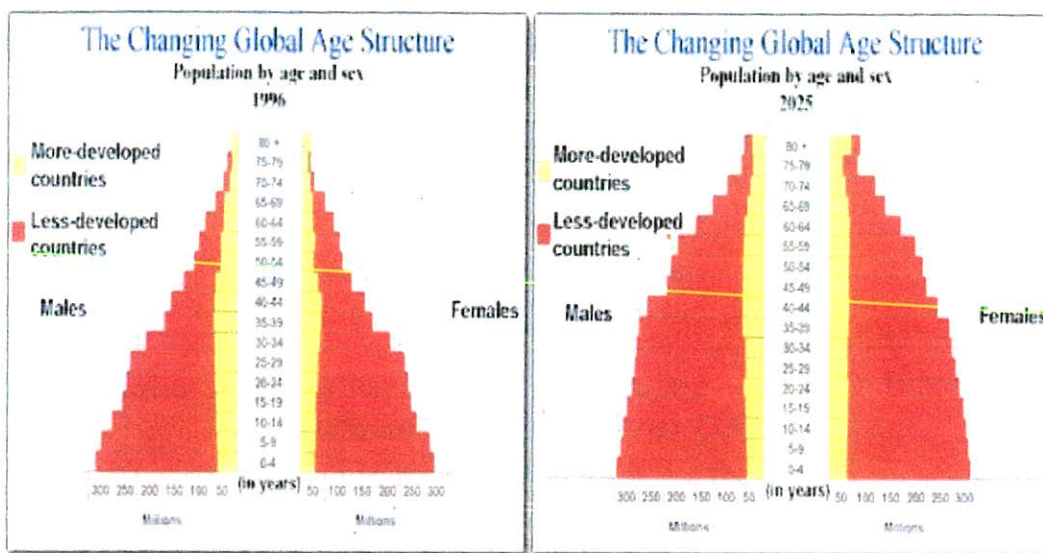
Source: U.S. Bureau of the Census, International Programs Center, International Data Base, December 1996.



ascend. The increase in the 60-and-over population in the industrialized nations of Europe and North America generally has outpaced total population growth in recent decades, with the notable exception of a steep

downturn in the early 1980's resulting from low birth rates during and after World War I (U.S. Bureau of the Census, 1996).

Source: U.S. Bureau of the Census, International Programs Center, International Data Base, December 1996.



In less-developed nations, the growth rate of the older people accelerated sharply after 1960 and is now substantially higher than that of the world's population of all ages. Less-developed all ages nations as a whole are ageing much faster than their more-developed counterparts. The world's 60-and-over population increased by more than 12 million in 1995; nearly 80 percent of this increases occurring in less-developed countries (U.S. Bureau of the Census, 1996).

"The world is now witnessing an extraordinary increase in the numbers and proportion of elderly people everywhere, especially in the newly industrialized countries and developing countries", said Dr. S. T Han, the Manila based World Health Organization director for western Pacific. Table

- a. One out of every ten persons is now 60 years or above; by 2050, one out of five will be 60 years or older; and by 2150, one out of three persons will be 60 years or older (United Nations, 1999).
- b. The older population itself is ageing. The oldest old (80 years or older) is the fastest growing segment of the older population. They currently make up 11 percent of the 60+ age group and will grow to 19 percent by 2050 (United Nations, 1999). The number of centenarians (aged 100 years or older) is projected to increase 15-fold from approximately 145,000 in 1999 to 2.2 million by 2050.
- c. The majority of older persons (55 percent) are women. Among the oldest old, 65 percent are women.
- d. Striking differences exist between regions. One out of five Europeans, but one out of twenty Africans, is 60 years or older.
- e. In some developed countries today, the proportion of older persons is close to one in five. During the first half of the 21st century that proportion will reach one in four and in some countries one in two.
- f. As the tempo of ageing in developing countries is more rapid than in developed countries, developing countries will have less time than the developed countries to adapt to the consequences of population ageing.
- g. The majority of the world's older persons (51 percent) live in urban areas. By 2025 this is expected to climb to 62 percent of older persons, although large differences exist between more and less developed regions. In developed regions, 74 percent of older persons

14 shows the number of older people, which is expected to surpass that of persons under age 15 during the 2000-2050 period.

Table 14: Developing countries where the number of older people is projected to surpass the number of persons under age 15 before 2050, by period when this would occur.

Period	Africa	Asia and Pacific	Latin America and the Caribbean
2000-2010	-	-	Cuba
2010-2020	-	Georgia - Korea Rep - Singapore	Barbados
2020-2030	Mauritius	Armenia - Azerbaijan - Bahrain - China - Korea DPR - Qatar - Thailand - United Arab Emirates	Puerto Rico - Trinidad & Tobago
2030-2040	-	Brunei Darussalam - Myanmar - Sri Lanka - Turkey	Bahamas - Chile - Guyana - Jamaica - Mexico - Panama - Suriname - Uruguay
2040-2050	Egypt - Morocco - Tunisia	Fiji, India, Indonesia, Iran, Kazakhstan, Kuwait, Kyrgyzstan, Lebanon, Malaysia, Mongolia, Viet Nam	Argentina - Belize - Brazil - Colombia - Costa Rica - Ecuador - Peru - Venezuela

Source: *Elaboration of data from United Nations, World population prospects. The 1998 revision, New York, 1999.*

The current demographic revolution is predicted to continue well into the coming centuries. Its major features include the following (www.igc.org/globalag/waa2/index.htm, 2001):

- a. One out of every ten persons is now 60 years or above; by 2050, one out of five will be 60 years or older; and by 2150, one out of three persons will be 60 years or older (United Nations, 1999).
- b. The older population itself is ageing. The oldest old (80 years or older) is the fastest growing segment of the older population. They currently make up 11 percent of the 60+ age group and will grow to 19 percent by 2050 (United Nations, 1999). The number of centenarians (aged 100 years or older) is projected to increase 15-fold from approximately 145,000 in 1999 to 2.2 million by 2050.
- c. The majority of older persons (55 percent) are women. Among the oldest old, 65 percent are women.
- d. Striking differences exist between regions. One out of five Europeans, but one out of twenty Africans, is 60 years or older.
- e. In some developed countries today, the proportion of older persons is close to one in five. During the first half of the 21st century that proportion will reach one in four and in some countries one in two.
- f. As the tempo of ageing in developing countries is more rapid than in developed countries, developing countries will have less time than the developed countries to adapt to the consequences of population ageing.
- g. The majority of the world's older persons (51 percent) live in urban areas. By 2025 this is expected to climb to 62 percent of older persons, although large differences exist between more and less developed regions. In developed regions, 74 percent of older persons

are urban dwellers, while in less developed regions, which remain predominantly rural, 37 percent of older persons reside in urban areas (United Nations, 1999).

- h. Over the last half of the 20th century, 20 years were added to the average lifespan, bringing global life expectancy to its current level of 66 years. Large differences exist between countries, however. In the least developed regions, men reaching age 60 can expect only 14 more years of life and women, 16 more, while in the more developed regions, life expectancy at age 60 is 18 years for men and 22 years for women (United Nations, 1999).
- i. The impact of population ageing is increasingly evident in the old-age dependency ratio, the number of working age persons (age 15 - 64 years) per older person (65 years or older) that is used as an indicator of the 'dependency burden' on potential workers. Between 2000 and 2050, the old-age dependency ratio will double in more developed regions and triple in less developed regions (United Nations, 1999). The potential socioeconomic impact on society that may result from an increasing old-age dependency ratio is an area of growing research and public debate.

Asia Get Watchful of Its Ageing Population

Long worried by the rapid growth of its young population, a more affluent Asia is today increasingly watchful of its swelling ranks of ageing citizens as well. The world's most developed countries still have the largest proportions of older populations. But the rate of population ageing in many developing

countries is now much faster than those of developed nations in the past. By 2020, over 70 percent of the people aged 60 years and over will be living in developing countries, five of them in Asia. China, India, Indonesia, Pakistan and Bangladesh will be among the 10 countries with the biggest older populations in the world by that time (ESCAP, 1996).

Japan is the world's most rapidly ageing country, and signs of similar trends are emerging in Asia's graying tiger economies such as South Korea, Taiwan and Singapore. The Japanese government, which gives a basic pension for citizens 65 years and older, is busy devising ways to cope with growing social security and health problems of its older people and to ensure not just longevity but quality and productivity of its citizens' later years. The Japanese today talk not only about "retirement" but about "second life", with many taking up other jobs or going into their own businesses, hobbies or doing volunteer community work (ESCAP, 1996). As the country's older populations has grown, many Japanese companies have also extended the average length of a working career and moved back retirement age from 55 years two decades ago to 60 years today. Some are considering moving it further to 65 years of age.

Tiny Singapore, a city state of two million people, has also taken note of the older people trend and stresses the importance of lifelong medical schemes that ensure ageing citizens are provided for later on.

In WHO's western Pacific region, which stretches from East Asia to the Pacific, the percentage of the older population is projected to increase from 9 in 1990 to 16 in 2020. By that time, nearly 30 percent of Japan's 125 million people would be aged 60 years or over. South Korea's older population is

expected to grow from 7.5 percent in 1990 to 18.8 percent by 2020 (U.S. Bureau of the Census, 1996).

China, the world's most populous nation, with 1.2 billion people, also has the greatest number of older persons. By 2020, China's older population will exceed 230 million – the current number of older people in the United States or the whole of Western Europe. By that time India's elderly folk will number 145 million, Indonesia 43 million, and Pakistan 18 million (HAI, 1999).

Ageing in Neighboring Countries

Over the last few years there has been an increasing interest in the study of ageing in both developed and developing countries. The examination of the age structure of a population of a country or a community at different

Box 4 : Population Ageing in SAARC Countries

In the SAARC countries the population aged 60 and over has grown more than twice as fast as the younger population since 1960. The elderly increased from 16.7 million in 1960 to 25.9 million in 1980 - a 55 per cent increase, for the population under age 65, the increase was only 24 per cent. The elderly have also increased as a proportion of the population, from 9.1 per cent in 1960 to 11.1 per cent twenty years later. The number of the very elderly aged 70 years and over is growing even more rapidly. In the same time interval those aged 75 to 84 rose 65 per cent while 85 years and over group rose 174 per cent (Ali, 1996). Declining death rates from heart disease, cardiovascular diseases, influenza and other causes of death contributed to the growth in the elderly population. However, the ageing process in the SAARC countries is still in a nascent state.

periods reveals the process of aging of the population. This process increases the population of adults and older people in the population and decreases the population of children and adolescents. In our neighboring countries the ageing process is rather a recent phenomenon and very recently its effect has attracted the social scientists interest (Khaleque, 1996).

It would be noted that all our neighbors, while they vary in size from very small to very large, have been and still are predominantly agrarian economies. They have the same type of population explosion problems and are battling for economic development (Pendse, 1998). Most have had a colonial past. And more importantly the population in all the countries shares the same oriental ethos of strong family ties. In many communities of these countries poverty, illiteracy and ignorance are the basic factors to act as the scourge of their ruination. As there survive more and more elderly, there are more poor, illiterate and ignorant persons who may find it difficult to adapt to new methods and techniques and thus to keep up with the changing society (Khaleque, 1996).

The population studies in these countries older people indicate a trend of increasing percentage of population above 60 years of age during the past two decades and a significantly longer life span for women compared to men. This trend is expected to be maintained in early this century and the higher dependency ratios would mean that in coming years, the responsibility for caring for the older people will fall either on the young wage earners or on the state (Pendse, 1998). A common observation about the burgeoning population in less developed countries is that "a vicious combination of poverty, malnutrition, poor sanitation, illiteracy,

unemployment, social apathy and lack of initiative for change have been continually plaguing the prospect of planned parenthood, better health and better living in these countries."

India

India is graying fast owing to better health facilities; the life expectancy at birth has gone up from 32 at time of Independence in 1947 to 62 in the present decade. Their number is increasing at such an alarming rate, that 80 million older people are expected to swell the country as it enters the 21st century (Sundaram, 1998). Increase in longevity, decrease in death rates, and improvement in health standards etc have contributed to the growth of older population. There is a fairly large number of older people who have widowed status, incidence amongst women is much greater than in men, Considering the percentage of 6.3 as at present or for that matter projected percentage of 8 of the older person the situation is not alarming for there are number of countries with older population of 10 to 20 percent of their total population. But in absolute number the older population of some of the countries assumes a frightening prospect. The magnitude of the problem is so overwhelming that even if we take one percent of the older population as socially and economically destitute, there be approximately 5 lakh people to be cared for by ten thousand institutions at the rate of 50 per institution for which a very large budget running into crores of rupees would be required. This is neither feasible, nor desirable. Compounding the situation is a country like India, with no social security net it is a fact that an overwhelming majority of the older people are in the unorganized sector. Out of the 60 millions 60 plus citizen in the country in 1991, only seven million are in the organized sectors. A sizeable majority of those in

unorganized sector either over around the poverty line or live below it. There are at present about 210 homes for the older people mostly in Tamil Nadu, Kerala, Maharashtra, West Bengal and Punjab (Sundaram, 1998). The solution to this gigantic problem is not easy but a way has to be found within the community.

Pakistan

This country seems to have lagged in following the general trend of increasing percentage of older population in total population. This may be due to faster addition of younger age group population in total and preference for male progeny over the female progeny within this group itself (Pendse, 1998).

Nepal

Though geographically small in size, the common features of rural-urban mobility, concerted efforts to bring down the fertility rates to the replacement level and to increase life expectancy of both sexes to about 65 years by the end of this century would affect the age structure of the population (Khaleque, 1996). This would also mean that older people would have less number of children to look after them.

Sri Lanka

The social well-being achieved by Sri Lanka in recent years, however, presents a very unique and exceptional picture for a small developing country and a more positive approach to the whole problems of ageing population. The crude birth rate has dropped from 36.6 in 1945 to 24.3 in

1985. The crude death rate has also fallen from 21.9 in 1945 to 6.2 in 1985. Maternal death rates, infant mortality rates have significantly lowered; literacy rate has gone up from 78.5 per cent in 1971 to 87.2 per cent in 1985. Surveys reveal that it is not justifiable any more to identify all older persons with the negative stereotype as frail, dependent and diseased (Pendse, 1998). While there would be many older persons whose needs are extremely urgent, there are many older persons who enjoy a relatively full rewarding life, contributing much to the welfare of the households and communities in which they live (Ali, 1996). They feel that the negative view that the older persons would be an undue burden or liability on the state in future may not be wholly tenable in Sri Lanka.

Thailand

It follows the general pattern of increasingly ageing population over the years. The general belief being that daughters look after the older persons more lovingly and sincerely (Pendse, 1998). The female progeny is looked after well and this is reflected in higher life expectancy of the females and their higher percentage in the total age over 60 years.

China

In nearly 40 years China's population has changed from a young type to a typical adult one. With estimated life expectancies of both males and females still on rise (75 years and 80 years respectively by 2050) they expect to have a thumping rise in the older population, to the extent of 412 million elderly people aged 60 and over (Pendse, 1998). All those who will be living in mid next century have already been born.

Action on Ageing: Global Review

The United Nations Principles for Older Persons were adopted by the UN General Assembly (resolution 46/91) on 16 December 1991. Governments were encouraged to incorporate them into their national programs whenever possible. The information available, so far, demonstrates that many governments and NGO's have been genuinely committed to the goals. Appropriate measures have been taken and others are planned in response to the ageing of populations. It is envisaged that, in the coming years, more action will be undertaken by governments towards accomplishing fully the goals and targets set in different Plan of Actions. The Report on the Observance of the International Year of Older Persons and on Progress in the Implementation of the Macao Plan of Action on Ageing for Asia and the Pacific reveals the following actions that the governments throughout the world have taken and are considering taking:

a. The Social Position of Older Persons

Governments have espoused various activities like observance of the Year, organizing poster design contests and photo exhibition, distribution of national awards to older persons etc. recognizing the importance of promoting positive attitudes towards older persons in preparation for an ageing society (ESCAP, 2001).

In order to promote and heighten understanding the issues related to ageing and older persons, many governments have focused on the development and coordination of policies and programs, carving out the specific national policies or plans for action, encouraging research for improving knowledge

and awareness, organizing seminars and conferences both at national and international scales.

b. Older Persons and the Family

In the Asian and Pacific region, traditionally family is the primary care provider for older family members. But a number of factors like existing socio-economic forces, declining family size, increasing women workforce, geographic mobility of family members have adversely affected the capacity of the family for providing the supportive measures.

Governments are aware of the existence of vulnerable and disadvantaged older persons, including those who are disabled, displaced, and financially insecure and lacking family support. Examples of efforts to promote the role of the family as caregiver can be found in the Islamic Republic of Iran; Macao, China; Malaysia; Mongolia; Thailand; Viet Nam and others (ESCAP, 2001). In the Islamic Republic of Iran, the Government provides the following services to families with an older person: paying a life pension for taking care of the older persons in the family; presenting medical rehabilitation equipment; offering consulting services and social work; and delivering training material in the field of special care for older persons. Consulting services are offered to families with older members and financial support is given to those families which look after their older members. In Macao, China, housing policies include supportive measures for families caring for older persons. Malaysia offers tax relief for family members on their medical expenses and purchases for their parents. In Mongolia, a system of social services delivered at home for single older persons has been initiated.

c. Health and Nutrition

As there is a strong need for establishing a systematic program of activities to educate the population on healthy ageing and raise awareness of the physiological changes that accompany old age, countries are investing in preventive and rehabilitation care and services, covering home health care as well as hospital care and mental health services. The coverage of such services, however, varies among countries as well as between the rural and urban segments within each country.

Geriatric training is provided in varying degrees to persons working in related health-care fields, such as physicians, nurses and social workers. For example, in Bangladesh, emphasis and support are given to the development of geriatric medicine and treatment (ESCAP, 2001). The development of geriatric medicine and care is also being promoted and a national geriatric council including representatives of the government has been formed. The financial implications of health programs for older persons in the future has been acknowledged and addressed by a majority of the governments in the region, a number of which provide concessions and incentives in relation to health care for older persons.

d. Housing, Transportation and the Built Environment

In the Asian and Pacific region, a large proportion of the older persons live with their families. Their quality of life is thus often dependent on the adequacy of their living conditions. Some governments have adopted housing policies which deal especially with the housing situation of older persons and which assist in enabling older persons to continue living at home.

Governments are, in addition, making special arrangements to meet the transportation needs of older persons. Concessions in travel fares should be considered for older persons commuting by public transport. Some governments have incorporated policies and programs which address the environment and infrastructure to facilitate accessibility and freedom of movement for older persons. Governments in China; Macao, China; Myanmar; Singapore; and Thailand have provided incentives and support for older person's accommodation. In other countries, such as Fiji, Malaysia, the Philippines and Mongolia, public travel concessions are offered to older persons (ESCAP, 2001).

e. Older Persons and the Market

Specialized goods and services are often required by many older persons, which make them a distinct and often disadvantaged group of consumers. In some countries, this has given rise to well-defined markets for older persons.

f. Income Security, Maintenance and Employment

Recognizing the benefits in allowing older persons to stay in the workforce, some governments are assisting older persons to do so by creating job opportunities and providing training as well as financial incentives for self-employment schemes.

Although the coverage varies among different countries and varies further between the rural and urban areas of each country, pension and social security schemes are offered to older persons. Some governments are in the process of reviewing the coverage of pension and social security schemes in terms of their availability and whether it corresponds to the standard of

living. Furthermore, governments have urged that extensive studies be made to provide new instruments of income security.

Governments in Bangladesh; Brunei Darussalam; Macao, China; Malaysia; Nepal; Pakistan; Thailand; and Viet Nam have some form of program or pension scheme for providing subsistence allowance for older persons. In China, the "Self-Help Enterprise" was set up to provide healthy old people with the opportunity to support them by working in an environment suitable to their physical condition. The Government of Fiji provides a nominal family assistance allowance to poor older persons on merit. The Government of the Islamic Republic of Iran provides interest-free loans with a long repayment period (ESCAP, 2001).

In the Philippines, older citizens are offered benefits and privileges such as discounts in restaurants, recreational facilities and other places of culture as well as hotels and lodging establishments. The Philippines has programs and services aimed at developing economic self-reliance and social responsibility among older persons. Skills training is provided to individuals or groups, and those who may wish to start their own livelihood project may avail themselves of the Self-Employment Assistance Program, whose initial capitalization is provided by the local government units. Grants-in-aid and bigger capital assistance which are interest-free are provided to groups of older persons to encourage their participation in income-generating activities.

g. Social Services and the Community

The opening of avenues for older persons' participation in community activities not only allows older persons to involve themselves with their

community but provides them with opportunities to pass on their knowledge and experience. Some countries have done this by inviting older persons to partake in the educational system on a community level as teachers and leaders; while in others it is through membership in community clubs and residents associations.

In Fiji, the Help Age Centre is a drop-in centre for older persons residing in Suva, the capital. One of the key activities of the Centre is the promotion and contribution of older persons to community development and social services, including vocational training, marriage counseling and teaching of local languages to tourists. In Macao, China, the Government, together with an education institute, is designing a non-formal senior education and literacy program in order to enable older persons to become active participants in the society and to further promote educational opportunities for them (ESCAP, 2001).

In fine, while for the fourth review and appraisal United Nations entities were asked to indicate the types and levels of activities that they have undertaken to assist in implementing the Plan of Action, 9 out of 13 have reported that they have collaborated with non-governmental agencies on projects related to ageing (see table 15). Seven of the entities indicated that they would participate in future inter-agency meetings on ageing.

Table 15: International activities on ageing: United Nations entities, based on replies to the 1996 questionnaires on the fourth review and appraisal of the implementation of the International Plan of Action on Ageing

Reporting issue	All United Nations entities a/		
	Yes	Total	Percentage
<i>Program on ageing incorporated in current medium-term plan</i>	2 (6)	13 (14)	15 (43)
<i>Focal point on ageing</i>	9 (12)	13 (14)	69 (86)
<i>Collaboration with non-governmental organizations on ageing-related projects</i>	9 (11)	13 (14)	69 (78)
<u>Activities on ageing engaged in since 1992</u>			
<i>Research</i>	10 (9)	13 (14)	77 (64)
<i>Publications</i>	9 (7)	13 (14)	69 (50)
<i>Reports</i>	7 (7)	13 (14)	54 (50)
<i>Development assistance</i>	2 (4)	13 (14)	15 (29)
<i>Advisory services</i>	4 (5)	13 (14)	31 (36)
<i>Training</i>	3 (3)	13 (14)	23 (21)
<i>Meetings</i>	7 (4)	13 (14)	54 (29)
<i>Database (s)</i>	3 (4)	13 (14)	23 (29)
<u>Activities undertaken to identify impact of ageing on national budgets or developmental activities</u>			
<i>Future size and distribution of older persons population</i>	3 (3)	13 (14)	23 (21)
<i>Future size of workforce</i>	4 (2)	13 (14)	31 (14)
<i>Future costs of pensions</i>	2 (1)	13 (14)	15 (7)
<i>Future costs of health care and social services for older persons</i>	2 (4)	13 (14)	15 (29)
<i>Consumption and its structure</i>	1 (4)	13 (14)	8 (29)
<i>Savings and investment</i>	1 (3)	13 (14)	8 (21)
<u>Projects undertaken to integrate the older persons into mainstream development activities</u>			
<i>Income-generating activities</i>	1 (3)	13 (14)	8 (21)
<i>Employment training and placement</i>	1 (3)	13 (14)	8 (21)
<i>Intergenerational activities</i>	2 (3)	13 (14)	15 (21)
<i>Older persons volunteer programs</i>	1 (4)	13 (14)	8 (29)
<i>Educational and/or cultural programs</i>	13 (3)	13 (14)	100 (21)
<i>Participation of the older persons in planning and development of services</i>	2 (1)	13 (14)	15 (7)

a/ 1992 figures in parentheses

Source: Report of the Secretary General, 25 February 1997-6 March 1997; (Commission for Social Development, 35th session, Item 3(b) of the provisional agenda E/CN.5/1997/1)

Social-Economic Situation, Government Policies and Specific State Sponsored Programs for the Older People in Our Neighboring Countries

The strikingly large numbers of the older persons in our neighboring countries by themselves warrant urgent attention to their welfare. The ageing phenomenon is normally identified with increasing proportion of relatively less productive population becoming a burden or becoming economically and socially more and more dependent with further increase in age. There is a greater awareness of this serious problem in official circles, non-governmental organizations and society itself (Pendse, 1998). This is leading to the study of the changing needs of the older people and formulation of appropriate policies or specific programs/projects for their welfare within the constraints of the available resources. Barring a few exceptions, however, other more urgent and basic priority areas drain away these meager resources. Thus despite clear perception of the older peoples' needs only small beginnings have been made in these projects.

There are some common approaches to be considered while facing these issues. To the extent to which persons in the older population become economically inactive, the burden of their dependency, both economic and social, on the more productive part of the population increases. Hence ways and means have to be found to keep such persons economically active as long as possible. One of the hurdles in this effort is the deteriorating physical health of the older population (Ali, 1996). All old age diseases are not terminal nor do they necessarily result in disability. Thus with a proper health education plan many such disease can be prevented or treated to

enable the older people live a more independent and healthy life. The need for geriatric hospitals or geriatric wards in big hospitals, funds for training geriatric doctors and nurses is being increasingly realized. Wherever state exchequer could step in to fill the gap. The other feature is that with increasing cost of living in most of these countries, the economic security provided by the pension schemes of the Government or Semi-Government organizations is no longer adequate (Pendse, 1998). Income support is essential to the retired persons from such units to fulfill their needs of food, shelter and other basic necessities including health care at least in urban areas where family support is likely to be deficient.

India

Having a rich cultural, social, ethnic, and religious diversity, India is a developing nation with under-developed economy. In terms of Human Development India exhibits lots of striking disparities. For instance, Life expectancy is steadily increasing and this could be attributed to the advancement of medical technology. However, on the other side the increased life expectancy is not free from morbidity or disability and hence, in general, it is not a healthy life expectancy (Kumar, 1999: 33). The World Bank report (1998/99) says that nearly 35 per cent of the total population is at below poverty line and the dependence ratio is about 65.5 per cent under constant economic pressure, from time to time, the growing needs and priorities of the younger generation is changing. Under such circumstances, having nearly 74 per cent of the agrarian population for whom the minimum basic amenities are inaccessible, the social assessment of the older populations economic status indicate that they are one of the most deprived

and marginalized section of the society with less bargaining power and weak fall back position.

The traditional social security systems such as self-sufficient village economy; institution of joint family; caste system and charity are gradually disappearing from the social structure of the society (Kumar, 1999: 33). Forced by these adverse economic conditions majority of the older people are looking for social security from the government. Though the present silent crisis is alarming the future situation, old age security is the last priority in our so called social policies.

Welfare activities in respect of the aged in India are virtually confined to the urban areas. These are mainly old age pension scheme and homes for the aged (Ramnath, 1998). There are at present about 210 homes for the aged mostly in Tamil Nadu, Kerala, Maharashtra, West Bengal and Punjab (Sundaram, 1998). However, the national policy aims to strengthen the legitimate place of older in society. It also aims to help older people live the last phase of their lives with purpose, dignity, and in peace. The State will support older persons, provide protection against abuse and exploitation, seek their participation and provide care services to improve the quality of their lives (HAI, 1999).

Pakistan

The first Action Plan for the Ageing prepared by the Federal Ministry of Health and Social Welfare in 1980 could not be implemented due to paucity of funds. Subsequently, however, due to persistent public clamor a National Plan for Senior Citizens has been prepared to cover the VII Five Year Plan

period (1988-93) and a long term perspective plan (1986-2006). The main provisions are (a) Establishment of Day Care Centers for Senior Citizens in major cities, (b) Home for the Elderly started in Punjab Province to be replicated in other provinces, (c) The Town Committees to register and maintain a record of Senior Citizens with regards to their problems, needs and potentialities, (d) Employment of suitably qualified senior citizens in Social Welfare Department, Programs for Mass Literacy and other welfare activities to utilize their talents, skills and expertise (Pendse, 1998).

A National Committee for Welfare and Socio-Economic Security of the Elderly has been recently formed consisting of representatives of Central and Local Government Offices and Voluntary Social Welfare Organizations.

Nepal

Decline in religious values and corresponding decline in extended family system due to changes in economic structure are bound to create hardship for the increasing numbers of the older people (Ali, 1996). At present apart from the provident fund scheme for Government employees and the employees of some manufacturing establishments, there are no provisions for economic security of the older persons in general. The National Commission on Population is aware of the situation and a number of measures to deal with the problems of the older persons are to be initiated in the near future (Pendse, 1998).

Sri Lanka

There is an increased awareness and a realize understanding of the ageing problem by the Sri Lankan Government. The Department of Social Services maintains three large older peoples' homes at Mirigama, Anuradhapuram

and Jaffna – Kaithady with total inmate strength of about 600. But disabled older persons are not admitted. Another form of State Assistance is the Public Assistance Scheme to poor, disabled older persons. This assistance caters to only 13 percent of the real need older persons (Pendse, 1998). There is also a Food Stamp Scheme which gives indirect income support to about 50 percent of the population. The Elderly Recipients account for 53 per cent of the total persons receiving this form of sustenance aid. The Government also pays a subsidy to 48 Elder's homes run by Voluntary Organizations (Khaleque, 1996).

The pension scheme for the Government employees covers only 16 per cent of those above the age of 60 years. Realizing that 70 per cent of the population were engaged in agriculture, the Farmers' Pension and Social Security Benefit Act was passed in 1987 with far reaching results and a similar Act was passed for the benefit of Fishermen (Pendse, 1998). This is basically a contributory scheme and has certain eligibility criteria to help only genuinely needy persons. There is also a highly Socialized Health Services Scheme under which free medical treatment is available to those who need it, irrespective of their age. The emphasis is on preventive measures rather than curative. Hence the existing older persons are somehow relegated to a secondary position. Since satisfactory housing is another critical need, the Government is committed to provide shelter for the homeless and those living in impoverished circumstances. Two programs, one by the name Hundred Thousand Houses Program (HTHP) and the other Million Houses Program (MHP) were launched and the former was completed in 1987 (Pendse, 1998). However, while this is good in itself, a housing policy especially designed for older persons is non existent because

the olders may not be able to raise the necessary resources to own residences. Some programs assist those who care for the older people to own residences to maintain the elderly would be necessary (Ali, 1996).

Thailand

This country responded very well to the United Nations call for action through the World Assembly on Ageing in 1983. The National Committee on Ageing adopted a Long Term Plan of Action for the Elderly (1982–2001). This plan covered five major aspects viz. Health Care, Education, Income and Employment Warranty including tax exemptions for low income, Social and Cultural needs, and Social Security (Pendse, 1998). The implementation of this plan is through both institutional and non-institutional routes. Operation of Homes for the Elderly, Social Service Centers for the Elderly, Non formal education programs, Health and Welfare facilities, Information dissemination are done through various Government Departments. The Non Governmental Organizations are also assisted in their projects designed to serve the needy elderly.

The Government employees enjoy the benefits of a Pension Scheme – either ‘life time scheme’ or a ‘lump sum scheme’ (Ali, 1996). State Enterprise employees get a lump sum amount equal to last salary multiplied by the years of services.

China

With a vast territory, regional differences in living conditions, welfare, medical and health care, and economic security are noticed as far as the urban and rural older persons are concerned. This is despite the Chinese

Constitution stipulating – "The Citizen of the People's Republic of China enjoys the right of being supported materially by the State and the society in cases of being older people, ill or losing the ability to work." Marriage Law as well as Inheritance Law and Criminal Law stipulate "Children are duty bound to support parents. Maltreating and forsaking family members are prohibited." However policies and programs pertaining to income security of the older people have become one of the focal points of economic reform of the country (Pendse, 1998).

Old Age Insurance was first introduced in 1952 for urban, state and collective owned employees and the coverage and benefits were expanded gradually. The amount of pension ranges between 60 per cent to 100 per cent of the original salary and those who have made special contribution get special additional pension or allowances from 5 per cent to 15 per cent. At the death of the retiree, the spouse receives a certain amount for funeral expenses and a smaller pension. All retirees can enjoy free medical care. Of course the vast majority of the working population, nearly 80 per cent, is still not covered by Old Age Insurance (Pendse, 1998). In some urban areas Social Welfare Programs are being implemented for such older people. In rural areas, older people as everywhere in the world do not enjoy retirement till they are physically unable to do what they could for earning a living and family is their main support in such cases. For those older people who are childless, disabled and without means of livelihood, a separate program of "Five Guarantees" covering food, clothing, shelter, medical care and funeral is being operated to give at least a subsistence level support.

Other significant programs attempted in China relate to what they call 'Contribution Activities of the Elderly' and 'Learning of the Elderly.' In the

former, the professional knowledge and experience of the older people is utilized for development projects. The latter program provides for places and opportunities for the older people to learn and study. There are more than 1000 such universities in China and 200,000 students. Through learning calligraphy, painting, flower planting etc., the older people can mould their temperament, renew their knowledge or learn new skills, resulting in high spirits and good health.

A very important institution is being funded by the Government in its national budget under the overall umbrella of Chinese National Committee on Ageing to plan and organize nationwide research activities in the field of ageing, to make recommendations for policy making and to develop international academic exchange and cooperation. Since its inception in 1985, China Research Centre on Ageing (CRCA a multi disciplinary institute) has prepared a draft document 'Rules for protecting the Legal Rights of the Elderly,' conducted cooperative activities with similar institutions in USA, Japan, European Countries, Thailand, Hong Kong, etc. compiled and published two major series 'Knowledge service for the Ageing Science' and 'The Questions and Answers to Life of the Elderly – 1,00,000 Know-How', and issues a widely welcomed periodical 'Research on Ageing' apart from weekly and monthly magazines specially published for Elderly Chinese (Pendse, 1998).

A concise but comprehensive description of government policies and state sponsored specific programs for the older people of some selected countries has been given in Appendix B.

Conclusion

The *World Population Prospects (1950-2050)*, a report issued by the United Nations in 1996, gives an idea of how fast societies are greying:

In Western Europe, it is expected in 50 to 100 years the number of people aged 65 and older to rise from 7 per cent to 14 per cent of its population. The same process took only 25 years in Japan, which is predicted to become the world's 'oldest society by 2010. South Korea's older people would increase from 5.6 per cent of the populace in 1995 to 11.45 by 2020. The proportion of India's older people is expected to rise from 4.59 per cent to 8.1 per cent of the population from 1995 to 2020, and China from 6.11 per cent to 10.51 per cent in the same span of time.

But population ageing is far from just an issue of numbers. It means more older people are living longer, raising the issue of quality of life and health services.

Governments will have to face the challenges of how to finance health care and social security needs for older citizens, even as urbanization and westernization in some areas bring about changes in traditional social means of caring for the older people.

Richer countries have better and more developed social security and health insurance sectors to cope with a growing older population. The Japanese, for instance, are resorting to hiring extra help to look after older people, and promoting their continued employment or "*re-employment*". But developing countries still coping with basic problems like maternal mortality and basic childcare are unlikely to have ready resources to cope with a rise in social

security needs. Even their private health and social schemes may prove inadequate.

"In the majority of these countries, due to lack of funds, social security schemes cannot be extended to large segments of populations," the WHO paper said.

Likewise, the presence of a growing older population means seeing illnesses from cardiovascular diseases to arthritis and problems like loneliness, alienation and integration in society.

"It is not clear whether the elderly are living a longer life of good quality, or just enduring a painful existence," the WHO paper said. "Evidence suggests that the later years of life are often years of living with disabilities."

In short, WHO said: *"The emerging social and public health consequences of ageing in developing countries must be taken very seriously."*

Asian families still consider taking care of the older people as their responsibility, unlike in the West where having them stay in old-age homes are common. Though some Asian countries like Japan do have publicly operated residences for senior citizens, many largely stick to the tradition of caring for their old folk.

Studies by the population resource centre, based at the University of Michigan in the United States, show this is the case in places like Thailand and the Philippines.

Older Thai parents commonly live with at least one child and the practice has persisted, despite the rapid social and economic change of the eighties and the large number of young adults leaving rural villages and flocking to

cities. Older Filipinos usually live with children or their other kin, and a common belief is that "putting the elderly in homes for the aged was unnatural if the person had children or other family members", a 1993 study by the population resource centre found.

B. Situation and Privileges of the Older Persons in Bangladesh

Introduction

The World's 580 million older people (60 years and more) include around 355 million in developing countries. By 2020, when the total will reach 1,000 million, seven of the ten nations with the largest older populations will be developing countries – Bangladesh with 14 million will hold the seventh largest (HAI, 1999).

Bangladesh is one of the world's poorest and least developed countries. Population ageing in Bangladesh is viewed as natural outcome of demographic transition that has started only in recent years (Kabir, 2000). Declining birth and death rates that represents the years of successful family planning and public health programs have led to rapid increases in the number of older people in Bangladesh.

The ageing of a population is a dichotomous process. One is the "*ageing at the base*" that results from a reduction of fertility while the other is the "*ageing at the apex*" of the population due to decline in mortality among the older people.

Bangladesh population is both ageing and younging. While the dominant trend throughout the nation's history has been one of younging due to higher fertility, the post 1950 period added an ageing tendency due to persistent improvement in mortality rates (Kabir, 1994).

The Situation of Older People in Bangladesh

The older persons (6 percent of the total population), in Bangladesh, are still passing their days' amidst the tender care and support mostly provided by their extended families without any remarkable backing from the national level. However, the situation is in transition as the family pattern gradually shifting toward the nuclear type due to the change in values, migratory tendency of their offspring and poverty. The only support to the older persons from the government is the provision of Old Age Allowance (Boisko Bhata). Again, the formal pensioners, retired government service holders, constitute only a negligible fraction of the total population (The Daily Ittefaq, 29th December 2001).

Economic solvency together with security can only prevent ageing up to a certain time. Our country is experiencing ageing in its population again, since about 75 percent of the total population is living below the poverty line. Every year, approximately 80,000 new older persons are entered into the group of the older persons who, in general, constitute a socially and economically vulnerable group with basic needs remaining unsatisfied in many cases (Abedin, 1998).

A research was conducted by Help Age International in order to present a picture of older people's situation in Bangladesh and to suggest ways in which they can best be assisted by government agencies and NGOs (HAI,

2000). The report depicted that poverty and exclusion are the greatest threats to the well being of older people, and poverty sets the context for everything else older people experience. With the poor health status they even lack access to basic health care and sanitation facilities.

In Bangladesh, older people are left out of the development process and they lack access to resources and income generating opportunities. As the dominant society emulates Islamic values, which enjoin family, kinship and community bonds in the life process, religion and tradition enjoins upon the younger generation to respect and take care of the older persons. In spite of the remaining support from the families, it is now being undermined gradually by poverty. The family cannot do as much as it would like to do for the older persons in spite of its best intentions on account of pauperized conditions (Habibullah and Wahid, 1987). In addition to this, the concept of nuclear family has introduced recently though limited to a small minority of the population (Sattar, 1995). One problem, which relates to the social adjustment in old age, is loneliness and social isolation. Awareness of old age issues among those who are approaching the retirement age has not been developed and arrangement for the creation of the awareness is negligible.

The situation and privileges for the older persons in Bangladesh, however, have been discussed more specifically in Chapter Nine naming Problems and Prospects of Older Persons in Bangladesh.

Care for the Older Persons

Care of the older persons is a very old issue in the history of human civilization. There exist different types of old age security measures fostered by the states or voluntary organizations in western countries. But in our

society, except traditional cultural of care in the kinship network system, the older people are helpless who can not satisfy their basic needs without help from the kin group. If we look at the old age care system in the developed world we can find that about 50.0 per cent elderly people in Brazil live in the joint family. On the other hand, about 69.0 per cent elderly people in Philippines, 85.0 per cent in Singapore. 71.0 per cent in Thailand and 82.0 per cent in Vietnam live with at least one of their children (Knodel and Debevalya, 1997: 9). In France 20.0 per cent, in the Netherlands less than 10.0 per cent live in the joint families. On the contrary, in United States about 50.0 per cent female between the ages of 77 to 87 years live alone. But in India only 12.4 per cent older male and 1.4 per cent female live alone (Chakrabarti, 1994). In Bangladesh about 11.30 per cent older persons live with their spouse or alone without any support from their children (Ibrahim, 1988: 7). A Table is given here to give a clear picture of the living arrangements of 306 elderly persons of rural Bangladesh.

Table 16: Living Arrangement of the Older Persons

Living Arrangements	Older Persons		
	Male	Female	Total
Living alone	12 (9.8)	2 (1.1)	14 (4.6)
Living with spouse only	31 (25.4)	31 (16.8)	62 (20.3)
Living with unmarried children	45 (36.9)	89 (48.4)	134 (43.8)
Living with married children	27 (22.1)	43 (23.4)	70 (22.9)
Living with divorced daughter	3 (2.5)	7 (3.8)	10 (3.2)
Living with the neighbors/ fictive kin	4 (3.33)	12 (6.5)	16 (5.2)
Total	122 (100)	184 (100)	306 (100)

Note: Figures within the parentheses indicate percentage.

Table-7.4 indicates that about two-third of the older persons live with their children and rests of them are live with spouse, alone, neighbors and fictive kin. It is surprising to note that, those who are living with their children,

among them two-third live with their unmarried children especially sons. Because, after the marriage of their sons, they want to form a neolocal residence with the tendency to form nuclear family to get materialistic benefit and thereby to avoid the burden to take care of the older parents, and also to avoid the conflict between the in-laws (Sarker, 1998). About 20.3 per cent older persons are living with their spouse only. Because of their children, especially sons are employed in urban areas but they keep occasional touch with their older parents. The process of keeping occasional touch is in the form giving cloth at the time of festivals and some of amount of money casually at the time of need like treatment and reconstruction of house, etc. About 5.2 per cent older persons live with the support of neighbors and fictive kin. The nature of the support is usually rent free accommodation, food, clothing and money for treatment. About 22.9 per cent older persons are living with the married children and grand children. The support of the older people with the married children may be of different in nature, which is given in the Table 17.

Table – 17: The Nature of the Support of the Older persons Living with their Married Children

Nature of Support	The older persons living with married children		
	Male	Female	Total
Constant support	15 (55.6)	20 (46.5)	35 (50.0)
Rational support	4 (14.8)	16 (37.2)	20 (28.6)
Shared support	8 (29.6)	7 (16.3)	15 (21.4)
Total	27 (100.0)	43 (100.0)	70 (100.0)

Note: Figures within the parentheses indicate percentages.

It is evident from the Table-7.5 that 50.0 per cent older persons live with their married children and sibling constantly. The percentage of constant

living in joint family is higher compared to female in Bangladesh. Because the degree of conflict between the mothers-in-law and the daughters-in-law is higher than father-in-law (Sarker, 1998).

To avoid this situation 37.2 per cent female and 14.8 per cent older male live in rotation system with their sons. The duration of rotation varies from one week to a month. Sometimes the older persons live with their children during this rotation period or sometimes they live separately with next door neighbors but they take their meals in rotation system. More than 21 per cent older persons live with their married children in shard system. In this system the older persons live with one of their married sons and in that case others also share the living expenditure equally with a view to showing honor to the existing values of our society (Sarker, 1998).

Social Protection System for Older Persons in Bangladesh

There are substantial differences among societies in terms of how they approach and define social protection. Differing traditions, cultures and organizational and political structures affect definitions of social protection, as well as the choice about how members of society should receive that protection. The definition of social protection provided by the UN Secretariat is as follows:

“Social protection is broadly understood as a set of public and private policies and programs undertaken by societies in response to various contingencies to offset the absence or substantial reduction of income from work; to provide assistance for families with children as well as provide people with health care and housing.”

In general the following points shall be noted in defining the terrain of social protection policy:

- a. Social protection embodies society's responses to levels of either risk or deprivation deemed unacceptable. Underpinning the operation of social protection systems, therefore, is a social consensus (which may be implicit or explicit) on fundamental values concerning acceptable levels and security of access to the means of meeting basic needs and fulfilling basic rights. These include secure access to income, livelihood, employment, health and education services, nutrition and shelter. Social protection is therefore multi-dimensional, and does not refer solely to meeting variability in cash income with public transfers or regulated insurance (which remains the predominant understanding in developed countries).
- b. Social protection deals with both the absolute deprivation and vulnerabilities of the poorest, and also with the need of the currently non-poor for security in the face of shocks and life-cycle events (particularly ageing).
- c. The character of the policy response may involve a range of different institutions: central or local government, civil society (voluntary or membership associations, trade unions, NGOs), the private sector.
- d. There are two predominant sub-categories of social protection. Social assistance encompasses public actions that are designed to transfer resources to groups deemed eligible due to deprivation.

Social insurance is social security that is financed by contributions and based on the insurance principle: that is, individuals or households protect themselves against risk by combining to pool resources with a larger number of similarly exposed others.

Ageing issue in Bangladesh had not been a mainstream concern until recently since the demographic transition started only in recent years (Kabir, 2000). Over the last century, the population 60 and over was increased by 1.31 percentage points while some recent projections show that it will increase by another 3.33 percentage points in the coming 25 years. Every year approximately 80,000 new older persons are entered into the group of the older persons who, in general, constitute a socially and economically vulnerable group with basic needs remaining unsatisfied in many cases (Abedin, 1998).

In Bangladesh, the existing social protection for older people is a combined effort between the older persons and their families to meet the basic needs. Government of Bangladesh has made the first move introducing the provision of a small amount of payment for disadvantaged older people since 1997-98. Such facility has been possible to offer to only about 7 per cent of the older population. Hence the responsibility for the welfare of the older people needs to be shared by the family as well as the community.

With the process of urbanization, industrialization, modernization, pauperization, individualization and the expansion of family planning program, the migration of the people is increasing. Changes are taking place

not only in the kinship structure but also in the parent-child relationship which putting them in the different worlds and also in different classes (Sarker, 1996). This rapid change in the parental and filial relationship leads the older people towards insecurity in Bangladesh. But still in this transitional situation the older persons have no alternative than to survive without the support of their relations (Sarker, 1998).

There are a number of actors involved in the process of caring the older persons in Bangladesh, of which the least important being the State. While considering the older persons themselves are the pivotal actors, rest are their caregivers and financial providers. However, in our settings,

Box 5 : Older Persons in our Constitution

The Constitution of Bangladesh recognizes the rights for the older persons. In its section 15 and 15/Gha, it has been clearly articulated that the rights of the older persons should have been preserved. However, rarely are there any activities, till today, to assist them except for the old age allowance (Boisko Bhata) in a narrow scope. On May 31st 1998, the government has launched the old age allowance scheme with the provision that the oldest ten persons in each union, of which women constitutes exactly the half, will be given Taka 100 per month. The government provides a total of Taka 48,37,32,000 each year to carry on the scheme thus implies that only 4,03,110 out of a total of about 75,00,000 older persons have been covered under the scheme (The Daily Ittefaq, 29th December 2001). The shocking feature is that, Taka 100 per month is bare minimum to bear all the expenses of an older person in Bangladesh.

the caregivers and financial providers are the family members, particularly children and their spouses.

In both the urban and rural areas of Bangladesh, majority of the older male and female receive some sort of economic assistance from others, either regularly or occasionally.

A large number of older people usually live with their offspring, 70 per cent in rural area and 86 per cent in urban area.

In our country the traditional gender norms play its role. The older people who do not seek for any financial assistance, the higher proportion of them is male with shelter. It reflects the patriarchal system of inheritance, particularly for landed property. Eventually the older females are relatively less empowered due to lack of access to financial resources. They feel social insecurity without shelter and perceive it as a basic need than having cash in hand. By providing help with shelter, food, medical and clothes costs, women are seen to be financially 'taken care of', be it by their children or their spouse. With respect to status of older women, many studies show that there is an association between the high risk of mortality and lack of access to resources for older women in traditional context of Bangladesh.

Very few welfare programs for the older people have been launched so far in Bangladesh. The support activities that are available at present in the country are accounted below:

1. Government Programs

In spite of the Government being aware of the implications of the ageing phenomenon, no formal program for the welfare of the older people could be

launched so far due to other urgent and pressing needs and short-term economic difficulties (Pendse, 1999). Whatever programs have been ostensibly designed for older age groups are available to a restricted class of society and almost 85 per cent of the older persons living in rural areas are without a public safety net. In a bird's eye view, these government welfare programs for the older people are accounted below:

- a. All retiree get pension at the time of their retirement from the government jobs after the age of 57 years. Another formal program, which covers only insignificant fractions of the total older population, is available only to the elite retired military personnel (Abedin, 1999).
- b. Most older and vulnerable ten persons (of them there must be at least five women) from each ward under the unions of the country will be given 100 Taka each per month for one year (Khan, 1998).
- c. With a view to impart life long facility for care, protection and leading a normal life of the older persons' government has planned to establish six centers for the older persons in 6 division of the country under the Annual Development Program (ADP). These centers will be called Shanti Nivas (Home for Peace).
- d. The proposed services under the fifth five-year plan are creating centers for older persons with facilities for light economic/income generating activities, geriatrics medical and

social welfare services for the poor and the older people (Khan, 1999).

- e. The Government of Bangladesh constituted a National Committee on Ageing as early as in 1982 with the Minister for Social Welfare as Chairman, the actual limited work for this committee has been done by the non-government organization Bangladesh Association for the Aged and Institute of Geriatric Medicines (BAAIGM) (Pendse, 1999).

2. Non-Government Initiatives

i. Bangladesh Association for the Aged and Institute of Geriatric Medicines (BAAIGM):

Ever since its establishment in 1960, Bangladesh Association for the Aged and the Institute of Geriatric Medicine (BAAIGM), the prime voluntary, non-profit, non-political and non-government organization at national level registered with the Ministry of Social Welfare, working for the welfare of the older persons in Bangladesh through its 45 branches all over the country (Abedin, 1999).

It is devoted to the welfare of older persons above 55 years of age. The services provided by this Association are:

Health Care Service:

- i. Free medical examination and advice,
- ii. All pathological services:
- iii. Physiotherapy treatment,

iv. Eye, Ear, Nose, Throat, Dental, Cardiology and Neurology.

Recreational and Socio-Economic Activities

Include Indoor games, Library, Picnics, Sports, Milad, Open house, Group discussion, Eid reunion etc. To encourage exchange of ideas and increase awareness of the problems of old age, income generation activities of destitute old persons, Relief and rehabilitation during natural calamities like cyclone, tidal bore, flood, etc., specially for the affected poor older people.

The Association has already constructed a dormitory building having 52 seats under a development project with a grant from GBO for providing shelter to the older persons for a nominal payment who have none to look after.

The organization is presently running the following programs:

- i. 50 Bed Geriatric Hospital, out-door Medicare programs and pathological services.
- ii. 50 capacity Dormitory for the older persons.
- iii. Recreation and library programs.
- iv. Training and management of income generation activities.
- v. Research and publication center.

ii. Elders Rehabilitation Center, Gazipur, Bangladesh

This organization is registered under the Department of Social Service. The organization has a land of 20 Acres where there is an arrangement of accommodation for 200 older people. At present 50 older persons (25 male and 25 female) of age 60+ are residing in this center (Abedin, 1999). They are given free accommodation, food, clothing and Medicare facilities. They

are being imparted religious and general education. The older persons are involved in gardening, farming, piscicultural and other recreational activities. The agency is run by a committee of 21 members. The sponsor of this organization seeks no government grant.

iii. Resource Integration Center (RIC)

One of the goals of RIC is to minimize the number of destitute, disabled, and vulnerable older persons. They provide 'community based habitation for older people,' credit and medical services. Some new programs include housing grants, an older peoples' club, a day care center, monthly pension and funeral support. Credit program helps older populations to become financially independent and to play a more prominent role in the community. Credit strengthens their role of women particularly because they have a greater need for economic sustenance. They also provide preventative and curative services with the support of Help Age International (HAI). Physicians make follow up visits at patients' homes, indicates there outreach community; and they have a strong referral system.

iv. Bangladesh Women's Health Coalition (BWHC)

BWHC is a national NGO, established in 1980 with a broad mission of improving the status of women. It initiated providing small-scale geriatric health services to the older women during the year 1998. In the year 2000, a new project *Older Women Health Project* was launched in order to improve health and social status of older women by providing access to appropriate health care services for older women, by improving their health seeking behavior and facilitating their active role in health promotion.

v. Service Center for Elderly People (SCEP)

SCEP, a non-government organization in Rajshahi starts working for the older people in 1994 with a slogan "A Care for the Generation". It provides health service and recreational facilities to the older persons of age 60 and more for their social and emotional peace. Persons of age 18 and above of Rajshahi city are eligible for membership, however, older persons are the registered members. Present activities of the SCEP for the registered older persons include listening to the radio, watching television, reading newspapers, magazines, playing indoor games. Every Friday health investigation of the registered older person is made. SCEP is a project of 'Rajshahi – Christians and Friendship Committee' and is run by the executive body of SCEP (Abedin, 1999).

vi. Elderly Development Initiatives (EDI)

EDI situated in Manikgonj near Dhaka. It is a community based self-help organization has some programs for the development of older persons in Manikgonj.

vii. Bangladesh Retired Government Employees Welfare Association, Dhaka.

This organization also offers medical services to its members and provides welfare services to retired employees and their families.

viii. Bangladesh Retired Police Officers Welfare Association, Dhaka.

Similarly, this organization offers socioeconomic services to retired police officials and their families.

ix. Defense Personal Welfare Trust, Dhaka

This trust provides socioeconomic and medical services for employees of the defense.

3. Role of Religious Teaching and Practices

The traditional support system for the aged now prevails in Bangladesh is:

- i. Islamic Teaching, foremost among them, the Institutions of Zakat (Obligatory tax) and Fitra (a core of the Islamic Social Justice).
- ii. Traditional Practices of alms giving, The Holy Quran enjoins various principles on support to the older people. In many verses there are explicitly commitments to show respect to the elderly, treat them kindly and give them elevated status in both family and community levels. These principles have had a far-reaching impact on traditional values and practices (Abedin, 1999).

Review on Boisko Bhata Scheme (Old Age Allowance)

A few studies (Majumder and Begum, 2001; CPD, 2001) have been conducted to evaluate the Boisko Bhata Scheme that was initiated on May 31, 1998. The scheme, first of its kind in Bangladesh, was introduced in connection with the GOB policy to support the vulnerable sections in the society and received critical acclaim as it sought to extend the safety net to the older group of people in the country, particularly in the context of absence of any direct welfare measure for this group of population (CPD, 2001).

Majumder and Begum (2001) investigated whether the beneficiaries are the most eligible ones and found that most of the older persons (about 52 per cent) who enjoy the benefit of Old Age Allowance program belong to the oldest age group of 70 years and above. About half of these very old beneficiaries belong to the age group 80 years and above (who can be termed as extremely older people) whereas at the national level most of the older population belongs to the ages under 65 years. Thus, it reflects that most eligible older persons were selected for Old Age Allowance since it is likely that among the older persons extremely old ones are in the most vulnerable situation. Despite the policy of the Old Age Allowance Program that women should constitute at least half of the beneficiaries, they found in their sample the male-female ratio is 100:98. They identified the relatively high mortality rate among the women population is mainly responsible for such anomaly. The official national statistics show that the life expectancy at birth was 60.6 for males and 59.8 for females (BBS, 1998). Table 18 shows the distribution of the Old Age Allowance recipients by selected socio-demographic factors.

In the same study, it was depicted that an average male recipient spent Tk.11.00 for transport to collect their allowance for the last time, whereas an average female recipient spent Tk.13.00 for the same. It was assumed that the allowance recipients have to spend a large amount of their allowance money for bribing the bank officers, Union Parishad chairman/members and ward commissioner/members since they helped them receiving allowance. But on a positive note, not a single recipient respondent reported such tips or any such deduction from their allowance money (Table 19).

Table 18: Distribution of the Allowance Recipient by Selected Socio-Demographic Factors

(Figures in percentages of total)

Socio-Demographic Factors	Allowance Recipients		
	Male	Female	Both
Age in Years			
< 57	2.0	-	1.0
57-59	3.1	6.1	4.6
60-64	17.7	32.7	25.3
65-69	22.9	12.2	17.5
70 +	54.3	49.0	51.6
Average (in years)	71.6	70.1	70.9
Marital Status			
Unmarried	-	-	-
Married	77.1	8.2	42.3
Widowed	21.9	90.8	56.7
Abandoned	1.0	1.0	1.0
Education			
Illiterate	66.7	87.8	77.3
Can sign only	17.7	9.2	13.4
I-V	11.5	3.1	7.2
VI +	4.0	-	2.0
Role in Independence War			
Involved in independence war directly or indirectly	6.1	-	3.1
Not involved	93.9	100.0	96.9
Household Size			
1	2.1	23.4	12.9
2-3	36.5	22.4	29.4
4-5	32.3	30.6	31.4
6 +	29.2	23.5	26.3
Average no. of household (in person)	4.3	3.7	4.0
Number of Living Children			
No living child	0	4.3	2.1
One living child	5.2	8.7	6.9
2-3 " "	19.8	25.0	22.3
4-5 " "	29.2	30.4	29.8
6 + " "	45.8	31.5	38.8
Average size of living children	5.0	3.9	4.3
Total no. of surveyed elderly	98	96	194

Source: Majumder, Pratima Paul and Begum, Sharifa (2001). The Old Age Allowance Program for the Elderly Poor in Bangladesh: A Review. Bangladesh Institute of Development Studies (BIDS), Dhaka.

Table 19: Percentage Distribution of the Allowance Recipient Older People by Expenditure they incurred in Withdrawing the Last Allowance

Sources of Expenditure	Mean Expenditure in Taka	
	Male	Female
Transport	11.0	13.0
Food	4.5	5.0
Tip to Bank Officer	0.0	0.0
Tip to Helper	0.0	0.0
Any Deduction during Withdrawal of Allowance	0.0	0.0
All	15.5	18.0

Source: As above.

Several major findings from the CPD (2001) study on the *Boisko Bhata* Scheme are replicated below:

- a. About 98 per cent of the respondents commented that it was a significant component of their income basket;
- b. Majority (82 per cent) of the respondents faced no difficulty in receiving their allowance;
- c. Eighty-eight per cent of the respondents thought that the present delivery system could be further improved in order to raise its efficacy;
- d. Eighty per cent respondents opined that the amount of the Bhata should be increased;
- e. About 36 per cent of the respondents thought that the cash allowance should be supplemented by food and clothing;
- f. About 74 per cent of the respondents said that they had to incur some expenses to receive their allowance. Asked to point out the type of expenses, 88 per cent of the respondents who informed that they had to incur expenses to receive the Bhata,

cited cost of transportation, and 12 per cent cited the cost incurred in buying revenue stamps;

In the same survey, certain instances were identified that Bhata (allowance) recipients had to make extra payments for receiving the Bhata. The study thus, recommended that the GOB should undertake corrective measures to eliminate the related malpractices which result in delays, harassment and inappropriate payments. They opined that Local administration and representatives of local government institutions could play an important role in this respect.

A Citable Initiative

Prime Bank Limited, a leading private commercial bank in Bangladesh, has recently launched a scheme for the senior citizens in celebration of its 7th anniversary. This was the first attempt in our country, so far, made by any financial institution that acknowledge the contributions to society by the senior citizens of the country by offering specialized services for them, something in return and to show that “we care”.

The bank offers 1 per cent more interest on all its deposit products to customers who have reached the age of sixty or above. They provide such customers with laminated cards and the customers need not to stand in the queue for counter services. In each Branch an officer has been deputed in order to provide them (senior citizens) personalized service. No doubt this very scheme would uphold the dignity of our senior citizens vis-à-vis would inspire other organizations in the country to come up with various services for the older persons to reveal that the credit has given where it is due (Prime Bank Instruction Circular No. Nil dated 09 April 2002).

Conclusion

Recent demographic trends in Bangladesh suggest fundamental social change is underway. Several contraceptive prevalence surveys and a demographic surveillance system have shown a fertility transition and a health transition are in progress. Amin (1995) argued that fertility decline has occurred despite remarkable persistence in the living arrangements of the older people and their dependence on sons; female headship patterns do not display dramatic increasing trends, and the increase in the proportion of nuclear households is better understood as a reflection of persistence, rather than change, in a traditional pattern of household formation. She identified several factors affecting household structure are increasing survival of sons to adulthood, changing fertility affecting household size, trends in female headship, life-cycle stage and income earning potential, and from marriage to household formation. Although some change in family and household living arrangements appears to have taken place during the past 20 years, these changes were not dramatic and did not translate to much change in the welfare provision for the older persons.

In Bangladesh, policy concern for the older persons has been most limited. There have been limited efforts made at public initiatives towards alleviating the situations of the older people in the country. It was the Third Five Year Plan of Bangladesh (1985-90), which for the first time acknowledged the issue of older people. The Plan aimed at "to propagate social, religious and cultural values amongst people for motivating them to share responsibilities of the old, infirm, beggar and other socially and physically handicapped members of the family and society and also to motivate people towards the

joint family system in order to share more responsibilities” (Third Five Year Plan, 1985/90: 394).

Subsequently, the Fourth Five Year Plan (1990/95) also called for to “motivate people to share responsibilities of the orphans, beggars and other socially disabled people”. It emphasized that “community and family based programs will be given greater emphasis in relation to care and rehabilitation of physically disabled; the aged, orphans and other disadvantaged groups” (Fourth Five Year Plan, 1990/95: XVIII-2). The Fifth Five Year Plan of Bangladesh (1997-2002) targeted to “create more centers for helpless old age people with facilities for the geriatrics” (Fifth Five Year Plan, 1997/2002: XXIV-3).

Historically, the concern for older people in the country has been limited to the pension scheme for public servants and various retirement benefits for employees of public sector corporations (Mahmood and Islam, 1997). However, the size of government and public sector employees has been most limited compared to country’s eight million older population. The Old Age Allowance Scheme, which was initiated in 1998, covers about 400 thousand older population. Consequently, the vast majority of the older people have remained outside the purview of any old age pension. Therefore, a concentered effort should be made by the all concerned to alleviate the situation of the older population in Bangladesh, which is the demand of the time.

Chapter Seven

SITUATION OF THE OLDER WOMEN

'We're independent. Even those of us
who have husbands are independent.
That's the strength that older people
Have. We have nothing to lose, and
everything to gain'

Doly Quijada, President, National
Association for Older
People, Bolivia

Chapter Seven

Situation of the Older Women

A. Global Situation

Introduction

Women, who represent more than half of the world's poor, and more than half of the world's elderly, also make up more than half of those already involved in senior enterprise projects. This makes credit, as well as aging, a women's issue -- one that I hope will become your issue. I could say that it is time to give credit where credit is due, but in fact, it is overdue. For if money talks, as the saying goes, then women have often been left speechless and older women, absolutely mute. If older people, and especially older women, are to become actors in the drama of their own lives, we need to deal not only with money, but also modes of thought. The frame of mind that sees older people as socially peripheral, non-contributory and merely dependent, a burden on society, must be dismantled - Ambassador Julia T. Alvarez of the Dominican Republic told the Nashville gathering at the Preparatory Event for the International Year of Older Persons, 1999 (internet site www.globalageing.org).

UN Secretary General Kofi Annan said in a message to 100 female leaders at a UN sponsored training conference that *As we reflect upon the achievement of a half century of human rights advocacy, and as we resolve*

to do better where we have failed or fallen short, the situation of older women warrants special mention (Internet site www.globalageing.org).

Also in 1992, and in commemoration of the tenth anniversary of the adoption of the Vienna International Plan of Action by the Conference on Ageing, the General Assembly adopted the Proclamation on Ageing in which it urged support of national initiatives on ageing so that older women are given adequate support for their largely unrecognized contributions to society (UN General Assembly Resolution 47\5, 1992)

In accordance with article 3 of the International Covenant on Economic, Social and Cultural Rights, by which States parties undertake *to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights*, the committee on Economic, Social and Cultural Rights considers that state parties should pay particular attention to older women who, because they have spent all or part of their lives caring for their families without engaging in a remunerated activity entitling them to an old-age pension, and who are also not entitled to a widow's pension, are often in critical situations (UNHCHR, 1995).

The question may arise that why everyone puts these feminist slants? It can best be answered by the followings with a bird's eye view.

It is, however, to consider the difference between biological roles (unchangeable, at least to some extent) and social roles (modifiable). The reality is that we are born as men or as women and there is nothing, or at least very little we can do about such a biological event. Society, however,

imposes certain characteristics and designates certain roles to one or the other sex. According to these societal rules it is expected that men will be physically strong, will play with arrows, guns, ploughing instruments, etc. and will go outside home while women are expected to be physically weaker than men, to play with dolls, kitchenware, etc. to stay inside home to bear and rear children, and in many cases depend on men. What is typically considered to be feminine or masculine varies from one society to another. These social roles are relative though these are taken as unchangeable in many cases. The cultural stereotypes that characterize the older people as a homogenous group, alienated and disadvantaged, it is surprising to realize that in reality the older people are found to be heterogeneous in the course of life (Ali, 1996).

Women and Ageing: Demographic Trends

Presently, women constitute the majority of the older persons throughout the world; about 55 per cent among the oldest-old, 65 per cent are women. In the developed world, differential mortality by sex currently favors females at all ages (particularly among the old-old); consequently, in Europe for example, in 1980 one out of four females was over 60 years of age compared to one out of seven males.

In the developing countries variations are wide. For instance, in Uruguay, Hong Kong and the Republic of Korea gender differences in old age are fairly similar to those in the developed world. In parts of South Asia the inverse applies, due to an excess of female mortality, particularly in the reproductive period (World Bank, 1992; Feachem et al., 1991), but due also

to the low status of woman as a result of differential access to medical facilities and less food. By the year 2020, the imbalance between the sexes is expected to worsen somewhat in developing nations, and improve in developed nations (Sen, 1994).

Women as Formal and Informal Care Givers:

Without questions, caring is a central and common feature of the personal and professional lives of many women (Baines, Evans and Neysmith, 1991). It is important to recognize that women are implicated in the care of older people in families as the majority of both formal and informal caregivers (Ward-Griffin, 1999: 61). The assumption that women do and should have primary responsibility for providing care to family members is likely to reflect in their own expectations, the expectations of others, and in policies and community services (Ward, 1993). Furthermore, this gendered-determined obligation of care often extends to women's work outside the home. Women who enter the nursing profession are primarily motivated by the ethic of service or care (Baines et al, 1991).

Feminist Perspectives on Women and Ageing:

The ageing of women is a global issue. With the numbers of older women projected to double from now to the year 2025 to 645 million, all societies must develop approaches that will recognize aging women's difficulties as well as honor their contributions (Browne, 1999).

Most of the problems associated with aging - poverty, chronic health ailments, limited social roles, increasing dependencies, and caregiving - correlate more to women than to men, although men are far from immune to them. In part, this is because women, throughout their lives, face a number of problems that have not been prevented or in some cases acknowledged as legitimate issues and corrected or compensated by society. Such gender inequalities only exacerbate women's problems as they age (Browne, 1999). And yet there is also evidence, often neglected, of older women's numerous strengths, contributions, and abilities.

Health Related Problems of the Older Women: An Emerging Issue in Developing Countries

Introduction

Other than maternal health there is little empirical information on women's health. Furthermore, health data, when available in developing countries, are rarely disaggregated by sex and age. Only 78 countries currently report cause of death statistics to WHO, and even these data are not necessarily available for each calendar year. These statistics cover only 35 percent of all deaths (about 50 million) that occur annually in the world (Ruzicka and Lopez, 1990). Moreover, there is a lack of data on disabilities and functional limitations.

In many developed nations where data are more available, older women have been found to manifest rates significantly higher than men for certain

chronic diseases such as arthritis, osteoporosis, diabetes, and hypertension. The pattern is similar in developing countries.

A study on adult disease patterns in Bangladesh, Jamaica, Malaysia, and the United States, finds that women report more problems than do men. This gender differential cuts across both economic and cultural dimensions. Furthermore, education has an effect on health-related behaviors, but its effect seems to dissipate as people age (Strauss et al., 1992).

A WHO survey in 1986 in Fiji, Malaysia, Philippines, and Republic of Korea reported that two-thirds of the older women responding had chronic health problems that impinged on their daily activities. The most common conditions were hypertension, pulmonary tuberculosis, peptic ulcer, heart disease, asthma, and abdominal pain. A survey of 1,004 older Nigerian women showed that weakness, poor vision, and arthritis were the most frequent causes of impairment. Women with primary education were most likely to complain of weakness.

Older Women and Causes of Mortality

In developing countries, the major causes of mortality for women older than 50 years are infectious diseases, cardiovascular and cerebrovascular diseases, cancer, and injuries. The ranking of these causes, however, varies by region and by the level of development, and differs from the ranking of male disease patterns.

In lower-income countries, causes of death are primarily a mix of infectious diseases and chronic diseases. In middle-income countries, the pattern is similar to that of developed countries: the major causes of death are cancer, cardiovascular and cerebrovascular diseases, and injury (Young, 1994).

Older Women and Causes of Morbidity

Loss of visual acuity and hearing, osteoporosis, malnutrition, and anemia are the major causes of morbidity. Diabetes is becoming a leading cause of morbidity among the older population in some developing countries. Furthermore, mental illness is being recognized as a problem of increasing importance. In developing countries the main diseases in adult and older women estimated in the World Development Report 1993 are cardiovascular (including cerebrovascular) diseases, accounting for 38.9 million disability-adjusted life-years lost (DALYs); cancer, 14.4 million; infectious and parasitic diseases, 10.2 million; neuro-psychiatric diseases, 7.4 million; digestive disorders, 5.1 million; and injuries, 4.7 million (Young, 1994).

Causes of Death of Older Women by Region

Causes of death for adult and older women, as for men, vary with a country's level of development. It is imperative to keep in mind the heterogeneity of developing countries (Young, 1994).

- a. In Asia and Africa where infant mortality rates exceed 200 per 1,000 live births, causes of death for older women are dominated by communicable diseases.

- b. In countries such as Argentina, Chile, China, Cuba, and Uruguay, where life expectancy is comparable to that in many developed countries, chronic diseases are of major concern.
- c. In other developing countries where life expectancy is 55 to 65 years, the causes of death are both communicable and chronic diseases. Morbidity and mortality records for women older than 50 in most regions of the developing world show a predominance of chronic diseases: cardiovascular diseases, cancers, diabetes, osteoarthritis, mental disorders.
- d. In Africa and South Asia, however, infections of the intestinal and respiratory systems still remaining as major causes of illness and death.
- e. In most regions of the world, cancers rank first or second as causes of death for women older than 50, followed by heart disease, cerebrovascular, diabetes, and injuries. The profile is different when data can be disaggregated by urban and rural residence, suggesting the influence of life style on patterns of disease.
- f. In more rural countries, major causes of death are still lack of basic environmental and preventive services.

Gender Questions

Older people also face the long and extensive discussed, unresolved gender issues. Social and religious customs, cultural taboos, and dress codes usually restrict the movement, speech and public exposure of women. Age and

gender barriers exclude the older female from decision making and resources. Furthermore, they are generally placed in the informal economic sector with insignificant marketable skills and no retirement compensation (Bono, 1999).

Older widows are often among the most marginalized in cultures where inheritance codes dispossess them on their husbands' death. They are less likely to remarry than widowers, leaving them isolated and often dependent on the goodwill of relatives or charity of neighbors.

Situation becomes worst during emergencies. Because older women become vulnerable as they are more likely to be confined in their home in maximum danger. They tend to be more numerous in refugee populations but a variety of social, religious and cultural factors undermine their capacity of protecting themselves and obstruct their access to essential services.

Contributions of Older Women

Older women, all over the developing world, make an 'invisible' contribution to their families and society at large, performing domestic tasks and caring for children and sick or disabled adults so that other members of the household may engage in visible activity (HAI, 1999). In addition, older women engage in a range of income-earning activities in the informal sector, which contribute to the household economy but are rarely acknowledged, or are seen only as '*reducing the burden of their presence.*'

In spite of numerous restrictions on their activity, older women in developing countries continue to be active and productive even in the face of ill health and disability. The Ghana research suggests that older woman actually employ a more diverse range of activities than man to sustain themselves and their families. International Labor Organization Studies of labor force participation by older people showed that in 1993, in at least 20 African countries, between 74 percent and 91 percent of people over 65 continued to work. *'In fact, there is no retirement age for an elderly woman until either death, dementia or disability claims her'* (Internet site www.agewave.com)

As well as the economic contribution they make, older women often have leadership roles, such as conflict resolution and cultural, religious and health education. These may be highly visible but are not measured in terms of value to the community. Although older women are routinely expected to manage any crisis that arises in a household, and to be custodians of culture and tradition, they are far less likely than men to be consulted when community problems or dilemmas are anticipate (Kumar, 1998). The skills of leadership, diplomacy and financial management, and the vast experience as career and counselor that the older women is likely to have acquired are rarely rewarded with a place in public or political life. Cultural taboos, lack of education and the sheer pressure of domestic and income earning duties conspire to keep older women out of decision-making bodies.

In the communities surveyed, it was found that older women, in addition to provide childcare for the family, also offer physical care and financial assistance to older men. It was apparently a recurrent theme in the research

that older men placed a high value on this support. However, according to the study, the contribution of older women was still less likely to be officially recognized (HAI, 1999).

Female Advantage in Life Expectancy Partially Offset by Disability

As life expectancy at birth and at older ages lengthens, the quality of that longer life becomes a major issue. The concept of healthy life expectancy (also called active life expectancy or disability-free life expectancy) refers to the average number of years that persons may expect to be free of limitations of function due to one or more chronic disease conditions. It is difficult to precisely compare measures of healthy life expectancy among nations because of computational and conceptual differences.

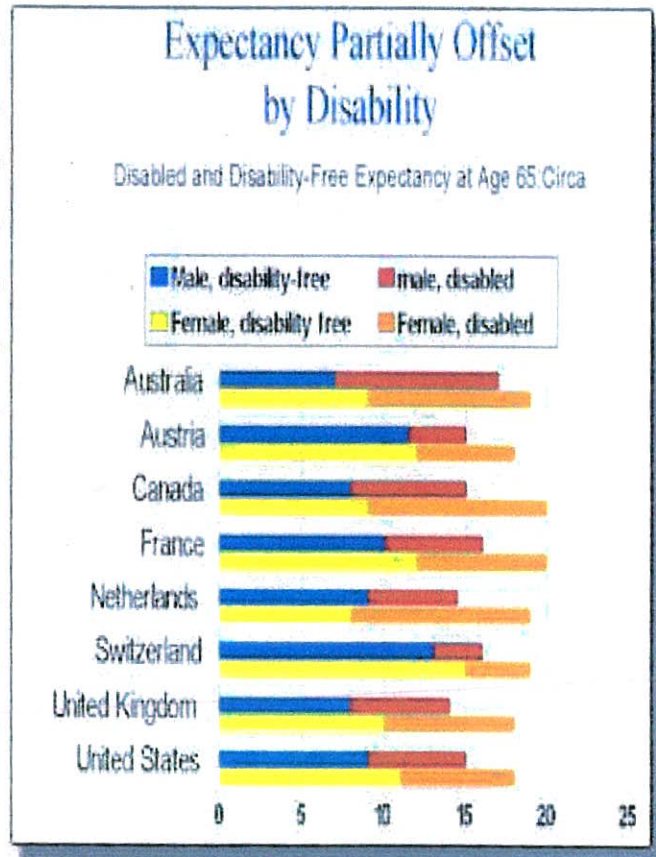


Figure 14: Expectancy partially offset by disability

Source: World Health Organization, 1995, commonality that has emerged from World Health Report 1995, Geneva.

Various studies show that women who reach 65 years of age can expect to live more disability-free years than their male counterparts (except in the

Netherlands). However, because women have higher life expectancy than do men at age 65 years, the proportion of disability-free remaining life at age 65 years tends to be greater for men (US Bureau of Census, 1996).

Economic Dependency of the Older Women

The size of the older female population needs to be examined in terms of labor force participation rates, as it reflects the nature and magnitude of their economic dependency and corresponding implications for social policy.

Available estimates on activity rates for 1990 show that in Asia one out of every five women aged 60-64 years is in active work force, and only a twelfth of the females aged 65 years of over are gainfully employed. These ratios are likely to be lower by the year 2020 when the labor force participation rate for women aged 60-64 years will be only 10 per cent, and for those 65 years or over it will be only 5 per cent (United Nations, 1988). The factors primarily responsible for the projected sharp decline in activity rates are increasing literacy among the young population, introduction of wage economy and mechanization of production.

Among sub-regions, the highest female participation rates are accounted for by Southeast Asia, where almost one-third of females aged 60-64 years, and one-sixth of those aged 65 years or over is participating in the labor force. The situation, however, has been projected to deteriorate with time in all sub-regions of Asia and the Pacific.

Labor force rates have been used to support views regarding the economic dependency of older woman on society. The rates appear to be much lower

for older women in the region as compared to those old men. Data indicate that labor force participation rates for men aged 60-64 years are as high as 77 percent in the South-east Asia, 74 percent in south Asia, 66 percent in East Asia and about 58 percent in the Pacific. Recorded female participation rates are extremely low, being less than 20 percent in all sub-regions, except Southeast Asia (United Nations, 1988). Even in the 65⁺ populations, activity rates for are over 30 percent all over the region, except for the Pacific sub region. Female activity rates, on the other hand, are recorded as below 10 percent in all sub-regions, with the exception of South-east Asia, where it is about 18 percent.

Table 20: Asian and Pacific Region: Activity Rates of Older Person by Sub Region 1990-2020

Region/ sub region	1990				2020			
	60-64		65 ⁺		60-64		65 ⁺	
	Male	Female	Male	Female	Male	Female	Male	Female
World	62.6	19.2	31.4	7.1	56.3	12.6	21.6	4.2
Asia	70.2	19.4	41.6	8.7	59.3	10.1	26.0	4.7
South Asia	74.4	17.6	53.7	8.9	62.1	11.5	32.7	5.3
South-East Asia	77.0	30.0	48.3	17.7	63.1	17.7	26.8	8.4
East Asia	66.2	17.6	32.6	6.7	56.1	6.2	21.8	3.4
Pacific	57.9	17.1	15.4	4.5	54.7	13.7	11.8	2.6

Source: United Nations (1988), *World Demographic Estimates and Projection, 1950-2025*. New York.

Substantially low female participation rates are also recorded at the country level. Activity rates for males aged 65⁺, for example were over 50 per cent in

India, Indonesia and Fiji, Malaysia, Sri Lanka and Thailand (Fong, 1980). In Contrast, activity rates for females aged 65⁺ were less than 10 per cent in most countries of the region, including the two largest countries, China and India, with the highest figure of 10.5 per cent for Indonesia. The situation has been projected to worsen by the year 2020.

The extent to which the above figures should be considered as indicative of actual dependency needs to be examined since in recent years' labor force statistics have come under heavy criticism because of their inaccuracy and incompleteness concerning women. Whereas official statistics frequently portray women as economically inactive members of society, their labor, especially among the poor, is essential for the survival of their families. In several national and international forums, the shortcomings of female labor force statistics have been repeatedly pointed out, and recommendations made to take immediate steps to improve these data so that the important economic role played by women may be reflected in labor force statistics. (ESCAP, 1982; United Nations, 1980; Dixon, 1982; Fong, 1980; and Boserup, 1975)

It is necessary to know how Economists and Statisticians define economic activity, i.e. how they distinguished between economic and non-economic activities, and therefore, labor force and non-labor force activities. The nature of many activities in which women are engaged in developing countries of the Asia and Pacific region are economic in nature, and should therefore be regarded as labor force activities. Those activities include animal husbandry (e.g. tending and milking) and home production of primary products (e.g. food processing, grinding and flour-making) for

family use and for sale. Yet the current distinction between labour force and non-labour force activities disregards the reality of women's work (Anker, Khan and Gupta: 1988).

More Vulnerable are the Single Older Women: Living a Precarious Life

Several researches demonstrate that in terms of their share, women outnumber men not only among the aged and older but also among the single older population. A study in Armenia, undertaken jointly by the Ministry of Statistics and by the World Bank, reveals that in 1996-1997, women accounted for 86.8 per cent of the 70,000-80,000 single pensioners. In Armenia, 22.3 per cent of single pensioners survive mainly as a result of humanitarian assistance, this being the sole source of subsistence for about 7 per cent of this group (AZG, 2000). The overwhelming majority of them are women. Especially precarious, is the situation of single pensioners who are 75 years or older and who survive exclusively on such assistance. Women account for 90 percent of this sub-group. Economic, physical and psychological insecurity, a lack of contact with relatives and friends and dependency on others, are among the acute problems for single older women (28.6 per cent, 27.2 per cent and 25.5 per cent respectively).

A study conducted on the single older person taken care of and are provided with medical and social services by the 'Mission Armenia Charity Union', has revealed that 15 per cent of single older person in Yerevan are in an extremely precarious socioeconomic situation; 43 per cent are in a poor situation; 35 per cent in tolerable and only 7 per cent in good circumstances. Over 91 per cent of the beneficiaries of the Union are women (AZG, 2000).

The prevalence of single older women throughout the world can be attributed to a number of reasons:

To begin with, since the average female life expectancy is greater, more married women in their later age lose their spouses than men do. Furthermore, after losing a spouse more men of that age re-marry, whereas women almost never do.

Secondly, women who are 60 years or older today were born before World War II, which caused an imbalance in the sexual composition of society and as a result, a considerable number of women in this age group either never married at all or their spouses were men whose health suffered in the war and who, not surprisingly, died prematurely.

Thirdly, because of the patriarchal system that men are the principal initiators of marital and family relationships and have obvious advantages over women in selecting a partner (considering the fact that after World War II, women far outnumbered men), some women never married and consequently remain single in their old age (AZG, 2000).

Finally, a dramatic increase in the mortality rates of people of working age (owing to armed ethnic conflict and poor socioeconomic conditions, etc.) has also contributed to the growth in numbers of single older people.

Conclusion

Carroll Estes, director of the Institute for Health and Aging at the University of California at San Francisco, blamed *the state and patriarchy* and an *entitlement war on women* for women's condition of lifelong dependency

and a *crisis* of aging that pushes millions of women into poverty, even in rich countries. She said women are robbed of needed Social Security benefits in retirement because of unpaid care-giving as wives and mothers that keeps the average woman out of the workplace for 15 years, compared with three years for men. Social Security benefits are based on a person's lifetime wages (Archibald, 1998).

Older women constitute a distinct population that requires interventions very different from those for younger women. Although medical care for managing diseases is the intervention most often used and the existing health services are geared toward acute rather than chronic care, preventive measures would be more appropriate and cost effective for the problems of older women. Prevention through early detection and treatment is available but still not widely accessible for the population that most needs the service (United Nations, 1998). For example, health education for diabetic patients can help those affected to improve their own capacity for self-care and hence reduce the likelihood of medical complications.

We should not keep the older women segregated from their daily work for their health security. In that case they will suffer from depression and loneliness. They will start to feel them burden of the society. Older women do a variety of domestic activities. We should value their activities properly. We also can engage them in income generation activities. They can work as school teachers, baby seeders, counselors, program designer etc. Older women can produce and analyze large quantities of key information about skill, resources and social structure.

The older women should not force out of their jobs by a rigid retirement age or other discriminatory practices. A flexible retirement scheme and legal protection will enable older women to remain economically active. Job creation and retention programs should be established to bring back older women. Such program will also enhance the employability of older women through upgrading of knowledge and skills (HAI, 1999). Self –employment among older women will be encouraged through advisory services and other assistance.

In fine, the issues of aged and older persons, especially of older women, have become a subject drawing the attention and concern of the international public. The increasing numbers of older people as well as the multiplicity of their fundamental problems has enforced the authorities and NGOs alike to take a position and action.

B. Bangladesh Situation and Privileges

Introduction

In the Asian and Pacific region, there is a crying need to focus the issues of the older women to the planners at both micro and macro levels because of the following reasons:

- a. They constitute the larger segment of the older population;
- b. They are, particularly a vulnerable group even within a socially disadvantaged group of older persons; and
- c. It is the society responsible for their poor situation around the region.

Over the entire life span, from childhood to old age, women's chances of ageing into financially secure, socially integrated and physically healthy persons are considerably marred by their unequal access to political opportunities for self representation of their best interests, their economic independence, and the health risks that they are subjected to, as a result of poorer nutrition, child bearing, and more labour-intensive work under harsher working conditions (ESCAP, 1991).

Table 21: Percentage of older women out of total female population

Year	Elderly women as % of total female population
1911	4.4
1921	4.1
1931	2.8
1941	3.7
1951	4.2
1961	4.9
1974	5.2
1981	5.59
1991	6.68
2001	9.06

Ever since the First world Conference on Women in Mexico (1975), gender issues have increasingly become a predominant theme of the worldwide development discourse. Bangladesh was one of the first developing countries to establish a Ministry of Women's Affairs in 1978, three years after the Mexico Conference.

Source: Sattar, M. A. (1981). *Sex and Age Composition of the Population*. Country Monograph Series No. 8, Population of Bangladesh, ESCAP, United Nations, Bangkok, Thailand.

Demographic Scenario of Older Females in Bangladesh

Bangladesh with relatively high proportion of young population has just experienced a transition from high to low levels of mortality and fertility. Over a period of more than two decades, the sex ratio decreased from 108 to 105. Bangladesh is one of only few countries in the world (India, Nepal, Pakistan, Sri Lanka, Papua New Guinea) where males outnumber females.

The population of older women is growing at a fast rate that accounts for a significant number, about 5 million (ESCAP, 1991) and among the older women in Bangladesh, 68 percent are widowed (The Daily Ittefaq, 29th December 2001).

The table 21 shows the number of older female population as a percentage of total female population in Bangladesh in the census years, 1911-2001. One of the chief characteristic of this population is that they are largely rural dwellers. The increase in life expectancy contributing to the ageing of older women

Contributions of Older Women in Bangladesh

A survey report for older women in Bangladesh (Samad and Abedin, 1998) reveals that the majority of the older females in Bangladesh are usually engaged in cooking (85.7 percent), cleaning (69 percent), and laundry (70 percent) and reports that their children buy the food (76.1 percent), pay the bills (68.9 percent), and take care of the property (70.8 percent).

The older women are considered the domestic authority of chores and household tasks; it is possible that other female members often share the burden of household chores.

Table 22: Percent distribution of older women according to main person responsible for selected household chores

Main person Responsible (for selected HH chores)	Household Chores					
	Buying food	Cooking	Cleaning	Doing laundry	Paying bills	Taking care of property
Female						
Self	4.2	85.7	69.0	70.1	0.0	1.8
Spouse	12.5	0.0	0.0	12.5	22.6	23.0
Child	76.1	10.6	24.6	14.3	68.9	70.8
Sibling	3.1	2.3	3.2	1.2	4.3	2.4
Grandchild	3.2	0.5	1.3	0.8	3.2	1.8

Source: Samad and Abedin, 1998; Table 3B.1

Social Issues for the Older Women in Bangladesh

Socio-economic, political, spiritual, religious and cultural factors in Bangladesh have an especially adverse impact on the lifestyles of the older women. The following, are important social issues for them:

- a. Economic insecurity:** they are in dire need of financial, food, clothing and energy resources as well as of household goods and other appliances;
- b. Health care insecurity:** in general they face inaccessibility to medication and quality medical services;
- c. Employment insecurity:** a lack of jobs basically denies the opportunity for the older women to have an

- additional source of economic security and to retain their social status;
- d. Social insecurity:** there are lacks of opportunities for primary services and treatment, home help and access to legal services to protect their rights;
- e. Mental insecurity:** they have few opportunities to be appreciated by society, friends and family in order to preserve their feelings of self-worth, physical and mental security and to share their experiences of life to younger generations;
- f. Social isolation:** there is little chance of maintaining contacts with their relatives, children, acquaintances, friends and people of the same age; of getting information on domestic and foreign developments; or for participating in a fully-fledged manner in the running of the family and in the administration of the community and the country.
- g. Mental and physical rehabilitation:** there is a lack of opportunities to make use of health care and physiotherapy rehabilitation services and for quality pastimes, necessary for the preservation of their mental abilities.
- h. Inaccessibility of the environment:** there is a lack of accessibility to social infrastructure and risks to health due to the degradation of the environment.

Generally speaking, to a great extent the issues fundamental to the older women are the same as those fundamental to older men in our country.

Vulnerability among Older Women in Bangladesh

Bangladesh is such a country where traditionally people love and respect the older people. The traditional joint families fulfill the basic needs. Now, the family structure in Bangladesh has greatly changed by the industrialization, modernization and westernization. The joint families have broken into nuclear families. As a result the older persons especially the older women are the ones victimized by the problem.

Now a day, a huge number of women are working outside the home. They take up almost all kind of professions: industrialists, labors, teachers, service holders, shopkeepers, businesswomen etc. Those women, who are not working outside also pass a busy time. They have to nurture the children, go to market and do their household works. Now they are more assertive about their position in the family. But those women, who are 60 years and above have lost their authority over the family because they are unable to carry on with their share of the activities (Nahar, 1999).

Several studies show that in our country setting, the older women group is the most vulnerable one due to the general attitude toward them, physical and mental harassment both at home and work place, economic insolvency, social alienation, powerlessness, insult from many aspects, lack of access into the decision making procedure and moreover, inaccessibility into the better healthcare support.

Initiatives for the Betterment of Older Women in Bangladesh

Several initiatives have been taken both from the government and non-government level in Bangladesh in order to overcome the poor situation of the elderly women. For example, they are among the beneficiaries of a loan scheme operated by the Grameen Bank to enable them to engage in a variety of income generation activities, such as sewing, weaving, fish net production, food processing, dairy and poultry production, and small scale trading. Loans are provided at interest rates considerably lower than those available through traditional village money lenders. These ventures have increased average family incomes by over 30 percent (Ageing International, 1988). Thus, their share of income in family has increased their dignity in the family as well as in the society.

Bangladesh Women's Health Coalition (BWHC) has initiated a small number of health programs for the older women in Bangladesh. They are increasingly being included in education services through clinic based health care centers in both urban and rural areas.

A National Committee on Ageing has already been set up in Bangladesh, which coordinates, monitors and formulates guidelines for activities relating to them to be carried out by various agencies and the ministry.

Conclusion

We should not keep the older women segregated from their daily work for their health security. In that case they will suffer from depression and loneliness. They will start to feel them burden of the society. Older women

do a variety of domestic activities. We should value their activities properly. We also can engage them in income generation activities. They can work as school teachers, baby seeders, counselors, program designer etc. Older women can produce and analyze large quantities of key information about skill, resources and social structure (HAI, 1999).

The older women should not force out of their jobs by a rigid retirement age or other discriminatory practices. A flexible retirement scheme and legal protection will enable older women to remain economically active. Job creation and retention programs should be established to bring back older women. Such program will also enhance the employability of older women through upgrading of knowledge and skills. Self –employment among older women will be encouraged through advisory services and other assistance.

In fine, the issues of ageing and older persons, especially of older women, have become a subject drawing the attention and concern of the international public. The increasing numbers of older people as well as the multiplicity of their fundamental problems has enforced the authorities and NGOs alike to take a position and action.

C h a p t e r E i g h t

PROBLEMS AND PROSPECTS OF THE OLDER PERSONS IN BANGLADESH

'Uncertainty rules
our lives'

Older men and women
Bangladesh

Chapter Eight

Problems and Prospects of the Older Persons in Bangladesh

Introduction

Many traditional beliefs and prejudices have been established surrounding the changes in human beings as they age. The prejudices characterize the older persons as passive, chronically sick, avoiding sexual feelings, depending on other's support and care, etc. These beliefs stigmatize the older persons to condemn themselves to a marginal social existence and to lead a life isolated from the works of other members of the family (Ali, 1996). The young members consider these practices as showing respect to the older persons on whom they rather seek advice for solution of various critical socioeconomic problems.

In 1994, the UN International Conference on Population and Development expressed regret that the older persons have come to be viewed as dependent beneficiaries of development rather than contributors to it. The time had come to put things right. One of the outcomes of the Geneva 2000 UN Social Summit was to renew its call that older people be recognized as contributors to, as well as beneficiaries of development. Yet, within the international development community, policies that support and enable older people remain few and far between (HAI, 2000).

As revealed by a research, older people identified their most important contributions as (HAI, 1999):

- a. Income generation and financial support to their family;
- b. Child care and care of other dependants/sick family members;
- c. Housekeeping and guarding;
- d. Disaster coping strategies;
- e. Recovery and reconstruction;
- f. A wide range of (indigenous) knowledge and experience;
- g. Traditional healing and crafts;
- h. Motivation of others and personal courage in adversity;
- i. Preservation and transmission of cultural heritage, stories, and activities;
- j. Family and community conflict resolution;
- k. Community knowledge that can assist in relief targeting and distribution.

These contributions also stand as well true for the older people in Bangladesh. Despite their remarkable contributions to the family and society as well, older people suffer from problems of varied dimensions. This is happening due to the very existence of a strong pattern of non-recognition of their overall contribution. While considering the growing number of older persons is itself a major problem for themselves, other problems that they face may be viewed from physical, economical, cultural, social, and psycho-social standpoints.

The older people are not a homogeneous group their chronological age. They differ among themselves in education, health, economic and social status, within a country and between countries. The opportunities and attitude of society towards the older are different in different society. So, it is very difficult to find out unique measures to address the problem of aging (Mian, 1996). The case of the older persons is an emerging social problem in Bangladesh. In the past, care of the older persons was the responsibility of the greater family in kinship network relations. The responsibility is now being narrowed down to the immediate family where the older persons are not getting proper treatment. In the past, the older persons would play significant role in the family and society to the highest of their powers and ageing was an experience, which would enjoy much facilities and honor (Sarker, 1998). But now a day the situation has become altogether changed and it is now considered as an acute problem.

One of the acute problems of the older persons is poverty since they have lost energy to earn. About 85.0 percent older persons people live in rural areas and more than 60.0 per cent of them do not own any cultivable land. In rural Bangladesh land determines who eats and who does not (Hartman and James, 1979). Consequently, many of the poorer section of the older persons do not get adequate food to survive. They can hardly consume meat, fish, egg, fruits, etc. and as a result many of them are under nourished (Sarker, 1998). In Bangladesh, elder abuse and neglect is a prime but hidden problem. Elder abuse and neglect comes in many forms-including physical, psychological, sexual, financial, self-neglect, and substance abuse. It occurs in community and institutional settings as well as at home and significantly

shortens the lives of the older victims. Although there are varying reports about its incidence, there is general consensus that it is vastly underreported.

The plague of underemployment causes the core problem faced by older persons. In our country, about 75 per cent of the people are below the poverty line and majority of the people do not get even 1650 calories a day. The family cannot do as much as it would like to do for the older persons in spite of its best intentions on account of pauperized conditions (Habibullah and Wahid, 1987). The older persons also suffer from the psycho-social problem due to loss of authority in decision making in family affairs, shift of resources and tradition control over the younger generation, devaluation of tradition skills, honor, prestige and dignity (Habibullah and Wahid, 1987).

Housing is another problem encountered by the older persons. About three-fourth of the total dwelling units of the older persons have only one room (Sadeque, 1990: 81). In the circumstances, many of the older persons are shelter less and significant numbers of them are to live with their neighbors. The poorer section of the older persons spends 80.0 per cent of their total income to collect food and as such they cannot afford minimum clothing (Sarker, 1998). One of the contributing factors that are responsible for health problem is poverty and dependence on traditional treatment system. Moreover, malnutrition makes them prone to disease, which helps increase morbidity and mortality.

As mentioned earlier, social adjustment in the second age is another problem of the older persons. There exists no such strong arrangement for the creation of the awareness of old age issues among those who are to approach the retirement age. While the unmet physiological needs may be viewed as

one vital aspect of the problems of older persons, still there are many. Under the existing system of health care, there is hardly any separate component for geriatric care, together with the health educational facilities that might benefit the older persons to get acquainted with the health and hygienic principles.

Bereavement of the spouse or some near and dear one is also an agonizing issue for the older persons in Bangladesh. As retirement from active life advances, possibility of accelerated physical degeneration and ailments become greater. A more acute problem is the passing away of family headships or power of decision making on family matters (Ibrahim, 1988), which very often results in loneliness and social isolation. Many of the affluent older persons usually live separately from their children and grand children especially in the urban areas. Very often they live in tension and anxiety since they are aloof from kith and kin and afraid of the occurrence of various incidences of their children, grand children and other relatives. Frustration and anxiety produce discomfort in the life of the older persons and help generate several kinds of diseases (Sarker, 1998). Moreover, in this isolated life they do not get emotional support especially in distressful situation. Many of the older persons feel tremendous mental depression after retiring from their services, which affects their mental health (Mazumder, 1994). Moreover, conflict between the in-laws creates mental torture and sometimes in the extreme case the older persons commit suicide to get rid of the oppression (Sarker, 1998).

In 1996, Ali found a few older persons who look forward to lead a life that can eschew decayed processes to remain very active to do their routine duties without help from others. They do not like to be on the dole but like to

enjoy fuller and more productive lives for a longer time. On the other hand there are a few older persons who consider old age as a time for reflection about death and withdrawal from the active world, undertake a passive role to devote more attention and time to leisure pursuits, seek help from other persons and become victim of ineluctable fate (Ali, 1996). They are found to be socially isolated and remain devoted to prayer for happiness in the eternal world involving deeply in a sublimated existence to follow philosophical principle that nothing is real but soul or spirit.

Antagonistic relationship between the mother-in laws and the daughter-in laws is a common feature of our society, which affects the care of the older persons especially in case of older persons women. Moreover, some of the older persons are single due to upon divorce or separation and living alone like destitute. This humiliated life sometimes encourages them to commit suicide or to depend on begging (Sarker, 1998).

Considering all these problems, however, the Government of Bangladesh has expressed its concern over this dire adverse situation of the older persons. Since the National Committee on Ageing was formed in 1982, experts, scientists, academicians along with the politicians are doing their utmost to overcome the existing situation by conducting relevant research and incorporating policies suitable for the older persons into their manifesto.

However, we are fortunate that the practice of looking after the older persons still exists in our country, as the concept of nuclear family has not made significant impact in the contemporary rural society.

Findings of the Survey

Age: Majority of the respondents was in the age group of 60-64. About 70 percent were in the sixties and 22 percent were in their seventies. Only 8.4 percent had crossed eighty. The mean age of the urban respondents

Table 23: Percentage distribution of older persons by age, sex and residence

Age (in years)	Rural					Urban				
	Male		Female		Total		Male		Female	
	%	f	%	f	%	f	%	f	%	f
60-64	53.8	64	41.2	54	47.2	118	48.6	54	41.7	58
65-69	35.3	42	34.4	45	34.8	87	27.0	30	23.0	32
70-74	8.4	10	15.3	20	12.0	30	17.1	19	10.8	15
75-79	1.7	2	6.1	8	4.0	10	4.5	5	11.5	16
80+	0.8	1	3.1	4	2.0	5	2.7	3	12.9	18
Total	100.0	119	100.0	131	100.0	250	100.0	111	100.0	139
Mean Age	64.8		66.5		65.7		66.1		68.4	
χ^2					18.35					

was 67.4 years and it is slightly higher (68.4 yrs.) in the male. The mean age is about 2 percent lower in both rural aged (65.7 yrs.) as well as in rural male (66.5 yrs.) compared to the urban ones. At 5 per cent level of significance, the chi-square value 18.35 indicates that the nature of area has a significant influence on the age distribution of the older persons.

Marital Status: The results of the survey reveal that out of 500 older persons aged 60 years and above, selected from both the rural and urban

Table 24: Marital Status

Marital Status	Rural		Urban		Total	
	%	f	%	f	%	f
Married	69.2	173	73.2	183	71.2	356
Widow	25.6	64	13.6	34	19.6	98
Widower	5.2	13	10.0	25	7.6	38
Divorced/ Separated	--	--	3.2	8	1.6	8
Total	100.0	250	100.0	250	100.0	500

areas equally, majority of the respondents (71.2%) were living with their spouses. The incidence of widowhood was

found to be higher (25.6%) among the rural older people compared to the urban (13.6%) ones. Noticeably, not a single evidence of divorce/separation was found among the older persons residing in rural areas.

The analysis indicates that none of the older persons remained unmarried though many of them became single afterwards-either widowed, widower, divorced or separated.

Table 25: Sex

Sex	Rural		Urban		Total	
	%	f	%	f	%	f
Female	47.6	119	44.4	111	46.0	230
Male	52.4	131	55.6	139	54.0	270
Total	100.0	250	100.0	250	100.0	500
Male female ratio	100:91		100:80		100:85	

Sex: Table 25 displays the distribution of the sample by

sex. The overall male-female ratio was around 100:85 i.e. among 500 respondents, 46 percent (230) were older female and 54 percent (270) were older male. However, male to female ratio was higher for rural subjects (100:91) than for urban ones (100:80).

Religion: Considering the two broad categories, Muslims and non-Muslims,

Table 26: Religion

Religious Status	Rural		Urban		Total	
	%	f	%	f	%	f
Muslim	85.6	214	87.6	219	86.6	433
Non Muslim	14.4	36	12.4	31	13.4	67
Total	100.0	250	100.0	250	100.0	500

the majority of the respondents in the study were Muslims (86.6%). Among the non-Muslims 31 (%) of

the rural and 26 (%) of the urban areas were Hindus and rest were Buddhists and Christians. The religious composition in this study reflected the same picture as that of 1981 census.

Educational Status: Exactly half (50%) of the rural and about one-quarter (24.8%) of the urban older persons was illiterate. The table also shows that the higher the age the greater the rate of illiteracy

Table 27: Percentage distribution of older persons by educational status

Level of Education	Rural		Urban	
	%	f	%	f
Illiterate	50.0	125	24.8	62
Class I-V	18.0	45	15.2	38
Class VI-VIII	7.2	18	10.0	25
Class IX-X	3.2	8	8.4	21
Class XI-XII	1.2	3	8.0	20
Graduation	--	--	6.0	15
No formal education but literate	19.2	48	24.4	61
Others	1.2	3	3.2	8
Total	100.0	250	100.0	250

indicating lower school enrollment in the past. Noticeably more (18%) rural older persons completed their primary education compared to the urban (15.2%) ones. High rate of no schooling and non-enrollment in graduation among the rural older persons reveals that rural older persons lag behind in education.

At 5% level of significance the chi-square value 60.17 indicates that the place of residence is not independent of the level of education.

Table 28: Percentage distribution of older persons by their present occupation

Present Occupation	Rural		Urban	
	%	f	%	f
Farming	11.2	28	--	--
Farm/Day Labor	17.6	44	13.2	33
Industrial Labor	--	--	6.0	15
Service	--	--	6.0	15
Business	3.6	9	4.8	12
Others*	67.6	169	70.0	175
Total	100.0	250	100.0	250

* Housewife, House tutor, Rickshaw Puller, Beggar, Retired etc.

persons were housewife, house tutor, rickshaw puller, beggar, retired etc that has been categorized as others. Only 11.2 percent of the rural older persons and none of the urban older persons were engaged in farming. Service was the present occupation for 6 percent of urban and none of the rural older persons. Only a few were involved in business.

Table 29 shows the percentage of widow/widower older persons by the time since they had lost their spouses. About 33 per cent of them who were residing in rural areas had lost their spouses 9 to 12 years ago whereas 31.9 per cent of the urban subjects had lost 5 to 8 years ago. Only a few of them, 3.9

Table 29: Percentage of widow/widower older persons by the time since they had lost their spouses

Time (in years)	Rural		Urban	
	%	f	%	f
0-1	3.9	3	6.8	4
1-4	12.9	10	17.0	10
5-8	26.0	20	31.9	19
9-12	32.5	25	20.1	12
13+	24.7	19	24.2	14
Total	100.0	77	100.0	59
Mean Time	9.5		8.6	

Present

Occupation: Table

28 shows the distribution of the respondents by their present occupation. The major occupation of both the urban and rural older

percent of rural and 6.8 percent of urban subjects had lost their spouses very recently during last 11 months.

However, the mean duration since they had lost their spouses was 9.5 years and 8.6 years for the rural and urban widowed/widower respectively.

Table 30: Percentage distribution of older persons by their age at first marriage

Age (in years)	Rural				Urban			
	Female		Male		Female		Male	
	%	f	%	f	%	f	%	f
-14	85.8	102	--	--	65.7	73	--	--
15-19	14.2	17	68.2	77	30.6	34	19.5	27
20-24	--	--	28.4	32	3.7	4	42.5	59
25-29	--	--	14.2	16	--	--	33.1	46
30+	--	--	4.2	6	--	--	4.9	7
Total	100.0	119	100.0	131	100.0	111	100.0	139
Mean age	13.2		20.6		14.4		23.7	
			17.1				19.6	

Age at First Marriage:

The table 30 reveals early marriage among the females older

women that are a typical situation in Bangladesh context. Of the older women about 86 per cent of the rural and 66 per cent of the urban females got married at or before the age of 14 whereas no male respondent got married by the same age. Evidence of late marriage was found only among male respondents in both areas. The mean age at first marriage for the urban (19.6) was higher than that of rural (17.1) older people. It was 23.7 years for the male respondents of the urban area.

Times of Marriages: Majority of the respondents i.e. 35.1 percent of rural and 41.1 percent of urban got married once in their lifetime followed by them

who got married twice. The times of marriages 4 and above were higher for the rural older people (6.7%) comparing to the urban. The mean times of

marriages for the rural and urban older people were 2.1 and 1.8 respectively.

The chi-square value 9.97 indicates that, at 5% level of significance the place of residence has significant influence over the number of marriage but

Table 32: Percentage distribution of older persons by duration of their conjugal life

Duration (in years)	Rural		Urban	
	%	f	%	f
-10	10.4	26	6.4	16
11-20	17.6	44	8.8	22
21-30	24.4	61	26.0	65
31-40	28.0	70	31.6	79
41+	19.6	49	27.2	68
Total	100.0	250	100.0	250
Mean	27.9		31.4	

conjugal life for about 31-40 years. After this period the conjugal life sustained for 19.6 percent of the rural and 27.2 percent of the urban older

Table 31: Percentage distribution of Muslim older persons by the number of marriages they got

Number of Marriages	Rural		Urban	
	%	f	%	f
1	35.1	75	41.1	90
2	31.4	67	37.0	81
3	27.1	58	19.7	43
4+	6.7	14	2.2	5
Total	100.0	214	100.0	219
Mean	2.1		1.8	

insignificant at 99 percent confidence interval.

Duration of Conjugal Life:

Table 32 gives the distribution of the respondents by duration of conjugal life. The modal group for both the areas is 31-40 i.e. majority of the respondents lived their

people. The mean years of conjugal life of the respondents were 27.9 and 31.4 for the rural and urban subjects respectively.

Table 33: Percentage of respondents by their number of children alive

No. of Children Alive: The average number of living children differed for rural and urban inmates and the same for rural inmates (4.9) was higher than that of urban inmates (4.2). A majority (38%) of the rural older people had 5-6 living

Number of Children	Rural		Urban	
	%	f	%	f
0	2.0	5	3.2	8
1-2	17.2	43	24.0	60
3-4	22.0	55	34.0	85
5-6	38.0	95	18.4	46
7-8	11.6	29	16.4	41
9+	9.2	23	4.0	10
Total	100.0	250	100.0	250
Mean	4.9		4.2	
χ^2				

children whereas this number for the urban older people was 3-4. Only a few 2 per cent of the rural and 3.2 per cent of the urban older people had no children alive.

Use of Contraceptives: A maximum of 77.2 percent respondents did not use contraceptives in their conjugal life. This figure for the rural older

Table 34: Percentage distribution of older persons by whether they used contraceptives in their conjugal life

Contraceptive Use	Rural		Urban		Total	
	%	f	%	f	%	f
Yes	3.2	8	14.4	36	8.8	44
No	80.4	201	74.0	185	77.2	386
No Response	16.4	41	11.6	29	14.0	70
Total	100.0	250	100.0	250	100.0	500

people, however, was higher (80.4 percent) than that of their urban

counterparts. 70 non-responses out of 500 were identified.

Living Arrangement: Living arrangement of the older people in any culture is an indication of the kind of socio-economic support they enjoy towards

the end of their life. The picture can be seen in table 35. More than half, 56.8 percent and 68 percent of rural and urban older persons respectively, of the respondents were living alone/with their spouses. The rest were living in the vicinity of their children and other relations, of which the majority lived in the neighborhood of their sons.

Table 35: Percentage distribution of older persons by their living arrangement

Living With	Rural		Urban	
	%	f	%	f
Self / Spouse	56.8	142	68.0	170
Son	35.2	88	25.6	64
Daughter	6.0	15	2.0	5
Other Relations	2.0	5	4.4	11
Total	100.0	250	100.0	250

Father's Age at the Time of Death: The table 36 shows the percentage distribution of older persons by their fathers' age at the time of death. Of the rural respondents, their fathers' mean age at the time of death was 69.6, a bit

Table 36: Percentage distribution of older persons by their fathers' age at the time of death

Age (in years)	Rural		Urban	
	%	f	%	f
30-45	7.6	19	16.8	42
46-60	23.6	59	20.4	51
61-75	38.0	95	25.2	63
76-90	23.2	58	27.2	68
91+	2.4	6	2.4	6
Father alive	5.2	13	8.0	20
Total	100.0	250	100.0	250
Mean age	69.6		71.0	
Correlation	0.85			

less than that of urban respondents' stands at 71. A nearly perfect positive correlation ($r = +0.85$) exists between the fathers' age of the rural older people at the time of death and that of urban older people.

Mother's Age at the Time of Death: The table 37 shows the percentage distribution of older persons by their mothers' age at the time of death. Of the rural respondents, their mothers' mean age at the time of death was 71.2, a bit higher than that of urban respondents stands at 68.4. A positive correlation ($r = +0.27$) exists between the mothers' age of the rural older people at the time of death and that of urban older people.

Table 37: Percentage distribution of older persons by their mothers' age at the time of death

Age (in years)	Rural		Urban	
	%	f	%	f
30-45	12.0	30	18.4	46
46-60	27.2	68	22.0	55
61-75	15.6	39	28.4	71
76-90	30.4	76	12.0	30
91+	7.2	18	9.6	24
Mother alive	7.6	19	9.6	24
Total	100.0	250	100.0	250
Mean age	71.2		68.4	
Correlation coefficient		0.27		

Present Working Status: The work participation among the rural older people is high as compared to their urban counterparts indicating that most

Table 38: Percentage distribution of older persons by their present working status

Working Status	Rural		Urban	
	%	f	%	f
Working	47.2	118	29.6	74
Not working*	52.8	132	70.4	176
Total	100.0	250	100.0	250

* Retired, housewife, different minor works

of them were working in agricultural sector in rural areas. About 47.2 percent of the rural and 29.6 percent of the urban older people were in the workforce. Almost 52.8 percent of the rural and 70.4 percent of the urban respondents were not working. This non-working category includes retired persons, housewife and different minor works (Table 38).

Presently Working Elderly by Their Occupation: Table 39 displays the percentage distribution of older persons who are presently working by their

occupation. Of them, 43 out of 118 rural subjects and none of urban subjects were engaged in farming. Around 17 percent of the rural older persons were doing business as against 27 percent of urban older people. Only 4.3 percent of rural and 16 out of 74 urban subjects were in service.

Time that Passed Since Stopping Work: Table 40 gives the distribution of respondents by the time in years since they have ceased to work. These are

Table 39: Percentage distribution of older persons who are presently working by their occupation

Occupation	Rural		Urban	
	%	f	%	f
Farming	36.5	43	--	--
Farm Labor	29.7	35	--	--
Industrial Labor	--	--	13.4	10
Service	4.3	5	21.6	16
Business	17.0	20	27.0	20
Others	12.5	15	38.0	28
Total	100.0	118	100.0	74

the workers who are no more in labor force. From the figures in the table, it

Table 40: Percentage distribution of older persons who are retired by time in years they have ceased to work

Time Length (in years)	Rural		Urban	
	%	f	%	f
1-5	39.2	47	32.0	49
6-10	34.2	41	29.5	45
11-15	16.8	20	23.5	36
16-20	6.8	8	10.5	16
20+	3.0	4	4.5	7
Total	100.0	120	100.0	153
No Response	--	12	--	23
Mean time	8.0		9.3	

is noted that 39.2 percent of the rural and 32 percent of the urban older people stopped work before a time interval of 1 to 5 years. In terms of time their withdrawal is somewhat recent. About 34.2 percent and 29.5 percent of them respectively did so around 6 to 10 years ago. As the time in years goes up, the

percentage of the respondents ceasing work goes down. This is natural. The mean times in years for the rural and urban respondents those have ceased to work were 8 and 9.3 respectively.

Reasons for Not Working: Table 41 shows this an overwhelming majority does not work, as their health does not permit. The figures in percentage vary from 47.9 for urban to 63.2 for rural respondents.

Table 41: Percentage distribution of older persons who are retired by reasons for not working

Reasons	Rural		Urban	
	%	f	%	f
Health does not permit	63.2	72	47.9	79
Mandatory retirement	--	--	9.1	15
Skill known is obsolete	6.2	7	10.3	17
Do not find suitable job	8.7	10	12.2	20
Need not to work	13.2	15	15.2	25
Others	8.7	10	5.3	9
Total	100.0	114	100.0	165
No response	--	18	--	11

A few complained that they did not find suitable job. However, there are people who are possibly economically

solvent, replied that they did not need to work. These figures in percentage were 13.2 and 15.2 in rural and urban areas respectively.

Table 42: Percentage distribution of older persons who are retired by their opinion on continue working

Willing to Continue Working	Rural		Urban	
	%	f	%	f
Yes	14.6	17	21.0	33
No	68.4	80	57.0	90
Depends on Circumstances	17.0	20	22.0	35
Total	100.0	117	100.0	158
No response	--	15	--	18

Opinion on Continue Working:

Table 42 reveals that 68.4 percent of the rural and 57 percent of the urban respondents were not willing to continue working. Only 14.6 percent and

21 percent of them respectively, of course, kept opinion in favor of

continuation in the labor force. Again almost the same proportion of them told that it depended on circumstances. Perhaps they referred to economic situations, health conditions and some other factors that might determine their continuation in active life.

Primary Occupation before Sixty Years of Age: Table 43 shows the distribution of older persons by primary occupation at their working age.

Farming and farm labor seems to have been the occupation of the rural respondents only.

Industrial labor constituted 18 percent of the urban respondents. It is a reflection of industrialization in the urban areas. However, a good percentage of the

Table 43: Percentage distribution of older persons by primary occupation at their working age (before 60 years of age)

Primary Occupation at Working Age	Rural		Urban	
	%	f	%	f
Farming	24.0	60	--	--
Farm Labor	9.2	23	--	--
Industrial Labor	--	--	18.0	45
Service	5.2	13	23.2	58
Business	8.4	21	21.6	54
Others	53.2	133	37.2	93
Total	100.0	250	100.0	250

respondents had their primary occupation other than service, business, farming and farm and industrial labor. About 23 percent and 22 percent of urban older people were primarily engaged in service and business making a significant difference with that of rural subject stands for 5.2 and 8.4 percent respectively.

Adequacy of Income to Meet Current Basic Needs: Table 44 reflects the distribution of older persons by adequacy of income to meet their current basic needs. A significant portion of the respondents opined that their income is inadequate to meet their current basic needs. Only 33.6 percent of urban and 13.2 percent of rural respondents told that they could adequately

meet their current basic needs. These groups of people are financially well off and perhaps saved money throughout their working life. The overall

Table 44: Percentage distribution of older persons by adequacy of income to meet their current basic needs

Adequacy of Income	Rural		Urban	
	%	f	%	f
Yes	13.2	33	33.6	84
No	86.8	217	66.4	166
Total	100.0	250	100.0	250

picture is somewhat depressing as it reflects acute poverty in the rural Bangladesh.

Sources of Income: Table 45 reveals the distribution of

older persons by their sources of income. Exactly half of the respondents were wholly dependent on others for their livelihood, as they had no sources of income. However, the percentage of these persons was higher in rural areas (58.8%) than in urban areas (41.2%).

Table 45: Percentage distribution of older persons by their sources of income

Sources of Income	Rural		Urban	
	%	f	%	f
Current work activities	6.0	15	11.2	28
Pension/Boynosko Bhata	3.2	8	5.2	13
Savings	3.6	9	7.2	18
Property	3.6	9	6.8	17
Multiple Sources	24.8	62	28.4	71
No Income	58.8	147	41.2	103
Total	100.0	250	100.0	250

multiple sources of income. A fewer portion of the respondents, 3.2 percent of rural and 5.2 percent of urban older people had been enjoying pension / Boynosko Bhata.

Needed Assistance: Respondents with inadequate income were asked to tell about the sources of assistance that they generally get to survive. The sources of such help can be seen in table 46. The major part comes from the offspring. The figures vary from 62.2 percent for the rural to 68.1 percent for the urban older people. This is somewhat encouraging as the figures indicate

that the relationship between parents and the children is still in good shape in Bangladesh. However, 79 percent of the subjects had multiple sources of

Table 46: Percentage distribution of older persons who do not have adequate income by sources of needed assistance (Reference table 21)

Source	Rural		Urban	
	%	f	%	f
Offspring	62.2	135.0	68.1	113.0
Brothers / Sisters	5.1	11.0	12.1	20.0
Other Relatives	10.2	22.0	19.3	32.0
Others	47.5	103.0	59.0	98.0
Multiple Sources	77.0	167.0	81.0	134.0
Total*	--	217.0	--	166.0

* More than one response possible

many as 222 of the total respondents, that is almost 58 per cent received needed assistance irregularly, of whom 65 percent were in rural and about 49 per cent were in urban areas. This is clearly an indication of the relatively high prevalence of economic hardship among the older

Table 47: Percentage distribution of older persons by how and when they receive needed assistance (Reference table 46)

How and When	Rural		Urban	
	%	f	%	f
Regularly	6.0	13	19.9	33
Irregularly	65.0	141	48.8	81
As and when required	17.1	37	27.6	46
No Response	11.9	26	3.7	6
Total	100.0	217	100.0	166

persons. Only a few, 13 out of 217 rural and 33 out of 166 urban older persons, receive assistance on a regular basis. Others get the same as and when required.

Sufficiency of the Amount of Pension: As depicted from table 48, only 8 out of 132 rural aged non-workers reported as pensioners. This figure for the urban aged is 13 out of 176, about 1.5 times of the rural ones. All the rural

assistance.

Patterns of Extended

Assistance: Table 47 shows the distribution of older persons by how and when they receive needed assistance. It was obvious that as

pensioners opined that the amount of pension was not sufficient at all to meet their basic needs. Again, all urban pensioners told that they received

Table 48: *Percentage distribution of pension holder older persons by sufficiency of the amount of pension to meet their basic needs as they opined*

Sufficiency	Rural		Urban	
	%	f	%	f
Not Sufficient at all	100.0	8	--	--
Moderate	--	--	92.3	12
Sufficient	--	--	7.7	1
Total	100.0	8	100.0	13

moderately sufficient amount of pension except one who went for "sufficiency" (Table 48).

Opinion on Pension

Drawing Procedure: Table 49 indicates the distribution of pensioners by their opinion on pension drawing

procedure. Exactly half of the rural pensioners opined that the procedure was

not unpleasant whereas more than half, 54.6 percent, of the urban pensioners termed the same a complicated and lengthy one. Again 30.6 percent of the urban pension holders called it a procedure of bribery

Table 49: *Percentage distribution of pension holder older persons by their opinion on pension drawing procedure*

Opinion	Rural		Urban	
	%	f	%	f
Very Complicated and Lengthy Process	12.5	1	54.6	7
Humiliating Process	--	--	7.4	1
Procedure of Bribery	--	--	30.6	4
Not Unpleasant	50.0	4	7.4	1
No Response	37.5	3	--	--
Total	100.0	8	100.0	13

and 1 out of 13 as a humiliating process. About 38 percent non-response was identified among the rural pensioners.

Rendering Monetary Help: Table 50 shows the distribution of older persons by whether they help any body with money. About 88 percent of the overall respondents could not help anybody with money. Only 17.6 percent of urban older persons could extend their hand towards others with money as

against 7.2 percent of the rural older persons, which is, again an indication

Table 50: Percentage distribution of older persons by whether they help any body with money

Whether They Help	Rural		Urban		Total	
	%	f	%	f	%	f
Yes	7.2	18	17.6	44	12.4	62
No	92.8	232	82.4	206	87.6	438
Total	100.0	250	100.0	250	100.0	500

of the prevalence of economic hardship among the respondents.

Types of Relations

Helped by the

Older Persons: Table 51 displays distribution of older person's types of relations who are financially helped by them. Most of them extended their help to their poor relatives followed by their offspring. Next were their siblings and the least

respondents

financially helped

others.

Land Ownership:

This can be seen in tables 52 from which it is noted that around 50 percent of the rural and 47 percent of the

Table 51: Percentage distribution of older persons types of relations who are financially helped by them (Reference table 50)

Types of Relationship	Rural		Urban	
	%	f	%	f
Son	27.6	5	25.0	11
Daughter	17.0	3	22.8	10
Brother / Sister	11.2	2	11.4	5
Poor Relatives	33.0	6	34.2	15
Others	11.2	2	6.6	3
Total	100.0	18	100.0	44

urban respondents do not have any homestead land. These people built houses in other's land though a comfortable house with due ownership rights is the desire of every older people. About 41 percent rural respondents and seventy-three percent urban respondents, again, do not own any agricultural land at all. Fifty-two out of 250 rural people have less than one acre of agricultural land. The mean acre of homestead and agricultural land for the

rural and urban respondents were 0.45, 1.6, 0.30 and 0.70. The overall situation thus seems to be somewhat depressing.

Table 52: Percentage distribution of older persons by land ownership

Land Owned (in acre)	Rural				Urban			
	Homestead		Agricultural		Homestead		Agricultural	
	%	f	%	f	%	f	%	f
0.00	50.4	126	41.2	103	46.8	117	72.8	182
0.01-1.00	34.4	86	20.8	52	51.2	128	--	--
1.01-2.00	10.4	26	14.4	36	2.0	5	20.4	51
2.01-3.00	4.8	12	6.8	17	--	--	--	--
3.01-4.00	--	--	2.8	7	--	--	3.6	9
4.01-5.00	--	--	4.8	12	--	--	--	--
5.01-10.00	--	--	6.0	15	--	--	2.0	5
10.01+	--	--	3.2	8	--	--	1.2	3
Total	100.0	250	100.0	250	100.0	250	100.0	250
Mean Land	0.45		1.60		0.30		0.70	

Monetary Asset and Debt: Table 53 reveals the distribution of older

Table 53: Percentage distribution of older persons by their monetary asset and debt

Amount (in Taka)	Rural				Urban			
	Monetary Asset		Debt		Monetary Asset		Debt	
	%	f	%	f	%	f	%	f
0.00	86.0	215	75.6	189	78.8	197	66.8	167
1-1,000	7.2	18	12.8	32	--	--	6.8	17
1,001-3,000	4.8	12	4.4	11	12.8	32	12.4	31
3,001-5,000	0.8	2	0.8	2	4.4	11	3.2	8
5,001-10,000	1.2	3	2.4	6	2.4	6	4.4	11
10,001-15,000	--	--	2.8	7	1.6	4	0.8	2
15,001+	--	--	1.2	3	--	--	5.6	14
Total	100.0	250	100.0	250	100.0	250	100.0	250
Mean Amount	230.00		872.00		748.00		1,618.00	

persons by their monetary asset and debt. Here monetary asset implied cash

in hand, savings in the bank/insurance etc. It was found that only 14 per cent of the rural and 21.2 per cent of the urban respondents had monetary asset, but of a very poor amount not worth mentioning. On the contrary, the strikingly encouraging picture is that about 76 and 67 percent of rural and urban respondents respectively did not owe any money to anybody. The average amount of monetary asset and debt of the rural older people was Taka 230 and 872 as against Taka 748 and 1618, that of urban older people respectively. However, it was very difficult to get the actual data.

Opinion on *Boisko bhata* (Old Age Allowance) Program: Respondents were asked for their opinion on *Boisko bhata* program. More than half of the respondents did not know about the program in detail. Among the respondents knew about the program, a

Table 54: *Percentage distribution of older persons by their opinion on the Boisko bhata (Old Age Allowance) program*

Opinion	Rural		Urban	
	%	f	%	f
Very good arrangement	16.8	42	25.2	63
Number and amount is very inadequate	22.0	55	9.6	24
A political stunt	6.8	17	7.2	18
Do not know in detail	51.6	129	66.8	167
Do not know the program	19.2	48	22.8	56
Total*	--	250	--	250

* More than one response possible

Condition: Table 55 presents the current health status of the respondents. They were asked to evaluate their health condition themselves. In the rural areas about 11 per cent of the respondents identified them as ill, 68 percent reported that their health status was neither completely ill nor

significant proportion of them termed this a very good arrangement whereas 22 per cent of rural and 9.6 per cent of urban respondents highlighted the inadequacy of its number and amount. According to a few it is a political stunt (Table 54).

Present Health

completely well and another 21 per cent commented that they were continuing with good health. The similar evaluation made by their urban counterparts that stand at 16 per cent, 53 per cent and 31 per cent

Table 55: Percentage distribution of older persons by their comments on their present health condition

Physical Condi- tions	Rural								Urban							
	Comments															
	Well		Modrt.		Ill		Total		Well		Modrt.		Ill		Total	
Health Status	20.8	52	68.4	171	10.8	27	100	250	30.8	77	53.2	133	16.0	40	100	250
Eye Sight	12.4	31	58.4	146	29.2	73	100	250	21.2	53	57.2	143	21.6	54	100	250
Hearing status	17.6	44	59.6	149	22.8	57	100	250	28.8	72	54.8	137	16.4	41	100	250
Utterance Capacity	44.0	110	48.4	121	7.6	19	100	250	49.6	124	45.2	113	5.2	13	100	250
Moveme- nt Ability	28.0	70	65.2	163	6.8	17	100	250	39.2	98	52.0	130	8.8	22	100	250
Sleep	34.4	86	51.2	128	14.4	36	100	250	27.6	69	51.2	128	21.2	53	100	250
Memory	29.2	73	66.8	167	4.0	10	100	250	41.2	103	51.2	128	7.6	19	100	250

respectively.

Eyesight: The problem of eyesight was more prevalent in rural areas compared to the urban areas. The proportion of the respondents reporting clear vision was only 12.4 percent in rural areas as that of 21.2 percent in urban areas. Respondents of rural and urban areas with ill eyesight constitute about 29 percent and 22 percent respectively.

Hearing Status: The overall hearing status is also poor in rural areas. About 60 per cent of the rural aged and 55 per cent of the urban aged reported that their hearing status was moderate i.e. neither completely ill nor well. The 23 per cent and 16 per cent respondents of the rural and urban areas had stated ill hearing condition respectively.

Utterance Capacity: About half of the urban respondents demanded that they had well utterance capacity compared to 44 per cent respondents in the rural settings. But the proportion of moderate utterance capacity is higher in the rural (48%) areas than that of urban (45%) areas.

Movement Ability: the rural respondents had reported about 13 per cent higher moderate mobility. On the other hand, well status of mobility was about 11 per cent higher among the urban respondents.

Sleep: the proportion of either extreme condition i.e. poor sleep was lower and good sleep was higher among the rural (14% and 34%) respondents than the urban (21% and 28%) ones. Equal proportion of the respondents in both the areas reported their sleep as of moderate status.

Memory: it was amazing that moderate memory status was about 16 per cent higher among the rural (66.8%) respondents than the urban (51.2%) counterparts. On

the contrary
good memory
status was about
12 per cent
higher among the
urban (41.2%)

Table 56: Percentage distribution of older persons by whether they are suffering from any disease at present time

Whether Suffering	Rural		Urban		Total	
	%	f	%	f	%	f
Yes	84.8	212	76.8	192	80.8	404
No	15.2	38	23.2	58	19.2	96
Total	100.0	250	100.0	250	100.0	500

respondents as that of rural (29.2%) older persons.

Disease: Table 56 shows the distribution of older persons by whether they are suffering from any disease at present. The picture was alarming as 84.8 percent of rural and 76.8 percent of urban subjects were suffering from diseases at the time of study. Only 19.2 percent of the overall respondents were free from any disease.

Disease Prevalence: Of the various diseases reported, the five most common ones that stood for the main ailments were: arthritis/rheumatism,

Table 57: Percentage distribution of older persons by the types of diseases currently they are suffering from (Reference table 56)

Types of Diseases*	Rural		Urban	
	%	f	%	f
Arthritis/Rheumatism	41.1	87	36.0	69
Hypertension	19.8	42	31.2	60
Diabetes	12.3	26	27.1	52
Heart Troubles	5.2	11	22.4	43
Asthma/Cold/Cough	47.2	100	33.3	64
Stomach Problems	13.3	28	21.4	41
ENT Problems	11.4	24	17.2	33
Eye Diseases	31.2	66	16.7	32
Weakness	52.4	111	33.3	64
Other Diseases**	27.4	58	26.6	51
Total	--	212	--	192
Mean number of diseases / head	2.61		2.65	

* More than one response possible

** Ulcer, Paralysis, Constipation, Urinary Trouble, Insomnia etc.

arthritis/rheumatism followed by 64 suffering from weakness and asthma/cold/cough.

The mean number of problems suffered by rural and urban group was 2.61 and 2.65 respectively. The difference in the prevalence of problems between the rural and urban groups was significant at 1per cent level. This study has

hypertension, Asthma/ cold/ cough, eye diseases and weakness. Among the rural population, a majority of them (52.4%) were suffering from weakness followed by asthma/ cold/ cough. Of the urban population the highest number, 69 out of 192 had

brought to light that the aged members are confronted with various problems (Table 57).

Place of Treatment:

Table 58 shows the distribution of older persons by place of getting treatment. Most of the rural older persons preferred traditional healing (40.4%)

followed by Ayurvedic /

Table 58: Percentage distribution of older persons by place of getting treatment

Treatment Place*	Rural		Urban	
	%	f	%	f
Hospital / Clinic / Health Center	9.6	18	36.1	61
Private Allopathic	6.4	12	18.9	32
Homeopathic	12.8	24	29.0	49
Ayurvedic / Hekimi	32.4	61	7.7	13
Traditional Healing	40.4	76	17.2	29
Others	5.9	11	4.1	7
Total	--	188	--	169

* More than one response possible

Hekimi treatment (32.4%). Around 10 per cent of them told that they received treatment from hospital /clinic/health center. On the contrary, the urban aged preferred hospital/clinic /health center and marginal portion of them, 4.1 per cent went poor Ayurvedic / Hekimi treatment. Of course, there

Table 59: Percentage distribution of older persons by whom of the family members/relations comes forward as care giver when they become sick

Family Members / Relations*	Rural		Urban	
	%	f	%	f
Wife / Husband	52.4	131	43.6	109
Son / Daughter in law	40.8	102	39.6	99
Daughter / Son in law	19.6	49	33.2	83
Grand Son / Daughter	7.2	18	13.6	34
Other Relatives	9.2	23	16.4	41
Neighbors	11.6	29	3.2	8
Total	--	250	--	250

* More than one response possible

family members / relations comes forward as caregiver when they become sick. Majority of the respondents, 52.4 per cent and 43.6 per cent of rural

were few in both areas that got treatment from other places. There was option for more than one response against this particular question.

Caregiver: Table 59 represents the distribution of older persons by who of the

and urban older persons, unsurprisingly identified their spouses as caregiver when they become sick. Around 40 per cent of the respondents in both areas are provided with care by their son-in-law/daughter-in-law. It was interesting that a good number of neighbors, 11.6 per cent came forward as caregiver in rural areas. There was option for more than one response against this particular question.

Habit of Smoking: Of all the male respondents, 115 male were reportedly smokers at the time of

interview. The prevalence of smoking was predominantly higher in rural

Table 60: Percentage distribution of male older persons by their current habit of smoking

Current Smoking Habit	Rural		Urban		Total	
	%	f	%	f	%	f
Yes	48.8	64	37.2	51	42.8	115
No	51.2	67	62.8	87	57.2	154
Total	100.0	131	100.0	138	100.0	269

aged (48.4%) than in urban aged (37.2%). At 5% level of significance, this difference is statistically significant (Table 60).

Other's Help in Daily Activities: Older persons were asked to tell whether they need other's help in daily activities. A significant number of

Table 61: Percentage distribution of older persons by whether they need others helps in daily activities

Other's Help Needed	Rural		Urban	
	%	f	%	f
Not Necessary	72.4	181	82.0	205
Sometimes Necessary	19.6	49	14.0	35
Necessary	8.0	20	4.0	10
Total	100.0	250	100.0	250

19.6 per cent in rural areas.

respondents in both areas answered that it was not necessary. Only 4 per cent of urban elderly and in rural areas just double needed other's help in their daily activities. The numbers of respondents who sometimes needed help vary from 14 per cent in urban to

Community Involvement and Participation: Inquiry was made in this respect from the older persons. Community involvement and participation was

operationalized by the membership of the respondents in co-operative/religious / non-government organization etc.

Table 62: Percentage distribution of older persons by the organizations they are associated with as member

Types of Organizations	Rural		Urban	
	%	f	%	f
Cooperatives	1.6	4	3.2	8
Socio Cultural Group	--	--	4.8	12
Religious Organization	5.2	13	8.4	21
NGO	--	--	4.8	12
No Membership	93.2	233	78.8	197
Total	100.0	250	100.0	250

Here observations were negligible. Seventy out of 500 respondents reported that they associated with some organization out of which 34 respondents were belonging to religious organizations. The participation rate was higher among the urban older people (Table 62).

Invitation in Social Functions: Older people were asked whether they get invitation in different local social functions. It was somewhat encouraging that the majority of the respondents were invited regularly. These figures

Table 63: Percentage distribution of older persons by whether they get invitation in different local social functions

Invitation	Rural		Urban	
	%	f	%	f
Regularly Invited	65.2	163	48.0	120
Occasionally Invited	20.0	50	38.0	95
Never Invited	14.8	37	24.0	60
Total	100.0	250	100.0	250

were 65.2 per cent and 48 per cent in rural and urban areas respectively. Only 14.8 per cent and 24 per cent of them respectively

never invited and others were occasional invited in different local social functions (Table 63).

Participation in Social Functions: Table 64 shows the distribution of older persons by their level of participation in different local social functions.

Among the older people who were invited, only 14.5 per cent of rural and 27.3 per cent of urban respondents did not participate in any social functions.

Table 64: Percentage distribution of older persons by their level of participation in different local social functions

Invitation	Rural		Urban	
	%	f	%	f
Regularly	47.0	100	32.7	62
Occasionally	38.5	82	40.0	76
Do not participate	14.5	31	27.3	52
Total	100.0	213	100.0	190

Approximately 40 per cent of them in each areas participated occasionally and the rest on a regular basis. The rate of participation was higher in rural areas.

Pattern of Welcome: This is shown in table 65 while attending any social occasion most of the older persons were paid moderate respect. Only 30.8

Table 65: Percentage distribution of older persons by how they are welcomed by other participants when attending social occasions

Pattern of Welcome	Rural		Urban	
	%	f	%	f
With due respect	30.8	56	20.3	28
With moderate respect	56.1	102	60.1	83
Do not pay respect	13.1	24	19.6	27
Total	100.0	182	100.0	138

per cent among rural and 20.3 per cent among urban respondents were welcomed with due respect. The percentage of

respondents in both areas those were not paid respect while attending social occasions varied roughly from 13 to 20 percent.

Familiarity with NGO Working with Older Persons Welfare Activities:

The picture that revealed from the study is that more than 90 per cent of the older persons of both areas were not familiar with any NGO working with older persons welfare activities, which is nonetheless surprising because of the fact that none but only few

NGOs in our country are engaged in such activities. This demands more NGOs need to work in this field. Only a very few are familiar with such a NGO though the figures for both areas did not exceed 10 per cent.

Knowledge on Different NGOs Working with Older Persons

Welfare Activities: Of the respondents familiar with at least one NGO working with older

Table 66: Percentage distribution of older persons by whether they are familiar with any NGO working with elderly welfare activities

Familiarity	Rural		Urban	
	%	f	%	f
Familiar	3.2	8	8.8	22
Not familiar	96.8	242	91.2	228
Total	100.0	250	100.0	250

Table 67: Percentage distribution of older persons by their knowledge on different NGOs working with elderly welfare activities

Invitation	Rural		Urban	
	%	f	%	f
BAAIGM	62.5	5	72.8	16
RGEA	--	--	18.2	4
Others	37.5	3	9.0	2
Total	100.0	8	100.0	22

persons welfare activities, 62.5 per cent of the rural and 72.8 per cent of the urban subjects knew the activities of BAAIGM. None but 18.2 per cent urban older persons of them named RGEA. Rest had knowledge on other NGOs (Table 67).

Level of Satisfaction Over the

Services Rendered by These Organizations: Almost all of the older persons knew the name of such NGOs did not have any idea about the services

rendered by them. Of the respondents who had knowledge on different NGOs a few were satisfied moderately

Table 68: Percentage distribution of older persons by their level of satisfaction over the service rendered by these organizations (Reference table 67)

Level of Satisfaction	Rural		Urban	
	%	f	%	f
Satisfied	--	--	4.6	1
Moderately satisfied	25.0	2	4.6	1
Not satisfied	--	--	9.2	2
No idea about the service	75.0	6	82.6	18
Total	100.0	8	100.0	22

and only 1 out of 22 urban

older persons was satisfied while 2 of them were not satisfied over the services rendered by these organizations (Table 68).

Opinion on Sources for Sufficiency of Care and benefit: The older persons were asked to opine whether their sources are sufficient for their care and benefit. Surprisingly, almost 99 per cent of the respondents did

Table 69: Percentage distribution of older persons by their opinion whether these sources (stated below) are sufficient for their care and benefit

Opinion	Rural					Urban				
	Communi ty	Govt.	NGO	Son / Daughter	Relatives	Community	Govt.	NGO	Son / Daughter	Relative s
Sufficient	2.0 (5)	6.0 (15)	--	29.6 (74)	9.2 (23)	6.4 (16)	--	0.4 (1)	20.4 (51)	2.0 (5)
Moderate	10.0 (25)	6.4 (16)	0.8 (2)	52.0 (130)	23.2 (58)	12.4 (31)	15.2 (38)	0.4 (1)	37.6 (94)	22.4 (56)
Not sufficient	19.6 (49)	12.0 (30)	--	14.4 (36)	53.2 (133)	33.2 (83)	32.8 (82)	0.8 (2)	26.4 (66)	31.6 (79)
Do not know	68.4 (171)	75.6 (189)	99.2 (248)	4.0 (10)	14.4 (36)	48.0 (120)	52.0 (130)	98.4 (246)	15.6 (39)	44.0 (110)
Total	100.0 (250)	100.0 (250)	100.0 (250)	100.0 (250)	100.0 (250)	100.0 (250)	100.0 (250)	100.0 (250)	100.0 (250)	100.0 (250)

not know whether the NGOs provide any are and benefit. Only 1 out of 250 urban older persons opined NGO as a sufficient source for their care and benefit. About 30 per cent of the rural and 20 per cent of the urban respondents thought their son/ daughter sufficiently provide them care and benefit as against 14.4 per cent and 26.4 per cent respectively thought the same insufficient.

Exactly 6 per cent and 2 per cent of the rural respondents believed that the government and community respectively provided them sufficient care and benefit. About 23 per cent respondents of both areas opined that their relatives provided the moderately sufficient care and benefit (Table 69).

Ways of Leisure Time Spending: Table 70 shows the percentage distribution of older persons by their leisure time spending. Of the rural respondents, about 43 per cent used to spend their leisure time taking rest, sleeping or by doing nothing special while 33.6 per cent perform religious activities

and 14

per cent

spend

chatting

with

others.

These

figures

Table 70: Percentage distribution of older persons by their leisure time spending

Ways	Rural		Urban	
	%	f	%	f
Perform religious activities	33.6	84	29.2	73
Watching TV / Listening Radio	5.2	13	12.8	32
Chatting with others	14.0	35	18.0	45
Ruminate the past	4.0	10	7.6	19
Readings books / papers	--	--	6.8	17
Take rest / sleep / nothing special	43.2	108	25.6	64
Total	100.0	250	100.0	250

for their urban counterpart were 25.6 per cent, 29.2 per cent and 18 per cent

Table 71: Percentage distribution of older persons by their participation in religious activities

Participation	Rural		Urban	
	%	f	%	f
Regularly	89.2	223	82.8	207
Irregularly	9.2	23	13.2	33
Do not perform	1.6	4	4.0	10
Total	100.0	250	100.0	250

people only.

respectively. A significant lower proportion of them spend their leisure time by watching TV/listening radio and ruminating the past. Habit of reading books/papers was found among the urban older

Participation in Religious Activities: Enquiry was made in this respect from the respondents of which about 89 per cent of the rural and 83 per cent for the urban respondents reported that they participate in religious activities on a regular basis while others participate irregularly except for 1.6 per cent rural and 4 per cent urban older persons who do not perform any religious activities (Table 71).

Participation in Family Decisions: Psychological satisfaction of the older people obtained through their participation in family affairs. About 86 per cent rural and 82 per cent

Table 72: Percentage distribution of older persons by how far their decisions are taken in family affairs

Decisions are been taken	Rural		Urban	
	%	f	%	f
Fully	85.6	214	82.0	205
Partially	10.4	26	15.2	38
Not at all	4.0	10	2.8	7
Total	100.0	250	100.0	250

urban respondents reported that their decisions are taken in family affairs that stands testify to the fact that the older persons in our society are being neglected within the family to almost relatively lower extent. About one-tenth of them reported that their decisions are taken partially while 10 rural and 7 urban older people out of a total of 500 respondents opined that their decisions are not taken at all. This is perhaps due to their relative non-possession of income flows or property ownership (Table72).

Opinion on the Negligence/Exclusion by the Family Members, Relatives and Neighbors: The respondents were asked as to whether they are being neglected/excluded by their family members, relatives and neighbors. About 15 per cent rural and 23 per cent urban respondents said "yes" to this very particular question. Around 20 per cent of both rural and urban respondents opined that they were being neglected /excluded in some cases. Nearly half of all respondents said "no" as their answer. Except for 223 non-respondents those who were being neglected /excluded were being so mostly from their neighbors (Table73).

Table 73: Percentage distribution of opinions of older persons whether they are being neglected / excluded by their family members, relatives and neighbors

Opinion	Rural				Urban			
	Family members	Relatives	Neighbors	Total	Family members	Relatives	Neighbors	Total
Yes	9.2	23	16.0	40	19.2	48	14.8	111
In some cases	21.2	53	18.4	46	18.0	45	19.2	144
No	51.2	128	40.0	100	36.8	92	42.7	320
No response	18.4	46	25.6	64	26.0	65	23.3	175
Total	100.0	250	100.0	250	100.0	250	100.0	750

Choice of Living Place: The older persons were asked as to whether they had any choice of living place. Sixty percent rural and about 76 per cent urban elderly reported their preference for living with own family. A total of 95 respondents reported that they did like living in the neighborhood of their sons while only 14 with their daughters/relatives. The area wise proportions for the older persons who wanted to live with son were: rural 31.6 per cent and urban 10.4 per cent. Only about 8 per cent of urban older persons had their choice for old home. Twenty-one were identified as non-respondents for this particular question (Table 74).

Table 74: Percentage distribution of older persons by their choice of living place

Choice	Rural		Urban	
	%	f	%	f
Own Family	60.0	150	76.4	191
Son	31.6	79	10.4	26
Daughter / Relatives	2.4	6	3.2	8
Old Home	--	--	7.6	19
No Response	6.0	15	2.4	6
Total	100.0	250	100.0	250

Types of Visit Paid by Their Children: The area wise proportions for the older persons under observation, by their sons/daughters who do not live

Table 75: Percentage distribution of older persons by how often their sons / daughters who do not live with them pay visit to them

Types of Visit	Rural		Urban	
	%	f	%	f
Weekly	27.2	68	19.2	48
Monthly	9.6	24	22.8	57
Yearly	33.2	83	15.6	39
Occasionally	30.0	75	39.2	98
No Visit	--	--	3.2	8
Total	100.0	250	100.0	250

with them pay visit weekly to them were: rural 27.2 per cent and 19.2 per cent.

Exactly 30 per cent of the rural and 39.2 per cent of the urban respondents opined that their children who do not live with them occasionally visited them.

About 16 per cent of urban older persons and slightly more than double of their rural counterparts reported this visit as "yearly". There were only 8 out of 250 urban older people whose children did pay not a single visit to them (Table 75).

Wanting of Family/Community Support: Older persons were asked to give their opinion on wanting of family/community support with time. The situation seems to be somewhat discouraging since maximum of them opined that this was breaking down with time. Of course, there were some, the figures for which were: rural 22.4 per cent and urban 10 per cent, who viewed no change. Out of 500 respondents, 33 non-responses were identified (Table 76).

Table 76: Percentage distribution of older persons by their views on whether family / community support for the elderly is waning gradually

Views	Rural		Urban	
	%	f	%	f
Yes	68.0	170	86.4	216
No	22.4	56	10.0	25
No Response	9.6	24	3.6	9
Total	100.0	250	100.0	250

Family Types Where the Older People Expect to Live: This is shown in table 77. About 91 per cent of the rural and 84 per cent of the urban older

Table 77: Percentage distribution of older persons by the type of family they expect more to live, if possible

Family Type	Rural		Urban	
	%	f	%	f
Extended / Joint Family	91.2	228	83.6	209
Nuclear	--	--	5.2	13
Alone	--	--	7.2	18
No Response	8.8	22	4.0	10
Total	100.0	250	100.0	250

persons had their expectation to live in extended/joint family. Only 7.2 percent of

the urban older persons wanted to live alone and 5.2 percent went for nuclear family.

Major Felt Problems of the Older Persons: The respondents were asked as to whether they were facing any major problems. Some problems were identified as

Table 78: Percentage distribution of major problems of older persons as they mentioned

Problems*	Rural	Urban
Physical illness	92.3	87.5
Lack of Medicare and special health service	90.0	81.2
Poverty and financial insecurity	86.1	79.4
Lack of employment and income opportunity	52.2	68.4
Exclusion and loneliness	35.9	57.3
Mental incongruity and social stress	19.5	48.0
Concern over family affairs	20.3	37.2
Others	18.0	13.2
Total	N = 250	N = 250

* More than one answer possible

very much common to them since almost all, more than 80 per cent of them, had to face physical illness, poverty and financial

insecurity, lack of Medicare and special health service altogether. Lack of employment and income opportunity was identified as a problem by 52.2 per

cent rural and 68.4 per cent urban respondents. The area wise proportions of the respondents who found exclusion and loneliness a problem was: rural 35.9 per cent and urban 57.3 per cent. Some other problems such as mental incongruity and social stress concern over family affairs etc. were also reported. However, there was provision for more than one response from this question (Table 78).

Recommendations to Overcome These Problems: The older people were asked to recommend steps against the problems they faced. Eighty-one

Table 79: *Percentage distribution of older persons by their recommendations for taking effective steps against the problems faced by them*

Recommendations*	Rural	Urban
Establish separate hospital and medicine service for older person	29.2	65.6
Arrange appropriate employment opportunity	8.0	53.2
Increase and enhance old age allowance	80.0	82.4
Advocate family members to take care for the older members	76.4	74.8
Establish different homes for older persons	7.0	38.4
Administer wide publicity on situation, needs and problems of older persons	6.0	26.0
Others (Specify)	4.0	9.6
No response	21.5	17.0
Total	N = 250	N = 250

* More than one answer possible

percent of the respondents in general recommended increasing and enhancing old age allowance. About 76 per cent rural and 75 per cent urban respondents suggested advocating family members with a view to take care for the older persons. Next proportions of the respondents (29.2% rural and 65.6% urban) were in favor of the establishment of separate hospital and

medical service for them. About 53 per cent urban and a few rural older persons recommended arranging appropriate employment opportunity.

A few respondents provided some other recommendations. Although there was provision for more than one answer, 19.25 per cent non-responses were identified for this particular question (Table 79).

Opinion of Older Persons on Whether Their Problems are Increasing and Becoming Complicated Day by Day: Table 80 depicts the area wise proportions i.e. about 66 percent of the rural and 83 percent of the urban

older persons opined that their problems were increasing and becoming complicated day by day.

Out of 250 respondents in each area, 16 rural and 28 urban respondents reported that their problems were not

Table 80: Percentage distribution of opinion of older persons on whether the problems of older people are increasing and becoming complicated day by day

Opinion	Rural		Urban	
	%	f	%	f
Yes	65.6	164	82.8	207
No	6.4	16	11.2	28
No Response	28.0	70	6.0	15
Total	100.0	250	100.0	250

increasing and becoming complicated with respect to time. Another 6 percent and 21 percent in urban and rural areas respectively made non-response for this question.

Views Regarding the Causes of Increasing Problems: Table 81 shows the percentage distribution of older persons by their views regarding the causes of gradual increase of their problems. About 98 per cent of rural older persons and 79 per cent of their urban counterparts viewed population explosion and reducing resources and services as the cause behind the increase of their problems. 40.1 per cent and 3.66 per cent urban and rural respondents identified pro-western attitude among the youth as the cause respectively. There are some other specific views that most of the older persons hold as

the causes of their increasing problems and are shown in table 60. There was provision for more than one answer from this question.

Table 81: *Percentage distribution of older persons by their views regarding the causes of gradual increase of their problems*

Views*	Rural		Urban	
	%	f	%	f
Population explosion and reducing resources and services	98.17	161	78.74	163
Decadence of social values and lack of religious and moral education	79.88	131	57.00	118
Social development, modernization and materialistic relationship	38.41	63	79.71	165
Pro western attitude among the youth	3.66	6	40.10	83
Indifferent attitude and negligence of the government and the society	96.95	159	86.96	180
Others	11.59	19	8.70	18
Total	--	250	--	250

* More than one answer possible

Social Visits: Inquiry was made into the social bonds of the older people with their relatives and friends. This was measured by the frequency of their social visits. About half of them in both areas

Table 82: *Percentage distribution of social visits of older persons*

visit occasionally to their relatives and friends that reveal an apparent depressing picture. Fourteen percent rural and 21.2 per cent urban

Nature of Social Visit	Rural		Urban	
	%	f	%	f
Once in a month	9.6	24	4.4	11
Once in a Week	4.0	10	12.4	31
Very often	14.0	35	21.2	53
Occasionally	48.4	122	53.6	134
Never	24.0	60	8.0	20
Total	100.0	250	100.0	250

respondents visit very often. However, a good percentage (rural 24% and urban 8%) also makes no such visit at all (Table 82).

Needed Assistance: The older persons with inadequate income were asked to tell about the sources of assistance they generally get to survive. The

Table 83: Percentage distribution of older persons who do not have adequate income by source of needed assistance

Source	Rural		Urban	
	%	f	%	f
Son	58.8	147	63.2	158
Daughter	25.2	63	28.4	71
Relatives	5.2	13	2.0	5
Neighbors and friends	6.4	16	4.0	10
NGO	2.0	5	2.4	6
Government	2.4	6	--	--
Total	100.0	250	100.0	250

sources of such help can be seen in table 83. They mention that the major part comes from their offspring. The figures vary from 58.8 percent for the rural to 63.2 percent

for the urban older persons who were assisted by their sons. This is somewhat encouraging as the figures indicate that the relationship between parents and the children is still in good shape in Bangladesh.

Only 6 out of 250 rural and none of the urban respondents got assistance from the government while about 2 per cent respondents from each area were being assisted by the NGOs. This demands to strengthen the existing programs of the government vis-à-vis the launching of the new ones.

Opinion on the Preparedness to Have a Sound and Peaceful Latter Life: Older

Table 84: Percentage distribution of older persons on the basis of their opinion on whether preparation should be taken earlier by every one to have a sound and peaceful latter life

Opinion	Rural		Urban	
	%	f	%	f
Every one must get prepared	11.6	29	31.6	79
One should get prepared	44.4	111	48.0	120
Not necessary	32.8	82	10.8	27
No Response	11.2	28	9.6	24
Total	100.0	250	100.0	250

persons were asked to opine on whether preparation should be taken earlier

by every one to have a sound and peaceful latter life. The area wise proportions of the respondents who opined that one should get prepared were: rural 44.4 per cent and urban 48 per cent. These figures were 11.6 per cent and 31.6 per cent respectively for those according to whom every one must get prepared. Of the 500 respondents, about 22 per cent said that it was not necessary to get prepared earlier by every one to have a sound and peaceful latter life (Table 84)

What Older Persons Should Do to Have a Peaceful and Socially Dignified Later Life? Table 85 depicts that most of the older persons i.e. 86 per cent rural and 82.4 per cent urban emphasized on performing religious

Table 85: Percentage distribution of older persons by their suggestions on what older persons themselves should do to have a peaceful and socially dignified later life

Suggestions*	Rural		Urban	
	%	f	%	f
Adapt with the changing environment	68.0	170	73.2	183
Keep control over talking and temperament	28.8	72	52.8	132
Perform religious activities regularly	86.0	215	82.4	206
Should have sufficient tolerance and satisfaction	76.4	191	78.8	197
Become flexible	43.6	109	64.4	161
Others (specify)	8.4	21	11.6	29
Total	--	250	--	250

* More than one answer possible

activities regularly. Again, 76.4 per cent rural and 78.8 per cent urban respondents suggested that the older persons should have sufficient tolerance and satisfaction. These figures vary from 68 per cent to 73.2 per cent for those who would like to adapt with the changing environment. There were some other suggestions that can be seen in the table and more than one answer was possible to this question.

Dress: As per observations of the field workers during interview, the proportion of the respondents wearing dirty clothes were about 47 per cent

in rural and 25 per cent in the urban areas. Again the rural areas had the lowest proportion (15.2%) of the respondents wearing clean and new clothes and the urban places had the

Table 86: Dress

highest proportion (38.4%). Approximately, remaining 37 per cent of the respondents had old but apparently clean clothes (Table 86).

Condition	Rural		Urban	
	%	f	%	f
Clean and new	15.2	38	38.4	96
Dirty	47.2	118	25.2	63
Old but clean	37.6	94	36.4	91
Total	100.0	250	100.0	250

Hair: One of the indicators of consciousness of personal hygiene is hair condition. Observed data showed that the majority (66.4%) of the rural older persons had their hair unkempt as against the highest figure, 46 per cent of

Table 87: Hair

Condition	Rural		Urban	
	%	f	%	f
Balled	8.4	21	15.6	39
Kempt / Combed	25.2	63	46.0	115
Unkempt	66.4	166	38.4	96
Total	100.0	250	100.0	250

the urban respondents

with kempt/combed hair.

This opposite picture

indicating relatively

good status with regard

to the same among the

urban older persons. Only a significantly lower proportion of the older persons in both areas were

balled headed (Table 87).

Beard: Table 88 shows that out of 131 rural male older persons only 8 were found shaved, 32 unshaved and 91 bearded. In urban areas as

Table 88: Beard

Condition	Rural		Urban	
	%	f	%	f
Shaved	3.2	8	10.4	26
Unshaved	12.8	32	5.2	13
Bearded	36.4	91	40.0	100
Older Women	47.6	119	44.4	111
Total	100.0	250	100.0	250

many as 100 out of 139 older persons were bearded while 26 were found shaved.

Nail: Table 89 indicates a significant difference in the area specific proportion with regard to this parameter. Of the older persons, 20.4 per cent

Table 89: Nail

Condition	Rural		Urban	
	%	f	%	f
Small and clean	20.4	51	39.2	98
Large but clean	13.2	33	18.4	46
Small but dirty	29.2	73	35.2	88
Large and dirty	37.2	93	7.2	18
Total	100.0	250	100.0	250

in rural areas had their nails small and clean as against about 39 per cent of their urban counterparts. The figures for older persons with their nails large but clean varies from 13.2 per cent in rural to 18.4 per cent in urban areas. The

proportion of older persons ranges from about 29 per cent to 35 per cent who had their nails small but dirty. Only 7.2 percent of the urban older persons were identified with large and dirty nails, the proportion of which is more than 5 times lower than that of urban older persons. This may be indicative of greater awareness of the urban older persons with respect to this very aspect.

Leg: Of the 250 older persons

Table 90: Leg

in each area, 65 in rural and 196 in urban areas kept their leg clean. In terms of dirty condition the situation in both

Condition	Rural		Urban	
	%	f	%	f
Clean	26.0	65	78.4	196
Dirty	74.0	185	21.6	54
Total	100.0	250	100.0	250

areas is almost reversal that, again indicates higher degree of consciousness among the urban older persons than that of their counterparts (Table 90).

Teeth: About 35 per cent of the rural older persons had no teeth as against

Table 91: Teeth

Condition	Rural		Urban	
	%	f	%	f
Clean	5.2	13	28.4	71
Dirty	60.4	151	44.4	111
Toothless	34.4	86	27.2	68
Total	100.0	250	100.0	250

27 per cent of their urban counterparts. With regard to cleanliness of teeth, rural older persons were much lagging behind their urban counterpart, as reflected in the respective

proportions of 5.2 per cent and 28.4 per cent. In terms of dirty teeth the area-specific complementary proportions were rural 60.4 per cent and urban 44.4 per cent reflecting a threatening situation of personal hygiene among the older people (Table 91).

Temperament: It appears that 38.4 per cent of the rural older people had gloomy temperament followed by 30 per cent moderate and 14 per cent jolly. These figures were 34.4 per cent, 35.2 per cent and 8.4 per cent for the urban older persons respectively. Avoidance tendency was identified among about 13 per cent and

Table 92: Temperament

14 per cent of the rural and urban older people. Only a few of them, ranges from 4.8 per cent to 8 per cent were petulant in nature.

Nature	Rural		Urban	
	%	f	%	f
Jolly	14.0	35	8.4	21
Gloomy	38.4	96	34.4	86
Moderate	30.0	75	35.2	88
Petulance	4.8	12	8.0	20
Avoidance tendency	12.8	32	14.0	35
Total	100.0	250	100.0	250

Case Study

To support the field study findings and to know the situation and feelings of the older persons more deeply some case studies have been conducted with different older persons in the study areas, which are presented below:

Case One

Mr. Md. Anwar Ali from Faridpur district is a retired Thana Education Officer. Since his boyhood, he was highly ambitious and active. The ultimate goal of his life was to be a rich man. Such determination contributed him to become successful in professional life. He earned money as much as he can and spent money luxuriously as well. He never bothered the ways of earning whether proper or improper. But in family life Mr. Anwar appeared to be equally unsuccessful. He failed to play his role as father as well as household head. Only two of his five sons got higher education. Unknowingly he ruined his other sons due to extreme emotional attachment. All of his three daughters were given early marriage. He was neither realistic nor a good planner for the betterment of himself and his family as well.

Days change. Mr. Ali retired from his service. His son who was addicted and gambler convinced him to give his gratuity money for investing in business. But all his money-his last resort was drained through gambling making the family utterly penniless. His spouse, the best companion of him, passed away leaving her husband in an ominous state. Now, Mr. Ali is counting the moments amidst loneliness and financial insecurity.

Case Two

Komla Rani Shaha is a name that only symbolizes the struggle in the journey of life. She had to start her journey when she was given marriage at the age of only eleven. Komla Rani applied her all out efforts to create a happy conjugal life. Her realistic character made her life more or less smooth without major interruptions.

But her happiness endured a very short time and she was cracked down with the dead of her husband. Thereafter she had to undergo the real hardships but never attempted to engage her elder son. Because she dreamt of that her elder son would be highly educated and honorable officer.

With the marriage of her elder son the whole family was disorganized and disintegrated. Falling the malicious glance of her daughter-in-law, Komla Rani is passing and exhausting, disregarded life and anxious moments thinking about the future of her two helpless sons.

Loosing power over the family and over her elder son and daughter-in-law, she has become inanimate and this undue experience causing her much mental sufferings. She is failed to get befitting dignity from the family though she had sacrificed her life for the betterment of it. Despite her untiring labour behind the family's development it is painful that now she is being avoided by its members. Furthermore, her incapability to adapt with the changing circumstances has created permanent mental imperfection.

Case Three

Mr. Afsar Uddin Biswas, seventy years old man, is a successful father, self-dependent farmer and respected social leader from Sylhet district. Over time, a lot of scarcity and uncertainty, many ups and downs have brought such dignity and affluence in his life. Mr. Afsar was mentally very strong and always hopeful for better future. He started from a little grocery. Now he is the owner of a big farmhouse, huge agricultural land, irrigation project, fish cultivation, plantation etc. He is a successful household head of an extended family. From dawn to dusk he passes a day watching his irrigation project, other cultivation sectors, domestic and religious works and amidst of his beloved grandson.

Case Four

Sharmin Akter, an older persons lady with discontented and tormented life starting from her so-called marriage. At her impressionable age she fell in love with a person of different religion. Uncontrolled emotional attachments lead them to develop illegitimate relationship. Then she changed her religion as demanded by her upcoming husband, converted into Muslim from Hindu and got married.

Nevertheless, Sharmin's dream was shattered into pieces as her husband was forcefully given marriage once again, and, he unpredictably, without any settlement of their relation, agreed to the new decision taken by his family. She became helpless as she did not have any documentary evidence of their marriage, and her Hindu relatives came forward as she changed the religion.

Since then a long anguishing life began and Sharmin had been therefore, struggling under a lot of mental pressure and infinite uncertainty.

Today, she is now in her old age, alone, apart from all relatives. But her daughter- the illegitimate issue of her love is the only beloved person in her segregated life. With fear of that somebody can disclose her past life to her daughter-in-law; she has kept her in a long distance. After retirement Sharmin is in a very awful and helpless situation. In any way she passes her days.

Case Five

An eighty-three years old man named Mr. Ahmed Fazal is a successful man who has had a magic touch throughout his life in all areas of home and outside. In his early life, he was not acquainted with any social problem as he was born in a very rich family. But with the death of his parents at the very outset of his service life, all responsibilities of the family came on his shoulder. Nevertheless he empowered his younger brother to look after the huge business they inherited.

Mr. Ahmed got married but his dreams were shattered into pieces as his newly wed wife fled to her earlier relation. It set him aside from re-marriage for ever. Despite breaking down, he broadened his mind and pledged devote himself in social development activities.

The woeful tale of Mr. Fazal was intensified further, when his only brother was killed in a road mishap leaving four hapless babies. But because of his

relentless efforts, the sorrowful moments of the family were tackled. His four nephews and nieces, indeed, grew up, educated, and established due to his able and affectionate fatherly role.

After retirement from the service, he had to make himself out and out social worker through his business he created different fund by the huge money which paved the way of expanding it in more people oriented sectors. Personally a very pious man spends five to six hours daily praying, reading holly Quran and other religious books. His physical condition is not bad. But ha has severe eye sight trouble what is deteriorating and turning into permanent blindness. He sometimes feels pretty satisfaction that he will alive in people's mind through his works, he is leaving behind his sons and daughters, who do not have any way to forget their father-who sacrificed his last drop of sweat for their service.

Conclusion

Irrespective of the nature and number of the problems, the older persons who are living in the joint families or living with their kin, get emotional support from their family members at least once in a while. Though the traditional family bonds are changing, any improvement in the general well being of the older persons must begin within the context of the family. In our country context, old age homes may not serve in all aspects. The older persons people need care, protection, emotional support and respect, which cannot certainly be given in the older persons homes. The family is the best place for them. Hence, there is a great need to consolidate the family bonds in the society where these have been snapped and where the process of loosening

the strength of these bonds has started (Kumar, 1996, p. 68). There is a need of proper social intervention so that these bonds get consolidated and strengthened.

Old age cannot be averted, but it can be put off, and most importantly, some of the problems attending the declining years can be avoided altogether (Kumar, 1996). The first pre-requisite in dealing with the new phenomenon of mass ageing is clearly to be aware what is happening.

This awareness must go beyond anecdotal evidence, and every effort should be made to obtain a clear picture of the population and the changes that are taking place. Even in developed countries there is only a very superficial awareness of the realities of mass longevity; the actual figures, the length of longevity, its social and economic implications.

The Government of Bangladesh is giving much priority to health program to bring health for all by 2005 A.D. Like children, the older persons also need health and personal care and hence there is a need to establish separate Geriatric wards in the hospitals with separate trained medical staff. Training in Health of the older persons should be wide and comprehensive, emphasizing a positive approach the healthy ageing which is a life-long process. The aim of healthy ageing is to reduce disability, either by prevention or rehabilitation. The holistic approach to health care for the older persons must be the crosscutting theme.

A National Committee on Ageing was formed to identify the problems of the older population, but includes a government or retired government

member without sufficient NGO representation. This could indicate a lack of representation of persons knowledgeable about the situation of poor older people (Abedin, 1999). However, this is of the utmost importance, not only to train personnel to gather and analyze data and to formulate relevant policy, but also to implement that policy in various fields and to train other to do so.

CONCLUSION AND RECOMMENDATIONS

'The elderly themselves are the best people who can articulate accurately issues that impact on them negatively, and through their voices and actions the public will be able to respond accordingly'

Rachel Mukwaya, Uganda Reach
the Aged Association

Conclusion and Recommendations

The prediction of the demographic structure of society in this century is an inexact science. The important factors that led the situation to the uncertainty are the size and structure of the present population and the distribution of the birth rate over time, which are affected by the proportion of women of childbearing age.

The number of older persons in the first twenty years of this twenty first century, throughout the world, is expected to increase from some 600 million to over 1000 million (WHO, 1989). However, the effect of premature mortality from AIDS in Africa and Asia, where the incidence of AIDS related deaths is reaching pandemic proportions, has not been included in the estimates. A whole generation of people currently age 15-44 is affected by HIV infection, which implies a marked decline in the population of older persons from 2020 onwards in the affected areas (Coleman et al, 1993).

The possibility of increasing life expectancy is perhaps another intriguing factor that might be limited by senescence as per the following four types of evidence:

1. Historically, the maximum human lifespan has not been observed to change except in populations where age documentation is poor and literacy rates are low;
2. The risk of death seems to increase as an exponential function of age;

3. Standard actuarial computations indicate that the elimination of cancer and heart disease would increase average life expectancy only minimally; and
4. Experimental evidence suggests that certain human cells are internally programmed for only a limited number of reproductions (Manton, 1982).

Instead of the theories of human ageing that lend support to the belief that the life expectancy is unlikely to increase much beyond present levels, we may expect that the medical science could play a vital role in increasing the quality of older persons' life taking into consideration the impact of environment and individual lifestyles on longevity from the twentieth century's lessons. However, if someone were to focus on just one theme it would be the theme of promoting the positive attitudes toward normal ageing and older people along with their attitudes toward themselves, which is undoubtedly difficult and that can ensure the quality of life for older people.

For most of the twentieth century, ageing policies were designed with a youthful society in mind. From this point onwards, policies for older persons, younger persons and in those between must be designed with an ageing society in mind, a society where every third individual will be over the age of 60. International, national, and local communities must begin now to adjust and align their infrastructures, policies, plans, and resources (United Nations, 2001).

As mentioned earlier that the Bangladesh population is both ageing and younging. While the dominant trend throughout the nation's history has been

one of younging due to higher fertility, the post 1950 period added an ageing tendency due to persistent improvement in mortality rates (United Nations, 1994). Over the last century, the population 60 and over was increased by 1.31 percentage points while some recent projections show that it will increase by another 3.33 percentage points in the coming 25 years. Every year approximately 80,000 new older persons are entered into the group of the older persons who, in general, constitute a socially and economically vulnerable group with basic needs remaining unsatisfied in many cases (Abedin, 1999). In Bangladesh, older people are left out of the development process and they lack access to resources and income generating opportunities.

The emerging ageing problem issue has major implications on two important areas, at household as well as national level. More resources are required to be allocated at household for taking care and meeting the basic needs of the increasing number of older population. At national level resources necessitated to be generated through economic development to cater for the older population.

To take care of the older people at the family level is declining with the increase of participation of womenfolk in the labor force. Because the women are the primary care taker of the older persons and the children, particularly in patriarchal societies like Bangladesh. In the circumstances, the traditional joint family system should be strengthened in order to keep the older people within their kinship network relations for providing necessary support (Sarker, 1998). Because the care of the older people should not only be the responsibility of the state and voluntary agencies

rather it should be the responsibility of the family first. Because good family relationships are invaluable treasure of people's age life (Zezian, 1996: 310).

Fictive kinship and neighborhood relations are important part of social environment in people's daily life. Care of the older people is also the responsibility of the neighbors. So, neighborhood relations and fictive kin relationships should be strengthened at the community level in order to provide old age services especially those who have limited scope to get services at the family level (Sarker, 1998).

It is needless to point out that the older people should be treated with kindness and respect. They should be helped in every possible way and consulted on taking decisions about important matters, so that they do not feel isolated, ignored and neglected by the members of the family/community in which they live (Ali, 1996). Old age should not be considered as a burden or liability at the individual, family and community levels. The presence of older persons and their rich experience may help immensely in retaining the cultural heritage and the moral bonds in terms of honesty, modesty, dignity and integrity which will be ensured among the younger generation for overall welfare in every sphere of life (Sarker, 1998).

Recently the need for future research on older persons received heightened attention all over the world. The areas of research and factors for conducting research could be taken into account are differential approach e.g. gender and spatial differentiation, application of qualitative in addition to quantitative methods of analysis, investigating the state of adherence to international conventions, addressing the demographic variables, exploring institutional efforts etc. Above and beyond there is a need for context

specific analysis of the ageing process amid diversified problems. Role of environment, food habits, religion are some important dimensions that influence the ageing process and care giving behavior in either way around, positively or negatively.

Highest possible attainable level of coordination and integration among government, non-government, community and household level are necessitated to combat the emerging problem of older population. Neither of them can alone address such an important problem. From the very outset only the well designed, appropriately focused, and highly committed programs can resolve this impending crisis worldwide. "*Live long amid productive life*" be the today's slogan for making all out efforts to present a healthy and happy moments in old age.

Recommendations

This study has made a humble attempt to furnish the profile of the *Senior Citizens* in Bangladesh. These unveiled facts have given us the ample of opportunities to recommend according to the needs of the basic social services for the older persons as well as the research on ageing and age related issues. So, keeping in mind the specific needs of older persons to lead productive and meaningful lives, following steps are recommended:

A. Services for the Older Persons

1. With rapid increase in population and increase in life expectancy, it is worthwhile that appropriate national policies be formulated and programmes be designed to meet the needs of senior citizens.
2. Government has to shoulder the primary responsibility in providing and ensuring the sustainability of social protection systems. In Bangladesh, there is limited coverage of formal systems of social protection, social security as well as public safety net. Only recently *Boisko Bhata* scheme has been introduced in the country but the coverage as well as the amount is too little to the overall demand. In addition to that the developing country like Bangladesh with economies in transition, most persons who are now old and who work are engaged in the informal economy, which often deprives them of the benefits of adequate working conditions and social protection provided by the formal sector economy. Hence, it will have to ensure that the social protection and social security systems cover an increasing proportion of the formal and informal working population

and to consider innovative social protection/social security programmes for persons working in the informal sector. It is also necessary to ensure the integrity, sustainability, solvency and transparency of pension schemes in Bangladesh. Where appropriate, multi-faced reform strategies should be implemented in order to place social protection and social security systems on a sound financial footing.

3. Older persons must be allowed as full participants in the development process and also share in its benefits. Because in our country context, the impact of population ageing on the socio-economic development of society, combined with migration, urbanization, the shift from extended to nuclear, mobile families engender the need for urgent action to ensure the continuing integration and empowerment of older persons. Organizations of older persons are an important means of enabling participation through advocacy and promotion of multigenerational interactions.
4. The urban setting is generally less conducive to sustaining the traditional extended family network and reciprocity system than are rural areas. Older migrants from rural to urban areas in developing countries often face loss of social networks and suffer from lack of supporting infrastructure in cities, which can lead to their marginalization and exclusion, particularly if they are ill or disabled. Hence, it is needed to foster the development of local financial services (including micro credit schemes and micro finance institutions) in under-served rural areas and to encourage the establishment and revitalization of small-scale enterprises by

providing funding or support for income-generating projects and rural cooperatives and by widening economic diversification.

5. For both humanitarian and economic reasons, it is necessary to provide older persons with the same access to preventive and curative care and rehabilitation as other groups. At the same time, health services designed to meet the special needs of the older population must be available. Medical professionals, hospitals, social welfare institutions and other related organizations should be assisted by the government to provide medicare to the older people. Now it is high time to promote affordable access to essential medications and other therapeutic measures by the older people in Bangladesh. The services and facilities that provide safety and treatment to meet the needs of older persons suffering from physical ailments and mental disorders are to be established. It is needed to promote equal access to care for older persons who are poor as well as those who live in rural or remote areas by, inter alia, the reduction or elimination of user fees, provisions of insurance schemes and other financial support measures.
6. All the health professionals and para-professionals who work with older persons and other professionals in the social service sector are needed to be trained in the field of geriatrics and gerontology. Informal caregivers also need access to information and basic training on the care of older persons.
7. Steps are to be taken to provide community-based care and support for family care. Caregivers are to be supported through psychological, economic, social and legislative mechanisms. Social support systems

are to be developed, both formal and informal, with a view to enhancing the ability of families to take care of older persons within the family and including particularly the provision of long-term support and services for the growing number of frail older persons in Bangladesh.

8. The media has to play an essential role in promoting images that highlight the wisdom, strengths, contributions, courage and resourcefulness of older women and men. Media needs to be encouraged moving beyond portrayal of stereotypes and to illuminate the full diversity of humankind. The support of the mass media is indispensable as it is the harbinger of change and can be guiding factors in fostering the role of older persons in development strategies, including in rural areas. Together with the private and public sectors, the media is to be encouraged to avoid ageism in the workplace and present positive images of older persons.
9. Developing partners/agencies/organizations should continue playing the role of complementing and supplementing the services rendered by the government of Bangladesh. These institutions should endeavor to undertake more community projects such as in social, health, legal aid, housing, education, communication and recreation services, to meet the needs of the older persons. These agencies can provide a platform where issues faced by the older persons may be presented to the relevant parties.
10. The older persons should not be taken as a burden or liability. They should be considered as valuable resources. It is essential for the

government and the society to realize that the older persons need not be relegated to the position of social dropouts. If they are given a congenial atmosphere the older persons can still contribute to current welfare and operate as a balancing factor between old values and new expectations. We will have to recognize the need to strengthen solidarity among generations, and intergenerational partnerships, keeping in mind the particular needs of both older and younger ones, and encourage mutually responsive relationships between generations.

B. Research Needs on ageing

1. There is scarcity of data on ageing and age-related issues in Bangladesh. So researchers should pursue studies in policy related areas of ageing where the findings may have practical and realistic applications.
2. Research should be undertaken on the determinants of healthy ageing so that they can lead economically productive and physically sound life.
3. In our country context researchers should emphasize the identification of current practices and options for maintaining material security into old age.
4. Research should be focused on family transition process that is underway in Bangladesh. They should take into consideration the changing family structures, intergenerational transfer systems and emergent patterns of family and institutional dynamics.

5. Population ageing has direct impact in the socio-economic development of society particularly in the countries with economic transition like Bangladesh. Because technological advancement and other socio-economic changes can marginalize older persons from the mainstream of development, taking away their purposeful economic and social roles and weakening their traditional sources of support. Hence, research should be done to investigate into the relationships between population ageing and socio-economic development.
6. The quality of life of the older people is strongly influenced by environmental, economic, and social determinants, including the physical environment, geography, education, occupation, income, social status, social support, culture and gender. Researchers should endeavor into quality of life and ageing in diverse cultural, socio-economic and environmental to enhance the quality and social dignity in old age.
7. The fields of geriatrics and gerontology are still least talked over issue. These areas are to be expanded to contribute in mechanisms of ageing and age related issues. All out efforts to be made to study the basic biological mechanisms and age associated disease with the prospects of achieving healthy, active, productive, successful and positive ageing to the very end through lifestyle modifications and interventions that work.

A p p e n d i x A

STATUS OF NATIONAL POLICIES ON AGEING IN SOME SELECTED COUNTRIES

'With modern medicine, many older
people are living longer than they
are prepared for'

Zdenek Placher, Zivot 90 Czech
Republic

Appendix A

Status of National Policies on Ageing in Some Selected Countries

Main Features of the Policy

Argentina

There is a document developed by the National Government called 'Basis for a National Plan on Ageing 1996-2000'.

The Plan deals with the situation of older people on the following themes:

- Causes on population ageing;
- Distribution by area and by sex;
- Socio-economic situation;
- Family and housing;
- Education;
- Health;
- Autonomy;
- Economic activity;
- Social security.

It aims to address problems such as:

- Fragmented care (coexistence of several Official Agencies at National, Provincial and Municipal level and a lack of communication between them).
- Dissipation of resources: inefficient use, lack of satisfactory impact on needs and demands of older people.

- Lack of social and epidemiological planning: problems in identifying beneficiaries and their concerns in the distribution of loans, and lack of monitoring and evaluation.
- Use of inadequate technologies and scarce cost studies.
- Absence of quality control in loans.
- Training and education in human resources are scarce.
- Unequal geographical distribution.
- Limited capacity for the beneficiary sector to manage, control and evaluate their programmes.

Barbados

The government has plans to adopt a national policy. Personnel from the Ministry of Health who attended the Caribbean Forum on Ageing will spearhead these efforts after May 1998. The policy is currently at draft stage.

Bolivia

The decree included key entitlement such as the 'Bonosol', an annual single payment to those older people not entitled to join pension programmes. Free health care was also extended to older people.

Cambodia

Expected to be drafted soon. The creation of a National Committee for the International Year of Older Persons and Help to the Aged was approved and signed by Prime Minister Hun Sen in October 1998, but this only exists on paper at present as the members have not yet been named. The Committee is expected to draft the national policy for older people.

element of the "Salto Social" plan is the "Revivir" programme, aiming to ensure basic services to older people without access to social security benefits.

Cuba

The policy provides for a comprehensive programme of community support and institutional care. House repairs and home help/meals services are offered to those still in their own homes. Community centers provide social activities and health services run by 'gerontological teams' of health and social workers.

Dominica

The Dominica Council on Ageing has submitted a draft set of policy recommendations to government in 1998. There are strong indications that this will be adopted as a policy in 1999. The main goal of the draft policy is to ensure that older people are provided with protection, care and opportunities to participate in the development of Dominica. It is guided by the United Nations Principles of Independence, Dignity, Care, Participation and Self-fulfillment. The document calls particular attention to the needs of older people in the areas of housing, health, transport and social services.

Ecuador

To achieve the social well-being of the older and ageing population through preventive and protective measures, as well as service provision, in the domains of healthcare, housing, environment, social services, education, personal development, culture, recreation, participation and social activities.

El Salvador

Organizational and management guidance and intervention.

Ethiopia

- Developmental: in which participatory developmental social welfare programmes and services will be expanded.
- Preventive: in which the causes of social problems are studied and preventive measures are taken, based on the studies.
- Rehabilitative: in which members of the society who are already suffering from various social problems and require special treatment and attention are rehabilitated.

Fiji

Currently in development.

India

- The national policy aims to strengthen the legitimate place of older in society.
- It also aims to help older people live the last phase of their lives with purpose, dignity, and in peace.
- The State will support older persons, provide protection against abuse and exploitation, seek their participation and provide a care services to improve the quality of their lives.

Indonesia

- Through the upgrading of the quality of life of the elderly population, their welfare condition, capabilities and community care to establish their integration with their social environment through and organized community effort between the government and communities.
- Better services and social welfare support for those who have physical or mental disabilities.
- Dignifying older people by giving them the respect they deserve.

Jamaica

- To ensure that senior citizens are able to meet their basic needs.
- To ensure that those in need are assisted and protected from abuse and violence and are treated as a resource and not a burden.
- To enhance the self-reliance and functional independence of senior citizens.

Jordan

- To protect the homeless and poor who have no one else to look after them, through the homes of the elderly.
- To provide services so that the elderly can remain in their own homes.

Lao PDR

The government is committed to policies that:

- Ensure the elderly can take part fully in socio-economic life;
- Strengthen the family system;
- Educate and mobilize public support.

Malaysia

- The creation of an enabling environment which allows for the elderly to live with full respect and self-worth.
- To ensure sufficient economic independence for the fulfillment of basic needs through income sources, family and societal support, self-effort and flexible social safety net programmes.
- Ensuring access to health, recreation, social welfare and finance which will support and sustain their optimum physical, mental and emotional well-being.
- Easy access to social and legal services to advance and sustain their rights.
- The creation of a comprehensive social security system to produce a stable income for the welfare of the elderly.
- Comprehensive data and information collection with the cooperation of both public and private agencies for planning purposes.

Mali

- Reduce the inequalities and injustices towards older people.
- Ensure better health and social welfare for them.
- Ensure the socio-economic development.
- Encourage them to have a dynamic community life.
- Help them to participate in an active city life.

Mauritius

Government policy is based on an active solidarity towards aged persons through the provision of added and adequate protection with a view to

ensuring that they have the necessary social, economic, and psychological support. Focus of the policy is to:

- Provide direct assistance (universal pensions and other allowances and facilities);
- Empower senior citizens;
- Provide welfare/recreational facilities;
- Provide homes for the elderly.

Mongolia

- Provide older people with opportunities to benefit from the contributions they have made to the development of the country.
- Develop and infrastructure that will guarantee all older people a livelihood, provide them with medical, social and cultural services and expand the range of subsidized services.
- Enable older people to continue an active life and contribute to the country's development.
- Promote and sustain the traditional love and respect of the elderly and the bonds between the generations.

Mozambique

In the process of being drafted.

Nepal

- To establish geriatric wards in regional hospitals.
- To establish residential homes for older people in each region and encourage NGOs to manage them.

- Implement income generation schemes for those in residential care.
- Utilize older people's experiences for the benefit of national development.

Pakistan

To promote the social and economic security of senior citizens while enabling them to contribute to national development.

Panama

- At a national level the policy aims at developing programme and services which are beneficial for the public.
- It tends to tackle the ageing phenomenon and the problems of old age by creating, empowering and improving new and existing administrative resources in the country.

Peru

PROMUDEH has convened a team of experts to work on Policy Procedures on Older People. The aim is to have a first draft ready for October 1999. However, ageing remains low on the government's priorities.

Philippines

'the State shall give full support to the improvement of the total well-being of the elderly and their full participation in society.

- Toward this end the State shall adopt policies ensuring the health, rehabilitation and self-reliance of older persons.

- Older persons have the same rights as other people to take their proper place in society. They should be empowered to be self-reliant and live freely and as independently as possible. This must be the concern of the family, community and government.
- The health care and rehabilitation of the disabled older persons shall be the concern of the government.
- The State recognizes the important role of the private sector in the improvement of the welfare of older persons and actively seeks their partnership.'

Singapore

- The welfare of the elderly person is the collective responsibility of the individual, the family, the community and the government.
- The integration of the older person, as an active and contributory member, into the mainstream of economic and community life.
- The family must provide the care, respect and emotional as well as financial support for the elderly person.
- The community including employers, neighbors, voluntary organizations etc is and important source of support enriching lives and providing services for those who cannot cope.
- The individual should strive to remain physically and socially active.
- The government in its turn will put in place the necessary infrastructure, resources and programmes.

South Africa

The guiding principle for the policy is that 'older persons should be enabled to live active, healthy and independent lives for as long as possible' (discussion document on ageing, 1995). Main features of the policy include:

- Responsibility for older people divided individuals, civil society and the state.
- Appropriate, affordable community-based care should include adequate housing as a cornerstone.
- Adequate primary health care is also critically important.
- 'The protection of the rights of older persons requires special attention in view of the prevalence of age discrimination and abuse' (discussion document on ageing, 1995).

South Korea

The policy proposes for areas of development until the year 2003:

- Building an infrastructure for economic independence.
- Securing a healthy life.
- Promoting an active life.
- Promoting social welfare.

Sri Lanka

- To enable all Sri Lankans on entering old age is lead socially, economically, physically, mentally and spiritually useful lives.

- The National Plan aims to plan the welfare of the older person on Sri Lanka in accordance with traditional custom while strengthening the family unit and making society aware of ageing issues.

St Lucia

Currently under review.

St Vincent & the Grenadines

A plan of action is being developed, for completion by the end of 1999.

Thailand

The long Term Plan for the Elderly outlines strategies in five areas:

- Health;
- Education;
- Income and employment;
- Social and cultural issues;
- Social welfare.

It aims to make the older person self-reliant and enable the family to give care and support.

Uganda

The government is currently developing a proposal for a research programme leading to the development of a policy proposal for Cabinet to recommend to Parliament.

Vietnam

In 1991 the government approved the 'Strategy for Socio-economic Stabilization and Development to the year 2000' which included various safeguards for sections of society as Vietnam developed into a market economy. The main features of the policies for older people are:

- The integration of the elderly into the community and enabling the family to implement its responsibilities of care for parents and grandparents.
- Amendments to the pension system to make it more effective.
- The establishment of a network of care and social centers.

Source: Randel et al. (Ed.) (1999). *The Ageing and Development Report: Poverty, Independence and the World's Older People*. HelpAge International. Earthscan Publications Limited, London.

A p p e n d i x B

SERVICES FOR THE OLDER PERSONS CURRENTLY AVAILABLE IN SOME SELECTED COUNTRIES

'I worked for my country for over 30
years but now I am retired and need
money for an operation they do not
want to know me'

Older Man, Tanzania

Appendix B

Services for the Older Persons Currently Available in Some Selected Countries

Australia

a. The Formal Structure of Care for the Elderly

Since late 1970s the commonwealth government began to be concerned about the rising public expenditures on the elderly. A couple of state and territory governments worked together actively in ageing around this time and they

- Created offices for the elderly and similar central agencies of government.
- Introduced age discrimination legislation that outlaws compulsory retirement.

These state government responses were as much a reaction to the growing voting power of the elderly as to the public costs of meeting their needs.

b. Income Maintenance and Employment

A flat rate age pension is managed by the Department of Social Security in Australia for about three-fourth of Australians aged 65 years and over. It has been paid by the common wealth government since 1908, either whole or in part. This is a minimum benefit but very effective in reducing poverty as it is received by all low- income elderly. Eventually any increase in the flat rate will automatically move them above the poverty lines.

c. Health Care Services

Health care services are provided to older Australians under a universal health insurance program, Medicare, since 1983 (Previously called Medibank, initiated in 1975). It is funded by a 1.25% levy on taxable income above a minimum level and cover 85% of the scheduled fee for medical services and 100% of services if they are bulk-billed by the provider. Older people are unlikely to pay to levy because of an income ceiling and receive a higher number of services per person and a higher average value of benefit per person than younger people.

d. Housing Resources

Two characteristic features of current housing arrangements of older Australians are high level of home ownership and the diversity of housing arrangements and conditions. Some 63.5% of people 65 years and over own houses, and another 8.3% are purchasers. Only 5.2% are public tenants while another 7.4% are private tenants. Of the 10% of people not in private dwellings, 4.4% lived in nursing homes, 2.4% in hostels (less intensive residential care), and 3.2% in other forms of sheltered accommodation (Howe, 1992).

e. Supportive Services

Long-term care refers to social, residential, and health services provided to chronically disabled persons over an extended period. It includes nursing homes and old people's homes, hostels and other elderly accommodation, and some types of rehabilitation services. Government dominates

institutional care, but other voluntary and private providers operate some services delivered to the home and community.

Canada

a. The Formal Structure of Care for the Elderly

Since the formation of Canada in 1987, different provinces were primarily responsible for health services, social services, housing, recreational services and education (Schwenger, 1987). But nothing was pointed out about the welfare services in the British North American Act (Schappell, 1987, p. 489). Poor relief was administered, if at all by local municipalities.

b. Income Maintenance and Employment

The basic benefit in Canada for the seniors, who are 65 and over, is the Old Age Security (OAS). It is taxable income and offered from the government transfer payments and supplemented by Guaranteed Income Supplement (GIS), which is an additional allowance, given to the maximum of a portion depending on the amount of cash income of the seniors. GIS benefits are not taxable. The less the amount of cash income from OAS or other sources the more the GIS.

There exists the provision of mandatory retirement in Canada in 7 of its 10 provinces and territories. The three other provinces Quebec, Manitoba and New Brunswick have abolished mandatory retirements as has the public service of the Federal Government.

c. Health Care Services

Universal medical care is provided for all Canadians and is essentially an insurance system covering hospital and physician costs. The average value for seniors of those services is estimated at \$2,000 (US\$1,430) per year. Medicare is provincially funded but relies heavily on federal transfer payments to the provinces and meets standards agreed to in a federal-provincial accord.

d. Housing Resources

About 8% of seniors live in various types of institutions. However there are policies in place to try to keep seniors in the community as long as possible, and there is a variety of community services available to assist Canadian seniors to remain in the community. These services vary in availability and quality from area to area and tend to be more plentiful in urban areas. Meals-on-wheels programs are well developed and are often provided by volunteer and nonprofit groups. Other services from homemaking, friendly visiting, shopping, and banking to yard maintenance and house repairs are also available. A number of senior's groups have evolved that exchange services. Some municipalities will clear snow for seniors, if requested.

e. Supportive Services

Canada has a history of providing a wide range of support services for seniors, and almost every type of program exists, at least in parts of the country. Most provinces have provincial government offices or secretariats that can be contacted for information and distribute print information. The federal government in Ottawa, through the Senior's Secretarial Health and

Welfare Canada, is a source of information. Furthermore, there are municipal resources in most towns and cities for information and services, as well as non-profit social service agencies.

Programs such as meals-on-wheels and wheels-to-meals (Congregate dining), as well as a range of homemaking and home care programs are either paid for under the health insurance plan under certain prescribed conditions or subsidized where necessary. In terms of community-dwelling elderly, in addition to in-home services, a strong network of senior citizens' centers provides information, educational opportunities, and leisure activities. These have formed an Association of Senior Centers. There are day care, and respite care beds. There are also hospice (Palliative care) units, and palliative care is also delivered in the home.

China

a. The Formal Structure of Care for the Elderly

Based on 1990 census, 8.6% of the total Chinese populations are over 60 years of age. Life expectancy for females at birth was 3.7 years more than for males. Males outnumber females between 60 to 64 years of age. But, after 65, females exceed males. The higher the age group the lower the sex ratio between men and women.

Three types of elderly are provided with family support-elderly living with children, those living alone, and those living in day care centers. To meet the growing need for elderly care in the process of family size nuclearization day care centers have been established. As these centers provide family

support in a traditional way, there are increasing needs for developing such centers.

b. Income Maintenance and Employment

The Chinese elderly mainly work in the fields of agriculture, forestry, fishery, and animal husbandry industries. A shift has been observed in the rise of proportion of workers in such sectors at 1990 census compared to 1982 census. Such shifting also signifies that younger generations transferred from these occupations to become industrial and commercial workers.

1990 census data shows that the employment rate was 28.4% among the Chinese elderly and higher for the age group of 60-64 years. The data also shows gender preponderance as employment rate was higher among the elderly male.

c. Health Care Services

Health services for the elderly in China are provided by the nationwide medical and health network from the central government down in the grass-roots levels (which serves the entire population). It is a three tiered medical service network embracing municipality, district, and neighborhood levels in the urban and country areas and township and villages' levels in rural areas. There were 132,000 outpatient departments and 60,000 hospitals with 2.6 million beds (averaging 2.3 per 1,000) in China in 1989 (China Research Center on Ageing, 1992). The situation is better in urban than in rural areas.

d. Housing Resources

The housing policies of urban areas and rural areas in China are quite different and are reflections of the housing problems of the elderly in these two geographic areas. Most rural old people live in the house they built by themselves in an area that was allocated to them by the collective. The number of the rooms and the style of the house depend on their family's economic ability. The usual house is single-story with three to five rooms and is built with bricks and tiles. No rent is required. In some more affluent villages, clusters of residential buildings, designed and built by the collective, have already appeared. There are kitchens and bathrooms in each house. The rent is still free, but there are charges for water and electricity. About 2% of the elderly who do not have their own dwelling live in their children's home, supported by the children.

Germany

a. The Formal Structure of Care for the Elderly

Germany is a welfare state. So it provides protection against risks in life in the form of state regulated contract between generations i.e. the financial transfers between the working populations and persons in education or retirement. If the family and self-help resources are exhausted, immediate care for the elderly is provided by religious or nonreligious welfare organizations. Public institutions are obliged to provide services in case of failure of these organizations to meet the requirements. Cities, not the federal government, are responsible for making the payments of the Federal Social Welfare Act.

b. Income Maintenance and Employment

Currently, the pension system may be regarded as a reward for leaving the place of work. (This means that if workers are needed, the age limit for retirement will be extended again.) Historically, the pension system is an achievement of social progress. In Germany since 1989, there have also been Survivor's Insurance for wage earners and, since 1911; there have also been benefits for salary earners. With the pension reform of 1957, pensions beyond the age of 65 years have been seen as a form of 'wage compensation'; they are adjusted to gross wage increases (now set to net wage increase). The pension limit has been flexible since 1973, with the option for men to retire at age 63 and women at 60.

Pensions are the main source of income for 80% of the elderly. Maintenance support by the spouse is the primary income for 13% (mostly women), and income by employment is the dominant resource for nearly 2%. Other sources come from personal property or national assistance.

c. Health Care Services

The statutory health insurance system (funded by contributions of employees and employers in equal amounts) 90% of the population as obligatory insured, voluntary insured, pensioners, and dependents from the financial risks of illness. It provides for medical care, sickness benefits, hospital treatment, home nursing, homemaker services, help for the family, and death benefits (according to the relevant legal provisions). The insurance protection also extends principally to measures of illness prevention and rehabilitation. Every dues paying member has to pay a monetary

contribution depending on income (those who have greater income must pay more).

More attention is paid to post-treatment training programs so that the rehabilitation gains in geriatric hospitals will not be lost again.

d. Housing Resources

The federal minister for town and territory planning and housing market has announced accommodation improvements for elderly persons as a key topic for policy development. More than 1 million dwellings are substandard residences, in which mainly single old persons are living. However, other problems exist: an insufficient number of residences for all people and a great demand for renovation of houses (especially in Eastern Germany).

e. Supportive Services

Types of social services are 'open' or ambulatory, semi-institutional, and institutional facilities. The open area contains information and counseling, congregation points, and clubs. Counseling services for the elderly are financed publicly, but they are installed in the central offices of authorities. Efforts have been made for counseling in the districts and in combination with home visits and group services. Old people's day centers and meeting points are used by organized seniors and by persons who already know each other.

Public and private firms provide meals-on-wheels in various locations. The distribution of the meals must be an effective manner; thus, it is not always

possible for the deliverer to add communication and counseling to the service.

Various welfare organizations offer many homemaker services and home nursing, often in competition with each other. Model counseling agencies give psychotherapeutic support to families with respect to the emotional problems linked with care giving.

Special benefits for elderly people consist of low-price senior tickets on the railways, exemption from radio and television fees under certain circumstances, fare reduction in public transport, and free admission to zoos and museums. The type and scale of privileges for elderly people in Germany vary widely from area to area.

Hong Kong

a. The Formal Structure of Care for the Elderly

In Hong Kong, services are provided for the elderly by two different sources. One is government and the other is private sector. Government gives subsidies and sets the fees for using various public services at a nominal level, as most of the majority can afford to pay. Private sector offers social services for the elderly at a higher fee. The elderly who can afford to pay higher fees will avail their services. So the private sector has enough opportunity to expand their services.

b. Income Maintenance and Employment

As it now stands, what the elderly in Hong Kong are entitled to are the old age allowance and the support from public assistance (if they are also poor).

Those elderly between 65 and 69 have to declare that they have neither an income nor assets above certain prescribed levels to be eligible. In 1992, the limits were set at monthly incomes of HK S 2,600 (US\$333) for a single person and HK \$3,900 (US\$500) for a married couple; assets were set at HK \$100,000 (US\$ 12,820) for a single person and HK\$ 150,000 (US\$19,230) for a married couple. For applicants reaching the age of 70, no income declaration is required. The old-age allowance that those aged 70 and over can receive is higher than that given to those aged below 70; in 1992, the amounts were, respectively, HK\$470 (US\$60) and HK\$413 (US\$53) a month. As the old-age allowance is non-means-tested, noncontributory, and regarded as the right of every elderly person residing in Hong Kong, the amount given has to be kept small in order not to financially overburden the government. The old-age allowance should therefore in no way be compared with retirement pensions provided in other countries. The purpose of the old-age allowance when it was first introduced in 1993 was seen as an incentive to encourage families to take care of their elderly members. In March 1992, Over 400,000 elderly persons were receiving the old-age allowance and costing the government an annual outlay of over HK\$ 2 billion (Social Welfare Department, 1992).

c. Health Care Services

The medical and health care system in Hong Kong is made up of two parts: an extensive public sector meeting the needs of the general public and a vigorous private sector catering to those who can afford to pay. In general, about 80% of the patients requiring hospital treatment make use of the services provided in public hospitals managed by the Hospital Authority, while the majority of those requiring only consultative services turn to the

private medical insurance and make greater use of the services provided in public hospitals and outpatient clinics.

Public medical and health services currently available to the elderly consist of preventive health care, community nursing service, community psychiatric nursing service, priority medical consultative for the elderly, infirmaries for the elderly, psycho-geriatric services, and hospice care. Presently, health promotion work is carried out by Department of Health and consists mainly of publicity campaigns and other community programs aimed at educating the elderly about disease prevention.

d. Housing Resources

With a population of nearly 6 million people and a hilly geography, housing naturally is the most difficult problem for most people living in the congested city. At the end of 1991, 40.5% of the population were living in public and aided housing, with another 7.5% in Home Ownership estates built by the Housing Authority (Phillips, 1992). The need of elderly for housing has long been attended to, with the first hostel for the elderly set up in the late 1960s; since then, a great variety of housing resources has been developed for them.

e. Supportive Services

Less than 4% of the elderly in Hong Kong are living in institutions; the great majority is staying in the community either by themselves or with their families. Community support services, comprising home help service, social center, multi-service center, and day-care center, constitute an important part of the social support network. Home help services render to the elderly such

help as the preparation of meals, personal care, escort, laundry, and home management. Around 3,000 elderly persons were being served by home helpers in March 1991. Social centers for the elderly provide a meeting point for them to meet their social and recreational needs.

India

a. Income Maintenance and Employment

The system of payment of person to government employees dates back more than 100 years – ever since the enactment of Pension Act of 1871. According to revised rules of 1972, in order for the retire to receive a pension immediately after retirement, the work for the calculation of the pension amount and so on is supposed to mandatory begin two years prior to superannuation of the concerned employee. In 1991, the Union government initiated the move to introduce a pension scheme for employees covered by the Provident Fund Act. In 1991, the Union Government's pension bill had increased to Rs. 31,000/- million (US\$ 100 million), with defense, railways, and telecommunications sectors taking the lion's share.

In the organized sectors of industry, retirement benefits are available to employees. Under the Employees Provident Fund and Miscellaneous Provisions Act, 1952, three schemes have been framed; Employees' provident Fund Scheme, Employees' Family Pension Scheme, and Employees' Deposit Linked Insurance Scheme. Under the Employees provident Fund Scheme, which covers employed drawing less than Rs. 1,600/- (US\$52) per month in establishments employing 20 or more persons, contributions are made to the Provident Fund by the employees, with a

matching contribution by the employer. After attaining the age of 55, a person is entitled to a full refund of contributions by him or her and by the employer to the fund, along with interest. More than 10,000 establishments have adopted this scheme, covering 11.31 million employees.

The Employees' Family Pension Scheme provides benefits to the members of the family of a deceased employee. Under the Employees' Deposit-linked Insurance Scheme, in the event of death or provident fund member while in service, the person receiving the provident fund is paid, in addition an insurance benefit.

The Gratuity Act, 1972 (as upgraded in 1987) is applicable to factories, mines, plantations, and so on and covers employees earning less than Rs. 2,540 (US\$81) per month. The benefit available under the scheme is a lump sum amount equal to 15 days' wages for each year of continuous service (not less than 5 years). A maximum amount of Rs. 50,000 (US\$1,613) is paid on termination of employment, superannuation, retirement, resignation, or death.

Old-age pensions, in the nature of public assistance, have been introduced by the state government in keeping with the goal of a welfare state. Pensions to the destitute old are now in operation in most of the country. The eligibility criteria vary from state to state. Most of the states have laid down 65 years as the minimum age of eligibility, while in a few states the age limit is 60 plus. Some states prescribe a lower age limit for females, widows, or persons suffering from physical or mental handicap and require a period of continuous residence in the state, in some cases, 10 years or more. Old age

pensions are given to a person with no source of income or with nominal income that is inadequate for survival and with no one to support the person.

Several insurance organizations offer some tax rebate in one form or the other. No doubt they are altruistically motivated but they are financial institutions nonetheless and hence are interested in keeping the investment amount with them as long as possible.

b. Health Care Services

Under the 'Health for All by 2000' program of the World Health Organization, India is committed to providing at least a package of health care services to all segments of the population, giving priority, however, to the underprivileged sections of society. Health care of the old is integrated into the overall health care system in the country, the basic unit of which is the primary health center in rural areas and municipal clinics in urban areas.

Elderly people make use of free medical services provided at government hospitals and dispensaries, and they also use privately run medical services, for which payments have to be made. For retired workers in the organized sector, certain facilities for health care are extended so that they continue to have benefits (with nominal payment) even after retirement. Under the central Government Health Services Scheme, employees and their families receive health care provided at a nominal cost.

c. Housing Resources

The national housing policy of 1988 has recognized the elderly as an especially disadvantaged group for whom housing schemes should

incorporate dwelling units of appropriate designs, formulated to meet their specialized requirements. However, a few social organizations are providing shelter to old people on a nonprofit, no-loss basis. A few state governments are also doing their part, but all the efforts are rather meager.

Recently, the Central Government set up the innovative central Government Employees' Welfare Housing Organizations. Central Government retirees can join this organization within five years of their retirement. Under this scheme this organization proposes to acquire land, in the first instance, in all important cities and built self-financed units.

The law for the welfare of the Aged originally defined three types of institutional facilities: nursing homes for the elderly, free homes for the aged, and homes for the aged with moderate fees.

Based on the Law for the Welfare of the Aged, the national government determines eligibility guidelines and standards, including equipment and staffing of each facility, and administratively oversees its operation. The nursing homes for the elderly provide nursing and personal care for the aged 65 and over who need constant care due to physical and/or mental functional limitations and who are without adequate family care. There is no income eligibility requirement. In 1991, there were 2,403 facilities accommodating 171,257 residents.

d. Supportive Services

Governments of each state, under the departments of social welfare, have lists of organizations working in the field of ageing. Also there is a list of old-age organizations put out by a national organization like International

Federation on Ageing working in the field of ageing. Other social welfare lists may have a section devoted to the list of old-age organizations. Seminar and conference reports on old-age may add lists of such organizations at the end of the report. But these lists are of little use of illiterate persons, and therefore many needy elderly may be in the dark with regard to the services available to them. Day Care Centers and Senior Citizens Club is a new but strong initiative in the country.

Japan

a. The Formal Structure of Care for the Elderly

In 1989, the Japanese Government formulated the Gold Plan i.e. ten-year strategy to Promote Health and Welfare services for the Elderly. This strategy was focused on expanding major community care services and long-term care facilities, a campaign for the reduction of bedridden elderly, promoting measures for productive ageing and research on ageing. For successful implementation of this strategy, revenue was being collected from newly imposed consumption tax and the law for the welfare of the aged and other related laws was amended. Such amendment included coordination among various care services by the municipal government, specification of major community care services in the laws, formulation of quantified goal for the development health and welfare services. The total amount of governmental expenditure for this plan from 1999 is estimated to be over 6 trillion yen (US\$41 billion).

b. Income Maintenance and Employment

Japan's income maintenance programs for elderly people basically comprise public pension insurance and public assistance. With reform in 1985, the public pension scheme changed to a so-called two-tiered structure. The National Pension, which had covered only the self-employed, became a 'basic benefit' covering both the self-employed and the employed.

Furthermore, what should not be overlooked is that Japan's public pension includes a noncontributory pension (financed by the National Treasury), Old Age Welfare Pension, besides the previously mentioned contributory pensions. It was established for those who were too old to participate in the National Pension when it started in 1961. Recipients of this pension are required to be 70 years and over and to have a low income under some amount. The fixed amount of its monthly benefit was nearly 31,000 yen (US\$231) in 1991. The number of recipients is steadily decreasing and numbered approximately 860,000 in 1991.

c. Health Care Services

The medical care financing program for the elderly, originally started in 1973 as a free medical program for those under a set income based on the Law for the welfare of the aged, became a universal provision with a moderate fee charged under the Law for the Health of the Aged in 1982. Under this program, people aged 70 and over and the bedridden elderly 65 to 69 can receive almost all medical care with a moderate fee. Of the remaining expenses, 70% are covered by the fund composed of all public medical insurance programs and 30% by public expenditure.

d. Housing Resources

The law for the welfare of the Aged originally defined three types of institutional facilities: nursing homes for the elderly, free homes for the aged, and homes for the aged with moderate fees.

Based on the Law for the Welfare of the Aged, the national government determines eligibility guidelines and standards, including equipment and staffing of each facility, and administratively oversees its operation. The nursing homes for the elderly provide nursing and personal care for the aged 65 and over who need constant care due to physical and/or mental functional limitations and who are without adequate family care. There is no income eligibility requirement. In 1991, there were 2,403 facilities accommodating 171,267 residents.

e. Supportive Services

Besides, nationally defined community care services, municipal governments provide their own supportive services with a grant from prefectural government or with their own budget. These services range from supplying diapers and other necessary daily goods and services for the bedridden elderly to subsidizing activity programs and transportation for senior citizens.

Home Help Services: The home help service is the oldest one articulated in the original law for the welfare of the aged and helps keep families intact and enables an older person to remain at home. The service may be provided up to four hours per day, six days a week, totaling 18 hours per week, to

those approximately 65 and over and their families in need of personal care and homemaking services.

Day Care Services: The day care service providers are programs to residents of the community aged 65 and over who are either frail or disabled. The service may maintain and promote their physical functioning, help to relieve their sense of isolation, and minimize the burden of family care givers.

Malta

a. The Formal Structure of Care for the Elderly

In Malta, government provides most of the services that are currently available for elderly people. Religious and voluntary organizations provide the same services in a limited but to a significant extent. Such system has been established due to long cherished paternalism by the Knights of Saint John, (1530–1798). They were seen as controlling not only the economic and military concerns but also the social welfare of the people.

b. Housing Resources

The social settings available for the elderly in Malta and assistance for maintaining the elderly in the dwellings of their choice deserve special emphasis. Any development in this area will come from facilities that already exist for the handicapped, in particular, from housing provisions for paraplegics and for the blind (there is no working definition of handicapped used by civil servants).

c. Supportive Services

Each village in Malta is served by a local Social Security district office with an attendant welfare officer who deals mainly with matters relating to financial benefit entitlement. The main beneficiaries of this service are the elderly, since they have the most consistent contact with the benefit office. This service might be further developed by the introduction of an advisory service dealing with social issues. This can be effected through a network of social workers employed within these offices.

Sweden

a. The Formal Structure of Care for the Elderly

By and large, government is responsible for the care of the elderly in Sweden. All medical and social services in Sweden are operated through a very large public sector. This sector is supported by high taxation and provides subsidies against medical and social services for the elderly people. Virtually state bears all such responsibilities as per legislation and guidelines formed by the government and parliament. Health care and social services are heavily subsidized with the recipient usually paying only a fraction of the actual cost.

b. Income Maintenance and Employment

The universal flat rate pension introduced in 1914 was ambitious for its time but provided poor coverage. Contemporary studies found that at least a third of the elderly also had to rely on poor relief and/or their family (Sundstrom, 1993). Then pensions were raised substantially, and municipalities began to

pay housing allowances to elderly in need. The latter still show large local variations. In a 1954 survey, 20% thought their economic situation unsatisfactory; 31% and that it has 'improved' (SOU, 1956) In recent surveys, very few elderly (about 2%) complain that they have trouble making 'both ends meet' or that they have recently worried about money.

c. Health Care Services

Health and medical care are regarded as an important part of the Swedish welfare system. Its fundamental principle is that all citizens are entitled to good health and equal access to health and medical care, regardless of where they live and their economic circumstances. In line with this principle, health and medical care is seen as a public sector responsibility supported by a national health insurance system and other social welfare services.

Health and medical care are financed primarily by income taxes levied by the country councils. These taxes are proportional; that is, they represent a given percentage of a person's taxable income, regardless of its size.

d. Housing Resources

At the level of national policy for housing of the elderly, the general objective set forth in the social Services Act states that old people should, if possible, remain in their own homes. This official policy of 'staying put' has been under debate. The municipalities are mandated by law to supply sheltered living for needy elderly, but it is often felt that this is insufficient. The elderly can exercise freedom of choice, but only after being assessed as in need.

Except for the types of residential living that are institutional in character, no segment of housing market is reserved or designed for the elderly. Postwar 'Pensioner flats' were, in no way, adapted for handicapped or frail persons but only meant to relieve the housings shortage of the time. These apartments are usually no longer reserved for the aged.

e. Supportive Services

The municipality is responsible for Home Help Services (hemtjansten), which provide help with shopping, cleaning, cooking, washing and personal hygiene to elderly and disabled persons living at home. In November 1991 about 13% in the age group 75-79 years received home help. In the age group 80-84 years, the corresponding figure was 25%; in the age group 85-89 years it was 39% and in the group 90 years and older it was 44% (Statistics Sweden, 1992b).

United Kingdom

a. The Formal Structure of Care for the Elderly

Presently Britain is concerned with the dramatic extension of healthy elderly people and has started to view them differently. Despite the change in country perception, still the state regulates official onset of later life at 60 for women and 65 for men, although they are capable to maintain active life for another 10 to 30 years. Automatically they become entitled for the benefits of elderly with the attainment of this threshold age limit. State is largely responsible for providing old age benefits for all public services i.e. health care and social services. Voluntary sector need to come forward to combat the situation. Consequently, such sectors become increasingly prominent

following the election of Margaret Thatcher's conservative administration in 1979.

b. Income Maintenance and Employment

The state retirement pension scheme, introduced in 1909, now forms the central core of income for the majority of people over the retirement ages of 60 for women and 65 for men. It was originally restricted to men in selected industries but was incrementally extended to compass all occupations and, in the early post-war period, to women both on the basis of their own employment and through their spouses. While there is still a small minority of elderly persons who remain ineligible for the state pension, the system is essentially comprehensive. When there are pension levels below the national standard, due to incomplete employment careers or insufficient payments of 'national insurance' there is recourse to a range of means-tested Social Security payments.

c. Health Care Services

Until the late 1980s it would have been possible to depict the British health care system as being the state funded NHS, which provided almost all of the nation's health care needs, plus a small private sector. It delivered health care in hospitals to all citizens, regardless of age, income or other status, free at the point of need. Primary health care was provided through teams led by primary care physicians (general practitioners), while local authorities had responsibility for environmental health. Hospital services were overseen at local levels by area health authorities, which, in turn, were accountable to regional health authorities and upward to the NHS Management Board.

General practitioners were 'independent contractors' with local Family Health Services Authorities (FHSAs).

d. Housing Resources

Over 95% of people of personable age in Britain live in private households. Within this total, about 5% live in some form of sheltered accommodations with a warden to provide general support and emergency services. Only about 10% of retired people (Law and Warnes, 1980) move more than 40 kilometers from their previous residence. The majority of these moves occur at or around retirement.

e. Supportive Services

The overwhelming proportion of support to older people comes from family, neighbors, and friends. The General Household Survey report on informal care givers (1988) reports there are over 6 million care givers in Britain, with 1.7 million caring for someone in their own home. Of these, 3.5 million are women and 2.5 million are men. There is no doubt that women are the principal care givers – numerically and in contribution.

United States

a. The Formal Structure of Care for the Elderly

Notwithstanding the legislative accomplishments initiated in 1935, the United States lacks a unified and comprehensive policy on ageing. There are, instead, about 50 major federal programs mandating the provision of services and benefits, but they have evolved incrementally and in response to specific public concerns. Funding those programs requires an increasingly

larger portion of the federal budget. Thus, while 15% of the total federal outlays was spent on the elderly in 1960, by 1991 these expenditures more than doubled, reaching the 31% level.

In 1991, 54% of the ageing-related expenditures was spent on retirement income, and an additional 26% covered the Medicare health insurance program costs. The funds for the remaining 20% were largely derived from general revenues and were spent, for the most part, on means-tested public assistance programs for needy or low-income elderly, such as medical (health), SST subsidized housing, food stamps, low-income home energy assistance, social services and low income persons, and so on. A smaller portion covers senior community service employment and OAA service programs.

b. Income Maintenance and Employment

The cornerstone of income maintenance in retirement is the Social Security Act of 1935. It includes the Old Age Survivors Insurance Program (OASI), which provides monthly benefits for retired workers as well as their dependents and survivors. Age 65 is presently established as the 'normal' retirement age for the collection of full benefits, but it is scheduled for postponement to age 66 in 2011 and to age 67 in 2022. Workers may opt to retire earlier, at age 62, but they will then experience a 20% lifetime loss of benefits.

Social security is compulsory program, and practically all working people, (94%) participate through monthly deductions in their paychecks. Employers withhold 7.65% for a worker's earnings up to an income ceiling of \$ 53,400

in 1991 and then match the same amount, for which they receive a tax credit. The maximum individual wage deduction is, consequently, \$4,985 a year, but additional wages are withheld at the rate of 1.45% beyond the \$53,400 limit and up to a maximum of \$125,000 in earnings, as a contribution to the Medicare health insurance program (Social Security Bulletin, 1990).

c. Health Care Services

Most older persons in the United States, about 71% of them, reported their health to be 'excellent', 'very good' in a 1989 Health Interview Survey conducted by the National Center for Health Statistics. However, given the higher survivorship rates, the acute care conditions that were prevalent earlier this century have given way to a more pervasive pattern of multiple chronic and disabling conditions (Particularly in advanced old age.) About 80% of the population age 65 and older are afflicted with at least one chronic condition. Arthritis leads among all chronic illnesses, and heart disease is both the leading predictor of short-stay hospital visits and the main cause of death, followed by cancer and stroke. Death rates from heart disease represent about 40% of all deaths among older persons, followed by cancer, which caused 21% of all deaths in this age population. It is noteworthy that deaths caused by heart disease and stroke have been declining since 1968, while the death rate from cancer is on the increase, a fact partially explained by the persistence of lung cancer.

The Medicare program was established in 1965 as an addition to the Social Security Act of 1935 and consists of two sub programs: Part A, a mandatory hospital insurance, as part B, a supplementary outpatient medical insurance,

which is optional. In 1991, 30.3 million older persons were covered by part A, and 29.8 million had elected to enroll in Part B.

d. Housing Resources

An assortment of program strategies helps older persons obtain, and live independently in, adequate housing. To begin with, low income elderly may apply for rent supplement funds. In such cases, eligible persons, on their own, select an appropriate unit in the open private market, but they must apply up to 30% of their income toward the rental costs. The government then picks up the difference between that portion and the total rental price.

There is also a wide assortment of planned forms of residential dwellings organized for the aged, including group-shared housing, adult foster care, and adult homes. These resources aim at reducing the incidence of premature institutionalization in nursing home-type facilities and combine varying degrees of independent living with limited forms of assistance and supervision. Continuing Care Retirement Communities (CCRCs) offer, in a single site, the advantages of independent living and supportive services, including health care. Their most important feature is the contractual assurance of lifetime care, including the provision of intensive, round-the-clock skilled nursing care when needed. Because of their high costs of operation, due, in part, to the quality of the amenities and services provided, CCRCs are accessible only to a minority of affluent elderly.

e. Supportive Services

Finding out what services are available, where they can be found, and whether one is entitled to get them could constitute an intimidating and

exhausting job in its own right. Information and referral services (I and R) have been created precisely to facilitate access and entry to the service system. They operate in the area agencies on ageing (AAs) and also in community voluntary organizations, social service departments, public libraries, senior centers, hospitals, and so on. I and R services often do not passively wait for people to make inquiries but also reach out to the community and try to locate or identify shut-in, isolated, and despondent people in need of assistance.

Multipurpose senior centers are probably the most frequently used community-based service. They were originally grass-roots rather than governmental-initiatives, but today they operate under both public-generally municipal and voluntary auspices.

Source: Gokhale, S.D. et al. (ed.) (1999). *Ageing in India*. Somaiya Publications Private Limited, Mumbai.

A p p e n d i x C

UNITED NATIONS PRINCIPLES FOR THE OLDER PERSONS

'Of course we always help our neighbors
in the future we will need
their help!'

Older man, Cambodia

Appendix C

United Nations Principles for the Older Persons

To Add Life to the Years That Has Been Added to Life

The UN Principles aim to ensure that priority attention will be given to the situation of older persons. The UN Principles address the independence, participation, care, self-fulfillment and dignity of older persons.

United Nations Principles for Older Persons

The General Assembly

- Appreciating the contribution that older persons make to their societies,
- Recognizing that, in the Charter of the United Nations, the peoples of the United Nations declare, inter alia, their determination to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small and to promote social progress and better standards of life in larger freedom,
- Noting the elaboration of those rights in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights and other declarations to ensure the application of universal standards to particular groups,
- In pursuance of the International Plan of Action on Ageing, adopted by the World Assembly on Ageing and endorsed by the General Assembly in its resolution 37/51 of 3 December 1982,

- Appreciating the tremendous diversity in the situation of older persons, not only between countries but within countries and between individuals, which requires a variety of policy responses,
- Aware that in all countries, individuals are reaching an advanced age in greater numbers and in better health than ever before,
- Aware of the scientific research disproving many stereotypes about inevitable and irreversible declines with age,
- Convinced that in a world characterized by and increasing number and proportion of older persons, opportunities must be provided for willing and capable older persons to participate in and contribute to the ongoing activities of society,
- Mindful that the strains on family life in both developed and developing countries require support for those providing care to frail older persons,
- Bearing in mind the standards already set by the International Plan of Action on Ageing and the conventions, recommendations and resolutions of the International Labor Organization, the World Health Organization and other United Nations entities,

Encouraged Governments to incorporate the following principles into their national programmes whenever possible:

Independence

- Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.

- Older persons should have the opportunity to work or to have access to other income generating opportunities.
- Older persons should be able to participate in determining when and at what pace withdrawal from the labor force takes place.
- Older persons should have access to appropriate educational and training programmes.
- Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
- Older persons should be able to reside at home for as long as possible.

Participation

- Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
- Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
- Older persons should be able to form movements or associations of older persons.

Care

- Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
- Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.

- Older persons should have access to social and legal services to enhance their autonomy, protection and care.
- Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
- Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

Self-fulfillment

- Older persons should be able to pursue opportunities for the full development of their potential.
- Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

Dignity

- Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
- Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

A p p e n d i x D

POLITICAL DECLARATION OF THE SECOND UNITED NATIONS WORLD ASSEMBLY ON AGEING, MADRID 2002

'We can't walk alone, but always
together'

Dona Severa, President, older
people's day centre, Huari, Bolivia

Appendix D

Second United Nations World Assembly on Ageing, Madrid 2002

Political Declaration

Article 1

We, the representatives of Governments meeting at this Second World Assembly on Ageing in Madrid, Spain, have decided to adopt an International Plan of Action on Ageing 2002 to respond to the opportunities and challenges of population ageing in the twenty-first century and promote the development of a society for all ages. In the context of this Plan of Action, we are committed to actions at all levels, including national and international levels, in three priority directions: older persons and development; advancing health and well being into old age; and, ensuring enabling and supportive environments.

Article 2

We celebrate rising life expectancy in many regions of the world as one of humanity's major achievements. We recognize that the world is experiencing an unprecedented demographic transformation and that by 2050 the number of persons aged 60 years and over will increase from 600 million to almost 2,000 million and the proportion of persons aged 60 years and over is expected to double from 10 per cent to 21 per cent. The increase will be greatest and most rapid in developing countries where the older population is expected to quadruple during the next 50 years. This demographic transformation challenges all our societies to promote

increased opportunities, in particular for older persons to realize their potential to participate fully in all aspects of life.

Article 3

We reiterate the commitments made by our heads of State and Governments in major UN conference and summits and their follow-up processes, and in the Millennium Declaration, with respect to the promotion of international and national environments that will foster a society for all ages. We furthermore reaffirm the Principles and Recommendations for Action of the International Plan of Action on Ageing 2002 endorsed by the United Nations General Assembly in 1982 and the United Nations Principles for Older Persons adopted by the General Assembly in 1991, which provided guidance in areas of independence, participation, care, self-fulfillment and dignity.

3. bis We emphasize that in order to complement national efforts to fully implement the International Plan of Action on Ageing 2002, enhanced international cooperation is essential. We therefore, encourage the international community to further promote cooperation among all actors involved.

Article 4 (former 5) deleted

Article 5 (former 2)

We reaffirm the commitment to spare no effort to promote democracy, strengthen the rule of law, promote gender equality, as well as to promote and protect human rights and fundamental freedoms, including the right to

development. We commit ourselves to eliminate all forms of discrimination, including age discrimination. We also recognize that persons, as they age, should enjoy a life of fulfillment, health, security and active participation in the economic, social, cultural and political life of their societies. We are determined to enhance the recognition of the dignity of older persons, and to eliminate all forms of neglect, abuse and violence.

Article 5 bis deleted

Article 6

The modern world has unprecedented wealth and technological capacity and has presented extraordinary opportunities: to empower men and women to reach old age better health, and with more fully realized well-being; to seek the full inclusion and participation of older persons in societies; to enable older persons to contribute more effectively to their communities and to the development of their societies; and to steadily improve care and support for older persons as they need it. We recognize that concerted action is required to transform the opportunities and the quality of life of men and women as they age and to ensure the sustainability of their support systems, thus building the foundation for a society for all ages. When ageing is embraced as an achievement, the reliance on human skills, experiences and resources of the higher age groups is naturally recognized as an asset in the growth of mature, fully integrated, humane societies.

6 bis At the same time, considerable obstacles to further integration and full participation in the global economy remain for developing countries, in particular the least developed countries, as well as for some countries with

economies in transition. Unless the benefits of social and economic development are extended to all countries, a growing number of people, particularly older persons in all countries and even entire regions will remain marginalized from the global economy. For this reason we recognize the importance of placing ageing in development agendas, as well as strategies for the eradication of poverty and in seeking to achieve the full participation in the global economy of all developing countries.

Article 7 (former 11) Deleted

Article 8 (former 7)

We commit ourselves to the task of effectively incorporating ageing within social and economic strategies, policies and action while recognizing that specific policies will vary according to conditions within each country. We recognize the need to mainstream a gender perspective into all policies and programmes to take account of the needs and experiences of older women and men.

new 8 bis: We commit ourselves to protect and assist older persons in situations of armed conflict and foreign occupation.

Article 9 (former 8) deleted

Article 10 (former 12)

The potential of older persons is a powerful basis for future development. This enables society to rely increasingly on the skills, experience and

wisdom of older persons, not only to take the lead in their own betterment but also to participate actively in that of society as a whole.

new 10 bis

We emphasize the importance of international research on ageing and age related issues, as an important instrument for the formulation of policies on ageing, based on reliable and harmonized indicators developed by, inter alia, national and international statistical organizations.

Article 11 (new)

The expectations of older persons and the economic needs of society demand that older persons be able to participate in the economic, political, social and cultural life of their societies. Older persons should have the opportunity to work, continuing to have access to education and training programs. The empowerment of older persons and the promotion of their full participation are essential elements for active ageing. For older persons, appropriate sustainable social support should be provided.

Article 12

We stress the primary responsibility of governments in promoting, providing and ensuring access to basic social services, bearing in mind specific needs of older persons. To this end we need to work together with local authorities, civil society, including non-governmental organizations, private sector, volunteers and voluntary organizations older persons themselves and associations for and of older persons, as well as families and communities.

new 12 bis

We recognize the need to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. We reaffirm that the attainment of the highest possible level of health is a most important worldwide social goal, whose realization requires action of many other social and economic sectors in addition to the health sector. We commit ourselves to provide older persons with universal and equal access to health care and services including physical and mental health services and we recognize that the growing needs of an ageing population require additional policies, in particular care and treatment, the promotion of healthy lifestyles and supportive environments. We shall promote independence, accessibility and the empowerment of older persons to participate fully in all aspects of society. We recognize the contribution of older persons to development in their role as caregivers.

Article 13 (new)

We recognize the important role played by families, volunteers, communities, older persons organizations and other community-based organizations in providing support and informal care to older persons in addition to services provided by Governments.

Article 14

We recognize the need to strengthen the solidarity among generations, and intergenerational partnerships, keeping in mind the particular needs of both older and younger ones, and encourage mutually responsive relationships between generations.

Article 15 (former 9)

Governments have the primary responsibility to provide leadership on ageing matters and on the implementation of the International Plan of Action on Ageing 2002 but effective collaboration between national and local governments, international agencies, older persons themselves and their organizations, other parts of civil society, including non-governmental organizations, and the private sector is essential. The implementation of the International Plan of Action on Ageing 2002 will require the partnership and involvement of many stakeholders: professional organizations; corporations; workers and workers organizations; cooperatives; research, academic, and other educational and religious institutions; and the media.

Article 16 (new)

We underline the important role of the United Nations system, including the regional commissions in assisting the Governments, at their request, in the implementation, follow-up and national monitoring of the International Plan of Action on Ageing 2002, taking into account the differences in economic, social and demographic conditions existing among countries and regions.

Article 17 (former 15)

We invite all people in all countries from every sector of society, individually and collectively, to join in our dedication to a shared vision of equality for persons of all ages.

A p p e n d i x E

INTERNATIONAL PLAN OF ACTION ON AGEING 2002

'I don't even know how to read--- I
only go out if my children take me'

Older woman, Lima, Peru

Appendix E

Second United Nations World Assembly on Ageing, Madrid 2002

International Plan of Action on Ageing 2002

Introduction

Deleted

bis. The International Plan of Action on Ageing 2002¹, adopted at the first World Assembly on Ageing in Vienna, has guided the course of thinking and action on ageing over the past 20 year, as crucial policies and initiatives evolved. Issues of human rights for older persons were taken up in 1991 in the formulation of the United Nations Principles for Older Persons², which provided guidance in the areas of independence, participation, care, self-fulfillment and dignity.

The Twentieth Century saw a revolution in longevity. Average life expectancy at birth has increase by 20 years since 1950 to 66 years and is expected to extend a further 10 years by 2050. This demographic triumph and the fast growth of the population in the first half of the 21st Century mean that the number of persons over 60 will increase from about 600 million in 2000 to almost 2,000 million in 2050 and the proportion of

¹ See *Report of the World Assembly on Ageing, Vienna, 26 July: 6 August 1982* (United Nations publication, Sales No. E.82.1.16), chap. VI, sect. A.

² Official Records of the General Assembly, Forty-sixth Session, *Supplement No. 49* (A/46/49), resolution 46/91, annex.

persons defined as older is projected to increase globally from 10 percent in 1998 to 15 percent in 2025. The increase will be greatest and most rapid in developing countries where the older population is expected to quadruple during the next fifty years. In Asia and Latin America, the proportion of persons classified as older will increase from 8 to 15 percent between 1998 and 2025, although in Africa the proportion is only expected to grow from 5 to 6 percent during the period but then doubling by 2050. In sub-Saharan Africa, where the struggle with the HIV/AIDS pandemic and with economic and social hardship continues, the percentage will reach half that level. In Europe and North America between 1998 and 2025 the proportion of persons classified as older will increase from 20 percent to 20 percent and 16 percent to 26 percent. Such a global demographic transformation has profound consequences for every aspect of individual, community, national and international life. Every facet of humanity will evolve: social, economic, political, cultural, psychological and spiritual.

Deleted (moved to declaration)

The remarkable demographic transition under way will result in the old and the young representing an equal share of the world's population by mid-century. Globally, the proportion of persons aged 60 years and older is expected to double between 2000 and 2050, from 10 to 21 percent, whereas the proportion of children is projected to drop by a third, from 30 to 21 percent. In certain developed countries and countries with economies in transition, the number of older persons already exceeds the number of children and birth rates have fallen below replacement levels. In some developed countries, the number of older persons will be more than twice that of children 2050. In developed countries the average of 71 men per

hundred women is expected to increase to 78. In the less developed regions, older women do not outnumber older men to the same extent as in the developed regions, since gender differences in life expectancy are generally smaller. Current sex ratios in developing countries average 88 men per hundred women among those 60 and older, and are projected to change slightly to 87 by mid-century.

Population ageing is poised to become a major issue in developing countries, which are projected to age swiftly in the first half of the twenty-first century. The proportion of older persons is expected to rise from 8 to 19 percent by 2050, while that of children will fall from 33 to 22 percent. This demographic shift presents a major resource challenge. Though developed countries have been able to age gradually, they face challenges resulting from the relationship between ageing and unemployment and sustainability of pension systems, while developing countries face the challenge of simultaneous development and population ageing.

5. bis. There are other major demographic differences between developed and developing countries. While the overwhelming proportion of older persons in developed countries live in areas classified as urban, the majority of older persons in developing countries live in rural areas today. Demographic projections suggest that by 2025, 82 percent of the population of developed countries will live in urban areas, while less than half of the population of developing countries will live there. In developing countries, the proportion of older persons in rural areas is higher than in urban areas. Although further study is needed on the relationship between ageing and urbanization, the trends suggest that in

the future in rural areas of many developing countries there will be a larger population of older persons.

5. ter. Significant differences also exist between developed and developing countries in terms of the kinds of households in which older persons live. In developing countries a large proportion of older persons live in multigenerational households. These differences imply that policy actions will be different in developing and developed countries.

Deleted

The fastest growing group of the older population is the oldest old, that is, those who are 80 years or more. In 2000, the oldest old numbered 70 million and their numbers are projected to increase to more than five times that over the next 50 years.

7. bis. Older women outnumber older men, increasingly so as age increases. The situations of older women everywhere must be a priority for policy action. Recognizing the differential impact of ageing on women and men is integral to ensuring full equality between women and men and to the development of effective and efficient measures to address the issue. It is therefore critical to ensure the integration of a gender perspective into all policies, programmes and legislation.

It is essential to integrate the evolving process of global ageing within the larger process of development. Policies on ageing deserve close examination from the developmental perspective of a broader life course and a society-wide view, taking into account recent global initiatives and the

guiding principles set down by major United Nations conferences and summits.

The International Plan of Action on Ageing 2002 calls for changes in attitudes, policies and practices at all levels in all sectors so that the enormous potential of ageing in the twenty-first century may be fulfilled. Many older persons do age with security and dignity, and also empower themselves to participate within their families and communities. The aim of the Plan of Action is to ensure that persons everywhere are able to age with security and dignity and to continue to participate in their societies as citizens with full rights. While recognizing that the foundation for a healthy and enriching old age is laid early in life, the Plan is intended to be a practical tool to assist policy makers to focus on the key priorities associated with individual and population ageing. The common features of the nature of ageing and the challenges it presents are acknowledged, and specific recommendations are designed to be adapted to the great diversity of circumstances in each country. The Plan recognizes the many different stages of development and the transitions that are taking place in various regions, as well as the interdependence of all countries in a globalizing world.

Deleted.

A society for all ages, which was the theme for the 1999 International Year of Older Persons, contained four dimensions: individual lifelong development; multigenerational relationships; the interrelationship between population ageing and development; and the situation of older persons. The International Year helped to advance awareness, research and policy action

worldwide, including efforts to integrate the issue of ageing in all sectors and foster opportunities integral to all phases of life.

The major United Nations conferences and summits and special sessions of the General Assembly and review follow-up processes have set goals, objectives and commitments at all levels intended to improve the economic and social conditions of everyone. These provide the context in which the specific contributions and concerns of older persons must be placed. Implementing their provisions would enable older persons to contribute fully and benefit equally from development. There are a number of central themes running through the International Plan of Action on Ageing 2002 linked to these goals, objectives and commitments which include:

New (a): The full realization of all human rights and fundamental freedoms of all older persons.

The achievement of secure ageing, which involves reaffirming the goal of eradicating poverty in old age and building on the United Nations Principles for Older Persons;

Empowerment of older persons to fully and effectively participate in the economic, political and social lives of their societies, including through income-generating and voluntary work;

Provision of opportunities for individual development, self-fulfillment and well-being throughout life as well as in late life, through, for example, access to life-long learning and participation in the community while recognizing that older persons are not one homogenous group;

Ensuring the full enjoyment of economic, social and cultural rights, and civil and political rights of persons and the elimination of all forms of violence and discrimination against older persons.

Commitment to gender equality among older persons through inter alia, elimination of gender-based discrimination:

Recognition of the crucial importance of families, intergenerational interdependence, solidarity and reciprocity for social development;

Provision of health care, support and social protection for older persons, including preventive and rehabilitative health care;

Facilitating partnership between all levels of government, civil society, the private sector and older persons themselves in translating the International Plan of Action into practical action;

Harnessing scientific research and expertise and realizing the potential of technology to focus on inter alia, the individual, social and health implications of ageing, in particular in developing countries.

Recognition of the situation of ageing indigenous persons, their unique circumstances and the need to seek means to give them an effective voice in decisions directly affecting them.

merged with para. 12

The promotion and protection of all human rights and fundamental freedoms including the right to development is essential for the creation of an inclusive society for all ages in which older persons participate fully and without discrimination and on the basis of equality. Combating

discrimination based on age and promoting the dignity of older persons is fundamental to ensuring the respect that older persons deserve. Promotion and protection of all human rights and fundamental freedoms is important in order to achieve a society for all ages. In this, the reciprocal relationship between and among generations must be nurtured, emphasized, and encouraged through a comprehensive and effective dialogue.

The recommendations for action are organized according to three priority directions; older persons and development; advancing health and well-being into old age; and ensuring enabling and supportive environments. The extent to which the lives of older persons are secure is strongly influenced by progress in these three directions. The priority directions are designed to guide policy formulation and implementation towards the specific goal of successful adjustment to an ageing world, in which success is measured in terms of social development, the improvement for older persons in quality of life and in the sustainability of the various systems-formal and informal- that underpin the quality of well-being throughout the life course.

Mainstreaming ageing into global agendas is essential. A concerted effort is required to move toward a wide and equitable approach to policy integration, the task is to link ageing to other frameworks for social and economic development and human rights. Whereas specific policies will vary according to country and region, population ageing is a universal force that has the power to shape the future as much as globalization. It is essential to recognize the ability of older persons to contribute to society by taking the lead not only in their own betterment but also in that of society as a whole. Forward thinking calls us to embrace the potential of the ageing population as a basis for future development.

II. Recommendations for action

Deleted (moved to Declaration)

A. Priority direction I: Older Persons and Development

Older persons must be full participants in the development process and also share in its benefits. No individual should be denied the opportunity to benefit from development. The impact of population ageing on the socio-economic development of society, combined with the social and economic changes taking place in all countries engender the need for urgent action to ensure the continuing integration and empowerment of older persons. Also migration urbanization, the shift from extended to smaller, mobile families, lack of access to technology that promotes independence and other socio-economic changes can marginalize older persons from the mainstream of development, taking away their purposeful economic and social roles and weakening their traditional sources of support.

Whereas development can benefit all sectors of society, sustained legitimacy of the process requires introduction and maintenance of policies that ensure the equitable distribution of the benefits of economic growth. One of the principles in the Copenhagen Declaration and Programme of Action is the creation of a framework by Governments to fulfill their responsibility for present and future generations by ensuring equity across the generations. Furthermore, the Millennium Summit affirmed the long-term imperative of eradication poverty and fulfilling the social and humanitarian goals set up by the global conferences of the 1990s.

Deleted

The attention of policy makers has been seized by the simultaneous need to adjust to the effects of and ageing labour force while improving labour productivity and competitiveness and also ensuring the sustainability of social protection systems. Where appropriate, multi-faceted reform strategies should be implemented in order to place pension systems on a sound financial footing.

Deleted

Issue I: Active participation in society and development

A society for all ages encompasses the goal of providing older persons with the opportunity to continue contributing to society. To work toward this goal, it is necessary to remove whatever excludes or discriminates against them. The social and economic contribution of older persons reaches beyond their economic activities. They often play crucial roles in families and in the community. They make many valuable contributions that are not measured in economic terms: care for family members, productive subsistence work, household maintenance and voluntary activities in the community. Moreover, these roles contribute to the preparation of the future labour force. All these contributions, including those made through unpaid work in all sectors b y persons of all ages, particularly women, should be recognized.

Participation in social, economic, cultural, sporting, recreational and volunteer activities also contribute to the growth and maintenance of personal well-being. Organizations of older persons are an important means of enabling participation through advocacy and promotion of multigenerational interactions.

Objective I: Recognition of social, cultural, economic and political contribution of older persons.

Actions

Ensure the full enjoyment of all human rights and fundamental freedoms by promoting the implementations of human rights conventions and human rights instruments, particularly in combating all forms of discriminations.

Acknowledge, encourage and support the contributions of older persons to families, communities and the economy.

Provide opportunities programs and support to encourage older persons to participate or continue to participate in cultural, economic and political, social life and lifelong learning.

Provide information and access to facilitate the participation of older persons in mutual self-help, intergenerational community groups and opportunities for realizing their full potential.

Create an enabling environment for volunteering at all ages, including public recognition and facilitate the participation of older persons who may have little or no access to the benefits of engaging in volunteering.

Promote a wider understanding of the cultural, social and economic role and continuing contribution of older persons to society, including that of unpaid work.

new (g) Older persons should be treated fairly and with dignity regardless of disability or other status and be valued independently of their economic contribution.

new (h) Take account of the needs of the older persons and to respect the rights to live in dignity in all stages of life.

new (i) Promote favourable attitudes among employers of the productive capacity of the older workers conducive to their continued employment and promote awareness of their worth in the labor market, including their self awareness.

new (j) Promote civic and cultural participation as strategies to combat social isolation and support empowerment.

Objective 2: Participation of older persons in decision making processes at all levels.

Actions

Take into account the needs and concerns of older persons in decision making at all levels;

Encourage (when they do not already exist) the establishment of organizations of older persons at all levels to, inter alia, represent older persons in decision making.

Take measures to enable the full and equal participation of older persons in particular older women in decision making at all levels.

(Deleted)

Issue 2: Work and the ageing labour force

Older persons should be enabled to continue with income generating work for as long as they want and for as long as they are able to do so

productively. Unemployment, underemployment and labour market rigidities often prevent this, thus restricting opportunities for individuals and depriving of their energies and skills. Implementation of commitment 3 of the Copenhagen Declaration of the World Summit for Social Development on promoting the goal of full employment is fundamentally important for these very reasons, as are the strategies and policies outlined in that Summit's Programme of Action and the further initiatives for growth of employment recommended by the twenty-fourth special session of the General Assembly. There is a need to increase awareness in the workplace of the benefits of maintaining an ageing workforce.

In developing countries and countries with economies in transition, most persons who are now old and who work are engaged in the formal economy, which often deprives them of the benefits of adequate working conditions and social protection provided by the formal sector economy. The life expectancy in many developed countries and countries with economies in transition exceeds the established retirement or pension age. In these countries, moreover, fewer persons are entering the labour market because of the decrease in the birth rate; this trend is often accompanied, by age discrimination. Labour shortages are likely to occur as a result of the decline in the pool of young persons entering the labour market, of the ageing workforce and of the tendency towards early retirement. In this context, policies to extend employability, such as flexible retirement new work arrangements, adaptive work environments, and vocational rehabilitation for older persons with disabilities are essential and allow older persons to combine paid employment with other activities.

Factors affecting older women in the labour market deserve special attention, particularly those factors which affect women's engagement in paid work, (like, inter alia, lower salaries, lack of career development due to interrupted work histories, family care obligations), their ability to build pensions and other resources for their retirement . A lack of family-friendly policy regarding the organization of work can increase these difficulties. Poverty and low income during women's earning years often can lead to poverty in old age. An integral goal of the International Plan of Action is to achieve age diversity and gender balance in the workplace.

In addressing the goal of employment for all, it must be recognized that the continued employment of older workers need not reduce labour market opportunities for younger persons and provides ongoing and valuable contribution to the improvement of national economic performance and output which in turn can benefit all members of society. The overall economy can also benefit from other plans to use older workers experience and skills to train younger and newer employees.

30. bis. Where potential labour shortages exist, this could necessitate major changes in existing incentive structures, to encourage more workers to willingly defer full retirement and continue to be employed, whether as part-time or as full-time employees. Human resources management practices and policies should take into account and address some of the specific needs of older employees. Appropriate adjustments may be needed to the workplace environment and working conditions to ensure that older workers have skills, health and capacity to remain employed into their later

years. This suggests that employers, workers organizations and human resource personnel should pay closer attention to emerging workplace practices, both domestic and international that might facilitate the retention and productive fulfillment of older workers in the workforce.

Objective I: Employment opportunities for all older persons who want to work.

Actions

Deleted.

new (a) bis. Place employment growth at the heart of macroeconomic policies , for example by ensuring that labour market policies aim to foster high rates of growth in production and employment for the benefit of persons of all ages;

new (a) ter. Enable older persons to continue working as long as they want to work and are able to do so.

Take action to increase participation in the labour market of the working age population and to reduce the risk of exclusion or dependence in later life. This action is to be promoted through policies such as, inter alia, increasing older women's participation, sustainable work-related health care services with emphasis on prevention, promotion of occupational health and safety to maintain work ability, and access to technology, life-long learning, continuing education, on-the-job training, vocational rehabilitation and flexible retirement arrangements as well as striving to reintegrate the unemployed and persons with disabilities into the labour market;

Make special efforts to raise the participation rate of women and disadvantaged groups such as the long-term unemployed and persons with disabilities, thereby reducing the risk of their exclusion or dependency in later life;

Promote self-employment initiatives for older persons, inter alia, by encouraging small and micro-enterprise development and ensuring access to credit for older persons, without any discrimination in particular gender discrimination;

Assist older persons already engaged in informal sector activities by improving their income, productivity and working conditions;

Eliminate age barriers in the formal labour market by promoting recruitment of older persons and preventing the onset of disadvantages experienced by ageing workers in employment.

Promote as appropriate, a new approach to retirement that takes account of the needs of the employees as well as the employers, in particular by applying the principle of flexible retirement policies and practices, while maintaining acquired pension rights. Possible measures to achieve this goal may include reducing the incentives and pressures for early retirement and removing disincentives to working beyond retirement age.

Recognize and accommodate the caring responsibilities of increasing proportions of workers for older family members and persons with disabilities and persons with chronic diseases, including HIB/AIDS by developing, inter alia, family-friendly and gender-sensitive policies aimed at reconciling work and care giving responsibilities;

Subsumed under (g)

bis. Remove disincentives to working beyond retirement age, for example through, inter alia, protecting acquired pension rights, disability

benefit rights and health benefits from being affected by delayed retirement age.

Promote new work arrangement and innovative workplace practices aimed at sustaining working capacity and accommodating the needs of workers as they age inter alia, by setting up employee assistance programmes.

Support workers in making informed decisions about the potential financial, health and other impacts, of a longer participation in the work force;

Promote a realistic portrait of older workers' skills and abilities by correcting damaging stereotypes about older workers or job candidates.

Take into account older workers' interests when policy or decision makers approve business mergers so that they are not subject to more disadvantages, reduction of benefits or loss of employment than their younger counterparts.

Issue 3: Rural development, migration and urbanization

In many developing countries, and countries with economies in transition, the ageing population is marked in rural areas, owing to the exodus of young adults. Older persons may be left behind without traditional family support and even without adequate financial resources. Policies and programmes for food security and agricultural production must take into account the implications of rural ageing. Older women in rural areas are particularly economically vulnerable, especially when their role is restricted to non-remunerated work for family upkeep and they are dependent on others for their support and survival. Older persons in rural areas in developed countries and countries with economies in transition often still

lack basic services and have insufficient economic and community resources.

Despite restrictions on legal international migration, migration flows have increased internationally. In developing countries and countries with economies in transition, economic support including remittances from children abroad is often a vital lifeline to older persons and through them to their communities and local economies. As international migrants from earlier decades grow older, some Governments are seeking to assist older migrants.

The urban setting is generally less conducive to sustaining the traditional extended family network and reciprocity system than are rural areas. Older migrants from rural to urban areas in developing countries often face loss of social networks and suffer from lack of supporting infrastructure in cities which can lead to their marginalization and exclusion, particularly if they are ill or disabled. In countries with long history of rural to urban migration and the expansion of underdeveloped cities, there is a growing population of poor older persons. The urban setting for the older migrant in developing countries and countries with economies in transition is often one of crowded housing, poverty, loss of economic autonomy and little physical and social care from family members who must earn their living outside the home.

Objective 1: Improvement of living conditions and infrastructure in rural areas.

Actions

Strengthen the capacity of ageing farmers through continued access to financial and infrastructure services and training for improved farming techniques and technologies;

Encourage the establishment and revitalization of small-scale enterprises by providing funding or support for income-generation projects and rural cooperatives and by widening economic diversification;

Foster the development of local financial services including micro credit schemes and micro finance institutions in under-served rural areas to encourage investment;

Promote ongoing adult education, training and retraining in rural and remote areas;

Connect rural and remote populations to the knowledge-based economy and society;

new (f) Ensure that the rights of older women in rural and remote areas are taken into account with regard to their equal access to and control of economic resources.

(new g) Encourage appropriate social protection/social security measures for older persons in rural and remote areas.

(new h) Ensure in rural and remote areas equal access to basic social services for older persons.

Objective 2: Alleviation of the marginalization of older persons in rural areas.

Actions

Design and implement programmes and provide services to sustain the independence of older persons in rural areas, including older persons with disabilities;

Facilitate and strengthen traditional rural and community support mechanisms.

Focus support on older persons in rural areas without kin, particularly older women who face longer old age often with fewer resources;

Give priority to the empowerment of older women in rural areas through access to financial and infrastructure services.

Promote innovative rural and community support mechanisms, including, inter alia, those that facilitate the exchange of knowledge and experience among older persons.

Objective 3: Integration of older migrants with in their new communities.

Actions

Encourage supportive social networks for older migrants;

Design measures to assist older migrants to sustain economic and health security;

Develop community-based measures, to prevent or offset the negative consequences of urbanization, such as establishment of centres for older persons;

Encourage housing design to promote intergenerational living, where culturally appropriate and individually desired;

Assist families to share accommodation with older family members who desire it.

- (e) bis. Develop politics and programmes that facilitate as appropriate and consistent with national laws the integration of older migrants into the social, cultural, political and economic life of countries of destination (and) that encourages respect for them.

Remove language and cultural barriers when providing public services to older migrants.

Issue 4: Access to knowledge, education and training

Education is a crucial basis for an active and fulfilling life. The Millennium Summit made a commitment to ensure that by 2015 all children complete a full course of primary schooling. A knowledge-based society requires that policies be instituted to ensure lifelong access to education and training. Continuing education and training are essential to ensure the productivity of both individuals and nations.

At the present time, developing countries have a large number of persons reaching old age with minimal literacy and numeracy, which limits their capacity to earn a livelihood and may thus influence their enjoyment of health and well-being. In all countries lifelong education and training is also a prerequisite for the participation of older persons in employment.

39. bis. A workplace with a diverse age distribution creates an environment where individuals can share skills, knowledge and experience. This kind of mutual training can be formalized in collective agreements and policies or left to informal practices.

Older persons facing technological change without education or training can experience alienation. Increased access to education at a younger age will benefit persons, as they grow older including in coping with technological change. Despite this however, illiteracy continues to remain high in many areas of the world. Technology can be used to bring persons together and thereby contribute to the reduction of marginalization, loneliness and segregation between the ages. Therefore, measures that enable older persons to have access to, take part in and adjust to technological changes should be taken.

bis. Training, retraining and education are important determinants of a worker's ability to perform and adapt to workplace changes. Technological and organizational changes may render and employee's skills obsolete and dramatically depreciate the value attached to previously accumulated work experience. Greater emphasis on access to knowledge, education and training opportunities is needed for older persons in the workforce. These persons often experience more difficulties adapting to technological and organizational changes than younger workers, particularly when considering the increasingly widespread use of information technologies.

Objective 1: Equality of opportunity throughout life with respect to continuing education, training and retraining as well as vocational guidance and placement services.

Actions

Achieve a 50 percent improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults;

Encourage and promote literacy, numeracy and technological skills training for older persons and the ageing workforce, including specialized literacy and computer training for older persons with disabilities;

Implement policies that promote access to training and retraining for older workers and encourage them to continue to use their acquired knowledge and skills after retirement;

Deleted

Ensure that the benefits of new technologies, especially information and communication technologies, are available to all, taking into account the needs of older women;

Develop and disseminate user-friendly information to assist older persons to be able to respond effectively to the technological demands of everyday life;

Encourage the design of computer technology and print and audio materials that take account of the changes in physical abilities and visual capacity of older persons.

Encourage further research to better determine the relationship between training and productivity so as to clearly demonstrate to both employers and employees the benefits of continuous training and education of older persons.

new (i) Raise the awareness of employers and workers organization of the value of retraining of older workers, particularly women.

Objective 2: Full utilization of the potential and expertise of persons of all ages, recognizing the benefits of increased experience with age.

Actions

(new a) Consider measures to fully utilize the potential and expertise of older persons in education.

Provide opportunities within educational programmes for the exchange of knowledge, and experience between generations, including the use of new technologies;

Enable older persons to act as mentors, mediators and advisors;

Encourage and support traditional and non-traditional multigenerational mutual assistance activities in the family, the neighborhood and the community with a clear gender perspective;

Encourage older volunteers to offer their skills in all fields of activities, in particular information technologies.

Encourage the utilization of the social cultural and educational knowledge and potential of older persons.

Issue 5: Intergenerational solidarity

Solidarity between generations at all levels in families, communities and nations is fundamental for the achievement of a society for all ages. Solidarity is also a major prerequisite for social cohesion and a foundation of formal public welfare and informal care systems. Changing demographic, social and economic circumstances require the adjustment of pension, social security, health and long-term care systems to sustain economic growth and development and to ensure adequate and effective income maintenance and service provision.

At the family and community level, intergenerational ties can be valuable for everyone. Despite geographic mobility and other pressures of contemporary life that can keep persons apart, the great majority of persons in all cultures maintain close relations with their families throughout their lives. These relationships work in both directions, with older persons often providing significant contributions both financially and, crucially, in the education and care grandchildren and other kin. All sectors of society, including Governments, should aim to strengthen those ties. Nevertheless, it is important to recognize that living with younger generations is not always the preferred or best option for older persons.

Objective 1: Strengthening of solidarity through equity and reciprocity between generations.

Actions

Promote understanding of ageing through public education as and issue of concern to the entire society;

Consider reviewing existing policies to ensure that they foster solidarity between generations and thus promoting social cohesion;

Develop initiatives aimed at promoting mutual, productive exchange between the generations, focusing on older persons as a societal resource;

Maximize opportunities for maintaining and improving intergenerational relations in local communities, inter alia, by facilitating meetings for all age groups and avoiding generational segregation;

- (d) bis. Consider the need to address the specific situation of the generation that has to care at the same time for their parents, their own children and grandchildren;

Promote and strengthen solidarity among generations and mutual support as a key element for social development;

Initiate research on the advantages and disadvantages of different living arrangements for older persons, including familial co-residence and independent living in different cultures and settings.

Issue 6: Eradication of poverty

The struggle against poverty among older persons aiming towards its eradication is a fundamental aim of the Plan of Action on Ageing. Although global attention has recently been focused more actively on poverty eradication targets and policies, older persons in many countries still tend to be excluded from these policies and programmes. Where poverty is endemic, persons who survive a lifetime of poverty often face and old age of deepening poverty.

For women, institutional biases in social protection systems, in particular those based on uninterrupted work histories, contribute further to the feminization of poverty. Gender inequalities and disparities in economic power-sharing, unequal distribution of unremunerated work between women and men, lack of technological and financial support for women's entrepreneurship, unequal access to, and control over capital, particularly land and credit and access to labor markets, as well as all harmful traditional and customary practices have constrained

women's economic empowerment and exacerbated the feminization of poverty. In many societies, female-headed households, including divorced or separated unmarried women and widows are at particular risk of poverty. Special social protection measures are required to address feminization of poverty, in particular among older women.

47. bis. Older persons with disabilities are also at greater risk of poverty than the non-disabled older persons partly because of workplace discrimination including employer discrimination and the absence of workplace accommodations of their needs.

Objective 1: Reduction of poverty among older persons.

Actions

New (a) Reduce the proportion of persons living in extreme poverty by one half by the year 2015.

Include older persons in policies and programmes to reach the poverty reduction target;

Promote equal access to employment and income generation opportunities, credit, markets and assets for older persons;

Ensure that the particular needs of older women, the oldest old, older persons with disabilities and those living alone are specifically addressed in poverty eradication strategies and implementation programmes;

Develop as appropriate and at all appropriate levels, age and gender-relevant poverty indicators as an essential means to identify the needs of poor older women and encourage the use of existing indicators of poverty so that the review is carried out according to age group and gender.

Support innovative programmes to empower older persons, particularly women, to increase their contributions to and benefit from development efforts to eradicate poverty.

new (f) Enhance international cooperation to support national efforts to eradicate poverty in keeping with internationally agreed goals in order to achieve sustainable social and economic support for older persons.

new (g) Strengthen the capacities of developing countries to address the obstacles that hinder their participation in an increasingly globalized economy in order to assist them in their efforts to eradicate poverty in particular among older persons.

Issue 7: Income security, social protection/social security and poverty prevention

Income security and social protection/social security measures, whether contributory or not, include informal as well as highly structured schemes. They are part of a foundation for economic prosperity and social cohesion.

Globalization, structural adjustment programmes, fiscal constraints and a growing older population are often perceived as exerting pressure on formal social protection/social security systems. Sustainability in the provision of adequate income security is of great importance. In developing countries with limited coverage formal systems of social protection/social security, populations are vulnerable to the market shocks and individual misfortunes that strain informal family support. In countries with economies in transition, the economic transformations have impoverished whole segments of the population, particularly older

persons and many families with children. Where it has occurred, hyperinflation has rendered pensions, disability insurance, health benefits and savings almost worthless.

Appropriate social protection/social security measures are required to address the feminization of poverty, in particular among older women.

Objective 1: Promotion of programmes to enable all workers to acquire basic social protection/social security, including where applicable, pensions, disability insurance and health benefits.

Actions

Develop and implement policies aimed at ensuring that all persons have adequate economic and social protection during old age;

Strive to ensure gender equality in social protection/social security systems;

Ensure where appropriate, that social protection/social security systems cover and increasing proportion of the formal and informal working population;

Consider innovative social protection/social security programmes for persons working in the informal sector;

Introduce programmes to promote employment of low-skilled older workers, giving access to social protection/social security systems;

Strive to ensure the integrity, sustainability, solvency and transparency of pension schemes, and, where appropriate disability insurance.

Establish a regulatory framework for private and supplementary pension, and, where appropriate, disability insurance.

New (h) Provide advice and counseling services for older persons with regard to all areas of social protection/social security.

Objective 2: Sufficient minimum income for all older persons, paying particular attention to socially and economically disadvantaged groups.

Actions

Consider establishing where appropriate, a non-contributory pension system and disability benefit system;

Organize, as a matter of urgency, where they do not exist, social protection/social security systems to ensure minimum income for older persons with no other means of support, most of whom are women, in particular those living alone and who tend to be more vulnerable to poverty;

Take into account the living standards of older persons whenever pension systems and disability insurance as appropriate, are being reformed;

Take measures to counteract the effects of hyperinflation on pension, disability insurance as appropriate and savings arrangements.

New (e) Invite the international organizations, in particular, the international financial institutions, according to their mandates, to assist developing countries and all countries in need, in their efforts to achieve basic social protection, particularly for older persons.

Issue 8: Emergency situations

In emergency situations, such as natural disasters and other humanitarian emergencies, older persons are especially vulnerable, and

should be identified as such because they may be isolated from family and friends and are less able to find food and shelter. They may also be called upon to assume primary caregiving roles. Governments and humanitarian relief agencies should recognize that older persons can make a positive contribution in coping with emergencies in promoting rehabilitation and reconstruction.

Objective 1: Equal access by older persons to food, shelter and medical care and other services during and after natural disasters and other humanitarian emergencies.

Actions

- new (a) Take concrete measures to protect and assist older persons in situations of armed conflict and foreign occupation including through the provision of physical and mental rehabilitation services for those who are disabled in these situations.
- (b) Locate and identify older persons in emergency situations and ensure inclusion of their contributions and vulnerabilities in needs assessment reports;
- (c) Raise awareness among relief agency personnel of the physical and health issues specific to older persons and of ways to adapt basic needs support to their requirements;
- (d) Aim to ensure that appropriate services are available and that older persons have physical access to them, and that they are involved in planning and delivering services as appropriate;
- (d) bis. Recognize that older refugees of different cultural backgrounds growing old in new and unfamiliar surroundings are often in special need

of social networks and of extra support and aim to ensure that they have physical access to such services.

Make explicit reference to, and design national guidelines for, assisting older persons in disaster relief plans, including disaster preparedness, training for relief workers and availability of services and goods;

Assist older persons to re-establish family and social ties, and address their post-traumatic stress;

Following disasters, put in place mechanisms to prevent the targeting and financial exploitation of older persons by fraudulent opportunities;

Raise awareness and protect older persons from physical, psychological, sexual or financial abuse in emergency situations, paying particular attention to the particular risks faced by women.

New Action (i) Encourage a more targeted inclusion of older refugees in all aspects of programme planning and implementation inter alia, by helping active persons to be more self-supporting and by promoting better community care initiatives for the very old.

New Action (j) Enhance international cooperation including burden sharing and coordination of humanitarian assistance to countries affected by natural disasters and other humanitarian emergencies and post conflict situations in ways that would be supportive of recovery and long term development.

Objective 2: Enhanced contributions of older persons to the re-establishment and reconstruction of communities and the rebuilding of the social fabric following emergencies.

Actions

Include older persons in the provision of community relief and rehabilitation programmes, including by identifying and helping vulnerable older persons;

Recognize the potential of older persons as leaders in family and community, for education, communication and conflict resolution;

Assist older persons to re-establish economic self-sufficiency through rehabilitation projects, including income generation, educational programmes and occupational activities, taking into account the special needs of older women.

Provide legal advice and information to older persons in situations of displacement and dispossession of land and other productive and personal assets;

Provide special attention for older persons in humanitarian aid programmes and packages offered in situations of natural disasters and other humanitarian emergencies.

Share and apply, as appropriate, lessons learned from practices that have successfully utilized the contributions of older persons in the aftermath of emergencies.

Priority direction II: Advancing health and well-being into old age

Good health is a vital individual asset. Similarly, a high overall level of health of the population is vital for economic growth and the development of societies. The full benefits of healthy longevity have yet to be shared by all humanity, evidenced by the fact that entire

countries especially developing countries and certain population groups still experience high rates of morbidity and mortality at all ages.

57. bis. Older persons are fully entitled to have access to preventive and curative care, including rehabilitation care and sexual health. Full access of older persons to health care and services that include disease prevention and involve recognition that health promotion and disease prevention activities throughout life need to focus on maintaining independence, prevention and delay of disease and disability treatment as well as on improving the quality of life of older persons who already have disabilities. The health care and services need to include the necessary training of personnel and facilities to meet the special needs of the older population.

The World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being, not merely the absence of disease and infirmity. To reach old age in good health and well-being requires individual efforts throughout life and environment within which such efforts can succeed. The responsibility of individuals is to maintain a healthy lifestyle; the responsibility of Government is to create a supportive environment that enables the advancement of health and well-being into old age. For both humanitarian and economic reasons, it is necessary to provide older persons with the same access to preventive and curative care and rehabilitation as other groups. At the same time, health services designed to meet the special needs of the older population must be available, taking into account the introduction of geriatric medicine in relevant university curricula and health care systems, as appropriate. In addition to Governments, there are other

important actors, in particular NGOs and families, which provide support for individuals in maintaining a healthy life-style while cooperating closely with government in creating a supportive environment.

An epidemiological transition is now under way in all regions of the world, indicating a shift in predominance of infectious and parasitic diseases to one of chronic and degenerative diseases. Many developing countries and countries with economies in transition however, are confronting a double burden of fighting emerging and re-emerging communicable diseases, such as HIV/AIDS, tuberculosis, and malaria in parallel with the increasing threat of non-communicable diseases.

The growing need for care and treatment of an ageing population requires adequate policies. The absence of such policies can cause major cost increases. Policies that promote lifelong health, including health promotion and disease prevention, assistive technology, rehabilitative care when indicated, mental health services, promotion of healthy lifestyles and supportive environments, can reduce disability levels associated with old age, and affect budgetary savings.

Issue 1: Health promotion and well-being throughout life

Health promotion encourages persons to monitor and improve their own health. The basic strategies for health promotion are laid down in the Ottawa Charter for Health Promotion (1986). Goals of increasing the healthy life span, improving the quality of life for all, reducing mortality and morbidity rates and increasing life expectancy were set at the International Conference on Population and Development (1994).

These goals can be more effectively achieved through implementation of actions recommended by the WHO to improve both public health and access to adequate health care.

Health promotion activities and equal access of older persons to health care and services that include disease prevention throughout life is the cornerstone of healthy ageing. A life course perspective involves recognizing that health promotion and disease prevention activities need to focus on maintaining independence, prevention and delay of disease and disability, providing treatment as well as on improving the functioning and quality of life of older persons who already have disabilities.

62. bis. Maintaining and enhancing health status requires more than specific actions to affect individual health. Health is strongly influenced by environmental, economic, and social determinants including the physical environment, geography, education, occupation, income, social status, social support, culture and gender. Improvements in the economic and social situation of older persons will result in improvements in their health as well. Despite improvements in legislation and service delivery, equal opportunities for women through the life course are still not realized in many areas. For women, a life course approach to well-being in old age is particularly important, as they face obstacles throughout life with a cumulative effect on their social, economic, physical and psychological well-being in the later years.

Children and older persons are more susceptible to various forms of environmental pollution than individuals in the intermediate ages and are more likely to be affected by even the lowest pollution levels. Medical conditions due to environmental pollution reduce productivity and affect quality of life of persons as they age. Malnutrition and poor nutrition also places older persons at disproportionate risk and can adversely affect their health and vitality. The leading causes of disease, disability and mortality in older persons can be alleviated through health promotion and disease prevention measures that focus, inter alia, on nutrition and physical activity and smoking cessation.

Objective 1: Reduction of the cumulative effects of factors that increase the risk of disease and consequently potential dependence in older age.

Actions

Give priority to poverty eradication policies to inter alia improve the health status of older persons, particularly the poor and marginalized;

bis. Ensure as appropriate, conditions that enable families and communities to provide care and protection to persons as they age.

Set targets, in particular gender-specific targets to improve the health status of older persons and reduce disability and mortality;

Identify and address the main environmental and socio-economic factors that contribute to the onset of disease and disability in later life;

Focus on the major known risks, arising from unhealthy diet, physical inactivity and other unhealthy behaviors, such as smoking and alcohol abuse in health promotion, health education, prevention policies and information campaigns;

Take comprehensive action to prevent the abuse of alcohol, to reduce the use of tobacco products and the involuntary exposure to tobacco smoke to promote the cessation of tobacco use at all ages.

Set in place and implement legal and administrative measures and organize public information and health promotion, including campaigns to reduce the exposure to environmental pollutants from childhood and throughout life.

Promote the safe use of all medications, and minimize misuse of prescription drugs through regulatory and education measures with the participation of the industry and professional sectors involved.

Objective 2: Development of policies to prevent ill-health among older persons.

Actions

Design early interventions to prevent or delay the onset of disease and disability;

bis. Promote adult immunization programmes as a preventive measure.

Ensure that gender-specific primary prevention and screening programmes are available and affordable to older persons;

Provide training and incentives for health and social service and care professionals to counsel and guide persons reaching old age on healthy lifestyles and self-care;

Pay attention to the danger arising from the consequences of social isolation and mental illness and reduce its risk to the health of older persons by supporting community empowerment and mutual aid groups, including

peer outreach and neighborhood visiting programmes and by facilitating the active participation of older persons in voluntary activities.

(d) bis. Promote civic and cultural participation of older persons as strategies to combat social isolation and support empowerment.

Rigorously implement and reinforce national and international safety standards, where applicable, that aim at preventing injuries at all ages;

Prevent unintentional injuries by developing a better understanding of their causes and by undertaking measures to safeguard pedestrians, implementing fall prevention programmes, minimizing hazards including fire hazard in the home and providing safety advice.

New Action (g) Develop at all levels statistical indicators on common disease in older persons to guide policies aimed at preventing further illness in this group.

New Action (h) Encourage older persons to maintain or adopt an active and healthy lifestyle, including physical activity and sport.

Objective 3: Access to food and adequate nutrition for all older persons.

Actions

Promote equal access to clean water and safe food for older persons;

bis. Achieve food security by ensuring a safe and nutritionally adequate food supply at both the national and international levels. In this regard, ensure that food and medicine are not used as tools for political pressure.

Promote lifelong healthy and adequate nutrition from infancy, with particular attention to ensuring that specific nutritional needs of men and women throughout the life course are met;

Encourage a balanced diet to provide adequate energy and prevent macro and micronutrient deficiency, preferably based on local foods through inter alia developing national dietary goals;

Pay particular attention to nutritional deficiency and associated diseases in the design and implementation of health promotion and prevention programmes for older persons;

Educate older persons and the general public, including informal caregivers, about specific nutritional needs of older persons, including adequate intake of water, calories, protein, vitamins and minerals;

Promote affordable dental services to prevent and treat disorders that can impede eating and cause malnutrition;

Include specific nutritional needs of older persons into curricula of training programmes for all health and relevant care workers and professionals.

New Action (h) Ensure appropriate and adequate provision of accessible nutrition and food for older persons in hospital and other care settings.

Issue 2: Universal and equal access to health care services

Investing in health care and rehabilitation for older persons extends their healthy and active years. The ultimate goal is a continuum of care ranging from health promotion and disease prevention to the provision of primary health care, acute care treatment, rehabilitation, community care for chronic health problems, physical and mental rehabilitation for older persons

including older persons with disabilities and palliative care³ for older persons suffering painful or incurable illness or disease. Effective care for older persons needs to integrate physical, mental, social, spiritual and environmental factors.

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. Older persons can experience financial, physical, psychological and legal barriers to health care services. They may also encounter age discrimination and age-related disability discrimination in the provision of services because their treatment may be perceived to have less value than the treatment of younger persons.

68. bis. We recognize the gravity of the public health problems afflicting many developing countries and least-developed countries, especially those resulting from HIV/ AIDS, tuberculosis, malaria and other epidemics. We stress the need for the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) to be part of the wider national and international action to address these problems.

68. ter. Intellectual property protection is important for the development of new medicines.

³Palliative care's definition based on WHO is active total care of patients whose disease is not responsive to curative treatment, by namely controlling pain and other symptoms of the disease and offering psychological, social and spiritual support to patients and their families.

We also recognize the concerns about its effects on prices. We agree that TRIPS agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitments to the TRIPS agreement we affirm that the agreement can and should be interpreted and implemented in a manner supportive of Governments' right to protect public health and, in particular, to promote access to medicines for all.

Governments have the primary responsibility for setting and monitoring of standards of health care as well as providing health care for all ages. Partnerships among Government, civil society including non-governmental and community-based organizations and the private sectors constitute valuable contributions to the services and care for older persons. It is crucial, however, to recognize that services provided by families and communities cannot substitute for an effective public health system.

Objective 1: Elimination of social and economic inequalities based on age, gender or any other ground including linguistic barriers to ensure that older persons have universal and equal access to health care.

Actions

Take measures to ensure equal distribution of health and rehabilitation resources to older persons and in particular increase access for these resources for older persons who are poor, and promote their distribution to poorly served areas, such as rural and remote areas, including affordable access to essential medications and other therapeutic measures.

- (a) bis. Promote equal access to care for older persons who are poor as well as those who live in rural or remote areas by, inter alia, the

reduction or elimination of user fees, provisions of insurance schemes and other financial support measures.

ter. Promote affordable access to essential medications and other therapeutic measures.

Deleted

Educate and empower older persons in the effective use and selection of health and rehabilitation services.

Implement international obligations to ensure the access of older persons to primary health care without discrimination based on age and other forms of discrimination.

(d) bis. Enhance the access of older persons to primary health care and take steps to eliminate discrimination in health care based on age and other forms of discrimination.

Utilize technology such as telemedicine, where available and distance learning to reduce geographical and logistical limitations in access to health care in rural areas.

Objective 2: Development and strengthening of primary health care services to meet the needs of older persons and promote their inclusion in the process.

Actions

New merged (a) and (b) Take measures to provide universal and equal access to primary health care and establish community health programmes for older persons.

(c) Support local communities in providing health support services to older persons.

(d) Include traditional medicine in primary health care programmes where appropriate and beneficial.

(e) Train primary health care workers and social workers in basic gerontology and geriatrics.

bis. Encourage, at all levels, arrangements and incentives to mobilize commercial enterprises, especially in pharmaceuticals, to invest in research aimed at finding remedies that can be provided at affordable prices for diseases that particularly afflict older persons in developing countries, and invite the World Health Organization to consider improving partnerships between the public and private sectors in the area of health research.

Objective 3: Development of a continuum of health care to meet the needs of older persons.

Actions

Develop regulatory mechanisms at appropriate levels to set appropriate standards of health care and rehabilitation for older persons.

Implement community development strategies that determine a systematic needs assessment baseline for the planning, execution and evaluation of locally based health programmes. The baseline should include contributions from older persons.

Improve the coordination of primary health care, long-term care and social services and other community services.

Deleted

Deleted

Support the provision of palliative care¹ and its integration into comprehensive health care. To this end, develop standards for training and palliative care¹, and encourage multidisciplinary approaches for all service providers of palliative care.

new (g) Promote the establishment and coordination of a full-range of services in the continuum of care, including, inter alia, prevention and promotion, primary care, acute care, rehabilitation, long-term and palliative care¹ so that resources can be deployed flexibly to meet the variable and changing health needs of older persons.

new (h) Develop specialize gerontological services and improve coordination of their activities with primary health care and social care services.

Objective 4: Involvement of older persons in the development and strengthening of primary and long-term care services.

Actions

Include older persons in the planning, implementation and evaluation of social and health care and rehabilitation programmes.

Encourage health and social care providers to fully include older persons in decision-making related to their own care.

Promote self care in older persons and maximize their strengths and abilities within health and social services.

new (d) Integrate the needs and perceptions of older persons in the shaping of health policy.

Issue 3: Older persons and HIV/AIDS

HIV/AIDS diagnosis among older persons is difficult because symptoms of infection can be mistaken for other immunodeficiency syndromes that occur in older persons. Older persons can be at increased risk of HIV infection merely because they are typically not addressed by public information campaigns and thus do not benefit from education on how to protect themselves.

Objective 1: Improvement in the assessment of the impact of HIV/ AIDS on the health of older persons, both for those who are infected and older persons who are caregivers for infected or surviving family members.

Actions

Ensure and expand the compilation of HIV/AIDS data to allow for the assessment of the extent of HIV/AIDS infection in older persons.

Pay special attention to older carers of HIV/AIDS patients, including collection of both quantitative and qualitative data on the health status and needs of older carers.

Objective 2: Provision of adequate information, training in caregiving skills, treatment, medical care and social support to older persons living with HIV/AIDS and their caregivers.

Actions

Revise as appropriate, public health and prevention strategies to reflect local epidemiology. Information on prevention and risks of HIV/AIDS for the general population should meet the needs of older persons.

Provide training to older caregivers to help them to provide effective care while minimizing the possible negative impact on their own health and well-being.

new (c) Ensure AIDS treatment and support strategies recognize the needs of older persons who are infected by HIV/AIDS.

Objective 3: Enhancement and recognition of the contribution of older persons to development in their role as caregivers for children with chronic diseases, including HIV/AIDS, and as surrogate parents.

Actions

Review the economic impact of HIV/AIDS on older persons, particularly in their role as caregivers, as agreed in the Declaration of Commitment on HIV/AIDS;

Introduce policies to provide in-kind support, health care and loans to older caregivers to assist them in meeting the needs of children and grandchildren in accordance with the Millennium Declaration;

Foster collaboration between government agencies and NGOs that work with children, youth and older persons on HIV/AIDS issues;

Encourage the elaboration of studies to better understand and highlight the contribution of older persons to social and economic development in all countries, particularly those severely affected by HIV/AIDS and disseminate the findings as widely as possible.

Issue 4: Training of care providers and health professionals

There is an urgent need worldwide to expand educational opportunities in the field of geriatrics and gerontology for all health professional who

work with older persons and to expand educational programmes on health and older persons for professionals in the social service sector. Informal caregivers also need access to information and basic training on the care of older persons.

Objective 1: Provision of improved information and training for health professionals and para-professionals on the need of older persons.

Actions

Initiate and promote education and training programmes for health professionals, social care professionals and informal care providers in the services for and care of older persons, including in gerontology and geriatrics and support all countries, particularly developing countries in these efforts.

Deleted

Deleted

Deleted

Provide health and social-care professional with continuing education programmes with a view to an integrated approach of health, well being and care of older persons as well as social and psychological aspects of ageing.

Expand professional education in gerontology and geriatrics, including through special efforts to expand student enrolment in geriatrics and gerontology.

Issue 5: Mental health needs of older persons

Worldwide, mental health problems are a leading cause of disability and of reduced quality of life. Mental health problems are clearly not an

inevitable outcome of growing old, but a significant increase in the number of older persons with mental illnesses can be expected due to population ageing. Various losses and life changes can often lead to any array of mental health disorders, which, if not properly diagnosed, can lead to inappropriate or no treatment and/or clinically unnecessary institutionalization.

80. bis. Strategies to cope with such diseases include medication, psychosocial support, cognitive training programmes, training for caring family members and caring staff and specific structures of inpatient care.

Objective 1: Development of comprehensive mental health care services ranging from prevention to early intervention, the provision of treatment services and the management of mental health problems in older persons.

Actions

Develop and implement national and local strategies designed to improve prevention, timely detection and treatment of mental illness in old age, including diagnostic procedures, appropriate medication, psychotherapy and education for professionals and informal caregivers;

new (a) bis. Develop, where appropriate, effective strategies to increase the level of quality assessment and diagnosis of Alzheimer's and related disorders at an early stage of the disease. Research on these disorders should be undertaken on a multidisciplinary basis that meets the needs of the patient, health professional and carers.

Deleted

Provide programmes to help persons with Alzheimer's disease and mental illness due to other sources of dementia to be able to live at home for as long as possible and to respond to their health needs;

Develop programmes to support self-help and provide respite care for patients, families and other carers

Develop psychosocial therapy programmes to assist in reintegration of patients discharge from hospitals;

Develop a comprehensive continuum of services in the community to prevent unnecessary institutionalization

- (f) bis. Establish services and facilities that provide safety and treatment and that promote personal dignity to meet the needs of older persons suffering from mental disorders.

Promote public information about the symptoms, treatment, consequences and prognosis of mental diseases.

new (h) Provide mental health services to older persons residing in long-term care facilities.

New (i) Provide ongoing training to health care professionals in the detection and assessment of all mental disorders and depression.

Issue 6: Older persons and disabilities

Incidence of impairment and disability increases with age. Older women are particularly vulnerable to disability in old age due to inter alia, gender differences in life expectancy and disease susceptibility, and gender inequalities over the life course.

82. bis. The effects of impairment and disability are often exacerbated by negative stereotypes about persons with disabilities, which may result in lowered expectations of their abilities and social policies which do not allow them to reach their full potential.

Enabling interventions and environments supportive of all older persons are essential to promote independence and empower older persons with disabilities to participate fully in all aspects of society. The ageing of persons with cognitive disabilities is a factor that should be considered in planning and decision making processes.

Objective 1: Maintenance of maximum functional capacity throughout the life course and promotion of the full participation of older persons with disabilities.

Actions

Ensure that the agendas of national policy and programmes coordination agencies dealing with disabilities include attention to issues concerning older persons with disabilities.

Develop as appropriate, gender and age-sensitive national and local policies, legislation, plans and programmes for the treatment and prevention of disabilities, taking health, environmental and social factors into account;

Provide physical and mental rehabilitation services for older persons with disabilities.

Develop community-based programmes to provide education on causes of disabilities and information on how to prevent or manage them throughout the life course;

Create age-friendly standards and environments to help prevent the onset or worsening of disabilities;

Encourage the development of housing options for older persons with disabilities that reduce barriers to, and encourage independence; and where

possible make public spaces, transportation and other services accessible to older person with disabilities, as well as commercial premises and services used by the general public.

Encourage the provision of rehabilitation and appropriate care and assistive technologies for older persons with disabilities to fulfill their need for services, support and full integration into society.

- (g) bis. Promote, in accordance with applicable international law, including international agreements acceded to, the accessibility to all without discrimination, including the most vulnerable sectors of the population, of such pharmaceuticals or medical technologies and their affordability for all, including disadvantaged groups.

new (h) Encourage and facilitate the establishment of self-help organizations of older persons with disabilities and their caregivers.

new (i) Encourage employer receptivity to older persons with disabilities who remain productive and capable of paid or volunteer work.

Priority direction III: Ensuring enabling and supportive environments

The promotion of an enabling environment for social development was one of the central goals agreed at the World Summit for Social Development. It was renewed and strengthened at the twenty-fourth special session of the General Assembly on social development. The commitment included essential framework conditions such as participatory, transparent and accountable political systems, and good governance at the national and international levels as established in the Millennium Declaration; recognition of the universal indivisible interdependent and interrelated nature of all human rights; increased external assistance to developing

countries through official development assistance and debt relief; recognition of the important interaction between environmental, economic and social policies; improved access for developing countries and countries with economies in transition to the markets of the developed countries; and reduction of the negative impact of international financial turbulence. Realization of these and other aspects of an enabling environment and the economic growth and social development to which they contribute will make possible the achievement of the goals and policies agreed upon in the present Plan of Action.

85. bis. The mobilization of domestic and international resources for social development is an essential competent for the implementation of the International Plan of Action on Ageing 2002. Since 1982, reforms to promote the effective and efficient utilization of existing resources have received increasing attention. However, inadequate national revenue generation and collection, combined with new challenges regarding social services and social protection systems due, for instance, to demographic changes and other factors, jeopardize the financing of social services and social protection systems in many countries. There is also grater acceptance that the increasing dept burden faced by the most indebted developing countries in unsustainable and constitutes one of the principal obstacles to achieving progress in people-centred sustainable development and poverty eradication. For many developing countries, as well as countries with economies in transition, excessive debt servicing has severely constrained their capacity to promote social development and provide basic services.

85. ter. We note with concern current estimates of dramatic shortfalls in resources required to achieve the internationally agreed development goals, including those contained in the United Nations Millennium Declaration². Achieving the internationally agreed development goals, including those contained in the Millennium Declaration, demands a new partnership between developed and developing countries. We commit ourselves to sound policies, good governance at all levels and the rule of law. We also commit ourselves to mobilizing domestic resources, attracting international flows, promoting international trade as an engine for development, increasing international financial and technical cooperation for development, sustainable debt financing and external debt relief, and enhancing the coherence and consistency of the international monetary, financial and trading systems.

The commitments to strengthen policies and programmes to create inclusive, cohesive societies for all- women and men, children, young and older persons-are also essential. Whatever the circumstances of older persons, all are entitled to live in an environment that enhances their capabilities. While some older persons need a high level of physical support and care, the majority are willing and capable of continuing to be active and productive including through voluntary activities. Policies are required that empower older persons and support their contribution to society. This includes access to basic services such as clean water and adequate food. It also requires policies that simultaneously strengthen both lifelong development and independence and that support social institutions based on principles of reciprocity and interdependence. Governments must play a central role in formulating and implementing policies that foster such and

enabling environment, while engaging civil society and older persons themselves.

Issue 1: Housing and the living environment

Housing and the surrounding environment are particularly important for older persons due to factors such as accessibility and safety; the financial burden of maintaining a home; and the important emotional and psychological security of a home. It is recognized that good housing can promote good health and well-being. It is also important that older persons are provided where possible, with adequate choice over where they live, a factor that needs to be built into policies and programmes.

In developing countries, and some countries with economies in transition rapid demographic ageing is taking place in a context of continuing urbanization, and growing number of persons who are aging in urban areas lack affordable housing and services. At the same time a large number of persons are ageing in isolation in rural areas, rather than in the traditional environment of an extended family. Left alone, they are often without adequate transportation and support systems.

In developed countries, the built environment and adequate transportation for older persons are also a growing concern. Housing developments are typically designed for young families who have their own transport. Transportation is problematic in rural areas, because older persons rely more on public transport as they age and it is often inadequate in rural areas. In addition, some older persons may continue to live in houses that they are unable to maintain after their children have moved out or after a spouse has died.

Objective 1: Promotion of “ageing in place” in the community with due regard to individual preferences and affordable housing options for older persons.

Actions

Promote the development of age-integrated communities;

Coordinate multi-sectoral efforts to support the continued integration of older persons with their families and communities;

Encourage investment in local infrastructure, such as transportation, health, sanitation and security, designed to support multigenerational communities;

Introduce policies and support initiatives that ease access of older persons to goods and services;

Promote equitable allocation of public housing for older persons;

Link affordable housing with social support services to ensure the integration of living arrangements, long-term care and opportunities for social interaction.

new (g) Encourage age-friendly and accessible housing design and ensure easy access to public buildings and spaces;

new (h) Provide older person, their families and caregivers with timely and effective information and advice on the housing options available to them;

Objective 2: Improvement in housing and environmental design to promote independent living by taking into account the needs of older persons, particularly those with disabilities.

Actions

Ensure that new urban spaces are free of barriers to mobility and access;
Promote employment of technology and rehabilitation services designed to support independent living;

Meet the need for shared and multigenerational co-residence through the design of housing and public space;

Deleted

New (e) Assist older persons to make their homes free of barriers to mobility and access.

Objective 3: Improved availability of accessible and affordable transportation for older persons.

Actions

(a) Improve the availability of efficient public transportation services in rural and urban areas;

(b) Facilitate the growth of both public and private alternative forms of transport in urban areas, such as neighborhood-based business and services;

(c) Encourage the training and assessment of older drivers, the design of safer roadways and the development of new kinds of vehicles that cater to the needs of older persons and persons with disabilities;

(d) Deleted

Issue 2: Care, and support for caregivers

Provision of care to those who need it, either by older persons or for them, is mostly done by the family or community, especially in developing countries. Families and communities also play a key role in prevention, care, support and treatment of persons affected by HIV/AIDS. Where the caregivers are older persons, provisions should be made to assist them; and where they are the recipients of care there is a need to establish and strengthen human resources and health and social infrastructures as imperatives for the effective delivery of prevention, treatment, care and support services. This care giving system should be strengthened and reinforced by public policies as the proportion of the population needing this care increases.

93. (bis) Even in countries with well-developed formal care policies, intergenerational ties and reciprocity ensure that most care is still informal. Informal care has a complementary character and does not replace professional care. Ageing in one's community is an ideal in all countries. In many countries, however, family care without compensation to caregivers is creating new economic and social strains. The cost to women, in particular, who continue to provide the majority of informal care, is now recognized. Female caregivers bear financial penalty of low pension contributions because of absences from the labour market, foregone promotions and lower incomes. They also bear the physical and emotional cost of stress from balancing work and household obligations. The situation is especially demanding for women with both child and elder care responsibilities.

In many parts of the world, especially Africa, the HIV/AIDS pandemic has forced older women, already living in difficult circumstances, to take on the added burden of caring for children and grandchildren with HIV/AIDS and for grandchildren orphaned from AIDS. At a time when it is more normal for adult children to look after their ageing parents, many older persons find themselves with the unexpected responsibility of caring for frail children or with the task of becoming sole parents to grandchildren.

In the last two decades, community care and ageing in place have become the policy objective of many Governments. Sometimes the underlying rationale has been financial, because, based on the assumption that families will supply the bulk of care, community care is expected to cost less than residential care. Without adequate assistance, family caregivers can be overburdened. In addition, formal community care systems, even where they exist, often lack sufficient capacity because they are poorly resourced and coordinated. As a result, residential care may be the preferred option of either the frail older person or the caregiver. In view of this range of issues, a continuum of affordable care options, from family to institutional, is desirable. Ultimately, the participation of older persons in assessing their own needs and monitoring service delivery is crucial to the choice of the most effective option.

Objective 1: Provision of a continuum of care and services for older persons from various sources and support for caregivers.

Actions

Take steps to provide community-based care and support for family care;

Increase quality of care and access to community-based long-term care for older persons living alone in order to extend their capacity for independent living as a possible alternative to hospitalization and nursing home placement;

Support caregivers through training, information, psychological, economic, social and legislative mechanisms;

Take steps to ensure the provision of assistance to older persons in cases where informal support is unavailable, has been lost, or is not desired.

Facilitate comparative research into care systems in different cultures and settings;

Prepare and implement strategies for meeting the special needs of ageing care givers for persons with cognitive disabilities;

Establish and apply standards and mechanisms to ensure quality care in formal care settings.

new (h) Develop social support systems, both formal and informal, with a view to enhancing the ability of families to take care of older persons within the family and including particularly the provision of long-term support and services for the growing number of frail older persons;

new (i) Enhance through appropriate measures self-reliance of older women and men and create conditions that promote quality of life and enable them to work and live independently in their own communities for as long as possible or as desired;

new (j) Promote provision of community-based care and support of family care, taking into account equal distribution of caring

responsibilities between women and men by measures for better reconciliation of working and family life;

Objective 2: Support the care giving role of older persons, particularly older women.

Actions

Encourage the provision of social support, including respite services, advice and information for both older caregivers and the families under their care.

Identify how to assist older persons, particularly older women in care giving and address their specific social, economic and psychological needs;

Reinforce the positive role of grandparents in raising grandchildren;

Take account of the growing numbers of older caregivers in service provision plans.

Issue 3: Neglect, abuse and violence

Neglect, abuse and violence against older persons takes many forms-physical, psychological, emotional, financial- and occurs in every social, economic, ethnic and geographic sphere. The process of ageing brings with it declining ability to heal, so that older victims of abuse may never fully recover physically or emotionally from trauma. The impact of trauma may be worsened because shame and fear cause reluctance to seek help. Communities must work together to prevent abuse, consumer fraud and crimes against older persons. Professionals need to recognize the risk of potential neglect, abuse or violence by formal and informal caregivers both in the home and in community and institutional settings.

Older women face greater risk of physical and psychological abuse due to discriminatory societal attitudes and the non-realization of the human rights of women. Some harmful traditional and customary practices result in abuse and violence directed at older women, often exacerbated by poverty and lack of access to legal protection.

99. bis Women's poverty is directly related to the absence of economic opportunities and autonomy, lack of access to economic resources, including credit, land ownership and inheritance, lack of access to education and support services and their minimal participation in the decision-making process. Poverty can also force women into situations in which they are vulnerable to sexual exploitation.

Objective 1: Elimination of all forms of neglect, abuse and violence of older persons.

Actions

Sensitize professionals and educate the general public, using media and other awareness-raising campaigns, on the subject of elder abuse and its various characteristics and causes;

Abolish widowhood rites that are harmful to the health and well-being of women;

Enact legislation and strengthen legal efforts to eliminate elder abuse;

Eliminate harmful traditional practices involving older persons;

Encourage cooperation between Government and civil society including NGOs in addressing elder abuse by inter alia, developing community initiatives.

new (f) Minimize the risks to older women of all forms of neglect, abuse and violence by increasing public awareness of, and protecting them against, such neglect, abuse and violence, especially in emergency situations.

new (g) Encourage further research into the causes, nature, extent, seriousness and consequences of all forms of violence against older women and men, and widely disseminate findings of research and studies.

Objective 2: Creation of support services to address elder abuse.

Actions

Establish services for victims of abuse and rehabilitation arrangements for abusers;

Encourage health and social service professionals as well as the general public to report suspected elder abuse;

(b) bis. Encourage health and social service professionals to inform older persons suspected of suffering abuse of the protection and support that can be offered.

Include handling of elder abuse in the training of the caring professions;

Establish information programmes to educate older persons about consumer fraud.

Issue 4: Images of ageing

A positive view of ageing is an integral aspect of the International Plan of Action on Ageing 2002. Recognition of the authority, wisdom, dignity and restraint that comes with a lifetime of experience has been a normal feature

of the respect accorded to the old throughout history. These values are often neglected in some societies and older persons are disproportionately portrayed as a drain on the economy, with their escalating need for health and support services. Although healthy ageing is naturally and increasingly important issue for older persons public focus on the scale and cost of health care, pensions and other services have sometimes fostered a negative image of ageing. Images of older persons as attractive, diverse and creative individuals making vital contributions must compete for the public's attention. Older women are particularly affected by misleading and negative stereotypes: instead of being portrayed in ways that reflect their contributions, strengths, resourcefulness and humanity, they are often depicted as weak and dependent. This reinforces exclusionary practices at the local and national levels.

Objective 1: Enhancement of public recognition of the authority, wisdom, productiveness and other important contributions of older persons.

Actions

and (b) Deleted

new (b) bis. Develop and widely promote a policy framework I which there is and individual and collective responsibility to recognize past and present contributions of older persons, seeking to counteract preconceived biases and myths, and to consequently treat older persons with respect and gratitude, dignity and sensitivity.

(c) Encourage the mass media to promote images that highlight the wisdom, strengths, contributions, courage and resourcefulness of older women and men, including older persons with disabilities;

(d) Encourage educators to recognize and include in their courses the contribution made by persons of all ages including older persons;

Encourage media to move beyond portrayal of stereotypes and to illuminate the full diversity of humankind;

Recognize that the media are harbingers of change and can be guiding factors in fostering the role of older persons in development strategies, including in rural areas;

Facilitate contributions by older women and men to the presentation by the media of their activities and concerns;

Encourage the media and the private and public sectors to avoid ageism in the workplace and present positive images of older persons.

new (i) Promote a positive image of older women's contribution in order to increase their self-esteem.

III. Implementation and follow-up

The implementation of the Plan of Action on Ageing 2002 will require sustained action at all levels in order to respond to the demographic changes that will occur and to mobilize the skills and energies of older persons. It will require systematic evaluation in order to respond to new challenges. In addition there is a critical and continuing need for international assistance to help developing countries to pursue policies that address ageing.

(104) bis. The implementation of the Plan of Action requires *inter alia*, a political, economic, ethical and spiritual vision for social development of older persons that is based on human dignity human rights, equality, respect,

peace, democracy, mutual responsibility and cooperation and full respect for the various religious and ethical values and cultural backgrounds of people.

(104) ter. Deleted

National action

Governments have the primary responsibility for implementing the broad recommendations of the International Plan of Action 2002. A necessary first step in successful implementation of the Plan is to mainstream ageing and the concerns of older persons into national development frameworks and poverty eradication strategies. Programme innovation, mobilization of financial resources and development of necessary human resources will be undertaken simultaneously. Accordingly progress in the implementation of the Plan should be contingent upon effective partnership between Governments, all parts of civil society and the private sector as well as and enabling environment based inter alia, on democracy, the rule of law, respect for all human rights, fundamental freedoms and good governance at all level; including national and international levels.

(105) bis. The role of NGOs is important in supporting Governments in their implementation, assessment and follow up of the International Plan of Action.

Efforts should be made to promote institutional follow-up to the Plan of Action, including as appropriate, the establishment of agencies on ageing and national committees. National committees on ageing that include representatives of relevant sectors of civil society, especially organizations of older persons, can make very valuable contributions and can see as national advisory and coordinating mechanisms on ageing.

Other crucial elements of implementation include effective organizations of older persons; educational, training and research activities on ageing; and national data collection and analysis, such as the compilation of gender and age specific information for policy planning, monitoring and evaluation. Independent, impartial monitoring of progress in implementation is also valuable and can be conducted by autonomous institutions. Governments, as well as civil society, can facilitate the mobilization of resources by organizations representing and supporting older persons by increasing incentives.

International action

107 bis. We recognize that globalization and interdependence are opening new opportunities through trade, investment and capital flows and advances in technology, including information technology, for the growth of the world economy, development and improvement of living standards around the world. At the same time, there remain serious challenges, including serious financial crises, insecurity, poverty, exclusion and inequality within and among societies. Considerable obstacles to further integration and full participation in the global economy remain for developing countries, in particular the least developed countries, as well as for some countries with economies in transition. Unless the benefits of social and economic development are extended to all countries, a growing number of people in all countries and even entire regions will remain marginalized from the global economy. We must act now in order to overcome those obstacles affecting peoples and countries and to realize the full potential of opportunities presented for the benefit of all.

107 (ter) Globalization offers opportunities and challenges. The developing countries and countries with economies in transition face special difficulties in responding to those challenges and opportunities. Globalization should be fully inclusive and equitable, and there is a strong need for policies and measures at the national and international levels, formulated and implemented with the full and effective participation of developing countries and countries with economies in transition to help them respond effectively to those challenges and opportunities.

108. In order to complement national development efforts, enhanced international cooperation is essential to support developing countries, least developed countries and countries with economies in transition in implementing this plan, while recognizing the importance of assistance and the provision of financial assistance. Inter alia,

In order to complement national development efforts, we recognize the urgent need to enhance coherence, governance, and consistency of the international monetary, financial and trading systems. To contribute to that end, we underline the importance of continuing to improve global economic governance and to strengthen the United Nations leadership role in promoting development. With the same purpose, efforts should be strengthened at the national level to enhance coordination among all relevant ministries and institutions. Similarly, we should encourage policy and programme coordination of international institutions and coherence at the operational and international levels to meet the Millennium Declaration development goals of sustained economic growth, poverty eradication and sustainable development.

Important efforts under way to reform the international financial architecture need to be sustained with greater transparency and the effective participation of developing countries and countries with economies in transition. One major objective of the reform is to enhance financing for development and poverty eradication. We also underscore our commitment to sound domestic financial sectors, which make a vital contribution to national development efforts, as an important component of an international financial architecture that is supportive of development.

Calling for speedy and concerted action to address effectively debt problems of least developed countries, low income developing countries and middle income developing countries in a comprehensive, equitable development oriented and durable way through various national and international measures designed to make their debt sustainable in the long term including as appropriate existing orderly mechanisms for debt reduction such as debt swaps for projects.

Recognize that a substantial increase in ODA and other resources will be required if developing countries are to achieve the internationally agreed development goals and objectives, including those contained in the Millennium Declaration.

Urges developed countries that have not done so to make concrete efforts towards the target of 0.7 per cent of gross national product (GNP) as ODA to developing countries and 0.15 per cent of GNP of developed countries to least developed countries and encourages developing countries to build on progress achieved in ensuring that

ODA is used effectively to help achieve development goals and targets.

Enhanced and focused international cooperation and an effective commitment by developed countries and international development agencies will enhance and enable the implementation of the Plan. International financial institutions and regional development banks are invited to examine and adjust their lending and grants practices to ensure that older persons are recognized as a development resource and taken into account in their policies and projects as part of efforts to assist developing countries and countries with economies in transition in the implementation of the Plan of Action.

Similarly, commitment by United Nations funds and programmes to ensure integration of ageing in their programmes and projects, including at country level, is important. Support by the international community and international development agencies for organizations that specifically promote training and capacity-building on ageing in developing countries is extremely important.

Other priorities for international cooperation on ageing should include exchange of experiences and best practices, researchers and research findings and data collection to support policy and programme development as appropriate; establishment of generating projects; and information dissemination.

The United Nations System Chief Executives Board for Coordination should include system-wide implementation of the International Plan of Action on Ageing 2002 in its agenda. The focal points that were set up

within the United Nations system in preparation for the World Assembly on Ageing should be maintained and strengthened. The institutional capacity of the United Nations system to undertake its responsibilities for implementation of the Plan should be improved.

As focal point on ageing in the United Nations system, the primary action of the Department of Economic and Social Affairs programme on ageing will be to facilitate and promote the Plan, including; designing guidelines for policy development and implementation; advocating means to mainstream ageing issues into development agendas; engaging in dialogue with civil society and the private sector; and information exchange.

The United Nations regional commissions have responsibility for translating the Plan into regional action plans. They should also assist upon request, national institutions in implementation and monitoring of their actions on ageing. The Economic and Social Council could strengthen the capacity of the regional commissions in this respect. Regional NGOs should be supported in their efforts to develop networks to promote the Plan.

113. There is a need to encourage and advance comprehensive, diversified and specialized research on ageing in all countries, particularly in developing countries. Research, including age and gender-sensitive data collection and analysis, provides essential evidences for effective policies. A principal task of the research component of the Plan is to facilitate as appropriate, the implementation of the recommendations and actions defined in the Plan of Action. The availability of reliable information is indispensable in identifying emerging issues and

adopting recommendations. Elaborating and using, as appropriate, comprehensive and practical tools for evaluation such as key indicators, is also necessary to facilitate a timely policy response.

114. International research on ageing is also needed to support policy responses to ageing and to the operational success of the International Plan of Action on Ageing 2002. This would assist in promoting international coordination of research on ageing.

Global monitoring, review and updating

115. Systematic review of implementation of the Plan by Member States is essential for its success in improving the quality of life of older persons. Governments, in cooperation with other stakeholders, can decide on appropriate review arrangements. Sharing of the outcomes of regular review among Member States would be valuable.

- 116/117. The Commission for Social Development will be responsible for follow-up and appraisal of the implementation of the International Plan of Action on Ageing 2002. The Commission should integrate the different dimensions of population ageing as contained in the current Plan of Action in its work. Reviews and appraisals will be critical for effective follow-up to the Assembly and their modalities should be decided as soon as possible.

A p p e n d i x F

INTERVIEW SCHEDULE

'I lost my house and almost every-
thing I possess but I got no support
from anyone in the village'

Older person, Tanzania

Appendix F

Interview Schedule

Institute of Social Welfare and Research

The University of Dhaka

Research questionnaire for "Problems of Ageing in Bangladesh- a Socio-Demographic Study" [Anonymity of the collected information will be preserved and only be used for the purpose of research].

A. Preliminary Information

1. Name of the respondent: _____
2. Village/ Mohalla: _____
3. Union/ Pouroshova: _____
4. District: _____

Signature of the supervisor

Date:

Signature of the interviewer

Date:

A. Household Information

5. Please give the following information

Sl. No.	Name of the family members	Relationship with the respondent	Marital Status	Age in completed years	Sex	Religion	Educational Qualification	Current Occupation (Main)
1.								
2.								
3.								
4.								
5.								
6.								
7.								

Code Direction

Relationship with the respondent

- | | |
|---|-----------------------------|
| 1 | Respondent himself/ herself |
| 2 | Husband |
| 3 | Wife |
| 4 | Son/ Daughter |
| 5 | Other relatives |
| 6 | Outsider |

Sex

- | | |
|---|--------|
| 1 | Male |
| 2 | Female |

Marital Status

- | | |
|---|----------------------------------|
| 1 | Married (Husband/ wife is alive) |
| 2 | Widow |
| 3 | Divorced |
| 4 | Separated |
| 5 | Unmarried |

Religion

- | | |
|---|-----------|
| 1 | Islam |
| 2 | Hindu |
| 3 | Christian |
| 4 | Buddhist |

Educational qualification

1	Illiterate
2	Grade I to V
3	Grade VI to VIII
4	Grade IX to X
5	Grade XI to XII
6	Graduation
7	No formal education but literate
8	Can read holy Quran
9	Others (specify) _____

Profession

1	Farming
2	Farm labor
3	Service (governmental)
4	Service (non-governmental)
5	Business
6	Industrial labor
7	Day labor
8	Unemployed/ retired
9	Others (specify) _____

6. (If widow/ widower), when did your husband/ wife die?

	years ago
--	-----------

7. How old you were when you get married for the first time?

Husband	_____ years
Wife	_____ years

8. How many times you get married in your lifetime?

Husband	_____ times
Wife	_____ times

9. What was/is the duration of your conjugal life?

	years
--	-------

10. How many children do you have?

Alive at present	Number
Dead at present	Number

11. Did you (husband/wife) use any contraceptive method throughout your marital life?

Yes

No

12. What is the relationship between you and the household head of the family where you are living at present?

Himself/ herself is household head

Son

Daughter

Close relative

Distant relative

Others (specify) _____

13. How old were your parents when they died?

Father	Years	Father is alive
Mother	Years	Mother is alive

14. Would you please tell me about your present working status?

Working

Non-working

15. (If presently employed), please tell about your primary and secondary sources of income?

Sl. No.	Type of work	Primary (1)	Secondary (2)
1.	Farming		
2.	Farming labor		
3.	Industrial labor		
4.	Service		
5.	Business		
6.	Others (specify)		

16. If retired, how long ago you stopped working?

Years

17. Why did you stop working?

Health does not permit

Need not to work

Did not find suitable job

Mandatory retirement

Others (specify) _____

18. At present, would you like to involve yourself in an income generating activities?

Yes

No

Depends on circumstances

No response

19. (If answer is Yes), Which type of work you are interested in?

1. _____

2. _____

3. _____

20. What was your primary and secondary occupation during most of your lifetime?

Sl. No.	Type of work	Primary (1)	Secondary (2)
1.	Farming		
2.	Farm labor		
3.	Industrial labor		
4.	Service		
5.	Business		
6.	Others (specify)		

21. Do you have sufficient income to meet your current basic needs?

Yes

No

22. (If Yes), Please tell me the source/s of your income?

Savings

Pension/ Boyosko Bhata

Property

Current job

No income

Others _____

23. (If No), Do you get needed assistance from any other source/s to meet your requirements?

Son

Daughter

Close relative

Distant relative

Friends

Others (specify) _____

24. When and how you receive such needed assistance?

Regularly	1	Irregularly	2
As and when required	3	No response	4

25. (Please ask question 25 and 26 to the pension holders only). How far the amount of pension is sufficient for the welfare of the elderly that is given in the country?

Not at all sufficient	1	Moderate	2	Sufficient	3
-----------------------	--------------------------------	----------	--------------------------------	------------	--------------------------------

26. Would you please tell your experience regarding pension drawing procedure?

1	Very complicated and lengthy process
2	Humiliating process
3	Have to pay bribe for drawing the pension
4	Not unpleasant
5	Others (specify) _____

27. Do you have to provide financial assistance to anybody else?

Yes	1	No	2
-----	--------------------------------	----	--------------------------------

28. (If Yes), Whom do you have to provide such assistance?

Wife/ Husband	1	Son	2	Daughter	3
Present family	4	Others (specify) _____			

29. Do you have any land of your own?

Sl. No.	Type of Land	Yes (1)	No (2)
1.	Homestead		
2.	Agricultural		

30. (If have own land), How much land do you have of your own?

Homestead	Agricultural
Acre	Acre

31. Please tell about your present monetary asset and debt?

1. Monetary asset Tk. 2. Debt Tk.

32. Are you facing any financial crisis at present?

Badly Moderate Not at all **D. Health Information**

33. Would you please tell me about your present physical condition?

Sl. No.	Health condition	Good (1)	Average (2)	Bad (3)
1.	Overall health status			
2.	Vision			
3.	Hearing			
4.	Utterance capacity			
5.	Movement ability			
6.	Sleep			
7.	Memory			

34. At present, are you suffering from any disease?

Yes No

35. (If Yes), which type of disease/ailment you are suffering from?

1 Rheumatism	2 Diabetes	3 High blood pressure
4 Heart disease	5 Cough/Asthma	6 Stomach problem
7 Others (specify) _____		

36. How long have you been suffering from this disease/ ailment?

 Years

37. From where you are getting treatment?

1 Hospital	2 Qualified allopathic doctor	3 Homeopathic
4 Ayurvedic/ Hekimi	5 Quack	6 Traditional healers
7 Others (specify) _____		8 No treatment

38. Who of the family members/ relatives comes forward as care giver when you become sick?

1 Husband/wife	2 Son	3 Daughter-in-law
4 Daughter	5 Son-in-law	6 Grand son/daughter
7 Other relative	8 Neighbor	9 Others (specify) _____

39. Do you smoke or take tobacco?

1 Regular	2 Sometimes
3 Regularly in the past but do not smoke at present	
4 Sometimes in the past but do not smoke at present	
5 Never	

40. Do you need other's help in performing your daily activities?

Not necessary 1	Sometimes necessary 2	Necessary 3
--	--	--

E. Social Information

41. At present which of the following organizations' member you are?

Sl. No.	Name of the Organization	Yes (1)	No (2)
1.	Co-operative society		
2.	Socio-cultural group		
3.	Religious organization		
4.	NGO group		
5.	Others (specify)		
6.	No membership		

42. Do you get invitation in different local socio-cultural functions?

1 Regularly invited	2 Occasionally invited	3 Never invited
--	---	--

43. Do you participate in the organizational activities and socio-cultural function when you are invited?

1 Regularly	2 Occasionally	3 Do not participate
--	---	---

44. How you are welcomed by other participants while attending social occasions?

- ☐ 1 With due respect ☐ 2 With moderate respect ☐ 3 Do not pay respect

45. Are you familiar with any NGO working with elderly welfare activities?

- ☐ 1 Familiar ☐ 2 Not familiar

46. If familiar, please tell the name/s of such organizations?

1.
2.
3.

47. How much you are satisfied over the services rendered by these organizations?

- ☐ 1 Satisfied ☐ 2 Moderately satisfied
☐ 3 Not satisfied ☐ 4 No idea about the service

48. Do you think that the sources (stated below) are sufficient for the care and benefit of the elderly at present?

Response	Community	Government	NGO	Son	Relatives	Others
☐ 1 Yes						
☐ 1 No						
☐ 1 Do not know						

49. How do you spend your leisure time?

- ☐ 1 Perform religious activities ☐ 2 Readings books / papers
☐ 3 Chatting with others ☐ 4 Watching TV / Listening Radio
☐ 5 Ruminates the past ☐ 6 Others (specify) _____

50. Do you participate in religious activities regularly?

- ☐ 1 Regularly ☐ 2 Irregularly ☐ 3 Do not perform

51. How far your opinions are regarded in taking decisions on family affairs?

☐ 1 Fully

☐ 2 Partially

☐ 3 Not at all

52. Do you being neglected/ excluded by your family members, relatives and neighbors?

Sl. No.	Member	Yes (1)	In some cases (2)	No (3)
1.	Family members			
2.	Relatives			
3.	Neighbors			

53. Do you want to live in any place other than your own family if you get opportunity?

☐ 1 Other family

☐ 2 Old home

☐ 3 Own family

☐ 4 Others (specify) _____

54. How often do your children who do not live with you pay visit to you?

Sl. No.	Living Place	Weekly (1)	Monthly (2)	Yearly (3)	Occasionally (4)	No visit (5)
1.	Living abroad					
2.	Living far away from the house					
3.	Living nearer to house					

55. Do you think that the family/ community support or support from the relatives is gradually waning?

Sl. No.	Member	Yes (1)	No (2)
1.	Family members		
2.	Relatives		
3.	Neighbors		

56. Which type of family you prefer to live more comfortably?

☐ 1 Joint family

☐ 2 Nuclear family

☐ 3 Alone

57. Would you please tell me what the major problems you are facing at present are?

☐ 1 Physical illness

☐ 2 Lack of treatment and special health service

☐ 3 Mental incongruity

☐ 4 Disregarded and neglected in the family

☐ 5 Lack of social security

☐ 6 Exclusion and loneliness

- ☐ 7 Lack of employment and income opportunity
- ☐ 8 Concern over family affairs ☐ 9 Others (specify) _____

58. What are the steps you would recommend against the problems that the elderly face?

- ☐ 1 Establish separate hospital and health service for older person
- ☐ 2 Arrange appropriate employment opportunity
- ☐ 3 Increase and enhance old age allowance
- ☐ 4 Advocate family members to take care for the older members
- ☐ 5 Expand religious and moral education
- ☐ 6 Establish club/organization for spending leisure time by the older person
- ☐ 7 Establish different homes for older persons
- ☐ 8 Administer wide publicity on situation, needs and problems of elderly
- ☐ 9 Others (Specify)

59. Do you think that the problems of older people are increasing and becoming complicated day by day?

- ☐ 1 Yes ☐ 2 No ☐ 3 No response

60. (If yes), What are the causes behind it?

- ☐ 1 Population explosion and reducing resources and services
- ☐ 2 Decadence of social values and lack of religious and moral education
- ☐ 3 Social development, modernization and materialistic relationship
- ☐ 4 Development of health service and increased life expectancy
- ☐ 5 Pro western attitude among the youth
- ☐ 6 Indifferent attitude and negligence of the government and the society
- ☐ 7 Others

61. How often do you visit to your relatives and friends?

- | | | | | |
|----------------------------|----------------|----------------------------|-----------------|----------------------------------|
| ☐ 1 | Once in a week | ☐ 2 | Once in a month | |
| ☐ 3 | Very often | ☐ 4 | Occasionally | ☐ 5 Never |

62. Please tell (in order) about the source/s of assistance that you generally get to survive.

- | | | | | | |
|----------------------------|----------------------|----------------------------|------------------|----------------------------|------------|
| ☐ 1 | Husband/wife | ☐ 2 | Son | ☐ 3 | Daughter |
| ☐ 4 | Close relative | ☐ 5 | Distant relative | | |
| ☐ 6 | Friends and neighbor | ☐ 7 | NGO | ☐ 8 | Government |

63. Do you think that preparation should be taken earlier by every one to have a sound and peaceful elderly life?

- | | | | |
|----------------------------|-----------------------------|----------------------------|-------------------------|
| ☐ 1 | Every one must get prepared | ☐ 2 | One should get prepared |
| ☐ 3 | Not necessary | ☐ 4 | No Response |

64. What older persons themselves should do to have a peaceful and socially dignified later life?

- | | |
|----------------------------|---|
| ☐ 1 | Adapt with the changing environment |
| ☐ 2 | Keep control over talking and temperament |
| ☐ 3 | Perform religious activities regularly |
| ☐ 4 | Should have sufficient tolerance and satisfaction |
| ☐ 5 | Become flexible |
| ☐ 6 | Others (specify) _____ |

65. Observations of the field workers during interview.

- | | | | |
|----------|-----------------------------------|-------------------------------------|---|
| 1. Dress | ☐ 1 Clean | ☐ 2 Dirty | ☐ 3 Ragged and old |
| 2. Hair | ☐ 1 Balled | ☐ 2 Combed | ☐ 3 Uncombed |
| 3. Beard | ☐ 1 Shaved | ☐ 2 Unshaved | ☐ 3 Bearded |

4. Nail ☐ 1 Small ☐ 2 Large ☐ 3 Clean ☐ 4 Unclean
5. Leg ☐ 1 Clean ☐ 2 Dirty
6. Teeth ☐ 1 Clean ☐ 2 Dirty ☐ 3 Toothless
7. Temperament ☐ 1 Jolly ☐ 2 Gloomy ☐ 3 Moderate
☐ 4 Petulance ☐ 5 Avoidance tendency

Thank you for giving us time and information.

A p p e n d i x G

BIBLIOGRAPHY

Thank you for opening our brains
again. Before my brain was just
going down, down, down. My
grandchildren laugh at me because
I can't do spellings. Now I tell
them I am going to school again
to open my brain'

Older woman, Republic of
South Africa

Appendix G

Bibliography

- Abedin, Samad (1999). *Social and Health Status of the Aged in Bangladesh*. CPD-UNFPA Programme on Population and Sustainable Development, Paper 4, Dhaka.
- Afzal, Mohammad (1995). *Special Corners of Population Ageing*. Paper presented in the Regional Seminar on Population Ageing and Development. 11-14 December. Bangkok, ESCAP.
- Alauddin, M. (1980). *Socio-economic Determinants of Fertility in Bangladesh: A Review*. ISWR. Dhaka University (Mimeo.).
- Amin, Sajeda (1995). *Family Change and Old Age Security: Some Evidence from a Bangladesh Village Study*. Paper presented at British Society for Population Studies Meeting on Fertility Transitions: The Current Position.
- Archibald, George (1998). UN Puts Feminist Slant on 1999 Year of Older Persons is designated for Women's Issues, *The Washington Times*, August 29.
- Atchley, Robert C. (1982). Retirement: Leaving the World of Work. *Annals*, 44, November: 120-131.
- Bangladesh Bureau of Statistics (1982). *Statistical Yearbook of Bangladesh*. P.67.
- _____ (1990). *Statistical Yearbook of Bangladesh*, Table 2.35, p.66.
- _____ (1996). *Report on Labor Force Survey*, Dhaka.
- _____ (1998). *Statistical Pocketbook of Bangladesh*, Dhaka.

- _____. (2001). *Preliminary Report*, Population Census, 2001, Dhaka.
- Barrow, Georgie M. and Patricia A. Smith (1979). *Ageing, Ageism and Society*. West Publishing Company, New York.
- Biegel, David E. and Blum, Arthur (ed.) (1990). *Ageing and Caregiving: theory, research and policy*. New Delhi, Sage Publications.
- Bond, John et al. (ed.) (1993). *Ageing in Society: An Introduction to Social Gerontology*. 2nd Edition. Sage Publications, London.
- Borgatta, Edgar F. and others (ed.) (1987). *Critical issues in ageing policy*. Newbury Park, Sage Publications.
- Chang, Tan Poo (1992). Implications of Change in Family Structures on Old-Age Support in the ESCAP Region. *Asia-Pacific Population Journal*, vol.7, No.2. June.
- Chawla, S. (1993). Demographic ageing and development. *Generations*, vol.17, No.4.
- Cox, Harold G. (1998). *Later Life: The Realities of Ageing*. New Jersey: Prentice-Hall, Inc.
- CPD (2001). Highlights of the CPD Study on Boyoshko Bhata Scheme of the Government of Bangladesh. *Press Release*, Dhaka.
- Cumming, Elaine (1963). Further thoughts on the theory of disengagement. *International Social Science*, 15: 377-393.
- Diamond, Peter (1995). *Government Provision and Regulation of Economic Support in Old Age*. In Bruno, Michael and Boris Pleskovic (ed.). Annual World Bank Conference on Development Economics. Washington, D.C: The World Bank.
- Domingo, L. and M. Asis (1994). Living Arrangements and Flow of Support between Generations. *Journal of Cross-Cultural Gerontology*.

- Dowd, James (1975). Aging as Exchange: A Preface to Theory. *Journal of Gerontology*, 30: 584-594.
- Duza, M. Badrud (ed.) (1990). *South Asia Study of Population Policy and Programmes: Bangladesh*. UNFPA. Dhaka.
- Encyclopedia Britannica* (2001). Deluxe CD Edition.
- ESCAP (1981). *Report of the Technical Meeting on Aging for the Asian and Pacific Region*. Bangkok.
- ESCAP (1981). *Country Monograph Series No. 8, Population of Bangladesh*. United Nations, New York.
- ESCAP, United Nations (1986). *The Elderly in Asia*. Bangkok.
- ESCAP, United Nations (1992). *Population Headliners*. No. 209. August.
- ESCAP, United Nations (1996). *Population Headliners* No. 256. September-October.
- ESCAP, United Nations (1997). Some problems and issues of older persons in Asia and the Pacific. *Asian Population Studies Series* No. 144. New York.
- ESCAP, United Nations (1997). *International and Regional Mandates on Ageing*. New York.
- Fauci, Anthony S. et al. (ed.) (1998). *Harrison's Principles of Internal Medicine*. 14th edition, vol.2. McGraw-Hill, New York.
- Gaullier, Xavier (1990). *Work, Aging and the Life Cycle: An Introduction to early Retirement Policies and their Implications for Workers in Mid-life*. In Habib and Nusberg (ed.) Ibid.

- General Assembly resolution 46/91 of 16 December 1991. *Implementation of the International Plan of Action on Ageing and related activities*, annex.
- General Assembly Resolution 47/5. *Proclamation on Ageing*, 16 October 1992.
- General Comment 6 (Thirteenth session, 1995). *United Nations High Commissioner for Human Rights, the Economic, Social and Cultural Rights of Older Persons*.
- Global Targets on Ageing for the Year 2001: a Practical Strategy. *Report of the Secretary General* (A/47/339), para 5.
- Global targets on ageing for the year 2001: a practical strategy. *Report of the Secretary General* (A/47/339), chapters III and IV.
- Gokhale, S.D. et al. (ed.) (1999). *Ageing in India*. Somaiya Publications Private Limited, New Delhi.
- Goldman, R.J. (1970). *Speculations on vascular changes with age*. Journal of the American Geriatric Society, vol. 18, p. 766.
- Governments of Bangladesh (GOB) (different years). *Five Year Plan of Bangladesh*. Ministry of Planning, Dhaka.
- Graeme, H. (1985). *Population Ageing: Some Demographic Issues in Developing Countries*. Background Paper prepared for the International Congress of Gerontology. New York. July 1985.
- Gubrium, Jaber F. and Sankar, Andrea (eds.) (1994). *Qualitative Methods in Aging Research*. SAGE Publications. California.
- Guyton, Arthur C. (1981). *Textbook of Medical Physiology*. 6th edition. W. B. Saunders Company, Philadelphia.

- Habib, Jack and Charlotte Nusberg (Ed.) (1990). *Rethinking Worklife Options For Older Persons*. International Federation on Ageing. Washington.
- Habibullah, M. and Wahid, M.A. (1987). *Existing Services Available to the Aged*, Bangladesh Journal of Geriatrics (January-June,) p.13.
- Haider, Jahangir (2001). *Assessment of Bangladesh Health System Performance as a Measure to Alleviate Poverty and Improve Quality of Life, Partnership Agreement on Poverty Reduction between ADB and GOB*. READ, Dhaka.
- Havighurst, Robert J. (1963). *Successful Aging*. In: Richard H. Williams, Clark Tibbitts and William Donahue (eds), *Process of Aging*. Vol. I, Alherton: New York.
- Heisel, M. (1988). Older Women in Developing countries. *Women and Health* 13(3/4), 253-72.
- HelpAge International (February 2000). *Uncertainty Rules Our Lives: The Situation of Older People in Bangladesh*.
- _____ (November 2000). *The mark of a noble society: Human rights and older people*.
- _____ (2002). *State of the World's Older People 2002*.
- Holosko, Michael J. and Marvin D. Feit (ed.) (1996). *Social Work Practice with the Elderly*. Toronto: Canadian Scholars' Press.
- Hooyman, N. R. and Kiyak, H. A. (1991). *Social Gerontology, a Multidisciplinary Perspective*. Allyn and Bacon, Boston, USA.
- Horiuchi, Shiro (1991). Assessing the Effects of Mortality Reduction on Population Ageing. *Population Bulletin of the United Nations*, Nos. 31/32, United Nations, New York.

- Hossain, M. Shahadat (1996). Population Growth and Structure. In Abul Barkat and S. R. Howlader (ed.), *Population and Development: National Plan of Action*. Ministry of Health and Family Welfare, Dhaka, GOB.
- Ibrahim, M. (1987). Tradition and Modern Development in Bangladesh Society. *Probin Hitaishi* (Bangladesh Journal of Geriatrics). January-June.
- ____ (1988). *A Survey on Health and Socio-Economic Problems of the Aged in Bangladesh*. BAAIGM, Dhaka.
- Jefferyn, Margot (ed.) (1989). *Growing old in the Twentieth Century*, London, Routledge.
- Kabir, M. (1991). *Aging in Bangladesh: Its Social, Economic and Health Consequences*, Proceedings of the workshop Dissemination of Current Statistics, organized by Bangladesh Bureau of Statistics (BBS), UNDP and CIDA, Dhaka.
- ____ (1999). *Demographic and Economic Consequences of Ageing in Bangladesh*. CPD-UNFPA Programme on Population and Sustainable Development, Paper 3, Dhaka.
- Kabir, Md. Humayun (1987). Aged People in Bangladesh: Facts and Prospects. *Rural Demography*. Vol. XIV, Nos.1 & 2.
- ____ (1992). *The Aging and the Aged in Bangladesh*, unpublished research paper. Institute of Statistical Research and Training (ISRT). Dhaka University.
- ____ (1993). Ageing in Bangladesh: The Demographic Picture. *Asian Population Studies Series*, No. 129. ESCAP.

- _____. (1994). *Local Level Policy Development to Deal with the Consequences of Population Ageing in Bangladesh*. Asian Population Studies Series No. 131-A, ESCAP, United Nations, New York.
- Kabir, Zarina Nahar (2001). *The Emerging Elderly Population in Bangladesh: Aspects of their Health and Social Situation*, Stockholm: Karolinska Institutet, Sweden.
- Khatun, Tahmina. (1997). The Problem of Ageing in Bangladesh. *Journal of the Asiatic Society of Bangladesh*. Vol. 42, No. 1, June.
- Kinsella, Kevin and Victoria A. Velkoff (2001). *An Ageing World: 2001*. U. S. Census Bureau, Series P95/01-1, Washington, DC.
- Kuroda, Toshio. (1987). Population Aging in Japan, With Reference to China. *Asia-Pacific Population Journal*. Vol.2, No.3, September.
- _____. (1991). Structural Change of Age Composition in the Future and Its Socio-Economic Implications. In: Population Ageing in Asia, *Asian Population Studies Series* No. 108. Bangkok, ESCAP.
- Leete, Richard (1987). The Post Demographic Transition in East and South Asia: Similarities and Contrasts with Europe. *Population Studies*. Vol. 41, No.2.
- Lemon, B. W. et al. (1972). An exploration of the activity theory of ageing: Activity types and life satisfaction among in-movers to a retirement community. *Journal of Gerontology*, 27: 511-523.
- Levin, Bebe et al. (1987). Change in student physicians, views on authority relationships with parents. *Journal on Health and Social Behavior*, 28: 258-272.
- Levin, Jack and William C. Levin (1980), *Ageism: Prejudice and Discrimination against the Elderly*, Belmont, Calif.: Wadsworth.

- Mahmood, Raisul Awal and Islam, ABM Shamsul (1997). *Social Policies for Elderly in Bangladesh*. Bangladesh Institute of Development Studies (BIDS), Dhaka.
- Majumder, Pratima Paul and Begum, Sharifa (2001). The Old Age Allowance Programme for the Elderly Poor in Bangladesh: A Review. *The Bangladesh Institute of Development Studies (BIDS)*, Dhaka.
- Miles, A. (1991). The Medical Control of Women. In *Women, Health and Medicine*. Philadelphia, Open University Press.
- Nahar, Nilufar (1999). Aged woman and their Psycho-Social Problems in Bangladesh, *Bangladesh Journal of Geriatrics*, Vol 36, No.1&2.
- Nasir, Rasheda Irshad and Fatema, Rezina Pervin (1996). *Aged Male and Female: A Sociological Analysis*. *Social Science Review*. Vol. XIII, No. 1, June.
- Paper prepared by Help Age International for the Conference *Older People- a Burden or a Resource?* 16 September 1999, Helsinki.
- Press, Irwin (1980). Problems in definition and classification of medical system. *Social Science and Medicine*, 14B: 45-57.
- ✓ Rahman, A. S. M. Atiqur (1990). Problems of Ageing: Bangladesh Perspective. *Dhaka Viswavidyalaya Patrika*. Vol. 36. February.
- _____ (1994). Socio-economic and Cultural Context of the Older Persons in Bangladesh: A Review. *The Journal of Social Development*. Vol. 9. No. 1 December.
- _____ (1998). 1999 – International Year for the Older Persons and Bangladesh. *Bangladesh Journal of Geriatrics*. Vol. 35. No. 2 October.

- _____ (1998). Problems of the Older Persons in Bangladesh: A Social Analysis. *Bangladesh Journal of Geriatrics*. Vol. 36. No. 1 2.
- _____ (2000). Population Ageing in Bangladesh. *Bangladesh Journal of Geriatrics*. Vol. 37. No. 1 2.
- _____ and Faisal Ahmed (2000). Beggary at Later Age: A Review. *Dhaka Viswavidyalaya Patrika*. Vol. 66 February.
- _____ and Hasan Reja (1997). Social Arrangement for the Welfare of the Older Persons in Bangladesh: A Review. *Dhaka Viswavidyalaya Patrika*. Vol. 56-58. October-June.
- _____ and M. A. Rahim (2000). Older Population: A Target Population of Social Workers. *Dhaka Viswavidyalaya Patrika*. Vol. 68 October.
- Randel et al. (Ed.) (1999). *The Ageing and Development Report: Poverty, Independence and the World's Older People*. HelpAge International. Earthscan Publications Limited, London.
- Rashid, K. M. (1998). Addressing Problems of the Aged. *Bangladesh Journal of Geriatrics*. Vol. 34, No. 1.
- Robbins, Stanley L. et al. (ed.) (1994). *Robbins Pathologic Basis of Disease*. 5th edition. Prism Books (Pvt.) Ltd., India.
- Rose, Arnold M. (1965). The subculture of aging. In: Arnold M. Rose and Warren A. Peterson (eds.), *Older People and their Social World*. Philadelphia: F.A. Davis.
- Rossi, A.S. (1989). *Normative Obligations and Parent- child help exchange across the life course*. Paper prepared for a conference on parent-child relations across the life span, University of Hampshire, 26-28 May.
- _____, and Rossi, P. (1990). *Of Human bonding: Parent- child relationships across the life course*. Howthorne, New York.

- Sarker, Prafulla C. (1980). *Social Structure and Fertility Behavior in Rural Bangladesh*. Center for Development Services, Dhaka.
- ____ (1988). *Sex preference and fertility behavior in rural Bangladesh*. *South Asian Anthropologist*, 9: 49-54.
- ____ (1996). *Ageing and culture of Sharing Responsibility for the Care of the Aged in Bangladesh*.
- ____ (1997). Dharma-Atmyo: Fictive Kin Relationship in Rural Bangladesh. *The Eastern Anthropologist*, Vol. 35, No.1.
- ____ and Tofazzal Hossain Monju (2002). *Include the Extended Older People: Formation of National Policy and National Plan for the Well-being of Older People in Bangladesh*. Presented as the keynote paper in the National Consultation on Ageing on 7 March 2002 at Dhaka, organized by ATCOA, RIC and ARC, B.
- Sattar, M. A. (1981). Sex and Age Composition of the Population. *Country Monograph Series No. 8, Population of Bangladesh*, ESCAP, United Nations, Bangkok, Thailand.
- Sen, Kasturi (1994). *Ageing Debates on Demographic Transition and Social Policy*, London and New Jersey.
- Tibbitts, C. and Donattve, W. (ed.) (1960). *Ageing in today's society*, Englewood Chiffs, Prentice-Hall.
- ✓ Uddin, M. A. F. Misbah. (1984). *Aging in Bangladesh: Socio-economic problems and consequences*, unpublished Master's Thesis at ISRT, Dhaka University.
- UNDP (1994). *Human Development Report*. New York.
- UNICEF (1997). *The State of the World's Children*. New York.
- U.S. Bureau of the Census (December 1996). *International Programs Center, International Data Base*.

United Nations (1983). *Vienna International Plan of Action on Aging*. New York.

_____ (1985). First Review and Appraisal of the implementation of the international plan of action on ageing. *Report of the secretary general*. New York.

_____ (1985). *Periodical on Aging-84*. Vol. 1.

_____ (1994). *The Elderly and the Family in Developing Countries*. Vienna.

_____ *World Population Prospects*. UN publications, Sales No. E.91, XIII.4.

_____ (1998). *International Plan of Action on Ageing and United Nations Principles for Older Persons*, New York.

_____ (2001). *The World Ageing Situation, Exploring a Society for All Ages*. New York. p. 99-110.

_____ (2002). *International Plan of Action on Ageing 2002*. Madrid.

_____ (2002). *Situation and Voices: The Older Poor and Excluded in South Africa and India*. Population and Development Strategies, No.2. New York.

_____ (2002). *Population Ageing and Development: Social, Health and Gender Issues*. Population and Development Strategies, No.3. New York.

United Nations Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995. (United Nations publication, Sales No. E. 96. V. 13).

United Nations Report of the Secretary General, 25 February 1997-6 March 1997. (Commission for Social Development, 35th session, Item 3(b) of the provisional agenda E/CN.5/1997/1).

- United Nations Report of the World Assembly on Ageing*, Vienna, 26 July-6 August 1982. (United Nations Publication, Sales No. E.82.I.16).
- Vatuk, Sylvia (1981). Cultural Perspectives on Social Services for The Aged in India. In Nusberg and Osaka (ed.). *The Situation for the Asian/ Pacific Elderly*.
- Warren, Marry (1993). An Age-Old Question. *The Bangladesh Observer*. 24 May 1993.
- Weg, Ruth (1978). *Nutrition and Later Years*. University of California. Los Angeles.
- Woodruff, Diana S. and James, E. Birren (1983). *Aging: Scientific Perspectives and Social Issues*. Brooks/Cole Publishing Company. California.

Internet Sites

- AARP Guide to Internet Resources Related to Ageing
- www.aarp.org/cyber/guide1.htm
- Administration on Aging of the US government
- www.aoa.dhhs.org/aoa.html
- AgeLight Institute
- www.agelight.org
- AgeWave
- www.agewave.com
- European Federation of the Elderly (EURAG)
- www.eurag.org
- EuroLink Age
- www.eurolinkage.org

Global Action on Aging

- www.globalageing.org

Helpage International

- www.helpage.org

- [International Federation on Ageing \(IFA\)](#)

International Association of Homes and Services for the Aged (IAHSA)

- www.aahsa.org

Link Age 2000

- <http://libraryAdvanced.org/10120/cyber/extended/polity.html>

National Institute on Ageing

- www.nih.gov/nia

Novartis Foundation for Gerontological Research

- www.healthandage.com

SeniorNet

- www.seniornet.org

Thirddage

- www.thirdage.com

University of Georgia Gerontology Center

- www.geron.org

UN-International Year of Older Persons

- www.un.org/dpcsd/dspd/iyop.htm

World Health Organization (WHO)

- www.who.ch