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poverty, neglect



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*To work for the cause and care of disadvantaged aged persons  
and to improve their quality of life.*

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## Widows of Vrindavan: Worst Victims of Patriarchal Society

Radhey! Radhey! I was greeted by an old lady with puckered face. She was sitting on the stairs of one of the Bhajan Ashrams in Vrindavan. Her short grey hair, crumpled dull saree, a small shawl that could barely protect her from the winter chill, dirty cloth bag and her walking stick conveyed very clearly that she was one of the infamous 'Vrindavan Widows'. She looked at me with her vacant eyes and started talking. I did not understand her; but listened to her and she was encouraged to talk. After a while she was summoned in the Ashram to sing the Bhajans. She went inside, but left me with some soul searching questions.

There were so many charitable and voluntary organisations working for the benefit of the widowed women living in Vrindavan and adjoining areas in Mathura district of Uttar Pradesh. Central and State Government had also started some welfare schemes for them; but still their condition remained more or less the same. There were shelter, health, food, income generation and many more programmes besides the donations in kind that were available for them. Still many of them were found outside the temples begging. The general sentiment in the city was extremely unsympathetic to these hapless women. The allegations against these women varied from use of *charas* to pretence of penury. Some were of the view that these women were actually gathering the items they received as gifts and donations to be sent later to their families in their native towns and villages. "They are very easy going and lethargy. They don't want to work to earn their living," said one person claiming to be conversant with the situation. He added with a degree of scorn, "They like to be wayward". I could see the threat felt by the paternalistic manager.

I listened to their comments and observations with scepticism. I was confused with lack of sensitivity and understanding of the real issues of the group of human-beings they were supposed to be serving. The disdain in their words annoyed me. However, I resisted the temptation to play the 'devil's advocate' and ask them questions from the subaltern point of view.

I have been working with HelpAge India for the last eight years and in all these years; we have made attempts, wherever possible to highlight the plight of the widowed, single and divorced (older) women. But, now I think that if we have to help these older women live a life of dignity and self fulfilment we have to go beyond merely quoting the census and other macro level data and combine it with gender sensitisation. The people who decide to work to improve the lives of women should first be able to empathise with them. They should de-learn the condescending attitude to the women. They should stop providing solutions to their problems based on superficial understanding. They ought to understand and feel the disempowerment of women who were discarded by the families they nurtured their entire life, had to live on charity compromising their dignity and self respect, live among strangers, according to the rules imposed by the Ashram managers, and sing the praise of God in prospect of an obscure *Nirvana!*

The managers ought to understand the deep emotional hurt, economic insecurity, emotional void that some of these women must have experienced for decades after they were thrown by their families. How, feeble they must have felt with all social networks being severed. How useless they must have felt with no social roles. And the most important point for all to remember is that they did not choose this sort of life. They just found themselves in this mode one day! How they must have coped with all the negative effects of all this socially acceptable inhuman behaviour!

It is true that *Roti, Kapda aur Makan* are the basic necessities of life; but equally true is the fact that (Hu) man does not live by bread alone! It suits one and all to congratulate each other by providing basic necessities of human life to these widowed women; but there is an urgent need to empower them and think beyond for ensuring them right to life with dignity, independence, self fulfilment and care. The same dilemma surfaced again in my mind. The society encourages women to be dependent, then treat them as burden fit

to be thrown away at will and then cannot accept if they lead an independent life!

The picture got a little more complex when some of the knowledgeable persons informed me that some of these women were visited by their family periodically and all the donations in kind like sarees, blankets, soap etc that they collected over a period of time were given to them for use; leaving these women in need again for the same articles. It adds to their social prestige among family members they said! However, for a moment I thought this was plain exploitation. But, then I rationalised it by the importance of psychological need to be acknowledged and appreciated.

These socially disconnected women probably go out of the way to please their families. They want to remain connected to their families at whatever cost! So they probably deny themselves these little comforts of life, face humiliation at the hands of donation managers just to be connected to their families.

I urge the experts in the fields of psychology, sociology to delve deep into the issues concerning the widows particularly the abandoned and establish needs of the women and then suggest some meaningful policies that would really change lives!

## EDITORIAL

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# A Gerontological Social Work Perspective on Case Management with Elderly People

Dr. Anupriyo Mallick\*

## Background

Case management has been a part of human service practice since the end of the nineteenth century, when Mary Richmond, one of the early pioneers of the field of social work, stressed coordination and consumer direction in social case work (National Association of Social Workers, 1992). In the 1920s and 1930s, An early form of case management was used in psychiatric care and by public health nurses (Huber, 2000). Case management emerged as a distinct concept in the 1960s to address the "complex, fragmented, duplicative and uncoordinated" systems that existed as a result of funding programmes through strict categorical channels. The term case management began to appear in the literature in the early 1970s (Grau, 1984) of forms across multiple settings and with a diverse array of goals and objectives. Since its inception, case management has emerged in a diversity of fields, including mental health, primary health care, long-term care, child welfare, disability, and aging (Moxley, 1996).

Traditionally, case management services for older adults were most common in not-for-profit agencies that primarily served frail, low-income seniors who were at risk, for institutionalisation. In more recent times, both public and private sectors have supported implementation of case management services with older persons, especially for those with long-term care needs.

Several factors have influenced the context for the development of case management services for older adults: population trends, such as the increased number of older Indians; advances in medicine resulting in prolonged life expectancies; families becoming more geographically dispersed; scarcity of resources, such as safe and affordable housing; the inability to contain the costs of health and mental health care; the privatization of care; and limitations of existing services in the community.

The increase in the number of older Indians has been accompanied by an

associated evolution of services for seniors, such as: home-care, companion services, adult day-care, home health-care, housing, transportation, and home-delivered meals.

These services intend to help older adults who remain in their own homes and communities, are provided mostly by NGOs and Voluntary Organizations. The result is a complex web of services and programs without a central point of entry. In an effort to help older persons and their families negotiate this intricate service network, many public and private programs developed case management as a core component of their services.

Social workers are often called upon as first responders in addressing the psycho-social needs of older adults and their caregivers. As case managers, social workers often act as permanent consultants or facilitators in the lives of older people who may still be capable of handling their personal affairs; but who need help with the vicissitudes of aging. Additionally, increasing numbers of older adults have physical disabilities, cognitive impairments, or mental illness. Of particular concern are those with complex conditions marked by chronic physical or mental health problems, multiple co-occurring disease-processes, and difficulties with personal, interpersonal, social, and economic situations. (Scharlach, Simon, & Dal Santo, 2003).

## Definitions of Case Management

Case management definitions differ according to the source or type of the definition. For example, regulators may provide administrative definitions that describe the goals of case management, but do not provide detailed means for meeting these goals. Professional groups may provide definitions that consist of more functional descriptions, which include the steps or tasks involved in meeting the purpose that case management serves. Finally, experts in the field of case management can provide definitions based on actual research and experience in the field.

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"Care or case management, including assessment, development of a service plan in conjunction with the consumer and other appropriate parties, authorisation and arrangement for purchase of services or linkages with other appropriate entities, service coordination activities, and follow-up to determine whether the services received were appropriate and consistent with the service plan." This definition focuses on the major tasks to be performed through the process of case management, emphasizing that case management has both consumer-directed and administrative components.

Applebaum and Austin (1990) define case management as "an intervention using a human service professional to arrange and monitor an optimum package of long-term care services." Case management has a unique role in assuring that vulnerable individuals receive the services they need.

The National Chronic Care Consortium (2000), for example, describes the primary focus of case management as "coordinating services for vulnerable clients" (p.1).

Great Britain's Social Services Inspectorate defines care management as "the process of tailoring services to individual needs" (Challis 1999). However, case management also has an administrative function, which has become more prominent in recent years, including purchasing or allocating services, restraining costs, and monitoring quality.

A comprehensive definition of case management, underscoring its procedures as well as its individual and system-level objectives, is provided by the Case Management Society of America: "A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and service to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes".

Lauber (1992) defines case management in community mental health facilities as "an integrated or coordinated system of: (1) individualized primary personal services (consisting of assessment, planning, treatment, and monitoring functions); and (2) environmental (or secondary) personal

services (consisting of advocacy, support, linkage and networking), with support from (3) interface services (consisting of client identification and outreach, administrative activities, public relations, and education and training)" (p. 9).

According to this definition, services are designed to facilitate client-competence and are dictated by the client's functioning level, case manager's skills and knowledge, and agency's policies.

The Social Work Dictionary (Barker, 2003) defines case management as: "A procedure to plan, seek, and monitor services from different social agencies and staff on behalf of a client." Case management is a highly individualised approach that considers the unique aspects of the person and at the same time provides a holistic orientation that views all aspects of the client-system, including the client-family, friends, their situation, and their environment. Case management, often referred to as care management, requires knowledge of community resources and entitlements, skills in matching clients with resources, linking of resources, and serving as an advocate. While there is no single definition of case management, the term generally encompasses the tasks of assessment, formulation of a case plan, coordination of the necessary services older clients need to remain living in the community, monitoring these services, and making adjustments to services when individuals' needs change."

### Principles and Values of Case Management

A number of basic principles and values akin to Social Work Practice have been identified as integral to high quality case management systems in long-term care. These include the following:

- A consumer-centered service that respects consumers' rights, values, and preferences
- Coordinates all and any type of assistance to meet identified consumer needs
- Requires clinical skills and competencies
- Promotes the quality of services provided

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**The Social Work Dictionary (Barker, 2003) defines case management as: "A procedure to plan, seek, and monitor services from different social agencies and staff on behalf of a client."**

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**As a counselor, for example, the case manager assists clients and their families with identifying and resolving personal and interpersonal barriers to obtaining care and meeting individual and family needs.**

- Strives to use resources efficiently (Geron and Chassler, 1995)
- Comprehensive model
- Addresses unique medical and social needs of the geriatric patient
- Involves consumers in care-planning and decision-making
- Provides appropriate access to specialty care, when needed
- Recognises the critical role of respite care-services for informal care-providers
- Prevents further disability by focusing proactively on ambulatory care
- Coordinates case management through an interdisciplinary team of professionals (including those with geriatric expertise), para-professionals, and family members or other caregivers
- Includes a full range of community-based services in the benefits package.

### Roles and Tasks of Case Managers

Despite the diverse definitions of case management, there is surprising consensus on the tasks performed by case managers, and the roles that case managers play, even across client populations and settings.

### Roles of Case Managers

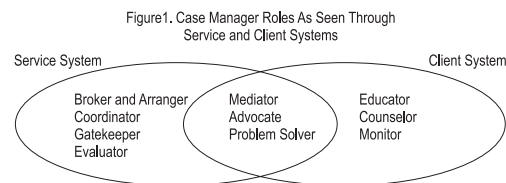
Applebaum & Austin (1990) and Kodner (2001) identify ten potential roles for case managers:

- Broker and Arranger
- Coordinator
- Gatekeeper
- Evaluator
- Educator
- Counselor
- Monitor
- Mediator
- Advocate
- Problem-Solver

The most common roles of a case manager in long-term care service delivery settings include that of broker/arranger, service coordinator, advocate, counselor, and gatekeeper.

Service system roles involve optimising the system's ability to respond effectively to

client needs. As a broker or service coordinator, the case manager is responsible for identifying and arranging services. In these roles, the case manager's primary focus is on assuring that clients receive the



services they need from other direct care providers. The case manager's contact with the client system may be quite limited. As a gatekeeper, the case manager is concerned with containing costs and assuring appropriate utilisation of resources, including ensuring that services are provided only to those clients who are appropriate for receiving them. Gate keeping is a key feature of the managed care model of case management.

In the role of evaluator, the case manager is responsible for assuring that case management goals are met, whether client-oriented, administrative, or system-oriented. This typically involves assessment of process and outcome objectives as well as mechanisms for quality assurance and quality improvement. Client system roles involve helping clients to optimise their ability to make effective use of existing services in order to meet their needs and improve their well-being. As a counselor, for example, the case manager assists clients and their families with identifying and resolving personal and interpersonal barriers to obtaining care and meeting individual and family needs.

As an educator, the case manager may teach clients and family members skills needed to provide care, to arrange needed services, or to judge the quality of services, thus empowering them to assume as much responsibility as possible for their own care. The case manager may also work with the client system to monitor the care that is being received, whether from informal or formal sources. The case manager also may operate at the interface of formal and informal support systems. As

problem solver, the case manager may respond to particular barriers to service access or utilisation.

As a mediator, the case manager may work to facilitate problem resolution between the service and client systems. As an advocate, the case manager may intervene with the service delivery system to assure that clients receive appropriate, high quality services. The advocacy role is common to all major models of case management, although the case manager's level of authority as the client's advocate may vary among the models. For instance, when the case manager and service providers are independent providers, the case manager may have less authority than in a managed care model in which the case management services are offered through the same organizational auspices as the service providers.

### How Case Management Works

Usually, one agency takes primary responsibility for a client and assigns a case manager, who coordinates services, advocates for the client, and who sometimes controls resources and purchases services for the client. Case management may involve monitoring the progress of a client whose needs require the services of several professionals, agencies, health care facilities, and human services programs. It typically involves client outreach and identification, comprehensive multidimensional assessment, and frequent reassessment. Case management can occur within a single, large organization or within a community program that coordinates services among agencies.

### Goals and Functions

The primary goal of case management is to optimise client functioning by providing quality services in the most efficient and effective manner to individuals with multiple complex needs (Bellos & Ruffolo, 1995). Like all methods of social work practice, case management rests on a foundation of professional training, values, knowledge, theory, and skills that are utilized to attain goals that are established in conjunction with the client and her or his family. Social work case managers

typically employ a social model of care. The National Association of Social Workers (1992, p. 22) presents four processes that are emphasized by case managers who are trained from a social work perspective:

1. Enhancing the developmental, problem-solving, and coping capacities of people.
2. Promoting the effective and humane operation of systems that provide resources and services to people.
3. Linking people with systems that provide them with resources, services, and opportunities.
4. Contributing to the development and improvement of social policies.

According to the NASW's information booklet for "Social Work Case Manager" and "Advanced Social Work Case Manager" certification (NASW, n.d.), social work case managers perform the following core functions:

- **Engagement:** Identification of, and outreach to clients;
- **Assessment:** Needs, functional, biopsychosocial, strengths, comprehensive intake, socio-cultural, and resource/financial assessments;
- **Planning:** Intervention, treatment, care, rehabilitation, strategic, support, and crisis intervention;
- **Implementation/Coordination:** Service brokering, monitoring service delivery, project implementation, and client support;
- **Advocacy:** Systems improvement, client well-being and functioning, liaison, and mediation;
- **Reassessment/Evaluation:** Monitoring, efficacy, efficiency, data collection, and analysis;
- **Disengagement:** Discharge planning, transfer, and termination.

The diverse and complex nature of providing services for an older population warrants comprehensive multidimensional assessments, coordination of care, and efforts to increase independence as much as possible (Scharlach, Simon, & Dal Santo, 2003). Not only are older clients

## ARTICLE

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**Ageing is a complex process, consisting of, and affected by, biological, psychological, and social factors. In the past, institutionalization was often seen as one of the most effective methods of providing continuous care for older persons**

faced with wide-ranging medical and care needs; but, they are also dealing with concerns related to loss, grief, fear, and anxiety over loss of independence, and end of life issues (Sowers-Hoag, 1997). When working with this special population, issues such as housing options, family dynamics, health-care, decision-making, financial planning, competency, end of life, and quality of life need to be addressed.

In case management with older persons, a clinical understanding is particularly important, because older clients tend to have multifaceted needs that put them at greater risk of abuse, neglect, and institutionalisation. While there may be situations in which case managers simply link clients with resources, the real world of professional social work case management is much more complex.

Clinical skills, such as the development of the client-worker relationship, interviewing, assessment, and problem solving are all crucial elements in the development and implementation of an accurate and holistic care plan (Sowers-Hoag, 1997). These skills are also necessary to understand and deal with a client's ambivalence, fears, and resistance. Research suggests that experienced professionals, such as master's level social workers, are best at providing case management services. Workers in the aging services arena who lack professional training and skills may unknowingly overlook essential aspects of assessment and case management, such as client self-determination and other related ethical issues that could result in

inadequate care (Scharlach, Simon, & Dal Santo, 2003).

### Conclusion

Ageing is a complex process, consisting of, and affected by, biological, psychological, and social factors. In the past, institutionalisation was often seen as one of the most effective methods of providing continuous care for older persons (Morrow-Howell, 1992). However, the current trend towards ageing in place has propelled the growing popularity of utilising case management as a means for helping older persons to live independently in the community. The increasing emphasis on the use of case management in the social service and health care delivery system is an attempt to provide a strategy that will minimise the gaps in services and fragmentation in the provision of services to older adult clients (Sowers-Hoag, 1997).

Today, professionally trained social workers providing case management services are required in virtually every service setting, from NGOs, to hospitals, from old age homes institutions to private practice. The expected rise in the number of older persons who will live in the community, along with continuing changes to the health care system, suggests that there is likely to be an even greater demand for professionally trained and credentialed social workers to provide and oversee case management services for older adults and their family caregivers.

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# WHO CARES FOR THE OLDEST OLD?

## Plight of the 80 Plus Population in Global Perspective

Prof. (Dr.). P.K.B. Nayar\*

### Magnitude of the Problem

There is a general tendency to treat all older persons as a homogeneous group and to design policies and programs. The oldest old, 80 years and over, stand out in striking contrast from the rest of the older on almost all major attributes—social, economic, psychological, and health. This is little understood and much less attended to by policy-makers and plan-implementers. This has been found to be the case even in international forums. While the Vienna International Plan of Action on Ageing 1982, (Sec.31 (I)) recognized the fact that "Policies for the elderly i.e., those beyond a certain higher age—'the old old'—have to be considered and programs implemented in response to their specific needs and constraints", the Madrid International Plan of Action on Ageing (2002) does not take adequate care of the problem of the oldest old. They are subsumed under the inclusive blanket of older persons.

The 80 plus age group differs from the 60–79 age group in several respects. This group is economically more dependent, socially more isolated, psychologically more depressed and need health and personal care. The special needs that emerge as a consequence of this scenario cannot be adequately and appropriately met by the policy and programs chalked out with the young-old in focus. Many of the plans that are formulated for the old-to provide for active aging, productive aging, independence, participation, empowerment, etc. do not fully apply to the oldest-old. According to Peter Laslett (1999) "Older populations have to be divided into a Third Age of active fulfilling retirement and a Fourth Age of incapacity and dependence, these two coming after the First Age of youth and Second Age of production and responsibility".

According to Nayar (1999) "Socially the old at this age get increasingly marginalised and progressively isolated from the active social network and lose their relevance. Actually, it starts from the family which defines a person's role in the family and society. Even when the old are traditionally considered as

head and the fountain of all authority in the family, they are physically unable to enforce their privileges on their younger kins. Materialistic values of the younger generation urge these kins not to permit the weak-old even to hold on to their de jure authority. Abuse and violence are more directed towards this category of the old as they are disabled, invisible and cannot fight back or defend themselves". Under this circumstance, a major part of the Rights of Older Person are beyond the capacity of this category to enjoy and are very difficult to enforce even when special compensatory measures are adopted in a big way.

Compared to the "young-old" (60–69 years) and "middle-old" (70–79 years) groups, the Oldest-old (80 years and above) suffer more from at least the following major disabilities afflicted by:

- A majority of them are afflicted by one or more chronic diseases—Rheumatism, arthritis, diabetes, hypertension, cardiac problems.
- They are less mobile, many are bed-ridden and many are suffering from terminal illnesses and physical disabilities.
- Depression at best and dementia at worst are seen among many of them.
- They are more likely to be victims of accidents/falls and consequent bone fractures.
- Nutritional deficiency is found more among them. Many would have lost their teeth and chewing will be a problem for many of them and this affects their food choice and intake and consequent nutrition.
- Many of them have problem in getting adequate care giving
- Loneliness, isolation, being cut off from social bonds and, in many cases, family bond are common among them.
- Abuse and neglect and even abandonment are the lot of a number of them, especially if they are unhealthy, physically disabled, mentally handicapped, and are poor. Their children and caregivers prefer to keep them secluded.

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Women constitute the largest segment of the oldest-old (more than three-fourth of the elderly) and the vast majority of them are widows. They suffer more from neglect, abuse and abandonment than men, especially when they are sickly, unproductive and totally dependent for their activities of daily life (ADL).

At this age, women also suffer from special health problems besides economic and gendered problems which become more acute at an advanced age. The fact of their living

The rate of growth is found to depend on the stage of development of the country. The over 80 population in the more developed regions is projected to be 3 times as large by 2050 as it was in 2006; but in the less developed regions it will be 7 times as large. Looked at differently, in 2006, the oldest-old constituted 13% of the population of the 60+. By 2050, 20% of the older population will be 80 years or over. The number of centenarians (aged 100 years and over) is to increase 18 fold, from

**Table 1. World Population 80-Plus—2000 and 2050 (Numbers in thousands)**

	2000			2050		
	Male	Female	Total	Male	Female	Total
80 - 89	21,951.80	39,138.50	61,090.30	125,207.00	189,153.80	314,360.80
90 - 99	2,046.80	5,930.20	7,977.00	17,551.80	43,834.50	61,386.40
100 +	30	150	180	450.3	2,768.60	3,218.90

*Source: World Population Ageing 1950-2050 Economic and Social Affairs, United Nations 2002 p. 48.*

longer than men curses them to a longer period of morbidity with consequent agony and misery ("expansion of morbidity syndrome"). These (and many other) peculiarities call for treating this segment as a special category among the old and to be provided special care and protection.

**Demography of the Oldest-Old**

The oldest-old (80 years and over) are the fastest growing segment of the world's population and are increasing more rapidly than the population of older persons (60+) and also of the general population. The numbers of the old are expected to rise from 688 million in 2006 to 1968 million in 2050 while those of the 80+ are expected to rise from 89.4 million in 2006 to 394 million in 2050. In proportional terms, the rise in the general population of the old during the interval is 2.87 times while that of the 80+ is 4.4 times.

approximately 180 thousand in 2000 to 3219 thousand by 2050. See table 1 for details.

Table 2 shows the share of 40 countries (14 developed and 24 developing) in the population of the old (60-plus) and oldest-old (80-plus) in the year 2006 and 2050. The list contains only countries which will have 10 million or more 80-plus persons by 2050. Though Sweden and Switzerland during this period will have slightly less than 10 million oldest-old, the proportion of this segment in their elderly population will be 31% and 37% respectively.

The developing countries accounted for more than 64% of the world's oldest-old in 2006 and the figure is estimated to rise to 71% in 2050. In this, the share of Asia will be 63% in 2050 (it was around 55% in 2006). India's share in this scenario will be 16.75% in 2050 against 13.4% in 2006.

**Table 2. Population Aged 60 and Over and 80 and Over (Numbers in Thousands)**

Country	No. 60 Plus		60+ as % of Population		No. 80 Plus		80+ as % of 60+ Population	
	2006	2050	2006	2050	2006	2050	2006	2050
World	687923	1968153	11	22	89430.0	393630.6	13	20
Developed	247753	40029	20	32	47073.1	11608.4	19	29
Developing	479763	1739315	7	18	43178.7	278290.4	9	16

**Women constitute the largest segment of the oldest-old (more than three-fourth of the elderly) and the vast majority of them are widows.**

While morbidity is a life-long phenomenon, there is a global tendency for morbidity to concentrate at the last stage of one's life, especially when the length of life gets increased.

Developed Countries								
Country	No. of 60+ in 2006 & 2050		60+ as % of Population in 2006 & 2050		No. of 80+ in 2006 & 2050		80+ as % of 60+ Population in 2006 & 2050	
Australia	3602	8356	18	30	720.4	2423.2	20	29
Canada	5939	13646	18	32	1187.8	4230.3	20	31
France	13031	20840	21	33	2997.1	6877.2	23	33
Germany	20864	27572	25	35	3755.5	9650.2	18	35
Italy	15109	21051	26	41	3172.9	7788.9	21	37
Japan	34751	46748	27	42	6792.7	19634.2	19	37
Netherlands	3214	5370	20	31	610.7	1718.4	19	32
Portugal	2376	3895	23	36	403.9	1051.4	17	27
Russian Fed.	24282	34755	17	31	3399.5	6603.5	14	19
S. Africa	3327	6352	7	13	266.2	1206.9	8	19
Spain	9339	16876	22	40	1867.8	5231.6	20	31
Sweden	2151	3106	24	31	473.2	962.9	22	31
Switzerland	1618	2443	22	34	1618.2	903.9	21	37
Turkey	5988	23056	8	23	419.2	3458.4	7	15
UK	12837	19741	21	29	2695.8	5922.3	25	30
USA	50905	104433	17	26	10690.7	29241.2	21	28

#### Morbidity of the Oldest-Old

The "compression of morbidity" hypothesis is most apt for the oldest-old as it fully explains their plight vis-à-vis morbidity. While morbidity is a life-long phenomenon, there is a global tendency for morbidity to concentrate at the last stage of one's life, especially when the length of life gets increased. Expectation of life at 80 in 2050 is calculated to be 8.8 years; but, studies have shown that healthy life-expectancy (life in good health) is much less at this age compared to younger age and it tends to decline steeply after this age. Studies have also shown that in many developed countries, while life expectancy increased, health expectancy also increased; but, at much lower rate than the former. (Gary Andrews, 2000)

The implication of extension of life for the oldest old is that the extended period could be expected to be less functional as it will be a period of disease and disability. Arthritis, respiratory diseases, circulatory diseases, diabetes, hypertension, and cancer take a higher toll from the oldest-old. In most of the countries they are also reported as cause of death in larger proportion than other diseases among the oldest-old except

diarrheal diseases. These, along with visual and hearing impairments, exclude a large number of older persons from the mainstream of productive life. In developed countries, the oldest-old absorb the lion's share of health-care services. In some countries at least, this has invited criticism from welfare-administrators. This is because of the high cost of geriatric care and existence of universal health insurance in these countries with free or highly subsidized medicare system which take away a large chunk of welfare expenditure.

In most developing countries health insurance exists only for a privileged few and the rest are left high and dry. In these countries, the plight of the oldest-old in the matter of health and health-care is gloomy and would continue to be so because globalisation has resulted in the increasing withdrawal of the government from the scene of poor people's health-care; privatisation and commercialisation of health-care have kept the poor old off the limits of even basic health-care needs. Absence of geriatric care and geriatric medical assistance in most developing countries also affects the oldest-old more than the younger-old as the former need it more.

Developing Countries								
Country	No.60 Plus		60+ as % of Population		No.80+		80+ as % of 60+ Population	
	2006	2050	2006	2050	2006	2050	2006	2050
Algeria	2170	12029	7	24	217.0	1684.1	10	14
Argentina	5494	12767	14	25	549.4	26801.7	17	21
Bangladesh	8264	40672	6	17	475.7	4473.9	7	11
Brazil	17066	63307	9	25	2389.2	13927.5	14	22
China	147799	431532	11	31	14779.9	99252.4	10	23
Colombia	3560	15323	8	23	498.4	3371.1	14	22
Dem. Rep. of Congo	2518	9825	4	6	176.3	786.0	7	8
DPR Korea	2595	5622	11	23	181.7	1012.0	7	18
Ethiopia	3720	14617	5	9	260.4	1315.5	7	9
India	89922	329683	8	21	8992.2	52749.3	10	16
Indonesia	19049	67355	8	24	1333.4	9429.7	7	14
Iran	4562	26393	6	26	456.2	3176.2	10	12
Morocco	2193	10082	7	22	175.4	1411.5	8	14
Mexico	8671	38063	8	27	1127.2	7993.2	13	21
Nigeria	6436	23195	5	9	450.5	1855.6	7	8
Pakistan	9445	46745	6	15	850.1	5609.4	9	12
Philippines	5221	52387	6	20	417.7	3554.2	8	14
Peru	2239	9231	8	22	260.7	1753.9	12	19
Poland	6579	12083	17	38	1052.6	3745.7	16	21
Rep. of Korea	6795	18401	14	41	679.5	5704.3	10	31
Sri Lanka	2284	6919	11	29	251.2	1453.0	11	21
U.R.Tanzania	2008	7158	5	11	160.6	572.6	6	8
Thailand	6945	20702	11	28	555.6	4347.4	8	21
Ukraine	9636	10224	21	39	1349.0	2044.8	14	20
Venezuela	2125	9421	8	22	232.7	1884.2	11	20
Vietnam	6358	29768	7	26	824.5	5060.6	13	17

*Source: Calculated from "Population Ageing 2006" (Data sheet published by UN Dept. of Economic and Social Affairs, Population Division, New York, 2006)*

The majority of the oldest-old are victims of a spate of diseases, most of them chronic. Life-style diseases which were until recently thought to be diseases of affluence are now manifesting themselves in all social strata. In fact, the developing countries are now having a double burden of morbidity—those of communicable and non-communicable diseases whose toll, again, is heavier on the oldest-old than on any other segment of the population.

Old age health-care is most expensive and certainly not affordable to the vast majority

of the oldest-old in the developing countries, What is more, many old age diseases have no cure and most require life-long treatment, putting extra burden on resources and care-giving, both of which are beyond the means and capacity of the oldest-old and their close kin.

#### 'Povertisation' of the Oldest-Old

While the old by definition are poor; povertisation of aging applies most appropriately to the oldest-old, the majority of whom are likely to be

Life-style diseases which were until recently thought to be diseases of affluence are now manifesting themselves in all social strata.

**It is also found that the quality of life of those living alone is lower than that of those living with kins. The mean value of their material well-being scale was 2.12 compared to those living with others, viz., 3.26.**

unproductive. More than half of the people in the developing countries are living on less than a dollar a day and this number can be safely projected to the older population, which means that there will be the same proportion of poor people and probably more among the oldest-old and their care-givers. Due to increasing urbanization and nucleation of families, the oldest-old get marginalized in the matter of proper housing and care-giving. A not-so-insignificant proportion of the old are living alone and the figures vary from country to country even though one may make a safe general statement that developed countries more than developing countries account for this phenomenon.

According to a US study (An Ageing World, 2001) since women outlive men in most countries of the world it is not surprising to find that the share of women living alone is higher than that of men. Proportions of elderly women residing singly are universally higher, reaching half or more in Denmark, Germany, and Sweden. Most other European countries have elderly populations living alone ranging from 17% (Greece) to 42.4% (Denmark) in the 1990s (Ibid. pp. 65–67). Data from Canada for the year 1996 showed that more than 700,000 elderly women were living alone, which was an increase of more than 180,000 since 1986. However, percentages in developing countries tend to be much lower. Among them, Morocco has the highest percentage 44.7% (US. 2001, p. 65). According to a UN Report, 3.1% of the older persons in the age group of 80–85 years and 3.4% of 85+ were living alone in India in 1998–99. (UN. 2006. p.144) The gender-gap for those living alone generally increases with age. For break down of available data by age-groups for US showed that in 1995, 20% men and 51% women in the 75–84 age- group were living alone and the corresponding figure for older persons in the age group of 85+ above it, was 36% and 61% respectively.

It is also found that the quality of life of those living alone is lower than that of those living with kins. The mean value of their material well-being scale was 2.12 compared to those living with others, viz.,

3.26 (UN 2005 p. 78). Even while they own houses, these houses lack many basic requirements—access to clean and fresh water, cooking, and toilet facilities. A study in Thailand showed that while 6% lived alone, 2% reported that they did not have anyone to help in times of sickness and disability. (UN 2005, p. 23)

The emerging trend of women's employment outside home has taken away the traditional care-givers from the family leaving another vacuum in the care-giving of the oldest-old. Ironically, since the majority of the oldest-old are women and since they live longer than men, more women than men are deprived of this very essential service in the last stage of their life.

There is hardly any social security or support system for the vast majority of the old in the developing countries. In these countries, social security and support are available only to those working in the organized sector and the overwhelming segment of the population work in agriculture and related occupations which are not covered by the social security net. To be sure, in many of these countries, old age pension for the destitute exists, but, in terms of both coverage of the beneficiaries and amount paid, it is inadequate. In India for example, old age pension exists in all states but they cover only around 75% of the deserving and needy and the amount, while varying from state to state, is inadequate even in the highest paid state.

It may also be pointed out that in many societies, women are excluded from entitlement to property—the major form of wealth in the developing countries—and even in cases where they do possess real estate, old age and senility prevent them from personally administering the property. This results in the use of the earnings by the kin. This is more so in the case of widows.

One faces the stark reality of privations of all sorts, more cruelly and almost defenseless when one enters the last lap of one's life. The amount of agony and misery that ill-health and poverty would heap relentlessly on this rapidly expanding segment of the population in their extended period of life cannot be

exaggerated. Adding life to the extended years is a chimera for them.

The problem of the oldest-old is a problem more of the less developed countries. The more developed countries have already evolved arrangements for social protection and health-care support for all their elderly including the oldest-old. Even in these countries the oldest-old suffer from problems, though of slightly a different sort, arising out of morbidity, loneliness, and absence of personal care.

### The Indian Scenario

India has a special reason for concern about the oldest-old in its population. Not only has India the second largest population of the elderly in the world, it is second in the population of the oldest-old as well. Its oldest-old is increasing at a very rapid rate. Due to progressive increase in life expectancy, there will be two generations of old persons in many families. While the nation is working hard to implement programs (addressed mainly) for the young-old, the task of providing for the oldest segment among them, which is complicated and expensive, will be taxing.

Table 3 shows the distribution of the 80-plus population by different age-groups for the years 2000 and 2050. The demographic dimension is not the only component of the problem. As in the case of the rest of the world's oldest-old; there are at least two other fronts craving for an answer—social security and health-care. Around 30% of India's population is living below poverty line and if this is projected to the families of the oldest-old and their caregivers, one will find that this segment is out for more hardship. Destitute (old) pension reaches to only about 60% of the deserving-old and in many states this is only a pittance compared to the need of this segment. This

means that the oldest-old among the poor are left high and dry in the matter of social security.

The other problem is health. The "compression of morbidity" syndrome will put all categories of the oldest-old in the same situation of morbidity. When the BPL syndrome on the one side and the mounting health care cost and increasing trend for Government to withdraw from free health-care for the poor on the other are conspiring against this segment of the population.

### Need for a New Perspective

It is necessary to view their problems and needs from a new perspective and to attend to them through a separate plan or at least a sub-plan on ageing, "Adding life to the years that have been added to life" has remained a pious wish. It may look ironical that on the one hand, we are trying to extend the life of the humans but on the other, we are leaving the "beneficiaries" in the lurch, without much effort to provide for a healthy and meaningful life for them. It seems that we are not even worrying ourselves about the quality of the extended life. There are hardly any transnational studies covering developing countries, on the quality of life of the oldest-old. UN, of course, has been cognizant of the problem and the UN General Assembly enacted in December 1991 the Principles of Older Persons encouraging all national governments to incorporate the now fairly well known five principles, viz. independence, participation, care, self-fulfillment, and dignity, into their national policy programs; whenever possible. While quite noble and laudable, these principles have not been seriously implemented by those concerned because there are administrative and operational difficulties in enforcing them. Like the Universal Declaration of Human Rights

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The more developed countries have already evolved arrangements for social protection and health-care support for all their elderly including the oldest-old.

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**Table 3. 80-Plus Population of India 2000 and 2050 (Numbers in thousands)**

	2000			2050		
	Total	Male	Female	Total	Male	Female
80–89	5,735.4	2,585.3	3,150.1	42,193.9	18,154.2	24,039.6
90–99	371.4	162.9	208.5	5,821.9	2,237.2	3,584.7
100 +	3.2	1.3	2.0	141.6	47.6	94.0

*Source: World Population Ageing 1950 - 2050 Economic and Social Affairs, United Nations 2002 p.270*

There is urgent need to consider the oldest old as a special category needing special attention.

(1948), these are also seen more in their violation than in observance.

There is urgent need to consider the oldest-old as a special category needing special attention. In fact, all indicators show that in the coming years, the real problem in ageing will be the ageing of the aged. Identifying their concerns and needs and attending to them will be the crux of the problem.

The following most vulnerable groups of persons among the oldest-old and the major areas of critical concern and requirements for them are identified as the components of the special programmes for the oldest-old.

#### Vulnerable Groups

The chronically/terminally ill, functionally impaired, bedridden, demented, cancer/HIV afflicted, etc.

#### Programmes

a) Special nutritional programs for all sub-

age groups and categories among the oldest-old.

- b) Living arrangements, especially for those living alone;
- c) Care-giver arrangement for all categories of the oldest-old (those living alone and those living in families and couples living separately from their kins);
- d) Special focus on widowed, childless, lonely and sick women who would be constituting the bulk of the oldest-old;
- e) Support system adequate for the problems and needs of the different categories and sub-age groups;
- f) Geriatric arrangements;
- g) Arrangements for continuous monitoring of the above items;

It is suggested that demographers, gerontologists and social scientists and policy-makers, among others, realize this fact and turn their attention to it.

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## Introduction

Speaking at a seminar hosted by HelpAge International and partners in Washington DC in 2002, Professor Joseph Stiglitz, Nobel Prize winner and former Chief Economist of the World Bank, said; "There is no subject of greater importance than the aging of the population and the provisioning of the social protection for older people. It affects the very nature of our societies and concerns not only older people, but all sections of the population".

Until a few couple of decades ago, the issue of the elderly was not in the forefront of the development agenda in the country. But now, the gradual marginalisation of the elderly in the decision-making process in an average family and the break-down of the family as a traditional social unit that took care of the elderly, sick, widows and orphans has brought forth problems of the elderly in the society. (Government of India, 2002).

Unfortunately, despite destitution being a critical social dimension of the problem of ageing, the database on it is quite inadequate at present. Nevertheless, these are some of the appalling features of older persons in India:

1. 90 per cent of older persons are from the unorganized sector, with no social security at the age of 60.
2. 30 per cent of older persons live below the poverty line and another 33 per cent just marginally over it.
3. 55 per cent of women over 60 are widows, many of them with no support whatsoever. ([www.helpageindia.org/ageingscenario.php](http://www.helpageindia.org/ageingscenario.php))

Recent studies found that industrialisation, migration, urbanisation and westernisation have severely affected value-systems. The erstwhile joint family—the natural support system has crumbled. The changing pace of life has added to the woes of the older person. The worries of the elderly are not only concentrated on economic front but on social front as well. (James, 1994; Irudaya Rajan, 2004; Alam and Karim, 2005).

In the context, this article discusses the situation of elderly in Orissa by assessing some major dimensions of vulnerability; which has a strong bearing on their well-being and urges the need for social security from right perspectives. The article is organised into four sections: Section I analyses in brief the trends in ageing and poverty across major states in India with particular reference to Orissa. This is based on NSSO's 60th round unit level data. Section II looks at the situation of elderly in Orissa by assessing three major dimensions of vulnerability (i) living arrangements, (ii) economic dependence, and (iii) economic support-providers based on the NSSO's two different round survey reports carried out during 1995-96 (NSS 52nd round) and 2004 (NSS 60th round). Section III examines the provision of social security arrangements in terms of its coverage and adequacy meant for these utterly destitute in the state. Section IV contains a few concluding observations.

## Trends in Ageing and Poverty in Orissa: A Closer Scrutiny

The growth in numbers and proportions of older people is most rapid in 'developing' countries. In India, in the year 2001 over 76 million were in the age group of 60 years and above. This population is expected to go up to 173 million by the year 2026 and a whopping 324 million by the year 2050 (Census of India 2001, 2006; HelpAge India-2005). It means that 7.45 per cent of the total population in the year 2001 belonged to the older age group. The proportion is expected to increase to 12.4 per cent by the year 2026 and ultimately to 21 per cent by the year 2050.

A closer scrutiny of aged population in Orissa reflects that both in absolute and relative terms it is rising rapidly. The number of elderly increased from 22.81 lakhs in 1991 to 30.39 lakh in 2001. The concentration of aged in terms of its share to total population is 8.26 per cent in the state. In fact, this proportion is found to be the highest amongst what are metaphorically called BIMARUO states in India. Moreover, the share is likely to increase in

## ARTICLE

# Poverty, Vulnerability and Social Security of Elderly in Orissa

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The old age dependency ratio has increased marginally from about 12.74 per cent in 1991 to 14.14 per cent in 2001, being somewhat higher for females than for the males.

the coming years and is attributed to demographic transition. A majority of the elderly of the state (88 per cent) live in rural areas. As per the Population Projections, the number of elderly in Orissa is likely to be around 62.69 lakh in 2026; i.e., an increase of more than two times in a span of 25 years, and the share of the elderly is expected to be 13.8 per cent of the total population (Census of India 2001, 2006).

An important way of looking at the burden of the elderly for any society is the old-age dependency ratio. The old age dependency ratio, defined as the number of persons in the age group 60 years and above-per 100 persons in the age-group 15–59 years; is a useful notional indicator of the extent of economic support those in the working age-group have to provide to the dependent-elderly. The old age dependency ratio has increased marginally from about 12.74 per cent in 1991 to 14.14 per cent in 2001, being somewhat higher for females than for the males. The ratio is found to be the fourth highest in the case of Orissa among the major states in the country following Kerala, Punjab, and Maharashtra. As per the Population Projections, the ratio would be around 21.2 per cent in 2026 (ibid.).

Any increase in the old age dependency ratio implies that an increasing number of the elderly, generally with altered physiological, psychological or sometimes even professional capabilities and with reduced

dependence, which was 65.29 per cent in 1983, declined significantly to 48.56 per cent in 1993-94 and further marginally to 46.4 per cent in 2004-05 (and which is found to be 1.7 times higher than the national average. Now the state earns the dubious distinction of being the poorest state in the country. Moreover, the absolute number of poor persons is found to be increasing at a significant rate of 1.5 lakh persons per annum between 1993-94 and 2004-05. As of now, 178.5 lakh people are below the poverty line in the state.

Moreover, a recent study showed that in all the states, excepting Orissa, the incidence of extreme poverty or chronic poor' in total population has declined between 1993-94 and 2004-05 (Mahendra Dev, Ravi, 2007). On the other, the share of work force in the organised sector is shrinking. At present it is estimated that only 5 per cent of the work force is in the formal sector in the state; most of which are assumed to be covered under statutory social security measures. Here a cursory attempt has been made to estimate the incidence of poverty as well as the profiles of poor households having aged persons—based 60th round NSS unit level data for the state and the result is shown in Table 1.

**Note:**

- (1) Marginally Above Poverty Line HHs (House Holds) are those whose per capita consumption lies between 100%

	Proportion of Households (HHs) having Aged Persons (%)			Distribution of Poverty Incidence (%)		
	Total	Rural	Urban	Total	Rural	Urban
Marginally Above Poverty Line	18.86	20.68	11.88	-	-	-
Below Poverty Line	45.54	48.91	32.57	-	-	-
Moderately Poor	25.73	27.53	18.77	56.50	56.30	57.65
Very Poor	19.81	21.38	13.79	43.50	43.70	42.35
Extremely Poor	3.63	3.88	2.68	-	-	-

work participation rates have to depend heavily on the working population in the age-group for support. This could have serious implications for the well-being of the elderly at household level (GoI, 2002).

It is worth mentioning that the poverty inci-

and 125% state-specific poverty line.

- (2) Moderately Poor HHs are those whose per capita consumption lies between 75% and 100% state-specific poverty line.
- (3) Very Poor HHs are those whose per

capita consumption is less than 75 per cent of the state-specific poverty line.

- (4) Extremely Poor HHs are those whose per capita consumption is below 50 percent from state-specific line.
- (5) Here in case of Orissa, the state specific official poverty line was Rs.325.79 and Rs. 528.49 respectively for rural and urban areas in 2004-05.
- (6) The definition of moderately poor, very poor and extremely poor is based on Radhakrishna, R. Rao, K. Hanumantha, Ravi, C. and Reddy, Sambu B. (2004), 'Chronic Poverty and Malnutrition in 1990s', Economic and Political Weekly, Vol.39, No. 28. (Computed from NSS 60th round (Jan-June 2004) Household data CD).

A perusal of data from table 1 brings out the following facts:

1. 46 per cent of households having older persons live below the poverty line and another 19 per cent just marginally over it and large disparities in terms of incidence of poverty is found between rural and urban areas in Orissa.
2. About one-fifth of the households having older persons are found to be in the grip of perennial poverty (i.e., very poor) and the incidence of extreme poverty as a sub-set of very poor is within a narrow range of 3-4 per cent in rural and urban areas.
3. Though the gap in poverty incidence of households having older persons between rural and urban areas is large enough; but, the distribution of these households in terms of moderately poor and very poor is more or less the same in these areas.

The magnitude of poorer people is relatively high compounded with an increase in the incidence of extremely poor and, on the other hand, the share of elderly population is increasing at a steady rate. So it suggests that a large number of older people in the state are either poor or at serious risk of poverty and extreme poverty.

Chronic Poverty Research Centre (CPRC) identifies a large segment of unemployable (like the old and the handicapped, the widows, the orphans)—owing to life-cycle contingencies or exigencies, to fall into the

category of being chronically poor in any society. The study shows that households with older people are poorer, almost without exception, in comparison to those households without them (Schwartz, 2003). The focus of this article is to analyse the situation of older people in Orissa and the next section addresses some basic issues pertaining to it.

### Selected Dimensions of Vulnerability among Elderly in Orissa

The elderly in a poverty-ridden state like Orissa are more vulnerable and in this context, the issue of social security assumes greater significance. To understand the nuances, an examination of some demographic and socio-economic indicators of older persons—in terms of their living arrangement, extent of economic independence, economic service-providers and health condition is required. At the outset, it needs to be mentioned that barring very few studies (like Panda, 1997) no such systematic attempts have so far been made in order to assess the growing insecurities being faced by the aged in Orissa. However, NSSO's two different round surveys carried out during 1995-96 (NSS 52nd round) and 2004 (NSS 60th round) give valuable information about the nature and dimensions of the conditions of and socio-economic problems faced by the aged in the state. The results of these two surveys in addition to that of the results of the last two censuses have been used in subsequent analysis and wherever possible, inferences have been drawn to assess the changes over this period.

#### 1. Living Arrangement:

The term 'living arrangement' is used to refer to one's household structure (Palloni, 2001). Irudaya Rajan *et al.* (1995) explains living arrangements in terms of the type of family in which the elderly live, the headship they enjoy, the place they stay in and the people they stay with.

The two rounds of surveys of NSSO give information on living arrangements of the elderly. The 2004 results for Orissa showed that about 50 per cent of the aged were living with their spouses and other members, and another 30 per cent were living without their spouses but with their

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The magnitude of poorer people is relatively high compounded with an increase in the incidence of extremely poor and, on the other hand, the share of elderly population is increasing at a steady rate.

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It is, therefore, pertinent to know who is providing economic support to the elderly. It is seen that of the economically dependent aged, a majority (about 78 per cent) had to depend on their children and a sizable proportion (13 per cent) on their spouses.

children, while about three per cent were living with other relations and non-relations. Nevertheless, about 12 per cent were living with their spouses only while about 3 per cent were still living alone. Moreover, the living arrangement of the aged has changed to some extent since 1995-96. A comparison of data between these two survey periods (1995-96 and 2004) reveals the following:

1. The proportion of the aged who lived with their spouses only had gone up significantly from 8 to 12 per cent in urban areas and remained the same in rural areas.
2. The proportion of the aged who lived with their children only had however, decreased from an already low of 31 per cent to 26 per cent in urban areas. On the other hand, the proportion of the aged who lived with other relations and non-relations had increased from 3 per cent to 5 per cent in urban areas. This probably reflects the further weakening of the extended family system in the state as evidenced in other part of the country.

### **2. Economic Independence:**

The living arrangement depicts how the well-being of the aged is ensured in the family. In our society. Similarly, the economic independence reveals the associated problem of day-to-day maintenance of livelihood of the elderly. The distribution of aged persons according to the state of economic independence for the state as per NSSO survey (NSS 60th round for the year 2004) shows that as high as 70 per cent of the aged had to depend on others for their day-to-day maintenance. The estimated number of aged dependent was found to be around 20 lakh in the state.

Compared to 1995-96, the results of the NSS for the year 2004 indicate the following:

1. The incidence of economic independence had decreased among elderly in rural areas.
2. The aged who had to depend on others (for their day-to-day maintenance) fully has increased both in rural and urban areas.
3. The economic condition of the elderly

females has deteriorated both in rural and urban areas.

### **3. Economic Support-Providers:**

As has been observed above, a large proportion of the elderly are economically dependent on others for their livelihood. It is, therefore, pertinent to know who is providing economic support to the elderly. It is seen that of the economically dependent aged, a majority (about 78 per cent) had to depend on their children and a sizable proportion (13 per cent) on their spouses. Only 3 per cent were supported by their grandchildren and the rest (6 per cent) had to depend on 'others', including non-relations.

In the intersurvey period, the distribution of the (economically dependent) aged changed in respect of the category of persons supporting them. The major findings:

1. The proportion of the aged males and females in rural areas depending on their children for economic support had decreased from 81 per cent in 1995-96 to 76 per cent in 2004.
2. Those depending on their spouse and on 'others', including non-relations, had increased (from 11 per cent and 3.6 per cent in 1995-96 to 14 per cent and 5.7 per cent in 2004 on their spouse and on 'others' respectively) significantly in rural areas.

### **Protective Social Security Arrangements for Elderly in Orissa**

All the state governments and Union Territories have their own schemes of social assistance programmes. By the end of the Seventh Plan (1985-90), all the states and UTs had old-age pension schemes; however, the extent of coverage was dependent on the resources of the states. Basically two social pension schemes namely, National Old Age Pension Scheme (NOAPS)<sup>2</sup> and State Old Age Pension Scheme (SOAPS)<sup>3</sup> (alongwith Annapurna Scheme<sup>4</sup> as a part of NOAPS) are in operation in the state. Now the amount of assistance under these two schemes is Rs. 200/- per month per beneficiary.

The Report of Working Group on Social Protection Policy—National Social Assistance Program and Associated Program, Gol (2006), Ministry of Rural

Development, New Delhi finds that the NOAPS severely suffers for two reasons which cut across the states: (i) it involves complex administrative procedures and, therefore, proves especially difficult for the illiterates, and (ii) the size of programme beneficiaries is capped artificially by using an arbitrary ceiling formula<sup>5</sup>.

On the other hand, the SOAPS is inadequate for two reasons, i) No systematic revision of coverage as well as amount of assistance under the scheme<sup>6</sup> ii) Since 1997 BPL list in the state has not been revised. It is feared that there are a large number of potential beneficiaries, at present, are excluded from the ambit of social protection measures.

### Concluding Observations

To conclude, this article has shown the extent of socio-economic vulnerabilities being faced by the elderly in the state and also has made an assessment of coverage under ongoing social security schemes for these destitute people. Moreover, till now, though these three above-mentioned means-tested public provisioning of social pensions are seen as 'largesse...to the destitute older people' and not as a right. However, there is a growing recognition that neglect of the rights of older people is unacceptable (HelpAge International, 2004).

The Report of the Working Group on Social Protection Policy-National Social Assistance Program and Associated Programs, Govt. of India (2006) observes that "The NSAP was intended to be a significant step towards fulfillment of the Directive Principles in Article 41 of the Constitution" and has recommended for universalisation of social assistance for persons who have little or no income, being unable to work, because of age, health or other reasons as a major form of comprehensive social security.

It is high time to implement recommendation put forth by the Working Group in letter and spirit without any delay. At the same, there is an urgent need for social insurance, particularly in the form of health insurance for the destitute old people as health risks being faced by them not only make them vulnerable but also to their

families by involving serious economic damages. This also needs government intervention, since private provider cannot venture into this sector due to the risk of bankruptcy.

#### Notes:

1. Mahendra Dev and C Ravi (2007) estimated it in terms of all those persons whose per capita expenditure is less than 75 per cent of the state-specific poverty line based on the NSS data. Their study shows that Orissa is the only state in India where the incidence of extreme poor has increased (from 23 per cent in 1993-94 to 28 per cent in 2004-05, which is found to be two and half times higher than that of all-India figure and that its relative share in poverty incidence has increased from 48 per cent to 54 per cent during these two periods).
2. NOAPS is one of the three components of NSAP which was introduced by the Central Government with effect from 15th August 1995 envisages at benefiting old and destitute persons of 65 years of age and above. The current target under this Scheme in the state is 6.43 lakh.
3. SOAPS was introduced in the State w.e.f. 1.4.1975 and has been benefiting persons, old and destitute persons, of 60 years of age and above, leprosy patients with visible signs of deformity and to destitute widows irrespective of age. For all the above categories, the annual income of the beneficiaries must not exceed Rs.3200/-. 6.75 lakh destitute people are receiving social assistance under this scheme (out of which around 40 per cent would be the widows and leprosy patients below 60 years of age).
4. On March 19, 1999 the Gol announced another social assistance scheme, "Annapurna", under which an eligible elderly destitute who is not availing pension under NOAPS, will be provided with 10 Kgs. of rice or wheat per month free of cost. The present coverage under Annapurna scheme (APY) is 64,800 in the state.
5. The ceiling formula used by the Centre to decide the size of target beneficiaries

## ARTICLE

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**It is high time to implement recommendation put forth by the Working Group in letter and spirit without any delay.**

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At the beginning of 8th Five Year Plan (FYP), the targeted number of beneficiaries under the scheme was 4.5 lakh which rose to 5.3 lakh and further to 6.4 lakh respectively at the beginning of the following two FYPs.

in each State, computed as: Numerical Ceiling = Total Population x Poverty ratio x Proportion of 65 and above x 0.5).

6. At the beginning of 8th FYP, the targeted number of beneficiaries under the scheme was 4.5 lakh which rose to 5.3 lakh and further to 6.4 lakh respectively at the beginning of the following two FYPs. It means that the increment in the number of beneficiaries (in relative

terms) has declined successively during the last three FYPs. On the other hand, the amount of assistance under the scheme remain unchanged till 2005-06 since 1990-91 to Rs.100/-. This means the value of assistance which was Rs.135 during 1990-91 in real terms (at 1993-94 prices) started declining to reach at Rs.52 during 2005-06 i.e. by 61.48 per cent in a span of sixteen years.

#### Acknowledgement

The writer is grateful to Prof. Sakti Padhi and Prof. Moneer Alam for their valuable comments and suggestions for the earlier draft of this paper. The writer is also thankful to the HelpAge International for providing Age and Social Security Report, free of cost. The usual disclaimer applies.

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*Hand pump in a village of Bachanahalli.*

## MANDYA CLEAN DRINKING WATER PROJECT

Mandya Clean Drinking Water Project is an initiative of HelpAge India long with the Indian Society of The Church of Jesus Christ of Latter-Day Saints. This Project covers 11 villages in the Mandya district of Karnataka. One of the major problems in these villages is non-availability of safe drinking water through out the year. The primary occupation of the villagers is agriculture. Most of them are daily wage workers. All able bodied people go in search of jobs to near by towns leaving the aged people to manage the house-keeping work like fetching water, looking after children and animal husbandry works. For all these activities water is a necessity. The aged people with their waning physical strength find it difficult to carry water from long distances. Many times older people fall ill because of non availability of safe drinking water. This project provides pure drinking water to these people and promises to improve the quality of their life.

Mandya Clean Drinking Water Project is being implemented in 11 villages of Malavalli Block of the district. St. Thomas Mission Society, Mandya is implementing the project through J. J. Constructions. The local Helpage India Team visited all the 11 villages and informed the villagers about

the project and requested their cooperation. Then in the presence of the community, a geologist marked points for drilling the bore wells. Overhead tanks were planned to be constructed in 7 villages and water was to be distributed through pipe lines with common taps. In addition to this 8 hand pumps were installed in 3 villages. The villagers were very enthusiastic about the whole project as it was aimed at fulfilling an essential requirement.

Some problems were encountered in three villages for site allotment for construction of over-head tanks namely Thengalli, Dsanadoddi and Pandithalli. During the survey the panchayat accepted to provide land for the purpose. But, at the time of construction, only after detailed discussion with the villagers and persuasion, the land was provided. Now the community actively participates in the project activities, they are involved in finalisation of location of the tanks, pipeline, and public tap connection etc. This project is likely to be completed by May 2009, thus providing clean drinking water to 11 villages and making a difference to their lives.

**Rambabu Thumala Cherla**  
Senior Manager, Helpage India  
Bangalore

## HIV/AIDS AND OLDER PEOPLE

Dr Chinmay Shah\*

"HIV/AIDS is a global problem of catastrophic proportions. The challenge is enormous, but we are not powerless to face it. That is why I have made it my personal priority to form a global alliance commensurate with the challenge."  
—United Nations Secretary-General Kofi Annan

Twenty years after the first clinical evidence of Acquired Immuno-deficiency Syndrome was reported, AIDS has become one of the most devastating diseases humankind has ever faced. While most of its victims are young adults, the pandemic has had major consequences for older people as well.

As a result of a lifetime of hardship, malnutrition, poverty and in older age, a high risk of chronic diseases, older people in most of societies are a vulnerable group. The AIDS pandemic is now posing an additional burden on them. In old age, when people may need support and care, many of them may have to take on the role of care-given for their grand children.

Thus, lack of economic, social and psychological support combined with the inaccessibility to health services threatens their ability to provide the care expected from them. All efforts must be made to support and address the vulnerability of these older people, not least because it is they who are rearing the future adult generation.

In the last 10 years, there has been a tenfold increase in the numbers of persons diagnosed at "65-plus with AIDS," according to a report by Marcia Ory of the National Institute on Aging and Karin Mack of the CDC. The report said about 10,000 people 65 years and older had AIDS.

The Joint United Nations Program on HIV/AIDS (UNAIDS) estimates that around 2.8 million adults aged 50 years and older are living with HIV, representing 7 per cent of all cases. Until recently, the term 'adult' in reports by UNAIDS referred only to those up to the age of 49. This definition changed in May 2006, since then all people aged over 15 have been included in the global statistics.

In the USA, 15% of all new reported HIV diagnoses occur among people over the age of 50, with a quarter of these among the over 60's.<sup>2</sup> It is estimated that by 2015, half of the 1 million Americans living with HIV will be older than 50.<sup>3</sup> In the UK, the Health Protection Agency reported that almost 4,000 HIV-infected people who were accessing care in 2006 were aged 55 years or over.<sup>4</sup>

Data from low-income countries like INDIA, on this subject is fairly patchy. HIV/AIDS surveillance is commonly conducted in antenatal clinics in low-income countries, largely because many people have little other direct contact with medical services. Data from antenatal clinics doesn't provide information about people who are above child-bearing age. Instead estimates must be based on household surveys and voluntary HIV testing and counseling (VCT) services.

The analysis of infection data collected from VCT centers in Uganda between 1999 and 2002 found that 4.6% of those who came to the centers were older people. Of these, 20% tested HIV positive (23.9% of women and 18% of men).<sup>5</sup> South Africa's national household HIV survey in 2005 found a prevalence of 10.8% among people aged 50–54, 4.5% among those aged 55–59, and 3.9% among those aged 60 and above.

### What Makes Older Adults Different?

#### Older adults

- Are less knowledgeable about HIV/AIDS
- Behave in ways that puts them at greater risk
- Are different because of their physical condition
- Have not received prevention messages
- Are less likely to be screened and receive early intervention
- Are more likely to have a severe HIV/AIDS disease course
- More likely to have a delayed diagnosis
- More likely to have shorter AIDS-free interval from HIV + diagnosis to AIDS diagnosis

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- More likely to have a higher number of opportunistic infections
- More likely to experience a rapid course of illness and a shorter survival rate
- Are more likely to be stigmatized and lack social support.

Several factors are contributing to the increase in AIDS among the elderly which are pointed out briefly as follow:

### Risk Factors

The dominant risk factor among the 50-and-over age-group is the same as for other age-groups. Specific risk behaviours, such as unprotected sex, multiple sexual partners, sexually transmitted infections and substance- abuse are also present in this age-group. "With the popular use of Viagra, more seniors are sexually active," said Donna Gallagher, Director of the New England AIDS Education and Training Center. But several studies conclude older Americans don't use condoms. In South Florida, public health workers have noticed a new phenomenon: elderly men cruising for prostitutes.

### Implications of Age

According to the US-based Centers for Disease Control and Prevention (CDC), age accelerates the progress of HIV to AIDS and blunts CD4 cell response to antiretroviral therapy. Age-related conditions, such as osteoporosis, increase the risk of severe complications. Intravenous infection is also a problem among seniors, partly because of aging baby boomers still doing drugs, but also because of diabetics sharing insulin needles.

### Unprotected Sex

Older people tend to view condoms primarily as a contraceptive measure, and women who no longer fear unwanted pregnancy may not insist on its use. A US study has shown that, compared with younger persons, only one-sixth of people over the age of 50 are likely to use condoms. Women also undergo physical changes with age that affect their vulnerability to HIV. In the post-menopausal stage, their vaginal walls are thinner and lubrication is often reduced. Many doctors believe older women are

more vulnerable to vaginal trauma during intercourse, and are thus at greater risk of contracting HIV. During the recent five-year period, the number of new cases in older women increased by 40 per cent.

### Delay Diagnosis

Early symptoms of HIV infection—fatigue, poor memory, shortness of breath, sleeplessness and weight loss—may be mistaken for signs of ageing, thus preventing those infected from seeking early medical help. The activists are also concerned that little research has been done to see if there is any adverse reaction between HIV/AIDS medication and traditional ageing drugs.

### Prevention

Health-providers often fall into the trap of age stereotypes, which can be a problem in prevention and diagnosis. Health-care workers are less likely to ask older patients about their sexual behaviour and do not provide the prevention information, that is routinely offered to younger patients. Nor do prevention education programmes target older people.

Perhaps due to an increasing denial of sexual needs; social barriers to discussions on sexuality become even stronger. This results in very few effective strategies for this population group.

Older people must wrestle with issues not faced by the young person. They find themselves adjusting to the physical and emotional changes associated with ageing in the setting of a debilitating illness. In addition, coping mechanisms among older people are weaker, and they are more prone to depression and less inclined to join support groups.

A number of strategies and behaviors can help mitigate the risk of HIV for older people and lessen the impact of HIV/AIDS on those already infected.

### Strategies and Behaviours

- Promote, maintain, and improve the health of older persons, especially those with care-giving responsibilities;
- Provide older people with education and information on HIV/AIDS and related care issues;

## HELPFUL TIPS

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**According to the US-based Centers for Disease Control and Prevention (CDC), age accelerates the progress of HIV to AIDS and blunts CD4 cell response to antiretroviral therapy.**

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## HELPFUL TIPS

**The crucial role that older people play in the care of AIDS-orphans is seldom given recognition or support and their health, economic and psycho-social needs are often neglected.**

- Provide psychological support and counselling for all care-providers health-care workers, and home-based care-givers;
- Reduce the double stigma (AIDS-related and ageism) and other prejudices among health care workers—particularly through training and education;
- Develop policies and initiatives to strengthen the capacity of older care-givers—such as economic support in the form of subsidies and education;
- Provide additional resources for the care-giver, including housing, medical care, and food.
- Reduce the stigma surrounding the sexual needs of older people and encourage them to discuss these issues with their health-providers and families;
- Educate healthcare-providers about the sexuality and sexual practices of older people to allow for improved communication and more accurate risk assessment;
- Integrate HIV programming into services for older persons, including secondary prevention—education (prevention among HIV-positive people), into specialized care-services;
- Educate HIV service-providers on the need to provide age-sensitive services and the specific issues related to HIV in an ageing population;
- Identify areas of research specifically looking into the interactions between age and HIV; Involve older persons in research on prevention and care;
- Programme to support the older people playing role as care-providers for chronically ill and terminally ill patients and the upkeep of children orphaned by AIDS.

So far, and paradoxically, this burden on older people has received little attention in discussions on policy and program development to support AIDS-orphans. The crucial role that older people play in the care of AIDS-orphans is seldom given recognition or support and their health, economic and psycho-social needs are

often neglected. Yet they continue to try to cope with the double burden of caring for their dying children and their orphaned grandchildren, often without even the most basic resources to do so.

### **Act to Prevent HIV/AIDS in Older-Persons**

For decades prevention programmes have been aimed at younger adults, but only a handful have been directed toward older-adults. Simply putting pictures of people with gray hair on posters that say "Stop AIDS" or "Wear a Condom" or "Practice 'Safe Sex'" (without saying what 'safe-sex' is) isn't likely to prevent infection in older-adults. A dedicated effort is required to identify older people's AIDS-related risk behaviours and to develop educational approaches and preventive strategies for modifying any risky behavior.

Prevention has always been the neglected stepchild in terms of funding, compared to biomedical research.

### **Challenges for Prevention**

- People over 50 years of age are much less likely to adopt HIV prevention strategies than are younger people who engage in the same behavioral risks.
- HIV and AIDS are seldom discussed within this community.
- Older people are not suspected of drug use.
- Many are sexually active, often demonstrating risky sexual behaviors, not using protection, using IV drugs, and sharing needles, which places them at high risk for transmission of HIV.
- Evidence points to many infected older people contracting the disease through same-gender sexual contact.
- In addition, older people are often finding themselves dating again due to being widowed or divorced and are engaging in sexual activity without protection.
- Prevention, counseling, testing and education efforts are not being directed their way, and this problem needs to be addressed in the health-care profession.

### Important Things to Remember:

- DO NOT assume older-adults know how HIV/AIDS is transmitted.
- DO NOT assume older-adults know their behavior puts them at risk.
- DO NOT assume older-adults will ask for an HIV/AIDS test if they feel at risk.
- DO NOT assume older-adults have the support necessary to deal with HIV/AIDS infection.
- DO NOT assume older-adults are NOT sexually active.
- DO NOT assume older adults are straight.
- Include a sexual history in other health history questions.
- Include questions about IV drug use.
- Consider HIV/AIDS as a possible cause of clinical disease and symptoms such as fatigue, altered mental status, rashes, chronic pain, and weight loss.

### Educate Older-Persons

Older people often depend upon primary care-providers for health information. Healthcare-providers must talk to their older patients about their risk and to educate them to prevent infection.

- Where is your patient getting information about HIV/AIDS if not from you?
- Patients have reported that their physicians don't ask.
- Talk about HIV/AIDS and risk behaviors with your patients.
- Talk about testing.
- Repeat prevention messages.
- Help older adults develop the skills to prevent infection.

### Screen & Diagnose of Older-Persons for HIV/AIDS

Older-persons are not routinely screened and assessed for HIV/AIDS. Health-care professionals rarely consider sexually transmitted diseases in the elderly. In several studies, routine HIV testing in the elderly was shown to be uncommon. As a result, infection is not detected early at a stage, when it can be most readily treated

and the risk of transmission to others is increased. Differential diagnosis may be challenging given the association of symptoms with multiple conditions.

### Finally, As an Individual Healthcare Provider or NGO you can:

- Identify older people's AIDS-related risk behaviors.
- Develop educational approaches and preventive strategies.
- Tailor messages for all older-adults.
- Give the "face of HIV/AIDS" gray hair.
- Know the resources in the community.
- Tailor messages for groups of older adults.
- Messages tailored to the older homosexual male or to the male who may not identify himself as homosexual but is at risk through this method of transmission are needed.
- Tailor messages for older adults at different stages of life.
- Train others to be educators.
- Dispel myths.
- Advocate for inclusions of older persons in programs targeting HIV prevention.

### Conclusion

The HIV epidemic means that older people are finding new importance as carers of children and sick adults and as wage-earners—even though they may themselves be experiencing the health problems associated with old age. In low-income countries, older people are becoming increasingly valuable to both the family and society.

The attitudes towards the elderly need to change and older people need to be given the rights and respect accorded to their children. The assumptions about older people need to be re-examined and HIV prevention messages need to realise that older people do have sex and take drugs. They need to know that they may be at risk of infection and they need to know how to protect themselves. The global fight against AIDS must not be allowed to overlook older people—HIV doesn't respect age.

It calls for practical and sustainable approaches that will improve the capacity

### HELPFUL TIPS

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**Differential diagnosis may be challenging given the association of symptoms with multiple conditions.**

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## HELPFUL TIPS

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**The governments should help older caregivers find ways to earn income and offer them psychological counseling and material supplies.**

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of older people. While promoting AIDS awareness through-out the population, government should provide older caregivers with better access to health-care via improved transportation and subsidised

medicines. The governments should help older caregivers find ways to earn income and offer them psychological counseling and material supplies.

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## Treadmill Exercise is Important for Stroke Rehabilitation

Individuals who have suffered strokes that resulted in paralysis or weakness of one side of the body often experience difficulty walking. A progressive treadmill exercise activates circuits in the brain that promotes recovery of walking skills. Strokes can interfere with the control systems within the brain that are required for normal walking. Researchers from the University of Maryland School of Medicine and their colleagues studied 71 stroke-patients over the age of 45 years who continued to have problems walking, even after completing conventional stroke-rehabilitation. These patients were placed on either a stretching program or a treadmill exercise program that gradually increased in duration and intensity. The researchers found that the patients who were enrolled in the treadmill exercise program experienced improvements in their walking speed and cardiovascular fitness. The researchers also used Functional Magnetic Resonance Imaging (fMRI) to evaluate brain function, and they found that training on a treadmill activated circuits within the brain which were associated with better walking.

The impaired ability to walk reduces mobility and fitness in stroke patients and also promotes the development of chronic disability. In this study, most of the participants had suffered their strokes many years before beginning the trial. Thus, the reported findings offer promise that it is possible for individuals with a remote history of stroke.

Source: [www.healthandage.com](http://www.healthandage.com)

## Sudden Deafness on One Side—Is It Diabetes?

Sudden loss of hearing can occur without obvious cause in older people. It's obviously distressing, especially if there's no clear reason for it. Sometimes, atherosclerosis or viral infections are blamed. In fact, however, diabetes is

probably a major cause. A Japanese study seems to confirm this. The researchers collected data on 148 patients over 40 who were diagnosed with one-sided sudden loss of hearing. They were examined for the presence of type-2 diabetes, diabetic retinopathy (changes in the retina produced by diabetes), and kidney changes. Blood pressure and blood lipids were measured, smoking status recorded, and a careful history was taken to determine possible cardiovascular disease. Ultrasound examinations of the carotid artery were made to measure the thickness of the inner layer of the artery and to detect atherosclerotic plaques.

Hearing function tests included pure-tone audiometry from 125 to 8,000 Hertz, with mean-hearing levels recorded from 250 to 4,000 Hertz. The tests were repeated after some weeks to detect possible recovery of hearing. People with idiopathic (i.e. of unknown origin) sudden hearing loss were treated with corticosteroids, unless there was a risk of specific side-effects of the drug (e.g. gastric ulcer, or an infection). Analyses were done to establish a profile of diabetic patients with sudden hearing loss, and this was compared with non-diabetics with the same problem.

Out of the 148 patients with sudden hearing loss, there were 24 type 2 diabetics—roughly 16%. They were about the same age as the whole collective—average age 60. The following differences were seen in the diabetic patients, compared with the non-diabetics:

- High blood pressure was more common.
- High cholesterol was more common.
- Hearing in the affected ear was worse in the diabetics.

There were no differences between the two groups with respect to the role played by age, vertigo, time since onset, and recovery rate (which was about 60%). However, when diabetic patients with sudden hearing loss were compared with

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The impaired ability to walk reduces mobility and fitness in stroke patients and also promotes the development of chronic disability.

## NEWS

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diabetics without hearing loss, it was clear that the glycosylated hemoglobin levels (HbA1c) were significantly higher in those with deafness (7.8% vs. 7.2%).

This study showed that one-sided sudden hearing loss of unknown origin may, in fact, be due to diabetes. The likely mechanism is not directly related to changes suggestive of atherosclerosis, as the carotid artery lining thickness

measurements were no different in the hearing-loss diabetics than in the non-diabetics. On the other hand, the increased HbA1c in the hearing-loss diabetics shows that the disease itself may be the responsible risk-factor. Whatever the mechanism, the message is fairly clear: if you suddenly go deaf in one ear, and there's no obvious cause for this, have your fasting blood sugar checked!

**Source: [www.healthandage.com](http://www.healthandage.com)**

The book under review has its roots in a day long seminar organised on August 17, 2006 by the Department of Sociology and sponsored jointly by the Indian Council Social Science Research, North Eastern Regional Centre (ICSSR - NERC), Shillong and Centre for Gandhian Studies and Research, Nagaland University. It comprises nine chapters based on papers presented during the seminar by the teachers of Nagaland University and its affiliated colleges and also the activists working among the elderly people of Nagaland. Besides, there is an introductory chapter and the Keynote address as well as the Valedictory address delivered at the seminar in the publication. The last chapter, short in length is in form of 'Recommendations', which is a welcome addition.

The book deals with a wide spectrum of issues affecting the lives of the elderly, for instance, biological, health care, psychological, socio-economic concerns, societal, organizational and institutional aspects, social planning and administration issues for welfare. As emphasized since ageing is inevitable, the main developmental or spiritual task is that of developing a sense of life's worth.

Chandrika Singh, in the chapter 'Problem of Old Age People and Social Remedy' explains that the greatest problem of the old age is mass poverty, economic crisis and uncertainty of future. The remedies which the author brings forth are that the elderly should not regard old age as a burden upon themselves or even upon the family and reiterates that this is a negative attitude which brings them disappointment, frustration and worry.

S.K. Gupta elaborates on the constitutional provisions and privileges available to older

people and further gives suggestions regarding the government's responsibilities towards the welfare of senior citizens. Visielie highlights the various dimensions of ageing in Nagaland from a sociological perspective. The paper gives a comparative study of the socio-cultural and economic dimensions of the roles and responsibilities accorded to and undertaken by the aged people in the social life of the Angami Naga.

A.Lanunungsang's contribution is a case study of Mokokchung Town which describes the problems of the aged and need for care. Ketshukietuo Dziivichii in his chapter 'Socio-Economic Status of the Aged among the Angami Nagas' portrays the experiences of older persons and several socio-economic and psychological problems within the family and society. I. Tongdangba Jamir has written about the need for establishing 'Old Aged Homes'. Mar Atsongchanger writes about the problems and prospects of the elderly in Dimapur and Pardeshi Lal discusses concerns related to Diabetes Mellitus. The ninth chapter written by Dr. P. Medem gives tips on active ageing.

This book is a valuable piece of resource on the concerns of the elderly in Nagaland. It gives a thorough update about their conditions and can prove useful for scholars, social workers and government agencies alike. Apart from pieces of writing, the book has compensated details by means of table charts which supply the required data so essential for a complete comprehension of the condition and status of the elderly.

*Reviewed by*  
**Kiran Puri,**  
*Director*

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*E-mail: kiran\_puri@yahoo.com*

## BOOK REVIEW

# Ageing in North East India: Nagaland Perspectives

*Edited by*

**A. Lanunungsang Ao**

*Printed by*

**(Akansha Publishing House,  
New Delhi, India, 2007,  
157 pages, Rs. 350,  
ISBN 978-81-8370-117-4.)**

# Ageing in North East India: Magnitude of the Problem of Elderly Persons in Mizoram

*Edited by*

Lianzela Vanlalchhavna

*Printed by*

Akansha Publishing House,  
New Delhi, 2007,  
119 pages, Rs. 350,  
ISBN 978-81-8370-102-0.

The book under review is a consolidated attempt to address issues related to ageing and the elderly persons in Mizoram by scholars who participated in the seminar organized by the 'Department of Economics', Mizoram University on October 19, 2006. The collection is compiled in a way that it portrays different aspects of the status, welfare and the neglect of the elderly in Mizoram and also addresses finding solutions to their grave concerns from a multi disciplinary approach.

The book comprises of six chapters and each chapter brings forth focus on a particular dimension which touches the lives of older people in Mizoram. Each author uses his or her disciplinary insight to deal with the diverse problems and issues concerning older people and here lays the strength of the book. The collection portrays specific facts related to the magnitude and growth of the elderly population, their socioeconomic status, information about their role and activities, health conditions, access to health care, and social security programmes. It also outlines role of state government and social work interventions.

Vanlalchhavna's examination of the gradual growth of elderly population in Mizoram is engaging. It suggests the necessity of taking into account the needs of this section of the population particularly when their share in the total population is rapidly increasing. As the pages of the book roll on one is absorbed with reflections on the changing scenario of the status of the elderly in Mizoram and reasons of why in the past they had commanded a lot of respect.

Older people in Mizo society controlled the sources of power, wealth and land and so had more status attached to their identity. With the change of life styles and the progression of urbanisation and migration, the old values of placing the elderly on the pedestal of respect and treating them as the resources of wisdom are dwindling. Hence, they are no longer regarded as the indispensable treasures of the society.

Thangchungnung's exploration on the deterioration in the status of the elderly is similar to that found in other parts of the country. As stated by him it is true that rapid transformation in society is due to capitalistic development, resulting in competitive race for accumulating wealth and destroying the cohesive fabric of social harmony. To solve this dilemma, the construction of old age homes would be welcomed.

Thanseia emphasizes the urgency for special provisions to the elderly in the state budget that would enrich and update their knowledge, integrate their traditional with contemporary needs and transmit them as socio-cultural heritage. The role of NGOs is in particular important as rightly pointed out.

Dr. Jane R. Ralte, emphasises that the health-care services for the vulnerable elderly population are still inadequate and need to be developed at all levels. Lalbiakimi gives a broad over view of the welfare measures taken by the State Government for the elderly people in Mizoram and Kalpana N. Desai along with Lalmiiianpuii give solutions for the physical, psychological, social and financial insecurities of the elderly.

Each chapter of the book is concerned with maintaining and enhancing the quality of life of older adults and their families. Thus recommended as a useful source of information and reference to academicians, scholars and social workers, and government agencies. It is also a good resource in the field of gerontology as it provides good insight into the State Policy towards the elderly which was formulated in 2006. The policy is particularly concerned with ameliorating physical, psychological, familial cultural, ethnic, racial, organizational and societal factors which serve as barriers to physical and emotional well-being in later life.

*Reviewed by*  
**Kiran Puri,**  
*Director*

Development, Welfare and Research Foundation  
*E-mail: kiran\_puri@yahoo.com*

2009

**22nd–24th January**  
**Multidisciplinary Approach to Healthy & Participatory Ageing**  
Mumbai, Maharashtra, India  
**Contact Person: Dr. Suja Koshy**  
Website:  
[http://www.svt.ac.in/svt\\_portal/www/index.html](http://www.svt.ac.in/svt_portal/www/index.html)

**9th–11th February**  
**International Colloquium on the Oldest-Old**  
**Theme: Problems and needs of the 80+ with focus on Health and Care-giving**  
Thiruvananthapuram, Kerala  
**Contact Person: Dr. P.K.B. Nayar**  
Email: [cgs@cgsindia.org](mailto:cgs@cgsindia.org)  
Website: [www.cgsindia.org](http://www.cgsindia.org)

**17th–22nd February**  
**Neurodegenerative Diseases: New Molecular Mechanisms**  
Keystone, Colorado, United States  
Website: <http://www.keystonesymposia.org/9j5>

**28th February–1st March**  
**Successful Aging: Integrative Medicine throughout a Lifetime**  
Newport Beach, CA, United States  
**Contact Person: Jodi Montano**  
Website:  
[http://www.sscim.uci.edu/index\\_2col.asp?page=16](http://www.sscim.uci.edu/index_2col.asp?page=16)

**8th–10th March**  
**19th Annual Rotman Research Institute Conference - Cognitive Aging: Research & Practice**  
Toronto, Ontario, Canada  
**Contact Person: Paula Ferreira**  
Website: <http://www.rotman-baycrest.on.ca>

**11th–15th March**  
**9th International Conference on Alzheimer's and Parkinson's Diseases**  
Prague, Czech Republic  
**Contact Person: Natalie Shabi**  
Website: <http://www.kenes.com/adpd/>

**21st–24th April**  
**Successful Aging for Women**  
Jeddah, Jeddah, Saudi Arabia  
**Contact Person: Asim Ibrahim**  
Website: <http://www.safwomen.com>

**22nd–24th May**  
**ICAAM Asia - International Congress in Aesthetic, Anti-aging Medicine & Medical Spa**  
Macau, China  
**Contact Person: Catherine DECUYPER**  
Website:  
<http://www.euromedicom.com/index.php>

**3rd–5th July**  
**1st Global Conference: Times of Our Lives: Making Sense of Ageing**  
Oxford, United Kingdom  
**Contact Name: Dr. Rob Fisher**  
Website: <http://www.inter-disciplinary.net>

**5th–10th July**  
**The 19th IAGG World Congress of Gerontology and Geriatrics**  
Paris, France  
**Contact Person: Dr. Bernard Forette**  
Website: <http://www.paris2009.org/>

**30th August–2nd September**  
**2009 International Conference on Ageing and Spirituality**  
Auckland, New Zealand  
**Contact Person: Dr. Gillian Reid**  
Website: <http://www.selwyncare.org.nz>

**3rd–7th September**  
**Strategies for Engineered Negligible Senescence (SENS)**  
Cambridge, United Kingdom  
**Contact Person: Dr. Aubrey de Grey**  
Website: <http://www.mfoundation.org/sens4/>

**30th October**  
**International Workshop on the Socio-Economics of Ageing**  
Lisbon, Portugal  
**Contact Person: Vera Bettencourt**  
Website: <http://www.iseg.utl.pt/ageing>

**19th–22nd November**  
**6th International Congress on Vascular Dementia**  
Barcelona, Spain  
**Contact Person: Liraz Bregman**  
Website: <http://www.kenes.com/vascular>

**13th–15th December**  
**18th WFN World Congress on Parkinson's Disease & Related Disorders**  
Miami Beach, Florida, United States  
**Contact Person Peter Sewell**  
Website: <http://www.kenes.com/parkinson/>

## CALENDAR

# Calendar of Events

# Announcements

**W**e always endeavour to make changes in this Journal so that it not only raises awareness about issues concerning ageing and aged in India among the students of gerontology and the other stakeholders; but, also reaches the widest possible cross-section of our population. Therefore, we propose to make available the editions of the Journal from this edition onwards in electronic format. If you wish to receive the electronic version please send in your request to [info@helpageindia.org](mailto:info@helpageindia.org). Please write R&D Journal in the subject column of the email.

You can also send in your comments on the articles and other columns in the Journal to the editor. Your opinion and suggestions are valuable to improve this Journal further.

**H**elpAge India Library and Information Centre holds a fine collection of books and journals in ageing and related areas. We are planning to acquire copies of thesis on ageing related subjects submitted by students to various Indian universities and research institutes for the award of Post-graduate/Doctoral degrees.

### Conditions:

- Only thesis for which a degree is awarded in/after 2001 will be considered.
- Researchers can submit their thesis in hard bound form or electronic form (in MS Word/PDF format).
- Each selected thesis will be awarded an honorarium as follows:

Thesis in hard copy	Rs. 750/-
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Thesis in electronic form	Rs. 250/-
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Thesis in both the forms	Rs. 1000/-
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- Selection of thesis is completely at the discretion of HelpAge India

**Interested researchers may contact us at** [info@helpageindia.org](mailto:info@helpageindia.org) or write for more details and application form

### Policy Research & Development Department

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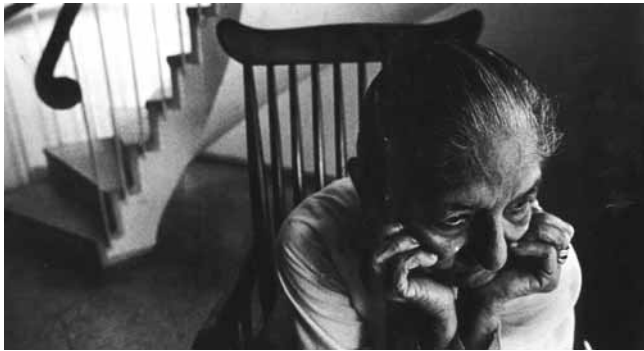
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R&D-J/07

# Information For The Contributors

**H**elpAge India—Research and Development Journal is the official journal of HelpAge India and is published thrice a year in January, May and October. It is devoted to publication of contributions that focus on the information pertaining to different issues concerned with older persons. The views expressed in the journal are the author's own and do not necessarily reflect those of the organisation.

## Manuscript

Only original papers written in English should be submitted in duplicate (copies on one side only) to the Editor, HelpAge India—Research and Development Journal, HelpAge India, C-14 Qutab Institutional Area, New Delhi - 110 016. The manuscript should be typed in double space with a wide margin and should not exceed 4000 words. Title page should carry the title of the paper, the name and affiliation of the authors. Contributors are requested to type their official designation and official addresses at the foot of the first page of the type/script. The research paper should be divided into Abstract, Introduction, Material and Method, Results and Discussion, Conclusion, Acknowledgement (if any) and References. Tables should be given in Arabic serial number and each on a separate page. References should be listed at the end of the paper in alphabetical order and they should include only works referred to in the text.

Use following format for the reference:

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Surname and initial of the author(s). Year of Publication. Title. Name of the Journal. Volume. Number: Page number.

### 2) For Books

Surname and initial of author(s). Year of Publication. Title. Edition. Place of Publication. Name of Publisher.

Note: Please follow above-mentioned system to help maintain a particular pattern in the Journal. Submit your contribution both on printed format (hard copy) and IBM compatible floppy diskette (3 1/2 size floppy or CD).

## Helpful Tips

You can contribute to this column by sending a small article (1000 words) on any subject that concerns the older persons. You can also send us such useful news items published in other magazines or journals. Please give proper reference for the same. Please follow instructions given in column (1) & (2).

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