Proceedings of the Seminar on Situation of the Elderly in Bangladesh: What do We Know?

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Introduction

Situation of the elderly (60 years and above) people is increasingly becoming a matter of global concern. In 1980, in Asian and Pacific region, the five top ranking developing countries in terms of number of elderly people were China, India, Indonesia, Pakistan and Bangladesh. In the year 2025, it is estimated that these five countries together, will count about 44% of the world's elderly population (United Nations, 1991).

Bangladesh is one of the 20 countries in the world with the largest elderly population. In Bangladesh, it is expected that proportion of elderly will be 7% of the total population by the year 2000 and 12% by the year 2025. The number of elderly population is expected to increase from 4.4 million in 1980 to 10 million in 2000 and 24 million in 2025 (United Nations, 1985). The elderly population in the country remains a neglected group. Because, traditionally public health measures are mostly focused on the younger population, particularly children and women of reproductive age.

The Research and Evaluation Division (RED) of BRAC organized a seminar on "Situation of the elderly in Bangladesh: what do we know?" The objective of the seminar was to highlight the extent of problems of elderly population as the result of emerging trends of single family, migration of children particularly sons. The seminar was chaired by Dr AMR Chowdhury, Director Research, BRAC. Three papers were presented in the seminar. These were: The Bangladesh situation by Zarina Nahar Kabir, a PhD student of Karolinska Institute of Sweden; Elderly situation in Sweden: a historical perspective by Dr Marta Szebehely of Stockholm Gerontology Research Centre, Sweden; and A healthy, happy, lively old age for everyone by AMM Abdul Jabbar of Probin Hitoishi Shangha, Dhaka. Professor Hamida Akter Begum of Psychology Department of Dhaka University and president of Women for Women was present as key discussant. Eminent scholars and researchers from ICDDR,B, University of Dhaka, VHSS, NIPSOM, NIPORT, BRAC, and different other organizations attended the seminar.

Situation of Elderly in Bangladesh

Zarina Nahar Kabir

Summary

There is a growing tendency of world's elderly (60 years and above) population and concentrating in the developing countries. By the year 2025, 72% of the world's elderly (858 million) population will be living in the developing countries. In 1980, China, India, Indonesia, Pakistan and Bangladesh were the five top ranking countries in terms of population lives in Asian and Pacific region. By the year 2025, these five countries will account for 44% of the world's elderly population.

In Bangladesh, there are 6 million elderly population. This number will be 10 million by the year 2000 and 24 million by 2025. Bangladesh is one of the 20 countries with the largest elderly population.

Traditionally, in Bangladesh, the responsibility for the welfare of the elderly lies with their children and the state has virtually no obligation to provide care for its elderly. Culturally a son, preferably the eldest one looks after their elderly parents. The daughters have no direct opportunity to look after her parents in old age due to two main reasons: there may be objections from her husband and her in-laws, and may view it as a shameful situation. What happens when there are no sons or when the sons are not available to look after the parents? Some elderly live on their own or have a poor relative stay with them to take care of them, while economic provision may be arranged by any children. Traditionally son provides food and shelter and his wife to takes personal care of her elderly parents-in-laws. Obviously, in case of a married elderly man, the primary caregiver is his wife if she is able. The riverse situation, husband caring for his wife, almost never occurs. However, majority of elderly people continue to live within extended family settings both in urban and rural areas, because social changes have not occurred significantly in the extended family. Moreover, the status of old people was not uniformly high in the past. It

is also observed that there was a strong correlation between level of status of elderly and their economic power.

Reproductive failure dramatically affects the care arrangement and physical and emotional well-being of elderly population. Older women with reproductive failure are such that their lives could deteriorate much faster than that of older men and even lead to destitution. This is so because of existing inheritance laws and customs of protection of male assets to a greater degree than the assets of female. Moreover, due to a big age difference between spouses, especially in the rural areas, most women spent their old age as widow.

Bangladesh has declared the target of "Health for all by the year 2000" like many other developing countries. But in practice the elderly are not covered. Nevertheless, there is no state policy regarding the elderly. Though a policy was drafted in the last year, but as far as we are aware it is still in draft form.

The situation of elderly people in Sweden: a historical perspective

Marta Szebehely

To become old is a universal experience, every society needs to relate to the consequences of aging in one way or another. But even if aging as such is universal, the everyday life of an old person varies between countries and historical periods - as well as between groups of elderly people in one country at the same time.

Even though most elderly people are healthy and can manage by themselves up to a certain old age, there are problems connected to aging which need to be solved.

When a person can no longer work he/she may need some type of *economic support*, if this person hasn't been able to save enough money during his/her working period of life (which has been and is possible only for small minority).

Enough to eat, a basic amount of clothes and somewhere to live (i.e. food and shelter) are necessary for all people no matter which culture or historical period. With increasing age also frequently comes the need for practical help - *care*: help with household tasks such as bringing food to the house, cooking and cleaning, but also in some cases help with personal care such as keeping the body clean or help with dressing or moving around.

Policies for the elderly (even in historical periods when it is not adequate to use the term 'policy') have to deal with these three problems: *means of support, housing, and care*. In early times these three aspects of old people's welfare weren't treated separately, but today Swedish social policy for the aged clearly stands on these three 'legs' in trying to find solutions of each of the three questions.

In Sweden - as well as in most countries - the family has taken the main responsibility for old people's welfare. But the family has never been enough for every elderly person - at least not in our society. There have always been groups of elderly people who either didn't have any family or who needed more than the family could give. What has changed in Sweden during history is mainly how much of the responsibility for economic support and care is taken by the family - there has been a shift in the boundary between the family on the one hand and voluntary organizations, the state and the market on the other.

The Swedish development of 'elder care policies' from middle age up until today could thus be summarized as:

- *Differentiation* - from total solutions to solutions of specific problems (economy, housing and care).

- *Shifting care work responsibilities* - a shift of the division between family, voluntary organizations, state and market, or to put it in other words, between unpaid and paid labour.

I will try to give a brief picture of this development.

Middle ages

In the middle ages most Swedish peasants owned their land. Some of the earliest local laws regulated how house and land were to be inherited. An old peasant who wanted to retire could let his son take over the farm, and as an exchange the inheritor was responsible for the support and care of his parents. If the children couldn't or didn't want to take care of the elderly, the law stated that other close kin could step in - both as caregiver/providers and as inheritors. Thus, in the middle ages there was a strict connection between inheritance and care for the old peasants.

Later on - from about the sixteenth century and until the nineteenth century - this connection between inheritance and provision/care often was regulated in a written contract between parents and children. Most often the eldest son inherited the farm, and signed a contract promising the parents to stay at the farm until the end of their lives. These contracts often strictly regulated how much food and firewood the elderly parents would get. One could say than in this way elderly people bought safety for their old age. This wasn't an easy situation for any of the parties. The farms were often small and gave hardly enough to live on for the younger couple and their children. The old parents could be seen as a burden, and there could be conflicts between the generations about how to rule the farm the household. Relations could be so tense that in the eighteenth century a law was enacted which prescribed the death penalty for those who did not respect their parents or spoke badly about them. Such a law wouldn't have existed if the problem didn't exist.

But not everybody had land, and in the eighteenth and nineteenth centuries the number of people without land increased - and so did the number of poor people. Until as late as the 1940s being old was equivalent to being poor for the vast majority of people in Sweden, and elder care was a part of the poor relief. So who was responsible for the poor elderly - and how was their need of food, shelter and care organized?

The ninetieth century

The main responsibility for the elderly (and other groups of poor people) fell on the *family*. If the elderly didn't have family, or if the family was so poor that they couldn't afford to help, the responsibility fell on the *parish*. The *parish* was a rather small geographical unit around one church, consisting of an average of 1500 people. The *parish* council (a local court) made all the decision about the poor relief (elder care was part of the poor relief) and there were different local solutions.

Most *parishes* built a *poorhouse* - typically a small house with one room, where 6-8 poor people, of different ages, but most of them old, sick or disabled, lived together - sharing

not only room but often also the bed. Those who were totally unable to get their own living got some help from the *parish*, the rest had to try to work for food, or rely on the mercy of the parishioners. The poorhouse was thus a solution to the housing problem, in some cases combined with economic support and care. Reasonably healthy inhabitants of the poorhouse were expected to pay their way by taking care of the sick and the frail elderly.

In some *parishes begging* was the solution - some frail groups of poor people were allowed to beg - otherwise begging was forbidden. But begging was only a solution of one problem - economic support. Those who didn't have a place to live or needed care were not helped by this solution.

In some *parishes* the poor were placed in the homes of parishioners - by some order of rotation - a certain number of days at each farm in the *parish* according to size. This *"board and lodging on rotation"* solved the need of both food, shelter and care - but was seen as a inhumane system both by the providers and the elderly.

The last form of "elder care policy" from the nineteenth century that I will mention is *auctioning off to the lowest bidder.* The *parish* council could decide to pay a family for lodging and taking care of the sick or frail elderly. In these cases the country council chose the lowest bidder. This solution 'solved' all three problems (food, shelter and care), but in most cases the reason for a family to accept this responsibility was need of the money-and the quality of care and lodging was often very low. This system which was used also for children without any family until the beginning of this century.

In the second half of the nineteenth century the number of poor - both older and younger - was increasing very fast. The main responsibility of providing support and care for the elderly still fell on their children, but a growing number of families couldn't live up to these norms and expectations. At this time Sweden was one of the poorest countries in Europe. More and more people couldn't make their living from farm work. Between 1850

and 1900, one million Swedish migrated to America (one million out of a population of 5 million). The proportion of elderly people started to increase - partly because of lower child mortality, partly because of migration - the younger left and the old people stayed in Sweden (Table 1).

Table 1. Demographic changes of elderly people in Sweden.

Year	% of Elderly (65+years) population
1750	6.2
1800	5.7
1850	5.8
1900	8.4
1950	10.2
1960	11.9
1970	13.6
1980	16.4
1990	17.6

This situation meant that there was a need for other ways of solving the growing need for economic support, housing and care of the elderly.

Swedish elder care in the twentieth century

In the beginning of this century elder care still was a part of poor relief, but now a process of differentiation started - different solutions to different needs.

In the beginning of the century there was a growing interest among wider groups about the situation of poor people and about the growing number of old people. Poorhouses, begging, board and lodging on rotation or auctioning to the lowest bidder - all were seen as a bad solutions. The 'new' solution in the beginning of the century was *the home for the aged:* an institution with an intention of being 'home like', with about 50 elderly

people living in rooms with four beds, with staff taking care of cooking, cleaning and - if necessary -also nursing. The home for the aged was seen as a shelter from the hard life old people had to deal with in the society. Institutional care was seen as a solution for all the three problems: for those elderly people who couldn't make their own living, for those who didn't have a home or who had bad housing conditions and for those who were frail and needed help - the institutional care in the homes for the aged was the society's only answer - the only old age policy in the first decades of this century.

During the first half of the century about 5 percent of the elderly (65 years+) lived in old age homes, and in the 1940s a government bill set the goal to rise this proportion to 10 percent - there should be place in homes for the aged for 10 percent of the elderly population (65+). But this growth of institutional care never took place. In the end of 1940s the institutional way was heavily criticized. The slogan 'care at home instead of caring homes' summarizes the new ideas. The institutions was seen as both expensive and inhumane for those elderly people who only had problem with housing or economic support, and also for those who had small to moderate care needs.

To make it possible to reduce the institutions three other reforms had to be implemented:

First - elderly people's need for economic support had to be solved.
Second - the housing problems needed a solution.
Third - practical help in elderly people's homes had to be organized.

Economic support: The answer to the problem of the private economy of the elderly was the *pension* system. The first pension system in Sweden was started in 1913, but although it covered almost the entire population, the amount was so low that it didn't solve the elderly people's need for economic support. In 1948 a new universal, flat rate pension reform was introduced. With this every citizen was eligible to a basic pension, regardless of previous income. This pension reform made it possible for the elderly to have a living - not on a very high level, but for the first time in Swedish history old age

didn't lead to poverty. In the 1960s another pension reform complemented the basic pensions - a supplementary pension based on income from gainful employment. Today the basic pension together with the supplementary pension equals about 70 percent of a person's earlier income.

Housing: Access to good housing for the elderly was formulated as a social-policy goal already in the late 1930s. A large number of small modern flats with subsidized rent were built. These so called *"pensioners' flats"* became an alternative to institutional care for those elderly people who couldn't manage home because of bad housing. Later on, from the 60s, the state also *subsidized modernization* of elderly people's ordinary dwellings - to enable old people to stay in their own homes as long as possible.

Home-based care: May be the most important social reform for the elderly was the introduction of *home help services.* In 1950 some voluntary organizations started to recruit housewives for few hours paid work per day, helping frail old people with household tasks. (To understand the importance of this innovative form of care it must be noted that domestic help always has been quite rare in Sweden, and after the 1930s it almost totally disappeared).

Home help services became very popular and expanded rapidly over the following decades. The state (i.e. the municipalities) took over, and the publicly financed home help became an important part of the emerging welfare state. By the end of the 1970s almost one in four elderly (65+) received help from the municipal home help service.

The proportion of elderly people in institutional care has only changed moderately during the last 40-50 years, even though there has been a decreasing trend during the last decade.

The proportion of elderly people receiving home help has changed much more, and there has been a considerable decrease during the last 15 years. Still there are three

times more elderly people receiving home help than there are elderly people receiving institutional care.

To understand the importance of the home help service - and thus also the problems caused by the decrease - we need some background facts of the Swedish situation: The low rate of different generations living together, elderly people's preferences about who they live with and receive care from, and finally the care giving resources available within the family.

Inter-generational cohabiting is rare in Sweden today, and has decreased during the last decades. The same tendency can be seen in a lot of other countries in the western world. The fall in inter-generational cohabiting cannot be interpreted as an expression of poorer solidarity between generations. The contact between elderly people and their families hasn't decreased during the last decades (Table 2).

Table 2. Sweden: Cohabiting and contact between generations (percent of elderly 65 years+).

	1954		1980/81		1988/89	
Elderly person living with a child	28		8		4	
Elderly person meeting one of their children every week...	31	59	57	65	63	67
...every month	21		20		20	
...more seldom/never	20		14		12	

Rather, improved personal finances, better housing and the extension of formal home-based care have enabled more elderly people to maintain their own households. Swedish elderly prefer what has been labeled 'intimacy at a distance' - they want to live by themselves, but to have close contact with their families. Elderly people's wish to be independent can also be illustrated by their *preferences about care* (Table 3).

Table 3. Who should do more to cover the increased need for care of the elderly? (Eurobarometer study, Sweden, 60+).

	%
Municipalities and countries ('the state')	86
The family	8
Voluntary organizations	1
Others (e.g., market)	2
Don't know	3
	100

Elderly people prefer to receive help from the formal home-help system, rather than to depend on their families. Older women are even more reluctant than men to receive care from their relatives - probably because they know more about the costs of care giving. Actually there are more daughters in "care giving age" willing to give care than there are elderly parents willing to depend on care from their children. The *care giving resources* within the family is in practice very much the care giving resources among female family members. Women's engagement in paid labour influences their ability to take a larger part of the informal care giving work.

Here we must note that Swedish women in the age when their parents begin to need care (which often is when the daughters are 50-65 years old) belong to the labour force to a much higher extent than in most other countries (Table 4).

Table 4. Women in paid labour, aged 55-64 years(% of total population).

Sweden	66
US	45
UK	39
Denmark	38
Germany	26
The Netherlands	17

Current Swedish policy
The current official policy for the care of elderly in Sweden can be summarized as:

- *the state has a duty to ensure that elderly people receive the service and care they require.*

The guiding principle is to allow for old people to stay as long as possible in their own homes, and to live as normal and independent a life as possible. Thus the intention is to:

- reduce institutional care
- give priority to home-based care
- make institutions as homelike as possible.

Since home-based care is of such importance in the Swedish model of old age care I will briefly describe the home help services in Sweden.

What is home help?
Home help can be practical help with household tasks such as cleaning, shopping, cooking or washing the laundry. It also includes personal care for example dressing/undressing, shower/personal hygiene or help with outdoor or indoor transportation.

Most home helpers are women (95 percent with little or no formal education). Most home help receivers are elderly. Among all those aged 65+, 16 percent receive home help, among those aged 80+ the proportion of home help receivers is 38 percent. Among the home help receivers 60 percent are 80 years or older, 66 percent are women and 80 percent are living on their own. Most elderly people who receive home help only receive few hours per week, but an increasing proportion of the clients receive daily help, including help in the evenings and at weekends (Table 5).

Table 5. How much home help?

"Home help receivers" 1993:	%	Types of help
1-2 hours/week	41	cleaning laundry
3-6 hours/week	25	shopping 'meals on wheels'
6-12 hours/week	16	cooking, shower
>12 hours/week	17	dressing/undressing, out of bed
	100%	
Help at evenings/nights:	24%	
Help at weekends:	33%	

Summary

The long-term trends I have discussed can be summarized *as a process of differentiation:* from 'global' solutions of the problems connected with old age to specific solutions of different problems (pensions, housing policy, home-based care, institutional care).

Another important long-term trend is the *shift of responsibilities:* from mainly family support and voluntary 'organizations' to a combination of family and state, from mostly unpaid labour to paid and unpaid labour in combination; from mostly informal care to a combination of formal and informal care. (Unchanged though is that both the paid and the unpaid labour is women's work). During the last decade when the formal elder care (both institutional and home-based care) has decreased, the boundary between the families and the state is changing in the opposite direction. Thus, the recent trend can be labeled a process towards an *informalisation of care* - a process which we have good reasons to be worried about - given what we know about old people's preferences about care and the care giving resources within the family.

A Healthy, Happy and Lively Old Age for Everyone

AMM Abdul Jabbar

I have been asked to talk about our experiences in working with the elderly in this country. Since experience is, essentially, a learning from the past, it will not be inappropriate to hark back three and a half decades and begin at the beginning.

Observe, then, a dedicated doctor, retired but active, running a clinic in the modest environs of his own house. There are not many people about -- perhaps three or four elderly or aged people, a laboratory technician, a clerk and the doctor himself. In the late afternoon the patients are attended to for about two hours. The good doctor lavishes the experience of a lifetime on his aging patients. He uses all his clinical expertise and his years of teaching experience in consoling them, understanding them, and eliciting information from them. These aged patients always felt that they had found a refuge at last, a place where they could talk about their problems freely and were given the attention they deserved. This was HEALTH CARE WITH A DIFFERENCE -- a far cry from the surging crowds at the city hospitals, where the aged could hardly hope to reach the doctor, let alone talk to him.

That was the beginning. The doctor was AKM Abdul Wahed, of revered memory, pioneer of work with the aged and aging in Pakistan and Bangladesh, perhaps even in the whole Indian subcontinent. It is my proud privilege to say that he was my father. Since those first few days and weeks of long ago, immediately after April 1960, when it was established, I have been intimately involved with the Bangladesh Association for the Aged and Institute of Geriatric Medicine and have been exposed to a slow but sure process of learning about aging and the aged. And that alone gives me the temerity to address this august assembly today. I am no geriatric expert, I speak only from down-to-earth experience and observation of what has actually happened.

From the beginning, emphasis has been laid on quality of life, of adding life to yeas. An early example will help illustrate this. In 1961 or early 1962, an old man of about seventy-five, was brought to the office of the association. He came by a car and in the absence of a stretcher, had to be placed on a chair which was carried by four or five burly young men. That was the beginning of a success story -- the story of a man's emergence from an immobile, handicapped state and the regeneration of his will to succeed, and a physician's dedication to serve the aged. This gentlemen, a retired railway station master, was by no means a poor man nor had he been abandoned by his offspring. In fact, he lived with his sons and was looked after very well. But no one in the family believed he would ever move or walk about. So, in the comfort of his home, he just sat like a vegetable and helplessly watched life go by. His illness was no more than atrophied muscles, unused limbs and complete lack of the will to try to be active. He would have to be coaxed, my father knew, to make an effort to move. He prescribed a regimen of physiotherapy and exercise and he patiently, painfully guided the gentleman through this process. Improvement was imperceptible and very slow at first, giving rise to frustration and a desire to give up. Then, perseverance paid off and remarkable progress was made. By the end of a year he was a changed man. Not only was he able to walk without help, but he also came to the association office by a rickshaw with his little grandson -- both enjoying each other's company, imparting quality into the old man's life. It was no longer a matter of just existing, life was now healthy, happy and lively! The old gentleman's last few years had been infused with life. He lived actively and happily for about five years till death finally overtook him. Had he not been brought to the Association, those last five years would have been vastly different -- a dull, immobile drudgery, a dreadful, vacant-eyed waiting for the end, in the midst of and in spite of the care and concern of his close kin.

To us at the Bangladesh Association for the Aged, that constitutes quality of life and to provide it is the raison d'etre of our existence. To that end we strive. We would like to be able to provide a healthy, happy, lively old age for everyone -- not a tall order impossible to achieve, when you consider the fact that everyone who does not die, will in time attain

old age. And a little understanding of the facts of old age, a little care, a little preparation will surely help everyone live a healthy, happy, lively and useful old age.

Over the years, during the association's slow but steady advance, in spite of tumbles and setbacks along the way, our experience is that progress is not always measured in terms of the number of elderly and aged people served, but more by the way they have been served. The yardstick is quality, not quantity. Of necessity, there has been a great increase in the number of aged persons attending, but the association has always endeavoured to improve quality. I would say there has been more than modest success in spite of the many constraints and obstacles.

In speaking of our experiences in geriatrics and gerontology, I am purposely going to let statistics be, for our clients the aged of Bangladesh, not statistics, they are people and a very special group of people with special needs. Let us see what the aged themselves think about it all.

Over the years, we have found that most aged people tend not to remain in touch with the association as soon as their physical illness is relieved. There is, by and large, no awareness of the fact that keeping in touch, exchanging ideas, meeting like-minded persons, young or old, can go a long way towards enhancing quality of life. Perhaps, in most cases, there is no understanding of what quality of life is all about.

There is no awareness, generally that it is possible, if the will is forthcoming to achieve better health, greater happiness and greater activity with a little learning and guidance. The aged one, and his or her relatives, have but to come to Probin Bhaban and gather some basic ideas about aging and the aged. The important thing is to keep in touch with the association and take whatever else is offered, rather than just get medicare.

In our efforts to increase this awareness among the population, and aged people in particular, we have been financially assisted to a significant extent by the World Health

Organization. Over a period of about ten years, workshops in Dhaka at the national level and in our branches at the district level, have been held, aiming at giving a clear understanding of basic health problems of the aged and the social and economic aspects of their lives. Both aged and young have attended these workshops. Doctors, lawyers, teachers, engineers, imams, social welfare workers and local leaders have all been involved and exposed to expert knowledge in this field.

It is our experience that there has been some increase of peoples' awareness in these two areas, specially during the last few years. Both aged and young have benefited. But there is yet a long way to go.

There is plenty of scope for further work in this direction -- holding more interesting and informative seminars and workshops; arranging for greater contact between aged and young, in order to encourage better understanding and cooperation; having special lectures or workshops for younger people, emphasizing the importance of being better prepared early in life, rather than having to face old age abruptly, at fifty-five or sixty!

All these and more can be the basis of future fruitful cooperation between BAAIGM (Bangladesh Association for the Aged and Institute of Geriatric Medicine), WHO, BRAC, Stockholm Gerontology Research Centre and other similar organizations.

A few words now, about the involvement and exposure of young people to aging and the aged. We have, from the very beginning, tried to get young people interested in the aged. In the mid-sixties we welcomed a steady trickle of students from the College of Social Welfare to BAAIGM, as a part of their course of studies. They came to the association and institute and learnt by doing, getting involved with our aged patients and finally preparing their report. I am happy to say that slowly, over the years, the trickle has turned into a steady flow. Students now also come from Department of Sociology and Psychology (Dhaka University), Jagannath University College, researchers from NIPSOM, and of course from the College of Social Welfare -- now Institute of Social

Welfare, Dhaka University. With all these young people milling about and mingling with the aged at Probin Bhaban, I am sure greater rapport is being established resulting in greater understanding of the problems of the aged by young people and vice versa.

The West, having studied the problem of the aged for over eight decades or more and having devised many efficient ways and means of giving them a healthy, happy and lively old age, has come to the conclusion, over the last one and a half decades, that family-based care is perhaps the best if it can be arranged. While the west is thus attempting to re-introduce family-based care, we in Bangladesh find that the family is still the main refuge of our aged people, as it has always been from time immemorial. The aged are still held in regard and are served and looked after in spite of economic constraints. Religious injunctions and deep family ties are responsible for this. It should be our endeavour to hold on to family care for our aged, no matter what. Our main concern, then will be for those aged persons who have no family. It is high time, this problem is addressed seriously to prepare for hard times ahead.

Finally, a word about research. From the very beginning, modest research work has been carried out in spite of the less than meager funds available. Clinical research on various changes in old age was done by Mrs Towhida Ahmad (my sister), assisted by our senior medical officer, Dr Lutfur Rahman. Research on changes in aged persons' urine during Ramadan fasting was done in the late sixties by Prof. Dr Abdur Rahman.

A survey on health and socioeconomic problems of the aged in Bangladesh, carried out during 1985-86, was perhaps the first epidemiological research on problems of the aged. About 1,600 aged persons were studied in detail and the report contained some useful statistics. Obviously, 1,600 is an insignificant part of the total number of aged persons in the country. For the figures to be truly factual and representative of the country, I feel at least fifty such surveys should be carried out -- the sooner the better.

Last but not the least, I must not forget to mention that our government recognizes the problems of our elderly and aging and has come forward, in no small measure, with financial aid to build up our central facility at Agargaon, where construction goes on apace. Funding is also available for continuing our work of ensuring a healthy, happy, lively old age for everyone at Probin Bhaban.

Discussion

A lively discussion was held after each presentation. Twenty-nine eminent scholars and researchers from ICDDR,B, University of Dhaka, VHSS, NIPSOM, NIPORT, BRAC and other organizations participated in the discussion.

The participants were interested to know the present situation of elderly and health care and facilities available for them. The discussants informed that the older people were not getting adequate health care or the existing health care facilities for the older people were under utilized. Moreover, the elder group of the society are mostly non-earning and thus, cannot afford appropriate health care whenever required.

One participant raised question that who were the elderly and how the age was determined? From the very beginning during the early sixties, Probin Hitoishi Shangha defined elderly people as those who were over 40 years of age because at that time the life expectancy was only around 30-40 years. Over the time the definition has been changed with the raising of life expectancy. Now people who are of 60 years and above are called elderly.

A few issues were raised on Dr Marta's presentation. Why home care for elderly people was decreasing in Sweden? Health care service delivery at home was popular and it was an important social reform in 1950s. During that period voluntary organizations provided health care through paid housewives. Over the time, the state took responsibility of elderly (over 65 years) and in 1970s almost every fourth elderly got services from 'home help services' run by the municipalities. Moreover, the economic crisis and single family norms make the elderly people more vulnerable in terms of receiving home care from their children. While cohabitation with children decreased from 28% in 1954 to 4% in 1988/89. The fact is that most of the elderly, particularly the young elderly, are healthy and they do not need special health care rather what they are getting now.

Mr Abdul Jabbar outlined the health related problems as the main problem of elderly in Bangladesh. He also mentioned that to solve this problem, the Probin Hitaishi Shangha was the only institute for elderly care in Bangladesh which provide health care through outdoor health services. This hospital provides medical care everyday by a medical officer. It also provides specialized care on medicine, cardiology, eye, ENT, dentistry, physiotherapy and psychotherapy by specialists.

Prof. Hamida Akter Begum of Dhaka University and President, Women for Women shared the finding of her recently conducted study on elderly women in Bangladesh. The study was conducted on 808 elderly women through-out Bangladesh (both urban and rural areas). Health related problems, particularly the eye problem, were found as their main problem. The health facilities were found less used by older women than men. Women became older sooner than men. Lower and middle class women sought some institutional health care from the government. Other psychological problems were fear of death, loneliness and social burden.

Most (98%) women wanted some sort of care provision from the society, 92% elderly women mentioned that separate house was needed for them, and 68% said that if possible they would like to live in separate houses. Prof. Begum concluded that "We should do something for the elderly women, as they are the most neglected part in the society. Because sons are migrating and the parents particularly the mothers are abandoned. She also mentioned that home should not be a dumping place for women."

Participants emphasized the involvement of government in elderly care studies. However, it was also pointed out that the government yet to undertake any programme for elderly care by the year 2000. Because existing health facilities are already overburdened with the health care for children and women of reproductive age. Emphasis was also given for active involvement of NGOs like BRAC, who can take initiative for elderly care. Finally it was observed that there is no correct information

regarding the problems of elderly people in Bangladesh, A few programmes are run by the government and NGOs. There is no fixed bed in hospitals and no fixed seat in any public transport for the elderly people.

Research Issues:

As a outcome of the seminar, the participants raised some research issues which are as follows:

1. What are the programmes run by the government and NGOs on elderly care in Bangladesh?
2. What are the social factors responsible for immobility of elderly people?
3. Peoples perception about elderly care?
4. Workload of elderly people.
5. Who is the richest person in a family and why a richest person is not cared by other family members?

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