DATA - BANK OF ORGANISATIONS WORKING IN THE FIELD OF _____.

I Name of the Organisation: Ashakta Poshaka Sabha.

Address :

Phone No: ____ Fax No: ____ E-Mail No: ____

II Type of Organisation (nature):

Government -
Quasi-government -
Non-government - ✓
Missionary -
Hospital based -

III Administrative data:

a) Head of the organisation/ Contact person -

b) Number of staff - 20.

c) Organisation structure - Governing Council/ Pres. B.K.S. Murthy.
Hon. Sec. Sampangiram Shetty
Vasudev Rao - Res. manager.

Gen. Manager
↓
Res. manager.

d) Other associates (friends, volunteers etc) -
Donations - philanthropic.

Rs. 50,000 per mth

e) Year of initiation/registration -
1923, Regd - 1926.

IV Area of work (Activities) -

(a) Health ✓ (b) Non-health (development)

i) Research

ii) Training

iii) Documentation

iv) Networking with other NGOs

v) Lobbying/planning with policy makers (government)

V Target populations:

a) Nature of target population (beneficiaries) - Aged

b) Total number covered - 40 (women), 30 (men)

≥ 70

c) Details -

Food, clothing, Medical, Shelter - aged, disabled ~~dd~~, destitute

Orphans - girls & boys.

70 girls - 50 boys.

VI Services Offered:

a) At Preventive level -

b) At Promotive level -

c) At Curative level -

VII Source of funds :

a) Internal -

b) External -
Rs. 50 per mth - Govt grant - 10 mths (children)

VIII Interaction with CHC :

a) CHC member(s) visited : 1

Name(s) - A.S

Date - 29/5/95

b) Previous participation with CH Forum : Yes / No

c) Participation requested at present for :
CH Forums

d) Expectations from the Forum :

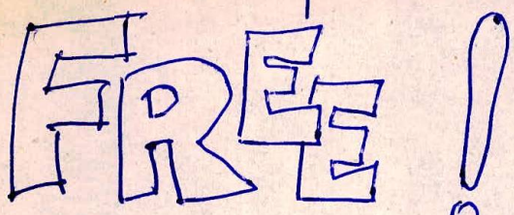
e) Discussion with :

f) Highlights of discussion :

g) Follow-up / Future action :

Staff Development Programmes -
Inservice trgn ?
Deputation ?
Attend workshops, conferences etc ?

GUESS THE AGE OF CHC contest

- Open to all CHC staff.
- Last date of entries - before 2000 A.D.! earliest by Sankranti 15/01/96.
- 

- ABSOLUTELY FREE !!
  ✓ trip to your inner feelings.
  ✓ opportunities to rejuvenate.

HOW TO ENTER THE CONTEST

1. Read CAREFULLY the accompanying compilation on "Symptoms of Ageing Organisations"
2. Read again to ensure that you have read it!
3. Now, pick any arbitrary date - the first that comes to your mind - anywhere between 3500 B.C. to 1996 A.D. will be considered suitable.
4. For this step, you can use a calculator / computer / the slip of blue coloured paper attached ~~be~~ overleaf - (i.e. if you don't trust your mental abilities)
   - Add or substract no. of years in units (1 to 9) or tens (10 to 90) or hundreds (100-900) or fractions thereof, for each ~~of~~ of the 35 items listed under "Description" and 31 items under "~~Manifestation~~".
   - Now, Multiply or Divide with the most probable item no. you identify ~~as~~ under "Symptoms".
5. Note down this figure and do not reveal it to anyone.
6. In case you win the contest, you will be informed by post.

RULES:
1. No queries / correspondence will be entertained on this matter.
2. This contest is not open to family members of CHC staff.
3. The decision of the judged is final.

(the above spelling is correct - please do not change)

ಪ್ರತಿ ನಂ -1

1. ಅಭಿವೃದ್ಧಿ :- ಸಮುದಾಯದ ಸರ್ವತೋಮುಖವಾದ ಬೆಳವಣಿಗೆಗೆ ಅಭಿವೃದ್ಧಿ ಎನ್ನುತ್ತೇವೆ.

2. ಸಂಘಟನೆ :- ಸಮುದಾಯದ ಅಭಿವೃದ್ಧಿ ಗುರಿಯನ್ನು ಇಟ್ಟುಕೊಂಡು ಎಲ್ಲರೂ ಒಂದೆಡೆ ಸೇರಿ ಒಗ್ಗಟ್ಟಾಗುವುದನ್ನು ಸಂಘಟನೆ ಎನ್ನುವರು.

3. ಪಾಲ್ಗೊಳ್ಳುವಿಕೆ :- ಈ ಸಂಘಟನೆಯಲ್ಲಿ ಎಲ್ಲರೂ ತಮ್ಮ ಸಲಹೆ ವಿಷಯವನ್ನು ಹಂಚಿ ಕಾರ್ಯದಲ್ಲಿ ತಮ್ಮ ಪಾಲಿನ ಸಹಕರಿಸುವುದು ಸಮುದಾಯ ಪಾಲ್ಗೊಳ್ಳುವಿಕೆ ಎನ್ನುವರು.

ಸಂಪನ್ಮೂಲಗಳ ವಿಧಾನಗಳು

I ಮಾನವ ಸಂಪನ್ಮೂಲಗಳು

1) ಅನುಭವ Experience
2) ವಿದ್ಯಾವಂತರು Educated
3) ಕಾರ್ಮಿಕರು Labourers
4) ಜಮೀನ್ದಾರರು Landlords
5) ಆಡಳಿತಗಾರರು Administrators
6) ಅಧಿಕಾರಿಗಳು Officers
7) ಯುವಕರು Youth
8) ನಾಯಕರು Leaders
9) ರಾಜಕಾರಣಿಗಳು Politicians
10) ಬುದ್ಧಿಜೀವಿಗಳು Intellectuals

II ವಸ್ತು ಸಂಪನ್ಮೂಲಗಳು

1) ನೈಸರ್ಗಿಕ (Natural) ಸಂಪನ್ಮೂಲಗಳು

1) ನೀರು water
2) ಅರಣ್ಯ Forest
3) ಪ್ರಾಣಿಪಕ್ಷಿ Animal/Birds
4) ಮಾನವರು Humans
5) ಖನಿಜ ಸಂಪತ್ತು Mineral resources
6) ಸಂಪತ್ತು Financial
7) ಗಾಳಿ Wind
8) ಕಾಲ
9) ಆಹಾರ (Food)

ಮಾನವ ನಿರ್ಮಿತ (Man-made) ಸಂಪನ್ಮೂಲಗಳು

1) ಕ್ರೀಡೆಗಳು (Sports)
2) ವ್ಯವಸಾಯ ಉಪಕರಣಗಳು Agri implements
3) ಆಹಾರ Food
4) ವಾಹನಗಳು Vehicles
5) ಕಾರ್ಖಾನೆಗಳು Factories
6) ಗ್ರಾಹಕ ವಸ್ತುಗಳು Consumer goods
7) ಸಾಂಸ್ಕೃತಿಕ cultural

III ಹಣಕಾಸಿನ ಸಂಪನ್ಮೂಲಗಳು

1) ಕಾಣಿಕೆಗಳು Gifts
2) ಚಂದಾ (chanda) / ತೆರಿಗೆ Tax
3) ಬ್ಯಾಂಕ್ Bank
4) ಸಹಕಾರ ಸಂಘ Cooperative Banks
? 5) ಸ್ಥಿರಾಸ್ತಿ ವಸ್ತುಗಳು
6) ಒಡವೆ Jewellery
? 7) ವಾಹನಗಳು Vehicles

IV ಸಂಸ್ಥೆಯ ಸಂಪನ್ಮೂಲಗಳು

1) ವಿದ್ಯಾ / Educational Institutions
2) ಸಂಶೋಧನಾ Research centres
3) ಹಣಕಾಸು Financial
4) ಸಂಘಟನೆ Groups/Organisation
5) ತರಬೇತಿ ಕೇಂದ್ರ Training centres
6) ಇಲಾಖೆಗಳು Departments
7) ಸಹಕಾರ ಸಂಘಗಳು Cooperative institutions
8) ದಾಖಲೆಗಳು Admission
9) ಶಾಲೆಗಳು ?
10) ಸಾಂಸ್ಕೃತಿಕ

Group 3

26-7-95

Girija

1 <u>ಸಮುದಾಯ</u> <u>ಅಭಿವೃದ್ಧಿ</u>

: ಒಂದೇ ಗುಂಪಿನಲ್ಲಿ ಒಂದೇ ಮನಸ್ಸು ಒಗ್ಗಟ್ಟು ರೀತಿಯ ಆಲೋಚನೆ ಶಕ್ತಿ ಇರುವುದರಿಂದ ಹಾಗು ಬೆಳವಣಿಗೆ ಅಭಿವೃದ್ಧಿ ಎನ್ನುತ್ತೇವೆ.

(2) <u>ಸಂಘಟನೆ</u> : ಸಮುದಾಯದ ಸಮಸ್ಯೆಗಳನ್ನು ಗುರುತಿಸಿ ಅದರಲ್ಲಿ ಮುಖ್ಯವಾದ ಸಮಸ್ಯೆಗಳನ್ನು ಹಾಗು ನಮ್ಮ ಶಕ್ತಿ ಸಾಮರ್ಥ್ಯವನ್ನು ಆಸಕ್ತಿಯನ್ನು ಮೂಡಿಸಿಕೊಂಡು ಅಭಿವೃದ್ಧಿಗೆ ಪ್ರಯತ್ನಿಸುವುದೇ ಸಂಘಟನೆ

(3) ಸಮುದಾಯದಲ್ಲಿ ಭಾಗವಹಿಸುವಿಕೆ ~~[illegible]~~ ಅಥವಾ ಪಾಲ್ಗೊಳ್ಳುವಿಕೆ ?

ಈ ಸಮುದಾಯದಲ್ಲಿ ತನ್ನ ಕರ್ತವ್ಯ ನಿಷ್ಠೆ ಶಕ್ತಿ ಸಾಮರ್ಥ್ಯ ಉದಾರ ಮನೋಭಾವ, ಜವಾಬ್ದಾರಿಗಳನ್ನು ತಿಳಿದು ನಿರ್ವಹಿಸುವುದೇ ಪಾಲ್ಗೊಳ್ಳುವಿಕೆ

Group 2 26-7-95

1. ಸಮುದಾಯದ ಅಭಿವೃದ್ಧಿ.

ಒಂದೇ ಗುಂಪಿನಲ್ಲಿ ಒಂದೇ ರೀತಿಯ ಬಿಳಿಯ ವಿಚಾರವಿನಿಮಯ ಆಸಕ್ತಿ ಇರುವುದಕ್ಕೆ ಸರ್ವತೋಮುಖವಾದ ಬೆಳವಣಿಗೆಗೆ ಅಭಿವೃದ್ಧಿ ಎನ್ನುತ್ತೇವೆ.

2. ಸಂಘಟನೆ.

ಸಮುದಾಯದ ಅಭಿವೃದ್ಧಿಯಲ್ಲಿ ನಮ್ಮ ಶಕ್ತಿ ಸಾಮರ್ಥ್ಯವನ್ನು ಹಾಗು ಆಸಕ್ತಿಯನ್ನು ನೋಡಿಕೊಂಡು ಅಭಿವೃದ್ಧಿಗೆ ಪ್ರಯತ್ನಿಸುವುದೇ ಸಂಘಟನೆ.

3. ಸಮುದಾಯದಲ್ಲಿ ಛಾಗವಹಿಸುವಿಕೆ ಅಥವಾ ಪಾಲ್ಗೊಳ್ಳುವಿಕೆ.

ಈ ಸಮುದಾಯದಲ್ಲಿ ತಮ್ಮ ಕರ್ತವ್ಯವನ್ನೆಲ್ಲ ಶಕ್ತಿ ನಿರ್ದೇಶ ವಿಚಾರ ಉದಾರ ಮನೋಭಾವ ಇವುಗಳನ್ನು ಅನುಸರಿಸುವವರೆಲ್ಲಾ ಸಮುದಾಯದಲ್ಲಿ ಛಾಗವಹಿಸುವಿಕೆ ಎನ್ನುವರು.

1] Smt Annapurna Hemant Deshpande
Y.V.K. Bijapur
Darbar galli - 2
Bagalkot road
Bijapur

ಕು. ಶಾರದ
ಮಾಚನಹಳ್ಳಿ
ಲಕ್ಷ್ಮಿದೇವಿ ಮಹಿಳಾ ಸಂಘ.
ನೆಲಮಂಗಲ [ತಾ]
ಬಿಲ್ಲನಕೋಟೆ [ಪೋ]
ಬೆಂಗಳೂರು [ಜಿ]

2] Ms. Shobha. B. Patil
Yuvak Vikas Kendra
Darbar galli - 2
Bagalkot road
Bijapur

3] ಹೆಸರು ವೆಂಕೋಬಾ
ಸಂಸ್ಥೆಯ ಹೆಸರು ಜನೋದಯ ಸಂಘಟನೆ
ಕೋನಾಪುರಪೇಟೆ ಮಾನ್ವಿ
ತಾ॥ ಮಾನ್ವಿ ಜಿ॥ ರಾಯಚೂರು
ಪಿನಕೋಡ ನಂಬರ 584123

ಹೆಸರು:- Krishnamurthy
Hanumantharaj, Venkata-raju & Rajanna
1038 Kacherkanahalli
Thomas town post
Bangalore 560084

4] S. Prafulla
Resource Scientist
Development Alternatives
Divya Pradeep,
10th cross, Ashoka Nagar
SIT Extension
Tumkur

Premalatha
Jayanthi
DAKSHEDTE TRUST
Ashok Road,
POST BELVAI-574213
Karkal Tq. (D.K.)

Sl. No.	Names	Address
1	Shivamally	Bosco yuvodaya 91 "B" Street 6th cross Gandhi Nagar Bangalore-9 Ph No. 2253392
②	VENKATARAJA / ~~RAJANNA~~ PRAXIS. 1038 Kacharakanahalli St. toms town post. Bangalore 84.	
3.	PAUL GNANAMITHRA.	— Development Education Society. (DEES) 5/1, 6th Main. S. K. Garden Benson Town Post Bangalore-560046
4.	C. JAYAMMA.	— RENUKA MAHILA MANDALA MARGANA HALLI NELAMANGAL TALUK BANGALORE DIST
5.	Sheela.S	— Sumangali Seva Ashrama Cholanayakanhalli R.T. Nagar Post BANGALORE-32
6)	Rajanna	— PRAXIS 1038, Kacharakanahalli St toms town (Post) Bangalore 560084

SL NO	NAME	ADDRESS NAME OF THE ORGANIZATION.	SIGNATURE
1	D. VENKATESH	CRUES POST BOX NO. 50. BANGARPET. TQ KOLAR.	
2	GIRIJA	INDRA MAHILA SANGA MACHANEHALLY NELAMANGALA .. TQ BANGALORE.	Girija
3. a	SHAKUNTHALA DESHPANDE	BELGAUM INTIGARTE RURAL DEVELOPMENT SOCIETY NAGANUR. GOKAK. TQ BELGAUM. 08332. 82272	
b)	Ravi kithur [RAVI K THORA]		
4.	DHANUNJAYA.	BIRDS Bhapooji Intigarte Rural Development Society. GANADALU. CHICKANAHALLY TUMKUR.	
5.	SAVITHRAMMA	INDRA MAHILA SAVITHRAMMA SANGHA. MACHANAHALLI NELAMANGALA .TQ BANGALORE. D	

PTO

Dhakshayini
Kannada Jyothi Education Society
S. G. Palya, Bangalore.

6] ಸ್ಥಳೀಯ ಸಂಸ್ಥೆಗಳು. - [ಯುವಕ ಮಂಡಲ, ಮಹಿಳಾ ಮಂಡಲ
ಸಹಕಾರ ಸಂಘಗಳು]

ಹಣಕಾಸಿನ ವ್ಯವಸ್ಥೆ:-

1] ಶಿಕ್ಷಣದ ವ್ಯವಸ್ಥೆಗೆ ದಾನವಾಗಿ ಬಂದದ್ದು

2] ವಾಹನ ಸೌಕರ್ಯ - ಸಂಬಂಧ ಪಟ್ಟವರನ್ನು ಕೇಳಲು 1000/Rs

3] ಡಿಪಾಸಿಟ್ ಹಣಕ್ಕಾಗಿ 2000/R.S

4] ನ್ಯಾಯಬೆಲೆ ಅಂಗಡಿಯನ್ನು ನೋಡಿಕೊಳ್ಳುವ ಕೆಲಸಕ್ಕಾಗಿ
ಕಾರ್ಯದರ್ಶಿ ಅವರಿಗೆ 1000/R.S ನೌಕರನಿಗೆ 500/R.S

5] ಇತರೆ ಖರ್ಚಿಗಾಗಿ 1000/R.S ಒಟ್ಟು Rs 5500/-

ಈ ಪ್ರೊಜೆಕ್ಟ್ ಯೋಜನೆಯ ಕಾರ್ಯಕ್ರಮ 2 ತಿಂಗಳು ಅವಧಿ
ಮೊದಲು ವಾರ ಸರಕಾರಿ ಅಧಿಕಾರಿಗಳೊಂದಿಗೆ ಚರ್ಚೆ
ಎರಡನೇ ವಾರದಿಂದ ತಿಂಗಳು ಪ್ರೊಜೆಕ್ಟ್ ಕಟ್ಟಡ ಸಾಮಗ್ರಿ ಸಂಗ್ರಹಣೆ ಕಟ್ಟಡ ಕಟ್ಟುವುದು.
ಮೂರನೇ ತಿಂಗಳು ಬೇಕಾಗುವ ಸಾಮಗ್ರಿಗಳನ್ನು ತರಿಸುವುದು ಮತ್ತು
ಜೋಡಿಸುವುದು ಹಾಗೂ ಇತರೆ ಕೆಲಸ

ಜವಾಬ್ದಾರಿಗಳು.

1] ಸರ್ಕಾರಿ ಅಧಿಕಾರಿಗಳಿಂದ ಸೌಲಭ್ಯದ ವಿವರಣೆಯನ್ನು ಪಡೆಯುವುದು
- ನಡೆಸುತ್ತಾರೆ. 4-5 ಜನ ಯುವಕರು ~~[illegible]~~ ಯುವಕ ಮಂಡಲ

2] ಸಾಮಗ್ರಿಗಳು ಗೋದಾಮಿನಿಂದ ತರುವ ವಿಧಾನ. ವಿವರ

3] ಪಟ್ಟಣದ ಸಾಮಗ್ರಿಗಳನ್ನು ಸಂಗ್ರಹಿಸುವುದಕ್ಕೆ 3-4 ಜನ

4] ಕಟ್ಟಡ ಕಟ್ಟುವುದಕ್ಕೆ ಉತ್ತಮ ಬಲ್ಲವನು

5] ಸಾಮಗ್ರಿಗಳನ್ನು ತರಿಸಲು ಹಾಗೂ ಅಂಗಡಿ ಜೋಡಿಸಲು 5 ಜನ

6] ನಿಯಮಗಳು. ಪ್ರತಿ ಒಂದು ವಾರದ ನಂತರ ಸೇರುವುದು

ನೌಕರ ಮತ್ತು ಕಾರ್ಯದರ್ಶಿ ಗ್ರಾಮಪಂಚಾಯಿತಿಯವರು
ಒಳ್ಳೆಯವರು ಸಂಘ ಸಂಸ್ಥೆಯವರು ~~[illegible]~~ ಸಲಹೆ ಮೇರೆಗೆ
ನೇಮಿಸುವುದು.
ಲೆಕ್ಕಿಗರು ಈ ಎಲ್ಲಾ ಕಾರ್ಯಗಳು ಸರಿಯಾಗಿ ನಡೆಯು
ವುದಕ್ಕೆ ಇಬ್ಬರು ಲೆಕ್ಕಿಗರು.
ಕಾಲ ಕಾಲಕ್ಕೆ ಅಕೌಂಟ್ ಒಪ್ಪಿಸಬೇಕು ಮಾತ್ರ ಪರಿಶೀಲನೆ.

ಹಳ್ಳಿಯ ಹೆಸರು ದೇವನಹಳ್ಳಿ

ಆವಶ್ಯಕತೆ :- ~~ರಸ್ತೆ ದುರಸ್ತಿಯ ಬಗ್ಗೆ~~

ನಿರ್ಣಯ.

ಊರಿನ ರಸ್ತೆ ಕಾರ್ಯದ ಬಗ್ಗೆ ಯೋಜನೆ

1. ರಸ್ತೆ ಸರಿ ಇಲ್ಲದ ತೊಂದರೆಯ ಜನರಲ್ಲಿ ಮನವರಿಕೆ ಮಾಡುವ ಅವರಿಗೆ ಯೋಜನೆಯ ಮೂಲಕ ತಿಳಿಸುವುದು. ರಸ್ತೆಯಿಂದ ನಮಗಾಗುವ ಅನುಕೂಲ ಹಾಗೂ ಅನಾನುಕೂಲದ ಬಗ್ಗೆ ತಿಳಿಸುವುದು.

2. ಗ್ರಾಮಸ್ಥರ ಸಭೆಯಲ್ಲಿ ಚರ್ಚೆ ಮಾಡಿ ರಸ್ತೆಯನ್ನು ಮರು ನಿರ್ಮಿಸುವ ಜನರಲ್ಲಿ ಮುಖಂಡರ ಮೂಲಕ ಸಂಪರ್ಕ ಬೆಳೆಸುವುದು.

6-- ರಸ್ತೆ ಮಾಡುವುದಕ್ಕೆ ಕಾರ್ಮಿಕರ ವೆಚ್ಚ ಪಡೆಯಲು P.W.D. ಗೆ ಮನವಿ ಸಲ್ಲಿಸುವುದು

3. ಗ್ರಾಮ ಪಂಚಾಯತಿ ಅಧ್ಯಕ್ಷರಿಗೆ ಗ್ರಾಮಸ್ಥರೆಲ್ಲರೂ ಸಹಿ ಮಾಡಿ ಮನವಿ ಸಲ್ಲಿಸುವುದು ಮತ್ತು ರಸ್ತೆ ಇಲ್ಲದೆ ವಾಹನಗಳು ಬರುತ್ತಿಲ್ಲ ಶಾಲೆ ಮತ್ತು ವಸ್ತುಗಳನ್ನು ಸಾಗಿಸಲು ಆಗುತ್ತಿಲ್ಲ.

4. ಊರಿನ ಶ್ರಮದಾನದ ಮೂಲಕ ಗ್ರಾಮಸ್ಥರನ್ನು ಒಟ್ಟುಗೂಡಿಸಿ ರಸ್ತೆ ಆರಂಭ ಮಾಡುವುದು. ಹಳ್ಳಿಯಿಂದ ಹಳ್ಳಿಗೆ ಊರಿನಿಂದ ಊರಿಗೆ ಹೋಗುವುದಕ್ಕೆ ಮುಖ್ಯವಾಗಿ ರಸ್ತೆ ಬೇಕು.

5. ~~ಗ್ರಾಮ~~ ಗ್ರಾಮ ಪಂಚಾಯತಿನ ಮೂಲಕ ಶಾಸಕರಿಗೆ ಮನವಿ ಸಲ್ಲಿಸಿ ಅದಕ್ಕಾಗಿ ರಸ್ತೆ ದುರಸ್ತಿ ಮಾಡಿಸುವುದರ ಬಗ್ಗೆ ಅವರಲ್ಲಿ ಒತ್ತಡ ಹಾಕುವುದು.

6. ಗ್ರಾಮಸ್ಥರಿಂದ ಸ್ವಸಹಾಯ ಸಂಘಗಳು ~~ಬಳಸುವುದು~~ ಕಲ್ಲು, ಮಣ್ಣು ಮುಂತಾದವುಗಳನ್ನು ಬಳಸಿ ತಾತ್ಕಾಲಿಕವಾದ ರಸ್ತೆ ದುರಸ್ತಿ ಮಾಡಿಸುವುದು.

7. ರಸ್ತೆ ದುರಸ್ತಿ ಯೋಜನೆಯು ಕಾಲ ಕಾಲಕ್ಕೆ ನಡೆಯುವ ಹಾಗೆ ಕ್ರಮಬದ್ಧವಾಗಿ ಮಾಡುವಂತೆ ನೋಡಿಕೊಳ್ಳುವುದು.

ಯುವಕ ಸಂಘ.

ಮಹಿಳಾ ಸಂಘ / ಸ್ವಸಹಾಯ ಸಂಘ.

ಜಲಾನಯನ ಸಂಘ

ಸಮುದಾಯ ಸಂಘ

ವಿವಿಧ ಸಂಘ ಸಂಸ್ಥೆಗಳ ಸಂಘಗಳು

ಈ ಎಲ್ಲಾ ಸಂಘಗಳನ್ನು ಬಳಸಿ ರಸ್ತೆ ದುರಸ್ತಿ ಮಾಡಿಸುವುದು.

ಬಜೆಟ್ಟು 60,000

ಊರಿನ ಹೆಸರು

ದೇವನಹಳ್ಳಿ

ಉಪಯೋಗ: ರಕ್ಷಿಯ ದುರಸ್ತಿಯ ಬಗ್ಗೆ.

ಈ [illegible] ಕ್ಷೇತ್ರಗಳಲ್ಲಿ ಸ್ವಯಂಸೇವಾ
ಸಂಸ್ಥೆಯಿಂದ ಮಾಡಿದ ಕೆಲಸಗಳು.

1 [illegible] — [illegible]

2 ಆರೋಗ್ಯ — [illegible]

3 [illegible] — [illegible]

4 [illegible]

5 [illegible] } — ಸ್ತ್ರೀ ಶಕ್ತಿ ಸಂಘ

6 [illegible] — ಯುವಕ ಸಂಘ

o

(1)   ಗುಂಪು 2

ಪ್ರಾಥಮಿಕ ಶಾಲಾ ಯೋಜನೆ

ಊರಿನ ಹೆಸರು - ಮಲ್ಲೇನಹಳ್ಳಿ - ದೊಡ್ಡಬಳ್ಳಾಪುರ ತಾ.

ಊರಿನ ಸಮೀಕ್ಷೆ

ಜನ ಸಂಖ್ಯೆ : 500
ಮನೆಗಳು : 100
ಶಾಲೆಗೆ ಹೋಗುತ್ತಿರುವ ಮಕ್ಕಳು : 30
ವಿದ್ಯಾವಂತರು : 50

ಊರಿನ ಸಂಪನ್ಮೂಲಗಳು

(1) ದೇವಸ್ಥಾನ
(2) ವಾಹನ ಸೌಲಭ್ಯ
(3) ಹಾಲು ಉತ್ಪಾದಕರ ಸಂಘ
(4) ದೂರವಾಣಿ

ಶ್ರೀಮಂತರು - 5% ಮಧ್ಯಮ ವರ್ಗ 30% ಇತರ 65%

ಯೋಜನೆಯ ಗುರಿ.
(1) ಪ್ರಾಥಮಿಕ ಶಾಲೆಯ ಮೂಲಭೂತ ಸೌಕರ್ಯ ಒದಗಿಸುವುದು (ಗ್ರಾಮಸ್ಥರ ಸಹಭಾಗಿತ್ವದ ಮೂಲಕ)

ಉದ್ದೇಶ (1) ಶಾಲೆಗೆ ಸೇರದಿರುವ ಶಾಲೆ ಬಿಟ್ಟಿರುವ ಮಕ್ಕಳನ್ನು ಶಾಲೆಗೆ ಸೇರಿಸುವುದು.
(2) ಗ್ರಾಮದ ಮಕ್ಕಳ ಕಲಿಕೆಗೆ ಪ್ರೋತ್ಸಾಹ ನೀಡುವುದು
(3) ಈ ಕಾರ್ಯಕ್ರಮದ ಅನುಷ್ಠಾನದಲ್ಲಿ ಗ್ರಾಮಸ್ಥರನ್ನು ತೊಡಗಿಸಿ ಶಾಲೆಗಳು ಸಹಕರಿಸುವುದು

ಸಂಪನ್ಮೂಲಗಳ ವಿತರಣೆ ಮತ್ತು ವೆಚ್ಚ   ಒಟ್ಟು ವೆಚ್ಚ 40,000

ಬಾಬ್ತು	ಗ್ರಾಮಸ್ಥರು	ಸರ್ಕಾರ	ದಾನಿಗಳು	ಒಟ್ಟು ವೆಚ್ಚ
ಪೀಠೋಪಕರಣ	30×40 (ಜನ)			10,000
ಶೌಚಾಲಯ ಕಟ್ಟಡ	5000	2000		7,000
ಸಾಮಗ್ರಿಗಳು	[illegible]			10,000
ಶ್ರಮದಾನ	ಗ್ರಾಮಸ್ಥರು			5,000
			8000	8,000
				40,000

ಯೋಜನೆಯ ಅವಧಿ

ಅನುಷ್ಠಾನ. (1) ಗ್ರಾಮ [illegible] ಜೊತೆ ಚರ್ಚೆ (15 ದಿನಗಳ ಒಳಗೆ)
(2) ಗ್ರಾಮಸ್ಥರೊಡನೆ ಚರ್ಚೆ

ಜವಾಬ್ದಾರಿ ಹಂಚಿಕೆ. ಸಂಪನ್ಮೂಲ ಕ್ರೋಢೀಕರಣಕ್ಕೆ 8 ಮಂದಿ ಗ್ರಾಮಸ್ಥರ ಗುಂಪು
ಸರ್ಕಾರ ಜೊತೆ ಸಂಬಂಧ - ಊರಿನ ಮುಖಂಡರು & ವಿದ್ಯಾವಂತರು

ಉಪನ್ಯಾಸ:

1. 2 ತಿಂಗಳು [illegible]
2. 2 ತಿಂಗಳು [illegible]
3. 2 ತಿಂಗಳು [illegible]

ಪ್ರದರ್ಶನ ಕಾರ್ಯಕ್ರಮ

1. [illegible]
2. [illegible]
3. [illegible]

ಪ್ರತಿ 15 ದಿನಗಳಿಗೊಮ್ಮೆ [illegible].

ವಿಳಾಸ

1) GOPINATH K N
Asst Co ordinator UT & I G P
A. P. H
Hinnur Road
Lingaraj pura
Bangalore 84.

2) Venkatesh H S
I. Y. D.
Doddasaggere - post
Koratagere - Tq
Tumkur - Dt.

3) [illegible]
[illegible]
[illegible] - ತಾ.
[illegible] ಜಿಲ್ಲೆ.

4) Premalatha
Dakshata trust
Ashok Road
Belvai

5) N. M. Naik.
Specialist (ISARD)
Institute for studies on Agriculture and Rural development.
Poona - Banglore Road.
DHARWAR 580008.

ಯೋಜನಾ ಪತ್ರ

ಹಳ್ಳಿಯ ಹೆಸರು ಮಾಚನ ಹಳ್ಳಿ

ಜನ ಸಂಖ್ಯೆ 600

ನಮ್ಮ ಹಳ್ಳಿಯ ಎಲ್ಲಾ ಜನರನ್ನು ಸಭೆ ಸೇರಿಸಿದಾಗ ಹಲವಾರು ಸಮಸ್ಯೆಗಳು ಕಂಡು ಬಂದರೂ, ಅದರಲ್ಲಿ ಮುಖ್ಯವಾಗಿ ಕುಡಿಯುವ ನೀರಿನ ಸಮಸ್ಯೆ ಕಂಡು ಬಂತು. ಬಹುಮತದಿಂದ ಈ ಸಮಸ್ಯೆಯನ್ನು ಬಗೆಹರಿಸಲು ಬಹುಮತಕ್ಕೆ ಬರಲಾಯಿತು.

ಇದಕ್ಕೆ ಬೇಕಾದ ಸಂಪನ್ಮೂಲ ಪಡೆಯುವ ವಿಧಾನ

① ಶ್ರಮದಿಂದ

② ಗ್ರಾಮಾಭಿವೃದ್ಧಿ ಸಮಿತಿಯಿಂದ

③ ಇತರೆ ಮೂಲಗಳಿಂದ

ಇದರ ವೆಚ್ಚ ನಿರ್ಣಯ ಸಭೆಯಲ್ಲಿ ಕ್ರೋಢಿಸಲಾಯಿತು.

ಒಟ್ಟು ವೆಚ್ಚ 15,000=00

ಕ್ರೋಢೀಕರಣದ ವಿಧಾನ

ಶ್ರಮದಿಂದ 3000 ರೂ

ಸರ್ಕಾರ ಸಮಿತಿಯಿಂದ 10000 ರೂ

ಇತರ ಮೂಲಗಳಿಂದ 2000 ರೂ

ಇದನ್ನು 1 ತಿಂಗಳಲ್ಲಿ ಕ್ರೋಢಿಸಬೇಕೆಂತ ತೀರ್ಮಾನ ತೆಗೆದು ಕೊಳ್ಳಲಾಯಿತು. ಇದರ ಮೊದಲ ಕಂತನ್ನು 1 ತಿಂಗಳೊಳಗಾಗಿ ಮಾಡಲು ತೀರ್ಮಾನ ಕೈಗೊಳ್ಳಲಾಯಿತು. ಇದಕ್ಕೆ ಸಂಬಂಧಪಟ್ಟ ಎಲ್ಲಾ ಇಲಾಖೆಯ ಅಧಿಕಾರಿಗಳನ್ನು ಭೇಟಿಯಾಗಿದ್ದು, ಅವರ ಅನುಮತಿ ದೊರೆತಿದೆ.

ಸಭೆಯ ತೀರ್ಮಾನದಂತೆ, ಮತ್ತು ಅಧಿಕಾರಿಗಳ ಅನುಮತಿಯ ಮೇರೆಗೆ 29-7-95 ಸಂಜೆ 4 ಗಂಟೆಗೆ ಕೆಲಸ ಕೈಗೊಳ್ಳಲಾಗಿದೆ.

~~ಈ~~ ತೀರ್ಮಾನವನ್ನು ದಿನಾಂಕ 29-6-95 ರಂದು ನಡೆದ ಸಭೆಯಲ್ಲಿ ಈ ನಿರ್ಣಯ ಕೈಗೊಳ್ಳಲಾಯಿತು. ತಕ್ಕ ಪತ್ರಗಳ ಹೊಣೆಗಾರಿಕೆಯನ್ನು ಸಭೆಯ ನಾಯಕರಿಗೆ ತಿಳಿಸಲಾಗಿದೆ

ಊಮಳಿ ಪಿನಪ್ಪರ ದಳ್ಳ. - -1-

ಈ ಹಳ್ಳಿಯ ಜನರು ಬೇರೆಡೆಗೆ ಹೋಗಿ ಅವಶ್ಯಕವಾದ ಸಾಮಗ್ರಿಗಳನ್ನು ಕೊಂಡು ತರುವುದನ್ನು ತಪ್ಪಿಸಲು ನ್ಯಾಯ ಬೆಲೆ ಅಂಗಡಿಯೊಂದನ್ನು ತೆರೆಯಬೇಕೆಂದು ಯೋಚನೆಯನ್ನು ಮಾಡಿದ್ದೇನೆ. Friday 15-96

ಮಾನವ ಸಂಪನ್ಮೂಲಗಳು:- ಜನಸಂಖ್ಯೆ 2000 ಜನ

1. ಯುವಕರು - ಸಂಘಟನೆ,
2. ಕಾರ್ಮಿಕರು - ಶ್ರಮ
3. ಜಮೀನ್ದಾರರು, ಸಂಘ ಸಂಸ್ಥೆಗಳು. ಬ್ಯಾಂಕ್. ದಾನಿಗಳು, ಹಣಕಾಸು
4. ಸರಕಾರಿ ಅಧಿಕಾರಿಗಳು. ಗ್ರಾಮಪಂಚಾಯ್ತಿ. ರಾಜಕೀಯವ್ಯಕ್ತಿಗಳು
 - ಪ್ರಭಾವ ದಾಖಲೆ ಸಾಮಗ್ರಿಗಳು.

ವಸ್ತು ಸಂಪನ್ಮೂಲ:-

ಸರ್ಕಾರದ ಜಾಗ

1. ಸ್ಥಳೀಯ ಸಾಮಗ್ರಿಗಳು - ಇಟ್ಟಿಗೆ, ಕಲ್ಲು, ಮಣ್ಣು, ಸಿಮೆಂಟ್.
2. ಪಟ್ಟಣದಿಂದ ತರಿಸಲು ಸಾಗಣೆ ಸೌಕರ್ಯ - ಸಂಗ್ರಹ.
3. ಸ್ಥಳದಿಂದ ಅಂಗಡಿಗೆ ಬೇಕಾದ ಸಾಮಗ್ರಿಗಳನ್ನು ತರುವುದು
 ಇವೆಲ್ಲದರ ವಿಶ್ಲೇಷಣೆ

ಗ್ರಾಮ ಸಭೆ - minutes.

1. ಗ್ರಾಮ ಸಭೆಯ ತೀರ್ಮಾನದ ಮೇರೆಗೆ ತಿಳಿದು ಬಂದದ್ದು ಏನೆಂದರೆ ಆ ಗ್ರಾಮಕ್ಕೆ ನ್ಯಾಯ ಬೆಲೆ ಅಂಗಡಿಯೊಂದು ಪ್ರಮುಖವಾದ ಅವಶ್ಯಕತೆ.

NET WORKing. - ಸಂಪರ್ಕ

1. ಊರಿನ ಮುಖಂಡರು
2. ಗ್ರಾಮಸಭೆ
3. ಸರ್ಕಾರಿ ಅಧಿಕಾರಿಗಳು
4. ಬ್ಯಾಂಕ್
5. ಸ್ಥಳೀಯ ರಾಜಕೀಯ ವ್ಯಕ್ತಿಗಳು.

Report of the Village-level training programme at RORES, Rawnipally.

Date : 12th June 1995.
Training conducted by : Dr. SPT
No. of participants : 50.

To sustain the health programmes being organised by the R.O.R.E.S project, it was decided to promote the concept of health - prevention, promotion and curative aspects, and revitalising the herbal / home remedies to the villagers directly. To make the ~~slogan~~ idea, 'People's Health in People's Hands', a realistic one, three members from each village were identified for a unique training programme. Mr. P.S. Reddy, N.P. the Project Director introduced the rationale behind the training programme to the 50 odd group of men and women. He briefed them about the interventions RORES has undertaken for the past one and a half years in areas of health, promotion of herbal remedies for common ailments etc. The motivated villagers were asked to be part help in this experiment. The new activities to be undertaken by the village group could be made participatory by integrating it with other Sangha activities.

Training session -
11.00 a.m - 1.00 p.m.
2.30 p.m - 4.30 p.m.

The day's training covered almost all aspects of health and development that was planned to be completed in two

days. The general observation was that the participants had a good basic understanding about health. Their previous knowledge helped in the smooth and fast transfer of knowledge. The group also participated well in the discussions, lot of queries were raised.

The training focused on knowledge of types of diseases/sickness, - how it spreads, signs & symptoms of the disease & simple, home remedies.

Apart from these, inputs were given in areas of Nutritio Water & Sanitation. The group consequently expressed some practical difficulties in implementing these sanitation programmes - more of this will be discussed in the next month's training.

Topics covered -

- ✱ Concepts of Health and Disease
- ✱ Modes of disease transmission - listing of the air-borne, water-borne diseases.
- ✱ Nutrition.
- ✱ Water & Sanitation.
- ✱ Specific diseases - Tuberculosis
  - Fever
  - Gastro-intestinal problems (diarrhoea, vomiting etc)
  - Upper respiratory problems (cough).
  - Typhoid
  - Asthma

There was a sharing of the participant's knowledge in treating the above problems through various herbs.

Contd - 2

Contd -

The second day's session was postponed to the next month as some participants expressed inability to attend due, to the Weekly Village Shandy (Sante).

Planning - What are the existing records maintained

26/9/95

Meeting with the health workers (staff)

Review:

- Baluadi - nutrition food - MCH - Mother's day. Care of pregnant women - Breast milk - Immunization - Growth monitoring chart.
- Herbal medicines - training
- Referral of chronic cases.
- Environmental sanitation, water, pollution etc - health education.
- List of gynaec pbms. - tonic - improvement in general health of women - some cases operated.
- Some pbms still persisting - ex. white discharge.

Tonic - Miracles - Very good.

- Kitchen garden - Nutrition - Baluadi.

Contri to Baluadi being ~~motivated~~ initiated at Sangha mtgs, how can a community be made to recognise the Baluadi functioning as an important part of dev?

Methods & Techniques of working with People

Street theatre, help of mass media for promotion of herbal medicines!

School Health
- Possible?
- Survey of schools & teachers. Contact with suitable teachers
- Class-wise curriculum.
- Trial with 1 Govt school, 1 pvt school.

Action plan for the next 3 months.

1 ಚಮಚ ಪುಡಿ, ~~1 ಲೋ~~ 1 glass concentrated juice +
" " ಜ್ಯೂಸ್ } + 1 kg jaggery (ಬೆಲ್ಲ)
" " ಬೆಲ್ಲ.

Contact VHAK for Kannada materials - S.H.

- Action plan for next 3 months -

Balwadi centres

1. Nutrition - Balwadi centres - once in a month Growth monitoring.
2. Immunization - what coverage? why no coverage?
3. ANC & PNC health edu for balwadi teachers
4. Vegetables - acquiring from villagers.

Environmental sanitation

1. Activity in 2 villages with the help of Gram Panchayat.

Nutrition -

1. Food for the very poor - chicken (not feasible)
2. Kitchen garden

Gynaec problems -

1. Regularise usage of medicine
2. Follow-up with the operated patients.

To,

The Principal,
The National College,
Jayanagar,
Bangalore.

Greetings from CHC!

Dear Sir,

This is with reference to the telephonic conversation last week.

As per your suggestion, I have listed down a few well-known personalities working in various areas of Social Welfare and Development. They can be contacted directly, if not possible, ~~arrange~~ me, at CHC would be glad to help you do the same. ~~We are~~

Do, let me know, if any other help is required from my end.

~~Yours~~ With warm regards,

Yours sincerely,
Anjana Srinivas

List of Contact Persons.

Contact Person & Address	Area of Specialization
1. Dr. H. Sudarshan, Vivekananda Girijana Kalyana Kendra, B.R. Hills - 571313, Via Chamarajanagar, Mysore District.	Tribal Welfare.
2 Dr. Gopal Dabade. 57, "SONI", Tejaswinagar Dharwad - 580002.	Rational Use of Medicines. (Has filed a Supreme Court Public Interest Litigation against certain MNCs). Part of Drug Action Forum-Karnataka
3. Dr. Shirdi Prasad Tekur. Community Health Cell. 367, "Srinivasa Nilaya", Jakkasandra, I Block, I Main, Koramangala Bangalore - 560034. Ph. No. 5531518.	Community Health and Traditional Medicines.
4. Mr. Sundaresh Pradhan. Bangalore Esperanto Centre No. 94, 24th Cross, 3rd Block East, Jayanagar - 560011. Ph. No. 6632914.	ESPERANTO. (Universal Link Language)
5. Dr. Ananthu & Dr. Jyothi NAVADARSHANAM, A-4, Whitefield Village, Whitefield, Bangalore	Organic Farming/ Sustainable Development

6. ~~Dr.~~ Mr. D.M. Naidu.
General Manager (Services),
The Association of the Physically Handicapped,
Hennur Road, (Kingarajapuram),
St. Thomas Town P.O.,
B'lore - 84.

Rehabilitation of the Physically Handicapped.

7. ~~Dr.~~ Ms. S. Suchasita Eashwar.
Exec. Director,
MADHYAM COMMUNICATIONS.
~~No. 1, 10th Cross, 10th Main, Vasantnagar, B'lore - 52.~~
No. 59, Millers Road, Benson Town. B'lore - 46.

Communications.

8. Dr. C.M. Francis
CHC.
(Address)

Time management. Management.

9. Mr. Kakshapatti / Ms. Nandana Reddy.
Concern For Working Children.
303/2 K.B. Shastrinagar,
Vinayapura Post.
Annasandrapalya,
B'lore - 17. Tel. 5275258.

Street Children & Child Labour.

10. Mr. S. Manjunath.
CIVIC - Co-ordinator.
(Citizen's Voluntary Initiative for the City).
C/o the B'lore General Education Trust
No. 25, II nd Floor, IV th Cross, Malleswaram
B'lore - 03. Ph. 366841.

11. Dr Veda Zachariah /
Dr. Babu Zachariah.
No. 47, KHB Colony,
Koramangala 8th Block,
Bangalore - 560034.

Sex Education /. School Health / Adolescent Education.

12. Mrs. Indumathi Rao.
Project Director,
Seva - in - Action,
No. 16, 11th Main,
4th Block, Jayanagar,
B'lore - 11.

Disability - Care and Rehabilitation.

13. Mr. Venkatesh,
Executive Director,
Action on Disability & Development * India,
No. 571, 17th Cross.
5th Main, 2nd Stage,
Indiranagar,
B'lore - 38.

Disability - Visual.

14. Dr. B.S. Paresh Kumar,
No. 27, Pattalamma Temple Street,
Basavangudi,
B'lore - 04.

Social Action.
(Ex - Student of Navé College).
Reader - Mysore Univ.

15. Dr. Srinivasa Murthy.
Head, Dept. of Psychiatry
NIMHANS,
Hosur Road, B'lore.

Mental Health in India.

16. Dr. Vanaja Ramprasad,
839, 23rd Main, 2nd Phase,
NAVDHANYA
J.P. Nagar, B'lore - 78.

Bio-Diversity/
Sustainable Agriculture

17. Dr. Srilatha Batliwala.
WOPRA Unit,
National Institute of Advanced Studies
Indian Institute of Science Campus.

Action Oriented Research.

18. Dr. Inamdar.
Principal, The Valley School.
'Harivanam',
17th K.M. Kanakapura Road,
Thatguni Post,
B'lore - 560062.

Educationist.

19. Dr. R. Nagarathna.
Director
Vivekananda Kendra Yoga
Research Foundation.
No. 9 Appajappa Agrahara
Chamarajpet
B'lore - 18.

Yoga therapist/
Nature Cure.

20. Mr. Y.G. Muralidharan.
CREAT Consumer Rights, Education
& Awareness Trust
239, 5th C Main, Remco Layout,
Vijayanagar,
B'lore - 40.

Consumer Awareness

21. Dr. Anila Ganesh / Dr. Arun Kotenkar
SMILE/SAMVADA.
3/2, 1st Cross,
Annapurna, Ph.
Sudhamnagar
B'lore - 27.

Student's Participation in Rural & Urban Community Development.

22. Mrs. Rukmini Krishnaswamy,
Director,
Spastic Society of India,
No. 31, Old Bimanangala Village,
5th Main, Indiranagar, 1st Stage,
B'lore - 38.

23. Mr. Soloman. J.D.
Movement For Alternatives & Youth Awareness.
4.38, 1st Floor, 19th Cross. (MAYA)
I & III Block East.
Opp Swimming Pool, Jayanagar
B'lore - 11. Ph. 6639857/6632615.

[redacted]

Mr. Somanath Nayak.
Nagarika Seva Trust,
Guruvayanakere.

Greetings from CHC!

With due apologies for the delay in thanking you for the hospitality extended to us ~~during~~ during our stay at Guruvayanakere we thank you immensely for the 3-day association with ~~NST~~ NST, Guruvayanakere.

It was indeed very satisfying & stimulating to give some health input to your group of farmers.

~~We expe~~ Since a month has ~~elapsed~~ elapsed we would like to be informed of the developments.

~~Our~~ regards to ~~all~~ the NST gp.

Specially regards to ~~Mrs~~ your family member

Thank you

Yours sincerely
(Dr. A.R. Sreedhara)

Encl: A report of the training prog held from 6th Nov to 8th Nov 95.

TRAINING AT NAGARIKA SEVA TRUST – 6th, 7th, 8th Nov '95

CHC conducted a three day training for initiating Comm. Health activities for Nagarika Seva Trust, Guruvayanakere from 6th to 8th of Nov '95. CHC was represented by Kum. A.S and Dr. A.R.S.

The trainee's gp comprised of Anganwadi teachers, Panchayat members, Non Formal Educators, Gram Sevikas, Teachers, Volunteers in ~~Employ~~ Envt. awareness, Mahila Mandal Sec, staff of NST and ~~tea~~ tailoring teachers. The total strength of partic were 60 on each of the 3 days.

The methodology followed included –
Lectures, Group Discussions, Games, Videos, A-V aids, & low-cost communication aids (like flipcharts & posters)

Day One (6/11/95)

Day one started with the formal intro of the CHC trainers & trainees. After the initial discussions wherein the expect were addressed & an agenda was formulated.
Concepts of HEALTH with all the parameters were discussed –

→ Defn of health
→ Concept of well-being
→ How to maintain health
→ Ill-health – Disease
→ Common problems (local)
→ Levels of Prevention
→ what is Community ~~Organisation~~
→ C.O.

→ C·P·
→ Rational Drugs & Use

Games played – Broken Squares
Pulley, Ring, Cards, 'Know Your Community'.

Day Two. (7/11/95)
The day started with trainees' report of Day One's sessions. The topics inputs given were on Food & Nutrition –
→ Nutrients,
→ Growth, Energy, Protective foods, Body building
→ Anaemia & malnutrition –
→ Simple household tips.
→ MCH.

This was followed by viewing the video on Pregnancy & Safe Motherhood. Discussions on Mother & child Health were followed later.

'Ramakka's story' was screened next & interesting discussions ensued. This gave on the small group discussions encompassed the foll pts –
- Community
- C·O, &
- C·P
- Economic Status, Socio-Eco status
- Utilisation of health svg – Empowerment.
- Probs relating to trans & communication
- Empower Probable solutions ?.

Personal Hygiene & Communicable diseases (A, H, E) were also discussed.

Day three (8/11/95)

After day two's reporting, the days session started with a brief input on 'Health Education'. Creating low-cost communication materials for local pbms with locally available resources were highlighted.

An input on 'Documentation' was also given, emphasizing on →

- Record keeping of the herbal remedies practised.

A lot of stimulating discussions were held on Govt Health Services and Govt Health Progeammes. Doubts about Immn were clarified.

An exercise on Community mapping helped the gp to identify Comm Resources, based on which the sub-gps were able to plan for diff contingencies. This exercise helped the partis to effectively discuss devp issues with the NST. Planning & Planning Cycle were discussed after the gp presentations.

Evaluation of the trngy:

1. On the whole, the participants found the 3 day trngy to be very helpful.
2. The use of games & other methodologies were well appreciated & found to demystifying the complex, technical health issues/terminologies.

However, they expressed a desire to know more about -
- Herbal medicine
- Acupressure
- First aid

Our impressions

The 60 odd trainees came from varied background which added lot of stimulation to the whole learning process. The various dimensions of each issue came alive. Many of the trainees' were well-informed & conscientized with contemporary issues in Health & Devp. The mingling nature of the trainees broke many barriers. It was observed that NST has set up a high value-based institution & initiated ~~is~~ work.

The CHC team experienced a fruitful & stimulating 3-day interaction with the NST gp.

Future plans -

It was agreed that after getting the basic inputs, each volunteer would try & formulate a plan of action to work in the health field. A follow-up meeting would be fixed at the end of 3 months.

MONTHLY MEETING AT RORES, GOWNIPALLY – REPORT:

DATE : 24th NOVEMBER 1995.
Dr. SPT, Dr. T.N.M, A.S.
VENUE : GOVT. DEGREE COLLEGE, GOWNIPALLY
NO. OF VOLUNTEERS ATTENDED : APPROXIMATELY 35.

→ The session began with a review of the past ~~one~~ two months experiences of the volunteers. The most common problem identified ~~in the past two months~~ since the last meeting was WORMS - tapeworms as well as pinworms
– It was emphasized that the volunteers who are also Sangha members have to make best use of the Sangha meetings to share health messages. ~~to Mr. Reddy~~.
→ A shift from curative health care to preventive health care necessary.
→ Action plans from Sanghas asked for. Volunteers decided to conduct one day Health Awareness 'melas' in their villages. Along with the RORES staff ~~they~~ the Sanghas would organise for street plays, film shows, 'kaaekale' and in between small inputs on health by ~~the~~ Dr. SPT & Dr. TNM. Planning for this progeamme was done entirely by the volunteers. Dates fixed are as follows:

1. Bykotoor and Gandarajapalli – (Dec 9th)
2. Korokanapalli (Dec 15th)
3. Cheelepalli (Dec 16th)
4. Digopapishettypalli & Egopapishettypalli (Dec 20th)
5. Morampalli (Jan 4th)
6. Kotayalyam (Jan 5th)
7. Byraganapalli (Jan 6th)

Lists of topics to be covered:
– Herbal remedies.

- Causes & prevention of diseases.
- Precautions to be taken.
- Problems related to women (gynaecology) and children (mixed reactions to this topic among the group).
- Common ailments, treatment.

→ ~~Importance~~ An analysis of the effectiveness of the treatment given by the volunteers was calculated approximately.

Ailments	No. treated.	No. cured.
1. Stomach ache/worms	6	3
2. Old cases	10+2	9+2
3. Scabies	10+5+6+4	10+5+3+3
4. Cough, cold...	2+3	2+3
5. Fever	2+4+4+4	2+3+4+4
6. Headaches/migraine/heaviness of the head	2+3+4+3+1	2+3+4+3+1
7. Diarrhoea	5	5
8. Urinary problems	3	3

4. ~~The cost saved (money)~~ Cost analysis -

The amount saved by the villagers taking herbal medicines as an alternative to allopathic medicines worked out to Rs. 3700 approximately. This included the transportation cost, consultation fees, medicines and the daily labour lost.

The volunteers ~~were very glad to Discuss this achievement~~ felt confident and motivated.

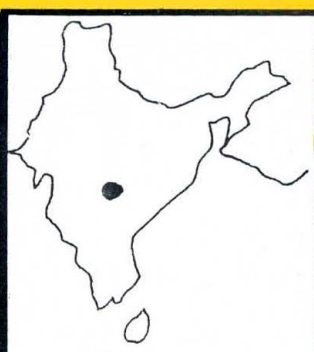
→ Common ailments during winter was listed out. Dr. T.N.M gave some tips on preventive measures to be adopted during this season (Diet, warm clothings, etc)

→ The famous "iron tonic" made out of drumstick leaves and jaggery has become quite famous. RORES staff have

manufactured about 300 bottles and distributed to anaemic mothers and pregnant women. The volunteers were ~~asked~~ taught to manufacture this tonic and educate their ~~the~~ people.

→ The health co-ordinator of RORES was asked to conduct a ~~follow up survey~~ authentic community study on the ~~95~~ women (from 30 villages) suffering from Gynaecological problems. An input was given to them earlier and the RORES staff had ~~been~~ helped in the treatment. Out of the 95 women, 60 got cured in a span of 3 months. 35 needed surgical interventions (most of 'em being cases of prolapsed uterus). Of the 35, ~~29~~ are cured, 5 not yet cured and 1 suffering from cancer of the cervix.

→ In the post-lunch session, in the discussion with the staff of RORES, Dr. SPJ suggested that since the health activities are in the third leg of intervention, (i.e from ~~of~~ inputs to RORES staff b) to identification of 3 volunteers from the village Sanghas c) to preventive and promotive action to the villagers directly) 'Health Committees' could be formed as a follow-up of the Health mela. These health committees could gradually be empowered to tackle common health problems on their own. These committee members ~~needs~~ may not be Sangha members alone.



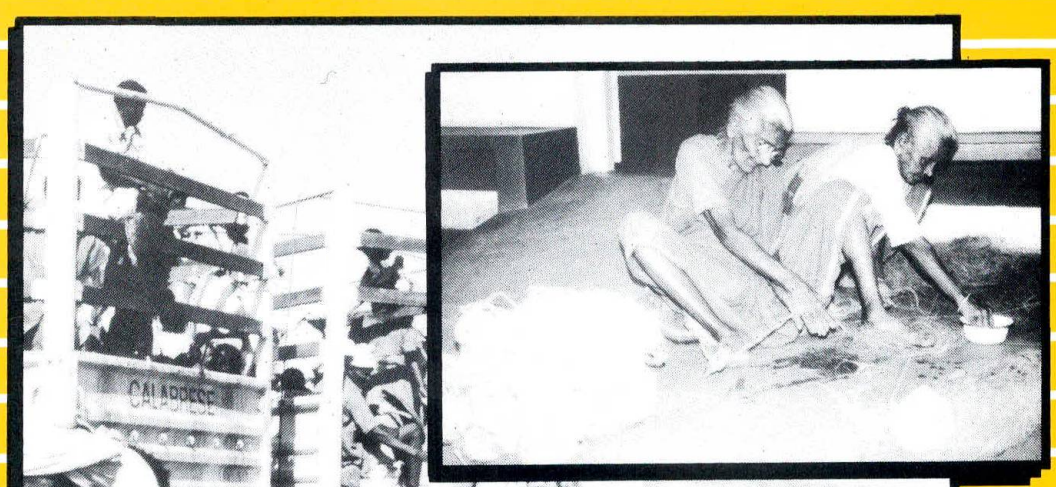
LEPROSY HOUSING PROJECT,
BETHANY COLONY, BAPATLA,
ANDHRA PRADESH, INDIA

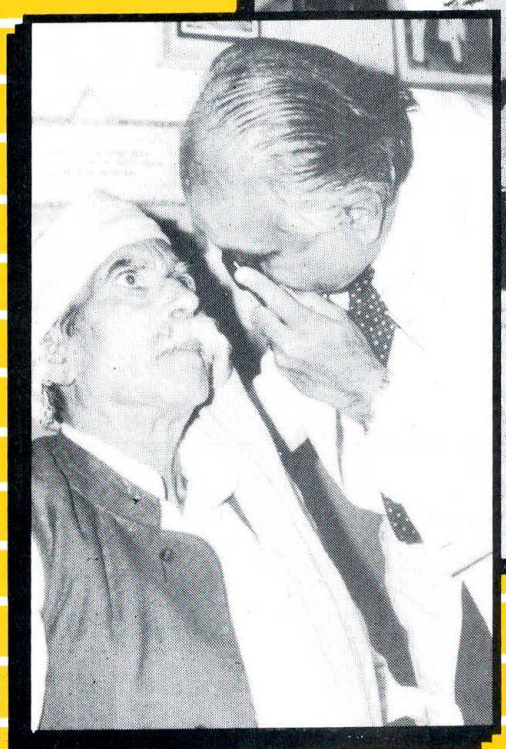
Urban Destitution/Health

AS/IND/122/EJ

Help the Aged

OVERSEAS PROJECT INFORMATION





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Leprosy Housing Project, Bethany Colony,

Bapatla, Andhra Pradesh, India

Bethany Colony is a small settlement of leprosy affected families situated on the outskirts of Bapatla in the state of Andhra Pradesh in Southern India. The colony was first established in 1933, although it was not until more recently that it began to take on its present shape of a village, rather than merely a collection of huts.

Leprosy sufferers were originally drawn to the area by a large leprosy hospital nearby. Once discharged from the hospital, they wre unable to return to their own villages as they were ostracised because of their disease and instead started their own settlement on derelict land next to the main East Coast railway.

As time has gone by, homeless leprosy sufferers have continued to settle at Bethany and some of the children of the original settlers have grown up as part of the colony. Although many of them do not suffer from leprosy themselves, they are nevertheless bound by the stigma of the disease and are unable to settle elsewhere as they are rejected by others.

Leprosy is a contagious disease, although the mode of transmission is not decisively known. There are several kinds of leprosy which differ in infectiousness and manifestation. Only a small proportion of people infected with the leprosy bacilli actually gets the disease. However, for those who do contract leprosy, regular drug therapy is essential to halt the progress of the disease, render the patients non-contagious and to ensure that they do not suffer the familiar progressive deformities.

In order to ensure that the leprosy patients at Bethany are able to receive the treatment they require, a clinic has been established in the heart of the community, making it easily accessible to the villagers. Leprosy patients from the surrounding area also receive treatment at the clinic. The clinic is managed by the villagers themselves, following appropriate training in the various skills required. Records are carefully kept and patients are monitored to ensure regular drug therapy. As there are no quick, visible results from the drugs, health education is vital to make certain that leprosy sufferers persevere with their treatment.

continued

One of the main problems facing the Bethany villagers is that they encounter great difficulty in securing employment outside the colony because of other people's fear of leprosy. Instead they have to beg in order to gain some form of regular income. Groups of villagers travel to the large towns on begging trips of several weeks, returning to Bethany when circumstances allow. Prolonged absences from Bethany mean that those suffering from leprosy may not be able to keep up the regular drug therapy they require.

In order to try and provide the means of earning a living for the Bethany villagers as many jobs as possible have been created within the village, although not sufficient yet to put an end to begging for everyone. There are limitations on the extent of labour which can be created for people with leprosy. Manual disabilities resulting from leprosy cover a wide spectrum and some jobs are therefore not suitable for leprosy patients. In spite of this, however, all jobs at Bethany are done by the villagers themselves. These include office work, weaving, shoemaking, animal care, as well as work in the school, the kitchens and the village shops. Over 100 women are employed in the weaving workshops, working in shifts to make beautiful bags which are in great demand.

Two Bethany men have recently been appointed as Managers to be trained in the administration of the colony, and another colony member is to be trained in social work later in the year.

Jacky Bonney, a British nurse who earlier worked at the nearby hospital, is the Administrator of the Colony. She wrote in a recent letter to Help the Aged, "The long-term vision of all Bethany's work being handled by Bethany people is beginning to take some physical form and I can hope that a vision may become reality".

A large number of the people living at Bethany are elderly and many of them suffer from severe disabilities, such as deformed limbs and blindness, caused by many years of untreated leprosy. They are unable to travel to the towns to beg because of their disabilities. Those with no family support are left destitute and have to rely on meals and free medical aid which are supplied at Bethany for elderly and infirm people. A few of the elderly people perform simple tasks in return for the food and a little pocket money.

The vast majority of the families in Bethany live in very flimsy dwellings, many of which have encroached on land which belongs to the railway. Some of the dwellings are situated just two or three metres from the main Madras to Calcutta railway line. The area is regularly hit by cyclones which sometimes destroy the Bethany dwellings, leaving the villagers homeless. Because of the stigma attached to leprosy, the villagers have nowhere to seek refuge when their homes are destroyed.

In spite of their depressing situation, there is a great community spirit amongst the Bethany villagers, who have made repeated attempts to improve the standard of their housing. In 1981, after protracted negotiation, they obtained from the local authority the right to 13 acres of land on which to build proper houses. However, the land they were given was unsuitable for the contruction of housing as the ground was very uneven.

continued

The Bethany villagers could not afford to have the land levelled themselves and therefore approached the local government for financial support, which they managed to secure.

In addition to paying for the land to be levelled, the government also agreed to contribute towards part of the cost of providing proper housing for the Bethany villagers, although it has been left up to the villagers themselves to find the remainder of the money required.

Since the traditional main source of income for the people of Bethany is from begging and this provides mere subsistence, the villagers are unable to donate even their time for the labour of building the new housing. However each family is giving a small sum of money each month towards labour costs, and those who are able to work are doing so at a lower rate of pay than imported labour.

In order to make up the remainder of the money needed to pay for the construction costs of over 300 houses, approaches have been made to charitable organisations for financial support.

Locally-based charities were unable to help, but Help the Aged has provided £14,754 and HelpAge India has also agreed to make a sizeable contribution to the programme.

Although Bethany Colony comprises all age groups, the combination of the grants from Help the Aged and HelpAge India make up 14% of the full amount of money required. This is commensurate with the percentage of elderly people who will benefit from the new housing at Bethany.

For further information, please contact:

Dee Sullivan
Press Officer

May 1987

DISASTERS
EMERGENCY
COMMITTEE

Secretariat:
9 Grosvenor Crescent
London SW1X 7EJ

Tel: 01-235 5454
Telex: 918657 BRCS G
Fax: 01-245 6315

EMERGENCY APPEAL FOR MOZAMBIQUE

INFORMATION SHEET

Six British charities launched a major appeal on June 24 for victims of war and drought in Mozambique. The Disasters Emergency Committee is appealing for funds for programmes in Mozambique and support for refugees from Mozambique in neighbouring countries.

Background

A tragic combination of war and natural disaster has brought the people of Mozambique to the edge of catastrophe. They are now suffering homelessness and destitution on a massive scale. The Mozambique Government estimates that, of a total population of 14 million, a third of the population is directly affected.

Parts of the north of the country can be reached only by air, other districts remain inaccessible. The focus of rebel activity shifts constantly and almost all the country's ten provinces have been affected.

War has forced people to flee their land and homes leaving crops untended. The conflict is regarded as part of a larger security crisis throughout the southern African region. Civilians have also been the object of attack, as have the country's essential services, key economic installations and transport networks. According to UN figures, 484 health posts have been destroyed since 1982 and safe drinking water is available to only 13% of the population.

Apart from displaced people within the country, over 460,000 people have crossed into neighbouring states in search of food and safety. Increasing numbers of refugees are arriving in Malawi, many in poor health. Since January more than 7,000 refugees have arrived along the Mazoe river in Zimbabwe.

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Tropical cyclones and drought have also taken their toll on the country's resources. The province of Zambezia, once considered the country's "bread basket" is now one of Mozambique's most stricken areas. From 1979-1984 the country was hit by drought for five years in a row and drought again struck southern provinces this year. Harvests of maize and rice, staple crops in Mozambique, have fallen sharply. The collapse of the country's market economy has been a disincentive to farmers to produce more than subsistence needs and has also contributed to the disastrous drop in food production.

The Country

Mozambique is a large country bordered by Zambia, Malawi, Tanzania, South Africa, Swaziland and Zimbabwe with 2,470 km of coastline on the Indian Ocean. (See map). The largest city is the capital, Maputo, (formerly Lourenco Marques) on the coast. The climate is tropical in the north and sub-tropical in the south. Mozambique gained independence from Portugal in 1975.

Needs

The Mozambique Government has established a major relief effort through the Department for the Preventon and Combat of Natural Disasters (DPCCN) but much more help is needed. The UN Food and Agriculture Organisation (FAO) conducted a crop assessment mission in March/April 1987. Their provisional estimate of food aid required for the year to April 1988 is 674,000 tonnes, plus other food requirements of 90,000 tonnes. The UN system has also identified urgent requirements in other essential areas:

* Health
* Water Supplies
* Agriculture
* Transport

The UN system set up a special emergency office in Maputo and earlier this year launched an appeal to governments for US$ 244 million. The British Government has offered £31 million both as emergency aid (including up to 30,000 tonnes of food) and help for long term development) through voluntary agencies and government channels

Disasters Emergency Committee

DEC agencies have been present in Mozambique for a number of years through international networks, local partners and field offices. In response to the growing crisis they have stepped up relief within Mozambique and for refugees over the borders.

The following gives a summary of the work of each agency for the people of Mozambique. Further details can be obtained from individual agencies.

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BRITISH RED CROSS, 9 Grosvenor Crescent, London, SW1X 7EJ, Telephone 01-235-5454

The British Red Cross supports its sister society the Mozambique Red Cross; both are part of the International Red Cross movement. Red Cross action in Mozambique includes a prosthetics programme for war amputees, among them children, and distribution of relief supplies to 40,000 displaced people in Zambesia and 125,000 people in urban areas. A British Red Cross delegate is in Mozambique identifying priority needs. The British Red Cross has chartered a ship to carry medical supplies, food and tents up the Mozambique coast. It has already shipped out clothes for 10,000 people. The Red Cross network also helps refugees from Mozambique in all five neighbouring countries.

CATHOLIC FUND FOR OVERSEAS DEVELOPMENT, 2 Garden Close, Stockwell Road, London, SW9 9TY, Telephone 01-733-7900.

CAFOD works through Caritas Mozambique, the Catholic Church agency for relief and development and one of the longest-established agencies in the country, and is able through national, regional and locally-based organisations to reach communities not targeted by the government - for example, displaced people who have no ration cards. Relief goods are brought in mainly from Zimbabwe and distributed through Caritas' local network of parishes. The main recipients are the old, the sick, children and pregnant and breast-feeding women. CAFOD also provides funds for programmes to help Mozambican refugees who have fled to neighbouring countries.

CHRISTIAN AID, 240/250 Ferndale Road, London, SW9 8BH, Telephone 01-735-5500.

Christian Aid funds the relief and development work of the Christian Council of Mozambique (CCM) which works with the Government's Department for the Prevention and Combat of Natural Disasters (DPCCN) in the provinces of : Maputo, Gaza, Inhambane, Manica and Sofala. Food, seeds, tools, blankets and soap are brought in by road or sea to Maputo and Beira. Through its sister organisation Christian Care in Zimbabwe, CCM buys food and other supplies for direct delivery to Tete province. In co-operation with other Christian Councils and agencies in the region, CCM is extending its programme to reach other northern provinces and in June 1987 appealed for USD4.5 million. Christian Aid contributed £350,000 to these programmes in 1986/87 and will be a major donor to following phases. It has provided an administrator for six months to work for CCM. Christian Aid also supports emergency programmes in all the five neighbouring countries with Mozambican refugees.

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HELP THE AGED, St. James' Walk, Farringdon, London, EClR OBE, Telephone Ol-253-0253

Help the Aged has a Zimbabwe based representative and from 1982-1986 provided drugs for distribution through the Christian Council of Mozambique. In 1987 the charity granted £60,000 for emergency relief - cloth, seeds, pullovers and blankets - distributed by the Zimbabwe - Mozambican Friendship Association (ZIMOFA) and Oxfam. Five thousand blankets have been shipped from the UK. Help the Aged has also made grants totalling nearly £40,000 to relief organisations in Zimbabwe, Christian Care and the Drought Operations Committee, to help elderly Mozambican refugees. The Charity has also employed an epidemiologist to study the needs of elderly Mozambicans and identify appropriate projects for it to support.

OXFAM, 274 Banbury Road, Oxford, OX2 7DZ, Telephone Oxford (0865) 56777

OXFAM opened a permanent office in Mozambique in 1983 and is involved in development programmes particularly in the north. Since 1984 OXFAM has funded substantial relief programmes and in 1986 the escalation of the war led to a sudden increase in the scale of operations, with £5.3 million allocated (in cash and in kind) over the first few months of 1987. OXFAM works through the agencies of the Mozambican Government, particularly the relief department, and has concentrated on provision of clothes, seeds and tools to the destitute in the provinces of Zambezia, Niassa amd Tete. An airlift is being organised (with Norwegian Redd Barna) to carry urgently needed supplies to remote areas, and a trucking operation is being organised in association with Band Aid.

THE SAVE THE CHILDREN FUND, Mary Datchelor House, 17 Grove Lane, Camberwell, London, SE5 8RD, Telephone Ol-703-5400

The Save the Children team of seven expatriates and 20 local workers has been working in Mozambique for three years. It has concentrated its £1.4 million programme of emergency aid in Zambezia, one of the worst hit provinces. This includes food, cooking utensils, seeds and farming tools and the transport to deliver those essentials to displaced families and those willing to look after lost or orphaned children. In addition SCF's long-term development work, essential to the rebuilding of the country's shattered economy, is running at well over £300,000 per annum.

Save the Children plans to spend money from the emergency appeal on the running costs of 25 trucks being shipped to Mozambique for emergency aid.

See over for details of how to make payment.

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If you would like to contribute to the Disasters Emergency Committee appeal for Mozambique, you may do so in any of the following ways:

- directly at any bank, post office or main building society
- by credit card, by telephoning 01-200-0200
- by sending a cheque or postal order to this address:
  Emergency Appeal for Mozambique
  PO Box 999
  London EC2R 7LD

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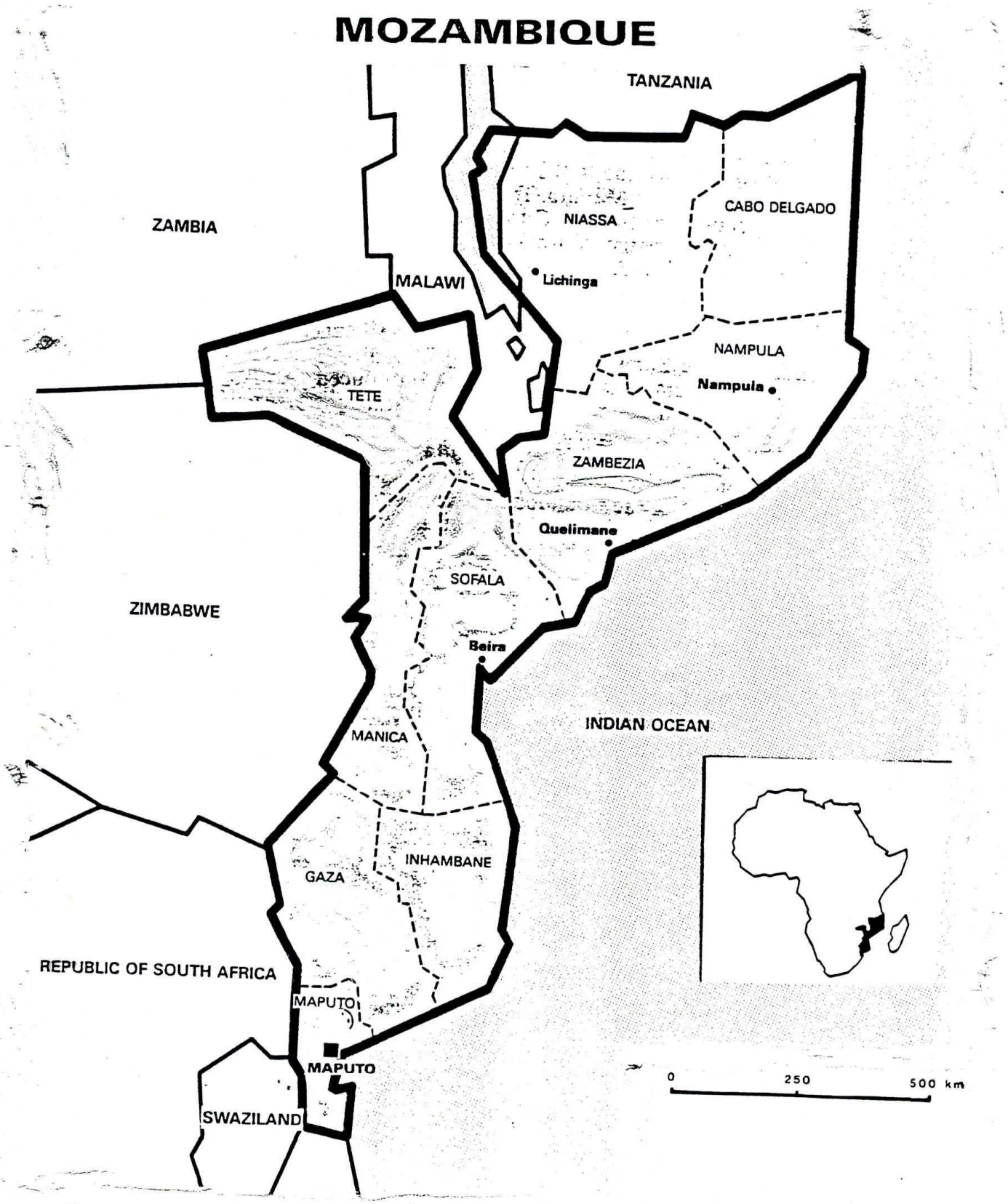
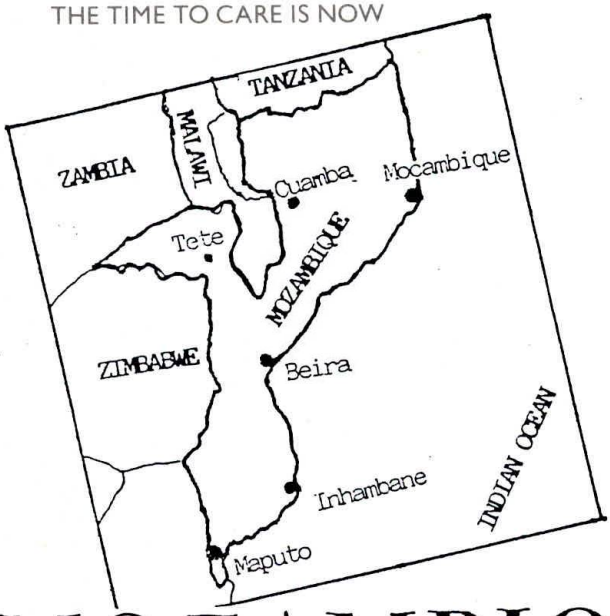


Help the Aged
THE TIME TO CARE IS NOW

St. James's Walk London EC1R 0BE
Telephone: 01-253 0253
Telex: 22811 HELPAG G

Patron: HRH The Princess of Wales

Help the Aged is a national charity dedicated to improving the quality of life of elderly people in need of help in the UK and overseas. We pursue this aim by raising and granting funds towards community-based projects, housing and overseas aid.



MOZAMBIQUE Emergency Report 2

The situation in Mozambique continues to worsen as the combined effects of war and drought drive more people from their homes, forcing many of them to abandon their livelihoods and all their possessions. Over one-third of Mozambique's fourteen million people are severely affected. Elderly Mozambicans are particularly vulnerable as the family support system on which they are dependent is breaking down under the effects of this destabilisation.

Over the past five years Mozambique has suffered a serious economic decline brought on by years of drought and MNR attacks on key industries, road and rail transport. Food production and essential services have been disrupted, resulting in widespread shortages of food, clothing and other basic items such as soap.

Recent visitors to Mozambique report that guerilla activity is increasing in the northern provinces of Mozambique. In Tete province it is becoming very dangerous to travel by road, and villagers in some northern areas are so terrified of rebel attacks in the night that they walk up to twenty kilometres to sleep in the nearest towns. There is little food in the area, and villagers have to eat their cash crops to survive.

Within Mozambique itself there are four million displaced people but no organised transit camps; those forced to leave their homes head for refuge in the 'secure' towns. People with relatives in towns stay with them - in some cases there are up to three families living in a house built for one.

Of the million or so Mozambican refugees in other countries some 80,000 are in Zimbabwe, 40,000 in camps. A fifth camp is being planned in the south.

Cathy Squire, Help the Aged's Asssistant Desk Officer for Disaster Response, returned last weekend from a visit to the Zimbabwe camps for Mozambicans to assess the situation. She reports that the camps are very isolated and that conditions are poor. The land may not be used for farming, and efforts to create an economy through skills training are severely limited because the locality is poor and there is not a large market for products. Some refugees work on the local commercial farms for starvation wages. Refugees who have been in the camps for some time are relatively well cared for, but the resources are inadequate to cope with the daily new arrivals. In the northern camp of Mazoe River Bridge up to forty refugees cross the border daily seeking shelter and security.

Describing the conditions of the new arrivals at Mazoe River Bridge, Cathy said, "The children were very thin and almost all of them had chest infections, colds and coughs. There were significant numbers of elderly refugees, and most of them were sitting around listlessly as there is nothing for them to do. As it is winter the nights are extremely cold with temperatures approaching zero. In many cases whole families have only a single blanket and have to sleep on the ground."

Kamil Piripiri and his wife Fania Sumbereru are both over 65 years of age, and lived in the Tete province of Mozambique as peasant farmers. Their two children who are married with families also live in the displaced people's camp in Nyamatikiti, northern Zimbabwe. Kamil and Fania left Tete in 1983 because of drought, hunger and the war. As peasant farmers they used to grow maize, sorghum and groundnuts. In the camp they grow tomatoes, paw-paw, and other green vegetables and fruit to supplement their daily diet of maize porridge (Sadza) with beans or with fish (Kapenta). They would like to return to Tete when the government of Mozambique is ready for their resettlement. They would need farming tools such as a hoe, axe, and spade, and seeds for at least the first year. They want to live independently of their children who have their own families to support.

Help the Aged has employed an epidemiologist on a short-term contract to study the needs of this group and to identify appropriate projects for the Charity to support. Help the Aged has a representative based in Zimbabwe, and from 1982 to 1986 provided drugs for distribution through the Christian Council of Mozambique. In 1987 the Charity has granted £60,000 for emergency relief - cloth, seeds, pullovers and blankets - distributed by ZIMOFA and Oxfam. 5,000 blankets have been shipped from the UK directly to the Mozambique Ministry of Health. Help the Aged has also made grants totalling nearly £40,000 to relief organisations in Zimbabwe, Christian Care and the Drought Operations Committee, to help elderly Mozambican refugees with shelter and clothing.

In 1963 the Disasters Emergency Committe (DEC) was set up to provide British aid agencies with a channel of co-operation for emergency relief overseas after large-scale disasters. Help the Aged joined the DEC in 1986 as an associate member.

The DEC launched its Mozambique appeal on 24 June 1987 with a four minute broadcast after the BBC '9 O'Clock News', and the ITN '10 O'Clock News'. On 25 June the appeal will also be broadcast after Radio 4's 'World at One' programme. The name of the appeal is 'Emergency Appeal for Mozambique', and the Post Office and all main banks will accept donations for it.

Help the Aged's share of the funds will be used for immediate relief programmes, such as the provision of food, clothing, seeds, soap and blankets for elderly Mozambicans. The Charity plans to support public health programmes and hopes to assist income-generating projects for communities supporting elderly people. Help the Aged will also support programmes through Mozambique's Ministry of Health.

For further information, please contact:

Dee Sullivan
Press Officer

24 June 1987

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MOZAMBIQUE

Emergency Report

Background

Over one-third of Mozambique's fourteen million people are seriously affected by war and hunger. Ten per cent of the population is over fifty years old. Many people are destitute, having been forced to flee their homes, are suffering from malnutrition and have little or no clothing.

The economic situation in Mozambique has been poor ever since the 1983-4 drought, but the sudden deterioration over the last six months is not principally due to drought but to the escalation of the South African-backed Mozambican National Resistance (MNR) activity. The rebels have been active mainly in the districts north of the Zambesi river, but especially in the districts bordering on Malawi. This consists of widespread attacks against population centres and sabotage. Villagers are attacked, crops and homes burnt, local government workers, teachers and health workers killed, and wells poisoned by dumping dead bodies in them. Villagers are forced to leave their villages and congregate in and around urban areas. Many have fled to Malawi, Zambia and Zimbabwe.

MNR guerillas systematically target key food and other industries, and disrupt road and rail transport with mine and rocket attacks. Agriculture employs nearly 85% of the labour force and provides the bulk of exports. The major products are cashew nuts, shrimps, cotton and maize. Industry accounts for only 10% of national income and is concentrated in agriculture processing and textiles, particularly in the Maputo region. Exports are mainly agricultural, but the largest single foreign currency earner has been remittances from miners working in South Africa, despite falls from this source following recent repatriations.

Trade has fallen sharply in recent years, having been severely disrupted by outdated equipment and by MNR activity destroying the country's transport system. Agricultural production has also dropped quite dramatically since 1981 due to droughts and MNR activity. Food shortages cause malnutrition, and the health services are unable to respond adequately. Supplies of many commodities - soap, clothing, seeds and tools, food, trucks - are scarce and difficult to distribute to areas in need, even when available, because of the danger of terrorist attacks. These attacks are a direct cause of the present famine and the reason for so many thousands of people having to flee their homes. The difficulties for relief agencies operating in Mozambique are exacerbated by the fact that MNR activity is directed at them. The overall situation is further aggravated by the drought in the southern provinces of Gaza, Inhambane and Maputo.

Over the past five years Mozambique has suffered a serious economic decline brought on by successive years of drought and flooding, by a lack of experienced managerial staff and inadequate capital investment, and above all by war and foreign destabilisation. If stability could be restored the country does have the resources to achieve steady growth. But any real progress will depend on peace, and the prospects for that in the immediate future are less than favourable.

Of the five million people seriously affected, one million are refugees in other countries - mainly in Zimbabwe, Malawi and Zambia - and four million are displaced within Mozambique, mostly in Sofala, Zambesia and Tete. Many of the displaced people are living in transit camps. Conditions in these camps are poor, with most people sleeping in the open and many suffering from malnutrition and disease.

Help the Aged in Mozambique

Help the Aged has a representative based in Zimbabwe, and since 1982 has provided the following assistance for Mozambicans in Mozambique:

1982	15 tonnes of used clothing donated to Ministry of Health for distribution
1983	Consignment of drugs to Christian Council of Mozambique for Minsitry of Health
1984	Consignment of drugs to Christian Council of Mozambique for Ministry of Health

1986 Consignment of drugs to Christian Council of Mozambique for Ministry of Health

The Charity has also assisted displaced Mozambicans in Zimbabwe:

1984 £4,000 to Christian Care for general relief programme

1984 £2,000 towards setting up the Drought Operations Committe

1984 £12,000 for general relief spent through the Drought Operations Committee

1984 £20,000 for general relief spent through the Drought Operations Committee

In 1987, Help the Aged has provided the following:

£10,324 on cloth, sewing kits and blankets purchased in Zimbabwe to be distributed by the Zimbabwe-Mozambican Friendship Organisation (ZIMOFA) in Tete

5,000 blankets to be shipped from the UK (about 4,000 already gone)

£15,076 spent on pullovers purchased in Zimbabwe, which Oxfam will distribute in Niassa

£10,000 spent on seed for Tete which will be distributed by ZIMOFA

£20,000 contributed to Oxfam's seed programme in Niassa

Because of the problems of communication it has been difficult to assess the numbers of affected elderly people there are. Often they are the 'hidden refugees' and go unrecorded by other agencies. Help the Aged has recently sent a representative to Zimbabwe to assess the actual numbers and situation of elderly Mozambicans.

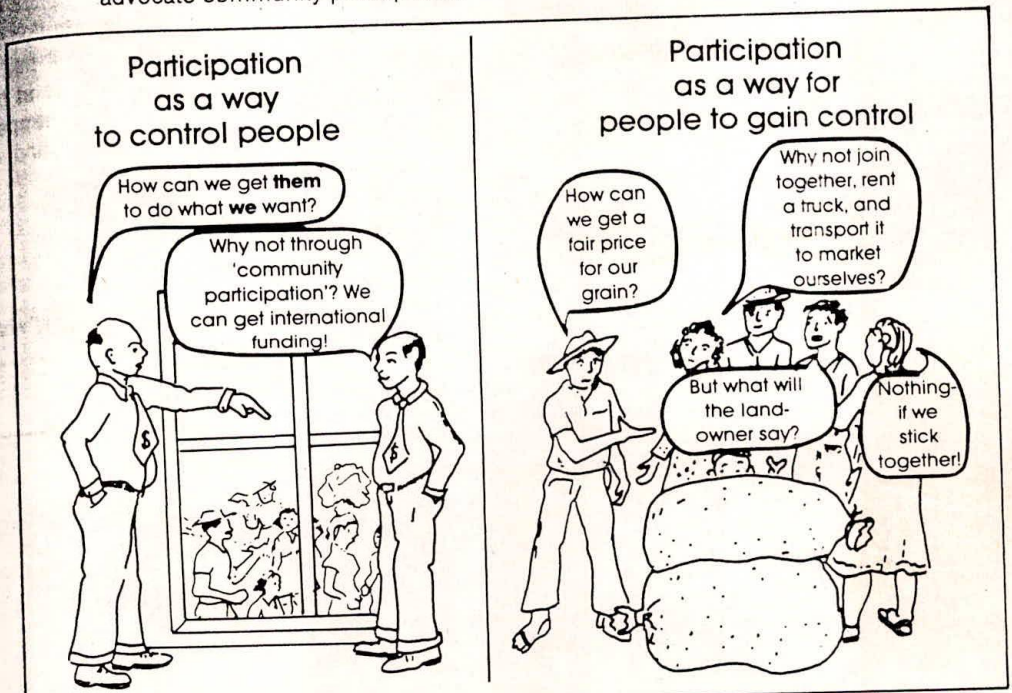
The problems of distribution to those in need which are caused directly by MNR acitivites mean that Help the Aged works very closely with other agencies operating in the area, such as Oxfam and ZIMOFA.

For further information, please contact:

Dee Sullivan
Press Officer

11 June 1987

A17. Werner & Bower caution us that there is often a sting in the tail when people advocate community participation:



Source: Werner and Bower, 1982:6-13

157, AICOBCO Nagar
BTM Layout, Madivala Post
BANGALORE 560068

Hope all is well. Pl. convey my regards to Rita, Nagaraj, Anthony, James & others. I remember all of them. Once met Chander on the road as we were riding.

With best regards
Sumangala

Sorry for the congested Post Card!

पोस्ट कार्ड POST CARD

Ms Anjana
COMMUNITY HEALTH CELL
367, Srinivasa Nilaya
Jakkasandra,
Main, I Block, Koramangala
BANGALORE

पिन PIN 560 034

Bangalore 68
29-6-95

Dear Aryana

Hope you were able to get back home easily the other day! I think I forgot the CHC's brochures & left them with you. Aryana, would you please do me a favour? I just cannot find time to take, more so as I have just joined APH & there is so much to do in the Communications Dept. There is a small book (like a hand book) in the CHC Library called "Managing Yourself" by Ken Cranikag. I am unable to find it in the shops. Would you please send me the name of the publisher so that I can ask St. Paul's Book Shop to get it for me. I would be highly obliged if you would do me this favour. You could drop a post card to the follg. address:

Backpage

WHAT earlier promised to emerge as a stable coalition has now started displaying cracks. The current fragility of the National Democratic Alliance owes little to the self-activity of the opposition parties; they continue to be mired in a morass of self-delusion and squabbling. The problem is entirely an internal one. The BJP, principal partner in the NDA, appears cornered. And contrary to expectations, the strains have been created not by a minor partner misbehaving and demanding more than its due share, but by its ideological fountainhead, the RSS.

For nearly a fortnight, instead of debating the implications of the much touted millennium budget, the Parliament was caught in a log jam. The opposition stalled all proceeding demanding that the Gujarat government revert its decision allowing government servants to take part in the activities of the RSS. Though the central government pointed out that it had no constitutional locus standi in the matter; that the RSS was a highly respected, non-political, socio-cultural organisation: and the RSS leadership itself clarified that it had not sought the revokation of the ordinance listing it as a proscribed organisation for government servants – no one took these clarifications/protestations seriously.

Even the constituents of the NDA – the DMK, TDP and Trinamul Congress – made evident their displeasure. Finally, the government had to relent. Senior party functionaries were despatched to Gandhinagar to make the state government see reason. The matter was resolved, but the government lost face. More than ever before, the schism between the BJP and the RSS came to the fore.

It has been evident for some time now that far from being jubilant about the BJP coming to power for the third time, the RSS leadership appears extremely uncomfortable with the actions and pronouncements of its ideological and organisational offspring. For years, and through some rather difficult times, the RSS has held firm to its worldview. Over time, those sympathetic to its *Weltanschauung* have grown in numbers. It has even acquired legitimacy in the eyes of the modern, urban middle class, more specifically those belonging to the upper caste-class strata.

It now faces the discomfiting situation of many of its favoured formulations being sacrificed at the altar of pragmatism and coalition dharma. Despite being in power (though through a surrogate) both at the centre and in a few crucial states, it has been unable to place Article 370, Uniform Civil Code, what to speak of the temple at Ayodhya on the agenda, even if on the backburner. Its preferences about swadeshi stand sidelined in the frenzied search for foreign capital and the rush to meet WTO guidelines; the committee to review the Constitution ignores it and makes clear that the basic structure will remain unaltered; even national pride has been given a go by, if the supplication displayed during the Clinton visit is any indication.

None of this can go down well with those who believe that they live by values and principles. Worse, those faithful deputed to keep the party on 'the straight and narrow' themselves seem to have been corrupted by the lure of power.

Is this because the basic relationship between the BJP and the RSS is altering? If in the past the BJP appeared dependant on the RSS, not just for ideological coherence but for dedicated cadres during elections, the situation today seems to have been reversed. The BJP, by reinventing itself, enlarging its social catchment and engineering effective coalitions, has grown from a 8% party to one garnering close to a quarter of the vote. The ability to dispense patronage and collect funds has provided it relative autonomy from the RSS.

The RSS, on the other hand, like most ideologically rigid cadre-based organisations seems to be facing difficulty in renewing itself. Its ability to attract fresh cadres, particularly from among the 'suitable' young remains suspect, despite claims about the phenomenal growth of the *shakhas*. Its efforts at social engineering by opening up leadership positions to the OBCs has often boomeranged. Remember the 'revolts' of a Kalyan Singh or a Shankersinh Waghela.

Yet, it cannot quite afford to fundamentally rock the boat. It is still unlikely that any other regime would be more favourably disposed to it; the chances of a deal like the one with Indira Gandhi in 1980 remain low. So all it can do is to fester in anguish, episodically inflicting pinpricks through a Murli Manohar Joshi, the flavour of the season. The recent elevation of K.S. Sudarshan as the *Sarsanghchalak* makes clear that the RSS is unwilling to live with its marginalisation. If anything, it will seek to reassert itself. Clearly we have interesting, and dangerous, times ahead.

Harsh Sethi

we ourselves may want to revise later in the light of disagreements or new evidence.

Just as the critique of essentialism has come full circle, raising several uncomfortable questions for social scientists, the emphasis on action research that has been so much a part of the anthropological critique since the 1970s has rebounded on the academy. The need to promote multivocality or dialogue within participant observation or the need to rethink ways in which anthropologists could help and repay people with whom they lived and studied led to the promotion of advocacy and development anthropology. The latter had the additional benefit of creating full time employment as anthropologists promoted themselves as virtuous 'bottom up' members of 'top down' teams.

Increasingly, however, the idea of proactive research is being taken away from the universities and placed within the domain of NGOs and consultants. Research that directly feeds into development projects is seen as action research. From the point of view of society or funders, there are many advantages to research being funded outside universities. For one, NGOs are often able to identify new issues, when academics are bound by the conventions of their field or by whatever theory is fashionable at the moment. Environment comes to mind, for instance, as a good example of a field where academic research has piggybacked on activist research. Other examples include feminist research, philanthropy and urban planning. NGOs are also often quicker to produce results and in a form that can be used by practitioners.

At the same time, there are several dangers in letting donors and NGOs define what is proactive research, and simultaneously define the proactive as the politically correct. First, research that is ostensibly done in collaboration with the subjects in pursuit of a particular agenda is glorified with the name participatory research, without questioning whether the agenda itself, such as joint forest management or family planning, is something that was developed in participatory fashion. Second, once a subject becomes fashionable, there is a tendency for people to jump on the bandwagon and produce endless case studies, many of which have limited value. Certainly, very little justifies the amount of funding that goes into such case studies with consultants charging fees that range from 2500-3000 a day. Third, the amount of money that goes into so-called research consultancies also undermines research that goes on in universities. It is hard for universities with comparatively limited resources to retain people, and besides, the pressure of having to compete with such organisations for funds means that much research in universities also tends to become project oriented, short term and driven solely by whether or not there are any policy implications. Finally, what tends to happen as a result of such donor driven research is an excessive focus on the poor as against a focus on the rich, on the presence or absence of social capital among the poor instead of how the practice of capitalism impedes development in a systematic manner.

Clearly, there is a need for research, whether inside or outside universities and unless universities and academic institutions clean up their act first, they are in no position to complain. Perhaps the first step towards proactive research, then, would be to direct attention to one's own institutional setting. Teachers who don't take classes, the practice of Ph.D supervisors hiring their own students as soon as they become heads of department, and all the myriad sins practised by academics need to be studied and written about. There was no protest, for instance, when a national research institute in Bangalore used the excuse that the rules did not permit someone without an MA in sociology from becoming a professor of sociology simply in order to keep someone out and appoint an internal candidate. Never mind that the person excluded just happened to be India's leading environmental sociologist. Such egregious nepotism, not by Hindutva activists or Marxists, but simply middle of the road, unremarkable academics, is exactly the sort of thing that lays the ground for far more dangerous ideological nepotism. Only if one tackles this will one be in a position to tackle the problem of political correctness in the Academy and ensure that research is judged by intellectual merit and not just by who is in a position of power at any given time.

Nandini Sundar

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How to meet old age and lead a happy life

Prof. P. Nataraj

THERE are many popular notions about old age. "Old age is the last stage of the life's jouruey". "Old age is the living grave" "Old age is the reversion to childhood or it is a second childhood"; but the only difference is that childhood marks the beginning of life whereas old age marks the ending of life. "Old age is man's most paradoxical and contradictory stage of life—wherein arises the life's last question, demanding solution but is unresolvable". "Man is as old as he feels" and "Woman is as old as she appears." So the feeling of old age begins in mind before it sets in reality. Some yield to the onslaught of age as under the power of a magnet and start growing old; whereas a few challenge the approaching years of old age boldly and strive to maintain zest for life. Sir M. Visveshvaraiah, Sri Shivarama Karanth, Mahatma Gandhi, Mother Theresa are the good examples for this. George Sokolsky says "Years are only artificial markings on Calendar. If the spirit is young, the years are not even remembered. If the spirit remains young one can sing a song of youth even at eighty as at eighteen, but it will have a new meaning and significance at eighty". "Old age is nothing but unconditional surrender to the increasing decline or deterioration which is a natural process of age". Scientifically speaking old age is the period of deterioration or decline of the physical, physiological and psychological faculties which are inevitable.

In old age, physically, the body shrinks, the chest bends, the shoulders sags, the skin wrinkles and loses its bloom; the muscles lose their resilience, the hairs become grey, scanty and lose their lustre; the eyes shrink and lose their brightness and become lazy; ears become less responsive and develop high tone deafness; gait becomes unsteady and so on. Physiologically, reflexes become slow, blood vessels and muscles of heart become hard, and B. P. raises; respiration becomes fast and shallow, digestion becomes slow and poor, excretory functions lose control and so on. Psychologically social, emotional, intellectual, motivational and creative functions become slow. Learning, memory, perception, attention, thinking, reasoning and other psychological faculties also become slow and decline in old age. Personality starts losing its integration and equillibrium.

Though ageing is an inevitable and universal phenomenon, the rate of decline varies from faculty to faculty and from individual to individual. Some scientists hold the view that "If we keep our interest grow with the progress of the world, if our education continues to grow, if our sense of humour is intact, if we do not overestimate ourselves

and our own thought and at the same time if we do not underestimate others and their opinion, we no not grow old soon."

The old people are characterised by a growing lack of self-assurance, anxiety due to fears of loneliness or insecurity; lack of interest in the world around, grumpiness, irritability, depression etc. They become egoistic, egocentric and introverted. Their range of interests shrinks and start dwelling in past glory than the present reality. They suffer from hypochondria. They have poor control of their impulses, emotions and reactions. Their perception, attention, learning, memory, intelligence, sociability, emotionality, motivation, creativity etc, start declining. This is the gloomy picture of old age.

Behavioural imbalances appear at the early stages of old age due to harmonal imbalance but equalibrium will be restored in a short span of 2 or 3 years. On the other hand if there are already predisposing conditions like personality cranks or cleavages, emotional imbalance and impulsivity, the stresses of the old age precipitate the existing conditions and cause senile psychosis—involutional meloncholia or arterioselerosis and so on.

A German Gerontologist distinguishes three types of old age and aged persons.

(1) The *Negativist* who declines old age and its qualities.
(2) The *Extrovert* who admits old age and his changing position within the family.
3) The *Introvert* who experiences ageing on an intellectual and emotional plane.

Due to physical, physiological and psychological decline or deterioration cited earlier, many problems crop up or confront the aged person such as problems of health, of reduced income, of place of living, of use of time, of loss of partner, of ill health, of loss of social status, of loss of independence and of generation gap to live with adult children and to deal with youngsters in and around.

These should be looked in a constructive way. Consult your personal doctor periodically and have physical check up annually and maintain the records to follow up. Then have balanced diet, moderate exercise and regularity in doing all these things. Also practice physical and mental relaxation atleast once a day.

Plan out your income from pension, rent and other sources of income. Also list out your requirements of food, clothing, housing, transportation, medical aid, taxes to be paid etc. Match the two; do not try to stretch your legs beyond the bed.

Even before retirement, both the husband and wife should plan out where to live after retirement. While so planning you have to consider the climate. cost of living facilities like medical, recreational and shopping availabilitiy etc. Availability of facilities to meet friends and relatives in the proximity should also be taken into account. To the extent possible live nearer your children so that you or they can visit as and when required.

Time is at your disposal after retirement. Happiness and pleasure comes not from rest but from doing something which is interesting and rewarding. So list out things you want do to spend time, their order of importance and priority of doing. Plan out these things before retirement, so that you can easily switch over to these activities soon after retirement.

In order to adjust well and to deal effectively with the persons whom you love and by whom you want to be loved, try to understand how they feel and act

with you. Cultivate youthful attitude and maintain interest in and acquaintance with young people with whom you deal. Do not be critical of what your adult chidren do. Recognise them as grownups, treat them as friends and permit them to live as they like. Try to think in retrospect how you were, or are, not a carbon copy of what your parents and grand parents were. So, do not expect them to be your carbon copy. This helps you to avoid the problems of generation gap.

Restrain yourself when you have an urge to comment on their doings. Do not impose your views on them and do not harp on your good old days. Try to keep yourself up-to-date, so that you can converse with them interestingly. Always keep yourself tidy and attractive in your dress and appearance to avoid causing embarassment. Do not demand special attention and consideration either at home or at a party, just because you are older than them. Do not allow yourself to indulge in self-pity. Maintain your faith in God and believe that everything is a part of the game and take things sportively. Do not give advice unless it is sought for.

Old couple must stay in their own house as long as possible, because it is easier to carry on the routine in a familiar setting.

Old age is what you have conceived in mind and you are never too late to learn. Learning makes a man fit company for himself. To learn is to know. To know is power and power is the captain of youth. Respect the laws of health and maintain an everlasing enthusiastic perspective of life. You cannot avoid or control your calendar birthdays, but still you can remain young in "mind and heart". So develop a lot of interest in everything around, travel now and then, have new things and meet new people. There are many wonderful things to see and do. Thank God for everything he has given you and for keeping you on this earth. Learn to enjoy your living.

Forget your past mistakes and disappointments but learn to gain from your experiences and live happily. Accept your physical limitations graciously; grow old with dignity, complain less and appreciate more. Have time every day for mental and physical rest. Cultivate tolerance. understanding, kindness and unselfishness from your experience. Avoid egoistic and egocentric behaviour. Do not worry over the future but live at present. Learn to smile more but frown less at everything. Do not add years to your life but add life to your years. At the tail end of your life, live for others' sake. Live gracefully, gratefully, peacefully and happily.

Thanks to the human heart by which we live
Thanks to its tenderness, its joys and fears,
To me the meanest flower that blows can give
Thoughts that do often lie too deep for tears.

—Wordsworth

6. Suitable low cost health insurance schemes should be provided for the benefit of senior citizens.

7. A certain number of beds for geriatric group should be earmarked in all hospitals.

8. A national day for senior citizens may be observed every year like the children's day, in order to focus public attention on the needs of senior citizens.

9. Free medical aid and special care for the old should be made available to all senior citizens in Govt. Hospitals and primary health clinics.

10. Free legal aid should be arranged to help the senior citizens from being exploited by their own kith and kin.

An all out effort should be made to help senior citizens to be self-reliant, co-operative with others and set a good example to the rest of the community. The theory of declining years refers to the body only, Man must continue to grow mentally and spiritually. The meaning and purpose of life must be pursued with determination so thar sufferings, loneliness and old age can be transcended. The spirit is ageless.

●

Financial problems of the aged and of Old age Homes

Rev : Fr. Dr. P.C. Eapen, M.A., Ph.d.(Nyu)

IN most of the developed and developing countries, old age has become a very heavy burden—a distressing ordeal. The problems of the aged and the ageing are becoming increasingly complex and frustrating. The time-honoured order of an in-built social security of the traditional joint family system is slowly giving place to a narrowly selfish, rugged individualism bereft of any human touch. The ever growing urbanization, the disintegration of the joint family, the emergence of the nuclear family, modernization, mobility, social change and the influence of the industrial culture have made deep inroads into our highly spiritual heritage and value system.

By the turn of the century, the population of the aged will reach a staggering figure of nearly 76 million. Poverty and destitution, predicament of husband and wife going to work, aping the West and forgetting our culture, lack of respect for the elders by the younger generation and above all, economic degradation due to the escalation of prices of all necessities are the main problems affecting the aged today.

In our country, medical science has certainly helped to add years to life ; but precious little is done to alleviate the physical, financial, social and psychological problems the aged have to confront. The senior citizens need, not our pity or charity but opportunity to live a fuller life independently. It is our social and moral responsibility to keep the senior citizens self-supporting, self-sufficient and contented.

We should persuade government and public agencies to provide subsidies for housing facilities. In Britain, home care is supplemented by Home Help service. Meals on wheels and Day-Care Centers designed to cater to the social and cultural needs of the senior citizens. It will be worthwhile to establish community service centres, to be maintained by service clubs like Lions, Rotary, Freemasons etc., for organising seminars, work shops, cultural and recreational programmes for and by the senior citizens.

Special Travel passes should be made available to senior citizens with provision for reserved seats on trains, buses and in theatres. Voluntary social agencies should be requested to arrange for the supply of free travel aids such as portable and folding wheel chairs, light travel bags, canes, walking sticks etc. The Social Welfare Department should be urged to issue identity cards to enable senior citizens to secure various social security benefits and to get atleast 50% concession, if not full at hospitals, clinics, medical srores, libraries and cultural programmes.

In the developing countries like India,

the disabilities arising from ageng will be compounded by those arising from poverty and under-nutrition, since a considerable proportion of senior citizens do belong to segments of the population below the poverty line. At present in our country, institutional arrangements and services designed to mitigate the problems of the aged are extremely inadequate. Our objective however, should be not just to ensure the survival of the elderly ; rather we must help them sustain their productivity and enjoy a good quality of life. Support to the elderly should therefore be more than a philanthropic 'charity' operation. By harnessing the rich experience of the senior citizens for productive endeavours, we will be adding to the Nation's wealth. An imaginative national policy should see them not as 'dependents' but as a valuable component of our national human resources.

Allocations for the welfare of the aged and arrangements for this purpose must find adequate focus in our national developmental programmes. The case for the aged must not be perceived as largely resting on "humanitarian" but on economic grounds. The case for reasonable allocations for the welfare of the aged will therefore need to be convincingly articulated on a scientific rather than just a sentimental basis.

We should not blindly copy the west. Old age homes where senior citizens feel lonely and isolated, however comfortable and posh they may be, are not in consonance with our culture. We will perhaps not be able to do without them either. But the real challenge is to ensure that our policy with respect to the aged reflects our national heritage and value system. What the seninor citizens normally look forward to is not necessarily comfort in solitary splendour, but certainly an opportunity to be an active part of the society in useful ways which will lend them dignity and emotional satisfaction.

Following are some suggestions :

1. A national council for senior citizens of India be constituted as a statutary body to function at the national level with state level committees in each of the states and in union territories of Indian Union to identify and strive to fulfil the needs and aspirations of senior citizens of India as also to productively utilise their rich experience besides assisting proper functioning of various types of homes established for the welfare of senior citizens

2. The Government of India be urged upon to immediately formulate a national policy on the "senior citizens" of the country with necessary provisions relating to financial assistance for the projects and programmes that are under way and those to be framed in future.

3. The Union Ministry of Railways be approached with a request that senior citizens of 58 years of age and above be allowed railway concession upto 50% in both 1st class and 2nd class railway tickets without any stipulation on minimum or maximum distances.

4. The Government of India and all state governments and union territories within Indian union be urged upon to provide suitable government land free of cost for the establishment of old age homes.

5. All the institutions established for the welfare of senior citizens and presently granted exemption at 50% for deduction under section 80 G of Income Tax Act 1961, be modified for 100% deduction from taxable income for all payments made to such institutions by the assessees.

The Status of the old in Rural Areas

Vani Venkataram

THE case of the aged infirm in our society makes an interesting sociological study. The child grows to be a man; the man works hard till he reaches old age; thereefter he deserves all kindness and consideration, so that the rest of his life may be peaceful. To achieve this, the attitude of the younger generation for whose benefit the old have slogged, is of vital importance. To ensure the development of such an attitude, educating the younger generation at home and in school on the right lines is of immense value. The education at home is the concern of the parents; likewise, the education at school is the responsibility of the teacher who should regard this as a sacred duty towards the young growing minds. In the curriculum of studies for the primary and middle schools, moral education must find a place so that this will act as a firm foundation for the development of the mind.

There are a few important causes for the present day problems facing the old people. One is the break up of the joint family system owing to the fast changing social and economic conditions. The opportunities for employment in one's own place being limited, the young ones migrate in search of jobs leaving the elders to take care of themselves. The attractions of the urban life naturally take away the young ones from their original rural areas; and when once they taste the comforts of city life, they do not wish to go back to villages. This increasing tendency has caused total disruption of the social structure in the rural areas.

There is a general concept that the old people in rural areas are different from the urban ones. Of course, there is logic behind this impression. People living in urban areas have the taste of scientific technological development which has not penetrated into the rural areas. The population explosion and concentration in urban areas have affected the lives of the people. People are facing grave economic problems due to the shortage of job opportunities and tough competitions in every field. There are many material attractions for the urban people. People with or without money want to possess these materials above everything else. Greed and avarice have increased and people are self-centred and selfish. The values that were cherished from ages galore in our society have been sacrificed at the alter of insatiable greed. This has led to the truncation of an otherwise nurtured ways for smooth living. The old are not treated as in olden days. The younger generation in thair process of acquiring alien cultures do not show respect, concern, care and love to the older people. There has been a feeling of insecurity and

unrest that has set in amongst the old people, which is compelling them to find other ways of getting peace in their lives. As we all know this search has given rise to formation of old age homes. But then, this is not unique to urban areas alone.

Pernaps, in urban areas the stress and struggle have led to these problems. If this alone is the cause then the rural old should be enjoying utmost veneration, respect, care and love from their filial ones, being isolated from the urban areas due to inadequate communication. But, on the contrary, the status of the rural poor is still more pathetic and pitiable. The people in rural areas have always lived in poverty with hand to mouth existence. Every member of the family works hard to earn his or their two meals. Their economic backwardness seems to be an abysmal well from which there is no escape. When people grow old they become totally dependant on their children. Now it is the turn of the younger ones to slog to make both ends meet. Their meagre earnings should feed more mouths in the family. This naturally leads to frustrations, unhappiness and unpleasantness. The old people are, time and again, taunted and insulted, and compelled to realise the fact that tkey are regarded as a burden, Atleast the urban middle class would have some financial cushion in most cases; but the rural old have nothing to lean upon. The facts gathared in interview held with a few old people are cited below:

Sidhaiah : Lives with his old wife. He has a small home of his own and is not dependant on his children. Wife, though old, break stones, brings home enough money for their food. He says when he falls sick his children show kindness.

Maramma : A widow stays with her son and daughter-in-law. Tho daughter-in-law does not feed her enough and that too not without nagging. She receives ragi ball at 7 a.m. and the next meal at 8 p.m. She is hurled with all kinds of abuses and insults. Most unhappy person indeed, waiting for her end in this world.

Janamma : She is shunted between her sons. No one is willing to keep her permanently. She has become the target of her children's envy and compeition. She feels that after the wives have come the mother is a total stranger to their sons and they do not show any affection.

Chikkamma: She lives with her daughter. The daughter is a worker in a field. She keeps taunting her mother often and wants her to go to her sons. There the daughters-in-law do not want her presence. This kind of cruel, inhospitable treatment has made her so unhappy that she prays to God to give her freedom from this earthly shackle.

Judging by all these, whether rural old or urban old, there is very little difference in human behaviour. Ultimately, it all depends on individuals and the goodness and values that are nurtured in them. Human beings are the same wherever they are. So it is a misnomer to think that the rural old being cut off from so called modern civilisation, are able to enjoy more security, better status and peaceful life.

The only solution seems to be in giving training to the children from very young age and prepare them mentally to understand the social problems and cherish the basic values. The regard, respect and care for the older generation have to be practiced by elders to show as an example to the children. Unless proper education in this matter is given, the solution to the

problem of the old people will permanently remain a distant dream.

In this context, mention has to be made of the conditions prevailing in developed countries. In U.K. and U.S.A. the Government is alive to the needs of the aged and infirm, and has introduced several amelicorative measures. Senior citizens, as the old are called, are given concessions for entry into some places of entertainment. Old age penson scheme is in operation. Government agencies extend courtesy and kindness to the senior citizens. Our great country, India, should try to emulate them.

Elder Citizens and their impact on Society

Sri M.S. Chandrasekharaiah

THE influence exercised by elder citizens on society will be analysed under two heads. These two influences are political and cultural. The latter term signifies the leadership role of the elders in the field of social reform, education and the preservation and perpetuation of our heritage.

The political role may be considered first. In the Western world the older citizens constitute a very powerful and influential voting lobby. In the U.S.A. for instance, right from the President down to an ordinary State Congressman (i.e., as distinct from the more powerful U.S.Congressman) all pay careful attention to what the senior citizens advocate as a group. The reasons for this are many. In the west the senior citizens form a relatively large segment of the society because of better living condition and health care. Their longevity is also great. They are all literate and many of them are highly educated. There is a good sprinkling of professonal people among them. Most of the senior citizens there are financially better off-with pensions being not very much below the last pay drawn. Almost everybody gets some social security payment. So the senior citizens are vocal, articulate and can afford to contribute to the campaign funds of such candidates as are willing to press for legistation favouring the cause of the older citizens.

There is another very important factol that strengthens the political or electora influence of the senior citizens. The senior citizens as a rule go to the polling booths in very large numbers. In America the average voter, as in India, is apathetic and cynical. A voter turnout of 50% or 52% is considered to be very good indeed. But the senior citizens are keen voters and enjoy the reputation of forming the largest segment of active voters. In the midst of general indifference and poor turnout, the votes of the senior citizens can make or unmake the political fortunes of many candidates. The candidates cultivate the electoral support of senior citizens and when elected they strive for legislation helpful to the older people. The lobbies of the senior citizen monitor the elected representatives, voting pattern in the Congress and hence succeed in extracting many concessions helpful to the old. That is how the senior citizens in the West got a good medical and health care system, enhanced old age benefits, concessional tickets for travel in the public transport system and concessional tickets for cinema and theatres. It is these extended and enhanced financial and physical amenities that have enabled the senior citizens to play a vital role in their society.

But the position of the elder citizens in

India by contrast, is pathetic. The vast majority of the old here are illiterate, and dismally poor. They are totally unaware of the issues facing them or of their role, struggling as they are to get the days' ration of rice or kerosene. So they do not constitute in anyway a voter's bank capable of drawing attention to itself. These people instead of influencing the candidates are themselves easily misled. No party pays any heed to them as a group because it is unorganised, inarticulate and unaware. The few small groups of senior citizens comprising of intellectuals and leaders in different walks of life find that their pleading for the cause of the senior citizens goes unheard. Their appeals are brusquely dismissed. One may mention here how unceremoniously and disdainfully the Government of Karnataka withdrew bus passes of the senior citizen; in the name of economy! The point to be stressed here is that senior citizens have got to work as a powerful voter lobby whatever be their own personal political loyalties. Otherwise they cannot improve their social conditions. This is important for the following reasons.

Most senior citizens grow beset with problems, many of which are not of their making. These are the problems of reduced income, increased financial responsibilities, i.e., marriage of a daughter to be arranged or the higher education of a son or daughter to be financed; or debts incurred earlier in similar contexts may become due for repayment. This is also the period of reduced physical stamina, failing health when Inertia due to age takes its toll. A few may have chronic ailments. As an English writer said "The diseases which we acquire in our old age are our true and lifelong friends". As the senior citizens grow their sense faculty may weaken or fail altogether. A Sanskrit comment runs as follows "Vardhakye Sarvendriyani avidheyah putra iva vartante." In old age all sense organs behave like disobedient sons. A few may even have to face terrible tragedies such as the death of a spouse or a loved member of the family. But let nobody be disturbed unduly by this grim side of life. The strengths of the old are their high degree of maturity and the courage of their hearts and mind. But maturity and bravery of the heart are not by themselves enough to enjoy a smooth sarling for the old. The society i.e., the state has to provide some basic amenities to the old and the state will not do it till the senior citizens make themselves heard. There is, for instance, no national system of medicare. The government sponsored General Insurance Corporation excludes from the purview of mediclaim those who are over 70. Actually it is this group that requires most, the benefit of the medicare scheme. Many old people suffer from the terror syndrome of falling so ill as to need hospitalization. Yet again we do not have a national and rational scheme of old age pension. What exists is a mockery and is only a political racket. The senior citizens do not enjoy any real concessions by way of amenities in the diverse walks of life. Better old age social security payments and a provision of efficient health care are not to be viewed as charities grudgingly given but they are really deferred benefits merited by a long stint of service. But this will be done only when senior citizens form a good lobby. They have to argue their case forcefully and exercise their vote at the hustings of the ballot.

Once the senior citizens are provided with minimum facilities to live a life of modest the style, they have a great role to play in

society. They have always been esteemed not simply because they are old. Mere growing old does not call for any celebration. But the elders are the link between the past and the future. They are inheritors as well as the bequeathers of our heritage. They have a great deal to communicate to others because of their rich experience, knowledge and aesthetic outlook. The older citizens need to educate themselves in order to pass on something truly worthy to the young. The young do respect the old when the latter have knowledge, wisdom and values to pass on. It is only when the old go on repeating some trivialities that the young dismiss them as wasters of time indulging in rigmaroles. The old, if not careful, face the risk of entering anecdotage. Useless reminiscences can lead to mere reminiscences" if I can coin such a term. The older citizens need to be well–versed in some field of study and in some branch of culture in order to enthuse our young and to mould their tastes and to whet their appetite to know. Senior citizens who can speak to their neighbours of a great book they read, of the innovative work they did or of the great music they heard can be wonderful sources of informal and enduring education. What the society needs is the type of senior citizens who are themselves very modern and path-breaking in their actions and outlook. They have got to convey right values and right task to the young. This is very important today when the mass media of information and entertainment so easily dull and deaden the minds of their captive audience. This is not the place to go into the reasons for this. Enough to say that our young are in the danger of becoming literate sophisticated philistines. It is the pressing duty of senior citizens to act as pockets of culture and wisdom. They have got to inculcate worthy attitudes and worthy ways in the sphere of intellectual and cultural pursuits in order to transform society and at the same time to make it appreciate its great cultural heritage. But the senior citizens can do this only if the where-withal of a modest living is provided to them. Then older citizens become elder citizens. They will wield a worthy and healthy influence all around them. Only then can they expect to receive the two blessings of a happy evening and an easy exit.

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14

Principles of Exercise for the Elderly

Bella J. May[a]

Let me grow lovely, growing old
So many fine things do.
—Baker (1)

WHO ARE THE ELDERLY?

At 85, Barbara Garden is part of the fastest growing age group in the United States today. She is a divorcée who lives alone in the suburbs of a large metropolitan city in the house she has lived in for the past 30 years. She walks 2 miles daily, controls hypertension with medication and diet, complains of joint pain from osteoarthritis, but is otherwise in good health. She is active in the senior center, although she complains of not having the energy she used to have.

Carol Sky, a widow, is 68 and has diabetes, hypertension, and degenerative joint disease, particularly in the knees and hips. She had a total left knee replacement about 3 months ago. She lives in a small house in a rural community not far from the farm where she raised her family. Her children, who live in other parts of the state, visit regularly.

Both of these women function independently, but if injury or disease should suddenly hospitalize either, how would they adapt?

Statistics indicate that the population is getting older and living longer. By the year 2000, almost half the deaths in the United States will occur after the age of 80 (2). An increasingly older population makes more demands on health services with individuals over 75 years as a group using more health care resources than any other single group. But the elderly seek quality in their lives and the opportunity to maintain good health as well as to functionally recover from the loss of health.

[a]The author is indebted to colleagues Jancis K. Dennis, Maggie Cooper, and Osa Jackson for their useful comments and suggestions during the development of the manuscript of this chapter.

There are many stereotypes of the elderly as a group; our own biases are affected by our experience. Health care providers, more frequently exposed to the person in poor health, functionally limited or with impaired intellectual capabilities, may believe that most older people have difficulty functioning. Kvitek, Shaver, Blood et al. (3) in a study involving 127 physical therapists, reported that therapists tend to set less aggressive goals for older individuals than for younger patients with the same disability. They also found a positive correlation between attitude toward the elderly as determined by a standardized questionnaire and agressiveness of goal setting; therapists exhibiting a more positive attitude set more aggressive goals. Actually, only about 5% of the older population lives in institutional settings. The majority live independently in their own homes (2).

Researchers generally divide the elderly demographically into three groups: the *young-old* (65–75), the *old* (75–85) and the *old-old* (85+). Research is increasing our knowledge of normal aging and our understanding of geriatric needs, but Schaie (4) urges caution, reminding us that many of the methods used to assess elderly function are not designed for real life situations and often do not consider motivation or emotional state, both important components to understanding elderly function.

Why a Special Chapter?

The reader may be wondering, "Why a chapter on geriatrics?" Life, growth and development are cycles, and humans do not function similarly in each phase. Just as the child presents with special problems and needs, so does the older person. The elderly client may have multiple disabilities, and the clinician must decide which cues are critical and how to best guide the person to reach desired goals.

Goals differ, and consideration of psychosocial and environmental concerns is paramount as the older client may view the disability quite differently from the therapist. Barbara Garden is hard of hearing and wears glasses. If she breaks her hip and the therapist comes to evaluate her when she does not have her hearing aid or her glasses, will she seem confused and not responsive? What goals will the therapist set? What about Carol? If she's hospitalized for a second total knee replacement, will she be able to participate in the exercise program as speedily as the therapist expects? Will the small community provide adequate support services?

It is not the purpose of this chapter to provide a list of specific exercises that can be performed in any particular situation. There are many exercise descriptions for the well elderly as well as for specific pathological conditions (5–9). The creativity and decision-making skills of the therapist working with an individual or group of clients is the best resource for specific therapeutic exercises. This chapter will consider the exercise needs of the well elderly and the older individual seeking rehabilitation services and will provide clinicians with principles for effective decision making.

THE WELL ELDERLY

The Aging Process

Individuals vary greatly in the rate, scope, and pattern of functional change, and there is often little relationship between chronological and physiological age. A sedentary and retired 55-year-old person with multiple physical

and psychosocial problems may be considered physiologically closer to 65 years, while an active and healthy 65-year-old may run a marathon at a pace considered appropriate for a 50-year-old.

PSYCHOMOTOR PERFORMANCE

The aging process inexorably brings changes in work capacity, muscle strength, and endurance. It has been estimated that work capacity in sedentary individuals declines about 30% between the ages of 30 and 70 (6). Decreases are generally in large movement made at maximum speed, and routine activities are affected more by a slowing of the reaction and decision-making time than by muscular limitations themselves. Given time for motor planning, the elderly can learn fairly complex movements. As individuals age, they may exhibit more caution in movement to compensate for the increased time needed to interpret and respond to stimuli. Such changes may be evident as the person walks with a wider base of support, takes shorter steps, and walks more slowly, particularly if there is joint pain or muscle weakness secondary to disability. The healthy elderly generally exhibit minimal gait changes; if marked changes are noted, they can usually be related to some sort of pathological problem that may be responsive to treatment.

Psychomotor performance may also be affected by loss of flexibility which can occur as the collagen fibers of ligaments, tendons, and capsule change from parallel to cross-linking. The spine also becomes less flexible secondary to loss of water in the nucleus and changes in the fibrous annulus of the interveterbral discs. Decreased activity is another contributing factor to loss of both flexibility and strength.

Loss of muscle strength is usually due to a complex combination of factors including decreased activity, decreased efficiency of the cardiovascular system, leading to decreased circulation. Some general lassitude and loss of strength may also be due to chemical factors, particularly lack of potassium secondary to changes in muscle cell permeability. Loss of strength can also be due to disease. Postural changes may be evident as an individual ages, particularly in women, as postmenopausal decreases in bone density may lead to poor posture, fractures, and pain.

SENSES AND PERCEPTION

Vision is usually one of the first senses affected by aging. Physiological changes may lead to decreases in depth perception, reading ability, and visual acuity. The client may have difficulty reading a home exercise program or seeing potential hazards in the environment. Decreases or loss of vision can limit mobility and isolate the older person.

Decreases in auditory function may start as early as age 40, affecting thresholds for tone, speech, and pitch. Hearing aids may compensate for some loss, but the individual may have difficulty differentiating between words with similar sounds or may be unable to attend to one particular auditory stimulus when surrounded by many different sounds, or if the stimuli come too fast. The older individual may simply need more time between words or fewer surrounding stimuli to discriminate between competing sounds.

COGNITION

Changes in memory, intellectual function, and learning ability vary greatly. In the absence of disease, the older person undergoes little loss of intel-

lectual function or memory as a direct result of aging. Schaie (4), in a 7-year study, reported that less than 50% of individuals over the age of 80 showed reliable intellectual decrements. Learning ability continues throughout life; elderly individuals are at some disadvantage when response rate is fast, and may exhibit some changes in ability to encode new concepts. Schaie (4) emphasizes that many of the tests of intellectual function are not accurate for an older population since they often do not consider past experiences and may not reflect real life situations.

LIFE-STYLE

Older individuals in a large city, interviewed for a television news special, stated that they primarily feared the loss of independence from disease or debility, rather than the loss of significant others. Our elderly clients may have recently lost a spouse, perhaps one or more close friends, and feel the loneliness, anxieties, and stress associated with such losses. Adaptability decreases with age, affecting coping ability. Older individuals have been found to function best in familiar settings; individuals who have been able to maintain themselves in the home they have lived in for years will often become quite dependent when moved to a new, unfamiliar environment. Life-style changes are a leading cause of stress among the elderly. Anxiety created by loss of ability and increasing isolation can be a great deterrent to rehabilitation.

BENEFITS OF EXERCISES

Preventive Measures

There are considerable data to substantiate that the declines of normal aging can be slowed through participation in comprehensive and well-designed fitness programs (10–17). Although VO_2 max has been found to decline with age, Fleg and Lakatta (18) reported no loss of VO_2 max when results were normalized for muscle mass. In a longitudinal study of 16,936 Harvard alumni, sedentary individuals were found to have a 31% higher risk of cardiovascular death than active alumni. Older active alumni (70–84 years) had an even lower risk of death than their less active counterparts (19).

Exercise has also been found to help reduce bone loss in postmenopausal women. Krolner, Toft, Nielsen et al. (20) studied bone mineralization in 31 healthy women ranging in age from 50 to 73. Mineralization of the lumbar spine increased by 3.5% among women in the exercise group, while it decreased by 2.7% in the control group. Sinaki and Offord (21) found a positive relationship between strength of back extensor muscles and bone mineralization. Brewer, Meyer, Upton et al. (22), studying the effects of physical activity on bone mineralization in premenopausal middle-aged women, reported that runners maintained mineral content of the distal radius longer than their more sedentary counterparts.

Agre, Pierce, Raab et al. (23, 24), followed three groups of elderly women (63–88 years) for 25 weeks. The control group was composed of women who agreed to delay involvement in an exercise program for 6 months. One experimental group participated in an exercise program using light weights on the wrist and ankles, and the other experimental group followed the exercises without the added weights. Participants in both exercise groups showed significant increases in strength of shoulder and knee musculature as compared with the

control group. There were no statistically significant differences between the group exercising with and without weights. Participation in light-exercises further appeared to have a positive influence on joint pain. Seventeen individuals who had reported some joint pain at the onset of the study reported decreased joint pain at the end, 10 indicated no change in joint pain, and only two indicated any increase as a result of the exercises. Similarly, participants in the two exercise groups showed significant improvements in flexibility in ankle plantar flexion, shoulder flexion, shoulder abduction, and left neck rotation compared with the control group. The group exercising without weights showed a significant improvement in shoulder abduction as compared with the group exercising with weights.

Patients with Disabilities

Disability does not appear to be a deterrent to exercising. Many individuals recovering from coronary disease participate in exercise programs and the benefits have been well documented. Ades, Hanson, Gunther et al. (25) recruited individuals recovering from myocardial infarction for a supervised coronary rehabilitation program. Participants were divided into those over and under 62 years of age. Although the older group achieved a lower peak exercise intensity, both groups obtained similar relative training benefits. However, despite similar recruiting efforts, only 19% of the older patients chose to participate, as opposed to 59% of the younger ones. The authors did not analyze the reasons for nonparticipation, but conjectured that multiple disabilities might have been a problem.

Zinman and Vranic (26) studied the effects of exercise on individuals with Type I and Type II diabetes. They recommended that individuals with diabetes be encouraged to participate in an exercise program, although the long-term benefits still need to be established. Exercises improve postprandial hyperglycemia, but may induce delayed hypoglycemia. The diabetic client needs to monitor his own blood glucose level and adjust both insulin and diet accordingly.

It is suggested that regular exercise improves intellectual and psychological function. Although caution is advocated in interpreting results of research, there have been statistically significant improvements in function among subjects who participated in a regular program of exercises and those who led a sedentary life-style both in and out of institutions (3, 27). Generally, researchers seem to agree that individuals with physical impairments can benefit from participation in regular exercises and that more research on the long-term benefits among the impaired elderly is needed (17, 28, 29).

WELLNESS EXERCISE PROGRAMS

Western society is becoming more health- and fitness-conscious, but many older individuals still consider physical exercise and activities something for the younger generation. Others want to maintain an active life-style, but do not know where to start or how to adapt the commonly available activities to meet their individual needs. Still others with some disability cannot find suitable programs or are afraid that exercise will exacerbate the disability. Attitudes are changing, as is evidenced by the increasing number of mall walking groups, water aerobic classes, exercise videos for the elderly, and similar commercial enterprises.

Assessment of the Well Elderly

The initial history includes a list of medications, a life-style inventory to determine current activity level, gross assessment of strength, flexibility, coordination, and balance. There is some diversity of opinion regarding the need for specific stress testing before the well elderly engage in a fitness program; most authors, however, advocate some determination of cardiovascular capacity to establish starting heart rate guidelines (10, 30–33). Standardized stress testing procedures may not always be suitable for the elderly individual. Smith and Gilligan (10) described a modified step-stair test where a sitting client raised one foot up to a step of a particular height over a specific time period. Guidelines were provided for determining MET levels for several different height steps.

Components of a Wellness Program

A wellness program includes activities designed to improve strength, increase flexibility, promote endurance, improve balance and coordination, be enjoyable, and fit into the person's life-style. May (34) reported on a series of programs designed for an Elderhostel camp which incorporated educational as well as activity sessions and were designed to enable the participants to make effective decisions when making life-style changes.

STRENGTHENING ACTIVITIES

Exercise for the upper and lower body as well as the trunk are part of a well-designed strengthening program. Active exercises, the use of free weights, and exercise equipment such as are available in health spas or fitness centers can all be used by elderly individuals, both men and women. Proper instructions are necessary to prevent injuries.

Major muscle groups need to be included with the weight selected to allow from 10 to 12 repetitions through the full range of motion. The trunk and upper body are frequently overlooked by the elderly; Barbara Garden may believe her walking program meets all of her fitness needs. The particular type of exercise needs to be selected according to personal preference. Many women, for example, may not care to exercise in the free weight section of health facilities, but would participate in low impact or water aerobic programs. Trunk exercises need to emphasize good posture but must consider individual variations in posture which may not be amenable to change.

FLEXIBILITY ACTIVITIES

Functional pursuits may be limited by lack of flexibility in major joints. One person may find it difficult to reach something in the cupboard, comb the back of the head, or even put on shoes and socks. Another with limited flexibility may not be able to respond to a sudden change of position or loss of balance. Flexibility activities are the most forgotten part of wellness programs.

Generally, individuals need to increase shoulder, trunk, and hip flexibility, particularly in extension and rotation ranges. Shoulder range of motion and upper trunk extension can be improved and maintained fairly effectively using combination movements and a small towel (Fig. 14.1).

The older client needs to be taught a safe, effective, and simple technique to stretch hamstrings and calf muscles. Long-sitting is probably the safest way,

in terms of balance
hamstrings.

Occasionally,
in one chair raising
back straight and re
hip flexor and rectu
and balance. Self-st
stand upright holdi
enough to provide

Figure 1

Figure 14.1 Increasing shoulder flexibility.

in terms of balance, but the client may stretch the low back more than the hamstrings.

Occasionally, an older person finds getting to the floor difficult and can sit in one chair raising the feet on a small stool or other chair while keeping the back straight and reaching for the toes (Fig. 14.2). Many older individuals have hip flexor and rectus femoris tightness which can interfere with good posture and balance. Self-stretch for these areas is difficult. One practical method is to stand upright holding to a chair or other support, one leg behind the other far enough to provide some range into hip extension (Fig. 14.3).

Figure 14.2 Stretching the hamstrings in a balanced position.

Figure 14.3 Stretching the hip flexors using a chair.

Good posture reduces stress and fatigue, but requires trunk flexibility and body awareness. Combining trunk and shoulder or trunk and pelvic movements or all three may be more effective than stretching each area individually. Some examples might include:

1. Stretching both arms to the ceiling then bending gently to each side;
2. Rotating to each side with the arms out to the side at shoulder height either stretched out or with the hands on the shoulders, letting the head lead and the trunk follow in a natural progression (Fig. 14.4);
3. Lying on the back with knees flexed and arms at side, allowing the knees to come to one side of the body (the left for example), following with the shoulders and head by bringing the right arm up over the head, maintaining the hand in contact with the floor, until the head rolls to the left naturally followed by the shoulders, and the person ends on the right side. The motion is then repeated in reverse to return to the back and then to the other side. The same activity can be done starting with the arm and letting the hip loosen and follow when the body is ready for the move (Fig. 14.5).

Therapists can design a variety of combination activities that teach the client coordination of shoulder, hip, trunk, and head and enhance smooth coordinated movements. The client must understand how the body moves and be

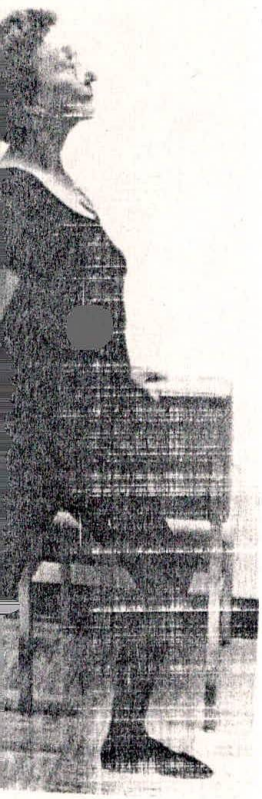

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Figure 14.4 Trunk mobility exercise.

Figure 14.5 Combined mobility exercise for hips, trunk, and shoulders.

encouraged to allow the body to move easily in performing flexibility movements. General guidelines for teaching flexibility include:

1. Start in a comfortable position;
2. Move slowly to the end of the range;
3. Hold at the end range for 10–20 seconds;
4. Feel a gentle pull or stretch, but no joint pain;
5. Return slowly to the starting position;
6. Use slow coordinated active motions involving varied body movements;
7. Repeat 3–5 times.

AEROBICS

Aerobic exercise programs are primarily designed to improve cardiorespiratory function, although many include flexibility and strengthening activities. The level of resting heart rate increase necessary to achieve a training effect among older people has been the subject of considerable research. Badenhop (35) reported changes in VO_2 max at a 30–45% increase in resting heart rate among volunteers over 60 years of age. But Lampman (32) recommended a target heart rate of 65–75% of maximum, and Smith and Gilligan (10) recommended targets of 40–70%.

Most researchers do agree that the elderly individual should start slowly and build intensity gradually and that individuality is needed in establishing target heart rates. It is important for the elderly to understand the difference between low intensity activities that accompany an active life-style and aerobic activities. Many people who respond to life-style questionnaires indicate that they garden, do housework, and stroll on the beach as part of their exercise program. Unless the program is designed to increase heart rate, it will not have the desired training effect.

Among the wide array of aerobic opportunities are: high and low impact classes, water exercises, exerdance classes, mini-trampoline programs, swimming laps, riding exercise bicycles, or using computerized rowing machines. Some sport activities provide aerobic training if continuous movements are involved. Water aerobics lessen stress on joints, but participants, particularly women, need to include some weightbearing activities as part of a management program for osteoporosis.

WALKING

One of the more popular activities is walking. Recommendations for an effective walking program include:

1. Wear well-fitting lace-type shoes which provide good support and shock absorbtion; wear thick socks that will absorb perspiration and protect the feet.
2. Wear comfortable, loose-fitting clothing appropriate to the temperature and weather.
3. Walk at a rate designed to bring the heart rate to target levels; 3 to 3.5 MPH may be a good training pace for the average person.
4. Walk in an easy, balanced position, head upright, looking ahead rather than directly at the ground, arms swinging easily with each stride, using a slight pushoff step with the rear foot and leaning forward just slightly

with each step. Take long easy steps from the hip, landing on the heel and rolling over the foot in a smooth motion. Avoid reaching for too long a step.
5. Walk continuously; frequent stops and starts interfere with the aerobic training effect.
6. Walk in an interesting area at a suitable time of day. Try to set aside the same time each day for the walk. Walk with others, if desired.
7. When walking up or down steep hills, lean forward slightly and shorten the stride a bit to maintain a balanced pace.
8. Start slowly, but gradually increase distance and time until desired maximums are achieved. Keeping a log of accomplishments enhances motivation.
9. Cool down with a flexibility program, a slower paced walk for another block or two, or some gentle conditioning exercises.

General Guidelines

Overall fitness programs for the well elderly must:

1. Be safe in that the potential for injury is minimized;
2. Be designed to improve muscle strength, flexibility, endurance, coordination, balance, and functional capabilities;
3. Be at an intensity level to provide a training effect;
4. Include a variety of slow and fast activities including a warm-up and cool-down period;
5. Allow participants to lower the level of participation, if desired;
6. Give participants an understanding of the purpose of the exercise and what sensations may be elicited;
7. Be performed regularly, at least 3–5 times per week;
8. Be performed for at least 30 minutes and preferably 1 hour each time; and,
9. Fit within the life-style and interests of the client to encourage consistency of participation over time.

In addition, aerobic programs should be of low impact and performed in a comfortable environment with a shock-absorbing floor, at appropriate levels of heat or air conditioning, and at a reasonable sound level. Elderly individuals may have difficulty discerning oral instructions above the loud noise of fast music frequently played as part of aerobic programs.

CONCEPTS OF EXERCISES FOR REHABILITATION

Assessment of Function

The elderly client usually presents with multiple problems which may include dysfunctions of motor control, of sensorium, of perception, and cognition. The client comes with certain expectations, fears, and a body image that may be altered by the aging process or the disability. There may or may not be significant others in the environment, but the individual has an established pattern of socialization, a broad background of experiences as a meaningful member of society, certain interests and hobbies, and an established personality. There are also economic factors that may also affect the client's ability to partic-

ipate in the therapeutic program. Additionally, there is a physical environment in which the therapist must function, an environment with time pressures, expectations of others, as well as rules and regulations.

The assessment is a broad-based determination of the client's current level of function, areas in need of development, and the potential for functional improvement. The disability may be the focus of the evaluation, but it is not the total evaluation. How valuable is it for the therapist to know that Barbara walked 2 miles a day and that Carol was fairly sedentary?

GROSS ASSESSMENT

Gross assessment of motor control including coordination of movement, available range of motion, balance, and functional capabilities provide information regarding specific deficiencies in need of intervention. Assessment of gross joint range is best performed in relation to functional activities. Keep in mind that the range of movement responses available to the elderly is smaller than that of younger individuals and smaller among the old-old in comparison with the young-old.

Postural assessment provides considerable information on movement difficulties, areas of pain or dysfunction, as well as potential difficulties with functional activities. The individual who is stooped or who does not straighten at the hips will expend more energy and find it difficult to walk, get up and down from a chair, or even move in bed. Posture and breathing are closely interrelated. A slumped posture limits respiratory excursion.

Movement dysfunctions or postural deviations that interfere with the normal movement patterns increase energy expenditure, depleting already limited reserves. This can create a negative cycle of reduced activity with increased deterioration of strength, posture, and limitation in joint motion.

FUNCTIONAL ASSESSMENT

The functional assessment is not limited to areas of deficiencies. There is much information to be gained by watching the performance of successful movements. Observations include noting how the person moves, current posture, and ability to vary from the posture, breathing during movement and at rest, motor planning is executing movement and responses to instructions. The desired level of function varies with each client, but most individuals strive for the greatest degree of control over their own lives as possible. For the individual in a nursing home, independence may mean the ability to get in and out of bed when desired and go down the hall to the dining area or social room. For others, it will mean a return to independent living and participation in sports and social activities. Therapists often focus on the components of function, such as strength, range of motion, or gait, rather than on the broader life-style, which includes the social and environmental as well as the physical aspects. The benefits of the therapeutic intervention are influenced by the client's ability to adapt and adjust to the therapeutic environment.

Motivation and Adaption

The ability to adapt to new situations varies with individuals, but there is evidence that adaptability decreases with age. The trauma of injury or disease, the strange environment of the hospital, the disruption of usual lifelong personal habits, the many unknown people, confusing activities, not clearly under-

stood instructions or information all impinge on the client and affect the ability to adapt and respond appropriately. Part of the therapeutic intervention is to build a sense of trust between the therapist and the client and to provide a safe environment requiring as little adaption as possible.

Motivation can be defined as the need or desire to achieve a particular goal or act in a particular manner. Motivation is a necessary ingredient in the success of any therapeutic activity. Is helping the elderly client to become motivated any different from helping younger clients to do so? The degree of congruence between the goals of the therapist and the client is reflected in the extent to which that individual is considered to be motivated. The goals may not always be the same, e.g., Carol might be concerned with the steps into her home rather than with the strength of her knee, and she may not relate the two.

Two types of motivation are recognized: internal and external. External motivation, that which is provided by another, is temporary in nature. Internal motivation, that which is provided by the person, and is often reflected in an internal dialogue or self-talk, is the one that lasts. Internal motivation can be positive or negative. Carol Sky may use negative self-talk to convince herself that she will not be able to manage the steps at home, while Barbara Garden may use self-talk to overcome her fear of walking again.

Jackson (36) identified a six-step approach to the unmotivated patient. Critical to the process is building trust between the clinician and the patient, giving the patient time to share individual concerns, and recognizing the importance of the client's goals. Jackson believes that creating a safe environment to promote a sense of self-worth and helping the client become more self-directed in the therapeutic process are important for motivation. Lewis (37) suggests asking the patient to select the best time of day for treatment and identifying the skills she would like to develop as ways of involving the patient in decision making.

Communications

Barbara Garden, sitting in a wheelchair in a busy physical therapy clinic, is not responding to the instructions given by the therapist. Speaking louder, the therapist repeats the instruction. Barbara looks, but does not respond. The therapist, shouting now, repeats the instruction a third time, speaking directly into her face. Familiar scene? Often, a mistaken assumption is made that a non-responding client simply doesn't hear the instructions. Instead, there may be a mismatch between the selected method of teaching and the client's preferred method of learning. Much of therapeutic exercise consists of teaching particular body movements—some simple, some quite complex. Individuals have one or more preferred modes of translating sensory information into meaningful patterns and linking new information with already existing data in memory.

To use new knowledge or perform new movements, new instructions or information must be linked to something known. Dickinson (38) described a communication technique known as neurolinguistic programming, where specific efforts are made to find existing anchors in a client's memory. The anchor is used as a link to teach new information. Everyone has many anchors. A particular tone of voice or visual scene, for example, can stimulate a particular emotional or physiological response; a foreign word associated with a familiar object translates an unknown into a known.

For the elderly client who may have decreased auditory or visual capabil-

ities, other means of linking information may be necessary. Therapists are skilled at using effective kinesthetic cues; the client, as a partner in the learning process, can often indicate preferred ways of learning. Given the opportunity, Barbara might have said to the therapist: "I can hear you with my hearing aid, but the noise in this room makes it difficult for me to understand what you are saying."

Unlike children, who are given time to learn new skills in a safe and quiet environment, the adult client is expected to adapt quickly to new situations and strange instructions. If the older client does not respond with the expected speed, he is considered "senile," "unresponsive," or "demented." Yet older clients, even those with some form of pathological dementia, if given time and appropriately structured learning tasks, can learn quite effectively (37).

Clients also need time to internalize one set of instructions before moving to the next. Single-stage commands—giving one instruction at a time—may allow the client to follow a complex exercise routine. Explaining the equipment slowly, providing an opportunity to explore through touch or by asking questions may reduce the uneasiness of trying something new. Client feedback is important, but questions such as "Do you understand?," "Do you have any questions?" or even "OK?" may elicit little more than a nod or shake of the head because it is too difficult and frightening to do otherwise. Time is a commodity too often lacking in busy departments, yet time for careful exploration and interactive communications, a quiet and safe environment, and an opportunity for the client to explore and voice personal needs are important ingredients for effective therapeutic exercises with the elderly.

Facilitating Breathing

Effective breathing and effective movements are closely interrelated. Although Carol Sky does not have identified respiratory disease, she, like many of our clients, may be found to have poor breathing patterns, a tendency to hold the breath when attempting movement, and a lack of awareness of her own breathing. Repetitive exercises will not necessarily improve breathing, since respiratory movements are only partially under voluntary control.

The first step is to determine the person's current respiratory status. Observe the client sitting or lying. Where are the respiratory movements? Is there much excursion of the thorax or chest wall? Is there evidence of diaphragmatic breathing? Does the client avoid some position, such as prone-lying, because of difficulty in breathing? Observe the respiratory rhythm: is it regular, irregular, fast, slow? Does the client sigh from time to time? Sighing, in the absence of depressed affect, is a forced exhalation designed to provide deeper inhalation and is a sign of poor ventilation.

The next step is to facilitate self-awareness. At different times in the exercise program, Carol can be encouraged to feel and describe her breathing, learning gradually how more effective breathing can make movement easier. The therapist observes, guiding, if necessary, by asking where and how the breathing is felt. Movement and breathing can be integrated starting wtih small movements the client can perform easily and building to the more complex and difficult movements. If Carol becomes short of breath easily, she can be taught to break up more difficult tasks into more easily achievable parts. Frequently, simple specific respiratory exercises, described in another chapter, can be incorporated in the total therapy program. The goal is to improve the quality of

breathing and help the client learn how more effective breathing can improve movement and reduce fatigue.

Facilitating Movement

Movement can be facilitated in a number of ways based on individual assessment that guides the therapist in the selection of appropriate patterns to achieve desired goals. Generally, elderly individuals respond better to functional movement patterns rather than specific muscle-strengthening exercises. Young-old individuals with single pathological problems who have participated in an active life-style may well benefit from the use of sophisticated isokinetic exercise machines. However, older people with multiple movement problems generally respond better to manual exercises or self-directed movements. Proprioceptive neuromuscular techniques can be quite effective as is the use of functional movements as exercises. For example, one natural sequence may be either weightshifting sitting, then standing to learn hip and trunk patterns. Another is sitting-to-standing activities, emphasizing forward weightshifting gradually onto the feet by bringing the head and shoulders and, if necessary, the arms forward until standing becomes a "natural sequellae (Fig. 14.6)." Combining knee flexion and extension with ankle motion, providing manual resistance at appropriate points, can facilitate the feeling of coordinated lower extremity function.

It is important for the client to participate in the exercises by learning how functional movements feel and allowing the body to move smoothly and easily rather than with excessive effort. Felderkrais (40) emphasized that movement should be pleasurable, as pleasurable movements relax respiration and are learned more easily. He advocated that movements should be light, easy, and energy-efficient. When teaching Felderkrais movements, both Jackson (41) and Wildman (42) stress that motor learning must be slow and comfortable, that

Figure 14.6 Sit-to-stand exercise.

fatigue, strain, or pain interfere with learning, and that new efficient and easy movement patterns will gradually substitute for older, less efficient patterns as the client develops body awareness. Rhythmic activities with slow reversal patterns can also enhance coordinated movement.

Imagery is another useful tool, the client being asked to remember the feeling of normal motion and to try duplicating it. Movements of an unimpaired extremity reinforces an image; or, the client's past experiences can guide the selection of appropriate images. Breaking a complex skill down into small steps will also make it easier to learn.

There are key words such as: "easy movement," "allow the body to . . . ," "feel light," "how can you make the movement as effortless as possible?" which may communicate the therapeutic intent. Feedback, given in a positive and supporting manner, must be accurate, clear, and directly related to what is being learned. It is important for the client to feel safe from possible fall or injury. Asking an anxious patient what would help him feel more secure may provide useful information.

Treatment Environments

The therapy department in a hospital or rehabilitation center represents a safe but closed environment. The client learns to move and function under guidance and with supervision. There are parallel bars for gait training, the mat table is broad, the therapist uses a safety belt, and there are no sudden movements from others to startle the client. The closed environment is predictable and does not reflect the real world the patient is preparing to reenter. Elderly clients must not be discharged from the hospital or rehabilitation center unprepared for adjustment to the more open environment of the home situation. It is thus important to teach transfers from surfaces of different height. Gait training on carpets and uneven surfaces, with people moving around, provides practice to help cope with a more open environment.

Often, Medicare regulations may mitigate against giving individuals both the time to develop self confidence in their abilily to function and the time to work effectively with significant others who may provide key support in the transition. All of these factors increase the need (a) for the client to be actively involved in establishing goals and determining how best to resume prior function; and (b) for the therapeutic environment to provide some opportunities for home-like adjustments.

Home health care has been established to serve as the bridge between hospital and home living. Where available, the home health therapist has the unique opportunity to work with the client in the familiar but more open environment of the home. Here the bed may be too low, the bathroom entrance too small, the bathtub without rails or seats, and the kitchen unusable by someone using a walker. There may be scatter rugs, a dog or cat, or telephone cords on the floor. If the client goes outside, there are jostling people, fast street lights, and limited transportation. The home health care therapist needs to assess the home situation and work with the client in meeting the most pressing needs. Barbara may be able to go to the bathroom alone using a walker, but may have difficulty getting food from the refrigerator to the stove and then to the table to eat the meals her neighbor brings in. The home health therapist needs to be aware of community resources available in each situation and to make appropriate referrals.

Exercising in the home setting requires considerable creativity and ingenuity. There is the challenge to design programs the client can carry out independently, using readily available materials such as cans of food for upper extremity movements, belts and elastic bands for both upper and lower limb exercises, and walls or doors as support for standing activities.

THE FRAIL ELDERLY

The frail elderly are generally those individuals with some permanent disability that interferes with full normal function. They may need considerable support for daily function, and may be in retirement or nursing homes, attending adult day care centers or living independently, but nevertheless unable to participate in regular wellness programs because of disability. Contrary to general opinion, the frail elderly can benefit from participation in properly designed exercise programs and can improve function through therapeutic exercises designed to meet individual capabilities. Hurley (8) outlined numerous wellness and fitness activities for groups and individuals in sheltered environments, and Chrisman (6) describes and illustrates adapted activities that can be performed sitting and with some external support.

Practice in finding and maintaining a well-balanced sitting posture enhances trunk flexibility and strengthening as well as improving breathing. Most upper extremity and trunk movements mentioned earlier can be performed by the frail elderly. Many lower extremity exercises can be done sitting or, if standing is possible, a chair or walker may be used to maintain balance (Fig. 14.7 and 14.8). The elderly tend to be rather cautious, so overactivity is rarely a problem, but proper safeguards must be employed.

Figure 14.7 Exercising with a chair for balance.

Figure 14.8 Sitting exercise.

In the group setting, staff are needed to safeguard individuals with poor balance, to provide kinesthetic cues for the visually impaired, or visual cues for the hearing impaired. A therapeutic activity program in a sheltered environment helps clients maintain and improve on gains made during therapy. Such programs provide outlets for physical and creative energy and emphasize the benefits of being well rather than being sick. Group exercises that involve a number of people, such as passing a ball around a circle on a sheet held by all participants, provide opportunities for social interaction as well. Internal motivation is a critical factor, as the individual who values activity will maintain participation and benefit physically, socially, and emotionally.

SUMMARY

Guidelines for developing exercise programs for elderly individuals have been provided. It is important to remember that the elderly are individuals with a zest for living and a desire to participate as fully as possible. In the words of Robert Browning (43):

Grow old along with me!
The best is yet to be,
The last of life, for which the first was made.

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MANJIT MAHANTA

ULFA cadres: mounting menace

his murder: either ULFA suspected he had come too close to Saikia or he may have lost their trust.

MAHANTA'S neighbour—considered to be an ULFA sympathiser—thinks it might be the handiwork of Jatiya Mukti Bahini, an organisation said to have been floated with Saikia's approval to counter ULFA. Recently, ULFA publicly passed the buck to the Bahini for crimes it was being held responsible for. Whatever the reason, an important channel for negotiations has been lost. ULFA, anyway, seemed extra chary of discussions: to the extent that it recently issued a public denial of reports of such a possibility. Negotiations with the Government, it said, would be held only on the fundamental issue of sovereignty.

But this is not the only front on which Saikia is being bombarded. His failure to tackle the intractable militancy problem has created doubts in the mind of the Central leadership about his ability to govern. He, however, dismisses the suggestion as "mere gossip".

If Saikia has bungled, ULFA has not been any smarter. After coming under pressure from the army, ULFA declared a ceasefire and apologised to the people at the end of February this year. It had counted on a people's movement building up against the army's deployment but the Assamese seemed to welcome it. Thinking the AGP might return to power, it allowed peaceful elections, not having bargained for a split in the party and a Congress(I) come-back. With Saikia—long-time foe—in the saddle, there was, therefore, only one option for the militants. To strike at the heart of a promise of restoring peace.

And instead of standing firm from the very beginning, Saikia allowed himself to be bullied and the ULFA stock to swell by conceding one demand after another. Also, as an army officer puts it, the Government compounded its error by withdrawing Operation Bajrang just when it had started getting public support in a big way.

According to Saikia, however, the problem requires delicate handling because at least 500 ULFA activists were inducted into the police force at the thana level while there are a large number of sympathisers lower down. By offering to resign, as he did last fortnight, Saikia will not be able to tame the tiger that has smelt blood. The situation calls for sensible stratagems, not merely showy gimmicks. ■

HOW IT HAPPENED

AUGUST 8: August 27 fixed as date for freeing of ULFA captives.

AUGUST 27: Saikia agrees to only an equal exchange.

AUGUST 29: ULFA demands 14 men for Paul and Raju.

SEPTEMBER 3: Adds four names. Saikia calls it absurd.

SEPTEMBER 5: ULFA threatens to kill hostages.

SEPTEMBER 7-8: ULFA kills Raju and Bipul Mahanta.

HITESWAR SAIKIA

"We will crack down"

WITH the ULFA menace looming larger than ever before, Special Correspondent FARZAND AHMED *spoke to Chief Minister Hiteswar Saikia at his Janata Bhavan office. Excerpts:*

Q. ***Your administration is seen as an ULFA hostage. How do you explain it?***

A. We have stopped agreeing to ULFA's terms. If things go on like this, we have to crack down.

Q. ***But you did nothing to get the hostages released for over two months. Why?***

A. We responded to the appeal of some people for negotiations. They advised me against any harsh measures. I contacted a cross-section of people—intellectuals, teachers, journalists, leaders of political parties, lawyers, film artistes.

Q. ***Why do you not then take your own decisions, as promised?***

A. My decisions are influenced by views of those I consult. It appears that I'm going soft and my government has become a prisoner, but it isn't so. Now my advisers feel that the time has come to take harsh measures.

Q. ***Does it include army deployment?***

A. We are thinking of that too.

Q. ***Has ULFA infiltrated the police force? Is a purge being planned?***

A. Yes, I have reports that ULFA boys were recruited in the police during the AGP rule. There's no plan to purge the force as yet, but such elements are being identified.

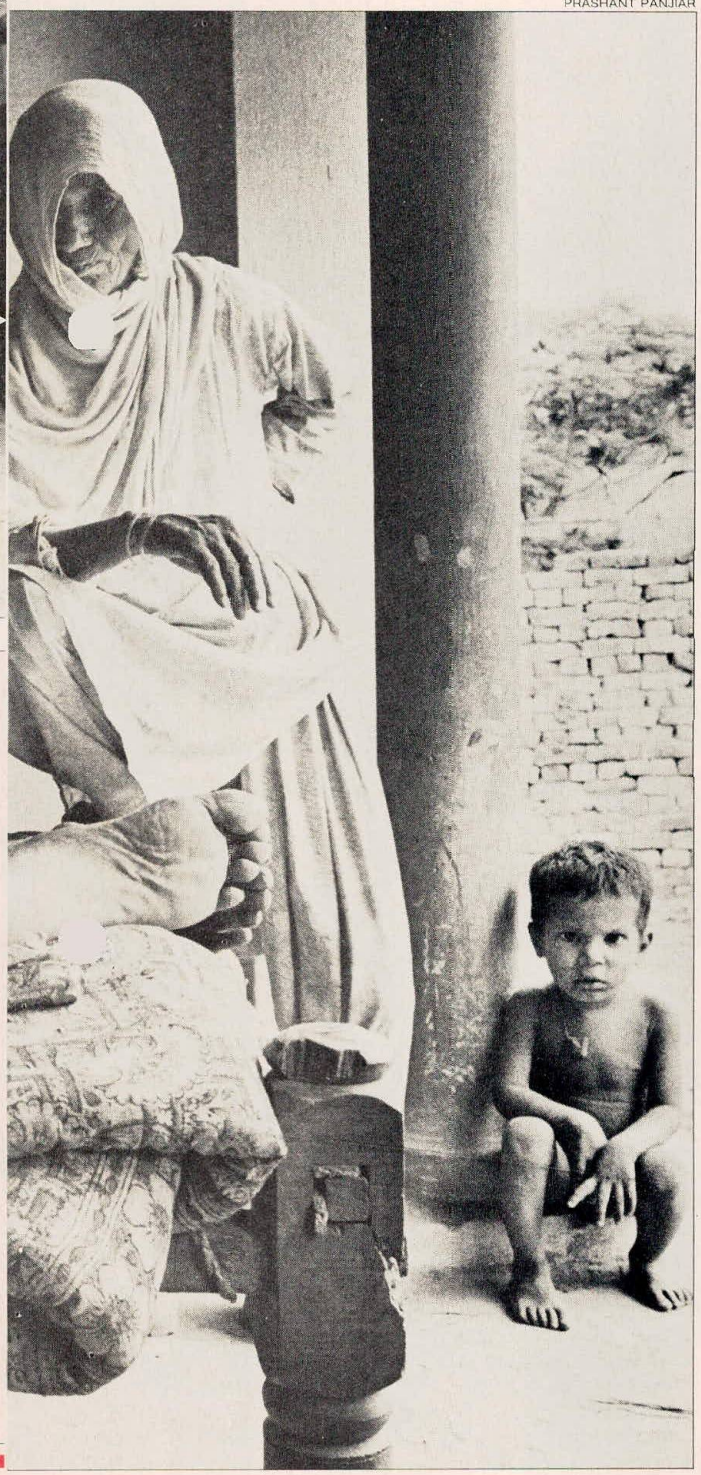
Q. ***Apparently the high command isn't happy.***

A. That's mere gossip. If the Centre wasn't happy I wouldn't have been given a free hand.

THE GREYING

OF INDIA

PRASHANT PANJIAR



By MADHU JAIN and RAMESH MENON

INDIA is growing old. Fast. By the turn of the century, there will be 76 million Indians over the age of 60, almost the entire population of Germany and twice that of most European countries. During the past decade, the increase in the aged population was a little over 38 per cent—the rest went up by only 19 per cent.

Alarm bells should be ringing. The only other segment of society multiplying at dizzying speed is the under-15s. With such double-dependency on the comparatively sluggish middle, the question that looms frighteningly large is: whose baby are the elderly? Especially in a world growing increasingly indifferent to them.

■ Longevity is up from 54 years in 1980 to 62.

■ India is greying rapidly. In 1971, 33 million were above 60. Today there are 55 million. By 2000 A.D. there will be 76 million.

It is a question the elderly are now asking. Never before have there been so many old people in the country. Nor so vulnerable. The final curtain now falls much later. Life expectancy today is over 62 years—it was 54 just 10 years ago and just about 30 years in 1947. Improved health standards, lower infant mortality, fall in birth rates, and medical breakthroughs are ushering in a grey tide.

Consequently, life's last two stages *vanaprastha* and *sanyas*—when one is meant to have spurned the world—are getting longer and death's shadow paler. The days stretch out like an infinite desert, monotonous and parched. "At 60 it was all done, now he has to continue for another 20 years," says Professor T.K. Oommen of the School of Social Sciences at Delhi's Jawaharlal Nehru University.

Those extra years—when "age's cruel knife" has already done its work—are no longer a bonus. At times, it is a death-in-life existence darkened by the clouds of loneliness. Traditionally, age had a value in itself. The *buzurg* were venerated because they were old. Their word was law. Even today in most villages, the more years you have, the greater the deference, explains noted sociologist Professor A.M. Shah of the Delhi School of Economics. Like Sonwati, who lives in a village some miles from Jodhpur. To enhance her status, she adds five years to her 75 years. Yet a silent revolution, a coup of sorts, is taking place. The patriarch, the matriarch, the eldest son, the aging boss, and the village elder are being elbowed aside. The youth are moving in.

Children are even throwing their parents out. In Madras, a 70-year-old man was left to die on a pavement at Egmore by his children. Lorry drivers finding him an eyesore decided to hasten his end. They threw him on a heap of broken glass.

But for Vidyavati, 90, roaming the streets of Delhi's

SAIBAL DAS

As life expectancy rises and the old lose their status, clouds of loneliness darken the extra years.

Gulmohar Park in search of shelter, it's a living death. She shuttled between her three daughters, until they would have no more of her. "They say the oil on my body soils their sheets; my cough disturbs their sleep."

Like shifting sands, change has been altering the social landscape of the country over the past two decades. Gerontologists fear that the elderly are in for a harrowing existence, as time-honoured attitudes towards them alter. The aged are gradually being divested of the one asset they always took for granted: authority. "Your children looked up to you; now you look up to them," says Shakuntala Varma, 68, whose husband died 26 years ago. Even the literature today reflects this displacement of the old. Writer Rajendra Yadav, who also edits the Hindi literary magazine *Hans*, says that most of the short stories he now gets depict the older people as redundant, irrelevant.

The "contraction" of the joint family alone is not responsible for the marginalisation of the elderly. Complex factors like urbanisation, the crunch on space, migration of youngsters to cities and abroad, inflation, a visible assertion of individualism and the onset of a youth-worshipping culture are responsible for the displacement.

Nowhere is this topsy-turvydom more manifest than in the relationships within the family. Age was synonymous with wisdom, values and a host of things that made Indian society so unique. A young nation like India prided itself on its veneration of the old. Looking after the aged was considered *punya*. In a country without social security, children are the only insurance policy for parents. "A child is like a sapling you plant. It will grow into a tree and in your old age you can sit under it for shade," says Satyavati Jain, 74.

BUT unfortunately, the sun bears down more harshly on the elderly today. The old and young are often a world apart. People take out a half-hour ritualistically for their elderly parents, a snatch in the morning before going to work, a pause between coming home and going out again to dinner, or vanishing into their rooms.

Dada and *dadi* and more often *nani* were institutions. They fulfilled an important role as a bridge between their children and their grandchildren. They were the conduits for stories from the Ramayan and Mahabharat—before television and *Amar Chitra Katha* comics usurped a role which gave them a sense of identity. Today, the grandparents sit in a corner while their grandchildren are glued to the small screen, video or snowed under by school books. The ear-shattering decibels—rock, pop or filmy—shut them out more completely.

Similarly, grandmothers have also begun to feel irrele-

"It was a question of prestige. If you didn't look after your parents it would be difficult to get your sisters or daughters married within the community."

—D.B. MALIK, 66, retired Hindustan Aviation Limited official

Many factors have contributed to India's greying crisis: the joint family has collapsed, the generation gap has increased, and rapid urbanisation has created a money and space crunch that has altered the once-respectful attitudes toward the old.

vant. Making pickles or *kanji* or knitting those fabulous sweaters was a trump card of sorts for them. Now, it is the age of the ready-made. Those pickles for which you hungered now come packaged, homely style, even labelled "Mother's". And clothes are off the peg, infinitely varied.

Language, or the lack of it, often separates the generations. The two teenaged sons of Suren Khirwadkar, 42, vice-president of CitiBank, Bombay, can't communicate with their grandmother—she knows only Marathi, they speak only English and some Hindi. Often, there is a cultural stumbling block. Muna Rana, 18, respects his 82-year-old grandfather but feels they have little in common. "The old should look after themselves," he says.

Widening the chasm further are the exigencies of modern life—the crunch of time, space and pressures. "Apartments build walls round individuals more than families do," says Khirwadkar. "Once the doors are closed, it's like an Englishman's castle. I am busy, my sons are busy, and my mother sits alone."

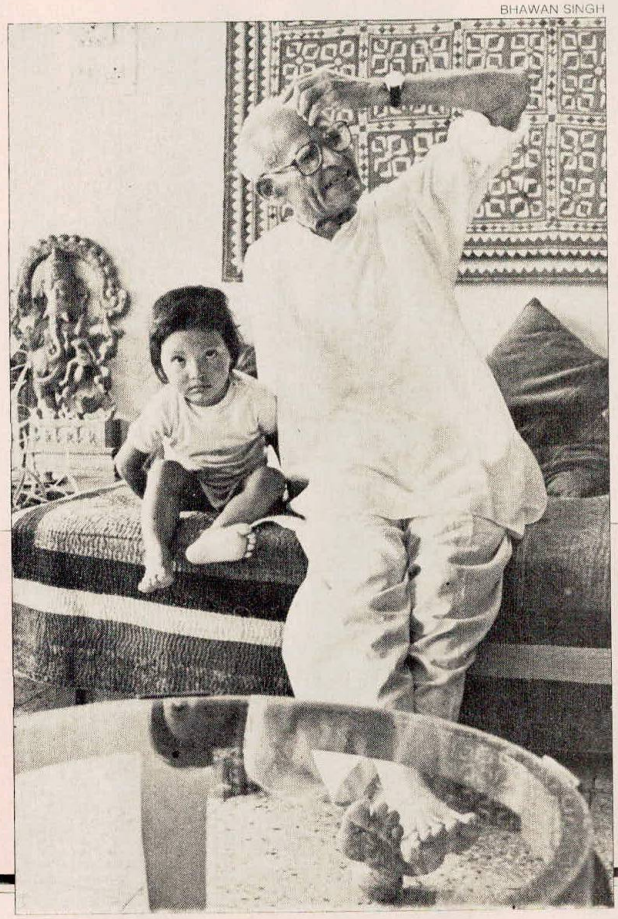
The city enhances the loneliness of the aged. The unhappiest are those who have moved from smaller towns and villages to the metros to live with their children. There they could at least sit on the veranda and exchange a few words with the milkman, the neighbour, or the vegetable vendor. Stuck in a high-rise, they may look out of the window on to a wall. Or to yet another window with the curtains drawn. Or down below, to life passing by at a frenzied speed totally alien to them.

Urbanisation and the premium on space have driven a wedge between the old and the rest. Where there were spacious bungalows, there are now two-room flats with everybody treading on each other's toes—and frayed tempers. G. Imlay, 79, a retired railway engine driver, moved into an old-age home in New Delhi along with his wife. "My daughter has two rooms and five kids. I'd be cranky and grumble all the time. Besides, they have an Indian-style toilet." Privacy is also a fairly new need in the cities. Children now want a room of their own. So, in a high-pressure society, grandparents become the odd people out, the appendages.

WORSE off are those who cross cultural zones. Whether it is a Mrs and Mr Swaminathan who move in at the onset of their twilight years from Madurai to Delhi to be with their children, or a Mrs and Mr Chopra who go to their NRI children in Tampa, Florida. Interestingly, those visits to the lands of plenty overseas are getting shorter. Surrounded by limitless stretches of highway—often with the idiot box their only plug into animate life—many elderly couples cut short their trips and return home. "I feel very lonely and restless in New Jersey. How much ice-cream can one eat and how much shopping can one do?" remarks a 72-year-old Mrs Kannan. Besides, today more women are going out to work, leaving the old in the care of servants or to themselves.

If the old are feeling left out in the cities, in the villages they are left behind.

BHAWAN SINGH



V.M. Mangalik, 75, retired chief engineer, Dehra Dun. He finds no time to feel bored as he runs the house, tends the garden, cooks, plays with neighbourhood children and makes himself socially useful.

"Happiness in old age can come only if we are not financially or psychologically dependent on our children."

BHAWAN SINGH

In the autumn of their lives couples forge a new togetherness.

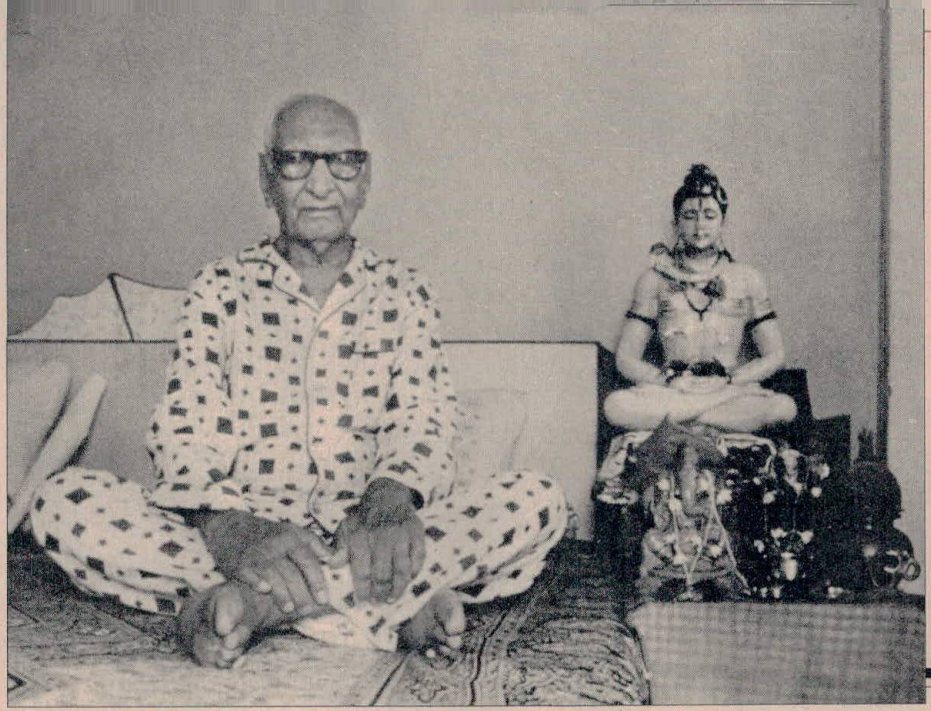
Large-scale migration of the rural youth to cities in search of better opportunities has compounded the crisis for the aged. With his son away in Delhi, Abdul Majeed, 65, a carpenter in Uttar Pradesh's Tengora village, has to take many breaks from work when aches rack his body. If he does not make a paltry Rs 25 a day, the family starves. Leela, 80, says he feels like an *awara* going around his village in Uttar Pradesh in search of some odd job. His three sons are away in various cities and they have their own children to look after, he rationalises.

NOR is it easy for the migrant sons to send money regularly. Says Ramnath, 30, a cobbler in Delhi: "We earn so little. How can we send money home?" The elders are left behind to fend for themselves. They do not have the advantages of medical care and rural development plans have not made any appreciable dents in reaching the rural aged.

In rural India, the semblance of respect for the aged that existed is gradually fading. "Many of us may not really care for our aged, but we dare not neglect them as the community around is always watching," says Narsingh Pal, 60, a villager from Bulandshahr district in Uttar Pradesh. In the cities, even moral sanctions by society no longer keep people from maltreating their old. "There was a bondage to the *biradari* (clan)," says D.B. Malik, 66, a retired Hindustan Aviation Ltd official. "If you didn't look after your parents, it would be difficult to get your sisters married." It mattered what others said. Today, even neighbours don't know what is happening. Those old watch-dogs, the unofficial ombudsmen, have gone.

Increasingly, the aged are being discarded by the young as soon as they have usurped their property. After Arunachalam, 60, was found on a garbage heap at Royapettah in Madras he was taken to an institution. His family soon turned up to retrieve him—but only until he was made to sign off his 10-acre property. Then, it was back to the streets. Similarly, Alamelu, 84, bundled off to an institution in Madras by her children when her husband died, was forced to relinquish her property.

What worries sociologists today is the abuse of the elderly, both physical and emotional. Hitting the headlines is the fairly new phenomenon of crime against the elderly. And, increasingly, murders. "Fifty per cent of the crimes against the elderly in Delhi involve family members because of inheritance



Parsuram Bhowjani, 108, a former sales officer of a silk firm, has four children but lives in Bandra, Bombay, alone and refuses to have anything to do with the world outside.

"I prefer yesterday. In my time a man was taken at his word. Now, everything is legal. There's no trust anymore."

severance of ties is not without pain. But guilt gets relegated to the corners of the mind. And couples get on with the business of life in a world moving too fast for them to carry the aged along. That guilt, though, catches up later. Take Vijay Aggarwal, 48, a senior executive in a Bombay multinational. He skipped rungs on his way to the top—he was a technical *ingenue*. His wife is from a far more sophisticated background and paints. Initially, he allowed his severely arthritic widowed mother to stay with him. But when they moved up the social ladder and began to entertain, the old mother didn't quite fit in with the decor. The pangs of remorse were muffled by his ambition and his wife's social aspirations. "I knew the nagging wouldn't stop. And I needed peace of mind." But now, pushing the half-century mark, the niggling doubts have returned like Banquo's ghost and he wonders whether his own children will do to him what he did to his mother. His suppressed anger towards his wife now finds unexpected outlets. He contemplates running away to an ashram.

He doesn't though. There are many who rationalise themselves out of this dilemma. What mitigates the guilt of those turning their parents away—to old homes, ashrams, other, kinder relatives or even on to the streets—are the demands of their children and their jobs. Says a middle-aged Bangalore executive: "Are we going to spend our savings looking after the aged who are anyway going to die soon or are we going to invest in our children who have a competitive future ahead?" It really is a question of choice, of priorities. "When there isn't enough milk, do you give it to your growing child or to your parents?" asks an unabashed Saudagar Singh, marketing consultant, in Delhi.

IN an age of conspicuous spending, each mouth to feed suddenly seems larger. Singh's parents now live in two small rooms at the other end of Delhi, marooned because they can't move out. Sometimes, when nostalgia gets the better of him he visits them without telling his wife—and armed with fruit and presents.

Sometimes, the elderly themselves make it easier for their children. Aware of the change taking place, they seek refuge in ashrams. Earlier they might have gone on yatras, but there was not such a rush to build rooms in places like Hardwar, Rishikesh, Pondicherry or Beas in Punjab. Or the need for 'Pay and stay' homes now being expressed or the plans for plush residential complexes for the platinum people. "Now, when I go at Pooja time, they besiege me with affection. That week is lovely. And I think about it the rest of the year," says a Bengali widow who stays in an ashram in Varanasi.

Old parents falling ill is a living nightmare for many. Visions of Kafkaesque hospitals frighten many couples. The honour which came with *seva* isn't there any more. They

"Like the planets, the old and the young move in their own orbits, without touching one another."
—RAJENDRA YADAV, Hindi writer

Like an amputation, this severance of ties is not without pain. But guilt gets relegated to the corners of the mind. And families get on with the business of life in a world moving too fast for them to carry the aged along.

would rather put their ailing parents in a nursing home, pay for it, take them flowers and have their children send them get-well cards.

While sons might be falling short in their filial duties, daughters seem to be taking on their reponsibilities. In a fundamental role-change, more women are now looking after their parents. Not too long ago, parents in many communities would not even drink a glass of water in their married daughter's house. But now perhaps because more women are earners too, they pass more easily from nurturing their children to nurturing their parents. "Now you even get the kind of mother-in-law jokes you find in Italy," says noted TV script-writer Manohar Shyam Joshi. "Men joke about being *ghar jamais* in their own homes."

What's lost in this quasi-banishment of the old from centre stage is not quantifiable. Nor quite definable. That sense of sanity, those solutions which can't come out of books or computers. Breaking with them is like removing the chains linking us to a past, to a culture, to a civilisation. The old are continuity itself, heirs to a collective wisdom. "With them goes whatever dignity or grace there was in the Indian family," explains Punjabi writer Krishna Sobti.

The elderly may be at fault—at times they are autocratic, unbending and demanding. But they do keep the family together. Somehow, they can paper over the differences within the family. They can keep tempers under control. And warts of the family hidden. And when they finally die, their children are pushed to the frontline.

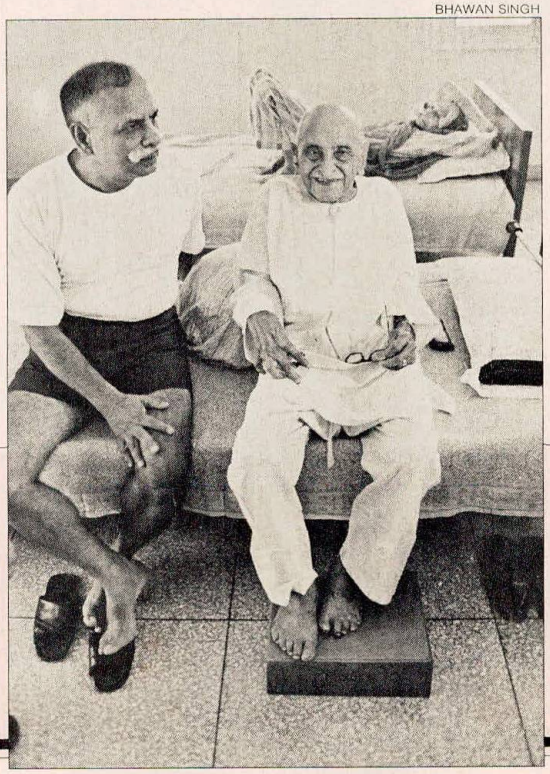
Time may not be seen as a "fleeing thief" as it is in the West. Aging is not quite that fatal an obsession in India. And death itself not so final an event—at least for those who believe in reincarnation. Death is taken in a more philosophical sense and with greater resignation, an acceptance of fate. But it is something the old now have to think about for a longer period. Especially, when they lose a spouse or friends.

OLD age becomes a life-reviewing time. The burden of memories can plummet them into depression. Often they are alone with their past. For Surendra Khanna, 77, a Delhi industrialist, it's time to go. "It's time for me. Enough. Most of my friends have died and now their children are going." According to a study on aged couples in Kottayam done by Father Jacob Cherian, as age advances, the frequency of thinking about death increases. Shakuntala Varma lost all her brothers and sisters. "When I am alone I keep thinking about death. Worse, when something happens to my friends, there's no one to whom I can talk about it." She describes the past like cinema reels of faces and situations which go past her eyes silently.

For many made to feel like burnt-out ends of humanity, old age may have become the ante-chamber of death. But for others, it's time to find new passions. Or to return to the forgotten ones. J.R.D. Tata re-energised life in his eighth decade by making family planning a personal crusade. Others are "adding life to years" by chasing causes—whether it's H.D. Shourie who in his late 70s is battling on for civic issues or Lakshmi Menon, 93, an external affairs minister of state with Nehru and Shastri, who nips round in her capacity as president of the All-India Committee for Eradication of Illiteracy among Women.

Others find second careers. Kranti, 64, a retired government engineer, has opened a showroom for electrical goods in his house in Delhi to fill those empty

BHAWAN SINGH



Lala Kanshiram Chawla, 104, retired government employee, who now lives with his son in Dehra Dun. He writes daily in papers on various subjects ranging from morality to humour.

"Values and priorities have changed. Gone are the days when being an aged person was an advantage."

PRASHANT PANJIAR

Not only their wealth, the old increasingly want to take good care of their health too.

hours. A growing number contribute their skills—as accountants or taxmen—to religious organisations like the Ramakrishna Mission. Many teach children Urdu or impart religious training at various *madrasas*.

And then there are the old who escape feeling old by looking after the old. M.M. Sabharwal, 70, who has been chairman of dozens of company boards is now chairman of Helpage and raises money for the elderly. None of these individuals consider themselves old—old is other people.

This last act of life is also the time for renewal. For eminent painter K.G. Subramanyam, in his 70s, this is the age to see life more clearly—without that meddlesome "passion coming in the way, like maya". The canvasses of Bhabesh Sanyal, 95, have the clarity and *joie de vivre* found in the drawings of children.

The grey brigade is now striking back. India does not have any "Grey Panthers"—the group of elderly Americans who fought for their rights. But some elderly people have begun to organise themselves over the past decade. In addition to Helpage India and Age-Care India, there are nearly a dozen groups like the Senior Citizens Federation, Indian Federation on Aging and National Federation for Senior Citizens, which are actively lobbying for various demands. The demands include 50-per cent concession in rail fare, separate geriatric wards, a network of 'Pay and stay' hostels for the elderly, patterned on the working women's hostels. Major R.S. Pannu, director-general of Helpage India, suggests that planners should create a "grey skills bank" where the aged can be converted from liabilities to assets by profiting from their vast experience.

EVEN more significant, there is a new, more upbeat mood evident. M.S. Rana who at 81 thinks he's "not old but only disabled" believes that people like him must spend on themselves. "We should dress well, look after ourselves and enjoy life." Every first Sunday of the month a group of about a dozen aged people in Delhi gather to "meet and eat" in a coffee house. "We don't talk about our children or grandchildren. We talk about the neighbours or what their daughter is up to," he says with a mischievous twinkle.

Some go on holidays, as opposed to just pilgrimages. Delhi's Mrs Varma and two other friends even older than her, went to Orissa and spent the whole day on the beach. "I'm not ready to sit in a corner with a *mala* and *bhajans*."

Others are tackling their truant offspring head-on. An elderly widower who had been shunted to the garage of his own house by his daughter-in-law sold the house while his family was on vacation. Yet another, on the advice of his friends, informed his son's office that he was not giving him any house rent—his son was claiming HRA from his employ-

"Life seemed eternal while they were there. As long as the parents are alive you don't really think of death, then you are next."
—RAJAN PRASAD, university professor

For many, old age may have become a wait for death, a long winter of neglect. But for others it's a second summer of renewal, the age to see life more clearly, the time to slough off cares and responsibilities. And death in itself is not so final an event, at least for those who believe in reincarnation.

ers. Promptly, the son not only started paying his father but stopped abusing him.

As India greys, new areas open up for innovative entrepreneurs. Beauty care, tonics, restoratives, so-called vitalisers like ginseng herb, travel and housing schemes, get a new clientele. Anjana Handa who runs a soft laser treatment clinic in New Delhi claims that she is besieged by callers—all above 45 wanting their wrinkles and sagging skin to vanish. Increasingly, the aged want to look good and exercise more than they ever did before.

THE aged have painfully realised that they must keep their wealth with them. They are no more willing away property to children or giving them all their property on a platter. The proverbial lady with the trunkful of jewels and possessions is now beginning to put her money in the bank. The old now have fixed deposits stashed away and make sure they have enough money to make them financially independent. Says Vidyaratna, 71, a retired education officer, who lives in a Hardwar ashram with his wife: "If we have money, everyone respects us. Even our children." In his ashram, there are nearly 300 couples living a totally independent life, in separate houses and running their own kitchens. Almost all of them are financially independent. Their children drop in to see them but few have any illusions—they know they do so because of their bank deposits.

There's also a silver lining to the grey clouds. Sometimes, there is love in the time of old age. Couples may have squabbled all their lives but in the autumn of their lives, the bonding between them strengthens. Old age often leads to a reordering of relationships among couples who battle loneliness. Some understand what love means only in their twilight years, says Bangalore-based psychotherapist Carlos Welch.

There are stirrings of a sort of an old people's liberation movement. But the vast majority is still at the mercy of their children or fate. With India greying so rapidly, the Government is still Rip Van Winkle-like about the phenomenon. No five-year plan has yet recognised the needs of the aged. At the World Assembly of Aging held in Vienna in 1982 it declared that "aging in India should not be viewed with anxiety".

Eminent sociologist M.N. Srinivas says the only way to avert a crisis is to create a consciousness of India getting greyer so that society is geared to meet the challenge in terms of infrastructure. Clearly, India needs to plan ahead for the aged.

Going the way of the West with homes for the aged is perhaps not the best answer. But the need to weave the aged back into the tapestry of life and not let them be isolated at its borders has never been so great.

(Some of the names have been changed to protect the privacy of the persons quoted.)

PRAMOD PUSHKARNA

Devaki Aggarwal, 68, a retired school principal, lives on three tin trunks on a New Delhi pavement, unwanted and uncared for, after relatives turned her out.

"My family comes to see me live on the roadside. But they will not give me their current address. They do not want me."

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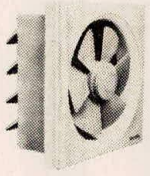

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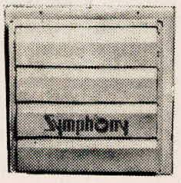

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The problem

'An old man loved is winter with flowers' (old German proverb).* To a society and culture that has long prided itself in its veneration of the elderly (witness the popularity of the Shravan Kumar story), the existential reality of the aged may come as a surprise. Our older citizens, on a daily basis, are reminded both of their expendability as also of the deepening coarseness society displays towards them. Be it the way they are treated within the family, the woeful inadequacy of healthcare provisions directed towards the old, and above all the increasing incidence of the violence they face – it is evident that modern Indian society is ill-prepared to meet the challenges posed by the greying of its population.

A part of this problem can be traced to material scarcities. Most societies, the poorer ones even more so, find it difficult to set aside scarce resources to take care of the elderly. Given the widespread application of the framework of triage, the elderly and infirm are invariably passed over in favour of those classified as productive and useful. But equally, the problem lies in the fetishization of youth. Modern industrial and post industrial cultures foreground the vitality and energy of the young as against the wisdom and experience of the old. And even though we have yet to approximate the western obsession with remaining young, we are clearly getting there.

It is likely that in earlier times ageing as a social problem did not preoccupy societies. Life expectancy was in any case low. Since only a few survived for long years, it was easier to either venerate them as repositories of wisdom and tradition or create social mechanisms which encouraged the aged to step away from the management of everyday concerns. The notions of *vanaprastha* and *sanyasa* probably evolved as a response to the need of displacing the old.

With an increasing proportion of our population living for ever longer years, we are now confronted with the problem of not knowing what to do with our elderly citizens. Simultaneously, our senior citizens too are challenged by how to creatively and usefully occupy themselves, and that in a society which displays little patience for the old. The joint family, long held out as our answer to this problem, is neither as widespread as popularly believed, nor does it seem capable of accommodating the pressures created by the demands of a modern urban and industrialized lifestyle.

If honourable living within a joint, multigenerational family has become difficult, a dignified separate existence too is not easy. Be it ensuring economic and physical security or accessing basic services, including healthcare, everyday living often creates trauma for our elderly. Far worse is the expression of societal neglect and unconcern. Increasingly pushed into mining their own resources, both economic and emotional, the aged are increasingly thrown into their own age cohorts, a process that can only strengthen feelings of alienation.

Such at least is the picture presented in our mass media or through the popular soaps and films. Even the more sensitive Bollywood productions, Saransh or 36 Chowringhee Lane, paint the elderly protagonists as somewhat feeble and helpless, unable to bring joy and meaning into their lives without an active association with the young. Just take an early morning walk and listen to the conversation of the old. It is either full of pride about successful children or, more frequently, about how they are treated within the household. The speech is marked by anguish and insecurity. Little wonder that so many older people are unwilling to settle

* *Folio*, October 1998.

their property matters, fearful that in the absence of economic resources they may be forced to move out.

Those who live on their own, a phenomenon now fairly widespread, are obsessed with issues of physical security, not surprising given the incidence of crimes targeting the old. The difficulties they face in accessing basic services – from medical to recreational – are legion. Over-riding all these is a feeling of loneliness and worthlessness.

Unfortunately, detailed research on the aged is hard to come by. For a start, even basic demographic data is only now being subject to detailed analysis. In the absence of indepth anthropological studies on the joint family system, both regionally and for different socio-cultural groups, we continue to believe in its resilience. We need to map out how our aged live – within joint families, alone, in ashrams or old age homes, where? Why is it that institutional care for the elderly – be it day care centres or residential homes – is more widespread in the West and South rather than the North. And above all, we need to improve our understanding of the non-urban middle class world. Far too often, both our understanding and consequent policy recommendations are overly conditioned by our middle class worldview.

In particular, we need to direct our attention towards the special problems faced by old women, more so widows. Except when controversies of the kind generated by the filming of Water arise, as a society we remain supremely unconcerned about their fate. In urban, middle class households they are reduced to the level of unpaid help; in rural and tribal society they are left to fend for themselves.

The government has recently formulated a national policy for older persons, listing out a range of social welfare measures targetted towards the elderly. A few states, notably Himachal Pradesh, have even experimented with legislating for the elderly, mandating them as a legal charge on their children. While the merits or otherwise of the proposed policy will continue to be debated, it remains a matter of concern that we have increasingly to rely on the state to provision for our elderly and that inter-generational relationships have to be recast in the language of legal rights and entitlements. As H.Y. Sharada Prasad, in a recent column in *Asian Age* presciently pointed out, ' It is not the government that has elderly parents, but we. It is up to us to take the initiative in protecting them.'

It is heartening that civil society has taken some steps in this direction, be it through setting up day care centres, old age residential homes, organising recreational activities for the elderly, arranging care of the indigent or terminally ill, and so on. The medical establishment too has got sensitized to the special problems faced by the elderly, both physiological and psychological. More important, the elder citizens have begun to organise themselves in forums for mutual support, as pressure groups for policy changes and so on. Outside the family, many older people have become active participants in NGOs, in helping improve civic life, in brief, carving out an active and useful role for themselves. The last in particular has been crucial in helping break the image of the elderly as dependant.

As long as we continue to perceive older persons as a problem, it will be difficult to move out of a utilitarian and instrumental focus. A civilized society must create conditions such that the aged can live lives of self-worth and dignity, more a source of joy than a burden. This issue of *Seminar* examines some of these concerns. There is no getting away from the fact that the elderly are today what we will be tomorrow.

National policy on older persons

C.P. SUJAYA

SINCE the time when development planning was initiated in independent India, the state has recognised older persons as a priority target group for social welfare interventions. The Directive Principles of State Policy in our Constitution enjoin the state to provide public assistance to older persons within the limits of its economic capacity. The early social welfare interventions for this group included old age pension and shelter. These were introduced by state governments in the '50s and the '60s and now most states have some form of old age pension scheme. Additional welfare schemes were launched in the succeeding decades.

The social welfare approach was conditioned by humane principles. Older persons were perceived as the natural recipients of welfare handouts, doles and institutionalised services. The state did not view them as a resource or as active participants in planning their own development and welfare. On the other hand, the state governments found that there were severe financial constraints in expanding these social welfa schemes to cover larger numbers o older persons.

The coverage of the population as well as the quantum of individual pension granted under the scheme remained minuscule. It became an ameliorative measure, aimed more at preventing destitution and penury rather than covering risks attendant with old age. This absence of an effective and comprehensive framework of social security assistance for the overwhelming majority of the older citizens continues to date.

The National Policy on Older Persons was announced by the gov-

ernment in 1999, declared as the International Year of Older Persons by the UN. The year 2000 has been declared as the National Year of Older Persons by the Government of India. The decision to frame a policy for older persons was first mooted in the '80s, following the World Assembly on Ageing held at Vienna in 1982. In 1987-88 an Inter Ministerial Committee was constituted by the GOI for this purpose. The process of formulating the policy gathered momentum in the two years preceding 1999. According to ministry officials, the process envisaged active involvement of voluntary organisations, research bodies, schools of social work, and so on. A number of regional consultations were held along with a national level consultation to discuss the draft policy document prepared by the ministry for getting feedback from a broad range of positions and approaches.

The national policy reflects a few basic and interlinking concerns. These include the impact of demographic changes overtaking the country's population in the wake of an increase in health coverage and the adoption of the small family norm resulting in an increase in the responsibility of the working population for elderly care; the magnitude of the task of reaching even minimal social assistance to the large numbers of the elderly; the effect of the changes in the economy due to urbanisation and industrialisation; and the introduction of new technology and new life styles and values on the structure and functioning of families and their capacity to care for the elderly.

The policy highlights the plight of the vulnerable within the older person's category such as widows, women in general, the poor, rural residents, the disabled and chronically (including mentally) ill and others.

The national policy is open ended. It promises an array of state interventions – support for financial security, health care, shelter and welfare, special focus on older women, protection against abuse and exploitation and special attention to rural areas. It also recognises that the state by itself cannot achieve these objectives, except partially.

Indeed, it is difficult to take these grand promises seriously, or envisage from where the funds for some of the new state interventions promised in the policy, even under such important heads as health, shelter and welfare, will be found given the precarious financial position of the government in the era of reforms, especially in the underfunded social sector.

For example, the policy commits to increase the coverage under the old pension scheme from the January 1997 level of 2.76 million to include all older persons under the poverty line. But it does not specify the number of older persons below the poverty line who are to be covered if this commitment is to be fulfilled. Nor does it speak of any probable deadline or phased deadlines by which the government plans to complete this coverage – or the magnitude of funds required to complete this gigantic task. The present pension rates paid to older persons throughout the country (Rs 30 to 250 per month) affords no income or livelihood security. It is only a token payment to ward off extreme destitution. Though the policy speaks of revising the rate at intervals so that 'inflation does not deflate its real purchasing power', no details have been given to show whether the base rate existing at present will be protected through indexing or whether a total review will be done on the basis of the need for economic sustenance.

Since the below poverty line population of older persons will continue to rise (due to falling death rates and no discernible decrease in poverty ratios), the commitment of ensuring full coverage will be a never-ending task. Even at present the population above 60 years in the country is estimated at a huge 67.2 million (1995), only a fraction of which is covered by the old age pension and other schemes meant to address destitution (such as pension for agricultural labourers, unemployment relief, and so on, some of which may be accessed by older persons). While there are no available figures showing the number of older persons who are below the poverty line, the incidence of poverty can be assumed to be higher in the older age groups than in the general population.

The policy statement itself has relied on the figure of 33% of the general population and concluded that one third of the population in the 60+ age group is below the poverty line. This may be an understatement. Still, accepting this figure, the number of poor older persons comes to about 23 million. Surveys from different sources show high numbers of chronically ill and disabled persons among the elderly. They also show that the elderly continue to work long after 60 years and that their average earnings are much lower than in other age groups. The burden of providing universal coverage of old age pension to the elderly poor, even within a phased period, therefore, seems beyond the capacity of the government given its financial position and a realistic perspective.

The same is true of other sectoral interventions mentioned in the document, such as strengthening the primary health care system and public health services, providing geriatric care facilities at secondary and terti-

ary levels, starting new specialised courses in geriatric medicine, starting mobile health services for the ailing old persons, meeting the education, training and information needs of the older persons, and so on.

The policy document, in so far as these commitments relating to state interventions are concerned, can at best be seen as a statement of intent. The addition of a financial memorandum or the formulation of a plan of action to implement the policy would have significantly improved its credibility and helped nail the policy down to the immediate tasks and sort out the medium and long term action perspectives. Though policies are not expected to spell out everything in minute detail, it is incumbent on the government to plan the implementation strategies, sequence the actions and, above all, garner its resources and match the plans and commitments with the needed funds.

But there is no mention in the document about the financial implications of carrying out the commitments made in the policy or from where these resources are going to be arranged in all the sectors. All that the policy contains is a statement that an action plan will be prepared by the government, that the policy itself will be widely disseminated and 'its features remain in constant focus'. But in the one year that has elapsed since the policy was announced, no plan of action has been formulated. The ministry, perhaps, is engaged in such an exercise at present.

Questions of financial capacity, capability and viability arise, therefore, from a plain reading of the many commitments of state action made in the policy by the government. How much can the government afford to spend on new schemes for older persons or to upgrade, improve, train, reorient, modify existing programmes to reach the older persons? How much clout does the Ministry of Social Justice and Empowerment have with other important ministries to ensure that the issues relating to older persons are given more importance in all their programmes?

The policy refers to the legal rights of parents without any means to be supported by their children having sufficient means. These rights are enshrined in the Cr. PC as well as in the Hindu Adoption and Maintenance Act 1956. The policy refers approvingly to the action taken by two state governments in introducing relevant legislation at the state level and speaks of encouraging other states to pass similar legislation so that old parents unable to maintain themselves do not face 'abandonment and acute neglect.' The provisions of Cr. PC and HAMA are seldom used by parents to go to court against the children. Most litigants under Section 125 of Cr. PC are spouses, that is, wives. The provision for maintenance of parents by children, wives by husbands, etc. under these statutes, however, is not to provide minimum income or old age security but to prevent destitution and vagrancy. It cannot, therefore, substitute for state action in providing risk cover to older persons.

Though the Himachal Pradesh Maintenance of Parents and Dependants Bill was passed by the state assembly in 1996, it still awaits Presidential assent. The bill empowers any person unable to maintain himself, who is resident in the state, to apply to the tribunal for an order directing the children, grandchildren, husband, father or mother as the case may be, to pay him a monthly allowance or any other periodic payment of a lump sum for his maintenance. The bill is aimed at providing relief not only to indigent parents (above 60 years) but to wives, children and dependants who are in a similar situation. The inability to maintain oneself is defined as not being able to meet the expenditure on basic amenities to meet physical needs including, but not limited to, shelter, food and clothing from his total or expected income and other financial resources.

Two mechanisms have been created in the bill, namely those of 'maintenance officer' and 'approved person or organisation'. The former is invested with the duty to help applicants in any legal proceedings under the act as well as to appear before t. court on their behalf. He can consult the parties concerned and bring about reconciliation; he can authorise underage applicants to ask for relief if he is satisfied that infirmity of mind or body makes it difficult for the persons to maintain themselves.

The 'approved persons or organisations' are those bodies engaged in social welfare or family welfare or others as approved by the state government 'whose association with a tribunal would enable it to exercise its jurisdiction more effectively in accordance with the purpose of this Act.' These organisations are authorised defray the expenses on maintenance of the persons who have been granted relief by the tribunal and claim reimbursement from the state.

The bill provides that lawyers shall not appear before the tribunal or represent any party. The maximum period of time to decide the application by the tribunal is six month from the date of application. The bill authorises the attachment of salary payable to any person against whom a maintenance order has been passed and who is employed by the state or central government or by a local authority or from a corporation engaged in any

trade or industry which is established by the state or central government, or by a government company.

There is a real reluctance on the part of parents to go to court against children. Though the Himachal Pradesh bill has some attractive features, including involvement of social organisations in the legal process, simplification of legal procedures, flexibility regarding age limits, ease of attachment of salaries, conciliation process, among others, it remains to be seen how often the statute will be made use of by older persons as compared to the other groups eligible to ask for relief, such as children and spouses.

The concerns of older persons are cross-cutting, relating to many different departments and ministries within the government. So far the needs and requirements of older persons were subsumed under the rubric of 'welfare' or 'social welfare'. Only the very poor or the destitute were directly targeted. Now the policy statement makes a break with the past by spelling out 'the principles... the directions, the needs that will be addressed and the relative roles of government and non-government institutions' to carve out 'respective areas of operation and action in the direction of a humane age-integrated society.' The policy further states that the thrust is 'on active and productive involvement of older persons and not just their care.'

This holistic approach toward older persons is sustained in the policy by identifying priorities such as social assistance and security, health, shelter, education, freedom from abuse and exploitation, research, training and manpower, besides several others. The challenge of implementing such a multi-level and multi-dimensional mandate is enormous. It calls for coordination, leadership, effective strategizing, networking, lobbying and advocacy. Above all, it calls for effective monitoring, feedback and continuous system improvement. The institutional mechanisms that are in place or are being set up to oversee the policy implementation are therefore of crucial significance.

In May 1999, the ministry notified a 39-member National Council for Older Persons under the Minister for SJE to advise, provide feedback, act as a lobby and advocacy forum, and deal with complaints from individuals. This body has representation from a few central ministries such as pensions, defence, railways, communications as well as from three state governments by rotation. A representative each from the National Commission for Women and the National Human Rights Commission finds place on the NCOP. But ministries dealing with a number of important aspects of the subject of ageing and older persons, such as the following, have not been represented on the Council.

* *health care and nutrition*: 'health care needs of older persons will be given high priority' (para 34 of the policy), 'the primary health care system will... be strengthened and oriented to meet the health care needs of older persons' (para 35 of the policy);
* *shelter*: 'housing schemes for urban and rural lower income segments will earmark 10% of the houses/house sites for allotment to older persons... older persons will be given easy access to loans for purchase of housing and for major repairs with easy repayment schedules' (para 48 of the policy), 'a multi-purpose centre for older persons is a necessity for social interaction and... it will... be necessary to earmark sites for such centres in all housing colonies... preferences will be given to older persons in the allotment of flats on the ground floor' (para 49 of the policy);
* *education*: 'discrimination... against older persons for availing opportunities for education, training and orientation will be removed... assistance for open universities will be sought to develop packages using distance learning techniques... educational curriculum at all stages of formal education as also non formal education programmes will incorporate material to strengthen intergenerational bonds and mutually supporting relationships' (para 56);
* *law*: 'the introduction of special provisions in IPC to protect older persons from domestic violence will be considered and machinery provided to attend to all such cases promptly... Tenancy legislation will be reviewed so that the rights of occupancy of older persons are restored speedily' (para 65 of the policy);
* *media*: 'the policy aims to involve mass media ...on ageing issues... to provide opportunities to media personnel to have access to information apart from their own independent sources... their participation in orientation programmes on ageing will be facilitated' (para 89 of the policy);
* *rural areas*, where the bulk of the older persons live, (in absolute terms as well as in terms of proportion of the population) and who are poorer, less literate and expect to live less than their urban counterparts; and
* *labour*, which deals with the problems of the unorganised workers in the country as well as with pension and social security.

The bulk of NCOP's members are experienced and well-known individuals from a wide range of backgrounds, including NGOs, citizen's groups, retired person's associations, law, social welfare and security, research, and medicine. The NCOP

is said to have not met so far. A smaller working group consisting of seven members of the NCOP has been set up to transact business on its behalf, which meets more frequently and consists of representatives of voluntary organisations, experts and other luminaries. It is chaired by the secretary of the ministry.

The secretariat of the National Council, Aadhar, is located in Agewell, a voluntary organisation working with elderly citizens. Besides providing assistance to the council, it is mandated to look into individual grievances of older persons, set up a voluntary network at district level throughout the country, compile data and information relating to ageing and older persons, and carry on advocacy and awareness programmes.

Launched in November 1999, Aadhar had, up to the middle of February 2000, initiated a process of setting up voluntary action groups at the district level throughout the country in consultation with the deputy commissioners/collectors and volags. It has been able to identify nearly 2300 individuals in over 120 districts to work on a voluntary basis for the cause of older persons.

Aadhar is also formulating a strategy for handling individual letters of grievance or complaints from older persons. These are received by the ministry from a variety of sources and normally dealt with cursorily in the usual bureaucratic style. It has received over 700 such letters, most of them from the Ministry of SJE, and is currently reviewing them to find solutions and identify interactions with the concerned authorities.

While the idea of locating the secretariat of the national council in a voluntary organisation is innovative, it remains to be seen how effective Aadhar will be in shaping the agenda and deliberations of the council, and to what extent the council itself, given its unwieldy size, can foster coordination among the sectors of health, housing and shelter, law, nutrition, education, rural development, and labour, in advocating the cause of older persons and confronting prevailing negative attitudes towards them.

Ageism and discrimination against the more vulnerable groups among the older persons has to be specially countered. The policy speaks of action plans to be prepared by each ministry of the government to implement those components of the policy which concern it. It speaks of ensuring flow of benefits to the older persons from general programmes, as well as from special programmes and schemes exclusively aimed at the older persons. It enjoins each ministry to decide on targets, time schedules, responsibilities, action points and report on progress in the annual reports.

All this calls for a high order of horizontal coordination between different government agencies. The appropriate instrument to facilitate this is an inter-ministerial committee which, though envisaged as a part of the institutional set up, has yet to be set up. Such a committee should be given the task of monitoring policy implementation in as much as it relates to the ministries and the state governments. It should also look for appropriate strategies for networking within and outside the government agencies.

We now look at some crucial issues related to the policy on older persons:

1. *Social assistance for the older persons*. The policy adopts a segmented approach to the provision of income security for older persons ('policy instruments to cover different income segments will be developed'). The policy categorises two-thirds of the population above 60 years as economically 'fragile' out of which one half is below the poverty line and the other half is above it, but belongs to the lower income group.

While the expressed need to increase the coverage of old age pensions to all those below the poverty line receives top priority in the document, the policy calls for a new pension scheme to be established for self-employed and salaried persons with provision for employers to contribute. This will be overseen by a strong regulatory authority which will make investment norms and safeguard pension funds. It is not clear for which economic category or socio-economic class or classes this new pension scheme is intended.

In pursuance of the policy commitment, the ministry appointed an expert committee 'to comprehensively examine policy questions connected with old age income security.' One report dealing with improving the existing pension provisions was submitted to the government in 1999. The second report, dealing with 'a new pension provision for excluded workers who are capable of saving even modest amounts and converting this saving into an old age income security provision' was submitted to the government in mid-January this year.

Looking at the problem of social security from the vantage point of the neediest, there is no doubt that the most vulnerable categories of older persons are those who have worked or may still be working as landless agricultural workers, small and marginal farmers, artisans in the informal sector, unskilled labourers on daily, casual or contract basis, migrant labour, informal self-employed or wage workers in the urban sector, and domestic workers. These categories

of persons have little or no job security nor any form of social security.

While a few state governments have provided some succour to these groups through special pension schemes and unemployment relief, their coverage is extremely thin. The condition of these citizens is most precarious as their engagement with the labour force is intermittent and they are subject to long spells of no work. They also have to continue working long past the age of 60 or 65 years, if health permits, for sheer survival. The concept of the age of retirement does not exist for them, nor does saving in youth for old age have much meaning.

Levels of indebtedness among these groups speaks volumes about their lack of capacity to save. The loans are taken for a mix of consumption and other 'productive' needs. This strata is increasing since the opening up of the economy to market forces, the loosening of controls and the increasing stress on industry to become globally competitive has increased casualisation of labour.

It is doubtful if the new pension scheme recommended by the Project OASIS expert committee would address the particular situation and context of the older persons who belong to this most vulnerable group of citizens in the country, even assuming that the below poverty households are not included in the scheme in view of the government's policy commitment to cover them under the old age pension scheme.

It is not possible to present an in-depth critique of this proposal in the paper. It is learnt that the OASIS report is being examined by the ministry. However, some of its premises are self-explanatory. One is that 'higher government spending on old age security has often been at the cost of expenditure on other important public goods and services and has increasingly been a serious drain on government finances.' The other is that 'the sheer number of the elderly is too large and the resources with the state are too small to make anti-poverty programmes the central plank in thinking about the elderly... that government dole is not sustainable on a significant scale.' Another observation made in the report is that 'India faces severe problems of poverty among the elderly.'

Poverty among the older persons is a direct consequence of the lack of income and livelihood security during the productive years of the vast majority of the rural and urban workers who are outside the formal or organised employment 'sheds', which itself is the result of the failure of development planning. Second, anti-poverty programmes are primarily aimed at providing a wage or self employment, and not doles. Third, attempts at combining thrift and credit activities with anti-poverty programmes have been quite successful in recent years. To focus on poverty among older persons without its political economy will not lead us to any sustainable solution for containing the problem of old age destitution.

The pension scheme is meant for persons who at a minimum save Rs 5 per day. Research by Project OASIS has found that only if this saving is sustained throughout the working life (of 35 years presumably), will it result in escaping the poverty line in old age, provided the pension assets are invested wisely. The project assumes an extremely large number of people who can save between Rs 3 to Rs 5 per day and thus prepare themselves for old age income security. However, the report presents no data on household expenditures or levels of indebtedness to sustain this assumption.

In discussing financial security of older persons, the policy statement shows a greater involvement with issues relating to pension and social security of workers in the urban and formal sectors of employment. The need to improve the procedures of settlement of pension cases, improvement of investments and accumulations in the provident funds, more efficient disposal of gratuity and other retirement benefits, have received greater attention in the document.

The policy refers to the need for a strong regulatory authority to oversee pension schemes and pension fund management. There are references to taxation policies and the need to reflect sensitively to the financial problems of older persons in the matter of standard deduction, annual rebate for medical treatment, etc., all aimed at the income tax paying minority in the country.

Similarly, references to post retirement employment, income generating activities after retirement, career guidance and counselling and training are obviously targeted at the better-off sections in the country. Summing up, the policy statement on social assistance and security for older persons has not given any meaningful recommendation for improving the later years of the largest group of income and asset poor rural and urban poor.

2. *Issues relating to older women – legal rights.* While there are a few references in the policy statement to the gender based status of marginalisation and vulnerability of older women, there is no concrete recommendation which addresses their particular circumstances on account of gender and age. Though reference is made in the policy statement to a higher incidence of widowhood, there is no mention of a need to review the

unsatisfactory status of women's property rights.

Widowhood is intolerable because women lack both social and economic support. Ageism and patriarchy combine to make older women the most vulnerable among older persons. Abuse of older persons has been mentioned in the policy but no special reference to violence against older women finds place. The introduction of special provisions in the Indian Penal Code to protect older persons from domestic violence is, however, a welcome feature, as is the commitment to create a machinery to promptly attend to all such cases.

The situation of older women needs special focus in any discussion on older persons. The high proportion of widows in the 60+ group, the more favourable female:male sex ratio in the 60+ age group, the glaring differentials in literacy and wages or earnings between older men and older women, the higher morbidity of older women as compared to older men, the differential access of older persons to health care based on gender – all serve to highlight the many points of interventions which should to be taken up at policy level.

Old age, as the policy document reminds us, is not a separate part of life. The policy views the life cycle as a continuum, of which post-60 life is an integral part. It does not view age 60 as the cut-off point for beginning a life of dependency. Women face discrimination on account of their gender throughout life. Patriarchy as a system of male domination appropriates women's sexuality, labour and fertility and keeps them subordinate.

This subordination takes the shape of discrimination, disregard, insult, control, exploitation, oppression and violence – within the family as well as in the workplace and in the larger society. Added to this, in the later years, is 'ageism' defined as 'a process of systematic stereotyping and discrimination against old people because they are old... and allows younger generation to see them as different from themselves... at times ageism becomes an expedient method by which society promotes viewpoints about the aged in order to relieve itself from responsibility toward them.'

Though the codification of Hindu laws in the 1950s has been hailed as a great breakthrough for women of the majority community in India, ground experience tells us that women's access to residence, property and maintenance remains fragile and more connected to marital status. The unfettered right to will away self-acquired property which was introduced in the Hindu Succession Act 1956 with much fanfare has diluted the inheritance rights of women. The continuing presence of the concept of coparcenary too has affected her rights to access inherited property. She has a right to inherit, but her right to ask for partition of property is subject to male approval and is not unfettered.

Judicial attitudes and pronouncements have led to women being considered incapable of managing property. The right of a woman to reside in her natal dwelling house is also made subject by the courts, to her being unmarried, while daughters who are divorced, deserted or widowed are often illegally excluded under patriarchal norms. Thus the situation of older women, intrinsically bound with their legal entitlements as well as their marital status, cannot be improved unless women's overall legal rights are assured. The policy statement does not refer to this aspect at all.

Without attacking the root cause of exploitation, which is women's unequal status in law, only cosmetic changes such as an increase in widow pension or adding to the support services available, are possible. The women's movement in India has not paid sufficient attention to the predicament of older women in the country. The many movements and campaigns for legal reform by women's groups should identify the peculiar circumstances in which older women have been placed on account of their lack of legal entitlements.

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Ageism

VINAY KUMAR SRIVASTAVA

[I] spent [my] childhood playfully;
youthfulness sleeping;
cried at the sight of old age.

–Lines from a Hindi film song

In England, about two-thirds of all hospital beds are occupied by those over 65. It is a huge economic burden on the community to meet the cost of retirement pensions and support vast medical social services. Besides, a great strain is placed on the younger generation to look after them.

–Park and Park (1970)[1]

Dyallpur in Punjab is seen as becoming 'grey': this 'greying' being synonymous with the elderly being left behind to look after themselves while the younger members of the family tread distant lands for better opportunities. The victims are aged parents who, having spent their life in bringing up their children, are ultimately left to fend for themselves.

– *The Hindustan Times* (9 July 1999)

MY work neither involves working with senior citizens nor on old age. Like most students of social anthropology, I am interested in kinship systems. However, my focus is more on the rich (i.e., upper and upper middle class) and elite strata of Indian society as it has been grossly neglected in the discipline with its concentration upon the institutions of tribes and peasants. An empirical study of kinship systems begins with the most elemental kin group, the family, which forms the cornerstone of human society. Studies on the family begin by exploring the rules of descent, succession and inheritance of office, domestic deities and ritual apparatus, wealth and other material appurtenances. It is in the passage from the elderly to their descendants that we look for the operation of these rules.

Kinship deals with the basic facts of life: birth and death. Populations are replaced but cultural rules and patterns of behaviour endure. The old are replaced; the new recruited and trained who, over time, get ready to be replaced. The developmentally-oriented view of life is the pith of kinship studies.

For the purposes of this brief note, we look at the elderly population, initially in the context of family, and then move to other institutions, of which the state is of tremendous importance. This is our vantage point: contextualizing old age and its bearers in various institutions.

During fieldwork in an upper and upper middle class neighbourhood in south Delhi, I spoke at length with some old people who spent most of the time at home while their sons and daughters-in-law, or daughters and sons-in-law, were away at work. From these conversations I learnt that age stratification is concomitant with ageism, a concept that implies discrimination on the basis of age categories. The maximum discrimination experienced by the aged was within the family. However, paradoxically, it is the family, a 'primary institution' in Abram Kardiner's words, which can tirelessly fight ageism.

In April 1997, at a meeting of Sandhya Jyoti, an all-India association of senior citizens, one speaker suggested holding Mr India and Ms India

1. J.E. Park and K. Park, *Park's Textbook of Preventive and Social Medicine*, Banarsidas Bhanot Publishers, Jabalpur, 1970, 13th edition 1991, p. 328.

contests for old people. The point this 'elderly citizen', as he called himself, was endeavouring to make was that the aged were not discarded people, they were 'very utilizable and useful'. Given the overarching emphasis society and its institutions place on youth, vitality and physical attractiveness, older people tend to become marginalized or 'invisible'. Many others who spoke at the meeting, felt that older people should be 'brought into the mainstream'. True, that none of the speakers were in any position to specify what that mainstream was, or which social ingredients comprised it. However, everyone intuitively knew that the need of the hour was to make older people more visible, 'drawn centripetally', so that not only were their needs and demands recognized but that they could emerge as a strong interest group. The proposed Mr and Ms India contest represented a symbolic expression of the changing attitudes towards old age.

It has to, for the 'global experiment in life extension' is underway.[2] Certain demographic facts are on record. The life expectancy of the ancient Romans was 22 years; an average global man today can expect to live for 65 years. The lowest lifespan today is 38 years in Sierra Leone; the highest is in Japan where a male is expected to live for 76 and a female for 83 years. Just 57 years ago, Japanese men could expect to live for only 35.4 years and women for 43.6. The average lifespan in India today exceeds 62 years, which in 1983 was around 52.

As a result of better nutrition, advances in public health, improved sanitation and myriad medical breakthroughs, the average human longevity has nearly doubled in the last 100 years. It will further increase: it may triple, quadruple, or perhaps the very concept of lifespan may be eliminated.[3] Human beings may live forever, with death becoming an event of the past. Bruce Sterling, a science fiction author, in his book *Holy Fire* describes the process that transforms a 95 year old woman into a girl of 20. In a complete cellular overhauling, new genetic material is spliced onto the ends of each of her chromosomes, a technique which not only revives her youthfulness but possibly negates the concept of lifespan.[4]

The global increase in longevity has led to a population explosion of older people. In the United States of America, people above the age of 65, who number 35 million today, will double by 2030. So will those who are 85 plus, sometimes called the 'oldest old', numbering about 4 million today. In Japan, one in six persons is over 65, and in a dozen years that proportion will change to one in four. India's elderly population (i.e., 60 years and above), which in 1996 was 60 million, is projected to rise to 76 million by 2001 (i.e., 7.7% of the population) and 113 million by 2016 (8.9% of the population).[5] The global elderly population is expected to touch 612 million by 2000. Reliable information on 'centurion old' (people living for more than 100 years) is not available for all countries; however, their number too has been steadily rising.[6]

Meantime, there has been a steady decline in global birth rates. It is not only because of the 'population bomb' that couples are encouraged to have fewer children – the 'one-child' norm adopted by China has been enforced punitively. Changes in gender relations (especially the ideology of gender equality) and several culturally tolerated alternatives to traditional institutions of family and marriage (such as cohabitation, gay families, staying single) too have contributed to decreasing fertility. It is observed that many married professional women prefer to remain childless; pregnancy and child-rearing is often interpreted by them as an onerous burden that thwarts upward career and professional mobility.

Modernity is inversely related to fertility and the desire to discover self-fulfilment in one's progeny. This ideology is most fully expressed in the western world; its individualism standing in marked contrast to the centrality otherwise accorded to large scale kin bonds. An individual desires to see himself achieve whatever he sets his eyes on, rather than expect his descendants to achieve what he has not been able to in his own lifetime. Self-fulfilment, more than an indirect fulfilment through investment in children, is what characterizes the modern man.

A drop in birth rates has important repercussions for the elderly. In proportional terms, fewer young and middle-aged people will be available to care for the older population in the years to come. During my fieldwork in urban south Delhi, I came across many households that consisted of grandparents, parents and a lone grandson. It was the grandson

2. See S.K. Ramoo, 'When You're Old and Grey', *The Hindu*, 18 August 1997; Jeffrey Kluger, 'Can Science Slow the Ageing Clock?' *Time*, 20 January 1997; Rick Weiss, 'Ageing: New Answers to Old Questions', *National Geographic*, November 1997.

3. Kluger (1997: 47).

4. c.f. Kluger (1997: 52).

5. See the advertisement inserted by the Ministry of Social Justice and Empowerment, Government of India, in the national dailies on the International Day for Older Persons, 1 October 1999.

6. For instance, the number of centurion Japanese has risen from 153 in 1963 to nearly 7400 in 1996 (Kluger 1997: 46-7).

who was expected to look after the elderly. One may imagine the pressure such grandsons experience. Many sons and grandsons, I learnt, sacrificed opportunities for career enhancement, especially those which demanded their geographical mobility, because they had to look after their old and ailing parents and grandparents.[7]

How the world will cope with a rising elderly population remains to be seen. While not furthering alarmist arguments, it is clear that younger groups will be entrusted with larger and graver responsibilities than now. Many nations are likely to promulgate laws requiring children, sons and/or daughters, depending upon the descent principle recognized by society, to take proper care of their parents in their dotage. Infringement of such laws will gradually become a serious offence as the elderly population becomes more 'visible' (demographically as well as politically) and its problems multiply manifold.

Old age is a cultural construction, in much the same way as are the other phases ('vocations') of life. For heuristic purposes, we have devised concepts like chronological age, biological age, psychic or mental age, social age, and many others. Since these are our constructions, each of them relevant to a specific discipline, problems are likely to surface when a specific categorization of age is sought to be harmonized with another. Take for example chronological age with social age; while the former is reckoned in years counted from the date of birth, the latter (social age) grades life in terms of activities an individual is supposed to carry out from birth to death.

A synchronization of chronological age with social age results in foregrounding normative propositions like 'girls should get married before they turn 25', or that 'one should retire at the age of 60'. In other words, activities are spread out according to the presumed conception of the chronological age.

One can easily visualise increasing conflict in situations when a global extension of chronological age is unmatched by a corresponding change in social age. In Britain, for example, the age of compulsory retirement for most men is 65, while for women it is 60; this despite the fact that women outlive men by several years.[8] Many European nations today favour a reduction in retirement age as a possible solution to ever-increasing unemployment. In these contexts, the beginning of old age coincides with retirement and is associated with particular kinds of welfare benefits, such as provident fund, pension, leave encashment, gratuity, and insurance payments.

When people retire at the age of 60 (or 65 as in these countries), they are invariably healthy and can still work for long hours and under pressure of time. They can easily continue with the same job for another decade or so without any substantial loss of efficiency. Retirement, thus, creates social, economic, and psychological problems for such individuals and quite often for members of their households.[9] A conflict situation arises because of a clear mismatch between chronological age and the corresponding gradation of social age. When the average life expectancy in India was 52, the retirement age for central university teachers was 65; this remains the same despite an increase in longevity.

It is against the dialectics of these two relations that we can understand ageism. To recapitulate, it is in relation to younger and middle-aged citizens, and second, in the relation between different age categories, that ageism makes sense. Ageism may be defined as discrimination against people on the basis of their age. It is an ideology much in the same way as sexism and racism.[10]

To retire women at 60 and men at 65 because of a perceived decline in their working ability and output is an example of the practice of sexism. To proclaim that people of a particular race are endowed with lower intelligent quotient than others indicates racism. Similarly, there are many stereotypes of older people. In Britain it is commonly believed that 'most of the over sixty-fives are in hospitals or homes for the elderly; that a high proportion are senile; that older workers are less competent than younger ones.'[11] It is likely that many of these beliefs might have come to dominate our consciousness because the young and middle aged citizens felt threatened about their future once they found that the coveted positions were being monopolized by older people. Such perceptions are equally widespread even in those social situations where the notion of retirement does not apply, like those relating to the world of arts and politics.

Robert Atchley rebuts many of the ageist stereotypes prevalent in English society. He points out that 95% of people over 65 live in private

7. See Kumkum Srivastava and V.K. Srivastava, 'When Peers are no More: Some Rambling Thoughts on Old Age', *The Anthropologist* 1(1), 1999, pp. 25-35.

8. Anthony Giddens, *Sociology*, Polity Press, Cambridge, 1989, p. 598.

9. See Herbert S. Parnes, *Retirement Among American Men*, Lexington Books, Lexington, Mass., 1985; John van Willigen, *Gettin' Some Age on Me*, The University Press of Kentucky, 1989.

10. Giddens, op. cit, 1989, p. 600.

11. Ibid., 1989.

dwellings and not in hospitals or homes for the elderly. Less than 7% of those over the age of 80 show pronounced symptoms of senile degeneration. The working ability and attendance records of workers over 60 are often superior to those of younger age groups.[12] Moreover, many tasks require experience for their accomplishment. In many cases, younger workers need to be guided by their senior colleagues. In a society marked by individualism, potential hostility between the younger and older age groups can be mediated by pointing out that their relationship is analogous to the one between the individual and culture; the former is high in energy, the latter in information. The young are the repository of energy, the old of knowledge; a synergism exists between the two similar to the interdependence between the individual and culture.

Many activist groups of older citizens have come into existence to combat ageism in the West. As the old form a larger proportion of the population they are likely to acquire greater political influence. In the US they have already created a powerful political lobby. Similar developments are visible in Britain. The scenario is set for a manifestation of antagonism between the younger and older citizens. One of the questions raised by an article in the *National Geographic* (1997) was, 'How would future generations fare in a world where the elderly – no matter how beloved – refused to depart?'

Growing ageism can be checked by encouraging sociological measures and strengthening institutions. Giddens (1989: 600) writes: 'A redefinition of the value and contribution of older people would increase the general level of social tolerance. Benefits at the moment monopolized by the young and middle-aged might perhaps become more evenly distributed in the future. At the moment, people in these age groups have a monopoly over education, work, power and material rewards. A more even distribution of these, from which older people can draw just as much profit as younger individuals, would be in the interests of social justice.' For bringing into existence a just society, a revolution in ethical and moral dimensions is imperative, and the family can play a big role in heralding it.

The problems of the old are usually expected to accentuate when joint families and households break down. This argument is similar to the one put forward by the Zagreb anthropologist in Lawrence Cohen's book, who believed that since the North-Eastern Indian hill community he had researched did not have 'bad families' (it had joint families) there was no senility, no dementia, no Alzheimer's, no 'crazy oldies'.[13]

Such views are normally forwarded by those who base themselves on a middle class picture of society and take for granted that something resembling a joint family was common to all strata of traditional society. In this they are mistaken. Social anthropologists and sociologists have abundantly shown that the emergence and social reproduction of the joint family is predicated on specific conjunctions of ideological and material factors.[14] Economic and ideational inequalities characterized all traditional societies. As an institution, the joint family was far from being common in all layers of society; that even in the landed, propertied groups, it was not prevalent at all points of time. After all the family, like any other institution, is a process in time.

Equally, it is wrong to assume that older persons were always respected and honoured in traditional societies. Emile Durkheim, the French sociologist, in his study of the sociological causes of suicide, documented cases from societies where the elderly not needed for the tasks of production and other work, were obliged to kill themselves. Durkheim called this an 'obligatory altruistic suicide'.[15]

Even the concept of renunciation, so central to the understanding of Hinduism, was probably devised as a way to keep the elderly out of the mundane society, dominated by the young and middle-aged. Perhaps at the latent level, renunciation was an ideological instrument to separate the young and middle-aged from the elderly, so that the people on their way out did not meddle with the affairs of the world which were the prerogatives of the people in the vocation of the householder (*grahastasrama*). Scholars writing on non-renunciation have shown the crucial importance of the householder (the young and the middle-aged) in perpetuating the economic and social life of the community.[16]

It is wrong to assume that the position of the patriarch, honorifically called *karta*, of an upper caste and class joint family, exemplified the typical pattern of a traditional society. Ethnographers have documented

12. Robert Atchley, *Social Forces and Ageing*, Wadsworth, Belmont, 1985; Also see Giddens, 1989, pp. 598-600.

13. Lawrence Cohen, *No Ageing in India: Modernity, Senility and the Family*, Oxford University Press, 1998, pp. 16-17.

14. See A. M. Shah, *The Family in India: Critical Essays*, Orient Longman, 1998.

15. Emile Durkheim, *Suicide: A Study in Sociology*, Routledge and Kegan Paul, London, (first published 1897, 1952 ed).

16. T.N. Madan, *Non-renunciation: Themes and Interpretation of Hindu Culture*, Oxford University Press, Delhi, 1987.

numerous cases of maltreatment of the old people, in verbal and physical terms, in villages which stereotypically are supposed to mete out the best treatment to their elderly population. Heise *et al.* have documented many cases of elder abuse, especially of widows, in the US (the only country for which such data is now available).[17]

During fieldwork with Rajasthani villagers, I routinely encountered situations where the elderly were abused for failing to do an assigned task to the satisfaction of others. They were often sternly admonished by their descendants to mind their own affairs. Little interest was paid to their suggestions. Often they were interrupted and told to be as pithy as possible. No wonder, whenever they found a listener (a role best performed by social anthropologists and sociologists), narrations of their life-event and stories were literally ceaseless.

Otherwise, the old people were a 'muted lot', to borrow the apt words of Edwin Ardener – their tongues were tied and lips pursed because of the structure of dominance. It was not that they did not speak, or put forward their point of view, but that they remained unheard. And if bed-ridden, their sons and daughters-in-law who served them grudgingly, routinely cursed them for their predicament, their *karma*. The glorification of the aged in traditional societies is perhaps more of an assumption than an ethnographically supported fact.

Even though most episodes of elderly maltreatment take place within the family, it nevertheless remains the most important institution for initiating an ideational revolution in society to effectively combat ageism. The role of the family in bringing up new generations of people is fundamental. Many values and ethical norms are inculcated in the young by the family. Children are the personalization of the sub-culture of the family in which they have been socialized. To combat ageism and to provide its critique we need to inculcate a view of life as a process; the family can play a central role in disseminating this ideology.

The proposed National Policy for Older Persons highlights (*i*) the need to regard life as a continuum and the age after 60 as another phase; and (*ii*) the need to create an age-integrated society with strong bonds between different generations and thereby create conditions suitable for the elderly to stay with their families. Both these aims can be best realized with the active intervention of the family.

Stronger bonds between generations can be created not by the measure of fiat, in the sense of making senior citizens press legal claims against their children for not taking adequate care of them in their old age, but by bringing about endogenous changes. The desire to take proper care of one's parents and grandparents should emanate from within, from a particular ethical (i.e., human) viewpoint, instead of being imposed and sanctioned from outside

'Within' changes carry conviction. Thus the conditions suitable for the elderly to stay with their families are not premised on a utilitarian model of a good samaritan, baby-sitting and policing the household, answering telephone calls, and handling domestic chores. Kinship, love and affection should have priority over economy, utility and profit. Within this framework, I keep my mother with me because I love her and not because she takes care of my children. She babysits, for she is a member of the household and not the other way round. The potential of the elderly has first of all to be acknowledged in the family. It is within the family, rather than through the state, that we can visualise a possibility of ameliorating the condition of the elderly.

To sum up, the definition of the concept of age is largely dependent upon the nature of the discipline; hence we speak of the biological, sociological and psychological conceptions of age. Old age is also culturally constituted; its connotation in a simple society may be qualitatively different from that in a complex modern society.

In recent years, older people, who now constitute a large proportion of the population of the industrial society, have started to press for greater recognition of their distinctive interests and needs. The struggle against ageism is an important aspect of this development. The family, as an institution, can play an exemplary role in fighting against ageism, and in the realization of many aspects which are now enshrined in the proposed National Policy for the Older Persons by inculcating a developmentally oriented view of life in succeeding generations.

One possible way of bringing the elderly population into the mainstream of society is through furthering an ideological revolution at the level of family. By focusing on the family, the intention is not to undermine the sociological importance of 'family-like' institutions, such as homes for the aged. However, we should not forget that a move to these homes may amount to announcing to the world that an inmate has produced unfilial children. No older person would like to make his children a butt of ridicule. I learnt this from my conversations with the old people in south Delhi and rural Rajasthan.

17. L. Heise et al., *Violence Against Women: The Hidden Health Burden*, World Bank Discussion Paper, 1994.

Social ageing in India and America

JOHN VAN WILLIGEN

'In India we have the joint family system, in the West you have old age homes. India is better.'

I have completed two very similar research projects on social ageing, one in America and one in India. My research work involved going back and forth between ageing research in both the United States and India for about the last 12 years. During this period I participated in scholarly discourse about ageing, the meaning of social research on ageing, and overall societal trends.

In this essay I will discuss some perceptions formed by these experiences. Many of my opinions derive from the juxtaposition of what I learned from those two research experiences and the way that Indian and American people regard each other in terms of ageing. I have been struck by the way Indian people perceive the situation of older people in India and the United States and how they evaluate that difference. The opening quote represents one viewpoint that I have frequently heard when interviewing people in India. I discuss some of these contrasts, including Indian perceptions of the United States compared to my perceptions of the United States and my view of Indian self-perceptions as they compare to what actually seems to be occurring to older people in India.

Much of this relates to my trying to figure out the reality and dynamic of the joint family and old people in India. Most Indian research scholars have a view about ageing in the United States which is suffused with stereotypes, and if not wrong only partially true. More often than not this is conveyed through smug expressions of India's 'moral superiority' and 'spiritual development' in contrast to the 'materialism' and 'moral decline' of the West.

The other side of the equation involves understanding the conceptions westerners have, both about the Indian family as a place for ageing and their own relations with their parents. Most westerners tend to romanticize

the Indian joint family while being fairly self-critical about their ability to care for their parents.

In India, with some limited exceptions, ageing researchers place a high value on the joint family. I always thought that they do so uncritically. Very much going against the grain, K. G. Desai, now retired from the Tata Institute of Social Sciences in Mumbai, once wrote that the joint family in India represents a forced choice, made because of inadequate retirement income that necessitates pooling, and expensive housing that compels sharing quarters. He concluded that if people had adequate assets they would live in nuclear family households.

In contrast to Desai's view, based on my research and the experience of living with a three-generation family in Delhi for many months, I came to the conclusion that a joint family was a good situation within which to grow old. It has been my experience that people are, for the most part, helpful and loving and that there were a lot of interesting things going on. It was a good place to be very old and very young.

My first social ageing research experience was in the United States. I studied rural people in a county near where I work at the University of Kentucky. Many families were involved in farming and there were no industrial jobs in the county. The annual production cycles of tobacco, corn, hay and beef cattle had an important impact on the flow of life. Many people had active religious lives and were concerned about their spiritual development, which was important to them. When Indians spoke of the materialism of the West, I automatically thought of the people I researched in rural Kentucky. It wasn't that way at all. They would attend church most Sunday mornings where they would listen to the preacher offer his or her views concerning the moral implications of the congregation's behaviour and how they could 'grow in Christ'. The 'religious discourse' would invariably end with an invitation to the congregants to 'publicly declare Christ as their saviour' and to submit to the sacrament of baptism.

Further, there was little tendency to conspicuously display wealth. After I got more familiar with the community, I could observe groups interacting which would include people the local equivalent of *crorepatis* as well as those who were more or less poor tenant farmers. They dressed the same and talked the same. Distinctions based on wealth were subtle and expressions of materialistic values were very subdued. Communicating equality represented an important value. The image of American materialism would be challenged by the experience of doing research in a place like this.

The situation of older people in this county was coloured by demography and migration. The percentage of older people was high. No broad-based, fertile, population pyramid here. It was more like a column. While some seemed to attribute the age structure to increased longevity, it was more a matter of out-migration. Many younger people were forced to move away because of limited employment and the relatively poor income provided by agriculture. Because of this the average age of the county was high and getting higher. In this rural American community, as everywhere else it seems, demography is an important factor structuring the nature of lives of ageing people. Often when we interviewed older people they lamented the fact that their children and other young people had to leave the community in order to support themselves. Old people would often talk about the lack of jobs for the youth rather than problems more associated with their age mates. The community represented a kind of demographic shell. The population was old.

Just as I was finishing the book about my Kentucky research, I got a Fulbright lectureship for India. This was not totally out of the blue as I had studied Hindi while a graduate student in anthropology and had intended to do my dissertation in India, although I never was able to. While lecturing about applied anthropology at Delhi University, a faculty member in psychology, N. K. Chadha, suggested that we collaborate on a research project. As I was just in the last stages of completing the Kentucky book, I suggested that we do a similar study in India. It was a good time for such a project, as there had been little research work on older people at that time. There was increasing unease about the apparently rapidly ageing Indian population. Now, ten years later, there is a lot of research and many publications, mostly by psychologists.

The neighbourhood we studied was established in the early 1950s, mostly by people who had migrated to Delhi from the Punjab during Partition. The circumstance of the neighbourhood's creation also relates to the population being mostly well-off business families. One effect of this was that most households consisted of joint families. It was interesting for me to deal with a sample in which there was such a big commitment to joint families. Chadha and I found that over 80% of the households were joint, mostly three generation, or formed of families of brothers. Had I limited my understanding to only the research from this study, I would have concluded that joint families in India

were robust and important. However, even in this setting, people said that the joint family was declining in importance or decreasing in frequency.

The idea that the joint family is disappearing is a widespread one. Most books published on ageing topics in India assert it. It has come to be a kind of standard introduction expressed as a forgone conclusion. This is not to say that there is much high quality evidence that this is true; it's just that many people lament the joint family's demise. The 'breakdown' in the joint family system is a recurring theme. I agree with Lawrence Cohen, an American medical anthropologist who has called the 'decline of the joint family' the central narrative of Indian gerontology.

However, there doesn't actually seem to be any research that conclusively demonstrates that the frequency of joint families is today less in India than in the past. On average, older Indians live in large households compared to Americans. I have seen citations from national surveys indicating that only 6% of the elderly population of India lives alone or with non-relatives. A comparable statistic for Americans from good national level data is just over 40%.

Statistics from India about co-residence indicate that joint family living is still common for old people. I probably overrate the importance of co-residence rather than family attachments, possibly because it is relatively easy to study who lives with who and more difficult to investigate family attachments. I assume that when people say that the joint family is disappearing, they are referring to something beyond 'mere living together'. I imagine that the way power and authority are structured in the household is an important part of the transformation and that people in joint families are increasingly 'just living together.'

In fact, every once in a while I still get a glimpse of the 'real joint family' pattern marked by robust patriarchal authority and large size. It seems clear that inspite of large co-resident households in the present, there is substantial difference with the situation in the past: more individualism, less pooling or sharing of assets, less gender inequality. Maybe it is true that mere co-residence is not that important and that the issue is something more like familial love, cooperation and commitment. Ironically, Indian interpretations of the American situation seem to focus on the American pattern of nuclear household residence irrespective of issues of commitment, familial love and cooperation. American families too exhibit familial love, cooperation and commitment; it's just that they don't live in the same houses or even in the same city.

I think co-residence is confused with family commitment. In my view Indians tend to look at American families in terms of the meaning they attach to the co-residence pattern found in America. Families who don't live together may in fact be quite committed to each other. My wife and I see or talk with our married daughters about once a week. We have no sons. When an acquaintance from India suggested that I must be lonely because I don't see them more frequently, I recall thinking facetiously, 'we use email'.

The Kentuckians whom I studied are family-oriented, yet they tend to live in nuclear family settings or alone. What do I mean by family orientation? They actively maintain ties of love, respect and support in spite of not living together. They do this by financing their children's education beyond high school (Rs 800,000-1,000,000); using influence and connections to get their children jobs; caring for grandchildren; inviting the family for Sunday dinner; nursing older relatives when they get sick; paying for their children's marriage; and making efforts to have people attend church together, among many other things. In Kentucky there is even a tradition of having family reunions for those that live elsewhere. In short, they express in strong terms a commitment to each other's welfare, it's just that they don't live with each other, especially after they graduate from high school.

They don't lament this. 'He still lives with his parents' is seen as some kind of low-level character flaw for anybody, especially a boy past high school. I recall that when my parents were alive they expressed the central American ageing narrative and often talked about not being a burden. They were proud of the fact that I did not have to support them in their old age. My father often teased me by suggesting that they would move in with my wife and I. They accomplished their independence, of which they were proud, through their savings and social security. As they got old it was more likely that they would se me money rather than the other way around. As their health declined, my sister and I began to do more and more for them. Our last act of caring was burying my father's ashes in a cemetery surrounded by family members from all over America.

The two communities saw families in very different temporal frameworks; existentially the Kentuckians and the Delhites present an interesting point of contrast. Given the religious beliefs found in the Kentucky community, people conceived that family groups could be together for eternity. As Christians, they saw themselves

going to heaven as individuals and being in contact. They spoke of seeing each other on the 'other side'. In fact, for some this represented a motivation to encourage younger family members to take up religious life and to tend to their spiritual development and salvation.

While I have found Indians to be expressive about the life of older people in America, Americans tend to have fewer opinions specifically focused on the situation of older people in India. If anything the tendency is to think of India as a country of young people while ignoring the large and rapidly growing older segment of the population. This relates to perceptions and misunderstandings about the implications of the differences in life expectancy between the two countries. There are those who confuse life expectancy with life maximum. This is a naive but common view. Beyond that is a tendency to take a romantic view of family life in Asia. Americans see India as a place where older people are treated with respect and honour in the context of extended families. Importantly, these romantics ignore the fact that structurally these families require a patriarchal bias. Power and wealth is concentrated in the hands of males – fathers and sons – and that the lives of women can be very restrictive.

It has been my experience that people in India closely associate nuclear family living arrangements and loneliness. I do think nuclear family life increases the risk of social isolation generally. At the same time loneliness is not a necessary outcome of a nuclear family based life strategy. In the India research we found that those who lived in nuclear families usually had more ties with people outside the household. I suppose you could say that they compensated for their somewhat diminished social situation. In fact their overall social network, including household ties, was slightly larger than of those living in joint family settings in the neighbourhood.

I found that the average size of older people's social network in both Delhi and Kentucky are identical. The Kentuckians lived in small households, often alone, while the Delhites mostly lived in joint family households.

Jointness requires wealth. It is quite clear that joint families are not as strong or frequent among poor people and landless rural people. It is also related to the economic strategy that the family uses. Jointness is less common among the salaried class like government servants. This is what the ageing research literature shows clearly. I always think of this when an Indian colleague makes the 'you have old age homes we have joint families' statement. Only a certain percentage of people live in these kinds of families. Certainly if you are poor there is a greater chance that you will be socially isolated. This is also apparent in certain kinds of upper-middle class families. I even learnt that the kind of household you live in largely depends on what kind of a neighbourhood you live in Delhi. For a while I rented a flat in a better south Delhi neighbourhood and learnt that better-off, older people, mostly women, lived alone. The wealthy and the poor share certain qualities in this regard.

Jointness requires a patriarchal social structure. The key to a joint family is the capacity to capture the love and attention of daughters-in-law. In America there are no daughters-in-law in the Indian sense. The 'joint family set up' is contingent on values-laws-practices that help men capture the labour of women, especially daughters-in-laws and have it appear morally good.

What do the Americans do? The view communicated by the opening statement that somehow the American 'old age home' is equivalent to the joint family is inconsistent with reality. India may well be a better place to age socially, but in America most old people don't live in 'old age homes'. The percentage is actually quite small. About 5% of the population 65 and over live in what are called nursing homes in the United States. The nursing home population is old, three out of four are 75 years or older. A large portion of the population is women. 34% of nursing home residents are women 85 and older. People in American nursing homes are chronically ill. They receive nursing care. I think Indian 'old age homes' are something like what Americans call 'assisted living'. These are fairly common. Usually this entails all the residents eating together and perhaps benefiting from some sort of social programmes and outings organized by the institution.

The number of persons living in old age homes in India must be very small. HelpAge India's 1995 national directory of old age homes in India based on extensive national survey, found only 12,702 residents. At the same time it showed that the number of residents was increasing and that there was a national shortage of beds. The distribution of old age home beds is highly variable from state to state in India, reflecting underlying demography. The relative availability is much higher in the South where populations have begun the demographic transition to lower fertility and lower mortality. When one looks at the distribution of this problem, one tends to think in terms of the primacy of demography. At this point we can assert the 'demography is not destiny' *mantra*, common in the

political action circles around ageing in the United States.

Further, some say that the pro-joint family rhetoric represents a denial of the emerging reality which keeps service providers and policy makers from working aggressively on the welfare problems of all older people. A reliance on the idea that the joint family will take care of older people would be especially hard on the destitute specifically and the poor generally.

We are largely forced by circumstances into certain patterns of arrangement of social life. Our values and self-concepts fit our circumstances only with considerable lag. Both in India and the United States there is a tendency to view this re-arrangement of domestic affairs as a kind of moral crisis rather than a somewhat inevitable fallout of demographic change.

It appears that family structures in India and the U.S. may be converging. As India's age demography transforms toward the pattern found in more heavily industrialized countries, the situation of older people will converge even more. India may well be on its way toward the kind of social circumstance experienced by older people in industrialized countries.

An ageing policy based on the idea that the joint family will sustain the needs of older people is problematic for these reasons: (*i*) large segments of the population do not have access to joint family life; (*ii*) the joint family requires a high extraction of women's energies who are often not vested in family property; and (*iii*) the family may be declining. There needs to be a more objective assessment of the situation of older people in order to anticipate societal needs in a reasonable way. This includes an objective understanding of the demography of age and the conditions of ageing for all segments of society as opposed to the reliance on wishful thinking and myth.

Ageing pains

SMITA KISHORE

AGEING is both a universal and a natural process. It is a change in demographic structure, a rise in the proportion of the aged population as compared to the overall population that has made them a highly visible section today. The United Nations declared the year 1999 as the International Year for Older Persons; the Indian government announced a National Policy for the Aged. Popular magazines, newspapers, radio and televisions have write-ups and pr grammes on the aged. The problem has now entered centre stage.

The media, however, has its own limitations and is able to provide, at best, a broad picture and at worst a homogenized perception of the aged. This paper based on fieldwork carried out between 1995-1997 in a north Indian city, attempts to capture the voices of the aged themselves. It is an effort to understand how the aged perceive their own situation.

This paper focuses on the middle class, and within the middle class the retired professional. A great deal of debate has centred around the extended family versus the nuclear family,

but little is available on the everyday aspects of family life in modern India. An attempt is therefore made to present the narratives of the aged and to capture the shifts in their daily lives.

This is not to suggest that the problems of the urban middle class aged are universal. I make this point because of the sharp vertical and horizontal divisions that mark Indian society. Though the middle class forms but a small proportion of the overall aged population, it is not only a dominant section, a reference model for society (though not always), but is also a section that has undergone dramatic socio-economic changes in recent decades.

The middle classes have experienced greater social mobility in their own lives as compared to their parents. Their children too have tended to break away from traditionally defined ways. A desire for upward mobility and an emphasis on education has meant, for many, a migration of children to bigger cities, both within and outside the country. They also constitute the first generation retirees who are trying to work out new norms and behaviour patterns. Further, they are characterized by reflexivity, that is, they think about and discuss their problems. This paper confines its attention to the changing nature and quality of relationships in the family and the implications this has for the urban middle class aged.

As Shah[1] points out, this is historically a modern and rapidly growing section among whom the institution of joint household though strong in the past is now becoming weak. It has been under the maximum impact of the ideology of individualism. It is articulate and makes its presence felt in the media, the bureaucracy and in the learned professions. It tends to perceive its problems as those of the entire society.

Though many studies have pointed out the role of the family for the elderly population, it was only during my field study that I understood its importance. This is not to deny other important facets related to the issue of ageing, but that family roles and relationships are fundamental factors affecting their daily lives as they provide a meaningful social role and emotional satisfaction after retirement.

In recent decades there has been a general debate about the changes taking place in the institution of the family with sociological literature[2] talking about the demise of the extended family, earlier the sole caretaker of the aged, and its replacement by an unstable nuclear family. Of late, this understanding has been criticized by those who argue that the concept of an isolated nuclear family represents more fiction than fact. Without underestimating some changes in structure, it is more important to look at the changes taking place in the function of the family. The first part of the paper looks at the changing nature of lived relationship with children, while the second dwells on the relationship between the spouses.

I first look at the relationship of the retirees with their children and their participation in various aspects of daily living. Most of the retirees in this study lived in a 'modified extended family'[3] where families, though spatially dispersed, score high on contact, interaction and change. Although many of them were positive about the concept of joint living, in practice they preferred the extended modified family. Sussman refers to this desire of the elderly to be close to relatives but not with them as 'intimacy at a distance'.[4] An elderly person expressed this clearly: 'I feel it is better to have an independent household. I prefer the idea of spending weekends together with the children and have a healthy relationship, rather than live together and have ill-feelings towards each other.' Yet another stated: 'I feel it is not the quantity but the quality of time spent together that really matters.' 'Living in the joint family is no guarantee that one is taken care of... values have changed, joint living may sound good but it may not be so rosy. Living independently does not mean that the love, affection and care factors have disappeared.'

'As a result of education, economic independence and changing values there may be conflict between the younger and older generations regarding small things like methods of cooking, preparing the menu between the mother-in-law and daughter-in-law. So it is in fact better to maintain a nuclear set.'

There was agreement that it was difficult to get along with the younger generation because of their different ways of thinking and doing things. One response was: 'Everything said and done... there does exist a generation gap. But if elders keep their mouths

1. A.M. Shah, *The Family in India: Critical Essays*, Orient Longman, New Delhi, 1998, pp. 76-77.

2. E.W. Burgers and H.J. Locke, *The Family*, American Book, New York, 1945; T. Parsons, The Social Structure of the Family, in R.N. Anshan (ed), *The Family: Its Function and Destiny*, Harper, New York, 1959; A. Ross, *The Hindu Family in its Urban Setting*, Oxford University Press, Toronto, 1961.

3. A.C. Kerckhoff, Nuclear and Extended Family Relationships: Normative and Behaviour Analysis, in E. Shanas and G. Streib (eds), *Social Structure and Family: Generational Relations*, Prentice Hall, New Jersey, pp. 93-112.

4. M.B. Sussman, The Family Life of Old People, in R.H. Binstock and E. Shanas (eds), *Handbook of Ageing and Social Sciences*, Van Nostrad Reinhold Co., New York, 1976, p. 222.

closed, the situation remains in control.' Another one felt that: 'Parents are expected to make all the adjustments. If we stay together we are taken for granted, as if we don't have our own viewpoints.'

The frequency of visits was higher during the festival seasons and in case of an emergency. Though mutual, the retirees clearly preferred that their children visit them rather than the other way round. They also wanted the frequency of visits to increase, though many of the children have settled abroad.

For some, their children's achievement was a source of pride: 'My son is brilliant. Since childhood he was of an independent nature. He got selected in one of the topmost universities in the States, did his Masters in business administration from there and is now placed highly... we feel proud of him. But at times we do miss him... he is too busy to visit us regularly. It has been almost six years since he last visited India. Though we do visit him once a year, he gets very little time to spend with us.' Another one was despondent: 'What can the younger generation achieve in this country?' But for another: 'My daughter is a very successful doctor in the US. Why should I worry?'

However, they admitted to feeling lonely and sad because the children were so far away and wished that they stayed somewhere nearby. Clearly a desire for proximity, fear of actual living together and the safety of being able to boast about them at a distance was all present simultaneously.

Another comment reads as: 'Both my son and daughter study abroad. Whenever my daughter or daughter-in-law are expecting we are sent the tickets beforehand. Both of us go for a time period after which their in-laws go for another six months... the baby-sitters are very expensive and also where can one get homely care by paying.' Some felt that: 'You take care, give your time, energy, love. After all they are your children. Still you can hear comments of dissatisfaction. It really hurts. But what to do... after all we are parents.'

When quizzed about the degree of agreement on various issues, most retirees felt that prior to retirement their children tended to either agree with them or preferred to keep silent in the face of disagreement. But after retirement the attitude changed with discussions and conversations with children usually resulting in heated arguments. It was the aged who tended to compromise even on small issues like choice of TV channels, what to eat for lunch or dinner. This compromise, however, was not without resentment: 'Just because one is old, one is expected to compromise on every small issue. My wife argues that see you are mature, old, he is a child and so on... as if once you grow old you are expected to lose interest, act as a saint.'

Apart from the frequency of visits and quality of conversation, it is also important to understand the process of decision making and the advisory role in the family. Before retirement it was solely the prerogative of the bread winner but after retirement it is more a matter between son and wife and does not extend to them. The young do not consult their parents before deciding on most matters. Some of the responses made this clear: 'They don't even bother to discuss with us, what are you talking about taking decisions. Husband and wife decide amongst themselves and only inform us of their decision.'

Another felt: 'They think they are more rational, smart and well educated and hence can think for themselves. I feel that as soon as a person retires he should take a back seat and accept a passive role if he wants to maintain even a little bit of respect.'

Others expressed their limited role in decision making: 'No, we don't decide on anything except for my wife and myself. My children come and inform us about their choice and we passively agree. After all, what is the use of showing annoyance except for troubling yourself and disturbing the peace within the family.' Most of them reported giving advice only wher asked to since most of the time thei concerns were not taken seriously. 'See, you put in so much of effort and pain to think about them, after all they are children. But what you get in return is humiliation. They turn a deaf ear and act as if they know the ins and outs of everything and need no advice.' 'I advice only when it is specially sought for, otherwise they are free to do what they think is right.' Another felt that: Once your children become economically independent, get married, have children, you should yourself withdraw from the role of advising and directing, if you want the respect to remain intact.' 'They think they are the best judge and we are outdated.'

An important observation to emerge from the interviews was that married daughters are increasingly playing an important role in taking care of their old parents. In fact, parents are happy to accept the help of daughters rather than sons: 'Earlier we stayed alone, but recently my daughter and her family has shifted to the town. In fact, my daughter forced her husband to get a transfer so that she could be near us. From that time onwards she has taken over all my responsibilities. Though she stays almost 10 kms away from the house, she drops in every other day with something she has cooked. My married

son stays close by, but he hardly gets time to visit us. Even when he does, he is more like a guest. The only help he can think of extending is financial.'

They also stressed the point that daughters not only provide care willingly, but also receive every form of help from parents as and when required. As Jerrome suggests, besides giving help daughters also receive greater help than the sons, at least in areas of childcare – the act of caring means caring about as well as caring for.[5] It seems that the moral responsibility, out of sheer affection and love, falls more on the daughters than on sons, which is also acceptable to the parents.

Another important observation to emerge was that the elderly did not like the idea of accepting financial help from children. Many of them saw self support as important for maintaining self-respect. 'By God's grace, even after retirement, my economic position is all right. Even now I have the capacity to help my children in times of need. I cannot imagine taking financial help from them at any point of time. What will be my position in the family as a dependant person? I could not take that kind of humiliation.'

When unwell the elders expect help from children, especially daughters, only to the extent that it does not become a burden on them. 'We take care of each other... at times children do come over, but one cannot expect them to disrupt their daily routine and take care permanently.' Those with children staying in the same city had a more active give and take relationship. However, nearly all stressed that it was unimportant for children to provide material help, but that they ought to show affection, love, keep in touch and give due respect. 'Believe me, although retirement has resulted in reduced income, it is sufficient for the two of us – me and my wife. I believe that one should cut ones coat according to the available cloth... the question of help from children does not arise. After all, it is the duty of parents to look after their children, at least financially. If there is anything that I expect from them, it is respect and care.'

For an overall understanding of family life, the relationship of the retirees with their spouse becomes important. The family in the West focuses on the husband-wife relationship, i.e. conjugal ties, while in Indian society family means strong ties with children. However, this study points towards a reaffirmation of spouse ties, especially after retirement – a shift from consanguineous to conjugal ties. Though most of the spouses were non-working, but even for those who did work, retirement did not pose a problem as they continued with the role of homemakers. But for almost all women the retirement of husbands was certainly seen as a period of crisis and transition. 'No matter how positively one thinks, it is definitely a period of transition. All of a sudden you are left with so much of free time and nothing concrete to do.'

Many respondents pointed to the problem of declining standards of living and to reduced income: 'Most of those retired are still capable of working. A person who has enjoyed power, prestige, status and comfort both at the workplace and home, is suddenly required to adjust to the loss in income, living standard... where does one get a full-time paid servant these days? Even they seem to be interested in government jobs.

It was also interesting to see how elderly couples adjust their lives and routines after retirement. In most cases a loosening of the rigid definition of 'male work' and 'female work' was noticed. In general the husbands increased their participation in household activities, especially male oriented work like payment of bills, buying grocery and so on. Although most spouses appreciated the shouldering of household responsibilities by husbands, an overindulgence in the domestic space was often unwelcome. 'I dislike the interference in my domestic chores, especially comments like the room is not properly dusted, what should be cooked and so on. After all, I have grown old doing these things. I know my work well. The problem is that there is plenty of free time and nothing really to be done, no regular routine of going to the office, so most of the time he tries to interfere in my affairs. What does he know of buying vegetables, what to cook and how to cook? But he does not hesitate in giving directions and analyzing critically. This becomes more of a burden.'

Another responded: 'When it comes to kitchen work, especially cooking, I prefer doing it on my own.' Not only this, the usual answer to the question, What do you do in your free time was, 'I don't get even a minute to sit and take rest... a woman's work never finishes... at times even the whole day seems less.'

Most of the spouses observed changes in their husbands' behaviour after retirement, although no pattern was noticed. Some of the responses were: 'He has become so critical of every small detail – be it family, children, cooking or politics.' 'He has become more helpful, giving extra time to household chores. But then I feel very bad seeing him do this work.

5. D. Jerrome, Intimate Relationship, in J. Bond and P. Coleman (eds), *Ageing in Society: An Introduction to Social Gerontology*, Sage, London, 1990, pp. 185-195.

In his service years, he never even picked up a thing, everything was ready.' 'Earlier he used to be so calm and quiet and understanding but now it is a different story. He gets irritated so easily, he has become very short-tempered.'

Though the wives occasionally made negative comments about their husbands' behaviour, they could not tolerate any criticism or disrespect from their children. 'Yes, I understand that at times he gets irritated with the children. I try to pacify him but I do not like my children answering back. So what if he has retired, we are old. Could we ever think of behaving like this with our parents?' 'I do not like my children interfering in our matters. Even if he says something which sounds out of place, it is for me to correct but certainly not my children. I am not ready for any disrespect shown to my husband.'

In case of illness the main caregiving function was performed by spouses. For most of them help is usually mutual between husband and wife. Often they do not ask for help unless compelled. An elderly woman commented: 'My husband usually takes care of me when I fall sick. You know, he gets nervous even if I catch a bit of a cold and cough or temperature. It is only when our sickness requires prolonged care that we bother our children. Normally we do not ask for help. Everybody, including our children, has their own families, their own lives. Why trouble them unnecessarily.'

Little direct exchange of help was observed except by spouses, and children in case of an emergency. Though both sexes showed an adjustment to the post retirement years, women were better adjusted than men, and often tended to become more dependent on their wives, especially emotionally, for all their needs. It was also interesting to notice how both partners tended to become more attached and devoted to each other. 'I cannot imagine life without him. We have had our share of fights, but now we are so dependent on each other. I know children are there to take care of us but I guess nobody can give the company and contentment that a spouse can, especially in old age.' 'I think we are the best of companions, sharing every aspect of life in its minute details. I wonder what will happen to him when I am not around.'

One of the retirees commented: 'You won't believe it, retirement has brought us closer. Earlier we were too busy with work and worrying about the children. Now that all of them are settled, we two are by ourselves to share every sorrow and happiness together.'

The devotion and love expressed for each other in old age was incredible, possibly because of stability in life, companionship over the years, and shared experiences. As is well established, during child rearing years the marriage relationship is subordinate to the demands of children, and husband-wife tend to grow apart.[6] The frequency of marital interaction reportedly increases in post parental years, particularly after retirement.

In old age, companionship and the freedom to express one's feelings without being judged becomes the most satisfying aspect of married life. This paper highlights the voices of the aged in the hope that this ethnographic material may help in providing important clues to understanding the life of the aged.

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6. cf M.F. Lowenthal and B. Robinson, Social Networks and Isolation, in R.H. Binstock and E. Shanas (eds), *Handbook of Ageing and Social Sciences*, Van Nostrad Reinhold Co., New York, 1976, p. 434.

Demographic transition

ASHISH BOSE

THE 21st century will witness a gradual transition to an ageing society the world over. The process which first started in low fertility western societies and in Japan is now spreading to the developing countries of Asia, Africa and Latin America. Countries like China and India will not only be at the forefront in terms of absolute number of total population, but also in terms of absolute number of the elderly (60+) population. In brief, the long term impact of decline in fertility and reduction in the size of family will lead to a decrease in the population of children (0-14 years), which in turn will push up the population in the working age group.

Depending on the decline in fertility and mortality rates and the increase in the expectation of life, this will lead to an increasing proportion of the elderly after a time lag. A greying of the population is inevitable and one must understand its implications. Paul Wallace[1], a popular writer, dramatically describes this phenomenon as 'agequake'. If we understand the implications of ageing, agequake will not descend on us unexpectedly like an earthquake with death and destruction all around. Instead, we will be prepared to face a world converging on the elderly.

In his recent book, *Understanding Greying People of India,* Arun P. Bali[2] has put together a set of papers

1. Paul Wallace, *Agequake: Riding the Demographic Rollercoaster Shaking Business, Finance and Our World*, Nicholas Brealey Publishing, London, 1999.

2. Arun P. Bali (ed), *Understanding Greying People of India*, Inter-India Publications, New Delhi, 1999, pp. 14-15.

commissioned by the Indian Council of Social Science Research (ICSSR). He rightly points out that the elderly are more vulnerable than younger persons to social and economic hardships because, 'in the process of development, poor sections lose ground in relative and perhaps also in absolute terms.' This may mean that apart from an increase in the elderly population, the population of the elderly poor will increase.

A comparative account of the elderly in India is presented by S. Irudaya Rajan and his colleagues[3] in another recent publication, *India's Elderly: Burden or Challenge?* They point out that while the increasing numbers of the elderly is attributed to demographic transition, 'their deteriorating condition is considered as the end result of the fast eroding traditional family system in the wake of rapid modernisation and urbanisation.'

Given the size and striking diversity of India, it will be hazardous to generalise on the impact of urbanisation and 'modernisation' on the elderly. In a recent survey of the elderly in a middle class locality of New Delhi (1997), we found that rapid urbanisation and the consequent increase in housing shortage tends to perpetuate the joint family system.

This is because most young married sons do not have the capacity to move out and pay exorbitant house rents. The result is a perpetuation of two and three-generation families staying together, creating perpetual tension between the generations, often leading to serious mother-in-law and daughter-in-law conflicts.

In order to understand the social, psychological, economic and other implications of an ageing population, one cannot rely only on Census data or for that matter, only on the demographic perspective. Specialised studies and in-depth interviews of the elderly would provide better insights than a statistical approach. Nevertheless, one does need a statistical account of the elderly for policy making, planning and specific programmes to help the elderly through governmental as well as non governmental efforts. The object of this paper is to give some highlights of the emerging demographic scenarios based on the latest data generated by the Census of India, NSSO and relevant United Nations publications.[4]

In 1991, when the last decennial Census was undertaken, the population of the elderly (60+) in India (excluding Jammu and Kashmir where no Census could be undertaken because of disturbed conditions) was 57 million compared to 20 million in 1951 (when the first Census after Independence was conducted).

* According to the official projections of the Registrar General, India, in 2001 the elderly population is estimated at 71 million, and 114 million by the year 2016 (the year for which the ultimate projections were made).

* The United Nations projections (medium variant) put the estimated number of elderly in India in 2000 at 77 million. The projection for the year 2025 is 168 million and for 2050 it is 326 million. These are frightening numbers: an elderly population of 20 million in 1951 increasing to 326 million in 2050.

* If we look at the proportion of the elderly to the total population from absolute numbers, we find that in 1951 it was 5.4% of the total population while in 1991 it was 6.7%. According to the Registrar General's projections, the figure will be 8.9% in 2016.

* According to the United Nations projections, in 2000, the elderly will account for 7.6% of India's population. By 2025 the comparable figure will be 12.7% and by 2050 it will be 21.3%.

* It should be noted that the proportion of 60+ female population is invariably higher than that of the male population. According to the UN projections, in the year 2000 the 60+ male population will constitute 7.1% of the total male population, while the comparable figure for 60+ females is 8.2%. By the year 2025, the male and female proportions will be 11.9% and 13.4% respectively, and by the year 2050, the comparable figures will be 20.2% for males and 22.4% for females. This is because of the higher life expectancy of females compared to that of males.

* According to UN estimates, during the period 1995-2000 in Inc the life expectancy of males stood at 62.3 years while that of females was 62.9 years. For the period 2020-25, the figures are 68.8 years for males and 72.1 years for females. For the period 2045-50 the estimates are 73 years for males and 76.9 years for females. It may also be noted that over the decades, the gap between male and female life expectancy is estimated to increase. In this situation at least, the gender gap affects the males adversely.

* The ageing of population consequent on the change in the age structure will be evident from the fact that all through the last four decades, the

3. S. Irudaya Rajan, U.S. Mishra, P. Sankara Sarma, *India's Elderly: Burden or Challenge?* Sage Publications, New Delhi, 1999, p. 20.

4. For detailed statistical data, see Ashish Bose and Mala Kapur Shankardass, *Growing Old in India: Voices Reveal, Statistics Speak*, B. R. Publishing Corporation, 2000 (in press). See also Census of India, 1991, *Ageing Population of India*, Registrar General, India, 1991; Census of India, 1991, *Population Projections for India and States, 1996-2016*, Registrar General, India, 1996; National Sample Survey, *The Aged in India: A Socio-Economic Profile*, 52nd Round, 1995-96, Department of Statistics, Government of India, Calcutta, 1998.

growth rate of the 60+ population has been consistently higher than that of the total population. During 1951-61, the decadal growth rate of the 60+ population in India was 26% compared to the growth rate of 21.6% for the total population. During the decade 1981-91, the comparable figures were 31.3% and 23.9%. The same story is repeated when we consider the male and female population separately.

Looking at regional variations we find that in 1991, three states in India, namely Uttar Pradesh, Maharashtra and Bihar had more than 5 million persons in the 60+ category. It may be noted that in most of the states the population of 60+ males exceeded that of 60+ females, notably in Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. But in Kerala, Maharashtra, Andhra Pradesh, Karnataka and Gujarat, the 60+ female population exceeded the 60+ male population.

Kerala had the highest proportion (8.8%) of 60+ population in 1991, followed by Himachal Pradesh (8.1%), Punjab (7.8%), Haryana (7.7%) and Tamil Nadu (7.5%). Among major states, the lowest proportion was in Assam (5.3%) followed by West Bengal (6.1%), Bihar (6.3%), Rajasthan (6.3%), Gujarat (6.4%). Madhya Pradesh (6.6%), Andhra Pradesh (6.8%) and Uttar Pradesh (6.9%).

According to the 1991 Census, there were 22.2 million elderly (60+) workers in India: 17.8 million males and 4.4 million females. This implies that 39.1% of the total 60+ population were workers. The male workforce participation rate was 60.5% while it was 16.1% for females.

There were more than a million elderly workers in each of the following states: U.P. (4.3 million), Bihar (2.3) , Maharashtra (2.2), M.P. (2.0), Andhra Pradesh (1.9), Tamil Nadu (1.7), West Bengal (1.3), Karnataka (1.2) and Rajasthan (1.0). The elderly workforce participation rates for these nine states are as follows: U.P. (45%), Bihar (42.4), Maharashtra (39), M.P. (46.1), Andhra Pradesh (43.4), Tamil Nadu (39.9), West Bengal (30.8), Karnataka (37.3) and Rajasthan (36.4). Andhra Pradesh has the highest female workforce participation rate (24.2%) among the elderly and West Bengal, the lowest (6.5%).

The distribution of the elderly workforce in nine industrial categories adopted by the Census is as follows: (*i*) Cultivators 55.9%, (*ii*) agricultural labourers 22.4, (*iii*) livestock, forestry etc. 1.6, (*iv*) mining and quarrying 0.2, (*va*) manufacturing etc. in household industry 2.4, (*vb*) manufacturing etc. in other than household industry 3.9, (*vi*) construction 1.0, (*vii*) trade and commerce 6.6, (*viii*) transport etc. 0.9, (*ix*) other services 5. It will be seen that over 78% of the elderly work force is engaged in agricultural activities. In the case of female workers, the figure is over 84%.

In the absence of any social security in the agricultural sector, the elderly fare badly and this is more true of the female workers. Even in the non-agricultural sectors, there is some social security only in the small organised sector. The problem is most acute in the informal or unorganised sector.

The National Sample Survey (52nd Round, 1995-96) collected data on the economic dependence of the elderly. The all India picture is as follows: Among the elderly rural males, 48.5% claimed that they were not dependent on others, 18% were partially dependent and 31.3% were fully dependent on others. In the case of elderly rural females, 70.6% were fully dependent on others, 14.6% were partially dependent and only 12.1% said that they were not dependent on others.

The urban scene was as follows: 51.5% of the elderly males claimed that they were not dependent on others, 29.7% were fully dependent and 16.9% were partially dependent. In the case of urban females, 75.7% were fully dependent on others, 11% were partially dependent and 11.5% were not dependent on others. In West Bengal, over 88% of the rural females and 85% of the urban females were fully dependent on others. These figures are the highest among all states.

In Kerala, which has the highest proportion of elderly in India and has several social security schemes, 73.6% of the rural females and 76% of the urban females are fully dependent on others. This shows how vulnerable elderly women are even in Kerala, known for its high order of social investment. The economic dependency ratio among females is the lowest in the rural areas of Himachal Pradesh where 48.7% of the females are fully dependent on others. Himachal has the highest ratio of economic independence (23.6%) among females in rural areas. A remarkable aspect about Himachali women is little appreciated: Because of the massive migration of men from the rural areas to the cities all over India, the women are left to fend for themselves, look after the children and the elderly as well as cattle and whatever land they possess.

The NSS statistics reveal that even the elderly females in the rural areas of Himachal Pradesh have to fend for themselves and not depend on others. The rural Himachali women have no alternative but to 'empower' themselves.

The NSS data provides details about the category of persons who

support the economically dependent elderly – children, grandchildren, spouse and others. In India as a whole, children support 73.2% of the rural males and 76.5% of the urban males and grandchildren support 4.8% of the rural males and 5.2% of the urban males. In the case of elderly females, children support 69.9% of the rural females and 67.9% of the urban females. The share of grandchildren is 5.2% and 5.5% respectively.

In brief, over 75% of the economically dependent elderly are supported by their children and grandchildren. This does indicate the almost total reliance on the family in the case of the elderly who are not economically independent. The figures for Kerala are telling: 83.2% of the rural elderly males who are economically dependent are supported by the children. In the case of urban elderly males, the figure is almost the same: 83.7%. In the case of females, the comparable figure is 72% both in rural and urban areas. The solidarity of the family sustains the elderly. But is this solidarity cracking up? Neither the Census nor the NSS can provide any data on the perception of the elderly. For this, one has to look to indepth case studies and surveys of the elderly.

We shall present some highlights of a survey which we conducted in a middle class locality in New Delhi (1997).[5] While one cannot generalise from such a small study, it does give a glimpse of what is in store for the elderly in India. Our survey revealed that 97.4% of the elderly think the joint family system is breaking down and 93.1% think the generation gap is widening in India and respect for the elderly is dying out. When asked about the role of family support in the future, 93% said that the family support system will decline and the elderly persons must learn to be self-reliant.

Over 81% of the elderly confessed to facing increasing stress and psychological problems in modern society, while 77.6% said that the mother-in-law daughter-in-law conflict was on the increase. When probe questions were asked, 62.9% of the elderly felt that the role of grandchildren will decrease in future while 82.8% said that the role of television will increase in future. Over 87% of the elderly stated that the government was not doing enough to take care of the elderly in India and about 38% supported the right to die (euthanasia) movement.

It must be noted again that our sample was confined to a middle class urban locality. Things would be much worse in poor localities as also in rural areas. Nevertheless, we do get an idea of the perception of the elderly which is not likely to differ substantially in rural and urban areas. As we have observed earlier, the extent of dependence on children is more or less the same in rural and urban areas. In short, it would be unrealistic to assume that in the years to come the government will step in to really take care of the elderly. Hope still lies in the solidarity of the family.

Undoubtedly, elderly widows are among the most vulnerable sections of India's population. We have conducted a detailed analysis of marital status in each state of India covering every individual district (based on unpublished 1991 Census data obtained from the Registrar General). Some highlights are presented below:

Of the total 60+ males in India, 3.5% are 'never married', 80.7% married, 15.5% were widowers and 0.3% divorced or separated. In the case of 60+ females, 1.4% 'never married', 44.2% married, 54% were widows and 0.4% divorced or separated.

Among the major states, West Bengal had the highest proportion of widows (65.1%) followed by Karnataka (63.2%), Andhra Pradesh (63.1%), Tamil Nadu (60.3%) and Orissa (60.2%). Overall, Pondicherry had the highest proportion of widows (67.7%). On the other hand, states with a low proportion of widows are Nagaland (24.5), Sikkim (32.1), Haryana (36.5), Mizoram (38.7) and Punjab (39.5). These figures are affected by a range of demographic, economic, health and socio-cultural factors.

If we break down the 60+ age group into 3 sub-groups we find that the percentage of widows is 46.3 in the 60-69 years, followed by 66.1 in the 70-79 age group and 69.8 in the age group 80+. The highest proportion of 80+ widows was in Himachal Pradesh (80.9%).

The total number of 60+ widows in India in 1991 was 14.8 million while the number of widowers was 4.5 million. Let us look at the absolute number of 60+ widows in some of the major states of India: Uttar Pradesh (1.8 million), Maharashtra (1.6), Andhra Pradesh (1.4), West Bengal (1.3), Tamil Nadu (1.2), Madhya Pradesh (1.2), Bihar (1.1) Karnataka (1.0).

Our district-wise analysis shows a high incidence of widows among the elderly females in West Bengal. In Bankura district, 72.4% of the 60+ women are widows. In Mayurbhanj district of Orissa, 66.7% of the elderly women are widows. In contrast, in Tuensang district of Nagaland, only 19.7% of the elderly women are widows. Without in-depth surveys and studies, it is difficult to comment on

5. Ashish Bose, *The Condition of the Elderly in India: A Study in Methodology and Highlights of a Pilot Survey in Delhi*, 1997 (UNFPA Project Report, Mimeo, to be published).

this striking diversity in the incidence of widowhood. This should merit high priority in social science research. Our sociologists and experts in gender issues must apply their minds to this problem.

To get an idea of our greying world in the decades to come, let us look at the proportion of children (below 15 years) and elderly persons (60+) in the world as a whole. According to United Nations[6] estimates and projections up to 2150, in 1995, children accounted for 31.3% of the world's population while the elderly claimed 9.5% of the world's population. These proportions will almost equal up by 2050 when the children's share will be 20.5% and that of the elderly 20.7%. By the year 2100, the elderly will shoot ahead and claim 27.7% of the population, compared to 18.3% for children. And by the year 2150, the proportion of children will dwindle to 17.5% while that of the elderly will be an all time high at 30.5%. In short, in the decades to come, there will be more elderly persons than children in our world.

A greying of the population is a long term and inevitable consequence of the sharp reduction in fertility levels. Since this reduction first took place in the developed countries, these are precisely the countries which are the front-runners of the greying revolution. The United Nations includes Europe, Northern America and Oceania in Group I countries while Africa, Latin Ame-rica, China, India and other Asian countries (excluding Japan) are included in Group II countries. The contrasts are striking between these two groups. In Group I, the old take over the young by the year 2000 when 18.9% are 60+ and 18.8% are below 25. In Group II countries, the old are 8% and the young 32.3% in 2000 but by the year 2075, the old will be 24.2% and the young 19.1%.

So in our countries the focus must be on the young, though the elderly merit increasing attention from planners and policy makers. Nevertheless, in the world as a whole, there is need for a change in vision. Caring for the old is not merely looking into their special needs of health care, housing and financial insecurity but a whole lot of complex issues have to be addressed. The empty nest syndrome reflected in small families, the conflict of generations, a loss of respect for the aged, the flaws of heartless institutional care of the elderly in old people's homes are only some of the issues which defy easy solution. Can spirituality come to the rescue of the old? Can modern science prolong healthy life to 120 years?

In one of his humorous poems, Rabindranath Tagore (1893)[7] suggested that the young and not the old should retire to the forest for they can appreciate what the forest offers: 'Like profuse blossoms, cooing of the cuckoo, moonlight peering through flowery boughs; young couples have no privacy at home, people come and go, bores show no sign of leaving, neighbours peep and eavesdrop – let the old stay at home, manage property, fight lawsuits, keep track of money, and let young couples move to the forest so that they can have all the time to themselves.'

6. United Nations, *Population Division, World Population Prospects: 1998 Revision*, New York, 1999. Vol I: Comprehensive Tables; Vol II: Sex and Age; United Nations, *World Population Projections to 2150*, New York, 1998.

7. Rabindranath Tagore 'Shastra' in *Kshanika*, 1893. Quoted by Asim Kumar Datta in *Understanding Greying People of India* (edited by Arun P. Bali), New Delhi, 1999.

Health issues

P.C. JOSHI and S.N. SENGUPTA

AT a recent meeting with a senior citizens' forum in Delhi, we raised the possibility of initiating a long-term medical study on the elderly. 'So you want to treat us as guinea pigs,' was the first query regarding our motive. The discussion then turned to the general issues of the elderly – from old age pensions and railway concessions, to health-related advancements and genetic factors in dementia. Clearly, the group was highly aware and keenly debated not just the latest media stories but the current scenario of the aged.

The elderly in India, especially the urban, have long been active advocates of a policy on ageing. They see the issue as concerning not only the social welfare department but the planning commission, since every department of the government is now involved with the special needs and requirements of the elderly.

The impetus to contemporary elderly concerns in India can be traced to three main developments. The first is the evolution of civil society and a mature democracy resulting in an expanding social commitment of the state. Beginning with the scheduled castes and tribes, the state has gradually accepted its legitimate responsibility to care for the disabled, destitute, mentally deranged and the elderly. This expansion has kept pace with the evolving image of these sections in broader society itself.

The second factor relates to the demographic transition in the country. From 12 million in 1901 the numbe. of the old rose to 57 millions in 1990 and is expected to cross the 100 million mark in 2013. Not only has the absolute number of the elderly increased, their proportion in the population too has risen. From a mere 5.1% in 1901, the elderly will become 21% of the population by the year 2050, estimates a United Nations projection.

The third factor is related to the growth of activism and advocacy spearheaded by groups of the elderly, non-government organizations and academicians. As a consequence, a

national policy for older persons has finally been formulated, enshrining the state's commitment towards its ageing population.

In our presentation the elderly population will be taken to mean people aged 65 and above. Although this definition is somewhat arbitrary, this criteria is used by many countries to decide eligibility for purposes of recruitment and rehabilitation in other societal programmes.

Projected Total Population and Elderly Population, 1990-2020
(in million: projections are medium variant)

Region	*1990*			*2000*			*2020*		
	Total	*≥65*	*≥80*	*Total*	*≥65*	*≥80*	*Total*	*≥65*	*≥80*
World	5296.3	327.6	52.9	6229.3	424.4	67.5	8049.9	705.7	123.9
Developed Countries	1211.1	145.5	31.3	1278.0	172.6	35.5	1387.2	232.8	54.4
Developing Countries	4084.2	182.1	21.6	4590.3	251.8	32.0	6662.7	472.9	69.0

Population ageing in developed countries is a reflection of a decline in both mortality and fertility. In some developed countries, 15% or more of the population is already 65 and older while 3.4% are aged 80 or older.[1] Although the percentage of the elderly in the population in developing countries is substantially lower than in developed countries, the absolute numbers of old people worldwide are considerable. For example, in India where only 3.4% are 65 and above, they still number 30 million. In 1988, there were an estimated 159 million persons aged 65 and older in developing countries compared to 140 million in developed countries and over 60% of the monthly global net increase in older persons was in the developing countries.

Between 1990 to 2025, the percentage of the population aged 65 and older is expected to increase to just over 20% in Europe and North America and to double from 5 to 10% in Asia, Latin America and the Caribbean.

The above projections indicate that by the year 2020, there will be 470 million people aged 65 and older in developing countries, more than double the number in developed countries. Three of the four countries projected to have the largest number of old people in the year 2025 are China, India and Indonesia.[2] The growth projected for older population in developing countries has considerable implications for health and social policies. The old population itself is getting older with people over 80 years of age forming the fastest growing subgroup of the population in many countries. Developing countries too are likely to experience a modest increase in the proportion of the population in the oldest age range.

In most developed countries, there are about 65 men for every 100 women in the age group of 65 and above. Generally in developing countries, especially India, there are more old men than old women. The sex ratio will probably fall in many developing countries with female life expectancy projected to increase faster than male life expectancy. In most developing countries, more than 50% of women aged 65 years and older are widowed and in some countries more than 75% of the women aged 75 and older are widowed. In contrast, there is no country in which more than 40% of men aged 75 and older are single.

Marital status has the greatest impact on living arrangements of the elderly population. In developing countries, the proportion of persons aged 65 and above who live alone ranges from 10% (Japan) to 90% (Sweden). This proportion is smaller in developing countries where there is a tradition of multi-generation households and both married and widowed older persons commonly live with their children and grandchildren.

The past century saw a remarkable improvement in life expectancy although tremendous disparities exist between developed and developing countries. Life expectancy at birth in most developed countries is 70-75 years for men and 76-81 years for women; it is 11 years less in developing countries. In the past few decades, there has also been a substantial reduction in mortality among older persons resulting in an increase in life expectancy at age 65.

A nationwide survey conducted by the National Sample Survey Organization,[3] reported that 45% of the elderly suffered chronic illnesses. Nearly 70% in the urban and 34% in the rural areas were economically dependent. The percentage of the elderly living alone was 6 and 8% respectively for the urban and rural areas. This proportion is, however, expected to increase in the coming years, necessitating appropriate measures for the rehabilitation of the elderly. These socio-demographic factors not only influ-

1. K. Kinsella and C.M. Taeubar, *An Aging World II*, US Government Printing Office, Washington D.C., 1992. Also, UNDP, *Human Development Report 1990*, Oxford University Press, New York, 1990.

2. J.S. Siegel and S.L. Hoover, 'Demographic Aspects of the Health of the Elderly to the Year 2000 and Beyond', *World Health Statistical Quarterly* 35, 1982, pp. 132-202.

3. NSSO, 'Socio-economic Profile of Aged Persons', *Sarvekshana* 15(1-2), 1991.

ence the extent and severity of morbidity among the elderly but also their quality of life.

In a developing country like India, the elderly people suffer from the dual medical problems of both communicable as well as degenerative disease. This is further compounded by impairments of special sensory functions like vision and hearing. The elderly are highly vulnerable to infectious diseases because of a decline in their immune functions and atrophic changes in various organs. The physiological changes in the old age lead to impaired cough reflex, impaired circulation and tissue perfusion. There is deficient collagen synthesis and poor wound healing. Further, incidence of infection remains high because of poor nutrition and high intake of immunosuppressive drugs.

Among infectious diseases, pneumonia is 50 times more common in the elderly than in adolescents and it accounts for half the deaths caused due to respiratory diseases, excluding cancer. Urinary tract infections are particularly common in the elderly. Asymptomatic bacteriuria affects 30% of elderly women and 7% of elderly men. The common cause of urinary tract infection in the elderly is insertion of catheter and other instruments.

The prevalence of TB is higher among the elderly than younger individuals. A study of 100 elderly people in Himachal Pradesh,[4] found that most of the patients came from a rural background. They were also smokers and alcoholics. Endocarditis thus is a major factor in elderly mortality, accounting for 50% of the cases. Besides these common infections, the elderly are also susceptible to gastrointestinal infections, pressure sores, septic arthritis, septicaemia and meningitis. The susceptibility of the elderly to these infections along with factors such as poverty, lack of proper nutrition and absence of comprehensive health care calls for special immunization programmes.

The chronic illnesses in the elderly usually include hypertension, coronary heart disease and diabetes mellitus. The prevalence of hypertension was found to be higher in females, affecting as many as 323 per 1000 females in the rural areas.[5] Coronary heart disease was found to be more common in urban areas, and higher for males than females. Given dietary changes and lifestyle factors, such diseases will show an increase in the coming years, thereby requiring special health, nutrition and lifestyle counselling. Diabetes mellitus, which affected 5 million elderly in 1996, is also higher in urban than rural areas.

To check for malignancy, population based cancer registries were initiated to estimate the incidence of cancer under the National Cancer Registry Programme of ICMR in Mumbai, Chennai and Bangalore in 1982 and in Delhi and Bhopal in 1987. The incidence of cancer was higher in both elderly males and females as compared to the total population. In 1996, the total number of elderly persons with cancer was around 0.35 million. Cancer prostrate is the commonest malignancy in males. The chance for contracting this disease among males over 50 years is 30% and mortality is 25%.

The WHO defines stroke or cardiovascular disease (CVD) as the rapidly developing clinical sign of focal or global disturbance of cerebral functions with symptoms lasting 24 hours or more or leading to death. The crude prevalence rate computed from different community surveys is about 200/100,000 persons. Hypertension, tobacco use, obesity and diabetes mellitus are important risk factors for stroke. Stroke victims impose enormous economic burden on our meagre health care resources.

Cataract is the most common cause of blindness among the elderly in India. Nearly 1.5% are blind, a majority of them in the rural areas Alongside physical disability blindness also impinges on the mental, social and financial status of the individuals and their families. The WHO-NCPB survey estimated that 12 million Indians were blind and in need of eye care services in 1989.[6]

A study on the health care for the rural aged in Madurai district, Tamil Nadu,[7] reported that of the 1910 elderly screened, 88% had visual complaints, 40% had locomotion difficulties, followed by symptoms of central nervous system (14%), cardiovascular (17%), respiration (16%), dermatological (13%), gastrointe tinal (10%), psychiatric (4%) and acoustic (8%). 2% of those sampled suffered from neoplasm. A study of the knowledge, attitude and practices[8] regarding nutrition among the

4. V.K. Arora and R.S. Bedi, 'Geriatric Tuberculosis in Himachal Pradesh: A Clinical Radiological Profile', *Journal of the Association of Physicians in India* 37, 1989, pp. 205-207.

5. R. Kutty, S. Radhakrishna, K. Ramachandran and N. Gopinath, 'Prevalence of Coronary Heart Disease in the Rural Population of Thiruvananthapuram, Kerala', *India International Journal of Cardiology* 39, 1963, pp. 59-70.

6. M. Mohan, 'Survey of Blindness in India (1986-89)', in *Present Status of National Programme of Control of Blindness*, Directorate of Health Services, Ministry of Health and Family Welfare, New Delhi, 1992, pp. 80-100.

7. A. Venkoba Rao, *Health Care of Rural Aged*, Indian Council of Medical Research, New Delhi, 1990.

8. M. Srivastava, U. Kapil, V. Kumar, A.B. Dey, K.M. Nagarkar and G. Sekaran, 'Knowledge, Attitude and Practices Regarding

elderly, observed that fruits, leafy green vegetables and milk were rarely consumed in adequate amounts in a general belief that such expensive foods should be given to younger people. No wonder most of our elderly population reports nutritional problems.

According to Government of India statistics,[9] cardiovascular disorders account for one-third of elderly mortality. Respiratory disorders cause 10% mortality while infections and tuberculosis account for another 10%. Neoplasm accounts for 6% and accidents, poisoning and violence constitute less than 4% of elderly mortality with similar rates for nutritional, metabolic, gastrointestinal and genito-urinary infections.

Elderly individuals usually face a higher risk of developing mental as well as physical morbidity. Their vulnerability to mental problems is due to ageing of the brain, physical problems, socio-economic factors, cerebral pathology, emotional attitude and family structure. The biochemical and morphological changes in the ageing brain of normal individuals are similar to those suffering from dementia. In most cases, mental illnesses coexist alongside physical problems in the elderly persons. Chronic physical disorders and sensory impairments (vision and hearing defects) are known to be especially associated with mental problems of the elderly.

The incidence of mental illness is strongly influenced by socio economic factors like educational levels, degree of economic support, whether living alone, and so on. The presence of dissatisfaction with life and feelings of loneliness and self-pity show a high correlation with mental problems. So does the family structure and situational factors such as a widowed status and fall in income. All these significantly contribute to emotional problems in old age.

The magnitude of mental morbidity in the Indian situation is a serious cause of concern. In India, nearly 4 million elderly persons (age 60 and above) are mentally ill, which, although lower than in western countries, requires to be taken seriously as the necessary psychiatric services fall woefully short of our requirements. Two-third of mental morbidity is affective disorders especially depression and late onset of psychosis, while one-third is dementia.

According to one estimate,[10] the prevalence of depression ranged between 13 and 22% among the elderly and it was most often associated with cerebral pathology. Many of the elderly suffer from higher mental function disturbances like memory problems. Another common problem reported in a major hospital study[11] was mania, accounting for 16% of the psychiatric diagnosis. Mania was more common in males and often accompanied by organic brain syndrome.

The risk factors for mental morbidity in the ageing population stand comparatively higher than for the general population, estimated at 7 per lakh for the general population as compared to 12 per lakh for the elderly. The main risk factors are loss of fortune, fall in self-esteem, sense of helplessness, poor education, substandard health, social and gender discrimination, financial debt and status as a widowed person.

Anxiety disorders are more common in the elderly population. Generalized anxiety disorders are accompanied by depression. In the category of late onset psychosis, the delusions in late paraphrenia may be persecutory, sexual and hypochondiacal. The hallucinations in the elderly are often multi-modal and associated with sensory impairments.

The psycho-physical problems which the elderly confront due to ageing and associated socio-cultural, nutritional and environmental factors demand that we perceive the health of the elderly within a holistic perspective. The maxim of adding years to life implies that the elderly receive adequate state and social support to live an active and socially productive life. At the minimum we require comprehensive health care directed to the elderly, in particular equipping our PHCs in geriatric care. Equally, it is important to learn from the experience of other countries where too the elderly face enormous problems due to weak social support mechanisms.

Fortunately, our cultural ethos gives a special place to the elderly as wise people and counsellors of society. Both geriatric support and social engineering aimed at improving the competence of the elderly and ensuring their active participation in society should be considered together in evolving any policy on ageing care. The experience and wisdom of old age is a treasure for any society; its gainful utilization would be beneficial for both the elderly as well as the younger generation.

Nutrition in Patients Attending Geriatric Clinic at AIIMS', in V. Kumar (ed), *Ageing: Indian Perspective and Global Scenario*, AIIMS, New Delhi, 1996, pp. 407-409.

9. S. Guha Ray, 'Morbidity Related Epidemiological Determinants in Indian Aged – An Overview', in C.R. Ramachandran and B. Shah (eds), *Public Health Implications of Ageing in India*, Indian Council of Medical Research, New Delhi, 1994.

10. A. Venkoba Rao, 'Mental Health and Ageing in India', *Indian Journal of Psychiatry* 23, 1981, pp. 11-20.

11. L. Thomas, *Late Night Thoughts of Listening to Mahler's Ninth Symphony*, Bantam Books, New York, 1984.

Societal responses

MALA KAPUR SHANKARDASS

INDIA has a rich tradition of philanthropic and voluntary activities for mitigating the sufferings of disadvantaged and marginalized people. The old, particularly the poor, frail, disabled and homeless over the centuries have been beneficiaries of various initiatives, though not adequate, supported by voluntarism and/or state provisions. Indeed, the voluntary sector was the first to respond to the problems of the elderly in India.[1]

Beginning with the enactment of the Societies Registration Act of 1860, 'voluntary organizations' encompassing a wide range of agencies, viz. societies, cooperatives, trusts, and trade unions – have been given a legitimate place in the welfare mechanisms in the country. They are now more popularly referred to as non-governmental organizations (NGOs) in order to have some uniformity with regard to international terminology.

While this uniformity makes for convenience, it also creates a false picture of homogeneity, particularly to those persons who are not connected with voluntary action.[2] There is a subtle difference between organized voluntary action and non governmental organization functioning, which can become critical when trying to match the opportunity structures provided by different organizations to potential workers.

In recent decades, the processes of social change – modernization, urbanization and technological change leading to urban migration, employment of women outside the home, nuclear families – have undermined the traditional patterns of care of the elderly, that is by the family. Given changing value systems and priorities, provisions for the care of older persons have increasingly to be provided by voluntary organizations/NGOs.

A directory of voluntary agencies for the welfare of the aged in India compiled in 1982 by CEWA[3] listed 379 agencies; the number of new ones established each decade showing an increase especially after India attained Independence. Significantly, mor than half are located in the southern states and Maharashtra. 13 states and union territories did not have any registered voluntary agency working for older persons. About 86% of the listed agencies are institutions providing services like day care, recreation, counselling, geriatric care (medical and psychiatric care) and financial as assistance. Information in the CEWA directory indicates that the number of NGOs per million persons aged 60 plus for the country as a whole is 6.46.

1. Manabendra Mandal, 'The Work of the NGOs for Older Persons', *Research and Development Journal* 5(1), 1998, p. 24.

2. K.K. Mukherjee and Sutapa Mukherjee, *Voluntary Organizations: Some Perspectives*, Gandhi Peace Centre, Hyderabad, 1988, p. 4.

3. Care of the Elderly: Directory of Voluntary Agencies for the Welfare of the Aged in India, CEWA, Madras, 1982.

A decade later in 1992, the Handbook of Information published by the Association of Senior Citizens[4] listed 665 organizations in India working in the field of welfare of the aged. The list included old age homes, day care centres, pensioners' associations, institutions providing medical help, institutes devoted to research, and associations of senior citizens.

Most registered voluntary agencies provide institutional care in the form of old age homes, either as free facilities or on a 'pay and stay' basis. Many of these are set up under religious auspices. Old age homes in India are used by the 'needy' elderly to pass their last days either as a last resort when for various reasons the family support system breaks down, or for seeking solace while disengaging from family and social concerns. The quality of care in these homes varies, ranging from the bare minimum of lodging and boarding facilities to provisions for medical services, though at only primary level, recreational pursuits, and social activity.[5]

A comprehensive analysis of old age homes in the country is not available though the first old age home in India was set up as far back as the early 18th century. A general understanding of the institutional care facilities available to older persons in the country is provided in a monograph titled, 'Care for Elderly'.[6] The monograph lists 329 institutions involved in care of the elderly, out of which only 4 were under the auspices of the government. 189 of the elderly care centres listed were run by Christians, 12 by Hindus, 2 by Muslims, and 117 were under secular auspices, with 5 put under the category of 'others'. Of the listed institutions 88% functioned as old age homes while 6% were engaged in providing health care and self-employment opportunities. 6% of voluntary organizations also provided day care facilities.

As of 1989, based on information in the monograph, 15,471 elderly were accommodated in old age homes available in the country. A Directory of Old Age Homes in India[7] published in 1995 referred to 354 institutions. Based on a nationwide survey and responses from 256 old age homes, the Directory indicated that 12,702 elderly persons resided in these establishments, not all of which were registered with the government. Another survey carried out on old age homes in the country by the Centre for Development Studies, Trivandrum[8] to which only 186 homes responded indicated that most of the funds for these institutions came through religious organizations, private sources and other types of trusts and caste organizations.

The role of voluntary agencies/NGOs in the care of older persons has become important because central and state government activities and funding for the welfare of the elderly are limited. In fact, the government solicits active participation of the voluntary sector to meet the needs of older persons. The role of the voluntary sector in ensuring welfare to various segments of the population, including the elderly, has been emphasized in the 8th and 9th plan documents. The National Policy on Older Persons announced in January 1999 by the government talks of promoting and assisting voluntary organizations for providing non-institutional services, construction and maintenance of old age homes, organizing services such as day care, multi-service citizen's centres, reach out services, supply of disability related aids and appliances, short term stay services and friendly home visits by social workers.

It was in 1983-84 that the government for the first time decided to make grants to voluntary organizations for services to the aged. The grants-in-aid-provision is for (*i*) rendering welfare services to the aged, such as health care, income generation, subsistence training; and (*ii*) for constructing homes for the aged. Over the years many NGOs have been supported from the budget outlays of the respective state governments. But, with most state governments giving low priority to the welfare of the elderly, and the low social encouragement given to the concept of 'voluntary' care vis-à-vis family care, the provision for grants has not been optimally used by the voluntary sector.

During the 8th five year plan, welfare measures for the elderly were made more specific and comprehensive. Consequently in November 1992, the Ministry of Welfare initiated a scheme called 'Welfare of the Aged' to encourage voluntary organizations through grant-in-aid assistance to provide old age homes, day care centres, mobile medicare and non institutional services for older persons above the age of 60. The scheme marks the entry of the ageing population as a target group in national planning and recognises the voluntary sector as constituting an important institutional mechanism in providing services complementing the endeavours of the state.

4. Handbook of Information, Association of Senior Citizens, Bombay, 1992.

5. Mala Kapur Shankardass, 'Towards the Welfare of the Elderly in India', *Bold: Quarterly Journal of the International Institute on Ageing*, 5(1), United Nations, Malta, August 1995.

6. Care for Elderly, a monograph, Madras Institute of Ageing, 1989.

7. Directory of Old Age Homes in India, Research and Development Division, HelpAge India, 1995.

8. For further details refer to S. Irudaya Rajan, U.S.Mishra and P. Sankara Sarma, *India's Elderly: Burden or Challenge?* Sage Publications, New Delhi 1999.

By 1995, 212 old age homes, 31 mobile medicare units, and a number of day care centres set up by the voluntary sector received assistance from government funds marked for the purpose. However, since the scheme did not specify the services to be provided, no proper monitoring/evaluation was carried out. Consequently we have no worthwhile assessment of the functioning of the scheme.

Though the government has voiced official support for a larger role for NGOs and a number of voluntary organizations are active in the field of ageing in different cities and regions, at the national level the inputs remain limited. Moreover, vast differences exist among NGO approaches, roles and capabilities. Some are part of the government service delivery system, some are small independent service organizations, and others are trying out new approaches.

A few NGOs have managed to establish a positive track record and gained support for their development work from international and national donors. Reference can be made here to five voluntary organizations functioning at the national level: Bharat Pensioners' Samaj established in 1960, CARITAS India (1962), Indian Association of Retired Persons (1973), HelpAge India (1978), and Age-Care India (1980).

Bharat Pensioners' Samaj is an all-India federation of pensioners associations headquartered at New Delhi. It functions as a nodal point for pensioners belonging to central and state governments and quasi-governmental organizations. It highlights the difficulties faced by aged pensioners and other senior citizens at various forums and strives to solve the grievances of its members by negotiating with appropriate authorities. It holds periodic seminars and conferences to focus on the problems of pensioners and other elderly citizens. The Samaj helps the needy pensioners through a benevolent fund created through contributions from its well-to-do pensioner members. All pensioners are eligible to become members of the organization as per the procedure laid down by the Samaj.

CARITAS India, a member of CARITAS International undertakes activities in different states and union territories of India. It is the official national level organization of the Catholic Bishops Conference of India, established for the education and animation of society at all levels. It aims to promote care for the sick, crippled, handicapped, destitute and the aged.

The Indian Association of Retired Persons is funded through membership fees, donations and grants-in-aid from the government and undertakes a variety of programmes for the welfare of retired persons. The association organizes regular talks and discussions with the authorities to project the problems faced by retired persons in society. Headquartered in Bombay, this voluntary body has opened its membership to all retired persons and those above the age of 60 years. It brings out a quarterly bulletin and in recent years has started a project for providing socio-medical and financial help to its members. It has also established a well-equipped library in Bombay.

Age-Care was established as a non-political, non-profit, secular, charitable, educational, cultural, and social welfare society for the care of the aged people. Initiated by its founder secretary, N.L. Kumar, who managed the support of a group of dedicated founder members from various walks of life and with diverse life experiences, it focuses on helping older persons to lead a healthy and dignified post-retirement life.

The membership to this voluntary body is open to all physically fit persons 21 years of age and above, irrespective of caste, creed or sex. With current membership of 1500 volunteers it enjoys patronage from the government, receiving grants for a number of its programmes and projects. It has also been recognized by the United Nations and is listed in the UN Handbook of Organizations active in the field of Ageing (1988 edition).

Age-Care India started off in 1981 organising free geriatric health check-up camps in Delhi for the urban poor and soon spread its network to provide the much needed health care services to the rural poor and elderly from low income groups around the metropolis. The camps, essentially a preventive measure, had till mid-1999 covered about 56,000 aged people above 50 years of age. The organization has over time opened branches at Jaipur for Rajasthan, Shimla for Himachal Pradesh, Dehra Dun for Uttar Pradesh, Faridabad for Haryana, Calcutta for West Bengal and Bhopal for activities in Madhya Pradesh.

Through voluntary donations from philanthropists and affluent persons in society, the organization has started a pension scheme providing Rs 100 per month to the economically weak and indigent elderly, particularly from rural areas. The scheme is intended to make a difference to the needy aged people above the age of 65 years. Similarly, a disability relief fund has been created at the Age-Care head office for rendering immediate financial assistance (upto a maximum limit of Rs 500) to the needy elderly during emergencies, accidents and sudden physical disability.

In addition, the organization has set up day care centres, holds regular weekly public lectures on topics of ageing and allied interests, also seminars and conferences, creates awareness about problems of older persons among school and college students, and organises yoga and nature cure training for the elderly. An innovative new project, day centre on wheels, which provides services like medical consultations, BP check-up, spot counselling, and collates information pertaining to available facilities and services for seniors. The organization brings out a monthly publication, *Age-Care News*, for the general reader and celebrates Elders' Day on 18 November every year to honour senior citizens above 80 years as part of its annual day function.

HelpAge India is the country's largest voluntary organization with 23 regional offices. Receiving nominal grants from the central government, the organization runs on charity funds collected through motivating students and youth organizations, from private and public sectors, and through selling flags and greeting cards. Its primary focus is to provide financial support to other voluntary agencies engaged in the welfare of the aged. Through its research and development centres, it trains personnel engaged in the care of the aged. It is accredited to the United Nations and is closely associated with Help the Aged, UK. It is also a founder member of HelpAge International.

Over the years, HelpAge India has supported 1,600 projects at a cost of Rs 130 crore.[9] In 1998-1999 alone, it supported 190 projects to the tune of over Rs 13 crore. One of the important initiatives taken by the organization is the mobile medicare unit (MMU) programme which enables older people to assume an active role in looking after their own health while encouraging others to do the same. 95 MMUs are at present servicing lakhs of older persons residing in slums, resettlement colonies and adjoining rural areas, providing medicines, counseling and health care free of cost. In 1998-1999 alone, HelpAge India spent over Rs 1 crore on the MMU project.

Besides these national level voluntary organizations, a number of regional and local level NGOs have set up multi-service facilities and innovative programmes. Mention can be made here of the Action for Social Help Assistance (ASHA), Family Welfare Agency, Dignity Foundation, Development, Welfare and Research Foundation (DWARF), Meals on Wheels, and so on, all operating in different parts of the country. Their activity relates to providing second careers, income generating activities, companionship, nutritional counselling, cooked meals, help-line services and promoting active ageing. As a result, in recent years age care services have become increasingly available in non-urban areas.

A new strata of old people requiring multifarious affordable facilities are the parents of non resident Indians (NRIs) or inland professionals/businessmen who though financially well-off are unable to personally attend to their parents. A large number of elderly now live alone without their children, and require care, assistance, help and services at their place of residence.

The Agewell Foundation, formally launched on 6 April 1999 at Delhi with support from the Ministry of Social Justice and Empowerment operates like a club by offering a life membership of Rs 5000 to an individual or an elderly couple. Children, especially NRIs, can sponsor their parents to the club, which is chiefly concerned with the problems of the privileged elderly otherwise lacking organized help.

The services arranged for the elderly range from legal assistance, financial advice, ambulance service, help with pension problems, property tax notice, wealth/income tax assessment orders, and so on. The Foundation levies a fixed tariff on the subscriber, to be billed every month depending on the frequency of use. It runs an employment exchange for older persons, help line, involves elders as volunteers for social work and provides a platform to interact with other fellow senior citizens. The Agewell Foundation while charging costs of professional services, acts as a bridge in helping members access the 'right' sources to alleviate their specific problems.

Despite the NGO/voluntary sector coming forward to meet the growing needs of older persons, further steps need to be taken to create mechanisms for the proper and adequate delivery of services. There is an urgent need to expand provisions, strengthen capacities, balance geographical distribution, critically evaluate the functioning of different programmes, involve the community in taking care of the aged, and sensitize and conscientize the populace to the issues of ageing.

Equally, there is need to set up an apex/nodal agency to coordinate and synergize the different activities and programmes, as also network the various actors. Given the increasing costs of service provision, we need to encourage resource sharing and promote voluntarism if we are to adequately respond to the diverse and multiple needs of our growing aged population.

9. HelpAge India, Annual Report 1998-1999.

Interview

M.M. Sabharwal *is best known for his extraordinary work in the care of the aged. After a distinguished corporate career, he joined HelpAge India, a voluntary charity organization set up by Help the Aged of U.K. in 1980. In his two decade long involvement with these organizations, he has served as Chairman of both HelpAge India and HelpAge International. Currently he is President Emeritus of HelpAge India and continues his active association with the movement of the aged. He was interviewed by* **Mala K. Shankardass.**

You joined HelpAge India, a charity organization at a time when you were a successful corporate sector executive. How did you make the move from a business orientation to voluntarism?

It was not difficult as my heart identified with the cause – to foster welfare especially of the needy aged. My only hesitation was whether I would be able to devote enough time to a cause which requires dedication and commitment. What prompted me to be part of the team to raise funds for programmes to assist the elderly was a belief in the need to raise awareness about the problems of the elderly in the country and start projects which would assist them irrespective of caste or creed. I do not believe in charity, 'giving fish to eat'; I am for teaching people how to fish. I look upon my involvement with ageing issues as a challenge, setting a new agenda for the welfare of the elderly, particularly those unfortunate poor, disadvantaged and isolated aged, who need help and assistance for integration in society.

It seems that your personal mission merged with that of the organization. How did you plan and work

towards the goal of improving the quality of life of older persons?

No programmes can be initiated and objectives achieved without funds. Resource mobilization – raising adequate funds for the ever-increasing number of age care programmes each year is of paramount importance. My connections with the corporate world were of some value and helped in building the image of the organization. We started with the school education-cum-fund-raising programme as our major fund-raising effort. Over time, it has become the mainstay of our resource mobilization activity which includes use of video films, audio-visuals, advertisements, sponsored events, and so on.

The involvement of school children in the cause can be judged from the fact that in 1998-1999 just one school – Holy Angels in Chennai – collected as much as Rs 5.04 lakh. Reaching out to people who believe in 'live to give' through students, direct mail appeal, sale of greeting cards, and through approaching corporate houses for donations and sponsorships, we were able to raise Rs 15.90 crore last year.

The funds finance a variety of age-care programmes focusing on enhancing the well-being of elders in society. We work towards ensuring and promoting dignity, empowerment and value of older persons. Over the years we have supported 1,600 projects at the cost of Rs 130 crore, this is of course calculating the costs at current price. We try to be conscious of present day circumstances.

What do you think is our most urgent problem? Has ageing emerged as an issue?

People living to older ages is an achievement. But when people live longer and enjoy no social security – have to live below the poverty line, as widows, lonely and ignored by families, community or society – then ageing becomes a problem. In India, we must realize that ageing of the population is taking place at a rapid pace. Today we have about 77 million elderly in the population, by 2025 they will be a whopping 177 million. The problem arises because 90% of older persons are from the unorganized sector which has no social security system for the old; about 80% live in rural areas with inadequate medical facilities; almost 40% are below the poverty line; 60% of 60 plus women are widows, the most disadvantaged in society; 73% of 60 plus are illiterates – the situation is grim for older persons in our society.

I believe that ageing is one of the most crucial issues vying for attention. If there is no intervention now, the situation will lead to an increase in the numbers of destitute elderly, decrease in per capita income and the quality of life of older persons. The basic problem of older persons in our society is a lack of security at three levels: financial, medical and emotional. We must have programmes to address these issues and plans to overcome these problems.

You have been involved with ageing issues now for twenty years, what concrete steps have been taken to tackle the problem?

HelpAge India's work encompasses a broad spectrum – from providing care to older persons, communication and advocacy, development of grassroot organizations and assisting the formation of national strategies, policies and legislation on ageing. We have designed and implemented programmes focusing on improved access to health and eye care services, community based services, income generating activities and training. Over the years the organization has conducted lakhs of cataract operations free. We have started and supported numerous income generating programmes which have helped the elderly to be gainfully occupied, improve the families' economic condition, provide relief from indebtedness, enable elderly to become owners of looms, raise the status of older persons, and so on. Our guiding principle is 'Earn a living, learn a craft.'

Our day care centres provide the elderly opportunities for companionship, recreation, healthcare and nutrition. We have also recently started income generation activities through these centres. For instance the centre at Yamuna Nagar, Haryana runs a *durrie* making project for older women. This project provides them with equipment and material. HelpAge India is supporting almost half the old age homes in the country and these now spell security, care and love for old people.

HelpAge India's Adopt-a-Gran (AAG) programme is widely acclaimed for its concept. It links older people in need with sponsoring families, individuals and corporates. Under this scheme help is provided in the form of food, clothing, medical care, bedding, articles of personal use and pocket money. Last year Rs 8.11 crore was spent on the AAG programme. Besides this, we have started another remarkable programme. HelpAge India has evolved the scheme of micro-credit under which some form of credit or revolving loan is provided to project participants to start income generating activities. Another innovative project is the production of vermi compost

through eco-friendly methods in Rajasthan, which is benefiting more than 100 older persons in the lower income group through each installation.

It seems that HelpAge India's main activities are fund raising and service projects for the elderly. Should not research be important to understand the situation?

At HelpAge India we are interested in studying the problems related to age-care and in evolving more effective techniques of training, research and development of facilities in order to optimize the returns and benefits of the funds spent on our programmes. On 4 October 1990, the President of India inaugurated our training, research and development centre in New Delhi. The centre is engaged in both training of personnel engaged in age-care work, and research and development connected with age-care.

We organize training workshops, seminars and visits to well run age-care institutions. These programmes are aimed at increasing the knowledge and skills of all levels of personnel engaged in voluntary organizations working for age-care. Our development activities focus on creating service facilities for elderly citizens in public institutions as well as in institutions in the government sector.

How is HelpAge India's liaison with the government?

We work in active association with government departments to further the cause of the elderly. In 1984 we served as the only voluntary organization representing the elderly on the working group appointed by the Planning Commission to prepare recommendations for the seventh five year plan. We are increasingly associated with various committees and groups constituted by the Government of India for the welfare of the elderly persons. We have also received active support from the directorates of education, social welfare and cultural affairs of various state governments and the Union Ministry of Welfare in the implementation of some of our programmes.

The organization runs projects in different parts of the country, what is its organizational structure?

We have distinguished national personalities like The President of India and the former President among our patrons. This imposes a great responsibility on us – while it enhances our image, we have to maintain and improve our credibility. The governing body comprises of eminent persons from different walks of life who oversee the affairs of the set up. The director general looks after the overall planning and implementation of our policies and programmes with the support of functional directorates at the head office. The organization has 24 regional and area offices located throughout the country. Though the functioning of HelpAge remains centralized, since it has expanded its operations to all parts of the country the time has come to initiate a process of decentralization. We plan to have members on the governing body representing the 4 metros of the country and provide greater autonomy to the regions.

Besides motivating people to donate for ageing concerns, has HelpAge been able to change people's ideas about ageing and related issues?

The wide acceptance of our Legacy Campaign indicates that people are now willing to think differently. In 1995-96 we launched a campaign to persuade people to think about HelpAge India in their wills. An increasing number of donors have shown their commitment to the cause of the aged by making HelpAge India a beneficiary in their will. I have willed my house to the organization and a number of my friends have also followed suit. There is this new phenomenon – promoting cause related marketing – which means that you buy a product and a small percentage goes to a cause. The Standard Chartered Bank has started a credit card scheme which is linked to HelpAge India; the Godrej companies have also come forward to support us in this endeavour.

What is the future of HelpAge India and of the voluntary sector in ageing issues?

HelpAge India has established itself nationally and internationally. We enjoy accreditation with the United Nations, are closely associated with Help the Aged, UK, and are a founder-member of HelpAge International which has a network in 50 countries. My association with both these organizations has helped the cause of the elderly to cross national boundaries. Since our annual income is growing, reaching Rs 20 crore this year, we are able to undertake new projects and expand as well as strengthen the old ones. We are currently helping evolve a plan of action for implementing the national policy on older persons announced by the government in January 1999.

The voluntary sector has a crucial role to play in raising awareness about ageing issues and initiating programmes for the welfare of the aged, particularly since the government has limited resources and requires support in reaching out to the needy section of society to enhance the facilities in existing and new age-care institutions.

The last scene

MOHAMMAD TALIB

EVERY society marks the biographical trajectory of its members into recognized scenes of a play. Each scene represents different roles and narrations, varying colours and costumes. As individuals graduate from one scene to another, they acquire newer identities and relations in the structure and dynamics of the play.

The imagery of drama is somewhat restrictive if deployed to understand life. While a play has clear cut scenes, actual life has several replays of the same drama enacted simultaneously. The final, the middle and the early scenes of a play coexist in actual life; it is their inter-relation which makes a scene or a group of actors problematic.

The last scene in life has invariably been understood either segmentally or integrally. In a segmental view, old age is set apart, constructed through stereotypes and discriminated against, simply because those enacting the last scene are considered worn out and removed from the central concerns of active, healthy and productive life.

Old age, viewed integrally, is understood as a repository of age-old wisdom and cumulative experiences. Viewed thus, old age gets metaphorized and embellished with respect and vital resources necessary for productive life. Seen as a single slice of life unconnected to its other phases, old age is often burdened with ageism, construed either as a second childhood or mere oblivion – in the words of Shakespeare 'Sans teeth, sans taste, sans everything' (As you like it, act 2, scene 7).

All societies evolve an intergenerational contract – between the generation now retired having lived its productive life, those in the productive segment, and the ones in the pre-productive stage. The intergenerational contract, implicit yet symbolised in cultural narratives, foregrounds interdependence and exchange of life

support provisions in material and symbolic terms. While no society can claim that it follows the contract in its full details, its breach generates ambivalence and is rarely justified in clear terms.

The Puranic story of Shravan Kumar provides one example of a sacred rationale for a mutual sharing of life resources between the post productive and productive members in a family. The story glorifies the relevance of and relation to old age and develops the logic to a point where, in the act of serving the old parents, Shravan Kumar and his wife not just lose their precious material possessions but even their lives. The story, however, resolves the tragic ending by relating the happening to divine will.

Old age thus becomes part of a sacred cosmos which in turn strengthens the intergenerational contract. The story further contrasts Shravan Kumar with his counterpoint Damodar who treats his parents as the burdensome junk of his life. Shravan Kumar carries his parents around in a *kanwar* (a bamboo device shouldered by pilgrims for carrying their belongings) in search of a cure for their blindness by visiting holy places. Damodar, on the other hand, drives his parents out of the house as he perceives them a useless dead weight.

In our society of mega projects and transnational corporations, the ancient intergenerational agreement seems to have broken down in favour of the productive and professional segment of society. Consequently, while the post productive segment slides into crass old age, the pre productive begins to suffer from child abuse. Is it because the rhythms of productive life are so focused and engaged that they neither have the time nor predisposition to look at the scaly margins of collective humanity?

Rarely does the dominant consciousness of the productive segment of society display an ability to step back and examine its basic premises. Ironically, the vantage point for self-reflection comes from its own counterpoint – old age or childhood. Alternatively, productive humanity is forced into introspection in moments of colossal failures. Moments of breakdown offer material to look at constituent parts holistically, integrally and without imposing segments or contending divisions on common humanity. By itself, productive humanity views old age in its own image and suggests remedial measures accordingly. For instance, most studies on old age in India, backed by western perspectives in gerontology, invariably evaluate old people along measures of consumption (life-support systems) or productivity (gainful work).

Market mechanisms often become the cultural matrix in planning remedial actions. But one may relate to old age through resources of life outside the state or the market, and locate the old, not as recipients of societal philanthropy but an authentic section of humanity capable of providing vital inputs to life in the making. In its own life domain, a large chunk of humanity is constantly glossed over or dismissed by the dominant spirit of working people. There is, however, a manner of retrieving or harnessing life expressions and resources dismissed or pushed into oblivion out of sheer haste.

One glimpse of the lost reality of old age can be gathered by stilling the image of an old man bending down to pick up his walking stick. For a moment ignore the intention of the old man in bending down as well as the walking stick. What is left is a movement of the body as if in a certain sequence of a performing art, displaying grace and elegance. The task of retrieving the charm requires a vantage point located in movement of poise and not haste. While haste is invariably unmindful of its context, poise always depends on the fit with the surroundings. This is also the distinction between the young and the old. Today much of the reality of old age remains under-represented.

The present note turns to selected writings in Urdu fiction to understand the age-old aspect of old age. This literature sensitises us to the need to counter ageism and to examine the biography of the old in their own terms.

Kashmiri Lal Zakir's novel *Doobtey Sooraj Ki Katha*[1] (The tale of the setting sun) pastes a poetic adage at the beginning of the story:

> Two fellow travellers, the sun and me/Had reached our station in the evening./Both were travel weary, slept on the earth's mattress/Next morning the sun woke up and left me in my sleep.

The poem captures the breakdown in the intergenerational agreement, paving the way for the creation of humanity left in the lurch. In the preface of the novel *Aao baat karen* (Let's Talk) the author argues that each fragment of life has a beating heart. He uses the metaphor of a mother and child. Though the growing child creates difficulties in communication and relationship, the mother rarely forgoes her responsibility. Even in moments when she cannot attend to the child or even comprehend it, the frame of the relationship is not transgressed.

As the child climbs the stairs of life, the mother gradually steps down the same ladder. While the child grows under the spreading light of day, the

1. Kashmiri Lal Zakir, *Doobtey Sooraj ki Katha*, Novelistan, New Delhi, 1985.

mother's canopy of sunlight slowly recedes. Though they converse with each other, there is a hiatus of several stairs of age between them. Both struggle to understand each other, but with effort and difficulty. And as the ladder of life between them grows, their communication suffers. There comes a point when the son stands on the highest point of the ladder and the mother on its lower terminal end. Communication between them is now near impossible.

The distance makes their voices inaudible to each other. One is in haste and has no time to listen to a long narration. But the mother is reticent. She sees no reason to be in haste because the final stairs disappear into nothingness. She is reminded of the time when her son would cry and even if the cry was incomprehensible she never opted out of the grid of communication. Now, when the mother slips on the stairs, she is overshadowed by a setting sun, and the son is looking elsewhere.

This precariousness of relations between two generations becomes the dominant theme of the novel. The life of Durga Das, the protagonist, is traced from youth to old age. The novel juggles with the dilemma of locating the aged – in the family or in an old people's home. The author opts for the family. Perhaps the novelist's sensitivity grounds the remedy in the expressive resources of the family and not the stark instrumentalities of the market of which the old people's home is one expression.

Can one simply break intergenerational relations? Perhaps not. Joginder Pal's *Maqamat*[2] (Stations) describes Jamal's encounter with various contrasting stations (as generational points) of his biographical journey. Jamal, in his mother's lap, learns to recite the word of God and wakes up into the world of insight and meaning. But in the next stage, when Jamal's children are growing, his mother is beginning to lose her bearings in life. She is physically and mentally challenged. And when she beats at her locked room in anguish, Jamal chooses to sedate her. Was this the quickest and least expensive remedy? Jamal gets the first clue to his mother's angst when his son, after marriage, pronounced that he wished to lead his life (with wife and children) in his own way, unencumbered by the old parents. Jamal now has the answer: his mother needed him, not the pills. He explains to his son how love for wife and children grows only if it has a wider constituency, that love for one's wife grows alongside love for one's parents. 'Please include Us in your We,' Jamal implores.

But Maqamat's characters encounter a complex principle of inclusion and exclusion among members in a group. Jamal mistakes his wife for his mother. Why this inclusion of his mother after her complete exclusion? Perhaps continuities in primary relationships, when partially blocked, display a reserve and resilience to reappear in multifarious forms independent of the actor's will. These relationships offer material for imagining a more sensitive blueprint for the inclusion of the aged in the community of the young.

Indeed, there could be yet another way. The story *Nannhi ki Naani*[3] (The little one's grandmother) by Ismat Chughtai describes an old woman who in a small town of some zamindari settlement had served as a maid to the families of the local elite ever since her childhood. Her salary consisted of the day's meals and clothes discarded by the family. She was forced to retire when she couldn't spot a lizard in the *daal* and a fly in the *rotis*. After retirement, she tries to carve out a niche for herself. She becomes a mobile prop in a given cultural setting and plays the role of an information conduit/carrier among families where she was a familiar presence.

Economically she was assetless and entirely dependent on her past patrons. Yet, she overcame her marginality by seeking membership in a common cultural universe. She is let in and accommodated. There was an ethos wherein she was assigned a position. For instance, everyone knew that she pilfered household articles, or demanded hospitality when the choicest food was cooked in limited quantity for special guests. She would entertain, embarrass, criticize, help – somehow succeeding in over-coming her marginality. There were sufficient fragments of both culture and relationships to which she had access. The story evokes the élan of a civilizational principle which binds the engaged and the retired without gratuity or regular financial support.

But Nanhi ki Naani ends tragically, thereby revealing the fragility of cultural resolution. A similar theme in a different setting is charted out in Hajra Kumar's *Mohabbut, Kitab Aur Tokrey*[4] (Love, books and baskets), the story of Master Shanker Das Nigam whose ageing happens coterminously with several other events in a small town. Master Nigam was fiercely fond of his rare books in Urdu and Persian, a passion not shared by his wife or anyone else.

2. Joginder Pal, 'Maqamat', *Naya Daur*, September 1996, pp. 27-30.

3. Ismat Chughtai, 'Nannhi ki Naani', in Asif Nawaz Choudhary (ed), *Ismat Chugtai ke Sau Afsaney*, Maktaba-e-Shero-o-Adab Lahore, n.d., pp. 1294-1308.

4. Hajra Kumar, 'Mohubbut, kitab aur tokrey', *Biswin Sadi*, April 1996, pp. 51-55.

He had not even deposited emotions in the family bank. As the country was partitioned and zamindari abolished, Master Nigam's sons grew into marriageable age. Meanwhile, his wife dies and he gets further confined to his idiosyncratic past. The memory of a platonic love is not enough to alter the solitariness of his life. Subsequently, when the sons get married, Master is further estranged from his family.

Master's esoteric engagements irked everyone in the family. At least in the past his wife would dry his damp books and the pickles under the sun in a common stroke. But with the passage of time, both Master Nigam as well as his chosen collection of books lose even their notional significance. Once when he is away for a long period his room is thoroughly cleaned and decked up for Diwali. The termite-eaten books and the wooden frame of the almirah are washed away. The 'worn out' books, Master Nigam's simulacra, are, however, rejuvenated in a curious manner. Mixed with water and clay, the old books are converted into a soft paper mash to make baskets for storing onions and potatoes. Master Nigam can't come to terms with the cataclysmic changes and passes away. On the 13th day after his death, 13 Brahmins are fed with the customary delectable eatables stored in the paper-mache baskets.

Is utility and productivity the only reference point for declaring an object or a habit obsolescent? Who is to judge? Who is labelled? How do the labelled respond? Perhaps piecemeal policy offers a restricted answer. For inviting a long term civilisational response to the query, one would draw attention to Joginder Pal's *Dadiyan*[5] (Grandmothers) in which the protagonist refuses to vacate her ancestral home to shift to a government quarter allocated to her grandson. When her grandson suggests that he would let out the parental house on rent, Dadi disagrees with him. She tells him that she will not leave the house alone, that if it is to be rented out, she too should be included in it. To give a further punch to her views she says, 'If the old are of no use, rent them out.'

What was so special about the house which Dadi was defending so fondly? It had nine little rooms, three of them without a roof. The other rooms were in no better shape. But when Dadi opted to stay back, she wasn't left alone. She found herself waiting for her own self as she moved from one room to the other. In one room Dadi found herself cutting vegetables, in the kitchen blowing the fire, in yet another resting on the bed, expressing concern.

The various dadis formed a moral community deposited in a robust and animated fashion in the seemingly dilapidated ancestral home. Not only did Dadi's ego lend itself to a plurality of alters, she even found herself merging into the inmates of the local environment. The larger kinship starting from Dadi included *koel*, a frequent visitor, which she named Kesri and a host of house sparrows who had built their nests in the house. Another long term resident who formed part of Dadi's practical kin was a king cobra. She had fed him a bowl of milk every evening from the time she became a member of the house after marriage. Dadi was Kesri as also the mango flower which she picked at onset of summer.

The mindscape and the landscape were part of a common being. Dadi, along with an entire milieu grew, matured and experienced ageing in a common frame. Dadi's house was slowly frittering away and so was she. When she died, the first of her kin to spread the news was the dog who visited Dadi every evening for his meal.

Joginder Pal's Dadiyan helps us to understand the nuances of displacement in society. Is compensation ever possible for a life lost? How can one provide a substitute for the house in which Dadi had spent her entire life? What about the villages and tribal lands which our policy makers cognize as just a simple piece of land? How can there be a simple substitute for a life whose complexity is unfathomable to an outsider? One reason why solutions to the problem of ageing cannot be meaningfully locate in only making the elderly either good consumers or good producers is because production and consumption do not exhaust all realms and realities of a human being.

In attempting to retrieve the age-old from old age, an integral view helps restore the linkages between post productive and productive segments of society. This view also recreates the centrality of mutualism in collective life. One last clarification about the age-old in old age: Its constituents cannot be seen as mere functional inputs into an inter-generational combine. They incorporate a capacity to offer a critique of the dominant order, of the ways of the productive working segments. This capacity is a repository of ultimate knowledge, though unrecognized by the rule of fashion. It generates another form of knowledge to understand one's relation to the limits of life; also the datedness of prevailing meanings with claims to perenniality. In its ability to carry a memory/record of how life was, old age confronts adulthood. It provides a powerful critique to alter the metaphors/the stereotypes which seek to lock old age in a fixed position.

5. Joginder Pal, 'Dadiyan', in *Joginder Pal ke Afsanon ka Intekhab*, New Delhi, Takhleeqkar Publishers, 1996. pp. 90-100.

Omission-commission

WITH time things change. Seasons change, nights change. Twelve miles away speech changes. How much is in the head, has anyone weighed it? One hopes to God that no one loses their head.

In a village waving in the breeze, lived Bania. A sweet grandson was born to him in late age; birth was in *Moola nakshatra* (the first star of the Sagittarius). So both his parents died when he was seven months old. The mother died first, then the father. Who can say what is going to happen? When the only son dies, grief is not ordinary. When Sethani saw her only son's dead body, she wept and wept and died. But Seth considered these events to be the result of his *karma*; he took courageous action.

Clasping his grandson to his breast, he continued to run his business somehow... and no one will know how he did it. Grandfather loved his grandson more than his own life; the child stuck to his lap twenty-four hours a day as though he was part of the same body. When the child would cry, grandfather would do what he could to stop the crying. He would make him drink milk; when the child insisted, he would walk on his knees. He became a horse to ride on... he would be beaten lightly with a whip. At night he would sleep on the wet side of the bed while the child slept on the dry side... and even in his dreams he did not get repulsed by the child's drool, shit and piss.

As he started learning to walk, the child began asking questions in his lisping way. In the middle of the night he would ask what is this and who says what... and grandfather would answer each question with enthusiasm. He would explain everything... he would be asked once, he would be asked thirty times. He would laugh and answer in sweet and mild tones. He would never make the child wait for an answer, or give another answer. He would not be anxious or angry, but explain with fourfold enthusiasm as though he was the questioner himself. As though each question was a new question. He would relate long forgotten memories to his grandson. What is this – a crow. What is this – *chandamama* (moon). What is this – a peacock. What is this – a tree. What is this – neem.

One day during the monsoon, grandfather was explaining the meaning of loss and gain to his grand-

* *Bhul-chook leni-deni* by Vijay Dan Detha and Komal Kothari. Transcreated from the Marwari original by Mohmaya.

son when lightning and thunder struck with great force. The child became frightened and cried, 'Which bad man is fighting with whom?' Grandfather soothed him and replied: 'This bad man is mad, he is constantly fighting with everyone and roaring and glittering for twenty-four hours. But we don't care about him.' He then put cotton balls into the child's ears. After this incident, he would put cotton balls into the child's ears every monsoon.

Once during the rains a frog hopped near the child. He pointed to it, what is this – a frog. What is this – a frog, a frog. On the third repeat, grandfather started to cough... the child continued to ask what is this, what is this, but grandfather could not form the word 'frog' fully. He coughed so hard that he became exhausted... *khal khal, khal khal*... till his guts started to hurt, eyes started to water. But the child's attention was still on the frog. In between coughs, grandfather managed to rasp out 'frog'. In the child's happiness lay his own.

While making bills in his shop, while weighing items, he was asked what is this? What is this? Not once was he miserly with an answer. What is this – ant. What is this – elephant. What is this – lamp. What is this – sun. In the light of the moon, the lamp, the sun, grandfather taught grandson all that he needed to know. Explaining, explaining, Seth became old. Grandson became a youth. He was married with much song and dance. His wife entered the house, *rimjhim rimjhim*.

Grandfather's birth became successful, but his body became old and weak. Teeth dropped out, hair fell out... his neck began to shake and illness began to stalk him. Every nerve became filled with weakness... cough fever pain anxiety... if god would only take me now, then my breath can leave my body. But death does not come soon and one must bear ones sorrows. His eyes became dim, ears could not hear properly.

All through the day and night, grandfather's cough would disturb the sleep of grandson sleeping beside his wife. He would be upset, but hesitated to scold him; he would admonish him many times, but grandfather could not control himself. Until his eyes gave away, he would wipe his spit and phlegm with his own hand... but when he became blind, he could not do this. He would wipe his drool with the end of the turban. Who would wash his clothes, who would bathe him? Grandson and his wife were young, they themselves were blind. They did not care. And then the business-accounts had to be kept and maintained... no one could take time off. Once he heard the sound of the door opening... he called out who is it? Grandson did not like the question and answered sarcastically, 'It is me'. While leaving he banged the door shut; grandfather asked who is it? Grandson became angry: 'How many times do I have to tell you, it is me! Why don't you nderstand it once? Why don't you start reciting gods name now... why should anything else concern you?'

Seth hesitated and said: 'Son, slowly slowly all meaning has been erased from my life, but before one dies all relationships cannot be broken off. I have been wanting to say something to you for a long time. If I do not say it now, it will remain forever in my heart.'

Grandson replied with irritation: 'After death, how can anything remain in your heart?'

Grandfather coughed and coughed '...son you do not even have time to listen to me. But I had all the time to give to you. Don't be so angry. You would ask me a question twenty, twenty times, and I would answer you immediately. And now you are upset when I ask you something twice.'

'So should I leave my work just for you', answered son. 'I too would work', said grandfather. 'But more than my business, I looked after you. Now you are big, but when you were a child I would consider your piss of more value than *gangajal*. I did not even dream of being treated like this. Once in the monsoon, frogs came into the water of the courtyard... you asked what is this? While saying the word frog I started coughing, and coughed so much that I thought I would die.'

'What nonsense!' said grandson angrily. 'Is it possible that I did not even know a frog? You have nothing better to do than accuse me falsely.'

Laughing his toothless laugh, grandfather countered: 'False accusations? Would I lie to you? In business the supreme quality is of ommission-commission... I now ask you for a favour. You cannot refuse me. When you have children you will understand the true meaning of return-favours.' Grandson was in a hurry, he was not inclined to wasting his time in such talk. 'But I have never taken any favours,' he said. Seth spat out phlegm and replied: 'The mistaken favour was all mine and it is my biggest mistake that I am in your care today. Now I have had enough... while dying I give you my blessings – may you live a thousand years. May there always be children's voices and laughter in your courtyard. And when the time comes, may your children treat you exactly in this way. Like you, may they never acknowledge return-favours. I hope I die now... go play the drum in happiness.'

Seth reached the end of his lonely life. Was his grandson happy? Only he knows that himself... but to keep up appearances he wept loudly and kept weeping long after the ceremony was over.

Books

SOCIAL AGING IN A DELHI NEIGHBORHOOD by John van Willigen and Narender K. Chadha. Bergin and Garvey, Westport, Connecticut and London, 1999.

THERE is no dearth of popular and academic articles and books on social ageing. Most of them are based on impressionistic findings and a few unstructured interviews with haphazardly drawn respondents. Having tended their aged parents and grandparents or some other kin, thereby experiencing the traumas of ageing, many authors claim to have an understanding of the problems and crises of the ageing population.

No doubt, a keen observer can gather important insights from the study of even a single case, and anthropology has a tradition of writing and analysing life history accounts of typical individuals, thus advancing inductive statements. Even general impressions of a phenomenon can be hypothesis-generating but the basic canon of sociological research is to focus on a community, either naturally given or 'constructed' by the researcher, before formulating propositions about the phenomenon.

van Willigen and Chadha, the former an American anthropologist and the latter an Indian psychologist, have in their book which appeared in the International Year of the Aged Peoples, 'constructed' a sampled community of older people. They carried out an intensive study, relying both on qualitative observations and quantitative analysis. Extremely well written, this Indo-American venture is a valuable addition to the literature on social gerontology and anthropology of ageing. It is also a good contribution to urban sociology.

Both van Willigen and Chadha have independently worked on ageing. Earlier in 1995 Chadha completed an ICSSR sponsored project on the problems of older people in Delhi, while van Willigen authored a well-known work on the social organisation of older people in a rural American community in Kentucky, USA in 1989. They met accidentally at the venue of the Indian Science Congress in Poona in 1988, and have since collaborated at researching and understanding social ageing in a North Indian city, resulting in several oft-quoted articles, and the book under review.

The authors conceptualised their division of labour as 'dialogic' since theoretical and epistemological differences exist between anthropology and psychology. They have chosen to explore a 'middle path between the tendencies of [the] two disciplines' (p. ix). Being a psychologist, Chadha takes responsibility for handling the complex statistical measures. Being an Indian, Delhite, Punjabi and a native speaker of the languages spoken by the 'community', he conducted the interviews, though van Willigen too participated in about a third of them.

Anthropologists are committed to placing culture traits, social institutions, customs and practices in their relevant contexts, to gauge the 'within' meanings. This is what van Willigen does best. His Kentucky 'community' of older persons is often compared with the Indian counterparts. The authors offer a commentary on certain interesting similarities and differences between the two situations, conscious of the qualitatively different social worlds. For instance, the size of the primary groups of older people in both Kentucky and Delhi is similar.

Both authors agree that the theoretical underpinning of Indian gerontological research is poorly developed. Clearly, Indian scholars often make a wholesale application of a theory developed in the West without thought to its relevance and context in India. This 'mimicry', as the authors describe it (p. x), suppresses the specific (i.e. cultural) characteristics of the local situation, the specific strategies the people adopt to survive in a particular milieu. This leads us to think that despite cultural differences people respond similarly to the predicaments of life and society. Social researchers have time and again exploded the myth of human generality which is created at the expense of particularity. Theory is best grounded in empirical reality.

The authors' theorising draws on their dialogue from the vantage points of their respective disciplines and cultural backgrounds. Their approach to theory is inductive; they move from the findings of empirical research in India to certain general propositions.

Social ageing refers to the changes in the content and meaning of peoples' behaviour and expectations over time. People take adaptive decisions with the passage of time to ensure their optimum survival. The content of such decisions, as also the resultant sociological context, is determined by their culture. Social ageing should be distinguished from biological ageing – the former is a cultural construction of the inevitability of the latter process.

van Willigen and Chadha build their theory of social ageing around five interconnected themes. But in what way does a holistic theory of social ageing emerge from this inter-relatedness is not spelt out anywhere in the book. This matter is left to the individual readers' analytical and theoretical abilities.

For understanding social ageing we need a developmentally-oriented view of life. While gerontologists concern themselves with the later periods (often 55 years and above) of individuals' lives, the conceptualization of the 'twilight' of life is dependent upon understanding the preceding phases right from the time of birth. Second, culture conditions the choices individuals make in their lives. The meanings people ascribe to their actions derive from culture. So do their models of the world, the phases in the life of an individual, role expectations and values. Third, history shapes and is shaped by social ageing. Demographic shifts influence our conception of ageing. For instance, the political economy of a nation is affected by the proportion of people who happen to be living primarily as consuming members (this includes a significant proportion of the aged). This feedback relationship of history and ageing is perhaps under-researched.

Fourth, people's social lives are expressions of individual agency and power. Though each individual makes personal choices about life in every community, this needs to be distinguished from individualism. Some individuals enjoy a wide choice set, others face highly restricted choices. In the same way, some persons exercise a great deal of power, others little, an important source of power being control over economic resources.

Finally, drawing on Claude Levi-Strauss' structuralism, is the idea that the human mind provides the structure within which social life occurs. The nature of human cognition is relevant to social ageing. This raises interesting questions, such as, Which cognitive patterns are associated with senescence? Why is it that the primary group in widely separated situations happens to comprise 25 individuals (p. 142-3)? van Willigen and Chadha opine that just as research on the impact of history on ageing and vice versa, the underlying structure of the human mind and the phenomenon of ageing and dotage too remains under-researched.

The basis of social life is interdependence between its members which is facilitated through exchange, the process of institutionalised give and take. Exchange theory, built around the mechanism of exchange, suggests that the individual's position in society is shaped by the content and nature of exchange (p. 8). Exchange is conditioned by the values of hierarchy, power differentials, wealth inequalities; it also reproduces the system. For example, people in the upper strata may offer gifts to those in the lower strata without receiving anything in return; these unreturnable gifts reinforce their position of superiority. The resultant inequality is reversed in the case of wife-givers and wife-takers in a patrilineal society wherein the former remains inferior to the latter although they not only transfer a woman (sister or daughter) but also a large number of prestations (dowry) without ever expecting reciprocity.

Imbalance in reciprocity surfaces when individuals start withdrawing from active interaction. Though many explanatory reasons are advanced, an important one is that as the power resource level of an individual declines and he realises his inability to maintain the norm of reciprocity (or redistribution), the best strategy for him is to withdraw. Withdrawal may help him maintain some esteem, while at the same time absolving him from the gruelling demands of interaction.

As a person's economic resources and power declines, his social world, the ensemble of social networks, also starts shrinking. Individuals interact because without it social life cannot be conducted; also because it is rewarding, in material, social, and psychological terms. Exchange theory questions the functional premise that interaction is a result of normative expectations and it fulfils socially required needs. Rather, the argument is that transactions are rewarding (and human beings are 'earthy') and individuals know about the advantages that flow from them. Exchange theory is post-functional; it focuses on the individual's motivation to participate and emphasises the inequality of rewards and inequality in social relations.

Exchange theory may yield profitable results in social gerontology. As individuals age, they experience a decrease in power resources to which they adapt through choice. This leads to a decrease in their social interaction. van Willigen and Chadha argue that exchange theory also explains why individuals decide to disengage themselves from the social world.

Another theory, important for a discussion of social ageing, is known as the disengagement theory. Advanced first in the 1960s, this theory submits that as people grow older, their frequency of social relations reduces, their interaction with the people around them becomes thinner and restricted, and they restructure the goals of their life. Not only do the aged want to disengage themselves but others (the so-called 'engaged lot') expect the older people to do just that. If they fail to dis-

engage, they may even invite vituperations. The norms may be relaxed for the disengaged; so also the expectations from them. Certain cultures (like the Indian) place high premium on disengagement, describing old age as a return to infancy and old people as 'children' (*burha baccha ek saman*). Just as norms and sanctions are relaxed for children, so are they for the aged.

One consequence of disengagement is that the individual becomes less vertically integrated with people of other (younger) age groups. His integration with his own age grade, horizontal integration, could certainly be far greater. This explains the success of several senior citizens' associations. Through disengagement the individual adapts to the two facts of life: the gradual decrement of strength and the expectation of death. Disengagement prepares a person to face his imminent departure. Disengagement theorists believe that theory is universally applicable, though mediated by culture. Equally, gender responses to disengagement are highly variable. In India, for instance, older women are less disengaged in comparison to their male counterparts.

Although severely criticised, disengagement theory stimulated substantial new research and analysis, as also the development of alternative theories relating to social welfare and geriatric practices. One of them, 'activity theory', which argues that successful ageing is contingent upon continued activity. If old people continue to work, remain preoccupied with activities, they will have greater life satisfaction, will not suffer from role loss, will have something to look forward to, and will remain integrated in society, both vertically and horizontally.

More than test disengagement theory, van Willigen and Chadha examine the lives of north Indian old people from the perspective of the various themes in an effort to constitute a theory of social ageing. They identify the cultural institutions that 'influence and provide meaning to social ageing processes' (p. 18) such as *asrama* (the vocations of life), *varna* (ritual ranking based on ascriptive categories), *purdah* (veiling, indicative of female seclusion), and the joint family pattern. It may be noted at the outset that the institution of *varnasrama* is essentially Hindu. Its utility, therefore, in understanding social ageing in other religious communities is doubtful, although they too value disengagement from worldly affairs.

Crucial to an understanding of social ageing in Hindu communities (and the authors worked chiefly with north Indian Hindus) are the institutions of *purusartha* (the 'aims of life') and *asrama* (the 'stages of life'). The former is a theoretical delineation of what humans should do, the meaning of their existence, how they are different from animals (*dharma*), how they should reproduce their own kind and the society (*kama* and *artha*), and how they should ensure their permanent release from the incessant cycle of birth, death and rebirth (*moksha*). The theory of *purusartha* offers a fine coexistence of the ideas of materialism and spiritualism; in the hierarchy it aims, *moksa* occupies the highest place and *kama* (carnal satisfaction) the lowest.

Purusartha finds a concrete expression in the practice of *asrama*, the vocations of life. The final release (of soul and its merger with the supreme soul, the *paramatman*) is possible when one renounces the world (*samnyasa*) after having disengaged oneself from the social world (during the third stage of life called *vanaprastha*). van Willigen and Chadha explore the relevance of this cultural model of engagement (in the vocations of celibate-student and householder) and disengagement (in the vocations of forest-dweller and renouncer) to the people in contemporary urban India. However, it must be remembered that the *purusartha-asrama vyavastha* (organisation of aims and stages of life) is relevant essentially for males of the Brahmin caste. Historians of ancient India point out that for the Kshtriya males death in the battlefield represented salvation; in other words, *purusartha* for the Kshtriya and Vaishya was different from what it was for the Brahmins. Disengagement had a different cultural content in different communities: going to the battlefield (often dressed like a renouncer) was symbolic of disengagement from the social world.

van Willigen and Chadha carried out their study in an upper class neighbourhood of Delhi, Rana Pratap Bagh. We do not know how they determined the class position of their respondents: Was it subjective, that is, based on how people described themselves in class terms, or was it an objective assessment? The survey data was drawn from a systematic, random sample of people (53% men and 47% women), 55 years and older (the age-range of their sample was 55 years to 90 years, the mean age being 65.6 years), through open-ended interviewing, participant observation, and a review of documents. Ethnographic research was carried out in the community as a whole. However, they do not specify which activities of the community they participated in, since they used participant observation as one of the techniques of data collection.

The chapters 'The Household and Social Ageing' and 'Networks: the World Beyond the Family', provide a sophisticated analysis of the data collected. The

former chapter analyses the social life of the aged people in the context of their households, the problems they face and their responses to them. It describes the nature of integration that older people have with their families and households. The chapter on networks focuses on the integration of the aged with the external world.

van Willigen and Chadha used 'interaction frequency categories to produce the list of persons that made up the network' (p. 120). Neighbours formed an important category of networks. In women's networks, there were more neighbours than was the case with men. Friends were the other component of network – men had more friends than women, indicating that they participated more in extra-domestic realms than the women, whose social world was confined largely to the household. The older people, mostly men, also participated in several associations, such as trusts and charitable societies, religious study groups, card playing groups, informal conversational circles, kitty parties (mainly women), worship groups, devotional singing (*kirtan*) groups, political parties, and street organisations.

Unlike expectations based on exchange theory, persons with smaller networks did not come across as healthier than others. They had lower incomes and exercised lower control over their worlds. They were also less satisfied with their lives. The mean network size of those who were placed in the rung of 'low satisfaction', in the life scale was 21.6; those classified in the 'high satisfaction' rung had a mean network size of 30.7 individuals (p. 134). Successful ageing requires a network of at least 25 individuals. This in turn is dependent upon material wealth, power relations, and degree of control over life.

These networks perform several functions; in particular by providing a group with which the individual can share grievances and frustrations emerging from the household. For instance, a widower may come home after severely criticising (and thereafter feeling 'light') his daughter-in-law in his conversational circle, and thereby find an outlet for his frustrations! Successful ageing is a function of health, power, and social involvement. It also depends upon the community ecology: if the community is homogeneous, there are greater chances for the emergence of mutual support associations.

However, gender distinctions are crucial. van Willigen and Chadha argue that power structures associated with the patrilineal, patrilocal, and patriarchal joint families constrain the ability of females to achieve successful ageing (pp. 138-9). Also, the control women exercise over their environment and household varies with age. A newly-married woman is powerless in a patri-joint family; yet she may get her way by using negative strategies such as crying, expressing displeasure, getting angry, refusing to speak, denying sex to her husband, and so on. By comparison, an old woman (the mother of grown-up sons) can get her decisions implemented in a positive manner – by relying on respect for age, or by operating through the medium of her sons and grandsons.

Women enjoy invisible power in joint families; they differ in how they exercise it. Most observers hypothesize that women are more easily able to adapt themselves to the demands of the household, particularly through daughters-in-law and grandchildren, than men; this may explain why widows are more integrated within households than widowers. Studies focusing on gender differentials, ageing, and power might provide answers to these questions.

Vinay Kumar Srivastava

THE FIRST FIVE YEARS: A Critical Perspective on Early Childhood Care and Education edited by Mina Swaminathan. Sage, Delhi, 1998.

THIS book is a must read for all those who consider themselves to be educators, particularly those who see education as a lever for societal change. For those of us who sit in urban isolation, far from the rural reality, it is as if 'turning and turning in the widening gyre the falcon no longer knows the falconer' (Yeats, The Second Coming). The commitment and dedication of those who have set up the various ECCE programmes gives a new tilt to the words that management gurus claim always go together, 'leadership and management'. Since the success of the projects described in the book is directly related to the quality of community participation achieved, one wonders whether management has any role at all to play in evolving leadership models.

The first part of the book is a veritable cornucopia of indigenous, educational endeavours packaged in the various case studies and moulded to shape and suit diverse terrains, people and sensitive local issues. Each of the cases discussed are unique and inspirational like the Mobile Crèches programme and the tale of Ambapali which introduces the NGO-government interface, or the Integrated Child Development Services programme run through Urmul. The story of how

SEWA, through hard work and dedication, gave birth to Shaishav which in turn empowered the women of Kheda district is of great significance. Equally illuminating is the excellent community-based model of a pre-school programme developed by the Palmyrah Workers' Development Society in the Tirunelveli and Kanyakumari districts of Tamil Nadu.

In an environment conditioned by media focus on lost causes and sensationalism, the warmth and positive flavour that pervades *The First Five Years* makes the book an inspirational heart warmer. This is especially relevant at a time when the Budget 2000 is out and the government has once again seen fit to increase allocation for Human Resource Development by a miserly .09% from 3.23% to 3.29% while increasing defence allotment to a whopping 19.51% of the plan outlay. The Probe report (OUP 1999) provides historical evidence of our government's continuous makeshift treatment to education over the years. Clearly yet another age is to go by before we focus attention at the marginalised in our country, the women and children in particular. Despite the Budget 2000 continuing this skewed vision we have no cause to despair, particularly if we believe the message in this book: The meek will yet inherit the earth!

The book is divided into two parts. The first part offers a micro perspective through documenting eight innovations in early childhood care and education in India; the second provides the macro perspective through six state of the art essays on the current status of ECCE in the country. The first two essays of part two provide the main background against which most of the other material presented can be viewed, especially the first eight vignettes. Margaret Khalkdena's essay, titled Early Childhood Care and Education in India, presents a historical perspective, tracing the development of ECCE in all its various colours and dimensions – from the early 17th century, through the colonial era and the introduction of the primary school system by the British, into the post colonial era, the framing of the Constitution in 1950 and in particular, Article 45, 'The state must endeavour to provide free and compulsory education for all children until they complete 14 years of age' (p. 168). Khalakdena traces the evolution of organized thinking on ECCE. She points out how the government has constantly shifted its stance on ECCE, never quite sure of where it wants to go. 'The subject of child welfare seems to have been apportioned an irregular staccato rhythm which could perhaps be expressed in the words: start... halt... shift... restart' (Luthra, 1979).

It was subsequent to the Fifth Plan that the government realized the importance of community participation and changed focus to supplementing the family rather than supplanting it (Myers, 1992). Khalakdena also highlights the stellar work by the voluntary sector and points to its spirit of dedication, commitment, teamwork, closeness to community and its continuous efforts at evolving new strategies based on the needs of the situation despite low remuneration in the sector. By comparison the private sector is characterized by a lack of vision and understanding about the needs and psychology of the pre-school child. What it offers can best be characterized as 'care shops' (p. 183) – places to prepare children for admission into the competitive primary schools.

Vinita Kaul points out how the growth of the ECCE movement showed that in the absence of appropriate and adequate training of teachers and workers, one could be left with a pre-school curriculum that is both 'child unfriendly' and 'burdensome'. She analyses the existing training programmes, highlighting the problems faced by the trainees who pass out from the Nursery Training Institutes, particularly vis-à-vis language. She also juxtaposes the one/two year teacher training programmes with those specifically offered by the various ECCE experiments, such as the training module for the workers of the Mobile Crèches programme. The Mobile Crèches offers an integrated programme which includes a crèche, a balwadi, non-formal education and adult education.

Francis Sinha focuses on ways to appraise the cost effectiveness of child-care programmes. She points to the differences between 'effectiveness' and 'efficiency', particularly in programmes which value the human quality both in terms of the teacher/worker as well as the learner/beneficiary. 'A programme is efficient if goals and objectives are achieved at a reasonable cost' (p. 211). To overcome this point, Sinha suggests methods of analyzing cost-effectiveness in quantified but non-financial terms by linking effectiveness to programme goals and objectives. An extremely interesting essay, especially for those who would like to use available resources in a disciplined manner to get maximum mileage.

All the case studies explore the interface between women's empowerment and child care. Rajalakshmi Sriram's article provides a perceptive and detailed analysis of this interface, complete with historical perspective. She correctly points out that in order for the empowerment process to take place among women it is necessary 'that women find time and space of their

own to re-examine their lives critically and collectively' (p. 224). Child care facilities not only give women the much needed time and space for introspection but also permit them to work both without anxiety about the welfare of their child, and thus increases their incomes and self-esteem and standing in the family and community.

The subsequent overview essays lend further depth to the various case studies. Each essay is a standing testimony to the dedication of the voluntary sector in particular through the vision and leadership of individuals, who are largely women, in transforming the lives of women and children in the rural sector. The case studies that discuss the problems faced by projects involving government and voluntary sector cooperation shed further light on the issue of cost effectiveness. It is clear that wherever the human element is important part and the programme concentrates on the process rather than on the product, we cannot go by simple cost effectivity.

The First Five Years is as much a labour of love as a lucid and analytical study of an area that requires a more detailed look by the government, private and voluntary sector if we are to see any change in the scenario as it exists today.

Annie Koshi

INDIA'S ELDERLY: Burden or Challenge? by S. Irudaya Rajan, U.S. Mishra and P. Sankara Sarma. Sage Publications, New Delhi, 1999.

THIS book explores the widespread feeling that the elderly are becoming a burden in Indian society. By defining India as an ageing nation, the authors caution us about the implications of an increasing growth rate of the elderly population, accompanied by a decline in the growth rate of the general population. They speculate that the decreasing rate of mortality may convert the country into a nation with a greater population of old, frail and dependent people presenting a burden on the socio-economic and health infrastructure if adequate measures are not taken for the well being of older persons. The transition from high to low fertility is expected to narrow the age structure at its base while broadening the same at the tip. For instance, by 2021 the growth rate of the elderly would be one and a half times higher than the growth rate of the general population.

The book under review studies the demographic transition and imbalances in the elderly population across the various states and union territories of India with special reference to Kerala. The authors indicate that the states of Kerala, Tamil Nadu and Punjab are likely to experience a rapid increase in their old age population in the coming decades. The demographic transition coupled with various socio-economic changes, would drastically impact the lives of the elderly. The book draws attention to the emergence of nuclear families, smaller number of children per couple, greater longevity, physical separation of parents from adult children as a result of rapid urbanization and age-selective rural-urban migration, which alters the dynamics of relationships between old and young generations. The discussion takes note of low literacy levels, marital status, economic situation and living arrangements of older persons. In this context the authors assess the future size and composition of the elderly society as well as their needs and the difficulties they face with regard to health, social adjustment and dependence. The book highlights that these issues become particularly critical for older women. Quite clearly, gender issues are relevant in analysis of population ageing as the proportion of elderly females increases faster than males in the older age groups.

The authors review the concept of adequate social security for the elderly meticulously. Despite the various provisions and facilities available in the country, much more is needed to provide equal opportunity, employment, social security and welfare to all. Efforts for poverty alleviation and providing financial security among the old need to be sensitive to both the rural-urban divide as well as the organized and unorganized sector differentials. The chapter on Policies and Programmes through a detailed study of numerous provisions like the provident fund, gratuity, life insurance and pension schemes, exposes the need to improve operational efficiency for successful implementation.

The overview of the findings of the National Sample Survey seems somewhat amiss since a couple of earlier books have already provided a thorough analysis. The detailed analysis from the ageing survey carried out by the authors with the collaboration of various leading research institutes in India is, however, welcome. An understanding of the situation of residential institutions for the elderly in the major states in India conducted through a mail survey is illuminating, as are the findings of the survey conducted among the inhabitants of old age institutions in Kerala and Tamil Nadu. The perceptions of the elderly gathered through group discussions throws fresh light on the meaning of old age, the advantages and disadvantages of being old, preferred living arrangements, community

involvement and the specific needs of elderly persons. It is significant how pertinent questions of retirement, re-employment, inequalities in pension and difficulty in obtaining benefits from social assistance schemes are to the elderly. The brief case studies, presented in the form of life histories, reflect different experiences of ageing which are meaningful for understanding variations among a cross-section of the elderly. The final chapter questions the conventional definition of the elderly (60 and above) and calls for a re-examination of the retirement age along with age dependency ratios.

The book would enlighten policy makers and researchers on the needs of the elderly, reorienting ones thinking to make the 'burden' as a 'challenge'.

Bhavna Puri

THE FAMILY IN INDIA: Critical Essays by A.M. Shah. Orient Longman, Delhi, 1998.

A.M Shah's book brings together eight essays published earlier. In the first essay he discusses the terminologies – elementary family, joint family, household and extended family, and the ambiguities he perceives in their conceptualisation by various sociologists. He makes a distinction between joint household and joint family. He accepts the legal conceptualisation of joint family, understood as jointness in property ownership and ritual performance of *shraddha* citing for this purpose Hindu Law and the Mitaksara. The members of a joint family on the other hand can well be residing in separate households. For the elementary and joint households, he uses the terms 'simple' and 'complex'.

The functional aspects of joint household and family are also discussed in this essay. In the former, Shah emphasises kinship composition, while in the latter, he stresses joint property ownership and ritual participation. He points to the sociological gap in the legal definition of joint family which overlooks the 'household' dimension and the pattern of residence, in this restricted sense that legally even an elementary family would be considered 'joint'. According to Shah, joint households are formed with the addition of extra members in the elementary family, and they can be patrilineal, matrilineal, or fraternal extended, with common residence and hearth. The joint family, however, represents separate households linked by a range of social, economic, ritual, and ceremonial relationships, governed by kinship positions which cannot be reduced to mere property relations.

In the next chapter, the author explores the changes in the household dimension of Indian society. He refutes the widely held belief that the erstwhile rural Indian joint family was the norm which under the impact of urbanisation disintegrated into the nuclear family. He reiterates the necessity to distinguish between household and family to avoid indiscriminate use of the latter term, which entails members having separate residences either in terms of simple or smaller joint households, but bound by a multitude of relationships.

Further, Shah lays stress on collecting the detailed composition of households to help delineate their various types and their frequency. He discusses the ongoing process of development and factors that lead to change in size of the household, thereby enabling a coexistence of simple and complex households at any point of time. The separation of households does not, however, sever the multiple familial ties. Contrary to the widespread belief that modernisation and industrialisation have enforced a nuclear family norm, the size of the household has been steadily increasing owing to a stronger influence of Sanskritization and adherence to traditional norms, notwithstanding migration and a general process in which the dispersed simple households become complex.

Shah extends this analysis by examining popular assumptions and media projections that the joint household is being replaced by the simple, nuclear household. Through an analysis of census data from 1871 to 1951, he first demonstrates that the joint household was never the norm. Its incidence was greater among higher castes and the business class which constituted a minor proportion of the population. Further, it existed more as a textual norm of joint property ownership and ritual participation. Another barrier was the low life expectancy and semi-nomadic life of landless people.

The author then argues that while the emphasis on joint households has declined somewhat for the professional class, it has increased in the rural masses, the urban business class and lower middle class, as well as among lower castes as a tool for Sanskritization and status mobility. This caused an increase in the average size of households and a corresponding increase in the incidence of joint households. It is necessary here to realise the existence of nuclear households in the past in order to gauge the steadily increasing incidence of joint households. Shah further states that even in the urban, westernised, highly educated professional class, married children tend to stay with their parents and, if possible, take care of them, thereby still sustaining

small yet joint households. Thus, socio-psychological, economic, demographic and status-oriented factors have contributed to a higher incidence of joint households.

In the next piece the author discusses the tensions and conflicts inherent in inter-personal relations, complex behaviour patterns of members of a traditional joint household, and how they lead to its dispersal. This dispersal is processual and if explicated step by step, places the household in varying contexts. The conflicting emotions and heartburn finally lead to the partition of the joint household. The author describes how the kinship composition of the household, education, an increase in age at marriage, and need to care for the aged dictate the nature of conflicts and the extent to which unity is preserved.

The next two essays titled 'Inter-household Family Relations' and 'Lineage Structure and Change in a Gujarat Village' explore the terms 'household' and 'joint family', distinguishing them from lineage. In the first, Shah conducts a systematic enquiry into the relationships between family members residing in separate households. The multi-functional joint family is distinguished from the lineage in its legal and scriptural sense, as a three to four generation group of males with their wives and children who enjoy rights in joint property and in the performance of ancestral *shraddha* rituals. The patrilineal kinship relations beyond this three or four generation family are understood as lineage relations.

In the next chapter we learn that the lineage span is much longer and requires the study of historical data and genealogical records in addition to the contemporary life of the people. The author highlights the increase in lineage groups within castes, enumerating as causal factors population growth per generation in patrilines, and the increased interest in genealogical records used as tools for social mobility and high status rank. Shah believes that the importance of lineage as a corporate group has declined among landowners and the privileged class with the removal of hereditary privileges in rural society and its declining role in politics. However, it has gained importance in groups who have acquired land and other assets and are literate enough to preserve their genealogical records. Further, marriage alliances are regulated according to the lineage affiliations and great significance is attached to the lineage groups in ritual occasions, lifecycle events, status differentiation, veneration of lineage deities, and folk culture. Even in modern India, the lineages as functional groups play an important role within the caste.

The author then moves to the studies on the prevalence of caste endogamy in Gujarat. Traditionally, since the principle of caste endogamy governs all marriages, the family becomes embedded in caste. The author describes a range of first to fourth order divisions within castes which are themselves endogamous groups; for these he uses the terms sub-caste and sub-sub caste. He states that each division/unit is significant for endogamy and the violation of the norm at each higher level alongwith the degree of social distance determines the severity of punishment. In modern, urban society, this situation is changing for with an increase in education and age of marriage, there is an urge to exercise freedom of choice in spouse selection.

In the final essay of the book, Professor Shah decries the lack of academic research on the family and the 'restricted' views of social workers, lawyers, and feminists which have affected family policy. He asserts the fundamental problem of having a uniform policy for India in the face of diverse ethnic, religious groups. The situations becomes more complex given a wide range of family units – simple, complex household, joint family, extended family, lineage.

Further, both popular and sociological discourse has promoted a wrong impression that the joint family is disintegrating. The author demonstrates that the trend is rather towards a spread of joint family relations. The author highlights the contradictions between policies concerning the different elements that constitute the family. On the one hand, responsibility for taking care of the aged is on the sons; on the other, couples are expected not to consider the birth of a son as mandatory in adherence to the two-child norm. The latter also ignores the patrilineal principle governing family and kinship and the equality of status between male and female children, a prerequisite for the norm to gain legitimacy. As the proportion of the aged increases, the traditional preference for son will persist. By making the family responsible, the state has further strengthened it.

Overall, A.M. Shah recognises the limited efficacy of state intervention and policy given its formal structure, disharmony between state and central legislatures, inadequate application of laws, the 'traditional' orientation of the bureaucracy, and so on. He ends by stressing the need for further rigorous research on the family, in particular the degree to which growing individualism is now influencing family matters.

Meera Ahmad

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Comment

Activism and academic angst

SINCE the 1967 annual meeting of the American Anthropological Association, the issue of ethical anthropology or action research has been central to debates within the discipline. In that meeting, several anthropologists like Kathleen Gough and Gerald Berreman wanted to pass a resolution condemning the Vietnam war, while others like Margaret Mead opposed it. Mead argued famously that political resolutions were not in the professional interests of anthropology. The floor, however, was swayed by Michael Harner who declared that 'Genocide is not in the professional interests of anthropology,' and the resolution was passed (Gough 1990: 1705).

Now that proactive social science is no longer confined to the Left, especially but not only in India, several people are beginning to rethink their earlier assumptions on how social science should engage with practical politics. The ICHR's recent decision to recall two volumes of the *Towards Freedom* project by Professors Panikkar and Sarkar, or the move to tailor textbooks and exam questions to the prejudices of the party in power are both excellent examples of social science research being defined in terms of 'political correctness'. One of the charges frequently levelled by the Right in its effort to appropriate the bureaucratic posts that supervise and fund research is that these posts were formerly bastions of the Left, who used them to push its own version of secular democratic history. Historical Materialism, according to our honourable Hindu historians, was then politically correct and now needs to be corrected politically.

It is worthwhile in this context to remind ourselves of the legacy of much of this proactive social science on the Left, broadly defined. My argument here

* This article originated in a panel discussion initiated by Majid Siddiqui on the 'pro-active and the politically correct' at the India International Centre in February. I am grateful to Majid and other participants in the discussion for their insights.

is that leftist preoccupations with the political underpinnings of their research are qualitatively different from those of the Right, not because of the soundness of their ideology per se but because they have generated new directions and methods in social science research. I write here from the perspective of my own discipline – what is regarded as anthropology in the US or UK and the twinned discipline of sociology/anthropology in India.

As a result of decolonisation and other radical movements in the '60s and '70s, there emerged a great deal of self questioning in all disciplines, reflected in journals like the *New Left Review*, or *Economic and Political Weekly*, to name two popular ones. These concerns led to a variety of theoretical shifts and new trends in the social sciences. In anthropology, this was reflected in newly developing fields such as feminist anthropology, Marxist anthropology which discovered class in age-sets and non-industrial societies, anthropological political economy which studied the contribution of imperialism in the formation of class, community and culture, and more recently, political ecology. Although conservative economists like Milton Friedman have been important to the disciplinary mainstream of economics, one is hard put to think of a single right-wing anthropologist who has pushed the discipline rightwards in a major way, or who has produced entirely new arenas of study. At best, debates have taken place over the symbolic versus material factors underlying social cohesion, or between so-called post-modernists and political economists, but much of this has been within a broadly democratic consensus. Of course, in the Indian context, the old Indological work on caste and religion continues, but there are also plenty of countervailing studies.

Apart from the effloresence of fields, political engagement on the Left has resulted in three broad directions of research: (*i*) an increasing focus on the impact of colonialism in shaping many apparently sociologically given categories such as caste or tribe. This was accompanied by an examination of the 'invention of tradition' which accompanied nationalist movements seeking to create ancient traditions for themselves; (*ii*) the trend towards 'reflexive anthropology'. By focusing on their own ancestors, anthropologists looked at the complicity of their own discipline in the invention of traditions, as also at the way in which the writing of ethnography distanced and marginalised the 'other'; (*iii*) the activist approach going under the names of 'development anthropology', applied anthropology, or 'action research'.

Academic interventions under each of these headings have been useful in challenging the status quo, both in real life and in the discipline. They have produced new and exciting ways of doing research – the use of history and literary criticism for example, or multi-sited ethnography instead of the single village, caste or religion study that dominated anthropology earlier. Yet, even within this iconoclastic tradition, there is the danger of new gods being installed, of political activism coming full circle and boomeranging on its protagonists. Below, I focus on two such dilemmas: the role of anthropologists in attacking essentialisms and invented traditions, and second, the role of social scientists in development studies. Ultimately, my argument is that one is brought back to the question of what counts as good research, or productive research, given the current standards of the discipline.

A favourite 'essentialism' that has long been the staple of anthropological attack is the notion of tribe. So long as anthropologists were attacking the notion of tribe developed by colonial anthropologists, they could unambiguously describe themselves as politically correct. For instance, in pointing out that tribes were not small bounded homogenous units, that they had no basis in race, that they were involved in diverse occupations, and had enjoyed political power based on internal stratification etc., anthropologists were challenging conceptions that had helped to sustain colonial rule. Pointing to the commonalities between adivasis and other groups around them could be part of a legitimate anti-colonial project in the face of attempts to preserve adivasi areas as legitimate objects for colonial paternalism.

However, the same kinds of arguments against the indigeneity of 'tribal' or adivasi populations in India, or against the theory of Aryan conquest, or against the idea that adivasi religions in central India are not sharply distinguished from folk Hinduism, often seems to support the Hindu fundamentalist argument which claims adivasis as 'backward Hindus'. They also come into conflict with adivasi movements which have adopted categories of indigeneity as part of their claims to the land. The claim that adivasis were first displaced by Aryans is a useful rejoinder when Hindutva forces attempt to claim some sort of historic victimisation or displacement. In a world where categories are created through reference to multiple publics in multiple contexts, the claim to have a deep connection to the environment is often a useful political tool to employ in the face of obdurate states intent on preserving their control over resources. In such con-

texts, anthropological critiques, both of certain categories like indigenous peoples or certain environmental movements, are doubly problematic.

In fact, much of the research on marginalised groups like adivasis or on social movements came about due to a desire to engage with political action, and do pro-active research. But in the process, anthropologists or sociologists have often highlighted the manner in which these groups construct identities, and the global sources of their self-descriptions, e.g. in North American environmentalism. As Peter Brosius has pointed out in a recent discussion in *Current Anthropology* (1999), there is a certain irony in the fact that critiques of essentialism which began as critiques of structures that perpetuate inequality have ended up turning against those who are challenging this inequality. Perhaps there is a need to make a distinction between the essentialism of the oppressor and the oppressed.

On the other hand, one might argue that any essentialism, especially one based on identity, is dangerous, regardless of who is claiming that identity. Certain categories, especially those involving identity and exclusion such as 'indigenous' lend themselves more easily to passion. They also enjoy better circulation in a globalised world where donor lending and military action have increasingly intervened to defend identities defined in religious or ethnic terms at the expense of identities based on other attributes such as class.

In other aspects, however, it is less easy to feel certain about the correctness of one's stand. For example, movements like Narmada Bachao Andolan or the fishworkers' movement are often criticised for claiming that adivasis or fishworkers want to preserve an environmentally friendly lifestyle, when in fact the adivasis and fishworkers themselves want all the attributes of an unsustainable lifestyle. This is pointed to as evidence of the essentialism of these movements and their leaders, or at best the use of 'strategic essentialism' in some political interest (see for example Baviskar 1997, Gupta, 1999). Yet, there is no corresponding focus on the essentialism of the market, or on the power of the hegemonic discourse which makes people reject their earlier lifestyles as backward. If movement leaders put words into the mouths of their followers, so do the state and market, and much more successfully at that, through all the advertising and official power at their service.

Opposing romantic essentialism or strategic essentialism to some authentic identity as described by a social scientist is problematic in that all identities are relational and contingent upon particular discourses and contexts. At various times people may want to drink Pepsi and drive around in fast cars, or watch Madhuri Dixit films on TV, without, however, wanting to lose out on their ancestral homes or destroy their traditional fishing grounds. To claim that environmentalism is an ideology foisted by activists on adivasis or fisherpeople because it appeals to international audiences ignores the local material context of this ideology. In his discussion of what fisherfolk hope to protect when they demand their 'right to nature' (Gupta 1999: 2316-7), Gupta assumes that their only concern is bettering their own livelihoods, which could be served by everyone being given assistance to acquire trawlers. However, as Aparna Sundar shows, the opposition to trawlers fishing in the monsoon is not because of envy, but because ordinary fishers and no just their leaders have an ecological understanding of the sea and its resources: 'When I suggested that the solution might be assistance for all fishers to acquire trawlers, I was told, "And will there be enough fish for that? The government encourages us to 'develop', to buy trawlers. But can we all do so? Can everyone own a plane or even fly in one"?' (Sundar 1999: 105-106). Of course, not every adivasi or fisher is an environmentalist. As in every society, there are class differences among them; some are more aware and articulate or just plain interested compared to others. Certainly, however, not all the voicing of environmentalism is due to outside activists, as the state would like to claim.

Calling something or someone 'essentialist' has become the favoured form of abuse in the social sciences these days, a superior variant to the older 'stereotype'. Yet, perhaps, we need to pause in our wholesale attack on essentialism and examine the con text in which we make the critique. An argument that is commonly made is that the anthropologist or sociologist has a professional duty to her discipline, which requires the production of truth, however unpalatable to the activists with and on whom she has done her research. This, however, often tends to be a rather self-serving argument, defining the 'truth' as whatever the anthropologist wants it to be. If one claims to be writing the truth about a people or a movement, that writing should be accessible to the people concerned to present their own version of truth. This is of course not a simple issue – some like the pseudo-Hindus of Benaras may refuse to recognise truths about themselves in a film like Water – but it is at least worth trying. It is also productive of better research. In many cases our 'truth' is based on short term research, which

GEN-1

The Pakistan-India People's Solidarity Conference

New Delhi, July 12, 2001

Declaration

I. Preamble:

For over half a century now, the people of India and Pakistan have borne the burden of hostilities between the two States. We, the representatives of numerous civil society groups, which have endeavoured for years to reform relations between India and Pakistan, welcome the Summit between General Pervez Musharraf and Prime Minister Atal Behari Vajpayee and urge that they seriously engage in a sustained dialogue. The resources of the two countries must be transferred from bombs to books, from submarines to schools, from missiles to medicines, from frigates to food, from runways for bombers to railroads for people. The two leaders must also pledge to eliminate the terrifying nuclear menace that threatens the people of the entire South Asia region and the whole world.

***

II. The Pakistan-India People's Solidarity Conference has identified and arrived at an agreement on three major areas of concern between India and Pakistan, which we feel need to be addressed by the two Governments. These are as follows:

Nuclear Weapons

The nuclear weapons programmes of India and Pakistan have heightened mutual tensions and placed the entire South Asian region in grave danger. The two countries must commit themselves to total nuclear weapons elimination in the world and to the complete dismantlement and destruction of their own nuclear armaments and associated systems, and jointly return to the agenda for global disarmament.

Democracy

We affirm that peace, democracy and justice are indivisible. Hostilities between India and Pakistan have dangerously fuelled religious fundamentalisms and national chauvinisms. The support extended to these forces by the Indian and Pakistani States seriously undermine democracy, the rights of working people, marginalised communities, minorities and women, and threaten intellectual freedom and free speech. We call for Pakistan's return to participatory democracy and representative rule based on the principles of non-exclusion of any section of society, respect for universal human rights and freedom, and speedy empowerment of the people. We also call for the strengthening of democracy in all parts of India to attain the same objectives. These acts are crucial for a lasting peace between the two countries. We call on the two leaders to recognise that today's needs and tomorrow's great possibilities are more important than yesterday's sad injuries, and that old mindsets need to change with the times.

Kashmir

The Kashmir issue is not only a territorial dispute between the two States but involves the people of Jammu and Kashmir (which includes Jammu, Kashmir, Ladakh, Muzzafarabad, Mirpur, Gilgit, and Baltistan). Therefore, a just and democratic resolution of the Kashmir dispute demands the involvement of the people on both sides of the LoC in a non-sectarian

solution. A Kashmir solution can work only in the atmosphere of Pakistan-India friendship, which both Governments must guarantee.

For fifty-four years the Indian and Pakistani States have not only failed to resolve the Kashmir dispute, but have also been responsible for grave Human Rights violations. The leaders of India and Pakistan should focus attention on the plight of the widows and half-widows, the orphans, the bodily wounded, the psychologically traumatised, the socially ostracised, and the physically uprooted—irrespective of religious, ethnic or political background. Let all sides reflect upon the tremendous suffering in Jammu and Kashmir caused by the denial of political, social, economic and human rights by India and Pakistan, and guarantee the implementation of full democratic and political rights to the people in all these areas.

III. We call on the two governments to:

1. Withdraw all draconian laws in both countries that violate Human Rights.
2. While we welcome all measures such as release of fisherfolk, easing of travel restrictions, this must be expanded to allow free movement of people between the two countries, and remove travel and visa restrictions, (including police reporting) through a formal agreement between the two governments.
3. Withdraw the order for prior Government permission and clearance to hold international meetings, conferences, seminars and workshops.
4. Lift restrictions on exchange of newspapers, magazines and journals, etc.
5. Normalise cultural and trade relations between the two countries.
6. Cease hostilities with immediate effect in Kashmir, initiate the process of disengagement of armed forces, and terminate support to armed groups, both State and non-State.
7. Involve the people of both sides of the LoC in finding a democratic, non-sectarian solution to the Kashmir problem.
8. Rehabilitate all those who have been affected by the war in Kashmir, particularly women, and create the conditions for the return of all refugees and exiles.
9. Commit to a Nuclear Freeze. This would entail no further nuclear testing, no development, deployment and induction of nuclear weapons, and no further efforts towards the setting up of Command and Control systems.
10. Take a principled stand against "missile defence" and for global nuclear restraint measures such as de-alerting and separation from warheads from missiles.
11. Develop a pacifist, non-militaristic, non-masculinist view of national security, which would lead to a mutual reduction in the armed forces, and utilise the freed resources for meeting the people's social and economic needs. Both governments should also commit themselves to a time-bound programme for the systematic reduction of military spending, both direct and indirect.
12. Agree to complete transparency in their CBMs.
13. Cease all acts of subversion, overt or covert as well as hostile propaganda and media campaign against each other.
14. Demilitarise Siachen Glacier

MESSAGE From H.H. DALAI LAMA

I am very happy to greet the participants of the Pakistan-India People's Solidarity Conference being held in New Delhi on July 12, 2001.

I have lived in India for over 42 years and I have for many years felt very strongly for the need for understanding and good relations between India and Pakistan. For many obvious reasons it seems senseless for the two countries not to have good relations. It pains me to hear and read about the great amount of suspicion and lack of understanding between the two countries, especially at the governmental level. At the same time I have been greatly encouraged by the friendly feelings that have been expressed and shared at the peoples' level, especially in the fields of culture and sports. I was therefore very happy when Prime Minister Vajpayee visited Pakistan a few years ago. I am now extremely happy that President Musharraf is soon visiting India at the invitation of the Indian Prime Minister. I am sure that these summits will go a long way in contributing to building trust and friendship between the two nations and their peoples.

I have always believed that attempts at various levels should be made in achieving understanding, trust and friendship between India and Pakistan. And in some cases private individuals and non-governmental organizations have a greater role to play. In fact I am quite certain that the contribution from such quarters has to some extent made it possible for the leadership in India and Pakistan to take the initiative in holding the forthcoming summit. I would therefore like to express my special appreciation to people like you who are holding this Pakistan-India People's Solidarity Conference.

May India and Pakistan see a new chapter of friendship and understanding for the peace and prosperity of the peoples of the two countries.

With my prayers and good wishes,

(Signed) Tenzin Gyatso
the Dalai Lama

July 11, 2001

Message from Jose Ramos Horta:

As you gather today in the Pakistan-India People's Solidarity Conference I extend to you all my warmest greetings and wishes of success in this Important and timely conference.

I have read the draft of your joint declaration and I believe it to be a very constructive and balanced document that could be easily endorsed and implemented by peoples and leaders of the region.

Civil society is playing an increasingly important role in shaping policies the world over and it could have a positive decisive impact on this seemingly intractable conflict. In this globalised community interconnected by the electronic media and the internet, foreign policy and the fate of nations can no longer rest solely in the hands of a small group of diplomats and politicians. You can make a difference, you can succeed where others have failed.

The peoples of Kashmir, India and Pakistan deserve the peace, tranquility and prosperity they have dreamed about for decades. Some of the best brains in the world originate from your region. They have excelled in every field of human endeavor. So it is natural that their combined intelligence and common sense will lead to some simple and creative solution.

In solidarity,

Jose Ramos-Horta
Nobel Peace Prize Laureate (East Timor)

Message from Cora Weiss:

Congratulations to every one of you assembled in this extremely important gathering at this extremely important moment in history. The Hague Appeal for Peace learned early on that governments will not move until and unless organized civil society leads the way. The heads of state of India and Pakistan should thank you. We also learned that no agreement can be sustained unless both government and civil society are at the table, with all the players, not just "the sides". Thus women, youth, the religious sector, diverse civil society bodies that will have to implement the agreement need to have a stake in creating the agreement. The South Asian conflict has gone on for far too long, with far too much waste in life and destruction of land and property. As two of the players are nuclear powers it has the potential of ending up destroying life on earth, unless it is contained and resolved.

At the Hague Appeal for Peace conference in May l999, Indians and Pakistanis and Kashmiris read each other's poetry, exchanged views for hours into the night, and demonstrated not just an ability to get aong, but a passionate desire to live together, side by side in peace.

I salute you for your constancy, for your dedication to seeing this unnecessary conflict resolved, for your courage and determination to help the governments which, like any people in trouble, often need third parties to show the path to peace.

We support the Agra summit. We support the statement of the Pakistan-India People's Solidarity Conference. We wish you every success.

With warm wishes,
Cora Weiss, President
Hague Appeal for Peace

Art of Living Foundation

Pakistan-India People's Solidarity Conference, July 12, 2001

Message from His Holiness Sri Sri Ravi Shankar

Human evolution is to move from limited boundaries to unlimited potential. For centuries, human race has made progress in the fields of science, technology and politics, and now it is time to bring back the human values that were somehow ignored in the past.

We need to remember first and foremost that we are part of one divinity and secondly that we are part of one human family. Right education is that which unites us in love and peace and takes us beyond the political, social, racial and religious boundaries.

I wish this conference reaches the people in both the countries and clears the misgivings by educating the people in our common heritage. I also wish this conference opens a new chapter in cooperation and brotherhood by reminding us that we need to live in harmony, enrich our diversity and forget and forgive all the past misgivings.

I congratulate the organizers of this conference for fostering brotherhood and peace in our continent.

Signed,
Sri Sri Ravi Shankar

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List of Participating/endorsing Organisations

- Action India, New Delhi
- Akhil Bharat Rachanatmak Samaj
- Akshara , Mumbai
- All India Bank Employees Association
- All India Central Council of Trade Unions
- All India Christian Council
- All India Democratic Women's Association
- All India Federation of Trade Unions
- All India Insurance Employees Association
- All India People's Resistance Forum
- All India Peace and Solidarity Organisation
- All India People's Science Network
- All India Progressive Women's Association
- All India Students Association
- All India Students Federation
- All India Trade Union Congress
- All India Youth Federation
- Alternate Lawyers Forum
- Anti-Nuclear Movement, Nagpur
- Anglo-Indian Guild
- Ankur, New Delhi
- Anumukti, Vedchhi (Gujarat)
- ASHA, Lucknow
- Association for Advocacy and Legal Initiatives, Lucknow.
- Association for Communal Harmony in Asia
- Association of Parents of Disappeared Persons, Kashmir
- Association of Peoples of Asia (India)
- Bank Employees Federation of India
- Bangalore Platform Against Nuclear Weaponisation
- BEL Employees Union, Bangalore
- Bharat Gyan Vigyan Samiti, Bangalore
- Centre for Education and Documentation, Bangalore
- Centre for Dialogue & Reconciliation
- Centre of Indian Trade Unions
- Centre for Social Work and Research, Tripura
- Centre for Women's Development Studies
- Centre for Peace & Progress, Kolkata
- Citizens Against Nuclear Energy, Bangalore
- Campaign Against Nuclear Weapons, Kolkata
- Champa Foundation, Delhi
- Chhattisgarh Anu Mukti Manch, Chattisgarh
- Citizen's for Democracy
- Delhi Forum
- Delhi Science Forum
- Democratic Teachers Front, Delhi
- Democratic Youth Federation of India

- Documentation & DisseminationCentre for Disarmament Information
- Ekta, Mumbai
- Eklavya, Madhya Pradesh
- FARR, Kalahandi, Orissa
- Federation of Medical & Sales Representatives Association of India
- Federation of Voluntary Organisations for Rural Development
- Focus on the Global South, Mumbai
- Forum Against Oppression of Women, Mumbai
- Forum for Confederation in the Sub-Continent, Delhi
- Forum for Science and Development, Karnataka
- Forum of Scientists, Engineers and Technologists, West Bengal
- Forum for Women's Health, Mumbai
- Foundation for Integrated Research in Mental Health, Thiruvanantpuram
- Free Legal Aid Committee, Jamshedppur
- Gandhi Peace Centre
- Gandhi Peace Foundation, Delhi
- Gandhi Seva Sansthan, Bihar
- General Insurance Employees Union
- Global Women's Lib (India)
- Greenpeace, India
- Harijan Sevak Sangh
- Haryana Gyan Vigyan Samiti
- Himachal Vigyan Manch
- Human Rights Forum, Hyderabad
- India Centre for Human Rights & Law, Mumbai
- India Peace Centre, Nagpur
- India-Pakistan Friendship Society
- India-Pakistan Soldiers' Initiative for Peace
- Indian Council of Trade Unions
- Indian Federation of Trade Unions
- Indian Institute for Peace, Disarmament and Environemntal Protection, Nagpur
- Indian National Social Action Forum
- Indian Scientists Against Nuclear Weapons, Bangalore
- Indian Scientists Against Nuclear Weapons, Chennai
- Indian Social Institute, Delhi
- Indian Society for Cultural Co-operation & Friendship, Delhi
- Initiatives Women & Development, Mumbai
- International Energy Initiative
- Institute of Women's Development, Orissa
- Jan Natya Manch, Delhi
- J&K Public Commission on Human Rights, Srinagar
- Jagori, New Delhi
- Jan Vigyan Vedica, Andhra Pradesh
- Jharkhand Organisaiton Against Radiation, Jaduugora

- Journalists Against Nuclear Weapons, Chennai
- Kali for Women, New Delhi
- Kinnaird College Old Students' Association, (India)
- Karnataka State Peace and Solidarity Organisation
- Kerala Shastra Sahitya Parishad
- Lawyers Collective, New Delhi
- Legal Resource Centre, Palampur, Himachal
- Left & Democratic Teachers' Forum, Delhi
- Lok Abhiyan, Lucknow
- Lok Raj Sanghatan, Delhi
- Lok Sahet Manch, Punjab
- Lokayan, Delhi
- Mahila Samakhya State Office, UP
- Mahila Sarvangin Utkarsh Mandal, Pune
- Manasa, Bangalore
- Madhya Pradesh Vigyan Sabha
- Media storm, New Delhi
- Movement in India for Nuclear Disarmament, Delhi/Mumbai
- Movement Against Nuclear Weapons, Chennai
- Muslim Women's Forum
- Nari Samata Manch, Pune
- Nirantar, Delhi
- Narmada Bachao Andolan
- National Alliance of Peoples Movements
- National Confederation of Officers Associations of Central PSUs
- National Council of Churches in India, Nagpur
- National Federation of Indian Women
- Naujawan Bharat Sabha
- New Entity for Social Action
- Nirantar, New Delhi
- Nishant Natya Manch, Delhi
- North East Network, Assam, Meghalaya.
- Oxfam India Trust
- Pakistan-India People's Forum for Peace and Democracy
- Partners for Law and Development, Delhi
- Paschimbanga Vigyan Manch, West Bengal
- PEACE, Delhi
- People Tree
- People's Rights Organisation, Delhi
- People Union for Civil Liberties, Delhi
- People Union for Civil Liberties, Jaipur
- People's Union for Democratic Rights
- Physicians for Peace, Chennai
- Pondicherry Science Forum
- Pravah, New Delhi
- Public Interest Research Centre, Delhi
- Raqs Media Collective, New Delhi
- Revolutionary Youth Association
- Saheli, Delhi

- SAHMAT, Delhi
- Sama, Delhi
- Samvada
- Sangini, New Delhi
- Sandarsh, Goa
- Science for Society
- Shramik Mukti Dal, Maharashtra
- Shakti Shalini, Delhi
- Society for Citizens Concerns, Delhi
- South Asian Network for Alternate Media
- Stree Sangam, Bombay
- Student Christian Movement, Trivandrum
- Students Federation of India
- Tamil Nadu Science Forum
- Tarshi, New Delhi
- Vachan, Nasik, Maharasthra
- Vanangana, Banda, UP
- Vikas Adhayan Kendra, Mumbai
- Visthar, Bangalore
- Wan Kamgar Sanghathna, Nagpur
- Women's Association for Mobilisation and Action, Lucknow. UP
- Women's Centre, Mumbai
- Womens Initiative for Peace in South Asia
- Workers Solidarity, Delhi
- World Conference on Religion and Peace
- Youth for Nuclear Disarmament, Delhi
- Youth for Unity & Voluntary Action
- Youth Welfare Association of Haryana

SOUTH ASIAN & Pak-India groups based abroad

- Ambedkar Centenary Trust, London, UK
- Asian South Pacific Bureau of Adult Education
- Association for India's Development (AID)
- India Development Service, Chicago.
- INFORM, the Women and Media Collective and the Movement for Inter-Racial Justice and Equality, Sri Lanka.
- Nuclear Disarmament Conference, Dhaka.
- South Asia Peace Coalition.
- Coalition for a Egalitarian and Pluralistic India(CEPI), Los Angeles
- Pakistanis for Peace and Alternative Development (PPAD)

S.No	Pakistani Organisations
1	National Workers Party (NWP)
2	Jeaye Sindh Mahaz
3	Saraiki National Party
4	Tehreeki Istiqlal
5	Baluchistan National Movement (B.N.M)
6	Labour Party Pakistan
7	Baluchistan National Party (BNP)
8	Balochistan National Congress (BNC)
9	Pakistan Institute of Labour Education and Research (PILER)
10	Railway Mehnatkash Union
11	Railway Inqilabi Union
12	Railway Workers Union
13	Muttahida Labour Federation
14	Pakistan Trade Union Federation
15	National Trade Union Federation
16	All Pakistan Federation of Labour
17	Workers, Employer Bilateral Council of Pakistan (WEBCOP)
18	Human Rights Commission of Pakistan (HRCP)
19	Anjuman Taraqqipasand Musannifeen
20	Progressive Writers Association
21	Social Democratic Movement
22	Forum for Peace & Development
23	Idara-e-Aman-o-Insaf
24	Tehrik-e-Niswan
25	Forum for Social Studies
26	Centre for Pakistan Studies (Karachi University)
27	Catholic Social Services
28	Hamdard institute of Information Technology
29	The News, Daily
30	Centre for Women's Studies
31	Dawn, Daily
32	Sustainable Development Policy Institute
33	Quid-e-Azam Universaty
34	Khaldunia High School, Islamabad.
35	Pakistan Medical Association (PMA)
36	International Physicians for Prevention of Nuclear War (Pakistan Chaper) (IPPNW)
37	Pakistan Doctors for Peace and Development (PDPD)
38	Wokers Educations and Welfare Association Peshawar
39	Baluchistan Institute of Development Sciences and Practices (IDSP)
40	Pakistan Women Lawyers Association (PAWLA)
41	Aurat Foundation
42	Baanh Beli
43	Women Action Forum (WAF)
44	Urban Resource Centre (URC)
45	Sungi Development Foundation
46	South Asia Partnership - SAP-Pak

The Pakistan-India People's Solidarity Conference
Signature Campaign for Peace

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The
Pakistan-India People's Solidarity Conference

Look at Us!

Just look at us. We fought side by side for our freedom, and then decided we couldn't live together, so we fought and parted. We couldn't live together and yet we haven't learned to live apart as civilised neighbours. More than half a century later we are still fighting. We are so obsessed with fighting each other and spending all our resources in destroying one another that nations a tenth of our size are far ahead of us. Ours is perhaps one of the few places left in the world which still suffers from drought and famine. And the rich nations? They grow richer on the blood we spill, on the one hand telling us we must behave ourselves and be friends, and on the other selling weapons we can hardly afford, to kill one another.

Just look at us. Over a billion people in South Asia are affected by the tensions between India and Pakistan. And yet, we are unable to resolve our differences and get on with life. Our leaders claim that they speak for all of us when they say they will not sell out the interests of their people when they talk to the "enemy." But when was the last time they asked you or me what we wanted? When was the last time we told them what we wanted?

When the Agra Summit was announced the people of India and Pakistan were hoping against hope for a breakthrough. In an expression of support for the reconciliation of the two countries hundreds of people gathered in New Delhi on 12th July, 2001. They were representatives of over two hundred broad-based civil society organisations and people's groups from India and Pakistan— many of whom have been working for peace in the subcontinent for years— who spoke for thousands of people at the grassroots level. All day they discussed, debated and even fiercely argued about the various issues that have plagued both countries, but in the end they achieved what their leaders were unable to achieve— a Joint Declaration!

This Declaration has also been endorsed by a number of eminent people: two Nobel Peace Prize Laureates— H.H. Dalai Lama and Jose Ramos Horta of East Timor; Cora Weiss,

President of the Hague Appeal for Peace and the International Peace Bureau, and the spiritual leader, Sri Sri Ravi Shankar. In fact Jose Ramos Horta, after reading the Draft Declaration called it " a very constructive and balanced document that could be easily endorsed and implemented by peoples and leaders of the region."

We believe that these are extraordinary times, which require extraordinary actions. But instead of seizing the moment, our leaders have allowed the hawks to have their way yet again. They have disappointed us. But can we afford to sit back and see all the goodwill and hopes generated by Agra trickle away before our eyes? Can we allow things to slip back to square one? Is this how we'd like the world to look at us, as people who are unable to resolve their differences?

Join the Signature Campaign for Peace being launched simultaneously in India and Pakistan, which will culminate at a Celebration for Peace at the Wagah Border on the night of 14th / 15th August.

Take five minutes to read the Joint Declaration.

Say YES to Peace by signing the form.

And then let's together say to the world:

Now look at us!

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REVIEW ARTICLE

Verbal Autopsies for Adult Deaths: Issues in their Development and Validation

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Chandramohan D (Tropical Health Epidemiology Unit, Department of Epidemiology and Population Sciences, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK), Maude GH, Rodrigues LC and Hayes RJ. Verbal autopsies for adult deaths: Issues in their development and validation. *International Journal of Epidemiology* 1994; **23**: 213–222.

Background. The verbal autopsy appears to be an attractive technique for the assessment of causes of adult death in settings where the proportion of people who die while under medical care is low. Verbal autopsies have been used extensively to assess causes of childhood deaths. The existing experience in verbal autopsies for adult deaths is limited mainly to maternal deaths. This paper aims to highlight the critical issues in verbal autopsies to assess causes of adult death which need further research.

Methods. This paper reviews the methods of verbal autopsy used in 35 published studies and discusses issues in the development of verbal autopsies, including mortality classification, design of questionnaires, interviewers, respondents, recall periods, procedures for deriving a diagnosis and the recording of single versus multiple causes of death. It also discusses issues in the validation of verbal autopsies, including the choice of reference diagnosis and the required sample size.

Results. The methodological approaches used in verbal autopsy studies have varied widely. Very few studies of the validity of verbal autopsies have been conducted. In these studies, the reported sensitivity and specificity varied widely between different causes of death and between studies.

Conclusions. The information available is inadequate to draw firm conclusions on preferred methodological approaches for verbal autopsies for adult deaths. Before these tools are used more widely for adult deaths, further research is required to compare alternative methods and to evaluate the validity of this tool in a range of settings.

Knowledge of the levels, causes, distribution and determinants of morbidity and mortality among adults in developing countries is extremely deficient compared with the information available for children. This lack of knowledge has been seen as an important determinant of the policy vacuum on adult health that exists within governments and agencies.[1]

In countries with poor data on adult mortality, vital registration systems are weak and the proportion of people who die while under medical care is low. In such settings, ascertainment of causes of death from data obtained from relatives or associates of the deceased through retrospective questioning in surveys or in demographic surveillance systems seems an attractive option.[2] This technique is known as verbal autopsy (VA) and has been used to assess causes of childhood deaths in several settings. Verbal autopsies have also been used to assess causes of adult deaths, but almost exclusively for maternal deaths.

The VA technique is based on the assumption that most causes of death have distinct symptom complexes, and that these can be recognized, remembered and reported by lay respondents. It also assumes that it is possible to classify deaths, based on the reported information, into useful categories of causes of death. The validity of VA is influenced by the cause of death *per se* and characteristics of the deceased and by several other factors, relating to the classification of causes of death, the design and content of the questionnaire and field procedures. Some of the key factors and processes are summarized in Figure 1. The determinants of validity shown in the Figure are far from complete and their relationships may be more complex than the framework shown.

The methodology of VA of childhood deaths was reviewed in an international workshop in 1990,[3] and discussed in the context of adult mortality in a further international workshop in 1993[4] (see overleaf). Despite growing interest there is still little information on the

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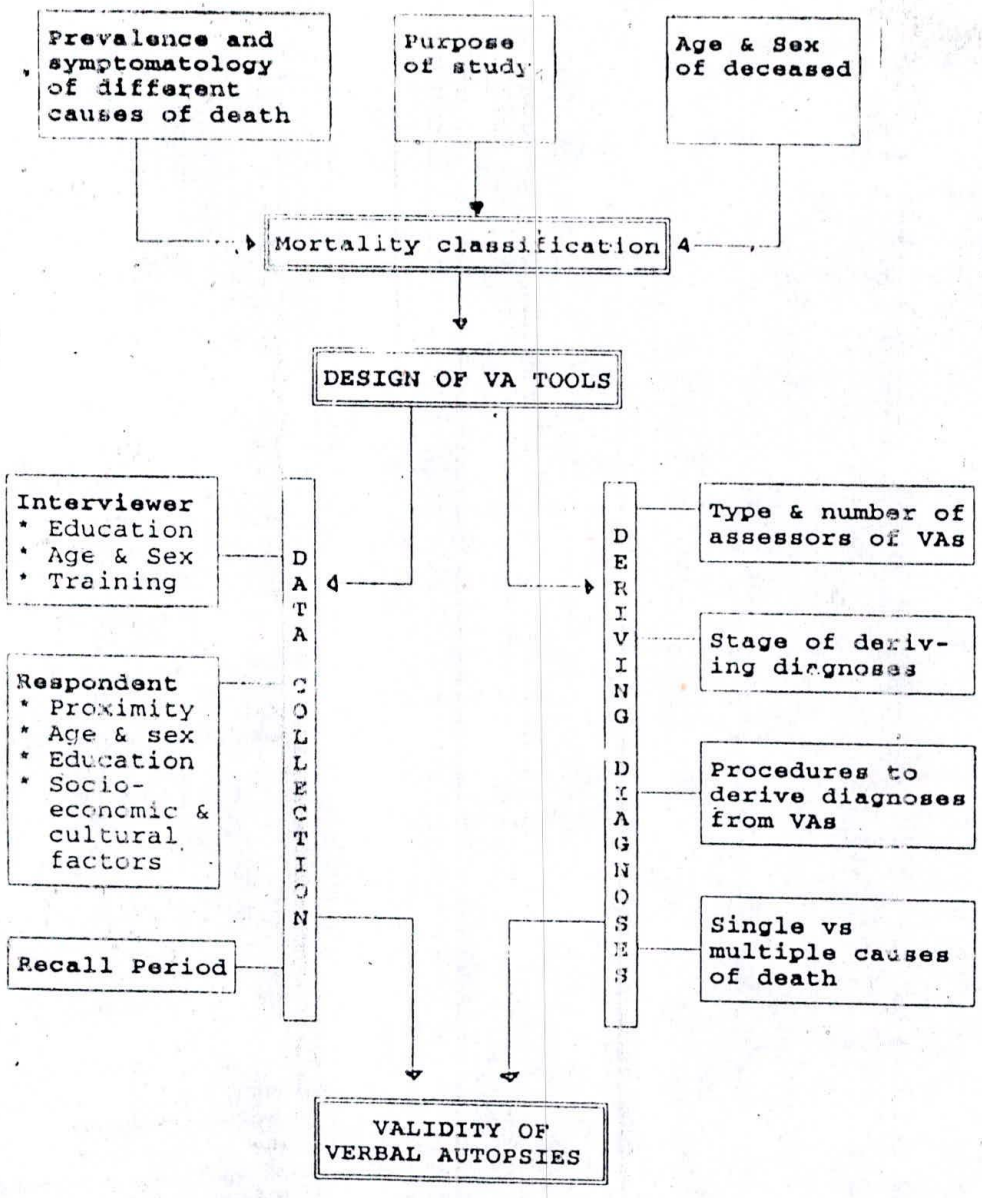

FIGURE 1 *Determinants of validity of verbal autopsies*

methodology or validity of VA for adult deaths. We have made a review of all the studies that we could find published up to mid-1993, and that have used VA. We identified for each study, the country, study period, age group, main objectives, number of deaths, approach to mortality classification, format of questionnaire, characteristics of interviewer, recall period, type and number of assessors and the procedures used to derive diagnosis. We described and discussed the methodological approaches applied in these studies in order to identify the critical issues in the development, use and validation of VA to determine causes of adult deaths.

A brief description of the 35 studies which were re-

*The report of the workshop on Verbal Autopsy Tools for Adult Deaths held at LSHTM 11-15 January 1993 is available on request.

TABLE 1 *Summary of 35 published studies using verbal autopsy tools*

No.	Study country	Study period	Age group	Main objectives of study/purpose of verbal autopsies	No. of deaths
01	India[4]	1988–1991	<5 years	to evaluate the impact of a community-based intervention for control of pneumonia	337
02	Nepal[5]	1986–1989	<5 years	"	
03	Tanzania[6]	1983–1985	<5 years	"	2101
04	Kenya	1985–1988	<5 years	"	1198
05	Papua New Guinea[8]	1981–1985	6–59 months	to estimate the efficacy of pneumococcal vaccine against acute lower respiratory tract infections	239 173
06	The Gambia[9]	1988–1990	<5 years	to evaluate the impact of insecticide-treated bed nets on malaria mortality	353
07	The Gambia[10]	1982–1983	3–59 months	to evaluate the impact of chemoprophylaxis or community-based treatment for control of malaria	241
08	Kenya[11]	1981–1983	<5 years	to evaluate the impact of a community-based malaria control programme	592
09	Ghana[12]	1989–1991	6–90 months	to evaluate the impact of vitamin A supplementation on all-cause child mortality and cause-specific mortality	892
10	Sudan[13]	1988–1990	9–72 months	"	240
11	Nepal[14]	1989–1990	6–60 months	"	358
12	Nepal[15]	1987–1989	<5 years	"	305
13	India[16]	NR[a]	<5 years	"	117
14	Benin[17]	1986–1987	4–35 months	to evaluate the impact of a primary health care project on all-cause child mortality and cause-specific mortality	284
15	Ethiopia[18]	1987–1988	<5 years	to establish the relative public health importance of causes of death	492
16	Bangladesh[19]	1982–1985	<5 years	"	1349
17	Bangladesh[20]	1975–1977	<5 years	"	12 893
18	The Gambia[21]	1982–1983	<7 years	"	184
19	Guinea Bissau[22]	1979–1980	<6 years	to establish relative public health importance of causes of death	144
20	Kenya[23]	1989–1991	<5 years	to estimate the validity of verbal autopsies to assess causes of childhood deaths	303
21	Philippines[24]	1987	<2 years	"	164
22	Liberia[25]	1987–1988	all ages	to assess the safety of a community-based treatment trial for onchocerciasis control	25
23	Papua New Guinea[26]	1982–1985	"	to assess the relative public health importance of causes of death	407
24	Senegal[27]	1983–1985	"	"	508
25	Bangladesh[28]	1982–1983	"	"	472
26	Nigeria[29]	1977–1978	"	"	228
27	Yemen[30]	NR[a]	"	"	125
28	Bangladesh[31–33]	1976–1985	15–44 years, women	to measure maternal mortality and to establish relative importance of causes of maternal deaths	542
29	Kenya[34]	1987	"	"	35
30	India[35]	1984–1985	"	"	134
31	Bangladesh[36]	1982–1983	"	"	58
32	Indonesia[37]	1980–1982	"	"	558
33	Egypt[37]	1981–1983	"	"	385
34	Bangladesh[38]	1967–1968	"	"	41
35	The Gambia[39]	1982–1983	"	"	15

[a] Not reported.

TABLE 2 *Methods used in 35 published studies using verbal autopsy tools*

No[a]	Approach to mortality classification	Format of questionnaire		Interviewer		Recall period	Derivation of diagnosis	
		Open	Structured	Type	Education		Assessors	Algorithm
01	restricted approach	NR[b]	yes	lay	12 years	1–2 weeks	two physicians	yes
02	NR	NR	NR	lay	NR	<1 month	two physicians	yes
03	NR	NR	NR	medical assistant	medical assistant	1–2 weeks	interviewer	no
04	NR	NR	yes	medical	clinical officer	1–6 weeks	interviewer	no
05	restricted approach	NR	yes	medical	nurse	NR	NR	yes
06	NR	NR	NR	lay	NR	NR	three physicians	no
07	NR	NR	NR	medical	physician	NR	interviewer	yes
08	NR	NR	NR	lay	NR	NR	NR	NR
09	restricted approach	yes	yes	lay	NR	0–9 months	three physicians	no
10	NR	NR	NR	lay	NR	NR	NR	NR
11	NR	NR	NR	lay	NR	0–2 months	two physicians	no
12	NR	NR	NR	lay	NR	NR	two physicians	yes
13	NR	NR	NR	lay	community health workers	NR	NR	NR
14	NR	NR	NR	medical	physician	NR	interviewer	no
15	NR	no	yes	lay	12 years	NR	NR	NR
16	NR	yes	no	lay	community health workers	NR	one physician	no
17	NR	yes	no	lay	12 years	NR	interviewer	no
18	restricted approach	NR	NR	medical	physician	0–3 months	three physicians	no
19	NR	NR	yes	lay	NR	NR	NR	NR
20	NR	yes	yes	lay	NR	1–16 weeks	three physicians	no
21	restricted approach	yes	yes	lay	university graduate	1–52 weeks	one physician /computer	yes
22	restricted approach	no	yes	medical	physician assistant	1–2 weeks	three physicians	yes
23	NR	yes	yes	medical	physician	2–52 weeks	interviewer	yes
24	restricted approach	yes	yes	lay	9 years	1–8 weeks	one physician	yes
25	restricted approach	yes	yes	lay	NR	1–44 weeks	one physician	yes
26	restricted approach	no	yes	lay	7 years	NR	interviewer	yes
27	open approach	NR	yes	lay and medical	anthropologist/ medical student	0–50 years	interviewer	no
28	open approach	yes	yes	lay	community health workers	NR	one physician	no
29	NR	NR	yes	lay	NR	NR	NR	NR
30	NR	NR	NR	lay	NR	NR	NR	NR
31	NR	no	yes	lay	12 years	NR	one physician	no
32	NR	no	yes	lay	NR	NR	one physician	no
33	NR	no	yes	lay	NR	NR	one physician	no
34	NR	yes	no	medical	physician	2–6 weeks	interviewer	no
35	NR	NR	NR	medical	physician	NR	interviewer	no

[a] Serial numbers in Tables 1 and 2 are the same and refer to the same study; references to each study are given in Table 1.
[b] Not reported

viewed is presented in Table 1. A summary of the methods used in these studies is presented in Table 2. Twenty-one studies have been done to assess causes of childhood deaths, eight to assess both adult and childhood deaths, and six to assess maternal deaths.

USES OF VERBAL AUTOPSIES

Data obtained from VA can be used to study trends in cause-specific mortality over time, to estimate differentials in cause-specific mortality between different groups, or to evaluate the effect of interventions. They can also be used to establish the relative public health importance of different causes of death in populations in order to identify priorities and appropriate interventions.

Verbal autopsies of childhood deaths have been applied to evaluate the impact of interventions against acute respiratory infections[4-8] and malaria,[9-11] to evaluate the impact of vitamin A supplementation[12-16] and of a primary health care project on cause-specific mortality,[17] and to establish the relative public health importance of causes of childhood death.[18-22,26-30] Verbal autopsies for adult deaths have been applied to establish the relative importance of causes of adult deaths[26-30] and to identify the common causes of maternal deaths.[31-39]

ISSUES IN THE DEVELOPMENT OF VERBAL AUTOPSIES

Mortality Classification

Two approaches can be adopted to develop and to derive diagnoses from VA. In the first, a mortality classification is produced and then VA tools (a questionnaire together with diagnostic algorithms or procedures to derive diagnoses) are designed to classify deaths into these pre-defined categories. We call this the 'restricted' approach. In the 'open' approach, a mortality classification is defined *post hoc* on the basis of the diagnoses derived from the VA. For the latter, the VA tools are not determined by a mortality classification defined prior to data collection. A special case of the restricted approach is the investigation of a single cause of death in the evaluation of a targeted intervention. For example, a VA tool to establish specifically whether a person died of AIDS or not.

Among the 35 published studies, 24 studies did not report the approach to mortality classification, nine studies had used the restricted approach and two studies had used the open approach. The studies which used the restricted approach did not report the criteria and the process used to develop the mortality classification. The use of different approaches to mortality classification may affect the validity of VA because of its influence on the design of the questionnaire, on the methods of deriving a diagnosis, and on the number and the combination of categories of causes of death diagnosed. For example, the use of filters and modules related to specific disease categories in VA questionnaires (see below) and predefined diagnostic algorithms is more appropriate for the restricted approach. The implications of differences in the design of questionnaires and methods of derivation of diagnoses are discussed later.

The categorization of causes of death in the mortality classification of the reported studies varied significantly. The number of categories ranged from 5 to 15 for childhood deaths, 5–16 for maternal deaths and 8–29 for adult deaths. The choice of categories will affect the complexity of diagnostic algorithms and the ability of assessors to reach a diagnosis. For example, diagnosing malaria, meningitis, typhoid, hepatitis and relapsing fever as separate categories will be more difficult and inaccurate than diagnosing just two categories, malaria and all other infections. A classification with fewer categories will lead to causes of death with closely related symptom complexes being grouped together and this will tend to increase the validity of the VA at the expense of less detailed information. Thus the validity of VA performed in Yemen (eight categories of causes of death) would be expected to differ from those performed in Papua New Guinea (29 categories) even if the cultural background and the methods used were the same.

A desirable feature of a broad mortality classification is that it could be used in different settings with minor modifications. Ideally, it should have a core that would be applicable in all settings, and it should also accommodate changes to reflect site-specific causes of death. A broad mortality classification should include all causes of death which are important public health problems and others for which there are well-recognized intervention strategies, and its disease categories should, as far as possible, have distinct and easily recognizable symptom complexes.

A knowledge of the cause structure of mortality of the population in which the VA is going to be applied would facilitate the development of a broad mortality classification according to the above criteria. However, this is unlikely to be available in most situations where VA are needed. As an alternative, mortality and morbidity data from health facilities could be used to assist the development of an appropriate mortality classification.

Design of Verbal Autopsy Questionnaires

Verbal autopsy questionnaires can have a number of different formats: open; checklist of symptoms; checklist with filter questions; or a combination of these. An open questionnaire is a blank page on which a trained interviewer enters reported signs and symptoms leading to death, and related information. A checklist is a list of

signs and symptoms, for each of which the interviewer establishes their presence or absence. A checklist with filters is a list of major symptoms and signs which, if present, are followed by a list of related questions or 'modules'. For example, in a 'cough module', a positive response to a filter question on history of cough would be followed by a module with questions on the duration and severity of cough, and the type of sputum. A module can be related not only to a symptom but also to a specific category of cause of death. In this case it will include questions on all symptoms required to diagnose the disease category in question. For example, 'cough' could be a filter question for entering into a 'pneumonia module' which will include questions on cough and also on symptoms such as difficulty in breathing, rapid breathing and fever, to reach or reject the diagnosis of pneumonia; while 'cough for > 4 weeks' could be a filter for entering into a 'pulmonary tuberculosis' (TB) module which will include questions on symptoms such as haemoptysis, weight loss, fever and difficulty in breathing. Combinations of an open section followed by a 'closed' checklist, either with or without filters, can also be used. Of the 35 published studies, three used an open questionnaire, 12 used a structured questionnaire (checklist with or without filters), seven used a mixed format and 13 did not report the format used.

The advantages and disadvantages of open or structured questionnaires for health interview surveys have been discussed.[40,41] However, the relative merits of the various formats of VA questionnaire have not been formally assessed. An open format VA questionnaire would require more skilled, and probably medically trained, interviewers and would increase inter-interviewer variability. A check list without filters would not require medically trained interviewers and would reduce interviewer bias, because interviewers are forced to consider all symptoms even if they make their own diagnosis while interviewing. However this format may not capture all details of the symptoms leading to death and may also increase the number of symptoms which are falsely reported to have been present. A checklist with filters would also not require medically trained interviewers, may be more efficient for data collection, and may reduce interviewer bias. Filters and modules based on a specific category of cause of death have been used in VA of childhood deaths where only a few causes of death were studied. However this format may be less useful for VA for adult deaths because the mortality classification is likely to have a larger number of categories of cause of death. A potential limitation of this format is that a false negative response to a filter question will result in the exclusion of a disease category and thus in lower sensitivity of the VA.

The importance of qualitative field research into local concepts of disease and terminology, to facilitate the process of translation and back-translation of VA questionnaires, has been described.[40-43] The presence of several languages and dialects within small populations will pose problems for the choice of language for VA questionnaires. In these situations, one could design VA questionnaires in all the local languages in the study population or in one major language with an accompanying list of symptoms translated into all other local languages. Ideally, a model VA questionnaire should be adaptable for different settings by incorporating the local concepts of disease and phraseology of symptoms.

Interviewers

Ten of the published studies used medically trained interviewers (seven by physicians and three by medical assistants/nurses), 24 studies used lay interviewers and one used a combination. The educational level of lay interviewers varied from 7 years of education to university degree (14 studies did not describe the level of education of the lay interviewers). It has been argued that medically trained interviewers are preferable, but the relative merits of the use of lay versus medically trained interviewers for VA have not yet been studied. Medically trained people are costly. They are more likely than lay interviewers to interpret the responses to reach a diagnosis during the interview and this may affect the repeatability of the diagnosis. If lay interviewers are to be used, a carefully designed, highly structured questionnaire is needed and this has several implications which are discussed earlier (see above). The preferred age, gender and education of lay interviewers will vary between different settings and with the choice of format of VA questionnaires.

Respondents

The best respondent is obviously the person who knows the most about the final illness of the deceased. Mothers are the principal respondents for childhood deaths. However, identifying the most appropriate respondent for adult deaths may be difficult because the relationship between carers and sick adults is likely to vary in different settings. For example, a spouse may not be the best respondent for female deaths and it has been suggested in the context of studies of maternal mortality that sisters are better respondents than husbands.[44] Thus it is important to enquire about the people who cared for or who lived with the deceased during the illness prior to death as well as about specific relationships to identify the most appropriate choice of respondent. In some cultural settings it may not be appropriate to restrict to a single respondent

Recall Period

The recall period in the reviewed studies ranged from 1 to 52 weeks except for one study where it was up to 50 years. Twenty studies did not report the range of recall period used. The implications of different recall periods have not been studied. It is assumed that a period exceeding 52 weeks is not advisable for childhood deaths, but there is no empirical evidence for this. Adult deaths are relatively rare events and in some societies premature death of an adult is likely to be regarded as more significant than that of a child. Therefore it may be possible to use longer recall periods for adult deaths. On the other hand, one could argue that mothers are intimately involved in the care of a sick child and so they may report the symptoms preceding death of a child more accurately than a relative caring for an adult. This would suggest that shorter recall periods might be necessary for adult deaths. Asking about a death soon after its occurrence may cause distress and so it may be advisable to define a minimum, as well as a maximum, recall period, as in several of the studies reviewed.

Derivation of Diagnoses

Diagnoses have been derived at differing stages in the VA process and by different types of assessors. The interviewers reached a diagnosis at the stage of interview in 10 studies (by a physician or medical assistant in eight and by a lay interviewer in two). Assessors who were different from the interviewers derived a diagnosis at a later stage in 17 studies. Eight studies did not report the stage of diagnosis or the type of assessors.

The procedures used to derive a diagnosis from VA also varied in the reported studies: according to predefined diagnostic algorithms in 11 studies (by a single assessor in five, by a panel of assessors in four, by a computer in one and the number of assessors was not reported in one); by assessors without algorithms in 17 studies (by a single assessor in 12 and by a panel of assessors in five); while no procedure for derivation was reported in seven studies.

A diagnostic algorithm consists of standard criteria based on the duration, severity and sequence of symptoms and signs used to reach a diagnosis. For example, an algorithm to diagnose meningitis might require a positive history of high fever, headache, vomiting, stiff neck, convulsions and unconsciousness. The specificity of an algorithm will increase, and the sensitivity will decrease as the number of symptoms and conditions included in the algorithm increase. Algorithms can be developed from text book descriptions of symptoms, from existing clinical algorithms, from local clinical experience or from a combination of these.

Derivation of a diagnosis at the stage of interview raises several problems. The validity of a diagnosis derived at the interview by lay interviewers without algorithms is likely to be poor. Although derivation of a diagnosis at this stage by medical interviewers may reduce the proportion of deaths which remain unclassified, it is likely that the repeatability of the diagnosis will be low if the diagnosis is derived without algorithms. Diagnostic algorithms for mortality classifications with 20 or more categories may be too complicated to be used during interviews, even by medically trained personnel. It would thus appear that diagnoses should be derived at a later stage, not at the interview.

Diagnoses derived according to diagnostic algorithms are likely to have better repeatability compared to diagnoses derived without algorithms. Therefore deriving diagnoses according to predefined diagnostic algorithms would be preferable for inter-population comparisons and to study changes in cause-specific mortality over time.

Although 11 studies reported the use of algorithms only one described the process used to define the algorithms. The validity of certain diagnostic algorithms for common causes of childhood deaths has been discussed.[45] However, the differences in the algorithms defined by different processes have not been studied. Algorithms developed from local clinical expertise may vary between different settings and may not be appropriate for international comparisons. Algorithms defined from text book descriptions may not be appropriate in some settings due to differences in cultural perceptions of symptoms and signs of diseases. It is likely that a combination of approaches would be the best way to develop a first draft of diagnostic algorithms, which could then be refined by field tests.

Single versus Multiple Causes of Death

Classification of causes of death into underlying, immediate and associated causes, and into primary and secondary causes, is complex and it is not clear that these terms are always used consistently. The ability to distinguish between an underlying and immediate cause based on VA information is doubtful. There is a danger that a secondary cause of death may be ignored in analysis and insistence on a single cause of death is an attractive option which would keep the analysis and presentation simple. However, ignoring multiple causes of death could lead to misleading results. One way of handling multiple causes of death would be to treat a common combination of causes as a category in its own right (e.g. having AIDS/TB as a separate diagnosis from either AIDS or TB) and to take this into account in the analysis and presentation of data. Alternatively, analysis could be performed by individual diagnosis, so that AIDS/TB

contributes once to the AIDS category and once to the TB category. The presence of multiple causes of death will have an impact on the estimated sensitivity and specificity of VA diagnoses.

ISSUES IN VALIDATION OF VERBAL AUTOPSIES

The reported validity of VA for childhood deaths varied considerably between studies[7,23–25] and the sensitivity and specificity of VA varied between different causes of death. For example, in Kenya[23] the sensitivity was 89% and specificity was 96% for malnutrition and 28% and 91% respectively for acute respiratory infections (ARI). Furthermore, the sensitivity and specificity for the same cause of death varied between different settings and tools. For example, in Philippines[24] the sensitivity of VA for ARI was 41–86% and the specificity was 41–93% depending on the diagnostic algorithms. These estimates of validity of VA for ARI are quite different from those reported from Kenya.

There is virtually no information on the validity of VA for adult deaths. There has been only one small validation study of 10 deaths in Liberia.[25] It is likely that the validity will vary in different settings, and so tools should be tested in several settings before being used to assess cause-specific mortality rates.[46]

Reference Diagnosis

In order to assess the validity of diagnoses derived from a VA it is necessary to compare them with a reference diagnosis. Validation studies will thus involve identifying deaths whose causes have been diagnosed by the reference procedure, and subsequently subjecting them to verbal autopsy. Ideally the reference diagnoses for validation studies should be accurate and reliable, and the deaths studied should be representative of the distribution of causes of death in the community. The following three options could be considered for reference diagnosis: (i) diagnosis reached by clinical necropsy; (ii) diagnosis of deaths in the community; (iii) hospital diagnosis.

Diagnosis by necropsy may be accurate, but would be very difficult to achieve in many places where only a small proportion of deaths go to necropsy, and where necropsy is not culturally accepted. This may result in a strong selection bias as the deaths that go for necropsy tend to be atypical.

The choice of diagnosis of all deaths occurring in a community as reference would be less susceptible to selection bias. However, since only a small proportion of deaths in the community are likely to be seen by a physician, in places where VA are needed, this is not a realistic option.

Choice of hospital diagnosis as reference may also introduce selection bias due to selective access, differential treatment success and the socioeconomic characteristics of those who use hospitals. The standard of hospital diagnosis depends on several factors such as the training and experience of physicians, local diagnostic preferences and availability of diagnostic facilities. Snow *et al.* have illustrated some of the inherent biases of the hospital-based approach to validate VA.[23,47] Nevertheless those studies[7,23–25] which have tested the validity of VA using hospital diagnosis as reference have been valuable in illuminating the limitations of VA for childhood deaths.

Sample Size

Ideally the sample size for a study to validate a VA tool should be estimated to give a sufficient number of deaths due to the rarest cause of interest to provide an acceptable confidence interval around the estimated validity of the VA for that cause. If the desired confidence limits are +/–10% for a sensitivity of 80% for a diagnosis, then approximately 100 deaths due to the given cause are required. Thus if the expected proportion of the total deaths due to that cause is 10% then 1000 deaths are required overall. The specificity will generally be estimated more precisely than the sensitivity, but will also vary with the proportional mortality of the cause in question.

This shows that very large sample sizes are required to obtain precise estimates of validity if there are many categories of cause of death. Nevertheless, misclassification of a cause of death into a closely related 'similar' category is of less concern than into a very different category. For example, misclassification of congestive cardiac failure (CCF) as myocardial infarction is of less concern than CCF as pulmonary TB. Thus, related categories of cause of death could be collapsed into broader categories to estimate the validity of VA, even if separate diagnoses were derived initially. It may be of value to study the validity of VA for many categories of cause of death, accepting wide confidence intervals for some of them.

CONCLUSION

Verbal autopsies have been widely used for childhood deaths, but adequate appraisal of their validity has not always been addressed. The marked variations and imprecise reporting of the procedures applied in the reported studies have made comparisons of results from these studies difficult. Furthermore, it cannot be assumed that methods appropriate for childhood deaths are necessarily applicable for adult deaths.

A considerable amount of methodological work

needs to be done before VA can be used on a wider scale to obtain useful and comparable data on causes of adult mortality for a range of developing countries. An increasing recognition of the urgent need for data on adult mortality and morbidity may require wider use of VA for adult deaths and this highlights the need for answers to the methodological questions discussed. Recently a team from the London School of Hygiene and Tropical Medicine has embarked on a project to develop and validate verbal autopsy tools to assess causes of adult deaths in three countries in sub-Saharan Africa. This study aims to answer some of the methodological questions raised in this review.

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Letters to the Editor

Study of the Disease-Health Seeking-Death Process: Another Use of the Verbal Autopsy

From GONZALO GUTIÉRREZ, HORTENSIA REYES, HOMERO MARTÍNEZ, PATRICIA TOMÉ AND HÉCTOR GUISCAFRÉ

Sir — Over the past 10 years, the verbal autopsy (VA) has been used by different researchers to investi causes of death in places where death registrations are scarce or non-existent.[1–3] The VA consists of an interview directed to a caregiver (usually the mother) close to the deceased subject, with the purpose of disclosing information about the cause of death.

During the past year, our group has used the verbal autopsy in a way that had not been reported previously. We have focused on the study of the process associated with the disease and subsequent health care-seeking behaviour, in children who die due to acute respiratory infection (ARI) or acute diarrhoea (AD).[4]

Our experience began with work at a state-wide level in a programme to reduce ARI and AD mortality in children. Thanks to the state government's interest in this programme, it was possible to have physicians certify up to 98% of deaths. From these death certificates, we identified those children who died of ARI or AD. Within 15–60 days of death, a public health nurse visited, at home, the mother or other close caregiver of every child who died of one of these two conditions, to conduct a VA. The main findings are summarized in Table 1. Over 60% of 98 children who died from ARI during 1991 died at home. Likewise, 58.9% of 34 children who died of AD during the same period died at home. In this particular state, no household is further than 30 minutes from a health facility using regular means of transportation. Eighty per cent of the children who died had received qualified medical care within 3 days of death, and in half the cases the child had been seen by the physician within 12 hours of death. Most of the attending physicians were in private practice. Based on current WHO case-management standards,[5,6] 50% of the children received incorrect medical treatment, based on the mother's recall, or were not referred to a hospital when they ought to have been as judged by the mother's clinical description at the time of consultation.

Based on these results, the state health authorities initiated a series of interventions to improve ARI and AD case management at the primary health care level. The most important strategy has been to establish treatment centers of excellence for ARI and AD, where government and private physicians can receive in-service training. Particular emphasis has been laid in bringing private physicians to these training courses. As an incentive, physicians receive points towards their curriculum (continual medical education), as well as a certificate of attendance. Continuous monitoring of childhood deaths in the state by VA will provide data to evaluate the impact of these training courses.

Following this successful experience, the Ministry of Health showed interest in the use of the VA, and has extended its use to the whole country, with special emphasis on those states where ARI and AD death rates are particularly high. The purpose of VA is to determine gaps in health care delivery that are amenable to intervention. Special attention has been placed in communities where cholera cases have been reported. VA are analysed monthly by an inter-institutional committee, integrated by physicians and nurses from

TABLE 1 *Main findings related to infant deaths from information gathered through verbal autopsies in the state of Tlaxcala, Mexico*

	Acute respiratory infection (n = 98)	Acute diarrhoea (n = 34)
1–6 months of age (%)	71.4	67.6
Died at home (%)	60.2	58.9
Received medical care prior to dying (%)	83.7	94.1
Incorrect medical treatment (%)	47.4	65.3
Late referral to the hospital (%)	42.6	34.7

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all the healthcare delivering institutions in the country. This committee gives recommendations to decision-makers, who in turn choose the best strategies to follow.

In summary, we have used the VA as an interface between epidemiology and ethnography, and have found it to be a useful epidemiological tool to understand the process of health-seeking behaviours, both from mother's and physician's point of view. By using VA at a state-wide level, we have discovered areas where appropriate interventions may lower mortality rates. Based on these results, we have planned and implemented a nation-wide programme to improve case management of ARI and CDD in primary health care facilities and at the home level. We plan to evaluate the impact of this intervention through continued use of VA.

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Exact Confidence Interval of the SMR Based on Prevalence Data

From JAMES LEE

Sir — The standardized morbidity ratio (SMR), computed by indirect standardization, compares the morbidity experience of the 'exposed' subjects with that of the 'standard population' allowing for adjustment of confounding. The SMR is simply the ratio of O to E, where O is the observed number of morbid events in the exposed group and E is the expected number of morbid events in the exposed group if the risk of the morbid event in the exposed group coincides with that of the standard population.[1,2]

Customarily, the computation of the confidence interval (CI) of SMR rests on two assumptions: E has negligible sampling error and O is a random Poisson variable. Some writers further assume that the proportion of the morbid event is small so that the variance of O is approximately O and that its sampling distribution is approximately Gaussian.[1,2] Other writers do not impose these assumptions so that the CI of SMR is based on the exact Poisson distribution.[3–5] However, none of the textbooks I have perused noted that the Poisson distribution is only valid for incidence data derived from a cohort study but not for prevalence data from a cross-sectional study. Yet the SMR is often estimated based on prevalence data, for example, to compare the prevalence of hypertension in a group of heavy smokers (exposed group) with the age-specific hypertension 'rates' in the general population (standard population). Since the prevalence 'rate' (actually the prevalence rate should be called a proportion) in the exposed group is clearly binomial and not Poisson, the CI of O should be computed based on the binomial distribution and not on the Poisson distribution or the Gaussian approximation. The use of Poisson is often justified by the fact that as sample size (n) increases towards infinity and the proportion of subjects with morbid event (p) approaches zero, and that np remains unchanged, the binomial distribution approaches the Poisson distribution. Nonetheless, these

TABLE 1 *95% confidence interval of SMR for prevalence data based on the binomial, Poisson and Gaussian distributions of O given O = 20, E = 10, SMR = 2, but with different sample size (n) and proportion (p)*

O	n	p	Binomial	Poisson	Gaussian
20	2000	0.01	(1.22–3.08)	(1.22–3.09)	(1.12–2.88)
20	200	0.10	(1.24–3.00)	(1.22–3.09)	(1.12–2.88)
20	100	0.20	(1.27–2.92)	(1.22–3.09)	(1.12–2.88)
20	50	0.40	(1.32–2.74)	(1.22–3.09)	(1.12–2.88)

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6 SCREENING IN ADULT WOMEN

As in most cases the woman is still the linchpin of the family, it is obviously worth making sure that she is as healthy as possible so that she is up to meeting the demands made upon her.
(COOK, 1987)

INTRODUCTION

WOMEN IN GENERAL THROUGHOUT THEIR LIVES HAVE more frequent contact with the health care services than men, particularly at the level of primary care. They consult not always on their own behalf but at certain periods acting as custodians of the health of their babies and children and the whole family. Rightly or wrongly, it is also still to a large extent women who take major responsibility for such matters as family planning. The opportunities for contact with health professionals in adult women are summarised in Table 17.

The main causes of death in women in adulthood, in the two age-groups discussed for men in Chapter 5—

TABLE 17. *Opportunities for health service contact in adult women*

LOCATION	TYPE OF HEALTH PROFESSIONAL
General practice	GP, health visitor, practice nurse
Hospital	Specialist medical or paramedical hospital staff as appropriate
Community	Dentist, chiropodist, family planning clinic, well-woman clinic, optometrist, pharmacist
Work	Occupational health physician, company doctor

GERI.

25–44 years and 44–64 years—are shown in Table 18. The main differences between the sexes are worth noting. In the younger age group, the percentage of

TABLE 18. *Main causes of death in adult women* (England and Wales 1986)

CAUSE	NUMBER		% TOTAL DEATHS	
Young adulthood (25–44 years)				
Malignant diseases	2585		47·2	
External causes				
Motor vehicle accidents	216		3·9	
Suicide	297	950	5·4	17·3
Others	437		8.0	
Circulatory disease				
IHD	249	781	4·6	14·3
Others	532		9·7	
Diseases of the nervous system including mental disorders	308		5·6	
Respiratory disease	202		3·7	
Other causes	654		11·9	
	5480		100	
Middle age (45–64 years)				
Circulatory disease				
Ischaemic heart disease	6439		18·6	
Other heart disease	889	10721	2·6	31·0
Cerebrovascular disease	2482		7·2	
Others	911		2·6	
Malignant disease				
Trachea, bronchus, lung	2838		8·2	
Breast	4658		13·5	
Alimentary tract	2600	16665	7·5	48·2
Others	6569		19·0	
Respiratory disease (including bronchitis)	2140		6·2	
Other causes	5020		14·5	
	34546		99·9	

women dying from external causes including motor vehicle accidents and suicide is half that in men, and the percentage of those dying from circulatory and heart disease is very much lower. For nervous and mental disorders, respiratory disease and other causes, men and women are about the same. But women have double the chance of dying from malignant diseases as their male counterparts. In the 45–64 year age group, women begin to catch up in relation to death from heart disease but remain decisively in the lead in death from malignant disease.

In this chapter we will look in detail at the current screening programmes for cancer of the cervix, which illustrate many of the problems which surround the enthusiastic but unsystematic introduction of screening, and for cancer of the breast which is currently being established. We will also consider very briefly the question of screening for osteoporosis and diabetes. Screening for psychiatric diseases, particularly depression, although common to both sexes, is discussed briefly in Chapter 5.

CERVICAL CANCER

It is claimed that the vast majority of cervical cancers (theoretically up to 90 per cent) could be prevented if all women were offered and complied with high quality cytological screening programmes (Berrino 1988). A national cervical screening programme was established in the United Kingdom in 1964.

The current national policy is to screen women aged between 20 and 64 at least every five years. The 1990 contract for general practitioners (Health Departments of Great Britain 1989) contains two target levels of 50 per cent and 80 per cent of women eligible for cervical cytology in general practice. The targets will be reached and payment made if 50 per cent or 80 per cent of women aged 25–64 years in England and Wales or 20–60 years in Scotland on a GP's list 'have had an

adequate cervical smear test during the previous 5·5 years'. Some of the possible difficulties involved in meeting these targets have been reviewed recently by Ross (1989).

The Strong Report on the Cervical Cytology Service in Scotland (1986) recommends screening at intervals of three years for all eligible women between the ages of 20 and 60 years. The results of a collaborative study of 10 screening programmes in eight countries to estimate the risks of cervical cancer associated with different screening policies suggested that screening should be aimed principally at women aged 35–60 years but should start some years before age 35 and that intervals between screening should be three years or less (IARC 1986). The study showed that screening every five years offered a high degree of protection but appreciably less than that given by screening every three years. There is little advantage to be gained by screening every year (Table 19). There seems to be agreement, therefore, that women eligible for cervical screening should be those in the age range 20–64, and that screening should be carried out at least every five years and preferably every three years.

However, the national programme has not yet resulted in the expected reduction in mortality from cervical cancer (Roberts 1982, Murphy, Campbell and

TABLE 19. *Percentage reduction in cumulative rate of invasive cancer in women aged 35–64 with different frequencies of screening**

SCREENING INTERVAL (YEARS)	% REDUCTION IN CUMULATIVE INCIDENCE	NO. OF TESTS
1	93·5	30
2	92·5	15
3	90·8	10
5	83·6	6
10	64·1	3

*From IARC (1986) and reproduced by kind permission of authors and publishers.

Goldblatt 1988), although as the ICRF Co-ordinating Committee on cervical screening (1984) pointed out

> with the exception of stopping the population from smoking, cervical cytology screening offers the only major proved public health measure for significantly reducing the burden of cancer today.

Various studies have shown that a reduction in mortality and morbidity is most marked in areas with comprehensive and systematic screening programmes such as British Columbia (Boyes *et al* 1982), Iceland (Johannesson *et al* 1982), Denmark (Berger 1979), Sweden (Patterson *et al* 1985), Finland (Hakama 1978, 1982), and some areas of Scotland (Duguid *et al* 1985; Macgregor *et al* 1985). In Norway by contrast where there has been only limited screening, there has been no demonstrable decrease in mortality (Houge 1980). And in the United Kingdom where the provision and quality of cervical cytology programmes varies widely across the country, the results of more than 20 years of cervical screening have been extremely disappointing. Within the United Kingdom, Scotland would seem to have a lower rate of mortality than England and Wales, but this is misleading. If figures for the two regions of Grampian and Tayside, where there are well-established screening programmes and more comprehensive coverage of the population, are removed, the rates for 1978 for the rest of Scotland were similar to those in England and Wales (Macgregor and Teper 1978).

The reasons for the failure of the national screening programme in the United Kingdom have been extensively examined and discussed. It is generally agreed that the problem is not so much of one of money or of expertise but of organisation, accountability, and commitment (Roberts 1982; Richards 1984). Of course it is unrealistic to expect that any non-communicable disease in adults can be completely controlled by a screening programme as Chamberlain (1984) has pointed out. There are various points at which a screening system may fail—it may fail to reach all of the

target population, it may fail to be sufficiently sensitive and frequent to detect all cases, it may fail to follow up all cases detected, and treatment when instigated may fail to cure or contain the disease. The British system has been subject to most if not all of these failings.

Effective implementation of screening has various requirements which have been clearly described (ICRF Co-ordinating Committee on Cervical Screening, 1984; Intercollegiate Working Party on Cervical Cytology Screening 1987; Smith and Chamberlain 1987). In 1984, the ICRF Co-ordinating Committee on cervical screening recommended a more organised and systematic approach. They drew attention to the fact that screening had tended to be applied differentially to women at least risk of developing cervical cancer while leaving those at high risk largely unscreened, and they summarised the extensive public debate on the reasons for this as follows.

1. Most cytological examinations are performed during examinations for obstetric or contraceptive purposes leaving women in the age range of maximum risk (age 40 years and over) relatively neglected.

2. The length of the prescribed screening interval (five years) and the lack of clear and well-publicised arrangements for undergoing examination do not encourage women to attend for a smear.

Based on examination of experience in Scandinavia, the Committee suggested that a successful screening service has at least seven basic requirements and these are summarised in Table 20.

A *Lancet* editorial (1985) pointed out that most successful cervical screening programmes have three main points in common. Firstly, they are organised as public health, cancer control programmes with the specific objective of reducing mortality. Secondly, they call the age groups at greatest risk (those aged over 30 years) and they persist. They concentrate first on women who have never had a smear and they use population registers. Thirdly, there is a specific individual in charge of screening who is responsible and accountable for the programme. In the United Kingdom, and in Norway, the objectives of screening were stated in procedural terms—to provide a cytology service—rather than in terms of outcome—to reduce mortality. The policy of concentrating on older and never screened women has not been implemented and it is no one's specific responsibility to see that it is. 'The blocks to effective action were neither scientific nor technical but administrative' (*Lancet* 1985).

TABLE 20. *ICRF Co-ordinating Committee (1984) requirements for a successful cervical screening programme**

1	Satisfactory resources for taking, examining, and reporting on smears
2	Acceptable arrangements for making and keeping appointments for examination
3	Acceptable arrangements for actual taking of smears—for example, choice between GP or well-woman clinic
4	Accurate listing of women in target population to enable complete initial call of eligible women and ensure regular recall as appropriate
5	An informed client population who know and understand the function of the procedure
6	Continuing scrutiny of records to ensure appropriate follow-up
7	Ability to monitor and efficiency and effectiveness of the programme and to adjust policies and procedures accordingly

*From ICRF (1984) and reproduced with kind permission of authors and publishers.

A successful screening service for cervical cancer must depend, we would argue, on three basic and practical elements which apply to screening in general. Firstly, and absolutely fundamental to the success or failure of the system, there must be an accurate, computerised data base which is continually updated to enable the right target population to be invited for screening and followed up. Secondly, women must be treated with respect as individuals who are presumed to

care about their own health. They must be given the necessary information about the smear test and its implications and offered choice of time and location when invited for screening. If the service wants to encourage women to be screened, then the onus must be on the service to make itself attractive, understandable, and accessible to the particular population involved. Thirdly, one person in each health district or health board area must be responsible and accountable for the screening programme.

These three elements are closely interrelated. The data base is essential to make sure that all eligible women are invited for screening and appropriately recalled; putting the onus on the service to sell itself to those invited is essential to ensure high compliance which should lead to the reduction in mortality that has so far eluded us; making one identifiable individual responsible and accountable for screening should be a guarantee that the system is properly established and monitored and that the follow-up and quality control implied in the invitation to be screened is satisfactory.

The data base

It could be argued with hindsight that the money spent on establishing the cervical screening programme in 1964 would have been spent more wisely on creating an accurate population index for health purposes in every health district or health board area in the country. But it is easy and usually idle to argue with hindsight. It is, however, clear that the age-sex registers of the family practitioner committees in England and Wales and the equivalent community health index in Scottish health board areas are inadequate, and it is now essential for a government committed to health promotion and disease prevention to provide adequate resources to create an accurate, updateable, computerised data base. Beginnings have been made and there are islands of excellence but the data base should exist in same form throughout the country.

As Day (1989) has recently commented

> it is an astonishing aspect of this country's health service that those responsible for preventive medicine do not have an adequate list of the population giving age and sex, and equally astonishing that the lists which do exist are only for administrative purposes, for use by those with no medical responsibilities.

This problem is well illustrated in a study in an inner London district undertaken after district health authorities had been instructed to operate a cervical cytology call and recall screening programme using the age-sex registers held by family practitioner committees (Beardow, Oerton, and Victor 1989). Out of 686 invitation letters sent to women by the family practitioner committees, 477 (69 per cent) were either inaccurate or inappropriate. Overall, 90 women attended for smear. Ninety-four letters were returned by the Post Office—either the addresses were incomplete, the person concerned had moved, or the building had been demolished. A further 98 women were not eligible for a smear having recently had one, and one person invited was a man. The 404 non-responders were sent a questionnaire.

Seventy-five of these were returned undelivered and 255 received no reply—personal visits to the latter showed that 151 of the women had moved from that address. Of the 74 women who completed the questionnaire, 41 considered themselves ineligible for screening, 32 because they had had a smear within the past three years, five because they had had a hysterectomy, and four because they were virgins.

As these authors point out, their results, although possibly exacerbated in a deprived inner city area with high mobility, do have wider implications for the success or failure of both cervical cancer and other screening programmes. About half of the invitations sent did not reach the women concerned because they had moved. A further fifth of the invitations were inappropriate for various reasons. Outside the conditions of a research study where personal follow-up

visits were possible, these women would have been wrongly identified as non-responders. It is also of concern that details of some smears taken within the past three years had not been appropriately recorded. The quality of the family practitioner committees age-sex registers in England and Wales or the community health index in Scotland—in theory the most accurate and extensive population indices available—is fundamental to the success of the screening programme and appears to be gravely deficient. In a study in an urban practice in London, Rang and Tod (1988) found that 30 per cent of invitations to women eligible for screening were returned as 'not known at this address', and a further 45 per cent did not reply. And even in a small stable general practice population, Ross (1989) found that between 2 and 4 per cent of patients eligible for screening could not be traced.

Bowling and Jacobson (1989) have also drawn attention to the fact that screening will fail if population registers are not improved. They cite a recent survey of the health of all people aged 85 years and over living at home in City and Hackney Health Authority which found that two-thirds of 3018 addresses on the family practitioner lists in 1986 were inaccurate (Bowling, Leaver and Hoeckle 1988). They make the valid point that between three-quarters and nine-tenths of the population consult their general practitioner during a year and consultation rates are higher among women and the elderly, both important target groups for current screening programmes and case-finding (OPCS 1986). If receptionists routinely checked patients' names and addresses when they consulted and immediately notified changes to the family practitioner committee or health board, addresses could be updated for most patients at little cost.

The women at risk

A change of emphasis from putting the onus on women to seek out the service to asking the service to attract the women is crucial to success. There is a danger in

any large national programme that the concept of the individual is lost in the mass of tests to be processed and data recorded. But every woman invited for screening is an individual in her own particular circumstances with her own set of beliefs and fears about health and disease. It therefore seems logical that there is more likelihood of a woman accepting an invitation to be screened if the reasons and potential benefits of the test are properly explained and she is offered some choice in the timing and location of the appointment. Hiscock and Reece (1988) found that most of the 91 (4·8 per cent) patients in their study found to have cervical intraepithelial neoplasia would have been missed if they had not been actively encouraged to attend for screening, and in 87 of these, the abnormality was found at an early stage when treatment offers excellent results.

Standing and Mercer (1984) in a study of cervical screening in general practice achieved a smear uptake rate of 96 per cent for all eligible women—100 per cent for eligible women under 35 years of age, 94 per cent for those over 35. They acknowledge that the success of their scheme was helped by having a stable personal list of patients, most of whom were known to the general practitioner. Uptake rates are bound to vary according to turnover rate of patients and their age and social class. Local factors will also influence the best method of taking smears. In this particular practice in a compact urban setting, the nurses backed up by the general practitioner worked best for effective screening. In inner cities, family planning and well-woman clinics may be more appropriate. Standing and Mercer emphasise the need for a change in the attitudes of general practitioners to practical organisation, record keeping and preventive medicine.

In a prospective, randomised controlled trial in a group practice with a list of 10,120 patients, Pierce and colleagues (1989) examined three different approaches to screening for cervical cancer (1) a traditional screening approach with all women at risk being sent a written invitation to have a smear test; (2) a systematic

opportunistic screening or case-finding approach with the notes of eligible women being tagged to remind the doctor to ask at any consultation about taking a smear; (3) an unsystematic opportunistic approach which relies on the doctor to raise the subject of a smear test during routine consultation without any reminder in the notes of eligible women. Not surprisingly, they found that systematic methods of call and recall were more effective than a non-systematic approach in encouraging women to have a smear but there was no significant difference between the two systematic methods at the end of the year of study.

It has been shown that older women dying of cervical cancer are likely not to have had a cervical smear test (Ellman and Chamberlain 1984). However, in the study just described (Pierce *et al* 1989) the response rate was not affected by age and the findings suggest that if women were invited to have a smear test by a doctor they would accept irrespective of age.

The current failure of the screening programmes to screen women at high risk seems to be due in large part, therefore, to a failure of the system to tell such women of the need for a test and invite them for screening at a convenient time and place rather than from a reluctance or refusal on the part of the women to respond positively to the invitation.

Pierce and co-workers (1989) also found that women who had had a smear test previously were more likely to respond positively to another invitation. Since more younger women are having smear tests, coverage is likely to improve in the future as women who have got used to the idea of having regular smears and who regard it as good health practice to do so, move up the age spectrum.

The question of choice of location for screening is quite important. There are those who are strongly opposed to opportunistic screening, partly on the very legitimate grounds of duplication of testing and overload on laboratory staff. However, some flexibility is surely necessary and opportunistic screening will continue to be essential if the system is to try to achieve maximum coverage. As Cook (1987) has pointed out, unless screening is treated practically it will still be the articulate predominantly middle-class women who will benefit most.

> For women living in the middle of wasteland housing estates or in country villages with little public transport, a visit to a screening centre might mean a protracted and difficult journey, often accompanied by several small children. In the end it all becomes too much trouble.

Rang and Tod (1988), for example, emphasise that in areas with a highly mobile population, possibly at increased risk from cervical cancer, the case for opportunistic screening by the general practitioner and in gynaecological and genitourinary clinics remains strong. It is, however, essential to the success of any screening programme that results are sent to the general practitioner and information is centrally collated and recorded. They also suggest that women should be encouraged to take responsibility for their own screening—each woman screened should receive a written report with the result of her test and a date for the next smear. This seems an excellent idea, in line with the whole concept of making the service attractive and accessible to women, and similar to the system of regular appointments with optometrist and dentist.

Cervical screening seems to be most effectively based around general practice although in certain areas, such as deprived inner cities, and among certain minority groups, a different approach may be necessary. As Havelock and her colleagues (1988) point out, the general practitioner is in a good position to offer information and re-assurance about the test, especially to older women who no longer attend antenatal, postnatal, or family planning clinics and whose opportunities for screening are therefore reduced. Among other advantages of a patient being screened in primary care is the fact that the result will come direct to the general

practitioner, be filed in the patient's records, and be accessible at any time (Ross 1989).

Responsibility for screening

The single factor of appointing one individual in each health district or board who is responsible for screening and accountable for the service is one that has been very much to the forefront in recent discussions on screening. Various types of health professional are involved in a cervical cytology service and co-ordination and communication can slip. The designation of one responsible person at sufficiently senior level should ensure smooth running of the system and satisfactory follow-up and quality control—all implicit in the invitation to be screened.

Preliminary results from a study of a district based call scheme in East Berkshire in 1986 showed a 25 per cent increase in uptake of screening in women with no history of screening (Havelock *et al* 1988) and suggest that a co-ordinated scheme with co-operation between the appropriate health authority and individual practices can improve coverage substantially.

In terms of follow-up, one of the essential conditions of any screening programme is that effective treatment is efficiently offered to all patients with abnormal results. When screening is actively proposed to asymptomatic people, the authorities encouraging the screening have a clear responsibility not only to provide such treatment but to document and monitor its effectiveness. Elwood and colleagues (1984) assessed outcome for all 1062 women who had a first report of abnormal cervical cytology in 1981. Satisfactory follow-up could be found for only 628 (59 per cent). For 275 (26 per cent) one subsequent normal smear had been reported but no other follow-up requested. For 43 (4 per cent) no subsequent test, after the abnormal smear, had been requested by the patient's general practitioner. Thirty patients (3 per cent) did not respond to a request for follow-up. Even after extensive efforts, outcome could not be established in the remaining 86 (8 per cent) of patients.

Kinlen and Spriggs (1978) looked at 101 women in Britain who had positive cervical smears, but after at least two years had escaped biopsy. Thirty-one were untraceable. Among the remaining 70 women there were 10 cases of invasive and three of micro-invasive carcinoma. The death rate in the 100 cases was 5 per cent compared with a death rate of 0·27 per cent in 4097 women in British Columbia treated for intraepithelial neoplasm grade III or more advanced lesions.

A recent report of the Intercollegiate Working Party on Cervical Cytology Screening stated that a disturbingly high proportion of women who had abnormal smears had not been investigated adequately (Sharp *et al* 1987), and Singer (1986) has suggested that many screening centres report satisfactory follow-up and management for only 60 per cent of cases. Robertson and colleagues (1988), in a follow-up study of 1347 women with mildly dyskaryotic smears for whom a repeat smear test was recommended, reported 434 (32 per cent) cases in which the woman was lost to follow-up before the implications of the abnormality could be evaluated.

One of the conclusions of an examination of a series of 173 women with cervical cancer in 1982 was that the follow-up of abnormal smears was poor because of lack of organisation, commitment, and a clear and consistent policy (Chisholm 1984).

Thus it seems clear that some women whose smears are positive are not being adequately followed up and this is an appalling finding after more than 20 years of a national programme of cervical screening. It would be the urgent responsibility of the screening supervisor to change this, and a recent report of a study in Melbourne, Australia describes a reminder system that should work in any country that provides screening for cervical cancer (Mitchell and Medley 1989). These workers studied response to the recommendation for early repeat smears in two groups of women whose initial cytological abnormalities were not considered sufficiently serious for immediate referral to a gynaecol-

ogist. If a repeat smear had not been received within three months of the recommended date a reminder letter was sent to the doctor who had taken the smear. They achieved response rates of 90 per cent and 82 per cent in the two groups and compliance increased with increasing age. As these authors point out

> Achieving high rates of follow-up smear tests and management in women with lesions that may be precursors for cervical cancer is critical to the success of a screening programme. Implementing fail-safe systems for ensuring that such abnormalities are not overlooked deserves a high priority in the design of screening programmes.

We would go further and say that, while no system can be expected to perform perfectly, a national screening programme without an excellent standard of follow-up is unethical.

Quality control is another area of great importance in a national screening programme. It is not acceptable to have widely varying standards of service in different areas of the country. As Berrino (1986) has emphasised, screening programmes should be backed by effective quality control systems as well as by the monitoring of efficacy and side-effects, health education, and standardisation of diagnostic and therapeutic protocols.

There are quality control systems in operation in this country such as, for example, one involving some 16 laboratories in Scotland where three main aspects are assessed—staining and preparation of slides, presence or not of cells, and reporting. These laboratories are now using standard forms and terminology at least for the purposes of the quality control circuit (Mann personal communication 1989).

As Smith, Elkind and Eardley (1989) have pointed out, prompt examination of smears demands considerable resources—in an average sized district about 20,000 smears a year will be examined. Truly important cytological abnormality signifies neoplastic change

which is likely, without treatment, to proceed to invasion. However, the prevalence of truly important cytological abnormality is probably between 0·02 per cent and 0·3 per cent—certainly well below 1 per cent. The prevalence of reported abnormality in most screening laboratories is higher than this and thus many innocent abnormalities are being detected which we cannot distinguish from those that are significant. This has obvious and important implications both for the women concerned and for health service resources. One of the major risks associated with cervical cancer screening is probably over-treatment at various levels of severity.

Smith and colleagues (1989) also state that examining smears when well over 90 per cent are expected to be normal is very different from examining specimens from people with important symptoms and an expectation that many will be abnormal. In almost all simple screening procedures there will be a high proportion of false-negative results unless independent re-screening is built into the system. Few laboratories seem to have satisfactory internal assessment of quality, and almost none have external assessment. A serious difficulty also is that agreement among competent observers is not good. This would be a clear area of priority for a screening supervisor and the eventual aim should be national guidelines and standards of quality control.

Summary

The national screening programme for cancer of the cervix in the United Kingdom is still beset by a number of serious difficulties. The principles of a good management system for cervical screening are well understood (Hobbs *et al* 1987). It should aim to reach the entire target population and ensure recall as appropriate. The invitation to attend should explain the purpose and implications of the test and whoever is providing the service should try to deal in advance with women's anxieties. There should be some choice in regard to time and location of the test. There must also be prompt

reporting of results with effective follow-up and treatment when necessary.

More than enough has been said about the deficiencies of the system thus far. It is now necessary to concentrate on getting it right and the three simple elements discussed here would go far towards this goal.

BREAST CANCER

Breast cancer is clearly an important health problem. It is the most common form of cancer among women in the United Kingdom and accounts for 20 per cent of all female cancer deaths and 4·5 per cent of total female deaths. In 1985 15,000 women in Britain died from cancer of the breast and we have the highest mortality rate from the disease in the world.

In 1987, The Government accepted the recommendations of the Forrest Report on Breast Cancer Screening and announced the establishment of a national breast cancer screening programme by 1990. The Forrest Working Group had concluded that deaths from breast cancer in women aged 50–64 years who are offered screening by mammography could be reduced by at least one-third (Forrest Working Group 1986). They recommended screening all women in the age range 50–64 years by single view mammography at intervals of three years. Women over 65 years should be able to attend for examination if they wish.

The evidence on which the Forrest recommendations were based came mainly from two large randomised clinical trials. The first of these was the Hospital Insurance Plan of New York (HIP study) which started in 1963 in 62,000 women aged 40–69 years who were randomly allocated to either a study or a control group (Shapiro 1977). Seven years after entry into the trial, cumulative breast cancer mortality in the study group was two-thirds that in the control group (Shapiro, Strax, and Venet 1977; Shapiro *et al* 1982). This difference between the two groups was maintained up

to the tenth year of the trial, and for cases diagnosed in the first 10 years, up to the fourteenth year after entry. More recently the Swedish Two Counties Trial in 133,000 women aged 40–74 years has shown a similar effect over a seven-year follow-up period (Tabar *et al* 1985). Mortality in the group randomised to screening was 31 per cent lower than that in the control group. Updated results recently reported show an increasingly significant deficit in deaths from breast cancer among the 77,092 women invited to screening in comparison with the 56,000 not invited (Tabar *et al* 1989).

Additional evidence of a reduction in mortality came from the results of two case-control studies in the Netherlands. The Nijmegen project (Verbeek *et al* 1984) selected women aged 35 years and over for breast examinations by mammography every two years. The Utrecht study (Collette *et al* 1984; De Waard *et al* 1984) selected women aged 50–64 years for an initial examination by mammography and physical examination with subsequent examinations at increasing intervals of 12, 18, and 24 months. In both studies mortality from breast cancer was substantially lower in women who accepted screening than in those who did not.

The first results of the UK Trial of Early Detection of Breast Cancer were published in 1988. Between 1979 and 1981, the trial enrolled women aged 45–64 in eight locations around the country. Annual screening by clinical examination, with mammography every second year in two of the centres (Edinburgh and Guildford) and breast self-examination in the other active centres, was provided over seven years for 45,841 women; 63,636 women were offered instruction in breast self-examination and were provided with a self-referral clinic; and 127,117 women, for whom no extra services were provided, made up the control population. Over the seven years there was a reduction in the risk of dying from breast cancer in women offered screening relative to that in the control group but no difference in mortality has so far been observed between women in the self-examination group and controls. The reduction

in the mammography group was 14 per cent when no allowance was made for underlying differences in breast cancer mortality between the populations but rose to 20 per cent when adjusted for differences in pre-trial mortality rates. The differences were not statistically signficant. There was no reduction in mortality during the first five years. The authors claim that these preliminary results are consistent with the hypothesis that screening can achieve a worthwhile reduction in mortality from breast cancer but stress that further years of follow-up are needed (UK Trial of Early Detection of Cancer Group 1988). This is a somewhat curious statement and the follow-up results will be of considerable interest.

In a prospective randomised trial in women aged over 45 years in Malmo, Sweden (Andersson *et al* 1988) 21,088 women were allocated to a study group and 21,195 to a control group. Women in the study group were invited to attend for mammographic screening at intervals of 18–24 months and five rounds of screening were completed. When the trial ended after almost nine years, there had been no overall fall in mortality in the study group. But among women aged over 55 years, mortality fell by one-fifth in women who were screened despite a lower rate of acceptance among the older than the younger women. Mortality also fell in the final years of the trial and just after it finished both in the whole screened group and in those aged over 55 years. The authors concluded that their data supported previous studies showing that invitation to mammographic screening may lead to reduced mortality from breast cancer, at least in women aged 55 years and over. Once again it seems difficult to regard these results as strong evidence in support of screening.

Experience with the failure of the cervical screening programme in Britain has led to a determination that the breast cancer screening programme will be properly planned, established, and evaluated. But there are problems as Acheson (1989) has pointed out. In the first place, although much is known about the aetiology of

breast cancer, it is still not possible to prevent it. Secondly, available treatment is far from satisfactory in that about two-thirds of those with the disease are likely to die of it sooner or later.

The intention in the national screening programme is that for every population of half-a-million there will be a screening office as the administrative centre which will hold details of eligible women in computerised form, one or more screening units, static or mobile, and one or more assessment centres with special back-up services including ultrasonography, radiology, cytology, and histopathology. It is envisaged that the system should be organised as part of primary care in which the general practitioner with nursing support will have an essential role in inviting women for screening and giving support at every stage as necessary (Acheson 1989). The Forrest requirements for a breast cancer screening service are summarised in Table 21.

Since 1987, when the Government announced the establishment of the programme by 1990, at least one screening centre has been set up in each region and expert groups have been formed to develop guidelines on quality assurance in mammography and pathology. The UK Co-ordinating Committee on Cancer Research is developing protocols for studies to look at screening in 40–49 year olds, at the intervals between screens, and at the question of the number of mammographic views necessary. These are all important issues on which clear evidence is not yet available and research is essential.

As Frost (1988) has pointed out, incidence and mortality rates rise sharply from about age 30 years up to the age of 50 years or so and then continue to rise less steeply. No study has tried to screen women by selecting those under the age of 35 years for breast examination because the potential for saving life is small and the effect of breast examination on women under the age of 50 years is uncertain. Both in Sweden (Tabar *et al* 1985) and Nijmegen (Verbeek *et al* 1985) no

TABLE 21. *Forrest Report requirements for organisation of a breast cancer screening programme*

1	Women in the target group should be sent a personal invitation from their general practitioner
2	Arrangements for recording positive results at the basic screen must include a fail-safe mechanism to ensure that action is taken on all positive results
3	Every basic screening unit should have access to a specialist team for the assessment of screen-detected abnormalities
4	A screening record system should be developed to identify, invite and recall women eligible for screening; to record attendance for screening and results; and to monitor the screening process and its effectiveness
5	There should be adequate arrangements for quality control both within and between centres so that an acceptable standard of mammography can be maintained
6	A designated person should be responsible for managing each local screening service. The person chosen would have managerial ability and is likely to have experience in community or preventive health care, although the radiological aspects must be the responsibility of a consultant radiologist. Setting up a breast cancer screening service will require substantial managerial effort

benefit was demonstrated for women under 50 years at the start of the trial, but the number of deaths in this age group was small and the analyses are therefore subject to considerable random variation. The HIP study showed no benefit after five years of follow-up, but after 14 years the reduction in mortality seen in those who entered the trial aged 40–49 years was similar to that in those aged 50 years or more at entry. It is not yet clear whether the reduction in mortality seen in those admitted to the trial aged 40–49 is the result primarily of the examinations they received after the age of 50 years (Shapiro *et al* 1982; Day *et al* 1985; Habbema *et al* 1986; Frost 1988). Further research is needed to clarify this.

Frequency of screening examinations is also a valid topic for research. As Frost (1988) emphasises, decreasing the time between breast examinations must increase the proportion of cancers found. All current screening is done first by selecting women above a certain age and offering examination at an interval between one and three years. Tabar and co-workers (1985) suggest that pre-menopausal women should be examined every 12–18 months and post-menopausal women every 18–24 months since the mean detection lead time in the former is shorter than in the latter. The answers to questions about the interval between examinations will come from studies where those screened are randomised to different examination schedules varying perhaps from one to five years.

Forrest recommended a single-view mammographic examination and this view has been shown to have a better rate of detection than either the cranio-caudal or latero-medial views and to be a satisfactory method of breast examination (Frost 1988). However, since the cost of mammography is not greatly increased by a second view and either of the others improves the rate of detection by about 5 per cent, this also requires further evaluation.

Although the national programme is being established, the debate over screening for breast cancer continues and there are those who remain to be convinced that this is the best use of resources.

The debate can be divided into two main issues. The first concerns the practical introduction of screening in service rather than research conditions—service versus research. The second relates to the magnitude of benefit, the use of resources, and the effect on the women involved—benefit versus harm.

Service versus research

The scientific evidence on which the Forrest Working Group based its recommendations came from studies carried out in experimental trials in research conditions with highly motivated and trained staff and excellent equipment and facilities. These will be hard to replicate in normal health service practice.

Most experts agree that research evidence on the value of breast cancer screening is strong despite discrepancies when small subgroups are examined (Ellman 1987). Feig (1988) reviewed data from the five main trials of mammographic screening and reached the conclusion that annual, two view mammography with a physical examination in women aged 40 years and over could reduce mortality by at least 40 per cent and possibly by as much as 50 per cent. In routine service conditions, however, the effect on mortality is unlikely to be so high—a realistic expectation might be a reduction in mortality of between 10 and 20 per cent.

Cuckle and Wald (1988) believe that the Government has allocated sufficient funds for the national screening programme to ensure a high-quality service, provided that it is properly organised and directed. Their experience in the Reading centre suggests that this is possible and that research can be an integral part of the regular screening service. They also point out that the screening centres currently being set up are a new venture in public health for the National Health Service. They fall outside the usual structure of medical practice which is based on general practitioners and hospitals. They must be recognised as a distinct entity and allowed to function as such within the guidelines of the Department of Health.

> Perhaps most important of all, there is the need to appoint someone who would have overall responsibility for the screening service. The lack of an accountable individual with appropriate resources and authority is largely responsible for the failure of cervical cancer screening in Britain. Having learnt the lessons from that programme, Britain now has the opportunity to implement breast cancer screening effectively from the start.

High compliance is also an important factor in effective population screening (Forrest Working Party on Breast Cancer Screening 1986) and response rates of 85 per cent and more have been reported from Sweden (Tabar *et al* 1985) and Holland (Verbeek *et al* 1984). In the United Kingdom thus far, responses have not been so favourable—60 per cent in Guildford and 61 per cent in Edinburgh (Roberts *et al* 1990).

Results of a study in which women were randomly allocated to a group receiving a letter of invitation to screening with a definite appointment time or a group which received an open-ended letter of invitation suggest that the inclusion of an appointment on the invitation significantly improves compliance with screening (Williams and Vessey 1989). This confirms earlier findings in cervical cytology screening (Wilson and Leeming 1987) and, as discussed earlier in this chapter, suggests that treating women with courtesy and encouraging them to take responsibility for their own health is sensible policy. In another study in the South-East London breast screening service, McEwen, King, and Bickler (1989) found that the overall response rate was 129 out of 283 (46 per cent) women invited but also found that 99 out of the 283 (35 per cent) did not receive their invitations. They state that the single largest contribution to increasing response rates is likely to be made by a more accurate data base and that general practitioners have an important role in counselling women whom they know have not attended for screening. This study confirms that in inner city areas with high levels of mobility, high rates of uptake will take some time to achieve.

Witcombe (1988) suggests the crucial questions are no longer whether early detection and treatment can prolong life but how far the quality of screening that has already been achieved in some research programmes can be maintained in community hospitals and what will be the cost to normal healthy women?

Training of radiologists will be essential but this will not in itself guarantee a good service. Without stringent centralised methods of quality control, screening will be demanded when skills are either not available or are inadequate. In 1987, some doubt was cast on the time scale of implementation of the Forrest Report—equipment can be bought but there are not enough radiolo-

gists and radiographers to operate the service and further training in the specialised techniques of assessment and diagnosis will be required (Ellman 1987; *Lancet* 1987). Further results from the UK Trial of Early Detection of Breast Cancer must also be awaited with interest particularly because it is the only population based study investigating whether the cheaper alternative of providing self-referral clinics for breast symptoms and teaching self-examination reduces mortality from breast cancer.

There has been extensive discussion of the value of breast self-examination in diagnosis and Hill and colleagues (1988) reviewed 12 separate published studies which related self-reported premorbid breast self-examination practices of patients with breast cancer to disease variables. They concluded that the evidence for breast self-examination as a worthwhile precaution which increases the probability of detecting breast cancer at an early stage is both more consistent and more favourable than is commonly accepted, and contend that the data they reviewed provide good grounds for encouraging women to practise breast self-examination regularly. Results of current prospective studies on this aspect in the United Kingdom (Dowle *et al* 1987) and the Soviet Union (Semiglazov and Moiseenko 1987) should help to throw further light on this.

Benefit versus harm

In 1985 Skrabanek, in an article entitled 'False Premises and False Promises of Breast Cancer Screening', contended that screening only adds years of anxiety and fear to those diagnosed and claimed that

> the philosophy of breast cancer screening is based on wishful thinking that early cancer is curable cancer, though no-one knows what is early.

In 1986 Wright examined data on screening for breast cancer and concluded that if women submitted to operation for benign disease are considered to be harmed by the screening process, then the harm to

benefit ratio could be as high as 62:1. He suggested that mass screening for breast cancer should be abandoned and the procedure reserved for women with high-risk factors. Schechter and colleagues (1986) also claimed that using a logistic model they were able to define a high-risk subgroup and that such a selection strategy might reduce initial visit mammography rates by up to 60 per cent with only a small reduction in case detection. However, the results of a study by Alexander, Roberts, and Huggins (1987) suggested that it is not at present possible to use risk-factor information to restrict screening to a high-risk group. And, as Alexander and co-workers (1988) further point out, Schechter and colleagues are the only recent workers to have been optimistic about this risk-factor approach, their study was restricted to volunteer women in whom 50 per cent of cases have experienced symptoms, and the complex criteria made it necessary for a woman to attend for an examination to determine whether she was in a high-risk category—in such circumstances, it seems doubtful that the woman in question would escape screening altogether although she might be offered a simpler form of screen. Alexander *et al* (1988) also emphasise that since it is not known whether a policy of allocating different recall times in mass screening would be acceptable in practice, research would be necessary before any proposal to adopt at risk strategy as part of public policy could be considered.

In 1988 Skrabanek further commented that the Forrest Report made no mention of the positive predictive value of mammography, the single most important piece of information for any screening test. He cited the Canadian national breast screening study, currently in progress, where a preliminary report showed a positive predictive value of 5–10 per cent. The implementation of the Forrest proposals, with an estimated positive predictive value of 5 per cent would thus result in 65,000 mammograms a year showing false-positive results. Skrabanek goes on to point out that the harm of screening is not confined to overdiagnosis. 'Overdiag-

nosis implies overtreatment, unnecessary biopsies, unnecessary mastectomies, and widespread anxiety and fear'.

Reidy and Hoskins (1988) state that, while we do not know what the optimal positive predictive value should be, the 33 per cent suggested by figures in the Forrest report (1986) seems too high, with the risk of missing an unacceptable number of cancers, and the 5–10 per cent quoted by Skrabanek (1988) too low, with the risk of exposing too many women to unnecessary biopsies.

The issues of fear and anxiety leading to an increase in psychiatric symptoms has also been considered. Dean and colleagues (1986, 1989) found a small percentage of women (8 per cent) who felt that breast screening had made them feel anxious about developing breast cancer. This group did have a higher psychiatric morbidity than their matched control group and it could be that a small subgroup of women are vulnerable and that screening has a detrimental effect on them from the psychological point of view. However, taking their sample as whole, these workers do not agree with the suggestion that screening for breast cancer increases psychiatric morbidity.

Ellman and colleagues (1989) support this finding. However, these authors stress that their study was carried out in a well-established screening programme in which clinical examination was included. The effect on psychological morbidity of introducing the national screening programme should be monitored. The comments of screened women indicate the importance of minimising delays in the diagnostic procedure and of maintaining full and honest communication throughout.

Warren (1988), in supporting the case for national screening, states that research results have concentrated on mortality statistics but that the benefits of screening to individual women are wider—namely, reduced morbidity and more modest surgery because of earlier diagnosis. This is a very important point and applies much more widely than simply to screening for breast cancer. In the new emphasis of screening for

prevention, we must look for less crude endpoints than mortality, convenient though this is as a tool of measuring success, and we will return to this in the final chapter.

Cuckle and Wald (1988) cite three main areas of concern relevant to the issue of benefit to harm. First, there are the special ethical considerations which apply to screening apparently healthy individuals and these we have already discussed. Secondly, screening will identify only about five women out of every 1000 as having breast cancer at their first attendance and fewer at subsequent recall visits. This makes it all too easy for a screening centre to become a dehumanised production line—this must be avoided and a pleasant environment provided to encourage women to attend and to return. Thirdly, screening itself generates anxiety. Women who have abnormal mammograms and are referred for further assessment are likely to be very distressed and it is therefore vital that appropriate counselling is available and that screening should select the smallest number of women for further assessment while detecting a satisfactory proportion of breast cancers. This mean that we must accept that screening cannot detect all cases of breast cancer.

Roberts (1989) poses the question as to whether we are going the right way to provide the best possible benefit for women? Screening is always a second best, an admission of the failure of prevention or treatment, and perhaps resources currently devoted to screening would be better used for research into an effective treatment. She quotes Lippman's belief that breast cancer could be the next human cancer capable of treatment and his work on measures based on growth factors (Lippman 1988). In a paper published after her death from breast cancer in June 1989, Roberts asks what screening can actually achieve? She also challenges the 'currently expressed or strongly implied statement that if women attend for screening everything will be all right' and concludes that breast cancer screening must be brought back into its proper perspec-

tive and we must examine what it is really trying to achieve in terms of benefit for women with breast cancer.

In response, Chamberlain (1989), while agreeing that screening is not the optimal way of controlling any disease, points out that in the absence of effective prevention or treatment, it is the third best measure of control and the best available to us on current knowledge. Ellman (1989) feels that the key question concerns the means of keeping costs and emotions under control. Some choice in determining how much screening one has is reasonable and a charge for screening above what is economically justifiable from a public point of view would be the fairest and most understandable method of controlling demand. Frankness about screening is essential. Ellman concludes by stating clearly that

> the 'free' service seeks to provide a reasonable but not the maximum possible degree of protection against later development of advanced cancer and by offering further screening (with explanation of the pros and cons) to those who want to spend extra money on it we may be able to promote more realistic expectations.

We will return to this concept in the final chapter.

Summary

We would place ourselves among those who feel that there are questions that should have been asked and answered before rather than after the introduction of national screening. There seems little doubt that, under experimental conditions, screening can reduce mortality from breast cancer by around 30 per cent. We consider it most unlikely that this can be replicated under normal service conditions. And of course mortality is not the only endpoint and a great deal of damage and anguish can result from an unsatisfactory screening service. No one has yet adequately measured the disbenefits of screening, particularly in view of the number of false-positive results produced in trials so

far. Eddy (1989), in a discussion of screening in those below 50 years of age, makes the point that it would be worth giving the women concerned the information that is available about the magnitude of benefit and risk and then asking them how they feel about screening. We must certainly move away from any idea that screening *per se* is bound to be beneficial and towards the dissemination of more complete information based on the research findings currently available.

This particular screening bandwagon, however, is now rolling and will be hard to stop. And, as Asbury (1989) has pointed out, while many fear that the programme may ultimately fail, not least because of an inadequate data base and low compliance, we should at least try to make it work well.

Among the most important features of the Forrest recommendations are the insistence on monitoring of the screening service and its effectiveness, the requirement for stringent quality control, and the designation of one person responsible for managing each local service. These are ingredients which, along with an improved data base and a courteous and informed approach to the target population, have been all too often absent from previous screening efforts and on them must depend the success or failure of this new national programme.

JOINT SCREENING FOR CANCER OF THE BREAST AND CERVIX

From time to time, it has been suggested that it might be possible to combine screening for cancer of the breast and cancer of the cervix on the practical grounds that it might be more convenient for women to have both tests at the same time and that it might also prove more cost-effective. This has traditionally been rejected because of the differences in age group and high-risk groups involved in the two diseases, and at present in Britain the different recommended intervals between screening.

However, Roberts and colleagues (1988) in a study of cervical screening at a breast screening clinic suggest that it is feasible to carry out breast screening and cervical screening at one clinic visit and that many women liked it and found it convenient. If three-yearly cervical screening were to be introduced as many people recommend, it would seem reasonable to offer combined screening to those in the 50–64 year group. As Roberts and colleagues pointed out, at least 65 per cent of women attend for breast screening when invited and the opportunity of offering a smear at the same time should not be missed. Their experience has also confirmed that women in the lower socio-economic groups are significantly less likely to attend when invited. And, as Leathar and Roberts (1985) had earlier suggested, screening might have more appeal for both older and less affluent women if it were placed in the context of total health care rather than with the emphasis placed starkly on specific disease entities.

Certainly combined screening would pose some administrative problems to begin with, but once the call-recall data base had been properly established, it should be possible, at least in the 50–64 year age group. It may be that the reasons this has not been officially considered thus far has more to do with the convenience of those offering the service than with consideration for the preference of the women involved. We would suggest further that a simple package including measurement of weight, blood pressure, questions on smoking habits, and screening for cancers of the breast and cervix in one visit should be tested for its acceptability to women.

A recent paper from Holland (Habbema *et al* 1990) concludes that decision-making processes in which screening programmes for breast and cervical cancer are considered separately should be abandoned. For both conditions, early detection and treatment offer the best opportunity for mortality reduction in the next decades. There are very close parallels between the two screening programmes—both aim at women only and

have as their main target the prevention of disseminated cancer with its almost inevitable consequence of death. For a woman dying of cancer the untimeliness of the death rather than the site of the primary tumour is usually the predominant feature. It, therefore, seems surprising that planning and evaluation of early detection programmes for cervical and breast cancer continue to be done quite separately.

OSTEOPOROSIS

With the development of techniques such as dual photon absorptiometry and quantitative computerised tomography, it is now technically possible to measure bone mass accurately in the spine and hip (Murby and Fogelman 1987). Many centres have been established for osteoporosis screening in the United States but the value of these has been the subject of much controversy (Ott 1986; Cummings and Black 1986; Hall 1987). The US Preventive Services Task Force in its assessment of the effectiveness of 169 interventions does not recommend routine radiological screening for postmenopausal osteoporosis. Currently available procedures are time-consuming and require considerable technical expertise. The costs of screening may be justified if the burden of suffering from the disease can be reduced but further research is required to demonstrate both clinical effectiveness and cost-effectiveness. The Canadian Task Force (1988) is also against routine radiological screening for this condition.

Fogelman (1988) raises the possibility of at least one bone mass measurement for all women at the time of the menopause to assess whether they have high, average, or low bone mass. This could identify those most at risk from osteoporosis—that is, those with a low initial bone mass. He further states that improvements in technology in the near future promise higher precision measurements with very much quicker scanning times.

For the moment, we feel it would be difficult to make a

convincing case for routine screening for osteoporosis but those at risk should be offered hormone replacement therapy. This is certainly an area to be watched in terms both of current research into diagnostic techniques and of the outcome of increasing uptake of hormone replacement therapy in menopausal women.

DIABETES

Diabetes is a major health problem in the developed world. It has been estimated that the incidence of the disease is now doubling every decade, and that although dietary habits may be partly responsible for this increase, the genetic factor is the most important one.

Screening for diabetes, however, suffers from two important limitations—the lack of an accurate and practical screening test and the absence of sufficient evidence that early detection and treatment improve outcome in asymptomatic people. The main forms of treatment for mild diabetes—modification of diet and exercise—are inexpensive and of considerable health benefit to an individual generally. In Britain there is no specific policy on screening adults for diabetes.

Recommendations against screening for diabetes in non-pregnant adults have been made by the Canadian Task Force (1979) and the US Preventive Services Task Force (1989). The latter's recommendation states

> In persons who are not pregnant, primary prevention rather than screening may be an important means of preventing diabetes and its complications.

Bennett and Knowler (1984) confirm that for the majority of subjects with undiagnosed non-insulin-dependent diabetes, evidence is lacking that early detection and intervention are beneficial in preventing complications or death. They concede that these recommendations may change in the light of various research projects currently underway.

Screening for gestational diabetes is discussed in Chapter 2. And screening in certain subgroups of the diabetic population can be of benefit. As Rohan, Frost, and Wald (1989) have shown in a recent assessment, screening diabetic patients for diabetic retinopathy does satisfy the main requirements for a worthwhile screening programme. A national screening programme could prevent over 200 new cases of blindness in those under the age of 70 years each year and an estimated 60 cases in those over the age of 70.

SUMMARY AND CONCLUSIONS

Screening in adult women includes the two national screening programmes for cancer of the cervix and the breast which illustrate many of the problems surrounding the whole concept of mass screening.

Cervical cancer screening has failed thus far for largely organisational reasons. As Johnson (1989) has pointed out, in a recent review of the literature, the success of the screening programme must depend on women's motivation to take part in the screening process and their acceptance of any subsequent medical procedures. Better management and careful monitoring of the system are required and changes to the current screening programme are essential to provide a service that can meet women's needs.

In a recent statement on the Edinburgh trial of screening for breast cancer, Roberts and colleagues (1990) reported a non-significant reduction in mortality from the disease after a follow-up period of seven years; only 61 per cent of the women initially invited attended for screening. The authors conclude

> The main value of our study may be to draw attention to the manner in which defects in a programme of screening can affect mortality reduction. These defects must be recognised and remedied if the UK breast cancer screening service is to produce a significant reduction in mortality from breast cancer in women in its target

population. If these defects were to persist we would only be spending resources recklessly and to little or no effect.

With the other conditions mentioned, osteoporosis is not a candidate for screening at the moment although with increasing health awareness in the public, improvements in technology available for measurement and diagnosis, and the probable benefits of hormone replacement therapy, those at risk should be encouraged to seek advice. Diabetes, while a major health problem and by no means confined to adult women, does not satisfy the criteria for screening.

In terms of screening in adult women, therefore, we would suggest that the emphasis at present should be on ensuring that the two major current screening programmes—for cervical and breast cancer—are effectively organised, administered, and evaluated, and that there is a positive and acceptable programme of appropriate health education to encourage women to look after their health and to support them in their efforts to do so.

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Chapter 2

Design of a Dutch study to test preventive home visits to the elderly*

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Summary

Preventive home visits to elderly people by public health nurses or health visitors aim to assess the functional abilities of aged persons in order to prevent or postpone health problems and institutionalization. There is as yet no consensus about the merits of such home visits in the Netherlands, partly because the empirical evidence is still weak.

This chapter presents the rationale and the design of a study on this subject in the Netherlands. It is argued that only a study with an experimental design, more specifically a parallel group randomized trial, can be informative. Next, the selection of the study population, methods of increasing the comparability at baseline, the choice of the contrasted interventions, and the outcome measurements are explained. These issues are discussed with reference to the designs of experiments conducted previously in Wales and Denmark.

Samenvatting

Preventieve ouderenbezoeken door wijkverpleegkundigen beogen gezondheidsproblemen en institutionalisering te voorkómen, dan wel uit te stellen. In Nederland bestaat discussie over het nut van dergelijke bezoeken, onder andere omdat de beschikbare bewijskracht uit (buitenlands) onderzoek nog gering is.

Dit hoofdstuk beschrijft de opzet van een onderzoek in Nederland naar de effecten van preventieve ouderenbezoeken. Eerst wordt betoogd dat een dergelijk onderzoek alleen zin heeft indien het wordt uitgevoerd in de vorm van een gecontroleerd experiment. Daana wordt ingegaan op de onderzoekspopulatie, de vergelijkbaarheid van de groepen bij de start van de studie, de interventies die met elkaar vergeleken worden en de effectmetingen. Deze keuzes bij de onderzoeksopzet worden toegelicht aan de hand van reeds eerder uitgevoerde experimenten in Wales en Denemarken.

Introduction

There is a growing interest in the effectiveness of geriatric assessment programmes (Rubenstein 1988, Kane 1988). In primary health care, medical screening for specific diseases seems to be disadvantageous (Frederiks 1986, Buckley and Williamson 1988). There are hardly any diseases to be found in aged persons which meet the criteria for screening. It is likely that the amount of needless disturbance and anxiety outweighs the positive effects in terms of case finding followed by successful treatment.

Instead of screening for diseases, assessment of the functional abilities of elderly people has been advocated. In this respect (repeated) assessment of the physical, mental and social functions is considered to be relevant. Public health nurses* and health visitors are well trained to assess these functions in elderly people living at home, and they can also give professional advice and guidance.

As in other countries, however, there is no consensus in the Netherlands as to the usefulness of such preventive home visits (van Rossum and Frederiks 1988). Those in favour claim it can add to the independence of elderly people, and prevent or postpone institutional care. Those opposed point at the privacy of elderly people, and emphasize that the home visits might lead to medicalization and thus to dependence.

Empirical research may be of help in settling the discussion. Its performance seems simple, but, if it is not well designed, the results are difficult to interpret. Generally, non-experimental studies in intervention research have little value. If health visitors can decide who will be visited and who will not, they will probably focus their attention on those elderly people who need the home visits most. As a result, there will be a clear prognostic incomparability between the contrasted groups ('confounding by indication'; Miettinen 1985), leading to biased results. It is an illusion to think that this can be smoothly corrected for with the help of data analysis techniques. Uncontrolled experiments also give rise to results that are uninterpretable. If all subjects receive the home visits, there is no contrast. Any improvement might be caused by the intervention, but also by other factors such as changing extraneous circumstances.

The performance of randomized trials is the only solution if one wishes to avoid these pitfalls. Among such trial designs, a cross-over experiment, such as was performed by Luker in Scotland (Luker 1981a and 1981b), again offers no satisfactory solution. Among other things, a carry-over effect is likely to occur in the second period of the cross-over.

For studies on the effectiveness of preventive home visits, only parallel group randomized trials make sense. By this we mean that the study subjects are randomly allocated to the experimental intervention or the control intervention (no, placebo or standard intervention), and that all participants are followed up simultaneously, measuring relevant outcomes. Fortunately, two such experiments have already been reported. One was performed in both a rural and an urban area in Wales (Vetter et al. 1984a and 1984b). The other was conducted in a suburb of Copenhagen, Denmark (Hendriksen et al. 1984). Both studies were of high quality and showed beneficial effects of preventive home visits.

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* Public health nurse ... he Netherlands execute the task of health visiting as well as that of home nursing care. A pre... ...ve home visit is the Dutch equivalent for a health visit.

In the Danish experiment the intervention was found to have reduced the mortality, the number of admissions to hospitals and nursing homes, and the medical care costs per subject. The use of home help and home nursing care had increased in the visited group. Data on several subjective measures, such as the quality of life, have as yet not been published. The results of the Welsh study were only partly consistent: reduced mortality in the urban area only, and a better functional status in the rural area only, while the subjective view of life seemed to have improved in both areas. No differences in the use of institutional care were reported.

It was felt that a replication was needed before definitive implementation of the preventive home visits in the Netherlands could be considered. In designing the experiment, we found it very helpful to discuss our study with the Welsh and Danish researchers. They gave us frank accounts of their experiences and, with hindsight, the drawbacks of their studies, and they encouraged us to perform a third experiment.

This chapter presents the design of the Dutch experiment, which aims to study the effects of preventive home visits on the health status and use of services by elderly people. A division is made into four sections: (1) study population, (2) comparability at baseline, (3) contrasted interventions, and (4) outcome measurements. The methodological choices will be explained with reference to the experiments in Wales and Denmark.

Study population

As in any other experiment, it is desirable to select as homogeneous a study population as possible. Compared to the previous studies, we decided to use stricter admission criteria (table 1). Partly based on the experience in these trials, it was thought that age could be an effect modifier, having its largest impact among elderly people between 75 and 84 years of age. Therefore, we restricted the study population to this age group. To avoid contamination by other nursing care beforehand, we excluded elderly people and their partners who were already receiving home nursing care at least once a week. Besides, home visits are not meant for these subjects, and it was also thought unlikely that the home visits could have any additional positive effects on these elderly persons.

The study was performed in Weert, a town in the south of the Netherlands, and some surrounding villages (60,000 inhabitants). This area was chosen, among other things, because of its clear system of services for the elderly. No major changes in the environment were expected and no other experiments among elderly people were in progress (or planned). Moreover, the municipalities and health care services showed a special interest in the study.

It is clearly advantageous to have baseline information about all participants in order to control comparability of the groups to be contrasted and for the measurement of changes of important outcomes. In the Welsh study interviews were used for this purpose. The Danish researchers, on the other hand, declined to perform a baseline measurement arguing (correctly in our opinion) that an interview resembles the intervention and that this may influence the control group (Hendriksen 1986). Advice and even referrals by the interviewer cannot always be precluded, and these are elements of the actual intervention. We solved this problem by using a postal questionnaire for our baseline measurement.

The questionnaire was sent out to every person between 75 and 84 years of age who was living at home (n=1,545). Among other things, the questionnaire dealt

with the admission criteria as well as relevant prognostic criteria (self-rated health, functional status, informal support and use of services). A covering letter explained what the goal of the experiment was and what was asked of potential participants. Those interested were invited to return the questionnaire and to sign their informed consent.

Table 1. Comparison of the study designs in Wales, Denmark, and the Netherlands: study population.

population	Wales	Denmark	the Netherlands
- type	healthy subjects	idem	idem
- recruitment subjects	rural: all 'patients' from a general practice urban: random sample of 'patients' from a general practice	random sample of the community	all subjects in area public health nurses association
- inclusion criteria	age 70 years or over, living at home	age 75 years or over, living at home	age 75-84 years, living at home
- exclusion criteria	no	no	home nursing care at least once a week
- baseline measurement	semi-structured interviews	no	postal questionnaire
- number of participants	n≈600 in each area	n≈600	n≈600
- assignment of treatments	unstratified randomization†	unstratified randomization†	stratified randomization†
- comparability groups at the start:			
- demographic	no differences	no differences	no differences
- prognostic criteria	no differences in functional status	unknown	no differences in i.a. self-rated health, informal support, use of home help; small difference in functional status

† Subjects living together were allocated together to one of the two groups.

The response was quite satisfactory: 85% (n=1,285) of the approached population returned the questionnaire.* Of these, 92% reported that they were willing to participate in the study. After exclusion of those elderly persons and their partners who were already receiving home nursing care, a random sample of 600 (out of 1,056) subjects could be drawn to form the study population.

This sample contained 20 persons who were found to live in a monastery. Because these subjects cannot be considered living independently at home (the monastery provides some domestic services for all inhabitants), we decided to exclude these subjects after all. Therefore, in the rest of this chapter, we will restrict the discussion to 580 participants in the experiment.

* Of the 1,545 persons who received a questionnaire, 26 appeared to have died or to have been institutionalized shortly before the questionnaire was sent out.

Comparability at baseline

It is a common approach in experiments to choose a study population and randomly allocate the subjects to the experimental or the control intervention. In this way, it is hoped to establish perfect prognostic comparability among the contrasted groups (no difference in outcome if the intervention does not work). However, due to random errors bias may easily occur (especially if the study population is not very large), unless extra precautions are taken. Therefore, it always makes sense to prestratify on important prognostic variables, in order to enhance prognostic comparability. Random allocation within each stratum now has to do with balancing the unknown or imprecisely measured prognostic variables. Properly measured but insufficiently balanced prognostic variables can be controlled for afterwards in a multivariate analysis.

Table 2. Distribution of some baseline measurements among the intervention and control groups.

characteristic		intervention group (n=292)	control group (n=288)
gender	male	42%	43%
	female	58%	57%
age	75-79	72%	73%
	80-84	28%	27%
composition of household	alone	39%	39%
	together	61%	62%
social class	low	27%	29%
	'medium'	61%	62%
	high	12%	10%
self-rated health*	0-5	20%	18%
	6-7	36%	37%
	8-10	45%	45%
functional status:**			
- ADL disabilities	0	91%	86%
	1-5	10%	14%
- household disabilities	0	38%	35%
	1-2	39%	39%
	3-5	23%	27%
use of home help	yes	19%	20%
	no	81%	80%
informal care available (if necessary)	yes	86%	88%
	no	14%	12%
contacts with GP in last 3 months	0-1	54%	56%
	>1	46%	44%

* For self-rated health, or perceived state of health, the participants were asked to rate their health status on a scale between 0 (poor health) and 10 points (excellent health).

** Functional status refers to ADL and household disabilities. With regard to ADL, 5 questions were asked, related to: walking stairs, bathing, dressing, rising from the bed, and using a normal toilet. As to the household activities, again 5 questions were asked, related to: shopping, cooking, laundering, making beds, and mopping/washing windows. For both ADL and household activities a score was computed for each participant between 0 (no disabilities) and 5 points (completely dependent).

With our postal questionnaire we measured many important prognostic variables. Among these, we chose to prestratify the participants on gender, composition of household, self-rated health, and social class (neighbourhood).* Randomization was performed by computer within each of the strata. After that, those elderly persons who turned out to have been allocated to the experimental intervention were once again randomly assigned to one of the three public health nurses who performed the home visits. In this way, our randomization procedure was far more precise than the procedures used in the Welsh and Danish studies, where prestratification was omitted (see table 1). The stratified randomization turned out to be quite successful; the distribution of almost all measured prognostic variables was equal among the contrasted groups (table 2).

Apart from the variables used for prestratification, there were no differences between the groups with regard to informal support, use of home help, frequency of social contacts and frequency of recent contacts with the general practitioner. Although we expected that the prestratification on self-rated health would also provide an equal distribution of the functional status of the elderly, it was found that, as an exception, the experimental intervention group scored slightly better on activities of daily living and household activities. However, this discrepancy can easily be corrected for in the data analysis.

Contrasted interventions

In accordance with the experiments in Wales and Denmark, it was decided to contrast the experimental intervention with no intervention, as our trial was primarily started as a replication of these studies. Hence, at this stage we did not choose to contrast the professional home visits with, for instance, home visits by volunteers. However, if home visits by public health nurses turn out to be effective, this possibility can be considered in a new experiment, which is to investigate the specific effect of professional versus nonprofessional preventive home visits.

For now, we can only guess at the possible effective element(s) of the home visit (e.g. quality of advice, referrals, a confidential relationship), since the visit is offered and investigated as a single package. Nevertheless, by carefully monitoring the visits we will try to shed some light on the mechanisms through which they might be effective.

Our intervention was largely a replication of the intervention in the Danish study (table 3). Participants were visited every third month for a period of three years. In this way the contrast between the interventions was much larger than in the Welsh study (two visits in two years). As in the Danish study the elderly persons could contact the nurse by phone every day to discuss problems or to ask for an extra visit.

The intervention was comparable to both previous studies as regards the following aspects. Each participant was visited by the same nurse during the entire study and the nurses were employed specifically to work on the study. In addition to the regular visits, extra visits could be paid if necessary. No physical examinations were performed during the visits. Instead, relevant topics were discussed with the subjects, information and advice were given and, if necessary, referrals to other services were made.

* Social class was not directly measured with the postal questionnaire. Instead, employees at the departments of social [illegible]rity of the municipalities rated each street as foremost low, 'medium', or high social class.

Table 3. Comparison of the study designs in Wales, Denmark and the Netherlands: interventions compared.

interventions compared	Wales	Denmark	the Netherlands
control intervention			
– active or inactive	no intervention (usual community care)	idem	idem
– concurrent or historical	concurrent	idem	idem
experimental intervention			
– duration	2 years	3 years	3 years
– schedule of visits	once a year	four times a year	four times a year
– fixed/flexible	extra visits if necessary	idem	idem
– ancillary "therapy"	no; if necessary, referrals are made	idem	idem
– intervention			
– performed by	one health visitor in each area	two health visitors and a physician	three public health nurses
– employment visitors	in care setting, specifically for study	idem	idem

Contrary to the previous studies (and partly based on the experiences gained in these studies), a checklist was used during the visit, instead of a problem sheet (Wales) or an incidentally used questionnaire (Denmark). The checklist contained relevant topics such as functional and mental status, social functioning, medication, status of sense organs, informal support and use of health services. In addition, guidelines for different topics were designed to enable the nurses to discuss topics systematically and to probe for underlying problems. However, these guidelines are not meant to standardize the home visits in detail.

An important difference with the Danish experiment was our decision to continue the visits if participants become institutionalized, and to include all subjects (living at home and institutionalized) in the outcome measurements. The latter in particular is of importance. If home visits prevent institutionalization, it is likely that in the visited group more people with functional incapacities will still be living at home after three years of intervention. If in the control group persons with an equal functional status have been institutionalized in the meantime, then outcome measurements restricted to people still living at home might lead to biased outcomes.

The control group was left 'untouched' during the intervention period (except for a postal questionnaire after one and a half years). However, the subjects in this group could use or apply for all the regular services in the area as before. The home nursing care organization in the research area agreed with our request that their nurses could pay no unsolicited visits during the experiment to participants of the study. By this, it was prevented that subjects in the control group would receive similar interventions as those in the intervention group.

Outcome measurements

The choice of relevant outcome parameters should be based on what the main goal of the intervention is supposed to be. This implies that the choice should not

necessarily be based on the precision with which certain measurements can be made (Feinstein 1977). Furthermore, if several outcomes are intended, it is desirable to distinguish a hierarchy in the importance of the chosen outcome measures.

We determined three categories of outcome measures, combining the measures chosen in the Danish and Welsh experiments. The primary interest in the experiment was the effects of the home visits on the health status of the elderly subjects, expressed in terms of (i.a.) self-rated health, well-being and functional and mental status (table 4). In addition, mortality was registered in both groups. However, we considered improving the quality, rather than the duration of life, to be the most important goal of the intervention.

As a secondary interest, data were collected on the use of health care and welfare services. This information was gathered to see whether the visits can indeed prevent or postpone institutionalization. These services included institutional care (hospital, nursing home, and home for the elderly), as well as the general practitioner, home help, and home nursing care. Thirdly, the cost effectiveness of the home visits was calculated for policy purposes.

Another important aspect of the outcome measurements involves the time interval(s) of the measurements. We copied the intervention period from the Danish study, expecting that three years would be a sufficient period of time to obtain convincing evidence as to the merits of the home visits. This expectation is strengthened by the results of the Welsh study, which had an even smaller contrast between the interventions. If preventive home visits turn out to be effective in our study as well, it would be interesting to see whether these effects last after the intervention period has ended. In the Danish trial the study population could be followed up for 2.5 years after the last intervention with respect to mortality and the use of services. The initial reduction of mortality was found to disappear during this period. The demonstrated trend of a reduction in institutional care (and hence a reduction in medical care costs), however, continued to be in favour of the group which had been visited.* We will perform a comparable follow-up of the study population after the intervention period has ended, although restricted to a period of one year.

We repeated the baseline measurement (postal questionnaire) halfway through and at the end of the intervention period. The response on both measurements was 97%. Because of the additional measurement halfway through the study, it was not only possible to analyze differences between the contrasted groups with respect to some of the primary outcome measures (self-rated health and functional status) at the end of the study, but also to analyze the changes over time.

Primary outcome measures that could not easily be measured with the postal questionnaires, i.e. well-being and indicators of mental status, were assessed during interviews at the end of the intervention period (response 92%). In addition, these interviews were used to obtain information on other health related measures, such as the use of aids, prescribed medication, and functioning of the sense organs.

The interviews were conducted by independent interviewers and not by the public health nurses (as was done in the Danish trial), to prevent information bias. Data on the use of services were, in contrast with the Welsh study, gathered concurrently (with the informed consent of the subjects). Although the data were collected concurrently, no separate analyses were performed for the two groups during the study. In this way, it was avoided that members of the research team

* This information has been obtained by personal communication with the Danish researchers.

Table 4. Comparison of the study designs in Wales, Denmark and the Netherlands: outcome measures and data collection.

outcome measures/ data collection	Wales	Denmark	the Netherlands
outcome measures			
- hierarchy in measures	no	yes	yes
- outcome measures	arbitrary sequence: - mortality - use of services - perceived status of life overall - functional status (ADL/household activities) - mental status (anxiety, loneliness, memory, depressive complaints)	1 use of services 2 mortality/cost effectiveness 3 'subjective' measures: (i.a.) - quality of life - loneliness - functional status	1 health status: - self-rated health - well-being - functional status (ADL/ household activities) - mental status (loneliness, memory, depressive complaints) - mortality 2 use of services 3 cost effectiveness
- drop outs:			
- percentage	1% (rural) and 2% (urban) refused outcome measurements	6% refused intervention or outcome measurements	2% refused intervention and 3-8% refused outcome measurements
- effects on results	probably small	probably small	probably small
data collection			
- subjects	all subjects	re 1/2: all subjects re 3: restricted to subjects still living at home	all subjects
methods	- interview	- interview - concurrent data collection on use of services	- interview - concurrent data collection on use of services - postal questionnaire
- observers	- independent interviewers	- visitors (visitors did not interview subjects of their own case-load) - co-operating services	- independent interviewers - co-operating services and researchers

influenced the intervention process by knowing interim results.

A brief outline of the Dutch experiment is presented in figure 1. By taking into account the experiences gained in the Welsh and Danish studies, we tried not merely to replicate but also to improve these studies. As discussed above, the main differences concern the stricter admission criteria, the baseline measurement, the random assignment of the interventions to the contrasted groups, an additional outcome measurement halfway through the study, the choice of the hierarchy of outcome parameters, and precautions to prevent biased measurements of primary outcome parameters.

An elaboration of the protocol, according to which the preventive home visits were carried out, will be discussed in chapter 3. The results of the experiment will be presented in the chapters 4 and 5.

Figure 1. Design of the Dutch study.

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